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Acronyms

ADB	Asian Development Bank
ADRA Fiji	Adventist Development and Relief Agency
AIDS	Acquired Immuno - Deficiency Syndrome
ANC	Antenatal Clinic
APLF	Asia Pacific Leadership Forum on HIV and AIDS
ART	Anti - retroviral therapy
ARV	Anti - retroviral
ATFF	AIDS Task Force in Fiji
AUSAID	Australian Agency for International Development
BCC	Behavior Change Communication
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CDO	Capacity Development Organisation
CG	Competitive Grant
CRIS	Country Response Information System
CWMH	Colonial War Memorial Hospital
DHS	Demographic Health Survey
EU	European Union
FASANOC	Fiji Association of Sports and National Olympic Committee
FBO	Faith Based Organizations
FCOSS	Fiji Council of Social Services
FNA	Fiji Nursing Association
FSEG	Family Support & Education Group
FSM	Fiji School of Medicine
FWRM	Fiji Women's Rights Movement
GFATM	Global Funds to Fight AIDS,TB and Malaria
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HSSWG	Health Systems Strengthening Working Group
ICAAP	International Congress on AIDS in Asia and the Pacific
IDU	Injecting Drug Users
IEC	Information Education Communication
ILO	International Labor Organisation
JICA	Japan International Cooperation Agency
KAP	Knowledge Attitude and Practice
M&E	Monitoring and Evaluation
MARPs	Most - at - Risk Populations
MOH	Ministry of Health
MOHWSA&PA	Ministry of Health Women and Social Assistance and Poverty Alleviation
MSC	Most Significant Change
MSIP	Marie Stopes International Pacific
MSM	Men who have sex with Men
NACA	National Advisory Committee on AIDS
NGO	Non-Government Organisation
NSP	National Strategic Plan
NYSS	National Youth Service Scheme
NZAID	New Zealand International AID and Development Agency
PC&SS	Pacific Council & Social Services
PHRP	Partners for Health Reform Project
PRHP	Pacific Regional HIV Program

PICTs	Pacific Island Countries and Territories
PID	Pelvic Inflammatory Disease
PIRMCCM	Pacific Islands Regional Multi-Country Coordinating Mechanism
PLHIV	People Living with HIV
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PRS	Pacific Regional Strategy On HIV And Other Sexually Transmissible Infections
PRSIP	Pacific Regional Strategy On HIV And Other Sexually Transmissible Infection Implementation Plan
PSHRC-FSM	Pacific STI HIV Research Centre
RFHAF	Reproductive Family Health Association of Fiji
RFMF	Royal Fiji Military Forces
RRGP	Rapid Response Grants Program
SAN Fiji	Survival and Advocacy Network for Sex Workers
SGS	Second Generation Surveillance
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
SS	Stepping Stones
STI	Sexually Transmitted Infection
SW	Sex Workers
SWAN	Sex Workers' Rights Advocacy Network
TB	Tuberculosis
ToT	Training of Trainers
TRP	Technical Review Panel
UN	United Nations
UNAIDS	Joints United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children's Emergency Funds
VCCT	Voluntary and Confidential Counseling and Testing
WHO	World Health Organisation

II. Status at a glance

The inclusiveness of the stakeholders in the report writing process

A working group managed the preparation of this country report. Its members were drawn from government (MOH, Fiji School of Medicine), non-government (Men Fiji, MSIP, PC&SS, SWAN) and multilateral agencies (UNAIDS, UNDP, WHO and SPC). The working group was established in June 2009 and confirmed the process and schedule for reporting. The working group communicated by email through 2009 and met regularly during the first quarter of 2010 to oversee the process of report development.

An orientation and consultation workshop was held in July 2009 to share the same level of understanding for M&E and UNGASS reporting with stakeholders. Forty-five participants attended from the following organisations and organisational units:

- Fiji Prisons and Correctional Service
- PC&SS
- Methodist Church
- UNDP- Fiji Multi-Country Office
- UNAIDS
- UNFPA
- ONOC/FASANOC
- Path Lab- HIV Department
- UNICEF
- MOH HQ
- MOH/ CWMH/Paediatrician
- MOH/ PO Blood Safety
- Fiji Women's Rights Movement (FWRM)
- PSHRC-FSM
- FSM
- MEN Fiji
- OB/GYN Department, CWMH
- MOH/ CWM- ANC Nurse
- MOH/ Health Information Unit
- WHO
- MOH-STI Clinics
- MOH/ Reproductive Health
- MOH- CCM Secretariat
- SAN Fiji
- MOH/ Adolescent Health
- MOH/ NACA
- FJN+
- ATFF
- ADRA Fiji
- SAN Fiji
- SPC
- MOH/ Adolescent Health
- RFHAF
- Red Cross
- FNA

The first discussion to inform the preparation of the second UNGASS indicator (NCPI) indicator started in this workshop. A MOH representative was nominated as a coordinator for the government part of the NCPI indicator and a representative from FSM was nominated to coordinate the civil-society part of the NCPI indicator.

Three organisations (FJN+, FSM and MEN Fiji) worked on research for their segmented theme "HIV for PLHIV, sex workers, and MSM" from June 2009 to February 2010.

Request letters for data collection were sent to three Divisional hospitals, three Hub Centres, Suva Private Hospital, Marie Stopes International Pacific (MSIP), PC&SS, Ministry of Social Welfare, Republic of Fiji Military Force, and Fiji Prison. Some data were obtained by phone calls to 27 hospitals and health centres.

An UNGASS Consultation workshop held in September 2009 finalized the indicators to be reported by Fiji in the UNGASS 2010 report. It was agreed that UN Agencies, Ministry of Health and other sector ministries, and Civil Society Organizations, and the SPC would collaborate to prepare the report for this round.

Ministry of Education, Ministry of Women and Social Welfare and the Royal Fiji Military Forces participated from the government arm and contributed data for Indicators 10, 11, 12 and 23. Pacific Counselling & Social Services, a Non-Government Organisation (NGO) that has a Memorandum of Understanding with the Ministry of Health Fiji to provide specialized pre- and post- test counselling to ANC mothers on HIV/AIDS contributed VCCT data. FJN+ shared their recently prepared first-ever Annual Report 2009 that including useful historical information on the formation and continuation of FJN+ since 2003. The Ministry of Health (MOH) was responsibility for coordinating the administration of the NCPI Part A, and UNAIDS and the Fiji School of Medicine coordinated the completion of the NCPI Part B for civil society.

An UNAIDS-funded local adviser and international M&E adviser, and a JICA volunteer that has been placed with NACA for over two years assisted in the final stage of data collection, compilation and writing of this report.

A final UNGASS stakeholder workshop was held on 26 March 2006 in Suva to receive feedback on the draft report, to work on national recommendations for remedial action and continue work on the UNGASS Indicator #2, the NCPI indicator.

The Status of the Epidemic

Changing Perception of HIV Epidemic in Fiji?

In 2003, the World Health Organisation (WHO 2004 p. 83) characterised the HIV epidemic in Fiji and other PICTs – with the exception of PNG –as follows:

> The epidemiology of HIV in low prevalence populations in the Asia Pacific region consists of imported HIV infections and then limited heterosexual transmission to the regular sex partners of HIV-infected persons. This is the general pattern found in most of the Pacific Island countries and areas… HIV is primarily a sexually transmitted infection in Pacific island countries. The

> rates of reported HIV infections via mother-to-child transmission, injecting drug use and MSM are low. There has been a steady increase in reported HIV and AIDS in the Pacific over the past decade, with recent sharp increases in several countries, including Kiribati, Tuvalu and Fiji.

As of December 31 2009, Fiji is still a low HIV prevalence country. The number of confirmed HIV cases has continued to steadily increase each year. The number of confirmed cases where mode of transmission is recorded as MSM, IDUs and perinatal transmission by Ministry of Health is still low. The number of cases where mode of transmission is recorded as 'heterosexual' is still high. More detailed information is given below (in Table 3 for example).

However there are several provisos or qualifications that should be made to the picture of HIV transmission that WHO painted in 2003.

The first proviso is that, while heterosexual transmission is the main MOH-reported mode of transmission in Fiji for confirmed cases (as shown in Graph 6 and Table 3), strictly speaking, it is not valid to generalise the characteristics (age, sex, mode of transmission, ethnicity) of confirmed cases to the epidemic in Fiji just as it is not valid to statistically generalise the results of a convenience sample to an entire population from which the sample is drawn. It is also probably safer to say 'sexual transmission' of HIV is the mode of transmission. Active second generation surveillance involving linked behavioural surveys and laboratory testing of blood/urine samples for MARPs such as sex workers and MSM along the lines already conducted for ANC attendees by SGS 2004-5 (Cliffe, Wang, and Sullivan 2006) and SGS 2008 (Anonymous 2009). For the sake of clarity, these SGS sources will be simply referred to as SGS 2004-2005 and SGS 2008 throughout this report.

The second proviso concerns the WHO's 2003 picture of transmission as occurring between 'regular' heterosexual partners. There is evidence that various population groups in Fiji are engaging in what UNGASS defines as "high-risk sex", that is, where one or both sexual partners have had more than one partner in the past 12 months, the subject of UNGASS Indicator #16). As noted in the UNGASS 2010 guideline for Indicator #16 (UNAIDS 2009 p. 57):

> The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners (concurrently or sequentially) have a higher risk of HIV transmission than individuals who do not link into a wider sexual network.

The WHO-supported Second Generation Survey conducted in 2008 in Fiji (SGS 2008) found that the mean number of sexual partners in the past 12 months reported by survey respondents was highest among male tertiary students (3.8) followed by male STI Clinic attendees (3.6), followed by seafarers (3), uniformed services (2.7), female STI clinic attendees (1.8), female tertiary students (1.5) and ANC attendees (1.1). Of course, the number of reported sexual partners varied widely between survey respondents. For example, the number of sexual partners reported by sampled STI Clinic attendees ranged between one and 20 for males and one and seven for females. Whether the multiple sexual partnerships are serial or concurrent does not effect or vary the risk of HIV transmission. This insight possibly explains the shift in international HIV indicators from distinguishing between 'regular' and 'non-regular' partners and condom use with each type of partner and to focus on number of partners over the past 12 months and condom use at last sex irrespective of whether the sex act was with a regular or non-regular partner.

The third proviso concerns the 2003 picture of HIV in the Pacific as driven by members of the general heterosexual population as a self-contained entity. SGS 2004-2005 and SGS 2008 data suggest that a small but significant proportion of SGS survey populations in Fiji that are not defined by UNGASSS as 'Most-At-Risk-Populations' (MARPs) are having sex with two UNGASS-defined MARP populations, sex workers and Men-Who-Have-Sex-With-Men (MSM). Between 3% (seafarers – SGS 2008) and 15% (male STI Clinic attendees – SGS 2008) of males respondents reported ever having sex with a man. Across male groups in the SGS 2008 survey, the percentage of respondents reporting that they had commercial sex in the past 12 months was similar, ranging between 7% (male STI clinic attendees) and 11% (uniformed services) with male tertiary students at 9% and seafarers at 11%. The percentage of 2004 SGS STI Clinic respondents who reported commercial sex in 2004 was much higher (20%) than in 2008 (7%), whereas the percentage of uniformed service respondents reporting commercial sex in 2004 was lower (6%) than in 2008 (11%). Incidentally, small numbers of females in the SGS 2008 ANC sample (one or 0.2% of 417 sexually active respondents) and 2% (one of 61 sexually active female tertiary students) reported female use of commercial sex. A recently released report on sex work and HIV prevention in Fiji – involving in-depth interviews with 40 sex workers in Suva, Nadi, Lautoka and Labasa – reported that 'clients come from all professional and ethnic groups, but are almost exclusively male' (McMillan, and Worth 2010 p. 1).

The SGS 2004-2005 and SGS 2008 were focussed on tertiary students, seafarers, uniformed services and STI Clinic attendees and only a small number of respondents reported interactions with MSM and sex workers. To obtain more reliable data on interactions between SGS populations and UNGASS-defined MARPs, larger sample sizes complemented by qualitative research would be desirable to further explore and valid some of the data that were based on very small numbers of responses and/or showing signs of inconsistency or misunderstanding on the part of respondents (especially relating to 'sensitive' topics involving MSM and commercial sex).

Sizable minorities of SGS survey populations have been having multiple sex partners over the past 12 months. Small proportions of males in SGS groups reported having sex with other males and paying for sex. Condom use has been low.

Condom Use

As explained by the UNGASS 2010 guidelines on UNGASS indicator #17 (UNAIDS 2009 p. 58):

> Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners". This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly…The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide the level of consistent condom use. However, the alternative method of asking whether condoms were always/sometimes/never used in sexual encounters with non-regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use during the most recent sex act will generally reflect the trend in consistent condom use.

So UNGASS #17 is an indicator of condom use among people engaging in 'higher-risk sex'. Condom use among people engaged in 'higher-risk sex' was lower than desirable among all groups surveyed in SGS 2008 with condom use at last sex

lowest among ANC attendees (5% or one of 21 ANC respondents who had more than one partner in past 12 months). The low rate of reported condom use at last sex among male STI Clinic attendees (10%) was particularly disturbing given the "strong evidence for the several biological mechanisms through which STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility" (HPA 2010). Condom use at last sex among female tertiary students with more than one partner in the past 12 months was also very low (13%). Condom use at last sex among male tertiary students engaged in higher-risk sex was highest (47%).

Comparatively high proportions of groups surveyed in SGS 2008 – over half of each group - reported 'never using condoms' in past 12 months. The SGS 2008 report includes data on frequency of condom use in past 12 months from ANC attendees, seafarers and uniformed service respondents and not from tertiary students. The recent study of sex work in Fiji noted that 'sex workers say that many clients don't want to use condoms and put pressure on sex workers to have sex without a condom. It is also common for sex workers to offer more money for sex without a condom' (McMillan, and Worth 2010 p. 1).

Links between Reported Risk Behaviour and STI and HIV Infection

SGS 2008 survey found an association between chlamydia infection among surveyed ANC attendees and risk factors including the number of (a) lifetime partners and (b) past-year partners of the ANC attendees. Chlamydia prevalence among sampled ANC attendees with one lifetime partner and one partner in past 12 months was significantly less than ANC attendees with two or more partners in their lifetime or in the past 12 months.

Chlamydia is an infection that has long been associated with pelvic inflammatory disease (PID), infertility and associated increase risk of HIV transmission. High rates of chlamydia infection combined with low rates of consistent condom use indicate communities with a high potential for HIV transmission. More generally, where the incidence/prevalence of STIs is high in a country, then there is the possibility of high rates of sexual transmission of HIV.

UNGASS guidelines paraphrase its indicator # 16 "Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months people as "percentage of people who have higher-risk sex" (p.56). The UNGASS construction of "more than one sex partner in past 12 months" as "higher-risk sex" is supported by the SGS 2008 survey showing higher chlamydia prevalence among people engaged in "higher-risk sex".

Although the sample size (especially for ANC attendees with two or more partners in past 12 months – there were only four sampled ANC attendees in this category) is too small for confident extrapolation to ANC attendees generally, only 12 of the 87 female ANC attendees reporting one lifetime partner (13.8%) tested positive for chlamydia compared to 38.2% (26 of 68) of female ANC attendees reporting two or more lifetime partners. Chlamydia prevalence among ANC attendees reporting one partner in the past 12 months was 21.6% (29 of 134 tested) compared to 75% (three of four tested) among attendees with two or more partners in past 12 months.

Chlamydia prevalence among the 161 (98.7%) ANC attendees tested for chlamydia in SGS 2008 that reported 'no concurrent partners in the past 12 months' was 24.2% (39 out of 161) whereas chlamydia prevalence was 100% (two out of two) among the small number of tested ANC attendees reporting that they had concurrent partners in the past 12 months.

The proportions of female 'general population' groups – ANC attendees and female tertiary students – that reported more than one partner in the past 12 months was relatively low (5% and 6% respectively). Perhaps unsurprisingly, given the association of between chlamydia infection and respondents with more than one sex partner over the past 12 months or lifetime and female, 20% of female STI Clinic attendees reported having more than one sex partner in the past 12 months. The proportion of males reporting more than one sex partner in the past 12 months was consistently higher than females. In most male populations surveyed in 2008, the proportion of males reporting more than one sex partner over the past 12 months was just over 30% (seafarers, male tertiary students and uniformed services) with the exception of male STI clinic attendees, 62% of whom reported having more than one sex partner in the past 12 months. UNGASS defines 'high-risk sex' as sex between people where at least one of them has had more than one sex partner in the past 12 months.

As shown in Table 1, from the draft report of the SGS 2008 survey, none of the 448 ANC attendees tested were HIV positive compared to the 27% positive for chlamydia.

Table 1: Prevalence of STIs and blood borne diseases for Antenatal women from Fiji

	N Reactive/ positive	N tested	%	Lower Confidence Interval (LCI)	Upper Confidence Interval (UCI)
Chlamydia	120	448	26.8	22.8	31.2
Gonorrhoea	10	448	2.2	1.1	4.2
HIV	0	448	0.0	-	-
Hepatitis B (Antigen)	10	448	2.2	1.1	4.2
Syphilis	12	448	2.7	1.5	4.8

Source: SGS 2008

Knowledge

The level of knowledge of HIV transmission and prevention is lower than desirable among all groups surveyed in the SGS 2008 study (namely, tertiary students, ANC attendees, STI Clinic attendees, seafarers and uniformed services personnel. Females had slightly higher levels of knowledge than males in the mixed-sex survey groups (tertiary students and STI Clinic attendees).

Positive Behavioural Trends

The available epidemiological information is not all doom and gloom, not all about vulnerabilities and risk behaviours. Some positive findings are evident among SGS

2008 groups that are closest to 'general-population' groups, ANC attendees and youth at tertiary institutions, including:

- Only 61 (25%) of female tertiary students and 180 (63%) male tertiary students – all aged between 15 and 24 years - in the SGS 2008 survey reported ever having sex.
- 98.7% (161 out of 163) of ANC attendees tested for chlamydia in SGS 2008 reported having concurrent partners in the past 12 months.
- Only 2% (eight of 417) ANC attendees interviewed in SGS 2008 reporting having overlapping partners in the past 12 months.
- 79.7% (134 out of 168) of ANC attendees for chlamydia reported having only one partner in the past 12 months.

Risk of Accelerated Rate of HIV Infection

Although HIV prevalence appears to be currently low, based on case reported and SGS data, the potential for an explosion or acceleration in the spread of HIV in Fiji is high. A significant minority of different key population groups in Fiji have multiple sex partners over the past 12 months. Condom use is low and at best inconsistent. The prevalence of STIs, especially chlamydia, is high and reflects multiple sex partners and low condom use and biologically increases the risk of HIV transmission. Male STI clinic attendees as a group have a comparatively high average number of sex partners in past 12 months and comparatively low reported condom use.

The Policy and Programmatic Response

Fiji's national HIV strategic plan 2007-2011 provides the overarching guiding framework for HIV policy and programs in Fiji. NACA is the national HIV/AIDS advisory and coordinating body and processes are well underway to give this body - and its secretariat - a legislative foundation. The national response involves a focus on general population and 'Most At Risk Populations (MARPs), normally defined in the Fijian context as sex workers, uniformed services, youth, seafarers and Men who have Sex with Men (MSM).'

The HIV National Strategic Plan's Monitoring and Evaluation Framework does not call for the annual sharing of information on the national-response activities. Consequently, it is not possible to map the functional, geographical and client-group contours of the national response (that is, for all HIV-related activities in Fiji) in the past two years or indeed previously as no body has responsibility for the annual collection and collation of this information. Sometimes, though, useful program information has been available for some programs in pre-2008 periods but this information has not been utilised for reporting on the nature of Fiji's national response. For this reason, overlooked information about program focus 2005-2008 has been retrospectively added to the 'program' section of this report to flesh out the historical picture of Fiji's national response for both international and Fijian audiences. Anyone not interested in the pre-2008 information on the national response can skip it and go straight to the 2008-2009 section.

UNGASS Indicator Data

Indicator	Sub - Population	2008					2009				
		Source*	**Numerator**	**Denominator**	**%**	**Remarks**	**Source***	**Numerator**	**Denominator**	**%**	**Remarks**
1.AIDS Spending. Domestic and international AIDS spending by categories and financing sources.	Public (USD)	Government, NGOs and multilateral and bilateral agencies consulted in course of developing National AIDS National Spending Assessment (NASA)	3,988,267	7,343,965	54%	See remarks in 2009 column that cover 2008 data as well.	Government, NGOs and multilateral and bilateral agencies consulted in course of developing National AIDS spending Assessment (NASA)	N/A	7,854,237	53%	The Government of Fiji's (GoF) financial contribution to the national HIV response has significantly increased absolutely and proportionally. In 2007, GoF funded 20% of the national response (589,593 USD). GoF funded over 50% of the national HIV response in 2008 (54%) and 2009 (53%). More detail is provided in National Funding Matrix uploaded to UNGASS website.
	International (USD)		3,355,698	7,343,965	46%			N/A	7,854,237	47%	International funding sources financed 80% (2,350,143 USD) of the national HIV response in 2007. The international financial contribution increased to 3355698 USD but fell proportionally to around 50% for 2008 and 2009 due to the increased public (government) contribution, a positive trend.
	Private (USD)		0	7,343,965	0%			19,715	7,854,237	0.25%	Private funding of the national response increased from zero in 2007 and 2008 to around 20,000 in 2009, also a positive trend.
	Total (USD)		7,343,965	7,343,965	100%			N/A	7,854,237	100%	Overall funding of the response increased from just under three million USD (2,939,736) in 2007 to almost eight million USD in 2009, a very significant increase. Compared to the baseline year of 2007, the funding of the national response increased by 2.4 in 2008 and by 2.6 in 2009. NASA data reported here do not represent the full picture of expenditure as some sources did not share their financial information with the NASA preparation team.

2. NCPI. National Composite Policy Index (Areas covered: prevention, treatment care and support, human rights, civil society involvement, gender workplace programmes, stigma and discrimination and monitoring and evaluation)	Government	Representatives of NGOs, Bilateral, Multilateral, Private, Government agencies consulted in course of developing NCPI document covering 2008 and 2009	Not applicable	Not applicable	Not applicable	The NCPI covers 2008 and 2009. See remarks in 2009 column.	Same source described in 2008 col.	53	85	62%	The NCPI (government) total score for this reporting period (2008-2009) was similar to the NCPI score given in the previous period (63%) and much lower than the 2004-2005 score (87%). The content of the NCPI has evolved over time so that total scores are not strictly comparable and the informants change over time. The NCPI development process continued up to late March 2010 so detailed content analysis of NCPIs over time and incorporation of material from final draft of NCPI into the UNGASS 2010 narrative report not possible. See Annex 1 of narrative report for more detail.
	Civil Society		Not applicable	Not applicable	Not applicable			55	95	58%	The highlight of the NCPI (Civil Society) report for 2008-2009 was that it was far more positive in its assessment and scoring of aspects of the national response that civil society members were asked to examine. The UNGASS report 2010 score was 58% compared to the UNGASS report 2008 aggregate score of 19% and UNGASS report 2008 aggregate score of 26%. See Annex 1 of narrative report for more detail. While the Government and Civil Society questions are not identical, it is a highlight that the enormous gap between government and civil society rating of aspects of the national response has reduced and become almost the same in the 2008-2009 period, a possible indicator of better working relationship, communication and shared perceptions of the national response's performance and progress. See Annex 1 of narrative report for more detail.

3.Blood Safety Percentage of donated blood units screened for HIV in a quality assured manner		National Blood Safety Bank	N/A	N/A	N/A	Data was not available.	11 Laboratories (3 divisional hospitals and 8/9 sub divisional hospitals)	11, 412	11,414	99.98%	All 12 laboratories that conduct blood testing meet two UNGASS quality assurance standards that is all laboratories have Standard Operating Procedures and External Quality Assurance Schemes. Numerator and denominator are based on the oral and written reports received from 11/12 centres where testing is done (all except for Wainibokasi Hospital). Two blood units were not tested for HIV and VRD in Rotuma Hospital due to an emergency. Data collection was guided by the 'Method of Measurement' instructions in UNGASS 2010 Reporting Guidelines
4.HIV Treatment: Antiretroviral Therapy. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	Male	Numerator is from Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji)	18	Not Available (N/A)	N/A	Denominator estimation data were not provided in Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji) and HIV/AIDS Estimation and Projection Regional Training Workshop 2009 Report.	3 Hub Centres	25	N/A	N/A	Numerator data were drawn from ART Patient Registers from the three Hub Centres in Fiji and reported by clinicians at the three Hub Centres to the UNGASS preparation team. Of the 52 cases with advanced HIV infection receiving ART, one was below 15 years. Sex disaggregation of numerator data were provided (27 females and 25 males) but the numbers did not add up to the total of 52 clients receiving ART so the fields have been labelled as 'missing data' in the online UNGASS reporting form. Denominator estimation data are not available as the SPECTRUM estimation exercise has not been conducted. The number of known cases with advanced HIV infection as 31 December 2009 is 54 as reported by Hub Centre clinicians. 28 female and 26 males were eligible to ART, and two (2) did not receive treatment due to personal beliefs.
	Female		21	N/A	N/A			27	N/A	N/A	
	<15		0	N/A	N/A			1	N/A	N/A	
	>15		39	N/A	N/A			51	N/A	N/A	
	Total		39	N/A	N/A			52	N/A	N/A	
5.Prevention of Mother-to-Child Transmission. . Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk		Data are from Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji)	6	N/A	N/A	Numerator data were provided by 3 divisional hospitals where all HIV positive pregnant women were referred for PMTCT. Denominator data were not provided in Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji), HIV/AIDS	Numerator data are from 3 ANC at divisional hospitals.	5	N/A	N/A	Comments in the 2008 'Remarks' cell apply to 2009.

of mother-to-child transmission						Estimation and Projection Regional Training Workshop 2009 Report or other sources. SAGS serological surveys of small samples of ANC attendees in 2004-05 and 2008 found no HIV positive cases.					
6. Co-management of Tuberculosis and HIV Treatment. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV		Numerator is from Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji).	2	N/A	N/A	Denominator data were not provided in Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji), HIV/AIDS Estimation and Projection Regional Training Workshop 2009 Report or other sources. HIV patients are not routinely tested for TB but TB patients are routinely tested for HIV.	Tamavua Hospital, Lautoka Hospital.	0	N/A	N/A	Tamavua and Lautoka Hospitals are the only two TB treatment centres, Tamavua being the national referral centre. The comment about the unavailability of denominator data consistent with UNGASS methodology in the 2008 'Remarks' cell apply to 2009. Numerator data came from TB Patient Registers as reported by clinicians at the two hospitals. In reporting period, there were no known cases of HIV - TB co-infection in Fiji
7. HIV Testing in the General Population. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results.	women 15 - 19	SGS Population based Surveys 2008	N/A	N/A	N/A	SGS 2008 included UNGASS consistent questions on this indicator, but did not conduct a DHS-style national household survey covering the general population. SGS 2008 focused on specific populations such as ANC women, STI clinic attendees, tertiary students, seafarers and uniform services. SGS report includes the data tables which disaggregate data by age and sex consistent with UNGASS Guidelines. The main findings are included in the UNGASS progress report 2010. Data on indicator # 7 that are consistent with UNGASS	N/A	N/A	N/A	N/A	No data collection exercise was conducted in 2009. Data on indicator # 7 that are consistent with UNGASS Guidelines are not available from any source.
	women 20 - 24		N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	women 25 - 29		N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	men 15 - 19		N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	men 20 - 24		**N/A**	N/A	N/A		N/A	N/A	N/A	N/A	
	men 25 - 29		N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	total		N/A	N/A	N/A		N/A	N/A	N/A	N/A	

						Guidelines are not available from other sources as well.					
8. HIV Testing in Most-at-risk Populations. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.	Sex - Workers	N/A	N/A	N/A	N/A	As noted in comment above, SGS 2008 included UNGASS consistent questions on the HIV testing, but its survey populations were not UNGASS-defined MARPs (see Indicator #7 comments).	N/A	N/A	N/A	N/A	No data collection exercise was conducted in 2009. Data on indicator # 8 that are consistent with UNGASS Guidelines are not available from any source. Information on IDUs is in the narrative section.
	MSM	N/A	N/A	N/A	N/A			N/A	N/A	N/A	
	Others	N/A	N/A	N/A	N/A			N/A	N/A	N/A	
9. Most-at-risk Populations: Prevention Programmes. Percentage of most-at-risk populations reached with HIV prevention programmes.	<25	N/A	N/A	N/A	N/A	Service utilisation data for some MARPs-related programmes are available, but not coverage data as MARP baseline surveys have not been conducted.	N/A	N/A	N/A	N/A	See comment for 2008.
	>25		N/A	N/A	N/A			N/A	N/A	N/A	
10.Support for Children Affected by HIV and AIDS. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.		Not applicable	Not applicable	Not applicable	Not applicable	UNGASS 2009 Guidelines indicate that this indicator is relevant to high HIV prevalence countries.	Not applicable	Not applicable	Not applicable	Not applicable	See comment for 2008. FJN+ supports ten orphans affected by HIV/AIDS whose parent(s) are members of FJN+.

11. Life-Skills based HIV Education in Schools. Percentage of schools that provided life skills-based HIV education within the last academic year.		N/A	N/A	N/A	N/A	UNGASS 2008 report stated that Life Skills Education had been piloted in few secondary schools. No figures were provided. UNGASS Guidelines require nationally-representative sample of schools (public and private, primary and secondary) to be asked whether they provide thirty hours annually of Life Skills Education for every grade. Such a survey was not conducted in Fiji.	Education Officer, Curriculum Unit, MoE	N/A	N/A	N/A	An UNGASS-consistent LSE-in-schools survey has never been conducted in Fiji. Programme data are available. Ninety-five percent (154 / 162) of secondary schools provide Life Skills Education (LSE). No primary school provides LSE. This information was provided by Ministry of Education Curriculum Unit. Over the past two years, LSE was implemented in most secondary schools, a large improvement on the situation reported in UNGASS 2008..
12. Orphans: School Attendance. Current school attendance among orphans and among non-orphans aged 10–14*		N/A	N/A	N/A	N/A	UNGASS consistent data collection method (population-based survey like DHS, AIDS Indicator Survey, Multiple Indicator Cluster Survey) was not conducted, and programme-based information is not available from Ministry of Education.	N/A	N/A	N/A	N/A	See comment for 2008.
13. Young People: Knowledge about HIV Prevention. 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*	Male (15-19)	N/A	N/A	N/A	N/A	SGS 2008 included UNGASS consistent questions on this indicator, but did not conduct a DHS-style national household survey covering the youth as part of the general population. SGS 2008 focused on tertiary students from three educational institutions as a sub-population of youth. SGS report includes the data tables which disaggregate data by age and sex consistent with UNGASS Guidelines. The main findings are included in the UNGASS progress	N/A	N/A	N/A	N/A	See comment for 2008.
	Male (20-24)	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	Female (15-19)	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	Female (20-24)	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	

						report 2010. Data on indicator # 13 that are consistent with UNGASS Guidelines are not available from other sources as well.					
14. Most-at-risk Populations: Knowledge about HIV Transmission Prevention. Percentage of most-at-risk populations 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	SGS 2008 included UNGASS consistent questions on Knowledge about HIV Transmission Prevention, but its surveyed populations were not consistent with UNGASS-defined MARPs.	N/A	N/A	N/A	N/A	See comment for 2008.
15. Sex Before the Age of 15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	Male (15-19)	SGS 2008	N/A	N/A	N/A	SGS 2008 included UNGASS consistent questions on this indicator, but did not conduct a DHS-style national household survey covering the youth as part of the general population. SGS 2008 focused on tertiary students from three educational institutions as a sub-population of youth. SGS report includes the data tables which disaggregate data by age and sex consistent with UNGASS Guidelines. The main findings are included in the UNGASS progress	SGS 2008	N/A	N/A	N/A	See comment for 2008.
	Male (20-24)		N/A	N/A	N/A			N/A	N/A	N/A	
	Female (15-19)		N/A	N/A	N/A			N/A	N/A	N/A	
	Female (20-24)		N/A	N/A	N/A			N/A	N/A	N/A	

						report 2010. Data on indicator # 15 that are consistent with UNGASS Guidelines are not available from other sources as well.					
16. Higher-risk Sex. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months.	Male 15 - 19	SGS 2008	N/A	N/A	N/A	SGS 2008 included UNGASS consistent questions on this indicator, but did not conduct a DHS-style national household survey covering the general population. SGS 2008 focused on specific populations such as ANC women, STI clinic attendees, tertiary students, seafarers and uniform services. SGS report includes the data tables which disaggregate data by age and sex consistent with UNGASS Guidelines. The main findings are included in the UNGASS progress report 2010. Data on indicator # 16 that are consistent with UNGASS Guidelines are not available from other sources as well.	N/A	N/A	N/A	N/A	See comment for 2008.
	Male 20 - 24		N/A	N/A	N/A			N/A	N/A	N/A	
	Male 25 -29		N/A	N/A	N/A			N/A	N/A	N/A	
	Female 15 - 19		N/A	N/A	N/A			N/A	N/A	N/A	
	Female 20 - 24		N/A	N/A	N/A			N/A	N/A	N/A	
	Female 25 - 29		N/A	N/A	N/A			N/A	N/A	N/A	
17. Condom Use During Higher-risk Sex. Percentage of adults aged 15–49 who had more than	Male 15 - 19	SGS 2008	N/A	N/A	N/A	SGS 2008 included UNGASS consistent questions on this indicator, but did not conduct a DHS-style national household survey covering the general population. SGS	SGS	N/A	N/A	N/A	See comment for 2008.
	Male 20 - 24		N/A	N/A	N/A			N/A	N/A	N/A	
	Male 25 -29		N/A	N/A	N/A			N/A	N/A	N/A	

one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Female 15 - 19		N/A	N/A	N/A	2008 focused on specific populations such as ANC women, STI clinic attendees, tertiary students, seafarers and uniform services. SGS report includes the data tables which disaggregate data by age and sex consistent with UNGASS Guidelines. The main findings are included in the UNGASS progress report 2010. Data on indicator # 17 that are consistent with UNGASS Guidelines are not available from other sources as well.		N/A	N/A	N/A	
	Female 20 - 24		N/A	N/A	N/A			N/A	N/A	N/A	
	Female 25 - 29		N/A	N/A	N/A			N/A	N/A	N/A	
18. Sex Workers: Condom Use. Percentage of female and male sex workers reporting the use of a condom with their most recent client.		N/A	N/A	N/A	N/A	SGS 2008 Behavioural Surveillance Surveys (BSS) did not cover sex workers.	N/A	N/A	N/A	N/A	See comment for 2008.
19. Men Who Have Sex with Men: Condom Use. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.		N/A	N/A	N/A	N/A	SGS 2008 did not have any a dedicated BSS on MSM, although MSM related questions were included in BSS for STI clients, tertiary students, and seafarers in 2008. SGS 2004-05 included MSM data for uniformed services.	N/A	N/A	N/A	N/A	See comment for 2008.
20. Injecting Drug Users: Condom Use. Percentage of injecting drug		N/A	N/A	N/A	N/A	No BSS was a conducted for IDUs in Fiji. IDUs are not identified as a MARP.	N/A	N/A	N/A	N/A	See comment for 2008, and IDU related information is given in the narrative report.

users who reported the use of a condom at last sexual intercourse.											
21. Injecting Drug Users: Safe Injecting Practices. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected.		N/A	N/A	N/A	N/A	No BSS was a conducted for IDUs in Fiji. IDUs are not identified as a MARP.	N/A	N/A	N/A	N/A	See comment for 2008, and IDU related information is given in the narrative report.
22. Reduction in HIV Prevalence. Percentage of young people aged 15–24 who are HIV infected.	ANC (15-24)	N/A	N/A	N/A	N/A	Measurement tool for this indicator # 22 is WHO Guidelines for HIV Sentinel Surveillance. Fiji does not have a sentinel surveillance system that normally includes a representative sample of ANC from capital city, other urban areas and rural areas with specific guidelines for timing and sampling of sentinel data consistent across sites and years. Fiji has case report data and SGS small-sample prevalence data. SGS 2008 tested 448 ANC attendees none of whom were HIV positive.	N/A	N/A	N/A	N/A	See comment for 2008, and 11/ 23 ANC facilities reported 12,535 ANC attendees were tested for HIV in 2009 of which 5 were HIV positive (0.04% of all ANC attendees tested in 2009 - not just 15-24 year olds - in the 11 ANC facilities that submitted data for this UNGASS report).
23. Most-at-risk Populations: Reduction in HIV Prevalence. Percentage of most-at-risk	Male	N/A	N/A	N/A	N/A	SGS 2004-05 and SGS 2008 used UNGASS consistent methodology except that they did not operate within a sentinel-site system which is absent in Fiji, and their biological surveys were	N/A	N/A	N/A	N/A	See comment for 2008. No MARP prevalence studies were conducted in 2009.
	Female	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	<25	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	
	>25	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	

populations who are HIV infected						only applied to ANC attendees.					
24. HIV Treatment: Survival After 12 Months on Antiretroviral Therapy. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Male	Monitoring and Reporting on the Health Sector Response to HIV/AIDS Annual Reporting Tool 2009 (Fiji)	N/A	N/A	N/A	Data were collected according to UNGASS Guidelines apart from disaggregation by sex and age.	Three hub centres (Suva, Lautoka and Labasa)	23	24	96%	Percentage of 2009 cohort surviving 12 months after initiation of ART was higher (94%) compared to 2008 cohort (79%). There are zero confirmed cases among children under 15 years in Fiji and no one is on ART in the age group <15.
	Female		N/A	N/A	N/A			25	27	93%	
	<15		N/A	N/A	N/A			0	0	0%	
	>15		N/A	N/A	N/A			48	51	94%	
	Total		22	28	79%			48	51	94%	
25. Reduction in Mother-to-child Transmission. Percentage of infants born to HIV-infected mothers who are infected Annual Treatment protocols and efficacy studies		N/A	N/A	N/A	N/A	See comments in 2009 remarks column.	N/A	N/A	N/A	N/A	Review of clinical records show that 0 (zero) HIV positive infants were borne to 5 HIV positive mothers in 2009 and 6 HIV positive mothers in 2008. However, a Spectrum exercise for estimating the number of HIV positive pregnant women has not been conducted as required by UNGASS reporting guidelines for this indicator.
* Source of any data (consistent and inconsistent with UNGASS Guidelines). Data that are inconsistent with UNGASS Guidelines are reported in the narrative report											

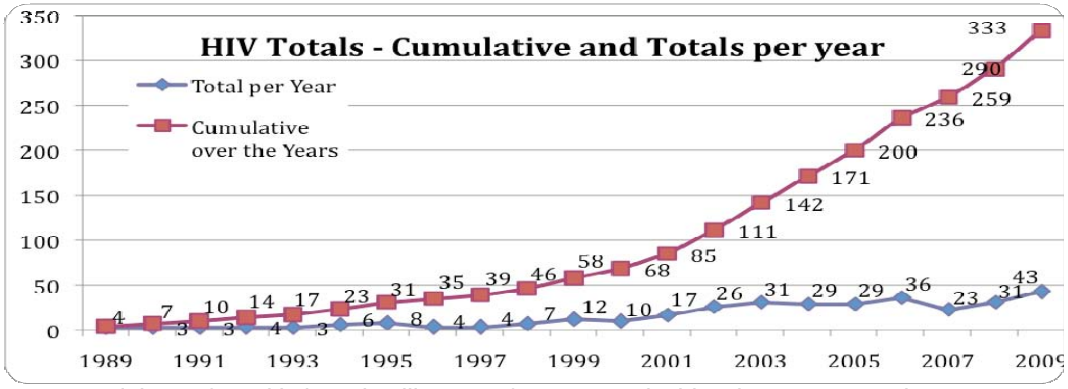
III. Overview of the AIDS epidemic

Fiji is classified as a low HIV prevalence country. Cumulatively, 333 confirmed HIV cases have been reported in Fiji between 1 January 1989 and 31 December 2009 by the Fiji Centre for Communicable Diseases Control known as Mataika House (Graph 1). The data shown in Graph 1 are results of confirmed samples, done in Mataika House. These samples were first screened at divisional hospitals and sub-divisional hospitals (Lautoka, Labasa and Suva).

While Fiji is currently a low prevalence country, the potential for rapid increase in the number of annual new cases has been recognised for some years due to social and economic context, and the SGS results from 2004-2005 and 2008 showing among other things an alarmingly high prevalence of chlamydia in surveyed populations in Fiji. Graph 2 shows the estimated number of new infections between 2009 and 2015 as calculated at a WHO HIV Estimation Workshop in 2005. The number of new cases confirmed each year has been exponentially increasing.

As shown in Table 2, the annual number of people in Fiji tested for HIV between 2005 and 2009 has varied between 2.94% in 2006 and 6.59% in 2005. In the past two years, around 3.33% and 5.08% were tested in 2008 and 2009 respectively. These figures may include a small proportion of people tested more than once annually and may involve some double counting. The test data in Table 1 are based on laboratory records from three Divisional Hospitals and eight Sub-divisional Hospitals[1]. The HIV Health information system is strengthening its Monitoring and Evaluation function including surveillance and routine monitoring for HIV-related services.

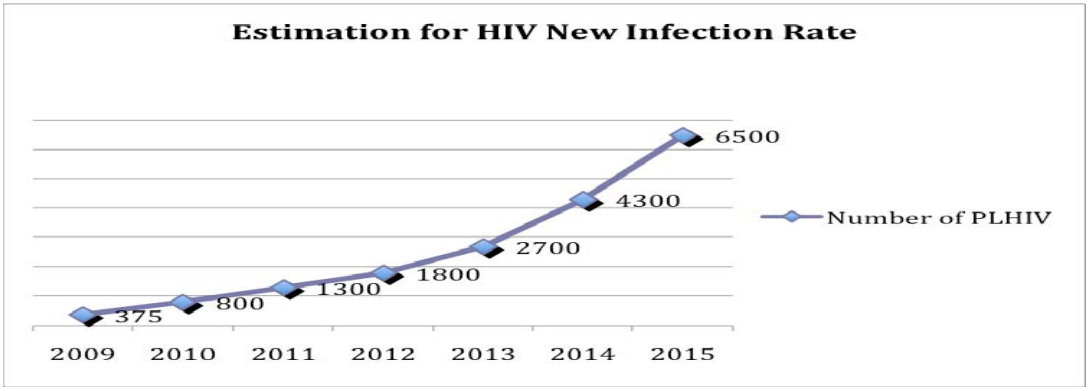
Graph 1: Cumulative and Annual Number of Confirmed HIV Cases



Source: Ministry of Health (2010), Fiji Centre for Communicable Diseases Control.

[1] The three Divisional Hospitals are Colonial War Memorial Hospital (Cent/East division), Labasa Hospital (Northern division) and Lautoka Hospital (Western division), and the eight sub-divisional Hospitals are at Levuka, Korovou, Rotuma, Rakiraki, Sigatoka, Nadi, Savusavu and Taveuni.

Graph 2: HIV Estimation 2005/2009



Source: WHO (2005), WHO HIV Estimation Workshop Report.

Table 2: HIV testing

Year	Number of people who tested for HIV (Blood donors, ANC attendants and general population)	Proportion of people who tested for HIV among population of Fiji[2]	Number of people who are diagnosed HIV	Proportion of HIV+ among people who tested for HIV	# of data source (Divisional and Sub divisional Hospitals)
2005	55211	6.59%	29	0.05%	3
2006	24648	2.94%	36	0.15%	3
2007	22535	2.69%	23	0.10%	3
2008	27865	3.33%	31	0.11%	3
2009	42507	5.08%	43	0.10%	11

Source: Ministry of Health (2010), Family Health Unit.

One possible reason that the number of HIV tests in 2009 is higher than in the 2006-2008 period is that the data for 2009 are based on records of HIV test from 12 HIV testing centres whereas previous data are based on test data from three divisional hospitals that are the tertiary hospitals in Fiji.

The trend of an increasing number of new HIV-Positive cases confirmed annually, especially over the past 12 years, has been mostly driven by the upward trend of diagnosis in two age groups (20-29 years and 30-39 years). In the past 12 years, for these two age groups, the upward trend of annual new confirmed cases has been interspersed with some periods where the trend has been downward. In the past two years, the current UNGASS reporting period, the trend for diagnosis in both age groups has been upwards. Similarly, in the past two years, the numbers of new diagnosed cases among aged people aged 30-39 and 40-49 years have also been increasing. The main increases in the annual number of new confirmed cases of HIV have been among Fijians rather than Indo-Fijians and other ethnic groups. Of course, the shape of Fiji's HIV epidemic (including its relative distribution among different ethnic groups in Fiji) should not be extrapolated from routine HIV test data. Unfortunately, data on the ethnic breakdown of HIV screening tests are not available to enable the prevalence among screening test sub-populations to be disaggregated and compared.

[2] Bureau of Statistics (2007). Total population of Fiji is , which was used for denominator. http://www.statsfiji.gov.fj/Key%20Stats/Population/2.5%20%20Pop%20by%20age07.pdf

According to MOH records, the main mode of HIV transmission for confirmed HIV cases is sexual transmission. Table 3 shows the number and percentage of all confirmed cases in Fiji between 1 January 1989 and 31 December 2009. Eighty-eight percent of all confirmed cases have been recorded as 'heterosexual transmission' by MOH. The second most common recorded mode of transmission is 'perinatal transmission' (7% of cases). MSM transmission is recorded for 2.4% of cases. Blood transfusion and Injecting Drug Use (presumably needle-sharing?) have been recorded as the mode of transmission in one case each.

Table 3: Cumulative Number and Percentage of Confirmed HIV Cases by MOH-Recorded Mode of Transmission as of Dec 31 2009

Mode of Transmission	Heterosexual	MSM	Blood Transfusion	I D U	Perinatal	Unknown	Total
Cumulative No.	294	8	1	1	22	7	333
Cumulative %	88.29%	2.40%	0.30%	0.30%	6.61%	2.10%	100%

Source: Ministry of Health (2010), Fiji Centre for Communicable Diseases Control.

Neither MOH 'mode of transmission' statistics for confirmed HIV cases nor SGS 2008 data nor PC&SS data on VCCT clients points to widespread injecting drug practices that could fuel the transmission of HIV through needle-sharing or through sex with injecting drug users.

The trends in the number of new cases annually should be interpreted, among other things, in the light of the number of HIV tests delivered annually. As shown in Table 2, the percentage of new confirmed cases out of all people tested has not shown an upward trend between 2006 and 2009 and has remained steady around 0.1%. Table 1 shows that number of HIV screening tests in 2009 increased over the past three years while the percentage of positive cases has remained around 0.1% with a minor change in the second decimal point (from 0.10% in 2007 to 0.11% in 2008, back down to 0.10% in 2009). Ninety-five health centres and hospitals can take blood samples and these are sent to nine out of sixteen sub-divisional hospitals that have the capacity to conduct HIV screening. If positive results are found, those samples are sent to National Centre for Communicable Disease Control.

The breakdown of the 95 facilities that can take blood samples is:

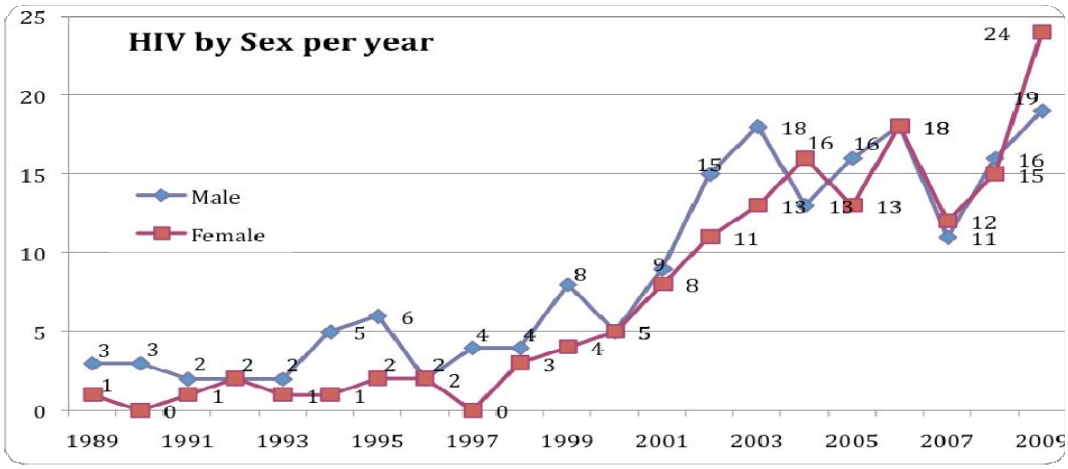
- Health Centres - 74
- Specialist hospitals - 2
- Divisional hospitals - 3
- Sub divisional hospitals -16

There are 101 Nursing Stations, but blood samples cannot be taken since collecting blood samples are not part of nurses' job description.

It is a worry that the annual number of HIV tests between 2006 and 2009 has been lower than in 2005.

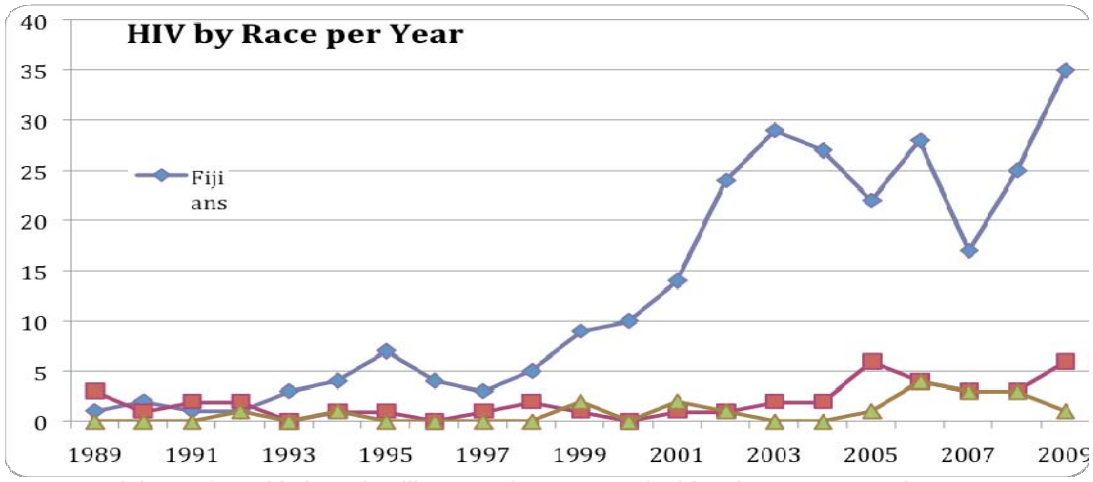
The following three graphs are commonly included in Fiji MOH Annual Reports and in previous UNGASS reports. They reflect HIV case reporting trends but should not be treated as true picture of the actual epidemiology of HIV among different sub-populations in Fijis.

Graph 3: Number of New Confirmed HIV Cases by Sex and by Year



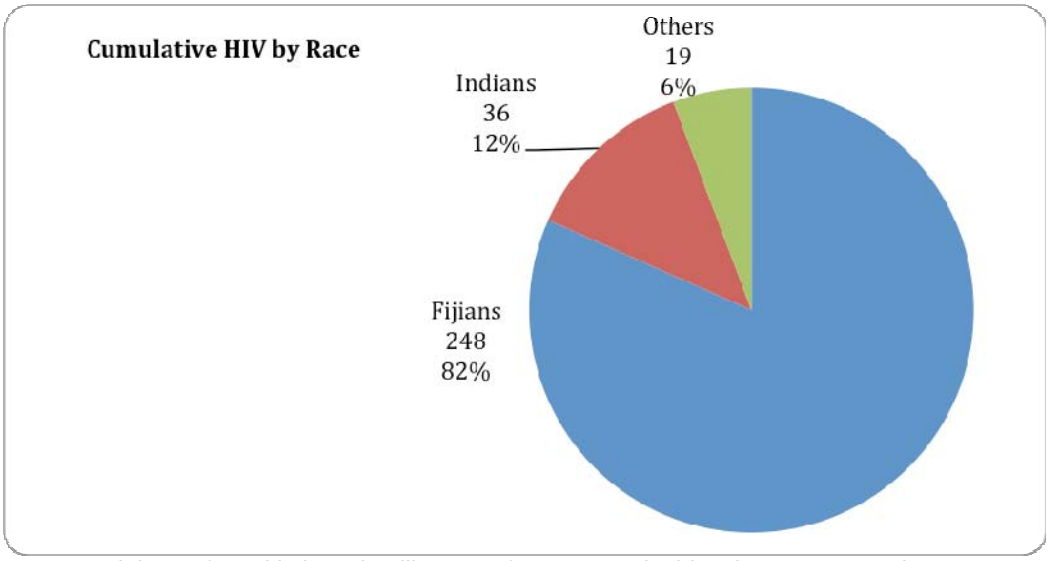
Source: Ministry of Health (2010), Fiji Centre for Communicable Diseases Control.

Graph 4: Number of New Confirmed HIV Cases by Year and Ethnicity



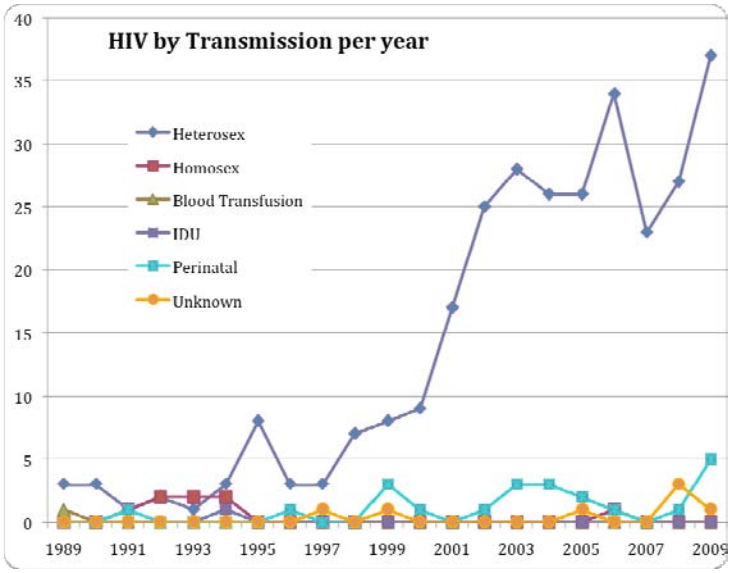
Source: Ministry of Health (2010), Fiji Centre for Communicable Diseases Control.

Graph 5: Breakdown of Cumulative Number of Confirmed HIV Cases by Ethnicity



Source: Ministry of Health (2010), Fiji Centre for Communicable Diseases Control.

Graph 6: Number of Confirmed HIV Cases by MOH-Recorded Mode of Transmission and Year



Source: Ministry of Health (2010), Fiji Centre for Communicable Diseases Control.

Heterosexual transmission is the main MOH-reported mode of transmission in Fiji for confirmed cases (as shown in Graph 3), however it is not valid to generalise the characteristics (age, sex, mode of transmission, ethnicity) of confirmed cases to the epidemic in Fiji. That is, we should not characterise the HIV epidemic in Fiji based on the characteristics of confirmed cases just as we should not statistically generalise the results of a convenience sample of respondents to a broader population. The characteristics of confirmed cases are likely to be affected by the profile of test-takers. Unfortunately, MOH's information system does not include a demographic profile of initial test-takers by age, sex, ethnicity etc.

The annual number of new confirmed male and female cases has been rising in most years between 1989 and 2009. The number of diagnosed HIV cases is higher among Fijians than Indo-Fijians and "Other' ethnic groups such as European.

Most Pacific Island Countries and Territories (PICTs), including Fiji, do not have surveillance systems able to provide accurate estimates of HIV and STI prevalence in their populations. To allow PICTs to have an idea of the burden, Global Fund provided funding and WHO with the support of the Secretariat of the Pacific Community (SPC) and the University of New South Wales, in collaboration with the MOH of Fiji, Samoa, Solomon Islands, Vanuatu, Tonga and Kiribati realised Second Generation Surveillance studies (SGS) on pregnant women in 2004-2005 and 2008. Contrary to more commonly reported and analysed HIV case reported data, the Second Generation Surveillance (SGS) data provide good behavioural and epidemiological population data on which targeted interventions can be designed.

The findings of the WHO-supported Second Generation Surveillance (SGS) study done in Fiji in 2004-2005 (and 2008, though this report is still in draft so data are unofficial) reported that 29% of the sample (303) of pregnant women attending antenatal care, tested positive for chlamydia, 1.7 % tested positive for gonorrhoea and 2.6 % tested positive for syphilis. In terms of chlamydia rates, this was the highest rate of the six countries involved in the 2004-2005 SGS. Chlamydia and gonorrhoea infection rates were higher in pregnant women under 25 years of age (34% and 3.1% respectively). As the WHO-supported report notes, the high burden of chlamydia among pregnant women is 'a strong indicator of a community at great risk for the introduction and rapid spread of HIV infection' (Cliffe et al. 2006 p. 28).

The 2008 SGS report is in its final phase before release. Preliminary analysis shows that STI infection rates among ANC females under 25 years have increased between 2005 and 2008: 37.5 % of pregnant women under the age of 25 were found to have chlamydia, 2.1 % were found to have gonorrhoea and 5.6 % were found to have syphilis. ***These are very alarming figures as this indicates increasing risk for the introduction and rapid spread of HIV infection*****!**

The currently ongoing data collection system for STI has not been corrected and it currently only notifies gonorrhoea and syphilis. With the information of the SGS, we need to understand the limited value of this notifying system, all the more as notifications are usually not done with necessary laboratory confirmations. The MOH is in the process of reviewing this notification system to allow for syndromic notification and annual surveillance of STIs in predefined surveillance sites with upgraded laboratory capacities to allow for regular etiological surveillance and resistance monitoring.

Nevertheless, if we look at the current notifications, the geographical spread of reported gonorrhoea (which is most likely more chlamydia than gonorrhoea, taking into account SGS information) and syphilis cases (which should be considered ulcerative genital diseases in most cases) is also interesting. MOH data for 2009 show that 82% of gonorrhoea cases and 66% of syphilis cases were reported in Central Division (Suva). However, this may reflect STI diagnostic services in Central Division more than the geographical distribution of STIs.

IV. National Response to the AIDS Epidemic

Overview

Some key milestones or highlights in Fiji's evolving national response over the past 20 years are presented in Table 4 below. While it is far from comprehensive or complete, it conveys the sense that response-related 'milestones' have become more numerous in the past four years compared to the previous 20 years. The current two-year UNGASS report period is not populated with many milestones, but the foundations of two future milestones have been laid and are likely to come to fruition in 2010 outside the current period: MOH HIV Work Place Policy and a HIV Decree, both largely developed during the reporting period but not yet finalised. The HIV Decree - currently in draft stage gives NACA legal status and its own legislatively-mandated secretariat and staff.

Table 4: Selected HIV Response Milestones in Fiji

Milestone	Year
NACA established	1987
First Fiji HIV-Positive case diagnosed	1989
AIDS Task Force Fiji (ATFF) established	1994
AusAID-funded Pacific Regional HIV/AIDS Initiative commenced	1997
NACA reactivated	2001
Fiji Network for People Living with HIV (FJN+) established	2003
First-ever Pacific Regional HIV Strategy and Implementation Plan (2004-2006) developed	2004
Hub Centre established by MOH in Suva (continuum of care)	2004
Fiji's National HIV/AIDS Strategic Plan (2004-2006) developed	2004
Pacific Regional HIV Program (PRHP) commenced, based in Suva and Noumea, and funded by Australian, French and New Zealand Governments	2004
Antiretroval Therapy (ART) available in Fiji	2004
Fiji was a beneficiary to Round 2 of GFATM in 2004 as part of the multi-country proposal of the Pacific Island Countries	2004
Second Generation Surveillance (SGS) involving Knowledge, Attitudes and Behaviour (KAP) surveys and HIV/STI testing conducted in Fiji and four other Pacific Island Countries	2004-2005
The scale and nature of Fiji's national HIV response changed and increased from 2005 in terms of increased number of HIV-active organisations, increased number of HIV activities conducted and increased number of HIV activities focussing on previously under-served non-urban areas	2005
Four HIV-specific grant programs (including the NAC Grant Program managed by NACA and FCOSS) established in Fiji and eight other PICTs with funding from Pacific HIV Regional Project funded by Australia, New Zealand and France	2005
Two Hub Centres established in northern and western divisions	2005
The community-development approach to HIV/STI prevention - Stepping Stones - piloted and multi-country ToT training conducted in Fiji	2006
Fiji developed its third HIV NSP 2007 – 2011	2007
SPC's HIV/STI Response Fund commences with AusAID and NZAID funding	2008
Second Generation Surveillance Survey conducted in Fiji	2008
STI treatment guidelines and surveillance system in review	2009
Roll out of training of STI treatment to health care centres and Training of Trainers (ToT) for further roll out of treatment of STIs to PHC level.	2009

'Background' information prior to the current reporting period is presented as a contribution to an ongoing process of reclaiming and acknowledging Fiji's past national HIV response. UNGASS reporting can and should be useful for national as well as international audiences and fleshing out some of the past response may be of interest to both audiences. The additional pre-2008 material is designed to show that there have been pockets of good program monitoring data in Fiji that are available for reporting on the national response for UNGASS and for national reporting purposes.

Background up to 2008

In 1987 the National Advisory Council on AIDS (NACA) was established. It did not function enough to the level required in addressing the exigencies of the epidemic until it was reactivated in 2001.

NACA is chaired by the Minister of Health reporting to Cabinet, and including major stakeholders of Government such as tertiary education Institutions, private sector, civil society organisations, churches and community leaders.

Following the implementation of successive mid-term plans, the first National HIV/AIDS Strategic Plan 2004-2006 was developed in 2004 as part of the comprehensive multisectoral response focusing on prevention, care and support for PLHIV. It had eight priority areas for action with a projected budget of F$5 million. Government allocations for the work plan were F$2,305,200 in 2004, F$1,663,000 in 2005, and F$998,500 in 2006.

In the same year (2004), a Hub Centre was established by the Ministry of Health (MOH) in Suva to facilitate access to information, counselling, testing, technical assistance, and access to Anti-Retroviral Therapy (ART). After the 12 months pilot, two additional HIV Hub centres commenced HIV treatment in the western and northern regions. The Hub Centres provided a good representation of the burden of the epidemic on the country. It was thus realized that the HIV case-load may be three times higher than detected by the Suva Hub Centre. By 2007, 100% of HIV positive pregnant women received a complete course of ARV for PMTCT (NACA 2009).

Additional programmatic and monitoring activities have been undertaken at the regional level. With support from the Pacific Regional HIV Program (PRHP) funded by Australian, New Zealand and French Governments (with AusAID as the main donor), the Pacific Regional Strategy (2004-2008) was developed and endorsed following extensive consultations involving regional and country partners. SPC that managed the regional-strategy component of PRHP led the development of an implementation plan (PRSIP I) for the Pacific Regional Strategy (PRS). A funding gap of USD 8,539,100 was identified and the ADB and NZAID pledged support for its implementation. The development and existence of PRS and PRSIP I was a key factor in additional four million AUD funding support from donors. The UN developed a Joint Programme 2006-2011 designed to complement regional resource mobilization efforts.

The scale and nature of Fiji's national HIV response changed and increased from 2005 in terms of increased number of HIV-active organisations, increased number of HIV activities conducted and increased number of HIV activities focussing on previously under-served non-urban areas. A key factor was the additional funding

and support available from the Pacific Regional HIV Project, funded by the Australian, New Zealand and French Governments.

From 2005, four new HIV-focussed grant programs were established in Fiji and many other Pacific Island Countries and Territories (PICTs) and these grant programs enabled previously HIV-inactive organisations to start HIV activities and HIV-active organisations to expand their HIV activities into existing and new areas. The four grant programs were:

- National AIDS Council (NAC) Grants Program.
- Competitive Grants (CG) Grants Program.
- Rapid Response Grants Program.
- Capacity Development Organisation (CDO) Grants Program.

In order to ensure that available monitoring data relating to these grant programs, especially the two most important programs (the NAC and CG Grants Programs) are entered into the historical register of Fiji's national response, some often-overlooked information pertaining to the period 2004-2007 will be provided by way of background. The background material also serves to illustrate that program monitoring of HIV interventions in Fiji has occurred but not comprehensively at a national level and a potential lesson is that some of the monitoring techniques that have been used at program level could be applied at national level.

NAC Grants Program

The following four graphs (PRHP 2008a pp. 20-22) show the Fiji program, target areas, focus areas, beneficiary groups, organisations' type and whether rural or urban in Fiji between 2005 and 2007.

The graphs show that the NAC grant program in Fiji:

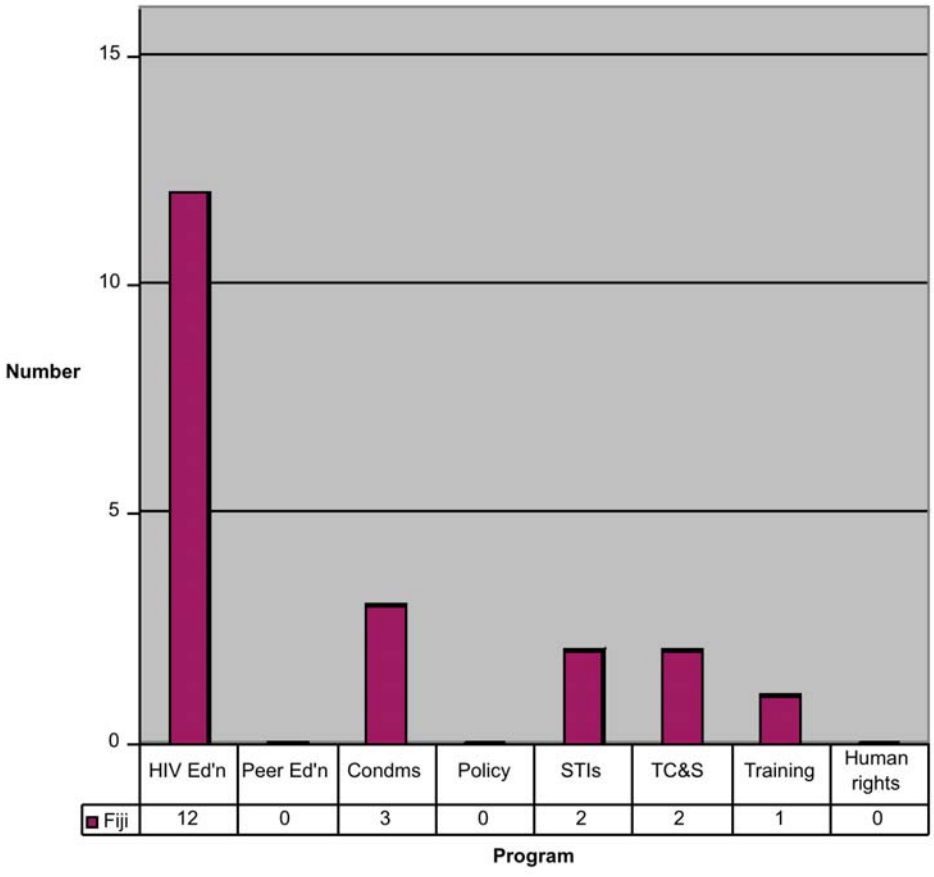
- Increased local NGO involvement in the national HIV response given that the predominant grant recipients were local NGOs.
- Expansion of HIV activities beyond urban areas, previously the most common focus of HIV activities in all PICTs including Fiji.
- Expansion of the number of Fijian organisations engaged in HIV activities, mostly small-budget and small-scale projects functioning for up to one year. For example in 2007, NAC grants "supported capacity building activities, HIV prevention programs such as HIV community education outreach and peer education programs, VCCT services, and PLWHA care & support programs, including a half way home for people living with HIV."(PRHP 2008a Annex 2, p. 4). Still, most NAC grant projects focussed on community education (general community including women and youth; some projects specifically target women and youth separately).
- The grant-holding agencies were all NGOs, including small Community Based Organisations (CBOs) and Faith-Based Organisations (FBOs). No government agency applied for funding.

The NAC Grants Program was managed by NACA in Fiji with the assistance of the CDO, Fiji Council of Social Services (FCOSS). The NAC Grant Program increased the amount of HIV-specific funds managed by a national body, NACA. Previously, NACA did not have access to a pool of funds dedicated to HIV projects that it managed including deciding which grant proposals were funded. Through this

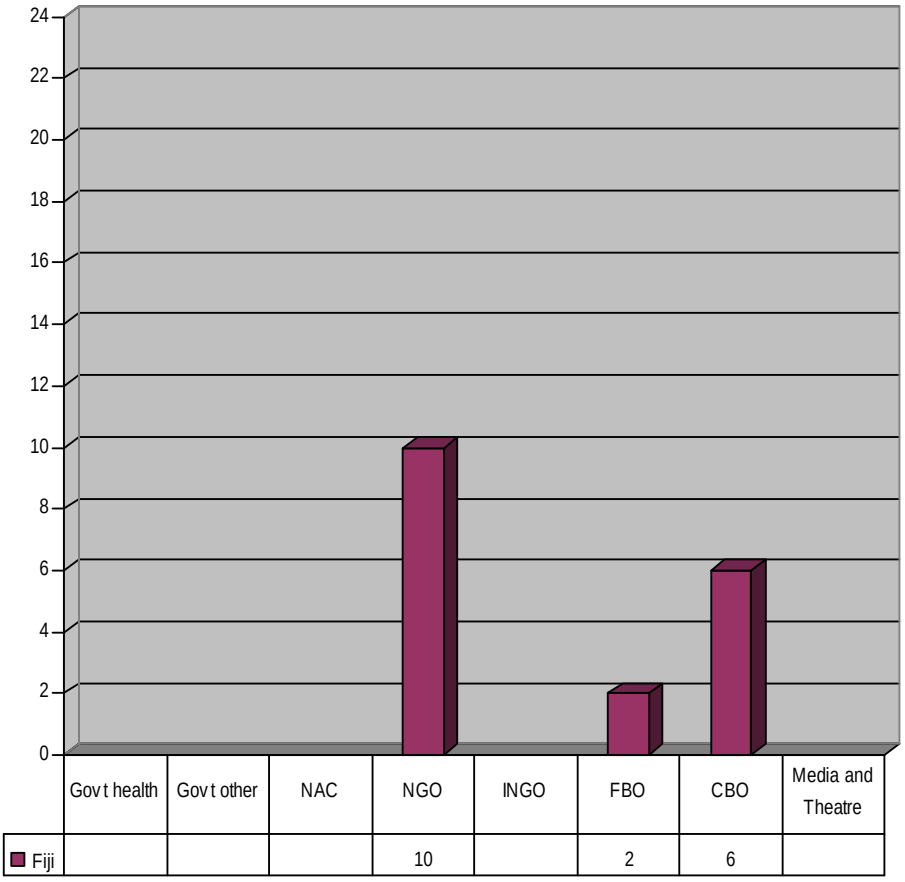
experience, NACA appraisal sub-committee members gained experience in grant appraisal.

A review of the NAC and CG Grants Programs in late 2006 described the focus of NAC Grants projects in Fiji as of late 2006 (PRHP 2006 p. 30):

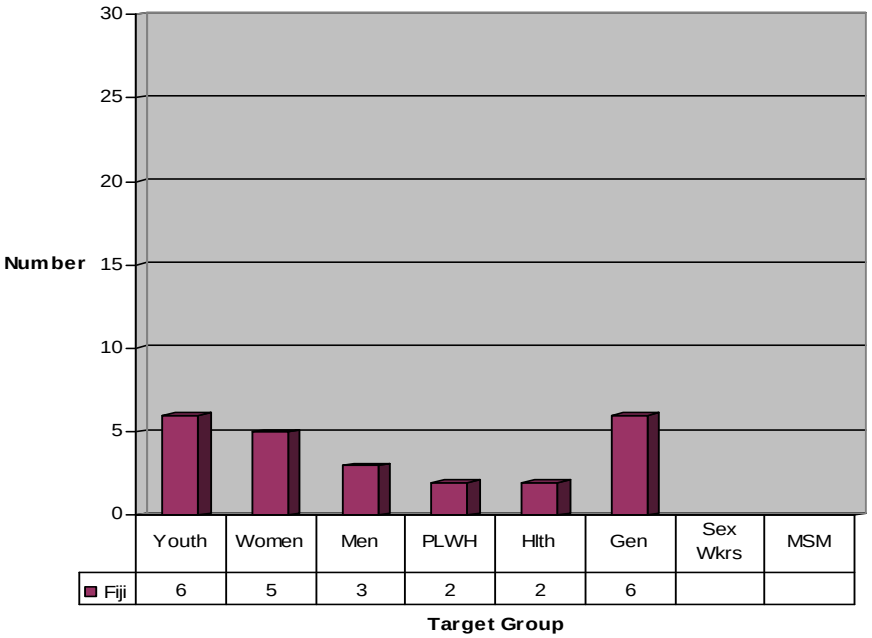
> "The NAC Grants Program projects contributed to five of the eight Priority Areas of the Fiji National HIV/AIDS Strategic Plan, representing a good coverage of focus areas for a small-grants program like the NAC Grants Program. Nine of the 11 funded NAC Grants Program projects focussed on preventing HIV infection among the general community, Priority Area 1 of Fiji National HIV/AIDS Strategic Plan, hereafter cited as 'NSP'. Six of the projects focussed on NSP Priority Area 2, prevention among youth. For the purposes of classifying projects as 'youth-focussed' for both PRHP's internal catalogue and Fiji NSP's classification system, projects were classed as 'youth-focussed' when the project paid special attention to young people (for example, by holding youth-only workshops as distinct from general-community training that may include some youth). Only one project, one managed by FJN+, focussed explicitly and predominantly on support of PLWHA, the focus of NSP's Priority Area 3. One of the 11 projects provided a Voluntary Confidential Counselling and Testing (VCCT) service under NSP Priority Area 4 (VCCT). None of the funded NAC Grants Program projects covered Priority Areas 5-8, namely, clinical management and treatment of HIV/AIDS (Priority Area 5), HIV/AIDS surveillance and research (Priority Area 6), Human Rights and HIV/AIDS (Priority Area 7) or coordination of the multi-sectoral response (Priority Area 8). It is not essential that the NAC Grants Program touches every NSP Priority Area. Priority Area 8 calls on NACA and other key government agencies to enable a well coordinated and integrated national response. The grant guidelines for both the NAC Grants Program and Competitive Grants Program preclude research-only proposals."



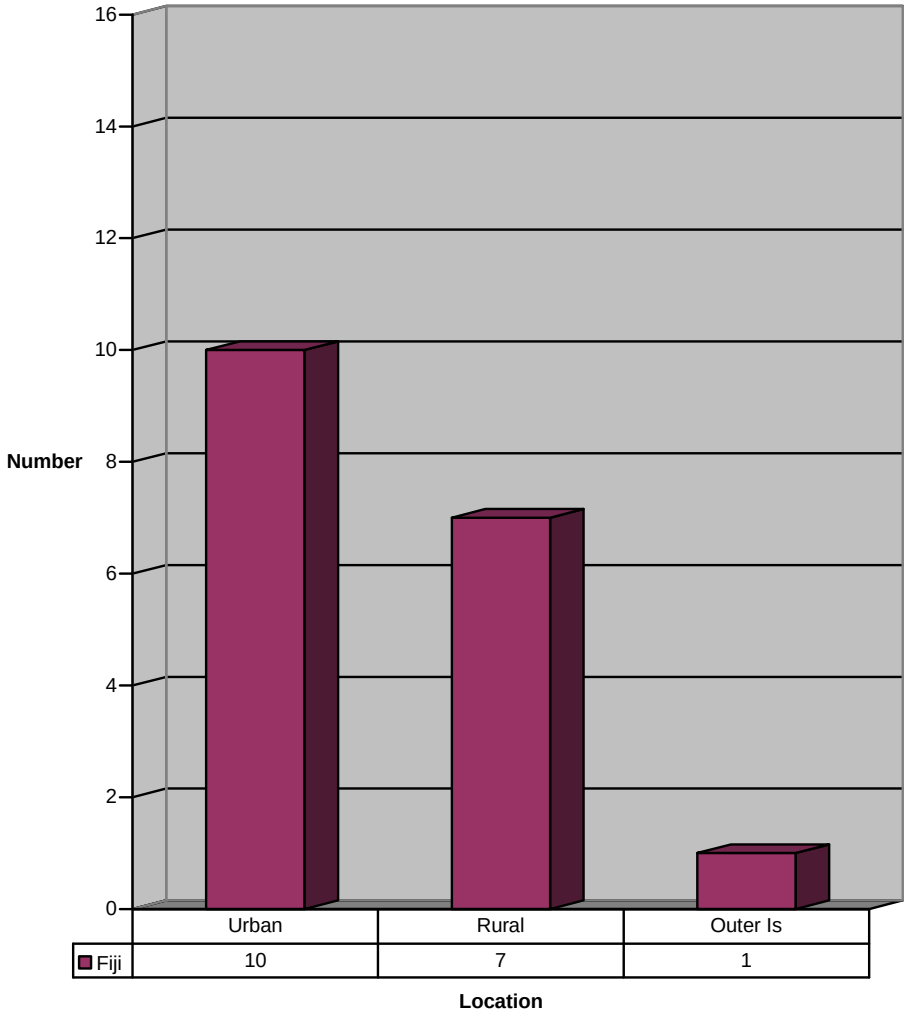
Graph 8: Number of Fiji NAC Projects by Type of Implementing Organisation



Graph 9: Fiji NAC Projects by Target Group

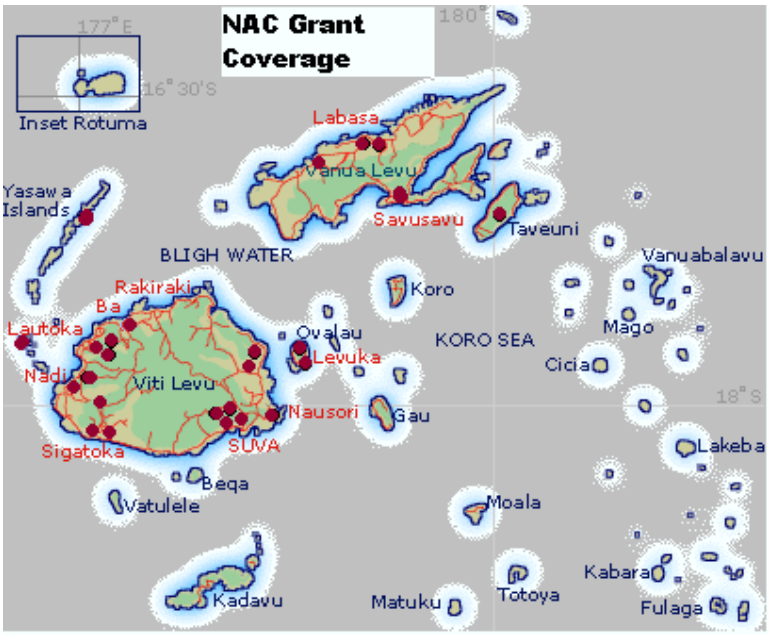


Graph 10: Fiji NAC Projects by Urban, Rural, Outer Island Locations



PRHP's 2006 evaluation included the following picture of the geographical focus of the 11 NAC Grants in Fiji. The red dots represent the location of beneficiaries of project activities rather than the location of activities themselves.

Graph 11: NAC Grant Geographical Reach as of last quarter 2006



Source: (PRHP 2006)

Competitive Grants Program

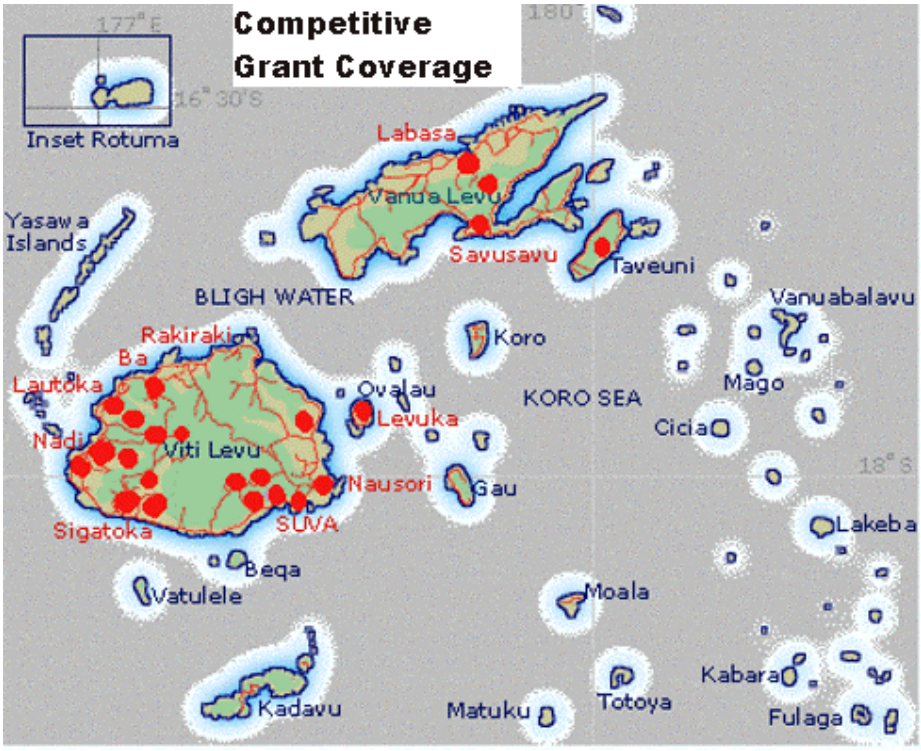
The Competitive Grants (CG) Program was conceived as 'blue-ribbon' regional grant program for more experienced agencies to submit higher-standard proposals.

PRHP's 2006 review of the NAC and CG Grants Programs in Fiji (PRHP 2006 p. 5) found that:

> The Competitive Grants Program represents a good mix of functional, population-group and territorial focuses. Like the NAC Grants Program, its geographical coverage is already good but should be expanded in future rounds to reach the interior villages of Viti Levu and Vanua Levu and the outer islands (eg Yasawas, Lau Group, Kadavu etc.).

The 2006 review report included a map of CG beneficiary locations (shown as Graph 12 below).

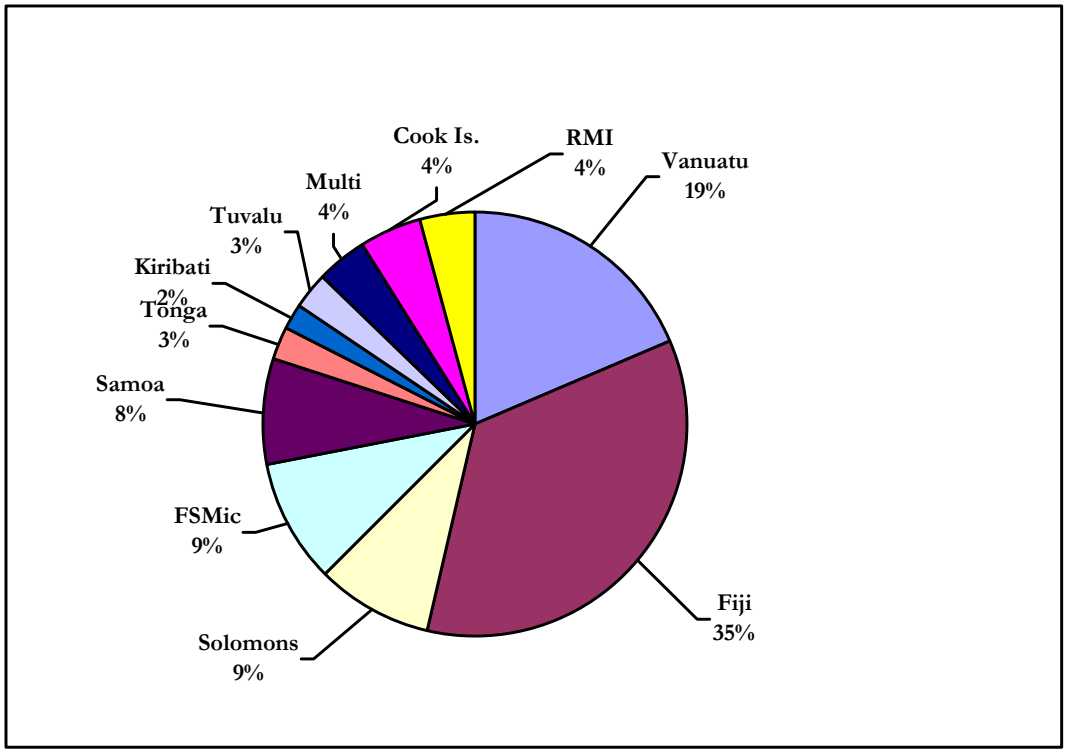
Graph 12: Competitive Grant Geographical Reach as of last quarter 2006



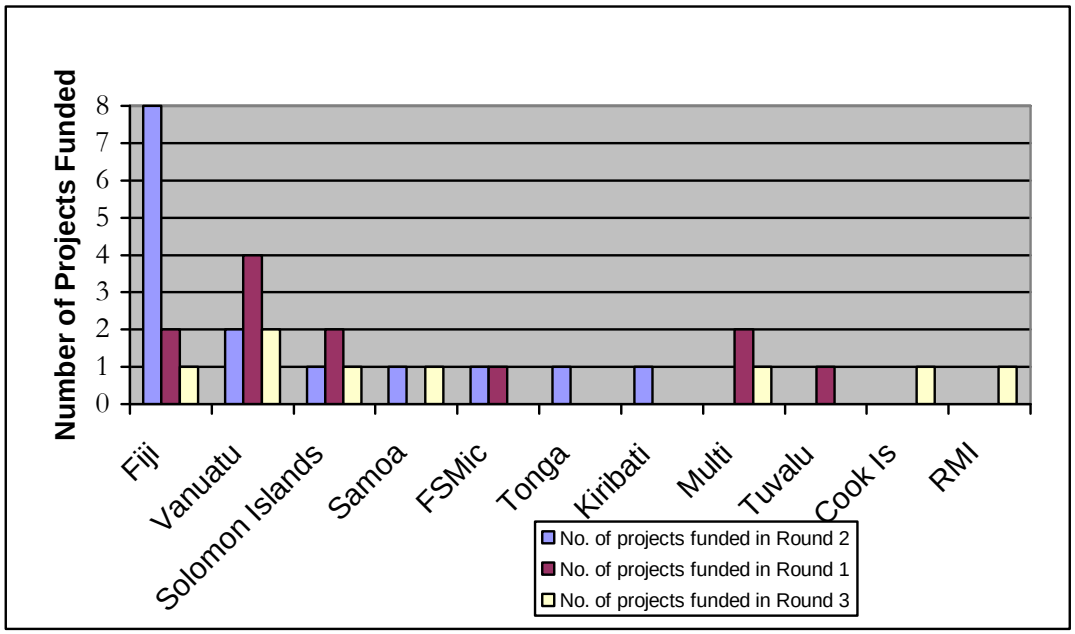
Source: (PRHP 2006)

As shown in Graphs 13 and 14, Fiji-focussed HIV interventions were awarded 35% of CG funding and 11 Fiji-focussed projects were funded in three rounds of competitive tendering among organisations working in 14 eligible countries. The grants were awarded on quality and relevance of proposals to national HIV strategies and responses. Graph 15 shows that Fiji's HIV response received the most financial support of any PICTs through the CG Program.

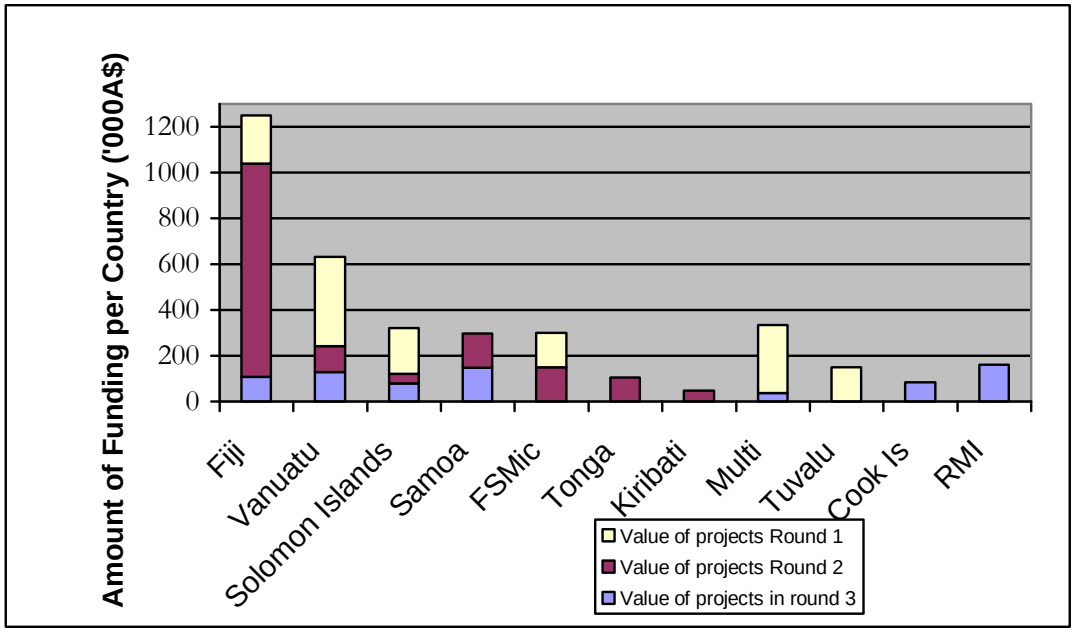
Graph 13: Percentage of Competitive Grant Proposals Approved by Country



Graph 14: Number of Competitive Grants Approved by Country



Graph 15: Value of Competitive Grant Funds per Country



PRHP's Grants Report 2007 (Annex 2, p.4) described the focus of the 11 CG projects operating in Fiji as follows:

> **"Competitive Grants Program** The eleven Competitive Grant projects targets rural nurses, young people (both rural and urban), seafarers, tertiary students, marginalised groups such as MSMs and sex workers, PLWHAs, antenatal mothers, special school teachers, including prison inmates and staffs. These projects build capacity of target groups, providing knowledge and skills to reduce their risk to HIV and STI transmission, promote behaviour change through provision of clinical services through a youth drop-in health clinic, peer education outreach and community education outreach programs. Further support develops BCC IEC materials that promote access to health services and improve HIV knowledge. A Competitive Grant project has provided institutional strengthening of an organisation that has provided job opportunities, as well as general support, for positive people. One Competitive grant project is currently under review due to issues relating to weak organisational systems & support. Further support will be provided based on sound organisational systems and other mechanisms are put in place."

The 2006 evaluation involved training project staff from a random sample of NAC and Competitive Grant projects on how to conduct 'Most Significant Change' (semi-structured) interviews with project staff and clients. The main findings on results were stated as follows (PRHP 2006 p. 5):

> "Evidence collected through 40 interviews with project implementers and clients from both NAC and CG grant programs show that all researched projects facilitated significant improvements in the practices of both project staff and clients. The stories of change are inspiring. Three of the four sampled Competitive Grant projects improved their organisational practices and their standing in Fiji and the Pacific region as a result of their involvement in the grant program and through PRHP training provided to grant-holders. Two of these projects were initially funded through the NAC Grants Program. Five of the eight MSC stories of NAC Grant implementers and two of the eight MSC stories from NAC grant clients described the newly-developed capacity of the implementer to conduct community education on HIV/AIDS and

related sensitive issues, learned through experience of implementing the project, often with supplementary training provided by PRHP. Six of the eight MSC stories from NAC Grant clients told of their newly-learned practice of talking about HIV, sexuality and related issues with family members such as husbands, sons and brothers and other relatives. Such improved communication led to a variety of knock-on effects (e.g. improved marriage; family avoided break-up; project client can talk in public about HIV; after talking with client, client's niece now settling down in marriage rather than having multiple sex partners etc.). Some pleasing gender-related changes are evident, especially concerning improved work- and life- competencies among female grant implementers and clients and improvements in communication and social relationships between the sexes within families. Three stories (one each from a NAC Grant implementer and client and one from a Competitive Grant project client) referred to reduced risk behaviours of the informants since their involvement in the grants program. Four of the sampled Competitive Grants project clients spoke of increased confidence to engage in community education on HIV and of their increased motivation to do so as a result of their training provided by the project. Four of the MSC stories told by Competitive Grants implementers refer to their improved skills and practices in one or more areas of proposal-writing, project management and administration, evaluation and reporting. Two of the MSC stories of NAC Grant implementers cited improved practices in proposal-writing and project administration, learned through their grant-project experience. In sum, the MSC stories tell of significant, positive changes among project implementers and clients."

Significant improvements in the service delivery models of three Fiji-based organisations, and PRHP's contribution, were identified in the Fiji grant-program evaluation (PRHP 2006 p. 64):

> "The grant programs have assisted all three organisations to develop and implement and over time to disseminate, very good service-delivery models in areas of:
> - Sexual and reproductive health (MSIP's three-pronged approach).
> - Combined focus on care, support and advocacy for PLWHA and on IEC/BCC to youth and general population through the one PLWHA organisation (FJN+)
> - Integrated program of VCT counselling, general counselling, routine HIV awareness activities and promotion of professional, client-centred service culture in a health-facility setting (FSEG – now PC&SS)."

In the course of the Fiji grant program evaluation, a senior MSIP staff member explained MSIP's three-pronged approach as follows (PRHP 2006):

> "The Competitive Grant Program provided funding and technical support to MSIP to implement a comprehensive, three pronged holistic approach to Sexual and Reproductive Health (SRH), involving the provision of SRH services at the Open Door Health Check Centre *and* outreach education *and* condom distribution to youth and the broader community beyond the Open Door Health Check Centre."

In relation to the capacity-development of MSIP, PC&SS and FJN+, facilitated by PHRP's grant funds and technical support, the Fiji grants-program evaluation report noted (ibid. p.66):

> "In short, a theme emerging strongly in three of the four sampled organisations [namely, the three organisations above] is that one or two PRHP-supported grant programs have assisted the organisations to move beyond their fledgling phase characterised by (a) their less-developed internal systems and organisational capacity (b) their *ad hoc,* non-systematic and/or non-comprehensive client-service models and (c) their marginalised external position or standing with local, national and international stakeholders. The stories told by staff members of

all three organisations describe significant and exciting improvements in the organisational capacity, service-delivery models and standing of all three organisations."[3]

One outcome of the improved service-delivery model of PC&SS was described as follows. "In Western Division, Fiji, the number of pregnant women annually receiving pre-test and post-test counselling has increased from around 10 before PRHP grant support (in 2004) to around 3000 now (2007).[4] The professional VCT counselling service was established and provided by PC&SS with support from PRHP's NAC and Competitive Grants Programs"(PRHP 2008b p. 129). By the end of 2007, PC&SS had been instrumental in increasing the range and quality of health services accessed by pregnant women diagnosed as HIV positive in the Western Division. By this time, any woman found to be HIV positive had access to a holistic health care team that included obstetricians, HIV specialist, paediatrician, counsellors and social worker. Prior to the development of the antenatal HIV VCT program (funded by PRHP's grant programs), no such holistic support team was available to mother, child or significant others (ibid).

Textbox 1: FJN+ Story Is Chosen as "Most Significant Change Story by Implementers" in Fiji Grants Program Evaluation, October 2006

"From a strong field of eight stories, the selection panel chose 'Ownership of Programs by Members' as told by Tuberi Cati and reproduced as Annex 13 [in the Fiji grants-program evaluation report].

"The story was selected as it shows the very significant and dramatic positive change in an organisation (FJN+) that existed in name and law only before the NAC and Competitive Grants Programs. The story-cluster of Tuberi shows that the organisation has moved from a group of individuals who were part of a UNDP program managed by ATFF to become the managers of their own project funded through the NAC Grants Program and then the Competitive Grants Program and the managers of their own organisation, FJN+. The story also shows the important example of increased skills of FNJ+ members in a range of areas including financial management, IEC development and proposal- writing skills. Since they have become an organisation, they have held regular monthly meetings with members (unlike their pre-grant situation), they have improved the level of support to HIV+ members and they have used the monthly meetings also as the main planning forum for the organisation. The MSC story describes the ideal service-delivery model where the clients needs shape their service-delivery organisation's agenda, programs and values. The representatives of clients actually run the organisation with the assistance of a non-member Project Manager who is responsive and accountable to the organisation's membership. Tuberi aptly named her MSC story-cluster as 'Ownership of Programs by Members'. Few organisations in the world are run by the clients of the organisation (and they are mainly self-help groups like FJN+). The model of a client-driven service (and if not that, at least client-sensitive service) is one worthy of emulation by other government and non-government service-delivery organisations. It is in this direction that FSEG [now PC&SS] is encouraging MOH's Western Division Health services and MSIP is moving in its flexible opening-hours and youth-friendly service provided by its Open Door Health Check centre."

Source: PRHP (2006) *Evaluation of NAC Grant Program and Competitive Grant Program in Fiji*, unpublished manuscript, p. 65.

[3] Ibid, p. 66.

[4] See, sample results on Access under AusAID's Gender Equality Policy's Theme Three, Health, include "Increased access by women to reproductive health services" (p. 31). This example also relates to another sample result for Access under Gender Equality Policy's Theme Three on Health, 'Increased use of health services by women, men, boys and girls according to their needs' (p. 31).

According to a recent report (NACA 2009 p. 6) on Universal Access to ARVs in Fiji, "By 2005, ART was available to all HIV positive patients who needed it" with funds provided by GFATM Round 4 [sic; should be Round 2]. Fiji was not successful in accessing GFATM Round 7 funds for continued GFATM ART funding.

FJN+ support services to its members also improved between 2005 and 2006 assisted by its NAC and CG Grants as described in the textbox below that appeared in the 2006 Fiji grants evaluation report (ibid., pp. 57-58).

Textbox 2: Improved Self-Help Services to PLWHA

Improved Compliance with ARV Treatment
Before, there was poor compliance with ARV treatment among FJN+ members. We had heard about peer-to-peer support but did not practice it. Most members didn't stick to ARV treatment. In 2004, 3 were on ARV; after 3 months, 2 dropped out to herbal treatment on basis of advice from the church they were attending. ATFF blaming herbal church that church told them to stop. Two people who dropped out did not appreciate importance of compliance and did not complete the preparatory phase before treatment. They attended only one counselling session and went for treatment. Fiji started ARVs in June 2004.Now, there is better compliance with ARV treatment among FJN+ members. All eligible FJN+ members (8) are on ARV treatment. Now, we are able to practice peer-to-peer counselling, sharing, team spirit and caring for each other better. In monthly meeting, we share information and experiences about ARV treatment and balanced diet. Positive people are more compliant with ARV treatment than before. Emosi (FJN+ Finance Officer) explains to people who drop in about balanced diet. Regular monthly meetings are important for promoting compliance. FJN+ members can see how well other people who are on regular ARV treatment are looking in each monthly meeting. It is an incentive to stay on treatment. Compliance with treatment is better and members at monthly meetings can visually see difference through treatment. This is motivating for members.

Now Assistance in Purchasing Drugs
Before, when FJN+ was under the umbrella of another organisation, FJN+ members had no financial assistance in purchasing drugs for the treatment of opportunistic infections. Now that FJN+ is institutionalised as its own organisation with its own Project Manager (enabled through core funding from the NAC and Competitive Grants Programs), it now provides financial assistance to members in purchasing drugs for the treatment of opportunistic infections.

More FJN+ Members have Social Welfare Monthly Assistance
Before FJN+ was supported by the NAC and Competitive Grants Programs, ATFF didn't allow Emosi time off to help FJN+ members to submit their applications for Social Welfare Monthly Assistance to the Ministry of Social Welfare. Only five out of the then 20 FJN+ members were on Social Welfare Monthly Assistance, all organised by Emosi in his own time outside of work hours.

Now, 15 FJN+ members receive Social Welfare Monthly Assistance, all organised by Emosi in FJN+ work time as part of his job and the organisation's role.

Increased Member Involvement
In 2004, eight members met, but not regularly as no provision for regular FJN+ monthly meetings under the UNDP Greater Involvement of PLWHA (GIPA) program managed by ATFF. In 2005, three couples and six singles went to Dr Jiko Luveni's house to meet.

Now, there are 18 FJN+ members. Six have passed away. Normally, around 15-16 people attend monthly meetings held at FJN+ office.

Source: Dr Jiko Luveni, Tuberi and Emosi, interview with Dr Tim OShaughnessy, 22 September, appearing in PRHP (2006) Evaluation of Fiji NAC and Competitive Grants Programs, pp. 57-58.

The NACA report (ibid.) noted several important pre-2008 highlights and features of the national response in Fiji:

> "Although political instability (4th coup in 20 years) hampered lots of achievements, particularly on health and education, the Government had doubled its budget allocation for implementing the National HIV/AIDS Strategic Plan from FJ$ 150,000 in 2003, to FJ$ 300,000 in 2004, FJ$500,000 in 2005 and the same amount for 2006. Fiji also benefited from GFATM Round 2 funding, Franco-Australian Pacific Regional HIV/AIDS Project, UNFPA condoms, UNICEF Pacific Stars program, ILO workplace programs, and from the NGO Fiji AIDS Task Force Fiji. In 2006 and early 2007, infection rates were on the increase and 'Most At Risk Populations' (MARP) emerging. The WHO assisted the government with workshops on HIV estimation, Second Generation Surveillance Survey and strengthening of HIV/AIDS strategic information. Upon the expiry of the first HIV and AIDS NSP, Fiji developed its second NSP 2007 – 2011, also reinforcing the multi sectoral response to the epidemic. It focuses on five priority areas that address the realities of sexual behaviour in the country, and the evolving epidemic."

Under the Rapid Response Grants Program, PRHP piloted Stepping Stones (SS) in Fiji in 2006 having organised training for SS facilitators from five PICT countries in early 2006. SS experts from Uganda facilitated the training. SS is a community mobilization strategy that focuses on improving gender relationships to address inequity. Following an evaluation, SS was revised to address the Pacific context and the program in 2007 was implemented in three locations in Fiji [as well as expanding across five countries in the Pacific).

A post-pilot monitoring and evaluation exercise found that it catalysed community-level in knowledge, attitudes and behaviours in partner locations that implemented it. Many of the MSC stories told by Stepping Stones' facilitators and participants (and the MSC technique was one of several data collection methods) exemplified gender-related changes. This was not surprising given that a focus on gender and gender issues is central to the Stepping Stones curriculum and discussion process (whereby discussion proceeds through a mix of small group sessions, where participants are divided into peer discussion groups on the basis of sex and age, and plenary sessions). PRHP's fourth annual report contained several examples of gender-related change catalysed by the Stepping Stones technique in the successful pilot villages. For example, the story of one female Stepping Stones (SS) participant, from Sasa village, suggested attitudinal and behaviour changes among herself and her friends to unsafe sex, club-going and possibly male-female relationships:[5]

> "Now, protecting myself from HIV has been the most important change for me. Before SS I would go to the nightclubs and have sex with boys. I believed the saying that flesh to flesh sex was best.

Textbox 3: Women Are Empowered

"I didn't ask, and the women in my village didn't really ask, for things from our village headmen. I didn't think it was the woman's place to do this. After finishing Stepping Stones, and having the special requests [i.e. Stepping Stones commitments], I am much more confident to ask for things to happen in my village".

Source: Interview with SS participant (Veniana Wagawai), Waikubukubu village, May 2006.

[5] Source: Interview with SS participant (Sitera Qata) from Sasa village, May 2006.

> Now, I am certain that I won't have sex without a condom with boys from nightclubs anymore. I make sure that I have condoms on me that I get from Di [a female SS facilitator in Sasa village, who tells her story above] or that I buy from the pharmacy. I still go to the nightclubs with my friends but not as much anymore. I want to protect myself for the future. I have to be alert and be careful so I can grow old and have a family of my own one day. Before Stepping Stones, I would take big risks with my health. Looking back before Stepping Stones, I can say I really don't know why I did that to myself and why I put myself at such a big risk! I feel angry with myself for doing it and SS made me and my girlfriends see how bad we had been treating ourselves."

A number of other SS participants spoke of positive attitudinal and behavioural changes in gender relations - in the direction of gender equality - as a result of the SS process. A female participant from Sasa village said:[6]

> "Before Stepping Stones, boys and girls in my village didn't really talk closely. If the boys did talk with us it would be about rude stuff or trying to get us to sleep with them. The six weeks we spent doing Stepping Stones brought the boys and girls together. I think we are more like friends now and they don't seem to always call rude things out to us. I think Stepping Stones made them see us more as people rather than just girls to have sex with."

Several stories of male participants from Sasa village corroborated the above story of improved attitudes and behaviour in everyday-life relations between males and females in Sasa village. For example, one young man said "Before Stepping Stones, even though I have known some of the girls in my village for my whole life, I never really talked with them or knew important things about them. I never really thought about getting to know them as they are girls and have their own secret stories."[7] Another young male SS participant said that 'Stepping Stones has made the boys think about girls differently. I now don't always try to have sex with them".[8]

One story showed that SS helped to give women in Waikubukubu village the confidence to speak out to their husbands about how they felt about their husbands' potential or actual infidelity.

> "I wondered if my husband had sex with another woman… after talking with the other women [during Stepping Stones], we all thought that way and it was good to listen to how they feel. We were all scared about it… we all decided to tell our husbands they couldn't have sex with another woman".

Another example of a remarkable SS-facilitated changes in how women see themselves, their place and their rights vis-à-vis men at home and in authority is described in Textbox 4 below.

Textbox 4: Improved Marital Relations

"My husband never cared about women's sicknesses. If I had a stomach ache and he wanted sex he would just have it. Now my husband tries to understand me as a woman. He talks to me more about women's sickness and if I don't feel like sex he is more understanding."

"Even though I am married with four children, I didn't know much about sex and the different names and styles. After SS and through talking with other women I have learnt a lot about sex and the different styles. My sex life with my husband is now much better."

Source: Interview with female Stepping Stones participant, Arieta Sivo**,** Sasa village, May 2006

[8] Source: Interview with young male SS client (Kilioni Nasalato) from Sasa village, May 2006.

One SS participant's story[9] showed that she had developed a heightened awareness of, and courage to advocate for, her economic rights as a sole-custodial parent (that is, as a wife whose husband left her with the sole responsibility of raising her daughter):

> "My husband left me and my daughter two years ago and does not pay child support. Before Stepping Stones, I was not able to insist on being treated a certain way…. After Stepping Stones, I am much more assertive… I am going to court next month to make my husband pay child support. If he doesn't pay it he will go to jail".

This story (above) also illustrates that the improved self-respect and assertiveness of females can trigger further positive ripple effects, for example, in improved *economic* relations between men and women.

PRHP supported the introduction of the Stepping Stones technique to the Pacific region to assist organisations, projects and communities to move from an "Information, Education and Communication" (IEC) approach to HIV/STI prevention to a "Behaviour Change Communication (BCC) approach. The IEC approach focuses on improving people's knowledge of HIV transmission and prevention – a standardised 'HIV 101 lecture' - based on the belief that ignorance was the main cause of people's risk behaviour. The BCC approach is a participatory, community-development, multi-method prevention approach tailored to specific target groups. A comparison of Round 1 and Round 2 CG project proposals submitted to PRHP showed a statistically significant improvement in the 'BCCness' of proposals between Round 1 and Round 2.

Reporting Period 2008-2009

Prevention

Fiji has continued its active focus on HIV prevention in 2008-2009 driven by a solid core of capable HIV-active agencies (local and international non-government agencies and multilateral agencies).

For example, Fiji has the highest number of projects funded by the Competitive Grants (stream four) and PRSIP Support Grants (stream five) of the Pacific Islands HIV and STI Response Fund 2009-2011 (hereafter 'Response Fund') managed by SPC. Response: 14 Competitive Grants projects and 11 PRSIP Support Grants were and funded approved in 2009. This figure has not been renumbered as it has been copied from the M&E Framework document of the Response Fund (RF).

[9] Source: Interview with SS implementer (Kelera Vauvau) from Waikubukubu village, a remote interior village on Viti Levu, May 2006. Incidentally, the Fiji Grants Grants Program Evaluation in 2006 recommended that the grants program's coverage be extended to remote areas of Fiji such as Waikbubuku village. It is pleasing to see PRHP's BCC program of activities taking place in such locations *and* linked with Fiji Government's health strategy! Waikubukubu village is one of the Fiji's Ministry of Health's 'Health Promoting villages'.

Graph16: Response Fund Projects by Grant Stream by Country

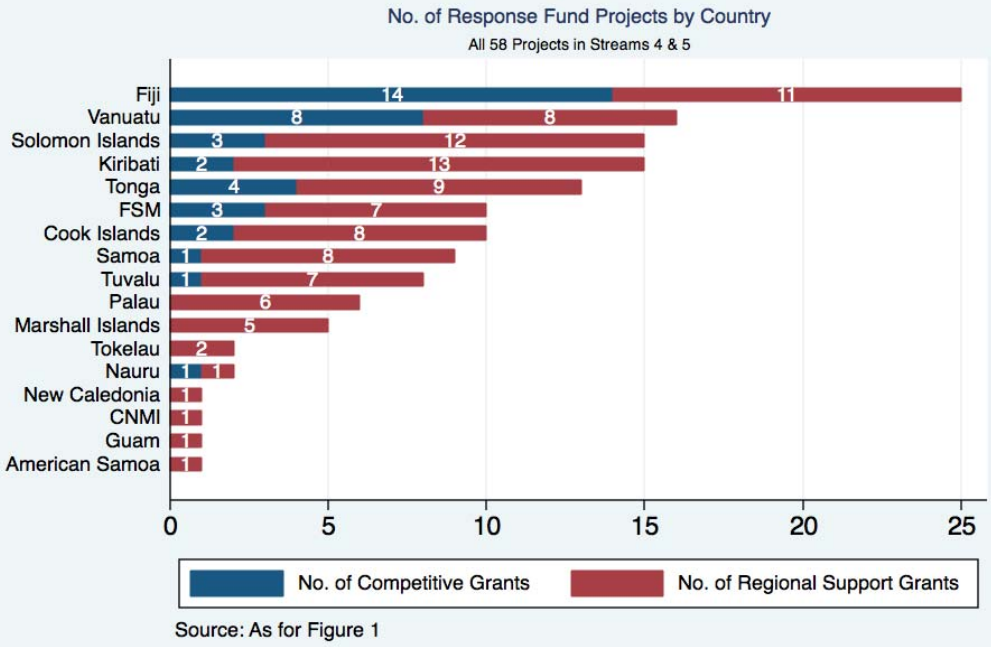


Figure 6: Geographical Spread of Response Fund Projects

Of the 25 RF-funded projects (streams four and five) in Fiji, 14 include a focus on prevention of HIV transmission and are managed by a range of local and international NGOs and multilateral agencies (the latter including ILO, UNAIDS).

The NAC Grant Program, initiated in 2005 with funding from PRHP has continued through to the present time. Nine projects have been funded through the NAC Grant Program in 2008 and 2009 using unallocated PRHP funds managed by SPC after PRHP's completion in September 2008.

Table 5: No. of NAC Grants in Fiji by Year 2005-2009

Year	No. of Projects Funded
2005	10
2006	6
2007	2
2008	2
2009	7

The report of the Post ICAAP workshop (Dezaki 2009), held at the JICA office on Tuesday 18th of August 2009, contains a useful reference to the kinds of HIV projects implemented by the participants' agencies. The workshop brought the 30 Fiji delegates to the ICAAP conference together to share their knowledge, skills and experiences with stakeholders in the country. The participants for this workshop were from Civil Society Organizations, Government departments and development partners such as UNAIDS that is also an HIV-project implementing agency.

Table 6: List of 'Common Approaches' to HIV Prevention in Fiji by Implementing Agency Generated at Post-ICAAP Workshop in Fiji

Common Approaches	**Implementing Agencies**
Peer Education	USP, FRCS, MoE, MOH
IEC material & condom distribution	USP, FRCS, MOH
Radio program	USP (FM88), MoE, MOH
Community awareness	MoY, Department of Youth, MOH

Table 7: List of "Other Projects' by Implementing Agencies Generated at Post-ICAAP Workshop in Fiji

Other HIV Projects in Fiji	**Implementing Agencies**
HIV awareness in youth camp	Fiji Muslim Youth Movement
Inform HIV-related issues through publications	Fiji Muslim Youth Movement
Mainstreaming HIV awareness into curriculum	USP
Life skill programme through NYSS	DoY
Prevention in workplace	FRCS
Support building partnerships between partners	UNAIDS
Technical assistance to Government and partners/stakeholders	UNAIDS

As noted in the indicator table presented earlier in this report, Life Skills Education (LSE) was introduced in pilot secondary schools in 2008 and has been scaled up to almost all secondary schools in 2009. Information on the number of grades per school that conduct LSE and for how many hours annually is not available.

There has been a smooth transition between PRHP's financial and technical support for the 'Stepping Stones' program (2006-2008) to FSPI that is managing two Response Fund Projects designed to improve Pacific organisations' capacity to implement the Stepping Stones technique in four PICTS including Fiji.

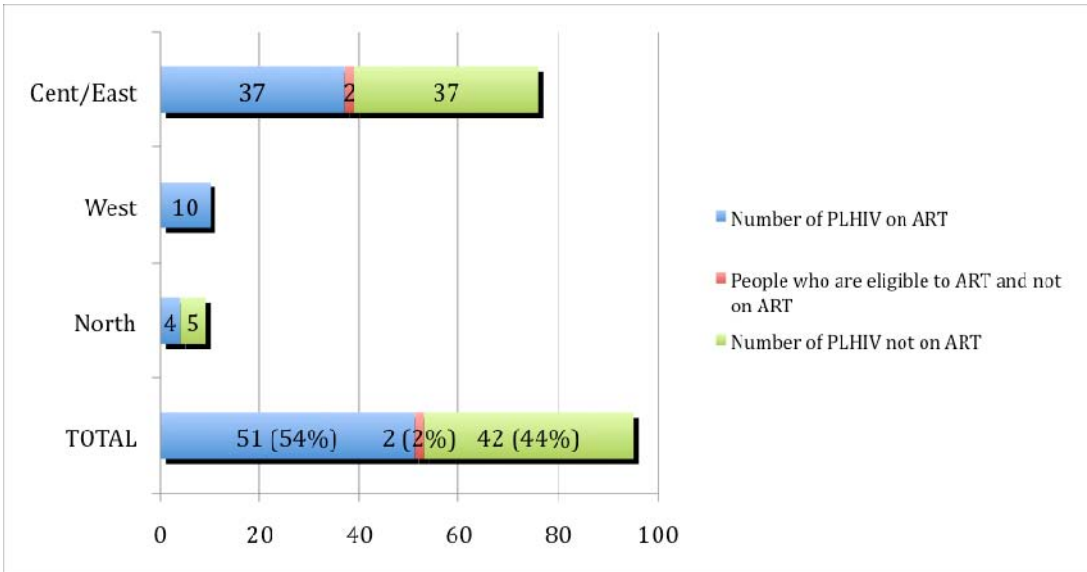
Treatment and Care

The 2008-2009 period saw several key improvements in treatment and care in Fiji.

MOH treatment and care guidelines and services were revised and improved and the three Hub Centres were 'strengthened'. The 2008 Annual Report of Ministry of Health, Women (MOHWSA&PA) noted that "numerous other HIV/AIDS clinical & technical activities were implemented in 2008 including the ARV Procurement & Treatment Guidelines review with strengthening of the 3 Hub Centres … and PMTCT project with UNICEF (was) established at CWM Hospital" (MOHWSA&PA 2009 p. 17).

In 2009, 48 PLHIV (34: Suva, 10: Lautoka, 4: Labasa) were on ART out of 95 PLHIV (75:Suva, 10 Lautoka, 9:Labasa) who were Hub Centre clients. Two PLHIV were eligible for ART under national guidelines but were not receiving it.

Graph 17: Number of Hub Centre PLHIV Clients on ART, Eligible for ART and not on ART in 2009



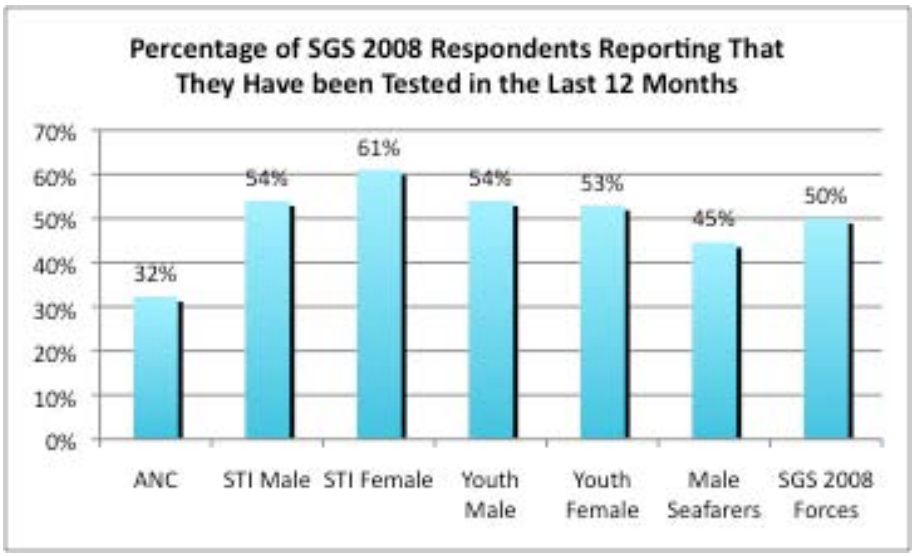
Source: Ministry of Health (2010), Family Health Unit.

Between 2005 and 2009, PC&SS in collaboration with its partner hospitals and with MOH expanded its VCCT service from one hospital at Lautoka (July 2005) to five hospitals: Nadi (Aug 2007), Labasa (Nov 17th 2008), Suva (CWM - 1st July 2009), Nausori 1st July 2009). In 2009, PC&SS provided a service accessible to 80-90% of pregnant women in Fiji. As noted in a recent PC&SS report on its contribution to the health sector in Fiji (PC&SS 2010 p. 5):

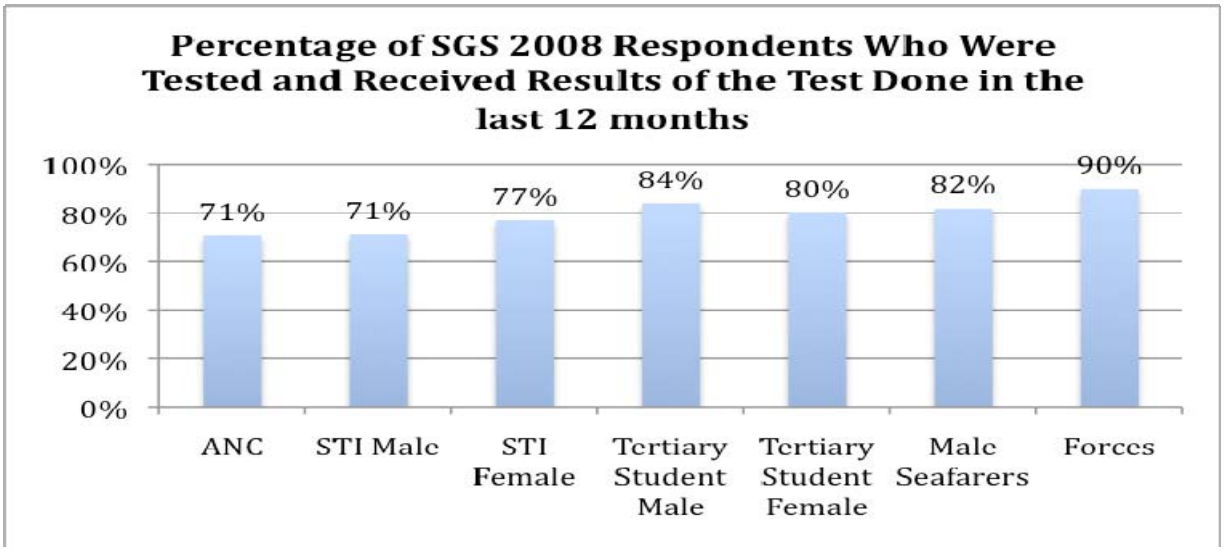
> In 2009 PCSS provided a total of 4791 pre-test counselling sessions. Two thousand four hundred seventy (52%) were completed in Lautoka, 1035 (22%) in Nadi, 861 (18%) in Labasa, 271 (6%) in Nausori, 148 (3%) in CWM, and there were 6 pre-tests that were not identified with a specific office. Four thousand two hundred and eleven (88%) of those who received pre-test counselling gave informed written consent to be tested. Fijians make up the largest proportion of clients; 3054 (64%) and ranged from 59% in Labasa to 77% in CWM. Indo-Fijians made up 33% and 3% were of other races. Females were the expected overwhelming majority (99%) and the sample included only 45 male clients. Forty-eight percent of the clients were age 25 or younger.

Over half of five of the seven sub-populations surveyed in SGS 2008 had received an HIV test in the past 12 months.

Graph 18: % of SGS 2008 Respondents Reporting that They Have Received Testing in Past 12 Months



Graph 19: % of SGS 2008 Respondents HIV Tested and Receiving their Results in the Last 12 Months



Interestingly, the highest proportion of respondents receiving their HIV test results out of all respondents who were tested were in the uniformed services and the lowest among ANC attendees. Nevertheless, over 70% of survey respondents across all surveyed populations that had been tested reported that they had received their results.

The 2008 SGS included questions on drug use and follow-up questions on injecting drug use in past 12 months for respondents who answered yes to the initial drug use questions. Very small numbers of people across the surveyed populations reported using Injecting drug in the past 12 months. The report noted that “Inconsistent replies were most common when asking about commercial/transactional sex, men having sex with men and injecting drug use, but often replies were given when the participants should have skipped that question” (p. 74) Seven of the nine tertiary

students who said they had injected drugs said they had injected cocaine and the report included the following note on this claim that was also made by one seafarer. “During the analysis there was some debate about the findings, in particular that the majority of injecting drug users answered that they had injected cocaine, as it is not commonly injected” (p.44). It appears that the ‘forces’ questionnaire asked about injecting drug use in past 30 days.

Table 8: No. of Respondents by Survey Population Reporting Injecting Drug Use in SGS 2008

Survey Population	**Sample Size**	**No. of Respondents Reporting Injecting Drug Use**
STI Clinic Attendees	151	1
Tertiary Students	543	9
ANC Attendees	417	1
Seafarers	256	2
Military and Police	262	2

PC&SS VCCT statistics also support the case for very low prevalence of injecting drug use in Fiji. Of the 1754 post-test counselling sessions conducted by PC&SS in 2007, injecting drug use as risk behaviour issue was flagged in only two cases. Of the 4791 clients provided with pre-test counselling by PC&SS in 2009, ‘less than one per cent’ reported injecting drug use (PC&SS 2010).

In 2008 and 2009, PMTCT programs were operating in the three divisional hospitals and case numbers are given in the UNGASS indicator table above.

There are two centers in Fiji where treatment for TB patients is provided. The Lautoka Hospital in the Western Division provides DOTS treatment and may refer cases to Tamavua PJ Twomey Hospital which is the main centre for treatment for TB. Labasa hospital in the Northern Division refers positively screened patients to Tamavua PJ Twoney hospital.

In preparation for the Global Fund Rounds 8 and 9 Monitoring and Evaluation Component of the TB Grant , a review of the TB register from 2007 – 2009 was done. It was found that there is inconsistency in reporting demographic details, registration number, incomplete treatment results leading to loss to follow-up.
Further more, the Tamavua PJ Twomey Hospital is the central reporting source to the Ministry of Health Information Unit. Therefore, Lautoka Hospital has to report all new cases to Tamavua PJ Twomey Hospital that will then compile the national statistics. There is a tendency of receiving reports late and the late reports are then counted in the next timeframe rather than the actual time of registration. For example, where a patient was seen in June 2009 but the records were sent in January 2010, the patient would be registered as a new patient for 2010.
In addition, TB cases are routinely tested for HIV but the converse does not happen. This may lead to some TB- HIV co-infection cases to be “missed”. The real burden of this co- infection may still be unknown in this country.

Support

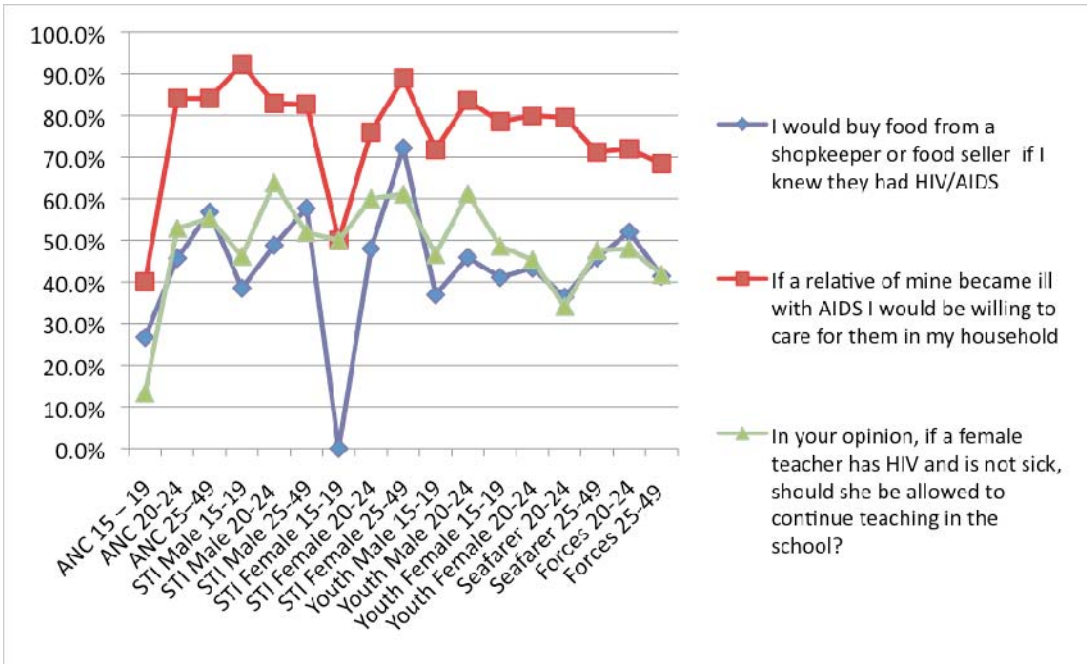
FJN+ provides the main organised support for positive people in Fiji. As noted earlier, FJN+ is a self-help organisation that is run by positive people for positive people and the wider community. As of the end of 2008, FJN+ had 37 positive members and 100

volunteers (FJN+ 2009). Between 2006 and 2008, FJN+ provided the following care and support services to members (FJN+ 2009 p. 9):

- PLHIV monthly meeting (minimum of 20 members every month)
- Counselling (5 members have identified counselling as a need in a month)
- Buddy program (18 members have identified the significance of practicing buddy approach)
- Half way home (4 PLHIV have been reconciled with their families thru the half way home program)
- Social Welfare Housing Assistance (4 members of the organization have received permanent housing assistance)
- Social Welfare Family Assistant Voucher (13 members have received their monthly allowance)
- Volunteers (100 volunteers mobilized to strengthen support for PLHIV)
- ARV Treatment (11 members are on ARV treatment)

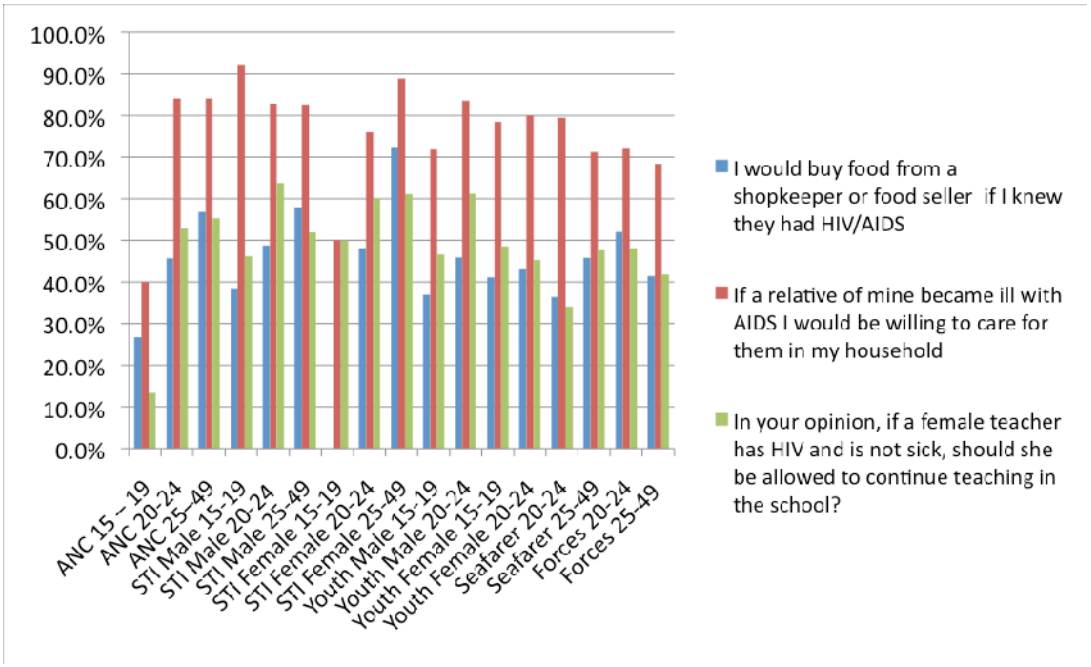
Acceptance of PLHIV is still lower than desirable. SGS 2008 included three common questions on stigma and discrimination. Not unexpectedly, higher proportions of sampled populations reported that they would be willing to care for a HIV Positive relative than buy food from a HIV Positive shopkeeper or support the continued employment of a female HIV Positive school teacher. For each of the three questions, the 15-19 year groups in samples of ANC attendees, male tertiary students and male and female STI Clinic attendees displayed lower levels of accepting attitudes compared to the older age groups, suggesting the need for Life Skills Education in primary schools as well as secondary schools consistent with the standard proposed in UNGASS indicator # 11 (at least 30 hours of LFA at each level of primary and secondary school). The answers to the three questions included in SGS 2008 are normally aggregated to form a composite 'accepting attitudes' indicator, however, this has not been done in the draft report on SGS 2008. SGS 2004-2005 reported on a composite 'accepting attitudes' indicator but did not report data on responses to each question and only one of its three questions matched the set of SGS 2008 questions. Data on the three SGS 2004-2005 questions (Respondents who would be wiling to share a meal with a person with HIV/AIDS and be willing to buy food from a shopkeeper who had HIV and would not want it to remain a secret if a family member had HIV infection) were not reported for each question but only as an aggregate total based on answers to the three questions as a group. It would be good for Fiji to have a copy of the SGS 2004-2005 raw data so that it can compare data on each common question in the two SGS surveys.

Graph 20: Accepting Attitudes Towards PLHIV by Sample Population, Age and Sex (line graph)



Source: Original graph based on SGS 2008 data

Graph 21: Accepting Attitudes Towards PLHIV by Sample Population, Age and Sex (bar chart)



Source: Original graph based on SGS 2008 data

The 2009 report of FJN+ describes its work of creating an enabling, accepting environment for PLHIV applicable to the period 2004-2009 and indicates positive signs of change in supportive and accepting attitudes:

> The program aims to commemorate those who have died of AIDS and those who are still living with HIV. These annual event has strengthen family support and a call for leaders to take the lead to light a candle with alacrity to break the darkness of fear, stigma & discrimination against people living with HIV. In particular the candle light event intelligibly cultivates motivation to

> those who have come public with their status to sustain their fidelity to the HIV response at all level… Advocacy has been a vital important role to this organization in preventing the further spread of HIV in Fiji. During the early days of FJN+ participation of positive people at communities, churches, provincial council and youth groups were very high in demand. The great demand has indicated the impact of giving a face and sharing reality experience to this epidemic. Through this program positive people have been able to mobilize and to gather support from families, communities, church leaders, political leaders and the public in general. Moreover an increase in our beneficiaries' members and volunteers is an indication of the positive response & acceptance for people living with HIV in Fiji.

FJN+ initiated its annual Candlelight Vigil in 2006 and it has been conducted annually since then.

Knowledge and Behaviour Change

In this section, candidate sources of information for UNGASS 2010 reporting are assessed for their consistency with UNGASS guidelines and information that helps to identify possible knowledge and behavioural factors that may play a role in the transmission or prevention of the epidemic.

Data on the knowledge, attitudes and behaviour of different segments of the population in Fiji have been collected in population surveys (such as SGS 2004-2005 (2006) and SGS 2008 and in program-specific (mainly qualitative) surveys such as PRHP's 2006 evaluations of its Fiji grants program and its Stepping Stones program in Fiji. However, for the most part, the survey data are not comparable across time. In the case of the two SGS surveys, the data reported are not exactly comparable as the questions on knowledge, attitudes and behaviour questions – and the associated indicators constructed from the respondents' answers - were not exactly the same. For example, the 'correct knowledge' indicator reported in the 2006 SGS Survey report was 'Percentage of respondents who can correctly identify consistent condom use, mutual monogamy between partners and abstaining from sex as methods to reduce risk of HIV transmission'. The 'correct knowledge' indicator reported in the 2008 SGS Survey Report was consistent with the current UNGASS 'correct knowledge' indicator and associated five 'correct knowledge' questions described below.

Some of the specific questions that make up the various knowledge, attitudes and behaviour questions are the same but data on the specific questions are not described in the 2006 SGS report and the data set is apparently still with the UNSW that conducted the study with WHO funding.

In short, it is not possible to track changes on the key UNGASS knowledge and behaviour indicators and not possible to extract some comparable data as Fiji MOH does not have access as yet to the SGS 2008 data set either (although the data are reported in more detail in the 2008 SGS report so it comparison would be possible if Fiji stakeholders had access to the raw data behind the SGS 2006 report.

SGS 2008 included UNGASS-consistent questions on the following UNGASS indicators on knowledge and behaviour of general populations and Most-At-Risk-Populations (MARPs):

- "Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission" (UNGASS indicator #13).

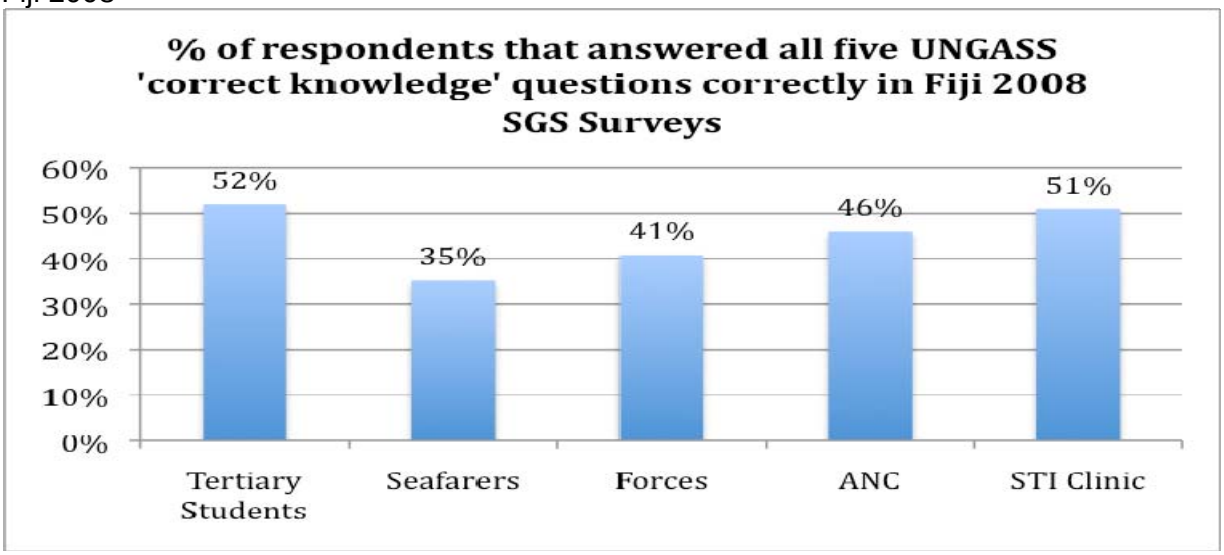
- Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS indicator #14)
- Percentage of young women and men aged 15–24 who have had sex before the age of 15 (UNGASS indicator #15)
- Percentage of adults aged 15–49 who have had sex with more than one partner in the last 12 months (UNGASS indicator #16)
- Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.

However, none of SGS 2008 data are fully consistent with UNGASS sampling strategies and/or population definitions. For example, the UNGASS guideline's definition of Most-At-Risk-Population' is "sex workers, injecting drug users and men who have sex with men" (UNAIDS 2009 p. 13) and not the Fiji SGS 2008 survey populations such as uniformed services, seafarers and STI clinic attendees.

SGS 2008 includes UNGASS-consistent questions relating to UNGASS indicator #13, but its sampling frame is youth at three Fijian tertiary institutions aged between 18-29 years (but the researchers analysed data for only 15-24 year olds for international comparability) and not a nationally representative sample of youth aged 15-24 years interviewed as a sub-sample of a national sample survey like the household Demographic Health Survey. The data are useful but their data collection is not consistent with recommended UNGASSS methodology. The SGS 2008 questions and sampling for MARPs falls outside the UNGASS definitional guideline for MARPs in the context of UNGASS indicator #14.

Cross-sectional comparison between different categories of respondent (youth at tertiary institutions, ANC attendees, seafarers, STI clinic attendees and military forces personnel) involved in the set of surveys in Fiji in 2008 is possible.

Graph 22: Correct Knowledge of HIV Prevention among Select Population Groups in Fiji 2008

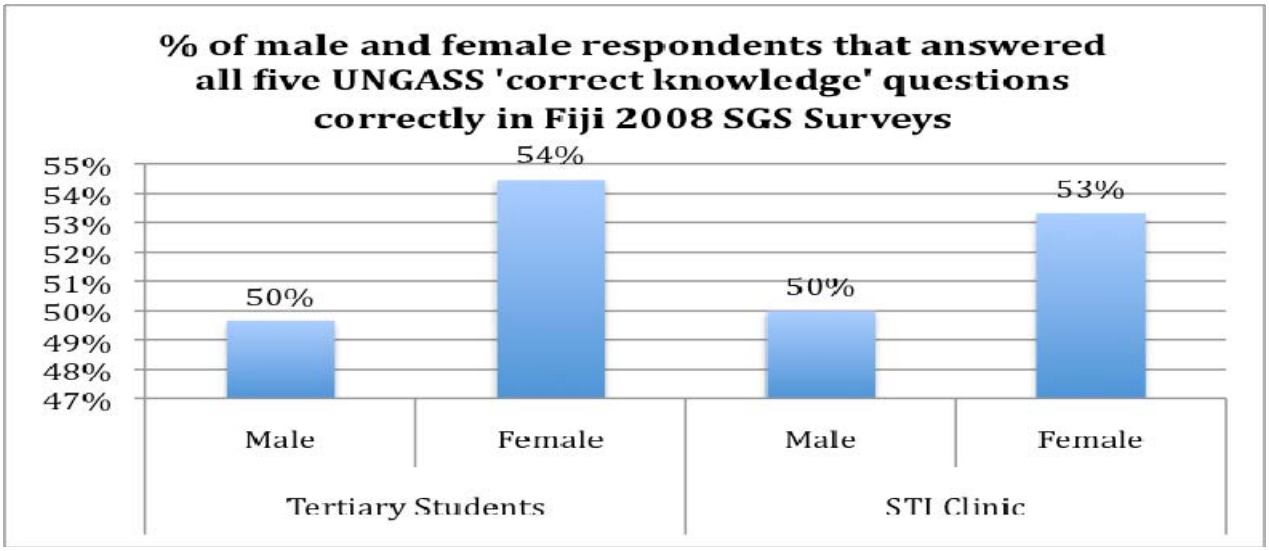


Source: Original graph based on SGS 2008 data

As shown in Graph 22, youth and STI Clinic attendees have similar levels of knowledge with just over half of respondents in those groups answering all five knowledge questions correctly. It appears that knowledge of HIV prevention is lowest among seafarers with only 35% of seafarer respondents answering all five knowledge questions correctly.

The levels of knowledge were similar among males and females in the tertiary youth and STI Clinic sub-populations but interestingly a slightly higher percentage of female respondents in both STI Clinic and tertiary youth groups answered all five knowledge questions correctly. All respondents among the seafarer and uniformed services groups were male. It appears that that gender may be a factor slightly affecting levels of knowledge.

Graph 23: 'Correct Knowledge of HIV Prevention among Youth and STI Clinic Attendee Respondents in 2008 SGS Survey Disaggregated by Sex



Source: Original graph based on re-analysis of data presented in Fiji SGS 2008

The level of knowledge of HIV transmission and prevention is lower than desirable among all surveyed groups. Levels of knowledge between males and females in mixed survey groups (tertiary students and STI Clinic attendees) were similar with the proportion of females with 'correct knowledge' was slightly higher than males in the tertiary student and STI Clinic groups. HIV education in Fiji needs to continue to focus on general population and Fiji's MARPs (including seafarers, the group with the lowest proportion of respondents with all five correct answers to basic HIV prevention and transmission questions).

UNGASS 2010 guidelines request that UNGASS indicator data are disaggregated by age as well and fortunately, SGS 2008 includes tables that present data disaggregated by age and sex. These tables are presented immediately below and retain the table style of the data source (Anonymous 2009). For seafarers and uniformed service respondents, knowledge of HIV prevention is similar across age groups 20-24 and 25-49. Teenage ANC attendees had a much lower level of knowledge of HIV prevention than 20-24 and 25-49 year olds (the latter two groups having broadly similar knowledge levels). However, in the case of STI clinic respondents, the 13 teen male and two teen female respondents all scored 100% on the five-question knowledge test in the survey. The overall sample sizes were too

small and clearly not designed to enable representative age-related sub-samples so any interpretation of age-related data should be cautious.

Table 9: Youth: Proportion of participants with correct knowledge of HIV prevention

	Male		Female	
	15-19 n=103	20-24 n=183	15-19 n=107	20-24 n=150
Having sex with only one, faithful uninfected partner can reduce the chance of getting HIV	79 (76.7%)	150 (82.0%)	86 (80.4%)	130 (86.7%)
Using condoms correctly can reduce the chance of getting HIV	84 (81.6%)	154 (84.2%)	86 (80.4%)	121 (80.7%)
A healthy looking person can be infected with HIV	87 (84.5%)	158 (86.3%)	93 (86.9%)	132 (88.0%)
A person can get HIV from mosquito bites?	63 (61.2%)	125 (68.3%)	82 (76.6%)	112 (74.7%)
A person can get HIV from sharing a meal with someone who is infected with HIV?	77 (74.8%)	155 (84.7%)	91 (85.0%)	130 (86.7%)
All answers correct:	43 (41.2%)	99 (54.1%)	59 (55.1%)	81 (54%)

Source: SGS 2008

Table 10: Seafarer: Proportion of participants with correct knowledge of HIV prevention

	20 – 24 n=44	25 – 49 n=212
Having sex with only one, faithful uninfected partner can reduce the chance of getting HIV	36 (81.8%)	167 (78.8%)
Using condoms correctly can reduce the chance of getting HIV	33 (75 %)	176 (83%)
A healthy looking person can be infected with HIV	33 (75%)	178 (84%)
A person can get HIV from mosquito bites?	23 (52.3%)	127 (59.9%)
A person can get HIV from sharing a meal with someone who is infected with HIV?	32 (72.7%)	163 (76.9%)
All answers correct:	15 (34.1%)	75 (35.4%)

Source: SGS 2008

Table 11: Forces: Proportion of participants with correct knowledge of HIV prevention

	20 – 24 n=25	25 – 49 n=237
Having sex with only one, faithful uninfected partner can reduce the chance of getting HIV	22 (88%)	197 (83.1%)

Using condoms correctly can reduce the chance of getting HIV	21 (84%)	183 (77.2%)
A healthy looking person can be infected with HIV	20 (80%)	196 (82.7%)
A person can get HIV from mosquito bites?	18 (72%)	148 (62.4%)
A person can get HIV from sharing a meal with someone who is infected with HIV?	23 (92%)	179 (75.5%)
All answers correct:	11 (44%)	96 (40.5%)

Source: SGS 2008

Table 12: ANC: Proportion of participants with correct knowledge of HIV prevention

	15 – 19 (15)	20-24 (138)	25 – 49 (264)
Having sex with only one, faithful uninfected partner can reduce the chance of getting HIV	7 (46.7%)	107 (77.5%)	209 (79.2%)
Using condoms correctly can reduce the chance of getting HIV	9 (60%)	110 (79.7%)	207 (74.4%)
A healthy looking person can be infected with HIV	11 (73.3%)	117 (84.8%)	221 (83.7%)
A person can get HIV from mosquito bites?	7 (46.7%)	102 (73.9%)	197 (74.6%)
A person can get HIV from sharing a meal with someone who is infected with HIV?	12 (80%)	101 (73.2%)	217 (82.2%)
All answers correct:	2 (13.3%)	62 (44.9%)	128 (48.5%)

Source: SGS 2008

Table 13: STI: Proportion of participants with correct knowledge of HIV prevention

	Male			**Female**		
	15-19 n=13	20-24 n=41	25-49 n=52	15-19 n=2	20-24 n=25	25-49 n=18
Having sex with only one, faithful uninfected partner can reduce the chance of getting HIV	13 (100%)	38 (92.7%)	45 (86.5%)	2 (100%)	19 (76%)	16 (88.9%)
Using condoms correctly can reduce the chance of getting HIV	12 (92.3%)	40 (97.6%)	44 (84.6%)	2 (100%)	22 (88%)	16 (88.9%)
A healthy looking person can be infected with HIV	12 (92.3%)	39 (95.1%)	44 (84.6%)	2 (100%)	21 (84%)	16 (88.9%)
A person can get HIV from mosquito bites?	10 (76.9%)	29 (70.7%)	31 (59.6%)	2 (100%)	21 (84%)	12 (66.7%)

A person can get HIV from sharing a meal with someone who is infected with HIV?	13 (100%)	34 (82.9%)	43 (82.7%)	2 (100%)	22 (80%)	16 (77.8%)
All answers correct:	7 (53.9%)	22 (53.7%)	24 (46.2%)	2 (100%)	13 (52%)	9 (50%)

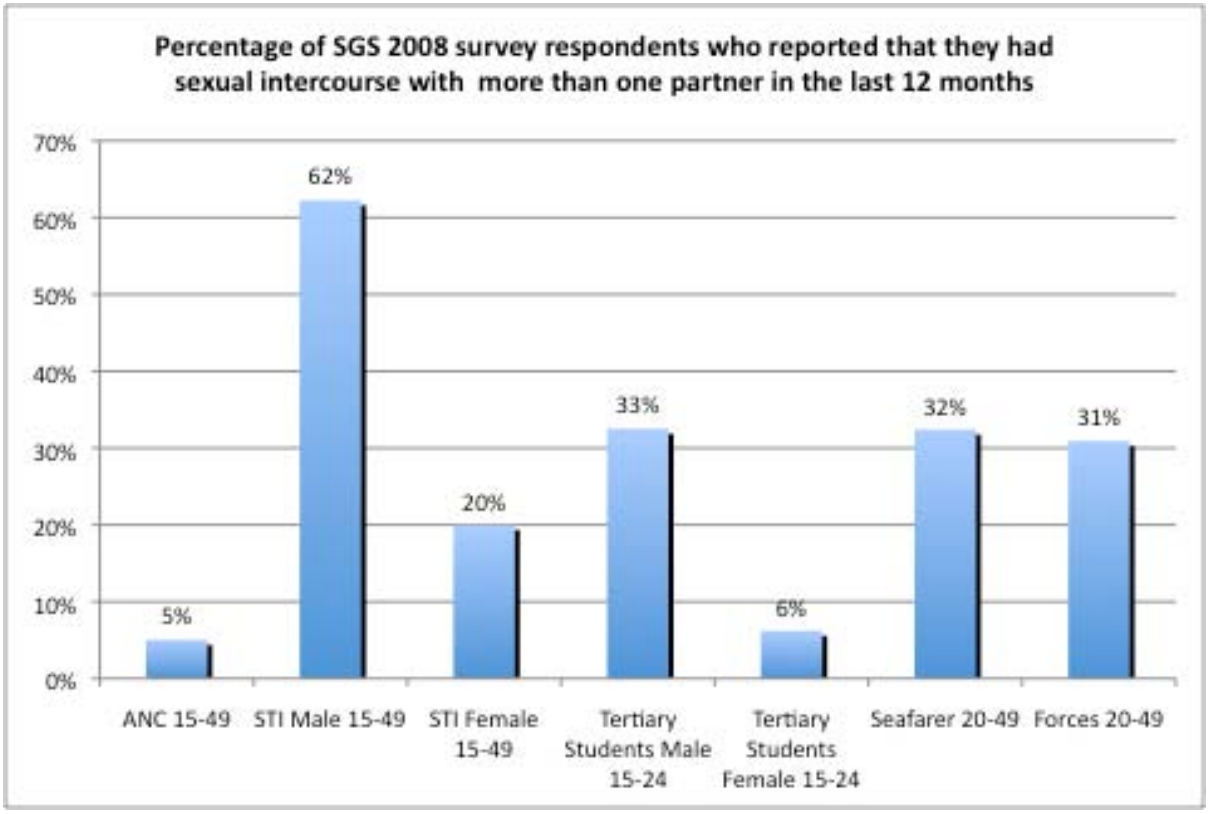
Source: SGS 2008

Source: SGS 2008

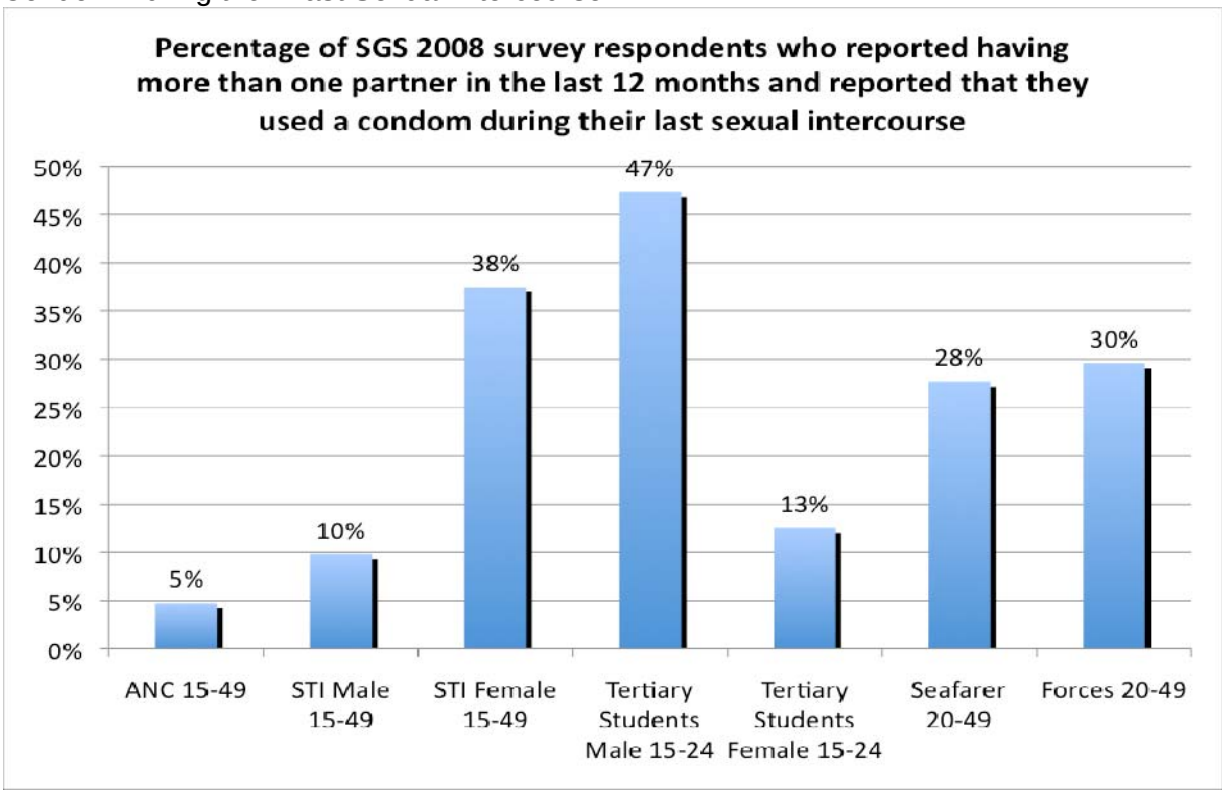
The SGS 2008 includes other questions - but not sampling strategy - that are consistent with UNGASS 2010 indicators. For example, the SGS has questions that are consistent with the questions for UNGASS indicators 16 and 17 but these indicators require national household surveys with representative samples of people 15-49 years old. The closest that SGS 2008 comes to general population sampling is a systematic sample of tertiary students at three Fiji educational institutions and these students were aged between 18 and 29. The SGS 2006 and 2008 conducted in Fiji were designed to collect data on at-risk populations including youth. As shown in Graph 24 below, male STI Clinic attendees aged 15-25 had the highest reported level of first sex before the age of 15 years (14% or 7 out of 49 respondents in that age group). Interestingly, female STI Clinic attendees had the lowest reported level of sex before 15 years, followed by ANC attendees.

Among the surveyed populations in the SGS 2008, the proportion of STI clinic males who had more than one partner in the past 12 months was far higher than any other group (62%, that is, 61 of 98 interviewed). As shown in Graph 24, a higher proportion of males than females across all sampled populations in 2008 SGS had more than one partner in the past 12 months. Relatively low proportions of sampled females (ANC attendees, female tertiary students aged 15-24 and female STI Clinic attendees) had more than one sexual partner in the past 12 months: 5% (ANC Attendees), 6% female tertiary students and the much higher 20% among female STI clinic attendees. Across all male groups (male STI Clinic attendees and male tertiary students, seafarers, uniformed services), the proportions of respondents reporting more than one partner in the past 12 months was higher than in female samples. Among three of the four male samples (male tertiary students, seafarers and uniformed services, the proportions were similar, just over 30%. The proportion among male STI clinic attendees (62%) was almost double that of the other male groups.

Graph 24: % of Respondents in Each SGS 2008 Survey Who Reported Having Sexual Intercourse with More than One Partner in the Last 12 Months



Graph 25: % of Respondents in Each SGS 2008 Survey Who Reported Having Sexual Intercourse with More than One Partner in the Last 12 Months and Using a Condom During their Last Sexual Intercourse



Source: Original graph based on SGS 2008 data

As shown in the above graph, the reported condom usage at last sex among respondents reporting more than one sexual partner in the past 12 months was highest among male tertiary students (47%) and female STI Clinic Attendees (38%) and lowest among (female) ANC attendees (5%) and, most worryingly, among male STI Clinic attendees (10%) and among female tertiary students (13%). The mean number of sexual partners in the past 12 months was highest among male tertiary students (3.8) followed by male STI Clinic attendees (3.6), followed by seafarers (3), uniformed services (2.7), female STI clinic attendees (1.8), female tertiary students (1.5) and ANC attendees (1.1).

SGS 2008 survey found an association between chlamydia infection among surveyed ANC attendees and risk factors including the number of (a) lifetime partners and of (b) past-year partners of the ANC attendees. Although the sample size (especially for ANC attendees with two or more partners in past 12 months – there were only four sampled ANC attendees in this category) is too small for confident extrapolation to ANC attendees generally, only 12 of the 87 female ANC attendees reporting one lifetime partner (13.8%) tested positive for chlamydia compared to 38.2% (26 of 68) of female ANC attendees reporting two or more lifetime partners. Chlamydia prevalence among ANC attendees reporting one partner in the past 12 months was 21.6% (29 of 134 tested) compared to 75% (three of four tested) among attendees with two or more partners in past 12 months.

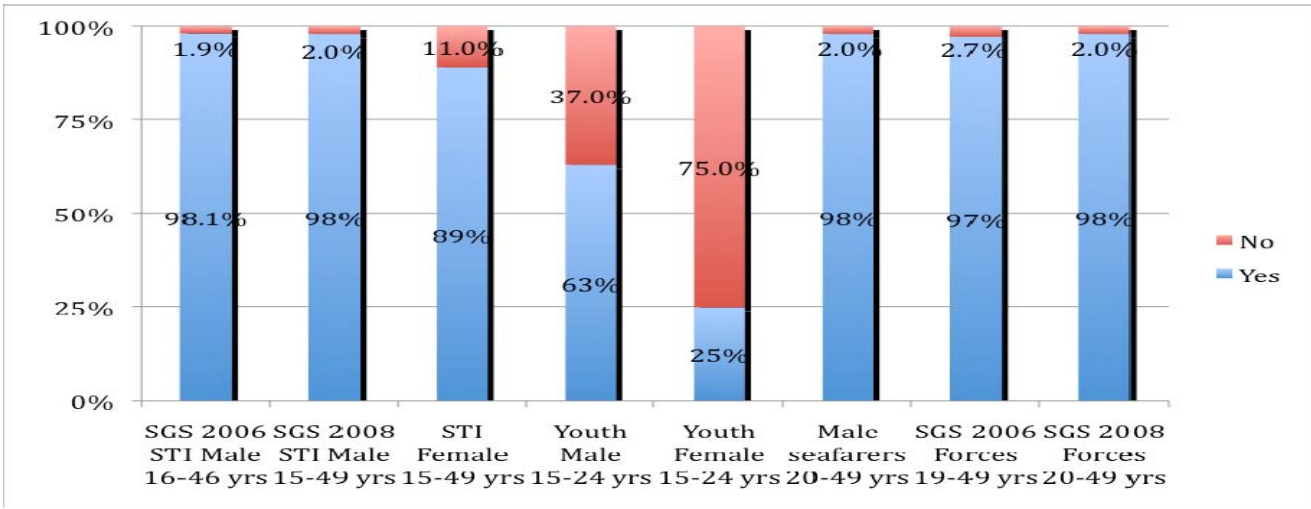
Table 14: Prevalence of Chlamydia by selected demographic and risk factors for 166 antenatal women from Lautoka (SGS 2008 p.80)

	N tested	N positive	%
Age group			
< 25 years	48	18	37.5
≥25 years	118	24	20.3
Currently married			
Yes	124	24	19.4
No	42	18	42.9
Education			
Primary school	13	1	7.7
Secondary school	110	32	29.1
Higher	43	9	20.9
Current living area			
City	63	16	25.4
Urban village	62	17	27.4
Rural village	40	9	22.5
Age at first sex			
< 18 years	22	9	40.9
≥18 years	140	32	22.9
Number of partners in life			
1	87	12	13.8
≥2	68	26	38.2
Number of partners in last 12 months			
1	134	29	21.6
≥2	4	3	75

Concurrent partners in last 12 months			
Yes	161	39	24.2
No	2	2	100
Ever used a condom			
Yes	102	27	26.5
No	77	17	22.1

According to data from SGS surveys 2004-2005 and 2008, condom use at first sex was high across all surveyed groups except for 2008 female tertiary students (only 25%) and 2008 male tertiary students (only 67%). STI Clinic females (2008) reported higher condom use at first sex (89%). Over 97% of respondents all other groups in the two SGS surveys in Fiji - all male incidentally - reported using a condom at first sex.

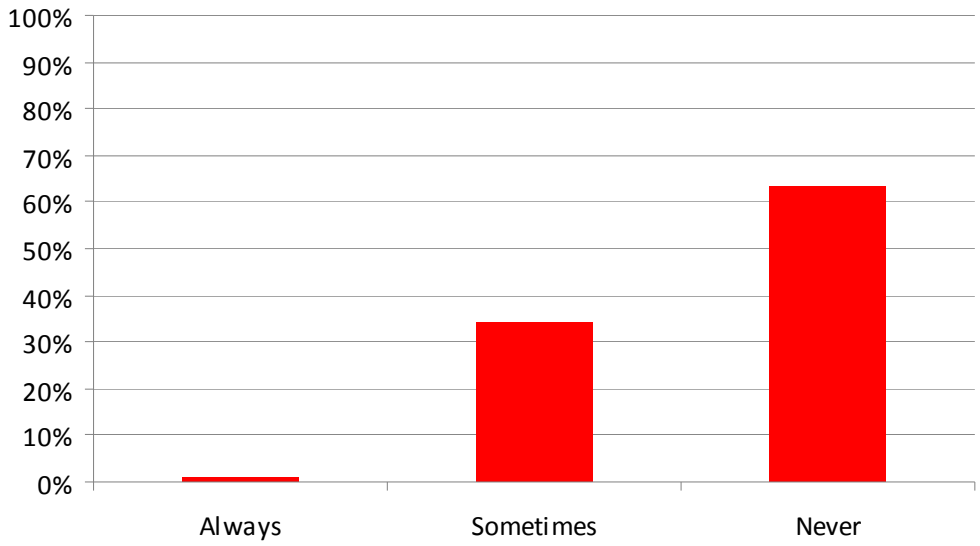
Graph 26: Data from SGS 2004-2005 and SGS 2008 on 'condom use at first sex'



Source: Original graph based on SGS 2008 data

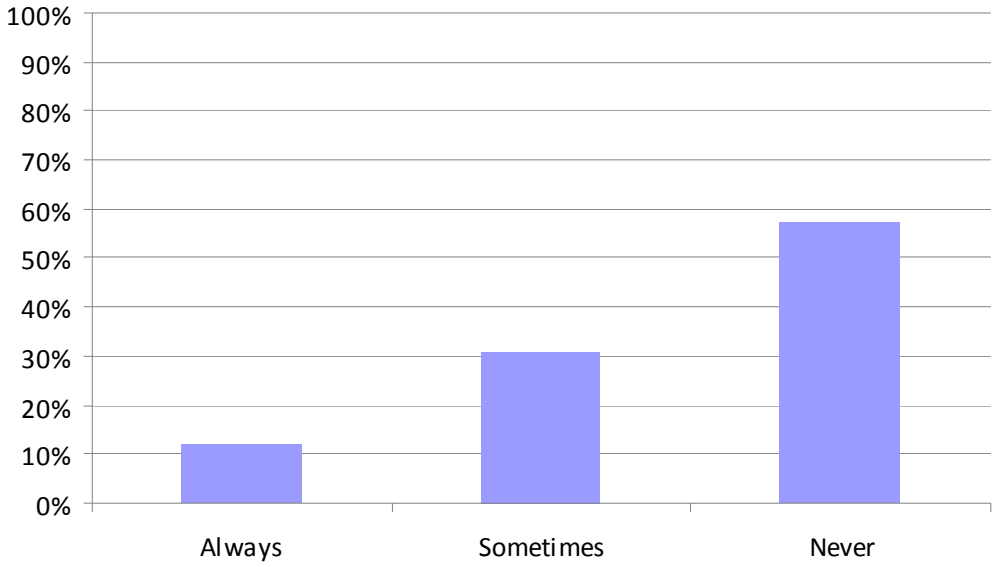
However, 'condom use at first sex' is clearly not a good indicator of continuing consistent condom use for people engaging in 'higher-risk sex'. Comparatively high proportions of each group surveyed in SGS 2008 on the question of frequency of condom use – over half of each group - reported 'never using condoms' in past 12 months. The SGS 2008 report includes data on frequency of condom use in past 12 months from ANC attendees, seafarers and uniformed service respondents and the relevant charts are reproduced below. The source for green-bordered graphs below is the SGS 2008 draft report.

Graph 27**: ANC Attendees:** Condom use during the last 12 months for all participants



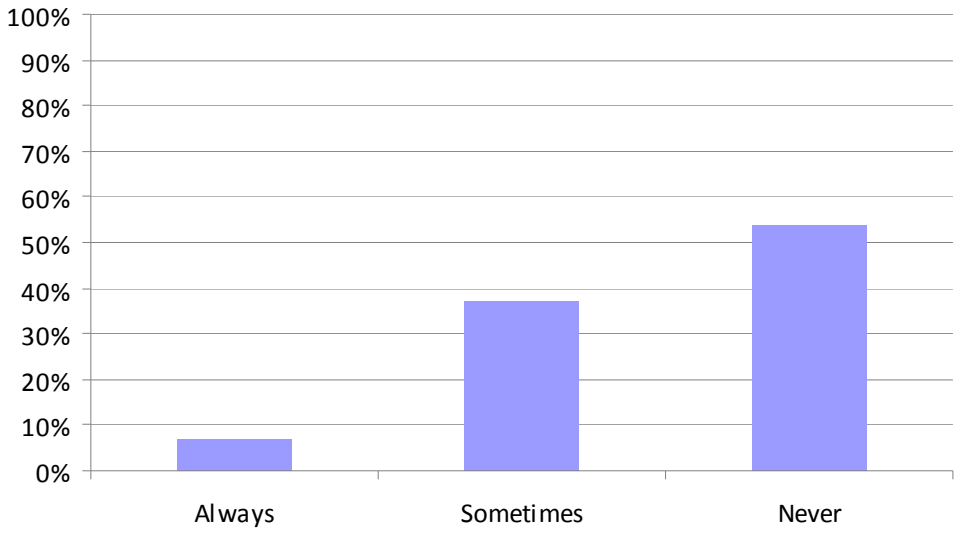
Source: SGS 2008

Graph 28: **Seafarer:** Condom use during the last 12 months with female partners



Source: SGS 2008

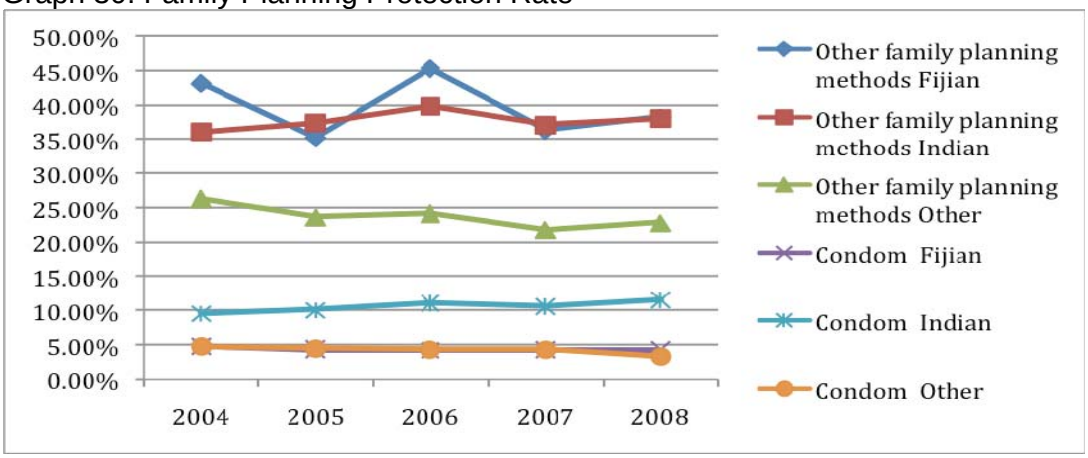
Graph 29: Forces**:** Condom use during the last 12 months with female partners



Source: SGS 2008

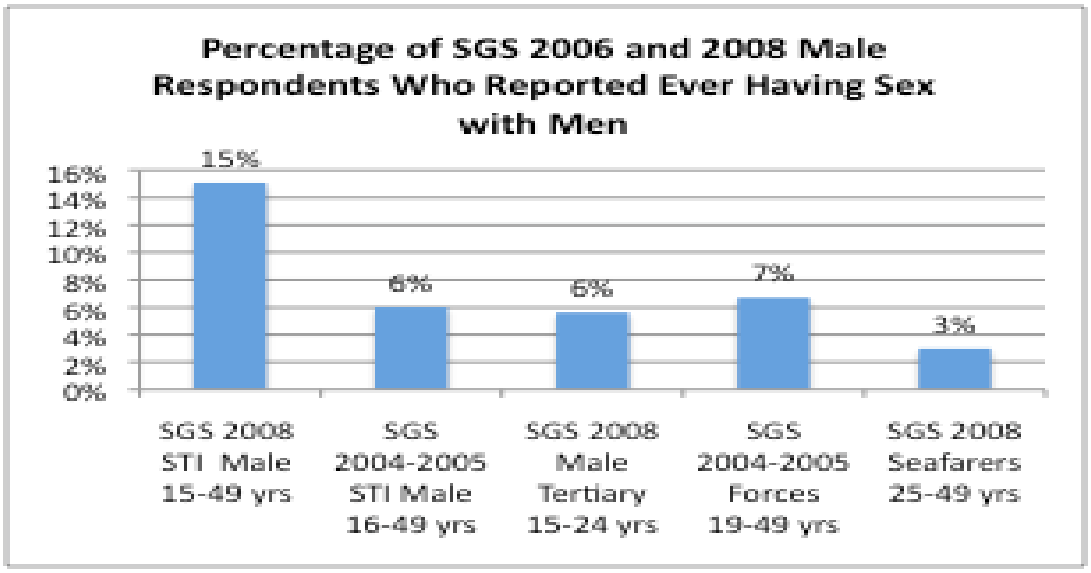
SGS data on low condom use is reinforced by MOH data on prevalence of family planning methods in Fiji. According to MOH data (2004-2008), condoms are used as a family planning method among a small proportion of Indo-Fijian couples (10%) and a smaller proportion of Fijian couples and 'other couples (5% of both groups). The relatively high proportion of unplanned pregnancies among ANC attendees noted in the SGS 2008 report (43.8%) is attributable to incorrect or no usage of family planning methods rather than of condoms alone.

Graph 30: Family Planning Protection Rate



Source: MOH (2010), Health Information Unit.

Graph 31: % of SGS 2004-2005 (2006) and SGS 2008 Male Respondents who Reported Ever Having Sex with Men



Source: Original graph based on SGS 2008 data

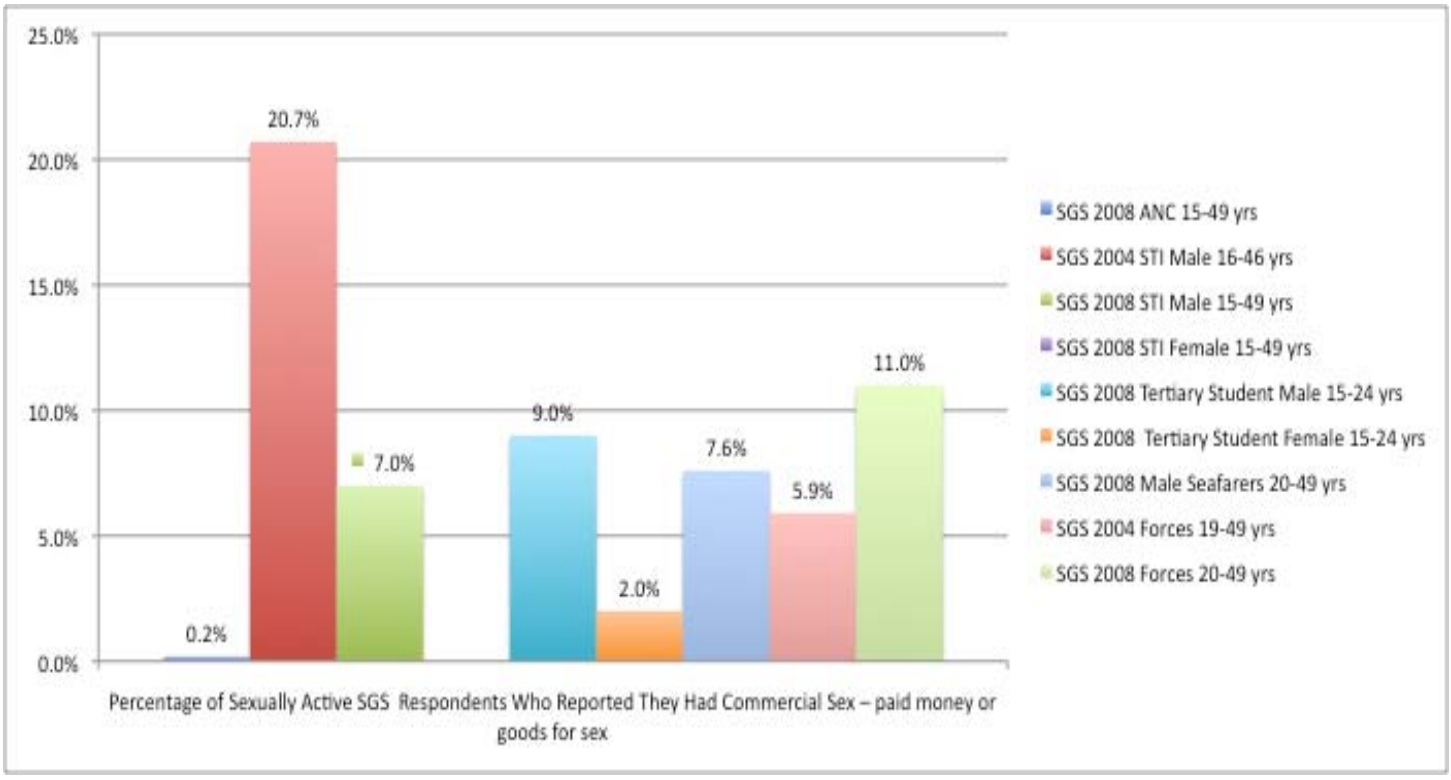
A proportion of sampled male STI Clinic attendees who reported ever having had sex with a man increased from 6% in SGS 2004-2005 (2006) to 15% in SGS 2008 . Otherwise the proportion of male respondents in the SGS 2006 and 2008 surveys is similar (around 6%-7%). MSM data for uniformed services in SGS 2008 were not reported in the main sections. The discussion section of SGS 2008 noted that:

> The answers to the questions about men having sex with men were generally not very consistent, but overall there is a range between 3% (seafarers) and 15% (STI clinic clients) who said that they had ever had sex with another man. The high prevalence for the STI survey is most likely due to the population group using the service, but in discussions with MOH staff the rather low numbers in the other surveys was doubted to be accurate.

Of the 15% (16) male STI Clinic respondents who said that they had ever had sex with a man, nine (56% of the 16) reported having anal sex in the past 12 months. Of these nine respondents, five said that they had ever used a condom during anal sex and one said they he had used a condom the last time he had sex. Of the six percent (10) of male tertiary students who said that they had ever had sex with a man, four said that they had sex within the past 12 months and three said they had used a condom the last time they had anal sex.

The SGS 2008 included questions on whether respondents had paid or received money, kind or favours for sex (“commercial sex”).

Graph 32: Proportion of Surveyed Groups Paying for Sex



Source: Original graph based on SGS 2008 data

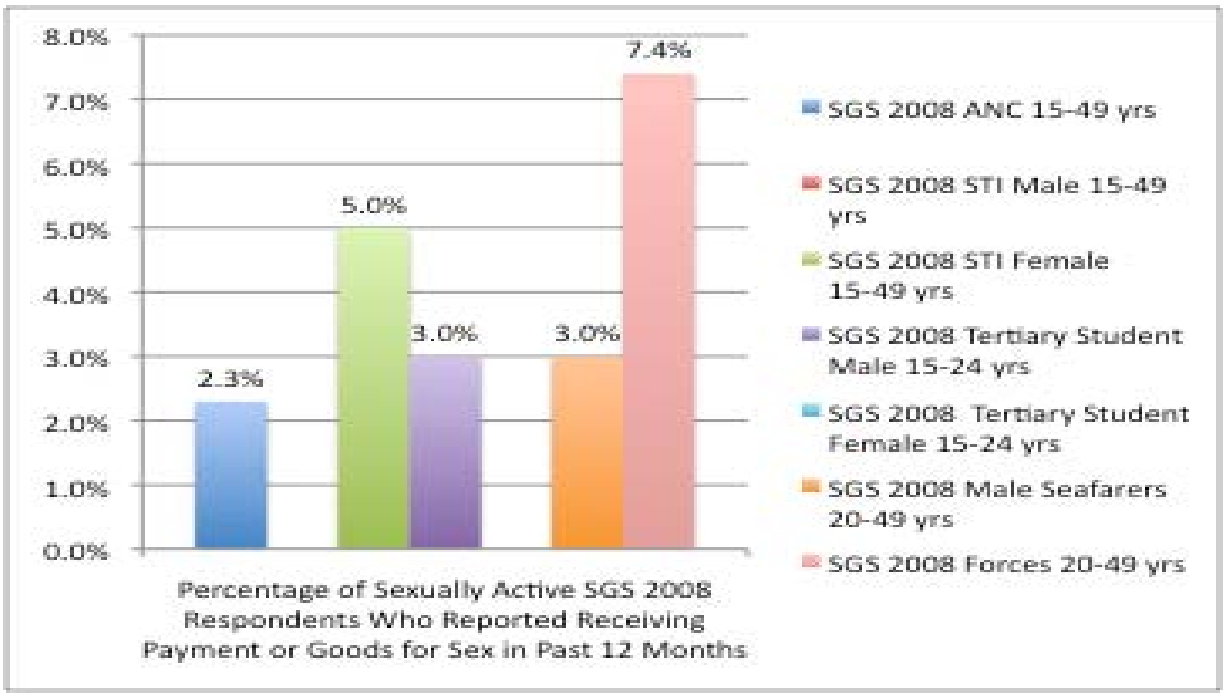
The SGS 2008 report noted that the answers for male STI Clinic respondents were too inconsistent to be meaningfully analysed (p.27):

> However when asked how many partners they had sex with when receiving money or goods, only men replied (5). No one had had given money or goods for sex in the last 12 months, but 7 men [7%] replied to the question about how many commercial partners they had in the last 12 months. Due to data inconsistency no further analysis was performed.

Nevertheless, across male groups in the SGS 2008 survey, the percentage of respondents reporting that they had commercial sex in the past 12 months was similar, ranging between 7% (male STI clinic attendees) and 11% (uniformed services) with male tertiary students at 9% and seafarers at 11%, The percentage of 2004 SGS STI Clinic respondents who reported commercial sex in 2004 was much higher (20%) than in 2008, whereas the percentage of uniformed service respondents reporting commercial sex in 2004 was lower (6%) than in 2008 (11%).
Small numbers of females in the SGS 2008 ANC sample (one or 0.2% of 417 sexually active respondents) and 2% (one of 61 sexually active female tertiary students) reported female use of commercial sex.

Only 61 (25%) of female tertiary students and 180 (63%) male tertiary students – all aged between 15 and 24 years - in the SGS 2008 survey reported ever having sex.

Graph 33: Proportion of Surveyed Groups Receiving Payment for Sex



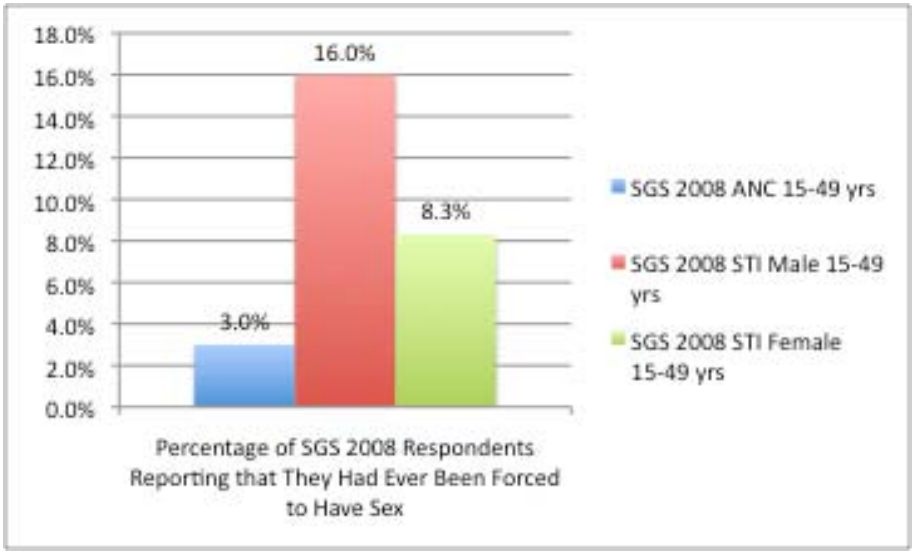
Source: Original graph based on SGS 2008 data

Small numbers of respondents in the SGS 2008 survey reported receiving money or goods for sex in the past 12 months. As sample sizes were small, very small numbers could look more sizable when expressed as percentages. For example, two of 40 female STI respondents (5%) who reported that they had ever had sex also reported that they had received money or goods for sex in the past 12 months. No male STI Clinic attends and no male tertiary students reported receiving money or good for sex, hence the absence of visible bars in the graph above for these groups. Eight (3%) of the sexually active seafarers reported receiving money or goods for sex. Nineteen (7.4%) of respondents in the uniformed services survey said they had received money or goods for sex, but here, as for the seafarers' commercial sex data, the report noted that the answers to the suite of commercial-sex questions was too inconsistent for further analysis (p. 64):

> No further analysis for commercial sex behaviour was performed, as the answers to the questions were too inconsistent. 35 individuals said they had either received or given money or goods for sex, but only 14 replied to the number of partners in the last 12 months and 26 replied to the questions about condom use.

SGS 2008 reports data on the question 'ever been forced to have sex' for only two of its five surveys. Twelve (3%) of ANC respondents and three of the female STI Clinic attendees (8.3%) and 15 (16%) of male STI Clinic attendees said that they had ever been forced to have sex. According to the report (p.26), "majority of men [male STI Clinic attendees] saying that their partners had forced them, and the women [female STI Clinic Attendees] naming neighbours and relatives"

Graph 34: Proportion of Surveyed Group Reporting Forced Sex



Source: Original graph based on SGS 2008 data

However, the available epidemiological information is not all doom and gloom, not all about vulnerabilities and risk behaviours. Some positive findings are evident among SGS 2008 groups that are closest to 'general-population' groups, ANC attendees and youth at tertiary institutions, including:

- Only 61 (25%) of female tertiary students and 180 (63%) male tertiary students – all aged between 15 and 24 years - in the SGS 2008 survey reported ever having sex.
- 98.7% (161 out of 163) of ANC attendees tested for chlamydia in SGS 2008 reported having concurrent partners in the past 12 months.
- Only 2% (eight of 417) ANC attendees interviewed in SGS 2008 reporting having overlapping partners in the past 12 months.
- 79.7% (134 out of 168) of ANC attendees for chlamydia reported having only one partner in the past 12 months.

Impact Alleviation

Although Fiji is a low prevalence country, some steps towards alleviating the socio-economic impact for infected and affected populations have been taken, especially through FJN+. As noted earlier in this document, FJN+ provides a half way home and four PLHIV have been reconciled with their families through the half way home program. FJN+ also assisted members to receive Social Welfare Housing Assistance (four members of the organization have received permanent housing assistance) Social Welfare Family Assistant Vouchers (13 members have received their monthly allowance) and ARV treatment (11 members are on ARV treatment) and mobilised 100 volunteers to strengthen support for PLHIV.

Of course all HIV prevention is *primary* 'impact alleviation' (that is, alleviating future socio-economic impact by preventing infections from occurring in the first place) exemplified by the prevention focus described earlier whereas the mitigation of socio-economic impact flowing from existing infections is second 'impact alleviation' that is exemplified by the FJN+ examples above.

No in-depth empirical study of the past, present or future impact of HIV on Fiji's society and economy has been conducted. One study (ADB Undated) modelled the economic effect on households in PNG and Fiji with special attention to the interaction between HIV and poverty. The study developed a HIV-impact model based on Asian and African studies and informed by Fijian household economic data. It applied the model to different HIV-prevalence scenarios in Fiji. Not all the assumptions of the model are applicable to Fiji and the study's discussion of the impact of HIV on PLWHA's use and access to formal credit is not applicable to the Fiji situation given the low utilisation of formal credit by non-poor and poor households in Fiji and other Pacific Island Countries.

Strategy, Policy, Leadership and Coordination

The NCPI Report (Government) describes the key achievements in 2008 and 2009 as follows (GoF 2010b p. 14):

> 1. Continuous budget line from the Government.
> 2. Presidential support to programme and legislation. There is increased support from the President, evidenced in his speaking publicly and favorably about HIV prevention efforts, especially condom uptake.
> 3. There is also evidence of increased effort to ensure the sustainability of the National response by creating HIV posts in various Ministries and Departments of Government.

It also notes 'remaining challenges':

> 1. Government line budget was decreased to FJD 300,000.
> 2. There is an inconsistency between Crimes decree and HIV decree for sex workers. Sex work is criminalised and also people who provide support for sex workers to be prosecuted.

NACA membership and functions in 2008-2009 period continues the profile described in Fiji's UNGASS 2008 report.

MOH's 2008 Annual Report recognised FHSIP's assistance in the development of the MOH HIV/AIDS workplace policy that has been awaiting endorsement by the MOH management. The policy will be presented to the National Health Executive Committee meeting at the end of March 2010.

NACA membership and functions in 2008-2009 period continues the profile described in Fiji's UNGASS 2008 report.

Fiji's Country Coordinating Mechanism (CCM) was established in 2008. Its latest progress report (CCM 2009b p. 1) gives the following useful details on Fiji CCM's origins and composition:

> Fiji CCM was established when Fiji pulled out from the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM) in 2008 after the Round 7 submission failed. Fiji formed its own CCM through a wider consultation with civil society organizations, the government, the development partners and UN Organizations. The first meeting convened on 15 May 2008 to discuss Submission for Round 8… Round 8 TB proposals were submitted and went through. TRP Clarifications followed until December 2009 where pre-signatory documents for Round 8 TB were finalized. The CCM also puts in a submission for Round 9. This time was for HIV and unfortunately Round 9 HIV was not successful but only the HSS component was approved.

To date, the Vice Chair of the CCM is the Acting Director of Public Health and National Advisor for Family Health. He is a member of the HSSWG since 2008. Whereas, the Chair is the Executive Director of AIDS Task Force Fiji, a civil society organization that has been active in strengthening the Health response to HIV since 1994. The CCM membership reflects a multi-sectoral approach. A number of Government Ministries are members and observers. These are Ministries of: Health, Women and Social Welfare, Fiji Military Forces, Labour, Youth, Education, Finance and National Planning. The Fiji CCM has 7 government members, 16 civil society organizations, 7 multi/ bilateral agencies and a total of 30 members. For the Civil society members, 11 NGOs, 2 Academic, 1 FBO and 2 CBO. For Government Membership distribution, Ministry of health, RFMF, Ministry of Education, Ministry of Labour, Ministry of Finance, Ministry of Youth and Ministry of Women & Social Welfare. For the Multilateral and Bilateral distribution, UNAIDS, UNICEF, UNFPA, UNDP, UNIFEM, WHO and EU. In terms of Fiji CCM Constituency representation, 29 organizations with 1 identified official members and 1 organization with 3 identified official members i.e. MOH. For alternate members, 17 organization with identified official alternates and 13 organizations with no identified official alternates. For the 17 organizations with identified official alternates, 8 organizations with 1 alternate, 8 organizations with 2 alternates and 1 organization with 3 alternates.

V. Best Practices

Possible 'best' or at least 'good' practices include the continued use of 'Stepping Stones' technique in Fiji, a good example of an approach that embodies adult-education, BCC and community-development principles to HIV/STI prevention. PC&SS's approach to VCCT counselling is another candidate. Also, the SGS surveys on which this report has relied so heavily is another candidate.

A Stepping Stones website (Anonymous Undated) gives the following background details on the Stepping Stones technique:

> Stepping Stones is a training package in gender, HIV, communication and relationship skills. It is also sometimes described as a life-skills training package, covering many aspects of our lives, including why we behave in the ways we do, how gender, generation and other issues influence this, and ways in which we can change our behaviour, if we want to. Stepping Stones was developed between 1993 and 1995, mainly in Uganda, working with a rural community, comprising Muslims, Protestants, Catholics and others, all living together in the same village. The package was designed in response to the vulnerability of most women, men and young people in decision-making regarding sexual behaviour, through men's gendered patriarchal domination of women and older people's generally repressive attitudes towards youth. Stepping Stones workshops are like a journey, or like a path of stones across a river. All the sessions use a participatory approach of non-formal learning through shared discussions and accompanying creative activities. All the exercises are based on participants' own experiences. Role play and drawing exercises enable everyone to take part: no literacy is needed, so everyone relies on their own experiences equally. Participants discuss their experiences, act them out, analyse them, explore and consider alternative outcomes, develop strategies for achieving them and then rehearse these together and reflect on them in a safe, supportive group. People feel safe because most sessions take place in groups of their own gender and age, with facilitators of the same gender and similar age. Participants also enjoy the sessions because there is a lot of fun and laughter as well as the more challenging work.

The partnership between PC&SS and MOH whereby the former is contracted to provide VCCT pre- and post- test counselling at the five hospitals in Fiji represents a good example of government-and-civil-society partnership and the model is worthy of more widespread use in the PICTs. In addition, and probably more importantly in terms of 'best-practice', the counselling program offered by PC&SS to pregnant

women and their partners extends the usual limited notion of the HIV testing in ANCs as being about prevention of mother to child transmission. The counselling also includes a risk assessment of the pregnant women (and sometimes partner) and advice on behaviour modification to prevent the risk of HIV/STI infection between themselves and others during pregnancy and afterwards. According to PC&SS records, 25% of pregnant women receiving such counselling reported that they are using condoms even during their pregnancy after such counselling.

FJN+ was assessed as a very good example of support organisation for positive people as a self-help run by positive people for positive people as well as incorporating an outreach function whereby positive people are also positively involved in mainstream prevention (including utilisation of Stepping Stones technique).

The two SGS surveys that combined structured interviews and blood/urine testing of key populations at risk of HIV and other STI infections in Fiji exemplifies 'best practice' and this 2010 UNGASS report has extensively used SGS data.

WHO (WHO 2010) describes SGS as follows and the SGS exercises well embodied the SGS principles:

> Second generation surveillance for HIV/AIDS is the regular, systematic collection, analysis and interpretation of information for use in tracking and describing changes in the HIV/AIDS epidemic over time. Second generation surveillance for HIV/AIDS also gathers information on risk behaviours, using them to warn of or explain changes in levels of infection. As such, second generation surveillance includes, in addition to HIV surveillance and AIDS case reporting, STI surveillance to monitor the spread of STI in populations at risk of HIV and behavioural surveillance to monitor trends in risk behaviours over time. These different components achieve greater or lesser significance depending of the surveillance needs of a country, determined by the level of the epidemic it is facing: low level, concentrated or generalized.

VI. Major Challenges and Remedial Actions

This section focuses on: (a) progress made on key challenges reported in the 2007 UNGASS Country Progress Report, if any; (b) challenges faced throughout the reporting period (2008-2009) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular; and, (c) concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets.

Follow-up on 2006-2007 Challenges

Table 15 below shows main challenges identified in the 2008 UNGASS report (albeit in the 'Best Practices' section) and follow-up action occurring in 2008-2009.

Table 15: Challenges and Remedial Action Identified in Fiji's UNGASS 2008 Report

No.	Challenge	Remedial Action
1	Professional counselling and testing is a major activity that should be supported and scaled-up to all major centres and health facilities in Fiji.	VCCT is now available at the three divisional hospitals
2	There is the need to make inroads to the MARP in	The pre-2008 period had seen greater "Inroads to MARP" in Fiji been made (e.g. through PRHP's

	our population so that intervention programmes could be implemented in terms of prevention measures, counselling for safer practices, and early treatment for any infections.	Competitive Grants projects) than acknowledged in Fiji's 2008 UNGASS report. Response Fund projects have not yet been catalogued for their target group focus. According to SPC financial data, 26.3% (16,647 USD) of the funds transferred from PRHP to SPC's Response Fund to manage in 2009 were spent by PC&SS's Sekoula sex worker project that combined HIV/STI prevention, early treatment for STI infection and improved SRH services for this vulnerable group. As noted earlier the part of Fiji's application to GFATM Round 9 that focussed on MARPs was not approved, among other reasons, **"**aiming to reach only 500 men who have sex with men and 400 female sex workers with BCC outreach appears grossly inadequate to have a significant impact in reducing HIV/AIDS transmission and maintaining low prevalence among 16,100 men who have sex with men and 2,900 female sex workers respectively" (TRP 2009 p. 3).
3	Political leadership needs to be stepped-up in terms of supportive legislation to set up the NACA (Council status) and this would provide a more participatory and representative membership to lead the national response to HIV in Fiji. Currently, much of the administrative work is carried out by the MOH secretariat and this is not ideal in terms of ownership by the wider community. It is still seen as too much vested in government bureaucracy and all its disadvantages.	Sections 6 and 16 of the draft HIV Decree (GoF 2010a) developed during 2009 and early 2010 are designed to remedy these problems by giving NACA ("HIV Council of Fiji" under section six of the decree) legal status with its own legislatively-mandated secretariat and staff. It is not clear how a national body could avoid be seen as 'vested in government bureaucracy" so the proposed secretariat may not remedy the 'bureaucratic' problem. As this decree has not been finalised, it is fair to say that the 2008 UNGASS statement (echoed in a GFATM Round 9 proposal below) still applies to the 2008-2009 period.
4	The NHASP 2007-11 needs to be fully costed at the start of each year to enable all stakeholders to draw up implementation plans for activities. This is not being effectively carried out and consequently much work has not been done in implementing the activities covered under the Plan.	Not addressed.
	More importantly is the need for a separate M&E unit to oversee the NHASP 2007-11 implementation and also data and information management. There are many indicators under this report that Fiji has not been able to collect because it	Not addressed. Incidentally, a national M&E Unit will not solve the M&E problems if there are not data (case, survey and narrative) to send 'up the line' to the M&E Unit.

	lacks the system and the resources to collect data and conduct evaluation. There needs to be institutional capacity building and health systems strengthening in M&E and research.	

2008-2009 Challenges and Suggested Remedial Actions

Many key challenges were identified in workshops held in 2008 and 2009 in Fiji and in the GFATM Round 9 proposal. The GFATM Round 9 proposal described four main challenges to which the proposal was designed to respond (CCM 2009a pp. 23-24):

> 1. Substantial lack of data on the epidemic's course and key affected populations due to: i) insufficient surveillance system, especially SGS; ii) no population estimation survey on MSM and SW; iii) no operational research on key issues such as the presence of high levels of Chlamydia among pregnant women or status of orphans and vulnerable children of PLHIV; iv) insufficient qualitative assessment of social and sexual networks of MSM and SW and a national baseline survey of their KAPB; iv) no M&E of outcomes of interventions among PLHIV and key affected populations [note: outcomes for FJN+, its members and other client groups were reported in PRHP 2006; the Sekoula sex worker projects was reviewed in August 2009 and outcomes described in evaluation report (PC&SS 2009)]; and v) inadequate funding, human resources and technical guidelines for collection, reporting, analysis, management and sharing of information. As a result, the epidemic's course is unknown, especially with MSM and SW because the collection of data among them is a big challenge. Surveillance data or other research are not appropriately disaggregated and do not reach the appropriate levels of reporting. The substantial lack of data hinders the systematic assessment of prevention response in terms of outcomes and impact. Fiji Health Information System is weak…
>
> 2. Limited coverage of prevention, treatment, care and support services for key affected populations mainly because of: i) lack of funding for prevention, treatment, care and support interventions; ii) lack of trained human resources and technical guidelines; ii) lack of data on prevalence and behavioral risks among key affected populations; iii) lack of client-friendly VCCT facilities; iii) stigma and discrimination; iv) minimal coordination mechanisms exist to form CoC; and v) behavioral data from SGS are not yet systematically used in the design, direction and evaluation of prevention activities…
>
> 3. Lack of enabling environment for an integrated National response as shown by the lack of HIV and AIDS specific legislation or a cohesive single national policy that will direct the formulation and implementation of national strategic plans, technical guidelines, and define the relationship between government and civil society. At present, much of the administrative work for NACA is being done by the MOH and there is no real ownership of the wider community yet. The NHSP 2007-2011 is not yet fully costed yearly and there is no separate M&E unit to oversee plan implementation and data management.
>
> 4. Inadequate representation of CSOs in policymaking bodies for HIV response which affect the design and implementation of national programmes because key affected populations, especially the MSM and SWs are not involved in the planning processes.

The Universal Access workshop held on 30 July 2009 identified the following obstacles that overlap with GFATM proposal's list (NACA 2009 p. 9):

A primary requirement to achieving the above targets by 2010 is based on overcoming obstacles that prevent people from accessing HIV prevention, treatment, care and support services. The participant identified the following obstacles impeding scaling up towards Universal Access:

1. The absence of laws and mechanisms to mitigate stigma, discrimination and gender inequality
2. Marginalised status of key population groups such as sex workers and men who have sex with men
3. Limited financial and human resources for the sustained availability and improved management and control of ART and other commodities
4. Weak civil society networks and limited participation of civil society organizations in communities
5. Weak monitoring systems and limited research particularly on vulnerable and high risk groups

The Post-ICAAP workshop identified the following prevention-related remedial actions (Dezaki 2009 pp. 2-3)[10]:

- BCC strategy to be integrated into all awareness activities in Fiji. M&E required to get the evidence need to inform future activities
- Upscale our efforts in addressing stigma and discrimination against those who infected and affected by the HIV and AIDS epidemic such as sex workers, MSMs and IDUs with the former two probably being most relevant to the context here in Fiji
- Situation Analysis to be conducted for scaling-up the programmes, projects and activities.
- Strengthen the programmes and programme management by introducing tools and knowledge acquired in the ICAAP with proper manners
- Introduce programmes for segmented or vulnerable groups. These need to be identified and not just based on groups identified overseas
- USP to explore the possibility of compiling and editing the Pacific papers and others relevant to the Pacific to be issues as a publication
- Members of CCM (which now included USP and FASANOC) explore the possibility of funding future activities to strengthen the partnerships between members of NACA, non NACA members and the wider community
- One of the gaps identified was the lack of business representatives attending ICAAP: To implement the work place programmes, a recommendation might be for NACA to explore opportunities to help the establishment of BAHA Fiji (Business coalition Against HIV and AIDS which is an initiative of the Fiji Australia Business Council /AusAID/UNAIDS APLF. Committee members include Wylie Clarke (also chair of the Fiji Red Cross) Caz Tebbutt (also President of Suva Rotary) and other luminaries of the business community). NACA can assist by working through the ILO Tripartite Forum (Government, Trade Unions and Employers). Surkafa Fakataufon from ILO was at ICAAP and can provide more information. UNAIDS APLF can be requested to help.

The Post-ICAAP workshop identified the following challenges – a few positives - relating to clinical management and continuum of care (Dezaki 2009 pp. 4-6):

- Supposed offer OIM, but not always available at Hubs, and OIM is not free- of-charge.

[10] The lists of challenges and/or remedial actions from the Post-ICAAP Workshop are exact quotes from the report but bullet points have been added.

- OMI =expensive at the pharmacies
- FJN+ fills some treatment gaps, but cannot do all.
- 6 NGOs currently support PLHIV.
- HIV/TB co-management happens form Tamavua Hospital
- PLHIV routinely tested for TB, but not the other way around
- Accessibility and affordability of drugs= large problem
- Accessibility issue for the poor at the rural levels.
- Expired drugs are often used
- Clinical management still in of public sector. Need civil society involvement
- Limited resources to complete broader clinical management (including testing)
- CD4 count and voluntary testing only happens at hubs
- Lack of resources to follow up the results
- System= unreliable
- Inconvenient
- Limited human resource (No clinician in Lautoka hub)
- Early ARV treatment should be available even if patient is in symptomatic stage - increases survival by 73%.
- Currently in rich countries, treatment is available when CD4<350 whereas in developing countries treatment is only offered once the CD4 falls below 200- this sort of discrimination should not be encouraged. There should be treatment available for all once their CD4 falls below 350 irrespective of the country they live in.
- Pregnant women not getting ARV for their own benefit in order to prevent transmission.
- There is a need to implement testing and care for all HIV infected infants.
- There is a need to improve the uptake of ARV by HIV infected pregnant women and children.
- All persons infected with TB should be tested for HIV.
- There is a need to help AIDS affected families in mitigating the effects of illness and health.

The Post-ICAAP workshop participants identified some remedial action to challenges in clinical management and continuum of care (Dezaki 2009 pp. 4-5):

- Improve ART management
- Ensure accessibility, availability and eliminate expired drugs
- Subsidise patients in providing OI drugs
- Partnership between credible NGOs and the Government in clinical management
- Skill HIV/TB co-management in other hub centres
- Training of doctors/ nurses on HIV clinical management and treatment
- PLHIV to be included at hub centres
- Monitoring and evaluation in clinical management

A number of remedial actions to challenges in the area of research and M&E were proposed by the Post-ICAAP workshop participants (Dezaki 2009):

- More research for segmented or vulnerable groups, social structures, systems, barriers and perceptions
- Conduct rapid assessment
- Work being undertaken in the local languages would be of great interest.
- Monitoring of existing projects and dissemination of information
- Better monitoring system
- Evaluate effective projects (disseminate information on success, failures and lessons learnt)

The report on sex work and HIV prevention in Fiji launched on March 23 2010 (McMillan, and Worth 2010 p. 23)makes a number of recommendations that are reproduced in full below:

> **Peer education**. Interventions based on peer education and condom distribution should be supported and scaled up. Outreach activities are particularly important because much of the sex work in Fiji involves transgender as well as female sex workers, the provision of water-based lubricants as well as condoms is essential. Fund the expansion of existing successful services into peri-urban areas such as the Suva-Nausori corridor.
>
> **Men**. The clients of sex workers need to become a focus of HIV prevention programs. In order for this to be effective more needs to be known about the beliefs and practices of men who buy sex in Fiji, with attention to the norms of masculine sexuality.
>
> **MSM**. The matter of sex between men needs to be acknowledged and destigmatized, Many men who buy sex with men also have sex with 'NO' men and may be married and identified as heterosexual. The HIV transmission risk and subsequent need for preventative interventions targeting men who have sex with men is likely to be disguised and obscured.
>
> **Condom Promotion**. Promote the public health benefits of condom use so that it is more acceptable among the general public. Currently condom use is strongly associated with sex work. Sex workers and their clients have non-commercial sexual relationships too and these regular partners are also associated with risk. Furthermore the clients of sex workers do not fall into any category more useful than that of "men". To effectively reach this group the wider community should be targeted.
>
> **Condom education in schools**. Young people are particularly vulnerable when they leave school. A good knowledge of HIV and HIV prevention is necessary before they leave school.
>
> **Support Groups**. Resource sex worker groups to promote cooperation rather than competition and to facilitate advocacy and Inclusion in program and policy making.
>
> A better integration of sex worker community into the decision making process of NGOs and government policy making would underwrite the development of workable and effective programs. Support the expansion of existing successful organisations into peri- urban and expanding settlement areas around Suva.
>
> **Workshops**. Fund civil society and community organizations with existing links to, and involvement with, sex workers to run intensive HIV prevention education and workshops (especially peer education) for sex workers around the country. Continue training and awareness programs aimed at service providers and the police.
>
> **Law**. Gendered economic inequalities, especially those that are entrenched in law, for example preventing women from inheriting land, should be addressed, as these seriously compromise women's' economic security. Economic insecurity is the key driver of sex work in Fiji. The recent Fiji crimes decree which came into effect in February 2010, which includes sex work, pimping, operating a brothel or other services which procure prostitution will deleteriously affect sex workers in terms of HIV and STI prevention, and will drive sex work underground. This decree which encourages the arrest and harassment of sex workers should be removed or relaxed and not tightened. A consideration of decriminalisation of sex work in Fiji may be unrealistic at this point in time. However, it is imperative to the effective prevention of HIV transmission that the reasons for the existence and inevitable persistence into the future, of sex work in Fiji is adequately acknowledged. Moreover, it is a keystone of HIV prevention that the sexual health needs of sex workers are attended to, and that sex workers are supported to be agents of safe sex and condom promotion. This cannot happen in an environment that includes 'crackdowns' on red light areas or other stigmatisation, harassment and Intimidation of sex workers.

Fiji's UNGASS 2010 reports on 7 of the 24 relevant UNGASS indicators based on research methods consistent with UNGASS guidelines and is able to report on progress towards UNGASS commitments on these indicators. In addition to the remedial-action suggestions above, perhaps the key remedial action at this stage of

the epidemic in Fiji is to improve the behavioural surveillance of the general population including youth (through conducting a national Demographic and Health Survey in 2011 or 2012) and to implement behavioural and biological surveillance of HIV and other STIs among candidate MARPs as there is little evidence available at present to ground the identification of MARPs in Fiji. Implementing a population-based survey (DHS) and MARP-focused behavioural/biological surveys will enable Fiji to have an evidence-based understanding of the Fiji-specific epidemiology of HIV to inform its national HIV response.

VII. Support from Fiji's Development Partners

As described earlier in this report, strong support given by development partners in earlier UNGASS reporting periods has continued through to the current period (2008-2009). NGO, bilateral and multilateral development partners are also grant recipients and project implementers so their main contribution to the national response including progress on UNGASS commitments is to implement and report well on their own projects and support calls for additional funding to improving the national response's M&E Framework and implementation.

VIII. Monitoring and Evaluation Environment

The M&E situation as described in Fiji's UNGASS 2008 report is still broadly applicable:

> An M&E framework for monitoring the NHSP 2007 to 2011 includes international Indicators which have been extracted from Universal Access, UNGASS and the MDGs. Data sources for collection and staff responsible for collection and Reporting have been identified however surveillance systems need to be strengthened to allow the planned collection of data. Challenges include human resource capacity (dedicated trained personnel at the various organizations that do data collection) and financial resources to ensure that the systems in place are functioning, or improved to ensure data is appropriately disaggregated, and reaches the appropriate levels for reporting. Collection of data from some most at risk populations eg. sex workers, MSM is a challenge. Capacity of NGOs that work with MARPs needs to be strengthened. Technical assistance provided by SPC, WHO, and UNAIDS is very much Appreciated and will continue to be required. Financial resources will be sought from development partners to implement the M&E implementation plan.

A number of M&E-related challenges and suggested remedial actions have been described above in the section on challenges and remedial action and in the NCPI reports of Government and Civil Society.

The M&E Framework of Fiji National HIV/AIDS Strategic Plan 2007-2011 envisaged that UNAIDS Country Response Information System (CRIS) when implemented would function as the national program database for reports on HIV activities and results (the latter through national indicators). However, CRIS has not yet been implemented in Fiji to date and no alternative national system of annual activity- or program- monitoring and reporting has been developed. As the Government NCPI Report noted, there is currently "No agreed operational plan and commitment for [HIV-related] M&E" (GoF 2010b p. 27) and the examples given in this NCPI report of utilisation of M&E data are all 'international', that is, used for reports to international bodies (e.g. on Universal Access to ARVs) or to support funding applications to international bodies (e.g. to support GFATM proposals).

There is no NACA annual report on the profile and progress of the national HIV response. Donor programs (like SPC's Response Fund) and implementing agencies (both government and non-government) report to their donors and stakeholders on

their own HIV and other activities, but there is no national synthesis of existing data or a national template to capture activity-level data on the national response for any time period. Activity-level data would include annual reporting on what HIV activities have been conducted by whom (implementing agency) with whom (target groups) and where (locations) and should be linked to costed annual national HIV work plans that are not yet established. Ideally, coverage data should be reported (estimated percentage of target population reached) but at this stage the introduction of coverage-reporting for project implementers is probably not feasible.

Some donor programs (e.g. PRHP) and implementing agencies (e.g. PC&SS) have had very good M&E systems but data from these sources have never been utilised for either UNGASS or national-level reporting to date. As noted earlier, the absence of an M&E Unit in NACA and the lack of a detailed M&E framework and implementation plan for the National Strategic Plan have been other obstacles. Any M&E Framework should include The national response M&E guidelines developed by the NSP project funded by the Response Fund (that commenced in 2009) include this kind of 'activity mapping', the kind exemplified in respect of the NAC and Competitive Grant Programs described earlier. The planned rollout of the Country Response Information System (CRIS) in Fiji is hoped to provide routine data and country specific indicators at divisional levels and will provide a database for national activity and outcome level data useful at national and global levels.

The NCPI (Government) identified the following as key M&E-related achievements since 2007:

1. Submission of UNGASS 2008 reporting
2. Health Sector Response Report 2009.
3. Implementation of National AIDS Spending Assessment.
4. National consultations towards universal access target setting
5. HIV estimation and projection workshop conducted in 2009
6. Training of staff for CRIS.

The NCPI (Government) identified the following as key M&E-related challenges since 2007:

1. Limited resources to undertake to undertake key M&E activities
2. Limited Human resources capacity to conduct regular M&E related activities
3. Lack of an effective M&E data collection system from the service delivery to the national level

Fiji has never conducted a Demographic Health Survey (DHS) or an extended DHS with a serological HIV test component. At present, the understanding of the profile of the epidemic in Fiji is based largely on case reports that do not provide a sound basis for making inferences about the prevalence and incidence of HIV among the different sub-populations that vary by locality, ethnicity, gender, age, sexual orientation, lifestyles etc. While an extended DHS is not warranted given the low prevalence context of Fiji, a 'normal' DHS, including HIV UNGASS-related questions and a statistically representative sub-sample of young people, should be funded and conducted every five years. Seven UNGASS indicators (7,10,12,13,15-17)

SGS behavioural and serological surveys of candidate MARPs such as sex workers, MSM, seafarers, uniformed services, prisoners, street children should be conducted to provide evidence to inform the identification of MARPs and to provide a better epidemiological profile of the HIV epidemic in Fiji. These surveys would provide data for five UNGASS indicators requiring 'behavioural surveys' (8,9,14,18,19). The M&E

Framework of Fiji HIV National Strategic Plan 2007-2011 incorporates the set of UNGASS indicators and so the implementation of Fiji's HIV M&E Framework requires regular DHS for general population indicators and behavioural surveys for MARPs.

References

ADB. Undated. "Poverty Implications of AIDS in the Pacific."

Anonymous. 2009. "Second Generation Surveillance Surveys of HIV, Other STIs And Risk Behaviours In Fiji (draft report on SGS Survey 2008)."

Anonymous. Undated. "Stepping Stones: Training package on gender, communication and HIV" [accessed on 19 March 2010, Undated]. Available at: http://www.steppingstonesfeedback.org/index.php/About/How_does_it_work/gb.

CCM. 2009a. "Fiji Proposal Submission GFATM Round 9 (4 August 2009)."

CCM. 2009b. "Progress Report - FIJI Country Coordinating Mechanism: Jan. – Dec. 2009."

Cliffe, S., Y. A. Wang, and E. Sullivan. 2006. "Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries." Manila.

Dezaki, K. 2009. "Post ICAAP Workshop Report."

FJN+. 2009. "FJN+ Annual Report 2009 (covering 2006-2008)."

GoF. 2010a. "Fiji Draft HIV Decree as at 10 February 2010."

GoF. 2010b. "NCPI Report: Government."

Health Protection Agency. 2010. "HIV and STIs" [accessed on 20 March, 2010]. Available at: http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1191942172118.

McMillan, K. and H. Worth. 2010. "Risky Business: Sex Work and HIV Prevention in Fiji."

MOHWSA&PA. 2009. "Annual Report 2008." Suva: Ministry of Health Women Social Welfare & Poverty Alleviation.

NACA. 2009. "National Consultations towards Universal Access Target Setting: Draft Report (21/12/09)."

PC&SS. 2009. "Review and evaluation: Pacific Counselling and Social Services - Sekoula Project."

PC&SS. 2010. "Contribution to the Health Sector in Fiji 2009."

PRHP. 2006. "Evaluation of Fiji NAC and Competitive Grants Programs."

PRHP. 2008a. "Grant Scheme Report 2007."

PRHP. 2008b. "Project Monitoring and Evaluation Report Number 4."

TRP. 2009. "GFATM Technical Review Panel form - Round 9 (assesing Fiji CCM's GFATM proposal)."

UNAIDS. 2009. "Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on the Construction of Core Indicators ".

WHO. 2004. "HIV/AIDS in Asia and the Pacific Region 2003."

WHO. 2010. "Second Generation Surveillance for HIV/AIDS" [accessed on 23 March, 2010]. Available at: http://www.who.int/hiv/topics/surveillance/2ndgen/en/.

Annex 1: NCPI Scores UNGASS 2006, 2008 and 2010 Reports

	Topic	2005		2007		2009	
		Actual score	Total score	Actual score	Total score	Actual score	Total score
Gov part	Strategy planning efforts in the HIV programmes	10	10	7	10	7	10
	The political support for the HIV programme	7	10	7	10	9	10
	Policy efforts in support of HIV prevention	10	10	4	10	6	10
	The implementation of HIV prevention programmes	9	10	7	10	7	10
	The implementation of HIV treatment, care and support programmes	10	10	9	10	8	10
	The efforts to meet the HIV-related needs of orphans and other vulnerable children	7	10	5	10	5	10
	The M&E efforts of the HIV programme	8	10	6	10	6	10
	To what extent are M&E data used in developing / revising the national AIDS strategy	No consistent question in 2005 and 2007 NSPI	No consistent question in 2005 and 2007 NSPI	3	5	2	5

	To what extent are M&E data used for resource allocation	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	1	5
	To what extent are M&E data used for programme improvement	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	2	5
	TOTAL	61	70	48	75	53	85
	%	87%		64%		62%	

	Topic	2005		2007		2009	
		Actual score	Total score	Actual score	Total score	Actual score	Total score
CSO part	The policies, laws and regulations in place to promote and protect human rights in relation to HIV	3	10	3	10	5	10
	The effort to enforce the existing policies, laws and regulations	2	10	2	10	6	10
	The efforts to increase civil society participation	2	10	0	10	7	10
	Civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)	No consistent question in 2005 and 2007 NSPI	No consistent question in 2005 and 2007 NSPI	2	5	4	5
	The services provided by civil society in areas of HIV prevention, treatment, care and support included in the national AIDS budget	No consistent question in 2005 and 2007 NSPI	No consistent question in 2005 and 2007 NSPI	2	5	4	5

	The services provided by civil society in areas of HIV prevention, treatment, care and support included in national AIDS reports	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	3	5
	Civil society included in the monitoring and evaluation (M&E) of the HIV response developing the national M&E plan	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	4	5
	Civil society included in the monitoring and evaluation (M&E) of the HIV response participating in the national M&E committee / working group responsible for coordination of M&E activities	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	0	5
	Civil society included in the monitoring and evaluation (M&E) of the HIV response M&E efforts at local level	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	1	5
	The civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	No consistent question in 2005, 2007 and 2009 NSPI	5	5

	Civil society able to access adequate financial support to implement its HIV activities	No consistent question in 2005 and 2007 NSPI	No consistent question in 2005 and 2007 NSPI	1	5	4	5
	Civil society able to access adequate technical support to implement its HIV activities	No consistent question in 2005 and 2007 NSPI	No consistent question in 2005 and 2007 NSPI	0	5	3	5
	The efforts in the implementation of HIV prevention programmes	4	10	2	10	5	10
	The efforts in the implementation of HIV treatment, care and support programmes	2	10	1	10	4	10
	TOTAL	13	50	13	70	55	95
	%	26%		19%		58%	