SOLOMON ISLANDS

GLOBAL AIDS MONITORING 2017

MONITORING THE 2016 UNITED NATIONS POLITICAL DECLARATION ON HIV AND AIDS

NATIONAL HIV/STI PROGRAMME
MINISTRY OF HEALTH AND MEDICAL SERVICES

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FOREWORD

During the 2016 High Level Meeting on Ending AIDS, Member States committed to end the AIDS epidemic as a public health threat by 2030, a key target for the 2030 Agenda on Sustainable Development, adopted by the UN General Assembly in 2015. At this meeting held 8th to 10th June 2016 in New York, United Nations Member States agreed to reach ambitious new targets by 2020, pledging to leave no one behind and end the AIDS epidemic as a public health threat by 2030. The 2016 UN Political Declaration on HIV and AIDS reaffirms previous commitments on HIV by the General Assembly made in 2001, 2006 and 2011, which initially led to a dramatic global decrease in new HIV infections and an unprecedented expansion of access to life-saving antiretroviral therapy – with over 17 million people on treatment by the end of 2015.

Solomon Islands welcomes the new Declaration, which endorses the target of ending the AIDS epidemic as a public health threat by 2030. It includes specific targets on HIV testing and treatment, so that 90% of people living with HIV know their HIV status, 90% of people diagnosed with HIV are put on antiretroviral therapy, and 90% of those on treatment achieve sustained viral suppression, with the aim of achieving dramatic reductions in new HIV infections, deaths and illness. WHO also welcomes the endorsement of global targets to tackle HIV and TB coinfection, and hepatitis B and C epidemics, as well as commitments to the dual elimination of mother-to-child transmission of HIV and syphilis.

This Political Declaration will enable Solomon Islands as a country to intensify and accelerate her National HIV response, to ensure that the national response is fully integrated into the broader Agenda for Sustainable Development, and ultimately to end the AIDS epidemic.

This report presents the country's progress made in achieving the commitments of the 2016 Declaration.

Thank You.

………………………………………………………..

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ACRONYMS AND ABREVIATIONS

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

MHMS	Ministry of Health and Medical Services
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men having Sex with Men
NCD	Non Communicable Diseases
NDS	National Development Strategy
NGO	Non Governmental Organisation
NHSP	National Health Strategic Plan
NMS	National Medical Stores
NRH	National Referral Hospital
NSP	National Strategic Plan
NTP	National Tuberclosis Programme
OI	Opportunistic Infection
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counselling
PLHIV	Persons Living with HIV
PNG	Papua New Guinea
PWD	Persons With Disabilities
PMTCT	Prevention of Mother To Child Transmission of HIV
PoC	Point of Care
PPTCT	Prevention of Parent To Child Transmission of HIV
PS	Permanent Secretary
PSC	Public Service Commission
RHC	Rural Health Clinic
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
RPR	Rapid Plasma Reagin
S4D	Sports for Development
SBD	Solomon Dollars
SGSS	Second Generation Sentinel Survey
SI	Solomon Islands
SIFHS	Solomon Islands Family Health and Safety Study
SIG	Solomon Islands Government
SINAC	Solomon Islands National AIDS Council
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberclosis
TPHA	Treponema Pallidum Haemagglutination Assay

UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USD	United States Dollars
VAW	Violence Against Women
VCCT	Voluntary Confidential Counselling and Testing
WB	World Bank
WHO	World Health Organisation

SUMMARY INDICATOR TABLE

Indicator	Value 2017	Source	Comments
COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020			
1.1 Percentage of people living with HIV who know their HIV status at the end of the reporting period	100%	Program reports	There are 13 PLHIV and they all know their status
1.2 Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period	76.9%	Program Reports	10 out of 13 PLHIV are on ART
1.3 Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	76.9%	Program Reports	The 10 PLHIV on ART have suppressed viral loads
1.4 Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period	76.9%	Program Reports	The 10 PLHIV on ART have suppressed viral loads
1.5 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 and <350 cells/mm3 during the reporting period	7.1%	Program Reports	1 patient who died in 2016 had a CD4 count <200 cells/mm3
1.6 Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period	0%	Program Reports	All PLHIV on ART accessed their medicines whenever due for refills
1.7 Total number of people who have died from AIDS-related causes per 100 000 population	2.3	Program Reports	A total of 14 people have died from AIDS related causes since the first case was discovered in 1994

Indicator	Value 2017	Source	Comments
COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018			
2.1 Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	60%	Program Reports	To-date, 5 children have been born to HIV positive mothers, 3 of whom have been tested at birth. No HIV exposed child reported in 2016
2.2 Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	0%	Program Reports	The 3 children tested at birth and 18 months were found HIV negative; 1 child died before being tested, and of the other two, were not tested. No HIV exposed child reported in 2016
2.3 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	0%	Program Report	Of all pregnant women tested in 2016, none was found HIV positive. NB only 13% (2,279 out of 17,293) were tested.
2.4 Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated	N/A	HMIS	Data not available at time of reporting
2.5 Percentage of reported congenital syphilis cases (live births and stillbirth)	N/A	HMIS	Data not available at time of reporting
COMMITMENT 3: Ensure access to combination prevention options, including			

Indicator	Value 2017	Source	Comments
pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners			
3.1 Number of people newly infected with HIV in the reporting period per 1000 uninfected population	2	Program Reports	2 new HIV positive cases were reported in 2016
3.2 Size estimations for key populations	N/A	N/A	Size estimations will be conducted in 2017
3.3a Percentage of sex workers living with HIV	N/A	N/A	IBBSS will be conducted in 2017
3.3b Percentage of men who have sex with men who are living with HIV	N/A	N/A	IBBSS will be conducted in 2017
3.3d HIV prevalence among transgender people	N/A	N/A	IBBSS will be conducted in 2017
3.3e Percentage of prisoners/inmates/detainees who are living with HIV	N/A	N/A	IBBSS will be conducted in 2017
3.4a Percentage of sex workers who know their HIV status	N/A	N/A	IBBSS will be conducted in 2017
3.4b Percentage of men who have sex with men who know their HIV status	N/A	N/A	IBBSS will be conducted in 2017
3.4d Percentage of transgender people who know their HIV status	N/A	N/A	IBBSS will be conducted in 2017
3.5a Percentage of sex workers living with HIV receiving antiretroviral therapy in the past 12 months	N/A	N/A	IBBSS will be conducted in 2017

Indicator	Value 2017	Source	Comments
3.5b Percentage of men who have sex with men living with HIV receiving antiretroviral therapy in the past 12 months	N/A	N/A	IBBSS will be conducted in 2017
3.5d Percentage of transgender people living with HIV receiving antiretroviral therapy in the past 12 months	N/A	N/A	IBBSS will be conducted in 2017
3.5e Percentage of prisoners living with HIV receiving antiretroviral therapy in the past 12 months	N/A	N/A	IBBSS will be conducted in 2017
3.6a Percentage of sex workers reporting using a condom with their most recent client	N/A	N/A	IBBSS will be conducted in 2017
3.6b Percentage of men reporting using a condom the last time they had anal sex with a male partner	N/A	N/A	IBBSS will be conducted in 2017
3.6d Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex	N/A	N/A	IBBSS will be conducted in 2017
3.7a Percentage of sex workers reporting having received a combined set of HIV prevention interventions	N/A	N/A	IBBSS will be conducted in 2017
3.7b Percentage of men who have sex with men reporting having received a combined set of HIV prevention interventions	N/A	N/A	IBBSS will be conducted in 2017
3.11 Percentage of sex workers with active syphilis	N/A	N/A	IBBSS will be conducted in 2017
3.12 Percentage of men who have sex with men with active syphilis	N/A	N/A	IBBSS will be conducted in 2017
3.13 HIV prevention and treatment programmes offered to prisoners while	N/A	N/A	IBBSS will be conducted in 2017

Indicator	Value 2017	Source	Comments
detained			
3.14 Prevalence of hepatitis and coinfection with HIV among key populations	N/A	N/A	IBBSS will be conducted in 2017
3.15 Number of people who received PrEP for the first time during the calendar year	N/A	N/A	IBBSS will be conducted in 2017
3.16 Percentage of men 15-49 that are circumcised	5.9%	DHS 2015	2,948 men aged 15-49 responded to have been circumcised
3.17 Annual number of males voluntarily circumcised	N/A	N/A	Not captured in DHS
3.18 The percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.	N/A	N/A	N/A
COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020			
4.1 Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV			
4.2a Percentage of sex workers who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	N/A	N/A	IBBSS to be conducted in 2017
4.2b Percentage of men who have sex with men who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced	N/A	N/A	IBBSS to be conducted in 2017

Indicator	Value 2017	Source	Comments
police harassment or arrest			
4.2d Percentage of transgender people who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	N/A	N/A	IBBSS to be conducted in 2017
4.3 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	N/A	N/A
COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year			
5.1 Percentage of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	N/A	N/A	N/A
5.2 Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods	N/A	N/A	N/A
COMMITMENT 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable			
8.1 HIV expenditure - Annex	US$641,180		In 2016 SIG allocated for the national response US$722,916 and spent US$641,180

Indicator	Value 2017	Source	Comments
COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights			
9. National Commitments and Policy Instrument – Annex	N/A	N/A	N?A
COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C			
10.1 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV	0	Program Reports	None of the 47 TB patients tested for HIV was found positive, and none of the 13 PLHIV presented with TB co-infection
10.2 Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care	0	Program Reports	None of the 13 PLHIV presented with TB co-infection
10.3 Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period	0	Program Reports	None of the 47 TB patients tested for HIV was found positive, and none of the 13 PLHIV presented with TB co-infection
10.4 Number of men reporting urethral discharge in the past 12 months	1,830	HMIS	Data complete only for Jan-Sept by time of reporting.

Indicator	Value 2017	Source	Comments
10.5 Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis	N/A	N/A	Syndromic management is used due to frequent stock-out of reagents
10.6 Proportion of people starting antiretroviral therapy who were tested for hepatitis B	0	Program reports	The 2 new cases in 2016 have not been started on ART
10.7 Proportion of people coinfected with HIV and HBV receiving combined treatment	0	Program Reports	No HIV and HBV coninfections reported
10.8 Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	0	Program Reports	The 2 new cases in 2016 have not been started on ART
10.9 Proportion of people coinfected with HIV and HCV starting HCV treatment	0	Program Reports	None of the 13 PLHIV were tested for HCV
10.10 Proportion of women living with HIV 30–49 years old who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid or vinegar (VIA), Pap smear or human papillomavirus (HPV) test	0	Program Reports	None of the 9 women living with HIV have been screened for cervical cancer using any method

1.0 INTRODUCTION

In June 2016, a new Political Declaration on HIV and AIDS: On the Fast-Track to accelerate the fight HIV and to End the AIDS Epidemic by 2030, was adopted at the United Nations General Assembly High Level Meeting on AIDS.

The new Declaration aims to broaden the HIV response, by imbedding it in the broader Agenda for Sustainable Development. It acknowledges the critical links between tackling HIV and a wide variety of other health and development issues and in the advancement of women and girls. By reaffirming the Agenda for Sustainable Development the Declaration not only calls for the end to AIDS but firmly links the HIV response to targets on ending the tuberculosis epidemic, combatting viral hepatitis and achieving universal health coverage. It recognizes the critical relationships that exist between poverty and development and HIV epidemics – noting that these broader development targets can only be achieved if HIV epidemics are addressed.

The Declaration calls for an expanded multisectoral response, a more comprehensive public health approach, even more ambitious HIV and development targets, a greater focus on equity and human rights, intensified action to address the needs of women and girls, and new approaches to ensure sustainable financing for HIV services.

It acknowledges the importance of WHO's recommendations on treating all people living with HIV and its guidance on evidence-based prevention services, particularly for key populations – those populations most at risk and affected by HIV. It makes reference to the World Health Organization Global Health Sector Strategy on HIV for 2016-2021, as a key tool for guiding the health sector contribution towards the multisectoral response to end the AIDS.

1.1 OVERVIEW OF THE COUNTRY EPIDEMIC AND DISEASE CONTEXT

1.1.1 The current and evolving epidemiology of the disease

The HIV prevalence rate in Solomon Islands has remained stagnant at 0.002% since 2010, with the latest study among 650 Ante Natal Care women in 2015 finding no HIV positive case. Solomon Islands has to date had 30 cumulative reported cases of HIV dating from 1994 to the end of 2016, with all but one of these cases having been identified since 2004, of which 2 of them were diagnosed in 2016. The figure below shows the number of cases reported per year, from 1994 to 2016, with the highest number of cases (four) being reported in 2004.

In Solomon Islands, Treatment, Care & Support (TC&S) services are available. Currently, 5/315 health facilities offer ART, including paediatric ART. These include National Referral Hospital (NRH), Helena Goldie Hospital, Gizo Hospital, Kilu'ufi Hospital and Lata Hospital. As at the end of 2016, the country had recorded a total of 14 AIDS related causes (8 males and 5 females), out of the total cumulative number of 30 cases reported since 1994. Of the remaining 16 cases, 13 (9 females and 4 males) are alive and in the country, whereas 3 (2 males and 1 female) are missing ie have been lost to follow-up because they were travellers / foreigners, and it is assumed that they returned to their countries. Although the most AIDS deaths have been among HIV patients detected in advanced stages of HIV disease, the risk of late diagnosis and premature death continues to be a problem due to the low HIV testing coverage and inadequate treatment management compounded by the limited laboratory capacity and equipment, which hampers effective patient monitoring. Intermittent availability of HIV testing kits also hampers the progress of increasing HIV testing coverage throughout the country.

With the rollout of the new HIV testing and treatment guidelines in 2016, Solomon Islands is now implementing the Test-and-Treat strategy to prevent AIDS related deaths among PLHIV. Therefore, all patients testing HIV positive are eligible for treatment despite their viral load or CD4 count. However, even with the very low numbers of HIV cases, not all people testing HIV positive are successfully enrolled and monitored in care and treatment, including ART. Patients continue to die due to non-response to treatment or adherence challenges. Some patients adamantly reject being enrolled in ART despite counselling by health workers. By the end of 2016, only 10 of the PLHIV in the country (3 males and 7 females) were receiving treatment; the remaining 3 PLHIV (1 male and 2 females) voluntarily were not on treatment, despite constant efforts to counsel them to be initiated on ART.

1.1.2 Country Risk Factors

Low HIV rates, but very high STI rates

While HIV rates are very low, very high STI rates in Solomon Islands reveal that the underlying behavioural risks are high, with a real potential for a future increase in HIV cases. Table (2) shows the results from routine testing in selected ANC facilities in 2014, which reveal very high rates of syphilis: the overall rate is 13.5 percent, with particularly high rates of 30.6 percent in Gizo, Western Province; and higher rates among the 15-24 year old group than in the 25+ group (15.8% vs. 11.8%).

Table 1: ***Number of ANC mothers tested and treated for syphilis in Solomon Islands in 2014***

SYPHILIS TESTING IN ANC, 2014 *(MHMS, HIV/STI Unit)*										
		TOTAL TESTED			TOTAL POSITIVE					
PROVINCE	Health facility	TOTAL	15-24	25+	TOTAL		15-24		25+	
HONIARA	NRH	5824	2488	3328	795	13,7%	415	16,7%	378	11,4%
WESTERN	HGH	629	262	367	86	13,7%	35	13,4%	51	13,9%
MALAITA	Kilu'Ufi	732	283	447	103	14,1%	54	19,1%	49	11,0%
CHOISEUL	Taro	271	119	152	1	0,4%	1	0,8%	0	0,0%
MALAITA	Atoifi	220	103	117	26	11,8%	12	11,7%	14	12,0%
WESTERN	Gizo	330	160	170	101	30,6%	38	23,8%	63	37,1%
MAKIRA	Kirakira	316	134	180	15	4,7%	7	5,2%	8	4,4%
TEMOTU	Lata	0	0	0	0		0		0	
TOTAL		8322	3549	4761	1127	13,5%	562	15,8%	563	11,8%

A study among young people in 2008 found high rates of chlamydia (males 10%; females 18%) and lower rates of gonorrhoea (males 4%; females 2%). Table (3) shows the findings from the same study, but among ANC women: high rates of hepatitis B (13.8%) and chlamydia (10.8%) *(MHMS, 2008).*

Table 2: ***STIs Prevalence among Antenatal Women, Solomon Islands, 2008 (MHMS, 2008)***

Prevalence of STIs among Antenal women, Solomon Islands, 2008			
	Tested	Positive	Rate
Trichomonas	189	34	18,0%
Hepatitis B	298	41	13,8%
Chlamydia	371	40	10,8%
Syphilis	296	10	3,4%
Gonorrhoea	371	5	1,3%
HIV	298	0	0,0%

Widespread high-risk sexual behaviours, including sex work and transactional sex
The high STI rates in Solomon Islands reveal underlying high-risk sexual behaviours, which have been confirmed by several behavioural studies among ANC women and youth. A study among youth in 2008 found that 16 percent of females and 19 percent of males had had *their first sexual contact before 15 (MHMS, 2008)*. Similar results were found in a study by UNICEF among mainstream and most-at-risk young people in 2009: 15 percent of all youth had first sex before 15; in Honiara this was considerably higher at 28.8 percent. The results revealed big differences in first sex before 15 between most-at-risk adolescents (52.4%); especially vulnerable adolescents (25%) and mainstream youth (4.5%), which shows the importance of differentiating between higher and lower risk youth for interventions *(UNICEF, 2010)*.

In the 2008 study among youth, more than half (52%) of the males and one-third (33%) of females had had *more than one sex partner in the last 12 months*, with an average number of partners of 3.8 for males and 2.6 for females *(MHMS, 2008)*. Furthermore, more than half (56%) of males and 41 percent of females had *concurrent sexual relationships (MHMS, 2008)*.
Low condom use

Several studies report low condom use among any population: results from a surveillance study among ANC women show that more than 10 percent had never heard of male condoms, while almost half (47%) had never heard of female condoms. Only half (53%) had ever used a condom, and 63 percent never used a condom in the past 12 months. The same study also included male and female young people, which showed higher condom use: 32 percent of males and 26 percent of females had used a condom at last sex. However, 38 and 42 percent of males and females respectively had never used a condom in the past 12 months. Most important reasons given for not using a condom included 'not easily available' (38%) and 'less pleasure' (21%) *(MHMS, 2008)*.

The 2009 UNICEF study which included adolescents and young people from different risk backgrounds reported condom use at last sex by 37.3 percent of all respondents, with higher percentages among males (42.3%) than among females (33.1%) *UNICEF 2010*. The study revealed interesting differences in *condom use at last sex* for different subgroups: *especially vulnerable* adolescents (54.5%), *most-at-risk* young people (48.8%) and adolescents (38.6%) used condoms more frequently than *mainstream* youth (33.8%), possibly reflecting greater sexual experience and skills. Condom use at last sex was also considerably higher among males (42.3%) than females (33.1%), possibly due to less negotiating power of girls with older sex partners. Age was another important factor, as condom use was considerably higher among young

people (20-24 years) (46.8%) than among adolescents (15-19 years) (31.1%) (*UNICEF 2010).*

Transactional sex and sex work

Several studies reveal that transactional sex and sex work are relatively common among young people. In the 2008 survey among young people,13 percent of males and 9 percent of females had engaged in transactional sex, receiving goods or favours for sex *(MHMS, 2008)*. In the bio-behavioural survey among ANC women in 2015, 2.1 percent of women reported they had received money or gifts in exchange for sex in the past 12 months *(MHMS, 2015b)*,

The UNICEF study in 2009 *(UNICEF, 2010)* among youth with different risk patterns – mainstream, most-at-risk and especially vulnerable – revealed that 12.4 percent of the total study population had had *sex for money*: almost one-fifth (18.7%) of females and 6.5 percent of males. Young people (20-24 years) engaged more in sex for money (15.1%) than adolescents (15-19 years) (10.1%). Commercial sex was much higher among youth in Honiara (23.3%) than in other provinces. A considerable proportion of youth also engaged in *transactional sex* – sex for gifts, goods or favours: 10.7 percent of the total population, with females 16.5 and males 5.2 percent. Alarmingly, two-thirds (66.1%) of those engaging in transactional sex had *not* used a condom at last sex *(UNICEF, 2010)*. *Reasons given for engaging in transactional sex* included 'need money' (60%), 'was forced' (11%), 'need food' (7.9%) and 'need drugs or alcohol' (3.2%) *(UNICEF, 2010)*.

Forced sex and gender-based violence

Apart from risk behaviours where partners have a level of control over condom use and other protection, *forced sex* leaves no room for protection, and therefore constitutes a key risk for HIV transmission, as well as other sexual and reproductive health problems, including unwanted pregnancy and psychological trauma. Studies on transactional sex reveal that part of this is forced sex (see above) *(UNICEF, 2010).*

Gender-based violence is a cross-cutting theme in most studies on HIV, STIs or reproductive health in the Solomon Islands. In the most recent survey among ANC women in 2015, 15.6 percent reported physical or sexual violence from male intimate partners in the past 12 months, with 6.3 percent reporting forced sex (past 12 months), while 12.3 percent reported 'ever forced sex' *(MHMS, 2015b)*. In the 2008 study among young people, almost half (48%) of female respondents reported 'ever forced sex', against one-quarter (25%) of males, most often by older males. Perpetrators of forced sex were mostly partners or 'friends' *(MHMS, 2008)*. The same

study also included ANC women, 29 percent of whom reported ever been forced to have sex.

The 2009 UNICEF study, which included sub-samples of most-at-risk and especially vulnerable adolescents and young people, showed even more worrying results: 38.1 percent of sexually active youth reported that they had been forced to have sex when they did not want to, with a large majority of 71 percent saying they were still vulnerable. The results showed stark variations across the different provinces, with more than two-thirds (68.3%) of youth in Choiseul reporting forced sex against 43.3 percent in Western Province; 30.4 percent in Malaita and 23.3 percent in Honiara *(UNICEF, 2010)*. Differences were even bigger among different groups of youth: 'mainstream' youth (17.3%), compared to most-at-risk adolescents (70.5%) and especially vulnerable young people (82.4%): these results show the need for accurate targeting of HIV/STI-prevention interventions, and the need to place these interventions in a wider perspective of sexual and reproductive health and rights, with *special attention for gender-based violence*.

Child trafficking and commercial sexual exploitation of children (CSEC)

A recent report gives further evidence of alarming types of sexual abuse, trafficking and sexual exploitation of children. It mentions that double standards attached to marriage and sexuality codes contribute to weaken women's intra-household bargaining power, thus reinforcing girls' and women's vulnerability to exploitation such as trafficking and commercial sexual exploitation. Findings from Choiseul Province in particular show an alarming influence of gender power relations involved in the recruitment of girls for transactional sex with logging workers *(Kojima et al, 2015)*. Logging sites and fisheries are mentioned as key risk areas for exposure to child trafficking and CSEC: children may go to logging or fishery sites to engage in vending or small jobs, and often get cash, alcohol or goods from foreign or local workers in exchange for running errands. So-called *solairs* are intermediaries who arrange local girls for foreign or fishery workers. Often, local girls working as house girls engage in transactional sex or forced sex.

Men who have sex with men

While several studies have looked into HIV, STIs and risk behaviours among ANC women or young people, very little research has been done among men who have sex with men (MSM). In the 2008 survey among young people, 0.8 percent of males (15-24 years) in Honiara reported sex with another man in the past 12 months *(MHMS, 2008)*. The UNICEF study among different types of youth in 2009 found only 5 respondents

out of 233 (2.1%) reporting sex with men in the past 12 months *(UNICEF, 2010)*. These percentages are not statistically significant, and may represent an under-estimate of the true proportion of MSM: homosexual acts are illegal in Solomon Islands, and there is strong societal stigma towards MSM, which may result in reluctance to report MSM behaviour in studies. As mentioned above, in the 2008 study among youth, 25 percent of males reported ever being forced to have sex, including by male perpetrators *(MHMS, 2008).* This may indicate that more men than commonly thought seek MSM sex, and may find it easier to force young men or boys into sex. Some programmes for MSM have been implemented in the last few years, but no HIV-related data has been collected and there is no documented evidence about their sexual risk behaviours.

1.2 STATE OF THE NATIONAL HEALTH SYSTEM & SERVICE DELIVERY

1.2.1 The Health Systems and Community Systems Context

The Human Development Index (0.51) places Solomon Islands 142 out of 187 countries, showing an overall low level of development (based on health, education and income). The Government is the main provider of health services in Solomon Islands and employs 97% of all health workers. The limited availability of skilled health personnel, infrastructure and financial resources, as well as the fact that health services that are not always responsive to the needs of society are a major challenge. Urbanisation in Solomon Islands is 20 percent and increasing at more than twice the overall rate of population growth. Government thus faces the twin challenges of continuing to service largely dispersed and often remote communities while also striving to respond to the pressure of urban growth. It is against this backdrop that disease control programmes have to be implemented. The Government also faces increasing pressures on the budget and revenue with a weak fiscal outlook.

1.2.2 Levels of Health Care

(1) Nurse Aid Posts (187) commonly located in remote areas and offer basic primary care, and public health and prevention services.

(2) Rural Health Clinics (102) offer the next level of care; they play a supervisory role to multiple Nurse Aid Posts within the same area, and arrange outreach activities.

(3) Area Health Centres (38) provide inpatient, outpatient, outreach and public health-care services to a wider population and act as referral facilities for a number of rural health clinics. Area Health Centres offer specific birthing facilities, as well as administration space and staff housing.

(4) Provincial Hospitals (8) are often the highest level of care logistically available; particularly to people residing in remote outer islands.
(5) The National Referral Hospital in Honiara provides the highest level of tertiary care and is staffed by local clinical specialists and also visiting specialists from overseas.

1.2.3 Human Resources for Health

Government is the main provider of health services in the country and employs 97 per cent of the country's health professionals. In 2013, Solomon Islands Government (SIG) employed 1,827 health workers of which 5.9 per cent were doctors, 44.3 per cent nurses and 5.9 per cent nurse aides. With 1.71 health workers (doctors, nurses and midwives) per 1,000 population this is well below the WHO minimum threshold of 2.3 workers per 1,000 population. Women make up 66.6 per cent of nurses and nurse aides but only 20.6 per cent of doctors. Almost all executive positions in MHMS are held by men, as are all nurse leadership positions. Male dominated leadership cuts across Solomon Islands political, cultural and religious domains (Thomas et al, 2014).

The uneven distribution of health workers across the country impacts on access to services and quality of care. Skilled health workers are concentrated in Honiara where only 12.5 per cent of the population live, and continuing migration of health workers to Honiara is likely to deepen the imbalance. In 2013, the doctor: population ratio was 1,319 in Honiara and 18,929 in rural areas; the nurse: population ratio was 305 in Honiara and 885 in rural areas. Human resources are also inequitably distributed across the provinces (Thomas et al, 2014).

The concentration of medical and specialist health staff in Honiara fuels high referral costs for the health system as well as adding strain on family incomes as people have to cover time away from their livelihoods, and living expenses while in Honiara. It also encourages by-passing of primary health-care facilities, increasing the cost to the system of delivering primary level care, as well as the out-of-pocket spending users make on services that could be provided closer to home. The Government's commitment to free health services does not incentivise care seeking at lower levels of the service delivery chain and as demands for hospital level care increase, this may put further pressure on the National Referral Hospital (NRH) (Thomas et al, 2014).

Poor working conditions, lack of, or poor quality accommodation and lack of school opportunities for children in rural areas increasingly discourage staff from taking rural and remote postings as expectations rise. Unattractive remuneration packages and limited support provided to health workers further add to the low morale

reported. Absenteeism and the difficulty in retaining staff in rural areas was recognised by all stakeholder groups; leaving some areas underserved. Weak supervision throughout the health system partly linked to high transport costs, lack of funding and low prioritisation, contributes to the problem of absenteeism (Thomas et al, 2014).

1.2.4 Essential medicines

As with many other countries in the region, Solomon Islands faces some difficulties in accessing essential medicines. There are no existing drug manufacturers in the country and pharmaceuticals are imported from foreign wholesalers and manufacturers in Australia, New Zealand, Japan, the United States and Singapore. Some medicines transit by Fiji as a regional hub. This affects the health system as a whole and HIV control is part of it. The availability of essential medicines nationally and provincially has increased dramatically over the past seven years. The availability of 447 essential medicines at the national level has increased from just 47 per cent in 2007 to 93 per cent in 2014. This is double the global average of 46 percent availability for public sector medicine. Availability of critical items at the Stores' 14 provincial medical stores have also more than doubled to 88 percent and 73 percent at the country's 310 rural health clinics.

1.2.5 Health planning and budgeting

SIG spends more than 10 percent of its domestic budget on the health sector and this is not expected to change. A 2010 analysis found that more than 40 percent of the budget was spent on primary health-care facilities and provincial hospitals, and 30 percent on NRH. This represents a modest proportion of the funding for primary care given the primary health-care emphasis of the service. The 2013 independent performance assessment of the Health Sector Support Programme (SWAp) found that 36.4 percent of the 2013 sector budget allocation was allocated to the provinces; increasing the share of provincial grants is one of the objectives of HSSP. Provincial budgets are used to hire direct wage employees and fund outreach and supervision activities, which are essential for increasing access to services. Budget constraints at the provincial level are commonly reported to result in cancelled outreach and supervision, and inhibit access to services of those living in remote and difficult to reach areas (Thomas et al, 2014).

A comparison of health spending for the different provinces shows an uneven distribution: e.g., Guadalcanal and Malaita, the two provinces with the largest populations, received a lower percentage allocation of the total provincial budget than their share of the total population. Looking at the headline budget allocations for

technical divisions in 2014, the allocations for vector-borne disease control and environmental health are significantly greater than all other technical programmes. Taking Reproductive and Child Health as a benchmark, vector-borne disease control receives twice as much funding, and environmental health almost three times as much. In contrast, given the reduced incidence of malaria, and the similar magnitude of deaths per year from malaria and maternity, the large investment in vector-borne disease control seems out of proportion. This is particularly so when we see the low level of funding to non-communicable disease which is the number one killer in the country (Thomas et al, 2014).

1.2.6 Health Services Delivery

A survey in 2006 found that nearly 87 percent of people sought care when ill (compared to 60-70% in low-income countries in East Asia and the Pacific). Of those who sought care, 85 percent went to a public sector provider and 4 percent to a private sector provider (mostly in Honiara); only 3.5 percent went to traditional healers (Maike, 2010). The private sector plays a very minimal role in health. There are four private hospitals, owned and operated through various church organisations. There is a small number of private sector medical clinics in Honiara and some private practice at the NRH and church hospitals.

Various factors combine to prevent or delay a visit to a clinic, including inaccessibility of transport, misdiagnosis, and self-medication. Travel logistics and costs are a major barrier to accessing services given rugged terrain, the large catchment area of some clinics, the high cost of petrol, variable income, unpredictable weather, poor road conditions, among others. Transportation costs are highest for villages that generally rely on outboard motor boats to access clinics. While there is a formalised referral system in place, it is not well adhered to by patients or health-care workers in the provinces, with many people bypassing provincial hospitals and going directly to the NRH for care. This is also due in part to the available transportation routes that make it easier to reach Honiara.

A number of health clinics requires significant upgrade, repair or renovation. The degradation of health facilities has happened over many decades, and while some have been damaged by cyclones and other natural disasters, most are not properly and regularly maintained. Recently a flooding disaster occurred in Solomon Islands in Honiara and Guadalcanal province (GP) in particular. The flash flood had significant impact on the health systems as well as on the environmental and socio-economic situation, with the loss of livelihoods. Several health facilities in Honiara City Council (HCC) and GP as well as the National Referral Hospital (NRH) at the central level have

sustained severe damages. A significant number of health facilities are without water or toilets with little implementation of infection control procedures as there is a significant number of facilities without sterilisers and appropriate medical waste disposal.

1.2.7 Health Information System

The health information system is under development and many improvements have been made over the past couple of years, including the preparation of annual statistical reports disaggregated by province and facility, and the preparation of the "Core Indicators Report". The latter benchmarks progress made against the National Health Strategic Plan that is the policy platform of the SWAp. However, gaps in reporting remain with estimates of 60 percent and 85 percent of reports being submitted in 2011 and 2012. Evidence gaps have also arisen due to the long time lag between DHS; the last was in 2007 and the next is due in 2014. No health focused household sample survey of a similar breadth and rigour has been undertaken in-between. Similarly there has been a long gap between household income and expenditure surveys, 2005/6 being the last one; and the next not due until 2014. The result has been a long period without accurate disaggregated evidence of key health outcomes and behaviours (Thomas et al, 2014).

The data that is being collected by facilities is reported up to provincial and national levels, but is often not used at the local level for provincial and facility-based planning and monitoring. In turn, there is a lack of geographic and context-specific planning. Further analysis is needed to find out how collection and use of this data could be improved, and potential integration of additional health information such as disability. There is a legal requirement to report all births and deaths in the Solomon Islands, but the system is outdated, time-consuming and costly as it requires the reporting person to visit Honiara. With support from UNICEF, the birth and death registration system became electronic in December 2012 but the Ministry of Home Affairs has not been able to devolve this responsibility to provinces so people still have to travel to Honiara (Thomas et al, 2014).

1.2.8 Governance, Policy and Coordination

Most signature authority remains at the central MHMS and most managerial capability remains concentrated in Honiara. Most substantive programmes are planned and managed from Honiara with little or no input from the provinces and many of these programmes' operations in the provinces are carried out with minimal provincial advance coordination – particularly the vertical programmes with major international funding.

Most organisational functions are operated in a very ad hoc manner – the development of systems and good system operation has not been a priority. When a different person takes over the charge of a programme or organisational unit, the programme's or unit's activities and modus operandi may change completely– not being dependent on any past system – unless there is international assistance with a tightly defined work plan. The main system weakness is its capacity to use limited resources efficiently especially a weakness in assessing the full costs and implications of the offer of external support.

1.2.9 Community systems

Community systems in Solomon Islands are strongly developed: traditional leaders and structures continue to play a key role in local decision making. Churches and faith-based organisations are well-organised and have a presence in all parts of the country, including remote rural areas. However, there are no formal functioning mechanisms for community participation in the delivery or management of health services in the Solomon Islands, although there is provision for Health Boards. There are few examples of citizen-led social accountability with most advocacy being driven by CSOs. Participatory planning is not well established in government, and recent efforts by the RWASH program to involve communities in the planning of water systems have struggled to negotiate space for women.

Church organisations and groups, village elders, and youth groups are key vehicles for promoting demand for services and behaviour change. The involvement of community-based structures and organisations is central to mobilising support for increased access to health services, addressing issues related to gender equity, gender-based violence and social inclusion. The existing relationships between non-state actors and communities to address the determinants of health and increase access to services, provide government with a platform to strengthen its partnerships with communities for more equitable and inclusive health (Thomas et al, 2014).

1.2.10 Equity Considerations

The previous section described the epidemiological context for HIV and STIs, as well as the key populations at risk of HIV infection, and other vulnerable populations with an increased risk of HIV infection. While the HIV vulnerability of these key populations is associated with specific risk behaviours, including unsafe sex with multiple partners, their vulnerability is often closely linked to *underlying social, economic and psychological factors*, which may also hamper their access to health and social services, including HIV-prevention and treatment services. A number of factors contribute to

disproportionately low access to prevention and treatment services for key populations.

The main reasons are:
1) The *lack of specific services and interventions* that are tailored to their needs and characteristics.

2) The *non-conducive social, cultural and legal* environments hampering access to HIV-prevention and other health services for key populations. The nature of Solomon Islands with a relatively small population – with most people living on small islands or in small communities, comes with very strong social control and limited possibilities to avoid societal expectations regarding traditional male and female gender roles.

3) In addition, due to the small population sizes and the long distances between islands and associated high transport costs in Solomon Islands, the *availability and accessibility of services is limited*, and physical access to prevention and treatment services may be difficult, particularly among rural populations and on outer islands. Other barriers include lack of funds to pay for transport and health-service fees: e.g., peri-urban communities in Honiara have to take two or three buses to reach a primary health-care centre and then spend the best part of the day in line waiting to see a nurse *(Thomas et al, 2014).*

Men who have sex with men (MSM) and male-to-female transgenders:
In Solomon Islands homosexuality men who have sex with men are little accepted, if not (culturally, morally and religiously) rejected. In addition, sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. MSM and transgenders are particularly hard-to-reach populations, as the majority will avoid seeking any specific services targeting MSM, for fear of being identified as "homosexual" by their families or the community. This is further compounded by self-stigma and low self-esteem among many MSM.

While some interventions were implemented for MSM in the past with support from the Response Fund, specific services targeting MSM are very limited, with only NGO still working with a very small number of MSM. In the virtual absence of MSM-specific programmes, very few are reached with HIV/STI-prevention services, including HIV testing. These low HIV-testing coverage rates may hamper early detection and timely access of MSM to ART, as well as treatment-as-prevention (TAsP) approaches. Compounding the self-stigma among MSM, *negative attitudes* towards MSM *in the health-care sector* may further hamper their access to health services such as STI

treatment and HIV testing, as MSM may avoid these services due to negative staff attitudes. In addition, non-acceptance by society may lead to low self-esteem among young MSM, which can lead to unhealthy behaviours associated with low control of sexual risks.

***Female sex workers and (young) women and girls engaging transactional sex – and their clients*:**
As mentioned in the previous section (1.1a), commercial sex work as seen in other parts of the world – e.g. brothels, street-based sex work, pimps – is much less present in Solomon Islands: few women engaging in sex work will self-identify as "sex workers". Rather, women and girls engage in transactional sex, providing sexual services in exchange for money, goods, food and alcohol, or other types of in-kind compensation. While unemployment and economic problems may be the main reason for engaging in transactional sex, girls and young women may also engage in sex in exchange for luxury goods or free entertainment. While HIV-prevention programmes for sex workers were supported in the recent past by the Response Fund, and some of those activities continue at a small scale in Honiara, few specifically target the many young women and girls engaging in transactional sex. Furthermore, *criminalisation* of sex work hampers the availability and accessibility of these programmes. Both selling sex as well as owning a brothel or "aiding or abetting" prostitution for personal gain are illegal under Section 153 and 155 of the Solomon Islands Penal Code. The current legal ground creates challenges for accessing sex workers for prevention and surveillance purposes. High STI rates among young women (and men) and among antenatal women, as well as high teenage-pregnancy rates reveal the widespread underlying risk behaviours of these women and girls.

In addition, existing reproductive and sexual health services – including HIV testing – predominantly target pregnant (often married) women. Access to reproductive health, STI treatment and HIV-testing services is much more limited for *young* women and men: While there is a limited number of *youth-friendly clinics,* mainly in the main towns of the different provinces, in most other locations young people may feel uncomfortable accessing SRH services in small island spaces, or be denied access to certain services altogether due to their young age. Hence, future programmes need to be better tailored to the needs of these young women and girls engaging in transactional sex, and their clients. Youth-friendly clinics were introduced by Save the Children and World Vision: an evaluation of these facilities in 2010 *(Save the Children et al, 2010) showed* that these clinics provided higher quality care through successful training of nurses in youth-friendly approaches. Improvements included better accessibility, privacy, confidentiality and convenience: these are key requirements to increase uptake of these services by key populations such as sex workers and MSM.

Those living in underserved areas i.e. people who live more than 10 Kilometres from a health facility and people living in remote locations:

Being a large scarcely populated and remote island state, Solomon Islands faces the issue of delivering health services in a difficult and high transport cost environment. Transportation between the country's many islands is mainly by ferry, outboard motorboat or canoe with limited and expensive interisland flights. The average distance a patient must travel to get treatment at the National Referral Hospital is more than 240km, with a range of 40-600km. Furthermore, these populations are more likely to have very low level of literacy and may have cultural and social traditions that could prevent them for seeking/accessing TB care. These populations also include marginalised ethnic groups, ethnic minorities, indigenous people and tribal communities. The size of these populations is substantial as most of the population in the country is highly dispersed and rural.

People living in urban informal settlements:

In the 2009 census, almost 20 percent of the country's total population lived in urban and peri-urban areas. However, with an annual urban growth rate of 4.7 percent, it is projected that, by 2020, about 25 percent of the country's population will be living in urban areas, as urbanisation is increasing at more than twice the overall rate of population growth. Urban growth is perceived as the cause of increased poverty, unemployment, and crime, as well as environmental degradation, high socio-economic inequality, and growing informal settlements which lack access to basic urban services. Approximately 35 percent of Honiara residents (22,600 persons) live in 52 informal settlements across the city *(Solomon Islands Government, 2011).* People living in urban informal settlements have potentially low levels of knowledge about HIV/STIs and less access to health-care services. This population includes at risk categories such sex workers and people with (excessive) alcohol and drug use, with further risk as a result of overcrowding in a geographical area with high population density and low housing standards. The population has also greater risk of malnutrition, diabetes and smoking. Gender inequalities and gender based violence are a common issue.

***Mobile male populations*:**

This group is at particular risk of HIV and STIs, as they are often away from their communities for extended periods of time. Research has shown that mobile men working in logging camps, mining camps or the fishing industry often engage with sex workers ot local women and girls engaging in transactional sex. A study in 2015 found that foreign and local workers at logging camps in Choiseul created a strong demand for local girls to engage in sex work *(Kojima et al., 2015).*

1.3 HIV POLICY DEVELOPMENT AND IMPLEMENTATION

1.3.1 National Strategic Plan 2014 - 2018

Solomon Islands updated its National Strategic Plan (NSP) for HIV & STIs in 2014 to run through 2018. The NSP was implemented in draft from until mid-2015 when it was finalised, with a completed operational plan and budget.

Key goals and Objectives of NSP

The NSP has an overarching goal which focuses on 1) Halting the spread of HIV so as to maintain the current very low HIV prevalence, and reducing HIV/AIDS-related mortality; with nine strategic objectives to achieve this goal.

Objectives of the NSP are as follows:

1. By 2018, to increase access to evidence-based HIV prevention in Solomon Islands
2. By 2018, to improve access, availability and effectiveness of HIV and STI testing and counselling services
3. By 2018, to maintain effective universal coverage of HIV treatment and increase access to quality care and support services for PLHIV
4. By 2018, to improve provision of quality, comprehensive case management of STIs
5. By 2018, to enhance capacity and engagement of leaders from multiple sectors at the national, provincial and community levels, and to encourage an environment which enables a comprehensive national HIV and STI response
6. By 2018, to enhance and strengthen the national strategic information, monitoring and evaluation system
7. By 2018, to strengthen governance, funding and coordination mechanisms towards a more effective, multi-sectoral contribution to the national HIV and STI response
8. By 2018, to ensure the national HIV and STI response is founded on principles of gender equity.
9. By 2018, to establish and maintain an environment in which PLHIV and vulnerable groups are enabled to live their lives free from stigma and discrimination.

Financial and technical support from the Solomon Islands Government (SIG), bilateral donors such as the Australian Department of Foreign Affairs and Trade (DFAT), multilateral donors such as GFATM, and UN agencies such as UNICEF, WHO, and UNFPA; has allowed the partial implementation of the NSP. This has mainly resulted in achievements at the programmatic level, while achievements at the outcome and impact level are more difficult to demonstrate and quantify.

This notwithstanding, it is difficult to identify the main outcomes and impact of the national response to date: while the limited available HIV-prevalence data seem to indicate continued very low HIV rates in the country, it is not clear to what extent this can be attributed to the programmes and services that have been implemented to date: coverage of HIV-testing services is still limited, several HIV cases may still go undetected. Furthermore, high to very high STI rates even among pregnant women and young people reveal the presence of high-risk sexual behaviours, including low condom use, which may also contribute to a future increase of HIV infection. Nevertheless, positive results can be seen in the high overall awareness and general knowledge of HIV/AIDS, although more specific knowledge on prevention methods is less widespread.

1.3.2 National HIV Legislation

Solomon Islands as a country a number of unfriendly HIV discriminatory laws and regulations, as elaborated in depth later in this document, which affect the rights of people living with HIV, or those of particular groups vulnerable to HIV infection such as sex workers and men having sex with men. However, it does have in its Constitution in Section 15 ample provision for discrimination, which protects its citizen from any form of discrimination. An HIV Legislative Task Force was established in 2009 to analyse legislative gaps and examine legal reforms towards addressing these, however the progress of this group is unknown. The HIV Legislative Taskforce in its May 2012 workshop developed a Draft HIV Management and Prevention and Control Legislation and also produced a Cabinet Paper to guide the request for a HIV Bill, which would be passed through the Ministry of Health and Medical Services for further review and tabling of a Bill in the next Parliamentary Session. However, as at December 2016, no further progress has been achieved in this regard.

1.3.3 National HIV Guidelines

a) National Consolidated Guidelines on the use of ARVs - 2016

In 2016, the country updated the National Consolidated guidelines for the use of ARVs for preventing and treating HIV infections among children, adolescents and adults. Initially, the country was using the 2013 WHO guidance, before updating in 2015 and later in 2016 following the release of new guidance from WHO in 2015 and 2016. The guidelines were developed based on the latest WHO guidance with regard to the use of ARVs for treatment and prevention of HIV among adults, adolescents and children, as well as guidance on the management of common co-infections and co-morbidities in the context of HIV.

The guidelines are ambitious in their expected impact, yet simplified in their approach, and firmly rooted in evidence. They take advantage of several recent global

trends, including a preferred treatment regimen that has been simplified to a single fixed-dose combination pill taken once per day, which is safer and affordable. The guidelines also take advantage of evidence demonstrating the multiple benefits of antiretroviral therapy. With the right therapy, started at the right time, people with HIV can now expect to live long and healthy lives. They are also able to protect their sexual partners and infants as the risk of transmitting the virus is greatly reduced. They bring clinical recommendations together with operational and programmatic guidance on critical dimensions of treatment and care, from testing through enrollment and retention, and from general HIV care to the management of co-morbidities.

b) National Guidelines for HIV Testing Services – 2015

The country also updated the National Guidelines for HIV testing Services in 2015 in line with the July 2015 WHO guidelines. The guidelines provide a new recommendation to support HTS by trained lay providers, considers the potential of HIV self-testing to increase access to and coverage of HIV testing, and outlines focused and strategic approaches to HTS that are needed to support the new UN 90–90–90 global HIV targets – the first target being diagnosis of 90% of people with HIV

c) National Guidelines for the Comprehensive Management of STIs – 2016

The country has developed National Guidelines for the Comprehensive Management of Sexually transmitted Infections (STIs) in the country. In these guidelines, the Ministry of Health and Medical Services (MHMS) issues guidance for prevention and treatment of STIs among the people of Solomon Islands, and caters for all population groups including pregnant women, adolescents, children and key populations. The guidelines have been developed in line with the latest WHO guidance 2016. In 30 August 2016, WHO released new guidelines for the treatment of 3 common sexually transmitted infections (STIs), in response to the growing threat of antibiotic resistance. Chlamydia, gonorrhoea and syphilis are all caused by bacteria and are generally curable with antibiotics. However, these STIs often go undiagnosed and are becoming more difficult to treat, with some antibiotics now failing as a result of misuse and overuse.

2.0 COUNTRY PROGRESS AGAINST COMMITMENTS OF THE 2016 UN POLITICAL DECLARATION ON HIV AND AIDS

2.1 **Commitment 1:** Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

2.1.1 Number of people living with HIV and HIV prevalence

Solomon Islands has to date had 30 cumulative reported cases of HIV dating from 1994 to the end of 2016, with all but one of these cases having been identified since 2004, of which 2 of them were diagnosed in 2016. The figure below shows the number of cases reported per year, from 1994 to 2016, with the highest number of cases (four) being reported in 2004.

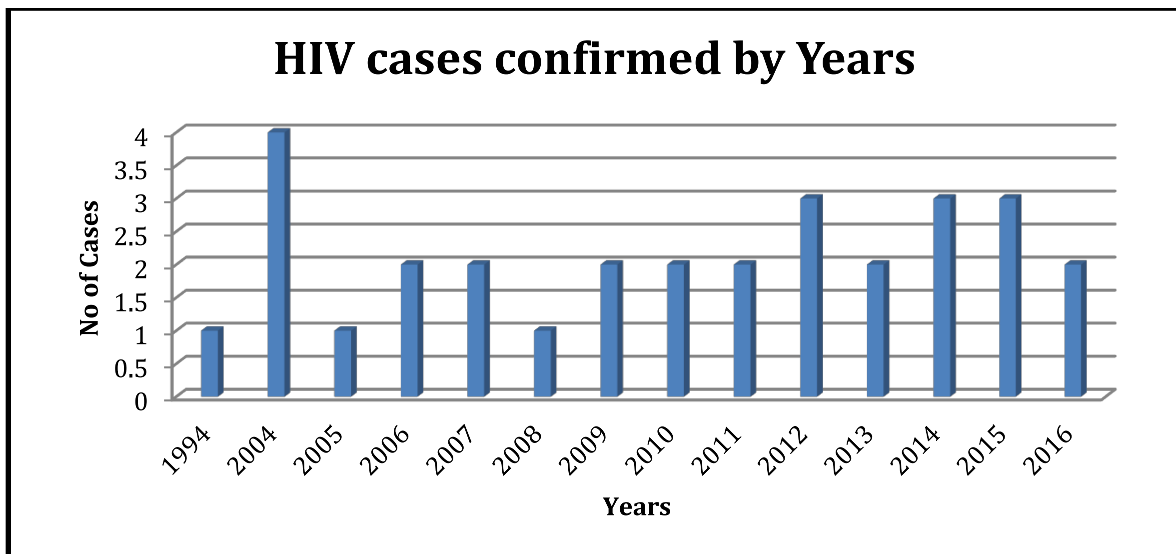


Figure 1: showing Number of HIV cases reported per year: 1994 - 2016

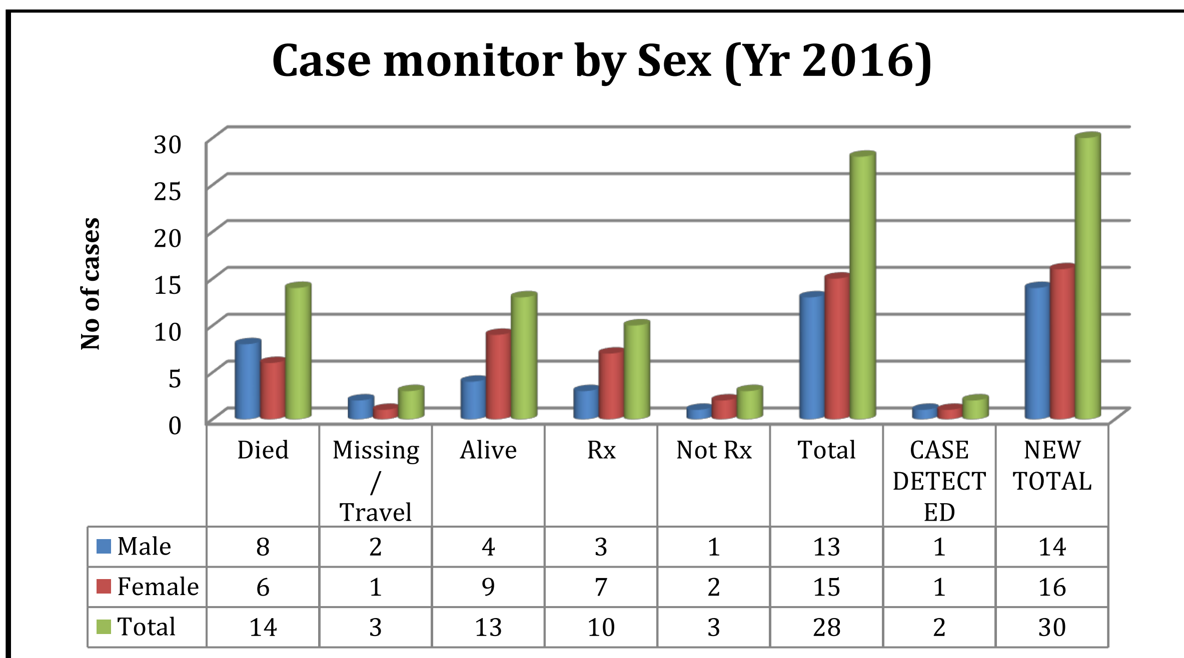
As at the end of 2016, the country had recorded a total of 14 AIDS related deaths (8 males and 6 females), out of the total cumulative number of 30 cases reported since 1994. Of the remaining 16 cases, 13 (9 females and 4 males) are alive and in the country, whereas 3 (2 males and 1 female) are missing ie have been lost to follow-up because they were travellers / foreigners, and it is assumed that they returned to their countries.

2.1.2 People living with HIV on antiretroviral therapy

In Solomon Islands, Treatment, Care & Support (TC&S) services are available. Currently, 5/315 health facilities offer ART, including paediatric ART. These include

National Referral Hospital (NRH), Helena Goldie Hospital, Gizo Hospital, Kilu'ufi Hospital and Lata Hospital.

With the rollout of the new HIV testing and treatment guidelines in 2016, Solomon Islands is now implementing the Test-and-Treat strategy to prevent AIDS related deaths among PLHIV. Therefore, all patients testing HIV positive are eligible for treatment despite their viral load or CD4 count. However, even with the very low numbers of HIV cases, not all people testing HIV positive are successfully enrolled and monitored in care and treatment, including ART. Patients continue to die due to non-response to treatment or adherence challenges. Some patients adamantly reject being enrolled in ART despite counselling by health workers. By the end of 2016, only 10 of the PLHIV in the country (3 males and 7 females) were receiving treatment; the remaining 3 PLHIV (1 male and 2 females) voluntarily were not on treatment, despite constant efforts to counsel them to be initiated on ART.



	Died	Missing / Travel	Alive	Rx	Not Rx	Total	CASE DETECTED	NEW TOTAL
Male	8	2	4	3	1	13	1	14
Female	6	1	9	7	2	15	1	16
Total	14	3	13	10	3	28	2	30

Figure 2 showing the cumulative AIDS mortality, and patients on treatment.

Although the most AIDS deaths have been among HIV patients detected in advanced stages of HIV disease, the risk of late diagnosis and premature death continues to be a problem due to the low HIV testing coverage and inadequate treatment management compounded by the limited laboratory capacity and equipment, which hampers effective patient monitoring. Intermittent availability of HIV testing kits also hampers the progress of increasing HIV testing coverage throughout the country.

2.2 **Commitment 2:** Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

2.2.1 Early Infant Diagnosis

Early infant diagnosis remains a challenge in Solomon Islands, mainly because of the low coverage of HIV testing services. Access to HIV testing services remains low, not only among pregnant women, but also among the general population at large. Only 13% and 15% pregnant women accessed HIV testing and knew their results in 2015 and 2016 respectively, leaving a big gap of uncertainty in the HIV status of several newborn babies in Solomon Islands.

In 2015 and 2016 UNICEF supported the MHMS to introduce early infant diagnosis of HIV through procurement of EID viral load cartridges, for testing using the GeneXpert Machnine, to help ensure HIV-positive babies are started on life- saving treatment as soon as possible. Although since the introduction of this service, not HIV exposed baby has been reported in the country, the introduction of the service, and availability of the supplies and testing technology in the country is a major accomplishment towards elimination of Mother To Child Transmission of HIV.

Previously, blood samples were sent to Australia for testing. As facilities usually waited until they had a complete batch of samples before dispatching them, there were significant delays. In many cases, the tests were not performed or the wait was several months long. This had detrimental effects on the health of the children, as without treatment half of all children born with HIV will die by the age of two and the majority will die by the age of five. The introduction of early infant diagnosis is considered an important step in the HIV response in the country. The service is to be closely monitored to inform future roll out in other Pacific Island Countries.

2.2.2 Pregnant women who were tested and treated for HIV and Syphilis

HIV:

The SGSS conducted in 2015 among 650 pregnant women in eight provinces about 14.1% antenatal women reported that they had 'ever been tested' for HIV and nearly half (7.6%) tested in the past year thus suggesting that access to HIV testing was low in the country. Of the people tested for HIV in the past year, about 5.2% had received the test results. Generally, younger women were less likely to take an HIV test than older women. Testing HIV was least among the youngest (15 – 19 y) women indicating the need of promotion of HIV testing among this high risk group. Access to

HIV testing, reasons for taking the test and getting the test results are presented in Table 3.6.1.

Table 3: Access to HIV testing in antenatal women by age group, 2015

Access to HIV testing	**Age group**				**All**
	15 – 19 (%)	***20 – 24 (%)***	**15 – 24 (%)**	**25 – 49 (%)**	
Testing HIV					
Ever tested for HIV	*3.7*	*12.1*	10.3	16.8	14.1
Tested in last 12 months	*1.8*	*4.8*	4.2	10.1	7.6
Received results who tested in last 12 months	*1.8*	*3.3*	3.0	6.8	5.2
Last HIV test taken					
< 3 months	*0.0*	*0.0*	0.0	13.5	10.4
3 - 12 months	*0.0*	*40.0*	36.4	18.9	22.9
12 + months	*100.0*	*60.0*	63.6	67.6	66.7
Reasons for taking the last test					
Personal choice	*100.0*	*45.5*	50.0	21.1	28.0
Medical check up	*0.0*	*36.4*	33.3	71.1	62.0
As part of donating blood	*0.0*	*9.1*	8.3	5.3	6.0
Unknown reason	*0.0*	*9.1*	8.3	2.6	4.0
Received last HIV test results	*100.0*	*70.0*	72.7	64.1	66.0

Those women who 'ever tested' for HIV, 10.4% did in less than 3 months while about two- third took the tests more than a year ago. The reason for taking the last HIV test was part of routine medical check-up (62%) for most women. About 28% women reported to take the HIV test as personal choice which indicates that a significant proportion had voluntary testing in Solomon Islands. Of the people tested for HIV, nearly two-third (66%) had received the result of the last HIV test undertaken.

Awareness of the availability of HIV services

Table 4 shows whether antenatal women believed that HIV testing results would remain confidential and, if not, the perceived reasons for the lack of confidentiality. Nearly 82% women reported that they believed it was possible to obtain a confidential HIV test. The proportion of women who had trust that such as test

would be possible was lower (nearly 76%) in the youngest group of women than others.

Antenatal women, who did not believe that getting confidential HIV testing was possible, provided a set of possible reasons of not getting a confidential test. Disclosure of test results by the service providers was feared by most antenatal women as they believed that friends, neighbours and other in the communities would find out the results from the service providers in some way. Unavailability of HIV testing services was also cited by 6.7% women. The problem of the lack of privacy in testing sites (4.5%) has also caused many antenatal women not to seek testing. Difficulties to reaching out the testing sites for many antenatal women were also cites as problems of getting HIV testing services.

Table 4: Perception regarding availability of confidential HIV testing, 2015

Perception about HIV services	**Age group**				**All**
	15 – 19 (%)	***20 – 24 (%)***	**15 – 24 (%)**	**25 – 49 (%)**	
Believe getting a confidential test is possible	*75.9*	*84.1*	82.4	81.2	81.7
Reasons why can't get a confidential HIV test*					
Friends, neighbours will find out the result	*5.7*	*3.8*	4.2	8.6	7.5
HIV testing service is not available	*7.3*	*5.3*	6.5	6.8	6.7
Testing site is too public	*3.8*	*2.4*	2.7	5.2	4.5
Testing site is too difficult to get to	*2.8*	*1.5*	1.9	2.3	2.2
Others	*1.9*	*2.7*	2.3	4.1	3.1
N	***53***	***207***	**260**	**360**	**620**

Willingness of taking HIV tests and PMTCT services

An attempt has been made to understand the willingness of taking HIV tests and PMTCT services as perceived by the antenatal women. Table 5 shows that nearly 99.2% of the antenatal women were willing to take an HIV test if offered in convenient locations. About 94.1% antenatal women would be willing to access PMTCT services if needed.

Those who were not ready to access the PMTCT services had provided reasons for not using them even if they were found infected with HIV. About 1.5% did not want to disclose their HIV status to their husbands, partners or neighbours while 1.2% found receiving PMTCT services as shameful or embarrassing. A small proportion of women expressed their desire to become a mother again and, thus, were not willing to accept any contraceptives as part of PMTCT services.

Table 5: Willingness of taking HIV testing and PMTCT services, 2015

Willingness of taking HIV test	Age group				All
	15 – 19 (%)	***20 – 24 (%)***	**15 – 24 (%)**	**25 – 49 (%)**	
Willing to take HIV test	*100.0*	*99.5*	99.6	98.9	99.2
Willing to access PMTCT services if needed	*94.3*	*95.7*	95.4	93.2	94.1
Reasons* for not using PMTCT services even if HIV+					
Fear of disclosing HIV status to others	*0.9*	*1.4*	1.3	1.9	1.5
Shameful or embarrassing	*0.9*	*1.2*	1.1	1.4	1.2
Desire to be pregnant	*0.0*	*0.3*	0.2	0.4	0.3
N	***53***	***207***	**260**	**360**	**620**

In 2016, UNICEF continued supporting the Ministry of Health and Medical Services to scale up point of care HIV testing services in the country. The country currently has 315 operational health facilities and through UNICEF support in terms of strategic Technical Assistance for HIV/AIDS, procurement of HIV testing supplies, and funding for HIV/AIDS interventions, point of care rapid HIV testing was rolled out and has been scaled up from 17 sites in 2014, 35 sites in 2015 and now 43 sites in 2016. HIV testing for PMTCT is particularly low in Solomon Islands, therefore, the scale-up of HIV testing is targeting antenatal care sites and hence there was an increase realized in the number of pregnant women tested, from 13 percent in 2014 to 15 percent in 2015. Data for 2016 had not yet been completed by the country at the time of compiling this report, however, another increase is expected compared to the previous year's figure.

Syphilis:

Overall, the prevalence of syphilis among antenatal women in Solomon Islands has historically been high compared to the prevalence rates estimated in other Pacific Islands countries (WHO 2006). From a very high prevalence (10%) in 2005 sentinel survey, the rate had reported to drop to as low as 3.5% in 2008 sentinel survey (MHMS and SPC 2009). One of the limitations in both surveys was that they were conducted in selected clinics by excluding most of the provinces. Sample sizes were also small and the refusal rates were high. The prevalence was estimated as 8% in 2012 in the SPC surveillance study (SPC 2012). The 2015 sentinel survey was designed to be largely representative of the antenatal women of the country covered wide geographical areas. The evidence presented in this figure does not indicate that the prevalence of syphilis infections among antenatal women in Solomon Islands has significantly declined since 2005. The trend in syphilis prevalence rates from 2005 to 2015 are presented in Figure below.

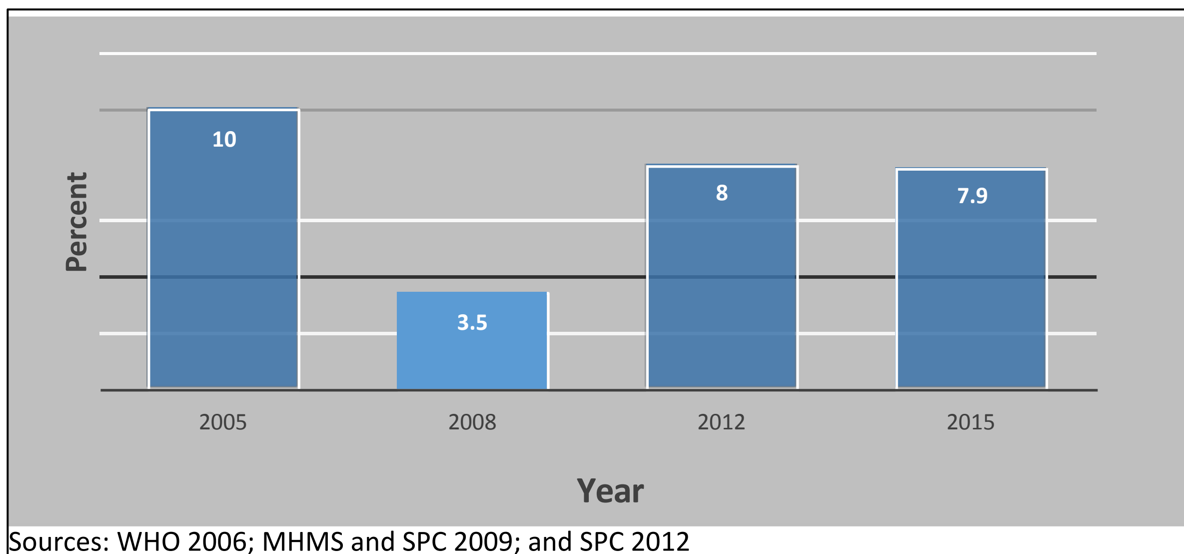


Figure 3: Trend in syphilis prevalence rates among antenatal women, 2005 - 2015

In the 2015 SGSS study in Solomon Islands, about 8.8% of specimens showed reactive rapid plasma reagin (RPR). However, not all reactive RPR results indicate active syphilis. In cases of positive RPR, Treponema pallidum haemagglutination (TPHA) test were performed. In this study, a combination of a positive TPHA and an RPR titre of 1:8 or more was considered suggestive syphilis. This approach was used to estimate syphilis in other studies in Solomon Islands (MOHMS and SPC 2009; Marks, Kako, Butcher et al. 2015).

Overall, the prevalence of positive syphilis serology in ANC attendees was estimated as 7.9% in the current survey. Figure 3.9.1 shows the distribution of syphilis prevalence rates by province covered by this survey.

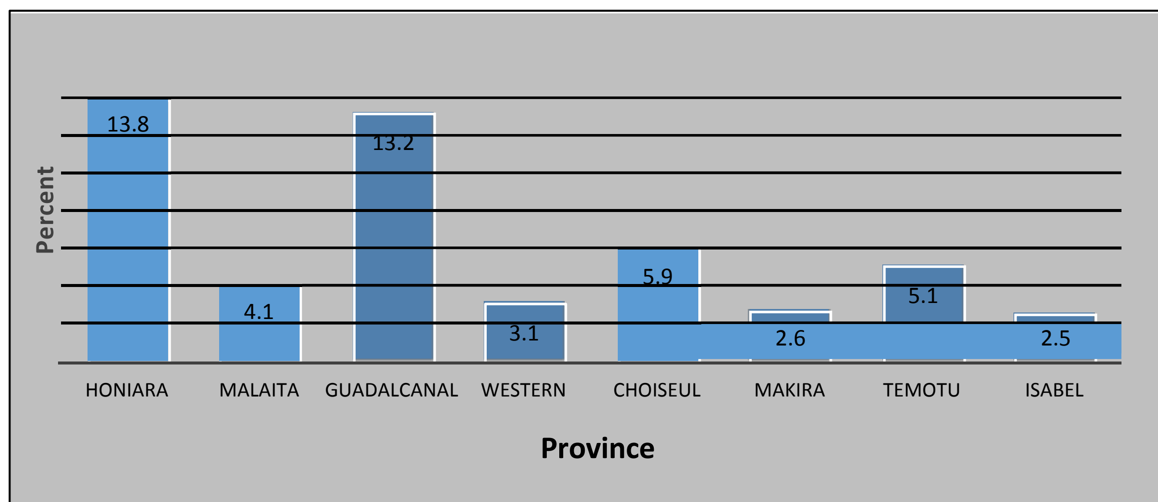


Figure 4: Syphilis prevalence rate by province, 2015

It appears that Honiara City (13.8%) and Guadalcanal (13.2%) share the largest burden of syphilis in the country. The next highest prevalence was in Choiseul province (5.9%) followed by Temotu (5.1%) and Malaita (3.4%) provinces. Western province, had a prevalence rate of 3.1%, Makira 2.6% and Isabel 2.5%. In the same study, about 6.8% women reported ever being diagnosed with an STI. The proportion of 'ever diagnosis' was relatively higher among older women (7.1%) than women in other age groups. Among those antenatal women who were ever diagnosed with an STI, about 37.2% were diagnosed with syphilis. Only 2.3% women reported that they received treatment. The proportion of women diagnosed and treated for STIs were higher among older than younger women.

Table 6: Diagnosis for STIs among antenatal women by age group, SGSS 2015

Diagnosis for STIs	**Age group**				**All**
	15 – 19 (%)	***20 – 24 (%)***	**15 – 24 (%)**	**25 – 49 (%)**	
Ever diagnosed with an STI	*5.6*	*6.7*	6.5	7.1	6.8
Type of STI diagnosed with					
Syphilis	*33.3*	*42.9*	41.2	34.6	37.2
Other STIs	*66.7*	*57.1*	58.8	65.4	62.8
% positive & received treatment	*1.9*	*1.9*	1.9	2.5	2.3
N	***53***	***207***	**260**	**360**	**620**

Antenatal women were asked to report if they had any symptoms of potential STI in the last month preceding the survey. About 14.3% women reported to have lower abdominal pain during sex, 4.1% women reported unusual genital or anal discharge, and another 0.6% reported rash, ulcer or sore around their genitals (Table 6). When aggregated all three symptoms, 16% antenatal women reported that they had at least one symptom in the past month. The reported symptoms were highest among the youngest group of women indicating the need of promoting STI prevention and services among this group of women.

2.2.3 Mother to Child Transmission of HIV

Solomon Islands to-date has no recorded case of MTCT. To-date, five children have been born to women living with HIV in the country out of which one of the children was not tested before before the child died, one was not tested at birth or in the first 18 months but later tested HIV positive at 13 years in 2014, and it is assumed that this was not a case of MTCT since global evidence shows that a child born with HIV is highly likely to die of AIDS related causes with the firt 2 or 5 years of life.. The other three were tested at birth and follow up testing was done at 24 months, and both tests were negative for HIV among all three cases. For all the cases no ARV syrap or PMTCT related medication was given to the children, but the mothers were on treatment and did not breastfeed.

In 2016, not HIV positive case was reported among all pregnant women who received an HIV test; and also, none of the 9 women living with HIV in the county were reported to be pregnant of giving birth. Therefore the rate of MTCT remained 0% in the country in 2016.

2.2.4 Prevention of Mother to Child Transmission of HIV

In the effort to strengthen PMTCT services, the country has continued to rollout HIV testing services at ANC clinics in all provinces except Rennel and Bellona Province. ANC testing coverage has been low in the country with only 13% and 15% of all pregnant mothers being tested in 2014 and 2015 respectively. In 2015, a total of 2,835 out of 18,406 pregnant women were tested for HIV in 2015. There were no HIV positive among the tested women. Also, none of the 10 women currently living with HIV became pregnant during this reporting period.

2.3 Commitment 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

To date, despite the fact that limited programmes for key populations have been implemented under the Response Fund, very limited systematic programmes or services for sex workers are available, nor are there reliable population-size estimations, nor is accurate data available on coverage of sex workers with HIV-prevention services or HIV testing. The hidden nature of most commercial and transactional sex work, and the specific context in which both commercial sex work and transactional sex take place, make it very difficult to come up with reliable estimates of the number of sex workers in Solomon Islands. The same applies to MSM in Solomon islands, where there are no programmes targeting them, nor are there reliable population-size estimations, nor is data available on coverage of MSM with HIV-prevention services or HIV testing. The stigma faced by MSM in Solomon Islands means that most MSM will keep their sexual orientation hidden from the community. This makes it very difficult to come up with reliable estimates of the number of MSM in Solomon Islands.

Tpo address the above gap, in 2015 Solomon Islands submitted a funding proposal for HIV/AIDS focusing on key populations, to The Global Fund. Overall, the funding proposal strongly focused on strengthening HIV prevention among key populations, by strengthening and expanding existing services for sex workers and women and men engaging in transactional sex, as well as establishing new services for men who have sex with men (MSM).

Studies among adolescents and young people have revealed high levels of unprotected sex with multiple non-regular partners, including sex work (12.4%) and transactional sex (10.7%) (UNICEF, 2010; pp. 65-66). Overall, sexual behaviours take place in a context of high rates of forced sex (ever forced sex: 48% females; 25% males); first sex before 15 years of age (16% females; 19% males); very low condom use (never condom use in last 12 months: 42% females; 38% males); multiple sex partners and concurrent sexual relationships (41% females; 56% males) (MHMS, 2008).

Overall, there is a thin line between sex work (sex in exchange for money) and transactional sex (sex in exchange for goods or favours), with a large percentage of sexual contacts involving some kind of transaction (money, goods, favours). While

overall HIV rates are still very low, the very high STI rates reflect the widespread high-risk sexual behaviours: in the 2015 study among ANC women, the syphilis prevalence rate was 8.8% (MHMS, 2015b). In a 2008 study among young women and men, STI rates were high: Trichomonas, 17%; Chlamydia 11%; Hepatitis B 14%; and syphilis 3% (MHMS, 2008). Much less research has been done among MSM: limited available data show high-risk unprotected sex with multiple sex partners, including forced sex: in a study among adolescents in 2010 half of male respondents from Choiseul province report that their first sexual contact was forced by a male adult.

In Solomon Islands, there is evidence of existence of key populations such as Sex Workers (SWs) and Men having Sex with Men (MSM). The 2008 SGSS asked male respondents aged 15 to 24 in Honiara city about relationships with male sex partners in the past 12 months. Of approximately 240 respondents, 0.8% reported sex with another man in the last 12 months. This figure may represent an under-estimate due to the illegality of male-to-male relationships in the country and social desirability bias due to stigma around sexual diversity. Also, three qualitative studies have identified practices of transactional and commercial sex and described such practices as common in the general population of young girls, women and young men, yet the number of individuals engaging in these activities is not well understood. Self-report of transactional and commercial sex among antenatal women is estimated at about 5%. This increases to about 20% in studies that have specifically targeted vulnerable groups, although inclusion criteria for "vulnerability" have been poorly defined.

International and Pacific experience has shown that:

- Access to condom and lubricant, accurate risk reduction information and STI/HIV testing and treatment services are the most basic components of HIV/STI prevention programs for sex workers and MSM;
- An enabling environment fostered through public and service provider attitudes, policing and the operation of the justice system, policy and the law, is essential to uptake of core HIV/STI prevention;
- Peer educator involvement is a key element of SW & MSM HIV programs;
- Ongoing investment in peer educators is critical to ensure that skills are adequate and messages are up to date and accurate. Peer educators also need training in a range of other skills such as problem-solving;
- Outreach is a crucial element of service delivery. Condoms and lubricant need to be available in hotels, bars and other SW/MSM hot spots.
- HIV/STI testing services are less stigmatising and more attractive when they are provided as part of a package with other health services;
- HIV/STI prevention services for sex workers and MSM must be confidential and safe, as well as free;

- Key population organisations and networks will mobilise around HIV/STI prevention activities if they are supported to do so;
- Key population organisations are key to a community empowerment approach, which has proven to be central to effective HIV/STI prevention, internationally; and
- The sustainability of HIV prevention programs for sex workers and MSM are underwritten by the capacity of, and resources available to, the implementing organisations.

In 2017, Solomon Islands will conduct a Mapping and Population Size Estimation (MPSE) and Integrated Bio- Behavioural Surveillance Survey (IBBSS) among Sex Workers (SWs) and Men who have Sex with Men (MSM) in Solomon Islands, and develop a country-specific Service Delivery Model for provision of HIV/AIDS services targeting key populations.

The MPSE and IBBSS will aim to collect the necessary strategic information on key populations through ethnographic mapping and to identify appropriate locations for implementing interventions so as to ensure optimum coverage of SWs & MSM in the national HIV/STI response, and to assess the prevalence of HIV and selected STIs as well as behavioral risk factors among these populations.

2.4 **Commitment 4:** Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

In Solomon Islands, a number of human rights barriers hamper access to health and HIV-related services for specific groups. Discriminatory legislation, policy and social practices remain in place that act as barriers to sexual health and well-being and promote stigma and discrimination. Specific aspects include: 1) Legal frameworks that criminalise sex work and male-to-male sex; and 2) Gender inequalities (norms, practices) that affect access of specific groups of women, girls, men and boys to health services, and HIV prevention, care and treatment in particular.

2.4.1 Key human rights barriers affecting access to health services

Legal frameworks that criminalise sex work and men who have sex with men (MSM) constitute an important human rights barrier to effective HIV service delivery.

Criminalisation of sex work – As mentioned above (1.1.b), "selling sex, owning a brothel or "aiding or abetting" prostitution for personal gain" are illegal under Section 153 and 155 of the Solomon Islands Penal Code. The criminalisation, punitive practices of law enforcement and other legal oppression of sex work create structural barriers to HIV/STI prevention and have a negative effect on community empowerment-based HIV programming. In addition, criminalisation may reinforce discriminatory and punitive attitudes at the community level and in health-care settings: e.g., experiences from Fiji show that the introduction of heavier penalties for people associated with the sex industry in 2010 had a negative impact on HIV responses (McMillan, 2013).

Criminalisation of homosexual acts – As mentioned in the previous sub-section (1.1.b), sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. Criminalisation of homosexuality is common in other countries in the Western Pacific, many of which have laws penalising "homosexual acts and sodomy"; prohibiting "buggery" or "permitting buggery" and "gross acts of indecency between males whether in public or in private". Other legal terms used to criminalise sex between men include prohibition of "indecent acts between males, regardless of consent" and "sodomy, including between adult males" or "the impersonation of a female by a male" (Cooper, 2013).

The fact that these laws exist does not mean that they are strictly enforced: sex workers, women or men engaging in transactional sex, MSM or transgender people are not systematically prosecuted in Solomon Islands. However, as a result of official legislation criminalising sex work and homosexual acts, the Ministry of Health and Medical Services and civil society service providers may feel restricted to offer services or programmes that specifically target sex workers or MSM, "because they engage in illegal behaviours". Thus, with many competing priorities and limited budgets, services for these populations are not prioritised. As a result, specific programmes for these key populations often depend on external donors and lack sustainability beyond the end of short-term projects. In addition, the existing legislation reflects prevailing social norms and values that stigmatise and discriminate against sex workers and MSM. Negative attitudes of health-care workers may pose a barrier for members of key populations to seek sexual and reproductive health services, HIV testing, access prevention services, or ART services.

2.4.2 HIV and Human Rights Legislative Compliance Review Findings

A HIV and Human Rights Legislative Compliance Review was conducted in Solomon Islands in 2009. This review used the principles set out in the *International Guidelines on HIV/AIDS and Human Rights* to assess the legal environment for the response to HIV in Solomon Islands. The International Guidelines on HIV/AIDS and Human Rights were published jointly by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1998, later revised and published again in 2006.

The review was premised around 10 "checklists adopted from the *Handbook for Legislators on HIV/AIDS, Law and Human Rights* to assess whether different areas of law are compliant with the International Guidelines. The checklists address the following topics: The review established the following:

CHECKLIST 1 – PUBLIC HEALTH LAW

1. Does the legislation empower public health authorities to provide the following comprehensive prevention and treatment services:

Information and education
Voluntary testing and counselling
STD, sexual and reproductive health services
Access to means of prevention e.g. condoms and clean injecting equipment
Access to HIV medication, including ART, treatment for opportunistic infections, and medication for pain prophylaxis?

Section 4 of the *Health Services Act* [Cap 100] requires the Minister to provide primary health care services throughout the country, which are to be free of charge unless regulations enable the setting of fees. Local authorities and provincial assemblies are required by the *Environmental Health Act 1980* to make bylaws for the provision of health services in their areas including education campaigns.

2. Does the legislation:

Require specific informed consent, with pre- and post-test counselling to be obtained from individuals before they are tested for HIV in circumstances where they will be given the results of the test (i.e. not unlinked, sentinel surveillance)?
Provide that if there are any exceptions to individual testing with informed consent, such testing can only be performed with judicial authorization?

There is no legislation that makes specific provision for informed consent and counselling in relation to HIV tests. The common law of England applies, which requires consent to a blood test. If consent is not given, the person taking blood may be liable under civil and/or criminal law for assault. Common law does not require pre and post test counselling.

Powers in prisons and migration legislation may enable compulsory testing in limited exceptional circumstances, although there are no HIV specific provisions.

The *Correctional Services Regulations 2008* Regulation 33 provides that every prisoner shall submit to a medical examination by the medical officer when directed by an officer, a medical officer, nurse or nurse aide and shall submit to such treatment, including vaccinations or inoculations, as the medical staff prescribe.

The *Immigration Act* [Cap 60] provides that a person entering the country may be subject to a medical examination if required by an immigration officer.

Under the National HIV/AIDS Strategic Plan, a policy of voluntary informed consent testing has been established.

Does the legislation only authorise the restriction of liberty/detention of persons living with HIV on grounds relating to their behaviour of exposing others to a real risk of transmission (i.e. not casual modes, such as using public transport), as opposed to their mere HIV status?

Does the legislation provide in such cases the following due process protections:
Reasonable notice of case to the individual;
Rights of review/appeal against adverse decisions;
Fixed periods of duration of restrictive orders (i.e. not indefinite);
Right of legal representation?

There is no legislation authorising restriction of liberty of people living with HIV.

The Environmental Health (Public Health Act) Regulations govern public health, and Part III deals with notifiable diseases, which are those listed in the Schedule. At present, HIV and AIDS are not on this list. However, the list may be added to from time to time by the Minister by notice, and he may also direct that all or any notifiable disease provisions do not apply in respect of any disease in the Schedule. Some provisions of Part III were never brought into force.

Part III contains brief provisions for notifying notifiable diseases, and the isolation and quarantine of infected persons and consequent disinfection procedures.

The Quarantine Act [Cap 106] gives powers to isolate and contain diseases, which under Section 2 are defined as smallpox, plague, cholera, yellow fever, typhus fever or leprosy or any disease declared by the Minister by order to be a quarantinable disease.

Does the legislation authorise health-care professionals to notify sexual partners of their patients' HIV status in accordance with the following criteria:
Counselling of the HIV-positive patient has failed to achieve appropriate behaviour change;
The HIV-positive patient has refused to notify or consent to notification of the partner;
A real risk of HIV transmission to the partner exists;
The identity of the HIV-positive partner is concealed from the partner where this is possible;
Necessary follow-up support is provided to those involved?

There is no legislation specifically authorising health-care professionals to notify sexual partners of a patient's HIV status.
Section 8(j) of the *Health Services Act* [Cap 100] permits the making of regulations regarding the confidentiality of patient information. However, the *Environmental Health (Public Health Act) Regulations* Regulation 7 provide that a medical practitioner or nurse attending a person suffering a notifiable disease shall inform the head of the person's family and the person's employer of the communicable nature of the disease and precautions to be taken to prevent its spread. However HIV has not been listed as a notifiable disease.

Does the legislation provide for protection of the blood, tissue, and organ supply against HIV contamination (i.e. requiring HIV testing of all components)?

There is a National Blood Policy that addresses blood quality issues. There is no blood safety legislation.

CHECKLIST 2 – CRIMINAL LAW

Does the law provide for the legal operation of needle and syringe exchange? Are intermediaries (e.g. clients who distribute to third parties) covered by such protection, and is the evidentiary use of needles and syringes with trace elements of illegal drugs restricted (e.g. immunity for contents of approved disposal containers).
No reports of injecting drug use in Solomon Islands were found, so legislation relating to needles and syringes is not considered necessary. Dangerous Drugs Act [Cap 98] provides offences for importing, selling and exporting illicit drugs.

Does the law allow the following sexual acts between consenting adults in private:
Homosexual acts e.g. sodomy;
Fornication or adultery;
Street sex work;
Brothel or escort sex work?
Homosexual acts e.g. sodomy

Section160 of the *Penal Code* criminalises 'buggery' with another person; the permitting of a male person to commit buggery on him or her; and attempts. The lesser offence of 'committing any act of gross indecency' by persons of the same sex is at Section 161. Attempting to procure another person of the same sex to commit an act of indecency is an offence.

In 1988, an appeal was taken in *DPP v Noel Bowie* [1988-1989] SILR 113, against the discriminatory nature of the offence of gross indecency between male persons. The appeal was successful, but the court suggested to Parliament the non-discriminatory solution of removing the word 'male', so that the offence was now gender-neutral. Rather than repealing the provision altogether, at least in respect of adults, Parliament made the recommended amendment. This was followed in December 2003 by a report of two women being charged for lesbian activity, but the outcome of this case is not known.

Fornication and adultery:

Section 18 of the Islanders Divorce Act [Cap 170] provides that a husband may, on a petition for divorce, claim damages from any person on the ground of adultery with the wife of the petitioner.

Sex work:

The *Penal Code* provides offences of—knowingly living on the earnings of prostitution (Section153(1)(a))persistent soliciting or importuning in a public place for immoral purposes (Section153(1)(b)aiding, abetting or compelling the prostitution of a prostitute for the purpose of gain (Section153(1)(c)keeping a brothel (Section155(a)) permitting premises to be used as a brothel (Section155(b)).

There is no law specifically against sex tourism, although such offences could be prosecuted under laws against prostitution. There are some press reports of sex tourism.

If sex work is prohibited, or there are prostitution-related offences, is there any exception for HIV prevention and care services (e.g. evidentiary immunity for carrying condoms)?

There is no exception in criminal law for HIV prevention and care services.

Does the legislation regulate occupational health and safety in the sex industry to require safer sex practices to be:
Practised by clients;
Practiced by workers; and
Promoted by owners/managers (including prohibiting the requirement of unsafe sex)?

Legislation does not regulate occupational health and safety in the sex industry.

Does the legislation protect sex workers, including children, from coercion and trafficking? Is the object of such protection the removal and support of such workers, rather than criminalizing their behaviour as opposed to those responsible (i.e. owners or intermediaries)?

Child prostitution and trafficking have been reported in a study of impacts of the logging industry.[1] The law prohibits trafficking in persons for labour or sexual exploitation. There are anecdotal reports that young women were trafficked from China and several Southeast Asian countries, for the purpose of sexual exploitation on foreign ships and in logging camps.[2]

[1] Tania Herbert, Church of Melanesia (2007) *Commercial Sexual Exploitation of Children: A report focusing on the presence of the Logging Industry in a Remote Region*.

[2] US Government State Department (2007) *Country Report of Human Rights Practices: Solomon Islands*.

Specific offences currently in the Penal Code that cover children include:
procuring a girl to become a prostitute, or become an 'inmate of a brothel';
detaining a girl in a brothel;
disposing of minors under the age of 15 years for prostitution or unlawful intercourse;
obtaining minors under the age of 15 years for prostitution or unlawful sexual intercourse. (Sections 144, 146, 147)

It is also an offence to procure or attempt to procure a woman for sexual intercourse using threats, intimidation, fraud or by giving her drugs (Section 145). The *Penal Code* also contains an offence of detaining a woman in a brothel, or detaining her for the purpose of her having sexual intercourse, against her will (Section 148).

Does the law provide for general, rather than specific, offences for the deliberate or intentional transmission of HIV?

Intentional HIV transmission is likely to fall within the general offences for causing grievous harm. The offence of grievous harm under Section 224 of the *Penal Code* requires intent to maim, disfigure or disable, or to do some grievous harm. It includes causing any dangerous or noxious thing to be taken or received by any person. Section 226 also makes causing grievous harm an offence.

The year and a day rule for unlawful killing is at Section 209. Therefore it would not be possible to obtain a murder or manslaughter conviction for HIV transmission.

CHECKLIST 3 – PRISONS/CORRECTIONAL LAWS

1. Does the legislation provide for access equal to the outside community to the following HIV-related prevention and care services in prisons or correctional facilities:
Information and education
Voluntary counselling and testing
Means of prevention e.g. condoms, bleach, and clean injecting equipment
Treatment – ART and treatment for opportunistic infections
Choice to participate in clinical trials (if available)?

There are no HIV specific provisions. New legislation comprehensively addresses prisoner's general rights to health services.
Section 43 of the *Correctional Services Act 2007* provides that health care facilities and primary care services shall be provided for prisoners to a community standard while also taking into account the special circumstances and health care needs of prisoners.

Section 44(3) provides that where a medical officer, nurse or nurse aide is of the view that a prisoner is in need of specialist treatment, he or she may make a report to the Commandant, and where practicable, may make arrangements for the prisoner to be referred to an appropriate medical practitioner.

Section 44(2) provides that Commandants may order that prisoners be medically examined, and the medical officer shall examine and treat any prisoner in need of medical attention.

Section 45 provides that arrangements shall be made for the provision of other medical and related services, in accordance with any relevant policy or program of the Ministry of Health including public awareness and education programs; vaccination programs or programs for the treatment or prevention of certain diseases; and support services for infants and mothers.

Section 47 provides that the Commissioner and Commandants shall ensure that conditions within correctional centres do not facilitate the spread of disease, and must implement recommendations made by medical officers or the Ministry of Health aimed at reducing the risk of the outbreak of disease.

The *Correctional Services Regulations 2008* provide:

136. The Commandant shall ensure that appropriate medical care in accordance with community standards is provided to prisoners and shall continue to carefully monitor the prisoners who are in need of, or who are receiving medical treatment.

137. If a medical officer is of the opinion that –
(a) a prisoner is mentally ill or mentally disordered;

(b) the life of a prisoner may be endangered by further imprisonment;

(c) a sick prisoner will not survive for the length of the sentence;
or
(d) a prisoner is totally and permanently unfit to live in correctional centre conditions the medical officer shall inform the Commandant. The Commandant shall report the case to the Commissioner without delay.

138. The medical officer shall report to the Commandant the case of any prisoner who the medical officer believes has special medical needs that may require an alteration to the living conditions of the prisoner. The Commandant shall, as far as circumstances permit, put into effect any recommendation made by the Medical Officer for the medical treatment of prisoners, including transportation to a hospital or other facility, isolation, specialist care, equipment or additional or alternative dietary supplements.

139. Any prisoner suffering from an infectious or contagious disease or transmissible condition, shall be immediately given treatment for the disease or condition. The Medical Officer, nurse or nurses aide treating the prisoner must take the necessary steps or precautions necessary to prevent the spread of the disease.

2. Does the legislation provide for the protection of prisoners from involuntary acts that may transmit the virus, e.g. rape, sexual violence, or coercion?

Prison offences including assaults are prescribed by *Correctional Services Regulations 2008*, Regulation 163. The Regulations also provide protection of prisoners from abuse by prison officers. Regulation 152 provides that any officer entering a prisoner's cell at night must be accompanied by another officer, except in cases of necessity or emergency. In these circumstances, the officer must immediately report the unaccompanied entry to the senior officer in charge of the centre. Regulation 153 provides that any male officer entering a part of the centre where women prisoners are located must be accompanied by a female officer.

3. Does the legislation provide for the confidentiality of prisoners' medical and/or personal information, including HIV status?

Section 46 of the *Correctional Services Act* provides that:
(1) Arrangements shall be made for keeping the medical records of prisoners confidential but prisoners should be notified of the results of any test or treatment, and provided with any necessary support. A prisoner shall not be regarded as the owner of any medical records kept but must be provided with any relevant information contained in the records upon request following their release from a correctional centre.

(2) A prisoner who has an on-going medical condition that has been treated while he or she has been in custody shall be given a discharge note confirming the nature of the illness and of the treatment provided.

(3) Information about the medical condition of any prisoner shall be notified as soon as possible to a Commandant if action is or may be required to ensure the safety and well being of officers, prisoners, visitors or any other person.

Regulation 135 *Correctional Services Regulations 2008* provides that when a Commandant is informed that a prisoner has a serious illness or injury, the

Commandant shall notify the most accessible known relative of the prisoner or the next of kin. As consent of the prisoner to disclosure is not specified, this regulation may lead to breach of confidentiality.

4. Does the legislation not require segregation of prisoners, merely on the basis of their HIV status, as opposed to behaviour?

Section 44(4) *Correctional Services Act* provides that a prisoner who is suffering from any disease or illness must only be held separately from other prisoners upon the order of a medical officer, nurse or nurse aide. Section 44(5) provides that notwithstanding this section a Commandant may order the separation of a prisoner who is apparently suffering from an illness if arrangements are made for a medical officer or nurse to examine the prisoner and confirm the need for separation as soon as is practicable.

5. Does the legislation (e.g. sentencing) provide for medical conditions, such as AIDS, as grounds for compassionate early release or diversion to alternatives other than incarceration?

Section 48 *Correctional Services Act 2007* provides that where a prisoner is suffering from an illness, disability or other condition or there are special circumstances that make their detention within a correctional centre impractical or undesirable, a Judge or Commissioner of the High Court may review the sentence of the prisoner and make orders for the release of the prisoner or for the prisoner to be moved to suitable accommodation outside of a correctional centre.

6. Does the legislation provide for non-discriminatory access to facilities and privileges for HIV-positive prisoners?

The Act does not specifically address non-discriminatory access to facilities and privileges.

CHECKLIST 4 – ANTIDISCRIMINATION LEGISLATION

Does the legislation provide for protection against discrimination on the ground of disability, widely defined to include HIV/AIDS?

Discrimination on the grounds of HIV or AIDS status is not unlawful. There is no disability discrimination legislation.

Section 15 of the *Constitution* makes discrimination unlawful but only on the grounds of race, place of origin, political opinions, colour, creed or sex.

Does the legislation provide for protection against discrimination on the ground of membership of a group made more vulnerable to HIV/AIDS e.g. gender, homosexuality?

There are very weak legal protections for vulnerable groups. There are no specific protections for people living with HIV or those assumed to have HIV by reason of their membership of a vulnerable group.

Subject to exceptions, the Constitution makes discrimination on the ground of sex unlawful in access to places, in provisions of law and in administration of the law by public authorities. In relation to sex discrimination:
no law may make any provision that is discriminatory either of itself or in its effect;
no person may be treated in a discriminatory manner by any person acting by virtue of any written law or performance of the function of any public office or any public authority;
no person may be treated in a discriminatory manner in respect of access to shops, hotels, lodging-houses, public restaurants, eating-houses or places of public entertainment or in respect of access to places of public resort maintained wholly or partly out of public funds or dedicated to the use of the general public.

Does the legislation contain the following substantive features:
Coverage of direct and indirect discrimination;
Coverage of those presumed to be infected, as well as carers, partners, family, or associates;
Coverage of vilification;
The ground complained of only needs to be one of several reasons for the discriminatory act;
Narrow exemptions and exceptions (e.g. superannuation and life insurance on the basis of reasonable actuarial data);
Wide jurisdiction in the public and private sectors (e.g. health care, employment, education, and accommodation)?

There is no HIV discrimination or vilification legislation.
Under the provisions of the *Constitution* that relate to sex discrimination, "discriminatory" is defined to mean affording discriminatory treatment to different persons attributable *wholly or mainly* to their respective descriptions by sex. This means that the ground must be more than one of several reasons for the discrimination, it must be wholly or mainly the reason for the discrimination.

“Discriminatory treatment" means subjecting persons of one such description to disabilities or restrictions to which persons of another such description are not made subject, or are accorded privileges or advantages which are not accorded to persons of another such description.

Does the legislation provide for the following administrative features:
Independence of a complaint body;
Representative complaints (e.g. public interest organizations on behalf of individuals)
Speedy redress e.g. guaranteed processing of cases within a reasonable period, or fast-tracking of cases where the complainant is terminally ill;
Access to free legal assistance;
Investigatory powers to address systemic discrimination;
Confidentiality protections e.g. use of pseudonyms in reporting of cases?

There is no HIV discrimination legislation.

Chapter IX of the *Constitution* establishes the Ombudsman, with functions to investigate the conduct of public bodies, members of the public service, the Police Force, the Prisons Service, the government of Honiara city, provincial governments, and other offices, commissions, corporate bodies or public agencies as prescribed by Parliament. Section 97(2) provides that Parliament may confer additional powers on the Ombudsman.

The Ombudsman has the power to subpoena and to investigate complaints of official mistreatment or unfair treatment. The Ombudsman has potentially far-ranging powers, but is limited by a shortage of resources.

Section 10(9) of the *Constitution* requires all court proceedings to be held in public. However, Section10(10) enables courts to be closed where the publicity of the case would prejudice the interest or justice of public morality, or where publicity would prejudice the interests of justice, or in the interests of decency, public morality, the welfare of persons under the age of eighteen years or the protection of the private lives of persons concerned in the proceedings.

Does the legislation provide for the institution administering the legislation (e.g. human rights commission or ombudsperson) to have the following functions:
Education and promotion of human rights;
Advising government on human rights issues;
Monitoring compliance with domestic legislation and international treaties and norms;
Investigating, conciliating, resolving or arbitrating individual complaints;
Keeping data/statistics of cases and reporting on its activities?

There is no Human Rights Commission. The Ombudsman office does not have specific powers in relation to HIV discrimination.

CHECKLIST 5 – EQUALITY OF LEGAL STATUS OF VULNERABLE POPULATIONS

1. Does the law ensure the equal legal status of men and women in the following areas:
Ownership of property and inheritance;
Marital relations e.g. divorce and custody ;
Capacity to enter into contracts, mortgages, credit and finance;
Access to reproductive and STD health information and services;
Protection from sexual and other violence, including rape in marriage;
Recognition of de facto relationships;
Prohibition of harmful traditional practices e.g. female genital mutilation?

Ownership of property and inheritance and capacity to enter into contracts, mortgages, credit and finance

Discriminatory customary laws in respect of property and inheritance may still legally operate. Section 15 of the *Constitution* makes sex discrimination unlawful but the prohibition on discrimination does not apply to:
the law with respect to devolution of property on death;
the application of customary law;
law with respect to land, the tenure of land, the resumption and acquisition of land and other like purposes.

Schedule 3 Paragraph 3 provides that customary law takes effect as part of the law to the extent that it is not inconsistent with the *Constitution* or any Act of Parliament.

Under the *Customs Recognition Act 2000*, custom may be pleaded as a question of fact except where its recognition would result, in the opinion of the court, in an injustice or

would not be in the public interest. This would allow a court to strike down a customary practice which contravenes constitutional rights.

Wills Probate and Administration Act [Cap 33] 1987, Section 84 provides for equal rights to inheritance for men and women, however the application of customary inheritance laws is permitted even though it may result in discrimination against women.

In *Tanavulu & Tanavulu v Tanavulu and SINPF,* the Solomon Islands Court of Appeal considered customary inheritance for the purpose of the Solomon Islands National Provident Fund Act. That Act provides that, if a member of the fund dies without nominating a beneficiary for their accumulated funds, distribution is to be in accordance with the custom of the member, 'to the children, spouse and other persons' entitled in custom. The Court of Appeal found that the Act was not unconstitutional because it discriminated against the widow. This decision confirmed that discrimination founded on customary law is lawful.[3]

The Constitutional preservation of discriminatory customary laws in respect of land and inheritance may contribute to women's HIV vulnerability. There are insufficient decisions involving resolution of conflict between customary law and anti-discrimination provisions to make any accurate predictions for the future.[4] Amendment of the Constitution should be considered to clarify women's rights to equality in inheritance, property and financial matters.

Although there is no legislative barrier to women from accessing loans or financial services, discrimination continues to hinder women from obtaining credit and loans to purchase property or businesses.[5] Anti-discrimination legislation protecting women from discrimination in access to services is required.

Marital relations e.g. divorce and custody and recognition of de facto relationships

Legislation requires the registration of marriages and prohibits bigamy. However, customary marriages are exempt from these requirements. Section 15 of the *Constitution* makes discrimination against women unlawful but the prohibition on

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[3] J Corrin Care (2000) Customary law and women's rights in Solomon Islands *Development Bulletin*, no. 51, pp. 20-22.

[4] Ibid p.22.

[5] V Jivan, C Forster (2007)*Translating CEDAW into Law - CEDAW Legislative Compliance in Nine Pacific Countries,* UNDP and UNIFEM Suva p.331

discrimination does not apply to the law with respect to marriage and divorce, and it does not apply to the application of customary law.

Divorce is based on fault based criteria including adultery, desertion and cruelty. A husband can sue a third party for an adulterous relationship with his wife but this action is not available for wives in relation to their adulterous husbands.

Legislation provides for maintenance orders during separation and after divorce for both children and spouses. However, the basis on which maintenance is provided is left largely to the discretion of the court with the broad criteria of 'just and necessary': *Islanders Divorce Act* [Cap 170] 1960, Section 21. Although unmarried mothers can claim for maintenance for children they must lodge the claim within 3 years of the child's birth denying the joint responsibility of maintaining children of both parents.[6]

There is no legislative provision for the division of property after separation and divorce and therefore any determination is left to customary law which may discriminate against women. Custody disputes are determined on the standards of 'just and necessary', *Islanders Divorce Act* [Cap 170] 1960, s 21. Customary law may also be relied on to assist in the determination of custody disputes, which may be influenced by payment of a bride price.

De facto relationships are not legally recognised.

Access to reproductive and STD health information services

Sections 157-159 of the *Penal Code* criminalise abortion, or the procurement of miscarriage. The procurer, the woman herself and the supplier of any means are all guilty. Section 221 provides that it is not an offence if the conduct is in good faith for the purpose of preserving the life of the mother.

Protection from sexual violence, including rape in marriage

Under the *Penal Code* Section136, rape is an offence but it is defined as unlawful sexual intercourse with a woman or girl only, so rape of a man by another man is not covered. There is no exclusion for marriage, so marital rape is included in the offence.

Does the legislation prohibit the mandatory testing of targeted or vulnerable groups, such as orphans, the poor, sex workers, minorities, indigenous populations, migrants,

[6] Ibid p.333.

refugees, internally displaced persons, people with disabilities, men who have sex with men, and injecting drug users?

There are no laws prohibiting mandatory testing of groups.

Does the law require children to be provided with age-appropriate information, education and means of prevention?

There are no laws requiring children to be provided with information or education about HIV and STIs, or to be provided with condoms or other means of prevention.

Does the law enable children and adolescents to be involved in decision-making in line with their evolving capacities in regard to:
Consent to voluntary testing with pre- and post-test counselling;
Access to confidential sexual and reproductive health services?

There are no laws specifically addressing children's and young people's rights of informed consent and access to confidential sexual and reproductive health services.

Does the law provide protection for children against sexual abuse and exploitation? Is the object of such legislation the rehabilitation and support of survivors, rather than further victimizing them by subjecting them to penalties?

Protection is provided by the *Penal Code,* which provides for offences for abduction of unmarried girl under 18 years to have carnal knowledge (Section 140); indecent assault (Section 141); defilement of girl under 13 (Section 142) and defilement 13 - 15 year old (Section 143).

Does the law provide an equal age of consent for heterosexual and homosexual acts? Does the law recognize same-sex marriages or domestic relationships?

Homosexual acts are illegal. The law does not recognize same sex relationships.

CHECKLIST 6 – PRIVACY/CONFIDENTIALITY LAWS

Does the legislation provide for general privacy or confidentiality protection for medical and/or personal information, widely defined to include HIV-related data?

There is no privacy or confidentiality legislation relating to medical records. Medical records are subject to common law confidentiality protections.

Does the legislation prohibit unauthorised use and disclosure of such data?

There is no legislation. Common law allows disclosure of medical records only in exceptional circumstances in the public interest, such as where third parties are at risk of serious injury.

Does the legislation provide for the subject of the information to have access to his or her own records and the right to require that the data are:
Accurate;
Relevant;
Complete;
Up-to-date?

There is no legislation.

Does the legislation provide for the independent agency administering the legislation (e.g. privacy or data protection commissioner) to have the following functions:
Education and promotion of privacy;
Advising government on privacy issues;
Monitoring compliance with domestic legislation and international treaties and norms;
Investigating, conciliating, resolving or arbitrating individual complaints;
Keeping data/statistics of cases and reporting on activities?

There is no legislation.

Does other general or public health legislation provide for the right of HIV-positive people to have their privacy and/or identity protected in legal proceedings (e.g. closed hearings and/or use of pseudonyms)?

There is no HIV specific law. Under the *Constitution* Section 10(10), Courts have discretion to close hearings where there are public interest factors including the protection of the private lives of persons concerned in the proceedings.

Does public health legislation provide for reporting of HIV/AIDS cases to public health authorities for epidemiological purposes with adequate privacy protections (e.g. coded rather than nominal data)?

There is no legislation providing for reporting of HIV or AIDS cases to public health authorities for epidemiological purposes

CHECKLIST 7 – EMPLOYMENT LAWS

Does the legislation prohibit HIV screening for general employment purposes, e.g. employment, promotion, training, and benefits?

Employment legislation consists of:
Employment Act [Cap 72]
Labour Act [Cap 73]
Safety at Work Act [Cap 74]
Trade Dispute Act [Cap 75]
Trade Unions Act [Cap 76]
Unfair Dismissal Act [Cap 77]
Workmen's Compensation Act [Cap 78]

HIV screening for employment is not prohibited. The following offer some potential protection for people living with HIV—
Unfair Dismissal Act Right not to be unfairly dismissed.
Trade Dispute Act Right to bring a case to trade dispute panel.

Does the legislation prohibit mandatory testing of specific employment groups, e.g. military, transport workers, hospitality/tourist industry workers, and sex workers?

Legislation does not prohibit mandatory testing of specific employment groups

Does the legislation require implementation of universal infection control measures, including training and provision of equipment in all settings involving exposure to blood/body fluids, e.g. first aid, and health care work?

Legislation does not specifically require implementation of universal infection control measures. *Safety at Work Act* [Cap 74] Part II provides that it is the duty of every employer to ensure, so far as is reasonably practicable, the health and safety at work of all his employees, including (Schedule 1)

arrangements for ensuring, so far as is reasonably practicable, safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances;
the provision and maintenance of a working environment for employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.

An employer's failure to provide effective infection control systems in heath care workplaces would be a breach of this duty.

Does the legislation require provision of access to information and education about HIV/AIDS for occupational health and safety reasons, e.g. workers travelling in areas of high incidence?

Legislation does not specifically require provision of access to information and education about HIV/AIDS, but there is a general duty under *Safety at Work Act* [Cap 74] Section 4 and Schedule 1 for the employer to provide "such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees".

Does the law provide for:

Employment security while HIV-positive workers are able to work (e.g. unfair dismissal rules); and
Social security and other benefits where workers are no longer able to work?

There is no legislation prohibiting discrimination on the grounds of HIV against employees although in some circumstances an unfair dismissal claim could be argued under the *Unfair Dismissal Act* [Cap 77]. The *National Provident Fund Act* [Cap 109] enables employees who have contributed to the fund to claim a disability benefit if assessed with a permanent physical or mental incapacity to work. The *Labour Act* provides for workers' medical attention and treatment, and sick leave entitlements are included in the Holidays, Sick Leave & Passage Rules (Section 80).

Does the law provide for confidentiality of employees' medical and personal information including HIV status?

Legislation does not provide for confidentiality of employees' medical and personal information including HIV status.

Does workers' compensation legislation recognize occupational transmission of HIV? The Workmen's Compensation Act [Cap 78] does not specifically recognize occupational transmission of HIV.

CHECKLIST 8 – THERAPEUTIC GOODS, CONSUMER PROTECTION LAWS

Does the legislation regulate the quality, accuracy, and availability of HIV test kits (including rapid home test kits, if approved)?

There is no legislation regulating HIV test kits.

Does the legislation provide for approval only to be given for sale, distribution, and marketing of pharmaceuticals, vaccines, and medical devices if they are:

Safe;
and Efficacious?

There is no legislation requiring registration of drugs or assessment and approval of pharmaceuticals, vaccines, and medical devices based on safety and efficacy data. The *Pharmacy and Poisons* Act [Cap 105] provides that the British Pharmacopoeia is the standard of quality or composition for all drugs or medicines.

Does the legislation provide consumers with protection against fraudulent claims regarding the safety and efficacy of drugs, vaccines, and medical devices?

Under the *Pharmacy and Poisons Act* [Cap 105] only a registered pharmacist or a bona fide assistant to a registered pharmacist, under the immediate and personal supervision and control of a registered pharmacist, shall dispense a drug or medicine.

Does the legislation regulate the quality of condoms? Does such regulation include monitoring compliance with the International Condom Standard?

There is no legislation regulating the quality of condoms.

Does the legislation ensure the accessibility and free availability of the following prevention measures:
Condoms
Bleach
Needles and syringes?

The *Pharmacy and Poisons Act* [Cap 105] Section 42(1) provides that no person shall publish any statement, whether by advertisement or otherwise, to promote the sale of any article as an instrument or appliance for preventing conception. This may prevent promotion of condoms.

Does the legislation enable consumers to gain access to affordable HIV/AIDS medication (for example, through the mechanisms of parallel importing or compulsory licensing of pharmaceutical products, inclusion of HIV-related medication in subsidization schemes for certain pharmaceuticals, and lack of duties/customs or tax)?

Solomon Islands is a member of WTO, and has obligations under the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). As a least developed country, Solomon Islands has until 2016 to introduce patent legislation that complies with TRIPS standards.

Under the *Registration of United Kingdom Patents Act* [Cap 179], patents registered in the UK can be automatically re-registered in the Solomon Islands. Registration confers on the applicant the same privileges and rights in so far as may be applicable to Solomon Islands as he is entitled to in the United Kingdom and as though the patent had been issued in the United Kingdom with an extension to Solomon Islands.

There is no legislation enabling parallel importing or compulsory licensing of pharmaceutical products. There is no legislation in relation to early working of a patented product to enable generic medicines to be approved for marketing as soon as possible after patent expiry

CHECKLIST 9 – ETHICAL HUMAN RESEARCH

Does the law provide for legal protection for human subjects in HIV/AIDS research? Does the legislation require the establishment of ethical review committees to ensure independent, ongoing evaluation of research? Do the criteria used in such evaluation include the scientific validity and ethical conduct of research?

The *Research Act* [Cap 152] requires permits to be issued for overseas researchers. There are no other specific legislative requirements. There is a national Health Research Ethics Committee at the Ministry of Health.[7]

[7] World Health Organisation Regional Office for the Western Pacific, Secretariat of the Pacific Community & the University of New South Wales (2006) *Second Generation Surveillance Surveys of HIV, other STIs and*

Does the legislation require subjects to be provided before, during and after participation with:

Counselling
Protection from discrimination;
Health and support services?
There are no specific legislative requirements.

Does the legislation provide for informed consent to be obtained from the subjects?
There are no specific legislative requirements.

Does the legislation provide for confidentiality of personal information obtained in the process of research?
There are no specific legislative requirements.

Does the legislation provide for subjects to be guaranteed equitable access to the information and benefits of research?
There are no specific legislative requirements.

Does the legislation provide for non-discriminatory selection of subjects?
There are no specific legislative requirements.

CHECKLIST 10 – ASSOCIATION, INFORMATION, CODES OF PRACTICE

Does the law enable the unrestricted movement of people because of their membership of vulnerable groups, e.g. sex workers?

The *Constitution* Section 14 provides that citizens have the fundamental right to freedom of movement. This may be difficult to enforce in practice particularly for populations who are marginalised and whose behaviours are criminalised such as sex workers and men who have sex with men.

Does the legislation enable the unrestricted association of members of vulnerable groups e.g. gay men?

Risk Behaviours in Six Pacific Island Countries (Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Vanuatu) WHO WC 503.41, p.81.

The *Constitution* Section 13 provides that citizens have the fundamental right to freedom of assembly and association. This may be difficult to enforce in practice, particularly in the case of associations of sex workers or men who have sex with men, as soliciting and buggery remain a crime.

Does censorship legislation contain exceptions for general and targeted HIV/AIDS information?

There are no exceptions for HIV information that contains sexually explicit information or images, although a defence may be available that disseminating the information or image is for educational purposes and public benefit.

The *Cinematograph Act* [Cap 137] provides for the censorship of films. Permits may be issued free for charitable, educational or public purposes.

Under the *Customs Act* [Cap 121] 'indecent or obscene prints, paintings, photographs, books, cards, lithographic or other engravings or any other indecent or obscene articles' are prohibited imports.

Sections 173 and 174 of the *Penal Code* prohibits the possession, sale, exhibition, or publication of obscene articles or those tending to corrupt public morals, and of obscene videos or photographs.

Do broadcasting standards contain exceptions for general and targeted HIV/AIDS education and information?

No broadcasting standards were identified. Under Section 24 of the *Broadcasting Act* [Cap 112] the Minister may prohibit the Solomon Islands Broadcasting Corporation from broadcasting any material, in which case the prohibition must be reported to Parliament.

Does the law require the following professional groups to develop and enforce appropriate HIV/AIDS Codes of Practice: Health care workers; Other industries where there may be a risk of transmission, e.g. sex or funeral workers; Media; Superannuation and insurance; Employers (in a tripartite forum involving unions and government)?

There is no legislation requiring professional groups to develop or enforce HIV Codes of Practice. Section 26 of the *Safety at Work Act* gives the Minister power to approve Codes of Practice as guidance. It would be beneficial to develop a Code of Practice on

HIV and employment, drawing on the International Labor Organization Code of Practice on HIV/AIDS to address issues such as workplace discrimination and universal infection control procedures.[8]

Are such Codes of Practice required to contain the following elements: Confidentiality/privacy protections; Informed consent to HIV testing; Duty not to unfairly discriminate; and Duty to minimize risk of transmission, e.g. occupational health and safety standards including universal infection control precautions?

No Codes are required.

2.4.3 Prevalence of recent intimate partner violence

a) Solomon Islands Family Safety Study of 2009

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

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

According to the SIFHS, women who were victims of Intimate Partner Violence (IPV) were significantly more likely to report that their current partner, or any other partner, had abused their children (emotionally, physically and/or sexually) (36%

[8] International Labor Organization (2001) *ILO Code of Practice on HIV/AIDS and the World of Work* www.ilo.org/aids

versus 11%, P<0.001). In fact, women who have experienced IPV are 4.5 times more likely to have children who are also abused than those who have not experienced partner violence (AOR1 = 4).

Second Generation Sentinel Study – 2015

In this Study, About 12.3% antenatal women reported that they were forced to have sexual intercourse at least once in their lifetime (Table 7). Younger women were more likely than older women to be the victims of sexual violence. Most often, the perpetrators were their partners, neighbours or family friends. Other sexual offenders included relatives and work colleagues. In most countries, sexual violence is not recognised as a health problem. As a result, harmful effects of coerced sex, are largely ignored by the public health professionals.

Table 7: Experience of having forced sex in antenatal women by age group, 2015

Forced sex	**Age group**				**All**
	15 – 19 (%)	***20 – 24 (%)***	**15 – 24 (%)**	**25 – 49 (%)**	
Ever forced to have sex	*14.8*	*13.9*	14.1	11.0	12.3
Relationship with person who forced to have sex*					
Partner	*25.0*	*20.7*	21.6	22.5	22.1
Relative	*12.5*	*17.2*	16.2	12.5	14.3
Neighbour	*37.5*	*20.7*	24.3	20.0	22.1
Work colleague	*0.0*	*3.4*	2.7	5.0	3.9
Stranger	*12.5*	*10.3*	10.8	20.0	15.6
Family friend	*12.5*	*27.6*	24.3	20.0	22.1

Violence against women was defined in this study as whether she had experienced physical or sexual violence from a male intimate partner in the past 12 months. About 15.6% antenatal women reported that they had been the victims of some form of physical or sexual violence from male intimate partners in the past twelve months (Table 8). The distribution of the types of violence are presented in Figure 5. It appears that 'slapping that could physically hurt 'or 'forcing to have sex against her will' were the most common forms of violence against women in Solomon Islands.

Table 8: Physical or sexual violence by the partners by age group of women, 2015

Experience of violence	Age group				All
	15 – 19 (%)	*20 – 24 (%)*	15 – 24 (%)	25 – 49 (%)	
Yes	*9.1*	*14.4*	12.9	17.2	15.6
No	*90.7*	*85.6*	87.1	82.8	84.4
N	***54***	***209***	**263**	**367**	**630**

Sexual abuse during pregnancy is an important risk factor for both the women and their unborn children that leads to increased risk of pregnancy complications, miscarriage and low birth weight delivery (Hadi 2000). The psychological well-being of women may also be affected by physical or sexual violence while it is still not known whether physically abused pregnant women are less likely to receive prenatal care than non-abused women. The long-term effects of sexual abuse are not clearly understood although it has been reported that abused women may develop such multiple medical complications as chronic pelvic pain and other somaticized symptoms (Hadi 2000).

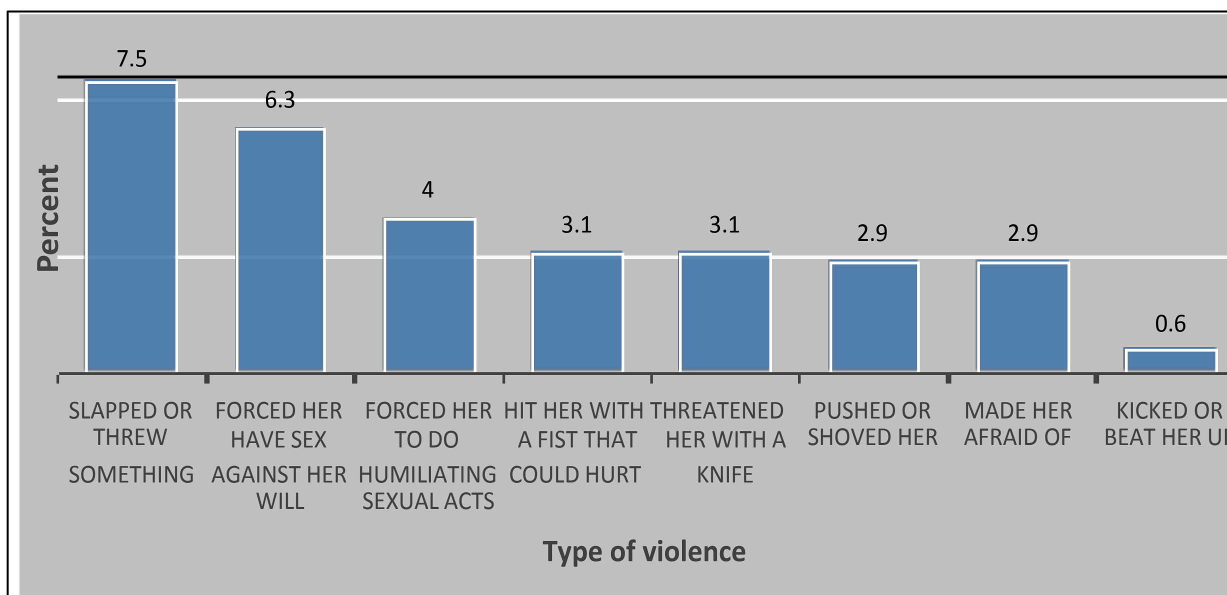

Figure 5: Physical and sexual violence against women from partners, 2015

Save the Children Study - 2016

In a 2016 study by Save the Children, over half (n=173, 58%) of the participants who had consumed alcohol in the past 12 months reported that they had become violent or aggressive at least once during a session of alcohol use in that period. Nearly two-thirds (64%) of this group indicated that alcohol was the cause of their violence/aggression on half-to-every occasion. Males were significantly more likely to report an instance of violence/aggression in the past year while consuming alcohol compared to females (63% vs. 40%, respectively), as were participants aged 20-24 years compared to those aged 15-19 years (69% vs. 47%, respectively).

In addition, survey respondents from Choiseul were significantly more likely to report becoming violent/aggressive during a session of alcohol use in the last year (77%), compared to Malaita (63%), Western (49%) and Guadalcanal (39%) provinces. The most commonly reported victims of such violence were these participants‟ parents (83%), 13 as demonstrated in Figure 1 below:

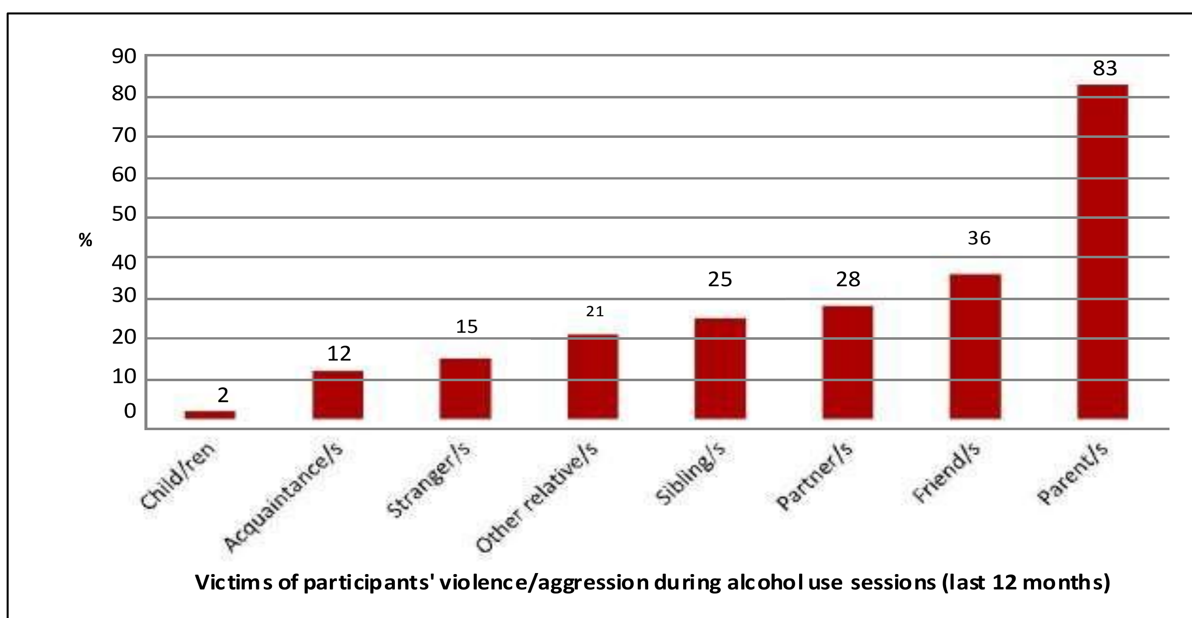

Figure 6: Victims of participants (n=173) who reported becoming violent/aggressive during at least one session of alcohol use during the previous year

Further bivariate analyses indicated a small number of additional factors that were significantly associated with becoming violent or aggressive during at least one session of alcohol consumption in the last 12 months:

- Older age among participants, i.e., within the 15-24 year age bracket (this finding held when age was analysed as both a continuous and dichotomous variable in relation to alcohol-related violence/aggression in the past year).

- Lifetime use of marijuana.
- Residing in rural/regional areas versus urban/peri-urban
- Consuming a higher number of store-bought drinks per „usual‟ session in the last four weeks.
    - Accordingly, spending a larger amount of money on alcohol per week in the last four weeks, in addition to experiencing alcohol-related financial problems in the past 12 months.
- Experiencing alcohol-related legal problems in the past 12 months.
- Recording less cumulative satisfaction or happiness with life, according to the PWI.

In 2016, the MHMS developed National GBV Guidelines containing Policy and Clinical Protocols for Minimum Standards of Treatment of Survivors of Sexual and Gender-based Violence. The guidelines were developed to ensure that there is appropriate delivery of a minimum standard of services to all victims of SGBV (HIV and STI services), who present to the health care system, based on the background that:

- Rape survivors need to access life-saving medicine in a timely manner.
- Abused women and children are likely to seek health services first before accessing other means of help.
- Family violence is often an underlying cause of injury, poor child development, ongoing health problems, and mental health conditions.
- Most women attend health services at some point, especially sexual and reproductive health, providing a point of contact and assessment for those exhibiting signs of SGBV.
- If health workers know about a history of violence they can give better services for women, including: Safety planning; Identifying women in danger and implementing safety strategies before violence escalates; Providing appropriate clinical care, reducing negative health outcomes and improving the health of survivors and their children; Assisting survivors to access the multisectoral support needed to end the cycle of violence in their family.
- International human rights principles and the Constitution of the Solomon Islands obligates MHMS to provide the highest standard of health care to all survivors of SGBV.

These guidelines further aim to ensure that quality medical and psychosocial care of survivors is given by all MHMS employees with adherence to Solomon Island law and international best practice for health sector responses to SGBV, and to: enhance skills, knowledge and information necessary for providing treatment, care and support to survivors of SGBV; improve knowledge on the importance of providing timely access to medical and psychosocial care; enhance skills, knowledge and information required for effective medico-legal interaction, which includes documenting and managing

survivor care to support medical as well as legal purposes; provide standards for provision of integrated medical and psychosocial services to survivors of SGBV; provide guidance on safe, confidential and consented referral of survivors between multi-sectoral services for survivors of SGBV; and provide the information needed by all health care providers to raise awareness and to advocate for prevention of violence in the communities in which they serve.

2.5 **Commitment 5:** Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

The high STI rates in Solomon Islands reveal underlying high-risk sexual behaviours, which have been confirmed by several behavioural studies among ANC women and youth. A study among youth in 2008 found that 16 percent of females and 19 percent of males had had *their first sexual contact before 15 (MHMS, 2008)*. Similar results were found in a study by UNICEF among mainstream and most-at-risk young people in 2009: 15 percent of all youth had first sex before 15; in Honiara this was considerably higher at 28.8 percent. The results revealed big differences in first sex before 15 between most-at-risk adolescents (52.4%); especially vulnerable adolescents (25%) and mainstream youth (4.5%), which shows the importance of differentiating between higher and lower risk youth for interventions *(UNICEF, 2010)*.

In the 2008 study among youth, more than half (52%) of the males and one-third (33%) of females had had *more than one sex partner in the last 12 months*, with an average number of partners of 3.8 for males and 2.6 for females *(MHMS, 2008)*. Furthermore, more than half (56%) of males and 41 percent of females had *concurrent sexual relationships (MHMS, 2008)*.
Low condom use

2.5.1 Risky behaviour among young people in Solomon Islands

Low Condom Use

Condom use remains a major challenge among young people in Solomon Islands, hence the prevalent rate of teenage pregnancy in the country. DHS (2007) found that by the age of 19, one in four teenage girls have become mothers with consequent impacts on their educational and economic prospects and those of their baby; children of teenage mothers tend to have poorer health and education outcomes. The median

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

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

Several other studies report low condom use among any population: results from a surveillance study among ANC women show that more than 10 percent had never heard of male condoms, while almost half (47%) had never heard of female condoms. Only half (53%) had ever used a condom, and 63 percent never used a condom in the past 12 months. The same study also included male and female young people, which showed higher condom use: 32 percent of males and 26 percent of females had used a condom at last sex. However, 38 and 42 percent of males and females respectively had never used a condom in the past 12 months. Most important reasons given for not using a condom included 'not easily available' (38%) and 'less pleasure' (21%) *(MHMS, 2008)*.

The 2009 UNICEF study which included adolescents and young people from different risk backgrounds reported condom use at last sex by 37.3 percent of all respondents, with higher percentages among males (42.3%) than among females (33.1%) *UNICEF 2010*. The study revealed interesting differences in *condom use at last sex* for different subgroups: *especially vulnerable* adolescents (54.5%), *most-at-risk* young people (48.8%) and adolescents (38.6%) used condoms more frequently than *mainstream* youth (33.8%), possibly reflecting greater sexual experience and skills. Condom use at

last sex was also considerably higher among males (42.3%) than females (33.1%), possibly due to less negotiating power of girls with older sex partners. Age was another important factor, as condom use was considerably higher among young people (20-24 years) (46.8%) than among adolescents (15-19 years) (31.1%) (*UNICEF 2010).*

Friendliness and Quality of Services for young people

The Primary Health Care (PHC) facilities in the country continue to have a strong focus on pregnant women and children during ANC and PNC clinics; therefore access by young people and men through the PHC system is inhibited, especially for vulnerable groups such as adolescents, Sex Workers (SW) and Men who have Sex with Men (MSM). Currently, these key populations, mainly comprising young people, have found it more convenient to access services at Youth Friendly Health Services (YFHS) facilities especially SIPPA clinics. There are currently seven active YFHS clinics in the country, 3 of which are Government Health Facilities (Rove Clinic in Honiara, Kukum Clinic in Honiara and GUNS Clinic in Western Provinces) and 4 run by Solomon Islands Planned Parenthood Association - SIPPA (SIPPA Honiara, SIPPA Gizo, SIPPA Taro and SIPPA Malaita) – a good start, but insufficient to meet needs given lack of young people's access to alternative sources of reproductive and sexual health information and clinical services and products.

Transactional sex and sex work

In Solomon Islands, young men and women are known to exchange sex for cash, food and goods. Social and cultural norms, including gender inequality and high rates of gender-based violence, further contribute to women and girls' risk and vulnerability to infection and contribute to barriers in access to HIV services.

Increased transactional sex activity is connected to areas of economic activity including mining, logging, canning and infrastructure projects, but detailed evidence of the scale of sex work and risk factors is not yet available. An assessment of vulnerable groups in 2006 by Save the Children attracted the participation of just 6 men having sex with men and 38 sex workers, providing evidence of the existence of these two vulnerable groups in the country. The national HIV programme plans to conduct detailed studies and mapping of key populations such as MSM and SW in 2017 under the newly acquired Global Fund HIV grant.

Several studies reveal that transactional sex and sex work are relatively common among young people. In the 2008 survey among young people,13 percent of males and 9 percent of females had engaged in transactional sex, receiving goods or favours for

sex *(MHMS, 2008)*. In the bio-behavioural survey among ANC women in 2015, 2.1 percent of women reported they had received money or gifts in exchange for sex in the past 12 months *(MHMS, 2015b)*,

The UNICEF study in 2009 *(UNICEF, 2010)* among youth with different risk patterns – mainstream, most-at-risk and especially vulnerable – revealed that 12.4 percent of the total study population had had *sex for money*: almost one-fifth (18.7%) of females and 6.5 percent of males. Young people (20-24 years) engaged more in sex for money (15.1%) than adolescents (15-19 years) (10.1%). Commercial sex was much higher among youth in Honiara (23.3%) than in other provinces. A considerable proportion of youth also engaged in *transactional sex* – sex for gifts, goods or favours: 10.7 percent of the total population, with females 16.5 and males 5.2 percent. Alarmingly, two-thirds (66.1%) of those engaging in transactional sex had *not* used a condom at last sex *(UNICEF, 2010)*. *Reasons given for engaging in transactional sex* included 'need money' (60%), 'was forced' (11%), 'need food' (7.9%) and 'need drugs or alcohol' (3.2%) *(UNICEF, 2010)*.

Forced sex and gender-based violence

Apart from risk behaviours where partners have a level of control over condom use and other protection, *forced sex* leaves no room for protection, and therefore constitutes a key risk for HIV transmission, as well as other sexual and reproductive health problems, including unwanted pregnancy and psychological trauma. Studies on transactional sex reveal that part of this is forced sex (see above) *(UNICEF, 2010).*

Gender-based violence is a cross-cutting theme in most studies on HIV, STIs or reproductive health in the Solomon Islands. In the most recent survey among ANC women in 2015, 15.6 percent reported physical or sexual violence from male intimate partners in the past 12 months, with 6.3 percent reporting forced sex (past 12 months), while 12.3 percent reported 'ever forced sex' *(MHMS, 2015b)*. In the 2008 study among young people, almost half (48%) of female respondents reported 'ever forced sex', against one-quarter (25%) of males, most often by older males. Perpetrators of forced sex were mostly partners or 'friends' *(MHMS, 2008)*. The same study also included ANC women, 29 percent of whom reported ever been forced to have sex.

The 2009 UNICEF study, which included sub-samples of most-at-risk and especially vulnerable adolescents and young people, showed even more worrying results: 38.1 percent of sexually active youth reported that they had been forced to have sex when they did not want to, with a large majority of 71 percent saying they were still vulnerable. The results showed stark variations across the different provinces, with

more than two-thirds (68.3%) of youth in Choiseul reporting forced sex against 43.3 percent in Western Province; 30.4 percent in Malaita and 23.3 percent in Honiara *(UNICEF, 2010)*. Differences were even bigger among different groups of youth: 'mainstream' youth (17.3%), compared to most-at-risk adolescents (70.5%) and especially vulnerable young people (82.4%): these results show the need for accurate targeting of HIV/STI-prevention interventions, and the need to place these interventions in a wider perspective of sexual and reproductive health and rights, with *special attention for gender-based violence*.

Child trafficking and commercial sexual exploitation of children (CSEC)

A recent report gives further evidence of alarming types of sexual abuse, trafficking and sexual exploitation of children. It mentions that double standards attached to marriage and sexuality codes contribute to weaken women's intra-household bargaining power, thus reinforcing girls' and women's vulnerability to exploitation such as trafficking and commercial sexual exploitation. Findings from Choiseul Province in particular show an alarming influence of gender power relations involved in the recruitment of girls for transactional sex with logging workers *(Kojima et al, 2015)*. Logging sites and fisheries are mentioned as key risk areas for exposure to child trafficking and CSEC: children may go to logging or fishery sites to engage in vending or small jobs, and often get cash, alcohol or goods from foreign or local workers in exchange for running errands. So-called *solairs* are intermediaries who arrange local girls for foreign or fishery workers. Often, local girls working as house girls engage in transactional sex or forced sex.

Men who have sex with men

While several studies have looked into HIV, STIs and risk behaviours among ANC women or young people, very little research has been done among men who have sex with men (MSM). In the 2008 survey among young people, 0.8 percent of males (15-24 years) in Honiara reported sex with another man in the past 12 months *(MHMS, 2008)*. The UNICEF study among different types of youth in 2009 found only 5 respondents out of 233 (2.1%) reporting sex with men in the past 12 months *(UNICEF, 2010)*. These percentages are not statistically significant, and may represent an under-estimate of the true proportion of MSM: homosexual acts are illegal in Solomon Islands, and there is strong societal stigma towards MSM, which may result in reluctance to report MSM behaviour in studies. As mentioned above, in the 2008 study among youth, 25 percent of males reported ever being forced to have sex, including by male perpetrators *(MHMS, 2008).* This may indicate that more men than commonly thought seek MSM sex, and may find it easier to force young men or boys into sex. Some programmes for MSM have been implemented in the last few years, but no HIV-

related data has been collected and there is no documented evidence about their sexual risk behaviours.

2.5.2 Services provided to adolescents and young people

According to a 2016 study by Save the Children, "Alcohol, other substance use and related harms among young people in the Solomon Islands", boredom and an excess of spare time were cited by both young people and key stakeholders as issues that lead to involvement in alcohol and other substance use (thereby increasing the likelihood of experiencing associated harms such as gender-based violence and engagement in risky behaviour). Previous research has demonstrated positive associations between unemployment and alcohol and other substance use in both directions; e.g., risky substance use is prevalent among unemployed individuals, and unemployment is a significant risk factor for substance use and the development of substance use disorders. The study recommended that sustainable, government-led approaches to generating employment and education opportunities – in consideration of relevant contexts (e.g., urban vs. rural regions) – could address this area and produce positive outcomes for young people, their families and the wider Solomon Islands community. Currently, Youth @ Work, an Australian government-funded initiative designed to generate and foster relevant knowledge, skills and employment opportunities among young people in the Solomon Islands, is a well-received program; however, given that Youth @ Work is primarily Honiara-based, its scope in reaching young people in other provinces is limited in the context of reportedly-high demand. Further, in focus group discussions both young people and key stakeholders highlighted and provided examples of the benefits of implementing sporting activities (e.g., soccer competitions, boxing clubs) in communities, including occupying time, generating skills and fostering positive relationships. Implementing similar programs on a wider scale (in urban, peri-urban and rural/regional areas) could result in additional positive outcomes among young people and the general community.

Adolescents being a core focus for HIV/AIDS response globally, UNICEF in collaboration with UNFPA and the Adolescent Health Development programme of Solomon Islands, has supported the scale-up of HIV/AIDS interventions targeting adolescents in the country. In 2016, UNICEF provided technical assistance in the development and printing of a national operational guidelines for provision of youth friendly health services; and the development and roll out of a peer educators training of trainers manual for capacity building of adolescents and youth in school and out of schools on HIV/AIDS prevention and treatment services. UNICEF has also supported the establishment and furnishing of two youth friendly health services facilities in two provinces, and will continue to support supplies for HIV testing and health education

material to these sites to increase awareness of HIV/AIDS among adolescents and young people, as well as increase uptake of HIV/AIDS prevention and treatment services friendly for adolescents. UNICEF will further train health workers on providing friendly HIV/AIDS services for adolescents.

Pacific Island Countries are faced with geographic challenges making it difficult for some remote islanders to access health facilities, hence UNICEF has continued to support the Ministry of Health and Medical Services to conduct community outreaches to bridge the gap of health awareness and access to health services. In 2016, funding support continued to the country to conduct community outreaches on teenage pregnancy, HIV/AIDS and STI awareness, testing and referral for treatment in eight of the ten provinces of the country. Outreaches were conducted in secondary schools and communities. The programme covered over forty Secondary Schools, thirty primary schools and twenty communities with health education outreaches. One HIV and STI testing and treatment outreach was conducted in Isabel province during a week-long annual cultural festival.

2.6 **Commitment 8:** Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

2.6.1 Total HIV expenditure

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

However, compared to other programmes, HIV is the least funded programme by SIG, with most of the SIG allocations being for payroll expenses eg staff salaries and benefits. The table below shows annual total expenditures with funds from both Government and Development Partners, for HIV, TB and Malaria Programmes, clearly showing where the country's priorities lie, probably based on their respective (disease) burdens to the country.

Table 9: showing Annual Expenditures for HIV, TB and Malaria 2014 - 2016

Programme	Funding Source	2014 ($)		2015 ($)		2016 ($)	
		Expenditure	Budget	Expenditure	Budget	Expenditure	Budget
HIV/STI	SIG	817,677	957,837	768,681	811,514	641,180	722,916
	Dev't Partners	659,350	1,688,282	92,009	293,388	522,268	1,293,436
HIV/STI Total		**1,477,027**	**2,646,119**	**860,690**	**1,104,902**	**1,163,448**	**2,016,352**
TB/LEP	SIG	505,178	515,793	533,169	498,644	566,812	521,759
	Dev't Partners	212,977	625,664	672,382	1,463,457	1,585,231	4,542,998
TB/LEP Total		**718,155**	**1,141,457**	**1,205,552**	**1,962,101**	**2,152,044**	**5,064,757**
NVBDC	SIG	1,891,268	1,972,757	2,230,963	2,120,890	4,612,162	4,688,136
	Dev't Partners	5,701,475	13,218,535	6,098,929	8,068,117	5,998,097	8,102,464
NVBDC Total		**7,592,743**	**15,191,292**	**8,329,892**	**10,189,007**	**10,610,259**	**12,790,600**

Funding for HIV activities from others sources remains very limited as well. Considerable funds were available several years ago from the Australian-New Zealand Response Fund, which supported HIV/AIDS programmes in the wider Pacific region, including Solomon Islands. In addition, very small amounts have been provided by UN agencies, notably UNICEF supporting PMTCT and adolescent health interventions, UNFPA supporting condom supplies and adolescent health. For 2016, UNICEF has committed USD 125,000 for HIV and STI-related activities, while DFAT has committed SBD 38,047 (equivalent of USD 4,853), and WHO USD 44,988.

Government and donor funds committed to the National Response activities for 2016 amount to USD 194,750, while the NSP budget for that year is USD 808,408: thus, a mere 24 percent of the total NSP budget for 2016 was funded, leaving a funding gap of 76 percent. Most of the government funding for HIV is allocated to payroll expenses eg staff salaries and benefits, as shown in table above.

With competing priorities and decreasing willingness of donors to fund HIV/STI-related interventions, the expected funding gap for the near future – including the 2017-2019 – is expected to go beyond the current 76 percent of the NSP budget.

2.7 **Commitment 10:** Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

2.7.1 Tuberculosis

HIV testing among TB patients in Solomon islands continues to be low in Solomon Islands, with only 57 out of 302 (18.9%) patients accessing HIV testing in 2016, according to the National TB Program report for 2016. Also, none of the 13 PLHIV currently in the country has been started on IPT as recommended by the new national HIV treatment guidelines. It is important to strengthen HIV testing among TB patients in Solomon Islands given the country is highly burdened by the disease. To-date, only one case of TB-HIV co-infection has been reported, and this occurred in 2015. The client was a late diagnosis after an HIV test was recommended while on admission in the TB ward. The client died soon after being enrolled on ART.

Historically, there has been few programmatic links between the Solomon Islands National TB Programme and the HIV response. In 2010, TB treatment and management guidelines were formally reviewed and updated to include HIV/TB co-management, and in 2011, 12 TB nurses and coordinators throughout the country were trained to do HIV counseling and testing. Since then, have been programmatic links between the NTLP and the HIV programs. TB/HIV collaborative activities were introduced in the TB manual updated in 2012 while the HIV programme staff were involved in the development of the TB NSP, which includes HIV in its situation analysis and its strategies. The same was true for the new HIV NSP in whose development the NTLP programme manager was involved while the National ART guideline has a special chapter devoted to TB/HIV collaborative activities.

TB staff have been trained on PITC and HIV testing has started to be routinely offered to TB patients in 2010 and PLHIV are screened for TB whenever they come to pick up their ARVs from the HIV programme although this is not performed on a systematic way. The TB recording and reporting system was revised in 2013 to capture all information needed to monitor collaborative TB/HIV activities from the TB programme side.

According to WHO, Tuberculosis is a major public health challenge in the Solomon Islands. Around 400 TB patients are registered every year, mainly young adults, and around 20% are children, indicating high transmission.

Solomon Islands has the highest number of TB cases in the Pacific Island Countries and Territories (PICTs) after Papua New Guinea. In 2012, the World Health Organization (WHO) estimated a TB prevalence of 830 cases with an estimated

prevalence rate of 151 cases per 100,000 population. For the same year, the estimated incidence rate was 97 cases per 100,000 population and the estimated mortality rate was 15 per 100,000 population[9]. In 2013, 360 TB cases (among them 352 new and relapses) were reported, representing a case notification rate of 62.2/100 000 population.

Most incident, i.e. new and relapses, TB cases all forms are in the 15-34 year age group (42.2%). Children under 15 represented 18% of all TB cases in 2013 indicating likely over diagnosis as childhood TB should account for 5–15% of all TB cases in low- and middle-income countries. The graphs below show that the age distribution of absolute numbers of cases is slightly different from the age distribution of notification rates. The highest number of absolute cases is in the 15–24 year age group, while the notification rate is highest in the 55–64 year age group. Also, the notification rate among people aged over 65 years is higher than in the age groups below 45 years of age, while the absolute number of cases is the lowest in this age group. The fact that the notification rates increase with age, with the oldest age groups having the highest rates, is a reflection of declining infection rates over time.

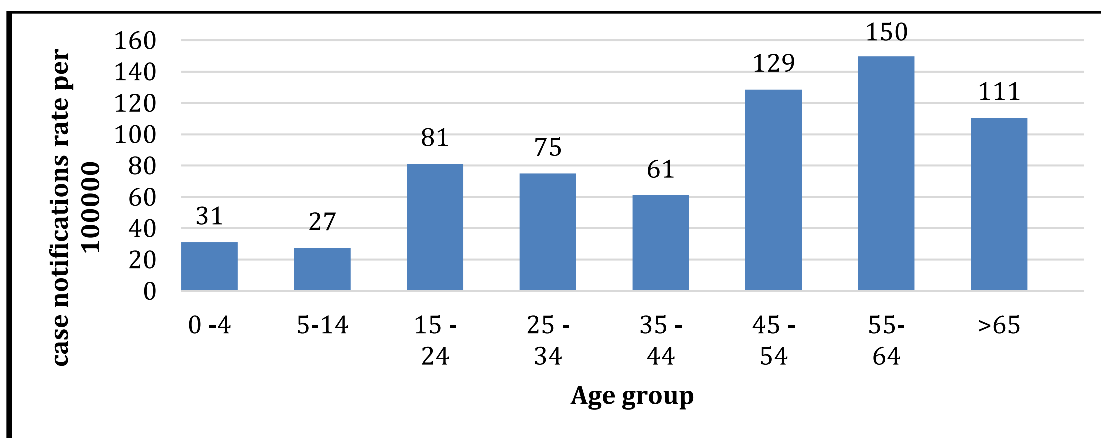

Figure 7 showing TB case notification rates by age group Solomon Islands, 2013

[9] Global TB Report, WHO, 2013, p270

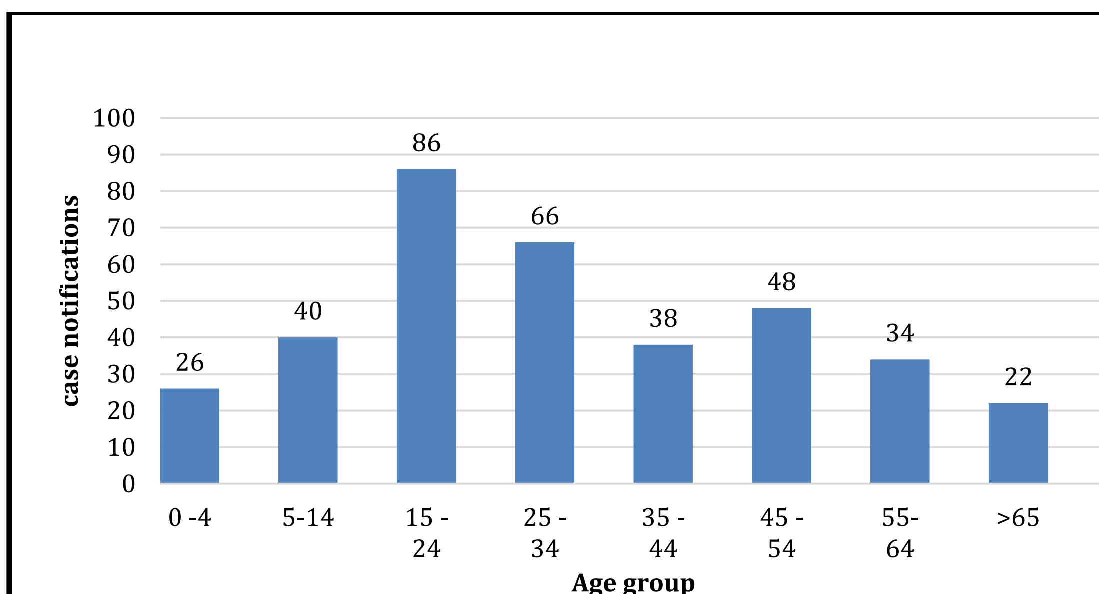

Figure 8 showing TB case notification by age group in Solomon islands, 2013

The TB death rate among all notified TB cases has not changed notably from 2005 to 2012, and has stayed below 7%. The TB death rate among new smear–positive cases has also stayed relatively stable between 1 to 2 % in that time. This number is very low, probably because smear positive patients who die before treatment start are usually not included.

Although no MDR case has been detected in the country WHO estimates that 4.9% of new cases and 23% of retreatment cases are with MDR. The neighboring country, Papua New Guinea, has already reported numerous MDR TB cases and some XDR TB cases. Similar a risk as it is for the case of HIV, PNG citizens living in Bougainville often cross the border several times a day in order to visit their family members and friends living in Solomon Islands. The first R resistant reported by Solomon Islands was originally from PNG. Adding to the likelihood of MDR is the fact that DOT is not taking place during the continuation phase of treatment.

2.7.2 Cervical Cancer

In Solomon Islands todate, women living with HIV have had cervical cancer screening as part of their integrated service, but the country is steadily making inroads in strengthening cervical cancer services in general, for all women especially young girls.

In 2015 and 2016, the Solomon Islands Ministry of Health and Medical Services (MHMS) (MHMS) implemented a human papillomavirus (HPV) vaccine coverage survey to generate population-based estimates of the coverage of fully vaccinated girls

according to the strategy employed in the region: percent of girls aged 9 to 12 years (as of end of April 2015) who received both HPV vaccine doses on schedule.
The survey involved implementing of vaccinations against HPV, which is the necessary cause of cervical cancer. The primary objective of HPV demonstration project was to learn from the delivery of HPV vaccine to a small population before possible scale-up nationally.

Honiara City Council and Isabel Province offered HPV vaccine to all girls aged 9 to 12 years at school, health centers, and through outreaches. After a national launch on 28 April 2015, two rounds of vaccinations were implemented in the first year of demonstration project: first round April-May 2015 (HCC) and June-July (Isabel); and second round February-March 2016 (both areas).

Administrative data collected through vaccine registries maintained by the province health office suggest that more than 90% of eligible girls received both doses of HPV vaccine. To confirm these results and to gain insight into the reasons why parents/guardians did or did not have their child vaccinated as well as the impact of the social mobilization activities, a community-based survey of HPV vaccine coverage was designed and conducted.

The HPV vaccine coverage survey is a part of the required evaluation framework of the Gavi-funded HPV vaccination demonstration program, which also includes an assessment of adolescent health interventions (to be conducted by WHO), a post-introduction evaluation or PIE (conducted by WHO), and a micro-costing exercise (conducted by the MHMS and PATH).

Vaccine coverage

The program in HCC and Isabel provinces was quite successful. In HCC, 71.8% of eligible girls were fully vaccinated, 11.6% received only one dose, and 16.6% were not vaccinated at all. In Isabel province, 91.1% were fully vaccinated, 5.4% received one dose, and 3.6% were not vaccinated.

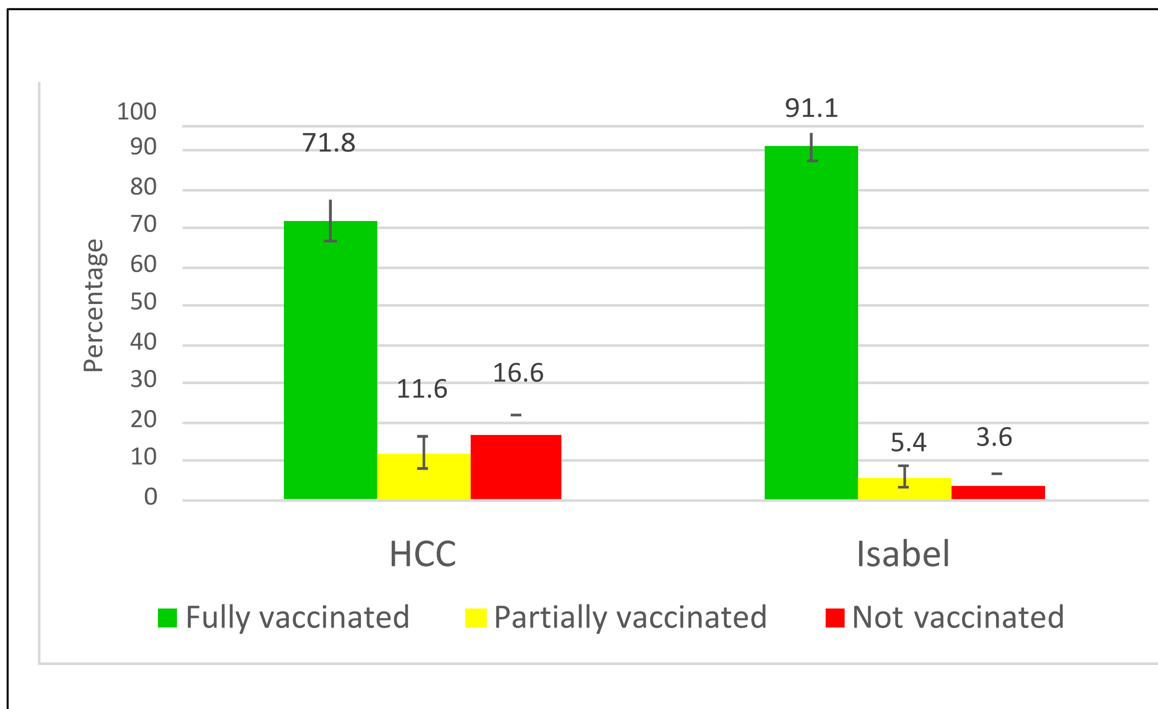

Figure 9: HPV vaccine coverage, HCC and Isabel province, Solomon Islands

Administrative data collected at the regional level reported that the vaccination coverage for both doses for girls in school was 77.4% in HCC and 85.1% in Isabel province. These coverage levels from the administrative data fall just outside the margin of error of the survey and suggest the possibility of under-reporting/under-recording in Isabel and over-reporting/over-recording in HCC.

There were too few girls out of school to accurately estimate coverage in these populations; however, it should be noted that only 2% (n = 6) of the girls in the survey in Isabel and 8% (n = 22) in HCC were reported to be out of school. Both provinces had some in- and out-migration to other provinces between the two doses, which elevated partial vaccination rates, particularly in HCC.

Table 10: Knowledge and awareness of cervical cancer, HPV, and HPV vaccination among parents/guardians of girls eligible for HPV vaccine, HCC and Isabel province, Solomon Islands, 2015

Subject matter	HCC (n=277)	Isabel (n=280)	Total (n=557)
Knew HPV vaccine protects against cancer	44.8%	53.6%	49.2%
Knew who was eligible to receive HPV vaccine	39.0%	44.3%	41.7%
Knew 2 doses were needed for protection	22.4%	27.5%	25.0%
For those that knew you needed 2 doses, correctly mentioned at least 6 months required between doses	38.7%	61.0%	51.1%
Had heard of cervical cancer	61.0%	68.6%	64.8%
Had discussed HPV vaccine with their child*	22.7%	30.0%	26.4%
Had heard rumors that HPV vaccine was not safe	13.4%	2.5%	7.9%

Despite low knowledge and awareness, more than 90% of parents/guardians in Isabel province and more than 70% of parents/guardians in HCC had their child vaccinated, and rumors was only a reason to not vaccinate for 3 of the 557 (<1%) parents interviewed. Parents/guardians were asked who they spoke with about HPV vaccination and what type of IEC materials they received prior to vaccination. The responses varied between HCC and Isabel province.

In HCC, parents spoke with health workers (21%), teachers (18%), and family members (16%) prior to vaccination. However, fully 24% indicated that they did not speak to anyone prior to vaccinations and 16% only heard about the program from their child (usually after vaccinations were completed). IEC materials and sensitization events were not frequently reported. They heard radio spots (18%), received a leaflet (15%), heard a radio talk show (15%), heard announcements at church (12%) and some received mobile text (10%).

By contrast, in Isabel province, parents spoke with health workers (35%), family members (13%), or community leaders (10%) prior to vaccination; 30% of parents spoke with no one. They heard announcements in churches (32%), received a leaflet (23%), attended a community meeting (16%) or heard a radio spot (16%) or talk show (11%).

More than half of parents interviewed did not pick any IEC material or activity when asked which one was most important for them. Among the 45% of parents who did answer this question, leaflets (27%) and announcements in church (25%) were considered the most helpful. Even though radio spots and show were a frequently mentioned activity that exposed parents to information about the HPV vaccination, only 10% selected this as “most helpful” for making a decision.

2.7.3 Sexually Transmitted infections

General STI rates in Solomon Islands

While HIV rates are very low, very high STI rates in Solomon Islands reveal that the underlying behavioural risks are high, with a real potential for a future increase in HIV cases. *Table 11* shows the results from routine testing in selected ANC facilities in 2014, which reveal very high rates of syphilis: the overall rate is 13.5 percent, with particularly high rates of 30.6 percent in Gizo, Western Province; and higher rates among the 15-24 year old group than in the 25+ group (15.8% vs. 11.8%).

Table 11: Number of ANC mothers tested and treated for syphilis in Solomon Islands in 2014

SYPHILIS TESTING IN ANC, 2014 *(MHMS, HIV/STI Division)*										
		TOTAL TESTED			TOTAL POSITIVE (No. and %)					
PROVINCE	Health facility	TOTAL	15-24	25+	TOTAL		15-24		25+	
Honiara	NRH	5,824	2,488	3,328	795	13,7%	415	16,7%	378	11,4%
Western	HGH	629	262	367	86	13,7%	35	13,4%	51	13,9%
Malaita	Kilu'Ufi	732	283	447	103	14,1%	54	19,1%	49	11,0%
Choiseul	Taro	271	119	152	1	0,4%	1	0,8%	0	0,0%
Malaita	Atoifi	220	103	117	26	11,8%	12	11,7%	14	12,0%
Western	Gizo	330	160	170	101	30,6%	38	23,8%	63	37,1%
Makira	Kirakira	316	134	180	15	4,7%	7	5,2%	8	4,4%
Temotu	Lata	0	0	0	0		0		0	
TOTAL		8,322	3,549	4,761	1,127	13,5%	562	15,8%	563	11,8%

A study among young people in 2008 found high rates of chlamydia (males 10%; females 18%) and lower rates of gonorrhoea (males 4%; females 2%). *Table 12* shows the findings from the same study, but among ANC women: high rates of hepatitis B (13.8%) and chlamydia (10.8%) *(MHMS, 2008).*

Table 12: STIs Prevalence among Antenatal Women, Solomon Islands, 2008 (MHMS, 2008)

Prevalence of STIs among Antenal women, Solomon Islands, 2008			
	Tested	Positive	Rate
Trichomonas	189	34	18,0%
Hepatitis B	298	41	13,8%
Chlamydia	371	40	10,8%
Syphilis	296	10	3,4%
Gonorrhoea	371	5	1,3%
HIV	298	0	0,0%

Chlamydia Statistics in Solomon Islands

Table 13 below shows the total number of *Chlamydia tests* reported in Solomon Islands in the period 2010-2015 compared to other 14 Pacific countries: as one of the largest Pacific Island countries with a total population of 625,000, representing one-third of the combined total population in the 13 countries in this report (except Fiji), Solomon Islands represented only 10.3 percent of all Chlamydia tests in this period, with a total of 12,281 tests. It has to be taken into account that no Chlamydia testing data was available for 2013 and 2015, so the actual number of tests will have been higher. Nevertheless, compared to other countries, a relatively limited number of Chlamydia tests has been conducted in Solomon Islands.

Table 13: Total No. of Chlamydia tests, by country, 2010-2015

Country	2010	2011	2012	2013	2014	2015	TOTAL	% of total
CNMI	n/a	n/a	n/a	n/a	n/a	1,271	1,271	1.1%
Cook Islands	622	598	878	729	472	240	3,539	3.0%
Fiji	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FSM (Micronesia)	5,719	4,574	4,279	3,127	2,261	2,081	22,041	18.5%
Kiribati	n/a	1,139	1,180	1,070	123	148	3,660	3.1%
Nauru	n/a	578	208	n/a	331	849	1,966	1.7%
Niue	n/a	26	6	12	4	21	69	0.1%
Palau	1,520	1,421	1,171	1,083	583	n/a	5,778	4.9%
Marshall Islands	n/a	1,744	1,227	1,949	2,232	66	7,218	6.1%
Samoa	2,462	5,995	6,232	5,733	4,276	2,025	26,723	22.5%
Solomon Islands	4,523	2,468	3,450	n/a	1,840	n/a	12,281	10.3%
Tonga	799	4,695	1,475	3,105	1,533	n/a	11,607	9.8%
Tuvalu	n/a	525	1,157	446	655	n/a	2,783	2.3%
Vanuatu	n/a	5,243	5,344	3,704	4,308	1,391	19,990	16.8%
TOTAL	15,645	29,006	26,607	20,958	18,618	8,092	118,926	100%

Figure 10 shows the *number of Chlamydia tests* among males, females, pregnant women (ANC), as well as totals for all tests (male and female) for the period 2010-2014 *(2015 data were not available yet)*. Data on testing among *males* is available only for 2011, 2012 and 2014 and represented a very small proportion (3.7%) of Chlamydia tests in those years, as most tests were done among women (96.3%), particularly in the context of antenatal care (ANC) (84.3% of all tests among females were done among ANC women). The graph in figure SI-1 shows a sharp decline in the number of tests among (ANC) women from 2010 to 2011, which is due to the fact that zero Chlamydia tests were reported for the first seven months of 2011, hence it is possible that the actual number of tests in 2011 was similar to the number in 2010.

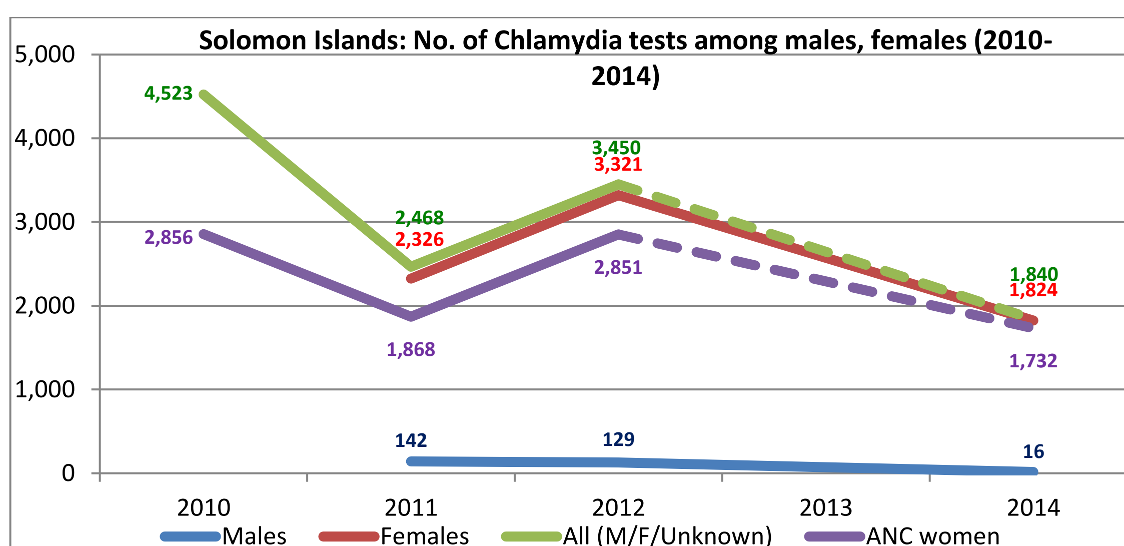

Figure 10: Total number of Chlamydia tests conducted in Solomon Islands among males and females (including ANC women), 2010-2014

On average 42.3 percent of all pregnant women were tested for Chlamydia at ANC services in the 2010-2014 period (excluding 2013, as no data were available): this is among the lowest proportions in the Pacific region, as in most countries in the region, more than 50 percent of all pregnant women are tested for Chlamydia.

Figure 11 below shows the number of Chlamydia cases detected in the 2010-2014 period: the trends closely follow the trends in numbers of males and females tested *(see Fig. 10 above)*, i.e. the more tests were done, the more Chlamydia cases were found. The low proportion of pregnant women, and the very low number of males tested for Chlamydia each year result in many Chlamydia cases remaining undetected, while evidence suggests that chlamydia *screening* is cost-effective at a prevalence of >3% *(Marrazzo et al., 1997)*. In this regard, the extremely low number of Chlamydia cases detected among males (only 5 cases in 2014) is particularly worrying.

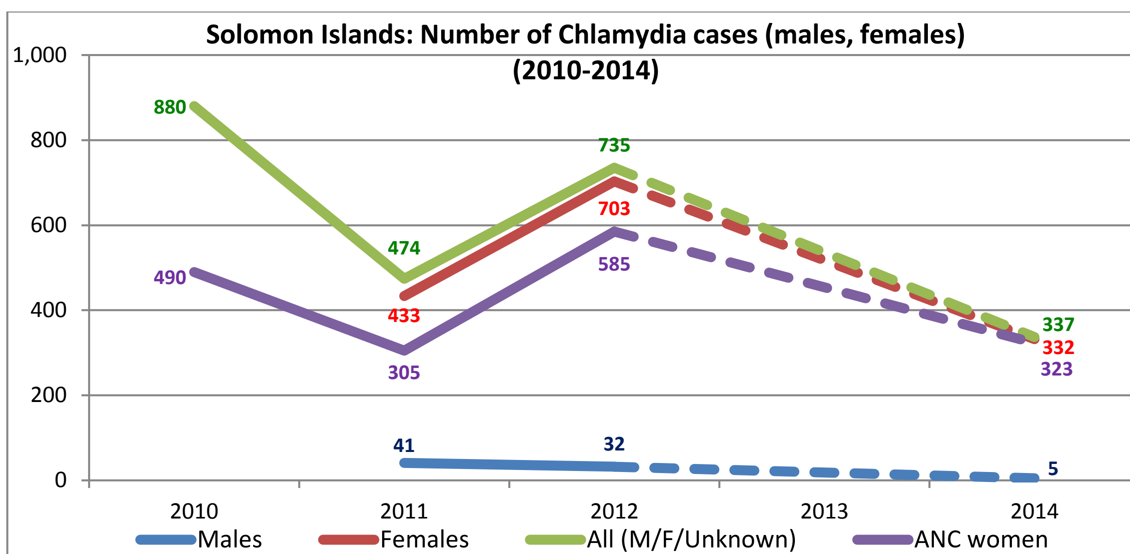

Figure 11: Total number of Chlamydia cases detected in Solomon Islands among males and females (including ANC women), 2010-2014

Figure 12 shows the *proportion of Chlamydia cases detected* among males and females (including ANC women) who were tested. The percentages do not reflect the accurate prevalence rates among these groups, as the data is facility-based – not population-based – and is therefore affected by selection bias. However, the results for *ANC women (purple line)* can be considered more representative of the general female population of reproductive age and are relatively high, ranging from 16.3 percent (2011) to 20.5 percent in 2012, with an average of 18.6 percent (2010-2014). These findings are consistent with those of a recent sexual health survey in 2014 among 296 women aged 16-49 attending three nurse-led community outpatient clinics in Honiara, which found Chlamydia infection among 20 percent *(Marks et al, 2015).* However, these percentages are *much higher* than the percentage found among ANC women in the regional study conducted in 2004-2005, which found Chlamydia among only 6.4 percent of pregnant women *(Cliffe et all, 2008).*

Overall, the proportion of Chlamydia cases among males and females (including ANC women) tested shows a relatively stable trend over time: the overall average (all women and men) is 19.8 percent, while for females this is 19.7 percent and for males 27.2 percent: the higher proportion found among males is due to the fact that most males are because they present with certain STI-related symptoms, hence they have a higher likelihood of having Chlamydia or another STI. The high average proportion of Chlamydia found among ANC women (18.6%) is, however, worrying, as it implies that almost one in every five women of reproductive age is infected with Chlamydia. Since most pregnant women are not tested for Chlamydia, many cases among this group remain undetected.

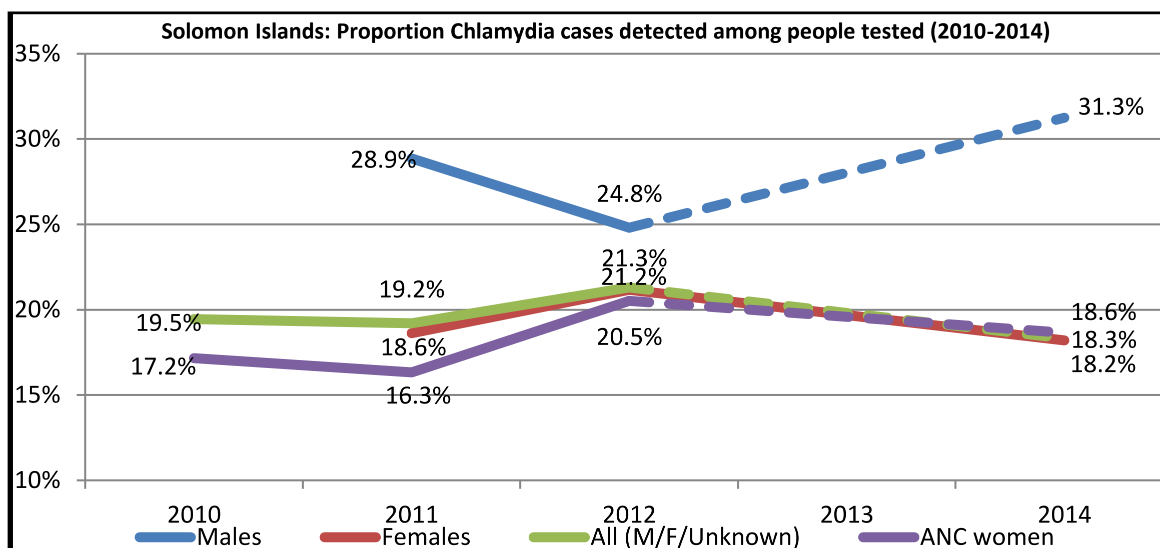

Figure 12: Proportion of Chlamydia cases detected in Solomon Islands among people tested (males, females, ANC women), 2010-2014

Table 14 shows that the overall *proportion* of Chlamydia cases among all people tested in Solomon Islands (19.8%) is slightly below the regional average of 20.1%. This is particularly true for females and ANC women, while for males the average proportion of detected cases is considerably above the regional average; however, given the very low numbers of males tested, these percentages may not be representative of the actual prevalence rates among males. As mentioned earlier, the proportion of Chlamydia cases found among ANC women (18.3%), is *much higher* than the percentages found among ANC women in the regional study conducted in 2004-2005, which only found Chlamydia among 6.4 percent of 241 pregnant women in Solomon Islands (7.3% under 25 and 5.7% above 25 years) *(Cliffe et all, 2008).*

Table 14: Proportion of Chlamydia cases among males & females tested, by country (2010-2015)

Country	Males	Females	ANC Women	Total M/F/ Unknown)
CNMI	67.2%	14.0%	30.7%	16.8%
Cook Islands	14.1%	15.9%	15.9%	15.6%
Fiji	n/a	n/a	n/a	n/a
FSM (Micronesia)	12.6%	17.3%	21.7%	15.8%
Kiribati	9.5%	13.8%	16.7%	12.4%
Nauru	16,5%	12,5%	12.6%	13.6%
Niue	0.0%	2.9%	3.2%	2.9%
Palau	16.9%	12.7%	12.5%	13.7%
Marshall Islands	14.1%	19.0%	25.5%	17.7%
Samoa	31.0%	27.9%	28.4%	27.3%
Solomon Islands	27.2%	19.6%	18.3%	19.8%
Tonga	24.6%	20.7%	23.0%	21.5%
Tuvalu	7.7%	10.6%	13.8%	9.5%
Vanuatu	29.3%	21.3%	19.7%	22.2%
Total all countries	17.5%	20.4%	21.9%	20.1%

Gonorrhoea Statistics in Solomon Islands

Table15 shows the total number of *Gonorrhoea tests* reported in Solomon Islands in the period 2010-2015 compared to other 14 Pacific countries; Solomon Islands represented only 6.3 percent of all Gonorrhoea tests in this period, with a total of 4,523 tests. This is a very low proportion, taking into account that Solomon Islands represents about one-third of the total population of the countries represented (except Fiji).

Table 15: Total No. of Gonorrhoea tests, by country, 2010-2015

Country	2010	2011	2012	2013	2014	2015	TOTAL	% of total
CNMI	n/a	n/a	n/a	n/a	n/a	819	819	1.1%
Cook Islands	622	598	360	384	506	196	2,666	3.7%
Fiji	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FSM (Micronesia)	5,995	4,811	3,868	2,696	496	1,246	19,112	26.8%
Kiribati	n/a	1,139	n/a	n/a	n/a	n/a	1,139	1.6%
Nauru	n/a	578	208	n/a	331	849	1,966	2.8%
Niue	n/a	n/a	n/a	29	1	n/a	30	0.04%
Palau	1,520	1,421	1,171	1,083	583	n/a	5,778	8.1%
Marshall Islands	n/a	1,744	470	1,060	235	40	3,549	5.0%
Samoa	2,462	5,995	324	109	9	n/a	8,899	12.5%
Solomon Islands	4,523	n/a	n/a	n/a	n/a	n/a	4,523	6.3%
Tonga	745	4,695	170	171	127	n/a	5,908	8.3%
Tuvalu	n/a	525	226	n/a	12	n/a	763	1.1%
Vanuatu	n/a	5,243	5,344	1,725	3,901	38	16,251	22.8%
TOTAL	15,867	26,749	12,141	7,257	6,201	3,188	71,403	100%

The very low number of Gonorrhoea tests reported by Solomon Islands is mainly due to the fact that data was available only for one year, 2010. *Table 16* shows the *number of Gonorrhoea tests* among pregnant women (ANC), as well as totals for all tests (male and female) in Solomon Islands in 2010. In the absence of sex-disaggregated data, it is unknown how many females and males were tested. From the available STI reports it is not clear whether tests were not conducted in the remaining years (2011-2015), or whether they were done, but not systematically reported. Overall, however, Solomon Islands faces particular challenges with regard to health information management, which hampers effective monitoring of trends, including for STIs.

Table 16: Number of Gonorrhoea tests, cases detected and proportion cases/tests in Solomon Islands among ANC women and males/females, 2010

Gonorrhoea 2010	ANC women	All tests (male, female)
No. of Gonorrhoea tests	2,856	4,523
No. of Gonorrhoea cases	119	515
Proportion Gonorrhoea cases/tests	4.2%	11.4%

The limited Gonorrhoea data available on 2010 reveal a relatively high proportion of cases (4.2%) among ANC women and among all people tested (11.4%). The findings among ANC women are reasonably consistent with those of a recent sexual health survey in 2014 among 296 women aged 16-49 attending three nurse-led community outpatient clinics in Honiara, which found Gonorrhoea infection among 5.1 percent *(Marks et al, 2015)*. However, the percentage among ANC women is much higher than the percentage found among ANC women in the regional study conducted in 2004-2005, which found Gonorrhoea among only 0.5 percent of pregnant women *(Cliffe et all, 2008).*

Table 17 shows that the overall *proportion* of Gonorrhoea cases among people tested in Solomon Islands (11.4%) is by far the highest in the entire region, which has an average of 4.7 percent of cases detected among those tested. Similarly, the proportion of Gonorrhoea cases detected among *ANC women* (4.2%), which may be a relatively good proxy indicator for the Gonorrhoea prevalence among all women of reproductive age, confirms that Solomon Islands has higher Gonorrhoea prevalence than all the other countries, with a regional average of 2.4 percent of cases detected among ANC women tested. This makes it particularly important to strengthen Gonorrhoea surveillance in Solomon Islands, among males, females and ANC women.

The proportion of Gonorrhoea cases found among ANC women (4.2%), is considerably *higher* than the percentages found among ANC women in the regional study conducted in 2004-2005, which only found Gonorrhoea among 0.5 percent of 241 pregnant women in Solomon Islands (0% under 25 and 0.8% above 25 years) *(Cliffe et all, 2008).*

Table 17: Proportion of Gonorrhoea cases among males & females tested, by country (2010-2015)

Country	Males	Females	ANC Women	Total (M/F/ Unknown)
CNMI	36.7%	3.3%	2.4%	5.3%
Cook Islands	25.4%	1.7%	1.1%	3.3%
Fiji	n/a	n/a	n/a	n/a
FSM (Micronesia)	5.7%	3.0%	2.4%	3.9%
Kiribati	2.2%	1.4%	0.9%	1.7%
Nauru	3.3%	1.8%	1.8%	2.1%
Niue	0.0%	0.0%	0.0%	0.0%
Palau	0.4%	0.3%	0.1%	0.3%
Marshall Islands	10.7%	2.0%	2.2%	3.0%
Samoa	36.1%	3.3%	3.0%	6.2%
Solomon Islands	n/a	n/a	4.2%	11.4%
Tonga	13.3%	4.3%	2.1%	7.1%
Tuvalu	5.2%	0.7%	0.9%	2.5%
Vanuatu	13.4%	3.6%	2.5%	5.0%
Total all countries	9.3%	2.9%	2.4%	4.7%

Syphilis Statistics in Solomon Islands

Table 18 shows the total number of *Syphilis tests* reported in Solomon Islands in the period 2010-2015 compared to other 14 Pacific countries: as with Chlamydia and Gonorrhoea (see above), Solomon Islands represented a relatively small proportion (11.6%) of all Syphilis tests in this period, with a total of 27,894 tests.

Table 18: Total No. of Syphilis tests, by country, 2010-2015

Country	2010	2011	2012	2013	2014	2015	TOTAL	% of total
CNMI	n/a	n/a	n/a	n/a	n/a	659	659	0.3%
Cook Islands	791	859	1,172	1,034	832	306	4,994	2.1%
Fiji	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FSM (Micronesia)	9,732	7,869	8,571	8,017	7,876	8,270	50,335	20.9%
Kiribati	n/a	1,342	2,303	6,766	1,957	2,635	15,003	6.2%
Nauru	n/a	726	354	n/a	475	669	2,224	0.9%
Niue	n/a	100	55	106	36	n/a	297	0.1%
Palau	1,810	2,020	1,642	1,553	1,466	n/a	8,491	3.5%
Marshall Islands	n/a	7,387	10,592	10,322	8,804	946	38,051	15.8%
Samoa	3,765	9,779	8,830	8,229	7,338	8,582	46,523	19.3%
Solomon Islands	n/a	7,800	6,206	n/a	8,322	5,566	27,894	11.6%
Tonga	n/a	5,535	5,510	5,860	5,596	3,296	25,797	10.7%
Tuvalu	n/a	810	779	413	175	461	2,638	1.1%
Vanuatu	n/a	6815	1,466	4,791	3,886	1,210	18,168	7.5%
TOTAL	16,098	51,042	47,480	47,091	46,763	32,600	241,074	100%

Figure 13 shows the *number of Syphilis tests* conducted among males, females, pregnant women (ANC), as well as totals for all tests (male and female) in Solomon Islands in the 2011-2015 period; no data was available on 2010 and 2013.

Compared to Chlamydia and Gonorrhoea, 2-3 times more Syphilis tests are conducted. However, the vast majority of the tests is done among pregnant women (89.4%), while very small numbers of males are tested: data on males is available for 2011 and 2012 only, revealing that only 220 and 121 men were tested in these two years, less than 5 percent of all tests among males and females. In 2011, a relatively large proportion of tests (approx. 26%) was not disaggregated for sex, but data reported on subsequent years shows that most or all Syphilis tests were done among women, especially pregnant women (100% of reported tests in 2014 and 2015).

Due to the particular difficulty of retrieving STI data in Solomon Islands, the available Syphilis data has been provided through different sources and is presented in different formats, with different levels of detail. The available information shows that all males were tested at STI clinics, while most females were tested at antenatal care facilities, while the remaining women were tested at STI clinics. No details are available on the number of people tested at blood banks, except for the second half of 2011, when blood donors (not sex-disaggregated) represented 42.8 percent of all tests, and ANC women the remaining 57.2 percent. Although no data is reported on Syphilis testing among blood donors in other years, this group may represent a similar proportion of all Syphilis tests in other years.

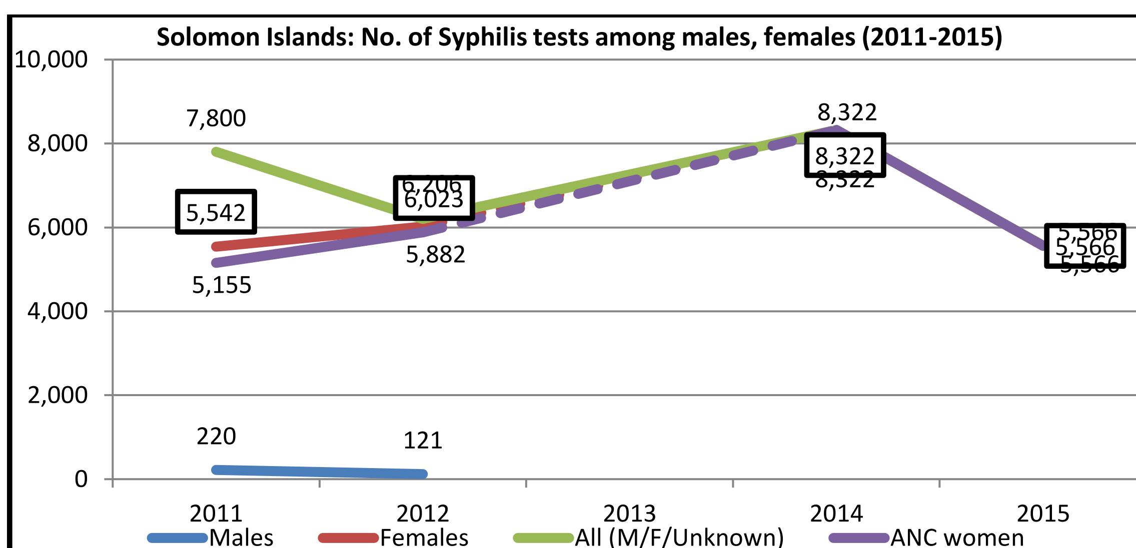

Figure 13: Total number of Syphilis tests conducted in Solomon Islands among males and females (including ANC women), 2011-2015

Figure 14 shows the total number of Syphilis *cases detected* among those tested in the 2010-2014 period. Since pregnant women represent a very large proportion of all tests each year, most cases are also found among this group. Therefore, the shape of the graph on Syphilis *cases detected* (Fig. 14) closely follows the shape of graph on the number of *tests conducted* (Fig. SI-7) The main difference in 2011 is due to the fact that a considerable number of tests among blood donors (n=2004) was reported in the second half of 2011. However, only 22 cases were found among these 2004 blood donors, a proportion of 1.1 percent: hence this group hardly influences the shape of figure SI-8, as the proportion of cases among ANC women tested is 10.7 percent; hence ANC women are responsible for most of the cases found.

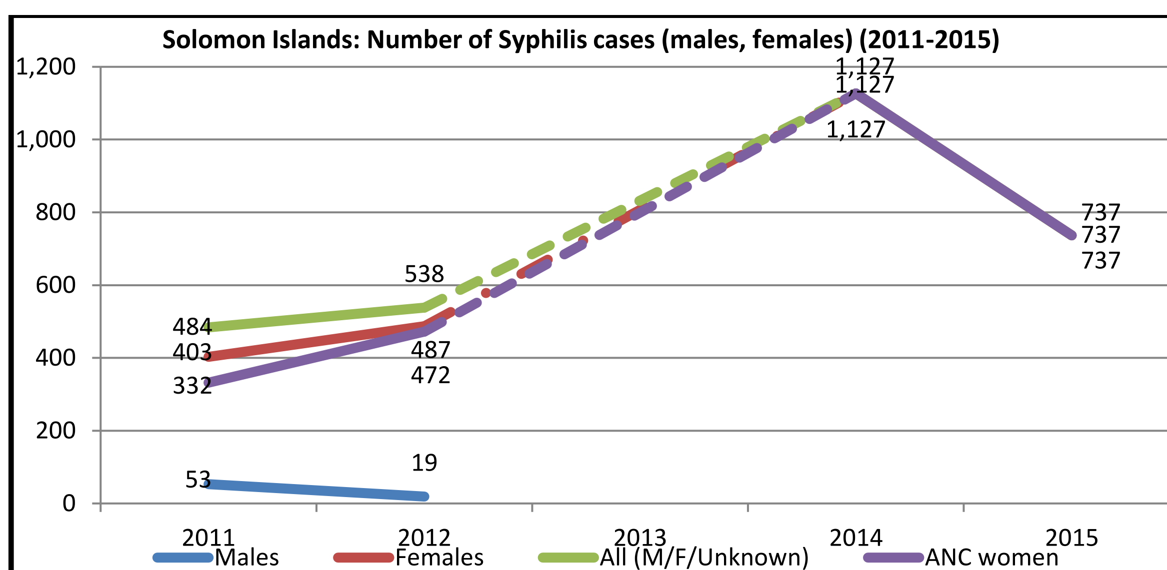

Figure 14: Total number of Syphilis cases detected in Solomon Islands among males and females (including ANC women), 2011-2015

Figure 15 shows the *proportion of Syphilis cases found* among males and females (including ANC women) who were tested. The percentages do not reflect the accurate prevalence rates among these groups, as the data is facility-based – not population-based – and is therefore affected by selection bias. However, the results for ANC women *(see purple line)* can be considered more representative of the general female population of reproductive age.

As mentioned, the number of males tested is very low and all were tested at STI clinics, hence the high proportion of cases (16-24%). The graph mainly shows the trends among ANC women, as they represent a very large proportion of tests and cases each year. The relatively large number of tests conducted among ANC women each year (ranging from 5,155 to 8,322) implies that the increasing trend observed in figure 15 is significant. The proportion of cases among ANC women tested shows a clear increase

from 6.4 percent in 2011 to 8.0 percent in 2012 and 13.5 and 13.2 percent in 2014 and 2015. This is an alarming increase that requires further analysis to identify the underlying factors causing this observed increase.

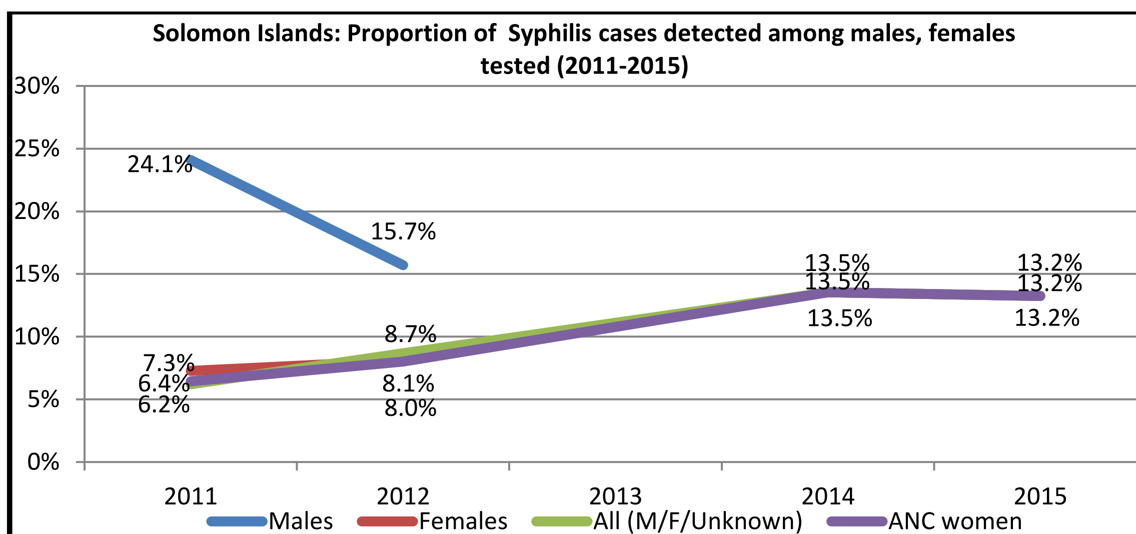

Figure 15: Proportion of Syphilis cases detected in Solomon Islands among people tested (males, females, ANC women), 2011–2015

Table 19 shows that the overall *proportion* of Syphilis cases among all people tested in Solomon Islands (10.4%) is *more than three times higher* than the regional average (3.1%). Proportions found among ANC women (10.7%) are *more than double* the average regional percentage (4.6%). The percentage found among ANC women is very similar to the percentage found among ANC women in the regional study conducted in 2004-2005, which found Syphilis among 10.0 percent of pregnant women *(Cliffe et all, 2008).* However, it is much higher than the results of a recent sexual health survey in 2014 among 296 women aged 16-49 attending three nurse-led community outpatient clinics in Honiara, which found Syphilis infection among 4.1 percent *(Marks et al, 2015).*

The very high proportion found among males in Solomon Islands (21.1%) is less significant, as it is based on tests among men attending STI clinics, which represent a very particular high-risk group, while in many other countries a (very) large proportion of tests is conducted among blood donors, who represent a much lower risk population than STI clients.

Table 19: Proportion of Syphilis cases among males & females tested, by country (2010-2015)

Country	Males	Females	ANC Women	Total M/F/ Unknown)
CNMI	n/a	0.0%	0.0%	0.3%
Cook Islands	1.0%	0.4%	0.2%	0.6%
Fiji	0.0%	0.0%	0.0%	0.0%
FSM (Micronesia)	2.1%	2.9%	2.6%	2.6%
Kiribati	3.3%	2.8%	1.0%	3.1%
Nauru	5.4%	7.9%	8.5%	6.8%
Niue	0.0%	0.0%	0.0%	0.0%
Palau	0.5%	1.2%	1.0%	0.8%
Marshall Islands	2.7%	3.7%	4.8%	3.5%
Samoa	0.2%	0.1%	0.06%	0.2%
Solomon Islands	21.1%	10.8%	10.7%	10.4%
Tonga	0.06%	0.05%	0.03%	0.05%
Tuvalu	6.0%	3.7%	2.1%	4.9%
Vanuatu	5.3%	3.7%	3.5%	5.8%
Total all countries	1.9%	3.9%	4.6%	3.15%

STI prevalence in 2016

Data available for 2016 at the time of compiling of this report (at 75% reporting for the year) shows over 300 cases of STIs reported nationally for the following 3 STI infections:

Table 20: showing Genital Ulcer Syndrome cases reported in 2016, by province in Solomon Islands (DHIS Feb 2016)

Geographic Area	Genital Ulcer Syndrome Cases 2016								
Province/National	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Central Islands					1				
Choiseul	1		1	4	1	3	6	1	
Guadalcanal		7	6	9	4	5	5	3	4
Honiara	17	6	9	15	17	17	23	20	25
Isabel			1	1			1	4	
Makira		1	1	4		2		1	1
Malaita	5	1	1	3	1	3	2	7	16
Renbel			2						

Geographic Area	Genital Ulcer Syndrome Cases 2016								
Province/National	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Temotu		2	1		1	2	2	3	4
Western	6	5	2	7	8	16	1	7	11
National Total	**29**	**22**	**24**	**43**	**33**	**48**	**40**	**46**	**61**

Table 21 showing Urethral Discharge Syndrome cases reported in 2016, by province in Solomon Islands (DHIS Feb 2016)

Geographic Area	Urethral Discharge Syndrome Cases 2016								
Province/National	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Central Islands	7	9	3	4	4	3	1	3	2
Choiseul	5	5	11	7	4	4	3	9	
Guadalcanal	15	15	27	20	16	30	10	14	30
Honiara	105	35	83	108	106	131	116	122	130
Isabel	2	4		1	2	3	4	1	4
Makira	10	11	13	5	7	16	11	11	13
Malaita	18	13	10	30	22	14	14	36	34
Renbel		1	2	3	1	1	1	1	
Temotu	4	4	4	6	6	6	6	2	3
Western	31	29	27	15	28	42	26	42	33
National Total	**197**	**126**	**180**	**199**	**196**	**250**	**192**	**241**	**249**

Table 22 showing Vaginal Discharge Syndrome cases reported in 2016, by province in Solomon Islands (DHIS Feb 2016)

Geographic Area	Vaginal Discharge Syndrome Cases 2016								
Province/National	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Central Islands	2	7	1		2	5	1	6	2
Choiseul	4	21	7	9	12	16	11	6	8
Guadalcanal	22	27	18	15	24	22	15	23	29
Honiara	158	47	98	172	171	165	117	161	164
Isabel	2	6	4	8	3	5	3	3	4
Makira	3	8	9	7	7	9	4	7	9
Malaita	9	36	48	55	66	29	32	70	57
Renbel		2	2		1	1		1	4
Temotu	6	6	6	8	6	6	10	6	5
Western	14	19	13	19	22	24	22	18	20
National Total	**220**	**179**	**206**	**293**	**314**	**282**	**215**	**301**	**302**

3.0 IMPLEMENTATION CHALLENGES AND LESSONS LEARNED

3.1 Challenges

Structural challenges

The geographic context of Solomon Islands presents major logistical and financial challenges. The per-capita cost of reaching small populations who are living in widely dispersed islands is extremely high. As a result, many interventions – especially for HIV prevention – are confined to the (few) main urban centres, with limited or no coverage in outer islands and rural areas.

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

Stigma & discrimination – especially towards key populations – hampers effective service delivery to sex workers and MSM. While there is traditional acceptance/tolerance of transgender persons, national laws and traditional cultural and religious norms and values strongly reject homosexuality, which makes it difficult to identify and reach these groups. Prevailing national laws and norms also prevent policy makers from prioritising programmes and allocating funds to these groups, while self-stigma keeps people from seeking services tailored to their needs, as they prefer to keep a low profile. Another prominent issue is the lack of confidentiality in small communities where "everyone knows everyone".

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

Gender inequalities lead to differential access to services for men and women, as well as for young people. Women – particularly young women – have less control over decisions regarding sexual and reproductive health, which may increase their vulnerability to HIV and STIs. E.g. women often have less control than men over decisions on contraceptive use, safe sex and casual partners of husbands or boyfriends, which increases their risk of exposure to HIV and STIs.

Culture and Religion
Religion and spiritual beliefs play a strong part in people's everyday lives. Competition between church affiliated groups sometimes leads to violent conflict. The practice of demanding compensation for social and legal wrong-doing is widespread and inhibits individuals and families seeking justice, such as in the case of violence against women, and has been known to be charged against health workers.
Strong kinship bonds and w*antok* identity is a social asset that fosters social cohesion and helps mobilise communities behind development agendas. However, as in the case of violence against women and girls, kinship and obligation inhibit families and women from seeking social justice as *wantok* allegiance and its maintenance takes precedence. As to be expected, in areas where social cohesion is strong, such as Isabel where one religious denomination holds sway, it is reported that it is easier to mobilise the community behind health and other development agendas.

Legal and policy environments
HIV prevalence remains very low in Solomon Islands. With many competing priorities and a limited government budget, HIV is low on the list of health and social priorities. As a result, the national response to HIV has heavily depended on external financial and technical support, with limited ownership and political and financial commitment, as evidenced by the limited annual SIG allocation of approximately SBD 150,000 only to the national response for the past two years. Resourcing and funding for sexual and reproductive health and HIV is for the most part funded by donors and development partners. The country also relies heavily on regional technical agencies and CSOs to provide technical assistance, as most Pacific Island Countries lack the capacity to fully provide the necessary services and programmes. *(SPC, 2014b)*. Thus, the long-term sustainability of the response beyond the short to mid-term support from external donors is limited, unless HIV-related services are integrated into broader programmes, such as sexual and reproductive health and public health systems.

In the *legal* sphere, criminalisation and punitive laws and regulations against sex work and homosexual acts continue to drive people underground and prevent governments from making targeted services available to these key populations. Sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. Both selling sex as well as owning a brothel or "aiding or abetting" prostitution for personal gain are illegal under Section 153 and 155 of the penal code. The current legal ground creates challenges for accessing most-at-risk populations for prevention and surveillance purposes.

Limitations of the Solomon Islands National AIDS Council (SINAC) the supposed coordinating body for the national response, has to-date impeded effective resource mobilisation, coordination, monitoring and evaluation of the response. Since 2011, there has been low engagement among SINAC members and limited commitment and capacity among SINAC leadership and staff to carry out the Council's national steering role. No representatives of SINAC spoke publicly or in the media on any HIV related topic / policy or in support of the response in 2013 and 2014. National level political changes, internal capacity gaps, and a reduction in the involvement of Civil Society stakeholders due to lack of funding and donor support, has eroded the effectiveness of SINAC, and has adversely impacted on the progress and performance of the national HIV response. In addition, an overlap of roles with Solomon Islands' National Country Coordinating Mechanism (SINCCM), whose mandate includes managing, coordinating and implementing the Global Fund Grant for Tuberculosis, HIV/AIDS and Malaria, has weakened SINAC's influence and profile. All these challenges have significantly impeded SINAC from playing an advocacy role for policy reforms and increased funding allocation for the national response.

Solomon Islands as a country has no specific anti-discriminatory laws and regulations to protect the rights of people living with HIV, or those of particularly vulnerable groups. However it does have in its Constitution under Section 15, a provision for discrimination, which protects its citizen from any form of discrimination. In 2014, there was no progress towards the protection or fulfilment of the rights of some vulnerable populations, or towards minimising their vulnerability. Political leadership, media coverage and public advocacy efforts in support of the HIV response waned in 2013. No progress towards the development of HIV-related legislation has been achieved to-date.

Health systems challenges

As mentioned earlier, uneven distribution of health workers across the country impacts on access to services and quality of care. Skilled health workers are concentrated in Honiara where only 12.5% of the country's population lives, and continuing migration of health workers to Honiara is likely to deepen the imbalance. In 2013, the doctor: population ratio was 1:1,319 in Honiara and 1:18,929 in rural areas; the nurse: population ratio was 1:305 in Honiara and 1:885 in rural areas. Human resources are also inequitably distributed across the provinces. The concentration of medical and specialist health staff in Honiara fuels high referral costs for the health system as well as adding strain on family incomes as people have to cover time away from their livelihoods, and living expenses while in Honiara. It also encourages by-passing of primary health care facilities, increasing the cost to the system of delivering primary level care, as well as the out of pocket spending users make on services that could be provided closer to home.

Poor working conditions, lack of or poor quality accommodation and lack of school opportunities for children in rural areas increasingly discourage staff from taking rural and remote postings as expectations rise. Unattractive remuneration packages and limited support provided to health workers further add to the low morale reported. Absenteeism and the difficulty in retaining staff in rural areas has been recognised by all stakeholder groups; leaving some areas underserved. Weak supervision throughout the health system partly linked to high transport costs, lack of funding and low prioritisation, contributes to the problem of absenteeism. Nurses at Kukum Health Clinic in Honiara, during the 2014 GESI study, reported high workloads, limited support, and few promotion prospects. They also felt that the Nursing Council was not an effective advocate for nursing in the country, and provided no tangible benefits to those registered.

Un-targeted HIV-prevention services

In Solomon Islands, these have so far tended to focus on the general population or in-school youth, with very limited services for key populations or other vulnerable groups. In part this is due to the limited research and the inadequate understanding of the risk dynamics and needs of the different groups. As mentioned, there is little differentiation between MSM, transgenders, bisexual men and other sexual minorities; or between commercial sex workers and women and girls engaging in transactional sex. Similarly, the specific HIV risks of mobile men, such as seafarers, fisher folk, taxi drivers, or uniformed men have not been clearly identified. The lack of adequate population-size estimations makes it difficult to set realistic targets and achieve sufficient coverage. Services and programmes for vulnerable and marginalised populations have in the past been offered by Save the Children and SIPPA, but the programmes ended over two years ago, leaving a gap of unreached key populations with HIV/STI prevention information and services. Many services have focused on married women and expecting mothers whereas the range of specifically designed services for single women, older women, men and transgender people is low. This leaves unmarried men and women, not pregnant women, youth, LGBT, and other marginalised populations often unable to access sexual health services. Similarly, young people often lack correct information, are exposed to misinformation, and have many questions but do not know where they can find reliable answers. The country is currently in the process of integrating comprehensive sexuality education in schools. Youth friendly health services are available in only seven (7) facilities across the country. Generally, coverage of YFHS in the PICTs remains low, with between 10% and 23% of young people utilising existing youth-friendly services (SPC, 2014b).

Strategic information

Despite clear articulation of the importance of strengthening strategic information in the NSP, many gaps and challenges remain: limited research has been done among key populations to identify specific sub-populations among MSM, sex workers that are particularly hidden and (hence) hard to reach. In this context, the dynamics of sexual networks are not sufficiently understood to develop targeted programmes for these groups. *Monitoring and evaluation* tends to be geared toward reporting to donors. The government and national NGOs have limited or no systems to monitor and evaluate their programmes, and use M&E data to inform programming decisions. There is a particular lack of operational research, which allows identifying effective approaches. Thus, many services are implemented with a focus on (donor-driven) “delivering outputs” rather than achieving meaningful outcomes and impacts.

Socio-economic Challenges

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

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

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

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

3.2 Lessons Learned

Lessons learned relate to the *programmatic* level as well as the *strategic* level.

3.2.1 Lessons Learned at Programmatic Level:

At the programmatic level, the first lesson learned is the importance of strengthening HIV testing as the entry point to treatment, care and support, as well as prevention – i.e. treatment as prevention, PMTCT and prevention of HIV transmission to partners. Increased HIV testing will also allow the (timely) detection of HIV cases that have been hidden to date. This requires a shift from the current focus on (passive) client-initiated

voluntary counselling and testing towards (proactive) provider-initiated testing and counselling (PITC) in the context of health care (e.g. antenatal women, STI and TB patients) and through (peer) outreach programmes to key populations. Replication of best practices from other PICTs is recommended E.g. positive experiences on mobile HIV test units and youth-friendly services in Cook Islands.

In the context of very low HIV prevalence, programmes and services need to have a stronger focus on key populations and other vulnerable groups. Limited resources, especially with decreasing donor funding, need to be used for programmes that are tailored to the specific needs of MSM, transgender persons, sex workers and their clients, (young) women and men engaging in transactional sex; mobile men, including seafarers and uniformed men. To this effect, partnerships and effective referral between government health and social services and civil society organisations – including organisations of PLHIV and organisations working with MSM and sex workers – need to be established and/or strengthened.

Strengthening coverage, comprehensiveness and quality of programmes for key and other vulnerable populations: the current low coverage highlights the need to develop and offer services that are better-tailored to the needs and expectations of specific populations. This requires: a) a better understanding of their characteristics through adequate size estimations and mapping, as well as qualitative socio-behavioural research to identify hidden populations and develop specific approaches to effectively reach them; b) Services need to be better tailored to the needs of specific groups: this requires ongoing revision of service packages and active involvement of sub-populations concerned in developing them. c) Comprehensiveness and quality of services are crucial: this requires diversification of services, a focus on lowering service thresholds, and more proactive approaches to delivering services.

Treatment, care and support: as mentioned above, more proactive provider-initiated testing and counselling –especially among key populations – is crucial for scaling up ART coverage, which in turn contributes to prevention (TasP). This involves more involvement of PLHIV and key populations and close collaboration with health and social services. Furthermore, the quality of treatment, care and support need to be improved to ensure treatment adherence. Special attention is needed for strengthening laboratory systems for monitoring ART patients, as well as early infant diagnosis. The rollout and adherence to the test-and-treat approach is recommended as will further simplify the technicality of determining when to initiate ART in PLHIV, and early treatment will reduce AIDS related deaths in the country.

3.2.2 Lessons Learned at Structural Level

Lessons learned at the strategic level involve the conditions in which services are delivered, and the support systems that need to be in place to sustain them. First of all, strengthening enabling environments is crucial for effective implementation of programmes and services. This involves: 1) Addressing legislation that criminalises sex workers and MSM or hampers the rights and free movement of PLHIV; 2) Strengthening the commitment and involvement of governments to prioritise HIV/STI programmes in the wider context of sexual and reproductive health; and allocate sufficient local resources to ensure sustainability; 3) Address the HIV-related prevailing stigma and discrimination at the level of communities and society as a whole through awareness and media advocacy programmes.

Secondly, structural challenges related to the geographic realities of the country and widely dispersed small islands can only be overcome by increased integration of HIV/AIDS-related services in existing health, social, and other services. This requires integrating HIV-related interventions in public health-care systems, sexual and reproductive health (SRH: including STI services), public education and information services. One of the key lessons learned from the 5-year Pacific Islands Response Fund for HIV & STIs, which provided almost USD 22 million to the Pacific region in the 2009-2014 period, was that there is a need for integrated SRH and well-being strategic plans and a move away from HIV-focused NSPs (SPC, 2014c). The recent launch of the 2015-2019 Pacific Sexual Health & Well-being Shared Agenda (SPC, 2014b) reflects an increasing recognition that HIV in the Pacific cannot be addressed as a stand-alone issue, but needs to be understood and dealt with in a broader context. Integration of HIV/AIDS in existing programmes and services of the health and other sectors will allow more cost-effective implementation.

Civil society plays a key role in the national response. Experiences with the Australian-supported Response Fund have shown the importance of involving communities and NGOs in local programmes and for reaching key populations. In this regard, strengthening civil society involvement requires technical capacity building of CSO staff and volunteers, as well as organisational and institutional strengthening. In order to improve sustainability of CSO programmes, they need to strengthen their skills in the field of management, financial systems, resource mobilisation, human resource management and M&E.

Special attention needs to be given to the gender dimensions of HIV risks and vulnerabilities. More specific attention needs to be given to the impact of gender-based and intimate-partner violence, including rape, on the possibility for women and girls to decide on their own sexual and reproductive health and rights, including preventing HIV infection. This includes a stronger focus on protection of victims and prosecution of perpetrators in close collaboration with social services and the justice system. In

addition, men and young men need to be more involved in SRH (including ANC) services, including as an entry point to PITC.

Strategic information needs to be the basis for, and guide the implementation of all HIV programmes and services. This requires strengthening routine surveillance and reporting systems, research and M&E systems. Low coverage and limited impact of programmes tends to be due to a limited understanding of the real drivers of the epidemic, of the populations most at risk, and their service needs. In addition, M&E and operational research need to be used systematically for adjusting and improving programmes that they respond to priority needs of beneficiaries.