



HIV AND AIDS DATA HUB FOR ASIA-PACIFIC

**EVIDENCE  
TO ACTION**

# Fiji

## Country Review March 2012

### FIJI AT A GLANCE

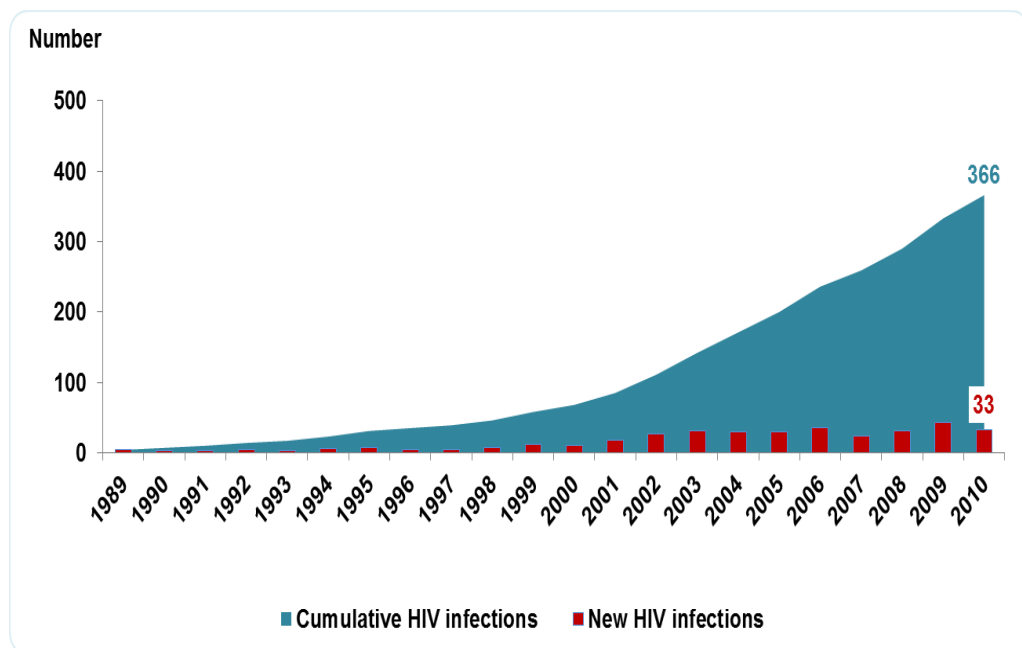
Total population (in thousands)	861 (2011) <sup>1</sup>
Population growth rate	0.8% (2010-2015) <sup>2</sup>
Population aged 15-59 (thousands)	543 (2010) <sup>1</sup>
Percentage of population in urban areas	52% (2010) <sup>2</sup>
Crude birth rate (births per 1,000 population)	22 (2009) <sup>5</sup>
Under-5 mortality rate (per 1,000 live births)	18 (2009) <sup>6</sup>
Human development index (HDI) - Rank/Value	100/0.688 (2011) <sup>7</sup>
Life expectancy at birth (years)	69.2 (2011) <sup>7</sup>
Adult literacy rate	N/A
Ratio of girls to boys in primary and secondary education (%)	102.8 (2008) <sup>3</sup>
GDP per capita, PPP (current international \$)	4,654 (2010) <sup>5</sup>
Per capita total health expenditure (PPP int.\$)	168 (2008) <sup>6</sup>



## HIV EPIDEMIOLOGY AND TRENDS

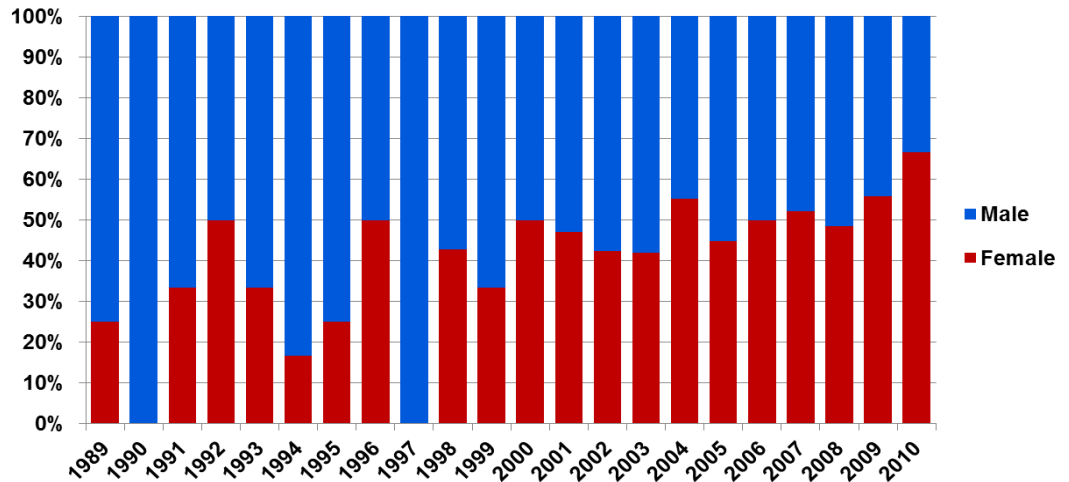
Fiji is classified as a low HIV prevalence country. The first cases of HIV were identified in 1989, and a cumulative 366 confirmed HIV cases were reported as of December 2010 (Figure 1). The main reported mode of transmission was heterosexual (89%), followed by perinatal transmission (6%) and homosexual transmission (3%). Only one known case of intravenous transmission has been reported in 1994.<sup>8,9</sup> According to the age-disaggregated data, HIV infection is greatly affecting young people with 75% of reported cases falling within the age group of 20-29 years.<sup>8</sup> Females accounted for 47% of cumulative reported cases, however, in recent years the proportion of females among annual reported cases was higher than that of males. For instance, in 2010, 67% of reported cases were females, which is an increase from 48% in 2008 and 56% in 2009 (Figure 2).<sup>8</sup> It may be a reflection of increased HIV testing at ANC (Antenatal Care) Centres as part of the scale-up in HIV testing.<sup>9</sup> In 2009, it was estimated using the Estimates and Projection Package that less than one thousand adults and children are living with HIV in Fiji, giving an estimated HIV prevalence of 0.1 % among adult (15-49) years.<sup>10</sup>

**Figure 1: Annual cumulative and new HIV infections, 1989-2010**



Source: Prepared by www.aidsdatahub.org based on Ministry of Health Fiji. (2011). Ministry of Health Annual Report, 2010

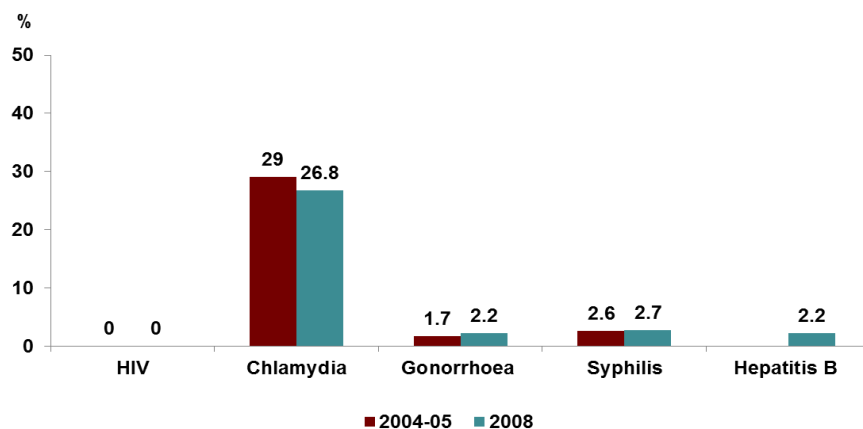
**Figure 2: Percent distribution of reported new HIV infections by gender, 1989-2010**



Source: Prepared by www.aidsdatahub.org based on Ministry of Health Fiji. (2011). Ministry of Health Annual Report, 2010

Sexually transmitted infections (STI) among ANC attendees have been found to be considerably high in Fiji. The data from the Second Generation Surveillance (SGS) 2008 showed Chlamydia prevalence to be the highest (26.8%), followed by syphilis and gonorrhoea with prevalence of 2.7% and 2.2%, respectively (N=448) (Figure 3).<sup>4</sup> The finding of high Chlamydia positivity is consistent with the previous study among pregnant women conducted in 2004 (SGS 2004 in 6 Pacific Island Countries) with a sample size of 303 pregnant women. The prevalence of Chlamydia, gonorrhoea, and syphilis were 29%, 1.7%, and 2.6%, respectively, and Chlamydia prevalence was the highest among the six Pacific countries surveyed. Young pregnant women under 25 years showed a higher Chlamydia prevalence than their older counterparts; 34% among pregnant women less than 25 years and 23.4% among those who were over 25 years.<sup>3</sup>

**Figure 3: HIV and STIs prevalence among antenatal care attendees, 2004-05 and 2008**



Sources: Prepared by www.aidsdatahub.org based on 1) Burnet Institute. (2008). HIV in the Pacific, 1984-2007, and 2) Fiji Second Generation Surveillance 2008 cited in Ministry of Health Fiji. (2010). UNGASS Country Progress Report: Fiji

#### Surveillance Systems:

- Case reporting system established in 1989 <sup>3</sup>
- Blood donors and military routinely screened for HIV. <sup>3:4</sup>
- Antenatal clinic attendees routinely screened for syphilis <sup>3</sup>
- SGS conducted twice (2004 and 2008) among pregnant women, STI clinic attendees, tertiary students, seafarers, and uniformed services. Key populations at higher risk such as Sex Workers (SWs), Men who have Sex with Men (MSM), and People Who Inject Drugs (PWID) were not included in the survey populations in either round.

### WHO IS AT RISK OF HIV IN FIJI?

Given the limited of serological and behavioural data, it is difficult to infer the trend of the epidemic among key populations at higher risk such as sex workers, people who inject drugs, and men who have sex with men.

#### Sex Workers

Sex workers were not included as a surveyed population in the Second Generation Surveillance (SGS) surveys carried out in Fiji in 2004-2005 and 2008. As a result, HIV and STI serological data and quantitative data on sex workers' risk behaviour and vulnerability are lacking.

A qualitative study was conducted by McMillan and Worth in 2009 with interviews of 40 female and transgender sex workers in Suva, Nadi, Lautoka, and Labasa. The research indicated that lack of education, poverty and low income, and family violence were all factors leading to entry into sex work in Fiji.<sup>11</sup> Indeed, almost one third of the population in Fiji are living below the national poverty line.<sup>5</sup> In addition, Fiji "National Research on Domestic Violence and Sexual Assault" found that 66% of women surveyed reported abuse by their partners; 30% of them suffered repeated physical abuse.<sup>12</sup>

*Risk Behaviour:* The same study by McMillan and Worth showed that most of the interviewed sex workers began selling sex at around 18 years of age and financial need was the primary reason for selling sex. The participants considered condom use a mean of self-protection, but although they preferred to use condoms for sex work, "many respondents" reported that they did not use condoms with their intimate partners. It was reported that the client often determined the terms of condom use and many clients were resistant to it. Fear of police harassment or arrest was found to be a disincentive to carrying condoms.<sup>11</sup>

*HIV Knowledge:* Most of the sex workers interviewed in the study seemed to have some level of HIV knowledge. The most well-informed SWs were those who had participated in workshops run by non-governmental organisations (NGO) involved in HIV interventions.<sup>11</sup>

*Sex Work and the Law:* Sex work is illegal in Fiji. The *Crimes Decree (Decree No.44)*, passed in February 2010, prohibits soliciting, as well as managing brothels. In particular, the offences related to sex work are included in Sections 230-231 of Part 13:

- Living on earnings of prostitution or persistently soliciting (punishment of imprisonment for 6 months);
- Loitering or soliciting for the purposes of prostitution, including both soliciting and seeking “the services of a prostitute” (punishment of imprisonment for up to 3 months and/or a fine);
- Operating a brothel (punishment of imprisonment for 5 years and/or a fine).

Under the new *Crimes Decree*, the term “prostitute” has been expanded to include not just females but also males and transgender sex workers.

McMillan et al. carried out a follow-up study in 2011 after the *Crimes Decree* took effect to analyse the social effects of the actions to impose the law with regard to sex work. It aimed to make heard the voices of sex workers, document their experiences, and to reflect the views of NGOs working with sex workers. The qualitative study sampled 13 female and 12 transgender sex workers, including 5 sex workers who had been arrested or detained by the military after the Decree was enacted. The most salient findings include:<sup>13</sup>

- The recent military involvement in policing sex work (in addition to the police) was found to be far more punitive, particularly in Lautoka.
- Though the *Crimes Decree* does not explicitly state carrying condoms is proof of soliciting, it was reported that both the police and military searched for condoms which led sex workers to understand that condoms can be used as evidence of sex work.
- Criminalisation of clients deterred them from using publicly identifiable services (and sex workers). As a consequence, activities became more covert, and the conditions under which sex work is conducted changed. Though soliciting via mobile phone and internet is also an offence, it has not deterred sex work. In fact, some sex workers were reportedly relying on these technologies to minimise the “physical visibility”, which they perceived as risky.
- Criminalisation of clients also resulted in a fewer number of regular clients and this financial pressure had negative implications on sex workers’ insistence and negotiation with clients to use condoms.
- The sense of vulnerability led to a disinclination to engage in networks and advocacy activities. As a result, sex workers tended to stay more hidden and be less accessible to peers, sex worker advocates and HIV prevention programmes.
- Service providers’ (NGO) “risk aversion” might lead to a closure of targeted interventions and condom distribution. In fact, one NGO that did sex worker outreach and condom distribution closed down in response to the enactment of the *Decree*.

### People Who Inject Drugs

Little is known about injecting drug use in Fiji and so far injecting drug use has not been a significant factor in Fiji's epidemic, with only one case reported to have resulted from injecting drug use. SGS 2008 included questions on injecting drug use and very few respondents (15 out of 1629) reported injecting drug use in the past 12 months. A maximum of 2 respondents from the respective surveyed populations (STI clinic attendees, ANC attendees, Seafarers, Police and Military) reported the practice of injection drug use in the past 12 months. However, nine tertiary students (out of 543) reported that they had injected drugs in the past 12 months.<sup>4</sup> The study also suggested other substance abuse, including Kava and Marijuana, among ANC attendees. Respondents were asked if they had ever tried the listed substances. Those that had not selected 'none' were asked about their substance use in the last 30 days. Over 70% confirmed they used 'Kava'. Data from the earlier SGS 2004 indicated that the percentages of injecting drug use among STI clinic attendees and male police and military were 1.9% and 0.9%, respectively.<sup>3</sup>

Data from the Pacific Counselling and Social Services (PC&SS) VCCT also support the case for very low prevalence of injecting drug use in Fiji. Of the 1,754 post-test counselling sessions conducted by PC&SS in 2007, injecting drug use as a risk behaviour issue was flagged in only two cases. Also of the 4,791 clients provided with pre-test counselling by PC&SS in 2009, 'less than one per cent' reported injecting drug use (PC&SS 2010)<sup>a</sup>.

Apart from the data on injecting drug use from the two rounds of SGS, there is no other specific survey or mapping exercise carried out in Fiji to understand the nature and types of drug use, injecting drug use, and associated risk behaviours.

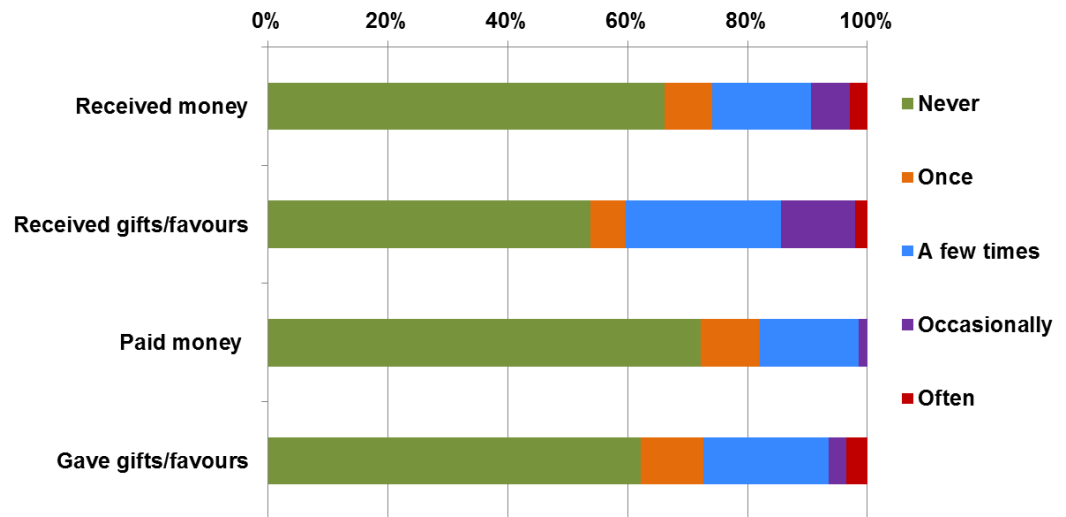
### Men who have Sex with Men and Transgender (TG)

There is a scarcity of data related to MSM and TG in Fiji. However, a recent community-led study in 2010 that used quasi-experimental<sup>b</sup> methodology with a sample of 212 MSM and TG shed some light on their risk behaviours, HIV knowledge, access to programmes and services, and stigma and discrimination factors. A core group of MSM and TG were recruited and trained as interviewers. They recruited respondents, through snowballing and convenient sampling methods, who had sex with a man/TG in the last 12 months. The median age of the respondents was 25.5 years and 8% of the respondents had no formal education.<sup>14</sup> They were asked to self-identify their gender and sexuality and 32% perceived themselves as straight, 15% as bisexual, 20% as gay, and 33% as TG. About one in seven respondents had ever been married to a woman and 44% reported they had sex with women in the last six months.<sup>14</sup> When this data is broken down by self-identified sexuality and gender identity, 93% of self-identified straight men and 77% of bisexuals had had sex with women in the last six months, whereas, only 7% of gay and 4% TG reported such behaviour. The majority of the respondents (85%) reported having had one or more casual partners in the last six months. Transactional sex was also common and two-thirds of the surveyed population reported paying or receiving money/gifts or favours in exchange for sex.<sup>14</sup> Figure 4 depicts a more detailed categorisation and frequency of transactional sex with another male.

<sup>a</sup> Pacific Counselling and Social Services (PC&SS) has an MOU with the Fiji Ministry of Health to undertake pre and post test counselling in all government health facilities where testing for HIV and STI is done

<sup>b</sup> Interviewer-administered questionnaire and qualitative focus group discussions

**Figure 4: Percentage of MSM who received or paid money/gifts in exchange for sex with another male in the last six months, 2010-2011**



Source: Prepared by www.aidsdatahub.org based on Bavinton B, Singh N, Naiker DS, Deo MN, Talala M, Brown M, Singh RR, Dewan S, and Navokavokadrau S. (2011). Secret Lives, Other Voices: A community-based study exploring male-to-male sex, gender identity and HIV transmission risk in Fiji. Suva, Fiji: AIDS Task Force of Fiji.

The respondents' condom use at last sex varied with the type of partner and it ranged from 42% to 62%. Consistent condom use was quite low and only 22% of the respondents reported consistent condom use in the last six months with any MSM or TG partners. It varied with the type of partner and 15% of the respondents always use condoms when having sex with straight male partners, while one third of them reported consistent condom use with gay or transgender partners.

Though the respondents demonstrated a high level of HIV knowledge and two-thirds of them could correctly answer all of the knowledge related questions, access to HIV testing and STI services was still limited. Only 11% were tested for HIV in the last 12 months and knew the test results and the respondents expressed the need for MSM-friendly clinics, in order to increase access to services.<sup>14</sup> Furthermore, MSM and TG-specific HIV prevention services are still limited in Fiji and more than one third of the respondents had neither been approached by outreach workers nor been given condoms and lubricants.

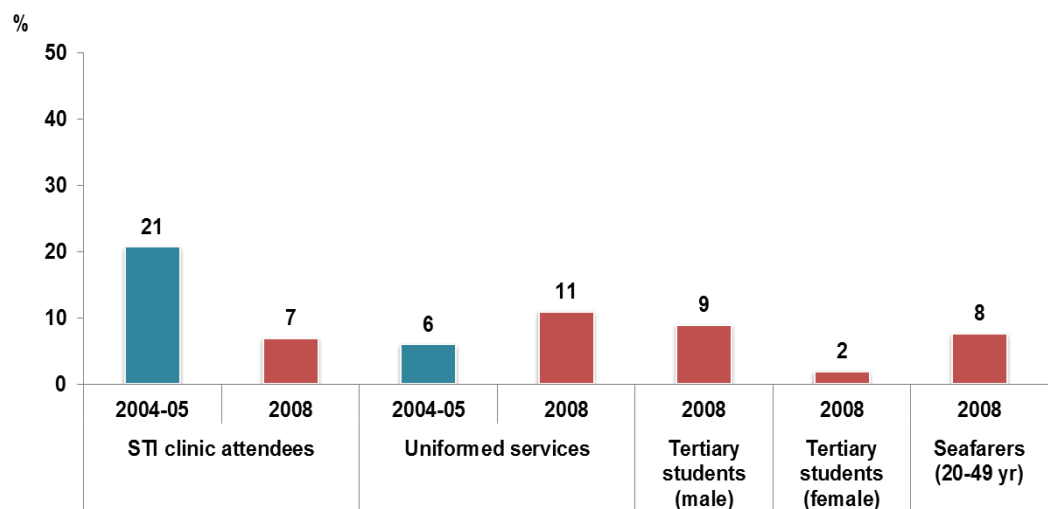
The majority of the surveyed MSM and TG felt the stigma associated with their sexuality and sexual orientation. More than half of the respondents (57%) experienced verbal abuse and almost one-third had been physically hurt in the past six months.<sup>14</sup> One in four respondents reported that they were forced to have sex against their will, at least once in their life time. Among those who were forced to have sex, half of them were TG and 31% were gay.

**Other Populations**

The data from SGS 2008 indicated a generally low HIV knowledge among surveyed populations. The level of comprehensive HIV knowledge<sup>c</sup> varied among them, ranging from 35% (among seafarers) to 54% (among female tertiary students). In addition, only 41% of uniformed services and 46% of ANC attendees could correctly answer all the knowledge related questions.<sup>4</sup>

There are no reliable estimates of the number of clients of sex workers in Fiji. SGS 2004 indicated that 21% of STI clinic attendees and 6% of uniformed services reported having had commercial sex in the last 12 months (Figure 5).<sup>3</sup> Based on the data from SGS 2008, uniformed services reported the highest percentage (11%) of having commercial sex in the last 12 months, followed by male tertiary students (9%), seafarers (8%), and male STI clinic attendees (7%), respectively (Figure 5).<sup>4</sup>

**Figure 5: Percentage of surveyed population who had commercial sex in the last 12 months, 2004 and 2008**



Source: Prepared by www.aidsdatahub.org based on Fiji Second Generation Surveillance 2008 & 2004-2005 cited in Ministry of Health Fiji. (2010). UNGASS Country Progress Report: Fiji

The percentage of men reporting having had sex with multiple sexual partners in the last 12 months was also high among the male groups participating in SGS 2008, particularly among male STI clinic attendees (62%) followed by male tertiary students (33%), and seafarers (32%), respectively (Figure 6).<sup>4</sup> Condom use at last sex was quite low among those who engaged in higher-risk sex<sup>d</sup>. It was well below 50% ( 10%-47%) across all male groups (STI clinic attendees, tertiary students, sea farers, and uniform services) with the lowest condom use among male STI clinic attendees (10%) and seafarers (28%)(Figure 7).<sup>4</sup>

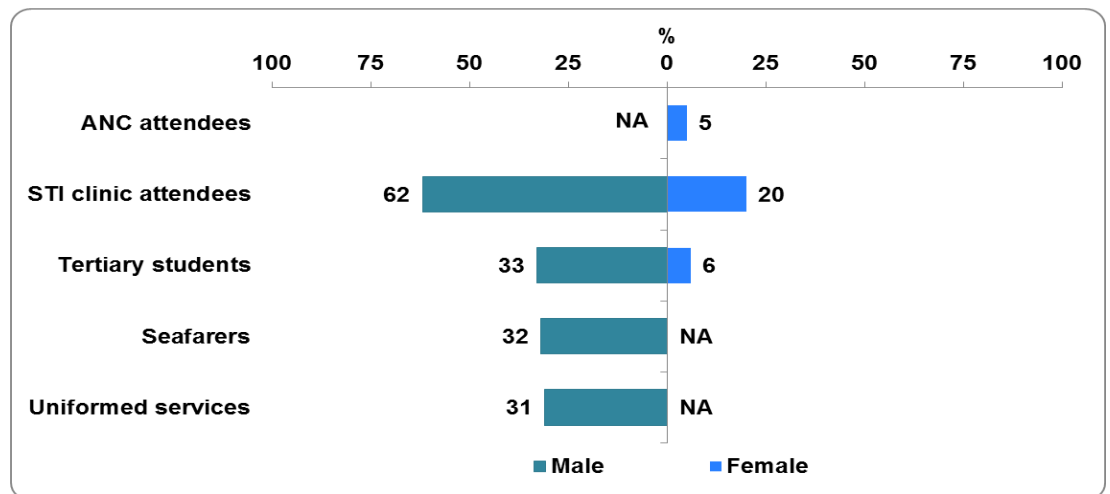
<sup>c</sup> able to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission

<sup>d</sup>Reported having sex with more than one sexual partners in the last 12 months



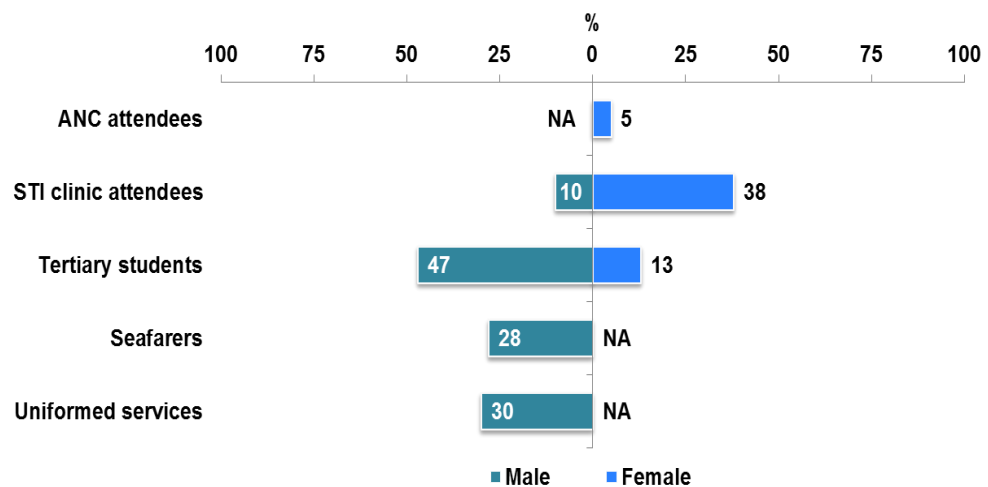
A lower proportion of women surveyed engaged in sexually risky behaviour. Only 2% of ANC attendees and 5% of female STI clinic attendees received payment or goods for sex in the last 12 months.<sup>4</sup> Furthermore, 20% of female STI clinic attendees, 6% of female tertiary students, and 5% of ANC attendees reported having had sex with more than one partner in the last 12 months (Figure 6).<sup>4</sup> However, condom use was quite low among these female groups who engaged in higher-risk sex and the reported condom use at last sex among STI clinic attendees, tertiary students, and ANC attendees were 38%, 13%, and 5% , respectively (Figure 7).<sup>4</sup>

**Figure 6: Percent of surveyed populations who had sex with more than one partner in the last 12 months by gender, 2008**



Source: Prepared by www.aidsdatahub.org based on Fiji Second Generation Surveillance 2008 & 2004-2005 cited in Ministry of Health Fiji. (2010). UNGASS Country Progress Report: Fiji

**Figure 7: Percent of surveyed populations who had sex with more than one partner in the last 12 months and reported condom use at last sex by gender, 2008**



Source: Prepared by www.aidsdatahub.org based on Fiji Second Generation Surveillance 2008 & 2004-2005 cited in Ministry of Health Fiji. (2010). UNGASS Country Progress Report: Fiji

**Vulnerability Factors**

- High level of sexual risk behaviours among men surveyed ( multiple sexual partners and low condom use);
- High prevalence of sexually transmitted infections;
- Poverty and violence against women

**Table 1: Availability of surveys and reports in Fiji**

Type of survey/report	Year	Surveyed population	Status
Second generation HIV surveillance surveys (SGS)	2004-05, 2008	ANC attendees, STI clinic attendees, Military and Police (2004-05 & 2008) Tertiary students and Male seafarers (2008)	Report available (2004-05) Conducted but the report not yet available (2008)
HIV sentinel surveillance survey	-	-	Not conducted
Behavioral surveillance survey	-	-	Not conducted
Mapping and size estimation of key populations at higher risk	-	-	Not conducted
HIV case reporting	Annually since 1989	-	Data available in Ministry of Health Annual Reports
UNGASS country progress report	2006, 2008, 2010	-	Report available
Risky business: Sex work and HIV prevention in Fiji (qualitative study)	2009	Sex workers	Report available
Stigma & discrimination index	2010	People living with HIV	Conducted but the report is not yet available
Secret lives and other voices (MSM behavioral survey)	2011	MSM, Transgender People	Report available
Integrated bio-behavioral survey among MSM	2011	MSM, Transgender People	Conducted but the report is not yet available

Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org)

**HIV, THE LAW AND HUMAN RIGHTS IN FIJI**

In the last 15 years, Fiji has achieved remarkable advancement in human rights, laws and policy related to HIV. Fiji’s *Constitution 1997* explicitly guarantees a number of HIV-related rights including the right to life and to non-discrimination.

Fiji is the only one country in the Pacific that has established a *Human Rights Commission*.<sup>15</sup> According to “*Human Rights Commission Act 1999 S.7*”, Fiji *Human Rights Commission* has powers to – “*Inquire generally into any matter, including any enactment or law, or any procedure or practice whether government or non-governmental, if it appears to the Commission that human rights are, or may be, infringed thereby;*” and to “*Investigate allegations of violations of human rights and allegations of unfair discrimination, on its own motion or on complaint by individuals, groups or institutions on their own behalf or on behalf of others;*”<sup>15</sup>

“Fiji’s Prisons and Corrections Act 2006” also complies with the accepted practices and standards identified in the context of HIV and AIDS, and in particular the International Minimum Standards on HIV/AIDS and Human Rights. It states that “*prisoners who are infected with HIV/AIDS are treated in a manner which takes into account their basic rights and special needs*”.<sup>15</sup>

“*Employment Relations Promulgation 2007*” protects the dignity of people living with HIV (PLHIV) and protects the right of PLHIV in the workplaces. It states that:

“6(2) *No person shall discriminate against any worker or prospective worker on the grounds of ethnicity, colour, gender, religion, political opinion, national extraction, sexual orientation, age, social origin, marital status, pregnancy, family responsibilities, **state of health including real or perceived HIV status**.....*”

The same law also protects employees from mandatory HIV testing through article 38(2):

“*It is prohibited and constitutes an offence where a contract of service specifies that a medical examination is required in the course of a worker’s employment, for the medical examination to comprise HIV/AIDS screening, or screening for sexually transmitted diseases or pregnancy.*”

Fiji explicitly prohibits discrimination on the basis of sexual orientation in its National Constitution of 1997. Furthermore, Fiji decriminalised consensual homosexuality through the *Fiji National Crimes Decree*, passed on 1 February 2010. In passing this law, Fiji became the first Pacific Island nation to remove colonial-era sodomy laws.<sup>16</sup> However, unfortunately, the caveat is that as mentioned previously, the same law strengthened the criminalization of sex work, thereby making it more difficult for interventions to reach sex workers and increasing their vulnerability and other human rights violations.

The Cabinet approved the *HIV/AIDS Decree 2011* on January 18, 2011 and it has since been acknowledged both locally and internationally as one of the most progressive HIV laws in the world.<sup>17</sup> The *Decree* aims to safeguard the privacy and rights of persons infected or affected by HIV and AIDS, by:<sup>18</sup>

- ensuring the confidentiality of personal information;
- creating an environment where persons are encouraged to access voluntary testing, counselling, and support services;
- empowering an affected person to seek redress from professional bodies and the courts if their rights have been violated; and
- promoting the need for everyone to be personally responsible for their own health and that of others through a duty of care

The Government of Fiji lifted its restrictions on entry, stay or residence based on HIV status in August 2011 and it was officially announced by the President of Fiji at the 10<sup>th</sup> International Congress on AIDS in Asia and the Pacific, which was held in South Korea.<sup>19</sup>

## NATIONAL RESPONSE

The National Advisory Council on AIDS (NACA) was established in 1987, 2 years before the first reported cases of HIV in Fiji. The AIDS Task Force Fiji (ATFF) was established in 1994 and NACA needed to re-establish in 2001 in order to effectively address the exigencies of the epidemic. NACA is chaired by the Minister of Health and includes other major stakeholders such as institutions, private sector, civil society organisations, and faith-based organisations.<sup>4</sup>

The first National HIV and AIDS Strategic Plan NSP (2004-2006) was developed in 2004, followed by NSP (2007-2011). NSP (2007-2011) focused on five priority areas, namely: Prevention; Clinical management; Continuum of care for PLHIV; STI/HIV-AIDS surveillance, research, monitoring and evaluation; and Coordination and good governance.<sup>20</sup>

The objective of priority area one *Prevention* was to reduce the risk of HIV transmission among identified vulnerable and marginalized populations and aimed at young people, vulnerable group, marginalised group, general community, and work places. Priority area two *Clinical management*, was to provide services for VCCT (voluntary confidential counselling and testing) and comprehensive, cost effective, accessible, and sustainable HIV care and treatment services to eligible PLHIV. Priority area 3 *Continuum of care for PLHIV*, overlapped with priority area 2, with additional objectives to address stigma-related issues, to promote empowerment, and to strengthen community based programmes. The goal of priority area 4-*STI/HIV-AIDS surveillance* was to establish effective and efficient surveillance and monitoring-evaluation systems, which would be responsive to the identified needs of all stakeholders. Priority area 5 *Coordination and good governance* aimed to ensure that national responses to HIV and AIDS were effectively coordinated and appropriate legislation and policies were in place to support HIV and AIDS management, in line with the principles of good governance, respect for human rights, and protection of the public. <sup>20</sup> A new NSP has recently been developed and is yet to be launched.

### HIV Testing

HIV testing in Fiji is almost entirely voluntary and accompanied by pre and post-test counselling. <sup>20</sup> The reported number of testing and counselling facilities in 2010 was 26, a slight decline from 31 testing and counselling facilities in 2009. Similarly, there was a reduction in the number of people tested for HIV in 2010 with 17,182 people tested for HIV, which was less than half of the number of the 42,507 people tested for HIV in 2009.<sup>4: 21</sup> The reason for the decline in the number of testing facilities and the number of tests conducted is unclear and cannot be surmised from the existing and available literatures.

On the other hand, there is a scale-up of HIV testing among pregnant women and all women attending antenatal clinics are offered counselling and testing.<sup>20</sup> HIV testing coverage among pregnant women was 83% (15,442 pregnant women tested for HIV) in 2010, an increase from 52% in 2009.

### Care and Treatment

Antiretroviral Therapy (ART) became available in Fiji in 2004.<sup>4</sup> The 'Hub Centre' was first established by the Ministry of Health in Suva in 2004 to provide information, counselling, testing and ART services. Then 2 more Hub Centres were added in northern and western divisions in 2005.<sup>4</sup> Antiretroviral drugs (ARV) are provided free but some problems regarding the procurement of ARVs were reported in a review of Fiji HIV response.<sup>20</sup> Different partners held different opinions on the delays/barriers in procurement and it seemed that there was no clearly identifiable single barrier and all the partners might need to work together to adequately address the issues and to overcome the barriers.<sup>20</sup> In 2008, 1 out of 6 health facilities dispensing ARVs experienced a stock-out of at least one required ARV in the last 12 months. However, information on ARVs stock-out is not available in recent years.

By 2010, 58 PLHIV were receiving ART with an estimated ART coverage of 33%. Regarding prevention of mother-to-child transmission (PMTCT), 14<sup>e</sup> pregnant women living with HIV received ARVs for PMTCT in 2010 with an estimated coverage range of 78% to over 95% (in-line with 2010 WHO guidelines).<sup>21</sup>

Though high STI prevalence was detected among ANC attendees, funding was limited for the provision of adequate diagnosis and treatment and the Marie Stopes Clinic provided treatment for STIs.<sup>20</sup>

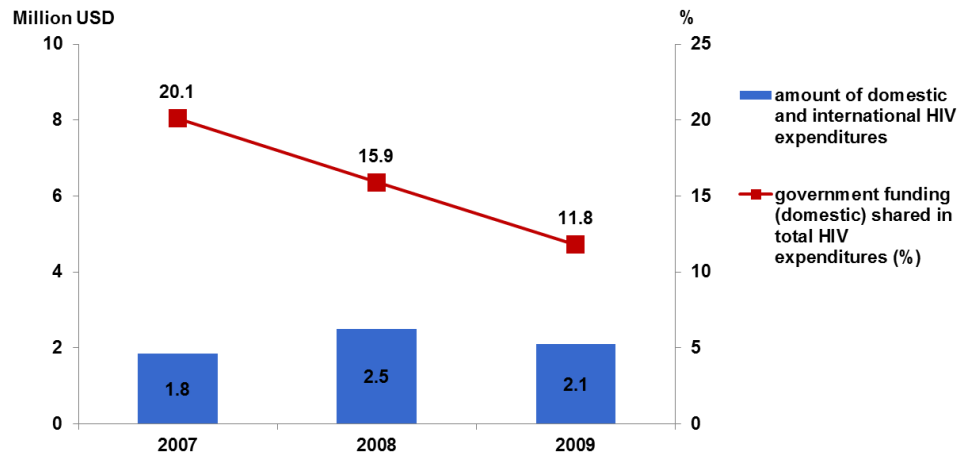
Fiji is a member of the World Trade Organisation (WTO) and as such subject to the 1995 TRIPS (Trade-Related Aspects of Intellectual Property Rights) requirements which include the obligation to provide patent protection for pharmaceutical products.<sup>15</sup> However, the 2001 Doha Declaration on public health related TRIPS flexibilities provided the legal space for WTO members to take measures to secure access to affordable medicines. Fiji is currently in the process of reviewing and amending their patent laws to ensure TRIPS compliance.<sup>15</sup>

## HIV AND AIDS FINANCING AND EXPENDITURE

In 2009, a total of US\$ 2.1 million was spent on AIDS, a slight decrease from US\$ 2.5 million the previous year (Figure 8). The contribution from domestic financing sources showed a notable decline from 20% in 2007 to 11.8% of AIDS spending in 2009.<sup>10</sup> Figure 9 displays the allocation of funding (in percentage) in different categories. There was a reduction in prevention spending from 2007 to 2009, in terms of actual amount as well as the proportion of total AIDS spending.<sup>10</sup> Only 0.8% (170,000 US\$) of the total AIDS spending was spent on prevention programmes for MSM and sex workers in 2009.<sup>10</sup> Over the same period, a considerably high proportion of AIDS expenditure was spent on "Programme management and administration strengthening" which accounted for 34% of the total AIDS spending in 2009, an increase from 26% in 2007. Furthermore, spending on enabling environment, programme management, prevention, and human resources were heavily dependent on international financing sources and 97%, 94%, 86%, and 76% of the respective spending came from the international funding sources.<sup>10</sup>

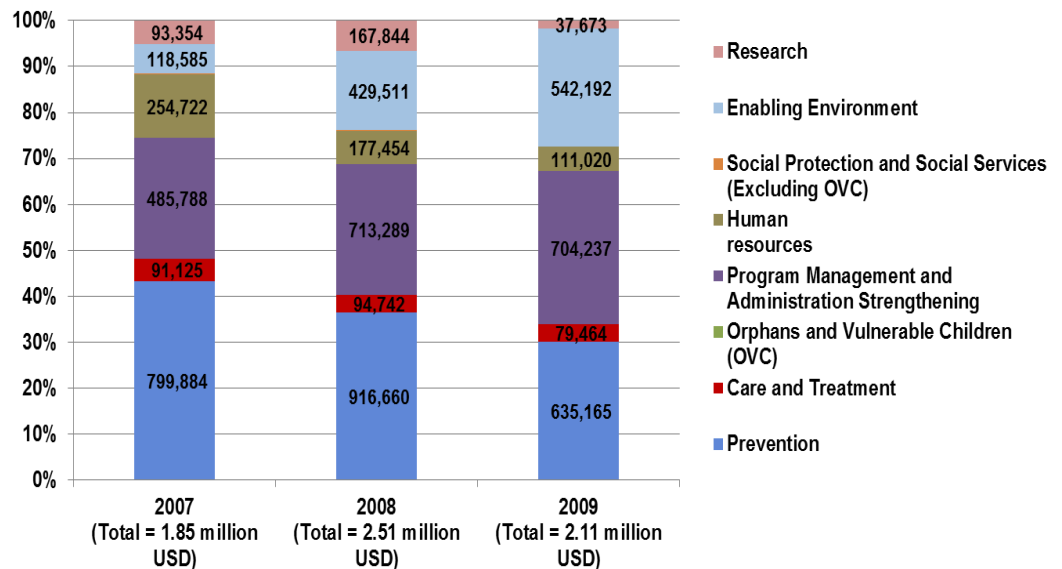
<sup>e</sup> Data were collected from Colonial War Memorial Hospital, Lautoka Hospital and Labasa Hospital

**Figure 8: Amount of domestic and international AIDS spending by financing sources and % shared by government, 2007-2009**



Source: Prepared by www.aidsdatahub.org based on UNAIDS. (2010). Global Report: UNAIDS Report on the Global AIDS Epidemic.

**Figure 9: Percent distribution of total HIV expenditures by major spending category, 2007-2009**



Source: Prepared by www.aidsdatahub.org based on UNAIDS. (2010). Global Report: UNAIDS Report on the Global AIDS Epidemic.

By 2005, four HIV-focused grant programmes were established in Fiji, which were; a) National AIDS Council (NAC) Grant Programme, b) Competitive Grant Programme, c) Rapid Response Grant Programme, and d) Capacity Development Organisation (CDO) Grant Programme.<sup>4</sup> The NAC Grant Program was managed by NACA with the assistance of the CDO and Fiji Council of Social Services (FCOSS). Fiji was awarded 35% of competitive grant funding available for the Pacific and 11 projects working in Fiji were funded in three rounds of competitive tendering (round 1 to 3).<sup>4</sup>

## References

- <sup>1</sup>UN Population Division. (2012). World Population Prospects, the 2010 Revision. Retrieved February 2012: [http://esa.un.org/unpd/wpp/Sorting-Tables/tab-sorting\\_population.htm](http://esa.un.org/unpd/wpp/Sorting-Tables/tab-sorting_population.htm)
- <sup>2</sup>UNFPA. (2011). *State of World Population 2011*.
- <sup>3</sup>Ministry of Health Fiji, Ministry of Health Kiribati, Ministry of Health Samoa, Ministry of Health Solomon Islands, et al. (2006). *Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in Six Pacific Island Countries*.
- <sup>4</sup>Ministry of Health Fiji. (2010). *UNGASS Country Progress Report: Fiji*
- <sup>5</sup>World Bank. (2012). World dataBank:World Development Indicators & Global Development Finance. Retrieved February 2012: [http://databank.worldbank.org/ddp/home.do?Step=2&id=4&DisplayAggregation=N&SdmxSupported=Y&CNO=2&SET\\_BRANDING=YES](http://databank.worldbank.org/ddp/home.do?Step=2&id=4&DisplayAggregation=N&SdmxSupported=Y&CNO=2&SET_BRANDING=YES)
- <sup>6</sup>WHO. (2011). *World Health Statistics 2011*.
- <sup>7</sup>UNDP. (2011). *Human Development Report 2011*.
- <sup>8</sup>Ministry of Health. (2011). *Annual Report 2010*.
- <sup>9</sup>Ministry of Health. (2011). World AIDS Day Speaking Notes. from [www.health.gov.fj/speeches/01/12/2011-wad-speaking-notes.html](http://www.health.gov.fj/speeches/01/12/2011-wad-speaking-notes.html)
- <sup>10</sup>UNAIDS. (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic*.
- <sup>11</sup>McMillan, K., & Worth, H. (2010). *Risky Business: Sex Work and HIV Prevention in Fiji*. International HIV Research Group, UNSW, Sydney.
- <sup>12</sup>Meleisea, P. S., UNDP Pacific Centre, UNDP Regional Project on HIV and Development, UNIFEM Pacific, et al. (2009). *Gender and HIV in the Pacific Islands Region: A Literature Review of Evidence with Recommendations*: UNDP Pacific Centre.
- <sup>13</sup>McMillan, K., & Worth, H. (2011). *Sex Workers and HIV Prevention in Fiji – after the Fiji Crimes Decree 2009*: International HIV Research Group, UNSW, Sydney.
- <sup>14</sup>Bavinton, B., Singh, N., Naiker, D. S., Deo, M. N., et al. (2011). *Secret Lives, Other Voices: A Community-Based Study Exploring Male-to-Male Sex, Gender Identity and HIV Transmission Risk in Fiji*. Suva, Fiji: AIDS Task Force of Fiji.
- <sup>15</sup>UNDP Pacific Centre. (2009). *Enabling effective responses to HIV in the Pacific island countries : options for human rights-based legislative reform*. Suva, Fiji
- <sup>16</sup>UNAIDS. (2010). Fiji First Pacific Island Nation with Colonial-Era Sodomy Laws to Formally to Decriminalize Homosexuality. *Feature Story* Retrieved February 26 from <http://www.unaids.org/en/resources/presscentre/featurestories/2010/march/20100304fiji/>
- <sup>17</sup>Fiji Government Online Portal. (2011). PM Highlights Fiji's Progressive Laws on Health Care. *News* Retrieved February 26 from [http://fiji.gov.fj/index.php?option=com\\_content&view=article&id=4910%3Apm-highlights-fijis-progressive-laws-on-health-care&catid=67%3Afiji-header-stories&Itemid=155](http://fiji.gov.fj/index.php?option=com_content&view=article&id=4910%3Apm-highlights-fijis-progressive-laws-on-health-care&catid=67%3Afiji-header-stories&Itemid=155)
- <sup>18</sup>Fiji Government Online Portal. (2011). Cabinet approves HIV/AIDS Decree 2011. *News* Retrieved February 26 from [http://www.fiji.gov.fj/index.php?option=com\\_content&view=article&id=3226:cabinet-approves-hiv-aids-decree-2011&catid=71:press-releases&Itemid=155](http://www.fiji.gov.fj/index.php?option=com_content&view=article&id=3226:cabinet-approves-hiv-aids-decree-2011&catid=71:press-releases&Itemid=155)
- <sup>19</sup>UNAIDS. (2011). Fiji Lifts Travel Ban for People Living with HIV. *Feature Story* Retrieved February 26 from <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/august/20110826cfiji/>
- <sup>20</sup>Ministry of Health, UNAIDS, & Burnet Institute. (2010). *Review of Fiji National AIDS Response and Assessment of Progress Towards Universal Access*. Unpublished.
- <sup>21</sup>WHO, UNAIDS, & UNICEF. (2011). *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access-Progress Report 2011*.