MINISTRY of HEALTH & MEDICAL SERVICES

Shaping Fiji's Health

Annual Report 2015

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MINISTRY OF HEALTH AND MEDICAL SERVICES

Annual Report 2015

August 2016

Hon Jone Usamate
The Minister for Health and Medical Services
Ministry of Health and Medical Services
Suva

Dear Hon Usamate,

I am pleased to submit the 2015 Annual Report in accordance with the Government's regulatory requirements.

Dr Josefa Koroivueta
Acting Permanent Secretary for Health and Medical Services

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Acronyms

ACBA	Australian Coding Benchmark Audit
ACP	Annual Corporate Plan
AHD	Adolescent Health Development
ALOS	Average Length of Stay
AMU	Asset Management Unit
ARH	Adolescent Reproductive Health
BFHI	Baby Friendly Hospital Initiative
BP	Business Plan
BOV	Board of Visitors
CBA	Child Bearing Age
CD	Communicable Diseases
CMNHS	College of Medicine, Nursing and Health Sciences
CPD	Continuing Professional Development
CPG	Clinical Practice Guidelines
CSN	Clinical Service Network
CWMH	Colonial War Memorial Hospital
DMFT	Decayed Missing Filled Teeth
DNS	Director of Nursing
DOTS	Directly Observed Treatment Short-course
DPPDU	Director Planning and Policy Development Unit
DSAF	Deputy Secretary Administration and Finance
DSHS	Deputy Secretary Hospital Services
DSPH	Deputy Secretary Public Health
EH	Environmental Health
EmNOC	Emergency Obstetric and Newborn Care
EPI	Expanded Program of Immunisation
ESKD	End Stage Kidney Disease
FCCDC	Fiji Centre for Communicable Disease Control
FHSSP	Fiji Health Sector Support Program
FJPH	Fiji Journal of Public Health
FNU	Fiji National University
FPBS	Fiji Pharmaceutical and Biomedical Services
GDP	Gross Domestic Product
GF	Global Fund
GMU	Grant Management Unit
GO	General Orders
GOPD	General Outpatient Department
GSHS	Global School-Based Health Survey
HC	Health Centre
HCF	Health Care Finance
HEADMAP	Health and Emergencies Disaster Management Plan
HIU	Health Information Unit
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome
HPTSG	Health Policy Technical Support Group
HQ	Headquarters
HRP	Health Research Portal
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illnesses
JICA	Japan International Cooperation Agency
KPI	Key Performance Indicator
LIMS	Laboratory Information System
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoHMS	Ministry of Health and Medical Services

MR	Measles and Rubella
MRI	Magnetic resonance imaging
MVA	Manual Vacuum Aspirator
NCD	Non Communicable Diseases
NCHP	National Centre for Health Promotion
NHA	National Health Account
NHEC	National Health Ethics Committee
NICU	Neonatal Intensive-Care Unit
NIMS	National Iron and Micronutrients Supplementation
NQSHL	National Quality Standards for Health Laboratory
NRP	Neonatal Resuscitation Programme
NSP	National Strategic Plan
NTBD	National Tooth Brushing Day
NTD	Neglected Tropical Diseases
OPV	Oral Polio Vaccine
PATIS	Patient Information System
Pac ELF	Pacific Programme to Eliminate Lymphatic Filariasis
PHIS	Public Health Information System
PICU	Paediatric Intensive Care Unit
PO	Purchase Order
PPHSN	Pacific Public Health Surveillance Network
PPTCT	Prevention of Parent-to-Child Transmission
PPP	Public Private Partnership
PPU	Post Processing Unit
PR	Principal Recipient
PSC	Public Service Commission
PSHMS	Permanent Secretary for Health and Medical Services
RCA	Root Cause Analysis
RDSSED	Road for Democracy, Sustainable Socio-Economic Development
RDQA	Routine Quality Data Assessment
RHD	Rheumatic Heart Disease
SDs	Subdivisions
SOPD	Special Outpatient Department
SHA	System Health Account
SPC	South Pacific Community
SP	Strategic Plan
STI	Sexually Transmitted Infections
TAS	Transmission Assessment Survey
TB	Tuberculosis
TISI	Then India Sanmarga Ikya Sangam Fiji
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USP	University of the South Pacific
VCCT	Voluntary Confidential Counselling Test
WDF	World Diabetes Foundation
WHO	World Health Organisation
WPRO	Western Pacific Regional Office

1. Permanent Secretary's Remarks

The year 2015 has been an interesting and challenging one for the Ministry. The Ministry reviewed its performance over the last 5 years and developed its National Strategic Plan 2016-2020, which was launched in December 2015.

The Annual Report 2015 highlights the key achievements and challenges which include a comprehensive health outcome report that demonstrates Ministry's performance against key health indicators. There has been progress made in some areas and the challenges faced in progressing in other areas are also acknowledged, as health status is affected by many factors some of which are beyond the health sector.

There is a need for a whole of society approach to address the growing burden of NCDs and MoHMS has been promoting and strengthening the Wellness Approach to health over the past year and will continue to do so. The Ministry continues to take a broader approach to handling challenges and is continuously working on improving efficiency and engaging with key partners in extending health service delivery.

Some of the key achievements for 2015 are highlighted below:

- Fiji hosted Pacific Health Ministers Meeting.
- Fiji received global award for Tobacco Control
- Minister was appointed the chair of the Regional Committee at the Civil Registration and Vital Statistics meeting in Thailand.
- New Nursing Station opened in Nayavuira.
- Vatukarasa health Centre, Sigatoka Maternity and Cuvu Health Centre opened.
- The relocated Nagatagata Nursing station
- Ministry hosted Pacific Public Health Surveillance Network Meeting.
- Fiji introduced new vaccine to eradicate polio disease.
- Ministry launched Sexual & Reproductive Health Manual to address reproductive health issues.
- New cervical cancer policy launched
- Health Ministry launched new data repository for easy access of information by the public on the internet.
- New mobile eye clinic launched to provide services to the people in the remote areas.
- Phase two and phase three of the CWM hospital Operating Theatre project completed.
- CWM hospital received new (trauma) equipment.
- Fiji won global prize for 2nd best cooking demonstration book, this was designed for healthy meal preparation.
- New NCD mobile wellness bus for the Northern Division for outreach programs in the rural areas launched

The above highlights some key initiatives taken to further improve service delivery as well as improve collaboration regionally on key health issues. There have been ongoing efforts to improve the performance of the health system in meeting the needs of the population, including effectiveness, efficiency, equitable access, accountability, and sustainability.

I would like to conclude by thanking all our partners and MoHMS team for their ongoing commitment towards improving the health of the population.

Dr Josefa Koroivueta
Acting Permanent Secretary for Health and Medical Services

2. Ministry of Health and Medical Services Overview

The Ministry of Health and Medical Services acknowledges that it is the right of every citizen of Fiji, irrespective of race, gender, creed or socioeconomic status, to have access to a national health system that provides high quality health services, the principal function of which is to provide accessible, affordable, efficient and high quality health care and strengthen community development leading to improved quality of life.

3. Ministry of Health and Medical Services Priorities

Strategic Pillar 1: Preventive, curative, and rehabilitative health services

1. Non-communicable diseases, including nutrition, mental health and injuries
2. Maternal, infant, child and adolescent health
3. Communicable diseases, environmental health and health emergency preparedness, response and resilience

Diagram note: the canoe represents the MoHMS initiative to promote health and wellness in the Fiji population

Strategic Pillar 2: Health systems strengthening

4. Primary health care, with an emphasis on continuum of care and improved quality and safety
5. Productive, motivated health workforce with a focus on patient rights and customer satisfaction
6. Evidence-based policy, planning, implementation and assessment
7. Medicinal products, equipment and infrastructure
8. Sustainable financing of the health system

Guiding Principles

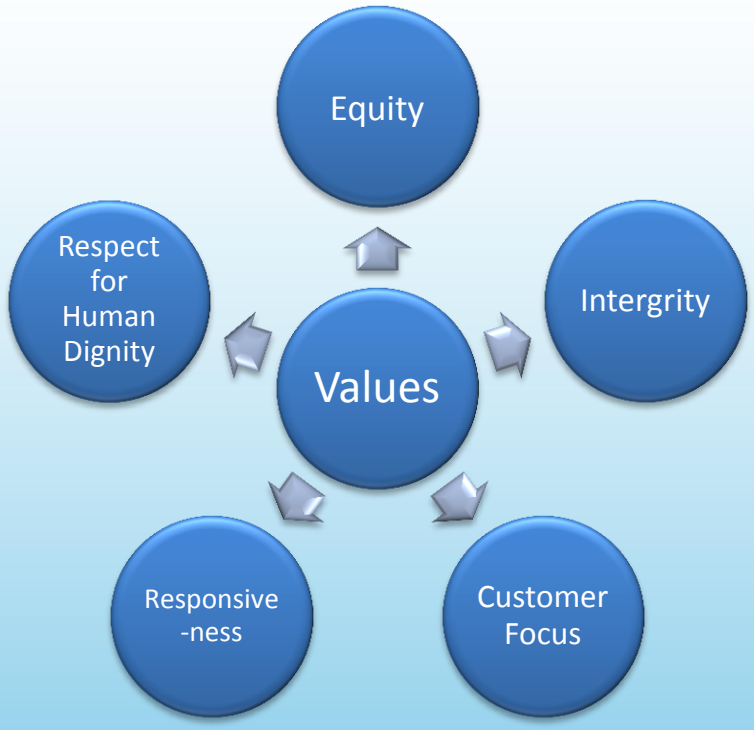
The Guiding Principles for Ministry of Health and Medical Services are,

Vision

A Healthy population

Mission

To empower people to take ownership of their health
To assist people to achieve their full health potential by providing quality preventative, curative and rehabilitative services through a caring sustainable health care system.



General Principles

1. Health in all Policies approach
2. Healthy Islands concept
3. Sustainable Development Goals (SDG)
4. WHO Health Systems Building Blocks
    - Leadership/governance
    - Health care financing
    - Health Workforce
    - Medical products, technologies
    - Health information and research
    - Service delivery
5. Universal Health Coverage

Legislation for which this portfolio is responsible,

No	Description
1	Constitution of the Republic of Fiji 2013
2	Fiji National Provident Fund Decree 2011
3	Fiji Procurement Act 2010
4	Financial Administration Decree 2009
5	Financial Instructions 2005
6	Financial Management Act 2004
7	Financial Manual 2014
8	Occupational Health and Safety at Work Act 1996
9	Ambulance Services Decree 2010
10	Allied Health Practitioners Decree 2011
11	Animals (Control of Experiments) Act (Cap.161)
12	Burial and Cremation Act (Cap.117)
13	Child Welfare Decree 2010
14	Child Welfare (Amendment) Decree 2013
15	Food Safety Act 2003
16	HIV/AIDS Decree 2011
16	HIV/AIDS (Amendment) Decree 2011
17	Illicit Drugs Control Act 2004
18	Marketing Controls (Food for Infants and Children) Regulation 2010
19	Medical Imaging Technologist Decree 2009
20	Medical and Dental Practitioner Decree 2010
21	Medical and Dental Practitioners (Amendment) Decree 2014
22	Medical Assistants Act (Cap.113)
23	Medicinal Products Decree 2011
24	Mental Health Decree 2010
25	Mental Treatment Act (Cap 113)
26	Methylated Spirit Act (Cap. 225A)
27	Nurses Decree 2011
29	Pharmacy Profession Decree 2011
31	Private Hospitals Act (Cap. 256A)
32	*Public Health Act (Cap. 111)
33	Public Hospitals & Dispensaries Act (Cap 110)
34	Public Hospitals & Dispensaries (Amendment) Regulations 2012
35	Optometrist and Dispensing Optician Decree 2012
36	*Quarantine Act (Cap. 112)
37	Quarantine (Amendment) Decree 2010
38	Radiation Health Decree 2009
39	Tobacco Control Decree 2010
40	Tobacco Control Regulation 2012
41	The Food Safety Regulation 2009
42	The Food Establishment Grading Regulation 2011
currently under review	

*Two pieces of draft legislation currently under review are the Quarantine Act Cap 112 and the Public Health Act Cap 111.

Key Cabinet Papers

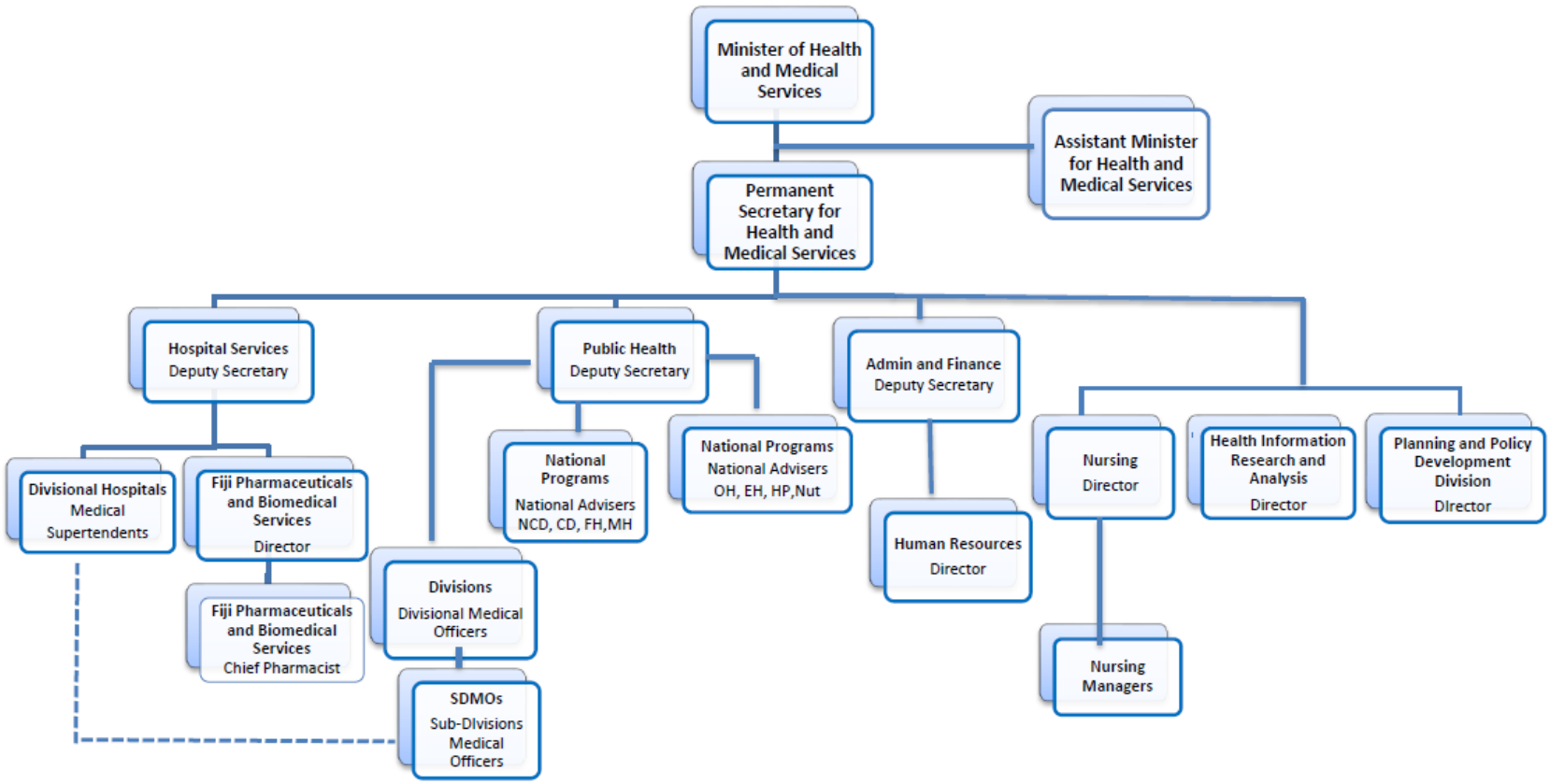
Table 1: Key Cabinet Decision for 2015

No	Cabinet Paper No	Cabinet Paper	Date Paper Tabled in Cabinet	Type of Paper submitted	Officer / unit Responsible	Cabinet Decision
1	CP(15) 54	Ministerial Visit to India and South Korea	27/3/15	Information Paper	DPSH and DSHS	Cabinet Noted the Memorandum submitted for Information by the Minister for Health and Medical Services
2	CP(15) 56	Report on the 2nd Meeting of African Caribbean and Pacific Minister of Health, 25-26th February 2015, Brussels, Belgium	27-03-15	Information Paper	DSPH	Cabinet Noted the Memorandum submitted for Information by the Minister for Health and Medical Services
3	CP(15)/ 55	National Mental Health and Suicide Prevention Policy (2015)	27-03-15	Information Paper	Mental Health Unit - Dr. Peni (A/NAMH)	Cabinet noted the Memorandum submitted for Information by the Minister for Health and Medical Services.
4	CP 5/92	Memorandum of Understanding between Guangdong Health and Family Planning Commission, People's Republic of China and Ministry of Health and Medical Services of the Republic of Fiji on the Establishment of the Fiji-Guangdong Medical Training Centre	30-05-15	Written Opinion	DSPH - SDMO Navua	Cabinet: 1) Endorsed the Memorandum of Understanding between the Guangdong Health and Family Planning Commission, People's of China and the Ministry of Health and Medical Services, the Republic of Fiji on the establishment of the Fiji-Gundong Medical Training Centre
5	CP 15/129	68th World Health Assembly;	31/7/15	Discussion Paper	DSPH	Cabinet : (i) Noted the 68th Health Assembly key resolutions applicable to Fiji's local and regional context; (ii) Endorse the adaptation of the following key 68th WHA Resolution in the relevant Government and Ministry work plans: a) WHA 68.4 Poliomyelitis; b) WHA 68.5 Recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation; c) WHA 68.6 Global Vaccine Action Plan; d) WHA 68.7 Global Action Plan on Antimicrobial Resistance; e) WHA 68.8 Health and the Environment;

						f) WHA 68.15 strengthening Emergency and Essential Surgical Care and Anaesthesia as Component of Universal Health coverage; g) WHA 68.19 Outcome of the Second International Conference on Nutrition; and h) WHA 68.20 Global burden of Epilepsy and the need for Coordinated Action at the Country Level to address its Health, Social, and Public Knowledge Implications.
6		Tabling of Annual Report – Ministry of Health & Medical Services Annual Report 2014	Tabled in Cabinet		A / DPPD	Minister for Health and Medical Services tabled the MoHMS Annual Report 2014.
7	CP 15/98	The Global Fund to Fight Aids, Tuberculosis and Malaria	19/6/15	Discussion Paper	GMU - A/MS Tamavua	1) Cabinet noted the Memorandum 2) Endorsed the Framework Agreement between the Global Fund to Fight Aids, TB and Malaria and the Government of the Republic of Fiji and 3) note the funding obligations of the Framework Agreement shall be subject to the 2016 Budgetary process.
8	CP 15/208	National Anti-Microbial Resistance Action Plan	27/10/15	Discussion Paper	CP- Apolosi Vosanibola - FPBS	Cabinet: 1) Noted the progress development of the implementation of the World Health Assembly Resolution on Global Action Plan on Anti- Microbial Resistance 2) Endorsed the adoption of the National Antimicrobial Resistance (AMR) Action Plan and 3) Endorsed the Formation of Multi-sectorial National AMR.
9	CP(15) 238	International Forum on Traditional Medicine	8/12/15	Information Paper	CP- Apolosi Vosanibola - FPBS	Cabinet Noted the Memorandum submitted for Information by the Minister for Health and Medical Services
10	CP(15) 239	Report of the 66th Regional Committee Meeting of the Western Pacific Region of the World health Organization	08/12/15	Information Paper	DSPH - CHI	Cabinet Noted the Memorandum submitted for Information by the Minister for Health and Medical Services

11	CP(15) 238	Technical Experts and Ministerial Consultation on Strengthening Climate Change Resilience through Reproductive, Maternal, New Born, Child and Adolescence Health	08/12/15	Information Paper	DSPH - CHI	Cabinet Noted the Memorandum submitted for Information by the Minister for Health and Medical Services

Figure 1: Ministry of Health and Medical Services Organisation Structure



4. Reporting on RDSSED 2009-2015

Outcome 1: Communities are serviced by adequate primary and preventative health services thereby protecting, promoting and supporting their wellbeing.

Table 2: RDSSED Performance Indicators for 2014 and 2015

Key Pillar(s) PCCPP	Targeted Outcome (Goal/Policy Objective RDSSED)	Outcome Performance Indicators or Measures (Key Performance Indicators –RDSSED)	2014	2015
Pillar 10: **Improving Health Service Delivery**	Communities are serviced by adequate primary and preventative health services thereby protecting, promoting and supporting their well-being.	Child mortality rate reduced From 26 to 20 per 1000 live Births (MDG).	18.0	16.6
		Percentage of one year olds Immunised against measles Increased from 68% to 95% (MDG).	82.5	83.2
		Maternal mortality ratio reduced from 50 to 20 per 100,000 live births (MDG).	44.4	29
		Prevalence of diabetes in 15-64yrs age reduced from 16% to 14% (note: baseline and target may need revision).	25.9	**
		Contraceptive prevalence rate (CPR)amongst population of child bearing age increased from 46% to 56% (MDG).	43.5	47.1
		Increased Fiji resident medical graduates from FSMed from 40 to 50 per year	73	68
		Increase annual budgetary allocation to the health sector by 0.5% of the GDP annually. An annual growth rate of 5% over the medium term	Increase of Health Budget by 0.52% of GDP as compared to 2013	Increase of Health Budget by 0.55% of GDP as compared to 2014
		Average length of stay for in-patient treatment reduced from 7 to 5 days	4.6	5.1
		Prevalence rate of STIs among men and women aged 15 to 25 (per 100 000 population)	84.02	79.2
		Admission rate for diabetes and its complications, hypertension and cardiovascular disease.	112.7	98.9
		Amputation rate for diabetic sepsis	15.4	17.0
		Prevalence of under 5 malnutrition (per 1000 population)	2*	38.3
		Prevalence rate of Tuberculosis reduced from 10% to 5% (part of MDG 22).	110	2015 will be estimated by WHO in the 2016 Report.

		Prevalence of anaemia in pregnancy at booking from 55.7% to 45%	31.1	32.4
		Rate of teenage pregnancy reduced by 5% (per 1000 CBA population)	4.91	24.3
		Adolescent birth rate (per 1000 girls aged 15-19yrs)	26.7	30.3

** from PHIS*

The Ministry has improved performance in the following categories: The child mortality performance indicator target has declined by 7.8% in 2015 and CMR being < 16 deaths per 1000 live births. There is a slight increase on one year old immunized coverage rates by 1.2% in 2015; the maternal mortality ratio has a reduction of 35% from 44.4 in 2014 to 29 per 100,000 live births in 2015. There was an improvement in CPR by 8.3% in 2015 being 47.1% compared to 43.5% in 2014 and these reflects the improvement in capturing CPR. The prevalence of anaemia increased by 4.2%; the drastic increase of teenage pregnancy could be due to the improved health information system in place which reflects the increased number of teen pregnancies being captured during ANC 1st visit booking. Adolescent pregnancy increased by 13.4% with birth rate at 30 per 1000 girls aged 15 – 19years in 2015. The average length of stay for hospital treatment increased over the year by 10.9% and this could be due to the increase in the number of undischarged patients. It has been noted that there was a slight decrease in the prevalence rate of STIs by 0.72% (this could be a reporting issue rather than a true decrease). Admission rate for diabetes and its complications decreased by 12.2% but the amputation rate for diabetic foot sepsis increased by 10.4%.
**diabetes prevalence is available but not by age group for major collections systems such as the PHIS

Outcome 2: Communities have access to effective, efficient and quality clinical health care and rehabilitation services.

Table 3: RDSSED Performance Indicators for 2014 and 2015

Key Pillar(s) PCCPP	Targeted Outcome (Goal/Policy Objective RDSSED)	Outcome Performance Indicators or Measures (Key Performance Indicators –RDSSED)	2014	2015
Pillar 10: Improving Health Service Delivery	Communities have access to effective, efficient and quality clinical health care and rehabilitation services.	Participation of private and health care providers increased from 2 to 10.	3 GPs 1 Private Dentists	12 GPs 5 Private Dentists
		Health (actual) expenditure increased from the current 2.19% to at least 5% of GDP by 2013	Health actual expenditure is 2.6% of GDP	Health actual expenditure is 2.8% of GDP
		Increase annual budgetary allocation to the health sector by 0.5% of the GDP annually.	Increase of Health Budget by 0.52% of GDP as compared to 2013	Increase of Health Budget by 0.55% of GDP as compared to 2014
		Doctors per 100,000 populations increased from 36 to 42.	60.6	82
		Outsourcing non-technical activities such as laundry, kitchen and security by end of 2011	Mortuary, Security and Cleaning services outsourced. Laundry and kitchen are still in process	Mortuary, Security and Cleaning services outsourced.

		Health Policy Commission established by 2011	Health Policy Technical Support Group established 2012	Health Policy Technical Support Group established 2012
		Average length of stay for in-patient treatment reduced from 7 to 5 days	4.6	5.1
		Elimination of stock outs of drugs from present 100 items per month	70.5	17.5%
		'Proportion of tuberculosis cases det ected and cured under directly obser ved treatment short course (DOTS)'.	Case Detection Rate=60% Treatment Success Rate=86%	Case Detection Rate=63% All forms: 87%, Bacteriologica lly confirmed TB cases: 86%
		Bed Occupancy Rate of Psychiatric beds	37.97	66
		Number of staff trained in mental health	7	2

The bed occupancy rates (only for St Giles Hospital) for Psychiatric beds increased by 73% due to a combination of reporting, decentralization of psychiatry services and establishment of stress wards. The ALOS increased by 10.9% in 2015.

5. Hospital Services

The Deputy Secretary Hospital Services is responsible for management and overall operation of the 3 divisional hospitals Colonial War Memorial (CWMH), Labasa and Lautoka Hospitals and the 2 specialised hospitals, Tamavua /Twomey and St Giles Hospital.

In addition to this core role, there are other areas that fall under the Hospital Services jurisdiction,

1) The Fiji Pharmaceutical and Biomedical Services (FPBS).
2) Health Systems and Standards.
3) Clinical Services Network.
4) Blood and Ambulance Services.
5) Overseas Referrals.
6) Specialist Visiting Teams.
7) Implementation of Service Excellence Framework.

Colonial War Memorial Hospital

Achievements

a. A Medical Team led by Dr Luke Nasedra, Consultant Anaesthetist left for Vanuatu for 6 weeks for the Cyclone Pam Relief Assistance from the Fiji Government.
b. CWMH Sport Day combined with FNPF for the first time ever on Saturday 16th May opened by PS Youth and Sports.
c. SDA Open Heart surgical team returns to CWMH after a lapse for one year; 243 patients were screened and 36 patients had surgeries.
d. Visiting Medical Team from Guangdong province, China visited CWMH from 29th May to 1st June 2015.
e. Visit by US Navy Hospital Ship Mercy with surgeries performed on board the ship and symposium held at CWMH – 6th to 10th June 2015.
f. Healthcare Waste Management Training Program conducted at CWMH by SPREP (Secretariat of the Pacific Regional Environmental Program) under EU funding.
g. Opening of the refurbished IWA Lau Ward by His Excellency the President Ratu Epeli Nailatikau. Refurbishment cost with purchase of new machines for the ward was $112,000FJD.
h. Visit by delegates of the Joint Working Group MoHMS Fiji and MoH India to CWMH.
i. New ambulance for CWMH valued at $105,000FJD donated by the Turkish government and received by MHMS.
j. UN supported mock disaster exercise conducted at Albert Park and CWMH with 20 "injured" patients referred to CWMH for further management.
k. Visit by Dr Tony Gherardin Senior Medical Advisor Department of Foreign Affairs and Trade, Government of Australia.
l. Launch of the new Wellness Aerobics DVD by acting DSHS at the Peace Garden, CWM Hospital coinciding with World Physiotherapy Day celebration.
m. 1st Audit of 5S implementation by the hospital audit team showed 57.1% overall compliance in 5S practice.
n. First ever Nephrology Workshop organized by Dr Amrish Krishnan on 18th September.
o. Friends of Fiji Open Heart team returns to CWMH after 8 years on 11th to 28th Sept 2015. A total of 24 adults and 16 children had cardiac operations from the team.
p. MHMS commissioned phase 2 and phase 3 of OT & ICU refurbishment project & new OPG, mammography, and Paeds DR Machine.
q. Launch of first ever Breast Awareness Campaign at Auditorium by PSHMS.
r. Donation of a total of $50,000 FJD received from John and Charles Wagner from their two Fiji based companies – Sustainable Mahogany Industries Ltd and Pacific Western Timbers (Fiji) Ltd.
s. Visit by US Ambassador Ms Judith Cefkin to CWMH.
t. Launch of Landscaping and Beautification Unit for CWMH by MS.
u. Launch of the Infection Prevention and Control Manual for Maternity Units at Paediatric Seminar Room by Hon Jone Usamate Minister for Health and Medical Services, and Hon Steven Ciobo, Minister for International Development and the Pacific, Government of Australia.
v. Dr Vipul Upadhyay Visiting Paediatric Surgeon and Paediatric Urologist commenced his annual 5-day visit performing specialist clinics and operations with Dr Josese Turagava at CWMH.
w. Donation of $10,000FJD received from the Women in Business (WIB) group represented by Ms Nur Bano, Ms Alison Southey and Ms Ana Tuiketei.

x. Donation of three Blood Pressure Monitors and three Thermometers received from Mrs Marica Hallacy BOV Board Member.
y. Hon Jone Usamate launched the Early Warning Signs for Childhood Cancer Poster and the National Paediatric Oncology Committee at the Paediatric Seminar Room.

Donation of medical equipment from Australian Aid to Paediatrics CWMH

Labasa Hospital

Achievements

a) 91% achievements towards 2015 Business Plan activities.
b) Opening of GOPD/Pharmacy Waiting area.
c) Commencement of exterior refurbishment.
d) Installation of Paging System.
e) Increase in establishment of Medical Officers and Medial Interns.
f) Implementation of 5S.
g) First ever Research Symposium for Labasa Hospital was conducted at the end of the year as an awareness purpose with the theme "Promoting Culture of Research".

Challenges

a) Business plan activities are carried out but there is no proper reporting of these activities.
b) No proper guidelines or standard operating procedures on existing processes.
c) Communication – information sharing is limited.
d) Training/Awareness Programs – limited, there are no specific plans in place to ensure all set out trainings/awareness programs are monitored and executed.
e) Limited resources – Human, financial, infrastructure and equipment.
f) Establishment of the Monitoring and Evaluation Team to oversee the progress throughout the year has not been successful.
g) Data Source – some are not very reliable; still finding difficulty in obtaining statistics from Patisplus and other electronic data sources.

Way forward

a) Re-defining of planned activities to ensure that everyone knows what is required to be done in order to get uniform feedback.

b) Establish Standard Operating Procedures for services provided and sharing this information across the board to ensure services are provided effectively.
c) Provision of resources (Human Resource, Financial, infrastructure, equipment) to enable achievement of desired outcomes.
d) Timely and accurate reporting.
e) Proper and regular trainings offered for Labasa Hospital.
f) Quarterly review/evaluation of Business Plan Achievements.

Lautoka Hospital

Achievements

a. Lautoka Hospital Mother safe hospital initiative audited from 0% in the first quarter to 83% in the 4th Quarter.
b. Zero infection outbreak.
c. Accident and Emergency Department construction works 95% completed.
d. Visiting teams included Orthopaedic Team from Sydney, Eye team and the China Medical team from the Wuhan Union Hospital. The overseas teams supported our local teams by performing surgical procedures such as Orthopaedic cases and Eye operations.
e. National tooth brushing was conducted in Ba Provincial School and Lautoka Andhra Sangam College.
f. Blood Donation Bus received.
g. The Lautoka Hospital organised a Sports family day on the 30th May 2015.
h. Staffs from the clinic went for the Yasawa Tour and the Prosthetic assessment to Nacula.
i. There was a decrease in number of Malnutrition cases in 2016 by 55%.

Challenges

a. Staff shortage due to expansion in services, promotion, transfer, resignation and retirement.
b. Equipment and infrastructure needs improvement.

Way forward

a. Strengthening human resources by ensuring person to post is facilitated and ensure all vacancies are filled in a timely manner.
b. Improving equipment and infrastructure by proper planning.

Tamavua / Twomey Hospital

Achievements

a. The Dermatology unit carried out 2 major outreaches in Bua and Yasawa.
b. The Albinism Symposium was launched on 12th August 2015.
c. Twomey hospital has now started clinic for Albinism cases.
d. Dermatology unit carries out rural outreaches every Mondays and in 2015 a total of 48 Outreaches were conducted.
e. Commissioning of the new Liquid Culture Machine in the laboratory which is the only machine in Fiji.
f. The Out-Reach Program of the Rehabilitation unit was very effective. Coverage area increased to include Yasawa and Rabi Islands. The increase in Out-Reach Rehab services saw a decrease in the number of clients accessing Out-Patient services directly at the Unit. Majority of the clients received services either in their homes

or at the Medical facility nearest to them. This saved clients lot of financial costs (Travel & Accommodation), and caregiver burden was reduced.

g. Rehab Unit managed to network with LDS Church Charity Department and Spinal Injuries Association. Our role was to identify and assess clients for mobility aid prescription (wheelchairs, walkers, crutches and canes). The prescribed forms were then forwarded to SIA for release of items. LDS Charity provided mobility aids free of charge. The end result was that clients needing mobility aids were assisted through the combined efforts of the three Organisations.
h. The TB Microscopy decentralised to Savusavu laboratory and for adequate performance on EQA.
i. Secured TB funding support from KOICA and on-going funding from Global fund as well as governments commitment to contribute to TB funding.
j. Establishment of TB Epidata- which is an up to date electronic TB database, recording 80+ data fields and connected laboratory module.
k. TB Program restructure and establishment of new posts to allow succession planning.
l. Filling of New TB establishment under project positions for the next 2 years to maximally implement the End TB Strategy.
m. Successful treatment outcome-Cure for Rifampicin resistant TB case in Nasoso, Nadi.
n. TB National Strategic Plan 2015-2020 (Executive summary & implementation plan) completed and endorsed at NHEC.
o. TB-HIV policy endorsed by NHEC and HIV committee.

Challenges

a. No communication for progress on clinical and professional development.
b. There were out of stock of consumables for liquid and solid cultures.
c. There was a delay in the procurement of the prosthetic materials from Jaipur India. The delay was mostly at the Procurement Office. This delay resulted in some disturbance to our clinics and functions of the prosthetic department.
d. High turn-over of specialised staff.
e. High caseloads of TB patient in Central/ Eastern division has put the team under pressure in terms of case follow up, reviews, late for clinic tracing, contact tracing, community visitation, etc.

Way forward

a. Timely procurement of prosthetic materials from India will not disrupt our Out-Reach programs and the overall functions of the prosthetic department.
b. Emergency equipment's and consumables could be available for better services.
c. Recruitment process to be fast tracked once a post becomes vacant.

6. Fiji Pharmaceutical and Biomedical Services Centre (FPBSC)

The Fiji Pharmaceutical & Biomedical Services Centre [FPBSC] main core services are:

a. Procurement and supply management [procuring, warehousing and distribution] of medical or health commodities.
b. Essential Medicines Authority – development of product standardization and appropriate usage.
c. Inspectorate Regulatory Authority – strengthening quality assurance process of products import into the country.
d. Bulk Purchase Scheme – commercial arm providing social support to the private sector.

These associate programs ensure that commodities procured by the government are safe to be used for the right purpose at the right place and at the right time.

Achievements

a) Standard 1, standard 2 and tracer product that is essential for laboratory and dental services provision was available at facility level.
b) Nil shut down of laboratory and dental services in any facility due to unavailability of laboratory reagents and Dental Prosthetic items.
c) Outbreak of diseases/ surge in positive cases of notifiable diseases was consistently followed up with facilities and proactive steps were taken to ensure continuous supply of related items.
d) Working in conjunction with donor organisations in planning process such as KOICA helping expend TB screening to 5 more labs in Fiji to increase service accessibility to public.
e) Successful implementation of the New CWM ICU equipment.
f) Enforcement of OH & S policy in the workplace and empowerment of committee.
g) Improvement in the availability of Tracer Products for Medicines at FPBS & Target Health Facilities.
h) Printing & Distributions of 4th Edition Essential Medicines List 2015
i) Advocating Antibiotic Week from 16th – 21st November 2015
j) Launching of the AMR National Action Plan 2015
k) Development/drafting of 6 Regulations for the Medicinal Products Decree 2011, and endorsement of 4 Regulations by the Fiji Medicinal Products Board.
l) Review of the Pharmaceutical Sector Strategic Plan.
m) Acquisition of the Drug Registration software through Australian Funding.

Challenges

a) Changes in testing policy such as implementation of revised Diabetes Management Guidelines laboratory testing criteria. Revised criteria are heavily dependent on regular blood testing for any suspected high glucose blood level individual. The poor and delayed communication of requirements to FPBS by specialised teams, outreach teams, public health screening programs for supplies requirements. In an effort to sustain all roles of MOHMS, such unplanned activities deplete stock levels faster than predicted leading to urgent purchases and over spending of allocation.
b) The noncompliance from end users to follow set guidelines to request for purchase of nonstandard items.
c) Poor supplier performance in relation to honouring lead times.
d) Internal challenges include lack of 'sense of urgency and responsibility' amongst staff members.
e) Very limited supervisory/audit visit opportunities to facilities were available in 2015.
f) Delays in finalizing contracts.
g) Systems and processes - causing delays in achievement of some activities.

Way Forward

a) Better and timely communication with all stakeholders, especially with special program managers.
b) Create awareness about role and processes of FPBS and what is the input required from end users.
c) Monitoring the end users and assisting them as required.

d) The need for further training in Quantification and management courses to upgrade capacity.
e) The need for Portable communication devices for efficient and effective response or communication.
f) Management to support the audit and training funding proposed.

Launch of Antibiotic week and National Antimicrobial (AMR) action plan

7. Divisional Report 2015

The Ministry of Health and Medical Services delivers health services throughout the four Divisions, Central, Eastern, Western and Northern. The Health services range from general and special outpatient, maternal child health care, oral health, pharmacy, laboratory, x-ray, physiotherapy, environmental, nutritional, outreach, school health and special clinical services.

Figure 2: Four Divisions within Fiji

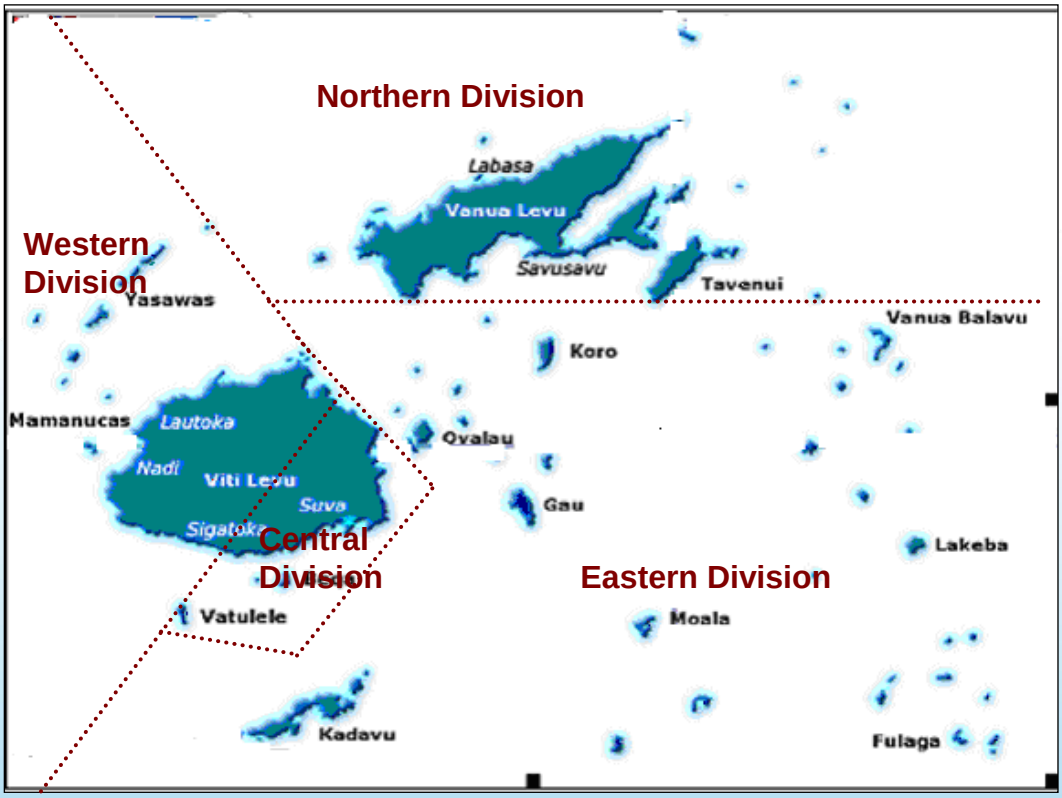


Table 4: Government Health Facilities

Health Facility	Central	Western	Northern	Eastern	Total
Specialized Hospitals/ National Referral	2	0	0	0	**2**
Divisional Hospital	1	1	1	0	**3**
Sub divisional Hospital [level 1]	0	3	1	0	**4**
Sub divisional Hospital [level 2]	5	3	2	5	**15**
Health Centre [level A]	7	4	1	0	**12**
Health Centre [level B]	2	4	3	1	**10**
Health Centre [level C]	12	20	16	14	**62**
Nursing Stations	21	25	21	31	**98**
Total	**50**	**60**	**45**	**51**	**206**

Central/Eastern Division

The population profile below are collated from the demographic counts that are received from the respective nursing zones, nursing stations and health centers.

The Central/Eastern division is the largest by population size and caters to about 100 health facilities. The total number of people in this division is 422,917 with the majority people residing in the Suva subdivision. The Central/ Eastern division is divided into 10 subdivisions as per table 4 below. The total population for the Central Division is 383,814 and the Eastern Division recorded 39,103.

Health services in the Central Division are delivered from 1 divisional hospital, 5 sub division hospitals (level 2), 21 health centres (7 level A, 2 level B, 12 level C), and 21 nursing stations.

Health services in the Eastern Division are delivered from 5 sub division hospitals (level 2), 15 health centres (1 level B, 14 level C), and 31 nursing stations.

Table 5: Demography of Central/Eastern Division

Subdivision	2014	2015
Suva	217,597	223,816
Rewa	84,872	88,361
Naitasiri	20,232	19,472
Serua/Namosi	29,588	30,587
Tailevu	22,384	21,578
Lomaiviti	16,187	16,187
Kadavu	10,946	10,978
Lomaloma	3,358	3,240
Lakeba	7,294	6,892
Rotuma	1,866	1,806
Total	**414,373**	**422,917**
Central (Total Population)	**374,673**	**383,814**
Eastern (Total Population)	**39,651**	**39,103**

In comparison to 2014 the total population for the Central division has increased by 9141 and Easter division saw a decrease of 548.

Western Division

The Western Division is divided into 6 sub division (Ra, Tavua, Ba, Lautoka/Yasawa, Nadi and Nadroga/Navosa) with a total population of 365,539. Health services are delivered from 1 divisional hospital, 6 sub division hospitals (3 level 1 and 3 level 2), 28 health centres (4 level A, 4 level B, 20 level C), and 25 nursing stations.

Table 6: Demography of Western Division

Subdivision	2014	2015
Ra	29,266	28,232
Tavua	26,376	26,551
Ba	56,143	56,450
Lautoka/Yasawa	132,385	110,733
Nadi	90,810	91,702
Nadroga/Navosa	52,730	51,871
Total	**387,710**	**365,539**

The total population for the Western division has decreased by 22,171 in comparison to 2014 which implies that the reporting of populations by the zones and divisions are not consistent and may not be valid.

Northern Division

The Northern Health Division office provides health services for 4 sub divisions of Bua, Cakaudrove, Macuata and Taveuni. Health services are delivered from 1 division hospital, 3 sub division hospitals (1 level 1 and 2 level 2), 20 health centres (1 level A, 3 level B, 16 level C) and 21 nursing stations.

Table 7: Demography of Northern Division

Subdivision	2014	2015
Bua	16,868	17,032
Cakaudrove	33,034	34,883
Macuata	64,439	66,699
Taveuni	16,649	16,668

Total	**130,990**	**135,282**

It is noted that the population size for the Northern division increased by 4,292 in 2015.

Table 8: Summary Population by Division

Division	2014	2015
Central	374,673	383,814
Eastern	39,651	39,103
Western	387,710	365,539
Northern	130,990	135,282
Total	**933,024**	**923,738**

Achievements

1) Expansion and strengthening of services.

a. Pilot program of Strengthening SOPD documentation and reporting.
b. NCD Task Force Committee established in the Central and Northern Division.
c. Revisiting 4 Health Promoting School setting, healthy workplace and community settings.
d. Strengthening home based care whereby 53 officers were trained on Motivational Interview.
e. Mental Health Gap training for 8 Medical officers and 15 Nurses.
f. Strengthening BPP/CRP training in the community.
g. Training of service providers on family planning package.
h. Divisional Quarterly supervisory visits conducted.
i. NCD screening target achieved in the Western Division.
j. Roll out of PEN Model in all SD Hospitals
k. Hosting of the Pacific Ministers Meeting at Yanuca Island for Review of the Healthy Island Setting.
l. Preparedness Plan for Ebola and other Emerging Diseases like Chikungunya and Zika Viruses in terms of Border Control especially at the International Airport in Nadi.
m. CD taskforce established in the Eastern Division.

2) Strengthening of Public/Private Partnerships.

a. "Dance for Health" at Shirley Park with an average of 35-40 participants 3 days per week.
b. Strengthening integration with key stakeholders MOEHA, MOY, private and public partners on service delivery for adolescent health.
c. Strengthening the implementation of oral health education in secondary schools advocating on the theme your smile matters.
d. Integrating involved stakeholders in reviewing of the current health care services.
e. Tobacco Free Settings for 3 Community Halls, 1 village and 1 City and Village was given award for the maintenance of Tobacco Free status for the past 20 years.
f. Active Hand Washing Program with donation of Anti-Bacterial Bodyguard Soap by Punjas Group of Companies to all Primary Schools in the West and Provision of Wash Stations in all Primary Schools in Ra subdivision.
g. Strengthening home based care in the central division

3) **Infrastructural improvements.**

a. Opening of Creche Room in Sigatoka Hospital.
b. Opening of the Extension of Sigatoka Hospital inclusive of the relocation of its Health Centre, Cuvu and Vatukarasa H/Cs in Sigatoka, Punjas H/C in Lautoka and Nagatagata N/S in Tavua and Nayau-i-ra in Ra SD.
c. New Capital Projects- Ba Hospital, Nasova Hospital in Keiyasi, re - location of Nacula H/C in Yasawa and the 2 new H/Cs in Votualevu and Korovuto.
d. Renovation of Lami Health Centre
e. Waivaka N/S refurbishment of clinic & new qtrs.
f. Extension of Birthing Unit- Makoi Health Centre

4) **Improvement in Services**

a. Trainings for 93% of MI- 139 staff, 67% FCT staff and PEN Model was completed and mop-up done for SOPD staff and MOs.
b. Implementation and monitoring of Learning and Training Development plan.
c. Foot Care Training and Attachments led to improved Amputation rates in the Western Division.
d. Multi- Disciplinary SOPD Services in all sub divisional Hospitals.
e. Mother Safe Hospital Initiative Audit with Sigatoka Hospital at 83% and Nadi Hospital at 93% which is the highest in the Nation.
f. Internal Assessment of Baby Friendly Hospital Initiative conducted with ratings of 83% for Nadi and 93% for Ra.
g. 80-100% HPV Coverage in the Western Division.
h. All Health Facilities are practising Integrated Management of Childhood Illnesses in the Western Division.
i. Water Safety Management Trainings and Development of Waste Care Management plans for SDs.
j. Motivational Interview Roll out Training, Foot Care Assessment Training facilitated through FHSSP and PEN Model Roll out Training completed for Central/Eastern Division.
k. 258% increase in Oral health coverage of students for secondary schools in the Central division.
l. A grand total of 90% of children between the classes 6-8 are dentally fit within the central division compare to 88% in 2014
m. 2 BFHI trainings at Rewa sub-division and 1 BFHI training at Korovou hospital conducted.
n. Community health worker Training for Central Division completed.
o. Training on foot care and NCD tool KIT facilitated in the Eastern Division.
p. Mother Safe Hospital Initiative implemented in all sub divisional hospitals.

Challenges

a. SOPD/ PEN Clinic- staff turn-over, limited space, designated nurses and MO, lack of manpower, consumables and teamwork.
b. Insufficient Budget to address planned activities.
c. Unfriendly Working Environment due to overcrowding, no staff rooms/ lockers, ventilation systems.
d. Lack of training opportunities.
e. Staff Morale and Attitude – lack of commitment/ motivation.
f. Limited space with no specific area for sterilization, storage and staff room in a few Dental Clinics in the Central division.

Opening of new nursing station Nayavu-I-Ra

8. Public Health Services

The Deputy Secretary Public Health is responsible for formulation of strategic public, primary health policies and oversees the implementation of public health programmes as legislated under the Public Health Act 2002. Effective primary health care services are delivered through the Divisional and Sub Division Hospitals and National Programs (Family Health, Wellness, Communicable Diseases, Food and Nutrition, Environmental Health, Oral Health and National Health Disaster and Emergency Management).

Wellness Centre

The Wellness Unit was established in February 2012 by the merging of Non Communicable Diseases (NCD) control unit and the Nation Centre for Health Promotion (NCHP).

Wellness unit is now rebranded **"Wellness Fiji – harvest the wellness in you"**.

All Fijians from conception to senior citizens have the potential to harvest wellness, as they sail throughout lifespan in settings.

The strategic objective for Wellness and NCD is to reduce premature deaths (deaths aged less than 60 years) due to non -communicable disease.

Achievements

a. "Tobacco Enforcement in Fiji" abstract was selected ahead of many other submissions from the Oceania at the Oceania Tobacco Control Conference (OTCC) in Perth, Australia.
b. World No Tobacco Day Award 2015 to MHMS by WHO.
c. Increased publicity for Physical Activity via newspaper, radio, Parliament, talk back, Breakfast show, TV and billboard.
d. 7 D Package (7 settings approach development process) presented and approved.
e. Publication of Global School-Based Health Survey (GSHS) results.
f. Established network and partnership with Five Religious Organisation.
g. Wellness Program conducted at 20 different sub-settings consisting of NCD Screening, Cervical Cancer Screening and TB Screening.
h. Implementation of wellness intervention programs in workplaces.

Mental Health

The Mental Health Unit core functions as stipulated in the Mental Health Decree 2010 in general involves:

- The coordination and promotion of the decentralisation of mental health services through the integration into primary health care and the general health care systems.
- The strengthening of existing community mental health services through the provision of training and adequate infrastructure and resources in the community.

Achievements

a. The pilot mHGap training for Lomaloma Community Health Workers in Vanuabalavu that was conducted with the assistance of WHO Funding and the MOH & Medical Services with the provisions of staffs to conduct training.
b. mHGap training for 26 staffs in Western Division on the 15th - 19th February.
c. Training in Psychological First Aid conducted in JJ's On the Park on Wednesday and Thursday (9/3/16-10/3/16) sponsored by WHO was attended by representatives from Empower Pacific and Red Cross, Fiji.
d. Screening of public with the assistance of the National Wellness Team as arranged with the National Wellness Centre.
e. Completion of documentation for the National Mental Health Endorsement Project with the Trade Mission of Taiwan is now to be submitted to Cabinet.
f. Minute to PS requesting rental of premises to allow Community Rehabilitations Outreach Program (CROP) to move to safe, suitable premises.

Way Forward

a) Training of Police Officers – this training was planned to be conducted with the police for the year 2015, this was not done therefore it has been deferred to year 2016 program.
b) Continuous training program on mHGap training for Public Health Nurses.

Family Health

The Programs functions are,

To manage, implement, monitor and evaluate programs pertaining to Reproductive Health, Maternal Health, Child Health and HIV/AIDS and Sexually Transmitted Infection.

Reproductive Health

Cervical Cancer Program (CECAP)

- The Cervical Cancer Program is known as the CECAP and is guided by the Cervical Cancer Screening Policy 2015.
- 70% of health facilities in the Cakaudrove Subdivision have trained staffs to conduct cervical cancer screening.
- 22 nurses have received training including maritime nurses – all health facility in Lautoka /Yasawa now have trained staffs who can conduct cervical screening ie 100 % coverage.
- 13 nurses nominated from health centers in the Central division attended the training.
- Tailevu Sub division – Thin Prep training on the 7th to 8th May, 2015.
- Refresher training on Thin Prep- Suva Sub- Division from 14th to 15th April for one group of Staffs and 16th and 17th for second group to cover the whole of Suva Sub- division.

Launch of Cervical Cancer Screening Policy and Cervical Screening and Cryotherapy training manual

Family Planning

- There were five trainings conducted at divisional and National level with the aim of up skilling health workers to be able to do proper counselling and provide modern methods of Family Planning (FP) at their stations.
- Eight Condom dispensers were installed in four Public Conveniences in the city of Suva, with the approval of the Suva City Council. Peer educators are tasked to refill these dispensers.

Maternal Health

Provides support to all Maternal and New-born Health Activities in Fiji, in the best possible way in order to achieve most of the Strategies as outlined in the Family Health Business Plan thus contributing to the reduction of Maternal morbidity and mortality in Fiji.

Achievements

- The first **'Violence against Women and Girls Clinical Guideline for Health care Workers in Fiji'** was launched on 5th December 2015.
- **Infection Control Manual for Maternity Services** was developed with the support from FHSSP; the manual was launched at CWM Hospital paediatric unit conference Room and rolled out with training.
- A **teenage pregnancy chart and hand held flyer** was successfully developed and printed with support from UNFPA, planned for distribution to all Health Facilities in 2016.
- **Mother Safe Hospital Initiative (MSHI)** - the 6 target facilities were audited twice a year with support from the Fiji Health Sector Support Program (FHSSP). Some facilities were audited once in the year. Generally all facilities have improved in comparison to 2014 audits.
- **Clinical Practice Guidelines (CPG)** - about 20 CPGs created by the NICU team this year and they are also looking at PICUs Clinical Practice Guideline.

Child Health

- **WHO Pocket book**- Seven (7) training were carried out with the main objective that at the end of the training, health workers will be up skilled in the Management of Common Childhood Illnesses focusing on the inpatient management of the major causes of childhood mortality.
- **Integrated Management of Childhood Illness**- One supervisory training conducted for the North, followed by three Facilitator training, and ten days basic training.
- **Paediatric Life Support**- Seven (7) trainings carried out. The main objective is that after each training, health workers are trained and equipped with the knowledge necessary for effective ways in managing emergencies in children. This will improve the outcome of serious illness and injuries in children where resources are limited, if the basic principles of resuscitation are adhered to.
- **Disability Management Support**- a speech Pathologist with extensive paediatric experience (Kat O Heir) was invited to Fiji to participate in a one week developmental clinic. She was joined by the other local doctors also carrying out workshops and lectures to nurses and doctors on child development, developmental milestones and intervention ideas; other specialists accompanying her provided lectures on cerebral palsy, child protection and genetics.
- **Paediatric Oncology Services** – Oncology communication material launched by the Honourable Minister for Health & Medical Services on the 19th of November, 2015.
- **Introduction of Inactivated Papilloma Virus Vaccination Program and EPI Training**. A National TOT was conducted in November; the 50 participants were mostly the DHS, SDHS, EPI focal people and MCH nurses. Following the National training, 29 follow up trainings was conducted in all the subdivisions in the month of December.

Expanded Programme of Immunization (EPI)

The EPI is a very important public health activity in Fiji. It is purported to improve child health and reduced child morbidity and mortality through vaccination. There have been many changes to EPI in the last year. These changes have occurred in programme delivery, the types and numbers of vaccines used, immunization schedule and how to care for and store vaccines.

The celebration of World Immunization Week together with the other Pacific Island Countries was a success. This was nationally launched at the Makoi health centre with the idea of strengthening communication as one of the strategies to improve attendance to MCH clinics.

The Post Introduction Evaluation (PIE) for new vaccines introduced in 2012, i.e. HPV, Pneumococcal vaccine and Rotavirus was carried out in September 7th – 18th, by two WHO consultants with our local team in the four Divisions,

the outcome were presented to NAFH and team from FHSSP. This PIE tool provides a systematic method for evaluating the impact of the introduction of a vaccine on the existing immunization system in Fiji. One of the main areas in particular that was identified was the impact of the Information Education materials (IEC) of the posters and brochures of each vaccine and how the Health Care Worker used these materials to communicate the benefits and value of the vaccines against the risks and the cost if the children were not vaccinated.

Fiji endorsed the Polio Endgame Strategic Plan (2013-2018) by supporting its efforts for global polio eradication. As outlined in the end game strategic plan, Fiji introduced one dose of Inactivated Polio Vaccine (IPV) in the routine immunization programs in December 2015, and will switch from tOPV to bOPV by 2016. The introduction of one dose of IPV will provide immunity against type 2 polioviruses and therefore mitigate the risks associated with potential type 2 vaccine derived poliovirus outbreaks following the global switch from tOPV to bOPV. This will also boost immunity against type 1 and 3 polio.

World Immunization Celebration

HIV/AIDS and Sexually Transmitted Infection

The Achievements for HIV/AIDS and Sexually Transmitted Infection Program were:

- **Policies and Guidelines**: The HIV Testing and Counselling Policy has been launched and ready for distribution to all HIV implementers as a guide for their VCCT services and also for the adoption of the new HIV Algorithm. This document was launched during the National Commemoration for World AIDS Day in Labasa [December, 2015].
- **National Strategic Plan**: 2015 saw the end of the 2012-2015 HIV & STI National Strategic Plan and the development of the 2016-2020 HIV & STI NSP. At the end of pocket consultations, trainings and stakeholders consultation and participation through the support of UNAIDS, WHO, UNICEF & SPC, a draft NSP is in place which will be submitted to the HIV/AIDS Board and also the Cabinet for endorsement on the 1st quarter of 2016.
- **New HIV Algorithm:** a project officer was recruited in the beginning of 2015 to coordinate and monitor the new HIV testing strategy in the divisional and sub divisional hospitals. 7 sites are currently conducting confirmatory HIV testing. 5 additional sites have been identified for 2016.
- **HIV Curative:** 4 new PIMA machines were procured through UNICEF for the 3 hub centers and Mataika House to assist clinicians in monitoring CD4 counts of PLHIVs. Training was conducted before the machines were used. Plans are in place for Mataika House to have a GenoExpert machine that will detect viral loads for PLHIV clients.
- **World AIDS Day:** the celebration for WAD was a success throughout Fiji. The National event was held in Labasa and other build up events in other parts of Fiji including Suva. The next national event [2016] is planned for the Western Division.

- **Capacity Building:** 4 clinicians were sent abroad through the support of the HIV/AIDS Board, UNICEF & OSSHHM for training in the following areas:
  a) HIV Spectrum Workshop [1 - Bangkok]
  b) HIV Clinical Management [2 - Mendi, PNG]
  c) HIV & Adolescent Health [1 - Bangkok]

  Local Trainings were conducted which included the following:
  a) VCCT Training
  b) PPTCT Training
  c) HIV Prescribers Training
  d) STI Syndromic Management Training

Launch of the HIV Testing & Counselling Policy during the WAD Celebration in Labasa

Way forward

- Strengthen data collation and reporting process from sub divisional and divisional level.
- Strengthen networking with hub centers to improve coordination and facilitation of HIV activities.
- The Neonatal Resuscitation Program provider course should be made a requirement for all midwives currently working in Divisional and subdivision Hospitals and should be included in nursing curriculum as a requirement for license.
- Internal allocation within Ministry of Health and Medical services is required for Reproductive and Maternal Health Program, noting that most of the trainings and program activities done by FHSSP will be handed over to the Ministry in 2016.
- Vacant positions to be filled to ease workload for the Hub teams. Divisional activities which were coordinated and facilitated by the Divisional HIV Project Officers were either delayed or not implemented because of the absence of the appropriate officers.

Communicable Diseases (CD)

The core responsibilities of Communicable Disease program are:

a. To assist and advice in the formulation of relevant national plans, policies, guidelines and protocols for the control of communicable diseases of priority to the Ministry of Health and Medical Services and PPHSN.
b. To establish and maintain an effective surveillance system for CDs of priority to Fiji and the Pacific Public Health Surveillance Network (PPHSN).
c. To provide high quality reference laboratory services for the diagnosis of priority CDs to Fiji and PPHSN.
d. To conduct, support and advise on the investigation of a communicable disease outbreak and the consequent response, monitoring and evaluation activity.

e. To assist and advice in the ongoing dissemination of information to the general public and also health care providers on communicable diseases and how to prevent them.
f. To develop, support and sustain communication networks with key stakeholders on communicable disease prevention and control.
g. Through NTCOPD secretariat functions, coordinate CD control activities amongst internal and external collaborating partners.
h. To provide consultation services on communicable disease issues from a community health perspective.
i. To assist and advice in the facilitation of training in CD surveillance, data management, outbreak investigation and control, for the health division.
j. To conduct operational research on communicable disease prevention and control.
k. To provide outpatient care and domiciliary support services for lymphatic filariasis patients.

Achievements

National Public Health Laboratory

- Timely reporting of CD results was achieved which assisted clinicians response to the particular CD.
- NPHL was able to support the sub divisional and Divisional laboratories in confirming the screening test results.
- PPHSN network enabled NPHL to assist few PICT in confirming there laboratory samples which was referred for testing and confirmation.
- Ebola suspected case was referred to VIDRL and the result was communicated within 24 hours from the reference lab.

NIC

- On-going SARI surveillance in ICU CWMH. Implementation of Assays for Influenza H7, H3 variant, and Flu B lineage typing and Mers-CoV and validation of assay by Dr Patrick Reading - WHOCC Melbourne. Ordering of reagents from IRR CDC. Participate in External Quality Assurance Program from Hong Kong and CDC. Revision of Influenza Testing SOP and revision of Flu Testing Algorithm.
- Acquiring new -80deg freezer through WHO for flu.
- IB VPD Surveillance – Routine testing of CSF by RT-PCR
- Assisting the typhoid research on environmental testing for S.Typhi on soil samples (first ever to be done)
- Attended training on Dengue serotyping in ILM Tahiti.
- Certification for Transport of Infectious Substances conducted by WHO. Assist with referral of samples to ILM.
- Actively assist in the Laboratory Quality Management System through formulation of policies and SOPs.

HIV

- All the three Divisional Hospital Laboratories including the selected assessed sub-divisional laboratories are fully competent and capacitated to effectively and efficiently conduct HIV confirmation using the New Rapid HIV confirmatory testing algorithm.

Rotavirus

- A batch with the total of 160+ samples was sent to MCRI in November. Also the laboratory has participated in proficiency testing program in which samples were tested and results were submitted to CDC Atlanta on 25/11/2015.
- Proficiency Test Results: 100%.

Water

- In the progress of writing a concept paper to introduce new technique in water testing.
- Liaising with RCPA in enrolling into external quality control program.

Vaccine Preventable Disease

- A successful review from WPRO of the Invasive Bacterial Vaccine Preventable Disease (IB-VPD) and Rotavirus (RV) Surveillance Systems.
- Invitation from WHO to join the Global Surveillance Network for Invasive Bacterial Vaccine Preventable Disease (IB-VPD).

- Establishing the molecular meningitis surveillance system with qPCR testing at FCCDC which has provided results on the common causes of meningitis in children in Fiji and identified an increase in Meningococcal cases.
- Serotyping of pneumococcal isolates at the reference laboratory to monitor the impact of PCV10 on pneumococcal strains causing disease.
- Maintaining the RV surveillance and having data for the evaluations of the RV vaccine.

Surveillance Unit

- Divisional Outbreak Response Team (DORT) Training completed in all 3 divisions.
- Leptospirosis, Typhoid and Dengue updates provided regularly.
- NTCOPD and Technical Working Group (Clinical, Prevention and Control, Communication, and Surveillance meetings).

Challenges:

- The NTD plan, including disease-specific implementation plans, has been facing numerous challenges through the years. The foremost challenge is ensuring financial allocations are available to carry-out activities. Whilst the LF and dengue program have government budget allocations, the other projects (STH, trachoma, and scabies) and program (leprosy) relies on CD and Twomey hospital funding to carry-out its activities, and in most cases donor funds are usually applied.
- Secondly, the program is currently not established within the health systems which provide a workload on the current project officer. This shortage is also seen within its programs which in turn results in lack of or poorly available surveillance and monitoring information.
- To have an establishment for the NTD program will enable availability of accurate information thus timely delivery of activities in the plan which in turn enables the country to fulfil its goal of eliminating and maintaining elimination levels for target diseases.
- Sentinel sites not able to send 5 samples per week per site as required by NIC for routine flu surveillance.
- Dengue serotyping not implemented and validated due to the above issue and therefore deferment till 2016 by Consultant for validation.
- Regular communication and HIV reporting needs to happen and enhanced progressively driven by the supervisors of the HIV surveillance network.
- PICT samples are also referred for further testing at NPHL for Rotavirus but due to poor communication within regional Lab there is a delay of samples received for further testing.
- Manual registration and electronic mailing of results consumes a lot of time in releasing results to the specific sites.
- More coordination is needed with the Environmental health team in receiving water sample for testing.
- Without a Vaccine Preventable Disease Surveillance Officer the work was supported by a partner project, the New Vaccine Evaluation Project which is due to end in June 2016.
- Establishment of a surveillance unit into the MoHMS and the turnover of CD Surveillance officer position results in interruption of implementation of activities.

Way forward

- More awareness on flu sampling through site visitation and timely reporting to sites
- On-going training on molecular testing.
- Reporting pathways and archiving of HIV testing information must be well established, clear and protocols adhered to so that it assures the confidentiality of HIV cases at all testing sites.
- Frequent communication with the Lab focal person on the proper sample collection and referral to NPHL for testing.
- Scheduling site visits to enhance the program assuring that standard protocols in place is adhered during all phases sample collection.
- Need to establish a National Vaccine Preventable Disease Surveillance Unit, led by MoHMS staff.
- Retain staff trained in VPD surveillance
- Submit proposal paper to NHEC for establishment of a Surveillance Unit.
- Better collaboration with divisional and sub-divisional team in completing surveillance activities.

Launch of MDA campaign 2015

Environmental Health (EH)

The Environmental department is responsible for:

a. Pollution control to ensure developments are carried out in sustainable manner without compromising the essential natural ecological processes of the environment.
b. The enforcement of the food laws to protect the consumers against unsafe, impure and fraudulently presented food by prohibiting the sale of food not of the nature, substance or quality demanded by the purchaser.
c. Emphasize the monitoring and improving sanitary conditions for populations in urban and rural areas.
d. Monitoring and controlling the agents of vector- borne diseases.
e. Monitor international travellers and cargoes via aircraft and vessels.
f. Community awareness programs to increase the people's capacity in understanding existing environmental risks and mitigation measures.
g. Ensure building plans are in compliance with standards prescribed under the appropriate building legislation prior to approval. It is also mandatory that EHO's conduct progressive inspections at critical stages of every approved building that is under construction.

Environmental Health encompasses all measures necessary to deal with issues such as environmental degradation and climate change, hazards including contaminated food and water, chemical exposure, and it also provided the opportunities to enhance health by planning for improved health outcomes and work towards health promoting environment.

The following legislation governs the EH department's responsibilities:

Public Health Act (Cap 111)
Food Safety Act 2003
Food Safety Regulation 2009
Quarantine Act (Cap 116)
Town and Country Planning Act (Cap 139)
Sub-Division of Land Act (Cap 125)
Burial and Cremation Act (Cap 117)
Tobacco Control Decree 2010
Tobacco Control Regulation 2012
Litter Decree 2009

Achievements

a) 626 import permits were issued to approve Food Business Operator (FBO) for importing perishable, non-perishable, frozen and other food products into the country. The food program managed to process and issue 5264 health license for both new and renewals for the year 2015.

b) A total of 237 community trainings were conducted in all divisions to promote healthy lifestyle and living condition. Tobacco free setting initiatives were also introduced in 24 rural communities. 6 were reported in the West, 7 in the Central, 8 in the North and 3 in the East.
c) In the year 2015, 11,937 vessels were cleared through the quarantine services. 5103 of the vessels cleared were aircrafts and the remaining 6834 were ships.
d) In total, 91 land developments were completed and Completion Certificate (CC) was issued.
e) Healthcare Waste Management Plans (HWMP) were developed and submitted by the 3 major hospitals. A generic HWMP was also developed and established as a guide for the 17 sub-divisional hospitals.
f) 6 major capacity building training was conducted for food and water safety.

Challenges

1. Insufficient manpower resources to provide maximum coverage of EH works in local populations given the growing effect of environmental degradation and health impact from uncontrolled and lack of monitoring of developments.
2. Lack of equipment's and non- availability of full time transport for EH stations lead to hindrance in services provided by EH.
3. Inconsistent reporting system and EH data management.
4. High costs of laboratory tests for pollution surveillance and food adulteration testing.

Way Forward

1. Provision of full time transport for each sub divisional health office.
2. Review current EH organizational structure and role to identify and address existing manpower needs.
3. Procurement of field kits for rapid air, soil and water pollution assessment.
4. Procure electronic data collection and analysis system similar to AKVOFLOW currently used by EHO's during disaster impact assessment for WASSH facilities.
5. Strengthen prosecution capacity through appropriate training of staffs in collaboration with SG's office local training program.
6. Increase of EH Food and Water quality assessment budgetary allocation to adequately cater for specific tests such as heavy metals etc.
7. Upgrading of Mataika Laboratory to become a certified reference laboratory for chemical and bacteriological testing facility.

Dietetics and Nutrition

Dietetics and Nutrition Unit is responsible for all aspects of Hospital Dietetics and Public Health Nutrition Services. It facilitates, coordinates and monitors at national level comprehensive preventive nutrition and curative Dietetics Services programs for the promotion and maintenance of good nutritional health of the population.

The nutritional wellbeing of a population is a critical indicator of national development. Fiji is beset with serious but preventable nutrition-related diseases such as diabetes, coronary heart disease, high blood pressure, obesity, anaemia and malnutrition in children. These preventable conditions burden the economy with excessive medical costs in relative as well as absolute dollar terms. Generally a healthy, well-nourished and educated population provides the best foundation for promoting national economic growth.

Dieticians have always been an essential component of the health team, complementing medical treatment with the provision of appropriate nutritional care to improve health status and lifestyles. Dieticians have taken challenges in planning, implementing, and monitoring, evaluating nutrition related intervention programs. Dieticians have also had challenges in projects that promote nutrition and wellness which have made the community and the government aware of the demands for better nutrition at all levels to improve quality of life for the people of Fiji.

Achievements:

a) Breastfeeding Week was celebrated at various subdivisions.
b) BFHI Internal Assessments for the Western Division was completed throughout the 6 subdivisions from October-November.

c) Nutrition Month activities were conducted at various subdivisions with the focus on the Act Against Anaemia campaign.
d) Khana Kakana Recipe book was awarded 2nd Place at the International Gourmet Cookbook Award. Locally - overwhelming positive request for the cookbook.
e) Hospital Equipment procurement is needed for the equipment to effectively facilitate daily food service operations.
f) Meal Satisfaction Surveys was conducted in various institutions.
g) SSF awareness programs was implemented through the various divisions.

Challenges

a) Supplementation Program needs to conduct end point evaluation of NIMS program, considering the recommendations in the Mid Term Evaluation Report (2013) and re-strategize with more thorough planning.
b) Wellness Unit – nutritional component of the Wellness Packages is currently under the NIMS PO. Staffing needs to be addressed to ensure effective implementation of both programs.
c) Reporting templates – difficult to ascertain correct coverage and reach of programs.
d) Dieticians' Toolkits is underutilised due to unavailability of consumables.
e) Inadequate clinical staff - Clinical CWM Ward Coverage per quarter - 1st Quarter - 45%; 2nd Quarter - 43.5%; 3rd Quarter - 42%; 4th Quarter - 38%; SOPD – 5% : (Bed State 450+, Dieticians – 10 – covering clinical and food service responsibilities), Western Subdivisional Hospitals - Total NCD cases admitted- 2059, Coverage by Dieticians - 47%.

Way forward

a) Reporting Format – standardization of reports for more effective compilation.
b) Align under 5 Nutritional status classification as per WHO classifications to improve detection and management of malnutrition cases.

c) Development and marketing of nutritional packages.
d) Development of auditing tool for various nutritional packages.
e) Conduct impact studies to assess interventions.
f) Capacity building - More opportunities for overseas and short term training attachments.
g) To increase establishments of dieticians to adequately cover all 3 cores of Dietetics and Nutrition – Clinical, Food Service Administration and Public Health Nutrition.
h) Clinical protocols – finalisation and endorsements by various CSNs.

National Food and Nutrition Centre

The NFNC is tasked with 4 main responsibilities:

1) Monitor the food and nutrition situation in the country through field surveys and assessment of the national food supply.
2) Advise Government (and other stakeholders) on the food and nutrition situation and formulate evidence-based policy and programmes to improve the nutritional status of the people of Fiji.
3) Coordinate and review nutrition programmes/projects and the Fiji Plan of Action for Nutrition (FPAN), which aims to combat nutrition-related diseases affecting the population.
4) Educate the population about adequate diet and nutrition.

Achievements

a) Completed all field work and data collection for the National Nutrition Survey(NNS).
b) Completed and validated all data entries for all NNS Questionnaires.
c) In-house presentation of basic NNS Preliminary Results.
d) Completed consultations and amendments for Policy papers and regulations.
e) Vacancies filled and staff needs met.
f) Requirements for Integration submitted.
g) Works on logistics for Govnet access commenced.
h) National calendar events and SSF Strategies coordinated and technical reports submitted.
i) Completed IYCF recipe testing and amendments made.
j) Nutrition component (Fruit and Vegetable Campaign) of HPS Initiatives coordinated and report submitted.
k) Quarterly prepositioning of all IEC materials to the Divisions.
l) Participation in technical meetings and plenary sessions with internal and external stakeholders, and submission of technical papers and reports.

Challenges

a) Unplanned activities due to ad hoc requests for nutrition services meant impeding planned activities.
b) Financial constraints for staff recruitment for NNS data entry during the year, purchase of appropriate equipment and furniture.
c) Staff overseeing more than 1 position and shared workloads.
d) Some activities are co-facilitated with the divisions and other ministries; delays and lack of support from them results on non-achievement of outputs.
e) Inconsistent supply of seeds and seedlings, poor monitoring and sustainability of hospital gardens
f) Activities not fully undertaken due to limitations of infrastructure.
g) Poor staff attendance to PA sessions and non-completion of Diet and PA Worksheet.
h) Networking with external stakeholders.

Way forward

a) Strengthen and improve networking with internal and external stakeholders and within government ministries to allow for successful implementation of food and nutrition programs within set timelines.
b) Strengthen M & E components of all food and nutrition activities and programs.

c) Funds to be secured first before conducting surveys to ensure achievement of targets within planned timelines.
d) Increase operational budget to meet the service needs of the Centre.

Oral Health

A healthy mouth and good oral hygiene is necessary for the health and wellbeing of each and every individual. This concept is at the centre of the oral health service delivery and oral health promotion for our citizens.

The Department of Oral Health is very proud of its achievement in their Business Plan with a successful implementation rate of 74%. In terms of service utilization, there were slight variations between 2014 and 2015 patient attendances, revenue collected, conservative restorations, extractions and the provision of prosthetic services. In addition to the high volume of services provided, the staff also had many opportunities for capacity building through Continuing Professional Development (CPD) sessions. The strong partnership with corporate bodies and service and religious organizations has resulted in more services provided for the underprivileged and at risk members of society.

There were several memorable achievements in the dental services; the most exciting being the addition of 40 new posts to the dental cadre in 2015, this allowed for more services to be provided and more senior posts to be created for long serving and deserving officers who have more responsibility, knowledge and skills.

Continuing Professional Development (CPD) sessions increased in numbers and quality, resulting in a more knowledgeable and informed workforce. We continue to strengthen our partnerships with service, religious and corporate stakeholders to promote oral health in all sectors of the communities.

Oral Surgery services in Fiji achieved a memorable and proud moment in history with our first two local dental officers graduating with a Diploma in Oral Surgery from the Fiji National University during the year. These dental officers are now able to provide a more extensive range of oral surgeries (cancers, trauma and other oral pathologies) locally rather than referring them overseas for treatment.

Taking prosthetic services (dentures) to the elderly in rural and maritime areas has seen a larger number of our senior citizens achieving a better quality of life through better smiles and restored nutrition.

The inclusion of secondary school children in our school program has seen the introduction of oral health promotion and tooth brushing after lunch for our adolescent population attending schools. We hope to eventually visit all secondary schools annually to decrease the burden of dental caries in our young adult population and reduce tooth lose.

To round off our achievements for 2015, we are indeed proud to have revised our 2006 policy and developed our National Oral Health Policy 2015.

The major challenge faced in delivering oral health services during the year has been the chronic shortage of staff; this caused a decline in curative services in the clinics and also decreased school coverage and outreach programs. Despite the addition of 40 new posts to the dental cadre, we were still not able to fill all the posts because there were not enough graduates to take up the posts. Service provision is always challenged and adversely affected by shortages in dental consumables / materials and machines and equipment breakdown.

We will vigorously pursue discussions with the Fiji National University to ensure that training numbers and quality of both under and post graduate training is aligned to the human resources for health needs of the country. The results of the pending 2011 National Oral Health Survey must be published and also plans developed for the next survey to be carried out in 2017.

It is anticipated that work will progress towards a more streamlined and inclusive oral health information in line with the ministry's central repositories and data collection and reporting processes.

The Oral Health (CSN) Clinical Service Network will focus their attention on clinical specialities to strengthen tertiary level of curative dental services.

We eagerly await the other 119 Cabinet Approved posts to be added to our establishment to enable us to provide better coverage of services and cater to the increased demands by the public for more services and tertiary level rehabilitation.

Table 9: Dental Statistics

	2014	2015	Change 2014 - 2015	
Attendances	298,458	297,542	916	↓0.3%
Revenue Collected	$606,383.39	$ 593,292.37	$13,091.02	↓2%
Conservative Treatment	57,979	58,126	147	↑0.3%
Prosthetics	3,593	3,751	158	↑4.2%
Extractions & Oral Surgery	102,638	104,851	2,213	↑2.1 %
Preventive Procedures	114,068	95,675	18,393	↓19%
School Services	139,865	106,253	33,612	↓32%
Outreach Programs Attendances	41,845	39,835	2010	↓5%

National Health Emergency & Disaster Management Unit

The National Health Emergency and Disaster Management Unit (NHED MU) was formally created in 2012 with the establishment of a permanent coordinator based at the Ministry's HQ. The Unit is aligned to the Public Health programs and reports to the Deputy Secretary Public Health.

The Unit's objectives are,

1. To strengthen and establish the MoHMS Emergency responses and build capacities and effective disaster response at all levels of health service delivery.
2. Establish and reinforce emergency health coordination including rapid health assessments.
3. Provision of technical and normative support to National Authority, UN agencies, NGOs for public interventions.
4. Define emergency health policy and program priorities in a structured manner.
5. Assist in the establishment and maintenance of health and nutritional surveillance, producing health intelligence and managing information for health advocacy.

Achievements

- Fiji's first ever Medical Deployment to the Pacific Region on 23rd March 2015.
- Distributed the HEADMAP and SOP 2013-2017 to 4 Divisions including partners – UNICEF/ WHO/SPC/NDMO.
- National Disaster Awareness Week celebrated in the month of October.

Challenges

- No specific budget allocated to the National Health Emergency & Disaster Program.
- The Unit is in its teething stages as it is manned by one officer.
- Integration of Disaster Risk Management into health programs and activities is a challenge.

Way forward

- The special funding for NHED MU needs to be provided. The unit cannot continue to rely on external (donor) funding and cannot utilize Public Health program Funds for its activities.
- It is envisioned that the long term target (10 to 15 years) would be to establish divisional level officers who are solely tasked to look after disaster management within their respective divisions.
- Increased awareness on Disaster Management at all levels and the need to have a risk based approach rather than event focused has been the norm over the years.
- There is a dire need for better coordination and support from the DMO's.

9. Administration and Finance

The role of Human Resources mirrors the vision, mission and values of the Ministry of Health and Medical Services in providing responsiveness and effective financial, human resource and training services to the Ministry staff to provide goods and services. These staffs are internal clients and the "produce" of this ministry that supports its effective function to provide quality health care services and promote wellness to all people of Fiji.

The Division is led by the Director Human Resource who reports to the Permanent Secretary for Health and Medical Services through the Deputy Secretary Admin & Finance for the development, implementation and monitoring of policies and guidelines in relations to Human Resource Management.

Training Unit

The Unit's objectives is to act as a central and initial point of reference in relation to all training activity conducted or proposed for delivery to MoHMS staff; to maintain a Master Training Plan that reflects outcomes of Training Needs Analysis in collaboration with recommendation of Divisional and Individual Learning and Development Plans and matches against the training that is provided by internal partners (including the PSHMS) and external donor bodies or Universities (including FNU, USP) and to manage and administer In-Service Training [IST] and Overseas Attachments for MoHMS Personnel including:

a) Compilation of Bond forms for MoHMS sponsored students,
b) Ensure payment of Tuition Fees for MoHMS sponsored students,
c) Facilitate overseas attachment arrangements for health workforce,
d) Facilitate participation of staff in PSC Scheduled training courses,
e) In-house training on HRIS to facilitate effective monitoring of workforce.

In 2015, the Ministry of Health and Medical Services, Training and Development Unit administered In Service Training to 98 officers at Local Institutions for Tertiary level programs. The unit further arranged logistics for 213 officers who attended short workshops overseas. In order to strengthen Human Resources Management the unit conducted 5 In House Workshops (mainly on FICAC Awareness) and facilitated 81 officers to attend 16 PSC Training.

The unit also provided Secretariat support to the National Training Committee which had 12 meetings and deliberated over 140 requests.

Personnel Unit

The functional role of the Personnel Team is to provide sound policy advice to the Director Human Resources. Sound policy advice are sourced from the 2013 Constitution of the Republic of Fiji, relevant Acts, 1999 PSC Regulations, 2011 General Orders [GO], PSC and Internal Circulars and Memorandums and other instructions that may be issued from time to time.

The Unit monitors and direct:

(a) Terms and Conditions of service - interpretation, clarification, compliance and changes. All Leave [Annual, Long Service, Sick, Bereavement, Maternity, Military, Sporting, Leave without Pay & Secondment & Long Service Leave Allowance]. Although Leave under the GO is deemed to be the right of officers, this is granted at fair and reasonable discretion of a supervisor.
(b) Late Arrival & Absenteeism Return & Salary forfeiture.
(c) Attrition – Retirement, Resignation, Death.
(d) Transfer/Posting – relevant allowances.
(e) Salary review & upgrading.
(f) Volunteers and attachees.
(g) Annual Performance Assessment [APA]
(h) Position Description [PD] & Individual Work Plans [IWP]

Table 10: Personnel Activities 2015

	Activity	Medical Officer	Nursing	Dental Cadre	Pharmacist	Allied Health Workers	Corporate Services	Government Wage Earners [GWE]	Total
1	Retirement	6	12	3	-	3	5	26	**55**
2	Resignation	32	84	8	11	18	6	48	**207**
3	Deceased	-	8			7	5	7	**27**
4	Deemed Resignation	-	13	3	1	1	3	12	**33**
5	Contract expired	1	-	-	-	1			**2**
6	Retirement on Medical ground	-	2	-	-	-	3	6	**11**
7	Leave Abroad	All Cadre							**408**
8	Leave Without Pay [LWOP]	All Cadre							**115**
9	Leave Allowance	All Cadre							**90**
10	Leave Compensation	All Cadre							**15**
11	Secondment	All Cadre							**110**
12	Forfeiture of salary	All Cadre							**510**
13	Posting & Transfer	All Cadre							**622**
14	Volunteers & Attachees	All Cadre							**92**
15	Salary Upgrade/Revision	All Cadre							**36**

Industrial Relations

The industrial Relations deal with the following issues:

a) Disciplinary cases in view of conduct and behaviour of the workers.
b) Grievances brought by officers in view of their supervisors.
c) Occupational, Health & Safety.
d) Ensure that all health facilities that have twenty or more workers are registered as per HASAW Act 1996 section.
e) The compliance of the HASAW Act 1996 and the 6 legal notices.
f) Workmen's Compensation.
g) Ensure that Laws of Fiji Cap 94 on Workmen's Compensation is adhered.

In 2015 there were 102 cases tabled before the National Disciplinary Committee. An increase of 6 more cases from 2014.

Post Processing Unit (PPU)

The Unit's role includes,

a) Management of all areas for recruitment.
b) Vacancy Processing.
c) Provide support and training of Divisional and Subdivisional HR staff to fully utilise the HRIS as a daily operational tool to monitor, manage and report on the workforce in an efficient manner.
d) Follow guidelines and requirements set out by the Fiji Public Service Recruitment and Promotion Policy, and State Service Decrees particularly the following principles.
e) Government policies should be carried out effectively and efficiently with due economy.
f) Appointments and promotions should be on the basis on merit & equal opportunity

Table 11: Post Processing Activities 2015

	Activity	Total
1	NSB Submission	619
2	Contract Renewed	689
3	Advertised and processed vacancy	163
4	Employments including interns	376
5	Re-engaged Officers	48
6	Project Officers appointed/appointments renewed	88

Table 12: MoHMS Staff Establishment 2015

Cadres	Approved	No Filled	Vacant
Medical [MD01-MD06]	747	504	243
Medical Assistant	6	3	3
Nursing [NU01-NU06]	2,621	2,476	145
Orderlies	58	48	10
Dental Officers	64	50	14
Para-Dental	177	119	58
Laboratory	177	158	19
Radiographers	75	55	20
Lab/X-Ray Assistant	21	21	0
Physiotherapist	46	26	20
Dieticians	79	69	10
Pharmacists	95	65	30
Environmental Health	124	111	13
Administrative Staff	182	153	29
Secretary/Typist	46	34	12
Statistician	13	13	0
Information Technology Staff	9	7	2
Stores Officer	32	28	4
Upper Salaried Staff	19	13	6
Bio-Medical Staff	23	17	6
Other Classifications	34	30	4
Established Staff Total	4672	4017	655
GWE Staff Total	1190	1083	107
OVERALL TOTAL	**5862**	**5100**	**762**

Workforce Planning

The Workforce Development Unit facilitates and coordinates the development, implementation and review of MoHMS Annual Strategic Workforce Planning process in collaboration with all other units of the Corporate Services Division. The primary aim of the Workforce Planning process is for Ministry of Health & Medical Services to achieve best workforce outcome to train, recruit, retain and advance critical skills, roles and support the Ministry of Health & Medical Services staff to provide and deliver quality health services to the citizens of Fiji.

Achievements:

a) Completion of the 2015 Employee Satisfaction Survey Report for 2016 Strategic Workforce Plan.
b) Completion of the 2015 MoHMS Succession Plan Report for 2016 Strategic Workforce Plan
c) Completion of the Workforce Survey (WS) Report for 2016 Strategic Workforce Plan.
d) Completion and endorsement of the 2015 Strategic Workforce Plan with all related attachments Succession Plan and Learning & Development Plan.
e) Consolidation of the Final draft of the Human Resource for Health (HRH) Manual and it's submission to NHEC for endorsement. Although the document has not been fully endorsed, the completion of the national consultation through the divisions and completion of the draft submitted for NHEC endorsement within specified time was a great achievement.
f) Revision, endorsement and implementation of the following Strategic Workforce Planning templates:
    - Employee Satisfaction Survey
    - Training Needs Analysis Surveys
    - Strategic Workforce Plan
g) Completion of the revised Annual Performance Assessment (APA) for Ministry of Health & Medical Services which incorporates the Technical and Clinical Competencies.
h) Completion and submission of the following Units WISN Report:
    - Executive Support Unit
    - Mental Health Unit
    - National Vaccine Preventable Surveillance Project
    - Typist Position – St. Giles Hospital
i) Conduct of (Human Resource Information System (HRIS) Online Training and roll out of HRIS to divisional and major hospital facilities.

The Planning Process that started in January 2013 is proposed to continue until December, 2017 [5 years Plan].

Human Resource Information System

Achievements

- Leave data and other backlog of data entry completed under various modules in HRIS online system.
- Annual Performance Assessment module has been implemented in HRIS online where APA ratings are updated in the system.
- HRIS Online User Guide developed and printed in April 2015 and distributed to users during training in the Divisions and at Head Quarters.
- HRIS Online awareness was conducted in all Divisions in May, 2015 during HRH Workforce National Workshop Series.
- Revised Performance Appraisal Template was made available to users through HRIS Online system.
- HRIS Online system was implemented at Divisional and Sub Divisional level.

Finance

The role of the accounts team is to monitor that goods and services are efficiently delivered on time as per the budgetary provision.

The Unit's objectives include,

a) Ensure equitable budgetary distribution to the Divisions and Sub-divisions.
b) Proper management of budget allocation which is fundamental to ensuring value for money in delivering services to the public as well as having cost effective internal controls within the purchasing and payments system. This plays an important role to ensure that wastage of funds, over expenditure, misuse and corruption does not happen.
c) Ensure Internal Control measures are in place, maintained and identified areas for improvements where appropriate and recommendations designed to assist the Ministry in order to improve the system and compliance with the Finance regulation.
d) Effective utilisation of the Financial Management Information System (FMIS).
e) To establish the Internal Audit team and processes at HQ, to cover areas in 3 main source of information:

I. Examination of evidence on payments etc. - supporting the payments to ensure that the Finance manual and other related regulation, process and procedures are complied with.
II. Review work performance and identify necessary changes to strengthen the unit's performance.
III. Interviewing personnel in order to confirm the functions and gain a holistic understanding of the procedures and control of the system and identify general responsibilities and roles of individual within the system.
IV. Having a job description for each position.

Achievements

- Budget preparation with the decentralization of the 2016 budget at cost centre.
- Opening up drawings account for Northern division.
- Budget increase for the Ministry for 2016.
- Minimizing customer complaints on payments.
- Managed to get Sahyadri trust fund on FMIS.
- Resolved Bulk Purchase Scheme – TMA trust issue from AFS.
- Improvement in revenue collection.

Asset Management Unit (AMU)

The Asset Management Unit looks after the management of non-technical physical assets for the Ministry of Health and Medical Services from Procurement right through to the writing-off and disposal of assets.

Key stakeholders AMU works closely with include Ministry of Finance (Fiji Procurement Office), Ministry of Works, Transport & Public Utilities, Ministry of Lands and Ministry of Industry & Trade.

Key Responsibilities include:

a) The AMU documents, registers, archives and monitoring of the physical assets of the Ministry nationwide.
b) Ensure that the acquisition of each physical asset is recorded with all relevant details in the fixed asset register.
c) Carry out Board of Survey procedures and inspections of assets on a regular basis.
d) Management of Quarters Issues
e) Management of Fleet
f) Infrastructure Maintenance Plan and Procurement Planning

Achievements

- Construction of New Ba Hospital project commenced.
- Construction of Makoi Maternity Unit commenced.
- Civil Works for New Naulu HC commenced.
- Major Maintenance works at Labasa Hospital, St Giles Hospital, Rakiraki SDH, Tavua SDH & Ba HC commenced.
- Medical Gas Reticulation Upgrade at Rakiraki SDH completed.
- Commissioning of New Suction Machine at CWMH.
- Completed maintenance of various other Health Centres and Nursing Stations.
- New Cardiac Ambulance launched for CWMH.

10. Health Information Research and Analysis Division

The Health Information, Research and Analysis Division is responsible for providing policy advice and management support to the Permanent Secretary for Health and Medical Services on the utilization of health data and information, health research and analysis; management and development of information and communication technology for the implementation of National Health Services Policies and Plan to ensure effective provision of health services throughout Fiji through an established monitoring and evaluation framework.

The Division also assists the Corporate Services Division in management of Information Systems relating to Asset, Finance and Human Resource Management; Public Health Division in disease surveillance and disaster management; Health System Standards; and other operational divisions in maintaining standards, monitoring and evaluation of health services; It plays a vital role in the compilation and analysis of health statistics and epidemiological data and management of the information system (software) and also purchase and maintenance of computer hardware. It also manages the entire computer network infrastructure of the Ministry together with all the servers and maintenance of the Ministry's website.

2015 had been marked as a successful year for the Division with significant contribution to health systems strengthening. Almost 85% of its overall performance targets were achieved as planned in the year 2015. Major contributions had been in areas of Information, Service Delivery, Leadership and Governance, HR/Training and Technology investments.

Achievements

The DHIRA had been able to produce many outputs from its 2015 Business Plan that has been seen as achievements for the unit as it has brought the results that it was intended for in strengthening Health Systems as described below:

HS 1.0 Leadership and Governance

Advocacy on Health Information Policy and critical role of information was made on various forums and meetings with both internal and external stakeholders to ensure reliable, timely and accurate health information is used for decision making. The Health Information Systems Strategic Plan 2012-2016 was reviewed and a new Clinical Information Systems/Health Information Systems (CIS/HIS) Strategic Plan 2016 – 2020 was developed. National Health Information Committee (NHIC) and National Civil Registration and Vital Statistics (CRVS) Committee were fully functional in addressing national policy issues and rectification of challenges whilst also addressing strategic needs for Fiji around HIS and CRVS.

HS 2.0 Finance

To address the Health Systems – Financing the unit conducted quarterly and bi-annual financial analysis and demonstrated cost centre feasibility assessments to the National Budget Steering Committee. It also assisted in the formulation of 2016 budget submission based on evidence of health information and service utilisation.

HS 3.0 Information

Objective: Strengthen the capture of relevant, reliable and timely health information

The Health Information Unit had compiled the information for the Annual Report 2014 together with the review/update format, content and data interpretation in quarterly Health Information Bulletins based on regular reporting from all routine information systems. It also updated and finalized the health information data flow mapping based on manager input for all major reporting systems such as PATIS, CMRIS, NNDSS, Diabetes Notification, Cancer Notification, MCDC and Hospital Returns. The unit also developed and updated the metadata (i.e., Performance Indicator Reference Sheets) for 2015 ACP indicators and started the drafting the metadata for 2016 ACP indicators. To ensure improvements in data quality Data Verification using the Audit Tool for PHIS was conducted at Facility Level, PATIS data entry audits were carried out in Divisional Hospitals and numerous supervisory visits were made across the country to ensure reporting standards were maintained. To further strengthen this the unit would collate, compile and analyse and provide feedback for reports (PATIS, CMRIS, Hospital Returns, NNDSS, MCDC) to respective facilities on a regular basis. Also Implemented an integrated disease notification surveillance system at all levels, with defined frequency. Maintain ICD morbidity and mortality coding in compliance with the WHO Family of International Classifications (WHO-FIC) standards. Developed plans and procedure to ensure all HIS sub-systems are standards-based to promote interoperability can support a national health observatory or dashboard.

Health Information Dissemination and Use

Production of quarterly and annual HIS reports to meet the needs of the intended audience. Provision of health data based on requests from existing data sources.

Data Request received	167
Completed	140
Verification	1
Relevant documents not provided	20
Cancel	6

Health Information Strengthening through training

Various training were conducted throughout the year for PATIS, PHIS, LIMS, HRIS, CMRIS, NNDSS, CAN REG and DM Notification Form training. One of the key training was for the doctors on cause of death training to improve vital statistics.

Conduct Cause of Death Trainings per quarter on targeted facilities

Facility & Date	Total Trained	Division
MoHMS Conference Room - 24th July	11	Central – 3, Western – 5, Northern – 2, Eastern - 1
Lautoka Hospital – 23rd – 25th September	60	Western [For Lautoka Hospital only]
Labasa Hospital – 4th November	18	Northern [For Labasa Hospital only]
TOTAL	**89**	

Objective: Strengthen and sustain eHealth foundations to improve the ICT workforce, infrastructure, services and applications

Information Communication and Technology Unit established further govnet connections to health facilities to enable access to email, internet, intranet and also various Health Information Systems such as PATIS, CMRIS, HRIS, LIMS, etc.

Connectivity Update:

Division	Sub Division	Accessibility	Division	Sub Division	Accessibility
Central	Suva Subdivision	Accessible	Northern	Cakaudrove Sub-Division	Accessible
	Serua/Namosi Subdivision	Navua Hospital has no connectivity but Navua HC already on Govnet.		Macuata Subdivision	Accessible
	Rewa Subdivision	Accessible		Taveuni Subdivision	Accessible
	Tailevu Subdivision	Accessible		Bua Subdivision	Accessible
	Naitasiri Subdivision	Accessible	Western	Nadroga/ Navosa Subdivision	Accessible
Eastern	Lomaiviti Subdivision	Levuka Hospital is on Govnet. but Levuka HC has no connectivity		Nadi Subdivision	Accessible
	Kadavu Subdivision	Accessible		Ba Subdivision	Accessible
	Lakeba Subdivision	Inaccessible(Planned for 2016)		Tavua Subdivision	Accessible
	Lomaloma	Inaccessible(Due to		Ra Subdivision	Accessible

	Subdivision	unstable power supply issues)			
	Rotuma Subdivision	Accessible		Lautoka/Yasawa Subdivision	Accessible

The ICT Unit also developed Disaster Recovery Plan and review licensing of all software to ensure compliance and concurrency. Standards on all applications were developed for easy data migrations/merging /reporting. Improvements were made on PATIS online functionality and use with additional modules added to capture medical reports online with better reporting features. LIMS was expanded to Lautoka hospital to allow all three Divisional hospitals to provide digital test results on PATIS automatically. The Public Health Information Systems (PHIS) was reviewed and enhanced were made to better collate births and maternal and child health information from both health centres and hospitals. The unit also supports and maintains health social media (website: www.health.gov.fj, Facebook www.facebook.com/FijiMoH and local shared drives). It has also conducted basic IT Training to Health Users. National Data Repository Portal went live http://www.health.gov.fj/fijindr/index.php/home to strengthen research and information use. Registration of eligible individuals for the Free Medicine Program had been carried out by the unit as well. Over 7000 people had been registered in the program so far.

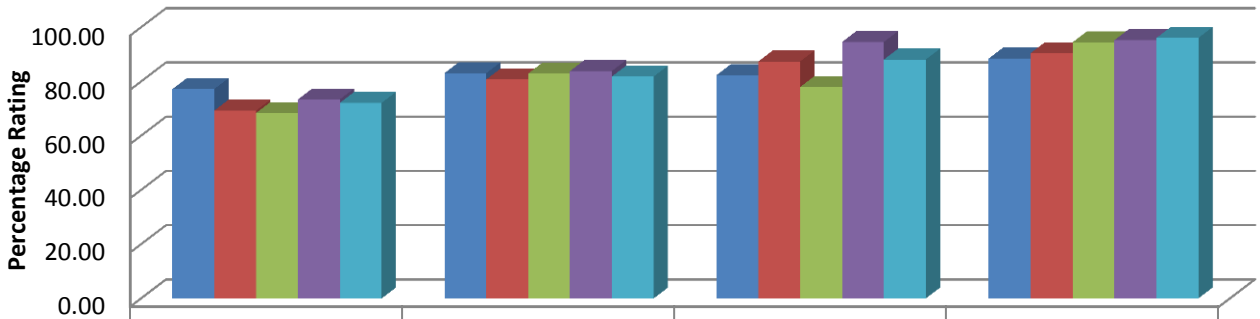
Objective: Strengthen health research (including system research and operational research) capacity, production and use.

The Research unit was able to institutionalise knowledge management through establishment of a searchable repository of all survey, research and statistical reports and consolidate HIS-relevant data from health areas and programmes using the National Data Repository. Training was conducted based on needs analysis for analytical and research skills for capacity development of staff. Reviewed procedures for approval of health-related research by the Fiji National Research and Ethics Review Committee (FNRERC) for adherence to ethical standards, and for the National Health Research Committee (NHRC) to advice on the technical soundness of health research conducted in the country. The Research unit trained sixteen (16) Divisional Research Coordinators on ME Research Fundamentals of the three (3) Divisions to be the arm of research at divisional level. One issue of the Volume 4 of the Fiji Journal of Public Health (FJPH) was published with the respective theme – Environmental Health and Climate Change in December 2015. Eight Published Researches were received on the portal. www.health.gov.fj/fijihrp Online Research Portal regularly updated. Total Proposal Submitted in Jan-Dec 2015 – 99; Total approved: 62; Total Ongoing - 99; Total Completed: 3 (these are completed studies and submitted study reports). FNHRERC meeting – nine (9) Full (Ethics) Committee meetings held from twelve (12) meetings scheduled for the year 2015.

Objective: Strengthen M&E capacity, processes, systems, and tools at the national, divisional, and sub-divisional levels.

The Monitoring and Evaluation unit of the Division also had a successful year. Monitoring and Evaluation Technical Team (METT) and Resource Network Terms of Reference was reviewed and updated. National meeting for M&E Resource Network facilitators was held with the launch of M&E facilitators guides. Simple M&E self-assessment tool to monitor M&E progress and needs in the MoHMS annually was developed and applied. Technical and logistical support was provided to Resource Network members to provide M&E guidance to their units. Standard reporting template for use in quarterly Divisional Plus meetings (for both clinical and public health content) was developed and implemented. Standard observation sheet to monitor presentation of data and data use for decision-making in quarterly Divisional Plus meetings was developed and implemented. M&E Resource Network Facilitator's Guide modules for core M&E training content was created published and launched including training (44 out of 45 reporting units established with fully trained M&E personnel). METT responsibilities into relevant Position Descriptions (public health and hospital managers) were incorporate to further strengthen and institutionalise it. Compilation and submission of ICO report and RDSSED report was done in a timely manner.

Figure 3: ICO Performance trend 2011-2015



	Q1	Q2	Q3	Q4
2011	77.20	83.08	82.34	88.48
2012	69.27	80.75	87.40	90.47
2013	68.40	82.94	77.99	94.46
2014	73.40	83.85	94.56	95.27
2015	72.12	81.84	88.11	96.05

HS 4.0 HR / Training

Staff performance assessment and capacity building were carried out throughout the year through internal (in-service) and external training and workshops. Human Resource Information Systems (HRIS) was strengthened to improve records for all health workers in the Ministry. Additional Staff were recruited as project officers to cater for increasing demands in the Division such as clinical coder, mortality data entry clerks, ICT Officers (4), Free Medicine Project Officers and PATIS Product Manager.

HS 5.0 Service Delivery

Technical assistance and support were provided to HR team in the development of online surveys (Qualtrics) and also to DLO during Health Emergencies and Disasters.

HS 6.0 Medicines, Consumables, Drugs, Infrastructure and Technology

Out of stock report for Supply Chain improvement were produced and provided to FPBS on a monthly basis to aid in better forecasting and procurement.

Challenges

Despite having contributed significantly towards the Annual Corporate Plan 2015 of the Ministry, the Division went through many challenges and constraints in its implementation of the Business Plan 2015. These had been due to limited budget, human resources constraints, availability of key stakeholders whilst others were due to external factors and procedures/processes in the Government machinery. Some of the projects that had been carried forward to 2016 due to these are:

Health Information (Collaboration and Coordination with both internal and external stakeholder challenge)

1. Review Medical Records Policy (retention, archival, disposal; align registers to current international practice and legal requirements)
2. Develop guidelines and implementation plans to address breaches in HI policy
3. Develop private and public health facility listings with service availability mappings for diverse diseases and combine into a single register or inventory, using standardised facility codes and accurate GIS coordinates

Monitoring & Evaluation (Internal stakeholders, human resources and budget constraints)

4. Develop/update metadata (i.e., PIRS) for 2016-2020 Nat'l Strategic Plan indicators to ensure annual monitoring
5. Develop Supervisory Visit Tool for Hospitals

Research (Collaboration and Coordination with both internal and external stakeholder challenge)

6. Research priorities for NSP 2016-2020, to be input into Health Information Strategic Plan
7. Prepare/update 10-year prospective matrix of national surveys to be conducted to meet MoHMS data needs

ICT (Collaboration and Coordination with external stakeholder challenge and budget constraints)

8. Design and establish a national ehealth governing council (ITC, MOH, Donors, PMs Office)
9. Implementation of Warehouse Management System
10. Provide technical guidance and assistance in the implementation of PACS/RIS for Radiology Unit
11. Provide technical assistance in the scoping of the Medical Supplies Information System

Other generic challenges that affected routine work were failure of reporting units submitting their reports on time, lack of enthusiasm and initiative from supervisors for monitoring, evaluating and learning from evidence to make necessary changes to routine work to make a difference. Most times the focus is on compliance as opposed to results and impacts of program implementation.

Launch of Monitoring and Evaluation Manuals

11. Planning and Policy Development Unit (PPDU)

The unit is responsible for coordinating the development, formulation and documentation of MoHMS Policies, the National Health Accounts, Donor Coordination, Department plans, and medium to term strategies in alignment with the MoHMS long term mission and vision.

PPDU is responsible for an inclusive planning process of national plans and strategies and ensure coherent implementation of the national strategy and a proactive approach towards the coordination of all health partners and external donors of the health sector in Fiji.

The main areas of work of the Unit can be characterized as follows,

a) Planning
b) Policy
c) Health Care Financing

Planning

The core responsibility of the Planning unit is development of National Health Strategic Plan for 5 years through a systematic process that takes into consideration ideas, thoughts and priorities of all levels of health workers, national, regional and international priorities. Coordinate and facilitates various activities in formulating the Annual Corporate Plan of the Ministry. Review and develop health services planning for divisions in Fiji in order identify services gap in different divisions and formulate necessary financial requirements for the provision of adequate HR, technologies and equipment and infrastructures. To continuously monitor and evaluate business plan quarterly reports and make recommendations based on results.

As reflected in the PPDU 2015 Business Plan (BP) some of the key achievements were:

a) The compilation and publication of the Ministry of Health and Medical Services Annual Report 2014.
b) The production of Ministry of Health and Medical Services National Strategic Plan 2016-2020 after various consultations with internal and external stakeholders.
c) The MoHMS National Strategic Plan 2016-2020 was launched by the Hon. Minister for Health and Medical Services Mr Jone Usamate on 16th December 2015.
d) MoHMS Annual Corporate Plan 2016 was developed after various consultations with respective Senior Managers. ACP 2016 planning consultation began in September 2016 and two workshops were held to finalize the ACP 2016, one was on the 16th of September and another on the 21st of October.

Policy

The Policy Unit is responsible for the technical support, initiation, coordination, monitoring and evaluation, of health policies having an impact on health care delivery and preventive service delivery in all facilities under the Ministry. The Director oversee the policy planning and development cycle through empowering and delegating required actions and stages of policy development cycle with the assistance of Senior Administrative Officer. The unit provides secretariat support to Health Policy Technical Support Group (HPTSG) Meetings and coordinates Stakeholders consultation.
The Unit constantly played a supportive and secretariat role to the major conventions and consultations either with internal or National policies.

Policies Developed and endorsed include:

1. National Management of the deceased at hospital facility
2. National Oral Health Policy
3. Mental Health and Suicide Prevention Policy
4. Community Health Worker Policy
5. Paediatric Oncology Policy
6. National Acute Rheumatic and Rheumatic Heart Diseases
7. National Wellness Policy
8. Standardisation of Laboratory Clinical Services Policy
9. National Ambulance Policy

Health Care Financing

The healthcare Financing Unit (HCF) within the Policy Planning and Development Division (PPDD) is responsible to coordinate monitoring of resource flow through production of National Health Accounts, writing of policy briefs from the NHA finds and recommendations, provide secretarial support for the National Budget Steering Committee meetings and sub-committees for budget management, evaluation and analysis of capital projects and its timely reporting to central agencies, conducting costing studies as and when required for possible outsourcing or Public Private Partnership (PPP) and provide local counterpart support to research institutions for undertaking health financing studies or analysis.

Some of the major achievements for the unit were:

a) Obtaining increases in the operational budget through the monitoring and evaluation of budget management using expenditure trends and forecast,
b) Regular monitoring of capital projects by measuring the actual utilization of funds and the reporting of physical progress which resulted in improvement in implementation,
c) The production of 2011-2014 National Health Accounts time series report using SHA 2011 guideline,
d) The successfully completion of the Sustainable Healthcare financing in Fiji and Timor-Leste (SHIFT) Study project,
e) Cost analysis for Chronic haemodialysis treatment (CHT),
f) Cost Analysis for Coronary Artery Bypass Grafting (CABG) and
g) Successful coordination of development partners meeting

12. The Nursing Division

The Division of Nursing is responsible for the planning, development, coordination, monitoring and evaluation of nursing standards, policies, and guidelines and protocols.
The objectives of nursing as a service, a profession and a practice is to provide quality nursing care via the overarching provision of nursing technical support mechanism for quality curative and preventative health care in Fiji Health System.

Nursing is managed in a 3 facet structure which includes clinical/curative, public health and basic specialization nursing covering midwifery, advanced nursing practice (NP), mental health, TB and Leprosy. Nursing in the three (3) divisional hospitals [CWM/Lautoka/Labasa] including St. Giles Hospital are managed by Manager Nursings whilst the four divisions [Central/Western/Northern/Eastern] are managed by the four (4) Divisional Health Sisters. The other specialist hospital [Tamavua/Twomey] is headed by the Sister In-charge.

Achievements

1. Completion of the development of the Nursing Regulations of the Nursing Decree 2011.
2. Development of the Nursing Internship Log Book. This will be used for the new cohort of Bachelor in Nursing graduates in January 2016.
3. Another new cohort of 200 nursing graduates had joined the nursing fraternity thus totalling the nursing establishment to 2800 (200 new additional nursing posts).
4. Work in Progress on the development of the Scope of Practice for Registered Midwives.
5. Overseas attachment for nurses in various specialization in Australia, New Zealand with in-service trainings in Japan, Thailand continued to be facilitated via invitations and sponsorship from countries and donor partners.
6. Formal Postgraduate nursing trainings continued to be offered through Fiji National University and TISI Sangam College of Nursing (PG Diploma in Midwifery, Advanced Diploma in Nursing Practice for Nurse Practitioners, Postgraduate Certificate in Mental Health, and Postgraduate Diploma in Nursing Management).
7. Tripartite Forum between Ministry of Health & Medical Services, Fiji Nursing Association and Fiji Nursing Council continue to meet every quarter to address nursing issues.
8. Retired Midwives were engaged by UNFPA to assist health service delivery in Vanuatu after the effects of Cyclone Pam. 3 Cohorts of 10 were engaged for a month duration.
9. Another cohort of 8 nurses were engaged as part of the Medical Team deployed to Golan Heights under the RFMF Regiment.
10. Uptake and compliance in renewal of Annual Practising License had seen noteworthy improvement in 2015 with only 14 non-compliant and were suspended.
11. In-services Training packages continued to be offered by the Fiji College of Nursing to assist nurses to gain their 20 CPD points which is the requirement for the renewal of the Annual Practising License.
12. First ever National Nursing Scientific Symposium themed 'Embracing and Enhancing Research – a way forward to improving nursing practice' was convened at the Pearl Fiji Resort on 19th & 20th November 2015 which saw approximately over 150 nurses attending. This 2 days symposium covered 20 Continuing Professional Points (CPD) and had seen some of our locally trained nurses who held nurse specialist positions off shore invited as guest presenters including the Chief Nurse of the Kingdom of Tonga, Dr Amelia Afuha'amango as one of the keynote speakers.
13. 3 days Refresher training for Nurse Practitioners organised at the Pearl Fiji Resort in a back to back arrangement with the National Nursing Scientific Symposium on from 16th -18th November 2015.

Challenges

a) Limited resources in implementing the Nursing plans.
b) High demand for an increase in nursing workforce at operational level which is further compounded with the development of new clinical services, the extension of hours in Primary Health facilities, establishment of new health facilities etc.

Way forward

1. Review of existing nursing structure to create top level positions.
2. Improve staffing distribution to allow better response to population health and health service needs.
3. Create specialist nursing cadre and its appropriate structure.
4. Work with the nursing education institutions in the development of nursing specialization curriculum.
5. Address nursing practice, attitude and competence gaps in nursing young workforce.
6. Fiji College of Nursing to offer more structured in-service trainings that will address nursing leadership, management and clinical specialization.
7. Solicit support for more scholarships for nursing post graduate trainings.
8. Creation of higher nursing positions to improve supervision, and ease of responsibilities and accountability in nursing practice.
9. Development of new nursing policies, standards and guidelines to improve practice and review existing ones that needs it.
10. Working conditions for nurses to be reviewed to include nursing specialization remuneration package proposals.

International Midwifery day celebration on May 5th. This event was fully funded by the UN Agency. The event was also marked by workshop for the Midwives.

13. Development Partner Assistance

Development partners and international organisations provide financial and technical assistance to Ministry of Health and Medical Services to deliver its mandate responsibilities.

Fiji Health Sector Support Program (FHSSP)

The Fiji Health Sector Support Program is a 5 year program of Australian government assistance to the Fiji Ministry of Health and Medical Services. The goal of the Fiji Health Sector Support Program is to remain engaged in the Fiji health sector by contributing to the Fiji MoHMS's efforts to achieve its higher level strategic objectives in relation to reducing infant mortality (MDG4), improving maternal health (MDG5) and prevention and management of diabetes, as outlined in the MOH's Strategic Plan (2011 – 2015). The total funding is 33million Australian dollars (AUD) over 5 years from July 2011 to June 2016. The program is managed by Abt JTA on behalf of the Australian government.

The objectives of the Fiji Health Sector Support Program are:

1. To institutionalise a safe motherhood program throughout Fiji at decentralized level;
2. To strengthen infant immunisation and care and the management of childhood illnesses and thus institutionalise a "healthy child" program throughout Fiji;
3. To improve prevention and management of diabetes and cervical cancer at decentralised levels;
4. To revitalise an effective and sustainable network of village/community health workers as the first point of contact with the health system for people at community level; and
5. To strengthen key components of the health system to support decentralised service delivery.

Achievements

- The antenatal care flipchart The Road to Safe Motherhood was piloted in the Northern and Western divisions covering eight medical areas.
- Latest Mother Safe Hospital Initiative (MSHI) audit results showed great improvements in reporting, newborn care and postpartum care. Of note was the significant improvement seen at Nadi Hospital, having scored 50% adherence to MSHI standards in Q2 2014 it increased to 92% in Q4 2015, meaning it is now 'fully functional' against 11 of the 12 standards. Sigatoka and Lautoka hospitals both improved from a divisional average of 69% in Q2 2015 to 83% adherence in Q4 2015.
- 100% of targeted facilities now have adequately trained doctors and nurses trained in EmONC.
- 83% of targeted facilities now have doctors and nurses who are adequately trained in birth preparedness planning and complication readiness planning.
- Procurement of pneumococcal and rotavirus vaccines was fully transitioned to MoHMS in 2016.
- Preliminary rotavirus vaccine impact results show a 60% reduction in the incidence rate of rotavirus admissions, and a 17% reduction in the incidence rate of overall diarrhoea admissions at CWMH in children under five years of age.
- 90% of target facilities have 60% of nurses trained in IMCI (up from 46%).
- From January-December 2015, a total of 153 doctors and nurses were trained in PLS with FHSSP funding (93% of our annual target). 83 of these were trained between July and December 2015.
- 35% of staff in targeted facilities trained on the Wellness Promotion Manual including motivational interviewing.
- 90% of targeted public health nurses in targeted facilities have been trained on 'inspect and protect' package for diabetic foot care.
- Procurement of human papillomavirus vaccine fully transitioned to MoHMS in 2016.
- 69 nurses trained on cervical cancer screening methods, and 15 laboratory staff trained in cytology and cervical cancer registration.
- 92% of active CHWs trained in the core competencies module.
- 67% of active CHWs trained in safe motherhood module.
- 59% of active CHWs trained in healthy child module.
- 46% of active CHWs trained in wellness module.

- Prioritised PHIS Review recommendations around changes to MCH data were completed in time for 2016. Refresher training in CMRIS and the revisions provided to 84 MoHMS staff.
- Refresher Training was conducted in all three divisional hospitals on the Admission-Transfer-Discharge module and Pregnancy & Birth. 71 staff were trained in the ATD Module and 42 staff trained in the Pregnancy and Birth Module.
- Sixty-five M&E Resource Network Facilitators were trained on M&E Fundamentals, bringing the national total to 196. The M&E Facilitators Guide is being used by these facilitators when coaching their units on planning, implementation and analysis of data from all relevant data sources for their respective MoHMS units.
- The Workload Indicator of Staffing Need (WISN) assessment tool was updated to support budgeted workforce projection analysis for the 2016 budget submission.
- The School Heath Policy has been drafted in consultation with the Ministry of Education and is focussed on the NCD crisis by addressing NCD related diseases in school children.

Donation of medical equipment from Australian Aid to Paediatrics CWMH

Grant Management Unit (GMU)

The Global Fund (GF) grant supports the Ministry of Health on strengthening of health systems and the control of tuberculosis (TB) in Fiji Islands. The Ministry of Health has set up the Grant Management Unit to manage grant implementation, coordination and reporting of the GF grant.

The GMU goals are:

1) To reduce the burden of TB in Fiji (target; 20/100,000 population in 2015).
2) To achieve improved TB and HIV/AIDS outcomes through strengthening the capacity of the health system to deliver services.
3) To strengthen the health system by means of improving the production, management and use of information.

The GMU objectives are:

1) To improve high quality DOTS in all provinces with increased case detection and high treatment success.
2) To address TB in high risk groups and underserved populations, TB-HIV and MDR-TB.
3) To engage and empower all health care providers and communities to control TB.
4) To strengthen the quality of laboratory services and procurement supply management.
5) To strengthen the organisational capacity of the Principal Recipient (MoHMS).
6) To improve data quality and management of information.

Achievements

- Signing of grant agreement between Government of Fiji and GF for the period of 1 July 2015 to 31 December 2017 of USD$4,445,477.
- Creation of separate budget line in the national budget for 2016 presented in 2015; separate allocation for Tamavua/Twomey Hospital.
- Strategic screening in HRGs has increased (particularly for contacts & HIV). Even though the number fell in Q4, the average for Q3 & Q4 is still high compared to NCE period.
- Use of new technology in TB laboratories (Gene Xpert; BDMGIT) has contributed to increase in bacteriologically confirmed cases – both Pulmonary & Extra-pulmonary cases.
- The diagnosis of cases have improved; although the NTP have not achieved the target of 384 for 2015 (actual – 377); the number of cases is still increasing but those registered are now Real TB cases – due to increases in bacteriologically confirmed cases.

Challenges

- Delay in recruitment process for new staff at National Staff Board level.
- Procurement process for tender items – Fiji Procurement Office tender board delay meeting due to non-attendance of members thus causing delay in approval of tenders and procurement of items or services and delays in technical specification submissions by NTP.
- Delay in disbursement of grant funds from Ministry of Finance which affect implementation of plan. GF disbursed funds on 18 August 2015 however fund were disbursed to GMU on 18 November 2015.
- Distribution of screening activities very low especially in the Western Division shows the different capacities to screen.
- Transfer of knowledge to Public Health (Diabetes Programmes) to conduct TB screening activities.
- TB-HIV collaboration needs to be strengthened – fluctuations in TB screening in Hubs and IPT uptake.
- Closure of Tagimoucia Ward (TB Ward) in Lautoka Hospital that affects treatment outcome (only 2 isolation beds in Medical ward; 1 Male & 1 Female).

Way forward

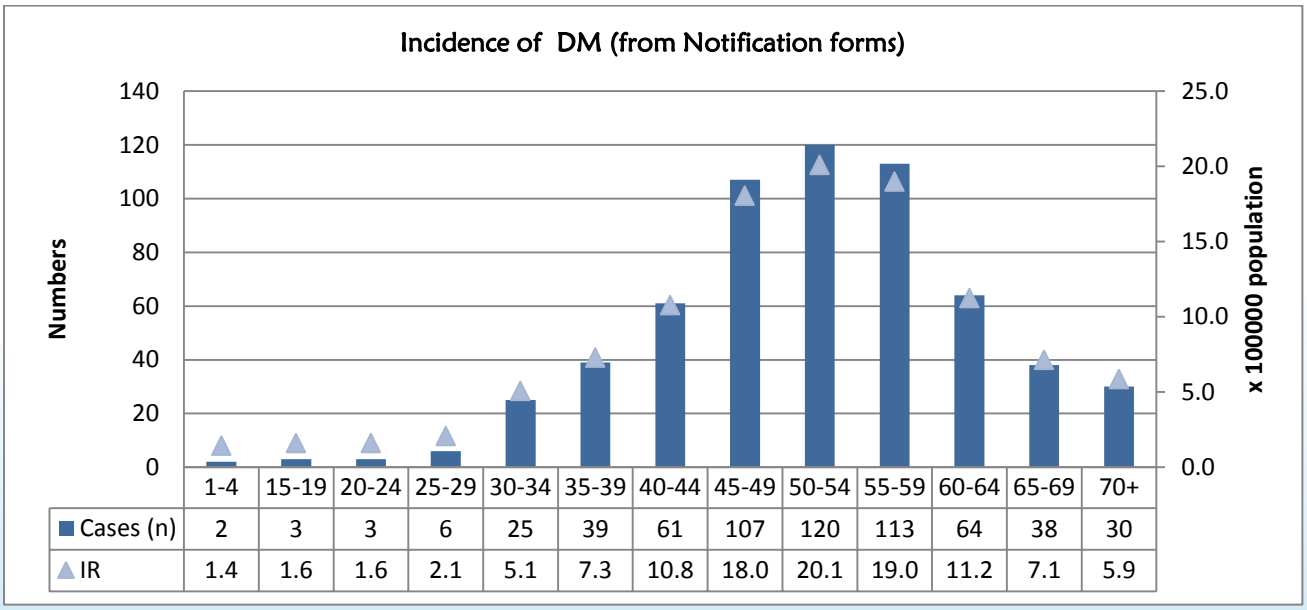
- Improve recruitment process for new staff. National Staff board to improve decision making process.
- Improve procurement process for tender items – Fiji Procurement Office tender board plan tender meetings regularly and ensure members attend.
- Ministry of Finance should follow the 10 working days RIE process when funds are disbursed from overseas funding agents it is received by the recipient within agreed timeframe.
- Seamless connections with both clinical and public health in continuum of care
- Strengthen public health network - transfer of knowledge to Public Health (Diabetes Programmes) to conduct TB screening activities.
- TB-HIV collaboration needs to be strengthened – fluctuations in TB screening in Hubs and IPT uptake.
- Management of Co-Morbid cases to be strengthened – increase stay in hospital and closer monitoring in the community.

14. Health Outcome Performance Report 2015

Non Communicable Disease

Diabetes

Figure 4: Diabetes Cases by Age Group 2015



	1-4	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Cases (n)	2	3	3	6	25	39	61	107	120	113	64	38	30
IR	1.4	1.6	1.6	2.1	5.1	7.3	10.8	18.0	20.1	19.0	11.2	7.1	5.9

Source: Diabetes Notification Forms, 2015

The above graphs shows that those in the 45-70yrs and above age groups were most afflicted [new cases] by Diabetes. However, there is significant underreporting on the DM notification forms. It was noted that male had aquired diabetes at an early age of 1-19 years age group. The denominatior used is the total of forms received from the facilities.

Table 13: Diabetes Cases by Facility 2015

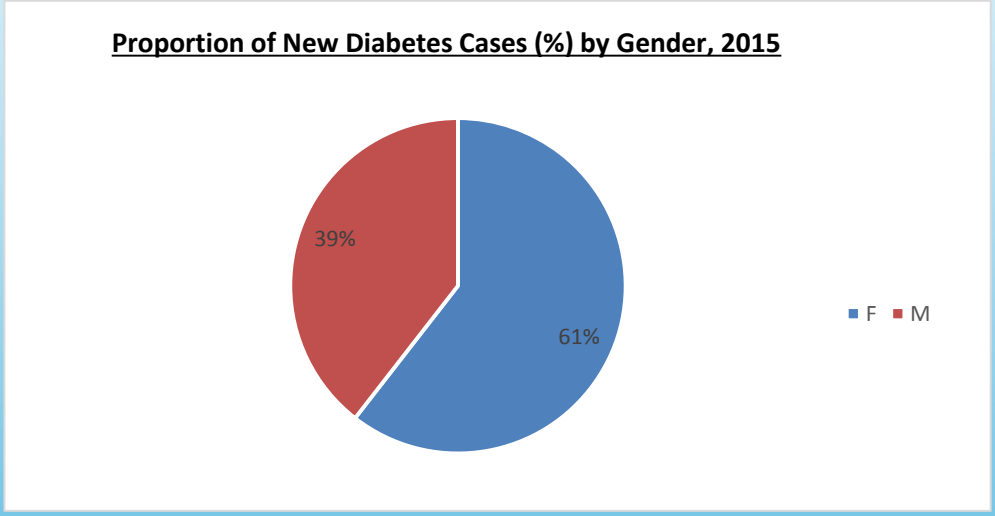
Sub Division	Reporting by Facility	Grand Total (# of patients notified)	Proportion (%) of DM forms received per Sub Division
Ba	Balevuto Health Centre	9	4
	Nailaga Health Centre	17	
Bua	Lekutu Health Centre	1	3
	Nabouwalu Hospital	17	
Cakaudrove	Savusavu Hospital	31	5
	Tukavesi Health Centre	2	
Lakeba	Lakeba Hospital	7	1
Lautoka	Lautoka Diabetic Hub	68	13
	Lautoka Hospital	1	
	Natabua Health Centre	11	
Lomaiviti	Levuka Hospital	4	1
	Qarani Health Center	2	
Lomaloma	Lomaloma Hospital	6	1
Macuata	Dreketi Health Centre	10	12
	Labasa Diabetic Hub	58	
	Naduri Health Centre	1	
	Wainikoro Health Centre	2	

Nadi	Nadi Hospital	245	40
	Namaka Health Centre	3	
Nadroga/Navosa	Korolevu Health Centre	1	2
	Lomawai Health Centre	13	
Serua/Namosi	Namuamua Health Centre	1	5
	Navua Hospital	33	
Ra	Rakiraki Hospital	5	1
Rewa	Wainibokasi Health Centre	2	0
Suva	CWMH	5	8
	Makoi Health Centre	12	
	National Diabetic Hub, Suva	21	
	Samabula Health Centre	1	
	Tamavua Twomey	1	
	Valelevu Health Centre	7	
Tavua	Tavua Hospital	21	3
	Grand Total	**618**	**100**

Source: Diabetes Notification Forms, 2015

The table above shows the proportion of DM notification received from the facilities. There were a total of 618 diabetic notifications received nationally compared to 609 cases for 2014 resulted to an increase by 1.5% in 2015. The vast majority of the new cases were reported from Nadi Hospital, Lautoka Diabetic Hub, and Labasa Diabetic Hub Centre. This may be due to good reporting from these facilities.

Figure 5: New Diabetes Cases (Incidence) by Gender and Age Group 2015



Source: Diabetes Notification Forms, 2015

The above pie chart shows the proportion for incidence of new diabetic cases. It clearly indicates that more female (374 cases) are diagnosed with diabetes than male (244) in 2015. The total number of DM received is 618 and female composed of 61% comapred to male with 39%. In an overal context, DM notification is still under reported as proportion calculation is based on the number of DM notification received at HIU.

Cancer

Table 14: Top 5 Leading Cancer Sites by Sex and proportion distributions, Fiji

Male	Cases 2015	%	Female	Cases 2015.	%
Prostate gland	49	11	Breast, NOS	270	28
Liver	36	8	Cervix uteri	221	23
Lung, NOS	25	6	Endometrium	64	7
Unknown primary site	21	5	Ovary	37	4
Colon, NOS	20	5	Unknown primary site	28	3
All Sites	435	100	All Sites	951	100

Source: Cancer Registry 2015

The leading causes of cancer in females are breast and cervical cancer followed by endometrial cancer. The leading cancer in males are cancer of the prostate glands, liver and lungs.

Table 15: Age Specific and Age Standardized Rates of all cancer sites per 100,000 population by age group, by World Standard Population 2000 – 2025 (direct standardization)

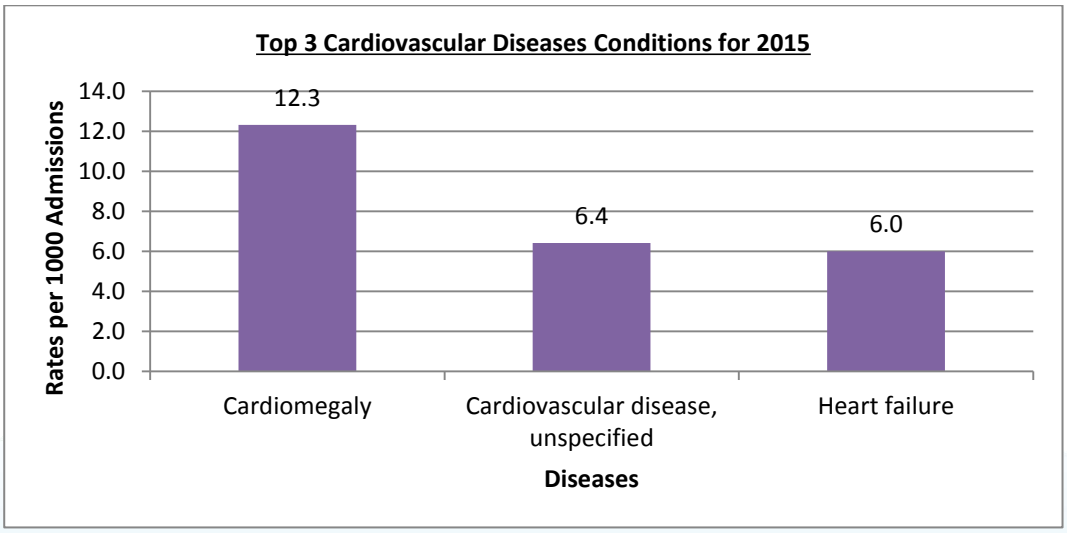
Age groups	Cases	FBOS Pop	Age Specific Rate	WHO Standard Pop weight	Age Standard Rate
1-4	5	87,233	5.7	0.09	0.51
5-9	8	87,958	9.1	0.09	0.79
10-14	8	77,539	10.3	0.09	0.89
15-19	14	76,094	18.4	0.08	1.56
20-24	25	72,967	34.3	0.08	2.82
25-29	42	67,321	62.4	0.08	4.95
30-34	63	66,470	94.8	0.08	7.21
35-39	79	59,976	131.7	0.07	9.41
40-44	86	52,703	163.2	0.07	10.75
45-49	129	50,191	257.0	0.06	15.52
50-54	153	48,931	312.7	0.05	16.79
55-59	203	40,556	500.5	0.05	22.77
60-64	162	30,198	536.5	0.04	19.95
65-69	140	21,883	639.8	0.03	18.93
70+	268	28,512	940.0	0.05	49.57
All Ages	1386	868,532	159.6	1	182.39

Source: Cancer Registry 2015

The table above shows the age specific and age standardised rates per 100,000 population. It is calculated using the WHO standard population and re-weighted by 1.

Cardiovascular

Figure 6: Leading 3 Cardiovascular Disease Conditions



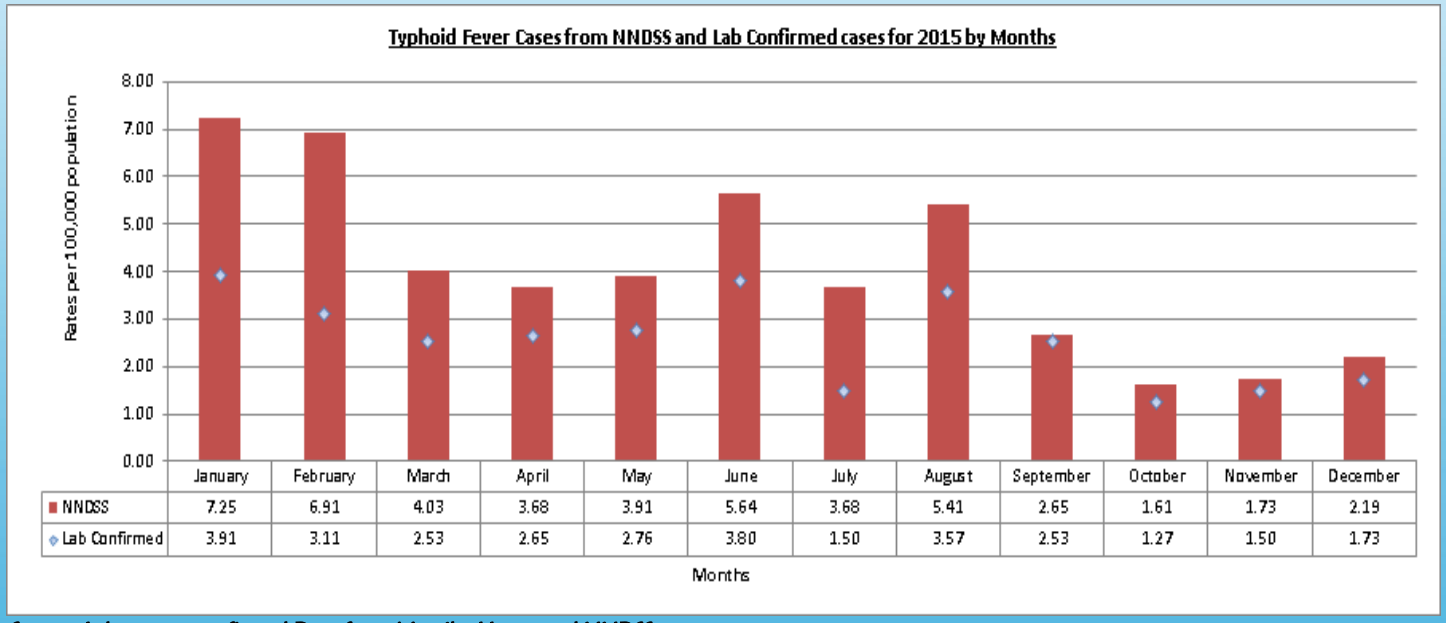
Source: PATISplus (Clinical Performance Management Report)

The most common cardiovascular diseases in 2015 included Cardiomegaly (ICD 10 AM code I51.7), Cardiovascular Disease unspecified (ICD 10 AM code I51.6), and Heart Failure (ICD 10 AM code I50.0 – I50.9)

Communicable Diseases

Typhoid

Figure 7: Typhoid Cases for 2015 by Month



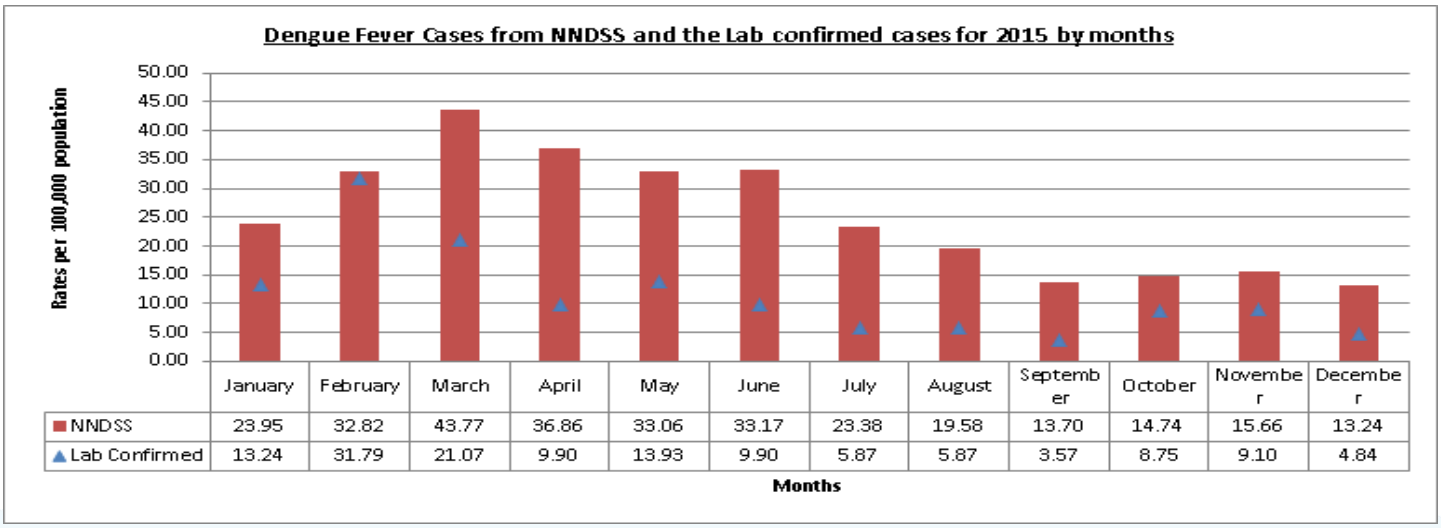
	January	February	March	April	May	June	July	August	September	October	November	December
NNDSS	7.25	6.91	4.03	3.68	3.91	5.64	3.68	5.41	2.65	1.61	1.73	2.19
Lab Confirmed	3.91	3.11	2.53	2.65	2.76	3.80	1.50	3.57	2.53	1.27	1.50	1.73

Source: Laboratory confirmed Data from Mataika House and NNDSS

There is high number of typhoid fever cases received through NNDSS data compared to Mataika house lab data as NNDSS captures the clinically suspected cases whereas lab data consists of only lab confirmed cases.

Dengue

Figure 8: Dengue Cases for 2015 by Month



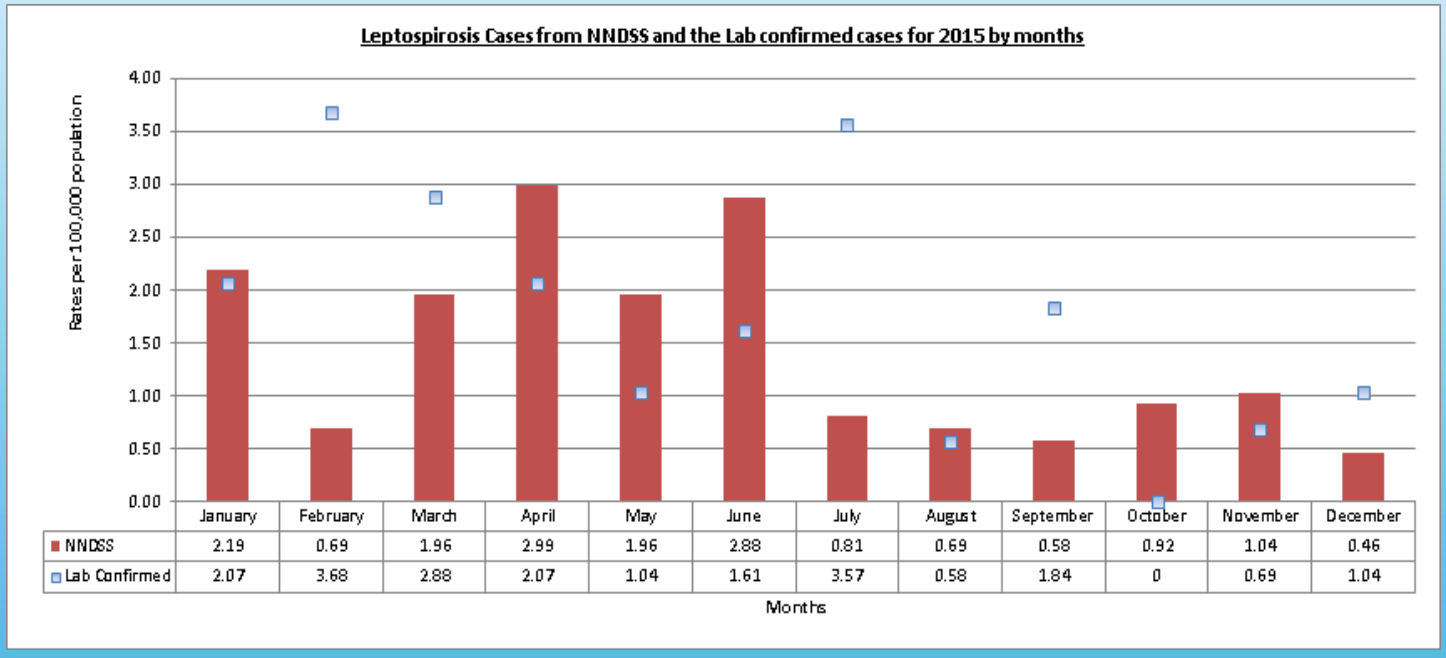
	January	February	March	April	May	June	July	August	September	October	November	December
NNDSS	23.95	32.82	43.77	36.86	33.06	33.17	23.38	19.58	13.70	14.74	15.66	13.24
Lab Confirmed	13.24	31.79	21.07	9.90	13.93	9.90	5.87	5.87	3.57	8.75	9.10	4.84

Source: Laboratory confirmed Data from Mataika House and NNDSS

There is an increase in cases since the beginning of the year until July as this was the period the outbreak was declared. The NNDSS cases are high as it reports the clinical and the suspected cases whereas lab only reports the confirmed cases (or lab positive cases).

Leptospirosis

Figure 9: Leptospirosis Cases for 2015 by Month



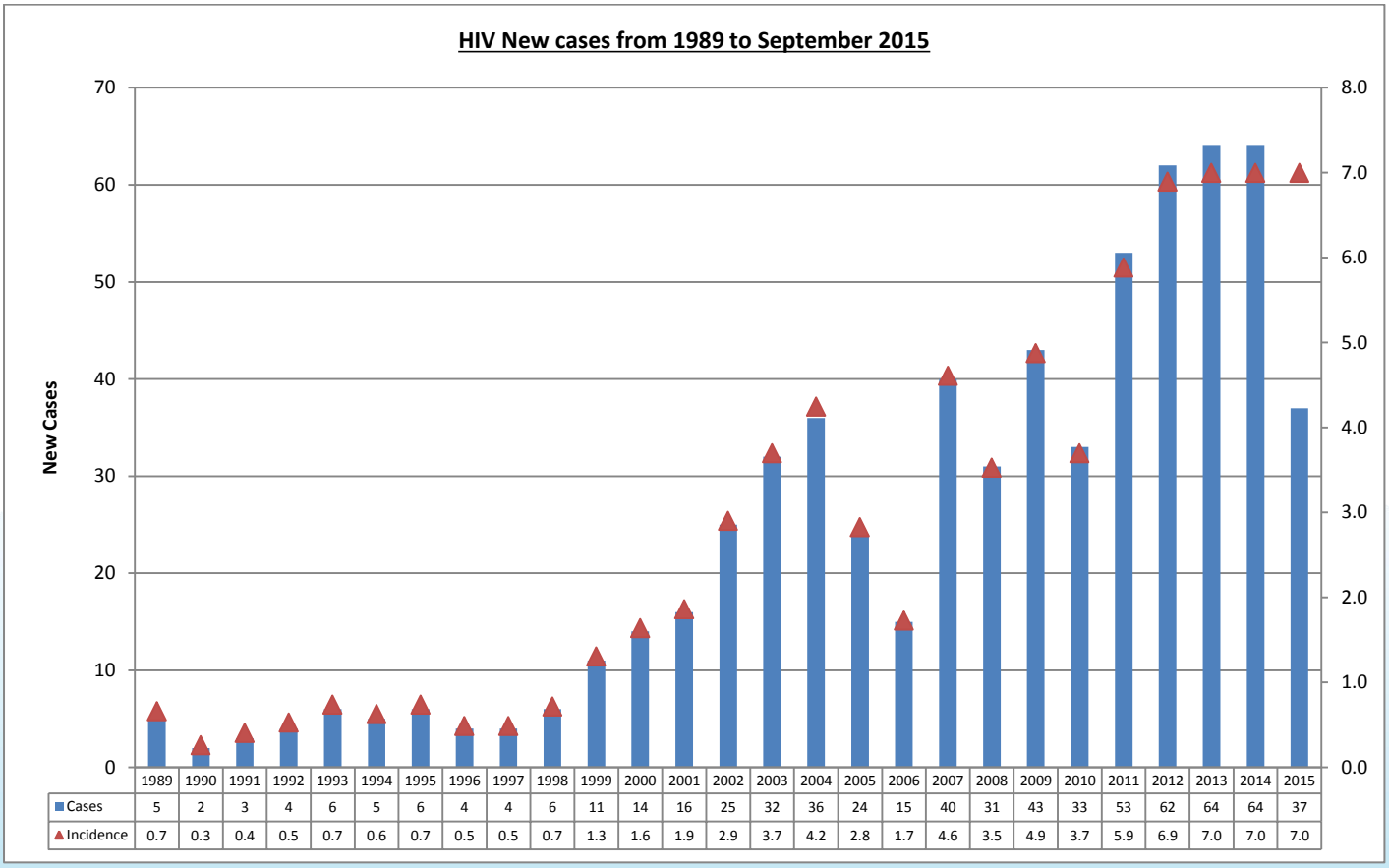
	January	February	March	April	May	June	July	August	September	October	November	December
NNDSS	2.19	0.69	1.96	2.99	1.96	2.88	0.81	0.69	0.58	0.92	1.04	0.46
Lab Confirmed	2.07	3.68	2.88	2.07	1.04	1.61	3.57	0.58	1.84	0	0.69	1.04

Source: Laboratory confirmed Data from Mataika House and NNDSS

There was no testing conducted in the month of October for the Lab data due to the stock out. The NNDSS data is lower than lab clinical diagnosis as diagnosis for leptospirosis is often challenging and cases are more than often identified through laboratory tests.

HIV

Figure 10: New HIV Cases 1989- Sept 2015

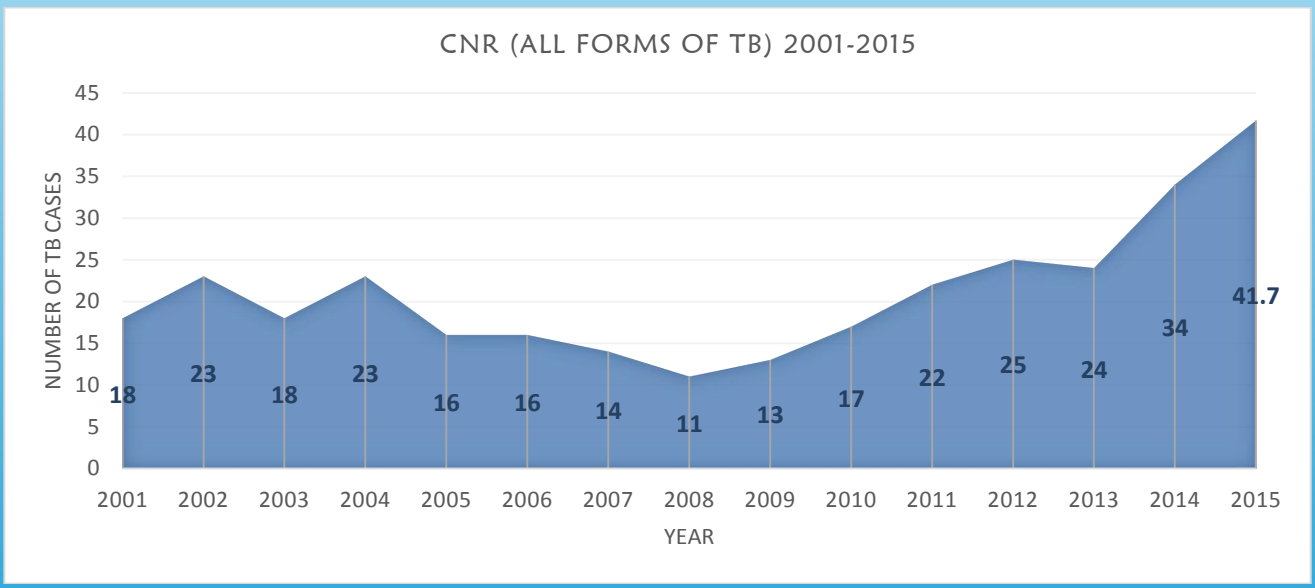


	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Cases	5	2	3	4	6	5	6	4	4	6	11	14	16	25	32	36	24	15	40	31	43	33	53	62	64	64	37
Incidence	0.7	0.3	0.4	0.5	0.7	0.6	0.7	0.5	0.5	0.7	1.3	1.6	1.9	2.9	3.7	4.2	2.8	1.7	4.6	3.5	4.9	3.7	5.9	6.9	7.0	7.0	7.0

HIV incidence has increased over the last 25 years from 0.7 to 7 per 100 000 population. This may be due to better diagnostics, better reporting and also may be a true increase in the number of cases.

Tuberculosis

Figure 11: Number of TB Cases (TB Notification)

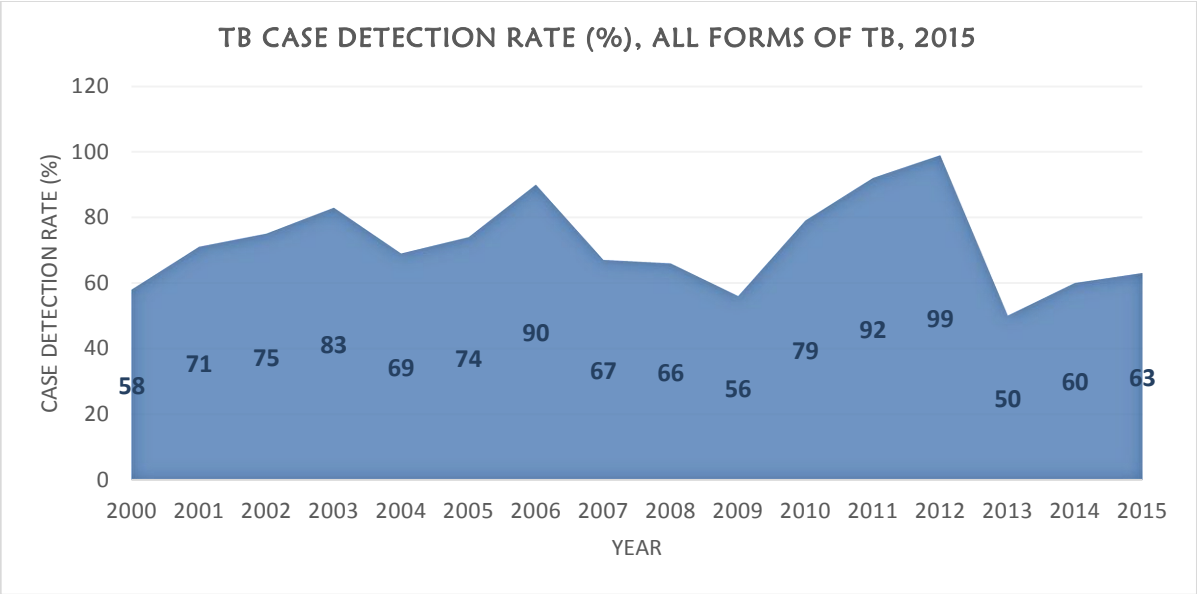


Source: National TB Program, 2015

In 2015, 362 cases of Tuberculosis (All forms) bacteriologically confirmed and clinically diagnosed was notified to the National TB Program. This represented 22 cases less than those reported in 2014.
The case notification rate stood at 41.7 per 100,000 population (All forms of TB, population estimate Fiji Bureau of Statistics, 2015)

The period 2010 to 2015 demonstrated steep increase in TB case notification rates and correlates with increased programmatic funding through the GFATM

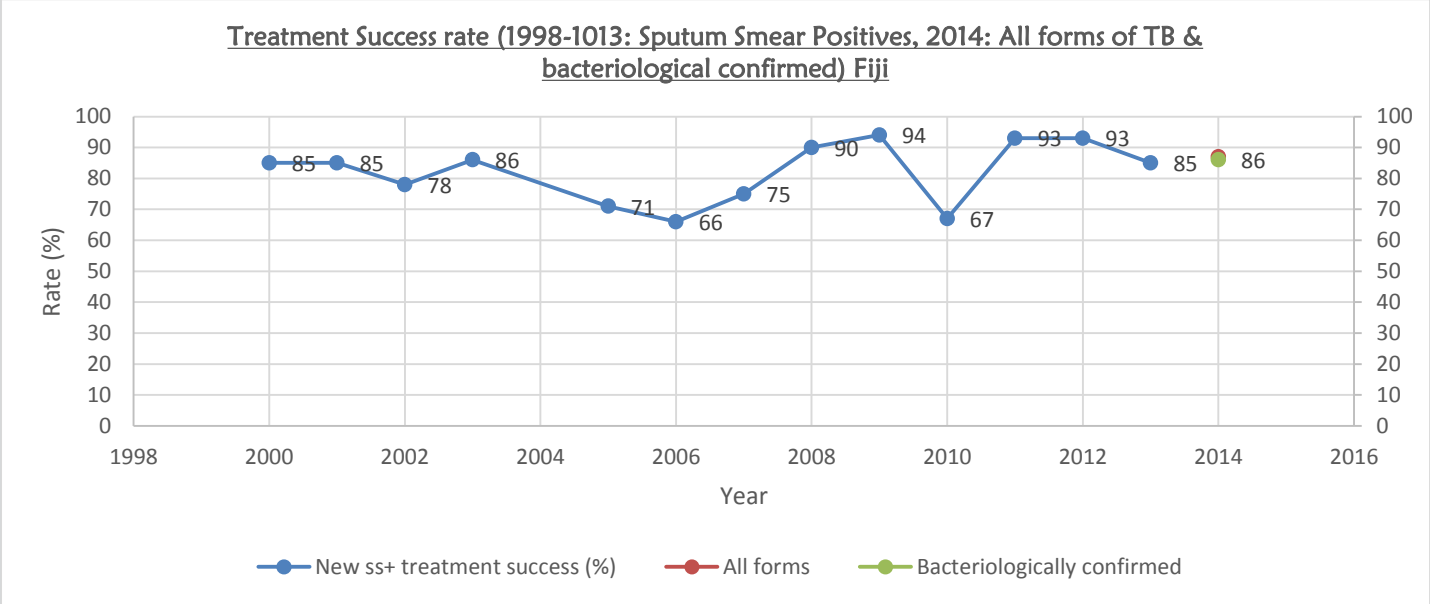
Figure 12: TB Case Detection Rate 2015



Source: National TB Program, 2015

In 2015, TB case detection rate was 63% (All forms of TB) high and erratic case detection in the past represent revisions in TB burden estimates by WHO at the request of the program.

Figure 13: New Sputum Smear Positive TB – Treatment Success Rate

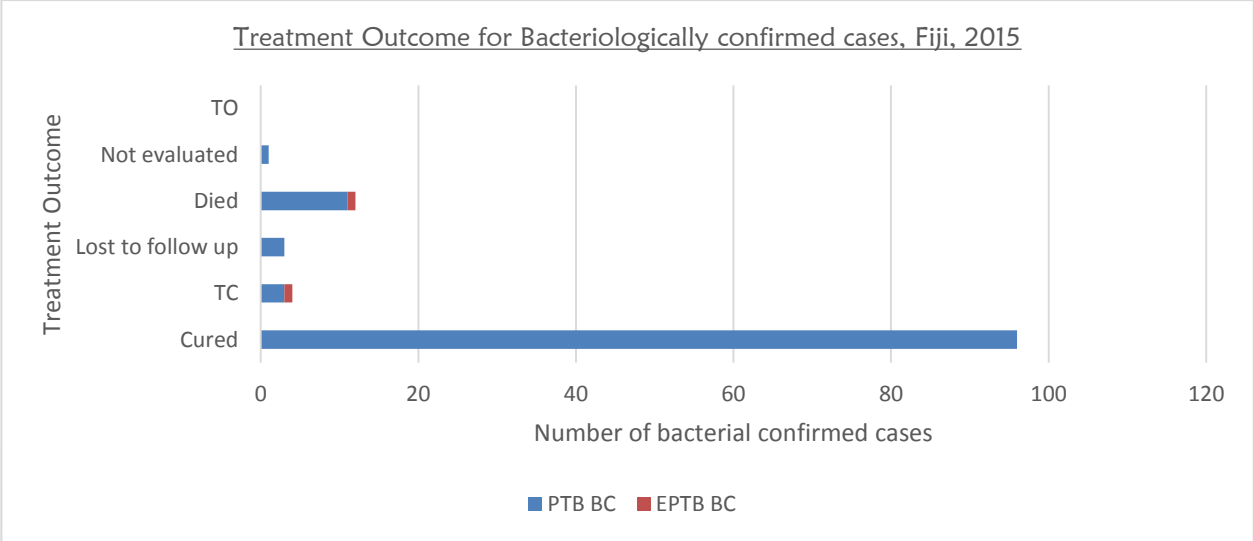


Source: National TB Program, 2015

Prior to 2014, the National TB program assessed and reported treatment success rate (TSR) among the cohort of sputum smear positives. In 2015, with the NTP adopting the new definitions for TB, TSR was measured among all forms

of TB as well as the bacteriologically confirmed TB cohorts. In 2015, the TSR for all forms of TB was 87% and for bacteriologically confirmed TB cases was 86% (The targeted TSR being > 85%) The NTP will be responsible for maintain this TSR.

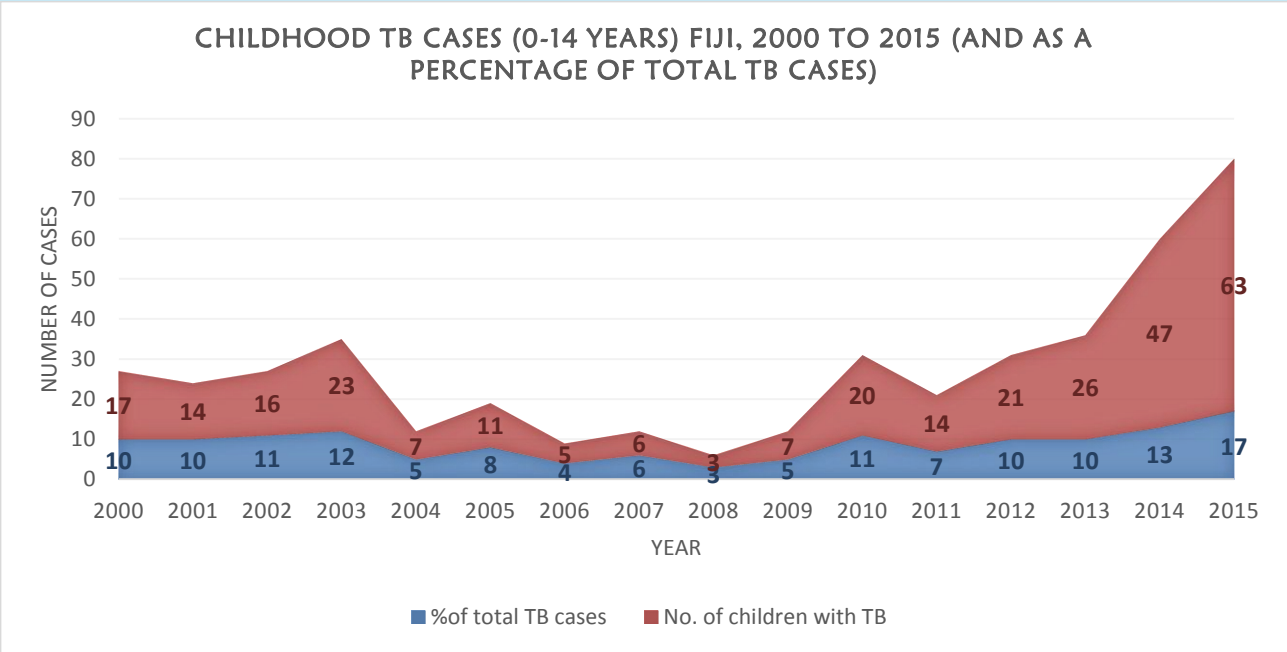
Figure 14: Treatment Success Rate among bacteriologically confirmed cases



National TB Program, 2015

The Treatment Success rate (TSR) for bacteriologically confirmed cases in 2014 was 86%. (100/116) of which PTB accounted for 98% of cases. Of the 16 cases that did not have a successful outcome 12 cases died (11 PTB and 1 EPTB). Additionally, 3 cases were lost to follow up and 1 not evaluated. The biggest contributing reason for poor outcome was death, which the program will have to address in the future.

Figure 15: TB in children

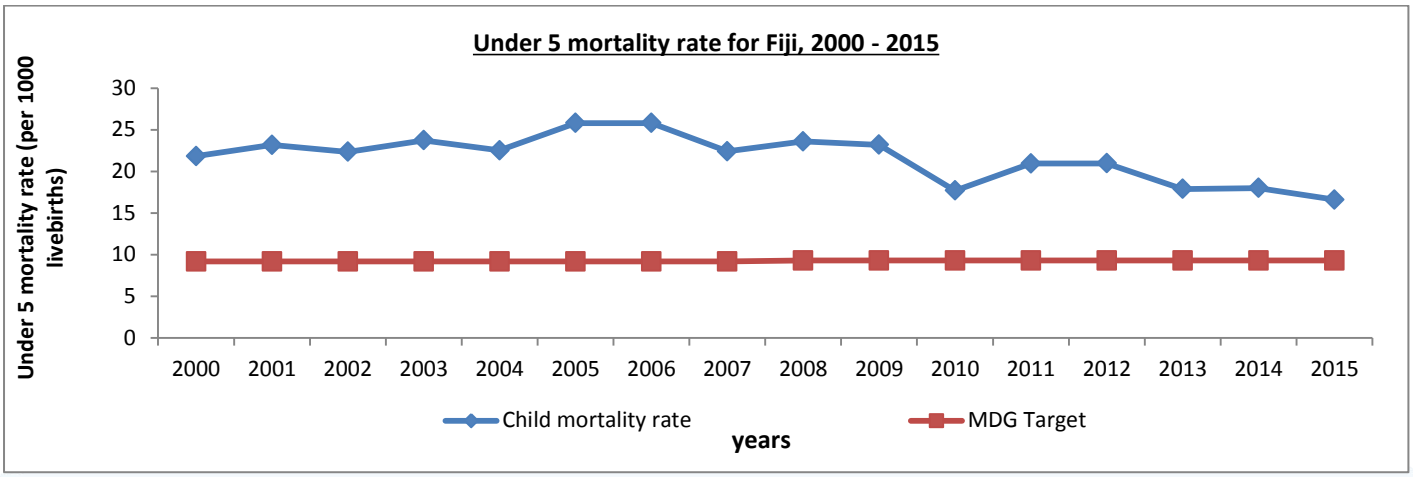


National TB Program, 2015

In 2015, childhood cases of TB (0-14 years) accounted for 17% (n. 63) of all TB cases. This represent an increase over the past few years.

Maternal Child Health

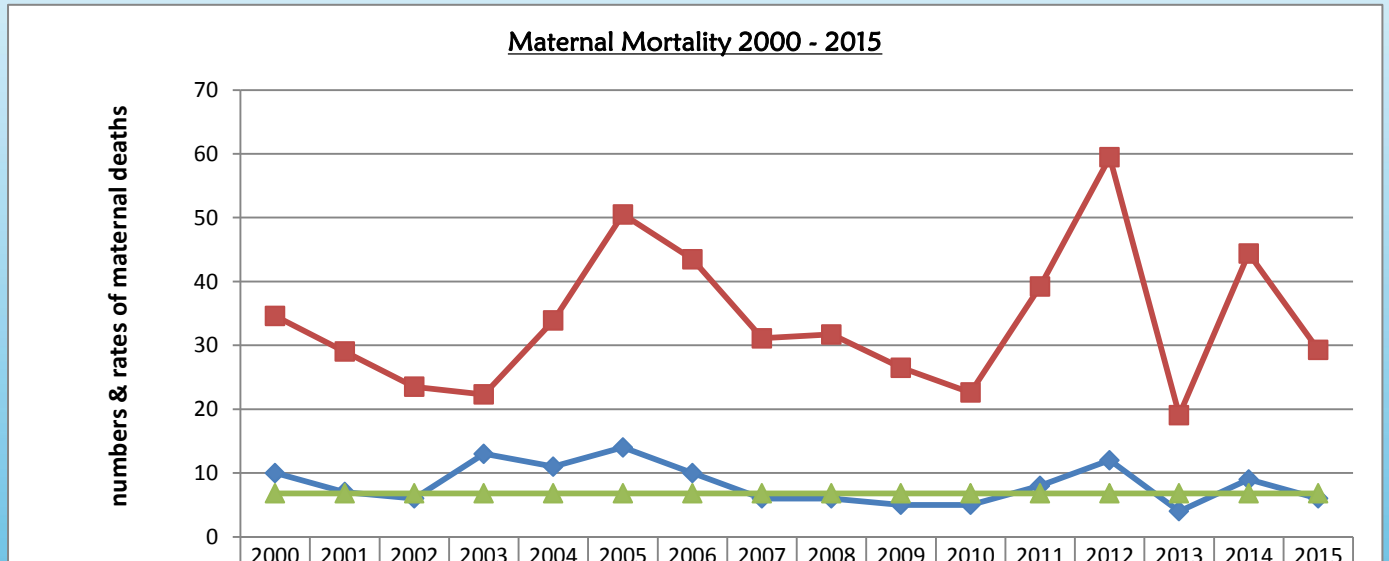
Figure 16: Under 5 Mortality Rate for Fiji 2000-2015



Source: Medical Cause of Death Certificate, 2000 – 2015, Ministry of Health,

There has been a fairly large reduction in the child mortality rate from the year 2000 but the MDG target has yet to be achieved. However, it is important to note that the MDG target may not be the best indicator for small island countries like Fiji due to the small population size.

Figure 16 (i): Maternal Mortality Ratio for Fiji 2000-2015

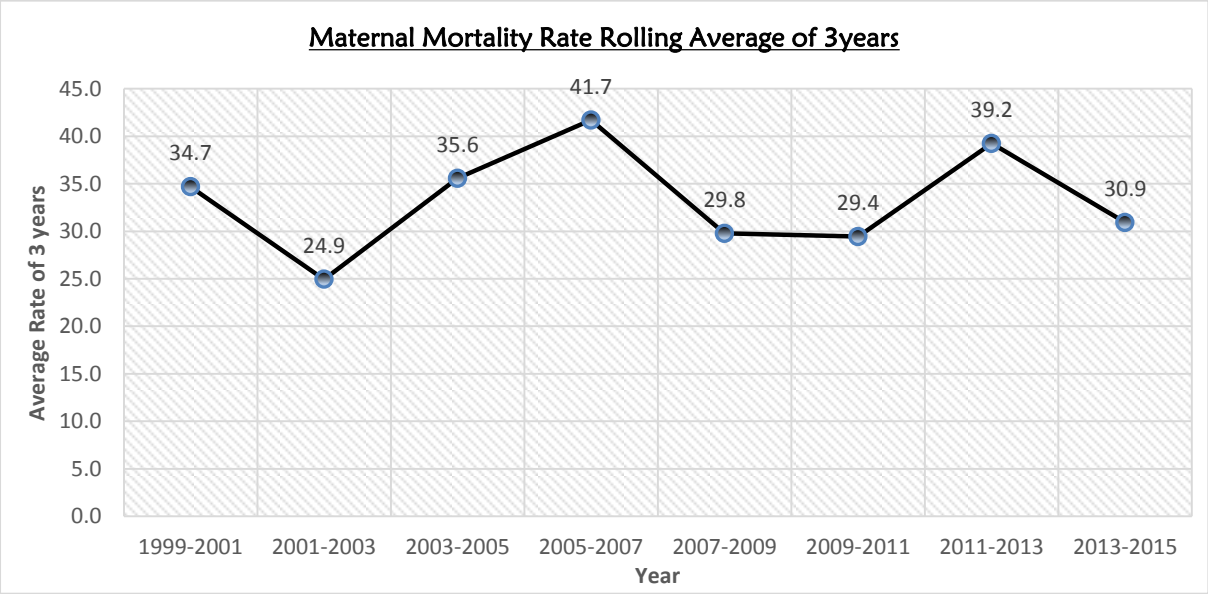


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
number	10	7	6	13	11	14	10	6	6	5	5	8	12	4	9	6
rate	34.6	29.03	23.5	22.3	33.9	50.5	43.5	31.1	31.7	26.5	22.6	39.2	59.47	19.07	44.4	29.3
MDG target	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8

Source: Medical Cause of Death Certificate, 2000 – 2015, Ministry of Health,

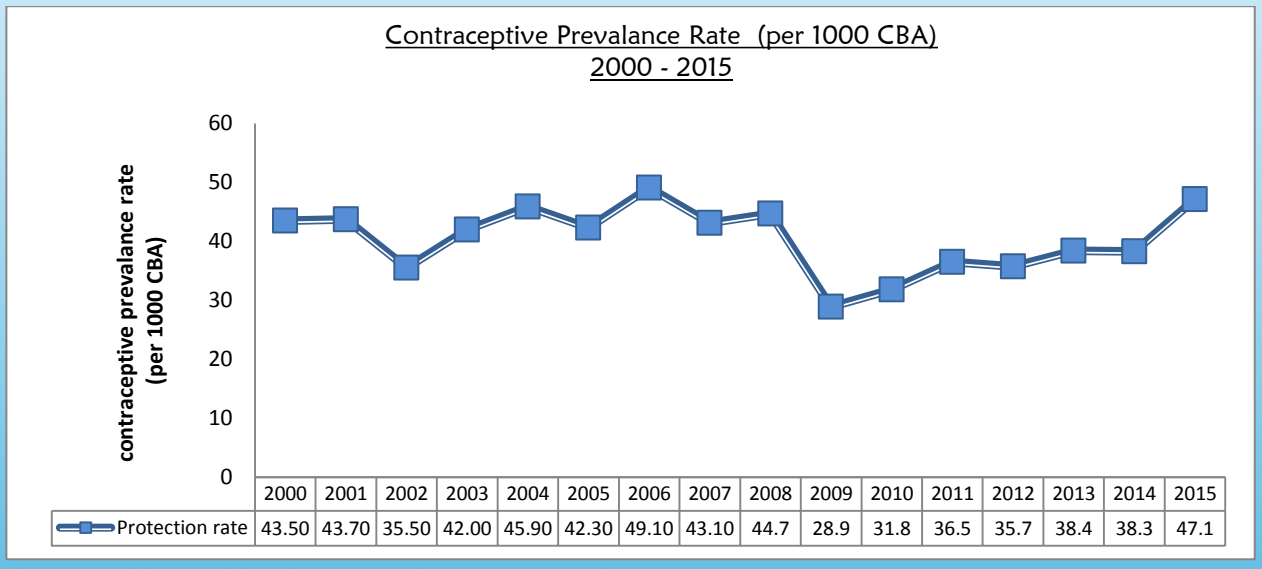
The MMR (per 100,000 live births) continues to be elusive of the MDG target; as developing countries like Fiji with small populations have large variations in the MMR with even a minute number of maternal deaths. There is a decrease of MMR from 44.4 in 2014 to 29.3 in 2015. The SDG targets Goal 3 is ensuring healthy lives and promote well-being for all at all ages. It is aimed by 2030 to reduce the global MMR to less than 70 per 100,000 live births.

Figure 16 (ii): Maternal Mortality Rate Rolling Average of 3 years



The above graph shows the' 3year average' of maternal mortality rate for the period 1999 – 2015; the trend still indicates that there is a need to improve awareness on maternal child health care and addressing these issues would help reduce maternal mortality.

Figure 17: Contraceptive Prevalence Rate for Fiji (per 1000 CBA) 2000-2015

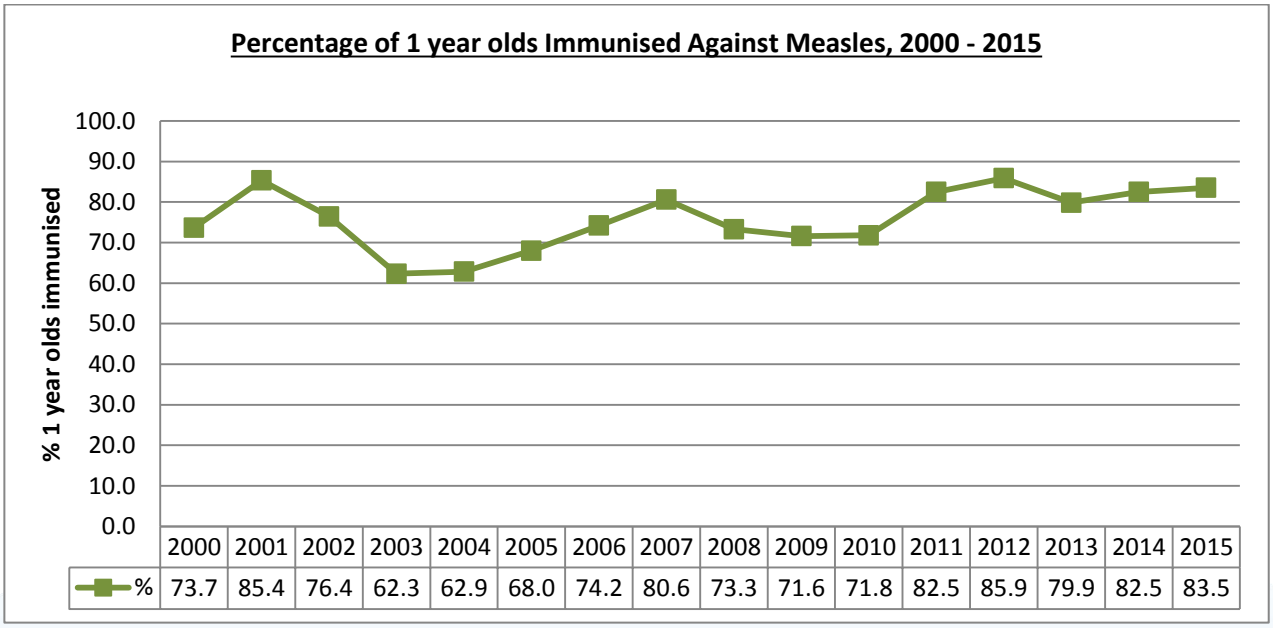


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Protection rate	43.50	43.70	35.50	42.00	45.90	42.30	49.10	43.10	44.7	28.9	31.8	36.5	35.7	38.4	38.3	47.1

Source: Public Health Information System, MoHMS

The CPR continues to increases to 47.1 in 2015 compared to 38.3 in 2014 which is an increase of 9%. A decrease in CPR in 2008 from 44.7 to 28.9 in 2009 is due to the changes been made to the reporting forms. In the last 5 years it shows a gradual increase of CPR and this may be due to improve in documentation and good record keeping.

Figure 18: Percentage of 1 Year Olds Immunised against Measles 2000-2015



Source: CMRIS Online [Hospital MCH & PHIS], MoHMS

There is a decrease of immunization coverage in 2013 by 7%. The immunization coverage rate continued to increase thereafter by 1.2% in 2015. The improvement may be due to proper documentation, and inclusion of data captured through hospital maternal child health report. The 2030 agenda for Sustainable Development Goal (SDG) as per Goal 3 Target is ensuring healthy lives and promote well-being for all at all ages. It is aimed that by 2030, for countries to end the epidemic of AIDS, Tuberculosis, Malaria, neglected tropical diseases and combat hepatitis, water borne diseases and other communicable disease.

16. Health Statistics

Table 16: Vital Statistics

	2014 (n)	2015 (n)
Population	**933,024**	**923,738**
Women (15-44yrs)	217,434	214,934
Total Live births	20,249	20,510
Crude Birth Rate /1000 population	*23.4	22.2
Crude death Rate /1000 population	*8.0	7.7
Rate of Natural Increase	1.5	1.6
Under 5 mortality rate/ 1000 livebirths (0-5 yrs)	18.0 (364)	16.6 (340)
Infant Mortality rate / 1000 live births (0-12months)	13.8 (280)	12.6 (259)
Perinatal Mortality (stillbirth and early neonatal deaths/1000 livebirths)	12.7 (259)	12.7 (262)
Early Neonatal (deaths 0-7days) /1000 livebirths	5.8 (118)	4.6 (94)
Neonatal Mortality (deaths 0-28days/ 1000 live births	7.7 (156)	6.8 (139)
Post-neonatal mortality (deaths 1-12 months)/ 1000 live births	6.2 (124)	5.9 (120)
Maternal mortality ratio /100,000 live births	44.4 (9)	29 (6)
General Fertility rate / 1000 CBA Population	99.4	95.4
Family Planning Protection Rate (per 1000 CBA Population)	43.6	47.1

**Use of FIBOS 2015 population projection*

Table 17: Life Expectancy – 2015

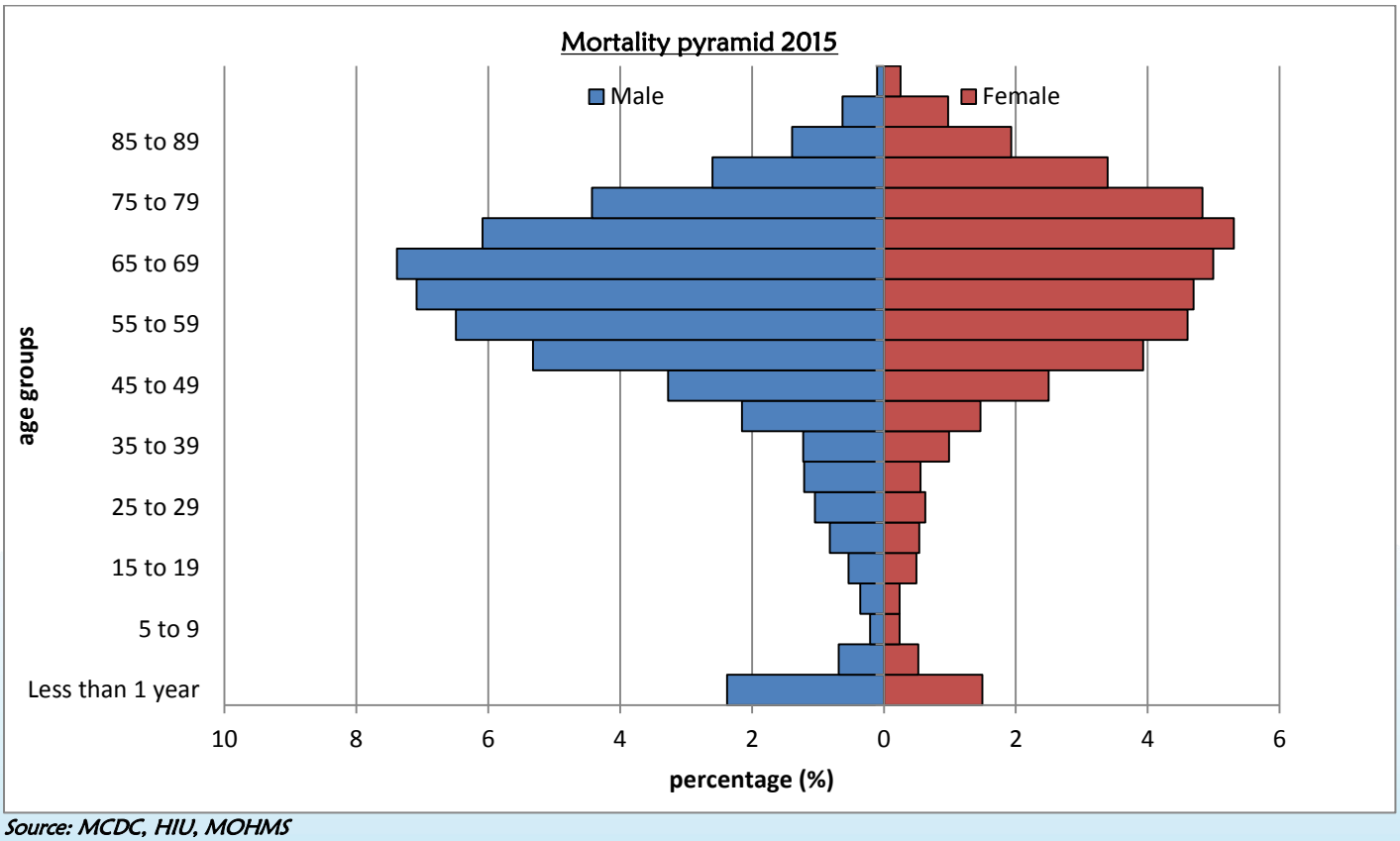
Life expectancy (years) at various ages

Age (yrs)	Male ex (95%CI)	Female ex (95%CI)	Total ex (95%CI)
at birth	67.1 (66.6-67.5)	71.9 (71.4-72.3)	69.4 (69.0-69.7)
at 5 yrs	63.6 (63.2-64.0)	68.0 (67.6-68.4)	65.7 (65.4-66.0)
at 15 yrs	53.8 (53.4-54.2)	58.2 (57.8-58.7)	56.0 (55.7-56.3)
at 40 yrs	30.7 (30.4-31.1)	34.7 (34.3-35.1)	32.7 (32.4-32.9)
at 60 yrs	15.9 (15.6-16.3)	19.2 (18.8-19.5)	17.6 (17.3-17.8)

Life expectancy is an estimate of the average number of years a person can expect to live, based on age-specific death rates in a given year. Life expectancy at birth is one of the most commonly used measures to describe the health status of a population. In Fiji, on average, a Fijian male born today is expected to live sixty-six (66) years if the economic status of the country remains the same with confidence interval of 65.9-66.8 percent whereas for a Fijian female is expected to live seventy-one (71) years with confidence interval of 70.3-71.2 percent. On average, a forty (40) year old is expected to live another thirty-two (32) years (CI, 31.6-32.1) and a sixty (60) year old is expected to live another sixteen (16) years (CI, 16.4-16.9).

Mortality Pyramid for Fiji – 2015

Figure 19: Mortality Pyramid for 2015



Source: MCDC, HIU, MOHMS

The mortality rates between males and females demonstrate that males have a peak between 50-79yrs and females have a peak between 55-84 yrs. Most males are dying earlier than females.

Table 18: Immunization Coverage 2015

Immunization Coverage (%) 0-1 yr	2014		2015	
	Number	%	Number	%
HBV0	20176	99.6	18060	88.2
BCG	19923	98.4	17790	86.8
DPT-HepB-Hib1	18319	90.5	18874	92.1
OPV1	18317	90.5	18843	92.0
Pneumoccal 1	18328	90.5	18870	92.1
Rotavirus 1	18320	90.5	18874	92.1
DPT-HepB-Hib2	18220	90.0	18509	90.4
OPV2	18211	89.9	18483	90.2
Pneumoccal 2	18199	89.9	18508	90.3
DPT-HepB-Hib3	18398	90.9	18225	89.0
OPV3	18383	90.8	18226	89.0
Pneumoccal 3	17776	84.9	18237	89.0
Rotavirus 2	17510	83.6	18182	88.8
MR1	16113	79.9	16908	83.5

Table 19: Notifiable Diseases 2015

No.	Diseases	Total	No.	Diseases	Total
1	Acute Poliomyelitis	0.0 (0)	30	Rheumatic Fever	3.34 (29)
2	Acute Respiratory Infection	7604.78 (61382)	31	Smallpox	0.0 (0)
3	Anthrax	0.0 (0)	32	Tetanus	0.0 (0)
4	Brucellosis	0.0 (0)	33	Trachoma	62.10 (539)
5	Chicken Pox	428.06 (3702)	34	Tuberculosis (a) Pulmonary	44.81 (389)
6	Cholera	0.0 (0)		(b) Others	2.07 (18)
7	Conjunctivitis	734.63 (6334)	35	Typhus	0.0 (0)
8	Dengue Fever	287.51 (2490)	36	Viral Illness/ Infection	5,837.61 (47905)
9	Diarrhoea	3248.67 (27328)	37	Whooping Cough	0.92 (8)
10	Diptheria	0.0 (0)	38	Yaws	0.0 (0)
11	Dysentry (a) Amoebic	0.23 (2)	39	Yellow Fever	0.0 (0)
	(a) Bacillary	18.43 (160)	40	**Sexually Transmitted Diseases**	
12	Encephalitis	0.23 (2)		(a) Gonorrhoea	130.85 (1135)
13	Entric Fever (a) Typhoid	48.73 (423)		(b) Candidiasis	19.00 (165)
	(b) Para Typhoid	0.23 (2)		(c) Chlamydia	0.35 (3)
14	Fish Poisoning	176.70 (1532)		(d) Congential Syphilis	2.07 (18)
15	Ciguatera Fish Poisoning	4.95 (43)		(e) Gential Herpes	0.0 (0)
16	Food Poisoning	3.34 (29)		(f) Granuloma Inguinale	0.0 (0)
17	German Measles (Rubella)	8.75 (76)		(g) Herpes Zoster	4.26 (37)
18	Infectious Hepatitis	36.63 (318)		(h)Lymphogranuloma Inguinale	0
19	Influenza	3,307.75 (27809)		(i) Ophthalmia Neonatorium	1.38 (12)
20	Leprosy	0.23 (2)		(j) PID	0.0 (0)
21	Leptospirosis	17.16 (149)		(k) Soft Chancre	0.0 (0)
22	Malaria	0.12 (1)		(l) Syphilis	64.29 (558)
23	Measles (Morbilli)	4.49 (39)		(m) Trichomoniasis	8.75 (76)
24	Meningitis	11.52 (100)		(n) Veneral Warts	0.0 (0)
25	Mumps	0.46 (4)			
26	Plague	0.0 (0)			
27	Pneumonia	678.82 (5856)			
28	Puerperal Pyrexia	0.0 (0)			
29	Relapsing Fever	0.0 (0)			

Source: NNDSS

The top notifiable diseases for 2015 are Acute respiratory infections, Viral infection, Diarrhoea, and Influenza.
The Incidence rates were calculated using the FIBOS Population of 868532 and expressed as per 100, 000 population.

Table 20: Health Service Utilization Statistics 2015

Divisional and Sub-Divisional Hospital Utilization Statistics

No	Institution	Number of Outpatient	Number of Beds	Total Admission	Total Discharge	Total Patient Days	Occupancy Rate	Daily Bed State	Average Length of Stay
1	CWM Hospital	117,899	481	25,962	25,762	159,971	91%	438	6.2
2	Navua Hospital	1,914	22	1,422	1,411	4,437	55%	12	3.1
3	Vunidawa Hospital	8,218	24	358	342	758	9%	2	2.2
4	Korovou Hospital	4,858	16	937	910	2,037	35%	6	2.2
5	Nausori Hospital	2,355	17	2,350	2,238	2,720	44%	7	1.2
6	Wainibokasi Hospital	3,497	12	808	783	3,440	79%	9	4.4
	Central Division Sub-total	**138,741**	**572**	**31,837**	**31,446**	**173,363**	83%	**475**	**5.5**
7	Lautoka Hospital	163,115	305	14,359	14,128	71,332	64%	**195**	5.0
8	Nadi Hospital	135,558	75	4,739	4,469	14,657	54%	**40**	3.3
9	Sigatoka Hospital	64,048	66	3,950	3,349	11,736	49%	**32**	3.5
10	Ba Mission Hospital	75,217	50	4,057	3,978	8,069	44%	**22**	2.0
11	Tavua Hospital	46,523	29	1,251	1,149	2,889	27%	**8**	2.5
12	Rakiraki Hospital	42,535	30	1,306	1,115	4,087	37%	**11**	3.7
	Western Division Sub-total	**526,996**	**555**	**29,662**	**28,188**	**112,770**	56%	**309**	**4.0**
13	Labasa Hospital	133,862	182	9,042	7,578	34,896	53%	96	4.6
14	Savusavu Hospital	67,329	56	2,103	2,048	5,929	29%	16	2.9
15	Waiyevo Hospital	16,417	33	1,083	1,045	2,799	23%	8	2.7
16	Nabouwalu Hospital	25,110	26	980	942	3,711	39%	10	3.9
	Northern Sub-total	**242,718**	**297**	**13,208**	**11,613**	**47,335**	44%	**130**	**3.6**
17	Levuka Hospital	21,508	40	755	710	2,410	17%	7	3.4
18	Vunisea Hospital	7,647	22	292	272	1,249	16%	3	4.6
19	Lakeba Hospital	3,831	12	173	154	553	13%	2	3.6
20	Lomaloma Hospital	5,996	16	103	90	480	8%	1	5.3
21	Matuku	1,808	5	49	49	134	7%	0	2.7
22	Rotuma Hospital	3,696	14	48	48	163	3%	0	3.4
	Eastern Division Sub-total	**44,486**	**109**	**1,420**	**1,323**	**4,989**	13%	**14**	**3.8**
	TOTAL (Divisional)	**952,941**	**1,533**	**76,127**	**72,570**	**338,457**	60%	**927**	**4.7**
SPECIALISED AND PRIVATE HOSPITALS									
No	Institution	Number of Outpatient	Number of Beds	Total Admission	Total Discharge	Total Patient Days	Occupancy Rate	Daily Bed State	Average Length of Stay
1	St Giles Hospital	7,785	86	460	356	20,861	66%	57	58.6
2	Tamavua/Twomey Hospital	22,189	91	361	329	15,278	46%	42	46.4
4	Military Hospital		9				0%	0	0
5	Naiserelagi Maternity	2,026	7	185	180	259	10%	1	1.4

	Specialized Hospital Sub-total	32,000	193	1,006	865	36,398	52%	100	42.1
	GRAND TOTAL	984,941	1,726	77,133	73,435	374,855	60%	1,027	5.1

Source: Hospital Monthly Returns and PATISPLUS

Based on the above reporting, the overall average length of stay is 5.1 days. The St Giles Hospital and Tamavua/Twomey Hospital have the longest average length of stay as the patients with mental and TB patients have longer Inpatient days. The Occupancy rate is at 60% which illustrates the number of beds occupied by hospital inpatients. The analysis is based on the reports received by Divisional and Sub divisional Hospitals. The discrepancy between discharges and admissions was noted to be 3698 patients; this meant that 3698 were not discharged from the hospitals. This also indicates the quality of entry from the providers and their level of supervision of data. This is also a quality check for the team at HIU and simply means that cases admitted are not discharged due to administrative omissions or in some cases due to chronic disease such as TB or psychiatric co-morbidities. The bed occupancy rates have improved and with improved statistics on admissions and discharges, the perception is that BOR will reflect the true facility incidence.

Table 21: Morbidity and Mortality Statistics 2015

i) **Top ten causes of mortality 2015**

#	Chapter	Diseases	Total	%
1	I00-I99	Diseases of the circulatory system	2267	33.9
2	E00-E90	Endocrine, nutritional and metabolic diseases	1461	21.8
3	C00-D48	Neoplasms	739	11.0
4	V01-Y98	External causes of mortality	404	6.0
5	J00-J99	Diseases of the respiratory system	347	5.2
6	A00-B99	Certain infectious and parasitic diseases	326	4.9
7	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	208	3.1
8	K00-K93	Diseases of the digestive system	194	2.9
9	N00-N99	Diseases of the genitourinary system	177	2.6
10	P00-P96	Certain conditions originating in the perinatal period	116	1.7
	G00-G99, L00-L99, Q00-Q99, D50-D89, M00-M99, F00-F99, O00-O99, H00-H59, H60-H95	Remainder of other diseases	449	6.7
	Grand Total		**6688**	**100.0**

The top cause of mortality remains NCD related (78% of top ten causes of mortality) with disease of the circulatory system being the top cause of mortality, similar to the top cause of mortality in 2014.

ii) Top ten causes of mortality 2015

Tabular	Diseases	Total	Proportionate Mortality (%)	Mortality Rate per 1,000 population
1-052	Diabetes mellitus	1318	19.7	151.8
1-067	Ischaemic heart disease	1108	16.6	127.6
1-069	Cerebrovascular diseases	495	7.4	57.0
1-066	Hypertensive diseases	320	4.8	36.8
1-068	Other heart diseases	275	4.1	31.7
1-094	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	208	3.1	23.9
1-076	Chronic lower respiratory diseases	188	2.8	21.6
1-012	Sepsis	185	2.8	21.3
1-086	Other diseases of the genitourinary system	155	2.3	17.8
1-046	Other malignant neoplasm	146	2.2	16.8
	Other diseases	2290	34.2	263.7
Grand Total		**6688**	**100.0**	**7.7**

The top seven diseases accounting for deaths in 2015 were all NCD related (60% of top ten deaths). Diabetes and its complications were the top cause of mortality in 2015.

Table 22: Top ten causes of morbidity by disease cause group 2015

No.	Disease Classification	Total Cases	Proportionate Morbidity (%)
1	Diseases of the respiratory system	5151	9.3
2	Diseases of the circulatory system	4834	8.8
3	Certain infectious and parasitic diseases	4445	8.1
4	Injury, poisoning and certain other consequences of external causes	3858	7.0
5	Diseases of the genitourinary system	2854	5.2
6	Diseases of the skin and subcutaneous tissue	2813	5.1
7	Diseases of the digestive system	2784	5.0
8	Endocrine, nutritional and metabolic diseases	2033	3.7
9	Neoplasms	1520	2.8
10	Certain conditions originating in the perinatal period	1430	2.6
11	Other diseases	23470	42.5
	Grand Total	**55192**	**100.0**

Source: HDD from Sub-Divisional and PATISPLUS

Diseases of the circulatory system are the leading cause of morbidity in our admitted population and the same trend was observed last year.

Table 23: Top ten causes of morbidity by disease 2015

No.	Disease Classification	Total Cases	Proportionate Morbidity (%)
1	Pneumonia unspecified	1454	2.6
2	Viral Infection unspecified	1315	2.4
3	Type 2 Diabetes Mellitus with foot ulcer due to multiple causes	898	1.6
4	Diarrhoea & gastroenteritis presumed origin	883	1.6
5	Septicemia unspecified	721	1.3
6	Congestive heart failure	680	1.2
7	Local infection of skin & subcutaneous tissue, unspecified	625	1.1
8	Stroke not specified as haemorrhage or infarction	573	1.0
9	Acute severe asthma	569	1.0
10	Cellulitis of lower limb	510	0.9
11	Other diseases	46964	85.1
	Grand Total	**55192**	**100.0**

Source: PATISplus (Clinical Performance Management Report)

Pneumonia unspecified is the leading cause of admissions, while the 10th leading cause of admission is Cellulitis of lower limb when compared to 2014 the leading cause of admission is Viral Infection and 10th leading cause was Acute subendocardial.

Table 24: Health Status Indicators 2014-2015

Indicator	2014 (n)	2015 (n)
Reduced Burden of NCD (Strategic Plan Outcome 1)		
Prevalence rate of diabetes (per 1000 population)	25.9*	105.6
Admission rate for diabetes and its complications, hypertension and cardiovascular diseases (per 1000 admissions)	112.7 (4638)	134.5(3876)
Amputation rate for diabetes sepsis (per 100 admission for diabetes and complications)	15.4 (628)	17.0
Cancer prevalence rate (per 100,000 population)	373.7 (1682)	353.3 (1387)
Cancer mortality (per 100,000 population)	79.9 (691)	85.1 (739)
Cardiovascular disease (ICD code I00-I52.8) Mortality rate per 100,000 population	215.4 (1862)	200.5 (1741)
Admission rate for RHD (1000 admission)	3.0 (125)	2.1 (116)
Motor and other vehicle accidents mortality rate (per 100,000 population)	7.3 (63)	7.9 (69)
Healthy teeth index (DMFT) – 12 year old	1.4	1.4
Begin to reverse spread of HIV/AIDS and preventing, controlling or eliminating other communicable diseases (Strategic Plan Outcome 2)		
HIV prevalence rate among 15-24 year old pregnant women per 1000		
Prevalence rate of STIs among men and women aged 15-24 years per 100000	84.02 (784)	79.2 (688)
TB prevalence rate per 100,000	110	2015 will be estimated by WHO in the 2016 Report.
TB case notification rate of new and relapse cases (per 100,000 population)	39	41
TB case notification of new smear positive cases (per 100,000) From 2015, the NTP notifies notification for bacteriologically	12.2	20[1]

1. Note: 2014 data is using smear positive cases (per 100,000), from the year 2015 the program will be using the 2013 revision - new definitions and reporting framework for tuberculosis which measures new bacteriologically confirmed TB cases instead.

confirmed TB cases (per 100,000 population)		
Tuberculosis case detection rate	60%	62.8%
TB treatment success rate	86%	All forms: 87%, Bacteriologically confirmed TB cases: 86%
TB death rate	4.7	3.02 (26)
Incidence of dengue (per 100,000 pop)	1150.20 (9942)	287.51 (2490)
Incidence of leptospirosis (per 100,000 pop)	20.36 (176)	17.16 (149)
Prevalence rate of leptospirosis (per 100,000 pop)	20.36 (176)	17.2 (149)
Incidence rate of measles (per 100,000 pop)	7.98 (69)	4.49 (39)
Prevalence rate of Leprosy (per 100,000 pop)	0.35 (3)	0.2 (2)
Incidence rate of Gonorrhoea (per 100,000 pop)	135.13 (1168)	130.85 (1135)
Incidence rate of Syphillis (per 100,000 pop)	60.74 (525)	64.29 (558)
Improved family health and reduced maternal morbidity and mortality (Strategic Plan Outcome 3)		
Maternal mortality ratio	44.4	29
Prevalence of anaemia in pregnancy at booking	31.1	32.4
Contraceptive prevalence Rate	43.5	47.1
Proportion of births attended by skilled health personnel	99.7	99.9
Improved child health and reduced child morbidity and mortality (Strategic Plan Outcome 4)		
Prevalence of under 5 malnutrition		38.3
% of one year fully immunized	82.5	83.5
Under 5 mortality rate/ 1000 births	18.0 (364)	16.6 (340)
Infant mortality rate (1000 live births)	13.8 (280)	12.6 (259)
Improved adolescent, health and reduced adolescent morbidity and mortality (Strategic Plan Outcome 5)		
Rate of teenage pregnancy (per 1000 CBA pop)	4.91	24.3
Number of teenage suicides	9	2

The health status indicators for 2015 demonstrate:

The prevalence rate of diabetes is better captured in Public Health Information System (PHIS) since DM notification is currently underreported, the use of PHIS data resulted in the sudden increase of prevalence rate of diabetes being 105.6 compared to 25.9 in 2014. PHIS currently has the best reporting frequency and completeness than the DM notification forms. There is an increased admission rates for diabetes and its complications by 19.3% the prevalence of Cancer decreased in 2015 compared to 2014 by 5.5% and cancer mortality increased by 6.5%. The cardiovascular diseases mortality rate decreased by 7% and the result could be due to the reporting coverage for MCDC; and the admission rates for RHD decreased by 30%. Mortality from MVAs increased by 8.2%. The incidence of Dengue decreased as last year was an outbreak (national) year. And also may be attributed to public awareness, promoting healthy living and interventions which may have also impacted on the incidence of leptospirosis. The MMR has decreased significantly in 2015 compared to 2014 by 35%, and the MDG target is yet to be realized. The other indicator of maternal health such as anaemia in pregnancy has increased by 4.2% and proportion of births attended to by skilled professionals remains consistent. There is an increase in CPR by 8.3%.This indicates an overall improvement in capturing maternal child health and births information in the PHIS and CMRIS reporting. Teenage and adolescent health issues have improved; the rate of teenage pregnancy increased drastically. The rate of suicide amongst teenagers decreased by 78% in 2015 and the figures are dependent on the number of reports received and analysed at HIU.

17. Overseas Patient Referral 2015

Table 25: Patient Referral by Medical Category, 2010-2015

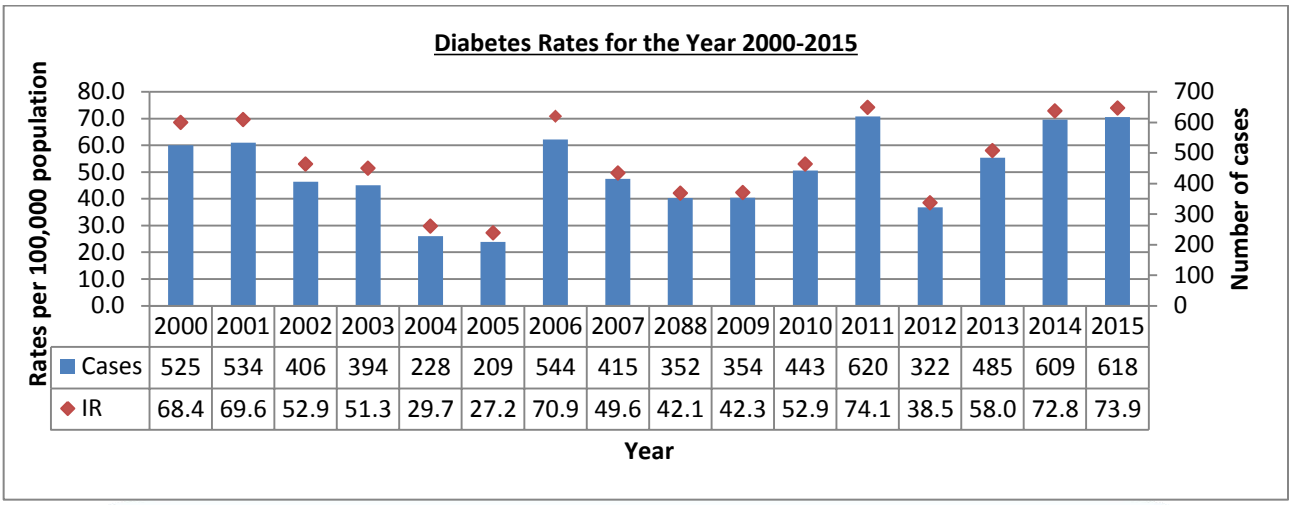
Category	2010	2011	2012	2013	2014	2015	Total
Cardiac	45	97	43	23	3	31	**242**
Oncology	30	50	23	17	22	20	**162**
Renal	2	7	4	1	2	3	**19**
Surgical	11	14	3	15	16	24	**83**
Ophthalmology	5	25	15	9	8	3	**65**
Other	0	10	12	2	3	4	**31**
Total	**93**	**203**	**100**	**67**	**54**	**84**	**601**

Table 26: Patient Referral Costs by Category 2015

Category	2015	Costs
Cardiac	31	$182,384.42
Oncology	20	$88,386.13
Renal	3	$273,479.42
Surgical	24	$13,877.86
Ophthalmology	3	$24,063.70
Other	4	$23,439.80
Total	**84**	**$605,631.33**

18. Disease Trend Analysis 2000-2015

Figure 20: Diabetes Cases 2000–2015

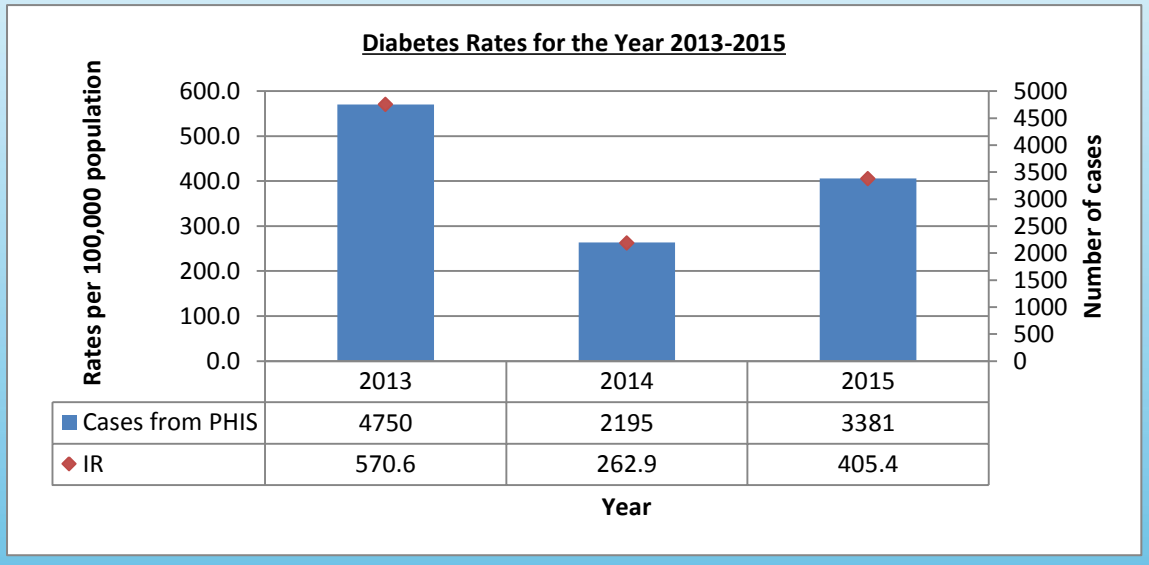


	2000	2001	2002	2003	2004	2005	2006	2007	2088	2009	2010	2011	2012	2013	2014	2015
Cases	525	534	406	394	228	209	544	415	352	354	443	620	322	485	609	618
IR	68.4	69.6	52.9	51.3	29.7	27.2	70.9	49.6	42.1	42.3	52.9	74.1	38.5	58.0	72.8	73.9

Source: Diabetes Notification, 2015

The number of diabetes cases remains variable depending on the number of cases reported. It is noted that there is an increase of notification received within the last 3 years, which shows an improvement in report submission even though it is still underreported.

Figure 21: Diabetes Cases 2013–2015

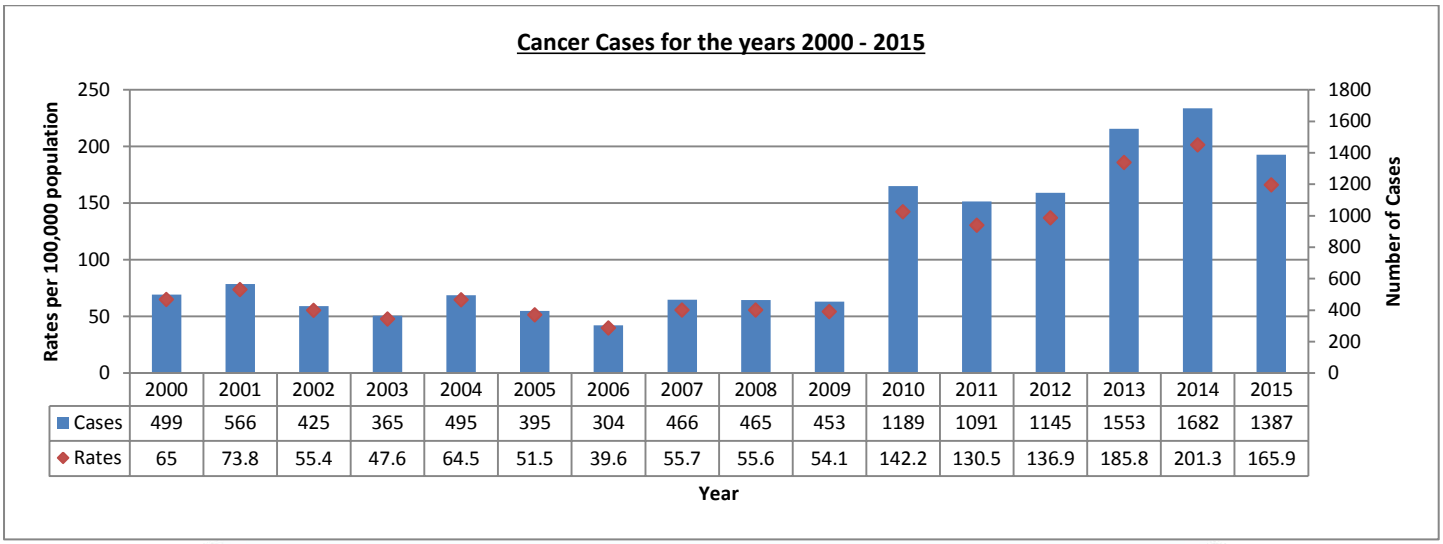


	2013	2014	2015
Cases from PHIS	4750	2195	3381
IR	570.6	262.9	405.4

Source: CMRIS Online [PHIS]

The number of new diabetes cases detected are from medical area level and below. Please note that PHIS reflects the more accurate numbers of new cases of Diabetes than the DM notification forms.

Figure 22: Cancer Cases from 2000 – 2015

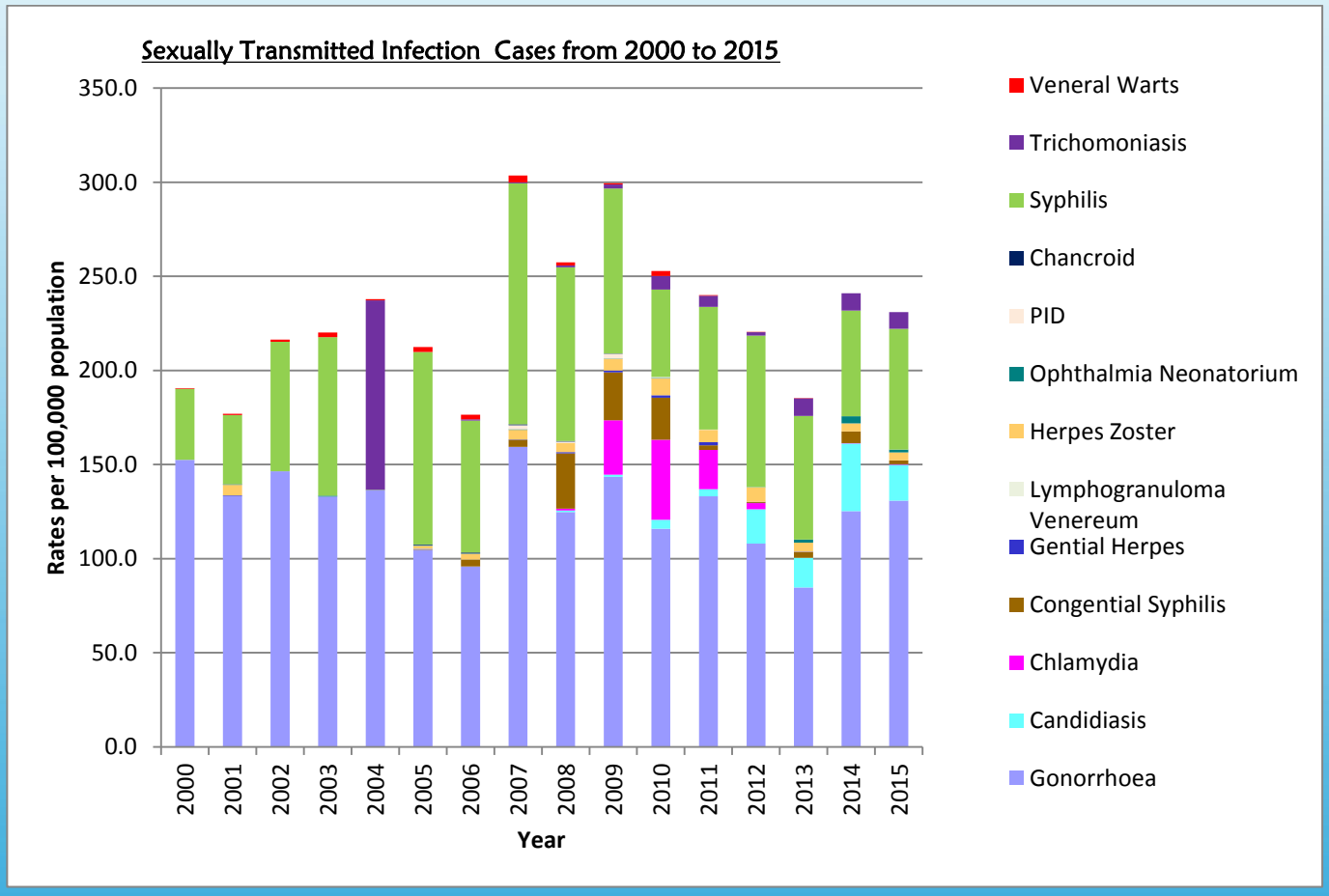


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Cases	499	566	425	365	495	395	304	466	465	453	1189	1091	1145	1553	1682	1387
Rates	65	73.8	55.4	47.6	64.5	51.5	39.6	55.7	55.6	54.1	142.2	130.5	136.9	185.8	201.3	165.9

Source: Cancer Registry 2015

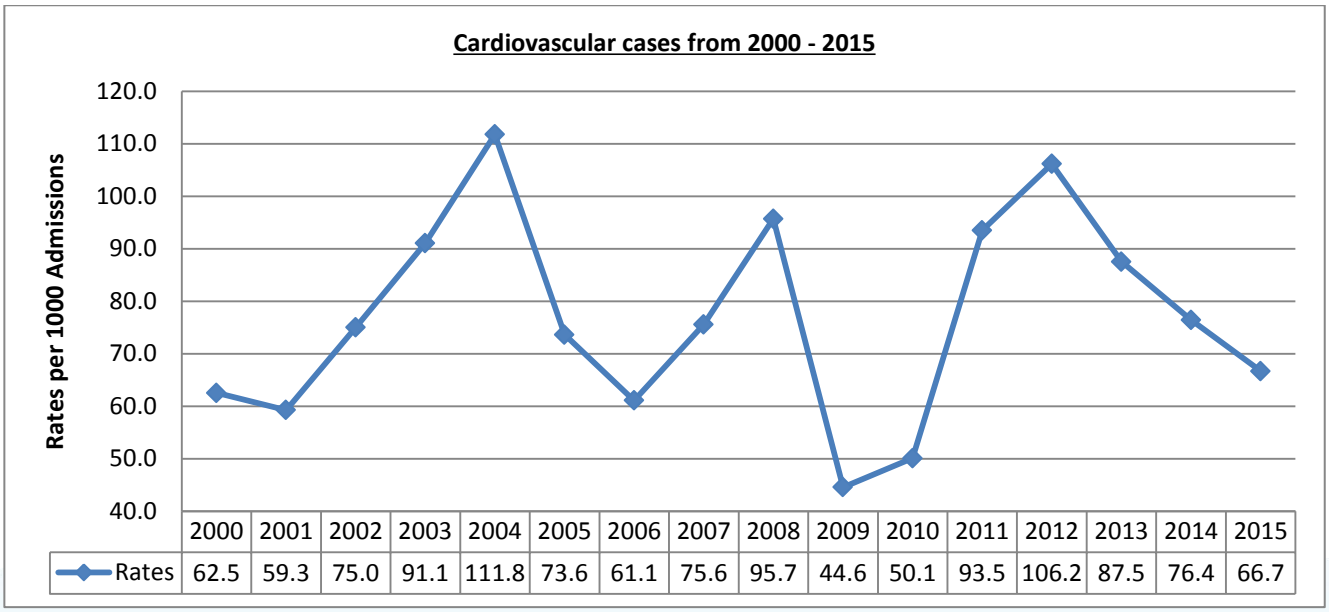
The number of cases of cancer increased in 2010 due to multiple sources of reporting. There is a decline in the cancer cases in 2015 with 1387 confirmed lab cases compared to 1682 cases in 2014. The number of cancer cases reported depends on the number of Pathology lab confirmed cases received from the 3 Divisional Hospitals.

Figure 23: Sexually Transmitted Infection Cases 2000-2015



The incidence of syphilis and gonorrhoea is variable over the years. This could be due to underreporting and differences in syndromic and laboratory case definitions.

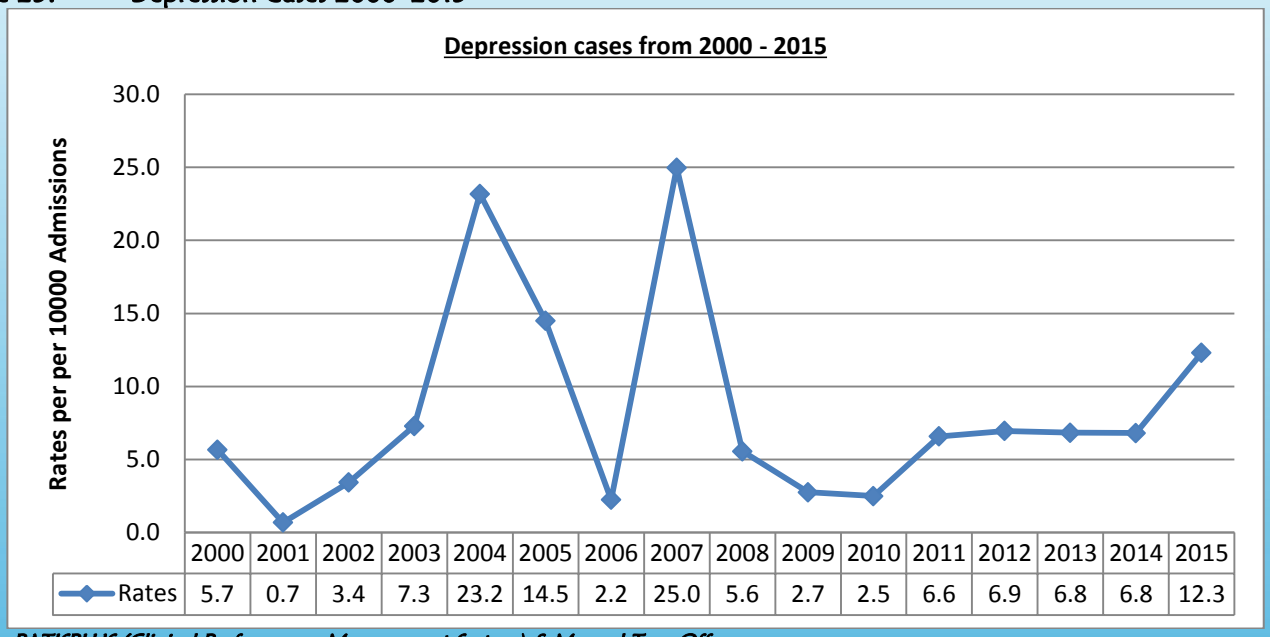
Figure 24: Cardiac Related Cases 2000–2015



Source: PATISplus (Clinical Performance Management System)

The trend of cardiac related cases fluctuates between the 15year periods (2000 – 2015). There were two peaks identified; 1st peak in 2004 with 111 per 1,000 admissions due to cardiovascular cases (I05 – I52.8) and 2nd peak in 2012 it recorded 106 per 1,000 admissions for cardiovascular cases (I05 – I52.8). The codes used are from ICD 10AM 4th edition. There was a slight decrease of admission in the two year period (2013 & 2014) and in 2015 an increase of 95 per 1,000 admissions for cardiovascular cases were noted. The fluctuation in rates reflected the inconsistency of information pertaining to CVD and may also be reflective of the need for improved data quality in this area.

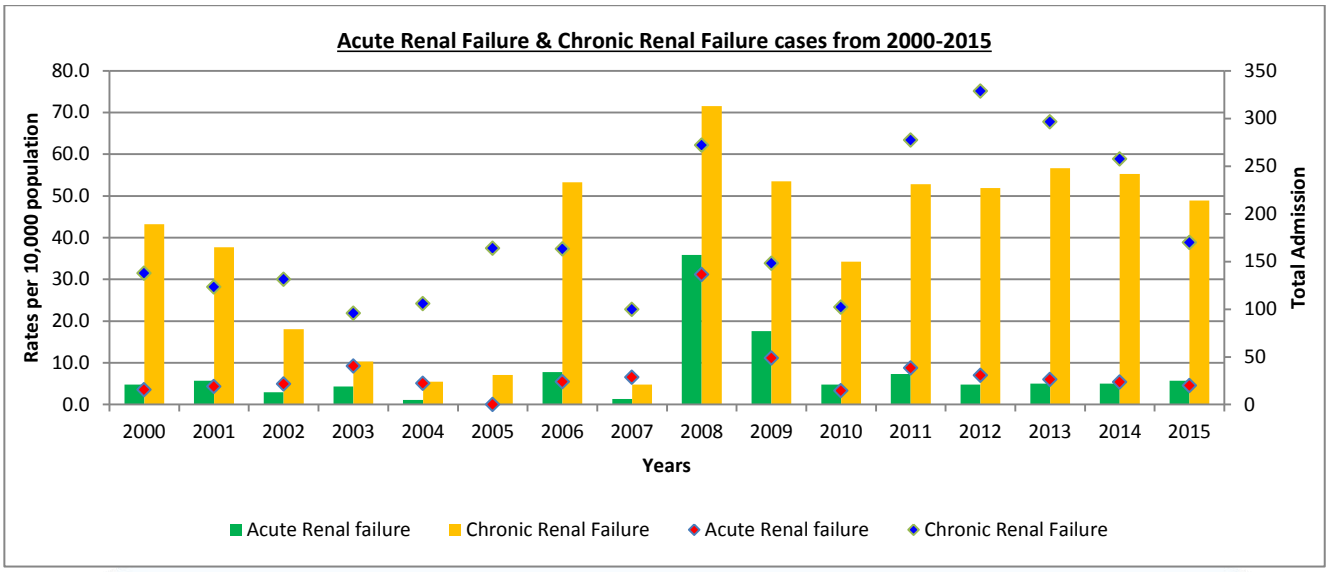
Figure 25: Depression Cases 2000–2015



Source: PATISPLUS (Clinical Performance Management System) & Manual Tear Offs

The trend of depression cases (F32 – F32.9) was fluctuating between2000 – 2007 and saw a major decline between 2008 – 2010. The codes used are from ICD 10AM 4th edition. This trend is reflective of inconsistency of information and suggests that there need to be data quality interventions similar to the CVD area.
However, it was apparent that the admission for depression cases continued to increase gradually in the last 4years. This could be due to stress, having certain medical illnesses and change in lifestyle.

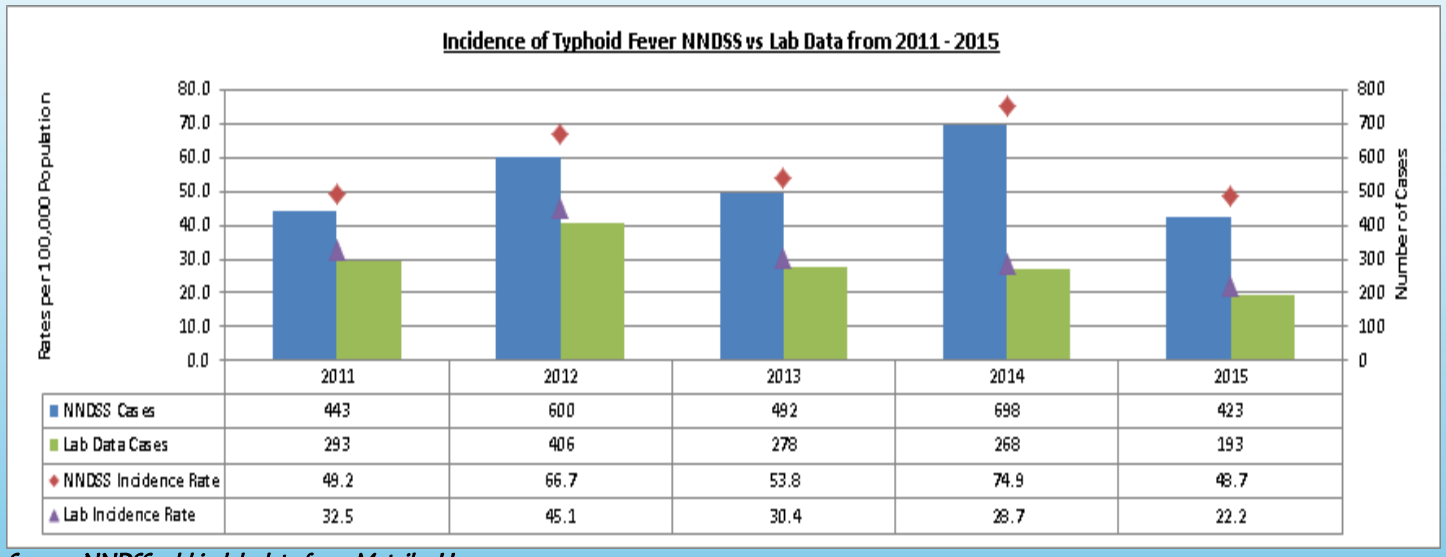
Figure 26: Acute and Chronic Renal Failure Cases 2000-2015



Source: PATISplus (Clinical Performance Management System)

There has been an increase in admissions for Chronic Renal Failure (N18 – N18.91) compared with Acute Renal Failure (N17 – N17.9) with both at a peak in the year 2008. A peak was also noted in 2011, and Chronic Renal Failure is a concern.

Figure 27: Typhoid Cases 2011–2015

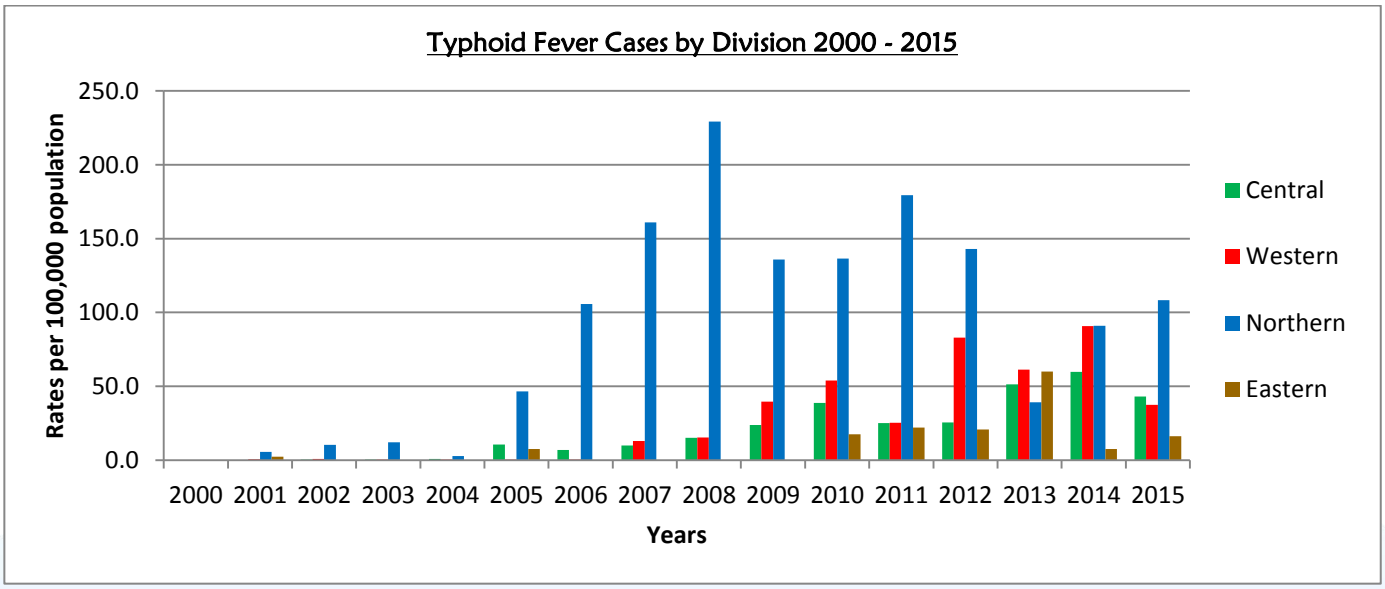


	2011	2012	2013	2014	2015
NNDSS Cases	443	600	492	698	423
Lab Data Cases	293	406	278	268	193
NNDSS Incidence Rate	49.2	66.7	53.8	74.9	48.7
Lab Incidence Rate	32.5	45.1	30.4	28.7	22.2

Source: NNDSS add in lab data from Mataika House

The number of Typhoid cases reported through NNDSS is more compared to lab confirmed cases in the last 5 years; The NNDSS incidence rate reduced by 35% in 2015 and lab incidence rate reduced by 23%. The analysis on NNDSS is based on the clinically diagnosed cases inclusive of government health facilities and few private practitioners whereas analysis for Lab data cases is based on the confirmed numbers that is provided by Mataika House. However, the last 5years have been also reflective of increased burden of typhoid in-country.

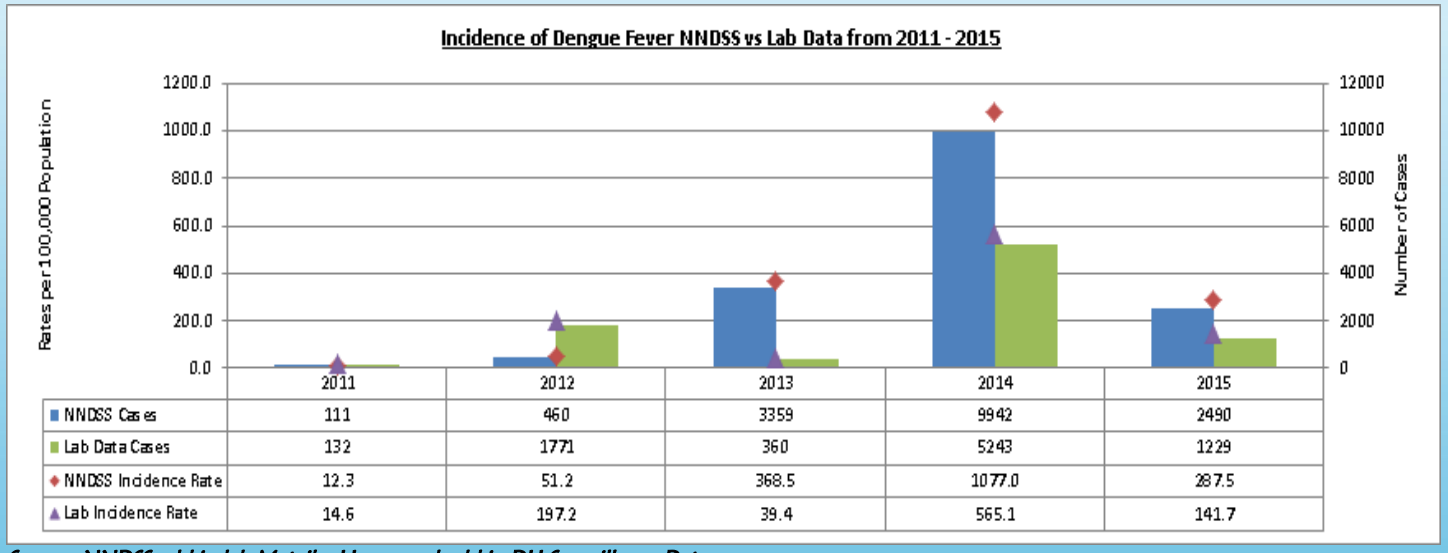
Figure 28: Typhoid Cases by Divisions 2000-2015



Source NNDSS

Typhoid dominates in the Northern division, followed by the Western divison, the Central divison and the lowest incidence was recorded from the Eastern Division. The ranking as such is repeated over the last 14 years. The number of typhod cases analysed also depends on the number of notifications received from the various health facilties.

Figure 29: Dengue Fever Cases 2011 - 2015

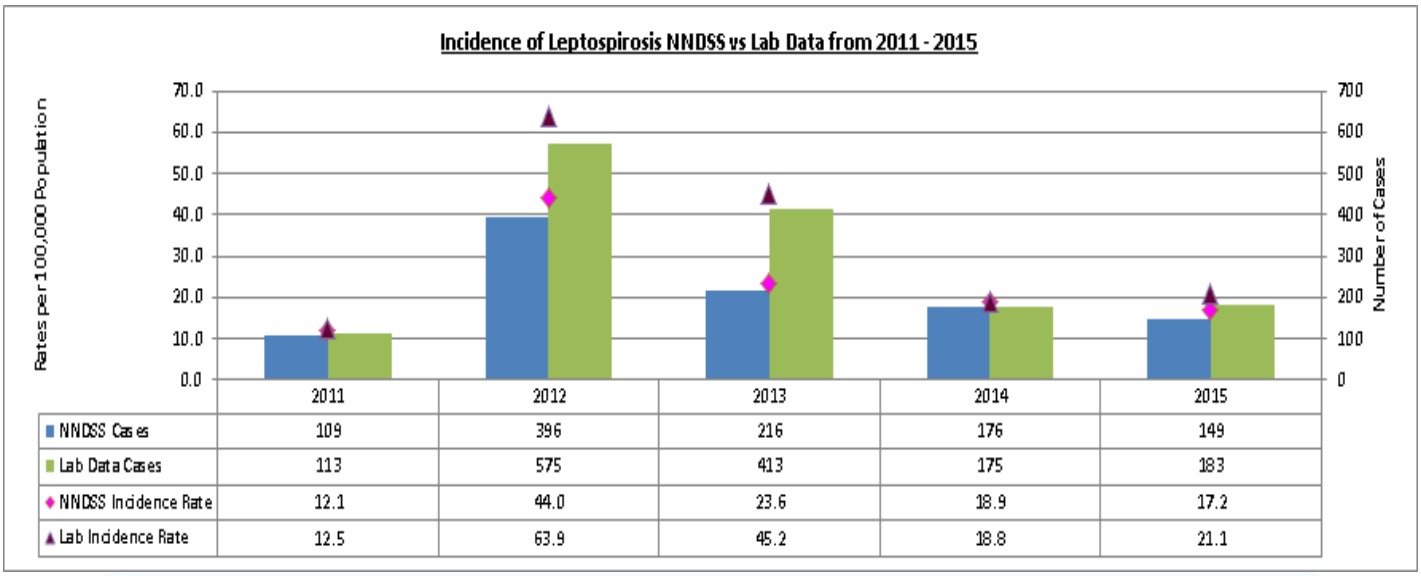


	2011	2012	2013	2014	2015
NNDSS Cases	111	460	3359	9942	2490
Lab Data Cases	132	1771	360	5243	1229
NNDSS Incidence Rate	12.3	51.2	368.5	1077.0	287.5
Lab Incidence Rate	14.6	197.2	39.4	565.1	141.7

Source: NNDSS add in lab Mataika House and add in DLI Surveillance Data

In 2014, there was a drastic increase from 2013 by 192.2% and this was due to the national outbreak. There is a decrease in dengue fever cases in 2015 by 73.3%. The analysis on NNDSS cases is based on the clinically diagnose cases inclusive of government health facilities and few private practitioners whereas analysis for Lab data cases in based on the confirmed numbers that is provided by Mataika House.

Figure 30: Leptospirosis Cases 2011-2015



	2011	2012	2013	2014	2015
NNDSS Cases	109	396	216	176	149
Lab Data Cases	113	575	413	175	183
NNDSS Incidence Rate	12.1	44.0	23.6	18.9	17.2
Lab Incidence Rate	12.5	63.9	45.2	18.8	21.1

Source: NNDSS add in lab data from Mataika House

In the general context, lab data cases is more than NNDSS cases. There was a peak in 2012 and this may be due to national outbreak. It declines in the 2years after and increase by 12.2% in 2015. The analysis are based on the reports received from the reporting facilities.

19. Donor Assisted Programs/Projects 2015

Table 27: Donor Assist Programs

i) Cash Grant

Donor	Program	Amount
Global Fund	Assistance for (Malaria / Tuberculosis) Program	$3,792,439
UNFPA	Family Planning	$339,069
UNFPA	Health Systems Strengthening	$35,000
UNFPA	Reproductive Health Program	$382,287
UNICEF	Health and Sanitation	$75,000
UNICEF	Policy Advocacy, Planning and Evaluation	$30,000
Total Cash Grant		**$4,653,795**

ii) Aid in Kind

Donor	Program	Amount
DFAT	Fiji Health Sector Support Programme	$8,659,508
JICA	Fiji-Okinawa Physiotherapy/Rehabilitation Project	$148,349
JICA	Filariasis Elimination Campaign	$195,820
JICA	Prevention and Control of NCDs	$27,759
NZAID	Medical Treatment Scheme	$471,254
Taiwan	Mental Health Care System Enhancement Project	$131,300
Taiwan	Mobile Medical Teams	$153,600
UNFPA	Technical Assistance	$70,000
UNFPA	Family Planning	$91,500
UNFPA	Health System Strengthening	$15,000
UNFPA	Reproductive Health Programme	$148,933
UNFPA	Volunteer Scheme	$494,001
UNICEF	Policy Advocacy, Planning and Evaluation	$190,000
UNICEF	Health and Sanitation Program	$85,000
WHO	Program Assistance	$1,137,847
Total Aid –in-Kind		**$12,019,871**

20. MDG Progress Report

Table 28: MDG Performance

Targets	2009	2010	2011	2012	2013	2014	2015
Goal 4 Reduce Child Mortality							
Child Mortality Rate/1,000 live births (0-5yrs)					17.9	20.1	16.6
Proportion of 1 year old immunized against Measles	71.7	71.8	82.5	85.9	79.9	82.5	83.5
Infant Mortality Rate/1,000 Live Births					13.7	15.8	12.6
Goal 5 Improve Maternal Health							
Maternal Mortality Ratio per 100,000 live births	27.5	22.6	39.8	59.47	19.07	44.4	29
Contraceptive Prevalence Rate among population of child bearing age	28.9	31.77	36.5	44.3	38.4	43.5	47.1
Rate of teenage pregnancy reduced by 5% (per 1000 CBA population)					7.75	4.9	24.3
Adolescent birth rate (per 1000 girls aged 15-19yrs)					40.1	26.7	30.3
Goal 6 Combat HIV/AIDS and other Diseases							
HIV/AIDS prevalence among 15-24 year old pregnant women					0.037		
Prevalence rate of STIs among men and women aged 15 to 25 (per 100 000				83	55	84.02	79.2
TB Prevalence rate (per 100,000)			40	30	51	110	2015 will be estimated by WHO in the 2016 Report.
TB Death rate (per 100,000)		2.68	3.44	3.56	3.7	4.7	3.02
TB Incidence rate (per 100,000)			27	24		67	2015 will be estimated by WHO in the 2016 Report.
TB Detection rate under DOTS (%)	56%	79%	92%	99%	50%	60%	63%
TB cure rate under DOTS (%)	94%	67%	93%	93%	85%	86%	All forms: 87%, Bacteriologically confirmed TB cases: 86%
Goal 7 Ensure environmental sustainability							
Proportion of population using and improved drinking water source					96%	96%	96%
Proportion of					87%	91.1%	91%

population using and improved sanitation facility							

The under 5 mortality rate has decreased significantly over the last 5 years with general improvement noted in immunization status of one-year olds. The MMR target is still elusive with an increase in the number of maternal deaths noted for 2014. However, the CPR shows improvement between 2013 and 2014.

21. Finance

Figure 31: Auditors Report 2015

OFFICE OF THE AUDITOR GENERAL

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MINISTRY OF HEALTH AND MEDICAL SERVICES
SPECIAL PURPOSE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2015

INDEPENDENT AUDITOR'S REPORT

Scope

I have audited the special purpose financial statements which have been prepared under the cash basis of accounting and notes thereon of the Ministry of Health and Medical Services for the year ended 31 December 2015, as set out in Notes 1 – 5. The special purpose financial statements comprise the following:

(i) Statement of Receipts and Expenditure;
(ii) Appropriation Statement;
(iii) Trading and Manufacturing Account (TMA);
(iv) Trust Fund Account – Statement of Receipts and Payments; and
(v) Statement of Losses.

The Ministry of Health and Medical Services is responsible for the preparation and presentation of the special purpose financial statements and the information contained therein.

My responsibility is to express an opinion on these special purpose financial statements based on my audit.

My audit was conducted in accordance with the International Standards on Auditing to provide reasonable assurance as to whether the special purpose financial statements are free of material misstatements. My audit procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the special purpose financial statements and evaluation of government accounting policies. These procedures have been undertaken to form an opinion as to whether, in all material respects, the special purpose financial statements are fairly stated and in accordance with government accounting policies in Note 2 and the Financial Management Act 2004, so as to present a view which is consistent with my understanding of the financial performance of the Ministry of Health and Medical Services for the year ended 31 December 2015.

The audit opinion expressed in this report has been formed on the above basis.

Qualifications

Cardiology Services Trust Fund Account Statement of Receipts and Payments

1. The Cardiology Services Trust Fund Account Statement of Receipts and Payments had a variance of $895,992 between the closing balance as at 31/12/13 and the opening balance as at 1/1/14. Because of this variance I was not able to ascertain the accuracy of the closing balance of $608,333 as at 31/12/14 in my previous year's audit.

   The variance was not resolved in 2015 and the closing balance of $608,333 was brought forward as opening balance as at 1/1/15.

2. The Cardiology Services Trust Fund Account Statement of Receipts and Payments had a closing balance of $534,299 as at 31/12/15 while the Cash at Bank balance was $594,954 and the Cash

Book balance was $373,148. The Ministry did not reconcile Cardiology Services Trust Fund account FMIS general ledger balance with Cash at Bank balance and Cash Book balance.

3. The bank reconciliation for the Cardiology Services Trust Fund Account for December 2015 included direct credits of $962,246, direct debits of $430,858 and lodgements not credited of $309,582 which have accumulated from previous years. The Ministry did not post the direct credits of $962,246 and direct debits of $430,858 into the FMIS general ledger. In addition the lodgements of $309,582 included in the FMIS general ledger will not be credited in the bank account in future as no actual cash exists with the Ministry.

4. The Cardiology Services Trust Fund Cash Account and the Cardiology Services Trust Fund Receipts and Payments had a credit balance of $270,709.32 and a debit balance of $270,730.40 respectively as per FMIS General Ledger as at and for the year ended 31/12/15.

   Because of the significant matters noted in the above paragraphs I am not able to ascertain the accuracy and correctness of the closing balance of $435,757 for the Cardiology Services Trust Fund Account Statement of Receipts and Payments for the year ended 31/12/15.

Trust Fund Account Statement of Receipts and Payments

The Ministry maintained CWM Hospital Cardiac Force Trust Fund Cash Account with a credit balance of $1,166, Fiji Children Overseas Treatment Trust Fund Cash account with a credit balance of $207,552 and the CWM Hospital Staff Trust Fund Cash Account with a credit balance of $25,469.

These Trust Fund Accounts with a total credit balance of $234,187 were not recorded in the FMIS general ledger and were not included as part of the Ministry's Special Purpose Financial Statements.

Trust Fund Account Statement of Receipts and Payments for Retention Sum

The Ministry did not maintain a separate Trust Fund Account to record the retention sums deducted from progress payments for capital works expenditure totalling $21,503,832. The Trust Fund Statement of Receipts and Payments for retention sum held were not included in the Special Purpose Financial Statements.

Trading and Manufacturing Account

The Ministry did not invite the auditors to observe the annual stock take at the end of the year. As a result I was not able to satisfy by alternative means the Closing Stock of Finished Goods of nil balance held at 31/12/15 which are stated in the TMA Trading Account.

Qualified Audit Opinion

In my opinion:

a) except for the matters referred to in the qualification paragraphs, the special purpose financial statements present fairly, in accordance with the government accounting policies stated in Note 2, the financial performance of the Ministry of Health and Medical Services for the year ended 31 December 2015.

b) the special purpose financial statements give the information required by the Financial Management Act 2004 in the manner so required.

Atunaisa Nadakuitavuki
for AUDITOR GENERAL

Suva, Fiji
29 July 2016

AUDITOR-GENERAL FIJI

Table 29: Segregation of 2015 Budget

Program / Activity	Original Budget ($m)	Revised Budget	% of Overall Revised Health Budget
Program 1 Activity 1 Administration	$24,420,240	$26,885,612	9.97%
Program 1 Activity 1 Research	$633,644	$633,644	0.23%
Program 2 Activity 1 Urban Hospitals	$100,266,025	$102,238,563	37.90%
Program 2 Activity 2 Sub Divisional Hospitals, Health Centres and Nursing Stations	$84,700,478	$79,991,257	29.66%
Program 2 Activity 3 Public Health Services	$5,512,669	$5,968,052	2.21%
Program 2 Activity 4 Drugs and Medical Supplies	$50,077,267	$50,077,267	18.57%
Program 3 Activity 1 Hospital Services	$3,217,565	$3,033,493	1.12%
Program 4 Activity 1 Senior Citizen' s Home	$910,344	$910,344	0.34%
Total	**$269,738,232**	**$269,738,232**	**100%**

Table 30: Proportion of Ministry of Health Budget against National Budget and GDP

Year	Revised Health Budget	National Budget	% of Overall Total Budget	% of GDP
2015	$269,738,232	$3,336,292,100	8.08%	3.48%

Table 31: Statement of Receipts and Expenditure for the Year Ended 31st December 2015

	Notes	2015 $	2014 $
RECEIPTS			
State Revenue			
Operating Revenue: Indirect Taxes		0	0
OPR		0	16,826
Rental for Land		0	0
Rental for Qrts		12,113	13,696
Commission		53,518	49,747
Miscellaneous Revenue		527,193	928,520
Fees Govt B/School		0	0
Total State Revenue	3 (a)	592,824	1,008,789
Agency Revenue			
Health Fumigation & Quarantine		1,696,697	1,778,602
Hospital Fees		3,166,652	2,112,170
License & Others		1,147,381	1,269,624
Fiji School of Nursing		0	0
Miscellaneous Revenue		(112,008)	215
Total Agency Revenue	3 (b)	5,898,722	5,160,611
TOTAL RECEIPTS		6,491,546	6,169,400
EXPENDITURE			
Operating Expenditure			
Established Staff	3 (c)	111,613,327	103,781,190
Unestablished Staff	3 (d)	13,110,237	14,300,629
Travel & Communication	3 (e)	4,599,599	4,249,572
Maintenance & Operations	3 (f)	12,775,696	12,772,759
Purchase of Goods & Services	3 (g)	42,745,792	35,265,801
Operating Grants & Transfers	3 (h)	1,045,988	1,170,544
Special Expenditure	3 (i)	10,205,271	7,332,660
Total Operating Expenditure		196,095,910	178,873,155
Capital Expenditure			
Construction	3(j)	21,503,832	31,306,429
Purchases	3(k)	9,506,003	8,745,113
Total Capital Expenditure		31,009,835	24,398,328
Value Added Tax		11,907,563	10,407,715
TOTAL EXPENDITURE		239,013,308	213,679,19

Table 32: TMA Trading Account for the Year Ended 31st December 2015

Trading Account		2015	2014
		($)	($)
Sales		426,341	544,121
Opening Stock of Finished Goods		22,711	34,196
Add : Purchases		385,252	403,115
Less : Closing Stock of Finished Goods		-	22,711
Cost of Goods Sold		**407,963**	**414,600**
Gross Profit Transferred to Profit & Loss Statement		**18,378**	**129,521**

Table 33: TMA Profit and Loss Statement for the Year Ended 31st December 2015

INCOME	2015	2014
	($)	($)
Gross Profit Transferred to Profit & Loss Statement	18,378	129,521.49
Total Income	**18,378**	**129,521.49**
EXPENSES		
Sales and Related Payments	43,752	48,269
Travel Domestic	1,044	1,108
Telecommunication	923	785
Office Upkeep and Supplies	948	321
Power Supplies	343	669
Special Fees and Charges	4,143	4,031
Rent	15,653	15,653
Total Expenses	**66,806**	**70,836**
NET (LOSS)/PROFIT	(48,428)	58,685

Table 34: TMA Balance Sheet for the Year Ended 31st December 2015

	2015	2014
	($)	($)
Current Assets		
Cash at Bank	563,028	488,827
Account Receivables	2,339	98,345
Finished Goods		22,711
VAT receivables	11,906	134,794
Total Current Assets	**577,273**	**744,677**
Current Liabilities		
	-	-
TOTAL NET ASSETS	**577,273**	**744,677**
EQUITY		
TMA Surplus transferred to consolidated fund	(397,915)	(384,998)
TMA ACC Surplus	1,023,616	1,070,990
Net Loss	(48,428)	58,685
Total	**577,273**	**744,677**

Table 35: Appropriation Statement for the Year Ended 31st December 2015

SEG	Item	Budget Estimate $	Appropriation Changes $	Revised Estimate $ a	Actual Expenditure $ b	Lapsed Appropriation $ (a-b)
SEG	Item	Budget Estimate $	Appropriation Changes $	Revised Estimate $ a	Actual Expenditure $ b	Lapsed Appropriation $ (a-b)
1	Established Staff	111,015,022	4,000	111,019,022	111,613,327	(594,305)
2	Unestablished Staff	11,997,912	-	11,997,912	13,110,237	(1,112,325)
3	Travel & Communication	4,615,400	729,040	5,344,440	4,599,599	744,841
4	Maintenance & Operations	12,989,300	1,295,362	14,284,662	12,772,696	1,508,966
5	Purchase of Goods & Services	44,586,690	3,165,577	47,752,267	42,745,792	5,006,475
6	Operating Grants & Transfers	1,007,520	110,000	1,117,520	1,045,988	71,532
7	Special Expenditure	11,433,795	590,718	12,024,513	10,205,271	1,819,242
	Total Operating Costs	**197,645,639**	**5,894,697**	**203,540,336**	**196,095,910**	**7,444,426**
	Capital Expenditure					
8	Construction	46,142,893	(5,500,012)	40,642,881	21,503,832	19,139,049
9	Purchases	7,550,000	2,105,314	9,655,314	9,506,003	149,311
10	Grants & Transfers	-	-	-	-	-
	Total Capital Expenditure	**53,692,893**	**(3,394,698)**	**50,298,195**	**31,009,835**	**19,288,360**
13	Value Added Tax	18,399,700	(2,499,999)	15,899,701	11,907,563	3,992,138
	TOTAL EXPENDITURE	**269,738,232**	**0**	**269,738,232**	**239,013,308**	**30,724,924**

Table 36: List of Health Facilities

Divisional Hospital			
Central	Eastern	Western	Northern
1. CWM Hospital		1. Lautoka Hospital	1. Labasa Hospital
Sub Divisional Hospitals			
1. Navua	1. Levuka	1. Sigatoka	1. Savusavu
2. Korovou	2. Vunisea	2. Nadi	2. Waiyevo
3. Vunidawa	3. Lakeba	3. Tavua	3. Nabouwalu
4. Nausori	4. Lomaloma	4. Rakiraki	
5. Wainibokasi	5. Rotuma	5. Naiserelagi Maternity	
		6. Ba	
Specialised Hospital			
1. St.Giles Hospital			
2. Tamavua/Twomey Hospital			
Private Hospitals			
1. Suva Private Hospital			
2. Nasese Medical Centre			

Health Centres and Nursing Stations

Central Division		Western Division		Northern Division		Eastern Division	
Health centres [21]	Nursing Stations[21]	Health Centres[28]	Nursing Stations [25]	Health Centres[20]	Nursing Stations [21]	Health Centres[15]	Nursing Stations [31]
Suva Sub-Division		*Lautoka/Yasawa Sub-Division*		*Macuata Sub-Division*		*Lomaiviti Sub Division*	
1. Suva	Naboro	1. Lautoka	Yalobi	1. Labasa	Cikobia	1. Levuka	Batiki
2. Raiwaqa		2. Kese	Somosomo	2. Wainikoro	Visoqo	2. Gau	Nairai
3. Samabula		3. Nacula	Yaqeta	3. Lagi	Coqeloa	3. Koro	Nacavanadi
4. Nuffield Clinic		4. Malolo	Teci	4. Naduri	Vunivutu	4. Bureta	Narocake
5. Valelevu		5. Natabua	Yasawa I Rara	5. Dreketi	Udu		Nawaikama
6. Lami		6. Viseisei	Viwa	6. Seaqaqa	Dogotuki		Nabasovi
7. Makoi		7. Kamikamica	Yanuya	7. Nasea	Kia		Nacamaki
Womens Wellness Centre		8. Punjas			Naqumu		Moturiki
Serua/Namosi Sub-Division		*Nadi Sub-Division*		*Cakaudrove Sub-Division*			
1. Navua	Raviravi	1. Nadi	Nawaicoba	1. Savusavu	Naweni		
2. Beqa	Galoa	2. Namaka	Momi	2. Natewa	Bagasau	*Kadavu Sub-Division*	
3. Korovisilou	Waivaka	3. Bukuya	Nagado	3. Tukavesi	Kioa	1. Vunisea	Ravitaki
4.Namuamua	Navunikabi		Nausori	4. Saqani	Tawake	2. Kavala	Soso
	Naqarawai		Nanoko	5. Rabi	Navakaka	3. Daviqele	Gasele
				6.Korotasere	Nabalebale		Naqara
Rewa Sub-Division		*Ba Sub-Division*		7.Nakorovatu			Vacalea
1. Nausori	Baulevu	1. Ba	Namau				Nalotu
2. Mokani	Namara	2. Nailaga	Nalotawa	*Bua Sub-Division*			Talaulia
3. Wainibokasi	Naulu	3. Balevuto		1. Nabouwalu	Bua	*Lakeba Sub-Division*	
	Nailili			2. Lekutu	Yadua	1.Lakeba	Vanuavatu
	Vatukarasa	*Tavua Sub-Division*		3. Wainunu	Navakasiga	2. Moala	Nayau
Tailevu Sub-Division		1. Tavua			Kubulau	3. Matuku	Oneata
1. Korovou	Verata	2. Nadarivatu	Nadrau			4. Kabara	Komo
2. Lodoni	Dawasamu		Nagatagata	*Taveuni Sub-Division*		5. Ono I lau	Moce
3. Nayavu	RKS			1. Waiyevo	Bouma		Nasoki
	QVS	*Nadroga/Navosa Sub-Division*		2. Qamea	Yacata		Cakova
	Tonia	1. Sigatoka		3. Vuna	Vuna		Totoya

		2. Lomawai	Loma				
Naitasiri Sub-Division		3. Keiyasi	Naqalimare				Levuka-I-Daku
1. Vunidawa	Lomaivuna	4. Raiwaqa	Nukuilau				Udu
2. Naqali	Waidina	5. Korolevu	Wauosi				Namuka
3. Laselevu	Narokorokoyawa	6. Vatulele	Tuvu				Fulaga
4. Nakorosule	Nabobuco	7. Cuvu					Ogea
	Nasoqo	8. Vatukarasa					Vatoa
		Ra Sub-Division				***Lomaloma Sub-Division***	
		1. Rakiraki	Vunitogoloa			1. Lomaloma	Mualevu
		2. Nanukuloa	Tokaimalo			2. Cicia	Tuvuca
		3. Namarai	Nasavu			***Rotuma***	
		4. Nasau	Nayavu-I-Ra			1. Rotuma	

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