

FIJI HIV SURVEILLANCE REPORT 2025

National Epidemiological Analysis · HIV Testing, Diagnosis & Care Cascade

2,016

new HIV diagnoses in Fiji in 2025 — a record high
Highest annual total since surveillance began in 1989



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Technical oversight: Dr Jason Mitchell, Interim Lead SRH & HIV Unit and Chair, N-HOCRT
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List of Abbreviations

Abbreviation	Meaning
ART	Antiretroviral Therapy
CD4	Cluster of Differentiation 4
CWM(H)	Colonial War Memorial Hospital
DFAT	Australian Department of Foreign Affairs and Trade
EID	Early Infant Diagnosis
HIV	Human Immunodeficiency Virus
LIS	Laboratory Information System
MOHMS	Ministry of Health and Medical Services
MOT	Mode of transmission
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
N-HOCRT	National HIV Outbreak and Cluster Response Taskforce
NHN	National Health Number
OI	Opportunistic Infection
PATIS	Patient Information System
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
POCT	Point-of-Care Testing
PWID	People who inject drugs
SRH	Sexual and Reproductive Health
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VL	Viral Load

Executive Summary



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The Fiji HIV Surveillance Report 2025 provides a comprehensive analysis of national HIV data, including trends in diagnoses, demographic and geographic patterns, testing activity and care outcomes. The report is intended to inform policy, guide programme implementation and support evidence-based decision-making for Fiji's HIV response.

Recent surveillance data show a notable increase in HIV diagnoses in Fiji, reflecting both changes in the epidemic and expanded testing services in clinical and community settings. The scale-up of laboratory diagnostics and community-based point-of-care screening has improved detection of previously undiagnosed infections. This broader testing coverage is a key step toward earlier diagnosis and better access to treatment and prevention.

The report highlights important demographic and geographic patterns in the distribution of HIV cases across the country. A substantial proportion of cases continue to occur among individuals in sexually active age groups, underscoring the need for sustained prevention efforts targeting populations at increased risk. Geographic analysis demonstrates variations in case distribution across divisions, reflecting differences in population density, testing coverage, and service accessibility.

Despite better testing availability, late diagnosis remains a significant concern, with many individuals diagnosed at advanced stages of HIV infection. This has serious implications for individual health and the risk of further transmission. Strengthening strategies for earlier testing and timely diagnosis will remain a key priority for the national programme.

The report also reviews progress along the HIV care cascade, including linkage to care, retention in treatment and viral load monitoring. While many individuals are successfully

linked to treatment, the findings identify areas where further efforts are needed to ensure ongoing engagement and optimal adherence.

The expansion of HIV testing services across Fiji has resulted in a substantial increase in testing activity. The report shows that both laboratory-based and point-of-care testing programmes have expanded access to HIV screening. Reactive results are confirmed through the national laboratory network, ensuring an accurate and reliable diagnostic surveillance system.

The Ministry of Health and Medical Services remains committed to strengthening Fiji's HIV response through partnerships, data-driven strategies, and the dedication of healthcare professionals and programme staff. The insights in this report will help guide national efforts to prevent new infections, improve treatment outcomes, and support the long-term health of communities across Fiji.

1. Introduction

National Overview of HIV in Fiji

HIV continues to pose a significant and evolving public health challenge in Fiji. Since the initial case was reported in 1989, national surveillance systems have been established to monitor HIV diagnoses, testing activity and engagement in care. These systems integrate laboratory, clinical, and programmatic data to offer a comprehensive understanding of the epidemic and inform national public health strategies.

For several years after the initial detection of HIV in Fiji, the number of reported cases remained relatively low, with annual diagnoses typically below 100. In recent years, however, there has been a substantial increase in HIV diagnoses, which is thought to be a consequence of: 1. unprotected sexual transmissions facilitated by the high rates of undiagnosed and untreated sexually transmitted infection; 2. high-risk intravenous drug use practices including the sharing of needles and syringes, the absence of a harm reduction programme, law enforcements efforts leading to a reduction in the availability of needles and syringes through the retail pharmacy networks across the country, and the various blood mixing practices; and 3. the tragic, preventable rise in mother-to-child transmission (MTCT) of HIV from parents to their children. This increase is further attributable to the national programme of expanded testing coverage and improved identification of previously undiagnosed infections within the population

By the end of 2025, Fiji had reported a cumulative total of 5,676 HIV cases. Of these, 2,016 cases were newly registered in 2025, marking the highest annual number of diagnoses since surveillance began. The rising number of reported cases highlights the changing epidemiological profile of HIV in Fiji and emphasises the need to strengthen prevention, testing and treatment services.

HIV testing in Fiji is provided through both facility-based laboratory testing and community-based point-of-care testing programmes. Individuals can access screening at hospitals, primary health facilities, and through targeted outreach services. A national laboratory network supports these services by conducting confirmatory testing and ensuring quality assurance of diagnostic procedures.

Timely linkage to care and sustained treatment for individuals diagnosed with HIV remain central priorities of the national response. Strengthening the HIV care continuum, from prevention, testing and diagnosis to treatment initiation and long-term viral suppression, is essential for improving health outcomes and reducing further transmission.

This report analyses HIV surveillance data from January to December 2025, offering insights into trends in HIV diagnoses, testing activity, and engagement in care throughout Fiji.

Purpose of the Report

This report provides an overview of HIV diagnoses and care engagement in Fiji from January to December 2025. It analyses national data to identify trends in detection, linkage to care, treatment uptake and retention.

This analysis highlights key epidemiological patterns and gaps in the HIV care cascade. The findings support evidence-based decisions to strengthen public health responses in Fiji.

The report supports the priorities of the Fiji HIV Outbreak Response Plan. It emphasises the expansion of available combination prevention interventions, accelerating the programme of testing, improving treatment linkage and sustaining viral suppression.

It also serves as a resource for the national programme, healthcare providers, policymakers and development partners. It provides data to guide targeted interventions, strategic planning and efficient allocation of resources to areas and populations most affected by HIV.

2. Data Sources and Methods

Overview of Data Sources

This report analyses HIV diagnoses, testing activity and engagement in care in Fiji, from January to December 2025. The analysis uses routinely collected national data for surveillance, diagnostics, clinical care, and programme monitoring within the Ministry of Health and Medical Services (MOHMS). The report provides a comprehensive assessment of HIV trends, diagnostic testing and treatment engagement nationwide.

The primary source of case-based information for this report is the national HIV database, the central repository for HIV diagnoses in Fiji. This database consolidates records of individuals diagnosed with HIV from multiple reporting systems and programme registers. The national HIV database was used to determine the number of newly registered HIV cases and to analyse the epidemiological patterns presented in this report.

Additional data sources were incorporated to support and validate findings from the national HIV database:

Laboratory Information System (LIS)

LIS provided information on HIV diagnostic and monitoring tests conducted across the national laboratory network. These data included HIV screening, confirmatory and viral load test results. Laboratory testing data was used to assess national testing volume, confirmatory testing activities and trends in laboratory diagnostics.

Laboratory Registers

Where electronic laboratory reporting was incomplete, facility-level laboratory registers were reviewed. These registers record HIV screening and confirmatory testing at health facilities and were used to supplement laboratory data and validate testing activity.

Divisional SRH Clinic Registers

Data from SRH clinic registers were also utilised. These registers document HIV testing outcomes, patient demographic characteristics and referral pathways for individuals accessing SRH services across the divisions.

Point of Care Testing (POCT) Data

POCT programme was included to capture HIV screening services delivered outside traditional laboratory settings. POCT services are conducted through community-based outreach programmes, peer-led testing initiatives and selected health facilities. These data were used to assess the scale and contribution of decentralised HIV screening to national coverage.

Divisional Paediatric Case Registers

For paediatric analysis, the report used divisional paediatric HIV case registers, which record children exposed to HIV and those diagnosed with HIV infection. These registers provide information on early infant diagnosis (EID), paediatric follow-up, and treatment monitoring.

Pharmaceutical Supply Data (mSupply)

Treatment-related information was obtained from mSupply, the national pharmaceutical supply chain management system. mSupply data provided insight into antiretroviral therapy (ART) dispensing, treatment initiation, medication distribution, supporting analysis of treatment uptake and patient engagement.

Patient Information System (PATIS)

PATIS is used in selected health facilities to maintain patient medical records, document clinic visits and capture HIV-related clinical services. This system provided supplementary information to support validation of treatment and care data.

National Tuberculosis Programme Case Register

The National Tuberculosis Programme case register was also reviewed to identify individuals affected by both tuberculosis (TB) and HIV, improving understanding of HIV and TB co-infection, and strengthening coordination between surveillance systems.

Data Integration and Deduplication

All datasets were compiled and integrated prior to analysis to improve completeness and ensure consistency across sources. Data cleaning included identifying and removing duplicate records, verifying patient identifiers and reconciling information across multiple data systems.

Records were primarily matched using the national health number (NHN), the unique patient identifier within the national health system. Where NHN information was incomplete or missing, name-based matching and manual verification were used to identify potential duplicate records across datasets.

Additional cross-checking was performed between laboratory records, treatment databases, and surveillance registers to ensure individuals were not counted more than once in the national case dataset. Where discrepancies were identified, records were reviewed against facility-level registers and corrected where appropriate. These processes ensured that the national dataset accurately reflected unique individuals diagnosed with HIV and minimised duplication across reporting systems.

Data Validation and Quality Assurance

Following data compilation and deduplication, further validation steps were taken to improve data quality. These included cross-referencing testing data with confirmatory records, verifying treatment status using pharmacy dispensing data and reviewing clinical records as needed.

Selected datasets were also compared across systems to confirm internal consistency. For example, confirmatory testing records were compared with the national HIV database to ensure alignment between laboratory diagnoses and registered HIV cases. Inconsistencies or missing information were identified, and records were manually reviewed and reconciled with available facility-level documentation.

Data Limitations

Despite efforts to ensure completeness and accuracy, several limitations should be considered when interpreting the findings presented in this report.

Routine surveillance systems may be affected by reporting delays, leading to some cases being registered after the reporting period. Incomplete data fields, variations in data entry practices, and differences in reporting across facilities can also affect data quality.

Linking patient records across multiple systems can be challenging when unique identifiers are missing or recorded inconsistently. In such cases, manual matching based on names and other identifiers was used, which may not capture all duplicate records. Furthermore, confirmatory testing volumes may include repeat testing among individuals previously diagnosed with HIV, which means that confirmatory testing activity does not always correspond directly to the number of newly diagnosed cases.

Despite these limitations, integrating multiple national datasets provides a strong foundation for understanding Fiji's HIV situation. Triangulating laboratory, clinical, treatment, and community testing data strengthens the overall surveillance system and supports evidence-based decision-making within the national HIV response.

3. Surveillance Findings

Trends in Newly Diagnosed HIV Cases and Cumulative Burden in Fiji (1989–2025)

HIV has been reported in Fiji since 1989, when the first five cases were documented. For more than two decades after the initial detection, the number of newly reported cases remained relatively low, usually between 10 and 40 per year as noted in Figure 1. This period saw a gradual increase in diagnoses, suggesting a low level of transmission detected in the population during the early years of the epidemic.

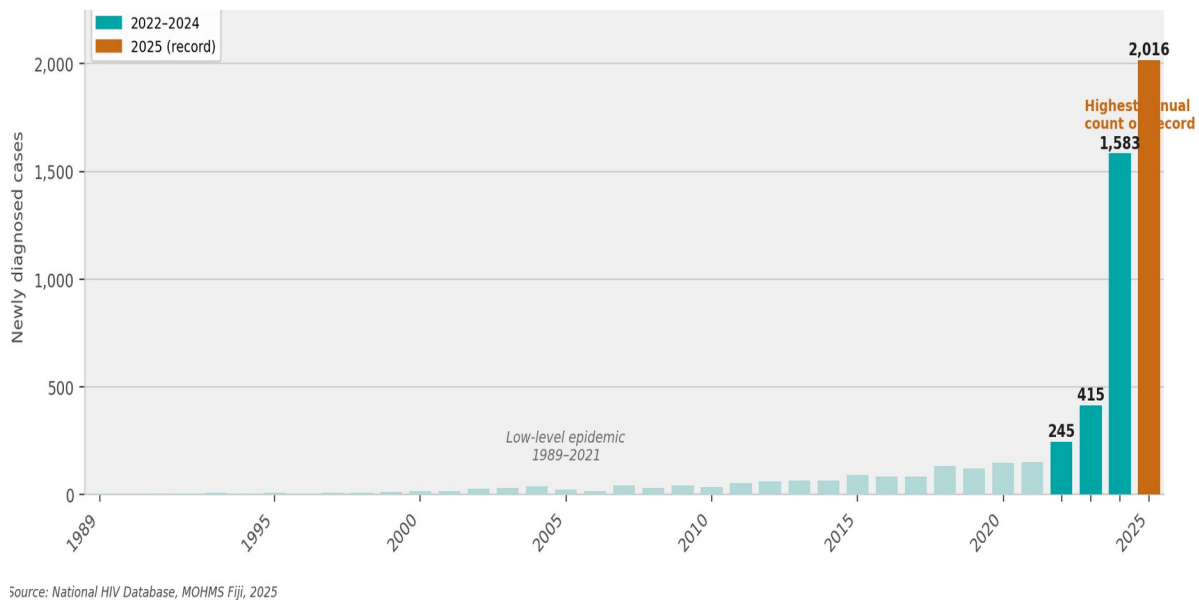


Figure 1 Annual Number of Newly Diagnosed HIV Cases, Fiji, 1989-2025

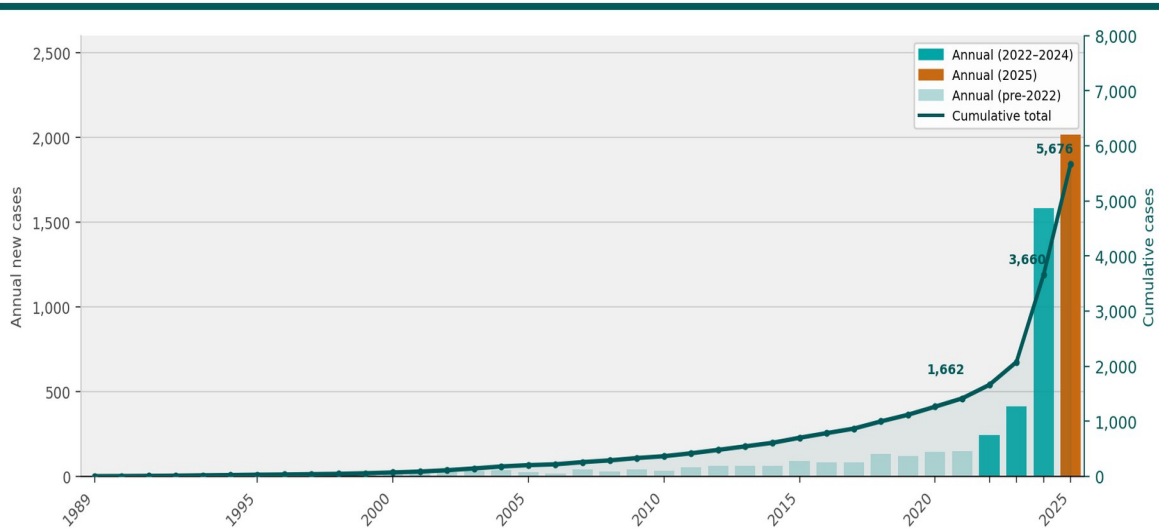
Between 2000 and 2014, annual reported cases increased slowly but steadily. During this period, the number of newly diagnosed cases rose from 14 in 2000 to 64 in 2014,

reflecting a gradual expansion of the epidemic alongside improvements in testing and surveillance systems.

From 2015 onward, a more pronounced increase in case detection was observed. Annual cases rose from 92 in 2015 to 131 in 2018, indicating a shift toward more sustained transmission and improved case identification. Although slight fluctuations occurred between 2016 and 2019, the overall trend was a gradual upward one.

A marked acceleration in reported HIV cases began in 2022, when annual diagnoses increased substantially. Newly reported cases rose from 245 in 2022 to 415 in 2023, then jumped to 1,583 in 2024. In 2025, newly reported HIV cases reached 2,016, the highest annual number recorded in Fiji since surveillance began.

This sharp increase in reported cases between 2023 and 2025 marks a significant shift in the epidemiological profile of HIV in Fiji. The rise in diagnoses likely reflects: expanded HIV testing approaches; increased case finding through community-based programmes, improved surveillance and reporting, the growing recognition of dangerous practices associated with intravenous drug use, the ongoing transmission of HIV infections through unprotected sexual transmission, facilitated by the large reservoir of untreated sexually transmitted infections across all segments of Fiji's population and identification of previously undiagnosed infections.



Source: National HIV Database, MOHMS Fiji, 2025

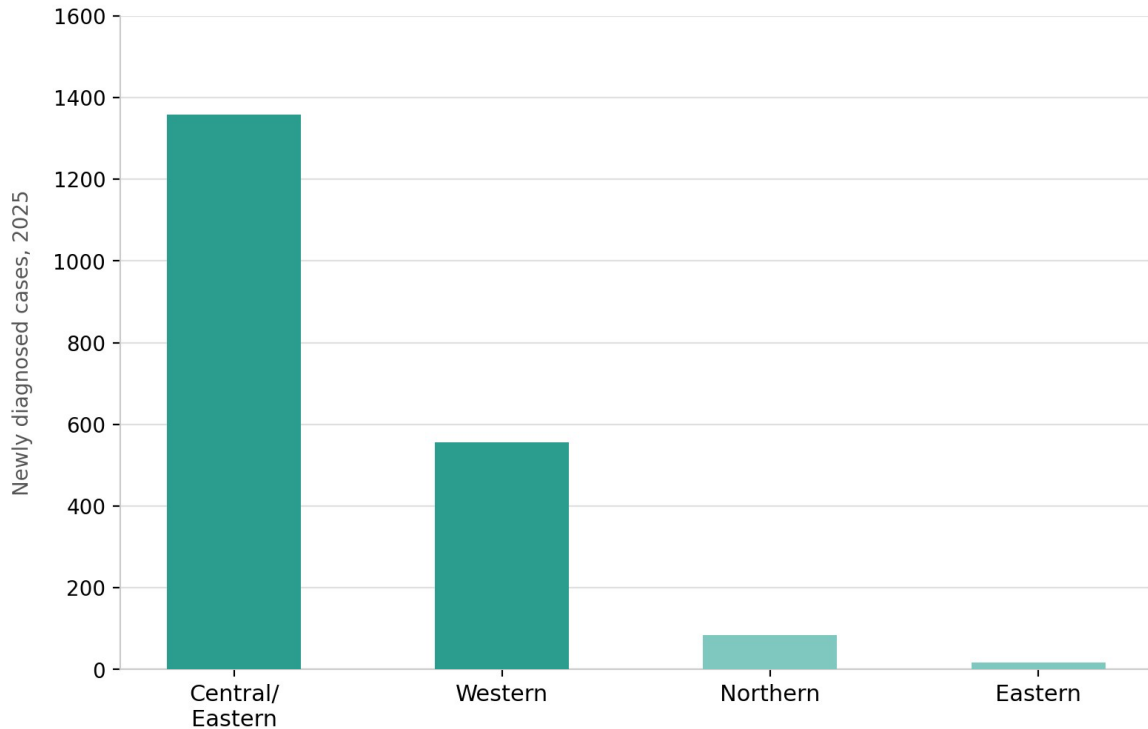
Figure 2 Cumulative Number and New Cases Diagnosed Annually, Fiji, 1989-2025

The cumulative number of reported HIV cases further shows the scale of this increase. From 1989 to 2021, Fiji recorded 1,662 cumulative cases. By 2023, this number had risen to 2,077, and by 2024, to 3,660. By the end of 2025, the cumulative number reached 5,676 as noted in Figure 2.

The cumulative trend shows that a substantial proportion of all HIV cases in Fiji have been identified in recent years, especially since 2023. This pattern suggests the country is experiencing intensified case detection and increased transmission.

Geographic Distribution of Newly Diagnosed HIV Cases by Division, Fiji, 2025

The geographic distribution of newly diagnosed HIV cases in Fiji from January to December 2025 reveals a pronounced concentration in the Central Division, followed by the Western Division, with significantly fewer cases reported in the Northern and Eastern Divisions, as illustrated in Figure 3 and summarized in Table 1.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 3 Geographic Distribution of newly diagnosed HIV cases by Division, Fiji, 2025

Of the 2,016 newly diagnosed HIV cases reported nationally in 2025, the Central Division accounted for the majority, with 1,359 diagnoses representing 67.4% of all reported cases. Over two-thirds of new HIV diagnoses in Fiji occurred within this division. The Western Division reported 556 cases, accounting for 27.6% of the national total. As the second most affected division, the Western region contributes more than one quarter of all newly diagnosed HIV infections. The Northern Division recorded 84 cases, representing 4.2% of total cases in 2025. The Eastern Division reported the fewest cases, with 17 diagnoses, representing 0.8% of all cases nationwide. The small number of reported cases in this division likely reflects the smaller population size and the geographic dispersion of communities across islands, which may limit access to testing and case detection.

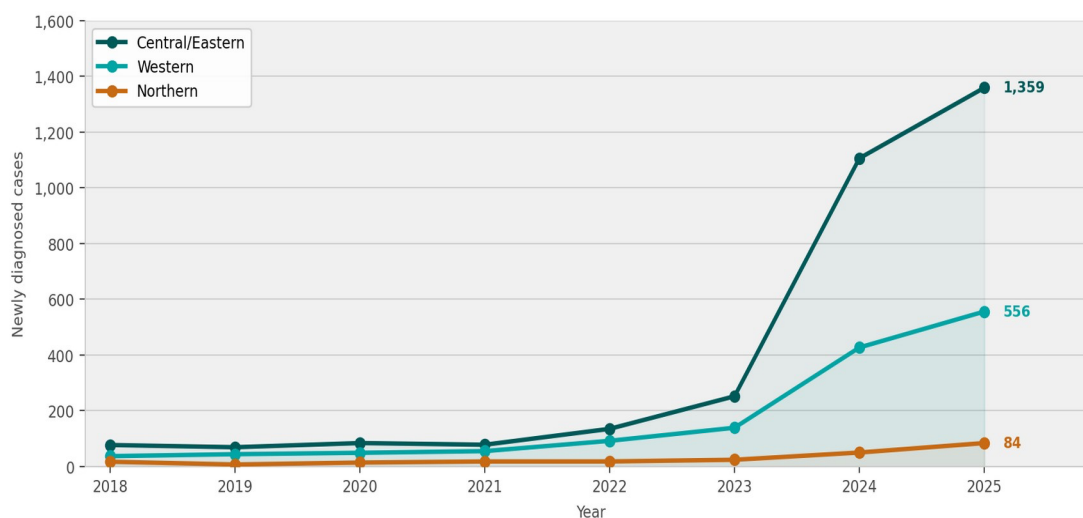
Table 1 Percent composition of newly diagnosed HIV cases by Division

Division	Number of Cases	Percentage
Central Division	1359	67.4%
Western Division	556	27.6%
Northern Division	84	4.2%
Eastern Division	17	0.8%

Case Distribution Trend Fiji, 2018-2025

An analysis of divisional trends from 2018 to 2025 demonstrates a marked increase in HIV diagnoses across all divisions. The Central Division consistently accounts for the largest proportion of cases during this timeframe.

Between 2018 and 2021, reported HIV cases across divisions remained relatively stable, with gradual increases in the Central and Western divisions. Beginning in 2022, there was a pronounced rise, especially in the Central Division, as illustrated in Figure 4. Diagnosed cases there increased from about 135 in 2022 to over 1,100 by 2024, reaching 1,359 in 2025. This sharp increase establishes the Central Division as the primary epicentre of the recent expansion in HIV diagnoses.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 4 Case distribution of newly diagnosed HIV cases 2018-2025

The Western Division also recorded a substantial increase during this period. Diagnoses rose steadily from lower levels before 2022 to 427 cases in 2024 and 556 in 2025. This trend shows a significant rise in detected HIV infections in the Western Division, although the overall magnitude remains lower than in the Central Division.

In contrast, the Northern Division has continued to report lower numbers of HIV diagnoses. While a gradual increase is observable, cases rose from fewer than 25 in earlier years to 50 in 2024 and 84 in 2025. Although the absolute numbers remain lower, the upward trend highlights the importance of maintaining strong surveillance and testing services in this division.

The trends indicate that the recent increase in HIV diagnoses in Fiji is primarily driven by the Central and Western divisions, which together account for most newly diagnosed cases. These findings highlight the need for geographically targeted prevention, testing, and treatment interventions, especially in urban and peri-urban settings where transmission may be more concentrated.

The divisional trend analysis also underscores the importance of expanding decentralised testing services, strengthening linkage to care, and improving early case detection as part of Fiji's broader national HIV response plan.

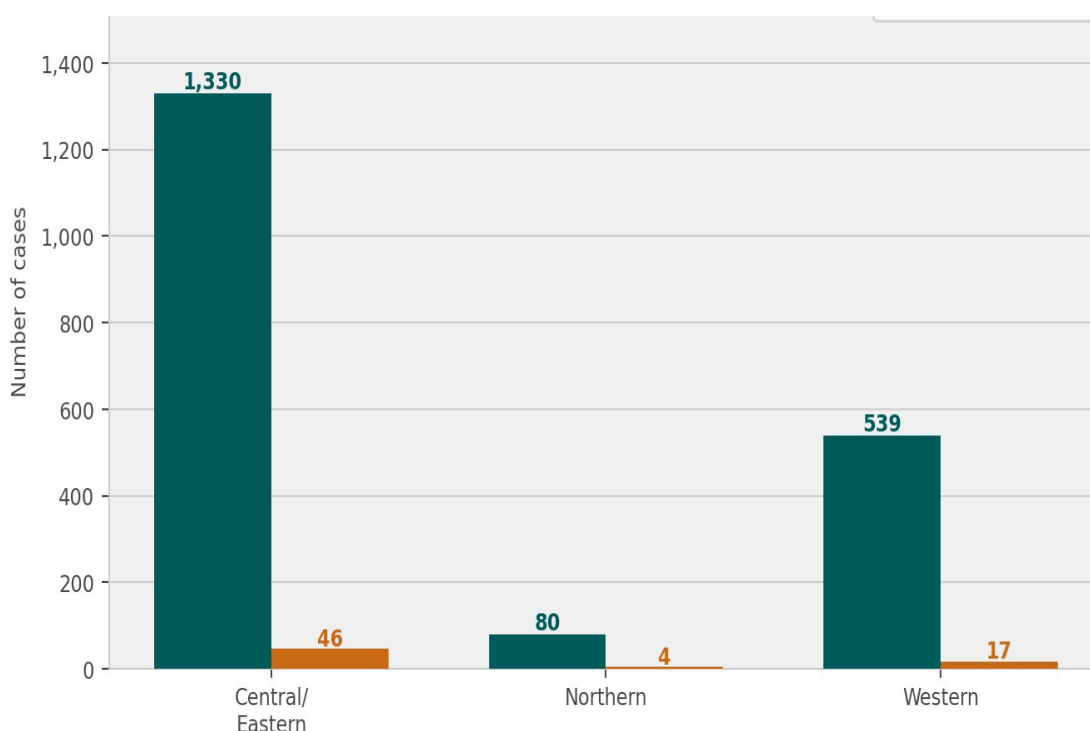
Distribution of Adult and Paediatric Cases by Division

Further analysis of geographic distribution reveals that both adult and paediatric cases were mainly concentrated in the Central and Western Divisions, consistent with the overall national pattern of HIV diagnoses, as noted in Figure 5.

The Central and Eastern Divisions combined reported the highest number of cases, with 1,330 adult cases and 46 paediatric cases. This division continues to represent the largest burden of HIV infections nationally.

The Western Division recorded 539 adult cases and 17 paediatric cases, the second-highest total in the country.

The Northern Division reported 80 adult cases and 4 paediatric cases.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 5 Distribution of Adult and Paediatric Cases by Division

Age Distribution of Newly Diagnosed HIV Cases in Fiji, 2025

Analysis of HIV diagnoses by age group (see Figure 6) from January to December 2025 demonstrates that the epidemic in Fiji is primarily concentrated among adolescents and

young adults, especially those aged 20–34 years. Understanding the age distribution of cases is essential for identifying priority populations for prevention, testing, and treatment interventions.

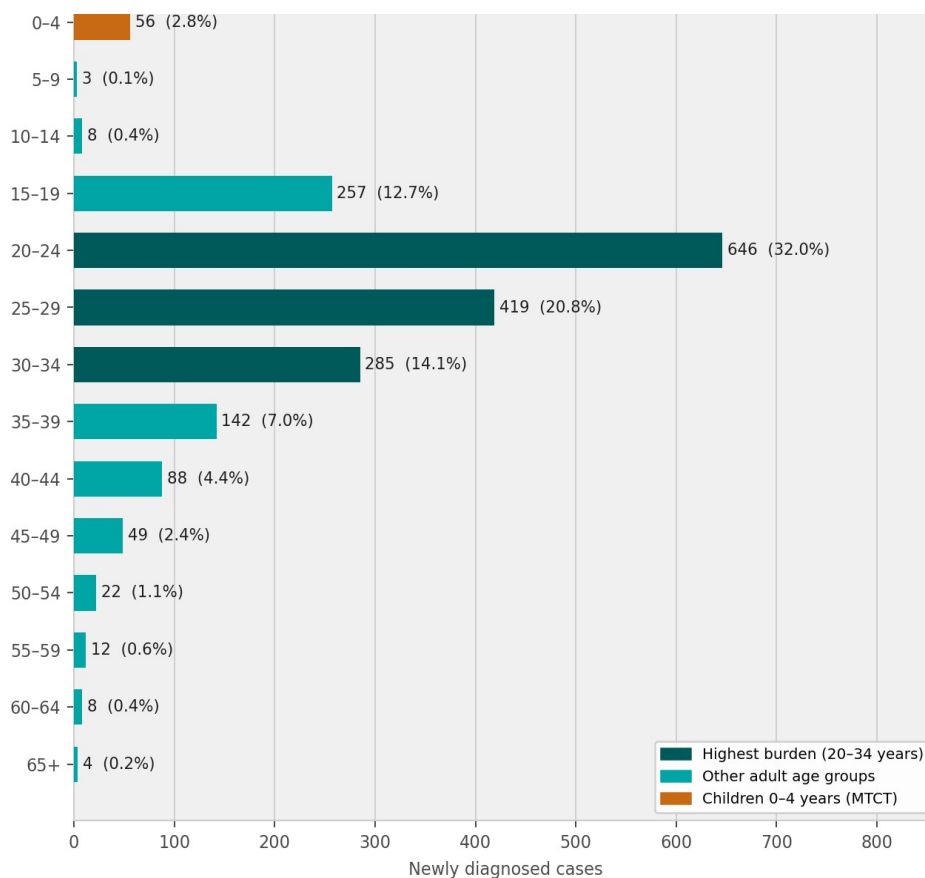


Figure 6 Distribution of HIV Cases by Age Group, Fiji, 2025

Among the 2,016 newly diagnosed HIV cases reported in Fiji in 2025, the 20–24-year age group accounted for the largest proportion, with 646 cases representing 32.0% of all diagnoses. This age group accounts for the largest contribution of new infections nationally.

The 25–29-year age group recorded 419 cases (20.8%), and the 30–34-year age group accounted for 285 cases (14.1%). Collectively, these three age groups (20–34 years) contributed 1,350 cases, representing approximately 67.0% of all new HIV diagnoses in 2025. This finding demonstrates that over two-thirds of reported infections occurred among young adults.

An additional 257 cases (12.7%) were recorded among adolescents aged 15–19 years, underscoring the vulnerability of younger populations and the need to strengthen HIV prevention and sexual health education for adolescents and youth.

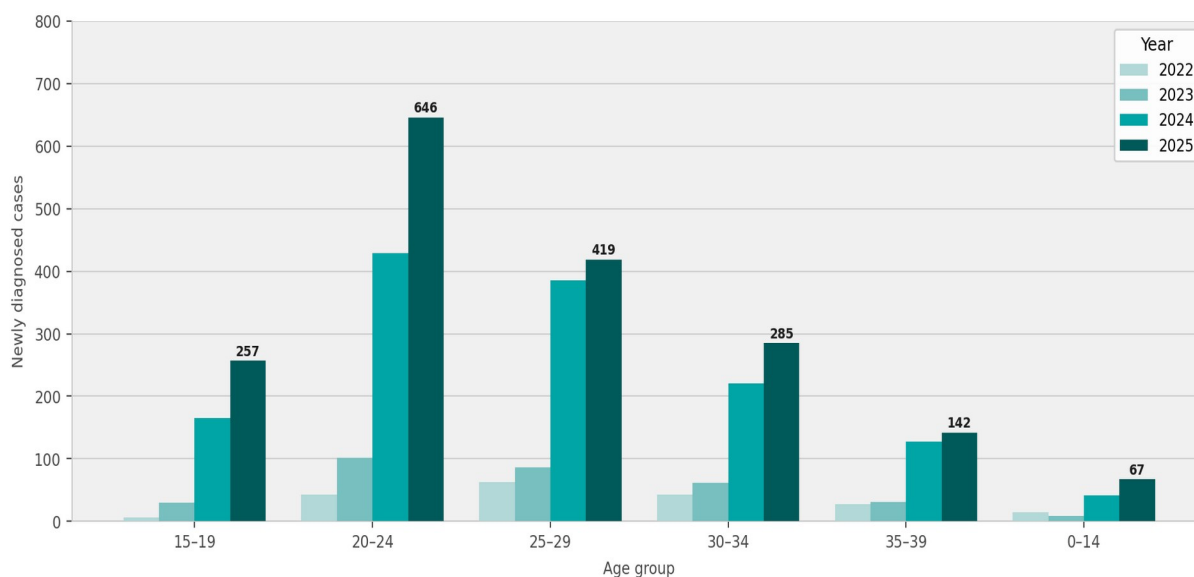
Among individuals older than 35 years, the number of cases declines. The 35–39-year age group recorded 142 cases (7.0%), followed by 88 cases (4.4%) in the 40–44-year age group, and 49 cases (2.4%) in the 45–49-year age group. Smaller proportions were observed among those aged 50 years and above, indicating continued but lower levels of HIV transmission in older age groups.

Within the paediatric population aged 0–14 years, 67 cases were recorded, representing approximately 3.3% of all reported HIV diagnoses in 2025. This total includes 56 cases among children aged 0–4 years (2.8%), 3 cases among those aged 5–9 years (0.1%), and 8 cases among children aged 10–14 years (0.4%). Although paediatric infections remain relatively low compared to adult cases, they require ongoing attention through strengthened prevention of mother-to-child transmission (PMTCT) programmes and early infant diagnosis services.

The age distribution demonstrates that the HIV epidemic in Fiji predominantly affects young and sexually active adults, particularly those aged 20 to 34 years, who account for most newly diagnosed infections.

Trends in HIV Diagnoses by Age Group in Fiji, 2022–2025

Analysis of HIV diagnoses by age group from 2022 to 2025 indicates a substantial increase in cases across most age groups, with the most pronounced rise among young adults aged 20–34 years. This cohort consistently represents the largest share of HIV diagnoses in Fiji, which is clearly noted in Figure 7.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 7 HIV Case Trend by Age Group 2022-2025

In 2025, individuals aged 20–24 years accounted for 646 cases (32.0%), the largest proportion of newly diagnosed infections. This represents a significant increase from 429 cases in 2024 (27.1%), 102 in 2023 (25.7%), and 43 in 2022 (17.5%), indicating a clear upward trend in this age group.

A similar pattern is evident in the 25–29-year age group, which recorded 419 cases in 2025 (20.8%), 386 in 2024 (24.4%), 86 in 2023 (21.6%), and 63 in 2022 (25.6%). Although the proportion fluctuated slightly between years, this age group remains a major contributor to new HIV diagnoses nationally.

The 30–34-year age group accounted for 285 cases in 2025 (14.1%), up from 221 cases in 2024 (14.0%), 61 cases in 2023 (15.3%), and 43 cases in 2022 (17.5%). This trend further highlights the concentration of HIV infections among adults in their late twenties and early thirties.

Among adolescents aged 15–19 years, 257 cases were reported in 2025 (12.7%), compared with 165 in 2024 (10.4%), 30 in 2023 (7.5%), and 6 in 2022 (2.4%). The

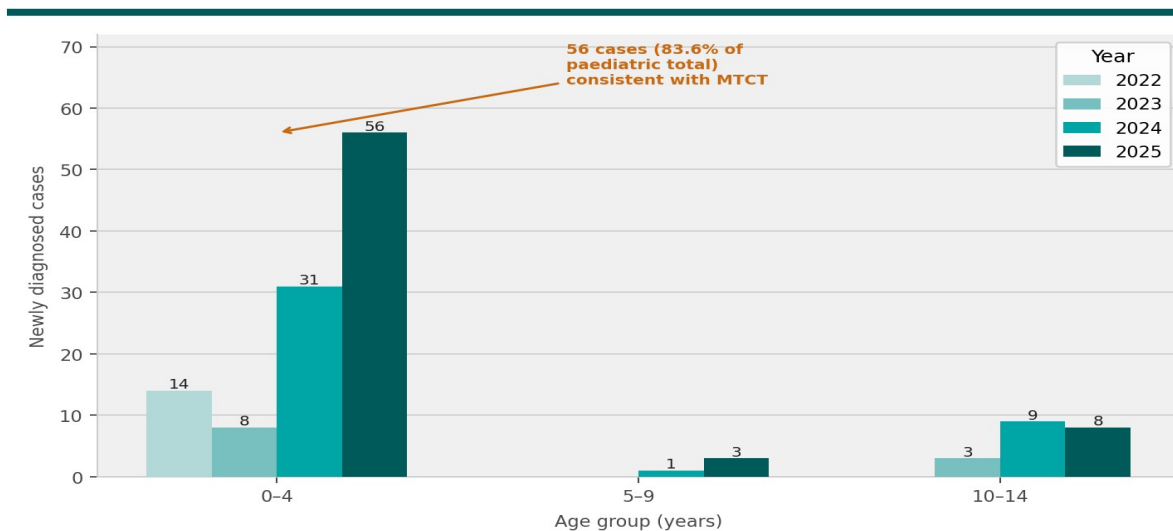
increasing proportion of diagnoses in this age group suggests a growing need for targeted HIV prevention and testing interventions among adolescents and young people.

Older age groups account for smaller proportions of cases but continue to contribute to the overall burden. In 2025, individuals aged 35–39 years accounted for 142 cases (7.0%), followed by those aged 40–44 years with 88 cases (4.4%) and 45–49 years with 49 cases (2.4%). The proportion of cases declines further among individuals aged 50 years and above, though diagnoses remain present across these age groups.

The overall trends from 2022 to 2025 demonstrate that the recent increase in HIV diagnoses in Fiji is primarily driven by young adults aged 20–34 years, who consistently account for the largest proportion of cases each year. This pattern highlights the need to strengthen youth-focused HIV prevention strategies, expand testing services, and improve access to treatment for young and sexually active populations.

Trends in HIV Diagnoses Among Individuals Aged 0–14 Years in Fiji, 2022–2025

Analysis of HIV diagnoses among children aged 0–14 years from 2022 to 2025 demonstrates a gradual increase in reported cases, with the majority occurring in the 0–4 year age group (see Figure 8). While paediatric cases represent a small proportion of the total national HIV burden, the trends observed have significant implications for prevention of mother-to-child transmission (PMTCT) and early infant diagnosis services.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 8 Trend of HIV Diagnosis in individuals Aged 0–14 Years

In 2025, 67 cases were reported among children aged 0–14 years, representing approximately 3.3% of all newly diagnosed HIV cases in Fiji. This compares with 41 cases in 2024, 9 cases in 2023, and 14 cases in 2022.

The 0–4 year age group consistently accounts for the largest proportion of paediatric diagnoses. In 2025, 56 cases were recorded in this age group, representing 83.6% of all paediatric diagnoses and 2.8% of total national HIV diagnoses. Cases in this age group are consistent with mother-to-child transmission during pregnancy, delivery, or breastfeeding, or delayed identification of children living with HIV acquired perinatally. The persistent burden in this age group suggests ongoing gaps in PMTCT coverage and early infant diagnosis.

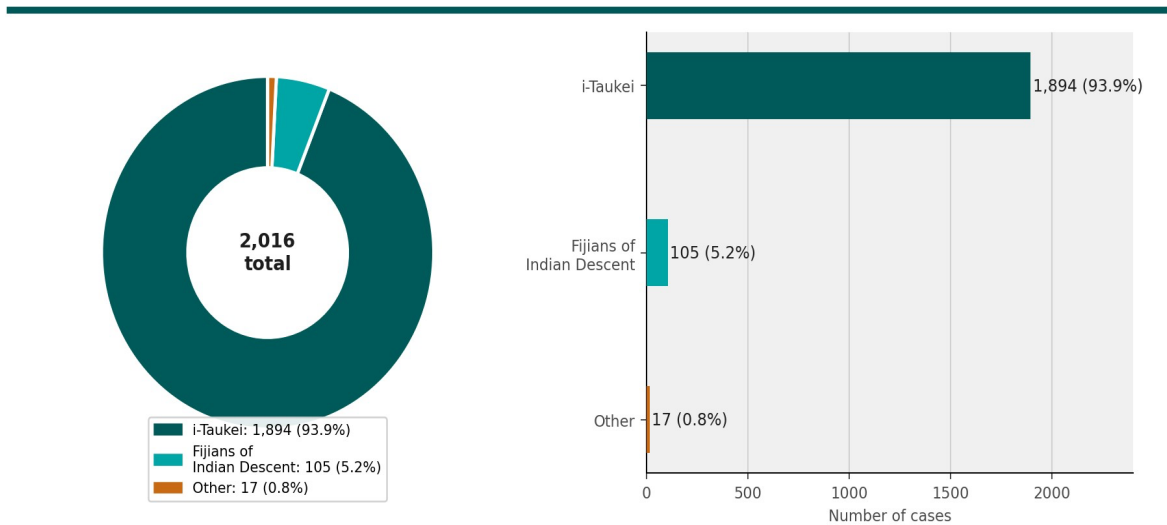
The 10–14 year age group accounted for 8 cases in 2025, representing 11.9% of paediatric diagnoses. While the numbers remain small, diagnoses in this age group may reflect a combination of delayed identification of perinatally acquired infection and, in older children, early exposure to transmission risk. The 5–9 year age group reported 3 cases in 2025, representing 4.5% of paediatric diagnoses.

The trends from 2022 to 2025 indicate that paediatric HIV diagnoses in Fiji are primarily driven by cases among children aged 0–4 years, consistent with mother-to-child transmission as the dominant route of infection in this population. Strengthening PMTCT services, expanding early infant diagnosis coverage, and improving follow-up of children

born to mothers living with HIV remain essential priorities to reduce paediatric HIV transmission and ensure timely diagnosis and treatment for affected children.

Distribution of Individuals Accessing HIV Diagnostic Services by Ethnicity in Fiji

The analysis of HIV diagnoses by ethnicity from January to December 2025 represents the distribution of individuals who accessed HIV diagnostic services and received a diagnosis during this period. These findings should be interpreted in the context of health-seeking behaviour, access to testing, and service utilisation, rather than as a direct indicator of HIV prevalence within specific ethnic populations. (Refer to Figure 9)



Source: National HIV Database, MOHMS Fiji, 2025

Figure 9 Distribution of cases by ethnicity Fiji, 2025

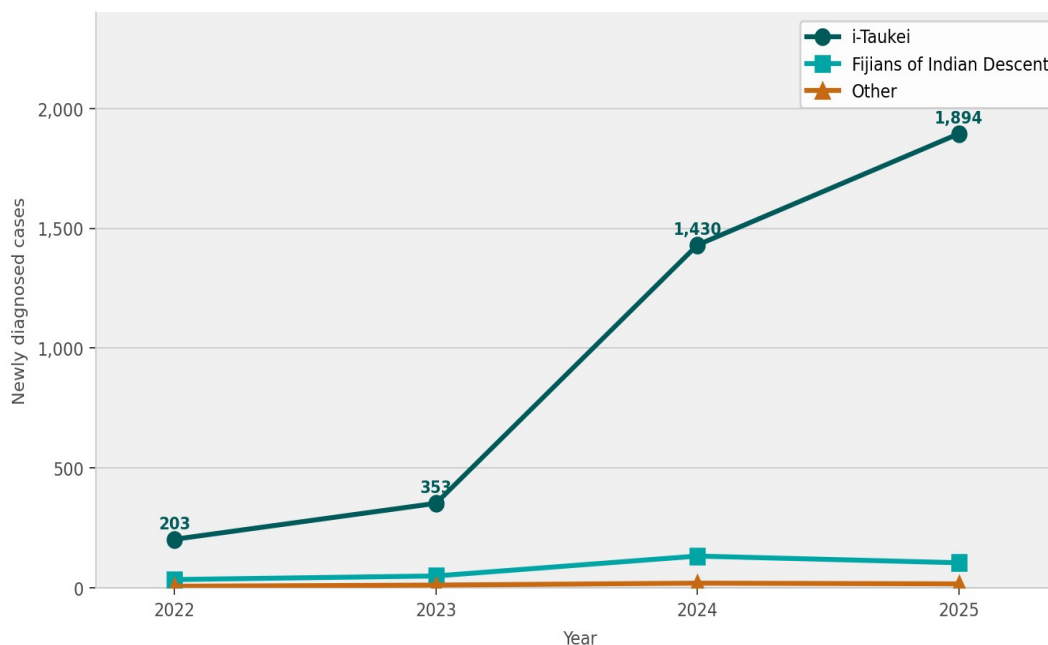
Among the 2,016 newly diagnosed HIV cases reported in Fiji in 2025, 1,894 cases (93.9%) were among individuals identifying as i-Taukei. Individuals identified as Fijians of Indian Descent accounted for 105 cases (5.2%), and 17 cases (0.8%) were recorded among individuals from other ethnic groups.

These figures represent the ethnic distribution of individuals accessing HIV testing and diagnostic services and should not be interpreted as evidence of differences in underlying HIV risk or prevalence between ethnic groups. Observed differences in the distribution of

diagnoses may result from factors such as healthcare utilisation patterns, testing uptake, geographic distribution of services, and population demographics.

Trends in Utilisation of HIV Diagnostic Services by Ethnicity in Fiji, 2022–2025

An analysis of HIV diagnoses by ethnicity from 2022 to 2025 indicates an overall increase in the number of individuals accessing HIV diagnostic services across all ethnic groups (see Figure 10). This trend parallels the broader national rise in HIV diagnoses during the same period. For individuals identifying as i-Taukei, diagnoses increased from 203 cases in 2022 (82.5%) to 353 cases in 2023 (85.8%), then rose substantially to 1,430 cases in 2024 (90.3%) and 1,894 cases in 2025 (93.9%). The rising proportion of diagnoses among i-Taukei individuals likely reflects increased utilisation of HIV testing services and the expansion of diagnostic activities in recent years among Fijians of Indian descent, 35 cases were reported in 2022 (14.2%), increasing to 50 cases in 2023 (12.2%) and 133 cases in 2024 (8.4%), before declining to 105 cases in 2025 (5.2%). Although the absolute number of diagnoses increased between 2022 and 2024, the proportion of cases decreased as the total number of HIV diagnoses rose nationally.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 10 Trend of HIV Diagnosis by Ethnicity 2022-2025

Cases among individuals categorised as other ethnic groups remained low throughout the reporting period: seven cases in 2022 (2.8%), 12 in 2023 (2.9%), 20 in 2024 (1.3%), and 17 in 2025 (0.8%).

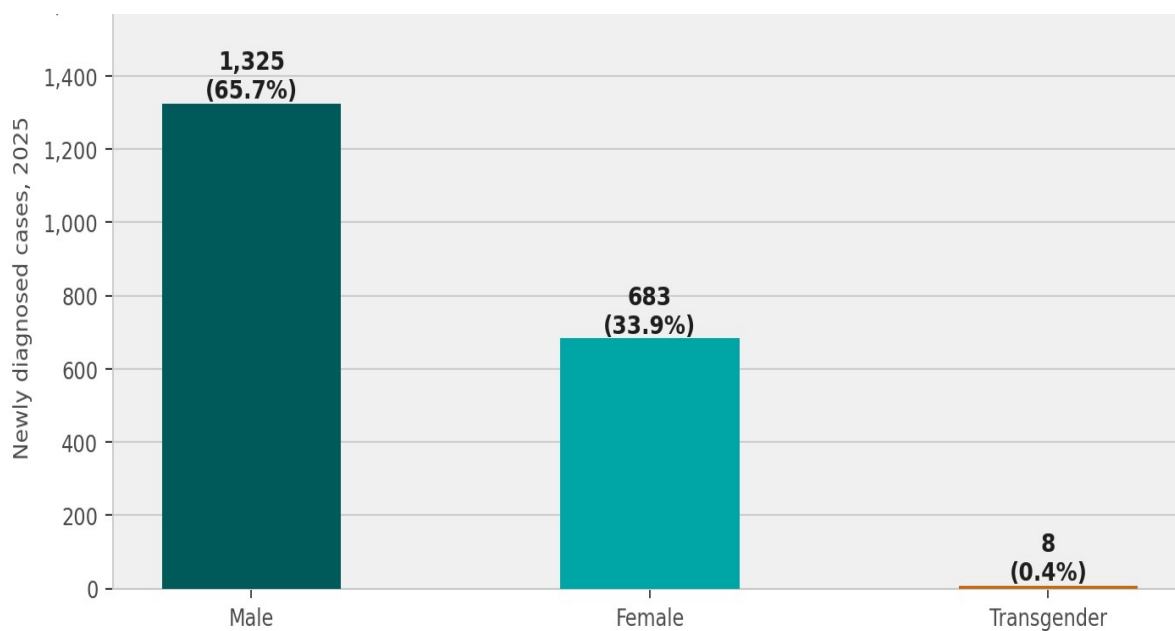
These findings highlight differences in patterns of access to HIV testing services among ethnic groups. Ongoing efforts to ensure equitable access to HIV testing, prevention, and treatment services for all communities in Fiji remain essential to the national HIV response.

Distribution of HIV Cases by gender, Fiji, 2025

Analysis of HIV diagnoses by gender from January to December 2025 indicates that most cases were reported among males. Females represented approximately one-third of newly diagnosed infections, while a very small proportion was recorded among individuals identifying as transgender.

Out of the 2,016 newly diagnosed HIV cases reported in Fiji in 2025, 1,325 cases were among males, representing 65.7% of all diagnoses. Females accounted for 683 cases,

representing 33.9%, while 8 cases (0.4%) were reported among individuals identifying as transgender (see Figure 11).



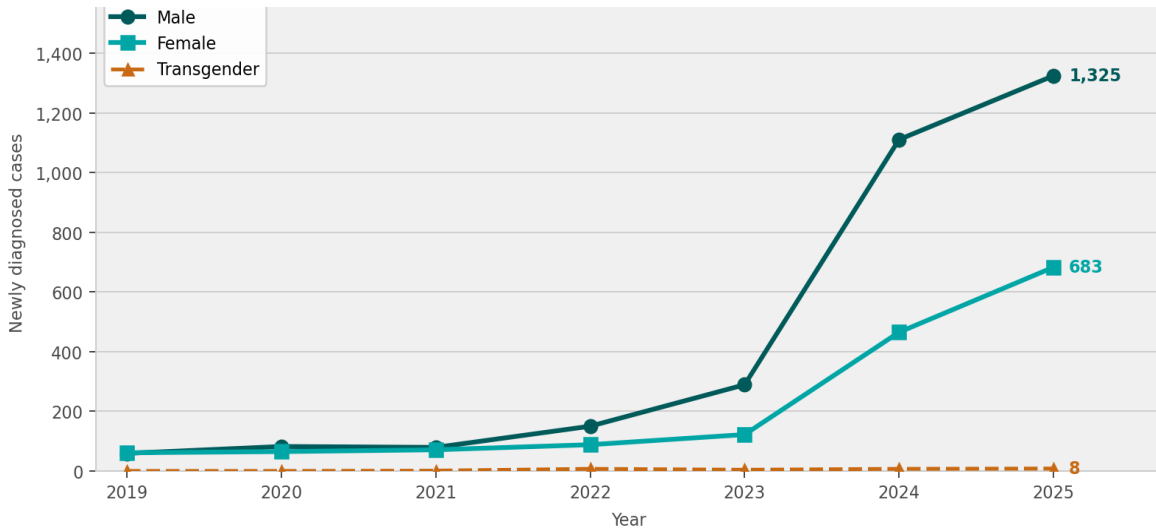
Source: National HIV Database. MOHMS Fiji. 2025

Figure 11 Distribution of newly diagnosed HIV cases by Gender, Fiji, 2025

The higher proportion of cases among males indicates that men currently represent a larger share of individuals diagnosed with HIV in Fiji. However, the substantial proportion of cases among females demonstrates that HIV transmission continues to affect both sexes and emphasises the need for gender-responsive HIV prevention, testing, and treatment services.

Trends in HIV Diagnoses by gender, Fiji, 2019–2025

An examination of trends in HIV diagnoses by gender from 2019 to 2025 reveals a steady increase in cases among both males and females. This pattern reflects the overall rise in HIV diagnoses nationally during this period (see Figure 12).

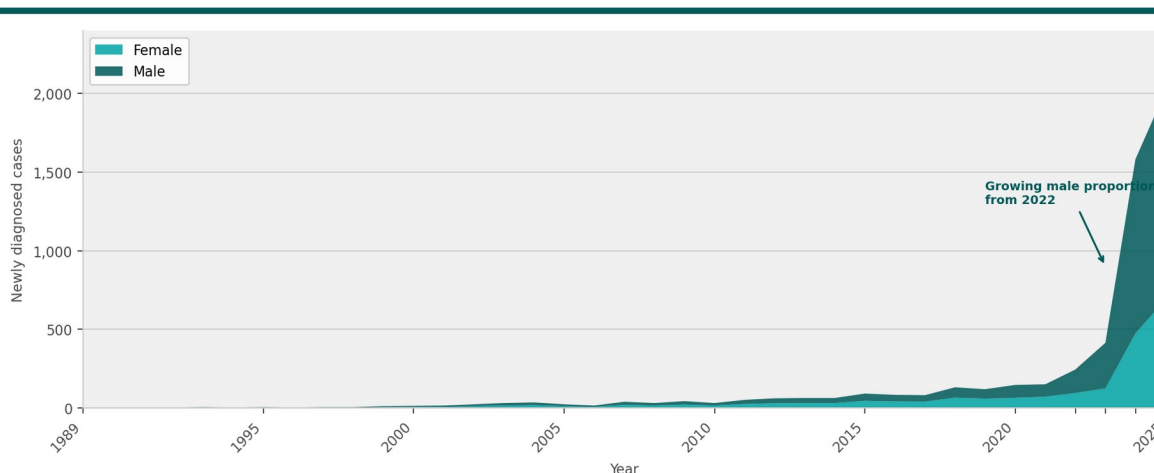


Source: National HIV Database, MOHMS Fiji, 2025

Figure 12 Trends in HIV Diagnoses by Sex, Fiji, 2019–2025

Between 2019 and 2022, the distribution of cases between males and females was relatively balanced (see Figure 13). In 2019, males accounted for 59 cases (49.2%), while females accounted for 61 cases (50.3%). A similar pattern was observed in 2021, where 79 male cases (52.3%) and 71 female cases (47.0%) were recorded.

However, beginning in 2022, a shift toward a higher proportion of diagnoses among males became more evident. In 2022, males represented 150 cases (61.2%), compared with 88 female cases (35.9%) and 7 transgender cases (2.9%).



Source: National HIV Database, MOHMS Fiji, 2025

Figure 13 Gender Distribution Trend of Newly Diagnosed HIV Cases Fiji, 1989-2025

This pattern continued in subsequent years. In 2023, males accounted for 289 cases (69.6%), compared with 122 female cases (29.4%) and 4 transgender cases (1.0%). The upward trend persisted in 2024, where 1,111 male cases (70.2%) and 465 female cases (29.4%) were recorded.

In 2025, although the proportion of male cases declined slightly compared with the previous year, males still accounted for most diagnoses with 1,325 cases (65.7%), compared with 683 female cases (33.9%) and 8 transgender cases (0.4%).

These trends demonstrate that although HIV diagnoses in Fiji occur among both males and females, the recent increase in cases has been more pronounced among males. This shift has contributed to the growing gender disparity observed in recent years, however, as noted in 2025 there appears to be a reduction in the ratio of males and females being diagnosed with HIV.

The presence of cases among transgender individuals, although small, underscores the importance of ensuring that HIV services remain inclusive, accessible, and responsive to the needs of all populations, including gender-diverse communities.

4. Mode of Transmission of HIV Cases, Fiji, 2025

A primary challenge in analyzing the mode of transmission (MOT) for HIV cases in Fiji is the incomplete behavioural risk information. Data on the likely mode of transmission are generally collected after patients are linked to care, typically during post-test counselling, clinical assessment, or follow-up consultations. Consequently, this information is often unavailable at the time of diagnosis.

In 2025, a significant proportion of individuals diagnosed with HIV had not been enrolled in care at the time of analysis. Of the 2,016 reported HIV cases, 845 individuals (41.9%) were not enrolled in care, limiting the availability of detailed behavioural information necessary to determine the likely mode of transmission. Therefore, the transmission data presented in this report primarily reflect individuals who have successfully linked to care and disclosed possible exposure risks during counselling or clinical assessment.

Cases classified as “unknown transmission route” include individuals for whom transmission information was not documented due to delayed linkage to care, incomplete case investigation, or non-disclosure of risk behaviour. Strengthening systems that facilitate early linkage to care following diagnosis will improve treatment outcomes and enhance the completeness of national HIV surveillance data.

Distribution of HIV Cases by Mode of Transmission

In 2025, the largest proportion of reported HIV cases were classified as having an unknown mode of transmission, accounting for 1,167 cases (57.9%). This outcome underscores the previously described limitations and emphasises the close association between linkage to care and the completeness of surveillance data (see Table 2).

Table 2 Summary of Mode of Transmission Data, Fiji, 2025

Mode of Transmission	Number of Cases	%
Unknown	1,167	57.9%
People who inject drugs (PWID)	362	18.0%
Sexual Transmission-Heterosexual	286	14.2%

Mode of Transmission	Number of Cases	%
Sexual Transmission – MSM	144	7.1%
Mother-to-child transmission (MTCT)	57	2.8%
Total	2,016	100.0%

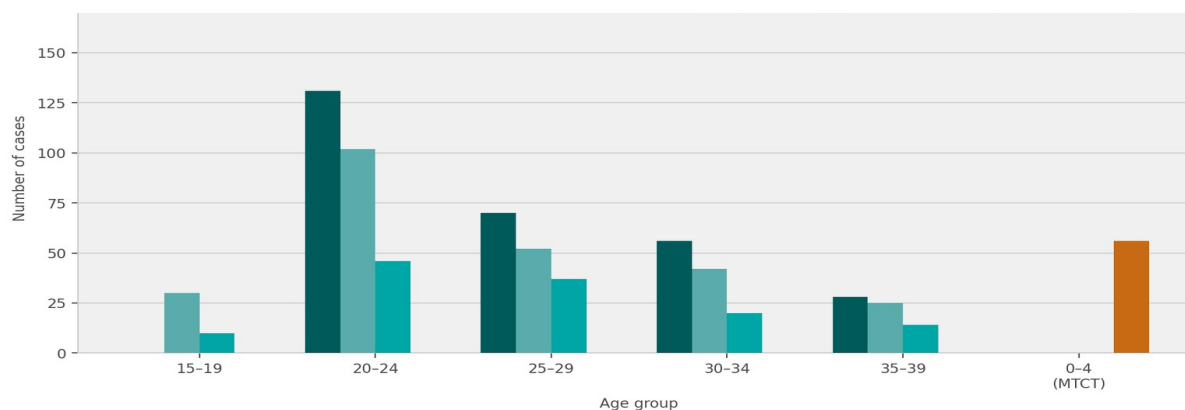
Among cases where a transmission route was identified (849), people who inject drugs (PWID) accounted for 362 cases (42.6% of cases with a known transmission route), representing the largest identified transmission category. This finding underscores the substantial role of injection-related transmission in Fiji's HIV epidemic.

Sexual transmission collectively accounted for 430 cases (50.6% of cases with a known transmission route), comprising 286 cases (33.7% of known transmission cases) attributed to heterosexual transmission, and 144 cases (17.0% of known transmission cases) attributed to male-to-male sexual transmission (MSM).

An additional 57 cases (6.7% of known transmission cases) were attributed to mother-to-child transmission (MTCT), primarily among children infected during pregnancy, delivery, or breastfeeding.

Age Distribution Across Transmission Categories

Analysis of transmission patterns by age group demonstrates that both injection drug use and sexual transmission are concentrated among young adults, specifically those aged 20 to 34 years as noted in Figure 14.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 14 Age Distribution among known mode of transmission cases, Fiji, 2025

The 20-to-24-year age group recorded the highest number of cases associated with injection drug use (131 cases), followed by the 25-to-29-year group (70 cases) and the 30-to-34-year group (56 cases). These same age groups also reported the highest numbers of sexual transmission cases, indicating that the epidemic is primarily affecting young and sexually active populations.

Sexual transmission among heterosexual individuals was most prevalent in the 20-to-24-year age group (102 cases) and the 25-to-29-year age group (52 cases). Male-to-male sexual transmission was also most frequently reported among individuals aged 20 to 24 years (46 cases) and 25 to 29 years (37 cases).

Mother-to-child transmission (MTCT) cases were predominantly observed among children aged 0 to 4 years, with 56 cases recorded. This reflects infections acquired during pregnancy, delivery, or breastfeeding.

These findings indicate that HIV transmission in Fiji is primarily occurring among young adults in their twenties and early thirties. Both sexual transmission and injection drug use contribute to new infections within these age groups.

Geographic Distribution of Transmission Categories

The distribution of HIV transmission categories (see Table 3) varied across Fiji's four divisions. However, these findings require cautious interpretation because a substantial proportion of cases are classified under an unknown mode of transmission. This

classification primarily results from incomplete behavioural information at the time of reporting, especially among individuals not yet linked to care. Consequently, the transmission patterns presented here may not fully represent the epidemiological profile of each division.

Table 3 Geographic distribution of known modes of transmission cases, Fiji, 2025

Modes of Transmission	Central	Eastern	Northern	Western	Grand Total
People who inject drugs (PWID)	270	5	2	85	362
Sexual transmission heterosexual	198	1	8	79	286
Sexual transmission-MSM	87		1	56	144
Mother-to-child transmission (MTCT)	37		4	16	57
Unknown	767	11	69	320	1167
Grand Total	1359	17	84	556	2016

The Central Division recorded the highest burden of HIV diagnoses, accounting for 1,359 cases (67.4%) of the national total of 2,016. The majority of cases within this division were classified under unknown mode of transmission (767 cases, 56.4%), highlighting significant gaps in behavioural data collection. Among cases with an identified transmission route, people who inject drugs (PWID) represented the largest category with 270 cases, followed by heterosexual transmission (198 cases), male-to-male sexual contact (MSM) (87 cases), and mother-to-child transmission (MTCT) (37 cases).

The Western Division reported 556 cases, representing 27.6% of all diagnosed cases nationally. As with the Central Division, unknown transmission accounted for the largest share (320 cases, 57.6%). Of the remaining cases with a recorded transmission route, 85 were attributed to PWID, 79 to heterosexual transmission, 56 to MSM, and 16 to MTCT.

The Northern Division recorded 84 cases (4.2% of the national total). Unknown transmission again predominated (69 cases, 82.1%). Among cases with a known route, 8 were attributed to heterosexual transmission, 4 to MTCT, 2 to PWID, and 1 to MSM.

The Eastern Division reported the fewest diagnoses nationally, with 17 cases (0.8%). Eleven cases were classified as unknown transmission. Of the remaining 6 cases, 5 were attributed to PWID and 1 to heterosexual transmission. No cases of MSM or MTCT were recorded in the Eastern Division during the reporting period.

Across all divisions, the consistently high proportion of cases classified under unknown mode of transmission reflects limitations in the completeness of behavioural data, driven primarily by gaps in linkage to care and incomplete documentation at the time of case investigation. The transmission distribution presented in this section therefore reflects only available reported information and should not be interpreted as the definitive transmission profile for each division.

Strengthening post-test counselling documentation, behavioural risk assessment, and early linkage to HIV care remains a priority to improve the completeness and accuracy of transmission data within Fiji's national HIV surveillance system.

Engagement in HIV Care by Mode of Transmission

Analysis of care status by mode of transmission (Table 4) provides additional insight into the relationship between behavioural risk factors and linkage to HIV care services. Transmission information is generally collected during post-test counselling or clinical intake after individuals have entered HIV care. Therefore, the completeness of transmission classification is closely associated with patient engagement in care.

Table 4 HIV Care Status Among cases with known mode of transmission

Mode of Transmission	Deceased	In Care Not on ART	In Care on ART	Not Enrolled in Care	Total
People who inject drugs (PWID)	3	38	316	5	362
Sexual Transmission – Heterosexual	4	21	252	9	286

Mode of Transmission	Deceased	In Care Not on ART	In Care on ART	Not Enrolled in Care	Total
Sexual Transmission – MSM	1	15	127	1	144
Unknown	49	54	249	815	1,167
Mother-to-child transmission (MTCT)	10	0	32	15	57
Total	67	128	976	845	2,016

Among the 2,016 individuals diagnosed with HIV in 2025, 976 (48.4%) were in care and receiving antiretroviral therapy (ART), while 128 (6.3%) were in care but had not yet initiated ART. Conversely, 845 (41.9%) were not enrolled in care, which significantly restricts the availability of behavioural and transmission data.

Among individuals who acquired HIV through people who inject drugs (PWID), 316 were receiving ART, constituting the majority in this category. Only five were not enrolled in care, which suggests strong engagement with HIV treatment services. Additionally, 38 were in care but had not yet initiated ART, and three deaths were recorded.

For cases attributed to heterosexual transmission, 252 individuals were receiving ART, 21 were in care but had not yet initiated ART, and nine had not enrolled in care. Four deaths were recorded in this category.

Among individuals identified with male-to-male sexual transmission (MSM), 127 were receiving ART, 15 were in care but had not yet initiated ART, and one was not enrolled in care. One death was recorded in this group.

For mother-to-child transmission (MTCT), 32 children were receiving ART, 15 were not enrolled in care, and 10 deaths were recorded. These findings highlight the continued need to strengthen prevention of mother-to-child transmission (PMTCT) and early infant diagnosis services.

The largest number of individuals not enrolled in care was observed among cases with an unknown mode of transmission, totaling 815. This group also accounted for 49 deaths and 54 individuals in care, but who had not yet initiated ART.

These findings demonstrate that the high proportion of unknown transmission categories is closely associated with individuals who have not yet been enrolled in HIV care. Enhancing rapid linkage to care following diagnosis will therefore strengthen treatment outcomes and improve the completeness and accuracy of behavioural surveillance data used to understand HIV transmission dynamics in Fiji.

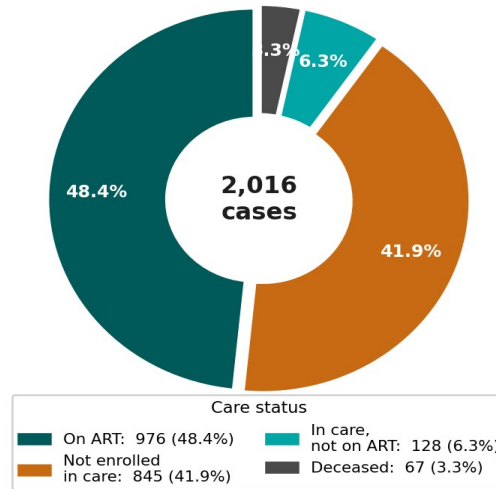
5. HIV Care Engagement and ART Status, Fiji, 2025

Assessment of engagement in HIV care and antiretroviral therapy uptake is essential for evaluating the effectiveness of the national HIV response (see Table 5). Timely enrolment into HIV care and prompt initiation of ART following diagnosis are necessary to improve patient outcomes and reduce HIV transmission.

Table 5 Percent composition of HIV care status

Status	Number of Cases	Percentage
On ART	976	48%
Not Enrolled in Care	845	42%
In care, not on ART	128	6%
Deceased	67	4%

Of the 2,016 individuals diagnosed with HIV in Fiji in 2025, nearly half were successfully enrolled in care and receiving treatment, whereas a substantial proportion had not yet been linked to care. Of the total cases, 976 (48.4%) were enrolled in care and receiving ART, 128 (6.3%) were enrolled in care but not yet initiated on ART, and 845 (41.9%) were not enrolled in care (see Figure 15).



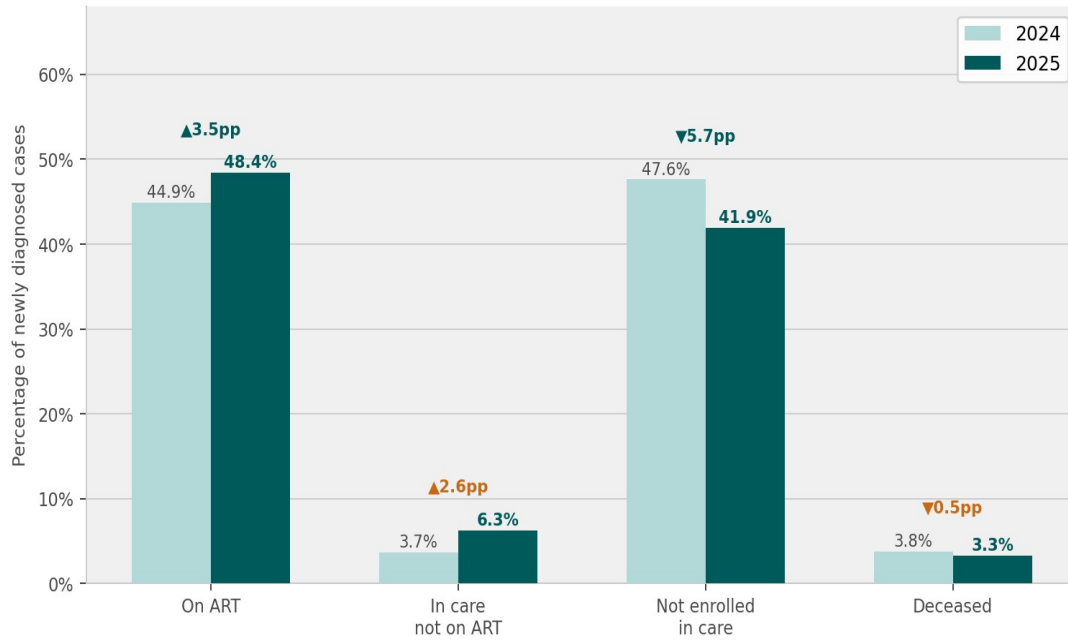
Source: National HIV Database, MOHMS Fiji, 2025

Figure 15 Care enrolment of newly diagnosed HIV cases, Fiji, 2025

Despite successful treatment initiation among many individuals, a considerable proportion of newly diagnosed cases remain outside the HIV care system. This represents a critical gap in the HIV treatment cascade.

Comparative Analysis of Care Engagement in 2024 and 2025

A comparison of care engagement between 2024 and 2025 offers insight into evolving trends in treatment uptake and linkage to care. The proportion of individuals receiving antiretroviral therapy increased from 44.9% in 2024 to 48.4% in 2025, reflecting a modest improvement in treatment initiation among diagnosed cases. Concurrently, the proportion of individuals not enrolled in care declined from 47.6% to 41.9%, indicating enhanced linkage to HIV care services (see Figure 16).



Source: National HIV Database, MOHMS Fiji, 2025

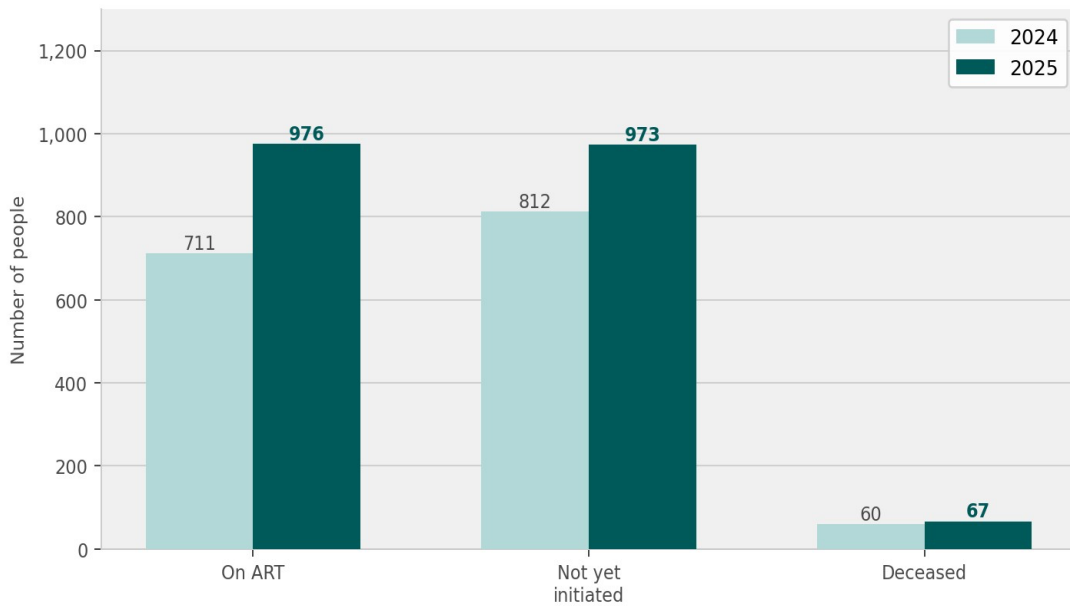
Figure 16 Comparative analysis of care enrolment status, Fiji, 2024 vs 2025

The proportion of individuals enrolled in care but not yet initiated on ART increased from 3.7% in 2024 to 6.3% in 2025. This trend suggests ongoing delays in treatment initiation for some patients.

The proportion of deaths remained stable in 2025.

Uptake of Antiretroviral Therapy Among Diagnosed HIV Cases

Comparing 2024 and 2025 shows a clear increase in the number of people receiving HIV treatment. In 2024, 711 individuals were on ART and 812 had not yet initiated ART. In 2025, these figures increased to 976 on ART and 973 not yet initiated, with 67 deaths reported, this is noted in Figure 17 below. The rise in ART numbers reflects both the growing number of diagnoses and expanded efforts to initiate treatment.

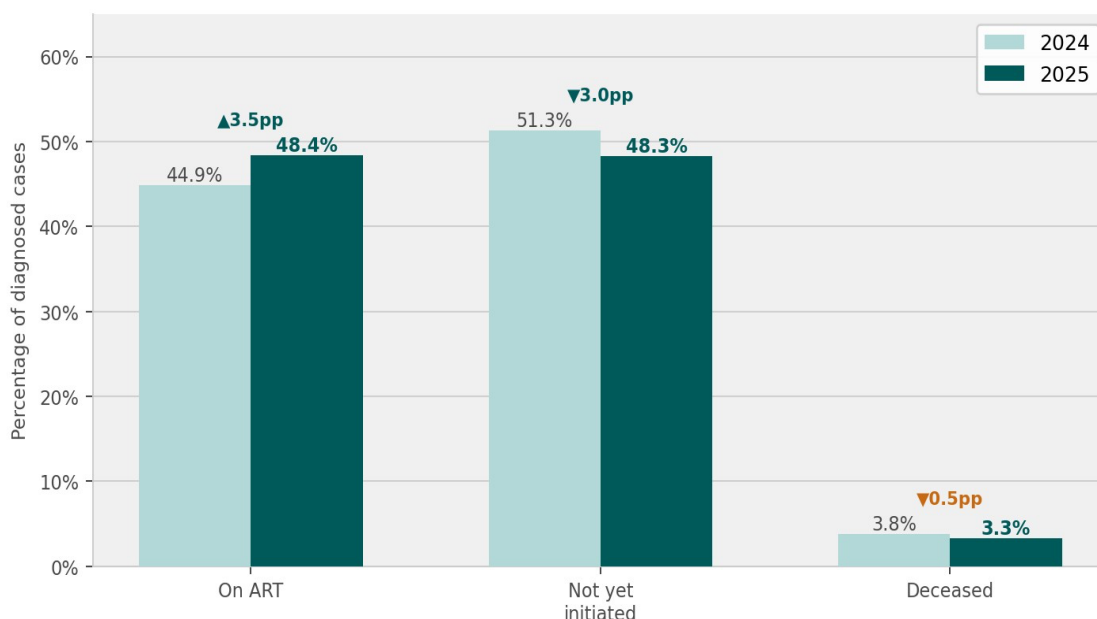


Source: National HIV Database, MOHMS Fiji, 2025

Figure 17 Absolute Number of Individuals on ART and Not Yet on ART, Fiji, 2024 vs 2025

Comparative Analysis of ART Status Percentages in 2024 and 2025

Analysis of ART uptake, as highlighted in Figure 18, shows a modest improvement in treatment coverage among people diagnosed with HIV. In 2024, 44.9% of diagnosed individuals were on ART, while 51.3% had not yet initiated treatment. By 2025, ART coverage rose to 48.4%, and the proportion not yet on ART fell to 48.3%. This indicates gradual progress in treatment initiation; however, nearly one in two people diagnosed with HIV remains untreated at the time of analysis.



Source: National HIV Database, MOHMS Fiji, 2025

Figure 18 Percent comparison of ART status 2024-2025

Care Engagement by Mode of Transmission

Care engagement varied across different modes of HIV transmission. Table 6 summarises care status by transmission category as recorded during case investigations in 2025.

Table 6 Care Status by Mode of Transmission, Fiji, 2025

Modes of Transmission	Deceased	In Care Not on ART	In Care on ART	Not enrolled in care	Total
People who inject drugs (PWID)	3	38	316	5	362
Sexual Transmission – Heterosexual	4	21	252	9	286
Sexual Transmission – MSM	1	15	127	1	144

Modes of Transmission	Deceased	In Care Not on ART	In Care on ART	Not enrolled in care	Total
Unknown	49	54	249	815	1,167
Mother-to-child transmission (MTCT)	10	0	32	15	57
Total	67	128	976	845	2,016

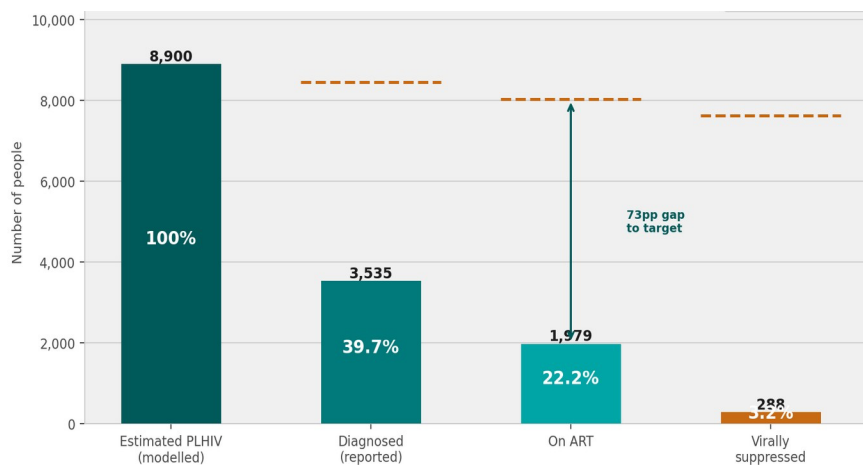
Overall, ART coverage was highest among cases linked to injection drug use, with 316 individuals receiving ART. Similarly, most cases reported as heterosexual transmission (252) and MSM transmission (127) were also on ART, indicating comparatively stronger linkage to treatment services within these groups.

In contrast, the largest gap in care enrolment was observed among cases with an unknown mode of transmission, where 815 individuals were not enrolled in care. This pattern suggests that delayed or incomplete linkage to care is contributing not only to poorer treatment coverage, but also to incomplete case investigation information, limiting the ability to accurately characterise transmission patterns and target prevention.

These findings reinforce the need to prioritise rapid linkage to care immediately after diagnosis, both to improve individual health outcomes through timely ART initiation and to strengthen the completeness and quality of Fiji's HIV surveillance data.

6. HIV Cascade of Care, Fiji, 2025

As shown in Figure 19, the HIV cascade of care describes the pathway from diagnosis to treatment initiation and, ultimately, viral suppression. Monitoring this cascade helps the national HIV programme assess whether treatment coverage is expanding and whether the response is achieving its central prevention objective, reducing onward transmission through viral suppression.



Source: National HIV Database, MOHMS Fiji, 2025; Modelled estimate 8,900 PLHIV

Figure 19 HIV cascade of care, Fiji, 2025

According to the national HIV database and treatment monitoring systems, 3,535 people living with HIV (PLHIV) had been reported in Fiji by the end of 2025. Of these, 1,979 were receiving antiretroviral therapy (ART) and 288 had documented viral suppression. This corresponds to 56% of reported PLHIV on ART and 15% with documented viral suppression.

The cascade highlights substantial gaps in the care continuum. While treatment coverage has expanded, the proportion with documented viral suppression remains low, likely reflecting incomplete or delayed viral load testing and reporting, alongside challenges with adherence and retention in care. Strengthening viral load monitoring and follow-up systems will be essential to translate treatment scale-up into sustained suppression and reduced transmission.

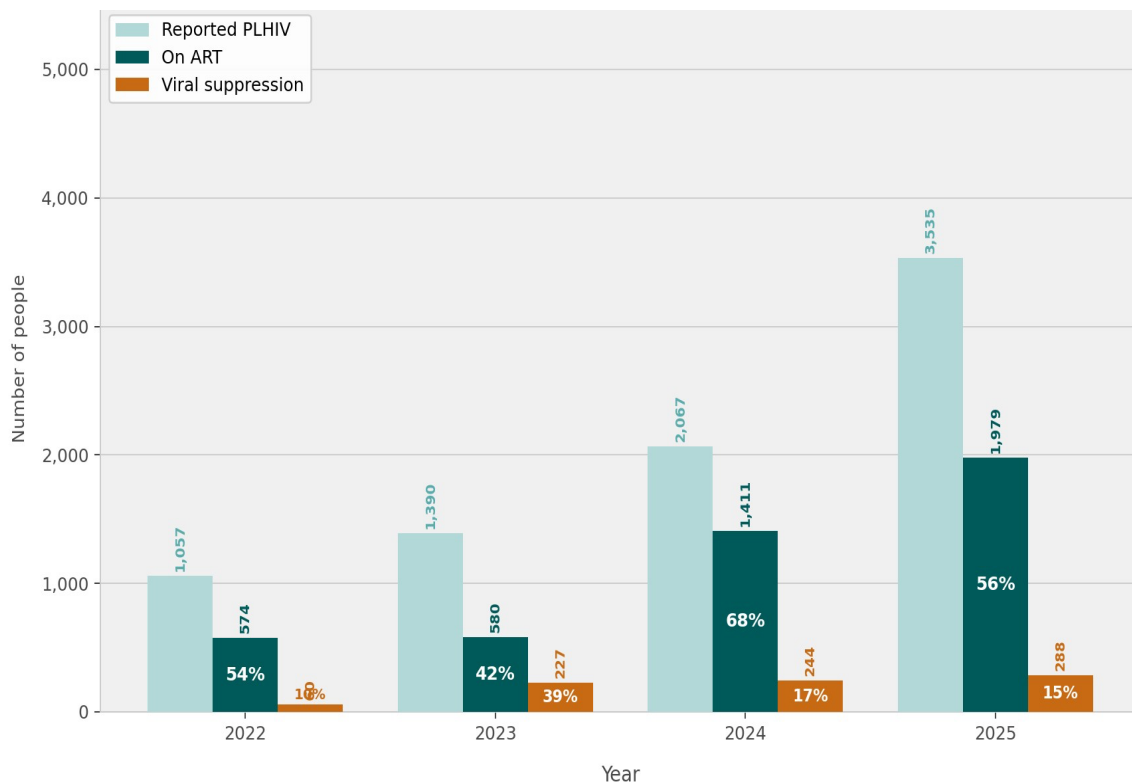
Trends in the Cascade of Care, 2022–2025

The HIV cascade of care describes the pathway from diagnosis to treatment and, ultimately, viral suppression. Tracking this cascade allows the national HIV programme to assess whether treatment coverage is expanding and whether the response is achieving its central objective, reducing illness and preventing onward transmission through viral suppression.

According to the national HIV database and treatment monitoring systems, 3,535 people living with HIV (PLHIV) had been reported in Fiji by the end of 2025. Of these, 1,979 were

receiving antiretroviral therapy (ART) and 288 had documented viral suppression. This means 56% of reported PLHIV were on ART, while only 15% had documented viral suppression (see Figure 20).

These findings point to significant gaps in the care continuum, particularly at the stage of viral load monitoring and confirmation of suppression. The low suppression figure is likely influenced by incomplete or delayed viral load testing and reporting, alongside ongoing challenges with adherence and retention in care. Strengthening viral load access, turnaround times and follow-up systems will be essential to translate treatment scale-up into population-level prevention impact.



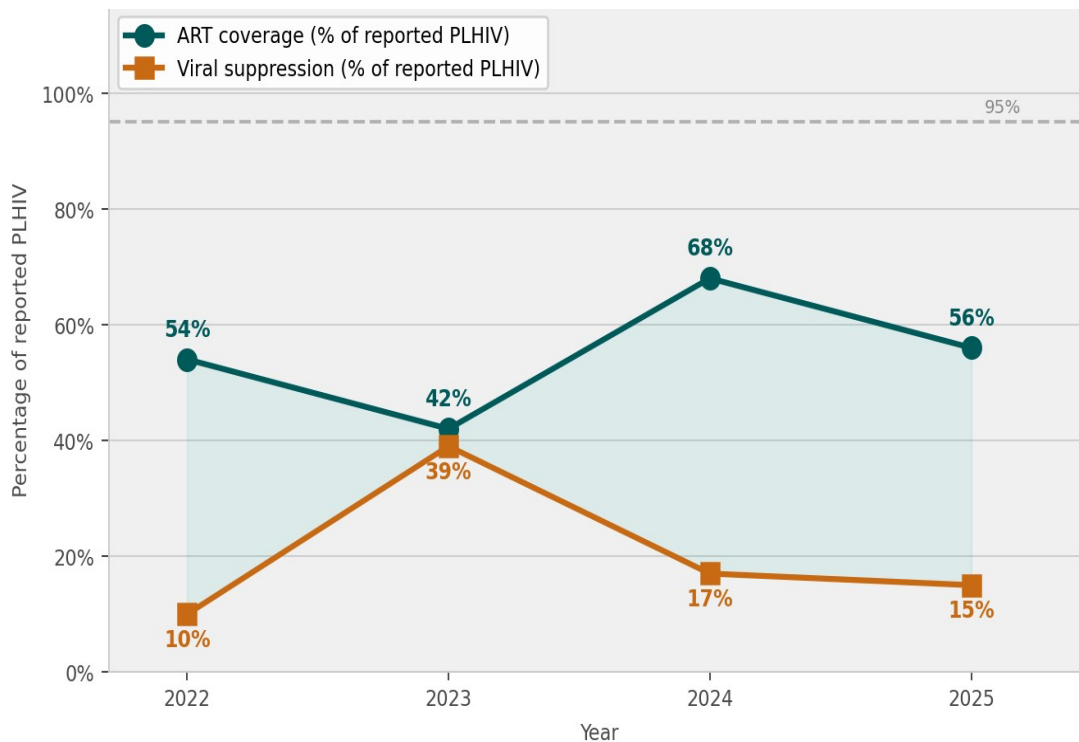
Source: National HIV Database, MOHMS Fiji, 2025

Figure 20 Cascade indicators between 2022 and 2025

ART Coverage and Viral Suppression Trends

As shown in Figure 21, the HIV cascade of care provides a clearer view of treatment performance over time. Between 2022 and 2025, ART coverage among reported PLHIV fluctuated: 54% (2022), 42% (2033), 68% (2024) and 56% (2025). Over the same period, documented viral suppression remained consistently lower: 10% (2022), 39% (2023), 17% (2024) and 15% (2025).

Overall, these trends suggest that while treatment initiation has expanded, achieving and documenting viral suppression remains a persistent challenge. The gap between ART coverage and documented suppression likely reflects a combination of incomplete or delayed viral load monitoring and reporting, alongside challenges in adherence and retention in care. Improving suppression outcomes will require stronger viral load systems (access, turnaround time and data capture), reinforced adherence support, and more effective follow-up to keep people engaged in care.



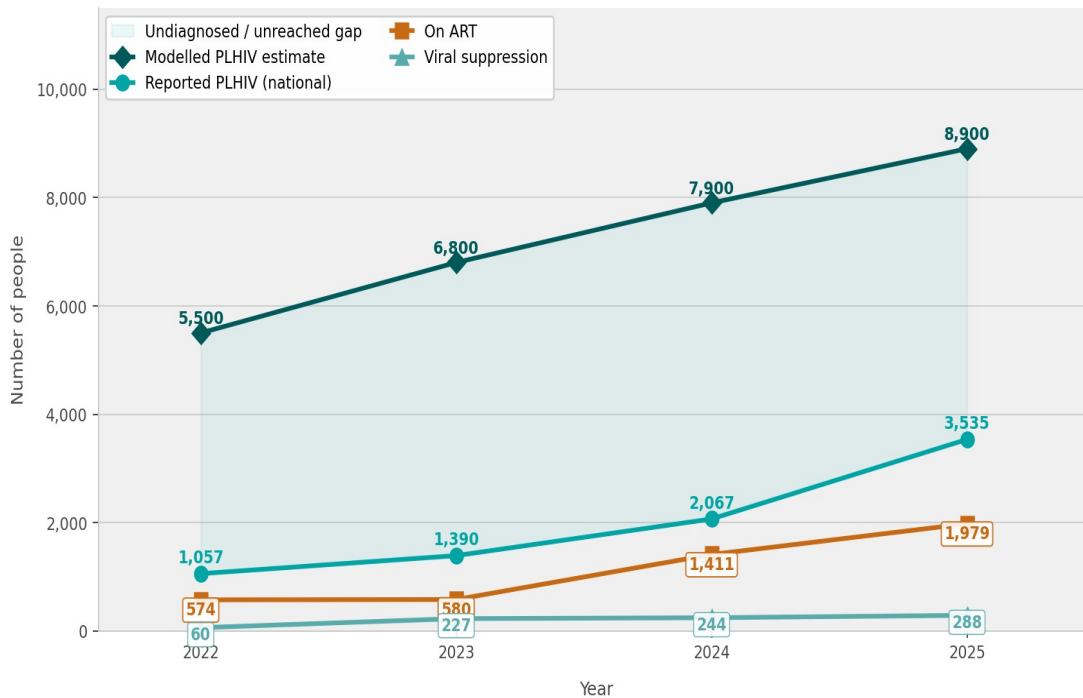
Source: National HIV Database, MOHMS Fiji, 2025

Figure 21 ART Coverage and Viral Suppression Trends, Fiji, 2022–2025

Cascade of Care in Relation to UNAIDS Estimates

As illustrated in Figure 22, comparison with UNAIDS estimates indicates a substantial gap between Fiji’s estimated HIV burden and the number of people captured in the national surveillance and treatment monitoring systems. UNAIDS estimates suggest that the number of people living with HIV in Fiji increased to approximately 5,500 (2022), 6,800 (2023), 7,900 (2024) and 8,900 (2025, modelled upper bound in the range). In contrast, national programme data record a lower number of individuals, indicating that a proportion of people living with HIV may remain undiagnosed, not yet linked to care, or not consistently captured within national monitoring systems.

This gap reinforces the need to intensify HIV testing and case-finding, strengthen referral and rapid linkage to care, and improve the completeness of national reporting systems so that the response is based on the full scale of the epidemic and can close the gap between estimated and diagnosed HIV cases.



Source: National HIV Database, MOHMS Fiji, 2025; Modelled PLHIV estimate

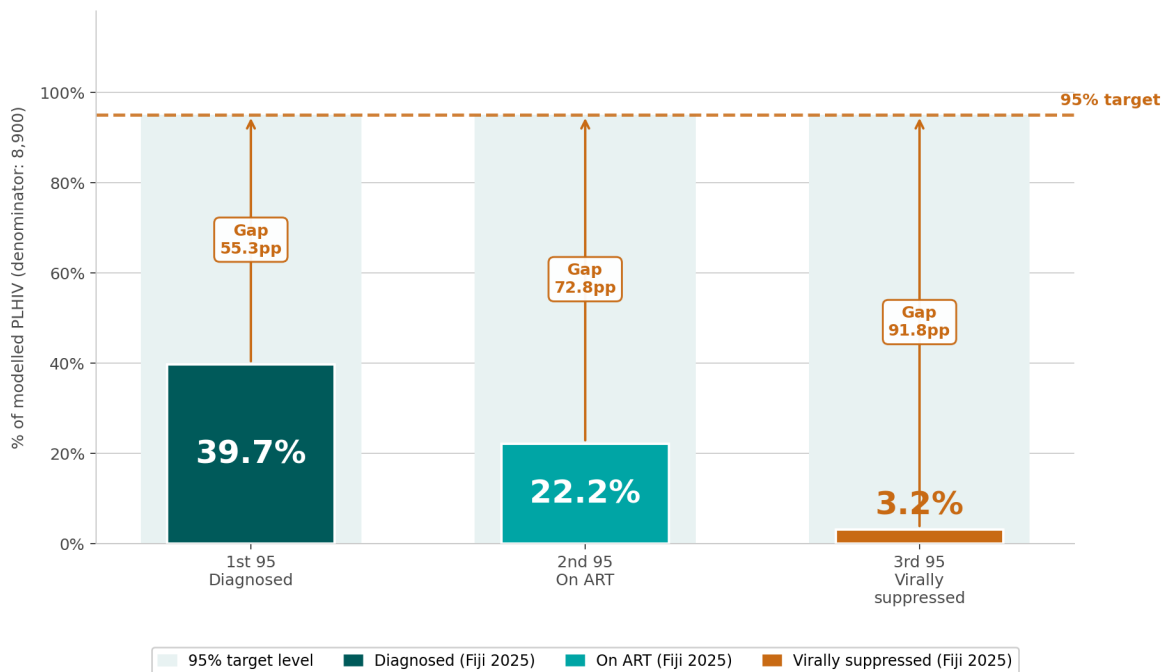
Figure 22 National Cascade Indicators Compared with Modelled PLHIV Estimates, Fiji, 2022–2025

Progress Toward Global HIV Targets

As shown in Figure 23, the global HIV response is measured against the 95–95–95 targets: 95% of people living with HIV should know their status; 95% of those diagnosed should be on treatment (ART); and 95% of those on ART should be virally suppressed.

Using Fiji’s available 2025 data and comparing national programme performance against UNAIDS estimates, Fiji is currently at approximately: 40% diagnosed, 22% on ART, and 5% with documented viral suppression (of all estimated people living with HIV). These results confirm that Fiji remains well below the 95–95–95 targets, with the largest gaps in treatment coverage and viral load monitoring/viral suppression.

Closing these gaps will require sustained investment to: expand HIV testing and case-finding, ensure rapid linkage to ART after diagnosis, strengthen adherence and retention support, and scale up viral load testing and reporting so that suppression is achieved and documented.



Source: National HIV Database, MOHMS Fiji, 2025; Modelled PLHIV estimate: 8,900

Figure 23 HIV Cascade of Care Relative to 95–95–95 Global Targets, Fiji, 2025

7. Advanced HIV Disease

CD4 cell count at the time of diagnosis remains an important indicator for assessing the stage of HIV infection and identifying individuals presenting with advanced HIV disease. Individuals with CD4 counts below 200 cells/mm³ are classified as having advanced HIV disease and are at increased risk of opportunistic infections and mortality.

Among the 2,016 individuals diagnosed with HIV in Fiji in 2025, CD4 count data were available for 333 individuals (16.5%), while 1,683 individuals (83.5%) did not have a documented CD4 result at the time of analysis.

Distribution of CD4 Counts

Table 7 presents CD4 count data for individuals with available results at the time of diagnosis. Of the 333 individuals with recorded CD4 data, 120 (36.0%) had counts below 200 cells/mm³, consistent with advanced HIV disease, while a further 93 (27.9%) had counts between 200 and 299 cells/mm³. Only 120 individuals (36.0%) presented with counts at or above 350 cells/mm³, the threshold generally associated with preserved immune function.

Within the advanced disease group, the distribution of CD4 counts indicates a significant proportion presenting at critical immunosuppression levels. As shown in **Table 7**, 25 individuals (7.5%) had counts below 50 cells/mm³, 43 (12.9%) between 50 and 99 cells/mm³, 29 (8.7%) between 100 and 149 cells/mm³, and 23 (6.9%) between 150 and 199 cells/mm³.

Taken together, these findings indicate that late diagnosis remains a significant challenge in Fiji's HIV response. Approximately two thirds of individuals with available CD4 data presented with counts below 300 cells/mm³, and more than one third had already reached advanced disease stage at the point of diagnosis. This pattern is consistent with delayed entry into testing and care services and underscores the urgent need to strengthen early testing, targeted outreach to key populations, and rapid linkage to antiretroviral therapy.

Table 7 CD4 Count Distribution and Care Status Among Diagnosed HIV Cases, Fiji 2025

CD4 Count (cells/mm ³)	Deceased	In care, not on ART	On ART	Not enrolled in care	Total
50 – 99	9	3	23	8	43
100 – 149	2	0	21	6	29
150 – 199	2	0	13	8	23
200 – 249	0	6	17	10	33
250 – 299	2	2	22	7	33
300 – 349	1	2	16	8	27
350 +	4	5	59	52	120
Not done	41	106	794	742	1683
Total	67	128	976	845	2016

Care Status Among Individuals with Advanced HIV Disease

Of the 120 individuals presenting with CD4 counts below 200 cells/mm³, 68 (56.7%) were receiving antiretroviral therapy at the time of reporting, while 7 (5.8%) were enrolled in care but had not yet initiated treatment. A substantial proportion, 26 individuals (21.7%), had not enrolled in care at all, representing a critical gap in linkage following diagnosis. Nineteen individuals (15.8%) were recorded as deceased.

The proportion of deaths among individuals presenting with advanced HIV disease is of particular concern. Combined with the high proportion not yet enrolled in care, these data suggest that a significant number of individuals are reaching health services at a point where immune function is already severely compromised, leaving limited time to initiate treatment and prevent HIV-related mortality. Strengthening early diagnosis, accelerating

linkage to care, and ensuring same-day ART initiation for individuals presenting with advanced disease are essential priorities for the national HIV response.

Interpretation and Data Quality Considerations

These findings should be interpreted with caution. A large proportion of individuals diagnosed in 2025, 83.5%, had no documented CD4 result, meaning the analysis above reflects only a subset of cases and may not be representative of the broader diagnosed population.

The absence of CD4 data is likely attributable to several programmatic factors: the national shift toward rapid ART initiation without routine baseline CD4 testing; a period in 2025 during which CD4 testing was temporarily unavailable; and limited accessibility in some settings due to the centralisation of CD4 testing in divisional laboratories.

Strengthening baseline CD4 documentation will require investment in both systems and practice. Enhancing routine CD4 testing at diagnosis for clinical staging, improving laboratory reporting and data linkage, and integrating CD4 results into national surveillance platforms are essential steps toward more complete monitoring of advanced HIV disease in Fiji.

Improved identification of advanced HIV disease will in turn support the implementation of comprehensive care packages, including screening and prophylaxis for opportunistic infections, for those presenting with severely compromised immune function.

CD4 Testing Service Interruptions

The completeness of CD4 data during the reporting period was materially affected by interruptions to testing services at two key MOHMS laboratories.

At Colonial War Memorial Hospital, CD4 testing was unavailable from March to August 2025 due to equipment failure, limiting baseline testing access for newly diagnosed patients during this period. Services resumed following the provision of a replacement analyser on loan from a service provider. At Labasa Hospital, CD4 testing services were disrupted from February 2025 and remained unavailable through the time of data analysis, meaning individuals diagnosed in the Northern Division during this period had limited or no access to baseline CD4 testing.

These interruptions are the primary driver of the high proportion of cases without documented CD4 results in the national dataset. The available CD4 data in this report should therefore be understood as a partial picture that may underestimate or incompletely reflect the true distribution of immune status at diagnosis across the diagnosed population.

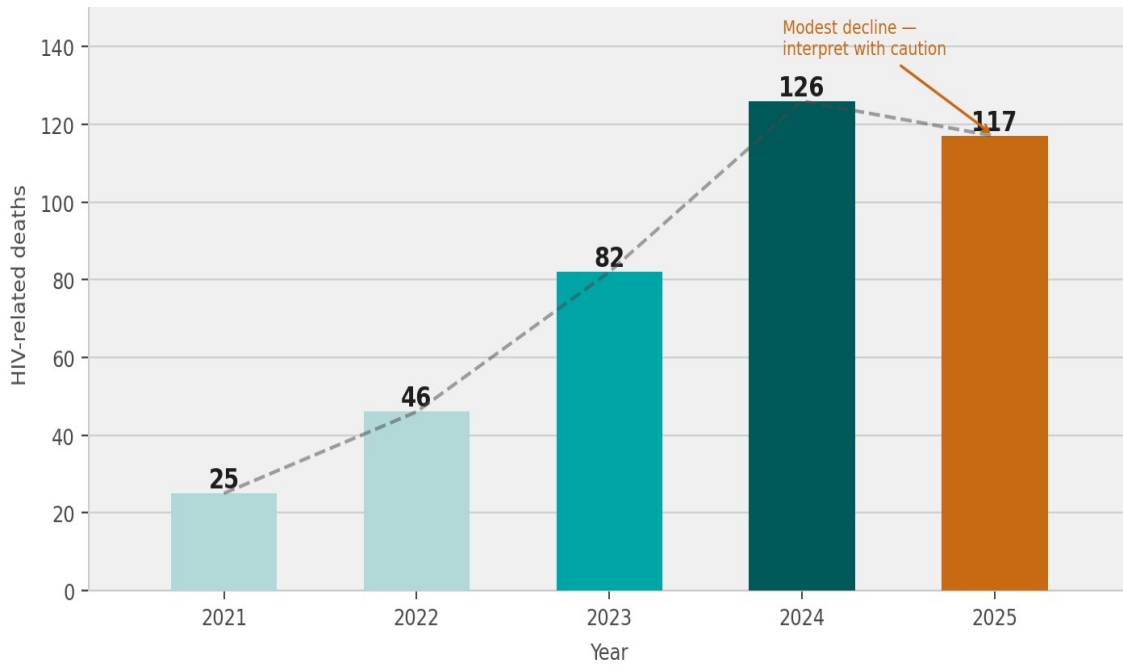
Strengthening laboratory equipment maintenance systems, establishing contingency referral pathways for CD4 testing during service disruptions, and improving the completeness of clinical staging data in national surveillance platforms are essential to prevent recurrence of these gaps in future reporting cycles.

Despite these limitations, the available data indicate that a considerable proportion of individuals continue to present with advanced HIV disease at the time of diagnosis, reinforcing the need for accelerated linkage to care and early treatment initiation as core priorities of the national HIV response.

8. HIV-Related Mortality

Monitoring HIV-related mortality is a critical component of HIV surveillance and programme evaluation. Mortality trends provide insight into the effectiveness of diagnosis, linkage to care, treatment initiation, and long-term clinical management across the national HIV response.

Between 2021 and 2025, Fiji recorded a consistent rise in reported HIV-related deaths, increasing from 25 in 2021 to 46 in 2022, 82 in 2023, and 126 in 2024 (Figure 24).



Source: National HIV Database, MOHMS Fiji, 2025

Figure 24 Annual HIV-Related Deaths, Fiji 2021–2025

In 2025, 117 HIV-related deaths were recorded, marginally lower than the 2024 peak, but remaining substantially elevated compared to earlier in the decade (Figure 25).

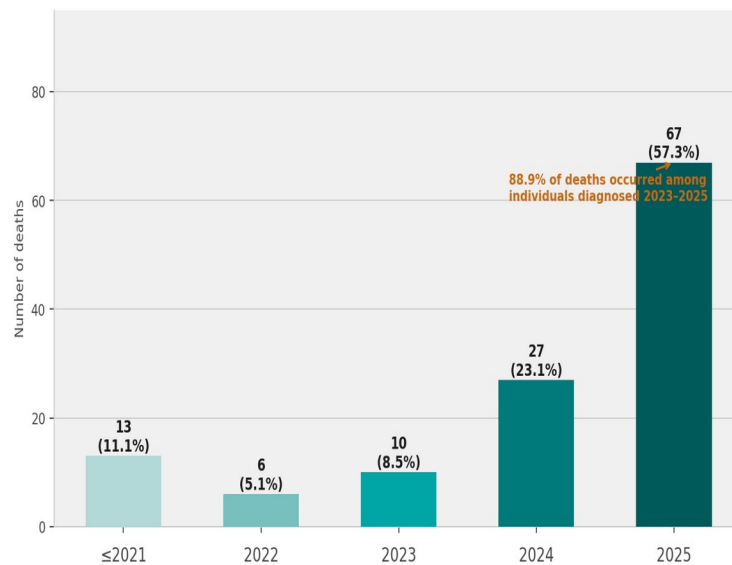


Figure 25 HIV-Related Deaths by Year of HIV Registration, Fiji, 2025

This upward trend should be interpreted in the context of Fiji's rapidly expanding HIV epidemic. The growth in reported deaths from 2022 onward broadly parallels the surge in new diagnoses observed over the same period, reflecting both a larger population living with HIV and a growing cohort requiring sustained treatment and care. The concentration of deaths in the 2022–2024 period is also consistent with patterns of late diagnosis and delayed presentation to care, whereby individuals are identified at an advanced stage of disease with limited time to achieve treatment stabilisation before adverse outcomes occur.

The modest decline observed in 2025 is noted, though caution is warranted in interpreting this as an indication of improving outcomes. Reporting delays, incomplete data capture at the time of analysis, and the continued high burden of advanced HIV disease at diagnosis suggest that the full mortality picture for 2025 may not yet be reflected in current surveillance data.

HIV-Related Mortality by Age Group and Division

Analysis of HIV-related deaths by age group demonstrates that mortality occurred across a broad age spectrum, with the majority of deaths concentrated among young adults and middle-aged individuals. As shown in Table 8, of the 117 HIV-related deaths recorded in 2025, 100 (85.5%) occurred among individuals aged 15 years and older, while 17 (14.5%) were among children under 15 years of age.

The highest numbers of deaths were observed in the 30–34-year age group (22 deaths), followed by 35–39 years (19 deaths), 25–29 years (17 deaths), 0–4 years (16 deaths), and 20–24 years (13 deaths). Taken together, individuals aged 25–39 years accounted for 58 deaths, representing the largest share of mortality and reflecting the disproportionate impact of HIV on economically active and productive age groups in Fiji.

Table 8 HIV-Related Deaths by Age Group and Division

Age Group	Central	Northern	Western	Total
0 – 4	9	1	6	16

10 – 14	0	0	1	1
15 – 19	1	0	2	3
20 – 24	11	0	2	13
25 – 29	11	2	4	17
30 – 34	13	4	5	22
35 – 39	9	2	8	19
40 – 44	7	1	2	10
45 – 49	1	0	2	3
50 – 54	3	0	4	7
55 – 59	1	0	1	2
60 – 64	2	1	1	4
Total	68	11	38	117

The 16 deaths recorded among children aged 0–4 years are of particular concern and underscore the continued need to strengthen prevention of mother-to-child transmission, expand early infant diagnosis, and improve access to paediatric HIV care services. This finding is consistent with the 56 MTCT cases recorded among the 0–4 age group in 2025, suggesting that transmission through this pathway remains insufficiently controlled.

Geographically, the Central Division recorded the highest number of deaths across most age groups, followed by the Western Division, consistent with the broader distribution of HIV diagnoses and the concentration of treatment services in these divisions. The Northern Division contributed a smaller proportion of deaths, though this should be

interpreted alongside known gaps in CD4 testing and clinical staging data for that division, as noted earlier in this report.

Geographic Distribution of HIV-Related Deaths

The geographic distribution of HIV-related deaths broadly mirrors the distribution of HIV diagnoses across Fiji's three divisions. The Central Division recorded the highest number of deaths at 68, followed by the Western Division with 38 deaths and the Northern Division with 11 deaths (Table 8).

The concentration of mortality in the Central Division is consistent with its disproportionate share of new diagnoses, 68.3% of all cases in 2025, and reflects the presence of major referral hospitals managing complex and late-presenting HIV cases. The Western Division's contribution to mortality is similarly proportionate to its diagnostic burden. The Northern Division recorded the fewest deaths in absolute terms, though this figure should be interpreted with caution given the documented interruptions to CD4 testing at Labasa Hospital from February 2025 onward, which may have limited the clinical staging and monitoring of individuals in advanced disease in that division.

Year of HIV Registration Among Individuals Who Died

Table 9 presents an analysis of the year of HIV registration among individuals who died, providing insight into the interval between diagnosis and mortality. Of the 117 reported deaths, 67 (57.3%) occurred among individuals diagnosed in 2025, 27 (23.1%) among those diagnosed in 2024, and 10 (8.5%) among those diagnosed in 2023. Individuals diagnosed between 2023 and 2025 collectively accounted for 104 deaths, representing 88.9% of total reported mortality.

Table 9 Year of HIV Registration Among Reported HIV-Related Deaths

Year of Registration	Central/Eastern	Northern	Western	Total
2015	0	0	2	2
2018	0	1	0	1

Year of Registration	Central/Eastern	Northern	Western	Total
2019	0	1	0	1
2020	1	0	0	1
2021	1	0	1	2
2022	2	3	1	6
2023	4	1	5	10
2024	16	2	9	27
2025	44	3	20	67
Total	68	11	38	117

The concentration of deaths among recently diagnosed individuals is a finding of significant programmatic concern. It suggests that a substantial proportion of those who died received their diagnosis within a short interval before death, pointing to one or more of the following: late presentation for HIV testing with advanced immune suppression already established at diagnosis; rapid disease progression due to delayed linkage to care; or insufficient time to achieve viral suppression and clinical stabilisation following treatment initiation. These findings are consistent with the CD4 data presented earlier in this report, where 36.0% of individuals with available results presented with counts below 200 cells/mm³ at diagnosis.

The geographic distribution of deaths, Central Division 68, Western Division 38, Northern Division 11, reflects the national distribution of HIV diagnoses and the concentration of referral and treatment services, as discussed in the preceding section and consistent with **Table 8**.

Taken together, the findings in **Table 9** reinforce the case for earlier HIV testing, universal same-day ART initiation, and strengthened advanced disease management protocols,

including prophylaxis for opportunistic infections, as immediate priorities for the national HIV response.

Data Sources for Mortality Information

The mortality data presented in this report were compiled through triangulation across multiple programmatic and health information system sources, including HIV Hub registers, divisional paediatric HIV registers, National TB Programme case registers, and the Patient Information System (PATIS/Tamanu). Data from these sources were cross-verified to identify and confirm reported deaths among individuals diagnosed with HIV.

This multi-source approach strengthens the completeness of mortality reporting beyond what any single register would capture, particularly for deaths occurring outside of HIV Hub settings or among paediatric cases managed through divisional services. However, it is acknowledged that not all deaths among people living with HIV may be captured across these systems, and some degree of under-reporting is likely, particularly in settings where cause of death recording and HIV status linkage remain incomplete. Continued investment in interoperability between these data systems will be essential to improving the accuracy and timeliness of HIV mortality surveillance in Fiji.

Data Limitations

Interpretation of the HIV-related mortality data presented in this report should proceed with caution given several limitations inherent in current reporting systems.

Mortality information is derived from multiple programme registers and health information systems, which vary in data recording and reporting practices across facilities. Several data fields were incomplete or inconsistently recorded, including dates of birth, National Health Numbers, patient name spelling, and linkage fields between clinical and surveillance datasets. These inconsistencies hinder accurate record matching across systems and increase the risk of both under-reporting and duplicate mortality records.

Additionally, deaths occurring outside healthcare facilities may not be captured in HIV programme registers or electronic health information systems in a timely or consistent manner, further contributing to under-ascertainment of mortality.

For these reasons, the mortality figures presented in this report should be regarded as provisional and likely subject to under-reporting. A comprehensive mortality audit and data-cleaning exercise are recommended as a priority action to improve the accuracy and completeness of HIV-related mortality data. Strengthening interoperability among surveillance databases, treatment registers, and national health information systems, including PATIS/Tamanu and HIV Hub registers, will be essential for more robust mortality monitoring in future surveillance cycles.

Notwithstanding these limitations, the observed mortality trends are consistent across multiple data sources and highlight the ongoing urgency of earlier diagnosis, improved linkage to care, and strengthened clinical management of advanced HIV disease as central priorities for Fiji's national HIV response.

9. HIV Testing and Diagnostic Yield

HIV testing in Fiji is delivered through two main diagnostic pathways: facility-based laboratory testing and point-of-care testing (POCT), provided through health facilities, community outreach services, and partner organisations. Screening tests conducted through either pathway identify potential HIV infections, with confirmatory testing subsequently performed within the national laboratory network prior to formal registration in the national HIV surveillance database. Analysing the relationship between screening volume, confirmatory testing, and registered cases is critical for interpreting trends in HIV case detection and evaluating the effectiveness of the national diagnostic system.

Expansion of Community-Based HIV Screening

Point-of-care testing services were progressively expanded across Fiji during 2024 and 2025 as part of broader efforts to improve access to HIV testing beyond traditional health facility settings. Rapid diagnostic tests are used for initial screening, with reactive samples referred to laboratories for confirmatory testing in accordance with the national HIV testing algorithm.

As shown in Table 10, POCT activity expanded substantially between 2024 and 2025. In 2024, 4,624 screening tests with valid results were conducted nationwide, yielding 284 reactive results and a reactivity rate of 6.1%. By 2025, POCT screening had increased to

18,201 tests nationally, with 788 reactive results recorded and a reactivity rate of 4.3%. This represents an increase of 13,577 tests, approximately a fourfold (294%) expansion in POCT activity over the two-year period.

Table 10 Point-of-Care Tests conducted 2024-2025

Year	Number of Tests	Number Reactive	Reactivity Rate
2024	4,624	284	6.1%
2025	18,201	788	4.3%

The decline in reactivity rate from 6.1% to 4.3% between 2024 and 2025 indicates that expanded services reached a broader population, including individuals with lower risk profiles than in earlier, more targeted testing efforts. This is a characteristic pattern of scaling up from concentrated to broader population screening and does not diminish the significance of the absolute increase in reactive results identified.

The geographic distribution of POCT activity is presented in Table 11. The Central Division accounted for the largest share of testing in both years, 2,881 tests in 2024 rising to 12,472 in 2025, reflecting the presence of SRH hubs, larger population centres, and active community testing programmes. The Western Division also contributed substantially, while the Northern and Eastern Divisions recorded lower volumes consistent with smaller populations and fewer testing sites. Testing volumes increased across all divisions between 2024 and 2025.

Table 11 Point-of-Care testing outcomes 2024 versus 2025

Division	2025 POCT Screening Tests	Reactive Results	2024 POCT Screening Tests	Reactive Results
Central	12,472	580	2,881	199
Western	3,413	167	940	72

Division	2025 POCT Screening Tests	Reactive Results	2024 POCT Screening Tests	Reactive Results
Northern	1,762	21	771	12
Eastern	554	20	32	1
National Total	18,201	788	4,624	284

Laboratory-Based HIV Testing

Laboratory testing remains the foundation of the national HIV diagnostic system, encompassing screening tests performed within hospital laboratories, referral laboratories, and specialised diagnostic services. In 2025, a total of 74,176 laboratory-based HIV screening tests were conducted nationwide (Table 12).

Table 12 Laboratory testing volume by division in 2025

Division	Laboratory Tests (2025)	Percentage
Central	37,545	50.6%
Western	25,769	34.7%
Northern	9,744	13.3%
Eastern	1,118	1.4%
National Total	74,176	100%

The Central Division accounted for more than half of all laboratory testing nationally at 37,545 tests (50.6%), reflecting the concentration of tertiary hospitals and referral laboratories within the division. The Western Division contributed 25,769 tests (34.7%),

while the Northern and Eastern Divisions recorded 9,744 (13.3%) and 1,118 (1.4%) tests respectively.

Total National HIV Testing Activity

Combining laboratory-based testing and POCT screening, a total of 92,377 HIV screening tests were conducted nationwide in 2025 (Table 13). Laboratory-based testing accounted for 74,176 tests (80.3%) and POCT for 18,201 tests (19.7%). This volume reflects significant national investment in expanding HIV testing services across both clinical and community settings.

Table 13 Total HIV testing activity in 2025

Testing Stream	Tests Conducted
Laboratory-based testing	74,176
POCT screening	18,201
Total National Testing	92,377

Confirmatory testing and case registration

Reactive screening results from both testing streams are referred for confirmatory testing within the national laboratory network. In 2025, a total of 2,717 confirmatory HIV tests were conducted nationally, resulting in 2,016 newly registered HIV cases, a national screening positivity rate of approximately 2.9%, corresponding to roughly three confirmed cases per 100 tests conducted (Table 14).

It is important to note that 701 of the 2,717 confirmatory tests (25.8%) were conducted among individuals with a previously documented HIV-positive status. This pattern suggests that a proportion of individuals already known to be living with HIV are being re-encountered in testing services and recaptured as status unknown, either to the individual or to the attending clinician. This finding points to gaps in patient identification systems

and underscores the need for stronger integration between testing platforms, treatment registers, and national surveillance databases.

As shown in Table 14, the Central Division recorded the highest testing activity and case detection, with 50,017 tests conducted and 1,359 registered cases, approximately 67% of all newly registered cases nationally, at a testing yield of 37 tests per registered case, the most efficient of any division. The Western Division recorded 29,182 tests and 556 registered cases at a yield of 52 tests per case. The Northern Division recorded 11,506 tests and 84 registered cases, with a substantially higher yield of 137 tests per case, which may reflect differences in population size, HIV prevalence, testing strategies, or referral pathway efficiency within the division. The Eastern Division reported lower overall volumes, registering 17 cases at a yield of approximately 98 tests per case.

Table 14 Distribution of confirmatory testing by division

Division	Total HIV Tests	Confirmatory Tests	% Positivity	Registered Cases	% Registered	Testing Yield (tests per case)
Central	50,017	1,752	3.5%	1,359	77.6%	37
Western	29,182	716	2.5%	556	77.7%	52
Northern	11,506	225	2.0%	84	37.3%	137
Eastern	1,672	24	1.4%	17	70.8%	98
National Total	92,377	2,717	2.9%	2,016	74.2%	46

Nationally, approximately 46 HIV screening tests were conducted for every registered HIV case in 2025, underscoring both the scale of investment required to sustain early case detection and the importance of maintaining broad testing coverage alongside more targeted strategies for populations at higher risk.

10. Discussion

This report provides a comprehensive analysis of HIV diagnoses, testing activity, and engagement in care in Fiji for the period January to December 2025. The findings highlight important epidemiological shifts in the national HIV landscape and identify critical areas requiring strengthened public health action.

The most significant finding is the continued acceleration of HIV diagnoses, with 2,016 newly registered cases in 2025, the highest annual number since national surveillance began (**Figure 1**). This increase reflects expanded HIV testing services, improved surveillance systems, and the identification of previously undiagnosed infections. The growth of both facility-based laboratory testing and community-based POCT programmes has substantially increased access to HIV screening nationwide, as documented in **Tables 10 through 14**.

The scale of testing activity in 2025, more than 92,000 screening tests across laboratory and point-of-care platforms (**Table 13**), demonstrates the national programme's commitment to broad population screening. However, the analysis of testing yield indicates that substantial effort is required to identify each new case, with approximately 46 tests conducted nationally per registered diagnosis (**Table 14**). This reflects both the broad screening approach adopted and the ongoing challenge of reaching undiagnosed individuals within a growing epidemic.

Confirmatory testing data highlight an important complexity in interpreting diagnostic activity. Of the 2,717 confirmatory tests conducted, 701 (25.8%) involved individuals with a previously documented HIV-positive status, suggesting that repeat testing and patient re-identification represent a meaningful proportion of current diagnostic workload. Strengthening patient identification and data linkage across testing and treatment systems will be essential to improving the efficiency of the diagnostic pathway.

CD4 data, while limited by the service interruptions described in the advanced HIV disease section, indicate that late diagnosis remains a significant concern. Among individuals with available CD4 results, 36.0% presented with counts below 200 cells/mm³, consistent with advanced HIV disease at diagnosis (**Table 7**). Mortality data reinforce this

pattern: 88.9% of deaths in 2025 occurred among individuals diagnosed between 2023 and 2025 (**Table 9**), suggesting that a substantial proportion of those who died had limited time between diagnosis and death to achieve clinical stabilisation on treatment. These findings collectively point to persistent gaps in early testing uptake and timely linkage to care.

Analysis of the HIV care cascade reveals further gaps downstream of diagnosis. Of 2,016 newly diagnosed individuals, 845 (41.9%) were not enrolled in care at the time of reporting (**Table 5**), representing the largest single gap in the continuum. Among individuals with advanced HIV disease, those presenting with CD4 counts below 200 cells/mm³, 21.7% remained unenrolled in care and 15.8% were recorded as deceased (**Table 7**), underscoring the clinical urgency of accelerated linkage and same-day ART initiation for this group.

Strengthening surveillance integration across testing, laboratory confirmation, treatment databases, and clinical systems will enhance the programme's ability to monitor the epidemic and respond effectively. Improved data linkage between POCT programmes, laboratory systems, and national surveillance platforms will also support more accurate tracking of diagnoses and patient outcomes across the care continuum.

11. Conclusion and Programmatic Implications

The findings of this report document a significant and sustained shift in the HIV epidemiological landscape in Fiji. The 2,016 newly registered cases in 2025 represent the highest annual number recorded since national surveillance began (**Figure 1**), and the data indicate that HIV transmission remains an active and growing public health concern requiring a sustained, coordinated, and adequately resourced national response.

The expansion of HIV testing services, documented across **Tables 10 through 14**, has substantially increased access to screening nationwide and represents a major programmatic achievement. However, the analysis consistently points to a critical imbalance between the scale of testing and the strength of the systems that follow diagnosis. Evidence of late presentation (**Table 7**), gaps in linkage to care (**Table 5**),

concentrated mortality among recently diagnosed individuals (**Table 9**), and a high proportion of deaths among individuals with advanced disease collectively indicate that diagnosis alone is insufficient without robust systems to ensure rapid treatment initiation and sustained engagement in care.

Addressing these gaps requires a strengthened approach across the full HIV care continuum. Expanding early testing, particularly among populations with limited engagement in routine health services and in the Northern and Eastern Divisions where testing yield and linkage rates lag behind national averages (**Table 14**), remains a key priority. Systems must ensure that individuals who test positive are rapidly linked to treatment, initiated on antiretroviral therapy without delay, and supported to remain engaged in long-term care.

Improving integration between POCT programmes, laboratory confirmation systems, treatment registers, and national surveillance platforms is a prerequisite for effective monitoring and patient management. Addressing the 25.8% of confirmatory tests conducted on previously diagnosed individuals (**Table 14**) requires investment in patient identification systems and cross-platform data linkage. Resolving the gaps in CD4 documentation, driven in large part by equipment failures at CWM Hospital and Labasa Hospital in 2025, will also be essential to ensuring complete clinical staging data in future surveillance cycles.

Programmatic priorities should include strengthening the HIV care cascade through improved case management, enhanced patient follow-up, and expanded support services; ensuring universal access to advanced HIV disease management, including prophylaxis for opportunistic infections; and completing a comprehensive mortality audit to improve the accuracy and completeness of mortality data, as recommended in the mortality data limitations section.

The findings provide a clear evidence base for national HIV policy and programme planning. Continued investment in testing expansion, treatment access, surveillance strengthening, and community engagement, sustained through collaboration between MOHMS, development partners including DFAT, UNAIDS, WHO, and the Global Fund,

and community organisations, will be essential to bringing Fiji's HIV epidemic under control and improving outcomes for all people living with HIV.