Solomons Islands HIV/AIDS programme

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Introduction

The projected population for 1994 is 360000 with 47% being below that age of 15 years. Life expectancy at birth is 60 years and an infant mortality rate of 42.3 per 1000 live births.

The major health problems are malaria, respiratory infections (including TB) and diarrhoeal diseases. In 1993 the incidence of all STD was 168.9 per 100000 population; this is most probably an under-estimate as reporting is often incomplete and does not include data from private hospitals and general practitioners. Hepatitis B carrier rates is estimated at 12.5%.

Homosexual behaviours is culturally and religiously forbidden in most communities but no study had been undertaken to determine its extend. Tattooing is traditional practice in some communities often using traditional instruments whereby sterility is questionable. No incidences of intravenous drug use has been reported and this practice is deemed very rare.

Sexually transmitted diseases (STD) are on the increase especially in the urban areas. There is no organised programme to deal with STD. This is dealt with in the general health care services. In the past decade, there has been and increase in the number of visitors to Solomon Islands particularly from Asia, Australia and New Zealand either as tourists, business persons including labourers, or as fishermen in the fishing industries. Also the number of Solomon Islanders going abroad had increased.

Table 1. HIV testing among groups in Solomon Islands as of 30 April, 1995

Group	Number tested	HIV positive
Blood donors	9800	0
STD patients	235	0
Others *	540	1
Totals	10575	1

** Includes patients with immune-suppressed condition, relapsed pulmonary TB, lymphomas, etc.*

Epidemiology of HIV infection/AIDS

The epidemiological situation regarding HIV infection/AIDS is not fully determined due to the absence of continuous surveillance, and the absence of representative serosurveys. The limited surveillance activities had yielded one HIV positive from tests carried out on 10575 individuals as shown in Table 1. There has been no AIDS case reported as of 30 April 1995.

The problems encountered in HIV epidemiological surveillance are as follows:

- justification to carry out surveillance on AIDS is inadequate as it is a low priority;
- inadequate HIV testing facilities and trained manpower especially in the Provinces;
- lack of support services such as counselling, expertise in management of HIV infection, and proper outreach services; and
- difficulty in identifying persons with at-risk behaviours and obtaining their cooperation.

The AIDS/HIV infection prevention and control programme

The national AIDS Policy was adopted in April 1988 with the formation of the National AIDS Committee (NAC) and a Short Term Plan (STP). The National AIDS Committee is an intersectoral Committee consisting of sixteen members and a core action group which consists of health personnel and non-government organisations (NGO) active in the implementation of the programme activities.

The prevention and control of HIV infection is integrated into the general health services utilising the Primary Health Care approach rather than running a vertical programme. Activities are co-ordinated, monitored and evaluated by the 'Action Group' of the NAC. Short and medium-plans have been developed.

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The STP was implemented with effect from March 1988. Twenty-nine activities and strategies were planned to be undertaken in the STP from March 1988 to March 1989. The STP activities were funded by the WHO and European Union. Some additional funds for community activities have since been obtained from organisations like the South Pacific Commission.

Assessment of the STP in 1988 showed that 40% of the planned activities were done; 28% were partially completed; and 32% were not implemented. The STP budget utilisation was 65%. As of December 1989, only 12% of the planned activities were not completed but the budget allocated for the STP had been fully utilised. The activities yet to be completed were the:

- KABP Study on HIV/AIDS in urban areas;
- establishment of laboratory facilities for HIV screening; and
- implementation of the sentinel sero-surveillance system.

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The main constraints encountered in the implementation of the STP were as follows: relative lack of support to the programme such as inadequate manpower and HIV testing equipments; difficulties in identifying individuals with at risk behaviours; and no favourable opportunities to undertake KAPB and sero prevalence studies.

A Medium Term Plan (MTP) was formulated in July 1989 for the period 1990 - 1994. The activities of the MTP included the following:

- public information and educational activities through the media, public talks, village meetings, and on World AIDS day campaigns;
- training of health workers in the management of HIV/AIDS cases and in counselling;
- conducted a KABP study on AIDS/HIV in 1991;
- establish laboratory HIV screening facilities for blood transfusion;
- distributed condoms as part of prevention of HIV infection;
  continue surveillance testings;
  developed information leaflets and pamphlets and distributed widely to the public;
  disseminated information on AIDS/HIV infection in the local newspapers as a "lift out centre page" since April 1995;
  mobilise the churches, women's groups, the youth and NGO's to be actively involved in the programme;
  conducted radio programmes on AIDS/HIV as panel discussion, talk-back shows, etc.; and
- integrated AIDS and STD as one programme and emphasised training in proper management of STD.

Discussion

Solomon Islands had recorded its first HIV positive person as of January 1995 and it confirms that the HIV pandemic had reached these islands. The possible important risk factors that may fuel the epidemic includes:

- the increasing incidence of STD especially in urban centres;
- increase in the number of visitors to the country from other parts of the world where the HIV infection is a problem;
- increase in the number of Solomon Islanders that travel overseas;
- not all blood for transfusion are screened for HIV especially in rural health centres with no such facilities;
- the poor socio-economic situation of the country; and
- the increase in teenage pregnancies and alcoholism with breakdowns in the socio-cultural values.

Despite these risk factors, there are useful to the control of the spread of AIDS/HIV. For example, the absence of intravenous drug abuse; the very low incidence, if any, of homosexuality; the presence of certain moral values and cultural behaviours; and the strong extended family system and support.

The national AIDS policy was formulated and adopted in 1988 with inputs from WHO experts, legal representatives, government officials, church, youth and women representatives, the NGO and some community leaders. The national AIDS policy, apart from setting out a programme approach and management structure, clearly adopts the principle of:

- utilising the normal public health approach to control the disease utilising known facts and experiences. In this regard there is no mandatory screening for HIV of all visitors, for employment purposes, etc. except for blood products before transfusion;
- non discrimination for HIV/AIDS persons;
- respect for human rights, individual rights and above all upholding the media/professional ethics and code of practice;
- upholding confidentiality in respect to patient information and conditions; and

- compassion, tolerance, respect and care for those in need and the sick (based on socio-cultural and religious values).

The policy addresses most of the controversial issues. It may appear that the policy is in favour of the HIV/AIDS person. However this is not so, as there are provisions to protect the public as well e.g. expatriates who are infected but knowingly infect others purposefully may be repatriated.

The individual rights and freedom of citizens are catered for under the constitution. The Public Health Act 1970 is specific in terms of empowering the doctors and health workers to do what is appropriate in terms of patients' needs and for the public interest. The Medical Code of practice also respects patients' rights and upholds confidentiality.

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The Health Services Amendment Act 1988, empowers the Minister of Health to make regulations and policies regarding patient care, management and treatment. It is under this Act that various regulations on any aspect of health care, prevention and promotion could be done, including confidentiality of patient information.

There is no reason to reform our legal system or policy in view of problems that arise with HIV/AIDS persons. As yet, we have only one HIV positive person but no AIDS case. However, the current policy on AIDS and the legal system had not been challenged.

When the news of the first HIV positive result was made public, as expected there were mixed public reactions and demand for the name of the person to be known; but confidentiality was maintained. To alleviate any fears or anxiety, the health ministry strengthened its public campaigns and reassured the public to be constructive and not to be emotional. The advise was more to behave responsibly and, if need be, to practice safe sex. The intensified public awareness campaign is still on at the present time.

References

References available from the authors on request. □