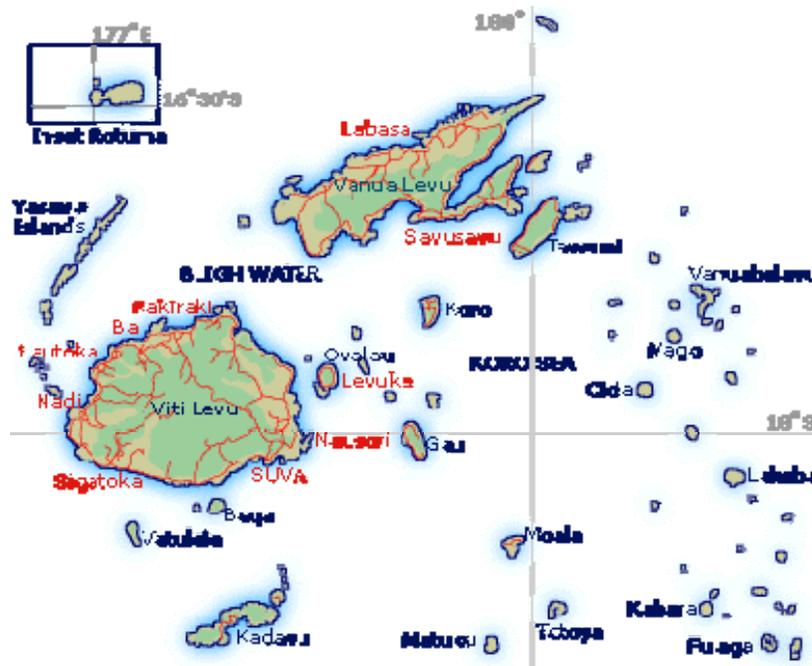




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Reporting Period: *January 2003-October 2005*

Fiji Islands





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Status at a Glance

Fiji consists of some 330 islands, of which about 100 are inhabited. The two largest islands, Viti Levu and Vanua Levu, contain most of the population and in 2004 the population in Fiji was approximately 850,000¹. This is larger than most other Pacific Islands and countries. Overall, Fiji has a multi-ethnic composition, comprising Fijians 54%, Indians 39% and Other 7%. An estimated 20% of the population reside in the capital, Suva. The estimated annual population rate of growth is 0.8%, the fertility rate is 3.3 children per woman and crude birth rate is 20.9 per 1000 population. In 2004, life expectancy at birth was 65 years for males and 69 years for females.

Access to health care is universal. In 2004 there were 17,714 deliveries and almost all births (97%) were in hospitals. In 2004 there were a total of 26 hospitals, 76 health centres and 339 doctors. Fiji is classified by the United Nations as a least developed country and the estimated Gross Domestic Product constant per capita was FJD3384 (\$1,952.40 USD) thousand in 2004². The economy is based largely on agriculture, mining and tourism.

Fiji has achieved the threshold levels of most of the (International Conference on Population and Development) ICPD + 5 goals except for the life expectancy indicator which is supposed to be 70 years in 2005. Fiji's life expectancy from birth is 66.6 based on the 1996 figures of the Ministry of Health. The current population growth rate was reported to be around 0.8 per cent while natural population growth rate in 1999 was 2.5 per cent. Migration and unreported deaths were given as explanation in the discrepancy in these numbers. The total fertility rate is 3.26 per cent while contraceptive prevalence rate is 43.5 per cent but this does not include those clients attended by private practitioners or those who get their supplies from non-government outlets. Infant mortality rate is 16.18 per cent while maternal mortality ratio is 38/100,000 live births.

The World Bank classifies Fiji as a lower middle-income country. Around 25 per cent of households live below the poverty line due to the uneven distribution of income. An additional one third of all households are highly vulnerable to poverty as a result of the flatness of the income distribution at this point (Fiji Government and UNDP, 1996). This 1996 study found that chronic illness or disability of an adult family member is often the cause for a vulnerable household to fall into poverty.

HIV/AIDS

Fiji recorded their first four cases of HIV in 1989, three being males and one being female. In the ten-year period between 1989 and 1998, Fiji had a total of 46 people

¹ www.statsfiji.gov.fj. Accessed September 2005

² www.spc.int/prism/economic/nataccts.html. Accessed October 2005



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diagnosed with HIV infections, an average of approximately 5 persons per year. In the five-year period between 1999 and 2003, a total of 96 new cases have been diagnosed with HIV, with the two highest figures being 26 in 2002 and 31 in 2003. As of May 2004 reported cases have increased to 156 - 60 % males. 82 % are indigenous Fijians. 78 % are between the ages of 20 – 39 years. 85 % of all the infections are through heterosexual relationship, with 7 % perinatal and 5 % through homosexual relationship. Given that testing is on a voluntary basis, these figures may only show the tip of a much larger pool of infections. The Ministry of Health believes there could be as many as 2,000 undiagnosed cases of HIV within Fiji.

In 2004 there were 40 adults and children living with HIV and 20 reported cases of new infection. The number of new cases reported each year has increased for the last 5 years and in response to this the government has begun to take initiatives towards prevention of its spread and identification and treatment of those affected. The adult prevalence in 2004 was 9.8 per 100,000 population aged 15-49 years. The number of deaths due to AIDS is not routinely available or reliable as cause of death due to AIDS/HIV infection is often misclassified or not recorded on death certificates for various reasons.

Overview of the AIDS Epidemic

UNGASS concentrated low prevalence core indicators

Core Indicator 3: Percentage (most-at-risk populations) who received HIV testing in the last 12 months and who know the results

Between 2003-2005 three SGS surveys were conducted in Fiji, one among STI clinic attendees, one among women attending antenatal clinics and one among uniformed services. As of November 2005, only data from the uniformed services study is available.

A total of 257 adult males were recruited from three survey sites in Fiji. Based on the inclusion criteria, participants where age was not stated and who were aged 50 years and older were excluded from final analyses. The final survey population comprised of 225 adult males, of who 72 (32.0%) were policemen and 153 (68.0%) were military personnel.

Participants' ages ranged from 19-49 years (mean 36.2 years, standard deviation 7.9 years), with 66.7% (150) of men aged 34 years and older. More than 72% of participants were from the capital city or urban villages. The majority of men (67.1%) attended secondary school and 28.4% had attended university or college. Less than half the men reported being away from home for more than one month in the last 12 months. Christianity was the predominant religion among the participants who were predominantly (80%) Fijian. Three quarters of men were married and currently living



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with their spouses. The median age at first marriage was 26 with a range from 15 to 42 years. Only 6 (3.2%) men reported they had more than one wife.

% of (most at risk populations) who <u>ever</u> received HIV testing in the who know the results³	Police & Military	28.4*
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**Explanation – The only HIV Testing done for the Military is with active duty personnel that have to perform their duties overseas as a requirement in the International UN system. The Police are not routinely screened for HIV on recruitment or even while in the Police Force.*

Core Indicator 4: Percentage (most-at-risk populations) reached by prevention programmes

As of November 2005, data for the UNGASS indicator is not available due to difficulties in obtaining data from multiple sites.

Core Indicator 5: Percentage of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

In the behavioural prevalence survey of risk behaviours related to HIV and/or STI infection in 257 male military personnel and policemen, a low level of knowledge of HIV protection methods was observed among men. Only 71 (31.6%) men had correct knowledge of HIV protection. A slightly higher proportion (46.7%) had the correct knowledge about HIV transmission. Only 19.1% of men had both correct HIV protection knowledge and HIV transmission knowledge. Approximately a quarter of participants (23.6%) had accepting attitudes to those with HIV infection.

% of (most at risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission⁴	Uniformed Services	24.4%
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³ UNGASS indicator was 'HIV testing and know the result in the last 12 months'. Data collected for this survey was 'ever' tested for HIV and knew the result.

⁴ Data not collected on transmission through sharing a meal. Indicator constructed using the following collected questions: condom protection; faithful partner; mosquito bite; Healthy looking person with HIV.



groups at higher risk of HIV infection. In particular, caution should be used in interpretation of the HIV prevalence results in Fiji due to difficulties in obtaining adequate sample sizes in small island states. Consideration of the necessary sample sizes required to reliably detect HIV prevalence in low prevalence settings should be given to future surveys. Approximately 40,000 HIV tests are done in Fiji every year, but data on testing to date has not been disaggregated by sex and risk group.

Table 1: Distribution of cumulative reported HIV cases by sex and mode of transmission in Fiji, end of 2004

	Fiji 1989-2004 – (correct figures)	Fiji cases in 2003 (correct figures)	Percentage of total HIV cases in 2004 (Correct figures)	HIV Cases 2005
Sex				
Male	101	18	13	16
Female	70	13	16	13
Unknown	0	0	0	0
Mode of transmission				
Homo/bisexual	7	0	0	0
IDU	1	0	0	0
Heterosexual	147	28	26	26
Blood products	1	0	0	0
Mother to infant	13	3	3	2
Other/unknown	2	0	0	1
TOTAL				

Source: MOH statistics Jan 2006

UNGASS generalized epidemic core indicators

Core Indicator 6: Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission

Of the 17, 714 women who delivered a baby in 2004, four (4) of these women were HIV positive, with only one (1) of these women receiving anti-retroviral prophylaxis to reduce the risk of mother-to-child transmission of HIV.

Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission
25.0%



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Core Indicator 17: Percentage of infants born to HIV infected mothers who are infected

There are currently 2 HIV positive babies, and 4 children are still being followed up by Ministry of Health Pediatricians because they are still less than 2 years of age.

Fiji now has a PMTCT Policy as of Jan 2006, after the endorsement of the National Executive Committee. The three health service divisions will have to operationalise this PMTCT Policy in terms of offering VCCT to all antenatal mothers that come in for ANC screenings in all health facilities. The challenge is now for the three health service divisions to create supportive environments and facilitate logistics in providing PMTCT as their core business to remote and dispersed communities.

National Response to the AIDS Epidemic

UNGASS concentrated low prevalence core indicators

Core Indicator 1: Amount of national funds disbursed by governments in low- and middle income countries

Government has doubled its budget allocation for the implementation of the National HIV/AIDS Strategic Plan from \$150,000 FJD (\$86,542USD, 1 FJD = 0.576950 USD) in 2003 to \$300,000 FJD (\$173,085 USD) in 2004 and has further increased this allocation to \$500,000 FJD (\$288,475 USD) for 2005 and the same amount for 2006.

Core Indicator 2: National Composite Policy Index

An important feature of Fiji's programme is the commitment of its leaders to publicly declare their support for the HIV/AIDS prevention programme particularly to people living with HIV/AIDS. Church groups have also mobilized their congregations to provide care and support for people living with HIV/AIDS. Particular emphasis has been placed on prevention activities with young people to prevent the spread of the infection. Strengthening the capacity of leaders at all levels is a crucial issue that is being addressed through the support of NGO partners and the private sector.

The National HIV/AIDS Strategic Plan 2004 - 2006

In recognition of the gloomy situation for HIV/AIDS with the potential for crisis development, a call for a comprehensive multisectoral response to focus on prevention, care and support for people living with HIV/AIDS was championed by NACA culminating in the formulation of the HIV/AIDS Strategic Plan 2004-2006. The



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Plan was developed through a multi-sectoral collaboration and consultation and with more attention directed to care and treatment.

The ***National Advisory Committee on AIDS (NACA)***, chaired by the Honorable Minister for Health is the main coordinating body of the HIV/AIDS programme in Fiji. It reports directly to Cabinet. Members include all major stakeholders in the Government, Tertiary Institutions, Private Sectors, Civil Societies including the Church. Government is in the process of revising the status of NACA to that of a Council with its mandate, staff and statutory authority. NACA co-ordinates the formulation of the country's HIV/AIDS Strategic Plan, mobilization of resources, monitoring of the implementation of the programme and conduct evaluation as appropriate. The implementing partners are the stakeholders from both the Government and NGOs, civil societies, the private sector, church and community leaders.

HIV/AIDS Policy. An Interim HIV/AIDS Policy of the Ministry of Health exists and provides the guideline for the HIV/AIDS programming. The Military, Prison and the Private sector are other sectors that have developed HIV/AIDS Policies and are in various stages of development. The Ministry of Labour and Industrial Relations has developed a “Code of Practice on HIV/AIDS in the Workplace” receiving its authority from the Constitution of the Republic of the Fiji Islands and the Industrial Relations Bill. The Industrial Relations Bill 2004 states:

No person shall discriminate against any employee or prospective employee on the grounds of ... state of health including real or perceived HIV status ... in respect of recruitment, training, promotion, in terms and conditions of employment, termination of employment or other matters arising out of the employment relationship.

Establishment of HIV/AIDS Hub Centre

- The Ministry of Health has established a Hub Center to facilitate treatment, care and support for People Living With HIV/AIDS (PLWHAs).
- The Center is an initiative to provide greater access of HIV infected individuals to information, counseling, technical assistance by trained staff and most importantly treatment with anti retroviral regimens.
- The Center is staffed with professionals, allied health workers from NGOs and PLWHAs who have been trained to provide quality care and treatment of HIV infected individuals.

After a 12 month pilot of the HIV treatment Hub centre in Suva, a review was done which recommended the roll out of HIV treatment, care and support to the west and



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northern regions of Fiji. Two additional HIV Hub centres were opened in Dec 2005 and they are also commencing HIV treatment programmes.



The following table highlights results from the National Composite Policy Index and is a summary of the HIV related policy environment in the Fiji Islands.

Data source name: National Composite Policy Index questionnaire

Data source type: Key informant interview s

TimeFrame: 01 01 2004 to: 25 08 2005

Frequency: year

As of date: dd mm 2005

A. Strategic Plan

1. Country has developed multisectoral strategies to combat HIV/AIDS Yes
2. Country has integrated HIV/AIDS into its general development plans Yes
3. Country has a functional national multisectoral HIV/AIDS management/coordination body Yes
4. Country has a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society Yes
5. Country has a functional HIV/AIDS body that assists in the coordination of civil society organizations Yes
6. Country has evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes No
7. Country has a strategy that addresses HIV/AIDS issues among its national uniformed services (including armed forces and civil defence forces) Yes

B. Prevention

1. Country has a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS Yes
2. Country has a policy or strategy promoting reproductive and sexual health education for young people Yes
3. Country has a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection Yes
4. Country has a policy or strategy that promotes IEC and other health interventions for cross-border migrants Yes
5. Country has a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities Yes



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6. Country has a policy or strategy to reduce MTCT

Yes

C. Human Rights

1. Country has laws and regulations that protect against discrimination people living with HIV/AIDS

Yes

2. Country has laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS

Yes

3. Country has a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations

Yes

4. Country has a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee

Yes

D. Care and Support

1. Country has a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups

Yes

2. Country has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups

Yes

3. Country has a policy or strategy to address the additional needs of orphans and other vulnerable children

No

Key successes and challenges faced and actions needed to achieve the goals/targets

[This section should focus on key challenges faced throughout the reporting period that hindered the national response and remedial actions planned to ensure achievements of agreed UNGASS targets.]

1. Absence of an appropriate legal framework
2. Limited HIV Research and Surveillance
3. Poor Monitoring and Evaluation tools
4. Limited funds for ARVs, OI drugs, condoms and other consumables
5. Limited innovative Health Promotion Strategies to promote and facilitate positive behavioral changes
6. Staffing capacity building including VCCT counseling & testing
7. Laboratory testing
8. Condom Promotion and Accessibility

Support required from country's development partners



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[This section should focus on key actions that need to be taken by development partners to assist countries in achieving their goals/targets. This is a wonderful opportunity for you to advocate for resources]

1. *Technical Assistance and support for positive behavioral changes facilitation*
2. *Technical dedicated HIV Staff capacity building*
3. *Funding*
4. *Develop Research and surveillance and HIV information systems*
5. *Fast track the development of HIV legislation*

Monitoring and evaluation environment

Capacity development in monitoring and evaluation has been highlighted as a need in the Fiji Islands. As of November 2005, Fiji does not have one national monitoring and evaluation plan. The Ministry of Health does have a functional health informational system and it does produce an annual evaluation report on HIV/AIDS, including surveillance reports. Capacity could be developed in the area of strategic planning and using evidence to develop and implement programs. Fiji has not had training in monitoring and evaluation at the national, sub-national levels or within civil society.

Annex 1: Consultation/preparation process for this national report

The UNGASS 2006 report was conducted with the support of UNAIDS Pacific and the Secretariat of the Pacific Community. Thank you to the Ministry of Health (MOH) (Fiji), World Health Organisation Western Pacific Regional Office (WHO WPRO), Secretariat Pacific Community (SPC) and University of New South Wales (UNSW) and the GFATM.

The National Composite Policy Index was conducted between July and October 2005. The data collected for the report was then collected via survey and vetted at a UNGASS Pacific region data workshop in October 2005. The report was then compiled and reviewed by the Ministry of Health.

Annex 2: Most-at-risk populations (MARP)

The vulnerability of women in Fiji to HIV is embedded in social and gender inequalities that limit the opportunities for women to deal with the risks of infection. Fiji experiences a relatively high incidence of sexual and domestic violence. In the mid-1990s, cervical cancer accounted for 37 per cent of all cancers in Fiji women, with an age standardised incidence rate of 114.6 per 100,000 women, a very high rate by international standards.



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Poor nutrition, especially in low-income households, increases susceptibility of women to infection. A study conducted in mid-1990s found that 32 per cent of women in Fiji were anaemic.

Sexually Transmitted Infections, including HIV, are emerging public health problems in Fiji. A recent rise in the number of HIV cases has been of concern within the country as well as the increasing number of patients accessing STI clinics. Among the factors influencing the population's vulnerability to HIV are: early initiation of sex, cultural taboos related to sexuality, high rates of sexually transmitted infection, gender inequalities, and a large young and transient population^{5 6}

It has also been noted that the uniformed servicemen are at increased risk for HIV infection and it seems that the IDU population is on the increase in Fiji. Further research needs to be conducted to verify these emerging most-at-risk-populations.

⁵ Baseline KABP survey Among Police and Military. Prevalence Surveys of Sexually Transmitted Infection among ANC And HIV Sero-Surveillance Among male Client STI Clinic Suva. Ministry of Health Fiji. 2004-2005 (draft report)

⁶ STI/HIV/AIDS Surveillance report. World Health Organisation Regional Office for the Western Pacific. Issue no. 18. July 2005