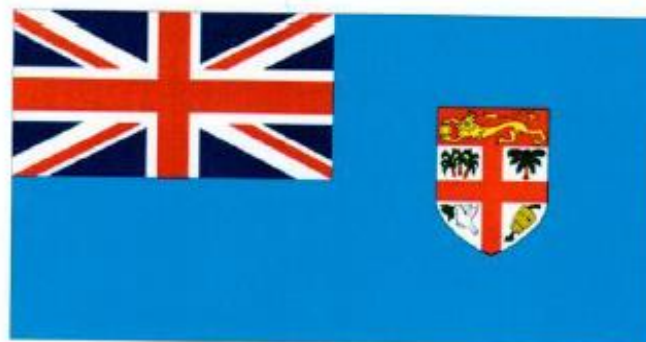


THE REPUBLIC OF THE FIJI ISLANDS



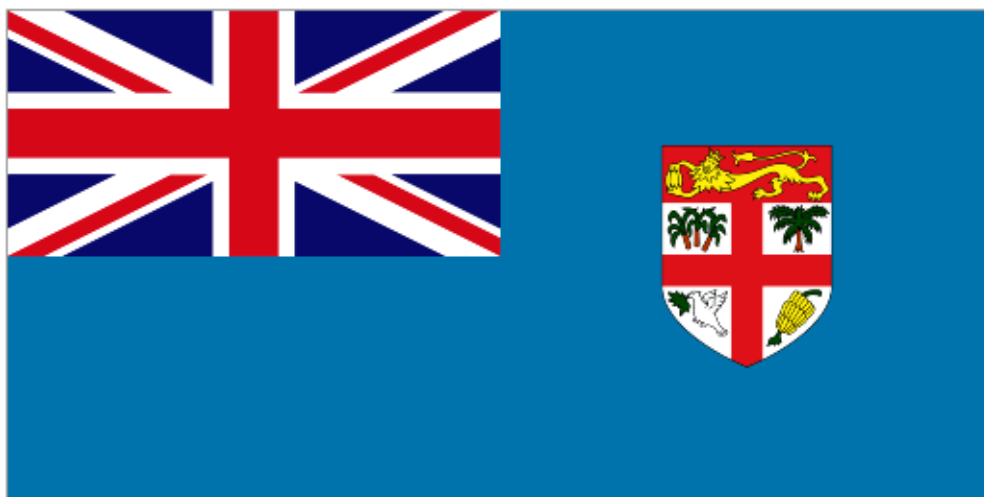
2016

GLOBAL AIDS MONITORING REPORT

Reporting Period: January to December 2016

Submission Date: 31<sup>st</sup> March 2017

# THE REPUBLIC OF THE FIJI ISLANDS



# 2016

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## Abbreviation

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AZT	Zidovudine
CEO	Chief Executive Officer – HIV/AIDS Board
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
GAM	Global AIDS Monitoring Report
HIV	Human Immune Deficiency Syndrome
IBBS	Integrated Biological & Behavioural Surveillance
IDU	Injecting Drug Users
IPPF	International Planned Parenthood Federation
KAP	Key Affected Population
MOH	Ministry of Health & Medical Services
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
NSAAC	National Substance Abuse Advisory Council
NSAP	National Strategic Action Plan
NSP	National Strategic Plan
NRL	National Reference Laboratory
OI	Opportunistic Infection
PICT	Provider Initiated Counselling & Testing
PLHIV	People Living with HIV
POC	Point of Care
PPTCT	Prevention of Parent to Child Transmission
PSHMS	Permanent Secretary for Health & Medical Services
RFHAF	Reproductive and Family Health Association of Fiji
RH	Reproductive Health
SAN	Sex Workers Advocacy Network
SDG	Sustainable Development Goals
SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted Infection

SW	Sex Workers
TB	Tuberculosis
ToR	Terms of Reference
VCCT	Voluntary Counselling & 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

The Republic of the Fiji Islands HIV & AIDS Country Status Report for 2016 obtains most of its HIV data from the Ministry of Health & Medical Services through its Fiji HIV Online Register which was established in 2015 through UNAIDS technical support. Surveillance data was obtained from the 2014 & 2015 Integrated Biological and Behavioural

Surveillance [IBBS] and other data gaps from several other implementing partners as referenced in the report.

This report serves to meet the UN reporting requirements on HIV & AIDS and also a key reference to Fiji's annual progress on implementation of prioritised HIV & AIDS strategies for 2016.

The HIV/AIDS Board of Fiji would like to express its deep appreciation and sincere thanks to all implementing partners who participated in the collation and development of Fiji's 2016 Global AIDS Monitoring Report. Your commitment and endless contributions is reflected in this comprehensive progressive country report.

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.

The 3 Hub Centers in Fiji and the Health Information Unit including the Fiji Communicable Control Disease Centre in Mataika House are sincerely acknowledged for their support in data collation and providing this important information to assist with the report.

We convey our compliments and sincere appreciation to UNAIDS for the continuous technical support and facilitation of the processes resulting in the production of this report.



CEO HIV/AIDS Board

31<sup>st</sup> March 2016



## Executive Summary

Fiji's 2016 Global AIDS Monitoring [GAM] report was prepared through a consultative government led process involving all key implementers to provide progressive updates [through pocket meetings] on the status of the HIV response in 2016. The report details key milestones achieved in 2016 in the areas of prevention, treatment, care and support and systems strengthening as aligned to the Global HLM targets and also to the 2016 – 2020 HIV & STI National Strategic Plan and the Fiji Ministry of Health & Medical Services [MoHMS] Strategic Plan and Annual Corporate Plan [ACP].

The GAM reporting period from January to December 2016 has been prepared predominantly through service utilization reports from service centres – which includes HIV testing and counselling (HTC), treatment, prevention, care and support services; monitoring and evaluation (M&E) data and e-interviews with key respondents from Government, civil society organizations (CSOs), including the Network for Positive People in Fiji and the key populations. All data information in the report has been validated and endorsed by the HIV/AIDS Board. The indicators comprehensively describe various facets of the epidemic in Fiji as well as progress of the national response to date.

The year 2015-16 featured a thorough review of the national response including the 2012-2015 Fiji National Strategic Plan on HIV & STI - an intensified exercise undertaken to prepare and strengthen the HIV response in the country through continuous partnership with key implementers. The year also witnessed high level consultations amongst local key partners resulting in a stronger collaborative response by all respondents in Fiji.

Although Fiji is classified as a low burden country, new HIV infections continues to increase which may be a result of the increase in HIV testing sites at sub national levels in the country. The intensified HIV response in 2016 has resulted in increased uptake of HIV prevention, treatment and care services leading to continued reduction in number of new HIV infections among children, and aids related deaths.

In terms of prevention, the scaling up of HCT services has benefitted people accessing services easily as compared to previous years. There has been sustained expansion of the national PPTCT Programme resulting 100% of pregnant HIV positive mothers accessing Anti-retroviral (ARV) drugs, and a drastic reduction in the number of babies born HIV positive to 0 by the end of 2016. There has also been intensified condom programming amongst the key populations [MSM, Transgender and Sex Workers] through the support of the Ministry of Health and Medical Services and the aggressive strategy implementation by the Rainbow Pride Foundation [RPF] and SAN Fiji resulting in the increase of condom accessibility by the key populations.

Under treatment and care, the country took an aggressive treatment scale up effort by adoption of 2013 WHO ART guidelines in 2013 and increased enrolment of people on ART in 2016 using the test and treat strategy [endorsed in principle but yet to be incorporated into the current Fiji ART Guideline. Treatment coverage for children is still lagging and Fiji is expected to improve with the test and treat and EID services.

The collaboration and integration of TB/HIV services has been realized from planning, resource mobilization to service delivery resulting in the increase of HIV-positive TB patients on antiretroviral therapy (ART) in 2016. TB prophylaxis coverage amongst HIV positive patients still needs to be strengthened.

Funding for HIV/AIDS in the Republic of the Fiji Islands remains predominantly domestic funded. The Fiji government contributes more than 80%, and 20% is from donor agencies including private sources. The government of Fiji also contributes 100% to the procurement of ART resulting in free provision of treatment to all PLHIVs. There is continuing evidence of the stewardship of the highest political leadership in response to HIV in Fiji.

In terms of programme response and system strengthening, the Republic of the Fiji Islands had launched its 2016-2020 National HIV & STI Strategic Plan that is aligned to the global targets of 90-90-90 and Fast-tracking approach. This was also the highlight of the HIV response in Fiji in 2016. Fiji plans to have other key planning and strategic documents developed in 2017 which includes; the national M&E Plan (2016-2020), the 2016-2020 National Implementation/Action plan and also the 2016-2020 National Indicator Guide on HIV.

Fiji through the continuous guidance and support of UNAIDS has also been able to have a fully functional online HIV registry since 2016 which has also been endorsed by the HIV/AIDS Board. Fiji hopes to develop and establish an online STI registry/database before the end of 2017.

The country sometimes experience stock outs of key items including test kits [Viral Load and CD4 kits] and STI drugs. This negatively affects the expanded demand generation. Test kits are currently funded through UNICEF and it is hoped that the Fiji government will narrow the gap.

Looking forward, the impact of the HIV/AIDS epidemic on the country's economy and human development index remains high hence Fiji will continue to intensify implementation of proven interventions to consciously reverse the trend of HIV in the country. Strategic and feasible interventions have been clearly articulated in the five year National HIV Strategic plan which is in harmony with the global targets for fast tracking HIV response and to realize a 90% reduction in new adult HIV infections, zero new infections among children, 90% reduction in stigma and discrimination faced by PLHIV, and 90% reduction in AIDS related deaths.

The HIV program in the country will continue to focus on HIV prevention as the key intervention to ending the epidemic, mobilising resources for the epidemic and building strategic partnerships with national and global stakeholders in the fight of the epidemic.

## 1.0 Status at a Glance

### 1.1 Introduction

The 2011 United Nations Political Declaration on HIV and AIDS commits all countries involved to provide to the General Assembly an annual report on progress achieved in realizing the commitments made in the Declaration. Fiji as a signatory to this commitment has been submitting regular reports since 2011 which has also benefitted Fiji especially in reviewing its progress and making strategic decisions in progressively strengthening its response. The 2016 GAM will provide data on the annual progress in the HIV response.

This is the first report for the beginning of the HIV related SDG targets and the 90-90-90 Fast Track Approach of the United Nations General Assembly Political Declaration on ending HIV and AIDS as a public threat by 2030.

This Section presents the methods and approach (process) used in compiling the 2016 Fiji GAM Report and the Indicator Table.

### 1.2 Inclusiveness of Stakeholders in the Report Writing Process

In the beginning of 2016, there were pocket meetings for all key stakeholders with representatives from our government partners including Ministry of Health and Medical Services, Ministry of Education, Ministry of Youth and Sports, Ministry of Employment, Ministry of Women, Children and Poverty Alleviation [MoWCPA], I-Taukei Affairs Board, National TB Programme and legal representatives from the Office of the Secretary General [SGs Office]. Representations from the civil society organizations included Fiji Red Cross Society [FRCS], Reproductive & Family Health Association of Fiji [RFHAF], Empower Pacific [EP], Medical Services Pacific [MSP] and National Substance Abuse Advisory Council [NSAAC]. Representations from the key populations included Sex Workers Advocacy Network [SANFiji], Rainbow Pride Foundation [RPF], Haus of Kameleon and the Fiji Network for Positive People [FJN+].

There weren't a lot of meetings done in 2016 due to the post TC Winston response by all organizations but correspondences and updates continued through email with a few one to one discussions especially with the CSO and key pops representatives.

On February 2017, an online survey form using Google Form was developed and the online link was disseminated to all stakeholders for their 2016 HIV activity report including financial reports as part of their inputs into the GAM report. The final report was submitted to the Permanent Secretary for Health & Medical Services for his endorsement on behalf of the HIV/AIDS Board.

## LIST OF REPORTED INDICATORS

Indicator	Value 2017	Source	Comments
<b>COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020</b>			
1.1 Percentage of people living with HIV who know their HIV status at the end of the reporting period		Numerator source from Fiji HIV online database	Not available since UNAIDS will use data from country's final spectrum file
1.2 Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period		Numerator source from Fiji HIV online database	Not available since UNAIDS will use data from country's final spectrum file
1.3 Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	85.5%	Fiji HIV online database	
1.4 Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period		Numerator source from Fiji HIV online database	Not available since UNAIDS will use data from country's final spectrum file
1.5 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm <sup>3</sup> and <350 cells/mm <sup>3</sup> during the reporting period	48.4%	Numerator source from Fiji HIV online database	
1.6 Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period	0		Currently there are only 3 hub centres that are providing ART to all PLHIVs under care. These hub centres have never experienced stock outs.
1.7 Total number of people who have died from AIDS-related causes per 100 000 population	Not available		Currently Fiji is trying to verify and validate its data on the LTFU cases which might also include some PLHIVs who have passed away. Correct data will be available once the data cleaning process on LTFU is completed.

<b>COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018</b>			
2.1 Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	100%	EID testing laboratories and sentinel site surveillance	
2.2 Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	Not available		
2.3 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV		Numerator from ANC.PMTCT registers and also the HIV registry	Not available since UNAIDS will use data from country's final spectrum file
2.4 Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated	Not available		
2.5 Percentage of reported congenital syphilis cases (live births and stillbirth)	Not available		
<b>COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners</b>			
3.1 Number of people newly infected with HIV in the reporting period per 1000 uninfected population	0.1065	Fiji HIV online database	
3.2 Size estimations for key populations			
3.3a Percentage of sex workers living with HIV	Not available		
3.3b Percentage of men who have sex with men who are living with HIV	Not available		
3.3d HIV prevalence among transgender people	Not available		

3.3e Percentage of prisoners/inmates/detainees who are living with HIV	Not available		
3.4a Percentage of sex workers who know their HIV status	Not available		
3.4b Percentage of men who have sex with men who know their HIV status	Not available		
3.4d Percentage of transgender people who know their HIV status	Not available		
3.5a Percentage of sex workers living with HIV receiving antiretroviral therapy in the past 12 months	Not available		
3.5b Percentage of men who have sex with men living with HIV receiving antiretroviral therapy in the past 12 months	Not available		
3.5d Percentage of transgender people living with HIV receiving antiretroviral therapy in the past 12 months	Not available		
3.5e Percentage of prisoners living with HIV receiving antiretroviral therapy in the past 12 months	Not available		
3.6a Percentage of sex workers reporting using a condom with their most recent client	Not available		
3.6b Percentage of men reporting using a condom the last time they had anal sex with a male partner	Not available		
3.6d Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex	Not available		
3.7a Percentage of sex workers reporting having received a combined set of HIV prevention interventions	Not available		
3.7b Percentage of men who have sex with men reporting having received a combined set of HIV prevention interventions	Not available		
3.11 Percentage of sex workers with active syphilis	Not available		
3.12 Percentage of men who have sex with men with active syphilis	Not available		
3.13 HIV prevention and treatment programmes offered to prisoners while detained	Not available		
3.14 Prevalence of hepatitis and coinfection with HIV among key populations	Not available		

3.15 Number of people who received PrEP for the first time during the calendar year	Not available		
3.16 Percentage of men 15-49 that are circumcised	Not available		
3.17 Annual number of males voluntarily circumcised	Not available		
3.18 The percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.	Not available		
<b>COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020</b>			
4.1 Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	Not available		
4.2a Percentage of sex workers who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	58.9%	IBBS Survey for Sex Workers in Fiji - 2014	
4.2b Percentage of men who have sex with men who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	35.9%	IBBS Survey for MSM in Fiji - 2014	
4.2d Percentage of transgender people who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	Not available		Need to do an IBBS survey which demarcates genders clearly including survey results.
4.3 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not available		
<b>COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year</b>			
5.1 Percentage of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Not available		

5.2 Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods	Not available		
<b>COMMITMENT 8: Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable</b>			
8.1 HIV expenditure - Annex			
<b>COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights</b>			
9. National Commitments and Policy Instrument – Annex			
<b>COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C</b>			
10.1 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV			
10.2 Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care	9.1%	Fiji Patient HIV online registry	
10.3 Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period	12.1%	ART Patient Registers – Fiji Patient HIV Online Registry	
10.4 Number of men reporting urethral discharge in the past 12 months	Not available		
10.5 Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis	Not available		
10.6 Proportion of people starting antiretroviral therapy who were tested for hepatitis B	100%	Fiji Patient HIV online registry	
10.7 Proportion of people coinfecting with HIV and HBV receiving combined treatment	Not Applicable		Fiji is not providing this at the moment although plans under way to provide treatment in the future.
10.8 Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	Not Applicable		Fiji is not providing this at the moment



10.9 Proportion of people coinfectd with HIV and HCV starting HCV treatment	Not Applicable		Fiji is not providing this at the moment
10.10 Proportion of women living with HIV 30–49 years old who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid or vinegar (VIA), Pap smear or human papillomavirus (HPV) test	Not available		

## 2.0 Overview of the AIDS 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 2015 is less than 1,000, and the prevalence rate for adults between the ages of 15-49 years old is at approximately 0.1%.<sup>1</sup>

From the first HIV confirmed case in 1989 to the end of 2016 [figure 1], a cumulative total of 740 confirmed HIV cases<sup>2</sup> were reported in the country through the endorsed Fiji HIV online reporting tool in 2015 using Google Form through UNAIDS support and in consultation with the Director for Health Information and Research for the Ministry of Health & Medical Services. The online reporting tool is real time that allows the hub medical officers to enter all newly diagnosed HIV positive cases within the hub centers and those confirmed through the new HIV algorithm from the nine [9] testing sites at sub divisional level and also from the three [3] divisional hospitals.

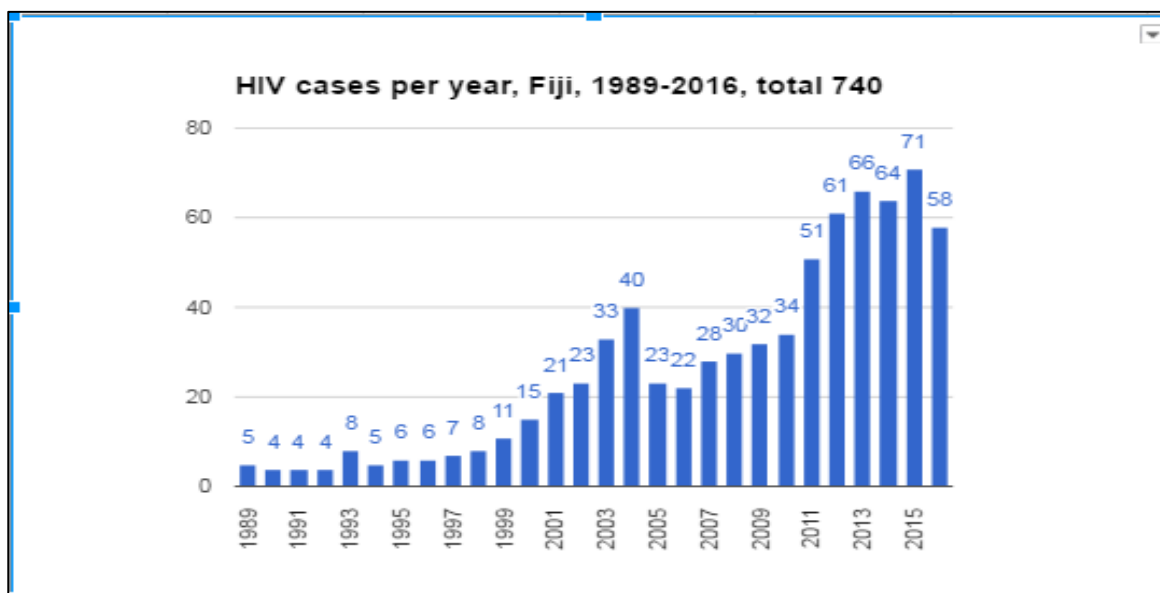


Figure 1: Fiji Newly Diagnosed HIV Cases per Annum: 1989-2016<sup>3</sup>

Figure 1 above shows the total number of newly diagnosed HIV cases from 1989 to 2016. As mentioned above, following data verification and validation through the use of the online reporting tool, Fiji had 58 new HIV confirmed cases in 2016. The increase in the number of new HIV confirmed cases in Fiji is a result of the increase in the number of

<sup>1</sup>HIV and AIDS Data Hub for Asia and the Pacific, December 2015 accessed on the 12<sup>th</sup> March, 2017 at <http://www.aidsdatahub.org/Country-Profiles/Fiji>

<sup>2</sup> Centre for Communicable Disease Control , Fiji Ministry of Health & Medical Services, December 2016

<sup>3</sup> HIV Online Data report, 2016

HIV testing conducted not only in the hub centres [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 in all sub divisional level. In addition, HIV testing has always been a component of the outreach programs to the communities and also during carnivals or festivals in Fiji eg: Hibiscus Carnival.

Figure 2 below shows the cumulative total of HIV cases in Fiji since 1989. Fiji to date has a cumulative total of 740 cases.

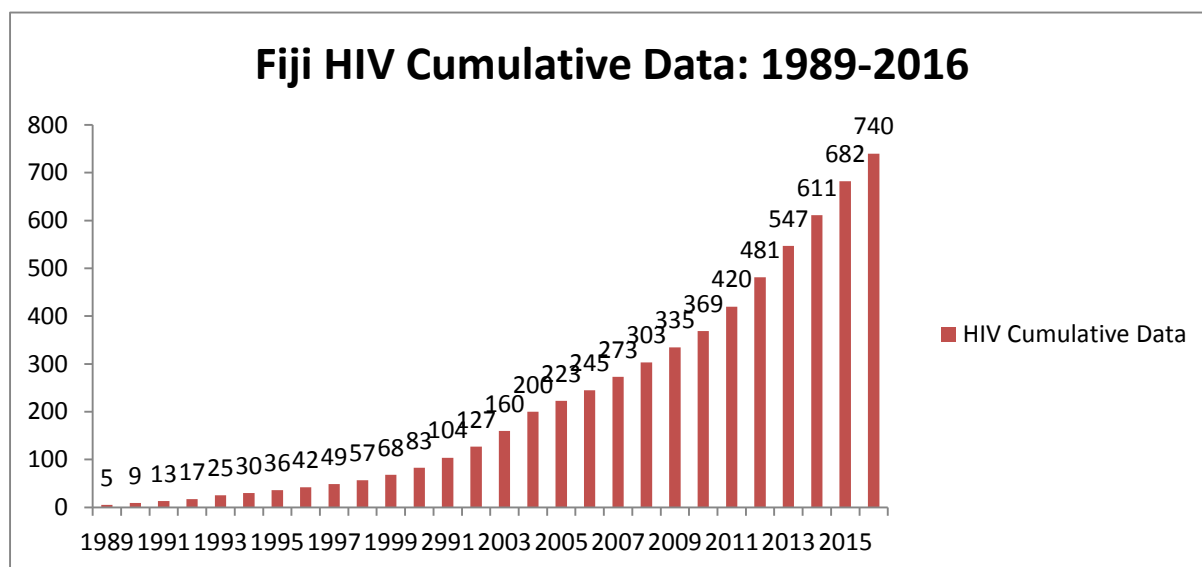


Figure 2: Fiji HIV Cumulative Statistics: 1989-2016<sup>4</sup>

Despite the global reduction in the number of new cases for HIV, the picture of Fiji is slightly different. The trend of the HIV infection in Fiji continues to increase especially amongst the 20-29 years followed by the 30-39 years as shown in figure 3. The HIV epidemic is disproportionately affecting young people.

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.

<sup>4</sup> Centre of Communicable Disease Control & Fiji HIV Online Report, December 2016

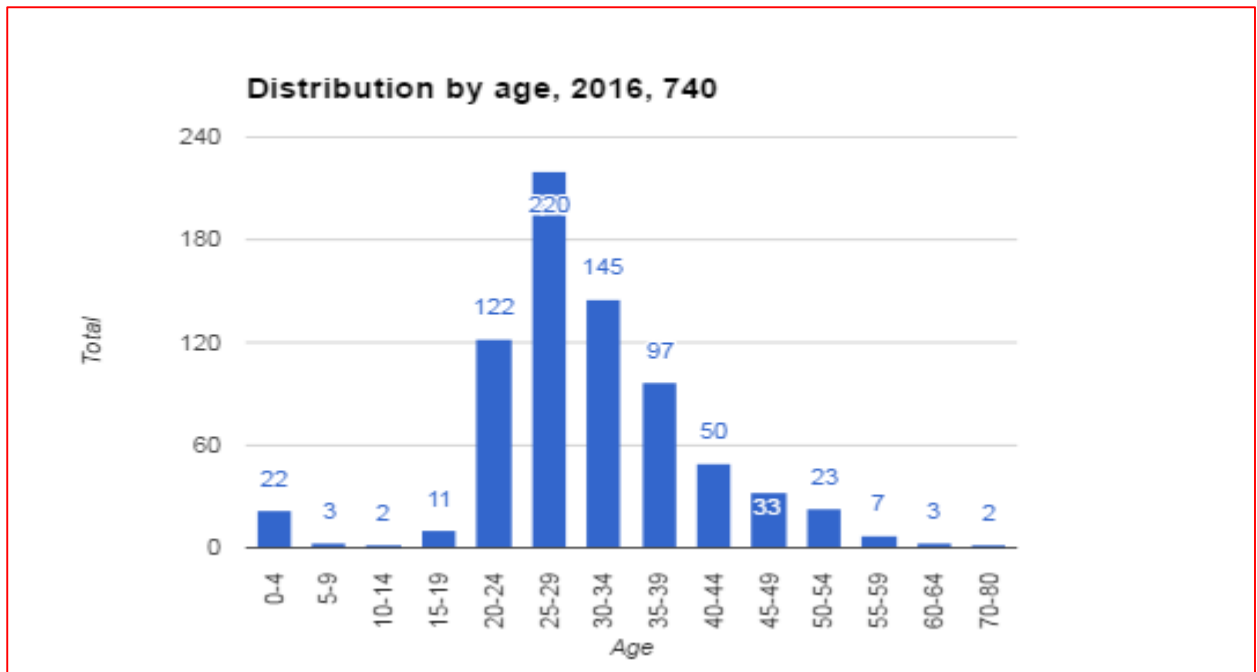


Figure 3: HIV Age Distribution in Fiji: 1989-2016<sup>5</sup>

With the introduction of the PPTCT program in 2010 and the PPTCT roll out to the sub divisions following the continuous PPTCT Practitioners Training, figure 4 shows a paradigm shift of the infection as compared in previous years where there were more males and fewer females. The increase in new HIV infections amongst women is a result of the HIV & STI compulsory screening for pregnant women during their antenatal care.

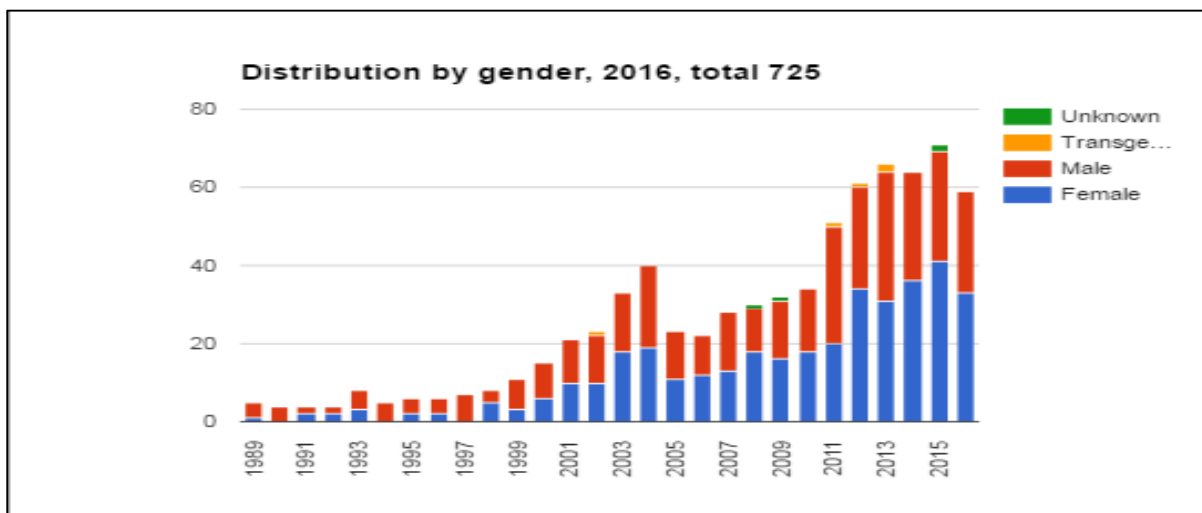


Figure 4: HIV Infection amongst Males, Females & Transgender: 1989-2016<sup>6</sup>

<sup>5</sup> Centre of Communicable Disease Control & Fiji HIV Online Report, December 2016

<sup>6</sup> Centre of Communicable Disease Control & Fiji HIV Online Report, December 2016

Since the identification of the first case in 1989 until to date, the rate of new HIV infections amongst the key population including MSM, transgenders, bisexuals and sex workers is very low 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.<sup>7</sup>

Figure 5 below shows the mode of transmission which is predominantly heterosexual [78.4%], followed by transmission through homosexual contacts [5.8%] and 3.2% of mother/parent to child transmission. The 10% unknown as reflected below are cases identified from previous years that had failed to disclose their sexual behaviour.

Fiji continues to strengthen its PPTCT programme especially in bridging gaps where children born from HIV positive mothers are appropriately followed up to prevent lost to follow ups – an issue of concern in HIV case management in Fiji.

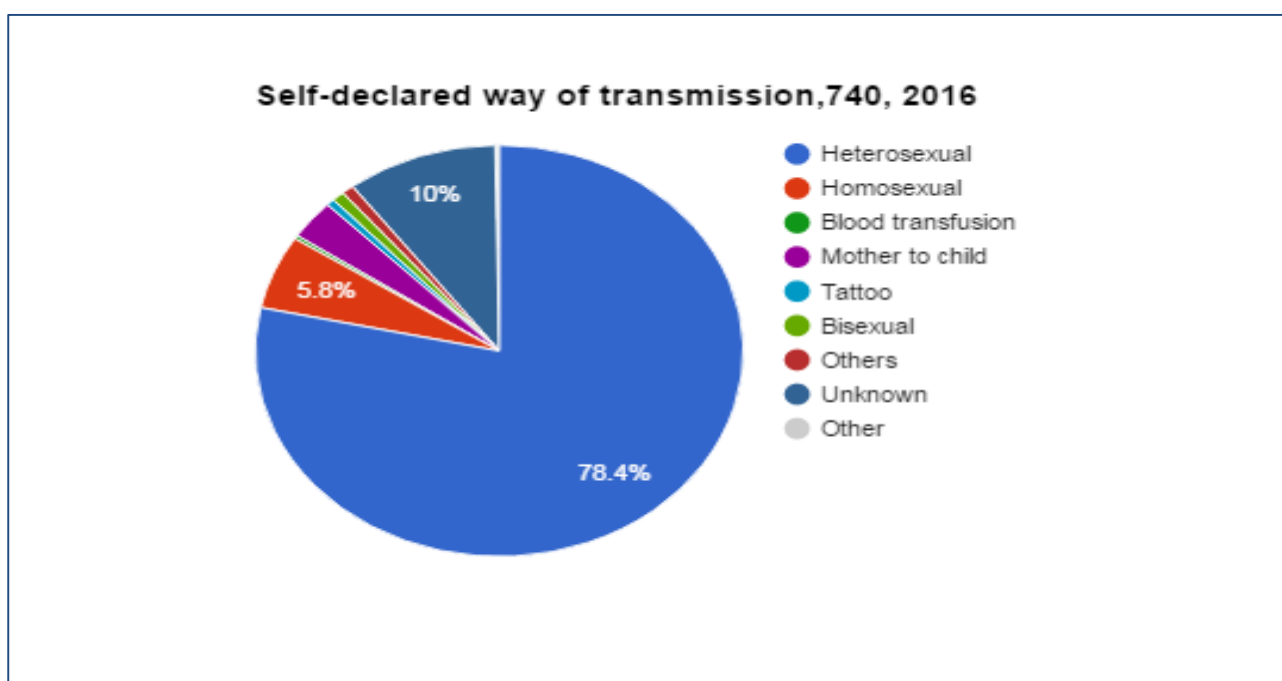


Figure 5: Mode of HIV Transmission: 1989-2016

Apart from the 3 main modes of transmission as shown in figure 5 above, there have also been reports of HIV infection through blood transfusion [BTF] – 0.2%, body piercing [tattoo] – 0.7%, a case of HIV transmission through sexual assault – 0.2%, bisexual of 0.7% and others – 1.3% .

<sup>7</sup> Integrated Biological Behavioral Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project, 2012.

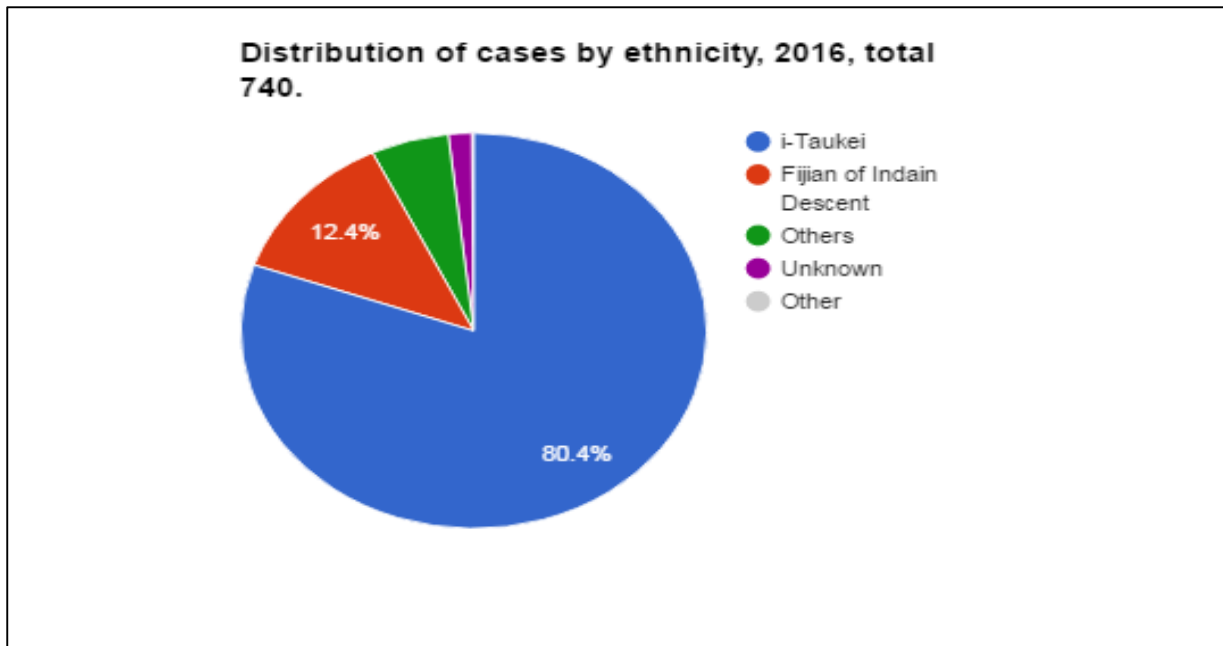


Figure 6: Rate of HIV Infection amongst Ethnicities: 1989-2016

Since 1989, the rate of infection amongst ethnicities has not changed. Figure 6 above shows that the i-Taukei population is predominantly affected [80.4%]. 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 where the population is mostly i-Taukei. 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. The HIV programme hopes to capture more Fijian of Indian Descent in 2017.

At the end of 2015, the 3 Sexual Reproductive Health Centres [also known as the hub centres] within the country reported a total of 173 HIV confirmed adult cases that were regularly accessing the clinic for their follow ups [figure 7] with a total of 13 Paediatric cases followed up at the paediatric hospital. This brings a total of 186 HIV confirmed cases having regular follow ups in Fiji at the respective health facilities. In 2016, there were 320 PLHIVs under care and regularly followed up in the clinic [figure 8].

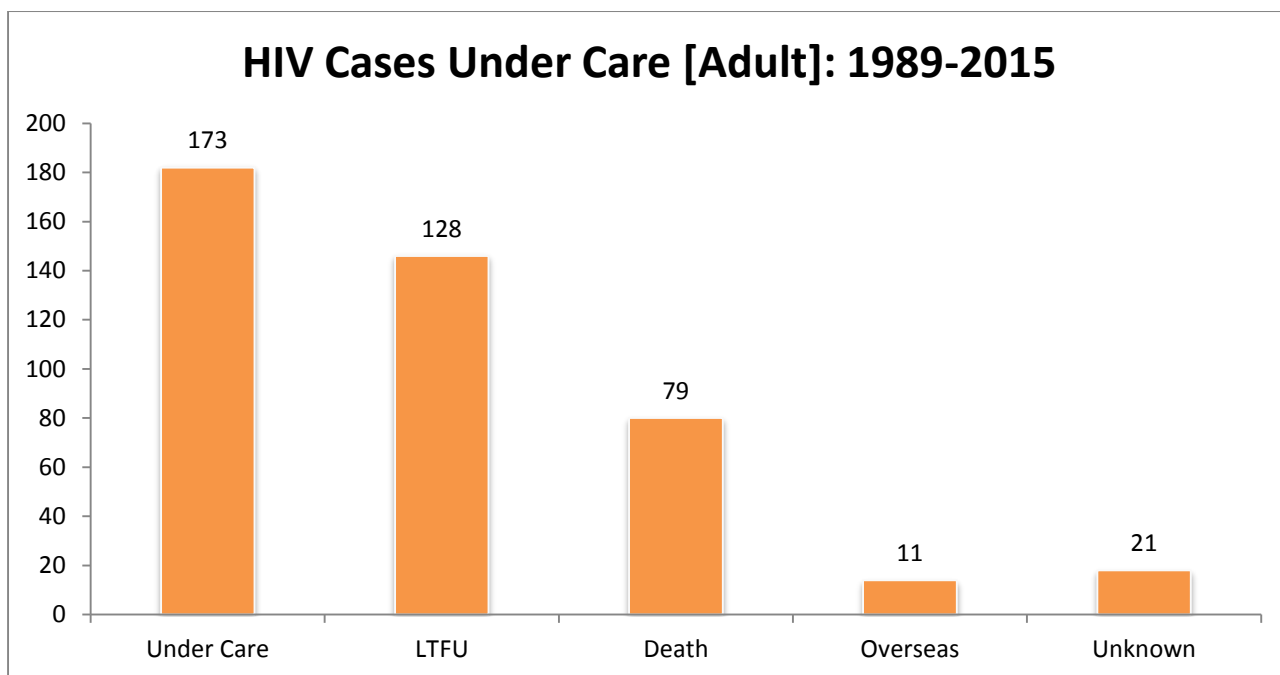


Figure 7: HIV Cases Under Care: 1989-2015

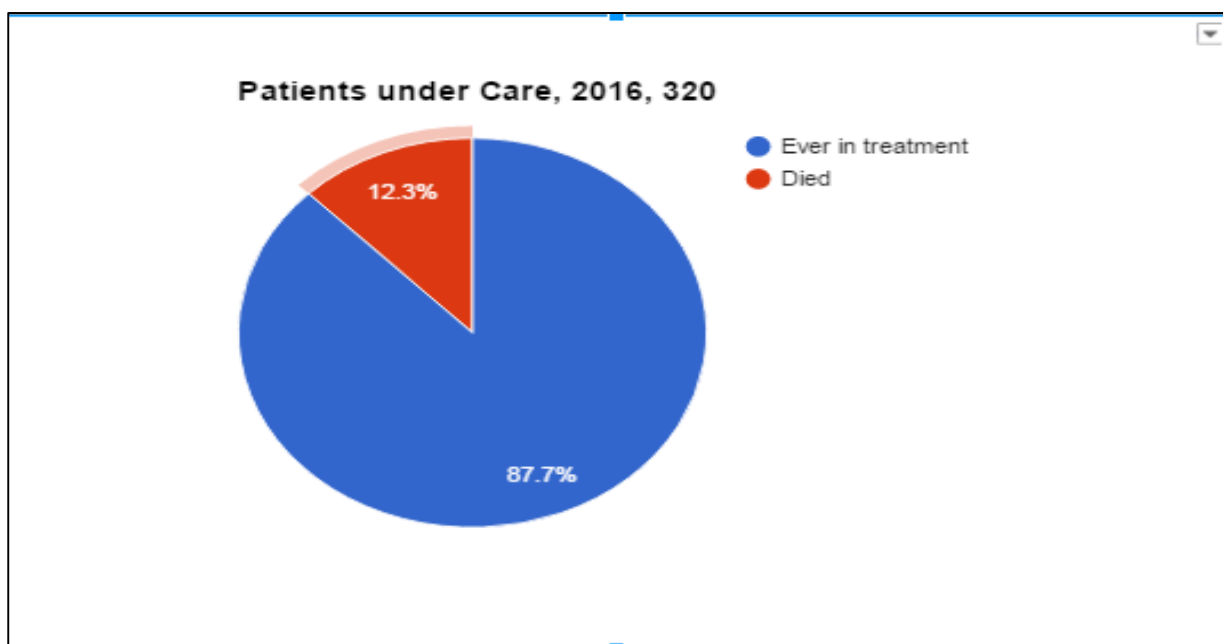


Figure 8: Total number of Patient in Care [2016]

Figure 9 below shows 30.6% of cases are categorized as lost to follow up [LTFU]. Some of these LTFU cases cannot be traced since they do not inform the clinic about their whereabouts. Some tend to give pseudo names during their first visit to the clinic and they fail to turn up for their results. This creates a problem for the hub staff to trace such patients. There are others who provide their personal information but fail to advise the clinic that they have relocated. There are some cases that have just defaulted clinics and have failed to turn up for their clinical follow up until they are really sick and need urgent medical care resulting in death when they are late. During the data validation and verification in 2016, it was also noted that more than 50% of

those categorised as LTFU were de-identified with unfamiliar codes not recognized by the current health service providers. Note that most of these de-identified cases were managed in the early years of the epidemic.

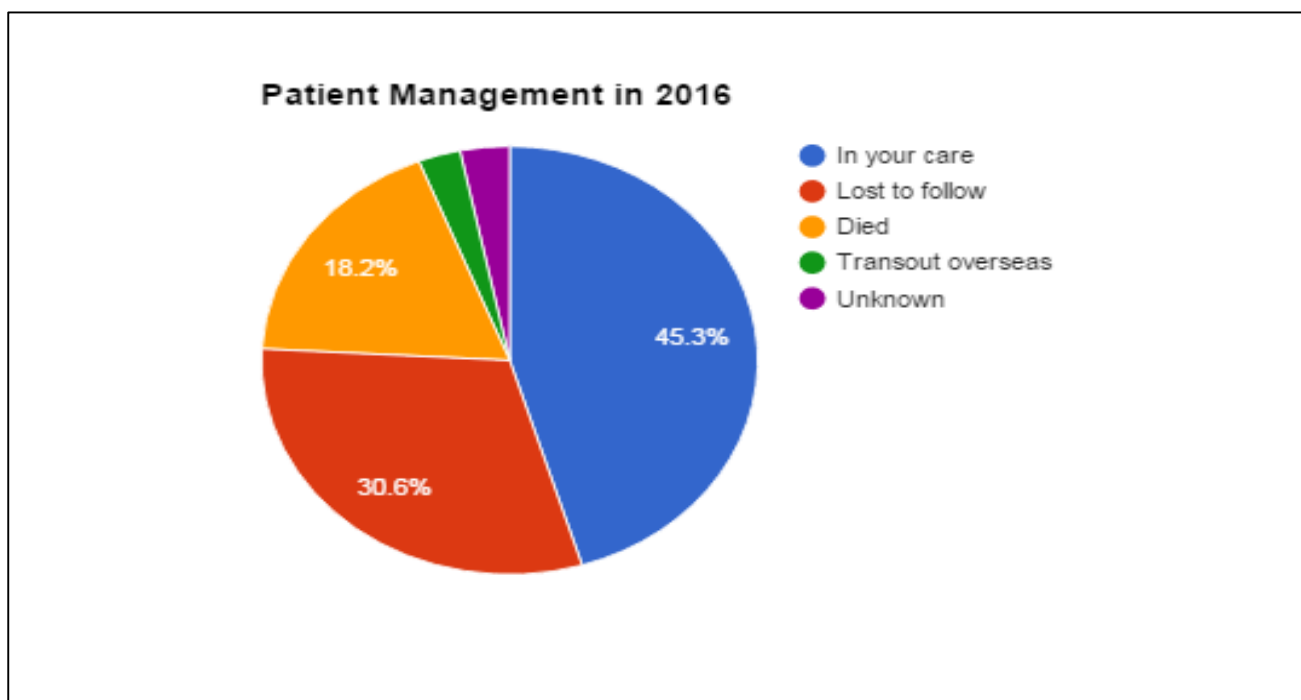


Figure 9: Percentage of HIV Cases on regular Follow Up: 1989-2016

The TB program is acknowledged for setting up a process to ensure that its TB cases are regularly followed up resulting in less LTFU cases. This best practice has been identified by the HIV program as a process which needs to be adapted to reduce the number of lost to follow ups within the HIV care and management program. This will also contribute to reducing the number of AIDS related deaths in the country and increasing the number of patients who needs to be on ART.

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. Fiji is committed to continue adhering to and implementing appropriate 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 the former Head of State and other government leaders.



The infection rate in the general adult population (15 to 49 year olds) is estimated to be approximately 0.12%.<sup>8</sup> 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,<sup>9</sup> “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, Mossman et al<sup>10</sup> report the zero HIV prevalence in female sex workers and 1.8% in transgender sex workers to give an overall prevalence of 0.7%.

### 3.0 National Response to the AIDS Epidemic

Prevention is a priority towards the HIV response in Fiji. The Fiji approach to prevention is a good example of what UNAIDS describes as “Combination Prevention”<sup>11</sup>. 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 behaviour change issues with peer educators or community leaders. For those wanting more time to think about whether their own behaviours place them at risk, information is provided in clinics which they can visit later on to receive counselling, 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. 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 following<sup>12</sup>:

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<sup>8</sup> UNAIDS & WHO – Epidemiological Factsheet, Fiji, 2010: accessed online on March 23, 2015 at <http://aidsinfo.unaids.org>

<sup>9</sup> 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the “Ten Targets” in Fiji Islands, 31<sup>st</sup> May, 2013

<sup>10</sup> 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.

<sup>11</sup> 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.

<sup>12</sup> Prevention Strategic Approach, National Strategic Plan for HIV & STI 2012-2015, Ministry of Health, Fiji.

- 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 “Meaningful involvement of people living with HIV” is applied within all programs. Currently, there are 3 HIV advocates based in the 3 hub centers in the country that are being 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. The Rainbow Pride Foundation – an organization that addresses human and gender based rights especially on MSM, transgender and sex workers, had provided complimentary services for the Health Ministry through condom promotion and distribution amongst the key populations in Fiji.

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.

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 behaviour 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, key populations including sex workers, MSM and transgenders are also target group. As compared to the previous NSP for STI & HIV in Fiji, the 2016-2020 NSP has strategies specifically focused on the sub-populations.

## **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.

There is a sex worker network that provide HIV and STI risk reduction information, condoms, and referrals to clinics, for sex workers including street kids and young people that access the drop in centre.

**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 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.

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 as<sup>13</sup>:

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<sup>13</sup> Sections 230-231 of Part 13 of the Crimes Decree, Crimes Decree 2009, Government of Fiji

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 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 counselling and they have the support of their FJN+ peers to help maintain safe behaviours. 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. This support group needs to be strengthened.

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 Counselling 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 counselling that enables the person receiving the test to give informed consent.

There has been a policy of provider-initiated counselling 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 - 250 nurses in counselling, many working in the sub-divisional and health centre level. In the antenatal clinics that do not have the EP/MOH partnership, the VCCT and PPTCT trained nurses 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 counselling, 100% 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 [option B plus]. Part of the PPTCT program is also focused on EID for infants – detecting the infection earlier for early treatment if required. Fiji acknowledges UNICEF for the procurement of a GeneXpert machine that has parameters for viral load, EID and TB testing.

The PPTCT counselling program continues to promote and strengthen 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
- Pediatric 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 [2013] – 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.

### *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 Centers around the country. In 2010 and 2011, an additional 28 people had started ART, bringing the total to 76. By the end of 2015 there were 259 eligible PLHIV who are on antiretroviral program. In 2016, 320 PLHIVs have started on ART. Fiji is now adapting the test and treat all approach which has been endorsed in principle but yet to be incorporated into the current ART guideline.

There were 6 TB/HIV co-infections in 2016 and the TB program has a 100% coverage on the management and treatment of these TB/HIV cases. The HIV programme needs to strengthen its TB screening and prophylaxis amongst its PLHIVs.

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, 2 medical officers' had attended 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. 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. There is also a GeneXpert machine available for viral load testing. Consistency of kit supplies needs to be more vigilant.
- d. Psychosocial support for PLHIV through the hub centers has been improved by the provision of counseling services through EP.
- e. 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 Psychosocial support for PLHIV and their families:**

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

As mentioned earlier in the report, provision of ART to all PLHIVs in Fiji is free – a continuous political commitment since the former Head of State [Ratu Epeli Nailatikau] was in leadership. This is a standing political commitment which has been in place since 2004.

Below are graphical illustrations of the status of HIV Treatment in Fiji from 2004 to December 2016.

Figure 10 below shows a graphical illustration of the number of cases who had started ART per year since 2004 until 2016. In the 1st few years of ART initiation, not many PLHIVs who were under care were put on treatment because of ART eligibility using the WHO criteria when ART was first introduced. More patients were recruited from 2012 onwards following the adoption of the 2013 WHO ART Guideline – CD4 count of 500 or less regardless of clinical staging.

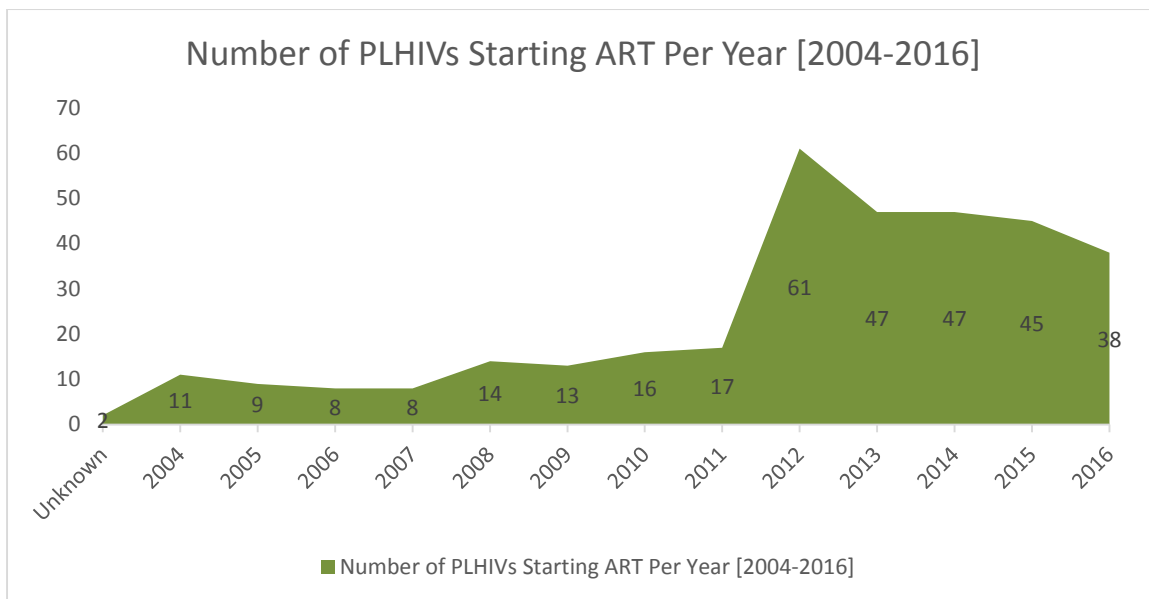


Figure 10: Number of Clients Starting ART per Year

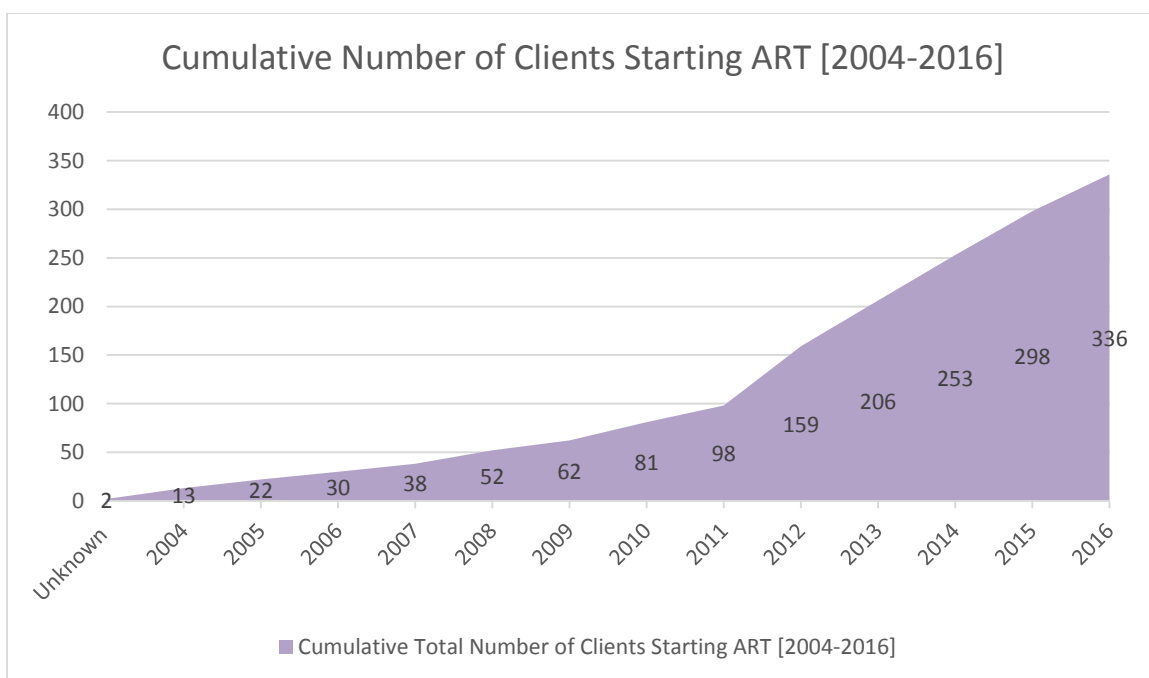
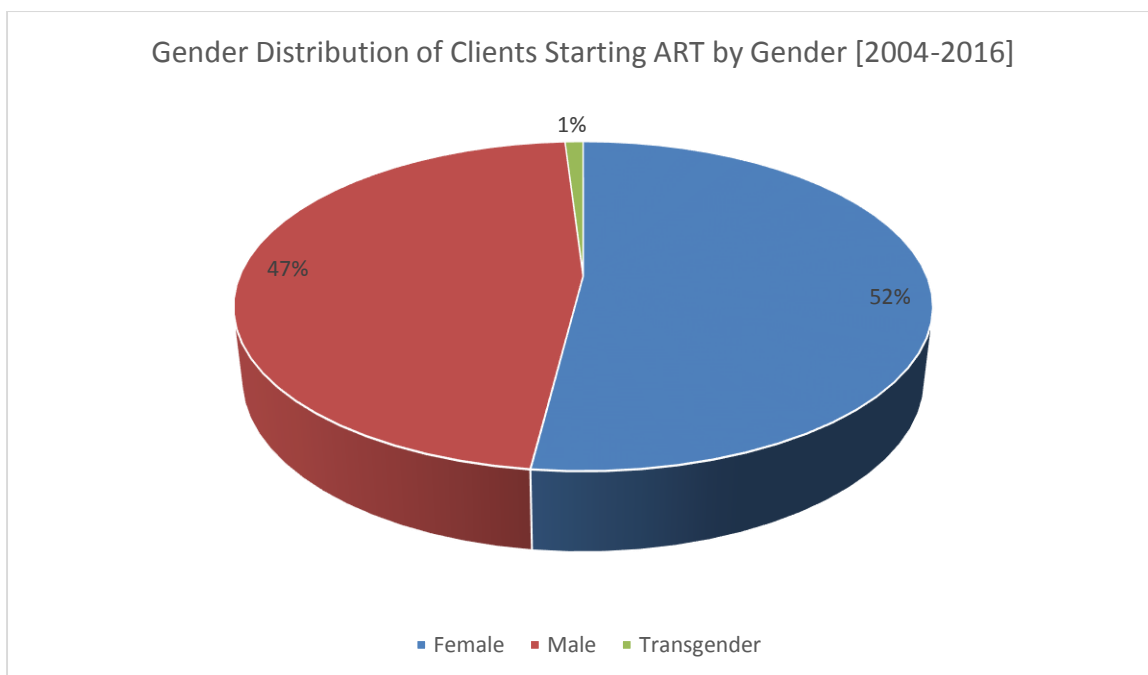


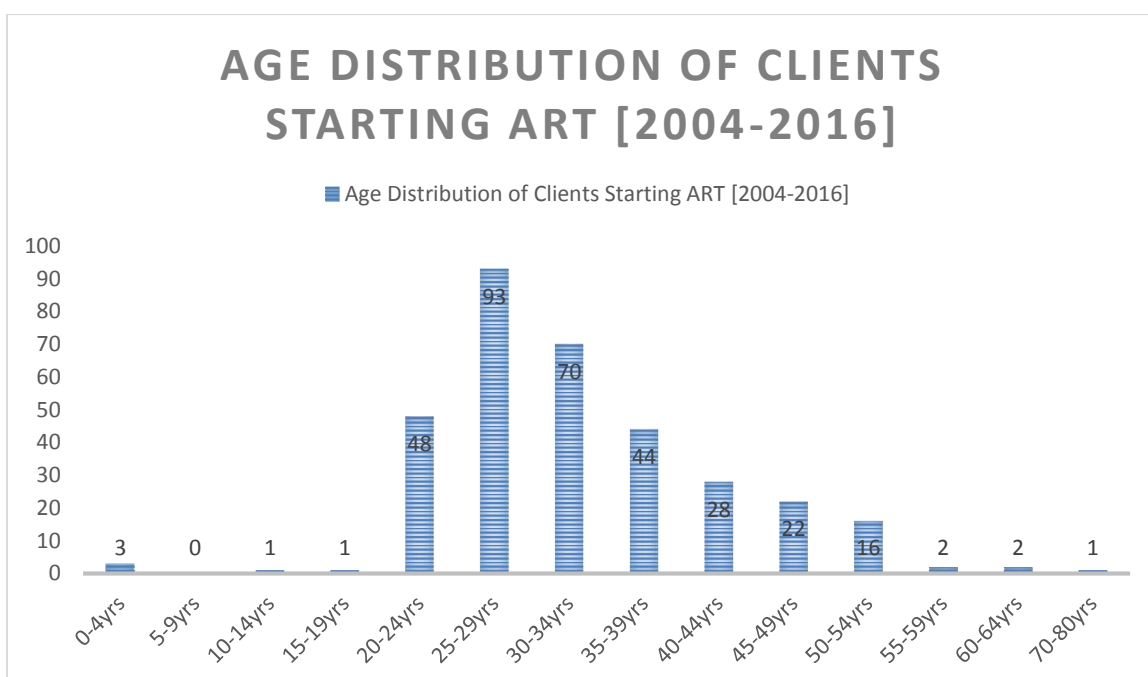
Figure 11: Cumulative Number of Clients Starting ART [2004-2016]

Figure 11 above shows the cumulative total of PLHIVs who had started on ART – a total of 336 cases. This is only 46% of the cumulative total of PLHIVs in Fiji. With the “Test and Treat” strategy that has been principally endorsed by the HIV/AIDS Board and also reflected in the 2016-2020 HIV & STI NSP, Fiji hopes to improve its ART coverage focusing on the 90-90-90 Treatment Strategy. Fiji also hopes to revise its treatment guideline in 2017 so that it will reflect the test and treat strategy.



**Figure 12: Percentage of Clients Starting ART by Gender**

Figure 12 above shows that since 2004, 52% of females, 47% of male and 1% transgender had started ART. Most of the females diagnosed were detected through antenatal clinic and were put on ART as part of PPTCT management since 2010.



**Figure 13: Age Distribution of Clients Starting ART [2004-2016]**

Figure 13 above shows that majority of clients who had started ART are between the ages of 25-34 years and also 35-39 years. This is also the predominantly affected age group in Fiji as shown in figure 3 [Overview of the AIDS Epidemic].

Out of the 337 cases who had started on ART, figure 14 below shows that 72% of these patients are still on ART until to the end of 2016. 19% has defaulted and other without any further information as noted from the Fiji HIV Patient Online Registry and 9% had died while on treatment.

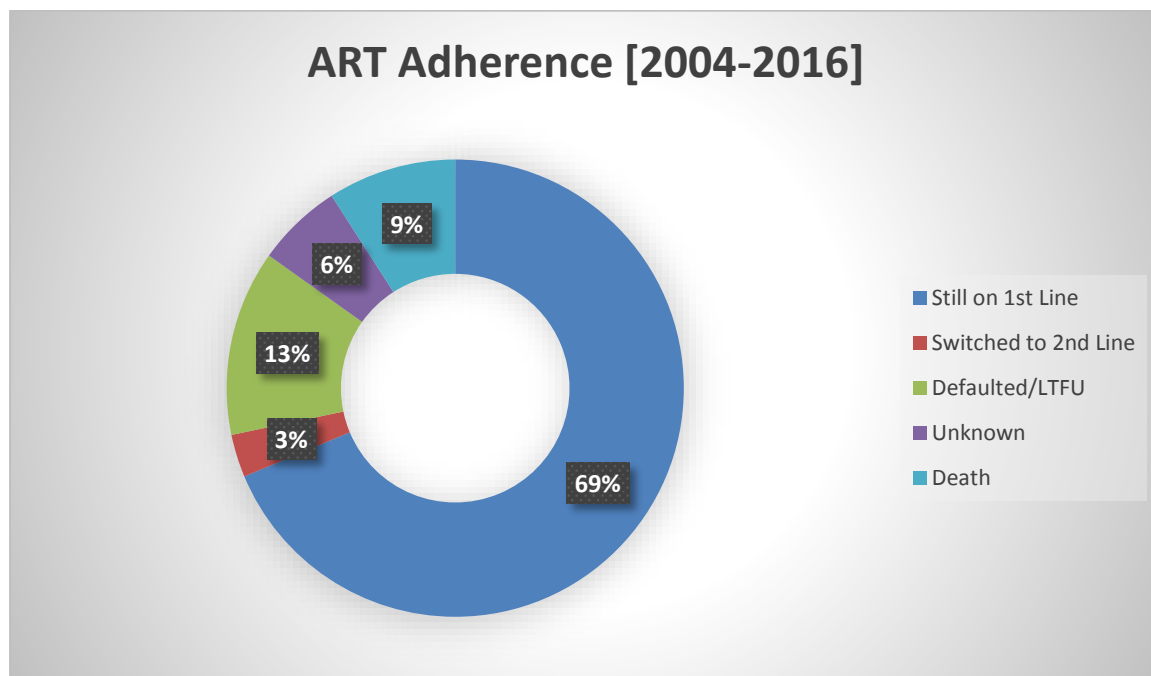


Figure 14: ART Adherence since 2004-2016

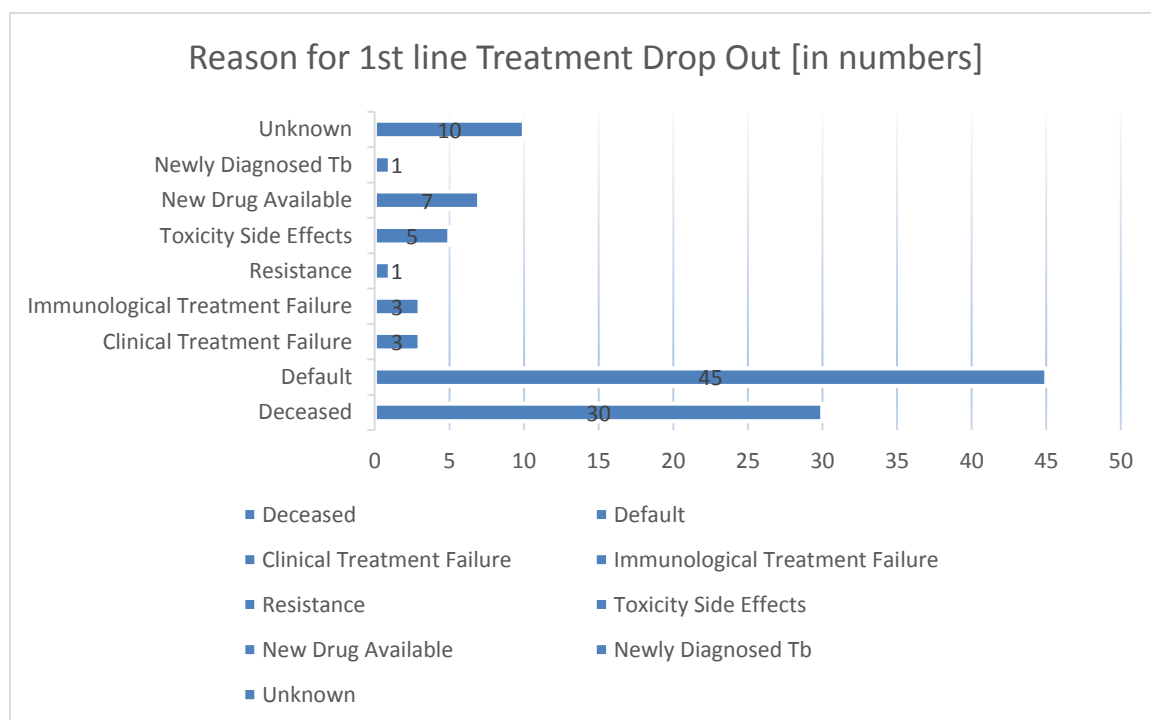
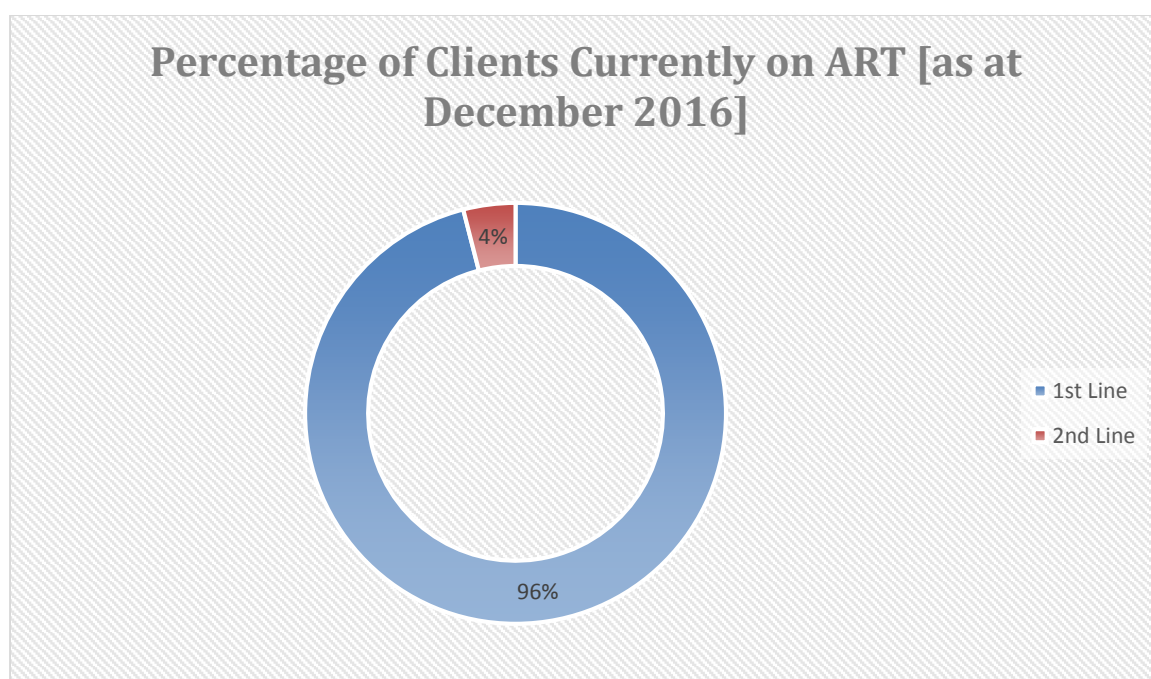


Figure 15: Reason for Dropping Out on 1st Line ART Treatment

For those cases that had stopped ART [1<sup>st</sup> line], apart from the 9% that had died, figure 15 above shows the reasons of stopping 1<sup>st</sup> line ART treatment. Majority had defaulted due to the following reasons; poor family support since client has not disclosed his/her status, financial problems which prevents them from coming to the clinic for follow up and ART replenishment, geographical locations of patients – not all cases are in the urban centers, some are in rural areas which makes it difficult to access health facilities especially during unfavorable weather conditions, the absence of medical officers as noted in the 2016 Fiji Stigma Index Survey is also a contributing factor to defaulters. Other patients as a result of long term side effects, drug toxicity and treatment failure were put on 2<sup>nd</sup> line regime until to date.



**Figure 16: Percentage of Clients on ART [1<sup>st</sup> & 2<sup>nd</sup> Line Regimen]**

Figure 16 above shows the percentage of clients who are still on treatment until December 2016. Currently there are 240 patients on ART [excluding those who have passed away and also the defaulters]. 96% are still on their 1<sup>st</sup> line regimen and 4% has switched to 2<sup>nd</sup> line due to treatment failure, drug toxicity and also the availability of a new drug [TDF/3TC/EFV].

Fiji targets to keep >90% of its patients on 1<sup>st</sup> line. Maintaining this target is an indication that patient management in Fiji while in care is very good.

For the 9% that had passed away, figure 17 and 18 shows the number of deaths per year while on treatment and also the cause of death. 77% were AIDS related as a result of clients presenting to the clinic late. The fear of the unknown and also stigma and discrimination in the early years of ART initiation was high which made it difficult for patients to be compliant with their drugs which led to some stopping their treatment resulting in death.

In the late 2012 and early years of 2013, a lot of patients who were on ART had resorted to faith healing and traditional healing resulting in their clinic default, increase in OIs which had also contributed to their deaths.

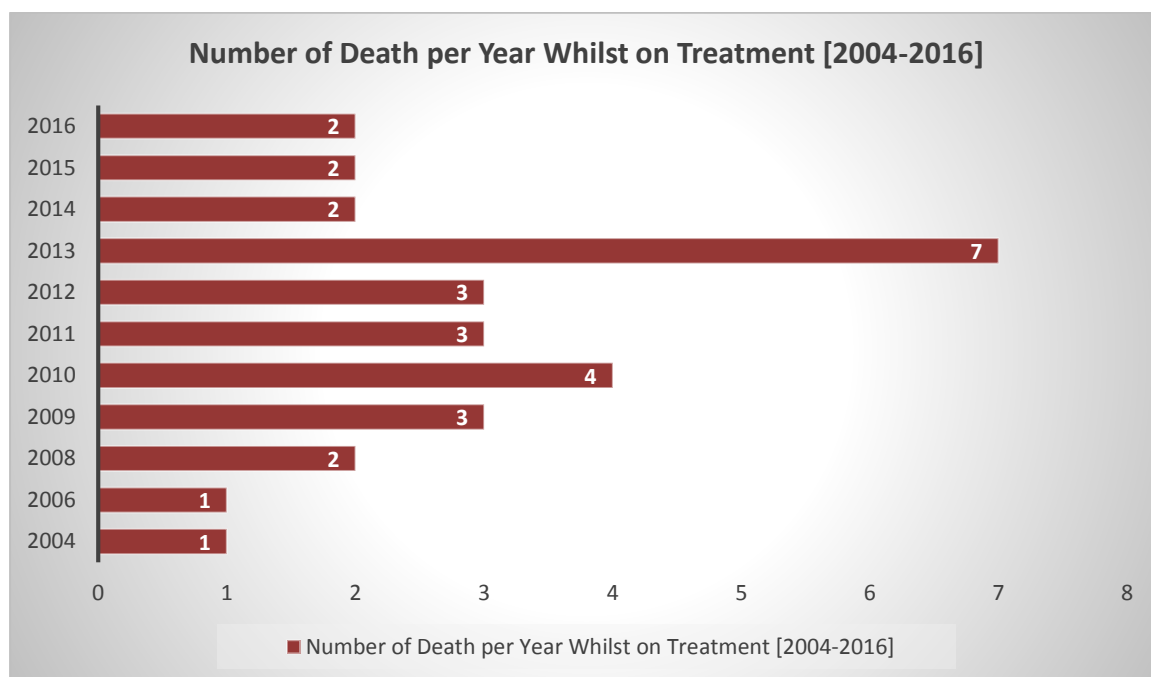


Figure 17: Number of Deaths per Year While on Treatment [2004-2016]

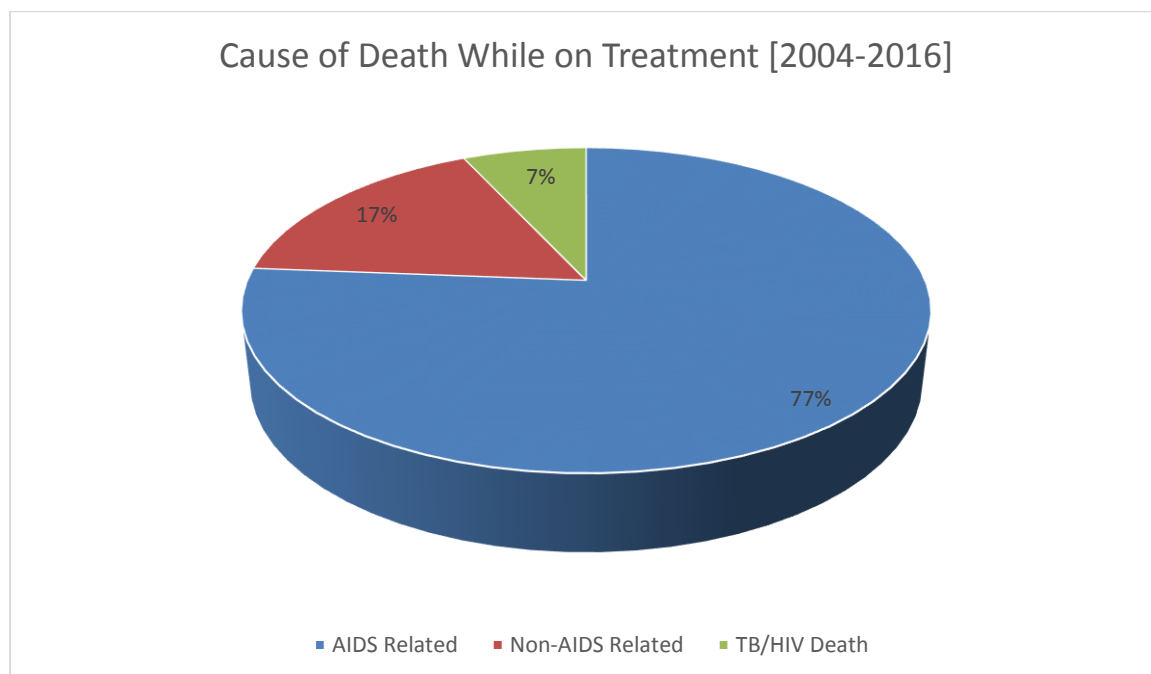


Figure 18: Cause of Death While on Treatment

Fiji currently has 3 hub centers within the 3 divisions that looks after all PLHIVs in the country. These centers also provide ART [supplies received from FPBS] for all clients in care within the mainland and also in the maritime. The hub staff also take their time to do home visits and replenish patients ART in their individual homes upon client's request. Public buses are also used to transport ART to patients in the rural and coastal areas upon client's request. Drugs are safely packed and sealed in small boxes and the bus drivers are responsible in dropping these drugs.

Fiji Pharmaceutical & Biomedical Services [FPBS] is a division of the Ministry of Health that regulates medicinal products. ART for the three hub centres are supplied through FBS on a quarterly basis.

## 5.0 COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

PMTCT represents a unique and convenient entry point for HIV care and treatment services, not only for women and their infants but also for sexual partners and other family members. HIV prevalence among antenatal attendees is typically higher than that found in the general population.

Fiji screens all its pregnant women accessing the antenatal clinic for HIV and other STIs. This is part of the routine screening for all pregnant women. HIV and STI screening is normally done during the 1<sup>st</sup> booking after a group counselling done by Empower Pacific.

The PMTCT programme had started in 2010 with Fiji's first PMTCT/PPTCT policy which was revised again in 2013 incorporating Option B plus for all newly diagnosed HIV positive pregnant women.

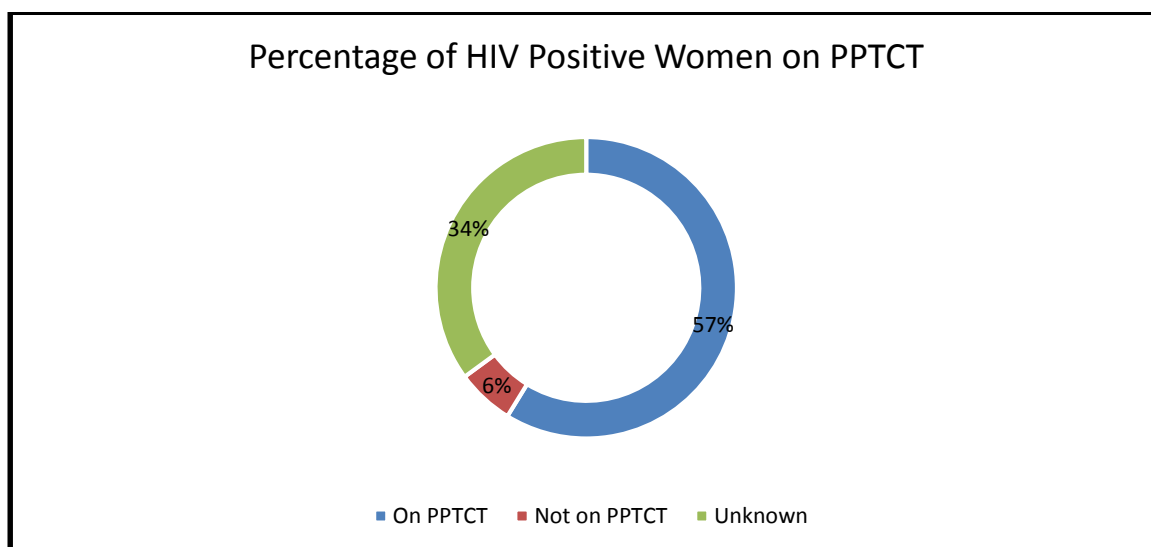


Figure 19: Percentage of HIV Positive Women on PPTCT

From a total of 364 HIV positive females, 38 were diagnosed from the antenatal clinic during antenatal care. 57% had undergone PPTCT care, 6% were not managed and 34% had no records of their PPTCT history during their pregnancy [figure 19].

Figure 20 below shows the total number of HIV positive pregnant women and the total number HIV positive babies born from HIV positive women in a particular year. Note that in some years [eg 2003 & 2014], the number of HIV positive babies were more than the number of HIV positive pregnant women. Fiji currently in the past years sends samples to Australia for EID on babies born from HIV positive mothers. Turnaround time of these EID results are delayed which can be more than 3 – 6 months hence treatment for babies are delayed. With the provision of a GeneXpert machine at the end of 2015, Fiji hopes to start conducting EID tests locally. This will prevent delay in diagnosis and treatment.

The PPTCT programme has immensely improved in 2015 and 2016. PPTCT coverage for 2015 was 88% and 2016 was 100%. PPTCT is an area that the HIV programme in Fiji is targeting to sustain its 100% coverage. This is only possible if PPTCT management at antenatal care and post natal care including pediatric follow up is strengthened.

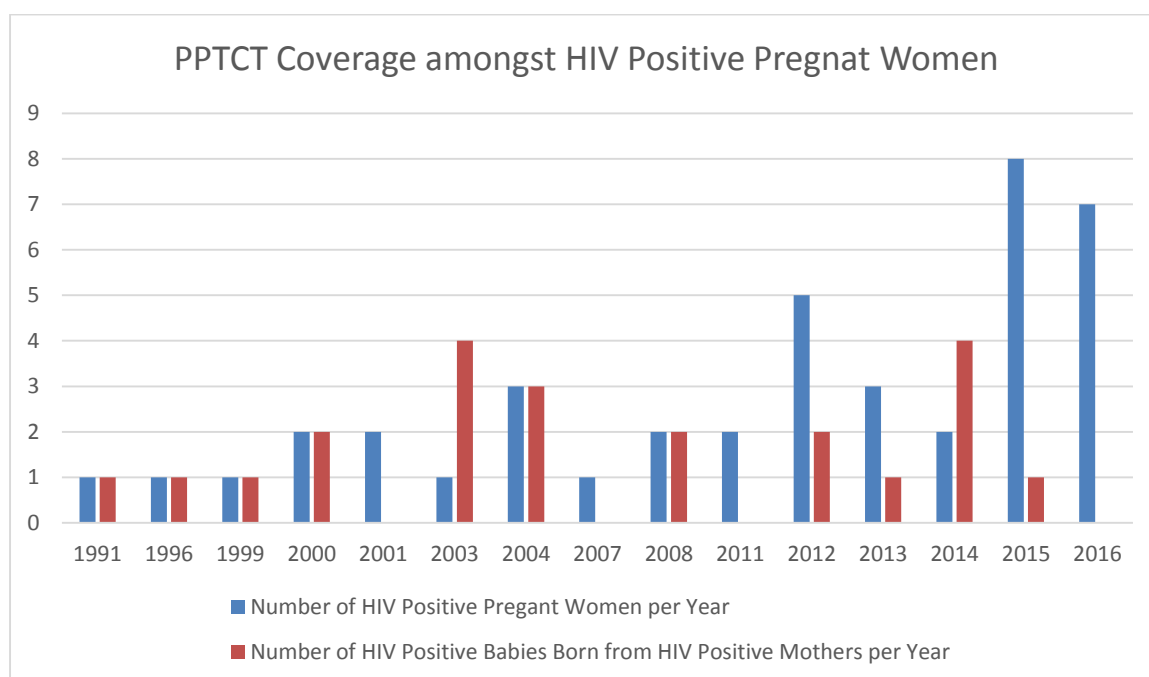


Figure 20: PPTCT Coverage amongst HIV Positive Pregnant Women

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



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 behavioural risk in prisons

#### 6.1 Integrated Biological and Behavioural Study for Sex Workers 2012:

In 2012, an integrated biological and behavioural 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 behaviour around safer sex practices. The following information on the research is extracted from the Integrated Biological Behavioural 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 centres (Suva, Nausori, Lautoka, Ba, Nadi, Labasa, Savusavu); and (ii) an integrated biological and behavioural surveillance (IBBS) survey administered to 298 sex workers. Biological samples provided by the sex workers were tested for HIV, Hep B, syphilis, chlamydia and gonorrhoea.

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.

### 6.2 Integrated Biological and Behavioural 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 gonorrhoea (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. <sup>14</sup>

### 6.3 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.

### 6.4 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,

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<sup>14</sup> WHO WE ARE; An exploration of the sexual practices and HIV Transmission of men who have sex with men and transgender population in Fiji.

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.

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

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.<sup>15</sup>

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,

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<sup>15</sup> Reference Fiji Women's Crisis Centre 2013, Somebody's Life, Everybody's Business.

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.<sup>16</sup>

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 workers in this area will be instrumental in addressing violence

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<sup>16</sup> Somebody's Life, Everybody's Business Survey 2013, FWCC.

against women in Fiji. This provides prophylaxis to women and girls exposed to penetrative sexual violence for HIV and other Sexually Transmitted Infections.

### 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 behaviours 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.<sup>17</sup>

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.

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.

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<sup>17</sup> McMillan K, Worth H, Risky Business: sex work & HIV Prevention in Fiji. Sydney, International HIV Research Group, UNSW, 2009

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 UNDP<sup>18</sup>. 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.

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

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<sup>18</sup> 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.

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 and one which was recently conducted in 2016, 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.

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

Instruction: This section should cover the detailed status of the young people in your country , usually the information comes from Knowledge attitudes and practices studies, otherwise provide a description of how young people are educated in your country about HIV, STI, condoms, pregnancy prevention. How religion and culture influences usage of condoms and contraception, what is the age when young people can access medical services without consent.

Research on the experiences of HIV positive women was reported by the Pacific Islands AIDS Foundation (PIAF) in 2011<sup>19</sup>. 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

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<sup>19</sup> 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.

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 2011<sup>20</sup>. 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.

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 an “In-School HIV Policy” in place [currently under review] 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 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. The education ministry works hand in hand with the health ministry and other

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<sup>20</sup> UNDP. Me, My intimate Partner and HIV: Fijian self-assessment of Transmission risks. Suva, UNDP, 2011



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 build-up 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 2016 and beyond.

## **9.0 COMMITMENT 8: Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable**

The total expenditure of the AIDS program from all sources for 2016 is shown below. The contribution from the Fiji government is \$350,000.00FJD. This covers both operational and administration costs for the Ministry of Health and also for any NGO or CSO that applies for financial assistance to implement HIV related activities aligned to the NSP.

As compared to 2015, financial commitment for HIV related activities [figure 22] was 56% domestic and 44% donor funded. Most of the donor funded activities was focused on PPTCT management and strengthening HCT in the country with support also to the sub populations.

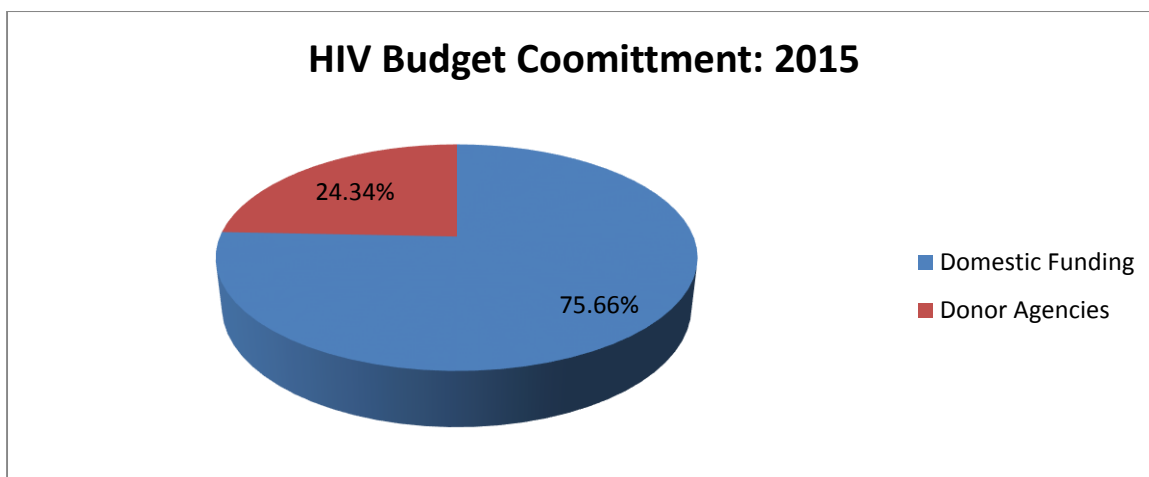


Figure 21: Financing Sources for Fiji

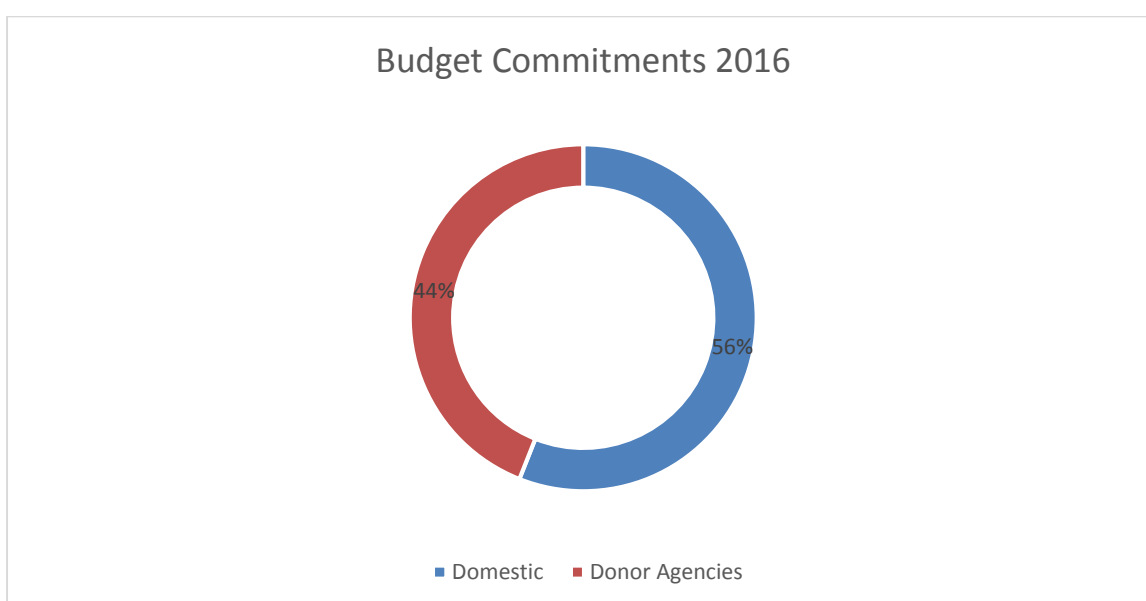


Figure 22: 2016 Budget Commitments

The bulk of expenditure in the AIDS Spending Category is attributed to Prevention [Target 1] – Table 1 and figure 23].

ASC	Amount (\$)
Target 1: Treatment, Care & Support	\$154,972.00
Target 2: Prevention of Vertical Transmission of HIV	\$77152.00
Target 3: Prevention	\$355660.00
Target 7: Community Mobilization	\$32224.00
Target 8: Government & Sustainability	\$121450.00
Target 9: Critical Enablers	\$10235.00

Table 1: AIDS Spending Contribution

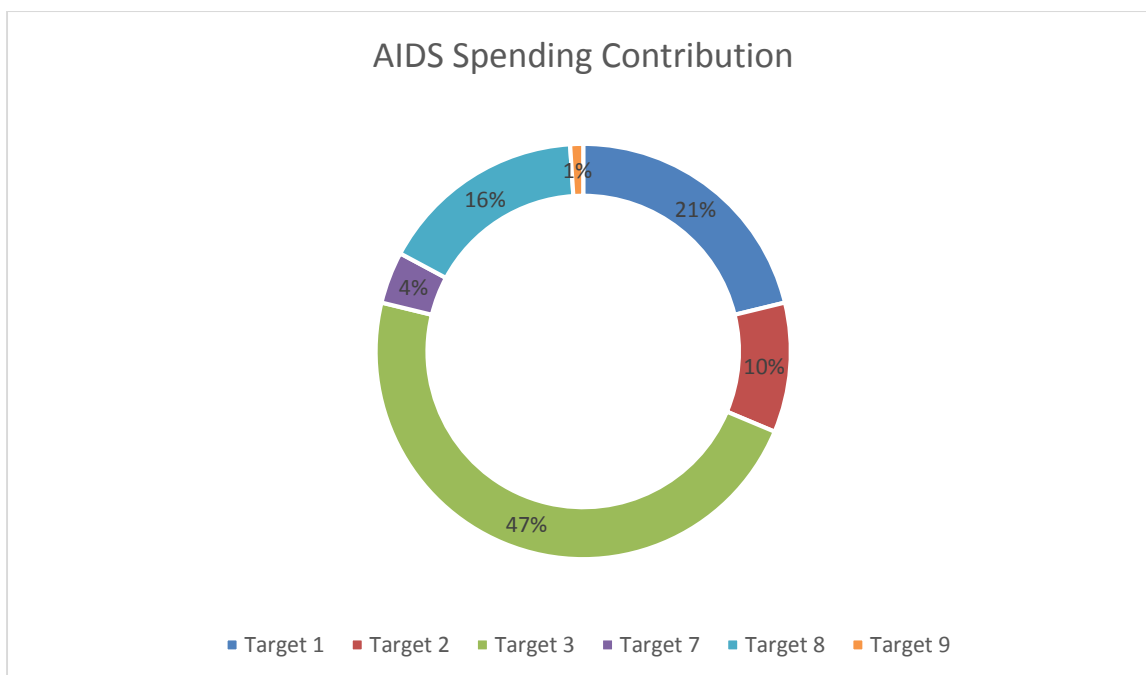


Figure 23: AIDS Spending Contribution 2016

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

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
- Pediatric AIDS treatment
- HIV testing and counselling for people with TB
- Psychosocial support for PLHIV

The TB program in Fiji has a 100% coverage on its TB cases who are diagnosed HIV positive as well. The HIV programme needs to strengthen its TB support programme.

Fiji will need to strengthen its screening for cervical cancer amongst its HIV positive women.

With the increase of Hepatitis B in Fiji and also chronic liver diseases, there is a taskforce with WHO support that is putting together a Hepatitis Policy and hopefully a strategic plan to address Hepatitis in the country.

## 11.0 The Situation with Human Rights in relation to HIV

The 2016-2020 NSP on HIV & STI for Fiji has 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.<sup>21</sup> The GUIDING PRINCIPLES of the NSP were focused on the following;

1. Universal health coverage.
2. Government stewardship and accountability.
3. Evidence-based interventions, services and policies.
4. Protection and promotion of human rights, gender equality and health equity.
5. Partnership, integration and linkage with relevant sectors, programs and strategies.
6. Meaningful involvement of people living with HIV, key populations and affected communities.

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.

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.<sup>22</sup>

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

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<sup>21</sup> Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015

<sup>22</sup> HIV/AIDS [Amendment] Decree 2011

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.

## 12.0 Best Practices

### 12.1 The HIV/AIDS [Amendment] Decree 2011:

The enactment of Fiji's HIV/AIDS Decree on 4th February 2011 signalled 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 3<sup>rd</sup> 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 counselling.

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 cabinet 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.

### 12.2 Former Head of State as Leading Example:

The former Head of State Ratu Sir Epeli Nailatikau, is in his 7<sup>th</sup> 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. He was also nominated at the end of 2015 as the UNAIDS Goodwill HIV Ambassador for the region.

Locally, he had 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.

The former 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 2016 WAD commemoration and the launch of the 2016-2020 NSP on HIV & STI, in attendance during the National CSO & Key Populations Capacity Building on HIV Programming, National Consultation on the Zero Draft on Ending AIDS as its Chairman to name a few.

Regionally, Ratu Epeli Nailatikau has been a part of the HLM HIV meetings in New York and also the IAS Conference in Durban, South Africa as an invited speaker to a few sessions.

The commitment and the passion that the former Head of State continues to show 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.

### 12.3 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, defence 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. The HIV programme hopes to have its budget increased in 2017.

#### 12.4 HIV Confirmatory Testing and Treatment:

HIV testing is now available at 11 sub divisional health facilities and the 3 divisional hospitals. This is to ensure that HTC is available and accessible. This is also made possible through mobile outreach programs during carnivals and those conducted by supporting NGO's. Plans are in place to roll out the new HIV Algorithm to other remaining testing sites following baseline assessment.

#### 12.5 Multi-sectorial Approach:

As compared to previous years, the greater involvement of key populations, 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 and most importantly the development of the 2016-2020 NSP on HIV & STI.

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

A gap identified in 2013-2014 has been strengthened in 2015 and has been sustained – greater involvement of the faith based organizations in the HIV response. This is not only reflected in their membership as part of the HIV/AIDS board but they have also been actively involved in the planning and development process of the NSAP, WAD and other HIV related meetings.

#### 12.6 PPTCT Program:

Provider initiated counselling 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 counselling, 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 counselling to each pregnant woman. With the assistance of EP, they have provided counsellors to provide either a one-to-one or group counselling before HIV screening is conducted [provided a patient consents].

The antenatal counselling 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 counselling 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.

#### 12.7. 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.

## 13.0 Major Challenges and Remedial Actions

### 13.1 Progress Made on Key Challenges Reported in the 2015 Country Progress Report:

The following is an update on the challenges reported in the 2016 Progress Report;

1. Provision of friendly facilities to accommodate the sub populations especially sex workers: in 2016 Medical Services Pacific and the Reproductive and Family Health Association of Fiji have been providing complimentary SRH services to the sub populations. Mobile clinics are also conducted in partnership with the hub centers. There is also a drop in center in operation facilitated by sex workers for sex workers.

There is still room for improvement in addressing the SRH, HIV & STI needs of the sub populations especially building their confidence to attend public clinics for follow consultation and follow up.

2. The 2016-2020 NSP has bridged the gap by specifically identifying targeted activities for each sub population.



3. A training was conducted for CSOs and key populations in 2016 [mid-year] to assist them in putting together activity plans as a team. MSM and transgenders were able to consult each other in developing an activity plan whilst the sex workers developed theirs.

### 13.2 Challenges during the Reporting Period:

- a. Although there are funds committed from donor agencies for HIV related plans, accessing these funds was impossible due to the change in financial reporting process by donor agencies. A programme will not be able to access its funding if another program has not liquidated its activities. This process delays planned activities, hence committed domestic funds is accessed.
- b. Continuous absence of medical officers from the hub centers which affects the management of PLHIVs a contributing factor to increase in LTFU of cases who are currently under care.
- c. Financial Gap will be experienced continuously especially with slim financial donor support.

### 13.3 Strategies to Strengthen the HIV response in Fiji

1. **Intergrated Service Delivery:** delivery of effective, safe, high-quality integrated health interventions to those infected and affected including key populations, women and young girls, adolescents and young adults.
2. **Consistent Leadership and Governance:** ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, appropriate regulations and incentives, attention to system design and accountability
3. **Financing:** increase domestic funding to assist in the mobilization of adequate resources for the targeted populations including pooling of resources to foster efficiency and spread costs and allocation of resources to produce tangible results.
4. **HIV Treatment and Management:** equitable access to ART not only at the hub centers but decentralizing ART access points and ensure that all PLHIVs are managed in line with the Test & Treat Strategy. Also ensure that all PLHIVs have viral load tests done.
5. **Strategic Information and Advocacy Materials:** production, analysis, dissemination and use of reliable and timely information on SRH, HIV, STI and other related information.

6. **Human Resources:** ensuring a sufficient number and mix of staff are available who are efficient, responsive and competent to achieve the best health outcomes possible for those infected and affected given available resources and circumstances.

## 14.0 Support from the Country's Development Partners

In 2016, Fiji through its HIV response has been receiving technical and financial support from UNAIDS, UNICEF and also WHO. Support included the following; procurement of CD4 cartridges for CD4 testing, HCT consumables for the hub centres and the laboratories, workshop and conference attendance of Fiji representatives including Ratu Epeli Nailatikau [former Head of State of Fiji who is UNAIDS Goodwill Ambassador for the Pacific Region], M&E Training and the establishment of the Fiji HIV Patient Online Registry to name a few.

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 especially in achieving the 90-90-90 Fast Track Target and ending AIDS as a public health threat by 2030.

## 15.0 Monitoring and Evaluation Environment

Following the development of the Fiji NSP on HIV & STI, its next step before the end of 2017 is to revise the current 2012-2015 M&E Framework so that it is aligned to the 2016-2020 NSP.

There is a National M&E technical working group endorsed by the Fiji HIV/AIDS Board and also chaired by one of the Board members. The role of the technical working group is to develop M&E tools to assist HIV implementers [both private and public partners] in monitoring and evaluating their activities.

A capacity building on HIV M&E was conducted in 2016 through UNAIDS technical support – this training has allowed the stakeholders to be more appreciative of the M&E concept and the importance of conducting M&E as part of system strengthening.

The Fiji Ministry of Health and Medical Services has a Policy & Planning Unit which monitors all activities implemented as per MoHMS strategic plan, but there is no M&E focal person solely available for the HIV & STI programme.

The M&E component of the HIV programme in Fiji is an area that needs to be strengthened in 2017. M&E results will benefit the programme implementers and especially the decision makers in making strategic decisions and bridging gaps for the response in HIV & STI in Fiji.

## BIBLIOGRAPHY (SOURCES)

1. HIV and AIDS Data Hub for Asia and the Pacific, December 2015 accessed on the 12<sup>th</sup> March, 2017 at <http://www.aidsdatahub.org/Country-Profiles/Fiji>
2. Centre for Communicable Disease Control , Fiji Ministry of Health & Medical Services, December 2016
3. HIV Online Data report, 2016
4. Centre of Communicable Disease Control & Fiji HIV Online Report, December 2016
5. Centre of Communicable Disease Control & Fiji HIV Online Report, December 2016
6. Centre of Communicable Disease Control & Fiji HIV Online Report, December 2016
7. Integrated Biological Behavioral Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project, 2012.
8. UNAIDS & WHO – Epidemiological Factsheet, Fiji, 2010: accessed online on March 23, 2015 at <http://aidsinfo.unaids.org>
9. 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the “Ten Targets” in Fiji Islands, 31<sup>st</sup> May, 2013
10. 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.
11. 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.
12. Prevention Strategic Approach, National Strategic Plan for HIV & STI 2012-2015, Ministry of Health, Fiji.
13. Sections 230-231 of Part 13 of the Crimes Decree, Crimes Decree 2009, Government of Fiji
14. WHO WE ARE; An exploration of the sexual practices and HIV Transmission of men who have sex with men and transgender population in Fiji.
15. Reference Fiji Women’s Crisis Centre 2013, Somebody’s Life, Everybody’s Business.
16. McMillan K, Worth H, Risky Business: sex work & HIV Prevention in Fiji. Sydney, International HIV Research Group, UNSW, 2009
17. 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.
18. 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.
19. UNDP. Me, My intimate Partner and HIV: Fijian self-assessment of Transmission risks. Suva, UNDP, 2011
20. Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015
21. HIV/AIDS [Amendment] Decree 2011