MINISTRY of HEALTH & MEDICAL SERVICES

Shaping Fiji's Health

REPUBLIC OF FIJI NATIONAL STRATEGIC ACTION PLAN ON HIV AND STIs

2016 -2020






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NATIONAL STRATEGIC ACTION PLAN ON HIV AND STIs

2016 -2020

DEDICATION

The Ministry of Health and Medical Services would like to dedicate the Strategic Plan 2016 -2020 to His Excellency, the Former President of Fiji, Sir Ratu Epeli Nailatikau, for his unwavering support and dedication in leading our response to HIV and AIDS. His absolute commitment to this cause is not only recognised in Fiji but regionally and globally as well.

Sir Ratu Epeli Nailatikau's most significant contribution in this area has been his continued advocacy in all primary (179) and secondary (180) schools in Fiji. In addition, he has supported the improvement and strengthening of HIV care and treatment in the country by ensuring political commitment to the provision of free antiretroviral treatment for people living with HIV/AIDS. Lending his personal example to our efforts to break down HIV stigma and discrimination, he has engaged directly with people living with HIV and key populations at higher risk.

His commitment and vision to Fiji's response to HIV/AIDS is reflected in the strategic approaches that have been adopted by way of the following measures, to name just a few:

- the enactment of the HIV/AIDS Decree which outlines a human rights framework for the response to the HIV epidemic and the establishment of the HIV/AIDS Board in 2011, which is responsible for coordinating Fiji's HIV response.

- The enactment of the 2009 Crimes Decree, which reformed the Penal Code and decriminalised male-to-male sex, thus removing a significant barrier to access to HIV prevention services for men-who-have-sex-with-men (MSM).

- The official announcement in August 2011 by the former President of Fiji at the 10th International Congress on AIDS in Asia and the Pacific, held in South Korea, regarding Fiji's lifting of restrictions on entry, stay or residence based on HIV status.

On December 1, 2015, UNAIDS appointed Sir Ratu Epeli Nailatikau as the Pacific Goodwill Ambassador for the Pacific island countries in recognition of his personal input into the global HIV/AIDS response.

The Ministry of Health and Medical Services, on behalf of Fiji, wishes Sir Ratu Epeli Nailatikau the best in his role as the Pacific Goodwill Ambassador for Pacific island countries and may God continue to shower him with good health, divine strength, knowledge and wisdom.

FOREWORD

The Fiji HIV/AIDS Board is deeply grateful for the continued commitment from Government through the Ministry of Health and Medical Services and the continued support of donor agencies and regional technical partners. This kind of support has benefitted Fiji's HIV response in its various components including prevention, treatment, care and support programs implemented by government agencies and other key partners - especially the key and vulnerable populations – who are also our target groups, as well as non-government organisations (NGOs) and faith-based organisations (FBOs).

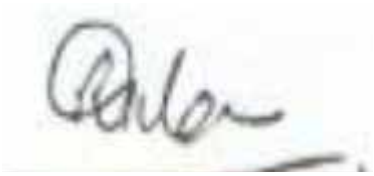
Throughout 2014, there has been a progressive commitment to improving the quality of lives of those living with and affected by HIV, including pregnant women and children, key populations at higher risk and other vulnerable populations, and, people with disabilities. This commitment is being strengthened further in the next five years through the development of the 2016-2020 National Strategic Plan on HIV and STIs.

The new plan was put through a series of national consultations, in keeping with the principles of "nothing about us without us", universal health coverage and, gender equality - to mention a few - thus echoing the call of leaving no one behind.

This new plan is aligned with the new directions of the WHO Global Health Sector Strategic Plans on HIV, STIs and Hepatitis; the UNAIDS 90-90-90 Fast Track Initiatives; and the Sustainable Development Goals (SDG).

Further, as Fiji strives to implement more responsive National HIV and STI programmes, costing requirements have been identified and clear monitoring and evaluation parameters developed. These will help to track the progress and assess the appropriateness of the response in the context of an evolving country epidemic.

Honourable Rosy Sofia Akbar



Minister of Health and Medical Services

ACKNOWLEDGEMENT

The HIV/AIDS Board of Fiji would like to take this opportunity to express its deep appreciation and sincere thanks to all those who participated in the development of the National Strategic Plan (NSAP) 2016-2020.

This NSAP has been brought to its final form after months of the combined efforts by many. This is a document that we can be justifiably proud of because it has been developed by Fijians for Fijians through a series of consultations among different national and local stakeholders. Such an extensive and all-encompassing exercise was made possible through the guidance and support of our regional technical partners. Thus, special thanks are accorded to the UNAIDS Pacific Office, the WHO Office of the Representative for the South Pacific, the UNICEF Pacific Sub-regional Office and the Secretariat of the Pacific Community. Their technical support in this participatory approach, including advice, consultation and participation in numerous meetings and workshops, helped us to develop a strategic plan that is responsive to our present context.

We owe the sincerest gratitude to all the contributions from the grassroots communities, specifically, our key and vulnerable populations, people living with HIV, young people, people with disabilities, and the spiritual leaders. Their input, along with that of our health service providers and representatives from government agencies, civil society organisations, and people from the academe, allowed us to incorporate critical prevention and treatment intervention, care and support services, and systems'-strengthening components. It also helped us raised the bar on the importance of gender, equity and human rights in all stages and aspects of this NSAP.

Special mention is accorded to our people living with HIV whose perspectives and inputs made this plan more practical and responsive to their needs.

We cannot thank everyone enough for the tireless efforts that were readily given towards the development of this NSAP. The full list of participants can be found in Annex 1.

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Abbreviations

AIDS - Acquired Immuno-deficiency Syndrome
ANC - Antenatal clinic
ART - Antiretroviral Therapy
ARV - Antiretroviral Drugs
CEDAW - Convention on the Elimination of all Forms of Discrimination against Women
CI - Confidence Interval
CMV - Cytomegalovirus
CC - Continuum of Care
CSE - Comprehensive Sexuality Education
FBO - Faith Based Organisation
FSW - Female Sex Worker
GDP - Gross Domestic Product
HIV - Human Immuno-deficiency Virus
IBBS - Integrated Behavioural and Biologic Surveillance
IDU - Injecting Drug User
IEC - Information Education Communication
LMIS - Logistics Management Information System
MDG - Millennium Development Goals
M&E - Monitoring and Evaluation
MHMS - Ministry of Health and Medical Services
MSM- Men having Sex with Men
NGO - Non-government Organization
NMTC - National Medicines and Therapeutics Committee
NSAP- National Strategic Action Plan
NSP - National Strategic Plan
PEP- Post Exposure Prophylaxis
PIC- Pacific Island Countries
PID - Pelvic Inflammatory Disease
PLHIV- People Living with HIV
PPTCT - Prevention-of-Parent-to-Child-Transmission
RDS - Respondent Driven Sampling
SDG - Sustainable Development Goals
SDH - Sub-Divisional Hospitals
SOGI - Sexual Orientation and Gender Identity
SS - System Strengthening
STI - Sexually Transmitted Infections
SW - Sex Worker
TB - Tuberculosis
TG - Transgender Feminine and Masculine (Transmen and Transwomen)
TGSW - Transgender Sex Worker
TPPA - Treponema Pallidum Particle Agglutination
UN - United Nations
UNAIDS- Joint United Nations Programme on AIDS
UNDAF - United Nations Development Assistance Framework
UNICEF - United Nations Children's Fund
UPR - Universal Periodic Review
WHO - World Health Organization

Executive summary

Twenty seven [27] years have elapsed since the first HIV case was reported in Fiji in 1989. Since then, in recognising HIV and AIDS as a development issue, the Government, through the collaboration of stakeholders and the coordination of the Ministry of Health and Medical Services, has sustained a national response, in conformity with the changing profile of the epidemic. As with the previous National Strategic Plan (NSP) for STIs, HIV & AIDS, this strategic plan has been updated and expanded to ensure that the response reaches beyond the health sector. Due to the diverse range of factors that have influenced the epidemic, multi-sectoral partners including other government partners, civil society organisations, faith-based organisations and the key affected populations have been actively involved, not only in the planning and the development of the national response, but also in the implementation of the national plan. Fiji's coordinated multi-sectoral response is showing positive achievements.

The National Strategic Action Plan (NSP) 2016-2020 on STIs, HIV and AIDS is linked to the Sustainable Development Goals (SDG), the ambitious treatment strategy [90-90-90] and the Fiji Ministry of Health and Medical Services Strategic Plan 2016-2020. This NSP will continue to place strong emphasis on strengthening the multi-sectoral collaboration as undertaken in the previous NSPs.

The lessons learnt and experience gained in the implementation and monitoring of previous NSPs have shown that there still are opportunities to strengthen the commitment and involvement of partners (most importantly, the targeted key populations) and also the prevention component of the national response. The 2016-2020 NSAP on STIs, HIV and AIDS intends to build upon the achievements and progress made during the implementation of the previous strategic plan as well as address emerging issues and challenges.

To achieve the vision and the goal of the strategy, the National Strategic Action Plan on STIs, HIV & AIDS 2016-2020 comprises four priority areas of intervention:

1. Prevention
2. Continuum of Care
3. System Strengthening
4. Monitoring, Evaluation and Research

The monitoring, evaluation and research component will ensure that progress is well understood, that achievable approaches are exploited to the fullest and that challenges are identified and corrected at the earliest opportunity.

The strategic response for the period 2016-2020 will be executed under the 4 priority areas above including monitoring and evaluation, with a corresponding cost over the five-year period as shown in the table below:

Priority Area	Six Year Total [FJD]
1. Prevention	$11,824,269
2. Continuum of Care	$12,530,802
3. System Strengthening	$4,578,151
4. Monitoring, Evaluation & Research	$3,526,418
TOTAL	$32,459,640

The NSAP requires that all those involved in the response redouble their efforts and work together in a more coordinated approach. While it is true that Fiji has made exceptional progress in managing its HIV and AIDS epidemic, there is still a significant distance to achieving the international goals of the 3 zeros and the 90-90-90 treatment strategy. These goals are within reach, as long as Fiji [as a whole] invests sufficient resources to address the causes and consequences of HIV infection and improving sexual reproductive health more generally. The 2016-2020 NSAP provides and paves the way for Fiji to achieve national and international targets including the SDGs.

The Strategy

Vision:

An AIDS and STI-free generation in Fiji

Goal:

Halt the spread of HIV, reverse the epidemic of STIs and improve the quality of life of people living with and affected by HIV.

The NSAP has been built to ensure that the following results are obtained:

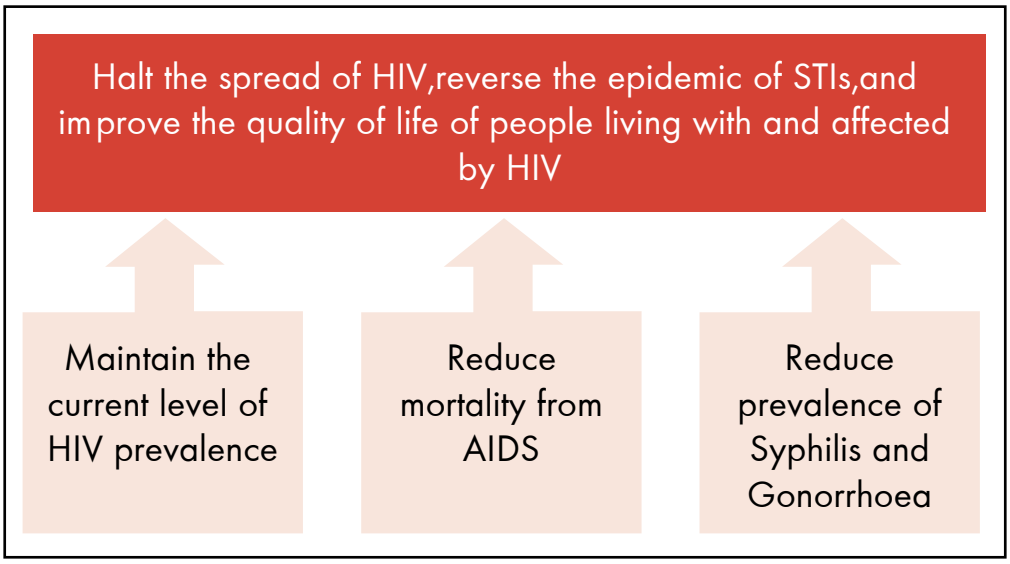

Figure 1: Goals for the NSAP 2016-2020

Impact Indicators	Available Data	
	2015	2020
Impact Indicator 1. Prevalence of HIV in general population (estimated)	0.14%[1]	0.14%
Impact Indicator 2. Prevalence in transgender sex workers	1.8%[2]	1%
Impact Indicator 3. Prevalence of Syphilis in general population	16%	1.6 %
Impact Indicator 4. Mortality rate from HIV	33%[3]	1%

Table 1: Impact Indicators for NSAP 2016 - 2020

[1]Estimated prevalence from Spectrum Projections and Estimations for HIV/AIDS for Fiji Ministry of Health & Medical Services [MoHMS] 2015
[2]Dr. Elaine Mossman and Dr. Michael Roguski, 1 Rani Ravudi, 2 Dr. Rachel Devi, 3 Integrated Biological Behavioral Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project
[3]Estimated Mortality from Spectrum Projections and Estimations for HIV/AIDS for Fiji, MoHMS 2015

Objectives

By 2020, Fiji will be guided by the objectives to reach the 90-90-90 targets:

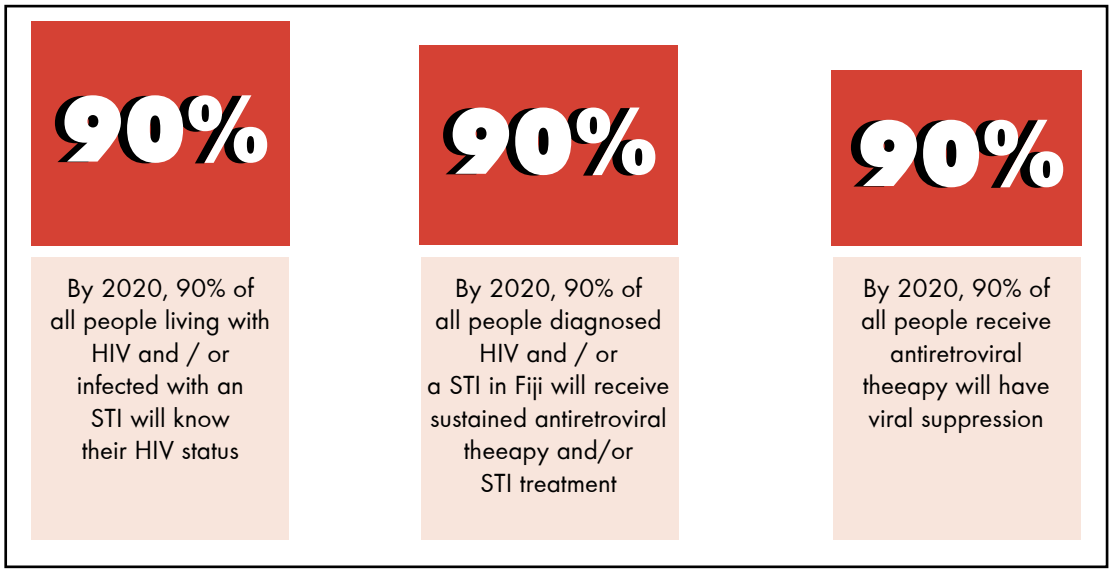

Figure 2: NSAP Objectives

Priorities

The current program strategy is built around identifying 90% of people living with HIV by scaling up a diversified prevention programme and enrolling them in treatment. Based on most recent evidence, a person with HIV who is adherent to antiretroviral treatment shows undetectable levels of HIV and does not further transmit the virus. This might break the cycle of the spread of HIV in Fiji. To achieve the objectives, the current programme is structured around four priority areas as follows:

Priority Area 1: Prevention
Priority Area 2: Continuum of Care
Priority Area 3: System Strengthening
Priority Area 4: Monitoring, Evaluation and Research

A more detailed description of Goals, Objectives, Priorities and Indicators may be found further.

NSAP Development

The HIV/AIDS Board, together with the Family Health Unit of the Ministry of Health and Medical Services, spearheaded the development of the National HIV and STI Strategic Plan 2016-2020 through a series of consultations with key implementers, partners and beneficiaries of the programme. This inclusive and participatory approach ensured that no one is left behind at any stage of this development process.

Consultative Process

These series of consultations were conducted from August to November 2015 and were facilitated by regional technical partners, namely, the UNAIDS Pacific Sub-regional Office, the UNICEF Pacific Sub-regional Office, the WHO Office of the Representative for the South Pacific and the Secretariat of the Pacific Community. There was participation from representatives from different government agencies, non-government and civil society organisations, faith-based organisations, key populations at higher risk, vulnerable populations, young people, people with disabilities, and people living with HIV. One unique approach that was applied was having an open voluntary participation for those who wanted to be part of the NSAP development group. All the participants who signified their intention to participate in these processes actively engaged and contributed strategically in the whole process. A complete list is included in Annex 1.

The **STEPS** undertaken were as follows:

- STEP 1: Brainstorming session with regional technical partners on the design, technical resources needed and timelines for the NSAP development process
- STEP 2: Call for members of the NSAP development group based on open mechanism and voluntary engagement
- STEP 3: Conduct the different consultations among different stakeholders and key partners
- STEP 4: Validate the different priority areas and service packages
- STEP 5: Convene the write-up sessions
- STEP 6: Cost services and develop the budget for the NSAP
- STEP 7: Presentation of the draft to people living with HIV (FJN+)
- STEP 8: Internal Consultation of the MOHMS
- STEP 9: Presentation and approval by the HIV/AIDS Board
- STEP 10: Presentation and approval by the Cabinet of Ministers of Fiji

The below diagram shows the significant timelines and milestones towards the NSAP development:

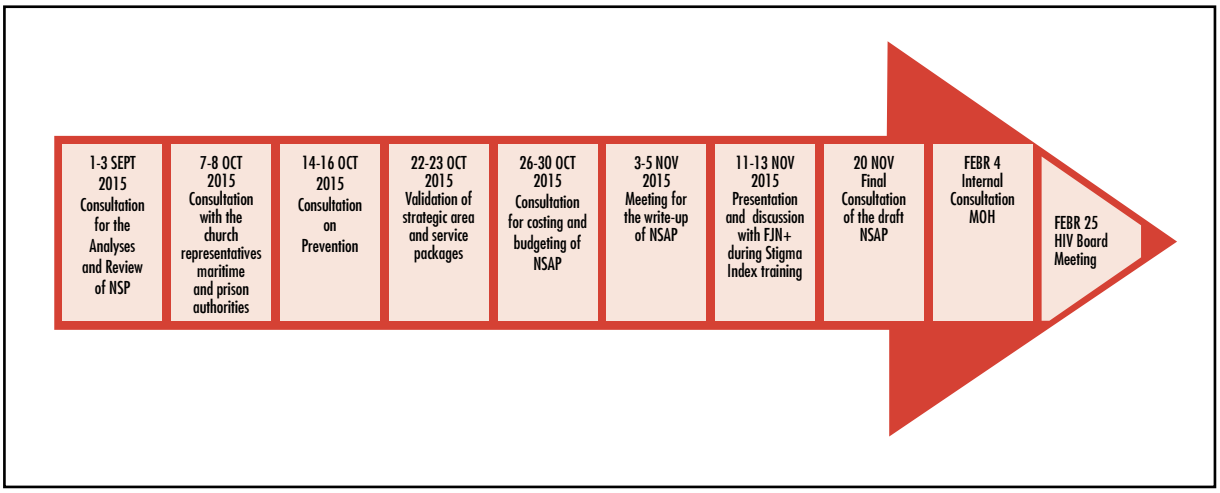

Figure 3: Timeline for the Development of the NSAP

The Guiding Principles

The NSAP development group agreed to and ensured that the following guiding principles were adhered to:

1. Universal health coverage.
2. Government stewardship and accountability.
3. Evidence-based interventions, services and policies.
4. Protection and promotion of human rights, gender equality and health equity.
5. Partnership, integration and linkage with relevant sectors, programmes and strategies.
6. Meaningful involvement of people living with HIV, key populations and affected communities.

The Country Context

Fiji is an archipelago with 332 islands and a population after the 2007 census of 837, 271 people. Since 1989 up to November 2015, a cumulative total of 647 confirmed HIV cases were reported in Fiji with a 15% increase from 2014 to 2015. However, it remains unclear how many of the people diagnosed with HIV are still alive.

Fiji's HIV epidemic is of low prevalence, estimated at 0.14%, with an estimated 732 people living with HIV in 2015. A gradual increase has been reported from 2010-2015, averaging 60 new cases per year, compared to 30 new cases per year from 2000-2008. In 2014, fifty eight percent (58%) were females, while 42% were males. This difference in percentage can be attributed to the increased testing offered during antenatal clinic check-ups. The 20-29 and the 30-39 age groups account for nearly 75% of all the infections reported up to the end of 2014. Almost the same percentage is reported in 2015. The primary mode of self-reported transmission was through heterosexual contact; followed by perinatal transmission; and homosexual contact.[4]

With regards to STIs, Fiji's MoHMS reported in 2014 a total of 2,248 STI cases through a mixture of syndromic and etiologic diagnosis and management. There were six syndromes being reported; and historically, three etiologies, namely chlamydia, gonorrhoea and syphilis. Since 2014, no chlamydia testing has been available in the country.

An evaluation of the appropriateness of the on-going response to the current HIV and STI situation found that the following factors were the main strengths of the NSAP 2011-2015:

1) the collaborative partnership between government agencies; non-governmental and community based organisations, academic institutions, key populations at higher risk, people living with HIV (PLHIV), health professionals and development partners;

2) STI and HIV services are available at divisional and sub-divisional levels;

3) the engagement of the PLHIV community in the provision of the care continuum;

4) guidelines and policies have been updated to the most recent WHO recommendations including the HIV care and antiretroviral therapy guidelines, HIV/TB collaborative activities guidelines, PPTCT policy, HIV testing and counselling policy and comprehensive syndromic management of STI guidelines; and

5) government service providers trained and received orientation on new recommendations.

However, there were still challenges that needed to be addressed, such as treatment defaulters, some restrictive policies, limited testing services tailored to reach key populations, and, information gaps about other key and vulnerable populations, to mention a few.

All these were considered in the development of the new NSAP. Likewise, key components were incorporated from the new WHO Global Health Sector Strategies on HIV, STIs and Hepatitis, the UNAIDS 90-90-90 Fast Track Initiatives, and the Sustainable Development Goals 2030 Agenda, as well as, linkages to other programmes such as TB, SRH Sexual Reproductive Health Program) specifically on Maternal and Child Health, Adolescent Health, and, ending violence against women and children.

As demonstrated in the previous AIDS response, time-bound targets drive progress, promote accountability and unite diverse stakeholders in pushing towards common goals. To accelerate progress towards ending the epidemic, new Fast-Track Targets have been established for the Sustainable Development Goals (SDG) era. These targets aim to transform the vision of zero

[4]Fiji Ministry of Health and Medical Services programme data

new HIV infections, zero discrimination and zero AIDS-related deaths into concrete milestones and end-points.

For the first time in Fiji, there is a consensus to aim for the following:

- that 90% of people living with HIV should know their HIV status;
- that 90% of people who know their status should be receiving treatment; and,
- that 90% of people on HIV treatment should have a suppressed viral load so that their immune system remains strong and they are no longer infectious.

These 90–90–90 targets apply to children and to adults, men and women, poor and rich, in all populations. There are even higher targets set for reaching pregnant women. This strategy is also known as the Test and Treat Strategy.

"Test and treat" programmes are based on the premise that the rate of new HIV infections can be reduced by rolling out universal HIV testing in order to diagnose all those living with HIV, as well as initiating antiretroviral treatment regardless of CD4 count or viral load. This will dramatically reduce the HIV transmission pattern.

Thus, Fiji will apply HIV prevention treatment methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission. ART reduces the HIV viral load in the blood, semen, vaginal fluid and rectal fluid to very low levels ('undetectable'), thus reducing the risk of HIV transmission.

The product of these series of consultations is the NSAP 2016-2020.

I. Introduction

Country Context

Fiji, an island nation in the south-west Pacific, midway between Vanuatu and the Kingdom of Tonga, is made up of 332 islands, one third of which is inhabited (Figure 7). Its population in 2007 was 837, 271 people, of whom approximately 57% were i-Taukei, 37% Fijians were of Indian descent and the remainder comprised other ethnic groups. Fiji is a multicultural and multi-religious country; most of the i-Taukei are either practising Christians or have some Christian background while Fijians of Indian descent are predominantly of the Hindu and Muslim faiths.[5] The adult literacy rate is around 94%. English is the official language while the Fijian and Hindi vernaculars are employed in daily use.[6]

The country is one of 22 Pacific Island Countries and Territories (PICTs) and one of five in the Melanesian sub-region, together with Papua New Guinea, Solomon Islands, New Caledonia and Vanuatu (Figure 7).

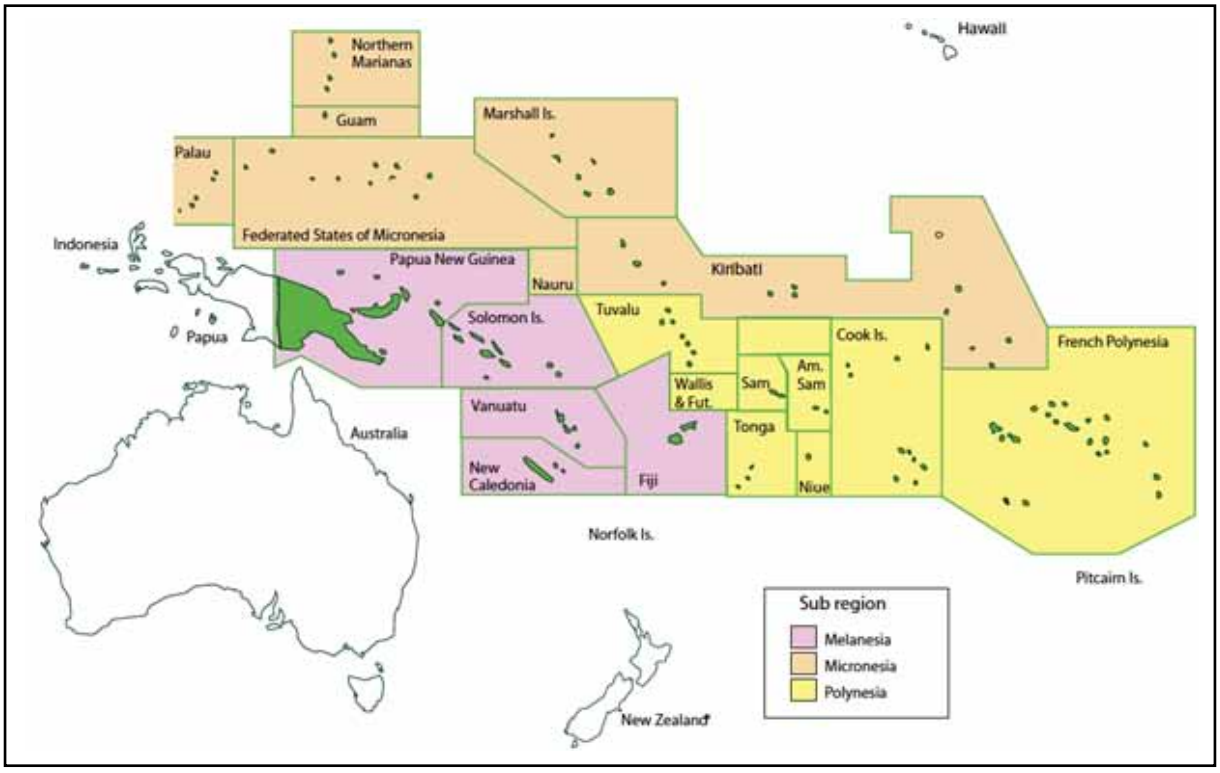

Figure 4: Map of the Pacific Island Countries and Territories

Of the population of 837 271, 51% live in urban areas, while70% occupy the two largest islands, Viti Levu and Vanua Levu, both of which account for 85% of the country's total land area. As of 2007, there were seven cities and towns, each with an urban population of 20,000 or more. (Figure 2). Of these, all are located on the main island, Viti Levu, except for Labasa (population 28,000) which is in Vanua Levu. Suva and Nasinu are Fiji's largest urban centres, each with about 85,000 inhabitants or 10% of the national population; the two centres are within 12 kilometres of one another, commuting between them is common and they are considered to have a high degree of social connectivity. Also proximate are Nausori (48,000) and Lami (20,000). Lautoka and Nadi, on western Viti Levu have about 52,000 and 42,000 inhabitants respectively. In

[5]Population GIS Maps based on the Population and Housing Census of 2007, National Bureau of Statistics, http://www.statsfiji.gov.fj/index.php/1996-pop-gis-maps.
[6]The Fiji Islands Health System Review, Dr Graham Roberts, Fiji National University et al, 2011

all provinces on both islands, individuals of reproductive age (15-59 years), make up between 56% and 66% of the total population (Figure 8). One in five (20.2%) Fijians are youth in the 15-24 year age group.

Male and female life expectancy stand at 63.8 and 67.6 years, respectively. The country has a medium human development index score of 0.702, equal to that of Belize, the Dominican Republic and neighbouring Samoa, well above the East Asia and Pacific average of 0.683 and ranking it 96th among nations on the Index.

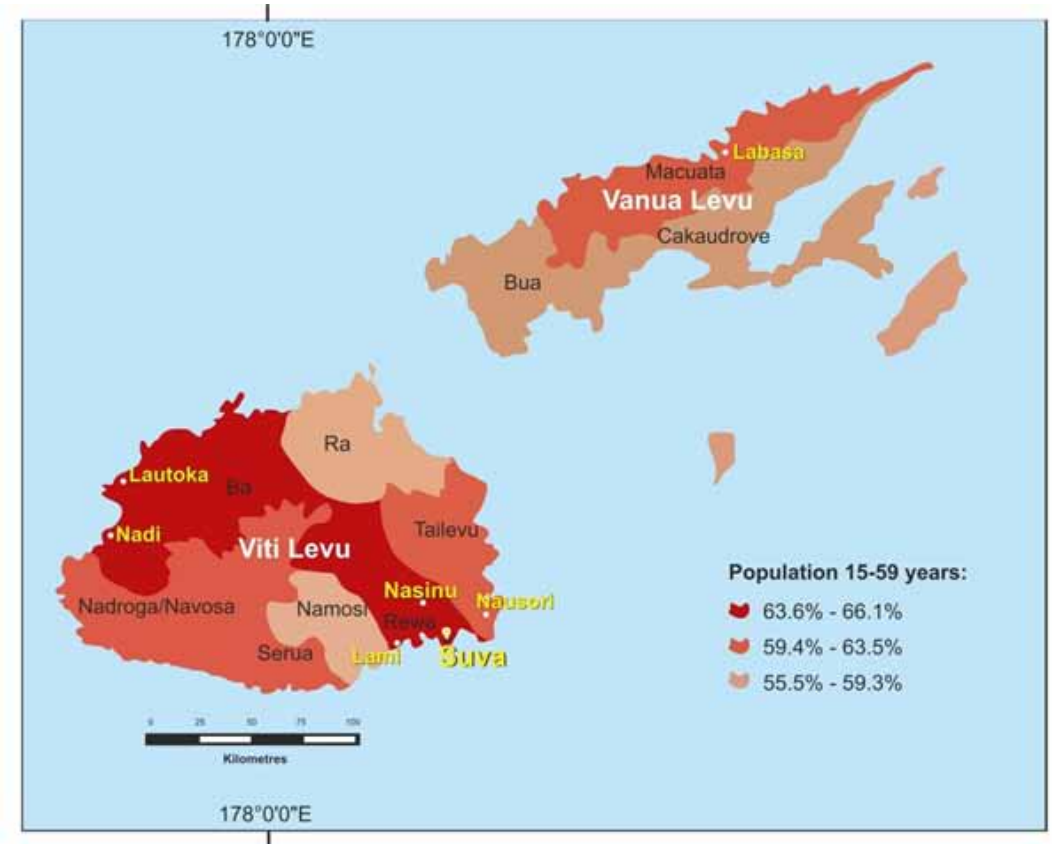

Figure 5: Cities and Towns with an Urban Population of 20,000 or more in Fiji in 2007

Fiji's Health's System[7]

Fiji has a well-established health structure and system in place to cater for urban and rural communities. It consists of three major divisional hospitals around Fiji located in the major cities/towns of the Central, Western and Northern Divisions. The Eastern Division does not have a divisional hospital due to the geographical challenge it faces.

Apart from the major divisional hospitals, each Division has sub-divisional hospitals. The Central Division has 6 sub-divisional Hospitals (SDH), Western has 6,Northern has 4 and the Eastern Division 4.The sub-divisions have concentrated health centres and nursing stations which are structured around the rural and peri-urban areas of Fiji.

The number of hospitals from Divisional Hospitals down to nursing stations in the various sub-divisions can be seen in Figures 9-11 below. To date, the structures in place demonstrate the accessibility of health care delivery in Fiji.

The sub-divisional hospitals and the three Divisional hospitals provide a comprehensive range of services, including core specialist services. The three Divisional hospitals and several at the sub-divisional level also serve as teaching hospitals for nursing and medical students. The Colonial War Memorial (CWM) Hospital serves as the national referral hospital for Fiji and is available to other countries in the region, as it provides additional specialised services, including renal, cardiac and cancer services. There are three specialised hospitals: the St. Giles Psychiatric Hospital; the P.J. Twomey Hospital for tuberculosis and leprosy; and, the Tamavua Rehabilitation Hospital. Each Divisional and specialised hospital is headed by a medical superintendent who reports to the Deputy Secretary for Hospital Services, the Head of the Clinical Administration Section in the MoH. The Clinical Services Planning Framework developed in 2005 outlines the delivery of clinical health services at the various service levels within each specialty area, benchmarked against the MoH Strategic Plan. A small private

sector includes two private hospitals in Suva that provide a range of specialised services several day clinics and 130 private general practitioners located mostly in the urban centres of the two main islands, Viti Levu and Vanua Levu. There is a private maternity hospital in the Western Division (co-funded through government grants) and another one is planned. In rural areas, traditional healers are visited for a variety of health problems, which can range from minor health ailments to more life-threatening diseases like cancer and poisoning.[8]

Three of the Divisions (Central, Western and Northern) provide specialised STI and HIV clinics; the management of STIs is integrated at all health facilities. The main weaknesses of the health sector include inadequate financial resources, staff shortages in sexual reproductive health settings and insufficient monitoring of asymptomatic cases. The strength of the Fiji programme is that more than 90 percent of it is supported by national funds, although that support is not entirely adequate in meeting all programmatic demands because community and faith-based organisations are also relying on the government grant through the HIV/AIDS Board.

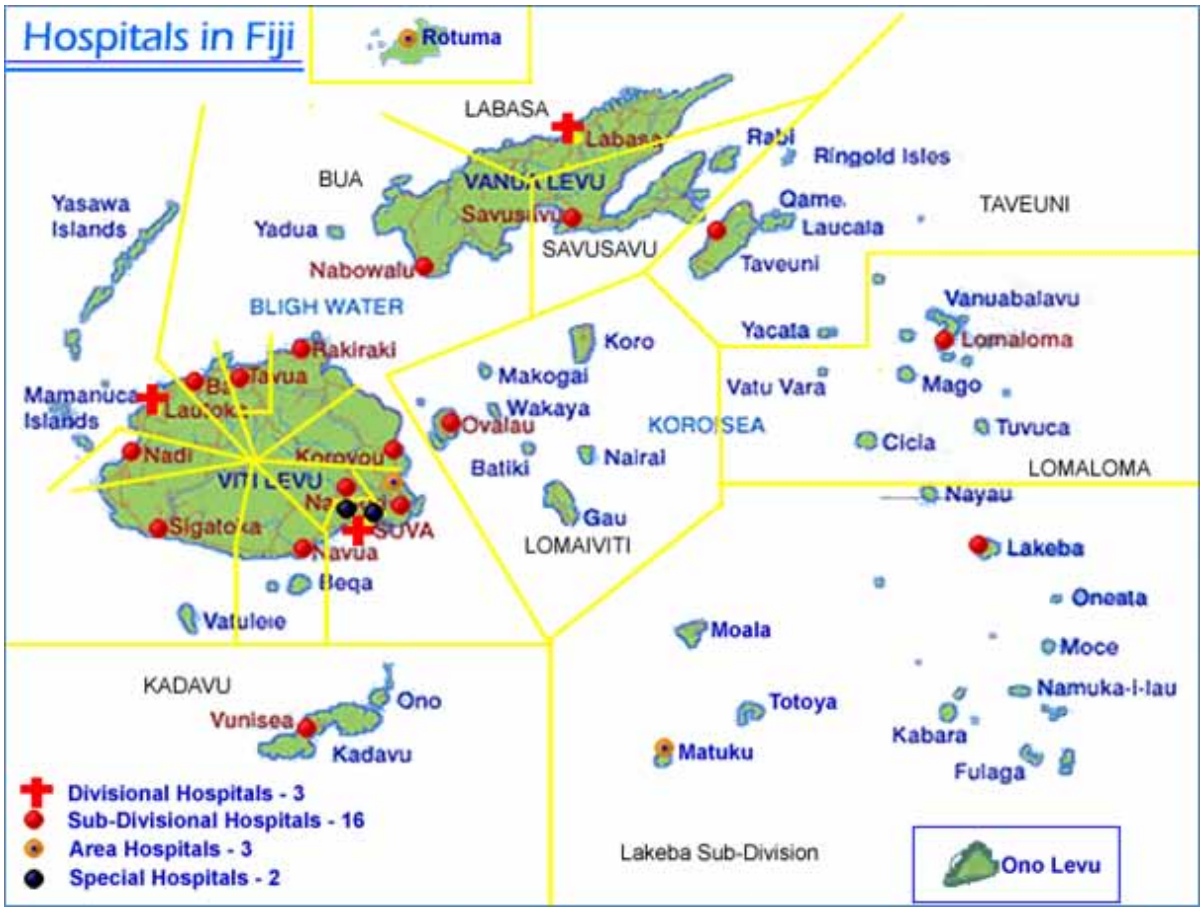

Figure 6: Hospitals in Fiji

[7]Fiji STI Action Plan and Integration Steps for Sexual Reproductive Health and Rights
[8]The Fiji Islands Health System Review, Dr Graham Roberts, Fiji National University et al, 2011

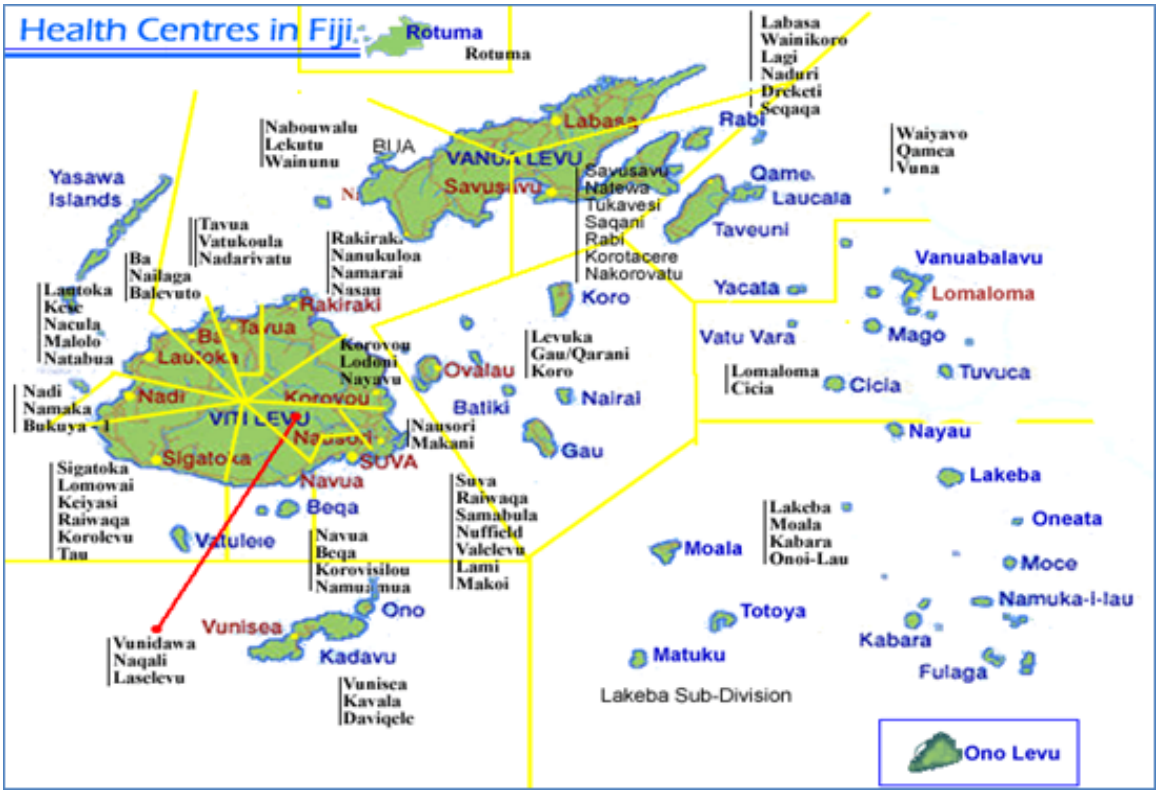

Figure 7: Health Centers in Fiji

Figure 8: Nursing Stations in Fiji

Socio-economic context

The Fiji economy is one of the most developed in the South Pacific. The main income generators are tourism, agriculture, mining, forestry, fisheries and remittances. The principal imports are mineral fuels, machinery and transport equipment, while food imports have been increasing.

Poverty and inequalities are key human development challenges. It is estimated that 34.3% of the population live below the basic needs poverty line (2003). Since 2008, real incomes of the poor have fallen sharply, bringing more households into poverty. The growth rate of GDP per person employed has fallen from a high in 1990 of 15% to -1.1% in 2008. The employment-to-population ratio has stayed steady from 2003 – 2008 at 56.4%. Fiji is one of six countries in the region that is "slightly off track" and/or demonstrating "mixed progress" towards the achievement of the Millennium Development Goals (MDGs). Donor aid to Fiji was only 1.8% of Gross National Income in 2008.[9]

Political Commitment

In January 2011, the Fiji HIV/AIDS Decree 2011[10] was enacted, culminating a process that began in 2004. The Decree outlines a human rights framework for Fiji's response to the HIV epidemic. It also legislates for the formation of a multi-sectoral HIV/AIDS Board responsible for coordinating the national HIV response.

The enactment of the 2009 Crimes Decree, which reformed the Penal Code and decriminalised male-to-male sex, removed a significant barrier to access to HIV prevention services for men-who-have-sex-with-men (MSM). The HIV/AIDS Decree 2011 further protects the rights of the MSM category's access to services. Together, these two Decrees should help enable more MSM to access HIV/STI prevention and treatment, care and support services.

Nevertheless, the integrated behavioural and biological surveillance (IBBS) among MSM in Suva and Lautoka conducted in 2010/11, found that 48% of respondents had been verbally abused while 28% had been physically abused in the preceeding 12 months. Additionally, 16% were denied access to a health care centre and 13% were tested for HIV without consent in the preceeding 12 months.[11] There is clearly more work to be done to ensure that the HIV/AIDS Decree protects the rights of MSM and supports the provision of HIV and STI prevention and care services.
Sex work is illegal in the same 2009 Crimes Decree. The harassment of sex workers by law enforcement agencies makes it more difficult for sex workers to access risk reduction services, including condoms. The 2012 Global AIDS Response Progress Report for Fiji stated that the risk of HIV and STI infection for sex workers and their clients had increased with the introduction of the 2009 Crimes Decree and the recent IBBS project among sex workers showed a prevalence of 1.8% of HIV in transgender women sex workers,[12] which is the highest prevalence registered in a key population group in Fiji.[13]

[9] The Millennium Development Goals in Pacific Island Countries, Asian Development Bank 2011.
[10] Government of Fiji. HIV/AIDS Decree 2011 (Decree No.5 of 2011). Republic of Fiji Islands Government Gazette, Vol. 12, 4th February 2012.
[11] Rawstorne, P., Man, W. Y. Maharaj, P., Rokoduru, A., Rasili, S., Vulavou, I., Worth, H. (2012). MENFiji Draft Report: An integrated bio-behavioural survey of transgender and men who have sex with men in Suva and Lautoka, Fiji. Males Empowerment Network, Fiji (MENFiji).
[12] Dr Elaine Mossman and Dr Michael Roguski,1 Rani Ravuidi,2 Dr Rachel Devi.3, Integrated Biological Behavioural Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project.
[13] Fiji Ministry of Health, Fiji Islands Global AIDS Progress Report 2012, 31st March 2012.

II. Situational Analysis

HIV Status at a Glance

Fiji is classified as a low HIV prevalence country. UNAIDS has estimated the number of people to be living with HIV in Fiji in 2015 as 732. The prevalence rate among adults between the ages of 15-49 years is approximately 0.14%.[14]

From the first HIV confirmed case in Fiji in 1989 to the end of 2014 (Figure 12), a cumulative total of 610 confirmed HIV cases were reported in the country in that period. The total number of cases diagnosed in 2014 was 64, similar to the number diagnosed in 2013, and the 62 cases diagnosed in 2012. Of the cases diagnosed in 2014, 58% were female and 42% male, a slight difference to the usual trends seen in the country.[15]

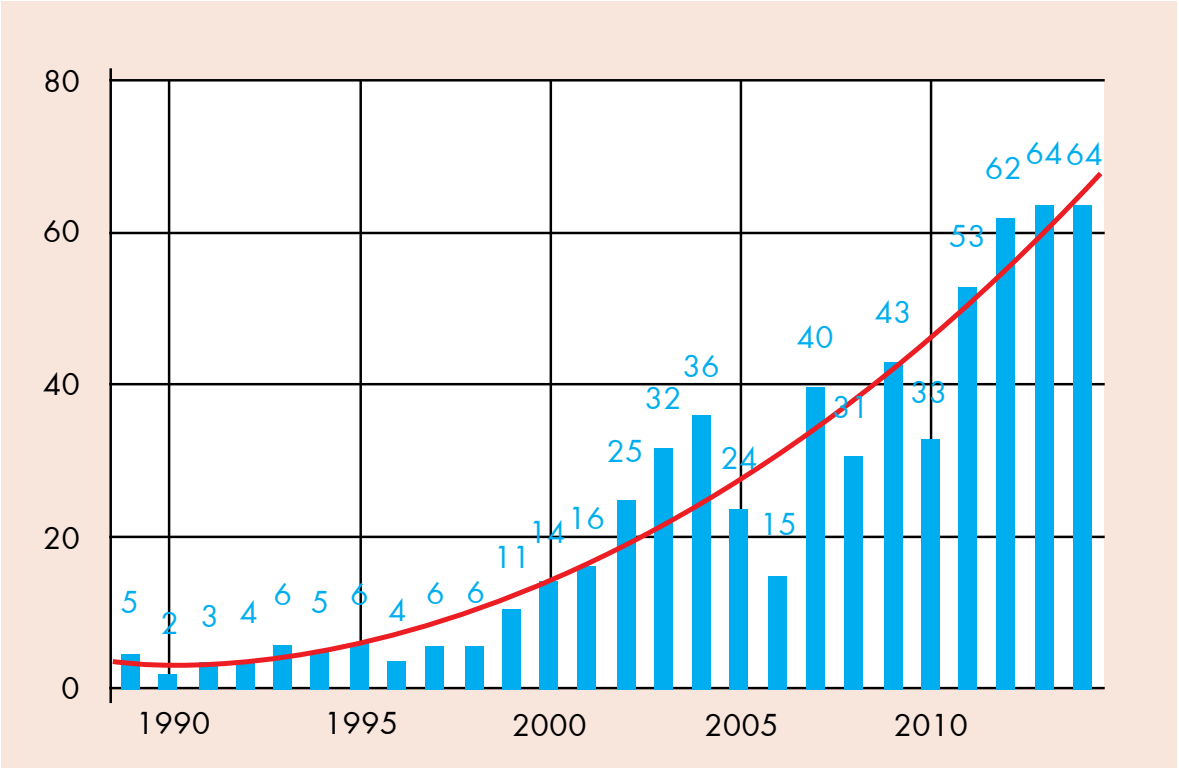

Figure 9: Number of New HIV Cases per Year 1989 - 2014

During the first 10 years of the HIV epidemic in Fiji, there were only a few HIV cases confirmed annually but this began to change from the year 2000. Between 2003 and 2010, there was an average of 30 new HIV infections detected annually. Thereafter, it has been gradually increasing and in the last 3 years (2012, 2013 and 2014), the total number of new HIV infections detected has been more than 60 per year. While globally there has been a reduction in new cases per year, Fiji has been showing increases.

The increase in the number of new HIV confirmed cases in Fiji is likely due at least in part, to expanded HIV testing services. It is noted that the upward trend in the number of annual case reports began well before the introduction of free antiretroviral therapy (ART) financed by Global Fund in 2004 and by the national government since 2008. While HIV testing services have been expanded, there are still areas which have limited services. Currently, there are no targeted HIV testing or prevention services for key populations at higher risk.

[14] Spectrum Projections and Estimations for HIV/AIDS for Fiji, Ministry of Health, 2015
[15] HIV/AIDS Board Annual Report – 2014.

Profiles of People Living with HIV (PLHIV)

In 2014, of the people newly diagnosed with HIV, 58% were female and 42% male. This can be a reflection of the increased HIV testing services in ANCs as part of the scale up in HIV testing and PPTCT care and management.

As of January 1, 2015 there were 301 women, 303 men and 6 unknown gender people registered with HIV.

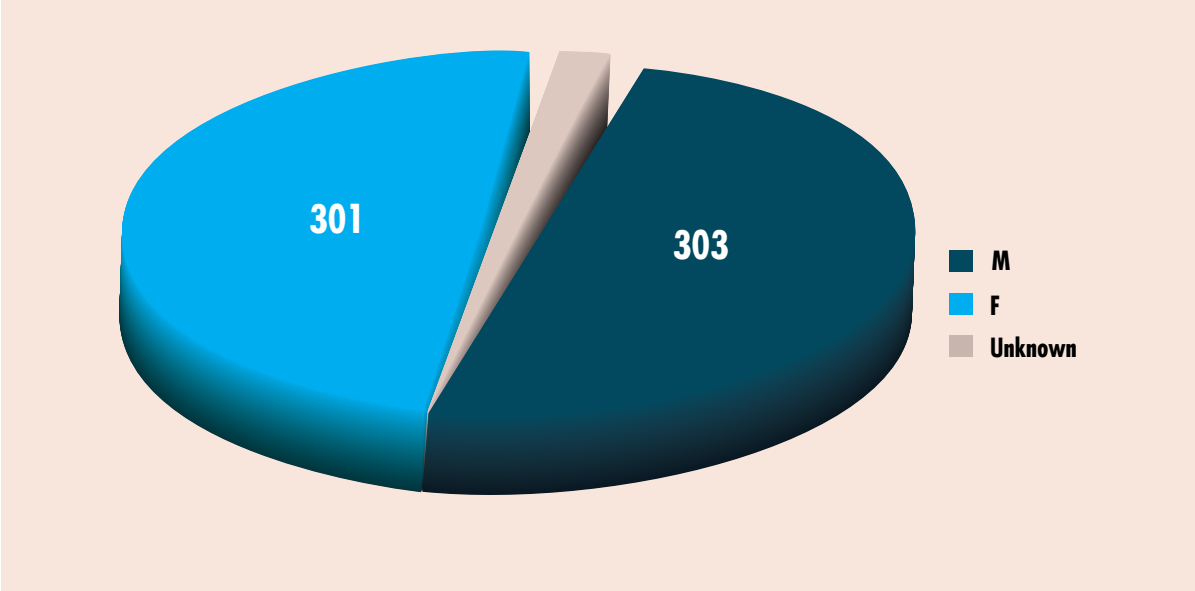

Figure 10: Gender Distribution of HIV Cases as of 2014

In terms of its ethnic profile, HIV is most commonly evident among the i-Taukei population of Fiji, followed next by Fijians of Indian descent and then by other ethnic groups, as indicated in the figure below. The extent to which diagnosed cases reflect the underlying distribution of infection in the population is unknown, but there is likely to be bias due to testing patterns and social desirability bias in reporting highly stigmatised behaviours.

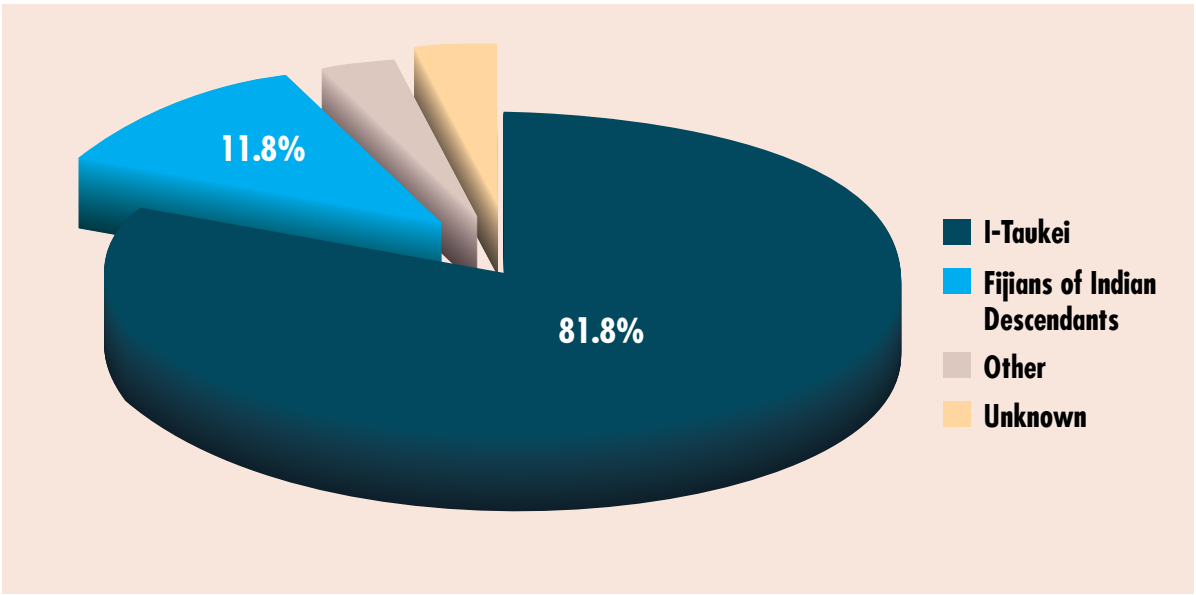

Figure 11: Distribution of HIV Cumulative Cases by Ethnicity, December 2014

Heterosexual contact has been found to be the most common mode of transmission, followed by perinatal contact, men who have sex with men and finally, modes of transmission that are unknown. There has been one case reported for each of the following modes of transmission: bisexual, transgender, IDU and body piercing.

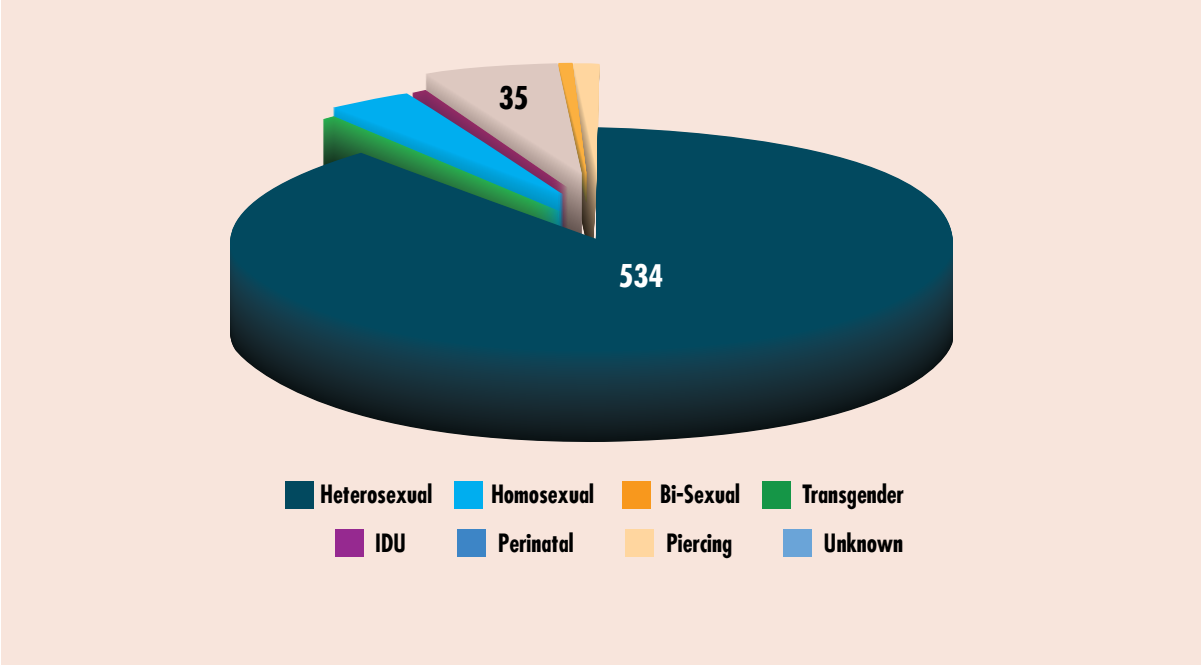

Figure 12: Distribution of HIV Cases by Mode of Transmission as reported by patients, cumulative to December 2014

HIV testing services

HIV testing through health services in Fiji is made available primarily through the screening of ANC women, blood donor screening and testing at the reproductive health clinics or "Hubs". Clients tested by the Hubs are on a walk-in basis, or as referrals from other health services and mobile testing conducted as a part of awareness and prevention outreach activities. Tests conducted for medical diagnosis are not included in these figures, but are thought to be minimal.

The relatively large increase in positivity in 2010 and 2011 occurred primarily from tests at the Hubs, where positivity increased from 0.29% to 0.51% (Table 1). Modest increases among ANC clients and blood donors are consistent with an upward trend.

Service	Number of HIV tests		HIV Positivity			
	2010	2011	2010		2011	
Antenatal screening	17,538	57%	17,787	55%	0.05%	0.06%
Blood donor screening	11,032	36%	11,573	36%	0.00%	0.02%
Reproductive health clinics ("hubs")	2,410	8%	2,771	9%	0.29%	0.51%
Total*	30,980	100%	32,131	100%	0.05%	0.08%

Table 2: HIV Tests and Positivity by Testing Services

* Excludes testing for medical diagnosis

HIV Treatment and Care

Sexual Reproductive Health Hub Centres are actively managing 279 cases of HIV, out of which 15 are paediatric cases. At the end of 2014, 208 people living with HIV were on ART. Out of the 208 people on treatment, the greatest majority are women.

Estimations and Projections in Spectrum for Fiji

The national HIV statistics of any given country usually will not include the number of undiagnosed infections. For the purpose of planning, however, countries are using Spectrum estimations to align the national strategic plan targets, indicators and budgets. The estimation tool usually is populated by data gathered from the surveillance studies conducted in the country. It is then projected to the estimations used for the demographic projections.[16]

Fiji ran Spectrum estimations in 2015[17] with a total estimated cumulative number of 732 PLHIV, with 432 male and 300 female. The projected prevalence in the age group of 14-49 is 0.14. The projections show that the epidemic is mainly projected among the male population, which might indicate a hidden MSM/transgender infection trend. However, the projected trend shows an increase in the number of female infections by 2020.

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total	439	483	533	593	660	732	810	895	987	1,089	1,202
Male	283	306	331	361	396	432	470	511	556	605	660
Female	156	178	203	231	264	300	340	384	431	484	543
Prevalence	0.08	0.09	0.1	0.11	0.13	0.14	0.16	0.17	0.19	0.21	0.23

Table 3: Estimated Cumulative Number of People Living with HIV 2010 - 2020

The current scenario of behaviours registered in the Fiji Population Spectrum estimates an increased trend of HIV prevalence reaching 0.23% by 2020 is possible.

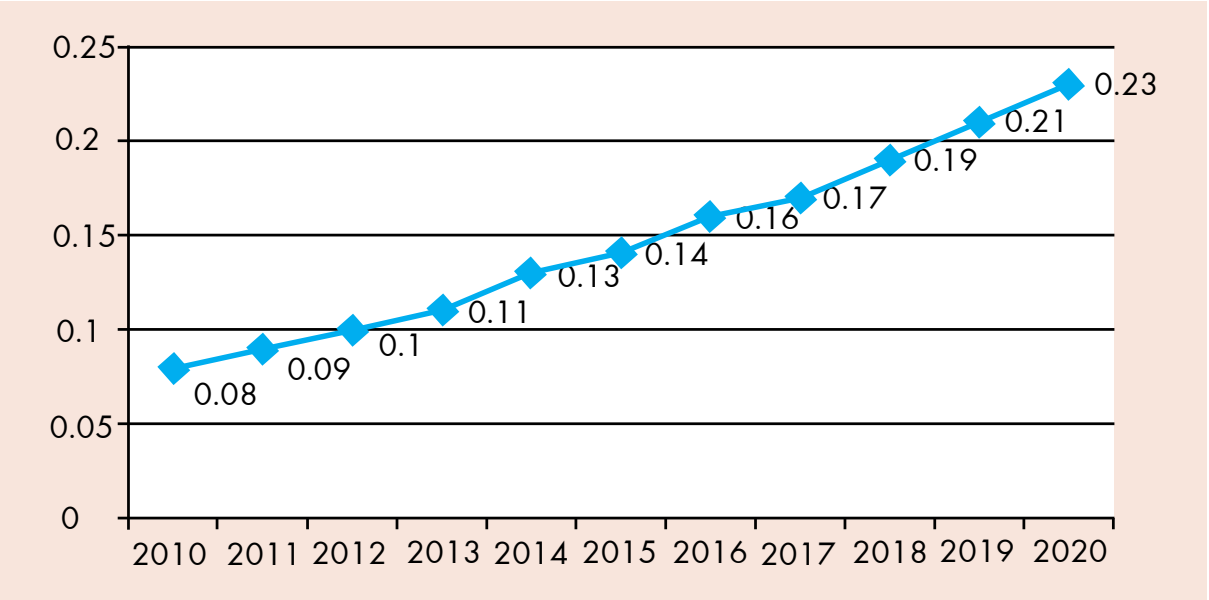

Figure 13: Estimated HIV Prevalence 2010 - 2020

[16] Fiji GARPR 2015.
[17] Spectrum Projections and Estimations for HIV/AIDS for Fiji, Ministry of Health, 2015.

At the current rate of HIV transmission, it is estimated that the number of new cases will increase by nearly 50% by 2020.

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total	60	68	73	79	87	96	108	121	135	151	168
Male	36	40	42	45	49	54	60	66	73	81	89
Female	23	28	30	33	38	42	49	55	62	70	79

Table 4: Estimated New HIV Infections 2010 - 2020

Using globally accepted methodologies and updated evidence on survival with and without treatment, it is estimated that a total of 241 people have died of AIDS related causes in 2015 in Fiji.

The estimations also show a clear indication that by 2020, the epidemic will scale up in key populations at higher risk, such as MSM and female transgender sex workers.

Sexually Transmitted Infections (STIs)

In 2014, Fiji recorded a total of 2,248 STI cases, which was the highest number of cases recorded since 2010. The increase in cases in 2014 may have been a result of focused activities to increase the capacity of health care workers to diagnose, treat and report on STIs.

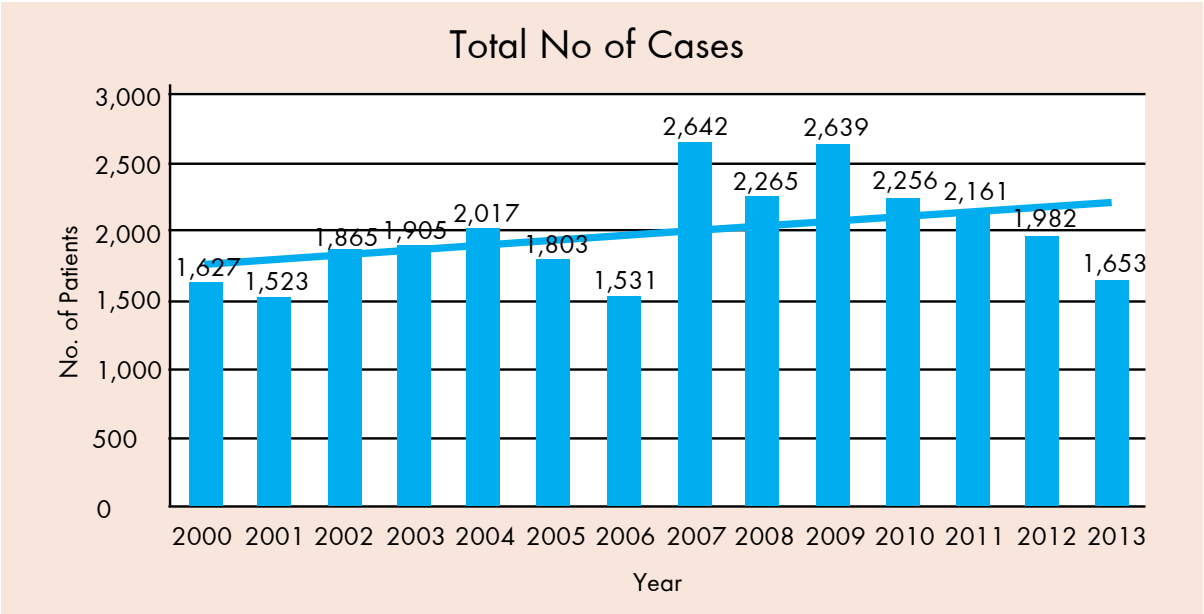

Figure 14: Total Number of STI Cases as of 2013

STI Syndromic Reporting

Fiji introduced syndromic reporting for STIs in 2011. There are six syndromes that are reported from the Sexual Reproductive Health (SRH) Clinics in the three divisions: urethral discharge, vaginal discharge, lower abdominal pain, genital ulcers, scrotal swelling and neonatal conjunctivitis. The three SRH clinics report syndromic cases on a quarterly basis. The data is presented in the table below.

The SRH Hub Centres reported one case of neonatal conjunctivitis, although it is commonly observed by the Paediatrics Departments in the three divisions. The limitation is that this data from the Paediatrics Department is not captured at the national level. The Fiji Government considers the prevention of neonatal conjunctivitis a priority and has responded by developing standard operating procedures for prophylaxis in 2014. The Government is also exploring options to strengthen national data collection so that this data is captured at the national level.

Syndromic Management	Central Division	Northern Division	Western Division	Total
Urethral discharge	529	145	262	936
Vaginal discharge	185	49	72	306
Scrotal swelling	2	Unknown	6	8
Genital ulcers	57	14	45	116
Lower abdominal pain	53	78	44	175
Neonatal conjunctivitis	0	1	0	1

Table 5: Syndromic Reporting by the SRH Hub Centers

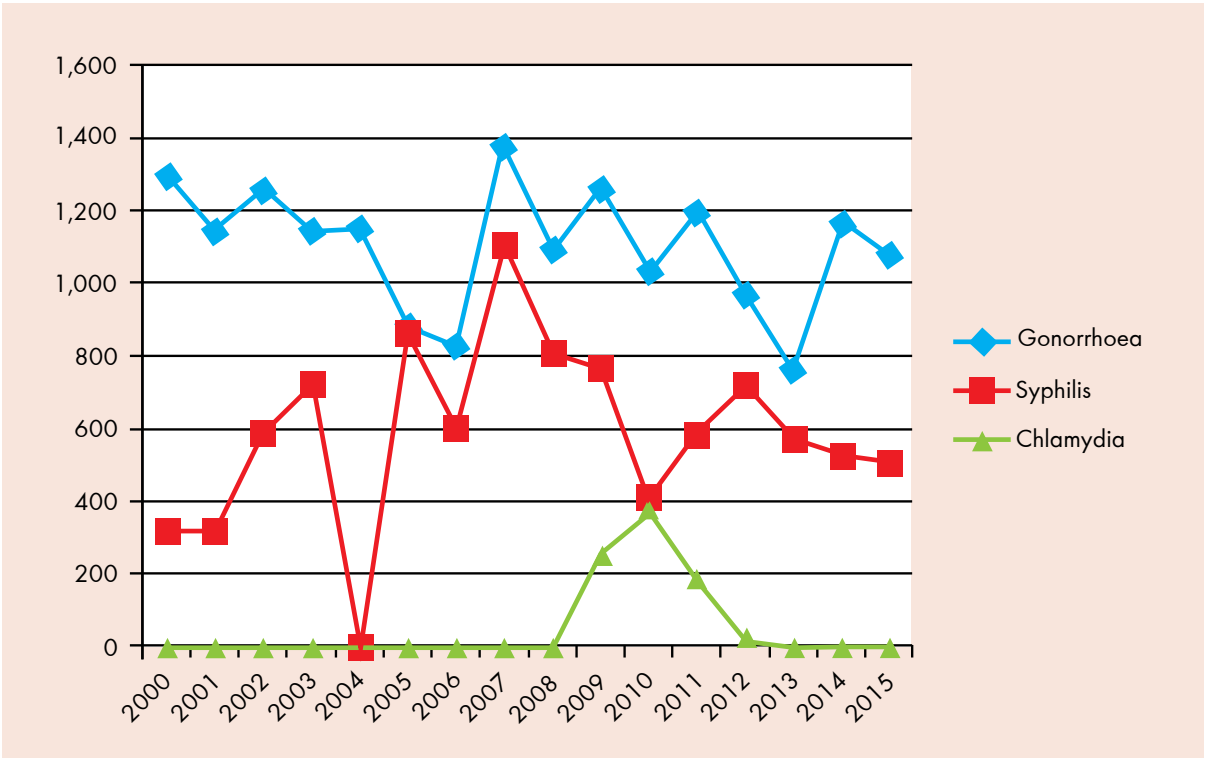

Figure 15: Annual Reported Cases of Selected STIs (Syphilis, Gonorrhea, and Chlamydia) 2000 - 2013

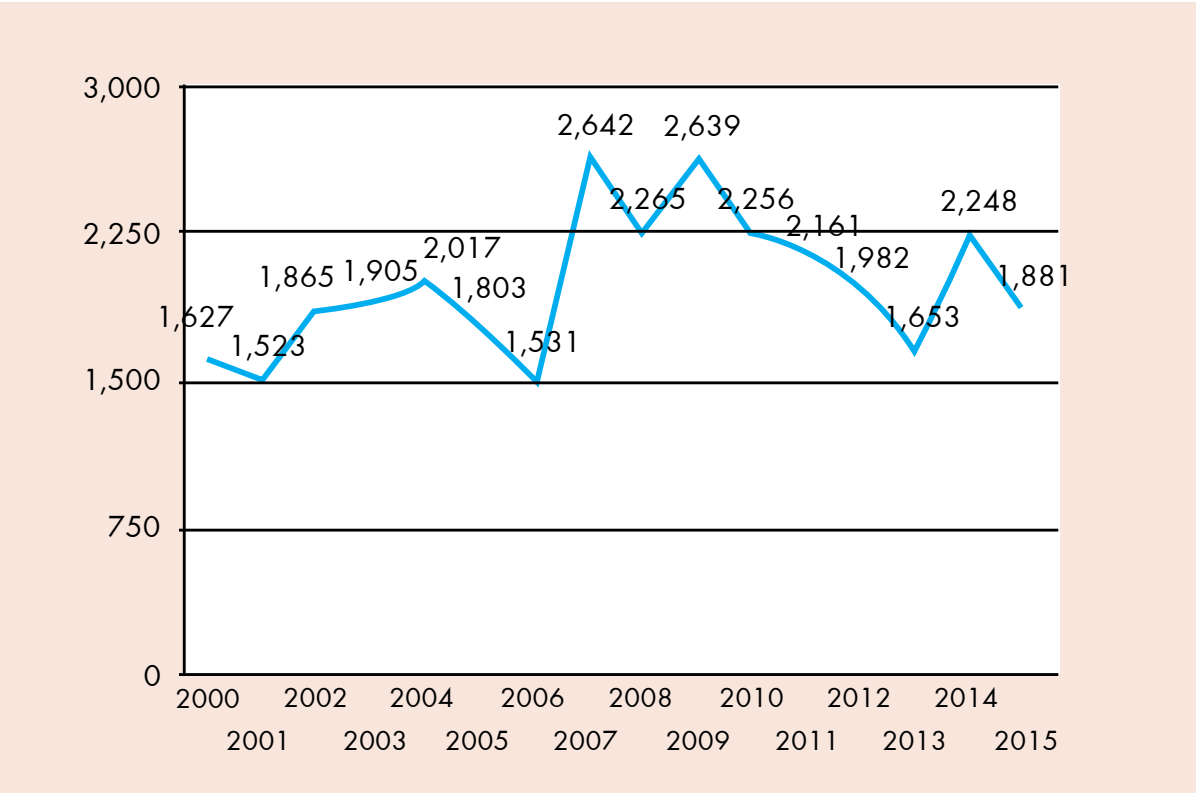

Figure 16: New Cases per Year of STIs, 2000 - 2013

An analysis of 14 STIs reported etiologically in Fiji from 2000-2013 reported in Table 5 shows a decrease in three main STIs (chlamydia, syphilis and gonorrhoea). However, in 2014, there is an increase in the total number of STIs to 2,248, likely due to the increased capacity of health care workers to syndromically manage and report STIs.

Disease	2010	2011	2012	2013	2014	2015
Candidiasis	45	34	164	144	335	162
Chlamydia	380	189	29	0	2	3
Chancroid	0	0	0	0	1	0
Congential Syphillis	0	20	5	28	57	17
Gential Herpes	12	15	2	1	0	0
Gonorrhoea	1,180	1,178	971	775	1,168	1,082
Herpes Zoster	83	58	69	44	41	18
Ophthalmia Neonatorium	4	0	1	15	34	12
PID	3	1	1	0	0	0
Syphillis	683	563	723	600	525	512
Trichomoniasis	66	53	16	86	85	75
Veneral Warts	23	3	1	1	0	0

Source: NNDSS, HIU, MoHMS

Table 6: STI Cases 2000 - 2013, MoHMS Programme Data

Key populations

Since the first case was identified in 1989, to date, the rate of new HIV infections among key populations including MSM, transgender, bisexuals and sex workers is below 5% as seen in Table 6. This is also confirmed in the integrated biological behavioural survey conducted in 2012 for sex workers in Fiji.

Population / Study	Study locations (total participants)	No. tested for HIV	HIV Prevalence % (95% CI) a
ANC (ages 15-49 years)			
SGSS, 2004	Suva (303)	301	0 (0.0 – 1.8)
SGSS, 2008	Suva (nr) Lautoka (nr)	448	0 (0.0 – 1.2)
STI clients (ages 15-49 years)			
SGSS, 2004 (male)	Suva (160)	nr	nr b
SGSS, 2008 (male and female)	Suva (nr) Lautoka (nr)	183	0 (0 – 3.0)
MSM and TG (ages 18 and older)			
IBBSS, 2010-11			
MSM	Suva (134) Lautoka (160)	279	0 (0.0 – 2.6)
TG	Suva (79) Lautoka (91)	159	1.3 (0.3 – 8.7)
Female and TG sex workers (ages 18 and older)			
IBBSS, 2012			
FSW	Suva, Nasinu and Nausori (79) Nadi (58) Lautoka and Ba (35) Labasa (13)	183	1.5 (0.0 – 3.9)
TGSW	Suva, Nasinu and Nausori (42) Nadi (30) Lautoka and Ba (28) Labasa (12)	109	1.8 (0.4 – 3.2)

Table 7: HIV Prevalence Findings in Key Populations from Previous Studies Conducted in Fiji

FSW are characterised by much higher rates of syphilis (VDRL+ and TPPA+) (22%) and gonorrhoea (19%) than the general population. Among MSM and TGs, the rate of prevalence of syphilis was ≥ 20% in Suva and Lautoka; gonorrhoea prevalence was 17% in Lautoka; and chlamydia prevalence was 5-6%. These findings for the MSM and TG populations are similar to FSW, with the exception of higher gonorrhoea prevalence in MSM.

Among TGFSW, high syphilis (30%) and moderate hepatitis (7%) rates were found, which is similar to the MSM population results. No chlamydia or gonorrhoea infections were identified. However, the status of chlamydia and gonorrhoea infections was unavailable for more than 50% of FSW and TGSW participants.

Inhabitants of correctional settings have not yet been examined but risk behaviours in this group have been reported to include male-to-male sex and the recycling of razors and sharp objects for tattooing. The practice of injecting drugs among sex workers and youth identified in previous surveillance studies, is not well understood. Additional knowledge gaps for surveillance include improving size estimates in key populations at higher risk using methods appropriate for hidden populations.

Policies

With a strong political commitment, Fiji is prepared at the strategic level to ensure PLHIV receive appropriate treatment and care. Huge steps were taken in 2014 with regards to implementing policies and guidelines to ensure the appropriate management, care and treatment of PLHIV. The HIV Care & Antiretroviral Therapy Guidelines (second edition), which recommended that people are initiated on ART at CD4 <500, and, treatment for discordant couples, was launched in 2014. In addition, a revised PPTCT Policy was finalised and launched in 2014, which included the introduction of Option B Plus for all HIV positive pregnant women. Through these policies, Fiji became the first country in the Pacific islands to update itself to the latest WHO guidance. Given the rapidity with which newer evidences on treatment approaches was generated in 2015, Fiji is again ready to update its guidelines to be in line with the new WHO recommendations.

The HIV testing and counselling policy was finalised in 2015. This policy officially endorses the new HIV testing algorithm and focuses on intensifying provider-initiated testing services. The policy decentralises HIV testing services to divisional and sub-divisional hospitals. Doing so has increased accessibility to HIV testing services, reduced turnaround time for obtaining results and dramatically reduced the number of indeterminate results.

Fiji developed and finalised the HIV/TB collaborative policy which allowed proper screening of the co-infection and strengthened the HIV/TB collaboration.

Fiji adopted the comprehensive syndromic management of STI guidelines in 2010. Subsequently in 2014, the Fiji STI Action Plan was developed, which focused on the prevention, continuum of care and monitoring, and evaluation and research related to STIs. Fiji also developed the standard operating procedures for providing prophylaxis to new-borns to prevent ophthalmia neonatorum and began implementation in 2015.

III. Response Analysis

Part of the series of consultative meetings held in 2015 was with various government ministries, non-governmental organisations and faith-based organisations, multilateral agencies, and, with representatives from key populations and people living with HIV, was to review the appropriateness of Fiji's response in the current epidemic context.

Strengths

As outcomes of the first consultation process, based on data from studies, reports and evaluations, the following strengths of the 2010 – 2015 NSP were identified:

Political commitment and Updated policies

- Strong political commitment from the highest leader in the country, the then President, approval of the HIV Decree and the development of the HIV Board
- Fiji's Inter-Faith Strategy on HIV & AIDS 2013-2017
- The success of Fiji's response to HIV and Sexually Transmitted Infections (STI) has largely been a result of a collaborative partnership between government agencies; non-governmental and community-based organisations, academic institutions, key populations at higher risk, people living with HIV (PLHIV), health professionals and development partners.
- Guidelines and policies have been updated to the most recent WHO recommendations including the HIV care and antiretroviral therapy guidelines, HIV/TB collaborative activities guidelines, PPTCT policy, HIV testing and counselling policy and comprehensive syndromic management of STI guidelines.

Prevention

The review noted that prevention had been the major priority within the national response to the HIV epidemic. Since the last NSP which was adopted in 2006, there had been expansion of prevention activities as well as strengthening of programmatic activities and increased collaboration between partners. There had been an increase in the number of NGOs involved in the national response. Some Fiji NGOs were, by 2010, playing leadership roles within the Pacific region.

The Fiji approach to prevention is a good example of what UNAIDS describes as "Combination Prevention", as outlined in the UNAIDS Outcome Framework. To explain, prevention programs "deploy a blend of biomedical, behavioural, and structural approaches tailored to address the particular and unique realities of those most vulnerable to HIV infection". In Fiji's case, prevention has often linked the availability of information in community settings with opportunities for community members to receive condoms, meet people living with HIV, and, discuss behaviour change with peer educators or community leaders. For those wanting more time to think about whether their own behaviours place them at risk, prevention provided referrals to clinics which provide counselling, testing or treatment services.

- All pregnant women have access to HIV testing services at their first antenatal visit and to date, 98% of pregnant women have opted to take an HIV test.
- The percentage of women in general who tested for HIV increased to 94%, with 60% of HIV+ pregnant women covered by Option B+
- HIV testing services have being decentralised to sub-divisional level clinics.
- Continued focus on HIV prevention for young people, using a range of strategies including family life education in schools, peer education for out-of-school youth, sporting activities and youth-friendly reproductive health services.

Continuum of Care

All PLHIV, once confirmed as positive, receive ongoing medical and psychosocial support from the Hub Centres. Antiretroviral drugs are provided free, funded by the Government. Hub Centres each have a doctor, a nurse, one or more volunteers, and since 2010, they each also have a full time HIV Advocate - a person living with HIV who works in the centre and in local communities, and, who is appointed by FJN+.

- Provision of free ART for all patients eligible for therapy.

- Treatment services decentralised to sub-divisional level clinics.
- Counselling and social support provided to HIV+ patients at the Hub and/or through the Fiji Network of positive people (FJN+) which has been particularly important for adherence to treatment.
- All PLHIV enrolled to treatment are being screened for TB.

System Strengthening

- Laboratory capacity was strengthened through the provision of essential equipment to test for HIV and monitor HIV treatment.

- Procurement systems were strengthened, enabling Fiji to become a central supply hub for the Pacific.

- Human resource capacity was strengthened through the provision of training on HIV treatment and care, STI syndromic management and HIV testing services.

Monitoring, Evaluation and Research

- Integrated behavioural and biological surveillance (IBBS) among sex workers, MSM and TG have been undertaken in order to improve understanding of the HIV epidemic in the country.

- Standardised reporting forms were developed to enable data collection and aggregation at national levels.

- To strengthen a national Monitoring and Evaluation System, combining HIV and STI routine surveillance and to build capacity of all partners to contribute to this system

Challenges and/or Opportunities

Despite the noted success of the programme, there are issues which need to be addressed, alongside opportunities for strengthening the programme, including the following:

Political Commitment and Updated Policies

- Criminalisation of sex work through the 2009 Crimes Decree increases the vulnerability of sex workers and clients to HIV/STIs and hampers sex workers' access to prevention and care services.

- Issues with registering NGOs for key populations at risk including sex workers, TG and MSM, which hampers the ability of NGOs to adequately target key populations with appropriate services.

- Limited implementation of the Inter-Faith Strategic Plan.

- The previous response did not fully engage faith-based organisations to the capacity in which they are able to raise awareness.

- As Fiji is an upper middle income country with a reported low disease burden, many donors did not continue to support the program which required MHMS to re-prioritise its activities based on available funding.

Prevention

- Social, cultural and religious norms negatively influence acceptability of, and access to, condoms.

- Access to HIV testing services, particularly for young people, sex workers and MSM is limited and is not aligned to the

needs of the key populations at risk, particularly community-based testing.

- The peer education programme has limited scope and is often delivered late in teenage years, missing those young people that have undergone early sexual initiation.
- There are limited HIV and STI prevention services available for inmates as only HIV testing services are offered.
- The proportion of TB patients tested for HIV has been steadily decreasing since 2010.

Continuum of Care

- Limited capacity of FJN+ to adequately engage and support the HIV response.
- There are treatment defaulters and there needs to be a better understanding of why these individuals are not adhering to their treatment.
- There has been no capacity to perform viral load monitoring of patients in the country.

System Strengthening

- There are opportunities to further integrate HIV and STI services into ANC services.
- There is no capacity to perform early infant diagnosis and treatment monitoring of patients through viral load testing.
- Funding limitations inhibit the expansion of etiological testing for chlamydia.
- The collaboration between the HIV and TB programs needs to be strengthened and sustained.

Monitoring, Evaluation and Research

- There is no research available to determine the risk of IDU to the HIV epidemic in Fiji, particularly among young people.
- There is a need to understand why there has been a reduction in the proportion of TB patients tested for HIV between 2010 and 2012.

IV. National Strategic Plan 2016 - 2020

The Approach towards the Development of the National Strategic Plan for 2016 – 2020

The new strategy in developing the new strategic plan was the result of a participatory approach where a series of consultations were conducted to engage key partners and players from government agencies, non-governmental organisations, civil society and faith-based organisations, as well as representatives from key populations at higher risk and other vulnerable populations (i-Taukei, seafarers, young people, etc.). This process was spearheaded by the Ministry of Health and Medical Services, with support from the Ministry's regional technical partners comprising UNAIDS, UNICEF, WHO and SPC.

This kind of strategic direction is based on the response analysis to the 2010-2015 National Strategic Plan, a review of the program data, a review of what has worked in other settings, reviews of the latest international guidance, and, the inputs provided by national stakeholders to outline the challenges that remain. The approach will ensure that:

- HIV prevention is integrated with STI prevention and is accompanied with improvements to reproductive health, as guided by the developing regional commitments on STIs and the Fiji Reproductive Health Policy
- HIV prevention, treatment and care will be supported through an improved enabling environment, informed by the promotion of human rights and reduction of stigma and discrimination, as guided by the HIV/AIDS Decree
- Testing and treatment will take place through a "Continuum of Care" principle, which recognises the need for specialised health services for key affected populations, an improved integration of HIV and STI diagnosis with reproductive health services available to all women and men, expanded access to counselling and referrals to peer support, and, the closer linking of community prevention programs to health services
- There will be a balanced approach which supports the needs and rights of people living with HIV; people in the key affected populations of sex workers, men who have sex with men, transgender people; and other people of all ages who are likely to be sexually active with multiple partners
- There will be intensified efforts to integrate gender issues with all programs and services in order to reduce gender in equalities, which affect both prevention and the continuum of care
- There will be improved governance, so that it is clear who makes final decisions about the implementation of this strategy, and that there are problem-solving processes in place so that problems can be identified and resolved quickly
- There will be improved monitoring and evaluation of national activities in the area of HIV, STI and Reproductive Health
- There will be improvements in research to improve the understanding of the size and extent of the HIV and STI epidemics, as well as in operational research to inform improvements

The new NSAP took into consideration the most recent global recommendations and strategic directions such as:

1. WHO Global Health Sector Strategies for STI, HIV and Hepatitis
2. UNAIDS 90-90-90 Fast Track Initiatives
3. Sustainable Development Goals

The NSAP Programme Goal and Objectives are fully aligned with the SDGs. The alignment can be followed in Figure 21.
As previous experience in Fiji's response to the AIDS epidemic has demonstrated, time-bound targets drive progress, promote accountability and unite diverse stakeholders in pushing towards common goals. To accelerate progress towards ending the epidemic, new Fast-Track Targets have been established for the SDG era. These targets aim to transform the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths into concrete milestones, and, end-points.

For the first time in Fiji, there is a consensus to aim for the following targets:

- That 90% of people living with HIV should know their HIV status
- That 90% of people who know their status should be receiving treatment, and
- That 90% of people on HIV treatment should have a suppressed viral load so that their immune system remains strong and they are no longer infectious.

These 90–90–90 targets apply to children and to adults, men and women, poor and rich, in all populations — and among pregnant women, should be at higher target levels. This strategy is also known as the Test and Treat Strategy. "Test and treat" programmes are based on the premise that the rate of new HIV infections can be reduced by rolling out universal HIV testing in order to diagnose all people living with HIV, and, initiate antiretroviral treatment regardless of CD4 count or viral load. This will dramatically reduce the HIV transmission pattern.

Thus, Fiji will apply treatment as prevention that refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission. ART reduces the HIV viral load in the blood, semen, vaginal fluid and rectal fluid to very low levels ('undetectable'), reducing an individual's risk of onwards HIV transmission.

The following principles will guide the implementation of this strategy:

1. Universal health coverage.
2. Government stewardship and accountability.
3. Evidence-based interventions, services and policies.
4. Protection and promotion of human rights, gender equality and health equity.
5. Partnership, integration and linkage with relevant sectors, programmes and strategies.
6. Meaningful involvement of people living with HIV, key populations and affected communities.

This process has again demonstrated the effectiveness of using a participatory approach in developing the strategic direction for 2016 – 2020. In the development of this new strategic plan, there was increased participation of key populations at higher risk, other vulnerable populations such as people with disability, young people, and, the faith-based organisations.

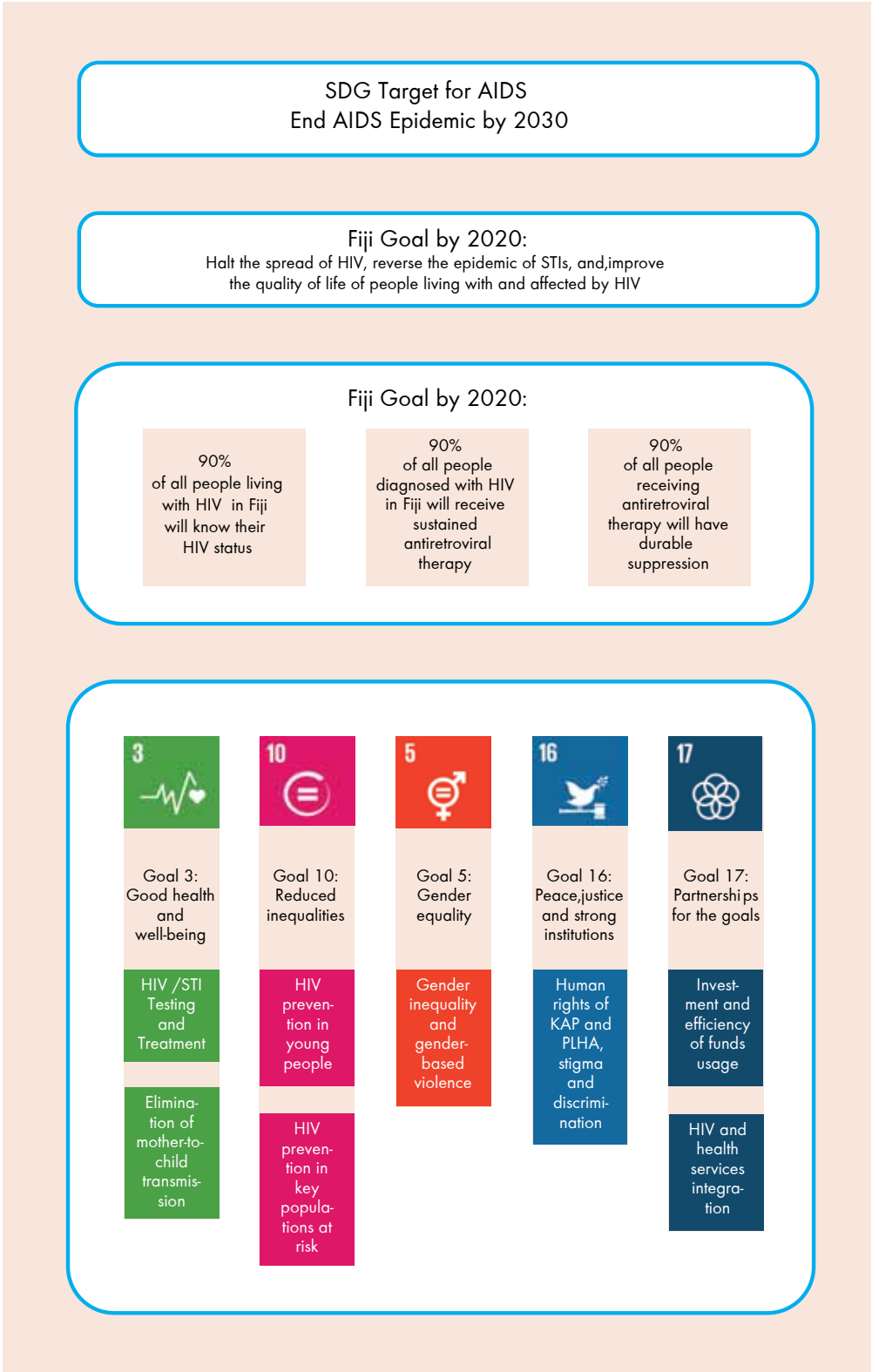

Figure 17: Alignment of NSAP Goals and Objectives with SDGs.

Strategic Direction

The Goal of the NSAP is to halt the spread of HIV, reverse the epidemic of STIs and improve the quality of life of people living with and affected by HIV.

The Results of the NSAP are the following:

1. Maintain the current level of HIV prevalence
2. Reduce mortality from AIDS
3. Reduce the prevalence of syphilis and gonorrhoea

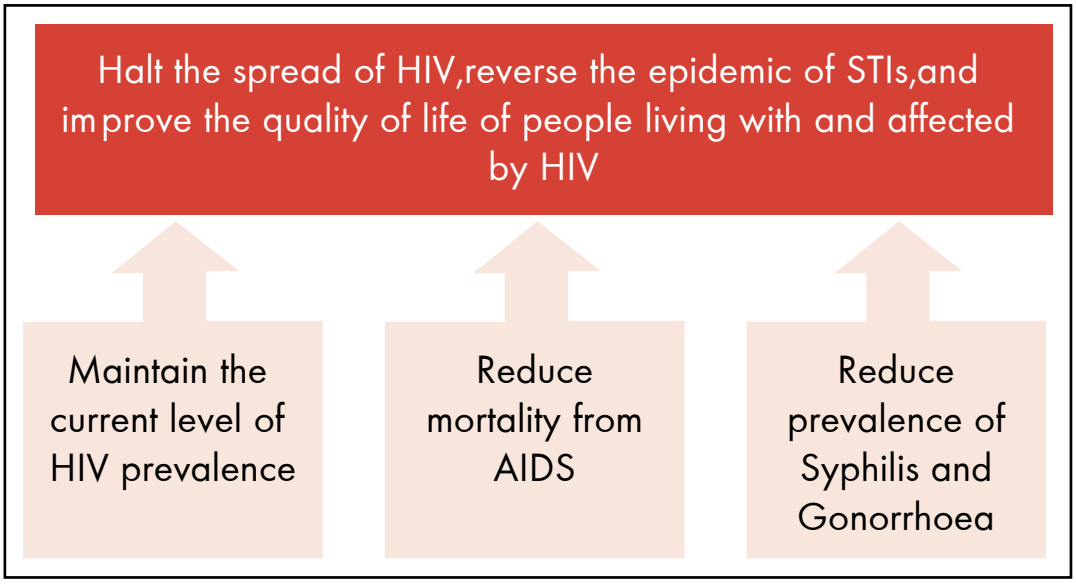

Figure 18: Results that would achieve the Goal of the NSAP

Impact Indicators	Available Data	
	2015	2020
Impact Indicator 1. Prevalence of HIV in general population (estimated)	0.14 %[18]	0.14%
Impact Indicator 2. Prevalence in transgender sex workers	1.8%[19]	1%
Impact Indicator 2. Prevalence of Syphillis in general population	16%	1.6 %
Impact Indicator 3. Mortality rate from HIV	33%3 [20]	1%

Table 8: Impact Indicators 2015 - 2020

[18] Estimated prevalence from Spectrum Projections and Estimations for HIV/AIDS for Fiji, Ministry of Health, 2015
[19] Dr Elaine Mossman and Dr Michael Roguski,1 Rani Ravuidi,2 Dr Rachel Devi.3, Integrated Biological Behavioural Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project
[20] Estimated Mortality from Spectrum Projections and Estimations for HIV/AIDS for Fiji, MOH, 2015

By 2020, Fiji will be guided by the objectives of reaching the 90-90-90 targets:

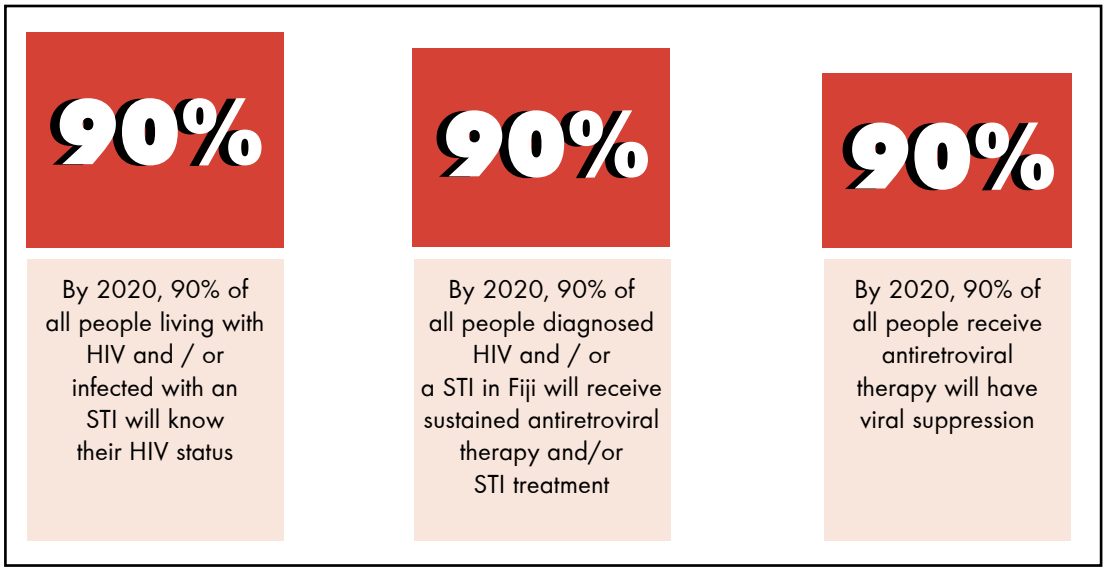

Figure 19: 90-90-90 Strategy Target by 2020

Priorities

1. Prevention
2. Continuum of Care
3. Monitoring and evaluation
4. Governance, coordination and partnerships

Cross cutting themes addressed in each priority area;
5. Gender
6. Human rights, stigma and discrimination

National Strategic Plan Areas and Objectives

Priority Area 1: Prevention

In this NSAP, the focus is on ensuring that prevention services are focused on high-impact interventions to reach vulnerable populations so as to achieve equity and ensure quality.

In terms of prevention services, key populations have been defined as men who have sex with men, transgender, people who engage in transactional sex and/or sex work. Other vulnerable populations have been defined as inmates, seafarers, young people most at risk, and, pregnant women and their children.

Since the presence of STIs increases the risk of HIV, the HIV and STI programme responses will be integrated. There are high reported rates of gender inequality and unplanned teenage pregnancies, therefore prevention will promote better understanding of reproductive health and the rights of women and children. There are also high reported rates of stigma and discrimination against people living with HIV and key populations, therefore prevention will be integrated with the promotion of human rights and respect for all Fijians, including young people, sex workers, transgender people and men who have sex with men.

Prevention programs will aim to change the perception that condoms are only important for sex work and for contraception, so that condom use for the purpose of disease prevention becomes more acceptable. Prevention programs will continue to involve people living with HIV in collaboration with peer educators, community organisations and health services staff.

Priority Area 1: Prevention

Result: 90% of all people living with HIV and/or infected with STIs in Fiji will know their status

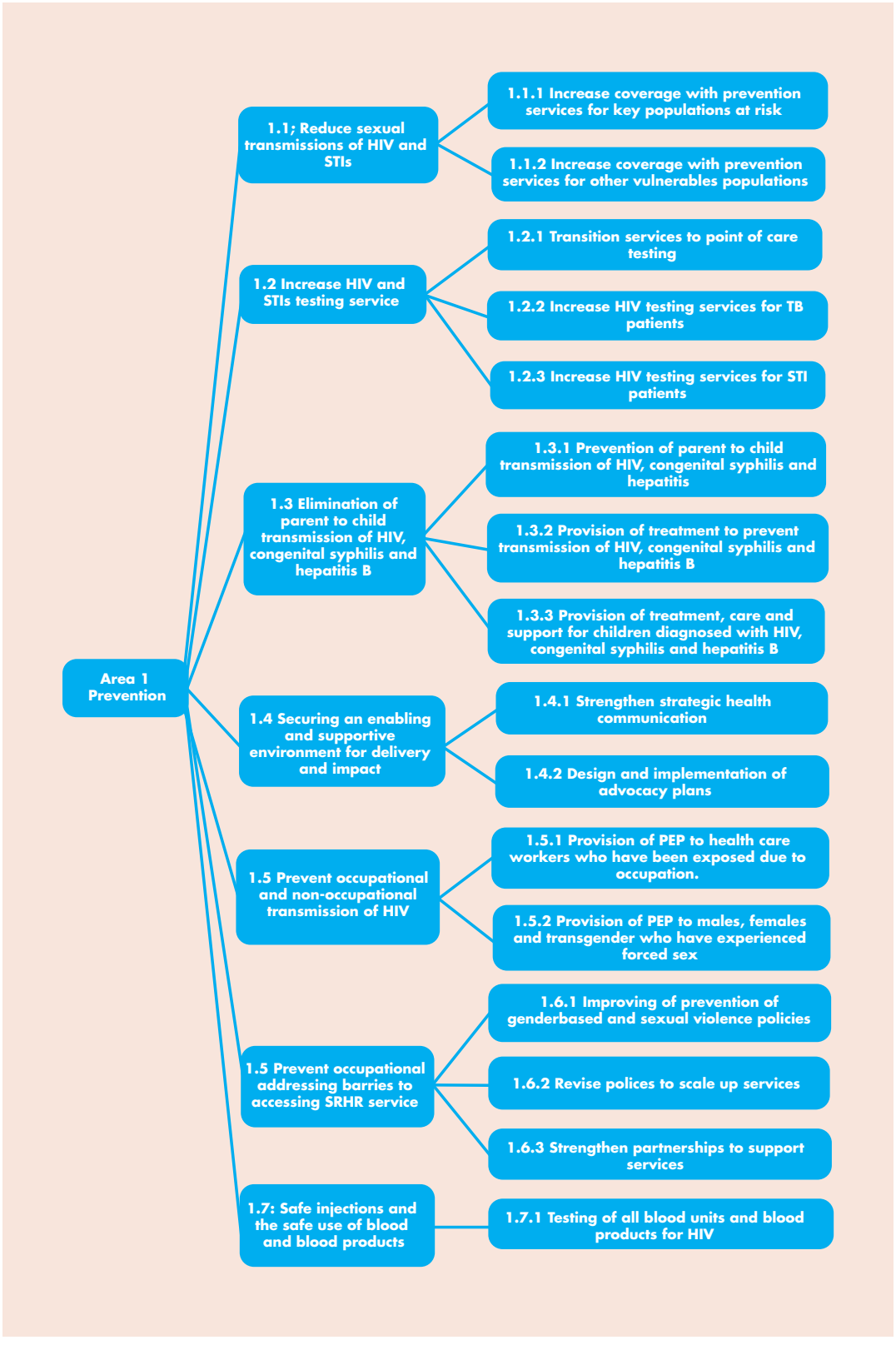

Figure 20: Logical Framework for Priority Area 1: Prevention

Prevention Area

Result: 90% of all people living with HIV and/or infected with STIs in Fiji will know their status

Objective 1.1 Reduce sexual transmission of HIV and STIs

1.1.1 Increase coverage with prevention services for key populations at risk

1.1.1.1 Increase coverage with prevention services for men who have sex with men through:

- 1.1.1.1.1 Outreach activities with information, education and communication, including the translation of key materials into local languages;
- 1.1.1.1.2 Provision of basic commodities (male and female condoms and lubricants, dental dams);
- 1.1.1.1.3 Provision of HIV and STI testing services by increase community-based testing by civil society;
- 1.1.1.1.4 Provision of HIV/STI treatment and provide referrals for support services;
- 1.1.1.1.5 Provision of integrated sexual and reproductive health services;
- 1.1.1.1.6 Provision of psychosocial support;
- 1.1.1.1.7 Provision of Hepatitis B screening and vaccination
- 1.1.1.1.8 Building capacity of non-governmental organisations to advocate for the rights for MSM populations
- 1.1.1.1.9 Build partnerships with faith-based organisations to address stigma and discrimination

1.1.1.2 Increase coverage with prevention services for transgender populations through:

- 1.1.1.2.1 Outreach activities with information, education and communication, including the translation of key materials into local languages;
- 1.1.1.2.2 Provision of basic commodities (male and female condoms and lubricants, dental dams);
- 1.1.1.2.3 Provision of HIV/STI testing services by increasing community-based testing by civil society groups;
- 1.1.1.2.4 Provision of HIV/STI treatment and provide referrals for support services;
- 1.1.1.2.5 Provision of integrated sexual and reproductive health services;
- 1.1.1.2.6 Provision of psychosocial support;
- 1.1.1.2.7 Provision of Hepatitis B screening and vaccination;
- 1.1.1.2.8 Building capacity of non-governmental organisations to advocate for the rights for TG populations
- 1.1.1.2.9 Build partnerships with faith-based organisations to address stigma and discrimination

1.1.1.3 Increase coverage with prevention services for males, females and transgender who engage in transactional sex and/or sex work through:

- 1.1.1.3.1 Outreach activities with information, education and communication, including the translation of key materials into local languages;
- 1.1.1.2.2 Provision of basic commodities (male and female condoms and lubricants, dental dams);
- 1.1.1.3.1 Provision of HIV/STI testing services by increasing community based testing by civil society;
- 1.1.1.3.2 Provision of HIV/STI treatment and provide referrals for support services;
- 1.1.1.3.3 Provision of integrated sexual and reproductive health services;
- 1.1.1.3.4 Provision of psychosocial support;
- 1.1.1.3.5 Provision of Hepatitis B screening and vaccination;
- 1.1.1.3.6 Building capacity of non-governmental organisations to advocate for the rights of sex worker populations
- 1.1.1.3.7 Partnerships with faith-based organisations to address stigma and discrimination

1.1.2 Increase coverage with prevention services for other vulnerable populations

1.1.2.1 Increase coverage with prevention services for male, female and transgender inmates through:

- 1.1.2.1.1 Outreach activities with information, education and communication, including the translation of key materials into local languages;
- 1.1.2.1.2 Provision of basic commodities (male and female condoms and lubricants, dental dams, PEP, blades and razors for inmates);
- 1.1.2.1.3 Provision of HIV/STI testing services by increasing community-based testing by civil society);
- 1.1.2.1.4 Provision of HIV/STI treatment and referrals for support services;
- 1.1.2.1.5 Provision of integrated sexual and reproductive health services;
- 1.1.2.1.6 Provision of psychosocial support;
- 1.1.2.1.7 Provision of Hepatitis B screening and vaccination;
- 1.1.2.1.8 Building capacity of non-governmental organisations to advocate for the rights of inmates.

1.1.2.2 Increase coverage with prevention services for male, female and transgender seafarers through:

1.1.2.2.1 Outreach activities with information, education and communication, including the translation of key materials into local languages;
1.1.2.2.2 Provision of basic commodities (male and female condoms and lubricants, dental dams);
1.1.2.2.3 Provision of HIV/STI testing services (increase community-based testing by civil society);
1.1.2.2.4 Provision of HIV/STI treatment and provide referrals for support services;
1.1.2.2.5 Provision of integrated sexual and reproductive health services;
1.1.2.2.6 Provision of psychosocial support;
1.1.2.2.7 Provision of hepatitis B screening and vaccination.

1.1.2.3 Increase coverage with prevention services for young people most at risk (male, female and transgender) through:

1.1.2.3.1 Outreach activities with information, education and communication, with particular involvement of faith based organisations as a major partner in reaching young people;
1.1.2.3.2 Provision of basic commodities (male and female condoms and lubricants, dental dams, PEP) and including translation of key materials into local languages;
1.1.2.3.3 Provision of HIV/STI testing services (increase community based testing by civil society);
1.1.2.3.4 Provision of HIV/STI treatment and provide referrals for support services;
1.1.2.3.5 Provision of integrated sexual and reproductive health services, noting the need to tailor services for people with disabilities;
1.1.2.3.6 Provision of psychosocial support;
1.1.2.3.7 Provision hepatitis B screening and vaccination; and
1.1.2.3.8 Strengthening of Comprehensive Sexuality Education (CSE) in primary and secondary schools.

Objective 1.2 Increase HIV/STI testing services

1.2.1 Transition services to point of care testing, where a rapid test is used where a finger is pricked to obtain a blood sample, the test is administered and results are provided at the same appointment by:

1.2.1.1 Training and sensitizing health care workers and counsellors to provide HIV/STI testing services;
1.2.1.2 Updating the HIV testing services protocol and algorithm; and
1.2.1.3 Providing referrals to the SRH Hub Centers.

1.2.2 Increase HIV testing services for TB patients by:

1.2.2.1 Training and sensitizing health care workers and counsellors to provide HIV/STI testing services; and
1.2.2.2 Providing referrals to the SRH Hub Centers.

1.2.3 Increase HIV testing services for STI patients by:

1.2.3.1 Training and sensitizing health care workers and counsellors to provide HIV/STI testing services; and
1.2.3.2 Providing referrals to the SRH Hub Centers.

Objective 1.3 Elimination of parent-to-child transmission of HIV, congenital syphilis and Hepatitis B

1.3.1 Elimination of parent-to-child transmission of HIV, congenital syphilis and hepatitis through:

1.3.1.1 Provision of integrated sexual and reproductive health services for women, men and transgender as part of an essential package of high impact interventions that need to be delivered along the continuum of health services;
1.3.1.2 Provision of basic commodities (including male and female condoms and lubricants, dental dams);
1.3.1.3 Outreach activities with information, education and communication messages on sexual and reproductive health rights and services for women of reproductive age including translation of key materials into local language;
1.3.1.4 Institutionalising point of care testing services at antenatal clinic for pregnant women and their partners;
1.3.1.5 Increasing testing services for pregnant women to first and third trimester
1.3.1.6 Ensuring testing services are available at the labour ward for unbooked mothers and postnatal testing for women who were late bookers;
1.3.1.7 Provision of early infant diagnosis within first six weeks of birth; and
1.3.1.8 Encouragement of exclusive breastfeeding for the first six months of life for ART adherent mothers.

1.3.2 Provision of treatment to prevent transmission of HIV, congenital syphilis and Hepatitis B through:

1.3.2.1 Provision of treatment including lifelong antiretroviral treatment for pregnant women who test positive for HIV;
1.3.2.2 Provision of treatment for opportunistic infections; and
1.3.2.3 Provision of prophylaxis.

1.3.3 Provision of treatment, care and support for children diagnosed with HIV, congenital syphilis and Hepatitis B

1.3.3.1 Provision of lifelong antiretroviral treatment for children who test positive for HIV;
1.3.3.2 Provision of treatment for syphilis and any other STI;
1.3.3.3 Set up referral mechanism from antenatal clinics to paediatric units; and
1.3.3.4 Set up referral mechanism to support groups for the families.

Objective 1.4 Securing an enabling and supportive environment for delivery and impact

1.4.1 Strengthen strategic health communication through:

1.4.1.1 Development of a targeted strategic health communication plan for key populations and other vulnerable groups;
1.4.1.2 Implementation of targeted strategic health communications for key populations and other vulnerable groups;
1.4.1.3 Development of targeted strategic health communication plan for faith-based organisations;
1.4.1.4 Implementation of targeted strategic health communications by faith based organisations;
1.4.1.5 Development of targeted strategic health communication plan for nongovernmental organisations
1.4.1.6 Implementation of targeted strategic health communications by nongovernmental organisations;
1.4.1.7 Development of targeted strategic health communication plan for governmental organisations; and
1.4.1.8 Implementation of targeted strategic health communications by governmental organisations.

1.4.2 Design and implementation of advocacy plans

1.4.2.1 Targeted advocacy to influence Parliamentary decision-making on:

1.4.2.1.1 Decriminalisation of sex work;
1.4.2.1.2 Legal gender recognition; and
1.4.2.1.3 Elimination of mandatory testing requirements in military and peacekeeping forces

1.4.2.2 Targeted advocacy to influence governmental policies related to:

1.4.2.2.1 Community-led testing;
1.4.2.2.2 Point of care testing;
1.4.2.2.3 Condom distribution in correctional facilities;
1.4.2.2.4 Strengthening implementation of HIV workplace policies and training by strengthening partnerships with Occupational Health and Safety (OHS) inspectors, employers' and workers' organisations;
1.4.2.2.5 Review of the medical school curriculum;
1.4.2.2.6 Review of anti-bullying policy in schools; and
1.4.2.2.7 Ensuring adherence to policies, protocols, standard operating procedures and guidelines.

1.4.2.3 Targeted advocacy at community levels to reduce stigma and discrimination through:

1.4.2.3.1 Work with faith-based organisations;
1.4.2.3.2 Out of school youths; and
1.4.2.3.3 Village headmen (turaga ni koro) in partnership with the Ministry of i-Taukei Affairs.

Objective 1.5 Prevent occupational and non-occupational transmission of HIV

1.5.1. Provision of PEP for occupational and non-occupational transmission of HIV

1.5.1.1 Provision of PEP to health care workers who have been exposed due to occupation.
1.5.2.1 Provision of PEP to males, females and transgender individuals who have experienced forced sex

Objective 1.6: Identifying and addressing barriers to accessing HIV and STI services

1.6.1 Improving the prevention of gender-based and sexual violence policies through:

1.6.1.1 Updating, finalising and ensuring adherence guidance on prevention and management of gender-based and sexual violence, with a focus on adolescents, young women and children.

1.6.2 Revise policies to scale up services.

1.6.2.1 Revise policies to enable after-hours services to enhance service provision to key populations and other vulnerable populations.

1.6.3 Strengthen partnerships to support services.

1.6.3.1 Strengthen partnerships with faith-based organisations to support scaling up of HIV and STI testing services.
1.6.3.2 Strengthen partnerships with correctional services to support scaling up of HIV and STI testing services.
1.6.3.3 Strengthen partnerships with the Ministry of Employment, Relations and Productivity and the Maritime Safety Authority of Fiji (MSAF) to support implementation of workplace policies.
1.6.3.4 Strengthen partnerships with the Ministry of Education to support implementation of Comprehensive Sexuality Education (CSE)

Objective 1.7: Safe injections and the safe use of blood and blood products

The strategy on safe injections and the safe use of blood and blood products is contained in the National Blood and Blood Product Transfusion Policy.[21]

[21] National Blood and Blood Product Transfusion Policy 2010 at http://www.health.gov.fj/wp-content/uploads/2014/05/Blood-Transfusion-Guideline.pdf

Priority Area 2: Continuum of Care

Result: 90% of all people diagnosed with HIV in Fiji will receive sustained antiretroviral therapy and will have viral suppression.

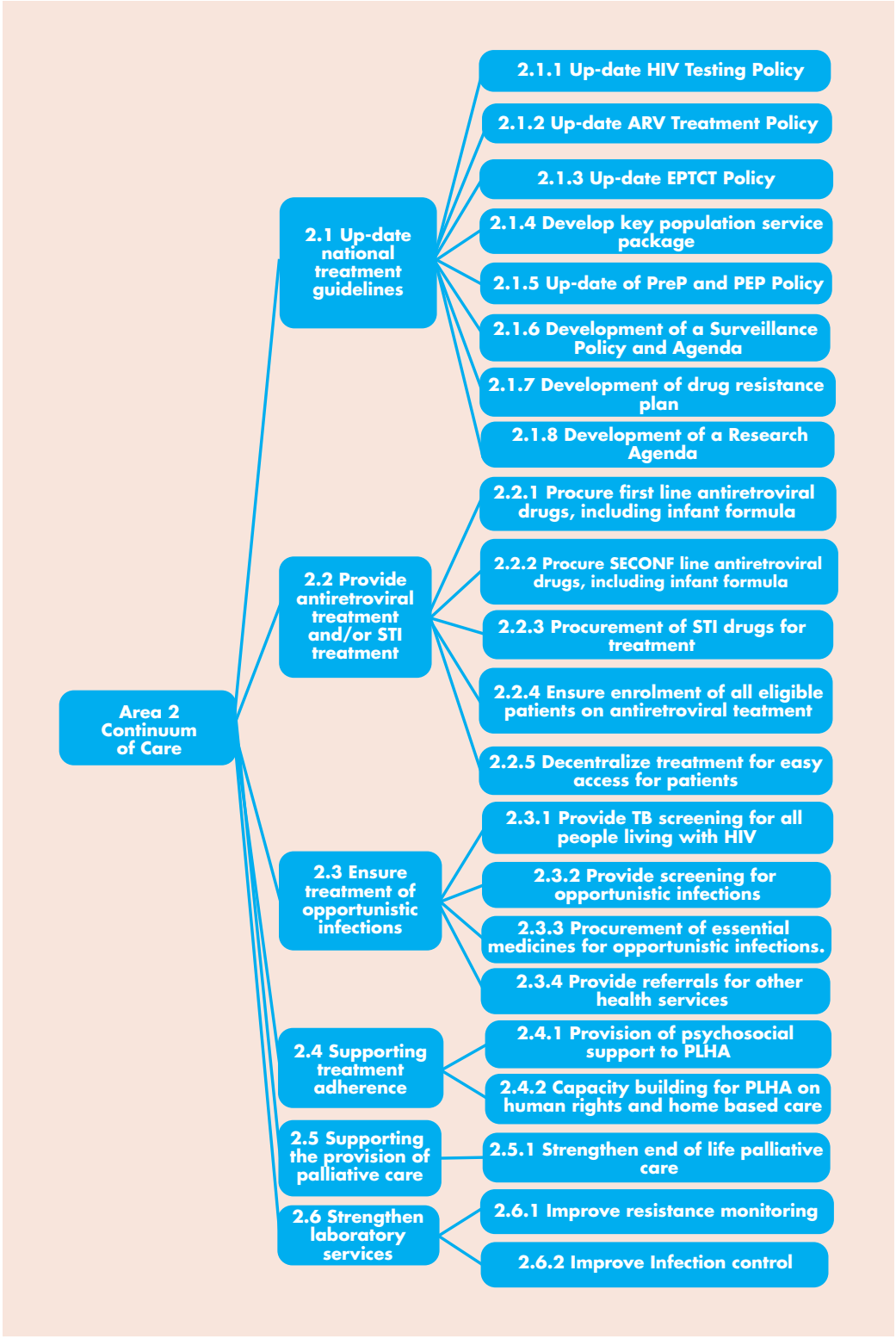

Figure 21: Logical Framework for Priority Area 2: Continuum of Care

Priority Area 2: Continuum of Care

Result: 90% of all people diagnosed with HIV in Fiji will receive sustained antiretroviral therapy

By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.
Update treatment plans that ensure continuity of treatment, as well as the timely transition from old to new treatment regimens and approaches.

Objective 2.1 Update and develop national guidelines

2.1.1 HIV Testing and Counselling Policy
2.1.2 Update HIV Care and ARV Therapy Guidelines
2.1.3 Update PPTCT Policy to eMTCT Policy
2.1.4 Develop key populations service package
2.1.5 Update of PreP and PEP Policy
2.1.6 Development of a Surveillance Policy and Agenda
2.1.7 Development of a drug resistance plan
2.1.8 Development of a Research Agenda

Objective 2.2 Provision of antiretroviral treatment and/or STI treatment

2.2.1 Procure first line antiretroviral drugs, including child-friendly formulations.
2.2.2 Procure second line antiretroviral drugs, including child-friendly formulations.
2.2.3 Procurement of STI drugs for treatment.
2.2.4 Ensure enrolment of all eligible patients on antiretroviral treatment.
2.2.5 Decentralise treatment as requested by patients.
2.2.6 Ensure provision of STI treatment to all symptomatic and asymptomatic patients.
2.2.7 Treatment monitoring through CD4 and viral load monitoring.
2.2.8 Provide key information on treatment, treatment adherence and monitoring including translation into local languages.

Objective 2.3 Ensure treatment of opportunistic infections

2.3.1 Provide TB screening for all people living with HIV.
2.3.2 Provide screening for pneumonia, toxiplasmosis, Hepatitis B, herpes, gastro-intestinal infections, CMV, fungal infections, cervical cancer and lymphomas.
2.3.3 Procure prophylaxis and other essential medicines for opportunistic infections, with priority to the provision of cotrimoxazole, dapsone and isoniazid.
2.3.4 Provide referrals for other health services.

Objective 2.4 Supporting treatment adherence

2.4.1 Provision of psychosocial support

2.4.1.1 Nutritional support for people living with HIV and their families;
2.4.1.2 Reimbursement of costs for transportation to have medical checks for people living with HIV;
2.4.1.3 Peer-to-peer support on adherence, nutrition, SRHR including the provision of a care package that includes key IEC materials;
2.4.1.4 Translation of IEC materials into local languages;
2.4.1.5 Support to parents to care for children living with HIV;
2.4.1.6 Support summer camps for children living with or affected by HIV;
2.4.1.7 Support for monthly peer support group meeting; and
2.4.1.8 Referral for other supportive services.

2.4.2 Capacity building for people living with and/or affected by HIV

2.4.2.1 Training of people living with HIV on human rights
2.4.2.2 Training of carers of people living with HIV on home based care

Objective 2.5 Support the provision of palliative care

2.5.1 Strengthen end of life palliative care
2.5.1.1 Development of palliative care guidelines

2.5.1.2 Support the provision of palliative care
2.5.1.3 Ensure access to opioid medicines for the management of pain and end-of-life care
2.5.1.4 Ensure provision of pastoral care people living with HIV and their family members
2.5.1.5 Strengthen partnerships with faith based organisations' welfare arms for the provision of safe homes
2.5.1.6 Home visitation by peer support group and/or health care workers

Objective 2.6 Strengthen therapeutic monitoring services

2.6.1 Improve drug resistance monitoring
2.6.2 Improve Infection control

Priority Area 3: System Strengthening

Result: Human Rights of KAP and PLHA are observed

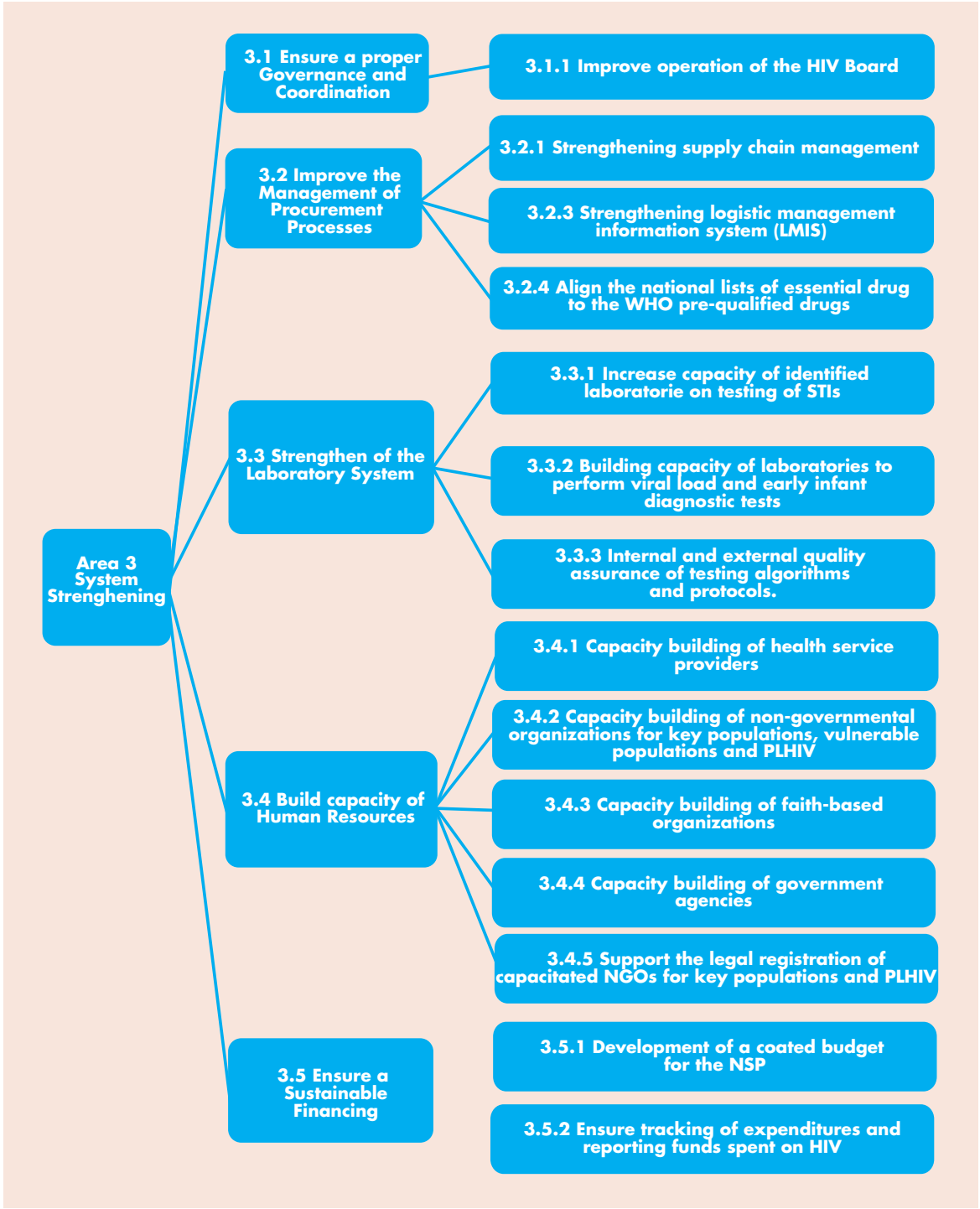

Figure 22: Logical framework for Area 3 System Strengthening

Priority Area 3: System strengthening

Result: Human Rights of KAP and PLHA are observed

Objective 3.1 Ensure proper Governance and Coordination

3.1.1 Improve operations of the HIV Board through:

3.1.1.1.Strengthening the four sub-committees of the HIV Board with the greater and meaningful involvement of key affected populations:

a. World AIDS Day committee
b. Prevention committee
c. Monitoring & Evaluation committee and
d. Continuum of Care committee

3.1.1.2. Review the ToRs and membership of the sub-committees;
3.1.1.3. Ensure at least quarterly meetings for each sub-committee and minutes are shared with the HIV Board within 5 days of the meeting;
3.1.1.4. Development of a HIV Board website;
3.1.1.5. Improve coordination with partners e.g. CSO, FBOS, international development partners, etc.;
3.1.1.6. Annual meeting and review for stakeholders to discuss annual reports, results and discuss and agree on the fol lowing year's implementation plan
3.1.1.7. Partners meet with the sub-committees on a quarterly basis

Objective 3.2 Improve the Management of Procurement Processes

3.2.1. Strengthening supply chain management at all levels via:

a. Capacity building
b. Supportive supervision
c. Strengthen forecasting
d. Supply management

3.2.2. Strengthening the logistics management information system (LMIS) and
3.2.3. Ensuring national lists of essential drugs are updated according to WHO pre-qualified products and nationally validated algorithms, ensuring that they are approved by the National Medicines and Therapeutics Committee (NMTC)

Objective 3.3 Strengthen the Laboratory System

3.3.1. Increase capacity of identified laboratories on testing of chlamydia, gonorrhoea via:

a. Equipment
b. Capacity building of health care workers, and
c. Supportive supervision.

3.3.2. Building capacity of laboratories to perform viral load and early infant diagnostic tests via:

a. Equipment
b. Capacity building of health care workers, and
c. Supportive supervision.

3.3.3. Internal and External quality assurance of testing algorithms and protocols.

Objective 3.4 Build capacity of Human Resources

3.4.1. Capacity building of health service providers in public and private sectors in:

a. Clinical management of HIV,
b. Syndromic management of STIs,
c. Sexual reproductive health and rights,

d. Sexual orientation and gender identity and expression, (SOGIE)
e. Stigma and discrimination, acceptance and confidentiality,
f. Counselling including adherence counselling,
g. Data collection, reporting and monitoring.

3.4.2. Capacity building of non-governmental organisations for key populations, vulnerable populations and PLHIV

a. Sexual orientation and gender identity and expression (SOGIE)
b. Stigma and discrimination
c. SRHR
d. Counselling including adherence counselling
e. HIV/STI testing services
f. Data collection, reporting and monitoring
g. Programme planning and management

3.4.3. Capacity building of faith-based organisations

a. Basic HIV/STIs and SRHR information
b. Sexual orientation and gender identity and expression (SOGIE)
c. Stigma and discrimination
d. Counselling including adherence counselling
e. Data collection, reporting and monitoring

3.4.4. Capacity building of government agencies

a. Basic HIV/STIs and SRHR information
b. Sexual orientation and gender identity and expression (SOGIE)
c. Stigma and discrimination
d. Data collection, reporting and monitoring

3.4.5. Support the legal registration of capacitated non-governmental organisations for key populations and PLHIV

Objective 3.5 Ensure a Sustainable Financing

3.5.1 Development of a costed budget for the NSAP

3.5.1.1 Developing a national budget to finance the HIV/STI programme
3.5.1.2 Engaging development partners, non-governmental organisations and the private sector to discuss and agree on contributions to the HIV/STI programme
3.5.1.3 Prepare project proposals to be shared with donors (development partners, non-governmental organisations and the private sector)
3.5.1.4 Engage with traditional and non-traditional donors

3.5.2 Ensure tracking of expenditures and reporting funds spent on HIV

3.5.2.1 Examine the sustainability of programmes in both the public and private facilities
3.5.2.2 Strengthen national health accounts to enable reporting of HIV/STI spending and analyses of cost efficiency

Priority Area 4: Monitoring, Evaluation and Research

Result: Effective monitoring of the NSAP ensured

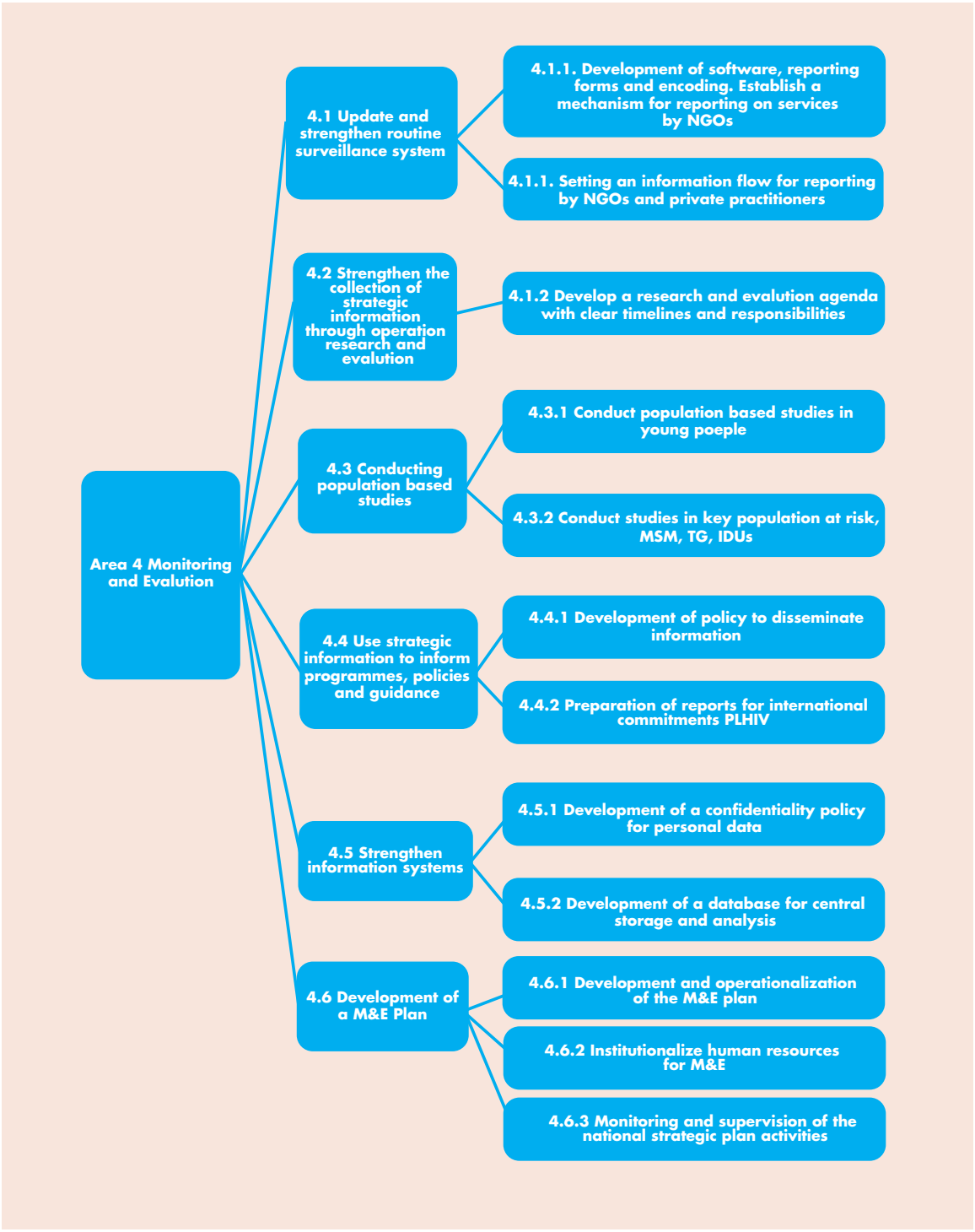

Figure 23: Logical Framework for Area 4 Monitoring, Evaluation and Research

Priority Area 4: Monitoring and Evaluation

Result: Effective monitoring of the NSAP ensured

Objective 4.1 Update and strengthen routine surveillance system

4.1.1 Development of software, reporting forms and encoding.

4.1.1.1 Develop a unique client and service provider coding system
4.1.1.2 Review and update reporting forms to collect essential data
4.1.1.3 Develop and use of an electronic, real time routine reporting system, including the procurement of necessary equipment to enable data collection

4.1.2 Setting an information flow for reporting by NGOs, private practitioners.

4.1.2.1 Training for the use of reporting forms
4.1.2.2 Establish mechanisms to continuously monitor service utilisation and acceptability and the preferences and needs of patients, communities and health care workers.
4.1.2.3 Non-governmental organisations providing services for key populations, vulnerable populations and PLHIV to report to the national government on all HIV/STI cases
4.1.2.4 Private practitioners to report to the national government on all HIV/STI cases

Objective 4.2 Strengthen collection of strategic information through operational research and evaluation:

4.2.1 Develop a research and evaluation agenda with clear timelines and responsibilities

4.2.1.1 Conduct Stigma Index for PLHA
4.2.1.2 Conduct annual national HIV/STI programme reviews
4.2.1.3 Conduct national HIV/STI programme mid-term evaluation
4.2.1.4 Quality of care review
4.2.1.5 PPTCT bottleneck analysis
4.2.1.6 Peer education review
4.2.1.7 Youth friendly/safe health services review
4.2.1.8 Life skills education assessment
4.2.1.9 Profiling of PLHIV

Objective 4.3 Conducting population-based studies

4.3.1 Conduct population-based studies in young people

4.3.1.1 Incorporate population-based studies into the operational research and evaluation agenda
4.3.1.2 Prevalence and behaviour survey in young people 15-24 years of age
4.3.1.3 Knowledge, Attitudes and Practices among seafarers
4.3.1.4 Second Generation Sentinel Surveillance HIV/STIs (including Hepatitis B) amongst ANC attendees
4.3.1.5 Prevalence and behavioural study among inmates

4.3.2 Conduct studies in key populations at risk, MSM, TG, IDUs

4.3.1.1 Integrated biological and behavioural study for key populations and vulnerable populations
4.3.1.2 Size estimation for TG, MSM and SWs

Objective 4.4 Use strategic information to inform programmes, policies and guidance

4.4.1 Development of a policy to disseminate information

4.4.1.1 Develop a dissemination policy to share information through a web-page and reports
4.4.1.2 Capacity building of decision-makers in data analysis and applying in planning procedures
4.4.1.3 Production of annual progress reports
4.4.1.4 Generation of data for global reporting requirements
4.4.1.5 Preparation of annual National AIDS Spending Assessment

4.4.2 Preparation of reports for international commitments

4.4.2.1 Preparation of reports for donors
4.4.2.2 Preparation of reports for Global AIDS Progress Reporting, SDGs, CEDAW, UPRs etc.

Objective 4.5 Strengthen information systems

4.5.1 Development of a confidentiality policy for personal data

4.5.1.1 Develop protocols for encoding of data to ensure confidentiality
4.5.1.3 Develop guidelines for physical and electronic security of data
4.5.1.3 Develop of guidelines on data transfer
4.5.1.4 Development of guidelines for storage of personal data

4.5.2 Development of a database for central storage and analysis

4.5.2.1 The development and use of an electronic, real time routine reporting system, including the procurement of necessary equipment to enable data collection, analysis and storage
4.5.2.2. Upgrade databases with key strategic information
4.5.2.3 Strengthen central storage for all operational research, population studies and surveys

Objective 4.6 Development of a M&E Plan

4.6.1 Development of the M&E plan and making it operational

4.6.1.1 Drafting and approval of the M&E information flows and responsibilities
4.6.1.2 Monitoring of the implementation of the policies and guidelines

4.6.2 Institutionalize human resources for M&E

a. M&E Officer for entire HIV/STI programme, responsible for data collection, validation and analysis for information from other governmental agencies, nongovernmental organisations and faith based organisations

4.6.3 Monitoring and supervision of the national strategic plan activities

4.6.3.1 Use of strategic information to understand the epidemic and response as a basis for advocacy, political commitment, national planning, resource mobilisation and allocation, implementation, and programme improvement.
4.6.3.2 Use of innovative survey methods, modelling and mapping tools, involving local communities and key populations, to generate detailed pictures of localised epidemics and estimates of key population sizes.
4.6.3.3 Ensure that data collection methods achieve high quality data, meet ethical standards and do not pose risks for communities and health care workers involved.

V. Results Framework

Note: A detailed M&E Plan will be developed to capture more Outcome and Output Indicators, information flows and reporting forms.

Impact Indicators	Available Data	
	2015	2020
Impact Indicator 1. Prevalence of HIV in general population	0.14 %	0.14%
Impact Indicator 2. Prevalence in transgender sex workers	1.8%	1%
Impact Indicator 2. Prevalence of Syphilis in general population	16%	1.6 %
Impact Indicator3. Mortality rate from HIV	n/a	1%

Key Intervention Area: Area 1 Prevention							
5-year goal: 90% of all people living with HIV and/or infected with STIs in Fiji will know their status							
Objectives	Indicators	Baseline			5-year Target (Date)		
		Numerator	Denominator	Percent	Numerator	Denominator	Percent
Objective 1 1.1.Increase coverage with prevention services for key populations at risk	Indicator 1.1.1 Percentage of KAP reached with HIV prevention programmes	n/a	8684	n/a	7815	8684	90
	Indicator 1.1.2. Percentage of MSM/TG reporting the use of a condom the last time they had anal sex with a male partner	67	307	22	7815	8684	90
Objective 1.2 Increase HIV/STI testing services	Indicator 1.2.1 Percentage of KAP that have received an HIV test in the past 12 months and know their results	125	307	41	7815	8684	90
	Indicator 1.1.2. Percentage of MSM/TG with syphilis	50	250	20	7815	8684	90
Objective 1.3 Elimination of parent to child transmission of HIV, congenital syphilis and hepatitis B	Indicator 1.3.1 Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	15	18	83	27	28	96
	Indicator 1.3.2 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at any ANC visit	20970	20970	100	30000	30000	100
	Indicator 1.3.2 Percentage of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	47	20000	0.2	0	300000	0
Objective 1.4 Securing an enabling and supportive environment for delivery and impact	Indicator 1.4.1 Percentage of men and women aged 15-49 tested for HIV in the last 12 months who know their results	44	83	53	n/a	n/a	100
	Indicator 1.4.2 Percentage of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	516	3193	16	n/a	n/a	2

Key Intervention Area: Area 1 Prevention							
5-year goal: 90% of all people living with HIV and/or infected with STIs in Fiji will know their status							
Objectives	Indicators	Baseline			5-year Target (Date)		
		Numerator	Denominator	Percent	Numerator	Denominator	Percent
Objective 1.5 Prevent occupational and non-occupational transmission of HIV	Indicator 1.5.1 Percentage of health care workers exposed to occupational HIV in PEP	n/a	n/a	n/a	n/a	n/a	100
Objective 1.6 Identifying and addressing barriers to accessing HIV and STI services	Indicator 1.6.1 Prevalence of recent intimate partner violence	2043	3193	64	n/a	n/a	0
Objective 1.7 Safe injections and the safe use of blood and blood products	Indicator 1.7.1 Prevalence of recent intimate partner violence	2043	3193	64	n/a	n/a	0

Key Intervention Area: Area 2 Continuum of Care							
5-year goal: 90% of all people diagnosed with HIV and/or STIs in Fiji will receive sustained antiretroviral therapy and/or STI treatment 90% of people on HIV treatment having a suppressed viral load							
Objectives	Indicators	Baseline			5-year Target (Date)		
		Numerator	Denominator	Percent	Numerator	Denominator	Percent
Objective 2.1 Update national treatment guidelines	Indicator 2.1.1 Policy and Programmatic Assessment	n/a	n/a	n/a	n/a	n/a	n/a
Objective 2.2 Provision of antiretroviral treatment and/or STI treatment	Indicator 2.2.1 Percentage of adults and children currently receiving antiretroviral therapy among all PLHA	208	732	28	1082	1202	90
	Indicator 2.2.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	37	52	71	1082	1202	90
	Indicator 2.2.3 Percentage of people on ART tested for viral load (VL) who were virally suppressed in the reporting period	n/a	n/a	n/a	1082	1202	90
	Indicator 2.2.4 Percentage of antenatal care attendees positive for syphilis who received treatment	n/a	n/a	n/a	n/a	n/a	90
Objective 2.3 Ensure treatment of opportunistic infections	Indicator 2.3.1 Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	11	64	17	972	1082	90
Objective 2.4 Supporting treatment adherence	Indicator 2.4.1 Percentage of PLHA that were covered by adherence programmes	n/a	n/a	n/a	972	1082	90
Objective 2.5 Support the provision of palliative care	Indicator 2.5.1 Percentage of PLHA covered by palliative care services	n/a	n/a	n/a	874	972	90

Key Intervention Area: Area 2 Continuum of Care							
5-year goal: 90% of all people diagnosed with HIV and/or STIs in Fiji will receive sustained antiretroviral therapy and/or STI treatment 90% of people on HIV treatment having a suppressed viral load							
Objectives	Indicators	Baseline			5-year Target (Date)		
		Numerator	Denominator	Percent	Numerator	Denominator	Percent
Objective 2.6 Strengthen laboratory services	Indicator 2.6.1 Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period	n/a	n/a	n/a	1082	1202	90

Key Intervention Area: Area 3 System Strengthening							
5-year goal: Human Rights of KAP and PLHA are observed							
Objectives	Indicators	Baseline			5-year Target (Date)		
		Numerator	Denominator	Percent	Numerator	Denominator	Percent
Objective 3.1 Ensure proper Governance and Coordination	Indicator 3.1.1 National Commitment Policy Index	14	16	88	16	16	100
Objective 3.2 Improve the Management of Procurement Processes	Indicator 3.2.1 Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months	n/a	4	n/a	0	4	0
Objective 3.3 Strengthen the Laboratory System	Indicator 3.3.1 Percentage of laboratories performing viral load testing and infant diagnosis testing	n/a	n/a	n/a	n/a	n/a	100
Objective 3.4 Build capacity of Human Resources	Indicator 3.4.1 Percentage of NGOs trained	n/a	n/a	n/a	n/a	n/a	80
	Indicator 3.4.2 Percentage of faith-based organisations trained	n/a	n/a	n/a	n/a	n/a	80
Objective 3.5 Ensure Sustainable Financing	Indicator 3.5.1 National AIDS Spending Assessment						80

Key Intervention Area: Area 4 Monitoring and Evaluation	
5-year goal: Effective monitoring of the NSAP ensured	
Objectives	Indicators
Objective 4.1 Update and strengthen routine surveillance system	Routine surveillance in place
Objective 4.2 Strengthen the collection of strategic information through operational research and evaluation	Research agenda developed
Objective 4.3 Conducting population-based ……..something missing here??	Number of surveys conducted
Objective 4.4 Use strategic information to inform programmes, policies and guidance	Reports produced
Objective 4.5 Strengthen information systems	Database in place
Objective 4.6 Development of a M&E Plan	M&E Plan developed and approved

VI. Resource Needs Estimation

Regulation and governance of health resources

The MoHMS receives its annual budget allocation from Cabinet through the Ministry of Finance and Ministry of National Planning and conforms to government accounting procedures and regulations. In purchasing health products, the MoHMS seeks the endorsement of the relevant regulating authority and complies with Ministry of Finance tendering procedures as enforced by the Fiji Procurement Office (formerly the Controller of government supplies). For example, in the purchase of medicines, the Fiji Pharmacy and Poisons Board ensures drug safety and efficacy (by only approving the import of drugs meeting British or United States standards), while the Fiji Procurement Office oversees the tendering process.

Costing methodology.[22]

The budget was prepared following the costing exercise which took place in Suva on October 26-30, 2015. During this phase, the working group used the draft version of the NSAP to identify for each activity of the plan, actors, venues, targets, frequency and necessary means. This large amount of information was consolidated under a single format after which, all the inputs needed to deliver the plan were identified. The essential unit-costs were grouped under packages and allocated line by line across the NSAP. In parallel, each unit-cost value was documented using an important array of sources: unit-costs from central database (http://www.avenirhealth.org/policytools/UC/), web research for commodities and utilities prices, medicines and medical consumables, stock management files from the Global Fund Principal Recipient, and, direct queries with certain service providers in the Suva region for certain prices in relation to communication material production and diffusion. Since the unit-costs provided from the Avenir Health database were not in line with the specifics of Fiji, only a cost assumption originating from that source for the ePTCT service, was used. The rest of the critical costs in terms of medical consumables and drugs were built from stock management files and estimation by the GF PR on the current caseload in the treatment programme. We also used various demographic data to estimate the potential for ePTCT, as well as other proxy indicators on TB to triangulate the potential for TB/HIV co-infection in the country. We finally computed in the potential evolution of testing and treatment output using projections provided by the UNAIDS (Fast Track Approach document, built from Spectrum estimates) to tie future costs to the potential of evolution of the various caseloads of the programme where costs are highly dependent on the level of output of the intervention. As for prevention activities, the target population sizes were provided by the technical working group in the absence of systematic surveys on the matter (a shortcoming addressed by this plan in the form of multiple surveys including the IBBS - Integrated Biological and Behavioural Surveillance conducted on sex workers, MSM and transgenders – which provided population sizes). Whilst COC costs (treatment) were tied to future caseload, it was considered that the target to be addressed by prevention activities will be flat across the programme since there were no data on the past performance of implementing partners to gauge their potential performance. Considering the very low awareness regarding HIV and the necessary protective measures linked to it, it was felt that a slight over-estimation of the actual potential prevention outputs and their means would give solid ground to such a vast and coordinated approach. Finally, the evolution of future prices to inflation was adjusted. An average 3% over the last 5 years has been registered in Fiji and this level of inflation was applied for the next 5 years. This is a risk since Fiji is highly dependent on oil prices thus it would be suggested to the HIV Board to pay close attention to Fiji's Consumer Price Index.

Synergies with development sectors include support for PLHA and their children, training faith-based organisation to expand HIV testing, and, strengthening of the health systems. Critical enablers include program enablers (community-centered design and delivery, mass media communication, programme management, procurement and distribution) and social enablers (political commitment and advocacy, legal policies and practices, community mobilization, stigma reduction, programmes to prevent gender-based violence.).

Community mobilisation can be divided into three categories: Outreach and engagement activities; support activities; and advocacy, transparency and accountability. These components fall into the category of critical enablers as well as basic programme activities.

Packages of interventions expanding services for each key population, including PLHIV, include costs for stigma reduction, removing discriminatory practices and gender-based barriers to education, prevention, treatment and support. In addition, social enablers include legal, mass media and community interventions to reduce discrimination.

[22] The Fiji Islands Health System Review, Dr Graham Roberts, Fiji National University et al, 2011

A full Costing Report, recording how costing was calculated, is available separately to this National Strategic Plan, and is available from the Ministry of Health and Medical Services.

Costing results

The estimated total cost of the implementation of the National Strategic Plan on HIV and STIs in 2012-2015 (in Fiji Dollars) is nearly FJD $33 million over the five years, as can be seen in the table below. In this table all the calculations are based on 2014 prices, which are adjusted to an inflation rate of 3%.

	Programmes values per year in Fiji Dollars					
	2016	2017	2018	2019	2020	Total
Prevention	2,870,149	2,098,200	2,227,277	2,331,007	2,297,636	11,824,269
COC	1,257,993	1,823,435	2,502,124	3,060,686	3,886,564	12,530,802
M&E	861,965	769,491	518,924	788,920	587,118	3,526,418
SS	1,473,851	409,188	1,335,853	359,337	999,922	4,578,151
Total	6,463,958	5,100,314	6,584,178	6,539,950	7,771,239	32,459,640
Time distribution	20%	16%	20%	20%	24%	100%

Table 9: Financial resources required to implement NSAP in 2016-2017 in Fiji

The budget will start with a spike in 2016 due to the necessary investment to initiate the programme (mostly equipment and training). It will then decrease in 2017 to progressively increase regularly to 2020 as the caseload of prevention and COC activities are expected to build up (data from the UNAIDS Fiji Fast Track Approach[23]). It is expected that the inflation will remain stable, at a rate of 3% per year.

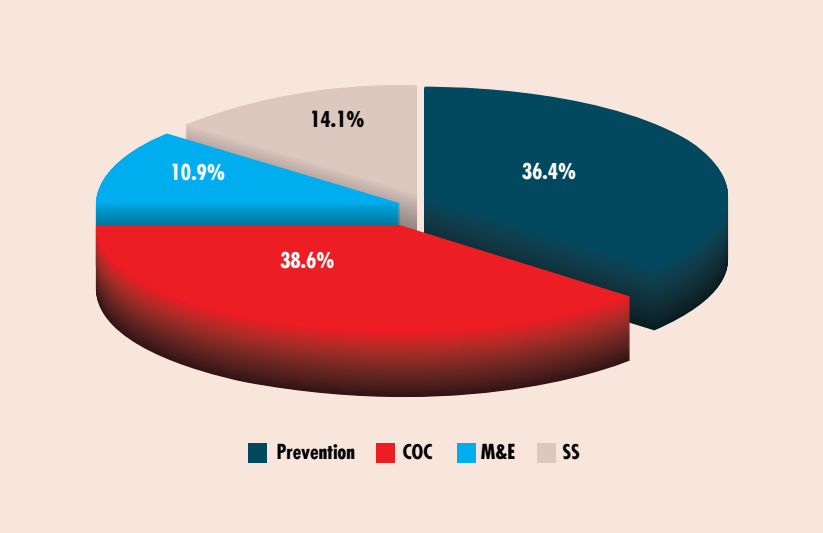

Figure 24: Gross Resources distribution over 2016-2020

[23] Fast Track Strategy: Country-Specific Targets and Resource Needs Fiji, 2015

The budget, following the logic of the NSAP, is fairly balanced between the Prevention and the Continuum of Care areas.

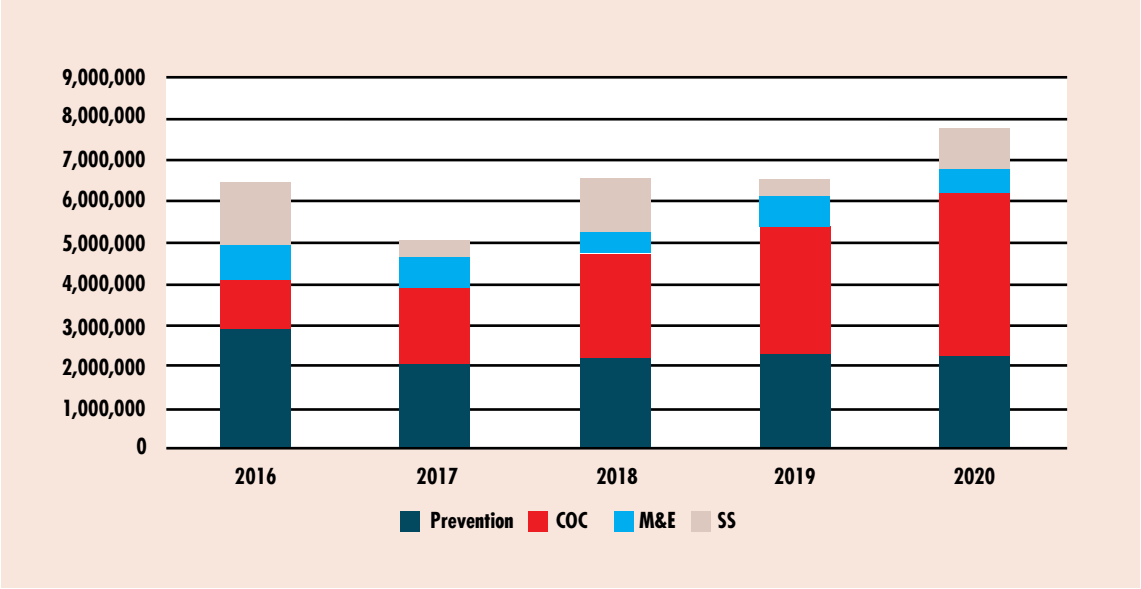

Figure 25: Resources distribution per programme area, 2016-2020.

The balance between Prevention and Continuum of Care is due to the fact that prevention actors (mostly advocacy groups) will be on the frontline in term of outreach and general prevention activities and will receive means accordingly. Besides, ART treatment is playing the role as prevention as well as any person in treatment will no longer transmit HIV.

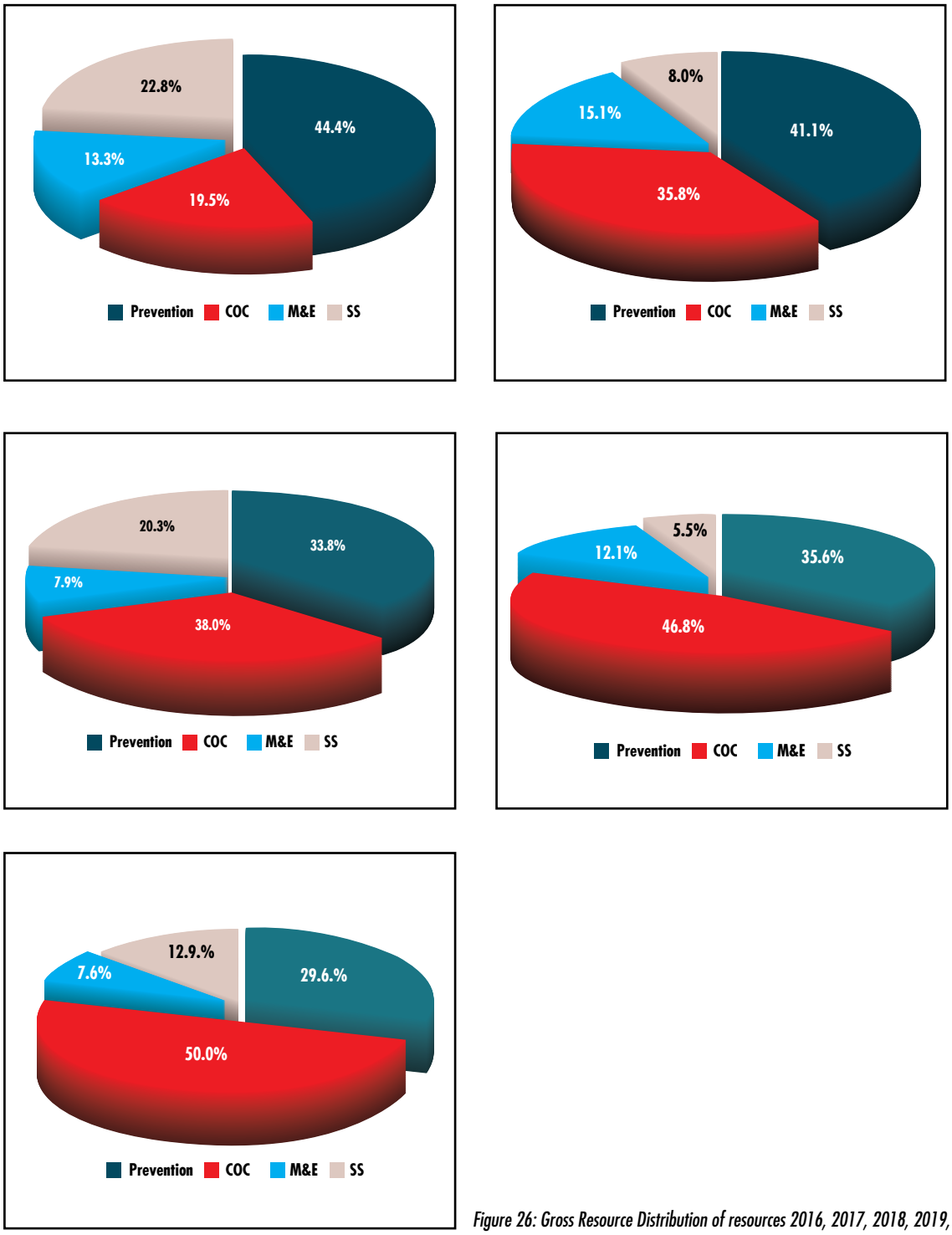

Figure 26: Gross Resource Distribution of resources 2016, 2017, 2018, 2019, 2020.

Distribution of resources per programme area

Prevention budget breakdown

The prevention budget was complex to build since multiple actors would deliver multiple prevention activities to a host of at-risk groups. To avoid duplications of costs, certain activities and targets were grouped (this is essentially the case for all activities under "1.1.1 Increase coverage with prevention services for key populations at risks"). For instance, a sex-worker group may target female sex-workers, transgender, and MSM sex-workers (targets which are addressed in the NSAP under multiple sub-categories but receiving the same mix of activities by mostly the same organisations). Hence, to ensure the consistency of the budget, various actors and targets under the same activity were grouped. Hence the budget for prevention is mostly target-led as the long list of potential groups intervening in the prevention area may or may not have the right capacities to deliver the activities. This is something that the HIV Board, supported by an enhanced information system, will have to actively monitor, and if need be, reallocate planned resources to the strongest organisations to ensure the global cost-effectiveness of the intervention.

Prevention activities are mostly driven by outreach and tasks involving direct contact between peers and at-risk populations. This distribution is fairly stable across the years and makes great sense when considering the generally poor level of public awareness public in regards to the HIV/AIDS epidemic, high proxy-indicators in relation to STIs, and, a very low reported utilisation of condoms.

New prevention technologies are mainly biomedical interventions: antiretroviral therapy as prevention, outreach to key populations for testing, Hepatitis B vaccination, rapid combo HIV/STI testing, and, peer navigators.

EMTCT goals are taken further into ending AIDS movement. The target coverage for the ART component of PMTCT is set at 90% in 2020 while the coverage for other prongs of the PMTCT package is set at 95%. The expected impact is a 98% reduction in perinatal HIV transmission and 87% reduction in HIV transmission during breastfeeding.

Finally, minimal training costs have been budgeted in Objective 1.7 since this activity should be standard procedure in any public facility, regardless of the HIV/AIDS epidemic.

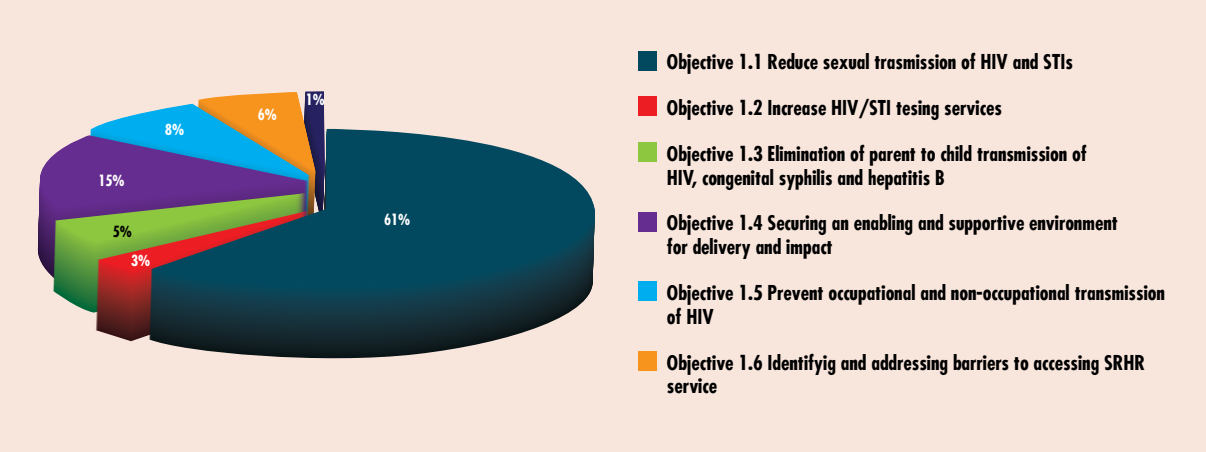

Figure 28: Resources distribution for the Prevention Area, 2016-2020.

			Prevention Values in Fiji $					
			Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
Objective 1.1 Reduce sexual transmission of HIV and STIs	1.1.1 Increase coverage with prevention services for key populations at risk		490,603	460,822	517,588	474,646	533,116	2,476,775
	1.1.2 Increase coverage with prevention services for other vulnerable populations	1.1.2.1 Increase coverage with prevention services for male, female and transgender inmates	417,705	419,814	443,143	432,408	456,438	2,169,508
		1.1.2.2 Increase coverage with prevention services for male, female and transgender seafarers	232,388	228,937	246,541	235,805	253,937	1,197,609
		1.1.2.3 Increase coverage with prevention services for young people most at risk (male, female and transgender)	261,028	268,859	276,925	276,925	285,233	1,368,970
Objective 1.2 Increase HIV/ STI testing services	1.2.1 Transition services to point of care testing		98,280	0	0	104,265	0	202,545
	1.2.2 Increase HIV testing services for TB patients		68,040	0	0	0	0	68,040
	1.2.3 Increase HIV testing services for STI patients		136,080	0	0	0	0	136,080
Objective 1.3 Elimination of Parent-to-child transmission of HIV, congenital syphilis and Hepatitis B	1.3.1 Prevention		194,360	52,242	53,809	91,906	55,423	447,741
	1.3.2 Treatment		64,638	0	0	0	0	64,638
	1.3.3 Care and support		43,092	0	0	0	0	43,092
Objective 1.4 Securing an enabling and supportive environment for delivery and impact	1.4.1 Strategic health communication	1.4.1.1 Development of a targeted strategic health communication plan	495,600	309,000	318,270	318,270	327,818	1,768,958
		1.4.1.2 Targeted communication materials are developed for key populations and other vulnerable groups	22,680	0	0	24,061	0	46,741
	1.4.2 Implementation of advocacy initiatives		0	0	0	0	0	0
Objective 1.5 Prevent occupational and non-occupational transmission of HIV	1.5.1 Provision of PEP to health care workers who have been exposed due to occupation		37,800	38,934	40,102	40,102	41,305	198,243
	1.5.2 Provision of PEP to males, females and transgender who have experienced forced sex		138,510	145,168	151,242	152,961	159,320	747,200
Objective 1.6: Identifying and addressing barriers to accessing SRHR services	139,104		143,277	147,575	147,575	152,003	729,535	
Objective 1.7: Safe injections and the safe use of blood and blood products (make reference to other document)	30,240		31,147	32,082	32,082	33,044	158,594	
Total	2,870,149		2,098,200	2,227,277	2,331,007	2,297,636	11,824,269	

Table 10: Budget breakdown for Prevention 2016-2020

			Weight per year and per activity					
			2016	2017	2018	2019	2020	Total cost
Objective 1.1 Reduce sexual transmission of HIV and STIs	1.1.1 Increase coverage with prevention services for key populations at risk		17.1%	22.0%	23.2%	20.4%	23.2%	20.9%
	1.1.2 Increase coverage with prevention services for other vulnerable populations	1.1.2.1 Increase coverage with prevention services for male, female and transgender inmates	14.6%	20.0%	19.9%	18.6%	19.9%	18.3%
		1.1.2.2 Increase coverage with prevention services for male, female and transgender seafarers	8.1%	10.9%	11.1%	10.1%	11.1%	10.1%
		1.1.2.3 Increase coverage with prevention services for young people most at risk (male, female and transgender)	9.1%	12.8%	12.4%	11.9%	12.4%	11.6%
Objective 1.2 Increase HIV/STI testing services	1.2.1 Transition services to point of care testing		3.4%	0.0%	0.0%	4.5%	0.0%	1.7%
	1.2.2 Increase HIV testing services for TB patients		2.4%	0.0%	0.0%	0.0%	0.0%	0.6%
	1.2.3 Increase HIV testing services for STI patients		4.7%	0.0%	0.0%	0.0%	0.0%	1.2%
Objective 1.3 Elimination of parent to child transmission of HIV, congenital syphilis and Hepatitis B	1.3.1 Prevention		6.8%	2.5%	2.4%	3.9%	2.4%	3.8%
	1.3.2 Treatment		2.3%	0.0%	0.0%	0.0%	0.0%	0.5%
	1.3.3 Care and support		1.5%	0.0%	0.0%	0.0%	0.0%	0.4%
Objective 1.4 Securing an enabling and supportive environment for delivery and impact	1.4.1 Strategic health communication	1.4.1.1 Development of a targeted strategic health communication plan	17.3%	14.7%	14.3%	13.7%	14.3%	15.0%
		1.4.1.2 Targeted communication materials are developed for key populations and other vulnerable groups	0.8%	0.0%	0.0%	1.0%	0.0%	0.4%
	1.4.2 Implementation of advocacy initiatives		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Objective 1.5 Prevent occupational and non-occupational transmission of HIV	1.5.1 Provision of PEP to health care workers who have been exposed due to occupation		1.3%	1.9%	1.8%	1.7%	1.8%	1.7%
	1.5.2 Provision of PEP to males, females and transgender who have experienced forced sex		4.8%	6.9%	6.8%	6.6%	6.9%	6.3%
Objective 1.6: Identifying and addressing barriers to accessing SRHR services			4.8%	6.8%	6.6%	6.3%	6.6%	6.2%

			Weight per year and per activity					
			2016	2017	2018	2019	2020	Total cost
Objective 1.7: Safe injections and the safe use of blood and blood products (make reference to other document)			1.1%	1.5%	1.4%	1.4%	1.4%	1.3%
Total			100%	100%	100%	100%	100%	100%

Table 11: Weight per year and per activity in the Prevention Budget.

Continuum of Care budget breakdown

The COC budget was somewhat of a challenge in the absence of relevant and accurate data in regards to previous years, notably in terms of actual consumption of both ARV and OI drugs. An estimated average costper-patient-per-year in terms of OI and ARV drugs (including an extra 30% procurement/logistic cost for any medical/pharmaceutical item) has been included in the budget. To ensure accurate forecasts of costings, accurate clinical information on patients will be required such as their clinical stage and when they began treatment. That kind of information will assist in ordering the right quantities of drugs.

To estimate the future caseload of the programme, we used the data generated by Spectrum, and provided by the UNAIDS Fiji along with its Fast Track Approach. It is also essential to understand that the impact of the prevention programme will greatly influence the COC one, since the former feeds the later.

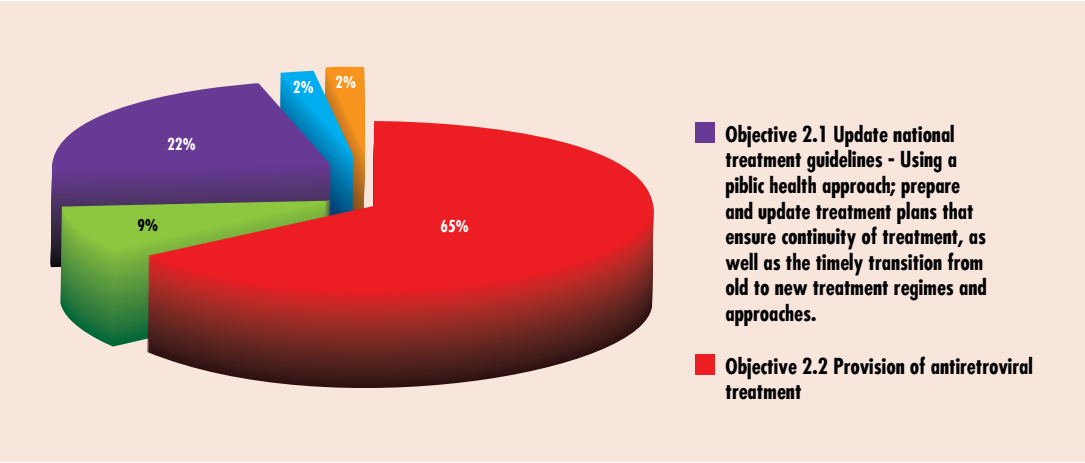

Figure 29: Resource distribution for Continuum of Care area, 2016-2020.

Quite logically, ARV and OI drugs make for the most of the budget since most of the HR costs in relation to the delivery of care are not covered by this budget, with the exception of peer-support and training.

Continuum of Care Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
Objective 2.1 Update national treatment guidelines - Using a public health approach, prepare and update treatment plans that ensure continuity of treatment, as well as the timely transition from old to new treatment regimens and approaches.		11,340	0	12,031	0	12,392	35,762
Objective 2.2 Provision of antiretroviral treatment	2.2.1 Procure first line antiretroviral drugs, including child-friendly formulations	465,448	862,941	1,283,865	1,678,901	2,197,187	6,488,343
	2.2.2 Procure second line antiretroviral drugs, including child-friendly formulations	54,254	100,588	149,652	195,699	256,112	756,305
	2.2.3 Treatment monitoring through CD4 and viral load monitoring	90,438	122,609	171,658	217,029	277,282	879,018
	2.2.4 Decentralise treatment as requested by patients	7,271	7,489	7,713	7,713	7,945	38,131
	2.2.5 Provide key information on treatment, treatment adherence and monitoring including translation into local languages						0
Objective 2.3 Ensure treatment of opportunistic infections	2.3.1 Provide TB screening	10,000	18,540	27,583	36,071	47,206	139,400
	2.3.2 Provide screening for pneumonia, toxiplasmosis, hepatitis B, herpes, gastro-intestinal infections, CMV, fungal infections, cervical cancer and lymphomas	63,718	118,133	175,756	229,835	300,786	888,229
	2.3.3 Procure prophylaxis and other essential medicines for opportunistic infections, with priority to the provision of cotrimoxazole, dapsone and isoniazid						0
	2.3.4 Referral for other health services	3,029	5,617	8,356	10,927	14,301	42,230
Objective 2.4 Supporting treatment adherence	2.4.1 Provision of psychosocial support	10,000	18,540	27,583	36,071	47,206	139,400
	2.4.2 Nutritional support for people living with HIV and their families	16,000	29,664	44,133	57,713	75,529	223,040
	2.4.3 Reimbursement of costs for transportation to have medical checks for people living with HIV	3,029	5,617	8,356	10,927	14,301	42,230
	2.4.4 Peer to peer support on adherence, nutrition, SRHR including the provision of a care package that includes key IEC materials	3,029	5,617	8,356	10,927	14,301	42,230

Continuum of Care Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
	2.4.5 Translation of IEC materials into local languages						0
	2.4.6 Support to parents to care for children living with HIV	1,212	1,248	1,286	1,286	1,324	6,355
	2.4.7 Support a summer camps for children living with or affected by HIV	94,500	97,335	100,255	100,255	103,263	495,608
	2.4.8 Support for monthly peer support group meeting	272,160	280,325	288,735	288,735	297,397	1,427,350
	2.4.9 Referral for other supportive services	3,029	5,617	8,356	10,927	14,301	42,230
	2.4.10 Capacity building for people living with and/or affected by HIV	37,800	38,934	40,102	40,102	41,305	198,243
	2.4.11 Training of people living with HIV on human rights	18,900	19,467	20,051	20,051	20,653	99,122
	2.4.12 Training of carers of people living with HIV on home based care	18,900	19,467	20,051	20,051	20,653	99,122
Objective 2.5 Support the provision of palliative care	2.5.1 Development of palliative care guidelines	19,494	0	20,681	0	21,302	61,477
	2.5.2 Support the provision of palliative care						0
	2.5.3 Ensure access to opioid medicines for the management of pain and end-of-life care	5,611	10,402	15,476	20,238	26,485	78,211
	2.5.4 Ensure provision of pastoral care people living with HIV and their family members	3,029	5,617	8,356	10,927	14,301	42,230
	2.5.5 Strengthen partnerships with faith-based organisations'welfare arms for the provision of safe homes						0
	2.5.6 Home visitation by peer support group and/or health care workers	8,213	10,956	13,856	16,427	19,965	69,417
Objective 2.6 Strengthen laboratory services	2.6.1 Resistance monitoring	13,559	13,965	14,384	14,384	14,816	71,108
	2.6.2 Infection control	24,028	24,748	25,491	25,491	26,256	126,014
Total		1,257,993	1,823,435	2,502,124	3,060,686	3,886,564	12,530,802

Weight per year and per activity for Continuum of Care							
		2016	2017	2018	2019	2020	Total cost
Objective 2.1 Update national treatment guidelines - Using a public health approach, prepare and update treatment plans that ensure continuity of treatment, as well as the timely transition from old to new treatment regimens and approaches.		1%	0%	0%	0%	0%	0%
Objective 2.2 Provision of antiretroviral treatment	2.2.1 Procure first line antiretroviral drugs, including child-friendly formulations	37%	47%	51%	55%	57%	52%
	2.2.2 Procure second line antiretroviral drugs, including child-friendly formulations	4%	6%	6%	6%	7%	6%
	2.2.3 Treatment monitoring through CD4 and viral load monitoring	7%	7%	7%	7%	7%	7%
	2.2.4 Decentralise treatment as requested by patients	1%	0%	0%	0%	0%	0%
	2.2.5 Provide key information on treatment, treatment adherence and monitoring induding translation into local languages	0%	0%	0%	0%	0%	0%
Objective 2.3 Ensure treatment of opportunistic infections	2.3.1 Provide TB screening	1%	1%	1%	1%	1%	1%
	2.3.2 Provide screening for pneumonia, toxoplasmosis, Hepatitis B, herpes, gastro-intestinal infections, CMV, fungal infections, cervical cancer and lymphomas	5%	6%	7%	8%	8%	7%
	2.3.3 Procure prophylaxis and other essential medicines for opportunistic infections, with priority to the provision of cotrimoxazole, dapsone and isoniazid	0%	0%	0%	0%	0%	0%
	2.3.4 Referral for other health services	0%	0%	0%	0%	0%	0%
Objective 2.4 Supporting treatment adherence	2.4.1 Provision of psychosocial support	1%	1%	1%	1%	1%	1%
	2.4.2 Nutritional support for people living with HIV and their families	1%	2%	2%	2%	2%	2%
	2.4.3 Reimbursement of costs for transportation to have medical checks for people living with HIV	0%	0%	0%	0%	0%	0%
	2.4.4 Peer to peer support on adherence, nutrition, SRHR including the provision of a care package that includes key IEC materials	0%	0%	0%	0%	0%	0%
	2.4.5 Translation of IEC materials into local languages	0%	0%	0%	0%	0%	0%
	2.4.6 Support to parents to care for children living with HIV	0%	0%	0%	0%	0%	0%
	2.4.7 Support a summer camps for children living with or affected by HIV	8%	5%	4%	3%	3%	4%
	2.4.8 Support for monthly peer support group meeting	22%	15%	12%	9%	8%	11%
	2.4.9 Referral for other supportive services	0%	0%	0%	0%	0%	0%
	2.4.10 Capacity building for people living with and/or affected by HIV	3%	2%	2%	1%	1%	2%

Weight per year and per activity for Continuum of Care							
		2016	2017	2018	2019	2020	Total cost
	2.4.11 Training of people living with HIV on human rights	2%	1%	1%	1%	1%	1%
	2.4.12 Training of carers of people living with HIV on home based care	2%	1%	1%	1%	1%	1%
Objective 2.5 Support the provision of palliative care	2.5.1 Development of palliative care guidelines	2%	0%	1%	0%	1%	0%
	2.5.2 Support the provision of palliative care	0%	0%	0%	0%	0%	0%
	2.5.3 Ensure access to opioid medicines for the management of pain and end-of-life care	0%	1%	1%	1%	1%	1%
	2.5.4 Ensure provision of pastoral care people living with HIV and their family members	0%	0%	0%	0%	0%	0%
	2.5.5 Strengthen partnerships with faith based organisations'welfare arms for the provision of safe homes	0%	0%	0%	0%	0%	0%
	2.5.6 Home visitation by peer support group and/or health care workers	1%	1%	1%	1%	1%	1%
Objective 2.6 Strengthen laboratory services	2.6.1 Resistance monitoring	1%	1%	1%	0%	0%	1%
	2.6.2 Infection control	2%	1%	1%	1%	1%	1%
Total		100%	100%	100%	100%	100%	100%

Table 12: Weight per year and per activity for Continuum of Care.

System Strengthening Budget Breakdown

The distribution of the budget in SS is vastly dominated by capacity building activities, under the chapter 3.4. Since little renovation and equipment purchase is to be considered (notably because some expensive items, such as diagnosis machines, will be procured by bi-lateral donors.

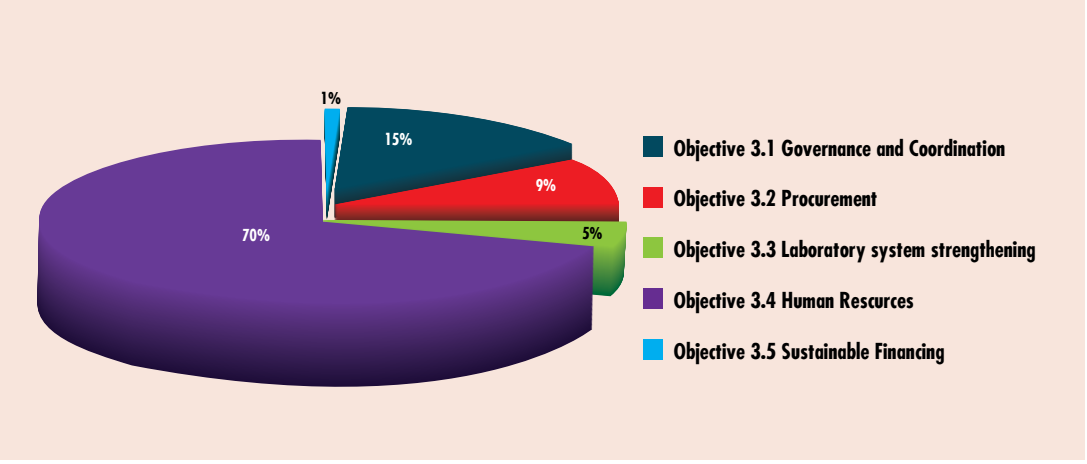

Figure 30: Resource Distribution in the System Strengthening Area.

System Strengthening Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
Objective 3.1 Governance and Coordination	HIV Board is responsible for advising the Minister of Health						0
	Create a sub-committee for prevention						0
	Strengthen four sub-committees of the HIV Board: World AIDS Day committee, Prevention committee, Monitoring & Evaluation committee and Continuum of Care committee	45,360	46,721	48,122	48,122	49,566	237,892
	Review the ToRs and membership of the sub-committees						0
	Ensure at least quarterly meetings for each sub-committee and minutes are shared with HIV Board within 5 days of the meeting	45,360	46,721	48,122	48,122	49,566	237,892
	Development of a HIV Board website (to be reconsidered for CEA)	16,555	2,836	2,922	2,922	3,009	28,244
	Partner coordination						0
	Annual meeting for key partners to discuss annual reports and results and discuss and agree on the following year's implementation plan	34,020	35,041	36,092	36,092	37,175	178,419
	Partners meet with the sub-committees on quarterly basis according to Health Divisions						0
	Development of a HIV/STI Divisional Directory of Contacts & Contexts (An additional activity added by team)						0
Objective 3.2 Procurement	Strengthening supply chain management						0
	Capacity building	113,400	0	120,306	0	123,915	357,621
	Supportive supervision						0
	Strengthen forecasting						0
	Strengthen logistics management information system (LMIS)						0
	Ensure national protocols are updated according to WHO pre-qualified products and nationally validated algorithms, and ensure these are approved by the National Medicines and Therapeutics Committee (NMTC)	34,020	0	36,092	0	0	70,112

System Strengthening Values in Fiji $								
			Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
Objective 3.3 Laboratory system strengthening	Increase capacity of identified laboratories to test for chlamydia, gon.							0
	Equipment							0
	Capacity building of health care workers							0
	Supportive supervision		37,120	38,234	39,381	39,381	40,562	194,677
	Build capacity of laboratories to perform viral load and early infant diagnostic tests							0
	Equipment							0
	Capacity building of health care workers							0
	Supportive supervision							0
	Quality assurance (internal and external)		3,456	3,560	3,666	3,666	3,776	18,125
Objective 3.4 Human Resources	3.4.1 Capacity building of health service providers	Clinical management of HIV	136,080	140,162	144,367	144,367	148,698	713,675
		Syndromic management of STIs	65,280	0	69,256	0	71,333	205,869
		SRHR						0
		Sexual orientation and gender identity and expression (SOGIE)	95,520	0	101,337	0	104,377	301,234
		Stigma and discrimination, acceptance and confidentiality	4,800	0	5,092	0	5,245	15,137
		Counselling including adherence counselling	0	0	0	0	0	0
		Data collection, reporting and monitoring	0	0	0	0	0	0
	3.4.2 Capacity building of non-governmental organisations for key populations, vulnerable populations and PLHIV	Sexual orientation and gender identity and expression (SOGIE)	143,280	0	152,006	0	156,566	451,852

System Strengthening Values in Fiji $								
			Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
		Stigma and discrimination						0
		SRHR	95,520	0	101,337	0	104,377	301,234
		Counselling including adherence counselling	231,600	0	5,092	0	5,245	241,937
		HIV/STI testing services						0
		Data collection, reporting and monitoring						0
		Programme planning and management						0
	3.4.3 Capacity building of faith-based organisations	Basic HIV/STIs and SRHR information	93,120	95,914	98,791	0	0	287,825
		Sexual orientation and gender identity and expression (SOGIE)	95,520	0	101,337	0	0	196,857
		Stigma and discrimination	4,800	0	5,092	0	0	9,892
		Counselling including adherence counselling	0	0	0	0	0	0
		Data collection, reporting and monitoring	0	0	0	0	0	0
	3.4.4 Capacity building of government agencies	Basic HIV/STIs and SRHR information	93,120	0	98,791	0	101,755	293,666
		Sexual orientation and gender identity and expression (SOGIE)	95,520	0	101,337	0	0	196,857
		Stigma and discrimination						0
		Data collection, reporting and monitoring						0

System Strengthening Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total cost
	3.4.5 Support the legal registration of capacitated nongovernmental organisations for key populations and PLHIV						0
Objective 3.5 Sustainable Financing	Identifying sustainable and innovative models for financing of the response and approaches for reducing costs so that so that people can access the necessary services without incurring financial hardship						0
	3.5.1 Develop a national budget for the financing of the HIV/STI programme						0
	3.5.2 Engage development partners, nongovernmental organisations and private sector to discuss and agree on contributions to the HIV/STI programme						0
	Prepare project proposals to be shared with donors (development partners, nongovernmental organisations and private sector)						0
	Engage with traditional and non-traditional donors						0
	3.5.3 Examine sustainability of programmes in both the public and private facilities	0	0	27,499	0	0	27,499
	3.5.4 Strengthen national health accounts to enable reporting of HIV/STI spending and analyses of cost efficiency	0	0	0	36,665	0	36,665
Total		1,483,451	409,188	1,346,038	359,337	1,005,167	4,603,181

Table 13: Budget Breakdown for System Strengthening, 2016-2020.

Weight per year and per activity System Strengthening							
		2016	2017	2018	2019	2020	Total cost
Objective 3.1 Governance and Coordination	HIV Board is responsible for advising the Minister of Health	0%	0%	0%	0%	0%	0%
	Create a sub-committee for prevention	0%	0%	0%	0%	0%	0%
	Strengthen four sub-committees of the HIV Board: World AIDS Day committee, Prevention committee, Monitoring & Evaluation committee and Continuum of Care committee	3%	11%	4%	13%	5%	5%
	Review the ToRs and membership of the sub-committees	0%	0%	0%	0%	0%	0%
	Ensure at least quarterly meetings for each sub-committee and that minutes are shared with HIV Board within 5 days of the meeting	3%	11%	4%	13%	5%	5%
	Development of a HIV Board website (to be reconsidered for CEA)	1%	1%	0%	1%	0%	1%
	Partner coordination	0%	0%	0%	0%	0%	0%
	Annual meeting for key partners to discuss annual reports and results and discuss and agree on the following year's implementation plan	2%	9%	3%	10%	4%	4%
	Partners meet with the sub-committees on quarterly basis according to Health Divisions	0%	0%	0%	0%	0%	0%
	Development of a HIV/STI Divisional Directory of Contacts & Contexts (An additional activity added by team)	0%	0%	0%	0%	0%	0%
Objective 3.2 Procurement	Strengthening supply chain management	0%	0%	0%	0%	0%	0%
	Capacity building	8%	0%	9%	0%	12%	8%
	Supportive supervision	0%	0%	0%	0%	0%	0%
	Strengthen forecasting	0%	0%	0%	0%	0%	0%
	Strengthen logistics management information system (LMIS)	0%	0%	0%	0%	0%	0%
	Ensure national protocols are updated according to WHO pre-qualified products and nationally validated algorithms, and ensure these are approved by the National Medicines and Therapeutics Committee (NMTC)	2%	0%	3%	0%	0%	2%
Objective 3.3 Laboratory system strengthening	Increase capacity of identified laboratories to test for chlamydia, gonorrhoea.	0%	0%	0%	0%	0%	0%
	Equipment	0%	0%	0%	0%	0%	0%
	Capacity building of health care workers	0%	0%	0%	0%	0%	0%
	Supportive supervision	3%	9%	3%	11%	4%	4%
	Build capacity of laboratories to perform viral load and early infant diagnostic tests	0%	0%	0%	0%	0%	0%
	Equipment	0%	0%	0%	0%	0%	0%

Weight per year and per activity System Strengthening								
			2016	2017	2018	2019	2020	Total cost
	Capacity building of health care workers		0%	0%	0%	0%	0%	0%
	Supportive supervision		0%	0%	0%	0%	0%	0%
	Quality assurance (internal and external)		0%	1%	0%	1%	0%	0%
Objective 3.4 Human Resources	3.4.1 Capacity building of health service providers	Clinical management of HIV	9%	34%	11%	40%	15%	16%
		Syndromic management of STIs	4%	0%	5%	0%	7%	4%
		SRHR	0%	0%	0%	0%	0%	0%
		Sexual orientation and gender identity and expression (SOGIE)	6%	0%	8%	0%	10%	7%
		Stigma and discrimination, acceptance and confidentiality	0%	0%	0%	0%	1%	0%
		Counselling including adherence counselling	0%	0%	0%	0%	0%	0%
		Data collection, reporting and monitoring	0%	0%	0%	0%	0%	0%
	3.4.2 Capacity building of non-governmental organisations for key populations, vulnerable populations and PLHIV	Sexual orientation and gender identity and expression (SOGIE)	10%	0%	11%	0%	16%	10%
		Stigma and discrimination	0%	0%	0%	0%	0%	0%
		SRHR	6%	0%	8%	0%	10%	7%
		Counselling including adherence counselling	16%	0%	0%	0%	1%	5%
		HIV/STI testing services	0%	0%	0%	0%	0%	0%
		Data collection, reporting and monitoring	0%	0%	0%	0%	0%	0%
		Programme planning and management	0%	0%	0%	0%	0%	0%
	3.4.3 Capacity building of faith-based organisations	Basic HIV/STIs and SRHR information	6%	23%	7%	0%	0%	6%
		Sexual orientation and gender identity and expression (SOGIE)	6%	0%	8%	0%	0%	4%
		Stigma and discrimination	0%	0%	0%	0%	0%	0%
		Counselling including adherence counselling	0%	0%	0%	0%	0%	0%
		Data collection, reporting and monitoring	0%	0%	0%	0%	0%	0%

Weight per year and per activity System Strengthening								
			2016	2017	2018	2019	2020	Total cost
	3.4.4 Capacity building of government agencies	Basic HIV/STIs and SRHR information	6%	0%	7%	0%	10%	6%
		Sexual orientation and gender identity and expression (SOGIE)	6%	0%	8%	0%	0%	4%
		Stigma and discrimination	0%	0%	0%	0%	0%	0%
		Data collection, reporting and monitoring	0%	0%	0%	0%	0%	0%
	3.4.5 Support the legal registration of capacitated non-governmental organisations for key populations and PLHIV		0%	0%	0%	0%	0%	0%
Objective 3.5 Sustainable Financing	Identifying sustainable and innovative models for financing of the response and approaches for reducing costs so that so that people can access the necessary services without incurring financial hardship		0%	0%	0%	0%	0%	0%
	3.5.1 Develop a national budget for the financing of the HIV/STI programme		0%	0%	0%	0%	0%	0%
	3.5.2 Engage development partners, non-governmental organisations and private sector to discuss and agree on contributions to the HIV/STI programme		0%	0%	0%	0%	0%	0%
	Prepare project proposals to be shared with donors (development partners, non-governmental organisations and private sector)		0%	0%	0%	0%	0%	0%
	Engage with traditional and non-traditional donors		0%	0%	0%	0%	0%	0%
	3.5.3 Examine sustainability of programmes in both the public and private facilities		0%	0%	2%	0%	0%	1%
	3.5.4 Strengthen national health accounts to enable reporting of HIV/STI spending and analysis of cost efficiency		0%	0%	0%	10%	0%	1%
Total			83%	68%	81%	62%	74%	77%

Table 14: Weight per year and per activity System Strengthening.

Monitoring, Evaluation and Research Budget Breakdown

The distribution of the budget in M&E is fairly even, with no real outlier. One objective, 4.5, appears as unfunded. This is because activities under this section do not require extra resources except for those ones already planned by the NSAP.

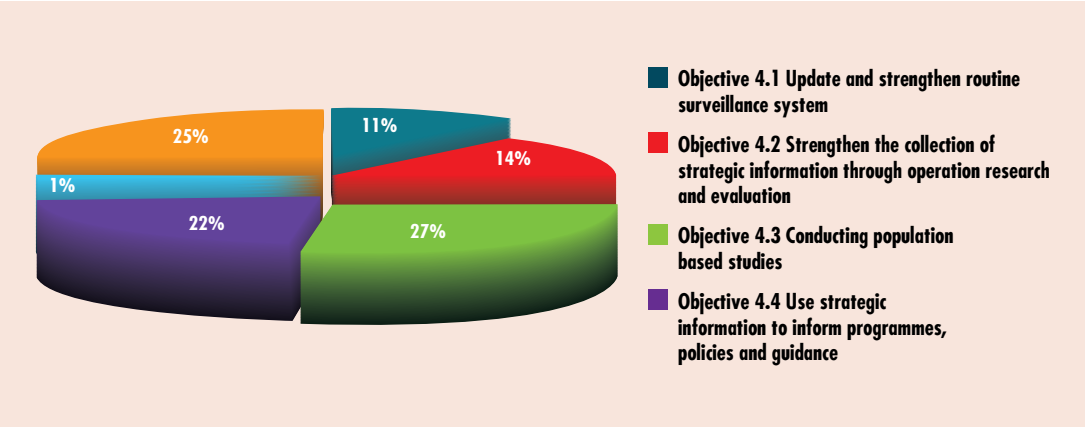

Figure 31: Resource distribution in the M&E area, 2016-2020.

M&E Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total Cost
Objective 4.1 Update and strengthen routine surveillance system	Develop a unique client and service provider coding system	16,688	6,058	6,240	6,240	6,427	41,654
	Review and update reporting forms to collect essential data	17,010	0	0	0	0	17,010
	Develop and use an electronic, real time routine reporting system, including the procurement of necessary equipment, to enable data collection	20,000	2,060	2,122	2,122	2,185	28,489
	Training for the use of reporting forms	58,902	25,072	25,824	25,824	26,599	162,220
	Establish mechanisms to continuously monitor service utilisation and acceptability and the preferences and needs of patients, communities and health care workers. (Client Satisfaction survey)	26,847	27,652	28,482	28,482	29,336	140,800
	Non-governmental organisations providing services for key populations, vulnerable populations and PLHIV to report to national government on all HIV/STI cases						0
	Private practitioners to report to national government on all HIV/STI cases						0
Objective 4.2 Strengthen the collection of strategic information through operational research and evaluation	Develop a research and evaluation agenda with clear timelines and responsibilities	14,663	0	15,556	0	16,023	46,243
	Conduct stigma index	0	0	0	54,997	0	54,997
	Conduct annual national HIV/STI programme reviews	0	23,360	24,061	24,061	24,783	96,266
	Conduct national HIV/STI programme mid-term evaluation	0	0	54,997	0	0	54,997
	Quality of care review	0	0	0	54,997	0	54,997
	PPTCT bottleneck analysis						0
	Peer education review for established organisations						0
	Youth friendly health services review	0	69,140	0	0	0	69,140
	Life skills education assessment	58,487	0	0	0	0	58,487
	Strengthen profiling of PLHIV	58,487	0	0	0	0	58,487
Objective 4.3 Conducting population-based studies	Incorporate population-based studies into the operational research and evaluation agenda	22,680	0	24,061	0	24,783	71,524
	Integrated biological and behavioural study for key populations and vulnerable populations	100,000	103,000	0	106,090	0	309,090

M&E Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total Cost
	Prevalence and behaviour survey in young people 15-24 years of age	100,000	0	0	106,090	0	206,090
	Knowledge, attitudes and practices among seafarers	40,000	0	0	42,436	0	82,436
	Prevalence and behavioural study among inmates	0	103,000	0	0	109,273	212,273
	Second Generation Sentinel Surveillance HIV/STIs (including hepatitis B) amongst ANC attendees	0	41,200	0	0	0	41,200
	Size estimation for TG, MSM and SWs	0	41,200	0	0	0	41,200
Objective 4.4 Use strategic information to inform programmes, policies and guidance	Strengthen implementation of dissemination policy						0
	Capacity building of decision-makers in data analysis and applying in planning procedures	45,360	46,721	48,122	48,122	49,566	237,892
	Production of annual progress reports	56,700	58,401	60,153	60,153	61,958	297,365
	Generation of data for global reporting requirements	7,560	7,787	8,020	8,020	8,261	39,649
	Preparation of annual National AIDS Spending Assessment	34,020	35,041	36,092	36,092	37,175	178,419
	Preparation of donor reports	4,000	4,120	4,244	4,244	4,371	20,978
Objective 4.5 Strengthen information systems	Implementation of a confidentiality policy						0
	Develop confidentiality policy and protocols for encoding of data to ensure confidentiality						0
	Develop and use an electronic, real time routine reporting system, including the procurement of necessary equipment to enable data collection, analysis and storage	12,000	2,060	2,122	2,122	2,185	20,489
	Upgrade databases with key strategic information						0
	Strengthen central storage for all operational research, population studies and surveys						0
Objective 4.6 M&E Plan	Development of the M&E plan and making it operational						0
	Drafting and approval of the M&E information flows and responsibilities						0
	Monitoring of the implementation of the policies and guidelines						0

M&E Values in Fiji $							
		Cost in 2016	Cost in 2017	Cost in 2018	Cost in 2019	Cost in 2020	Total Cost
	Human resources for M&E - M&E Officer for entire HIV/STI programme, responsible for data collection, validation and analysis for information from other governmental agencies, nongovernmental organisations and faith-based organisations	28,000	28,840	29,705	29,705	30,596	146,847
	Monitoring and supervision of the national strategic plan activities						0
	Ensure that data collection methods achieve high quality data, meet ethical standards and do not pose risks for communities and health care workers involved.	3,402	3,504	3,609	3,609	3,717	17,842
	Use of strategic information to understand the epidemic and response as a basis for advocacy, political commitment, national planning, resource mobilisation and allocation, implementation, and, programme improvement.	46,440	47,833	49,268	49,268	50,746	243,556
	Use innovative survey methods, modelling and mapping tools, involving local communities and key populations, to generate detailed pictures of localised epidemics and estimates of key population sizes.	90,720	93,442	96,245	96,245	99,132	475,783
Total		861,965	769,491	518,924	788,920	587,118	3,526,418

Table 15: M&E Budget Breakdown, 2016-2020.

Monitoring and Evaluation weight per year and per activity							
		2016	2017	2018	2019	2020	Total cost
Objective 4.1 Update and strengthen routine surveillance system	Develop a unique client and service provider coding system	2%	1%	1%	1%	1%	1%
	Review and update reporting forms to collect essential data	2%	0%	0%	0%	0%	0%
	Develop and use an electronic, real time routine reporting system, including the procurement of necessary equipment to enable data collection	2%	0%	0%	0%	0%	1%
	Training for the use of reporting forms	7%	3%	5%	3%	5%	5%
	Establish mechanisms to continuously monitor service utilisation and acceptability and the preferences and needs of patients, communities and health care workers. (Client Satisfaction survey)	3%	4%	5%	4%	5%	4%
	Non-governmental organisations providing services for key populations, vulnerable populations and PLHIV to report to national government on all HIV/STI cases	0%	0%	0%	0%	0%	0%
	Private practitioners to report to national government on all HIV/STI cases	0%	0%	0%	0%	0%	0%
Objective 4.2 Strengthen the collection of strategic information through operational research and evaluation	Develop a research and evaluation agenda with clear timelines and responsibilities	2%	0%	3%	0%	3%	1%
	Conduct stigma index	0%	0%	0%	7%	0%	2%
	Conduct annual national HIV/STI programme reviews	0%	3%	5%	3%	4%	3%
	Conduct national HIV/STI programme mid-term evaluation	0%	0%	11%	0%	0%	2%
	Quality of care review	0%	0%	0%	7%	0%	2%
	PPTCT bottleneck analysis	0%	0%	0%	0%	0%	0%
	Peer education review for established organisations	0%	0%	0%	0%	0%	0%

Monitoring and Evaluation weight per year and per activity							
		2016	2017	2018	2019	2020	Total cost
	Youth friendly health services review	0%	9%	0%	0%	0%	2%
	Life skills education assessment	7%	0%	0%	0%	0%	2%
	Strengthen profiling of PLHIV	7%	0%	0%	0%	0%	2%
Objective 4.3 Conducting population-based studies	Incorporate population-based studies into the operational research and evaluation agenda	3%	0%	5%	0%	4%	2%
	Integrated biological and behavioural study for key populations and vulnerable populations	12%	13%	0%	13%	0%	9%
	Prevalence and behaviour survey in young people 15-24 years of age	12%	0%	0%	13%	0%	6%
	Knowledge, attitudes and practices among seafarers	5%	0%	0%	5%	0%	2%
	Prevalence and behav-ioural study among inmates	0%	13%	0%	0%	19%	6%
	Second Generation Sentinel Surveillance HIV/STIs (including hepatitis B) amongst ANC attendees	0%	5%	0%	0%	0%	1%
	Size estimation for TG, MSM and SWs	0%	5%	0%	0%	0%	1%
Objective 4.4 Use strategic information to inform programmes, policies and guidance	Strengthen implementa-tion of dissemination policy	0%	0%	0%	0%	0%	0%
	Capacity building of decision-makers in data analysis and applying in planning procedures	5%	6%	9%	6%	8%	7%
	Production of annual progress reports	7%	8%	12%	8%	11%	8%
	Generation of data for global reporting requirements	1%	1%	2%	1%	1%	1%
	Preparation of annual National AIDS Spending Assessment	4%	5%	7%	5%	6%	5%
	Preparation of donor reports	0%	1%	1%	1%	1%	1%
Objective 4.5 Strengthen information systems	Implementation of a confidentiality policy	0%	0%	0%	0%	0%	0%

Monitoring and Evaluation weight per year and per activity							
		2016	2017	2018	2019	2020	Total cost
	Develop confidentiality policy and protocols for encoding of data to ensure confidentiality	0%	0%	0%	0%	0%	0%
	Develop and use an electronic, real time routine reporting system, including the procurement of necessary equipment to enable data collection, analysis and storage	1%	0%	0%	0%	0%	1%
	Upgrade databases with key strategic information	0%	0%	0%	0%	0%	0%
	Strengthen central storage for all operational research, population studies and surveys	0%	0%	0%	0%	0%	0%
Objective 4.6 M&E Plan	Development of the M&E plan and making it operational	0%	0%	0%	0%	0%	0%
	Drafting and approval of the M&E information flows and responsibilities	0%	0%	0%	0%	0%	0%
	Monitoring of the implementation of the policies and guidelines	0%	0%	0%	0%	0%	0%
	Human resources for M&E - M&E Officer for entire HIV/STI programme, responsible for data collection, validation and analysis for information from other governmental agencies, nongovernmental organisations and faith-based organisations	3%	4%	6%	4%	5%	4%
	Monitoring and supervision of the national strategic plan activities	0%	0%	0%	0%	0%	0%
	Ensure that data collection methods achieve high quality data, meet ethical standards and do not pose risks for communities and health care workers involved.	0%	0%	1%	0%	1%	1%

Monitoring and Evaluation weight per year and per activity							
		2016	2017	2018	2019	2020	Total cost
	Use of strategic information to understand the epidemic and response as a basis for advocacy, political commitment, national planning, resource mobilisation and allocation, implementation, and, programme improvement.	5%	6%	9%	6%	9%	7%
	Use innovative survey methods, modelling and mapping tools, involving local communities and key populations, to generate detailed pictures of localised epidemics and estimates of key population sizes.	11%	12%	19%	12%	17%	13%
Total		100%	100%	100%	100%	100%	100%

Table 16: Monitoring and Evaluation weight per year and per activity.

Annex 1.

List of participants to the consultations meetings

NSP Review and Situational Analysis

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Vatea Ravoka	MoHMS
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Ryan Hatch	Ministry of Employment and Industrial Relations
Sainitiki Ravuso	Ministry of Defence
Jesoni Kuruyawa	i-Taukei Affairs Board
Simon Cheer	NSAAC
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Paulini Vakacegu	Empower Pacific
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Jacobi Ford	Peace Corp Volunteer
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Dr Dennie Iniakwala	SPC
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Sr Nanise Degei	Catholic Church
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NSP Final Review & Endorsement

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