

FIJI HIV & AIDS RESPONSE PROGRESS REPORT

Monitoring Progress towards the Targets of the 2011 UN Political Declaration on HIV and AIDS

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AZT	Zidovudine
BAHA	Business Collation on HIV & AIDS
CEO	Chief Executive Officer
CoC	Continuum of Care
CSO	Civil Society Organization
EP	Empower Pacific
FCCDC	Fiji Communicable Control Disease Centre
FHSSP	Fiji Health Sector Support Program
FJN+	Fiji Network for Positive People
FNU	Fiji National University
GARPR	Global AIDS Response Progress Report
HIV	Human Immune Deficiency Syndrome
IBBS	Integrated Biological & Behavioral Surveillance
IDU	Injecting Drug Users
IPPF	International Planned Parenthood Federation
KAP	Key Affected Population
MDG	Millenium Development Goals
MOH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NCD	Non Communicable Disease
NCPI	National Commitments and Policy Instrument
NGO	Non-Government Organization
NHSP	National Health Strategic Plan
NSP	National Strategic Plan
NRL	National Reference Laboratory
OI	Opportunity Infection
PICT	Provider Initiated Counseling & Testing
PLHIV	People Living with HIV
POC	Point of Care
PPTCT	Prevention of Parent to Child Transmission
RFHAF	Reproductive and Family Health Association of Fiji
RH	Reproductive Health
SAN	Sex Workers Advocacy Network

SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted Infection
SW	Sex Workers
TB	Tuberculosis
ToR	Terms of Reference
VCCT	Voluntary Counseling & Confidential Testing
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ACKNOWLEDGEMENT

On behalf of the HIV/AIDS Board and the Ministry of Health & Medical Services [MoHMS], we would like to extend our gratitude to everyone that has contributed in the compilation of the 2014 Global AIDS Response Progress Report [GARPR] for Fiji.

To the key stakeholders who have been actively been involved in the reviewing of all HIV related activities in 2014 including key populations, government agencies, community based organizations and our donor partners. Fiji's response to HIV would not have had successes without the collaborative and continual support, commitment and contribution of the team in country.

The Sexual Reproductive Health Clinics and the Divisional HIV core teams are acknowledged for their active participation in collating data for HIV & STIs. These data has contributed to the compilation of the online 2014 Global Aids Progress Report for Fiji.

EXECUTIVE SUMMARY

For almost 25 years, the success of the Fiji's response to HIV has largely been a result of a collaborative partnership between our government agencies; communities based organizations, NGO's, academic institutions, key populations and health professionals. This year has again demonstrated the effectiveness of this partnership approach which has also strengthened as compared to previous years.

The HIV/AIDS Board is deeply grateful for the continued commitment from government through the Ministry of Health & Medical Services and also the continued support from donor agencies. This support has benefitted the HIV response in the country in its various components including prevention, treatment, care and support programs implemented by government agencies and our other key partners especially the key populations, NGOs and the FBO's.

For the past years, the response to HIV in the country has been encouraging. The most significant is the continued leadership and commitment from H.E. The President in the response to HIV through advocacy and awareness programs covering 85% [153/180] of the secondary schools in Fiji. He has also led by example in the response to reduce HIV stigma and discrimination, a threat to the HIV response. Fiji is honored to have H.E. The President in leading the way and more in the HIV response and we wish him continued success in the future.

Another important milestone in the year 2014 was undoubtedly the launch of the HIV Care & Antiretroviral Therapy Guideline 2nd Edition, the PPTCT Policy, PPTCT Training Manual and the PPTCT Participants Manual. The PPTCT policy includes the introduction of the Option B Plus for all HIV positive pregnant women. Following the launch of the PPTCT policy and it's training manual, PPTCT Train of trainers was conducted including divisional training to support the expansion of the PPTCT program to the sub divisional level.

Apart from the PPTCT trainings conducted, VCCT training was also conducted targeting the private practitioners which was coordinated by Suva Private Hospital supported by Ministry of Health & Medical Services with Empower Pacific as facilitators for the training.

Fiji was also able to launch its IBBS survey for MSM and Sex Workers through the support of UNAIDS & FNU. These studies were also used in the IAS Conference in Melbourne, Australia. A taskforce was set up to look at the recommendations raised from the two studies which is still in progress.

As part of the monitoring component of the HIV response, the HIV/AIDS Board had endorsed the establishment of a National HIV Monitoring & Evaluation Technical Working Group with its Terms of Reference. This TWG is chaired by the Permanent Secretary for Youth & Sports.¹

¹ HIV/AIDS Decree [Amendment] 2011, Part 2 Section 9 [13]

Throughout 2014, we continued our commitment to improving the quality of those living with and affected by HIV. Reflecting on the work of the HIV/AIDS Board in 2014, there has been many highlights and the MHMS with the HIV/AIDS Board will continue to invest valuable time to decision making, reflecting on and reviewing diverse areas of work and performing a governance role.

As you read this report, you will come to learn the collective successes that we have had with the HIV response particularly in the past year. When so much progress has been achieved globally, regionally and locally in stemming the tide of the HIV transmission and AIDS related death, we need to multiply our investment and commitment to ensure that our response is sustained and also has a high impact. In certain parts of the world, the end of HIV is already in sight. If Fiji is focused on the 2014 World AIDS Day Theme “AIDS WILL LOSE”, this is certainly not a time for us to decelerate our efforts. Let us continue to strengthen our bond and our bid to accelerate progress towards an AIDS-free generation.

1.0 STATUS AT A GLANCE

1.1 Inclusiveness of Stakeholders in the Report Writing Process

In the beginning of 2014, all key stakeholders including government agencies, civil society organizations [CSO], faith based organizations [FBO], key populations including PLHIVs and the donor agencies as our technical advisors came together for 2 ½ days to review the work that was done in 2013 and develop a 2014 activity work plan. The Annual HIV Activity Work Plan was aligned to the Fiji HIV & STI National Strategic Plan [NSP] 2012-2015 and the GARPR indicators. In this 1st consultation and planning meeting, gaps were identified and recommendations were discussed for improvement in relations to collaboration, implementation and monitoring and evaluation.

Fiji had taken a step forward in 2014 by utilizing its local human resources to evaluate its HIV response with the support from WHO, UNAIDS, UNFPA & UNICEF as technical advisors. This was empowerment for Fiji in terms of using internal human resources including the National HIV Monitoring & Evaluation Technical Working Group [M&E TWG] to develop a working plan for the country under the current national strategic plan.

A mid-year review meeting was conducted in August, 2014 to gauge the progress of the country's response as per endorsed work plan and a place to recognize and respond to certain recommendations made which needed to be implemented or strengthened at various levels and by different organizations. This review meeting was coordinated and facilitated by the M&E technical working group (TWG) which was chaired by the Permanent Secretary for Youth & Sports [PSYS - also a HIV/AIDS Board member] and facilitated by the HIV/AIDS board CEO and National Advisor Family Health.

In the last quarter of 2014, a review and planning meeting was conducted to update all HIV implementers in the country on the progress updates of the HIV implemented activities, identify gaps for improvement and develop a plan for the way forward on the country's response to HIV & AIDS in 2015, basically closing the loop for monitoring and evaluation by having planned, assessed and redeveloped the plans for the last phase of NSP.

The meeting had representatives from our government partners including Ministry of Health and Medical Services, Education Ministry, Youth and Sports Ministry, Ministry of Employment, Ministry of Women, Children and Poverty Alleviation [MoWCPA], I-Taukei Affairs and legal representatives from the Office of the Secretary General [SGs Office]. Civil Society organizations including Fiji Red Cross Society [FRCS], Reproductive & Family Health Association of Fiji [RFHAF], Empower Pacific [EP], and National Substance Abuse Advisory Council [NSAAC] were part of the meeting. The key populations included Sex Workers Advocacy Network [SANFiji], Rainbow Pride

Pacific, Haus of Kameleon and FJN+ who were actively involved along with our UN partners and WHO.

The meeting objectives included the following;

- Review all HIV related activities and programs from all partners. This included an evaluation on their progress and challenges encountered.
- Review all data collated as per indicators in the GARPR report and the country's NSP indicators.
- Incorporate reviewed and analyzed data into the country's annual report and the GARPR report.

On March 26th, 2015 – a consultative meeting was conducted with the inputs from key stakeholders on the compiled GARPR for Fiji and amendments were made before the final report was circulated to the members of the HIV/AIDS Board for their endorsement.

1.2 Status of the Epidemic

Fiji is classified as a low HIV prevalence country. As estimated by UNAIDS in the latest data hub for Asia and the Pacific, the number of people estimated to be living with HIV in Fiji in 2013 is less than 1,000, and the prevalence rate for adults between the ages of 15-49 years old is at approximately 0.1%.²

From the first HIV confirmed case in 1989 to the end of 2014 [figure 1], a cumulative total of 610 confirmed HIV cases³ were reported in the country through the data collation from the Fiji Center for Communicable Disease and Control and verified by the National Advisor for Family Health (NAFH) with the respective treatment and care sites for HIV in Fiji.

The total number of cases diagnosed alone in 2014 was 64, similar to the number diagnosed in 2013, and the 62 cases diagnosed in 2012. Though to note that in 2014 there was 58% females and 42% males, a slight different to the usual trend seen in the country.

The Ministry of Health and Medical Services (MoHMS) through the Family Health Unit is carrying out a data verification process to confirm the number of patients of the cumulative figure that are living or have died. At the completion of this verification process, Fiji will be able to determine the number of HIV confirmed cases that are still living and how many had succumbed due to AIDS related illness or death of any kind. This verification will assist the hubs in identifying the lost to follow up cases which need to be followed up for appropriate HIV

²HIV and AIDS Data Hub for Asia and the Pacific, December 2014 accessed on the 12th March, 2015 at <http://www.aidsdatahub.org/Country-Profiles/Fiji>

³ Centre for Communicable Disease Control , Fiji Ministry of Health & Medical Services, December 2014

management and treatment. The 3 Sexual Reproductive Health Centers within the country reported that in 2014 there were 264 HIV confirmed adult cases who regularly accessed the clinic for their follow ups with 15 Pediatric cases followed up at the pediatric hospital. This brings a total of 279 HIV confirmed cases having regular follow ups in Fiji at the respective health facilities.

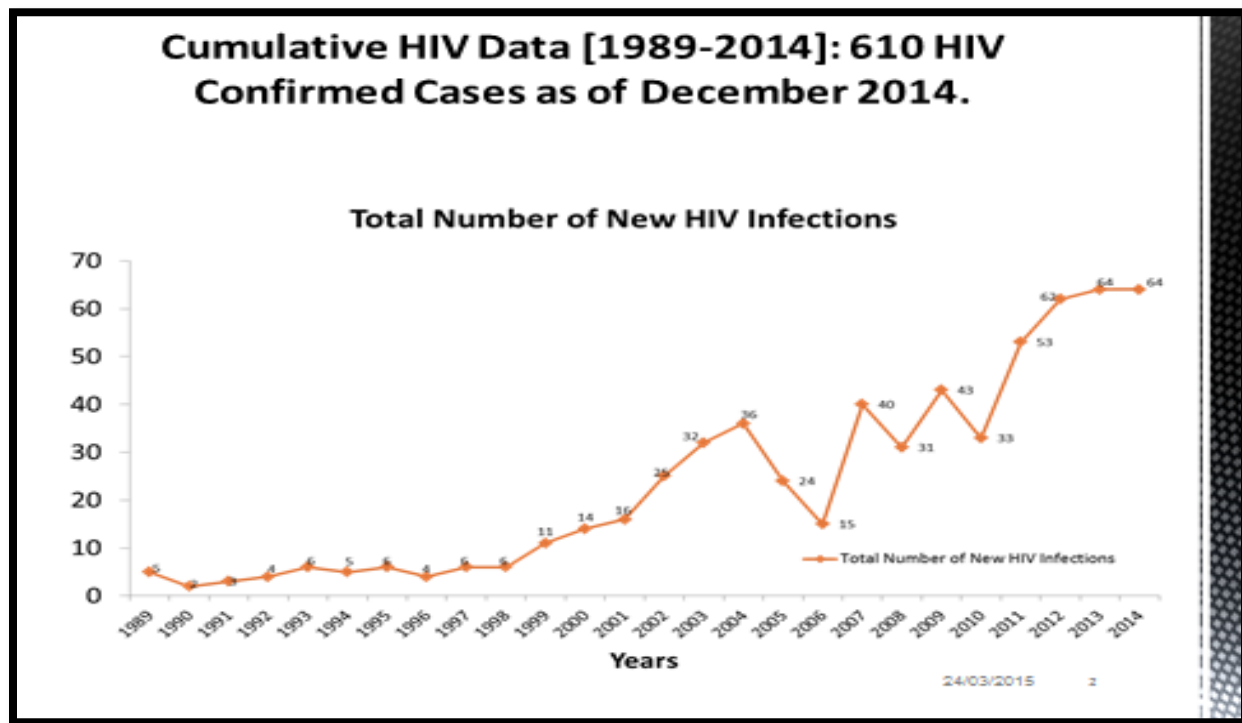


Figure 1: Fiji HIV Cumulative Data [1989-2014]

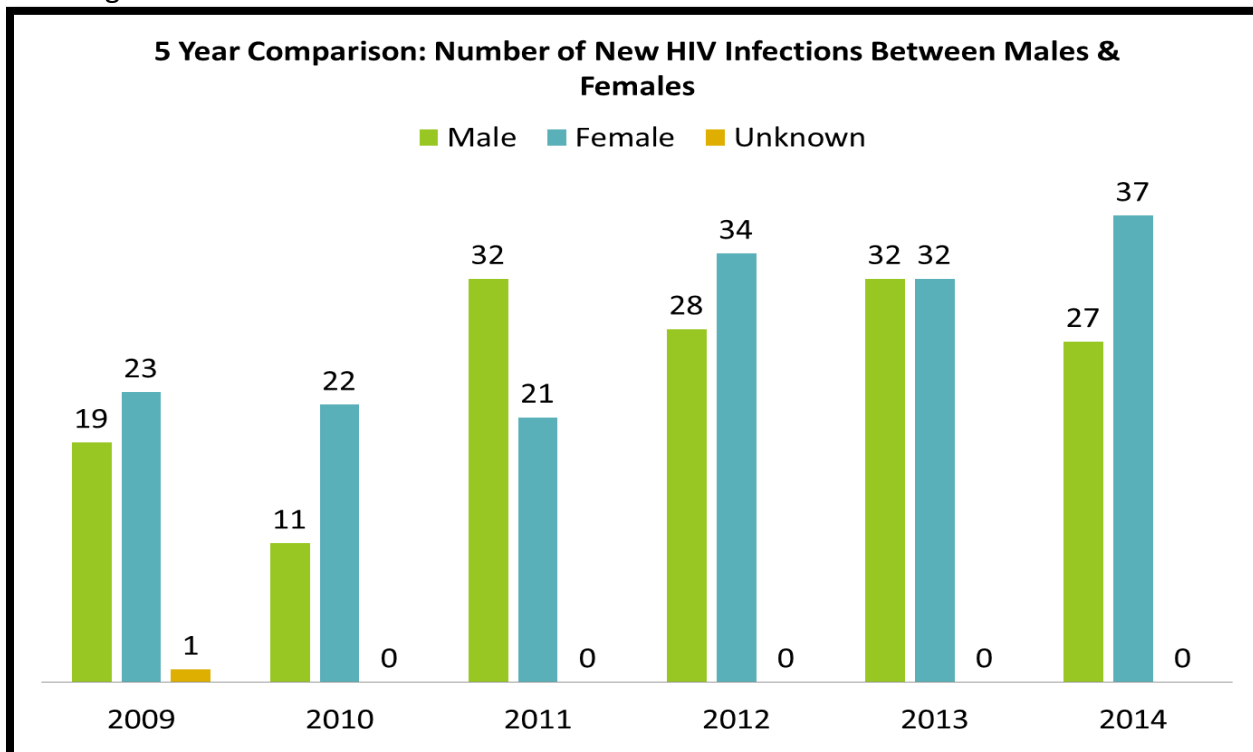
During the first 10 years of the HIV epidemic in Fiji, the number of HIV confirmed cases detected annually was a few to count but this began a slow but steady increase of 1-2 new HIV confirmed cases per year. The slow increase had changed from the year 2000 to date. In 2000-2008, there was an average increase of 30 new HIV infections and had increased one third higher as compared to the first 6 years of the epidemic. In 2013 and 2014, total number of new HIV infections was 64 respectively. Despite the global reduction in the number of new cases for HIV, the picture of Fiji is slightly different.

The increase in the number of new HIV confirmed cases in Fiji is a result of the increase in the number of HIV testing conducted not only in the hub centers [Reproductive Health Clinics] at divisional level, but HIV testing has also been expanded to the sub divisions especially through the new HIV Algorithm roll out and also the availability of PPTCT services in ante natal clinics at sub divisional level. In addition, HIV testing is also a component of the outreach programs to

the communities and also during carnivals or festivals in Fiji eg: Hibiscus Carnival & Procer Music Festival.

Since the identification of the first case in 1989 until to date, the rate of new HIV infections amongst the key population including MSM, transgender’s, bisexuals and sex workers is very low as seen in Table 1, and this is also confirmed in the integrated biological behavioral survey conducted in 2012 for sex workers in Fiji. Although the levels of other STI [eg: syphilis] is high amongst sex workers in Fiji, the HIV epidemic is not expanding through sex workers.⁴

Fiji and the Pacific have a different picture as compared to other countries in the world on the main mode of HIV transmission. It is not through MSM, SW or IDU’s but is primarily heterosexual followed by perinatal, homosexual and bisexuals and one case of injectable drug use noted some years back [Table 1]. Young adults from the age of 20-29 years are predominantly affected. In the year of 2013 we saw an equal distribution of male and female [50%] who are infected as compared to previous years where majority of the cases detected were amongst the male populations [figure 3 below]. There has been a paradigm shift in 2014 where there is 58% of females and 42% of males affected⁵. This can also be a reflection on the increased HIV testing in the ANCs as part of the scale up in HIV testing and PPTCT care and management.



⁴ Integrated Biological Behavioural Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention
Figure 2: 5 Year Comparison on the Number of New HIV Infections between Males and Females in Fiji

⁵ Centre for Communicable Disease Control , Fiji Ministry of Health & Medical Services, December 2014

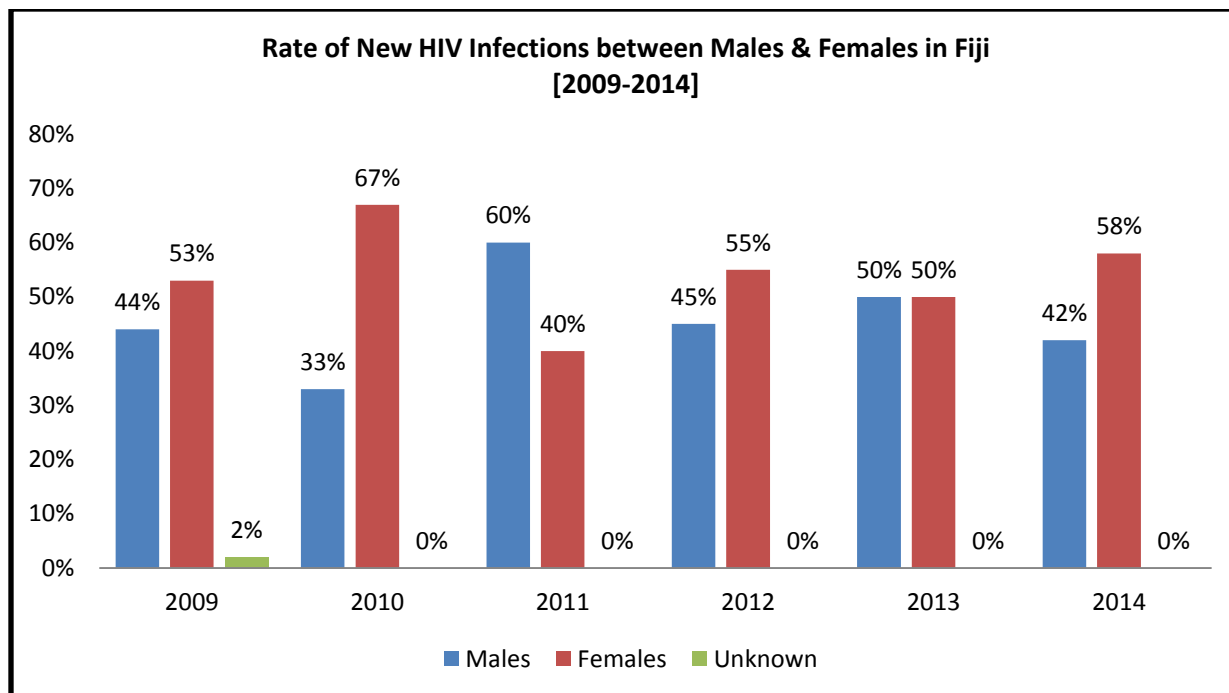


Figure 3: 5 Year Comparison on the Rate of New HIV Infections between Males & Females [2009-2014]

HIV is also commonly seen amongst the i-Taukei population of Fiji followed by Fijians of Indian Descent and then others as indicated in figure 4 below.

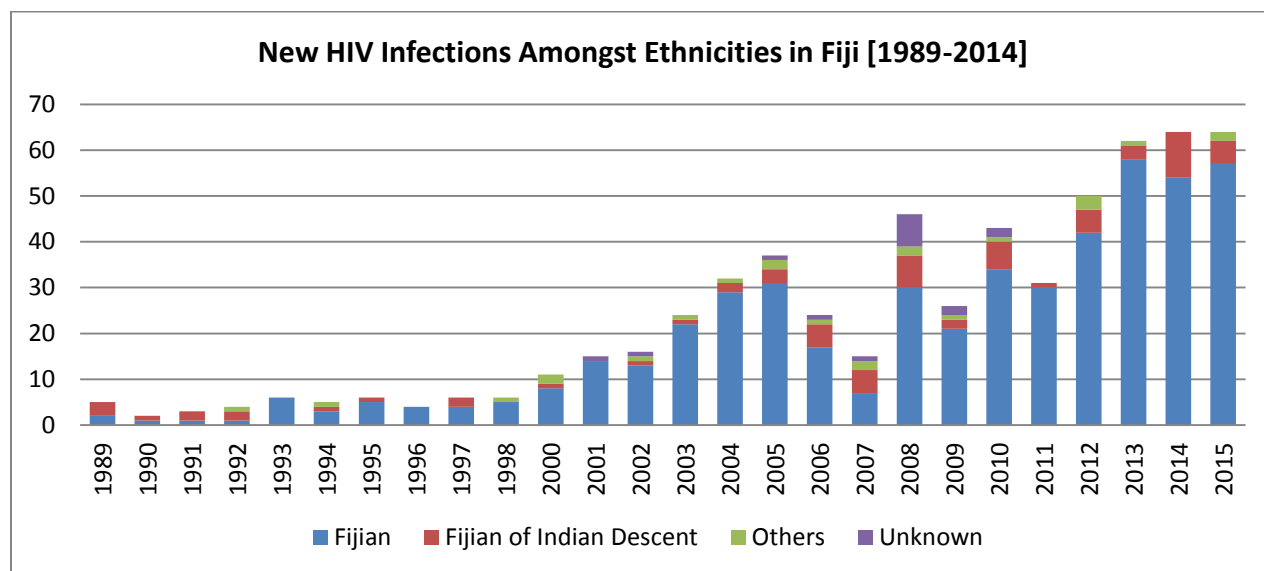


Figure 4: HIV Infections amongst Ethnicities in Fiji [New HIV Infections - 1989-2014]

Fiji has noted its increase in the number of cases over the last few years and is committed in focusing on implementing extra-ordinary strategies to ensure that tangible results are obtained. With a strong political commitment, Fiji is prepared at the Strategic level to ensure appropriate treatment and care for patient. It has taken huge steps in the year of 2014 with regards to

implementing the policies and guidelines – which is paramount in the appropriate management, care and treatment of PLHIVs.

In addition, the strengthening of collaboration with other key stakeholders including the community organizations and the key populations has created a stronger foundation on Fiji's response to HIV with the continuous political commitment from H.E. The President and other government leaders.

Table 1: HIV Cumulative Data [1998-2014]

TOTAL		SEX			RACE				MODE OF TRANSMISSION								AGE GROUPS							
Year	Total	M	F	U	Fij	Ind	Oth	U	Hetro	Homo	Bi	Trans	IDU	Peri	B/piercg	ukn	0-9	10-19	20-29	30-39	40-49	50-59	60+	Ukn
1989	5	4	1	0	2	3	0	0	3	0		1	0	0	0	0	0	0	3	1	0	1	0	0
1990	2	2		0	1	1	0	0	3	0		0	0	0	0	0	0	1	1	0	0	0	0	0
1991	3	2	1	0	1	2	0	0	1	1		0	0	1	0	0	0	0	0	2	0	0	0	1
1992	4	2	2	0	1	2	1	0	2	2		0	0	0	0	0	0	0	2	1	1	0	0	0
1993	6	4	2	0	6	0	0	0	1	2		0	0	0	0	0	0	0	3	3	0	0	0	0
1994	5	5		0	3	1	1	0	3	2		0	1	0	0	0	0	0	2	1	2	0	0	0
1995	6	4	2	0	5	1	0	0	8	0		0	0	0	0	0	0	0	2	2	2	0	0	0
1996	4	2	2	0	4	0	0	0	3	0		0	0	1	0	0	1	0	2	1	0	0	0	0
1997	6	6		0	4	2	0	0	3	0		0	0	0	0	1	0	0	2	2	2	0	0	0
1998	6	3	3	0	5	0	1	0	7	0		0	0	0	0	0	0	0	4	0	2	0	0	0
1999	11	8	3	0	8	1	2	0	8	0		0	0	3	0	1	0	0	5	3	1	0	0	2
2000	14	8	6	0	14	0	0	0	9	0		0	0	1	0	0	0	1	3	6	2	0	0	2
2001	16	7	9	0	13	1	1	1	17	0		0	0	0	0	0	0	0	11	5	0	0	0	0
2002	25	16	9	0	22	1	1	1	25	0		0	0	1	0	0	0	1	17	4	1	0	0	2
2003	32	18	14	0	29	2	1	0	28	0		0	0	3	0	0	2	0	12	11	3	1	0	3
2004	36	18	18	0	31	3	2	0	26	0		0	0	3	0	0	1	0	16	11	3	2	1	2
2005	24	14	10	0	17	5	1	1	26	0		0	0	2	0	1	0	1	5	9	3	2	0	4
2006	15	5	9	1	7	5	2	1	34	1		0	0	1	0	0	0	2	7	2	2	1	0	1
2007	40	19	21	0	30	7	2	1	23	0		0	0	0	0	0	0	2	23	13	1	0	0	1
2008	31	7	20	4	21	2	1	7	27	0		0	0	1	0	3	3	1	15	4	1	1	0	6
2009*	43	19	23	1	34	6	1	2	37	0		0	0	5	0	1	3	1	16	12	3	3	1	4
2010	33	11	22	0	30	1	0	2	33	0		0	0	0	0	0	0	1	22	8	1	0	0	1
2011	53	32	21	0	42	8	3	0	48	4		0	0	0	1	0	0	1	25	20	6	1	0	0
2012	62	28	34	0	58	3	1	0	55	3		0	0	4	0	0	4	2	34	16	5	1	0	0
2013	64	32	32	0	54	10	0	0	53	5	1	0	0	5	0	0	5	0	28	21	8	2	0	0
2014	64	27	37	0	57	5	2	0	60	0	0	0	0	4	0	0	5	0	36	17	4	1	0	1
TOTAL	610	303	301	6	499	72	23	16	543	20	1	1	1	35	1	7	24	14	296	175	53	16	2	30

1.3 The Policy and Programmatic Response

In the period of 2012-2013, Fiji had developed a number of policies and standard guidelines to guide health care workers on the prevention, treatment, care and support for those living with and affected by HIV. These guiding documents were endorsed by the appropriate advisory committees such as the National Health Executive Committee and the National Medicines and Therapeutics Committee before the final endorsement by the HIV/AIDS Board.

In 2014, these endorsed documents were printed and launched before distribution to all health facilities at all levels. Below are the policies which were endorsed, launched and distributed.

1.3.1 HIV Care and Antiretroviral Therapy Guideline 2nd Edition:

The utilization of the above guideline which includes the WHO revised criteria as endorsed in June 2013 including the Option B plus has strengthened the expanded ART program as part of Fiji's strategic plan. This is a crucial component in the care and treatment of PLHIVs that has been designed to strengthen the sustainability of the Care and Treatment component in Fiji. Including the provision of the recommended drug regimens, regular monitoring of PLHIV who are either on ART or not. It also focuses on the capacity building of health care professionals on the appropriate CoC.

The revised treatment guidelines factors:

- 1) Change in the CD4 count level to 500
- 2) Treatment of discordant couples
- 3) Officially places option b+ as the option for all PPTCT patients though Fiji had adopted the use of Option B plus in May 2012.

The only regimen that Fiji has kept of its own is the use of Zidovudine (AZT) for babies who need prophylaxis for the first 6 weeks of life under the PPTCT program since it was seen that babies started to have elevated transaminases to the Niverapine usage.

In addition, this standard care and treatment guideline has also included the introduction and management of Opportunistic Infections to ensure that health care workers were well versed with diagnosing and treating PLHIVs experiencing OI's.

1.3.2 Fiji Policy on Prevention of Parent to Child Transmission [PPTCT] of HIV:

An important component of Fiji's prevention strategy is the prevention of HIV transmission from parents to children or PPTCT. In strengthening the PPTCT program, the revised PPTCT

policy⁶ endorsed in 2013 was launched in June 2014 with its PPTCT training manual. This was followed by with the PPTCT training on train the trainers and a PPTCT training of other implementing health care workers..

In 2014, a total of 9 trainers were trained in the PPTCT TOT program and 35 [Central/Eastern & Northern Division] HCW were trained as PPTCT Practitioners. These trainings were facilitated by our trained PPTCT trainers within the Ministry.

PPTCT in Fiji has come a long way. The health facility services have changed significantly. PPTCT came into the country bringing hope HIV positive families who are now able to have children who are negative for HIV. ⁷

Apart from the PPTCT Program, Empower Pacific has also been assisting in facilitating the VCCT Training in 2014 targeting the General Practitioners and the clinicians at the Suva Private Hospital [SPH]. This has been an important private public partnership for the HIV Program and increasing accessibility of HIV services to the patients that are accessing the private services in Fiji.

Under the private public partnership with the private health system, the Ministry has collaborated and supported training for private practitioners who can treat and provide necessary care with the assistance of public practitioners. This is encompassed in the HIV Testing and Counseling Policy and the Prevention of Parent to Child transmission of HIV policy (PPTCT).

Provision of free treatment [ART] is a significant contributor towards the prevention arm of the HIV program.

[1.3.3 HIV testing and Counseling Policy⁸:](#)

The policy was developed to guide and improve HIV diagnosis, prevention and systems for holistic treatment, care, and support, including surveillance and reporting. It ensures that standards of practice are consistent with the international and regional protocols to promote HIV counseling and testing services as a core initiative in the fight against HIV.

The policy targets all HIV counseling and testing services conducted within the private and public facilities, including but not limited to hospitals, health centers, laboratories and prisons.

⁶ This is the revised PPTCT policy from 2010 which also includes the introduction of Option B plus for all HIV positive pregnant women. Option B+ was adopted by Fiji as part of the PPTCT program in 2012 after the programmatic update was introduced in April 2012.

⁷ Fiji Policy on Prevention of Parent to Child Transmission [PPTCT] of HIV, Ministry of Health, 2014

⁸ HIV Testing & Counseling Policy, Ministry of Health Fiji, 2013

The policy was endorsed in March 2015 NHEC meeting and is currently in the process of having it printed for launch and implementation.

The policy includes the recent development of the new HIV Testing Algorithm of the three rapid tests which was also endorsed in 2013 by the Ministry of Health with the support of UNICEF, WHO, UNAIDS, SPC, NRL and FCCDC (Fiji Center for Communicable Disease Control). Following the endorsement of the introduction and the roll out of the new HIV Algorithm in Fiji, a HIV & STI Laboratory Project Officer was recruited to be the focal person in monitoring the program from sub divisional to national level.

Understanding that the case loads in the Divisional and Sub-Divisional Hospitals are significantly different, there are three different algorithms endorsed for this roll out. The additions of Insti and Uni-Gold rapid test kits are now a part of the confirmatory process for HIV with determine rapid test being the screening test. The introduction of the new algorithm is hoping to see no indeterminant cases in Fiji with a quick turnaround time for all HIV results.

In 2014, a total of 7 HIV testing sites under the new HIV Algorithm were established. This was through the coordination and facilitation of the HIV/STI Lab Project Officer. The process of establishing these testing sites includes the following;

1. Baseline Assessment of the Identified HIV Testing Sites/Laboratories
2. Strengthen gaps identified from the baseline assessment
3. On Site Training of Laboratory Technicians, VCCT Nurse & Medical Officer
4. Roll out of New HIV Algorithm

The project officer continues to monitor the services from these sites ensuring no disruption is faced for the services. In addition, the officer is also responsible in collating and analyzing data received from the testing sites. FCCDC continues to be the quality assurance lab in Fiji.

As part of system strengthening in the care of people living with HIV, the Ministry with the support of UNICEF procured three PIMA machines to assist the divisional hospitals in monitoring the CD4 counts of PLHIV.

A GeneXpert machine available through the TB/HIV program is available in the country which is used for TB testing, and it has capacity to detect viral loads in PLHIVs.

[1.3.4 Fiji TB/HIV Collaborative Policy:⁹](#)

In 2014, there were 385 patients registered on TB treatment by the National TB programme, 79% were tested for HIV infection and there were 1.6% TB/HIV co-infected cases in 2013 and 3.9% in 2014.

The TB/HIV Policy was endorsed in 2014 and will be launched in 2015 to initiate appropriate implementation of its policy direction needed under preventative, treatment and care services for all TB/HIV patients. The development of the policy is based on the following objectives:

- Establish mechanisms for collaboration at all levels in terms of program management and also implementation of the TB/HIV program.
- Increase detection of TB in PLHIV and vice versa.
- Optimize management and care for TB/HIV co-infection.

The collaboration in this regards will be seen from National level down to the Divisional and Sub-Divisional level where programs are implemented. It ensures the Three I's of TB with monitoring and evaluation of the TB/HIV Collaboration.

[1.3.5 Standardization of HIV Reporting:](#)

To strengthen the adherence of the policies mentioned above, the ministry through the Family Health Unit is currently using an endorsed standardized HIV reporting template. This reporting template [with the process supported by UNICEF] is used by the Reproductive Health Clinics, Pediatrics and Obstetric clinics in Fiji. This reporting process is a tool is a monitoring tool that would ensure data security and also the credibility of the report which would assist in planning and strategic decision making at national level.

The Ministry of Health & Medical Services through the Family Health Unit and the support of UNAIDS, WHO and UNICEF are currently in the process of developing a user friendly software or online database system to assist the clinicians in collating and analyzing data from their clinics.

[1.3.6 Fiji National Strategic Plan 2012-2015:](#)

Fiji is now in its final year of implementation on its 2012-2015 STI & HIV National Strategic Plan. The current strategic plan focuses on four [4] strategic approaches with its priorities on; prevention, continuum of care, monitoring and evaluation, governance, coordination and partnerships, cross cutting themes addressed in each strategic areas, gender and human rights, stigma and discrimination.¹⁰ These priorities are overlapped in each of the four approaches

⁹ Fiji TB/HIV Collaborative Policy, Ministry of Health, 2013

¹⁰ Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015

resulting in the strengthening of the implementation of planned activities designed within the strategic plan.

The development of the NSP is through the collaboration and consultations of all key stakeholders in the country from government agencies, community organizations, FBOs, key populations such as PLHIV, MSM and SW, academic institutions and health care workers who are directly involved in patient care and treatment.

Through the endorsement of the HIV/AIDS Board, a National HIV Monitoring & Evaluation Technical working group was established to monitor and evaluate the implementation of the NSP. Through the technical working group coordination all stakeholders are involved in a consultative meeting for the development of the annual work plan and also its mid-term reviews.

1.3.6.1 Prevention Strategic Approach¹¹

Prevention is a major priority within the national response to the HIV epidemic. Prevention activities are focused on the key affected populations [KAP], reproductive health and gender awareness for young people, PPTCT through community education and awareness and also the safety of health care workers and patients through blood safety.

Fiji's approach to prevention has not only included the health ministry but also the collaboration work with CSOs, government partners such as the Ministry of Education Ministry of Labor department, media outlets, private sectors, peer educators and people living with HIV [PLHIV]. The multi-sectorial approach towards prevention is a successful strategy for the country.

Prevention programs targets all levels [national to community levels] and specifically tailored for the different types of communities it addresses. These programs are coordinated and facilitated by the various HIV implementers within the country that works with the specific targeted population. For example; SAN Fiji [sex workers network] will conduct prevention programs for the sex workers whereas the peer educators with Ministry of Health work with the Education Ministry targeting the in-school children and young adults. The involvement of PLHIV during the awareness preventative programs provides an added impact to the program or implementation of activities.

HIV advocates for Fiji have proven to have a huge impact on issues pertaining to stigma and discrimination. Putting a face to the disease brings reality to the community that PLHIV are just like anyone else in society and they have a right to life and all that it has to offer. We have seen

¹¹ Prevention Strategic Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015

a reduction in stigma and discrimination where positive persons have been advocates and continue to see success stories of these around Fiji. We are forever thankful to the bold PLHIV who are either HIV advocates within the Ministry of Health or based with the Fiji Network for Positive people (FJN+).

VCCT programs are also part of the awareness activities in communities and during major events around Fiji, these major events can be from sporting events to carnivals. Time is given at the end of the awareness sessions for the community to voluntarily come for HIV counseling and testing. This approach works well especially in remote areas in Fiji where POC testing is not accessible. For others who have yet to make a decision, information is provided where they can access further services for HIV testing, treatment and support. To note over the last few years we have seen an increase in the number of people who are tested positive from these outreach awareness programs. These outreach activities not only detect HIV cases but also other STI related illnesses.

1.3.6.2 Continuum of Care [CoC] Strategic Approach

The CoC approach focuses on five objectives which includes; HIV testing, diagnosis and treatment, PPTCT, it focuses on the testing and treatment of STIs, RH for PLHIVs and community based care, support and life skills capacity building for PLHIVs.

Fiji has encompassed counseling, testing, treatment and care through the Continuum of Care approach where these services are linked allowing a greater involvement of support organizations in the counseling, treatment, care and support of PLHIVs. For example, Empower Pacific [a counseling service] provides counseling to ante natal mothers [VCCT] and refers any newly diagnosed PLHIV mothers to the Hub centers for further treatment and care. The above approach also strengthens linkage with community programs especially in the area of reducing stigma and discrimination not only to the infected but also to those affected with HIV.

FJN+, the network for positive people had begun a capacity building program to empower PLHIVs in Fiji. The activity with the technical assistance from FCOSS was focused on income generation and methods of starting a small business. Following this training, 6 PLHIVs who are FJN+ members have enrolled into developing and starting their small business.

1.3.6.3 Governance & Coordination Strategic Approach

Fiji's strength in the HIV response through the Health Ministry is the collaboration and support received from other support organizations that are also providing services related to HIV. This includes government agencies like the Ministry of Employment that deals with HIV in the Workplace and also targets private sectors, Ministry of Women, Children & Poverty Alleviation that provides financial support to PLHIVs and is also providing complimentary services for the

country by strengthening reproductive health in women. There are NGO's like Fiji Red Cross Society, RFHAF that focuses on sea farer's, FASANOC on the other hand targets sports man and woman on HIV and SAN Fiji, Haus of Kameleon and Rainbow Pride Fiji focuses on sex workers, transgender and MSM to name a few of the many organizations we have in Fiji.

All HIV implementers in the country are guided by the Fiji National Strategic Plan 2012-2015 with their planned HIV activities. Key stakeholders are consulted through consultative meetings to identify strategies for improvement and support in the HIV response.

The HIV/AIDS Board governs and monitors all HIV related activities to ensure that implementation of these activities are effective and tangible results are produced. PLHIVs are represented in the HIV/AIDS Board as a board member and voice of the People living with HIV.

To assist the Board in its governance and strategic approach, there are working groups of the Board such as the Continuum of Care working group, the HIV Testing and Counseling Committee, and the M&E working group which are think tanks for the Board.

The HIV/AIDS Board was initially known as the National Advisory Committee for AIDS [NACA] before the endorsed HIV/AIDS Decree in 2011. From a 20-30 member advisory committee, the committee members had reduced to only 13 members as stated in the Decree. Membership of the Board includes;

1. Permanent Secretary of Health [also Chairman of the HIV/AIDS Board]
2. Permanent Secretary of Education
3. Permanent Secretary of Immigration, Defense & Security Services
4. Permanent Secretary of Youth & Sports
5. Permanent Secretary of Women, Children & Poverty Alleviation
6. Representative from the UN Agency
7. Clinician and Manager of the HIV programe from the Ministry of Health and Medical Services
8. Representative from the CSO's
9. CCM Chairman
10. Representative from the academic institution
11. Representative from the Positive People

Recently the Board had also endorsed to have a representative from the women's' group and also a representative from the FBO's since there were issues around women and the church discussed in the recent Board meetings.

The Board as mentioned above is the governing body in the country that coordinates and monitors the HIV response and it also plays an important role in the following;¹²

1. Consider and recommend the goals and objectives for the national response to HIV/AIDS generally in Fiji to ensure that for all quality goods, services and information for HIV prevention and control, treatment, care and support, including antiretroviral therapy and any other safe and effective medicines including traditional and herbal remedies, diagnostics and other technologies for preventive, curative and palliative care of HIV/AIDS related illness are made available and accessible on a sustained and equal basis,
2. Advise the Minister
 - on the mobilizing, disbursement and monitoring of resources including financial resources
 - on the development, review, update and a prepare the content for the NSP to respond to HIV/AIDS in the country.
3. Evaluate and review the human rights based policy guidelines, programs and activities for the response to HIV/AIDS at all levels and report to the Minister.
4. Consider and advise the Minister on training and support for the programs designed to increase HIV/AIDS awareness and protective measures against HIV.
5. Promote research, awareness materials and information sharing on HIV/AIDS and may issue guidelines for the conduction of research on HIV and HIV related matters.
6. Advise the Ministry on access to sustained, appropriate, and affordable treatment for persons living with HIV or affected by HIV/AIDS, the prevention of infection with HIV and the promotion and protection of the rights of persons living with or affected by HIV/AIDS and those at risk of infection.
7. Advise the Minister on any matter relating to HIV/AIDS as may be requested by the Minister from time to time;
8. Foster national, regional and international networks among stakeholders engaging in continuing HIV/AIDS programs and activities; and
9. To keep under the review the appropriateness and effectiveness of this Decree, the regulations, policies, standards of practice, guidelines and codes of conduct made under it and to propose any changes or modifications, the Board deem necessary in writing to the Minister.

The Board overall has wide powers to drive policy, and to advise the Minister on HIV/AIDS matters in Fiji and keep under review, the effectiveness of the Decree through the assistance of its CEO.

¹² HIV/AIDS Decree 2011, Part 2, Section 4

In 2014, the Board had also developed its Standard Operating Procedures to guide the Board with its functions as per decree.

It is through the guidance and strategic directions of the Board with the active involvement and strong advocacy from the President of Fiji as the Ambassador of the Board that has played an important role in the coordination and successes of the HIV response in the country. The collaboration and involvement of all key stakeholders in the country's response to HIV has strengthened as compared to previous years.

1.3.6.4 Monitoring, Evaluation & Research Strategic Approach

The establishment of a National Monitoring & Evaluation technical working group in 2014 has bridged the M&E gap that has been vacant for a while. The M&E technical working group has played an important role in monitoring the HIV response through the guidance of the developed annual work plans.

Part of their monitoring process is through the mid-year and annual review meetings where all stakeholders meet to share progress of their activities; challenges faced and identified strategies to improve.

HIV/AIDS Board had endorsed the development of "The National Results Monitoring and Evaluation Framework of the Fiji HIV and STI National Strategic Plan 2012-2015" in 2013 to coordinate stakeholders towards one agreed country-level monitoring and evaluation system. The framework was designed to be used by the national and sub-national program managers and all those involved in the following:¹³

1. Planning and implementing program
2. Monitoring and evaluation
3. Using data and information for policy development and program improvement.

It provides a consistent integrated framework for monitoring programmatic progress and evaluating the outcomes of the Fiji multi-sectoral response to HIV, following the NSP 2012-2015. It also provides guidance and assistance in the following areas;¹⁴

1. To facilitate data collection and analysis of the multi-sectoral response to HIV and STI, as planned in the NSP 2012-2015, through addressing both the course of the epidemic as well as the coverage of crucial services that are part of the national response, in addition to the yearly work plans and specific activities by participating entities which contribute to the NSP objectives.

¹³ The National Results Monitoring and Evaluation Framework of the Fiji HIV and STI National Strategic Plan 2012-2015

¹⁴ The National Results Monitoring and Evaluation Framework of the Fiji HIV and STI National Strategic Plan 2012-2015, Specific Objectives of the M&E Framework

2. To ensure the accountability and multi-sectoral approach towards a Results-Based M&E of the national response in terms of immediate quality outputs that will contribute to better outcomes and ultimately the expected or higher impact.
3. To provide a mechanism to bring together opportune, strategic and quality information concerning the elements of the multi-sectoral response and to make this information available to decision-makers.
4. To obtain and manage evidence based information that will i) guide the decision-making process and ii) provide feedback on how to be more strategic at the policy development, strategic planning and implementation levels.
5. To increase focus on monitoring the implementation of the work plans (Programmatic M&E).
6. To collect the information required by managers for reporting to the national and international level on achievements and progress made.
7. To contribute to the development and strengthening of the M&E Culture in the health sector and other sectors
8. To increase M&E advocacy to support better performance and alignment
9. To develop better-aligned and harmonized M&E systems at the country level

The National HIV and STI Programme team at the Ministry of Health and Medical Services is responsible for the coordination of the overall monitoring and evaluation of the multi-sectorial strategy, in close collaboration with the HIV National Board the Chief Executive Officer and the M&E Technical Working Group.

The framework is not only used by the health ministry staff but all stakeholders are empowered to take ownership of the document and to be used as part of their M&E tool in the HIV response.

[1.3.7 The HIV/AIDS \[Amendment\] Decree 2011 \[or Law and Prevention on HIV in Fiji\]:](#)

In January 2011, the Fiji HIV/AIDS Decree 2011 was enacted, culminating a process that began in 2004. The Decree outlines a human rights framework for the response to the HIV epidemic from this point on. It also legislates for the formation of a new multisectoral HIV/AIDS Board that is responsible for coordinating the national HIV response, including for the first time in the history of the HIV response in Fiji, a full-time Chief Executive Officer, answering to the Board, responsible for managing and coordination of all HIV activities in the country.

The HIV/AIDS Decree was endorsed after years of lobbying and assistance in preparation by UNAIDS and other civil society groups, determined to enable a legal framework in Fiji which would facilitate an approach to HIV/AIDS based on human rights, non-stigmatization, education, and awareness.

The purpose of the Decree as set out in its title is – ***“TO PROVIDE HUMAN-RIGHTS BASED MEASURES TO ASSIST IN HIV PREVENTION, AND HIV/AIDS CARE AND SUPPORT AND FOR RELATED PURPOSES.”*** Section 3 provides that in interpreting the provisions of the Decree, and when exercising any power under it, regard should be had to international human rights standards and in particular to ICCPR, ICESCR, CEDAW, CRC, and CRPD, in addition to the international Guidelines and UN Declaration of Commitment.¹⁵

The Decree makes it unlawful to discriminate against any person who is either living with HIV, or is affected by HIV/AIDS. The latter group is all those people who are partners friends, close and extended family members, work colleagues and members of the same religion, of a person who has tested positive for HIV antibodies or antigen. Apart from a general anti-discrimination provision, the Decree makes it unlawful to refuse accommodation, to refuse employment or promotion, to refuse entry in educational institutions, to refuse partnership in a company, to refuse membership of groups and clubs, to a person who is living with HIV or affected by HIV/AIDS.

The Decree provides an enabling environment for changes in social and professional attitudes. It is a significant and enlightened step towards the effective and human rights based approach to the prevention and care of those who live with HIV or are affected by HIV, in Fiji.

[1.3.8 Resources:](#)

Government of Fiji expenditure on the national HIV response in 2014 constituted approximately \$300,000FJD apart from finances that were used to procure ART in the year of 2014. The other major contributor to the budget provided to the Government for the HIV program directly to the Ministry of Health was through UNICEF an amount of \$80,000.00 which was used for a significant number of programs in the year. WHO supported the local HIV programs in the area of strategic health communications, STI and other HIV related activities, OSSHHM has been supportive in terms of clinical attachments for Hub medical officers to Mendi, Papua New Guinea.

With the Government’s commitment towards provision of free ART for PLHIV in the country and the increment of its prevention and advocacy allocation towards the HIV program in 2015

¹⁵ HIV/AIDS [Amendment] Decree 2011

by \$50,000 is an example of its commitment. With the support of donor partners we are able to fill in the GAPS of funding.

Indicator #	Indicators	2013			2014			Remarks
		Numerator	Denominator	%	Numerator	Denominator	%	
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	44	83	51%	No new data available	No new data available		Second Generation Surveillance Report, 2008
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	13	543	2.4%	No new data available	No new data available		Second Generation Surveillance Report, 2008
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	363	1616	22.5%	No new data available	No new data available		Second Generation Surveillance Report, 2008
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	103	363	28.4%	No new data available	No new data available		Second Generation Surveillance Report, 2008

1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	No new data available	No new data available		Second Generation Surveillance Report, 2008
1.6	Percentage of young people aged 15-24 who are living with HIV*				No data available	No data available		Fiji does not currently collate data for this specific age group amongst ante natal clinics
1.7	Percentage of sex workers reached with HIV prevention programs	202	297	68.01%	No new data available	No new data available		IBBS Survey 2012
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	270	297	90.91%	No new data available	No new data available		IBBS Survey 2012
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	104	297	35.02%	No new data available	No new data available		IBBS Survey 2012
1.10	Percentage of sex workers who are living with HIV	3	293	0.1%	No new data available	No new data available		IBBS Survey 2012
1.11	Percentage of men who have sex with men reached with HIV				No new data available	No new data available		IBBS Survey 2012

	prevention programmes				available	available		
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner				No new data available	No new data available		IBBS Survey 2012
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results				No new data available	No new data available		IBBS Survey 2012
1.14	Percentage of men who have sex with men who are living with HIV				No new data available	No new data available		IBBS Survey 2012
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes				This indicator is currently not applicable for Fiji – but should be considered to be investigated further.	This indicator is currently not applicable for Fiji – but should be considered to be investigated further.		
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse				This indicator is currently not applicable	This indicator is currently not applicable		

					for Fiji – but should be considered to be investigated further.	for Fiji – but should be considered to be investigated further.		
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected				This indicator is currently not applicable for Fiji – but should be considered to be investigated further.	This indicator is currently not applicable for Fiji – but should be considered to be investigated further.		
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results				This indicator is currently not applicable for Fiji – but should be considered to be investigated further.	This indicator is currently not applicable for Fiji – but should be considered to be investigated further.		

2.5	Percentage of people who inject drugs who are living with HIV				This indicator is currently not applicable for Fiji – but should be considered to be investigated further.	This indicator is currently not applicable for Fiji – but should be considered to be investigated further.		
3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	14	22	63.64%	15	15	100%	Data is obtained from the pilot reporting tool for HIV in the country. Fiji uses the Option B plus, thus all pregnant women who are diagnosed to be positive are put on a life time therapy [TDF, 3TC, EFV]
3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	11	11	100%	15	15	100%	Pilot reporting template for HIV. Secondary to Option B plus, Fiji is able to keep their babies

								breastfed which is also factored into the Fiji PPTCT Policy 2013 as well.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	9	14	64.29%	6	15	40%	This data is obtained from the reporting template for HIV.
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	7	22	31.8%	5	34	14.7%	This data is obtained from the reporting template for HIV.
4.1	Percentage of adults and children currently receiving antiretroviral therapy*	172	277	62.1%	Data currently not available	Data currently not available		Data obtained from pharmaceutical reports
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	47	67	70.1%	Data currently not available	Data currently not available		
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	4	4	100%	11	11	100%	Data information source from the HIV Reporting template and also the TB

								Report for 2014
6.1	Domestic and international AIDS spending by categories and financing sources				Data available on online report [6.1]	Data available on online report [6.1]		
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months				2043	3193	64%	
8.1	Discriminatory attitudes towards people living with HIV				No data available	No data available		
10.1	Current school attendance among orphans and non-orphans aged 10–14*	1	1	100%	No data available	No data available		
10.2	Proportion of the poorest households who received external economic support in the last 3 months				No data available	No data available		Data for this is important and Fiji has a social welfare system which offers social welfare, though unfortunately we have had patients

								who have sought external economic support and there's no data on these patients.
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Table 2 Indicator List for GARPR

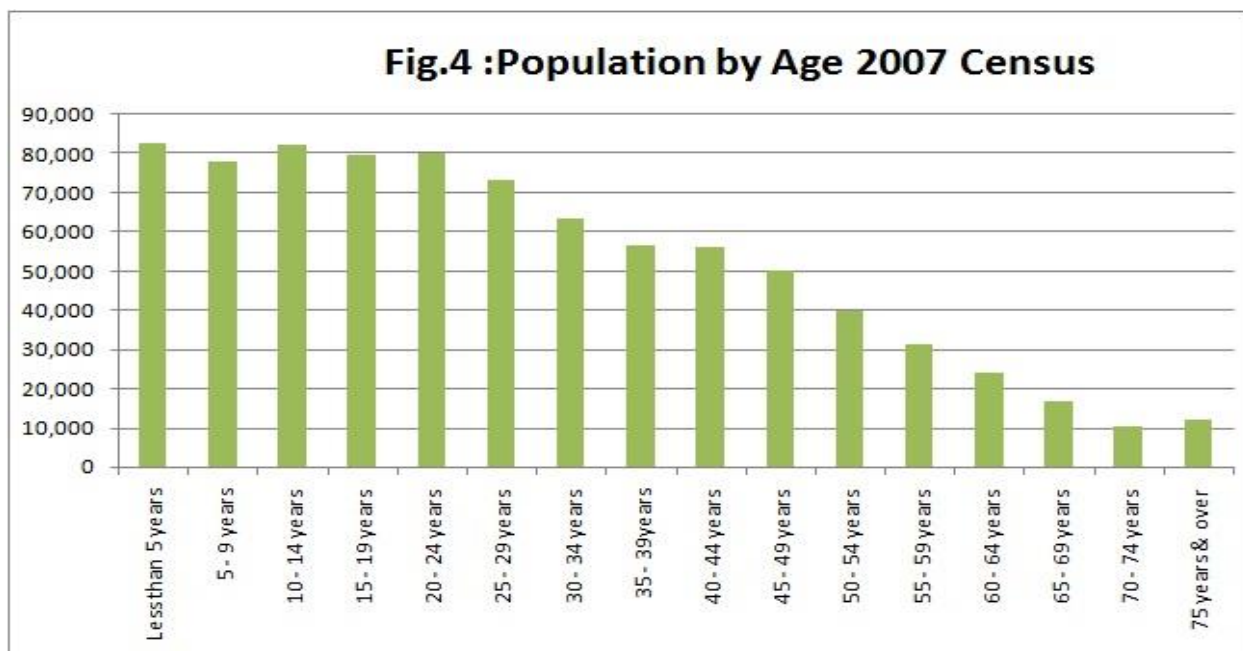


Figure 6: Age Distribution as per 2007 Census¹⁷

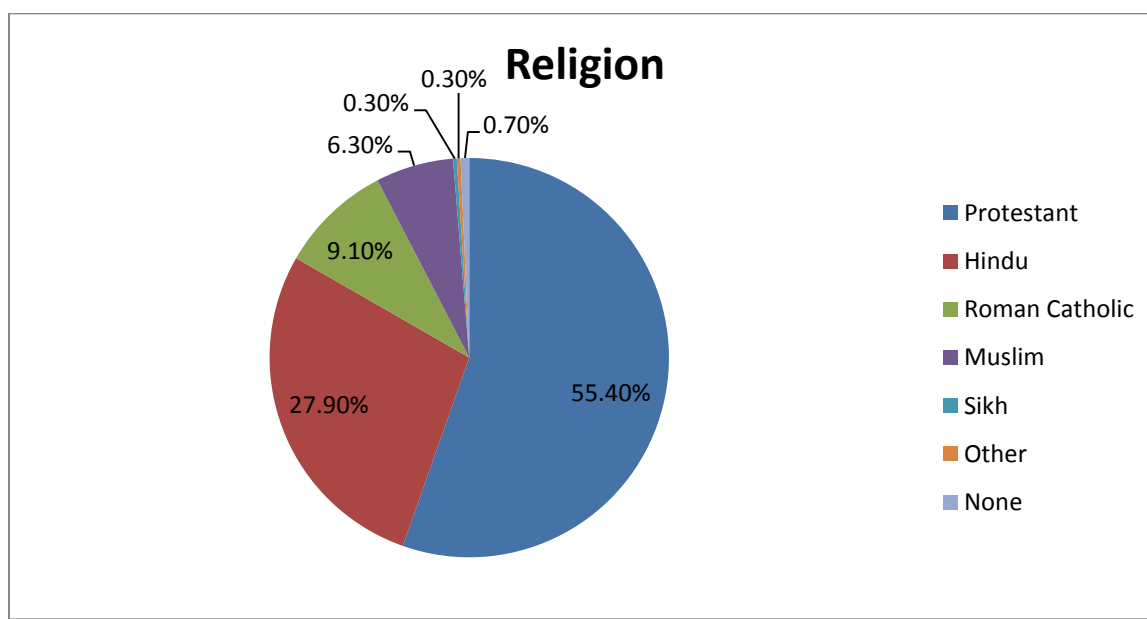


Figure 7: Existing Religions in Fiji¹⁸

¹⁷ Population by Age 2007 Census, Fiji Bureau of Statistics, 2013: accessed on line on 27th March 2015 at <http://www.statsfiji.gov.fj/index.php/chart-gallery/209-population-by-age-2007-census>

¹⁸ Fiji Facts & Figures, Infoplease 2013: accessed on line on 24th March 2015 at <http://www.infoplease.com/country/fiji.html?page=4>

2.3 Fiji Economy¹⁹

Fiji is a small island country with a population of 0.824 million in 2007 and a population growth rate of 1.4 percent between 1975 and 2007. It is classified by the World Bank (2002) as an upper-middle income country with a Gross Domestic Product (GDP) per capita (PPP, 2005 international \$) in 2008 of around \$4050. While since independence in 1970, Fiji implemented import substitution policies to stimulate economic growth, beginning in 1986, backed by the International Monetary Fund (IMF), Fiji liberalized its economy. In doing so, Fiji has since followed an export-led growth based strategy for development. Despite these efforts though, Fiji's economic growth has been weak and volatile (see Figure 1), ranging from -8.4 percent to 10.4 percent, with nine years of negative growth. Three of the widely cited reasons for Fiji's weak economic performance have been intermittent political instability, poor economic and financial management, and expiry of land leases since 1997, which have basically seen the decline of the sugar industry. The sugar industry has traditionally been regarded as the backbone of the economy in terms of employment and foreign exchange earnings. The decline of the industry has thus hurt Fiji's economic and social development.

Poverty and inequalities are key human development challenges. It is estimated that 34.3% of the population live below the basic needs poverty line (2003). Since 2008 real incomes of the poor have fallen sharply, bringing more households into poverty. The growth rate of GDP per person employed has fallen from a high in 1990 of 15% to -1.1% in 2008. The employment to population ratio has stayed steady from 2003 – 2008 at 56.4%. Fiji is one of six countries in the region that is “slightly off track” and/or demonstrating “mixed progress” towards the achievement of the Millennium Development Goals. Donor aid to Fiji was only 1.8% of Gross National Income in 2008.²⁰

In successive development plans since independence, the state recognized that around 20 percent of GDP equivalent private investment will be required consistently to achieve an average economic growth rate of 5 percent per annum. Unfortunately, due in large part to intermittent political instability, Fiji failed to attract the desired level of private investments. At best, on average, private investments since post-independence have averaged between 8-10 percent of GDP. Lack of private investment has contributed to weak economic growth, unemployment and poverty. Economic growth since independence has averaged between 2-3 percent. During the same period, the population growth rate was around 1.4 percent. As a result of low economic growth accompanied by population growth, both unemployment and poverty have grown. While government has introduced a number of policies to assist the

¹⁹ Snapshot of Fiji's Economic Performance, Fiji MDG 2009 2nd Report, pg 12

²⁰ MDG's, Fiji Annual Program Performance Report 2011, AusAid

elderly, destitute and disabled, such as the food voucher programme and the social welfare scheme.²¹

2.4 Fiji Education:

Fiji has officially achieved universal primary education (96.7% in 2008) and has a high literacy rate of 99.5% amongst 15 – 24 year olds. However, in 2008 there was a 13.9% drop out rate of students between years one and five, which indicates that many children are leaving school without having learnt to read and write to a functional level.²² This reflects the difficulty some families have in affording education for their children.

Since the mid-1990s, the Ministry of Education has paid tuition fees for all primary school pupils, but families must pay related costs, such as uniforms, transport, school fund-raising, etc, which amount to around F\$200 per pupil per year. Some low-income families have difficulty in meeting this cost.²³

All children are expected to complete a full course of primary education. In 2009, the state also introduced the policy of free bus fares for school children in an attempt to reduce the financial burden on parents unable to afford transportation costs involved in sending children to school. Similarly, the state also makes available free textbooks and tuition fees, not only for primary school education but also for secondary school education.²⁴

A wide range of policies have been implemented by the government to ensure access to primary education for all. Apart from the policies to ensure access to free education for all, the education system also focuses on improving the health of the children in school holistically. The education sector has significantly increased its support in the sexual and reproductive health program. This includes the partnership with the health ministry in the development and implementation of the school canteen policy to improve and strengthen the provision of healthy and nutritious food to children in schools. In addition, the education system through the endorsement of the HIV/AIDS Board also has a “In-School HIV Policy” in place which focuses on the prevention of stigma and discrimination of any HIV positive person in school. Through NSAAC’s support [an arm of the Education Ministry focusing on drugs and substance abuse in

²¹ Post Independence Development Project, Fiji MDG 2009 2nd Report, pg 13

²² Fiji Facts & Figures, Infoplease 2013: accessed on line on 24th March 2014 at <http://www.infoplease.com/country/fiji.html?pageno=4>

²³ Achieve Universal Primary Education; Millenium development Goals Fiji National Report, National Planning Office, Ministry of Finance and National Planning

²⁴ Post Independence Development Objective, Fiji MDG 2009 2nd Report, pg 14

children], it will assist the education ministry in evaluating the implementation and adherence of the In-School HIV policy in all schools.

Teen age pregnancy is on the rise in the country including STI and HIV amongst young people [Table]. The education ministry works hand in hand with the health ministry and other support organizations in addressing this issue through the introduction of Family & Sexual Life Education in schools. Talks are also in progress to include Family Life Education to teachers as part of their pre-service curriculum. There are also plans to include this curriculum as part of the students' internal and external exams. The education system through its drugs and substance abuse advisory council [NSAAC] has been actively involved in the response to HIV including training of peer educators in schools. It is also focusing now having a WAD buildup campaign in school during school whilst students are still in school. This is incorporated into the International Drugs and Substance Abuse Day.

It seen in Fiji, that it is not only the health ministry that is injecting its local resources into the HIV response, but all other agencies including other government agencies, private sectors, NGOs and key populations [to name a few] have also increased their resources to the response. For example, the I-Taukei Affairs Ministry and the I-Taukei Affairs Board has also been collaborating with the health ministry with regards to addressing social issues in the community – especially on teen age pregnancy, HIV & STI. This is reflected in the involvement of the health ministry in the strategic planning process for the I-Taukei Affairs Ministry focusing on activities from national to the village or community level. The I-Taukei Affairs Board is the entry point to the village and community settings in rural areas. Without the assistance or the involvement of this organization, activities planned for the rural areas will not be successful.

Fiji working together as a country to respond to the HIV epidemic especially in making recommendations for improvement from mid-term reviews and work planning meeting through a collaborative effort has made an impact to governments increase in commitment for 2015.

[2.5 Organization of the Health System:](#)

The Health Ministry in Fiji is the largest and also the only public health sector in the country as compared to other health agencies. It provides free health care services to the public and to a limited extent to visitors and persons referred from within the region.

The Ministry of Health of the Republic of Fiji has a mandate to support every citizen of the nation irrespective of ethnicity, gender, creed, or socioeconomic status to have access to a national health system providing quality health care with respect to accessibility, affordability, efficiency and a strengthened partnership with communities for which this

health care is provisioned, to achieve the best possible health care and well-being, in order to improve the quality of life of the citizens of the Republic of Fiji.

To achieve this, the health ministry ensures that health services are accessible and available not only in the urban areas but also to the rural areas including the maritime zones. There are different levels of care through a hierarchy of facilities within the public health sector:



Figure 8: Hierarchy of Care within the Ministry of Health & Medical Services in Fiji.

2.6 Health Facilities & Service Provision



The main clinical services are provided through a network of 16 Sub-divisional Hospitals and 3 Divisional Hospitals located in Suva, Lautoka and Labasa that provide a comprehensive range of services from trauma to high dependency units. They also serve as teaching hospitals for students including trainee nurses and doctors, lab and x-ray students and also volunteers and care givers on clinical placement.

There are 5 subdivisions in the Central Division, 4 in the Eastern Division, 6 in the Western Division and 4 in the Northern Division.

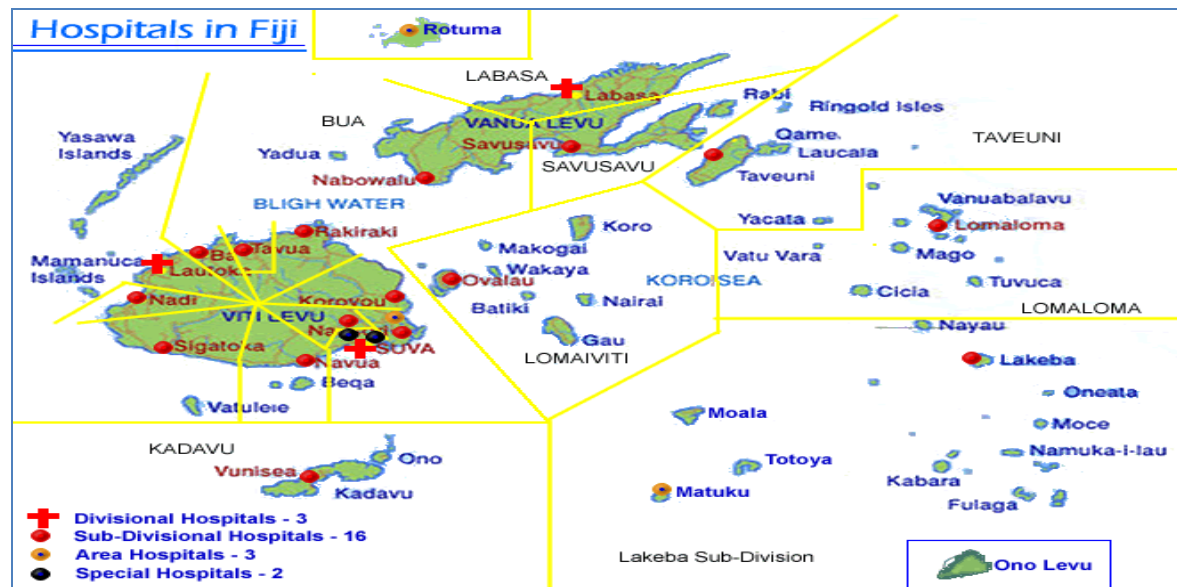


Figure 9: Locations of Hospitals, Sub Divisional Hospitals, Area Hospitals & Special Hospitals in Fiji

Health Facility	Central	Western	Northern	Eastern	Total
Specialized Hospitals/ National Referral	2	0	0	0	2
Divisional Hospital	1	1	1	0	3
Sub divisional Hospital [level 1]	0	3	1	0	4
Sub divisional Hospital [level 2]	4	2	2	5	13
Health Centre [level A]	7	4	1	0	12
Health Centre [level B]	2	3	3	1	9
Health Centre [level C]	12	18	16	14	60
Nursing Stations	21	25	21	31	98
Private Hospital	1	1	0	0	2
Total	49	57	45	51	203

²⁵Table 3 Health Facilities in Fiji

The Colonial War Memorial Hospital (CWM) in Suva serves as the Divisional Hospital for the Central and Eastern Divisions, and also serves as the National Teaching Hospital and also the National Referral Hospital not only for the country but also for the region. It is supported by specialist hospitals that include the National Psychiatric Hospital [St. Giles Hospital], the P.J. Twomey Hospital for tuberculosis and leprosy and the Tamavua Rehabilitation Hospital for specialist rehabilitation services.

²⁵ Table 4, Government Health Facilities, Ministry of Health Annual Report, 2013

Public health services are provided through the 16 Sub-divisional hospitals (SDH) and the 77 Health Centers (HC) and 101 Nursing Stations (NS). The health centers are the recipient health facility for all cases referred from the Nursing Stations through the district nurses. A HC is managed by a Medical Officer or Nurse Practitioner plus 3-4 nurses or more depending on the population size it looks after. All NS in Fiji is managed by a registered staff nurse who provides services including general outpatient & special outpatient clinics, antenatal and maternal child clinics [a core areas of the primary health care and is usually offered at all levels of the health system], and also domiciliary and outreach visits to communities within his/her catchment area. These nursing stations are either funded and built by the community, donor agencies or government and are approved based on adherence to the minimum standards of a government station. At the community/village level, there are volunteered trained community health care workers who manage village dispensaries for minor illnesses.

In 2013, MoHMS had the opportunity to recruit a Community Health Care Worker Project Officer to coordinate, facilitate and sustain the program. Patients may first see a VHW/CHW or enter the public health service system directly by being visited at home by a nurse or by going to a NS, HC or SDH. They may then be referred to higher-level health facilities as appropriate. All consultations, laboratory and radiological investigations and admissions are free to the public attending public health facilities, except for some treatments in dental services and where they choose to be admitted to the paying wards.

Within the private health sectors, there is a private hospital located in Suva that provides a range of specialized services, and there are several day clinics and 110 private general practitioners located in the urban centers of the two main islands Viti Levu and Vanua Levu. These services also include maternal child care [ante natal & post natal] not only with private practitioners but also with some major NGOs including the Fiji Reproductive Health Association. Other major NGOs that works with health are; Fiji Red Cross, Medical Services Pacific, Empower Pacific [part of the PPTCT program] and the Fiji Network of People Living with HIV.

There are 37 antenatal clinics around the country. Services provided include information and education, health promotion, screening and interventions for women of reproductive age to reduce risk factors that may affect future pregnancies. Women are urged to seek antenatal care early in their pregnancies at the nearest health facility providing it, although there is a high incidence of late presentation for antenatal checks. These ante natal clinics or health facilities also have PPTCT practitioners who have been trained to provide PPTCT services.

Postnatal checks are offered to mothers 1 week and six weeks after delivery and family planning services are available at the maternity units, health centers and nursing stations as part of preventative measures to post-partum deaths. There is also the Women's Wellness

Centre based at CWM Hospital that accommodates working women for family planning services within the greater Suva area.

2.6 Fiji – Millennium Development Goal [Health]²⁶

The Family Health Unit manages MDG's 3, 4, 5, and 6. The MDG goals are interrelated and contribute to each other in terms of programs and addressing mortality and morbidity. Thus a holistic, comprehensive approach is being addressed maternal child health issues and sexual reproductive health issues. This has been strengthened by have strong pillars in the strategic and policy direction with important monitoring and evaluation frameworks.

One such important strategic framework is the results framework developed by the national advisor family health and used for all planning and implementing purposes. **(Annex 1)**

Maternal mortality in Fiji declined dramatically from the 1970s due to high quality service and increasing hospital deliveries but improvements have stagnated or “plateaued” in recent years, with the number of annual maternal deaths fluctuating in the range of 4 to 12 since 2000.²⁷ Analysis of deaths in the last five years highlighted underlying causes from delayed presentation (which was often linked to poverty, low levels of education) and pre-existing cardio-vascular problems (including rheumatic heart disease) and other NCDs. While nearly 99% of women receive at least one antenatal visit,²⁸ only 10.7% of pregnant women had an antenatal visit in their first trimester in 2013.²⁹ These issues highlight the importance of promoting early antenatal care and raising the standards and consistency of emergency obstetric care to manage pregnancy complications.

The government commitment to addressing early booking has been strengthened through the Food Voucher Program where Health works closely with Ministry of Women, Children and Poverty Alleviation provide food vouchers to women depending on when they book. This program is for the rural communities encouraging women to book in early, as the earlier they book the more food vouchers they get. This anecdotally has shown an increase in bookings early. Though data for 2014 will confirm this further.

Child mortality before the age of five years and before the age of one year declined by 44% and 40%, respectively, between 1990 and 2010, coinciding with substantial increases in child immunisation to the point where an estimated 91-95% of children nationally were fully immunised (i.e., receiving all ten doses on the immunisation schedule) as of 2013.³⁰ However,

²⁶ MDG Performance, Fiji Ministry of Health Annual Report, 2012

²⁷ Global Health Observatory, from Civil Registration data

²⁸ UNICEF Fiji Case Study

²⁹ MoH Annual Report 2013

³⁰ Immunisation Coverage Survey 2013

perinatal mortality, which includes stillbirths and neonatal deaths (in the first 28 days of life), remains high at 14.7 deaths per 1,000 births. Neonatal deaths now account for 50% of under 5 mortality,³¹ with half of those deaths happening in the first 7 days of life (early neonatal mortality). Also concerning is the fact that as of 2012 30% of infant deaths occurred in the homes or in the community, including in urban areas where health facilities are geographically accessible.

More than 99% of the deliveries are happening at the health facilities. With such high numbers of delivering occurring in the hospitals there is capacity for the Ministry to ensure that at least all pregnant women are provided for with HIV Testing and Counseling.

Table 4 Proportion of women who delivered in each health facility

Site	Health facility					
	Hospital	Health centre	Home	Nursing station	Private	Not stated
Central	97.7% (94.4–99.0) [291]	1.3% (0.3–5.2) [4]	0.3% (0.0–2.4) [1]	-	0.3% (0.0–2.4) [1]	0.3% (0.0–2.4) [1]
Eastern	87.7% (80.4–92.5) [263]	6.0% (2.9–12.1) [18]	2.3% (0.8–6.5) [7]	4.0% (1.3–11.4) [12]	-	-
Northern	98.0% (95.3–99.2) [294]	1.3% (0.4–4.3) [4]	0.3% (0.0–2.4) [1]	0.3% (0.0–2.4) [1]	-	-
Western	97.7% (94.9–98.9) [292]	1.0% (0.3–3.0) [3]	1.3% (0.5–3.4) [4]	-	-	-
National	97.3% (95.8–98.2) [1,140]	1.4% (0.7–2.7) [29]	0.8% (0.4–1.6) [13]	0.2% (0.0–0.6) [13]	0.1% (0.0–1.0) [1]	0.1% (0.0–1.0) [1]

2.7 Fiji – Non Communicable Disease:

The health status indicators for 2013 demonstrate: Consistency in the facility based prevalence of Diabetes; whilst indicating increased admission rates for diabetes and its complications including amputation rates. The prevalence of Cancer increased in 2013 compared to 2012 (by 33%) as did Cancer mortality (by 3%). This may be due to Breast and Cervical cancers. The prevalence rate of cardiovascular diseases decreased by 11% as did the admission rates for RHD

³¹ UNICEF Fiji Case Study

– by 26% (may be due to reporting on the PATIS system). Mortality from MVAs remained relatively stable. The incidence of Dengue increased predominantly due to the outbreak experienced in 2013, with a decrease in incidence of leptospirosis, syphilis and gonorrhoea. The MMR has improved significantly in 2013 compared to 2012, although the MDG target is yet to be realized. The other indicators of maternal health such as anaemia in pregnancy and proportion of births attended to by skilled professionals show improvements. The improvements in CPR are moderate. Improvements overall in the arena of child health have been noted. Teenage and adolescent health issues need improvements; the rate of teenage pregnancy increased (by 95%) and so did the rate of suicide amongst teenagers (by 15%).³²

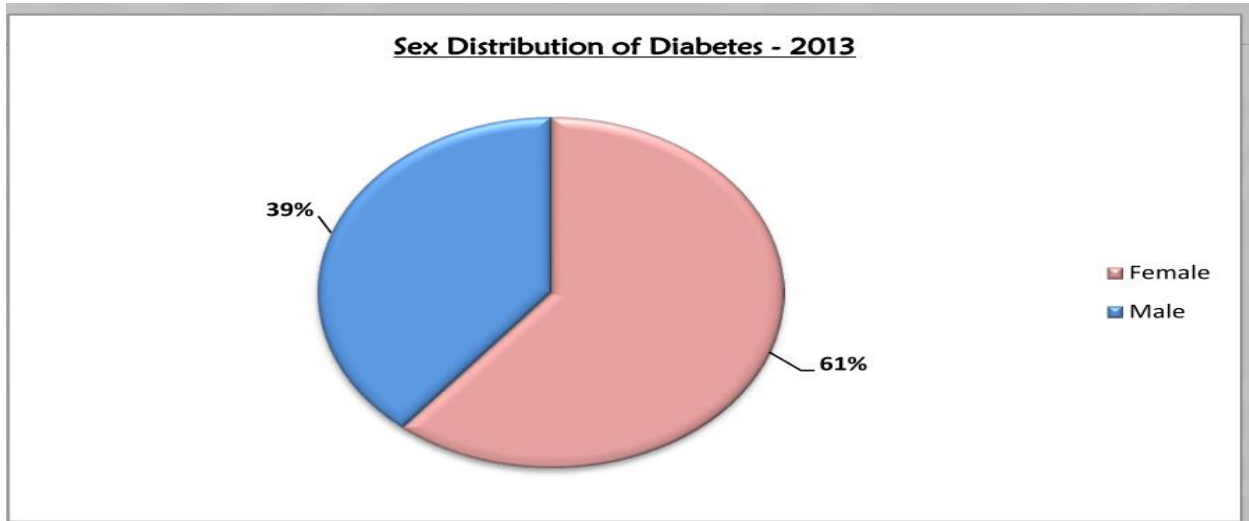


Figure 10 Diabetes Cases by Sex Distribution

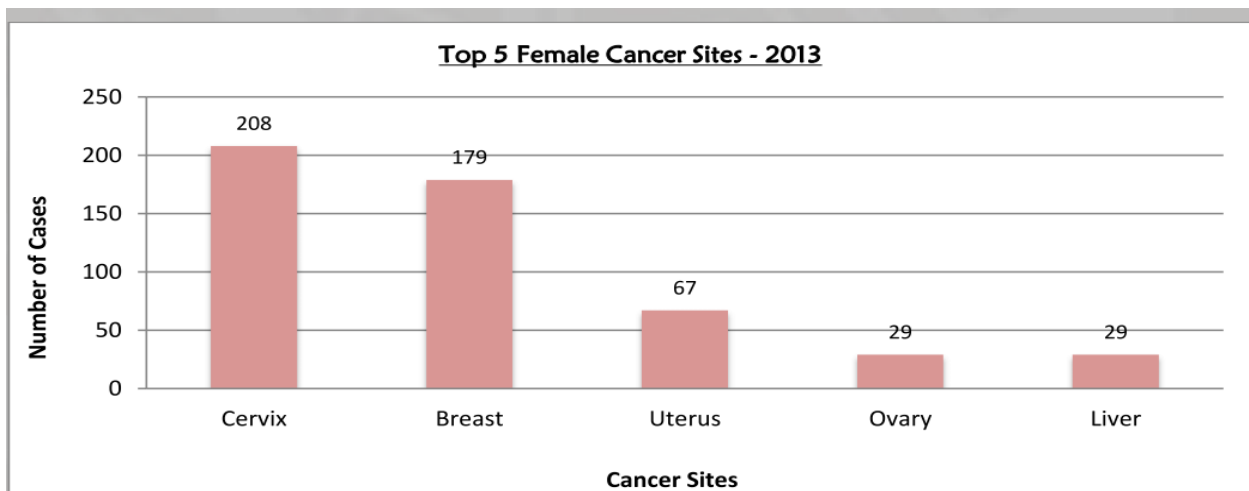


Figure 11 Top Female Cancer Sites for 2013 in Fiji

³² Fiji NCDs, Ministry of Health Annual Report, 2013

Fiji continues to develop activities and strategies to address the double challenge of communicable and non communicable diseases. The Ministry of Health & Medical Services introduced the “Wellness” approach as an innovative means of addressing health issues. The approach refocuses service delivery, specifically targeting the seven stages of life from conception to old age. It is also focused on the seven determinants of health; breathing, eating, drinking, moving, thinking, resting and reproduction.

Year	Revised Health Budget	National Budget	% of Overall Total Budget	% of GDP
2013	\$169,155,048	\$2,327,385,300	7.27%	2.18%

³³Figure 12 Annual GDP for MOHMS 2013

Challenges in the Fiji health system are largely related to workforce where staff shortages are hampered by the continuous exit of qualified nationals and the inability to attract international specialists, the high turnover of staffs internally hinder the implementation and sustainability of programs, the high workload and competing demands on staff in the sub divisional levels, limited capacity development. There are also challenges within the health information unit of the ministry. This includes the timely collation, analysis and distribution of data in a timely manner, standardization of data collection processes and limited operational research to name a few.³⁴

2.8 HIV Salient Statistics:

The infection rate in the general adult population (15 to 49 year olds) is estimated to be approximately 0.12%.³⁵ It is not a ‘concentrated’ epidemic because the HIV prevalence is not greater than 5% in any key population. Integrated Behavioral and Biological Surveys (IBBS) of men who-have-sex with-men (MSM) and sex workers were conducted in 2011 and 2012 respectively. The study by Rawstorne et al,³⁶ “An integrated bio-behavioral survey (IBBS) of transgender and men who have sex with men in Suva and Lautoka, Fiji”, reported the overall HIV prevalence in MSM was 0.5%, but 1.3% among transgender MSM. In their 2012 study,

³³ Proportion of Ministry of Health Budget against National Budget and GDP, Ministry of Health Annual Report, 2013

³⁴ Organization Wide Challenges, Fiji Ministry of Health Annual Report, 2012

³⁵ UNAIDS & WHO – Epidemiological Factsheet, Fiji, 2010: accessed online on March 23, 2015 at <http://aidsinfo.unaids.org>

³⁶ 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the “Ten Targets” in Fiji Islands, 31st May, 2013

Mossman et al³⁷ report the zero HIV prevalence in female sex workers and 1.8% in transgender sex workers to give an overall prevalence of 0.7%.

A 'mixed epidemic' is one where there is substantial contribution to overall transmission from both the general population sexual behavior patterns and defined key population group(s). At the end of 2014, a cumulative total of 610 HIV infections had been detected in Fiji since 1989, of which >80% were reported to be heterosexually transmitted [figure 7], 20 (approximately 3.7%) were transmitted through male-to-male sex, 1 ((0.2%) through injecting drug use and 31(5.7%) through perinatal transmission.³⁸[Table 2].

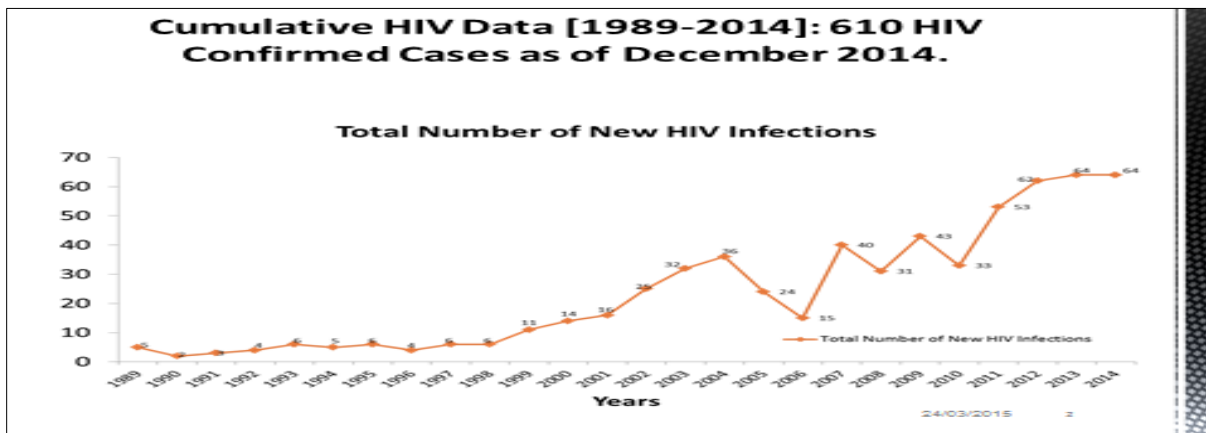


Figure 13: The above graph shows the number of new HIV confirmed cases in Fiji annually since 1989.³⁹

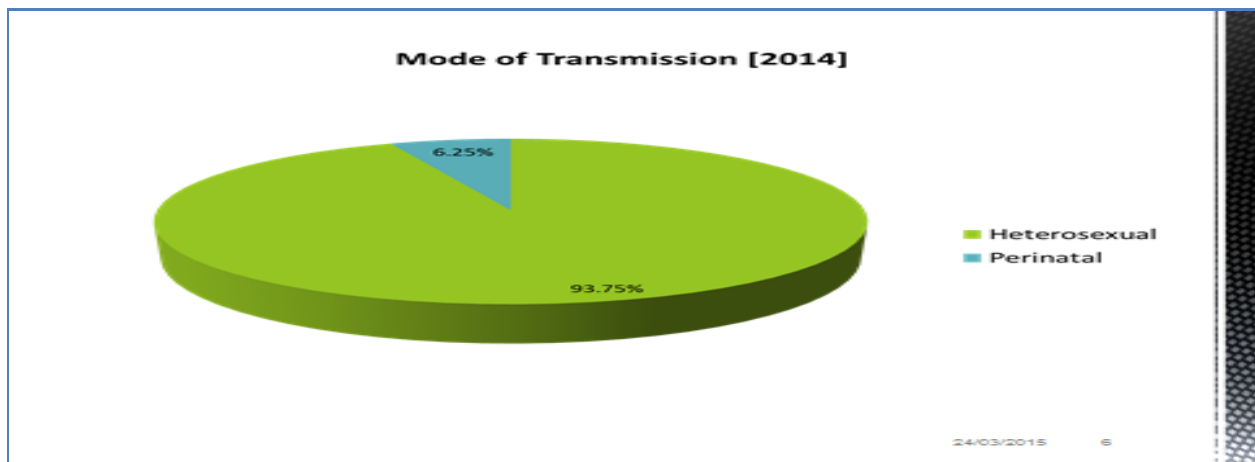


Figure 14: Mode OF Transmission for HIV for 2014

³⁷ Confidential Report: IBBS Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project. Commissioned by UNAIDS Pacific Office and MoH with assistance from FNU.

³⁸ Fiji Ministry of Health, December 2014, Centre for Disease Control

³⁹ Fiji Ministry of Health, December 2014, Centre for Disease Control

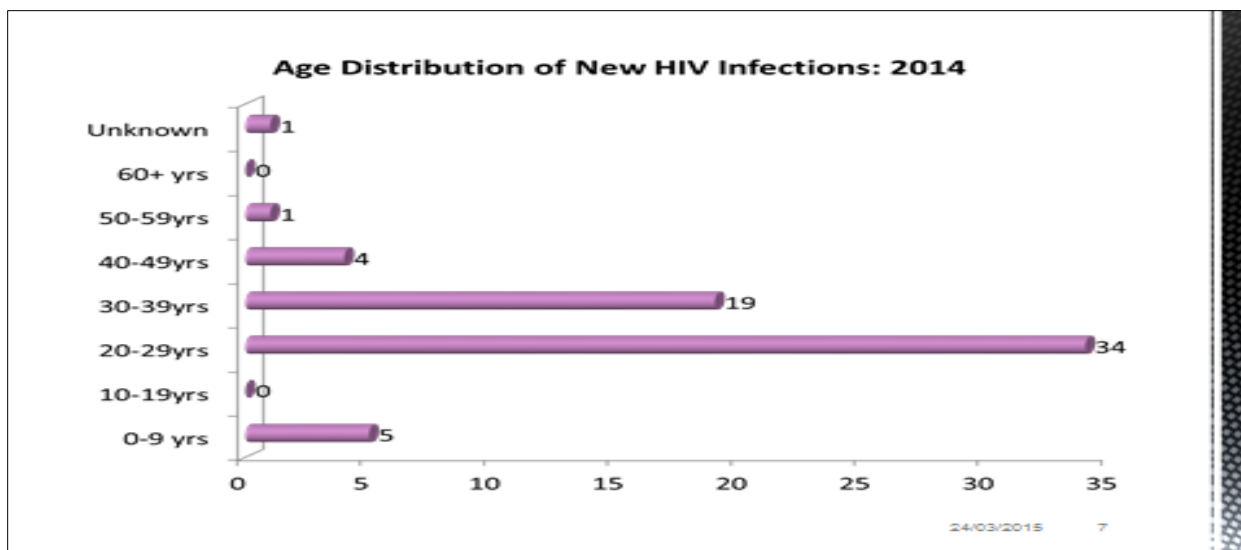


Figure 15: Age Distribution of New HIV Infections for 2014

The HIV epidemic is disproportionately affecting young people. Together the 20-29 and the 30-39 age groups account for over 77% of all the infections reported to date (Figure 8). The majority of HIV infections (87.5%) have been among indigenous Fijians (ITaukei), whilst Fijians of Indian Descent constitute 9.3% of reported cases.

The possibility of increase of HIV infection amongst the i-Taukei population is the result of the increase in advocacy and awareness programs in the i-Taukei communities or villages. With the community or village life setting in Fiji, the i-Taukei community is more clustered as compared to the Fijians of Indian descent [scattered]. This is one of the reasons why targeting the i-Taukei population is easier. Secondly, there is an increase in the i-Taukei population that has gained the confidence to access HIV testing.

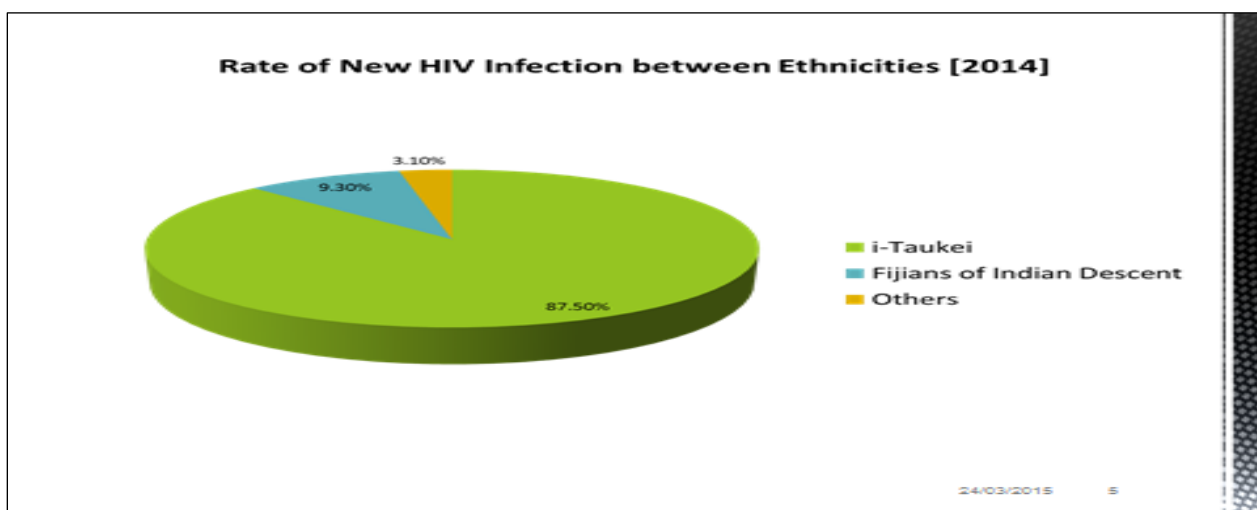


Figure 16: Fiji HIV Infection - Disaggregation by Ethnicity in 2014

In 2014, it was seen that there was a paradigm shift on the distribution of HIV transmission between males and females as compared to previous years [figure 10]. An analysis of the annual number of reported infections shows an increasing trend of the proportion of infections detected in females relative to males. In 2003, 58% of HIV cases were male versus 42% female; in 2006, equal numbers of infections were reported in males and females. In 2009, the male to female ratio was reversed and 55% of infections were in females compared to 45% in males. In 2010, the trend continued with 67% of new infections in females and 33% in males. There was another reversal of the trend in 2011, with more males (60%) infected.

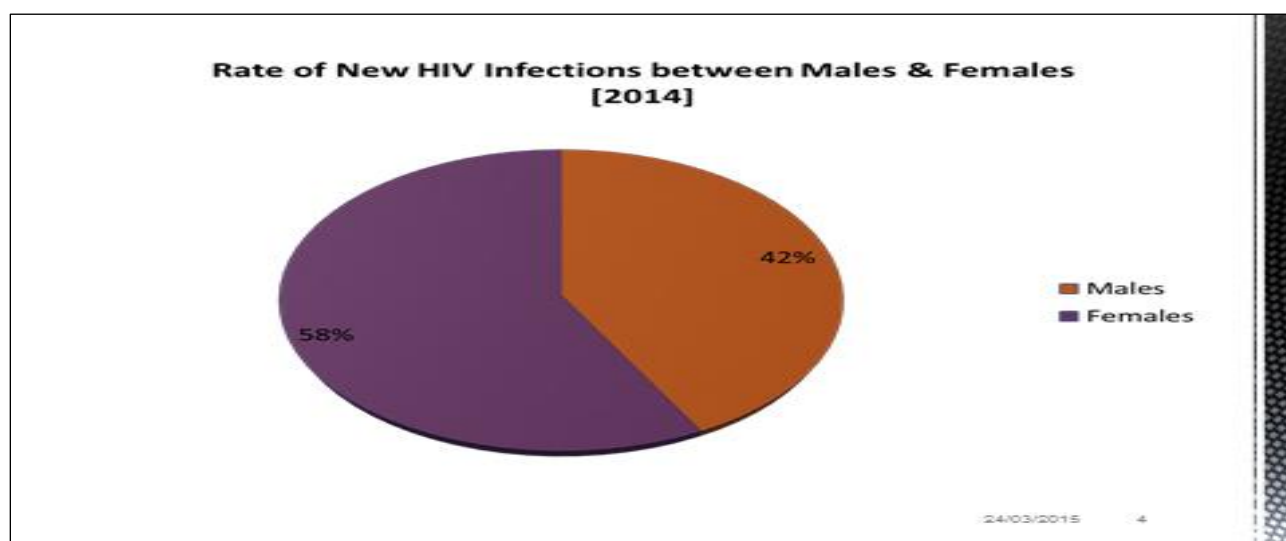


Figure 17: HIV Infection disaggregated by sex

There has been a change in the gender distribution of HIV infection in Fiji. The above graph shows that there are more females newly diagnosed with HIV than males in 2014.

The high prevalence of STIs in young people indicates that they are sexually active with possibilities of more than one partner with unsafe sexual practices. These unsafe practices with the so called "sexual networks" are dense enough to enable transmission of STIs amongst young heterosexuals. The spread of HIV in Fiji is not only within the mainland but this has also spread to other smaller islands in Fiji as a result of visitors to the mainland and vice versa. This scenario is also seen with Fiji and other neighboring countries. If there was a sudden influx of people infected with HIV after visiting high prevalence areas of nearby countries, then HIV could spread rapidly throughout Fiji.

[2.9 Epidemiological Research:](#)

The fact that case reports of HIV amongst sex workers and men who have sex with men are low indicates that the HIV epidemic is not expanding through the groups who are most usually considered to be key affected populations.

[2.9.1 Pre-Surveillance Assessment:](#)

Pre-surveillance assessment was carried out with the support of UNICEF for Fiji looking at the previous studies and possible key populations through the current STI and HIV data in country. The Findings showed that the key affected populations which need to be relooked at were:

- IBBS:
 - MSM-TG, including population size estimation
 - Sexually active youth (18-24) frequenting night venues

- Other:
 - Retrospective study to describe likely sources of HIV exposure in PLWH
 - Additional recommended activities (2014+):
 - STI prevalence study in antenatal women
 - Rapid assessment of IDU situation
 - Qualitative study of behavioral risk in prisons

[2.9.2 Integrated Biological and Behavioral Study for Sex Workers 2012:](#)

In 2012, an integrated biological and behavioral research amongst sex workers was conducted by UNAIDS Pacific Office, MoHMS and assisted by FNU. The research was the first large scale quantitative research on sex workers to be conducted in Fiji. The research findings has enabled an understanding of the nature and extent of sex work in Fiji, rates of HIV and STI infection among sex workers and their knowledge and behavior around safer sex practices. The following information on the research is extracted from the Integrated Biological Behavioral Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project.

The study consisted of two main components (i) a population size estimation of sex workers in Fiji based on counts in seven centers (Suva, Nausori, Lautoka, Ba, Nadi, Labasa, Savusavu); and (ii) an integrated biological and behavioral surveillance (IBBS) survey administered to 298 sex workers. Biological samples provided by the sex workers were tested for HIV, Hep B, syphilis, chlamydia and gonorrhea.

Among the 293 IBBS participants that gave a blood sample there were three HIV positive results and one in determinant test result. All three positive results were transgendered sex workers, while the in determinant result was a female sex worker. Two of the HIV-positive results were from Suva and the third from Nadi, all were I-Taukei Fijian and over 25 years. Only one of the positive results reported that they had previously been tested for HIV and knew their result.

Using the weighted sample that had been adjusted to more accurately reflect the distribution of sex workers in Fiji, this rate of HIV infection equates to an overall prevalence rate of 0.7% (95% CI: 0% - 1.5%) across all sex workers or 1.8% (95% CI: 0.4% - 3.2%) for transgendered workers.

2.9.3 Integrated Biological and Behavioral Study for Men who have sex with men:

Research was conducted amongst men who have sex with men in Fiji in 2011. Which was launched in 2014. The research conducted showed that there were 464 men who had sex with other men in the previous twelve months participated in the study and successfully completed the questionnaire. Of this a total of 213 (45.9%) were recruited in Suva comprising 134 men and 79 Transgender and 251 (54.1%) were recruited in Lautoka comprising 160 men and 91 transgender. The majority (94%) were younger than 40 years of age. Most were i-taukei, 85% in Suva and 69% in Lautoka with fewer Indo-Fijians (6% in Suva and 24% in Lautoka). Overall the sample was relatively well educated: 34% educated beyond high school level.

The estimate prevalence for past or current infection with Syphilis that is RDS adjusted was 20% (95%CI: 12.0%-32.5%) for Suva and 24% (95% CI: 16.1%-32.0%) for Lautoka. The RDS-adjusted prevalence estimate for current Syphilis infection was 7% (95% CI:3.4%-13.2%). Estimated prevalence for gonorrhea (RDS adjusted)was 17% (95% CI:9.5%-23%)in Lautoka and 3% (95% CI: 0.6%-7.0%) in Suva. Estimated Chlamydia prevalence (RDS adjusted) was 9% in suva and 7% in Lautoka. Estimated prevalence of current infection with any STI (RDS adjusted) was higher in lautoka (26%)compared with Suva (19%). Estimated hepatitis B prevalence (RDS adjusted) was 4% in Suva and 7% in Lautoka.

Of those who tested for HIV and excluding the two participants with indeterminant results, the adjusted HIV prevalence was 0.5% (95% CI: 0.1%,1.6%) for the overall sample. ⁴⁰

2.9.4 Injectable Drug Use:

Currently, Fiji has very few reports of injecting drug use which is very unlikely to be a driver for the increase in new HIV infections. Although injecting drug use is not reported in the country, this should not allow complacency since Fiji is currently known as a port of drugs exchange in the region. The education system has reported that there are other types of social drugs being used in the country and especially by students which includes glue sniffing and cannabis smoking. There is a need for the health ministry, education ministry and the defense department to work together in investigating further on the use of illicit drugs in Fiji.

⁴⁰ WHO WE ARE; An exploration of the sexual practices and HIV Transmission of men who have sex with men and transgender population in Fiji.

2.9.5 General:

With a low HIV prevalence, as is indicated by the small numbers of cases detected through current HIV testing strategies, it is difficult and would prove to be very expensive to conduct surveillance through population wide random samples. As a result of this, there is no baseline indicator at present for either the prevalence or incidence of HIV amongst any specific population or the whole population.

Hence, the continuation of sentinel surveillance through antenatal clinics, and occasional surveillance amongst groups likely to be key affected populations, will continue. However, this means that assumptions have to be made about which people are likely to be most affected, where to place prevention resources, and what level of concern to have about the likelihood of an expanding HIV epidemic.

It is clear that HIV is present in Fiji and is also expanding. This has severe consequences for the people infected, for their partners and newborn babies, and for their families and communities who are affected by the presence of HIV and by other people's reactions to it.

2.10 Gender Based Violence

Gender Based Violence is indeed a significant public health challenge in many countries and Fiji is no exception to this. Globally it is estimated that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime.

Approximately 30% of women who have been in a relationship report that they have experienced some form of physical or sexual violence by their partner (WHO 2013)!

It is estimated that the prevalence of lifetime intimate partner violence and sexual violence in the Pacific ranges between 60-80%.

“The Fiji Women's Crisis Centres (FWCC) National Violence against Women prevalence study published in Fiji in 2013, revealed that the rates of violence against women and girls are among the very highest in the world, 64% of women who have ever been in an intimate relationship have experienced physical and/or sexual violence by a husband or intimate partner in their lifetime, and 24% are suffering from physical or sexual partner violence today.

Overall, 72% of ever-partnered women experienced physical, sexual or emotional violence from their husband/partner in their lifetime, and many suffered from all 3 forms of abuse simultaneously.⁴¹

⁴¹ Reference Fiji Women's Crisis Centre 2013, *Somebody's Life, Everybody's Business*.

The high proportion of women who have experienced very severe physical attacks is alarming: 44% or more than 2 in 5 ever-partnered women have been punched, kicked, dragged, beaten up, choked, burned, threatened with a weapon, or actually had a weapon used against them.

Almost half (47%) of the women who experienced physical and/or sexual partner violence in their lifetime have been injured; and more than 1 in 10 have lost consciousness or 1 in 50 now have a permanent disability.

Among those who needed health care due to injuries, less than 2 in 3 actually received health care; among these, 1 in 3 did not tell the health care worker the reason for the injury.

Women living with physical and/or sexual violence have much more poorer health and are hospitalised more often.

Women living with physical, sexual or emotional violence have more symptoms of emotional distress and are significantly more likely to think about and attempt suicide than those who have not experienced intimate partner violence.

15% of ever pregnant women were beaten during pregnancy, and one third of these were punched or kicked in the abdomen while pregnant by their husband/partner.

Women Living with Physical and/or Sexual Violence are more likely to have unwanted pregnancies; their husbands and partners are more likely to have prevented them from using contraception. Women beaten during pregnancy are more likely to have had a miscarriage.⁴²

In response to the national agenda of eliminating violence against women in Fiji, there is currently a national task force which meets regularly made of intergovernmental, UN Agencies, inco-operated with the Fiji Women's Crisis Centre, Fiji Women's Rights Movements and other important Non-Government Organizations to address violence against women in Fiji.

Ministry of Health and Medical Services sits on this task force through the Family Health Unit, and with the support of UNFPA (United Nations Population Fund) the Health sector developed a guideline for addressing holistically women and children affected by violence, whether it be physical or sexual.

The Ministry had lacked the capacity to train and also lacked standard guidelines in addressing violence. The guideline named, "Responding to intimate partner violence and Sexual Violence Against Women," Health Guidelines for Comprehensive case management.

The guidelines have now been endorsed and discussed at national levels with consultation at national and divisional level. The development and now the launch and training of health care

⁴² Somebody's Life, Everybody's Business Survey 2013, FWCC.

workers in this area will be instrumental in addressing violence against women in Fiji. This provides prophylaxis to women and girls exposed to penetrative sexual violence for HIV and other Sexually Transmitted Infections.

[2.11 Social Research Provides Further Understanding of Factors Influencing the Situation](#)

Recent social research sheds further light on the current situation of HIV and STI transmission, people's behaviors and their experiences of stigma and discrimination.

The experiences of sex workers were explored through qualitative research of the Pacific Sexual and Reproductive Health Research Centre (PacS-RHRC) and the University of New South Wales, resulting in the published report, "Risky Business", in 2009.⁴³

The "Risky Business" research found that all sex workers from Suva, Lautoka, Nadi and Labasa had decided for themselves to become sex workers and none had been forced or sold against their will. Clients of sex workers were mostly males and were from all ethnic groups in Fiji; were foreign and local; and also came from all professional backgrounds. The sex workers were 'reasonably informed' about HIV as a result of various awareness workshops conducted by NGOs, peer educators and schools. Sex workers used condoms, though not all of them were consistent condom users.

The research found two distinct groups of workers. One group reported a professional approach to sex work. They were mostly using condoms, negotiated condom use, educated clients about HIV and condom use, and also cited their right to protect themselves. The second group reported a more casual approach to sex work: they said they 'went with the flow', were also seen as 'amateurs' and had 'sex for fun'. This second group's actions resulted in higher risks of HIV transmission. However, the research also found that when clients preferred not to use condoms, sex workers offered other services such as oral sex, masturbation or non-penetrative sex, and charged more.

Most sex workers had used sexual health clinics for STI or HIV tests, but said they would prefer that the same services to be made available through their support organizations or from community clinics: past experiences indicated that those clinics were more 'friendly and welcoming places'. Many sex workers wanting to be assured of confidentiality used the services of private doctors more than the public health facilities. The research found that public services could be improved through provision of transport, evening sessions, use of mobile clinics, provision of childcare facilities and availability of drop in centers.

⁴³ McMillan K, Worth H, Risky Business: sex work & HIV Prevention in Fiji. Sydney, International HIV Research Group, UNSW, 2009

Sex workers working from the streets, especially transgender sex workers were more likely to experience harassment and abuse from men, street kids and the police. Transgender sex workers experienced violence and sexual abuse from heterosexual men. All sex workers were likely to experience being robbed or being driven out of town and village boundaries where they worked.

This research established that resistance to condom use comes from male clients, not from sex workers themselves. It demonstrated that there is a need to work with male clients of sex workers, to promote condom use and to address attitudes to masculinity. These attitudes undermine realistic and effective perceptions, ideas and solutions about HIV transmission between men who have sex with men and heterosexual males. Peers of sex workers and experienced sex workers were reported as being important facilitators of condom use, HIV risk education, testing and treatment service information and support for attendance at health services.

The situations for men and transgender people who have sex with men were explored through two research projects which were completed in 2011. One was conducted by the AIDS Task Force of Fiji, supported by UNDP, and published as “Secret lives, other voices... a community based study exploring male to male sex, gender identity and HIV transmission risk in Fiji”. The other was an Integrated Biological and Behavioural Surveillance project amongst men who have sex with men. This was conducted by MEN-Fiji and PacS-RHRC, and the results were announced but not published at the time of developing this strategic plan.

The research of the AIDS Task Force of Fiji was supported by UNDP⁴⁴. Respondents reported a diversity of sexual and gender identities and gender expressions: straight, bisexual, gay and transgender were terms that people used to describe themselves. Many had lives that are integrated with the broader Fiji community and do not want to develop a separate “gay” community, though they do want a stronger sense of community with each other. Many had sex with women as well as men (48.1% had ever done this), thus indicating the need to ensure HIV transmission remains low within this group as a strategy to keep HIV incidence low within the whole community. The majorities were in regular relationships but 84% reported one or more casual sexual partners within the previous six months. Anal sex was common (98.1% had engaged in this in the previous six months) and, while condom use was common it was not universal and condoms were not used in all encounters. Alcohol and drug use were not associated with decisions on whether to use condoms.

⁴⁴ Bavungton G, Singh N, Naicker DS, et al. Secret lives, other voices ... a community based study exploring male-to-male sex, gender identity and HIV transmission risk in Fiji, Suva, AIDS Task Force of Fiji 2011.

Many men and transgender people who have sex with men reported severe experiences with stigma and discrimination, including being talked about by others, suffering verbal abuse and very high levels of physical abuse: 30.3% had been physically hurt in the last six months. Rates of HIV testing were very low, with only 10.5% having had an HIV test and been back to find the results in the last 12 months. The report made clear that negative experiences of health services which did not understand their lives or needs were barriers to both seeking health services and returning to them.

The experiences of people living with HIV were explored through research by FJN+. This included development of a baseline Stigma Index in 2010, which outlines the experiences of people living with HIV in Fiji. This identified barriers to people joining the network and barriers to people accessing other health services.

Research on the experiences of HIV positive women was reported by the Pacific Islands AIDS Foundation (PIAF) in 2011⁴⁵. This found two areas in which HIV positive women's experiences are different to those of other women or those of HIV positive men.

First, women generally assume more responsibility of home-based care for those who are infected and affected, especially for those who are sick or dying as a result of HIV&AIDS, along with the orphans. Girls are taken out of school (rather than their brothers) to care for family members who are HIV positive. While positive men are usually cared for by their partners, mothers, sisters and daughters, women who are either widowed by AIDS or who are positive themselves are often isolated and excluded, in many situations having no property rights which can result in them being thrown out of their home.

Second, HIV positive women are more likely to experience gender-based violence, struggle to access treatment and basic health services due to the competing priority to provide basic needs, such as food, for their families, and due to the costs associated with travel to access treatment. Most testing for HIV happens in antenatal clinics resulting in women often being the first person in a relationship or family to find out their status, as a result women are often blamed for bringing HIV into relationships and experience violence from their partner, family and community as a result. The existence or fear of violence impacts on women's decision to disclose their status and seek treatment. In many cases, positive women face stigma and exclusion, which is aggravated by their lack of rights.

Because many Fijians are not in the usually described "key populations", research was also conducted by UNDP to provide better understanding of relationships and HIV risk in 2011⁴⁶.

⁴⁵ Pacific Islands AIDS Foundation. Experiences and Perspectives of women living with HIV in Fiji and Papua New Guinea. Suva, PIAF/Pacific Islands HIV & STI Response Fund/Commonwealth Foundation, 2011.

⁴⁶ UNDP. Me, My intimate Partner and HIV: Fijian self-assessment of Transmission risks. Suva, UNDP, 2011

This explored marriages, de facto marriages and other relationships amongst 74 participants from six population groups: health workers, university students, religious leaders, taxi-cab drivers, lesbian, gay and transgender persons, and people in sex work. Five of the 74 were HIV positive. This research found that respondents did not have good understanding of HIV and STI risks with regular intimate partners, did not use condoms consistently, and had poor skills in identifying their own levels of risk.

Women and girls often want to use condoms, but they find communication about this is difficult with intimate partners. Both women and men have unrealistic expectations that “trust”, “love” and “faith” will prevent HIV and STI transmission. Most participants believed that their partners did not have other partners, whereas this was not the case. Amongst those who did not use condoms, 62% cited “faithfulness” as the reason. It is clear that many people believe that “knowing your partner” is protection in itself. There was almost no specific knowledge of the nature of testing for HIV or STIs, and some believed that testing is itself a method of prevention. Knowledge of STIs, including causes, names and symptoms, was minimal. Frank discussion rarely took place between partners about sex, condoms, desire, or STI and HIV transmission. This research indicates that most people “externalize risk”, meaning that they consider risk of HIV and STIs occurs only for other people, particularly for sex workers. The report recommends that prevention programs and health services increase efforts to help people to understand that intimacy carries risks, even with people who are well known.

[2.12 National HIV Legislation: The HIV/AIDS Decree:](#)

The Fiji HIV/AIDS [Amendment] Decree which was gazetted by the Government of Fiji in February 2011 is now in its 4th year of implementation. The Decree outlines a human rights framework for the response to the HIV epidemic from 2011 onwards. The HIV/AIDS Decree has been acknowledged both locally and internationally as one of the most progressive HIV laws in the world. The 45-section Decree aims to safeguard the privacy and rights of persons infected or affected by HIV and AIDS by the the following:

- Encouraging voluntary testing and behavioral change
- De-stigmatize HIV status
- Criminalize discrimination and de-criminalize HIV status
- Identify vulnerable groups and ensure they are empowered to demand safe sex
- Education and awareness on prevention of HIV infection
- Protecting the unborn child from contracting the infection.

The Government of Fiji lifted its restrictions on entry, stay or residence based on HIV status in August 2011 and it was officially announced by the President of Fiji at the 10th International Congress on AIDS in Asia and the Pacific, which was held in South Korea⁴⁷.

Through the HIV/AIDS Decree the HIV/AIDS Board was also established with the appointment of its first CEO. The Board is the governing body that reviews and adopts the 2012 - 2015 national strategic plan and also ensures that the country's response is aligned to the Decree and also the NSP to ensure that "recognized universal human rights standards" are adopted, "To protect all such rights including the highest possible standard of physical and mental health including the availability and accessibility of HIV prevention and HIV/AIDS treatment, care and support for all persons regardless of age, gender, gender orientation or sexual orientation"⁴⁸. The HIV/AIDS Decree provides that any policies issued by the HIV/AIDS Board will have the force of law, and that any person who contravenes the policies commits an offence. The Decree indicates in the clearest possible terms a political will to adopt a law based on the International Guidelines.

2.13 Human Rights:

The HIV Decree is there to provide Human Rights-based Measures to assist in HIV Prevention, and HIV/AIDS care and support and for related purposes. The decree in this context provides a right from an unborn child to persons either infected or affected by HIV/AIDS issues in the country.

This is regardless of the status of an individual being positive or negative. Also providing and securing the rights of health care workers to the appropriate treatment, care and support that they provide for persons living with HIV.

Under the Constitution of Fiji 2013, every individual has a right. In this regards in relations to sexual orientation as well is recognized.

Right to equality and freedom from discrimination : Section 26:⁴⁹

(1) Every person is equal before the law and has the right to equal protection, treatment and benefit of the law.

(2) Equality includes the full and equal enjoyment of all rights and freedoms recognised in this Chapter or any other written law.

(3) A person must not be unfairly discriminated against, directly or indirectly on the grounds of his or her:

⁴⁷ Government of Fiji. HIV/AIDS Decree 2011 [Decree No. 5 of 2011]. Suva, Government of Fiji, 2011

⁴⁸ Section 3-1[a], Guiding Principles, HIV/AIDS [Amendment] Decree 2011. Government of Fiji, 2011

⁴⁹ Constitution of the Republic of Fiji 2013

a) actual or supposed personal characteristics or circumstances, ***including race, culture, ethnic or social origin, colour, place of origin, sex, gender, sexual orientation, gender identity and expression, birth, primary language, economic or social or health status, disability, age, religion, conscience, marital status or pregnancy; or***

(b) opinions or beliefs, except to the extent that those opinions or beliefs involve harm to others or the diminution of the rights or freedoms of others, or on any other ground prohibited by this Constitution.

2.14 National Strategic Plan⁵⁰:

The period covered by the GARPR 2014 will be the final two years of the implementation of the five-year 2012 – 2015 NHSP. The NHSP has 4 strategic approaches:

- **Prevention Strategic Approach:** Because there is low prevalence of HIV, but high prevalence of STIs, prevention of HIV and STIs will be integrated. Because there are high reported rates of gender inequality and unplanned teenage pregnancies, prevention will also promote better understanding of reproductive health and the rights of women and children. Because there are high reported rates of stigma and discrimination against people living with HIV and people from key populations, prevention will be integrated with the promotion of human rights and respect for all Fijians, including sex workers, transgender people and men who have sex with men. Prevention programs will aim to change the perception that condoms are only important for sex work and for contraception, so that condom use for the purpose of prevention of diseases becomes more acceptable amongst all people. Prevention programs will continue to involve People Living with HIV in collaboration with peer educators, community organizations and health services staff.
- **Continuum of Care Strategic Approach:** The strategic approach to provision of counseling, testing, treatment and care will continue to be based on the concept of “Continuum of Care”. This means that prevention will be linked with referrals to treatment, diagnosis will be linked with counseling and referrals for some people to psychological support, medical services will incorporate involvement of counselors from the community sector and peer support by and for people living with HIV, and treatment and care will be linked with community programs to reduce stigma and discrimination. Within the Continuum of Care Framework, there will continue to be close collaboration between services provided by the Ministry of Health and the community sector. Certification of counselors is a requirement of the HIV/AIDS Decree.

⁵⁰ The following section is extracted from the “Approach of the National Strategic Plan for 2012-2015.” National Strategic Planning for HIV & STI, 2012-2015. Ministry of Health Fiji.

- **Governance Strategic Approach:** The implementation of the National Strategic Plan will depend on the continued success of collaboration between many partners from different sectors. To ensure this is effective, a governance structure which is the HIV/AIDS Board makes decisions affecting all partners, receive reports on monitoring and on potential improvements to policies and programs, solve problems efficiently and quickly, and improve the national response over time. People living with HIV will be involved at all levels of governance, including having representation at the highest level, the HIV/AIDS Board.
- **Monitoring & Evaluation Strategic Approach:** The strategic approach strengthen Monitoring and Evaluation includes its integration with the overall Health Information System (HIS) for the Ministry of Health. This ensures that monitoring and evaluation of HIV and STI are improved and aligned with the use of strategic information in Reproductive Health and other health issues.

The NHSP not only describes strategies and activities for each Strategic Areas but also includes projected costing for all activities. It also includes a monitoring and evaluation plan with defined indicators and a data collection plan. This NSP puts into practice the intentions of the HIV/AIDS Decree and also ensures that the country is aware of the importance of responding to the HIV epidemic, and also adhering to the human rights and governance framework outlined in the Decree.

2.15 HIV/AIDS Board:

The enactment of the HIV Decree in February 2011 also saw the establishment of the HIV/AIDS Board in September 2011.

The HIV/AIDS Board is mandated through the HIV/AIDS Decree to provide strategic leadership and coordination of interventions on HIV and AIDS in Fiji. Through the guidance of the HIV/AIDS Decree, the Boards' functions are as follows:⁵¹

10. Consider and recommend the goals and objectives for the national response to HIV/AIDS generally in Fiji to ensure that for all quality goods, services and information for HIV prevention and control, treatment, care and support, including antiretroviral therapy and any other safe and effective medicines including traditional and herbal remedies, diagnostics and other technologies for preventive, curative and palliative care of HIV/AIDS related illness are made available and accessible in a sustained and equal basis

11. Advise the Minister:

⁵¹ HIV/AIDS [Amendment] Decree 2011: Part 2, Section 8 (1a-i)

- on the mobilizing, disbursement and monitoring of resources including financial resources
 - on the development, review, update and a prepare the content for the NSP to respond to HIV/AIDS in the country.
12. Evaluate and review the human rights based policy guidelines, programs and activities for the response to HIV/AIDS at all levels and report to the Minister.
 13. Consider and advise the Minister on training and support for the programs designed to increase HIV/AIDS awareness and protective measures against HIV.
 14. Promote research, awareness materials and information sharing on HIV/AIDS and may issue guidelines for the conduction of research on HIV and HIV related matters.
 15. Advise the Ministry on access to sustained, appropriate, and affordable treatment for persons living with HIV or affected by HIV/AIDS, the prevention of infection with HIV and the promotion and protection of the rights of persons living with or affected by HIV/AIDS and those at risk of infection.
 16. Advise the Minister on any matter relating to HIV/AIDS as may be requested by the Minister from time to time;
 17. Foster national, regional and international networks among stakeholders engaging in continuing HIV/AIDS programs and activities; and
 18. To keep under the review the appropriateness and effectiveness of this Decree, the regulations, policies, standards of practice, guidelines and codes of conduct made under it and to propose any changes or modifications, the Board deem necessary in writing to the Minister.

The Board strives to become efficient in leading the country to be free from HIV & AIDS by providing strategic leadership for a multi-sectorial national HIV & AIDS response in Fiji.

2.16 Monitoring and Evaluation Framework:

There is a monitoring and evaluation framework for the 2012 – 2015 NHSP. A training on the fundamentals of M&E was conducted in the three divisions [Western, Northern & Central/Eastern] targeting the health care workers and all key stakeholders involved with the HIV response. An M&E working has been identified following a National HIV implementation meeting in 2013 to monitor the

HIV response. A term of reference for the working group has been developed and has yet to be endorsed by the HIV/AIDS.

The Ministry of Health currently assists in the monitoring of some aspects of the health sector response to HIV through the surveillance system established for the HIV program, such as the number of pregnant women tested for HIV, the number of people on ART, etc. The recruitment of a surveillance officer is currently in process that will create and manage a central database for all STI and HIV data. This will enhance and strengthen data management with HIV which will assist in identifying trends and understanding some aspect of the epidemic.

MOH is only one of the many partners of the HIV response. Since there are many HIV related projects and activities implemented by other partners apart from MoH, an M&E working group has been identified [but yet to function] to be the central monitoring working group of the national response. The M&E working group is separate from the NASA working group which was established in 2012 to monitor and analyze Fiji's expenditure on HIV/AIDS.

2.17 National Funding of HIV and AIDS Prevention, Treatment, Care and Support Services:

The total expenditure of the AIDS program from all sources for the years 2012 to 2013 is shown in Figure 16 & 17 below. The contribution from the Fiji government was \$300,000.00FJD respectively in 2012 & 2013.

The proportions of funding utilized for the different program categories are shown in Figure 18. Prevention had the largest share of the available resources, with 64%, followed by program management with 22%, with human resources 12% and enabling environment 8%⁵².

The bar graph above indicates the total amount of funding (financial and non-financial) invested and spent in the HIV response by different financial sources.

⁵² Fiji National AIDS Spending Assessment Report, 2012

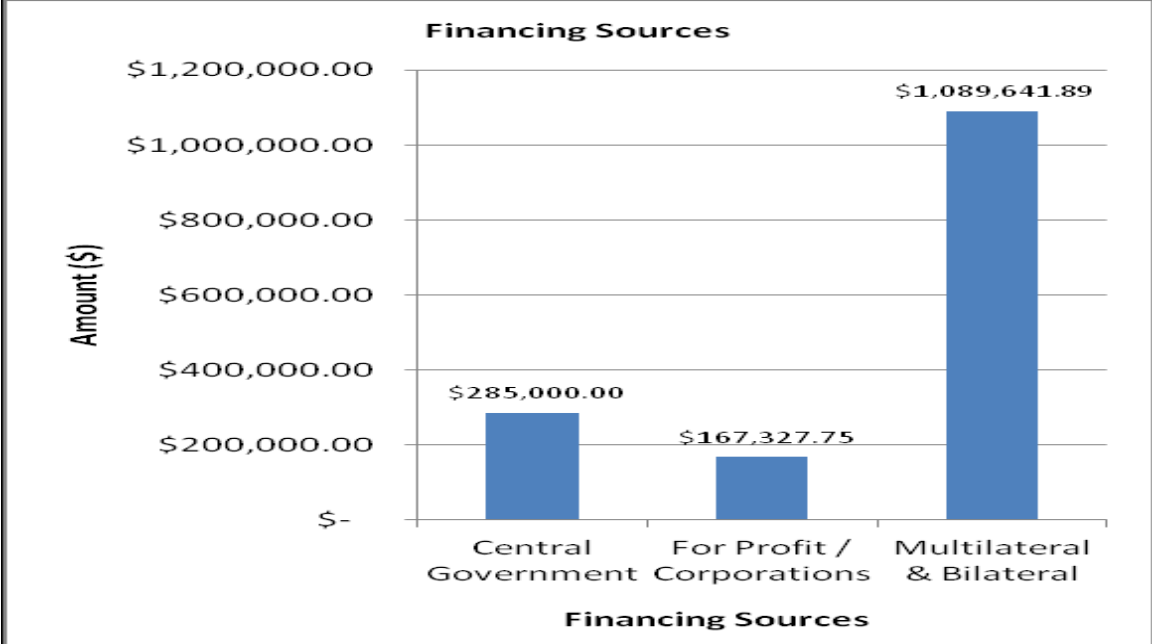


Figure 18: Financing Sources for Fiji

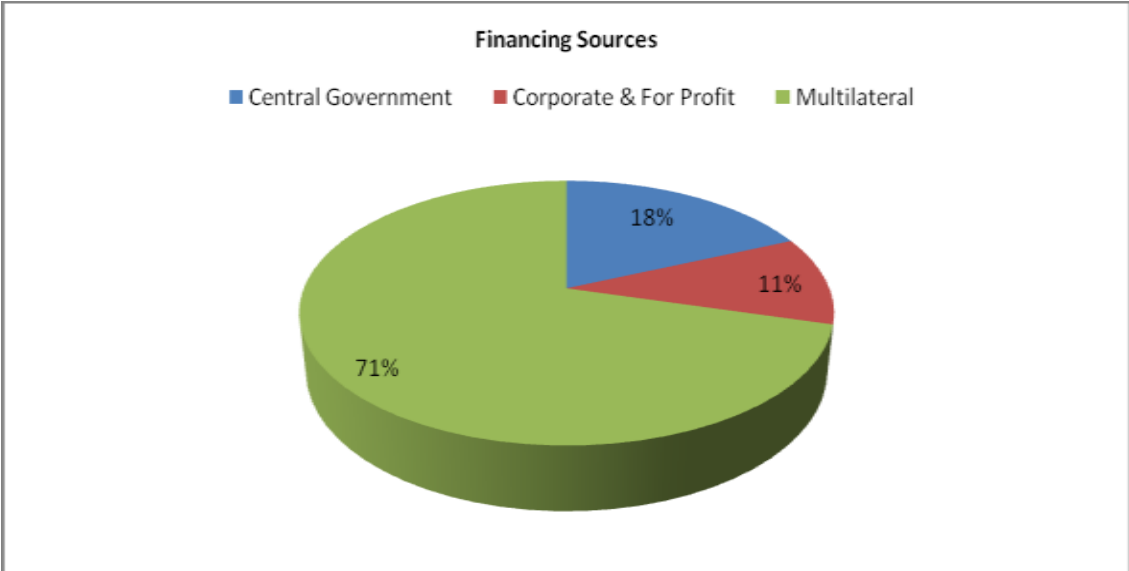


Figure 19: Funding Sources

The pie chart exemplifies two thirds of investments in the HIV response is sourced from multilateral / bilateral organizations.

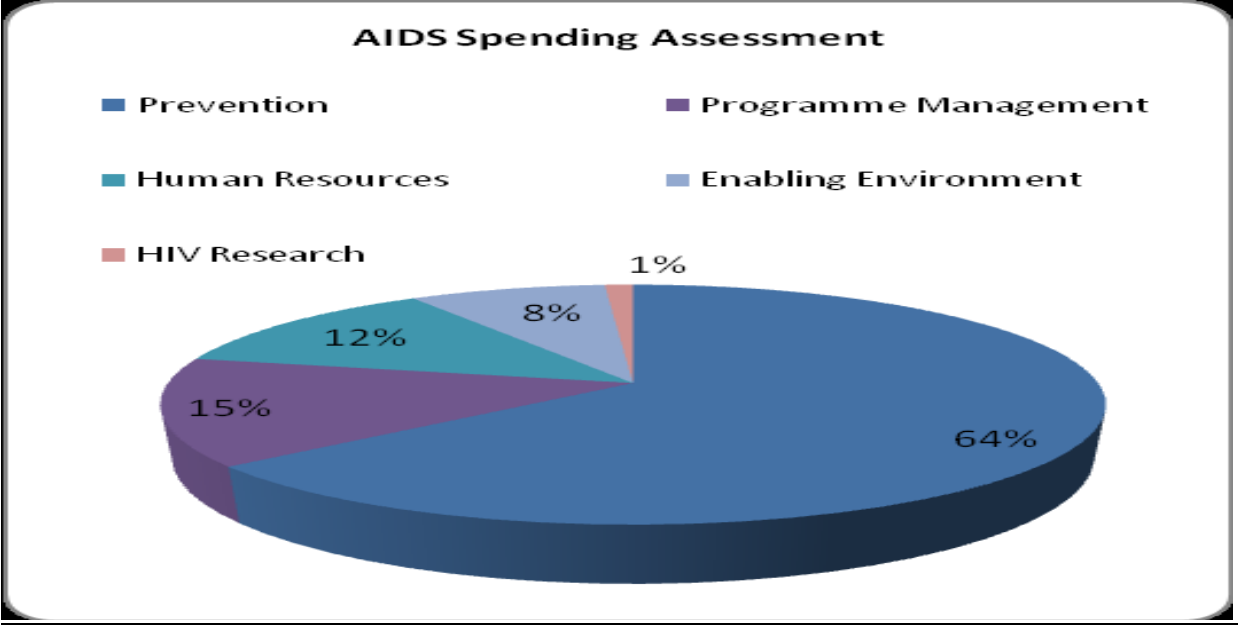


Figure 20: AIDS Spending Assessment Fiji

The bulk of expenditure in the AIDS Spending Category is attributed to Prevention. Only 1% of total expenditure is engaged in HIV research

ASC	Amount (\$)
Prevention	\$ 986,531.05
Care & Treatment	\$ 0.00
OVC	\$ 0.00
Programme Management	\$ 223,391.91
Human Resources	\$ 190,780.00
Social Protection	\$ 0.00
Enabling Environment	\$ 123,562.68
HIV Research	\$ 17,704.00

Table 5: AIDS Spending Contribution

In 2014, domestic funding was also \$300,000.00FJD [excluding the donor funds from UNICEF & WHO] as compared to 2012 & 2013 to support the HIV response in the country. Below is a graphical illustration of the utilization of the domestic funding in 2014.

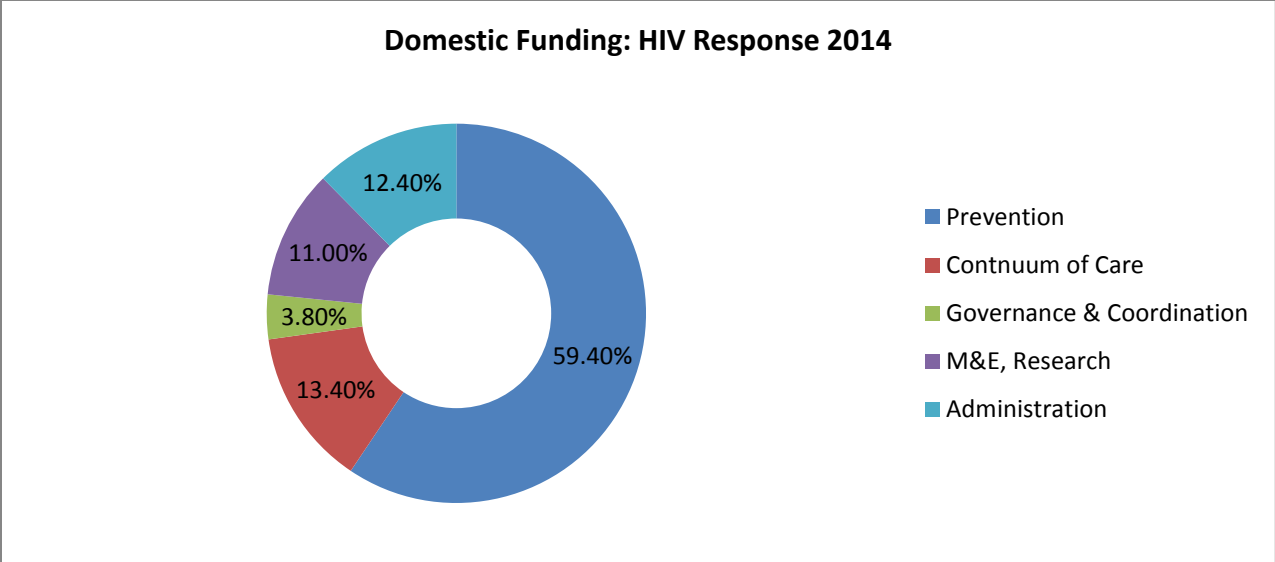


Figure 21 Domestic Funding for HIV Response in Fiji 2014

As noted above, more than 50% of the domestic funds are towards the prevention component of the HIV response. This is followed by the treatment, care and support component [CoC].

To ensure that there is efficient utilization of funds producing tangible results, the M&E TWG will strengthen the area of monitoring & evaluating all HIV related activities.

3.0 NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Prevention is a priority towards the HIV response in Fiji. This can be clearly shown as well in figure 18 above with the HIV expenditure allocation. The Fiji approach to prevention is a good example of what UNAIDS describes as “Combination Prevention”⁵³. This means that prevention programs “deploy a blend of biomedical, behavioral, and structural approaches tailored to address the particular and unique realities of those most vulnerable to HIV infection”.

Prevention often links provision of information in community settings with chances for community members to receive condoms, meet people living with HIV, and talk about behavior change matters with peer educators or community leaders. For those wanting more time to think about whether their own behaviors place them at risk, information is provided on clinics which they can visit later on to receive counseling, testing or treatment services. Most prevention programs include specific information about the nature of HIV, means of transmission, value of treatment, and specific initiatives to reduce stigma and discrimination.

⁵³ Piot P, Bartos M, Larson H, Zewdie D, Mane P. Coming to terms with complexity: a call to action for HIV prevention. Lancet. 2008 Sep 6;372(9641):845-59.

All groups involved in peer education reported extensive training of their peer educators, not just single sessions based on information.

Collaborations between the government agencies and the community organizations including NGOs and key populations is more recognized as compared to previous years. This is seen in the multi-sectorial participation during either a review consultative meeting or a planning meeting for HIV related activities. Both agree that the country is able to identify specific needs for the prevention programs in Fiji. These needs are based on the strategic approach to prevention which includes the following⁵⁴:

- Prevention among key populations
- Prevention and reproductive health and gender awareness for young people
- Prevention of parent to child transmission through community education and referrals
- Blood safety

There is an appropriate balance between focused prevention for vulnerable groups and more general programs for the whole community. Because almost all transmission is through sexual behavior, the groups identified as most vulnerable were sex workers and their clients, men who have sex with men, and the out of school youths.

There has been increased emphasis on prevention through workplaces and organizations and events. The Ministry of Labor with Fiji Red Cross has been actively involved in the prevention programs for workplaces. This also includes a familiarization program on activities carried out in the hub centers, involvement of PLHIVs in the training and also the development of HIV in the Workplace Policy for each participatory organization.

HIV prevention is also linked to broader issues in Adolescent Health and Development and in Sexual and Reproductive Health through comprehensive peer education programs to in-school and out of school youths. All organizations including the education ministry through NSAAC, RFHAF, MoH, and FASANOC [to name a few] provide extensive training for their peer educators and good follow-up. Peer were really “peers”: for example, with RFHAF the peer educators were young people; in sports programs the peer educators were sports players; for sex workers the peer educators were sex workers, and so on. This resulted in ongoing needs for training of new peer educators each few years, but this was considered to be useful.

The concept of “Greater involvement of people living with HIV” is applied within all programs. HIV implementing organizations including the schools and FBOs involve people from the national network of people living with HIV (FJN+) in their outreach and education work. Currently, there are 3 HIV advocates based in the 3 hub centers in the country that are being

⁵⁴ Prevention Strategic Approach, National Strategic Plan for HIV & STI 2012-2015, Ministry of Health, Fiji.

paid by the Ministry of Health as support personnel to the Ministry for PLHIVs. This is an agreement between FJN+ and MoH which is annually renewed on the basis that performances by the advocates are satisfactory.

Condoms are increasingly available in many locations including clinics, stores and nightclubs and are promoted in most education sessions conducted by peer educators and also health care workers during outreach programs. As part of the condoms campaign in Fiji, it is working together with the Suva City Council to install condom dispensers in 5 sites within the city area [public conveniences]. This will be monitored by the peer educators during the 1st 6 months of its introduction to monitor and evaluate the utilization of these dispensers.

HIV prevention is linked to broader issues in Adolescent Health and Development and in Sexual and Reproductive Health, primarily through the Ministry of Health and its public clinics and hospitals. Ministry of Health and the Adolescent and Reproductive Health Program has established a youth friendly drop in center “Our Place”. This serves as a “one stop shop” for adolescent and reproductive health, which can address STIs as well as HIV and other health issues. The establishment and operation of the youth friendly clinic is based on the Pacific Regional Guideline on Standards for Youth Friendly Clinics, which was produced by the SPC’s Adolescent Health and Development (AHD) program.

HIV and STI prevention for young people and other key affected population is a top priority for the Fiji national response. There is strong national leadership on the issue especially from H.E. The President of Fiji who has visited secondary schools in Fiji as part of the preventative programs for the youths and young adults.

A significant proportion of the resources for the response is dedicated to protecting the youth from HIV infection. A range of methods is being used to inform and educate young people in and out of school about HIV, STI and sexual and reproductive health. As indicated in the NCPI, the national policy supports HIV education in primary and secondary schools, and teachers have been trained to provide HIV education for their students. Although schools and young people are the most targeted population for HIV & STI prevention, the question on the behavior change is yet to be answered. There is a need to explore this further. This in return will assist the country in strategizing it’s response in reducing new HIV infections amongst the affected age group.

The 2008 Second Generation Surveillance Survey (SGS), reported in the 2010 Fiji UNGASS Report, assessed the HIV related knowledge for different categories of youth as follows:

- Male and female students from three Fijian tertiary institutions at 50% and 52% respectively.

- 20 to 24 year old seafarers at 34.1%
- 20 – 24 year old uniformed services personnel at 44%
- 15 – 19 year old pregnant women attending ANC clinics at 13.3%
- 20 – 24 year old pregnant women attending ANC clinics at 44.9%
- 15 – 19 year old male and female STI clinic attendees at 53.9% and 100% respectively
- 20 – 24 year old male and female STI clinic attendees at 53.7% and 52% respectively

The level of knowledge of HIV transmission and prevention is lower than desirable among all surveyed groups. It is also lower than the target of 70% of young men and women aged 15 to 24 or risk group correctly identified ways of preventing sexual transmission of HIV and reject major misconceptions in the 2007 – 2011 NHSP. The high levels of STI infection as well as teen pregnancies is further evidence that there still much to do to protect young people.

3.1 Prevention: Specific Sub-populations with Higher Risk of HIV Exposure:

Since prevention is a cornerstone for the HIV response, sex workers are a target group.

Sex workers

Government respondents of the NCPI agree that “the majority of people in need have access to risk reduction for sex workers. CSO respondents on the other hand do not agree that sex workers can access risk reduction services. Given that CSOs deliver over 25-50% of risk reduction services for sex workers, their assessment of the reach and coverage of the risk reduction programs is more likely than the assessment of government respondent.

Sex workers include women and transgender. They mostly live and work in urban centres, though the 2009 research by McMillan et al on sex work in Fiji noted that there are some sex workers in rural areas and some travel to and from urban areas. Ethnic Fijian [I-Taukei] sex workers are better networked and more easily accessible through outreach preventative programs and other services than Indo Fijian sex workers. Migrant Chinese sex workers in Suva form a distinct community of their own – these workers seldom speak more than rudimentary English and no Fijian, nor do they access local HIV and STI prevention resources⁵⁵⁵⁶.

There are three sex worker networks that provide HIV and STI risk reduction information, condoms, and referrals to clinics, for sex workers, the Survival Advocacy Network (SAN), Pacific Rainbows Group and the Rainbow Women’s Network. The works of the three networks are described below.

The Survival Advocacy Network (SAN), which is affiliated with Women’s Action for Change and formally established by the Australian sex worker network [Scarlett Alliance], works with both women and transgender sex workers. SAN has volunteers in all three divisions. They provide support to both full time sex workers and “dabblers”, who as the name suggest do sex work from time to time when they

⁵⁵ Karen McMillan and Heather Worth, 2010. Risky Business: Sex Work and HIV prevention in Fiji.

⁵⁶ Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013

need money. SAN provides support to sex workers through weekly meetings, and outreach at night at the locations where sex workers are operating. There has been no official estimate of the sex worker population in Fiji. However, SAN estimates that they are reaching up to 100 sex workers in the western division.

The Pacific Rainbow Group is affiliated with the then PCSS [now Empower Pacific] and runs the Sekoula Project, which is funded by the Response Fund. The Sekoula project was initially funded by the Pacific Regional HIV Project and began in 2008 by establishing a Drop-in Centre or safe space for sex workers to meet. Sex workers from three towns in the Western Division, Ba, Lautoka and Nadi met once a week on “flower days” to exchange information and discuss issues of concern. Field workers employed by the project conducted outreach to sex workers on the street to provide information and condoms and lubricants, invite them to “flower days” and provide referrals to the EP counseling and social welfare services as needed⁵⁷.

McMillan and Worth (2009) reports that most of the sex workers interviewed in their qualitative study of 40 sex workers, seemed to have some level of HIV knowledge. The most well-informed sex workers were those who had participated in workshops run by non-governmental organizations (NGO) involved in HIV interventions.

Introduction of the Crimes Decree in February 2010, changed the landscape for sex work and the networks support sex workers to reduce their risk of HIV and STI infection. Sex work was illegal in the Penal Code that was replaced by the Crimes Decree. Sex work continues to be illegal in Fiji. There are two notable changes between the Penal Code and Crimes Decree. The first is that the term “prostitute” has been expanded to include not just females but also males and transgender sex workers. The second notable change is that clients of sex workers can now be prosecuted if they seek and/or use the services of a sex worker or make arrangements to do so. Sections 230-231 of Part 13 of the Crimes Decree describe the sex work offences as⁵⁸:

The follow-up study by McMillan and Worth on the effects of the Crimes Decree on sex workers found that there have been a number of detrimental effects on HIV prevention in Fiji since the enactment of the Crimes Decree, including:

- A heightened fear of brutality and harassment from law enforcement agents has reduced sex worker opportunity for negotiation with clients, including condom negotiation
- The criminalization of clients has reduces the ability of sex workers to negotiate over the terms of the transaction and created more pressure to accept the clients’ terms. Fear of losing a client is an incentive to comply with a client’s wishes for sex without a condom.

Male, female and transgender sex workers operate in Fiji. The numbers of sex workers have not been determined, but they mostly work in the urban centres of Suva, Lautoka, Nadi and Labasa. Risk reduction services provided to sex workers by peer networks associated with CSOs have made sex

⁵⁷ Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013

⁵⁸ Sections 230-231 of Part 13 of the Crimes Decree, Crimes Decree 2009, Government of Fiji

workers knowledgeable about HIV related risk and means of protection. Many practice safe sex with their clients although the clients resist condom use. They do not however, practice safe sex with non-commercial intimate partners. The Crimes Decree introduced in 2009 has made it more difficult for sex workers to access risk reduction services, including condoms. The risk of sex workers and their clients to HIV and STIs infection has heightened with the introduction of the Crimes Decree.

Men who have sex with men (MSM):

Similar to the finding with sex workers, Government & CSO respondents of the NCPI agree that “the majority of people in need have access to risk reduction for MSM.

MENFiji, an NGO established in 2008, provides prevention programs for these men, but deliberately organizes initiatives which welcome all men and talk about men’s sexual health, not just prevention for men who have sex with men. They focus on behavior not identity, and their activities recognize that many men have sex with both men and women. Their main activity is HIV awareness through netball events. These involve a range of men, not just men who have sex with men, but they provide an opportunity for honest and detailed information sessions along with access to referrals and sometimes on site counseling and testing. MENFiji have identified that there are social or sexual networks of men who have sex with men in tertiary institutions, prisons and uniformed groups, and amongst sex workers, hairdressers, garment factory workers and hotel workers. MENFiji is finding ways to establish partnerships and outreach work amongst these networks and institutions. MENFiji is associated with the Pacific Sexual Diversity Network.

The social and political environment for HIV/STI prevention activities for MSM improved with the enactment of the 2009 Crimes Decree, which reformed the Penal Code and decriminalized male-to-male sex. The HIV/AIDS Decree 2011 further protects the rights of MSM to access to services. Together, these two Decrees should make it easier to reach MSM with HIV/STI prevention services.

3.2 People living with HIV:

The government and CSO respondents of the NCPI agree that the majority of people living with HIV have access to HIV prevention programs. Members of the Fiji Network for HIV+ people (FJN+) strongly agree that they have access to services to prevent HIV infections.

In general, people living with HIV are very knowledgeable about the risk of becoming infected with and of transmitting HIV. They have good access to condoms and sexual health services although they are sometimes challenged with attitudes from the hub staff. They have good access to supportive counseling and they have the support of their FJN+ peers to help maintain safe behaviors. Finally, PLHIV who are on ART treatment will have low viral load, which reduces their infectiousness if they were to have unprotected sexual intercourse. They may also have some protection to re-infection because of the ARVs in their blood stream.

It is important to acknowledge that people living with HIV are not a homogenous group, and that their risk of re-infection or their access to prevention services may be more influenced by sub-group they

belong to than by the fact that they have HIV. For example, a transgender with HIV may be uncomfortable using the health service like other transgender, even though other PLHIV who are in contact with the health services are comfortable with using the services. For this reason, FJN+ had also established a support group for PLHIV MSM targeting the MSM who were HIV infected.

People living with HIV, from FJN+ believe that stigma and discrimination are being addressed and that they are mostly accepted within the Fijian community. This is an achievement not only for FJN+ but for the country as a whole. This is mostly due to the efforts of PLHIV who have been openly engaged with the national HIV response. The HIV/AIDS Decree 2011 offers further protection from stigma and discrimination for PLHIV, which will enhance their access to prevention services.

3.3 HIV Testing and Counseling Services:

The HIV/AIDS Decree has mandated that, except in the routine testing of blood or blood products donated for transfusion, all HIV testing in Fiji should be voluntary and be preceded by pre-test counseling that enables the person receiving the test to give informed consent.

There has been a policy of provider-initiated counseling and testing (PICT) in operation for antenatal clinic attendees, STI clinic patients, TB patients and others in using the health care service who exhibit symptoms that require investigation. However, a provider (health care professional) can offer or recommend a test, but cannot compel the patient to take the test. The Decree states very clearly in Section 2.-(29) that it is unlawful to request that a HIV test be performed except with voluntary informed consent of the person being tested.

Following a baseline assessment on the sub division laboratories in the country, Fiji has adopted the new HIV algorithm testing which will be rolled out to the sub divisions. This will ensure that POC testing is available and accessible to the community.

Initial testing of infants born to HIV+ mothers is performed between four to six weeks of age or at the earliest opportunity thereafter using virological assay. Dried blood spots are collected from the infant and sent to Australia for testing.

3.4 Prevention of Parent-to-Child-Transmission of HIV Services:

The available data on antenatal HIV testing of pregnant women indicates that there has been a huge improvement in the PPTCT program in Fiji since the program began in 2005.

Empower Pacific has also trained over more than 200 nurses in counseling, many working in the sub-divisional and health center level. In the antenatal clinics that do not have the EP/MOH partnership, the nurses with counseling training in VCCT & PPTCT facilitate the HIV testing process.

The antenatal HIV testing program is in compliance with the new HIV/AIDS Decree because the women are not coerced to take the HIV test. EP shows in the NCPI report that in the ANCs where they operate, after the pre-test counseling, about 98% of pregnant women opt to take the test.

All pregnant women who test HIV+, including those who have an indeterminate HIV test result are provided with ARV prophylaxis. Part of the PPTCT program is also focused on EID for infants – detecting the infection earlier for early treatment if required.

The PPTCT counseling program began a new initiative to promote further involvement of men in reproductive health, which has potential to substantially improve women’s ability to plan pregnancies and adopt a range of options to reduce potential of mother to child transmission.

3.5 Treatment, Care and Support:

The essential elements of the treatment, care and support program are:

- Antiretroviral therapy (ART) for PLHIV
- ART for TB patients
- Treatment for opportunistic infections
- Cotrimoxazole prophylaxis in PLHIV
- Pre and post test counselling and supportive counseling,
- Laboratory testing of CD4+ cell count and viral load testing,
- Early infant diagnosis (EID) for HIV exposed infants
- Paediatric AIDS treatment
- HIV testing and counselling for people with TB
- Psychosocial support for PLHIV

The treatment, care and support program was rated seven out of 10 by both civil society and government in the NCPI – an assessment tool used as part of the GARPR reporting process to gauge the level of commitment and response to the epidemic the government sector and the private sectors, NGOs and key population. For 2014, this evaluation [NCPI] is not carried out but a review will be done in 2016 as stated in the 2014 GARPR guideline.

3.6 Antiretroviral Therapy

Antiretroviral treatment for people living with HIV in Fiji began in 2004 and was initially only provided from the reproductive health clinic, also known as the Hub, in Suva. The program has expanded with the establishment of treatment sites or Hubs Centre in Lautoka and Labasa, the largest towns in the Western and Northern Divisions respectively. In addition to the Hubs, ART is also provided in three divisional hospitals in the country, namely Lautoka, Labasa and Colonial War Memorial (CWM) hospitals.

There has been a significant scaling-up of the ART program in the last couple of years. At the end of 2009, 48 PLHIV were receiving ART from the three Hubs Centres around the country. In 2010 and 2011, an additional 28 people had started ART, bringing the total to 76. By the end of 2014 there were 206 eligible PLHIV who are on antiretroviral program.

The scaling up of the ART program has been successfully achieved through the following:

- a. Training and development of multidisciplinary core teams consisting of a doctor, nurse, one or more volunteers and a full time HIV Advocate, a person living with HIV (appointed by FJN+) for each Hub Centre. This provides a more holistic approach to treatment, care and support. In addition, OSSHHM has sponsored 3 medical officers' clinical placements in PNG and also mentoring programs in country.
- b. With the assistance of the HIV+ advocates [who are PLHIV support persons in the three divisions] who travels with the outreach team to provide HIV education, community members have begun to acknowledge the reality of HIV and also be encouraged to have a HIV test since treatment was available if they were diagnosed positive.
- c. Following WHO guidelines, the threshold for ART eligibility has been increased from 350 to 500 CD4+ cell count, which has increased the number of eligible patients. Additionally, All HIV+ children are given on ART. The ART for children is no longer dependent on their CD4+ count.
- d. Constant reliable CD4+ testing is now available at Mataika House Reference Laboratory . PIMA machines are also available in the three divisions to assist the clinicians in monitoring the CD4 counts of patients who are on ART. This was procured in 2014 through financial support from UNICEF.
- e. Psychosocial support for PLHIV through the hub centers has been improved by the provision of counseling services through EP.
- f. Fiji has introduced through the TB program the use of the Gene-Xpert machine to be used for TB patients and the HIV Team have explored the possibility of carrying out viral load testing through this same machine in the divisions.

Antiretroviral drugs are provided free to PLHIVs and discordant couples, and funded by the Government of Fiji. Fiji is the only Pacific Island country that is currently funding ART for all people living with HIV. Medications for opportunistic infections are not provided free of charge. PLHIV who need OI medications have to pay for them. Many PLHIV cannot afford to pay for the medications. FJN+ assists PLHIV who cannot afford OI medications with the cost of the medications through their hardship grants.

3.7 HIV & TB:

HIV testing and counseling for people with TB has been established and all PLHIV are screened for TB. In 2014, 11 TB/HIV co-infections were detected and enrolled in TB and ARV treatment programs.

Psychosocial support for PLHIV and their families:

One of the primary objectives of Fiji Network for HIV+ people is to provide support, including psychosocial support for PLHIV. FJN+ organizes monthly meetings in the three divisional capitals – Suva, Lautoka and Labasa – for the members. Issues of concern are discussed at these meetings. If individual

members have specific support needs the FJN+ Care and Support officer meets with them separately and determines what kind of support is required facilitates access for the member. The Care and Support Officer has facilitated access of unemployed FJN+ members to the social welfare benefit provided by the Ministry of Social Welfare. In addition, with the assistance of FCOSS, FJN+ members have been trained and are also encouraged to enroll in small business programs. FJN+ has 6 members enrolled to start their generation income.

The treatment, care and support program that was rated as 60% in the 2013 NCPI as response from the CSOs has improved. There is **still** a possibility that there may be PLHIV who are not in touch with the health care system who need treatment. Every effort must be made in the near future to encourage them to access treatment. It is also very likely that there are people with HIV infection who are not aware of their status hence, POC testing has been introduced.

4.0 BEST PRACTICES

4.1 The HIV/AIDS [Amendment] Decree 2011:

The enactment of Fiji's HIV/AIDS Decree on 4th February 2011 signaled the maturity of the national response to the HIV epidemic, which began with the detection of the first infection in 1989. It is now in its 3rd year of implementation although not all 42 sections have been fully implemented.

Since 2003, with the first public declaration of HIV+ status, increasing numbers of PLHIV have been public about their status and have been involved in community education about the effects of stigma and discrimination. Stigma and discrimination, which have very devastating effects on people infected and affected by HIV, in addition to rendering many of the efforts to control the epidemic ineffective, can really only be changed in the hearts and minds of the community. In Fiji change of hearts and minds is well underway because of the bravery of the many people with HIV who are willing to speak openly about their status.

The HIV/AIDS Decree 2011 frames the national HIV response from a human rights perspective and makes it "unlawful to discriminate, directly or indirectly, against a person having or affected by HIV/AIDS". The Decree makes it a requirement for HIV tests to be conducted only with informed consent and with counseling.

The HIV Decree legislates for the establishment of a multi-sectorial Board, which is responsible to the Minister of Health, to oversee the implementation of the national response. The Board has been successfully functioning and it reports on the status of the HIV response to the Minister annually and also to H.E. The President as and when required. A full time Chief Executive Officer was appointed to manage the national response on behalf of the Board.

As per Decree, the Board has also established technical working groups to support the implementation of the HIV strategies as indicated in the NSP.

4.2 Head of State as Leading Example:

H.E. The President, is in his 6th year as the HIV Ambassador for Fiji. His role as the HIV Ambassador and his commitment to the HIV response is not only recognized locally, but globally as well.

Locally, he has visited more than 80% of the secondary schools in Fiji to advocate to the students, teachers and parents on HIV & STI. He openly talks about sexual reproductive health to the schools even though this is seen as a “taboo” in most traditional families – where issues around sexual health cannot be discussed openly. He has plans to complete his school visits by the end of 2015.

The President of Fiji has also made himself available to attend or to be a part of most of the local events which are HIV related including the launch of the IBBS surveys for sex workers in Fiji and MSM, the launch of the Pacific Shared Agenda in Fiji, the extra ordinary Board meetings with the HIV/AIDS Board and the WAD event to name a few.

Regionally, H.E. The President has been a part of the regional HIV meetings including the IAS Conference held in Melbourne.

The commitment and the passion that the Head of State has shown is a leading example to all political leaders not only in Fiji but to the region as well. This is seen as the foundation driver to the HIV response.

4.3 Political Commitment:

Political commitment from the government leaders and parliamentarians is shown by the representation of key government bodies in the HIV/AIDS Board including the education department, youth and sports, women, children and poverty alleviation, defense and immigration and the health department. Other government departments including the employment department, office of the attorney general, I-Taukei Affairs are actively involved in the program level.

Political commitment is continuously seen through the following areas to name a few:

1. **ART Provision for PLHIVs in Fiji:** patients who are on ART in Fiji do not buy their drugs because this is provided free from the government. This also includes the provision of OI prophylaxis as compared to other Pacific Island Countries.

2. **HIV Advocates [PLHIV support persons in the 3 Divisions]:** through the Ministry of Health & Medical Services and the HIV/AIDS Board there are HIV advocates in the 3 divisions in Fiji to work with the Hub Centers as part of the PLHIV peer support program. These advocates are paid through a grant provided to their organization [FJN+] from the Health Ministry to support them financially [salaries].
3. **Domestic Funding:** through the support of political leaders, the government of Fiji ensures that there is a separate location for the HIV response annually. In 2014, a request for an increase in domestic assistance for 2015 for the HIV response was approved from cabinet.
4. **WAD 2014:** during the WAD event in 2014, the Speaker of the Parliament had requested that the Parliament House be also decorated with a Red Ribbon and that all 52 members of the Parliament be provided with HIV related information as part of their WAD commemoration in Parliament House. Before the meeting on the 1st December, 2014, the Speaker of Parliament with the members of Parliament shared a moment of silence to remember those who had been part of the response since the beginning of the epidemic in the country.

[4.4 HIV Confirmatory Testing and Treatment:](#)

HIV testing is not only available at Divisional level but this has also rolled out to the sub divisional levels as mentioned earlier. This is to ensure that HTC is available and accessible. This is also made possible through mobile outreach programs.

[4.5 Multi-sectorial Approach:](#)

As compared to previous years, the greater involvement of the key populations, community or civil society organizations, faith based organizations, academic institutions and government agencies has been more prominent. This is reflected in the mid-year review meetings and a collated development of the HIV annual work plans.

In addition, events such as the WAD have seen an active involvement from all sectors – government, private, academic and key populations.

[4.6 PPTCT Program:](#)

Provider initiated counseling and testing (PICT) of pregnant women has been successfully established as part of the prevention of parent-to-child-transmission of HIV (PPTCT) program in Fiji. All pregnant women are offered an HIV test at their first antenatal visit, together with other health checks. While other health checks such as measurement of weight and blood pressure and tests for syphilis and Hepatitis B – are mandatory, the HIV test needs to be provided with informed consent and counseling, as mandated by the HIV Decree 2011. In busy

antenatal clinics with many patients and few staff, it is difficult for the overworked nurse(s) to spend an extra half hour to provide pre-test counseling to each pregnant woman. With the assistance of EP, they have provided counselors to provide either a one-to-one or group counseling before HIV screening is conducted [provided a patient consents].

The antenatal counseling program goes beyond encouraging pregnant women to have a HIV test. By providing women with information about HIV transmission and prevention of infection, and assisting them to assess their own risk of infection, the counseling session extends the benefit of the antenatal visit to the rest of the pregnancy and beyond.

In recognition of the role that male partners play in the risk of pregnant women to HIV/STI, EP has also included the men as partners program to accommodate male partners and spouses of pregnant women. EP has noted an increase in male partners accessing ANC with their wives and female partners.

The provider initiated integrated antenatal pre and post HIV/STI test interviews have been shown to be an effective way to promote awareness, risk minimization, and encourage access of health services for men and women. The inclusion of the information on NCD's (such as diabetes, cervical and breast cancer, alcohol and drug use,) and screening for mental health and Intimate Partner Violence represents a significant opportunity to address these major health concerns with women throughout Fiji (ie, most women will present at the antenatal clinic at one period in their lives). This information, and the subsequent referrals offered, will in many cases represent one of the few opportunities some women have to seek help, which they otherwise may never have known existed. Finally, this program is an excellent example of partnership between a civil society organization and the government that leads to provision of better services for patients.

The adoption of the shared agenda has also strengthened the integration of services within the sexual health program.

[4.7. Family Life Education in Schools:](#)

The education ministry has included sexual and family life education as part of the school curriculum. There are also plans to incorporate this into the internal and external exams. Plans are also in progress to include this in the pre-service for teachers.

5. MAJOR CHALLENGES AND GAPS

The major challenges and gaps in the national HIV response were collated from the Government and Civil Society NCPI and also from the mid-term review conducted in 2013.

- a. Limited friendly facilities to address the needs of key populations especially for sex workers. Although desensitization programs has been conducted through the sex workers network and the academic institution [FNU], through the survey conducted by McMillan & Worth [2010] there is a need to have health facilities to address these specific population.
- b. The main challenge faced by CSOs is addressing values and having the capacity to lobby and advocate for prevention programs successfully through FBOs, traditional leaders and parents.
- c. Difficulty in forecasting the number of PLHIV who would become eligible for ART. There is no data from population based prevalence surveys or sentinel surveillance of adults to be used to estimate the number of PLHIV. This made it difficult to budget accurately for procurement of sufficient ART.
- d. Many people with HIV infection do not present for HIV testing until late in the infection. These individuals are often quite ill and have a high mortality risk.
- e. Fiji's classification as an upper middle income country in 2009 prevents it from meeting the basic criteria for accessing funding from the Global Fund
- f. The network for positive people [FJN+] is currently facing a financial crisis and creating a threatening environment in the operation of the organization. This organization has been dependent mostly on donor support for its daily financial operations. Since the response fund has ceased and donor support has withdrawn until strategic organizational structure is in place, the government through the health ministry and the support of H.E. The President and international support [WHO, UNAIDS & UNICEF] have been in consultation and has implemented an emergency strategy to allow the organization to rebuild itself again. This increases domestic funding which may affect other HIV related planned activities.
- g. Donor funds are slim which puts more commitment on the country to inject more funds to domestically support some or even all HIV related programs.
- h. The below mentioned are recommendations from the Integrated Biological and behavioral studies carried out for both sex workers and men who have sex with men.

- 1) *In future studies, it is important to investigate also on the number of pregnancies and abortions experienced by the sex workers*
- 2) *A multi-sectorial approach is important in moving the strategies forward*
- 3) *Recommendations from both IBBS studies [MSM & Sex Workers] needs to be merged together and an action plan needs to developed to address the recommendations from both studies*
- 4) *Actions identified from the plan needs to be clear and is ensured that it is addressed at different levels [policy and political and also at the operational level]*
- 5) *It is important to understand the targeted population that the awareness program will be conducted to [eg: young people <20yrs]. With the sex workers population, awareness conducted must be targeted not only for the sex workers but also for their clients,*
- 6) *The term decriminalizing sex work in the report should be replaced with the term “regularizing sex work,”*
- 7) *There is a need to have proper referral systems especially for in-school youths,*
- 8) *There is a need to address sexual health issues both in-school youths and the out of school youths,*
- 9) *Program implementers need to have a consensus definition on the term “youth”*
- 10) *There is a need to have psychosocial support for the sex workers population especially when there are experiences of rape from clients.*

6.0 SUPPORT FROM THE COUNTRY’S DEVELOPMENT PARTNERS

Fiji has been receiving support from development partners such as UNICEF, UNFPA, WHO, UNAIDS, ILO for both technical and financial support. The success of the implementation of the HIV response would not have been possible without the support of the donor partners. Fiji would still need their technical and financial assistance if the visionary targets needs to be achieved by 2015 and beyond.

7.0 MONITORING AND EVALUATION ENVIRONMENT

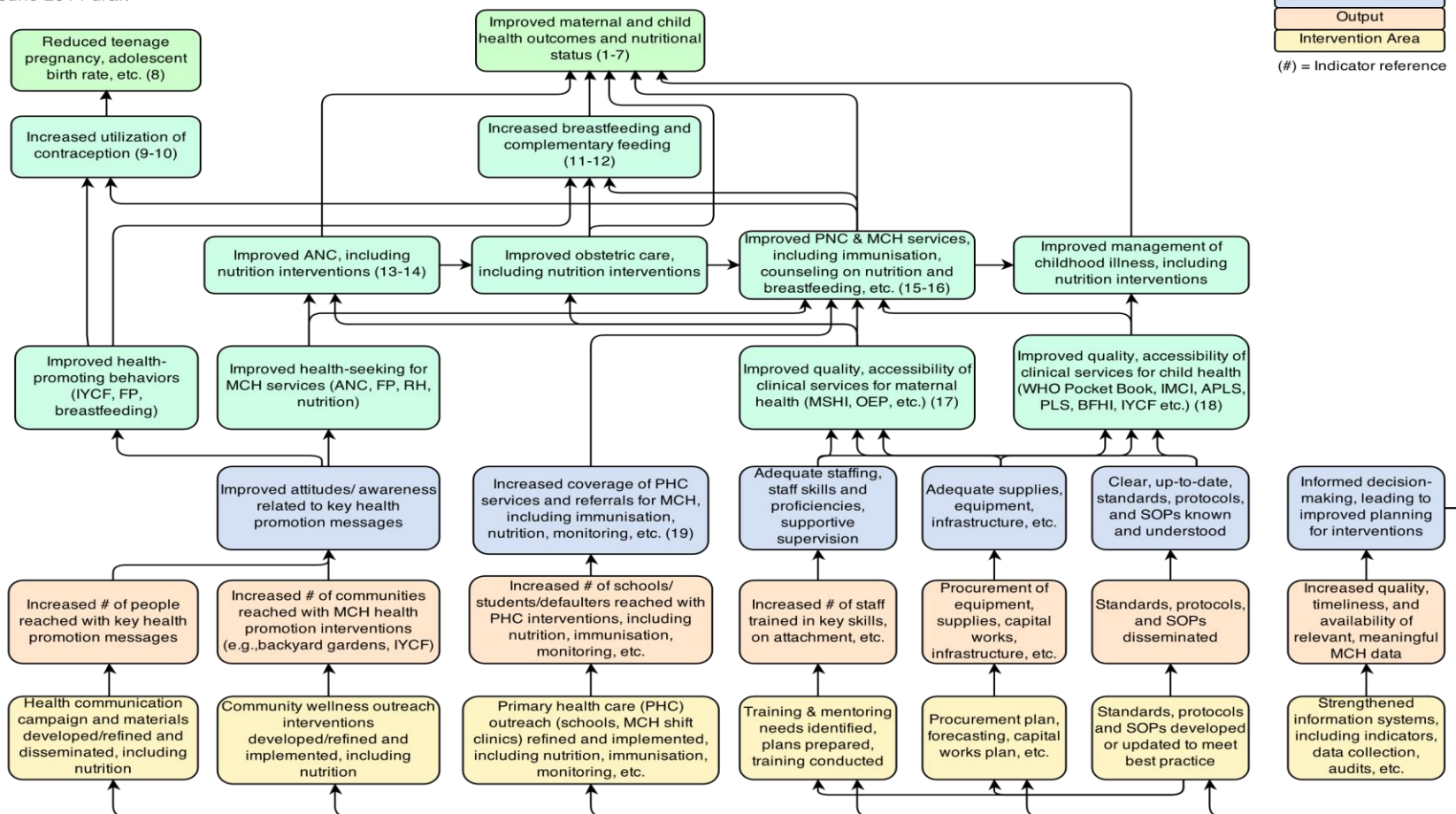
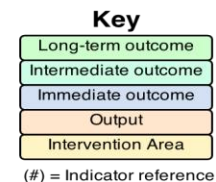
Although there is an M&E framework in place for 2012-2015, the implementation of this framework needs to be strengthened. With the establishment of the M&E technical working group, centralization of the management of data and monitoring of the HIV response will be

strengthened. In return, Fiji will also be in a better position to identify strategic implementations and respond strategically to the epidemic.

Annex 1 RESULTS FRAMEWORK FOR MATERNAL AND CHILD HEALTH

Fiji Ministry of Health Maternal & Child Health Results Framework

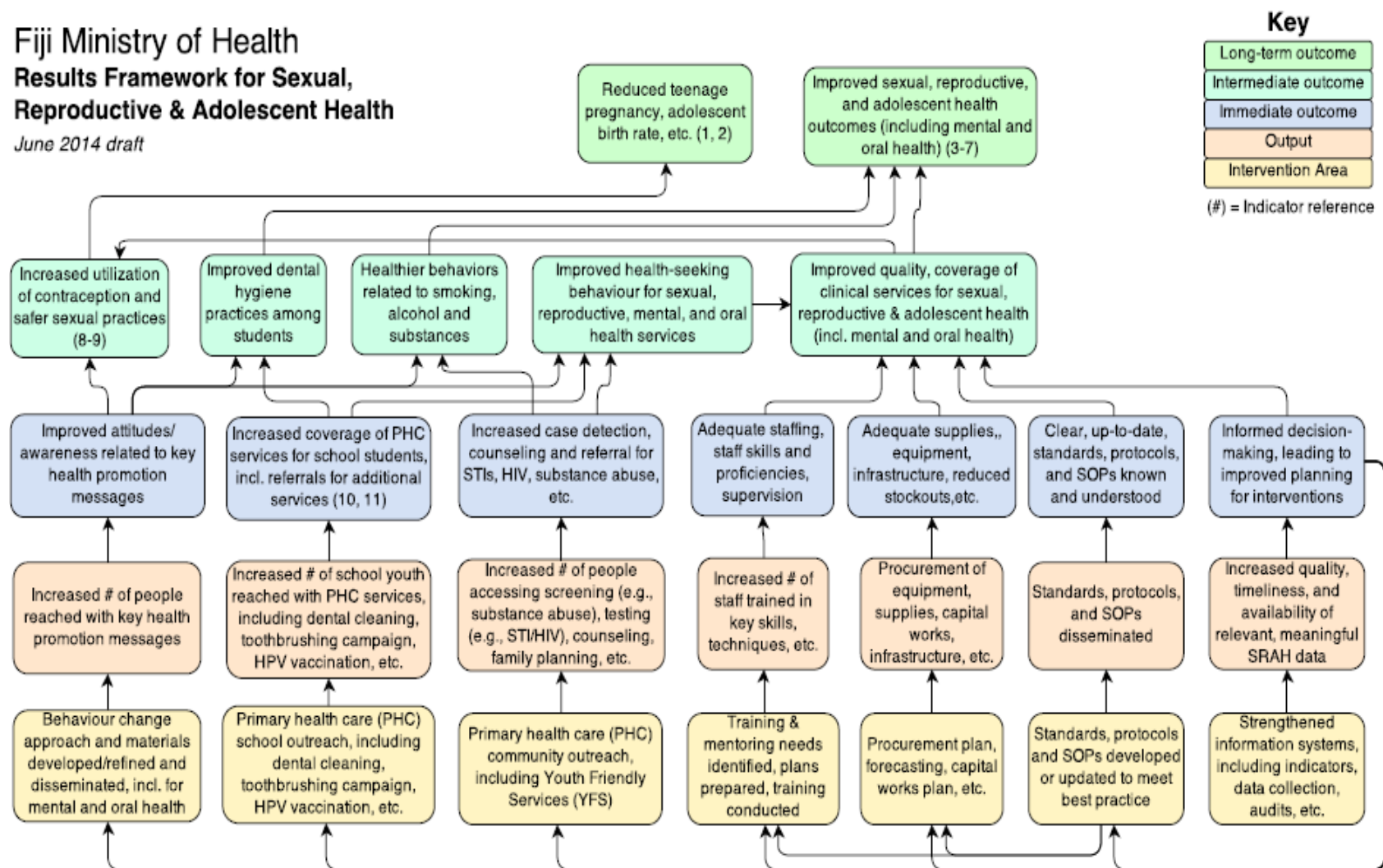
June 2014 draft



Annex 2 RESULTS FRAMEWORK FOR SEXUAL REPRODUCTIVE AND ADOLESCENT HEALTH

Fiji Ministry of Health Results Framework for Sexual, Reproductive & Adolescent Health

June 2014 draft



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