The Fiji national response to HIV and sexually transmitted infections: Mapping key successes and challenges.

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ABSTRACT

Since the introduction of the HIV/AIDS Decree in 2011 and the development of the latest National Strategic Plan, Fiji has seen an expansion in its national response to HIV and STI prevention, treatment, care and support. To date, there has been no review of this response. This paper maps and critically analyses the various components of Fiji’s national HIV and STI response, identifying key policy and programmatic strengths and areas requiring additional investment and support. It highlights the imperative of addressing current gaps in education, service delivery, surveillance and research in order to ensure the success and sustainability of HIV and STI prevention efforts in Fiji.
INTRODUCTION

Fiji is classified as a low HIV-prevalence country with a cumulative total of 508 cases\(^1\) (Nailatikau, 2013; UNAIDS, 2012a). This represents a HIV prevalence rate of 0.05 per cent of the total population. However, whilst much of the world has seen a decline in new HIV notifications (UNAIDS, 2013), Fiji continues to see a steady increase in its annual number of reported HIV cases. Like much of the Pacific, sexually transmitted infections (STIs) other than HIV are particularly prevalent in Fiji (Cliffe, Tabeizi, & Sullivan 2008; Fiji Ministry of Health, 2012; UNAIDS, 2012a). Available data indicates that young people and specifically young iTaukei (Indigenous Fijians) are disproportionately affected by HIV and other STIs. In 2010, 69% of chlamydia notifications were recorded in the 20-29 year age group, with iTaukei making up 81% of all chlamydia notifications (Fiji Ministry of Health, 2012; UNAIDS, 2012a). Similarly, in 2011 47% of HIV notifications were recorded in the 20-29 year age group, and iTaukei made up 82% of all recorded HIV cases in the country. High STI rates among young iTaukei emphasise the potential for the high rates of sexual transmission of HIV among this group and into the general population in Fiji. Addressing endemic STI rates and increasing HIV rates among young people in Fiji is integral to ensuring the country does not experience a HIV epidemic like that of nearby Papua New Guinea.

The Fiji national response to HIV and STIs is multi-sectoral and collaborative, operating largely within a rights-based framework. It has a strong focus on the prevention of HIV and STIs through the provision of HIV and STI education and prevention programmes, and sexual and reproductive health (SRH) services. This work is largely done by government, non-government (NGO) and international non-government organisations (INGO), faith based organisations (FBOs) and the University of the South Pacific (USP). To date there has been no review of this official response. This paper maps and critically reviews the various components of Fiji’s national HIV and STI response, identifying key policy and programmatic strengths and areas requiring additional investment and support.

HIV AND STI GOVERNANCE, POLICY AND LEGAL FRAMEWORK

A key strength of the national HIV and STI response is the policy, legal framework and governance structures that guide the delivery of programmes and services. This framework response is coordinated by a multi-sectoral HIV/AIDS Board (Fiji Ministry of Health, 2011). The Board was established after the enactment of the 2011 Fiji HIV/AIDS Decree and is responsible for the review and adoption of national strategic plans. The HIV/AIDS Decree provides a legal framework for Fiji’s national HIV response that safeguards the privacy and rights of people living with HIV (PLHIV) and those affected by HIV and AIDS (Government of Fiji, 2011; UNAIDS, 2012a).

Fiji’s national HIV and STI policy is informed by the Pacific Regional Strategy on HIV and other STIs 2009-2013, the Fiji Reproductive Health Policy, and recommendations made by the STI Regional Working Group for the Pacific (Fiji Ministry of Health, 2011). The Fiji Government has adopted an inter-governmental approach with a number of Ministries aiding HIV and STI policy development, governance, programming and service delivery. Assisting the Government’s
national HIV and STI response, both financially and with technical support are a number of UN agencies including UNAIDS, UNDP, UNFPA, UNICEF, UNWomen and the World Health Organization.\(^2\)

Fiji’s national response to HIV and STIs is set out in the latest National Strategic Plan on HIV and STIs, 2012-2015 (henceforth NSP). The NSP was developed by the Fiji Government in conjunction with UN agencies, FBOs, NGOs and the University of the South Pacific. It was guided by recommendations from a review of the 2007-2011 Fiji National HIV/AIDS Strategic Plan which highlighted a number of challenges to the national response. This included challenges to prevention among youth and women, stigma and discrimination issues for PLHIV, the need for greater male involvement in reproductive health, and the need to expand diagnosis and treatment of STIs (Fiji Ministry of Health, 2011).

The NSP provides a multi-sectoral approach to HIV and STI prevention, treatment, care, governance and research. It is strongly focused on strengthening prevention efforts, particularly among youth whilst also increasing testing and improving the quality of care and support provided to those living with or affected by HIV/AIDS (Fiji Ministry of Health, 2011). Enhancing inter-sectoral collaboration, coordination and governance and operating within a rights-based framework are core principles that underpin the plan. Strengthening monitoring and evaluation of the national HIV and STI system, improving surveillance systems, and increasing research into risk behaviours and programme and service effectiveness are also a core component of the NSP.

The NSP acknowledges the low prevalence of HIV but high prevalence of STIs in Fiji, and has therefore, for the first time integrated prevention and treatment of HIV with STIs. The focus on detecting and treating STIs through the Continue of Care strategy corresponds with recommendations made by the STI Regional Working Group for the Pacific in 2010 and the Pacific Regional Strategy on HIV and STIs 2009-2013, both of which call for greater detection and treatment of STIs, and in particular chlamydia (Fiji Ministry of Health, 2011; Secretariat of the Pacific Community, 2009; STI Regional Working Group for the Pacific, 2010). The NSP calls for the expansion of primary point of care sites, presumptive treatment of chlamydia for pregnant women and their partners, and improvements to services so they are more accessible and ‘client-friendly’.

When compared to the national strategic plans of other Pacific Island Countries, it is evident that Fiji’s NSP is more comprehensive, with many countries simply aligning their response with the wider Pacific Regional Strategy on HIV and other STIs 2009-2013. It is important to note that not all Pacific Island countries have active HIV and STI national strategic plans which Fiji’s can be compared to; however, all are currently in the process of being drafted. With higher rates of HIV recorded in Fiji, it is understandable that the country would have a more in-depth and targeted response to HIV and STI than many of its neighbours.

The exception to this is Papua New Guinea’s (PNG) National HIV and AIDS Strategy 2011-2015. Similar to Fiji’s NSP, PNG’s Strategy focuses on prevention, counseling, testing, treatment, care and support (National AIDS Council of Papua New Guinea, 2010a). The marked difference
between the two strategies can be seen in PNG’s greater commitment to system strengthening, and in particular improving information systems such as HIV and STI surveillance, and increasing biological, behavioural and operational research. Importantly, this includes the development of a separate National HIV and AIDS Strategy 2011-2015 Monitoring and Evaluation Framework to guide system strengthening (National AIDS Council of Papua New Guinea, 2010b). The depth of PNG’s national strategic plan is not overly surprising when the size of its AIDS programme budget and the support it receives from the international community are considered. In 2010, PNG’s monitoring and evaluation budget alone represented more than Fiji’s total AIDS programme budget for 2011 (just over 3 million compared to 2.25 million). The lack of a monitoring and evaluation framework in Fiji, and the importance of developing strong monitoring and evaluation and research components to Fiji’s national response are discussed below.

In addition to government policy, a number of other sectors have developed their own strategies to guide their response. Faith based organisations have played an active role in Fiji’s national HIV response since the mid 1990s (UNICEF, 2013). In 2004, the Nadi Declaration was signed and endorsed by 17 member churches of the World Council of Churches and the Pacific Conference of Churches. This declaration was designed to be a policy document that FBOs could use to guide their HIV programmes. It outlines the need to respond to HIV/AIDS within a human rights framework that includes ensuring access to treatment, voluntary confidential counseling and testing (VCCT), education on sexuality and the provision of condoms where appropriate. Whilst this document represented an important step forward in the Christian churches response to HIV, it was not distributed broadly nor have many of the policies been implemented (UNICEF, 2013).

More recently FBOs response to HIV and STIs has been guided by the Fiji Inter-Faith Strategy on HIV and AIDS, 2013-2017 (henceforth the Inter-Faith Strategy). Developed in partnership between UN agencies, FBOs and the Fiji Ministry of Health (MoH), the strategy is designed to strengthen the overall national response to HIV and AIDS (UNICEF, 2013). Specifically, the strategy sets out actions FBOs can undertake to prevent HIV infection and ensure PLHIV receive adequate treatment, care and support, and is designed to direct FBOs response to issues related to HIV and AIDS. The Inter-Faith Strategy aligns closely with the NSP through a focus on improving prevention, treatment, care and support.

The development of the Inter-Faith Strategy in Fiji has set the country apart from other Pacific Island countries, which do not have country specific FBO strategies. However, Pacific wide policies and guidelines do exist to guide Pacific Island countries such as the Pacific guide on responding to HIV for Christian Ministers, Pastors and Communities developed by the South Pacific Association of Theological Schools in partnership with UNAIDS and UNDP (South Pacific Association of Theological Schools, 2012).

The University of the South Pacific (USP) has also developed its own policy to guide the organisation’s response to HIV. Developed in 2001, USPs HIV/AIDS Policy focuses on discrimination, confidentiality, prevention, and health and safety (University of the South Pacific, [no date]) and are accounted for through a number of mechanisms. For instance, discrimination is addressed through an anti-discrimination policy for any staff or student with HIV/AIDS. Confidentiality on the other hand, relates to the university’s commitment to ensure the rights and
confidentiality of all students and staff. Prevention, which is another crucial area, is addressed through the university’s HIV prevention and education programmes. Lastly, health and safety of staff and students are upheld by adhering to legal, ethical and medical principles.

GAPS IN HIV AND STI GOVERNANCE, POLICY AND LEGAL FRAMEWORK

Significant improvements have been made to the policy and legal framework that guides Fiji’s national HIV and STI response in recent years. In particular, the 2011 HIV/AIDS Decree, the NSP’s integration of prevention and treatment of HIV with STIs, and the continued focus of prevention efforts will help to strengthen the overall response. However, gaps in governance, policy, and legal frameworks persist. This includes the lack of new strategies in the NSP to increase HIV and STI testing among youth - a situation that has become a reason for concern given the high rates of HIV and STIs among young people in Fiji. As a result, additional strategies at multiple levels are required to increase and normalise testing among young people and improve their uptake of services.

Limited policy and guidelines concerning system strengthening also represents another gap in the national response to HIV and STIs. The development of a separate monitoring and evaluation framework to sit alongside the NSP to guide and improve the strength of Fiji’s HIV and STI surveillance and operational research is urgently needed.

PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

SRH services in Fiji are mainly offered through government run clinics managed by the Fiji Ministry of Health. The MoH’s approach to delivering SRH services aligns with the NSP through its commitment to provide HIV and STI information, testing and treatment services and the availability of free condoms. These SRH services include three Hub Clinics, one in each of the three divisions (Suva, Lautoka and Labasa). These Hubs provide access to information, HIV and STI testing, counseling, antiretroviral therapy (ART), as well as reproductive health services. Three divisional and 16 sub-divisional hospitals also provide SRH services throughout Fiji, including counseling and testing (UNAIDS, 2012a). Confirmatory testing is undertaken either at Mataika House Reference Laboratory in Suva, or at the three divisional hospital laboratories, with a plan to decentralise testing to sub-divisional hospitals which will reduce the length of time for confirming HIV diagnosis (UNAIDS, 2012a).

In addition to the Hub Clinics, the MoH which is supported by the Secretariat of the Pacific Community (SPC) Adolescent Health and Development Programme (AHD), has established 24 ‘youth-friendly’ services operating around the country called ‘Our Place’ (UNAIDS, 2012a). These clinics are designed to be a drop in centre where youth can seek information and assistance for HIV and STIs as well as other health issues.

The MoH also sets up mobile booths at major community events, such as the annual Hibiscus Festival and on campus for two weeks a year at the University of the South Pacific’s Laucala Bay campus for SRH services and HIV and STI testing. SRH services, including HIV and STI testing, pap smears or contraceptives are not available to USP students through the Medical
Centre outside of MoH initiated campaigns. The exception to this is the availability of free of charge condoms from selected locations across the Laucala Bay campus.

The availability of testing in other health facilities across Fiji is dependent on the facilities’ laboratory capacity and in the case of HIV, whether there is a staff member trained to conducted pre and post-test counseling (UNAIDS, 2012a), and as such HIV and STI testing outside of main centre’s in Fiji is limited. Whilst 51% of the Fiji population lives in urban areas many people continue to live in rural areas and outer islands which often lack basic health services, including SRH services (Fiji Islands Bureau of Statistics, 2008; World Health Organization, 2011). This is not a problem unique to Fiji; people living outside of urban areas and particularly those living in remote outer islands across the Pacific have limited access to comprehensive SRH services (Asian Development Bank, 2009; Kennedy et al., 2013; UNAIDS, 2009).

Where services are available in Fiji, people are often unwilling to access these services due to confidentiality and privacy issues, as well as wider socio-cultural norms and taboos relating to sex (Jenkins, 2005; Mitchell, 2013). The availability of STI testing, and in particular chlamydia testing is also an issue in urban areas in Fiji. Between 2011 and 2012, whilst the author was undertaking research on the HIV and STI risk of young women in Suva, the availability of chlamydia testing was sporadic at the Hub clinic due to a hold on the reagent need for testing. Testing was available at the Suva Private Hospital and through private doctors but for a considerable cost outside the reach of most Fijians. In addition to government run SRH services, a few NGOs are offering SRH clinical services in rural and urban areas in Fiji, including Medical Services Pacific (MSP) (Fiji Ministry of Health, 2011).

GAPS IN THE PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Whilst SRH services are offered free of charge by the MoH and NGOs at a number of clinics in Fiji, access to these services and in particular HIV and STI testing outside Fiji’s main centres is limited. Where services are available many people, and in particular youth are reluctant to access these services. A much greater commitment to advertising the availability of services to the general population, improving the range of SRH services offered (particularly in rural and remote areas), and addressing underlying social and cultural barriers that inhibit access to these services is required.

The availability of staff trained to provide pre and post test counseling for those seeking HIV testing has also been flagged as an issue of concern requiring attention. The sporadic availability of chlamydia testing throughout Fiji should also be considered a critical issue. The hyper-endemic rates of chlamydia in the country requires urgent attention for alignment with the NSP call for increased testing and treatment. The introduction of rapid STI testing, and in particular chlamydia testing, would help to address this issue.

The lack of SRH services, including HIV and STI testing on campus at the University of the South Pacific represents another significant gap. Over 7000 students study at USP’s Laucala Bay campus, many of whom come from across Fiji and the Pacific to undertake tertiary education (University of the South Pacific, 2008). These young people face the challenge of negotiating
their social and sexual lives in a new and unfamiliar environment, often away from the protective structures of their family home. Recent data suggests that tertiary students in Fiji engage in high-risk behaviours such as multiple sexual partnerships, low and inconsistent condoms use and binge drinking (Hammar, 2011; Kaitani, 2003; Mitchell, 2013; UNAIDS, 2012a) and as such are particularly vulnerable to poor SRH, including HIV. To better service the needs of students and to complement existing SRH education programmes on campus, as well as to align more closely with the NSP, the introduction of SRH services including HIV and STI testing in the USP Medical Centre is warranted.

**SEXUAL AND REPRODUCTIVE HEALTH EDUCATION**

SRH education is a key component in the national HIV and STI response in Fiji and is strongly focused towards youth. Primary and secondary schools receive SRH education through the Family Life Education (FLE) programme run by the MoH and the Fiji Ministry of Education (MoE) (UNAIDS, 2012a). A key intervention of the regional AHD programme the FLE programme aims to improve students’ knowledge, attitudes, self-efficacy and risk behaviour concerning SRH and other life issues (Secretariat of the Pacific Community, 2010). A recent shift has seen the FLE programme moved from an elective subject to it being institutionalised in all schools through its incorporation into the general curriculum (Seru-Puamau & Roberts, 2009; Secretariat of the Pacific Community, 2010). Prior to its incorporation into the general curriculum, critiques of the FLE programme suggested there was limited uptake and resistance from teachers and parents, as well as limited teacher training and support, and monitoring and evaluation of the programme (Sami, 2006; Chandra, 2000). The conservative, abstinence based education model of FLE has also been criticised (Sami, 2006).

FBOs in Fiji have integrated SRH education, including HIV and STI prevention into their wider youth programmes. For example, in 2003 the Youth Division of the Methodist church introduced the ‘4 corners’ programme. This programme incorporates four components: spirituality, *i-Taukei* culture and practice, service to the community, and *vuli* (to learn). The *vuli* or education component of the programme includes discussions on health issues, including SRH issues. The programme, as with many other FBO programmes, includes guest talks provided by MoH nurses or Fiji Network of People Living with HIV (FJN+) members. These workshops largely focus on providing youth with information on HIV and STIs and are designed to be taught alongside church teachings on sexuality. FJN+ member discuss HIV issues and the realities of living with HIV to participants. To date the SRH education provided by FBO has never been evaluated and as such the impact of such programmes is unknown.

Christian church teachings on sexuality in Fiji typically follow an abstinence (abstinence before marriage and faithfulness within marriage) model where condom use as a form of HIV and STI prevention is not openly discussed. However, the development of the Nadi Declaration and the Inter-Faith Strategy suggest FBOs are becoming increasingly aware of the importance of condoms in preventing HIV and STIs. The Seventh Day Adventist (SDA) church stands as a good example of this shift. Through its development agency the Adventist Development and Relief Agency (ADRA), the SDA church runs a Youth Information Centre in Suva. This Centre
provides SRH and drug and alcohol education, access to the internet, and job seeking workshops. Importantly, condoms are made available free of charge at the Centre. The education provided at the Centre follows the SDA church abstinence approach but also incorporate the B and C aspect of the ABC model (i.e. be faithful and use condoms). This represents an important step forward in FBO’s response to HIV and STIs in Fiji.

The NGO sector in Fiji has a number of organisations that include SRH education in their programme work. The largest is the Reproductive and Family Health Association of Fiji (RFHAF), the local arm of the International Planned Parenthood Federation (IPPF). RFHAF provides SRH education largely focused towards youth at primary, secondary and tertiary levels. RFHAF’s SRH education programme follows a specific tool developed by the organisation called the ICLSSE (integrated comprehensive life skills with sexuality education) tool. This tool focuses on behaviour change and topics include discussions on values, sexuality, and healthy relationships. RFHAF’s SRH education does use the ABC approach; however condoms are discussed in the context of family planning, and worryingly their use in HIV and STI prevention is not advocated.

Women’s organisations such as the Fiji Women’s Crisis Centre (FWCC) and the Fiji Women’s Rights Movement (FWRM) play an important role in providing SRH education to young women through specific programmes. The FWCC includes a topic on reproductive health and HIV in its regional training programme. The FWRM incorporates education on violence against women, reproductive health, and HIV/AIDS into its larger Emerging Leaders Forum programme for young women. In addition, FWRM GIRLS Theatre project runs a Parent’s and Caregivers information sessions where UNFPA comes to discuss SRH issues with girls aged 10-12 years.

SRH education is also provided on campus to USP students through the USP Peer Education Network. Funded up until recently under the AHD programme and supported by the MoH, SPC, UNFPA and UNICEF, selected students undergo 5 days of Peer Education training. Students undergo a pre-test to assess their SRH knowledge and on completion of their training are tested again to evaluate improvements in their knowledge. Refresher workshops are held periodically to address any gaps in knowledge and provide updated statistical information.

The content of the Peer Education training aligns with the USP HIV/AIDS Policy and the NSP, namely to increase awareness of HIV and STIs and prevent transmission among youth. The education is an extension of the ABC model to include ABCDE (abstinence, being faithful, condoms (correct and consistent use), doing other things, education (being informed). Whilst the current training curriculum is broader than most SRH programmes in Fiji, adequate training and education on youth sexuality is currently missing from the USP Peer Education training with sexuality only briefly touched on during broader SRH education and it is predominately heterosexual in focus.

After each outreach activity Peer Educators are responsible for submitting reports to the Counseling Centre detailing activities undertaken and evaluating the strengthens and weaknesses of the outreach. Whilst some training and outreach activity evaluation exists, there is a lack of programme evaluation and as such little is known about the reach or impact of the Programme.
GAPS IN SEXUAL AND REPRODUCTIVE HEALTH EDUCATION

There are a number of SRH education programmes targeting youth in Fiji, however these programmes are currently limited in quality and scope. Specifically, their use of an abstinence based model of education ignores the realities of endemic STI rates, increasing HIV rates and low condom use among young people. The range of topics covered in SRH education programmes is narrow and is often exclusively heterosexual in focus.

Some SRH education programmes have moved towards an ABCDE (abstinence, being faithful, condoms, do other things, education) model, most notably the USP Peer Education Network. This model focuses more on the provision of information to assist young people to be prepared if they do have sex and to make their own informed decisions about sexual activity. However, abstinence messages coupled with teaching of safe sex messages and condom distribution could be considered contradictory and confusing for young people. The development of culturally and age-appropriate education programmes that include a discussion on youth sexuality, desire and pleasure in the context of risk would be an important step forward in addressing the needs of Fijian youth. Increasing the availability of information on family planning methods and HIV and STIs symptoms is also needed.

Whilst there does appear to be an internal shift among some Christian denominations in Fiji to a more progressive outlook on HIV and STI prevention approaches, there is still a long way to go. Improvements to current SRH education that include culturally appropriate discussions on condoms as a form of HIV and STI prevention is warranted. Increased advocacy for young people to access SRH services and seek HIV and STI testing is also needed and should include a built in mechanism to evaluate the effectiveness of referrals. The SDA church currently stands as a good model of how to effectively balance church beliefs and teachings on sexuality with sound prevention programmes that also include the provision of condoms in Fiji. The adoption of this model by other FBOs would be an important step forward in their response to HIV and STIs.

A review of current SRH education programme in Fiji suggests there is a need to increase training at two levels. Firstly, increasing training and support for teachers to deliver FLE curriculum would ensure the programme is delivered effectively and in turn help to negate resistance to the programme from teachers. Secondly, increasing training of peer educators would ensure they have thorough, relevant and up-to-date SRH information. Increasing support and debriefing for peer educators would also be beneficial, with most peer educators currently receiving limited mentoring and debriefing is ad hoc at best. Increasing supervision through mentoring and debriefing would help to build peer educators’ confidence and arm them with skills required to undertake their roles and to adequately manage negative responses to their outreach activities.

The lack of a monitoring and evaluation component to SRH education programming in Fiji stands as a significant gap impacting on the longevity of these programmes. Without a strong evaluation framework little is known about the reach and impact of their activities. Furthermore, the lack of evaluation means it is difficult to ascertain if the programmes have met their objectives and thus if they are meaningful. A formalised monitoring and evaluation strategy should be integrated into all SRH education programmes to ensure strengths and weaknesses of the programme are
highlighted and addressed quickly, such evaluations can also be used to garner more support for the programmes.

A RIGHTS-BASED APPROACH

The national HIV and STI response in Fiji operates within a human rights-based framework that includes a focus on gender equality and the rights of PLHIV. The enactment of the 2011 HIV/AIDS Decree provided the legal framework for this rights-based approach. The Fiji HIV/AIDS Decree was developed over a seven year period and outlines a human rights framework which aims to ensure the privacy and rights of PLHIV and those affected by HIV and AIDS (Government of Fiji, 2011; UNAIDS, 2012a). The issue of stigma and discrimination has been partly addressed in the Decree, with people now legally able to seek redress through the courts if their rights have been violated (Government of Fiji, 2011; UNAIDS, 2012a). It also ensures that policies developed by the HIV/AIDS Board will have legitimacy and any person who breaches these policies is committing an offence (Fiji Ministry of Health, 2011).

The NSP is intended to put into practice objectives outlined in the HIV/AIDS Decree, namely responding to the HIV epidemic within a human rights framework that includes the reduction of stigma and discrimination (Fiji Ministry of Health, 2011). The NSP addresses issues of gender equality, human rights, stigma and discrimination through each of its priority areas. This includes increased presence of PLHIV and other minority groups in public events, the use of HIV advocates in Hub Centres, and increasing operational research to evaluate the effectiveness of current programmes to deal with issues of stigma and discrimination (Fiji Ministry of Health, 2011). Stigma and discrimination of PLHIV and minority groups such as transgender people, sex workers and men who have sex with men (MSM) is a significant problem in Fiji (Bavinton et al., 2011; McMillan & Worth, 2010; Pacific Island AIDS Foundation, 2011; UNAIDS, 2012a). This includes stigma and discrimination in access to health services as well as verbal, physical and gender-based violence.

A number of NGOs in Fiji apply a strong rights-based approach to addressing issues of SRH rights (SRHR) and HIV. These organisations negotiate their work in a politically unstable environment, with limited political positioning which inevitably constrains and limits the scope and depth of their work. However, despite this, many NGOs continue to push conservative boundaries and advocate for change in policy. This includes the work of women’s organisation such as FWCC, FWRM, Women’s Action for Change (WAC) and Fem’LINK Pacific. These organisations advocate women’s rights and increasing women’s civil participation, reduce gender-based violence and SRHR. In 2013, FWRM ran a SRHR strategy meeting that brought together Pacific feminists and women’s rights advocates with the aim of advancing the SRHR agenda in the Pacific. The results of the meeting included an outcome statement that called for improvements to SRHR such as the right to legal and safe abortions for all Pacific women and girls, and the importance of addressing high levels of STIs among Pacific women and girls. Addressing both of these issues would be an important step in the national response to HIV and STIs in Fiji and the Pacific more broadly.
Advocacy organisations such as FJN+, the Survival Advocacy Network (SAN), and Men’s Empowerment Network of Fiji (MENFiji) undertake work concerning the rights and needs of PLHIV, sex workers, MSM and transgender people (Fiji Ministry of Health, 2011; UNAIDS, 2012a). FBOs have also adopted a right-based approach that is largely guided by the Nadi Declaration and the Fiji Inter-Faith Strategy on HIV and AIDS, 2013-2017. The Transformational Leadership Development training for church leaders is one programme that aims to better address the rights of PLHIV and reduce HIV/AIDS stigma and discrimination (UNDP, 2012).

GAPS IN THE RIGHTS-BASED APPROACH

Whilst significant progress has been made to reduce gender inequality, stigma and discrimination and increase the rights of PLHIV and other minority groups, gaps in the rights-based approach remain. This includes the introduction of the ‘Prostitution offences’ section in the Crimes Decree 2009. This Decree outlines a wide range of offences relating to sex work, including the criminalisation of the client and does little to safeguard the human rights of sex workers (Government of Fiji, 2009).

The SRHR of women are also limited due to the criminalisation of abortion in Fiji, with abortions only legal in the case of incest or rape. Following the call from women’s organisations such as FWRM and legislating safe abortions for women and girls would be an important step forward to ensure a rights-based approach to SRH. Addressing gender-based violence experienced by women, including women living with HIV and other minority groups is also a much needed and important component of the national response to HIV and STIs in Fiji.

PROMOTION OF BEHAVIOUR CHANGE

The promotion of behaviour change is a key strategy in the overall national HIV and STI response. The NSP calls for a focus on behaviour change, including the reduction of barriers to safe sex practices such as negative perceptions of condom use, as well as barriers to HIV and STI testing. Behaviour change is largely addressed through prevention programmes, such as peer education that targets individuals, families, and communities and is strongly youth focused. Peer education is used by all sectors in Fiji including the MoH, FBOs, NGOs and tertiary institutions. Outreach activities typically include the distribution of SRH information and resources, one-to-one peer counseling, referrals to SRH and other services, demonstration of male and female condom use, and the distribution of condoms and lubricant.

Whilst behaviour change is an important component of a country’s national response, behaviour change programmes in Fiji are currently limited. The quality of behaviour change interventions, and in particular the quality of peer education programmes is highly varied. Training provided to peer educators is often limited to a 5 day training course and an annual refresher course, with limited access to mentoring and debriefing outside these times. The depth and scope of topics covered during the training is also limited to abstinence or ABC models, which in turn limits the capacity of peer educators to provide relevant information to peers. Assessment and evaluation of peer education programmes is also limited or nonexistent, with past reviews of peer education
programmes in Fiji and the wider Pacific showing peer educators are not routinely assessed for correct knowledge or their facilitation skills (UNICEF, 2007).

Another limitation of behaviour change programmes in Fiji is their failure to engage with local sexual cultures, opting instead to largely utilise Western models of behaviour change in programmatic work. Without critically engaging with and unpacking the underlying social and cultural taboos associated with sex and sexuality in Fijian culture current behaviour change models are failing to meet their objectives of increasing condom use and HIV and STI testing and ultimately reducing HIV and STI rates.

GAPS IN THE PROMOTION OF BEHAVIOUR CHANGE

Peer education is a widely adopted and effective way to promote HIV and STI behaviour change in Fiji. However, there are currently gaps in this approach that include limited scope of topics in training courses and subsequently the limited technical capacity and knowledge of peer educators. In order for programmes to be effective, additional topics and training that unpacks and addresses underlying social and cultural barriers to safe sex practices and testing is needed. A lack of adequate mentoring and debriefing for peer educators is also an issue within some programmes. Increasing supervision through mentoring and debriefing is needed and would increase the skills and technical capacity of peer educators.

HARM REDUCTION APPROACH

National policy and programmes that address alcohol and substance misuse in the context of HIV and STI risk behaviours are an important part of a country’s national HIV and STI response. The latest NSP does not specifically set out any strategies to deal with the issue of alcohol and substance use in the context of HIV and STI prevention. This represents a significant gap in the NSP as research has shown a strong link between alcohol and drug use and increased risk of HIV and STI transmission (Morojele et al., 2006; Patrick, 2012; Weiser et al., 2006). Addressing the harms associated with alcohol and substance use is instead largely managed by the National Substance Abuse Advisory Council (NSAAC).

NSAAC is a statutory body within the MoE whose role includes undertaking research and policy development, providing information and education, and promoting treatment and care concerning substance use in Fiji (Fiji Ministry of Education, 2013). Education programmes include drug prevention and awareness education in schools, which takes place through the FLE programme and includes topics on HIV and STIs. This education uses an abstinence approach to drug use and minimising the use of alcohol and substances through the use of scare tactics with limited information on strategies for responsible drinking.

NSAAC also provides training to the USP Peer Education Network during their initial training week. As with the education provided in schools, this training is abstinence focused and provides peer educators with little information on strategies or skills to advocate for peers to reduce the harms associated with their alcohol and drug use. In addition to NSAAC education, the Fiji Police are sometimes invited to talk about drug and alcohol issues with young people. This most
often occurs in church youth groups such as the Methodist church ‘4 Corners’ programme.

Other aspects of a harm reduction approach, including enforcement of liquor licensing laws and responsible service of alcohol are largely nonexistent in Fiji. Similarly, there is little policy regulating the environment in which alcohol is marketed, particularly its price and availability. Restrictions on nightclub and bar opening hours and the availability of takeaway alcohol are also minimal.

GAPS IN THE HARM REDUCTION APPROACH

Whilst alcohol and substance use education is provided through the NSAAC in Fiji, the scope of this education is limited. It focuses largely on an abstinence model to substance use through the use of scare tactics. Specifically, there is currently no education that provides young people with strategies to drink responsibly and reduce harms associated with their drug use. The inclusion of harm reduction approaches to drug and alcohol use education alongside SRH education through all sectors in Fiji is needed. Past research suggests harm reduction is effective in reducing alcohol and drug related harms among young people (Marlatt & Witkiewitz, 2002; Monti et al., 1999; Toumbourou et al., 2007). The implementation of a harm reduction approach to alcohol and substance use in Fiji would be an important step forward in the national response to both alcohol and substance misuse and HIV and STI prevention.

In conjunction with a harm reduction approach to alcohol and drug use education, there is a need for stronger enforcement of liquor licensing laws such as responsible service of alcohol. Increasing the cost of alcohol, reducing availability of takeaway alcohol, banning alcohol advertising, and reducing nightclub and bar opening hours would also assist in reducing overall alcohol harm (including alcohol fuelled violence and sexual assaults), and as a result HIV and STI risk. There is also a need for stronger partnerships between the MoH, law enforcement, and liquor licensing to ensure harm reduction approaches are realised.

TARGETED GROUPS

The official response to HIV and STIs focuses strongly on the prevention, counselling and testing of key populations. Key populations include: youth, sex workers, MSM and transgender people (Fiji Ministry of Health, 2011). It also includes other key populations such as individuals who engage in unprotected sex with multiple partners, those employed in the tourism and seasonal agricultural industry, seafarers, members of the uniformed services such as the military, police and prisons services and PLHIV. Importantly, the latest NSP has identified young people as a key population in their own right (Fiji Ministry of Health, 2011). The acknowledged vulnerability of youth is also reflected in current prevention programmes, with each sector specifically targeting youth in their programming.

Whilst policy and programmes targeting key populations in a country’s national HIV and STI response are important to ensure these groups have access to SRH education, information and services, it can in turn increase their exposure to stigma and discrimination from the wider population. This is evident in Fiji, where a moral othering of HIV and STIs sees the general
population externalise infection risk outwardly to ‘other’ people, such as people who engage in casual and commercial sex, MSM, and transgender people (Hammar, 2011; Mitchell, 2013). The strong focus on these groups in HIV and STI prevention efforts has clearly aided this moral othering. It is therefore important to design prevention programmes that target the whole population, with smaller discrete programmes that target specific at risk groups. Using a combined approach that simultaneously targets the whole population and smaller subsets of the population will help to reduce stigma and avoid moral othering in the community.

GAPS IN THE TARGET GROUP RESPONSE

The strong focus on youth and other most at risk groups (MARG) adds strength to the national response. However, prevention programmes targeting perceived MARG must be discrete and sit alongside larger prevention programmes that target the entire population to ensure minority groups are not subject to further stigma and discrimination. Additional programmes that target young women would also add strength to the national HIV and STI response and could include topics such as increasing young women’s communication skills and self-efficacy in condom negotiation.

PREVENTING MOTHER TO CHILD TRANSMISSION

The prevention of Mother-to-Child-Transmission (PMTCT) is guided by the Fiji Policy on Prevention of Parent to Child Transmission of HIV 2010 (Fiji Ministry of Health, 2011). The NSP addresses PMTCT through the provision of community based prevention programmes as well as clinic based initiatives that provide ART for PMTCT and treatment for HIV positive women and their children. All pregnant women and their partners attending antenatal clinics in the 3 divisional hospitals in Suva, Lautoka and Labasa and two sub-divisional hospitals in Nadi and Nausori are offered HIV and STI testing through a partnership between MoH and the Pacific Counselling and Social Services (PCSS) (Fiji Ministry of Health, 2011; UNAIDS, 2012a). In 2012, the MoH/PCSS partnership reached 13,000 pregnant women which represented 60% of pregnant women in the country (UNAIDS, 2012a). In antenatal clinics that did not fall under the MoH/PCSS partnership trained nurses facilitated HIV testing. Altogether it is estimated that approximately 80% of pregnant women in Fiji received a HIV test as part of their antenatal care, up from 66% in 2010 (UNAIDS, 2012a).

GAPS IN MTCT PROGRAMMES

Whilst HIV and STI testing is offered to pregnant women attending antenatal clinics in Fiji, not all women choose to take the test. Increasing uptake of HIV tests among antenatal clinic attendees and their partners would be an important step in the overall response and provide valuable and more representative data on HIV rates among women and men in Fiji.

MONITORING AND EVALUATION OF IMPACT

There is currently no national HIV and STI monitoring and evaluation reporting mechanism in Fiji. The MoH monitors some aspects of the national response through surveillance systems, such
as the number of pregnant women receiving HIV tests and the number of people receiving ART (UNAIDS, 2012a). UNAIDS also works closely with SPC to track HIV and AIDS notifications in Fiji and develops the annual HIV global data reports. However, there is currently no central database where this information is sorted, and as such data is rarely analysed to identify trends.

Due to the absence of a national reporting mechanism, most projects undertaken by NGOs, and other sectors only provide monitoring and evaluation reports internally or to their funders (Fiji Ministry of Health, 2011; UNAIDS, 2012a). Monitoring and evaluation of programmes is important to account for resources, improve the overall programme and to show whether the interventions have met their objectives (World Health Organization, 2004). It also provides a strong evidence-base in which future programme and service delivery can be modelled. Without a national surveillance, monitoring and evaluation reporting system in Fiji, there is limited information available to either learn from past research and programmes or improve future planning, programme and policy development. It is also difficult to determine if current programmes and services are appropriately targeted and achieving desired goals. Similarly, there is no way to properly assess real cost for the programmes, and therefore adequately budget for their continuation.

The latest NSP attempts to address this lack of a national reporting mechanism through integrating HIV and STI monitoring and evaluation into the overall Health Information System (HIS) under the MoH (Fiji Ministry of Health, 2011). Once developed this will help to improve the monitoring and evaluation of HIV and STIs, and further align this data with information on other health issues such as reproductive health.

**GAPS IN MONITORING AND EVALUATION OF IMPACT**

The lack of a national HIV and STI reporting mechanism is a major gap in the overall response. Without such a system surveillance data, lessons learnt and information collected during project is not fed back and subsequently this information is not being used to inform policy and programming. Similarly, without specific guidelines to assist organisations in the monitoring and evaluation of their HIV and STI programmes evaluation is often done in an ad hoc manner, or not at all.

The latest NSP’s commitment to integrate monitoring and evaluation into the overall HIS is an important step forward. Once this system is in place the capacity of all sectors to contribute data to this system must be secured. It is also essential that dedicated staff exist to collate and interpret this data and distribute it for future use.

**RESEARCH AND EVIDENCE FOR PROGRAMMING**

Research concerning HIV and STIs, including risk behaviours, health service usage, and barriers to safe sex are minimal in Fiji. There is currently no publically available nationally representative HIV and STI surveillance data. The last Second Generation Surveillance (SGS) survey was conducted in 2008 which has led to a reliance on the use of old data to inform HIV and STI policy and programme work at all levels in Fiji. The 2008 SGS only included a biological surveillance of antenatal clinic attendees and therefore missed other important groups such as youth and men.
The latest NSP attempts to address the lack of representative and meaningful HIV and STI research and data through increasing research efforts in a number of areas. This includes research that examines trends in HIV and STI infection and increasing evaluation of programme and service effectiveness. The NSP also outlines the move to undertake HIV and STI Integrated Behavioural and Biological Surveillance (IBBS) surveys among key populations (Fiji Ministry of Health, 2011).

GAPS IN RESEARCH AND EVIDENCE FOR PROGRAMMING

There is currently limited research and a lack of up to date, representative HIV and STI data in Fiji and a reliance on old data which limits the scope of evidence for future programming. Given the high rates of HIV and STIs among young people in Fiji, youth should be a priority in the NSP research agenda. There is a clear need for an IBBS survey of HIV and STIs among youth in conjunction with a nationally representative KAP survey, as well as qualitative research examining risk behaviours and barriers to safe sex practices. An updated nationally representative SGS survey that includes IBBS is also warranted and would provide the evidence-based for the direction of future HIV and STI policy and programming. The availability of timely, up to date and representative data on STI notifications within the whole population and key groups is also required.

CONCLUSION

The strength of Fiji’s national response to HIV and STIs comes from its multi-sectoral collaborative approach. Key strengths include a strong focus on prevention among youth through the use of peer educators to disseminate SRH information, increased focus on gender equality and SRHR, and the expansion of FBOs prevention programmes. The development of a HIV/AIDS Decree and the increased focus on a rights-based approach are also key strengths to the overall response.

Despite recent improvements, gaps remain. These include the limited scope and depth of education programmes that focus largely on an abstinence model of education that ignores the realities of endemic STI rates, increasing HIV rates and low condom use in Fiji. The introduction of culturally and age-appropriate education programmes that include a discussion on sexuality, desire and pleasure in the context of risk would be an important step forward in addressing the needs of the Fiji population, and in particular Fijian youth. Increasing training, debriefing and support for those delivering SRH education, including teachers and peer educators would also be beneficial.

The importance of peer education as an effective way to promote HIV and STI behaviour change in Fiji has been widely recognised. However, the limited technical capacity and knowledge of peer educators represents a gap in this approach. To increase programme effectiveness, additional training for peer educators that unpacks and addresses underlying social and cultural barriers to safe sex practices and testing is needed.

Poor access and uptake of SRH services, including HIV and STI testing has also weakened
the overall response. Improving the range and reach of current SRH services, increasing public knowledge of the availability of services, increasing the availability of staff trained to undertake VCCT, increasing the availability of STI testing, and addressing underlying social and cultural barriers that inhibit access to SRH services are needed.

The lack of harm reduction strategies in addressing alcohol and drug misuse in the context of HIV and STI risk behaviours is a significant gap in the national response. The inclusion of harm reduction approaches to drug and alcohol use education alongside SRH education is needed. In addition, there is a need to improve policy concerning the advertising, sale and availability of alcohol, and stronger enforcement of liquor licensing laws.

The absence of a national monitoring and evaluation reporting mechanism, the lack of nationally representative HIV and STI surveillance data, and the lack of research examining HIV and STI risk behaviours also limit the overall response. Improving and increasing HIV and STI surveillance, monitoring and evaluation of programmes and operational research will provide a strong-evidence base that can be used to inform policy and programmatic work. The absence of these components in the national response has meant that policy and programmes have been planned and implemented without a clear understanding of the problems and issues they are trying to address. Maintaining and supporting established multi-sectoral relationships, whilst also addressing current gaps to education, service delivery and research, is central to the success and sustainability of current and future HIV and STI prevention efforts in Fiji.

ENDNOTES

1 Fiji had 508 HIV notifications as of June 2013. This is the most recent data publically available.

2 The total expenditure for the AIDS programme in Fiji in 2011 was US$2.25 million (UNAIDS, 2012a). This figure includes funding from public (government), international and private donors. International and private donor contribution represents about 80% or 1.8 million of the total budget.

3 PNG’s total AIDS spending was over 131 million in 2010, of which just over 104 million was received from international donors (UNAIDS, 2012b).

4 See Labbé 2011 for a discussion on popular discourses and representations of HIV in Fiji.
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