

Global AIDS Progress Report 2012

Fiji Islands



Reporting period: January 2010 – December 2011

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Abbreviations

ADRA	Adventist Development Relief Agency
ANC	Ante Natal Clinic
ART	Antiretroviral Therapy
ATFF	AIDS Task Force of Fiji
CD4	Cluster of Differentiation 4 (a CD4 count is a proxy indicator of the state of the immune system)
CWM	Colonial War Memorial Hospital
FASANOC	Fiji Association of Sports and National Olympic Committee / International Olympic Committee
FBOs	Faith Based Organisations
FijiSTAHS	Fiji Students Stand Against HIV and AIDS
FJN+	Fiji Network of People Living with HIV
FLE	Family Life Education
FNU	Fiji National University
FRCS	Fiji Red Cross Society
FSPI	Foundation of the Peoples of the South Pacific International
FWCC	Fiji Women's Crisis Centre
GDP	Gross Domestic Product
GNI	Gross National Income
Global Fund	Global Fund for AIDS, Tuberculosis and Malaria
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioural Surveillance
IPPF	International Planned Parenthood Federation
MEN-Fiji	Men's Empowerment Network of Fiji
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men who have sex with men
MTCT	Mother To Child Transmission
NACA	National Council on AIDS (Peak body of last strategy, to be replaced now by the new HIV/AIDS Board)
NASA	National AIDS Spending Assessment
NGO	Non Government Organisation
NRL	National Reference Laboratory (Australia)
NSP	National Strategic Plan
OSSHMM	Oceania Society of Sexual Health HIV Medicine
PacS-RHRC	Pacific Sexual and Reproductive Health Research Centre (based at FNU)
PCSS	Pacific Counselling and Social Services
PIAF	Pacific Islands AIDS Foundation
PLHIV	People living with HIV
PMTCT	Prevention of Maternal to Child Transmission
PPTCT	Prevention of Parent to Child Transmission
PRSIP II	Pacific Regional Strategy Implementation Plan (second of these)
RHAF	Reproductive and Family Health Association of Fiji

UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund (current full title from website)
UNGASS	United Nations General Assembly Special Session (e.g. UNGASS on AIDS)
UNICEF	United Nations Children’s Fund (current full title from website)
UNIFEM	United Nations Development Fund for Women (current full title from website)
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USP	University of the South Pacific
SAN	Survival Advocacy Network
SENPEF	Support and Empowerment Network for Peer Educators of Fiji
SGS	Second Generation Surveillance (meaning integrated biological and behavioural surveillance)
SPC	The Secretariat of the Pacific Community
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNGASS	UN General Assembly Special Session on AIDS (UNGASS Report is the annual reporting of progress on recommendations of that Special Session)
VCCT	Voluntary and Confidential Counselling and Testing
WAC	Women’s Action for Change
WHO	World Health Organization

I. Status at a glance

Inclusiveness of stakeholders in the report writing process

An orientation and consultation workshop was held in 23 February to discuss the preparation of the 2012 Global AIDS Response Progress Report. The 30 participants in the workshop were partners in the HIV response from the public sector (Ministries of Health, Youth, Education, Women & Social Welfare, and Labour), civil society, and multilateral organisations.

A core group of five consisting of representatives from the public sector (MOH), civil society and the UN was selected to work with a technical adviser engaged to assist in preparing the report. The core group included the two coordinators, one each from public and civil society sectors, selected to lead the preparation of the national commitment and policy reports. The core group met as a whole face-to-face three times during the preparation of the GAPR report and via electronically continually.

The national commitments and policy instrument (NCPI) was sent electronically to all stakeholders who attended the initial consultation meeting for completion. In addition, the Technical Adviser conducted face-to-face interviews with selected key informers using the NCPI. The Technical Adviser analysed the completed government and civil society NCPI questionnaires. Separate meetings for government and civil organisations were held to validate the findings of the completed questionnaires and agree on the responses from each sector. The Technical Adviser finalised the NCPI for the government and civil society sectors and prepared a table comparing the ratings for each of the NCPI sections with the rating from previous years.

The data for all the indicators (where such data existed), including the expenditure from all funding sources, was compiled by the core team, which assessed their validity at one of their face-to-face meetings. The Technical Adviser compiled the first draft of the Indicator table.

The core team presented the indicator data and to all the stakeholders at a final validation meeting in March 2012. Feedback from the stakeholders was incorporated into the report.

The narrative report was compiled by the Technical Adviser based on reviews of national and project reports from partners engaged in the HIV response, interviews with key informants, analysis of NCPI questionnaires, and analysis of HIV, AIDS and STI data from the Ministry of Health.

Status of the epidemic

Fiji is classified as a low HIV prevalence country. The UNAIDS and WHO Epidemiological Factsheet for Fiji estimated the number of people living with HIV in 2009 to be about 500, and the prevalence rate for 15 – 49 year olds at approximately 0.12%.¹ There have been no epidemiological HIV sero-surveys of the general population conducted, but the number of HIV infections detected among the many thousands of HIV tests undertaken each year support (see Table 1 below), supports the estimated prevalence of 0.12%.

At the end of 2011, a cumulative total of 420 confirmed HIV cases had been reported in the country since the first case was diagnosed in January 1989. However it is unclear how many of the confirmed HIV cases are still alive. At present (March 2012), fewer than 100 HIV+ cases are in contact with the health care services.

In the first 10 years of the HIV epidemic in Fiji, there was a slow but steady increase in the number of HIV infections detected annually, with between three and eight new infections reported. The rate of increase in HIV diagnoses quickened from 2000 with an average of 30 HIV infections diagnosed annually between 2000 and 2008. However in 2009, the number of infections diagnosed, 43, was about one third higher than the annual figures for the previous six years. The number of new HIV infections in 2010 and 2011 were 33 and 54 respectively. The overall impression of the HIV epidemic in Fiji is one of continuous incline, although the rate of increase is not steep.

Heterosexual intercourse is the primary reported mode of transmission, and this is not necessarily linked with sex work. The confirmed cases where mode of transmission is recorded does not indicate that any specific population group has a higher number of HIV infections. More detailed information is given below.

The policy and programmatic response

Fiji developed a new national strategic plan in 2011 for the period 2012-2015, following the completion of the 2007 – 2011 National HIV/AIDS Strategic Plan (NHSP). The review of the 2007-2011 NHSP that preceded the development of the new plan identified the many achievements and challenges of the national HIV response.

Prevention

Prevention had been the major priority within the national response to the HIV epidemic. Since the last National Strategic Plan was adopted in 2006, there had been expansion of prevention activities as well as improvements in the methods used and collaboration between prevention partners. Young people have been a major focus of HIV prevention activities, with in-school education provided by the Ministry of Education and many out-of-school peer education programs provided by the Ministry of Health and civil society organisations.

The Fiji approach to prevention was described as a good example of “Combination Prevention”. Programs have often linked provision of information in community settings with chances for community members to receive condoms, meet people living with HIV, and talk about behaviour change with peer educators or community leaders. For those wanting more time to think about whether their own behaviours place them at risk, prevention provided referrals to clinics, which provide counselling, testing or treatment services. The review noted that there was an appropriate balance between focused prevention for vulnerable groups and more general programs for the whole community.

There has been an increasing focus on prevention of mother to child transmission (PMTCT) with the provision of HIV testing to pregnant women attending antenatal clinics (ANCs). The collaboration between the Ministry of Health and Pacific Counselling and Social Services (PCSS), an NGO specialising in counselling and social support, to provide this service at ANCs ensures that the HIV test is accompanied by pre- and post-test counselling and informed consent. All HIV+ women receive anti-retroviral prophylaxis as do the new-born infants.

Continuum of treatment, care and support

Antiretroviral therapy (ART) has been available, free of charge, for people living with HIV (PLHIV) in Fiji since 2004. Antiretroviral drugs were initially provided through a Global Fund project. Since 2008, the government of Fiji has assumed the responsibility of providing ARVs for all those in need of treatment. Three Hub centres, one in each of the three divisions of the country provide ART for PLHIV, HIV testing STI management, and reproductive health services to the public.

The Fiji Network of People Living With HIV (FJN+) is an important part of the continuum of treatment care and support. The network provides peer support and assists its members to maintain their health by remaining on ART. Most importantly, FJN+ has played a prominent role working to reduce stigma and discrimination against PLHIV. People living with HIV are invited to be part of many community awareness outreach initiatives and community events. The very close collaboration between many partners means that people living with HIV are now very visible in all public components of the national response and available for immediate involvement in support of people newly diagnosed with HIV.

Coordination and Governance

The National Advisory Committee on AIDS (NACA) was the peak body responsible for coordinating the national HIV response. The effectiveness of NACA varied significantly over the period of implementation of the 2007 – 2011 NHSP. By the time of the review of the 2007 – 2011 NHSP in

2011, it was clear that NACA was largely irrelevant to many of the partners involved in the HIV response. There was however, a clear need for national coordination because there was no national monitoring or even reporting mechanism established, and most projects reported only to their own organizations or to donors. Even projects with extensive monitoring did not feed information or lessons learned to any national monitoring or coordination group. This meant that information was not used for ongoing planning and revision of the national response.

The Fiji HIV/AIDS Decree

In January 2011, the Fiji HIV/AIDS Decree 2011² was enacted, culminating a process that began in 2004. The Decree outlines a human rights framework for the response to the HIV epidemic from this point on. It also legislates for the formation of a new multisectoral HIV/AIDS Board that will be responsible for coordinating the national HIV response. For the first time in the history of the HIV response in Fiji, there will be a full-time Chief Executive Officer, answering to the Board, responsible for managing coordination

Resources

Government of Fiji expenditure on the national HIV response in 2010 and 2011 constituted approximately 20% of the total expenditure of US\$2.1 million and US\$2.5 million respectively. Funding from international sources, mostly, the Australian and New Zealand government and the United Nations Agencies, made up the bulk of the expenditure. In 2009, the Government of Fiji's contribution to the national AIDS expenditure was about US\$480,000, slightly more than was provided in the subsequent two years. However the government's funding was 10% of the total expenditure of over US\$4.1 million in 2009. Since 2009, the HIV expenditure has halved, with all the reduction being from the funding provided by International sources. The very high dependence of the national HIV response on funding from international sources is of great concern because it is not clear that the government can fill the gap if and when the international funding ends.

Table 1: Global AIDS Progress Report 2012: Indicator Table

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
1.1	Percentage of young women and men aged 15 – 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		N/A	N/A	N/A	N/A	N/A	N/A	No data collection exercise was conducted for this indicator in 2010/2011. The most recent survey of young people's knowledge about HIV prevention was the 2008SGS which included GAPR-consistent questions on this indicator but was not a DHS style national household survey covering youth as part of the general population. Fiji's first national DHS is scheduled to take place in 2012
1.2	Percentage of young women and men who have sexual intercourse before the age of 15		N/A	N/A	N/A	N/A	N/A	N/A	No data collection exercise was conducted for this indicator in 2010/2011. As reported in Fiji's 2010 UNGASS Report, the 2008 SGS included questions consistent with this indicator but not consistent with the DHS-style measurement recommended in the Guidelines. Data for Indicator 1.2 are not available from other sources.
1.3	Percentage of adults aged 15-49 who have sexual intercourse with more than one partner in the past 12 months		N/A	N/A	N/A	N/A	N/A	N/A	No data collection exercise was conducted for this indicator in 2010/2011. As reported in Fiji's 2010 UNGASS Report, 2008 SGS included consistent questions on this indicator, but did not conduct DHS-style national household survey covering general population. The 2008 SGS focused on specific populations such as ANC women,

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
									STI Clinic attendees, tertiary students, seafarers and uniformed services. The percentages of respondents who reported sexual intercourse with more than one partner in the last 12 months were as follows: ANC women (15-49): 5% STI Male (15 – 49) : 62% STI Female (15 – 49): 20% Tertiary Students Male (15 – 24): 33% Tertiary Students Female (15 – 24) :6% Seafarers (20 – 49): 32% Uniformed Services (20 – 49): 31%
1.4	Percentage of adults aged 15-49 who had more than sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse		N/A	N/A	N/A	N/A	N/A	N/A	No data collection exercise was conducted for this indicator in 2010/2011. As reported in Fiji's 2010 UNGASS Report, 2008 SGS included consistent questions on this indicator, but did not conduct DHS-style national household survey covering general population. The 2008 SGS focused on specific populations such as ANC women, STI Clinic attendees, tertiary students, seafarers and uniformed services. The percentages of respondents who reported sexual intercourse with more than one partner in the last 12 months who report the use of a condom in their last sexual intercourse were as follows: ANC women (15-49): 5% STI Male (15 – 49): 10% STI Female (15 – 49): 38%

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
									Tertiary Students Male (15 – 24): 47% Tertiary Students Female (15 – 24): 13% Seafarers (20 – 49): 28% Uniformed Services (20 – 49): 30%
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	N/A	N/A	N/A	No data collection exercise was conducted for this indicator in 2010/2011. Data on Indicator 1.5 that consistent with GAPR 2012 Guidelines are not available from any source.
1.6	Percentage of young people aged 15-24 who are living with HIV		4	8744	0.05%	3	10804	0.03%	There is no HIVsentinel surveillance of women attending antenatal clinics in Fiji. However the denominator could be calculated from program data. Over 95% of pregnant women in Fiji attend antenatal care at least once during their pregnancy. The implementation of the PPTCT policy of HIV tests for all pregnant women is fully decentralised, reaching over 90% of pregnant women. The data from the five largest ANCs supported by PCSS is disaggregated by age, so the % of pregnant women in the 15 – 24 age group tested for HIV is calculated at 48%. This percentage was applied to the total number of women tested to calculate the denominator for both 2010 and 2011.
1.7	Percentage of sex workers reached with HIV prevention programmes		N/A	N/A	N/A	N/A	N/A	N/A	No data collection exercise was conducted for this indicator in 2010/2011. Data on Indicator 1.7 that consistent with GAPR 2012 Guidelines are not available from any source.

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
									An IBBS of sex workers is in progress.
1.8	Percentage of sex workers reporting the use of condoms with their most recent client		N/A	N/A	N/A	N/A	N/A	N/A	See comments for 1.7 above
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	N/A	N/A	N/A	See comments for 1.7 above
1.10	Percentage of sex workers who are living with HIV		N/A	N/A	N/A	N/A	N/A	N/A	See comments for 1.7 above
1.11	Percentage of men-who-have- sex-with-men reached with HIV prevention programmes.								The source of the data for this indicator is the draft report of the 2011 Integrated behavioural survey of transgender and men who have sex men in Suva and Lautoka conducted by MENFiji ³ The report is not complete and all indicators have not been calculated. A 2011 report by AIDS Task Force of Fiji (ATFF) of a community-based study exploring male-to-male sex, gender identity and HIV transmission in Fiji, calculated that the percentage of MSM and transgender who knew where to get and HIV test and have been given condoms in the past 6 months was 40.1% (N=201) ⁴ .
	a. Knew where to get an HIV Test		N/A	N/A	N/A	450	464	97%	
	b. Had been given condoms in last 6 months		N/A	N/A	N/A	315	464	67.8%	
	c. Knew where to get and HIV test and had been given condoms		N/A	N/A	N/A				

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
1.12	Percentage men reporting the use of a condom the last time they had anal sex with a male partner		N/A	N/A	N/A	178	353	50.5%	The source of the data for this indicator is the draft report of the 2011 Integrated behavioural survey of transgender and men who have sex men in Suva and Lautoka conducted by MENFiji.
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and who know their results		N/A	N/A	N/A	71	464	15.3%	The source of the data for this indicator is the draft report of the 2011 Integrated behavioural survey of transgender and men who have sex men in Suva and Lautoka conducted by MENFiji.
1.14	Percentage of men who have sex with men who are living with HIV		N/A	N/A	N/A	2	438	0.5%	The source of the data for this indicator is the draft report of the 2011 Integrated behavioural survey of transgender and men who have sex men in Suva and Lautoka conducted by MENFiji.
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes		N/A	N/A	N/A	N/A	N/A	N/A	Little is known about injecting drug use in Fiji and so far injecting drug use has not been a significant factor in Fiji's epidemic, with only one case reported to have resulted from injecting drug use. SGS 2008 included questions on injecting drug use and very few respondents (15 out of 1629) reported injecting drug use in the past 12 months. A maximum of 2 respondents from the respective surveyed populations (STI clinic attendees, ANC attendees, Seafarers, Police and Military) reported the practice of

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
									injection drug use in the past 12 months. However, nine tertiary students (out of 543) reported that they had injected drugs in the past 12 months. ⁴
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse		N/A	N/A	N/A	N/A	N/A	N/A	See 2.1 above
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected		N/A	N/A	N/A	N/A	N/A	N/A	See 2.1 above
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results		N/A	N/A	N/A	N/A	N/A	N/A	See 2.1 above
2.5	Percentage of people who inject drugs who are living with HIV		N/A	N/A	N/A	N/A	N/A	N/A	See 2.1 above
3.1	Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child transmission		8	10	80%	11	N/A	N/A	Denominator calculated by multiplying the HIV prevalence in pregnant women (calculated at 0.04% in 2010 and 0.05% in 2011) by the total number of pregnancies in a year. The number of pregnancies in 2011 is not yet available, so Indicator 3.1 for 2011 cannot be calculated.

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		N/A	N/A	N/A	15	16	93.8%	The Denominator includes women with indeterminate HIV test results, but had been put on ARV prophylaxis while the confirmation of test result was undertaken.
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months		N/A	N/A	N/A	N/A	N/A	N/A	There was no consensus among stake holders on the output from Spectrum; it was therefore decided not use the spectrum estimates.
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	Male	27	N/A	N/A	40	N/A	N/A	Numerator is annual aggregation of data from three Hub centres and tertiary hospitals providing ART to eligible adults and children. Three patients, one male and two females withdrew from treatment. See 3.3 above
		Female	31	N/A	N/A	34	N/A	N/A	
		<15	1	N/A	N/A	2	N/A	N/A	
		>15	57	N/A	N/A	72	N/A	N/A	
		Total	58	N/A	N/A	74	N/A	N/A	
4.2	Percentage of adults and children	Male	25	N/A	N/A	5	8	62.5%	Source of 2010 Data is Fiji's Universal

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
	with HIV known to be on treatment 12 months after initiation of antiretroviral therapy								Access 2011 Report 2011 Data is collected from ART registers of three Hub centres and divisional hospitals providing ART to adults and children. One female patient discontinued treatment, one male patient was lost to follow-up and another male patient died.
		Female	26	N/A	N/A	7	8	87.5%	
		<15	0	N/A	N/A	0	0	0	
		>15	51	N/A	N/A	12	16	75%	
		Total	51	52	98%	12	16	75%	
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Male				4	N/A	N/A	Source of 2010 data is Fiji's Universal Access 2011 Report. Sex disaggregation is not provided. The numerator for 2011 is the Ministry of Health TB registry. The GAPR guidelines advises that the Denominator is obtained from the WHO website. The most recent estimate of incident TB in HIV+ people in Fiji is for 2010 and is given as <10. Therefore the denominator cannot be determined for 2011.
		Female				0	N/A	N/A	
		Total	3	3	100%	4	N/A	N/A	
6.1	Domestic and International AIDS	Public	419,594	2,100,661	20.0%	467,601	2,255,211	20.8%	Government of Fiji expenditure on the

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
	spending by categories and financing sources	(Government) USD							national HIV response in 2010 and 2011 constituted approximately 20% of the total expenditure of US\$2.1 million and US\$2.5 million respectively. Funding from international sources, mostly, the Australian and New Zealand government and the United Nations Agencies, made up the bulk of the expenditure. In 2009, the Government of Fiji's contribution to the national AIDS expenditure was about US\$480,000, slightly more than was provided in the subsequent two years. However the government's funding was 10% of the total expenditure of over US\$4.1 million in 2009. Since 2009, the HIV expenditure has halved, with all the reduction being from the funding provided by International sources
		International (USD)	1,677,396	2,100,661	79.8%	1,787,610	2,255,211	79.2%	
		Private (USD)	3,661	2,100,661	0.2%	0	2,255,211		
		Total (USD)	2,100,661	2,100,661	100%	2,255,211	2,255,211	100%	
7.1	National Commitments and Policy Instrument	Government				42	70	60%	The overall assessment given by government of the national HIV response of 60% is lower than the 69% achieved for the 2010 UNGASS Report. Comparing the ratings for the different sections of the NCPI reveals that the low ratings given for the 'Orphans and Vulnerable Children' and the Monitoring and Evaluation' Sections had the most impact in reducing the overall rating for the national response by government. This is a more accurate assessment of the status of the response than the 2010 UNGASS report

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
									which gave a rating of 1 for OVC, although the situation is exactly the same as it was two years ago i.e there is no planned response for OVC affected by HIV because to date there have been very few of them and the extended family is still able to cope with looking after them. With regards to the assessment of the M & E systems, again the assessment provided in this reporting period is more accurate and backed by the review of the NSP undertaken in 2010, which found the national M & E system to be rudimentary. All other areas of the national response were rated highly by the government.
		Civil Society				36	50	72%	The rating given by civil society for the national response has improved every year for the last four reporting periods, from a low of 18% in 2006 to 72% for 2011. In many ways this high rating is reflection of the strong partnership that exists between civil society and government for implementing the national HIV response. There is a recognition among CSOs that they have equal status in decision making and that the work they do is regarded as a crucial part of the response. There is an increased level of trust and an atmosphere of all pulling together for the

Indicator #	Indicator	Sub-population	2010			2011			Remarks
			Numerator	Denominator	%	Numerator	Denominator	%	
									common good.
7.2	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		N/A	N/A	N/A	N/A	N/A	N/A	There is no data available for this indicator from the recommended method of measurement, population based survey, at this time. A survey of violence against women in Fiji has been conducted, but the results are not yet available. However information from a variety of sources indicate that domestic violence is widespread in Fiji. Figures from the Fiji Women's Crisis Centre show that 80% of women have witnessed some form of violence in the home; 66% have been physically abused by partners and nearly half repeatedly abused. 26% of women have been beaten while pregnant; 48% of married women have been force into sex by their husbands; and 13% of women have been raped. ⁵
7.3	Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age		N/A	N/A	N/A	N/A	N/A	N/A	There is no data available for this indicator.
7.4	Proportion of the poorest households who received external economic support in the last 3 months		N/A	N/A	N/A	N/A	N/A	N/A	There is no data available for this indicaor

II. Overview of the AIDS epidemic

Much of the information for this section is sourced from the recently completed Fiji National Strategic Plan 2012 – 2017, supplemented by Fiji Islands Health System Review, Health Systems in Transition, Vol 1, No. 1 2011 and the Australia - Fiji Health Sector Support Project 2011 – 2015 Design Document (November 2010)

Fiji socio-economic context

Fiji Islands is a lower middle-income country, with a population of 837,271 at the 2007 census. Table 2 shows the 2005 population distribution by age group:

Table 2: Population distribution by age group, 2005

Age Group	Population	% of Total
<15	243,121	29.1%
15 - 19	79,518	9.5%
20 – 24	80,352	9.6%
25 – 49	300,170	35.8%
50+	134,110	16.0%
Total	837,271	100%

Source: The Fiji Islands Health System Review, page 12

Fiji is a multi-cultural and multi-religious country made up of indigenous iTaukei Fijians (56.8%), Indo-Fijians (37.4%) and other minorities, including Caucasian and Chinese. iTaukei Fijians are predominantly of Christian faith and Indo-Fijians of Hindu and Muslim faith. The rural and urban populations comprise 49% and 51% respectively, making Fiji the most urbanised Pacific Island country.⁶

The Fiji economy is one of the most developed in the South Pacific. The main income generators are tourism, minerals, fish resources and remittances. The principal imports are mineral fuels, machinery and transport equipment, as well as an increase in food imports. The economic context is summarized in the draft UN Development Assessment Framework (UNDAF) country assessment Desk Review of 2011, from which the details of the rest of this section were extracted.⁷

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

Fiji has officially achieved universal primary education (96.7% in 2008) and has a high literacy rate of 99.5% amongst 15 – 24 year olds. However, in 2008 there was a 13.9% drop out rate of students between years one and five, which indicates that many children are leaving school without having learnt to read and write to a functional level. In both access and achievement, gender parity has been achieved in the basic education system, although there is increasing imbalance in the number of boys who are dropping out as compared to their female counterparts.

Organisation of the health system

The Ministry of Health (MOH) is the largest player in the health sector, providing health care services directly to citizens of Fiji, and to a limited extent to visitors and persons referred from within the region, through a hierarchy of facilities:

- Village/community health workers,
- Nursing stations
- Health centres
- Sub-divisional hospitals and
- Divisional and specialized hospitals.

This framework was established some 40 years ago to provide health access to all, and has continued to serve the people of Fiji very well.

The main clinical services are provided through a network of 16 Sub-divisional Hospitals and 3 Divisional Hospitals located in Suva, Lautoka and Labasa that provide a comprehensive range of services. They also serve as teaching hospitals for nursing and medical students. There are 5 subdivisions in Central, 4 in Eastern, 6 in Western and 4 in Northern Divisions.

The Colonial War Memorial Hospital (CWM) in Suva serves as the Divisional Hospital for Central and Eastern Divisions, and also serves as the National Referral Hospital. It is supported by specialist hospitals that include the national St. Giles Psychiatric Hospital, the P.J. Twomey Hospital for tuberculosis and leprosy and the Tamavua Rehabilitation Hospital for specialist rehabilitation services.

Public health services are provided through the 16 Sub-divisional hospitals (SDH) and the 77 Health Centres (HC) and 101 Nursing Stations (NS). A health centre is point for a number of nursing stations within a designated SDH supervised medical area. A HC is managed by a Medical Officer or Nurse Practitioner plus 1 or 2 nurses. A NS is generally staffed by one nurse who conducts outreach visits to communities in a designated nursing area. In addition, Community Nursing Stations are facilities that fully operate and function as a nursing station except that they are built and funded by the community themselves on approved based on adherence to the minimum standards of a government station⁸.

The MoH has provided basic training to community members to create a cadre of Village Health Workers (VHW) in rural villages and Community Health Workers (CHW) in urban areas. Patients may first see a VHW/CHW or enter the public health service system directly by being visited at home by a nurse or by going to a NS, HC or SDH. They may then be referred to higher-level health facilities as appropriate. All consultations, laboratory and radiological investigations and admissions are free to the public attending public health facilities, except for some treatments in dental services and where they choose to be admitted to the paying wards.

A small private sector includes one private hospital in Suva that provides a range of specialized services, several day clinics and 110 private general practitioners located in the urban centres of the two main islands Viti Levu and Vanua Levu.

There is also a wide and increasing range of health services, including antenatal and postnatal care provided privately through some 120 private practitioners, a private hospital and a range of NGOs.

The major NGOs working in health in Fiji include the Fiji Reproductive Health Association, the Fiji Red Cross, Medical Services Pacific, and the Fiji Network of People Living with HIV.

Maternal health care is one of the core areas of the primary health care and is usually offered at all levels of the health system.

There are 37 antenatal health care facilities around the country. Services provided include information and education, health promotion, screening and interventions for women of reproductive age to reduce risk factors that may affect future pregnancies. Women are urged to seek antenatal care early in their pregnancies at the nearest health facility providing it, although there is a high incidence of late presentation for antenatal checks. The percentage of births attended by skilled personnel has remained consistently above 98% and is currently estimated to be 98.8%. Postnatal checks are offered to mothers six weeks after delivery and family planning services are available at the maternity units, health centres and nursing stations.

Fiji made considerable progress in improving its key MDG health indicators in the 1990s. During that period, life expectancy, maternal and infant mortality improved significantly, with maternal mortality ratios (MMR) improving from 156.5 (per 100,000 live births) in 1970 to 53.0 in 1980, to 41 in 1990 and to 22 in 2003. However from around 2003 progress stalled and began to deteriorate, with MMR peaking at 50 in 2005 and with a current MMR of 31.7 in 2008, well above the 2015 MDG target of 10.3.⁹

As Fiji transitions to an upper-middle income country, non-communicable diseases (NCD) are becoming an increasingly important cause of mortality and morbidity. By 2007, around 82% of deaths in Fiji were due to NCDs, 10% to communicable diseases and another 8% to other causes¹⁰. High prevalence rates of diabetes, cardiovascular disease, cancer and hypertension are attributed to lifestyle changes, poor diet, smoking and changing patterns in physical activity, and continuing nutritional problems particularly in school children and women. Diabetes now affects over 18% of the population¹¹ and together with hypertension is a significant risk factor for coronary and vascular disease. Importantly, diabetes itself also carries a very significant morbidity.

Challenges in the Fiji health system are largely related to staffing and human resources shortages, inadequately equipped facilities and ineffective coordination and management of programs and services. Lack of action aimed at priorities emanating from research contributes to inadequate evidence-based programming and poorly informed policy formulation.

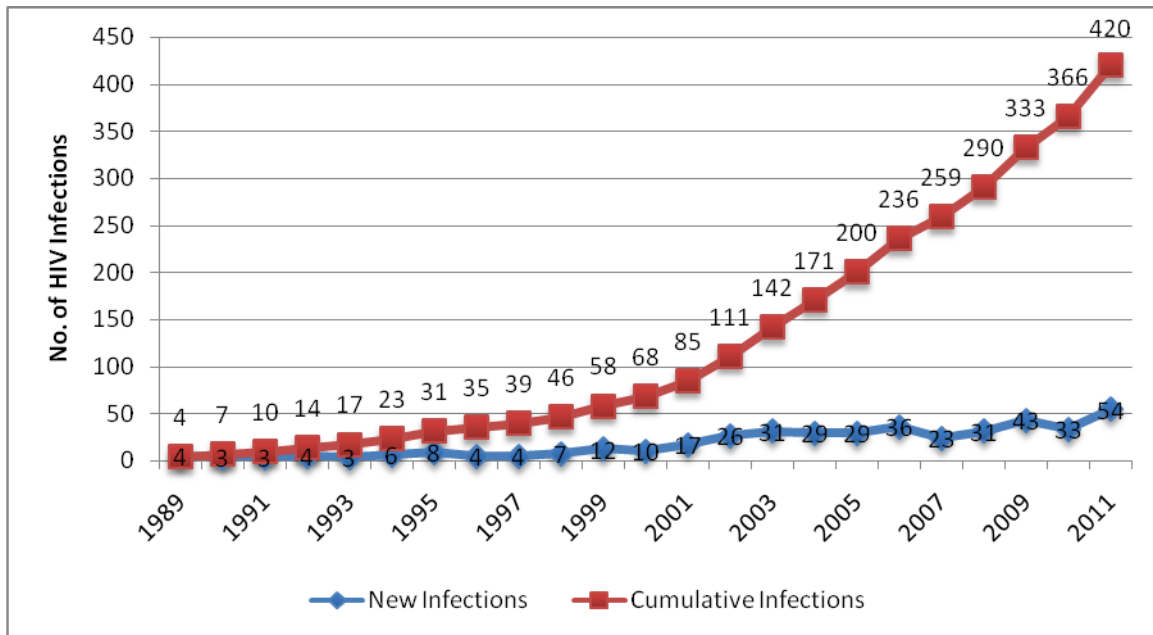
The expenditure of the Ministry of Health as a percentage of GDP was 2.87% at 2008, and the broader Government expenditure was 35.19% of GDP. In this context, health expenditure is between 9-11 percent of Government expenditure each year.

HIV salient statistics

Although Fiji is estimated to have low HIV prevalence, the number of people diagnosed with HIV is increasing every year. A graph of annual newly diagnosed HIV infections and the cumulative number of infections is shown in Figure 1. A cumulative total of 420 confirmed HIV cases were reported in Fiji between January 1989 and December 2011 by the Fiji Centre for Communicable Diseases Control (Figure 1), though it remains unclear how many of these are still alive. This way of presenting the HIV data informs about the history of the epidemic, but does not reveal much about what to expect in the future.

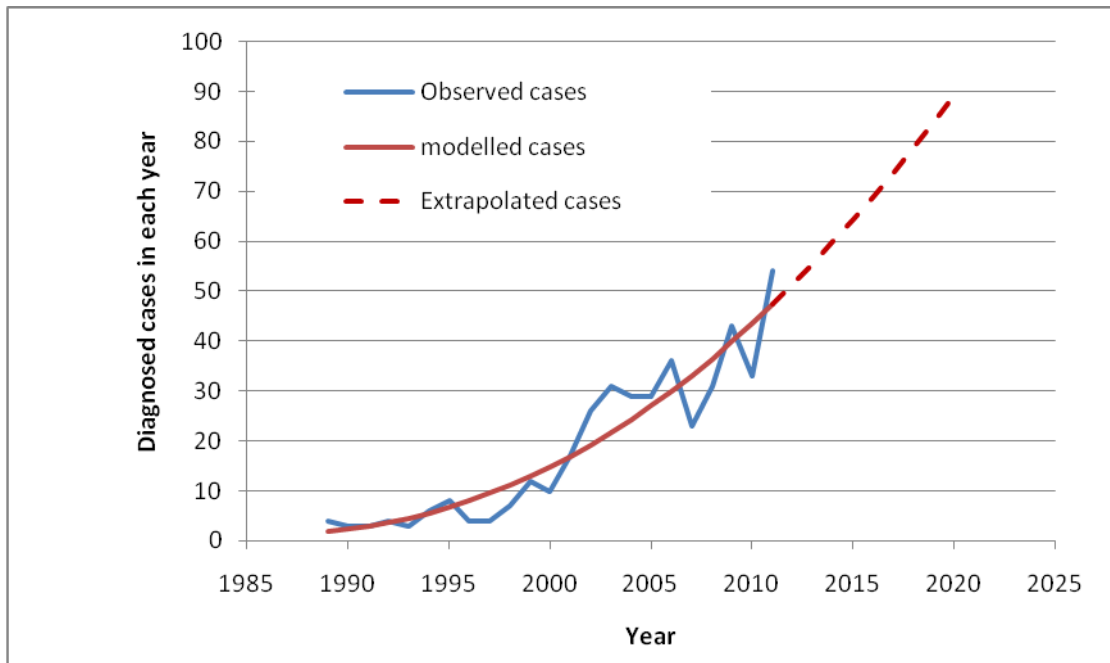
Figure 2 presents the expectation of the future of HIV epidemic (up to 2020), using the annual observed cases (blue line). The annual number of diagnosed cases was turned into rates using the UN population data and projections for Fiji. A fit of the second order polynomial function ($R^2 = 0.87$) to the observed rates from 1989 to 2011 was produced (red solid line). The rates were extrapolated to 2020 and the expected cases calculated using UN population projections for Fiji. Figure 2 shows that the HIV epidemic is still in the exponential growth phase and is not showing any sign of levelling off. By 2020, the expected number of diagnosed infections will be 104. At a time when the number of new infections in many parts of the world is either decreasing or stable, the prospect of an exponentially rising epidemic is of great concern.

Figure 1: Newly diagnosed and cumulative HIV infections in Fiji (1989 - Dec 2011)



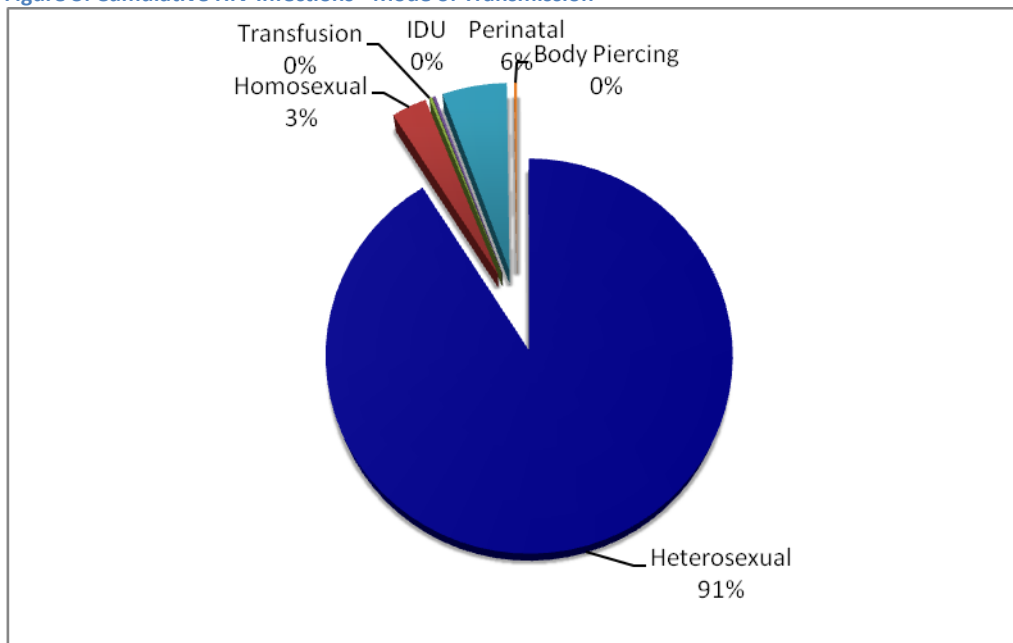
Source: Fiji Ministry of Health, December 2011, Fiji Centre for Communicable Disease Control

Figure 2: Projection of annual HIV infections to 2020



For all the HIV infections notified to the Ministry of Health, heterosexual transmission was reported for 91% of cases. However, community groups informing development of 2012 - 2015 strategic plan noted that the severe stigmatisation of sex work and of sex between men may mean that it is almost certain that people are under-reporting their involvement in these behaviours. Male-to-male sex accounts for 3% of reported infections; 7% of reported infections are from mother to child transmission (Figure 3).

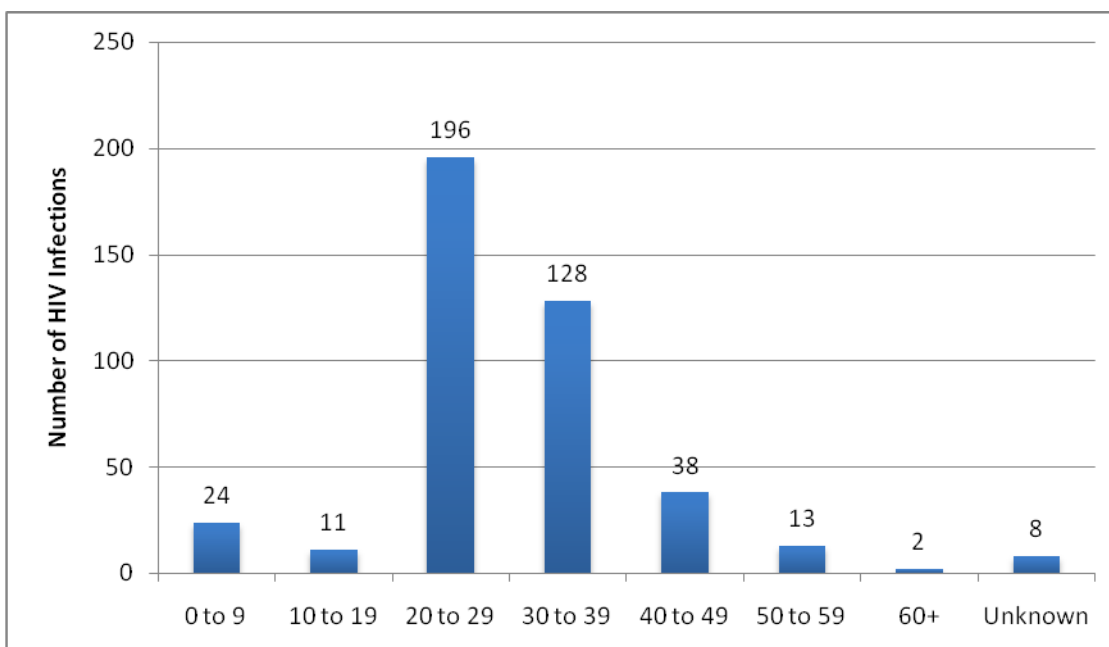
Figure 3: Cumulative HIV Infections - Mode of Transmission



Source: Fiji Ministry of Health, December 2011, Fiji Centre for Communicable Disease Control

The HIV epidemic is disproportionately affecting young people. Together the 20-29 and the 30-39 age groups account for over 77% of all the infections reported to date (Figure 4). The majority of HIV infections (82%) have been among indigenous Fijians (ITaukei), whilst Indo-Fijians constitute 13% of reported cases.

Figure 4: Cumulative HIV infections - Disaggregated by Age



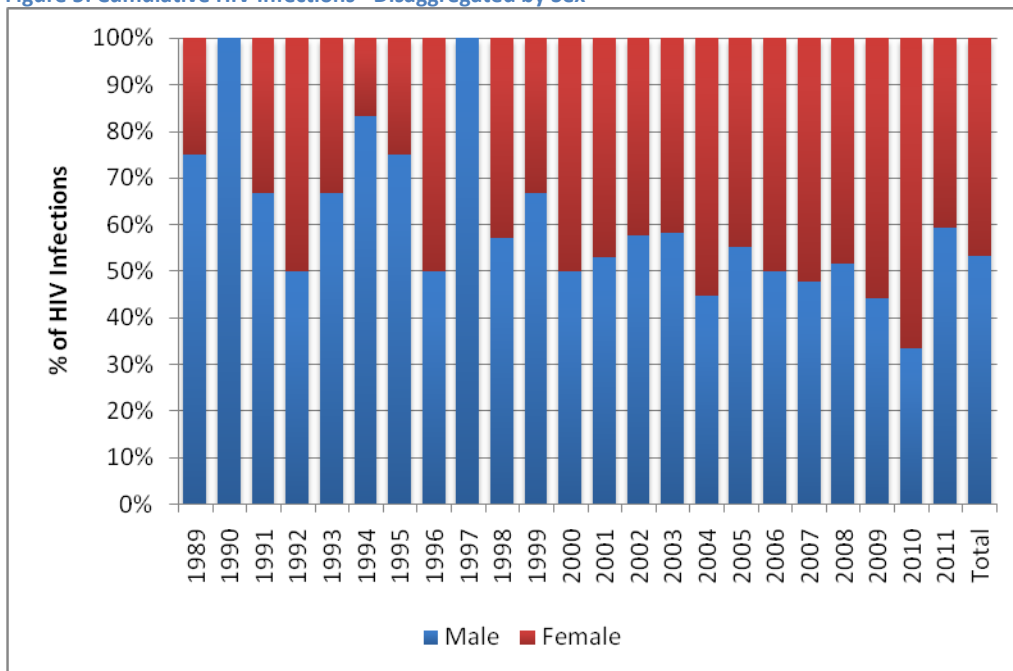
Source: Fiji Ministry of Health, December 2011, Fiji Centre for Communicable Disease Control

Slightly more (53%) of the people infected with HIV have been male and 47% female. An analysis of the annual number of reported infections shows an increasing trend of the proportion of infections detected in females relative to males. In 2003, 58% of HIV cases were male versus 42% female; in 2006, equal numbers of infections were reported in males and females. In 2009, the male to female

ratio was reversed and 55% of infections were in females compared to 45% in males. In 2010, the trend continued with 67% of new infections in females and 33% in males. There was another reversal of the trend in 2011, with more males (60%) infected (Figure 5).

The increasing proportion of female infections, compared to males, may suggest that females are at higher and increasing risk of HIV infection. However, it is also likely that it is a reflection of who gets tested. HIV Testing of pregnant women as part of prevention of parent to child transmission (PPTCT) program means females are over represented in the total number of people receiving HIV tests. Unfortunately the HIV test data obtained from the laboratories in the course of preparing this report are not disaggregated by sex or age so it is not possible to analyse the male and female breakdown of HIV tests to determine a possible explanation for the increasing ratio of female to male infections.

Figure 5: Cumulative HIV Infections - Disaggregated by Sex



Source: Fiji Ministry of Health, December 2011, Centre for Communicable Disease Control

Sexually Transmitted Infections (STIs)

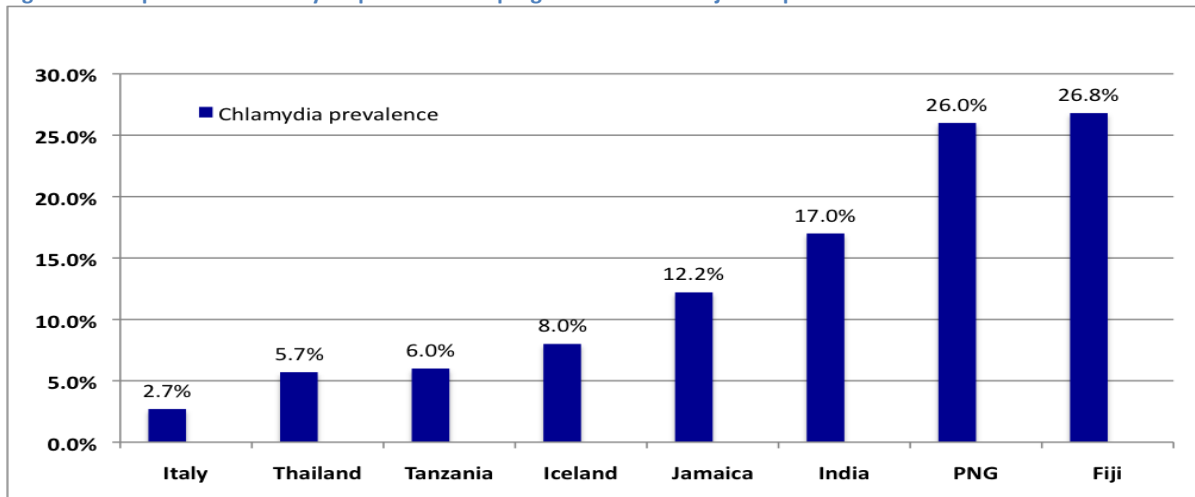
In contrast to the low HIV prevalence existing in the country, a survey of pregnant women attending antenatal clinics in 2004 found that 29% were infected with Chlamydia, 1.7 % with gonorrhoea and 2.6% with syphilis.¹² Among younger women (<25 years), the Chlamydia prevalence was even higher at 34%. In 2008, another survey of pregnant women found levels of Chlamydia (26.8%), gonorrhoea (2.2%) and syphilis (2.7%) infection similar to the 2004 study. Once again, young pregnant women under 25 years had a much higher prevalence of 37.5%.

These studies indicate that Chlamydia is hyper-endemic in the sexually active population in Fiji, with one-third of sexually active males and females potentially infected. Most will be unaware that they are infected because the infections will be asymptomatic and can only be diagnosed by laboratory testing. Chlamydia testing has only recently become available in Fiji and the tests are only conducted at the Mataika House Reference Laboratory in Suva. Most people do not have access to laboratory diagnosis of chlamydia.

Figure 6 shows that the chlamydia prevalence in Fiji is very high compared with many other countries, and similar to reports from a nearby country with an expanding HIV epidemic, Papua New Guinea (Figure 6). The high prevalence in young people indicates that they are sexually active with

more than one partner, and sexual networks are dense enough to enable transmission of STIs amongst young heterosexuals. The data points to widespread risky sexual behaviour. This means that if HIV was introduced in larger case numbers, for example 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.

Figure 6: Comparison of Chlamydia prevalence in pregnant women in Fiji with prevalence in 7 countries



Sources: *STI Epidemiological Update PICTs 2009. HIV & STI Surveillance, SPC July 2010 & Fiji Ministry of Health, 2008 SGS Report.*

The need for further epidemiological research

The fact that case reports of HIV amongst sex workers and men who have sex with men are low indicates that the HIV epidemic is not expanding through the groups who are most usually considered to be key affected populations. However, more needs to be known. Integrated Biological and Behavioural Surveillance amongst sex workers, which is scheduled to start in mid 2012, to shed more light on the potential of a concentrated epidemic amongst sex workers. Similar research was conducted amongst men who have sex with men in Fiji in 2011, and the tentative results of this indicate that this group is not yet experiencing a concentrated epidemic.¹³ Two HIV infections were detected in 438 study participants, giving a national HIV prevalence of 0.5% among MSM. While this is higher than the calculated HIV prevalence of 0.05% among pregnant women attending antenatal clinics, the numbers are very small to afford any certainty about the calculations.

There are very few reports of injecting drug use amongst people in Fiji, so this is also unlikely to be a driver of an expanded epidemic.

In summary, there is no baseline indicator at present for either the prevalence or incidence of HIV amongst any specific population or the whole population. When prevalence is low, 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.

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.

Nonetheless, it is clear that the HIV epidemic is present in Fiji. 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.

Social research provides further understanding of factors influencing the situation¹

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 2009.¹⁴ Integrated Biological and Behavioural Surveillance amongst sex workers will be conducted in 2012, supported by UNAIDS.

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 organisations 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 centres.

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

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

The situations for men and transgender people who have sex with men were explored through two research projects which were completed in 2011. One was conducted by the AIDS Task Force of Fiji, supported by UNDP, and published as "Secret lives, other voices... a community based study exploring male to male sex, gender identity and HIV transmission risk in Fiji". The other was an Integrated Biological and Behavioural Surveillance project amongst men who have sex with men. This

¹This section was extracted from the Fiji National HIV Strategic Plan 2012 – 2015, Ministry of Health.

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.¹⁵ 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 majority 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 negative experiences of health services which did not understand their lives or needs were barriers to both seeking health services and returning to them.

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

Research on the experiences of HIV positive women was reported by the Pacific Islands AIDS Foundation (PIAF) in 2011.¹⁶ This found two areas in which HIV positive women’s experiences are different to those of other women or those of HIV positive men.

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

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

Because many Fijians are not in the usually described “key populations”, research was also conducted by UNDP to provide better understanding of relationships and HIV risk in 2011.¹⁷ 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 “externalise 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.

The National Food and Nutrition Centre of the Ministry of Health will undertake an Assessment of Nutritional Status and Dietary Intake of people living with HIV, in collaboration with FJN+ and PIAF, in the final months of 2010.

National HIV Legislation – The HIV/AIDS Decree 2011

There had not been a legal framework for the Fiji national HIV response until The Fiji HIV/AIDS Decree was gazetted by the Government in February 2011. The Decree was developed over seven years and outlines a human rights framework for the response to the HIV epidemic from this point on. The HIV/AIDS Decree has been acknowledged both locally and internationally as one of the most progressive HIV laws in the world.¹⁷ The UNAIDS Fiji country review¹⁸ presents a succinct summary of the key aspects of the 45-section Decree as follows: The *Decree* aims to safeguard the privacy and rights of persons infected or affected by HIV and AIDS, by:¹⁸

- Ensuring the confidentiality of personal information;
- Creating an environment where persons are encouraged to access voluntary testing, counselling, and support services;
- Empowering an affected person to seek redress from professional bodies and the courts if their rights have been violated; and
- Promoting the need for everyone to be personally responsible for their own health and that of others through a duty of care

The Government of Fiji lifted its restrictions on entry, stay or residence based on HIV status in August 2011 and it was officially announced by the President of Fiji at the 10th International Congress on AIDS in Asia and the Pacific, which was held in South Korea.¹⁹

The HIV/Decree also legislates for the formation of a new multi-sectoral HIV/AIDS Board, which will be the body that reviews and adopts the 2012 - 2015 national strategic plan.¹⁹

The HIV/AIDS Decree provides a legal and political environment for implementation of the 2012 – 2015 strategic plan in ways which ensure that “recognized universal human rights standards” are adopted, “To protect all such rights including the highest possible standard of physical and mental health including the availability and accessibility of HIV prevention and HIV/AIDS treatment, care and support for all persons regardless of age, gender, gender orientation or sexual orientation”. The HIV/AIDS Decree provides that any policies issued by the HIV/AIDS Board will have the force of law, and that any person who contravenes the policies commits an offence. The Decree indicates in the clearest possible terms a political will to adopt a law based on the International Guidelines.

National Strategic Plan

The period covered by the GAPR 2012 was the final two years of the implementation of the five-year 2007 – 2011 NHSP. The NHSP had five priority areas with the following objectives:

- Priority Area 1- Prevention: to reduce the risk of HIV transmission among identified vulnerable and marginalized populations and aimed at young people, vulnerable group, marginalised group, general community, and work places.
- Priority Area 2 - Clinical management of HIV/AIDS: to provide services for VCCT (voluntary confidential counselling and testing) and comprehensive, cost effective, accessible, and sustainable HIV care and treatment services to eligible PLHIV.
- Priority Area 3 - Continuum of care for people living with or affected by HIV: overlapped with priority area 2, with additional objectives to address stigma-related issues, to promote empowerment, and to strengthen community based programmes.
- Priority Area 4 - Research, surveillance, and Monitoring and Evaluation; and Coordination and good governance.
- Priority Area 5 - Coordination and good governance aimed to ensure that national responses to HIV and AIDS were effectively coordinated and appropriate legislation and policies were in place to support HIV and AIDS management, in line with the principles of good governance, respect for human rights, and protection of the public.²⁰

The NHSP described strategies and activities for each Priority Area and included costing for all activities. It also included a monitoring and evaluation plan with defined indicators and a data collection plan.

A review of the implementation of the NHSP 2007 – 2011 was conducted in 2011. The findings will be described in the next section of this report – the national response to the AIDS Epidemic. An important finding from discussions with a number of partners was that, few, if any of the organisations involved in the HIV response used the NHSP to guide their work. The civil society organisations were usually working in their area of expertise, eg counselling or peer education for young people. If their work happened to overlap with an aspect of the NHSP, that was fine. Secondly there was no coordination or monitoring of the work being done by civil society sector and no effort to relate it to what is expressed in the NHSP.

A new National Strategic Plan was developed in 2011 for the period 2012 - 2015, informed by the findings from the review of the 2007 – 2011 NHSP. This NSP will put into practice the intentions of the HIV/AIDS Decree. This will ensure that the whole population is aware of the importance of responding to the HIV epidemic, and of doing so in ways that adhere to the human rights and governance framework outlined in the Decree.

National HIV coordination mechanism

Until the end of 2011, the National Advisory Committee on AIDS (NACA) was responsible for coordinating the national HIV response. NACA was established in 1987, two years before the first HIV infection was detected in the country. With no epidemic to respond to, NACA was, understandably, not very active. Over the years there have been periods of inaction and periods when it functioned very well. NACA was chaired by the Minister of Health, who reports to the Cabinet. The membership of NACA has also varied significantly over the years. Initially, NACA was inclusive, with a membership consisting of all the partners involved in the national HIV response. Then the membership was streamlined and only two CSOs, selected by the Minister of Health, remained members. This alienated many of the former members of the organisation.

The functioning of NACA depended to a large extent on the Ministry of Health. The interest in, and time allocated to the HIV response, fluctuated, due to the burden of programs and responsibilities

assigned to key people who organised NACA and were likely to attend all the meetings and expect action on decisions made at the meeting. At the time of the review of the implementation of the 2007 – 2011 NHSP in June 2010, NACA was going through one of its more inactive phases and had not met for about one year. Only one of the Working Groups had met that year (Working Group for Prevention), and ad hoc committees were being formed to address different specific issues within the areas of treatment and research, though in both cases there were no specifically national committees to play a coordination role.

The enactment of the HIV Decree in February 2011 meant that HIV/AIDS Board, when established would replace NACA. The ten member HIV/AIDS Board has been established by mid 2011. Two members of the Board represent CSOs, and one of the CSO representatives is a persons living with HIV. The Board now has responsibility for the national HIV response, and has met twice.

Monitoring and evaluation framework

There is a monitoring and evaluation framework for the 2007 – 2011 NHSP, but like the rest of the document, it was never used. Ministry of Health monitors some aspects of the health sector response to HIV through the surveillance system established for the HIV program, such as the number of pregnant women tested for HIV, the number of people on ART, etc. However there is no central database. This means that the data is almost never analysed to identify trends or understand some aspect of the epidemic.

MOH is only one of the many partners of the HIV response. While many projects implemented by other partners are monitored and evaluated, and some organisations conduct thorough monitoring of their own projects, there is no central monitoring of the national response. Ironically, reports are often made to donors, including to the Secretariat of the Pacific Community (SPC), but these are not requested by the National Advisory Committee on AIDS or the Ministry of Health, because there are no staff designated to collate this monitoring information.

This includes a lack of monitoring of expenditure. The financial tables and graphs included in the Review of the NHSP 2007 – 2011 had to be developed specifically within this Review. It is noted that the Ministry of Health has limited monitoring capacity for any diseases, and it would make sense for monitoring of HIV and STI projects to be part of a general improvement in national monitoring capacity. Needless to say, without adequate central monitoring, there is also no central use of monitoring or evaluation information to inform development of policies or programs.

National funding of HIV and AIDS prevention, treatment and care and support services

The total expenditure of the AIDS program from all sources for the years 2009 to 2011 is shown in Figure 7 below. The expenditures for 2010 and 2011 were US\$2.1 million and US\$2.25 million respectively. The expenditure for 2009 was twice the expenditures for 2010 and 2011. The contribution from the Fiji government averaged about US\$450,000 a year and represented about 20% of the total expenditure for 2010 and 2011. The funding provided by development partners has roughly halved from 2009 to 2010.

The proportions of funding utilised for the different program categories are shown in Figure 8. Prevention had the largest share of the available resources, with 29%, followed by program management with 22%.

Figure 7: Total AIDS Expenditure (209 - 2011) disaggregated by funding source

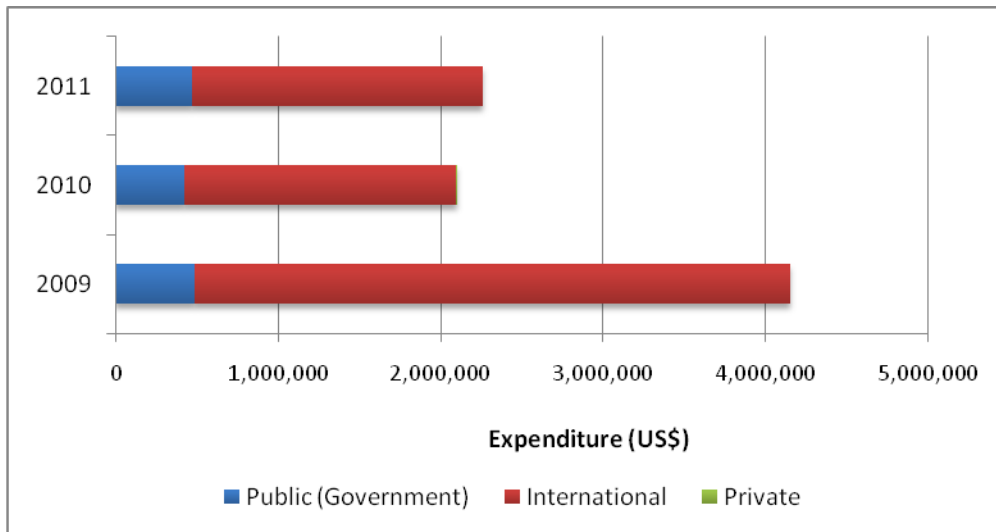
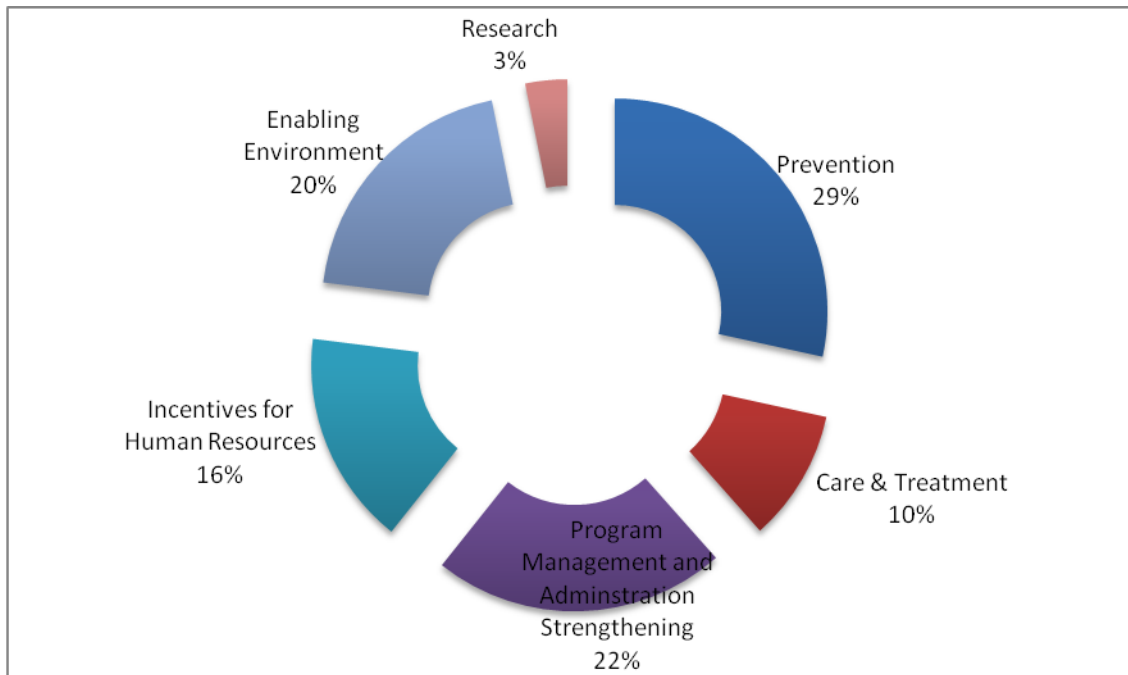


Figure 8: Proportions of AIDS expenditure per program category



III. National response to the AIDS epidemic

This section of the report draws on the review of the 2007 – 2011 NHSP which was conducted in September 2010, supported by UNAIDS.

Prevention is the top priority in the Fiji national HIV response and is allocated the lion’s share of the funding available for the response (see Figure 8 above). Since the inception of the 2007 – 2011 NHSP, there has been a great expansion of prevention activities, as well as improvements in methods used and collaboration between prevention partners.

The Fiji approach to prevention is a good example of what UNAIDS describes as “Combination Prevention”^{21,22}. This means that prevention programs “deploy a blend of biomedical, behavioural,

and structural approaches tailored to address the particular and unique realities of those most vulnerable to HIV infection”.

In Fiji’s case, 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 matters 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 on 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.

The government respondents of the NCPI gave a rating of seven (out of 10) for the policy efforts of HIV prevention in 2011. They gave a similar rating of seven out of 10 for the implementation of HIV prevention programs in 2011. The CSO rating for implementation was the same as the government’s rating. The similar ratings given by government and civil society partners indicate that there is strong agreement among the partners involved in the HIV response that the implementation of HIV prevention programs has been good in 2011. There are, however, some interesting differences in the assessments given by government and CSO respondents to different prevention activities.

The biggest differences were in the ratings given by the two sides on risk reduction programs for men who have sex with men, sex workers and intimate partners of STI patients and PLHIV. The different ratings for sex workers and MSM will be discussed under the appropriate sub-headings.

With few exceptions, there is little information about any behaviour changes that have resulted from the implementation of the myriad prevention activities undertaken by both government organisations and CSOs, which were rated 7 out of 10 in the NCPI. This is because with one exception, there have been no population-based surveys of knowledge, behaviour or attitudes since the 2008 Second Generation Surveillance surveys which were reported in the 2010 UNGASS report. The one exception were the findings of the integrated behavioural and biological survey of MSM conducted in 2011, which will be reported under the MSM sub-section below.

Prevention: Young people

Both Government and CSOs “Agree that the majority of people in need have access to school-based HIV education for young people” and “HIV prevention for out-of-school young people”.

Schools have HIV programs organised by the Ministry of Education, including Family Life Education and FijiSTAHS (Fiji Students Stand Against HIV and AIDS). Training and follow up are provided to the FijiSTAHS as peer educators and leaders, encouraging students to become peer educators, orators and debaters. This enables at least some students to explore issues of relevance themselves. Close associations exist between sporting associations and their HIV Champions and school students, so even limited information provided in schools is likely to lead interested students to seek further information from these other sources as required. Peer education takes place in schools and at inter-school gatherings for sport or music. 40 schools include peer education in 2010, with a total student population of 25,000. This is not universal coverage but it is extensive, the peer education approach is useful, and the approach is being expanded to other divisions. The Ministry of Education has developed Family Life Education materials for teachers and students, for incorporation into general curricula, rather than for separate HIV education. Health Sciences includes STI, HIV and Adolescent Health, and the Ministry of Health and Ministry of Education collaborate in this. Since 2007 there have been 94,697 pieces of education material distributed. This takes place with collaboration of the National Substance Abuse Advisory Council, which means HIV is situated within coverage of broader health issues. Ninety-five percent of schools have programs in Adolescent Health and Development, which include peer educators. The Ministries of Education, Youth, Women and NGO partners meet

quarterly to share information. This includes NGO partners working with high risk groups, as well as Fiji Red Cross.

Coverage of youth through Red Cross peer education is fairly extensive. Thirteen of the 15 Red Cross branches are involved throughout Fiji, with 17 peer educators employed. Sixty-five to 70 communities were reached in 2007-2009.

Youth friendly clinics

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 have established 24 “youth friendly clinics” called “Our Place”, around the country. These are 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 clinics are 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. “Our Place” clinics are very popular with young people. In 2011, close to 75,000 adolescents and youth, 27,045 in the 10 – 14 age group, 24,451 in the 15 – 19 age group and 23,315 in the 20 – 24 year age group, used the services provided by “Our Place” clinics around the country. Staff of “Our Place” also work with wheelbarrow boys and street kids. They distribute condoms to nightclubs, and are monitoring uptake through nightclub staff daily reports, including on how many are taken by women or men.

Sexually transmitted Infections (STI) and Teenage Pregnancies

STI infections in adolescents and youth as well as teenage pregnancies are indicators of unprotected sex in young people. Table 3 shows the number of reported cases of gonorrhoea, chlamydia and syphilis in 2010 and 2011, disaggregated by age. The number of teenage pregnancies reported by the sub-divisional hospitals was 1,527 and 1,338 for 2010 and 2011 respectively.

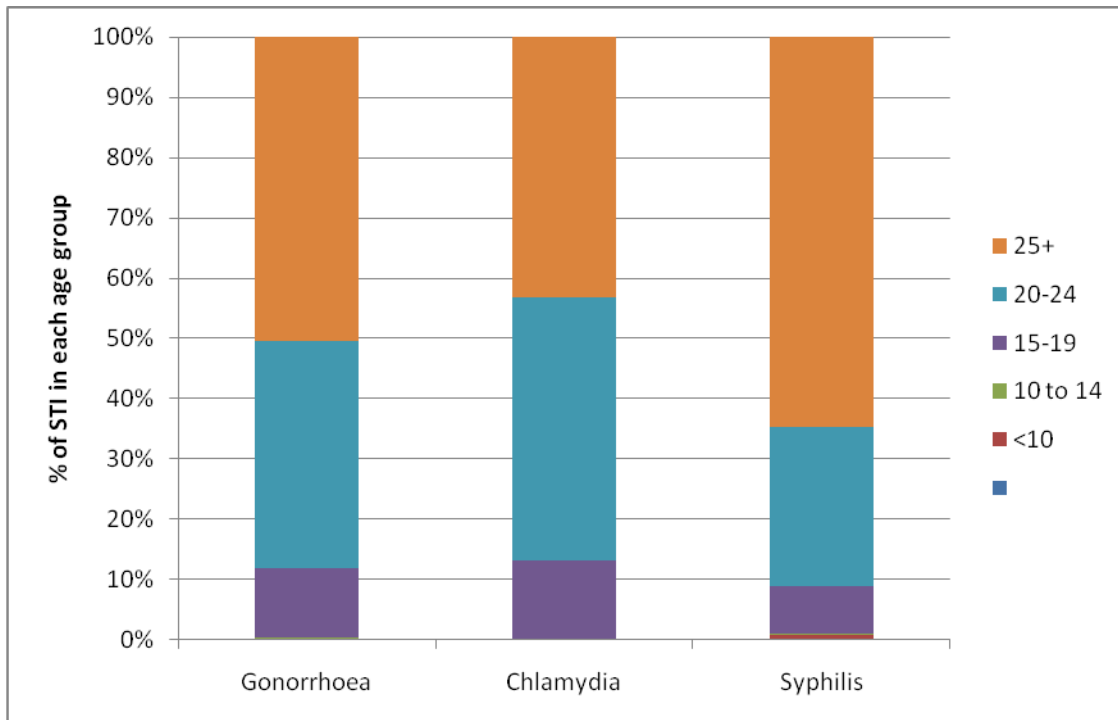
Table 3: Gonorrhoea, chlamydia, and syphilis infections, disaggregated by age (2010 & 2011)

STI	2010				2011			
	10 to 14	15 to 19	20 to 24	>25	10 to 14	15 to 19	20 to 24	>25
Gonorrhoea	4	136	446	594	1	154	394	641
Chlamydia	1	49	166	164	0	28	75	86
Syphilis	1	35	119	290	1	26	127	415

Source: Ministry of Health, Fiji

In 2010, approximately 50% of gonorrhoea cases, 55% of chlamydia infections and 35% of syphilis cases were in 15 to 24 year age bracket (Figure 9). Data for 2011 showed similar disaggregation of infections.

Figure 9: Gonorrhoea, Chlamydia and Syphilis infections by Age Group (2010)



Source: Fiji Ministry of Health

In conclusion, HIV and STI prevention for young people is a top priority for the Fiji national response. There is strong national leadership on the issue. At a recent national forum hosted by the President of Fiji during the visit of the Executive Director of UNAIDS to the country, the President invited the representatives from the student body of all the secondary schools in Suva to participate. He made a commitment to visit all the schools in the coming year to support their HIV prevention efforts.

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.

The question is whether all the effort is paying off. Are young people more knowledgeable about HIV and STIs, and more importantly, are they protecting themselves from infection or unwanted pregnancies?

There has not been a nationally representative survey of HIV related knowledge and attitudes of 15 to 24 year old youth conducted in Fiji. However, 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.

Prevention: Specific sub-populations with higher risk of HIV exposure

Epidemiological data to date do not clearly identify which sub-populations are at higher risk of HIV exposure. However the social research conducted recently into sex work and MSM do provide a good reason to pay attention to these two sub-populations as part of an effective response to the epidemic in Fiji. This section will describe the status of the prevention activities undertaken with sex workers and men who have sex with men. Although not regarded as sub-populations in the same way as sex workers and MSM, women in violent domestic situations have also been identified as vulnerable to HIV. Prevention of recent intimate partner violence is one of the indicators of the successful response to HIV. A description of what is happening with respect to intimate partner violence will also be briefly described in this section.

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 75% 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 areas²³.

There are three sex worker networks that provide HIV and STI risk reduction information, condoms, and referrals to clinics, for sex workers, the Survival Advocacy Network (SAN), Pacific Rainbows Group and the Rainbow Women’s Network. The work of SAN and Pacific Rainbows Group are described below. There is no information available about the Rainbow Women’s Network.

The Survival Advocacy Network (SAN), which is affiliated with Women’s Action for Change, 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. The Labasa Hub staff and PCSS in Labasa have confirmed that the education, and condom distribution services provided by SAN has helped to make the Labasa sex workers the most informed group in the community.

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

The 2010 PCSS report²⁴ of the counselling and social services provided to sex workers associated with Sekoula provides some insight into the lives of the sex workers. Forty-nine sex workers were referred to PCSS by Sekoula, 43% female, 8% male and 49% transgender. More than half (55%) were under 25 years of age. The group was relatively well educated with most reporting having either secondary (76%) or tertiary (16%) education, while 8% indicated they had a primary education. Eighty percent came from urban areas and 20% from rural areas. About 43% of this group reported daily or weekly use of alcohol, 39% daily or weekly use of marijuana and 31% used kava on a daily or weekly basis. Twenty-nine percent of the sex workers indicated they had experienced one or more previous incarcerations and 41% indicated they had only transient accommodation.

The age of first sex ranged from 9 to 21 years old; with 39% reporting their first sexual experience was at 14 years of age or younger. Only 27% of the group was at least 18 years old at the time of their first sexual experience. The duration of sex work ranged 2 months and 20 years.

The sex workers had fairly high level of knowledge about HIV risk and prevention:

- 82% correctly identified that having sex with only one faithful, uninfected partner can reduce the risk of HIV
- 96% correctly identified that using condoms can reduce the risk of HIV transmission
- 96% correctly identified that healthy looking people can be HIV+
- 86% correctly identified that a person can not get HIV from mosquito bites
- 94% correctly identified that a person can not get HIV by sharing a meal with someone who is infected

McMillan and Worth (2009) also report 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 organisations (NGO) involved in HIV interventions.¹¹

The high knowledge about HIV risk among the Sekoula sex workers had translated into behaviour change. Seventy percent had an HIV test in the last 12 months and knew their result and 86% knew how and where to access an HIV test. The group was also fairly knowledgeable about STIs, with 92% indicating they knew what an STI was. Knowledge of specific STI's ranged from 47% knowing what Chlamydia was to 90% knowing what Gonorrhoea was. Seventy percent indicated they had been tested for STI in the past 12 months and knew their result; and 90% knew where to get an STI test.

Ninety-eight percent of the sex workers reported that they began using condoms during the preceding 12 months to protect against HIV/STIs. All the sex workers indicated they had used a condom with their most recent client. However, only 37% reported using a condom with their most recent non-commercial partner. This is similar to the finding from the McMillan and Worth study, which reported that many sex workers did not use condoms with their intimate partners. All the male, and 91% of transgender sex workers associated with Sekoula indicated they had used a condom with their last anal sex. Although reported condom use is high, sex workers reported that many clients were resistant to it. Fear of police harassment or arrest was found to be a disincentive to carrying condoms.¹¹

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 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:

- Living on earnings of prostitution or persistently soliciting (punishment of imprisonment for 6 months);
- Loitering or soliciting for the purposes of prostitution, including both soliciting and seeking “the services of a prostitute” (punishment of imprisonment for up to 3 months and/or a fine);
- Operating a brothel (punishment of imprisonment for 5 years and/or a fine).

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
- NGO nervousness as a result of the policing of sex workers and uncertainty about the implications of the Decree have resulted in the closure of programs, withdrawal of support and services, and the cessation of information and HIV prevention workshops for sex workers. This has compromised sex workers’ access to sexual health services such as HIV and STI testing and treatment.
- The criminalisation 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.

In summary, 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 2010 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 respondents of the NCPI agree that “the majority of people in need have access to risk reduction for MSM. CSO respondents on the other hand do not agree that MSM can access risk reduction services. Given that CSOs deliver over 75% of risk reduction services for MSM, their assessment of the reach and coverage of the risk reduction programs is more likely than the assessment of government respondent.

The 2010 review of the NHSP 207 – 2011 reported that MSM in Fiji are mostly not visible and don’t identify as gay. MENFiji, an NGO established in 2008, provides prevention programs for these men, but deliberately organises 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 behaviour not identity, and their activities recognise 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 counselling 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 decriminalised 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.

As mentioned previously, two studies completed in 2011 have provided much relevant information about HIV related knowledge and behaviours of MSM. The AIDS Task Force of Fiji study, "Secret lives, other voices... a community based study exploring male to male sex, gender identity and HIV transmission risk in Fiji, used the snowball method to recruit 212 MSM respondents for study. The study by Rawstorne et al²⁵, "An integrated bio-behavioural survey (IBBS) of transgender and men who have sex with men in Suva and Lautoka, Fiji", used respondent driven sampling (RDS) to recruit 464 MSM. The use of RDS enables a probability sample to be derived, which enables inferences to be made about the population of interest, in this case MSM and transgender. This is an advantage over snowball and other non-probability sampling methods. The ATFF study provides a useful description of diversity of sexual and gender identities and gender expressions in Fiji. The measurement of HIV-related knowledge and behaviours and rates of HIV and STI infection provided by the Rawstorne et al IBBS study will serve as a baseline evidence for evaluating the effectiveness of prevention efforts for MSM.

The vast majority of participants had heard of HIV and AIDS (93%) and over half (54%) of the overall sample knew someone with HIV. Of those who had heard of HIV and AIDS (N=432), the proportion who correctly answered HIV knowledge questions ranged from 77% to 91% with the lowest knowing that a person cannot get HIV from mosquito bites and the highest proportion knowing that correct condom use can reduce the chance of getting HIV. Suva participants generally had better HIV knowledge than Lautoka participants.

The size of the MSM population in Fiji has not been determined, so coverage of HIV programs directed to MSM cannot be determined. Nevertheless, information from the IBBS indicates that nearly three quarters (74.2%) of MSM in Suva and Lautoka have been reached with prevention programs. Specifically, 67.8% had been given condoms through and outreach service in the last 12 months, and 97% knew where to get an HIV test.

With regards to sexual practice, almost all participants had experienced anal intercourse with another male; in the previous 6 months, 76.1% had anal intercourse with a male. About half (50.5%) of the participants used a condom at last anal intercourse with their regular and casual male partners. The majority (87%) of participants were concordant in their condom use behaviour (i.e. they either used condoms with both their last casual and regular male partners or did not use condoms with both types of partners).

More than half (58%) of the respondents had sex with a female in the last 6 months. Condom use with female partners was slightly less likely than condom use with male partners in the last six months, with 39% using a condom with a female partner at the last sexual intercourse, compared with 50% or 51% who used a condom with a male.

Rates of HIV testing were very low, with only 15.3% (71/464) of study participants having had an HIV test and been back to find the results in the last 12 months. The ATFF study had an even lower percentage (10.3%) of participants having a HIV test and knowing their result.

The majority of the study participants consented to being tested for STIs and HIV. The estimated prevalence of Chlamydia, Gonorrhoea, Syphilis, Hepatitis B and HIV are presented in Table 4 below. There were a total of two participants (one in Suva and one in Lautoka) who tested HIV positive. The unadjusted HIV prevalence was 0.5% (95% CI: 0.1%, 1.6%) for the overall sample.

Table 4: Estimated prevalence of STIs and HIV in MSM in Suva & Lautoka

STI	Estimated prevalence (Suva)	Estimated prevalence (Lautoka)
Chlamydia	9%	7%
Gonorrhoea	3%	17%
Syphilis	20%	24%
Hepatitis B	4%	7%
HIV	0.5%	

Source: Rawstone et al: An integrated bio-behavioural survey (IBBS) of transgender and men who have sex with men in Suva and Lautoka, Fiji, Draft report

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. 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.

People living with HIV, from both FJN+ and PIAF, believe that stigma and discrimination are being addressed and that they are mostly accepted within the Fijian community. So the battle for the hearts and minds of the community to overcome stigma and discrimination is being won. 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.

Intimate partner violence

A national survey of domestic violence has not been completed in Fiji. Nevertheless, information from a variety of sources indicate that domestic violence is widespread in the country. Figures from the Fiji Women’s Crisis Centre show that 80% of women have witnessed some form of violence in the home; 66% have been physically abused by partners and nearly half repeatedly abused. 26% of women have been beaten while pregnant; 48% of married women have been force into sex by their husbands; and 13% of women have been raped.²⁶

Screening of pregnant women who were receiving HIV pre-test counselling from PCSS counsellors for domestic violence in 2011 revealed that 1031 women (17.5%) in the antenatal clinics had experienced domestic violence. Three hundred and forty-seven women considered the level of violence distressing enough to want to access counselling services.

There are a number of initiatives in place to address the issue of intimate partner violence. The Ministry of Women and Social Welfare have stepped up the implementation of the “Zero Tolerance” for Gender Violence program. Communities that wish to join the campaign receive training on gender issues, including gender based violence. They establish a committee consisting of the village chief, religious leader, women’s group and youth representative that will counsel perpetrators of domestic violence and provide support for the victims. They encourage neighbours to intervene when violence is taking place, and report perpetrators to the police. After adequate preparation, which can take up to one year, the community declares “Zero Tolerance” when they all agree that they are ready. This is marked with a ceremony attended by the Minister of Women. The Ministry monitors the community for any reports of violence against women.

HIV testing and counselling services

Civil Society respondents to the NCPI agree with the statement that “the majority of people in need have access to testing and counselling. Government respondents were neutral on the question – i.e. neither agreed nor disagreed. The majority of HIV tests in 2010 and 2011 were performed on donated blood and pregnant women. Together these two categories constituted approximately 80% of all HIV tests in the country (see Table 5 below). The statement of the majority of people in need having access to testing and counselling applies to pregnant women and blood donors. The testing data in Table 5 does not support the statement being true for all others who are neither pregnant nor donating blood.

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.

A two-step HIV testing algorithm is used in Fiji. Determine is used as the screening assay for rapid antibody testing. Two rapid tests (Uni-Gold and Insti) are conducted in parallel as the confirmatory test. Any discordant results arising from the two parallel confirmatory tests (Uni-Gold and Insti) are repeated after 4 weeks with new blood sample from the client. The Determine screening test can be done at the sub-divisional hospital level (there are 16 sub-divisional hospitals). Testing can also be obtained at the three reproductive health clinics or Hubs, one in each of the three divisions. At present all confirmatory tests using Uni-Gold and Insti are done at the three divisional hospital laboratories, under technical oversight from the National Reference Laboratory, Mataika House. There is a plan to decentralise the confirmatory tests to the sub-divisional hospitals. This will further reduce the length of time for confirming a HIV diagnosis and lead to better health outcomes for patients.

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.

The availability of HIV test services in a health facility depends not only on the laboratory capacity to conduct the test, but also on whether there is a trained counsellor available to conduct the pre-and post-test counselling.

As described in the Best Practice section of this report, the Pacific Counselling and Social Services (PCSS) has been working in partnership with the MOH since 2005 to provide pre-and post-test counselling to pregnant women attending ANCs. PCSS is a recognised regional provider of quality

counselling training and has developed a 10-day specific Reproductive Health Practitioner Course for healthcare workers that has seen over 100 HCW in Fiji accredited. So increasingly, health care workers at all levels of the service will have the skills to provide counselling associated with taking a HIV test.

The number of HIV tests performed each year from 2005 to 2011 is shown in Table 4 below. There is no clear pattern about either the number of tests conducted or the case detection rate for each year, except that the % of HIV infections detected in the total amount of tests performed in 2011 is twice the equivalent figure in 2010. It is not possible to say if this represents a trend upwards with regard to HIV diagnoses.

Table 5: HIV testing in Fiji - 2005 to 2009

Year	Number of HIV tests conducted	Proportion of tests as percentage of Fiji population	Number of HIV+ diagnoses	Proportion of HIV infections among total HIV tests conducted	Number of data sources (Divisional and Sub-divisional hospitals)
2005	55,211	6.54%	29	0.05%	3
2006	24,648	2.94%	36	0.15%	3
2007	22,535	2.69%	23	0.10%	3
2008	27,865	3.33%	31	0.11%	3
2009	42,507	5.08%	43	0.10%	11
2010	35,518	4.3%	33	0.1%	22
2011	37,788	4.6%	54	0.2%	22

Source: Ministry of Health 2011, Records of Divisional and sub-divisional hospitals

The number of HIV tests performed in 2010 and 2011, disaggregated by objective of testing is shown in Table 5 below. The total number of HIV tests performed each year does not include travel or visa related tests. But the number of such tests is not large and should not change the total number of tests significantly. The key point to note from the table is that almost all the tests performed can be described as provider initiated. There are almost no tests that can be described as VCCT – for example a test resulting from a person reflecting on their sexual behaviour, deciding that they may have been at risk at some time in the past and going for a test to find out if they are infected or not. This suggests that the information and advice about going for a test is falling on deaf ears. There is a need to review behaviour change communication materials and activities aimed at encouraging HIV testing and indeed all aspects of HIV prevention programs.

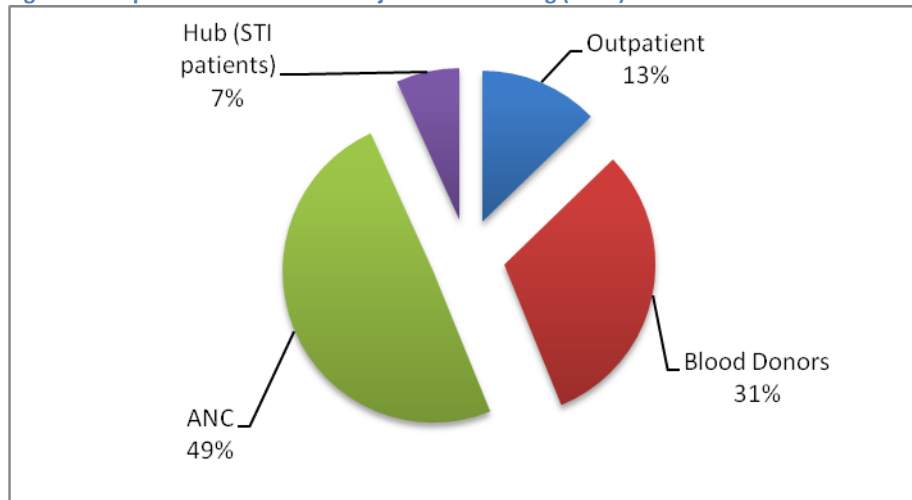
Table 6: HIV tests in 2010 & 2011 - Disaggregated by objective of testing

Objective of testing	2010				2011			
	Number of HIV tests	% Total HIV tests	Number HIV+	% HIV infections	Number of HIV tests	% Total HIV tests	Number HIV+	% HIV infections
Outpatient	4,538	12.8%	-	-	5,657	15%	-	
Blood Donors	11,032	31.1%	0	0	11,573	30.5%	2	0.02%
ANC	17,538	49.3%	8	0.05%	17,787	47.1%	11	0.06%
Hub (STI patients)	2,410	6.8%	7	0.29%	2,771	7.4%	14	0.51
Total	35,518				37,788			

Source: Records of divisional and sub-divisional hospital laboratories, Hub Centres, Mataika House

Figure 9 shows the percentages of tests done by objective of testing. Nearly half of all tests performed are of pregnant women. Blood donors make up one third of tests performed. The data on testing of Hub patients is of particular interest. The sexual and reproductive health clinics, nicknamed the Hub, in each Division are the specialist STI clinics in the three divisional capitals of Suva, Lautoka and Labasa. The patients tested are STI clinic attendees. The Hub patients contribute only 6.8% and 7.4% of the total HIV tests performed in 2010 and 2011 respectively. The percentage of HIV infections among the tests conducted is between five to eight times higher than the percentage seen in ANC patients. This group of patients is the closest to a ‘high risk’ group that has emerged in the HIV situation in Fiji. It is important that sentinel surveillance is established at the three Hub Centre clinics and the situation watched for while to check the trends of infection in the group.

Figure 9: Proportion of HIV tests x Objective for Testing (2010)



Source: Ministry of Health – Laboratories from sub-divisional and divisional hospitals

Challenges to HIV testing and counselling

- **Increasing the number of people who know their HIV status:** One of the objectives of HIV education is to motivate people to get a test. As explained above, the data in Table 5 and Figure 9 reveal that there are few people motivated to know their HIV status. A challenge for the HIV testing and counselling program is to determine why the education programs are failing to motivate people to be tested for HIV and utilise the findings of the review to develop different programs that will help increase the number of people who know their status.
- **Further decentralise HIV and STI testing by introducing new and improved rapid and confirmatory tests:** The need to introduce new and improved processes for rapid testing and confirmatory tests for both STIs and HIV, following introduction of new regional and national guidelines, and evaluated before expansion to the whole country.
- **Increasing the availability of trained counsellors in sub-divisional and health facility levels:** Further strengthen and increase MOH VCCT trained nurses.

Prevention of parent-to-child-transmission of HIV services: stats & facts

Civil Society respondents to the NCPI agree with the statement that “the majority of people in need have access to prevention of mother to child transmission of HIV. Government respondents were neutral on the question – i.e. neither agreed nor disagreed. The available data on antenatal HIV testing of pregnant women indicates that there have been huge improvements in the PMTCT program in Fiji since the program began in 2005.

The initial partnership between PCSS and the MOH that sparked the start of the counselling and testing program has expanded from a pilot program in one hospital that reached about 1,300 and is

now established in the three divisional and 2 sub-divisional hospitals. In 2012, the MOH/PCSS partnership will reach about 13,000 pregnant women with HIV counselling and testing. This represents 60% of pregnant women in the country. PC&SS has also trained over 100 nurses in counselling, many working in the sub-divisional and health centre level. In the antenatal clinics that do not have the PCSS/MOH partnership, the nurses with counselling training facilitate the HIV testing. Altogether, it is estimated that up to 80% of pregnant women received an HIV test as part of antenatal care in 2011, up from 66% in 2010.

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. PCSS data shows that in the ANCs where they operate, after the pre-test counselling, about 98% of pregnant women opt to take the test.

All pregnant women who test HIV+, including those who have an indeterminate HIV test result are provided with ARV prophylaxis. The two options of maternal ARV prophylaxis used are maternal AZT based on the 2010 WHO guidelines, and the maternal triple ARV prophylaxis. Early infant diagnosis has been established for babies exposed to HIV. Dried blood spots are collected between four to six weeks after birth and sent to a laboratory in Australia for virological testing. HIV exposed infants are given co-trimoxazole prophylaxis from 4 – 6 weeks for the prevention of opportunistic infections until the baby is confirmed negative.

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

The salient facts about the PPTCT program have been summarised in Table 6 below.

Table 7: Salient facts about PPTCT Program

ISSUE	STATUS FOR 2010 & 2011
Total estimated number of pregnant women	Estimated number of pregnant women in: <ul style="list-style-type: none"> • 2010: 23,178 • 2011:>25,000
ANC coverage and skilled delivery coverage	98.8%
Services and tests routinely offered to pregnant women	<ul style="list-style-type: none"> • Weight and height measurement • Blood pressure measurement • Urine testing • Blood testing to detect syphilis and severe anaemia
Coverage for services and tests routinely offered to women	Coverage for all ANC services except for HIV testing is 98% Coverage for HIV testing was 66% in 2010 ²⁷
Does the country have PMTCT/ PPTCT policy/ guidelines? If yes, when it was adopted? – Have WHO PMTCT ARV guidelines (2010) been incorporated into the national guideline? Does it cover other STI’s?	<ul style="list-style-type: none"> • PPTCT Policy was adopted in 2010 • WHO’s PMTCT ARV guidelines have been incorporated into to the national guidelines • The policy includes screen HIV+ pregnant women for syphilis, Hepatitis B, and

ISSUE	STATUS FOR 2010 & 2011
	Chlamydia.
Treatment and prophylaxis (including Co-trimoxazole) regimen used in the country for pregnant women and infants	<p>Option A: Maternal AZT (based on WHO 2010 guidelines)</p> <p>Option B: Maternal triple ARV prophylaxis</p> <p>Infants: Co-trimoxazole prophylaxis [see above]</p>
Policy position on infant feeding (in line with the national breastfeeding policy) and testing (if it is not covered in the HIV testing and counselling section)	<p>Infant feeding</p> <p>Counselling for “best feeding choice” where the mother is HIV positive, the safest options for infant feeding are:</p> <ul style="list-style-type: none"> • Replacement feeding, provided it is feasible, acceptable, safe, sustainable and affordable and that the MOH should provide the baby’s milk up to 12 months of age. • In all other cases, exclusive breast feeding with rapid weaning at 6 months is still recommended and also is in harmony with Fiji’s national policy for Baby Friendly Hospital Initiatives <p>HIV testing for infants</p> <p>The PPTCT policy recommends that infants exposed to HIV are should be tested between 4 to 6 weeks of age using a virological assay n whole blood or dried blood spots. The dried blood samples are sent to a laboratory in Australia for testing.</p>
Number of health facilities providing ANC services	37
Number of health facilities providing ANC services that also provide HIV testing and counselling services for pregnant women	<p>16 Sub-divisional hospitals</p> <p>3 Divisional hospitals</p>
Number of health facilities that offer ART	<p>Six (6), namely</p> <ul style="list-style-type: none"> • Colonial War Memorial Hospital (CWMH) • Suva Reproductive Health Clinic (The Suva Hub) • Lautoka Hospital • The Lautoka Reproductive Health Clinic[Hub] • Labasa Hospital • Labasa Hub

ISSUE	STATUS FOR 2010 & 2011		
Number of pregnant women tested for HIV in 2010 and 2011. Depending on availability of data this indicator could be further disaggregated by number of pregnant women counselled, tested and received test results.	<ul style="list-style-type: none"> • 2010: 17,538 • 2011: 17,787 		
Number of new HIV cases among pregnant women	<ul style="list-style-type: none"> • 2010: 8 • 2011: 11 		
Number of HIV positive pregnant women delivered in 2010 and 2011	In 2011, 16 HIV+ pregnant women delivered. This number included women whose HIV test result was indeterminate and had been given ARV prophylaxis while the confirmatory tests were being conducted		
Number of pregnant women tested for syphilis	<ul style="list-style-type: none"> • 2010: 20,903 pregnant women tested for syphilis • 2011: 19,161 pregnant women tested for syphilis 		
Reported cases of syphilis and HIV among ANC attendees in 2010 and 2011		Syphilis	HIV
	2010	892	8
	2011	700	11
Reported cases of vertical transmission of HIV in 2010 and 2011	<ul style="list-style-type: none"> • 2010: Reported cases of vertical transmission was 1 • 2011: Reported cases of vertical transmission was 2 		
Data on ARV prophylaxis for pregnant women	88% (14/16) of HIV-positive pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission in 2011		

Table 8: Rates of HIV & Syphilis in ANC attendees (2010 & 2011)

Year	Number of ANC Attendees	Number of ANC attendees tested for		% ANC attendees tested for		Number of new cases among pregnant women		% new cases among pregnant women		% new cases among pregnant women who tested for HIV	
		Syphilis	HIV	Syphilis	HIV	Syphilis	HIV	Syphilis	HIV	Syphilis	HIV
2010	26,286	20,903	17,538	79.52%	66.72%	892	8	4.27%	0.05%	5.09%	
2011	28,726	19,161	17,787	66.70%	61.92%	700	11	3.65%	0.06%	3.94%	

Source: Ministry of Health – Records of divisional and sub-divisional hospitals

Challenges for PPTCT Program

The key challenges to the PPTCT program are:

- Attaining universal access of pregnant women to HIV counselling and testing program:** Antenatal HIV testing has been decentralised and is now estimated to be reaching approximately 80% of pregnant women. It is possible that outside of the five hospitals where PCSS and MOH work in partnership, the counselling provided to the women is rudimentary, hence missing the opportunity to enhance the benefit of the contact of the pregnant woman with the health service beyond the HIV test. The challenge in the next reporting period is to extend the counselling and testing program to the remaining ANCs, and thus reaching all pregnant women.
- Early screening of pregnant women:** Although 98%+ of pregnant women attend antenatal care at least once in their pregnancy, many do not attend until late in their pregnancy. This means that HIV testing occurs late in the pregnancy, thus reducing the chance of a successful intervention to prevent transmission to the infant. It is important that pregnant women are encouraged and motivated to book in first trimester so that screening and treatment if necessary can be administered early.
- Male involvement in reproductive health:** Given the power differential between men and women, women are more likely to adopt sexual behaviours that do not expose them to infection with STIs and HIV while they are pregnant and breastfeeding if their partner is supportive of the changed behaviour. A pilot program conducted by PC&SS of providing information to male partners and encouraging them to access testing and counselling was successful in getting a small number male partners to attend ANC with their wives/partner. An evaluation of the male involvement initiative should be conducted and if found to be effective, expanded to all antenatal sites.
- Undertake a campaign to prevent and treat syphilis in pregnant women:** In addition to HIV testing, pregnant women are also tested for other STIs including syphilis. In 2010 and 2011, 892 and 700 cases of syphilis were diagnosed in the 17,538 and 17,787 pregnant women tested respectively, giving rates of 4.3% and 3.7%. The reported STI data from MOH for 2010 shows that there were 234 cases of congenital syphilis which confirms the high level of syphilis found in the pregnant women. There is an urgent need to develop and implement a strategy to prevent and treat syphilis and congenital syphilis.

In summary, from a small base of one ANC site, the PPTCT program has scaled-up rapidly and is now estimated to reach 80% of pregnant women, although the quality of counselling varies between sites

with PCSS counsellors and those without. In accordance with the national PPTCT policy, HIV+ pregnant women are given antiretroviral prophylaxis if they do not require ART for their own health. After birth, the exposed infant is given co-trimoxazole and ARV prophylaxis and virological testing conducted when they are 4 to 6 weeks old to determine their HIV status.

The rate of syphilis in pregnant women is alarming, with the concomitant high number of congenital syphilis cases, is cause for great concern. Urgent attention needs to be paid to prevention and treatment of syphilis in pregnant women.

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 counselling,
- Laboratory testing of CD4+ cell count and viral load testing,
- Early infant diagnosis (EID) for HIV exposed infants
- Paediatric AIDS treatment
- HIV testing and counselling for people with TB
- Psychosocial support for PLHIV

The treatment, care and support program was rated eight out of 10 by both civil society and government in the NCPI. For the government, this rating was consistent with the ratings given for since 2006. For civil society the rating for 2012 was a big Improvement on the ratings for the 2010, 2008 and 2006 UNGASS reports, when the ARV treatment was rated 4, 1, and 2 out of 10 respectively. Although many aspects of the implementation of the treatment, care and support program were highly assessed by both the government and civil society NCPI respondents, two aspects of the program were noticeable by the poor assessment they received. Access to post-exposure prophylaxis (PEP) for sexual assault was regarded as poor, as was TB preventive therapy for PLHIV.

Antiretroviral therapy

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

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

Three people previously enrolled PLHIV, two females and one male, dropped out of the treatment program, so the total on ART at end of 2011 was 73. The male patient was lost to follow-up. The two female patients that dropped out were persuaded by a traditional herbalist that they could be cured

by the herbs if they stopped taking ARVs. The false promise of a cure is a big concern and is being addressed on many levels. FJN+ is conducting an intensive campaign among the members and providing counselling to members that have been contacted by herbalists and who are considering the false offer of a cure. The Ministry of Health has provided information through the radio warning PLHIV about the dangers of following the advice of the herbalist.

The age and sex disaggregation of the number of PLHIV on ART is shown in Table 9 below.

Table 9: PLHIV on antiretroviral therapy, disaggregated by age and sex

Age Group	Male	Female	Totals
<15	0	1	1
15-19	0	2	2
20-24	2	4	6
25 - 49	33	26	59
>50	3	2	5
Drop-out	1	2	3
Total (Including withdrawals)	39	37	76
Total (Excluding withdrawals)			73

The scaling up of the ART program was achieved by:

- 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.
- Conducting outreach to communities to provide HIV education and encouraging counselling and testing. Each Hub Centre employs an HIV+ advocate who travels with the outreach team to provide HIV education. The participation of the PLHIV in the outreach enables community members to acknowledge the reality of HIV, which can be invisible because of the relatively small numbers of people infected.
- Following WHO guidelines, the threshold for ART eligibility has been increased from 200 to 350 CD4+ cell count, which has increased the number of eligible patients. Additionally, All HIV+ children are given on ART. The ART for children is no longer dependent on their CD4+ count
- Constant reliable CD4+ testing is now available at Mataika House Reference Laboratory
- Psychosocial support for PLHIV using the Suva Hub has been improved by the provision of counselling services by PCSS
- Improved forecasting of drug procurement and increased procurement of ART and opportunistic infection (OI) medications has ensured that there have been no stock-outs of ARV and OI medications.

Seventy-two of the 73 PLHIV on ART are on first line therapy which is a combination of 3 medications from the following selection: Nevirapine, Efavirenz, Lamivudine, Zidovudine and Tenofovir. There is only one patient on second line therapy which consists of Kaletra, Abacavir and Didanosine.

At the end of 2011, 75% (12/16) of PLHIV on antiretroviral treatment had remained on treatment for 12 months after they started. This was significantly less than was achieved for 2010 when 98% (51/52) PLHIV remained on treatment 12 months after they started. The lower 12 month retention in 2011 was primarily due to the traditional herbalist persuading two PLHIV to discontinue treatment in favour of the promised 'cure' from herbs. Additionally in 2011 a male patient died.

Antiretroviral drugs are provided free, 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+ and PIAF assist PLHIV who cannot afford OI medications with the cost of the medications.

HIV & TB

HIV testing and counselling for people with TB is established and all PLHIV are screening for TB. In 2010 and 2011, three and four TB/HIV co-infections were detected and enrolled in TB and ARV treatment programs.

Psychosocial support for PLHIV and their families

One of the primary objectives of Fiji Network for HIV+ people is to provide support, including psychosocial support for PLHIV. FJN+ organises monthly meetings in the three divisional capitals – Suva, Lautoka and Labasa – for the members. Issues of concern are discussed at these meetings. If individual members have specific support needs the FJN+ Care and Support officer meets with them separately and determines what kind of support is required facilitates access for the member. For example, if counselling is required, arrangement is made with the PCSS counsellors to see the member. A key problem for many of the members is lack of employment and income. The Care and Support Officer has facilitated access of unemployed FJN+ members to the social welfare benefit provided by the Ministry of Social Welfare.

Challenges for treatment, care and support program

The treatment, care and support program is well regarded by government and civil society partners in the national response. The availability of free ARVs had encouraged PLHIV to contact the health care services and enrol for treatment. The lack of confidentiality and discriminatory practices that characterised some parts of the health care service with regards to PLHIV has diminished and the experiences of PLHIV with the health care services have improved. The challenges that remain and need to be addressed in the coming years include:

- ***Improving access of PLHIV in rural and remote island areas to ART:*** PLHIV living in rural and remote island areas have poor access to ART because the treatment is only provided in the capital cities of each division. PLHIV who do not live in any of the three capital cities have to travel to the closest Hub to obtain their medications and have their blood tests for CD4+ cell count and viral load done. For those that are not employed, the travel costs can be prohibitive. There is a need to decentralise the ART to sub-divisional level, at a minimum in the future.
- ***Reducing stigma and discrimination toward PLHIV from HCS:*** Despite improvements in the attitudes of health care workers (HCW) towards PLHIV, stigma and discriminatory practices continue to dog the experience of PLHIV when they use the health care system. The HIV/AIDS Decree 2011 offers legal protection against discrimination. It is important to continue the

education of health care workers about the Decree and their responsibility to uphold the law. Additionally the battle for 'hearts and minds' of HCW with respect to stigma and discrimination should continue.

- ***Achieving universal access to treatment:*** A cumulative total of 420 HIV infections have been identified in Fiji. At the end of 2011, fewer than 100 PLHIV are in contact with the health care services. Since identification of HIV infections in Fiji go back more than 20 years, and ART has only been available in Fiji since 2004, it can be assumed that many of those infected with HIV would have already died. It is not known how many PLHIV who know they are infected have not been in contact with the health services. Fiji is able to provide ART to all PLHIV if they contact the health care services. A challenge to the treatment and care program is to encourage PLHIV to contact the health services to determine whether they need ART
- ***Improving nutritional care for PLHIV:*** The core team providing ART in each Hub does not include a dietician. It is important to include a dietician in the core team to improve the diet of PLHIV.
- ***Developing a policy on the role of traditional medicine/herbalist in treatment care and support:*** The experience of PLHIV on ART, discontinuing their treatment on the advice of alternative medicine practitioners has happened in the past and the present. Traditional medicine is an important part of Fijian life, yet very little evidence is available with regards to HIV treatment and care process. While they are not acknowledged, traditional medicine practitioners will continue to be a negative force by persuading PLHIV on ART to abandon the treatment in favour of traditional medicine which has not been proven to be effective against HIV. It is important that MOH develops and implement a policy on engaging with traditional medicine practitioners.
- ***Improving treatment options for infants:*** Lack of access to alternate drugs especially for infants can affect the effectiveness of ART for the HIV exposed infant.

In summary, the treatment, care and support program is well established and well regarded by government, civil society partners and the beneficiaries of the services provided, achieving a rating of 80%. ART has been scaled up and reaches all PLHIV who are in contact with the health services and meet the eligibility criteria for treatment. A total of 73 PLHIV are accessing ART, an increase of 28 from 2010 to 2011. 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. The HIV counselling and testing program must be strengthened and scaled up to improve access to testing. Challenges to the treatment, care and support program have been identified (see above), which will need to be addressed in order to enhance the program.

IV. Best practices

The HIV/AIDS Decree 2011

It was seven years in the making, but 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.

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 status. 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.

The HIV Decree 2011 adds the strength of the law to the changing of hearts and minds with regards to stigma and discrimination. The Decree 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-sectoral Board, which is responsible to the Minister of Health, to oversee the implementation of the national response. The Board is required to report on the status of the HIV response to the Minister annually. A full time Chief Executive Officer is to be appointed to manage the national response, together with additional staff required. The CEO will be the first full time manager of the national HIV response in Fiji. If implemented as legislated in the Decree, this holds big promise for a better coordinated and managed national response, with all partners better informed about the HIV situation and response.

While the content of the HIV Decree is noteworthy, the development of the decree is equally significant. As mentioned above, it took seven years, from when it was first conceived to develop legislation for the national HIV response, to the final product. The timeline for the process is shown in the diagram below. There were many stops and starts, and along the way the very nature of the legislation changed from the initial intention described in the 2007 – 2011 NHSP (Page 79) – which was to “protect the innocent public from wilful transmission” – to the legislation that places everyone’s human rights at the centre of the analysis. The inclusive process used to draft the legislation, where civil society was consulted and encouraged to contribute ideas about issues that needed to be addressed by the Decree, was important in reaching the desired outcome. When the draft decree had been prepared, Ministry of Health organised public consultations in all three divisions to obtain inputs from the wider community. After it was enacted, Ministry of Health, with support from UNAIDS conducted public awareness and education about the Decree.

The deliberate effort to involve all partners in the national response, as well as the general public in the preparation of the Decree has led to a high degree of ownership by all parties. During the process of consultations undertaken to prepare the 2012 GAPR report, many people, from both civil society and government expressed their satisfaction with the passing of the Decree and regard it as a high achievement in the history of the national HIV response.

More than a test: Maximising the impact for HIV counselling and testing for pregnant women

Provider initiated counselling and testing (PICT) of pregnant women is now an established 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. Before the HIV Decree, the ANC nurse could simply inform the pregnant woman that her blood was being checked to make sure that all is well with the baby. Pregnant women expect these health checks, so not many would question that they were being tested for HIV.

In 2005, Pacific Counselling and Social Services[PC&SS], an NGO specialising in providing counselling services, in partnership with the Western Division Health Service, and funded by the Pacific Regional HIV Program (PRHP), piloted a program to provide HIV education and counselling for pregnant women attending the Lautoka Hospital ANC. The women were provided with HIV education in a group and then pre-test counselling individually. The individual sessions were used as an opportunity

for each woman to assess her risk of STI/HIV infection and to decide to be tested for HIV. The success of the pilot program led to expansion to other major ANCs in the country. At present the partnership between PCSS and MOH to provide antenatal counselling is operating in the five largest ANCs in the country, reaching over 65% of pregnant women in the country.

There was concern among some health care workers that if pregnant women are given the option of not taking the HIV test, many of them would refuse to take the test. PCSS' program data shows that this fear is unfounded. In 2011 approximately 98% of the 8,600 women who received pre-test counselling from PCSS counsellors consented to have the HIV test.

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. The results from the implementation of the program in 2011 will illustrate this point. Of the 8,600 women tested for HIV, 7,197 returned for post-test counselling. ANC women reported a significant number of changes following the pre-test session, in fact only 9.3% said they made no changes. Sixty percent of the female clients who participated in the post-test counselling, reported being sexually active since the pre-test interview. Twenty two percent of these clients in the post-test session indicated that they started using condoms for prevention of HIV/STIs since the pre-test session, with 3.9% reporting that they already were using them. This is a significant increase (25.9% in total) from the 7.4% who reported using condoms prior to pre-test session.²⁸

Since the inception of the ANC counselling [PICT] program in 2005, other elements have been added in order to provide a more holistic check for the mental and physical health of the pregnant women. The pre-test assessments now include mental health, non-communicable disease (NCD) and other breast cancer and cervical cancer information.

In 2011, a pilot screening for domestic violence was included in the assessment interview. In total, 1031 women (17.5%) in the antenatal clinics answered yes to at least one of the screening questions indicating past or current domestic violence. Three hundred and forty-seven women considered the level of violence distressing enough to want to access further counselling services, which was provided.

In recognition of the role that male partners play in the risk of pregnant women to HIV/STI, PCSS introduced an extension of the education and counselling program to men. Women in the antenatal program were offered a "men's pack" to give to their partner, containing IEC materials regarding sexual health for the couple during pregnancy and breastfeeding, condoms and lubricant, an invitation to accompany their partner and be involved in the antenatal care including a general counselling session with a male counsellor, and a card for free replenishment of their initial supply of condoms throughout the duration of the pregnancy and while their partner is breastfeeding. In 2011 a total of 60.9% of women confirmed at post-test that they had given the men's pack to their partner (women who did not take a pack were generally those who reported no stable relationship).

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 very high percentage of women who receive post test counselling at four of the major hospitals in Fiji (98.4%) shows how well integrated these services are into routine antenatal care in a way that is both effective and efficient. 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 organisation and the government that leads to provision of better services for patients.

V. Major challenges and gaps

The major challenges and gaps in the national HIV response were collated from the Government and Civil Society NCPI.

Political Support and Leadership

Political support and leadership was rated highly in the NCPI, achieving a score of 8 out of a 10. Both government and civil society are in agreement about the level of political support the HIV response is enjoying. The passing of the HIV/AIDS Decree has been a concrete demonstration of the support of the government for sensible, human rights based legislation and policies with regards to HIV. The gaps identified that required some leadership are as follows:

1. Government to have continued meaningful dialogue with the churches on sensitive issues surrounding sexuality
2. Regulating and enforcing the HIV/AIDS Decree in all sectors: public, private, faith-based organisations (FBO) and CSO.
3. Obtaining the endorsement of the Minister for Education to extend the Family Life Education Curriculum for all schools.
4. Traditional and religious leaders have a huge role to play and whilst some have come on board, more needs to be done to accept key and vulnerable populations e.g. MSMs and sex workers, thus making it easier for these groups to access all services and programs.

Human Rights and Legislation

1. Section 23 of the HIV/AIDS Decree states that “ where the provisions of any other written law are specially inconsistent with the provisions of this Decree, this Decree prevails to the extent necessary for the purposes of this Decree. It may be necessary to challenge the Crimes Decree in the court, as it applies to sex work, as an attempt to decriminalise sex work and ensure that sex workers access prevention and care services.
2. There is a need to continue to work on changing the attitudes of the police and the judiciary on HIV/AIDS issues. Changes in the attitudes of the police and judiciary on HIV/AIDS issues. Although there is no longer a criminal offence of wilful transmission of HIV in the HIV Decree there is still an offence in the Crimes Decree which is general and covers all diseases, of negligently spreading infectious disease. The police will need continued education to focus of the criminal offences of denying access or of unlawful discrimination rather than on the spreading of disease provision in the Crimes Decree.

Monitoring and Evaluation

1. Monitoring and evaluation of the national response is regarded by all parties as woefully inadequate. There was a rating of 4 out of 10 for M & E from the government NCPI. As discussed in another part of this report, there was no overall monitoring of the implementation on the 2007 – 2011 NSPH hence there is no indication that the NSP 2007 - 2011 was being used to guide the national response. The challenge is to develop a monitoring and evaluation system

and plan for the new NSP that utilises data already being produced by different partners and not imposing additional burdens on them to collect different data.

2. The new M & E plan should include a process for sharing information with all partners in the HIV response on a regular basis and for using information for policy, planning and for procurement of goods.

Prevention

- The biggest proportion of resources for HIV is dedicated to prevention, and there are many HIV education activities for different population groups being implemented in the country. However, it is not clear what kind of coverage has been achieved and whether the education is having the desired effect of changing attitudes and behaviours. For example educating the community about the importance of knowing one's status is not leading to people asking for HIV tests. There is a need to evaluate the prevention programs in the country to determine whether they are working and to improve them.
- Condom use among Fijians of i-Taukei descent continues to be low. The 2011 study on the relative risks of HIV and STI transmission in the context of intimate, companionate relationships in Fiji, *Me and My Intimate Partner and HIV*²⁹ reports that 25% of respondents used a condom at their last sex. This finding is in agreement with earlier studies on sexual behaviour by Kaitani (2006)³⁰, and the 2008 SGS studies reported in the 2010 UNGASS³¹. It is assumed that knowledge about HIV risk and means of prevention is high in the community, although there has been no DHS-style study to assess the level of knowledge. It is also assumed that condoms are readily available. Hence the lack of behaviour change evidenced by the low condom use rate is a challenge that needs to be addressed if the HIV response is to be more effective.
- The need to ensure that young people receive support for prevention of sexual transmission, and support for gender awareness, not just information about HIV as a disease
- The need to address the issues of stigma, discrimination and human rights
- The need to continue to promote community discussion of gender inequalities and gender based violence, because these affect women and transgender people's ability to make their own choices about who to have sex with and when
- The need to provide more support to people living with HIV so that they understand the value of treatment as one way to prevent further HIV transmission, and the importance of continuing to avoid transmission of STIs
- Challenging ideas that distributing condoms and educating people about HIV encourages young people to be promiscuous
- The Crimes Decree introduced in 2010 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.

Counselling and Testing

- ***Increasing the number of people who know their HIV status:*** One of the objectives of HIV education is to motivate people to get a test. As explained above, the data in Table 5 and Figure 9 reveal that there are few people motivated to know their HIV status. A challenge for the HIV testing and counselling program is to determine why the education programs are failing to

motivate people to be tested for HIV and utilise the findings of the review to develop different programs that will help increase the number of people who know their status.

- **Further decentralise HIV and STI testing by introducing new and improved rapid and confirmatory tests:** The need to introduce new and improved processes for rapid testing and confirmatory tests for both STIs and HIV, following introduction of new regional and national guidelines, and evaluated before expansion to the whole country.

Prevention of parent to child transmission of HIV

- **Attaining universal access of pregnant women to HIV counselling and testing program:** Antenatal HIV testing has been decentralised and is now estimated to be reaching approximately 80% of pregnant women. It is possible that outside of the five hospitals where PCSS and MOH work in partnership, the counselling provided to the women is rudimentary, hence missing the opportunity to enhance the benefit of the contact of the pregnant woman with the health service beyond the HIV test. The challenge in the next reporting period is to extend the counselling and testing program to the remaining ANCs, and thus reaching all pregnant women.
- **Early screening of pregnant women:** Although 98%+ of pregnant women attend antenatal care at least once in their pregnancy, many do not attend until late in their pregnancy. This means that HIV testing occurs late in the pregnancy, thus reducing the chance of a successful intervention to prevent transmission to the infant. It is important that pregnant women are encouraged and motivated to book in first trimester so that screening and treatment if necessary can be administered early.
- **Male involvement in reproductive health:** Given the power differential between men and women, women are more likely to adopt sexual behaviours that do not expose them to infection with STIs and HIV while they are pregnant and breastfeeding if their partner is supportive of the changed behaviour. A pilot program conducted by PCSS of providing information to male partners and encouraging them to access testing and counselling was successful in getting a small number of male partners to attend ANC with their wives/partner. An evaluation of the male involvement initiative should be conducted and if found to be effective, expanded to all antenatal sites.
- **Undertake a campaign to prevent and treat syphilis in pregnant women:** In addition to HIV testing, pregnant women are also tested for other STIs including syphilis. In 2010 and 2011, 892 and 700 cases of syphilis were diagnosed in the 17,538 and 17,787 pregnant women tested respectively, giving rates of 4.3% and 3.7%. The reported STI data from MOH for 2010 shows that there were 234 cases of congenital syphilis which confirms the high level of syphilis found in the pregnant women. There is an urgent need to develop and implement a strategy to prevent and treat syphilis and congenital syphilis.

Treatment Care & Support

- **Improving access of PLHIV in rural and remote island areas to ART:** PLHIV living in rural and remote island areas have poor access to ART because the treatment is only provided in the capital cities of each division. PLHIV who do not live in any of the three capital cities have to travel to the closest Hub to obtain their medications and have their blood tests for CD4+ cell count and viral load done. For those that are not employed, the travel costs can be prohibitive. There is a need to decentralise the ART to sub-divisional level, at a minimum in the future.
- **Reducing stigma and discrimination toward PLHIV from HCS:** Despite improvements in the attitudes of health care workers (HCW) towards PLHIV, stigma and discriminatory practices continue to dog the experience of PLHIV when they use the health care system. The HIV/AIDS Decree 2011 offers legal protection against discrimination. It is important to continue the

education of health care workers about the Decree and their responsibility to uphold the law. Additionally the battle for 'hearts and minds' of HCW with respect to stigma and discrimination should continue.

- **Achieving universal access to treatment:** A cumulative total of 420 HIV infections have been identified in Fiji. At the end of 2011, fewer than 100 PLHIV are in contact with the health care services. Since identification of HIV infections in Fiji go back more than 20 years, and ART has only been available in Fiji since 2004, it can be assumed that many of those infected with HIV would have already died. It is not known how many PLHIV who know they are infected have not been in contact with the health services. Fiji is able to provide ART to all PLHIV if they contact the health care services. A challenge to the treatment and care program is to encourage PLHIV to contact the health services to determine whether they need ART
- **Improving nutritional care for PLHIV:** The core team providing ART in each Hub does not include a dietician. It is important to include a dietician in the core team to improve the diet of PLHIV.
- **Developing a policy on the role of traditional medicine/herbalist in treatment care and support:** The experience of PLHIV on ART, discontinuing their treatment on the advise of alternative medicine practitioners has happened in the past. Traditional medicine is an important part of Fijian life, yet is not acknowledged in the HIV treatment and care process. While they are not acknowledged, traditional medicine practitioners will continue to be a negative force by persuading PLHIV on ART to abandon the treatment in favour of traditional medicine which has not been proven to be effective against HIV. It is important that MOH develops and implement a policy on engaging with traditional medicine.
- **Improving treatment options for infants:** Lack of access to alternate drugs especially for infants can affect the effectiveness of ART for the HIV exposed infant.

Orphans

Raising awareness and recognition that the absence of a policy to address orphans and vulnerable children is a significant gap in the national response to HIV. MOH needs to facilitate a discussion of key stakeholders working with orphans and vulnerable children to identify what needs to be done and develop a policy if this is required.

Funding

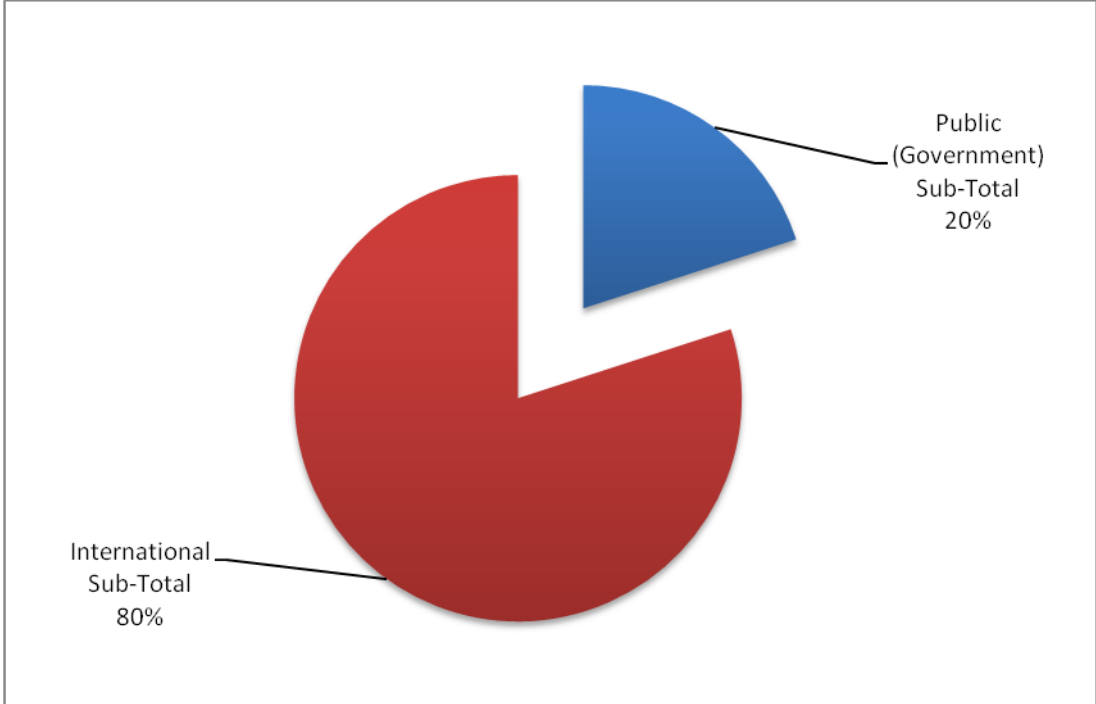
The main source of funding for the HIV response in Fiji is the Pacific Response Fund, which is scheduled to end in 2013. It is not clear where funding for the response will come from after the Response Fund finishes.

VI. Support from the country's development partners

Fiji enjoys strong support from the development partners for the national HIV response. The main development partners are: the Australian government through the Australian Agency for International Development (AusAID), the New Zealand government through the New Zealand Agency for International Development (NZAID), International Labour Organisation (ILO), UNAIDS, UNDP, UNFPA UNICEF, UN Women, ILO, and World Health Organisation (WHO) provide both financial and technical support for all areas of the national response. As the AIDS Spending Assessment shows, approximately 80% of the total expenditure of US\$2.25 million and US\$2.1 million for 2010 and 2011 respectively was provided by development partners. Proportions of the AIDS Expenditure on the HIV

from the government, international (development partners) and private sectors for 2011 is in the Figure below.

Figure 10: Proportions of total AIDS expenditure provided by government and international sources



The majority of the funding provided by development partners goes to civil society organisations and has ensured that they are able to national response. This has enabled the government to utilise most of the national allocation for the HIV response on activities implemented by government agencies.

In addition to providing financial support, the development partners also provide technical support and capacity building. Examples of the technical support provided are as follows: UNAIDS provided technical support for the review of the 2007 2011 NHSP and for the development of the 2012 to 2015 NSP. WHO provided a consultant to facilitate the drafting of the HIV/AIDS Decree 2011. Support has been provided to a number of CSOs to conduct research. These processes have been used to strengthen the capacity of the partners in research. For example, MENFiji, with funding from the Response Fund was able to engage the UNSW to assist them to conduct the Integrated behavioural and biological survey of MSM in 2011.

References

- ¹ UNAIDS and WHO. Epidemiological Factsheet, Fiji, 2010: accessed online on 26th March 2012 at <http://aidsinfo.unaids.org>
- ² Government of Fiji.HIV/AIDS Decree 2011 (Decree No.5 of 2011). Republic of Fiji Islands Government Gazette, Vol. 12, 4th February 2012
- ³ Rawstorne, P., Man, W. Y. Maharaj, P., Rokoduru, A., Rasili, S., Vulavou, I., Worth, H. (2012). MENFiji Draft Report: An integrated bio-behavioural survey of transgender and men who have sex with men in Suva and Lautoka, Fiji. Males Empowerment Network, Fiji (MENFiji).
- ⁴ Bavinton G, Singh N, Naiker 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
- ⁵ UN Women. Ending Violence Against Women and Girls, Evidence, Data and Knowledge in Pacific Island Countries: Literature Review and Annotated Bibliography, 2nd Edition, July 2011, Page 15.
- ⁶ Asia Pacific Observatory on Health Systems and Policies.The Fiji Islands Health System Review. Health Systems in Transition, Vol 1, No.1, 2011
- ⁷ UN Development Assistance Framework.Desk Review for Fiji Islands. Zero draft, 15 June 2011
- ⁸ Asia Pacific Observatory on Health Systems and Policies Fiji Islands Health System Review, Health Systems in Transition, Vol 1, No. 1 201
- ⁹ The Australia - Fiji Health Sector Support Project 2011 – 2015 Design Document (November 2010), page 6
- ¹⁰ http://www.wpro.who.int/countries/2008/fij/health_situation.htm
- ¹¹ MOH Annual Report 2009
- ¹² World Health Organisation, 2006: Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries (2004 – 2005), p21.
- ¹³ Report of MEN Fiji, to be published in September 2011. Some of the yet to be published tentative results were reported in consultative workshops for development of this national strategic plan.
- ¹⁴ McMillan K, Worth H. Risky Business: sex work & HIV prevention in Fiji. Sydney, International HIV Research Group, UNSW, 2009
- ¹⁵ Bavinton G, Singh N, Naiker 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
- ¹⁶ Pacific Island AIDS Foundation.Experiences and perspectives of women living with HIV in Fiji and Papua New Guinea. Suva, PIAF/Pacific Islands HIV and STI Response Fund/Commonwealth Foundation, 2011
- ¹⁷ UNDP. Me, my intimate partner and HIV: Fijian self-assessment of transmission risks. Suva, UNDP, 2011
- ¹⁸ UNAIDS. Fiji Country Review, draft, February 28.
- ¹⁹ Government of Fiji.HIV/AIDS Decree 2011 (Decree no. 5 of 2011). Suva, Government of Fiji, 2011
- ²⁰ Ministry of Health. Fiji National HIV/AIDS Strategic Plan 2007 – 2011.
- ²¹ Sibide M, Buse K. Fomenting a prevention revolution for HIV. Lancet. 2010 February 13, 2010;375:533-5.
- ²² 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.
- ²³ Karen McMillan and Heather Worth, 2010. Risky Business: Sex Work and HIV prevention in Fiji.
- ²⁴ Pacific Counselling and Social Services, 2010. 12 Month Data for PCSS' Sekoula Services, January to December 2010
- ²⁵ Rawstorne, P., Man, W. Y. Maharaj, P., Rokoduru, A., Rasili, S., Vulavou, I., Worth, H. (2012). MENFiji Draft Report: An integrated bio-behavioural survey of transgender and men who have sex with men in Suva and Lautoka, Fiji. Males Empowerment Network, Fiji (MENFiji).
- ²⁶ UN Women. Ending Violence Against Women and Girls, Evidence, Data and Knowledge in Pacific Island Countries: Literature Review and Annotated Bibliography, 2nd Edition, July 2011, Page 15.
- ²⁷ Government of Fiji, Ministry of Health, Universal Access Report - Monitoring and reporting on the health sector response to HIV/AIDS, 2010
- ²⁸ Pacific Counselling and Social Services. Statistical report with basic analysis and interpretation of 12 months data from provider initiated integrated antenatal HIV/STI pre and post test counseling – January to December 2011.
- ²⁹ Hammar, L, 2011. Me, My Intimate Partner, and HIV: Fijian self-assessments of transmission risks. UNDP Pacific Centre, Suva, Fiji
- ³⁰ Kaitani, M. (2006). Sexual Behaviour of Fijian Men, Centre for Development Studies, USP.
- ³¹ Fiji Islands National AIDS Committee, March 2010. UNGASS Country Progress Report 2010, Page 7.