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# Working with the Tabu: HIV/AIDS Education Strategies in Fiji

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## HIV/AIDS Education Strategies in Fiji

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*To everyone who is devoting time and energy to the fight against HIV/AIDS,*

*especially Tuberi Cati, Niraj Singh and Josaia Valerusa*

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**Abstract**

The focus of this paper is the cultural *tabu*, or taboo, in Fiji that prevents the open discussion of sex and therefore complicates education efforts towards HIV/AIDS awareness and prevention. Specific factors perpetuate the *tabu* including using it as an excuse to simply ignore a complex issue such as HIV/AIDS and using it to keep sex off social agendas in a predominantly Christian nation. Where organizations have taken strides to work with or break the *tabu,* the author examines and analyzes various education strategies employed by a variety of sectors including schools, health care facilities, faith-based organizations, the HIV positive community, non-government and government organizations. The most effective educational strategies involve peer education and influencing prominent social leaders to speak about sex and make it less of a *tabu* subject.

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## ACRONYMS

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|---|---|
| **AIDS** | acquired immune deficiency syndrome |
| **ARV** | antiretroviral |
| **ATFF** | AIDS Task Force Fiji |
| **HIV** | human immunodeficiency virus |
| **MSI** | Marie Stopes International |
| **NGO** | non-government organization |
| **PLWHA** | people living with HIV/AIDS |
| **SPC** | Secretariat of the Pacific Community |
| **STI** | sexually transmitted infection |
| **WHO** | World Health Organization |

## INTRODUCTION

In May 2006, the Ministry of Health reported 205 known cases of HIV in Fiji, while the estimated number of unreported actual cases ranges in the thousands. The number of reported HIV cases is diminutive in comparison to nations like South Africa - where the number of infected people totals in the millions - but in a country of only 860,000 people, that relatively small number actually represents a significant portion of the population in Fiji. There are a number of factors that make Fiji particularly prone to the spread of HIV including a highly mobile population of seafarers and international peacekeepers, a large youth population eager to explore sexually, contact with tourists, gender inequalities and sexual violence against women, alcohol and drug use leading to risky sexual behavior, and a cultural *tabu*, or taboo, that prevents open discussion of sex (Drydale & Le-Bars, 2005, p. 30). Additionally, there are numerous other issues associated with HIV/AIDS that are

particularly unique to Fiji as a small island nation, including community reactions to people living HIV/AIDS and how Fiji's size as a nation limits the number of resources available to combat the virus. While these particular topics are deeply concerning and worthy of study, this paper will focus particularly on the cultural *tabu* that limits sex education and therefore makes it difficult to educate people about HIV/AIDS and prevent its transmission.

Although HIV/AIDS is the specific topic of my research, many of the questions I asked local professionals and many of the areas I pursued had to do more with sex education in Fiji. Much of the education related to HIV/AIDS in Fiji occurs as part of a broader category, including sexual and reproductive health, sexually transmitted infections (STIs) and safe sex practices. Many of the examples from various organizations in this paper refer to sex education but each of those examples is also closely linked to that organization's HIV/AIDS awareness campaign.

**METHODOLOGY**

My main objective was to determine how HIV/AIDS awareness programs were being implemented to fit within the cultural context of sex as a *tabu* subject in Fiji. I also wanted to investigate what role the government, non-government organizations (NGOs), schools and faith-based organizations each play in the HIV/AIDS awareness effort. While this is a very small-scale study, I tried to get a variety of perspectives and opinions on the subject by interviewing people from both rural and urban areas, people working for the Fiji government and people employed by NGOs, and those who are both designing the programs and implementing them.

The majority of the information presented in this paper is from interviews with local professionals within these different realms. In most cases, I did not have an appointment to speak with one particular person at an organization. I either called

ahead to find an appropriate time to stop by and then I just spoke with whoever was available within the organization, or I visited organizations accompanied by Taomi Tapu-Qiliho or Nicole Beck, both knowledgeable in the area of HIV/AIDS, and they introduced me to people within that particular organization with whom I could speak. My interviews were relatively unstructured; aside from a few specific questions I had at the outset of the interview, I typically allowed the interviewee to talk and I generated my questions based on the progression of the interview.

Since the nature of my topic is in itself *tabu*, I had to be very mindful of whom I was speaking with and how explicit I could be with my questions. Most of the people I interviewed were very comfortable talking about sex-related topics, but several were more conservative. My fear was that if I jumped too quickly into blunt questions about HIV/AIDS education related to sex, the interviewees would not directly answer my questions. My strategy when working with more conservative informants was to build rapport by talking about their own organization and their involvement with it, and then work into the subject of HIV/AIDS and then into the touchier topics related to contraceptive use. Despite my best efforts to make the informants comfortable, I did receive some shy responses of which I cannot guarantee that I heard the complete and fully accurate truth. However, it is also important to consider that people may have been more comfortable talking with me about HIV/AIDS and sex education because I am not Fijian, making it more acceptable to talk to someone outside the culture about something that is *tabu* within the culture.

One of the more frustrating challenges of my topic has been conducting research online at the University of the South Pacific. While there is an abundance of information about sex education as it is related to society and culture available through an online research database, the University of the South Pacific's internet

filter wouuld not allow me to access it without special permission on a site by site basis because the literature I was trying to access contained the word “sex.” In cases where sex is paired with another word such as “education” I was minorly successful in my internet queries, but nonetheless, it presented a challenge. Apparently sex is even *tabu* at the South Pacific’s leading university.

**BACKGROUND ON HIV/AIDS**

Though HIV and AIDS often appear to be synonymous, they are in fact different from each other. HIV stands for Human-Immunodeficiency Virus. The virus attacks the immune system by destroying white blood cells that normally fight infection in a healthy person. HIV can be transmitted from person to person through penetrative sexual intercourse (vaginal, oral, or anal); sharing needles for drug use, tattooing or body piercing; sharing blood or blood products; or from mother-to-child either during pregnancy, childbirth, or through breast milk. In a healthy person, HIV takes an average of ten years for disease symptoms to appear so unless that person has had a blood test to confirm that they are HIV positive, they can be unknowingly carrying and transmitting the disease to other people (Weinrich & Christoph, 2004, pp. 1-2). While there is no immunization available to prevent HIV or cure HIV once it is contracted, anti-retroviral (ARV) drugs are available to combat the virus. Though ARVs have unpleasant side effects, require strict adherence to dosages and are costly, they have allowed people living with HIV/AIDS (PLWHA) to live longer, healthier and more fulfilling lives (Drysdale & Le-Bars, 2005, p. 28).

AIDS, or Acquired Immune Deficiency Syndrome, develops after someone has contracted the HIV virus. AIDS is a collection of symptoms, signs and diseases caused by HIV. Opportunistic infections the immune system in a healthy person could normally combat, such as tuberculosis, diarrheal illnesses or pneumonia, take

advantage of an immune system that has been compromised by HIV (Drysdale & Le-Bars, 2005, p. 20). AIDS is the last stage of HIV and it can develop as early as three years or as late as twelve years after contracting HIV ("HIV/AIDS: Most…," Fiji Red Cross Society). It is usually during this stage that an HIV positive person becomes infected with an illness their weakened immune system cannot fight and the end result is death. This paper will refer to HIV and AIDS as a combined term since they are so closely linked.

## HISTORY OF HIV/AIDS IN FIJI

The first reported case of HIV in Fiji occurred in 1989 and by the year's end there were a total of four known cases. Since then, the trend has generally increased with a peak number of 31 newly reported cases occurring in 2003 (See Appendix). In February 2006, five new cases had already been reported suggesting another record-breaking number of cases by the year's end. As mentioned previously, the Ministry of Health reports the current number of known cases of HIV in Fiji at 205 but the World Health Organization (WHO) "recommends using a simple formula of multiplying the total number of reported HIV and AIDS cases by ten" (SPC, 2004, p. 81) which puts the actual number over 2,000.

In terms of HIV-related deaths, statistics from December 2003 report that fifteen people in Fiji have died from AIDS (SPC, 2004, p. 82). However, it is accurate to assume that the actual number of HIV-related deaths is actually much greater and that more people have died since that information was published. One contributing factor to the inaccuracy of HIV/AIDS death statistics is that the Fijian Coroner's office does not use HIV/AIDS as a cause of death nor does it list it on a death certificate as the cause of death. Subsequently, no post-mortem HIV/AIDS testing is performed leaving the actual number of HIV-related deaths unknown

(electronic communication Beck, 12/05/06).

## CULTURAL ISSUES SURROUNDING HIV/AIDS IN FIJI

### *TABU*

*Tabu*, pronounced "tam-boo" in Fijian, is a word that is derived from Polynesian culture referring to something that is socially or culturally prohibited; *tabu* is the word from which the English word "taboo" stems. Something that has been labeled *tabu* in Fijian culture cannot be touched, approached, or in some cases, spoken of (MSN Encarta, 2006). In Fiji, talking openly about sex is *tabu*. There is some argument whether sex has always been *tabu* in Fiji or if it has only become a *tabu* subject with the arrival of Christianity in the late 19th Century, but regardless of how the *tabu* came to be, it is preventing open and honest discussion about HIV/AIDS transmission.

It is relatively simple to talk about HIV/AIDS as a lethal virus, but the cultural dilemma emerges when it is time to talk about how that illness is transmitted. Talking about sex in general can be difficult enough for any educator presenting to a timid audience, but effective HIV/AIDS education includes discussing what types of sexual activities can result in the transmission of HIV/AIDS. Explicitly identifying and describing anal sex, oral sex, and vaginal sex as ways to transmit HIV/AIDS can be particularly complex, especially when an audience may already be apprehensive to receive the information to begin with.

Fijian parents often struggle to talk to their children about sex when they begin to enter adolescence. Instead of confronting the subject themselves, some parents believe that it is the job of the schools to educate their children and therefore leave it up to the teachers to educate their children (interview Lingham, 19/04/06). However, the topics related to sex and the depth of information provided to children in schools

varies (see Efforts in Schools section). Many parents are uncomfortable bringing sex up with their children; this leaves Fijian adolescents with a minimal sex education or information based solely on what they might have heard from their friends, and it only perpetuates the cultural *tabu* that sex is an awkward subject and teaches children to be wary of talking about sex.

Steve Vete of UNAIDS and an HIV/AIDS expert in the Pacific region argues that the cultural *tabu* surrounding talking about sex is only a myth. He believes that the *tabu* only applies in certain situations where sex is talked about publicly among people who don't know each other or when brothers and sisters are together. In some Fijian homes, it is not customary for brothers and sisters to speak to each other at all once they reach adolescence (Williksen-Bakker, 2002), so speaking about a more sensitive subject such as sex would be particularly uncomfortable for certain family members. Hila Raen, a US Peace Corps volunteer working in public health, faced difficulties when developing her HIV/AIDS awareness program for a rural village near Sigatoka. With a limited number of facilitators to talk to the entire community, Raen was struggling to devise a workshop that would allow the youth and the parents to break apart to have their own question and answer session as it would be awkward for children to be asking questions about sex in front of their parents and vice versa. Raen's solution was to find a way to separate the groups so each could have their own question and answer session (interview Raen, 27/04/06). This aligns with Vete's assertion that there are few constraints involved with talking about sex among peers or people who feel comfortable with each other (Vete, 1994, p. 10).

Given Vete's argument that talking about sex is only *tabu* in certain situations, he further hypothesizes that sex and related topics have become *tabu* on a larger scale throughout Fiji and other Pacific cultures because bureaucrats, members of the clergy,

other important community leaders have actually made it *tabu*. He hints that some church leaders are some of the main perpetuators of the *tabu* with the purpose of furthering a part of their own agenda: keeping sexual education out of schools (ibid:9). Instead of developing culturally appropriate scenarios in which sex education, including HIV/AIDS education, can take place, many leaders are choosing to simply "perpetuate the myth that it is totally unacceptable for [Pacific Islanders] to talk about such sensitive issues" (ibid:9-10) and live on in silence.

### VARYING DEGREES OF TABU: THE RURAL/URBAN DIVIDE

The level to which the *tabu* of openly talking about sex exists seems to generally follow a scale based on where a community is located. Josaia Valerusa is a peer educator based in the more developed town of Sigatoka on the western side of Viti Levu but he also works with more remote villages in the Nadroga province. These rural communities located in the interior highlands of Fiji, some of which are only accessible by horseback, have more limited access to materials and the media that may have pre-educated them on sex and HIV/AIDS or otherwise desensitized them to the *tabu* of talking about sex openly. In contrast, Valerusa notes that the students he works with who come from "schools near the road," or those who are located closer to Western influence, tourism, television and magazines react in ways that suggest they have seen and heard about sex before; this population is less inhibited about talking about sex, but Valerusa says it is still "not like Suva" in terms of the openness with which the subject can be discussed (interview Valerusa, 27/04/06).

In and around Fiji's capital city of Suva where there is strong Western influence and a greater concentration of people who are more highly educated, sex, HIV/AIDS transmission and condom usage is more than just accepted – it's actively

talked about. Suva serves as the HIV/AIDS awareness hub not only for Fiji, but for most of the other surrounding Pacific Island nations as well. Organizations with HIV/AIDS education on their agenda abound. Pamphlets with information about using condoms, STIs and HIV/AIDS are available publicly in coffee shops or obviously displayed in the reception area of these organizations; in some cases, condoms are also available for people to walk in and help themselves. In contrast, in more rural areas outside of Suva, these same resources are available but they are tucked away in drawers and available only upon request. The *tabu* does not limit the amount of information available, it simply inhibits the accessibility of that information.

### OTHER FACTORS PERPETUATING THE TABU

Even in health care clinics, a presumably safe place to talk about sex-related issues and HIV/AIDS awareness, there are large discrepancies that prevent people in need of information from feeling comfortable enough to seek it. The Fijian communal culture and lack of confidentiality and sensitivity training for nurses are barriers to creating safe environments and perpetuate the *tabu* and feeling of uneasiness for people who are seeking sex-related counseling or services. Steve Vete (1994) says:

> Even when there is sex education, many factors prevent the frank and open discussions of these subjects so the correct facts and messages do not get through. Some of these factors include the lack of training of teachers, parents and others in issues such as sexuality, and personal embarrassment.…The judgmental values of some people in the community often discourage young people form (sic) asking explicit questions or raising issues which might be troubling them. (p. 9)

For example, condoms are readily available throughout the country at health clinics, hospitals and shops, but there is a huge stigma associated with going to get them. In smaller areas, the chances are high that the person in charge of distributing or selling condoms knows the person who is there to get them either by familial relation or by association. In such a tight knit, communal culture where everyone seems to know everyone, the person pursuing condoms has strong reason to assume that whoever he or she gets them from knows his or her parents. At one family planning clinic, an informant says that the one time she has seen someone come to the clinic for condoms, which speaks largely to the environment created by the staff if hardly anyone comes to the clinic for the purpose for which it was intended, the nurses laughed after he left. Another informant at the same clinic says, "Nurses have big mouths." He adds that nurses are in need of greater confidentiality and sensitivity training. Young people who come to clinics often and rightfully fear that the nursing staff will talk about who came to get condoms and eventually that information may make it back to that young person's parents.

In addition to confidentiality and sensitivity training, some nurses lack any HIV/AIDS training at all. In Pacific Magazine, the co-founders of Fiji's HIV Positive Network for PLWHA report that "although education efforts are often aimed at the community… health professionals in the region are frequently ill-prepared to provide services to people with HIV and AIDS" (Johnson, 2005). That definitely seems to be the case for one informant who has been a registered nurse for the past 17 years and is now working at the Cuvu Nursing Station in the Nadroga province. The nursing station serves two communities for minor ailments and injuries and the clinic does distribute some family planning supplies. She openly admits lacking knowledge about HIV/AIDS and says she is "not empowered enough to go out" and learn on her

own (interview informant A, 28/04/06). Some nurses, despite their education, simply have not made HIV/AIDS agenda a priority. In these cases, the cultural *tabu* "has been convenient for lackluster health workers inclined to focus on other not necessarily less critical but less complex health problems" (Johnson, 2005).

## WORKING WITH THE *TABU*: HIV/AIDS EDUCATION STRATEGIES

### UTILIZING LANGUAGE BARRIERS

Though the official language in Fiji is English, most Fijians learn both their indigenous language (Fijian or Fiji Hindi) and English simultaneously. Some indigenous Fijians learn both Bauan, the dialect of Fijian spoken nationwide, and the Fijian dialect spoken in their own geographic region. English is used in business and schools, but in casual settings when Fijians are together they generally speak Fijian and when Indo-Fijians are together they generally speak Fiji Hindi. While most people in Fiji have an extremely strong English proficiency, they sometimes lack knowledge of specific technical, medical or scientific terms in English. For this reason and to make the audience more comfortable, HIV/AIDS educators will often present in a group's indigenous dialect. Josia Valerusa, a peer educator in the Nadroga province on the west side of Viti Levu, says that his educational program is better received because he can speak the Nadroga dialect with the people who listen to his presentations. He establishes himself as a peer, or someone his audience can feel comfortable listening to and more importantly, feel comfortable enough to ask their questions. Valerusa's audience identifies and connects with him and his message on a deeper level simply because they come from the same place and literally speak the same language (interview Valerusa, 27/04/06).

While using a group's native language to present information on HIV/AIDS can be advantageous, it can also present problems. Tuberi Cati, an HIV/AIDS

educator from the Fiji Positive Network of PLWHA, often delivers her presentations in Fijian for the same reason Valerusa delivers his in the Nadroga dialect. However, the Fijian language lacks words that are necessary to adequately describe how HIV is transmitted. For example, Cati's talk includes differentiating which sexual acts can result in the transmission of HIV and which cannot: penetrative sex and non-penetrative alternatives. However, there is no word for "penetration" in the Fijian language. Instead, she must actually describe vaginal, anal and oral sex. Cati says having to be so explicit in her language can be more difficult when she's facing a group that may already be a little apprehensive about talking about sex to begin with (interview Cati, 04/05/06). Despite the challenge of this *tabu*, she knows that it is more important to forge through an uncomfortable subject than let silence prevent important HIV/AIDS education.

### EFFORTS BY FAITH-BASED ORGANIZATIONS

Faith-based organizations in Fiji have taken a variety of stances on HIV/AIDS including both extremely conservative and extremely progressive views. Nicole Beck, a US Peace Corps volunteer working for the STI Clinic in Suva, visited a facility run by the Catholic church for single mothers to deliver a health promotion presentation. When she started talking about safe sex and condom use, she got the signal from one of the organizers to stop the presentation even though every woman in the room was either pregnant or had already had a child out of wedlock (interview Beck, 26/04/06). In another startling example, an informant reported that in three separate instances a particular church entered the homes of PLWHA and forcefully removed their antiretroviral drugs.

Luckily other members of the Fiji community of faith-based organizations have taken more progressive steps towards educating their parishioners about

HIV/AIDS and developing communities to care for PLWHA. In early 2004, a delegation from the Pacific Member Churches of the World Council of Churches' (WCC) convened in Nadi to reevaluate the way churches in the region are currently responding to HIV/AIDS in the region; the result of the gathering was the Nadi Declaration, a document stating the WCC's position on HIV/AIDS and describing its strategies to both develop educational strategies and provide a more caring, supportive environment for the PLWHA community. In terms of HIV/AIDS education, the Declaration explicitly announces the Pacific churches' goal to work with the *tabu* by "promot[ing] education about HIV/AIDS and open discussion on the issue of sexuality that equip communities to prevent this eminently preventable disease. It is unethical not to engage with and work to overcome the ignorance, silence and fear" (Nadi Declaration, 2004, p. 4) Though there are still many ethical dilemmas tied to social behavior and the church's teachings, it seems that most faith-based organizations in Fiji are able to look past the *tabu* to a certain degree and recognize that it is now more important to educate their congregations about HIV/AIDS.

## EFFORTS BY NON-GOVERNMENT ORGANIZATIONS

Non-government organizations (NGO) in Fiji seem to be making the most headway in effective HIV/AIDS education campaigns. There are numerous organizations in Fiji who have HIV/AIDS education on their agenda, but two organizations seem to stand out as frontrunners in the NGO sector: AIDS Task Force Fiji and Marie Stopes International Fiji. These two organizations are highly effective because they have developed strategies that work with the Fijian culture and respect the *tabu*. Though both organizations have an array of HIV/AIDS education programs, I have chosen to highlight just two of their initiatives.

### *AIDS Task Force Fiji: the Social Gatekeeper and End-User Studies*

AIDS Task Force Fiji (ATFF) is a non-government organization based in Suva. Identified by UNAIDS as one of the most successful organizations in HIV/AIDS arena in Fiji, ATFF provides voluntary HIV counseling and testing, outreach programs and peer education throughout the greater Suva area. ATFF's organizational strategy in terms of HIV/AIDS and safe sex education is to do what the community wants. One of their main strategies is to train a peer educator from a vulnerable group, such as sex workers or street kids, and empower that individual to reach out to others within his or her community to share information, offer ATFF's clinical services and distribute condoms.

Despite the strength of ATFF's peer education program and their push for condom use, ATFF still began to notice an increase in syphilis cases in Fiji in the last ten years, which can be a strong predictor of behavioral risks that can also lead to HIV transmission. This rising trend indicated that the multitude of marketing campaigns throughout Fiji to promote safe sex and condom usage had been ineffective. In 2005, ATFF launched an attitudinal study to examine why.

The study investigated outside factors that could be counter-productive to the message the audience was hearing about safe sex and condom use. ATFF hypothesized that although youth were receiving the message about safe sex, "there were social forces that kept them from either learning more about safe sex practices or … there may not be the opportunity to utilize practices such as condom usage" (Taylor & Singh, "Establishing…," 2005, p. 5). ATFF used the term "social gatekeeper" to refer to these "individuals in a society or ethnic culture who have a large amount of influence as to whether new social conventions or habits are adopted or shunned by making a societal sanctioned statement as to the acceptability, or not, of a practice" (Taylor & Singh, "Measuring…," 2005, p. 7). The study identified

religious, political, media and school leaders as some of Fiji's most prominent social gatekeepers (refer to Appendix C for a complete list). ATFF then gathered representatives from these groups who had changed their beliefs from not promoting safe sex to pro-condom usage and interviewed them to find out why and how their attitudes had changed. The study revealed that personal testimonies given by current HIV positive people and statistics were the most influential in changing a social gatekeeper's attitude. Many gatekeepers were affected emotionally when they saw how 'normal' a PLWHA appeared and when they could compare the age of a PLWHA to that of someone they knew, such as their own child. Statistics helped to prove to gatekeepers that HIV/AIDS is in fact affecting the Fijian population.

ATFF's attitudinal study allowed them to examine the social leaders who may have perpetuated the *tabu* by not speaking about safe sex and HIV/AIDS prevention, find out what made them change their beliefs, and then use that information to further work with the *tabu* to get their message about safe sex across. ATFF is currently in the process of taking the findings from its study and applying it in their next marketing campaign. Unfortunately the progress of the campaign is currently being slowed by financial and legal hurdles, but when it does come to fruition, they hope to involve social gatekeepers as speakers in their marketing materials to help dissolve the *tabu* and make the audience more willing to accept the message (interview N. Singh, 03/05/06).

### *Marie Stopes International Fiji & the Direct Mail Project*

Marie Stopes International (MSI) is a non-government organization with offices around the world that offers among its many services family planning, contraceptive distribution, information on HIV/AIDS prevention and sexual and reproductive health. The Fiji division of Marie Stopes International Pacific is based

in Suva and the organization does work with some other Pacific Island nations in the region. MSI has taken a unique approach to providing information about HIV/AIDS and sexual health to its constituents throughout the country while respecting Fiji's "culture of silence." From 2002-2004 MSI pilot tested the Direct Mail Project in Fiji, an educational strategy devised after surveying people in both Fiji and Papua New Guinea (where there is an alarming number of HIV cases) to determine what information people want and what the best method is to get that information to them. The result of that survey was the Direct Mail Project, a confidential way to send information by mail. MSI's brochure describes the reasoning behind the project: "Our culture of silence does not allow us to openly address prevention and treatment of HIV/AIDS, STIs nor family planning. The Direct Mail Project provides a way for the public to access information on sexual and reproductive health" (Direct Mail Project brochure, Marie Stopes International Fiji).

To implement the program, MSI ran advertisements on television, radio stations and in newspapers providing an address for people to write to in order to receive information about sexual health issues. Anyone who wrote in then received information directly by mail in an unmarked envelope. Additional information sent to the same address was posted in an envelope of a different color to ensure anonymity. Saras Singh, the Regional Program Director of MSI, says the Direct Mail Project was a huge success. MSI received approximately 10,000 requests per year for information in each of the three years that the campaign ran. Using the postal system works well because it allows people in remote locations to have access to information and it protects the confidentiality of those who are seeking it. Singh says MSI will restart the program and run it for the next three years in addition to running similar programs in the Federated States of Micronesia, Kiribati and Tuvalu (interview S. Singh,

05/04/06).

MSI's success with the Direct Mail Project is a result of their embracing the *tabu* and working with it, not against it. By respecting the culture of silence and finding a way to accommodate the needs of people who live within it, they were able to effectively disseminate information without offense.

### EFFORTS BY THE POSITIVE COMMUNITY

The Fiji HIV Positive Network is a group of PLWHA based in Suva. Located in an otherwise abandoned warehouse building provided by the Ministry of Health, the Network provides outreach programs to groups and communities that request presentations. Tuberi Cati, co-founder of the Network and one of their strongest educators. She is HIV positive and lost her first husband to the virus. Cati has worked with groups from a range of levels from being invited to speak the Great Council of Chiefs (Fiji's body of traditional leaders) to villagers at the community level. Cati has developed a series of strategies to make her HIV/AIDS education presentations effective. She does not think PowerPoint presentations are effective; the best way is to make teaching participatory and to tell a story that humanizes what she is saying. She perceives that many young people do not think HIV/AIDS is an important issue, so it is important for her to make it real to them.

Another highly effective education strategy she has developed to help dissolve the barriers of talking openly about sex is to engage the help of an influential community leader. Cati will ask a traditional or church leader to stand up at the beginning of a workshop and actually say the word "sex" and tell a story or give an example that illustrates that it is acceptable to talk about sex. In the past she has asked the *roko tui*, the spokesperson of a province, to travel with her and ask people to listen to her important message. Hearing a leader talk about something that may

otherwise be *tabu* helps sensitize the audience to be more receptive to what Cati has to say (interview Cati, 04/05/06).

## EFFORTS BY THE NATIONAL GOVERNMENT

### *Primary and Secondary Schools*

The HIV/AIDS education effort in schools varies across Fiji. Though the Ministry of Education nationally mandates the curriculum, the amount of information presented to students depends on the resources available to the school and the people involved with actually delivering information to students.

The Ministry of Health provides a team of nurses to deliver presentations on reproductive health in primary schools throughout Fiji. Fiji's Central Division School Team, consisting of five nurses, visits 56 primary schools throughout the Central Division surrounding Suva delivering reproductive health programs. In 2006 alone, the Team has 79 programs scheduled at various schools and institutions, but no portion of their agenda includes HIV/AIDS awareness. Bulou Makutu, one of the School Team nurses, said she had recently attended a workshop in Nadi about HIV/AIDS and part of the workshop included how to present information to younger children; Makutu hopes to incorporate information about HIV/AIDS into the school team presentations for children in classes five and six starting in the next school term (interview Makutu, 03/05/06).

Though the government directly allocates resources for primary schools, the school team does not visit secondary schools where students are at the age of potentially becoming sexually active and in the greatest need of sex education. The curriculum for students at the secondary school level does include HIV/AIDS information (interview Lingham, 29/04/06). However, the amount and depth of information that is actually presented to students regarding safe sex and HIV/AIDS

transmission and prevention is often dictated by the headmaster or school principal. Some schools are very liberal with the amount of information they teach to their students and others are very conservative. Ram Lingham, a general science teacher at All Saints Secondary School in Labasa, is able to teach in-depth about reproductive health including how STIs are transmitted and how they can be prevented using contraceptives. The textbook Lingham uses with his Form Four science class unambiguously lists which types of sexual activities can and cannot transmit the HIV virus, from the more mild open-mouth kissing to much more explicit anal sex. Students are also bluntly told how to use condoms and where they can go to get them (interview Lingham, 19/04/06).

In the past fifteen years, Lingham has noticed a change in attitude toward sex education in schools. Just in the past five years HIV/AIDS information has made its way into textbooks. Additionally, All Saints Secondary has moved part of the curriculum to form one classes where they get their first formal introduction to sex education. The subject only used to be taught in form four, but teachers began realizing that students at that age had already absorbed much about sex from their peers. Parents are also realizing the importance of sex education as well. Lingham reports that some are starting to talk to their kids about sex; the *tabu* still exists, but the "sex is dirty" mentality is beginning to fade (interview Lingham, 19/04/06).

In direct contrast to Lingham's relatively progressive environment, US Peace Corps volunteer Hila Raen has received varied reactions from the school principals regarding the information she asks to present in secondary schools. For many of the letters she sends to secondary schools asking if the school would like her to present on sexual education she never receives a response. In schools that do invite her to present, she meets with principals before she visits schools to deliver her health

promotion presentations and gives principals a choice as to which materials she can use during her presentation. Raen reports that most principals approve talking about self-esteem and sexuality, but generally avoid the materials specifically regarding safe sex (interview Raen, 27/04/06).

### STI CLINIC

The STI Clinic located in Suva serves as the nation's HIV/AIDS hub. The clinic has the capacity to draw blood samples to test for HIV, provide pre- and post-test counseling, and is the only facility that distributes important antiretroviral drugs to PLWHA. Despite the clinics importance in the region, it is located in an old warehouse; there are no private rooms for counseling and the clinic is now too hot to store and test blood samples. There is no reception desk and the work table in the main room is often occupied by staff or nursing students, eliminating any atmosphere of privacy. For people who are already nervous about coming in for condoms, counseling or treatment, the environment is intimidating. In a culture where a *tabu* already makes difficult to create an open environment in a clinic devoted to STIs, the facilities provided by the Ministry of Health diminish the efforts of the qualified nursing staff.

### *Case Study: Josaia Valerusa & Noikoro Awareness Program*

The best education methods seem to be those that take the *tabu* into account and find ways to accommodate it. Richard Parker says, "AIDS education and prevention programs that are community-based and culturally sensitive – programs aimed at transforming social norms and cultural values … [are the programs] that will ultimately promote safer sexual practices" (Parker, 2001, p. 168). For this reason Josaia Valerusa's program in the Noikoro district is presented as a case study because he carefully considers the components that make up the Fijian *tabu* and in order to

accommodates the *tabu* in his rural education program and ensure its effectiveness.

Valerusa, an indigenous Fijian man, has been a peer educator for the Ministry of Health and specifically Sigatoka Health Center since 1999. He works closely with the Sigatoka community and places elsewhere within the Nadroga province. Recently community leaders in the Noikoro district, located in the interior of Viti Levu, requested an HIV/AIDS awareness meeting for each of the nine villages located within the district. Valerusa drafted a proposed agenda and budget for the day-long awareness program that would be implemented in each village. The agenda not only includes time to talk about anatomy and physiology from which to base the rest of the workshop and sessions to discuss HIV/AIDS, STIs and teen pregnancy, but also specifically allotted time for a *sevusevu*, morning and afternoon tea, lunch and an evening *talanoa*. These additional components have been added to make his program fit within the normal protocol of a day in a Fijian village. Valerusa can ensure that his audience is comfortable with his program and what he has to say by creating an atmosphere of normalcy as he runs his program to fit within what his audience knows traditionally. He has a better chance of working with the *tabu* and educating his audience if he respects it.

These important traditional elements not only increase the time Valerusa must devote to each village, but also increases the amount of money needed to implement the program. The budget for each program is FJD$306, totaling FJD$2760 for the entire initiative. The breakdown of costs include transportation, photocopying costs for related handouts, *yaqona* for the *sevusevu*, and a significant portion of the budget devoted to catering costs to feed everyone in attendance. In a country where funding in difficult to come by, it would seem that the costs of food and *yaqona* could be significantly downsized or removed altogether. However, Valerusa is adamant that

these two components are critical to the program because food is such an integral part of the culture and it would be unthinkable to enter a Fijian village without presenting a *sevusevu* (interview Valerusa, 27/04/06). Though funding presents a problem, Valerusa insists on respecting the Fijian culture and doing things according to protocol; his message cannot be effective if he fails to follow tradition.

To further accommodate Fijian tradition, the timetable allots two hours from 8:00-10:00pm for an evening *talanoa* (chat) and question and answer session. Valerusa designed this part of the program to fall later in the evening to allow people who had to work during the day to attend. Traditionally, this is also the prime time to sit around the *tanoa* and discuss issues. He stresses that it is critical not to simply pack up and leave when the last formal education session is finished at 4:00pm; he and the other facilitators must respect "Fiji time," the concept used to describe the slower pace with which things are enjoyed in Fiji, by taking an extra night in the village to participate in the *talanoa* when community members may be braver enough to ask their important questions (interview Valerusa, 27/04/06).

Though Valerusa's program seems to be perfectly tailored to fit within the Fijian culture to maximize the amount of information absorbed by the community members, his initiative has gotten caught up in the bureaucracy of the Ministry of Health. When Valerusa was interviewed at the Sigatoka Health Clinic, he was able to immediately locate and retrieve his proposal from the head nurse's desk - it had been sitting unopened in the same place he dropped it a month ago. Additionally, there is no guarantee of funding for Valerusa's proposal. Though he's confident that "funding will come from somewhere," though he cannot explicitly identify an organization that will sponsor the program (ibid). The harsh reality is that the Ministry of Health has allocated FJD$3,000 to the Sigatoka Health Clinic's health promotion budget for the

entire year - when Valerusa's program for just the Noikoro district alone costs nearly that much, coming up with that much money for one initiative is going to be a huge challenge.

Valerusa's program makes an ideal case study for HIV/AIDS education in Fiji because it highlights an excellent education strategy that takes Fijian culture into consideration and it also reveals the reality of funding available from the national government. Valerusa has designed an ideal program that will maximize his efforts as a teacher by accommodating an entire village's timetable, but unfortunately it may never come to fruition.

**ANALYSIS**

HIV/AIDS is a multi-layered, multi-dimensional topic with footholds in all levels of government and all realms of society. Having to work with a *tabu* that makes it difficult to talk about such a complex issue only heightens the challenge. After examining a variety of organizations in a variety of sectors within Fiji, the organizations that seem to be the most successful in their HIV/AIDS education campaigns are those that take the *tabu* into account and take steps to accommodate it in their outreach.

Since talking about something that is *tabu* makes people uncomfortable, the easiest way to work with the *tabu* is to find other ways to make people comfortable. Making people feel at ease in any educational situation is imperative, especially when the subject matter can be culturally sensitive. Information needs to come from someone the audience can trust and identify with and the physical environment must be comfortable as well. That environment can be an entire village seated around a *tanoa,* in the privacy of a youth's own home as they open private mail or in a clinic where a client's needs can be addressed discreetly. The *tabu* is only revered in the

first place because people in positions of influence and power have propagated in the past and made people feel uneasy with the subject, so a situation where people can be at ease and have an open mind is one of the more important steps to get around the *tabu*.

However easy that may seem in theory, there are a variety of other factors that complicate education efforts. Effective HIV/AIDS education strategies are beginning the emerge around Fiji, but there is a lack of support from the national government – an important place for funds necessary to see these strategies through to completion. The Ministry of Health "is the most criticized ministry" in Fiji (interview informant A, 28/04/06). Shortage of staff, funds, training and initiative from those higher up in the organization have limited what the Ministry of Health has been able to do to about HIV/AIDS. However, even without the money for extra funds the national government could begin to help make a difference. Every successful education strategy has revealed the importance of respected people in Fijian society (the gatekeepers) speaking about HIV/AIDS in order to break down the *tabu*. Even if the national government cannot allocate funds to help implement HIV/AIDS education programs, they can at least start talking about it. The national government, which is full of both politically and traditionally respected leaders, can strengthen its commitment to HIV/AIDS education simply by speaking about the *tabu* subject and making the nation more comfortable talking about HIV/AIDS.

**CONCLUSION**

Though many different organizations are devoting time to educating people about HIV/AIDS in Fiji, there is a huge lack of cooperation and collaboration. Organizations such as Marie Stopes International who are piloting innovative education programs and AIDS Task Force Fiji who are studying the particulars of

what changes attitudes towards the *tabu* are pivotal in the awareness effort. However, resources are limited in single organizations and the national government is not taking heed of the important educational strategies the grassroots level organizations are developing and implementing. Collaboration between organizations (including those at the federal level) to combine financial and intellectual resources is crucial to ensure that the educational needs of the entire nation are met. Perhaps the most critical resource these organizations can share in Fiji's fight against the spread of HIV/AIDS is the knowledge of best practices of how to work with the *tabu* of talking openly about sex and provide the necessary HIV/AIDS awareness to work towards an HIV-free Fiji.

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## APPENDIX A - Glossary of Fijian Words

roko tui – person in charge of a district

sevusevu - traditional Fijian ceremony in which a root plant is presented by a visitor to the chief of the village in order to be accepted into the village

tabu - referring to something that is socially or culturally prohibited; “taboo”

talanoa - conversation or chat

tanoa - bowl from which yaqona (kava) is served

yaqona - root plant that is pounded and mixed with water and drank; also known as kava

## APPENDIX B - Map of Fiji

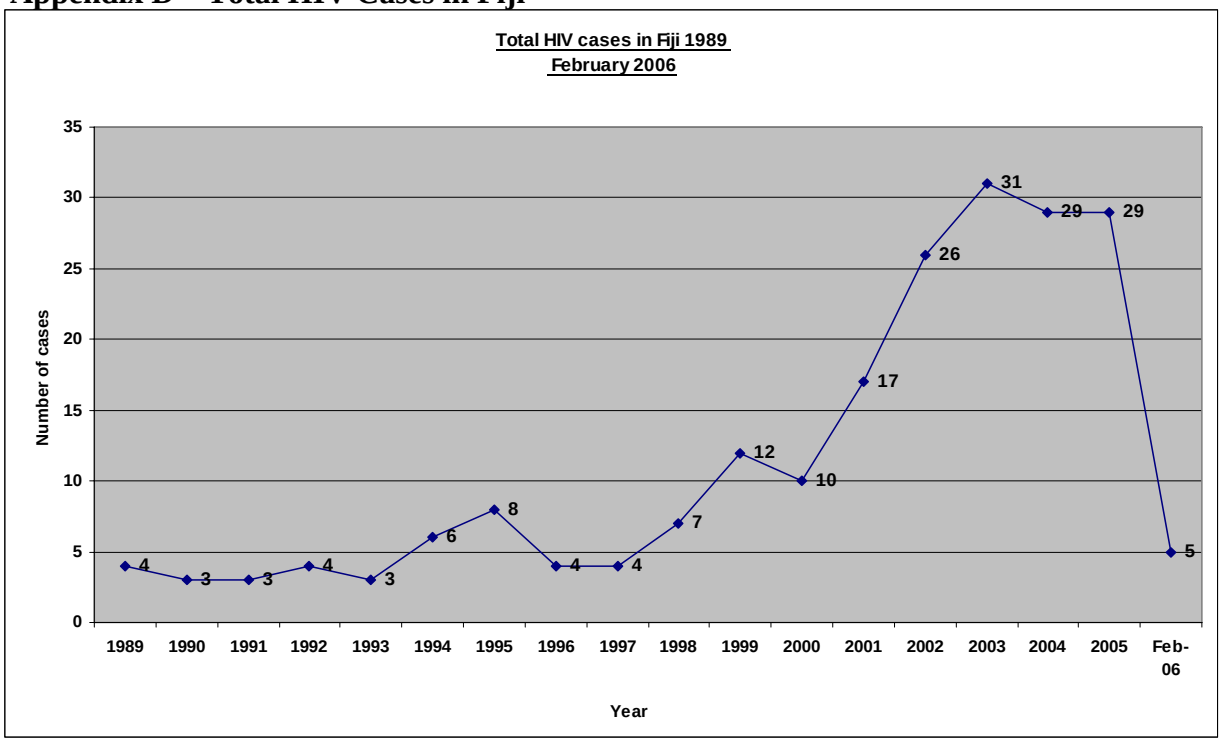

From http://www.fijifvb.gov.fj/about/geograph/map.shtml

## APPENDIX C - Table of Social Gatekeepers

| Group | Reason to ID as Social Gatekeeper |
|---|---|
| Parliamentarians | Placing government money into social marketing campaigns. |
| Chiefs | Being custodians of traditional ethnic culture vs. the need to modernise to the realities of HIV/AIDS. |
| Religious leaders | Being custodians and guides to a spiritual life that traditionally views 'safe sex' as naturally occurring when people follow the doctrines of the religion. |
| Pharmacy staff | Attitude to youth buying or wanting to buy condoms. |
| Medical/family planning centre staff | Attitude to youth or married individuals who might be having an extra-marital affair, requesting access to condoms. |
| Teachers | In promoting sex education in the classroom that includes safe sex practices such as condom usage. |
| Police | Officers are required to interact with the sex work community. |
| Media | Being able to place a 'postive' or 'negative' spin on safe sex promotions. |

From Taylor, R. & Singh, N. (2005) "Establishing more effective social marketing strategies for condom usage in the Pacific." p. 9

## Appendix D – Total HIV Cases in Fiji




Statistics provided by J. Vakalalabure, UNAIDS 2 May 2006.