MINISTRY OF HEALTH AND MEDICAL SERVICES

SOLOMON ISLANDS

NATIONAL STRATEGIC PLAN FOR HIV AND STIs

2014-2018

FINALIZED NOVEMBER 2015

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ABBREVIATIONS

ADRA	Adventists Development Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention of the Elimination of all forms of discrimination against women
FBO	Faith Based Organisation
FGD	Focus group discussion
GEWD	Gender Equality and Women's Development
HIV	Human Immunodeficiency Virus
KRA	Key Results Area
LFA	Logical Framework Approach
M&E	Monitoring and Evaluation
M&E TWG	Pacific Regional Monitoring and Evaluation Technical Working Group
MHMS	Solomon Islands, Ministry of Health and Medical Services
NCRA	National Coalition for Reform and Advancement Government
NFTF	NSP Finalization Task Force
NGO	Non-Government organisation
NSP	National Strategic Plan
PICTs	Pacific Islands Countries and Territories
PLHIV	People living with HIV
PMTCT	Prevention of Mother To Child Transmission (of HIV).
PRSIP II	Pacific Regional Strategy and Implementation Plan, HIV and other STIs (2009–2013)
RAMSI	Regional Assistance Mission to Solomon Islands
SGS	Second Generation Surveillance Survey
SIDT	Solomon Islands Development Trust
SIG	Solomon Islands Government
SINAC	Solomon Islands National AIDS Council
SIPPA	Solomon Islands Planned Parenthood Association -
SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted infection
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV
UNGASS	United Nations General Assembly Special Session on HIV
UNICEF	United Nations Children and Educational Fund
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization
WV	World Vision International
YFHS	Youth Friendly Health Services

FOREWORD

We are pleased to write on this special occasion an introduction to the National Strategic Plan of Solomon Islands 2014-2018 that the Government of the Solomon Islands has produced in large consultation with stakeholders from government, non-government and technical partners. Compared to the previous NSPs, the Solomon Islands has achieved impressive results in identifying the country priorities and making estimations for the resource needs and aligning the NSPs to the Declaration of Commitment on HIV/AIDS of 2011. We are proud of many activities implemented during the years to ensure wide information dissemination, advocacy, education and availability of Voluntary Counseling and Testing is made available to all citizens of Solomon Islands which has brought us to the present where the national emphasis is now shifting to quality of services.

With this NSPs you will find evidence of raised expectations of the Government of Nauru translated into figures and a performance based evidence of the key players in the national response to AIDS. With this NSP there is a rising expectation on our government, not only to honour the commitment to the Political Declaration on AIDS endorsed in 2011 but also to ensure that the interventions set out to reach the commitments are successful, constructive and accountable. Common objectives such as reaching 'Universal Access to Prevention, Care and Treatment' and the Political Declaration of 2011 helped us to realize that HIV is one of the world's challenges which is too interconnected and complex for any country to handle. These challenges further consolidates the need for greater collaboration between government and civil society.

Though Solomon Islands has registered a low number of HIV cases we are strong in our resolve to support further AIDS response and ensure the quality of NSP increases along with the increased quality of strategic planning, coordination and transparency of decision making as well improved monitoring and evaluation.

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Hon. Dr. Tautai Angikimua Kaitu'u

Minister for Health and Medical Services

Solomon Islands

ACKNOWLEDGMENT

The MHMS would like to recognize the authors of this document, specifically Gabriela Ionascu (Strategic Information Advisor - UNAIDS Pacific Office) for her Technical Assistance in the development of this National Strategic Plan (NSP) for HIV and STIs in 2014; and Sam Obwona Opwonya (HIV/AIDS Consultant - UNICEF Solomon Islands Field Office) for updating, costing and finalization of the document in 2015.

Special recognition must also go to John Gela (SINAC Coordinator) and Dr Henry Kako (Director HIV/STI Division MHMS) and his team for their support and resourcing of the multiple inputs which have culminated in this National Strategic Plan for HIV and STIs 2014-2018.

The MHMS acknowledges the contribution of the many national and provincial stakeholders who contributed their time, knowledge and guidance in reviewing drafts of this NSP and especially to the members of the National Planning Team, for their patience and hard work throughout a lengthy, multi-staged process.

Finally, particular mention must also go to specific Development Partners notably UNAIDS, UNICEF, SPC, Burnet Institute and FNU Pacs-RHRC for their assistance and support, both in terms of technical oversight, direct input to the planning and NSP development processes as well as financial support to the process.

The Solomon Islands Government appreciates all of your efforts and recognizes the good partnership relationships which have led to such an important policy document to guide the response to HIV and STIs in the country.

Tagio Tumas!

…….....

Dr. Tenneth Dalipanda

Permanent Secretary

Ministry of Health and Medical Services

CLARIFICATION OF TERMS AND CONCEPTS

Comprehensive integration of HIV and STI responses: In recognition of the resource constraints associated with delivering an effective national HIV and STI response in Solomon Islands, as well as the unique geography and dispersed population which makes comprehensive coverage of interventions difficult to achieve and maintain, this National Strategic Plan has been developed under the guiding principle of comprehensive integration of all approaches with existing services and programs (as appropriate), such as integration of prevention activities into Reproductive Health and Family Planning programs, or youth-focused social events.

Key Populations at higher risk of Exposure to HIV and STIs (formerly known as Key vulnerable groups or Most at risk Populations-MARPs: A common characteristic of HIV epidemics globally is the existence of specific groups whose behaviours, practices and/or circumstances place them at particular risk, or contribute to their vulnerability to HIV and STI transmission.

The make-up of these groups differs from country to country, or even from setting to setting within a given country, however in a resource-poor setting such as Solomon Islands, identifying and working with these vulnerable groups offers an opportunity to achieve greater outcomes in terms of HIV and STI prevention, diagnosis and treatment by targeting interventions and resources specifically to these groups of highest need.

At this time, there is insufficient evidence to conclusively identify vulnerable groups for targeted interventions in Solomon Islands; however this scarcity of evidence will aim to be addressed within this National Strategic Planning period. Until this evidence exists, however, a number of specific groups have been identified through observation and programming experience as being particularly vulnerable to HIV and STIs. These are referred to in this National Strategic Plan simply as **key vulnerable groups** or **identified vulnerable groups,** however they may include, but are not limited to:

- Men who have sex with men
- Transgender
- Female and male sex workers
- Seafarers
- Pregnant women
- Children born to HIV-positive women
- People living with a disability.

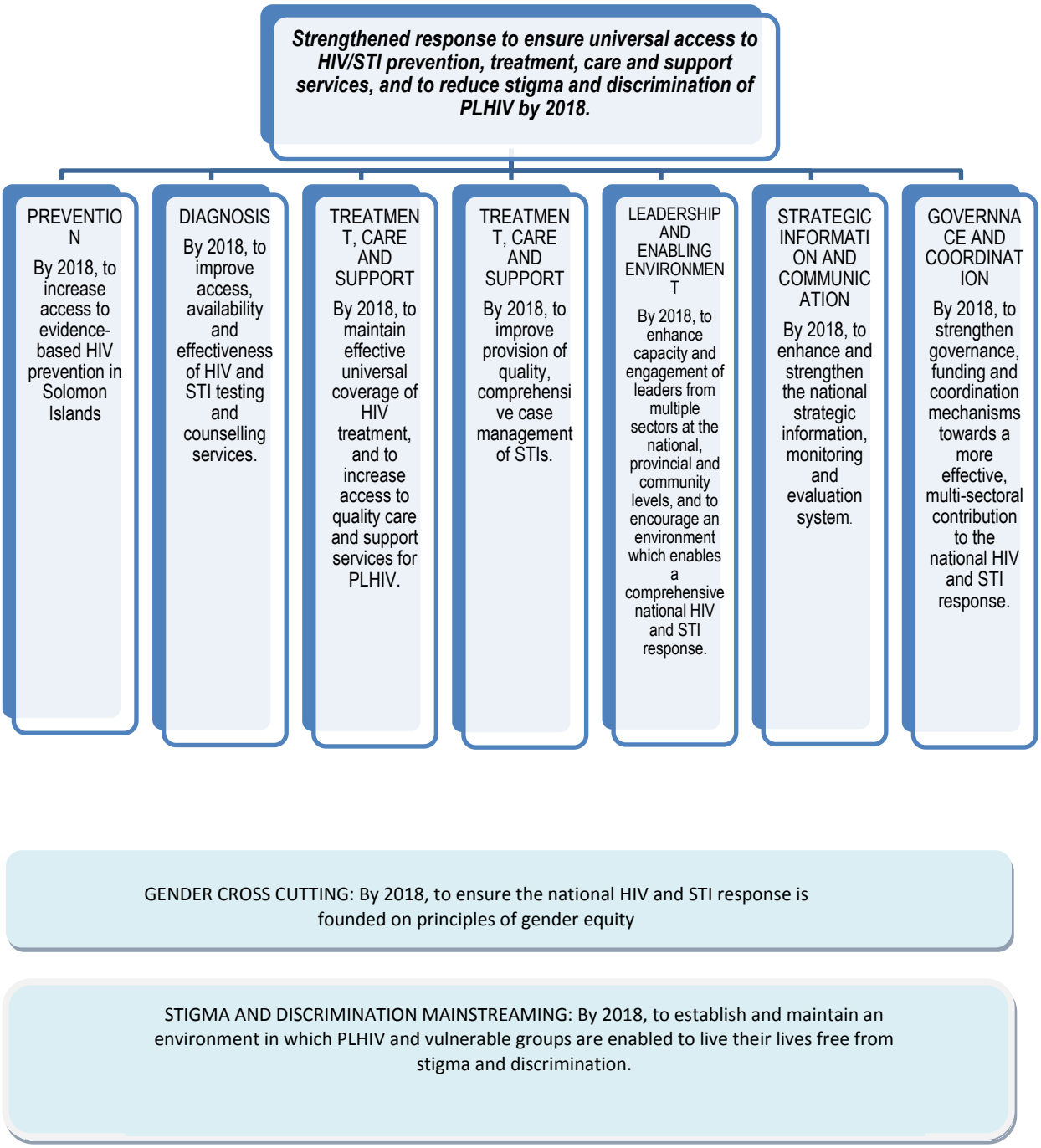
Persons Living with HIV (PLHIV)

Solomon Islands has registered cumulatively 22 cases of HIV by end of 2013 of which 8 are death cases and 11 are in ART Treatment of which 5 are males and 6 females. Three HIV positive case is not in treatment yet. The majority of HIV cases are coming from Honiara (capital), Malaita and Western Province.

CONCEPTUAL FRAMEWORK

The NSP 2014-2018 is structured around an Overarching Goal, seven Thematic Areas and two cross-cutting areas as , all forming a total of nine objectives as follows:

Figure 1:



1.0 INTRODUCTION

This National Strategic Plan for HIV and STIs 2014-2018 provides strategic guidance and direction to all individuals, groups, organisations and agencies responsible for contributing to the national HIV and STI response in the Solomon Islands.

This plan is based upon the commitments of the Government of the Solomon Islands to its people as documented in the overarching vision statement in the National Health Strategic Plan (2011 – 2015):

> ***"The people of the Solomon Islands will be Healthy, Happy and Productive"***

Further to this, for HIV and STIs as one of the guiding principles for this plan, the specific vision is:

> ***"The Health and well being of the people of Solomon Islands will not be undermined due to the burden of HIV, AIDs and STIs"***

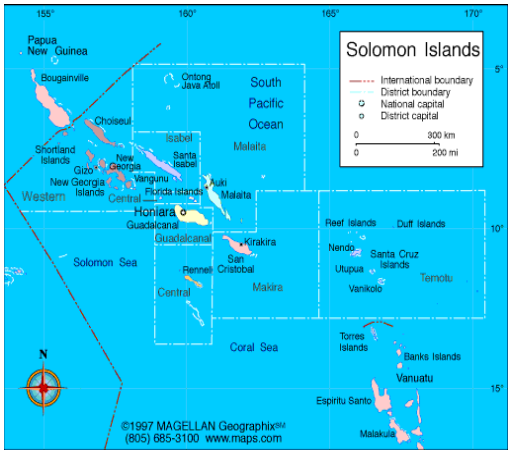
The strategic priorities, concepts and processes described within this National Strategic Plan endeavour to ensure the combined efforts and resources of all implementing stakeholders are utilised in a coordinated, complementary approach which addresses the most urgent, evidence-based HIV and STI needs in the country.

The National Strategic Plan for HIV and STIs 2014-2018 has been designed to assist all stakeholders to develop their annual activity plans to meet national strategic priorities. Due to the five year duration of the National Strategic Plan, it is acknowledged that these priorities may change as a result of altered disease prevalence and patterns (perhaps resulting from changed behaviours and practices of some groups and/or improved surveillance and testing). The National Strategic Plan therefore strongly advocates for ongoing monitoring and evaluation and improved surveillance processes to inform revision of the national response priorities on a regular basis, and for annual plans, as well as a comprehensive mid-term strategic plan review in 2017 to address these revisions.

1.1 BACKGROUND

1.1.1 COUNTRY PROFILE & HISTORY

The Solomon Islands is a chain of more than 990 islands, which together cover a land mass of 28,370 square kilometres with 5,313 kilometres of coastline[1]. With the land area and a population of approximately 515,870 (2009 Census), Solomon Islands is the second largest developing country in the South Pacific region, next to neighbouring Papua New Guinea[2]. The main islands are Choiseul, Guadalcanal, Santa Isabel, San Cristobal, Malaita and New Georgia. Volcanoes with varying degrees of activity are situated on some of the larger islands, while many of the smaller islands are simply tiny atolls covered in sand and palm trees.



(figure 2: Map of Solomon Islands)

The country is divided into nine administrative provinces (Central Islands, Choiseul, Guadalcanal, Isabel, Makira, Malaita, Rennell and Bellona, Temotu and Western Provinces), and one capital territory (Honiara). Most Solomon Islanders live in rural communities based on traditional village social structures and are dependent on subsistence agriculture supplemented by cash cropping, fishing and forest products.

Table 1: Country Profile

Solomon Islands Country Facts[1]	
Official name	Solomon Islands
Location	Latitude 8 00 S; Longitude 159 00 W
Capital	Honiara
Government and legal status	Independent Nation - independence was achieved on 7 July 1978
Head of State	Queen Elizabeth II represented by the Governor General
Head of Government	Prime Minister
Land area	28,370 square km
Exclusive economic zone (EEZ)	1,340,000 square km
Population (2008 mid-year estimate)	517,455
Population Density (persons per square km)	18
Urban Population (%)	16
Dependency Ratio (15-64)	82
Median Age	19.8
Youth % (15-24)	19.7
Annual intercensal growth rate (%)	2.7
Real GDP Growth (est 2007)	5.4%
GDP Per capita (USD) – 2006	753
CPI (annual % change)	6.1%
Exports 2006	129,546 (000 USD)
Imports 2006	231,020 (000 USD)
Trade Balance 2003	-101,474 (000 USD)
Crude Birth Rate per 1000	34.0
Crude Death Rate per 1000	7.5
Total Fertility rate	4.8
Infant mortality rate per 1000	66.0
Male Life Expectancy at birth	60.6
Female Life Expectancy at Birth	61.6
Labour Force (2007 estimate)	249,200
Labour Force Participation male (2007 estimate)	31
Labour Force Participation rate female (2007 estimate)	15
Geographical note	Solomon Islands is an archipelago of volcanic origin with some degree of volcanic activity.
Religions(2006)	Christianity – Anglican, Roman Catholic, Baptist, Methodist and Presbyterian
Languages	English (official), Melanesian Pidgin is spoken with numerous indigenous languages
Official currency	Solomon Islands dollar

History: It is thought that people have lived in the Solomon Islands since at least 2000 B.C. The country was explored in 1568 by Alvaro de Mendana of Spain, and was not visited again for about 200 years. In 1886, Great Britain and Germany divided the islands between them, but later Britain was given control of the entire territory. The Japanese invaded the islands in World War II, and they were the scene of some of the bloodiest battles in the Pacific theater, most famously the battle of Guadalcanal. The British gained control of the island again in 1945, which became the British Solomon Islands Protectorate (BSIP).

In 1976 the Solomon Islands became self-governing and gained independence on 7th July 1978, and in July 2011, the Country celebrated its 33 years independent anniversary.

[1] Source: SPC Statistics and Demography Programme (and its Pacific Regional Information System - PRISM) www.spc.int/prism)

[2] Solomon Islands country profile: http://www.spc.int/images/stories/SPPU/solomon%20islands%20country%20profile%20final.pdf

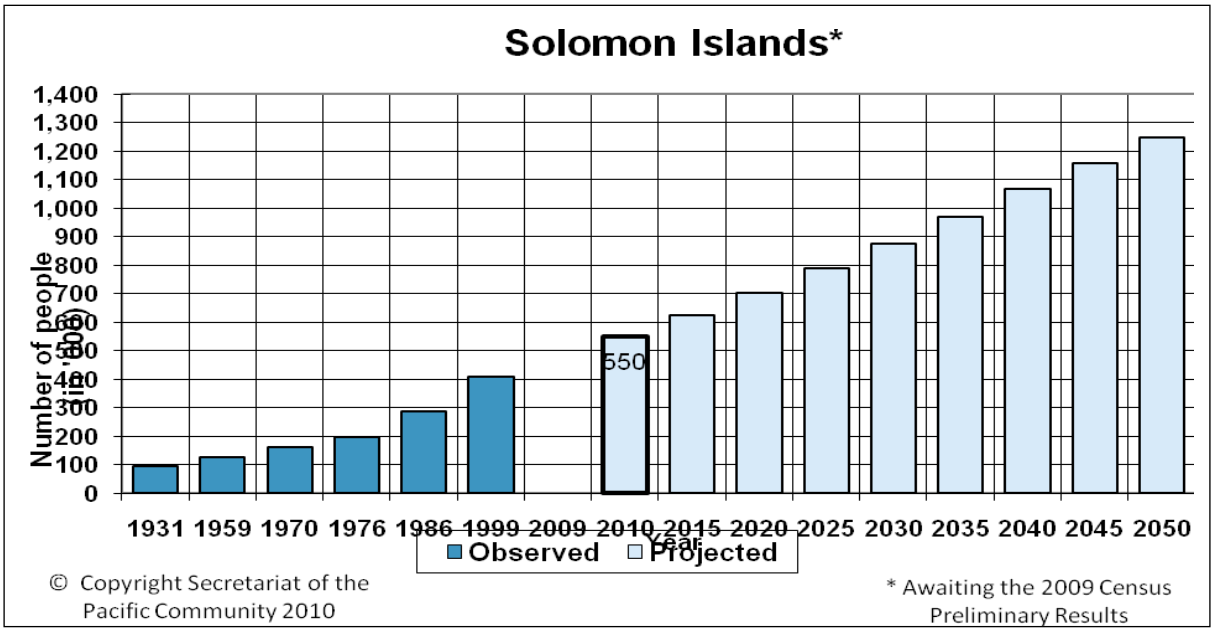
1.1.2 THE GOVERNMENT

The Head of State is the Queen of England, represented by the Governor General who resides in the country. The country is a Parliamentary democracy and a Commonwealth realm unicameral National Parliament (50 seats; members elected from single-member constituencies by popular vote to serve four-year terms). The elected MPs elect the Prime Minister who then chose the members of Cabinet. There are 9 provinces and 1 capital territory*; Central, Choiseul, Guadalcanal, Honiara*, Isabel, Makira, Malaita, Rennell and Bellona, Temotu, Western provinces. National governments are elected every 4 years and the last election was held on 4th August 2010 which essentially indicates that next to be held in 2014. Provincial governments are also elected 4 years and timing varies between each provinces.

1.1.3 THE PEOPLE

According to the most recent national census (conducted in December 2009), the Solomon Islands population is 515,870, of which 59.3% are under 25 years of age. 80.3% of the population live in rural areas[3]. The population is growing at an annual rate of approximately 2.6 per cent, and nearly half of the population is 14 years of age or under.

Figure 3: Population projection[4]



Between 1998 and 2003, Solomon Islands endured a period of civil conflict, which contributed to the near collapse of a number of essential public services, including health, education and the judiciary. Since 2003, with support from the Regional Assistance Mission to Solomon Islands (RAMSI) and a number of international development partners, Solomon Islands has worked towards the restoration of peace and the re-establishment of basic, essential services with a view to consolidating and promoting economic and social development.

A widely dispersed, young and mostly rural-dwelling population; a difficult-to-access geography; and recovering essential services following recent political and civil upheaval each pose unique challenges to Solomon Islands' delivery of an effective national response to HIV and STIs. An appropriate, innovative and locally-identified national strategic framework for addressing HIV and STIs has the greatest potential to meet these challenges through a systematic and sustainable response.

[3] Solomon Islands Government (2011). Report on 2009 Population and Housing Census: Statistical Bulletin 06/2011: Basic Tables and Census Description. Honiara, Solomon Islands Government.

[4] Source: SPC Demography and Statistic Programme, 2010

1.2 HIV AND STI SITUATION IN SOLOMON ISLANDS

1.2.1 PREVALENCE OF HIV AND STIs

Solomon Islands have had 21 cumulative cases of HIV dating from 1994 to the end of March 2013, with all but one of these cases having been identified since 2004[5]. Of these 21, seven have died from AIDS related causes, 10 are receiving antiretroviral therapy and one does not yet meet the criteria for treatment but remains under medical management[6].

In 2015, a Second Generation Sentinel Surveillance (SGSS) on HIV and syphilis at was conducted at Antenatal Care (ANC) clinics in eight of the ten provinces in Solomon Islands. The objectives of this survey were to estimate HIV and syphilis prevalence rates among ANC attendees, identify risk factors of HIV and syphilis infections, assess knowledge of and attitudes towards HIV, monitor trends in prevalence of HIV and syphilis, and examine how sexual behaviours were associated with HIV and syphilis infections.

Prevalence of HIV infection

This 2015 ANC-based sentinel survey did not detect any HIV infection among pregnant women who visited the clinics to receive routine antenatal care. It should be noted that no HIV infections were detected in earlier sentinel surveys conducted in 2005 and 2008 as well. Detecting no HIV positive case in 2015 should not be considered as a clear indication of the absence of HIV infection among antenatal women. A more plausible explanation would be that HIV prevalence among women has remained low in the country and the sample size was not large enough to capture the HIV positive cases. It is also recognized that women living with HIV may have declined to participate in the study.

Prevalence of syphilis infection

The 2015 SGSS study among ANC attendees revealed a 7.9% prevalence of syphilis among 650 ANC mothers tested, which was consistent with estimated syphilis prevalence rates found in other studies conducted in Solomon Islands in 2005 (10%) and 2012 (8%). Prevalence of syphilis infections appears to be higher in Honiara city and Guadalcanal province and among the relatively younger (< 24 years), less educated, and women with multiple sex partners.

1.2.2 HIV MORBIDITY AND MORTALITY (1994 – 2013)

HIV in Solomon Islands is thought to be primarily heterosexually driven, however a limited evidence base inhibits a more robust understanding of risk behaviours amongst certain vulnerable groups. There have been no reported cases of mother to child transmission.

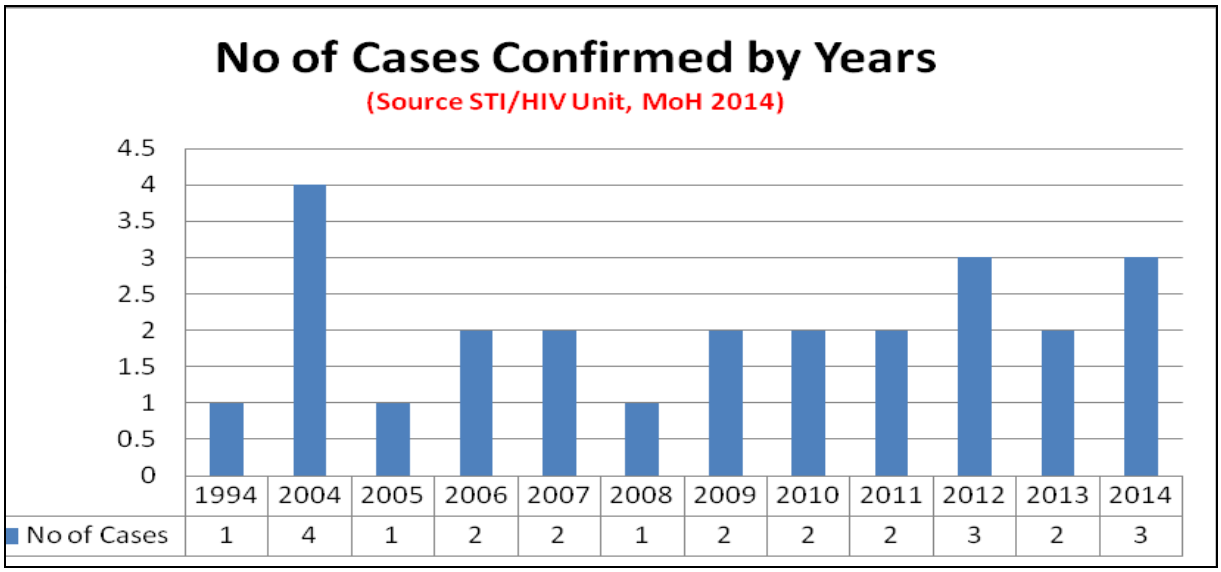
Compared with other Pacific Island Countries and Territories, Solomon Islands has reported a relatively low number of HIV infections. However, while the official HIV prevalence rate is low (2 per 100,000)[7] questions have been raised as to the whether this figure underestimates the true burden of HIV through under-reporting of new cases as a result of gender and socio-cultural barriers to utilising HIV testing and counselling services (such as actual or perceived stigma and discrimination directed towards those found to be HIV positive); a paucity of testing services limiting access; and a weak, poorly representative surveillance system.

[5] UNGASS Country Progress Report, Solomon Islands.
[6] SINAC (2011). Solomon Islands National Review of Responses to HIV and STIs, December 2011.
[7] UNGASS Country Progress Report, Solomon Islands.

Table 2: Cumulative Number of HIV Cases in Solomon Islands 1994 - 2015

Sex	Age	Total # Diagnosed with HIV	Total # Living with HIV in SI	Travellers / Foreigners	Total AIDS death
Female	Adults	14	9	1	4
	Children (<15 Years)	0	0	0	0
Male	Adults	12	3	2	7
	Children (<15 Years)	0	0	0	0
	Total	26	12	3	11

Figure 4: Progression of the HIV Epidemic in Solomon Islands



Despite the low prevalence of HIV, data consistently show that a high proportion of both women and men are infected with STIs across the country. Limited laboratory testing facilities and poorly trained and resourced health workers in many settings, especially rural areas, make confirmatory diagnosis of specific infections difficult to ascertain, however comprehensive syndromic diagnosis and management of suspected STIs, and a number of surveillance activities[8] provide a strong indicator of this significant contributory risk factor to both STI-related morbidity and HIV transmission. Furthermore, the high prevalence of STIs indicates that certain risk behaviours, such as unprotected sex with multiple partners are widespread, which in turn poses a serious risk for the exponential transmission of HIV.

[8] Solomon Islands Government (2008). Second Generation Surveillance of Antenatal Women and Youth, Solomon Island, Honiara.

1.2.3 HIV AND STI RISK FACTORS

Studies of sexual risk behaviours and HIV knowledge include the 2006-2007 Demographic Health Survey (DHS), a representative sample of men and women in households, the 2005 and 2008 SGSS studies in antenatal women and youth, and a knowledge, attitudes and practices (KAP) survey conducted as part of a larger study entitled Bad Sickness in 2008-2009. All of these studies showed high STI prevalence and widespread risky sexual behaviours.

In addition to strong indications for high STI prevalence and widespread, risky sexual behaviours, the UNGASS Country Progress Report (2010)[5] identified a number of other risk factors which have the potential to contribute to the transmission of HIV and STIs in Solomon Islands:

- Multiple sexual partners (although information relating to partner concurrency is limited) [4].
- Unregulated and potentially unsafe tattooing practices.
- High internal migration, particularly to urban centres where there may be reduced cultural and familial influences on social and sexual practices.
- Transactional sexual activities such as exchange of goods, beer, cigarettes and/or money for sex.
- International travel for training, education and employment, often in conjunction with access to cash through allowances or wages that enable travellers to purchase sex for money or goods, thereby increasing risk of acquiring infection overseas.
- High population of young people (59.3% <25 years of age) [9], a large proportion of whom are sexually active (approximately 60.0% of those aged 15-25)[6].
- Close proximity to, and informal, cross-border trade with Papua New Guinea, a country with a rising, generalised HIV epidemic.
- Commercial industries (such as logging, mining and fishing) representing a range of risk factors, including prevalence of "mobile men with money" (represented by both Solomon Island and foreign nationals).
- Gender inequality which reduces women's ability to negotiate for safer sexual practices[10].
- High rates of gender based violence[11].
- Cultural and religious values in conflict with a number of HIV and STI prevention messages and practices.

Largely young population:

According to the most recent national census (conducted in December 2009), the Solomon Islands population is 515,870, of which 59.3% are under 25 years of age. 80.3% of the population live in rural areas. The population is growing at an annual rate of approximately 2.6 per cent, and nearly half of the population is 14 years of age or under.

Low rate of condom use, high rate of unprotected sex .

Most estimates are below 20%, with the highest at 26% for condom at last sex by men with a non-marital, non-cohabiting partner (2008 DHS), and 45% for consistent condom use by youth with non-commercial partners (2005 SGSS); however the same estimate in the 2008 SGSS was lower (<11%).

(UNICEF 2010: 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).

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[9] Solomon Islands Government (2011). Report on 2009 Population and Housing Census: Statistical Bulletin 06/2011: Basic Tables and Census Description. Honiara, Solomon Islands Government.

[10] SPC (2009). Solomon Islands Family Health and Safety Study: A study on violence against women and children. Solomon Islands Ministry of Women, Youth & Children's Affairs, Honiara.

[11] SPC (2009). Solomon Islands Family Health and Safety Study: A study on violence against women and children. Solomon Islands Ministry of Women, Youth & Children's Affairs, Honiara.

In 2015 SGSS study, while awareness of condoms was very high (90%) - consistent use of condoms for protection from being infected was low at 32%. Only 31.5% used condoms in the last 12 months. About 41% reported that their pregnancy was not intentional. Low use of condom indicates that current condom promotion programmes are of limited effect. It is essential to identify both programmatic and cultural barriers in using condoms to reduce both unwanted pregnancies and the risk of being infected with STIs. Ensuring consistent use of condoms should be considered as a strategy to prevent spreading of HIV and STIs.

Key Populations such as MSM and Sex Workers

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

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. By contrast, 10.5% of male youth and 5.8% of female youth in the 2008 SGSS reported having ever received gifts or favours in exchange for sexual intercourse (transactional sex). About 5-6% reported selling sex for money (commercial sex). The percentage of men who had ever purchased sex across studies ranges from about 1% to 10% (SGSS), with transactional more common than commercial sex. In comparison, 17-19% of the vulnerable female youth reported commercial or transactional sex in the Bad Sickness study.14. A qualitative study by Save the Children involving 38 sex workers at 194 young people ages 14-25 identified practices of buying and selling sex by both males and females, as well as very low and inconsistent use of condoms in 20 communities in Honiara, Western and Malaita provinces.15

High levels of forced sex

Forced sex is very common in the Solomon Islands. Of ANC women in the 2008 SGSS, 28% reported ever being forced to have sexual intercourse. Of female youth identified as vulnerable for the Bad Sickness study in 2008-2009, nearly half (49%) reported forced sex, as well as 28% of vulnerable males. Prevalence of forced sex was high (>20%) in all provinces surveyed (Choiseul, Malaita and Western).

Sexual exploitation of children associated with foreign and local workers at a logging camp in the Arosi area of Makira province was documented extensively by a qualitative study conducted in 2006. More than 70 cases of sexual abuse were identified involving children and young women ages 11 to 19, including prostitution, selling children and young women into marriage with foreign workers and child pornography.

Marital status and living arrangement

The 2015 SGSS revealed that nearly 51.3% of antenatal women attended the clinic were married and about 39% were living with sex partners (not husbands). Of the pregnant women, 93.7% of them maintained a relationship with the father of the unborn child although 10.6% of pregnant women were not living with their husbands or sex partners.

Pregnancies and miscarriages

From the 2015 SGSS study, of the women attending antenatal clinics, about 59% had planned to become pregnant and nearly 69% were previously pregnant at least once before the current pregnancy. As expected, the proportion of previous pregnancy was higher among older women. Among younger (15 – 19 y) women, 18.5% were pregnant at least once and 2% were

pregnant twice before the current pregnancy. Miscarriage or abortion was high as nearly 13% women reported having at least one miscarriage or abortion. The proportion of miscarriage was 11.5% in relatively younger (20 – 24 y) and 7.4% in very young (15 – 19 y) women.

Early Sex Debut

The 2015 SGSS also established that about 52% antenatal women had sex before 18 years of age and about 9.1% became sexually active before they reached 15 years. Average number of sex partners was 3.6. About 74.5% women had multiple sex partners in their lifetime while 9.3% were engaged in concurrent sexual relationships in the past year. About 2.1% women reported being engaged in transactional sex.

Violence against women

The ground breaking Solomon Islands Family Health and Safety Study conducted by SPC in 2009 revealed extremely high incidence of violence against women and children. Two out of three women (64%) aged 15-49, who have ever been in a relationship, reported experiencing some form of physical and/or sexual violence by an intimate partner. Sexual violence was more common. Violence reported was more likely to be severe than moderate, including punching, kicking, and having a weapon used against them. Levels of violence were higher in Honiara than the provinces, and this may be related to the wider availability and consumption of alcohol (which acts as a dis-inhibitor), as well as social problems such as unemployment and overcrowding. The study also found high levels of child sexual abuse and forced first sex. Some 37% of women aged between 15 and 49 reported they had been sexually abused before the age of 15 with girls mostly at risk from male acquaintances and male family members. Of women who reported to have ever had sexual intercourse, 38% reported that their first sexual intercourse was coerced or forced. The Solomon Islands Family Health and Safety Study (SIFHS) in 2009 also found that for many girls their first experience of sexual intercourse was forced. According to the SIFHS, women who were victims of Intimate Partner Violence (IPV) were significantly more likely to report that their current partner, or any other partner, had abused their children (emotionally, physically and/or sexually) (36% versus 11%, $P<0.001$). In fact, women who have experienced IPV are 4.5 times more likely to have children who are also abused than those who have not experienced partner violence (AOR1 = 4).

The 2015 SGSS revealed that about 15.6% of the 650 antenatal women reported that they had been victims to some form of physical or sexual violence from male intimate partners in the past twelve months. Experience of being forced to have sexual intercourse in their lifetime was 12.3% among women. Younger women were more likely than older women to be the victims of sexual violence. The perpetrators, most often, were their partners, family friends or close relatives. Other sexual offenders included neighbours, relatives or even work colleagues. Violence against women and sexual abuse during pregnancy is an important risk factor for both the health of women and their unborn children that leads to increased risk of pregnancy complications, miscarriage and low birthweight delivery.

PMTCT through early ANC attendance and testing

Although the recommended first visit to the antenatal clinic is during the first trimester of pregnancy, only 5.9% pregnant women attended in the first trimester and 48.5% attended in the second trimester of pregnancy in 2015. Further communications and outreach to encourage early attendance of ANC may be useful.

According to the Global AIDS Response Progress Report (2014) and Health Sector HIV reports, the current rate of Mother to Child Transmission of HIV is 20%. One of 5 children so far born to HIV positive mothers, turned out HIV positive after being tested at 13 years during the reporting period. In 2014, only 13.9% (2,388) of the total number of pregnant women (17,181) were tested for HIV on their in the country. In 2014, only 63.2% (1,511) of pregnant women tested for HIV (2,388) received their results. In 2014, 17 health facilities were providing HIV testing services. Support from UNICEF, this has been scaled up to 35 in 2015, out of 315 health facilities operational in the country and most of which are providing ANC services.

High rate of Alcohol and Drug use

Alcohol consumption among antenatal women in the country has been low (18.6%). The use of betel nut has been reported 79%. About 22.4% antenatal women reported to use tobacco during pregnancy. It is suggested that health education programmes targeting women should have a focus in reducing substance use particularly during pregnancy.

Knowledge of HIV transmission

Awareness of HIV is almost universal (99%) among antenatal women. Most antenatal women correctly answered both prevention questions while 51% correctly responded to three misconceptions of HIV transmission and common fallacies. However, only 44.2% women could answer all five questions correctly indicating the need of targeted interventions to reduce the gaps in HIV prevention programming. Radio (85%) has remained the main sources of HIV prevention knowledge through which most antenatal women received messages regarding prevention of HIV infections. There are opportunities to more effectively utilize popular media to further promote the most needed information to the people.

Attitudes towards Persons Living with HIV

Prevalence of stigma about HIV and discriminatory attitudes towards persons living with HIV (PLHIV) has remained quite high in Solomon Islands. Willingness to have casual contact with a shopkeeper or vendor if the person has HIV was reported at 40%. The proportion of antenatal women having accepting attitudes for a female teacher 'who had HIV and was not sick' to keep teaching in the school was reported at 36.4%. It is important to re-examine ongoing HIV educational contents to ensure appropriate messages are included to effectively reduce stigma about HIV and discriminatory attitudes towards PLHIV.

HIV and syphilis testing and treatment

Provision of confidential HIV testing has been very limited for antenatal women in Solomon Islands. The principal barriers to HIV testing were the unavailability of testing services in most ANC clinics and perceived lack of confidentiality. The scope of testing and treatment of syphilis has also been very low. As a result, only a very small proportion of pregnant women had syphilis tests in their previous pregnancies. The survey indicates that most antenatal women (94.3%) would seek PMTCT services if needed. Antenatal women trust clinics and hospitals more compared to traditional healers or indigenous practitioners. Nearly all women (97.2%) would go to government health facilities to receive treatment for syphilis if needed. The findings indicate that demands for HIV and STI services would increase if the benefits of testing are promoted further and services are made available to them. Promotion of HIV and syphilis testing and treatment services should be increased along with the expansion of HIV/syphilis testing and treatment services in the country.

1.3 GOVERNANCE AND COORDINATION:

The Solomon Islands National AIDS Council (SINAC) is a multi-sectoral body comprising representatives from government ministries, civil society, faith based organisations and people living with HIV. It was convened in 2004 to provide the overarching authority and oversight for the national HIV and AIDS response, including guidance, coordination, approval and accountability relating to policy development and program implementation.

While SINAC is responsible for the oversight of the National HIV and Other STIs Responses, this governance and coordination is complimented by the Solomon Islands National Country Coordinating Mechanism (SINCCM) whose mandate and focus is essentially the Global Fund Grant management, coordination and implementation processes for Tuberculosis, HIV/AIDS and Malaria.

SINAC operates on the “Three Ones Principles” as well as a “Fourth One” dictated by PRSIP;

- **One** agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners
- **One** National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System
- **One** Funding Mechanism that unified the processes for HIV response cognisance of the different requirements of grants and funding streams

SINAC meets quarterly, with ongoing Secretariat support provided through an employed coordinator, who operates within the HIV/STI Department of the Ministry of Health and Medical Services (MHMS).

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

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. Further, 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 (GFATM), has weakened SINAC’s influence and profile.

1.4 STRATEGIC PROGRAM GUIDANCE AND IMPLEMENTATION

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

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

The years 2011 and 2012 have operated under the previous 2005-2010 plan. This new **National Strategic Plan for HIV and STIs 2014-2018** continues this commitment to guiding the national response through multi-sectoral collaboration and strategic direction and coordination based on evidence of the most appropriate interventions for HIV and STI prevention, treatment and care in Solomon Islands.

1.5 POLICY AND LEGISLATION:

Solomon Islands has no specific discriminatory laws and regulations to protect the rights of people living with HIV, or those of particularly vulnerable groups, however it does have in its Constitution 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 have now developed a Draft HIV Management and Prevention and Control Legislation and also produced a Cabinet Paper to guide the request for a HIV Bill, that would be passed through the Ministry of Health and Medical Services for further review and tabling of a Bill in the next Parliamentary Session. This National Strategic Plan has identified legal and policy reform as a national response priority for this period 2014-2018.

1.6 RESOURCING

Resources for the national HIV and STI response is predominately met through international development partners, and coordinated through SINAC and the HIV/STI Department of the MHMS. The government's commitment to the national response is demonstrated through an annual budget provision[12]. A National AIDS Spending Assessment (NASA) was conducted in 2011 with support from UNAIDS, and the draft report provides details of expenditure towards the national response to HIV and AIDS (not necessarily STIs)[13]. From 2008 – 2010, the total expenditure for the HIV and AIDS response was US$3,251,745, of which 41.6% was provided by international NGOs, 24.1% by multi-lateral agencies and 17.3% by bilateral arrangements (although both multi- and bilateral agencies also supported the work of many of the International NGOs).

Resourcing for the national HIV and AIDS response is strongly weighted towards prevention (34.4% of expenditure), program management and administration (25.6%), and human resources (21.4%). Consistent with the low national prevalence of HIV, treatment, care and support and all other interventions consumed less of the response expenditure (11.4% and 7.2% respectively). There has not been a comprehensive analysis on spending to address other STIs in Solomon Islands.

1.7 IMPLEMENTATION

The national response to HIV and STIs has been a truly multi-sectoral collaboration since the 1990s, both in the development of strategic priorities, and implementation of activities under these. Government activities have been coordinated and led by the MHMS' HIV/STI Department, in conjunction with a number of other Ministries for specific activities, and a large number of international and national NGOs and faith based organisations (including SIPPA, World Vision, Save the Children, Church of Melanesia, Oxfam, Solomon Islands Red Cross Society, ADRA, SPC, WHO, UNICEF and UNFPA) have contributed a range of general and targeted activities from the national down to the community level.

The national response has focused strongly on raising awareness of, and promoting the prevention of HIV and STIs amongst the general population, and more recently, amongst specific, identified vulnerable groups (such as young people and seafarers). Diagnosis, treatment and care of HIV and STIs is conducted through a network of primary health care clinics and centres, HIV testing services centres and youth-focused health services run by government, NGOs and faith based organisations across the country. Over 30 health facilities are currrently screening for HIV through Rapid Diagnostic Testing. Testing facilities for many STIs are insufficient, with most health services relying on syndromic management algorithms for diagnosis and treatment.

15.Review of Laws Re: HIV, Ethics and Human Rights, Solomon Islands. UNAIDS.2013.

[12] UNGASS Country Progress Report, Solomon Islands..

[13] Government of Solomon Islands (2011). DRAFT Solomon Islands National AIDS Spending Assessment (NASA), 2008 – 2010. Honiara. UNAIDS.

2.0 PROCESS OF DEVELOPING THE NSP

2.1 DEVELOPMENT OF THE FIRST NSP (2003/2005-2010)

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

i. Reduction of risky behaviour and vulnerability to HIV and STIs.

ii. Enhance Voluntary Counselling and Testing of HIV as an entry point for confidential prevention and treatment services for STIs and AIDS (including blood safety).

iii. Enhance HIV and STI surveillance, treatment and care.

iv. Enhance capacity building for the national HIV response at both the community and institutional level.

v. Ensure sustainable development to enable an environment for behavioural change, de-stigmatization and against discrimination impacting on prevention and care.

2.2 REVIEW OF THE FIRST NSP (2003/2005-2010)

The Solomon Islands conducted a *National Review of Responses to HIV and STIs, from 16-23 November 2010*. The review was facilitated by Burnet Institute, as part of the National Strategic Frameworks Project, supported by the SPC Response Fund, and assisted by the UNAIDS Pacific Monitoring and Evaluation Officer. The objectives of the review were to evaluate how successfully the National Strategic Plan has guided the national response over the last six years, assess progress, identify potential improvements for the next planning period, and assess progress towards Universal Access to prevention and treatment. The review included a "Capacity Assessment", which considered the capacity of the national stakeholders to engage in further development of various aspects of the National Strategic Framework. It then included a "Quality Assessment" of the existing National Strategic Framework. The planning group also reviewed national planning documents and conducted a consultation meeting with national stakeholders.

In the next stage, the National Planning Team reviewed specific issues using a facilitated process based on a method called the Evaluation Wheel. Issues discussed included risk and behaviours, condoms, STI diagnosis and treatment, testing for HIV and STIs, care and support, gender, youth, and stigma and discrimination. For each issue, the small groups discussed and reported on these questions: What can we say now? What questions remain?

Using a similar process, participants discussed issues of governance and coordination. These issues included the role and functioning of the Solomon Islands National AIDS Council (SINAC), the working groups addressing different issues, costing and resources, provinces and rural areas, monitoring and evaluation, technical partners and coordination of technical assistance.

2.3 DEVELOPMENT OF THE NSP 2014-2018

The years 2011 and 2012 operated under the 2005-2010 plan before a new NSP was developed. Before 2013, the HIV response, and prevention and awareness activities in particular, were delivered in collaborative partnership with a wide group of international and national NGOs, multilateral agencies, churches and community-based organisations. However, programming and funding for the HIV response has significantly decreased, and in 2013, only one NGO and one faith-base organization were directly implementing HIV-related activities in Solomon Islands.

In 2013, a change of leadership in the HIV Unit, coupled with the uncovering of major fraud within the Ministry of Health, were critical incidents that adversely impacted on the HIV programme's effectiveness and achievements, and undermined staff morale.

In July 2014, a country dialogue was held to review the 2011-2015 NSP, taking into account the various challenges experienced in the National Response since the last review, and other factors unfolding in the response. The country dialogue was conducted in preparation of the Global Fund Concept Note which produced adjustments to the draft NSP to better reflect the epidemiological situation and the country needs. Thus, key populations such as MSM and TG, FSWs have been declared priorities for the NSP. Additionally scale up testing in pregnant women, ART treatment and monitoring and evaluation systems have been considered as crucial in the national AIDS response.

The NSP 2014 – 2018 was developed based on the following considerations:

a) Constitutional Rights And Policies:

i. The Constitution of Solomon Islands Statutory Instruments 1978 No 788 that guarantees the protection of the fundamental rights and freedom of the individual; and also guarantees the protection of right to life. This also implies the rights of PLHIV to be free from stigma and discrimination and their rights to enjoy the highest quality of life possible.

ii. The Right of Every Individual to Access to proper Health Care as stated in the *National Coalition for Reform and Advancement (NCRA) Government Policy Statement Part 9, section 9.2* that upholds the conviction that: "*A health people make a healthy nation*"

iii. The overarching National Health Strategic Health Policy that states that: " The Health Sector and health related sectors will continue to try to reduce the other causes of the Solomon Islands disease burden, however, the services to implement mitigation of these liner priority causes will be uneven and often under resourced services".

iv. The Combined National Health Vision and the HIV and STI Control Mission that: "*The people of the Solomon Islands will be Healthy, Happy and Productive, and: The Health and the wellbeing of the people of Solomon Islands will not be undermined due to the burden of HIV and STIs.*"

b) Commitments of the Solomon Islands Government (SIG) to Global Trusties and agreements that include but are not limited to the followings:

i. The Pacific Regional Strategy and Implementation Plan II for HIV and STIs (2009-2013) as a collective regional response to halting the spread and impact of HIV and other STIs.

ii. The SIG National Policy on Gender Equality and Women's Development (GEWD) particularly in the priority outcome areas:
   - Improved and equitable health and education for women, men, boys and girls, and
   - Elimination of violence against women.

iii. This policy was enacted based on the Solomon Islands Government commitment to the Convention of the Elimination of all forms of Discrimination Against Women (CEDAW) as a legally binding United Nations treaty that was ratified by Solomon Islands Government (SIG) in 2002.

iv. The 2001 United Nations General Assembly and Special Sessions (UNGASS) declaration of commitment on HIV.

v. The commitment of SIG to the achievements of the Millennium Development Goals (MDG) by 2015 and Sustainable Development Goals (SDG) by 2030.

vi. The adoption of the 2005 World Summit *"Three Ones"* and, as required by PRSIP, the "*Forth One*" principles of:
   - One agreed HIV Action Framework
   - One National HIV Coordinating Authority
   - (Now constituted as the Solomon Islands National Aids Council – SINAC)
   - One agreed HIV National M&E system
   - One funding mechanism (PRSIP II)

vii. The 2008 Paris Declaration on Aid Effectiveness and the Accra Agenda for Action

viii. The Convention on the Rights of Children ratified by Solomon Islands Government on 10 April 1995.

c) **Technical Considerations**

The development of this NSP was in cognizance of the following factors that are unique to the Solomon Islands:

i. Burden: While the prevalence of HIV in the Solomon Islands is low at 0.0002% (2010 estimate); the prevalence of other STIs which can fuel an HIV epidemic remains unacceptably high (23.3/1000, 2007 estimate), and continues to increase at an alarming rate.

ii. Regional Collaboration: The limited resources of Solomon Islands as a developing low income nation calls for participation in a regionally coordinated response to the threats of HIV; which as an epidemic can overwhelm the resources of the nation and that of similar economies that are members of the Pacific Islands Countries and Territories (PICTs). Hence, the SIG has signed on to the Pacific Regional Strategy and Implementation Plan II (PRSIP II), for HIV, AIDS and other STIs (2009-2013).

iii. Comprehensive Coordinated Response: An holistic approach to combating the threat of HIV and STIs that leverages political commitment at the highest level to the UN Summit Outcome 2005 " three one" principles that leverage the complementary mutually re-enforcing elements of a continuum of case-ranging from primary prevention, to diagnose, care and support and the limitation of disabilities of infected persons.

iv. **Gender Discrepancies:** The rates of HIV and STIs are disproportionately higher in women than men, coupled with a higher dependency on women to care for infected family members. This place a higher burden on women in terms of those infected and affected requiring gender mainstreaming strategies to deal with this discriminatory burden.

v. **Young Population:** From the mid census (2009) estimates, over half of the Solomon Islands population are under the age of 25 years with about 43% under the age of 15 years. This necessitates the collection of data and revision of data collection mechanisms in youths to include the 10-14 years age group as recommended by PRSIP II; as well as, the concerns of national stakeholders who have targeted interventions within the 10-14 year group and their being sexually active (reference: SI SGS, 2008).

vi. **Key Populations at higher risk of exposure to HIV and STIs:** The re-focusing of high impact interventions to groups of individuals deemed to be more at risk based limited studies (the MOH/UNICF KAP Survey, 2009 and the MOH/SPC SGS Survey, 2008) and project activity reports to the followings:

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

  As at the moment, there is no evidence to suggest consideration of Injection Drug Users (IDU) as a MARP in the Solomon Islands.

vii. **Mode of transmission:** As at this point the heterosexual mode of transmission is considered to be the main one in the absence of data from key populations at risk.

viii. **Drivers of HIV/STIs:** HIV and particularly the high rate of STIs in the Solomon Islands appears to continue to be fueled by the followings

- Lack of knowledge of HIV and STIs transmission
- Low perception of risk
- Multiple sexual partners
- Lack condom use

- Lack of income related to transactional sex
- Lack of access to effective services
- Gender inequality, including the inability of women to negotiate condom use; and the Solomon Islands Family Health and Safety Study (2009) that shows that about 64% of women have suffered gender based violence with sexual health implications (sexual violence)

With Technical Assistance from UNICEF through a long term HIV/AIDS Consultant, the 2014-2015 NSP was updated, costed and finalized in September 2015 based on new data from the 2015 SGSS study on HIV and Syphilis among ANC, as well as updated country data from the 2014 GARPR and Health Sector HIV/AIDS progress reports.

3.0 METHODOLOGY

3.1 NSP DEVELOPMENT PHASES & INPUTS

The various stages and inputs of the National Strategic Framework process consist of five complete phases:

Table 3:

Phase	Inputs and explanation
Phase 1: Preparation (Readiness to Plan)	Formation of a National Planning Team with complementary skills to contribute to leadership of a comprehensive National Strategic Plan. Assessment of national capacity to lead and develop the National Strategic Plan. Assessment of the quality of the existing national response to date.
Phase 2: Assessment of the National Response	Gathering of prevalence data from a range of available sources to inform an epidemiological summary. Sources may include surveillance data (both routine and discreet surveys), program implementation reports, operational and formal research reports, case studies, situation assessments. Consultative review of the existing response with national (and potentially sub-national) stakeholders. National AIDS Spending Assessment (NASA).
Phase 3: Develop the National Strategic Plan	Defining the strategic and programmatic outline of the National Strategic Plan, engaging in national and sub-national consultation to inform a final, prioritised and endorsed National Strategic Plan.
Phase 4: Develop the Monitoring and Evaluation Framework	Building upon the National Strategic Plan to articulate how the response can be guided and measured to ensure progress and effectiveness of all stakeholder inputs. This will be developed in a consultative process to ensure relevance to, and ownership by implementing stakeholders.
Phase 5: Implementation	Emphasising the ongoing nature of the National Strategic Framework, this Phase moves beyond development of the National Strategic Plan, and demonstrates how collection of data during the course of the National Strategic Plan period will re-shape the implementation of the response.

The following discussion outlines the steps taken to develop this National Strategic Plan for HIV and STIs 2014-2018;

Phase 1: Preparation (Readiness to Plan), August 2010: A workshop of key national stakeholders was held to introduce the National Strategic Framework project and the process and draft planning tools which would be utilised.

Workshop facilitators, Bruce Parnell (Burnet Institute, Australia) and Mohamed Turay (UNAIDS, Pacific) led the participants in two consultative activities to assess the capacity of national stakeholders to lead and develop the National Strategic Framework, and to review the quality of the existing national response to date. These activities culminated in the identification of a National Planning Team tasked with leading and contributing to the development of the National Strategic Framework, and to communicating regularly with important national and provincial stakeholders to gather information and to communicate progress.

Terms of Reference were developed for the Team (and later revised in May 2011) to facilitate endorsement from their organisations.

This Phase concluded with the National Planning Team's identification and articulation of the next steps for the Solomon Islands national HIV and STI strategic planning process. Full details of this Phase can be sourced from the report, *"Readiness to Plan" Workshop 18 – 20 August 2010*.

Phase 2: Assessment of Response, November 2010 – July 2011: Bruce Parnell (Burnet Institute, Australia) worked with the National Planning Team to conduct a consultative review of the existing national HIV and STI response, involving;

- Review of relevant national documents, including the existing National Strategic Plan and various monitoring reports.
- Key informant interviews with a selection of national implementers from different sectors and engaged in different types of responses (e.g. prevention for general community, prevention for risk groups, testing, reduction of stigma and discrimination, research, engagement in different parts of the country).
- Reporting findings to a National Stakeholders' Workshop.

This review input was followed by a detailed appraisal of surveillance data and other evidence to inform an epidemiological summary of HIV and STIs amongst the general population and identified vulnerable groups in Solomon Islands. The appraisal utilised the limited, available surveillance data, behavioural and biological surveillance reports and a number of reports of discreet research conducted by technical agencies and international NGOs. This summary was developed to confirm and/or complement the findings of the consultative review, to ensure development of the new National Strategic Plan would be based on situational evidence.

For full details of the review workshop and outcomes, and the epidemiological summary, see the report, *Report on Review Processes and Findings, 16 – 23 November 2010*.

This Phase of the National Strategic Framework for HIV and STIs was completed with the release of a draft National AIDS Spending Assessment (NASA) in July 2011[14]. This document, referred to in detail above, documents the financial contributions to the national response from various national and international stakeholders/partners, and describes the proportion of total expenditure utilised for different aspects of the response. This information is useful for allocating strategic priorities as part of the development of the new National Strategic Plan.

[14] Solomon Islands Government (2011). DRAFT Solomon Islands National AIDS Spending Assessment (NASA), 2008 – 2010. Honiara. UNAIDS.

Phase 3: Developing the National Strategic Plan, May – August 2011: In May 2011, Mr. Chris Hagarty (Burnet Institute, Australia) and Dr. Dennie Iniakwala (SPC) led the National Planning Team and national stakeholders in a series of meetings and workshops to confirm the information derived through the consultative review of the national response in conjunction with the release of data presented in the epidemiological summary. These two sources of information, combined with the capacity and quality assessments conducted during the 'Readiness to Plan' phase contributed a comprehensive picture of the national HIV and STI situation and response, upon which to commence identification of strategic priorities.

A goal, strategic and programmatic priorities were identified within six thematic areas and two cross cutting themes, and objectives, outcomes, outputs and activity groups were allocated to these to create a draft outline for the National Strategic Plan.

This draft outline was presented to national and provincial stakeholders by the National Planning Team in a series of meetings in Honiara and key, identified provinces in June and July 2011. Standardised processes were developed to guide these consultations. Feedback confirmed the relevance of the National Strategic Plan to sub-national stakeholders, and identified gaps and issues to be addressed in subsequent drafts.

The draft outline was also provided to technical partners within the Regional Planning, Monitoring and Evaluation Group for feedback and direction.

In August 2011, Bruce Parnell (Burnet Institute, Australia), Dr. Dennie Iniakwala (SPC), Dr. Olayinka Ajayi (SPC) and Mr. Parvez Sazzad Mallick (a M&E Consultant fielded by UNICEF) led a further series of workshops with the National Planning Team and national stakeholders to confirm the draft outline of the National Strategic Plan in light of feedback from the provincial and regional consultation, and conducted a number of processes through which to prioritise the various outputs with a view to allocating resource weighting across the various thematic areas and cross cutting themes.

A draft National Strategic Plan for HIV and STIs was prepared immediately after this input in August.

The draft underwent further review between September 2011 and August 2012 by a Solomon Islands NSP Finalization Task Force (NFTF) led by Dr Nemia Bainivalu and an in-country FTF Team backstopped by Dr. Olayinka Ajayi (SPC) and Dr. Dennie Iniakwala (SPC) in consultation with key national stakeholders and regional partners before finalisation and submission for endorsement from SINAC and the Government of Solomon Islands.

Phase 4: Finalization the National Strategic Plan, July 2014: Finalizing and costing of the NSP has been ensured by the MOH HIV/STI Unit with support from UNAIDS in a country dialogue with CSOs, NGOs and FBOs.

Phase 5: Modification and ratification, September 2015: Modification of the NSP was done in September 2015 by the MHMS HIV/STI Division, with technical Assistance from a UNICEF HIV/AIDS Consultant. The NSP was modified / updated based on new data from a 2015 SGSS study in preparation of a HIV concept note submitted to GFATM in September 2015; and it was also fully costed, and linked to the NHSP 2016-2020.

3.2 STAKEHOLDERS INVOLVED IN DEVELOPMENT PROCESS

The National Planning Team consisted of the following individuals and organisations, however it was agreed that not the entire group had to be present in order to progress on specific tasks and inputs;

Table 4:

MHMS	2 entities	Public Health Directorate
		HIV/STI Unit
NGOs and Churches	6 entities	(International, National NGO, Churches)
		Oxfam (Capacity Development Organisation)
		Church of Melanesia
		World Vision
		Save the Children
		SIPPA
		National Council of Women
Ministries (non-Health)	3 entities	Ministry of Education
		Ministry of Women, Youth and Children's Affairs
		Ministry of Police and Justice
Secretariat		SINAC Secretariat, HIV/STI Division - MHMS
Technical Partners	5 entities	UNICEF, SPC, WHO, UNAIDS and Burnett Institute.

4.0 STRUCTURE OF THE NSP

4.1 BACKGROUND ON STRUCTURE

The form and structure of this 2nd NSP (2014-2018) differs from that of the preceding 1st NSP (the NHP & MSP, 2005-2010) The 1st NSP (2005-2010) was based on multiple goals that were stated and numbered as HIV Policies, and then linked to Key Results Areas (KRAs). However, while keeping a performance and key results areas orientation focus, the structure of this NSP (2014-2018) draws largely from the Monitoring and Evaluation Framework of the *Second Pacific Regional Strategy and Implementation Plan for HIV and other STI (PRSIP II, 2009 – 2013)*.

This structure was selected to enable Pacific Island Countries and Territories to develop their national strategic plans for HIV and STIs in such a way as to plan, implement, monitor and report the progress and effectiveness of their national responses in line with the indicators and format of both the Pacific Island HIV and STI Response Fund, and national reporting commitments for UNGASS.

Furthermore, the structure of this NSP is informed by a Logical Framework Approach (LFA) presented earlier as a conceptual framework that identifies an overarching goal that is informed by prioritised objectives and outcomes, which would be achieved through meeting activity and/or effectiveness targets at output and activity group levels.

4.2 MAJOR THEMATIC AREAS

Consistent with the PRSIP II Monitoring and Evaluation Framework, **six major thematic areas** have been incorporated into the Solomon Islands National Strategic Plan for HIV and STIs 2014-2018:

1. Prevention
2. Diagnosis
3. Treatment, care and Support
4. Leadership and Enabling Environment
5. Strategic Information and Communication
6. Governance and Coordination

4.3 CROSS CUTTING THEMES

An additional **two cross cutting themes** were also identified by national stakeholders for inclusion in the National Strategic Plan:

7. Gender
8. Stigma and Discrimination

Table 5

Major Thematic Areas	**Cross Cutting Themes**
1. Prevention 2. Diagnosis 3. Treatment, Care and Support 4. Leadership and Enabling Environment 5. Strategic Information and Communication 6. Governance and Coordination	7. Gender 8. Stigma, Discrimination and Human Rights

5.0 GOALS, OBJECTIVES & STRATEGIC APPROACHES

5.1 OVERARCHING GOAL

This plan is for guiding national approaches for halting the spread and impact of HIV and STIs in the Solomon Islands, the first one being the antecedent 1st National HIV Policy and Multi-sectoral Strategic Plan (2005-2010). The overarching priority of this NSP is to re-direct high impact interventions to the under-served and most at risk population groups. This NSP places particular emphasis on improved communication to halt the transmission of HIV and STIs through informed HIV and STIs awareness and behaviour charge interventions, as well as improved access to quality prevention, care and support services aimed of enhancing the quality of life and dignity of PLHIV and affected persons, as well as reduction in the transmission of HIV and STIs to others.

Overarching Goal: "*By 2018 to halt the spread of HIV in general population, reduce HIV prevalence among key affected populations and AIDS related mortality in the Solomon Islands."*

Achievement of the national response in relation to the overarching goal stated above will be measured against the **Programme Goal:** *"By 2018 to halt the spread of HIV in general population, reduce HIV prevalence among key affected populations and AIDS related mortality in the Solomon Islands"*

Output Indicators:

- By 2018, Zero HIV Incidence:
    - The number of new HIV infections in the Solomon Island population annually
- By 2018, HIV prevalence maintained (from 2013).
    - Percentage of young people aged 15–24 who are HIV infected
    - Percentage of most at risk populations who are HIV infected
    - Percentage of adults (>=15 years) and children (<15 years) who are known to be alive at 12, 24, 36 and 48 months after initiation of antiretroviral therapy. Annual program monitoring data
- By 2018, Zero Parent to Child Transmission of HIV
    - Percentage of infants born to HIV Infected mothers who are infected
- By 2018, Reduction in STIs prevalence.
    - The proportion of young people and antenatal attendees with STIs that were detected during diagnostic testing
- By 2018, zero related deaths from AIDS
    - Percentage of PLHA in ARV treatment
    - Percentage of adults (>=15 years) and children (<15 years) who are known to be alive at 12, 24, 36 and 48 months after initiation of antiretroviral therapy. Annual program monitoring data

5.2 THEMATIC AREAS OBJECTIVES AND INTERVENTIONS

5.2.1 THEMATIC AREA 1: PREVENTION:

Consistent with the low HIV prevalence, prevention has consumed the majority of resources for the Solomon Islands' HIV response to date. However, prevention will continue to be a major priority under this 2nd NSP, with added focus on a more comprehensive approach to the prevention of STIs. In addition, a priority for this Strategic Planning period is the targeting of prevention interventions to particularly vulnerable groups.

A comprehensive approach to HIV and STI prevention has been articulated under this Thematic Area, incorporating general and targeted awareness campaigns, behaviour change interventions, a prevention of mother to child transmission program, improved condom supply and distribution strategies, scaling-up of youth friendly health services and integration of HIV and STI prevention activities with disaster preparedness interventions.

Table 6

Strategic Objective 1: By 2018, to increase access to evidence-based HIV prevention in Solomon Islands		
	Strategic Outcomes	**Interventions**
1.1	Improved knowledge and safe behavioural practices of all target groups.	▪ Scale up prevention activities for MSM, FSWs and transgender ▪ Scale up and strengthen coordination of behavioural change and communication programs ▪ Scale up youth friendly health services ▪ Increase the availability and accessibility of condoms to the general population and most at risk population
1.2	Reduced risk and vulnerability to HIV infection of all target populations, including situations related to adverse circumstances such as disasters.	▪ Develop and integrate emergency preparedness response guidelines into the national HIV/STI Management Strategy ▪ Collaborate with the Infection Control Unit of the National Referral Hospital to expand Infection Control and Safety Training to health workers and other individuals involved in HIV/STI Response ▪ Screen all donated body fluids and organs for transfusion transmissible infections ▪ Collaborate with the National Blood Bank and Solomon Islands Red Cross (SIRC) to promote the exclusive use of Voluntary Non-Remunerated Blood Donation (VNRBD) ▪
1.3	Improved and equitable age responsive health and sexual education for girls, boys, women and men.	▪ Mainstream gender into school curricula with MoEHRD. ▪ Collaborate with Ministry of Education to incorporate comprehensive life skills and sex education syllabus into school curriculum and national level

5.2.2 THEMATIC AREA 2: DIAGNOSIS:

The new National Strategic Plan aims to increase the early detection of HIV and other STIs to reduce further infections and facilitate timely treatment through scaling-up and promotion of VCCT services and laboratory facilities, and to introduce point of care/rapid testing for HIV. Improvements in contact tracing for prevention of further transmission of HIV and STIs has also been identified for the new planning period.

Table 7

Strategic Objective 2: By 2018, to improve access, availability and effectiveness of HIV and STI testing and counselling services		
	Strategic Outcomes	**Interventions**
2.1	Expanded national coverage of HIV & STI testing and counselling services	▪ Strengthen Laboratory Quality Management System (LQMS) ▪ Scale up; expand the coverage and resource HIV and STI cancelling and testing program ▪ Scale up and expand the coverage of PPTCT with particular focus to rural population ▪ Scale up diagnosis in MSM, FSWs and transgender through rapid testing;
2.2	Increased utilisation of HIV & STI testing and counselling services	▪ Scale up integration of HIV & STI counselling and testing into Sexual and Reproductive Health Services ▪ Improve quality of HIV & STI counselling and testing services by developing and implementing minimum standard guidelines in accordance with latest WHO guidelines ▪ Awareness campaign to create demand for voluntary counselling and testing services to both general population and key populations at higher risk of exposure to HIV & STI

5.2.3 THEMATIC AREA 3: TREATMENT, CARE AND SUPPORT

Treatment, care and support of HIV and STIs are considered separately within the priorities set under this thematic area. A commitment to maintaining universal coverage of antiretroviral therapy for people living with HIV, and in-patient support services for people suffering from AIDS-related illness has been made with full understanding that improved testing and surveillance could influence increased incidence, and a commitment to supporting families and carers of people living with HIV with information and education has also been articulated.

Improved and promoted testing and counselling services, contact tracing and laboratory facilities have been identified for a focus on STI treatment and care within this National Strategic Plan.

Table 8

Strategic Objective 3: By 2018, to maintain effective universal coverage of HIV treatment, and to increase access to quality care and support services for PLHIV		
	Strategic Outcomes	**Interventions**
3.1	Increased quality and coverage of Continuum of Care (CoC) for HIV (CoC covers all treatment related needs including mx. of HIV pregnant women, +ve infants, and TB-HIV Co-infections)	▪ Reactivate and establish new HIV Core team(This also includes collaboration and linkages with the National TB program for TB-HIV Co-infections management) ▪ Formalise the establishment of Continuum of Care frameworks
3.2	Strengthened processes for ARV with zero occurrence of stock outs	▪ Resource HIV treatment commodities ▪
3.3	Established Post Exposure Prophylaxis Guidelines and support processes	▪ Revise existing hospital based PEP SOP for adoption as a National PEP Guideline
3.4	Increase adherence to ART treatment	▪ Community support to patients living with HIV/AIDS ▪ Provision of nutritional support to PLHIV ▪ Support for referrals and appointments

Table 9

Strategic Objective 4: By 2018, to improve provision of quality, comprehensive case management of STIs		
	Strategic Outcomes	**Interventions**
4.1	Completed roll out of the new treatment regimen and guidelines for comprehensive case management of STIs based on OSSHHM recommendations	▪ Roll out and implement treatment guidelines and Standard Operating Procedures (SOP) for STI Management ▪ Monitor Health staff delivery of STI Case Management accordance to National Treatment Guidelines. ▪
4.2	Increased quality and coverage of comprehensive case management for STIs	▪ Integrate HIV, STI Comprehensive Case Management and SRH across all levels of care
4.3	Strengthened processes for STI commodities with zero occurrence of stock outs	▪ Strengthen procurement and supply management for STI commodities

5.2.4 THEMATIC AREA 4: LEADERSHIP AND ENABLING ENVIRONMENT

Prioritised within the National Strategic Plan are efforts to build capacity and encourage leaders at different levels to work towards enabling environments which support engagement of people living with HIV and identified vulnerable groups to benefit from the national response.

Table 10

Strategic Objective 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		
	Strategic Outcomes	**Interventions**
5.1	Increased political commitment backed by increased resourcing of the HIV and STI response	▪ Multi-sectoral advocacy of the NSP at all levels ▪ Advocate for political commitment and spending for HIV and STI control
5.2	Increased pool of leaders and key individuals who are well informed and knowledgeable of HIV and STIs and their impacts so as to reduce barriers for accessing effective HIV and STI services	▪ Strengthen integration and participation of leaders from Community and religious sectors in the HIV and STI response ▪ Engage and conduct HIV and STI awareness workshops for leaders at all levels ▪ Ensure HIV and STI services are responsive to the needs of PLHIV and key populations at higher risk of exposure to HIV and STIs
5.3	Increased awareness of the urgent need for a comprehensive HIV legislation among leaders (political, tribal, religious, community, private sector and informal) at all levels	▪ Advance the current HIV Legislation under review ▪
5.4	Coordinated multi-sectoral Civil Society Organizations (CSO) response against violations and abuse of the rights of individuals particularly PLHIV	▪ Strengthen, expand and coordinate multisectoral CSO collaborative initiatives
5.5	Increased proportion of public and private establishments that implement HIV and STI workplace programs	▪ Develop National guidelines for HIV and STI Work Place program and advocate for its implementation in public and private organisations
5.6	Increased ability of women to participate in Sexual and Reproductive Health (SRH) decision making	▪ Conduct participatory learning workshops/programs to build knowledge and skills in relationship communication and risk awareness.(Stepping Stones)

5.2.5 THEMATIC AREA 5: STRATEGIC INFORMATION AND COMMUNICATION

The review of the existing national HIV and STI response identified planning, monitoring, evaluation, surveillance, research and information sharing between stakeholders and communities as considerable weaknesses, and these has therefore been prioritised in this National Strategic Plan.

Specific emphasis has been placed on identifying and documenting vulnerable groups and the behaviours and practices that contribute to their vulnerability; and on building capacity of implementing stakeholders to conduct reliable field research and disseminate findings.

Table 11

Strategic Objective 6: By 2018, to enhance and strengthen the national strategic information, monitoring and evaluation system		
	Strategic Outcomes	**Interventions**
6.1	Enhanced leadership and managerial competencies to deliver the national M&E system for HIV and STIs	▪ Develop a M&E software to accommodate reporting ▪ Advocate for improved political commitment and leadership support for M&E System ▪ Advocate for increased timely funding for the M&E System
6.2	Developed and enforced policy requiring multisectoral reporting of all STI & HIV data to the MOH HIV Unit	▪ Instil an M&E culture among stakeholders in the HIV & STI response ▪ Review and strengthen the implementation of national guidelines and SOPs on data quality, audit, and supervision at all levels of collection and aggregation
6.3	Strengthened MOH STI & HIV Unit M&E capabilities	▪ Strengthen and expand human capacity to enhance the effectiveness of the M&E Systems ▪ Continue monitoring and evaluation of comprehensive HIV & STI care and support services
6.4	Integrated HIV& STI data and information systems that draw from diverse sources	▪ Implement M&E curriculum to build capacity of multisectoral cross-cutting team involved in National HIV & STI response ▪ Strengthen and support the National Health Information System to adequately cover STI & HIV information needs and requirements
6.5	Improved data quality with respect to accuracy timeliness and completeness for evidenced based decision making	▪ Improve the ability of SINAC to effectively use strategic health information to inform the national response
6.6	Improved HIV & STI Surveillance Research and Communications to inform national response	▪ Strengthen the capacity for design, conduct, and analysis of data and the use of findings from surveys, surveillance and research studies

5.2.6 THEMATIC AREA 6: GOVERNANCE AND COORDINATION:

The need for improved governance and guidance of the national response was identified within the review of the existing response, and this National Strategic Plan prioritises improved resourcing for SINAC to oversee donor coordination and to work with stakeholders to improve efficiency and accountability relating to financial management and reporting.

Table 12

Strategic Objective 7: By 2018, to strengthen governance, funding and coordination mechanisms towards a more effective, multi-sectoral contribution to the national HIV and STI response		
	Strategic Outcomes	**Interventions**
7.1	Legislated articles on the formation, constitutionality and authority of SINAC as the single highest national body in the coordination of the national response to STI and HIV, on the basis of the Solomon Island Government commitment to the "Three Ones" principles	▪ Advocate for the tabling of a Bill to formally recognise SINAC and its roles and functions as the highest national response coordinating body ▪ Advocate for multi-sectoral recognition of SINAC ▪ Partnership and collaboration with Solomon Islands National Country Coordinating (SINCCM) as a sub complimentary Global Fund for Malaria and TB focused coordinating entity ▪ Established Solomon Islands Provincial AIDS Committees (SIPAC) at as sub-national arms of the Solomon Islands AIDS Council to enhance local community participation in the coordination of the national response
7.2	Developed periodic / mid-term review of a costed National Strategic Plan supported by an M&E framework for HIV and STIs	▪ Perform periodic review (mid-term and end-term) of 2014-2018 NSP ▪ Develop NSP 2019-2024
7.3	Strengthened capacity of the STI/HIV Unit of the MOH to manage, coordinate, integrate, plan and monitor activities of all stakeholders within and outside the health system	▪ Review, develop and advocate for a capacity strengthening plan for MOH- STI and HIV unit and for the resourcing of the implementation of the plan ▪ Put organizational structures and processes in place
7.4	Strengthened capacity and improved effectiveness of the SINAC and its sub-committees (e.g. National Aids Council Grants Committee – NAC) to direct and coordinate the national response at all levels	▪ Review, build and strengthen the capacities of SINAC, NAC, SIPAC, MOH- STI and HIV Unit, CSOs, FBOs, INGOs for the multi-sectoral national response ▪ Strengthen interaction, information sharing, resource sharing and networking between and among SINAC, NAC, MOH-STI and HIV Unit, the CDO and implementing partners at all levels
7.5	Improved capacity of the SINAC and NAC to advise and oversee Financial processes including donor coordination; and improved efficiency and accountability relating to financial management and reporting at all levels	▪ Build the capacity of identified SINAC key staff in Administrative and Financial Management
7.6	Strengthened capacity of CSOs, FBOs, the private sector and other institutions to effectively implement integrated HIV and STI programs	▪ Increase participation and resourcing of FBOs, CSOs, INGOs, the private sector and other institutions implementing HIV and STI programs and knowledge bridging activities
7.7	Gender mainstreamed into all areas of the HIV and STI national response at all levels	▪ Incorporate CEDAW, GEWD and EVAW principles and policies into the implementation of this NSP

5.3 CROSS CUTTING THEMES, OBJECTIVES AND INTERVENTIONS

5.3.1 GENDER:

A consistent, gender inclusive approach was identified as missing from the existing national HIV and STI response. In further consideration of the gender-related issues which contribute to increased vulnerability of Solomon Islands women to HIV and STIs, it was agreed that a gender-focused approach should cut across all aspects of the National Strategic Plan.

The approach aims to promote awareness of HIV and STI-related gender issues amongst the general population, identified vulnerable groups and national and sub-national leaders, and to conduct regular gender audits of the response.

Table 13

Strategic Objective 8: By 2018, to ensure the national HIV and STI response is founded on principles of gender equity		
	Strategic Outcomes	**Interventions**
8.1	Gender mainstreamed into all areas of the HIV and STI national response at all levels	▪ Incorporate CEDAW, GEWD and EVAW principles and policies into the implementation of this NSP
8.2	Increased collaboration between MoWYFA and SINAC and MoH in mainstreaming gender issues in SRH	▪ Promote and integrate gender sensitivity training and awareness in all HIV and STI programs at all levels
8.3	Improved capacity for gender mainstreaming by political and community leaders as well as all implementing partners at all levels of the national response	▪ Build gender mainstreaming capacity of key stakeholders at all levels
8.4	Improved gender and human rights sensitivity of all HIV and STI programs and service	▪ Advocate for equal rights of women and PLHIV within programs and among service providers
8.5	Improved equitable participation of women and men in general and sexual and reproductive health decision making and leadership	▪ Expand the roles and increase participation of men as partners in reproductive health
8.6	Reduced occurrence of all gender based violence and its sexual health implication	▪ Strengthen and expand Stepping Stones and other gender responsive BCC programs

5.3.2 HUMAN RIGHTS, STIGMA AND DISCRIMINATION:

A consistent approach to assuring human rights and reducing stigma and discrimination of people living with HIV and identified vulnerable groups is advocated in this National Strategic Plan. This aims to ensure all activities are planned and implemented with particular attention to consistent messages which avoid stigmatising language and concepts.

Recognising that Solomon Islands has no non-discriminatory laws and regulations to protect the human rights of PLHIV or those of particularly vulnerable groups, legal and policy reform to address gaps in policy has been identified as a national response priority for the period 2014-2018.

Table 14

Strategic Objective 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.		
	Strategic Outcomes	**Interventions**
9.1	Realized human rights based legislative reform to assure non-discrimination of PLHIV and key populations at higher risk of exposure to HIV and STIs.	▪ Advance policies and human rights-based legislative reforms to prevent stigma and discrimination.
9.2	Increased equitable participation and empowerment of PLHIV and key populations in the national response and decision making.	▪ Promote active involvement of PLHIV according GIPA and MIPA principles, and empowerment of key populations.
9.3	Zero occurrences of stigma and discrimination within all sectors and at all levels	▪ Advocate to the general population, service providers and key stakeholders for zero tolerance of stigma and discrimination.
9.4	Increased championing of anti-stigma and anti-discriminatory practices by political and community leaders and key celebrities.	▪ Established anti-stigma and anti-discriminatory ‘champions’ program

6.0 IMPLEMENTATION PLAN, BUDGET CONSIDERATIONS AND M&E

6.1 RESOURCING THE NATIONAL STRATEGIC PLAN

An important factor in ensuring national HIV and STI strategic plans contribute to an effective national response is to identify the cost of strategic priorities against which realistic budgets can be produced, and resources allocated.

For this detail to be produced, sophisticated tools must be utilised to determine unit costs of interventions, upon which entire National Strategic Plans can be costed. Unfortunately an appropriate tool is yet to be identified for use in Pacific countries, and therefore a fully costed National Strategic Plan for Solomon Islands is currently beyond reach.

In order to provide some guidance to SINAC and the National Planning Team to assist their estimation of costs for the National Strategic Plan, a process was conducted with the National Planning Team and national stakeholders during strategic planning workshops in August 2011 to determine the appropriate weighting of resources for the national HIV and STI response from 2011-2015. An updated costing of the operational inputs to the NSP was done in September 2015 with technical assistance from the UNICEF HIV/AIDS Consultant. See Annex I for a detailed operational plan and budget of the NSP 2014-2018.

6.2 NSP OPERATIONAL PLAN AND BUDGET

MINISTRY OF HEALTH & MEDICAL SERVICES - SOLOMON ISLANDS												
NSP 2014-2018 COSTING												
Strategic Outcomes	**Activities**	**Operational tasks**	**Annual Target**	**Unit / inputs**	**Unit Cost (SBD)**	**Yrs**	**Total Cost Per Year (SBD)**					**Cost over 5 Yrs (SBD)**
							2,014	**2,015**	**2,016**	**2,017**	**2,018**	
Objective 1: By 2018, to increase access to evidence-based HIV prevention in Solomon Islands												
1.1: Improved knowledge and safe behavioural practices of all target groups.	1.1.1: Scale up prevention activities for MSM, FSWs and transgender;	Production of IEC materials targeting MSMs and FSWs	5,000	piece	20	5	100,000	100,000	100,000	100,000	100,000	500,000
		Identify and train MSM and SWs as peer educators, to implement a peer-to-peer approach to provide health education to key populations	20	cost of training 1 peer educator in Honiara for 5 days	12,500	2	0	0	250,000	250,000	0	500,000
		Distribute condoms to key populations through condom distributors and peer educators	288	Monthly transport refund to submit reports	100	5	28,800	28,800	28,800	28,800	28,800	144,000
		Outreaches for health education targetting key populations	40	1 day allowance and trip fuel for an outreach team of four including a mobilizer on ground	900	5	36,000	36,000	36,000	36,000	36,000	180,000

	1.1.2: Scale up and strengthen coordination of behavioural change and communication programs	Workshop to develop BCC Strategy	1	Conference and catering costs for 30 participants	15,000	1	0	0	15,000	0	0	15,000
		Workshop to disseminate Communication strategy	1	Conference and catering costs for 30 participants	15,000	1	0	0	15,000	0	0	15,000
		Printing / production of communication strategy	1	Printing of 50 copies of the strategy	15,000	1	15,000	15,000	15,000	15,000	15,000	15,000
		Training of civil society and government stakeholders on effective communication strategies	2	Conference and catering costs for 30 participants for a 3 days workshop	45,000	1	0	0	0	90,000	0	90,000
	1.1.3: Scale up youth friendly health services	Furnish youth friendly spaces in facilities	10	Furniture ie two tables, four chairs and three waiting benches	10,000	5	100,000	100,000	100,000	100,000	100,000	500,000
		produce and distribute youth friendly IEC materials including SRH flipchard, brocures on HIV/STIs, posters, etc	1,000	100 copies of different IEC types per facility	10	5	10,000	10,000	10,000	10,000	10,000	50,000
		Train health workers in handling and counselling of young people	100	Three days training for 10 health workers	4,500	5	450,000	450,000	450,000	450,000	450,000	2,250,000
1.2: Increased availability and access to appropriate and	1.2.1: Increase the availability and accessibility of condoms to the general	identify and train 6 condom distributors per province	60	Cost of training a condom distributor in the provinces for two days non residential	3,000	2	0	0	180,000	0	180,000	360,000

differentiated prevention services.	population and most at risk population	Procure and put condom dispensers at 10 convininent spots per province targeting hot spots and key populations	100	dispenser	300	5	30,000	30,000	30,000	30,000	30,000	150,000
		Facilitate condom distributors weekly to monitor and distribute condoms	2,880	Weekly allowance	100	5	288,000	288,000	288,000	288,000	288,000	1,440,000
		Procure male condoms for distribution to the general population and key populations	2,880,000	pieces	0	5	864,000	864,000	864,000	864,000	864,000	4,320,000
		Procure female condoms for distribution to the general population and key populations	50,000	pieces	3	5	150,000	150,000	150,000	150,000	150,000	750,000
1.3: Reduced risk and vulnerability to HIV infection of all target populations, including situations related to adverse circumstances such as disasters.	1.3.1: Develop and integrate emergency preparedness response guidelines into the national HIV/STI Management Strategy	Conduct consultative workshop to develop guidelines	1	Conference and catering costs for 30 participants	45,000	1	0	0	0	45,000	0	45,000
		Conduct annual training of stakeholders on emergency response in the context of HIV	1	Conference and catering costs for 30 participants	15,000	5	15,000	15,000	15,000	15,000	15,000	75,000

1.4: Assured universal precautionary practices and zero occurrence of any form of Transfusion Transmissible Infections (TTI)	1.4.1: Collaborate with the Infection Control Unit of the National Referral Hospital to expand Infection Control and Safety Training to health workers and other individuals involved in HIV/STI Response	Conduct a 1 day training of health workers on infection control and safety in the health facility	50	Cost of training a healthworker for 1 day non residential	1,500	1	0	0	75,000	0	0	75,000
	1.4.2: Screen all donated body fluids and organs for transfusion transmissible infections	Training of health workers from provincial hospitals and NRH on the recommended testing protocol for screening of blood for transfusion	20	three days non residential training	4,500	2	0	0	90,000	90,000	0	180,000
		Procure HIV test kits for screening of blood donors	6,000	kit/100 tests	8	5	48,000	48,000	48,000	48,000	48,000	240,000

	1.4.3: Collaborate with the National Blood Bank and Solomon Islands Red Cross (SIRC) to promote the exclusive use of Voluntary Non-Remunerated Blood Donation (VNRBD)	Sign MoU with SIRC	1	N/A	0	1	0	0	0	0	0	0
1.5: Improved and equitable age responsive health and sexual education for girls, boys, women and men.	1.5.1: Mainstream gender into school curricula with MoEHRD.	Conduct 2 days gender mainstreaming workshop	1	Conference and catering costs for 30 participants for two days non residential	30,000	1	0	0	30,000	0	0	30,000
	1.5.2: Collaborate with Ministry of Education to incorporate comprehensive life skills and sex education syllabus into school curriculum and national level	conduct 5 days workshop to review the Secondary School curriculum and integrate comprehensive life skills and sex education	1	Conference and catering costs for 30 participants for 5 days residential for participants from provinces	85,000	1	0	0	85,000	0	0	85,000
Sub-total Objective 1							**2,134,800**	**2,134,800**	**2,874,800**	**2,609,800**	**2,314,800**	**12,009,000**
Objective 2: By 2018, to improve access, availability and effectiveness of HIV and STI testing and counselling services.												

2.1: Expanded national coverage of HIV & STI testing and counselling services	2.1.1: Strengthen Laboratory Quality Management System (LQMS)	Conduct consultative workshop to develop LQMS guidelines	1	3 days non residential workshop	5,500	1	0	0	0	0	5,500	5,500
	2.1.2: Scale up; expand the coverage and resource HIV and STI cancelling and testing program	Procure and supply Determine HIV RDT kits to health	200	kit / 100 tests	800	5	160,000	160,000	160,000	160,000	160,000	800,000
		Training of health workers on RDT	100	Three days training for a health worker in the provinces	4,500	5	450,000	450,000	450,000	450,000	450,000	2,250,000
		Refurbish and furnish facilities to have private room, waiting area, 2 benches, 2 chairs and a table for HIV testing and counseling	20	basic refurbishing cost per facility	10,000	5	200,000	200,000	200,000	200,000	200,000	1,000,000
		Training of health workers on syndromic mnagement of STIs	50	non residential training /person per 5 days	7,500	2	0	375,000	375,000	0	0	750,000
		Procurement of STI pack, and treatment of STI diagnosed cases	5,000	STI treatment pack	30	5	150,000	150,000	150,000	150,000	150,000	750,000
	2.1.3: Scale up and expand the coverage of PPTCT with particular focus to rural	Training of antenatal nurses from ANC clinics on RDT	60	Training for a health worker for 3 days in the province	4,500	5	270,000	270,000	270,000	270,000	270,000	1,350,000

	population	Conduct quarterly support supervision visits to ANC clinics (5 clinics per quarter per province)	200	DSA and fuel costs for 1 days for 1 personnel	700	5	140,000	140,000	140,000	140,000	140,000	700,000
	2.1.4: Scale up diagnosis in MSM, FSWs and transgender through rapid testing;	Conduct monthly HIV testing outreaches targeting key populations in all provinces	120	Allowances for 2 counselors per outreach	200	5	24,000	24,000	24,000	24,000	24,000	120,000
2.2: Increased utilisation of HIV & STI testing and counselling services	2.2.1: Scale up integration of HIV & STI counselling and testing into Sexual and Reproductive Health Services	Distribute HIV test kits to RH clinics with	12	Monthly shipment charges and fuel	1,000	5	12,000	12,000	12,000	12,000	12,000	60,000
	2.2.2: Improve quality of HIV & STI counselling and testing services by developing and implementing minimum standard guidelines in accordance with latest WHO guidelines	Conduct consultative meeting to review and update national guidelines on HIV and STIs including PPTCT Policy, HTC Policy, ART policy and STI policy	1	1 day meeting involving 30 participants representing HIV stakeholders	8,000	1	8,000	8,000	0	0	0	8,000

		Conduct validation meeting to review and update national guidelines on HIV and STIs	1	1 day meeting involving 30 participants representing HIV stakeholders	8,000	1	0	8,000	0	0	0	8,000
		Production of updated policy guidelines (50 copies of 3 guidelines for HIV treatment, HIV testing and counselling, and comprehensive STI management)	150	copy of guidelines document	300	1	0	0	45,000	0	0	45,000
		Dissemination and training of health workers on updated guidelines	100	5 days dissemination workshop in each province - residential	2,100	1	0	0	210,000	0	0	210,000
	2.2.3: Awareness campaign to create demand for voluntary counselling and testing services to both general population and key populations at higher risk of exposure to HIV & STI	Conduct daily radio spots, three times a day, on HIV and STI testing and awareness, on the most popular radio station in all 10 provinces	10,950	radio spot	20	5	219,000	219,000	219,000	219,000	219,000	1,095,000
		Conduct monthly radio talkshows on HIV and STI testing and awareness, on the most popular radio station in all 10 provinces	120	radio talk show	1,000	5	120,000	120,000	120,000	120,000	120,000	600,000

		Billboards with messages to promote HIV counseling and testing	10	billboard	5,000	1	0	0	0	50,000	0	50,000
Sub-Total Objective 2							**1,753,000**	**2,136,000**	**2,375,000**	**1,795,000**	**1,750,500**	**9,801,500**
Objective 3: By 2018, to maintain effective universal coverage of HIV treatment, and increase access to quality care and support services for PLHIV.												
3.1: Increased quality and coverage of Continuum of Care (CoC) for HIV (CoC covers all treatment related needs including mx. of HIV pregnant women, +ve infants, and TB-HIV Co-infections)	3.1.1: Reactivate and establish new HIV Core team(This also includes collaboration and linkages with the National TB program for TB-HIV Co-infections management)	1 day training for provincial HIV Core Care Teams on the CoC package	10	catering costs for 1 day for 15 participants	3,000	1	0	0	30,000	0	0	30,000
		Facilitate monthly CCT meetings at provincial level	120	refreshments per meeting	500	5	60,000	60,000	60,000	60,000	60,000	300,000
	3.1.2: Formalise the establishment of Continuum of Care frameworks	Development, printing and distribution HIV CoC referral pathway and tools	120	printing costs	1	5	120	120	120	120	120	600
		support transport costs for CCT members to followup and support PLHIV	200	trips	200	5	40,000	40,000	40,000	40,000	40,000	200,000
3.2 Strengthened processes for ARV with zero occurrence of stock outs	3.2.1: Resource HIV treatment commodities	Procurement of ARVs	20	Annual dose per patient	3,500	5	70,000	70,000	70,000	70,000	70,000	350,000
		Procurement of Viral Load catridges for patient monitoring	8	catridges	1,500	5	12,000	12,000	12,000	12,000	12,000	60,000

		Facilitate monthly transport for distribution / refills	200	trips	200	5	40,000	40,000	40,000	40,000	40,000	200,000
		Conduct bi-annual HIV treatment monitoring	24	trips / shipment of samples	200	5	4,800	4,800	4,800	4,800	4,800	24,000
3.3: Established Post Exposure Prophylaxis Guidelines and support processes	3.3.1: Revise existing hospital based PEP SOP for adoption as a National PEP Guideline	Update and include PEP protocol as part of consolidated ART guidelines	1	implemented as part of Consolidated ART	0	1	0	0	0	0	0	0
		Procure PEP kits for distribution to counter occupational exposure of health workers, GBV survivors of rape, and the general population exposed to HIV infection through different means.	100	monthly dosage	180	5	18,000	18,000	18,000	18,000	18,000	90,000
3.4: Increase adherence to ART treatment	3.4.1: Community support to patients living with HIV/AIDS	Training of community service providers	10	training for 3 days	4,500	2	0	0	45,000	45,000	0	90,000
		Facilitate monthly followup visits for community service providers to support adherence	200	visits	300	5	60,000	60,000	60,000	60,000	60,000	300,000
	3.4.2: Provision of nutritional support to PLHIV	Procure and distribute monthly supply nutritional package of foods to PLHIV	240	packs	5,000	5	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000

		Link PLHIV to nutritional support programmes	20	patients	0	5	0	0	0	0	0	0
	3.4.3: Support for referrals and appointments	support transport costs for referral of PLHIV patients to strengthen adherence	200	trips	500	5	100,000	100,000	100,000	100,000	100,000	500,000
Sub-total Objective 3							**1,378,000**	**1,378,000**	**1,423,000**	**1,423,000**	**1,378,000**	**6,980,000**
Objective 4: By 2018, to improve provision of quality, comprehensive case management of STIs.												
4.1: Completed roll out of the new treatment regimen and guidelines for comprehensive case management of STIs based on OSSHHM recommendations	4.1.1: Roll out and implement treatment guidelines and Standard Operating Procedures (SOP) for STI Management	Printing and distribution of STI treatment flow chart	50	copies	150	1			7,500			7,500
	4.1.2: Monitor Health staff delivery of STI Case Management accordance to National Treatment Guidelines.	Conduct quarterly support supervision visits to health facilities providing STI treatmet	80	trips	700	5	56,000	56,000	56,000	56,000	56,000	280,000
4.2: Increased quality and coverage of comprehensive case management for STIs	4.2.1: Integrate HIV, STI Comprehensive Case Management and SRH across all levels of care	Refresher training of health workers in MCH clinics for 5 days to provide HIV/STI case management	30	health workers	12,500	1	0	0	0	375,000	0	375,000

4.3: Strengthened processes for STI commodities with zero occurrence of stock outs	4.3.1: Strengthen procurement and supply management for STI commodities	Print and distribute stock monitoring cards	600	cards	1	5	600	600	600	600	600	3,000
		Conduct 3 days residential training for Procurement Officers / pharmacy managers from provincial hospitals, NRH, NMS and National Pharmacy in supply chain management	15	Residential training in Honiara for 3 days	7,500	1			112,500			112,500
Sub-total Objective 4							**56,600**	**56,600**	**176,600**	**431,600**	**56,600**	**778,000**
Objective 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.												
5.1: Increased political commitment backed by increased resourcing of the HIV and STI response	5.1.1: Multi-sectoral advocacy of the NSP at all levels	Conduct 1 day advocacy workshops in 10 provinces involving all stakeholders	10	workshop conference and catering costs	8,000	5	80,000	80,000	80,000	80,000	80,000	400,000
	5.1.2: Advocate for political commitment and spending for HIV and STI control	Produce and disseminate / present quarterly advocacy factsheets and data on HIV and STIs targeting National Parliament and Cabinet	4	factsheet	1,000	5	4,000	4,000	4,000	4,000	4,000	20,000

5.2: Increased pool of leaders and key individuals who are well informed and knowledgeable of HIV and STIs and their impacts so as to reduce barriers for accessing effective HIV and STI services	5.2.1: Strengthen integration and participation of leaders from Community and religious sectors in the HIV and STI response	Develop key messages for awareness creation by community / religious leaders	1	consultative meeting for 1 day	8,000	1	0	0	8,000	0	0	8,000
	5.2.2: Engage and conduct HIV and STI awareness workshops for leaders at all levels	Conduct 1 day advocacy and sensitization training workshops targeting community and religious leaders in the 10 provinces	10	Conference	8,000	5	80,000	80,000	80,000	80,000	80,000	400,000
	5.2.3: Ensure HIV and STI services are responsive to the needs of PLHIV and key populations at higher risk of exposure to HIV and STIs	Conduct client satisfaction survey targeting PLHIV and key poulations	1	3 months consultancy	150,000	1	0	0	0	150,000	0	150,000
5.3: Increased awareness of the urgent need for a comprehensive HIV	5.3.1: Advance the current HIV Legislation under review	Facilitate bi-monthly meetings for the HIV task force	8	light refreshments per meeting	500	1	0	0	4,000	0	0	4,000

legislation among leaders (political, tribal, religious, community, private sector and informal) at all levels		Develop and review cabinet paper through a 1 day consultative workshop with stakholders	1	worksop costs	8,000	1	8,000	8,000	8,000	8,000	8,000	8,000
5.4: Coordinated multi-sectoral Civil Society Organizations (CSO) response against violations and abuse of the rights of individuals particularly PLHIV	5.4.1: Strengthen, expand and coordinate multisectoral CSO collaborative initiatives	Facilitate monthly coordination meetings at national and provincial levels, hosted by SIG or CSO with conference facilities, for planning and reporting on the national response	120	light refreshments / lunch	2,000	5	240,000	240,000	240,000	240,000	240,000	1,200,000
5.5: Increased proportion of public and private establishments that implement HIV and STI workplace programs	5.5.1: Develop National guidelines for HIV and STI Work Place program and advocate for its implementation in public and private organisations	Conduct 1 day consultative meeting to develop workplace policy	1	workshop	8,000	1	0	0	0	0	8,000	8,000
		Conduct 1 day dissemination workshop to roll out the guidelines	1	workshop	8,000	1	8,000	8,000	8,000	8,000	8,000	8,000

5.6: Increased ability of women to participate in Sexual and Reproductive Health (SRH) decision making	5.6.1: Conduct participatory learning workshops/programs to build knowledge and skills in relationship communication and risk awareness.(Stepping Stones)	3 days refresher training of stepping stones community facilitators	60	non residential training for 3 days	4,500	1	0	0	270,000	0	0	270,000
		Facilitate monthly community empowerment group sessions using stepping stones methodology to build knowledge and skills of women and empower them in SRH decision making	72	Sessions (budget is for lightt refreshments ie water / bisquit for 15 participants)	250	5	18,000	18,000	18,000	18,000	18,000	90,000
		Monthly transport and lunch allowance for stepping stones facilitators to conduct group sessions	72		150	5	10,800	10,800	10,800	10,800	10,800	54,000
Sub-total Objective 5							**448,800**	**448,800**	**730,800**	**598,800**	**456,800**	**2,620,000**
Objective 6: By 2018, to enhance and strengthen the national strategic information, monitoring and evaluation system.												
6.1: Enhanced leadership and managerial competencies to deliver the national M&E system for HIV and STIs	6.1.1: Develop a M&E software to accommodate reporting	Engage consultant to develop national HIV database	1	Consultancy	150,000	1	0	0	150,000	0	0	150,000
		Conduct training of HIV Unit staff on HIV database and reporting	20	3 days training for HIV unit staff and implementing partners	4,500	1	0	0	0	90,000	0	90,000

	6.1.2: Advocate for improved political commitment and leadership support for M&E System	Link HIV database to the MHMS HIS	1	N/A	0	1	0	0	0	0	0	0
	6.1.3: Advocate for increased timely funding for the M&E System	Conduct Annual National M&E Conference (1-day advocacy and orientation of MHMS planning and budget committees, as well as development partners on M&E)	1	workshop	8,000	5	8,000	8,000	8,000	8,000	8,000	40,000
6.2: Developed and enforced policy requiring multisectoral reporting of all STI & HIV data to the MOH HIV Unit	6.2.1: Instil an M&E culture among stakeholders in the HIV & STI response	Develop and distribute a standard monthly reporting tool to be used by all HIV / STI implementing partners	240	printing costs	1	5	240	240	240	240	240	1,200
		Conduct quarterly joint support supervision visits to HIV/STI project sites together with the implementing partners	8	visit	5,000	5	40,000	40,000	40,000	40,000	40,000	200,000
	6.2.2: Review and strengthen the implementation of national guidelines and SOPs on data quality, audit, and supervision	Conduct 1 day onsite training of provincial HIV coordinators and RH coordinators on M&E and data quality audits	20	DSA, travel, accomodation	3,500	1	0	0	70,000	0	0	70,000

	at all levels of collection and aggregation	Conduct quarterly data quality audits at random sites selected per province	40	trip and DSA	300	5	12,000	12,000	12,000	12,000	12,000	60,000
6.3: Strengthened MOH STI & HIV Unit M&E capabilities	6.3.1: Strengthen and expand human capacity to enhance the effectiveness of the M&E Systems	Conduct 3 days training of provincial HIV coordinators and RH coordinators on M&E	20	training in honiara, residential	5,000	1	0	0	0	100,000	0	100,000
	6.3.2: Continue monitoring and evaluation of comprehensive HIV & STI care and support services	Conduct regular monitoring visits (quarterly)	40	trip costs	3,500	5	140,000	140,000	140,000	140,000	140,000	700,000
6.4: Integrated HIV& STI data and information systems that draw from diverse sources	6.4.1: Implement M&E curriculum to build capacity of multisectoral cross-cutting team involved in National HIV & STI response	Conduct 3 days non residential workshop to develop national M&E Curriculum	1	Conference and catering costs for 30 participants for three days	24,000	1	0	0	0	24,000	0	24,000
		Orientation of HIV stakeholders on M&E curriculum (1 day workshop for 15 participants per province)	10	hall hire and catering costs for 1 day for 15 participants	4,000	1	0	0	0	40,000	0	40,000
	6.4.2: Strengthen and support the National Health Information	Training of provincial STI/HIV teams on HIS	10	trainings	35,000	1	0	0	0	350,000	0	350,000

	System to adequately cover STI & HIV information needs and requirements	printing and distributionj of reporting forms	1,200	copies	1	5	1,200	1,200	1,200	1,200	1,200	6,000
6.5: Improved data quality with respect to accuracy timeliness and completeness for evidenced based decision making	6.5.1: Improve the ability of SINAC to effectively use strategic health information to inform the national response	Involve SINAC members in all M&E trainings	3	trainings (cost already covered)	0	5	0	0	0	0	0	0
6.6: Improved HIV & STI Surveillance Research and Communications to inform national response	6.6.1: Strengthen the capacity for design, conduct, and analysis of data and the use of findings from surveys, surveillance and research studies	Training of medical statistics team on HIV/STI surveillance and reporting for decision making and advocacy	1	training for 3 days, non residential, at MHMS headquarters	12,000	1	0	0	0	12,000	0	12,000
Sub-total Objective 6							**201,440**	**201,440**	**421,440**	**817,440**	**201,440**	**1,843,200**
Objective 7: By 2018, to strengthen governance, funding and coordination mechanisms towards a more effective, multi-sectoral contribution to the national HIV and STI response.												

7.1: Legislated articles on the formation, constitutionality and authority of SINAC as the single highest national body in the coordination of the national response to STI and HIV, on the basis of the Solomon Island Government commitment to the “Three Ones” principles	7.1.1: Advocate for the tabling of a Bill to formally recognise SINAC and its roles and functions as the highest national response coordinating body	Consultative meeting with SINAC members and stakeholders for 1 day to develop cabinet paper and roadmap for passing the bill into law	2	workshops	4,000	1	0	0	8,000	0	0	8,000
	7.1.2: Advocate for multi-sectoral recognition of SINAC	Multisectoral stakeholders meeting to orient stakeholders on the law when passed, and on the roles of SINAC	1	1 day workshop at hotel	8,000	1	0	0	0	8,000	0	8,000
	7.1.3: Partnership and collaboration with Solomon Islands National Country Coordinating (SINCCM) as a sub complimentary Global Fund for Malaria and TB focused coordinating entity	Annual joint review meetings with SINAC and SINCCM to review the national response	1	workshop	4,000	5	4,000	4,000	4,000	4,000	4,000	20,000

	7.1.4: Established Solomon Islands Provincial AIDS Committees (SIPAC) at as sub-national arms of the Solomon Islands AIDS Council to enhance local community participation in the coordination of the national response	Advocate for the establishment of SIPAC as a sub-national arm of SINAC	4	Advocacy meeting	2,000	1	0	0	8,000	0	0	8,000
7.2: Developed periodic / mid-term review of a costed National Strategic Plan supported by an M&E framework for HIV and STIs	7.2.1: Perform periodic review (mid-term and end-term) of 2014-2018 NSP	Constitute NSP review team / committee	1	meeting	500	1	0	0	0	500	0	500
		Facilitate NSP review meetings	3	light refreshments / lunch for committee of 10	1,500	1	0	0	0	4,500	0	4,500
		Validation meeting to finalize NSP review report with stakeholders	1	workshop	4,000	1	0	0	0	4,000	0	4,000
	7.2.2: Develop NSP 2019-2024	Constitute NSP development team / committee	1	meeting	500	1	0	0	0	0	500	500
		Facilitate NSP development meetings	3	light refreshments / lunch for committee of 10	1,500	1	0	0	0	0	4,500	4,500

		Validation meeting to finalize draft NSP with stakeholders	1	workshop	4,000	1	0	0	0	0	4,000	4,000
7.3: Strengthened capacity of the STI/HIV Unit of the MOH to manage, coordinate, integrate, plan and monitor activities of all stakeholders within and outside the health system	7.3.1: Review, develop and advocate for a capacity strengthening plan for MOH- STI and HIV unit and for the resourcing of the implementation of the plan	Engage consultant to conduct capacity needs assessment of the National hIV/STI response to develop 5 years multi-sectoral MoH Capacity Building Plan for HIV/STIs	1	Consultancy for 3 months	150,000	1	0	0	0	0	150,000	150,000
		Conduct workshop to develop 5 years multi-sectoral MoH Capacity Building Plan for HIV/STIs targeting all stakeholders including NGOs	1	3 days workshop	12,000	1	12,000	12,000	12,000	12,000	12,000	12,000
	7.3.2: Put organizational structures and processes in place	Engage consultant to review HIV staff job descriptions and departmental roles and responsibilities in the HIV / STI response	1	3 months consultancy	150,000	1	0	0	0	150,000	0	150,000

7.4: Strengthened capacity and improved effectiveness of the SINAC and its sub-committees (e.g. National Aids Council Grants Committee – NAC) to direct and coordinate the national response at all levels	7.4.1: Review, build and strengthen the capacities of SINAC, NAC, SIPAC, MOH-STI and HIV Unit, CSOs, FBOs, INGOs for the multi-sectoral national response	Develoment and orientation workshop for stakeholders on ToRs and mandate of SINAC, NAC, SIPAC, MOH- STI and HIV Unit on the national response	1	1 day workshop	4,000	1	0	0	0	4,000	0	4,000
		Facilitate quarterly SINAC and SIPAC meetings	40	meeting / light refreshments	2,000	5	80,000	80,000	80,000	80,000	80,000	400,000
	7.4.2: Strengthen interaction, information sharing, resource sharing and networking between and among SINAC, NAC, MOH-STI and HIV Unit, the CDO and implementing partners at all levels	Joint monthly coordination meetings at national and provincial levels, for information sharing and joint planning	120	meetings / light refreshments	2,000	5	240,000	240,000	240,000	240,000	240,000	1,200,000
7.5: Improved capacity of the SINAC and NAC to advise and oversee Financial processes including donor coordination; and improved efficiency and accountability	7.5.1: Build the capacity of identified SINAC key staff in Administrative and Financial Management	Training on Financial management and reporting	1	3 days training - non residential	12,000	1	0	0	0	12,000	0	12,000

relating to financial management and reporting at all levels												
7.6: Strengthened capacity of CSOs, FBOs, the private sector and other institutions to effectively implement integrated HIV and STI programs	7.6.1: Increase participation and resourcing of FBOs, CSOs, INGOs, the private sector and other institutions implementing HIV and STI programs and knowledge bridging activities	Conduct multi-sectoral training on HIV mainstreaming	1	3days training	24,000	1	0	0	0	0	24,000	24,000
Sub-total Objective 7							**336,000**	**336,000**	**352,000**	**519,000**	**519,000**	**2,014,000**
Objective 8: By 2018, to ensure the national HIV and STI response is founded on principles of gender equity												
8.1: Gender mainstreamed into all areas of the HIV and STI national response at all levels	8.1.1: Incorporate CEDAW, GEWD and EVAW principles and policies into the implementation of this NSP	Collaborate with the GBV programme of of the MHMS Social Welfare Division and MoWYFA through joint quarterly planning meetings	4	meetings , light refreshments	500	5	2,000	2,000	2,000	2,000	2,000	10,000
		Train the community male advocates on GBV prevention and promotion of women's rights	10	trainings at provincial level	4,000	1	40,000	0	40,000	0	0	40,000

8.2: Increased collaboration between MoWYFA and SINAC and MoH in mainstreaming gender issues in SRH	8.2.1: Promote and integrate gender sensitivity training and awareness in all HIV and STI programs at all levels	Conduct 3 days gender training for national and provincial HIV teams including SINAC and SIPAC coordinators	1	3days residential training for 30 days in Honiara for 30 people	45,000	1	0	0	0	0	45,000	45,000
8.3: Improved capacity for gender mainstreaming by political and community leaders as well as all implementing partners at all levels of the national response	8.3.1: Build gender mainstreaming capacity of key stakeholders at all levels	Conduct gender mainstreaming training for 3 days (non residential) for political and community leaders at provincial and national levels	10	training	4,500	1	0	0	0	45,000	0	45,000
8.4: Improved gender and human rights sensitivity of all HIV and STI programs and service	8.4.1: Advocate for equal rights of women and PLHIV within programs and among service providers	Conduct gender analysis survey to determine engenderness of HIV/STI service provision	1	3 months consultancy	150,000	1	0	0	0	150,000		150,000
		Conduct orientation of health workers on human rights provisions as per the HIV/STI policy guidelines	30	IEC materials on PLHIV and women's rights to be displayed at health facilities		5	0	0	0	0	0	0

		Sensitization of communities on women and PLHIV rights through weekly radio spots	480	radio spots	20	5	9,600	9,600	9,600	9,600	9,600	48,000
8.5: Improved equitable participation of women and men in general and sexual and reproductive health decision making and leadership	8.5.1: Expand the roles and increase participation of men as partners in reproductive health	Identify and train male adovates for uptake of RH	60	Training for 1 male advocate in the provinces for three days non residential	4,500	1	0	0	270,000	0	0	270,000
		Refresher training for male advocates	60	Training for 1 male advocate in the provinces for three days non residential	4,500	1	0	0	0	0	270,000	270,000
		Facilitate weekly community outreaches targeting men to mobilize them for SRH services	2,880	I day allowance, fuel costs.	200	5	576,000	576,000	576,000	576,000	576,000	2,880,000
8.6: Reduced occurrence of all gender based violence and its sexual health implication	8.6.1: Strengthen and expand Stepping Stones and other gender responsive BCC programs	Conduct training of stepping stones community facilitators on gender based violence prevention and response, and reporting / referral	10	provincial trainings for 6 participants for 5 days (residential)	12,600	5	126,000	126,000	126,000	126,000	126,000	630,000
		Facilitate transport for referral and response to GBv cases	500	transport or shipment of testing kits / specimen for testing	100	5	50,000	50,000	50,000	50,000	50,000	250,000
		Facilitate community sensitization sessions on GBV prevention	72	monthly sensitization allowance for male advocates	100	5	7,200	7,200	7,200	7,200	7,200	36,000

		Facilitate community awareness through weekly radio spots on GBV prevention and referral pathway, and punishment of perpetrators	480	radio spots	20	5	9,600	9,600	9,600	9,600	9,600	48,000
		Provide livelihood support to GBV affected households of women and children in cases of arrested violent husbands or seperation	20	Block support for Income Generating Activity, including training and financial support	5,000	5	100,000	100,000	100,000	100,000	100,000	500,000
		Support feeding of women and children for a week during protection	100	Block figure	2,000	5	200,000	200,000	200,000	200,000	200,000	1,000,000
Sub-total Objective 8							**1,120,400**	**1,080,400**	**1,390,400**	**1,275,400**	**1,395,400**	**6,222,000**
Objective 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.												
9.1: Realized human rights based legislative reform to assure non-discrimination of	9.1.1: Advance policies and human rights-based legislative reforms to prevent stigma and	Conduct 1 day advocacy meetings with the National Parliament to advocacy for policy reforms	2	meetings at hotel conference facilities	8,000	5	16,000	16,000	16,000	16,000	16,000	80,000

PLHIV and key populations at higher risk of exposure to HIV and STIs.	discrimination.	Conduct 1 day stakeholders consultative meeting to develop cabinet paper for policy reforms	1	meeting at hotel conference facilities	8,000	1	0	0	8,000	0	0	8,000
9.2: Increased equitable participation and empowerment of PLHIV and key populations in the national response and decision making.	9.2.1: Promote active involvement of PLHIV according GIPA and MIPA principles, and empowerment of key populations.	Involvement of PLHIV and key populations in planning and implementing the response	3	ongoing	0	5	0	0	0	0	0	0
		Conduct 3 days advocacy training for PLHIV and key populations at national level	1	training in honiara, non residential	12,000	2	0	0	0	12,000	12,000	24,000
9.3: Zero occurrences of stigma and discrimination within all sectors and at all levels	9.3.1: Advocate to the general population, service providers and key stakeholders for zero tolerance of stigma and discrimination.	produce and disseminate anti-stigma billboards	3	billboard	5,000	1	15,000	0	0	15,000	0	15,000
		Sensitization of the public on HIV modes of transmission to demistify myths and misconceptions	288	weekly radio spots	20	5	5,760	5,760	5,760	5,760	5,760	28,800
9.4: Increased championing of anti-stigma and anti-discriminatory	9.4.1: Established anti-stigma and anti-discriminatory 'champions' program.	Identify icon artist as anti-stigma ambossador as as edutainment approach	1	None	0	1	0	0	0	0	0	0

practices by political and community leaders and key celebrities.		facilitate anti-stigma campaign drive allover the country through edutainment	1	travel and accomodation costs for artist, MHMS team	50,000	1	0	0	0	50,000	0	50,000
Sub-total Objective 9							**36,760**	**21,760**	**29,760**	**98,760**	**33,760**	**205,800**
Grand Total							**7,465,800**	**7,793,800**	**9,773,800**	**9,568,800**	**8,106,300**	**42,473,500**

6.3 MONITORING AND EVALUATION FRAMEWORK

Abbreviations for Indicator ID#

Thematic Area (TA)		*Abbreviation*
1	Prevention	PR
2	Diagnosis	DX
3	Treatment Care and Support	TC
4	Leadership and Enabling Environment	LE
5	Strategic Information and Communication	SC
6	Governance and Coordination	GC

Cross Cutting Issues

7	Gender	GD
8	Stigma and Discrimination	SD

Indicator Type (IT)	*Abbreviation*
Impact	IM
Outcome	OC
Output	OP

SOLOMON ISLANDS NATIONAL STRATEGIC PLAN 2014-2018 FOR HIV/AIDS & STIS - MONITORING & EVALUATION FRAMEWORK

NSP Reference	Indicator Description	Indicator ID#	Responsibility	Method of Collection	Frequency	Indicator Reference
10	**GOAL: By 2018, Halt the Spread of HIV and reduce Transmission of STIs through the reduction of risk and vulnerability in the Solomon Islands populations, with specific focus on vulnerable groups**					
10.1	The number of new HIV infections in the Solomon Island population annually	IM-1	MoH	Routine Data	Annual	GARPR
10.2	Percentage of young people aged 15–24 who are HIV infected	IM-2	MoH	Routine Data	Annual	GARPR
10.3	Percentage of most at risk populations who are HIV infected	IM-3	MoH	Routine Data	Annual	GARPR
10.4	Percentage of adults (>=15 years) and children (<15 years) who are known to be alive at 12, 24, 36 and 48 months after initiation of antiretroviral therapy. Annual program monitoring data	IM-5	MoH	Patient Records	Six monthly	GARPR
10.5	Percentage of infants born to HIV Infected mothers who are infected	IM-4	MoH	Routine Data	Annual	GARPR
10.6	The proportion of young people age 10 – 24 with STIs (syphilis) that were detected during diagnostic testing	IM-6	MoH	Routine Data	Annual	GARPR
10.7	The proportion of pregnant women with STIs that were detected during diagnostic testing	IM-7	MoH	Routine Data	Annual	GARPR

Strategic Objective 1: By 2018 to halt the spread of HIV in general population, reduce HIV prevalence among key affected populations and AIDS related mortality in the Solomon Islands					
Strategic Outcome 1.1: Improved knowledge and safe behavioural practices of all target groups.					
Percentage of identified vulnerable groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	**PR-OC-1.1.1**	HIV STI Program	IBBS	2 Years	P Draft
Percentage of "identified male vulnerable population" reporting the use of a condom the last time they had vaginal/anal sex with a commercial female/male partner.	**PR-OC-1.1.2**	MHMS	IBBS/BSS (Special Surveys)	2 years	
Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	**PR-OC-1.1.3**	a. MOFT b. MHMS	a. DHS (Population Based Survey) b. IBBS	2 Years	GARPR
"Percentage of women and men aged 15–49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	**PR-OC-1.1.4**	MHMS Stakeholders working with general population	IBBS/BSS	2 Years	GARPR
Number of HIV/STI promotional campaigns held to increase community awareness about the available services and using those at the facilities.	PR-OP-1.1.1	MHMS Stakeholders working with general population	Program reports	Quarterly/annually	
Strategic Outcome 1.2: Increased availability and access to appropriate and differentiated prevention services					
Number of male and female condoms sold and/or distributed disaggregated by type in the last year	**PR-OC-1.2.1**	MHMS	Survey	Annually	
Number and Percentage of youth accessing Youth Friendly Health Services (that provide at a minimum counseling and testing) disaggregated by gender, type of services and setting.	**PR-OC-1.2.2**	MHMS	Quarterly/Annual Program monitoring data	Quartly/Annually	
Number of youth friendly health service (YFHS) centers	**PR-OC-1.2.3**	MHMS	Annual Program Monitoring	Annually	

scaled up as per National Guidelines in last one year. Facility					
Percentage of health centers providing the package of PPTCT services disaggregated by provinces as per national standards[15] in last one year.	**PR-OP-1.2.1**	MHMS	Annual program monitoring data	Annually	Universal Access
Percentage "identified vulnerable population" reached 16 with HIV/AIDS prevention programs.	**PR-OP-1.2.2**	MOH Stakeholders Working with vulnerable populations	IBBS/BSS Annual Program monitoring data/ Special survey (Rapid situational assessment)	2 years	GAPR
Proportion of health centers that experienced stock-out of condoms in last one year.	**PR-OP-1.2.3**	MHMS	Program Records	6 monthly/Annually	
Strategic Outcome 1.3: Reduced risk and vulnerability to HIV infection of all target populations, including situations related to adverse circumstances such as disasters.					
Emergency preparedness plan is incorporated in the national HIV/ STI guidelines in the next 12 months	**PR-OP-1.4.1**	MHMS	Administrative Records	June 2013	National
Strategic Outcome 1.4: Assured universal precautionary practices and zero occurrence of any form of Transfusion Transmissible Infections (TTI)					
Percentage of units of blood collected from VNRBD	**PR-OC-1.5.1**	Lab Department, National Referral Hospital & Red Cross	Program Records	Annually	
Number and percentage of targeted staff and volunteers trained in Infection Control and Safety	**PR-0P-1.5.1**	Infection Control Unit, NRH & MHMS	Training Records	Annually	
Percentage of donated blood units screened for HIV in a quality-assured manner	**PR-OP-1.5.2**	Lab Department, National Referral Hospital & Red Cross	Program Records	Annually	
Strategic Outcome 1.5: Improved and equitable age responsive health and sexual education for girls, boys, women and men.					

[15] Definition of minimum PMTCT package should be defined in SI context. E.g. 1. HIV counseling and testing; 2. ARV prophylaxis to prevent MTCT; 3. Counseling and support for safe infant feeding practices; 4. Family planning services; 5. Safe obstetric practices Referral to: 6. HIV care and treatment

[16] The definition of "reach" should be defined.

Number and Percentage of schools that provided (age-responsive gender sensitive) life-skills-based HIV education in the last academic year 656	**PR-OC-1.6.1**	Stakeholders working with schools	Survey: school Programme review and Annual program monitoring data	2 years	GARPR

Strategic Objective 2: By 2015, to improve access, availability and effectiveness of HIV and STI testing and counseling services					
Strategic Outcome 2.1: Expanded national coverage of HIV & STI testing and counselling services					
Percentage of men and women of 15-49 years who received an HIV test in the last 12 months and who know their result	DX-OC-2.1.1	MHMS	Annual program monitoring data in VCCT centers/ ANC for women/ DHS with the serological marker/special survey		
Percentage of pregnant women who received an HIV test in the last 12 months and who know their result	DX-OC-2.1.2	MHMS	Annual program monitoring data in VCCT centers/ ANC for women/ DHS with the serological marker/special survey		
Percentage of identified vulnerable population who received an HIV test in the last 12 months and who know the result.	DX-OC-2.1.3	MHMS	BSS/IBBS	in every 2 years/ Annual Program monitoring data	
Number and percentage of Level 2 laboratories strengthen to provide HIV confirmatory testing, CD4 cell count and viral load (disaggregated)	DX-OC-2.1.4	MHMS	Laboratory program records	Annual	Universal Access
Number of HIV-positive patients who were screened for TB in HIV care or treatment settings.	DX-OP-2.1.1	MHMS	Quarterly/Annual program monitoring data.	Quarterly/Annual	
Percentage of TB patients who were screened for HIV in TB care or treatment settings.	DX-OP-2.1.2	MHMS	Quarterly/Annual program monitoring data		
Strategic Outcome 2.2: Increased utilisation of HIV & STI testing and counselling services					

Proportion of pregnant women_accessing ANC services who tested positive for STIs disaggregated by STI type	DX-OC-2.2.1	MHMS/SIPPA	Quarterly/Annual program monitoring data	Quarterly/Annual	
Number of male partners of pregnant women accessing ANC services who tested positive for STI disaggregated by STI type	DX-OP-2.2.1	MHMS/SIPPA	Quarterly/Annual program monitoring data.	Quarterly/Annual	
Number of male partners, of HIV infected pregnant women, who were tested for HIV and received their results through post-test counselling	DX-OP-2.2.2	MHMS/SIPPA	Quarterly/Annual program monitoring data.	Quarterly/Annual	

Strategic Objective 3*:* By 2015, To maintain effective universal coverage of HIV treatment, and to increase access to quality care and support services for PLHIV.					
Strategic Outcome 3.1: Increased quality and coverage of Continuum of Care (CoC) for HIV (CoC covers all treatment related needs including mx. of HIV pregnant women, +ve infants, and TB-HIV Co-infections)					
Percentage of HIV-infected pregnant women receiving anti-retroviral to prevent mother-to-child transmission.	TC-OC-3.1.1	MHMS/Stakeholders	Annual program reports	Annually	
Percentage of adults (>=15 years) and children (<15 years) with advance HIV infection receiving antiretroviral therapy.	TC-OC-3.1.2	MHMS/stakeholders	Annual program monitoring data.	Annually	
Number of infants born to HIV-infected women who received ARV prophylaxis to reduce the risk of mother-to-child transmission.	TC-OP-3.1.1	MHMS Stakeholders	Continuous		UNAIDS
Number and percentage of PLHIV (disaggregated by those who are on ART and those who are not on ART) receiving regular blood monitoring and treatment	TC-OP-3.1.2	MHMS	continuous		
Number of PLHIV receiving in-patient and other support services.	TC-OP-3.1.3	MHMS Stakeholders	Program reports		GFATM
Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment.	TC-OP-3.1.4	MHMS	Quarterly/Annual program monitoring data.		
Number of discordant partners of PLHIV appropriately counseled, diagnosed and treated.	TC-OP-3.1.5	MHMS	Quarterly/Annual program monitoring data	Annually	
Number of health staff/service providers trained in caring for PLHIVs	TC-OP-3.1.6	MHMS	Quarterly/Annual program	Annual	

suffering from AIDS related illness			monitoring data.		
Number of community facilitation committees and families mobilized and trained for providing care and support services to PLHIV.	TC-OP-3.1.7	MHMS	Quarterly/Annual program monitoring data.	Annual	
Number of adults and children on ART lost to follow-up, dead, transferred out or stopped at 12 months after initiation.	TC-OP-3.1.8	MHMS	Annual program monitoring data.	Annual	
Strategic Outcome 3.2: Strengthened processes for ARV with zero occurrence of stock outs					
Number and Proportion of treatment centres that experienced stock-out of ARV and OIs drugs within the last 14 days	TC-OP-3.3.1	MHMS	Monthly reporting data	6 monthly	
Strategic Outcome 3.3: Established Post Exposure Prophylaxis Guidelines and support processes					
Number and percentage of health facilities with post-exposure prophylaxis (PEP) services available for those at risk of HIV infection through occupational and/or non-occupational exposure to HIV	TC-OC-3.5.1	MHMS	Administrative Records	Annual	
Number and percentage of occupational exposure incidents reported and successfully treated each year	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	
Strategic Outcome 3.4: Increased adherence to ART					
Percentage of PLHIV enrolled on ART	TC-OC-3.5.1	MHMS	Administrative Records	Annual	
Number of PHLIV who have been on ART for the last one year (12 months)	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	
Number of PHLIV who have been on ART for the last two years (24 months)	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	
Number of PHLIV who have been on ART for the last three years (36 months)	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	
Number of health care workers trained on ART prescription	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	
Number of health facilities offering ART	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	
Number of stock-outs of ART experienced	TC-OC-3.5.2	MHMS	Care Facilitates Incident Reports	Annual	

Strategic Objective 4: By 2018, To improve provision of quality, comprehensive case management of STIs					
Strategic Outcome 4.1: Completed roll out of the new treatment regimen and guidelines for comprehensive case management of STIs					
Guidelines for Comprehensive Case Management of STIs in place	TC-OP-3.4.1	MHMS	Administrative records	December 2013	
Strategic Outcome 4.2:Increased quality and coverage of comprehensive case management for STIs					
Proportion of targeted health facilities that have instituted the comprehensive STI care package per national guidelines (Operational at all levels of care disaggregated by setting and location)	TC-OC-3.5.1	MHMS	Administrative Records	Annually	
Strategic Outcome 4.3: Strengthened processes for STI commodities with zero occurrence of stock outs					
Number and Proportion of health centers that experienced stock-out of STI drugs within the last 14 days	TC-OC-3.6.1	MHMS	National Medical Stores Records	Six Monthly/Annually	

Strategic Objective 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.					
Strategic Outcome 5.1: Increased political commitment backed by increased resourcing of the HIV and STI response					
Number of advocacy meetings conducted and IEC distributed at the national and provincial level for the introduction and implementation of NSP.	LE-OP-4.1.1	MHMS/SINAC	Quarterly/Annual reporting	Annually	
Number of “Leader forums” conducted/attended at national and provincial level to communicate the contents and results of the NSP.	LE-OP-4.1.2	MHMS/SINAC	6 monthly/annually reporting	Annually	
National composite Policy Index/GARP as part of UNGASS reporting.	LE-OP-4.1.3	MHMS/SINAC	Annual reporting	Annually	UNGASS
Domestic and international AIDS spending by categories and financing sources	LE-OP-4.1.4	MHMS/SINAC	Every 2 years	Every 2 years	UNGASS (NASA)
Strategic Outcome 5.2: Increased pool of leaders and key individuals who are well informed and knowledgeable of HIV and STIs and their impacts so as to reduce barriers for accessing effective HIV and STI services					
Number of National and provincial leaders engaged in overseeing the national HIV and STI response against the agreed targets within the NSP.	LE-OP-4.2.1	SINAC/MHMS	Annual reporting		

Strategic Outcome 5.3: Increased awareness of the urgent need for a comprehensive HIV legislation among leaders (political, tribal, religious, community, private sector and informal) at all levels					
Involvement of a comprehensive range of governmental, nongovernmental community and private partners in collaborative development of the HIV Legislation 321	LE-OC-4.3.1	SINAC/MHMS	Meeting Records and Minutes		
Number and percentage of legislative amendments and introduced laws required for the removal of legal barriers to effective HIV prevention, care and support delivery have been passed	LE-OP- 4.3.1	SINAC/MHMS	Parliamentary Records SINAC reports	Annually	
Strategic Outcome 5.4: Coordinated multi-sectoral Civil Society Organizations (CSO) response against violations and abuse of the rights of individuals particularly PLHIV					
Number of Coordinated Civil Society Organizations (CSO) advocacy programs/events against violations and abuse of the rights of individuals particularly PLHIV	LE-OP-4.4.1	SINAC/MWYC/CSO	Program reports Meeting Records and Minutes	Annually	
Strategic Outcome 5.5: Increased proportion of public and private establishments that implement HIV and STI workplace programs					
National Task Force on HIV STI workplace policy formed and operational	LE-OP-4.5.1	MHMS	Program reporting	Dec 2014	
National Policy is in place against pre-employment and mandatory HIV testing	LE-OP-4.5.2	MHMS	Annual Program Report.	Dec 2015	
Number of workplaces with non- discrimination policies towards PLHIV [disaggregated by public and private Organization]	LE-OP-4.5.3	MHMS/SINAC	Monitoring Records	Annually	
Strategic Outcome 5.6: Increased ability of women to participate in Sexual and Reproductive Health (SRH) decision making					
Progress in decision making by in involving women in the programming cycle of HIV/STI prevention programmes and SRH services targeted at them	LE-OP-4.6.1	MHMS			

Strategic Objective 6: By 2015, to enhance and strengthen a national strategic information and monitoring and evaluation system through the establishment of an effective communication, surveillance and research network
Strategic Outcome 6.1: Enhanced leadership and managerial competencies to deliver the national M&E system for HIV and STIs

Establishment of functional M&E Cross Cutting Team, with TOR and members endorsed	SR-OP-5.1.1	MHMS/SINAC	Administrative Records and Meeting minutes	December 2013	GF, PRSIP
Provincial AIDS council/committees are formed with Terms of References (ToRs) that includes inputs for review of M&E program performance by December 2014	SR-OP-5.1.2	MHMS/SINAC	Meeting reports	Annually	
Strategic Outcome 6.2: Developed and enforced policy requiring multi-sectoral reporting of all STI & HIV data to the MOH HIV Unit					
Data Reporting and Sharing Policy is instituted and enforced	SR-OP-5.2.1	MHMS/SINAC	Program reports	Annually	
Strategic Outcome 6.3: Strengthened MOH STI & HIV Unit M&E capabilities					
The HIV/STI M&E position is established within the organizational structure by June 2013 with required technical manpower at the HIV/STI unit by June 2014.	SR-OP-5.3.1	MHMS	Program reports	Annually	
M&E capacity building plan is developed by Dec 2013	SR-OP-5.3.2	MHMS	Program report	Annually	
Trained and re-trained HIV/STI M&E focal persons (HIV Coordinators) are in place at national and provincial level by December 2013	SR-OP-5.3.3	MHMS	Program reports	Annually	
Strategic Outcome 6.4: Integrated HIV& STI data and information systems that draw from diverse sources					
Standardized national HIV/STI M&E forms are developed with guidelines and in place by December 2013. [National and provincial and community level]	SR-OP-5.4.1	MHMS	Program reports	Annually	
Strategic Outcome 6.5: Improved data quality with respect to accuracy timeliness and completeness for evidenced based decision making					
Number and percentage of line ministries and other Government departments/Civil Society Organizations/private sectors/Faith based organizations regularly reporting and requesting data to the HIV/STI unit database for monitoring the progress made in implementing NSP.	SR-OP-5.5.1	MHMS/SINAC	Program reporting.	Quarterly/Annual	
Data triangulation workshop, size estimation workshop for “identified vulnerable population” and HIV estimation workshop conducted at least twice during 2014-2018.	SR-OP-5.5.2	MHMS/SINAC	Program reporting	Annually	
Strategic Outcome 6.6: Improved HIV & STI Surveillance Research and Communications to inform national response					

Guidelines on study/research protocols and designs are developed and adopted	SR-OP-5.6.1	MHMS	Program reporting	Annually	
Number of research and studies conducted and disseminated for use to inform the national responses	SR-OP-5.6.2	MHMS	Program reporting	Annually	

Strategic Objective 7: By 2018, to strengthen governance, funding and coordination mechanisms towards a more effective, multi-sectoral contribution to the national HIV and STI response.					
Strategic Outcome 7.1: Legislated articles on the formation, constitutionality and authority of SINAC as the single highest national body in the coordination of the national response to STI and HIV, on the basis of the Solomon Island Government commitment to the "Three Ones" principles					
Legislation formerly recognizing SINAC as the highest HIV/STI national response coordinating body as part of the HIV Bill in place	GC-OC-6.1.1	SINAC	Meeting reports/minutes	December 2014	
Strategic Outcome 7.2: Developed periodic / mid-term review of a costed National Strategic Plan supported by an M&E framework for HIV and STIs					
National Strategic Plan for HIV and STI supported by an M&E framework in place	GO-OP-6.2.1	MHMS/SINAC	Annual reporting	Annually	
Review of the M&E plan and reporting process is held annually.	GO-OP-6.2.2	MHMS/SINAC	Annual reporting	Annually,(2 reviews midterm and end of term)	
Evidence of improved net-working among government, CSO, FBOs, etc based on the NSP	GO-OP-6.2.3	MHMS/SINAC	Meeting reports	Annually	
Strategic Outcome 7.3: Strengthened capacity of the STI/HIV Unit of the MHMS to manage, coordinate, integrate, plan and monitor activities of all stakeholders within and outside the health system					
Human resource needs (positions, number and required skills) assessment done for the HIV/AIDS Program	GC-OP-6.3.1	MHMS	Planning Records	June 2013	
Human resource needs and development plan developed and implemented.	GC-OP-6.3.2	MHMS	Planning Records	June 2013; Implement June 2014	
Training of HIV/STI Unit Human resource personnel program management and coordination (link to indicator GC-OP-6.3.1)	GC-OP-6.3.3	MHMS	Program reporting	2014	

Strategic Outcome 7.4: Strengthened capacity and improved effectiveness of the SINAC and its sub-committees (e.g. National Aids Council Grants Committee – NAC) to direct and coordinate the national response at all levels					
Involvement of a comprehensive range of governmental, nongovernmental, community and private partners in collaborative activities	GC-OC-6.4.1	SINAC	Administrative Records	Quarterly/Annually	
Number of quarterly meeting held amongst SINAC and stakeholders	GC-OP-6.4.1	SINAC	Meeting Records and Minutes	Quarterly/Annually	
Number of SINAC led M&E cross-cutting team meetings (link to SR-OP-5.1.1)	GC-OP-6.4.2	SINAC	Meeting records	Quarterly/Annually	
Number of times SINAC disseminated updates (through workshop/newsletter etc.) on the national HIV program response to the stakeholders. Quarterly/semi-annually/annually	GC-OP-6.4.3	SINAC	Administrative Records		
Strategic Outcome 7.5: Improved capacity of the SINAC and NAC to advise and oversee Financial processes including donor coordination; and improved efficiency and accountability relating to financial management and reporting at all levels					
National HIV/STI Response Financial Management Procedures is developed and endorsed(link to SR-OP-5.2.1)	GC-OP-6.5.1	SINAC/MHMS	Administrative Records	Dec 2013	
NSP costed for the entire period and budget revised Annually	GC-OP-6.5.2	SINAC/MHMS	Administrative Records	Period Costing; Revised Budget Annually	
The National HIV/STI Program produces an annual report that includes a comprehensive financial component	GC-OP-6.5.3	SINAC/MHMS	Program Records	Annually	
Strategic Outcome 7.6: Strengthened capacity of CSOs, FBOs, the private sector and other institutions to effectively implement integrated HIV and STI programs					
Number of CSO/FBO/DPs participated in the strategic development, planning and implementation of interventions.	GC-OP-6.6.1	SINAC/CDO	Meeting Reports	Quarterly/Semi-Annual	

Strategic Objective 8: By 2018, to develop and implement a national HIV and STI response which is founded on principles of gender equity					
Strategic Outcome 8.1: Gender mainstreamed into all areas of the HIV and STI national response at all levels					
Guidelines and protocols for gender audits are developed and adapted	CCG-OP-7.1.1	MWYC/MHMS	Program reporting	Annually	

Number of baseline and follow-up gender audits completed.	CCG-OP-7.1.2	MWYC/MHMS	Program reporting	Annually	
Gender disaggregated data (indicators of NSP-M&E framework) are reported wherever applicable.	CCG-OP-7.1.3	MWYC/MHMS	Program reporting	annually	
Strategic Outcome 8.2: Increased collaboration between MoWYFA and SINAC and MoH in mainstreaming gender issues in SRH					
Number and percentage of recommendations from gender audits translated into action.	CCG-OC-7.2.1	MWYC/MHMS/SINAC	Program reporting	annually	
Strategic Outcome 8.3: Improved capacity for gender mainstreaming by political and community leaders as well as all implementing partners at all levels of the national response					
Number of community outreach workers/peer educators and leaders trained on HIV, STI and issues related to gender (disaggregated)	CCG-OP-7.3.1	MHMS//SINAC/stakeholders	Program/training reporting	Annually	
Number of national and provincial-level leaders sensitized with advocacy activities related to HIV, STI and gender. [Information should be disaggregated by types of leader and gender]	CCG-OP-7.3.2	MHMS/SINAC/stakeholder	Program reporting	Quarterly/annual reporting.	
Strategic Outcome 8.4: Improved gender and human rights sensitivity of all HIV and STI programs and service					
Number of gender specific IEC materials and communication strategies developed to increase awareness of HIV, STIs and issues relating to gender and vulnerability within the general community	CCG-OP-7.4.1	MHMS/stakeholders	Program reporting	Annually	
Number of gender appropriate HIV prevention mass media communication campaigns held to increase awareness of HIV, STIs and issues relating to gender and vulnerability within the general community.	CCG-OP-7.4.2	MHMS/stakeholders	Program reporting	Annually	
Strategic Outcome 8.5: Improved equitable participation of women and men in general and sexual and reproductive health decision making and leadership					
Number of programs conducted gender sensitive activities (e.g. stepping stones) by types of participants	CCG-OP-7.5.1	MHMS/stakeholders	Program reporting	Annually	
Number of participants (by types) reached through gender sensitive activities (e.g. stepping stones)	CCG-OP-7.5.2	MHMS/stakeholders	Program reporting	Quarterly/Annual reporting	
Strategic Outcome 8.6: Reduced occurrence of all gender based violence and its sexual health implication					
Number of clients seen at targeted HIV/STI Control and SRH	CCG-OP-7.6.1	MHMS/MWYC/stakeholders	Program reporting	Monthly/annually	

facilities with gender based violence issue					

Strategic Objective 9: By 2018, to establish and maintain an environment in which people living with and/or affected by HIV (including particular vulnerable groups) are enabled to live their lives free from stigma and discrimination.					
Strategic Outcome 9.1: Realized human rights-based legislative reform to assure non-discrimination of PLHIV and key populations at higher risk of exposure to HIV and STIs.					
National legislation in place to address AIDS related Stigma and Discrimination, and rights (e.g. access to services) of PLHIV and vulnerable populations.	SD-OC-8.1.1	MHMS/SINAC	Parliamentary/SINAC progress reports	Annually	
Strategic Outcome 9.2: Increased equitable participation and empowerment of PLHIV and key populations in the national response and decision making.					
Evidence of increased involvement of PLHIV in the programming cycle of HIV/STI prevention programmes and SRH services targeted at them 295	SD-OC-8.2.1	MHMS	Program reporting	Annually	NCPI National GIPA/MIPA
Strategic Outcome 9.3: Zero occurrences of stigma and discrimination within all sectors and at all levels					
Operational research on "The people living with HIV Stigma Index"[17] is conducted by December 2013.	SD-OP-8.3.1	MHMS	Operational research report	June 2014	
Number of cases has been discriminated due to HIV and HIV related issues. (People living with and/or affected by HIV including particular vulnerable groups)	SD-OP-8.3.2	MHMS	Operational research report	Annual reporting.	
Strategic Outcome 9.4: Increased championing of anti-stigma and anti-discriminatory practices by political and community leaders and key celebrities.					
Number of leadership forums established to advocate against stigma and discrimination. ["Leadership forums" of different constituency groups (e.g. Media, Youth, Sports, Celebrities, Women, Business coalition etc as well as	SD-OC-8.6.1	MHMS/stakeholders	Events reporting	Annually	

[17] "The People Living with HIV Stigma Index" documents how people have experienced - and been able to challenge and overcome - stigma and discrimination relating to HIV over a 12 month period. This index - using participatory and operational research methodologies - will fill this gap in our understanding.

nominating “Goodwill Ambassador”]					
Number of national leaders and key prominent figures and celebrities took part in HIV/AIDS campaigns, programs, preparing manuals and IEC materials. [Information should be recorded by types of personnel]	SD-OP-8.6.2	MHMS/stakeholders	Campaign report	Annual reporting.	

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The following documents were utilised to inform the development of this National Strategic Plan, either as a direct reference, or as background information:

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