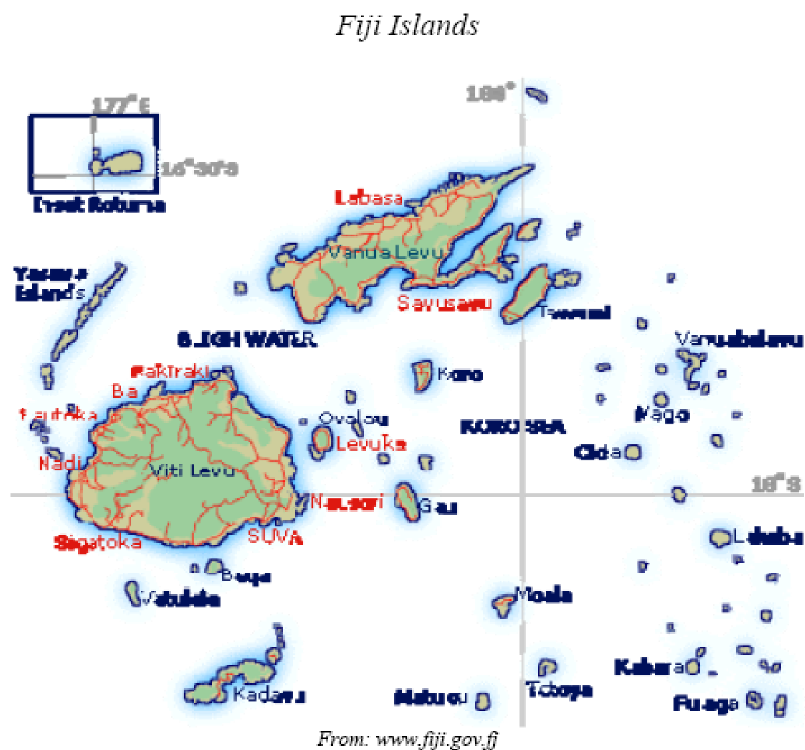
UNGASS 2008 COUNTRY PROGRESS REPORT

Fiji

Reporting period: 1 January 2006 – 31December 2007



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Submission date: 31 January 2008

Acronyms and Abbreviations

AIDS	acquired immunodeficiency syndrome
ATFF	AIDS Task Force Fiji
ARV	Antiretroviral
FWRM	Fiji Women's Rights Movement
HIV	human immunodeficiency virus
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MSM	men who have sex with men
NACA	NACA
NASA	national AIDS spending assessment
NCPI	national composite policy index
NCM	national coordinating mechanism
NGO	non-governmental organisation
PLWH	people living with HIV
PMTCT	prevention of mother-to-child transmission
RFHAF	Reproductive Family Health Association Fiji
SGS	second-generation surveillance
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCCT	voluntary confidential counselling and testing
WAC	Womens Action for Change

Table of Contents

Acronyms and Abbreviations 2
Status at a glance 4
Overview of the AIDS epidemic 10
National response to the AIDS epidemic 11
Best practices 13
Major challenges and remedial actions .... **Error! Bookmark not defined.**
Support from the country's development partners 16
Monitoring and evaluation environment 16
References 16
ANNEXES 16
ANNEX 1: Consultation and Preparation Process 17

Status at a glance

Inclusiveness of the Stakeholders in the Report Writing Process

The compilation of this country report was done by a core group comprised of the NACA (National Advisory Committee on AIDS) Secretariat - MOH, technical advisers from the Secretariat of the Pacific Community and logistic facilitation from the UNAIDS office in Suva. The report process was preceded by a training on M&E, and establishment of the national M&E framework for the national HIV/AIDS strategies. The core group collected information through desk review, surveillance and survey reports, interviews with key persons, and a consultation workshop of NGOs where they focused on Part B of the NCPI[1]. The main stakeholders from government, civil society, and development agencies were brought together to review and endorse the UNGASS report in its entirety. Fiji's Minister for Health, Women and Social Welfare was subsequently briefed and requested to sign the final document.

Status of the epidemic in Fiji

Fiji has a cumulative figure of 259 HIV positive cases (from year `1989 to December 2007)[2], therefore classified as low prevalence under the WHO classification. Graphs 1 and 2 show the trend in the progression of HIV. From 1989 in the next decade or so, Fiji has passed the slow burning stage of the disease. The trend now is that in the past four to five years, Fiji is in the escalating phase of the disease. However, these figures only reflect laboratory confirmed and reported cases. These figures may be under-reported due to various factors, including insufficient surveillance, a large number has not presented for testing due to a lack of information, stigma and discrimination.

The number of new infections has levelled of in the years 2006 and 2007. However, it is too early to definitely state that the trend is reversing. Youth continues to be the most affected group, and the Fijian ethnic group still with a disproportionate majority. Heterosexual transmission is the main reported mode of transmission, followed by peri-natal transmission. There is also a tie in with increasing number of female positive cases.

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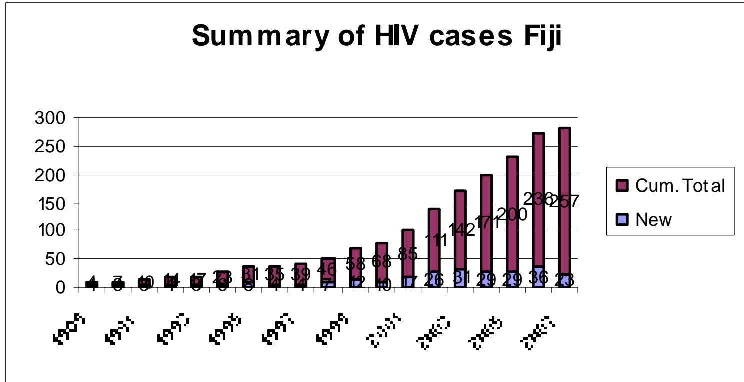
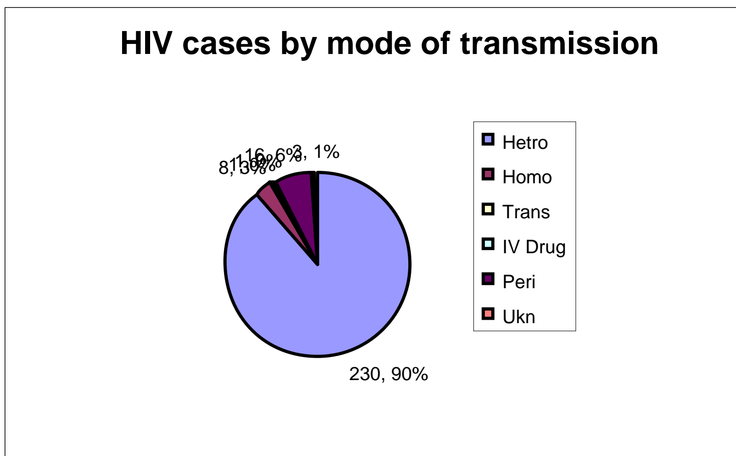
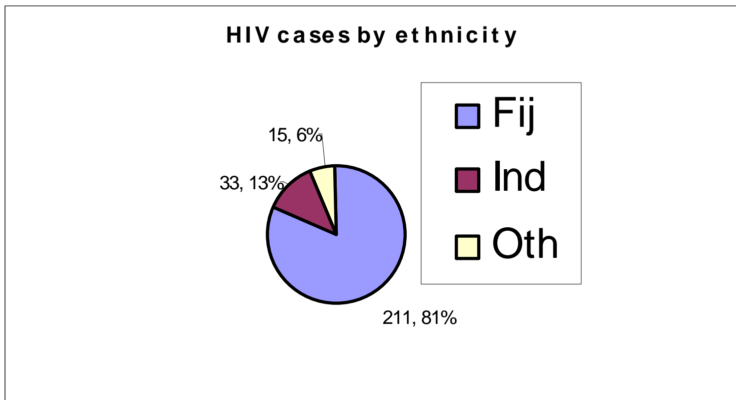
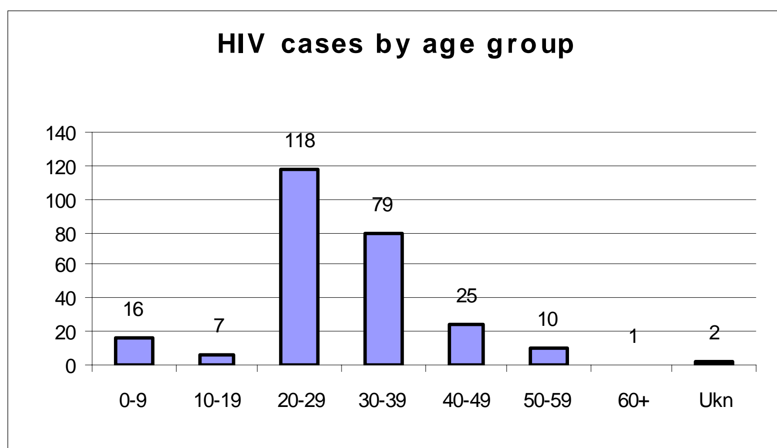
[1] The inclusiveness of Civil Society was limited due to time constraints

[2] Refer to diagram 1


Summary of HIV cases Fiji
300
250
200
150
100
50
0
Cum. Total
New


HIV cases by mode of transmission
Hetro
Homo
Trans
IV Drug
Peri
Ukn
230, 90%


HIV cases by ethnicity
Fij
Ind
Oth
15, 6%
33, 13%
211, 81%



The status of the epidemic in the Pacific Region

HIV infections have now been reported in every country or territory in the Pacific island region, barring two of the smallest countries, Niue and Tokelau. Although the epidemics are still in their early stages in most places, preventative efforts need to be stepped up. [3]

More than 90% of the 11,200 HIV infections reported across the 21 Pacific island Countries and Territories by mid-2004 were recorded in Papua New Guinea where an AIDS epidemic has reached generalised status. Recorded HIV infection levels are low in the rest of the Pacific Island region, and the total number of reported HIV cases exceeds 150 in New Caledonia (246), Guam (173) and French Polynesia (220).

The data provided is based on limited HIV surveillance. The high levels of other sexually transmitted infections, significant high risk behaviour and the high mobility of some most-at-risk groups in some Pacific Island Countries, including Fiji, present a potential for the rapid spread of HIV throughout the Pacific region.[4]

Policy and Programmatic Response

The main document that guides programmatic responses in Fiji is the National HIV Strategic Plan 2007-11 (NHSP). All the main stakeholders were involved in the design and formulation of the strategies in 2006/2007. The NHSP includes an M&E framework and for the first time; it also includes budget estimates. Fiji's M&E framework was developed by a workshop of government and civil society representatives. Taking into account the Millennium Development Goals, UNGASS, Universal Access, ambitious and realistic indicators and targets were identified at country-level, with technical support from the Secretariat of the Pacific Community and UNAIDS Pacific.

[3] UNAIDS website: www.unaids.org/en/Regions_Countries/Regions/Oceania.asp Dec 13, 2007.
[4] SPC website: www.spc.int Dec 13, 2007

There are five subcommittees of NACA for each priority area in the NHSP (I. Prevention; II. Clinical /hospital based activities; III. People living with HIV; IV. Surveillance, Research & M&E; V. Good Governance, Legal Issues & Human Rights). Stakeholders are encouraged to join the subcommittee/s that covers their areas of interest. Sub-committees report to the quarterly NACA meeting. NACA has the national overview of national responses to HIV and AIDS.

The government supports the implementation of the NHSP through an annual Budget allocation, which currently stands at FJD$500,000. This financial assistance is channelled through the Ministry for Health (expanded in January 2008 to Ministry for Health, Women and Social Welfare).

Stakeholders who wish to implement the NHSP can apply to NACA for funding assistance. The Minister for Health is the Chair of NACA and is the link to Cabinet. There are 10 NACA members, including four NGO representatives selected by government and 5 government representatives in addition to the Chair. The number of NACA members was reduced in October 2007 to improve efficiency.

HIV policies are being implemented to strengthen PMTCT and VCCT. The development of national workplace policies is ongoing. The bulk of national resources are channelled into prevention as it is the mainstay of the national response.

Core Indicators for the Declaration of Commitment Implementation (UNGASS)
2008 reporting

Indicators	Data Available and Reported Yes or No	Method of Data Collection
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	Yes	National AIDS Spending Assessment Financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index	Yes	Desk review and key informant interviews
Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Yes	Programme monitoring/special survey
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Yes	Programme monitoring and estimates
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Yes	Programme monitoring and estimates
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Yes	Programme monitoring
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	No	Population-based survey
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	No	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	No	Behavioural surveys
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	N/A	Population-based survey
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Yes	School-based survey
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	N/A	Population-based survey

13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	No	Population-based survey
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No	Behavioural surveys
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Yes	Population-based survey
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	No	Population-based survey
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	No	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No	Behavioural surveys
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	N/A	Special survey
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	N/A	Special survey
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	Yes	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	No	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Yes	Programme monitoring
25. Percentage of infants born to HIV infected mothers who are infected	Modeled	Treatment protocols and efficacy studies

*Millennium Development Goals indicator

Overview of the AIDS epidemic

Data sources: National Statistics from Mataika House (HIV confirmatory laboratory); Hub Center reports to NACA; Report of HIV Estimation workshop Nov. 2007

Trend analysis

For the past six years, there has been an average of 29 new HIV cases annually. A bright picture this would appear, however, if this is just the tip of the iceberg than this is indeed worrying. Fiji needs to continue prevention efforts to remind the populace that HIV has not reached a crisis situation but it could very soon if risk behaviours are not curtailed.

The continuing high incidence of STIs like syphilis and gonorrhoea is a more reliable proxy indicator of the high prevalence of unprotected sex practices within the community. If HIV is to get introduced into this pool of MARP (STI patients) then this would spell disaster for Fiji. MARP groups deserve a lot of attention in terms of addressing issues like positive behaviour changes and creating supportive systems and environments.

Mode of transmission

About 90% of HIV cases in Fiji are reported to be acquired through heterosexual transmission. This has to be verified and further researched into this mode of transmission.

It is difficult to gauge the major mode of transmission due to difficulties in data collection. These are some of the contributing factors: alcohol, drugs, coercion, money, and the sensitivity of the diversity of sexuality present a huge challenge.

Research into HIV issues are still in its infancy in Fiji. One way of getting more quality information is through strengthening VCCT services. Fully understanding the problem is the first step to designing a solution to address it!

Sex and age distribution

Males (56%) and young people (20-29 yrs) (45%) are the predominantly affected group. However, the past four years has seen an equal number of female new HIV cases and this could reflect changing views about counselling and testing and also a change in health-seeking behaviour. Understanding Fijis HIV epidemic means understanding the social (and sexual) behaviours of these two groups and this picture is also reflected in the burden of STIs in Fiji. A lot of light could be shed if time and resources are provided to look into the values and behaviours of young people in terms of their vulnerability and empowerment.

Ethnic distribution

Fijians are the predominantly affected racial group (81%). They are also the major ethnic group in Fiji in terms of population. This proportion is also reflected in STI statistics. The implication is that every Fijian must be responsible for addressing this sad picture – no longer does society need to put the responsibility on Fijian leaders – whether in government, civil societies, Fijian institutions, or Christian churches – but the main responsibility must rest on Fijian families and the dominant role parents and guardians play in addressing the wider issues of cultural, social and religious values and morals. Prevention activities must however include the other ethnic groups in Fiji.

National response to the AIDS epidemic

Prevention

Most prevention activities over the past two years have focussed on raising awareness about HIV/AIDS amongst the general population and also for MARPs who are accessible, e.g. uniformed servicemen and women and their families, STI patients through the STI Hub Centres, and young people through the Adolescent Health development programme and Lifeskills at secondary schools. There is a move now to focus on behaviour change and empowerment.

The counselling and testing component was also a focus in terms of mobilising high-risk individuals to present for VCT. This VCT component is routine in STI Hub centres for clients, in uniformed services before departure and also upon return to Fiji, and also for antenatal mothers at the 22 ANC throughout Fiji. The PMTCT component is also implemented at the 3 divisional hospitals where combined obstetricians and paediatricians ensure that protocols and policy are followed.

Treatment

ART in Fiji is currently funded by Global Fund Round 4 and this is ending this year. This will create alarm since Fiji's bid for the Global Fund Round 7 was unsuccessful. This means finding alternate funding sources to continue the ART for the 22 individuals who are currently on treatment. This would mean diverting a portion of the Fiji Government allocation of $500,000 this year to be used for ART procurement in the short term.

Research needs to address the issues of compliance to ART, the provision of OIs and their sustainability.

Care and support

The NGOs have been a pillar of support and strength to HIV/AIDS patients and their families. Support for accommodation, meals, travels and other medications are challenges for the government and NGOs. Legislation and policies are being looked at in terms of ensuring that those affected by HIV/AIDS are not discriminated in anyway because of the positive status. The NGOs and the MOH

also endeavour to work with affected families so that total care is directly provided by the family members but with able support from social and religious groups. The approach is to strengthen the existing social welfare organisations to include the needs of PLHs and their families. We are now establishing a continuum of care framework to address care and support services.

Knowledge and behaviour change

Fiji's BCC efforts have focused on: youth (in and out of school), Fijian communities (village, church groups, women), PLH, prison inmates, and work places. A recent survey amongst young people showed that majority are aware of HIV/AIDS. However, this has not been translated into positive health indicators in that Fiji still has a high prevalence of STIs and teenage pregnancies. The next round of SGS and DHS would hopefully provide meaningful information to gauge Fijis success (or otherwise) in terms of making positive impact on high-risk sex behaviours.

Impact

Current health indicators show that HIV prevention has not really made any impact on rates of new HIV infections and also on STI rates. Sexuality and reproductive health are not topics that are commonly discussed openly and frankly around the family table. If parents (adults) are not comfortable talking about sex openly with their children and who else is there to in form young people about sexuality and positive behaviour.

The best role model should be parents – but if they do not fit into that position and status then it is a sad situation for society. Social gate keepers such as church leaders, community leaders, parliamentarians can play a positive role in promoting positive change and opening up the discourse on sex and sexuality.

Indicator 1: National AIDS Spending Assessment

The sources of funding in the NASA have been extracted from the national Ministry of Health statistics. Limited reporting was recorded from the civil society, represented by a group of NGOs who were concerned about the potential for abuse of their financial data.

Indicator 2 National Composite Policy Index
Please refer Notes on NCPI Part B

Countries should also use the National Composite Policy Index (NCPI) data to summarise progress made in policy/strategy development and implementation, and include a trend analysis on the key NCPI data since 2003 if possible. Countries are encouraged to report on additional data to support their analysis and interpretation of the UNGASS data.]

Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner.]
All blood products donated in Fiji is tested in a quality-assured manner. As a matter of policy, no blood can be donated to another recipient without fulfilling the strict guidelines of a full infectious disease screen for VDRL, hepatitis B and C, HIV, etc.
All 22 hospitals in Fiji have blood donor services backed up by a well equipped laboratory for blood screening tests in fulfilling quality assurance.

Indicator 4 - HIV Treatment: Antiretroviral Therapy - 2007
There are currently 22 cases on HIV treatment out of a total of 28. All these drugs are provided and supervised through 3 Hub Centres and 3 main divisional hospitals. It includes 1 child and 21 adults. ART is currently funded through GF Round 4 and will end in June 2008. Fiji then has to look for alternate funding sources for its ART.

Indicator 5 - Prevention of Mother-to-Child Transmission - 2007
Currently, only 6 mothers are HIV positive and all are on ART for PMTCT. This is being supervised at the main hospital in Suva.

Indicator 6 - Co-Management of Tuberculosis and HIV Treatment
There are only 2 cases of co-infection with TB/HIV that are on treatment and follow-up. All HIV cases are not routinely investigated for TB although the converse is that all TB cases are tested for HIV infection. These co-infected cases are treated at the TB hospital in Tamavua.

Indicator 11 - Percentage of schools that provided life skills-based HIV education in the last academic year
Life skills education is currently taught only at secondary schools although there are discussions to introduce them at primary school level too. This programme started off at few pilot schools and is now being scaled-up to all secondary schools in Fiji.

Indicator 15 - Percentage of young women and men aged 15-24 who have had sexual
intercourse before the age of 15
The recent survey on young people (15-24 yrs) in 2007 showed that about 50% have engaged in sex by the age of 15 years. This is very alarming to everyone – especially to parents and teachers who have the most influential role in educating school children and young people on sexuality and safe behaviours (apart from inculcating moral values)

Indicator 22 - Percentage of young women and men aged 15-24 who are HIV-infected
Over the past six years, the 20-29 year age group has been the most affected in Fiji. This is also reflected in STI prevalence rates. The message needs to

urgently get out to young people of the need to change sex behaviours in order to prevent HIV infection.

Indicator 24 - HIV Treatment: Survival After 12 Months on Antiretroviral Therapy
Over the past 12 months, 22 HIV/AIDS patients out of a total of 28 are still alive after initiation of ART drug treatment. It is hoped that closer supervision and follow-up will improve compliance rate and subsequently survival rates.

Best practices

Professional counselling and testing is a major activity that should be supported and scaled-up to all major centres and health facilities in Fiji. There is the need to make inroads to the MARP in our population so that intervention programmes could be implemented in terms of prevention measures, counselling for safer practices, and early treatment for any infections.

Political leadership needs to be stepped-up in terms of supportive legislation to set up the NACA (Council status) and this would provide a more participatory and representative membership to lead the national response to HIV in Fiji. Currently, much of the administrative work is carried out by the MOH secretariat and this is not ideal in terms of ownership by the wider community. It is still seen as too much vested in government bureaucracy and all its disadvantages.

The NHASP 2007-11 needs to be fully costed at the start of each year to enable all stakeholders to draw up implementation plans for activities. This is not being effectively carried out and consequently much work has not been done in implementing the activities covered under the Plan.

More importantly is the need for a separate M&E unit to oversee the NHASP 2007-11 implementation and also data and information management. There are many indicators under this report that Fiji has not been able to collect because it lacks the system and the resources to collect data and conduct evaluation. There needs to be institutional capacity building and health systems strengthening in M&E and research.

Notes from NCPI 2007 – Part B – Civil Society:

These were challenges and remedial actions identified by civil society representatives while completing the NCPI.

Human rights and Governance

While some most-at-risk populations have been represented in the National Strategic Plan, this has been tokenistic at best. In addition, there is minimal gender and HIV and AIDS coverage in the NSP. Six NGOs who are significant stakeholders were excluded from the Country Coordinating Mechanism during the Fiji Global Fund Round 7 process in July 2007.

Civil society representation on NACA are currently government appointees and therefore not truly representative of civil society in general.

Partnerships

While there is a NHSP, there is no current HIV and AIDS-specific legislation, nor a cohesive single national policy from which the NSP programmes should 'flow'. The WHO is currently drafting the 'HIV and AIDS Prevention' promulgation. A national policy would define the relationship between government and civil society to ensure a holistic national response and counter existing fragmentation.

The 'HIV and AIDS Prevention' promulgation has been drafted by a WHO consultant and is awaiting Cabinet approval.

It is difficult to challenge governance issues when NGOs with views that are divergent from government positions are removed from national committees.

Participation of Civil society and vulnerable groups

The civil society organizations on the NACA were selected by government and therefore are not representative of civil society in general.
There is neither 'open call' nor transparent process for civil society to access funding via the national mechanism.

Six NGOs were excluded from the Country Coordinating Mechanism during the Fiji Global Fund Round 7 process in July 2007. The excluded NGOs were removed for challenging governance practices. However, these NGOs continue to lobby for the adoption and implementation of good governance practices in the national HIV response.

Vulnerable and marginalized groups (i.e. MSMs and sex workers) are not involved in the design and implementation of national programmes.
NACA application processes are not transparent. Representatives of the women's movement applied for membership in mid-2006 but have yet to receive a response from the Ministry of Health.

Weak human rights mechanisms

Inadequate resources and capacity for the Fiji Legal Aid Commission and Fiji Human Rights Commission has resulted in weak provision of services for people infected and affected by HIV and AIDS, and members of vulnerable and marginalised groups.

There is no channel of redress for PLWAs regarding HIV issues.

Treatment

While we are aware that there are three national hub centres, we are not privy to information about the scope and scale of services provided, nor the priority areas identified at district level. This is due to the exclusion of civil society organizations

from the national response since July 2007 after being excluded form the Country Coordinating Mechanism and the NACA. The absence of a Freedom of Information Act exacerbates this problem.

Support from the country's development partners

a) The development partners (SPC, UNAIDS, WHO, UNFPA, UNICEF, ILO, AusAID) have provided technical and financial support. They have been involved in the planning of the national strategies, and conducted training on indicators and M&E. They have been proactive in assisting countries to improve surveillance and to conduct surveys to supplement the information required for the reports. get the stakeholders together and to collectively agree on the relevance of the indicators and their data sources.

Monitoring and evaluation environment

An M&E framework for monitoring the NHSP 2007 to 2011 includes international Indicators which have been extracted from Universal Access, UNGASS and the MDGs. Data sources for collection and staff responsible for collection and Reporting have been identified however surveillance systems need to be strengthened to allow the planned collection of data .

Challenges include human resource capacity (dedicated trained personnel at the Various organizations that do data collection) and financial resources to ensure that the systems in place are functioning, or improved to ensure data is appropriately disaggregated, and reaches the appropriate levels for reporting.

Collection of data from some most at risk populations eg. sex workers, MSM is a challenge. Capacity of NGOs that work with MARPs needs to be strengthened. Technical assistance provided by SPC, WHO, and UNAIDS is very much Appreciated and will continue to be required. Financial resources will be sought from development partners to implement the M&E implementation plan.

ANNEXES

ANNEX 1: Consultation and Preparation Process

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes
b) NAP	No
c) Others (please specify)	No

With inputs from

Ministries:

Education	No
Health	Yes
Labour	No
Foreign Affairs	No
Others (please specify)	Yes – Women's and Youth
No	

Civil society organizations	Yes
People living with HIV	No
Private sector	No
United Nations organizations	No
Bilaterals	Yes
International NGOs	Yes
Others	Yes
(please specify)	Secretariat for the Pacific Community

Was the report discussed in a large forum? Yes

Are the survey results stored centrally? No

Are data available for public consultation? Yes

Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Dr JOSAIA SAMUELA

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