ANNUAL REPORT

FOR 2013

FAMILY HEALTH UNIT

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Acknowledgements

The Family Health Unit would like to take this opportunity to thank the Honorable Minister for Health, Permanent Secretary for Health and the Deputy Secretary for Public Health for its continual guidance and direction in relations to Family Health programs for the country.

We would also take this time to thank all the other Directors, National Advisors, donor partners such as FHSSP, WHO, UNICEF, UNAIDS, SPC, UNDP, OSSHHM, IPPF, and all others for their continual support toward the different programs under the Unit.

Also taking this opportunity to thank all the National CSN Heads namely, Dr James Fong and Dr Joseph Kado and their hard working teams for their continual support towards the support and help in implementing the program in the year 2013.

The support from the Divisional Medical Officers and Medical Superintendents from the three divisional hospitals.

Apart from that the thanks also goes out to the staff of the Family Health Unit:

- Sereima Vatuvatu HIV CEO
- Sepesa Rasili Adolescent Health Co-ordinator
- Abdul Hussain Reproductive Health Project Officer
- Tomasi Niucavu National HIV Project Assistant
- Sr Sera Waqa (WHO)
- Sr Litiana Volavola (EPI Co-ordinator)

Without your support and direction the achievements of the Unit wouldn't have been possible. A big Vinaka Vaka Levu to you all and looking forward to a prosperous 2014.

Family Health Unit

The Family Health Unit is comprised of four major programs as highlighted above: The achievements and challenges for the year of 2013:

Sexual Health Program

At the National level there were quite a few happenings in the area of Sexual Health:

Policy and Guideline Developments:

1) ***Prevention of Parent to Child Transmission of HIV Policy 2013-2016:***

a. It is no longer just a Voluntary Approach for HIV Counseling and Testing but inclusive of VCT and PITC (Provider Initiated Counseling and Testing).
b. All Health Centers must provide PITC for ANC mothers if not refer patients to the Sub-Divisional Hospital for Counseling and Testing.
c. The introduction of Rapid Testing for Women who come in with an unknown status thus provision of Counseling and Testing can be provided on site, rather than delaying for more than 24 hours and the privilege of prophylaxis is not provided for those patients who are exposed.
d. The Development of a HIV Core Team which looks at the issues of the HIV positive cases, both Males and Females regardless of age should be discussed in line with the HIV decree.
e. Introduction of the Option B plus for all confirmed HIV positive women, where when a woman is pregnant and HIV positive she is put on therapy, and continues on therapy for a life time.
f. With the introduction of Option B Plus and in June 2013 the New WHO guidelines which has introduced the one Pill a day, which reduces pill burden for patients with HIV and on treatment.
g. The method of delivery is via Normal Delivery, unless indicated for a caesarean otherwise.
h. All infants regardless of feeding option need to be on a 6 week prophylaxis for Anti-Retroviral Therapy.
i. The provision of Formula Feeding for babies born to HIV positive mothers are no longer recommended, thus the removal of provision of Formula Milk for one year.
j. Option B plus has provided protection for mothers to breastfeed babies for as long as they prefer. Thus the removal of the point 4.9 from the current policy.

k. The frequency of review of all infants by the pediatricians has been amended to suit appropriate care and treatment.
l. The inclusion of private practitioners to follow up the HIV positive pregnant women on the basis that they have undergone necessary training and under the guidance of the experts of the PPTCT Core Team.
m. Inclusion of the Monitoring and Evaluation systems in place to strengthen the current reporting channels.

TB/HIV Collaborative Policy:

A) The major objectives of the Policy is to:
    i. Establish mechanisms for collaboration at all levels in terms of program management and also implementation of the TB and HIV programme.
    ii. To increase detection of tuberculosis in people living with HIV infection and vice versa.
    iii. To optimize management and care for TB/HIV co-infection
B) Under the Policy will be the establishment of a National and Divisional Coordinating Committee for the collaborative TB/HIV program needs.
C) The Early Detection of TB and HIV is paramount for treatment and care mainly:
    i. Initiation of Antiretroviral Therapy for all TB patients who are positive for HIV regardless of CD4 cell count.
    ii. Initiation of Cotrimaxole Prophylaxis for prevention of other opportunistic infections from affected a TB/HIV patient as patients is further immunocompromised secondary to the co-infection.
    iii. Ensure that isoniazid prophylaxis is made available to patients who are eligible for it to prevent HIV patients from becoming infected or latent TB being activated.
D) The Policy will bring about a guidance to ensure that all TB patients are counseled for HIV and tested if consented[1] and that all HIV patients are tested for TB using the gene expert.
E) All prevention programs should be done in a collaborative manner where applicable for the reasons of cost effectiveness and for the close relation the two diseases have.
F) The Treatment of all TB patients who are tested positive for HIV need to be initiated on Anti-Retroviral Therapy within the 8 weeks of TB treatment following the 2013 Anti-Retroviral therapy guidelines for Fiji.

[1] Being in Line with the HIV Decree and the HIV Testing and Counseling Policy

G) It is paramount that all Health Care workers in the area of TB and HIV are trained in a set of training as outlined in the Policy to ensure adequate and appropriate treatment and care of all patients.
H) In terms of communications strategy for TB and HIV, this also needs to be done in a more collaborative manner, to reduce the associated stigma and discrimination in relation to HIV.
I) All necessary data collected under the TB and HIV programe needs to be in line with the information systems of the MOH Health Information Unit. While the systems are being developed for direct reporting. There needs to be submissions of reports to HIU on a regular basis as outline in the Policy.
J) The reporting done locally is lined against international indicators as well, since Fiji reports at the global level as well. Thus to ensure the ease of reporting, this process needs to be aligned.
K) The TB/HIV Policy is in line with the Public Health Act and the HIV Decree 2011 as its legislative directions.
L) Monitoring and Evaluation under the Policy has become of paramount importance as we continue to strengthen the two programs. We need to learn from the data we gather to better evaluate and improve our programs in place.

HIV Testing Strategy in Fiji:

1.1 Up scaling the applicability of the HIV confirmatory algorithm in Fiji entailed adapting two separate algorithms for designated high-throughput and low-throughput government operated HIV testing laboratories.

1.2 The HIV algorithm is thus developed for the Low Through Put and High Through Put to suit our population which vary in the different sites around Fiji.

1.3 Current HIV testing:

i. Sub-Divisional Laboratories

Use's Determine test for patient and donor screening

ii. **Divisional Laboratories at CWMH, Lautoka and Labasa**

Use's Vironostika EIA test for patient and donor screening.

Use's Determine test for emergency blood donor screening.

iii. **Central Laboratory at FCCDC at Mataika House**

Performs HIV confirmation 1 – using Enzygnost HIV 1/2 EIA test
Performs HIV confirmation 2 – using Vironostika HIV 1/2 EIA test
Performs HIV confirmation 3 – using Determine HIV 1/2 rapid test

1.4 Proposed testing Strategy for Laboratories in Fiji Region:

i. Sub-Divisional Laboratories

- Will use Determine test for patient and blood donor screening
- Will use Uni-Gold™ Recombigen HIV® and Biolytical Insti™ HIV1/HIV2, in parallel for confirmation.

ii. Divisional Laboratories at CWMH, Lautoka and Labasa

- Will use Vironostika HIV 1/2 EIA test for patient and donor screening.
- Will use Determine test for emergency blood donor screening.
- Will use Uni-Gold™ Recombigen HIV® and Biolytical Insti™ HIV1/HIV2, in parallel for confirmation.

iii. **Reference Laboratory FCCDC at Mataika House**

- Will use Enzygnost HIV 1/2 EIA test for monitoring and evaluation for the two testing HIV algorithms.
- Will use Murex HIV 1/2 EIA test for monitoring and evaluation for the two testing HIV algorithms.

1.5 All laboratories will communicate at set intervals by submitting a standard line list for patient's which will comply with patient confidentiality status. Mataika House will consolidate and prepare reports of various formats primarily for Ministry of Health National Family Health Advisor and HIU.

1.6 It will be mandatory for all the laboratories carrying out HIV testing to participate in External Quality Assurance program coordinated by FCCDC, Mataika House and also to send 5% of the random negative samples, all presumptive negative samples and all positive samples to Mataika House for monitoring and evaluation purpose.

1.7 All surveillance data obtained from HIV testing to be centralized and controlled by Mataika House.

HIV Care and Antiretroviral Therapy Guidelines:

A) The developed Guidelines is much more than just on the Antiretroviral Therapy, it has a more comprehensive component on care and support of People Living with HIV commonly known as the continuum of care (COC). Thus serves as a guide for all HIV Clinicians in Fiji.

B) The Guideline will be recommending that we initiate patients on therapy depending on eligibility and eligibility is:[2]

i. For all patients who CD4 Count is <500cells/mm3

ii. TB/HIV patients

[2] Annex 1: HIV Care and Antiretroviral Therapy Guidelines, Second Edition 2013

iii. Hepatitis B and HIV patients
iv. Pregnant women who are HIV Positive go on Option B Plus
v. All children less than 5 years of age are initiated on therapy.
vi. Discordant couples (where if one partner is positive and the other negative, the patient is initiated on therapy to prevention infection from spreading to the partner)-Treatment as Prevention.

C) Option B plus has been adopted as the option for treatment for all HIV positive pregnant women. Meaning patients are on treatment and once initiated it's for life.
D) There is a Section which comprises the HIV Testing and Counseling Component for patients which complements the HIV Testing and Counselling Policy for Fiji.[3]
E) The new guidelines also guides clinicians who aren't familiar with HIV care as to how to do an initial assessment and initiate therapy.
F) There is a wider discussion on Opportunistic Infections (OI) in terms of treatment and care, since OI's are the major cause of death among HIV patients. This will help and support clinicians treat HIV Patients with OI's in a more efficient manner.
G) The importance of a HIV treatment care team in the Divisions is highlighted and it becomes paramount for Holistic patient care.
H) The regular clinical follow ups and necessary monitoring and evaluation has also become a part of the guidelines to facilitate and support the HIV program in a more comprehensive manner.
I) The Guideline is a form of the HIV standards of practice for the HIV clinics and also for the PPTCT program.

HIV Testing and Counselling Policy:

A) The HIV/STI Counseling and Testing Policy encompasses all areas of HIV Counselling in terms of Voluntary, Provider Initiated and mandatory Testing. Which is in line with the HIV/AIDS Decree 2011
B) Thus the importance of the policy to be in place prior to the HIV Confirmatory Testing Rolling out in a more comprehensive manner in Fiji. The need to ensure that HIV Counselling and testing is made available in all sites around Fiji. Making the HIV/STI counseling and testing Policy paramount for appropriate implementation, and reporting of all HIV Testing and Counselling Services around Fiji.
C) HIV/STI testing when accompanied by comprehensive pre and post-test counselling also provides valuable epidemiological and behavior change information to better inform the response to the epidemic.
D) The main objectives of the HIV/STI Counselling and Testing Policy are to:
i. Standardise HIV/STI Testing and counselling systems and strategies in place.

[3] Submitted as an Information Paper to NHEC

ii. Systemetically structure screening and testing.
iii. Formalise the establishment and recognition of HIV Confirmatory services at the Divisional and Sub-Divisional Hospitals
iv. Facilitate Reporting data sets
v. Ensure Confidentiality for all testing for HIV or STI's
vi. Allow for a Holistic Approach to Counselling and Testing
vii. Strengthen Prevention Efforts
viii. Maximise Efficient Use of resources
ix. Addressing the MDG's through promoting up scaling of counselling and testing in Fiji.

E) The HIV/STI Counselling and Testing Policy is quiet Comprehensive and encompassing areas such as the different types of Counselling that is available in Fiji, the different Models of HIV testing and Counselling, Guiding Principles for HIV/STI counselling and testing, highlighting the eligible populations and it sheds a lot more light into the components of Counselling and Testing, ending of with the Monitoring and Evaluation Component for HIV/STI counseling and Testing.
F) The Policy has indeed been long awaited for the country to standardize and strengthen the process of HIV/STI counselling and Testing in Fiji.

Millennium Development Goals:

A) Scaling up in the areas of Prevention, Treatment and Care is paramount to move towards MDG 6.
B) Scaling up in the areas of:

-Communications Strategy: Needs to be a targeted approach:

i. Targeted to the Key Affected Populations
ii. PPTCT program
iii. Youth
iv. General Community
v. Communications also needs to address Treatment, Care and Support
vi. Advocating and ensuring that the general public is aware on the HIV Decree 2011

C) Prevention:

i. Targeted community awareness to Key Affected Populations
ii. HIV/STI awareness for in school and out of school youth
iii. Condom Accessibility and availability for the general public

D) Treatment and Care:

i. Ensuring that all patients eligible for therapy are initiated on therapy
ii. Strengthening Fiji's PPTCT program
iii. Holistic Approach in terms of HIV care and support
iv. Ensuring the HIV therapy is available in Fiji when needed
v. Strengthen HIV Treatment and Care training for all health care workers pre-service and in service.
vi. Strengthening Reporting for the HIV Programs.
vii. Annual Audits on HIV Diagnosis, Treatment and Care for all Divisions.
viii. Gradual Decentralization of HIV services to ensure universal access is available to all patients who have them when they need them.

Trainings:

There were quite a few trainings in the year of 2013:

1) *Prevention of Parent to Child Transmission of HIV which occurred in three divisions:*

- Central Division
- Western Division
- Northern Division

The training encompassed all components of PPTCT from Basic background to treatment to monitoring and evaluation. The revised training manual was used for the training in the three divisions though we weren't able to distribute the manual to all except a draft manual to the Northern Participants since it was finalized in the third quarter of the year 2013.

2) *HIV Prescribers training:*

This has been the third year of running for the training which has become an important training for the dissemination of Basic HIV information to medical personals to help identify HIV in the country. HIV Prescribers has been a national training for the past three years and in the coming year (2014) we hope to make it a divisional training ensuring that more health care workers are trained in HIV care to help facilitate the decentralization of the program.

3) *Voluntary Counseling and Confidential testing (VCCT):*

There was a huge need for counselors around the country to ensure that all HIV testing was happening in line with the HIV Decree. We have empower pacific covering the main divisional hospitals and some sub-divisional hospitals (Nausori and Nadi hospitals only) thus we need to ensure that enough counsellors are available for coverage of HIV testing in the other sub-divisions around Fiji.

There were in total 6 trainings for VCCT which included:

- 2 Central Division Trainings
- 2 Western Division Trainings
- 2 Northern Division Trainings

There has been accreditation of sites to be VCCT compliant around the country. These site visits have been done by both the Divisional Hub medical officers and the Empower Pacific team. For further report please do not hesitate to contact the family health unit for details.

The trainings were supported by Family Health Funds under the HIV Prevention and Control Allocation and as well as National TB programme.

4) Sub-Divisional Training on STI Syndromic:

In 2013 we did trainings for STI Syndromic at the Sub-Divisional level which factored in more health care workers trained in the area of STI.

The STI training is usually done by the Medical Officers in Charge of the Sexual Reproductive Health Clinics around Fiji working closely with the HIV STI team from Headquarters and other partner organizations such as SPC, OSSHHM or UNICEF.

With the STI training people are also taught the syndromic reporting which needs to happen in all centers around Fiji.

We need to strengthen the current reporting systems in place for syndromic reporting ensuring that Health Information Unit is a part of the data collection that needs to be carried out.

Apart from the policies and trainings done at National Level, there were a significant number of outreach programs which took place in the three divisions. These outreach programs encompass educational HIV/STI sessions and Voluntary Counseling and Testing, these counseling and tests done during outreach have reported a number of positive cases from the various divisions, though majority of the cases have been from the Central and Western Division. For further reference please refer to ***Annex 1: Reports from the Sexual Reproductive Health Clinics.***

HIV DATA 2013

Table 1 Cumulative HIV Cases Fiji 1989 to 2013

Table 1: Cumulative HIV Cases Fiji 1989 to 2013																								
TOTAL		SEX			RACE				MODE OF TRANSMISSION								AGE GROUPS							
Year	Total	M	F	U	Fij	Ind	Oth	U	Hetro	Homo	Bi	Trans	IDU	Peri	B/piercg	ukn	0-9	19-Oct	20-29	30-39	40-49	50-59	60+	Ukn
1989	5	4	1	0	2	3	0	0	3	0		1	0	0	0	0	0	0	3	1	0	1	0	0
1990	2	2		0	1	1	0	0	3	0		0	0	0	0	0	0	1	1	0	0	0	0	0
1991	3	2	1	0	1	2	0	0	1	1		0	0	1	0	0	0	0	0	2	0	0	0	1
1992	4	2	2	0	1	2	1	0	2	2		0	0	0	0	0	0	0	2	1	1	0	0	0
1993	6	4	2	0	6	0	0	0	1	2		0	0	0	0	0	0	0	3	3	0	0	0	0
1994	5	5		0	3	1	1	0	3	2		0	1	0	0	0	0	0	2	1	2	0	0	0
1995	6	4	2	0	5	1	0	0	8	0		0	0	0	0	0	0	0	2	2	2	0	0	0
1996	4	2	2	0	4	0	0	0	3	0		0	0	1	0	0	1	0	2	1	0	0	0	0
1997	6	6		0	4	2	0	0	3	0		0	0	0	0	1	0	0	2	2	2	0	0	0
1998	6	3	3	0	5	0	1	0	7	0		0	0	0	0	0	0	0	4	0	2	0	0	0
1999	11	8	3	0	8	1	2	0	8	0		0	0	3	0	1	0	0	5	3	1	0	0	2
2000	14	8	6	0	14	0	0	0	9	0		0	0	1	0	0	0	1	3	6	2	0	0	2
2001	16	7	9	0	13	1	1	1	17	0		0	0	0	0	0	0	0	11	5	0	0	0	0
2002	25	16	9	0	22	1	1	1	25	0		0	0	1	0	0	0	1	17	4	1	0	0	2
2003	32	18	14	0	29	2	1	0	28	0		0	0	3	0	0	2	0	12	11	3	1	0	3
2004	36	18	18	0	31	3	2	0	26	0		0	0	3	0	0	1	0	16	11	3	2	1	2
2005	24	14	10	0	17	5	1	1	26	0		0	0	2	0	1	0	1	5	9	3	2	0	4
2006	15	5	9	1	7	5	2	1	34	1		0	0	1	0	0	0	2	7	2	2	1	0	1
2007	40	19	21	0	30	7	2	1	23	0		0	0	0	0	0	0	2	23	13	1	0	0	1
2008	31	7	20	4	21	2	1	7	27	0		0	0	1	0	3	3	1	15	4	1	1	0	6
2009*	43	19	23	1	34	6	1	2	37	0		0	0	5	0	1	3	1	16	12	3	3	1	4
2010	33	11	22	0	30	1	0	2	33	0		0	0	0	0	0	0	1	22	8	1	0	0	1
2011	53	32	21	0	42	8	3	0	48	4		0	0	0	1	0	0	1	25	20	6	1	0	0
2012	62	28	34	0	58	3	1	0	55	3		0	0	4	0	0	4	2	34	16	5	1	0	0
2013	64	32	32	0	54	10	0	0	53	5	1	0	0	5	0	0	5	0	28	21	8	2	0	0
TOTAL	546	276	264	6	442	67	21	16	483	20		1	1	31	1	7	19	14	260	158	49	15	2	29

In 2013 Fiji reported 64 new cases from January to December. Thus the cumulative cases to date in regards to HIV in Fiji is standing at 546 as of December 2013. There has been a slight increase in the number of cases for the year by 2 which is a rise of approximately 3.2% in 2013.

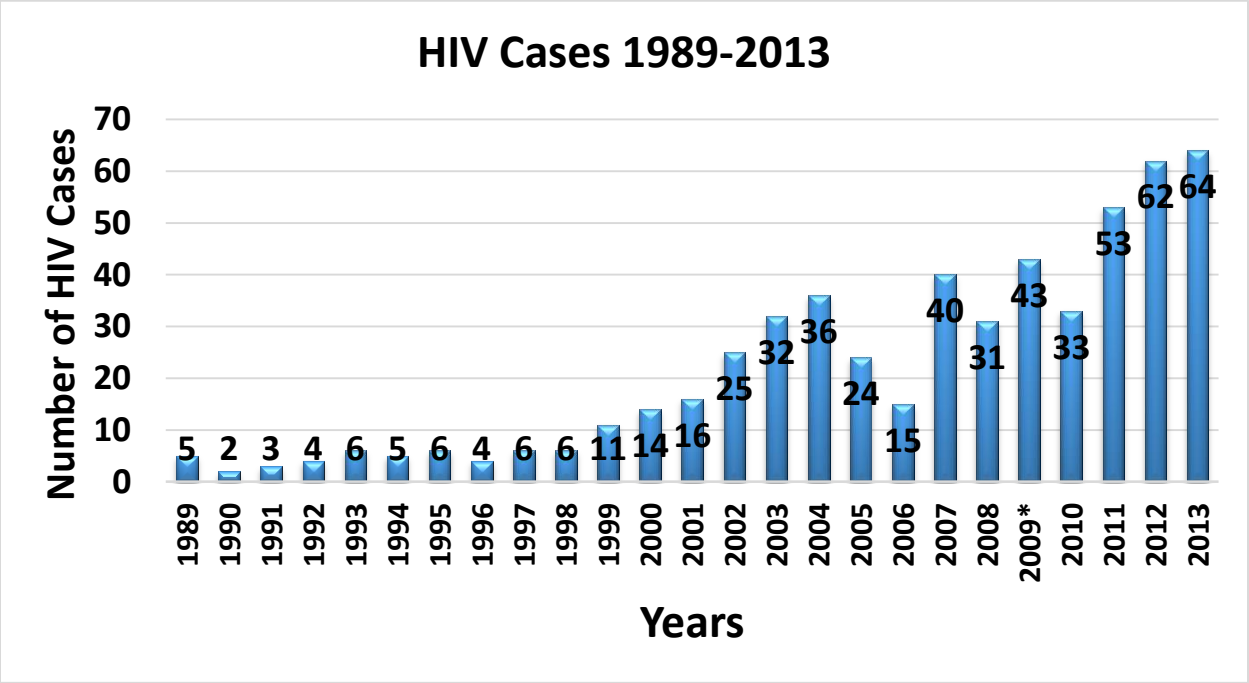


Figure 1 HIV Cases 1989 to 2013

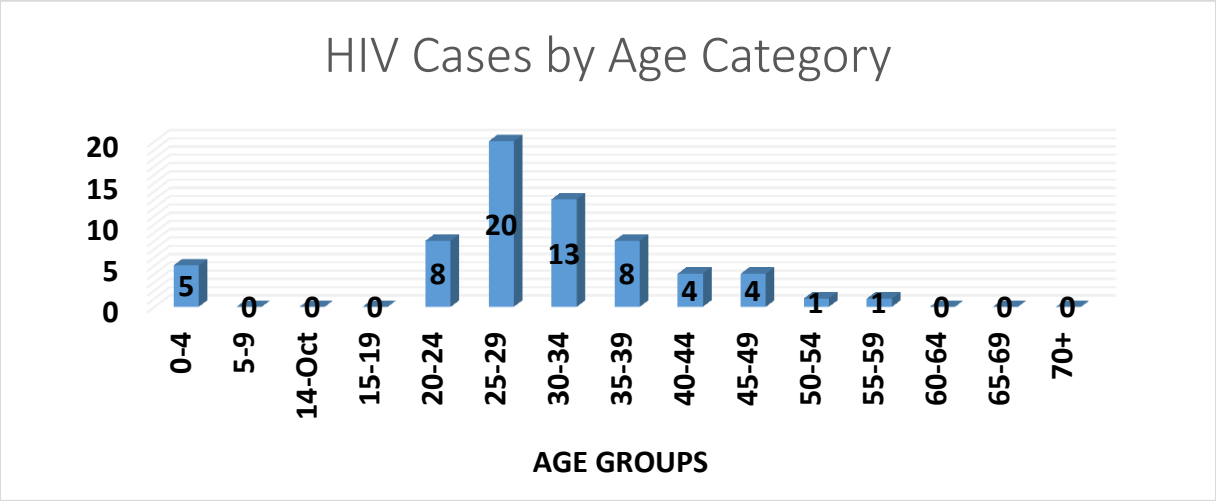


Figure 2 HIV Cases Dissegregated by Age

The age category for HIV cases in Fiji still remains between the age of 20 to 29 though there is a significant number of patients detected are also within the age of 30-39.

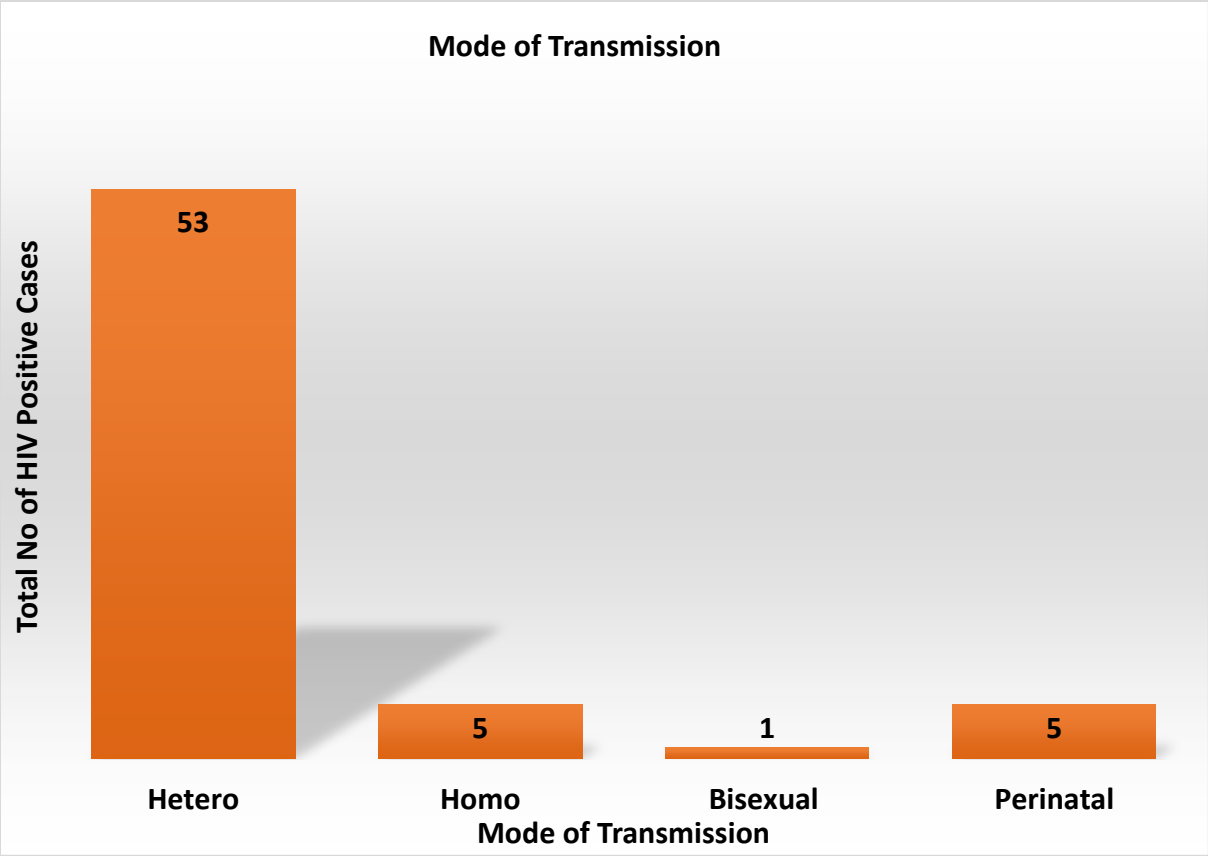


Figure 3 Mode of Transmission for HIV

In Fiji the main mode of transmission has always seen to be amongst the heterosexual group. Fiji's cases are unlike the global figures where HIV is seen to be amongst the Men who have sex with Men (MSM), Sex workers and Injectable Drug Use. Apart from Heterosexual cases we have seen 5 cases of HIV amongst Men who have sex with men and perinatal followed by one bisexual Male.

In the year of 2013 there weren't any sex workers diagnosed from HIV.

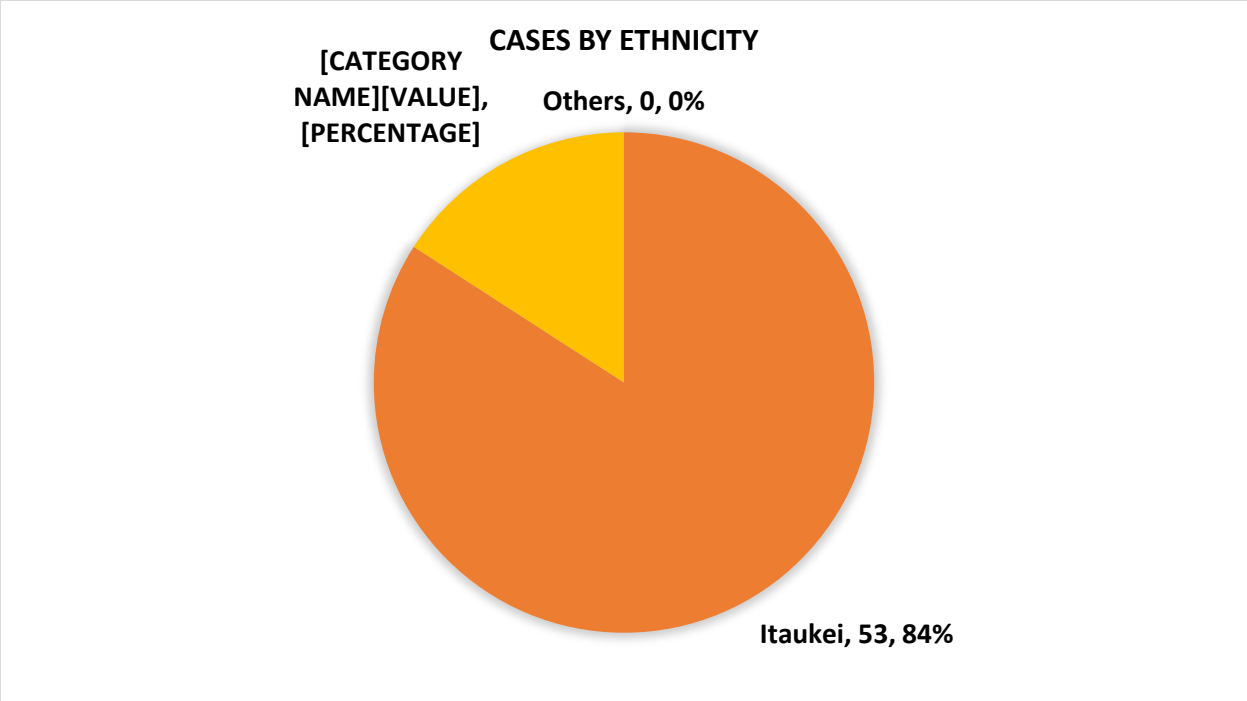


Figure 4 HIV Cases by Ethnicity

The above graph shows that majority of the cases is noted to be amongst the ITaukei Population of Fiji.

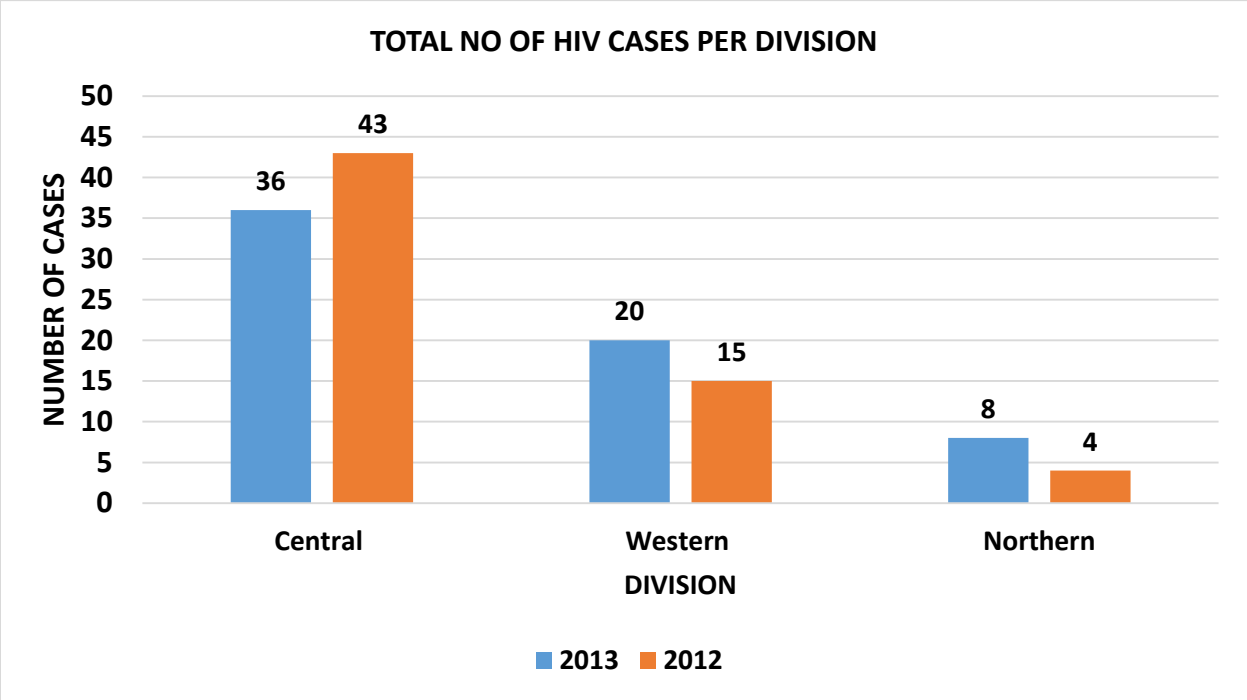
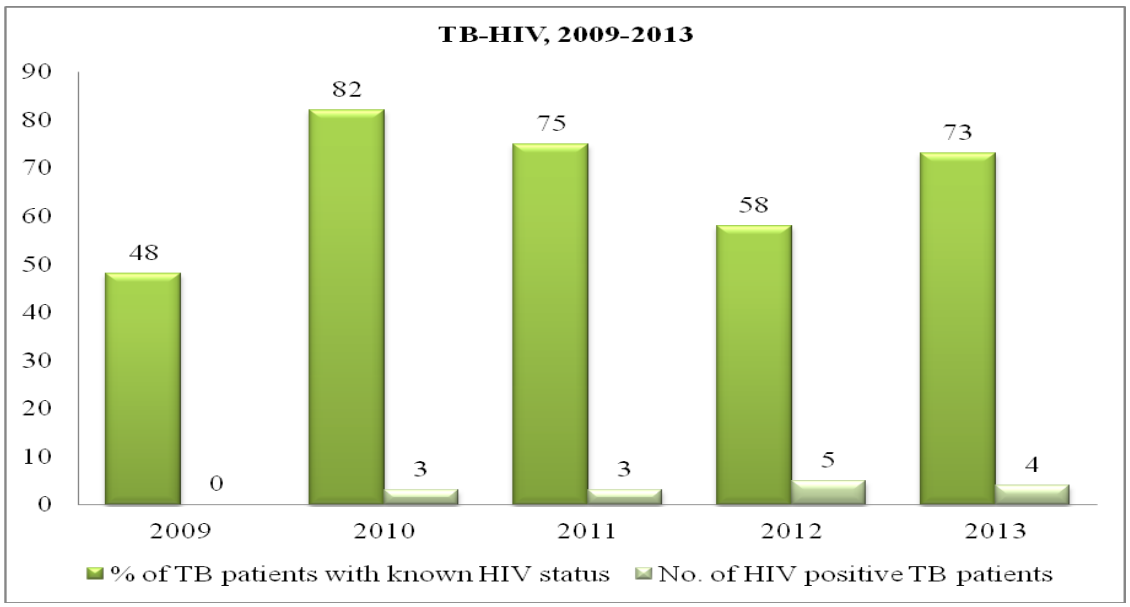


Figure 5 HIV Cases by Division

There was less cases detected in Suva in comparison to 2012 though there was a 100% rise in the northern division and a 25% increase in HIV cases in the Western Division in comparison to 2012.

TB/HIV Cases



TB/HIV Collaboration in Fiji has significantly grown in the past few years. This has contributed to new machines for diagnosis of TB cases amongst HIV patients and vice versa. Gene Expert has contributed towards the efficient diagnosis of TB amongst HIV Positive patients and all HIV Positive patients undergo TB screening using Gene Expert and an X-Ray.

Table 2 TB/HIV Cases 2013

Division	No. of PLHIV Screened	No. of Active TB Cases Detected	Prophylaxis
Central	29	0	1
Western	12	1	-
Northern	2	0	2
Total	**43**	**1**	**3**

Figure 6 TB HIV Co-Infection 2013

With the TB/HIV Collaborative Policy 2013-2016 Fiji has contributed towards the use of Isoniazid Prophylaxis Therapy for its patients where necessary. There is a slow increase in the number of patients with TB testing for HIV under the VCCT/PITC program of the TB/HIV Collaboration. There was one death for TB/HIV though not AIDS or HIV related.

Prevention of Parent to Child Transmission of HIV:

Fiji saw 14 cases of PPTCT in 2013, out of which 3 were on treatment prior to the intervention of the PPTCT program. Of the 14 patients there were 11 patients who were diagnosed in Antenatal Clinic and all patients had undergone PPTCT though to note that one patient had defaulted clinic after delivery thus the child and mother are currently lost to follow. Otherwise there was 100% coverage for PPTCT cases in 2013 from data received from the three divisions.

Apart from the one patient mentioned above, all the rest had undergone Early Infant Diagnosis, and received antiretroviral therapy for 6 weeks to reduce the transmission of HIV from mother to child in this instance, which is 92.9% for the year of 2013.

The 14 patients were all on triple therapy for HIV. The first option in this instance is the one pill a day tablets. Which is the combination of Tenofovir, Efevirance and Lamivudine which is the latest WHO guidelines released in June 2013 which Fiji has adopted soon after.

Patients on therapy

In 2013 there were a total of 59 patients in the three divisions that were started on therapy. This is inclusive of both old and new patients who became eligible in the year of 2013 during the follow up clinics.

Though to note that there were a total of 188 patients eligble for therapy at the end of 2013, and out of which 172 patients are on therapy. Those who are eligible and not on therapy are either currently being worked up for treatment including counseling, or lost to follow.

Though as of 2013 there are 277 patients that are registered in the clinics in the three Hub Centers and at the Pediatric Units. Out of these approximately 54 patients are lost to follow up.

Of the 172 patients on therapy only two are currently on second line therapy for treatment. For over 3 years now Fiji hasn't reported any stock outs for treatment of all HIV patients in Fiji.

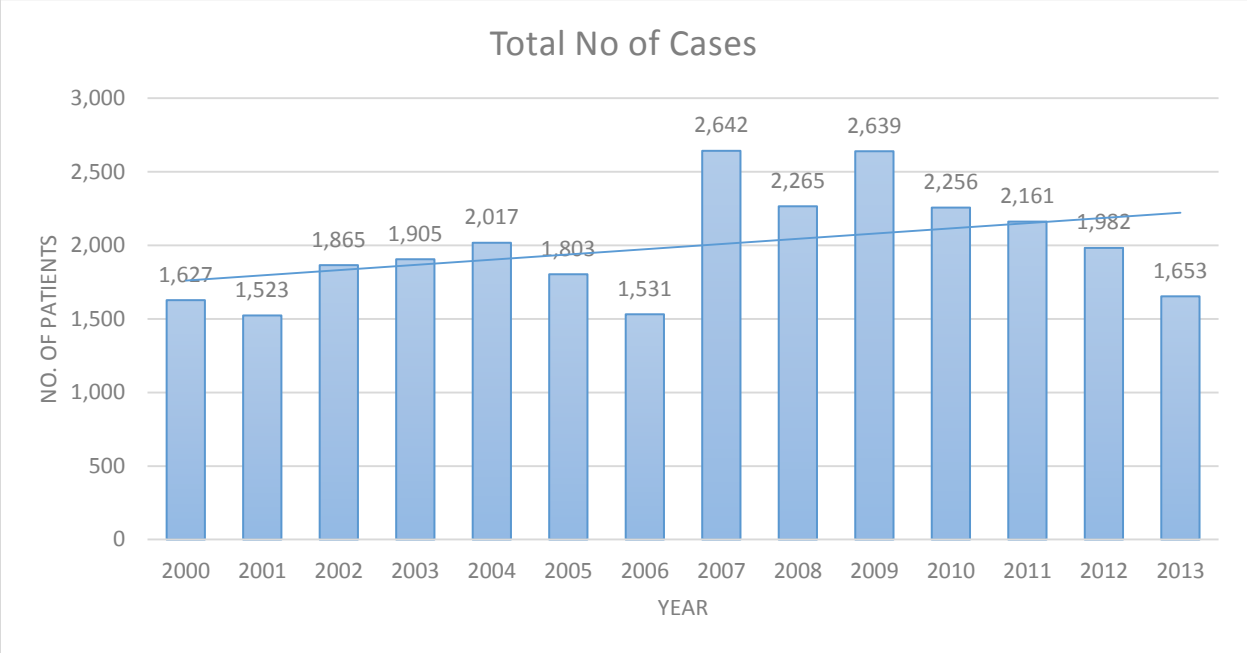
STI DATA (Source Health Information Unit)

Table 3 STI Cases by Year and Disease

STI Diseases	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Candidiasis	0	0	0	0	0	0	0	0	7	10	42	34	164	144
Chlamydia	0	0	0	0	0	0	0	0	10	255	380	189	29	0
Congential Syphils	0	0	0	0	0	2	32	32	257	224	199	22	5	28
Gential Herpes	0	2	0	0	0	2	0	2	6	9	12	15	2	1
Gonorrhoea	1,302	1,147	1,262	1,150	1,155	889	832	1,382	1,095	1,264	1,034	1,198	971	759
Granuloma Venerum	0	0	0	0	0	2	1	0	0	0	0	0	0	0
Herpes Zoster	0	48	0	0	2	12	26	44	42	55	80	59	69	43
Opthalmia Neonatorium	0	2	0	5	1	2	1	3	1	1	3	0	1	15
PID	0	0	0	0	0	0	0	18	7	23	3	1	1	0
Soft Chancre	0	1	0	0	0	3	4	5	2	1	0	0	0	0
Syphils	322	317	592	728	0	868	609	1,110	811	773	415	587	723	576
Trichomoniasis	0	0	0	0	853	0	6	5	9	19	65	53	16	86
Veneral Warts	3	6	11	22	6	23	20	31	14	5	23	3	1	1
Vaginitis	0	0	0	0	0	0	0	10	4	0	0	0	0	0
Total	**1,627**	**1,523**	**1,865**	**1,905**	**2,017**	**1,803**	**1,531**	**2,642**	**2,265**	**2,639**	**2,256**	**2,161**	**1,982**	**1,653**

Fiji recorded in 2013 a total number of 1653 cases of Sexually Transmitted Infections. Which is approximately 17% less than the year of 2012. This data is from the National Notifiable's Diseases which comes directly to the Health Information Unit on a weekly basis.

Figure 7 NNDSS Reporting



Fiji has started syndromic reporting which needs a lot of strengthening in 2014. There has been gradual increase in the number of reports coming in but we have noticed issues pertaining to the reports that come in from the health facilities based around Fiji.

STI Syndromic Reporting: (Hub Centers Only with Northern Health Facilities)

Table 4 Syndromic Reporting by the 3 Hub Centers

SYNDROMIC MANAGEMENT	Central Division	Northern Division	Western Division	Total
URETHRAL DISCHARGE	529	145	**262**	936
VAGINAL DISCHARGE	185	49	**72**	306
SCROTAL SWELLING	2	Unk	**6**	8
GENITAL ULCERS	57	14	**45**	116
LOWER ABDOMINAL PAIN	53	78	**44**	175
WARTS	36	Unk	**16**	52
NEONATAL CONJUNCTIVITIS	0	1	**0**	1

The above 6 syndromes is what Fiji should be reporting on nationwide, as we strengthen reporting from the other sites we have credible data on reporting from the three main sites around Fiji which is the Sexual Reproductive Health Clinics in the three divisions. The three SRH clinics report quarterly on the Syndromic cases seen by the respective clinics. To note that warts is also reporting in the above table.

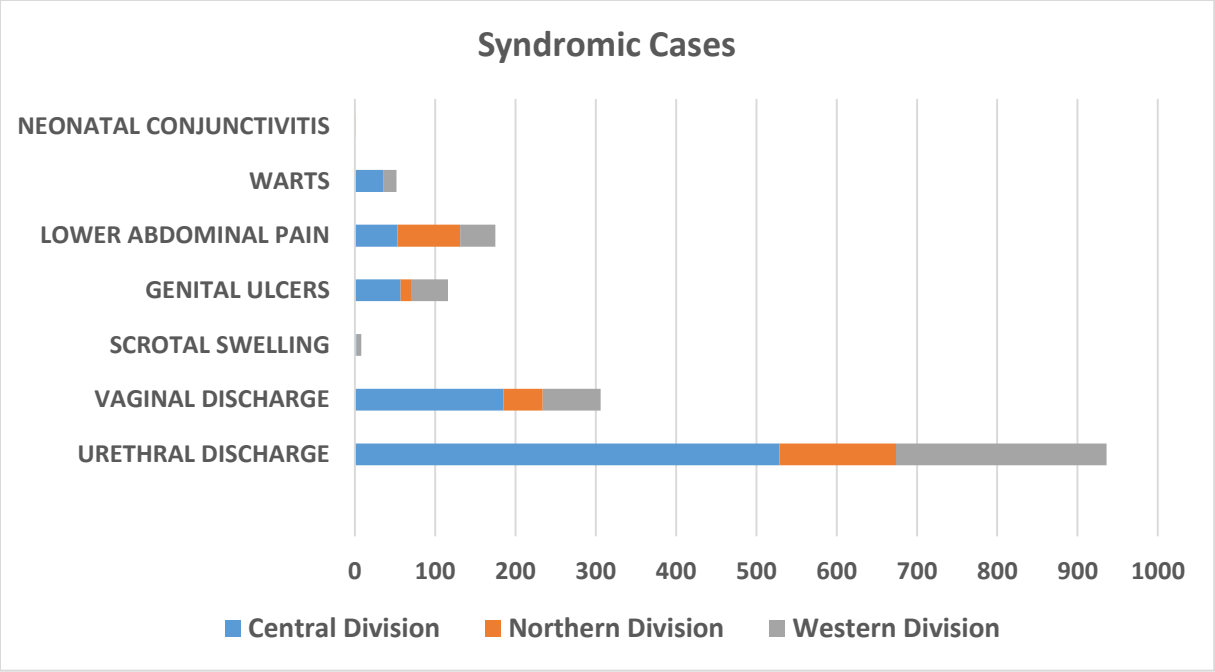


Figure 8 Syndromic Reporting by Hub Centers

The main syndromic case seen in the divisions is Uretheral Discharge Syndrome, followed by Vaginal Discharge, Lower Abdominal Pain, Genital Ulcers, Scrotal Swelling than Neonatal Conjunctivitis. Though to note that the majority of the Neonatal Conjunctivitis would be reported by Pediatrics Department in the three divisions.

The additional STI factored above here is WART's.

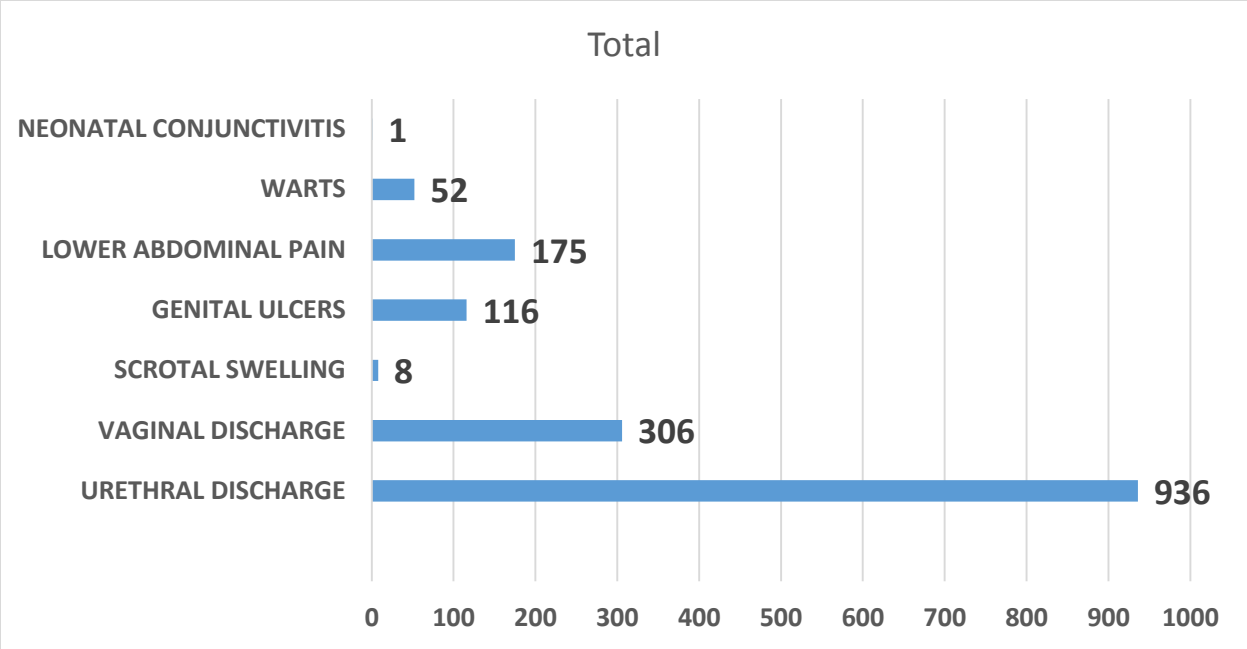


Figure 9 Total Syndromic Cases (Hub Centers) Showing the total number of cases for each syndrome and warts.

Maternal Health and Gender:

Maternal Health and Gender has had its challenges though some of the achievements for the year for 2013 were:

Development of the first ever maternal health strategic plan for Fiji. This was facilitated by a consultant supported by FHSSP along with a review of the maternal health program for Fiji. This strategic plan has contributed towards a more strategic direction for maternal and child health care for Fiji in line with International Goals (Millennium Development Goals) and Local Targets of maternal and child health.

Fiji Government committed to ensuring that all health facilities from the health centers up to the Sub-Divisional Hospitals are well equipped with necessary equipment's needed to ensure efficient service delivery. This is an important component alongside the trainings that have been happening in Fiji in relations to maternal health. The equipment's purchased were supported by the Fiji Government and also FHSSP.

All Health Centers and Nursing Stations were provided with delivery packs to ensure that if a delivery was to happen in these sites there was basic necessary equipment's available for these centers. Apart from these centers the Sub-Divisional Hospitals were equipped with equipment's made available from MOH, UNFPA and FHSSP standards set against the audit that was carried out for Safe Motherhood in Fiji.

Apart from the equipment's made available for these centers Fiji was also able to procure some equipment's for the Divisional Hospitals. This support was provided by FHSSP.

There is developments in regards to the Clinical Practice Guidelines for maternal health which have been finalized and ready for printing in early 2014.

Strengthening the early morning rounds by the three divisional hospitals have been good for the maternity unit and in 2013 there was the first combined meeting with Obstetrics and Maternity to ensure a collaborative effort to reduce maternal and child mortality rates in Fiji. This meeting ensured that pediatrics registrars were a part of the morning hand over for maternity and there was more collaborative efforts to tackle perinatal mortality.

In regards to family planning Fiji has been in the process of developing a training manual with an action plan to ensure the skill set, equipment's, improved data collation and communications were available for all to facilitate the increase in uptake of contraception where necessary.

Millennium Development Goal Paper presented to NHEC:

Role Delineations:

i. **Divisional Hospital:** Low and High Risk ANC; Planned Low and High Risk Intra-partum Care; High Risk Postpartum Care
ii. **Sub-divisional Hospitals**: Low Risk ANC; Planned Low Risk Intra-partum Care; MCH Clinics
iii. **Health Centers And Nursing Stations:** Low Risk ANC; Unplanned Low Risk Intra-partum Care; MCH clinics

Fiji Emergency Obstetric and Neonatal Care training needs to be strengthened around the country to help support the skilled staffing under maternal and neonatal care.[4]

Ensuring the Minimum standard obstetric Equipment upgrade in Fiji at all levels, from the Comprehensive to Basic Mother safe facilities in Fiji

Need for Legislative support for Rural Antenatal Care: this involves the Food Voucher System being put in place again.

Decentralisation of Obstetric Clinical Skills: Supporting the Divisional EmONC program, development and support of the Manual Vacuum Aspiration; training inco-operated into the Fiji EmONC program on Manual Removal of Placenta.

There is a need to strengthen Communication links with Divisional and Sub-Divisional hospitals

Strengthening of Outreach Support Visit Services. This support goes in terms of Consultant and Senior Registra support to the other Divisions in need and also the regular outreach programs from Divisional hospitals to the Sub-Divisional Hospitals.

Strengthening of the Monitoring and Evaluation of the Obstetric and Gynaecological services around Fiji.

VIA Program[5]

Visual Inspection of the Cervix with Acetic Acid (VIA) is a cost-effective and efficient way of performing cervical cancer screenings that can assist in increasing the screening of women in Fiji by the Ministry of Health.

VIA can be performed alongside Pap smears to increase efficiency and reduce the laboratory bottleneck for our target population. Women eligible for VIA screening should be aged 30-50

[4] What will it take to Achieve Millennium Development Goals, An international Assessment by UNDP 2010
[5] Quote from Cervical Cancer and Prevention Report

years old, not pregnant, have no prior history of cervical surgery, present a non-suspicious looking cervix and a clearly identifiable squamo-columnar junction.

AWARENESS AND SCREENING

Cervical cancer awareness was performed from January through December with outreach programs and with assistance from local media. Thousands of men, women, and children were educated on the prevalence of cervical cancer, its transmission, and various prevention strategies in addition to other reproductive health topics.

After the Stakeholders conference in January 2013, screening efforts in the Suva Sub-Division shifted from Makoi Health Center and rotated through the other Central Division health centers every 3 weeks as follows:

Table 5 Awareness Screening Program in Health Facilities in Suva Sub-Division

DATES	HEALTH FACILITY
Feb 18th – March 8th 2013	Valelevu Health Center
March 11th – March 20th 2013	Raiwaqa Health Center
April 2nd – April 18th 2013	Samabula Health Center
April 22nd – May 10th 2013	Nuffield Clinic
May 13th – May 31st 2013	Lami Health Center
June 10th – December 31st 2013	Suva Health Office

Additional outreach and screenings were performed in the Serua Province by invitation and with assistance from the Serua Provincial Women's Club.

Moreover, various outreach events were completed by invitation or as a direct result of training workshops. Workplace screenings also began and we anticipate these to increase in 2014.

Table 6 Screening Program in the Serua Namosi Sub-Division

	FACILITY NAME	TOTAL POPULATION	TOTAL WOMEN	EXPECTED TARGET POPULATION 30-50 YRS	TOTAL WOMEN SCREENED	TOTAL WOMEN SCREENED (VIA) 30-50 YRS	HEALTH % COVERAGE ACHIEVED 30-50 YRS
SERUA/NAMOSI SUB-DIVISION							
1	**Beqa Med Area**				**39**		
2	**Navua Med Area**	**29,701**	**14,851**	**1,931**			
3	**Namuamua Med Area**						
4	**Korovisilou**	**6,630**	**3,315**	**431**	**176**		**40.8%**
REWA SUB-DIVISION							
5	**Nausori**	**82,000**	**41,000**	**5330**	**183**	**121**	**2.27%**
SUVA SUB-DIVISION							
6	**Makoi Med Area**	**27,136**	**13,568**	**1,764**	**218**	**145**	**8.21%**
7	**Samabula Med Area**	**16,702**	**8,351**	**1,086**	**104**	**85**	**7.82%**
8	**Raiwaqa**	**29882**	**14941**	**1,942**	**141**	**139**	**7.16%**
9	**Nuffield**	**48,811**	**24,405**	**3,173**	**87**	**71**	**2.23%**
10	**Lami**	**28,825**	**14,413**	**1,874**	**208**	**190**	**10.13%**
11	**Valelevu**	**53,228**	**26,614**	**3,460**	**98**	**90**	**2.60%**
12	**Suva**	**14,900**	**7,450**	**969**	**322**	**254**	**26.21%**
NAITASIRI SUB-DIVISION							
13	**Vunidawa Med Area**	**19,873**	**9,936**	**1,292**	**61**	**51**	**3.94%**

Table 7 Suva Area Screening Outcomes from September to August 2013

TOTALS	ITAUKEI	INDO-FIJIAN	OTHERS	TOTAL WOMEN SCREENED	REASONS FOR REFERRALS
VALELEVU HEALTH CENTER					
Total Seen	49	47	2	**98**	
Total Cryotherapy Treatment	2	-	-	**2**	
Total Referrals	1	1	-	**2**	1 Polyp, 1 Extensive Acetowhite
RAIWAQA HEALTH CENTER					
Total Seen	77	53	11	**141**	
Total Positive	4	4	-	**8**	
Total Cryotherapy Treatment	3	3		**6**	
Total Referrals	3	-	-	**3**	2 Extensive Acetowhite, 1 Prolapse
No VIA	1	-	-	**1**	
SAMABULA HEALTH CENTER					
Total Seen	62	39	3	**104**	
Total Positive	7	4	1	**12**	
Total Cryotherapy Treatment	5	3	-	**8**	

False Positive	1	1	-	**2**	
Total referral	1	-	1	**2**	2 Extensive Acetowhite
No VIA	-	-	-	**-**	
NUFFIELD CLINIC					
Total Seen	45	32	13	**100**	
Total Positive	7	3	2	**12**	
Total Cryotherapy Treatment	2	1	2	**5**	
Default Cryo	2	1	-	**3**	
Total Referrals	5	1	-	**6**	1 Growth, 1 Abnormal Cx, 4 Extensive Acetowhite
No VIA	-	-	-	**-**	
LAMI HEALTH CENTER					
Total Seen	131	6	16	**153**	
Total Positive	10	1	2	**13**	
False Positive	1	-	1	**2**	
Total Cryotherapy Treatment	3	1	-	**4**	
Default Cryo	4	-	-	**4**	
Total Referrals	4	-	-	**4**	2 Polyp, 1 Abnormal Cx, 1 Extensive Acetowhite
No VIA	-	-	-	**-**	
MAKOI HEALTH CENTER					
Total Seen	100	112	6	**218**	
Total Positive	11	16	1	**28**	
False Positive	2	2	-	**4**	
Total Cryotherapy Treatment	4	15	1	**20**	
Default Cryotherapy	1	0	0	**1**	
Total Referrals	8	9	1	**18**	2 Abnormal PV Bleeding, 6 Extensive Acetowhite, 5 Suspicous Cx, 1 Purulent dischrge, 2 No SCJ
Default Referral	1	1	0	**2**	
SUVA HEALTH OFFICE					
Total Seen	174	101	47	**322**	
Total Positive	2	3	2	**7**	
False Positive	-	-	-	**0**	
Total Cryotherapy Treatment	2	2	2	**6**	
Default Cryotherapy	-	-	-	**0**	
Total Referrals	-	1	-	**1**	1-Extensive Aceto white

Table 8 Hospital Gynae Clinic Referrals by Age and Race from September 2012 to December 2013

REASONS FOR REFERRALS	WOMEN 30-50 YEARS OLD			WOMEN < 30 YEARS OLD		
	ITAUKEI	INDO-FIJIAN	OTHERS	ITAUKEI	INDO-FIJIAN	OTHERS
Extensive/Scattered Acetowhite Lesions	13	2	-	-	1	-
Abnormal/Suspicious for Cancer	5	2	-	-	-	-
Post Cryotherapy	-	-	-	1	1	-
Endo-cervical Lesions	1	-	-	-	-	-
Polyps	14	-	2	-	-	-
Other Reasons	1	-	-	-	-	-

Table 9 Referral Outcomes from Gynae Hospitals

REFERRAL OUTCOMES	TOTAL
LGIL/CIN 1 with HPV changes	**4**
Squamous Cell Cancer in situ	**3**
HGIL confirmed	**5**
Squamous Metaplasia with HPV	**5**
LETTZ done	**5**
Hysterectomy done	**1**
Awaiting LETTZ biopsy results	**2**

Table 10 Ministry of Health Staff Trained in VIA

CENTRAL DIVISION			
2011 TRAINING			
Medical Field	**Name**	**EDP**	**Residence**
N/P	Emaline Works Nasilivata		Raiwaqa Health Center
S/Nurse	Lidia Torovi		Makoi Health Center
S/Nurse	Selai Samuela		Valelevu Health Center
Doctor	Litia Narube		CWM Hospital O&G Unit
Doctor	Mere Kurulo		CWM Hospital O&G Unit
Doctor	Danela Tassel		CWM Hospital Forenseic Unit
S/Nurse	Regina Serukalou		Nayavu Health Center
S/Nurse	Naomi Salabuco		Dogo Health Center
Sister	Vitalina Sautu		Korovou Hospital
2013 TRAINING: JUNE 3-7			
Medical Field	**Name**	**EDP**	**Residence**
Doctor	Kelera Bavadra		CWM Hospital O&G Unit
Doctor	Nanise Sikiti		CWM Hospital O&G Unit

Sister	Ana Tube	31432	Vunidawa Health Center
S/Nurse	Sisifo Teonea		Lami Health Center
S/Nurse	Susana Tamanisoata		Navua Health Center
S/Nurse	Olivia		Nausori Health Center
2013 TRAINING: NOV 11-15			
Medical Field	**Name**	**EDP**	**Residence**
S/Nurse	Elisa Ranubu	32876	Vunidawa Health Center
N/P	Raijieli Nakuru	32251	Nakorosule Health Center
S/Nurse	Kashmir Chand	33257	Naqali Health Center
S/Nurse	Sainimere Navisa	34180	Lomaivuna Nursing Station
S/Nurse	Arieta Turaganivalu	33509	Laselevu Health Center
N/P	Akanisi Toloi Talawadua	32438	Laselevu Health Center
Zone Nurse	Mikaele Ravouvou	34750	Vunidawa Health Center
S/Nurse	Setaita Suka	33189	Vunidawa Hospital
2013 TRAINING: DEC 9-13			
Medical Field	**Name**	**EDP**	**Residence**
Staff Nurse	Miriama Rokoleba	34038	School Health Team
Staff Nurse	Edwina Raihman	33659	Wainibokasi Health Center
Zone Nurse	Sera Tamoi	33311	Naqeledamu Zone
District Nurse	Fulori Leweni	33361	Wainibokasi Health Center
Zone Nurse	Emeline Tuicakau	33243	Nausori Health Center
MCH/FP Nurse	Marica Donumaivanua	32180	Mokani Health Center
Staff Midwife/ANC	Alanieta Tuamoto	32191	Nausori Hospital
District Nurse	Motea Nukucagina	33403	Baulevu Nursing Station

WESTERN HEALTH DIVISION			
2013 TRAINING: JUNE 3-7			
Medical Field	**Name**	**EDP**	**Residence**
N/P	Emaline Works Nasilivata		Lautoka Hospital
Doctor	Luse Tinaikui		Lautoka/Yasawa
Doctor	Virisila Sema		Lautoka Hospital
Professor	Swaran Naidu		Viseisei Health Center
S/Nurse	Veena Devi		Lautoka Hospital
S/Nurse	Mereseini Naiola		Ba Health Center
2013 TRAINING: NOV 25-29			
Medical Field	**Name**	**EDP**	**Residence**
S/Nurse	Amelia Ake		Viseisei Sai Health Center
S/Nurse	Jijilia Koroi	34382	Viseisei Health Center
FP Nurse	Melaia Tuiwara	33840	Lautoka Health Center

FP Nurse	Mere Rai Vatege	32670	Tavua Health Center
Zone Nurse	Sovaia Sataru	33863	Ba Health Center
Staff Nurse	Sanita Tonono	35952	Ba Mission Hospital
Staff Nurse	Florence Nainima	32155	Ba Mission Hospital
Zone Nurse	Esili Naulivou	33117	Nadi Health Center
S/Nurse	Julie Rika	33371	Naviti SRHC
S/Nurse	Luisa Lubi Tuivuya	32459	Nailaga Health Center
S/Nurse	Arieta Tonono	32866	Keiyasi Health Center
N/P	Mealia Busa	32374	Namarai Health Center
N/P	Asena Kauyaca	32227	Raiwaqa Health Center
N/P	Susana Bari	32606	Bukuya Health center.
Zone Nurse	Sereana Tirau	33312	Balevuto Health Center

NORTHERN HEALTH DIVISION			
2013 TRAINING: JUNE 3-7			
Medical Field	**Name**	**EDP**	**Residence**
Doctor	Viliame Nasila		Labasa Hospital
Doctor	Loata Tora		Wainikoro Health Center
Sister	Fane Biraki		Labasa Hospital
Sister	Mere Tikoibua		Savusavu
FP Nurse	Annie Daugunu		Labasa Hospital

EASTERN HEALTH DIVISION			
2013 TRAINING: OCTOBER 14-18			
Medical Field	**Name**	**EDP**	**Residence**
N/P	Alanieta Ragogo		Kavala Health Center
N/P	Melaia Vakausausa		Bureta Health Center
N/P	Asenca Rika		Matuku Health center
Sister	Selai Camaibau	32728	Levuka Hospital
S/Nurse	Lynn Babakola	34807	Nawaikama Nursing Station
S/Nurse	Diakisi Rabuku	33647	Nacavanadi N/Station
S/Nurse	Ruci Tuisinu	34063	Levuka Health Center
S/Nurse	Mareta Dikeve	34168	Nabasovi, Nursing Station, Koro
S/Nurse	Mereani Vuso	33543	Levuka Health Center
S/Nurse	Komal Devishna	34519	Levuka Health Center
S/ Nurse	Manish Chand	33837	Nairai Nursing Stations
S/Nurse	Ana Vateitei	34163	Vadravadra Nursing Station
PH	Vilisi Wailevu	31992	Levuka Health Center
S/Nurse	Peniseni Veilawa	33288	Qarani Health Center

There were in total 71 health care workers trained on VIA in the country to date from 2011 to 2013. Though to note the initial training was for the pilot phase in Fiji. After the successful pilot Fiji decided to roll out VIA around Fiji, thus the increase in the significant number of personals in the year of 2013.

All three divisions were part of the training in Fiji to ease the roll out of VIA. Which has to date worked out well, we have been supported in a significant manner from FHSSP for the VIA program since 2013 November.

The VIA program has its own challenges but despite that we have done well in regards to the roll out, and sustainability needs to be taken up by the Ministry of Health in the year of 2014 for it to become a part of the normal program in the Ministry and not a separate project.

Maternal Health Training for 2013

Table 11 Training Data for Maternal Health

Objective 1	Course Title	Total Trained	Number Males	Number Females
	Baby Friendly Hospital Initiative (BFHI) course	17	2	15
	Birth Preparedness and Complication Readiness Plan	461	49	413
	Clinical Attachment	13	0	13
	Emergency Obstetric and Neonatal Care	180	31	149
	Facilitator Training	4	1	3
	Family Planning and Counselling	58	0	58
	Mother safe Hospital Initiative	17	1	16
	Pap Smear Training	12	1	11
	Partograph Presentation	13	1	12
	Safe Motherhood Training	9	2	7
	VIA Training	40	3	37
	Sum Of tot_all:	824	91	734

Reference: FHSSP

There were a number of trainings and clinical attachments carried out in the year of 2013 as mentioned above. Overall capacity building was of 824 health care workers around Fiji including the comprehensive breakdown of the VIA training that we saw above.

There is still in need for more training the above areas, though to note that in 2014 we will be up-scaling trainings in certain other areas such as:

1) Family Planning with Fiji's own Training package
2) Manual Vaccum Aspirate training
3) Need to Increase Pap Smear Training alongside VIA training

Apart from strengthening the Health care workers with the above trainings we will continue to carry out much of the trainings mentioned in the list to ensure that the skill set is maintained and strengthened around Fiji.

Expanded Food Voucher Program: (Ministry of Women Social Welfare and Poverty Alleviation & MOH)

The Expanded Food Voucher Programme is a collaborative work with Ministry of Health and Ministry of Women and Social Welfare and Poverty Alleviation. Where all pregnant women in a rural setting is assisted with Cash Food Vouchers for the first three confinements. The only exception to this programme is where they are either a civil servant or already under a scheme of the Social Welfare department.

The expanded food voucher program is expected to ensure that women receive money for their nutritional support and ensure that all women book early at a health facility.

Ministry of Health will also be assisting these women who need to deliver at a divisional hospital with passage to ensure that they are supported for the safe delivery at a tertiary hospital.

Family Planning:

Fiji wasn't able to carry out a significant number of trainings for Family Planning in 2013 as the training manual isn't finalized. The highlighted number trained were as mentioned under the training report. There is yet a lot to be done in this area to improve our Family Planning numbers in Fiji. Strengthening family planning strengthens issues pertaining to maternal issues such as maternity related morbidities and mortalities.

Fiji significantly strengthened the Jadelle insertions in the main hospitals when the issue of anesthetist rose, thus over the past 6 months or so there has been almost 20 jadelle insertions every day for women who aren't able to have a tubal ligation.

Table 12 Family Planning Aceptors for 2013 around Fiji

Family planning acceptors,from January to December 2013										
Division	**CBA**	**Oral Pills**	**IUCD**	**Depo Provera**	**Noristerat**	**Implants**	**Condoms Female**	**Condoms Male**	**total**	**% protected**
Central	**86116**	5775	876	5058	9747	2058	132	4097	27743	32.2
Eastern	**7226**	947	279	965	1701	1096	63	355	5406	74.8
Northern	**32773**	2299	62	1172	3425	419	72	2402	9851	30.1
Wester	**78082**	8104	1959	4487	9332	3092	244	5198	32416	41.5

n										
total	**204197**	**17125**	**3176**	**11682**	**24205**	**6665**	**511**	**12052**	**75416**	**36.9**
Family planning Performance Measure from January to December 2013										
Division	**CBA**	**Oral Pills**	**IUCD**	**Depo Provera**	**Noristerat**	**Implants**	**Condoms Female**	**Condoms Male**	**% protected**	
Central	**86116**	20.8	3.2	18.2	35.1	7.4	0.5	14.8	32.2	
Eastern	**7226**	17.5	5.2	17.9	31.5	20.3	1.2	6.6	74.8	
Northern	**32773**	23.3	0.6	11.9	34.8	4.3	0.7	24.4	30.1	
Western	**78082**	25.0	6.0	13.8	28.8	9.5	0.8	16.0	41.5	
total	**204197**	**22.7**	**4.2**	**15.5**	**32.1**	**8.8**	**0.7**	**16.0**	**36.9**	
source: Public Health Information System [PHIS]										

Table 13 Percentage Protected for FP per Division and Annual

	% protected
Central	32.21585
Eastern	74.81317
Northern	30.05828
Western	41.51533
total	**36.93296**

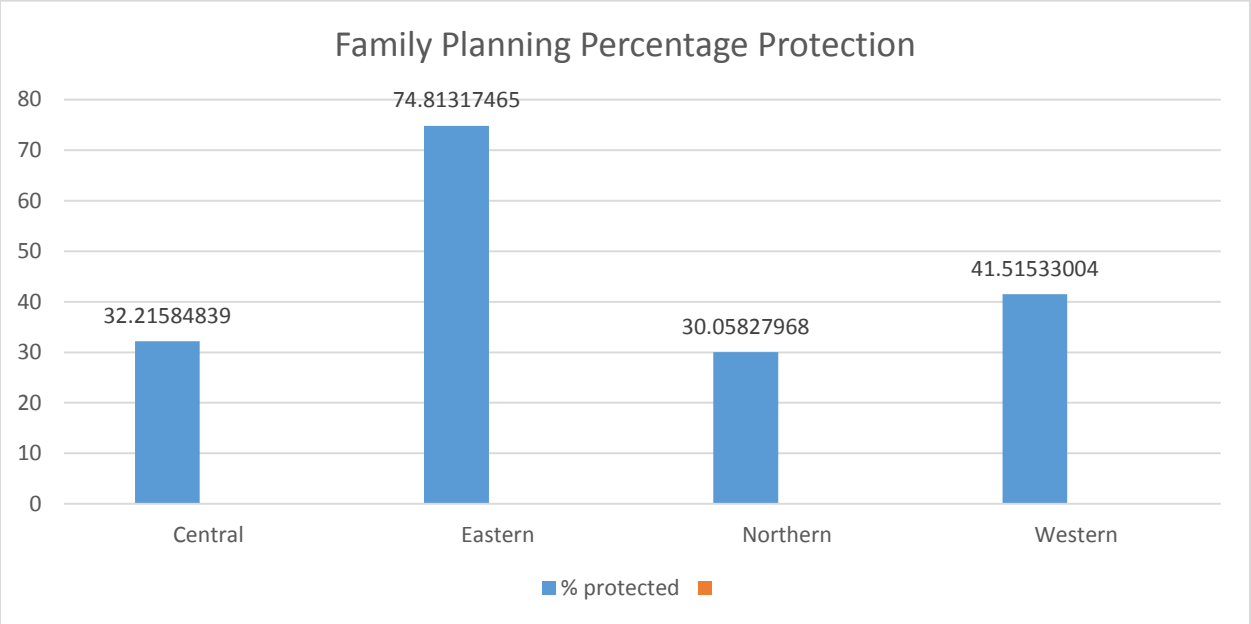


Figure 10 Family Planning Percentage Protection

Fiji's Family Planning rates have been 2009 at 28.9%, 2010 at 31.77%, 2011 at 36.5% and in 2012 at 44.3% and as shown above in 2013 we are sitting at 36.9%. Though to note that this may be under reporting, as we haven't factored in the Jadelle insertions that are happening in the Divisional hospitals since last year.

The above data shows that Eastern Division of Fiji has the highest percentage of coverage over the

Strengthening of reporting in 2014 would show us how we are doing as a country in regards to family planning. We have a long way to go when we talk about reaching 56& for family planning rates for Fiji according to the Millennium Development Goals.

Strengthening data, ensuring adequate training, availability of commodities and equipment's will help us strengthen the coverage rates for Family Planning in Fiji. These are identified areas over the period of 2013 and ensuring these components match with our communications messages for the community is important. Thus Family Health unit is working closely on the Strategic Health Communications in these important areas.

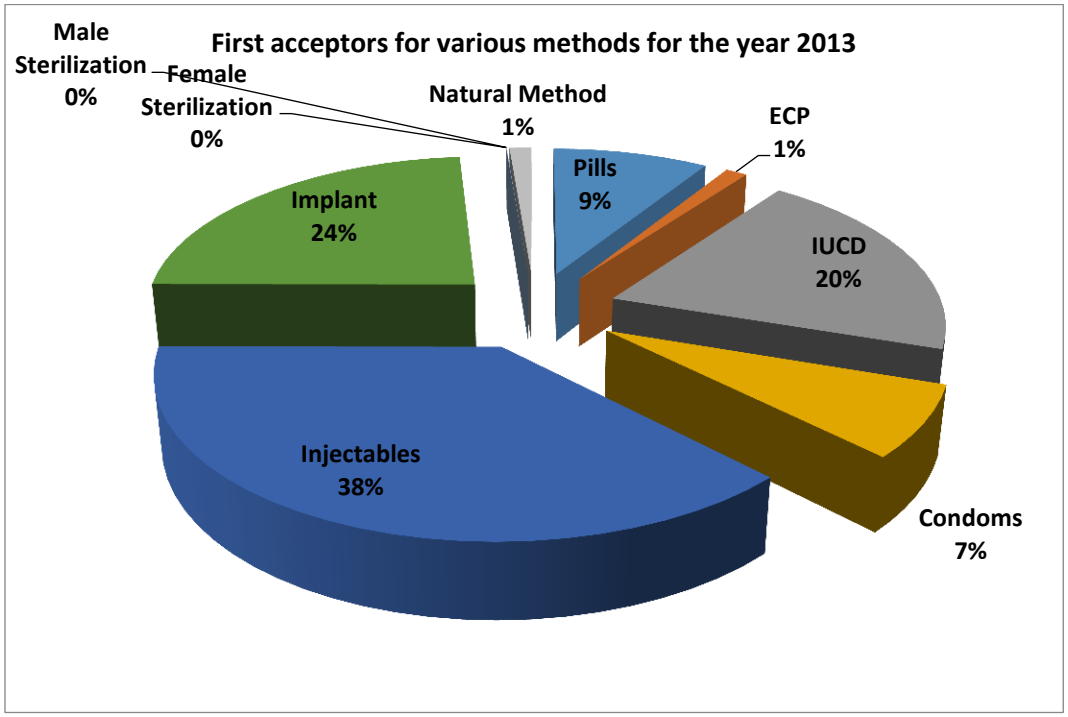


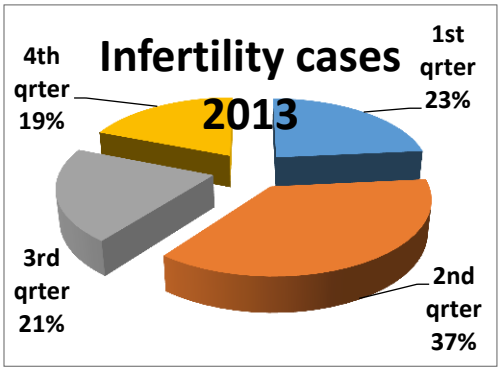
Figure 11 First Acceptors for Oxfam Clinic for 2013

INFERTILITY CASES

Oxfam currently has been one of the main centers around Fiji which serves for issues pertaining to infertility apart from the Divisional hospitals. With the opening of the two other Divisional Centers for Reproductive Health we should be able to strengthen this component in the other two divisions.

Table 14 Total Number of Clients Seen in regards to Infertility Issues

	1st qrter	2nd qrter	3rd qrter	4th qrter	TOTAL
Total	**42**	**66**	**37**	**34**	**179**



Of the total infertility investigations and patients dealt with, we aren't sure how many were males and females. This may be underreporting of infertility rates in Fiji as we are just capturing one center for Fiji in this regards. A need to strengthen reporting is important in this regards.

Figure 12 Infertility Cases for Oxfam Clinic only 2013

Table 15 Proportion of Women who delivered at a Health Facility

Site	Health facility					
	Hospital	Health centre	Home	Nursing station	Private	Not stated
Central	**97.7%** (94.4–99.0) [291]	**1.3%** (0.3–5.2) [4]	**0.3%** (0.0–2.4) [1]	-	0.3% (0.0–2.4) [1]	0.3% (0.0–2.4) [1]
Eastern	**87.7%** (80.4–92.5) [263]	**6.0%** (2.9–12.1) [18]	**2.3%** (0.8–6.5) [7]	4.0% (1.3–11.4) [12]	-	-
Northern	**98.0%** (95.3–99.2) [294]	**1.3%** (0.4–4.3) [4]	**0.3%** (0.0–2.4) [1]	0.3% (0.0–2.4) [1]	-	-
Western	**97.7%** (94.9–98.9) [292]	**1.0%** (0.3–3.0) [3]	**1.3%** (0.5–3.4) [4]	-	-	-
National	**97.3%** **(95.8–98.2)** **[1,140]**	**1.4%** **(0.7–2.7)** **[29]**	**0.8%** **(0.4–1.6)** **[13]**	**0.2%** **(0.0–0.6)** **[13]**	**0.1%** **(0.0–1.0)** **[1]**	**0.1%** **(0.0–1.0)** **[1]**

During the Survey there was approximately 98.9% of the women were known to have delivered at a health facility, though to note majority off the deliveries occurred in the Hospitals sitting at a percentage of 97.3% followed by the health centers and nursing stations of Fiji at 1.4% and 0.2% consecutively. It shows an increased health seeking behavior amongst all pregnant women who deliver around Fiji.

Table 16 Proportion of Women who received most recent dose of TT at each health facility

Site	Proportion of women who received most recent dose of TT at each health facility					
	Hospital	Health centre	Outreach	Nursing station	Private	Not stated
Central	**83.2%** (73.5–89.9)	**10.1%** (4.7–20.4)	2.7% (1.3–5.4)	-	0.7% (0.2–2.6)	3.4% (1.4–7.9)
Eastern	**63%** (52.4–72.5)	**17.3%** (9.6–29.3)	4.0% (1.7–9.1)	11.0% (5.8–19.7)	-	4.7% (2.4–9.0)
Northern	**76.0%** (62.6–85.7)	**16.0%** (7.4–31.1)	1.7% (0.6–4.5)	1.7% (0.5–5.9)	-	4.7% (2.5–8.4)
Western	**73.6%** (59.0–84.3)	**10.0%** (3.9–23.6)	4.0% (1.7–9.4)	4.0% (0.8–17.3)	1.3% (0.4–4.3)	7.0% (2.5–18.2)
National	**77.4%** **(70.6–83.1)**	**11.4%** **(7.2–17.5)**	**3.1%** **(1.8–5.1)**	**2.3%** **(0.8–6.4)**	**0.8%** **(0.3–1.9)**	**5.0%** **(2.8–9.0)**

The above percentages shows the number of women who actually received TT at the respective health facility during there last pregnancy.

Cervical Cancer National Data:

The trend annually remains for clients requesting or recommended for infertility tests and counseling.

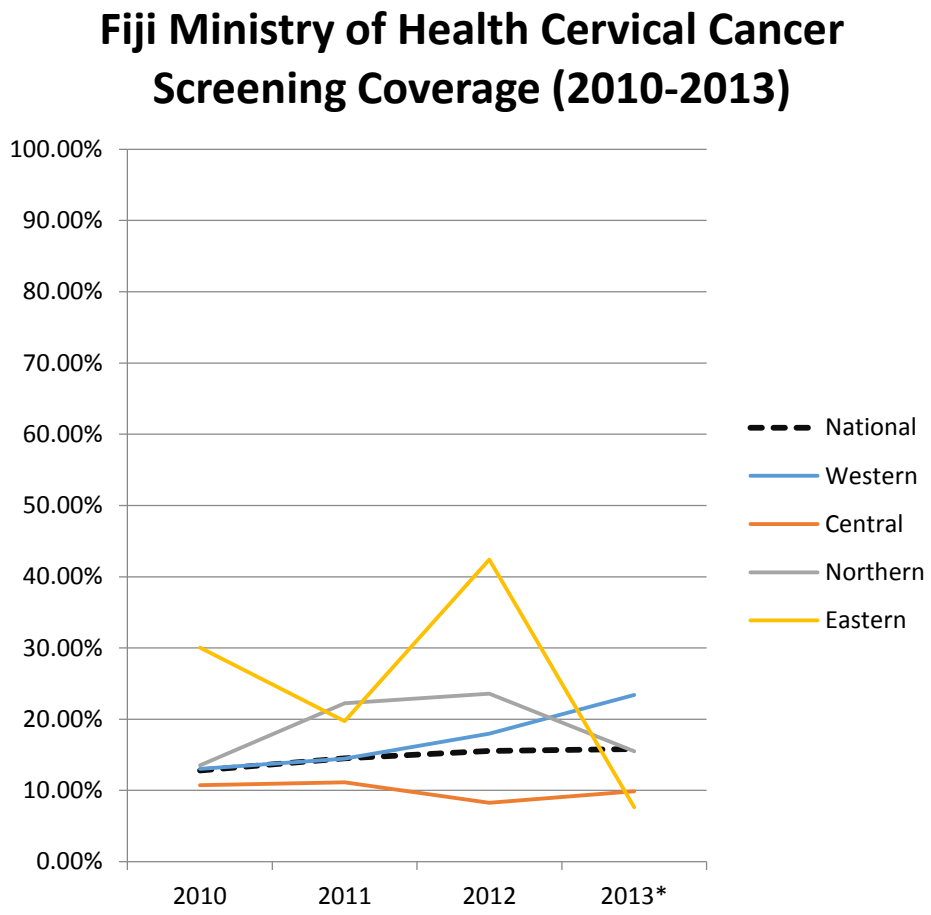


Figure 13 Cervical Cancer Screening Coverage from 2010 to 2013

Cervical Cancer Screening coverage has shown to be low for the past 4 years though number of cases detected is high. There is a need to increase and strengthen the need to ensure a good pap-smear coverage and VIA coverage. As we roll out VIA there is a need to ensure that we also carry out pap-smear around Fiji to ensure that Pap smear and VIA are carried out equally around Fiji.

There may be a need to ensure that all pregnant women who undergo ANC also receive Pap's Testing around Fiji to help reach the appropriate age group with women and increase numbers for testing in a more cost effective manner. As these women will be part of the ANC for the period of her pregnancy.

Cervical cancer screening							6 months	Annual
Target population	**Pap (NP)**	**Pap (ARP)**	**Pap (PNC)**	**Pap (FP)**	**VIA (FP)**	**Combined**	**Coverage**	**Projected**
81608	**59**	**0**	**192**	**5470**	**726**	**6447**	**7.90%**	**15.80%**
Data source: Public Health Information System (PHIS); Health Information Unit, Fiji Ministry of Health								

Figure 14 Cervical Cancer Screening Coverage

In 2013 with the Pap Smear Coverage and VIA for Fiji we were only able to cover approximately 15.80% of the estimated 81,608 women in Fiji. Increasing coverage with initiative ideas is important.

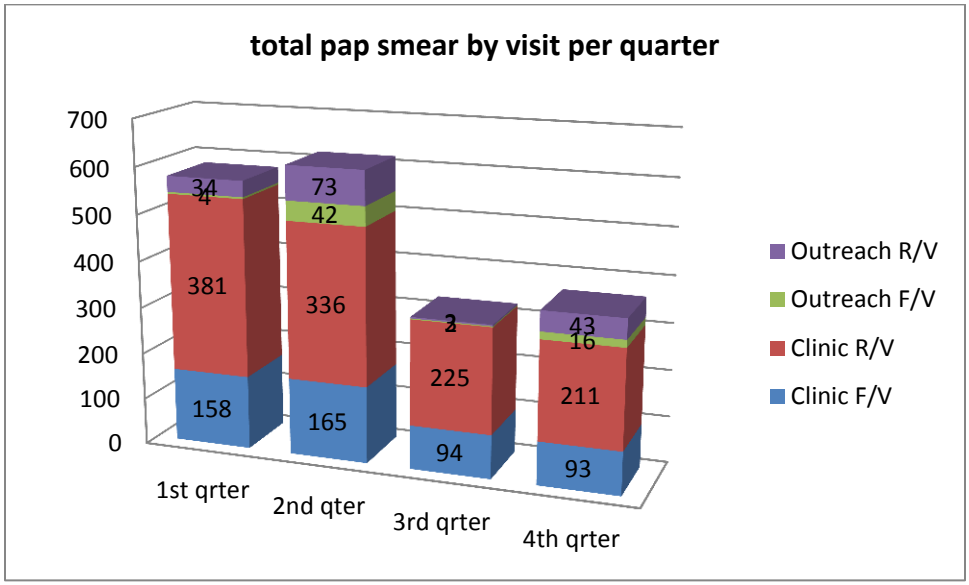


Figure 15 Pap smear numbers for Oxfam Clinic

The above graph shows the number of cases that were seen at the Oxfam Clinic alone during Clinic hours and during their outreach programs.

Gender

Ministry of Health Fiji had a gender consultant who reviewed the Ministries response to Gender with action plans. The recommendations from the Gender Report led to the development of the Gender working group which developed and action plan for the Ministry of Health, an important component of the Action Plan was the development of the Gender Training manual for the Ministry to carry out trainings for the Senior Managers, Divisional Teams for both the Public Health Sector inclusive of the Hospital Departments.

Child Health Program:

Overview:

Child Health began in 2013 with the launch of its Child Health Policy and Strategic Plan 2012-2015 during the Immunization week. The launch in-cooperated the Launch of the Immunization week to strengthen Immunization around Fiji with defaulter tracing.

Otherwise the year was a successful year for both public health as well as the hospital services. The development of certain policies and guidelines with the development of the Clinical Practice Guidelines for NICU. There were purchase of equipment's by FHSSP and WHO to strengthen the service provision by our hard working health care workers in the Hospitals and at the Sub-Divisional Hospitals.

Attached to the child health component is also the number of trainings that were carried with number of staff trained. IMCI is now decentralized to the nursing stations and health centers.

HPV vaccine roll out with the HPV campaign has been successful with a good initial coverage. There is a need to continue to strengthen the follow ups in the Divisions around Fiji and ensure timely reporting of the program which is embedded in the School Health Program.

The year of 2013 served well to strengthen the Neonatal Resuscitation Program in Fiji with an added advantage of having a Dr Vereti coming back after trainings in neonatology. Ministry of Health has now rolled out the NRP trainings in the divisions with central finishing in 2013 with the other two divisions to cover in 2014. This has been the initial Training of Trainers training which has turned out to be successful to date.

Fiji conducted an Immunization Coverage Survey in 2013 during the period of August to October. The coverage has shown success in regards to the Immunization program in Fiji at a coverage rate of 91.4% with card though with card and parent confirmation at 94.8%, though to note that those parents who confirmed the Immunization by card and parent confirmation was checked at the health facility to ensure that the records also recorded the immunization coverage. Though to note that with the immunization program there is a need for timeliness of immunizations around Fiji. Now timeliness can be captured with the new Child Health Card.

There have been movements forward in regards to Vaccine Preventable Diseases in Fiji, in regards to the routine follow up and zero reporting by the pilot sites around Fiji. Though to note that the addition of Rotavirus and Pneumococcal

Policies and Manuals

The Child Protection Guidelines:

The Guidelines contribute to the fulfilment of a few different policies and international Conventions, some being:

i. Convention on the Rights of the Child (Protection Rights and Survival and Development Rights)
ii. Millennium Development Goals (MDG's 1, 4 and 5)

iii. Government of Fiji's National Strategic Policy, Roadmap for Democracy and Sustainable Development 2009-2014.
iv. Ministry of Health's Strategic Plan 2011-2015
v. Certain Legal Perspectives of Children: Child Welfare Decree, Crimes Decree and Domestic Violence Decree.

- The public health models attempt to prevent or reduce a particular illness or social problem in a population by identifying the risk factors. The health care workers are strategically positioned to protect children from possible violence, abuse or neglect by providing interventions at the primary, secondary and where needed at the tertiary level.
- Health Sector Procedures are where the 3R's of Child Protection comes into play. The three R's being:
    i. Recognize: Descriptive on the signs of child abuse or neglect
    ii. Respond: Assess child's and parents respond and HCW responds in an appropriate manner if he/she recognizes.
    iii. Record: Using Appropriate forms to record the abuse or neglect
- There will be a need to identify individuals at the Divisional level to become Child Protection Focal points, these will be new responsibilities for people existing in the current structure.
- Health Child protection Focal points will become the contact person within and outside of Ministry for referrals, networking and communications.
- Each Division in the country will need to have a Child Welfare Decree Notifications Folder, which will be deemed necessary to send to the Director Social Welfare. The PATIS system should in-cooperate abuse and or neglect in its records. The PATIS codes will be from the WHO international Classification of Diseases (ICD).
- There are two mandatory trainings for health care workers under the Child protection guidelines:
    i. 1 Hour induction/in service training for all health care workers.
    ii. 1 Day training for all health care workers involved with children.
- Ministry of health is committed to ensuring that health facilities are safe places for children, families and staff. Health Managers are to ensure that the safest possible environments and practices are in place.
- The Child Protection Guidelines need to be read in line with the Child Welfare Decree 2010.

Vaccine Storage Guidelines: Keeping it Cold 2013-2016:

The Vaccine Storage Guidelines: Keeping it Cold 2013-2016 shows a comprehensive care and management of Cold Chain. It highlights the mandatory steps that a Health Care Worker needs to carry out in every station to maintain the cold chain in place.

- There is a regular update on immunizations and vaccine management by various means some of which include: newsletters articles or supervisory visits and other methods of support offered at Sub-Divisional, Divisional and National Level.
- The Vaccine Storage Guidelines need to go in line with the Immunization Policy 2013-2016 and health care workers need to abide by it.
- Vaccine Management starts from knowing your cold chain, and this may vary from site to site as the availability of different kinds of fridges would affect the Vaccine Management.
- Paramount to maintain an effective cold chain system from the manufacturer to the administration so that the potency and safety of vaccine is maintained.
- Our Health Centers and Nursing Stations have to follow certain protocols to safely and effectively manage our vaccines:
    i. About Cold Chain and why it is important
    ii. Key Staff members responsible for vaccine management
    iii. Vaccine Refrigerator and monitoring equipment
    iv. Ordering of Vaccines
    v. Receiving of Vaccines
    vi. Storing of Vaccines
    vii. Loading the Vaccine Refrigerator
    viii. Loading a Vaccine Carrier
    ix. Loading a Cold Box
    x. Daily Monitoring and recording of the vaccine refrigerator temperature.
    xi. Managing a Power Failure
    xii. Action in the event of a cold chain breach
    xiii. Appropriate Disposal of Vaccines
    xiv. Maintenance of the vaccine refrigerator and monitoring equipment.

- In Fiji there are a few different kinds of fridges we use:
    i. Ice Lined Refrigerator (Electric and Solar)
    ii. RCW 50 EG (gas or electric)
    iii. Domestic Refrigerators (Electric)
- Equipment Monitoring is of great importance and the practice listed under the section of checking and recording the vaccine refrigerator temperature should be followed for

the purposes of the Temperature Check and Equipment maintenance should follow practice listed under equipment maintaining our monitoring.

- The guidelines should be closely followed for all purposes inclusive of the Outreach Immunization Clinics done around the country secondary to defaulter tracing and for the geographical challenge patient's face.
- The new component that has come about is the accreditation of the Cold Chain, Cold chain accreditation is a tool to support immunization provider's cold chain management practices. The Accreditation has two parts to it;
    i. Provider Self-Assessment
    ii. Cold Chain Accreditation Immunization Provider Review
- All immunization providers who store vaccines must achieve Cold Chain Accreditation, including private practices, health centers, nursing stations, emergency wards and hospital wards. The Accreditation is valid for up to two years based on the accreditation reviewer's findings.

Fiji National Immunization Policy and Procedure Manual 2013-2016:

The policy for the first time has a historical background to it to capture the History of Immunizations in Fiji which hasn't been captured anywhere else to date. Thus showing the progress the country has made since the 1880's to 2013. To date having 12 Vaccines in the countries Immunization Schedule.

- To ensure that the Vaccines are effective for its purpose the Ministry is targeting to achieve and maintain >95% coverage for all vaccines routinely given for EPI.
- The main objectives of the Policy is to:
    i. To protect every newborn, child, pregnant women and those considered at risk from vaccine preventable diseases with the use of appropriate and potent vaccines.
    ii. To protect the general population at large from vaccine preventable conditions as well
    iii. Further Develop and support the cold chain at all levels of the health care system.
    iv. To improve Immunization coverage
- Fiji has Four Immunizations Schedules which are:
    i. Schedule A: for infants under 18 months of age
    ii. Schedule B: for school age children
    iii. Schedule C: for un-immunized children
    iv. Schedule D: for women of child bearing age

- Immunization of HIV infected babies and mothers and Hepatitis B immunization Schedule for adults are also two additional components apart from the 4 schedules mentioned above.
- The policy also encompasses around Vaccine Administration, Consent and Vaccination for Travelers.
- Immunization by General Practitioners(GP's) have been expanded since ministry provides free vaccines for their private patients and it had been noted that patients were being charged a price for the vaccine which was given free to the private GP's.
- To note that the immunizations done by nurses and doctors is covered under the Public Health Act.
- The Immunization Policy needs to be read in line with the National Vaccine Storage Guidelines: Keeping it cold to ensure that the vaccine that is administered to the patient is viable. The Cold Chain system in the country becomes very important in the efficacy of the vaccines administered.
- Above all ensuring a good, easy, and timely reporting for the Immunization program is very important for the EPI programmer to work efficiently.

Millennium Development Goal Paper:

Acceleration of MDG 4 progress could be made if attention was given to factors surrounding the perinatal period as 56% of all U5 deaths were during this time. The recommendations mentioned below should go in accordance to the Child health Review 2010 as a guiding document for movement towards and achievements of MDG 4.

Communications Strategy:

- Early recognition of sick kids and also child protection issues.
- Tally- how many children should we allow to die this year [current 420= 20/1000LB => 210 for 2014]
- Weekly tally of under5 deaths in MoH media page/FBC TV/Fiji One/Mai/Radio
- Kids programs e.g. Get Set [working with wellness unit]

Community IMCI-pilot & roll out in 2014/2015

- Include UMAC Tapes for nutritional assessment.

Primary Care Workers:

- Nutritional assessment of all U5s (under-nutrition underlies the majority of deaths)-info as part of communication strategy
  - ✓ Pre-school [+/-]school meals with ?SCF

- ✓ Meals supplements
- ✓ Dept. of SW support/ other FBO/CSO

- IMCI training/clinics:
  - ✓ ALL U5's attended using IMCI strategy whether seen by Nurse or MO
  - ✓ PLS

Secondary Care:

- IMCI/PLS/PB/NRP training [Need new WHO PB edition]
- Community Re-feeding centres for mal/under nourished children
- APLS coverage of all SDH/ED
- as per NCSP review- SDH to come under DSHS and bigger SDHs to have core specialty registrars on rotation –Sigatoka /Ba /Nadi /Rewa /Navua /Valelevu /Savusavu
- Community Paediatrician position

Tertiary care:

- Neonatal care
- NRP training & Upgrade LW resuscitation equipment in all 3 div hospitals
- Surfactant
- Improved respiratory support monitoring equipment
- PGE1 supply & Stream-line overseas referral of urgent Cyanotic CHD cases
- POINTS training
- CPG training and adherence monitoring
- PNW CPG
- PICU & Others
- PGD in Child Health Nursing
- Basic training
- IMCI/PLS/WHO PB/Basic for Nurses
- IMCI/APLS/Basic for Paeds
- Other CPG development

Infant Mortality 2013

			Infant			
			Neonatal			
		Perinatal				
Year	Division	Stillbirth	Early neonatal death	Late neonatal death	Post neonatal death	Total
2013	Central	78	66	26	65	157
	Eastern	0		2	11	13
	Northern	26	34	11	17	62
	Western	63	47	22	58	127
	Total	167	147	61	151	359

Table 17 Infant Mortality Figures 2013 Information Source: Health Information Unit

The above figures were recorded by the health information unit in 2013, Fiji saw a total of 359 infant mortalities. There was 167 stillbirths, Neonatal Death of 208 and Post Natal Death of 151.

Trainings for Child Health:

Table 18 Pediatric Training Coverage for Fiji

Objective	Course Title	Total Trained	Number Males	Number Females
2	Advance Pediatric Life Support (APLS) course	46	15	203
	Advance Pediatric Life Support (APLS) course ToT	7	5	2
	Clinical Attachment	1	0	1
	DBS Sampling for M&R Testing	24	3	21
	Early Childhood Educators Training	59	4	55
	EPI Training	175	14	161
	FANEM Training	39	6	33
	Health Card Training	19	1	18
	Healthy Child-CSN Basic Training	18	5	13
	IMCI Facilitators Training	40	1	39
	IMCI Training	145	12	133
	Infant and Child Health Training	19	0	19
	Pediatric Life Support (PLS) course	96	5	91
	Training of Trainers	15	1	14
	Tropic Refresher Training	12	8	4
	WHO Blue Book Training	41	2	39

	NRP TOT	20		
	Sum Of total:	**776**	**82**	**846**
All Child Health Trainings for 2013				

The above trainings were done for child health in 2013 with the support of all the heads of CSN (Dr Joseph Kado), hardworking consultants, Registrars and interns in the Divisions. The support of FHSSP towards these were tremendous with the TSO's in the Divisions to ensure the smooth roll out and support towards the team.

The strength of the team was the Training plan from the beginning of the year with a team to ensure that trainings were carried out as planned by the team. Which did happen, there were additional trainings that were in-cooperated as time went, namely the NRP trainings.

Fiji Immunization Coverage 2013: *(Data Source: Health Information Unit)*

Table 19 Immunization Coverage for Fiji by Division

Immunized Tabular Report from January to December 2013												
Division	**DPTHep BHib1**	**OPV1**	**Penumoccal1**	**Rotavirus 1**	**DPTHep BHib2**	**OPV2**	**Penumoccal 2**	**DPTHep BHib3**	**OPV3**	**Penumoccal 3**	**Rotavirus2**	**MR1**
Central	8975	8968	8962	8953	8622	8582	8449	8495	8484	8313	8158	7341
Eastern	539	541	533	537	693	700	676	779	781	725	702	851
Northern	2,952	2,993	2,976	2,949	2,947	2,950	2,936	2,914	2,923	2,851	2,824	2,696
Western	6072	6075	5952	5963	5948	5946	5843	5957	5924	5714	5653	5192
total	**18538**	**18577**	**18423**	**18402**	**18210**	**18178**	**17904**	**18145**	**18112**	**17603**	**17337**	**16080**
Immunized Performance Report, from January to December 2013												
Division	**DPTHep BHib1**	**OPV1**	**Penumoccal1**	**Rotavirus 1**	**DPTHep BHib2**	**OPV2**	**Penumoccal2**	**DPTHep BHib3**	**OPV3**	**Penumoccal 3**	**Rotavirus2**	**MR1**
Central	109	109	109	109	105	104	102	103	103	101	99	89
Eastern	42	42	41	41	54	54	52	60	60	56	54	66
Northern	84	85	84	83	83	83	83	82	83	81	80	76
Western	82	82	80	80	80	80	79	80	80	77	76	70
total	**91.9**	**92.1**	**91.3**	**91.2**	**90.2**	**90.1**	**88.7**	**89.9**	**89.8**	**87.2**	**85.9**	**79.7**
source: Public Health Information System [PHIS]												

The above shows the coverage rate from the health information unit for Fiji in the year of 2013. This may be underreported.

Fiji Immunization Coverage Survey 2013:

Survey: key findings and recommendations[6]

Comparison with 2008 survey results

- Full coverage with all ten antigens on the childhood immunisation schedule has remained unchanged at 95%, as measured by documented evidence and parental recall.
- Maternal tetanus toxoid coverage was measured differently in the 2008 and 2013 surveys. Based on the 2008 approach to measurement, the proportion of adequately immunised women has increased from 67% to 74% nationally. Using an improved methodology, however, the 2013 survey has found that only 58% of women are adequately immunised. This figure is not comparable to the 2008 survey results.

Childhood immunizations

- Immunisation coverage confirmed by card is close to or above the level needed for herd immunity for all vaccines. Based on documented evidence of vaccinations given, 91% of all children have received all ten antigens on the national schedule; this figure increases to 95% when parental recall in the absence of documentation is taken into account. The lowest coverage for any single vaccine dose is for measles-rubella with national coverage measured at 92% (documented) or 96% (including recall). These coverage levels indicate strong functioning of routine EPI services in Fiji. Given the solid performance of the routine EPI service, efforts aimed at strengthening routine services as opposed to mounting supplementary activities should be encouraged. High quality administrative data and communicable disease surveillance are necessary elements.
- Timely administration of vaccines has improved since 2008. Nonetheless, timeliness of vaccinations remains an area where further improvement is necessary, especially for the birth dose of hepatitis B vaccine (HBV0). HBV0 was confirmed as given within 24 hours for only 69% (including recall) of children. 17% (including recall) of children received HBV0 more than 24 hours after birth and the timeliness of HBV0 was unknown for a further 4% (including recall) of children. Administration of HBV0 within the first 24 hours of life is considered optimal for protecting a neonate from perinatal transmission of hepatitis B virus.
- Card retention by parents in 2013 (divisional range: 80% – 84%) is consistent with retention in the 2008 survey (divisional range: 71% – 85%) but remains lower than the retention reported in the 2005 survey (100%). Based on reasons cited for why children were not fully immunised, improving parent retention of cards may help to improve coverage, and perhaps timeliness of immunisation.
- Statistically significant differences between card-confirmed divisional coverage rates were observed. Statistically significant differences were also observed in the estimates using card plus parental report when comparing coverage between male and female children and when comparing iTaukei and Fijian of Indian Descent children.
- Lack of awareness of the need for immunisation, loss of immunisation card and postponement of immunisation were the main reasons cited for why children were not fully immunised. A small qualitative assessment with health care workers and with parents could shed light on whether the failure to immunise children is due to difficulties with accessing

[6] Fiji National Immunization Coverage Survey 2013

immunisation services, a reluctance to utilise services, a poorly functioning health service or a combination of all three.

Maternal tetanus toxoid immunizations

- The proportion of women who are not immune to tetanus (42%) is relatively high. Almost all of these non-immune women (98%) could have been successfully immunised if given the correct number of tetanus toxoid doses during their antenatal clinic visits.
- Most women receive one dose of tetanus toxoid during pregnancy, regardless of parity or immunisation history. This means that women can be under-immunised in earlier pregnancies and over-immunised in subsequent pregnancies. Health staff must be reminded of the need to deliver doses of tetanus toxoid according to the national immunisation schedule, including catch-up doses for under-immunised women.
- Awareness among pregnant women of the need to protect their child against neonatal tetanus is low. Few women are given cards and even fewer keep them. Tetanus toxoid information and immunisation cards should be routinely provided through antenatal clinics as part of the normal health education given to mothers during pregnancy. Other avenues of providing information to expectant mothers should also be considered.

Herd immunity

- The final dose in each vaccine series was compared to the benchmarks for herd immunity. Based on verification by immunisation card alone, the estimated national and divisional coverage rates exceed the benchmark for herd immunity for polio, diphtheria and rubella[7]. With the exception of Eastern Division, the estimated national and divisional coverage rates exceed the benchmark for herd immunity for pertussis. For measles, divisional and national coverage rates fall within, but do not exceed the benchmark.
- A less conservative estimate using card plus parental report results in divisional and national coverage rates that meet the benchmarks for polio, diphtheria, pertussis, measles and rubella.

Reasons for immunisation failure

- The parents of the 61 children who were not fully immunised were asked why their child was not fully immunised. From the parent's response, the enumerators identified the single most important reason. Nationally, Obstacles (35%, n=20) and Lack of Motivation (33%, n=18) were the main categories of reasons why a child was not fully immunised. However, **the single most common response for failure to fully immunise was "Lost card"** (20.6%, n=13) indicating that retention of the child's immunisation card is an important consideration in motivating parents to get their children fully immunised.
- 11% (n=8) of parents said that they did not know that their child needed to be immunised or were unaware that additional vaccine doses were needed. No parents stated that their child was not fully immunised due to belief that immunisations are ineffective. Fear of side effects was only given as a reason for two children.

[7] Michigan Center for Public Health Preparedness (n.d.). epiCentral. University of Michigan. Available <https://practice.sph.umich.edu/micphp/epicentral/basic_reproduc_rate.php>, accessed 13 November 2013.

Table 20 Coverage Survey Results 2013

Child's Age	Vaccine	Means of Verification					
		Card (N=1,209)			Card + Parental Report (N=1,209)		
		Proportion	95% CI	n	Proportion	95% CI	n
Birth	BCG	95.3%	93.4 – 96.7	1,144	98.7%	97.8 – 99.3	1,194
	HBV0	95.4%	93.4 – 96.8	1,143	98.8%	97.8 – 99.3	1,193
	OPV0	95.1%	92.9 – 96.6	1,140	98.5%	97.3 – 99.1	1,190
6 Weeks	Pentavalent 1	95.3%	93.1 – 96.8	1,145	98.7%	97.6 – 99.3	1,195
	OPV1	95.3%	93.2 – 96.8	1,146	98.7%	97.6 – 99.3	1,196
10 Weeks	Pentavalent 2	95.1%	92.9 – 96.7	1,143	98.5%	97.3 – 99.2	1,193
	OPV2	95.1%	92.9 – 96.7	1,143	98.5%	97.3 – 99.2	1,193
14 Weeks	Pentavalent 3	94.9%	92.7 – 96.4	1,141	98.3%	96.9 – 99	1,191
	OPV3	94.9%	92.7 – 96.5	1,142	98.3%	96.9 – 99.1	1,192
12 Months	Measles-Rubella 1	92.3%	89.4 – 94.4	1,114	95.6%	93.2 – 97.2	1,164
Received all 10 vaccines		**91.4%**	**88.5 – 93.6**	**1,098**	**94.8%**	**92.3 – 96.5**	**1,148**

Coverage of Immunizations according to vaccine administered.

Table 21 Immunization Coverage by Division

Division	Means of Verification								
	Card Cardholders as denominator (n=1,152)			Card Whole sample as denominator (n=1,209)			Card + Parental Report Whole sample as denominator (n=1,209)		
	Coverage	95% CI	n	Coverage	95% CI	n	Coverage	95% CI	n
Central	95.1%	90.3 – 97.6	271	90.0%	84.9 – 93.5	271	93.4%	88.2 – 96.4	281
Eastern	93.2%	88.7 – 96	261	86.7%	81.3 – 90.7	261	93.7%	89.4 – 96.3	282
Northern	97.6%	94.9 – 98.9	288	94.1%	88.2 – 97.2	288	97.4%	94.3 – 98.8	298
Western	95.2%	90.5 – 97.6	278	92.4%	86.4 – 95.8	278	95.3%	90.8 – 97.7	287
National	**95.5%**	**93.1 – 97**	**1,098**	**91.4%**	**88.5 – 93.6**	**1,098**	**94.8%**	**92.3 – 96.5**	**1,148**

From the above data it shows that the highest coverage rates seen for the Divisions was noted in Northern Division followed by Western, Central and then Eastern Division. Eastern Division is faced with the geographical challenge.

Table 22 Immunization Coverage by Information Source

Child's Age	Vaccine	Information Source					
		2008 Coverage survey*	2008 Coverage survey#	2010 Annual report	2011 Annual report	2013 Coverage survey*	2013 Coverage survey#
		Coverage	Coverage	Coverage	Coverage	Coverage (95% CI)	Coverage (95% CI)
Birth	BCG	79.9%	100%	98.7%	96.1%	95.3%	98.7%
	HBV0	79.7%	99.8%	101.9%	97.9%	95.4%	98.8%
	OPV0	79.7%	99.8%	98.6%	96.3%	95.1%	98.5%
6 Weeks	Pentavalent 1	79.7%	99.8%	80.8%	91.3%	95.3%	98.7%
	OPV1	79.7%	99.8%	80.7%	91.2%	95.3%	98.7%
10 Weeks	Pentavalent 2	79.4%	99.5%	80.5%	91.8%	95.1%	98.5%
	OPV2	79.4%	99.5%	80.3%	91.9%	95.1%	98.5%
14 Weeks	Pentavalent 3	78.9%	98.8%	77.2%	90.7%	94.9%	98.3%
	OPV3	79.2%	99.3%	76.7%	90.8%	94.9%	98.3%
12 Months	Measles-Rubella 1	75.6%	93.6%	71.8%	82.5%	92.3%	95.6%
Received all 10 vaccines		**75.2%**	**93.1**	**n/a**	**n/a**	**91.4%**	**94.8%**

The above graph shows the Immunization coverage for all children in Fiji over the last 5 years. Showing the improvement of immunizations in Fiji since 2008.

Vaccine Preventable Disease:

In the year 2012 Fiji Introduced 3 additional vaccines which were: Rotavirus, Pneumococcal, and HPV vaccine though two are part of a childs immunization schedule and the HPV part of the school program and is not mandatory for students and this vaccine is given upon confirmation of parental consent.

Table 23 Vaccine Preventable Disease Cases from 2011-20

Selected VPD	National Trend	Cumulative Total 2013		Cumulative Total 2012		Cumulative Total 2011	
		# of test	+ve	# of test	+ve	# of test	+ve
Measles	↔	65	0	180	0	543	1
Rubella	↑	65	4	180	24	543	153
Polio	—	4	0	-	-	-	-
Rotavirus	↑	373	54	182	30		

Figure 16 National Trend for Rotavirus 2013

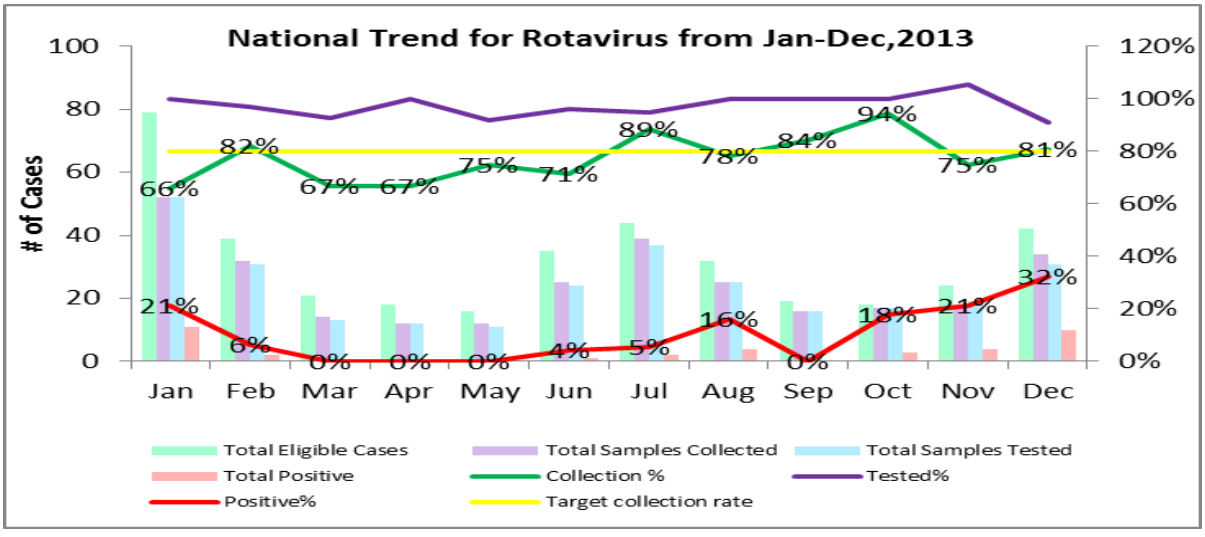
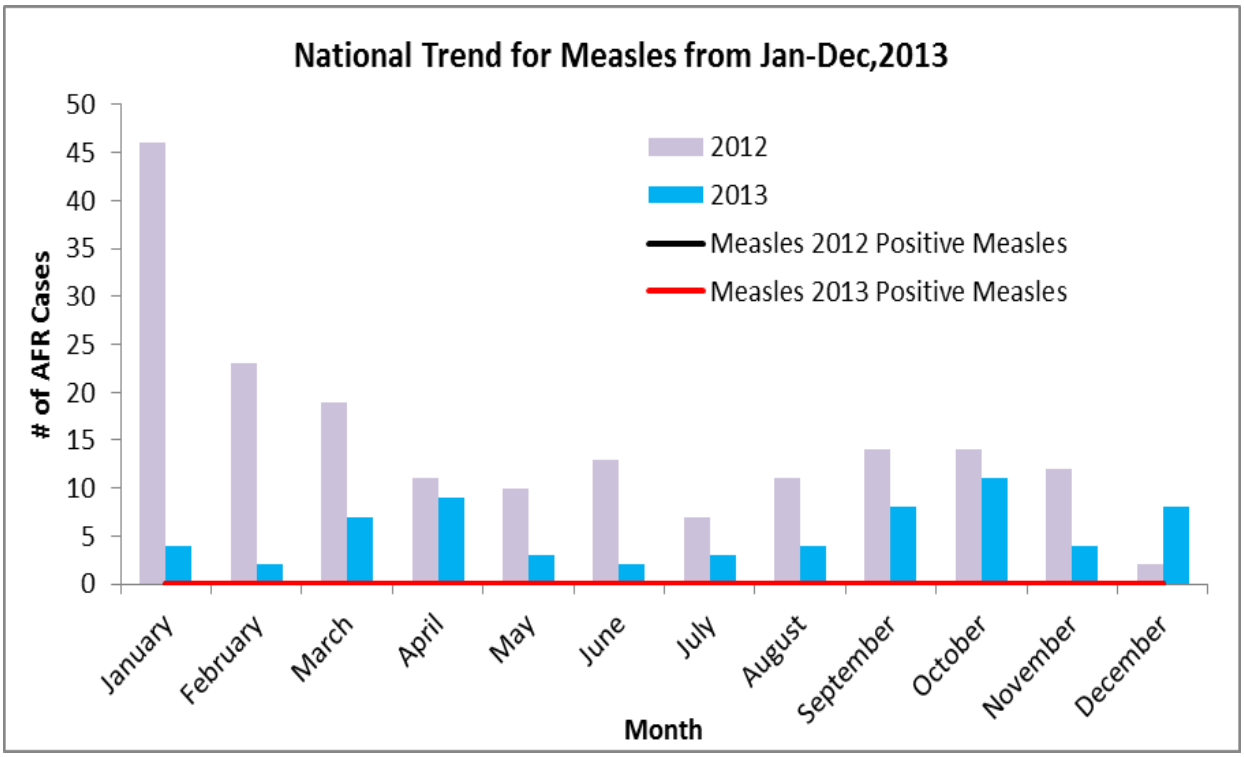


Figure 17 National Trend for Measles 2013

From the surveillance system in place for certain sites, we saw in 2013 54 new cases of Rotavirus, 4 for Rubella and Zero for Measles. We have reduced in regards to Rubella but increased in terms for Rotavirus, though to note that the patients who were diagnosed with Rotavirus were patients who haven't had the immunization for Rotavirus.



The above graph shows zero reporting of Measles in the year of 2013 and 2012.

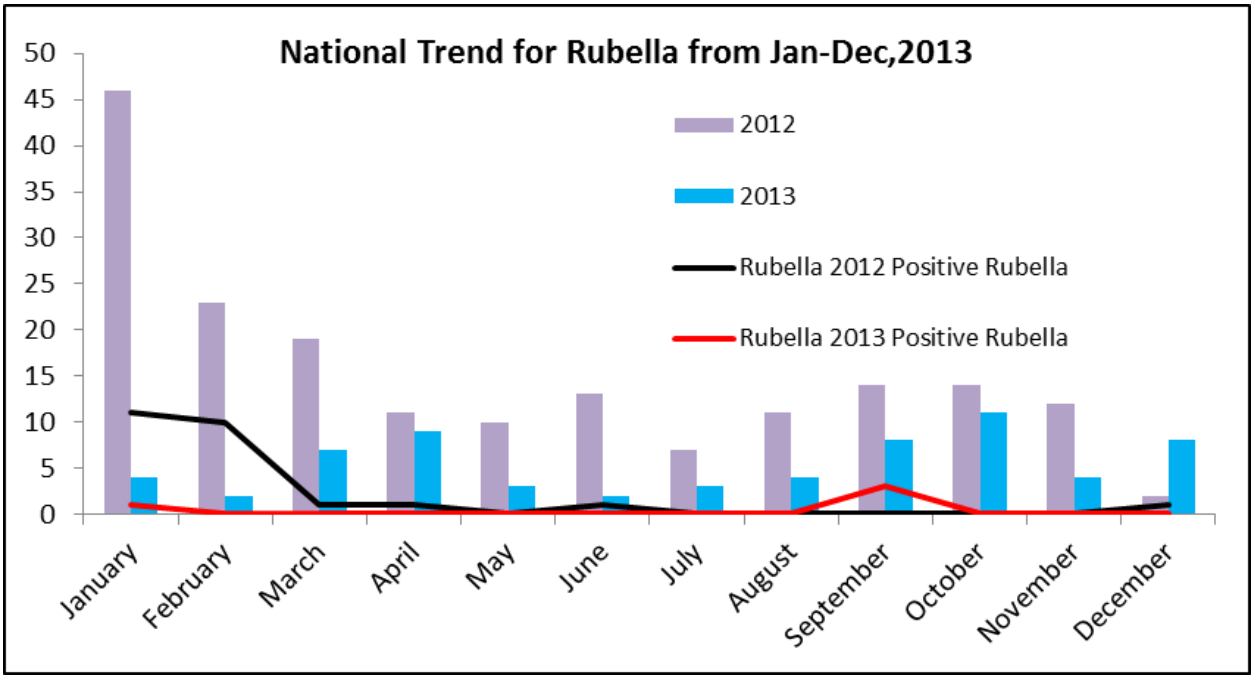


Figure 18 National Trend for Rubella 2013

Fiji recorded minimal cases in 2013 for Rubella in comparison to 2012.

Table 24 HPV Coverage per division and National for 2013

Division	HPVNr To Be Immunised	HPV1	HPV2	HPV3
All	***6890***	***7234***	***5723***	***4320***
Central	**2697**	**2997**	**2423**	**2226**
Eastern	**370**	**368**	**110**	**59**
Northern	**1326**	**1156**	**1218**	**831**
Western	**2497**	**2713**	**1972**	**1204**

HPV was introduced in Fiji as a regular program part of vaccination in 2013, this was a first year of coverage and it is a program which seeks parental consent for immunization. There is a maximum of three vaccinations needed for appropriate intervention.

The above mentioned data may be currently under reported though coverage may be more, data is still being collected from the Divisions in this regards.

Malnutrition

Cases of Severe Malnutrition- Fiji 2007-2013

Fiji in the past few years has been reporting on the number of severe cases of Malnutrition in Fiji from the three major divisions why inpatient management of such patients takes place. We are currently missing on the Mild and Moderate Malnutrition cases which is reported by the Dieticians.

Fiji has strengthened its management of severe malnutrition management with the support of UNICEF providing with the F75/F100 and Resomal packs for our malnourished children in Fiji.

In the past three years we have seen a reduction in the number of cases reported. The number of deaths associated with severe malnutrition was 9 for the period of January to December 2013 similar to the numbers died in 2012.

Table 25 Severe Malnutrition in Fiji (Divisional Hspts)

Cases	2007	2008	2009	2010	2011	2012	2013
Suva	8	18	20	18	60	56	39
Lautoka	12	8	6	0	59	38	40
Labasa	12	9	2	0	21	15	19
TOTAL	**32**	**35**	**28**	**18**	**140**	**109**	**98**
Deaths					17	9	9

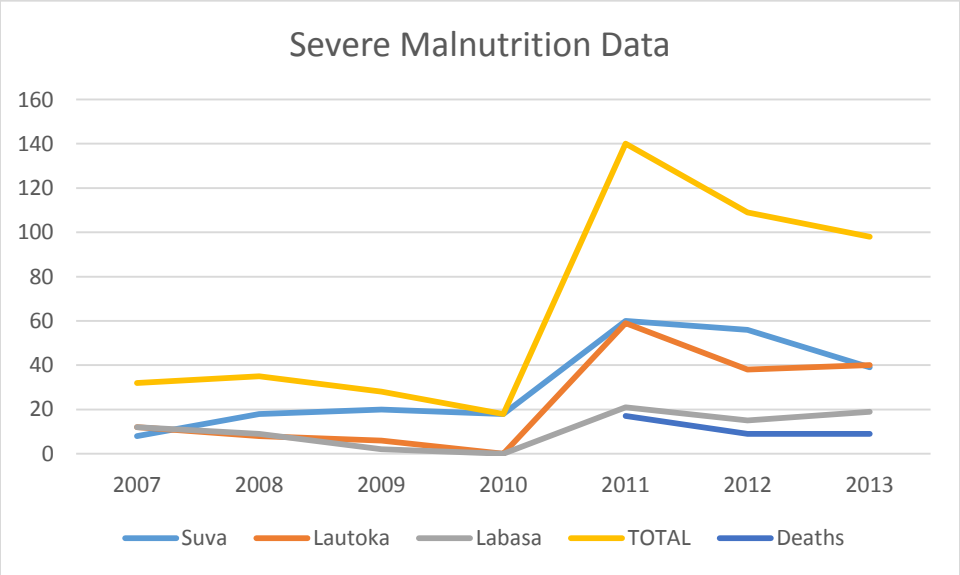


Figure 19 Severe Malnutrition Cases

The trend of severe malnutrition is one of down going.

Adolescent Health Program:

Overview of Adolescent Health Development Program:[8]

	Indicator	Output
1	Number of programs targeted at adolescents: • Increased number of adolescents reached and aware of AHD program; • Increased understanding of ASRH Issues • Strengthened partnership with Ministry of Education	Outreach (school health team & community): 1. # of schools reached – 500 2. # of communities reached – 450 3. # of adolescents & youth reached – 38,707
		Strengthened partnership with MoE (NSAAC) for Peer Education training in schools – Peer Educator was resource person at trainings: 1. Lomaiviti (Levuka Schools) 2. Kadavu 3. Lakeba 4. Vanuabalavu 5. Lami
		Strengthened partnership with Ministry of Youth & Sports through outreach: 1. Kadavu 2. Levuka 3. Lami
		Strengthened partnership with FASANOC STOP HIV Program – training of STOPHIV Champions & community outreach: Community Outreach 1. Nadi 2. Levuka 3. Suva
		Coordinated Stepping Stones program – trainings conducted across the four subdivisions; 1. North, Cakaudrove – Korotasere 2. West, Ra – Malake 3. Central, Rewa – Young Peoples Department, Davuilevu
		Advocate for ASRH in the media - articles submitted and printed on Health Page (Fiji Sun) – 5 1. AHD background 2. Adolescent Health & changes in the body 3. Sexual Health & Services 4. Services provided by the AHD Program 5. Partnership with FNU, School of Nursing – Peer Education Training program

[8] Reference Adolescent Health Annual Report 2013

		Coordinated surveys in partnership with development partners (UNICEF). Two surveys conducted: 1. National Youth Friendly Health Services Guideline drafted – Youth Friendly Health Service Guideline to be to be implemented in 2014 2. Toolkit developed from Rapid Assessment of Communication needs for HIV/AIDS/STI programs
2	AHD Program Review & Planning	1. Revised Quarterly reporting templates 2. Revised Project Descriptions 3. Drafted Program AWP 4. Provided comments on Peer Educators IWP (subdivisional)
3	Administrative/Management support to HIV Project	1. Provided support for National AIDS Spending Assessment (NASA) exercise : a. Finalization of 2011 NASA Report b. 2011 NASA Report endorsed at Q1 National HIV/AIDS Board meeting, 12 March 2013 2. Coordinated the Q1 meeting of National HIV/AIDS Board, March 12, 2013 – secretariat 3. Drafting and signing of MOA: a. National Fire Authority b. Fiji Network for People Living with HIV (FJN+) 4. Recruitment of CEO of National HIV/AIDS Board (coordinated shortlisting, interview, recruitment)
4	Administrative/Management support to RH project	1. Coordinated National Expenditure (NEX) Evaluation for UNFPA funded activities 2012 - submitted for vetting and report received from UNFPA. 2. Coordinated Conference on Repositioning Family Planning 3. Coordinated the Sexual and Reproductive Health Management Training for Nurses (North – 15 participants) 4. Coordinated/Facilitated finalization of Annual Work Plan (AWP) with UNFPA for 2013 – 2017 – AWP signed and endorsed
5	Monitoring and Evaluation of program	1. Supervisory visits - Supervisors (SDHS) understand Peer Educators role & reporting/communication channels 2. Peer Educators reports now part of SDHS's monthly & quarterly reports 3. Increased understanding and integration of Peer Educators/Education activities into sub-divisional programs – school health visits, community outreach

		4. Coordinate collation of quarterly reports from officers (subdivisional)

Additionally the program has expanded its capacity with regards to the skills of its project officers (Peer Educators) that would need to be enhanced further through proper training. These activities include:

1. Conducting health awareness during disease outbreaks (dengue, typhoid)
2. Providing basic information and support for mental health related issues and activities
3. Providing basic information on the HIV Decree
4. Conducting VCCT during outreach or basic HIV information at ANC clinics

Teenage pregnancy

Table 26 Teenage Pregnancy in Fiji 2013

Teenage Pregnancy 2013							
Division	**Ethnicity**	**PHIS**		**Hospital**		**Grand Total**	**Rate (per 1000 CBA pop)**
		< 15	**15 - 19**	**< 15**	**15 - 19**		
Central	**Fijian Indian**	**0**	**1**	**0**	**73**	**74**	
	iTaukei	**5**	**91**	**0**	**22**	**118**	
	Others	**0**	**0**	**0**	**1**	**1**	
	Total	**5**	**92**	**0**	**96**	**193**	**2.24**
Eastern	**Fijian Indian**	**0**	**0**	**0**	**3**	**3**	
	iTaukei	**11**	**84**	**0**	**0**	**95**	
	Others	**0**	**0**	**0**	**4**	**4**	
	Total	**11**	**84**	**0**	**7**	**102**	**14.12**
Northen	**Fijian Indian**	**0**	**41**	**1**	**54**	**96**	
	iTaukei	**5**	**246**	**0**	**8**	**259**	
	Others	**2**	**28**	**0**	**2**	**32**	
	Total	**7**	**315**	**1**	**64**	**387**	**11.81**
Western	**Fijian Indian**	**1**	**18**	**2**	**229**	**250**	
	iTaukei	**5**	**105**	**0**	**151**	**261**	
	Others	**0**	**0**	**0**	**9**	**9**	
	Total	**6**	**123**	**2**	**389**	**520**	**6.66**
	Grand Total	**29**	**614**	**3**	**556**	**1202**	**5.89**
source: PHIS & Hospital Monthly Return							
Note: CWM & Labasa numbers are yet to be included in this table.							

In this regards Health Information may be able to give data later on which is inclusive of the two hospitals CWMH and Labasa Hospital**.**

Miscellaneous:

NHEC Papers for Family Health for 2013:

1) *Safe Motherhood Policy 2013*
2) *Expanded Immunization Policy 2013-2016*
3) *Child Protection Guidelines*
4) *Cold Chain Guidelines (Keeping it Cold)*
5) *TB/HIV Collaborative Policy*
6) *HIV Testing and Counseling Policy*
7) *PPTCT Policy 2013-2016*
8) *HIV Treatment and Care Guidelines 2013*
9) *MDG 4,5, and 6 paper for Family Health*
10) *Revised HIV Testing Algorithm for Fiji*

The above mentioned papers were submitted to NHEC in the March and October meeting seeking the National Health Executive Committees endorsement for move forward in the various components mentioned via the papers.

The papers can be found with the Executive Secretariat Unit based in Headquarters on the 3rd Floor of the Ministry of Health.

All the mentioned papers mentioned above were endorsed by NHEC with a prior wide range of consultations that had taken place.

Surveys and researches:

1) EPI Coverage Survey 2013
2) Pre-surveillance Survey for SGS
3) Research on PPTCT case analysis for 2010-2012
4) Research on CD4 count against Lymphocyte count amongst HIV Patients in Fiji (Operational Research with FNU)
5) Research on Urethral Discharge Amongst Men in Fiji

Reviews and Strategies for Family Health Programs:

1) Maternal Health Review and Maternal Health Strategic Action Plan Development (FHSSP Supported)
2) Review of the Health Information Systems for STI's (WHO Supported)
3) Review of the STI/HIV Program in Fiji (WHO supported)

Development of Training Manuals in 2013:

1) Gender Training Manual
2) IMCI Community Health Worker Manual
3) Family Planning Training Manual

Clinical Practice Guidelines:

1) NICU CPG's
2) Maternal Health CPG's
3) HIV CPG's (HIV Treatment and care Guidelines Fiji 2013)

CONCLUSION:

The year of 2013 was a challenging year with a lot of hurdles like a roller coaster ride, a year of learning and growing up in the position as a National Advisor for Family Health. I would like to take this opportunity to thank our Honorable Minister for Health for the continual support for all the programs under the Family Health Unit, the Permanent Secretary for Health, Dr Eloni Tora for his continual support and guidance in this area, and also the support of the few Deputy Secretary of Public Health in the year of 2013.

Definitely with the support staff of Family Health and Head Quarters the achievements of 2013 wouldn't have been possible, but above all through God's grace we had a successful year for the Family Health Unit.

The year 2013 was a year of great achievement in regards to scaling up programs, strengthening and advocating for more support in certain areas of Family Health. The year was strengthened for the Unit with the edge of Monitoring and Evaluation added to the Unit as a strong pillar which added to the Unit a proper planning process.

From where we were, we as a unit have taken steps up, though much is yet to be done. Moving towards achieving our goals as a unit, and towards the Millennium Development Goals is paramount for the Unit. We know at this stage we may not be able to achieve our MDG goals set at the international standard but Fiji is definitely moving towards it.

There were lessons learnt in 2013 that would help improve 2014, some of these include proper planning with partners for implementation of programs though an important component for the whole unit was to secure staffing for the various programs under Family Health to ensure smooth roll out and closer follow up by project officers, such as Child health and Reproductive Health.

Family Health is committed to make a difference in the areas of Family Health for the people of Fiji.

For any further questions pertaining to this report and any further elaborations needed please do not hesitate to contact the undersigned.

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Family Health Unit

Ministry of Health

Fiji Islands