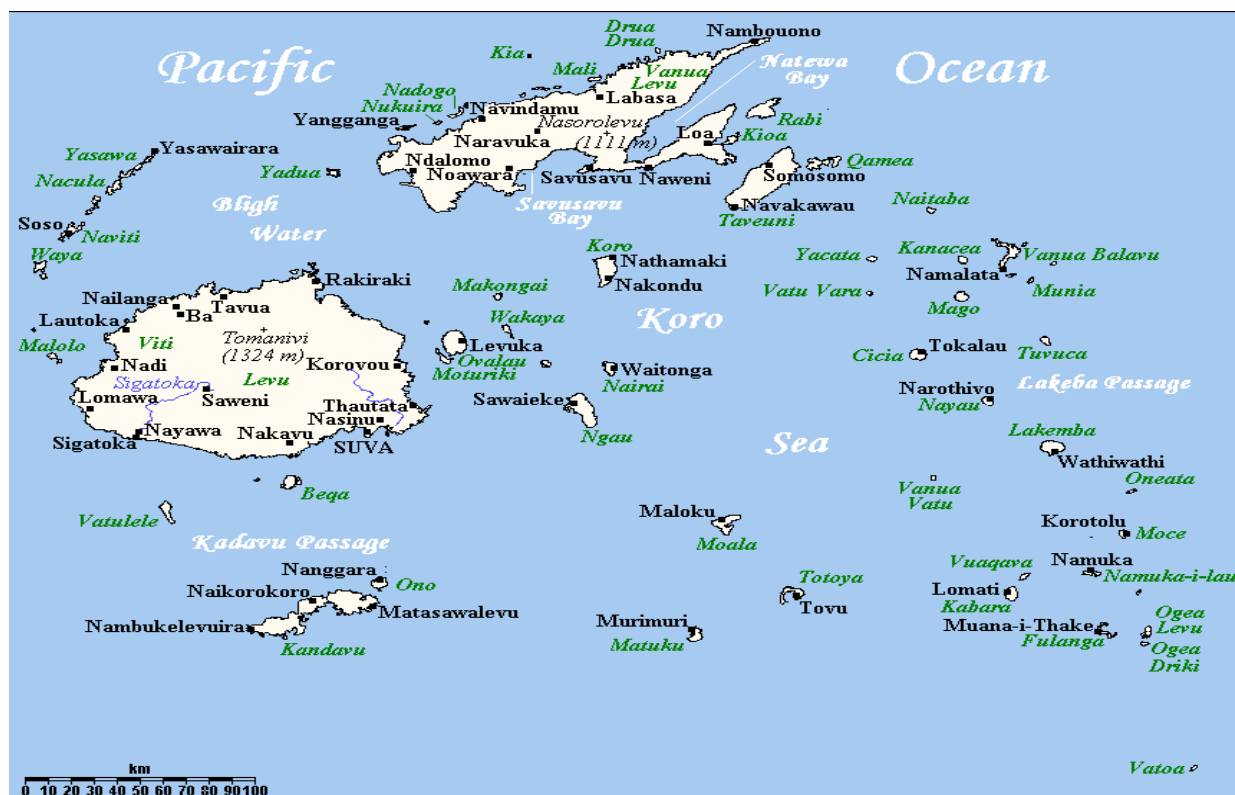


# Global AIDS Progress Report 2013

## FIJI ISLANDS



SUBMISSION DATE: 31<sup>ST</sup> MARCH 2014

## Table of Contents

1. Acronyms.....	2
2. Acknowledgements.....	4
3. Status at a Glance .....	5
4. Status of the Epidemic .....	6
5. The Policy and Programmatic Response .....	7
6. Fiji National Strategic Plan 2012-2015 .....	10
7. The HIV/AIDS [Amendment] Decree 2011 .....	13
8. Resources .....	13
9. Overview of the AIDS Epidemic .....	21
10. Fiji Geographical Lay-out.....	21
11. Fiji Economy .....	23
12. Fiji Education .....	24
13. <i>Organization of the Health System</i> .....	24
14. Fiji – Non Communicable Disease.....	27
15. HIV Salient Statistics.....	28
16. Fiji Spectrum Data:.....	34
17. Sexually Transmitted Infections:.....	36
18. Epidemiological Research:.....	37
19. NATIONAL STRATEGIC PLAN:.....	43
20. Fiji's National Response to the AIDS epidemic: .....	49
21. Prevention: Specific Sub-populations with Higher Risk of HIV Exposure:.....	51
22. Best practices.....	57
The HIV/AIDS [Amendment] Decree 2011 .....	57
PPTCT Program.....	58
23. Major Challenges and Gaps:.....	59
24. Support from the Country's' Development Partners.....	60
25. MONITORING and Evaluation Environment:.....	60
26. General Remarks:.....	61
27. REFERENCES.....	62

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AZT	Zidovudine
BAHA	Business Collation on HIV & AIDS
CEO	Chief Executive Officer
CoC	Continuum of Care
CSO	Civil Society Organization
EP	Empower Pacific
FCCDC	Fiji Communicable Control Disease Centre
FHSSP	Fiji Health Sector Support Program
FJN+	Fiji Network for Positive People
FNU	Fiji National University
GARPR	Global AIDS Response Progress Report
HIV	Human Immune Deficiency Syndrome
IBBS	Integrated Biological & Behavioral Surveillance
IDU	Injecting Drug Users
IPPF	International Planned Parenthood Federation
KAP	Key Affected Population
MDG	Millenium Development Goals
MOH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NCD	Non Communicable Disease

NCPI	National Commitments and Policy Instrument
NGO	Non-Government Organization
NHSP	National Health Strategic Plan
NSP	National Strategic Plan
NRL	National Reference Laboratory
OI	Opportunity Infection
PICT	Provider Initiated Counseling & Testing
PLHIV	People Living with HIV
POC	Point of Care
PPTCT	Prevention of Parent to Child Transmission
RFHAF	Reproductive and Family Health Association of Fiji
RH	Reproductive Health
SAN	Sex Workers Advocacy Network
SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted Infection
SW	Sex Workers
TB	Tuberculosis
ToR	Terms of Reference
VCCT	Voluntary Counseling & Confidential Testing
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## Acknowledgements

The Ministry of Health would like to thank all who have contributed in the compilation of the National Narrative Report for Fiji 2013 under the GARPR reporting and the online reporting.

Especially those who have contributed to the consultation meetings, national stakeholder meetings and a special thank you to all the HIV core teams in the Divisions, and the clinicians who have taken out time to report on data for HIV in contribution towards the GARPR 2013.

A big Vinaka Vaka Levu to you all.

## Status at a Glance

### Inclusiveness of Stakeholders in the Writing Process

In the 1<sup>st</sup> two quarters of 2013, a consultant was recruited to review Fiji's progress towards the 2011 UN General Assembly Political Declaration of the "10 Targets." Following this review with the support of the core team coordinated from the Health Ministry, a consultative workshop was conducted to review and validate the country's data and progress response. The international donor agencies, government partners & CSO's were part of this consultative review. Gaps were identified and recommendations were discussed for improvement.

In the last quarter of 2013, a GARPR training coordinated and facilitated by UNAIDS & UNICEF was held in Nadi where three [3] candidates from Fiji were nominated to be part of this training and also become the focal points for the GARPR for the country. There were two focal points from the government agency and one representing the NGO's. Following this meeting, a plan was put in place for the GARPR reporting process including data collation for the report. The processes for the development of the country's report included the following;

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

On the last week of January [28<sup>th</sup>-30<sup>th</sup>], a consultative meeting was held to update all HIV implementers in the country on the progress updates of HIV implemented activities, identify gaps for improvement and develop a plan for the way forward on the country's response to HIV & AIDS.

The consultative meeting included an orientation on the GARPR process which was facilitated by UNAIDS and the process and preparation needed for the development of the country's report. The participants during this consultative and planning meeting included partners from the government agencies which included the Health Ministry, Education, Youth and Sports, Labour Ministry and the Ministry of Women, Social Welfare and Poverty Alleviation. Civil Society organizations and the international and regional donor agencies were a part of the meeting.

The core team at National Level was able to compile the report based on the reviews and updates of implemented activities from government and CSO partners who were engaged

in the HIV response, the mid-term review report of the country's response of the "Ten Targets" in the Fiji Islands and also HIV & AIDS data collated from the Health Ministry.

On March 24<sup>th</sup>, 2014 – the CSOs had met to discuss their feedbacks as required on the NCPI. This discussion was coordinated by the MoH and facilitated by FJN+. Feedbacks on the NCPI following the discussion were collated and sent to all CSOs for their comments and validation before the final response was entered into the NCPI.

### Status of the Epidemic

Fiji is classified as a low prevalent country for HIV. As estimated by UNAIDS and WHO, the number of people estimated to be living with HIV in 2012 is about 1000, and the prevalence rate for 15-49 years old is at approximately 0.2%.<sup>1</sup> Although there has been no epidemiological HIV sero-surveys conducted for the general population, the number of thousands of HIV tests undertaken annually supports the above mentioned prevalence. [Ref. Table 1].

From the first HIV confirmed case in 1989 to the end of 2013, a cumulative total of 546 confirmed HIV cases<sup>2</sup> were reported in the country through the data collation from the Reproductive Health Centers, all VCCT sites and the data analysis was undertaken by the Centre for Communicable Disease at Mataika House and the Family Health Unit under the Ministry of Health. The data was validating with all the treatment and care centers around Fiji. To date it is unclear how many HIV confirmed cases are still living and how many had succumbed due to AIDS related illness. As reported from the 3 Reproductive Health Centers within the country, 243 HIV confirmed cases are regularly followed up in the Hub Centers around Fiji with 14 pediatric cases in the three Divisional Hospitals thus a total of 277 patient who are currently enrolled for care in Fiji at the respective health facilities.

During the first 10 years of the HIV epidemic in Fiji, the number of HIV confirmed cases detected annually were a few to count. Slow but steady increase of 1-2 new HIV confirmed cases per year. This slow increase had changed from the year 2000 to date. In 2000-2008, there was an average increase of 30 new HIV infections and had increased one third higher as compared to the first 6 years of the epidemic. In 2012 and 2013, total number of new HIV infections was 62 and 64 respectively. Despite the global reduction in the number of new cases for HIV, the picture of Fiji is slightly different.

Unlike the global picture where the main mode of transmission is seen to be amongst the MSM, SW and IDU's the same cannot be said about the Pacific and Fiji. The main mode of

---

<sup>1</sup> UNAIDS & WHO Epidemiological Estimates, Fiji 2012: accessed online on 13<sup>th</sup> March, 2014 at <http://www.unaids.org/en/dataanalysis/knowyourepidemic/epidemiologypublications/>

<sup>2</sup> Fiji Ministry of Health, December 2013, Centre for Communicable Disease Control

transmission in Fiji is primarily heterosexual followed by perinatal, homosexual and bisexuals and one case of injectable drug use noted some years back. Young adults from the age of 20-29 years are predominantly affected. In the year of 2013 we saw an equal distribution of male and female [50%] who are infected as compared to previous years where majority of the cases detected were amongst the male populations.

HIV is also commonly seen amongst the ITaukei population of Fiji followed by Fijians of Indian Descent and then others.

Fiji has noted its increase in the number of cases over the last few years and has initiated a response which needs to be extraordinary as identified by the HIV/AIDS Board. We as a country need to be prepared at the Strategic level to ensure appropriate treatment and care for patient thus taking on huge steps in the year of 2013 in regards to policy and planning has been paramount.

### [The Policy and Programmatic Response](#)

In the period of 2012-2013, Fiji has developed a number of policies and standards to guide health care workers on the prevention, management, treatment, care and support for all people living with HIV or affected by it. Policies developed and endorsed by the HIV/AIDS Board, the National Health Executive Committee and the National Medicines and Therapeutics Committee. The policies and standards set by the country in 2013 are briefly highlighted below.

#### *HIV Care and Antiretroviral Therapy Guideline 2nd Edition:*

The strengthening of an expanded antiretroviral therapy (ART) program has been included in the strategic plan. Standard treatment guidelines are considered to be crucial for optimal care for PLHIV and moving towards treatment as prevention for Fiji has been an important step in the last few years of its response in country. The guidelines are designed to provide a technical basis for the sustainability of the HIV care/ART program in Fiji – appropriateness of drug regimens being recommended, clinical monitoring, and training of health care professionals. The guideline is considered as a Standard of Practice in regards to Treatment and Care for HIV in Fiji.

The HIV Treatment and Care Guidelines for Fiji was developed after the global release of the WHO Consolidated Guidelines 2013 in June last year. This was very timely for Fiji and Fiji was prepared to adopt the new WHO guidelines knowing that it would be a benefit for the country. The revised treatment guidelines factors in the change in the CD4 count level to 500, treatment of discordant couples and officially places option b+ as the option for all PPTCT patients though Fiji had adopted the use of Option B plus in May 2012. The only



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

With the consolidated guidelines was the introduction of the Opportunistic Infections to ensure that our health care workers were well versed with this and knew how to diagnose and treat patients with any OI's affecting positive people around Fiji.

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

Within the preventative strategy one of Fiji's strategies is to prevent the transmission of HIV from a positive parent to their child during pregnancy, labour, delivery or infant feeding and to ensure that the HIV negative baby remains negative. The Fiji PPTCT policy is a revision of the 2010 PPTCT policy.

The introduction of Option B plus for all positive pregnant women in country, and introducing breastfeeding for all positive mothers on this basis has been considered. The Option B plus has been adopted in the country as of May 2012 after the programmatic update was introduced in April 2012. As Fiji was in the process of revising its policy it came at an opportune time for the country to adopt this move which was scientifically proven by WHO. The only difference as mentioned above is the use of Zidovudine as first option for babies in place of Niverapine as it was noted that Fiji had a number of pediatric cases who had reacted to Niverapine and had deranged Liver Function Tests. Secondly as Fiji is funding its own ART it would be cost effective in this sense since we don't have to introduce patients on second line therapy when initiating patients on therapy.

### *HIV Testing & Counseling Policy*<sup>3</sup>

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

The policy targets all HIV counseling and testing services conducted within the private and public facilities, including but not limited to hospitals, health centers, clinic, laboratories and prisons. It also targets all laboratory facilities, health service clinic, training institutions and regional partners with a mandate in addressing HIV/AIDS in Fiji.

In-cooperated into this policy is the recent development of the new HIV Testing Algorithm of the three rapid tests which was also endorsed in 2013 by the Ministry of Health with the

---

<sup>3</sup> HIV Testing & Counseling Policy, Ministry of Health Fiji, 2013

support of our partners in UNICEF, WHO, UNAIDS, SPC, NRL and especially FCCDC (Fiji Center for Communicable Disease Control). Fiji has endorsed a new HIV Algorithm where by confirmation for HIV Tests will be happening at Sub-Divisional Level and at the Divisional Hospitals and FCCDC will be our quality assurance lab in Fiji.

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

#### *Fiji TB/HIV Collaborative Policy<sup>4</sup>*

In 2012, there were 218 patients registered on TB treatment by the National TB programme, 58% were tested for HIV infection and there were 2.3% TB/HIV co-infected cases in 2012 and 1.6% in 2013. To ensure that appropriate preventative, treatment and care services is provided for all TB/HIV patients, the policy was developed based on the following objectives:

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

The TB/HIV Collaborative Policy ensures that the two programs not just test and treat but also strengthens collaborative efforts towards preventative programs for the country. The collaboration in this regards will be seen from National level down to the Divisional and Sub-Divisional level where programs are implemented. It ensures the Three I's of TB and has an important tag of monitoring and evaluation to it.

#### *Standardization of HIV Reporting:*

It was paramount that Fiji urgently looked into this to ensure that our monitoring and evaluation component within the ministry of good. We needed to standardize report from the sites giving care for HIV which were at the Hub Centers (HIV/STI clinics), Obstetrics and pediatrics clinics around Fiji. With the above policies we have inco-operated reporting with a flow of data to respective officers and the health information unit in the Ministry to ensure security of data, and credibility of data to report against and strengthen the policy and planning component for the Ministry.

---

<sup>4</sup> Fiji TB/HIV Collaborative Policy, Ministry of Health, 2013

The process was supported by UNICEF, though we have developed the reporting templates they are currently being piloted by all sites after the endorsement of the HIV/AIDS Board. The finalized reporting template will be presented to the National Health Executive Committee for its endorsement. Thus now Fiji will be able to properly report appropriately against much of the indicators at the National level.

The above policies are aligned to the Millennium Development Goals (MDG) 6, the National Strategic Plan for HIV/STI 2012-2015 and the HIV/AIDS [Amendment] Decree 2011. These were important steps that the country needed to take to ensure that we were prepared from a strategic level to operational level to ensure the move towards Zero AIDs related deaths, Zero New HIV Infections and Zero Discrimination.

## **Fiji National Strategic Plan 2012-2015**

Fiji is currently in its 3<sup>rd</sup> year of implementation on its 2012-2015 National Strategic Plan on HIV & STIs. The current strategic plan focuses on four [4] strategic approaches with its priorities on; prevention, continuum of care, monitoring and evaluation, governance, coordination and partnerships, cross cutting themes addressed in each strategic areas, gender and human rights, stigma and discrimination.<sup>5</sup> These priorities are overlapped in each of the four approaches resulting in the strengthening of the implementation of planned activities designed within the strategic plan.

### *Prevention Strategic Approach<sup>6</sup>*

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

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

---

<sup>5</sup> Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015

<sup>6</sup> Prevention Strategic Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015

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

HIV advocates for Fiji have proven to have a huge impact on issues pertaining to stigma and discrimination. Putting a face to the disease brings reality to the community that PLHIV are just like anyone else in society and they have a right to life and all that it has to offer. We have seen a reduction in stigma and discrimination where positive persons have been advocates and continue to see success stories of these around Fiji. We are forever thankful to the bold PLHIV who are either HIV advocates within the Ministry of Health or based with the Fiji Network for Positive people (FJN+).

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

### *Continuum of Care [CoC] Strategic Approach*

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

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

In the HIV/AIDS [Amendment] Decree 2011, all health care workers who have been trained on VCCT needs to be authorized by the Permanent Secretary for Health [who is also the Chairman of the Board] before they can practice as VCCT practitioners.<sup>7</sup> In 2013, a total of 116 VCCT practitioners were trained and were also authorized to practice as VCCT counselors. Currently there are 176 active VCCT counselors in Fiji.<sup>8</sup> These are health care workers within the Health Ministry that has been trained through Empower Pacific.

The PPTCT policy was reviewed and endorsed in 2013. It had incorporated the Option B plus for PLHIV mothers with a focus on PPTCT. As a country we are trying to achieve by 2015 zero new HIV infection in those children.

FJN+, the network for positive people had begun a capacity building program in 2013 to empower PLHIVs. The activity with the technical assistance from FCOSS was focused on income generation and methods of starting a small business. Following this training, 6 PLHIVs who are FJN+ members have enrolled into developing and starting their small business.

Fiji over the last year has ensured that all the divisions around Fiji provide a CoC team, for it to work we need people who are committed and that is an observation, sustaining it needs to ensure that the secretariat is active and making things happen with the chair of the CoC team. The Divisional Core teams have developed Terms of References (TOR) adopting one but to suit their geographical setting and people, though to note that there is no significant difference these TOR's.

### *Governance & Coordination Strategic Approach*

Fiji's strength in the HIV response through the Health Ministry is the collaboration and support received from other support organizations that are also providing services related to HIV. This includes government agencies like the Ministry of Labor that deals with HIV in the Workplace, Ministry of Women, Social Welfare & Poverty Alleviation that provides financial support to PLHIVs and has started on reproductive health in women. There are CSOs like BAHA that works with the business houses regarding HIV in the workplace and also targeting tourism and sea farer's are Fiji Red Cross Society, RFHAF, FASANOC on the other hand targets sports man and woman on HIV to name a few of the many organizations we have in Fiji.

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

---

<sup>7</sup> Fiji HIV/AIDS [Amendment] Decree 2011; Part 4 Section 27

<sup>8</sup> VCCT Training Report, Empower Pacific, 2013

The HIV/AIDS Board governs all activities implemented for HIV to ensure the country's effective response to HIV. PLHIV are represented in the HIV Board as well to ensure their voices are heard. To assist the Board in its governance and strategic approach, there are working groups of the Board such as the Continuum of Care working group, the HIV Testing and Counseling Committee, Prevention working group and the M&E working group which is still in its birthing stages.

### *Monitoring, Evaluation & Research Strategic Approach*

Under the NSP 2012-2015 Fiji is working towards to strengthening the Monitoring and Evaluation component in the Ministry as well as with the core partners in the area of Sexual Health. To strengthen the monitoring and evaluation of the national HIV & STI program, it works closely with the Fiji National University to carry out effective operational researches. With the support of the technical personal with the Fiji Health Sector Support Program of Fiji (FHSSP) the HIV program has used its technical expertise to strengthen the understanding and capacity of M&E in Fiji. With the support and assistance of this person we have developed a national work plan template in line with the NSP to develop National Work plan two years in a row with a tag of M&E to it.

Apart from the above we have managed to strengthen the capacity of staff in the three major divisions in the area of M&E in 2013 to strengthen the M&E teams in the divisions as well as at the National office. To further strengthen the step taken in 2013 of paper based reporting template, a surveillance officer has also been identified to specifically focus on data management as scale up of program is happening and data management by the National Family Health office is difficult.

### **The HIV/AIDS [Amendment] Decree 2011**

The HIV/AIDS Decree 2011 is slowly being implemented in the country. For example the recruitment of a full time Chief Executive Officer who is responsible to the Board and helps coordinate the HIV national response with the Family Health Unit under the Ministry of Health. The person oversees the authorization of VCCT and PPTCT practitioners via the Chair of the board, the establishment of working groups to assist the Board in the implementation of activities, etc. The Decree also outlines a human rights framework for the response to the HIV epidemic.

### **Resources**

Government of Fiji expenditure on the national HIV response in 2013 constituted approximately \$300,000FJD apart from finances that were used to procure ART in the year

of 2013. The other major contributor to the budget provided to the Government for the HIV program directly to the Ministry of Health was through UNICEF an amount of \$54,974.00 which was used for a significant number of programs in the year. There were some direct payments made by UNICEF which isn't accounted for here.

Fiji has been independent in its response over the last 2 years with minimal support from donor funds. Majority of the treatment either for ART or OI therapy/prophylaxis is provided by the Government of Fiji budget.

Thankful to WHO for the support towards the ART procurement last year of \$20,000 FJD and for a other support towards HIV/STI programs for Fiji and other donor partners who have supported in various other forms such as UNFPA, SPC, OSSHHM, IPPF and a few others to name.

Indicator #	Indicators	2012			2013			Remarks
		Numerator	Denominator	%	Numerator	Denominator	%	
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	N/A	N/A	N/A	44	83	5.1%	Second Generation Surveillance Report, 2008
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	N/A	N/A	N/A	13	543	2.4%	Second Generation Surveillance Report, 2008
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	N/A	N/A	N/A	363	1616	22.5%	Second Generation Surveillance Report, 2008
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last	N/A	N/A	N/A	103	363	28.4%	Second Generation Surveillance Report, 2008



	intercourse*							
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	N/A	N/A	N/A				Second Generation Surveillance Report, 2008
1.6	Percentage of young people aged 15-24 who are living with HIV*	N/A	N/A	N/A	N/A	N/A	N/A	Fiji does not currently collate data for this specific age group amongst ante natal clinics
1.7	Percentage of sex workers reached with HIV prevention programs	N/A	N/A	N/A	202	297	68.01%	
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	N/A	N/A	N/A	270	297	90.91%	
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	104	297	35.02%	
1.10	Percentage of sex workers who are living with HIV	N/A	N/A	N/A	3	293	1.02%	

1.11	Percentage of men who have sex with men reached with HIV prevention programmes	N/A	N/A	N/A	N/A	N/A	N/A	
1.12	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	N/A	N/A	
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	N/A	N/A	N/A	
1.14	Percentage of men who have sex with men who are living with HIV	N/A	N/A	N/A	N/A	N/A	N/A	
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A	N/A	N/A	N/A	N/A	N/A	
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A	N/A	N/A	N/A	N/A	N/A	

2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A	N/A	N/A	N/A	N/A	
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	N/A	N/A	N/A	
2.5	Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A	N/A	N/A	N/A	
3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	N/A	N/A	N/A	14	22	63.64%	Data is obtained from the pilot reporting tool for HIV in the country.  Fiji uses the Option B plus, thus all pregnant women who are diagnosed to be positive are put on a life time therapy [TDF, 3TC, EFV]
3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants	N/A	N/A	N/A	11	11	100%	Pilot reporting template for HIV. Secondary to Option B plus, Fiji is able to keep their babies breastfed which is also factored into

	during breastfeeding							the Fiji PPTCT Policy 2013 as well.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	N/A	N/A	N/A	9	14	64.29%	
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	N/A	N/A	N/A	7	22	31.8%	
4.1	Percentage of adults and children currently receiving antiretroviral therapy*	N/A	N/A	N/A	172	277	62.1%	Data obtained from pharmaceutical reports
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	N/A	N/A	N/A	47	67	70.1%	
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	N/A	N/A	N/A	4	4	100%	

6.1	Domestic and international AIDS spending by categories and financing sources	N/A	N/A	N/A				
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	N/A	N/A				Data not available
8.1	Discriminatory attitudes towards people living with HIV	N/A	N/A	N/A				
10.1	Current school attendance among orphans and non-orphans aged 10–14*	N/A	N/A	N/A	1	1	100%	
10.2	Proportion of the poorest households who received external economic support in the last 3 months	N/A	N/A	N/A				Data for this is important and Fiji has a social welfare system which offers social welfare, though unfortunately we have had patients who have sought external economic support and there's no data on these patients.

## Overview of the AIDS Epidemic

### Fiji Geographical Lay-out

Fiji is situated in South West part of the Pacific Ocean about 1,960 mi (3,152 km) from Sydney, Australia and comprises of 332 islands. About 110 of these islands are inhabited. The two largest are Viti Levu (4,109 sq mi; 10,642 sq km) and Vanua Levu (2,242 sq mi; 5,807 sq km).<sup>9</sup>

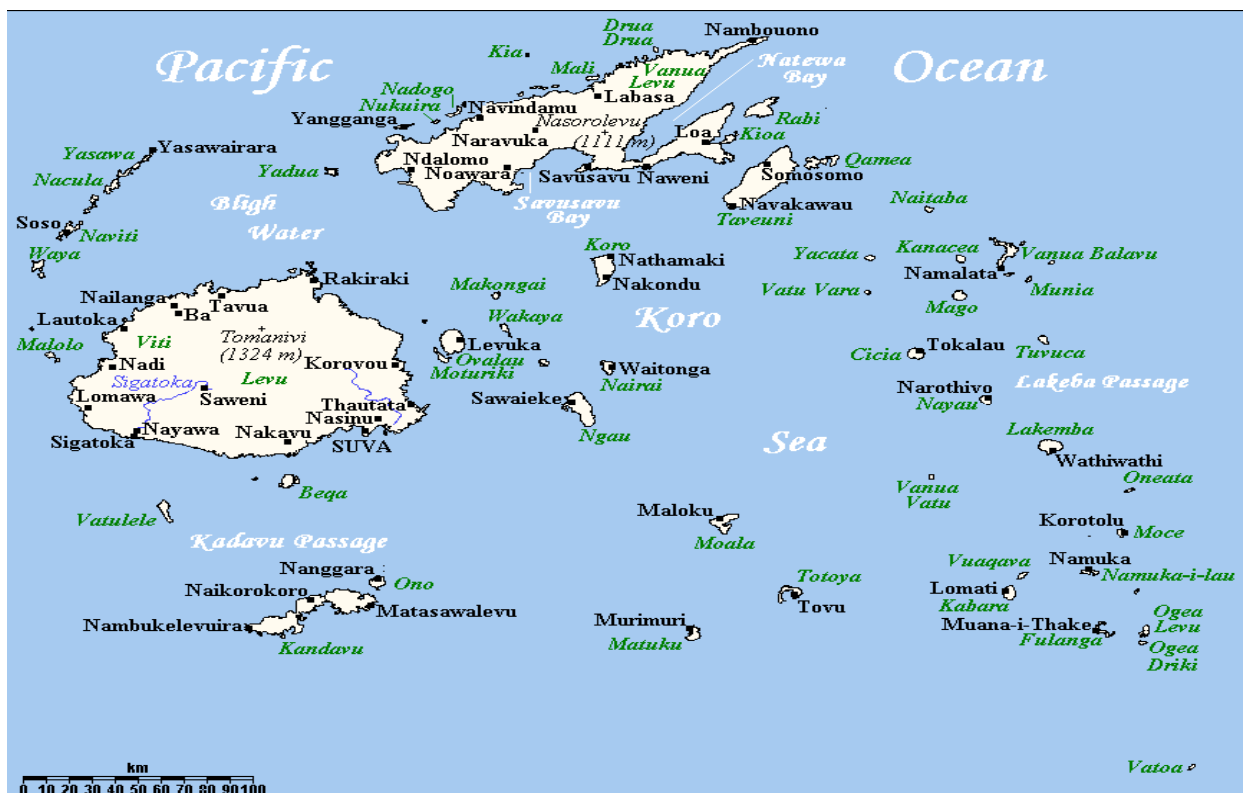


Figure 1: Geographical Lay out of Fiji

### **Demographic Overview**

Fiji is a multi-cultural country with a population of 387,271 made up of indigenous iTaukei [Fijians] (56.8%), Indo- Fijians (37.4%) and other minorities, including Caucasian and Chinese and other Pacific Islanders who either come to study or work in Fiji. Fiji is also well known for its multi religious status where majority are from the Christian faiths followed by Muslims and Hindu, Bhuddist faiths. Fiji is known to be the most urbanized country in the Pacific which comprises of 49% rural and 51% urban populations.

<sup>9</sup> Fiji Geography, Infoplease 2013: accessed on line on 24<sup>th</sup> March 2014 at <http://www.infoplease.com/country/fiji.html>

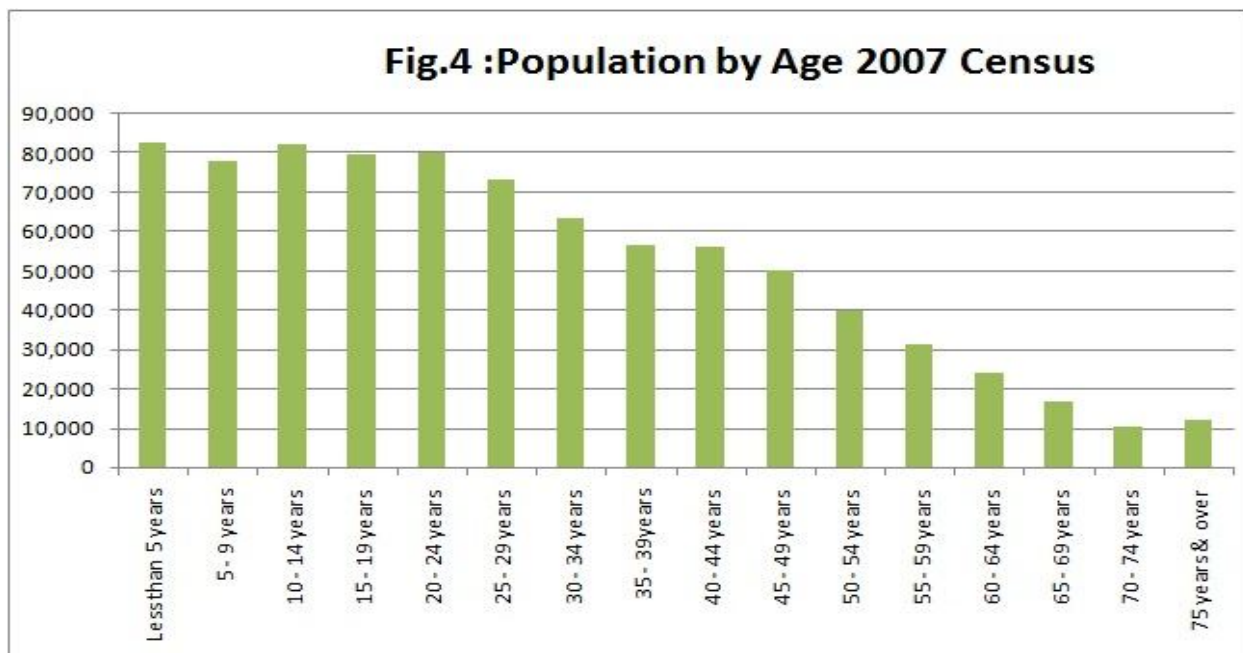


Figure 2: Age Distribution as per 2007 Census<sup>10</sup>

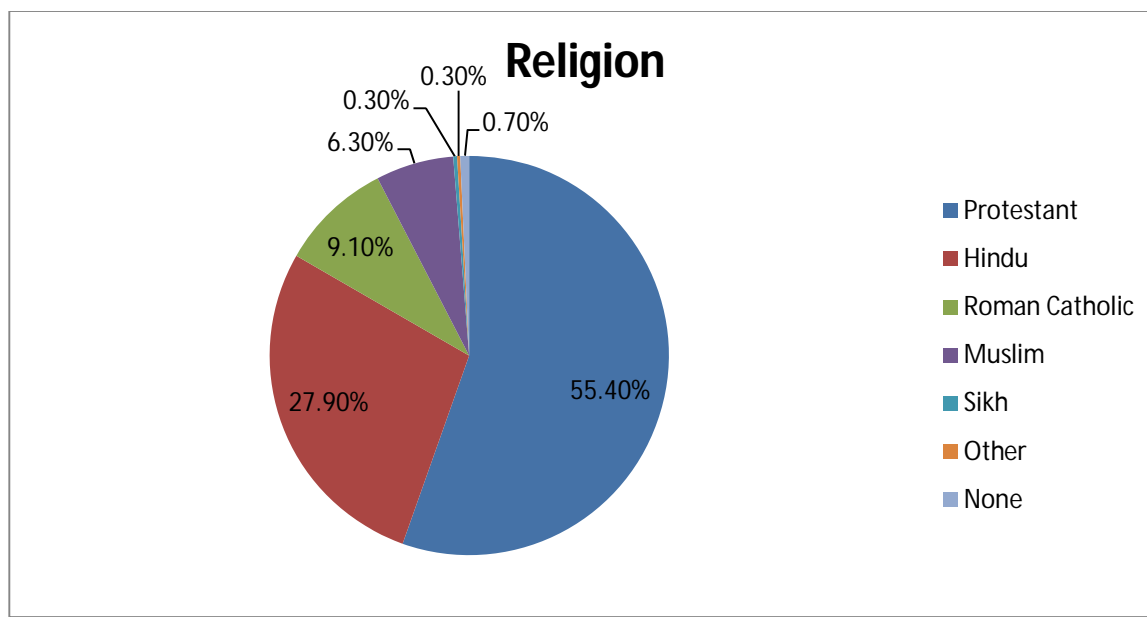


Figure 3: Existing Religions in Fiji<sup>11</sup>

<sup>10</sup> Population by Age 2007 Census, Fiji Bureau of Statistics, 2013: accessed on line on 27<sup>th</sup> March 2014 at <http://www.statsfiji.gov.fj/index.php/chart-gallery/209-population-by-age-2007-census>

<sup>11</sup> Fiji Facts & Figures, Infoplease 2013: accessed on line on 24<sup>th</sup> March 2014 at <http://www.infoplease.com/country/fiji.html?page=4>

## Fiji Economy <sup>12</sup>

Fiji is described as a middle-income country and one of the more developed of the Pacific island economies, although it remains a developing country with a large subsistence agriculture sector. In 2012, Fiji's economy grew by 2.5%. For 2013, the Reserve Bank of Fiji officially forecasts a 2.7% growth rate to be driven by the agriculture, manufacturing and the financial intermediation sectors. This growth is expected to be felt broadly across the economy. The year-end 2012 inflation was just below 3 %.

For many years' sugar and textile exports drove Fiji's economy. However, decline in preferential market access and the phasing out of a preferential price agreement with the European Union [to sugar price reductions of 36%] undermined earnings and the potential of these two sectors in becoming competitive in globalized markets. In 2005, the income from garments plummeted by 47%. Garments now account for around 9% of Fiji's exports and sugar approximately 20.9%. Other important export crops include coconuts, dalo, tropical fruits and ginger. Fiji has extensive mahogany timber reserves, which are being exploited. Fishing is an important export and local food source. From 2011, fish became one of the leading domestic export commodities. Gold from Fiji's only gold mine is also an important export industry and is expected to continue its positive performance with rising gold prices.

From 2000 the export of still mineral water, mainly to the United States, had expanded rapidly. Water exports in 2010 were estimated at \$119.2 million.

In recent years, growth in Fiji has been largely driven by a strong tourism industry. Tourism has expanded since the early 1980s and is the leading economic activity in the islands. Fiji's gross earnings from tourism in 2011 totaled \$1.051 billion, more than the combined revenues of the country's top five exports (fish, water, garments, timber, and gold).

Since the 1960s, Fiji has had a high rate of emigration, especially true of persons with education and skills seeking better economic opportunities abroad. The economic and political of 1987 and 2000 have also added to the outward flow by persons of all ethnic groups.

Poverty and inequalities are key human development challenges. It is estimated that 34.3% of the population live below the basic needs poverty line (2003). Since 2008 real incomes

---

<sup>12</sup> Economy, Fijian Economy 2013: accessed on line on 24<sup>th</sup> March 2014 at [http://www.fijihighcommission.org.uk/about\\_3.html](http://www.fijihighcommission.org.uk/about_3.html)



of the poor have fallen sharply, bringing more households into poverty. The growth rate of GDP per person employed has fallen from a high in 1990 of 15% to -1.1% in 2008. The employment to population ratio has stayed steady from 2003 – 2008 at 56.4%. Fiji is one of six countries in the region that is “slightly off track” and/or demonstrating “mixed progress” towards the achievement of the Millennium Development Goals. Donor aid to Fiji was only 1.8% of Gross National Income in 2008.<sup>13</sup>

### Fiji Education

Fiji has officially achieved universal primary education (96.7% in 2008) and has a high literacy rate of 99.5% amongst 15 – 24 year olds. However, in 2008 there was a 13.9% drop out rate of students between years one and five, which indicates that many children are leaving school without having learnt to read and write to a functional level.<sup>14</sup> This reflects the difficulty some families have in affording education for their children.

Since the mid-1990s, the Ministry of Education has paid tuition fees for all primary school pupils, but families must pay related costs, such as uniforms, transport, school fund-raising, etc, which amount to around F\$200 per pupil per year. Some low-income families have difficulty in meeting this cost.<sup>15</sup>

Recently, Fiji through the Ministry of Education has reinforced the school policy where all children must attend primary school. Strategies have been put in place by the current government as opportunity for all children to become literate. For example, free education has been provided to all children at the primary level including provision of free text books and free bus fares. This reduces the financial burden that most families in Fiji are facing.

### Organization of the Health System

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

A healthy population in Fiji that is driven by a health care is the vision of the MoH. To achieve this, the health ministry ensures that health services are accessible and available

---

<sup>13</sup> MDG's, Fiji Annual Program Performance Report 2011, AusAid

<sup>14</sup> Fiji Facts & Figures, Infoplease 2013: accessed on line on 24<sup>th</sup> March 2014 at <http://www.infoplease.com/country/fiji.html?pageno=4>

<sup>15</sup> Achieve Universal Primary Education; Millenium development Goals Fiji National Report, National Planning Office, Ministry of Finance and National Planning

not only in the urban areas but also to the rural areas including the maritime zones. There are different levels of care through a hierarchy of facilities within the public health sector:

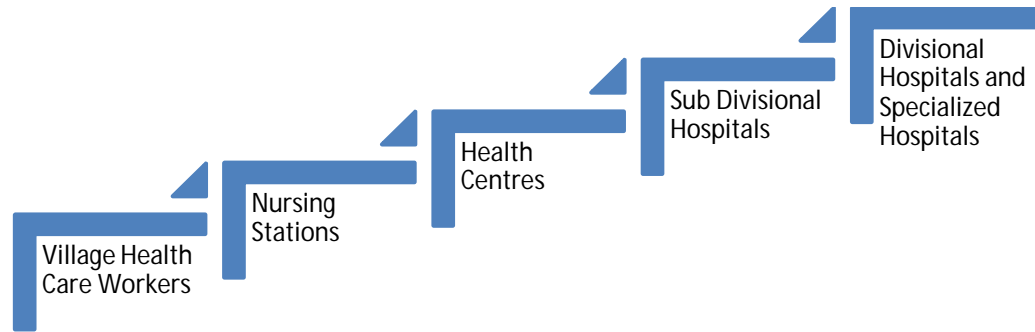


Figure 4: Hierarchy of Care within the Ministry of Health in Fiji.

### HEALTH FACILITIES & SERVICE PROVISION

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

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

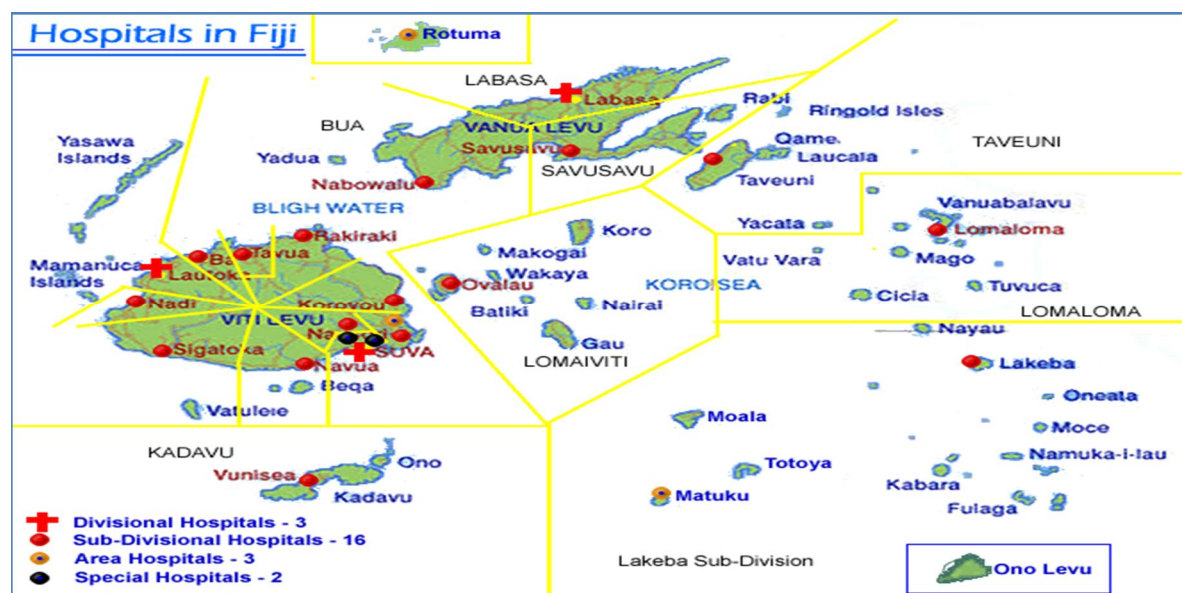


Figure 5: Locations of Hospitals, Sub Divisional Hospitals, Area Hospitals & Special Hospitals in Fiji

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

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

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

Within the private health sectors, there is a private hospital located in Suva that provides a range of specialized services, and there are several day clinics and 110 private general practitioners located in the urban centers of the two main islands Viti Levu and Vanua Levu. These services also include maternal child care [ante natal & post natal] not only with private practitioners but also with some major NGOs including the Fiji Reproductive Health Association.

Other major NGOs that works with health are; Fiji Red Cross, Medical Services Pacific, Empower Pacific [part of the PPTCT program] and the Fiji Network of People Living with HIV.

There are 37 antenatal health care facilities around the country. Services provided include information and education, health promotion, screening and interventions for women of

reproductive age to reduce risk factors that may affect future pregnancies. Women are urged to seek antenatal care early in their pregnancies at the nearest health facility providing it, although there is a high incidence of late presentation for antenatal checks. The percentage of births attended by skilled personnel within a health facility is high. Postnatal checks are offered to mothers six weeks after delivery and family planning services are available at the maternity units, health centers and nursing stations. There is also the Oxfam Clinic based at CWM Hospital that accommodates working women for family planning services within the greater Suva area.

#### FIJI – MILLENNIUM DEVELOPMENT GOAL [HEALTH]<sup>16</sup>

Table 2: Fiji's Progress on MDG [Health]

		2009	2010	2011	2012
<b>Goal 4: Reduce Child Mortality</b>	Under 5 Mortality Rate	23.2	17.7	20.95	20.96
	Proportion of 1 yr old immunized against measles	71.7	71.8	82.5	85.9
Goal 5: Improve Maternal Health	Maternal Mortality Ratio per 100,000 live births	27.5	22.6	39.8	59.47
Goal 6: Combat HIV/AIDS and other Diseases	Contraceptive Prevalence rate among population of child bearing age	28.9	31.77	36.5	44.3
	Proportion of TB cases detected and cured under DOTS	94	67	93	

#### Fiji – Non Communicable Disease

Non-communicable diseases (NCD) are becoming an increasingly important cause of mortality and morbidity in the Country. 22.8% of those diagnosed with diabetics are between the ages of 50-54 with 57% females and 43% males. The most common cardiovascular diseases included congestive cardiac failure [46.3%], hypertension [29.8%] and unstable angina [23.8%] respectively<sup>17</sup>.

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

<sup>16</sup> MDG Performance, Fiji Ministry of Health Annual Report, 2012

<sup>17</sup> NCD Health Outcome Performance Report, Fiji Ministry of Health Annual Report, 2012

The expenditure of the Ministry of Health as a percentage of GDP was 2.10%, health expenditure is 7.36% percent of Government expenditure in 2012.<sup>18</sup>

Challenges in the Fiji health system are largely related to workforce where staff shortages are hampered by the continuous exit of qualified nationals and the inability to attract international specialists, the high turnover of staffs internally hinder the implementation and sustainability of programs, the high workload and competing demands on staff in the sub divisional levels and limited capacity development. There are also challenges within the health information unit of the ministry. This includes the timely collation, analysis and distribution of data in a timely manner, standardization of data collection processes and limited operational research to name a few.<sup>19</sup>

### HIV Salient Statistics

Following a mid-term review which was conducted in the 1<sup>st</sup> and 2<sup>nd</sup> quarter of 2013, the HIV epidemic in Fiji cannot still be classified into any of the three categories which are globally used to describe epidemics. Fiji is neither generalized, concentrated or mixed.<sup>20</sup>

Fiji's HIV epidemic is not 'generalized' because the prevalence has not reached 1% in pregnant women, which is seen as a proxy for the general population. The infection rate in the general adult population (15 to 49 year olds) is estimated to be approximately 0.12%.<sup>21</sup> It is not a 'concentrated epidemic because the HIV prevalence is not greater than 5% in any key population. Integrated Behavioral and Biological Surveys (IBBS) of men who-have-sex with-men (MSM) and sex workers were conducted in 2011 and 2012 respectively. The study by Rawstorne et al,<sup>22</sup> "An integrated bio-behavioral survey (IBBS) of transgender and men who have sex with men in Suva and Lautoka, Fiji", reported the overall HIV prevalence in MSM was 0.5%, but 1.3% among transgender MSM. In their 2012 study, Mossman et al<sup>23</sup> report the zero HIV prevalence in female sex workers and 1.8% in transgender sex workers to give an overall prevalence of 0.7%.

---

<sup>18</sup> Proportion of Ministry of Health Budget against National Budget and GDP, Fiji Ministry of Health Annual Report, 2012

<sup>19</sup> Organization Wide Challenges, Fiji Ministry of Health Annual Report, 2012

<sup>20</sup> 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the "Ten Targets" in Fiji Islands, 31<sup>st</sup> May, 2013

<sup>21</sup> UNAIDS & WHO – Epidemiological Factsheet, Fiji, 2010: accessed online on March 13, 2014 at <http://aidsinfo.unaids.org>

<sup>22</sup> 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the "Ten Targets" in Fiji Islands, 31<sup>st</sup> May, 2013

<sup>23</sup> Confidential Report: IBBS Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project. Commissioned by UNAIDS Pacific Office and MoH with assistance from FNU.

A 'mixed epidemic' is one where there is substantial contribution to overall transmission from both the general population sexual behavior patterns and defined key population group(s). At the end of 2013, a cumulative total of 546 HIV infections had been detected in Fiji since 1989, of which 483 (88%) were reported to be heterosexually transmitted [figure 7], 20 (approximately 3.7%) were transmitted through male-to-male sex, 1 ((0.2%) through injecting drug use and 31(5.7%) through perinatal transmission.<sup>24</sup>[Table 2] It remains unclear how many of these cases are still alive.

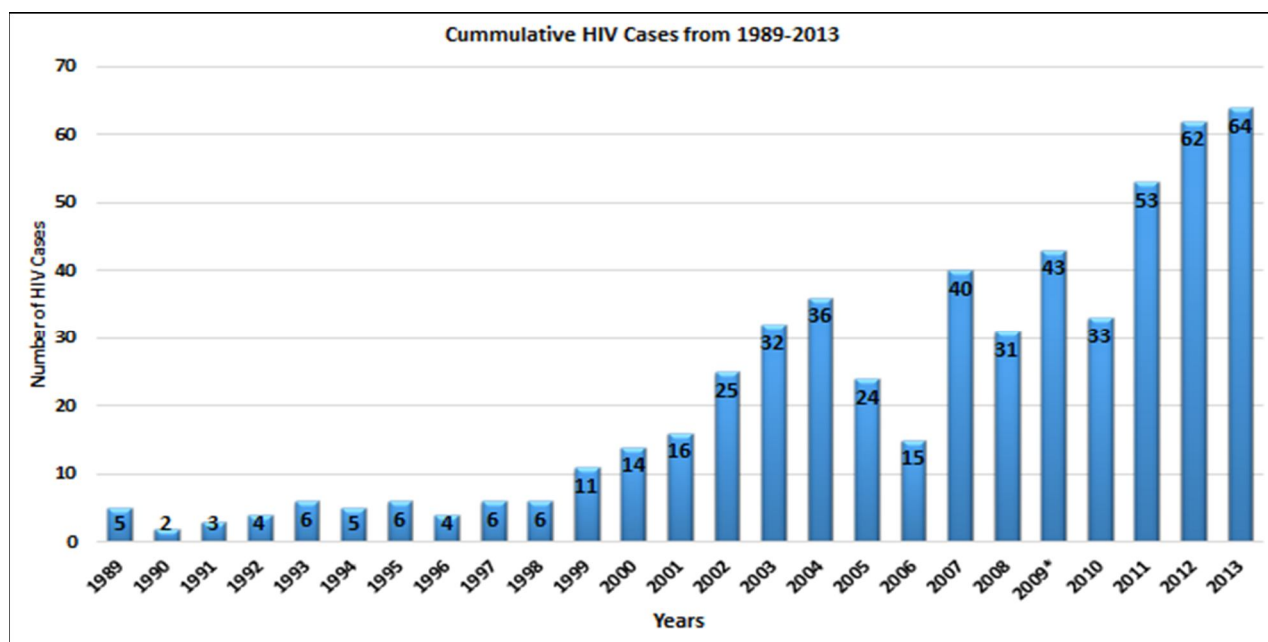


Figure 6: The above graph shows the number of new HIV confirmed cases in Fiji annually since 1989.<sup>25</sup>

<sup>24</sup> Fiji Ministry of Health, December 2013, Centre for Disease Control

<sup>25</sup> Fiji Ministry of Health, December 2013, Centre for Disease Control

Data, 2013

U	RACE				MODE OF TRANSMISSION								AGE GROUPS							
	Fij	Ind	Oth	U	Hetro	Homo	Bi	Trans	IDU	Peri	B/piercg	ukn	0-9	19-Oct	20-29	30-39	40-49	50-59	60+	Ukn
0	2	3	0	0	3	0		1	0	0	0	0	0	0	3	1	0	1	0	0
0	1	1	0	0	3	0		0	0	0	0	0	0	1	1	0	0	0	0	0
0	1	2	0	0	1	1		0	0	1	0	0	0	0	0	2	0	0	0	1
0	1	2	1	0	2	2		0	0	0	0	0	0	0	2	1	1	0	0	0
0	6	0	0	0	1	2		0	0	0	0	0	0	0	3	3	0	0	0	0
0	3	1	1	0	3	2		0	1	0	0	0	0	0	2	1	2	0	0	0
0	5	1	0	0	8	0		0	0	0	0	0	0	0	2	2	2	0	0	0
0	4	0	0	0	3	0		0	0	1	0	0	1	0	2	1	0	0	0	0
0	4	2	0	0	3	0		0	0	0	0	1	0	0	2	2	2	0	0	0
0	5	0	1	0	7	0		0	0	0	0	0	0	0	4	0	2	0	0	0
0	8	1	2	0	8	0		0	0	3	0	1	0	0	5	3	1	0	0	2
0	14	0	0	0	9	0		0	0	1	0	0	0	1	3	6	2	0	0	2
0	13	1	1	1	17	0		0	0	0	0	0	0	0	11	5	0	0	0	0
0	22	1	1	1	25	0		0	0	1	0	0	0	1	17	4	1	0	0	2
0	29	2	1	0	28	0		0	0	3	0	0	2	0	12	11	3	1	0	3
0	31	3	2	0	26	0		0	0	3	0	0	1	0	16	11	3	2	1	2
0	17	5	1	1	26	0		0	0	2	0	1	0	1	5	9	3	2	0	4
1	7	5	2	1	34	1		0	0	1	0	0	0	2	7	2	2	1	0	1
0	30	7	2	1	23	0		0	0	0	0	0	0	2	23	13	1	0	0	1
4	21	2	1	7	27	0		0	0	1	0	3	3	1	15	4	1	1	0	6
1	34	6	1	2	37	0		0	0	5	0	1	3	1	16	12	3	3	1	4
0	30	1	0	2	33	0		0	0	0	0	0	0	1	22	8	1	0	0	1
0	42	8	3	0	48	4		0	0	0	1	0	0	1	25	20	6	1	0	0
0	58	3	1	0	55	3		0	0	4	0	0	4	2	34	16	5	1	0	0
0	54	10	0	0	53	5	1	0	0	5	0	0	5	0	28	21	8	2	0	0
6	442	67	21	16	483	20		1	1	31	1	7	19	14	260	158	49	15	2	29

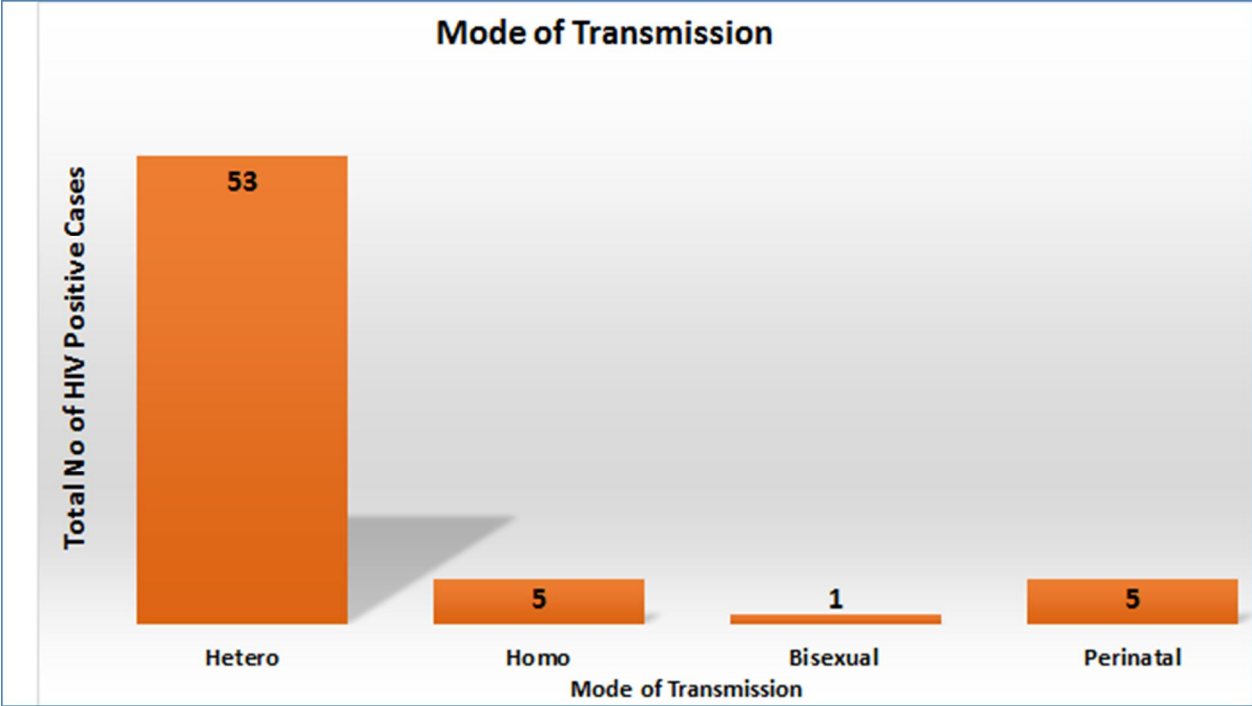


Figure 7: Mode OF Transmission for HIV for 2013

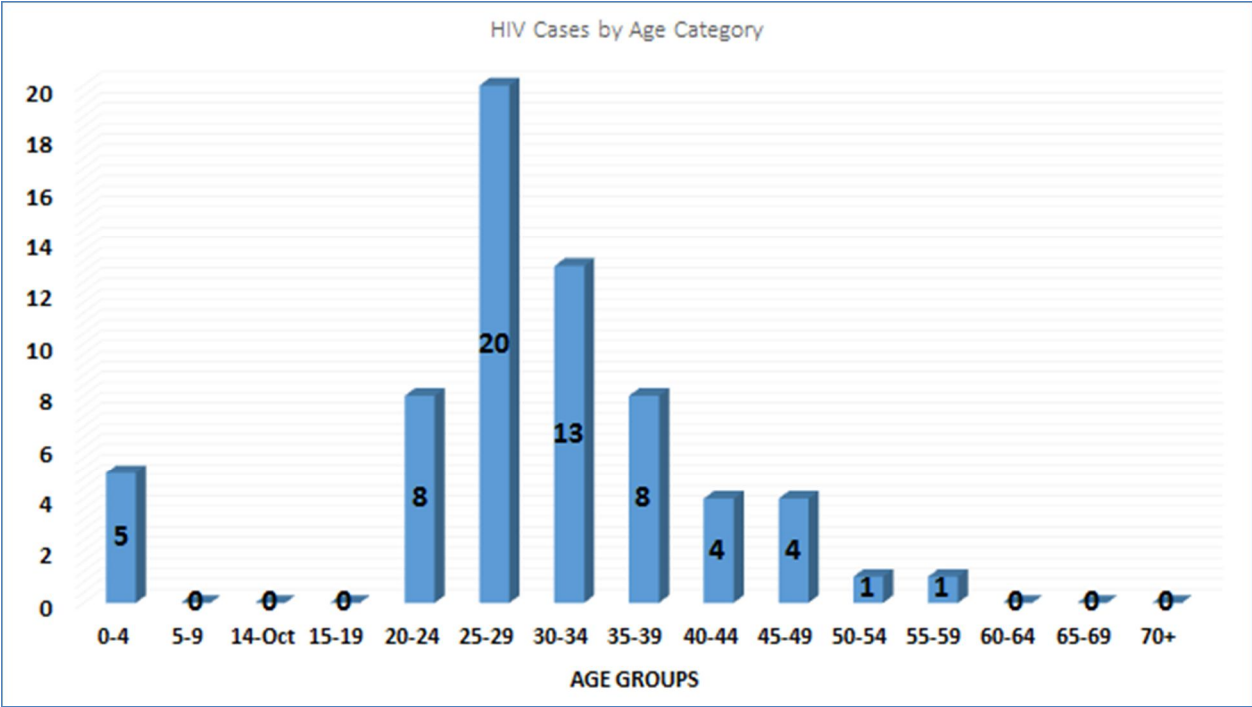


Figure 8: There hasn't been a change in the age distribution of those HIV confirmed cases. The young adults between the ages of 25-29 are the most affected followed by those between the ages of 35-39 years.



The HIV epidemic is disproportionately affecting young people. Together the 20-29 and the 30-39 age groups account for over 77% of all the infections reported to date (Figure 8). The majority of HIV infections (82%) have been among indigenous Fijians (ITaukei), whilst Indo-Fijians constitute 13% of reported cases.

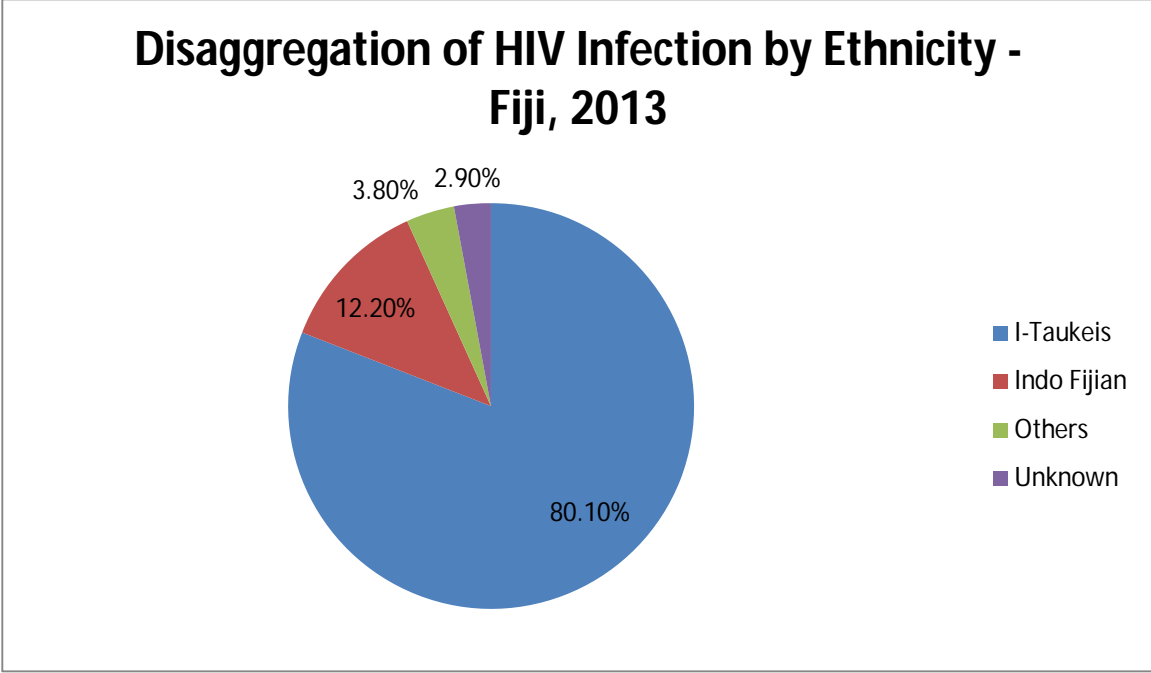


Figure 9: Fiji HIV Infection - Disaggregation by Ethnicity in 2013

In 2013, it was seen that there was an equal gender distribution on HIV as compared to previous years [figure 10]. An analysis of the annual number of reported infections shows an increasing trend of the proportion of infections detected in females relative to males. In 2003, 58% of HIV cases were male versus 42% female; in 2006, equal numbers of infections were reported in males and females. In 2009, the male to female ratio was reversed and 55% of infections were in females compared to 45% in males. In 2010, the trend continued with 67% of new infections in females and 33% in males. There was another reversal of the trend in 2011, with more males (60%) infected.

The increasing proportion of female infections, compared to males, may suggest that females are at higher and increasing risk of HIV infection. However, it is also likely that it is a reflection of who gets tested. HIV Testing of pregnant women as part of prevention of parent to child transmission (PPTCT) program means females are over represented in the total number of people receiving HIV tests. There is a need to analyze the male and female breakdown of HIV tests to determine a possible explanation for the increasing ratio of female to male infections.

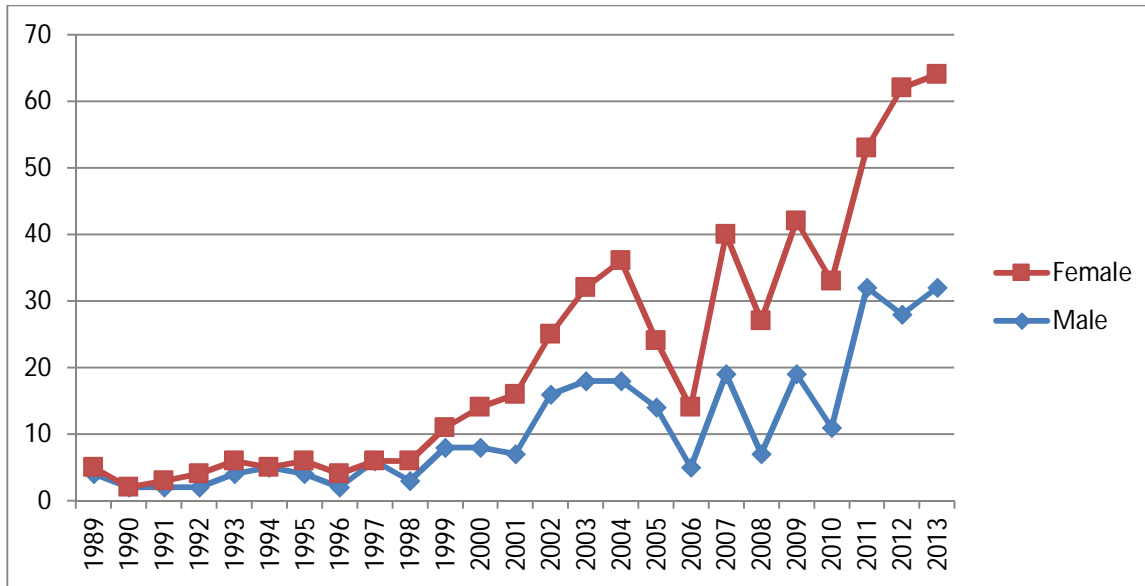


Figure 10: Disaggregation by sex [HIV infection] from 1989 - 2013

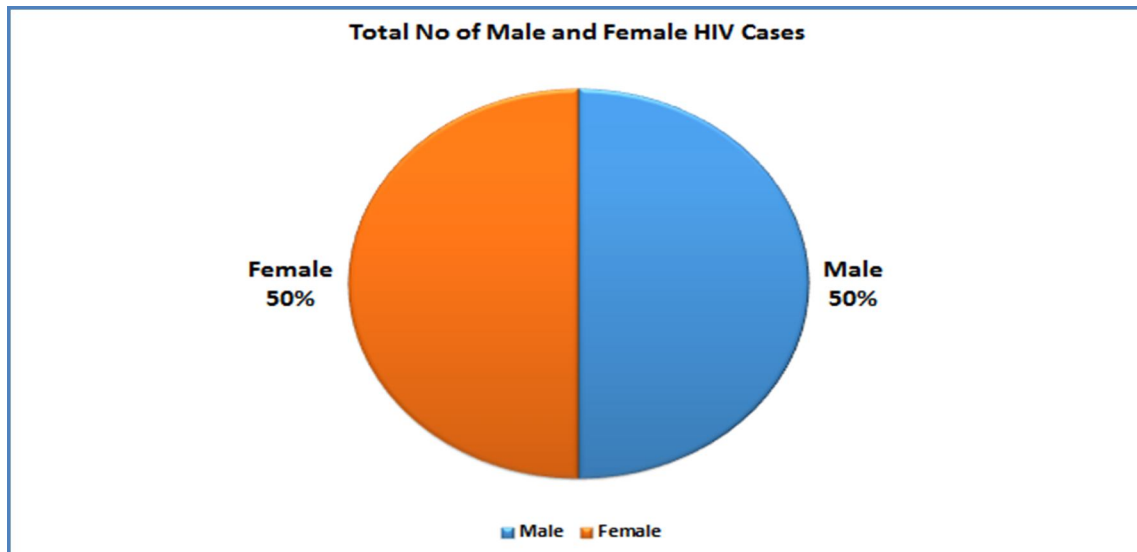


Figure 11: There has been a change in the gender distribution of HIV infection in Fiji. The above graph shows that there's an equal percentage distribution of HIV infection amongst males and females.

## Fiji Spectrum Data:

Following the initial phase of the estimation and projection process which was undertaken in Bangkok on the 22<sup>nd</sup> – 26<sup>th</sup> April, 2013, a workshop attended by stakeholders from the Fiji Ministry of Health, other sector ministries, civil society and the UN supporting agencies was convened in Fiji to review and validate the Spectrum file. At the workshop, consensus was reached on the results by reviewing data used and assumptions made in the configuration of the Spectrum model for Fiji. The following graphs are extracted from the Estimation & Projection Summary Report – Fiji's HIV Epidemic 2013 by UNAIDS & Fiji MoH.

### Estimations by 2013 and Projections by 2020:

A total of 128 new HIV infections is estimated for 2013, and 91 projected by 2020 [12 below].

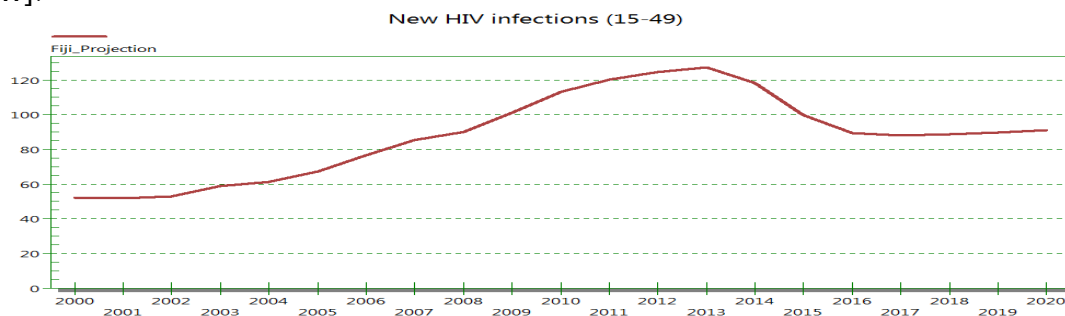


Figure 12: Estimated new HIV infections

New HIV infections among children 1-4 yrs is estimated to be 8 by 2020 [figure 13 below]

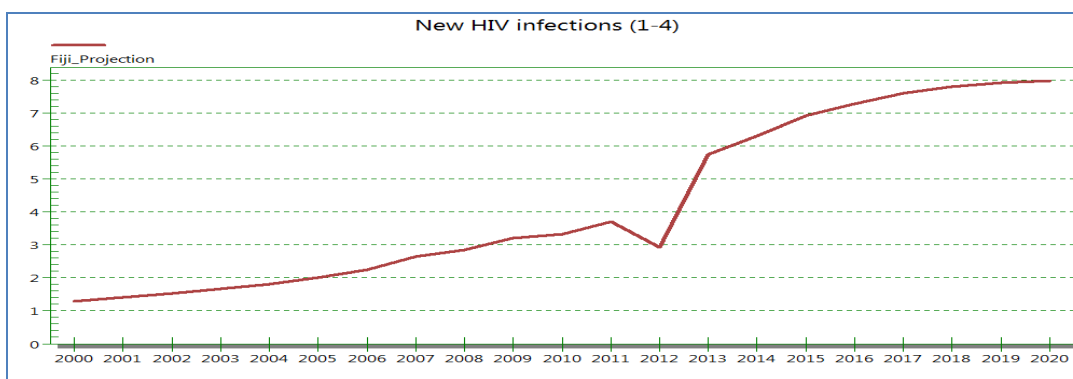


Figure 13: New HIV infections amongst children

HIV prevalence among those age 15-49 yrs. is estimated at 0.20% in 2013, and projected to be 0.28% in 2020

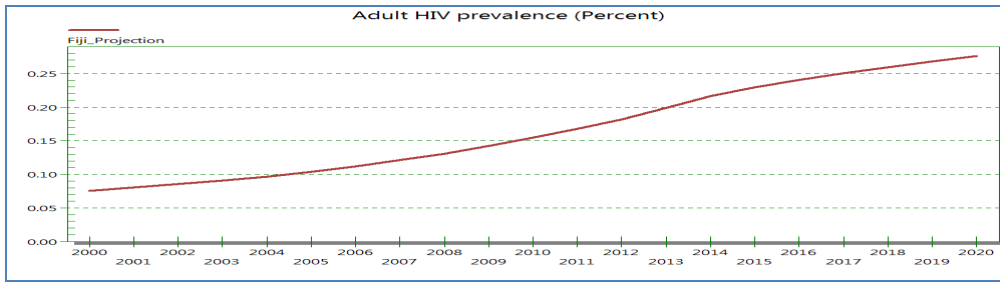
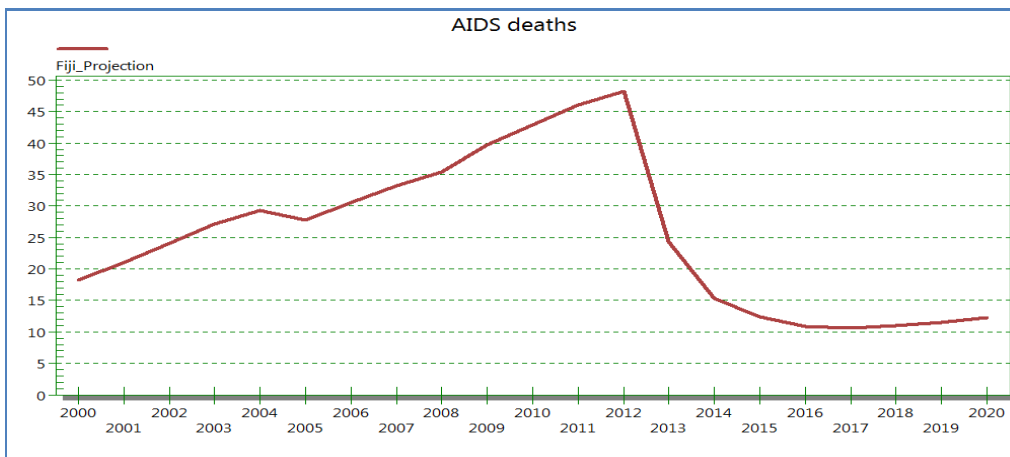
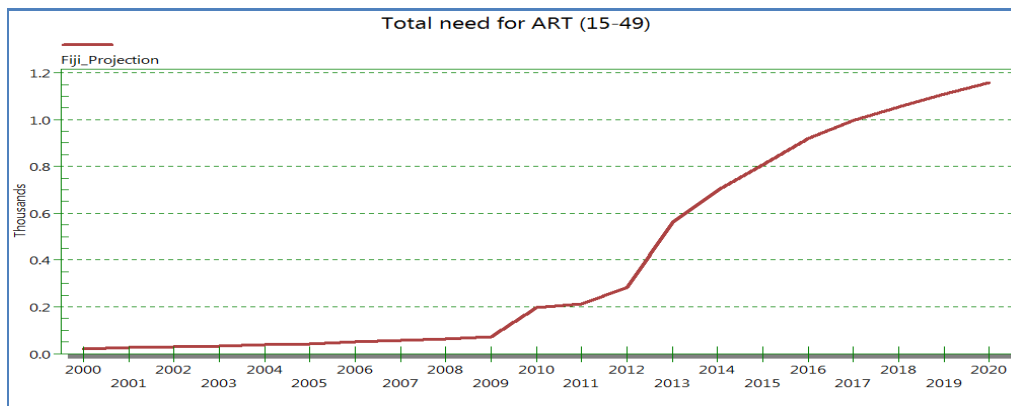


Figure 14: HIV prevalence among those age 15-49 yrs

Annual total deaths are estimated to be 24 in 2013, and 12 by 2020.



Total need for ART is estimated at 282 in 2012 and projected to be 1,159 in 2020.



## Sexually Transmitted Infections:

Chlamydia is shown in a few studies that it is hyper-endemic especially amongst the sexually active population in Fiji where one third of males and females are potentially infected. A survey of pregnant women attending antenatal clinics in 2004 found that 29% were infected with Chlamydia, 1.7 % with gonorrhoea and 2.6% with syphilis<sup>26</sup>. Among younger women (<25 years), the Chlamydia prevalence was even higher at 34%. In 2008, another survey of pregnant women found levels of Chlamydia (26.8%), gonorrhoea (2.2%) and syphilis (2.7%) infection similar to the 2004 study. These studies confirm that Sexually Transmitted Infections (STIs) has a higher prevalence as compared to the low HIV prevalence in the country.

Chlamydia testing was available in Fiji though currently we do not routinely do Chlamydia testing, though when done it is conducted only at the National Reference Laboratory in Mataika House.

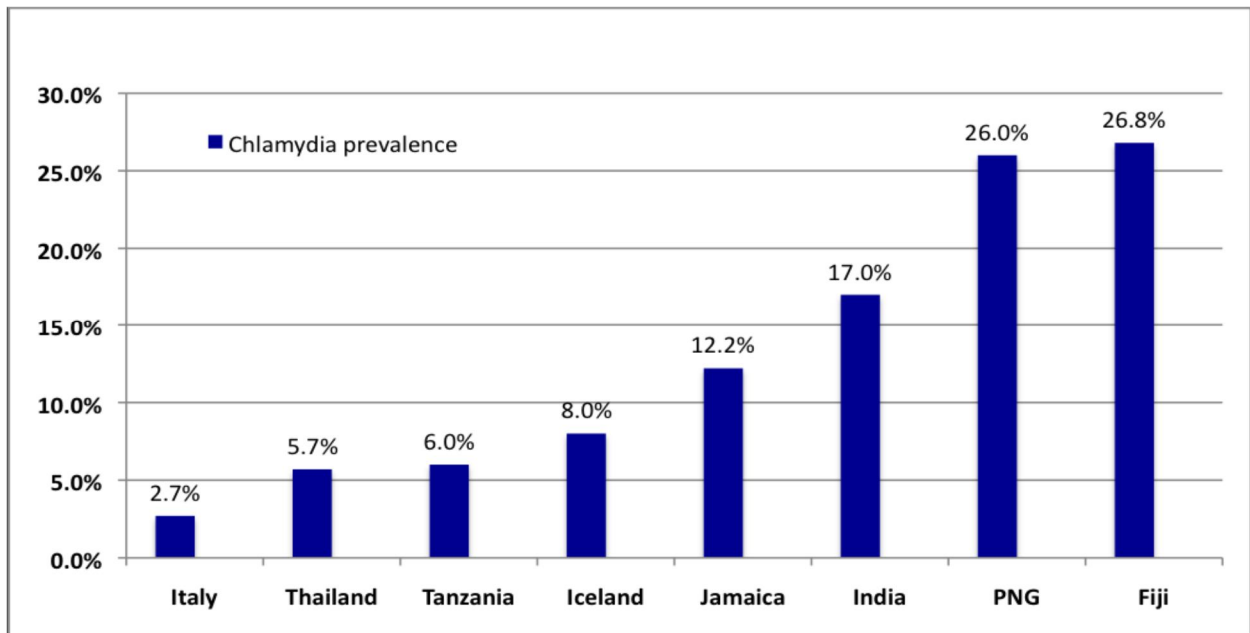


Figure 15: Comparison of Chlamydia prevalence in pregnant women in Fiji with 7 other countries<sup>27</sup> 2008

Prevalence of chlamydia in Fiji is high when compared to many other countries. With the high chlamydia prevalence in the country and other STIs like syphilis and gonorrhoea, Fiji is also at risk of having a possible rapid increase of HIV resulting in an epidemic. This is possible especially when neighboring countries like Papua New Guinea has an expanding HIV epidemic.

<sup>26</sup> World Health Organization, 2006: Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries (2004 – 2005), p21.

<sup>27</sup> STI Epidemiological Update PICTs 2009. HIV & STI Surveillance, SPC July 2010 & Fiji Ministry of Health, 2008 SGS Report.

The high prevalence of STIs in young people indicates that they are sexually active with possibilities of more than one partner with unsafe sexual practices. These unsafe practices with the sexual networks are dense enough to enable transmission of STIs amongst young heterosexuals. The spread of HIV in Fiji is not only within the mainland but this has also spread to other smaller islands in Fiji as a result of visitors to the mainland and vice versa.

### **Epidemiological Research:**

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

#### *Integrated Biological and Behavioral Survey for Sex Workers 2012*

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

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

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

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

Similar research was conducted amongst men who have sex with men in Fiji in 2011, results has yet to be published.

Currently, Fiji has very few reports of injecting drug use which is very unlikely to be a driver for the increase in new HIV infections. But this needs to be investigated further due to the increase in drug use in the country.

With a low HIV prevalence, as is indicated by the small numbers of cases detected through current HIV testing strategies, it is difficult and would prove to be very expensive to conduct surveillance through population wide random samples. The SGS 2008 shows some data in relations to Injectable drug usage in Fiji.

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

It is clear that HIV is present in Fiji and is also increasing by the year. This has consequences for the people infected, their partners and newborn babies, and for their families and communities who are infected or affected by it.

### *Social Research Provides Further Understanding of Factors Influencing the Situation*<sup>28</sup>

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

The experiences of sex workers were explored through qualitative research of the Pacific Sexual and Reproductive Health Research Centre (PacS-RHRC) and the University of New South Wales, resulting in the published report, "Risky Business", in 2009.<sup>29</sup>

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

The research found two distinct groups of workers. One group reported a professional approach to sex work. They were mostly using condoms, negotiated condom use, educated clients about HIV and condom use, and also cited their right to protect themselves. The

---

<sup>28</sup> This section is directly extracted from the Fiji National Strategic Plan for HIV & STI 2012-2015

<sup>29</sup> McMillan K, Worth H, Risky Business: sex work & HIV Prevention in Fiji. Sydney, International HIV Research Group, UNSW, 2009

second group reported a more casual approach to sex work: they said they 'went with the flow', were also seen as 'amateurs' and had 'sex for fun'. This second group's actions resulted in higher risks of HIV transmission. However, the research also found that when clients preferred not to use condoms, sex workers offered other services such as oral sex, masturbation or non-penetrative sex, and charged more.

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

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

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

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



The research of the AIDS Task Force of Fiji was supported by UNDP<sup>30</sup>. Respondents reported a diversity of sexual and gender identities and gender expressions: straight, bisexual, gay and transgender were terms that people used to describe themselves. Many had lives that are integrated with the broader Fiji community and do not want to develop a separate “gay” community, though they do want a stronger sense of community with each other. Many had sex with women as well as men (48.1% had ever done this), thus indicating the need to ensure HIV transmission remains low within this group as a strategy to keep HIV incidence low within the whole community. The majorities were in regular relationships but 84% reported one or more casual sexual partners within the previous six months. Anal sex was common (98.1% had engaged in this in the previous six months) and, while condom use was common it was not universal and condoms were not used in all encounters. Alcohol and drug use were not associated with decisions on whether to use condoms.

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

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

Research on the experiences of HIV positive women was reported by the Pacific Islands AIDS Foundation (PIAF) in 2011<sup>31</sup>. This found two areas in which HIV positive women’s experiences are different to those of other women or those of HIV positive men.

First, women generally assume more responsibility of home-based care for those who are infected and affected, especially for those who are sick or dying as a result of HIV&AIDS, along with the orphans. Girls are taken out of school (rather than their brothers) to care for family members who are HIV positive. While positive men are usually cared for by their partners, mothers, sisters and daughters, women who are either widowed by AIDS or who

---

<sup>30</sup> Bavungton G, Singh N, Naicker DS, et al. Secret lives, other voices ... a community based study exploring male-to-male sex, gender identity and HIV transmission risk in Fiji, Suva, AIDS Task Force of Fiji 2011.

<sup>31</sup> Pacific Islands AIDS Foundation. Experiences and Perspectives of women living with HIV in Fiji and Papua New Guinea. Suva, PIAF/Pacific Islands HIV & STI Response Fund/Commonwealth Foundation, 2011.

are positive themselves are often isolated and excluded, in many situations having no property rights which can result in them being thrown out of their home.

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

Because many Fijians are not in the usually described "key populations", research was also conducted by UNDP to provide better understanding of relationships and HIV risk in 2011<sup>32</sup>. This explored marriages, de facto marriages and other relationships amongst 74 participants from six population groups: health workers, university students, religious leaders, taxi-cab drivers, lesbian, gay and transgender persons, and people in sex work. Five of the 74 were HIV positive. This research found that respondents did not have good understanding of HIV and STI risks with regular intimate partners, did not use condoms consistently, and had poor skills in identifying their own levels of risk.

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

---

<sup>32</sup> UNDP. Me, My intimate Partner and HIV: Fijian self-assessment of Transmission risks. Suva, UNDP, 2011

## NATIONAL HIV LEGISLATION – THE HIV/AIDS DECREE 2011:

The Fiji HIV/AIDS Decree which was gazetted by the Government of Fiji in February 2011 and amended on the 26<sup>th</sup> August 2011 is now in its 4<sup>th</sup> year of implementation. The Decree outlines a human rights framework for the response to the HIV epidemic from 2011 onwards. The HIV/AIDS Decree has been acknowledged both locally and internationally as one of the most progressive HIV laws in the world. The 45-section Decree aims to safeguard the privacy and rights of persons infected or affected by HIV and AIDS by the following:

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

The Government of Fiji lifted its restrictions on entry, stay or residence based on HIV status in August 2011 and it was officially announced by the President of Fiji at the 10th International Congress on AIDS in Asia and the Pacific, which was held in South Korea<sup>33</sup>.

Through the HIV/AIDS Decree the HIV/AIDS Board was also established with the appointment of its first CEO. The Board is the governing body that reviews and adopts the 2012 - 2015 national strategic plan and also ensures that the country's response is aligned to the Decree and also the NSP to ensure that "recognized universal human rights standards" are adopted, "To protect all such rights including the highest possible standard of physical and mental health including the availability and accessibility of HIV prevention and HIV/AIDS treatment, care and support for all persons regardless of age, gender, gender orientation or sexual orientation"<sup>34</sup>. The HIV/AIDS Decree provides that any policies issued by the HIV/AIDS Board will have the force of law, and that any person who contravenes the policies commits an offence. The Decree indicates in the clearest possible terms a political will to adopt a law based on the International Guidelines.

---

<sup>33</sup> Government of Fiji. HIV/AIDS Decree 2011 [Decree No. 5 of 2011]. Suva, Government of Fiji, 2011

<sup>34</sup> Section 3-1[a], Guiding Principles, HIV/AIDS [Amendment] Decree 2011. Government of Fiji, 2011

## NATIONAL STRATEGIC PLAN<sup>35</sup>:

The period covered by the GARPR 2013 will be the final two years of the implementation of the five-year 2012 – 2015 NHSP. The NHSP has 4 strategic approaches:

- **Prevention Strategic Approach:** Because there is low prevalence of HIV, but high prevalence of STIs, prevention of HIV and STIs will be integrated. Because there are high reported rates of gender inequality and unplanned teenage pregnancies, prevention will also promote better understanding of reproductive health and the rights of women and children. Because there are high reported rates of stigma and discrimination against people living with HIV and people from key populations, prevention will be integrated with the promotion of human rights and respect for all Fijians, including sex workers, transgender people and men who have sex with men.

Prevention programs will aim to change the perception that condoms are only important for sex work and for contraception, so that condom use for the purpose of prevention of diseases becomes more acceptable amongst all people. Prevention programs will continue to involve People Living with HIV in collaboration with peer educators, community organizations and health services staff.

- **Continuum of Care Strategic Approach:** The strategic approach to provision of counseling, testing, treatment and care will continue to be based on the concept of “Continuum of Care”. This means that prevention will be linked with referrals to treatment, diagnosis will be linked with counseling and referrals for some people to psychological support, medical services will incorporate involvement of counselors from the community sector and peer support by and for people living with HIV, and treatment and care will be linked with community programs to reduce stigma and discrimination. Within the Continuum of Care Framework, there will continue to be close collaboration between services provided by the Ministry of Health and the community sector. Certification of counselors is a requirement of the HIV/AIDS Decree.
- **Governance Strategic Approach:** The implementation of the National Strategic Plan will depend on the continued success of collaboration between many partners from different sectors. To ensure this is effective, a governance structure which is the HIV/AIDS Board makes decisions affecting all partners, receive reports on monitoring and on potential improvements to policies and programs, solve problems efficiently and quickly, and improve the national response over time. People living with HIV will be

---

<sup>35</sup> The following section is extracted from the “Approach of the National Strategic Plan for 2012-2015.” National Strategic Planning for HIV & STI, 2012-2015. Ministry of Health Fiji.

involved at all levels of governance, including having representation at the highest level, the HIV/AIDS Board.

- *Monitoring & Evaluation Strategic Approach*: The strategic approach strengthen Monitoring and Evaluation includes its integration with the overall Health Information System (HIS) for the Ministry of Health. This ensures that monitoring and evaluation of HIV and STI are improved and aligned with the use of strategic information in Reproductive Health and other health issues.

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

A review of the implementation of the NSP 2012 – 2015 will be conducted in 2015 with preparations for this review in 2014.

#### **HIV/AIDS BOARD:**

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

The HIV/AIDS Board is mandated through the HIV/AIDS Decree to provide strategic leadership and coordination of interventions on HIV and AIDS in Fiji. Through the guidance of the HIV/AIDS Decree, the Boards' functions are as follows:<sup>36</sup>

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

---

<sup>36</sup> HIV/AIDS [Amendment] Decree 2011: Part 2, Section 8 (1a-i)

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

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

#### **MONITORING AND EVALUATION FRAMEWORK:**

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

The Ministry of Health currently assists in the monitoring of some aspects of the health sector response to HIV through the surveillance system established for the HIV program, such as the

number of pregnant women tested for HIV, the number of people on ART, etc. The recruitment of a surveillance officer is currently in process that will create and manage a central database for all STI and HIV data. This will enhance and strengthen data management with HIV which will assist in identifying trends and understanding some aspect of the epidemic.

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

**NATIONAL FUNDING OF HIV AND AIDS PREVENTION, TREATMENT AND CARE AND SUPPORT SERVICES:**

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

The proportions of funding utilized for the different program categories are shown in Figure 18. Prevention had the largest share of the available resources, with 64%, followed by program management with 22%, with human resources 12% and enabling environment 8%<sup>37</sup>.

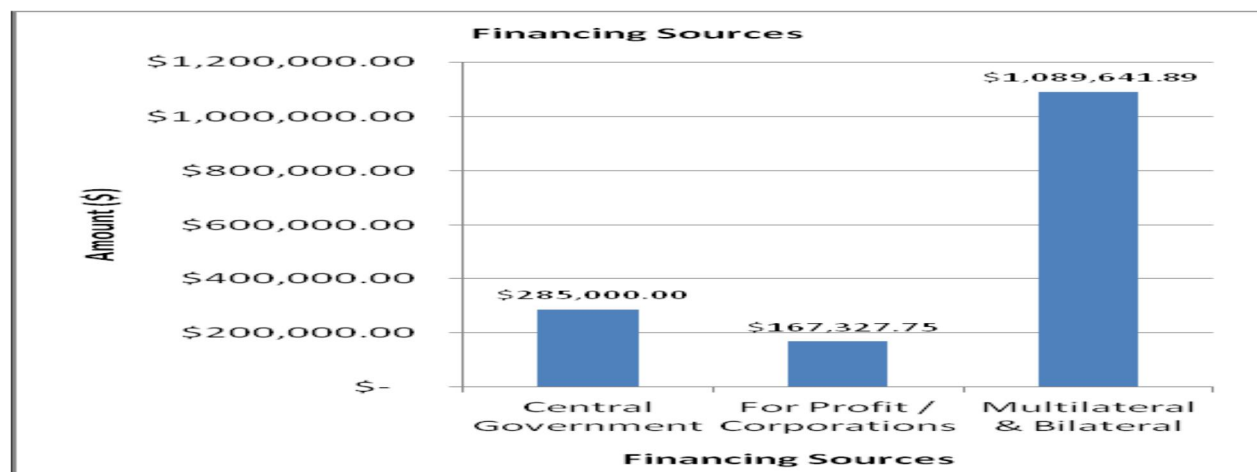


Figure 16: The bar graph above indicates the total amount of funding (financial and non-financial) invested and spent in the HIV response by different financial sources.

<sup>37</sup> Fiji National AIDS Spending Assessment Report, 2012

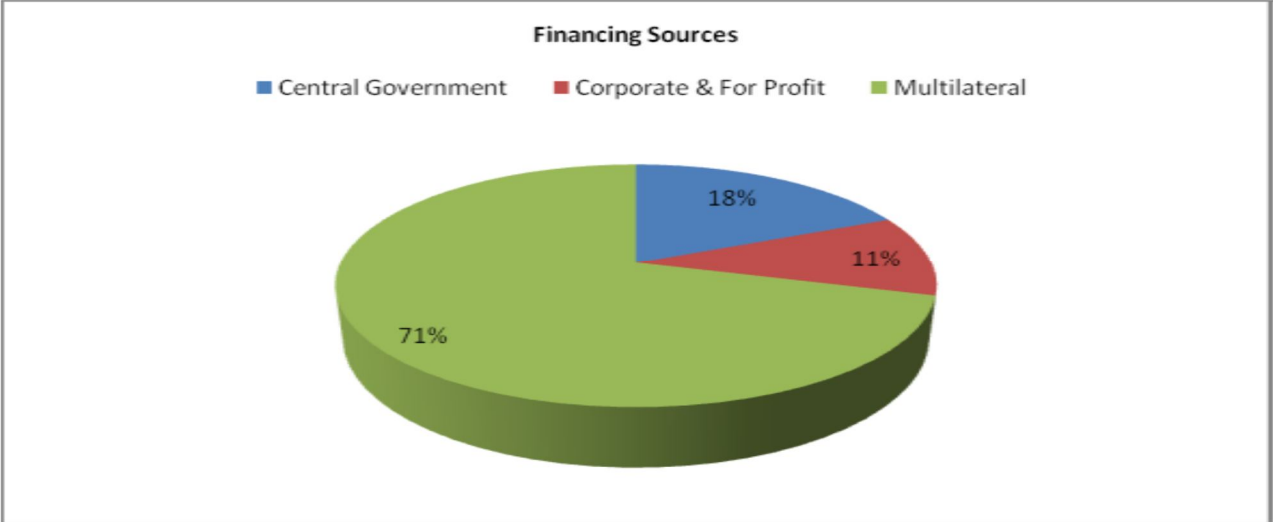


Figure 17: The pie chart exemplifies two thirds of investments in the HIV response is sourced from multilateral / bilateral organizations.

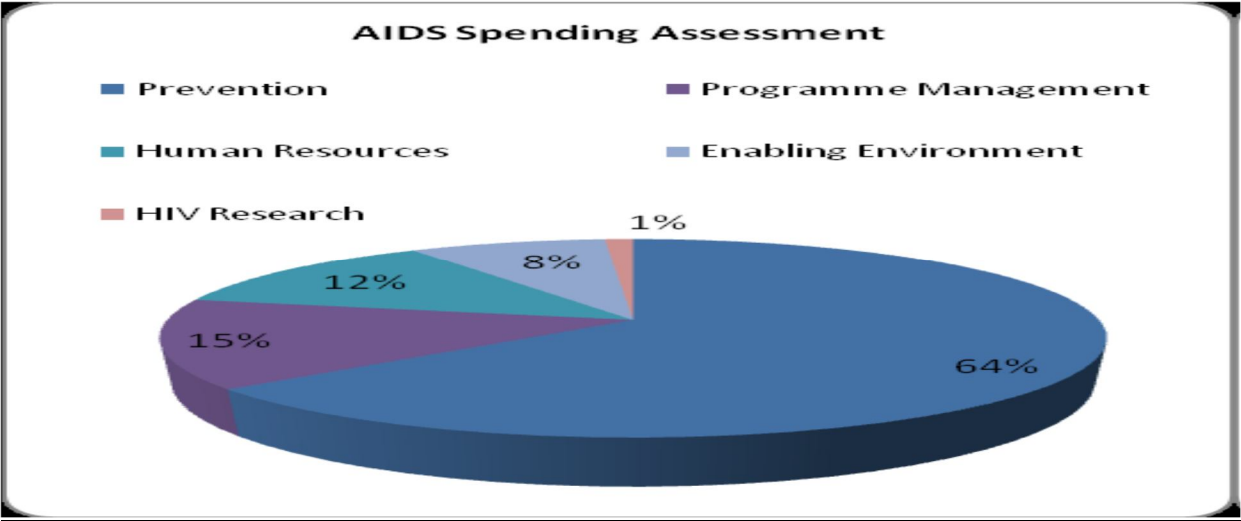


Figure 18: The bulk of expenditure in the AIDS Spending Category is attributed to Prevention. Only 1% of total expenditure is engaged in HIV research



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

Table 2: AIDS Spending Contribution

## Fiji's National Response to the AIDS epidemic:

Prevention is a priority towards the HIV response in Fiji. This can be clearly shown as well in figure 18 above with the HIV expenditure allocation. The Fiji approach to prevention is a good example of what UNAIDS describes as "Combination Prevention"<sup>38</sup>. This means that prevention programs "deploy a blend of biomedical, behavioral, and structural approaches tailored to address the particular and unique realities of those most vulnerable to HIV infection".

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

Both government respondents and CSOs gave a rating of 5 for the efforts of HIV Prevention in 2013. The similar ratings given by government and civil society partners indicate that there is strong agreement among the partners involved in the HIV response that the implementation of HIV prevention programs has been good in 2013. Both agree that the country is able to identify specific needs for the prevention programs in Fiji. These needs are based on the strategic approach to prevention which includes the following<sup>39</sup>:

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

There is an imbalance between focused prevention for vulnerable groups and more general programs for the whole community. Here in school and out of school youths are targeted, communities, young people during the carnivals and the list goes on.

There has been increased emphasis on prevention through workplaces and organizations and events. The Ministry of Labor with BAHA and Fiji Red Cross has been actively involved in the prevention programs for workplaces. This also includes a familiarization program on

---

<sup>38</sup> Piot P, Bartos M, Larson H, Zewdie D, Mane P. Coming to terms with complexity: a call to action for HIV prevention. *Lancet*. 2008 Sep 6;372(9641):845-59.

<sup>39</sup> Prevention Strategic Approach, National Strategic Plan for HIV & STI 2012-2015, Ministry of Health, Fiji.

activities carried out in the hub centers, involvement of PLHIVs in the training and also the development of HIV in the Workplace Policy for each participatory organization.

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

The concept of “Greater involvement of people living with HIV” is applied within all programs. HIV implementing organizations including the schools and FBOs involve people from the national network of people living with HIV (FJN+) in their outreach and education work. Currently, there are 3 HIV advocates based in the 3 hub centers in the country that are being paid by the Ministry of Health as support personnel to the Ministry for PLHIVs. This is an agreement between FJN+ and MoH which is annually renewed on the basis that performances by the advocates are satisfactory. Although there are advocates in the hub centers, there is a need for capacity building.

Condoms are increasingly available in many locations including clinics, stores and nightclubs and are promoted in most education sessions conducted by peer educators and also health care workers during outreach programs. There are plans to install condom dispensing machines in academic institutions as part of the condom campaign and HIV preventative program.

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

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

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

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

- Male and female students from three Fijian tertiary institutions at 50% and 52% respectively.
- 20 to 24 year old seafarers at 34.1%
- 20 – 24 year old uniformed services personnel at 44%
- 15 – 19 year old pregnant women attending ANC clinics at 13.3%
- 20 – 24 year old pregnant women attending ANC clinics at 44.9%
- 15 – 19 year old male and female STI clinic attendees at 53.9% and 100% respectively
- 20 – 24 year old male and female STI clinic attendees at 53.7% and 52% respectively

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

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

Since prevention is a cornerstone for the HIV response, sex workers are seen to be part of the most at risk group.

#### *Sex workers*

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

Sex workers include women and transgender. They mostly live and work in urban centres, though the 2009 research by McMillan et al on sex work in Fiji noted that there are some sex workers in rural areas and some travel to and from urban areas. Ethnic Fijian [I-Taukei] sex workers are better networked and more easily accessible through outreach preventative programs and other services than Indo Fijian sex workers. Migrant Chinese sex workers in Suva form a distinct community of their own – these workers seldom speak more than rudimentary English and no Fijian, nor do they access local HIV and STI prevention resources<sup>40</sup>.

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

*[The Survival Advocacy Network \(SAN\)](#)*, which is affiliated with Women’s Action for Change and formally established by the Australian sex worker network [Scarlett Alliance], works with both women and transgender sex workers. SAN has volunteers in all three divisions. They provide support to both full time sex workers and “dabblers”, who as the name suggest do sex work from time to time when they need money. SAN provides support to sex workers through weekly meetings, and outreach at night at the locations where sex workers are operating. There has been no official estimate of the sex worker population in Fiji. However, SAN estimates that they are reaching up to 100 sex workers in the western division.

*[The Pacific Rainbow Group](#)* is affiliated with the then PCSS [now Empower Pacific] and runs the Sekoula Project, which is funded by the Response Fund. The Sekoula project was initially funded by the Pacific Regional HIV Project and began in 2008 by establishing a Drop-in Centre or safe space for sex workers to meet. Sex workers from three towns in the Western Division, Ba, Lautoka and Nadi met once a week on “flower days” to exchange information and discuss issues of concern. Field workers employed by the project conducted outreach to sex workers on the street to provide information and condoms and lubricants, invite them to “flower days” and provide referrals to the empower pacific, counseling and social welfare services as needed<sup>42</sup>.

*[Rainbow Women’s Network \[RWN\]](#)* is a grass roots group that had developed locally with no external support. This group is driven by the local community. It has sourced a little in the way of small grants from local community funders to pay for workshops but otherwise there has been no external funding. For this reason, HIV/STI programs cannot be sustained and prevention programs including condom distributions are on ad hoc basis.<sup>43</sup>

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

---

<sup>40</sup> Karen McMillan and Heather Worth, 2010. Risky Business: Sex Work and HIV prevention in Fiji.

<sup>41</sup> Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013

<sup>42</sup> Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013

<sup>43</sup> Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013

Introduction of the Crimes Decree in February 2010, changed the landscape for sex work and the networks support sex workers to reduce their risk of HIV and STI infection. Sex work was illegal in the Penal Code that was replaced by the Crimes Decree. Sex work continues to be illegal in Fiji. There are two notable changes between the Penal Code and Crimes Decree. The first is that the term “prostitute” has been expanded to include not just females but also males and transgender sex workers. The second notable change is that clients of sex workers can now be prosecuted if they seek and/or use the services of a sex worker or make arrangements to do so. Sections 230-231 of Part 13 of the Crimes Decree describe the sex work offences as<sup>44</sup>:

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

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

Male, female and transgender sex workers operate in Fiji. The numbers of sex workers have not been determined, but they mostly work in the urban centres of Suva, Lautoka, Nadi and Labasa. Risk reduction services provided to sex workers by peer networks associated with CSOs have made sex workers knowledgeable about HIV related risk and means of protection. Many practice safe sex with their clients although the clients resist condom use. They do not however, practice safe sex with non-commercial intimate partners. The Crimes Decree introduced in 2009 has made it more difficult for sex workers to access risk reduction services, including condoms. The risk of sex workers and their clients to HIV and STIs infection has heightened with the introduction of the Crimes Decree.

#### *Men who have sex with men (MSM):*

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

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

---

<sup>44</sup> Sections 230-231 of Part 13 of the Crimes Decree, Crimes Decree 2009, Government of Fiji

ways to establish partnerships and outreach work amongst these networks and institutions. MENFiji is associated with the Pacific Sexual Diversity Network.

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

### *People living with HIV:*

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

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

It is important to acknowledge that people living with HIV are not a homogenous group, and that their risk of re-infection or their access to prevention services may be more influenced by sub-group they belong to than by the fact that they have HIV. For example, a transgender with HIV may be uncomfortable using the health service like other transgender, even though other PLHIV who are in contact with the health services are comfortable with using the services. For this reason, FJN+ had also established a support group for PLHIV MSM targeting the MSM who were HIV infected.

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

### *HIV Testing and Counseling Services:*

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

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

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

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

### *Prevention of Parent-to-Child-Transmission of HIV Services:*

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

The initial partnership between EP and the MOH that sparked the start of the counseling and testing program has expanded from a pilot program in one hospital that reached about 1,300 and is now established in the three divisional hospitals and the sub divisional hospitals. Empower Pacific has also trained over 200 nurses in counseling, many working in the sub-divisional and health center level. In the antenatal clinics that do not have EP/MOH partnership, the nurses with counseling training facilitate the HIV testing.

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

All pregnant women who test HIV+, including those who have an indeterminate HIV test result are provided with ARV prophylaxis.

The PPTCT counseling program began a new initiative to promote further involvement of men in reproductive health, which has potential to substantially improve women's ability to plan pregnancies and adopt a range of options to reduce potential of mother to child transmission. This program with Empower Pacific is known as Men as Partners.

### *Treatment, Care and Support:*

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

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



The treatment, care and support program was rated seven out of 10 by both civil society and government in the NCPI. It cannot be seen as perfect but there is always room for improvement.

### *Antiretroviral Therapy*

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

There has been a significant scaling-up of the ART program in the last couple of years. At the end of 2009, 48 PLHIV were receiving ART from the three Hubs Centres around the country. In 2010 and 2011, an additional 28 people had started ART, bringing the total to 76. By the end of 2013 there were 172. All eligible PLHIV who are in contact with the health care system are on therapy or being worked up to start on therapy.

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

- a. Training and development of multidisciplinary core teams consisting of a doctor, nurse, one or more volunteers and a full time HIV Advocate, a person living with HIV (appointed by FJN+) for each Hub Centre. This provides a more holistic approach to treatment, care and support. In addition, OSSHHM has sponsored 3 medical officers' clinical placements in PNG and also mentoring programs in country.
- b. With the assistance of the HIV+ advocate who travels with the outreach team to provide HIV education, community members have begun to acknowledge the reality of HIV and also be encouraged to have a HIV test since treatment was available if they were diagnosed positive.
- c. Following WHO guidelines, the threshold for ART eligibility has been increased from 350 to 500 CD4+ cell count, which has increased the number of eligible patients. Additionally, All HIV+ children less than 5 are started on ART. The ART for children is no longer dependent on their CD4+ count though dependent on age and eligibility for the older kids.
- d. Constant reliable CD4+ testing is now available at Mataika House Reference Laboratory
- e. Psychosocial support for PLHIV through the hub centers has been improved by the provision of counseling services through EP.

Antiretroviral drugs are provided free, and funded by the Government of Fiji. Fiji is the only Pacific Island country that is currently funding ART for all people living with HIV and also all opportunistic infections are provided free of charge with the exception of a few when OI drugs are out of stock. Many PLHIV cannot afford to pay for the medications. FJN+ assists PLHIV who cannot afford OI medications with the cost of the medications through their hardship grants when the need arises.

### *HIV & TB:*

HIV testing and counseling for people with TB has been established and all PLHIV are screened for TB. In 2012 and 2013, 9 TB/HIV co-infections were detected and enrolled in TB and ARV treatment programs.

To strengthen the TB/HIV management, a policy has also been developed to guide clinicians and health care workers in the management of HIV with TB co-infections and for collaborative work.

### *Psychosocial support for PLHIV and their families:*

One of the primary objectives of Fiji Network for HIV+ people is to provide support, including psychosocial support for PLHIV. FJN+ organizes monthly meetings in the three divisional capitals – Suva, Lautoka and Labasa – for the members. Issues of concern are discussed at these meetings. If individual members have specific support needs the FJN+ Care and Support officer meets with them separately and determines what kind of support is required which facilitates access for the member. A key problem for many of the members is lack of employment and income especially with the level of education that they have. The Care and Support Officer has facilitated access of unemployed FJN+ members to the social welfare benefit provided by the Ministry of Social Welfare. In addition, with the assistance of FCOSS, FJN+ members have been trained and are also encouraged to enroll in small business programs. FJN+ has 6 members enrolled to start their generation income.

The treatment, care and support program is rated as 60%. This is slightly lower than the 2012 rating. Although it is established and regarded by government, civil society partners and the beneficiaries of the services provided, this area needs strengthening. There is a possibility that there may be PLHIV who are not in touch with the health care system who need treatment. Every effort must be made in the near future to encourage them to access treatment.

## **Best practices**

### **The HIV/AIDS [Amendment] Decree 2011**

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

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

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

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

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

### PPTCT Program

Provider initiated counseling and testing (PICT) of pregnant women has been successfully established as part of the prevention of parent-to-child-transmission of HIV (PPTCT) program in Fiji. All pregnant women are offered an HIV test at their first antenatal visit, together with other health checks. While other health checks such as measurement of weight and blood pressure and tests for syphilis and Hepatitis B – are mandatory, the HIV test needs to be provided with informed consent and counseling, as mandated by the HIV Decree 2011. In busy antenatal clinics with many patients and few staff, it is difficult for the overworked nurse(s) to spend an extra half hour to provide pre-test counseling to each pregnant woman. With the assistance of EP, they have provided counselors to provide either a one-to-one or group counseling before HIV screening is conducted [provided a patient consents].

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

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

In recognition of the role that male partners play in the risk of pregnant women to HIV/STI, EP has also included the men as partners program to accommodate male partners and

spouses of pregnant women. EP has noted an increase in male partners accessing ANC with their wives and female partners.

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

## **Major Challenges and Gaps:**

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

- a. There is a need for CSOs to collaborate more and discuss on implemented activities for the HIV response especially when resources are limited.
- b. Limited friendly facilities to address the needs of key populations especially for sex workers. Although desensitization programs has been conducted through the sex workers network and the academic institution [FNU], through the survey conducted by McMillan & Worth [2010] there is a need to have health facilities to address these specific population.
- c. Sex work is still criminalized by the Crimes Decree 2009.
- d. The main source of funding for the HIV response in Fiji is the Pacific Response Fund, which has come to an end in 2013. Finance will be a challenge especially in operationalizing activities for example, retaining of human resources to implement planned activities as experienced by Empower Pacific including the sustainability of the counseling services in hospitals as part of the PPTCT program.
- e. The main challenge faced by CSOs is addressing values and having the capacity to lobby and advocate for prevention programs successfully through FBOs, traditional leaders and parents.

- f. Many people with HIV infection do not present for HIV testing until late in the infection. These individuals are often quite ill and have a high mortality risk.
- g. Fiji's classification as a middle income country in 2009 prevents it from meeting the basic criteria for accessing funding from the Global Fund
- h. The economic growth rate in the country has gone from -1.3% in 2010 to 1.9% in 2012. In this economic climate, it may be difficult for government to provide more funding for the HIV response.

### **Support from the Country's' Development Partners**

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

### **MONITORING and Evaluation Environment:**

Although there is an M&E framework in place for 2012-2015, the implementation of this framework needs to be strengthened. With the establishment of the M&E technical working group and the recruitment of the surveillance officer, centralization of the management of data and monitoring of the HIV response will be strengthened. In return, Fiji will also be in a better position to identify strategic implementations and respond strategically to the epidemic in response to HIV and also STI's.

## General Remarks:

Fiji has come quite far in its response to HIV in Fiji since 1989 to 2013, and has seen an improvement in the way things are done at all levels. There is more recognition and support for the HIV program at all levels. There has been:

- advances in treatment and care of PLHIV
- early detection of HIV
- reduction in stigma and discrimination
- accessibility of SRH services for PLHIV
- excellent laws in place to protect the rights of PLHIV and those affected by it
- strengthened core teams around the divisions
- policies and legislations in place
- standardization of reports for HIV with involvement of ministries health information system
- Improved collaboration with partners either amongst the civil society organizations or with UN agencies.

There is a continual need for Leadership, Partnership and Ownership of the HIV Response in Fiji, without this commitment we will not go far. It needs collaborative efforts at the strategic and implementation level. Much is yet to be done.

**Together we can make a difference.**

## REFERENCES

1. UNAIDS & WHO Epidemiological Estimates, Fiji 2012: accessed online on 13<sup>th</sup> March, 2014 at <http://www.unaids.org/en/dataanalysis/knowyourepidemic/epidemiologypublications/>
2. Fiji Ministry of Health, December 2013, Centre for Communicable Disease Control
3. HIV Testing & Counseling Policy, Ministry of Health Fiji, 2013
4. Fiji TB/HIV Collaborative Policy, Ministry of Health, 2013
5. Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015
6. Prevention Strategic Approach of the National Strategic Plan for 2012-2015, Fiji National Strategic Plan on HIV & STIs 2012-2015
7. Fiji HIV/AIDS [Amendment] Decree 2011; Part 4 Section 27
8. VCCT Training Report, Empower Pacific, 2013
9. Fiji Geography, Infoplease 2013: accessed on line on 24<sup>th</sup> March 2014 at <http://www.infoplease.com/country/fiji.html>
10. Population by Age 2007 Census, Fiji Bureau of Statistics, 2013: accessed on line on 27<sup>th</sup> March 2014 at <http://www.statsfiji.gov.fj/index.php/chart-gallery/209-population-by-age-2007-census>
11. Fiji Facts & Figures, Infoplease 2013: accessed on line on 24<sup>th</sup> March 2014 at <http://www.infoplease.com/country/fiji.html?pageno=4>
12. Economy, Fijian Economy 2013: accessed on line on 24<sup>th</sup> March 2014 at [http://www.fijihighcommission.org.uk/about\\_3.html](http://www.fijihighcommission.org.uk/about_3.html)
13. MDG's, Fiji Annual Program Performance Report 2011, AusAid
14. Fiji Facts & Figures, Infoplease 2013: accessed on line on 24<sup>th</sup> March 2014 at <http://www.infoplease.com/country/fiji.html?pageno=4>
15. Achieve Universal Primary Education; Millenium development Goals Fiji National Report, National Planning Office, Ministry of Finance and National Planning
16. MDG Performance, Fiji Ministry of Health Annual Report, 2012
17. NCD Health Outcome Performance Report, Fiji Ministry of Health Annual Report, 2012
18. Proportion of Ministry of Health Budget against National Budget and GDP, Fiji Ministry of Health Annual Report, 2012
19. Organization Wide Challenges, Fiji Ministry of Health Annual Report, 2012
20. 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the "Ten Targets" in Fiji Islands, 31<sup>st</sup> May, 2013
21. UNAIDS & WHO – Epidemiological Factsheet, Fiji, 2010: accessed online on March 13, 2014 at <http://aidsinfo.unaids.org>
22. 2011 UN General Assembly Political Declaration on HIV & AIDS: Mid-term review report of the "Ten Targets" in Fiji Islands, 31<sup>st</sup> May, 2013
23. Confidential Report: IBBS Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project. Commissioned by UNAIDS Pacific Office and MoH with assistance from FNU.
24. Fiji Ministry of Health, December 2013, Centre for Disease Control

25. Fiji Ministry of Health, December 2013, Centre for Disease Control
26. World Health Organization, 2006: Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries (2004 – 2005), p21.
27. STI Epidemiological Update PICTs 2009. HIV & STI Surveillance, SPC July 2010 & Fiji Ministry of Health, 2008 SGS Report.
28. This section is directly extracted from the Fiji National Strategic Plan for HIV & STI 2012-2015
29. McMillan K, Worth H, Risky Business: sex work & HIV Prevention in Fiji. Sydney, International HIV Research Group, UNSW, 2009
30. Bavungton G, Singh N, Naicker DS, et al. Secret lives, other voices ... a community based study exploring male-to-male sex, gender identity and HIV transmission risk in Fiji, Suva, AIDS Task Force of Fiji 2011.
31. Pacific Islands AIDS Foundation. Experiences and Perspectives of women living with HIV in Fiji and Papua New Guinea. Suva, PIAF/Pacific Islands HIV & STI Response Fund/Commonwealth Foundation, 2011.
32. UNDP. Me, My intimate Partner and HIV: Fijian self-assessment of Transmission risks. Suva, UNDP, 2011
33. Government of Fiji. HIV/AIDS Decree 2011 [Decree No. 5 of 2011]. Suva, Government of Fiji, 2011
34. Section 3-1[a], Guiding Principles, HIV/AIDS [Amendment] Decree 2011. Government of Fiji, 2011
35. The following section is extracted from the "Approach of the National Strategic Plan for 2012-2015." National Strategic Planning for HIV & STI, 2012-2015. Ministry of Health Fiji.
36. HIV/AIDS [Amendment] Decree 2011: Part 2, Section 8 (1a-i)
37. Fiji National AIDS Spending Assessment Report, 2012
38. Piot P, Bartos M, Larson H, Zewdie D, Mane P. Coming to terms with complexity: a call to action for HIV prevention. Lancet. 2008 Sep 6;372(9641):845-59.
39. Prevention Strategic Approach, National Strategic Plan for HIV & STI 2012-2015, Ministry of Health, Fiji.
40. Karen McMillan and Heather Worth, 2010. Risky Business: Sex Work and HIV prevention in Fiji.
41. Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013
42. Karen McMillan and Heather Worth, 2010. Risky Business: Sex Work and HIV prevention in Fiji.
43. Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013
44. Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013
45. Sex Work and HIV/STI Prevention in the Pacific Region, SPC, 2013
46. Sections 230-231 of Part 13 of the Crimes Decree, Crimes Decree 2009, Government of Fiji