Research Article **ISSN: 2581-8015**

International Journal of Nursing and Healthcare Research

Journal home page: www.ijnhr.com

https://doi.org/10.36673/IJNHR.2026.v10.i01.A04

HIV/AIDS IN FIJI: EPIDEMIOLOGY, RISK DETERMINANTS, PUBLIC HEALTH RESPONSES AND THE PATH TOWARD ELIMINATION IN A PACIFIC SMALL ISLAND DEVELOPING STATE

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ABSTRACT

Fiji, a small island developing state (SIDS) in the South Pacific, is generally known for its low HIV/AIDS prevalence. Nonetheless, recent increases in case notifications, localized outbreaks among key populations, significant barriers to testing and treatment and limited surveillance capacity raise concerns about the potential for epidemic growth. This research provides an in-depth overview of Fiji's HIV situation, examining epidemiological trends, biological and behavioral risks, socio-cultural and structural factors that affect vulnerability, the state of public health and clinical infrastructure and the policies guiding the national response. Using data from UNAIDS, WHO, the Fiji Ministry of Health and Medical Services (MHMS), the Pacific Community (SPC) and recent research, it highlights over 1,100 confirmed HIV cases since 1989, with a notable increase in diagnoses since 2012. Key populations-including men who have sex with men (MSM), transgender women (*vakasalewalewa*), sex workers and people who inject drugs-bear a disproportionate share of the burden. Challenges such as stigma, discrimination, criminalization of same-sex conduct, limited access to antiretroviral therapy (ART), inadequate laboratory infrastructure and a shortage of healthcare workers hinder effective responses. The report reviews the HIV and AIDS Decree 2011, the National Strategic Plan for HIV and STIs and international collaborations, offering evidence-based recommendations to enhance prevention, testing, treatment and care that respect human rights and cultural sensitivities. Overall, the findings underscore the need for sustained investment, strong political will and community engagement to prevent Fiji's relatively low-level epidemic from becoming a major public health crisis.

KEYWORDS

HIV/AIDS, Fiji, Stigma, Public health and Small Island Developing States.

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INTRODUCTION

HIV and AIDS continue to be major public health challenges worldwide. Since their identification in the early 1980s, approximately 85.6 million people globally have contracted HIV, leading to about 40.4 million deaths (UNAIDS, 2023a)[1]. While significant advances have been achieved in prevention, testing,

treatment and care-turning HIV from a fatal disease into a manageable chronic condition for many-inequities persist. Low and middle-income countries, especially marginalized and key communities within them, bear a disproportionate burden (WHO, 2023)[2]. In the Pacific Islands, HIV has historically received less focus than in regions like sub-Saharan Africa and Southeast Asia, which report higher infection rates. Factors such as small populations, geographic isolation and low numbers of people living with HIV (PLHIV) in most Pacific Island Countries and Territories (PICTs) contribute to the perception that the region is a lower priority in the global HIV response (SPC, 2022)[3]. Yet, this view overlooks significant vulnerabilities and emerging trends. Papua New Guinea, the largest country in the region, experiences a generalized epidemic with an estimated adult HIV prevalence of 0.9% (UNAIDS, 2023b)[4].

Several other PICTs, including Fiji, are witnessing rising case notifications and concentrated epidemics among key populations. Without sustained investment and vigilance, the situation could worsen (Buchanan-Aruwafu *et al*, 2017[5], SPC, 2022[3]). Fiji, an archipelago of over 330 islands with around 926,000 residents, holds a notable place in the region's HIV profile. As the second-most populous Pacific nation after Papua New Guinea, Fiji is a popular tourist destination and a central hub for regional transport and commerce, with high levels of population mobility. These factors can aid in HIV transmission (UNAIDS, 2022)[6]. The country reported its first HIV case in 1989 and by December 2022, approximately 1,126 cases had been confirmed (Ministry of Health and Medical Services [MHMS], 2023)[7]. Although Fiji's adult HIV prevalence of roughly 0.13% remains low on a global scale, the increase in new diagnoses since 2012 has raised alarms among public health officials and advocates (MHMS, 2023, UNAIDS, 2022)[6,7].

This paper offers a thorough, evidence-based overview of Fiji's HIV situation across various areas. It explores: (1) the epidemiological profile, including trends in incidence, prevalence, and mortality; (2) biological, behavioral and structural factors influencing HIV risk and vulnerability; (3) the experiences of key populations and vulnerable groups such as MSM, transgender women, sex workers, youth and mobile populations; (4) the health system's efforts, including testing, treatment, care and laboratory infrastructure; (5) socio-cultural influences like stigma, discrimination, gender roles and the roles of religion and culture; and (6) the policy, legal, and programmatic frameworks guiding Fiji's national HIV response. By combining data from government, international organizations and academic research, this analysis seeks to identify gaps and opportunities. This study underscores the importance of understanding HIV in low-prevalence areas like Fiji, which face unique challenges and opportunities. Although the smaller number of people living with HIV and the concentrated nature of the epidemic suggest that elimination is possible with enough investment and political commitment, HIV often remains a low priority. This can lead to complacency, insufficient funding, and neglect of the most vulnerable groups. Such oversight risks allowing the epidemic to grow unchecked, making future control more difficult and costly (Godwin, 2012[8], McMillan and Worth, 2019[9]).

LITERATURE REVIEW

HIV in the Pacific Islands: Regional Context

The Pacific Islands region includes 22 countries and territories that cover about one-third of Earth's surface. The HIV situation varies widely: Papua New Guinea faces a generalized epidemic, while countries like the Cook Islands, Niue and Tokelau report few or no cases (SPC, 2022)[3]. Nations such as Fiji, New Caledonia, French Polynesia, Guam and Samoa experience low-level or concentrated epidemics mostly driven by sexual transmission among key populations (UNAIDS, 2022)[6]. The Pacific Community (SPC), through its Public Health Division, acts as the main regional authority for HIV and STI surveillance, prevention and response. The Pacific Sexual Health and Well-being Shared Agenda 2015-2019 and its successor offer strategic guidance, emphasizing rights-based approaches, community involvement, and integration of HIV efforts into broader sexual and reproductive health (SRH) initiatives (SPC, 2014)[10]. The Global Fund to

Fight AIDS, Tuberculosis and Malaria has been a key financial supporter of HIV programs in the Pacific, providing funds through multi-country grants managed by the United Nations Development Program (UNDP) and carried out in partnership with national governments and civil society groups (Global Fund, 2022)[11]. Despite these efforts and funding channels, the Pacific Islands face unique challenges in implementing effective HIV responses. These include small, scattered populations over large oceanic areas, which hinder service delivery and surveillance; limited healthcare and laboratory capacity; significant stigma and discrimination against HIV and marginalized groups; criminalization of same-sex behavior and sex work in some areas; cultural and religious conservatism that makes open discussions about sexuality and health difficult; and other urgent health issues, especially non-communicable diseases (NCDs), which cause roughly 75-80% of all regional deaths (WHO, 2021a[12], McMillan and Worth, 2019[9]).

HIV Epidemiology in Fiji: Historical Overview

Fiji reported its first HIV case in 1989. During the first decade, the number of new cases was low, averaging fewer than ten annually (MHMS, 2023)[7]. Most early infections were caused by heterosexual contact, with some linked to travel or migration (Buchanan-Aruwafu *et al*, 2017)[5]. In the 1990s and early 2000s, HIV was a minor concern in Fiji's public health scene, receiving limited attention, funding, or targeted programs from policymakers. A significant shift happened in the mid-2000s when expanded testing, particularly through increased voluntary counseling and testing (VCT) services and rapid diagnostic tests, resulted in a sharp increase in reported cases (MHMS, 2015)[13]. This rise likely reflected both improved detection and a genuine increase in HIV transmission, although the precise contribution of each factor remains unclear due to limited surveillance data (SPC, 2022)[3]. The upward trend persisted through the 2010s and into the 2020s, with annual diagnoses escalating from around 30-40 cases in the early 2010s to over 80 cases by 2022 (MHMS, 2023)[7].

Key Populations and Concentrated Epidemics

Research conducted globally and specifically in the Pacific consistently highlights certain groups as being at higher risk of HIV infection, stemming from a mix of biological, behavioral, and structural factors. These so-called "key populations," as defined by UNAIDS and WHO, include men who have sex with men (MSM), transgender individuals, sex workers, people who inject drugs (PWID) and inmates in prisons and closed facilities (UNAIDS, 2023a)[1]. In Fiji, studies using Integrated Bio-Behavioral Surveys (IBBS) and other methods have revealed significantly higher HIV rates among these key groups compared to the general population. For instance, a 2017 IBBS conducted in Suva and Lautoka among MSM and transgender women found HIV prevalence rates of about 5.3% for MSM and 11.8% for transgender women, while the overall prevalence in the general population was around 0.13% (MHMS and SPC, 2019)[14]. These numbers underscore that Fiji has some of the highest HIV prevalence levels among MSM and transgender individuals in the Pacific, highlighting the concentrated nature of the epidemic and the urgent need for focused interventions.

Sex workers in Fiji face an increased risk of HIV, although detailed prevalence data are limited. A situational analysis by the Fiji Network for People Living with HIV/AIDS (FJN+) and international partners identified high rates of inconsistent condom use, limited access to healthcare and significant experiences of violence and exploitation among sex workers (FJN+, 2018)[15]. The criminalization of sex work under the Crimes Act 2009 makes things worse by pushing the industry underground and discouraging sex workers from seeking health services (Godwin, 2012)[8].

Sexually Transmitted Infections as Co-factors

The link between sexually transmitted infections (STIs) and HIV is well known through medical research. STIs that cause genital ulcers, such as syphilis and herpes simplex virus type 2, significantly raise the chances of both contracting and spreading HIV (Cohen *et al*, 2012)[16]. In Fiji, high STI rates have long been a public health issue, with ongoing high levels of chlamydia, gonorrhea,

and syphilis, especially among young people and vulnerable groups (MHMS, 2021)[17]. Screening for syphilis during pregnancy shows that about 2.5–3.5% of pregnant women have non-reactive results, which indicates ongoing spread within the community (SPC, 2022)[3]. These elevated STI rates create a biological environment that makes HIV transmission more likely and underscores the need for comprehensive prevention and treatment strategies for both HIV and STIs.

Stigma, Discrimination, and Criminalization

HIV-related stigma and discrimination based on sexual orientation and gender identity are pervasive throughout Fiji, posing significant obstacles to prevention, testing, treatment, and care. Studies by the Fiji Human Rights and Anti-Discrimination Commission (FHRADC) and civil society organizations reveal common experiences among people living with HIV (PLHIV), including family rejection, job loss, denial of healthcare, and social exclusion (FHRADC, 2018)[18]. A 2016 survey, the People Living with HIV Stigma Index in Fiji, showed that about 40% of PLHIV encountered at least one form of discrimination in the previous year, with healthcare-related discrimination being especially troubling (FJN+, 2017)[19].

Theoretical Frameworks

This paper uses several theoretical frameworks to understand the HIV situation in Fiji. The social-ecological model (Bronfenbrenner, 1979[20], McLeroy *et al*, 1988[21]) offers a layered view of how personal behaviors, relationships, community influence, institutional practices, and policies contribute to HIV risk and vulnerability. Additionally, syndemic theory, described by Singer and Clair (2003)[22], highlights how multiple co-existing epidemics-such as HIV, STIs, substance abuse, mental health issues and gender-based violence-interact and reinforce each other, worsening the overall disease impact. The human rights-based health approach, supported by international law and organizations such as UNAIDS and the Global Commission on HIV and the Law (2012)[23], emphasizes the importance of rights, dignity, and non-discrimination in effective HIV responses.

METHODOLOGY

Study Design

This study combines a thorough secondary data analysis with a systematic narrative review to explore the HIV situation in Fiji. It integrates quantitative epidemiological data from government surveillance, international sources and surveys with qualitative insights from research articles, policy papers, program reviews, and civil society reports. This approach effectively addresses the research aims, as HIV data in Pacific Island contexts are often fragmented and require triangulation across multiple sources (Creswell and Clark, 2017)[24].

Data Sources

The following primary data sources were used:

UNAIDS AIDS info Database (2010-2023): Providing national-level estimates of HIV prevalence, incidence, ART coverage and other key indicators.

Fiji Ministry of Health and Medical Services HIV/STI Case Surveillance Data (1989-2023): Providing case notification data, demographic profiles of diagnosed cases and programmatic data on testing and treatment.

Integrated Bio-Behavioral Survey (IBBS) among MSM and Transgender Women in Fiji (2017): Providing prevalence and behavioral data for key populations.

WHO Global Health Observatory Data: Providing health system indicators and comparative data.

SPC HIV/STI Surveillance Reports: Providing regional context and comparative data.

Global Fund Program Reports for the Pacific Multi-Country Grant: Providing programmatic data on HIV service delivery.

Peer-reviewed literature was identified through systematic searches of PubMed, Scopus, Web of Science, and Google Scholar.

Grey literature from NGO reports, policy documents, and media reports**.**

Ethical Considerations

Since this study uses only secondary and publicly available data, it did not require formal ethical approval. Nevertheless, the authors followed ethical standards for responsible data handling, including verifying data accuracy and preventing the

identification of individuals or communities in ways that could cause harm.

RESULTS AND FINDINGS

Epidemiological Trends

Cumulative Cases and Annual Notifications

Since 1989, Fiji has recorded approximately 1,126 confirmed HIV cases up to December 2022 (MHMS, 2023)[7]. Around 410 people are believed to have passed away, leaving an estimated 716 individuals living with diagnosed HIV. When including undiagnosed cases, UNAIDS estimates that the total number of people living with HIV in Fiji ranges from about 1,300 to 1,500, showing that many infections still go unnoticed.

The trend in annual new HIV diagnoses is shown in Figure No.1 and Figure No.2 below.

The data reveal several important patterns. First, there is a steady and significant rise in the number of new diagnoses each year, which increased approximately fourfold from 18 in 2005 to 82 in 2022. This upward trend notably accelerated after 2012, likely due to expanded HIV testing and possibly a true increase in transmission. In 2020, new diagnoses suddenly declined to 58 from 79 in 2019, probably because of COVID-19 pandemic-related disruptions in testing and healthcare access, which redirected resources, limited movement and discouraged people from seeking care (MHMS, 2021[17], UNAIDS, 2021[25]). The increase resumed in 2021 and 2022, reflecting renewed demand for testing and ongoing transmission.

Demographic Profile of HIV Cases

Analysis of the demographic profile of HIV cases in Fiji reveals important patterns by sex, age, ethnicity and geographic location.

Several insights can be drawn from Table No.2. About 60% of the cases are among men, which matches the known trend of the epidemic being concentrated among MSM and the fact that men tend to engage in riskier sexual behaviors. The higher number of cases in the 25-34 (35.3%) and 15–24 (19.0%) age groups shows how young adults are significantly affected, highlighting the importance of targeted prevention efforts for youth and young adults. The fact that the iTaukei community represents 65.3% of cases, while accounting for about 57% of the population, might suggest differences in testing access, sexual behaviors, or exposure to risk factors, though more research is needed to understand these patterns. The distribution of cases in the Central/Eastern and Western Divisions corresponds with Fiji's main cities-Suva and Lautoka/Nadi-where higher population density, movement, tourism and testing services are common. The data on transmission modes reveals that the majority, at 62.0%, is through heterosexual contact, with MSM or bisexual contact making up 20.8%. However, these figures should be interpreted with caution. The 'unknown/other' category, which accounts for 13.5%, may include cases where the transmission route-particularly MSM contact-was not disclosed due to stigma (Bavinton *et al*, 2019)[26]. Mother-to-child transmission (MTCT) accounts for 3.7% of cases, highlighting both longstanding challenges in preventing vertical transmission and the progress made through the increased use of prevention of mother-to-child transmission (PMTCT) services in recent years (MHMS, 2023)[7].

HIV Prevalence Among Key Populations

The 2017 IBBS among MSM and transgender women in Suva and Lautoka offers the most comprehensive data on HIV prevalence among key populations in Fiji. Key findings are summarized in Table No.3.

The IBBS results reveal several important issues. HIV prevalence among men who have sex with men (MSM) is at 5.3%, which is about 40 times higher than the estimated rate in the general population (0.13%). For transgender women, the prevalence is even higher at 11.8%, roughly 90 times greater. Rates of sexually transmitted infections like syphilis, chlamydia, and gonorrhea are also much higher than in the general population. Despite these risks, only 36.2% of MSM and 28.4% of transgender women consistently use condoms with casual partners. HIV testing in the past year remains low-less than one-third in both groups-showing barriers to access and awareness. Additionally, high levels of physical (22.5% among MSM and 38.6% among transgender women) and sexual violence (14.3% among MSM and 27.1% among transgender women) highlight the

serious challenges faced by these communities, which are closely linked to their vulnerability to HIV and ongoing human rights issues.

Risk Determinants

Behavioral Risk Factors

Several behavioral risk factors, including inconsistent condom use, having multiple sexual partners, transactional sex, early initiation of sexual activity, and substance use linked to sex, play a role in HIV transmission in Fiji. Data from the IBBS indicate that consistent condom use remains low among MSM and transgender women. The 2021 WHO STEPS survey revealed that about 29% of adults with multiple partners used a condom during their last sexual encounter, highlighting ongoing gaps in safer sex practices (WHO, 2021b)[27]. Additionally, a 2016 Fiji-based GSHS found that only 43.2% of sexually active students aged 13-17 used a condom at last sex, with 23.1% having had sexual intercourse and 7.8% beginning before age 14 (WHO, 2016)[28]. These figures suggest that risky sexual behaviors start early, emphasizing the importance of comprehensive sexuality education and youth-friendly sexual health services. Substance use, including alcohol and drugs like cannabis, often links to unprotected sex, impaired risk assessment, and increased vulnerability to coercion and violence in Fiji, as shown by qualitative studies among key populations (McMillan and Worth, 2019[9], FJN+, 2018[29]).

Structural and Social Determinants

In Fiji, factors such as poverty, inequality, migration, mobility, gender relations, stigma, discrimination and the legal system all play a role in shaping HIV risk. These issues affect people at different levels-personal, relationships, community, institutions and policies-helping to determine where individuals are more vulnerable or resilient (Auerbach *et al*, 2011)[30].

Poverty and inequality

Economic marginalization increases the risk of HIV through several channels: such as engaging in transactional or survival sex, having limited access to healthcare and essentials like condoms, and facing fewer educational and employment opportunities that could offer protection (Gillespie *et al*, 2007)[31]. In Fiji, approximately 29.9% of the population lives below the national poverty line (Fiji Bureau of Statistics, 2021)[32], with poverty disproportionately impacting groups already at a higher risk of HIV.

Migration and mobility

Fiji, a regional transportation, commerce and tourism hub, experiences high population mobility. This mobility has been linked to increased HIV risk in numerous global studies (Deane *et al*, 2010)[33]. Factors such as tourism-related sexual activities, the movement of seafarers, labor migration and shifting populations between cities and rural areas all contribute to the wider geographic spread of HIV. With approximately 900,000 international visitors each year during non-pandemic times (Fiji Bureau of Statistics, 2023)[34], the tourism industry often becomes a setting where transactional sexual encounters occur (McMillan and Worth, 2019)[9].

Gender dynamics

Gender inequality and gender-based violence (GBV) play a significant role in increasing HIV vulnerability in Fiji, particularly among women and girls. A 2019 survey conducted by the Fiji Women's Crisis Centre revealed that approximately 64% of women in intimate relationships had experienced physical and/or sexual violence from their partners. This kind of violence not only undermines women's ability to insist on condom use but also raises their biological risk of HIV through trauma-related mucosal damage. Additionally, it creates barriers to accessing testing and treatment services. For transgender women and men who have sex with men (MSM), gender non-conformity often leads to heightened vulnerability due to violence, discrimination, and social exclusion, which further increase HIV risk.

Health System Response

HIV Testing Services

HIV testing in Fiji is convenient and available at a variety of facilities, including the Fiji Centre for Disease Control (Fiji CDC), divisional hospitals, sub-divisional health centers and select primary healthcare clinics. The main ways people get tested are through voluntary counseling and testing (VCT), provider-initiated testing and counseling (PITC) and screening during pregnancy to prevent mother-to-child transmission (MHMS, 2023)[7]. Rapid diagnostic

tests (RDTs) are used for initial screening, with confirmatory testing done at the Fiji CDC laboratory in Suva. Confirmatory tests include enzyme-linked immunosorbent assay (ELISA), and, if necessary, Western blot or PCR-based tests (MHMS, 2021)[17].

The data shown in Table No.4 and Figure 4 highlight significant gaps at each stage. About 55% of people living with HIV (PLHIV) know their status, meaning that nearly half remain undiagnosed-a missed chance for treatment and a continued risk of transmission. Of those diagnosed, roughly 68% are on antiretroviral therapy (ART), leaving nearly a third without access to vital treatment. Among those on ART, only around 52% have achieved viral suppression, pointing to issues such as adherence challenges, drug resistance, or insufficient viral load monitoring. Consequently, only about 19% of all PLHIV in Fiji are virally suppressed, falling far short of the UNAIDS target of 86%, and highlighting the urgent need to expand testing and treatment efforts across all stages.

Antiretroviral Therapy (ART)

Fiji first introduced ART in 2004, initially using regimens based on zidovudine (AZT) and nevirapine (NVP). Over time, the treatment program has been updated to align with evolving WHO guidelines. Currently, the first-line regimen is tenofovir/lamivudine/dolutegravir (TLD), which matches the WHO-recommended best option (WHO, 2021c[35], MHMS, 2023)[7]. ART is provided free of charge through Fiji's public health system, supported by government funding and assistance from the Global Fund.

As of December 2022, around 530 people in Fiji were actively on ART, which is about 68% of those with a confirmed diagnosis but only roughly 37% of all estimated PLHIV (MHMS, 2023)[7]. ART services are offered at a few treatment sites, mainly at the CWM Hospital Communicable Disease Clinic in Suva, the Lautoka Hospital HIV Clinic and Labasa Hospital, with some decentralization to smaller hospitals (MHMS, 2023)[7]. This setup, concentrated in major hospitals, can make it difficult for patients in rural areas and on outer islands to access care, as they often face high travel costs and long journeys to attend appointments (Bavinton *et al*, 2019)[26].

Challenges to expanding and maintaining ART in Fiji include issues like supply chain vulnerabilities, such as periodic stockouts of antiretroviral medications. Limited laboratory capacity affects the monitoring of CD4 cell counts and viral loads. Additionally, the need for clinic visits imposes time and financial burdens. Stigma also hampers adherence and retention in care. Moreover, the absence of differentiated service delivery models makes ART provision less simple and decentralized for stable patients.

Prevention of Mother-to-Child Transmission (PMTCT)

Fiji has made notable progress in PMTCT. Routine HIV screening is offered to all pregnant women attending antenatal care (ANC) services and HIV-positive pregnant women are provided with ART to prevent vertical transmission (MHMS, 2023)[7]. ANC HIV testing coverage has increased steadily, reaching approximately 85% of pregnant women attending ANC in 2022 (MHMS, 2023)[7]. The MTCT rate has declined from an estimated 25-30% in the pre-ART era to approximately 5-8% in recent years, although the goal of eliminating MTCT (defined as a rate below 2% for breastfeeding populations) has not yet been achieved (WHO, 2021c)[35].

Laboratory Infrastructure

HIV diagnostic and monitoring laboratory services in Fiji are mainly centralized at the Fiji CDC in Tamavua, Suva, with some capacity available at divisional hospital laboratories. The Fiji CDC laboratory handles confirmatory HIV tests (ELISA, Western blot), CD4 cell count testing, and, since 2019, HIV viral load testing using the GeneXpert platform, which is also used for tuberculosis diagnosis (MHMS, 2023)[7]. However, routine viral load monitoring-crucial for evaluating treatment success and detecting failures-remains limited. By 2022, only about 45% of patients on ART had at least one viral load test in the previous 12 months, which is below the WHO recommendation for annual viral load testing for all patients on ART (MHMS, 2023[7], WHO, 2021c[35]).

Socio-Cultural Context

Stigma and Discrimination

HIV-related stigma and discrimination continue to be major obstacles to an effective HIV response in Fiji. The 2016 People Living with HIV Stigma Index in Fiji revealed that PLHIV face stigma and discrimination in various settings, including within families, communities, workplaces, and healthcare facilities (FJN+, 2017)[19]. Key findings showed that:

40.2% of PLHIV experienced at least one form of discrimination in the previous year.

28.5% gossiped about it because of their HIV status.

18.3% endured verbal insults, harassment, or threats.

12.7% faced discrimination in healthcare settings, such as being denied treatment, experiencing breaches of confidentiality, or being treated differently from others.

15.6% felt self-stigma, with feelings of shame, guilt and self-blame.

22.4% avoided seeking healthcare out of fear of discrimination.

These issues are deeply troubling because stigma and discrimination hinder prevention efforts by discouraging testing and disclosure, disrupting treatment by limiting access and adherence, and compromising care quality and continuity. The stigma related to HIV often intersects with negative attitudes toward sexual orientation and gender identity, creating layered barriers especially for MSM and transgender PLHIV, who can face rejection and violence from multiple sources (FJN+, 2018[15], Bavinton *et al*, 2019[26]).

The Role of Religion and Culture

Fiji is a deeply religious society, with about 64% of its people identifying as Christians-mainly Methodist, Catholic and Assembly of God-28% as Hindus, and 6% as Muslims (Fiji Bureau of Statistics, 2023)[34]. Religious institutions are at the heart of community life and hold considerable sway over social norms related to sexuality, gender and morality (Ryle, 2010)[36]. While faith-based groups have made valuable contributions to HIV care-offering counseling, home-based support, and material aid to people living with HIV, they also sometimes reinforce stigma by portraying HIV because of sinful actions, especially sexual immorality and homosexuality (McMillan and Worth, 2019)[9].

Gender and HIV

Gender dynamics significantly influence HIV vulnerability in Fiji. Women and girls face heightened risks due to gender-based violence, including sexual violence and coercion, as well as unequal power relationships that hinder their ability to negotiate condom use. Economic dependence may also lead to engagement in transactional sex (FWCC, 2019). The high rate of intimate partner violence-affecting 64% of ever-partnered women-serves as a major structural factor increasing HIV risk for women (FWCC, 2019)[37].

Policy, Legal and Programmatic Frameworks

The HIV and AIDS Decree 2011

The HIV and AIDS Decree 2011, later affirmed as legislation under Fiji's 2013 Constitution, serves as the main legal framework guiding the country's response to HIV. When it was enacted, the Decree was seen as progressive and included several key provisions (Government of Fiji, 2011)[38].

Non-discrimination: Outlaws discrimination against people living with HIV (PLHIV) in areas such as employment, education, healthcare, housing, insurance and access to services.

Confidentiality: Ensures the privacy of HIV-related information and imposes penalties for unauthorized disclosure.

Informed consent: Mandates informed consent for HIV testing, with certain exceptions like blood donation and organ transplants.

Access to treatment: Recognizes the right of PLHIV to receive treatment, care and support.

Prevention: Calls for HIV prevention efforts, including condom distribution and education.

National HIV/AIDS Committee: Creates a multi-sectoral body to coordinate the national HIV response.

Although the Decree offers a solid legal foundation, implementing it has faced challenges. Reports from civil society groups reveal ongoing discrimination against PLHIV, breaches of confidentiality-especially in healthcare and small communities-and limited awareness among both PLHIV and service

providers about the protections the Decree offers (FJN+, 2018[15], FHRADC, 2018[39]).

National Strategic Plan for HIV and STIs

Fiji's national HIV response is guided by the National Strategic Plan for HIV and STIs, with the most recent version covering 2016–2020 and an extension to 2023 while awaiting a new plan (MHMS, 2016)[40]. The plan outlines four main priorities:

Prevention: Reducing new HIV and STI cases through targeted programs for key and vulnerable groups, promoting and distributing condoms, PMTCT and raising community awareness.

Treatment, care, and support: Increasing ART coverage, supporting adherence and retention, and enhancing services for people living with HIV.

Enabling environment: Tackling stigma and discrimination, defending human rights, involving communities, and strengthening policies and laws.

Strategic information: Enhancing surveillance, monitoring, evaluation, and research to guide effective programs.

The plan aligns with regional and global frameworks, including the UNAIDS Strategy, the Pacific Sexual Health and Well-being Shared Agenda and the Sustainable Development Goals, particularly SDG 3. Target 3.3: "End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases by 2030" (UNAIDS, 2021[41], SPC, 2014[10]).

The Role of Civil Society

Civil society organizations (CSOs) are essential in Fiji's fight against HIV, especially in reaching key and vulnerable groups. Groups like the Survival Advocacy Network Fiji (SAN Fiji), which supports MSM and transgender communities; the Fiji Network for People Living with HIV/AIDS (FJN+); the Rainbow Pride Foundation; and the Fiji Red Cross Society offer prevention, testing, treatment and advocacy services that supplement government efforts (Global Fund, 2022)[11]. These organizations are supported by the Global Fund (via the UNDP-managed multi-country grant), UNAIDS, and other international partners. Nonetheless, CSO capacity is limited by scarce and often short-term funding, small organizational size and a challenging environment shaped by social stigma and, at times, political opposition (McMillan and Worth, 2019)[9].

International Partnerships and Funding

International partnerships and external funding are vital for maintaining Fiji's HIV response. The Global Fund to Fight AIDS, Tuberculosis and Malaria is the main external supporter, contributing about US$3–4 million annually for HIV programs across the Pacific, with a portion allocated to Fiji (Global Fund, 2022)[11]. Organizations such as UNAIDS, WHO, UNDP, UNFPA, UNICEF, and the SPC offer technical assistance, policy advice and coordination support. Australia and New Zealand, through their bilateral aid initiatives, also help strengthen Fiji's HIV efforts and health systems in the region (Australian Government Department of Foreign Affairs and Trade, 2021)[42]. However, concerns exist about the sustainability of Fiji's HIV response as external funding priorities change and middle-income status prompts a transition from international aid to domestic funding. Fiji's designation as an upper-middle-income country by the World Bank (2022)[43] may jeopardize future eligibility for Global Fund support, risking a "transition trap" where external assistance diminishes before local capacity is fully prepared to take over (Godwin, 2012[8], Global Fund, 2022[11]).

The Impact of COVID-19 on the HIV Response

The COVID-19 pandemic, which hit Fiji hard in 2021 with a significant Delta variant outbreak, profoundly affected the country's HIV response. These challenges included:

Disruption of HIV testing services: Movement restrictions, closures of health facilities, and the redeployment of healthcare workers to fight COVID-19 led to fewer HIV tests, as seen in the lower number of new diagnoses in 2020 (MHMS, 2021)[17].

Breakdowns in ART supply chains: International shipping issues and local logistical hurdles threatened the steady supply of antiretroviral therapy, causing some patients to experience delays in refilling their medications (Global Fund, 2022)[11].

Limited access to prevention services: Lockdowns disrupted condom distribution, outreach programs for key populations, and STI treatment services (UNAIDS, 2021)[25].

Mental health strain: The psychological toll of the pandemic-marked by anxiety, isolation, financial struggles, and grief-worsened mental health issues among people living with HIV and key communities (FJN+, 2021)[44].

Resource shifts: The urgent need to respond to COVID-19 diverted financial and human resources away from HIV and other health programs, raising concerns about the long-term sustainability of HIV efforts (WHO, 2021a)[45].

The bars show testing volumes of approximately 18,500 (2018), 21,200 (2019), 12,800 (2020), 16,400 (2021) and 22,500 (2022). The sharp decline in 2020 (a 39.6% decrease from 2019) is annotated as "COVID-19 impact," and the recovery in 2021–2022 is annotated as "Post-COVID recovery."

Discussion

A Low-Prevalence Epidemic with High Concentration

The epidemiological data presented in this paper confirm that Fiji has a low-prevalence, concentrated HIV epidemic. Adult prevalence in the general population remains well below 1%, and the epidemic is mainly concentrated among key populations, especially men who have sex with men (MSM) and transgender women. This epidemiological profile has important implications for shaping the national response. In concentrated epidemics, the most effective use of resources is to prioritize prevention efforts for key populations while maintaining broad awareness and surveillance in the general population (Wilson and Halperin, 2008)[46]. However, reaching key populations in Fiji is challenging due to stigma, discrimination, criminalization (particularly of sex work) and the close-knit nature of communities, which makes maintaining anonymity difficult (McMillan and Worth, 2019)[9].

The striking disparity in HIV prevalence-40 times higher for MSM and 90 times higher for transgender women-matches patterns seen in other low-prevalence countries in Asia and the Pacific (UNAIDS, 2022)[6]. These gaps are driven by a mix of biological factors (such as a higher chance of HIV transmission through unprotected anal sex compared to vaginal sex), behavioral factors (like inconsistent condom use and multiple partners), and structural issues (including stigma, violence, and limited access to services) (Beyrer *et al*, 2012)[47]. Addressing these gaps requires comprehensive interventions at biological (e.g., distributing condoms and lubricants, PrEP), behavioral (e.g., behavior change campaigns, peer education), and structural levels (e.g., anti-discrimination laws, community empowerment, training healthcare workers to be more sensitive).

The Testing and Treatment Cascade Gap

The analysis of Fiji's HIV testing and treatment cascade highlights significant gaps at every stage. About 55% of people living with HIV (PLHIV) are aware of their status, 68% of diagnosed individuals are on antiretroviral therapy (ART) and 52% of those on ART have achieved viral suppression. This results in an overall viral suppression rate of roughly 19%, well below the UNAIDS target of 86%. These gaps have serious consequences for both individual health and the spread of the virus within the community. People who remain undiagnosed or are not on effective ART continue to pass the virus to others, sustaining the epidemic. On the other hand, when a large portion of the HIV-positive population maintains viral suppression-an approach known as "treatment as prevention" (TasP)-new infections can be significantly reduced (Cohen *et al*, 2011)[48].

Closing the cascade gap will require a multi-pronged approach:

First "95" (knowing status)

mmExpanding testing through community-based testing, mobile testing units, self-testing (which has been shown to increase testing uptake among key populations globally), index testing (offering testing to the sexual partners and contacts of newly diagnosed individuals), and integration of HIV testing into routine healthcare encounters (WHO, 2019)[49].

Second "95" (on treatment)

Implementing "Treat All" (immediate ART initiation regardless of CD4 count, as recommended by WHO since 2015), addressing barriers to treatment uptake including stigma, distance, cost, and provider attitudes and adopting differentiated service delivery models (e.g., multi-month dispensing, community ART delivery) to simplify and decentralize treatment access (WHO, 2021c)[35].

Third "95" (virally suppressed)

Strengthening viral load monitoring capacity, providing adherence support (including peer counseling, adherence clubs, and digital health interventions), addressing treatment side effects and drug resistance through clinical management and access to second/third-line regimens, and managing co-morbidities that affect treatment outcomes (Dolutegravir Transition Task Team, 2020)[50].

Pre-Exposure Prophylaxis (PrEP): An Underutilized Prevention Tool

Pre-exposure prophylaxis (PrEP)-the use of antiretroviral medications by HIV-negative individuals at significant risk of infection-has been proven through numerous clinical trials and implementation studies to be highly effective in preventing HIV when used as prescribed (Grant *et al*, 2010[51], WHO, 2015[52]). WHO recommends PrEP as an additional preventive measure for those at substantial risk of HIV, including men who have sex with men (MSM), transgender women, serodiscordant couples and sex workers (WHO, 2015[52]).

As of 2022, access to PrEP in Fiji remains very limited. A small pilot program launched in Suva in 2021 with support from international partners has reached only a few individuals, and PrEP has not yet been incorporated into national treatment guidelines or expanded sufficiently to impact the epidemic (MHMS, 2023)[7]. The potential benefits of PrEP for Fiji's key populations are considerable: modeling studies in similar settings suggest that PrEP could reduce HIV incidence among MSM by 20-40% when combined with existing prevention strategies (Pretorius *et al*, 2010)[53]. Scaling up PrEP in Fiji will require overcoming regulatory, logistical, financial, and demand-related barriers, including raising awareness, improving acceptability, and promoting adherence among potential users (Bavinton *et al*, 2019)[26].

Stigma as the Central Barrier

The evidence presented in this paper convincingly highlights stigma and discrimination as the main obstacles to an effective HIV response in Fiji. Stigma manifests at various levels: internalized stigma (self-blame and shame among people living with HIV), anticipated stigma (fear of discrimination that discourages testing and disclosure), enacted stigma (actual experiences of discrimination and violence) and institutional stigma (policies and practices that discriminate against people living with HIV and key populations) (Earnshaw and Chaudoir, 2009[54]). In the Fiji context, HIV-related stigma is deeply linked with stigma related to sexual orientation and gender identity, creating complex and layered barriers for MSM and transgender individuals living with HIV. Tackling stigma requires comprehensive approaches across multiple levels, including community awareness campaigns to dispel myths and misconceptions about HIV; training healthcare workers to deliver non-judgmental, confidential care; enforcing the non-discrimination provisions of the HIV and AIDS Decree 2011; engaging religious and community leaders as advocates for compassion and inclusion; and empowering people living with HIV and key populations to speak out for their rights and participate actively in creating and implementing programs (UNAIDS, 2020)[55].

Sustainability Challenge

Fiji's HIV response largely depends on external funding, especially from the Global Fund, which raises questions about its long-term sustainability. Since Fiji is classified as an upper-middle-income country, it might become less eligible for international HIV funding in future cycles. This means the country will need to rely more on domestic resources. To manage this shift without disrupting services, Fiji must increase its domestic HIV budget, use existing resources more efficiently and carefully plan the transition of responsibilities from international partners to local organizations and government agencies.

Integration with Broader Health and Development Agendas

The HIV response in Fiji is closely connected to the country's overall health and development challenges. Non-communicable diseases (NCDs) represent the leading health burden, responsible for about 80% of all deaths (WHO, 2021a)[45]. This prioritization creates competition for scarce health resources and political focus, often leading to HIV being seen as a

lower concern. Nonetheless, there are valuable synergies between HIV efforts and broader health system improvements. Enhancements in laboratory capacity, supply chains, community health worker programs, and HIV data systems also strengthen the entire health system. Likewise, integrating HIV services with sexual and reproductive health (SRH), TB and NCD care can enhance efficiency and expand reach (WHO, 2021c)[35].

Description: A conceptual diagram illustrating the multi-level determinants and consequences of HIV in Fiji. At the center is "HIV Transmission and Outcomes". Surrounding this are concentric rings representing: (1) Individual-level factors (knowledge, attitudes, behaviors, biology); (2) Interpersonal factors (partner dynamics, family support, peer influence); (3) Community factors (stigma, social norms, cultural practices, religious influence); (4) Institutional factors (health system capacity, healthcare worker attitudes, laboratory infrastructure) and (5) Structural/policy factors (poverty, inequality, gender norms, legal environment, international funding).

Table No.1: Demographic Profile of Cumulative HIV Cases in Fiji (1989–2022)

S.No	Characteristic	Category	Number (%)
1	Sex	Male	678 (60.2%)
		Female	448 (39.8%)
2	Age at Diagnosis	0–14 years	45 (4.0%)
		15–24 years	214 (19.0%)
		25–34 years	398 (35.3%)
		35–44 years	267 (23.7%)
		45–54 years	134 (11.9%)
		55+ years	68 (6.0%)
3	Ethnicity	iTaukei (Indigenous Fijian)	735 (65.3%)
		Fijian of Indian Descent	298 (26.5%)
		Other (Rotuman, Part-European, Chinese, Other Pacific)	93 (8.3%)
4	Geographic Division	Central/Eastern (Suva, Nausori)	567 (50.4%)
		Western (Lautoka, Nadi, Ba)	389 (34.5%)
		Northern (Labasa, Savusavu)	125 (11.1%)
		Unknown/Other	45 (4.0%)
5	Mode of Transmission	Heterosexual	698 (62.0%)
		MSM/Bisexual	234 (20.8%)
		Mother-to-child	42 (3.7%)
		Unknown/Other	152 (13.5%)

Source: MHMS HIV/AIDS Unit, 2023. Note: Percentages may not sum to 100 due to rounding.

Table No.2: HIV and STI Prevalence Among Key Populations in Fiji (IBBS 2017)

S.No	Indicator	MSM (n=398)	Transgender Women (n=152)
1	HIV prevalence (%)	5.3	11.8
2	Syphilis Sero-reactivity (%)	8.7	14.2
3	Chlamydia prevalence (%)	15.4	18.9
4	Gonorrhea prevalence (%)	9.8	12.6
5	Consistent condom uses with casual partners (past 6 months) (%)	36.2	28.4
6	Ever tested for HIV (%)	52.1	48.7
7	Tested for HIV in past 12 months (%)	31.4	26.8
8	Experienced physical violence (past 12 months) (%)	22.5	38.6
9	Experienced sexual violence (past 12 months) (%)	14.3	27.1

Source: MHMS and SPC, 2019. IBBS among MSM and Transgender Women in Fiji.

Table No.3: Structural Determinants of HIV Risk in Fiji

S.No	Determinant	Indicator	Value	Source
1	Poverty	Population below poverty line (%)	29.9	Fiji Bureau of Statistics, 2021
2	Income inequality	Gini coefficient	36.7	World Bank, 2020
3	Gender-based violence	Women experiencing intimate partner violence (%)	64	FWCC, 2019
4	Youth unemployment	Youth unemployment rate (15–24) (%)	18.4	ILO, 2022
5	Education	Mean years of schooling	10.2	UNDP, 2021
6	Tourism arrivals	Annual international arrivals (pre-COVID)	~900,000	Fiji Bureau of Statistics, 2019
7	Condom access	Condom use at last high-risk sex (%)	29	WHO STEPS, 2021
8	HIV testing	Adults ever tested for HIV (%)	~35	UNAIDS, 2022

Sources: MHMS and SPC, 2019. IBBS among MSM and Transgender Women in Fiji.

Table No.4: HIV Testing and Treatment Cascade in Fiji (Estimated, 2022)

S.No	Cascade Indicator	UNAIDS 95-95-95 Target	Fiji Estimate (2022)	Gap
1	PLHIV who know their status (%)	95	~55	40
2	PLHIV who know their status and are on ART (%)	95	~68	27
3	PLHIV on ART who achieve viral suppression (%)	95	~52	43
4	Overall: PLHIV who are virally suppressed (%)	86 (95×95×95)	~19	67

Source: UNAIDS AIDS info, 2022, MHMS, 2023. Note: Estimates are subject to uncertainty due to limited surveillance data.

Table No.5: ART Service Delivery Infrastructure in Fiji (2022)

S.No	Facility	Location	Division	Services	Patients on ART
1	CWM Hospital Communicable Disease Clinic	Suva	Central	ART, VCT, CD4/VL monitoring, PMTCT	285
2	Lautoka Hospital HIV Clinic	Lautoka	Western	ART, VCT, CD4 monitoring	155
3	Labasa Hospital	Labasa	Northern	ART, VCT	55
4	Sub-divisional hospitals (various)	Various	All	Basic ART, referral	35
5	Total	-	-	-	~530

Source: MHMS HIV/AIDS Unit, 2023.

Table No.6: Laboratory Capacity for HIV Diagnosis and Monitoring in Fiji (2022)

S.No	Service	Available	Location(s)	Capacity (tests/year)	Coverage (%)
1	Rapid diagnostic testing	Yes	All divisions	>20,000	~85 of ANC; ~35 general
2	ELISA confirmatory testing	Yes	Fiji CDC, Suva	~3,000	All reactive RDTs
3	Western blot	Yes	Fiji CDC, Suva	~500	Indeterminate results
4	CD4 cell count	Yes	Fiji CDC, Suva; CWM Hospital	~2,000	~60 of ART patients
5	Viral load testing (GeneXpert)	Yes	Fiji CDC, Suva	~1,200	~45 of ART patients
6	Drug resistance testing	No	Not available in-country	N/A	Samples sent overseas
7	Early infant diagnosis (PCR)	Limited	Fiji CDC, Suva	~100	Variable

Source: MHMS, 2023; WHO, 2021c.

Table No.7: Key Components of Fiji's National HIV Response Framework

S.No	Component	Lead Agency	Key Partners	Status (2022)
1	HIV Testing (VCT, PITC, PMTCT)	MHMS	SPC, WHO, Global Fund	Expanding, coverage gaps remain
2	ART Provision	MHMS (CWM, Lautoka, Labasa)	Global Fund, WHO	Active; scale-up needed
3	PMTCT	MHMS (ANC services)	UNICEF, WHO	Improving; MTCT rate declining
4	Condom programming	MHMS, Fiji Red Cross	UNFPA, SPC	Ongoing; distribution gaps
5	Key population programs	CSOs (Survival Advocacy Network, FJN+, Rainbow Pride Foundation)	UNDP, Global Fund, UNAIDS	Active but underfunded
6	Stigma reduction	FHRADC, CSOs	UNAIDS, UNDP	Limited impact to date
7	Surveillance, M and E	MHMS (Fiji CDC)	SPC, WHO	Improving; significant gaps
8	Legislative framework	Attorney General's Office	UNDP, UNAIDS	HIV/AIDS Decree in place

Source: MHMS, 2016; Global Fund, 2022.

Table No.8: Comparative HIV Indicators: Fiji and Selected Pacific Island Countries (Latest Available Data)

S.No	Country	Estimated PLHIV	Adult Prevalence (%)	ART Coverage (%)	PMTCT Coverage (%)	Key Pop. Programs
1	Papua New Guinea	55,000	0.9	47	55	Limited
2	Fiji	~1,400	0.13	~37	~85	Active (CSO-led)
3	New Caledonia	~350	0.11	>80	>95	Established
4	French Polynesia	~280	0.10	>75	>95	Established
5	Samoa	~120	0.05	~40	~70	Emerging
6	Tonga	~60	0.05	~35	~65	Limited
7	Vanuatu	~50	0.02	~30	~60	Very limited

Sources: UNAIDS, 2022; SPC, 2022; WHO, 2021a. Note: Estimates are subject to uncertainty.

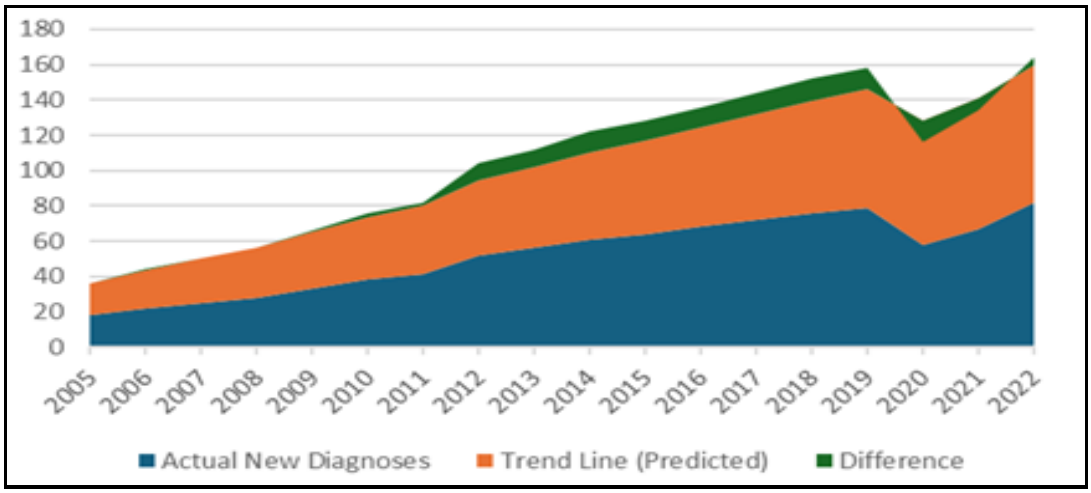

Figure No.1: Annual New HIV Diagnoses in Fiji, 2005–2022

Source: Compiled from MHMS HIV/AIDS Unit surveillance data, 2005–2022; UNAIDS, 2022.

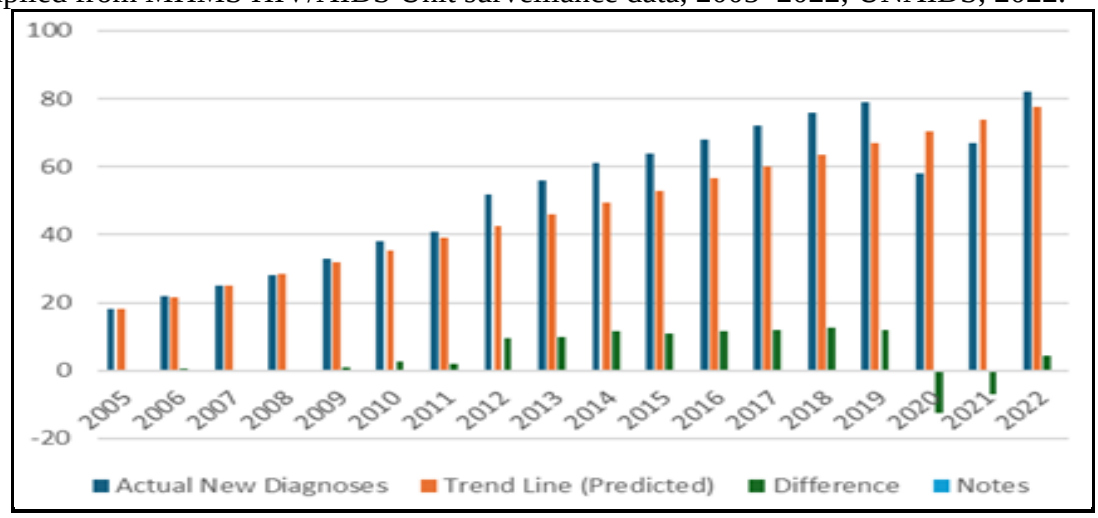

Figure No.2: Annual New HIV Diagnoses in Fiji, 2005–2022

Source: Compiled from MHMS HIV/AIDS Unit surveillance data, 2005–2022; UNAIDS, 2022.

Figure No.3: HIV Prevalence Comparison: General Population vs. Key Populations in Fiji

Source: MHMS and SPC, 2019. IBBS among MSM and Transgender Women in Fiji.

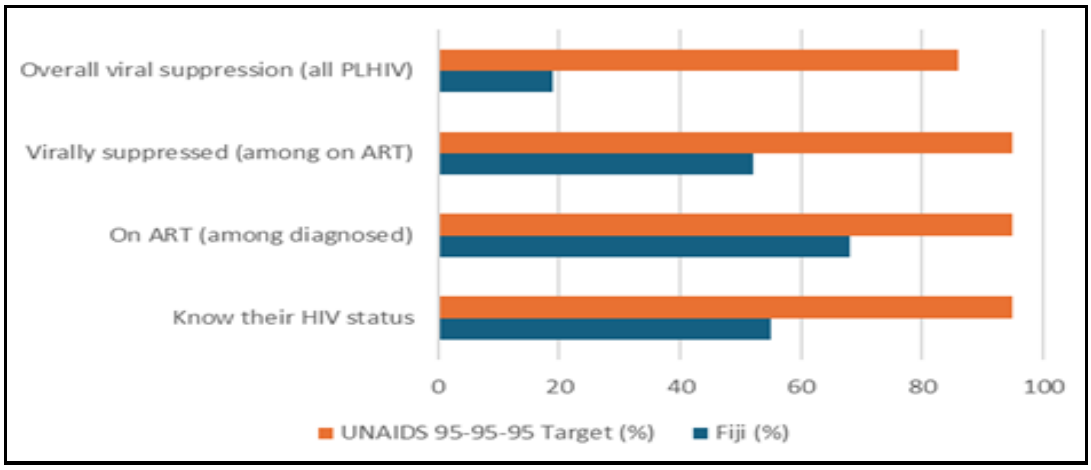

Figure No.4: HIV Treatment Cascade in Fiji Compared to UNAIDS 95-95-95 Targets (2022)

Source: UNAIDS AIDS info, 2022, MHMS, 2023. Note: Estimates are subject to uncertainty due to limited surveillance data.

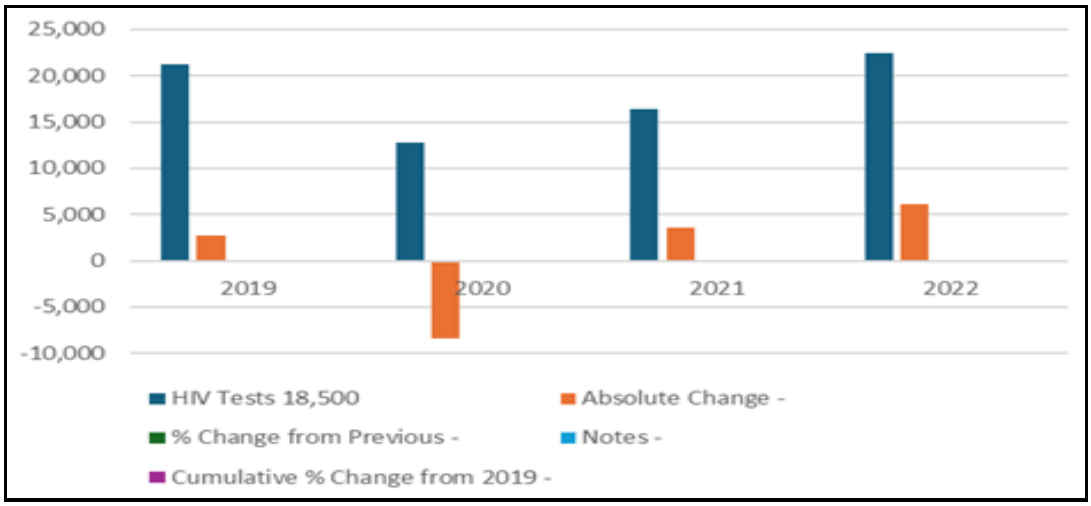

Figure No.5: Impact of COVID-19 on HIV Testing Volume in Fiji, 2018–2022

Sources: UNAIDS, 2022; SPC, 2022; WHO, 2021a.

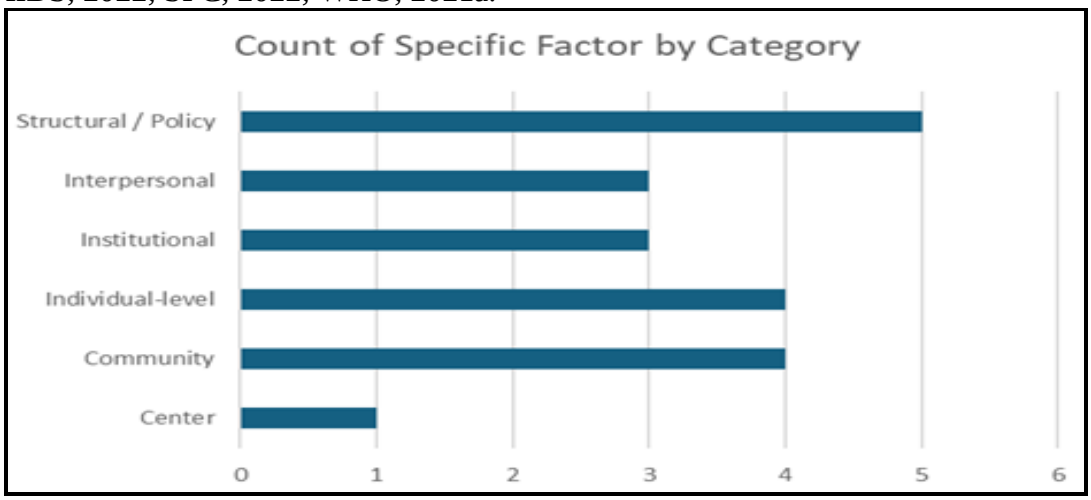

Figure No.6: Conceptual Framework: Determinants and Consequences of HIV in Fiji

MHMS and SPC, 2019[57]. IBBS among MSM and Transgender Women in Fiji.

CONCLUSION

Fiji's HIV epidemic, although relatively small in scale, presents serious and increasingly pressing challenges to the nation's public health, social harmony, and development goals. The epidemic's concentration among key groups-especially men who have sex with men and transgender women, who face HIV prevalence rates 40 to 90 times higher than the general population-calls for a focused, rights-based approach that respects cultural sensitivities and addresses biological, behavioral and structural factors contributing to vulnerability. The existing gaps in testing and treatment, with only about 19% of people living with HIV achieving viral suppression, highlight both a failure to safeguard individual health and a missed chance to maximize preventive benefits through effective treatment.

This paper identifies stigma and discrimination as the main obstacles hindering Fiji's HIV response. Stigma affects all levels-from individuals and relationships to communities, institutions, and broader societal structures-and influences every aspect of prevention and testing, treatment, care, and advocacy. Combating stigma must therefore be central to Fiji's national HIV strategy, requiring ongoing commitment, strong leadership and active involvement of communities, including those living with HIV and key populations.

At the same time, the health system requires significant strengthening, expanding testing services, increasing access to antiretroviral therapy and viral load monitoring, introducing pre-exposure prophylaxis (PrEP) and improving laboratory and supply infrastructure. These efforts should go hand in hand with legal and policy reforms, such as enforcing anti-discrimination laws and revising laws that hinder progress. Ensuring sustainability will depend on increasing domestic funding and strategic planning to transition from external support to local resources.

Fiji is at a crucial point in its fight against HIV. The country has a real opportunity-through decisive action, sustained investment and genuine collaboration among government, civil society, communities and international partners-to control the epidemic and work toward the UNAIDS goal of ending AIDS as a public health threat by 2030. However, neglect, insufficient funding, and ongoing stigmatization could allow HIV to spread further, incurring far greater human and financial costs to address. The choice is clear and the urgency cannot be overstated.

DECLARATION OF COMPETING INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have influenced the work reported in this paper.

FUNDING

This research did not receive any specific grant from funding agencies in the public, commercial, or non-profit sectors

ACKNOWLEDGEMENT

The authors wish to express their sincere gratitude to Department of Social Sciences, Fiji National University, Natabua, Lautoka, Fiji Islands for providing the necessary facilities to carry out this research work.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

BIBLIOGRAPHY

1. UNAIDS, The path that ends AIDS: UNAIDS Global AIDS Update 2023, *UNAIDS*, 2023a.
2. World Health Organization, Global HIV programme: Data and statistics, *WHO*, 2023.
3. Pacific Community, Pacific HIV/STI surveillance report 2022, *SPC*, 2022.
4. UNAIDS, AIDS info: Country factsheets-Papua New Guinea, *UNAIDS*, 2023b.
5. Buchanan-Aruwafu H. HIV and the Pacific: Structural factors and the epidemiology of risk, *Routledge Handbook of Global Public Health in Asia, Routledge,* 2017, 478-495.
6. UNAIDS, AIDS info: Country factsheets-Fiji, *UNAIDS*, 2022.
7. MHMS, *HIV/AIDS Surveillance Data: Annual Summary 2022, Government of Fiji*, 2023.

8. Godwin J. Sex work and the law in Asia and the Pacific: Laws, HIV and human rights in the context of sex work, *UNDP,* 2012.
9. McMillan K, Worth H. The impact of socio-cultural context on young people's condom use: Evidence from two Pacific Island countries, *Culture, Health and Sexuality,* 21(6), 2019, 615-631.
10. Pacific Community, Pacific sexual health and well-being shared agenda 2015–2019, *SPC,* 2014.
11. Global Fund to Fight AIDS, Tuberculosis and Malaria, Pacific multi-country grant progress report, *Global Fund,* 2022.
12. World Health Organization, Fiji health system review, *WHO Regional Office for the Western Pacific,* 2021a.
13. Ministry of Health and Medical Services, *National HIV/STI Annual Report 2015, Government of Fiji,* 2015.
14. Ministry of Health and Medical Services and Pacific Community, Integrated bio-behavioural survey among men who have sex with men and transgender women in Fiji: Final report, *MHMS/SPC,* 2019.
15. Fiji Network for People Living with HIV/AIDS, Situational analysis of HIV service access for key populations in Fiji, *FJN+,* 2018.
16. Cohen M S, Council O D, Chen J S. Sexually transmitted infections and HIV in the era of antiretroviral treatment and prevention: The biologic basis for epidemiologic synergy, *Journal of the International AIDS Society,* 15(1), 2012, 17091.
17. Ministry of Health and Medical Services, Annual report 2021, *Government of Fiji*, 2021.
18. Fiji Human Rights and Anti-Discrimination Commission, Annual report 2018, *FHRADC,* 2018.
19. Fiji Network for People Living with HIV/AIDS, People Living with HIV Stigma Index: Fiji country report, *FJN+,* 2017.
20. Bronfenbrenner U. The ecology of human development, *Harvard University Press,* 1979.
21. McLeroy K R, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs, *Health Education Quarterly,* 15(4), 1988, 351-377.
22. Singer M, Clair S. Syndemics and public health: Reconceptualizing disease in bio-social context, *Medical Anthropology Quarterly,* 17(4), 2003, 423-441.
23. Global Commission on HIV and the Law, Risks, rights and health, *UNDP,* 2012.
24. Creswell J W, Clark V L P. Designing and conducting mixed methods research, *SAGE Publications,* 3rd Edition, 2017, 520.
25. UNAIDS, Confronting inequalities: Lessons for pandemic responses from 40 years of AIDS, *UNAIDS Global AIDS Update,* 2021.
26. Bavinton B R, Mahony A, Kaldor J M. HIV prevalence and risk behaviours among men who have sex with men and transgender women in the Pacific Islands: A systematic review, *Sexual Health,* 16(4), 2019, 283-294.
27. World Health Organization, WHO STEPS noncommunicable disease risk factor survey: Fiji 2021, *WHO,* 2021b.
28. World Health Organization, Global school-based student health survey: Fiji 2016 fact sheet, *WHO,* 2016.
29. Fiji Network for People Living with HIV/AIDS, Situational analysis of HIV service access for key populations in Fiji, *FJN+,* 2018.
30. Auerbach J D, Parkhurst J O, Caceres C F. Addressing social drivers of HIV/AIDS for the long-term response: Conceptual and methodological considerations, *Global Public Health,* 6(3), 2011, S293-S309.
31. Gillespie S, Kadiyala S, Greener R. Is poverty or wealth driving HIV transmission? *AIDS,* 21(7), 2007, S5-S16.
32. Fiji Bureau of Statistics, Household income and expenditure survey 2019-2020: Poverty analysis, *Government of Fiji,* 2021.
33. Deane K D, Parkhurst J O, Johnston D. Linking migration, mobility and HIV, *Tropical Medicine and International Health,* 15(12), 2010, 1458-1463.

34. Fiji Bureau of Statistics, Key statistics: Population and demography, *Government of Fiji,* 2023.
35. World Health Organization, Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: Recommendations for a public health approach, *WHO,* 2021c.
36. Ryle J. My God, my land: Interwoven paths of Christianity and tradition in Fiji, *Ashgate*, 2010, 304.
37. Fiji Women's Crisis Centre, Somebody's life, everybody's business: National research on women's health and life experiences in Fiji (2019 update), *FWCC*, 2019.
38. Government of Fiji, HIV/AIDS Decree 2011, *Laws of Fiji*, 2011.
39. Fiji Human Rights and Anti-Discrimination Commission, Annual report 2018, *FHRADC*, 2018.
40. Ministry of Health and Medical Services, National strategic plan for HIV and STIs 2016–2020, *Government of Fiji,* 2016.
41. UNAIDS, Confronting inequalities: Lessons for pandemic responses from 40 years of AIDS, *UNAIDS Global AIDS Update 2021*, 2021.
42. Australian Government Department of Foreign Affairs and Trade, Development assistance in the Pacific: Health and HIV, *DFAT*, 2021.
43. World Bank, Country classification by income level, *World Bank*, 2022.
44. Fiji Network for People Living with HIV/AIDS, Impact of COVID-19 on people living with HIV in Fiji: A rapid assessment, *FJN+*, 2021.
45. World Health Organization, Fiji health system review, *WHO Regional Office for the Western Pacific*, 2021a.
46. Wilson D, Halperin D T. Know your epidemic, know your response: A useful approach, if we get it right, *The Lancet*, 372(9637), 2008, 423-426.
47. Beyrer C, Baral S D, Van Griensven F, Goodreau S M, Chariyalertsak S, Wirtz A L, Brookmeye R. Global epidemiology of HIV infection in men who have sex with men, *The Lancet*, 380(9839), 2012, 367-377.
48. Cohen M S, Chen Y Q, McCauley M, Gamble T, Hosseinipour M C, Kumarasamy N, Fleming T R. Prevention of HIV-1 infection with early antiretroviral therapy, *New England Journal of Medicine*, 365(6), 2011, 493-505.
49. World Health Organization, Consolidated guidelines on HIV testing services, *WHO,* 2019.
50. Dolutegravir Transition Task Team, Guidance on dolutegravir transition in the Pacific, *WHO/SPC,* 2020.
51. Grant R M, Lama J R, Anderson P L, McMahan V, Liu A Y, Vargas L, Glidden D V. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men, *New England Journal of Medicine*, 363(27), 2010, 2587-2599.
52. World Health Organization, Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV, *WHO,* 2015.
53. Pretorius C, Stover J, Bollinger L, Bacaer N, Williams B. Evaluating the cost-effectiveness of pre-exposure prophylaxis (PrEP) and its impact on HIV-1 transmission in South Africa, *PLoS ONE,* 5(11), 2010, e13646.
54. Earnshaw V A, Chaudoir S R. From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanism measures, *AIDS and Behavior*, 13(6), 2009, 1160-1177.
55. UNAIDS, Evidence for eliminating HIV-related stigma and discrimination: Guidance for countries to implement effective programmes to eliminate HIV-related stigma and discrimination, *UNAIDS*, 2020.
56. Ministry of Health and Medical Services and Pacific Community, Integrated bio-behavioural survey among men who have sex with men and transgender women in Fiji: Final report, *MHMS/SPC,* 2019.
57. International Labour Organization, ILOSTAT database: Fiji labour market indicators, *ILO*, 2022.

58. Leckie J. The complexities of women's agency in Fiji, Gender politics in the Asia-Pacific region, *Routledge*, 1st Edition, 2002, 156-180.
59. McLeroy K R, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs, *Health Education Quarterly*, 15(4), 1988, 351-377.
60. Ministry of Health and Medical Services, National HIV/STI annual report 2015, *Government of Fiji*, 2015.
61. Ministry of Health and Medical Services, Annual report 2021, *Government of Fiji*, 2021.
62. Singer M, Clair S. Syndemics and public health: Reconceptualizing disease in bio-social context, *Medical Anthropology Quarterly*, 17(4), 2003, 423-441.
63. UNESCO, International technical guidance on sexuality education: An evidence-informed approach, *UNESCO*, Revised Edition, 2018.
64. United Nations Development Programme, Human development report 2021/2022, *UNDP*, 2021.
65. World Bank, World development indicators: Fiji, *World Bank*, 2020.

Please cite this article in press as: Shivneel Kumar and Ravinesh Rohit Prasad. HIV/AIDS in FIJI: Epidemiology, risk determinants, public health responses and the path toward elimination in a pacific small island developing state, *International Journal of Nursing and Healthcare Research*, 10(1), 2026, 16-36.