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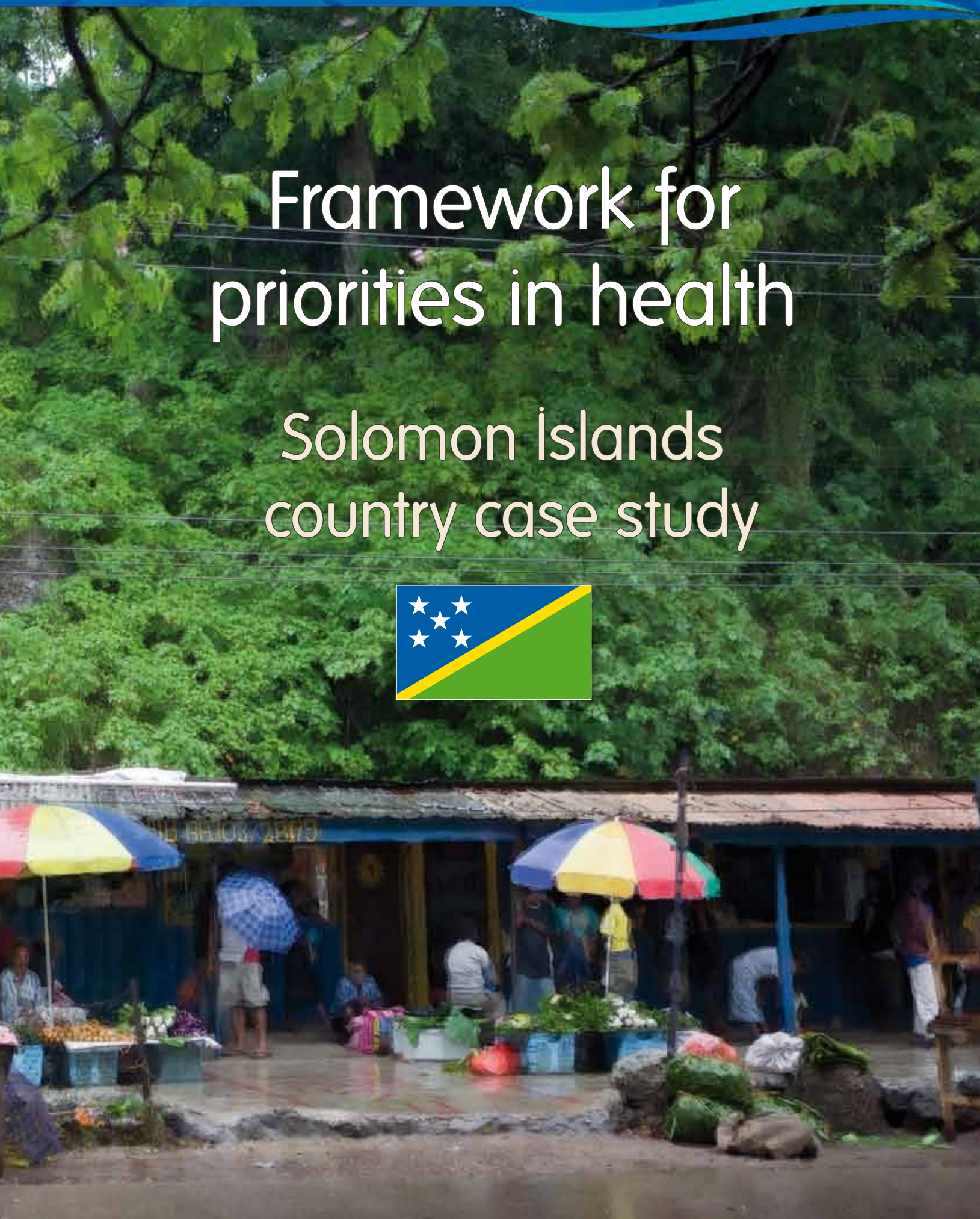
Framework for priorities in health

Solomon Islands country case study



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Solomon Islands country case study

Prepared by Phyllis Maike
for the Public Health Division,
Secretariat of the Pacific Community

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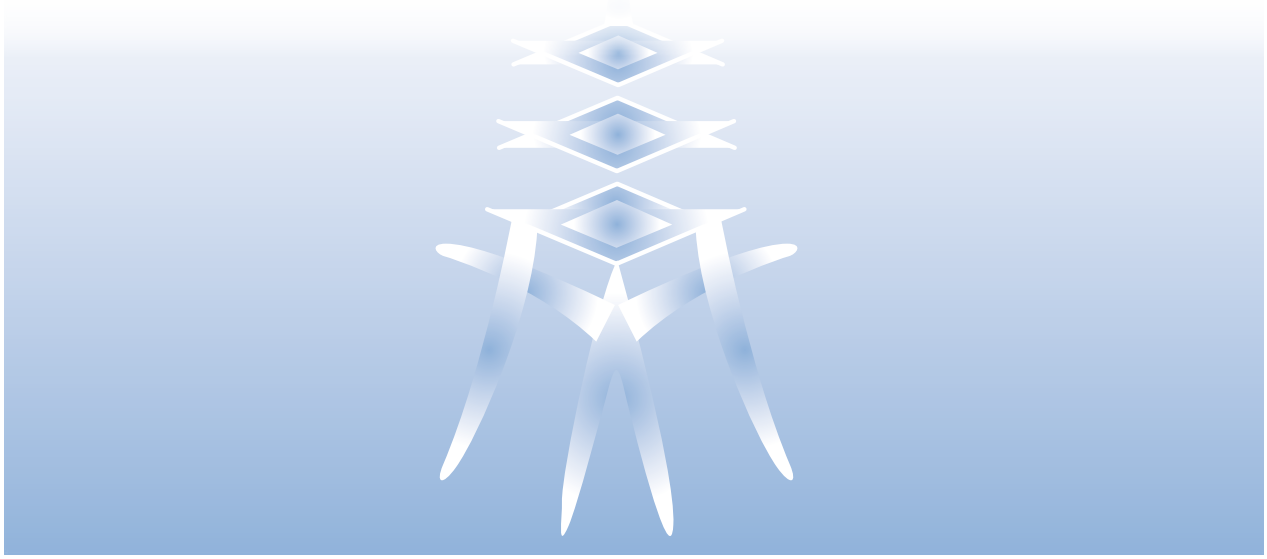


Foreword by the Solomon Islands Caretaker Minister of Health and Medical Services

The Framework for Priorities in Health seeks to articulate the most important priorities in health in the region, and to examine those priorities and emerging gaps in relation to existing national and regional strategies and funding. The data and analysis that has resulted from the case study on the health sector done in our country is an essential tool for our national planning. Being part of this regional exercise has been vital to us, as it informs my ministry of a wider regional perspective and is assisting us to prioritise and plan in relation to our specific national needs.

High quality health for our citizens is a top priority of the Solomon Islands Government. The Ministry of Health and Medical Services is currently putting in place a new five-year National Strategic Health Plan that will pave the way towards the future of health care in our country.

In Solomon Islands, 85% of the population lives in rural areas. Access to health care facilities can be problematic, given transport issues and distance between clinics. Rural health care centres and provincial hospitals are far from the hub of the capital. These factors must inform our strategic thinking to ensure that we are able to deliver quality health care services to the whole nation.

This study has helped to highlight for our ministry priorities and gaps that will inform our policy and resource allocation decisions over the next five years by helping to provide an overall perspective.

The Secretariat of the Pacific Community (SPC) Public Health Division has been providing support, technical expertise and capacity building to the ministry for many decades. We acknowledge the great support of SPC in helping the ministry to look at our unique situation, and to use the knowledge gained to inform our fellow

regional governments to enable us all to learn from each other and to progress our national goals for health in a proactive and effective way.

The ministry wishes to acknowledge SPC for completing this case study for Solomon Islands as one of three Pacific Island country case studies that will contribute to the regional Framework of Priorities. It is a key priority for us to look at the social determinants of health and to anticipate where the ministry can find efficiencies and work proactively to ensure better health outcomes.

This vital study has demonstrated that we need to prioritise a clear linkage between the ongoing systems strengthening of national programmes and provincial health divisions, and the primary care network in the rural areas. It has summarised our desire to have better monitoring of service delivery quality and support at all levels. We have articulated in this document that provincial operational planning and budgeting, linking activity to budgets, identifying areas for savings and minimising budget diversions are high priorities for this planning cycle. Our ministry has prioritised monitoring equity (gender/poverty/ethnicity) in access to service.

To this end, the study has provided excellent compilation of data and consultations from all parts of the health care sector in the country.

The Solomon Islands government will utilise the Framework of Priorities analysis to work better with donor partners to meet gaps emerge on a national level.

With the Cairns Compact on Strengthening Development Coordination in the Pacific, our leaders have expressed their concern that the Pacific region remains off-track to achieve the Millennium Development Goals (MDGs) by 2015. They agreed that given the continued need to improve on achievement of development outcomes, coupled with the global financial crisis, more effective coordination of the resources available to the region is paramount. The Framework of Priorities is a tool to move us all forward to meet these worthy goals as individual nations and as a region.

Honorable Clay Forau,
Caretaker Minister
Ministry of Health and Medical Services

Foreword by the Secretariat of the Pacific Community

At the first meeting of the Pacific Ministers of Health held in Yanuca, Fiji Islands in 1995, the ministers developed a vision of 'Healthy Islands' for our region. It was visionary in that it recognised that improving the health of our communities is not solely the responsibility of the Ministries of Health, but of everyone – every sector and actor, including the government, civil society, faith based organisations, the private sector and individuals.

Now, more than a decade since the Healthy Islands Declaration, there has been a renewed call by Ministers of Health to reinvigorate the vision, especially given that improvements in health outcomes have not been equitable across the region despite significant increases in the overall resources available to address some of the public health challenges in the region. Indeed, we are at a crossroads because the progress previously made on selected health indicators for some Pacific Island countries and territories (PICTs) has slowed or even reversed. Many PICTs are struggling to meet the 2015 Millennium Development Goal (MDG) indicators, particularly those relating to maternal and child health.

To a large extent, many PICTs continue to address key health challenges only through the lens of the health sector and this has been one of the impediments to achieving improved health outcomes for all. More could be gained if governments and administrations also address the major determinants of health involving the physical environment and social and economic factors which are outside the scope of the health sector.

In acknowledging this and in response to a call made during the 5th Conference of the Pacific Community, the Secretariat of the Pacific Community (SPC) commissioned a series of pilot studies in three PICTs as a prelude to developing a Framework for Priorities in Health. Each study is intended to articulate in one document the important health priorities of that country, including determinants of health that lie outside the health sector. To the extent possible, the study attempts to map the existing national resource allocations from national budgets and development partner financing against the existing national (and regional) health strategies, and to highlight important national-level gaps that should be urgently addressed to achieve better outcomes.

SPC is pleased to have Solomon Islands as one of the three countries included in the 2009 pilot study; the results of the Solomon Islands study are presented in this report.

Based on an analysis focused on the three pillars – health determinants, health systems and health outcomes, the report summarises the findings of the Solomon Islands pilot case study in terms of the current health status, the relations between social determinants and health systems that impact on health outcomes (including cross-cutting themes on poverty), the capacity of the health system to deliver equitable services to communities, and the alignment of development assistance with national health priorities.

The pilot study has confirmed the importance of major health issues in Solomon Islands such as non-communicable diseases (NCDs), maternal and child health and malaria, which are major cost components of the health budget, and contribute to a low life expectancy. It also highlights some positive recent major gains in health outcomes, particularly for the incidence of malaria, which continues to show a sustained downward trend across most of the country.

The study outlines some weaknesses in the health system, and the mismatch between the stated health priorities for the country and the resources (and development partners' support) to address these in a sustainable and meaningful way. It also identifies some particular challenges in Solomon Islands, such as the relatively high cost of delivering services to the rural and provincial areas, and imbalances in the allocation of resources due to the strong focus given to the national

hospital and curative services when the majority of the population is living in the rural provinces and outer islands. It recommends that sufficient resourcing be allocated to provincial health divisions for strengthening the delivery of outreach and primary health care services and for improved planning and accountability, linking activity to budgets, identifying areas for savings and minimising budget diversions. The study recommends strengthening monitoring frameworks with appropriate performance targets and indicators.

The study also shows the major impact of determinants of health, such as population growth, limited opportunity for employment and education, economic conditions, personal risk factors for NCDs and some communicable diseases, and limited coverage for improved water and sanitation. It also recommends improving monitoring for greater equity (on the basis of gender/poverty/ethnicity) in access to services, or the strengthening of primary health care and the empowerment of communities to enable them to support healthcare staff, monitor performance and provide independent feedback to provincial health divisions. The study outlines the important role of civil society in achieving longer term impacts in health, noting that cross-sectoral approaches must be strengthened with civil society as well as between the different sectors of the government.

Some lessons drawn from other pilot studies are shared with this pilot study for Solomon Islands and can feed into the broader policy debate among development partners about the best and most efficient ways of delivering development assistance for health in the Pacific.

Some of the results of this analysis are already being translated into action through the shift to giving more resources and autonomy for the provinces, the increased focus given to prevention and primary health care vs. high cost services, as well as the ongoing sector-wide approach process moving towards more aligned and harmonised support of health development aid to Solomon Islands national systems and plans.

SPC is appreciative of the efforts of the Ministry of Health and Medical Services and assures the Solomon Islands Government of our ongoing commitment to support the ministry through the reforms that it has embarked on. SPC views itself as an extension of the national services of its member countries and endeavours at all times to work with existing mechanisms of national governments and as requested by governments. SPC will continue to support for the work of the Ministry of Health and Medical Services and Solomon Islands Government in seeking to improve development outcomes across all sectors in which it provides assistance.

SPC thanks the Solomon Islands Government, staff of the Ministry of Health and Medical Services, senior staff of other ministries, members of civil society, faith based organisations and community groups, as well as key development partners for participating in the pilot study. We hope that the findings will be used and also updated periodically to maintain evidence-based discussions with Solomon Islands' major donor partners and technical agencies to ensure better targeting and alignment of assistance to improve health outcomes for the people of Solomon Islands

William Parr
Director – Public Health and
Social Resources Divisions, SPC

Executive summary

Background

The Framework for priorities in health seeks to articulate the most important priorities in health in the region, and to examine those priorities in relation to existing national and regional strategies and funding.

Solomon Islands is one of three initial national case studies carried out (together with Nauru and Palau) for the purposes of developing, testing and strengthening the methodology for gathering national-level data in support of a regional framework.

Approach

A Framework for priorities in health two-persons team took part in a week-long health conference and Donor Partners Joint Annual Program Review (in June 2009) of the sector-wide approach that brought together health stakeholders from the capital, Honiara, and surrounding provinces. Ministry of Health and Medical Services (MHMS) budgets and expenditures, programme and partners' reports, and the MHMS annual report were made available during the conference.

The health conference and Donor Partners Joint Annual Program Review was followed by two half-days of guided multi-sectoral focus group discussions with key informants. Other sources of information included the National Health Strategic Plan 2006–2010, Medium Development Term Strategy 2008–2010, and various other surveys and reports.

Findings

Socioeconomic background

The Solomon Islands economy is historically based on a few commodities, with a particular dependence on unsustainable logging. The years of social unrest (1999–2003) saw a sharp economic decline, with per capita gross domestic product (GDP) as low as USD 1014 in 2008 (it was 753 in 2006) and is the lowest in the region except PNG. Debt servicing continues to consume 14% of the total Solomon Islands government budget. Solomon Islands has a very young population: 39% of the population is less than 15 years of age, while women of the child-bearing age (15–49) account for 25% of the total the population. The fertility ratio is 4.6. About 42% of Solomon Islanders are in the dependency age range (i.e. younger than 15 or older than 64, and thus not considered economically active).

Chronic poverty is currently not very evident in Solomon Islands because of the social safety net provided by families and the land tenure system. Limited access to basic services and income generating opportunities forms the basis of poverty. About 23% of the total population is under the basic needs poverty line, including 5% of people in Honiara and 18% in rural areas. Basic needs poverty affects 32% of Honiara's households and 19% of rural households.

Health outcomes

Health services have recovered from the impact of the social unrest years, with marked reductions in recent years in the incidence of malaria (the primary disease-related cause of death in Solomon Islands). More than one-third of primary health care (PHC) contacts for the last 10 years have been for acute respiratory infections (ARI) followed by malaria and other communicable diseases.

The immunisation rate is generally high at 83%, and the introduction of pentavalent vaccine may further improve statistics, by reducing dropout rates for subsequent shots. However, male babies have higher immunisation rates than do females, and their dropout rate is also higher. The maternal mortality ratio and infant mortality rate are relatively high. Major causes of childhood deaths are pneumonia, malaria, acute gastroenteritis and meningitis, while major causes of neonatal death are prematurity and low birth weight, sepsis and birth asphyxia. The most common causes of maternal deaths are postpartum and ante-postpartum haemorrhaging, puerperal sepsis, complications from malaria in pregnancy, and pregnancy-induced hypertension. Only 51% of mothers receive postpartum checks. Anaemia in pregnancy varies by province, but affects up to 44% of women aged 15–49 and up to 60% of pregnant women.

Non-communicable diseases (NCDs), family planning, reproductive health (teenage pregnancy), and nutrition are existing priorities but receive insufficient budgetary support. Curative services consume major portions of MHMS's budget, with minimal funding dedicated to preventative care; this is particularly pronounced in the PHC network. Large amounts of funding and human resources have been directed to Honiara for the National Referral Hospital (NRH), administrative costs, and the Honiara City Council (HCC), which has prevented increases to provincial health budgets.

Emerging health issues include threats from pandemic flu (H1N1 and avian flu), HIV, and mental health. Family planning (including teenage pregnancy), nutrition and NCDs also need urgent attention to enable MHMS to manage the health burden in the future.

Social determinants of health

Extended family networks provide the basis for 'share and care', for particularly for young people. However, with 39% of the population being less than 15 years old, and 25% of the total population being of childbearing age, the burden on family safety nets is heavy, particularly in urban areas, where families are heavily dependent on money for daily sustenance.

Sixty-four per cent of urban households and 25% of rural households have piped water in their houses. Twenty-eight per cent of urban households and 92% of rural households do not have access to improved sanitation facilities, resulting in a continued high incidence of water-borne diseases. Ready access to fresh water by households remains a challenge in both urban and rural areas, compromising personal hygiene, and contributing to ongoing health problems. Skin diseases, ear infections, diarrhoea, yaws and trachoma were the third most common reason for PHC contacts in 2008 (after ARI and malaria and fever). Around 12% of children under 5 are malnourished and 34% of children suffer from anaemia, while up to 44% of women aged 15–49 years old suffer from anaemia. Any services offered to disabled children are generally restricted to urban areas.

Customary land tenure has ensured access to land for subsistence for most families in rural areas. However, this very tenure system has also been abused to allow large-scale unsustainable logging operations that benefit very few resource-owning individuals. Lack of planning on customary land before committing to permanent cash crops is also resulting in land shortages in some parts of Solomon Islands. The impact of climate change is serving to exacerbate land and health problems.

Primary education is free and easily accessible in rural villages, and attendance is generally high. Issues of affordability affect attendance at the secondary level, with a higher proportion of students from urban areas. Introduction of a fee-free basic education policy in 2009 will change this pattern. More analysis should be done to develop further policies and programmes that will enable rural girls and girls from poor families to attend higher education, thereby enabling them and their families to break free from the cycle of poverty affecting poor families.

Poverty exists in the country, regardless of whether it is acknowledged by Solomon Islanders. Given the country's very young population and rapid rural–urban migration, and a government and economy that are unable to harness this vast human resource, it is likely that the future will bring more social problems.

Personal risk factors

Solomon Islands ranks second in the world in oral cancer, which is found to be particularly prevalent among people with combinations of tobacco smoking and chewing betel nut quid. A study has found that smoking and chewing now starts at a much earlier age than it did a few years ago.

Sexually transmitted infections (STIs) and HIV are rising. The 2006–2007 Solomon Islands Demographic and Health Survey (SIDHS) found that 15% of women and 24% of men reported having sex with someone other than their usual partner during the 12 months prior to the survey, with 4% of female respondents and 7% of male respondents having more than one sexual partner. Condom use is low (18% among women and 28% among men). The Second Generation Surveillance of Antenatal Women and Youth findings

show significant rates of STI infection among pregnant women: 23% of those aged 15–24 years suffered from trichomonas infection, and 16% from chlamydia; trichomonas affected 14% of those aged 25–44 years, with chlamydia found in 6%. Among youth, nearly 20% of females and 10% of males tested were found to have chlamydia, 10% of youth tested had active syphilis and 3% had gonorrhoea. Statistics on STIs suggest an alarming potential for the spread of HIV, which is already an epidemic in neighbouring Papua New Guinea.

Sedentary lifestyles with changing dietary intake are contributing to a steady increase in obesity, diabetes, hypertension and other associated complications.

Social protection

Sixty-four per cent of females responding (aged 15–49) to a gender-based violence survey have experienced physical and/or sexual violence from sexual partners. The Christian Care Centre provides a temporary shelter for women and children experiencing violence.

People with disabilities have very limited services provided to them, and most are urban-based. Mental health patient admissions continue to increase, with the majority being relapse cases. Families and communities need to be trained to provide a supportive environment for patients who have managed to exit from psychiatric units.

Contributions to the National Provident Fund (NPF) by employers and employees provide income at retirement age to those involved in formal employment.

Health system and services

The health system in Solomon Islands is formed by a network of primary health centres, with provincial hospitals for secondary care, and NRH in Honiara for secondary and some tertiary care. Two church organisations (United Church and Seventh-day Adventist) have traditionally operated hospitals offering secondary and some tertiary care in Western and Malaita provinces. There are 327 facilities throughout the country.

Curative services and administrative costs have traditionally consumed more than 40% of MHMS's budget. Nine provinces share 26% of the budget yet provide care for 85% of the population in the rural areas.

About 20% of all health workers are at NRH, including two-thirds of all medical doctors. The recently approved doctor's scheme of service provides a relatively competitive remuneration package, while nurses' remuneration has been a point of contention, contributing to generally low morale. Very limited donor support has gone into improving situations for nurses. About 44 kit houses have been imported for staff housing to be built in Western and Guadalcanal provinces. The impetus for this in the Western Province was the loss of extensive staff housing due to the 2007 tsunami.

While various MHMS programmes seek to provide skills training and capacity building, there is a perception – particularly among rural nurses – that there is still some favouritism in selection of staff for these programmes. Analysis of health workforce data shows that smaller provinces are better staffed than bigger ones. At the international level, Solomon Islands ranks fourth in nurses per 10,000 population when compared with seven other Pacific Island countries, Timor Leste and Philippines, but ranks third to last with respect to physicians. There are four training schools for nurses locally. Doctors undertake tertiary training in Fiji (Fiji School of Medicine), Papua New Guinea, Australia and New Zealand, and more recently in Cuba, through support from the Solomon Islands government and its development partners.

In 2008, the sector-wide approach (SWAp) to health was introduced with the Australian Agency for International Development (AusAID), the World Bank, the World Health Organization (WHO) and other United Nations (UN) agencies being primary signatories along with the Solomon Islands government. The rationale is that both the Solomon Islands government and donor partners are funding a single sector strategy and expenditure programme. This multi-sectoral approach, the Health Sector Support Program (HSSP) is informed by the eight priority areas identified in the National Health

Strategic Plan (NHSP 2006–2010), which is undergoing review in 2010. The eight priority areas are 'people focus', public health programmes, malaria, common childhood illnesses, NCDs, HIV and STIs, family planning and reproductive health, and health systems strengthening. HSSP has developed annual monitoring indicators and a 'Vision 2012', outlining what it hopes to achieve by 2012.

The governance arrangement of HSSP makes it necessary for dialogue and consultation to take place between the Executive Committee and the various heads of the programmes, between MHMS and donors, and MHMS and its partner organisations – including non-governmental organisations (NGOs) and faith-based organisations (FBOs) – contributing to health outcomes. Donors are also encouraged to establish a regular dialogue with each other.

The major health burden is still from communicable diseases, but NCDs are increasing. A large portion of the health budget is consumed by curative services, leaving little for preventative care and health promotion. Health promotion, preventative care and other public health major programmes (community-based rehabilitation, social welfare and mental health) have very limited rural outreach. The draft National Strategic Health Plan, which is to be released in early 2011 covers the next four-year period, addresses this problem and emphasises reforms to move to primary and preventative health care and more decentralised services.

Health financing has ranged between 12% and 16% of the Solomon Islands government recurrent budget in the last few years. In 2009, the total health sector budget was SBD 405 million, of which 48% was funded by health sector donor partners (principally Australia through HSSP). With heavy donor dependence, financing sustainability of the health sector has been an ongoing issue. Under HSSP, several options to enhance sustainability will be put in place, including fees for selected services, revenue retention rules, and increasing MHMS revenues from sale of services and goods (up to 5% of the MHMS budget). These recommendations were also put forward by the NRH Enquiry Committee, commissioned by Parliament to examine the effectiveness of NRH in 2009.

Health information for decision-making is a focal area of HSSP in terms of systems strengthening. The PHC health information system (HIS) provides the most comprehensive data on primary health contacts. There are, however, parallel information systems, including the hospital information system, the reproductive health system, the Solomon Islands malaria information system and others. A hospital information system introduced limited scope for gender and poverty disaggregated data. Work is in progress to link the different systems.

Pharmaceutical and health products procurement and supply management are functional but continuously experiencing stock shortages due to an outdated, low functioning procurement system.

Summary and conclusions

Priorities and gaps

The priority areas identified in the NHSP 2006–2010 can be broadly categorised as addressing three interconnected areas: 'people focus', diseases and system strengthening. The following section summarises the gaps and priorities identified in the analysis, using health system building blocks, and following the broad categorisations used in the NHSP 2006–2010.

People focus: Gaps

Health promotion: These activities remain very limited, especially in rural areas. Preventative care has yet to be integrated with curative services. Health promotion staff positions in several provinces are vacant. Grants to provinces are not sufficient to enable them to finance preventative public health activities. Health promotional activities also need to be action-oriented and engaging, instead of focusing just on awareness and information sharing.

Family planning: According to the 2007 SIDHS, there is an unmet need of 11% for family planning or limiting reported by currently married women. There is a lot of misinformation and uncertainty about physical effects of various family planning methods on women. There is potentially a high unmet need, especially if women become better informed and have access to a variety of low-cost contraceptive choices. This is

particularly true in the rural areas. Family planning education outreach is very limited, and is primarily provided when pregnant mothers come in to antenatal clinics, instead of through outreach by nurses. Nearly two-thirds of women who took part in the Second Generation Surveillance reported that their pregnancies had not been planned. Of these, 85% aged 15–24 and 69% aged 25–44 reported that they did not use any form of contraceptive in the three months prior to becoming pregnant. The Central Province has reported increasing participation of men in non-scalpel vasectomies.

Teenage pregnancy and maternal health: Despite the small decline in adolescent fertility in the last 20 years demographic and health survey results show that early childbearing is still prominent. The Sexual Reproductive Health Programme and Family Planning are not sufficiently addressing this issue. Parents need to be involved so that they come to terms with the fact that their children are sexually active and that they have a role to play in encouraging preventative and safe sex practices.

Nutrition: Education needs to be undertaken in communities through nurses at clinics, and women's and church networks. The nutrition unit needs to be elevated in importance and be strengthened in terms of financial and human resources. In 2009 the nutrition unit within MHMS was staffed by just three personnel, and all provincial positions were vacant. Dependence on imported food and movement to a cash economy has led to greater reliance on rice, tinned fish and refined flour and sugar. This in turn has led to higher rates of diabetes, high blood sugar and malnutrition across the country.

Sanitation: The Solomon Islands household income and expenditure survey (HIES) for 2005–2006 reported 31% coverage in improved sanitation facilities for the whole country. This finding is further supported by the 2007 SIDHS findings, which show that 60% of households throughout the country do not have access to improved sanitation facilities, with the percentage increasing to 92% for rural households. Lack of sanitation facilities and unhygienic practices are a primary contributing factor to continuous occurrences of diarrhoeal diseases, particularly among children under age 5 years.

Diseases

HIV and STIs: There is a major gap between knowledge of diseases, particularly HIV and AIDS, and uptake of safe sex measures, regardless of available funding. The Second Generation Surveillance of Antenatal Women and Youth found that 80–90% of youth correctly answered all five United Nations General Assembly Special Session questions on HIV transmission and major misconceptions. However, of the 56% of males and 40% of females who reported having more than one sexual partner, only 30% of males and 25% of females used condoms when they last had sex. This study found very high rates of STIs among both pregnant women and youth.

NCDs: Knowledge on preventative health measures is generally lacking among most people, making it difficult to link lifestyle to diseases. Opportunities for early detection are insufficient throughout the country, either because of a lack of equipment or insufficient knowledge and skills by health care providers at the PHC network.

Communicable diseases: These preventable diseases continue to place a heavy burden on the health care system. For some of these diseases, increased interventions in healthy settings and the promotion of hygienic practices should have an immediate impact, whereas others, such as water-borne diseases, need inputs relating to sanitation and clean drinking water facilities.

System strengthening: Gaps

The following are needed:

- A clear linkage between the ongoing systems strengthening of national programmes and provincial health divisions, and the primary care network in the rural areas.
- Monitoring of service delivery quality and support at all levels.
- Provincial operational planning and budgeting, linking activity to budgets, identifying areas for savings and minimising budget diversions (this requires skilled bookkeepers or accountants in all provincial centres. At this time only some of the provincial health care centres have trained accounting staff. Capacity building is critical in this area as well as in project and grants management.
- Monitoring equity (gender/poverty/ethnicity) in access to service.
- Strategic plan to have a simple monitoring framework with appropriate performance targets and indicators.
- Strengthening of village committees to enable them to support health care staff, monitor performance and provide independent feedback to provincial health divisions.

Provisional recommendations

Disaster Response Health Plan: The occurrence of natural disasters (and the associated impact on human health) is increasing, and health authorities need to develop a coordinated response to disasters. While the renewed effort on the Malaria Elimination Program is a good start in preventing epidemics, planning for disaster response is needed in conjunction with the National Disaster Management Office

Population policy: A more aggressive policy to manage the currently unsustainable growth in the population is needed. The growth of all government services including health and education as well as the economic growth of the country are all trailing behind the explosive growth of the population, and without donor support Solomon Islands will not be able to continue providing quality services to all. Thus far, Solomon Islands have not been able to harness its vast human resource for productive uses. Failure to manage the ongoing growth of the population will result in serious consequences for the country.

Multi-pronged or holistic health promotion strategy implemented concurrently at the community level: There are multiple health issues (with respect to communicable diseases, NCDs, reproductive health and family planning) that can be addressed concurrently through a programmed and coordinated public health promotion; this should involve more than passive educational talks and materials, and involve development of creative action-oriented programmes in collaboration with partners and related sectors. Targeted actions are more

effective than generalised actions. The issue of scale for targeted actions can be addressed by integrating promotions with PHC activities and human resources, and engagement and capacity building of NGOs and FBOs. For rural clinics and health care staff, this could be met by a six monthly programme that can be tailored to specific needs and fully resourced, with health promotion staff and expertise from MHMS providing backup support and monitoring. For some areas (e.g. sanitation facilities), it may be possible to achieve wider coverage if MHMS provides partial subsidies rather than supplying sanitation facilities free of charge. However, such actions should be based on clearly defined criteria ensuring that poor households are not excluded.

Increased and sufficient resourcing of provincial health divisions and improved planning and accountability: The strength of health care in Solomon Islands is its rural PHC network. However, for a number of years the provincial health divisions have not been allocated sufficient financial, equipment and human resources, with the bulk of resources committed to NRH and Honiara. Opportunities for staff development have also been unfairly limited to Honiara-based staff. While moving resources to the frontline of health care delivery is one of the focal areas of AusAID-funded support into the health SWAp, it is imperative that a clear workable mechanism be in place defining resource allocation between the head office, NRH and the provinces. This should be well understood and easy to use without additional technical support to ensure ownership by MHMS. Planned technical support to the provinces for financial planning and management (through HSSP) should ensure accounts and administrative staff are in place in all provincial divisions.

Policy and funding coherence and development effectiveness

HSSP and the more recent SWAp formation provides an opportunity for donor harmonisation and alignment of support to identified priorities. However, MHMS must lead the process through continuous policy dialogue for donors and other partners, as there is otherwise an ongoing risk that assistance will remain donor driven and not be well aligned with national priorities. Programs such as malaria control that attract multiple funding sources and technical support present opportunities to strengthen broader health services.

Cross-sectoral approaches to social determinants

Those in the health sector and their development partners must pay more attention and resources to sustainably address social determinants of health that are external to the health sector but which influence health outcomes if there is to be a realistic expectation of a long-term reduction in priority diseases such as NCDs (which require good collaboration between the health sector and the agriculture, fisheries, sports, commercial and other sectors).

Abbreviations and acronyms

ARI	acute respiratory infections
BCC	behaviour change communication
CNURA	Coalition Government for National Unity and Rural Advancement
DWEs	direct wage employees
EPI	Expanded Programme on Immunisation
FBOs	faith-based organisations
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Malaria and Tuberculosis
HCC	Honiara City Council
HIES	Household Income and Expenditure Survey
HIS	Health Information System
HISP	Health Institutional Strengthening Programme (AusAID)
HIV	human immunodeficiency virus
HSSP	Health Sector Support Programme
MMR	maternal mortality ratio
MHMS	Ministry of Health and Medical Services
MTDS	Medium Term Development Strategy
MWYCA	Ministry of Women, Youth, Children Affairs
NCDs	non-communicable diseases
NDMO	National Disaster Management Office
NHSP	National Health Strategic Plan
NGOs	non-governmental organisations
NPF	National Provident Fund
NMS	National Medical Store
NPHL	National Public Health Laboratory
NRH	National Referral Hospital
NSO	National Statistics Office
PacMISC	Pacific Malaria Initiative Support Centre
PHD	Provincial Health Director
PHC	primary health care
PIP	Public Investment Program
PWDs	persons with disabilities
RAM	Rotarians Against Malaria
RAMSI	Regional Assistance Mission to Solomon Islands
SDH	social determinants of health
SIDHS	Solomon Islands Demographic and Health Survey
SPC	Secretariat of the Pacific Community
SRH	sexual and reproductive health
STIs	sexually transmitted infections
SWAp	sector-wide approach
UNDP	United Nations Development Programme
UPNG	University of Papua New Guinea
USD	United States dollar
WHO	World Health Organization

Chapter 1: Introduction

Background to the Framework for Priorities in Health

Most Pacific Island countries and territories (PICTs) experience a 'triple burden of disease' – a high level of communicable diseases, a high and increasingly severe burden of non-communicable diseases (NCDs), and emerging risks from new diseases and changes in our social and physical environment. The emergence of new, global disease threats – combined with the region's inherent fragility and susceptibility to natural disasters and climate change – poses a further threat to human health.

The Pacific has achieved steady improvements in some health indicators, but progress in other areas has been slow. Pacific Island governments need to increase investments in public health in order to protect the security and well-being of their people; however, many ministries of health are not well enough resourced to meet all of these demands.

The Pacific Plan articulates a new vision of 'regionalism' in the Pacific, and 'Improved Health' is its sixth Strategic Objective. The 5th Conference of the Pacific Community and the 38th Pacific Forum Leaders meeting in Tonga approved the development of a Framework for Priorities in Health to inform the possible future development of a regional health strategy and a regional health fund.

In their Vanuatu Commitment, Pacific ministers of health reaffirmed the benefits of regional cooperation, as well as the need to develop regionally and nationally appropriate responses to Pacific health needs. The ministers requested that the Secretariat of the Pacific Community (SPC) proceed with data collection for developing a framework that would include:

a) consultations with PICT ministers of health in order to develop possible mechanisms that will strengthen regional cooperation in health without duplicating work already undertaken; and

b) continued exploration of possible mechanisms that will facilitate additional funding of regional and national health priorities and gaps in the Pacific.

The framework's purpose

The Framework for Priorities in Health seeks to:

- identify the most important priorities in health in the Pacific, ranked in order of importance by each member country or territory and the overall regional picture, including the broader determinants of health status that lie outside the health sector (see Section 1.3);
- match priorities and resource allocations by national budgets, and development partner financing through regional and bilateral funding streams;
- map all existing strategies in health (national and regional) against the priorities and source of funding;
- link priorities in health to international and regional agreements and resolutions;
- map all stakeholders currently engaged in the health sector in the Pacific Islands region; and
- identify important gaps at national levels that require urgent attention to achieve better health outcomes.

Although not a health strategy *per se*, the framework may provide supporting information that PICTs can use during their consultations with development partners and a basis for regional organisations to align their programmes with national priorities and gaps (according to the Pacific Aid Effectiveness Principles).

Social determinants of health

We have long known that the real determinants of health status and health outcomes lie largely outside the health sector. Good nutrition, education, water, sanitation and housing, freedom from poverty, social support and a good quality physical environment are basic requirements for a healthy population.

Climate change could also have major consequences for health outcomes in the region, including for food security (resulting in malnutrition and deteriorating child health), access to basic health services and decent housing (because of population displacement), and public health – most notably an increasing incidence of water-borne diseases (e.g. diarrhoeal) and vector-borne diseases (e.g. malaria, dengue and filariasis).

The Final Report of the World Health Organization (WHO) Commission on Social Determinants of Health identifies these and many other factors, including the influence of inequity and social justice.

The Commission on Social Determinants of Health Report also explores possible solutions (many of which, like the causes, lie outside of the health sector). The Commission encourages governments to adopt a 'whole-of-government' (or multi-sectoral) approach in order to effectively address the causes of ill-health, and achieve good health outcomes for their populations.

The Framework for Priorities in Health will endeavour to capture information on the social determinants of health at both the national and regional level, and the degree of inter-sectoral collaboration in addressing those determinants.

Health systems

WHO has proposed a single framework (Figure 1.1), composed of six building blocks, to be used when analysing health systems (WHO 2007). These building blocks are often managed by different units within the health sector but, because they influence all aspects of a country's health system and the services it delivers, they all relate to each other.

This approach has been further developed by the WHO European Observatory on Health Systems and Policies, and this methodology has been used to inform the data collection at the country level and guide the content of this report.

A specific area of the health system provides and maintains essential public health functions, including: surveillance, health situation monitoring and analysis; health promotion; social participation and the involvement and empowerment of citizens in health; public health regulation and enforcement; research, development and implementation of innovative public health solutions; and reducing the impact

of emergencies and disasters on health. Like the determinants of health, these functions often require inter-sectoral and international collaboration to effectively pre-empt or respond to health problems.

The case studies contributing to the Framework for Priorities in Health seek to gather information on all these aspects of national health systems, with a special focus on health budgets and financing (including gaps and mechanisms of aid coordination), the health work force, service delivery (including for emerging and previously-identified areas of priority), information systems, and mechanisms for policy development.

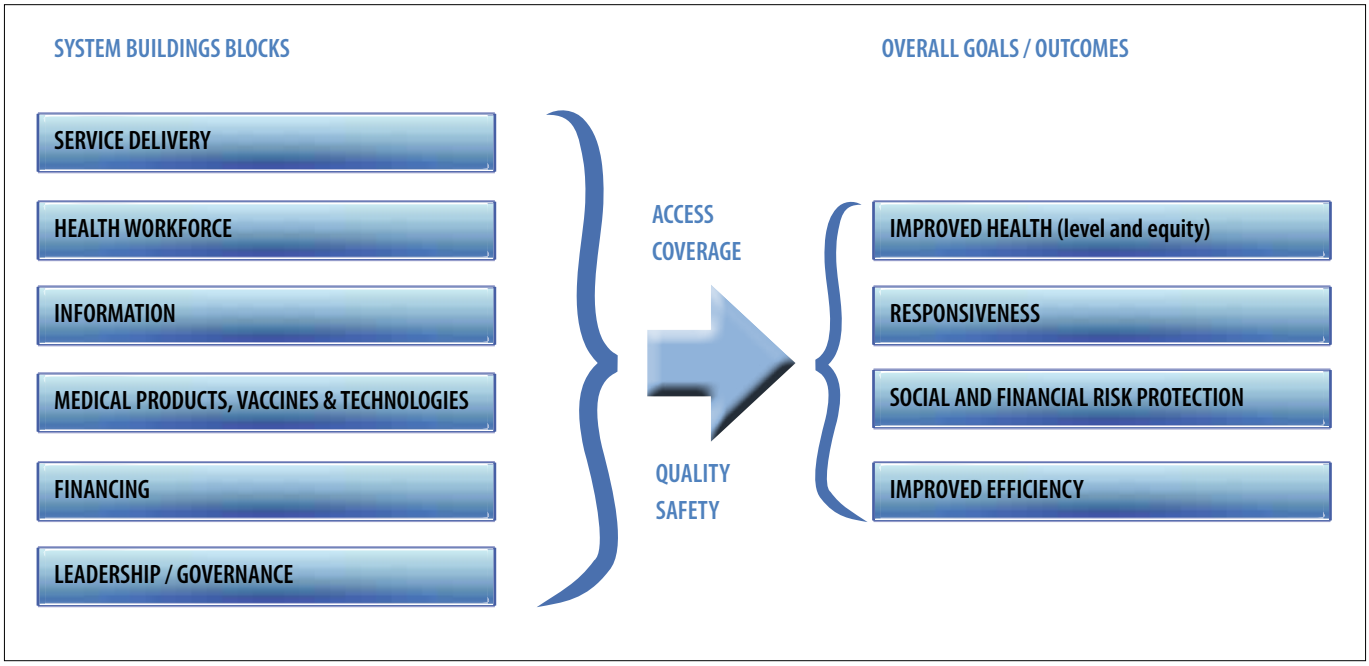
The 'building blocks' approach does, however, assume a central – perhaps dominant – role for government in the national health system. Where information was available, the place of non-state actors such as local and international non-governmental organisations (NGOs), faith-based organisations (FBOs) and the private sector in service provision, the health work force and other aspects of the health system has been included.

Donor coordination and harmonisation

The Paris Declaration on Aid Effectiveness, the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee guidelines on donor harmonisation, the Accra Agenda for Action and the International Health Partnership all identify the need to align development activities with country priorities, and invest in building effective country systems.

In the Pacific Islands, the principal avenues of donor-funded technical and financial support for national health systems are currently through regional or national (i.e. bilateral) projects. Only two countries have a sector-wide approach in health, and it is uncommon for others to receive non-earmarked core budget support. The proliferation of these funding mechanisms (through disease-specific regional projects addressing single health issues such as HIV infection, tuberculosis, malaria or NCDs) has resulted in an increasingly fragmented donor environment, with limited horizontal or 'diagonal' strengthening of health systems around those specific disease programmes.

Figure 1-1: The six building blocks of a health system: aims and desirable attributes



Source: WHO 2007.

The Pacific Islands Forum Secretariat has developed the Pacific Aid Effectiveness Principles, which are derived from the Paris Declaration and reaffirmed by the Accra Agenda for Action. For development assistance activities, the Pacific Principles emphasises country leadership and ownership, multi-year commitments by development partners, alignment with nationally identified priorities, greater Pacific ownership of regional development, coordinated approaches, increased use of local systems, and more efficient provision of technical assistance. They also emphasise the importance of clear, inclusive monitoring and evaluation mechanisms that can demonstrate progress towards improving health outputs and outcomes, and encourage international agencies to move towards joint appraisal and reporting systems that support mutual accountability (rather than requiring their own separate arrangements).

Methodology

The pilot phase

Four countries – Nauru, Palau, Solomon Islands and Cook Islands – initially expressed interest in undertaking pilot framework assessments during 2009. Across the Pacific, these countries represent a diversity of ethnic and regional distribution, geographic sizes and populations, economic and social development, and geo-political affiliation. Cook Islands subsequently withdrew due to extensive internal strategic planning, leaving three pilot countries.

A written country report will be developed following each assessment.

Each pilot country case study will contribute lessons and analyses on health priorities, systems and gaps. These were summarised jointly in a discussion paper for the Pacific Health Ministers Conference in Madang, Papua New Guinea in July 2009, and an overall synthesis report – or draft framework – which has collected common themes from each country case study and feedback from health ministers.

Solomon Islands country study

The information used in this report came primarily from a week-long health conference and Donor Partners Joint Annual Program Review of the national health sector-wide approach (SWAp) held in June 2009. This conference brought together programme divisions within the Solomon Islands Ministry of Health and Medical Services (MHMS), all provincial health directors and their heads of nursing, other government ministries, NGOs, FBOs and donors. The conference presented a unique opportunity to gather information from discussions on health sector realities and challenges, and follow-up discussions with specific people. In preparing for the donor review and conference, MHMS, including the National Referral Hospital (NRH) (for the first time), prepared extensive financial and activity reports for 2008 and plans for 2009. This also included reports from partner NGOs and FBOs.

The conference was followed by two half-days of guided multi-sectoral focus group discussions with key informants. Other sources of information included the National Health Strategic Plan 2006–2010, Medium Development Term Strategy 2008–2010, and various surveys and reports.

Chapter 2: Solomon Islands background and context

Figure 2.1: Solomon Islands

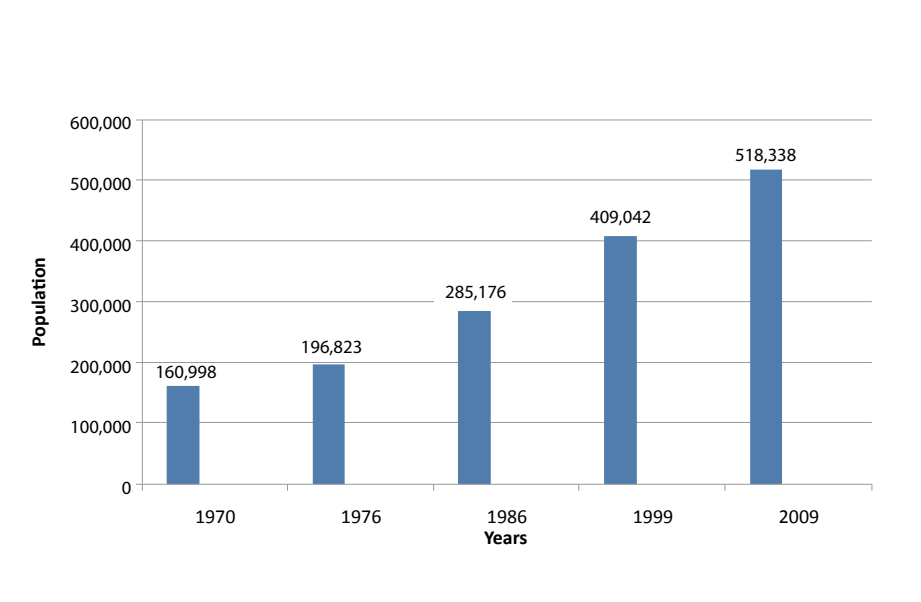
Geography

Solomon Islands is an archipelago in the western Pacific, comprising 992 volcanic and low-lying atoll islands, and covering an area of 28,000 square kilometers. The archipelago lies between latitudes 5°S and 12°S and longitudes 155°E to 170°E (Figure 2.1). Solomon Islands is made up of nine provinces, and the capital is Honiara.

Demography

The 1999 census estimated the population of Solomon Islands to be 409,042. The male population outnumbered the female population, with a sex ratio of 106 males to 100 females, and a growth

Figure 2.2: Population growth (1970–2009)



rate of 2.7%. Figure 2.2 shows the trend in population growth between 1970 and 1999, with an estimate for 2009. A population census was conducted in November 2009. The 2010 mid-year population estimate is 549,574 inhabitants with an annual growth rate for 2010 at 2.7, the highest in the region.

The population of Solomon Islands tripled between 1970 and 2009, a period of only 39 years; this is an important factor to take note of in planning development services in the country. Some of the demographic characteristics of Solomon Islands are shown in Table 2.1.

- Solomon Islands has a very young and growing population, with children aged less than 15 years accounting for 39% of the total population in 2007. The median age is 19.6. The average household size is 5.3 people, a one-person reduction from 6.3 people recorded in 1999.

- Women of child bearing age (15–49) account for 25% of the total population.

- While only 3% of the total population were in the old-age category (65 years and over), 39% were under age 15 years. Assuming that the cut-off points for the economic activity age group were 15 and 64 years, then 42% of Solomon Islands' population are still within the dependency age range.

- With 25% of the total population consisting of women of childbearing age whose contraceptive prevalence rate is only 11%, Solomon Islands will continue to be among the countries with the highest population growth rates.

Government

In 1893, the British government established a protectorate over the eastern group of islands with Germany controlling most of the west. Following the Anglo-German agreement of 1899, the British protectorate was extended to all nine main island groups, which now make up the nation of Solomon Islands. Britain granted Solomon Islands internal self-government in 1976, followed by independence on 7 July 1978. Upon independence, Solomon Islands joined the Commonwealth, with Queen Elizabeth II as its head of state, represented by a Governor General. Solomon Islands is currently a unitary state with two levels of government: national and provincial. The national parliament comprises 50 members who are elected for a four-year term under a 'first past the post' voting system. The prime minister is elected by a simple majority of Parliamentary members. Party structures in Solomon Islands are fluid. A Political Party Integrity bill, aimed at stabilising the government, is undergoing a public consultation process.

The provincial government structure evolved out of local government features of the colonial bureaucracy, which divided the country into four districts, each

Table 2.1: Demographic data for Solomon Islands

Indicators	2006	%	2007	%
Total population	**483,083**	**100**	**495,026**	**100**
Male population	248,944	52	255,063	52
Female population	234,139	48	239,963	48
Population < age 1	14,445	3	14,448	3
Population < age 5	69,559	14	70,380	14
Population < age 15	**190,666**	**39**	**194,118**	**39**
Population aged 15–64	277,139	57	285,168	58
Female pop aged 15–49	119,160	25	122,573	25
Population aged 65 +	15,278	3	15,740	3
Sex ratio (number of males to 100 females)	106:100		106:100	

headed by an expatriate district officer. In 1981, with the passing of the Provincial Government Act, seven provinces were created: Guadalcanal, Malaita, Makira Ulawa, Temotu, Isabel, Central and Western. In 1991, Choiseul separated from Western Province and Rennell Bellona from Central Province, bringing the number of provinces to nine. Each province is governed by a Provincial Assembly. The Provincial Assembly for each province comprises elected politicians empowered to pass ordinances that are not in conflict with national policy or legislation. The size of each Provincial Assembly varies according to the number of wards, typically between 9 and 30 members. Each Provincial Assembly is headed by an Executive, which is led by the Premier, elected by an absolute majority of Provincial Assembly members (Cox and Morrison 2004).

The Provincial Government Act also envisages a third tier of government, allowing Provincial Assemblies to create Area Councils for local administration. Area Councils, however, were abolished in 1996, leaving a gap between the provincial administration and the village level. This gap has been further eroded by the closure of many provincial sub-stations due to financial cuts. This link between the village and the provincial and national governments is now filled by elected (provincial and national) members, and has become increasingly politicised. Isabel is the only province that seems to have an organised and functional link between the province and the village level through the Church of Melanesia and their Council of Chiefs in a tripartite arrangement that was independently formed in the province (Cox and Morrison 2004).

Economy

The outbreak of ethnic tensions in 1999 resulted in a sharp decline in law and order, leading to a steep decline in the economy. With the arrival of the Regional Assistance Mission to Solomon Islands (RAMSI) in 2003 and the restoration of law and stabilisation of government finances, the economy has since recovered. The economy has grown at a rate of over 5% per annum since 2004. According to the Central Bank of Solomon Islands (CBSI) Annual Report 2008, the economy grew by an estimated 6.7%, down from 10.8% growth in 2007. Gross domestic product (GDP) totalled SBD 528 millions USD in 2008, up from 394.5 million and from SBD 369.9 million the previous years. Nominal GDP per capita rose to a record high of USD 1,014 in 2008 from USD 840 in 2007.[1] In real terms, GDP per capita rose by 3.8% in 2008, still among the lowest in the Pacific.

Inflation at the end of December 2008, based on the Honiara Retail Price Index was 19.4% (three months moving average), compared with 10% in 2007. The inflation rate during the year reached as high as 23.5%, the highest recorded since the ethnic crisis.

1 *1 SBD (Solomon Dollar) equaled USD 0.12 at the time this report was written.*

Table 2.2: Government finances as a percentage of GDP, 2004–2007

Central government expenditure (% of GDP)	2004	2005	2006	2007 (est.)	2008 (proj.)
Total revenue	**48.1**	**78.8**	**64.7**	**69**	**62**
Recurrent revenue	*26.3*	*29.7*	*32.3*	*36.8*	*33.2*
Grants	*21.8*	*49.1*	*32.5*	*32.2*	*28.8*
Total expenditure	**39.1**	**63.6**	**63**	**70.4**	**66.4**
Recurrent expenditure	*21.6*	*26.7*	*30.7*	*33*	*33.7*
Development expenditure	*17.4*	*36.9*	*32.3*	*37.5*	*30*
Overall balance	**9**	**15.2**	**1.7**	**-1.5**	**-4.5**
Foreign financing (net)	0	4.7	2.1	3.2	-1
Domestic financing (net)	-6.7	-2.3	-1.8	-1.1	-0.1
Other	-2.3	-2.4	-0.1	0.7	0.4
Financing gap	0	-14.5	1.8	0.1	-5.2

Source: Pretorius et al. 2008

The main driver for this high inflation rate was the high world oil prices, which passed through the imports (CBSI 2009).

According to CBSI, total government revenue in 2007 was SBD 1,207 million. Total expenditure increased by 31% over 2006 to SBD 1,196 million. The Solomon Islands government total expenditure for 2008 was SBD 1,571 million, with an additional SBD 201 million supplementary budget approved later in the year (Table 2.2). Government expenditure as a percentage of GDP has generally been increasing. The government continues to allocate 15% of its revenue to debt management with the ultimate goal of reducing its debt to 30% of GDP (Table 2.3).

Despite the strong recent growth, the Solomon Islands economy continues to face a number of challenges. The majority of the population is involved in subsistence or cash crop agriculture, with less than one-quarter of the population involved in any paid work. Exports remain commodities-based, and include round logs or timber, fish, cocoa and copra or copra oil and palm oil. Current logging rates are unsustainable. The annual rate of increase on exports has been decreasing over the last few years due to a reduction in most export sectors, particularly forestry. Aid expenditures account for more than 30% of GDP (excluding police spending). The very high level of population growth in Solomon Islands (2.7% per annum) means it will be difficult to continue achieving real GDP per capita growth as the logging industry declines over the next few years. GDP per capita was USD 6,425 in 2007, and increased to USD 7,083 in 2008, which is still among the lowest in the Pacific region. The inflation rate has been in the 'double digits', reaching 23% in one quarter in 2008. This is mainly due to increases in fuel prices passed through the prices of imported goods.

Socioeconomic indicators

The RAMSI 2008 People's Survey found that 39% of respondents said their financial household situation is worse than it was two years ago, 33% said it is better, while 25% said it is the same (ANU Enterprise 2008). Solomon Islands scored among the lowest in the United Nations Development Programme (UNDP) Human Development Index (HDI). The only PICTs that scored lower were Vanuatu, Kiribati and Papua New Guinea. While chronic poverty may not exist in Solomon Islands due to family safety nets and a heavy reliance on the subsistence economy, an increasing percentage of the population lacks access to basic services provided by both public and private sectors, and lacks opportunities to generate income that would enable them to participate fully in the cash economy and the necessities that it creates. This was well put by Rick Hou, former Governor of CBSI, in his opening speech for the 2007 CBSI Annual Report launch.

> *'During the past three decades, there was an apparent lack of appreciation of the enormous disparities in population densities and natural resources endowment between provinces. There was no policy in relation to the fast growing population and the consequential demands on government versus economic output during the period. Given that the economy has not been growing in concert*

Table 2.3: Key economic indicators

	Calendar year			
	2005	**2006**	**2007**	**2008**
Nominal GDP (SBD 000s)	3,117	3,475	3,278	4,092
% change in GDP		11.4	6	25
Consumer price index-annual average inflation	7.3	11.3	10	19.4
Exports *(free on board [FOB],SBD 000s)*	1,061.9	1,255.9		1,657
Imports *(SBD 000 FOB.)*	1,701.9	1,989.1		2,063

Source: CBSI 2009

with the population, and given that a large portion [40%] of the population is young, the pressures that come with it are a real time bomb. Land disputes have increased as communal land and its resources are exploited with the growing population. Policy could be redesigned to harness this vast human resource into productive use and enabling them take a more active role in economic development. Rural dwellers can help deal with the inflated price of rice by returning to traditional root crops that are more nutritious and healthy forms of food'.

Development financing and coordination

Donor harmonisation and alignment

In line with the Paris Declaration and the Pacific Principles on Aid Effectiveness, donor support to Solomon Islands is generally directed by the development policy document of the government of the day. Emerging out of the civil unrest years through the support of RAMSI, the National Economic Recovery, Reform and Development Plan – which lapsed in 2006 – focused on economic recovery, institutional reforms and strengthening in an effort to restore peace and harmony in the country. The National Economic Recovery, Reform and Development Plan has been replaced by the Medium Term Development Strategy 2008–2010 (MTDS). The Ministry of Planning and Aid Coordination is responsible for the overall development planning and coordination of development partner assistance in Solomon Islands.

The MTDS 2008–2010 outlines the government's development priorities and objectives. These include:

A. Reconciliation and rehabilitation
   a. Pursue meaningful reconciliation between people at all levels of our society, which should lead to national healing.
   b. Foster a greater sense of national unity and identity.
   c. Rehabilitate damaged social and economic infrastructure as well as build new ones to stimulate economic growth especially in rural areas.

B. National security and foreign relations
   a. Sustain the peace process and law and order to ensure the nation attains sustainable peace and harmony.

C. Infrastructure development
   a. Rehabilitate damaged social and economic infrastructure as well as build new ones to stimulate economic growth especially in rural areas.

D. Social services
   a. Address basic needs of people in the villages and the rural areas where the majority of our people live and ensure real improvement in their standard of living. This includes villages on islands as well squatter communities in the urban areas.
   b. Work towards food security for the nation and ensure a healthy, literate and contented population.
   c. Generate opportunities for the growing population and achieve high economic growth, wealth and social wellbeing for all Solomon Islanders.

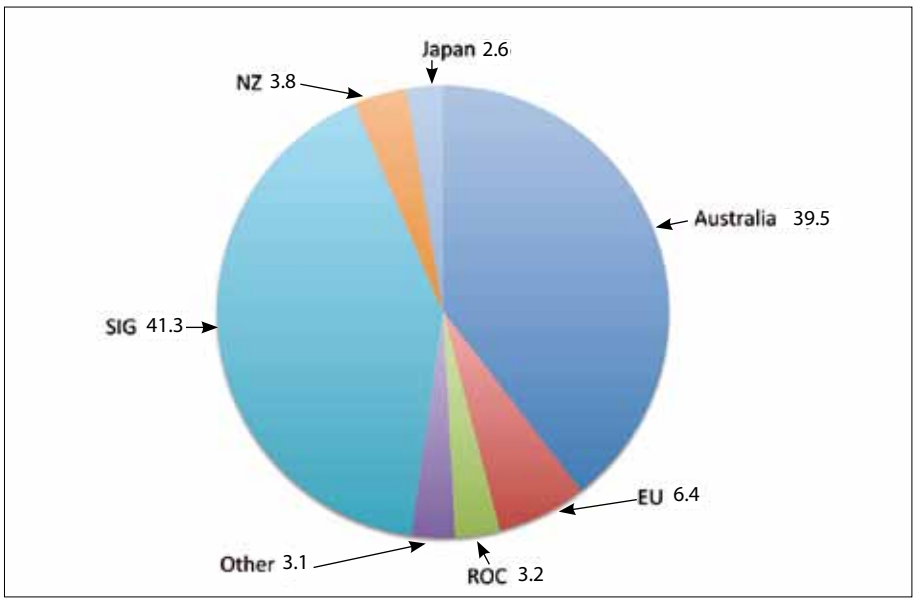
E. Economic/productive sectors
   a. Ensure that the roles of chiefs are strengthened, recognised and respected, and put in place measures to protect the traditional rights of resource owners so that they are awarded maximum benefit from the development of their resources.
   b. Pursue public sector reform and shift resources towards private sector driven economic growth.
   c. Generate opportunities for the growing population and achieve high economic growth, wealth and social well-being for all Solomon Islanders.
   d. Shift emphasis towards the development of tourism, fisheries and marine resources. Also prevent and ban any activities that would pollute Solomon Islands airspace.
   e. Ensure the sustainable utilisation and conservation of natural resources, protection of the environment and successful adaptation to climate change.

F. Public sector management

a. Achieve political stability and decentralise decision-making.

b. Encourage a gradual approach to the state government to build up the socio-political, economic and cultural capacities of the provinces.

Figure 2.3: Donor contributions to Solomon Islands Budget, 2008



Source: Ministry of Development Planning and Aid Coordination 2008

The MTDS, influenced heavily by the current Coalition for National Unity and Rural Advancement (CNURA) government, was largely unimplemented, due to reductions in the development budget that resulted from the global financial crisis. It is nonetheless a good basis for long-term comprehensive planning and directing of government and donor resources where support is most needed. Delivering sectoral plans by the ministries, monitoring and evaluation so that the desired outcomes are achieved remains a major weakness and an ongoing challenge that needs to be dealt with to achieve development outcomes that addresses the people's needs.

Development financing

The Solomon Islands government has been heavily dependent on donor partners to finance recurrent and development budgets. In 2008, donor support amounted to 59% of the total recurrent and development budget. Significant contributions to the national budget come from Australia, European Union, New Zealand, Taiwan and Japan (Figure 2.3).

Table 2.4: Budget allocations by priority area

Priority area	2005–2007 (%)	2008 (%)	2008–2010 (%)	% Change from 2005 to 2010
National security	58.5	42.1	34.5	-24
Infrastructure	8.4	10.7	12.8	4.4
Governance	10.7	10.6	9.7	-1
Economic	12.9	18.3	20.1	7.2
Civil	0.1	2.1	2.9	2.8
Social	8.4	15.7	19.8	11.4
Reconciliation	1.0	0.5	0.2	-0.8
Total	100	100	100	

Source: Ministry of Development Planning and Aid Coordination 2008

Trends in the development budget reflect the changing priorities of the government and donors. There has been a shift in development funding in Solomon Islands, from restoration of national security and government functions (post-conflict period) to economic and social development and the supporting infrastructure.

The national security budget was reduced by 24% from 58.5% during 2005–2007 to 34.5% during 2008–2010, while notable budget increases took place in the social, economic and infrastructure sectors (Table 2.4).

Chapter 3: Health status and outcomes

Health system outputs, coverage of interventions

The law and order problems in Solomon Islands experienced during 1999–2003, and the disruption it caused to the health system and services, has eroded the health outcomes achieved prior to 1999. The health system, however, has mainly recovered, with national programmes reestablishing themselves and health care services being increasingly used.

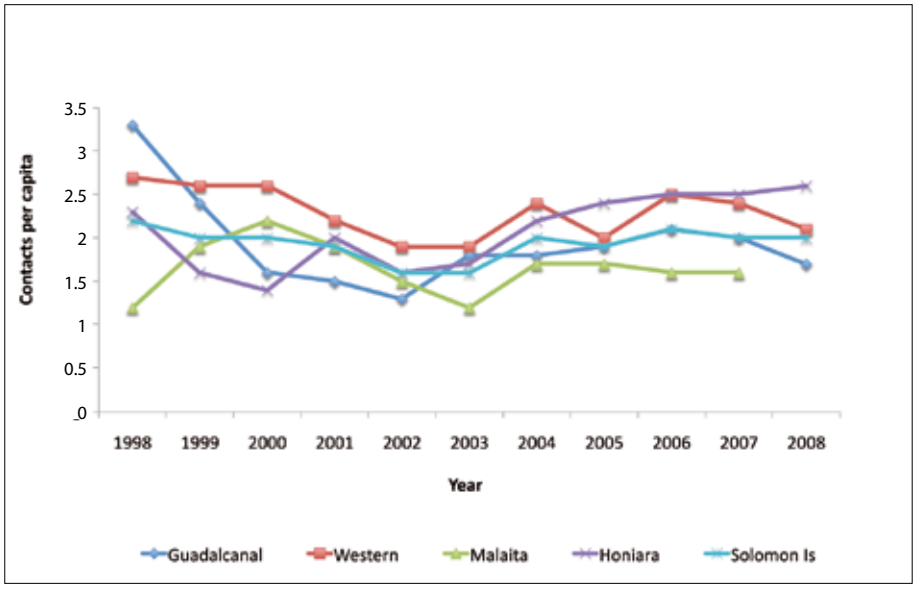
Health service

During the height of the political turmoil and social unrest, total outpatient contacts at provincial health centres decreased by 14% compared to the pre-unrest period. Acute care contacts per capita decreased in all provinces with Malaita and Guadalcanal provinces recording contacts as low as 1.2 and 1.3, respectively.

With political stabilisation, service usage recovered within two years, ranging between 2.0 and 2.5 per capita contacts in most provinces (Figure 3.1). This is consistent with the RAMSI People's Survey 2007, which found that per capita outpatient contact in the preceding year was 2.7 (ANU Enterprise 2007). Primary health care (PHC) facilities are, therefore, on balance reasonably well used, given the constraints of scale and distance in highly variable settings.

Principal causes of admissions in the provincial hospitals are malaria, acute respiratory infections (ARI), pneumonia, injury or trauma, diarrhoea, gastritis, diabetes, neonatal sepsis, hypertension, obstetric, asthma, and abscess.

Figure 3.1: Acute care contacts per capita, 1998–2008



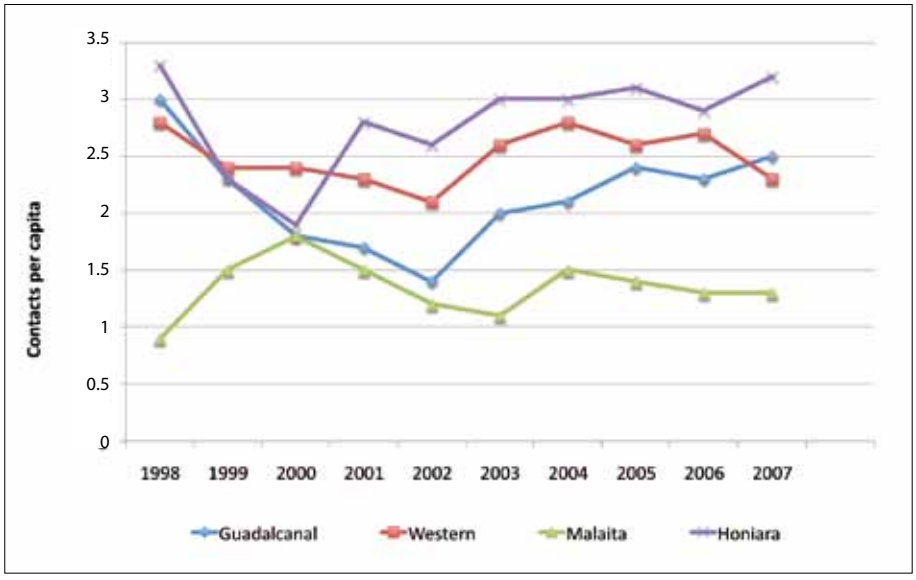
Source: MHMS 2009

Children's health

Case fatality data from most hospitals is incomplete or absent, and was particularly so during the years of the civil conflict. Common causes of hospital admission in children aged 1–60 months are malaria, ARI, skin infections, diarrhoeal disease, tuberculosis, trauma, and bone or joint infections. The common causes of admission for neonates are sepsis (skin infection, pneumonia bacteraemia, ophthalmitis and cord infection), prematurity, low birth weight, and birth asphyxia. Admissions data from the National Referral Hospital for 2008 show rates for antenatal (9%), paediatrics (9%) and special care nursery (7%) wards ranking third and fourth, beaten only by postnatal (36%) and gynaecology (10%) and surgical (10%) wards. Child welfare contacts per capita (Figure 3.2) at the primary health clinics have been around two for the last 10 years. Disaggregation of data on contacts by province shows greater disparity, with Malaita having the lowest contacts per capita, while Honiara has relatively the most contacts. Table 3.1 shows progress in Solomon Islands on childhood health indicators.

Infant and under-5 mortality rate: At the National Referral Hospital, where the only comprehensive disease-specific case fatality data exist, the common causes of childhood deaths were pneumonia, malaria, acute gastroenteritis and meningitis. Among neonates, the most common causes of death were complications of prematurity and low birth weight, sepsis and birth asphyxia (MHMS 2007). Household income survey data show that 13% of children under age 5 are malnourished, while the 2007 Solomon Islands Demographic and Health Survey (SIDHS) findings show that 2.4% of children are severely underweight, increasing the risk of morbidity and mortality as well as impairment in mental development.

Figure 3.2: Child welfare contacts per capita



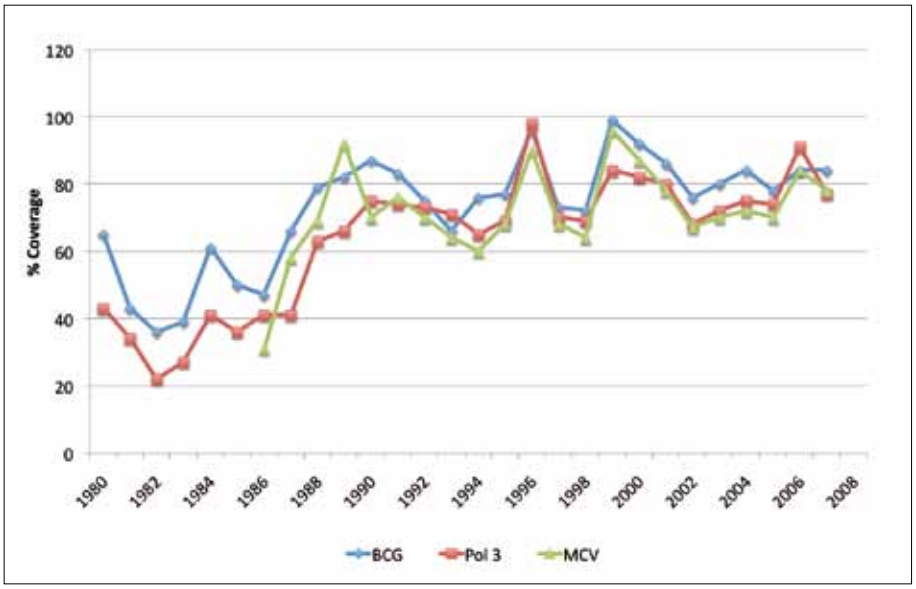
Source: MHMS 2009

Table 3.1: Progress on child health indicators

Indicators	1990	2000	2006	2007
Under-5 mortality rate (per 1,000 live births)		73	73	37
Infant mortality rate (per 1,000 live births)	96	66	55	26
Neonatal mortality rate (per 1,000 live births)				17
Proportion of children aged 1 immunised against measles (%)	61	55	80	87
Proportion of children aged 12–23 months vaccinated with BCG (%)	87	92	84	83
Proportion of children aged 12–23 months vaccinated with three doses of DPT (%)	77	82	91	79
Proportion of children aged 12–23 months vaccinated with polio (%)	75	82	91	77
Proportion of children aged 12–23 months given Vitamin A dosing and deworming				

Source: MHMS 2006a; National Statistics Office (NSO), SPC & Macro International 2009; WHO/UNICEF 2008

Figure 3.3: BCG and polio 3 immunisation coverage, 1980–2007

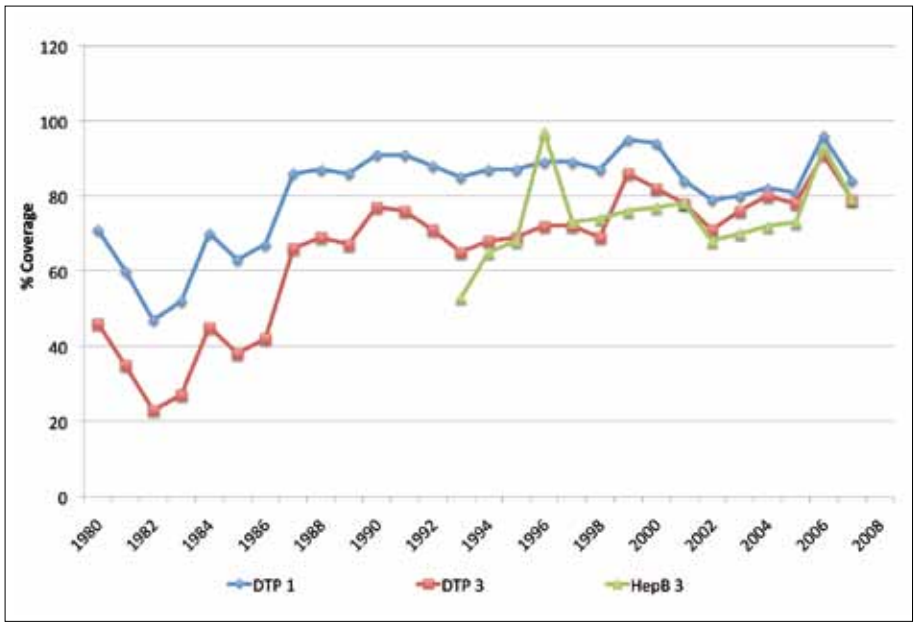


Source: WHO/UNICEF 2008

Immunisation coverage: According to WHO, a child is considered fully vaccinated if he or she has received a BCG vaccination against tuberculosis; three doses of DPT vaccine to prevent diphtheria, pertussis, and tetanus (DPT); at least three doses of polio vaccine; and one dose of measles vaccine. Health facilities throughout Solomon Islands maintain routine weekly schedules when mothers can bring their babies in for vaccinations and receive family planning advice from nurses.

Figures 3.3 and 3.4 show the coverage for BCG, last dose of polio, and the first and last doses of DPT and measles immunisations.

Figure 3.4: DTP immunisation coverage, 1980–2007



Source: WHO/UNICEF 2008

The 2007 SIDHS findings suggest that overall, 83% of children aged 12–23 months were fully vaccinated with BCG, measles and three doses of DPT and polio. BCG coverage was slightly higher than other vaccines. There seems to be little variation in coverage between urban and rural areas, although, children born to uneducated mothers are less likely to receive full immunisation (67.2%) compared with 86% of children whose mothers have at least secondary schooling. A considerable drop-out rate of coverage is seen with each subsequent dose of DPT and polio vaccines. This pattern is consistent with health information system (HIS) records. Male babies in Solomon Islands are getting better immunisation coverage at 90% overall, while only 75% of female babies are fully immunised. The drop-out rate for female babies is also markedly higher than for male babies. Lower immunisation coverage for female babies is probably a reflection of their lower status, which is still the case in Melanesian societies, particularly those in rural areas with children born to less educated parents.

UNICEF and WHO continue to support cold chain equipment and vaccine supply through the National Medical Store (NMS). The high cost of gas for refrigerators to maintain cold chains and vaccine stock-outs in addition to transportation costs, continue to be constraints to further improvements in the Expanded Programme on Immunisation (EPI) coverage. Introduction of solar photovoltaic refrigerators in some isolated clinics is a positive improvement to the cold chain system. Spot checks in 2008 found that all facilities visited had functional cold chain equipment (with backup plans) and all EPI vaccines in stock. However, records of refrigerator temperatures were extremely variable and in most cases unmonitored, unserviceable and unsuitable for the purpose (Foster et al. 2009). This was also the case in the NRH paediatrics ward storage refrigerator.

In July 2008, MHMS introduced the pentavalent vaccine, a combination of five vaccines (DPT/Hep B/Hib). Introducing the pentavalent vaccine means fewer trips to clinics for child immunisation. This is especially important for mothers who have to walk long distances carrying their babies to the clinic. It also simplifies administration, making it less likely to miss an individual dose of the vaccine, directly contributing towards higher overall coverage against all individual vaccines. Outreach programmes by provincial nurses and doctors are limited.

Maternal care

Table 3.2: Progress on maternal health indicators

Indicator	1990	2000	2005	2006	2007
Maternal mortality ratio (per 100,000 live births)	550	195	184	223	103
Delivery in health facility				86	79
Proportion of births attended by skilled birth professionals (%)	85		82		86
Antenatal care				76	95
Postpartum care					57
Postnatal visit	91	91		94	
Mothers who received postpartum care from a health professional for their last birth					58
Mothers who received their first postpartum checkup within 2 days of delivery of last birth					51
Total fertility rate	5.8	4.8			4.6
Contraceptive prevalence rate (%) - % married women aged 15–49		10			11

Source: MHMS 2009; MHMS 2008; SPC 2009

Table 3.2 shows progress in Solomon Islands on maternal health indicators.

Maternal mortality ratio: The maternal mortality ratio has decreased from the early 1990 level but is still relatively high at 73 in 2008. The United Nations Population Fund (UNFPA) Facility Assessment for Family Planning and Obstetric Care in 2006 found that the most common causes of maternal deaths were postpartum and antepostpartum haemorrhage, puerperal sepsis, complications from malaria in pregnancy, and pregnancy-induced hypertension. Stock-outs of essential antibiotics to treat puerperal sepsis, and distance and delays in transferring women with complications to centres that provide emergency obstetric care have been major contributing factors to high incidences of maternal deaths. Women of childbearing age also experience high rates of domestic violence, which cannot be ruled out as a contributing factor in some cases. With WHO support, a midwifery school has been established with the goal of eventually training every nurse, particularly those working in rural areas.

Antenatal care (ANC): Antenatal attendance is high at 95% in 2007. However, coverage for very young mothers (under age 20) tends to be slightly lower. A separate study found that first ANC attendance is usually late, at 19 weeks of gestation, and is infrequent with more than 64% of pregnant women making less than 50% of the recommended number of ANC visits (Appleyard et al. 2008). Maternal health education is usually conducted during antenatal clinics. However, rural nurses reported that health education was not usually carried out because there was insufficient time to cover all required topics. Many pregnant women rush their ANC visit as they had 'many things to do' or that their shared transport is waiting for them. Understaffing of rural health centres also affects nurses' ability to conduct (maternal) health education.

Tetanus toxoid immunisation coverage: Tetanus toxoid (TT) immunisation is given to pregnant women in order to prevent neonatal tetanus – one of the leading causes of neonatal death in developing countries. A woman needs two doses of TT during her pregnancy for full protection. Twenty six per cent of all women claimed to have received two or more TT injections

during their last pregnancy, and just over half had their last pregnancy protected against neonatal tetanus due to previous immunisations.

Child birth care: Eighty-five per cent of births in Solomon Islands are delivered in health facilities while 14% of births take place at home. Guadalcanal Province reported higher percentages of home deliveries (at 29%), followed by Malaita (at 18%), and other provinces (at 9%). Eighty-six per cent of deliveries were attended by a health professional. Mothers with some education and mothers living in urban areas were more likely to get medical support than less educated women in rural areas. Guadalcanal Province reported the lowest percentage in deliveries attended by a skilled provider (at 69%) followed by Malaita Province (at 82%).

Postpartum care: According to the 2007 SIDHS, over one-quarter of women who gave birth in the five years preceding the survey did not receive any postpartum care, 57% were seen for their first postpartum checkup by a doctor, nurse or midwife, 14% were seen by an auxiliary nurse or midwife, and less than 2% were seen by other health providers, including traditional birth assistants.

Teenage pregnancy and motherhood: Teenage pregnancy increases the risk of morbidity and mortality for both mother and child. It is also associated with unprotected sex for young women, leading to unwanted fertility and a higher risk of sexually transmitted infections (STIs). Teenage pregnancy can result in adverse consequences for girls, such as loss of educational opportunities and high rates of single mothers struggling to raise children on their own. Early childbearing is also associated with higher fertility levels.

SIDHS findings show that 12% of women in Solomon Islands begin childbearing at ages 15–19. More women who have begun childbearing reside in rural areas, have only a primary education, and live in the fourth, second and lowest wealth quintiles. Across the region, women from Guadalcanal are more likely to have begun childbearing earlier (13%) than those women from other regions. The mean age of first sex was 17.3 years for women aged 15–24 and 18.3 years for women aged 25–44 (NSO, SPC & Macro International 2009).

Fertility and family planning coverage: The fertility ratio is 4.6%, only a modest reduction of 0.2% from 4.8 recorded in the 1999 census. The rural fertility rate is higher than the urban rate, at 4.8 and 3.4 births, respectively. Regardless of the slight decrease in adolescent fertility in the last 20 years (111 live births to 70 live births per 1,000 women), there is evidence of continued early childbearing. According to 2007 SIDHS results, 12% of women start childbearing aged 15–19, and 9% of them are mothers at 15 years old. The median age at first birth made a modest increase from 20.8 to 21.6 years.

With the vast majority of Solomon Islands women reporting some problem in accessing health care, it appears prudent to take note of reported service deficiencies. Guadalcanal reported the highest proportion of women noting problems in accessing services, as well as the lowest number with skilled providers assisting during childbirth.

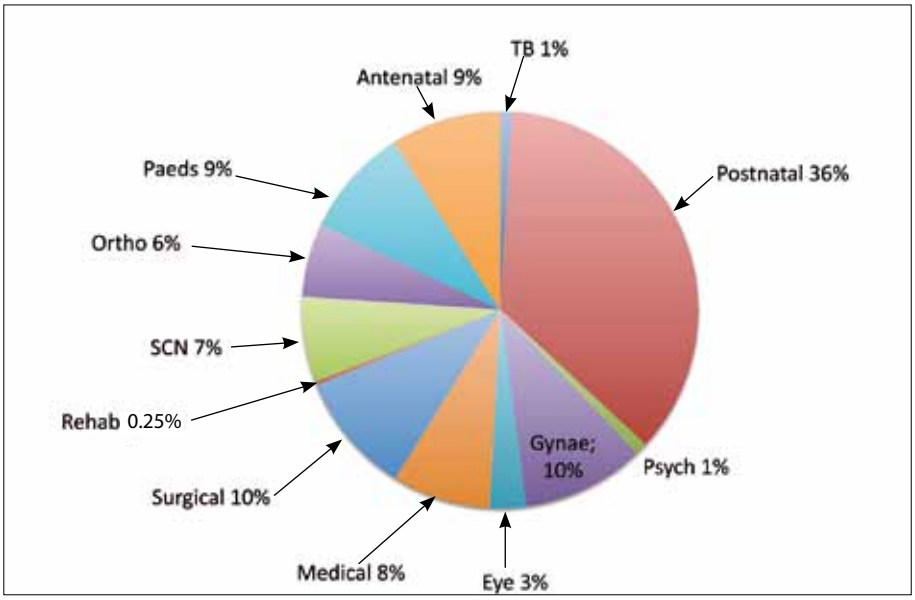
Attention is needed on timing and quality of ANC. With the median gestational age at first visit almost in the third trimester, a more proactive approach encouraging women to attend earlier is needed. In addition, TT coverage is quite low, with just over half of women reported to have had their last pregnancy protected.

With a quarter of women reporting no postpartum service coverage, it is unclear from the survey whether this is due to a lack of access or a lack of service uptake; however, it would be good sexual and reproductive health practice to bring coverage closer to 100 percent.

Source: SISO, SPC & Macro International 2009

Family planning coverage is about 35% of the total existing demand. SIDHS 2007 show that the total demand for family planning services for currently married women is 46%. Overall, 11% of currently married women have an unmet need for family planning services in Solomon Islands, of which 7% were birth spacers and 4% birth limiters. Younger women less than 35 years are less likely to have their family planning needs met. Additionally, demand for birth spacing is more common in younger and rural women, while the demand for birth limiting is common in older and urban women. A similar pattern is observed in men.

Figure 3.5: Hospital admissions by ward, 2008



Source: MHMS 2009

Disease burden and trends

Morbidity and mortality

The disease burden in Solomon Islands is a mix of communicable public health issues and rapidly growing lifestyle diseases such as diabetes, obesity, hypertension, cancers, and potentially HIV (MHMS 2008). Services by MHMS in some areas are more effective than others, such as family planning, facility-based deliveries, and non-communicable disease prevention and early detection.

Hospital admissions by ward: Data from the hospital admissions give an indication of disease burdens and trends. Figure 3.5 shows NRH admissions by ward in 2008.

Besides postnatal, NRH admissions in 2008 was led by the gynaecology, surgical, antenatal, paediatrics, medical and SCN wards. This highlights the disease burden of women and children's health as well as non-communicable diseases, as highlighted by the 10% of admissions into the surgical ward being for diabetic vascular disease. The total hospital death rate is 5.3%.

Contacts at the PHC level show a consistent pattern over the last 10 years, with ARI, fever and clinical malaria being the primary reasons for health care attendance. These are followed by skin diseases, ear infection, diarrhoea, yaws and red eye. At the PHC level, the burden of diseases is still with communicable diseases. Consistently low levels of contacts with diseases relating to sexual and reproductive health (e.g. STIs, penile or vaginal discharge, genital ulcers) probably have more to do with a lack of presentation of cases at health care centres, and not low rates of incidences. It is important to note that other unlisted diseases are lumped into the 'other' category, making it difficult to detect changing patterns or emerging diseases from the reports.

Communicable diseases

Acute respiratory infection: More than one-third of PHC contacts over the last 10 years have been for ARI. Children under age 5 years are particularly vulnerable to ARI, which is one of the common causes of hospital admission for children aged 1–60 months in Solomon Islands. Admissions to the paediatric ward in NRH ranked the third highest in 2008. ARI contacts for 2008 were 30% of total contacts, an increase of 38% from 2007. This pattern is either a result of better access to health services or improvements in health-seeking behaviour. Alternatively, it may also be an indication of a general deterioration in the quality of life. The

2006–2007 household income and expenditure survey (HIES) found that about 61% of children under age 5 were reported to have asthma.

Skin diseases, diarrhoea, yaws, red eye: Consistently high incidences of these diseases is an indication of general exposure to poor environmental health conditions, unhygienic practices, and limited access to proper or improved water and sanitation facilities.

Leprosy: Seventeen new cases of leprosy were reported in 2008, giving a case notification rate of 2 per 100,000 population. The national prevalence of leprosy in 2007 was 2.4 per 100,000.

Tuberculosis: The total number of tuberculosis (TB) cases reported in 2008 was 387, making the case notification rate of 75 cases per 100,000 population. The case detection rate (SS+ve) was 48%, falling far below the estimated incidences of 70% by WHO. Case notification rates in some provinces remain very low (Figure 3.6) (MHMS 2009).

Table 7: Proportion of PHC attendance by contacts (%), 1998–2008

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ARI	18.3	21.4	18.7	20.6	19.4	17.9	20.9	21.3	22.7	21.1	29.1
Diarrhoea	2.6	2.2	1.9	1.5	1.5	1.7	1.7	2.4	1.9	2.4	2.2
Fever	19	17	16	16.4	17.6	15.4	14.5	13.6	13.6	12.6	10.7
Red eye	2	2.3	1.7	1.6	1.5	1.3	1.3	1.7	2.1	1.7	1.7
Yaws	2.7	2.5	2.8	2.3	2.9	3.7	2.5	2.3	1.9	2	2.2
Skin diseases	7.1	5.8	5.6	4.8	4.8	4.8	4.8	5	4.4	5.5	5.3
Ear infection	2.9	2.9	2.7	2.8	2.7	2.9	2.9	3	2.9	3.2	3.4
Vaccine preventable	0.003	0	0.006	0.002	0.005	0.001	0.003	0.022	0.003	0.008	0.013
STI	0.3	0.3	0.3	0.3	0.2	0.3	0.3	0.4	0.5	0.6	0.4
Penile discharge	0.13	0.12	0.12	0.09	0.1	0.12	0.11	0.11	0.2	0.2	0.12
Vaginal discharge	0.11	0.11	0.13	0.11	0.1	0.1	0.14	0.18	0.23	0.28	0.16
Genital ulcer	0.04	0.06	0.05	0.06	0.04	0.04	0.04	0.12	0.04	0.1	0.07
Clinical malaria	13.9	14.3	16.4	17.5	18.9	20.8	17.4	17	15.8	15.4	11.9
Other	31.4	31.4	34.1	32.4	30.6	31.4	33.8	33.4	34.3	35.7	33.3
Solomon Islands	861,758	814,411	852,959	849,049	744,956	792,341	918,739	960,002	1,071,746	972,732	616,376

Source: MHMS 2009

Figure 3.6: Case notification by provinces (all cases), 2008

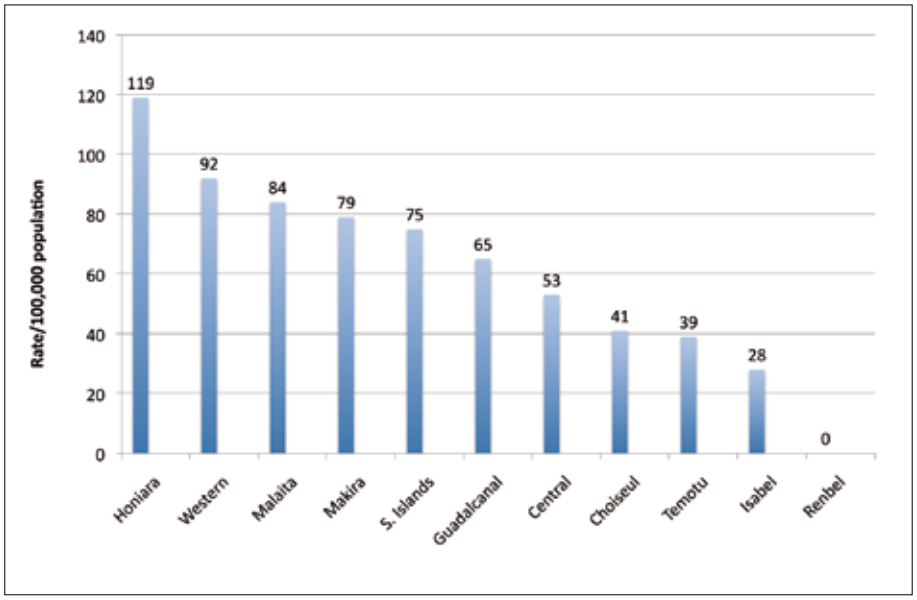
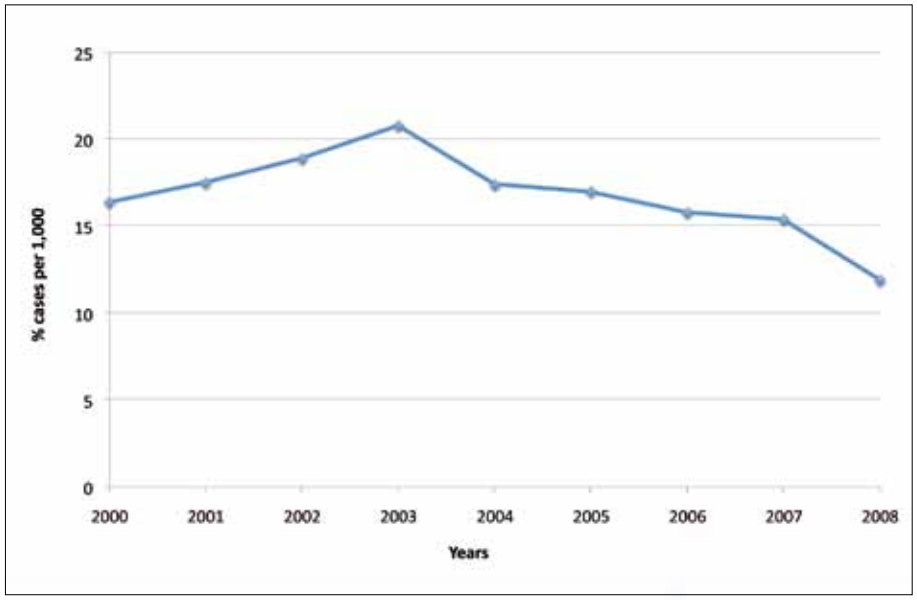


Figure 3.7: Trend in malaria incidences



The cure rate for sputum smear-positive cases in 2007 was 75%, while the treatment success rate was 92% at the national level. Smaller caseloads in some provinces meant very high treatment success rates. The TB death rate in 2007 was 7%. Delayed case detection is an issue, with many cases diagnosed in advanced stages. TB, like other viral diseases, has the potential to become an epidemic given the very common and unhealthy behaviour of betel nut spitting among Solomon Islanders.

Malaria: Malaria has been one of the most common causes of death in Solomon Islands, and the country still has the highest incidence outside of Africa. Up to 25% of PHC contacts throughout the country are for malaria and fever. Incidences peaked at the height of the ethnic tension. However, there has been a sustained reduction in incidences to pre-conflict levels since political stability has been attained. Figure 3.7 highlights the decreasing trend in incidences of malaria since its peak in 2003 for Solomon Islands.

Figure 3.8: Annual parasite incidence by province and insecticide treated net distribution

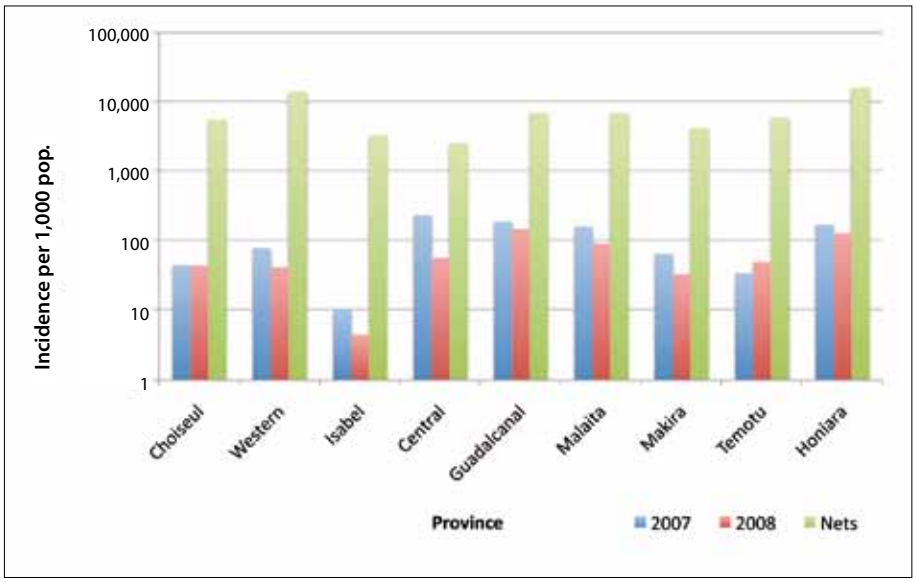


Figure 3.8 shows annual incidence per 1,000 population as well as insecticide treated net (ITN) distribution. The highest incidence in 2008 was rural Guadalcanal followed by Honiara, Malaita and Central provinces. In 2007, Choiseul Province had the highest annual death rate due to malaria followed by rural Guadalcanal, Isabel and Central provinces.

ITN distribution is highest in Western Province and Honiara, followed Guadalcanal, Malaita and Temotu. ITN distribution by population indicates that per capita distribution is disproportionately higher in smaller provinces.

Sexually transmitted infections (STIs): Provincial health centre contacts show that incidences of STIs continue to increase. According to MHMS, STIs, endemic chlamydia and syphilis are common among pregnant women. Data are available on routine screenings of pregnant women during antenatal care in urban and few rural centres that have such facilities. The findings of the tests carried out during the Second Generation Surveillance of Antenatal Women and Youth in 2008 (SPC and MHMS 2008) shows trichomonas was the most commonly detected STI (23% among women aged 15–24, and 14% among women aged 25–44) followed by chlamydia (16% among women aged 15–24, and 6% among women aged 25–44). Among youth, nearly 20% of females and 10% of males who were tested had chlamydia, 10% of youth tested had active syphilis, and 3% had gonorrhoea. Given the disease pattern, it is possible that there are many healthy people who may not know about their status or knowingly do not seek medical help in order to avoid embarrassment. There seems to be no correlation between knowledge of STIs and HIV and AIDS, and behavioural change as seen by the involvement of youth in high-risk unprotected sexual behaviours. The Second Generation Surveillance found that among youth, 99% of males and 97% of females had heard of HIV or AIDS prior to taking part in the survey. However, only 30% of males and 25% of females reported using a condom the last time they had sex. Knowledge of HIV was high, with each knowledge question correctly answered by 80 to 90% of youth. Two-thirds of males (66%) and 54% of females correctly answered all five United Nations General Assembly Special Session questions on HIV transmission and major misconceptions (SPC and MHMS 2008).

Non-communicable diseases

Type 2 diabetes, obesity, cancer, cardiovascular and cerebrovascular diseases are increasingly becoming main causes of death in Solomon Islands.

Diabetes: Diabetic cases (type II) have steadily increased over the last eight years (2000–2008), particularly among those aged 30 and older, with cases among men higher than among women. HIS data from 2006 shows that 90% of these cases were Melanesians, followed by Micronesians at 4% and Polynesians at 3% (MHMS 2006c). Diabetic vascular disease accounted for 10% of surgical ward admissions at NRH in 2008, while admissions at operating theatres and clinics accounted for 3%. Hypertension is the leading complication in diabetic patients, and is becoming a serious problem in the country. Generally, diabetic patients do not seek medical help until later stages of the disease. Dedicated diabetes clinics have been established at NRH and other hospitals in response.

Obesity: The 2006–2007 SIDHS found that 44% of women, 29% of men and 0.8% of children were obese, with urban residents of higher education levels more likely to be obese. Obesity increases the risk of diabetes, hypertension and other diseases.

Oral and pharyngeal cancers: Solomon Islands has the highest prevalence rate in betel quid chewing, and its oral cancer incidence ranked second in the world (Tovosia et al. 2007). Research has shown that the starting age for both smoking and betel nut chewing has decreased to very early teens or younger. Early exposure to carcinogenic substances increases the risk of cancers. A Tobacco Control Bill was passed in Parliament in March 2010.

Cervical and breast cancer: Increasing incidence of cancer cases are being seen at NRH. According to NRH Gynaecology Ward medical officer, Dr Zutu, cervical cancer is among the most prevalent forms of cancer observed. An increasing number of Solomon Islands women aged 20–35 are being diagnosed with cervical cancer, mostly from the provinces, in particular Temotu and Makira. Unfortunately, the majority of cases were sent home as nothing else could be done to assist them because the cancer had reached the last stages. Most of these women did not survive. Cervical cancer is the leading cancer in the country followed by breast cancer.

Early detection is one of the biggest challenges of the National Cancer Program because of a lack of facilities and equipment in some of the provincial hospitals, and no equipment at all in any of the rural clinics. Tests are sent to Australia, and it usually takes six to eight weeks for the results to be released, depending on payment. Delays at NRH also affect private medical clinics because they depend on NRH to send and receive test results. Women in rural areas are not well informed or educated about reproductive health, and they need to overcome socio-cultural barriers, as well as embarrassment and fear, so that they can be checked by health professionals.

Emerging health issues

H1N1 (swine flu) and avian flu: With the H1N1 virus now declared pandemic and unstoppable (according to WHO), the virus will, at some point, reach Solomon Islands. Health officials are concerned that dirty habits such as spitting betel nut, sharing cigarettes, and using the same lime for betel nut chewing are ways that the virus will potentially spark a 'wildfire' in the country. MHMS does not have sufficient medication, facilities or human resources to deal with an H1N1 epidemic. SPC and WHO have brought in some H1N1 medications (Tamiflu) but the supply will not be sufficient should there be a full-blown epidemic. Clear guidelines need to be developed to assist in prioritising the use of the available flu medication. Available supplies of antibiotics, oxygen, and IV fluids in rural health facilities is a challenge as most people who get very sick and die during an influenza pandemic have developed secondary bacterial pneumonia.

HIV: The number of HIV-positive cases has increased from 4 in 2004 to 12 in 2008. HIV testing is only available at 12 health facilities throughout the country, and given that testing is voluntary, relatively low number of tests can be performed at each site. The prevalence of STIs in the country is an indication of how quickly HIV will spread among the population, particularly with a HIV being a generalised epidemic in neighbouring Papua New Guinea. Embarrassment and fear of being stigmatised keeps people from getting diagnosed. The 2007 SIDHS found that 61% of women and 70% of men know that consistently using a condom can reduce the chances of getting HIV and AIDS. However, only 18% of women and 26% of men involved in high-risk sex used condoms in the 12 months prior to the survey. The Second Generation Surveillance found that among youth, only 30% of males and 25% of females used a condom the last time they had sex, regardless of having knowledge of the disease. Only 2.5% of pregnant women reported that they had ever had an HIV test and received the results. Less than 7% of youth reported ever having an HIV test. It is therefore possible that the number of cases is much higher than the officially documented cases.

Mental health: Statistics on contacts and admissions of mental health patients continue to increase. This could be the result of increased outreach and detection by the mental health services and the workforce. It is also possible that the violence, fear and many other social problems experienced during the tension years – coupled with increased consumption of alcohol, locally brewed kwaso, drugs (marijuana) and increasing rates

of family breakdowns – is causing mental disturbances, instability, depression and suicide attempts particularly among youth, uneducated and unemployed people. The National Mental Health Strategy 2006–2010 provides a framework for action for mental health care in Solomon Islands. This integrated mental health model covers a wide spectrum of mental health interventions – from mental health prevention and promotion, to mental health care for people suffering from mental disorders of different levels of severity and/or complexity.

The main psychiatric centre is located at Kilu'ufi hospital in Malaita Province, and not in Honiara, creating complex issues with regard to services by other provinces. In 2008, 73% of admissions at Kilu'ufi psychiatric unit were from Malaita, while the remaining 27% were referrals from the rest of the country, including 23% from NRH. Both Kiluúfi psychiatric unit and the Acute Ward at NRH are recording high rates of relapses (75 and 73%, respectively). This calls for better family, community and PHC support of patients who have been treated and released from the psychiatric units.

Chapter 4: Determinants of health

Early childhood development

Early childhood development – including physical, social or emotional, and language and cognitive domains – has a determining influence on subsequent life chances and health through skills development, education and occupational opportunities

Family support: The extended family network is the first line of support available to families in Solomon Islands. In rural areas where a subsistence lifestyle allows flexibility, caring of children and sharing of food is very common. This sharing and caring helps to keep family ties strong and always ensures children have an adult to take care of and raise them. 'Adoption' is a very common practice in Solomon Islands, and is done without any negative connotation that it usually carries in western countries. Such support from families however, is getting overwhelmed and disintegrating quickly due to many changes in lifestyle and economics (monetisation) thereby affecting the ability of potential caregivers to provide the needed care.

Education: The level of education attained can have a significant influence on an individual's demographic and health behaviour. There is a strong connection between education level and contraceptive use, fertility, general health status, morbidity and mortality of children. In Solomon Islands, primary education is free but not compulsory. As of early 2009, fee free basic education is available up to grade 9 for all children.

Figure 4.1: Educational attainment of Solomon Islanders

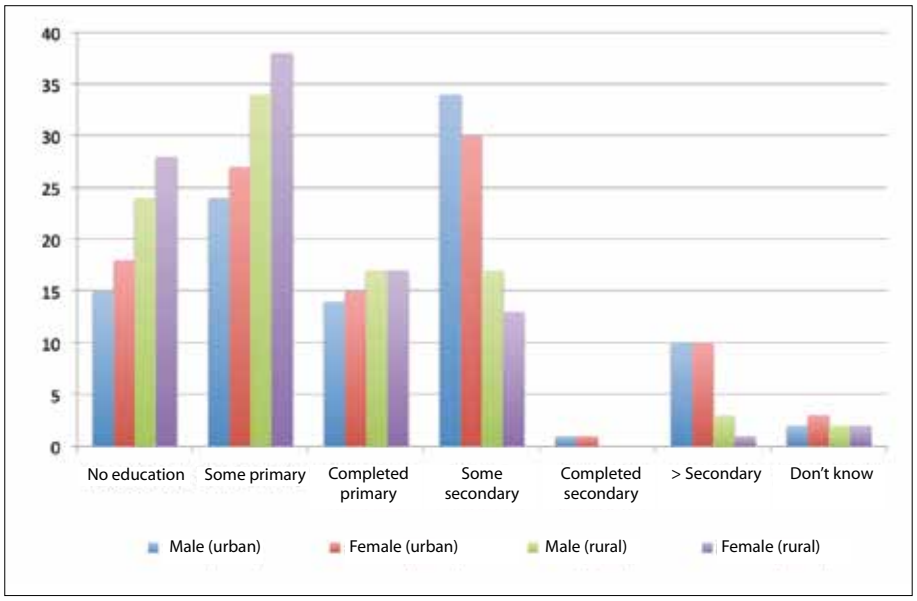


Figure 4.1 shows the findings of the 2007 SIDHS on educational attainment of both rural and urban male and female Solomon Islanders. The majority of Solomon Islanders have attended some school, with a higher concentration in primary education for rural males and females. The pattern is reversed at secondary school where school fees apply and the attendance rate for lower income rural children drops off; urban males and females dominate at 34% and 30%, respectively, as opposed to 17% and 13% for rural males and females. Among the lowest wealth quintile, males have better opportunities to go further into secondary education than females. Those in the higher wealth quintiles have better chances of completing secondary school and beyond. The 2007 SIDHS also found that most children in Solomon Islands enter primary school later than age 6 – the official primary age of primary education. Education can help people break free from the poverty cycle, although there must be strategies in place that improve opportunities to complete secondary education, particularly for those from lower wealth quintiles. Survey results have also shown that better educated women take better care of their children

Services for disabled children: Services offered to disabled children are very limited and mostly urban based. This includes services provided by MHMS through NRH and provincial hospitals (community-based rehabilitation [CBR], rehabilitation division, TB and leprosy) and a few NGOs (e.g. the Red Cross Society, Disabled Association, Blind People's Association), most of which depend heavily on donor funding for continuity (MHMS 2006c). Disabled children in rural areas do not have access to most of these services.

Nutrition: According to the 2007 SIDHS, 'Adequate nutrition is critical to child development, and the period from birth to two years of age is important for optimal growth, health and development. Unfortunately, this period is often marked by faltering growth, micronutrient deficiencies, and common childhood illnesses such as diarrhoea and acute respiratory infections (ARI). Poor nutritional status is related to maternal malnutrition, low birth weight, inadequate breastfeeding and weaning diets, and childhood diseases' (NSO, SPC & Macro International 2009).

The SIDHS findings showed that 2.5% of children were overweight while 2.4% of children were severely underweight. Consumption of vitamin A-rich foods is high at 90.6% while consumption of iron-rich foods is very low at 32%. One-third of all children surveyed by SIDHS had mild iron deficiency or anaemia. According to HIS data, 13% of children under age 5 are malnourished, which results in an increased risk of morbidity and mortality as well as impairment in mental development. The findings further highlighted that 44% of women of child-bearing age were anaemic, of whom, 60% were pregnant. Health officials believe that this is an underestimation of anaemic cases due to a lack of proper equipment in most health facilities. The nutritional status of people is also heavily influenced by changing dietary preferences (e.g. a shift from root crops to white rice and noodles), and the cost of living in urban areas being far more expensive than the disposable income of most people in formal employment.

Child safety: Solomon Islands has been a member of the International Labour Organization since 1985 but has not ratified C 182 – Worst Forms of Child Labour Convention or C 138 – Minimum Age Convention. However, of the 14 conventions that have been ratified to date, two deal specifically with children and young people: C 16 – Medical Examination of a Young Person (SEA), and C 81 – Labour Inspection Convention. The Labour Act has established the minimum age for admission to employment at 12 years with exceptions allowed for children employed by or in the company of their parent or guardian in light work or agricultural and/or domestic work, or other forms of employment as may be approved by the Minister of Labour. Children under 12 are prohibited from working in any capacity in the industrial or commercial sectors.

The National Advisory Council on Children was established in 1993 and ratified the Convention on the Rights of the Child in 1995. A children's desk officer – established within the Youth, Women and Sport Division of the Ministry of Home Affairs – was responsible for monitoring the coordination of national programmes and actions that focused on children. From 2007, the newly established Ministry of Women, Youth and Children's Affairs has been the focal point for implementing child-related programmes and policies. While the establishment of the Ministry of Women, Youth and Children's Affairs was an important step towards recognising the need to deal with the situation of women and children, there has not been sufficient political will to support the implementation of necessary changes.

The Royal Solomon Islands Police Force established a Domestic Violence Unit and developed a Family Violence Policy and the Sexual Assault Unit. It is also working in collaboration with Social Welfare at MHMS in its Child Protection Program and the Christian Care Centre on the Commercial Sexual Exploitation of Children. A refuge for women and children who experience violence was established at the Christian Care Centre in 2005 (UNICEF 2008).

Environment and healthy settings

Urban and community planning

Urban areas: The Physical Planning Act (and related legislation) provides the basis for urban planning on crown land in Solomon Islands. The Act is in desperate need of updating and enforcement, particularly in Honiara. In reality there is no form of physical planning taking place in Honiara. This lack of proper urban planning (buildings and services) and monitoring of standards is contributing to poor quality of basic services (e.g. water and sanitation, access roads, electricity), overcrowding, lack of public spaces, and a general absence of standards.

Rural areas: Customary land is not subjected to any particular legislation or regulation except for those relating to economic activities such as the Forestry, Mining, Fisheries and the Environment Acts. This leaves the responsibility of appropriate physical development on customary lands to clans and landowning groups. Influential and selfish individual landowners, in partnership with foreign loggers, have therefore manipulated the lack of overall land-use regulation and exploited the resources at the expense of the rest of the landowners, leaving them vulnerable to many unwanted environmental problems. Unsustainable logging and the traditional slash-and-burn agriculture is systematically destroying soil quality (a food security issue) and is reducing the quality of rivers and streams. Climate change will only make problems relating to food security and water quality and availability more severe in the near future.

Table 4.1: Percentage of household final consumption expenditure at constant 2004 prices

	Constant 2004 prices (SIB millions)				
	2003	**2004**	**2005p**	**2006p**	**2007p**
Food	57.7	54.9	54.2	54	53.9
Beverages and tobacco	2.9	3	3	3	3
Clothing and footwear	1.7	1.8	1.8	1.8	1.8
Housing, water, electricity, gas and fuels	19.5	20.2	20	19.7	19.3
Furnishings, household equipment and routine maintenance	3.1	3.2	3.1	3.1	3.2
Health	2.1	2.2	2.2	2.1	2.2
Transport	4.5	5.9	7.3	7.8	7.9
Leisure, entertainment and culture	0.8	0.8	0.8	0.8	0.8
Education	4.3	4.5	4.4	4.3	4.4
Hotels, cafes and restaurant	0.9	1	1	1	1
Miscellaneous goods and services	2.5	2.5	2.5	2.5	2.6
Total household final consumption expenditure	**1863**	**1884**	**2000**	**2098**	**2152**

Source: NSO 2008
p – projected final consumption expenditure

Housing: Crown land in Honiara and other urban areas is very limited. The arrival of RAMSI and foreign development workers (donor personnel) has created a housing shortage and has increased rental prices above the affordable range for most Solomon Islanders on a local salary. Housing and utilities account for 19–20% of an urban family's expenditure, surpassed only by food, which accounts for up to 54% of household spending (Table 4.1). Urban drift, leading to higher levels of unemployment and growing numbers of people living in squatter settlements and sub-standard housing conditions, contributes to further deterioration of urban social environments. Many of the poor live in low-quality housing without proper access to water, sanitation and other basic services. Poor housing conditions lead to poor health, poor employment prospects, and poor educational attainment. According to data from the 2006–2007 SIDHS, one-fifth of all households (19.4%) use only one room for sleeping. The percentage of household members in rural areas (21%) who sleep in one room is higher than in urban areas (11%). Households in urban areas are more likely to use two or more rooms for sleeping than households in rural areas.

The type of fuel used for cooking, the location where food is cooked, and the type of stove used are all related to indoor air quality and the degree to which household members are exposed to the risk of respiratory infections and other diseases. About 13% of Solomon Islanders cook in the same house, while 82% use a separate building. Smoke from solid fuels for cooking (e.g. charcoal, wood, and other biomass fuels) is a major cause of respiratory infections. Clean fuel is not affordable in most cases and most households (92%) resort to using solid fuels that emit a lot of smoke. As a result, household members are likely to be exposed to air pollution.

Water and sanitation: Sixty-four per cent of urban households have water piped into their house or yard. Water in most urban areas is provided by Solomon Islands Water Authority, which is inconsistent and unreliable, leaving families without water for days. Access to piped water into locations close to homes in rural areas in Solomon Islands is very low at 25%. Considering that 85% of the country's population lives in rural areas, this means that the majority of the rural population lacks access to an improved water

supply. People are therefore dependant on tanks, dugout wells, and streams and rivers that are prone to contamination. Six out of ten rural households throughout the country do not have access to an improved or non-shared sanitation facility (NSO, SPC & Macro International 2009).

Exposure to diarrhoea-causing agents is frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta. The proper disposal of human faeces is extremely important in preventing the spread of diseases. Findings from the 2006–2007 SIDHS show that only 29% of children's stools were disposed of hygienically (i.e. the waste was put into a toilet or latrine, or buried, or the child used a toilet or a latrine), while almost half of all children's waste was thrown into the river or the sea. It is not surprising that the safe disposal of children's stools is higher in urban areas (81%) than in rural areas (22%) given the very low availability of sanitation facilities in rural areas (29%).

Waste management programmes: As with many Pacific Island countries, waste management is a serious problem, particularly in urban areas. The Honiara Town Council and other provincial authorities have not been able to provide household waste disposal services to most residential neighbourhoods since the late 1990s. Households dispose of their kitchen waste either by bringing it to bins along the main road in town, or throw it to nearby bushes, which is a serious health hazard as it provides ideal breeding places for mosquitoes (as evidenced by the very high incidences of malaria in Honiara. It also poses a potential for an explosive outbreak of dengue fever should there be an introduction of the virus from overseas, for example Queensland, Australia where dengue is endemic.

Access to land: Customary ownership of land has ensured that families and extended families share and have access to land for gardening and other subsistence activities. However, activities such as large-scale unsustainable logging operations and poor agricultural practices are leaving people vulnerable to poor harvests, thus making them prone to a reduction in food security. While there is no documentation on food shortages in the country, there is ample ad hoc evidence from rural people who report that their gardens are routinely flooded or destroyed by pigs, in addition to having normal land pressures that are the result of a rapidly increasing population. Committing large plots of land to commercial agriculture without taking into account the daily needs of the rapidly growing population will become a problem in most places in rural Solomon Islands in the near future.

At least one group of Solomon Islands citizens, those who originate from Kiribati, are disadvantaged because of their lack of customary land ownership rights. Other groups from small, remote outlying islands such as the Temotu Group, Ontong Java and Sikaiana are greatly disadvantaged by their geographically remote locations and the associated difficulties in receiving services provided by the government or businesses. Women and children are generally disadvantaged by because they do not play a role in decision-making with regard to land and resources.

Response to climate change: The severity and frequency of king tides has dramatically increased, resulting in higher rates of home and food losses, particularly in the atoll Islands of Sikaiana, Ontong Java, Lord Howe and the artificial islands of Malaita. On the larger volcanic islands, the high frequency of very heavy rainfalls has led to serious flooding and erosion on several islands, most recently on Guadalcanal. Threats from a reduction in food security, an increase in water-borne and infectious diseases, and losses of homes are becoming a reality for most island people. Responding to community health needs during disasters is straining the health system, and is exacerbated by the increasing threat from the spread of infectious diseases (due to a lack of access to clean water), water-borne diseases, and nutritional-related health issues.

Solomon Islands so far has been more reactive and less proactive in preparing for such disasters. There has yet to be a National Sustainable Development Strategy developed. A 'dependency syndrome' now makes people expect relief from the government and donors instead of holding onto and practicing their age-old proven food security methods, which in the past, has sustained them during lean times. Unfortunately, environmental factors combined with population growth and

unsustainable resource use practices have also weakened the ability of traditional methods to cope with severe climate related problems. The Solomon Islands government has several programmes that are intended to respond to climate change. Experience has shown, however, that government-led programmes rarely reach the intended beneficiaries in rural areas.

Table 4.2: Risk factors common to all major non-communicable conditions

Risk factor	Condition			
	Cardio-vascular disease	Diabetes	Cancer	Respiratory conditions
Smoking	x	x	x	x
Alcohol	x		x	
Nutrition	x		x	
Physical inactivity	x	x	x	x
Obesity	x	x	x	x
Raised blood pressure	x	x		x
Blood glucose	x	x	x	
Blood lipids	x	x	x	

Source: WHO n.d.

The National Disaster Committee (NDC), with support from the National Disaster Management Office (NDMO), has been coordinating relief efforts during disasters. With support from AusAID, NDC is developing a Disaster Risk Management Plan. The NDMO Strengthening Project aims to reduce vulnerability through integrated and sustainable disaster and emergency risk management. This aim is pursued through a focus on improving disaster risk management arrangements at the national and provincial levels, strengthening NDMO's institutional capacities, and building better prepared and more resilient communities. According to the AusAID 2007 Office of Development Effectiveness (ODE) report, the project has significantly improved NDMO's ability to manage a disaster as evidenced by the April 2007 tsunami response compared with cyclone Zoe in 2002. Despite these significant achievements, the review found that the project has been unable to pursue high-level advocacy with the Solomon Islands government with regard to disaster management, has had limited success in encouraging disaster risk management awareness in other government departments, and has failed to use available grant funds strategically in order to assist in building community resilience (AusAID Office of Development Effectiveness 2008a).

Personal risk factors affecting health status

Alcohol, smoking and betel nut quid: According to a recent survey, 77% of the population chews betel nut, 53% smoke tobacco and 37% drink alcohol. Tobacco/cigarette roll and betel nut stalls are a common site in all neighbourhoods of Honiara and other urban areas. Alcohol use has been rapidly increasing, with a local brew called *kwaso* readily available at affordable prices. Apparently, because of the high demand for these products, a survey in Honiara squatter settlements on livelihood options found that these products also provide the most lucrative income generation options for vendors (Chevalier and Russell 2009).

Oral cancer is one of the most common cancers in Solomon Islands, where betel quid chewing is prevalent. A five-year study (1994–1997 and 1999) on the prevalence of oral cancer was conducted on 48 reported cases, using patients' records at the NRH Dental Department. The study investigated the relationship between smoking and betel nut chewing in patients with oral cancer. It was found that males aged 45 years and older were most affected, with 90% of oral cancer patients both smoking and chewing betel nut (Lumukana and King 2003). A separate study observed a trend between chewing prevalence and the incidence of oral and pharyngeal cancer by different countries. Solomon Islands has the highest prevalence in betel quid chewing and its oral cancer incidence ranks second in the world (Tovosia et al. 2007). These studies have shown that the combinations of tobacco

smoking and betel nut chewing are the main risk factors for oral and pharyngeal cancer. Other cancers relating to smoking (e.g. prostate, stomach and lung cancer) are also on the rise. According to the Solomon Islands Tobacco Products Act, only people 18 years and older can smoke. The above-mentioned study also found that smoking and betel nut chewing now start much earlier than they did a few years ago. Smoking and betel nut chewing are very common among early teenagers and school students.

Sexual behaviour: The 2007 SIDHS found that in the 12 months prior to the survey, 15% of women and 24% of men had sex with someone other than a marital partner, with 4% of women and 7% of men having more than one sexual partner during that period. Among those having higher-risk sex, only 18% of women and 28% of men said that they used a condom at the last such sexual encounter. Of the youth who took part in the Second Generation Surveillance, the average number of partners in the 12 months prior to that survey was 3.8 for males and 2.6 for females. Among youth, 56% of males and 40% of females had overlapping sexual relationships, with 13% of males and 8% of females having group sex. However, only 30% of males and 25% of females reported using a condom the last time they had sex. Such behaviour enables rapid spread of STIs and HIV throughout the country. Solomon Islands has a very young population and high rates of unemployment. Increased dissatisfaction and disillusionment leads young people to abuse alcohol, *kwaso* and drugs, and often also lead them toward unsafe sexual practices or illicit sexual activities, thereby making them prone to STIs and HIV. High rates of sexual violence also contribute to increased rates of STIs and unplanned pregnancies.

Physical fitness: The rural population in Solomon Islands is primarily engaged in subsistence livelihoods that require a fair amount of physical labour on a daily basis. This has ensured that physical fitness is maintained. Organised sports, especially for youth, are a popular means of keeping fit.

The urban population, however, particularly those with access to vehicles or who are not physically active, are getting less and less exercise. According to the 2007 SIDHS, 30% of women were overweight and 14.5% obese, while 24% of men were overweight and 5% were obese. It was also found that overweight or obesity was more pronounced in Honiara (58% of all women and 46% of all men) than anywhere else in the country. A recent MHMS initiative has now led to a number of government ministries as well as private houses and churches having organised sporting activities.

Dietary intake/nutrition: Solomon Islanders, like many Pacific Islanders, have undergone massive changes in their food consumption patterns and preferences. Changes in dietary intake, combined with a heavy dependence on processed and fatty foods, are directly affecting people's health, both in urban and rural areas. The Solomon Islands HIES 2005/2006 collected data on estimated food expenditure for both urban and rural households. Table 4.3 lists the top 10 foods among the lowest three per capita expenditure deciles in urban and rural areas.

Table 4.3: Top 10 household food items per expenditure among the lowest three deciles

Honiara	Rural areas
▶ Rice	▶ Kumara
▶ Second grade Taiyo	▶ Rice
▶ Noodles	▶ Other fish
▶ Kumara	▶ Cassava
▶ Bread (all sorts)	▶ Taro
▶ Slippery cabbage	▶ Cooking bananas
▶ Tuna/bonito	▶ Slippery cabbage
▶ Other fish	▶ Dry coconut
▶ Cabin biscuit	▶ Noodles
▶ Cassava	▶ Reef fish

Source: NSO and UNDP 2008

Nutritional intake in rural areas is high in carbohydrates with white rice being second only to kumara. Honiara household diets are not only heavy in carbohydrates but also processed foods with low nutritional value such as noodles, white bread and the lowest grade Solomon tuna.

Distribution of money, power and resources

Poverty and hardship

Distribution of wealth: Using household assets as a proxy for wealth, the 2007 SIDHS calculated the long-term standard of living of households and grouped them into five wealth levels. The wealth index measures a household's standard of living relative to other households based on the wealth index by residence in Solomon Islands. These distributions indicate the degree to which wealth is distributed by geographic areas.

Table 4.4: Wealth quintiles

	Wealth quintile				
Residence/region	**Lowest**	**Second**	**Middle**	**Fourth**	**Highest**
Residence					
Urban	0.6	1.1	3.4	13	81.9
Rural	23.2	23.1	22.7	21.1	9.9
Region					
Honiara	0.2	1.5	2.3	10.8	85.2
Guadalcanal	26.1	16.5	19.2	20.9	17.2
Malaita	21.2	22.8	23.6	20.4	12
Western	9	12.7	20.1	27.8	30.4
Other provinces	25.4	27.1	22.9	19.3	5.3
Total	**20**	**20**	**20**	**20**	**20.1**

Source: NSO, SPC & Macro International Inc. 2009

Not surprisingly, the SIDHS findings show that wealth is concentrated in urban areas. Among the urban population, 82% are in the highest wealth quintile, compared with 10% of rural households. About 95% of the urban population is in the top two (fourth and highest) household wealth quintiles, while nearly half of the rural population is in the two lowest household wealth quintiles (Table 4.4).

Using assets as a measure of wealth masks the reality of hardships that most families face in Solomon Islands on a daily basis, particularly those in the urban areas. Assets are capital investments and do not necessarily attract income to cater for daily basic needs of households. In reality, most of the assets are a major financial strain on households because they are likely to have been acquired through a bank loan with high interest rates. According to the HIES 2005/06

Poverty/hardship: While Solomon Islanders might not be well off in financial or material terms, their strong family and community ties have traditionally provided social safety nets for the most disadvantaged and vulnerable. However, the increasing monetisation of Pacific economies, the impact of television and the Internet, and the increasing rural–urban migration (which leads to greater urbanisation), have begun to undermine these traditional structures.

In the Pacific, it is often said that everyone is poor but no one suffers poverty. In the sense of experiencing absolute poverty and destitution this is generally true. But within every society there are those who are more disadvantaged and poorer than others.

Poverty, or perhaps more correctly 'hardship', is defined in human development terms as: An inadequate level of sustainable human development, manifested by a lack of:

- access to basic services such as health care, education and clean water;
- opportunities to participate fully in the socioeconomic life of the community; and
- access to productive resources and income generation support systems (rural credit, capital, markets, skills) to meet the basic needs of the household, and/or customary obligations to the extended family, village community and/or the church.

Source: SISO & UNDP 2008

Table 4.5: Incidence, depth and severity of poverty

Millennium Development Goal indicators	Solomon Islands	Honiara	Provincial urban centres	Rural
1.1 Proportion of population below USD 1 (PPP) per day	Purchasing power parity exchange rates are not available for Pacific Island countries			
Proportion of population below basic needs poverty lines (BNPL)	22.7	32.2	13.6	18.8
Proportion of population vulnerable to falling into poverty; per capita adult equivalent<10% above BNPL	4.2	5.6	4.3	4.1
1.2 Poverty gap ratio				
Depth of poverty	7.5	8.5	3.1	6.1
Squared poverty gap ratio				
Severity of poverty	3.5	3.4	1	2.8
1.2 Share of poorest quintile (20%) in consumption by region	6.7	10.1	9.5	8
Gini coefficient (0 = perfect equality; 1 = perfect inequality)	0.39	0.3	0.31	0.32
1.9 Proportion of households per adult equivalent food expenditure below minimum level of dietary energy consumption	8.6	1.7	0.6	6.4

PPP: purchasing power parity

Source: NSO & UNDP 2008

data analysis, the average incidence of basic needs poverty, as measured by the head count index (HCI), is estimated to be 18.8% of all households or 22.7% of the total population (Table 4.5). Honiara households recorded a poverty incidence of 24.6%, provincial urban households had a rate of 11.2% and rural households had a rate of 15.2%. In terms of population, the incidence of basic needs poverty is estimated to have affected 32.2% of Honiara's population, 13.6% of the provincial urban population, and 18.8% of the rural population.

There are, however, many more households and individuals who have expenditures that are only just above the basic needs poverty line and are, therefore, vulnerable. The proportion of the population that is vulnerable to falling into poverty is 5.6% in Honiara, 4.3% in provincial centres and 4.1% in rural areas. This suggests that despite Honiara being a source of employment for many, there are many households whose income cannot cover the basic needs costs of a reasonable minimum standard of living, and who can be classified as working poor. With rising prices and/or declining incomes these people are highly vulnerable to slipping below the poverty line.

Inequality in Solomon Islands is relatively low within each region as measured by the Gini coefficient. There is, however, a higher measure of inequality at the national level mainly due to wide differences between income and expenditure levels in Honiara and rural areas.

Both the HIES 2005/06 and the 2006–2007 SIDHS data highlight the fact that households in lower income wealth brackets in both urban and rural areas are less likely to progress beyond primary and early secondary education, thus making it difficult to break free from the 'vicious cycle of poverty of opportunity'. A combination of low educational attainment, socio-cultural factors relating to age, gender and other personal characteristics further limit freedom of choice, or socioeconomic opportunity.

Social protection

Ethnic tension and urbanisation: The social unrest between 1999 and 2003 was a time of rapid social change – when social values collided, economic order collapsed, and social harmony and mutual respect was challenged. The 'tension' lives on for many people and has created different behaviour. Morals have collapsed and even with RAMSI present, there is still rampant corruption, permanent fear of gangs, and powerless police. Substance abuse is on the rise and starts as early as primary school.

The ongoing transition from traditional Melanesian societies governed by *kastom* and village-based lifestyle to urbanised settings has not been very successful so far. The marriage between the highly diverse and regionally defined Solomon Islands cultures and attitudes, and western urban lifestyles and norms is complicated by a number of factors:

- high population growth, with 42% being below 15 years of age;
- high unemployment rates;
- high percentage of the urban population living in poverty;
- lack of programmes to engage youth positively;
- high rates of urban squatting; and
- a continuing rate of urban drift.

Family problems such as marital separation, infidelity, affairs, divorce, and drunkenness have escalated. Dysfunctional families result in more drinking, domestic violence, child abuse and involvement in criminal activities. With inter-marriages there are more bi-ethnic and tri-ethnic households, which can lead to tensions or difficulties in resolving differences without offending culture or sensitivities. Parents are stressed, resources are stretched thin, and social roles are being redefined.

National Provident Fund (NPF): The NPF is an assurance scheme for all employees. Employers are required by law to make monthly payments of 12.5% of an employee's gross monthly salary to the fund, with 7.5% coming from the employer and 5% coming from the employee. An individual can have access to the fund upon reaching retirement age. Upon approval of application by fund management, members can also use 80% of their contributions for loan collateral with commercial banks. Despite the private sector being the highest contributor to NPF payments, it is a well-known fact that there is widespread non-compliance with this requirement among certain types of businesses.

Domestic violence: Domestic violence is often viewed as a personal problem and even an acceptable and necessary form of 'discipline' for women in Solomon Islands. Such acts of violence are rarely addressed by community leaders or reported to police by the victims due to fear that it will bring further violence. Solomon Islands ratified the Convention on the Elimination of All Forms of Discrimination (CEDAW) in 2004. While there is no law on domestic violence, Penal Code, Cap 5, Part XVI deals with offences against morality, and Sections 128–146 cover certain particular situations relating to sexual abuse of children, especially girls. Penal Code section 133 (1) states that a person who unlawfully and indecently assaults any woman or girl is guilty of a felony, and liable for imprisonment for a term of five years. The Penal Code urgently needs to be updated to provide better protection for women and children, and the institutions that provide support to them need to be strengthened (AusAID Office of Development Effectiveness 2008b). A national policy to eliminate violence against women was launched during the International Women's Day celebrations in March 2010.

The Family Support Centre (an NGO) is one of the only agencies that provides services for women and children who experience domestic violence. Findings from the Solomon Islands Family Health and Safety Study (SPC 2009) has also led MHMS to draft a Gender-based Violence policy and clinical protocols for treatment of survivors of violence who present to an MHMS facility in order to establish a mechanism whereby patients who suffer from domestic violence receive the necessary support within MHMS and as part of a formal referral system of stakeholders outside of MHMS.

The Solomon Islands Police Force has also established a new combined Domestic Violence and Sexual Assault Unit (and has drafted a Family Violence Policy). Since the 1990s, there has been a marked improvement in police handling of domestic violence cases – which used to be treated as 'domestic matters' – to now being a crime (at least in urban centres). However, the police

force and the justice system are very male dominated institutions and their willingness to provide support to women can be heavily influenced by their view on appropriateness of violence against women.

A refuge for women and children who experience domestic violence was established in 2005 at the Christian Care Centre under the Church of Melanesia on the outskirts of Honiara.

While progress has been made in urban areas towards ensuring that women maintain their basic human rights, in rural areas, this progress has been extremely limited given the very limited resources and lack of awareness.

Disabled people and mental health issues: People with disabilities (PWDs) are a very marginalised group in Solomon Islands. Their human rights are often abused, especially with regard to discrimination; PWDs are often denied respect; a decent home; food, clean water and clothing; education, employment, health and life; and the right to take part in community activities. This often results in economic poverty and poverty of opportunity for PWDs. Local organisations are effectively restricted in providing services and resources to PWDs due to services being limited to Honiara only, financial constraints, limited trained personnel, poor transport and communication facilities, and negative attitudes towards PWDs by the public due to a lack of awareness. These constraints result in PWDs finding it very difficult to access services, including equipment and aids needed for their disability; and access quality information and skills that would assist them to be independent and self reliant. PWDs have limited mobility and are continuously discriminated against by people in their communities (Disability Survey Project Advisory Committee 2006).

Universal health care

It is a constitutional right of each community member to have equal access to health care of a reasonable quality, essential drugs and other public health services (MHMS 2004). The mission of MHMS is to promote, protect and maintain the good health and well-being of every man, woman and child in Solomon Islands. Generally, health care services are provided free by MHMS. There is, however, inequality in terms of access to health facilities and clinics, health resources and health workers at different locations in the country. Health-seeking behaviour is also influenced by geographical, social, economic and cultural factors (Ministry of Development Planning and Aid Coordination 2008). Once a patient enters the referral system, the medical services in the respective hospitals provide support with food and transport costs to the hospital and back to the village, a policy designed to enable low-income rural people to access specialist care either at provincial hospitals or NRH. This system, designed to ensure equal access to health care, has been the subject of abuse and fraud in most hospitals, as highlighted in the NRH audit. Immunisation programmes have improved markedly but childhood illnesses continue to a problem. Surveys such as HIES 2005/06 and the 2007 SIDHS highlight the gender inequalities in educational attainments and literacy, the impact of poverty on people's ability to access health care (transport costs), language barriers, cultural taboos and staff attitudes.

This universally free health care with no clearly defined limits contributes heavily to the health system being unable to cope with the demand placed on it. Such a free system removes the onus of care for individual health from the people to the state, particularly in some preventable diseases such as certain types of NCDs.

Out-of-pocket health expenditures account for less than 3% of total household final consumption expenditure. This partly reflects the availability of highly subsidised health care. Private clinics, which are mostly located in Honiara, charge fees for their services, with consultation fees varying between SBD 100 and SBD 200 per person. These fees vary from clinic to clinic, with some clinics charging slightly higher fees for non-Solomon Islanders. Services offered are limited, with only a few clinics having basic equipment to support diagnosis. Private clinics are mostly accessible to those with a regular income in Honiara.

Policy coherence and consistency with SIDHS

Reconciliation is the number one priority of the CNURA-led government. Reconciliation and the associated rehabilitation to support it is fundamental to sustained development, peace and harmony in Solomon Islands. Second in priority is social and economic development, with the objectives of:

- addressing the basic needs of people in villages and rural areas where the majority of the people live, and ensuring real improvements in their standard of living; this includes villages as well as squatter communities in urban areas;
- working towards food security for the nation, and ensuring a healthy, literate and contented population; and
- achieving high economic growth, wealth and social well-being for all Solomon Islanders.

The social sector is high on the priority list of the CNURA government, with policies suggesting that medium-term development in education and health will contribute to well-being through poverty reduction and economic development (Ministry of Development Planning and Aid Coordination 2008). The government's commitment to improving health and education is demonstrated in its increasing contribution towards the social sector budget, up to 32% in 2009. Donors have also increased contributions to the social sector over the last three years, with allocations to the sector increasing from 9.8% to 19.8% of the total development budget.

Translating government objectives, policies and budgets into practical and effective programmes that improve livelihoods, both in urban and rural areas, continues to be a challenge. Despite their inadequacies and the need for improvement, the health and education sectors have the greatest ability to reach rural communities.

Private sector engagement, responsible marketing

Other than government taxes levied on tobacco, alcohol and gambling (and restrictions on their use by minors), and restrictions on the opening hours of alcohol outlets, very little has been done to engage the private sector in a coordinated way.

Corporate social responsibility is not very visible in Solomon Islands. This is partly due to a lack of government authorities imposing legislation, as well as the absence of consumer-led targeted actions holding private entities responsible for their actions. There are few isolated efforts such as the ANZ Bank and Solomon Brewery sponsoring drums for rubbish bins in Honiara, Solomons Tobacco sponsoring tree planting along the main road, and other contributions towards the Honiara Beautification Committee.

Gender equity

'Achieving gender equality and empowering women is a goal in itself… […] It is also a condition for building healthier, better educated, more peaceful and more prosperous societies. When women are fully empowered and engaged, all of society benefits. Only in this way can we successfully take on the enormous challenges confronting our world – from conflict resolution and peace-building to fighting AIDS and reaching all the other Millennium Development Goals.'

Source: http://www.spc.int/women/women_csw51_info2.htm

The Ministry of Women, Youth and Children's Affairs (MWYCA) was established in 2007 as a focal point for implementing women's, youth and child related programmes and policies to ensure progress towards equity. MWYCA, with the support of other groups such the RAMSI programme on Machinery of Government, has been busy trying to put women in leadership positions (e.g. board members and reserved seats for women in parliament) in an effort to gender sensitise higher level decision-making. The bill for reserving seats for women in the parliament was refused for first hearing by the government in 2009. There is no female representation at the highest level of decision-making within the country – the parliament. Implementation of CEDAW principles and gender mainstreaming in Solomon Islands, as in most other PICTs, so far has been mostly limited to talk and minor token gestures. At the higher government levels, very little change has been made to legislation, policies and programmes to ensure that women have access to opportunities that will enable them to participate in decisions that concern them, particularly the illiterate majority that form the backbone of rural economies and subsistence livelihoods. According to a UNDP report (2002), there are significant differences between men and women with regard to access to resources, decision-making and status in Solomon Islands, as evidenced the country's gender related index of 0.596, and the gender empowerment measure of 0.593.

Education is a precursor to other attributes of gender empowerment. Provision of free basic education up to grade 9 is an important change in policy towards improving the opportunities of the rural poor in Solomon Islands. However, further assessment should be made on what factors influence poor families' decisions regarding their children's education to ensure that appropriate programmes are implemented that further enhance their ability to have equal opportunities to attend school.

A gender-sensitised health approach should highlight the fact that women's health is not limited to their biological reproductive role, but also includes the social, cultural and economic particularities that make up their social context (Mackintosh and Tibandebage 2004). According to Public Investment Program (PIP), the key challenge to gender mainstreaming within MHMS is developing an institutional culture that recognises differences and disadvantages, builds on the strengths of individuals, communities and institutions, and strives to empower women through health service delivery. Translating gender mainstreaming from institutional (MHMS) discourse to planning, management and service delivery has yet to take form. With MHMS's commitment to people-focused approaches, opportunities exist to implement gender mainstreaming. Health interventions (curative and preventative) must take into account social, cultural and economic norms that influence gender relations, division of labour, roles and responsibilities, differences in age and ethnicity to ensure appropriateness, accessibility and acceptability. Interventions designed to achieve gender equality in health must involve men, communities and the society in general as partners in health. This also applies to other sectors and donor partners who rarely target gender equality through mainstreaming.

Understanding the issues and correcting the inequalities within MHMS would be an important step before the organisation can mainstream gender through health service delivery in communities. A lack of gender-sensitive human resource development policies perpetuate a situation where women represent 50% of the workforce, yet hold only 10% of executive-level positions. Training opportunities awarded to staff

also continue to be male dominated. Gender-sensitive approaches to service delivery to improve service quality have yet to be properly incorporated into institutions that provide nursing and medical qualifications in Solomon Islands (JTA International 2006).

Up until mid-2008, HIS data did not include disaggregated information on gender, poverty, and ethnicity. Since then, a revised HIS data collection tool was designed with a limited number of sex disaggregated fields. Collection of sex disaggregated data provides information into who uses health services and the gendered characteristics of ill health within the population. This can significantly contribute to better understanding the social, economic and cultural factors that cause ill health and the tools needed for improving health service delivery.

HSSP will support gender mainstreaming in MHMS by:

- taking an integrated approach to gender in all facets of health service delivery;
- establishing inter-departmental partnerships between MHMS and other relevant government departments;
- establishing partnerships between MHMS and civil society organisations;
- establishing a gender focal point within MHMS;
- collecting improved gender disaggregated data;
- improving human resource management with MHMS; and
- developing gender-sensitive monitoring and evaluation methods.

Chapter 5: Health system and services

Evolution of the health system

The geographic distribution of population in Solomon Islands has resulted in health services being largely community-based. The PHC network was introduced in 1978. A network of hospitals, area health centres and clinics, nurse-aide posts and village health posts provide government health care services in collaboration with health service partners.

The health care referral system consists of a network of six different levels of health facilities, from village health worker posts to NRH. This referral system forms the structural backbone of the country's health care system. The PHC network weakened in the early 1990s with the re-introduction of vertical programmes whereby donors were providing funding directly to the programmes within MHMS in isolation from other programmes.

MHMS has formulated national health policies and plans since the mid-1980s that are used by all stakeholders involved in health services delivery. The 1999–2003 National Health Developmental Plan took a wider, systematic approach. It focused on capacity building in the areas of management and supervision, health financing, human resources and infrastructure development, health information systems and health services planning, with the long-term goal of improving the use of resources and value for money,

'The Solomon Islands view Primary Health Care as philosophy, an organisational structure, a level of care and set of programmes.'

WHO 2001

and redistributing resources in a manner that supports PHC services. In addition, the plan sought to strengthen PHC services in rural areas, where 80% of the country's population lives. The eight broad policies in the plan were concerned with developments to improve management and supervision within MHMS, including access to PHC for rural people, human resource development, and strengthening the capacity of disease control programmes to reduce morbidity and mortality. This plan also concentrated on the promotion of safe and healthy initiatives, health education and promotion and supporting the rollout of reproductive health programmes, especially on family planning. Given the prevailing resource limitations, priority was given to developing partnerships for health.

The civil strife that occurred during this period seriously impacted health service delivery and outcomes, and the key focus of the Ministry of Health Work Plan for 2004–2005 was restoration of health services after the conflict. The programme of actions, therefore, incorporated i) restoration of basic health services, and ii) building health services capacity at the national and provincial levels to sustain and enable change management. Capacity building was also undertaken in planning using logframe matrices, enabling divisions, provinces and national secondary care programmes to develop and produce cost estimates for their 2005 Operational Plans, thereby contributing to the budget process.

The goal of the current National Health Strategic Plan (NHSP) 2006–2010 and the MHMS Corporate Plan is to create an enabling environment within MHMS to adopt a people-centred approach to public health. This is to be achieved by: i) moving to a sector-wide approach to health services delivery; ii) realigning health services to support an integrated approach to health care at all levels that addresses community needs; iii) including health promotion within all health services delivery and programme areas; and iv) integrating social welfare, community-based rehabilitation and mental health services (MHMS 2007).

Health sector policies and plans

The health sector policy is informed by the eight strategic priority areas identified in the NHSP 2006–2010: a focus on people; public health programmes; malaria; common childhood diseases, NCDs; HIV and STIs; family planning and reproductive health; and health systems strengthening.

While the focus areas are comprehensive – covering diseases, systems and people – the strategic plan falls short in defining implementation arrangements, resources, and measurable indicators, and pays insufficient attention to poverty, gender and ethnicity. The top priority – promoting a people-focused approach to health – has received the least attention, due to a lack of resources. A review of the NHSP is underway, and it is paramount that the strategy further clarify aspects of policies, resources, action plans and implementation arrangements, with explicit attention to poverty and gender.

The Health Sector Support Program (HSSP), a sector-wide approach (SWAp) to health service delivery, was launched in 2008. AusAID, the World Bank, WHO, UNICEF and UNFPA were the initial partners of MHMS, with the potential for additional donors in the future. The rationale for the SWAp is that both the government and its development partners are financing a single-sector strategy and expenditure programme, and in the process, simplifying financial and reporting procedures. This addresses one of the most important problems faced by the health sector: multiple sources of funding with multiple procedures, which is particularly burdensome for provincial health care departments, which have limited financial management capacity.

One of the building blocks of HSSP is a partnership agreement to be signed by all donor partners, even if initially they are not ready to pool funds into a common account to be managed by a single financial system. (See Annex 2 for Solomon Islands–Australia Partnership for Development and Detailed Performance Framework.) The World Bank provides technical assistance where needed.

HSSP employs three assistance instruments: investments in system capacity, including physical investments, training, and technical assistance; current expenditure support, in cases where the government lacks the resources to finance those costs adequately;

and a framework of agreed policy shifts to raise quality, productivity, and equity of the health system.

The timeframe of HSSP runs in parallel to support provide by AusAID as outlined in the AusAID Partnership Agreement. Tables 5.1–5.3 outline the outcomes that HSSP aims to achieve by 2012, the 'Vision 2012', the building blocks of the health SWAp and the annual monitoring indicators for HSSP.

Table 5.1: MHMS Vision 2012

	Themes		
Areas of achievement	**Management**	**Sustainability**	**Service performance**
Investments completed	Provincial infrastructure and equipment in place		
	NRH equipment in place		
	NRH and Provincial Hospital Health information system in place		
Policy shifts	2nd NRH Audit Four provincial hospital audits	Fees for selected services introduced for NRH and some provincial hospitals	Regular schedule of HIV sentinel surveillance/ testing adopted
	Staff incentive pilot in place in NRH following new policy from MHMS	Revenue retention rules revised for all health facilities	Under-performing provinces identified and approved for service intensification
	Staff assignment to frontline policy		
	Demand management of emergency services in place		
	Formal evaluation undertaken of service/innovation effectiveness		
	Provincial expenditure reports on hospital and primary facilities		
Targets/goals achieved	NMS and facility stock-outs down	MHMS receives 16% of government budget in all years	Malaria incidence and case fatality rate down; measles up
	NMS unit prices down	60% government share of total recurrent expenditures	Percentage of population screened for NCDs up, and NCD policy adopted
	New donor(s) pooling in HSSP	40% health sector expenditure	Antenatal care, skilled delivery, and child immunization rates steadily improve
	100% MHMS review of donor financed technical assistance	MHMS revenues increase to approx. 5% of total MHMS budget	AIDS stays low; TB cure rate up
	Hospital unit costs (per bed day) down		People-focused program in place with 2 activities in 5 provinces

Source: MHMS 2008

Table 5.2: HSSP building blocks

Building block	HSSP application	Timetable	Issues
1. 5-year Investment Plans for Key Programmes	Foundation for MTEF	2008	Malaria in hand, but other strategic areas not planned or costed beyond 2008
2. MTEF	Incomplete MTEF in hand – full MTEF pending	2008	Need financing plans from Ministry of Finance and donors
3. Health Sector Strategy	NHSP 2006–2010	2006 (done)	World Bank and AusAID accept NHSP as the strategic foundation for HSSP
3. Fiduciary Agreements	Financial Arrangements and Procurement Manual in hand (see Program Implementation Plan - PIP)	2007 (done)	World Bank and other donors may need further refinements or amendments before pooling
4. Donor Partnership Arrangement	Agreement for all donor partners covering joint conventions, excluding financial	2008	Draft available. Many donors seek such an agreement, even if they cannot enter any pooling arrangements
5. Joint Financing Agreement	Core agreement of HSSP	2008 for signing	Draft available. This will include AusAID, MHMS and Solomon Islands government, possibly other donors
6. Monitoring and Evaluation Framework	Included in the HSSP program document, vital for performance orientation	Revised and finalised by end 2008	Should include indicators, mid-point targets, programme goals
7. Policy Framework	The essential policy changes to enable performance gains	2008	Should include all policy milestones agreed with MHMS and the government
8. HSSP Programme Document	Summary document for all parties to HSSP	Revisions and additions in 2008	Should summarise all aspects of HSSP
9. PIP	Detailed discussion of implementation arrangements	Draft completed in 2007	Needs retrofit to final program document

HSSP = Health Sector Support Program; MTEF: Medium Term Expenditure Framework

Source: MHMS 2008

Table 5.3: HSSP annual monitoring indicators and targets

Strategic theme/indicators	Baseline value	2012 target	Comments on progress
Sustainability			
1. Health sector expenditure on frontline/ total health expenditure	32% 2005 (HER)	>40%	46.5% in 2009 including MHMS recurrent and development budget and contributions from donors
2. Solomon Islands government share of total public health recurrent expenditure	50% 2005 (HER)	>60%	51.5% in 2009 budget. Would have decreased given the freeze on public expenditure towards end of 2009 caused by financial difficulties
3. MHMS revenues/MHMS budget	no data	>5%	Less than 1% from sale of drugs in 2008
4. Recovery of cost per hospital bed day – NRH and provincial hospitals	no data		
Service performance			
5. CPR	25% 2007 (SIDHS)	>30	
6. Maternal tetanus (valid)	19-56% 2004 UNICEF	>60% valid	
7. Measles (valid)	96% (all) in 2007 (DHS)	80% valid	A nationwide three weeks catch up immunisation campaign on measles, vitamin A and de-worming doses carried out in late 2009 for 1–5 year olds.
8. Percent of population tested and treated for hypertension and diabetes	no data		
9. Malaria test confirmed (slide or other test)/1,000 pop	156 per 1,000 in 2006 (SIMIS)	80/1000	Provincial health reports in 2009 indicating reductions
10. Malaria case fatality rate	Hospital Information		
11. TB/STIs Indicator	no data		
Management			
12. Percent Essential Drug List stock outs in health facilities last 3 months	-	<20% average	
13. # Provinces with 2 People Focus Program active	0 in 2007	5	Provincial reports in 2009 highlighted talks conducted on healthy settings.

HER = Health Expenditure Review; SIMIS = Solomon Islands Malaria Information System

Source: MHMS 2007, 2008; Chamberlain 2006

While the financial support from AusAID for HSSP is providing overall support to most programmes within MHMS the main support is for 1) the focus on people, through a re-energised and refocused health promotion initiative that works directly with communities and encourages participation by all; 2) a malaria prevention programme targeting progressive elimination; and 3) sustained health systems strengthening, including financial management, procurement, health information systems, comprehensive infrastructure restoration and maintenance, human resource management, hospital management systems, and pharmaceutical/medical supplies procurement and distribution.

A consensus developed during consultations among health leaders and decision-makers regarding prioritisation of identified strategic areas; they agreed that in order to reduce the burden on curative services (and in particular NRH), more effort must be put into getting people to take control of their own health. More resources, particularly in rural areas, need to be put into preventative and healthy living promotions that are integrated into PHC services. A second priority is strengthening the system so that it can respond effectively to health needs and diseases. Family planning is also ranked as a priority, as rapid population growth will have a detrimental effect on health services.

Non-health sector policies and plans

There are many existing programmes and projects throughout the country, both by government, non-governmental sectors and donors that have a bearing on health outcomes (Table 5.4). The free basic education policy of the Ministry of Education will contribute to improved health outcomes in the future, as children whose mothers have had some secondary education are more likely to be better immunised and less likely to be malnourished. The food security programmes in the Ministry of Agriculture and Ministry of Fisheries and their donor partners, and the elaborate rural networks of churches and NGOs working in a wide range of sectors – from food security to water and sanitation and strengthening of community governance – all have a bearing on health outcomes.

Table 5.4: Non-health sector partners contributing towards health outcomes

Development/ organisation /activity	Areas of focus	Approach	Province
Adventist Development Relief Agency (ADRA)	HIV/AIDS	Training; health promotion	Honiara, national media
Australian Volunteers International	HIV/AIDS	Volunteer	Through ADRA
Catholic Church Health Care Services Clinics Malaita	Health care services	Clinics	Malaita
Church of Melanesia	HIV/AIDS; primary health, sex abuse, trauma, psychological issues	Service delivery; training; advocacy; resource provision; health promotion	Temotu; Makira; Isabel; Choiseul; Guadalcanal; Central Provinces and Honiara
Commonwealth Youth Program	HIV and AIDS, reproductive health	Training; advocacy; participatory process	Honiara
Kastom Gaden	Nutrition and food security	Demonstration centres; training; promotion; media	Nationwide
Don Bosco	Diseases	School-based	Honiara
Girl Guides	HIV and AIDS; sex and reproduction		Honiara
Grassroots Network	Disability; diseases; sex abuse; trauma	Counselling; training; advocacy	
First Lady Charity	Women and children's health	Resources provision	Honiara

Table 5.4: Non-health sector partners contributing towards health outcomes (contd)

Honiara Clinic	HIV and AIDS; primary health, sex and reproduction; family planning; diseases	Counselling; training; advocacy	Honiara
Japan International Cooperation Agency	Primary health; family planning; disability	Building clinics; malaria	
Oxfam International	HIV and AIDS; sex abuse	Training; advocacy; participatory development processes	Honiara
Regional Rights Resource Team (SPC)	HIV and AIDS; disability		
Rotarians Against Malaria	Malaria	Equipment; resources	Choiseul; Guadalcanal; Malaita; Western
Save the Children Australia	HIV and AIDS; mental health	Health promotion; training; advocacy; research; planning	Western, Isabel, Malaita, Guadalcanal, Makira, Honiara
National Council of Women	HIV and AIDS	Health promotion	Makira, Western, Temotu, Honiara, national (media)
Seventh Day Adventist Church	Health care service, PHC	Service delivery, training, health promotion	Malaita, Guadalcanal; Western Province; Isabel; Makira Province
United Church	Health care Service, PHC	Service delivery, training, health promotion	Choiseul; Western Province
Solomon Islands Christian Association	HIV/AIDS; primary health; family planning	Health promotion; advocacy; training; participatory process	Honiara; Malaita
Solomon Islands Planned Parenthood Association	Disability; sex and reproduction; sex abuse	Health promotion; training; resource provision; research; advocacy; participatory processes	Honiara, Makira
Soroptomist	HIV and AIDS; primary health; family planning; sex and reproduction	Participatory process	Honiara
SWIM	Disability	Community-based advocacy	Honiara
Solomon Islands Development Trust	Mental health, malaria, village development workers	Health promotion; advocacy; training; participatory process	
Solomon Islands Red Cross Society	Blood bank, disaster relief	Service provision	Honiara
Rokotanikeni Association	Nutrition, reproductive health, gender equality, domestic violence	Participatory process	Malaita
Voice Blong Mere	HIV and AIDS; gender equality, domestic violence	Media	National
Christian Centre	Domestic violence and abuse;	Service provision; health promotion	Honiara
World Vision	Water and sanitation; nutrition, domestic violence, substance abuse	Health promotion; resource provision; training; participatory processes	6 provinces

Sources: MHMS 2007, consultations

MHMS recognises the important role its partners play in contributing towards improving health outcomes. There is a need for better coordination of this collaborative effort in planning (pre-project proposal) and implementation to ensure activities are not concentrated in certain locations. The MHMS (through the SWAp) can probably facilitate the process.

The MHMS leadership has a very strong interest in developing partnerships with NGOs and FBOs. One of the recommendations of the 2009 Joint Programme Review is to establish a multi-sectoral working committee to develop a National Partnership Policy and Plan for working with FBOs and NGOs. It is important to note, however, that the partnership should go beyond traditional clinical services, and include health promotions, prevention and rehabilitation. Also, a meaningful partnership will require attitudinal change within MHMS, which needs to accept other stakeholders in the health arena as equal partners.

Health service delivery and organisation

Physical resources

The health networks throughout the country consist of a hospital, area health centres, rural health clinics, and nurse aid posts (Table 5.5); in some areas there are malaria community posts and community health workers. There are six government hospitals and two mission hospitals. NRH is in Honiara; the five other hospitals are Kilu'ufi (Malaita Province), Gizo (Western Province), Kira Kira (Ulawa/Makira Province), Buala (Isabel Province), Taro (Choisieul Province), and Lata Hospital (Temotu Province). The Gizo hospital was badly damaged by the 2007 tsunami and has yet to resume functioning at full capacity. Rennell and Belona, Central Islands, and Guadalcanal provinces have primary health facilities in the communities and a provincial hospital providing secondary services, with access to NRH. The Honiara City Council is regarded as a province, and provides PHC and access to NRH for secondary health care. The referral system is not well understood, however, resulting in the bypassing of services offered by the provincial systems and overwhelming the NRH primary and secondary services.

Table 5.5: Total number of health facilities by province 2006–2008

Provinces	2006	2007	2008	Population projections 2009	People per facility
Guadalcanal	32	36	36	79,190	2200
Western	54	58	59	83,759	1420
Malaita	59	59	76	143,852	1893
Temotu	15	17	17	21,190	1246
Central	24	24	25	24,226	969
Choiseul	24	26	26	24,060	925
Isabel	31	32	34	23,209	683
Makira	32	36	36	38,123	1,060
Honiara	14	14	15		
Renbel	3	3	3	2,174	725
Solomon Islands	**288**	**305**	**327**		

Source: MHMS 2009

There were 327 health facilities in the country at the end of 2008. The average number of people per facility is lower in smaller provinces. Note also that assessing accessibility in this way masks geographical distribution, which hampers access to facilities and services. Most facilities (particularly in the provinces) are in a poor state and in need of repair. Funds for rehabilitating, refurbishing and extending health facilities throughout the country come from the government's development budget as well as HSSP and other development partners. As a result of the global financial crisis, however, much of MHMS's development budget was not available, and very little infrastructure maintenance or construction occurred in 2009.

Role of central and provincial governments in health service provision

Responsibilities for health service programming and delivery are shared between the national and provincial levels.

National MHMS key responsibilities include:

- overall health strategy development, policy planning and development, and policy guidance to provinces;
- strengthening technical programmes (e.g. essential public health functions) provided at the national level;
- ensuring the availability of skilled human resources;
- strengthening pre-service training and curricula;
- infrastructure planning and, currently, management and maintenance planning;
- monitoring and evaluation (M&E) of the sector's performance through M&E of national programmes and support to provincial M&E; and
- coordinating, packaging, and undertaking procurement of inputs for programmes.

Provincial MHMS key responsibilities are:

- operational management of national health policies in the provinces;
- implementation of key health strategies and of technical initiatives;
- planning, budgeting, managing, accounting for, and monitoring health service delivery (including both primary health programmes and provincial hospital services);
- integrating national health policies into health service delivery at the provincial level; and
- staffing management.

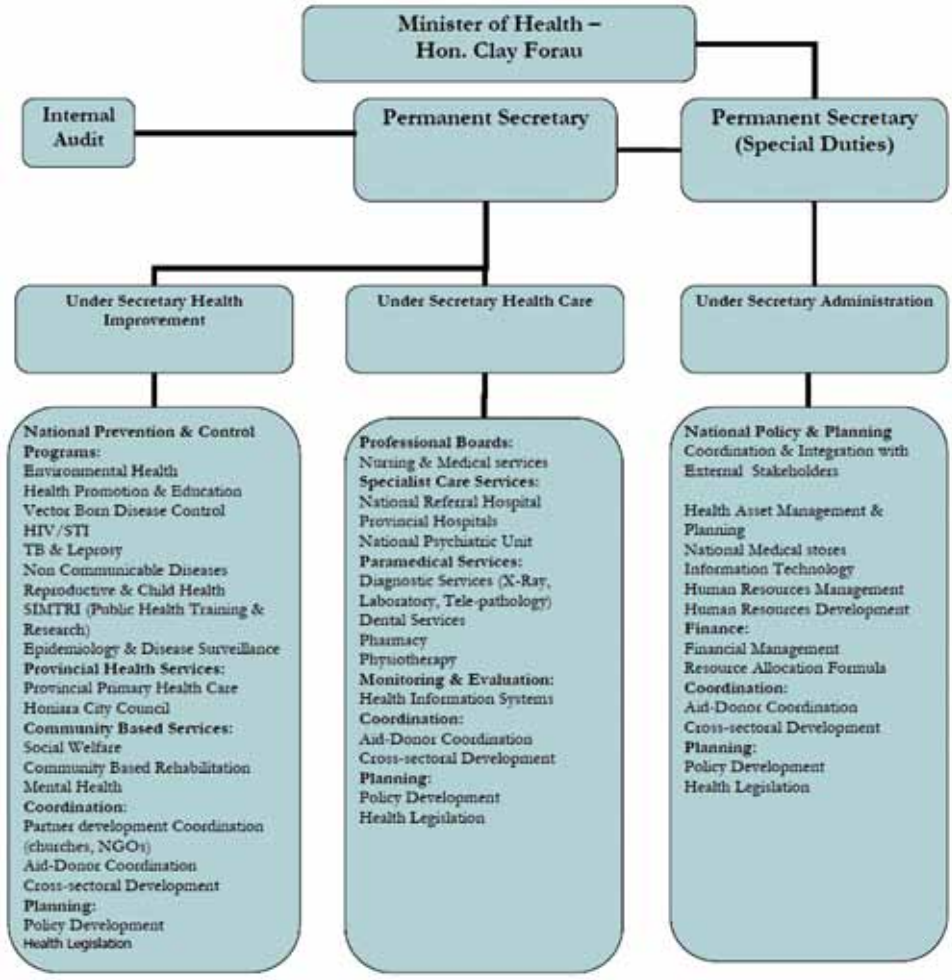
Role of non-state providers

Faith-based organisations in Solomon Islands play a significant, albeit minority, role in the health system, although not on the same scale as in Papua New Guinea. The Seventh-day Adventist Church and United Church in Solomon Islands provide the bulk of health and medical services in the church sector, with a newly established Catholic church backed by the Good Samaritan hospital in Guadalcanal Province. The church-controlled facilities get grants from the government to support their operations. The churches also run training schools for nurses.

The two churches have proposed memoranda of understanding (MOUs) for the last few years with MHMS to strengthen their partnerships. These MOUs have yet to be discussed. There is a strong interest within the current leadership in MHMS to strengthen relationships with churches and other stakeholders. All churches also undertake many health educational awareness activities through their health departments. For example, awareness talks and programmes on HIV and AIDS and other STIs, and general community health are facilitated within church networks (e.g. women's and youth groups). During the 2009 HSSP annual review, it was resolved that a multi-sectoral working committee be established to develop a National Partnership Policy and Plan for working with FBOs and NGOs, demonstrating recognition by MHMS of the role that FBOs and NGOs have played in the health sector.

A number of private clinics in Honiara offer services, but patients are referred to NRH for secondary care support. According to the health utilisation survey, private doctors are highly regarded but expensive, and financially inaccessible by most people. Some private companies, donor-funded projects and statutory bodies subsidise basic health care locally for their staff through selected private clinics and doctors. Such support is usually for basic services, while more serious problems are referred to NRH.

Figure 5.1: MHMS organisational chart (central and provincial)



Source: MHMS 2008

Communicable disease control

Common childhood illnesses: The Reproductive and Child Health Division is responsible for implementing programmes and services relating to improving health outcomes for women and children. The implementation of EPI, a programme of the division, has been particularly successful because of the integration of its core activities into the general health services system as one of the principal components. Provincial coverage varies as a result of factors such as access, transport, communication, stock-outs, and storage issues. The Reproductive and Child Health Program operates under their five-year plan (the National Child Health Plan 2005–2010), which covers EPI, integrated management of childhood illness, hospital care for children, safe motherhood, neonatal care, and nutrition, with close collaboration with programmes in malaria, TB/leprosy and HIV (MHMS 2005). Progress in improving maternal and child health has been slow but steady.

The goal of the programme is to reduce morbidity and mortality of children less than 5 years of age due to common childhood illnesses. This is to be achieved through:

- strengthening of early diagnosis, appropriate treatment and management of childhood infections, via the Integrated Management of Childhood Illnesses programme;
- improving family knowledge of common childhood infections and the importance of prevention and seeking early care;
- increasing outreach and appropriate interventions and treatment in high incidence areas;
- strengthening EPI to increase immunisation coverage; and
- increasing multi-sectoral collaboration to reduce common childhood diseases.

Malaria: The goal of the National Malaria Program 2008–2014 is effective control and progressive elimination of malaria by 2014. Historically, malaria has been one of the largest killers in Solomon Islands, surpassed only by ARI in children under 5 years. However, malaria statistics show that there has been a decline in incidence over the last few years throughout the country. The annual incidence rate has decreased from 130.91/1,000 in 2007 to 82.321/1,000 in 2008, an encouraging result for the malaria programme. The malaria programme is involved in a wide-range of activities in the following areas:

- Vector control programmes and research
- Laboratory diagnosis of malaria
- Malaria surveillance
- Drug efficacy studies
- Formulating malaria treatment policies and guidelines
- Malaria health promotion

One of strongest weapons in the fight against malaria is the use of insecticide-treated mosquito nets while sleeping. The programme record shows that by 2008, there were 66,565 treated nets distributed among 21,007 households throughout the country. This includes re-treatments and treatment of conventional nets. The programme provides free nets to children under 5, disabled people and pregnant women. The 2006–2007 SIDHS found that three-quarters of Solomon Islands households own a mosquito net, with about equal proportions in urban and rural areas. About half of households in both urban and rural areas own an insecticide-treated mosquito net. About two-thirds of children under age 5 and 60% of pregnant women sleep under a mosquito net.

The renewed global fight against malaria presents funding opportunities for Vanuatu and Solomon Islands to embark on ambitious malaria elimination programmes, with Temotu and Isabel provinces being the initial target provinces in Solomon Islands. The malaria programme is supported by a Malaria Reference Group (MRG), an advisory body that meets twice per year, and a recently implemented AusAID-funded Pacific Malaria Initiative Support Centre (PacMISC), a consortium consisting of Queensland Institute of Medical Research, Australian Army Malaria Institute and the University of Queensland. The PacMISC is to provide support in operational research and technical assistance, programme management support, support in teaching and training and monitoring and evaluation.

HIV and STIs: The programme's goal is to ensure that the burden of HIV and AIDS will not undermine the health and well-being of the people of Solomon Islands by:

- reducing risk-taking behaviours and vulnerability to HIV and STIs;
- expanding and/or enhancing voluntary confidential counselling and testing as an entry point for prevention and treatment of STIs and HIV;
- improving and/or enhancing HIV and STI surveillance, treatment and care;
- undertaking capacity building for the national HIV response at both community and institutional levels; and
- addressing discrimination issues and promoting de-stigmatisation and positive behaviour change to improve prevention and health care.

TB and leprosy: TB and leprosy are both present in Solomon Islands, and neither shows recent signs of rapid increase in incidence. TB prevalence is the second highest in the Pacific. Leprosy persists but the incidence is limited to Guadalcanal. MHMS's goal is to reduce TB mortality, morbidity and transmission of the infection by increasing detection to 70% of estimated incidence and increasing cure rate of 85% of detected new sputum smear-positive cases. Training health workers to improve their knowledge and skills to assist with effective and efficient control of TB is an ongoing activity of the programme.

Primary, referral services, secondary and tertiary care

The national health system is based on the PHC approach, and features a network of clinics, aid posts, area health centres, provincial hospitals and a national referral hospital (Table 5.6). The Honiara City Council (HCC) is regarded as a province and provides PHC services and access to the NRH. In addition to the NRH, there are five government hospitals and two mission hospitals.

Table 5.6: PHC network

Level	Authority	Institution	Principle workers	Medical services provided
6	National	National Referral Hospital	Specialists, GPs, Nurses, Paramedics	Secondary and tertiary care (day & inpatient)
5	Provincial	Provincial hospitals	GP Doctors, Nurses and Paramedics	Primary and secondary care (day & in patient)
4	Area Council	Area health centres	Assistant Nursing Officers, Nurses, Nurse Aides	Primary care (day & some admissions, especially postnatal)
1–3	Wards	Rural health clinics/ aid posts	Nurses, Nurse Aides, Village Health Workers	Primary (day care)

Given the country's multi-province, multi-island setting, the PHC system has served the nation well, particularly with respect to curative services. The referral system remains a challenge, particularly in moving seriously sick or injured people to the provincial hospitals or NRH. There is no formal patient transport mechanism in place, and moving people by commercial aircraft is potentially hazardous, while movement by boat is too slow for seriously ill individuals. The referral system is not well understood and patients from the provinces have the tendency to bypass the provincial hospitals and go to NRH for secondary care, mainly because available transportation routes make it easier to reach Honiara. This has contributed to the heavy demand placed on NRH services, however. The current MHMS leadership is interested in regionalising secondary hospital services within provinces by further strengthening the church hospitals and upgrading some Area Health Centres to manage the traffic to NRH.

Public health services

Public health services in Solomon Islands include all preventative and control programmes, both by MHMS and their partners in health services, including environmental health, health promotion and education, vector born disease control, HIV and STIs, TB and leprosy, NCDs, reproductive and child health, provincial PHC, community-based services such as social welfare, community-based rehabilitation, and mental health. It also includes training for research and surveillance and coordination with partners. Most provincial health divisions have some established staff posts responsible for public health functions based at the provincial headquarters. However, rural outreach is still very limited.

Barriers to care: Access, outreach and utilisation of preventative, promotive, and rehabilitative care is lacking in most of the rural areas because:

- The preventative and control programmes are urban-based (mostly in Honiara), and make just a few quick trips to the provinces. These programmes also have yet to be well integrated into the main (curative) health services in the provinces, affecting lines of responsibilities in delivery, monitoring, and the sense of ownership of the programs by provincial programmes.
- A number of health promotion positions in the provinces remain vacant.
- PHC staff lack the skills, knowledge and information to deliver programmes that are not integrated into the general health services, and are either hesitant or incapable of delivering such programme services. There is a need for continuous upskilling, mentoring and monitoring of field nurses to equip them with the necessary skills and attitude.
- PHC facilities are understaffed and burdened with curative services.
- Provincial health budgets are insufficient to carry out the necessary work. Programme budgets are not integrated into the transfers and grants to the provinces, and lack clear allocations. Additionally, monthly grants to the provinces are spent mostly on direct wage employees.

Access to health facilities and services in a widely dispersed country like Solomon Islands is determined by several important factors relating to the country's geography. The performance of the health system in Solomon Islands has been positive despite recent

challenges, with three-quarters of the population using public health facilities. The most common reasons for people not seeking health care services when sick are: clinic being too far away, (41%), inability to pay for transport (6%), and bad weather (5%) (MHMS 2006a). According to the RAMSI People's Survey 2008, 12% of their respondents have health centres in their communities, 46% can reach a health centre within an hour, while the rest may take up to half a day or longer to reach one. There are approximately 6,234 villages in Solomon Islands, spread between the nine provinces and numerous islands and islets, with an estimated population of 535,007 in 2008. There were 327 health facilities throughout the country as of the end of 2008.

Utilisation of available services is determined by health seeking behaviour, which in Solomon Islands is heavily influenced by superstition and poor understanding of diseases, gender-based cultural barriers, the availability of medicines, and the availability of appropriately skilled staff and their attitudes towards people. Utilisation of health care services by uneducated rural women is particularly affected by the attitudes of health care staff. Utilisation of private health care services in urban areas is determined largely by ability to pay, and is thus far limited to 3% of the total population.

According to the HIES Health Module 2006, 87% of the population seeks care when sick. Among the health seekers, 85% sought care from a public facility, 4% from private providers, and 3.5% from a traditional healer. Of those who did not seek health care, 23% always use a traditional healer first, while 5% said that clinic staff were not friendly.

Role of international 'actors'

Solomon Islands MHMS also has a long-standing 'ten beds per year' arrangement with St. Vincent Hospital, Australia, in which MHMS meets airfares and visa costs while the cost of specialist care, accommodation and subsistence is covered by St. Vincent Hospital. The main criterion for referral is certainty by the local medical team that the patient has a high chance of recovery given the specialist care. Over the years, the number of patients benefiting from this service has grown beyond 10 beds per year, however, with politicians abusing their powers and bypassing referral channels based on medically sound reasoning. In 2008, the total budget for overseas referral was SBD 25,697 while the actual expenditure was SBD 48,643.

There are also arrangements for overseas medical missions by specialist doctors who visit the country to provide their services. Some of these missions are a regular as part of bilateral support; for example, AusAID funds an arrangement with the Royal Australasian College of Surgeons to provide visiting teams and individual specialists, while others are voluntary and self funded. The Asian Medical Doctors Association funded cold chain equipment for EPI in 2008. Solomon Islands also has a bilateral health development arrangement with the government of Cuba, whereby Cuban doctors serve in hospitals in Solomon Islands in specialist areas that are lacking locally. The bilateral arrangement also has a human resource development component under which 100 Solomon Island students are sent to Cuba each year to study for a medical degree. Such arrangements are necessary because the health system lacks doctors in some specialist tertiary services. Local health officials and medical doctors have a mixed reaction to the arrangement. Some feel that Cuban doctors help to fill the gaps and such an arrangement is affordable for the government, while other local doctors have left the country over this issue. NRH medical lab has had long established working relationship with medical laboratories overseas, for example Royal Brisbane Hospital Pathology, in Australia where specimens are sent for testing and analysis.

Development partners play an important role in supporting MHMS in its delivery of quality health services throughout the country. Support is provided for funding of specific programmes and activities, advice, research, and surveillance and monitoring of health outcomes. Most partners have longstanding relationships with MHMS and either maintain country offices or operate through representatives. A brief review of MHMS partners and the support (financial and technical) they provide (recent and current) follows.

World Health Organization

WHO focuses on the following:

- reducing the health, social and economic burden of communicable diseases;

- combating HIV and AIDS, tuberculosis and malaria;
- preventing and reducing disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence, injuries and visual impairment;
- reducing morbidity and mortality and improving health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improving sexual and reproductive health and promoting active and healthy ageing for all individuals;
- reducing the health consequences of emergencies, disasters, crises and conflicts, and minimising their social and economic impact;
- promoting health and development, and preventing or reducing risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex;
- promoting a healthier environment, intensifying primary prevention and influencing public policies in all sectors so as to address the root causes of environmental threats to health;
- improving nutrition, food safety and food security throughout life, and in support of public health and sustainable development;
- improving health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research; and
- ensuring improved access, quality and use of medical products and technologies.

AusAID

- Support is provided through the Health Sector Support Program, with a focus on:[2]
- improving long-term financial sustainability of public health services;
- increasing management capacity within public health system at the central and provincial level;
- creating incentives for better health performance;
- investments in water and sanitation and malaria programmes;
- improving communications, consultation and participation between MHMS divisions and provincial health divisions;
- promoting active partnerships, both internally and with all stakeholders including churches, NGOs, development partners and others;
- ensuring adequate resources reach the provinces and are managed to best effect to support the delivery of rural health services;
- improving the quality of data collection (including by hospitals), appropriate information production, extensive information sharing, and information utilisation at the community, provincial and national levels;
- addressing the much-needed renovation/ maintenance of health infrastructure and staff housing and construction of new staff housing where necessary;
- maintaining and extending clean water and sanitation, with priority given to schools, clinics and communities;
- establish quarterly reporting including comprehensive financial reports, progress against core performance indicators and addressing issues at all levels;
- supporting a re-energised and refocused health promotion initiative working directly with communities and encouraging participation by all; and
- increasing malaria prevention and control in all provinces.

Secretariat of the Pacific Community

Priority Area1: 'People focus'

- PHC training for field staff, including on health promotion and use of behaviour change communication (BCC) tools;
- leadership and management training for coordinators and managers to deliver a PHC approach programme and manage its resources;
- rebuilding the health promotion programmes within MHMS to support the people-focused approach;
- supporting health promotion education of some health promotion staff;
- liaising with the SPC Media Centre for attachments and advice on equipment upgrades;
- liaising with the SPC PHP BCC specialists for advice and support on information, education and communication materials production and capacity building for impact assessment;

2 *From: AusAID and Solomon Islands Government 2009*

- liaising with SPC PHP Healthy Pacific Lifestyle section for alcohol and tobacco use prevention activities;
- use of SPC's PRIPPP Small Grant Scheme for implementation of a risk communication plan for epidemic diseases, including pandemic influenza; and
- support for information and method sharing in a Healthy Settings approach.

Priority Area 2: Public Health Programmes (goal: strengthen public health functions to respond adequately to community health needs)
TB programme
- Development of protocols for contact tracing (a methodology for the region was developed for use in PICTs);
- routine collection of TB surveillance data (SPC collects quarterly TB data from Solomon Islands);
- participation in joint DOTS training missions (SPC and WHO);
- support for proposal development; and
- other support to be identified.

Epidemic preparedness and response capacity
- Support for avian and pandemic influenza preparedness;
- strengthening of national infection control (including training);
- support for lab-based influenza surveillance;
- procurement: personal protective equipment stockpile;
- technical assistance to address legislative and legal gaps for avian and pandemic influenza preparedness and the new international health regulations; and
- evaluation, finalisation and implementation of early warning and response system (SPC partner agency).

Human resource development and capacity building for implementing public health functions
- data for decision-making (short Field Epidemiology Training Programme) for key response health staff.

Priority Area 3: Malaria (goal: reduce malaria incidence and mortality)
- financial and technical support from SPC as a 'Principal Recipient' of grant funds from The Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM);
- procuring treatment and rapid diagnostic tests, bednets and indoor residual spraying of key malaria breeding and transmission sites
- training of malaria microscopists;
- training of health workers in on updated national malaria treatment guidelines, and the appropriate use of rapid diagnostic tests;
- training of nurses in rapid diagnostic tests use; and
- monitoring of drug resistance.

Priority Area 4: Common childhood diseases (goal: reduce morbidity and mortality of children under 5 due to common childhood illnesses)
- potential support to paediatric capacities: public health training for paediatric registrars; and
- potential support to National Child Health Committee operations.

Priority Area 5: NCDs (diabetes, cardiovascular disease, cancer and tobacco-related diseases)
(goal: prevent, moderate and control NCDs)
- expanding NCD programme to provincial level;
- reviewing NCD screening methods;
- strengthening of NCD database; and
- finalising NCD policy and use of findings to formulate NCD strategies.

Nutrition
- National Nutrition and Healthy Lifestyle Plan – a multi-sectoral approach to address nutrition and lifestyle related diseases 2007–2017; and
- collaboration with other SPC programmes to support PHC model.

Priority Area 6: HIV and AIDS and STIs (goal: prevent the health and well-being of the people of Solomon Islands from being undermined due to the burden of HIV and AIDS)
- support for implementation of NSP for HIV and AIDS through grants programme;

- support for targeted BCC initiatives; needs to be expanded to the provinces;
- support for voluntary confidential counselling and testing services to meet minimum standard for HIV testing, including laboratory testing;
- support for HIV and STI core care team both at national and provincial levels; and
- support for collaboration between HIV and TB programmes.

Priority Area 7: Family Planning and Reproductive Health (goal: improve reproductive health services and increase uptake of family planning methods)

- Under the UNFPA–UNICEF–SPC joint Adolescent Health and Development programme, SPC will work with MHMS to focus more efforts on sexual and reproductive health of young people – especially prevention of teenage pregnancy and STIs/HIV and other related issues.

Priority Area 8: Health System Strengthening Accountability and infrastructure (goals: improve management and leadership throughout the MHMS to achieve health and ensure existence of appropriate infrastructure reflective of identified needs and resources)

- SPC to provide advocacy and training support role in the areas of leadership and management (with partners such as WHO and training institutions);
- training on M&E for specific programmes and general health planning, and data analysis;
- financial management of grant programmes or schemes;
- procurement of programme-related equipment; and
- review of legislation in relation to HIV, IHR and pandemic or epidemic preparedness, and other health issues.

Information management

- Support to be identified.

Organisational change

- To be determined, in relation to the proposed integrated approach to two existing activities at the community level: the Kastom Garden and Tidy Village initiatives.

World Bank

- A signatory to the SWAp has committed USD 1.5 million through a TA grant with HSSP 2008–2012, targeting the areas of public health expenditure management and sector performance monitoring complementing the health systems focus of HSSP and the NHSP (AusAID and Solomon Islands Government 2009).

UNICEF

- Provides support to address the Common Childhood Illnesses programme, EPI, nutrition and health promotion.

UNFPA

- Supports the reproductive health programme and family planning, activities on gender violence, roll-out of the family health cards, and condom supply to the provincial health centres.

Global Alliance for Vaccines and Immunization

- Supports EPI.

Japan International Cooperation Agency

- Addresses water and sanitation, infrastructure (Gizo Hospital), malaria, and EPI.

Rotarians Against Malaria programme

- Construction of malaria staff housing, malaria lab and pharmacy.

Role of traditional healers, traditional birth attendants

Traditional healers and birth attendants still play quite an important role in most parts of the country. The HIES Health Module 2006 found that 2.7% of the survey population use traditional healers first for all sickness. Regardless of ongoing socio-cultural changes, Melanesian societies, including Solomon Islands, still hold strong beliefs in witchcraft, which in turn influences their response to illnesses and health-seeking behaviour.

Traditional birth attendants have an important role in some parts of the country due to access, cost of transportation, lack of female nurses in nearby clinics, and other unknown reasons. The HIES 2005/6 found

that 44% of women who gave birth in the village (10% of the survey sample) were assisted by customary midwives. The maternal mortality ratio is quite high in some provinces (such as Makira and Malaita), where traditional birth attendants are also quite actively involved.

Patients rights, choice and empowerment

Patients' rights are barely discussed in relation to public health care services in Solomon Islands, and are not demanded by the patients and their families in most instances. There have been situations where patients and their relatives who ask questions or seek explanations have been met with harsh responses from overworked and frustrated nurses. Nurses have expressed dissatisfaction with medical doctors who are not consistent in the performance of their duties. Patients may bear the brunt of these frustrations, but they do not always know their rights and are thus not in a position to defend themselves. Following public hearings the NRH Enquiry Committee recommended that a patients complaints tribunal be developed and implemented immediately.

Private health care is not an option for most people, as their ability to pay for services or drugs is very limited.

Health workforce

MHMS employed 1,840 staff in 2009, an increase of 22 positions from 2008 (Table 5.7).

In 2009, more than 40% of the ministry staff were based in Honiara: 15% at the headquarters, 23% at NRH and 5% at HCC. Sixty-five percent of the medical doctors in the country are based at NRH. Sixty-two percent of the health workforce serves PHC in the provinces, most of whom are nurses and nurse aides. However, classifying HCC clinics as part of the provincial network masks the additional human and financial resources devoted to serving Honiara.

Table 5.8 compares staffing levels to projected provincial populations. The smaller provinces (Renbel, Temotu, Isabel and Central) have the highest above-average staffing levels, as they are more isolated and there is a minimum level of staffing required to provide a basic level of service. Proximity to NRH explains the significantly below-average staffing at HCC. It also explains some, but not all, of Guadalcanal's below-average staffing. It is important to note that the ratio of 1 health staff to 318 patients is quite high considering provision of quality care. It also assumes that there is equal distribution of the population within the provinces.

Table 5.7: Ministry-funded staffing as of December 2008

	2009 Budget								
	Medical & dental	**Nurses**	**Nurse Aides**	**Profes-sional**	**Profession-al Helpers**	**Administra-tion**	**Ancillary**	**TOTAL**	**% of total**
Headquarters staff	9	171	27	99	1	72	19	398	15%
NRH	87	216	73	85	6	82	56	605	23%
Provinces	35	496	0	290	9	17	12	859	33%
Provinces-DWEs	3	26	412		153	43	134	771	29%
TOTAL	**134**	**909**	**512**	**474**	**169**	**214**	**221**	**2633**	
% of total staff	5%	35%	19%	18%	6%	8%	8%	100%	

DWEs: direct wage employees; NRH: National Referral Hospital

Source: MHMS 2008, 2009

Table 5.8: Comparison of provincial staffing to population projections, 2009

	Population projection	Number of provincial health staff	Number of people per health staff member	Percent above or below (-) average staffing level
Western	83,759	358	234	26%
Isabel	23,209	124	187	41%
Central	24,226	127	191	40%
Honiara CC	78,190	125	626	– 97%
Guadalcanal	79,555	175	455	– 43%
Temotu	21,190	118	180	44%
Makira	38,123	138	276	13%
Malaita	143,852	341	422	– 33%
Choiseul	24,060	102	236	26%
Renbel	2,174	22	99	69%
TOTAL	**518,338**	**1630**	**318**	**Average**

Source: MHMS 2009

Table 5.9: Comparison of staffing to population

	Difference with the 2009 average; % above or below (-) average							
	Doc-tors	Regis-tered Nurses	Nurse Aides	Profession-als	Profes-sional Helpers	Administra-tion	Ancil-lary	Total
Western	19%	0%	42%	12%	33%	46%	44%	26%
Isabel	48%	48%	12%	48%	38%	62%	41%	41%
Central	18%	24%	45%	32%	73%	7%	-14%	40%
Honiara CC	-32%	-71%	-227%	-75%	4%	-126%	-2102%	-97%
Guadalcanal	-79%	-36%	-66%	-31%	-1%	8%	-273%	-43%
Temotu	52%	100%	100%	100%	100%	34%	100%	44%
Makira	14%	20%	13%	11%	-10%	37%	-7%	13%
Malaita	-39%	**-23%**	**-30%**	-28%	-358%	-233%	19%	-33%
Choiseul	19%	36%	38%	29%	-91%	-39%	-13%	26%
Renbel	85%	80%	14%	80%	65%	100%	100%	69%

Source: MHMS 2009

The smaller provinces stand out in terms of above-average staffing. The eradication of malaria campaign in Temotu is expected to further bring in significant resources (finance and human resource) to the Temotu Province.

The below-average staffing levels at HCC are not so significant, given that it is located in Honiara and has access to NRH. Lower staffing and other resourcing levels in Guadalcanal is usually explained by proximity to services in Honiara. However, the high incidence of diseases and high maternal and infant mortality ratios indicates that residents may actually not have easy access to Honiara.

Apart from ancillary workers, Malaita falls below average staffing levels in all staffing groups, particularly in terms of professional helpers and administrative staff (Table 5.9).

Table 5.10: International comparisons – nursing staff

Indicator	PNG	Vanuatu	Timor -Leste	Samoa	Fiji	Micro-nesia	Solo-mon Islands	Kiri-bati	Philip-pines	Cook Islands
Number of nursing and midwifery personnel	2841	360	1795	310	1660	250	1389	260	480,910	80
Nursing and midwifery personnel density (per 10,000 pop. 2006)	5	16	16	17	20	23	27	28	56	57
Staffing for year	2000	2004	2004	2003	2003	2003	2009	2004	2002	2004
Actual population in 000, 2006 WHO Report	6202	222	1114	185	833	111	518	94	86,264	14

Source: MHMS2009

Table 5.11: International comparisons - physicians

Indicator	PNG	Van-uatu	Solo-mon Islands	Kiri-bati	Sa-moa	Timor -Leste	Fiji	Micro-nesia	Philip-pines	Cook Islands
Number of physicians	275	30	77	20	50	353	380	60	90,370	20
Physicians density (per 10,000 population)	0.4	1.4	1.5	2.1	2.7	3.2	4.6	5.4	10.5	14.3
Staffing for year	2000	2004	2009	2004	2003	2007	2003	2003	2002	2004
Actual population in 000, 2006 WHO Report	6202	222	518	94	185	1114	833	111	86,264	14

Source: MHMS 2009

International comparisons with other countries at a similar developmental stage show that Solomon Islands has a comparatively higher density of nurses than some countries in the region (27 per 10,000), while comparison for physicians per 10,000 is very poor at 1.5 per 10,000 population (Tables 5.10 and 5.11). This is based on 2009 data for Solomon Islands, while data for the other countries is from much earlier years, meaning the situation may have changed.

Training/capacity building: There are four nurse training institutions nationwide. The Solomon Islands College of Higher Education (SICHE) School of Nursing and Health Studies provides three years of pre-service training plus one year of probation for nurses. Three other nursing schools exist outside SICHE: two are run by churches and the third by the government. The School of Nursing curriculum was reviewed in 2009 to align it to strategic areas. Formal training for all doctors is taken overseas. There are plans for both the Fiji School of Medicine and the University of Papua New Guinea to establish a clinical school in Honiara for later-year medical and allied health students to complete their training in-country. WHO's Pacific Open Learning Health Network also provides

an opportunity for relevant post-graduate training, particularly in public health.

Various programmes continue to provide in-service training, mostly in the form of short courses to health care providers and trainers, both locally and overseas (given opportunities). A qualitative survey of health staff views on staff management detected a widespread perception of favouritism in the granting of in-service training, limitations on professional advancement, and an urban bias in training and other benefits.

Remuneration: Qualified local medical doctors have been leaving for more attractive packages overseas. The recently revised Scheme of Service has made employment packages for local doctors more competitive. Doctors posted at the provincial hospitals receive a 20% bonus as an incentive. The salary package for nurses has been a matter of ongoing discussion, however, and has generally been dealt with in a piece-meal manner.

The issue of poor housing conditions for nurses throughout the country has been raised repeatedly by the nursing council to the MHMS management, but has not been adequately addressed. This is an important issue that management needs to deal with, due to its bearing on nurse morale and performance. Forty-four prefabricated houses have been imported from Papua New Guinea Forest Products to be erected in Tetere, Gizo, Munda and Sasamungga. Nurses in NRH have access to a shuttle bus for transportation, particularly late at night. Alternatively, nurses should be paid a decent wage so that they can afford decent housing and their own transportation. Mission hospital nurses receive lower salaries than government nurses, but their housing is better, and other services are subsidised. Subsidies are beneficial, but they perpetuate the 'welfare' aspect of nurses' employment and don't place them in charge of their own destiny. HSSP aims to implement a staff performance incentive pilot at NRH following new policy from MHMS.

Direct wage employees (DWEs): DWEs are staff employed by the provincial health divisions who are not on the staff establishment plan, and therefore not included in the public service payroll for MHMS. These include nurses, cooks and cleaners. Nurses are employed at the provincial health divisions to cater for shortfalls in the staffing needed to operate clinics in rural areas. Construction of clinics by politicians, church organisations and donors without prior consent of MHMS and the provincial government contributes to this a situation. On the other hand, MHMS lacks a facilities development plan that is forward looking, and which can be used by both politicians and provincial decision-makers instead of ad hoc decisions made for political reasons. DWE salaries and curative services consume a major percentage of provincial grants, leaving little for preventative work.

Information systems

There are several parallel information systems within the different MHMS programmes, including:

1) HIS, with a focus on PHC contacts from the provinces and HCC;
2) NRH Medical Records, which collects information relating to NRH contacts and activities, including contacts with primary health care;
3) the Malaria Information System, which focuses primarily on malaria information; and
4) the Reproductive Health Monitoring System.

There has been a high degree of duplication, parallel data collection, and inconsistencies in information collection by the various systems. Data reporting from primary health clinics appears to be good (i.e. valuable information is available on supervisory and clinical outreach from provincial to peripheral centres), but no systematic and coordinated qualitative data are collected from the hospitals.

There are also gaps in the existing information collection systems in relation to emerging diseases such as NCDs (diabetes), cancers, and HIV and AIDS, which are becoming important causes of death in Solomon Islands. Disaggregated data on gender, poverty and ethnicity are also lacking. The HIS also does not have targets and indicators to trigger epidemic alerts. There are also inadequate data on causes of child and adult deaths in Solomon Islands.

Addressing the gap in information gathering is one of the major focuses of the systems strengthening of

HSSP. Through HSSP, MHMS engaged an information systems specialist to: i) assess the different systems and design a system that links the different databases into an MHMS data warehouse, ii) create an e-library, and iii) establish an MHMS intranet and Website. This work is being prioritised by MHMS, and is overseen by a special HIS strategic task force chaired at the under-secretary level. A new HIS data collection tool was implemented in 2008 that tries to fill data gaps.

Monthly reporting to HIS varies from province to province, with a total reporting rate of 91% for the whole country in 2008, a reduction of 6% from 2007. Remoteness, communication difficulties, and understaffing are among the primary reasons for failure to report. Provinces with notable improvements in reporting for 2009 are using the existing network of health high-frequency radios. There is a potential to use the Rural Internet Connectivity Systems (RICS) project (being implemented by SPC) to facilitate reporting for remote areas. It is important that HIS in Honiara analyse data on a regular basis and provide timely feedback to provincial hospitals to aid decision-making and timely response.

Health products, vaccines and technologies

The National Medical Store (NMS) is responsible for procuring and storing medical supplies, as well as related inventory management, shipping to secondary provincial storage points, and assisting with provincial stock management and distribution. Ongoing shortages at NMS have resulted mainly from delays in the lengthy international competitive tendering process introduced in 2007. Additionally, the April 2008 tender was awarded to a single supplier who is struggling to deliver orders. Stock shortages in provincial hospitals and clinics have been due to irregular shipping, limited storage space, and stock diversion and ordering by pharmacy assistants and nurses. Supply software is being used to manage stocks and put in place tracking to minimise stock diversion. Online ordering has been introduced and used by NRH pharmacy, with plans to extend it to other provincial pharmacies with supporting infrastructure.

Several improvements in 2008 resulting from technical support included:

- updating of the standard Pharmacy Officer Certificate course that was developed in the 1990s;
- localising a pharmacy intern course by development of a comprehensive one-year programme, incorporating tutorials, rotations, assignments and pre-requisite tasks;
- continuation of refresher courses for pharmacy officers;
- updating the essential drugs list, which has long been outdated; and
- replacing and upgrading of the air conditioning system at NMS.

Health financing

Recurrent funding of the health sector has fluctuated over the years largely due to the changes in government revenue, priorities and donor support. The government and its development partners accounted for 94.5% of health financing in Solomon Islands in 2004. Table 5.12 outlines the Solomon Islands government public recurrent expenditure on different sectors as a percentage of the government's total recurrent budget.

The health sector allocation accounted for 16% of the Solomon Islands government recurrent budget in 2007, and increased to 17% in 2008 as a result of support from AusAID (through HSSP). Health and education remain priority sectors for the government.

Table 5.13 shows the 2008 MHMS budget by source. The 2008 MHMS budget (excluding 'off-budget' funds) was SBD 313.8 million, an increase of 115% in the overall budget from 2007. This was largely a result of AusAID support of SBD 80 million for HSSP, which was made available to MHMS in July 2008. AusAID (through Health Information Strengthening Programme (HISP), HSSP and the National Public Health Laboratory (NPHL) was the biggest donor to the health sector in 2008. In 2009, the MHMS budget increased to about SBD 405 million due to allocations for capital development and HSSP funds. Table 5.15 shows changes in the MHMS budget between 2005 and 2009. There is a notable reduction in the administrative budget for 2009. The hospital continued to receive the largest share of the budget (30.1% in 2009), while provincial health systems and facilities, and public health programmes have had very modest, annual

Table 5.12: Health expenditure as share of government recurrent budget (in %)

	Budgeted			Actual		
	2004	**2005**	**2006**	**2004**	**2005**	**2006**
Agriculture and Lands	4.4	5.1	4.3	4.2	3.7	3.8
Auditor General	0.4	0.6	0.5	0.2	0.3	0.3
Education and Human Resources Development	29.4	30.4	32.4	28.1	27.9	31.9
Finance and Planning	4.6	9.6	6.8	15.1	10.3	10.5
Foreign Affairs and Commerce & Industries	3.8	4.9	5.6	4.2	5	4.6
Governor General	0.4	0.4	0.3	0.4	0.5	0.3
Health and Medical Services	**17.4**	**14.6**	**13.6**	**13.4**	**14.9**	**13.2**
Infrastructure Development	5.8	4.7	6.4	4.8	5.3	6.8
National Parliament	2.9	2.5	2	3.3	2.8	2.7
Natural Resources	2.4	2.6	3.3	1.8	2.1	2.1
Prime Minister Office and Cabinet	5.9	4.5	3.8	5.7	5.4	5.2
Pensions and Gratuities	0.9	0.5	0.5	0.4	0.4	0.4
Police and Justice	15	12	11	11.2	12.7	10
Provincial Government and Home Affairs	6.9	7.6	9.4	7.2	8.8	8.3
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Pretorius et al. 2008

Table 5.13: MHMS budget by funding source, 2008 (in SBD)

Funding source	Budget
Solomon Islands government – Recurrent	164,688,035
Solomon Islands government – Development	20,844,068
HSSP	80,000,000
HISP/HSSP	14,439,695
Tsunami relief funds	17,494,433
SPC	134,996
Solomon Islands Malaria Initiative	8,605,750
Embassy of Italy	460,901
AusAID – NPHL	6,493,030
Global Alliance for Vaccines and Immunisation	713,985
Total	**313,874,893**

Source: MHMS 2009

incremental increases. Health grants to the provinces have decreased over time despite increased health needs as shown in Table 5.14.

Table 5.14: Provincial grants as percentage of total MHMS budget

Year	Provincial grants as % of MHMS budget
1982	43.5
1992	28.7
2001	37
2008	22.1

Sources: WHO 2001; MHMS2008

Malaria, being the single most important killer in the country has been attracting large donor support (e.g. from Solomon Islands government, GFATM through SPC, Rotarians Against Malaria (RAM) HSSP and PacMISC), and this has contributed to the reduction

in malaria incidence since its peak in 2003. However, a proper analysis should be conducted of how broader health system benefits can accrue from such heavy expenditure on malaria. Issues include i) how well the malaria programme and its budgets are integrated into the primary health system and its rural outreach, ii) opportunity costs of running a parallel programme to that of provincial health centres, and iii) whether the malaria programme can contribute towards broader health promotion activities that in turn contribute to general improvements in health outcomes.

Provincial budget planning, execution and accountability are still major issues that need to be addressed. Provincial health care systems are given a lump sum amount and the tendency has been for the funds to be allocated to curative and administrative costs, with little if any funds left for preventative and rehabilitative services. Lack of planning, insufficient management personnel and skills to support PHDs, insufficient funding, and insufficient accounting personnel and skills are all contributing to difficulties at the provincial level. Additional issues include the

Table 5.15: Budget by programme activity

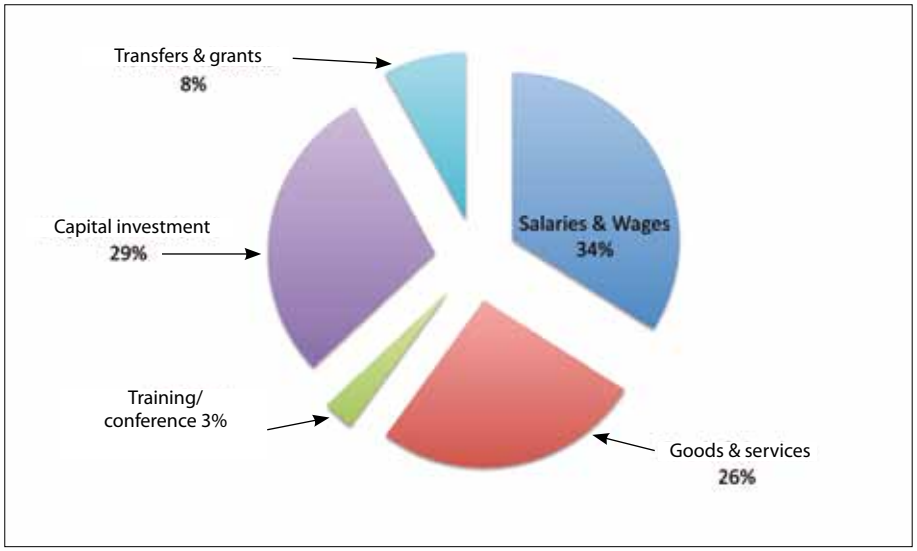
Programme	Total budgets (%)			Percent change (2008–2009)
	2005	2008	2009	
Administration	17	25	14.3	–10.7
Hospital care and facilities	32	22	30.1	8.1
PHC and facilities	4	26	26.4	0.4
Family health care	13	1	2.4	1.4
Disease control		1	4.5	3.5
Environmental health		3	4.3	1.3
Health promotion and education		2	2.6	0.6
Malaria control		9	6.3	–2.7
Medicines and equipment	17	11	8.2	–2.8
Human resources development	7	1	0.8	–0.2
Other functions	10			

Source: MHMS 2009

degree to which public health programmes that are planned in Honiara are reflective of provincial health needs, and are owned by the provincial health systems, and whether funding is provided. Acquittals on actual expenditures by provinces were very poor in 2007 and 2008, with only one church hospital reported for all quarters in 2008.

Figure 5.2 shows the grouping of 2009 health budget into input categories (MHMS 2009), which are included in the total budgets of each programme. Eight per cent of the total budget is shared between nine provinces in transfers and grants to be used in delivering services; these transfers and grants are also used for salaries of DWEs, which are not included in the MHMS salaries and wages budget.

Figure 5.2: 2009 Budget by input category



Financial sustainability

The ability of the health sector to continue providing health services of an acceptable quality and standard is a pressing issue for MHMS, given that the sector is heavily dependent on donor partners. While the sector remains a priority in government budget allocations, the actual support provided is dependent on the government's revenue. The government revenue base is threatened by the financial crisis and diminishing revenues from the forestry sector as a result of unsustainable harvesting, meaning the threat of health budget cutbacks and continued dependency on donor partners is highly likely.

HSSP will seek to address the following issues related to financial sustainability in the health sector:

- introduction of fees for selected services at NRH and some provincial hospitals;
- revision of revenue retention rules for all health facilities; and
- increases in MHMS revenues to more than 5% of the total health budget.

These recommendations were raised by the NRH Enquiry Committee in their report, suggesting that there may be political will to support these measures.

Leadership, governance and policy development

The turnover among MHMS top management positions has been high, making it difficult to maintain stability and continuity. Between January and June 2009, both the MHMS and the permanent secretary positions changed three times. Two of the three under-secretaries and eight out of nine provincial directors were also new in 2009. Stability in MHMS is maintained mostly at the programme and operational levels. Although appointing new management staff may impact continuity and thereby progress, it is important that MHMS upgrade staff skills and leadership. Introducing new leadership may also bring fresh perspectives to old problems.

MHMS (through NHSP) has mapped health sector priorities until 2010. Most of these priorities are not new, but the shift towards a sector-wide approach (through HSSP) to address them highlights renewed motivation to enhance coordination and reduce fragmentation and transaction costs related to multiple projects and donors and their procedures. These focus areas also reflect the priorities of the government in the MTDS.

In implementing the sector-wide approach in health, it was clear that there was a real need for a consultative and participative forum and process bringing all

development partners and stakeholders together to address core policy issues. The major recommendations from the first Joint Annual Performance Review in 2009 were:

- MHMS Executive Committee (comprising the permanent secretary and the under-secretaries) to be retained as the principal decision-making body, and to meet on a monthly basis. In addition, a larger body including heads of departments and provincial health directors (when available) is being formed to consider and advise on policy issues. Minutes of Executive Committee meetings are disseminated to heads of departments and provincial health directors. The Executive Committee had at least one meeting with the heads of departments and provincial health directors in late 2009.
- FBOs and NGOs to develop a central coordination body for health matters to work with MHMS in areas of coordination and support. This has yet to be fully implemented. Broad-based consultations with traditional partners involved in providing curative health services, such as ADRA, United Church and Church of Melanesia, are ongoing.
- Development partners have established a coordination group in order to improve development partner coordination and information sharing with MHMS. The development partners coordination group meets on a monthly basis and the chairperson role rotates between partners.

HSSP has created a forum for dialogue between various programmes within the health sector, the provincial health systems and their partners (including NGOs and FBOs), and donor partners. The forum places provinces and their rural health services delivery at the core of discussions. Provincial health directors voice frustration, however, that too much discussion is taking place with little being done to strengthen the capacity of provincial health systems. Dialogue and areas of collaboration between the health sector and the non-health sector (both government and non-state actors and donors) with bearing on health outcomes needs to be strengthened. Although the number of NGOs and FBOs involved in activities that influence health outcomes is large, it is imperative that they must be involved in the dialogue. The 2010 draft National Strategic Health Plan does, in fact, move towards decentralisation of budgeting and support for health care outcome delivery to the provincial level, so it is imperative that this shift is supported by donor partners to ensure that provincial health centres can effectively and better deliver health care services at the rural level.

Issues surrounding NRH services have recently attracted political interest. In April 2009, the Parliament resolved to appoint a Special Select Committee to 'inquire into and report on the quality of medical services provided at the National Referral Hospital (NRH) … in particular how they are managed and administered and how they may be improved'. The NRH Inquiry Committee conducted public hearings and put forward recommendations (see Annex 1 for details). If implemented, the three recommendations should have a significant impact on MHMS service provision. They are:

- The Solomon Islands government should reprioritise its budget process for NRH and MHMS and lift the current health budget reservation and exempt health from any future budget reservations.
- NRH should establish a governance structure to improve patient care and a quality control framework; develop a human resource management system for quality care as well as staff development; establish a patients' complaints tribunal; develop occupational health and safety procedures for staff; review public entry into NRH; and develop a system to ensure regular maintenance of key medical equipment.
- There should be an introduction of fee-for-service and private wards for those who can afford them, which may help in managing non-urgent cases at emergency and ear, nose and throat (ENT) departments; consideration of a children's hospital; guidelines for doctors who carry out duties at NRH and in private practice; and support for staff housing and transport (National Parliament of Solomon Islands 2009).

It is encouraging to see that the three recommendations, even though directed at NRH, are generally in support of most of what MHMS would like to achieve through HSSP, as outlined in the MHMS Vision for 2012. The fact that an Enquiry

Committee established by Parliament put forward such recommendations may ensure that the political will needed to implement them exists.

Any changes in NRH must not take place without enacting policy changes regarding many other issues that contribute to NRH inefficiencies, including the government's financial system, the decisions surrounding the level of care to be provided at NRH vs. provincial hospitals, and the limits to 'free' government health services. For rural patients, access to hospitals services requires consideration of shipping services and routes.

Other essential public health functions

Surveillance, research and control of public health risks and hazards

The monthly reporting to HIS by PHC facilities is probably the most comprehensive system for surveillance currently in place. There is limited scope for disaggregated data on gender, ethnicity and poverty, and therefore the health needs of specific groups are difficult to gauge. MHMS has been providing training to nurses to ensure collection of quality data. Other data sources include the programme-based information systems such as the reproductive and child health database, the malaria information system and the NRH medical records, which have been upgraded to provide hospital statistics for the first time in 2008. Data from provincial hospitals are still lacking. Under HSSP, quarterly reporting by all divisions and hospitals (including all provinces) has been introduced, which should also provide information.

Surveys, mass campaigns (malaria testing, immunisations, etc.), both by the MHMS programmes and donor partners, also contribute towards control of public health risks.

Health promotion

In Solomon Islands, health promotion cuts across all other national health programmes, particularly the five key health issues identified in the NHSP 2006–2010 (namely, malaria, STIs and HIV, NCDs, reproductive health, childhood illnesses and public health). The strategic plan was still under development in 2009.

Broad strategies currently used are:

- Healthy or tidy village settings (healthy/workplace concept and health promoting schools).
- Social mobilisation in coordination with global and national key strategic health campaigns, and in collaboration with key stakeholders (NGOs, churches and communities at all levels). Includes World Tobacco Free Day, World Sight Day, World HIV Day, etc.
- Development and distribution of information, education and communication materials and media to support national health programmes with health information dissemination. Daily programme on the national radio. Unfortunately, access to shortwave radios in very limited in the rural areas.
- Research and evaluation to produce evidence-based behaviour change intervention and develop benchmarks for monitoring of cost effectiveness.

Integrating health promotion activities on preventative care into PHC is increasingly important, and could entail MHMS programmes providing technical expertise (information and field support where necessary) in their areas of health concern, while the health promotion programme coordinates and delivers promotional activities in communities and schools, through the PHC systems in the provinces, and partners such as NGOs and FBOs. This would not only coordinate and integrate delivery of activities, but more importantly share limited financial and human resources between programmes. Provincial reports in early 2009 indicated that integrated tours by most programmes included health promotion. However, it should be emphasised that promotions about healthy or tidy village settings should go beyond giving community talks and sharing posters, and engage the communities in organising, planning and implementing their plans. Communities can also be involved in monitoring the impacts of their actions. Community engagement is a strength of NGOs and FBOs, and this should be taken into account when planning health promotional activities. The health promotion team can engage with NGOs and FBOs during the project identification stage to ensure health needs are addressed, geographical coverage is equitable, support (with information and technical expertise) is provided where needed during implementation, and

monitoring and evaluation of outcomes is undertaken. Diseases that receive significant financial support (e.g. malaria and HIV) should be used to contribute to achievement of broader health outcomes. Collaboration between MHMS and non-health sectors with bearing on health outcomes also need to be strengthened.

Social participation and empowerment

Solomon Islands presents significant geographic challenges, and most health clinics are extremely isolated, with hardly any contact with provincial medical authorities. This makes it imperative that communities are empowered to make decisions and implement actions to support their nurses and nurse aides, as well as monitor delivery of service.

NGOs and FBOs have proven track records of effectively using participatory processes to enhance participation in planning and implementing activities in the communities. While MHMS recognises and acknowledges the role of NGOs in improving health outcomes, and the need to enhance collaboration with them, the call for a formal agreement between these organisations has yet to eventuate. Such arrangements are happening on an ad hoc basis, such as the Guadalcanal Province health division engaging Solomon Islands Development Trust and World Vision for promotional activities in 2009.

Most villages throughout the country have a clinic committee, but very few are functional, as their purpose is not defined properly. Clinic committees are just one of many village committees. Simple training would be beneficial to help committees identify their roles, develop activities they can carry out to support their health centres, and select monitoring indicators to measure the performance of their health facility and community. They also need to know who to report to in the provincial health divisions.

Public health regulation and enforcement

Legislation relating to health is contained in various laws, including: those relating to public health, dangerous drugs, environmental health, health services, health workers, medical and dental practitioners, mental treatment, nursing council, pharmacy and poisons, and hospital regulation. Other health-related legislation includes the consumer protection act, water quality and safety standards, food hygiene regulations act, employment and labour laws, and laws on town and country planning. The above lists are not exhaustive but highlight the fact that there appears to be sufficient legislation in Solomon Islands that should ensure acceptable safety and health standards are maintained. However, some issues relating to this legislation are:

- Most of the legislation is outdated and has not been reviewed since independence.
- The average person in Solomon Islands (including health workers) hardly knows about the existence of this legislation; even if they do, it is highly likely that they do not know the details and how they relates to their safety and health.
- Enforcement of requirements in this legislation (e.g. safety standards) is minimal, even by those legally mandated to uphold them, who seem to see no need to uphold any standards or monitoring. Mechanisms for public input on health issues are lacking (other than through the newspaper). When concerns are raised (by the public or even through official enquiries and audits), action to remedy the situation is usually very slow in being implemented. In the case of village committees on health and general governance, lack of clarity regarding overlapping roles and functions, reporting, and channels for feedback (including the appropriate persons or offices within the MHMS structure) undermines their ability to function as an oversight body in rural areas.

Evaluation and promotion of equitable access

Past HIS data collection has not collected information on gender and poverty, but the form in use since the end of 2008 has addressed this issue. Other targeted surveys such as the 2006–2007 SIDHS are important sources of disaggregated health information (by gender, age, and wealth levels), which is useful for identifying groups in need. The Family Health Card programme is also geared toward understanding the health needs of families in the process identifying those in need of certain support. Feedback from nurses in Malaita already using the Family Health Card is very positive. The World Vision survey on people with disabilities led to the setting up of the community-based rehabilitation unit within MHMS, while the collaborative survey

with the Ministry of Women, Children and Youth (with technical support from SPC) on gender-based violence has contributed to the planned development of a gender-based violence policy. Work on mental health by Solomon Islands Development Trust has also contributed toward the Mental Health Policy.

There is clearly an imbalance between the distribution of public health resources (staffing and budget) and the concentration of those who need this support the most. Eighty-five per cent of residents in Honiara are in the highest wealth quintile, compared with 17.2% in Guadalcanal, 12% in Malaita, 30.4% in Western Province and 5.3% in the other provinces. Additionally, 85% of the total population are in the rural areas. Despite that, more than 38% of the health workforce (those in NRH, Headquarters and HCC), and more than 30% of the government-funded total recurrent budget was dedicated to Honiara in 2009.

Disaster preparedness and response

The increasing occurrence of natural disasters throughout the country is a cause for concern. Sustainable use of resources and conservation and adaptation to climate change are priorities outlined in the MTDS, and the government has been involved in high-level consultations highlighting the issues of climate change and its impact. However, Solomon Islands has yet to develop a National Sustainable Development Strategy (NSDS). Solomon Islands has been participating in several regional climate change adaptation programmes through the Secretariat of the Pacific Regional Environment Programme.

A coordinated programmatic approach addressing the health aspects of disaster is needed. There is renewed effort and resourcing of the Malaria Elimination Program in Solomon Islands. This is important, as changes in rainfall patterns and temperatures will affect mosquito populations, the rate of parasite multiplication in carrier mosquitoes (*Anopheles farauti*), as well as mosquito biting rates. Higher humidity increases mosquito longevity, increasing the incidence rates of malaria in areas already affected, as well as in areas with low case loads.

Extreme events such as cyclones and flooding are known to be associated with several direct negative effects on public health, including loss of life, injury and outbreaks of cholera and other diarrhoeal diseases. Water quality and water shortages, as may be experienced under drier future conditions, may also result in an increase in diarrhoeal disease. MHMS responds to disasters by putting in place emergency surveillance systems to monitor disease outbreaks. Provincial health directors have been voicing their concern over the lack of additional resources to rectify shortfalls in their health budgets due to resources being committed to disaster response. MHMS requires funding to enable deployment of an emergency surveillance system to detect and monitor disease outbreaks during disasters, but this remains a challenge. There needs to be a disaster response plan for the health sector developed, with earmarked funding. This is a Pacific-wide issue, and could be considered as a regional support programme.

The National Disaster Council (NDC) supported by the National Disaster Management Office (NDMO) under the Ministry of Home Affairs has the primary responsibility for disaster risk management in Solomon Islands. The NDC is currently reviewing the institutional framework for disaster risk management (DRM) as they plan to develop a National Action Plan for DRM and disaster risk reduction. This new plan and legislation also provides for a broader NDC membership, including the Prime Minister's Office, the Ministry of Development Planning and Aid Coordination; the Ministry of the Environment, Conservation and Meteorology; the Ministry of Mines and Energy; the Ministry of Agriculture and Livestock and the Ministry of Women Youth and Children (International Strategy for Disaster Reduction and World Bank 2009).

Chapter 6: Analysis and conclusions

Health priorities

Documented priorities

MHMS ***vision***
The overarching vision for MHMS is to see a '*healthy, happy and productive Solomon Islands people*'. MHMS will continue to work to improve standards and services in a manner appropriate to changing needs and environmental factors.

MHMS ***mission***
The mission statement of MHMS is to '*promote, protect and maintain the good health and well-being of every man, woman and child in Solomon Islands'*. MHMS respects the fundamental rights of individuals, but equally acknowledges the rights and core values of the community, as well as wider groups in Solomon Islands society, without distinction of race, gender, religion, political belief, economic or social condition, to have access to proper health and medical services. Furthermore, MHMS believes that health and well-being are not solely the responsibility of MHMS, but are in fact, the responsibility of all people. MHMS pledges to provide a high quality national health system that is accessible, appropriate, responsive and equitable, within the context of national health legislation and within the limits of resource availability.

Solomon Islands National Health Strategic Areas 2006–2010
Strategic area 1: People focus
Strategic area 2: Public health programmes
Strategic area 3: Malaria
Strategic area 4: Common childhood diseases
Strategic area 5: Non-communicable diseases
Strategic area 6: HIV and AIDS and sexually transmitted diseases
Strategic area 7: Family planning and reproductive health
Strategic area 8: Health system strengthening
- *8.1: Accountability*
- *8.2: Infrastructure*
- *8.3: Information management*
- *8.4: Organisational change*

Source: MHMS 2006b

Emerging priorities

H1N1 virus and the ongoing threat of avian flu: There is a need to accumulate sufficient medication in case of an outbreak, develop guidelines for treatment, and the bigger need of increasing public awareness on prevention measures to avoid an epidemic.

Water-borne diseases: Water-borne diseases are a concern due to increasing impacts of climate change and increasing occurrences of flooding and coastal inundation. Additionally, lack of proper sanitation facilities, particularly those in rural areas, exacerbate this problem.

NCDs: The burden of disease from NCDs is steadily increasing. Cases are generally presented late at hospitals. Knowledge of prevention, disease management or self care, and opportunities for early detection for effective case management by health professionals is very limited, particularly in rural areas.

Teenage pregnancy: The mean age at first sex was 17.3 years for women aged 15–24. Additionally, 85% of pregnant women aged 15–24 who took part in the Second Generation Surveillance stated that their pregnancies were unplanned. Regardless of the slight increase in the age-specific fertility rate, about 12% of

girls in Solomon Islands have children by the age of 15, thus increasing the risk of maternal or infant mortality and also contributing to high fertility rates.

HIV and AIDS: HIV and AIDS have already reached the epidemic stage in neighbouring Papua New Guinea. The number of cases in Solomon Islands is small but slowly increasing. It seems that knowledge and information about HIV and AIDS is abundant, but safe sex practices – as seen in the very low usage of condoms among those involved in high-risk sex – is a concern.

Assessment of the health system

The health system has generally recovered from the deterioration in services and outcomes experienced as a result of the political unrest between 1999 and 2003. Such a recovery has been possible due to the commitments of successive governments to prioritise the health sector. Equally important though has been development partners' support to the sector. The health system however, is so large that it has outgrown its ability to cope and respond to many health needs.

In 2008, administration absorbed 20% of the MHMS budget, NRH consumed 25% while the nine provinces shared 26% of the total budget. The 2009 budget shows only slight incremental increases in public health allocations. More than 40% of human resources are committed to NRH, its headquarters and the Honiara City Council. More resources need to be directed towards PHC services.

Table 6.1 summarises key issues and gaps in health services and systems.

Health service delivery: The NHSP 2006–2010 promotes PHC and outreach. However, the overall health system places a significant emphasis on patient coming to the health facility. Part of the problem is that NHSP 2006–2010 does not outline what services will be delivered, how they will be delivered, the cost of delivery or who will deliver the services. There must be decisions on what services NRH and other hospitals will provide, at what cost and what further resources to be committed to PHC and outreach, allowing for more resources into prevention and control of diseases, and rehabilitation.

Curative services are well established throughout the country. The preventative, control, and rehabilitation services (public health), however, have limited rural reach. There is a very strong emphasis on prevention and control in NHSP 2006–2010 but insufficient funds are allocated to support the programme. Also, integrating preventative health and other public health activities with main curative health services in rural areas would be more effective than trying to run parallel programmes that need extra resources and time, and lack ownership at the local level. This also means multi-skilling the nurses to be able to perform basic duties in their communities with backup and support from appropriate programme staff. Awareness talks and materials used in weekly radio programmes should also be made available to nurses and the PHC system because radio coverage is limited to certain parts of the country, and very useful information rarely gets out to those who need it the most. The availability of the radio network throughout the country provides medical doctors with a wonderful opportunity to support and provide advisory services to nurses in rural areas.

Health financing: Maintaining Solomon Islands government contributions into the health sector is very important to maintaining the level of services provided. With economic downturn and decreasing government revenues (due to a reduction in income from logging and fishing industries), the budgetary commitment from the Solomon Islands government is very tenuous. MHMS will continue to be dependent on development donor partner support to maintain health service delivery. It would be useful for MHMS in planning service delivery if donors could make reasonable and predictable long-term budgetary commitments towards the health budget. There is scope for MHMS to increase its revenue base from the sale of goods and services, particularly in Honiara and provincial centres.

Providing monthly grants to the provinces is a good practice because it gives provincial health divisions the flexibility to commit resources where their health needs are. Provincial health divisions, however, need to develop clear budgeted plans, linking their grants to activity budgets and health needs and operationalise their plans with minimal diversions. Development of plans by provincial health divisions will also force

Table 6.1: Summary of key issues and gaps in health services and systems

Building block	Issue
Health service delivery	▶ Policy decision regarding NRH and provincial hospital services to manage traffic to NRH ▶ Maintenance of facilities and equipment ▶ Strengthening and increasing outreach of preventative and public health services through integration into clinical services ▶ Health promotion to complement passive promotional techniques (e.g. radio, posters, community talks) by implementing action-oriented healthy village initiatives throughout the country through health facility staff ▶ Implementing NCD programme in rural areas, more effort in promoting family planning and reproductive health
Health workforce	▶ Support and monitoring of performance from supervisors and use of incentives to improve staff morale and performance ▶ Update of human resource development plan for MHMS ▶ Coordinated training to ensure multi-tasking of staff due to isolation of health facilities throughout the country and limited resources ▶ Assign more staff at PHC and rural facilities, especially in provinces that have below-average staffing levels ▶ Address issue of NRH doctors also in private practice to avoid conflict of interest and professional and ethical commitments to service provision at the hospital
Health information	▶ Collection of disaggregated data to identify disease patterns or trends and access or use of services by groups ▶ Timely feedback to provincial health divisions on disease patterns for management decisions or strengthening analytical capabilities at the provincial levels ▶ Better use of high frequency radios for quick and affordable support to rural health clinics ▶ Knowledge of HIV and AIDS (and STIs) and safe sex practices
Vaccines, health products and technologies	▶ Stock-outs at the medical store and improvement of the tendering process ▶ Joint procurement of medical supplies with private providers ▶ Rehabilitation of the cold chain and storage systems ▶ Making necessary equipment and expertise available at rural facilities to enable early detection and treatment of NCDs
Health financing	▶ Impact of reduction in government revenues on health budget ▶ Increasing MHMS revenue from goods and services ▶ Focusing resources on preventative and primary care to manage costs at secondary and tertiary care ▶ Protecting and increasing grants to PHC with the aim to increase efforts in healthy village initiatives ▶ Broadening impact of single disease funding (e.g. GFATM) ▶ Burden of wages of DWEs in the provinces who play an important role in health service delivery ▶ Planning and managing budgets
Leadership and governance	▶ Danger of HSSP being too focused on higher level systems and policies strengthening and not enough focus to frontline and or rural health service delivery ▶ Output-based monitoring indicators incorporated in national health strategic plan ▶ Maintenance of wider consultation guiding policy decisions the direction of sector-wide approach ▶ Active coordination, collaboration and support of partners (FBOs and NGOs) in health service delivery ▶ Initiative to collaborate with non-health sectors that have bearing on health outcomes ▶ A resourced plan to coordinate response on disasters

heavily funded programmes – such as malaria, HIV and other project-based budgets – to contribute resources towards these plans, and getting them to have impact beyond the immediate disease of concern.

Financial planning, budget execution and accountability at the provincial level need to be improved. Accounting staff from provincial health departments need to be provided with adequate training and support to be able to use accounting software and produce appropriate reports not only for grant disbursement but planning purposes as well. Issues raised by the auditor general must be taken seriously and acted upon in order to build confidence in MHMS's financial management. Under HSSP, the World Bank will be providing technical assistance in planning provincial health divisions.

Health workforce: HSSP is heavily into systems and governance strengthening but may not be paying sufficient attention to workforce conditions and how they affect service delivery. While system improvements contribute towards better service delivery, in reality this does not always hold true as can be seen from previous support in systems strengthening by AusAID. Dealing with the people working behind the systems, makes a big difference in commitment, motivation and willingness to perform well. Workforce morale has been described as low and workers as overworked, with numerous issues raised about working conditions, housing, and remuneration. Engaging a human resource specialist to develop a human resource and facility plan would be a big step in the right direction, particularly for the future, with the intention to start an incentive strategy pilot at NRH. Support and monitoring of nurses and nurse aides posted in rural clinics generally needs strengthening. Nurses are left to their own devices for extended periods of time. Clinic committees in rural areas generally lack the capabilities to support as well as monitor nurses' performance. Clear guidance is needed on the role of clinic committees, how they should support nurses, as well as who they should report to above their immediate nurse.

With more emphasis on public health and preventative measures, there will also be a requirement to continuously upskill health care workers to help them reorient their approaches in health service delivery. Additionally, the same staff will be required to support more varied programmes given the increasing disease patterns and public health programmes. Health care workers in the field therefore need to be multi-skilled and knowledgeable.

Health information: Efforts at integrating various information systems within MHMS is in progress. Information collection from rural facilities has been problematic and quite weak in some provinces. In order for information collection to be meaningful, it has to analysed and the findings need to be fed back to specific provinces for decision-making in a timely manner. Alternatively, provincial HIS staff can be skilled enough to be able to carry out analysis of provincial data, and give feedback to their management on a timely manner. Maintaining data quality and integrity is an important ongoing challenge and relies heavily on ability of isolated health care staff to record and report accurately on data. Additionally, health care workers must understand the need for disaggregated data in order to provide accurate reports. The introduction of Family Health Cards seem to have been positively received and has been found useful by health care workers in one of the provinces that has been implementing the program since mid-2008.

Vaccines, health products and technologies: Stock-outs at the national medical stores and provincial pharmacies were ongoing in 2009. Under HSSP, a procurement specialist was recruited. The specialist is already familiar with MHMS, his counterparts, and with the Solomon Islands government financial instructions governing procurement. It is hoped that support to national medical stores and pharmacies will soon put an end to stock-outs. Effective use of the stock monitoring system (mSupply) should contribute to proper management of supplies at provincial pharmacies and hospitals, and reduce diversion. Joint procurement of medical supplies with private providers should be explored.

The cold chain and storage systems in most facilities need servicing, maintenance or replacement.

Improving the rural reach of NCD programmes has been limited, due to the unavailability of necessary equipment and expertise at rural facilities.

Leadership and governance: Under HSSP, an Executive Committee – comprising the permanent secretary and the under-secretaries – as the principal decision-making body is supported by a larger body, including heads of departments and provincial health directors (when available) to consider and advise on policy issues is being formed.

NHSP, which provides the roadmap for health service delivery, is in review. The Vision 2012 already outlines what HSSP intends to achieve by 2012. Developing a long-term comprehensive and properly costed health plan that would ensure government and donor resources are directed where support is most needed is important. Monitoring targets, indicators and mechanisms must be put in place to measure the achievement of desired outcomes of health plans. Provincial health directors need to be supported both with administrative and accounts staff. Dialogue between MHMS and donors (and among donors) should be regular and consistent to ensure that health assistance reflects health priorities. Donors and technical partners should commit formally to align with national mechanisms and priorities under the new national health plan from 2011.

With regards to HSSP, there needs to be a clearer linkage provided between the focus of HSSP (systems strengthening) and the front-line service delivery at the PHC facilities at the rural areas. Review of sector-based support programmes in 10 sectors in six African countries by the Overseas Development Institute (ODI) (Williamson and Dom 2010) has shown that on one hand, it has contributed towards expansion of services leading to improved accessibility, particularly when there is heavy financing of service delivery inputs. On the other hand, the non-financial inputs seem to be heavily concentrated at the main centres with minimal trickle down effect of personnel and systems strengthening further away from the centres. There is a danger that a similar pattern maybe occurring in Solomon Islands with support to the health sector. That most of the non-financial inputs (technical assistance) of donor partners into HSSP seem to be Honiara-based (i.e. urban) with little direct support going towards strengthening the PHC network to ensure efficient, effective and of good quality and equality in health service delivery improvements. While it is important that limited support be targeted towards where it should make the most difference, experience has shown that benefits of previous strengthening support targeted to the Honiara health bureaucracy have not always trickled down to the provincial PHC levels. This has been a longstanding concern for provincial health centres that has yet to be dealt with effectively. The World Bank, through HSSP, is addressing this issue in providing technical assistance to the provincial health divisions in financial planning and management. More of such support should be done to ensure all levels of health services are strengthened.

FBOs and NGOs play a major role in clinical and health promotional services in the country. The Joint Annual Partners Review in 2009 (MHMS 2009) recommended that an FBO or NGO coordinating body be formed to collaborate with MHMS. This recommendation can only be realised if MHMS takes a leading role in developing this coordinating body. Such a coordinating body should streamline and coordinate collaboration efforts by NGOs and FBOs with MHMS as well as contribute towards defining areas where support is mostly needed by the health sector. For health promotions, the role of the health sector would be identifying disease burdens and trends, and providing technical information and expertise where needed, while NGOs would carry out the community processes for healthy village settings. Some aspects of health services, particularly health promotion, could be projectised to provide resources for NGOs and FBOs collaborating with MHMS to increase their outreach activities. Output-based monitoring by MHMS would be important to ensure desired health outcomes are achieved.

Determinants of health

Efforts to improve health outcomes within existing financial resources would require health plans to focus at addressing the broad underlying determinants of health as opposed to the manifestations of ill health. This implies the active involvement of non-health institutions and comprehensive interventions that combine approaches such as communication for behaviour change, information, education and communication, social marketing, advocacy and social mobilisation and engagement with communities through the PHC network and partners.

Disease burden in Solomon Islands is still heavy from preventable communicable diseases and increasingly lifestyle-induced NCDs (e.g. type 2 diabetes, oral cancers, obesity, and hypertension) are becoming significantly important as well. In order to manage the costs of health care as well as achieve quality and equality in health outcomes, more emphasis must be placed in addressing the causes rather than the symptoms of communicable diseases and NCDs.

Partnerships for health: Health is largely determined by factors outside of the health sector. Traditionally, the health sector and its development partners pay little attention to these external determinants. If the burden on health services is to be managed, MHMS must take a leading role in forging effective partnerships with other sectors. Without such collaborations, reductions in incidences in priority areas cannot be achieved. For example, NCDs require collaborations with the Ministries of Agriculture, Fisheries, Youth and Sports, Chamber of Commerce. ARI and diarrhoea require collaborations with authorities involved in housing, waste management and water services.

FBOs, NGOs and CBOs have established rural networks, and are particularly effective in raising awareness and promoting healthy lifestyles at the village level. Effective partnerships between government and NGO sectors in Solomon Islands are very weak. Within the health sector, such collaborations have been traditionally with FBOs providing clinical services. In order to extend the rural reach of preventative, promotive and rehabilitative programs, other partners must be involved directly. MHMS's budget is insufficient to provide support to these organisations. Regardless, MHMS should develop a plan on how they will collaborate with FBOs, NGOs and donors to support those plans. Additionally, more needs to be done to encourage private businesses to become involved with improving health outcomes.

Poverty, gender and disability

The Solomon Islands government in its MTDS is committed to working towards achieving the MDG targets. However, poverty and gender inequality have received little specific attention in national health sector policy or funding agreements with major donors and technical partners. Because the health service is heavily subsidised, affordability of the actual service is not an issue. Other factors relating to access and use of services, however, remain a challenge for certain groups of people within the society.

Poverty: While there is no chronic poverty in Solomon Islands as seen elsewhere in the world, poverty does exist in terms of lack of access to basic services and opportunities to earn income. Honiara, with a higher percentage of its population living under basic needs poverty (32%), ranks third lowest (82.3%) in health services utilisation. Temotu and Makira provinces, which are among the provinces with highest percentages of their households being under the basic needs poverty line, also have the lowest health services utilisation (82.2% in Temotu and 78% in Makira). With hospitals being located in provincial centres, and shipping services and routes being irregular and inconvenient, most rural families face difficulties accessing services.

Private health services are highly regarded but also expensive and unaffordable for most. While MHMS refunds transportation costs associated with hospital admissions and referrals, for less educated rural people issues relating to cultural beliefs, language barriers and self confidence (particularly for uneducated women) can further disadvantage them in accessing available services. With regard to equality in educational attainments, strategies must be in place that improve opportunities for completion of secondary education, particularly for those from lower household wealth quintiles.

Gender: The 2006–2007 SIDHS had several gender related findings including high dropout rates on immunisation for girls while educated mothers making better choices for their families (e.g. nutrition and immunisation). Health-related gender inequality and potential disparities include the current and potential burden of illnesses associated with gynaecological malignancy and pre-malignant lesions, and the lack of access to oncology services throughout the country, the lack of access to family planning services and the burden of childbearing and high fertility rates, information on preventative care, and services needed to make the right choices. Women may be expected to

bear a disproportionate burden from these emerging health problems. Alternatively, women may have access to information but do not have decision-making authority over them and their family's health.

Disability/mental health: Services for people with disabilities and mental health are very limited, and the responsibility lies primarily with families, NGOs and FBOs. One of the strategies is to promote a people focus to integrate social welfare, community-based rehabilitation and mental health services into the main health care service. However, this has been hampered so far by a lack of staffing, equipment and sufficient financial support. The main psychiatric unit is in Malaita Province, effectively limiting access by most of the other provinces. The CBR Unit within MHMS has yet to increase its rural reach.

Limitations of available information: Collection of disaggregated data in the monthly contacts is important to be able to analyse the extent or causes of unequal access to services. Equally importantly, performance and outcome indicators must be disaggregated by gender, age group, income quintile or other socioeconomic characteristics to make monitoring of the extent of inequality and success of interventions used. Better information is needed on the size and location of populations not currently well served or accessing services, and to inform policies and approaches to address these issues

Gaps

The priority areas identified in the NHSP 2006–2010 can be broadly categorised as addressing three interconnected areas: people focus, diseases and system strengthening.

People focus: Gaps

Health promotional activities are still very limited and even more so in the rural areas. Preventative care has yet to be integrated into the curative services. Health promotion staff positions in several provinces are reported to be vacant. Grants to the provinces are not sufficient to enable them to finance preventative public health activities. Health promotional activities also need to be action-oriented and engaging instead of just awareness and information sharing.

Family planning: According to SIDHS, there is an unmet need of 11% for family planning among unmarried women. There is quite a lot of misinformation and uncertainty about effects of various family planning methods on a woman's body, as cited by 37% of women who are not using contraceptives. Potentially, the unmet need is higher, especially if women get better informed. Family planning education outreach is very limited because it is mostly provided when pregnant mothers come in for antenatal clinics instead of the nurses going out. Nearly two thirds of women who took part in the Second Generation Surveillance reported that their pregnancies had not been planned. Of these, 85% aged 15 to 24 years and 69% aged 25 to 44 years reported that they did not use any form of contraceptive in the three months prior to becoming pregnant. Central Province has reported increasing participation of men in the uptake of non-scalpel vasectomy.

Teenage pregnancy and maternal health (SRH): The reproductive health programme and family planning are not addressing this issue properly. Parents need to be involved so that they come to terms with the fact that their children are sexually active and that they have a role to play in encouraging preventative and safe sex practices.

Nutrition: Education needs to go out to the communities through nurses at the clinics, women and church networks. The unit needs to be elevated in importance and be strengthened in financial and human resources. The Nutrition Unit within MHMS in 2009 was staffed by only three people. The provincial positions were all vacant.

Sanitation: HIES 2005/06 report 31% coverage in improved sanitation facilities for the whole country. This finding is further supported by SIDHS 2007 findings that 60% of households throughout the country do not have access to improved sanitation facilities, with the percentage increasing to 92% for rural households. Lack of sanitation facilities and unhygienic practices is a primary contributing factor to continuous occurrences of diarrhoeal disease, particularly with children under five years old.

Diseases

HIV and STIs: There is a major gap between knowledge of the disease, in particular HIV/AIDS and uptake of safe sex measures regardless of major funding put into it. The Second Generation Surveillance found that 80–90% of youth correctly answered all five United Nations General Assembly Special Session questions on HIV transmission and major misconceptions. However, of the 56% of males and 40% of females who reported involving in overlapping sexual relations, only 30% of males and 25% of females used condoms in their last sex. This study found very high rates of STIs among both pregnant women and youth.

NCDs: Knowledge on preventative health measures is generally lacking among the majority of the population making it difficult to link lifestyle to diseases. Opportunities for early detection are insufficient throughout the country either due to lack of equipment or insufficient knowledge and skills by health care providers at the PHC network.

Communicable diseases: These preventable diseases continue to place heavy burden on the health care system. For some of these diseases, increased interventions in healthy settings and promotion of hygienic practices should have immediate impact whereas others such as waterborne diseases need more input into sanitation facilities and clean drinking water facilities.

System strengthening: Gaps

- Clear linkage between the ongoing systems strengthening between the national programmes and the provincial health divisions and further to the primary care network in the rural areas.
- Monitoring of quality of service delivery and support provided at all levels.
- Provincial operational planning and budgeting linking activity to budgets, identifying areas for savings and minimising diversions from budgets.
- Monitoring of equality (gender/poverty/ethnicity) of access to service.
- Strategic plan to have a simple monitoring framework with smart performance targets and indicators.
- Strengthening of village committees to be able to support health care staff, monitor performance and provide independent feedback to provincial health divisions.

Development effectiveness

Balance between funding and national priorities

Malaria, the main killer disease in Solomon Islands, has received the most budget support, principally from GFATM (through SPC), Solomon Islands Malaria Initiative, PacMISC and HSSP. It appears, however, that opportunities presented by availability of such funds (particularly GFATM) have not been used to achieve broader health benefits. Such grants-based support is often related to specific projects and activities with little effort to integration and rarely provides support for health budgets that addresses necessary long term recurrent costs to ensure maintenance of improved health outcomes achieved.

The introduction of a sector-wide approach in Solomon Islands is to minimise such unnecessary duplications and transaction costs in dealing with dealing with various donors. The goal of this approach is for donors to contribute towards one budget that funds well defined, evidence based health priorities in the country.

The effectiveness of regional funding and technical assistance

Regional organisations have proven themselves to be useful vehicles in representing a collective voice on issues of concern to the small island nations of the Pacific. Similarly, they have played an important role in securing global funding resources that would have otherwise be inaccessible to smaller countries due to donor requirements or heavy administrative burdens for application. The actual implementation and outcomes of these regional projects has been mixed messages and lessons learnt.

Benefits and advantages: Presence of technical expertise in the regional implementing agencies and their wide networks can prove useful in tapping into resources. Also where more than one agency is involved in a regional program, they can identify synergies and harmonise approaches to enhance assistance. It also

provides opportunities for participating countries to adopt cross-sectoral collaborative strategies in country.

Regional aid that allows for implementation through small grants to government, non-government sectors and directly with communities provide some flexibility and opportunities to align with national strategies and local needs. It also allows for collaboration between different implementation parties on the ground as well as sourcing necessary external technical assistance.

Working through regional organisations the small Pacific Island countries have been able to indirectly source support from global agencies such as GFATM, that would otherwise be inaccessible because of scale, cumbersome administration, or non-availability of technical expertise and experience necessary to access such big grants. Economies of scale can be realised in multi-country programmes that require procurement of equipment.

Disadvantages of regional approaches: The primary disadvantage of regional approaches is around the issue of who owns and defines the priorities for action. In developing regional strategies, differences between countries tend to be overlooked and the priorities lumped into convenient categorisations that meet specific donor requirements but are not very meaningful to specific countries. This raises issues around equity in benefits between the countries in the region and the regional organisations.

Confusion surrounding who the regional countries are answerable to can arise. A clear example of this is the Malaria Control Programme in Solomon Islands funded by GFATM through SPC whereby the local programme maintains contact directly with GFATM as well as through SPC.

The focus of donor funding earmarked for specific health problems (e.g. malaria control, HIV, NCDs) tends to be very specific and targeted, rather than integrative and holistic achieving broader 'diagonal' strengthening of the health system for longer term improvements in health outcomes. This can be particularly pronounced where a relatively small amount of funding is to be divided between a number of countries.

Incompatibility between national financial management and disbursement mechanisms and the regional organisations has a tendency for parallel mechanisms to be setup with specific requirements. This distracts from service delivery and can create duplication and inflexibility in integration into broader health programmes.

Provisional recommendations

Disaster Response Health Plan: With increasing occurrences of natural disasters and their associated impact on human health, it is necessary for health authorities to develop a coordinated response to disasters. While the renewed effort of the Malaria Elimination Programme is a good start on preventing epidemics, there needs to be better planning and preparedness to respond to disasters.

Population policy: There needs to be a more aggressive policy to manage the currently unsustainable growth in population. The growth of all government services, including health and education as well as the economic growth of the country, are all trailing behind the explosive population growth. Without donor support, Solomon Islands will not be able to continue providing quality services to all. Thus far, Solomon Islands has not been able to harness its vast human resource into productive use. Failure to manage ongoing population growth will result in serious consequences for the country.

Multi-pronged or holistic health promotion strategy implemented at the community concurrently: There are multiple health issues in communicable, NCDs, reproductive health and family planning that can be addressed concurrently through programmed and coordinated public health promotion that goes beyond producing passive educational talks and materials, and develops creative action-oriented programmes in collaboration with partners and related sectors. Targeted actions are more effective than generalised actions. The issue of scale for targeted actions can be addressed by integrating promotions with PHC activities and human resources up-skilling and engaging NGOs and FBOs. For rural clinics and health care staff, a six monthly tailorable programme fully resourced

with necessary information with health provider staff and expertise from health providing backup support and monitoring. For some areas such as sanitation facilities, it may be possible to achieve wider coverage if MHMS gets into part subsidy arrangements instead of providing sanitation facilities free of charge. Such actions, however, should be based on clearly defined criteria ensuring that poor households are not excluded.

Sufficient resourcing of provincial health care networks and improved planning and accountability: The strength of health care in Solomon Islands is its rural PHC network. However, for many years the PHC network has not been allocated sufficient financial, equipment and human resources, while bulk of resources has been committed to NRH and Honiara. There have also been issues of opportunities for staff development being unfairly limited to Honiara-based staff. While moving resources to front-line of health care delivery is one of the focal areas of AusAID-funded support into the health SWAp, it is imperative that a clear workable mechanism is put in place that defines resource allocation between the head office, NRH and the provinces. This should be well understood and easy to use without additional technical support to ensure ownership by MHMS. Accounts and administrative staff should be in place in all provincial divisions so that their capacity can be built through the planned technical support to the provinces for financial planning and management through HSSP.

Chapter 7: Next steps in developing the Framework for Priorities in Health

Next steps for Solomon Islands

The Solomon Islands MHMS was invited to consider some of the priorities and gaps and the possible strategies and approaches developed to address them in this country case study. A draft of this document was presented to the National Health Conference held in September 2010.

The National Health Strategic Plan has been reviewed in 2010. It is possible to incorporate priorities, gaps and innovative approaches into the new strategic plan and programme level operational plans and budgets, and in the negotiations of funding agreements with major donors. The establishment of a sector-wide approach in health with a dedicated five-year financing commitment from AusAID, World Bank and UN agencies is an important milestone and an important opportunity for MHMS to draw up national level health priorities and better align these crucial funding agreements with national priorities and gaps.

A robust, costed national health strategy and annual health sector operational plan – to which all partners in the sector are committed – is an acknowledged cornerstone of development effectiveness in health. The challenge will then be moved to ensuring optimal use of funds and the effective delivery and achievement of outcomes that will meet MHMS's priority targets as well as Solomon Islands' national commitments to achieve regional and global (MDG) health targets.

Achieving the right balance between nationally and regionally delivered assistance is also necessary. For Solomon Islands, a shift towards aligning aid through the multi-sectoral approach in place would be important especially with efforts gone into detailed costing of the health sector Medium Term Expenditure Framework. However, this would most likely be contingent on:

- maintenance of a suitable and equitable forum for policy, technical and financial dialogue between

the government and principal donors and technical partners in the health sector;
- careful adherence to national health strategy and policies, with a view to eliminating divergence of expenditure from the approved MHMS budget; and
- establishment of a clear strategy on health sector engagement with partners in health (including NGOs and FBOs) and non-health sectors with bearing on determinants of health.

It is important that Solomon Islands have the capacity to analyse and prioritise national health issues and challenges, to maintain consistent dialogue with development partners, and to manage aid within the health sector effectively. A monitoring framework with simple set of outcome indicators included in the National Health Sector Strategy can be used to monitor progress relative to the priorities and gaps identified.

Unless we direct sufficient resources towards addressing and monitoring the social determinants of health in parallel with health outcomes, we will not be able to effectively meet the challenges laid before us in the *Healthy Islands* agenda. The development of analytical tools also provides a good opportunity to catalyse the harmonisation of multi-sectoral approaches within national governments, between regional development partners and technical agencies, and between divisions and programmes within SPC's Public Health Division.

Developing the Framework for Priorities in Health

Meeting of Pacific health ministers

The methodology and key findings in relation to development effectiveness was presented in the Aid Effectiveness session at the Pacific Ministers of Health Meeting in Madang, Papua New Guinea, in July 2009.

The three initial country 'frameworks' case studies commissioned by the Secretariat of the Pacific Community in early 2009 were tabled at the Pacific Ministers of Health meeting in Madang in July 2009. At that meeting it was determined that the three pilot studies (Nauru, Palau and Solomon Islands) constitute a good start in gathering information for the establishment of a Framework for Priorities in Health document, but that additional case studies would be required to further inform it.

Using the analytical tool for national self-assessments

Countries may wish to consider using the Framework for Priorities in Health methodology as one of the analytical tool to support the development or review of their national health strategies and plans. The framework can serve as a basis to inform effective donor funding, and enhance better alignment of development assistance in health, as well as a guide to building or strengthening multi-sectoral mechanisms to address the social determinants of health and the strengthening of health systems.

Targeted technical assistance could also be available, as required, through the four AusAID-funded academic units (referred to as the 'knowledge hubs') and the collective technical expertise of the WHO Regional and South Pacific offices, the SPC Public Health Division (with its access to cross-sectoral resources within SPC), health and social sector advisers from several of the region's principal donors (AusAID, NZAID and the World Bank) and other supporting partners in other countries such as New Zealand as well as regional academic institutions such as the Fiji School of Medicine.[3]

Strengthening the effective use of regional resources

Lessons drawn from Solomon Islands' experience of regional funding and technical assistance mechanisms will feed into broader discussion and debate among development partners about the best and most efficient ways of delivering development assistance for health in the Pacific.

3 *The 'knowledge hubs' can provide expertise in health systems and financing (the Nossal Institute, University of Melbourne), health information systems and information management (the School of Population Health, University of Queensland), human resources mapping and analysis (the School of Public Health and Community Medicine, University of New South Wales) and maternal and child health (a collaboration between the Burnet Institute and the Centre for International Child Health, Melbourne, and the Menzies Institute, Darwin).*

An initial meeting between the principal donors in the South and Central Pacific, AusAID and NZAID, and the region's principal technical agencies, SPC and WHO, was held in August 2009. This forum subsequently expanded to include high level consultation with other funding agencies (e.g. the World Bank, which has assisted in the establishment of sector-wide approaches to health in Papua New Guinea, Samoa and Solomon Islands) and may include at a later stage relevant agencies from other major countries (e.g. the United States Centers for Disease Control and Prevention, which is active in the North Pacific).

High level discussions are currently taking place in the region between major donors (AusAID, NZAID and the World Bank) and critical partners like WHO and SPC as part of the evolving Health Policy and Systems Working Group for the Pacific (the Quintilateral), and are identifying innovative approaches to improve the aid architecture in the region as well as aid effectiveness. The group was formed to consider the lack of progress of the health MDGs and looked at options for improving aid effectiveness. It seeks to strengthen aid effectiveness of development assistance for health in the Pacific region particularly assistance provided through regional approaches.

Reflections are taking place about the logic and better identification and alignment of regional programmes with national priorities, the review of the current Aid architecture , the review of health SWAPs, the identification of innovative tools for the improvement of health planning and country health sector programming. Other topics include the harmonisation of development assistance and the regional aid architecture, governance mechanisms, and modalities of strengthened cooperation to better support and address countries priorities and gaps. The joint work has already identified common issues and messages that need to be refined to provide sound and very practical directions for the future and develop best practices for aid and assistance based on evidence focusing on innovative thinking towards aid effectiveness and results.

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Annexes

Annex 1: NRH Enquiry Committee Recommendations 2009

Recommendation 1
The Committee recommends that the Solomon Islands government, through the budget process, reprioritise funding of the National Referral Hospital (NRH) to allow the hospital to deliver a standard of health care commensurate with the hospital's position as the primary health care service provider in Solomon Islands; and to immediately lift any reservation that may currently be on the health budget and exempt health from any future budget reservation.

Recommendation 2
The Committee recommends that with better funding of the NRH by the Solomon Islands government, the NRH management progress the following initiatives at once:

- The establishment of a basic clinical governance framework at the NRH as a matter of priority to improve patient care and outcomes;
- The development of a quality control framework with a focus on the systems of the Medical Records Department, and an absolute priority placed on the implementation of the ICD 10 software package and associated clinical indicators in 2010;
- The establishment of absolute minimum staffing levels for key departments such as the Accident and Emergency Department, and the recruitment of personnel to meet those absolute minimum staffing levels as necessary;
- The immediate rectification of the current nurse to patient ratio to ensure adequate minimum care for patients of NRH, including the development and immediate implementation of a scheme to re-engage retired nurses to assist with nursing responsibilities and training of nurses;
- The development of a human resource management system to ensure that all personnel, including nurses, have access to training and development opportunities, that all staff receive regular performance appraisal and reporting, that all staff follow the applicable rules (including the General Orders) on staff workplace attitude and ethics, and that where vacancies arise those vacancies are filled promptly on the basis of merit;
- The immediate implementation of a Patient Complaints Tribunal;
- The implementation of proper occupation health and safety procedures, laboratory procedures and infection control measures to ensure healthy and safe working environment for NRH staff, patients and visitors;
- The review of the hospitals security services including the implementation of a visitors register and the engagement of a private security firm to provide security services at NRH;
- The development of systematic processes for the regular replacement and maintenance of key medical equipment,

Recommendation 3
The Committee recommends that the Solomon Islands government, the Ministry of Health and Medical Services (MHMS) and NRH management work together to address the following matters:

- The viability and appropriateness of introducing a fee for certain patients of NRH, especially as may be used to manage the presentation of non-urgent cases to the Accident and Emergency Department and ENT Department;
- The possibility of establishing a private ward at NRH to ease the burden on the public hospital;
- The possible establishment of a chapel at NRH;
- The possible establishment of a children's hospital in the medium to long term;
- The possible long-term move of NRH to a new site, and where that site should be located;
- The development of appropriate arrangement to guide doctors who carry out both NRH duties and private practice;
- The provision of assistance to staff of NRH for housing and transport to and from work.

Annex 2: Solomon Islands – Australia Partnership for Development

Detailed performance framework

PRIORITY OUTCOME 1: IMPROVED SERVICE DELIVERY				
Aspirational goal: The Partnership will strengthen public health functions that are responsive to community health needs and improve progress towards the MDG targets by 2015.				
Partnership outcomes	**Solomon Islands Medium Term Development Strategy outcomes**	**Objectives**	**Indicators**	**Milestones**
Increase percentage of population with access to a health facility staffed by a health care worker and stocked with appropriate medicines.	Proportion of people with access to at least a rural health clinic within one hour of travel increased from 61% to 67%. At least two rural communities benefit from new health clinics each year. Essential drugs and medicines available at all levels and at all times.	1. Upgrade, maintain and increase health care facilities such as hospitals, clinics and aid posts and provide the necessary equipment to enable health workers to discharge their duties more effectively. 2. MHMS develop efficient systems for the procurement, and supply of essential medicines down to the rural health clinic level. 3. Improved transport infrastructure for Provincial Health Offices to improve access and supply of essential health services.	Increased numbers of correctly stocked and staffed health clinics reported in biennial nationally coordinated Provincial Health Facilities Stock Take. Improvements in time taken to reach a Health Facility reported in Health Income and Expenditure Survey (HIES). Reduced numbers of stock-outs reported in the MHMS Health Information System (HIS)	**2008** ▶ Arrangement between HSSP and SKM implemented. ▶ MHMS five year Infrastructure Plan developed and endorsed. **2009** ▶ Establish baseline through first Health Facilities Stock Take. ▶ Increased HSSP budget support provided for Infrastructure Program. ▶ 40 new staff houses constructed. ▶ Upgrades to and construction of key health facilities commenced. ▶ Provincial funding support provided through HSSP to enable purchase of vehicles and boats to improve access, supply and outreach at community level.

Partnership outcomes	Solomon Islands Medium Term Development Strategy outcomes	Objectives	Indicators	Milestones
Reduce malaria incidence in high endemic provinces and elimination in Temotu Province.	MDG 6: Malaria incidence per 100,000 people reduced from 19,600 in 2005 toward 8,000 by 2015. MDG 6: Reduce annual malaria related deaths from 7/100,000 in 2007 to <0.1/100,000 in 2014. Reduce national parasite incidence rate from 128/1,000 population in 2007 to 46/1,000 by 2014. Eliminate Malaria in Temotu by 2016.	1. Scale-up activities identified in the Solomon Islands National Malaria Action Plan (MAP) 2008–2014 and associated annual plans. 2. MHMS engage NGOs and CBOs effectively to assist with roll out and scale-up. 3. Effective coordination of donors engaged contributing to the National MAP.	Improving trends in high endemic provinces reported through the Solomon Islands Malaria Information System (SIMIS) against MDG 6 targets outlined in the MTDS and the NHSP 2006–2010. Increased bed net coverage (reported in annual survey and SIMIS). Increased application of IRS to households in hotspot areas (reported in SIMIS). Positive progress towards elimination in Temotu reported in results from annual surveys and the SIMIS.	**2008** ▶ MHMS and donor endorsement of the National MAP. ▶ Commencement of new COARTEM anti-malarial treatment roll-out. ▶ Completion of bed net baseline study. ▶ Establishment of baseline data in Temotu (annual malaria survey). ▶ Bed net storage sheds and staff housing constructed in Temotu. **2009** ▶ Commencement of GFATM RCC funding. ▶ Malaria stakeholders coordination committee established. ▶ Improved MHMS capacity to distribute bed nets and undertake IRS in identified households.

Partnership outcomes	Solomon Islands Medium Term Development Strategy outcomes	Objectives	Indicators	Milestones
Increase access to clean water and proper sanitation.	MDG 7: Access to clean water and proper sanitation increased significantly by 2010 compared to 70% and 31% in the HIES 2005/6. Each year, not less than 10 rural communities benefit from improved water supply and sanitation.	1. Renovate and install water supply and sanitation infrastructure at provincial health facilities, schools, and rural communities. 2. Improve community education and awareness of benefits provided by better water and sanitation. 3. Increase the number of health facilities with safe waste disposal.	Increased numbers of health and school facilities equipped with adequate water and sanitation, reported in biennial nationally coordinated Provincial Health Facilities Stock Takes. Increased number of households in rural villages and peri-urban areas with access to clean, safe and reliable water supplies (reported by RWSS).	**2008** ▶ MHMS endorsement of the Solomon Islands Access for Clean Water and Sanitation Initiative (SIACWSI). ▶ Increased allocation of HSSP budget support to EHD/RWSS. ▶ Provision of TA to strengthen institutional and management capacity in RWSS. ▶ MHMS implementation of service delivery agreements with NGOs for roll out of SIACWSI. **2009** ▶ Establishment of baseline water and sanitation data using the Health Facility Survey. ▶ Increased collaboration with MEHRD. ▶ Development of a monitoring and evaluation plan to enable EHD/ RWSS to commence the recording of qualitative information on their annual RWSS programme. ▶ Allocation of HSSP budget support to RWSS for implementation of Water and Sanitation activities. ▶ Allocation of HSSP budget support to NHSP 1, People Focus. ▶ Increased roll out of Healthy Settings model to communities. ▶ Allocation of SIACWSI funding to SOPAC Water Safety Program.

Partnership outcomes	Solomon Islands Medium Term Development Strategy outcomes	Objectives	Indicators	Milestones
Reduced maternal and infant mortality rates.	MDG 4: Under 5 mortality rate per 1,000 reduced from 56 in 2005 towards 12 in 2015. MDG 4: IMR reduced from 34/1000 live births towards 25 in 2015. MDG 5: Reduce MMR from 184/100,000 live births by 2010. MDG 5: Births attended by skilled health staff increased from 87% in 2005 to 95% by 2012.	1. Strengthen early diagnosis, appropriate treatment and management of childhood infections. 2. Improve family knowledge of common childhood infections. 3. Increase outreach and appropriate interventions and treatment in high incidence areas. 4. Improve reproductive health services and increase uptake of family planning methods. 5. Improve neonatal care.	Improving trends against targets for MDGs 4 and 5 outlined in the MTDS and the NHSP 2006-10 reported in the MHMS Reproductive Health Information System (RHIS), HIES, Demographic and Health Survey and Census. Increased level of emergency obstetric care reported by health facilities through the MHMS HIS. Improved access to quality maternal and neonatal care reported through the MHMS HIS.	**2008** ▶ Roll out of the improved HIS to all provinces. ▶ Disaggregation of HIS data by gender and age. **2009** ▶ Verification of baseline MHMS Reproductive Health Statistics including IMR/MMR. ▶ Integration of RHIS reporting cycles with other MHMS information systems. ▶ Allocation of HSSP Budget Support to Reproductive Health Program. ▶ Increased Provincial funding support for health facilities.

Annex 3: WHO Support to Solomon Islands 2010–2011

Solomon Islands is an archipelago of 922 islands, 347 of which are inhabited. Its land area of 28,900 km^2 is widely scattered over 1.3 million km^2. The population was estimated at 496,000 in July 2006 (Asian Development Bank estimate). An estimated population increase of 59,000 persons during 2000–2005 supports a demographic trend, creating increasing pressure on infrastructure and employment, as well as raising growing environmental issues.

Social disturbances in recent years have challenged economic and health improvements. The government's Medium-Term Development Strategy for 2008–2010 has identified a number of health-related outcomes. These include rehabilitating damaged economic infrastructure as well as building new infrastructure to stimulate economic growth especially in rural areas and to work towards food security for the nation and ensure a healthy, literate and contented population. Expected health-related outcomes in the 2008–2012 United Nations Development Assistance Framework include strengthened equitable social and protection services through support to the development of evidence-based policies and enabling environments; and improved capacity to deliver affordable, quality, basic social services with strengthened safety nets and an emphasis on equality, inclusiveness and access. These areas of collaboration have been reflected in the World Health Organization (WHO) country programme budgets over the last two biennia. WHO's programme is managed through a country office.

In 2010–2011, WHO technical cooperation with the government is expected to focus on the following WHO strategic objectives:

Strategic objective / Office-specific expected result

SO1 To reduce the health, social and economic burden of communicable diseases.

- Support provided to increase the immunisation coverage in Malaita, Western and Renbel provinces.
- Support provided to Solomon Islands for preventing and controlling dengue fever.
- Support provided in achieving the minimum capacities and functions required by the International Health Regulations (2005).
- To facilitate effective operations and response by partners and the Ministry of Health and Medical Services to declared emergencies and situations due to epidemics and pandemics.

SO2 To combat HIV/AIDS, tuberculosis and malaria.

- Support provided in the reduction of HIV risk behaviors by means of prevention, advocacy using human rights approach and adopting high confidentiality standards.
- Support provided to the Solomon Islands National Tuberculosis (TB) Control Program for the expansion and implementation of DOTS strategy in the prevention, early detection, diagnosis, treatment and control of TB and promoting the delivery and access to health services to the population most in need. Other areas of support will include strengthening human resources through training, strengthening laboratory capacities and monitoring and evaluation.
- Support provided to MHMS to implement internationally accepted norms, standards and guidelines for the quality, safety, efficacy and cost-effectiveness and to strengthen the national regulatory system and quality assurance of medical products and technologies.
- Support provided to Solomon Islands to strengthen national and provincial surveillance, evaluation and monitoring systems including monitoring of drug and insecticide resistance.
- Support provided to the HIV unit to help build capacity with non-governmental organisations (NGOs), churches and community-based organisations (CBOs) to effectively implement HIV programmes.
- Support provided to Solomon Islands for operational research capability strengthening in malaria control and elimination.

SO3 To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence, injuries and visual impairment.

- Support provided to the Solomon Islands National NCD Control Program for Policy development, programme implementation, monitoring and evaluation, strengthening of health and rehabilitation systems and services, implementation of prevention programmes and capacity building in the area of chronic non-communicable conditions, including cardiovascular diseases, cancer, chronic respiratory disease and diabetes. Other areas of support will include population wide approaches to tobacco, alcohol, unhealthy diet and physical inactivity as risk factors; and in relation to approaches directed at individuals at high risk from these risk factors, as well as the prevention of others.
- Improvements made in Solomon Islands' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of mental health disorders.
- Support provided to oral health services promotion in Solomon Islands.
- Support provided to MHMS to help decrease the prevalence of trachoma in the country.
- Guidance and support provided to Solomon Islands to improve the ability of their health and social systems to prevent and manage chronic non-communicable conditions, mental and behavioural disorders, violence, injuries, and disabilities together with visual impairment including blindness.

SO4 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

- Support provided to MHMS to be able to deal with the issue of anaemia in pregnancy, which requires special attention as this problem has increased over the last few years, contributing to the high maternal mortality rate in the country.
- Support provided to MHMS to reduce neonatal mortality and morbidity through improved neonatal resuscitation.
- Support provided for capacity building and training for the implementation of childhood policies and strategies development.
- Support provided to MHMS in the provision of adolescent and youth health services.
- Support provided for the roll-out of the Family Health Card strategy in the provinces to improve access to reproductive health and family planning services, strengthen community involvement and expand health workers' understanding of what is happening in their catchment area that affects the health of families.

SO5 To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact.

- Support provided to Solomon Islands to implement food safety mitigation and environmental health emergencies.

SO6 To promote health and development, and prevent or reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.

- Establish and strengthen provincial healthy setting models and committees.
- Support provided to the Social Services unit to demonstrate to parents and care-givers positive child-rearing practices.
- Social mobilisation to support 'World No Tobacco Day' and effect community behaviour change interventions as regards alcohol, tobacco and other drugs (ATOD).
- Training of trainers to establish behaviour change models for intervention activities.

SO8 To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

- Support provided to the Solomon Islands government for the implementation of environmental threat mitigation to health and review of legislation and National Environmental Action Plan.
- Support provided to the Solomon Islands to strengthen health care waste management systems

and services at primary and secondary care centres.

- Support provided to Solomon Islands for procuring, promoting and implementing health care waste management policy.
- Support provided to Solomon Islands to develop policies, strategies and recommendations to improve access to clean and safe water over drought and wet seasons resulting from impacts of climate change.

SO9 To improve nutrition, food safety and food security, throughout the lifecourse, and in support of public health and sustainable development.

- Effective programmes established to ensure good growth for women and their children through the introduction of the new growth monitoring guidelines by training health workers in the use of the new WHO growth charts and the use of iron supplementation for women in child-bearing age groups.
- Infant and young child feeding (IYCF) training for health workers and communities implemented.
- Support Solomon Islands' efforts to improve nutrition, food safety throughout the life course and in support of public health and sustainable development through data collection and food analysis.
- Support Solomon Islands' efforts to improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development through strengthening National Food Program.

SO10 To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research.

- Support provided to establish a workable health information system with selected core indicators that link provinces and hospitals.
- Support provided to strengthen the ongoing e-learning and other e-health applications.
- Support provided to improve the production, distribution, skill-mix, retention and the management of the workforce in the Solomon Islands.

SO11 To ensure improved access, quality and use of medical products and technologies.

- Support provided to develop, monitor or revise comprehensive policies on access, quality and use of essential medical products and technologies.

Annex 4: United Nations Development Assistance Framework Pacific Support Strategy 2003–2007

UNDAF Objective 3: Improve access, quality and delivery of basic services to all sections of the community			
3.1 Health sector reformed and staff trained to promote equitable distribution of health services in the country.	Health sector reform program reviewed and strengthened. Improvement in the quality of blood supply from the blood bank. Number of female and male health professionals trained. Reduction in distance travelled by women to reach basic health care.	Develop appropriate policies and provide technical support. Blood safety programme supported at national and provincial level. Quantitative and qualitative health workforce planning implemented to ensure adequate staffing and skill mix of health workers at the provincial level.	WHO WHO WHO/UNFPA
3.2 Improvement in health settings.	Number of men and women village volunteers trained in the maintenance of water system. Number of men and women health workers trained in basic health/reproductive health care. Enactment of safe food act all over the country. Percentage of population with access to safe drinking water systems and sanitation in villages and rural areas. Number of men and women villagers trained in maintenance of water and sanitation system. Prevalence of intestinal Helminths and parasite load in the population.	Strengthen the national program of safe drinking water in villages (rural water supply) through active community participation. Programme of ongoing training/HRD of health personnel and volunteers appropriate to local health system Food safety programme strengthened through implementation of Safe Food Act. Integrated programme on hygiene, sanitation and helminthiasis under health island initiative.	WHO UFPA/WHO/UNICEF WHO WHO

3.3 Reduced morbidity and mortality from communicable diseases (malaria, TB, pneumonia, dengue, ARI) in the country.	Reduction in the annual incidence rate of malaria by 50 to less than 100 cases per 1000 population by 2004 and further 30% reduction by 2007. Management of severe malaria cases improved in the clinics. Malaria mortality to be reduced by 50%. Reduced morbidity and mortality, including among children, caused from diarrhoea, pneumonia, dengue and other communicable diseases. Percentage of population that has access to DOTS.	Malaria control programme restored at the national and provincial level. National TB control programme strengthened through development of strategies to improve the directly observed treatment short course (DOTS). Increased national capacity for integrating sexually transmitted infection (STI) prevention and care services. Support for equitable distribution of facilities, equipment, supplies and staffing for health centers throughout the country.	WHO WHO WHO UNICEF/WHO
3.4 Reduced morbidity and mortality from non-communicable diseases in the country.	Radio programmes and health education through the media. Tobacco use assessment to be carried out. Provincial training organised.	Establishment of an effective surveillance system and reporting of accurate data of non-communicable diseases. National tobacco control programme strengthened. Training for community leaders.	WHO/UNFPA WHO WHO
3.5 Reproductive /maternal health improved through delivery of cost-effective reproductive health strategies	Improved access to cost effective quality reproductive health services i.e. family planning services; maternal health care; and reproductive health services for adolescents. Reduced maternal morbidity and mortality and neonatal deaths. Increased life expectancy. Increased age of marriage especially young girls.	Restoration and improvement of reproductive health services for women and adolescents	UNFPA/WHO

3.6 National multi-sectoral HIV/AIDS strategy developed and implemented.	Sectoral budget support reflects multi-sectoral response to HIV/AIDS. STI management and surveillance in place. Increased number of HIV/AIDS specific activities in reproductive health programmes. National legislation enacted to reflect ethics and human rights strategy.	National budget development support training in multi-sectoral response requirements. Surveillance and counseling skills strengthened. HIV/AIDS integrated into reproductive health programmes. Participation in regional training on law, ethics and human rights strategy training and development. Peer education and life skills training for youth.	UNDP WHO UNICEF UNICEF UNICEF

Annex 5: Solomon Islands and SPC Joint Country Strategy 2009–2012

Solomon Islands

and

Secretariat of the Pacific Community

Joint Country Strategy 2009–2012

November 2008 – Solomon Islands Government Approved

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1. Introduction

The Solomon Islands and Secretariat of the Pacific Community (SPC) Joint Country Strategy (JCS) is designed to guide the provision of SPC technical assistance and other support services to Solomon Islands over the next four years, from 2009 to 2012. It is firmly based upon Solomon Islands' development priorities and takes into consideration SPC's capacity and comparative advantage in relation to previously supported activities and future priorities as described in the SPC Corporate Plan 2007–2012.

SPC and the government of Solomon Islands recognise that Solomon Islands' national development challenges, as articulated in its Medium-Term Development Strategy 2008–2010, are rather broad and will require more time and greater involvement in more sectors than SPC can offer through this JCS. With this understanding, the Solomon Islands–SPC JCS 2009–2012 is founded on an established and fruitful partnership and is framed as the first four-year component of the longer-term relationship between SPC and Solomon Islands.

The timing of the Solomon Islands–SPC JCS 2009–2012 is significant as it comes at a time when the Solomon Islands government is undertaking reforms and coincides with the intention of the government to ensure that development is centred on people. The Solomon Islands–SPC JCS 2009–2012 builds upon the experiences of implementing development activities during past years, which involved commitments by both the government of Solomon Islands and SPC, respectively, to implement a more systematic monitoring of mutually supported development activities, an approach that continues to be reflected in plans for future programme activities.

The recently drafted Solomon Islands Medium-Term Development Strategy outlines development priorities that support and build upon the government's policy statements and includes a wide range of sectors, covering all areas in which the Solomon Islands government delivers services. SPC has the technical expertise to contribute to the achievement of priorities in many of these sectors. In particular, it can contribute and offer expertise in: addressing the basic needs of people in health and food security; improving rural economic production; sustainable use and management of the environment and natural resources, including agriculture, animal husbandry and fisheries; enhanced health management; maintenance of an inclusive, vibrant, peaceful, and productive society in harmony with the Solomon Islands culture; strengthened institutional support systems for development planning and, as mentioned above, monitoring and evaluation.

The Solomon Islands–SPC JCS 2009–2012 is based upon four components:

1. The Solomon Islands development priorities (Section 2);
2. The SPC programme of assistance to Solomon Islands (Section 3), which summarises key areas of assistance that will be, or have been, provided under the JCS from 2006 to 2012;
3. Development partnerships and synergies (Section 4); and
4. The Solomon Islands–SPC JCS 2009–2012 monitoring framework (Section 5).

The annexes contain more detail about SPC assistance under JCS and information pertaining to SPC's services.

2. Solomon Islands development priorities

The Medium-Term Development Strategy 2008–2010 identifies and aligns priority areas to national objectives. Note that within each priority area, specific activities have also been identified.

A. Reconciliation and rehabilitation
   a. Pursue meaningful reconciliation between people at all levels of society, which should lead to national healing.
   b. Foster a greater sense of national unity and identity.
   c. Rehabilitate damaged social and economic infrastructure.

B. National security and foreign relations
   a. Sustain the peace process and law and order to ensure the nations attains sustainable peace and harmony.

C. Infrastructure development
   a. Rehabilitate damaged economic infrastructure as well as build new infrastructure to stimulate economic growth, especially in rural areas.

D. Social services
   a. Address the basic needs of the people in villages and the rural areas where the majority of people live and ensure real improvement in their standard of living. This includes villages on islands as well as squatter communities in urban areas.
   b. Work toward food security for the nation and ensure a healthy, literate and contented population.
   c. Generate opportunities for the growing population and achieve high growth, wealth and social well-being for all Solomon Islanders.

   Priorities in education: free basic education and development of tertiary and vocational educational resources.
   Priorities in health: rural water supply and health centres along with programmes to combat malaria and HIV/AIDS.

E. Economic/productive sectors
   a. Ensure that the role of chiefs is strengthened, recognised and respected, and put in place measures to protect the traditional rights of resource owners so that they are awarded maximum benefit from the development of their resources.
   b. Pursue public sector reforms and shift resources toward private sector driven economic growth.

c. Generate opportunities for the growing population and achieve high economic growth, wealth and social well-being for all Solomon Islanders.
d. Shift emphasis toward the development of tourism, fisheries and marine resources. Also prevent and ban any activities that would pollute Solomon Islands air space.
e. Ensure the sustainable utilisation and conservation of natural resources, protection of the environment and successful adaptation to climate change.

Priorities: palm oil development, mineral prospecting, value added activities in fisheries and forestry, and promotion of tourism.

F. Public sector management
   a. Achieve political stability and decentralise decision-making.
   b. Encourage a gradual approach for state governments to build up the socio-political, economic and cultural capacities of the provinces.

3. SPC programme of assistance to Solomon Islands

The Solomon Islands Medium-Term Development Strategy contains specific key areas to which SPC technical expertise has already contributed and to which it can continue to contribute. Therefore, assistance under the Solomon Islands–SPC JCS 2009–2012 is linked to building strong partnerships; assessing what development and other strategies work and are appropriate; creating sustainability and prosperity; developing resources, capacity, structure, policy and processes; supporting the economic future of Solomon Islands; improving communications; fostering innovation; and fostering a greater sense of national unity and identity.

To support Solomon Islands in the implementation of its Medium-Term Development Strategy, SPC will continue to provide assistance in the following areas:

Reconciliation and rehabilitation, with an emphasis on culture through support of the development of a national cultural policy, the adaptation and implementation of model law and the provision of technical assistance and support for the preparations for the 11th Festival of Pacific Arts, which will be hosted by Solomon Islands.

To assist in the implementation of Solomon Islands infrastructure development priorities, the Regional Maritime Centre will provide technical support and assistance in maritime and shipping policies and legislation; adaptation of model polices and legislation; establishment of a monitoring regime for compliance with international standards; and meeting other training requirements in the sector.

Given the vast number of development priorities in social services, SPC's Public Health Programme (PHP) will provide: technical assistance to strengthen primary health care (PHC) so that focused services and programmes can be delivered through community mobilization and participation in all provinces; PHC training, including health promotion and the use of behaviour change communication (BCC) tools; leadership and management; and support of public health education of health promotion staff. Furthermore, PHP will assist in the development of protocols for contact tracing, routine collection of tuberculosis (TB) surveillance data, DOTS (directly observed treatment, short-course) training and development support; support to avian and pandemic influenza preparedness; and financial and technical support in fighting malaria (i.e., treatment and rapid diagnostic test [RDT] procurement, microscopist training for nurses and health workers in malaria treatment, bednet and ICON insecticide procurement and drug resistence monitoring). Additionally, support will be provided to expand the non-communicable diseases (NCD) programme to the provincial level, review NCD screening methods, strengthen NCD databases, formulate NCD strategies, finalise NCD policy, and develop the national nutrition and healthy lifestyle plan. To support the implementation of the national strategic plan (NSP) for HIV & AIDS, PHP will provide targeted BCC and support for voluntary confidential counseling and testing (VCCT) services to meet minimum standards for HIV testing.

SPC will provide technical assistance to strengthen the health system through advocacy and training support in the areas of leadership and management; financial management of grant programmes; monitoring and evaluation (M & E) for health planning and data analysis; and the provision of technical support in the procurement of programme related equipment and the review of legislation pertaining to HIV, International Health Regulations (IHR), pandemic/epidemic preparedness and other related issues.

Within the key priorities in the economic and productive sectors, the SPC Marine Resources Programme will provide technical support and advice to review and update the Fisheries Act of 1998, coupled with the standardization of fisheries regulations and licensing arrangements. The programme will further assist in the development of adequate biosecurity controls and regulations, strategy to assess the economic viability and fishing impact on reef resources, and support in a technical role to the improvement of the Community Fisheries Management Programme through the establishment of management plans to ensure sustainable management of marine resources and aquaculture. The SPC Marine Resources Programme will also provide additional technical assistance in the sustainable management of commercial fisheries through the development of pump boat fishery and small-scale pole and line fishery incorporating community participation. Capacity building in stock assessment, observer training and data collection, processing, and database development will also be provided.

SPC's Land Resources Division will provide technical assistance and support to improve animal genetic resources, the quality of breeding stock, animal management, and paravet training accreditation. It will also build capacity and assist in the production of extension materials for a sustainable forestry programme. Training in forestry milling and downstream processing of forest products will be conducted along with support to review and revise current legislation of forest utilization. SPC's Land Resources Division will also provide technical assistance in forest certification and formulation and in implementation of the code of logging practice, and will provide technical support in the development of a forestry conservation management programme.

Furthermore, capacity will be built in crop production and protection of cash crops, supported by improvements in crop management practice, crop production systems, and market supply chains, and support will be given to develop a food security programme along with the establishment of a laboratory to house entomology, plant pathology and animal health activities. Technical assistance will be offered to assist in the identification of suitable oil palm development and to build capacity in biosecurity and quarantine to improve the efficiency of operations, including management of pest control and plant diseases. Additionally, SPC will support the development of underutilised species for food security and trade and provide technical support to review and develop country policy on correct pesticide use, document agriculture land use, develop a sustainable land use policy, develop an agriculture act (legislation) and improve skills in participatory approaches.

In the areas identified under priorities for civil affairs, SPC's Human Development Programme will build capacity and assist in the review of the National Youth Congress,

assist in the development and delivery of women and youth economic empowerment activities, and, through a participatory approach, involve youth in the agriculture extension training. Additionally SPC will provide technical support for improved statistics on gender and youth through specific youth and gender indicator initiatives. Further assistance will be provided in the review of women's legislative frameworks and technical assistance to the Women's Development Programme through an institutional strengthening review of national women's machinery. Support for a woman's health and nutrition and gender based violence and child abuse survey will also be provided.

The Statistics and Demography Programme (SDP) will provide technical support and capacity building to conduct the village resources survey; the gender based violence survey; the demographic and health survey; to collect Solomon Islands Census and SolGOV Australian Agency for International Development (AusAID) Pacific Malaria Initiative Support Centre (PacMISC) malaria eradication data. The Regional Media Centre (RMC) will technical advice in television production, audio and visual requirements, government new magazine, and various documentaries on development initiatives.

4. Adopting an integrated approach

In order to make a real impact for the people, SPC, with the Solomon Islands government, has agreed to take an integrated approach in the assistance and support that it provides. SPC has a comparative advantage in piloting this multi-sectoral approach to support the development and implementation of two national initiatives: the Kastom Garden Initiative and the Tidy Village Initiative. Multi-sectoral teams from SPC with counterpart multi-sectoral teams from the Solomon Islands government will work together to take a more coordinated and integrated approach in implementing the two initiatives.

Each of the initiatives requires technical support from across the programme areas of SPC; thus the programme areas of health, land resources, fisheries, and social resources will work together within SPC and with their counterparts in the Solomon Islands government on the Kastom Garden and Tidy Village initiatives.

5. Development partnerships and synergies

Despite being resource rich, Solomon Islands maintains bilateral relations with Australia, New Zealand, the European Union, Japan, and Taiwan/Republic of China (ROC) in order to deliver development results to the community. The government of Solomon Islands and its bilateral, multilateral and regional partners, such as the United Nations,[1] the

[1]UN Development Programme (UNDP), UN Population Fund (UNFPA), UN Children's Fund (UNICEF), Joint UN Programme on HIV/AIDS (UNAIDS), UN Educational, Scientific and Cultural Organization (UNESCO), UN Office for the Coordination of Humanitarian Affairs (UNOCHA), Office of the UN High Commissioner for Refugees (UNHCR)

international financial institutions (IFIs),[2] and the Council of Regional Organisations in the Pacific (CROP)[3] agencies, develop and cooperate on activities to attain development results for the people. Also identified as key partners in its development process are civil society organisations[4] that are able to deliver results to the communities.

It is anticipated that ongoing support will be forthcoming from these sources during the next few years as Solomon Islands continues to sustain its relationship with international and regional development partners, as well as bilateral development agencies. Increasingly, in line with the Paris and Pacific Declarations on Aid Effectiveness, development partners have and are developing country strategies that are closely aligned to key development priorities articulated by the government.

Under the framework of the Regional Assistance Mission to the Solomon Islands (RAMSI), several bilateral partners have and will continue to provide the much needed technical capacity and capacity supplementation to enable Solomon Islands to undergo a smooth economic recovery and implement a restructuring programme that should deliver the desired development results for its people.

A key subregional union for Solomon Islands is the Melanesian Spearhead Group (MSG), where there is agreement to promote and strengthen inter-membership trade; exchange of Melanesian cultures, traditions and values; sovereign equality; economic and technical cooperation between states; and the alignment of policies in order to further MSG members' shared goals of economic growth, sustainable development, good governance and security. This proves a useful union for Solomon Islands as its key trading partners are Fiji, Papua New Guinea and Vanuatu.

Development assistance to Solomon Islands is not specifically pecuniary; much of it involves technical assistance for capacity building and capacity supplementation. For example, over the past few years the support SPC has provided has facilitated SPC staff in providing technical assistance in Solomon Islands, as well as providing funding for representatives of the Solomon Islands government to attend regional meetings and workshops. The Solomon Islands–SPC JCS 2009–2012 has been designed specifically to achieve such synergy. Possible SPC assistance to Solomon Islands according to this Solomon Islands–SPC JCS 2009–2012 is reflected in the matrix in Annex 1.

[2]World Bank, Asian Development Bank and International Monetary Fund

[3]Forum Fisheries Agency (FFA), South Pacific Applied Geoscience Commission (SOPAC), Pacific Islands Forum Secretariat (PIFS), South Pacific Regional Environment Programme (SPREP), University of the South Pacific (USP), South Pacific Board for Educational Assessment (SPBEA), Fiji School of Medicine (FSchM), SPC, Pacific Islands Development Program (PIDP), Pacific Power Association (PPA), southpacific.travel

[4] Also referred to as non-state actors and including faith based organisations

5. JCS monitoring framework

The Solomon Islands–SPC JCS 2009–2012 has been designed to allow its activities to be monitored so that performance can be mutually assessed at the programme level. Although several planned activities could be categorised as ongoing, others represent new initiatives. The impact of most activities will be apparent reasonably quickly over the life of the four-year strategy.

The appropriate section of the Solomon Islands government to monitor the Solomon Islands–SPC JCS 2009–2012 is the Ministry of Development Planning and Aid Coordination in conjunction with the Ministry of Foreign Affairs. The SPC counterpart section is the Strategic Policy and Planning Unit, located within the SPC Executive Branch. It is suggested that the Solomon Islands–SPC JCS 2009–2012 be formally reviewed once a year, as part of the formal high-level consultations held between the SPC Executive and the Government of Solomon Islands. These consultations are part of the SPC Corporate Plan 2007–2012 initiative to realise the SPC Executive's vision to improve communication and collaboration with national decision-makers and officials through senior management visits to member countries and territories, including small island states.

Monitoring, review and evaluation will be an integral element of the Solomon Islands–SPC JCS 2009–2012 implementation. The Solomon Islands Ministry of Development Planning and Aid Coordination with the SPC Strategic Policy and Planning Unit will be responsible for gathering information from their respective counterparts concerning the implementation of JCS activities. This information will form the basis of the performance discussions during the annual high-level consultations mentioned above. It is emphasised, however, that this annual exercise will not be a substitute for monitoring and evaluation arrangements at the activity level. It will be essential that both SPC and Solomon Islands government counterpart staff maintain their own sector performance management arrangements, which will feed into the annual joint monitoring process. Additionally, at the activity level, SPC programmes will make provision for monitoring and review of the activities identified in the Solomon Islands–SPC JCS 2009–2012 at the beginning of all activity implementation cycles and when reporting annually to donors and the Committee of Representatives of Governments and Administrations (CRGA), taking into consideration the proposed inputs when assessing the outputs.

Following the monitoring exercise at the annual high-level consultations, the Solomon Islands Ministry of Development Planning and Aid Coordination and the SPC Strategic Policy and Planning Unit will prepare a joint report for both the Solomon Islands government and the SPC Executive for tabling at the CRGA the same year. This report will highlight relevant issues discussed during the annual high-level consultations and will detail progress against the performance framework over the past 12 months, or over the period since the previous annual high-level consultations. Where appropriate, the report will recommend revisions to the Solomon Islands–SPC JCS 2009–2012 based upon the lessons learnt in implementing it, the government of Solomon Islands' budget, emerging development priorities, any strategic or other key plans of the Solomon Islands'

government and SPC programmes, and the relevant experiences of other development partners.

A full review of the Solomon Islands–SPC JCS 2009–2012 will be jointly conducted at the end of the JCS period in 2012. Again, this approach is consistent with the government of Solomon Islands' intentions to embark on a programme of performance monitoring, and will draw on the results of the government of Solomon Islands' own monitoring and evaluation activities and recommendations. As well as assessing the implementation of the current strategy and identifying lessons for future reference, the proposed joint Solomon Islands government and SPC review of the Solomon Islands–SPC JCS 2009–2012 will propose strategic directions for the next Solomon Islands–SPC JCS.

ANNEX 1 **DETAILED JOINT COUNTRY STRATEGY PROGRAMME**
SOLOMON ISLANDS INTEGRATED STRATEGIC ACTION PLAN ACTIVITIES, SPC ACTIVITIES MATRIX

Solomon Islands Medium Term Development Strategy (SIG MTDS) Priority area 1: Reconciliation and rehabilitation – cultural identity **National objective 1: foster a greater sense of national unity and identity**					
SPC strategic support: **Policy support for the development of a cultural policy** **Technical assistance for implementation of the model law on the protection of traditional knowledge and culture** **Technical assistance and support for preparations for the 11th Festival of Pacific Arts in 2012**					
Sectoral objectives and strategies	**SPC Solomon Islands significant strategic activities**	**Expected implementation completion**			
		2008	**2009**	**2010**	**Out years**
B 1.2.1 **Heritage and culture programme** Goal: restore, strengthen and promote cultural identity	**Heritage and culture programme** • Development of cultural policy [SPC–Human Development Programme (HDP)]	√	√	√	√
	• Adaptation and implementation of model law	√	√	√	√
	• Phased technical assistance and support for 11th Festival of Pacific Arts preparations, including: - Planning - Budgeting - Property rights issues - Media copyright issues - Quarantine - Hosting arrangements	√	√	√	√

SIG MTDS Priority area 3: infrastructure development **National objective 3: rehabilitate damaged social and economic infrastructure as well as building new ones to stimulate economic growth, especially in the rural areas**					
SPC strategic support:					
Sectoral objectives and strategies	**SPC Solomon Islands significant strategic activities**	**Expected implementation completion**			
		2008	**2009**	**2010**	**Out years**
B 3.2.1 **Inter-island shipping development programme** Goal: enhance the prosperity, well-being and participation of the community by providing integrated, efficient and affordable infrastructure and transport systems supported by ethical, professional, proficient and valued staff	**Inter-island shipping development programme** • Creation and maintenance of up-to-date maritime and shipping policies and legislation				
	• Advice on adapting model policies and legislation to fit national context				
	• Establishment of a monitoring regime to assist maintenance of compliance with international standards				
	• Assistance in adapting models to suit local policy environments				
	• Provision of STCW-95 (International Convention on Standards of Training, Certification and Watchkeeping for Seafarers) and ISPS Code (International Ship and Port Facility Security Code) short course curricula to training institute				
	• Revision of regional training syllabi to ensure all new international requirements are included				
	• Advice and assistance for maritime training institutions (MTIs) in adopting curricula				
	• Provision of appropriate training to decision-makers, MTI staff, maritime administration personnel, port operators and other key target groups				
B 3.4.1 **Telecommunications development programme** Goal: establish adequate, efficient and reliable telecommunication and email service in the rural	**Telecommunications development programme** • Rural Internet Connectivity System (RICS)/One Laptop Per Child OLPC/South Pacific Islands Network (SPIN) [SPC IT PIFS]	√	√	√	

areas	• New telecommunications legislation including competition and full implementation [PIFS]	√			
	• Rural telecommunications [World Bank, AusAID, PIFS]		√	√	

SIG MTDS priority area 4: social services sectors
National objective 4: work toward food security for the nation and ensure a healthy, literate and contented population

SPC strategic support:

- **Technical and advisory support and capacity building to enhance public health systems, including their management and infrastructure, to prevent, control and manage communicable and non-communicable diseases**
- **Support multi-sectoral community based initiatives that promote health and development**

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
B 4.2.1 **Public health programme** Goal: ensure that the Solomon Islands people are healthy, happy and productive and that the Ministry of Health is promoting, protecting and maintaining good health and well-being, hence improving the quality of life of all the people of Solomon Islands **Strategic area 1: people focus** Goal: promote a people-centred approach to health, focusing on the needs and aspirations of the Solomon Island people	The joint MHMS-SPC strategic plan revolves around strengthening PHC that aims to deliver people-focused services and programs through community mobilization and participation in all provinces. The bottom-up approach to strengthening PHC will require that staff gain a better understanding of its concepts and principles and the application of health promotion as a key tool in community-based health initiatives. **People focus** Training and capacity building will be required for developing a receptive mindset for 'people-focused' community based health services. Three key activities are identified: a) PHC training including health promotion and use of BCC tools – all field staff			√	√
	b) Leadership and management training for coordinators and managers – to deliver a PHC approach programme and to manage its resources			√	√
	c) Rebuilding the health promotion programmes within MHMS to support the people-focused approach Joint PHC will build on existing community-based initiatives			√	√
	Health promotion It is understood that a review of health promotion programme(s) will take place with AusAid assistance. It will determine priority				

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	areas for potential support, which could include: • Supporting health promotion education of some health promotion staff (MHMS? SPC?)		√	√	√
	• Liaising with SPC Media Centre for attachments and advice on equipment upgrade		√	√	√
	• Liaising with PHP BCC specialists for advice and support on information, education and communication materials production and capacity building for impact assessment		√	√	√
	• Liaising with PHP Health Pacific Lifestyle section for alcohol and tobacco use prevention activities		√	√	√
	• Considering the use of the Pacific Regional Influenza Pandemic Preparedness Project (PRIPPP) Small Grant Scheme for the implementation of a risk communication plan for epidemic diseases, including pandemic influenza		√	√	√
	• Providing support for information and method sharing in Healthy Settings approach (e.g., with Fiji)		√	√	√
Strategic area 2: public health programmes Goal: strengthen public health functions to respond adequately to community health needs	**TB programme** • Development of protocols for contact tracing (a methodology for the region was developed for use in Pacific Island countries and territories [PICTs])	√			
	• Routine collection of TB surveillance data (SPC collects quarterly TB data from Solomon Islands)	√	√	√	√
	• Participation in joint DOTS training missions (SPC and World Health Organization [WHO]) (SPC provided training in TB programme management and DOTS)	√			
	• Support for proposal development (Section Head has developed a proposal in collaboration with WHO and the Ministry of Health)	√			

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	Support to be identified • Support for the review of policy and protocols (SPC? WHO?) • Support for joint national TB/HIV meeting in Dec. 2008 (needed for HIV health workers only) to address HIV testing in TB patients (Oceania Society for Sexual Health and HIV Medicine [OSSHHM] +/- SPC? WHO?) • Support for programme activity implementation impact assessment (SPC? WHO?)		√ √	√	
	Epidemic preparedness and response capacity • Support for avian and pandemic influenza preparedness: . Task force meetings . National testing exercise . Feedback on national influenza preparedness plan		√	√	
	• Strengthening of national infection control (including training)		√		
	• Support for lab-based influenza surveillance		√		
	• Procurement: personal protective equipment stockpile		√	√	
	• Technical assistance to address legislative and legal gaps for avian and pandemic influenza preparedness and the new IHR		√		
	• Evaluation and finalization of early warning and response (EWAR) system (SPC partner agency)		√		
	• EWAR implementation		√		
	Human resource development and capacity building for implementing public health functions • Data for decision-making (short Field Epidemiology Training Programme) for key response health staff	√			
Strategic area 3: malaria Goal: reduce malaria incidence and mortality	**Malaria -** financial and technical support from SPC through Global Fund to fight AIDS, Malaria and Tuberculosis (GFATM) Regional Command Centre (RCC) as 1st recipient	√	√	√	√

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	• Procurement of treatment and RDT	√	√	√	√
	• Training of malaria microscopists	√	√	√	√
	• Training of health workers in malaria treatment	√	√	√	√
	• Training of nurses in RDT use	√	√	√	√
	• Monitoring of drug resistance	√	√	√	√
	• Procurement of bednets	√	√	√	√
	• Procurement of ICON	√	√	√	√
Strategic area 4: common childhood diseases (acute respiratory infections, malaria, diarrhoeal diseases, skin infections and vaccine preventable diseases) Goal: reduce morbidity and mortality of children under five due to common childhood illnesses	**Common childhood diseases** Support to be identified • Potential support to paediatric capacities: public health training for paediatric registrars (FSchM? PHP?)	√	√		
	• Potential support to National Child Health Committee operations (meetings…) (PHP?)	√	√		
Strategic area 5: NCDs (diabetes, cardiovascular disease, cancer and tobacco related diseases) Goal: prevent, moderate and control non-communicable diseases	**NCDs** • Expansion of NCD programme to provincial level	√	√	√	√
	• Review of NCD screening methods	√	√	√	√
	• Strengthening of NCD database	√	√	√	√
	• Finalisation of NCD policy	√	√	√	√
	• Use of survey findings to formulate NCD strategies	√	√	√	√
	Nutrition • National Nutrition and Healthy Lifestyle Plan – a multisectoral approach to address nutrition and lifestyle related diseases – 2007–2017				

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	Collaborate with other SPC programs to support PHC model • Land Resources Division (agriculture, animal health) • Fisheries • Human Development Programme	√	√	√	√
Strategic area 6: HIV/AIDS and sexually transmitted infections Goal: prevent the health and well-being of the people of Solomon Islands from being undermined due to the burden of HIV/AIDS	**HIV/AIDS and sexually transmitted infections** • Support for implementation of NSP for HIV and AIDS through grants programme	√	√	√	√
	• Support for targeted BCC initiatives; need to be expanded to provinces	√	√	√	√
	• Support for VCCT services to meet minimum standard for HIV testing, including laboratory	√	√	√	√
	• Support for HIV and STI core care team both at national and provincial levels	√	√	√	√
	• Support for collaboration between HIV and TB programmes	√	√	√	√
Strategic area 7: family planning and reproductive health Goal: improve reproductive health services and increase uptake of family planning methods	**Family planning and reproductive health** • Under the UNFPA–UNICEF–SPC joint Adolescent Health and Development programme, SPC will work with MHMS to focus more efforts on sexual and reproductive health of young people—especially prevention of teenage pregnancy and STIs/HIV and other related issues	√	√	√	√
Strategic area 8: health system strengthening **8.1 Accountability (finance, staff and accountability)** Goal: improve management and leadership throughout the Ministry of Health to achieve health	**Health system strengthening** • SPC to provide advocacy and training support role in the areas of leadership and management (with partners like WHO and training institutions)				
	• Training on M & E for specific programmes and general health planning, and data analysis				
8.2 Infrastructure Goal: ensure existence of appropriate infrastructure reflective of identified needs and	• Financial management of grants programmes or schemes				
	• Procurement of programme-related equipment				

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
resources	• Review of legislation in relation to HIV, IHR and pandemic/epidemic preparedness, and related to other health issues				
8.3 Information management Goal: redevelop and increase capacity and utilisation of Ministry of Health, health information systems	Support to be identified • Support for public health education of Health Statistician (MHMS? SPC?)				
	• Potential support to improve vital statistics (SDP? PHP?)				
	• Potential support in FH card data management and utilization (MHMS Stats? SPC PHP?)				
	• Development of data management and utilization capacity at provincial level				
	• Development of information sharing and dissemination mechanisms				
	• Creation of national database for multiple users with standard report generation				
	• Review of legislation in relation to HIV, IHR and pandemic/epidemic preparedness and other related to health issues				
8.4 Organisational change Goal: create an enabling environment in the Ministry of Health to adopt a people-centred approach to public health	To be determined, in relation to the proposed integrated approach to two existing activities at the community level: the Kastom Garden and Tidy Village initiatives				
SIG MTDS priority area 5: economic and productive sectors **National objective 5: generate job opportunities for the growing population and achieve high economic growth, wealth and social well-being for all Solomon Islanders**					
SPC strategic support: **Technical and advisory support and capacity building in the sustainable management of integrated forest and agriculture systems and animal health and production**					

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
B 5.2.1 **Livestock development programme** Goal: development and rehabilitate livestock to increase economic growth, rural incomes and health	**Livestock development programme** • Improvement of animal genetic resources	√	√	√	√
	• Facilitation of quality improvement through exchange of breeding stock	√	√	√	√
	• Animal management and processing	√	√	√	√
	• Paravet training accreditation through linkages with formal training institutions: (Vudal University/USP/James Cook University)	√	√	√	√
B 5.2.2 **Smaller holder commercial tree crops programme** Goal: establish and strengthen smaller holder commercial development	**Smaller holder commercial tree crops programme** • Capacity building on crop production and protection of cash crops (cocoa, coconut and kava)	√	√	√	√
	• Improvement of crop management practice (weed, pest and disease)	√	√	√	√
	• Identification of crop production systems and market supply chain	√	√	√	√
B 5.2.3 **Food security programme** Goal: promote food security to ensure a health population	**Food security programme** • Development of emergency response plan	√			
	• Establishment of a laboratory (to house entomology, plant pathology and animal health laboratory activities integrating with quarantine activities to facilitate market assessment)	√	√	√	√
	• Capacity building in biosecurity and quarantine to improve the efficiency of operation	√	√	√	√
	• Strengthening and improvement of the capacity of the Extension and Information Division	√	√	√	√
	• Production of extension materials	√	√	√	√
	• Revision of pest list database	√	√	√	√
	• Capacity building in pest and disease and weed work	√	√	√	√

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	• Country pest and disease diagnosis	√	√	√	√
	• Atoll food production	√	√	√	√
	• Management of taro and yam anthracnose disease	√	√	√	√
	• Drafting and enactment of bisoecurity law	√	√	√	√
	• Development of bioscecurity information facility	√	√	√	√
B 5.2.4 **Exotic and indigenous crop programme** Goal: Encourage and support further research into protection and use of existing cash crops	**Exotic and indigenous crop programme** • Redevelopment of cocoa industry		√	√	
	• Market access for indigenous crops such as kava		√	√	
	• Development of underutilised species for food security and trade (domestic, regional and overseas)		√	√	
B 5.2.5 **National oil palm programme** Goal: restore commercial plantations that contribute to economic growth	**National oil palm programme** • Identification of suitable oil palm development		√	√	√
Additional priority strategic development activities for agriculture (not in MTDS)	**Additional priority strategic development activities for agriculture (not in MTDS)** • Creation of a positive image of agriculture to counter other socio-economic issues	√	√	√	√
	• Review and development of a country policy document on proper use of pesticides		√		
	• Creation of sustainable land use management policy		√	√	
	• Documentation of agriculture land use	√	√	√	√
	• Capacity building of: - agriculture land use section - agriculture planning division	√	√	√	√
	• Establishment of satellite dish facility, including personnel training	√	√	√	√
	• Skills training in librarianship and general computer use using		√		

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	participatory approach				
	• Development of an Agriculture Act		√	√	
	• Collection of baseline information on agriculture in Solomon Islands	√	√	√	√
	• Introduction of organic standards training programme		√	√	√
	• Links to education, especially RTCs		√	√	√
	• Support the development and implementation of an integrated farming system (including the promotion of agroforestry) among local farmers to improve farm production	√	√	√	√

SIG MTDS priority area 5: economic and productive sectors
National objective 5.3: ensure the development and sustainable utilization of sea and marine resources to benefit and contribute to the well-being of Solomon Islanders (and to ensure that fisheries and marine resources are managed in a sustainable manner for the long-term benefit of the people of Solomon Islands) [technical and advisory support and capacity building in planning and implementing the sustainable use of fisheries resources for economic growth, food security and livelihoods, and the adaptations needed to ensure that these benefits are maintained in the face of climate change]

SPC strategic support:
Technical and advisory support and capacity building in sustainable utilization of sea and marine resources

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
B5.3.1 **Improvement of community fisheries management programme** Goal: increase opportunities for fishermen and contribution to economic growth by proper management of community fisheries sector	**Improvement of community fisheries management programme** • Review and revision of the Fisheries Act 1998		√		
	• Standardization of fisheries regulations covering tuna, inshore fisheries, communities and community-based management, and aquaculture [SPC, FFA, non-governmental organisations (NGOs) and other stakeholders]		√		
	• Review and revision of all licensing arrangements for commercial export fisheries in Solomon Islands [Coastal Fisheries Programme (CFP), FFA, NGOs]			√	
	• Development and implementation of adequate aquatic biosecurity controls and regulations on regional standards [CFP]		√		
	• Examination of compliance requirements by international organisations that will affect imports and exports of marine products [CFP]	√			
	• Assessment and promotion, if viable, of the potential for community-based bait fishing to supply small-scale tuna fishing operations [CFP]			√	
	• Capacity building in fish aggregating device (FAD) rigging and deployment, and FAD fishing skills				√
	• Development of a strategy to assess the economic viability and fishing impact on reef resources of the current rural fishing centres [CFP]			√	

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
	• Examination of: - activities that can be integrated into the operation of the rural fishing centres to assist in their viability - small-scale value adding process for marine products		√		√
	• Monitoring and data collection programme for inshore fisheries resources, with an initial focus on commercial invertebrate species for export with community input and participation [CFP]		√		
	• Establishment of management plans, at the national, provincial and community level, to ensure sustainable management of marine resources and aquaculture, including traditional knowledge where available [CFP and assistance from FFA, NGOs and other stakeholders]	√	√	√	√
	• Creation of standardised and coordinated community-based coastal fisheries management programme including all stakeholders in the process	√	√		
B 5.3.3 **Sustainable management of commercial fisheries programme** Goal: ensure that commercial fisheries are supported for sustainable development and management	**Sustainable management of commercial fisheries programme** • Development of pump boat and small-scale pole-and-line fisheries incorporating community participation, with [CFP and joint SPC/FFA DEVFISH project]	√	√	√	
	• Exploration of areas for private sector development of the industrial tuna fishery [SPC/FFA DEVFISH (Development of tuna fisheries in Pacific ACP countries) project]		√	√	
	• Capacity building in - stock assessment - observer training and data collection - processing, and database development [OFP with joint OFP/FFA]	√	√	√	√

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
B 5.3.3 **Promotion of local participation in fisheries programme** Goal: provide opportunities for Solomon Islanders to participate in fisheries development and management initiatives	Note: Local participation in fisheries programmes is included or incorporated under the significant strategic actions listed above. Note: Community and other stakeholders will be representative of youth and gender.	√	√	√	
Additional areas for consideration 1. Planning the use of fish for food security. Provision of sufficient fish for the future food needs of the nation's rapidly growing population.	**Planning the use of fish for food security** • Deployment of low-cost inshore FADs for subsistence fishing (see also B 5.3.1)		√	√	√
	• Establishment of small pond aquaculture, including the import risk analysis (IRA) for nile tilapia		√	√	√
	• Planning for storage and distribution facilities for low-cost tuna landed in Honiara by industrial tuna fleets		√	√	√
	• Coordination with demographers to understand where and how quickly urban and rural populations will expand to identify main needs for fish for food		√	√	√
2. Development of sustainable aquaculture. Provision for Solomon Islanders to derive new sources of income and food from aquaculture.	**Sustainable aquaculture** • Implementation of the national aquaculture plan		√	√	√

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
3. Adaptation of fisheries management to build resilience to climate change. Provision of options for industry and communities to adapt to the changing climate in ways that maintain the benefits of fisheries.	**Adaptation** • Identification of the implications of climate change for the contributions of fisheries to economic growth, food security and livelihoods	√	√	√	√
	• Implementation of management measures and policies to diversify the way fish are produced, processed and distributed to build resilience to climate change	√	√	√	√

SIG MTDS priority area 5: economic and productive sectors
National objective 5.4: ensure the sustainable utilization and conservation of natural resources, protection of the environment and successful adaptation to climate change

SPC strategic support:
Technical and advisory support and capacity building in the sustainable management of integrated forest and agriculture systems

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
B 5.4.1 **Sustainable forestry programme** Goal: increase establishment and improve management of small-scale, family owned timber plantations and commercial forestry plantations	**Sustainable forestry programme** • Capacity building in: - forestry extension workers in community based plantation development - technical staff on the establishment of commercial forestry plantations	√	√	√	√
	• Production of extension materials for national awareness and extension programme through production of documentaries (DVD), brochures, pamphlets, posters, etc.		√	√	
	• Formulation of legislation proposals regarding forestry plantation development		√	√	
B 5.4.2 **Sustainable forest industries and downstream processing programme** Goal: increase benefits to the country, rural areas and resource owners from forestry by increasing value added through downstream processing	**Sustainable forest industries and downstream processing programme** • Capacity building in forestry milling and downstream processing of forest products		√	√	√
	• Marketing strategies/opportunities for agroforestry commodities		√	√	√
	• Review and revision of the current legislation on forest utilization (Forest Resource and Timber Utilization Act)		√	√	
	• Forest certification and the formulation and implementation of the code of logging practice		√	√	
B 5.4.4 **Forestry conservation management programme**	**Forestry conservation management programme** • Survey of the flora of Solomon Islands		√	√	√

Sectoral objectives and strategies	SPC Solomon Islands significant strategic activities	Expected implementation completion			
		2008	2009	2010	Out years
Goal: conserve and maintain the natural state of the forest to protect environment and biodiversity	• Capacity building of herbarium staff		√	√	√
	• Establishment of in situ and ex situ conservation area		√	√	√
	• Capacity building on forest restoration/rehabilitation of forest degraded areas		√	√	√
	• Support for implementation of a national strategy and action plan for the conservation, management and utilization of forest genetic resources		√	√	√

SIG MTDS priority area 6: civil affairs **National objective 6: Address the basic needs of the people in villages and rural areas where the majority of our people live and ensure real improvement in their standard of living. This includes villages on islands as well as squatter communities in the urban areas as given in the policy statements.**					
SPC strategic support: **Technical advisory support for implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), improved data and information, policy review and improvement – women** **Capacity building and technical assistance to strengthen civil society and faith based organizations – youth and women**					
Sectoral objectives and strategies	**SPC Solomon Islands significant strategic activities**	**Expected implementation completion**			
		2008	**2009**	**2010**	**Out years**
B 6.1.1 **Rights of women programme** Goal: promotion and better protection for the rights of women in Solomon Islands	**Rights of women programme** • Legislative frameworks review [SPC/HDP and UN Development Fund for Women (UNIFEM)]	√	√		
B 6.1.2 **Women's development programme** Goal: increase women's participation in national development and economic capacities through coordinated cross-cutting programmes	**Women's development programme** • Gender based violence and child abuse survey, analysis and reporting, dissemination of findings, national and community-level interventions [SPC HDP, gender based violence (GBV) project, SDP and RMC]	√	√	√	
	• Woman, health and nutrition		√	√	√
	• Institutional strengthening review of the national women's machinery, including review of the national women's policy and technical advisory support for policy implementation [SPC HDP]	√	√	√	√
B 6.2.1 **Youth development programme** Goal: protect and promote youth rights, strengthen their capacities, and increase their participation in planning, decision-making and development; create linkages with others in the ministry in agriculture training	**Youth development programme** • National Youth Congress review and capacity building	√	√		
	• Development and delivery of women and youth economic empowerment activities [SPC – HDP, Marine Resources Division and Land Resources Division]		√	√	
	• Improvement in statistics on gender and youth at national level through specific youth and gender indicator initiatives [SPC – HDP and SDP]	√	√	√	
	• Increase in youth involvement in agriculture participatory extension		√	√	√

Other strategic areas of SPC support					
Sectoral objectives and strategies	**SPC Solomon Islands significant strategic activities**	**Expected implementation completion**			
		2008	**2009**	**2010**	**Out years**
Priority strategic development activities for media not in MTDS • **Capacity building in broadcast**	**Media** [SPC RMC] • Television production (scripting, camera, editing)	√			
	• Design audio visual studio and equipment requirements		√		
	• Government news magazine production (equipment procurement and production advice)		√	√	
	• Media internship in conjunction with the 11th Festival of Pacific Arts		√	√	
	• Documentary on Kastom Garden	√			
	• Media campaign on GBV project	√			
	• Documentary on GBV research	√	√		
Priority strategic development activities for statistics and demography not in MTDS • **Technical support and capacity building**	**Statistics and demography** [SPC SDP] • Village resources survey	√	√		
	• GBV survey	√	√	√	√
	• Demographic and health survey	√	√		
	• Solomon Islands Census	√	√		
	• SolGOV AusAID PacMISC malaria eradication	√	√		

ANNEX 2: SPC, the organisation, its role in the region and its programmes

Our vision for the region is a secure and prosperous Pacific Community, whose people are educated and healthy and manage their resources in an economically, environmentally and socially sustainable way.

Our mission is to help Pacific Island people position themselves effectively to respond to the challenges they face and make informed decisions about their future and the future they wish to leave for the generations that follow.

Our corporate objectives are to have an increased focus on member priorities; strategic engagement at national, regional and international levels; and strategic positioning to respond to the increasing demands placed on the organisation to achieve member priorities.

SPC services are provided primarily in the form of technical assistance, training and research. These services are available in both French and English, SPC's two official languages. The focus of SPC's work can and does change over time in response to evolving regional needs and regional collaborative arrangements with other organisations. The organisation currently focuses on three sectors: Land Resources, Marine Resources and Social Resources.

The **Land Resources Division** provides advice, expertise, technical support and training to member PICTs on all aspects of forestry, agricultural diversification, genetic resources, plant health, crop production, animal health and production, and biosecurity and trade. The programme's key objectives are to improve biosecurity and trade facilitation and to increase sustainable management of integrated forest and agriculture systems.

The **Marine Resources Division** includes coastal and oceanic fisheries and maritime programmes.

- The goal of the **Coastal Fisheries Programme** is to help Pacific Community members optimise the social and economic value of small-scale fisheries and aquatic living resources, over the long term. The programme includes fisheries information, nearshore fisheries development, aquaculture, fisheries training, and the Reef Fisheries Observatory.
- The **Oceanic Fisheries Programme** works to provide members with the scientific information and evidence they need to rationally manage pelagic fisheries (specifically those fisheries that exploit the region's tuna, billfish and related fish species). The programme includes ecosystem monitoring and analysis, and oceanic fisheries statistics.
- The **Regional Maritime Programme** focuses on the maritime transport sector, working to strengthen the capacity of Pacific Islanders to manage, administer, regulate, control and gain employment in the sector.

The **Social Resources Division** focuses on the following areas:

- The **Public Health Programme** assists members in developing healthier Pacific Island communities through sections working in public health surveillance, communicable and non-communicable diseases and adolescent reproductive health.
- The **Statistics & Demography Programme** works to improve the availability, analysis and utilisation of socio-economic data through strengthened national statistics systems and support to household income and expenditure surveys and national census surveys.
- The **Human Development Programme** assists members to empower Pacific Island women and young people, improve skills development and build strong cultural identities.
- The **Regional Media Centre** aims to promote the benefits of increased participation by Pacific people and governments in the media.
- The **Information Communication Technology Programme** aims to facilitate access to digital communication through a Pacific VSAT (very small aperture terminal) 'hub' and connectivity of PICTs via submarine fibre-optic cables.

Annex 6:

Solomon Islands Health Sector Support Program Technical Cooperation Framework Preparation

DRAFT Terms of reference

1. Background

Between 1999 and 2003, Solomon Islands experienced a period of crisis marked by civil conflict and natural disasters which interrupted the delivery of PHC in the country. The health system has made dramatic progress in re-establishing itself following the end of civil conflict and has now reached performance levels comparable to the pre-conflict situation. Although the health care system has had considerable success in maintaining staff, equipment, and medical supplies across a relatively wide network, emerging communicable and non-communicable diseases, high infant, maternal death, and fertility rates add to the significant public health challenges facing Solomon Islands. The problems posed by endemic communicable diseases and maternal health issues remain a critical focus of the delivery system.

In early 2008, the Ministry of Health and Medical Services (MHMS) commenced establishment of an overall sector-wide approach (SWAp) to support the delivery of health services in Solomon Islands. The SWAp aims to provide a participatory framework through which all donors and stakeholders may contribute to a single programme approach to support continued development and implementation of the Solomon Islands National Health Strategic Plan 2006-10 (NHSP)[1].

Development partner (DP) provided technical cooperation[2] in support of the MHMS SWAp is delivered under a range of arrangements that can be broadly categorised as:

1. Long term advisers (AusAID, World Bank).
2. Programme support (regional and multi-country (e.g. UN, WHO and SPC).
3. Short term inputs (all partners).

Currently, there is no framework for managing the variety of technical assistance and cooperation provided to the Solomon Islands health care systems or a strategy linking overall objectives outlined in the NHSP and MHMS operational plans to outcomes that can be generated through technical cooperation and technical advisers.

Programme inputs from the SPC and UN agencies tend to be planned in isolation and have different approval and reporting cycles to those used by the government. Sometimes funding agencies (such as AusAID) contribute to this situation by designing specific programme requirements as a condition of funding to UN agencies and SPC.

Selection and oversight arrangements for long term technical advisers vary according to the requirements of the funding agency. There is no mechanism for coordinating their work around agreed priorities or for performance management.

1. *SWAp Partnership Arrangement signatories as at February 2010: Solomon Islands Government; Government of Australia; World Health Organization; World Bank; United Nations Children's Fund; United Nations Population Fund; Government of Japan. Development partners contributing to the sector that have not yet formally signed the Partnership Arrangement include: Secretariat of the Pacific Community; United Nations Development Program; and the Republic of China (Taiwan).*

2. *The DAC defines Technical Cooperation as 'the provision of know-how in the form of personnel, training, research and associated costs'. The main elements of DAC donors' Technical Co-operation programmes are study assistance through scholarships and traineeships; the supply of personnel, such as experts, teachers and volunteers; research on the problems of developing countries, for example tropical crops and diseases.*

All agencies fund short term technical inputs (reviews, analytical work, planning sessions, workshops etc.) at various times but there is no mechanism to plan, coordinate or ensure best use is made of these inputs or the visiting experts. Nor are there agreed quality assurance processes in place which support the principle that advice should be evidence based, transparent and contestable.

Overall, technical cooperation is fragmented with little consideration given to sector wide cost implications, value for money or sustainability. There is no framework in place that supports the MHMS to take greater control and ownership of the technical inputs offered or provided, or to ensure they are aligned with agreed priorities and implementation needs. Nor are there joint mechanisms for agreeing priorities, modes of delivery, or quality assurance (performance assessment of long term advisers, peer review of proposals or reviews, etc). Development of a technical cooperation framework would greatly improve selection, management, and coordination of technical cooperation through the SWAp and assist all partners address the strategic priorities agreed for the health sector in Solomon Islands.

2. Objectives of the assignment

To develop a technical cooperation framework for the Solomon Islands Health SWAp and to provide MHMS and development partners a clear analysis of current technical cooperation impact and effectiveness and initial recommendations on next steps to ensure effective implementation of the framework.

3. Scope of the assignment

To work with MHMS and the Solomon Islands Health SWAp partners to develop a framework that ensures all current and future technical cooperation:

- Enables MHMS Executive to maintain overall management and decision making responsibility.
- Is cost effective and of high quality (transparency and opportunity costs should be fully considered).
- Integrates with MHMS operational plans.
- Harmonises and aligns, both with MHMS programme structures and externally with wider DP programmes if possible.
- Includes sound management arrangements.

The technical cooperation framework should address the following issues:

- Required processes that are needed to identify, plan, coordinate and quality assure short term and program inputs.
- Clarify the role, mandate and contribution to be expected from the UN agencies and SPC.
- Identification of the number and composition of long term technical advisers and possible alternatives that could be used for some specific areas (e.g. Health Information Systems).
- MHMS processes and systems needed to support capacity for management of performance and quality of long term advisers.
- Identification of effective reporting and working arrangements to ensure integration and quality of all technical cooperation.
- The types of joint DP arrangements that would best support the MHMS processes.
- Recruitment and logistical support for technical advisers and whether it can be outsourced or developed in-house, and what model is most suitable for Solomon Islands context.
- Orientation, succession planning, utilisation of available products, and relevance for the Solomon Islands Health SWAp.

The framework should be developed in a participatory and flexible way that builds ownership and understanding of the purpose and value of such a framework, leads to a shared understanding of the constraints and drivers on partners in relation to harmonising technical cooperation and identifies possible implementation issues. Ownership by MHMS is critical. There may be value in mapping current and planned inputs in order to shape and influence discussions.

The consultant should also consider developing tools that may be needed to support the framework. For example guidance notes for Solomon Islands Government and DPs on topics such as 'Making the most of the UN' or 'Managing a peer review of a document'.

4. Duration and phasing

The activity will involve a desk study and in-country components to be undertaken over six to nine weeks between ****** (Ministry to determine appropriate timing) 2010 according to the outline below:

Component	Location	Time
1. Initial consultations with AusAID Canberra (Pacific Branch and HHTG Health Adviser) and Post. Initial consultations with MHSM (US Health Care??)	Tele-conference	2 x 2 hours
2. Desk review of relevant Health SWAp documentation.	Desk study	1 week
3. Identification of international best practice for technical cooperation in a SWAp.	Desk study	1-2 weeks
4. In-country consultations – initial meeting with the MHMS / workshops MHMS and SWAp DPs including mapping and possible DP survey.	Honiara, Solomon Islands	2-3 weeks
5. Analysis of existing technical cooperation.	Desk study / in-country – To be determined	1 week
6. Presentation workshop regarding initial recommendations to MHMS and SWAp DPs.	Honiara, Solomon Islands	1 day
7. Development of final recommendations for a technical cooperation framework and submission to MHMS and development partners.	Desk	2 weeks

** Note: One week is considered as five consultant days.*

5. Required skills

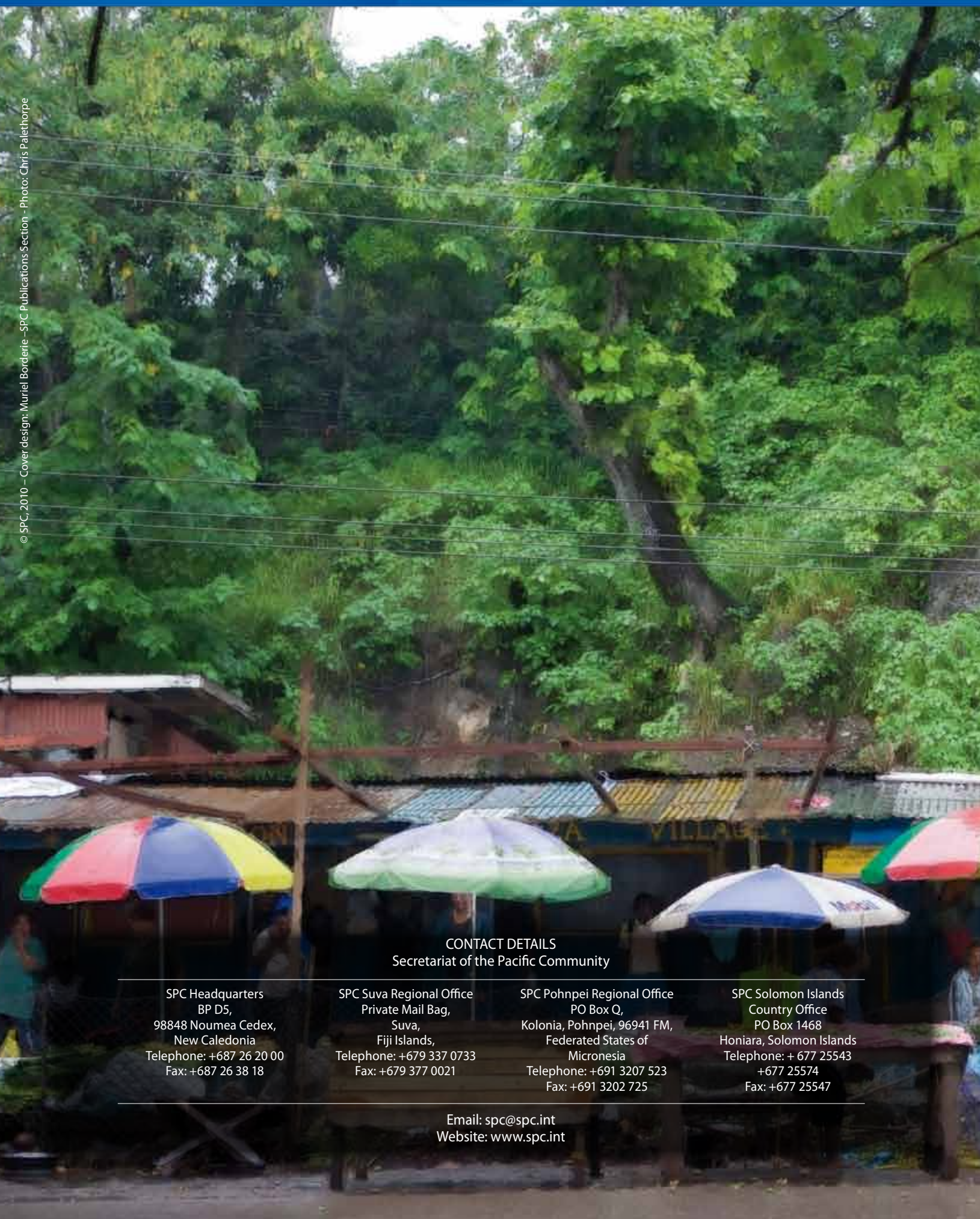
The following skills and experience are required:

- Understanding of government structures and management arrangements
- Experience in improving technical cooperation in developing countries, particularly in SWAp contexts
- Ability to work collaboratively with a wide range of stakeholders and government officials in-country
- Understanding of the range of technical inputs typically provided by DPs in a health development programme for a low capacity, post-conflict country such as Solomon Islands
- Strong facilitation skills and/or experience to enable a participatory process for the development of a technical cooperation framework
- A good understanding of health development issues in the Pacific (optional)

6. Reporting

The consultant is responsible for submission and presentation of the following reports:

1. In-country aide memoire of no more than 10 pages, outlining initial findings and thinking regarding a technical cooperation framework, to be presented to the MHMS and development partners before departing Honiara.
2. A report of no more than 20 pages (excluding annexes) outlining:
   a. Findings from analysis of existing technical cooperation.
   b. Appropriate examples of international best practice for technical cooperation in a SWAp (as listed in section 4 above), relevant for Solomon Islands context.
   c. Recommendations to the MHMS and development partners on possible options for implementation of a technical cooperation framework.
3. The final report is to be submitted within four weeks of completing the in-country components.



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