HEALTH EQUITY MATTERS
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Building the Community-Led HIV Response in Fiji

(July 2025 – June 2026)

End of Program Internal Evaluation Report

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We thank the teams at PSGDN, Rainbow Pride Foundation, Survival Advocacy Network, Strumphet Alliance, and FJN+, as well as representatives from the Ministry of Health and Medical Services, DFAT Local Post.

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Acronyms and Abbreviations

Acronym	Full Term
ART	Antiretroviral Therapy
ARV	Antiretroviral
CSO	Civil Society Organisation
DFAT	Australian Department of Foreign Affairs and Trade
FJN+	Fiji Network of People Living with HIV
HEM	Health Equity Matters
HIV	Human Immunodeficiency Virus
MEL	Monitoring, Evaluation and Learning
MHMS	Ministry of Health and Medical Services
PLHIV	People Living with HIV
POCT	Point of Care Testing
POW	Peer Outreach Worker
PSGDN	Pacific Sexual and Gender Diversity Network
RPF	Rainbow Pride Foundation
SAN	Survival Advocacy Network
TOR	Terms of Reference

Executive Summary

This report presents the findings of an internal end-of-program evaluation of Building the Community-Led HIV Response in Fiji, a 12-month DFAT-funded program (July 2025–June 2026) delivered by Health Equity Matters (HEM) with five Fijian partner organisations: PSGDN, Rainbow Pride Foundation, FJN+, Strumphet Alliance and the Survival Advocacy Network. The program strengthened key population and PLHIV-led organisations, established a national peer outreach model, and deepened community participation in national HIV coordination.

The evaluation assessed the program against four OECD-DAC criteria, drawing on desk review, seven KIIs, a 14-response stakeholder survey, and a June 2026 field visit to Suva.

Summary of Findings

#	DAC Criterion	Key Evaluation Question	Summary Assessment	Rating
KEQ1	Relevance	To what extent did the program respond to Fiji's HIV context and priorities, particularly the need to strengthen community-led responses and coordination?	Program design and partner selection closely matched Fiji's HIV context, MHMS priorities and key population needs.	**Strong**
KEQ2	Effectiveness Stream 1 (KP & PLHIV Org Strengthening)	To what extent were KP-led and PLHIV-led organizations strengthened?	OCAs and organisational development delivered and valued across all 5 partner organisations; pre/post capacity change not yet formally measurable.	**Strong**
KEQ3	Effectiveness Stream 2 (Peer Outreach)	To what extent was the community-led outreach model established and contributing to program objectives?	Outreach model fully operational and reaching key populations at scale; referral and testing attribution data not yet reliable.	**Moderate**
KEQ4	Effectiveness Stream 3 (National Coordination)	To what extent did the program strengthen community perspectives informing national HIV planning and policy processes?	Funded partner organisations meaningfully engaged in national coordination; inclusion less consistent for community organisations outside the program.	**Strong**
KEQ5	Efficiency	Were program resources and implementation arrangements appropriate and workable given the scale and timeframe?	Partnership arrangements functional and well regarded; short mobilisation period and resourcing gaps (e.g. divisional coordinator compensation) constrained delivery.	**Strong**
KEQ6	Sustainability	What lessons from implementation indicate potential for continuation of key program elements?	Strong partner commitment and clear priorities for continuation; funding continuity, registration costs and government uptake remain material risks to organisations.	**Moderate**

The program was consistently rated highly relevant, meaningfully strengthened five partner organisations, established outreach reaching over 7,000 clients in five months, and shifted community organisations' role in national coordination. The partner relationship was independently rated a strength throughout across all those involved directly.

Two areas were rated Moderate. Peer outreach outcomes cannot yet be fully evidenced: no shared referral definition exists across divisions, a gap the program has already begun addressing. Sustainability is constrained by external factors, not partner commitment: MHMS wants to co-fund community organisations but hasn't yet. We must learn from the past of Fiji's 2012 HIV funding collapse that preceded the current epidemic resurgence.

Community-led responses were valued by every stakeholder consulted. Measured against a genuinely difficult starting point, nascent, often unregistered partners and a rapidly worsening epidemic, this represents strong performance.

Key recommendations:

- DFAT advocacy with MHMS and Finance on government co-financing of peer outreach;
- Support for partner organisations' formal registration; and dedicated budget for program kick-off and reflection in future design.

This evaluation was conducted internally by HEM staff, with independence supported through a locally based Fijian consultant conducting most KIIs, anonymous survey responses, and exclusion of the Pacific Program Lead from KII conduct and analysis. Full limitations are detailed in the Methodology section.

Program Overview

Building the Community-Led HIV Response in Fiji is a 12-month program (1 July 2025 – 30 June 2026) funded by the Australian Government (DFAT) and delivered by Health Equity Matters (HEM) in partnership with Fijian community organisations. The program was funded at AUD 838,576 through the Fiji HIV Support Package, but also ran alongside and intersected with the Indo Pacific HIV Partnerships, in response to a sustained rise in HIV infections in Fiji and the Government's commitment to a more community-led national response.

Following an inception phase in 2025, the program design was refined to focus on three integrated streams:

1. Strengthening Key Population and PLHIV-Led Organisations

This stream focuses on identifying and strengthening organisations led by key populations and people living with HIV. Activities include organisational capacity assessments, tailored organisational development plans, mentoring and technical assistance, and small grants to support governance and systems strengthening.

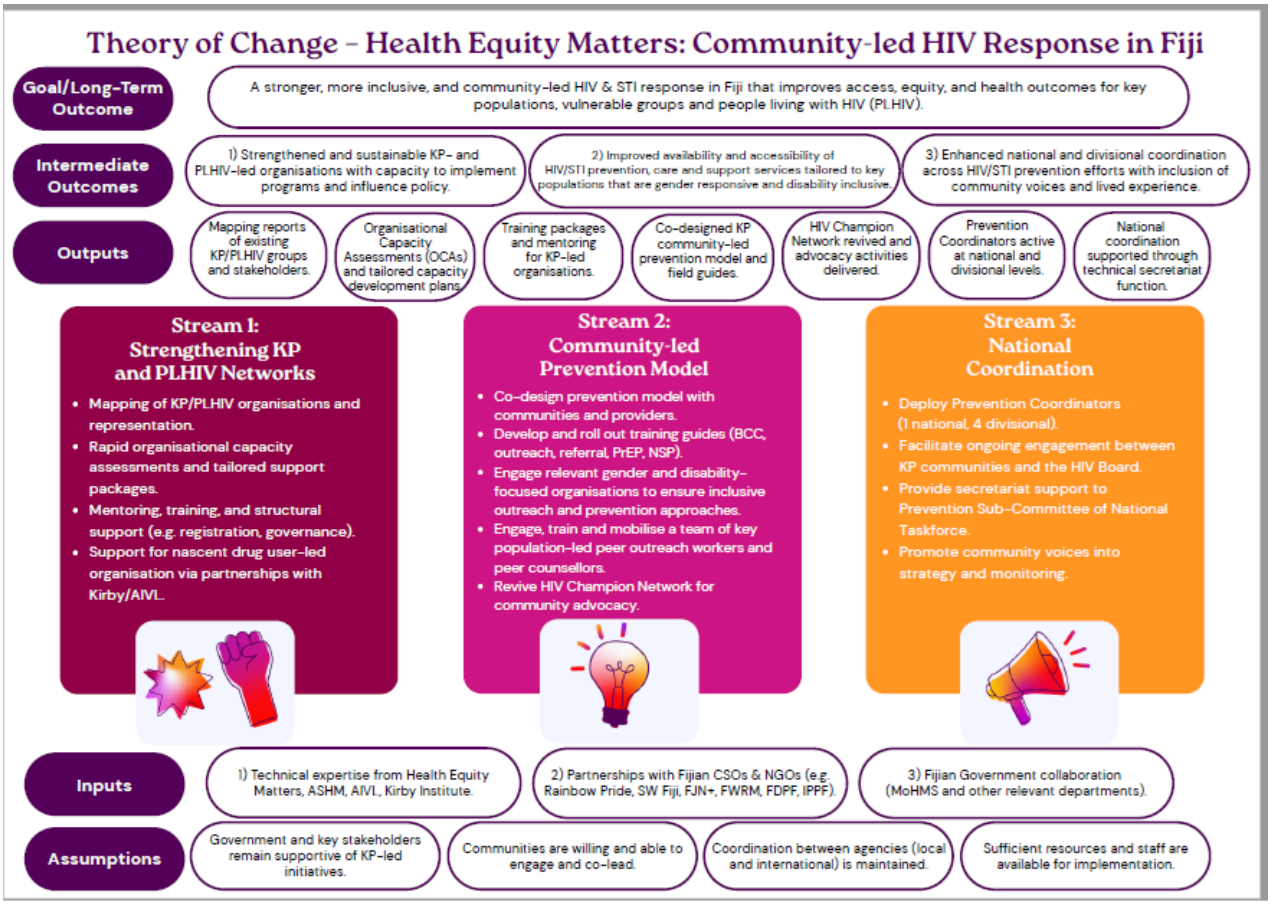
2. Developing and Implementing a Community-Led Outreach Model

This stream supports the development and rollout of a national peer outreach model designed and delivered by community organisations. Outreach activities include HIV prevention education, PrEP promotion, condom and lubricant distribution, HIV testing referrals, peer counselling and other community-led services.

3. Supporting National Coordination

The program provides technical and secretariat support to strengthen national HIV prevention coordination mechanisms and ensure that community perspectives inform national planning and policy processes.

Together these streams aim to contribute to a stronger, more inclusive and community-led HIV response in Fiji that improves access to prevention and care for key populations and people living with HIV. The program's Theory of Change is below.



The program was delivered through PSGDN as lead implementing partner and fiscal sponsor to RPF, FJN+, Strumphet Alliance, SAN, and Aruka, working alongside the Ministry of Health and Medical Services (MHMS) and DFAT Suva Post. Together, the three streams aimed to build a stronger, more inclusive and community-led HIV response in Fiji that improves access to prevention and care for key populations and people living with HIV.

Methodology

Purpose and approach

This evaluation assessed the overall performance and preliminary outcomes of Building the Community-Led HIV Response in Fiji (July 2025–June 2026), a 12-month DFAT-funded program delivered by Health Equity Matters (HEM) in partnership with Fijian community organisations. It was conducted as an internal end-of-program evaluation, designed to be proportionate and fit-for-purpose given the program's scale, duration and available resources. The evaluation was not designed to demonstrate impact as this is not possible with a program period of 12 months.

The evaluation assessed the program against four OECD-DAC criteria adapted to the program context: relevance, effectiveness, efficiency and sustainability. Effectiveness was assessed separately across the program's three streams: organisational strengthening of key population (KP) and PLHIV-led organisations (Stream 1), the community-led peer outreach model (Stream 2), and national HIV coordination support (Stream 3).

Scope and boundaries

This evaluation covers the SURGE Fiji funding component only. It does not assess the wider Indo-Pacific HIV Partnership or the broader regional program managed with UNAIDS, which is subject to a separate six-country midterm evaluation led by UNAIDS (expected in Q3 and Q4 of 2026[1]).

For Stream 2, this evaluation relied on desk review rather than independent data collection. A separate Peer Outreach Rapid Assessment Report, " Locally Led, Community Delivered A Rapid Interim Review of a Peer-Led HIV Outreach Model in Fiji" (July2026) already provides a detailed assessment of outreach effectiveness, including reach, referral pathways, workforce structure, barriers and sustainability scenarios. To avoid duplicating that work and placing further burden on local partners, this evaluation drew on the validation report's findings by reference rather than repeating them. The validation report is annexed to this evaluation.

Methods

The evaluation used a mixed-methods approach combining desk review, key informant interviews and an online survey, with findings triangulated across all three sources.

- **Desk review.** The evaluation team reviewed the program proposal and workplan, MEL framework, quarterly reports, organisational capacity assessment (OCA) records, coordination meeting records, and the Peer Outreach Validation Report (May 2026). A full list of documents reviewed is provided in Annex 1.
- **Key informant interviews (KII).** Seven semi-structured interviews were conducted with representatives of partner organisations and key stakeholders: DFAT Suva Post, MHMS, PSGDN, Rainbow Pride Foundation (RPF), FJN+, Strumphet Alliance and the Survivor Advocacy Network (SAN). Interviews were conducted by the Evaluation Lead and an independent, locally based Fijian consultant completed in person in Suva between June 9 to 19th. The interview with

[1] It is important to note that many activities were partly funded by the Indo-Pacific HIV Partnership as well as through the SURGE funding under Stream 1.

MHMS was conducted online on June 25th. Interview guides for each stakeholder group are provided in Annex 2.

- **Online survey.** A short anonymous survey was distributed to a broader group of stakeholders, including all KII participants plus partner organisation staff, divisional coordinators, and technical and coordination partners (Kirby Institute, ASHM, Doherty Institute, IPPF, UNDP, UNAIDS, WHO). Fourteen responses were received, from HEM, MHMS, FJN+, DFAT, RPF, ASHM, Kirby Institute and AIVL. Some agencies did not respond to the survey as this was voluntary, this is noted as a data gap rather than a negative finding.
- **Triangulation.** Findings from desk review, KIIs and the survey were triangulated. Where sources conflicted or gaps existed, this is noted explicitly in the findings rather than resolved by assumption.

Sampling

Participants were selected purposively based on their direct involvement in program implementation, coordination or oversight, and their ability to speak credibly to the evaluation criteria. All KII participants were also invited to complete the survey to allow triangulation of qualitative and quantitative data at the individual level.

Limitations

- **Short program duration.** At 12 months, the program is too short to assess sustained outcomes. This evaluation reports on early progress and outcomes rather than impact.
- **Internal evaluation.** The evaluation was conducted by HEM staff, the grant recipient, and full independence was not possible by design. This was mitigated through: independent conduct of the majority of KIIs by a locally based Fijian consultant; anonymous survey responses; structured tools applied consistently across stakeholders; exclusion of the Pacific Program Lead from KII conduct and analysis due to a conflict of interest; and triangulation of KII and survey data from the same participants.
- **Stream 2 assessed by desk review only.** Detailed outreach effectiveness is covered by the Peer Outreach Validation Report (May 2026) rather than repeated in this evaluation. However, it's important to note that peer outreach and some feedback also came out in the open-ended responses and through the KIIs.
- **OCA pre/post comparison.** Change in organisational capacity could only be assessed where follow-up OCA data existed; where it did not, findings rely on qualitative evidence from KIIs. Future evaluations and OCA follow-up assessments will be able to measure improvements overtime. OCA comparative assessments are not typically done within less than 12-month time period.
- **The MEL framework** specified many indicators, predominantly output-level rather than outcome-focused, and not all were collected within the program period. This limited the extent to which this evaluation could draw on indicator-level data to assess effectiveness; findings rely primarily on KII and survey evidence instead.

Conflict of interest

The Evaluation Lead is employed by HEM, the organisation responsible for program delivery and the DFAT grant recipient. This is an inherent limitation of an internal evaluation, acknowledged

transparently and mitigated through: independent conduct of the majority of KIIs by a locally based Fijian consultant; exclusion of the Pacific Program Lead, who holds direct implementation responsibility, from KII conduct and evaluation analysis; and validation of findings with key stakeholders prior to finalisation. Given the size and scope of the program, it was decided an internal evaluation was appropriate.

Data Ethics and Confidentiality

This evaluation did not directly collect data from key population or PLHIV individuals. Data collection for this evaluation was limited to KIIs and survey responses from organisational representatives, program staff, and government and donor counterparts. Where key population-level data is referenced in this report (e.g. reach and workforce figures in Stream 2), it is drawn from existing aggregate, de-identified program records and the Peer Outreach Validation Report, which governed its own consent and data collection processes with peer outreach workers separately. This evaluation did not impose any additional data collection burden on key population clients.

Key Findings

Findings are organised against the four OECD-DAC criteria adapted for this evaluation: relevance, effectiveness, efficiency and sustainability. Coherence and impact were scoped out of this evaluation given the program's 12-month duration and scale, consistent with the Evaluation Plan (Section 1.3). Effectiveness is reported separately by program stream, in line with the evaluation matrix. Each section responds directly to the sub-questions set out in the matrix, drawing on desk review, KIIs and survey data, triangulated across sources.

Disaggregation by organisation type (KP-led vs PLHIV-led) is reported where evidence allows. Reach and workforce data are disaggregated by division and key population group. Nearly half of the 7,099 clients reached were recorded without a key population identified, which limits the reliability of this disaggregation.

Summary of Findings

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KEQ6	Sustainability	What lessons from implementation indicate potential for continuation of key program elements?	Strong partner commitment and clear priorities for continuation; funding continuity, registration costs and government uptake remain material risks to organisations.	**Moderate**

Relevance

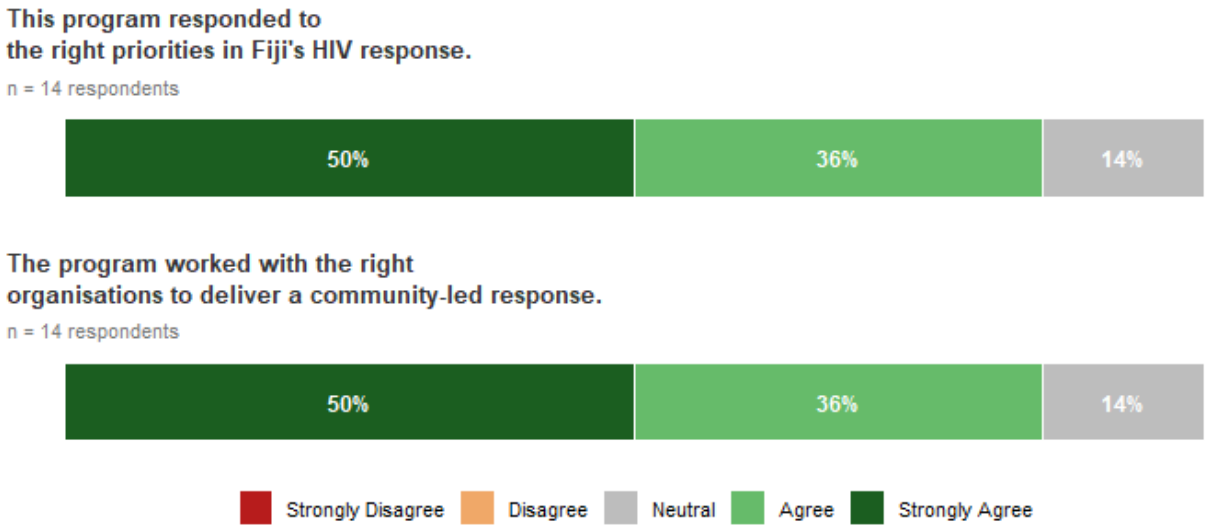
KEQ1 - To what extent did the program respond to Fiji's HIV context and priorities, particularly the need to strengthen community-led responses and coordination?

Sub-Questions

- Was the program design consistent with Fiji's epidemiological context at the time of design?
- Did the program respond to the priorities of MHMS and the national HIV response?
- Were the approaches selected (community-led, KP-focused) appropriate for reaching the populations most affected?

Overall assessment: The program was rated highly relevant across every data source. All 7 KIIs and 12 of 14 survey respondents affirmed both that the program responded to the right priorities and worked with the right organisations, with no Disagree responses recorded.

Figure 1: Stakeholder Survey Results – Relevance



Was the program design consistent with Fiji's epidemiological context at the time of design?
MHMS confirmed the program was requested directly in response to a declared HIV outbreak and a documented rise in new infections among key populations. MHMS noted that DFAT's funding flexibility, compared with more constrained mechanisms such as the Global Fund, allowed the program to be shaped around the emerging epidemiological picture rather than a fixed prior design. DFAT Suva Post independently described the response as needing to match *"the beast of the epidemic,"* corroborating MHMS's account of urgency driving design.

Did the program respond to the priorities of MHMS and the national HIV response?
MHMS stated the program matched what it had requested of DFAT, though it developed this without a formal needs assessment given the pace required. MHMS also valued HEM's ability to fund community organisations directly — something MHMS said its own bureaucratic processes could not do.

Were the approaches selected (community-led, KP-focused) appropriate for reaching the populations most affected?
This was the most strongly evidenced sub-question. All five KP-led and PLHIV-led partner organisations (PSGDN, RPF, FJN+, Strumphet Alliance, SAN) independently described the peer-led, community-based model as reaching populations clinical health services alone could not engage. Several linked this to their

own population group: Strumphet Alliance noted the program was the first to formally include sex workers, including those who also use drugs or are transgender; FJN+ described alignment with its existing strategic goals supporting people living with HIV.

Evidence strength: Strong. Triangulated across desk review, all 7 KIIs, and 14/14 survey respondents on the two directly relevant survey items, with independent corroboration from government (MHMS), donor (DFAT) and all five community partner organisations.

Effectiveness

Stream 1 — Organisational Strengthening

KEQ2 - To what extent were KP-led and PLHIV-led organizations strengthened?

Sub-Questions

- Were organisational capacity assessments completed for partner organisations?
- Were OD plans developed and are they being used?
- Where pre/post OCA data exists, is there evidence of change in organisational capacity?
- Did partners perceive the capacity strengthening support as relevant and useful?

Note: a separate UNAIDS-led six-country regional evaluation is underway, finalising after this evaluation's period of performance. This evaluation's findings will be shared with UNAIDS to avoid duplication of future analysis.

Overall assessment: All five partner organisations were meaningfully strengthened, primarily through organisational capacity assessments (OCAs) and the governance, finance and safeguarding support that followed. The main limitation is measurement as the period of performance of the grant is less than one year and the period is not enough to include both baseline OCA and a follow-up OCA and would be against best practice to conduct both of those in a period of less than 12 months.

Were OCAs completed and OD plans developed? Four of five organisations completed a full OCA Baseline including RPF, FJN+, Strumphet Alliance and SAN. PSGDN's OCA baseline (2024) is now due for updating, which had not occurred within the program period and is funded through a separate UNAIDS funded project. RPF's developed their first-ever strategic plan and draft policy suite developed despite a small two-person team. All four are using their OD plans: FJN+ has improved board and finance documentation; Strumphet Alliance and SAN are both progressing toward formal registration. RPF is looking to re-registering the organisation and strengthening governance structures

Is there evidence of change? Reported changes include FJN+'s expanded outreach infrastructure and national recognition, Strumphet Alliance's increased visibility (including an invitation to speak at a Women Deliver event), and SAN's re-engaged board and formalised child protection policy. However, measurable quantitative changes through longitudinal OCAs did not take place during the period of performance due to the funding being less than 12 months.

PSGDN's 2024 baseline is the only documented starting point conducted before the life of this program. PSGDN's follow-up OCA will be conducted and supported under UNAIDS separate funding. The other partner organisations were supported with OCA baselines that will be followed up and measured quantitatively in future years to measure change over time. Organisational capacity takes times and is not a short term activity.

Did partners find it useful? Strongly and consistently, yes. Strumphet Alliance named OCA and strategic planning support as work that must continue. A PSGDN staff called a safeguarding training delivered

through the program *"a crucial component that came at the right time."* PSGDN also flagged its own resourcing limit directly: *"burnout is real and we need more staff."*

Range of perspectives. AIVL, a technical partner in the PWID space rather than a direct grantee, offered a more critical view of organisational development sector-wide, noting trust between organisations remains limited and that genuine capacity strengthening requires sustained, resourced engagement rather than being assumed. This is a counterpoint from outside the funded partner group, not a critique of this program's Stream 1 work specifically.

Evidence strength: Strong. Triangulated across desk review (OCA records where available), all 5 relevant KIIs, and survey responses from HEM, DFAT, MHMS and AIVL. Weaker specifically on the pre/post capacity-change sub-question, where only qualitative evidence exists.

Stream 2 — Community-Led Outreach

KEQ3 - To what extent was the community-led outreach model established and contributing to program objectives?

Sub-Questions

- Were Was the outreach model developed and operational by end of program?
- Were outreach activities linked to referral pathways and other program streams?
- What does the Peer Outreach Validation Report indicate about early effectiveness?

As set out in the Evaluation Plan, this stream was assessed by desk review only. Detailed effectiveness data (reach, referral pathways, workforce structure, barriers and sustainability scenarios) is provided by Annex 3: Peer Outreach Validation Report (HEM, July 2026), which this evaluation references rather than repeats, to avoid re-consulting peer outreach workers already surveyed at a 94% response rate. The full report is annexed to this evaluation.

Overall assessment: The outreach model is fully operational and reaching key populations at meaningful scale. Its ability to demonstrate outcomes, rather than activity, is currently limited by a systemic referral and data-attribution gap, which the program has already begun to act on.

Was the outreach model developed and operational by end of program?
Yes. The model launched December 2025 and by April–May 2026 comprised of 54 outreach positions across Fiji's four divisions, serving MSM, transgender people, sex workers, people who inject drugs, and street-based populations in partnership with Aruka.

Between December 2025 and April 2026, the program reached 7,099 clients. Delivery was joint across RPF, SAN and Strumphet Alliance, reflecting the community-led design intended from the outset. At the time of writing the evaluation, the program was still in process of conducting their final report which should include the people reached until June 2026.

Were outreach activities linked to referral pathways and other program streams?
Partially. However, this was the clearest identified gap. The Validation Report found no shared definition of "referral" across divisions, with at least four distinct activities recorded under one indicator, and no mechanism to confirm whether a referred client attended for testing, since MOHMS intake forms don't capture referral source. The model is well linked to Stream 1, with HEM concurrently supporting RPF, SAN and Strumphet Alliance's organisational development, and hub staff in the Western division described functional, relationship-based referral pathways where the model is working well.

Improvements were also identified that could strengthen referral and linkages to the wider MHMS led HIV national program.

What does the Peer Outreach Validation Report indicate about early effectiveness?
The model is delivering real, valued outreach including building trust and reaching key populations mainstream services struggle to engage. Partners consistently mentioned the value of trust-building and support for informal PLHIV support and key populations. In addition to areas to strengthen the effectiveness of outreach on the programmatic side, the report also identified sustainability risks including payment delays, divisional coordinators working well beyond contracted hours without added pay, and safety concerns (More than 76% of surveyed peer outreach workers reported feeling unsafe at some point during outreach). The current stipend was assessed as a subsistence-level top-up, not a living wage. The government in the future may want to look at providing outreach workers with a proper wage rather than part-time volunteer stipend.

The program has already begun acting on the report's recommendations. Of the immediate-term actions, HEM has hired a dedicated finance officer for PSGDN and formally revised the divisional coordinator role's scope, hours and compensation. Engagement with MOHMS on adding a referral-source field to intake forms, identified as the single highest-impact fix for the attribution gap, had not started at the time of this evaluation.

Range of perspectives: Not applicable — this stream was assessed by desk review of the Validation Report only, consistent with the Evaluation Plan's scope boundary.

Disaggregation: Reach is disaggregated by division, age, gender and key population grouping. Though many key populations feel unsafe disclosing their status and may decide not to share given criminalisation and stigma.

Evidence strength: Strong for reach and operational status. Moderate-to-weak for outcome attribution; a gap the report itself identifies, and one the program has already started addressing.

Stream 3 — National Coordination

KEQ4 - To what extent did the program strengthen community perspectives informing national HIV planning and policy processes?

Sub-Questions

- Were national HIV coordination mechanisms supported as intended?
- Did community-led organisations participate meaningfully in national coordination processes?
- Is there evidence that community perspectives informed national planning?

Overall assessment: The program meaningfully strengthened community participation in national coordination for its five funded partners, independently corroborated by both MHMS and DFAT. This didn't extend as consistently to community organisations outside the funding relationship which is a limitation.

Were mechanisms supported and was participation meaningful? Yes to both, for funded partners. MHMS confirmed KP civil society organisations are now "more coordinated and working together across different key population groups" than previously, a dynamic it described as new for many of these organisations. DFAT independently corroborated a marked shift in community organisations' visibility

and voice. FJN+ now co-leads civil society representation in the National HIV Response Partnership Forum; RPF sits on the Prevention TWG and pushed back against a development partner attempting to determine community representation on its behalf.

Strumphet Alliance called its inclusion in national working groups "genuine partnership beyond tokenism" and has since supported reviving the five-organisation Fiji Sex Workers Alliance. SAN reported formal inclusion after what it described as years of exclusion, which is quite a meaningful and impactful change as a result of this funding and support.

PSGDN, in its coordinating role, gave a more qualified account: funded partners are engaged, but organisations outside the funding relationship are less consistently included, which PSGDN attributed to how invitations and information are distributed rather than deliberate exclusion noting a recent PrEP Technical Working Group that included additional organisations as a positive counter-example.

Did community perspectives inform national planning? Yes, with specific examples: DFAT and RPF both pointed to the national HIV Peer Outreach Guidelines and the forthcoming HIV and ART National Guidelines as forums that formally incorporated peer outreach worker roles and civil society input meaningfully.

MHMS raised a gap running the other way: it doesn't currently receive systematic reporting from the organisations engaged in peer outreach through this program and would value more structured information flow to strengthen the case for continued investment in data and connecting directly to the attribution gap identified in Stream 2 of the program.

Evidence strength: Strong. Independently corroborated across MHMS, DFAT and all five partner KIIs, with consistent survey responses. The finding on uneven inclusion of non-partner organisations rests on a single source (PSGDN) and should be read as a flagged observation, not a fully triangulated finding.

Efficiency

KEQ5 – Were program resources and implementation arrangements appropriate and workable given the scale and timeframe?

Subquestions

- Were partnership arrangements between HEM and Fijian partner organisations functional and appropriate?
- Were resources allocated and used appropriately given the scale and duration?
- Did partners perceive implementation arrangements as workable?
- Was the program able to adapt activities in response to need and the evolving epidemiological context?

Overall assessment: Program resources and implementation arrangements were appropriate and workable. The partnership between HEM and Fijian partner organisations was consistently and independently rated as a strength; the principal constraint was a compressed mobilisation period and resulting friction in the flow of funds through the partnership chain, rather than a deficiency in program design.

Strengths

All five partner organisations independently rated the HEM partnership positively. RPF described it as *"wonderful, out of all the partners we worked with,"* valuing HEM's approach of setting direction while leaving implementation decisions to partners. Strumphet Alliance credited a locally based HEM coordinator with avoiding delays typical of international partnerships. The program also demonstrated adaptability: funds were reprogrammed as needs shifted (FJN+), POW training was redesigned mid-program to draw jointly from RPF, SAN and Strumphet Alliance, and additional partners (SAN, Strumphet Alliance, Aruka, the Angel Collective) were incorporated beyond the original design.

Constraints

Mobilisation was compressed: partner funding began in September 2025, part-way through the 12-month period, leaving limited time for joint planning. PSGDN noted no budget line existed for a kick-off or reflection session, stating *"we didn't have the opportunity to plan and strategize as the consortium."* This is corroborated by the Peer Outreach Validation Report, which independently found the divisional coordinator role under-resourced and no dedicated finance officer in place.

A related friction emerged in how funds moved through the partnership chain. While 12 of 14 survey respondents rated implementation arrangements Agree or Strongly Agree, RPF's National Coordinator rated this item Neutral, attributing it to tranche delays through PSGDN affecting POW and coordinator stipends. A second RPF respondent raised the same issue independently: *"financial alignments and disbursement between HEM, PSGDN and RPF could reduce operational disruptions."* This is a notable internal variation, given RPF's own KII account of the partnership was strongly positive at leadership level — the friction sits specifically at the funds-flow and field level.

The program's MEL framework was itself a source of inefficiency. It specified many indicators, weighted toward outputs rather than outcomes, and not all were collected within the program period. This represents an avoidable reporting burden built into program design, distinct from the resourcing and funds-flow constraints.

Dissenting view: AIVL, a technical partner not directly funded or involved in program delivery, rated implementation Disagree. Their response reflects broader concerns about trust and resourcing across Fiji's HIV partnership landscape rather than a specific complaint about only Health Equity Matters program's implementation and is reported here as a sole minority view differing from all other organisation feedback.
Evidence strength: Moderate-to-strong. Partnership functionality and adaptability are well triangulated across all 7 KIIs and 12 of 14 survey responses. Resource-use assessment is weaker, as financial reports and the workplan tracker listed in the Evaluation Matrix were not reviewed.

Sustainability

KEQ6 – What lessons from implementation indicate potential for continuation of key program elements?

Sub-questions

- Which program elements were most valued by partners and stakeholders?
- What capacity gains in partner organisations are likely to endure?
- What would partners and stakeholders prioritise for future programming?

Overall assessment: Partners and stakeholders were consistently positive about the program's direction, with clear priorities for continuation. The risk to sustainability is not partner commitment, which is strong, but external factors: external donor funding continuity and the pace of government co-investment in the future once donor funding leaves.

Future government co-investment is a risk. MHMS confirmed it wants community organisations funded as resourced partners, not engaged as unpaid volunteers, but that this currently relies on external donor funding, with the barrier sitting in broader government financing processes outside the HIV Unit's control.

This echoes history: Fiji's 2012 loss of Global Fund eligibility collapsed HIV funding from US$2.3m in 2011 to US$0.4m in 2012 in a single year[2]. This significant drop in funding and program was noted before the period new infections began their sustained rise. Causation can't be established from this evaluation's data, but the pattern supports treating funding continuity as a real risk to meeting and maintaining epidemic control.

Most valued and most enduring. Organisational strengthening (OCAs, governance and finance training, safeguarding) and the peer outreach model itself were named most consistently. PSGDN's Executive Director called OCA support *"the backbone for sustainability and continuity."* RPF, Strumphet Alliance and SAN each named formal registration as their top priority, as the gateway to receiving donor funds directly. Governance gains included FJN+'s board and finance documentation, SAN's re-engaged board, Strumphet Alliance's constitutional progress which were described as durable and sustainable beyond the life of the program. RPF also noted that workload-sharing between RPF, SAN, Strumphet Alliance and FJN+, replacing previously more competitive relationships, is a cultural shift expected to persist independent of funding.

Priorities for future programming:

[2] https://doi.org/10.59425/eabc.1725616800

- Longer, more predictable funding cycles (HEM, RPF, PSGDN). “T*he sector has been under resourced for years." – Community organisation*
- Continued peer outreach funding, including stipend adequacy, corroborated by the Peer Outreach Validation Report.
- Dedicated budget and activities built into the program for reflection, evaluation, and learning from program implementation to inform future programming (PSGDN).
- Expansion to under-served groups including targeted adolescent key populations (MHMS), reach beyond the Central division (FJN+), increase reach of people who inject drugs (SAN).
- Livelihoods and vocational support for peer workers, a gap DFAT noted the program doesn't currently address.

Key lessons. Community-led design works best paired with adequate, flexible resourcing, not goodwill alone and this was echoed across partner KIIs and the Validation Report. Cultural and contextual grounding of the programs matters. SAN highlighted the HIV message framing around Fijian concepts of collective responsibility rather than imported models was important. An anonymous RPF respondent put it simply: *"community-led means community resourced and community trusted."*

Range of perspectives. AIVL offered a more cautious view of organisational development sector-wide: *"it takes a lot of time to build trust, and it needs more than words*".

Disaggregation: KP-led organisations (RPF, Strumphet Alliance, SAN) prioritised registration and direct funding specifically. FJN+ (PLHIV-led) emphasised program innovation and cross-learning instead, citing a peer counselling model adapted from Papua New Guinea.

Evidence strength: Strong for partner-level findings, triangulated across all 7 KIIs and most survey open-ended responses, cross-validated by the Validation Report. The historical funding-pattern context is external, supporting rather than primary evidence.

Lessons Learned

Lessons below are drawn directly from triangulated findings across the four OECD-DAC criteria assessed in this evaluation. Community-led responses were valued by everyone involved, and the program delivered at real scale in a short period, against a genuinely difficult starting point including nascent, several unregistered partner organisations, and a rapidly worsening epidemic. The lessons below are less about whether the model works, that was clearly affirmed, and more about what future phases need to get right operationally to sustain it.

1. Peer-led models can scale quickly when partner organisations are trusted and resourced, not just engaged. The outreach workforce reached 7,099 clients in five months, delivered jointly by three community organisations that were themselves mid-strengthening. The lesson for future design: capacity building and delivery can run in parallel successfully, but only if delivery partners are resourced as genuine implementers, not treated as lower-capacity subcontractors. There is also real work to be done to ensure what is scaled up, is most effective and that given limited time and resources there is a focus on targeting and prioritization to improve case finding and linkage to care.

2. Rapid mobilisation was necessary, but also difficult to launch program implementation and services quickly. Short funding left not much time for planning and a need to move quickly into service delivery. This was inevitable given the rapid scale of the HIV crisis. Future programming should allow for time to stop, reflect and be agile with implementation approaches to optimise program implementation.

3. Funding that passes through multiple organisational layers creates delays, independent of how well each relationship functions. Every individual partnership relationship in this program was rated positively. Funds-flow delays through the chain still occurred and affected frontline stipends. The lesson is structural, not relational and will take time to solve as smaller integral organisations to reaching key populations build their organisational capacity. The layered funding arrangements need careful attention to ensure efficient program implementation and payment.

4. Standard referral and clinical metrics understate what peer-led outreach actually delivers. Trust-building, informal PLHIV support, and unrecorded referrals are central to how this model works, but invisible to the data tools currently in use. Future peer-led programs need to invest in M&E systems designed for all aspects of peer outreach that may also support the case for government funding this program. It is important any M&E systems are fit for purpose and do not overwhelm program implementors with burdensome reporting requirements, which risks taking staff away from providing services.

5. Government co-financing readiness has to be built during the next phase of the program, not sought once donor funding ends. Fiji has lost peer prevention capacity to funding withdrawal in the past (2012), and MHMS has confirmed it wants to co-invest but faces barriers beyond just the HIV Unit. Waiting until program end to pursue this pathway repeats a known risk and should be advocated for over the upcoming years at multiple levels of diplomacy and advocacy.

6. **MEL frameworks need to be proportionate to program capacity and weighted toward outcomes.** This program's MEL framework specified many indicators, predominantly output-level, and not all were tracked within the period. A framework this size creates reporting burden without commensurate insight, particularly for a short, fast-mobilised program. Future program design should build lean, outcome-focused M&E frameworks scoped realistically to what implementing partners can collect, not aspirational frameworks assembled at proposal stage.

Recommendations

Recommendations are grouped by DAC criterion and tagged to their Key Evaluation Question (KEQ), consistent with the evidentiary structure used throughout Key Findings.

Relevance (KEQ1)
No recommendations arise from this criterion. Relevance was rated Strong across all data sources, with no identified gap requiring action.

Effectiveness, Stream 1: Organisational Strengthening (KEQ2)

- Support RPF, Strumphet Alliance, FJN+, and SAN to progress formal registration. All three organisations named this as the gateway to receiving donor funds directly and their top sustainability priority.
- Schedule follow-up OCAs for all partner organisations in the next program phase. Ensure adequate time between baseline and follow-up OCA to assess meaningful and measurable pre/post comparison of organisational capacity change.

Effectiveness, Stream 2: Peer Outreach (KEQ3)
All Stream 2 recommendations are those of the Peer Outreach Validation Report (Section 5, Summary of Recommendations; full detail in Annex 3). This evaluation does not add or modify those.

Effectiveness, Stream 3: National Coordination (KEQ4)

- Recommend a review of key population community organisations are included in coordination mechanisms. While this program's five funded partners were meaningfully included, there are additional organisations outside this funding relationship who will benefit from meaningful engagement in the coordination mechanisms.
- Establish a structured reporting flow from funded community organisations to MHMS. MHMS confirmed it would like to strengthen reporting, and it would support the case for future government investment.

Efficiency (KEQ5)

- Simplify future program MEL frameworks to a smaller set of priority indicators weighted toward outcomes rather than outputs, scoped to what implementing partners can realistically collect within a short program period. This reduces reporting burden and improves the usability of indicator data for future evaluations.
- Build a dedicated budget line for a program kick-off and a mid-program reflection session into future program design.
- Review the funds-flow arrangement between HEM, PSGDN and downstream partners. Tranche delays affected peer outreach worker and divisional coordinator stipends.

Sustainability (KEQ6)

- DFAT should utilize high-level advocacy with MHMS, the Ministry of Finance and other relevant government stakeholders to support government co-financing of peer outreach, given Fiji's demonstrated history (2012) of losing prevention gains due to reduction in external donor funding.
- PSGDN should continue working towards progression of a formal MOU between PSGDN and MHMS as a priority.

Annexes

- Annex 1: Documents Reviewed
- Annex 2: Evaluation Plan
    - Data Collection Tools (KII + Survey Questionnaire)
    - Survey Distribution and KII Participant List
- Annex 3: Peer Outreach Validation Report (June 2026)
- Annex 4: Stakeholder Survey Results

Annex 1: Documents Reviewed

#	Document
1	Building the Community-Led HIV Response in Fiji — Updated Proposal & Workplan (2025–2026)
2	Workplan Gantt Chart
3	Monitoring, Evaluation and Learning Framework
4	Budget
5	Project Risk Register
6	Project MEL Plan
7	Program Design: Fiji Community-Led HIV Prevention
8	Community Perspectives in Embedding Gender Equality, Disability and Social Inclusion in Fiji's HIV Response (Brief for DFAT)
9	Health Equity Matters — Fiji Support Overview (2025–2026)
10	Quarterly Reports (Q1–Q3)
11	Organisational Capacity Assessments — PSGDN, RPF, FJN+, Strumphet Alliance, SAN
12	Peer Outreach Database
13	Peer Outreach Validation Report (Rapid Interim Review of the Peer-Led HIV Outreach Model in Fiji)
14	Peer Outreach Recommendations and Action Plan Tracker
15	Evaluation Plan and Data Collection Tools

SURGE Building the Community-Led HIV Response in Fiji (July 2025–June 2026)

Evaluation Plan and Data Collection Tools

May 2026

Evaluation Team

- **Evaluation Lead**: Matthew Kusen, Senior Technical & Program Advisor – International
- **Program Lead/Advisor**: Jessica Hill, International Program Specialist
- **Independent Evaluation Consultant**: Saimone Simione Morua Tuni

Section 1 — Refined Methodology

1.1 Purpose and use of this evaluation

This document sets out the evaluation plan and data collection tools for the internal end-of-program evaluation of *Building the Community-Led HIV Response in Fiji (2025–2026)*, a 12-month initiative funded by the Australian Government (DFAT) and delivered by Health Equity Matters in partnership with Fijian community organisations.

The purpose of this evaluation is to assess the overall performance and early outcomes of the program and to generate practical learning for future programming. It is not designed to prove impact as the program duration and resources are insufficient for that. However, the evaluation is designed to provide credible evidence of progress against intended outcomes, assess the appropriateness of the program's implementation approaches, and document lessons that can inform future community-led HIV programming in Fiji.

The primary audience for this evaluation is Health Equity Matters program leadership and implementing partner organisations. Findings will be used to strengthen implementation approaches and inform future program design. Secondary audiences include the Ministry of Health and Medical Services (MHMS), DFAT (Canberra and Suva Post), and technical partners involved in Fiji's HIV response.

Following an inception phase in 2025, the program design was refined to focus on three integrated streams:

1. Strengthening Key Population and PLHIV-Led Organisations

This stream focuses on identifying and strengthening organisations led by key populations and people living with HIV. Activities include organisational capacity assessments, tailored organisational development plans, mentoring and technical assistance, and small grants to support governance and systems strengthening.

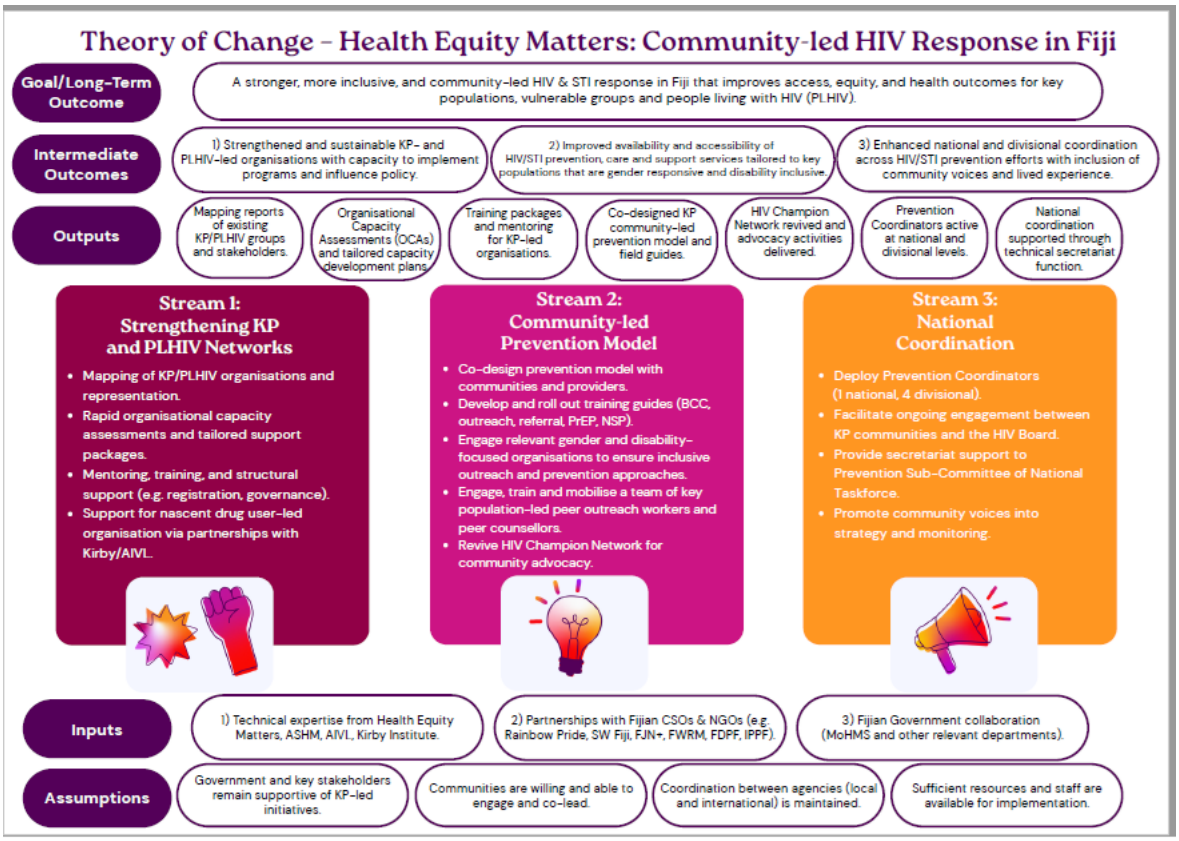
2. Developing and Implementing a Community-Led Outreach Model

This stream supports the development and rollout of a national peer outreach model designed and delivered by community organisations. Outreach activities include HIV prevention education, PrEP promotion, condom and lubricant distribution, HIV testing referrals, peer counselling and other community-led services.

3. Supporting National Coordination

The program provides technical and secretariat support to strengthen national HIV prevention coordination mechanisms and ensure that community perspectives inform national planning and policy processes.

Together these streams aim to contribute to a stronger, more inclusive and community-led HIV response in Fiji that improves access to prevention and care for key populations and people living with HIV. The program’s Theory of Change is below.



1.2 Scope and boundaries

This evaluation covers the SURGE Fiji funding of the program and does not assess the wider Indo-Pacific HIV Partnership or the broader regional program managed in partnership with UNAIDS, which is subject to a separate evaluation commissioned by UNAIDS across six countries. That evaluation is planned to be completed between July – September 2026.

The program being evaluated is a 12-month initiative (1 July 2025 to 30 June 2026) with a total budget of AUD 500,000. Given the scale and duration, this evaluation has been designed to be proportionate and fit-for-purpose, conducted using existing program resources with an estimated level of effort of 10 to 15 working days across the evaluation team.

The evaluation assesses program performance against four OECD-DAC criteria across three program streams:

- Criteria: relevance, effectiveness, efficiency and sustainability
- Stream 1: organisational strengthening of key population and PLHIV-led organisations
- Stream 2: community-led peer outreach
- Stream 3: national HIV coordination support

One important scope boundary applies to Stream 2. A separate Peer Outreach Validation Report completed in May 2026 provides a detailed assessment of outreach effectiveness including reach, referral pathways, workforce structure, barriers and sustainability scenarios. To avoid duplication and minimize burden on local partners, this evaluation does not repeat that work. Stream 2 is assessed with findings from the validation report conducted between APril – May 2026.

1.3 Evaluation criteria and key questions

This evaluation assesses program performance against four OECD-DAC criteria adapted to the program context: relevance, effectiveness, efficiency and sustainability. Given the scale and duration of the program, the evaluation does not attempt to assess all possible dimensions of each criterion. Key evaluation questions and corresponding evidence are set out in the Evaluation Matrix (Section 2, Tool 1).

1.4 Methods

The evaluation uses a mixed-methods approach combining desk review with targeted stakeholder engagement. Methods were selected to be proportionate to the scale and timeframe of the program while ensuring findings are credible and triangulated across multiple sources.

- **Desk review:** The primary first step. Review of key program documentation including the program proposal and workplan, MEL framework and results matrix, quarterly reports, organisational capacity assessment records, coordination meeting records, and the Peer Outreach Validation Report (May 2026).
- **Key informant interviews (KIIs):** Seven individual semi-structured interviews with representatives of partner organisations and key stakeholders. Interviews will be conducted by the Evaluation Lead and, where agreed, by the local Fijian consultant ahead of the field visit. The field visit to Suva (16-19 June 2026) will be used to conduct remaining KIIs and validate emerging findings with stakeholders. The indicative split between interviews conducted before and during the field visit will be confirmed closer to the time based on stakeholder availability.
- **Online survey:** A short anonymous survey distributed to a broader group of stakeholders including partner staff, divisional coordinators, technical partners and coordination of stakeholders. The survey captures perceptions of program effectiveness, coordination quality, implementation challenges, and sustainability. Outreach workers are not included in the survey as their perspectives are covered by the Peer Outreach Validation Report.
- **Triangulation:** Findings from all three methods will be triangulated before reporting. Where sources conflict or gaps exist, this will be noted explicitly in the report.

1.5 Sampling

All sampling is purposive. Participants were selected based on their direct involvement in program implementation, coordination or oversight, and their ability to provide credible evidence against the evaluation criteria.

KII participants:

- DFAT Suva Post
- Ministry of Health and Medical Services (MHMS)
- PSGDN (sub-grantee of Health Equity Matters and lead implementor in Fiji)
- Rainbow Pride Foundation (RPF)
- FJN+ (PLHIV-led organization)
- Strumphet Alliance
- SAN

All KII participants will also complete the online survey. This allows quantitative and qualitative data to be triangulated.

Survey participants in addition to the list of those who are being interviewed for the KII also include:

- Partner organisation staff
- Divisional coordinators
- Technical partners including Kirby Institute, ASHM, Doherty Institute, IPPF and UNDP
- Coordination stakeholders including UNAIDS and WHO

Technical partners and coordination stakeholders are included in the survey rather than KIIs to keep the evaluation proportionate to the scale of the program while still capturing their perspectives.

Where data permits, findings will be disaggregated by sex/gender and organisation type (KP-led/PLHIV-led). Any gaps in disaggregation will be noted in the report.

1.6 Limitations

The following limitations are acknowledged and have been considered in the design of the evaluation and the interpretation of findings.

- **Short program duration:** At 12 months, the program period is insufficient to assess sustained outcomes or longer-term change. This evaluation assesses early outcomes and progress toward intended results rather than impact. Findings should be interpreted accordingly.
- **Internal evaluation:** The evaluation is conducted by staff employed by Health Equity Matters, the grant recipient. Full independence is not possible by design. This limitation is mitigated through: use of anonymous survey responses to reduce social desirability bias; structured data collection tools applied consistently across all stakeholders; independent conduct of selected KIIs by a locally based Fijian consultant; all KII participants also completing the online survey to allow triangulation of qualitative and quantitative data; and explicit acknowledgement of this limitation in the final report. Findings will be validated with key stakeholders prior to finalisation.

- **Small evaluation team:** The international program team is small and the evaluation lead carries dual responsibilities as both MEL Lead and Senior Technical Advisor. This is acknowledged as a resourcing constraint inherent to the scale of the program and organisation. The evaluation has been scoped and designed to be realistic given available capacity.
- **Data availability:** Where data gaps exist they will be noted explicitly rather than papered over.
- **OCA pre/post comparison:** Change in organisational capacity can only be assessed where follow-up OCA scores were recorded. Where pre/post comparison is not possible, findings will rely on qualitative evidence from KIIs and document review.
- **Stream 2 desk review only:** Detailed assessment of outreach effectiveness is covered by the Peer Outreach Validation Report (May 2026). This evaluation does not repeat that work in order to minimize duplication and overwhelming partners who are simultaneously responding to a fast-paced emergency HIV epidemic in Fiji.

1.7 Conflict of interest

The Evaluation Lead is employed by Health Equity Matters, the organization responsible for program delivery, and the recipient of the DFAT grant being evaluated. This is an inherent limitation of an internal evaluation and is acknowledged transparently. The following mitigation plans have been put in place to minimize any conflict of interest.

- The majority of KIIs are conducted by an independent locally based Fijian consultant.
- The Pacific Program Lead, who has direct responsibility for program implementation, does not lead interviews or evaluation analysis.
- Findings are validated with key stakeholders prior to finalization.

Section 2 — Data Collection Tools

Tool 1 — Evaluation Matrix

Master reference for the evaluation. All other tools derive from this matrix.

Criterion	Key Evaluation Question	Sub-questions	Evidence to Seek	Data Sources	Method
RELEVANCE	To what extent did the program respond to Fiji's HIV context and priorities, particularly the need to strengthen community-led responses and coordination?	• Was the program design consistent with Fiji's epidemiological context at the time of design? • Did the program respond to the priorities of MHMS and the national HIV response? • Were the approaches selected (community-led, KP-focused) appropriate for reaching the populations most affected?	• Alignment with Fiji HIV epidemiological trends • Coherence with MHMS priorities and national HIV response • Responsiveness to key population needs	• Program proposal and design documents • National HIV situation reports (where available) • KII: MHMS, partner organisations	Desk review + KIIs + Survey
EFFECTIVENESS Stream 1 Organisational Strengthening	To what extent were KP-led and PLHIV-led organizations strengthened? *A separate UNAIDS-led regional evaluation (6-country) is underway. This will be finalized after this Evaluation is complete outside the period of performance for this grant. Our findings will be shared to UNAIDS to avoid duplication.*	• Were organisational capacity assessments completed for partner organisations? • Were OD plans developed and are they being used? • Where pre/post OCA data exists, is there evidence of change in organisational capacity? • Did partners perceive the capacity strengthening support as relevant and useful?	• Completion of Organisational Capacity Assessments and Organisational Development Plans; • Evidence of capacity improvements • Partner perception of usefulness and relevance of capacity support	• OCA tools and results • Organisational development plans • KIIs • Survey: partner staff	Desk review + KIIs + Survey
EFFECTIVENESS Stream 2 Community-Led Outreach	To what extent was the community-led outreach model established and contributing to program objectives?	• Was the outreach model developed and operational by end of program? • Were outreach activities linked to referral pathways and other program streams? • What does the Peer Outreach Validation	• Outreach model developed and operational by end of program • Model linked to referral pathways and other program streams • Validation report findings on early effectiveness	• Locally Led, Community Delivered: A Rapid Interim Review of a Peer-Led HIV Outreach Model in Fiji (May 2026) • Peer Outreach Database	Desk review *Detailed effectiveness assessment (reach, referrals, workforce structure, barriers, sustainability scenarios) is covered by a separate report*[1].

[1] "Locally Led, Community Delivered: A Rapid Interim Review of a Peer-Led HIV Outreach Model in Fiji (May 2026)" This evaluation references findings from this report rather than duplicating

Criterion	Key Evaluation Question	Sub-questions	Evidence to Seek	Data Sources	Method
		Report indicate about early effectiveness?	integrated by reference		
EFFECTIVENESS Stream 3 National Coordination	To what extent did the program strengthen community perspectives informing national HIV planning and policy processes?	• Were national HIV coordination mechanisms supported as intended? • Did community-led organisations participate meaningfully in national coordination processes? • Is there evidence that community perspectives informed national planning?	• Evidence of community perspectives reflected in national planning outputs • Stakeholder perceptions of coordination quality and inclusiveness • Secretariat functions delivered as intended	• Meeting minutes and coordination records • KIIs • Survey	Desk review + KIIs + Survey
EFFICIENCY	Were program resources and implementation arrangements appropriate and workable given the scale and timeframe?	• Were partnership arrangements between HEM and Fijian partner organisations functional and appropriate? • Were resources allocated and used appropriately given the scale and duration? • Did partners perceive implementation arrangements as workable? • Was the program able to adapt activities in response to need and the evolving epidemiological context?	• Functionality of partnership arrangements; • appropriateness of resource use; • partner perceptions of implementation arrangements; • evidence of program agility and adaptation	• Workplan progress tracker • Financial reports • KII: HEM staff, partner leads • Survey: partners	Desk review + KIIs + Survey
SUSTAINABILITY	What lessons from implementation indicate potential for continuation of key program elements?	• Which program elements were most valued by partners and stakeholders? • What capacity gains in partner organisations are likely to endure? • What would partners and stakeholders prioritise for future programming? • What are the key lessons learned for community-led HIV programming in Fiji?	• Elements identified as high-value by partners and stakeholders • Capacity gains in partner organisations likely to endure • Enabling conditions for future support • Key lessons for future community-led	• KII • Survey	KIIs + Survey

information. No separate KIIs or survey questions on outreach were developed to minimize duplication.

Criterion	Key Evaluation Question	Sub-questions	Evidence to Seek	Data Sources	Method
			HIV programming in Fiji		

Disaggregation: Where data is available, findings should be disaggregated by sex/gender and organisation type (KP-led vs PLHIV-led).

Tool 2 — KII Guide: DFAT, MHMS, PSGDN, RPF, FJN+, SAN, Strumphet Alliance

Seven individual semi-structured KIIs will be conducted with representatives of partner organisations and key stakeholders. Separate interview guides were developed for four stakeholder groups, reflecting differences in their roles, relationships to the program, and the evaluation criteria most relevant to their perspective. All guides follow a consistent structure: a brief introduction and consent process, a set of core questions and reflections.

The following guides are annexed to this document:

- Annex A: KII Guide — DFAT Suva Post
- Annex B: KII Guide — MHMS
- Annex C: KII Guide — PSGDN
- Annex D: KII Guide — KP and PLHIV-led organisations (RPF, FJN+, SAN, Strumphet Alliance)

Organisation	Name (Position)	Contact Emails
1. DFAT Suva Post	Dr Frances Bingwor (Senior Program Manager – Health) Emeline Cammack (Counsellor, Human Development)	frances.bingwor@dfat.gov.au emeline.cammack@dfat.gov.au
2. MHMS	Jason Mitchell (Lead – HIV & SRH Unit / Chair of HIV Taskforce Emali Tuirara (HIV Prevention Lead) Dr Dashika Balak (HIV Clinical Treatment Lead) Ashna Shaleen (HIV Coordinator – Australia Fiji Health Program (Ashna is DFAT funded but embedded in HIV Unit)	j.mitchell.dr@gmail.com emtuirara@gmail.com gothika.dashika@gmail.com ashna.shaleen@fpsp.org.fj
3 PSGDN	Loata Tucika – Executive Director Bulou Tokalaulevu – Finance Manager Joseva (Seru) Etuini– MEL Coordinator Maria – Programme Manager Benjamin Patel – Finance & Admin / HEM Coordinator	psgdn.executive@psgdn.com fin.manager@psgdn.com mel.coordinator@psgdn.onmicrosoft.com programme.manager@psgdn.com fijihemc@healthequitymatters.org.au
4 RPF	Asaeli Sinusetaki – Executive Director Atu Dokonivalu – National Peer Led Outreach Coordinator	asinusetaki@gmail.com fijinclpc@healthequitymatters.org.au / adokonivalu@gmail.com
5 FJN+	Joeli Colati – Executive Director Rochelle Naulunimagiti – Peer Counselling Manager Rebecca Kubunavanua – Board Member Christopher Lutukivuya – Board Member	Fjnplus@gmail.com naulunimagitir@gmail.com rebeccakubunavanua@gmail.com christopher.lutukivuya@gmail.com
6 SAN	Sesenieli (Bui/Butch) Naitala – National Coordinator	survivaladvocacynetworkfiji@gmail.com
7 Strumphet	Sophie Radrodro – National Coordinator Uha Fifita (unsure of official title)	strumphet.alliance.network@gmail.com fifitauha@gmail.com

Tool 3 — Stakeholder Survey

A short anonymous online survey will be distributed to a broader group of stakeholders than those participating in KIIs. The survey complements the KII data by capturing a wider range of perspectives on program effectiveness, coordination quality, implementation arrangements and lessons learned. All KII participants will also complete the survey, allowing triangulation of qualitative and quantitative data at the individual stakeholder level.

The survey is designed to take no more than 10-15 minutes to complete. It will be distributed via an online link in English. Responses are anonymous and participants are asked only to identify their organisation so findings can be disaggregated where relevant. The survey will be distributed in early June and closed by June 15th.

The survey instrument is annexed to this document as Annex E.

Section 3 — Evaluation Plan

Phase	Tasks	Timing
1. Preparation	Desk review; finalise data collection tools; brief local consultant; distribute survey	May 2026
2. Data Collection	KIIs (independent and field visit); survey; field visit Suva	June 1— 19 June 2026
3. Analysis and Drafting	Thematic analysis; triangulation; draft report	22- 26 June 2026
4. Finalisation	Incorporate feedback; finalise and share report	30 June 2026

Annex A: Key Informant Interview Guide

DFAT Local Post – Suva

Format: Individual semi-structured interview
Duration: 30–45 minutes
Conducted by:

Introduction (5 minutes)
Thank you for making time for this interview. I am conducting an independent end-of-program evaluation of the Building the Community-Led HIV Response in Fiji program, funded by DFAT and delivered by Health Equity Matters and partners. The program took place between July 2025 – June 2026.

The evaluation assesses program performance against four criteria: relevance, effectiveness, efficiency and sustainability. Your perspective is valuable.

Your responses will inform the evaluation findings but will not be attributed to you by name in the final report, however we may mention your organization DFAT given the relevance as the donor. If at any point there is something you would prefer not to be attributed to you or your organisation, please let me know.

I will be recording this conversation to assist with notetaking. The recording will remain within the evaluation team and be deleted once the report is finalised. Are you comfortable with that?

Section 1: Relevance

1. From your perspective, was this program responding to the right priorities in Fiji's HIV response?
2. Did the program work with the right organisations to deliver and strengthen a community-led response to the HIV epidemic?
3. Did the program appear to complement and align with other HIV-related activities happening in Fiji during this period?

Section 2: Effectiveness

4. From your perspective, did the community organisations involved in this program appear to be strengthened or better positioned because of this program's support?
5. Did you observe any change in how community perspectives were represented in national HIV coordination processes during the program period

Section 4: Sustainability and future programming

6. Which elements of this program were most valuable from your perspective in contributing to the overall community HIV response?
7. What are the key lessons learned to inform future community-led HIV programming in Fiji?

Closing
Is there anything about the program or the broader response in Fiji that you think this evaluation should understand that we have not covered yet?

Annex B: Key Informant Interview Guide

Ministry of Health and Medical Services (MHMS)

Format: Individual semi-structured interview
Duration: 45–60 minutes
Conducted by:

Introduction (5 minutes)
Thank you for making time for this interview. I am conducting an independent end-of-program evaluation of the Building the Community-Led HIV Response in Fiji program, funded by DFAT and delivered by Health Equity Matters and partners. The program took place between July 2025 – June 2026.

The evaluation assesses program performance against four criteria: relevance, effectiveness, efficiency and sustainability. Your perspective as a key government stakeholder in Fiji's HIV response is particularly valuable to this evaluation.

Your responses will inform the evaluation findings. If at any point there is something you would prefer not to be attributed to you or your organisation, please let me know.

I will be recording this conversation to assist with note-taking. The recording will remain within the evaluation team and be deleted once the report is finalised. Are you comfortable with that?

Section 1 — Relevance

1. From MHMS's perspective, was this program responding to the right priorities in Fiji's HIV response, and did it work with the right organisations?
2. How well did this program align with MHMS's own priorities and direction for the national HIV response?

Section 2 — Effectiveness
Stream 3 — National coordination

4. Did the program strengthen community participation in national HIV coordination and planning processes, and were community perspectives meaningfully reflected in national planning?

Section 3 — Sustainability

5. Which elements of this program do you think are most important to continue or build on?
6. What are the key lessons learned and what would you want to see done differently in future programming?

Closing
Is there anything about the program or the broader response in Fiji that you think this evaluation should understand that we have not covered yet?

Annex C: Key Informant Interview Guide

PSGDN

Format: Individual semi-structured interview
Duration: 45–60 minutes
Conducted by:
Introduction (5 minutes)
Thank you for making time for this interview. I am conducting an independent end-of-program evaluation of the Building the Community-Led HIV Response in Fiji program, funded by DFAT and delivered by Health Equity Matters and partners. The program took place between July 2025 – June 2026.

The evaluation assesses program performance against four criteria: relevance, effectiveness, efficiency and sustainability. Your perspective as a key implementing partner in Fiji's HIV response is particularly valuable to this evaluation.

Your responses will inform the evaluation findings. If at any point there is something you would prefer not to be attributed to you or your organisation, please let me know.

I will be recording this conversation to assist with note-taking. The recording will remain within the evaluation team and be deleted once the report is finalised. Are you comfortable with that?

Section 1 — Relevance

1. From your perspective, did this program respond to the right priorities in Fiji's HIV response, and did it work with the right organisations?

Section 2 — Effectiveness

Stream 1 — Organisational strengthening

2. What organisational capacity support did PSGDN receive through this program, and do you feel your organisation is better positioned as a result?

Stream 3 — National coordination

3. Did the program strengthen community participation in national HIV coordination and planning, and were community and key population perspectives meaningfully reflected?
4. How would you describe the secretariat and coordination support provided through this program?

Section 3 — Efficiency

5. How did the partnership arrangement with HEM work in practice, and were you able to adapt activities in response to emerging needs?
6. Were there any aspects of the implementation arrangements that could be improved?

Section 4 — Sustainability and future programming

7. Which elements of this program were most valuable to continue?
8. What are the key lessons learned and what would you want to see done differently in future programming?

Closing
Is there anything about the program or the broader response in Fiji that you think this evaluation should understand that we have not covered yet?

Annex D: Key Informant Interview Guide

Implementing Organisations

Format: Individual semi-structured interview
Duration: 45–60 minutes
Conducted by:
Interviewer note: *FJN+ is a PLHIV-led organisation. Questions should be framed around their mandate to support people living with HIV where relevant. RPF, SAN and Strumphet Alliance are KP-led organisations and questions should be framed around their mandate and key population communities where relevant.*

Introduction (5 minutes)
Thank you for making time for this interview. I am conducting an independent end-of-program evaluation of the Building the Community-Led HIV Response in Fiji program, funded by DFAT and delivered by Health Equity Matters and partners. The program took place between July 2025 – June 2026.

The evaluation assesses program performance against four criteria: relevance, effectiveness, efficiency and sustainability. Your perspective as a key implementing partner in Fiji's HIV response is particularly valuable to this evaluation.

Your responses will inform the evaluation findings. If at any point there is something you would prefer not to be attributed to you or your organisation, please let me know.

I will be recording this conversation to assist with note-taking. The recording will remain within the evaluation team and be deleted once the report is finalised. Are you comfortable with that?

Section 1: Relevance

1. From your perspective, did this program respond to the right priorities in Fiji's HIV response?
2. How well did the program design reflect the needs and priorities of your community (key population communities / people living with HIV)?

Section 2 — Effectiveness
Stream 1 — Organisational strengthening
3. What organisational capacity support did your organisation receive through this program and how useful was it?
4. Do you feel your organisation is better positioned or more capable as a result? Can you give a specific example?

Stream 3 —National coordination
5. Did the program strengthen your organisation's participation in national HIV coordination and planning processes?
6. Were the perspectives of your community (key populations / people living with HIV) meaningfully reflected in national HIV planning during this program period?

Section 3 — Efficiency
7. How did the partnership arrangement with Health Equity Matters work in practice, was it functional, appropriate and responsive to your needs?
8. Were there aspects of the implementation that could be improved?

Section 4 — Sustainability and future programming
9. Which elements of this program were most valuable to your organisation and should be continued?
10. What are the key lessons learned and what would you want to see done differently in future programming?

Closing
Is there anything about the program or the broader response in Fiji that you think this evaluation should understand that we have not covered yet?

Annex E: Stakeholder Survey

This survey supports an independent end-of-program evaluation of Building the Community-Led HIV Response in Fiji (July 2025 – June 2026), a 12-month program funded by the Australian Government (DFAT) and delivered by Health Equity Matters in partnership with Fijian community organisations. The program worked across three streams: strengthening key population and PLHIV-led organisations; supporting a community-led peer outreach model; and strengthening national HIV coordination. The evaluation assesses program performance against four criteria: relevance, effectiveness, efficiency and sustainability. Your perspective is valuable.

The survey should take no more than 10 minutes to complete. Responses are not tied to you as an individual but may be referenced by organisation.

Section A — About you

1. Name of organisation - (optional)
2. Which best describes your organisation?
    - Community/KP-led organisation
    - PLHIV-led organisation
    - Government (MHMS)
    - Donor (DFAT)
    - Technical partner (including UN agencies)
    - Other
3. How closely were you involved in this program?
    - Directly involved in implementation
    - Involved in coordination
    - Aware of the program, but not directly involved

Section B — Relevance and effectiveness

4. This program responded to the right priorities in Fiji's HIV response.
   (Likert: Strongly agree — Strongly disagree)
5. The program worked with the right organisations to deliver a community-led response.
   (Likert: Strongly agree — Strongly disagree)
6. What did you observe as the most significant result or contribution of this program? *(Open)*

Section C — Efficiency and partnerships

7. The partnership and implementation arrangements were appropriate and workable.
   (Likert: Strongly agree — Strongly disagree)
8. The program was able to adapt to emerging needs and the evolving HIV context in Fiji.
   (Likert: Strongly agree — Strongly disagree)

Section D — Sustainability and lessons

9. What is the most important lesson from this program for future community-led HIV programming in Fiji? *(Open)*
10. What aspects of the program could be improved or done differently? (open)

Closing

11. Any final reflections or comments you would like to share? *(Open)*

Survey Distribution List

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A Rapid Interim Review of a Peer-Led HIV Outreach Model in Fiji

Assessing early implementation of the Peer Outreach Worker program through Rainbow Pride Foundation in partnership with Survival Advocacy Network and Strumphet Alliance

Health Equity Matters | July 2026

Prepared by: Philips Loh, Senior Program and Technical Advisor, Health Equity Matters

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We thank the teams at PSGDN, Rainbow Pride Foundation, Survival Advocacy Network, Strumphet Alliance, and FJN+, as well as representatives from the Ministry of Health and Medical Services, the Kirby Institute, AIVL, and the Angels Collective. We also thank Dr Suwastika Naidu and Dr Sunia Vosikata for conducting the financial benchmarking study that forms part of this review.

Conflict of Interest

This review was conducted by Health Equity Matters, which holds the funding contract for the program under review. The author has no personal financial interest in the findings or outcomes of this review.

Acronyms and Abbreviations

Acronym	Full Term
AIVL	Australian Injecting and Illicit Drug Users League
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASPHA	Australian Support for Pacific HIV Action
CSO	Civil Society Organisation
DFAT	Australian Department of Foreign Affairs and Trade
FJN+	Fiji Network of People Living with HIV
HEM	Health Equity Matters
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioural Survey
IEC	Information, Education and Communication
MEL	Monitoring, Evaluation and Learning
MOHMS	Ministry of Health and Medical Services
MOU	Memorandum of Understanding
MSP	Marie Stopes Pacific
NCLPC	National Community-Led Prevention Coordinator
PLHIV	People Living with HIV
POCT	Point of Care Testing
POW	Peer Outreach Worker
PSGDN	Pacific Sexual and Gender Diversity Network
RFHAF	Reproductive and Family Health Association of Fiji
RPF	Rainbow Pride Foundation
SAN	Survival Advocacy Network
SDMO	Subdivisional Medical Officer
SRH	Sexual and Reproductive Health
TOR	Terms of Reference

Executive Summary

1. Introduction and Purpose

This report presents findings from the rapid Interim Review of Rainbow Pride Foundation's (RPF) peer-led HIV prevention outreach program in Fiji. The program is implemented by RPF in partnership with other Fiji-based key population led groups SAN and Strumphet, in collaboration with the Fiji Ministry of Health and Medical Services (MOHMS) and other partners. Funding is provided by the Australian Department of Foreign Affairs and Trade (DFAT) through a one-year contract with Health Equity Matters as part of its Surge funding to address the recent outbreak of HIV in Fiji. Health Equity Matters manages the outreach program through a contract with Pacific Sexual and Gender Diversity Network (PSGDN), who subcontracts the activity to RPF.

The review was conducted in April and May 2026, ahead of the new DFAT-funded 2.5 year Australian Support for Pacific HIV Action (ASPHA) grant period beginning in mid-2026. Its purpose is to take stock of what is working, what needs strengthening, and what needs to be in place before the program is scaled up further. It is a practical, light-touch stocktake designed to produce actionable recommendations within a short timeframe.

This internal stocktake addresses five key review questions:

1. Is the outreach model working effectively?
2. Can we demonstrate that outreach is driving HIV testing?
3. Is data collected consistently and telling the right story?
4. Are stipends and costs appropriate?
5. Is training and supervision adequate?

These five questions are addressed across the findings in Section 3, organised under the thematic areas of: referral quality and data consistency; stipend and payment systems; supervision and support structures; hub engagement and attribution; and training adequacy. The stocktake includes a financial benchmarking component covering stipend rates and allowance structures for outreach workers and coordinators in Fiji, conducted by external specialists commissioned as part of this review (see Annex 3).

The HIV peer outreach program in Fiji is delivered through several distinct streams operating across Fiji. This internal stocktake focused primarily on the main RPF-coordinated cohort of peer outreach workers (POWs) working across Fiji's four divisions. POWs serve men who have sex with men, transgender people, people who inject drugs, sex workers, and street-based populations, including through engagement with Aruka (a local street-based welfare agency). This cohort comprised 60 trained workers, of whom 54 were active at the time of review.

This stocktake does not assess Aruka as a separate organisation or program component but references its work where relevant to understanding the broader outreach landscape and referral pathways.

The Angels Collective is a separate community-led peer education initiative made up of people with lived and living experience of injecting drug use. It was initially formed under DFAT Surge funding to the Kirby Institute and was supported by Australian technical partner, the Australian Ilicit Drug User's League (AIVL). It has since transitioned to private philanthropic funding and is working towards establishing itself as a self-governed community organisation. It operates only in the Central Division.

FJN+ (Fiji Network of People Living with HIV) activities, including the Home Visitation Program and the PLHIV peer counselling stream, also partly-funded through Health Equity Matters under DFAT Surge funding, are also

outside the scope of this stocktake. They are referenced only where needed to clarify the boundaries between different peer support and outreach functions.

Data collection

See Annex 2 for the full list of stakeholders consulted. Data was collected through:

- A focus group discussion with peer outreach workers across all four divisions
- Group interviews with all four divisional coordinators (Central, Western, Northern, Eastern)
- An interview with the National Community-Led Prevention Coordinator at RPF
- An interview with key representatives from the Ministry of Health and Medical Services (MOHMS) HIV Unit
- A group interview with Health Equity Matters-supported civil society organisations (CSOs)
- A peer outreach worker survey (51 responses from 54 active POWs)
- An interview with Kirby Institute and AIVL who are supporting the Angels Collective
- A virtual interview with SRH hub and subdivisional care team staff from the Western and Central Division.
- A financial benchmarking study examining stipend rates and allowance structures for community-based outreach workers and coordinators across government, NGO, and civil society sectors in Fiji (see Annex 3).

Where relevant, findings are triangulated across multiple sources. The review was conducted entirely remotely and virtually due to timing and budget. No in-country visits took place, however, locally-based Health Equity Matters personnel supported the process in Fiji. Participants were assured that nothing would be attributed to them by name in the final report.

2. Program Context

The RPF-led peer outreach program formally commenced in December 2025, after a period of establishment which included recruitment of the National Community-Led Prevention Coordinator, the 4 divisional coordinators, and the peer outreach workers, followed by training delivered for the Divisional Coordinators + the peer outreach workers.

At the time of the review, the RPF program had 60 trained peer outreach workers with 54 currently active. Workers are generally deployed on a flexible schedule of up to 10 hours per week across two shifts, with rosters built from a community mapping exercise conducted during initial training and regularly updated. Workers receive a stipend of FJD 50 per five-hour shift. Most workers were receiving two shifts per week at the time of review, reflecting additional allocation to address earlier underspend resulting from the program's delayed start.

The program is managed at the national level by the National Community-Led Prevention Coordinator (NCLPC) at RPF, with four divisional coordinators responsible for day-to-day supervision, data collation, payment processing, and community liaison. It was designed and is implemented in partnership with two civil society organisations, Survivor Advocacy Network (SAN) and Strumphet Alliance, which bring significant community leadership and expertise in reaching key populations. Their involvement reflects a deliberate commitment to community-led program design from the outset. In parallel, Health Equity Matters is supporting the development of

organisational, operational, and technical capacity-building plans for all three of these organisations – currently, and as part of the next program phase[1].

The table below shows the current workforce breakdown by division, key population, and outreach shifts per week across all funded streams.

	Shifts per week				
Division	**TG / MSM**	**Sex Workers**	**People who inject drugs**	**Aruka (street-Based)**	**Total**
Central	15	6	10	2	33
Western	22	2	2	2	28
Northern	7	3	2	0	12
Eastern	4	0	0	2	6
Total	**48**	**11**	**14**	**6**	**79**

The program is operating within a supportive and rapidly evolving strategic environment. MOHMS has expressed commitment to continued partnership. At the commencement of the initiative, Health Equity Matters assisted MOHMS to develop a set of national peer-led HIV Outreach Guidelines to promote a consistent approach across the program. These have recently been endorsed and are being circulated.

The Guidelines set out the package of services to be delivered through peer outreach:

1. Reaching key and vulnerable populations with appropriate information and education about HIV risk and prevention, testing, and treatment (through physical and/or virtual outreach)
2. Distributing/providing access to the means of HIV prevention: condoms, lubricants, and sterile needles and syringes and other injecting equipment
3. Providing an effective referral for HIV testing and other health services, including sexual and reproductive health, hepatitis, TB, drug treatment
4. Conducting or supporting HIV testing and counselling in community settings with immediate linkage to ART for PLHIV and PEP, PrEP and other prevention services for people who test negative
5. Providing support and navigation services to help people living with HIV access and remain on treatment (with explicit attention to VST clients[2], including navigation to gender-affirming health services where available, and mental health support to reduce stigma-related barriers and connected to ongoing monitoring and care)

Significantly, MOHMS is for the first time moving towards a target-driven, cascade-based approach to the HIV response with setting specific targets by division and key population, grounded in population size estimates. This represents a shift from activity-based reporting toward outcome-based accountability, and the peer outreach program will need to align with this direction in the next phase-- including the ability to report against divisional targets rather than aggregate reach figures alone.

[1] Funding to support organisational capacity building of the Fijian CSOs includes funds directly from DFAT under the 12-month Surge funding, as well as through Health Equity Matters' Australian Government-funded Indo Pacific HIV Partnership, which is jointly delivered with UNAIDS (through until mid 2028). This will also be supported under ASPHA.
[2] Vakasalewalewa, Sian and Trans

Preliminary data covering December 2025 to April 2026 shows that the outreach program reached 7,099 clients across the four divisions in its first five months of operation. The Western division accounts for the largest share of clients reached (4,113), followed by Central (1,694), Eastern (754), and Northern (538). The monthly trend shows strong growth — from 308 clients in December 2025 to 3,118 in March 2026 — reflecting the program's rapid scale-up as the full POW cohort became operational.

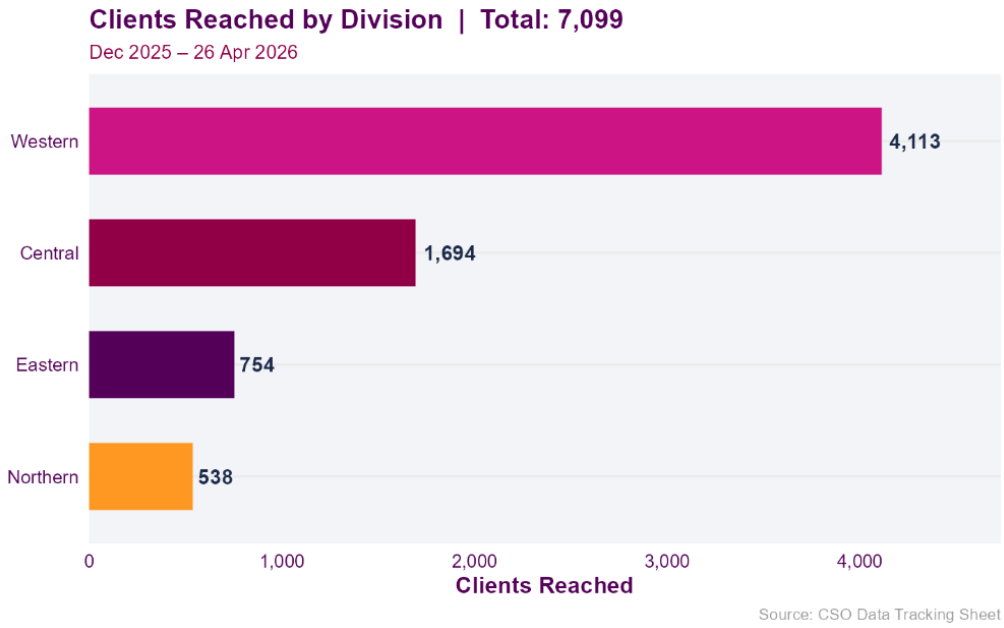


Figure 1: Total clients reached by division, December 2025 to April 2026 (n=7,099). Source: CSO Data Tracking Sheet. The Western division accounts for 58% of all clients reached, reflecting the larger POW cohort and higher number of outreach shifts allocated to that division.

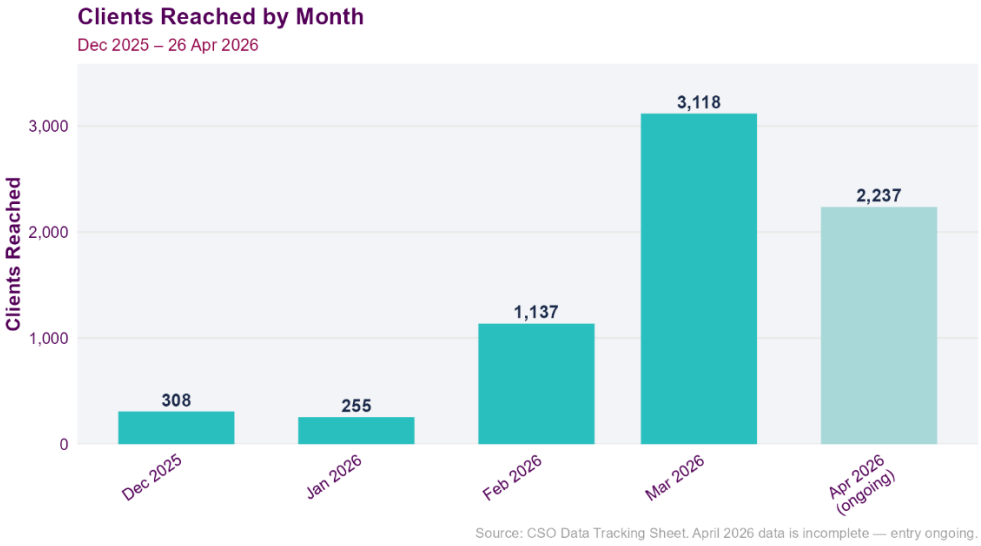


Figure 2: Clients reached by month, December 2025 to April 2026. Source: CSO Data Tracking Sheet. April 2026 data is incomplete as data entry was ongoing at the time of reporting. The strong growth trajectory from

December 2025 to March 2026 reflects the program's rapid scale-up as the full peer outreach worker cohort became operational following initial recruitment and training delays.

3. Findings

Findings are organised around the five thematic areas identified in the Terms of Reference. Each section describes what the review found, the significance of those findings, and recommendations for action.

3.1 Referral Quality and Data Consistency

This is the most significant and complex finding area of the review. It speaks directly to review questions 2 (demonstrating that outreach drives testing) and 3 (data consistency and program story).

What the review found

There is no shared, consistent definition of what counts as a client 'referral' across the four divisions. The review identified at least four distinct activities being recorded under the same referral indicator in POW tally sheets:

- Type 1 — Giving someone verbal information about where and how to get tested
- Type 2 — Issuing a physical referral card for HIV testing
- Type 3 — Accompanying a client to a testing clinic
- Type 4 — Participating in a joint community testing event with MOHMS, RFHAF or MSP on-site

At the time of the review, different divisions were applying different definitions. In the Western division, giving information during a conversation (even without a card being issued and without the person attending for testing) is counted as a referral. In the Central division, a referral is counted only when a card is issued. In the Northern division, the threshold appears higher - a referral is only counted when the POW physically accompanies the client to the clinic. In the Eastern division, referral counting is most closely tied to event-based testing activities in collaboration with MOHMS.

This means that referral numbers across divisions are not comparable. A high referral count in one division may represent something fundamentally different from a high count in another. This inconsistency undermines the program's ability to report its reach reliably or make the case for continued investment.

A further problem exists at the recording level. The POW data form and the RPF HIV tracking sheet are structured differently, creating a mismatch between what POWs capture on the ground and what the tracking sheet requires. As a result, meaningful conversations happening during outreach are frequently going unrecorded. The Western divisional coordinator identified this gap independently and developed a separate referral guide, calling POWs individually to explain recording standards. This is a workaround that reflects the absence of a standardised approach rather than any individual failing.

CSO partners also raised concerns about the accuracy of some reporting, including the possibility that contacts or referrals are occasionally recorded that did not occur. There is currently no systematic mechanism (e.g., spot checks or field observation) to verify reporting quality.

A related data quality issue is the consistent recording of key population categories. Of the 7,099 clients reached between December 2025 and April 2026, nearly half were recorded without any key population group identified. This limits the program's ability to demonstrate that it is reaching its priority populations and to report disaggregated data to DFAT and MOHMS.

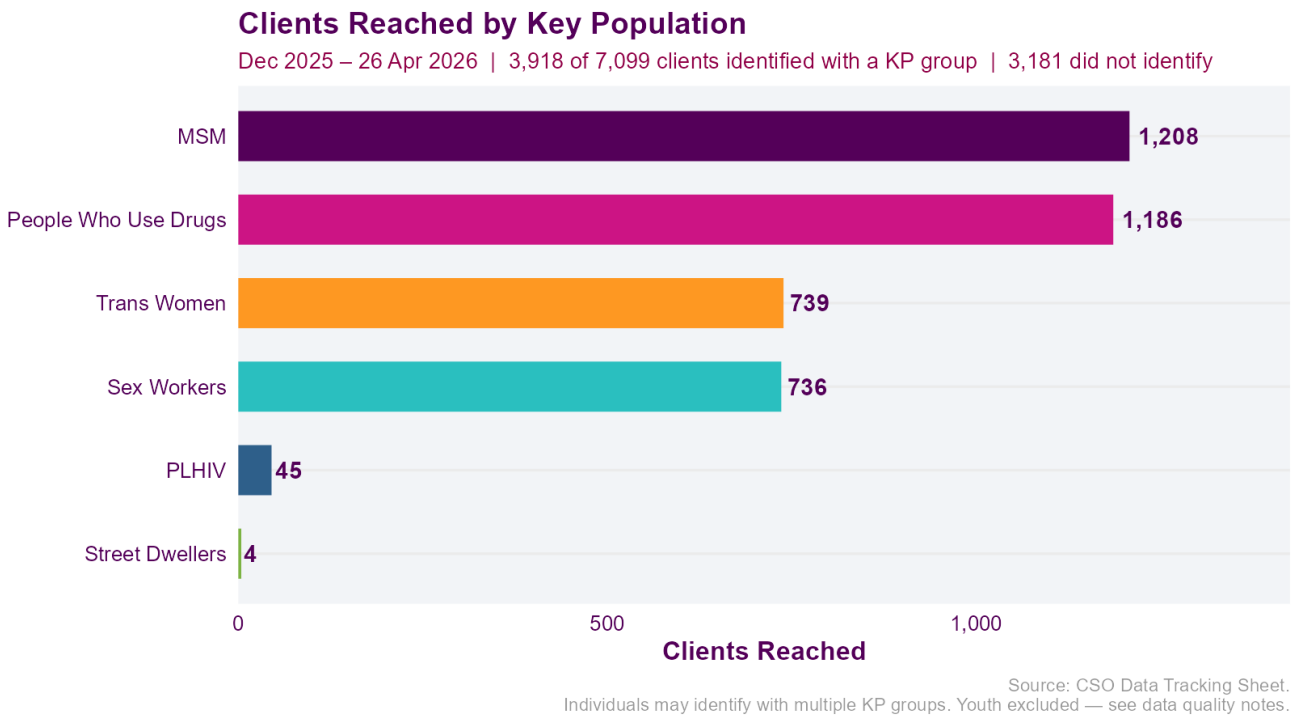


Figure 3: Clients reached by key population group, December 2025 to April 2026. Of 7,099 clients reached, 3,918 were recorded with a key population identification and 3,181 did not identify with any key population group. Individuals may identify with multiple key population groups. Youth excluded — see data quality notes in Section 3.1. Source: CSO Data Tracking Sheet. The proportion of clients not recorded against a key population category is a significant data quality concern discussed in Section 3.1, reflecting both the complexity of key population identification in Fiji and the need for clearer recording guidance for peer outreach workers.

This is not straightforward to resolve. Key populations in Fiji overlap significantly, and many people reached during outreach move across multiple risk categories rather than fitting neatly into one. Anecdotal evidence from across the program also suggests that many young people do not identify with traditional key population categories, even where their behaviours place them at elevated risk. Any approach to improving KP recording will need to account for this complexity.

Repeat contacts

Repeat contacts with peers are not currently being recorded systematically. There is no standard mechanism for POWs to distinguish a first contact from a follow-up with the same individual, or to demonstrate longitudinal engagement with the same person over time. This limits the program's ability to show one of the core strengths of a peer-led model which is that trusted relationships are built over multiple encounters, not just single contacts.

However, designing a system to track repeat contacts is not straightforward. Collecting identifying information such as names or phone numbers creates real risk for key population clients (men who have sex with men, transgender people, sex workers, and people who inject drugs) for whom exposure could mean discrimination, violence, or legal jeopardy, and many will disengage if they feel their identity is being recorded. A simple tally system, on the other hand, cannot distinguish between new and repeat contacts at all. Some programs have addressed this through self-generated anonymous codes (i.e., where a client creates a personal code from non-identifying information) but this adds friction during outreach and requires the client to remember their code

across sessions. In practice, much of the repeat contact tracking that does happen relies on POWs knowing their community personally, which is real but invisible in the data. Any solution needs to balance the program's need for longitudinal evidence against the privacy and safety of the people it serves.

It is worth noting that the Angels Collective does distinguish between new and existing clients in its data form, asking peer educators explicitly whether a contact is someone they have engaged with before. However, like the RPF program, the Collective does not track individuals across multiple sessions. There is no unique identifier or equivalent mechanism, and their experience reinforces the view that individual tracking is not appropriate in this context, for the same privacy and safety reasons outlined above. This cross-program consistency reinforces the view that the repeat contact challenge is a genuine methodological issue inherent to low-threshold peer outreach with key populations, not simply a gap in the RPF program's tools.

Data comparability across outreach streams

A related but more acute version of the referral definition problem exists in relation to people who inject drugs outreach and the Angels Collective. Because the Collective operates independently outside the RPF management structure, there has been limited visibility across programs into how each defines and counts referrals, who they are reaching, and whether reported figures are produced on a comparable basis.

This review found that both programs have been grappling with the same underlying problem independently. The Angels Collective has acknowledged their previous referral-to-testing figure could not be disaggregated into its component parts: information provision about HIV testing, referrals to HIV testing, accompanied referrals to a clinic for HIV testing, and information about HIV treatment options and referrals to HIV treatment had all been counted together under a single referral indicator. The Collective has since revised its data form to separate these categories, moving toward a definition of referral that distinguishes between information provision and referrals and focuses specifically on facilitated or accompanied referral. This mirrors the direction that the RPF program is also moving in.

This convergence is encouraging. As both programs develop and as the broader outreach landscape in Fiji matures, establishing minimum shared reporting standards covering at least referral definitions and contact recording will be important for producing a coherent picture of POW program reach and impact.

Tracking how many referred clients actually get tested

There is currently no reliable system to confirm whether a client referred by a POW actually attended for testing. The feedback loop that exists is informal and inconsistent:

- In the Eastern division, the subdivisional medical officer provides aggregate testing figures from joint outreach events, which the coordinator uses to cross-reference POW reports. This is the most structured feedback mechanism across the four divisions.
- In the Central division, the coordinator visits sub-divisional offices approximately monthly and checks informally whether referrals were acted on. This depends on individual initiative and personal relationships rather than a formal process.
- In the Western and Northern divisions, there is limited to no formal feedback loop. Coordinators rely on POW follow-up with individual clients, which is inconsistent.

At the national level, MOHMS confirmed that point of care testing (POCT) intake forms do not currently record referral source. This means there is no routine way to know whether a client presenting for testing was referred by a peer outreach worker. MOHMS expressed openness to exploring whether a referral source field could be added to the standard POCT intake process, which would be a significant step toward closing this attribution gap.

Recommendations

1. Develop a standardised referral framework that clearly defines and disaggregates the four types of referral activity, with a separate recording column for each. Apply this consistently across all divisions and for all outreach programs regardless of the donor/funding source.

2. Deliver dedicated training to all POWs and coordinators on what counts as each referral type and how to record it. This should be incorporated into the next training cycle, not left to individual divisional coordinators.

3. Formally engage MOHMS on the addition of a referral source field to the POCT intake form. This would provide the independent verification mechanism needed to attribute testing outcomes to program activity.

4. Establish a data quality spot-check mechanism (e.g., a quarterly process in which the NCLPC or an assigned supervisor accompanies a POW on outreach and reviews the corresponding data form.

5. Establish minimum shared reporting standards that covers referral definitions, contact recording, and testing outcome follow-up. This should apply across outreach streams contributing to the broader program picture.

6. Engage the Angels Collective and other organizations with POW early in the next program phase to explore alignment on these standards.

7. Ensure that the data tool update process currently underway explicitly addresses the methodological challenge of repeat contact recording and balances the need for longitudinal evidence against the privacy and safety of key population clients.

Note: A broader effort to improve HIV prevention data consistency across civil society organisations in Fiji is already underway. PSGDN, UNDP and MOHMS are coordinating a CSO HIV Prevention Data Toolkit Survey, being distributed to 12 national member organisations conducting outreach and collecting prevention data. This initiative directly addresses many of the measurement gaps identified in this section. HEM and RPF should ensure their own data improvement efforts are aligned with and informed by this process.

3.2 Stipend and Payment Systems

Payment delays were raised by multiple stakeholder groups including: peer outreach workers, divisional coordinators, CSO partners, and the NCLPC. It was the most consistently and urgently expressed concern across all interviews. This speaks to review Question 4 (whether costs and stipends are appropriate and sustainable in practice).

What the review found

The intended payment cycle is that POWs submit data sheets at the end of each week, the divisional coordinator verifies and submits to the NCLPC, and payment is processed by the following Monday. In practice, payments have regularly arrived on Tuesday or Wednesday, and in some cases later still.

The NCLPC confirmed that the delays are not caused by late POW submissions, verification problems, or transfer failures. The bottleneck is the internal payment initiation process. The person with access to the payment initiation system is a former RPF staff member now working externally. The current temporary administrative assistant does not hold this access. RPF is actively working to transfer access, but this has not yet been resolved. More broadly, there is no dedicated finance officer for this work. The administrative function is covered by a part-time temporary assistant working three days per week.

Payment method also varies across divisions. In the Western division, during the early months of the program, the coordinator was travelling two hours to withdraw cash from a Vodafone outlet and distribute stipends in person to POWs without phones. In the Central division, some POWs without phones receive payment through CSO partner organisations, who distribute cash on RPF's behalf. This arrangement, while based on trust, is not independently verifiable and introduces financial risk.

The impact

The effects of payment delays go beyond inconvenience. Even small delays erode trust between POWs and the program. In one division, workers stopped doing outreach after the first payment round was delayed. CSO partners observed that ongoing delays risk demotivating workers who are already contributing from a place of community commitment rather than financial incentive and that losing these workers means losing trusted community access that cannot easily be replaced.

Divisional coordinators bear the reputational burden of payment delays. They field anxious questions from POWs, often without visibility on when payments will be processed or why they have been delayed. The absence of predictable communication about timelines compounds the impact. Some POWs reported using their own money to support client transport, food, or small items to build trust and enable clinic attendance, particularly when program payments or client transport support were delayed or unavailable

POWs raised concrete practical suggestions: an emergency contingency fund for outreach activities, advance payment or pre-approved activity budgets, and a transparent payment timeline tied to submission dates — for example, submit data sheet by Sunday, receive payment by Thursday.

Stipend rate and allowance adequacy

Beyond the payment process itself, the review commissioned a financial benchmarking study to assess whether the current stipend rate is appropriate and how it compares with practice across comparable roles in Fiji's government, NGO, and civil society sectors (see Annex 3).

The benchmarking study drew on data from 17 organisations and assessed findings against Fiji's cost of living, using a basic daily food basket of FJD $25–$35 as a minimum sustainability benchmark.

The current stipend of FJD $50 per five-hour shift sits at the median of NGO practice for outreach worker roles in Fiji. Assessed against cost of living, it is broadly sufficient to cover a day's food and local transport but leaves no margin for housing, utilities, or family support. The benchmarking study characterised this as a subsistence top-up rather than a living stipend.

A more significant gap lies in the absence of a structured allowance framework. Workers are currently absorbing transport costs personally, and there is no formal communications allowance despite POWs being expected to maintain contact with coordinators and clients using their own devices and data. The benchmarking study found that travel and communications costs should be treated as operational reimbursements separate from the base stipend, not bundled in or left unaddressed. It recommended a travel reimbursement of FJD $0.50 per kilometre or receipt-based reimbursement for public transport, and a communications allowance of FJD $10 per day capped at FJD $100 per month.

For divisional coordinators, the benchmarking study identified a clearer adequacy gap. The median coordinator stipend across comparable NGO roles in Fiji ranges from FJD $80 to $150 per day, with a recommended rate of FJD $90 per full day reflecting supervisory responsibility. The current coordinator arrangement — which, as described in Section 3.3, involves work well beyond contracted scope and is not reflected in compensation at any level comparable to this range.

Recommendations

1. Resolve the payment initiation access issue as an immediate priority. Recruit a dedicated, full-time finance officer before the next program phase begins. Continued reliance on a former staff member for financial initiation is not a sustainable arrangement.
2. Develop and communicate a standardised payment calendar to all POWs and coordinators including clear timelines and a commitment to early communication when delays are anticipated.
3. Move toward universal direct bank transfer for all POW stipends. Support POWs who lack mobile money access to set up accounts, rather than routing payments through third-party organisations.
4. Review the arrangement whereby CSO partner organisations collect and distribute stipends on behalf of RPF. While currently based on trust, this is not independently verifiable and should be formalised or replaced with direct payment.
5. stablish a structured allowance framework separate from the base stipend, covering travel reimbursement (FJD $0.50 per kilometre or receipt-based reimbursement for public transport) and a communications allowance (FJD $10 per day, capped at FJD $100 per month). Workers should not be absorbing operational costs personally.

3.3 Supervision and Support

This section addresses review question 5 (whether training and supervision are adequate and whether workers feel supported). It covers both the divisional coordinator tier and the POW tier.

Divisional coordinators: scope mission creep and overload

The divisional coordinator role was originally contracted at 25 hours per week, with a scope primarily focused on data collation, tracking sheet updates, and divisional logistics. In practice, all four coordinators are working well beyond this scope. The NCLPC estimated that most are effectively working 40 hours per week.

Their actual responsibilities include: attending external partnership meetings; travelling to remote areas to reach POWs, supply condoms and IEC materials, and collect data forms; managing payment disputes and fielding POW enquiries; coaching individual POWs on referral recording and data forms; and in some cases, personally funding printing costs for tally sheets and storing program supplies at home.

This expanded scope is not reflected in their compensation. Coordinators are absorbing travel costs, time, and the emotional labour of managing a team of community volunteers without additional remuneration or formal recognition. The NCLPC acknowledged this explicitly, noting that the current arrangement works partly because of the team's passion and commitment, and that this goodwill is not a sustainable basis for program operations. The NCLPC also noted concern about burnout and the risk to the strong team culture that currently holds the program together. It should be noted that the ASPHA program budget from 1 July 2026 includes additional allowances for divisional coordinators and POWs, covering travel, communications, and other operational costs, as well as dedicated funding for ongoing supervision, training, and refresher sessions. The recommendations in this section should be read in that context, as several are already being addressed through the next program phase design.

A related gap sits within the supervisory dimension of the coordinator role. The coordinator development approach to date has focused primarily on operational functions: data collation, payment processing, logistics. It has not included structured training in people management, constructive communication, or how to create an enabling environment for community volunteers. As hub staff observed during the review, POWs bring deep community knowledge and trust that formal health systems cannot replicate, and the way coordinators engage with and support their teams directly affects whether that trust is maintained or eroded. Capacity building in team leadership and people management should be a core component of the coordinator development plan going into the next program phase, including the program-wide training planned for July 2026.

Workforce mobilisation and shift allocation

A question raised during the review concerns how flexibly the program can deploy its available workforce, including the reserve and backup cohort of trained POWs, in response to program needs. The process by which shift allocations are determined and communicated from the NCLPC and program management level down to divisional coordinators week to week is not fully transparent. It is unclear whether divisional coordinators have real-time visibility into how many shifts they are authorised to allocate, or whether there is a dynamic weekly or fortnightly planning conversation between the NCLPC, program management, and divisional coordinators to track utilisation and adjust allocations accordingly.

This matters practically. An earlier period of underspend on stipends, which resulted from the program's delayed start, has since been addressed by allocating additional shifts, with most POWs now allocated two shifts per week. But the absence of a clear, documented shift allocation process means this kind of adjustment relies on informal communication rather than a systematic planning mechanism. As the program scales, a more structured approach to workforce utilisation tracking will be important for maximising outreach coverage and maintaining financial accountability. This can be done through a shared spreadsheet, a regular coordination call, or other mechanism.

The review also notes that program coordination currently relies heavily on informal communication channels, such as WhatsApp and Viber Groups, and individual initiative at the national coordination level. While these tools are widely used and functional in the Fijian context, the absence of documented coordination processes means the program's operational continuity depends significantly on key individuals. As the program scales, strengthening coordination systems including clearer documentation of processes, decision making, and follow up will reduce this reliance and build organisational resilience, regardless of the communication platforms used.

POW-level supervision

The picture of support at the POW level is mixed. The majority of POWs reported regular weekly check-ins with their coordinator, and these relationships are a genuine strength of the current model. However, a meaningful proportion reported infrequent or no regular supervision contact, and fewer than half of survey respondents said they feel consistently well supported in their role.

The most commonly requested improvements were more training opportunities, better communication from leadership, more regular coordinator check-ins, and access to counselling or mental health support. The latter points to an emotional dimension of the role that is not currently addressed in either training or supervision structures. POWs are regularly encountering people in crisis, newly diagnosed, or in unsafe situations, and there is no formal mechanism for debriefing or psychological support.

There is no formal structured supervision schedule that applies consistently across all divisions. Some coordinators check in with POWs weekly; others contact individual POWs only when issues arise. There is no standard record of supervision conversations, no consistent mechanism for field visits, and no formal pathway for escalating concerns from POW to NCLPC level.

CSO partners raised concerns about the accuracy of some information being shared by POWs during outreach and that MOHMS staff have flagged some information quality issues. Monthly refresher sessions or touch-base calls were proposed as a way to address this.

Recommendations

1. Formally revise the divisional coordinator role before the next program phase. This should include a realistic assessment of actual hours worked, a revised job description reflecting the full scope of the role, increased compensation proportionate to actual responsibilities, and a travel reimbursement mechanism.
2. Establish a structured, documented shift allocation process: including a regular coordination rhythm between the NCLPC, program management, and divisional coordinators. This should ensure workforce utilisation is tracked, adjustments are made proactively, and divisional coordinators have clear and timely visibility into their allocation.
3. Develop a structured supervision framework and apply it consistently across all four divisions. This should include a minimum supervision schedule for POW check-ins, a field observation process, and a clear escalation pathway when POWs raise concerns.
4. Establish quarterly refresher training for both POWs and coordinators to maintain information quality and reinforce data recording standards.
5. Include team leadership and people management capacity building in the coordinator development plan, incorporating this into the program-wide training planned for July 2026.

3.4 Hub Engagement and Attribution

This area represents a systemic gap that limits the peer outreach program's ability to demonstrate its value and build the evidence base for government co-investment. It speaks directly to review question 2 (demonstrating that outreach drives testing).

The attribution gap

When a POW refers a client to an SRH hub or MOHMS clinic for HIV testing, there is currently no way to confirm that the client arrived, was tested, received their result, or that the referral was attributed to the outreach program. The POCT intake form does not ask where or how the client heard about testing. There is no standard system for clinics to record referral source.

This means the program can report the number of referrals made by POWs but cannot verify what happened after the referral was issued. The data therefore reflects activity — conversations, cards issued, clients accompanied — but not outcomes: tests completed and results received. This is a significant constraint on the program's ability to make the case for continued investment.

MOHMS confirmed awareness of this gap and expressed openness to inserting a referral source field into the POCT intake process. The diagnostic team at MOHMS was identified as the appropriate point of contact for this conversation.

A clinical perspective from the treatment and care side reinforced this finding, noting that referral source is only identifiable when a peer outreach worker physically accompanies a client, and that a single system-wide approach to capturing referral source may not be feasible across all hubs, with tailored solutions potentially needed for each facility.

Hub recognition of POWs

Survey responses indicated that most Peer Outreach Workers have visited the hub or clinic to which they refer clients, and that most feel staff recognise them and understand their role. This suggests that the hub orientation gap, while real, may be more acute in some locations than others. However, open-ended responses highlighted important access and coordination barriers that are not visible in the aggregate survey figures.

For example, one Peer Outreach Worker noted that the nearest testing clinic was more than 40 kilometres away, with clients required to pay FJD 5.45 in bus fare each way. Others pointed to the need for better coordination between outreach streams operating in the same area.

The review found that referral relationships vary across divisions and are strongly shaped by local relationships with MOHMS staff. In some locations, there appears to be a clearer shared understanding of the POW role, which supports more functional referral and feedback loops. A significant development in this regard is that MOHMS has included peer outreach worker standard operating procedures and terms of reference in the HIV and ART National Guidelines currently being updated. The rollout and training for these guidelines will include an explicit focus on the role of peer outreach workers and civil society organisations more broadly, which should strengthen recognition of the Peer Outreach Worker role across clinical settings over time.

Across all divisions, stigma and discrimination remain significant barriers to hub utilisation for some key populations. Community members have expressed a preference for services to be brought to them rather than attending a clinic, which has implications for service delivery design.

What effective hub-POW collaboration looks like in practice

Interviews with hub and subdivisional care team staff in the Western division provided insight into what a functioning hub-POW relationship can look like on the ground. Where the relationship is working well, POWs are able to bypass the standard hospital intake process and go directly to care team staff when accompanying clients or making referrals.

Joint outreach and testing events are also organised between POWs, subdivisional care teams and MSP (or, up until recently, RFHAF). Testing is conducted in community settings, with reactive cases linked to care on the same day where possible. In one joint event, 25 people were tested, with six reactive results. Of these, 3 have since been linked to treatment, with follow-up continuing for the remaining three.

Hub staff described this as the result of deliberate relationship-building over time. Internal MOHMS collaboration across departments was built first, before extending partnerships to CSOs. The key lesson for other contexts is that health staff across departments need to understand that CSOs exist and play a legitimate role in the response. This requires active investment from SRH programme leadership and cannot be assumed.

Hub staff also observed that the value POWs bring is greater than what referral cards capture. Some clients referred by POWs arrive at the clinic without their card, meaning card-based counts are likely to underestimate

actual referrals. Even where a POW accompanies a client directly to the clinic, that contribution is not specifically captured in hub data under current systems.

MOHMS Western division also anticipates that POWs will play a significant role in the upcoming Integrated Biological and Behavioural Survey (IBBS), pointing to an expanding role for the program in the national HIV response beyond its current funded scope.

Recommendations

1. Formally engage MOHMS on the addition of a referral source field to the POCT intake form. This is the single highest-impact step available for closing the attribution gap.
2. Establish a hub orientation process at the start of each program cycle and whenever new POWs are onboarded, so that hub staff in each division know who the peer outreach workers are and understand their role before clients are referred.

3.5 Training Adequacy

This section addresses review question 5 (whether training prepared workers for their role and aligns with the national guidelines). Findings draw primarily from the POW focus group and survey, with additional input from coordinators and CSO partners.

What the review found

POWs consistently reported that the initial training, which lasted approximately two days, was not sufficient to fully prepare them for the role. Specific gaps identified include:

- A deeper understanding of all four referral types and how to record each one consistently
- Practical confidence with filling in the data forms and tally sheets
- Guidance on supporting people living with HIV
- Communication skills and approaches for difficult conversations during outreach
- Personal safety protocols and what to do when outreach situations feel unsafe

Outreach workers engaged in PWID outreach also highlighted frustration at being unable to consistently provide sterile injecting equipment, noting that discussions around harm reduction were sometimes undermined when practical prevention supplies were unavailable.

Several POWs felt well prepared in foundational HIV knowledge but underprepared for the operational realities of the role e.g., how to approach someone during outreach, what to do if a client becomes distressed, and how to work appropriately with someone who has just tested positive. One POW recommended extending training to at minimum one week. Multiple POWs and coordinators expressed the aspiration for POWs to eventually be trained to conduct point-of-care testing (POCT) themselves, which would remove the dependency on MOHMS staff presence at testing events.

The nationally endorsed peer-led outreach model guidelines were not known to divisional coordinators at the time of the review. Their roll-out should be a priority for the next training cycle.

Capacity building for coordinators

Divisional coordinators also identified a need for capacity building specific to their functions, including data management, partnership coordination, and the administrative dimensions of the role. The current model assumes a high degree of informal knowledge and self-direction that is not sustainable as the program scales.

Recommendations

1. Extend the next round of POW training to a minimum of five days. Structure it to cover both knowledge content (HIV, all four referral types, data recording, safety) and practical skills (approaching clients, documenting sessions, handling challenging situations).
2. Formally incorporate the nationally endorsed peer-led outreach model guidelines into the training curriculum and use it as the reference standard across all divisions.
3. Develop a structured induction process for new divisional coordinators covering data management, payment processing, supervision responsibilities, and partnership engagement.
4. Build quarterly refresher sessions into the program calendar for both POWs and coordinators.
5. Explore, in partnership with MOHMS, the feasibility of training a sub-cohort of POWs to conduct POCT as a medium-term program development goal.

3.6 Peer Outreach Worker Safety and Wellbeing

Safety during outreach emerged as an important operational issue during the review. More than three in four POWs reported feeling unsafe during outreach at some point, with similar concerns raised through the focus group discussions and open-ended survey responses.

The most commonly reported concerns included working in isolated or poorly lit locations, harassment from community members, police interactions, and travelling long distances after dark. Some POWs described conducting outreach in communities where they are personally known as members of key population groups, increasing their exposure to stigma, discrimination, or harassment.

The review found that safety practices currently rely heavily on local judgement, relationships, and informal approaches developed by coordinators and outreach workers themselves. While some teams already use paired outreach approaches in certain settings, there does not appear to be a consistent programme-wide framework for assessing risk, documenting incidents, or determining when additional safety measures may be required.

Transport and geography also emerged as practical safety considerations. In some divisions, POWs described travelling significant distances for outreach activities, sometimes late at night and with limited transport options available.

The emotional demands of the role were also raised consistently throughout the review. POWs regularly support community members experiencing crisis, stigma, unsafe living situations, new HIV diagnoses, or drug dependence. However, there is currently limited structured space for debriefing, peer support, or discussion of the emotional impact of outreach work. Requests for counselling, mental health support, and more regular opportunities for peer connection appeared repeatedly in survey responses and in focus group discussions.

These findings suggest that worker safety and wellbeing should be considered as part of future programme strengthening discussions. This may involve relatively low-cost measures such as developing a simple safety checklist for outreach planning, incorporating safety and self-care into refresher trainings, using existing coordinator structures for informal debriefing, and documenting serious safety concerns more consistently over time.

Recommendations.

1. Develop a POW safety and wellbeing framework for the next programme phase, including basic outreach safety guidance, incident documentation, and incorporation of self-care and debriefing discussions into existing coordinator and refresher training structures.

4. Cross-Cutting Themes

Four themes emerged consistently across the finding areas and warrant separate attention.

The program is delivering more than the data shows

A consistent finding across all stakeholder groups is that significant work is happening on the ground that is not being captured in the data. POWs are having extended, trust-building conversations that do not result in a referral card being issued but represent genuine progress in shifting community attitudes toward testing. Coordinators are doing community liaison, partnership management, and informal coaching that falls outside their contracted scope. These contributions are real, but currently invisible in program reporting.

The current data collection tools were not built to capture the full range of value that peer outreach workers generate. Addressing this should be a priority for the next program cycle.

The program's community relationships are a significant asset

Despite the operational challenges documented in this report, the program benefits from a committed and motivated team. Divisional coordinators are going well beyond their contracted scope out of genuine commitment. POWs express pride in their work and a desire to do it more effectively. CSO partners are engaged and have clear views on what needs to improve. MOHMS is open to strengthening the partnership.

This relational capital is fragile. It has been built through personal trust and shared purpose. The payment delays, coordinator overload, and operational frustrations documented in this report represent real risks to the cohesion and morale that the program currently depends on. Addressing these operational issues is not simply a management matter. It is essential to protecting the community relationships that make the program work.

Early evidence of private sector engagement is also emerging. In the Western division, a hotel group has begun supporting peer outreach workers to conduct outreach activities, pointing to a potential avenue for expanding program reach beyond current funded capacity.

The upcoming Integrated Biological and Behavioural Survey (IBBS) being planned by MOHMS is a further signal of the program's growing value. Hub staff have already identified POWs as central to making that survey a success, pointing to an expanding role for the program in the national HIV response beyond its current funded scope.

Outreach is expanding beyond prevention informally

During interviews, divisional coordinators and peer outreach workers described instances where POWs supported people already living with HIV during outreach. This included informal assistance with ARV follow-up, linkage to social welfare services, and emotional support. Outreach workers also described informally supporting PWID and other clients living with HIV through accompaniment to clinics, medication pick-up, and follow-up with clients lost to care. In several cases, workers reported maintaining contact through phone calls or personal visits to encourage re-engagement in treatment services.

This is not currently a formally designed component of the outreach model. It is also distinct from the FJN+ Home Visitation Program, which is a separate FJN+ initiative outside the scope of this programme, and from the FJN+ peer counselling stream. Shifts under the FJN+ Peer Counselling Program commenced in mid-May 2026, and only initially in the Central Division.

What is being described here is informal, ad hoc support happening at the margins of outreach. POWs are responding to needs they encounter in the field because they are trusted community members and because those needs are real.

This suggests that, in practice, outreach is already extending beyond its original prevention focus, even if this is not yet captured in program data or reflected in the current theory of change. This emerging area of PLHIV support should be documented and considered in the next program phase, with attention to clear attribution, defined roles, referral pathways, and appropriate training for POWs who are likely to encounter PLHIV during outreach.

A clinical perspective from the treatment and care side added weight to this finding and pointed toward a concrete pathway for formalising it. Under the HIV Act, any person who is formally part of a patient's treatment, care, and support team is legally permitted to know that patient's HIV status. This means peer outreach workers could be formally embedded in care teams without breaching confidentiality, provided their role is clearly defined. MOHMS is currently decentralising HIV services to 21 subdivisional care teams, of which 14 are already operational. These care teams represent a significant opportunity for peer outreach workers to extend their role beyond prevention and testing and into supporting people living with HIV to access care closer to where they live, assisting with treatment adherence, and helping re-engage those who have been lost to follow-up. Formalising this connection, including introducing peer outreach workers to subdivisional care teams and clarifying their role within them, should be explored as part of the next program phase design.

Clinical staff working in treatment and care described three distinct categories of people not currently engaged in the HIV response: those who have never been tested; those who have been tested but never linked to care or treatment; and those who started ART but have since dropped out. The third category represents the most immediate opportunity, as these are people the health system already has records for. However, reaching them is difficult in practice. Contact details in clinic records are frequently outdated, meaning clinical staff often cannot trace patients through formal channels alone. Furthermore, clinical staff are often under-resourced, meaning they might not have the time to do it. Peer outreach workers, with their existing community relationships and trusted presence, are well placed to support re-engagement in ways the formal health system currently cannot.

A further coordination gap exists at the clinical level: counsellors within SRH hubs report uncertainty about whether to refer people living with HIV to FJN+ or to peer outreach workers, reflecting the absence of a clear service directory describing who provides what across the prevention and care continuum, though it is expected that this will rapidly improve imminently in the Central Division, now that the FJN+ Peer Counselling Program is live.

Recommendation

Document the informal PLHIV support currently happening during outreach and assess whether it should be formalised as a component of the enhanced outreach model in the next program phase. If so, ensure POWs receive appropriate training and that data tools are updated to capture this activity separately from prevention-focused outreach contacts.

Intersectionality and peer matching in people who inject drugs outreach

A question that surfaced through the review, including in conversation with organisations working in the people who inject drugs outreach space in Fiji, is whether peer outreach to people who inject drugs should be delivered exclusively by peers with lived experience of injecting drug use, or whether peers from other key populations can legitimately provide harm reduction information and support to people who inject drugs clients.

The Angels Collective model is built on strict peer matching: peer educators are people with their own lived and living experience of injecting drug use, and this is treated as a non-negotiable design principle. The RPF program whilst still peer-based, takes a different approach, recognising the significant intersectionality of key populations in Fiji. A POW who is a man who has sex with men and also a sex worker may well be the right person to have a harm reduction conversation with someone who injects drugs because the trust relationship already exists, and because in practice the populations overlap considerably. The RPF model does not require a POW to share the same primary risk behaviour as the client in order to provide information or support.

Both approaches reflect considered design choices. The evidence base for the Pacific context is still developing. This question deserves consideration in the design of the next program phase, particularly as the people who inject drugs cohort expands.

Pathway to government co-investment

A significant theme in the MOHMS interview was the question of how the government could eventually co-invest in or absorb elements of the peer outreach program. MOHMS was clear that the willingness is there. There is no scepticism about the value of community-led programming in Fiji, and peer outreach is understood as the most effective way to reach key populations. The barrier is procedural rather than political.

For a CSO to receive government grants, it must have a formal MOU with the Ministry. Entering an MOU requires meeting audit, finance, and registration criteria that smaller CSOs cannot yet meet. The only community organisations currently holding MOUs with MOHMS are MSP, RFHAF, and Empower Pacific. PSGDN was identified as a potential fiscal partner through which smaller CSOs could access government grants which is a model worth exploring. An MOU between MOHMS and PSGDN would allow PSGDN to act as fiscal agent for its member organisations. This is being actively explored, and HEM is supporting PSGDN to progress this.

A further development that could ease the pathway is the cabinet submission currently being prepared by the HIV unit (due by June 2026) to convert the unit into a project management unit. If endorsed, this would give the unit direct control over finances, bypassing the Ministry's standard procurement and audit processes, and significantly reducing the barriers to engaging CSOs in formal funding arrangements.

MOHMS also emphasised the importance of routine reporting from CSOs to the Ministry. Currently, the Ministry has limited visibility into what community organisations are doing on the ground, receiving only brief updates at prevention subcommittee meetings. A commitment was made during the review to establish a monthly brief to MOHMS covering key activities, reach data, and emerging challenges. This briefing is timed to coincide with the monthly prevention subcommittee meeting. This should be formalised as a program commitment going into the next phase.

Recommendations

1. Actively support PSGDN to progress an MOU with MOHMS as a medium-term sustainability goal, with a view to PSGDN acting as fiscal agent for member CSOs engaging in government-funded community health activities
2. Formalise the commitment to monthly reporting from Health Equity Matters (on behalf of the 4 CSOs + PSGDN) to MOHMS covering key program activities, reach data, and challenges. This should be timed to the prevention subcommittee meeting cycle. This reporting will be transitioned across to the CSOs to lead in 2027.
3. Monitor progress of the HIV unit cabinet submission and engage proactively with MOHMS on how a project management unit model could strengthen and simplify the government-CSO funding pathway.

5. Summary of Recommendations

Immediate — before next program phase begins

1. Resolve the RPF payment initiation access issue and recruit a dedicated, full-time finance officer.
2. Develop and communicate a standardised, transparent payment calendar to all POWs and coordinators.
3. Formally revise the divisional coordinator role, including scope, hours, compensation, and travel reimbursement.
4. Begin formal engagement with MOHMS on adding a referral source field to the POCT intake form.
5. Develop a standardised referral framework with four disaggregated recording columns and distribute to all divisions.
6. Formalise the commitment to monthly reporting from RPF to MOHMS covering key program activities, reach data, and challenges. This should be timed to the prevention subcommittee meeting cycle.
7. Establish a structured allowance framework separate from the base stipend, covering travel reimbursement and communications costs for peer outreach workers. Workers should not be absorbing operational costs personally.

Short-term — first quarter of next program phase

6. Extend POW training to a minimum of five days and incorporate the nationally endorsed peer-led outreach model guidelines.
7. Develop and implement a structured supervision framework with consistent minimum standards across all four divisions.
8. Establish a hub orientation process so that hub staff know who the peer outreach workers are and understand their role.
9. Establish quarterly refresher training for both POWs and coordinators, including mental health self-care and safety components
10. Introduce a data quality spot-check mechanism, e.g., some form field observation of outreach sessions.
11. Establish a structured shift allocation process with a regular coordination rhythm between the NCLPC, program management, and divisional coordinators.
12. Engage the Angels Collective and other organisations that have POW on minimum shared reporting standards across outreach streams.
13. Include team leadership and people management capacity building in the coordinator development plan for July 2026.

Medium-term — within the next program phase

13. Explore the feasibility of training a sub-cohort of POWs to conduct POCT, in partnership with MOHMS.
14. Move toward universal direct bank transfer for all POW stipends.
15. Document the division hub partnership model and the Central division hub rostering approach as potential good practice for replication.
16. Assess whether the informal PLHIV support currently happening during outreach should be formalised as a component of the enhanced outreach model.
17. Ensure the data tool update process addresses the methodological challenge of repeat contact recording in a way that protects the privacy and safety of key population clients.
18. Consider developing a simple, POW safety and wellbeing framework for the next programme phase, including basic outreach safety guidance, incident documentation, and incorporation of self-care and debriefing discussions into existing coordinator and refresher training structures.

19. Actively support PSGDN to progress an MOU with MOHMS as a medium-term sustainability goal, with a view to PSGDN acting as fiscal agent for member CSOs engaging in government-funded community health activities
20. Monitor progress of the HIV unit cabinet submission and engage proactively with MOHMS on how a project management unit model could strengthen and simplify the government-CSO funding pathway.

6. Limitations

This stocktake was conducted entirely remotely and did not involve in-country observation. The review team was unable to observe outreach sessions, inspect physical data forms, or visit SRH hubs. Findings are therefore based entirely on self-report from interviews and the POW survey. However, it did benefit from well established and robust relationships with key stakeholders and regular in-country visits in the lead-up to the review, as well as ongoing remote working relationships between HEM and key local stakeholders.

The POW survey received 51 responses from an active cohort of 54 peer outreach workers, representing near-complete coverage. The survey was administered electronically, which may have excluded the small number of workers with very limited phone or internet access.

Hub and clinic staff perspectives were partially captured through an interview with Western and Central Division SRH and subdivisional care team staff. Perspectives from hub staff in the Northern divisions was not obtained and would further strengthen the picture on attribution, hub-POW working relationships, and testing pathway gaps.

This report covers the main RPF-coordinated POW cohort. It does not assess all peer-led HIV outreach work in Fiji, nor does it assess separate outreach or peer support initiatives outside the scope of this review.

Annexes

Annex 1— Stakeholders Consulted

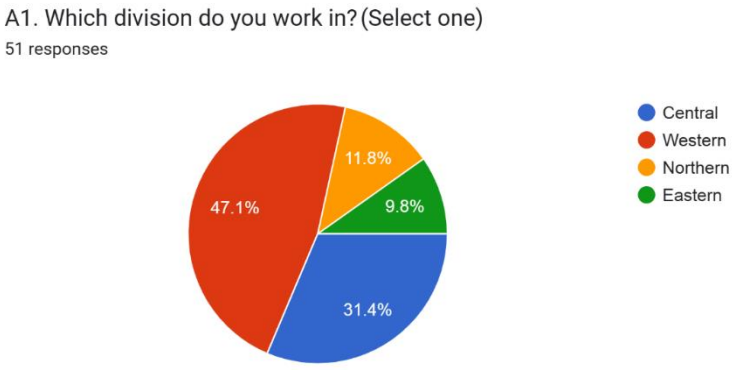
All interviews and the focus group discussion were conducted virtually between April and May 2026. No in-country visits took place. Participants were assured that nothing would be attributed to them by name in the final report.

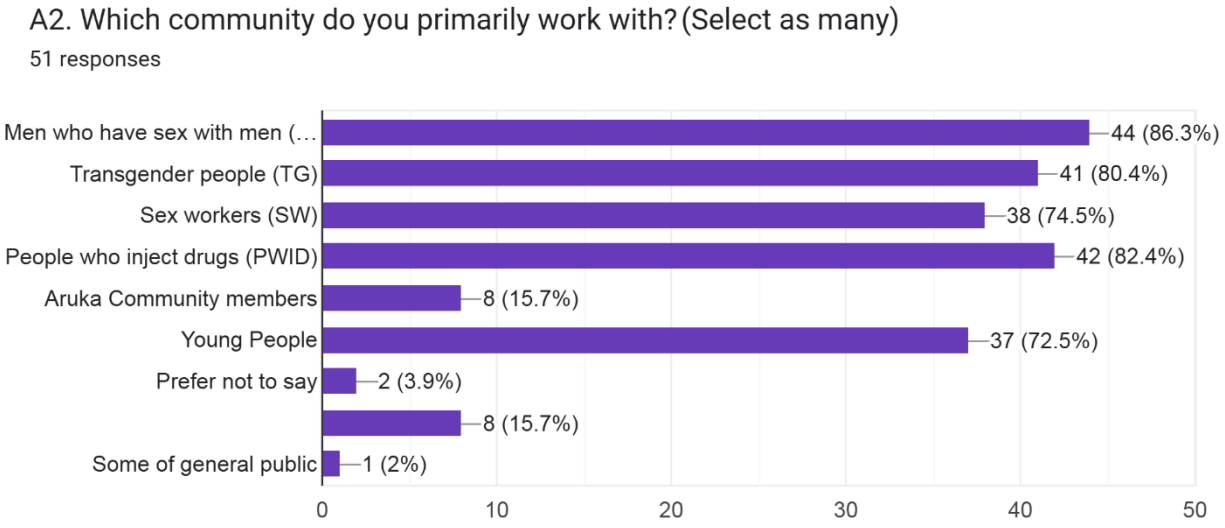
Stakeholder Group	Method	Date
National Community-Led Prevention Coordinator and RPF leadership	Group interview	21 April 2026
Peer outreach workers across divisions	Group discussion	22 April 2026
Divisional coordinators — Central, Western, Northern, Eastern	Group interview	23 April 2026
HEM-supported civil society organisations (Survival Advocacy Network, Strumphet Alliance, FJN+)	Group interview	27 April 2026
Ministry of Health and Medical Services (Lead HIV Task Force, Lead Prevention Sub-group)	Group interview	30 April 2026
Peer outreach workers across divisions	Online survey — 51 responses from 54 active POWs (94% response rate)	28 April to 10 May 2026
Organisations supporting outreach to people who inject drugs (AIVL, Kirby Institute)	Group interview	6 May 2026
SRH hub and subdivisional care team staff, Western Division	Group interview	8 May 2026
Peer outreach workers who do PWID outreach (Central, West)	Group Discussion	13 May 2026
Ministry of Health and Medical Services (Treatment, Care and Support Lead)	Interview	15 May 2026

Annex 2: Peer Outreach Worker Survey Responses

The peer outreach worker survey was administered online between 28 April and 10 May 2026. Of 54 active peer outreach workers, 51 responded (94% response rate). The survey covered six thematic areas: respondent profile, training, supervision and support, referrals and data recording, hub engagement, stipend and resources, and safety.

Demographic (2 Questions)

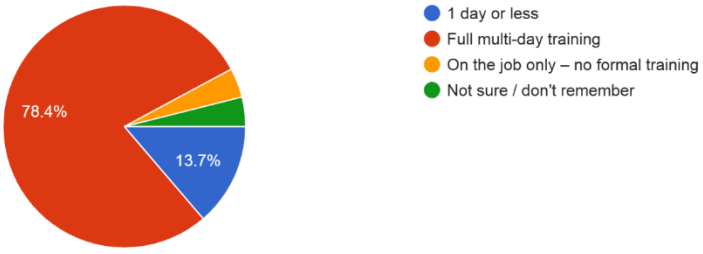




Section B: Training (3 questions)

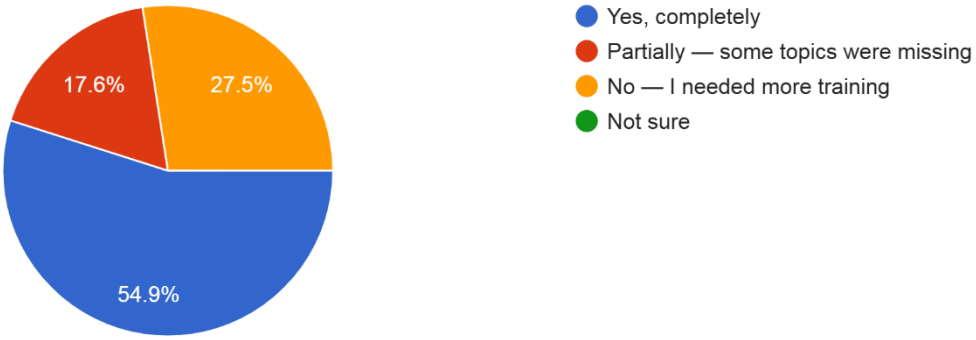
B1. How many days of initial training did you receive before starting outreach? (Select one)

51 responses



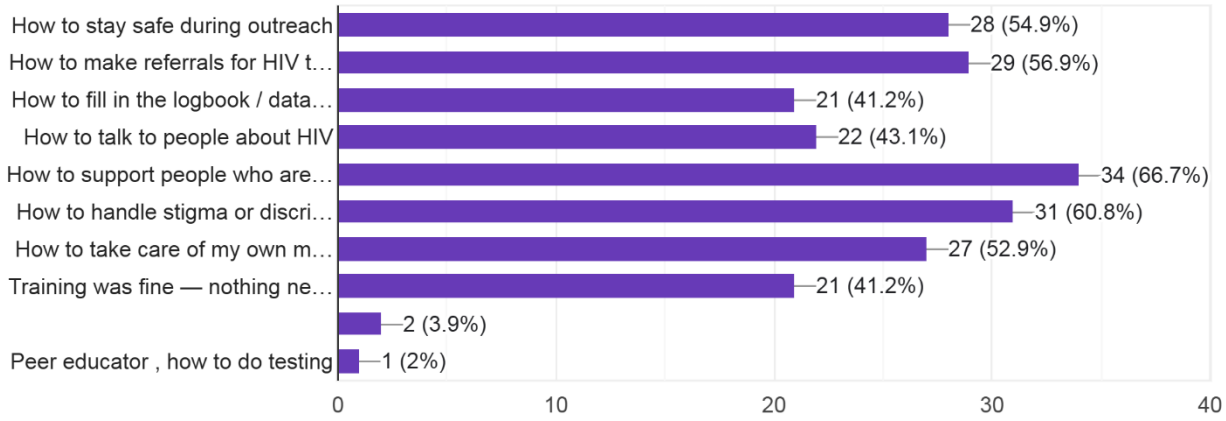
B2. Was the training enough to prepare you for your role? (Select one)

51 responses



B3. What topics do you wish had been covered more in training? (Select all that apply)

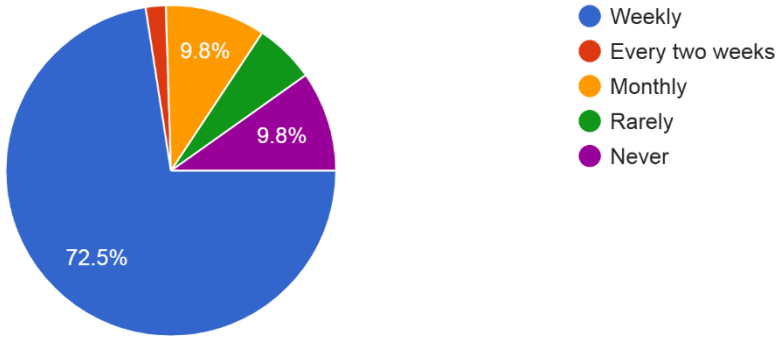
51 responses



Section C: Supervision and Support (3 questions)

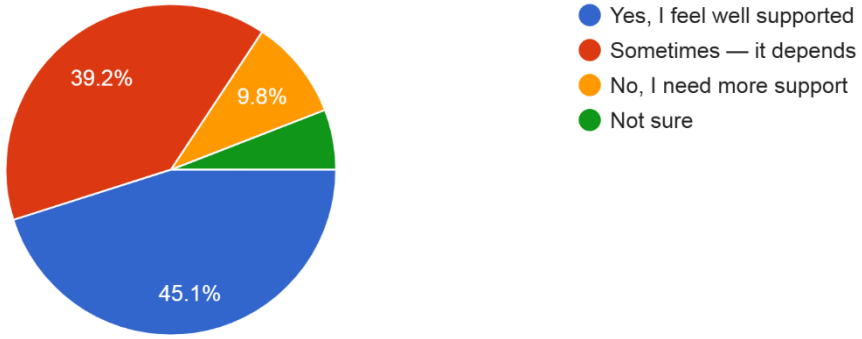
C1. How often do you have a check-in or supervision with your coordinator? (Select one)

51 responses



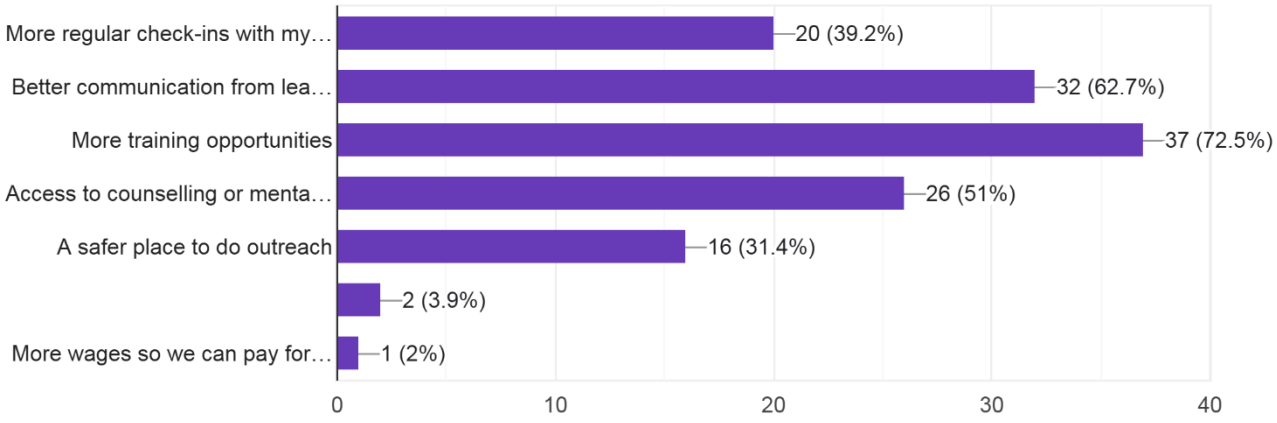
C2. Do you feel supported in your role as a peer outreach worker? (Select one)

51 responses



C3. What would help you feel more supported? (Select all that apply)

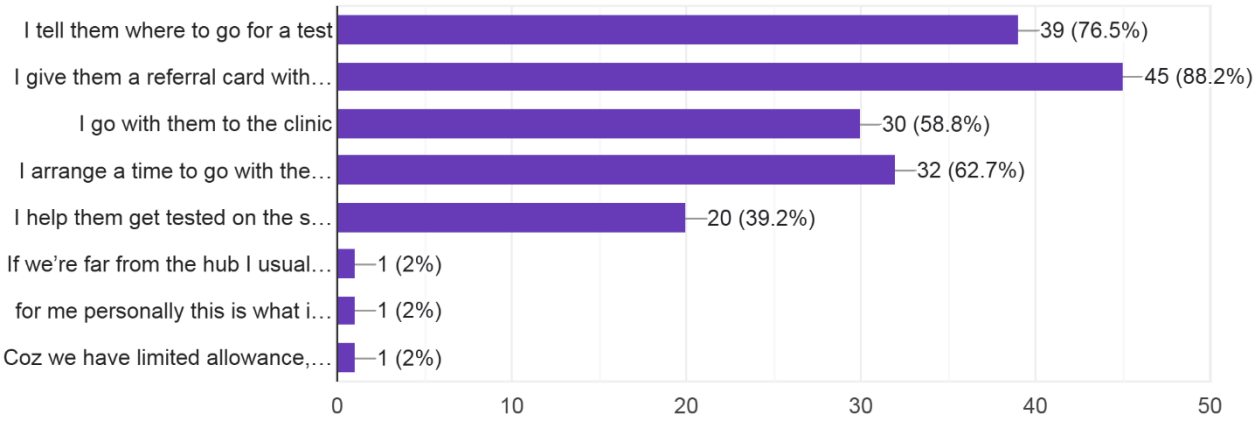
51 responses



Section D: Referrals and Testing (7 Questions)

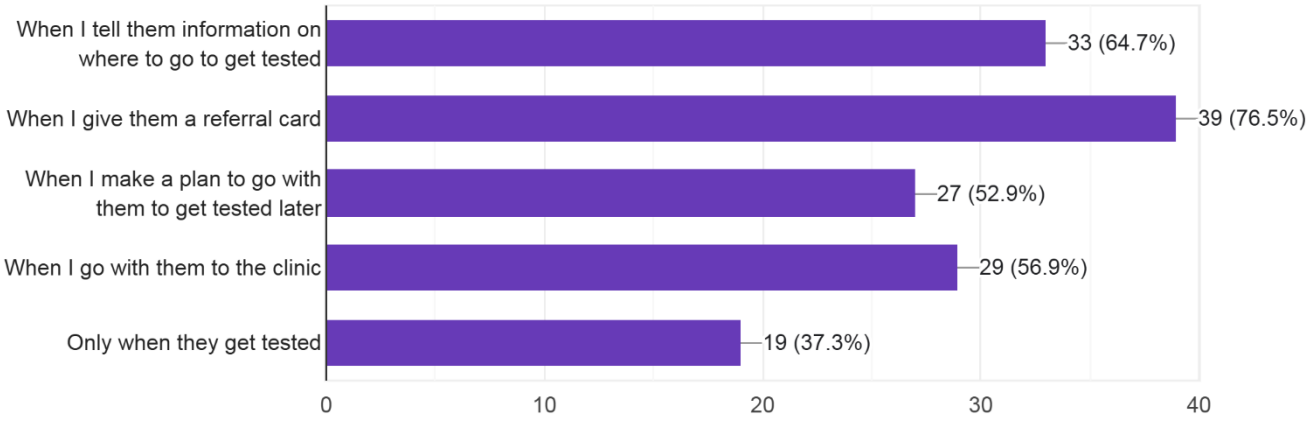
D1. When someone you meet during outreach wants an HIV test, what do you usually do? (Select as many options as relevant).

51 responses



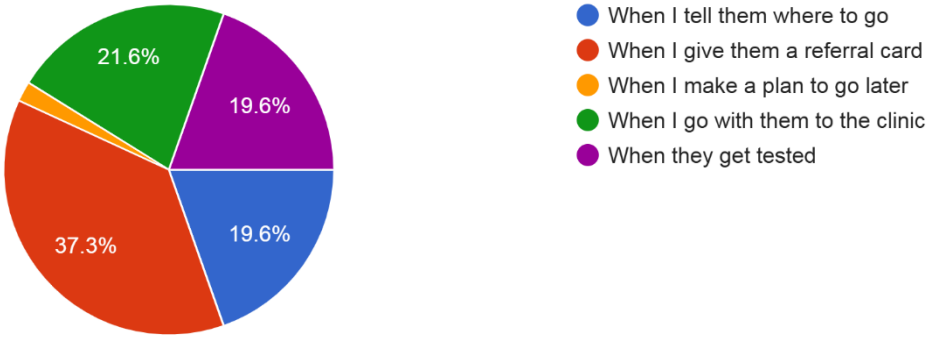
D2A. When do you write a (testing) referral in your book? (Choose all that apply)

51 responses



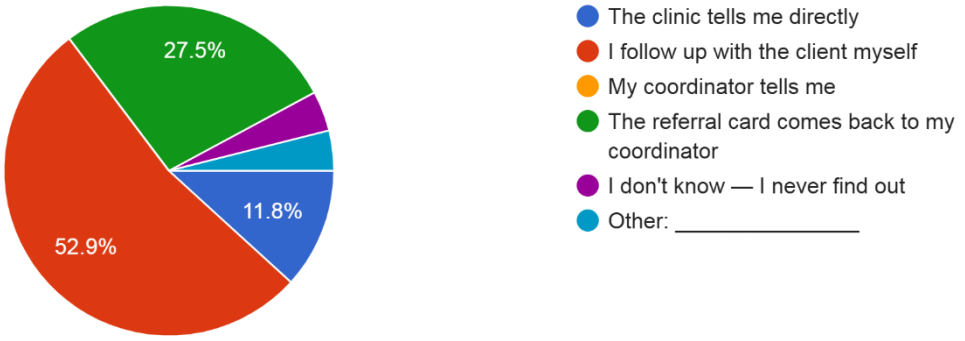
D2B. D3. Which one do you use MOST to write a (testing) referral? (Choose ONE only)

51 responses



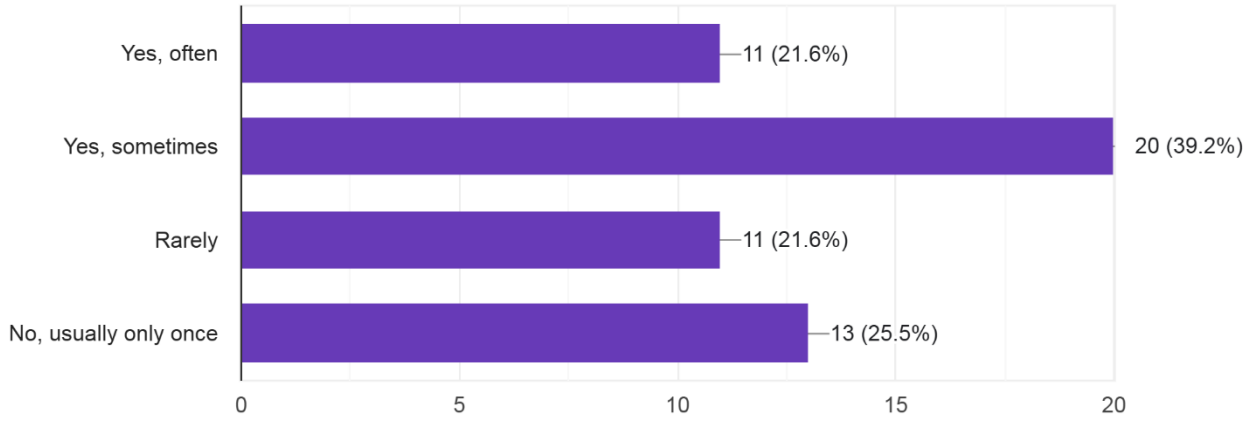
D3. How do you know if a client you referred actually got tested for HIV? (Select one)

51 responses



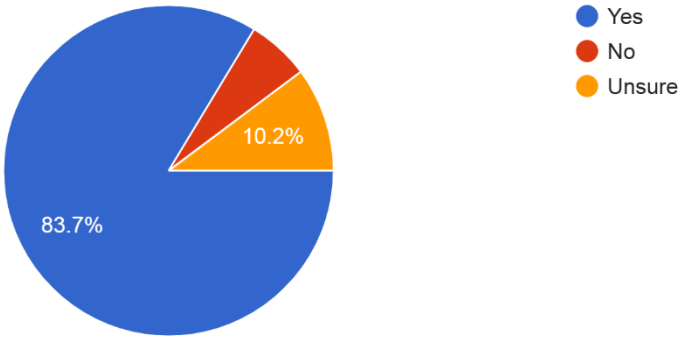
D4. Do you see the same people multiple times during outreach over multiple sessions? (Select one)

51 responses



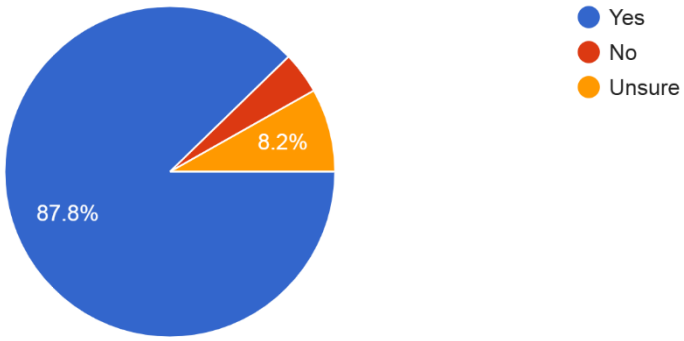
D5a. When you visited the SRH hub/clinic, did staff recognise you as a peer/outreach worker?

49 responses



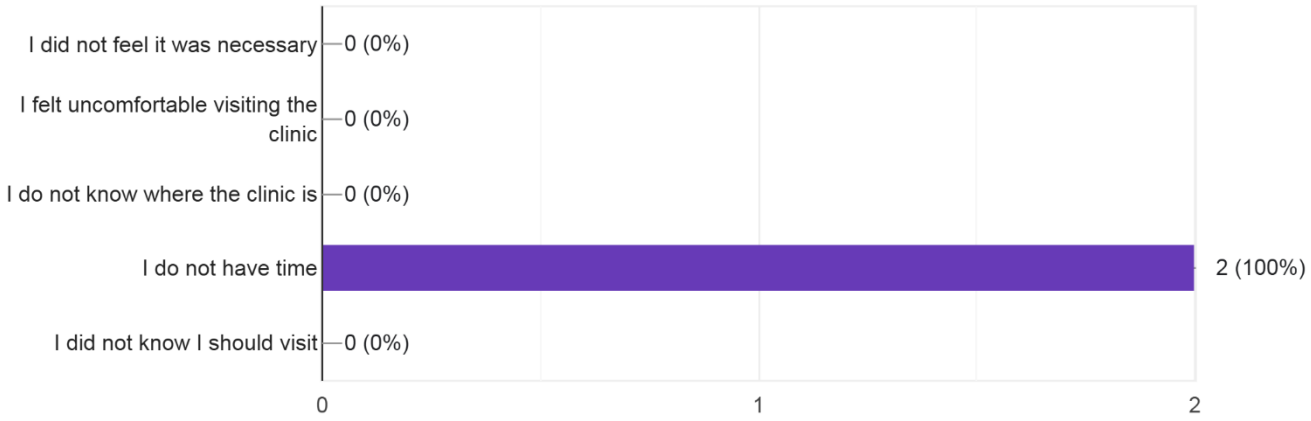
D5b. Did staff understand your role as a peer/outreach worker?

49 responses



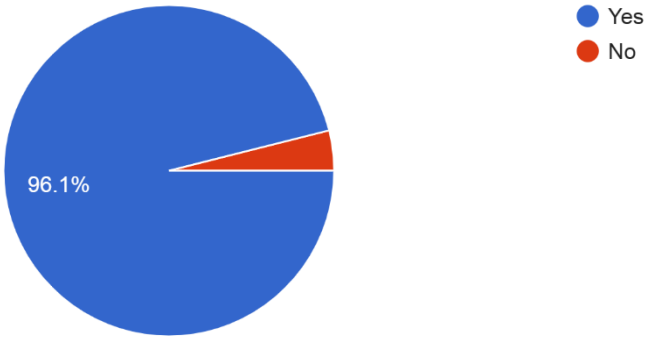
D5d. What are the main reasons you have not visited the SRH hub/clinic? (Select all that apply)

2 responses



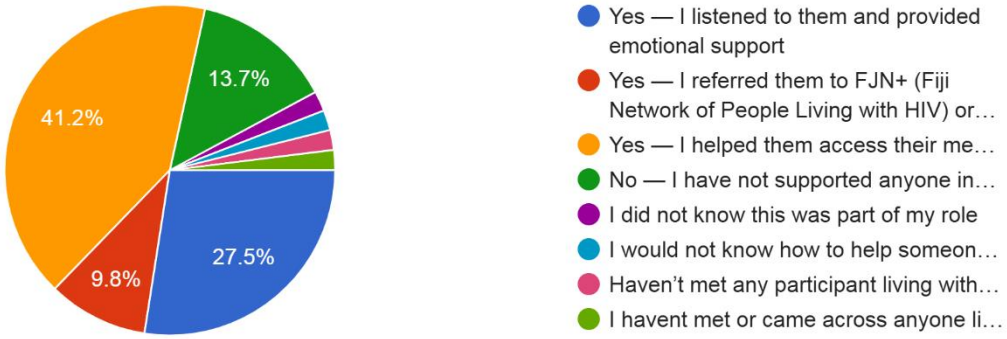
D6. Have you ever visited the SRH hub or testing clinic that you refer people to?

51 responses



D7. During outreach, have you ever supported someone who is already living with HIV — not to get tested, but with other needs?

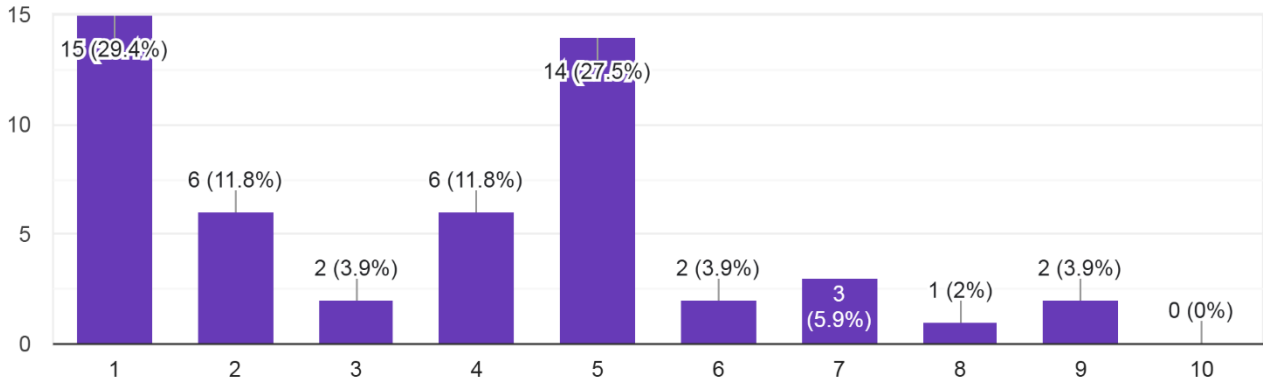
51 responses



Section E: Stipend and Resources (3 questions)

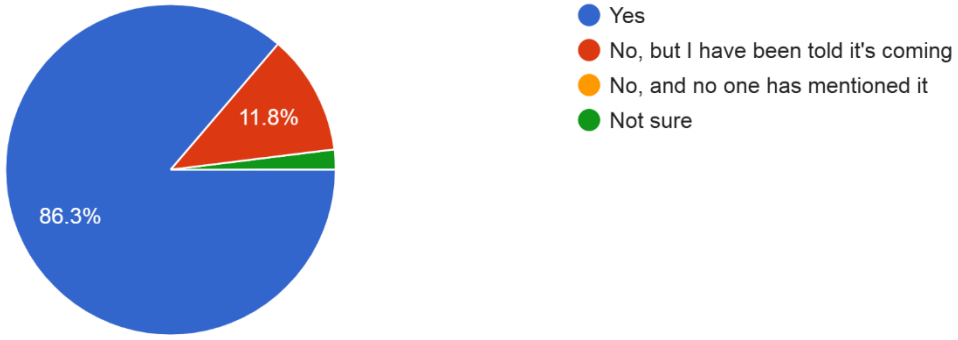
E1. How do you feel about the current stipend (FJD 50 for a 5-hour shift)? (Select one)

51 responses



E2. Do you have an official ID card that shows you are a peer outreach worker? (Select one)

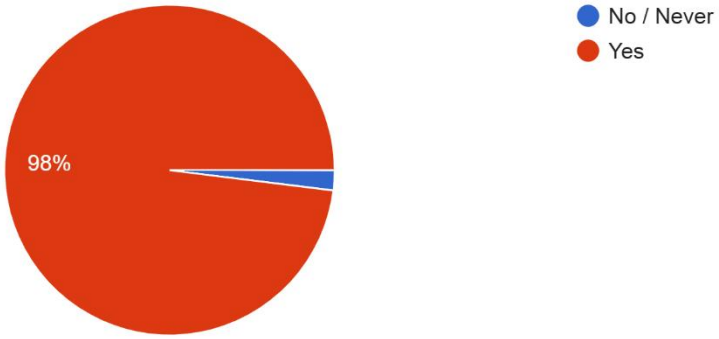
51 responses



Do you have an official ID card?

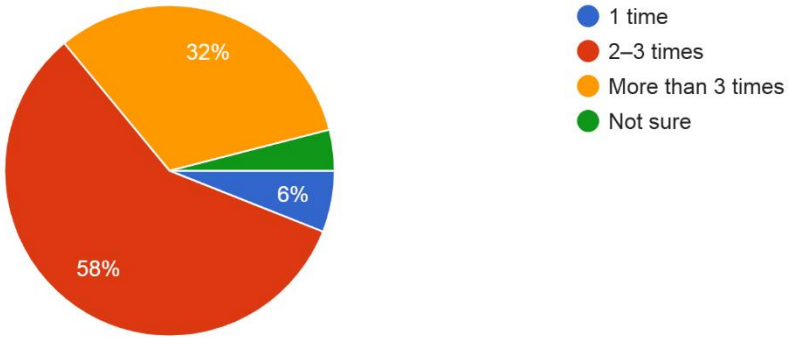
E3. Have you ever experienced delays in receiving your pay or stipend?

51 responses



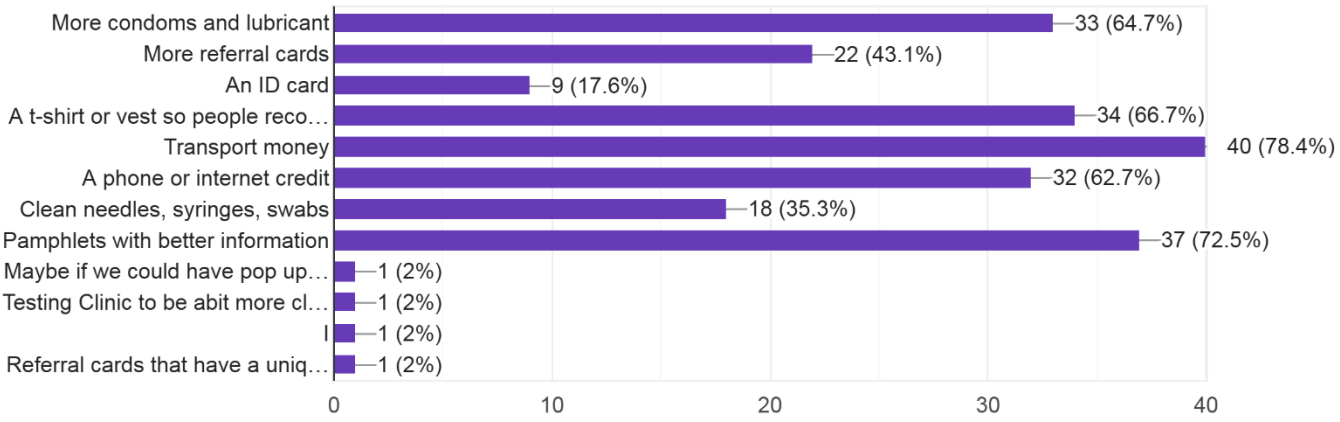
E3A. If yes, how many times

50 responses



E3. What resources would make your job easier? (Select all that apply)

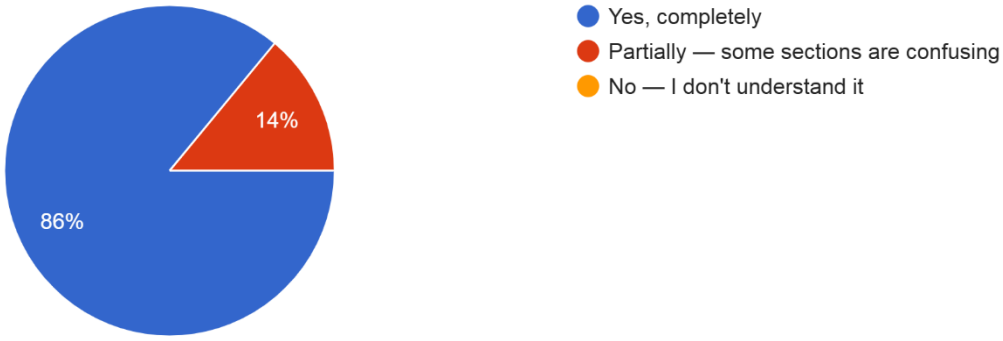
51 responses



Section F: POW and Data Forms (2 questions)

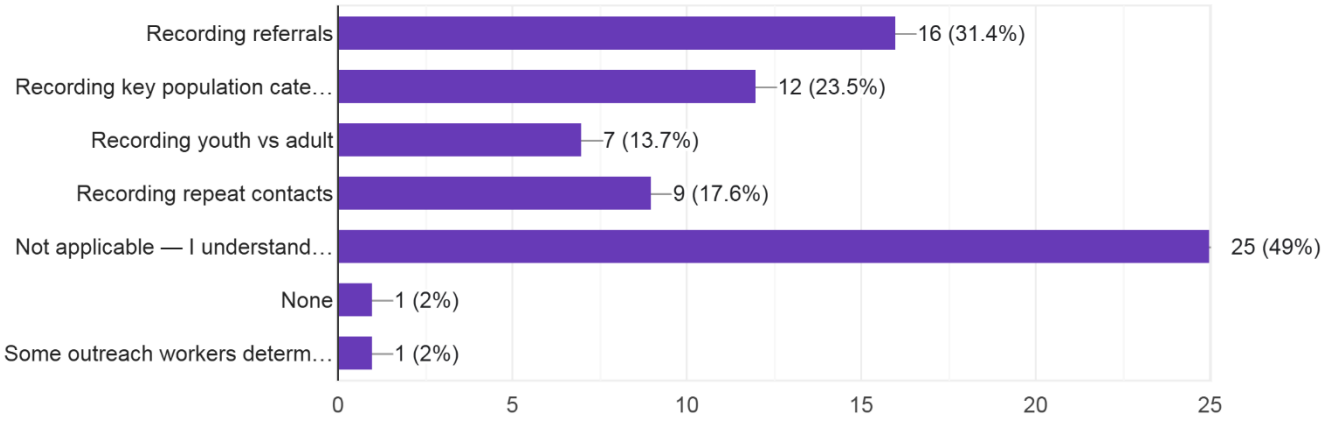
F1. Do you understand how to fill in the outreach POW Contact form (data form)? (Select one)

50 responses



F2 If the logbook is confusing, which parts are difficult? (Select all that apply)

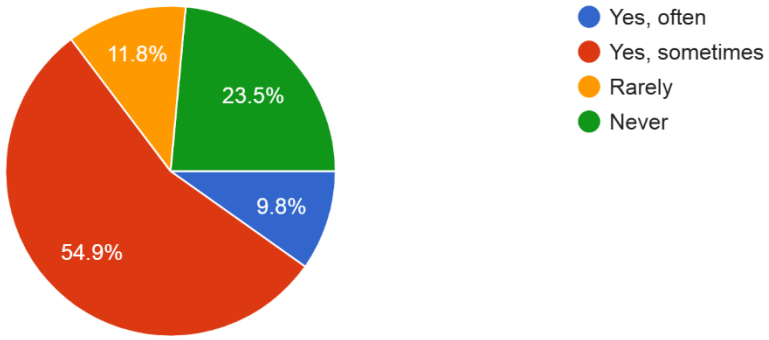
51 responses

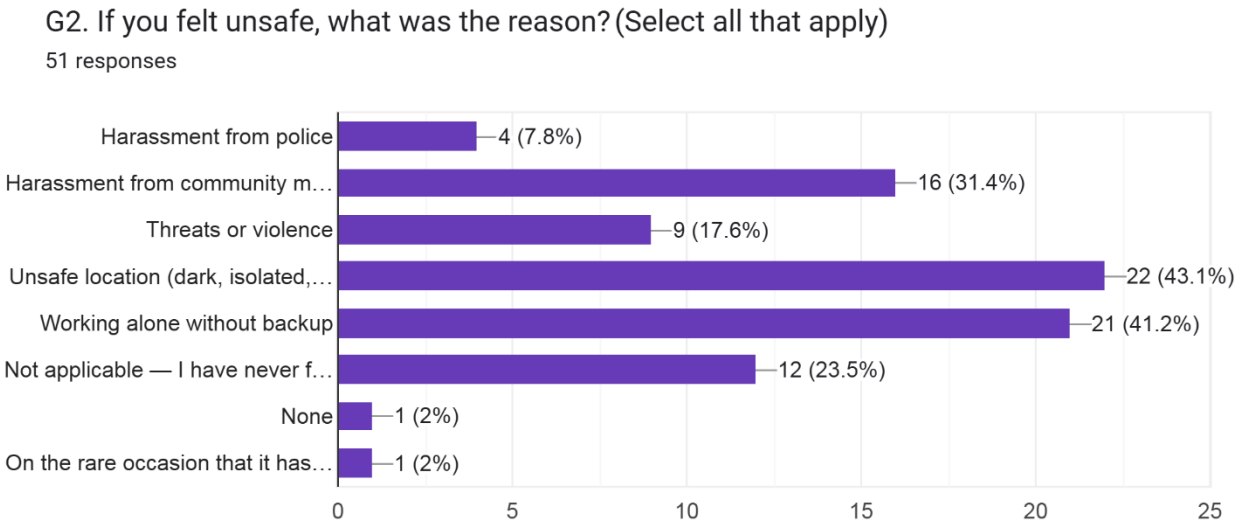


Section G: Safety and Challenges (2)

G1. Have you ever felt unsafe during outreach? (Select one)

51 responses





What is one thing that would most improve your work as a peer outreach worker?

The most common recommendation was improved transport support, including higher transport allowances, transport for outreach to remote communities, and reimbursement for accompanying clients to clinics. Many respondents also highlighted the need for timely payment of stipends, noting that delays affect their ability to conduct outreach and support clients.

A second major theme was additional training and expanded responsibilities. Peer outreach workers requested refresher training, training in counselling and communication skills, and opportunities to become certified to provide HIV testing or point-of-care testing (PoCT). Several respondents felt that enabling peer outreach workers to conduct testing or work alongside mobile testing teams would improve referral completion and increase access to testing, particularly where clinics are difficult to access.

Respondents also identified the need for better equipment and resources, including mobile phones, uniforms or identification, umbrellas and raincoats, adequate prevention commodities (particularly female condoms), and reliable access to harm reduction supplies. Other suggestions included stronger support from coordinators and the Ministry of Health, greater teamwork, improved integration with health services, and increased access to youth-friendly and community-based services.

Overall, the responses suggest that peer outreach workers are seeking practical improvements that would strengthen outreach effectiveness, reduce logistical barriers, improve referral completion, and better equip them to meet community needs.

Annex 3: Financial Benchmarking Study — Stipend Rates and Allowance Structures for Fiji-Based Outreach Workers

This annex summarises the key findings and recommendations of a financial benchmarking study conducted by Dr Suwastika Naidu and Dr Sunia Vosikata in May to June 2026, commissioned by Health Equity Matters to establish evidence-based stipend rates for Fiji-based community outreach personnel. The full report, including detailed comparator data, is available from Health Equity Matters on request.

Purpose

The study benchmarked existing stipend and allowance practices across government, NGO, civil society, and corporate social responsibility programs in Fiji, assessing fairness and sustainability against Fiji's cost of living. Data was collected from 17 organisations across government, NGO, and statutory body sectors.

Key findings

Current stipend practices for community-based outreach workers and coordinators in Fiji are inconsistent, often inequitable, and lack a sustainable foundation. The study identified three tiers of practice:

- Government entities universally pay no stipend to outreach workers, relying on existing salaried staff or unpaid volunteers.
- NGOs providing stipends cluster around FJD 50 per day for outreach workers, with coordinator rates ranging from FJD 80 to FJD 165 per day.
- A small cluster of organisations provide higher bundled allowances that combine base stipend with communications and travel costs.

The most common arrangement across all sectors is unpaid voluntary work. A basic daily food basket in Suva was estimated at FJD 25 to FJD 35, meaning the most common NGO outreach worker rate of FJD 50 per day provides only a marginal subsistence top-up with nothing remaining for housing, utilities, or family support. This model is fundamentally fragile, leading to high turnover and excluding those who cannot afford to work without adequate compensation.

Recommendations

The study recommends the following stipend framework for Health Equity Matters and its Fiji-based partners:

Base stipend rates:

Role	Half-day (up to 4 hours)	Full day (more than 4 hours)
Outreach worker	FJD 30	FJD 50
Outreach coordinator	FJD 50	FJD 90

Allowance structure:

Allowance	Recommended rate
Communications	FJD 10 per day, capped at FJD 100 per month
Travel	FJD 0.50 per kilometre or receipt-based reimbursement

Meals (if away from home more than 6 hours)	FJD 15 per meal, reimbursed on declaration

The study recommends that no partner organisation funded by Health Equity Matters pay below the FJD 30 per half-day floor, and that communications and travel be treated as operational cost reimbursements rather than personal income bundled into the base stipend.

The full report, including detailed comparator data, is available from Health Equity Matters on request.

Annex 4: Stakeholder Survey Results

This annex presents results from the anonymous online stakeholder survey (14 responses), referenced throughout Key Findings. Consistent with the survey consent statement, responses are attributed by organisation, not by individual name.

Section 1: Respondent Profile

Organisation	Respondents
MHMS	4
Rainbow Pride Foundation (RPF)	3
FJN+	2
Health Equity Matters	1
Australian High Commission, DFAT	1
ASHM Health	1
Kirby Institute	1
AIVL	1

Figure 1: Respondent by Type of Organisation

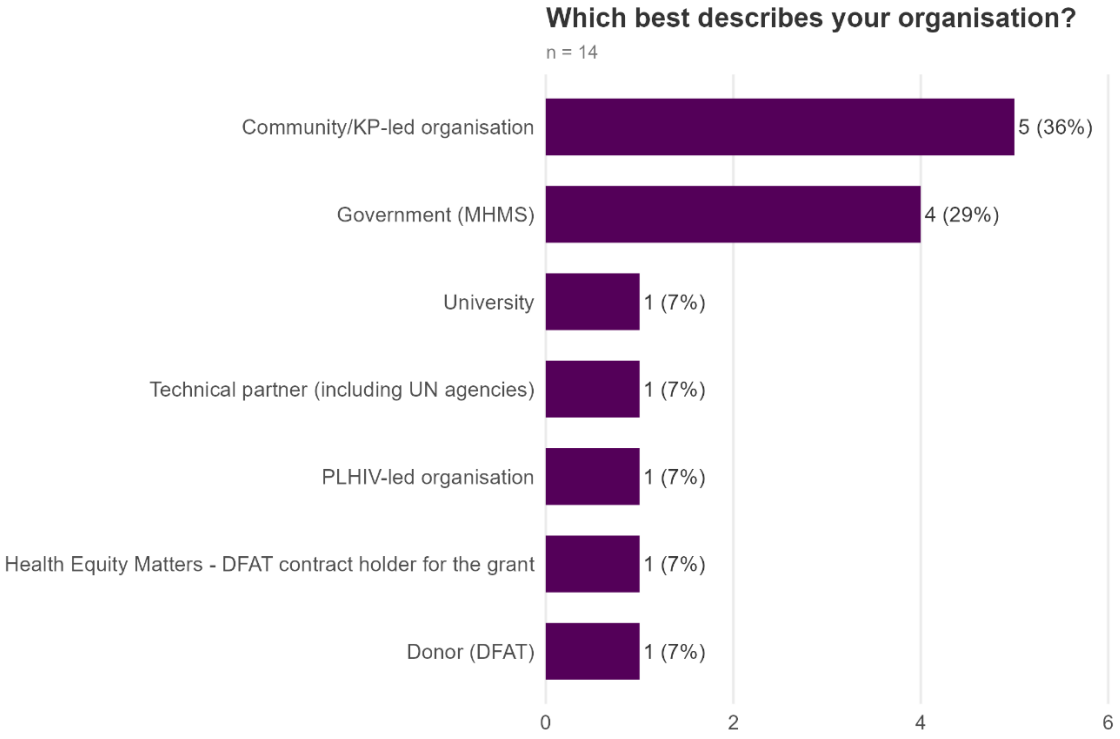
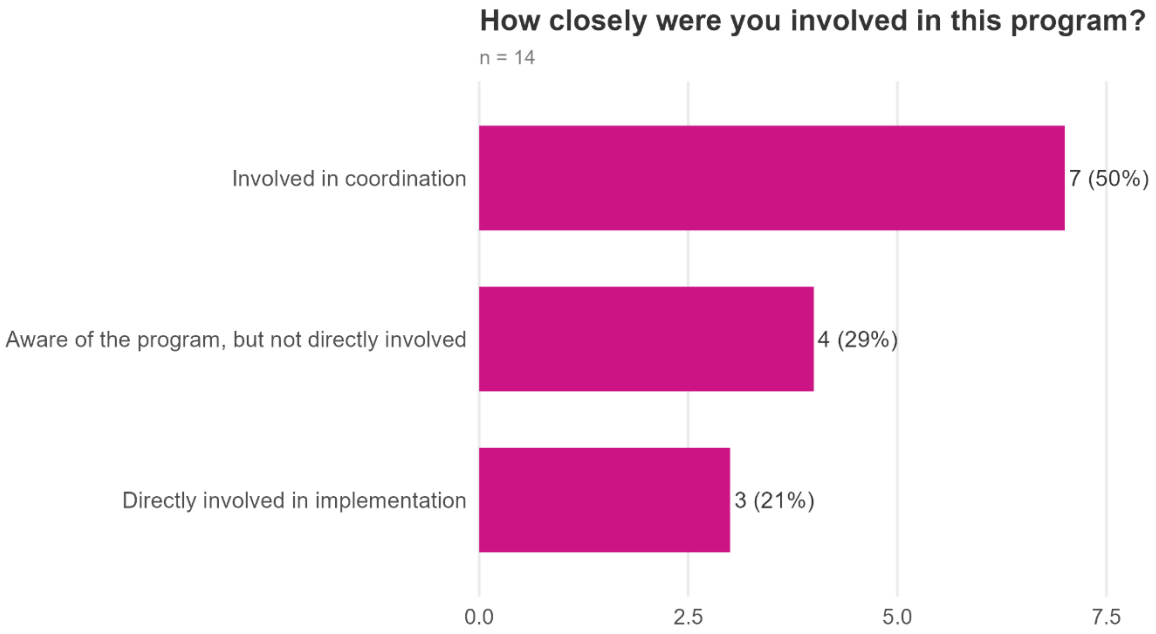


Figure 2: Involvement in the Program



Section 2: Quantitative Results

Likert-scale responses across the four survey items directly cited in Key Findings. SA = Strongly Agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly Disagree.

Survey Item	SA	A	N	D	SD
This program responded to the right priorities in Fiji's HIV response.	7	5	2	0	0
The program worked with the right organisations to deliver a community-led response.	7	5	2	0	0
The partnership and implementation arrangements were appropriate and workable.	4	7	2	1	0
The program was able to adapt to emerging needs and the evolving HIV context in Fiji.	4	7	2	1	0

Figure 3: Relevance Likert Scale Questions

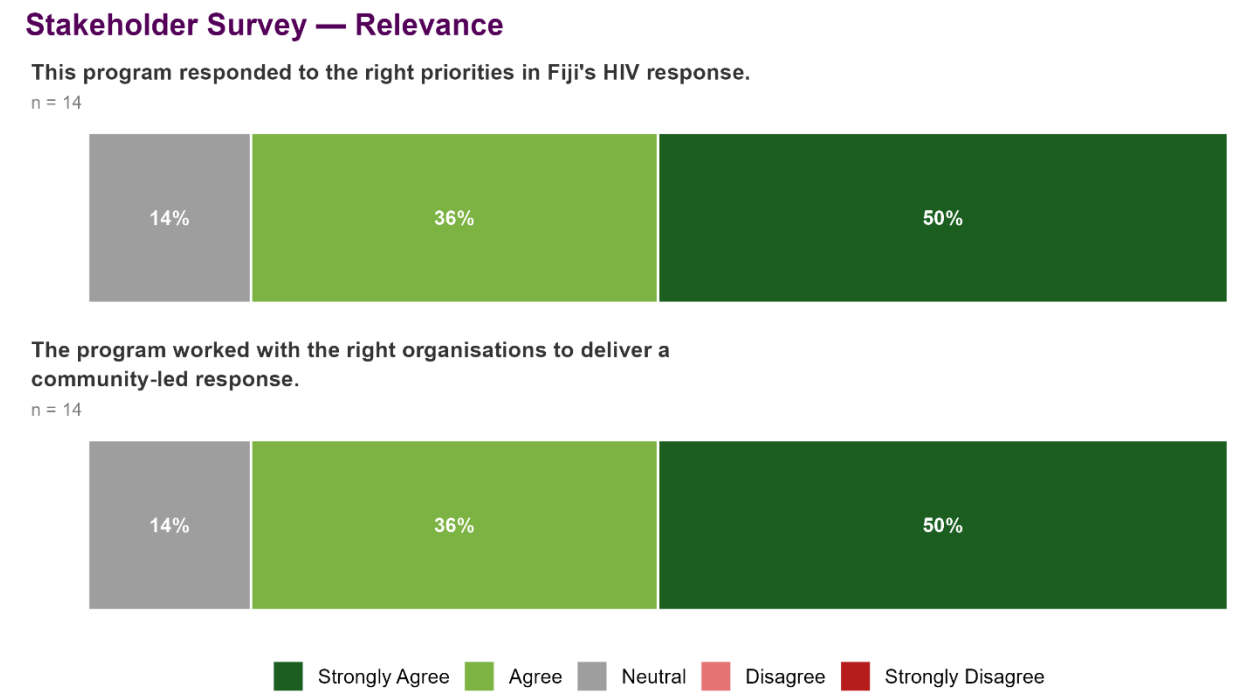
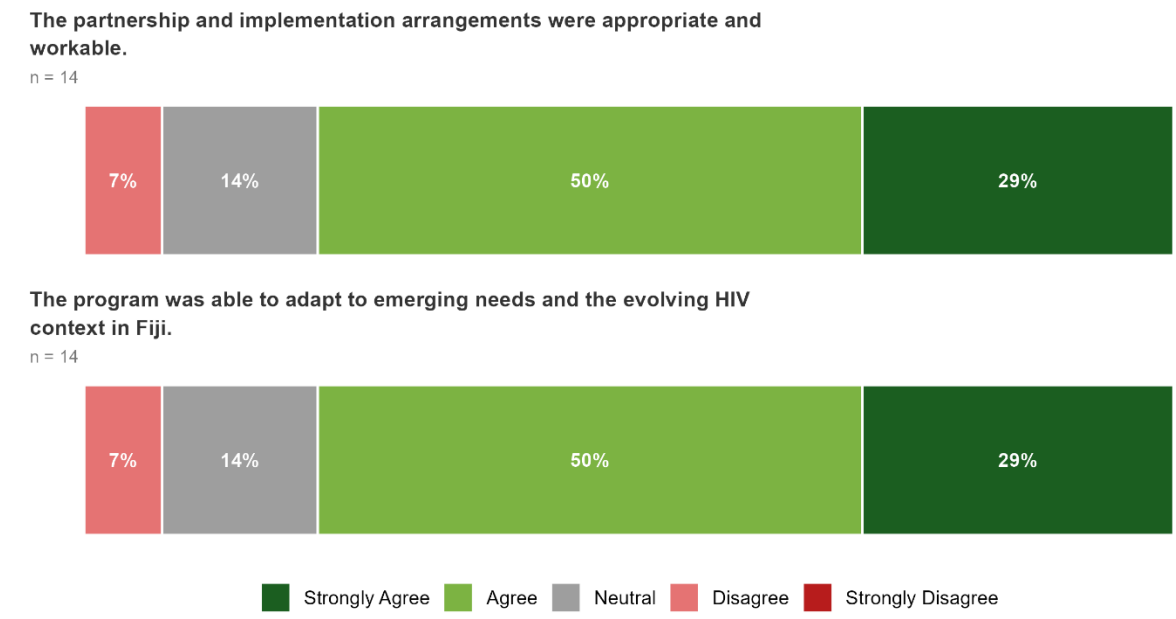


Figure 4: Efficiency Likert Scale Questions



Section 3: Thematic Summary of Qualitative Survey Response

This summary groups open-text survey responses (Q6, Q9, Q11, Q12) into recurring themes, rather than reproducing all responses individually. This summary is intended to demonstrate thematic analysis of the qualitative data and also inform the criterion-specific findings in Key Findings.

Funding and resourcing adequacy *(raised by 7 of 14 respondents)*

The most consistently raised theme. Respondents across HEM, FJN+, MHMS, RPF and AIVL described the community sector as chronically under-resourced and linked short program funding cycles directly to disruption and stress for implementing organisations.

> *"The sector has been under resourced for years and during the time of this grant the sector was largely being rebuilt from the ground up."* — Health Equity Matters

Training and supervision *(raised by 9 of 14 respondents)*

Raised most frequently overall. Respondents, particularly from RPF and MHMS, wanted more comprehensive and ongoing training for peer outreach workers and coordinators, alongside stronger, more consistent supervision structures.

> *"Peer outreach is crucial for meeting the first 95% of the HIV cascade... but the workforce needs to be expanded."* — Kirby Institute

Geographic and population reach *(raised by 9 of 14 respondents)*

Equally frequent. Respondents wanted the program's reach extended beyond the Central division and beyond currently prioritised key populations, including to adolescents and people who inject drugs.

> *"To ensure that we cover all peers in our reach and not have limitations just mainly to the central area."* — Fiji Network Plus

Referral and data quality *(raised by 5 of 14 respondents)*

Respondents from FJN+, MHMS and RPF independently raised gaps in how referrals and outcomes are recorded and reported, consistent with the referral attribution gap identified in the Peer Outreach Validation Report.

> *"Should be able to share reports, community organisations to take lead in the response."* — SRH and HIV Unit, MHMS

Government co-investment *(raised by 4 of 14 respondents)*

MHMS and RPF respondents both raised the need for government financing to sustain the response beyond the life of donor funding, consistent with the sustainability risk identified in Key Findings.

> *"While HEM's work was strong and instrumental in delivering peer outreach work, there is a need to have more strategic direction linked closely to diagnostics and treatment."* — MHMS

Trust between organisations *(raised by 4 of 14 respondents)*

A smaller but distinct theme, raised most directly by AIVL, whose response cautioned that rebuilding trust across Fiji's HIV partnership landscape takes sustained effort beyond this program's own partners.

> *"It takes a lot of time to build trust, and it needs more than words."* — AIVL

Formal registration and direct funding *(raised by 1 of 14 respondents)*

Raised explicitly by one respondent in the survey, though it recurred more extensively across the KIIs (see Key Findings, Sustainability). RPF specifically linked registration to the ability to receive funds directly rather than through an intermediary.

> *"RPF, if registered, can receive funding directly from HEM?"* — Rainbow Pride Foundation

Service delivery adaptation (FJN+)

FJN+ reported adapting its peer counselling model in response to a specific access barrier: some sex worker PLHIV clients found it difficult to attend counselling sessions due to transport costs. In response, counsellors shifted to home visits rather than requiring clients to travel.