

Sexual and reproductive health and gender-based violence in Fiji: A review of policy and legislation



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Acronyms

| | |
|-----------------|---|
| CEDAW | The Convention on the Elimination of all Forms of Discrimination Against Women |
| CRC | Convention on the Rights of the Child |
| CRPD | Convention on the Rights of Persons with Disabilities |
| DFAT | Australian Department of Foreign Affairs and Trade |
| DVRO | Domestic Violence Restraining Order |
| EVAW | Elimination of violence against women |
| FJHC | Fiji Judicial High Court |
| FLE | Family life education |
| FWCC | Fiji Women's Crisis Centre |
| FWRM | Fiji Women's Rights Movement |
| GBV | Gender-based violence |
| GBVIE | Gender-based violence in emergencies |
| HFRSA | Health facility readiness and service availability |
| HIV/AIDS | Human immunodeficiency virus/Acquired immunodeficiency syndrome |
| HPV | Human papillomavirus |
| HRADC | Human Rights and Anti-Discrimination Commission |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| ICPD | International Conference on Population and Development |
| IWDA | International Women's Development Agency |
| JICA | Japan International Cooperation Agency |
| LGBTIQ | Lesbian, Gay, Bisexual, Trans, Intersex and Queer ¹ |
| MHMS | Ministry of Health and Medical Services |
| MISP | Minimum Initial Service Package |
| MMR | Maternal mortality rate |
| NGO | Non-Government Organisation |
| NSP | Fijian Ministry of Health and Medical Services National Strategic Plan 2016-2020 |
| NZAID | New Zealand Agency for International Development |
| RRRT | The Pacific Community Regional Rights Resource Team |
| SDGs | Sustainable Development Goals |
| SGBV | Sexual or gender-based violence |
| SPC | The Pacific Community |
| SRH | Sexual and reproductive health |
| SRHiE | Sexual and reproductive health in emergency |
| SRHR | Sexual and reproductive health rights |
| STDs | Sexually transmitted diseases |
| STIs | Sexually transmitted infections |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNHRC | United Nations Human Rights Council |
| UNICEF | United Nations Children's Fund |
| WHO | World Health Organization |
| ZTVFC | Zero Tolerance Violence Free Communities Program |

¹ We recognise the LGBTIQ is contested as a descriptor, with some activists rather promoting a focus on the diversity of sexual orientation and gender identity and expression (SOGIE) in any community. However, LGBTIQ is most commonly used in policy documents in the Pacific region and is therefore what we have used in these reports.

Executive summary

In 2015, the United Nations set an ambitious agenda of Sustainable Development Goals (SDGs) to address poverty, injustice, and environmental destruction. Through the SDGs, nations committed to gender equality and health and notably established universal access to sexual and reproductive health and rights (SRHR) as a global target. Additionally, and relatedly, the SDGs include a specific target to ‘eliminate all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation’ (UN General Assembly, 2015). While laws and policies alone cannot achieve these targets, scholars and practitioners agree that an enabling legal and policy environment continues to play an important role in advancing SRHR and eliminating gender-based violence (GBV).

Review of the policy and legal landscape for realising SRHR and preventing and responding to GBV is a high priority for the Pacific region. Governments in the Pacific have committed to international and regional strategies to address SRHR and GBV, but there is a need to analyse existing national legislative and regulatory frameworks to identify the ways policy and legislation may work to support SRHR and prevent GBV, or conversely may undermine appropriate services and responses. For instance, many Pacific countries have plural legal systems that draw upon multiple sources of law, which may lead to conflict between statutory and customary law. This can particularly impact policies and laws related to SRHR and GBV (McGovern et al. 2019; Garcia-Moreno et al. 2015). Consequently, the UNFPA Pacific Regional Support Office commissioned a review of SRH and GBV related legislation and policy in six Pacific countries—Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. This report summarises findings from the review undertaken for Fiji and offers key legislative and policy recommendations to help promote SRHR and reduce GBV in Fiji.

Background

Located in the South Pacific, Fiji consists of about 330 islands and over 500 islets. The country became an independent republic in 1970 and has often faced political instability and ethnic tensions. While nearly half of Fijians live in rural areas, that proportion is decreasing while the urban population is rapidly growing. This shift, along with limited access to basic health infrastructure—such as sanitation systems or unpolluted water—creates various service planning and delivery challenges. Domestically, Fiji maintains a common law legal system inherited from British colonial rule. However, the traditional conciliation practice of bulubulu also occurs in many iTaukei villages and is a process through which community members can atone for wrongs and foster healing. At the international level, Fiji is party to CEDAW, CRC, CRPD, ICCPR and ICESCR. These distinct factors all impact policies and legislation related to SRHR and GBV in Fiji.

Methods

The purpose of this study was to identify and analyse policies and legislation related to SRHR and GBV in Fiji. The study consisted primarily of a desk-based review, which examined national legislation, policies, peer reviewed literature, and other published reports relevant to SRHR and GBV in Fiji. Document search and retrieval occurred from July 2020 to July 2021. The second stage of the review involved a content analysis of the included documents. The analysis focused on key domains and corresponding indicators adapted from themes under SDG Indicator 5.6.2 and commitments under international frameworks (such as the 1994 ICPD Programme of Action), and conventions, including those relevant to priority populations outlined in the CRPD and the CRC.

Key findings

Gender equality and non-discrimination

- The *Constitution* in Fiji does not specifically guarantee gender equality, but it does assert that a person must not be discriminated against on the grounds of personal characteristics or circumstances, including sex, gender, sexual orientation, gender identity and expression, disability, marital status, or pregnancy.
- Additionally, the *National Gender Policy (2014)* establishes a general framework to promote gender sensitive approaches and policies across government ministries and in civil society.

Sexual and reproductive health and rights

- Desk review findings indicate that current legislation and policy in Fiji partially contribute to an enabling environment to promote SRHR, but gaps remain. Importantly, Fiji lacks a current national SRH policy, with the *Reproductive Health Policy (2010)* serving as the most recent strategy. However, the authors acknowledge a new Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy is under development at the time of writing.
- In the domain of sexual health, Fiji has taken significant steps to increase its HPV vaccine coverage, and the HPV vaccine is now administered to girls via schools. However, there is currently no policy, guidelines or strategy on cervical cancer prevention or elimination. Additionally, the *HIV/AIDS Act 2011* notably prohibits discrimination based on HIV status and guarantees the rights to full informed consent, pre and post-test counselling, availability of testing, and confidentiality regarding HIV testing results.
- While legislation and policies do not restrict access to contraception and family planning services, findings suggest a lack of explicit and substantial guarantee of these services in Fiji. For example, there is no standalone law that mandates access to contraceptive services. Additionally, the *Reproductive Health Policy (2010)* includes key targets around family planning service provision, but this has not been updated since 2010. There is a lack of clear policy or clinical guidance to support the evolving capacity of adolescents to consent to contraceptives.
- Findings also reveal substantial policy and legislative gaps in the provision of comprehensive sexuality education (CSE) in Fiji. There is no specific legislative mandate for CSE in the national Fiji school curriculum. Additionally, while the National Gender Policy (2014) establishes a target for family life education (FLE) in all secondary schools (with FLE concepts also covered in primary schools through Healthy Living classes), the FLE curriculum is not sufficiently comprehensive (as assessed against the UNESCO Sexual Education Review and Assessment Tool) and does not focus on gender roles and drivers of inequality in particular.
- In the domain of maternal health, while the *Constitution* broadly enshrines the right to access reproductive health care, there is no law that explicitly mandates access to maternity care. The *Reproductive Health Policy (2010)* also includes provisions for maternal health but there is no current work plan available.
- Compared to other Pacific countries, the legal framework around abortion in Fiji is less restrictive, but gaps remain. The *Crimes Act 2009* allows medical practitioners to perform the procedure to save a woman's life, to preserve a woman's physical health, and to preserve a woman's mental health, in cases of rape. It is important to note, however, in certain cases the law does require third-party authorisation for the procedure (for example parental or judicial consent for a minor), which may constitute a barrier to

access. Furthermore, legislation does not guarantee access to post-abortion care, which could especially impact women who undergo unsafe or 'clandestine' abortions.

Gender-based violence

- This desk review suggests that Fiji has instituted important policies and legislation to reduce GBV, but barriers persist. One major gap is that Fiji lacks a primary national strategy on GBV, although the *National Action Plan to Prevent Violence Against All Women and Girls (2021-2026)* is currently under development. Instead, Fiji relies on a patchwork of policies and guidelines to address GBV, including the *National Gender Policy (2014)* and the *Women's Plan of Action (2010-2019)*. This decentralised approach can produce challenges, especially with GBV data collection, resourcing, and budgeting.
- Findings indicate some legal gaps regarding domestic violence in Fiji. For example, while the *Sentencing and Penalties Act 2009* allows judges to consider domestic violence as an aggravating factor in enhancing punishment in criminal offences, it also allows mitigating factors to be considered in sentencing.
- The *Crimes Act 2009* criminalises sexual assault and rape and establishes a relatively broad definition of rape that includes non-consensual penetration of the genitals, anus, or mouth. The Act also incorporates a reasonably comprehensive definition of consent and asserts that a person's submission without physical resistance cannot alone constitute consent. However, one gap is that legislation does not explicitly clarify if these provisions apply to non-consensual sex within relationships.
- The *Responding to Intimate Partner Violence and Sexual Violence Against Women and Girls (2015)* establishes clinical guidelines to support the health sector response to GBV. Additionally, the *National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018)* outlines protocols for trauma-informed and survivor-centred identification and management of GBV.
- From an overarching legal perspective, it is also important to note Fiji's plural legal system and the lack of clarity around application of state laws with traditional rules or custom. For instance, legislation implies that customary practices of forgiveness could be used to influence criminal prosecution or sentencing, although the *Criminal Procedure Act 2009* notes that the promotion of reconciliation will not apply to domestic violence offences.

SRH and GBV in key populations

- Adolescents and youth: Various policies and laws contribute to help promote SRHR and reduce GBV for adolescents and youth in Fiji. For instance, the *HIV/AIDS Act 2011* explicitly legislates for adolescent access to voluntary HIV testing and treatment. Additionally, the legal minimum age for marriage is 18 years, and consent to marriage is required. Education is also compulsory for boys and girls aged 6 to 15 years, and the *Constitution* guarantees the right to primary and secondary education. However, there are a number of key gaps or barriers identified in this review:
 - While the age of sexual consent is 16 years, the *Crimes Act 2009* considers it sufficient defence if the perpetrator argues that they believed the person was above 16 in cases involving minors between the ages of 13 and 16—suggesting a need to review this Act to ensure young people are adequately protected.
 - There are no legislative protections preventing expulsion of girls from school on the grounds of pregnancy.
 - There is an absence of legislative guarantee and policy guidance on adolescent access to SRH services.

- People with disabilities: There is notable legal and policy support for the needs of people with disabilities in Fiji. The *Constitution* prohibits discrimination based on disability, and the *Fiji Disability Action Plan (2002)* broadly refers to the right to access health and live free from violence. Nevertheless, opportunities for improvement exist. For instance, while the *Rights of Persons with Disabilities Act 2018* importantly guarantees the right to SRH and to retain fertility, findings suggest that consent to medical intervention (e.g., contraception) may not always be realised in practice, implying a need for further legislative and policy review in partnership with persons with disabilities.
- LGBTIQ people: There is evidence of legislative and policy progress to support LGBTIQ people in Fiji. Indeed, Fiji adopted legislation in 2010 to decriminalise consensual same-sex relationships, and the *Constitution* prohibits discrimination based on gender and sexual orientation. However, legal gaps remain; for example, the *Family Law Act 2003* does not apply to LGBTIQ relationships. Furthermore, opportunities exist to specifically address the needs of LGBTIQ people in key SRH and GBV policies.
- Sex workers: Findings reveal extremely limited relevant policy provisions for sex workers in Fiji. The criminalisation of sex work (*Crimes Act 2009*) creates barriers to accessing SRHR and increases sex workers' vulnerabilities to violence. To that end, the *National Strategic Action Plan on HIV and STIs (2016-2020)* includes an action to lobby for policy change and decriminalise sex work, but the extent to which this has progressed is unclear.

Humanitarian and disaster contexts

- Current policy and legal structures in Fiji partially incorporate SRHR and GBV in humanitarian and disaster contexts but could benefit from more explicit provisions. For example, the *National Disaster Risk Reduction Policy 2018-2030* notes the need to access SRH and GBV services, and the *National Humanitarian Policy 2017* discusses the requirement for the cluster system. However, current disaster and emergency policy and legislation do not specifically require integration of the Minimum Initial Service Package (MISP) for SRH and the Minimum Standards for Prevention and Response to GBV in Emergencies.

Conclusion and recommendations

General recommendations

- Review and repeal old, and create new, national legislation in line with human rights obligations and international commitments. Any legislative reform should be approached in a comprehensive and integrated manner involving consultation with civil society and key population groups, including gender impact assessment to understand possible unintended consequences.
- Ensure institutional mechanisms are resourced to allow effective planning, monitoring and review such as the policy and planning units within the Ministry of Health and Medical Services and the Ministry of Women, Children and Poverty Alleviation, inter-agency committees and the taskforce for the Elimination of Violence Against Women (EVAW).
- Strengthen mechanisms for data collection to support monitoring and evaluation of policy and legislative implementation to ensure annual targets are met and allow evidence-based reform (health management information systems (HMIS), GBV and SRH, interoperability of administrative data systems and collection of GBV service data).
- Further develop a national strategy to address harmful and discriminatory gender stereotypes in partnership with women's organisations, LGBTIQ groups, disabled people's organisations, community leaders, schools, faith-based organisations, and the media. Part of this should include considering ways to strengthen the definition of discrimination against women in the Constitution and the possibility of a standalone Gender Equality law.

SRHR recommendations

- Prioritise the finalisation of the new RNMCAH policy. This should include:
 - a clear definition of sexual and reproductive health and rights in line with the ICPD and an integrated essential service package (for example, based on the Guttmacher Lancet commission).
 - The accompanying workplan should set clear, measurable targets that are adequately costed, reviewed, and updated annually.
 - Special provisions should be integrated for particularly vulnerable groups including adolescents and youth, people with disabilities, LGBTIQ communities, and sex workers, recognising the unique barriers they experience to accessing SRHR.
 - Ensure that the policy clearly links to sexual and reproductive health in emergencies (SRHiE), acknowledging the importance of prepositioning and long-term preparedness including the ability to pivot from ongoing integrated SRHR services to initial SRH services in emergencies (e.g., MISIP) and back again.
 - Clearer directives for health providers on consent for access to contraceptives (including emergency contraception) for adolescents.
 - Evidence-based resourcing (e.g., health readiness assessments).
 - Examine the private sector's role in health service provision to ease burden on government services in line with the NDP, recognising the important role of CSOs in community-based SRHR.
- Consider legislating for guaranteed access to contraception, family planning and maternal health services with specific directives on ensuring access for adolescents and youth and marginalised population groups. Legislation should include provision for full, free and informed consent for services (including contraception), taking into consideration the evolving capacity of adolescents in line with

international best practice. In the case of Fiji, new legislation could use the existing *HIV/AIDS Act 2011* as an example.

- Consider legislating that integration of comprehensive sexuality education (CSE) into the national curricula be mandatory, and the CSE curriculum include a comprehensive range of topics (as outlined in the UN International Technical Guidance on Sexuality Education and the UNESCO Sexuality Education Review and Assessment Tool).
- Further research into the SRH needs of sex workers and barriers impacting on access to SRH services to inform advocacy, policy and possible law reform. Better understand legislative implications of SRH services for women in sex work (e.g., risk of prosecution) and multisectoral partnerships for referral into exit programmes and alternative income generating opportunities.
- Following the proposed action in the *National Strategic Action Plan on HIV and STIs (2016–2020)*, consider steps towards decriminalising sex work. In view of clear evidence that the criminalisation of sex work leads to poorer sexual and reproductive health outcomes for both sex workers and their clients, and to significant risk to the personal physical safety and health of sex workers, decriminalisation would decrease stigma and increase women's access to SRH information and services.
- Conduct further research into the impacts, causes, and consequences of unsafe abortion practices. Legislate for access to post-abortion care, regardless of legality of abortion, ensuring that women are not liable to prosecution.
- Consider development of a costed cervical cancer elimination policy aligned to the current WHO Cervical Cancer Elimination Strategy, in order to guide and evaluate programming and enable coordination of partner efforts.
- Further research should be conducted to understand how legal and policy provisions for the SRHR of persons with disabilities in Fiji are implemented and monitored in practice. This should include looking at the accessibility of services; service providers awareness and understanding of the CRPD and the Rights of *Persons with Disabilities Act 2018* and obligations therein in relation to SRH; and understanding the specific barriers experienced by people with disabilities themselves to accessing SRHR.

GBV recommendations

- Prioritise the development of the *Fiji National Action Plan to Prevent Violence Against All Women and Girls* and an aligned institutional mechanism to ensure its effective implementation. This should include resourcing and strengthening GBV data collection (both administrative service level data and population data); and ensuring adequate resourcing and allocation of budget.
- In consultation with community leaders, consider reforming the *Sentencing and Penalties Act 2009*, and related legal mechanisms, to ensure that *bulubulu*, or any other inappropriate reason, is no longer considered as a mitigating factor in sentencing rape or cases of domestic violence. Additionally, review the provisions which allow for the involvement of traditional and community leaders in identifying and reviewing sentences for those found guilty of offences, with a view to developing explicit guidelines and regulations, in consultation with community leaders, which limit the range of circumstances where leaders' involvement is allowed, recognising the seriousness of domestic violence cases (s 54).
- Considering the feedback from the Auditor General in future iterations of the Women's Plan of Action to give greater strategic priority and focus to primary and secondary prevention of violence outcomes

that address the drivers of gender-based violence, to align more closely with the Beijing Platform for Action 1995.

- In line with recommendations from the Auditor General, review the *Domestic Violence Act 2009*, with a view to addressing the ways that the gender neutrality of the provisions may unequally and unfairly impact women. This will require investment in exploring the unintended consequences of current legislation on key groups and ensuring a highly consultative approach to any further reforms.
- In addition to the protections in place with the minimum marriageable age, criminalisation of early marriage, and the requirement of full, free and informed consent of both parties to marriage, consider criminalising forced marriage, recognising that it is a serious breach of human rights and a form of GBV.
- Consider strengthening the legislative protections in place against intimate partner sexual assault by providing that sexual assault provisions apply 'irrespective of the nature of the relationship' between the perpetrator and complainant; or stating that 'no marriage or other relationship shall constitute a defence to a charge of sexual assault' under the legislation.
- Review the *Family Law Act 2003* with a view to expanding protections that apply to the LGBTIQ community.
- Review *Crimes Act 2009* with a view to criminalising and incorporating specific provisions for sexual harassment.
- Consider reviewing the provision in the *Crimes Act 2009* s 215(2) for mistaken age defence in cases of sexual relations with minors between the ages of 13 and 16 with a view to creating greater onus on the defendant to ascertain age, for example by adding a 'reasonable steps' requirement.
- Conduct further research on reproductive coercion (including integrating reproductive coercion questions into national violence against women (VAW) surveys) as a starting point to inform appropriate policy and legislative measures.
- Review GBV responses across ministries to ensure alignment with the 2018 national service delivery protocol for GBV.

Humanitarian and disaster recommendations

- Ensure that there are specific provisions in relevant health and related disaster policy and legislation to require the MISP for SRH objectives and related indicators to be embedded.² Ensure this is situated in a broader health policy that strengthens health systems as part of SRH preparedness and readiness.
- Ensure new policy such as the forthcoming *Fiji National Action Plan to Prevent Violence Against All Women and Girls* explicitly considers GBV in emergencies. Ensure GBViE standards are embedded in policy and legislative frameworks and national cluster guidance to specific actors providing ongoing lifesaving services. This should include government and non-government services.
- Consider integrating SRHiE and GBViE standards in policies relating to disaster as they are due for review. Include measures to prevent sexual exploitation, abuse and harassment. In particular, the forthcoming *Disaster Management Framework* provides an opportunity to draw on existing international

2 Consider assessing feasibility of embedding in policy a requirement for the Government of Fiji to periodically assess readiness for implementing the MISP.

and regional commitments, such as KAILA, and explicitly commit to MISP, essential services standards, and GBViE standards.

- Ensure national fiscal and budget policy includes gender and emergencies responsive budgeting, especially SRHiE and GBViE budget disaster planning for the most marginalised communities and individuals.

1 Introduction

1.1. Background and objectives

In 2015, the member states of the United Nations adopted 17 Sustainable Development Goals (SDGs) to address poverty, discrimination, abuse, preventable deaths and environmental destruction. Universal access to sexual and reproductive health and rights (SRHR) is among the global targets of the SDGs, reflected primarily under the goals for health and gender equality (UN General Assembly, 2015). SDG Targets 3.7 and 5.6 in particular call for universal access to SRHR, in line with the 1994 International Conference on Population and Development (ICPD) Programme of Action, the Beijing Platform for Action and their respective review conferences, as a precondition for achieving gender equality and empowering all women and girls (UN Population Fund [UNFPA], 1995; United Nations, 1995).

The SDGs also include a specific target, 5.2, to ‘eliminate all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation’ (UN General Assembly, 2015). This is consistent with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (UN General Assembly, 1979), to which Fiji is a signatory, and the Declaration on the Elimination of Violence Against Women (UN General Assembly, 1993). Legislation criminalising violence against women scaffolds the right of women to live free from violence. While recognising that laws alone are not enough to eliminate violence, legal sanctions can act as a deterrent and legislation can be responsive to victims by providing protection and access to support services (Klugman, 2017). The realisation of SRHR requires that women and girls live free from violence, with research repeatedly demonstrating the close and consistent relationship between exposure to violence and sexually transmitted infections, unintended/unplanned pregnancy, abortion, an increased number of sexual partners, and women not having reproductive autonomy (Grose et al., 2021). In addition, particular violations of women’s SRHR (including but not limited to forced sterilisation, forced abortion, forced pregnancy, and denial of SRH services) may in themselves constitute forms of violence against women.

Many nation states, including a number in the Pacific, have plural legal systems in which multiple sources of law are drawn upon simultaneously, for example customary or religious law alongside statutory law. These plural systems can in some cases lead to contradiction in the interpretation or enforcement of laws and can undermine constitutional and statutory provisions that seek to address discriminatory or harmful practices. This is particularly evident in relation to gender justice, SRHR, and violence against women (McGovern et al., 2019; García-Moreno et al., 2015). In some countries, constitutional laws and legal structures sustain and foster discrimination in relation to SRHR and GBV, for example undermining women’s ability to freely enter or leave marriage, requiring third-party authorisation to access services, restricting access to particular health services (such as abortion), and by not recognising all forms of GBV. Legislative review has been recommended to address high rates of GBV and discrimination faced by women and minority groups in the Pacific (Chetty & Faletua, 2015).

Stigmatisation and criminalisation of some sexual behaviour and SRHR services and entitlements influences people’s health-seeking behaviour (UNFPA, 2019a). This in turn impacts on demand for SRH services including family planning (UNFPA, 2019a). Given the scope of factors that shape individuals’ health care-seeking behaviour, it is vital to “promote policies, laws and initiatives that support non-stigmatizing, culture- and gender-responsive SRHR programmes and services” (UNFPA, 2019a, p.26). While governments in the Pacific have committed to international and regional strategies to address SRHR and GBV, there is a need for further analysis of current barriers and enablers arising from existing national legislative and regulatory

frameworks. The ability to achieve universal access to SRHR and elimination of GBV hinges on a supportive legal and policy environment.

A review of SRH and GBV legislation and policy has been undertaken in six Pacific Island countries, including Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. These reviews contribute to UNFPA's work in the Pacific that aims to support countries to meet human rights commitments, progress towards the SDGs, ICPD 1994 Programme of Action and ICPD25 national commitments, and commitments related to the UN High-level Meeting on Universal Health Care (2019).

Specifically, these reviews sought to address the following questions:

1. What national laws, regulations, and policies exist in each of the six Pacific Island countries that govern (a) access to sexual and reproductive health; and (b) prevention of and protection from gender-based violence?
2. What are the key factors influencing universal access to sexual and reproductive health and prevention of and response to GBV that may emerge as a result of existing legislative and policy frameworks in each of the six Pacific Island countries?
3. What are the legislative and policy gaps in the protection and promotion of the right to SRH and the elimination of GBV in each of the six Pacific Island countries?

This report provides a summary of findings from the review undertaken for Fiji and key recommendations for further legal reforms and policy strengthening in relation to SRHR and GBV.

1.2. Methods

This study was primarily a desk-based review and analysis of policies and legislation related to (a) sexual and reproductive health and rights and (b) intersecting GBV in Fiji. The review encompassed national legislation, policies, peer reviewed literature and other published reports relevant to SRHR and GBV in Fiji (see references for full list of sources).

Legislation is used throughout the report to refer to legally enforced and enforceable Acts, Bills, subsidiary regulations and orders made under the Acts and the *Constitution*. Policies refer to government documents that provide a policy statement, position or guidance and broadly includes policies, plans and strategies.

The documents were identified through a systematic search of relevant databases including Scopus, HeinOnline, AGIS, and other online sources, including Pacific Islands Legal Information Institute (PacLII databases). Refer to search terms in Annex 1.

Document search and retrieval was undertaken over the period April to October 2020.

Government websites were searched for up-to-date policies, legislation and reports, some linking directly back to PacLII. Lastly, general Internet searches were conducted to capture any other relevant reports and grey literature. UNPFA country focal points were contacted to provide assistance in accessing any policy documents, legislation or relevant reports not accessible online. Documents were categorised by type and analysed for relevance.

Table 1: Documents reviewed during the development of the Fiji report

| Source | Results | Omitted | Reviewed | |
|-----------------|--|---------|------------|-----|
| Databases | Scopus | 319 | 173 | 146 |
| | HeinOnline | 35 | 14 | 21 |
| | AGIS | 6 | 2 | 4 |
| | Index to Legal Periodicals and Books (H.W. Wilson) | 6 | 6 | 6 |
| Book chapters | | | 5 | |
| Grey literature | | | 46 | |
| Total | | | 228 | |

The second stage of the review involved a content analysis of included documents. Analysis was completed according to key domains and corresponding indicators (refer to Table 2 under Section 3, Summary of Key Findings) adapted from:

1. Themes under SDG Indicator 5.6.2 (Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education), including access to maternity care, contraception and family planning, comprehensive sexuality education and information, sexual health and wellbeing.
2. Commitments under international frameworks and conventions, particularly the 1994 ICPD Programme of Action and respective review conferences and the CEDAW, general recommendations 19 (1992) & 35 (2017) provisions intersecting with SRHR.

While it is beyond the scope of this report to review commitments in relation to all international and regional instruments to which Fiji is party, the report does consider commitments relevant to priority populations as outlined in the CRPD (to which Fiji acceded in 2010), and the CRC (to which Fiji acceded in 1993).

Additionally, feedback was sought from relevant stakeholders in the field of SRHR and GBV in Fiji, which aimed to ensure the accuracy and comprehensiveness of the report, and relevance of recommendations.

1.3. Limitations

There are a number of limitations of this review that need to be considered when interpreting findings and recommendations:

- The review focuses on the existence (or otherwise) of SRH and GBV policy and legislation. It was beyond the scope of the review to explore the implementation, enforcement and effectiveness of the documented policy and legislation.
- The documentation search was limited to documentation available online and in English. While effort was made to access documents referred to in literature not available online through UNFPA country focal points, it was not possible to complete a more comprehensive search of hard-copy or other documents not publicly accessible in the available time.

- The study did not cover all implementation level documentation such as practice guidelines or sub-national documents that may have included more specific guidance on SRH and GBV.
- There are likely to be initiatives at a country level to address particular priorities and gaps in current national policy and legislation, including sub-national initiatives. As the scope of this review is on national level legislative, policy and strategic planning documentation, such initiatives may not be captured here.
- While the review did incorporate GBV legislation and policy in so far as it intersects with SRHR, it cannot be considered a comprehensive GBV legislative review in its own right. The review did not comprehensively cover for example access to justice, sentencing, and policing.

2 Country profile

2.1. Background

Fiji is made up of about 330 islands and over 500 islets, with a population of around 900,000 people. Fiji became an independent republic in 1970, but retained a common law legal system inherited under British colonial rule. Fiji has a history of political instability and ethnic tensions with four coup d'états (1987 [two], 2000 and 2006) and four different constitutions since independence (Burness, 2013). In the most recent 2006 coup, Josaia Voreqe 'Frank' Bainimarama was installed as military commander. An election was held in 2014 officially instating him into power and he has retained power through the 2018 election as leader of the Fiji First party. However, both local and international commentators have noted the fragility of Fiji's democratic institutions, particularly in light of restrictions on the media (O'Sullivan, 2018).

Fiji is a multiracial and multicultural country. The Fijian population comprises 57 per cent iTaukei peoples (indigenous Fijians) and 37 per cent Indo-Fijians (descendants from indentured labourers transported by the British). The remainder of the population are Chinese, Caucasians, and other Pacific Islanders (Fiji Bureau of Statistics, 2007).

The Fijian constitution protects the use of iTaukei language, Fiji Hindi, and English; however, English tends to be the language common to all. Section 31(3) of the Constitution provides that both iTaukei and Fiji Hindi shall be compulsory subjects in primary schools. The majority of iTaukei identify as Christian and most Indian Fijians are Hindu with a minority identifying as Muslim (World Health Organization [WHO], 2011).

Under the *iTaukei Land Trust Act 1940*, the majority of the nation's land (91 per cent) is controlled by iTaukei peoples and administrated by the iTaukei Land Trust, with such being available for lease but not sold (iTaukei Land Trust Board, 2020).

Fiji is divided into four divisions—western, central, eastern and northern—with the highest percentage of the population residing in the central division, where the capital, Suva, is located (Cammock et al., 2018). These divisions are further divided into 14 provinces, in addition to the island of Rotuma which retains a degree of independence (Corrin & Cappa, 2015). Census data show that 44 per cent of Fijians live in rural areas; however, that proportion is decreasing. Between 2007 and 2017 the urban population increased by 16.3 per cent, while the rural population decreased by 5.1 per cent (Fiji Bureau of Statistics, 2018).³ The rate of total births per woman has stabilised over the last decade; in 2018 it was 2.8 (World Bank, 2020). Life expectancy has steadily been increasing albeit at a slow rate with the average life expectancy currently reaching 67 years (World Bank, 2020).

Fiji is considered a middle-income nation and ranks 93/189 countries in the Human Development Index (UNDP, 2020). In 2008, it was reported that fewer than 50 per cent of Fijians were able to access basic health infrastructure, such as sanitation systems or unpolluted water (O'Brien and Farran, 2015). Many Pacific region non-government organisations (NGOs) and multilateral agencies are based in Fiji due to its central location and connectedness with other nations through air travel and technological communications.

3 This change is due to both people leaving rural areas and also an extension in the urban boundaries (Fiji Bureau of Statistics, 2018).

2.2. Legal frameworks

2.2.1. The legal system

The *Constitution of the Republic of Fiji* ('*Constitution*') establishes Fiji's system of government, providing for three separate arms of the State—the legislature (parliament), the executive (the administrative arm of government) and the judiciary (the legal branch of government). Parliament is the legislative branch of the state under which laws are passed, made up of elected members either independent or, in the majority of cases, belonging to a political party. The judiciary is responsible for interpreting and enforcing the laws of Fiji. The *Constitution* makes the judiciary independent from other arms of the government with authority exercised through the court system. The courts include the Supreme Court, the Court of Appeal, the High Court, the Magistrate Courts and other courts and tribunals that may be created through the law (Parliament of the Republic of Fiji, n.d).

2.2.2. The Constitution

The most recent *Constitution* of Fiji was drafted in 2013, retaining some provisions from the 1999 constitution, such as chapter 2 (the 'Bill of Rights') and the establishment of the Human Rights and Anti-Discrimination Commission (HRADC). Fiji is a dualist state and as such, international legal conventions once ratified are required to be incorporated into domestic law through the legislature. Notwithstanding this, section 7(1) of the *Constitution* states that when interpreting and applying the *Bill of Rights*, courts may 'consider international law, applicable to the protection of the rights and freedoms' of Fijians. This has enabled courts to consider international treaties and conventions in their interpretation of constitutional rights, even where such international laws have not been expressly incorporated into domestic law. This is critical as an avenue for accountability, redress, and recourse where there may be gaps or contradictions to international commitments in national legislation.

Importantly, rights to sexual and reproductive health are subject to broad constitutional protection in Fiji. The *Constitution* includes the right to health under section 38(1), which specifically mentions reproductive health, requiring the government to:

'take reasonable measures within its available resources to achieve the progressive realisation of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, *including reproductive health care*' (emphasis added).

Where the government does not have the resources to guarantee this right, the government must demonstrate that such resources are not available (s 38(3)). What is more, s 41(1)(c) specifically protects the right of children to access basic health care (s 41(1)(c)).

Although there is no express statement of the equality of women and men in the Fijian *Constitution*, it is founded on values that underpin gender equality, including: common and equal citizenry; respect for human rights, freedom and the rule of law; an independent, impartial, competent and accessible system of justice; equality for all and care for the less fortunate; and human dignity, respect for the individual, personal integrity and responsibility, civic involvement and mutual support. These values inform the *Bill of Rights* contained in ch 2 of the *Constitution*.

The Bill of Rights contains several key rights that relate to gender equity and GBV:

- Section 11(2) protects the rights of persons to live **free from violence**: '(2) Every person has the right to security of the person, which includes the right to be free from any form of violence from any source, at home, school, work or in any other place.'
- Section 26 sets out certain rights 'to equality and freedom from discrimination', both direct and indirect (s 38 under the 1997 *Constitution*). Section 26(3)(a) prohibits discrimination based on 'supposed personal characteristics or circumstances, including race, culture, ethnic or social origin, colour, place of origin, sex, gender, sexual orientation, gender identity and expression, birth, primary language, economic or social or health status, disability, age, religion, conscience, marital status or pregnancy'. Unlike some other rights and freedoms which can be limited during states of emergency (under s 43), the *Constitution* does not allow s 26 to be limited in these circumstances. However, s 26(8) does set out some exceptions to the protections provided for in s 26(3)(a), including for any law or administrative action that concerns marriage, adoption or the devolution of property on death. Although freedom of speech is protected in s 17, hate speech that is discriminatory and 'constitutes incitement to cause harm' is a limit on this freedom.
- Access to justice in a court of law is also protected in the *Bill of Rights* (s 15), as are the principles of national justice (s 16). The Legal Aid Commission, which provides free legal services across Fiji, was established under s 118 of the *Constitution*. Section 15(10) outlines that the State 'must provide legal aid through the Legal Aid Commission to those who cannot afford to pursue justice on the strength of their own resources, if injustice would otherwise result'.

Pursuant to these provisions, Fiji's constitution also protects persons with disabilities and LGBTIQ communities to live a life free of gender-based violence and discrimination and to access justice.

The *Constitution* sets out specific protection of the rights of children under s 41(1)(d): 'Every child has the right to be protected from abuse, neglect, harmful cultural practices, any forms of violence, inhumane treatment and punishment, and hazardous and exploitative labour'. Furthermore, under s 41(2) the best interests of the child are the 'primary consideration in every matter concerning the child,' incorporating international law obligations.

The Human Rights and Anti-Discrimination Commission (HRADC), also governed by the *Human Rights Commission Decree 2009*, is responsible for monitoring Fiji's compliance with human rights obligations and making recommendations to government about existing and proposed laws that affect rights and freedom. The commission has the power to investigate matters on its own initiative and complaints received that relate to human rights violations and discrimination. It cannot make enforceable determinations; however, it can make applications to court for legal remedies or redress. It should be noted that, as an institution, the HRADC has been criticised for failing to comply with the 1993 Paris Principles on a number of bases: it is unable to investigate the validity of decrees made by the President; appointment processes lack transparency; and it has limited resources to adequately investigate complaints and reach the broader Fijian population (UNHRC, 2019b).

2.2.3. Relevant commitments and human rights conventions

The SDGs were set in 2015 by the United Nations General Assembly, with Fiji adopting the 2030 Development Agenda at this time. Targets that Fiji has committed to under the SDGs, specifically relevant to this review, are shown in Table 2 below, alongside their internationally agreed indicators:

Table 2: Relevant SDG targets and indicators

| SDG target | Aligned indicators |
|--|--|
| 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births | 3.1.1 Maternal mortality ratio and rate 3.1.2 Proportion of births attended by skilled health personnel |
| 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births | 3.2.2 Neonatal, infant, and under-5 mortality rates |
| 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases | 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations |
| 3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes | 3.7.1 Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (10-14 years, 15-19 years) per 1,000 women in that age group |
| 5.2 Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation | 5.2.1 Proportion of ever-partner women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence |
| 5.3 Eliminate all harmful practices, such as child early and forced marriage and female genital mutilation | 5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18 5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age |
| 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population Development and the Beijing Platform for Action and the outcome documents of their review conferences | 5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care 5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care information and education |

This review will prepare Fiji to report against SDG indicator 5.6.2 in particular.

Fiji was one of the first of the Pacific nations to ratify CEDAW, doing so on 28 August 1995. However, it has not ratified the CEDAW Optional Protocol which sets up a mechanism for individuals to submit complaints to the Committee on the Elimination of All Forms of Discrimination against Women. In the past decade in particular, Fiji has become party to key international human rights conventions, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 2018, and the CRPD in 2010.

The right to health generally is an economic, social and cultural right, contained within the ICESCR (art 12). More specific to sexual and reproductive health, CEDAW contains articles concerned with reproductive health, obliging state parties to ensure 'access to health care services, including those related to family planning' and access to 'appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (art 12). The CRPD also outlines the right for persons with disabilities to access the same health care as other persons, including sexual and reproductive health (art 25). Though not legally binding, Fiji has also signed the UN Declaration of Commitment on HIV/AIDS (2001) which sets out various commitments in relation to coordinated leadership, prevention and response, including measures to address gender-based violence.

Many CEDAW obligations have not been comprehensively translated into domestic legislation; however, some obligations have been incorporated into policy, such as the *National Gender Policy (2014)*. Courts have been willing to draw on international obligations in their interpretation of women's rights in light of s 7(1) of the *Constitution*, which enables the judiciary to refer to international law when considering breaches of the *Bill of Rights* (Farran, 2015; O'Brien and Farran, 2015; Zorn, 2016). CEDAW has been particularly important in informing the Fijian Courts' interpretation of the constitutional right to freedom from discrimination in sexual and gender-based violence cases. For example, in the case of *Balelala v State [2004] FJCA 49*, the Court found that the requirement that the Court caution against accepting rape and sexual violence victims' testimony where the evidence was uncorroborated ('the corroboration rule') discriminated unlawfully against women in breach of s 26 of the *Constitution*, read alongside international law under CEDAW. This finding in this case was affirmed by the legislature in the *Criminal Procedure Act 2009* (s 129): 'Where any person is tried for an offence of a sexual nature, no corroboration of the complainant's evidence shall be necessary for that person to be convicted; and in any such case the judge or magistrate shall not be required to give any warning to the assessors relating to the absence of corroboration.' The *Balelala* case evinces a willingness on the part of Fijian courts to incorporate international human rights commitments and principles into Fijian law.

Fiji also ratified the Convention on the Rights of the Child (CRC) in 1993, which protects a child's right to live free from violence. Fiji has recently further ratified the CRC's optional protocols on the involvement of children in armed conflict and on the sale of children, child position and child pornography. Under article 19 of the CRC, parties 'shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.'

The CRC has not been expressly incorporated into Fijian domestic law. However, there are many legal provisions that protect that rights and values of the CRC, such as non-discrimination or protection of the best interests of the child, as well as policy reforms that have sought to translate such values (Lechuga Foundation & Sexual Rights Initiative, 2010). Some of the principles and rights of the CRC have been incorporated into legislation, such as the *Domestic Violence Act 2009*, *Family Law Act 2003* and *Human Rights and Antidiscrimination Commission Act 2009*.

Courts have also been willing to draw on the CRC to protect the rights of children and have struck out

legislative provisions that are inconsistent with the Convention. Similar to the case of *Balelala v State*, international principles of non-discrimination were drawn upon by the Fijian courts to overturn the requirement that children’s unsworn testimony be corroborated in order to convict an accused. In the case of *State v AV* [2009] FJHC 18, the defendant was accused of raping a four-year-old girl and the case turned on the evidence of the child. Section 10 of the *Juveniles Act 1973* (ch 56) prohibited convictions based on the uncorroborated unsworn evidence of child witnesses. The Court found this provision of the *Juveniles Act 1973* to discriminate against children and failed to provide them with equal protection before the law, compared to adults. The Court also noted that the CRC allows for ‘judicial involvement’ where it is necessary to protect children (see [34]). Accordingly, the Court struck s 10 from the *Juveniles Act 1973*. This finding was later confirmed in the case of *Kumar v State* [2015] FJCA 32.

In contrast, in the case of *Chief Executive Officer for Education v Gibbons* [2013] FJCA 9, the Court held that the CRC can be used as guidance in cases that concern the rights of children. However, it was noted that provisions of the Convention could not form a cause of action in themselves unless incorporated into legislation.

In June 2020, Fiji became the second state to ratify International Labour Organization’s Violence and Harassment Convention (2019) legislation particularly relevant to responses to sexual and harassment and GBV in Fiji.

The following table summarises the key international conventions, relevant to this review, to which Fiji is party.

Table 3: Relevant international human rights conventions

| International instruments | Ratification |
|--|--------------------------|
| International Convention on the Elimination of All Forms of Racial Discrimination (1969) <i>See in particular Article 5 (Right to health and to live free from violence)</i> | 1973 |
| International Covenant on Civil and Political Rights (1976) <i>See in particular Article 12 (right to health)</i> | 2018 |
| International Covenant on Economic, Social and Cultural Rights (1976) <i>See in particular Article 12 (Right to health) and General Comment No 22 on the right sexual and reproductive health</i> | 2018 |
| Convention on the Elimination of All Forms of Discrimination against Women (1981) <i>See in particular Article 12 (Elimination of discrimination in access to health care services including family planning), Article 13 (2.b Access to health care facilities including family planning for rural women), Article 16 (Elimination of discrimination in marriage, including in relation to family planning and elimination of child marriage); and CEDAW Committee General Recommendation No.35 on gender-based violence against women</i> | 1995 |
| Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1987) | 2016 (with reservations) |
| Convention on the Rights of the Child (1990) <i>See in particular Article 13 (Right to seek, receive and impart information), Article 19 (Right to be protected from all forms of violence and abuse), Article 24 (Right to health and health care), Article 34 (Right to be protected from sexual exploitation and abuse). General Comment No 15 on the right of the child to highest attainable standard of health</i> | 1993 |

| | |
|--|--------------------------------|
| Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (2002) | 2021 |
| Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (2002) | 2021 |
| Convention against Transnational Organized Crime (2000) and Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000) | 2017 |
| International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (2003) <i>See in Particular Articles 16 (Right to protection by the state from violence) 28 (Right to medical treatment), 43 and 45 (Access to health services)</i> | 2019 (with a reservation) |
| International Convention for the Protection of all Persons from Enforced Disappearance (2010) | 2019 (with a reservation) |
| Convention on the Rights of Persons with Disabilities (2008) <i>See in particular Article 16 (Freedom from exploitation, violence and abuse), Article 21 (Right to information), Article 23 (Right to marriage, parenthood, family planning and retention of fertility), Article 25 (Right to health and health care, including specific SRH)</i> | 2010 |
| Optional Protocol to the Convention on the Rights of Persons with Disabilities (2008) | 2010 (signed but not ratified) |
| International Labour Organization's Violence and Harassment Convention (2019) | 2020 |

(Source: OHCHR (2020) 'Status of Ratification')

2.2.4. Regional agreements and frameworks

In addition to its obligations under international human rights conventions, Fiji has committed to various regional agreements which concern the development of sexual and reproductive health in the Pacific, such as the Pacific Youth Development Framework 2014–2023 (Pacific Community, 2015) and the Pacific Sexual Health and Well-Being Shared Agenda 2014–2019 (Pacific Community, 2014). In 2008, the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2009-2015 (Pacific Policy Framework) was developed. This framework includes specification about policies and process as well as services, supply chains and financing. Fiji endorsed the framework in a commitment to universal access to reproductive health services and contraception. Fiji has also endorsed the Moana (2013) declaration recognising the crucial role parliamentarians play in advocating for implementation of the ICPD Programme of Action. Commitments made under Moana include ensuring sexual and reproductive health is integrated into national development strategies, health plans, and national budgets, among others. In October 2015, Fiji hosted and adopted 'KAILA' Pacific Voice for Action on Agenda 2030 to strengthen Climate Change Resilience through Reproductive, Maternal, Newborn, Child and Adolescent Health. Fiji is also a signatory to other regional health frameworks including the Yanuca Island Declaration on health in Pacific Island countries and territories promoting the 'The Healthy Islands' vision, adopted by the Pacific Health Ministers in 1995.

2.3. The health system and context

The Ministry of Health and Medical Services is the principal health-care funder and provider in Fiji and oversees the development, implementation and monitoring of key health (including SRH) policies and guidelines. Health care is delivered at primary, secondary and tertiary levels. Primary health care consists of nursing stations, health centres and sub-divisional hospitals, and secondary and tertiary care is provided mostly by divisional hospitals. Nursing stations are often where people first come into contact with the health system and are generally in rural locations (Asante et al., 2017). The Family Health Unit within the Ministry of Health and Medical Services, provides oversight of maternal and child health, reproductive health, and HIV and STIs. Fiji has reportedly commenced meetings and planning to establish a Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Network to strengthen coordination and integration of SRH and child and adolescent health.

In the last two decades, there have been efforts to decentralise Fiji's health system, in order to increase community participation and access (Mohammed et al., 2016). However, whether these efforts have resulted in meaningful devolution of decision-making is questioned, suggesting that while workload has shifted from tertiary hospitals to peripheral health centres it has been accompanied by limited transfer of administrative authority (Mohammed et al., 2016; Peckham, 2016). The Ministry of Health and Medical Services Strategic Plan (2020-2025) places renewed focus on decentralisation to achieve universal health coverage (UHC) while strengthening integrated health services under a 'one system approach'.

The Ministry of Health and Medical Services receives funding predominantly from the government in addition to funding from external partners and donors such as the governments of Australia, New Zealand, China, Japan, and India; the Global Fund to fight AIDS, Tuberculosis and Malaria; the Pacific Community (SPC); the WHO; UNAIDS; UNFPA; UNICEF; and the International Labour Organization (MoHMS, 2020a). The public health system is largely funded through income tax, and private health expenditure accounts for only 25 per cent of total health expenditure (Asante et al., 2017). Reproductive health made up 6.9 per cent of the Ministry of Health and Medical Services total expenditure in 2015 with contraceptives comprising only 0.1 per cent of Ministry of Health and Medical Services expenditure in 2015 (MoHMS, 2017).

The role of the UN, NGOs and civil society in progressing a sexual and reproductive health agenda in Fiji has been significant. UNICEF, UNFPA and the WHO collaborated with the Ministry of Health (now Ministry of Health and Medical Services) in 2010 to prepare the Reproductive Health Policy. The Ministry has acknowledged the significant role that NGOs have played raising community awareness of SRH issues (Chandra, 2016). The new Ministry of Health and Medical Services strategic plan highlights the importance of partnerships with civil society organisations in servicing hard to reach areas and providing specialised services (MoHMS, 2020b). While it was beyond the scope of this review to map SRH stakeholders, a list of some of the key organisations and bodies involved in delivering SRH services in Fiji can be found in Annex 2

In addition to civil society and UN partnerships, the Ministry of Health and Medical Services' Strategic Plan (2020) emphasises the importance of a 'whole of government' approach ensuring better collaboration with other government departments on key health-related and SDG issues, including the Ministry of Education, Ministry of Women, Children and Poverty Alleviation, Ministry of Agriculture, Ministry of Rural Development, Ministry of Youth and Sports, and the Fiji Police Force, to name a few. This whole of government approach is highlighted as being particularly important in reducing sexual and gender-based violence.

The Ministry of Women, Children and Poverty Alleviation is the primary government jurisdiction responsible for creating, implementing and monitoring national GBV policy commitments in Fiji. To date there has been no overarching national strategy or action plan on eliminating GBV, however it is incorporated into a number of other policies and guidelines that will be explored further in this report. The Department of Women (DoW)

within the Ministry of Women, Children and Poverty Alleviation established an Elimination of Violence Against Women (EVAW) Taskforce in 2013 to progress interagency coordination and collaboration. Despite this and other progress made, institutional capacity to adequately plan, coordinate and monitor the implementation of key GBV policy commitments has been a challenge (Office of the Auditor General [OAG], 2019). An audit conducted by the Auditor General's Office found that institutional mechanisms including key monitoring and advisory committees proposed under the Women's Plan of Action (2010-2019) had not been established (OAG, 2019).

With the absence of a national plan or strategy, there has been no dedicated national GBV budget. Between 2014 and 2017/2018 only 1.64 per cent of the government's overall budget was allocated to the Ministry of Women, Children and Poverty Alleviation and just 0.09 per cent was allocated to the Department of Women.

As is the case with SRH, civil society and UN partnerships have been pivotal in progressing the GBV policy and legislative agenda. In particular, the Fiji Women's Rights Movement and Fiji Women's Crisis Centre (FWCC) both support monitoring and advocacy linked to women's human rights and have been engaged in CEDAW and Universal Periodic Report shadow reporting. Annex 3 summarises some of the key GBV organisations and bodies in Fiji.

3 Summary of key findings

The following table summarises Fiji's legislation and policies according to key SRHR and intersecting GBV domains. Legislation and policy is mapped against the domains according to corresponding indicators, as outlined in the methodology. The indicators are intended to identify the extent to which Fiji's current national legislation and policies align with relevant international frameworks and commitments around universal access to SRHR and eliminating GBV. It should be noted that the GBV indicators included in this review are only those which intersect most closely with SRHR.

Table 4: Summary of the sexual and reproductive health and gender-based violence desk review

| Domain | Sub-domain | Specific indicators | Status | Notes |
|--|-----------------------|--|---------|--|
| Gender equality and non-discrimination | | Constitutional guarantee of substantive equality between men and women | Partial | The <i>Constitution</i> s 26(3)(a) provides broad anti-discrimination clause including on the basis of sex and gender. The <i>National Gender Policy</i> (2014) sets out a general framework to promote gender sensitive approaches and policies across government ministries as well as in civil society, in order to address gender equality and eliminate discrimination. No detailed definition of discrimination against women in the <i>Constitution</i> or overarching legislation on gender equality. |
| | | Does the Constitution contain an anti-discrimination clause on the grounds of sex, gender, marital status, sexual orientation or disability? | Yes | The <i>Constitution</i> s 26(3)(a) A person must not be unfairly discriminated against, directly or indirectly on the grounds of his or her- actual or supposed personal characteristics or circumstances, including race, culture, ethnic or social origin, colour, place of origin, sex, gender, sexual orientation, gender identity and expression, birth, primary language, economic or social or health status, disability, age, religion, conscience, marital status or pregnancy. |
| SRH general | National SRH strategy | National sexual and reproductive health policy (or strategy) ⁴ | Partial | <i>Reproductive Health Policy</i> (2010). Ministry of Health. (Note that the status of this indicator has been assessed as partial as it has not been updated since 2010). |
| | | Does it include allocation of resources (including budget) to achieve targets and indicators to measure implementation? | No | The <i>Reproductive Health Policy</i> (2010) includes a National Reproductive Health Work Plan for 2010-2011 that outlines key targets and budget allocation; however, authors have not been able to access anything more recent at the time of this review. A new <i>Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy</i> is currently under development. |

⁴ "Recognizing that countries are in different positions in terms of resources, capacity, and the policy and legal environment, the most realistic option is for countries to commit in principle to a comprehensive approach to SRHR by adopting the definition proposed by the Gutmacher-Lancet Commission" (UNFPA, 2019a, p. 32). The Gutmacher-Lancet commission provides an outline of a comprehensive SRH essential services package in line with the ICPD Program of Action and other key international frameworks (Starrs, et al., 2018). Refer to Annex 4. Official adoption of a defined package of SRHR health services is a clear commitment that helps to ensure accountability.

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-------------|---------------------------|--|---------|--|
| SRH general | Fertility | Population policy on fertility (raise, lower, maintain) | No | There is no evidence of a population level policy on fertility rate for Fiji. |
| | | Population policy on adolescent birth rate | Partial | Outcome indicator 'reduction in unplanned adolescent pregnancy' in Section 4 Policy statements on adolescent health and development in the <i>Reproductive Health Policy</i> (MoH, 2010, p. 22). Note there has been nothing developed more recently. |
| | Adolescent and youth SRHR | Legislated equal minimum age of 18 for marriage | Yes | <i>Marriage Act (Amendment) Decree 2009</i> s 12 minimum marriageable age is set at 18 for both males and females, further the <i>Marriage Act (Amendment) Decree 2009</i> s 29 establishes marriage of a minor as a criminal offence. |
| | | Law requires full and free consent of both parties to a marriage | Yes | <i>Family Law Act 2003</i> s 32(2)(d)(i). Consent to marriage is not real consent if obtained under duress. Note forced marriage is not criminalised. |
| | | Legislated minimum age of consent to sexual activity | Yes | The <i>Crimes Act 2009</i> s 212, s 214, s 215 Age of sexual consent is 16 years. The <i>Crimes Act 2009</i> s 207 A child under the age of 13 is incapable of giving consent. Note it is a sufficient defense in cases of sexual relations with minors between the ages of 13 and 16 that the person charged had reasonable cause to believe and did in fact believe the person was of or above the age of 16 s 215(2). Concluding observations on the fifth periodic report of Fiji from the Committee on the Elimination of Discrimination Against Women recommends clearer legislative provision that the 'burden of proof regarding exculpating circumstances relating to the victims age lies with the perpetrator' (CEDAW, 2018, p. 8). Provision that it shall be sufficient defense to a charge of indecent assault that the offender was of similar age to the boy or girl and that consent to the act of indecency was given in the context of a continuing friendship s 212(3)(b). This close in age provision provides some protection of rights of adolescents. |
| | | Legislated compulsory primary and secondary education for boys and girls | Yes | The <i>Constitution</i> s 31 stating every person has the right to primary and secondary education <i>Education Act 1966</i> and subsidiary Compulsory Education Order 1997; Compulsory Education Order 1998 and Compulsory Education Order 1999 Compulsory education for 6–15-year-olds. |
| | | Legislated prohibition on expulsion from school due to pregnancy | No | No explicit protection from expulsion in current legislation. |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|---------------|--------------------|---|--------|--|
| Sexual health | STIs, HIV and AIDS | Law(s) or regulation(s) that guarantee access to: | | |
| | | Voluntary counselling and testing | Yes | <i>HIV/AIDS Act 2011</i> ss 27-33 guarantees right to full informed consent, pre and post-test counselling and availability of testing. While noting that <i>HIV/AIDS Act 2011</i> s 4 (1) states that 'provisions of any other written law are specifically inconsistent with the provisions of this Act, this Act prevails to the extent necessary for the purposes of this Act', there still exists a provision in the <i>Public Health Act 1935</i> ss 84-89 on venereal disease that allows for compulsory examination and treatment (which have not been repealed). |
| | | Treatment and care | Yes | <i>HIV/AIDS Act 2011</i> s 3(a) principles enunciated for guidance of persons and bodies acting within Fiji ensuring availability and accessibility of HIV/AIDS treatment, care and support for all persons regardless of age, gender, gender orientation or sexual orientation. The <i>National Strategic Plan on HIV and STIs (2016-2020)</i> . |
| | | Confidentiality | Yes | The <i>Constitution</i> s 24(1) guarantees the right to personal privacy including personal information and communications. <i>HIV/AIDS Act 2011</i> ss 34 – 36 guarantees the right to confidentiality regarding HIV testing results. Further, contravention of confidentiality can constitute a criminal offence (s 34(3); s 35(2); s 36(2); s 41). |
| | | No legislative restrictions to the above based on: | | No legislative restrictions to access voluntary counselling and testing, treatment and care and confidentially based on age, sex, marital status, third-party authorisation. |
| | | (a) age | Yes | |
| | | (b) sex | Yes | |
| | | (c) marital status | Yes | |
| | | (d) third-party authorization (e.g., spousal, parental/guardian, medical) | Yes | |
| | | Legal prohibition of discrimination based on HIV status | Yes | <i>HIV/AIDS Act 2011</i> ss 21-22 prohibits discrimination on basis of HIV status. While noting that <i>HIV/AIDS Act 2011</i> s 4 (1) states that 'provisions of any other written law are specifically inconsistent with the provisions of this Act, this Act prevails to the extent necessary for the purposes of this Act', there still exists provisions under the <i>Public Health Act 1935</i> ss 84-89 on venereal disease which allow for compulsory examination and treatment and restrictions to employment while suffering from an STI (which have not been repealed). |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------------------|---------------|---|---------|---|
| | HPV | Law(s) or regulation(s) mandating access to HPV Vaccine for adolescent girls? | Yes | HPV vaccine included on <i>Fiji Essential Medicines List 4th Edition (2015)</i> HPV is included on Fiji's national immunisation schedule (WHO, 2021) – administered in Class 8 to girls via schools. |
| Contraception and family planning | Contraception | Does any law(s) or regulation(s) guarantee access to contraceptive services? | Partial | No standalone law or regulation mandating access to contraceptive services, however there are some provisions in: The <i>HIV/AIDS Act 2011</i> s 26 provides that a person cannot be denied access to contraception, under section 26, it is illegal to knowingly deny a person the 'means of protection' of themselves or another from HIV The <i>Constitution</i> s 38(1) The State must take reasonable measures within its available resources to achieve the progressive realisation of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, including reproductive health care. (2) A person must not be denied emergency medical treatment. |
| | | Essential medicines include: | | Fiji Essential Medicines List 4 th Edition (2015) |
| | | Female condoms? | No | 15.7.2 Male condoms listed as only barrier method contraceptive |
| | | Contraceptive implants? | Yes | 15.7.5 Implantable contraceptives – Estonogestrel (Implanon) & Levonorgestrel (Jadelle) 15.7.6 Intrauterine devices – Copper Intrauterine TCu380A |
| | | Emergency contraception (levonorgestrel)? | Yes | 15.7.3 Levonorgestrel 0.75 mg |
| | | Law(s) or regulation(s) that guarantee the provision of full, free and informed consent for contraceptive services (including sterilisation)? | Partial | No standalone law or regulation mandating full, free and informed consent specifically to contraceptive services, however there are some provisions in: The <i>Constitution</i> s 11(3) Every person has the right to freedom from scientific or medical treatment or procedures without an order of the court or without his or her informed consent, or if he or she is incapable of giving informed consent, without the informed consent of a lawful guardian. Note that forced sterilisation and forced pregnancy are only criminalised in instances classed as 'crimes against humanity' under offences against the international order in the <i>Crimes Act 2009</i> ss 91-92, where the perpetrators conduct is committed intentionally or knowingly as part of a widespread or systematic attack directed against a civilian population. |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------------------|-----------------|--|----------------|---|
| Contraception and family planning | Contraception | Does any law(s) or regulation(s) guarantee access to Emergency contraception? | Partial | No standalone law or regulation guaranteeing access to emergency contraception, however there are some provisions in: The <i>Constitution</i> s 38(1) The State must take reasonable measures within its available resources to achieve the progressive realisation of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, including reproductive health care. s 38(2) A person must not be denied emergency medical treatment. Levonorgestrel 0.75 mg is included on the <i>Fiji Essential Medicines List 4th Edition</i> (2015). |
| | | No legislative restrictions on the above based on: | | Contraceptives are not subject to any legal prohibitions. |
| | | (a) age | Yes | |
| | | (b) Marital status | Yes | |
| | | (c) 3 rd party authorization (e.g., spousal, parental/ guardian, medical) | Yes | |
| Family planning | Family planning | Policy on provision of family planning services | Partial | <i>Reproductive Health Policy</i> (2010) includes key targets around provision of FP services, however as noted above at the time of review a current National Reproductive Health Work Plan could not be accessed. <i>Ministry of Health and Medical Services Strategic Plan (2020-2025)</i> Outlines plan for integrated health services (broadly including reproductive health) at primary, secondary and tertiary levels including government, private and traditional providers (p12). |
| | | Through government sources? | Partial | <i>Ministry of Health and Medical Services Strategic Plan (2020-2025)</i> States Fijian population can access health services for free or at low cost through government providers (broadly including reproductive health services). All contraceptives included on the EML are available in principle free of charge from government health clinics. |
| | | Financial support for provision through non-government? | No | It is unclear in current policy commitments whether family planning through non-government services are subsidized by the government. The Fiji Free Medicine Program allows patients meeting eligibility criteria to access included medicines through private pharmacies, however this list does not currently include contraceptives. |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|---|----------------|---|---------|---|
| Comprehensive sexuality education and information | CSE law | Legislated mandatory integration of comprehensive sexuality education into national school curriculum | No | The <i>Constitution</i> s 31(4) gives the state the power to 'direct any educational institution to teach subjects pertaining to health, civic education and issues of national interest, and any educational institution must comply with any such directions made by the State, which provides a constitutional basis for requiring comprehensive sexual education as part of curriculum, where the government chooses to exercise such a right, however there is no specific legislative mandate for CSE in national curriculum. |
| | CSE curriculum | Minimum requirements for the curriculum to cover: | | <i>Reproductive Health Policy</i> (2010) Outlines FLE under section 4 on adolescent health including goal to revise curriculum, provide and embed training for teachers. <i>National Gender Policy</i> (2014) provides a target for FLE in all schools and FLE program (revised 2015) has four key focus areas in the curriculum: (1) Human Growth and Development; (2) Building Healthy Relationships; (3) Personal and Community Safety (4) Personal and Community Health. |
| | | Relationships? | Yes | |
| | | Understanding gender? | Partial | Gender roles are not critiqued and LGBTQIQ identities and sexualities are avoided. |
| | | Violence and safety? | Yes | |
| | | Sexuality and sexual behavior? | Partial | LGBTIQ identities and sexualities are not covered. |
| | | Sexual reproductive health? | Yes | |
| | | Human body and development? | Yes | |
| Maternal health | Maternity care | Does any law(s) or regulations (s) guarantee access to maternity care? Specifically: | Partial | Though there is a constitutional right to reproductive health services (discussed above), there is no right under the <i>Constitution</i> or in legislation to access antenatal or maternal health care in particular. The <i>Private Hospitals Act 1979</i> details conditions under which a private hospital may offer maternity care. The <i>Public Hospitals and Dispensaries Act 1955</i> (s 37) entitles women attending the antenatal clinic to free accommodation, maintenance and other hospital services. |
| | | Comprehensive prenatal care | Partial | As above, right to access reproductive health care broadly is enshrined in the <i>Constitution</i> however there is no particular law or regulation mandating access to maternity care. <i>Reproductive Health Policy</i> (2010) covers prenatal care, skilled birth attendants, emergency obstetric care and post-natal and newborn care, however there is no current workplan with specific targets indicators or budget allocation available. |

| Domain | Sub-domain | Specific indicators | Status | Notes | |
|-----------------|----------------|--------------------------------------|---|--|--|
| Maternal health | Maternity care | Delivery by skilled birth attendants | Partial | | |
| | | Emergency obstetric care | | | |
| | | Post-natal and newborn care | | | |
| | | | No legislative restrictions based on: | | No specific legislative prohibitions on maternity care. |
| | | | (a) age | Yes | |
| | | | (b) Marital status | Yes | |
| | | | (c) 3rd party authorization (e.g., spousal, parental/guardian, medical) | Yes | |
| | Abortion | | Legal ground on which abortion is permitted? | | Abortion is considered a criminal offence, unless performed by a medical practitioner in good faith and with reasonable care and skill, under the following circumstances: |
| | | | To save a woman's life | Yes | The <i>Crimes Act 2009</i> s 234(5)(a)(b) Serious danger to the physical or mental health of the woman. |
| | | | To preserve a woman's physical health | Yes | The <i>Crimes Act 2009</i> s 234(5)(a)(b) Serious danger to the physical or mental health of the woman. |
| | | To preserve a woman's mental health | Yes | The <i>Crimes Act 2009</i> s 234(5)(a)(b) Serious danger to the physical or mental health of the woman. | |
| | | In case of rape | Yes | The <i>Crimes Act 2009</i> s 234(2)(c) Pregnancy is result of rape. | |
| | | In cases of fetal impairment | Partial | The <i>Crimes Act 2009</i> s 234(9)(a) after 20 weeks, justified where two medical practitioners agree that the mother or child has a severe medical condition that justifies the procedure. | |

| Domain | Sub-domain | Specific indicators | Status | Notes | |
|---------------------------|------------|--|--|--|--|
| Maternal health | Abortion | If abortion is legal on some or all grounds, no restrictions based on: | | | |
| | | (a) Medical professional authorization | Partial | The <i>Crimes Act 2009</i> s 234(9) After 20 weeks gestation permission required by two medical practitioners, both agreeing that the mother or child has a severe medical condition that justifies the procedure. | |
| | | (b) Parental or Judicial consent for minors | No | The <i>Crimes Act 2009</i> s 234(10)(a) a woman who is a dependent minor (under the age of 16) shall not be regarded as having given informed consent unless a custodial parent has been informed. A dependent minor can apply to a magistrate for an order that a custodial parent should not be notified (11). | |
| | | (c) Husband's consent for married women | Yes | No legislative restriction. | |
| | | Women cannot be criminally charged for illegal abortion | No | The <i>Crimes Act 2009</i> s 235 A woman commits a summary offence if she, being pregnant, with intent to procure her own miscarriage (a) administers to herself any poison or other noxious thing; or (b) uses forces of any kind; or (c) uses any other means; or (d) or permits anything or means to be used administered to her. Penalty – Imprisonment for 7 years. | |
| | | Guaranteed access to post-abortion care is mandated in policy or legislation, irrespective of legal status of abortion | No | Guaranteed access to post-abortion care is not mandated in legislation. <i>Reproductive Health Policy (2010)</i> Section 5 includes provision of post-abortion care including informing public policy makers about the magnitude and consequences of unsafe abortion for an informed discussion on laws, policies and services. | |
| | | Lifesaving commodities | National list of essential medicines includes ⁵ : | | Fiji Essential Medicines List 4 th Edition (2015) & Obstetrics and Gynecology Clinical Practice Guidelines Version 1.1, June 2014 |
| | | Oxytocin | Yes | Section 20 Uterotonics and antiuterotonics | |
| | | Misoprostol | Yes | Section 20 Uterotonics and antiuterotonics | |
| | | Magnesium Sulfate | Yes | 10.4 Medicines in the treatment of pre-eclampsia & Vital medicines list | |
| Injectable Antibiotics | Yes | Vital Medicines List - Benzylpenicillin | | | |
| Antenatal corticosteroids | Yes | 7.1.1 Corticosteroids Dexamethasone injection 4mg, Prednisolone | | | |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------|--|--|----------------------------|--|
| Maternal health | Lifesaving commodities | Chlorhexidine | Yes | 12.1 Antiseptics |
| | | Resuscitation devices for newborns | No | Not included in EML |
| | | Amoxicillin | Yes | 6.1.1.2 Aminopenicillins |
| | | Oral rehydration salts | Yes | 14.5.1 Oral rehydration |
| | | Zinc | Yes | 14.5.2 Supplements for diarrhea in children & 24 Vitamins and Minerals |
| | | Family/ work balance | Legislated Maternity leave | Yes |
| Gender-based violence | National action plan or strategy on violence against women | Legislated paternity leave | Yes | The <i>Employment Relations Act 2007</i> Not less than five working days paternity leave s 101A(1) and paid paternity leave if he has completed more than three months' continuous service s 101A(2). |
| | | Does legislation guarantee provision of childcare by the employer or state? | No | No laws or regulations covering the provision of childcare for children under five years of age. |
| | | National action plan or strategy on gender-based violence? ⁶ | Partial | To date there has been no overarching national plan or strategy on GBV, however the <i>National Action Plan (2021–2026)</i> to prevent violence against all women and girls is currently under development, reportedly in the consultation phase. While there is currently no overarching national strategy, GBV is covered in multiple other national plans and policies discussed in the main report, in particular the <i>National Gender Policy (2014)</i> and the <i>Women's Plan of Action (2010-2019)</i> . |
| | | Does it include allocation of resources (including budget) to achieve targets? | No | With the absence of a national plan or strategy, there is no comprehensive national GBV budget. Aspects of Fiji's GBV response have been funded under separate national strategies and plans, as discussed in the main report. |

6 In line with Essential Services Package for women girls subject to violence <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------|--|---|---------|--|
| Gender-based violence | National action plan or strategy on violence against women | Does it include benchmarks, indicators to measure implementation of legislation? | Partial | The National Gender Policy (2014) set several targets around legislative review including review of the Family Law Act 2003 and regulations, the Domestic Violence Act 2009, the Crimes Act 2009, the Criminal Procedure Act 2009, the Sentencing and Penalties Act 2009, the Child Welfare Act 2010, among others. In addition is another target to ensure regular analysis of the impact of national legislation and policies on women and the ways in which they are being implemented. It is unclear however whether such review and analysis has occurred and the mechanisms through which it is to be conducted. This has also been incorporated into the latest 5-Year & 20-Year National Development Plan - Transforming Fiji (2017-2036) (p. 57). |
| | | Does it establish multisectoral referral mechanisms? | Partial | The National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018) Ministry of Women, Children and Poverty Alleviation developed by The Elimination of Violence Against Women taskforce with technical support from UN women outlines inter-agency, multisectoral referral guidelines. The extent to which these referral mechanisms are working in practice has not been comprehensively evaluated at the time of this review, though the authors are aware of current work underway localizing the SDP to Department/ Provincial levels including response to COVID-19 pandemic. |
| | | Does it establish mechanisms for collection of GBV data, including administrative and case management data? | Partial | Responding to Intimate Partner Violence and Sexual Violence against Women and Girls (clinical guidelines) (2015) Ministry of Health and The National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018) MWCPA and provide standardized data collection tools and provide some information on information sharing (e.g., informed consent and confidentiality). While there are targets in various policies to collect data, there is no provision in policy for a mechanism to coordinate and collate administrative data. |
| | Criminalisation & civil legislation | Are there measures in place to address domestic violence through civil and criminal law offenses? | Yes | While there are no standalone domestic violence offences in the Crimes Act 2009, a breach of a Domestic Violence Restraining Orders (DVROs) constitutes a criminal offence (Domestic Violence Act 2009 s 77). Under the Crimes Act 2009, violence that takes place in domestic spaces can also be considered criminal where it falls under the ambit of other crimes. A non-exhaustive list of existing criminal offences that may be relevant in domestic violence incidents are outlined in the main report. The Sentencing and Penalties Act 2009 provides an opportunity for judges to enhance punishment for domestic violence cases based on aggravating factors, but also allows for mitigating factors to be considered in sentencing. |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------|-------------------------------------|---|---------|--|
| Gender-based violence | Criminalisation & civil legislation | Criminalisation of sexual violence | Yes | <i>Crimes Act 2009</i> ss 206-224 criminalises sexual assault and rape (as defined below). Sexual harassment is outlined in the <i>Employment Relations Act 2007</i> s 76, however not explicitly criminalized. |
| | | Comprehensive definition of domestic violence in legislation, including physical, sexual, psychological and economic violence | Partial | Under the <i>Domestic Violence Act 2009</i> the definition includes physical violence, sexual violence, property damage, threats or intimidating behaviour, stalking, as well as persistent behaviour that is cruel, abusive, inhumane, degrading, provocative or offensive s 3(2). Violence includes causing a child to witness any of these behaviours s 3(2)(g). The definition of domestic violence does not include economic abuse. |
| | | Domestic violence legislation covers marital relationships | Yes | <i>Domestic Violence Act 2009</i> s 2 |
| | | Domestic violence legislation covers non-marital relationships | Yes | <i>Domestic Violence Act 2009</i> s 2 |
| | | Domestic violence legislation covers same sex relationships | Yes | Provisions in the <i>Domestic Violence Act 2009</i> are framed in gender neutral terms and so are capable of including same-sex relationships (s 2). However same sex relationships are not explicitly included. |
| | | Domestic violence legislation covers non-cohabiting relationships | Yes | <i>Domestic Violence Act 2009</i> s 2 |
| | | Domestic violence legislation covers family relationships | Yes | <i>Domestic Violence Act 2009</i> s 2 |
| | | Domestic violence legislation covers members of household | Yes | <i>Domestic Violence Act 2009</i> s 2 |
| | | Broad definition of sexual assault including rape, criminalized as a crime against the right to personal security and physical, sexual and psychological integrity? | Yes | <i>Crimes Act 2009</i> ss 206-224 Outlines sexual offenses including rape (s 207) covering penetration of the vulva, vagina, anus with anything or body part and penetration of the mouth with a person's penis without consent. |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------|-------------------------------------|---|--------|--|
| Gender-based violence | Criminalisation & civil legislation | Sexual assault within a relationship specifically criminalized (e.g., “no marriage or relationship constitute a defense to a charge of sexual assault under the legislation”)? | No | Despite a reasonably comprehensive definition of consent, there is no express direction that the rape and sexual assault provisions apply to non-consensual sex within relationships, or any distinction made for marital rape or rape that occurs within relationships. |
| | | In relation to sexual assault, defense of consent is defined as ‘unequivocal and voluntary agreement’ explicitly including a non-exhaustive list of circumstances which cannot constitute consent | Yes | <i>Crimes Act 2009</i> ss 206(1)-(2) defines sexual consent as freely and voluntarily given by a person with the necessary mental capacity to give consent, and the submission without physical resistance by a person shall not alone constitute consent. A non-exhaustive list of circumstances not constituting consent is outlined including circumstances of threat, intimidation, fear and authority. |
| | | Prohibitions on the use of corroboration, prior sexual conduct and proof of resistance in sexual offence proceedings | Yes | Key legislative changes made through the <i>Criminal Procedure Act 2009</i> , set out that: <ul style="list-style-type: none"> • Corroboration is not required in sexual offence cases (s 129), affirming case law; and • Evidence of past sexual history is not permissible (s 130). The definition of consent including “the submission without physical resistance by a person shall not alone constitute consent” <i>Crimes Act 2009</i> ss 206 (1)-(2). |
| | | Legislation guarantees issuance and monitoring of eviction, protection, restraining or emergency barring orders against alleged perpetrators, including adequate sanctions for non-compliance | Yes | <i>Domestic Violence Act 2009</i> provides that a Domestic Violence Restraining Order (DVRO) can be sought to protect victims of domestic violence. DVRO matters are civil in nature unless the order is breached, which constitutes a criminal offence (s 46). Applications for DVROs to protect people from violence may be made by the police, the victim, or a carer, parent, or guardian of the victim (s 14, s 19). |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|-----------------------|-------------------------------|---|-------------------|--|
| Gender-based violence | Health sector response to GBV | <p>Are there clinical guidelines/SoP for identification and management of cases of GBV, including sexual assault and domestic violence, for use in the health sector?</p> <p>Does legislation or policy guarantee access to health care and reproductive health care (incl. emergency contraception and post exposure prophylaxis against HIV) for victim/survivors of GBV?</p> | <p>Yes</p> | <p><i>Responding to Intimate Partner Violence and Sexual Violence against Women and Girls (clinical guidelines)</i> (2015) MOH</p> <p><i>The National Service Delivery Protocol for Responding to Cases of Gender-Based Violence</i> (2018) MWCOPA outlines comprehensive protocols for trauma-informed and survivor-centered identification and management of GBV, including sexual assault and domestic violence.</p> |
| | | <p>Partial</p> | | <p><i>The National Service Delivery Protocol for Responding to Cases of Gender-Based Violence</i> (2018) MWCOPA in particular has required key government ministries and services providers to provide a signature of understanding agreeing to abide by the service delivery protocol. This includes a range of services in line with the Essential Services Package for women girls' subject to violence.</p> <p>As above, legislation does guarantee the right to access post-exposure prophylaxis against HIV, however there is no legislative guarantee of access to emergency contraception.</p> <p>The <i>Domestic Violence Act 2009</i> s 13(2) provides that a police officer must at the scene of a domestic violence incident, assist the victim to access health care.</p> |
| | | <p>No restrictions on the above based on marital status, residency, age or other factors?</p> | <p>Yes</p> | <p>No legislative restrictions on the above</p> |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|--|----------------------|--|----------------|--|
| SRH and GBV in key populations (cross cutting) | Legislative barriers | No additional legislation that restricts access to SRH or GBV response services, or otherwise undermines the SRH and protection from GBV, for: | | |
| | | Adolescents and youth | No | As above, restrictive abortion laws requiring parental or judicial consent and gaps in legislation including absence of guaranteed access to contraceptives including emergency contraception, absence of prohibition on school exclusion due to pregnancy, absence of legislation mandating CSE in national curriculum all undermine SRHR. Provision of defense in cases of sexual relations with minors between the ages of 13 and 16 that the person charged had reasonable cause to believe, and did in fact believe the person was of or above the age of 16 in the <i>Crimes Act 2009</i> s 215 (2) does not fully place onus on the defendant to have ascertained age. |
| | | People with disabilities | Partial | Whilst <i>Rights of Persons with Disabilities Act 2018</i> s 44 guarantees right to SRH and to retain fertility, consent to medical intervention (e.g., contraception) in practice needs to be looked at more closely in partnership with persons with disabilities. |
| | | LGBTIQ people | No | While gender neutral language in the <i>Domestic Violence Act 2009</i> increases application and protections for LGBTIQ people, the <i>Family Law Act 2003</i> does not apply to LGBTIQ relationships. |
| | | Sex workers | No | Sex work is criminalised under the <i>Crimes Act 2009</i> ss 230-231 impacting on access to SRHR and vulnerability to violence. |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|--|-------------------|--|----------------|--|
| SRH and GBV in key populations (cross cutting) | Special provision | Special provisions in legislation or policy to improve access to SRH and ensure protection from GBV for: | | |
| | | Adolescents and youth | Partial | <p>Adolescent and youth SRHR is a key pillar of the <i>Reproductive Health Policy (2010)</i> (noting that this requires review and update).</p> <p>Adolescent and youth specific SRHR and GBV targets are incorporated into a number of other national policies, including:</p> <ul style="list-style-type: none"> <i>Ministry of Health and Medical Services National Strategic Plan (2020-2025)</i> <i>National Strategic Action Plan on HIV and STIs (2016–2020)</i> <i>The National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018)</i> MWCOPA includes guidance on adolescents and children. <i>The HIV/AIDS Act 2011</i> explicitly legislates for adolescent access to voluntary HIV testing and treatment. <i>The Child Welfare Act 2010</i> provides for mandatory reporting to child welfare authorities in cases where a professional becomes aware that a child has been or is likely to be harmed. Fiji Ministry of Education has a <i>Child Protection Policy (2010; revised 2015)</i> <i>Child Protection Guidelines for Health Workers in Fiji, (2012)</i> (Ministry of Health (now Ministry of Health and Medical Services) and Fiji Interagency Guidelines on Child Abuse and Neglect |
| | | People with disabilities | Partial | <p>The <i>Constitution</i> provides for the right to equality and freedom from direct and indirect forms of discrimination based on ‘disability’ (s 26). Members of the community living with disabilities are entitled to the same constitutional rights to health, health care and reproductive health as everyone else (s 38).</p> <p>The <i>Fiji Disability Action Plan (2002)</i> refers broadly to right to access health and to live free from violence, however does not explicitly address Sexual and Reproductive Health.</p> <p><i>Rights of Persons with Disabilities Act 2018</i> s 44 guarantees right to the ‘same range, quality and standard of free or affordable health care... including sexual and reproductive health’. Further specific provisions s 42(1) on the right to marry decide freely and responsibly on the number and spacing of their children and to retain their fertility on an equal basis with others.</p> <p>Disability is incorporated in varying degrees within key national policies though notably not in the <i>Reproductive Health Policy (2010)</i>.</p> |

| Domain | Sub-Domain | Specific indicators | Status | Notes |
|--|-------------------|--|---------|--|
| SRH and GBV in key populations (cross cutting) | Special provision | Sex workers | No | There are extremely limited special provisions available for sex workers. Importantly, the <i>National Strategic Action Plan on HIV and STIs (2016–2020)</i> includes an action to undertake 'targeted advocacy to influence Parliamentary decision-making on the decriminalisation of sex work' (Action 1.4.2.1.1). The extent to which this has occurred is unclear. |
| | | LGBTIQ people | Partial | <p>Legislation was adopted in 2010 to decriminalize consensual same-sex relationships creating significant progress in access to SRHR.</p> <p>Fiji provides a constitutional right to non-discrimination on the basis of gender and sexual orientation Constitution s 26 (3)(a)</p> <p>There are some provisions in policy, however these provisions are limited. For example:</p> <p><i>National Gender Policy (2014)</i> MWCPA includes a target on training health workers including non-discrimination on grounds of gender and sexual orientation.</p> <p><i>The National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018)</i> MWCPA outlines minimum inclusive standards, core concepts for training frontline workers incorporating LGBTI issues.</p> <p>Other key SRH and GBV policies do not explicitly address the needs of the LGBTIQ community.</p> |
| Plural legal systems | | No constitutional / statutory/customary/ traditional/ religious laws contradictory to any of the above | No | <p>The conciliation practice of bulubulu takes place in many iTaukei villages and is a process through which community members can atone for wrongs and foster healing. This is explored in further detail in the main report.</p> <p>There is no provision in the criminal legislation which states that customary practices of forgiveness shall not affect criminal prosecution or sentencing, however there is a provision in the Criminal Procedure Act 2009 s 154(6) that states the promotion of reconciliation does not apply to offences of domestic violence, as defined by the <i>Domestic Violence Act 2009</i>.</p> |

| Domain | Sub-domain | Specific indicators | Status | Notes |
|---------------------------|--|--|---------|--|
| Humanitarian and disaster | Provisions for SRH in disaster legislation and national plans | Are there provisions in relevant health or disaster policy and legislation to require that the Minimum Universal Service Package (MISP) for sexual and reproductive health objectives and related indicators are assessed, resourced and delivered? | Partial | <p>The <i>National Disaster Risk Reduction Policy 2018-2030</i> mentions access to health and notes need to access to SRH and GBV services.</p> <p>The <i>National Humanitarian Policy for Disaster Risk Management</i> notes the requirement for the cluster system including health, relevant to Objective 1 MISP. Note also Fiji National GBV Sub Cluster Guidance on GBV Case Referral.</p> <p>A number of other policies and plans are important to SRH emergency preparedness and response, though none specifically integrate the MISP:</p> <p><i>Fiji Essential Medicines List 4th Edition (2015)</i></p> <p><i>National Strategic Health Plan (NSP) 2016–2020</i></p> <p><i>The National Strategic Action Plan on HIV and STIs 2015-2020</i></p> <p>Note opportunity to include SRHIE and GBVIE in draft Disaster Risk Management Bill 2020 (draft) and draft Climate Change Bill 2019.</p> |
| | Provisions for GBV in disaster legislation and national policy and plans | <p>Are there provisions to respond to VAW/GBV in emergencies in legislation, policy and plans?</p> <p>Are the specific provisions in policy and legislation to require alignment with the Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.</p> | Partial | <p>There is no provision in the <i>Domestic Violence Act 2009</i>, however there is indirect provision under the <i>National Humanitarian Policy (2017)</i>, which governs and requires a government-led humanitarian coordination mechanism in Fiji; the cluster system has established a GBV sub-cluster. The Fiji National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018) provides an emergency referral guidance as an annex. The Gender-Based Violence (GBV) Working Group, is formed under the Fiji Safety and Protection Cluster, via the Ministry of Women, Children and Poverty Alleviation (MWCOPA). There is also a national Code of Conduct for All Workers in Emergencies (Government of Fiji 2016).</p> <p>The <i>National Disaster Risk Reduction Policy 2018- 2030</i> also requires a response to GBV and a rights-based approach.</p> <p>While not specific to GBV, the <i>National Climate Change Policy (2018-2030)</i> includes principles of gender-responsiveness and considering 'gender issues'. The <i>National Adaptation Plan 2018</i> integrates a gender and human rights-based approach.</p> |

4 Sexual and reproductive health in law and policy

This section of the report outlines national policy documents, highlighting their relevance to SRHR. Policies along with legislation are then explored further according to key SRH domains developed for this review. As noted earlier, there is substantial overlap between issues relevant to SRHR and to GBV, though the current policy landscape specifically relevant to GBV will be the focus of Section 5 of this report.

4.1. Domestic legislation and policy

The following table summarises the key national legislation, policies and guidelines that govern access to sexual and reproductive health in Fiji.

Table 5: Domestic legislation and policies that relate to sexual and reproductive health in Fiji

| Domestic legislation and policies that relate to sexual and reproductive health | |
|---|---|
| Legislation | <i>HIV/AIDS Act 2011</i> |
| | <i>Rights of Persons with Disabilities Act 2018</i> |
| | <i>Employment Relations Act 2007</i> |
| | <i>Crimes Act 2009</i> |
| | <i>Public Hospitals and Dispensaries Act 1955</i> |
| | <i>Public Health Act 1935</i> |
| | <i>Private Hospitals Act 1979</i> |
| Policies and guidelines | |
| Ministry of Health and Medical Services | Ministry of Health and Medical Services Strategic Plan (2020-2025) |
| | National Strategic Action Plan on HIV and STIs (2016–2020) |
| | HIV/AIDS National Strategic Plan (2007-2011) |
| | The Fiji Reproductive Health Policy (2010) |
| | National Code of Practice for HIV/AIDS in the Workplace (2008) |
| | National Medicinal Products Strategic Plan (2013 – 2018) |
| Ministry of Women, Children and Poverty Alleviation | Fiji Essential Medicines Formulary (2006) |
| | National Gender Policy (2014) |
| | Women’s Plan of Action (1999-2008); Women’s Plan of Action (2010-2019) |
| Ministry of Economy | National Policy on Ageing (2011-2015) |
| | 5-Year & 20-Year National Development Plan -Transforming Fiji (2017-2036) |

5-Year & 20-Year National Development Plan—Transforming Fiji (2017-2036)

In 2017, the Fijian government launched its 5-Year and 20-Year National Development Plan (NDP) under the Ministry of Economy. It emphasises inclusive socio-economic development to improve the social well-being of all Fijians, with no one being left behind 'regardless of geographical location, gender, ethnicity, physical and intellectual capability and social and economic status'. In aligning with international commitments, it explicitly integrates a number of the SDG 3 targets and indicators into the plan, including:

- reducing the maternal mortality ratio to less than 39.2 per 100,000 births (i.e., less than 8 maternal deaths) by 2021;
- reducing the infant mortality rate to less than 8 per 1,000 live births by 2030;
- reducing the total number of confirmed HIV cases to less than 900 by 2021; and
- reducing premature mortality due to non-communicable diseases (NCDs) to less than 20 per cent by 2030.22

The NDP also set targets for increasing cervical cancer screening coverage rate from 23 per cent in 2017 to 50 per cent by 2021 and ensuring that more than 90 per cent of people who are HIV positive receive antiretroviral therapy by 2021.

Additionally, it outlines strategies, including:

- Increase awareness of, and capacity for, education on social issues such as drug education, HIV/AIDS, GBV, respectful relationships, sex education, NCDs, cyber safety, and mental health at school.
- Provide family planning and reproductive health information and resources.
- All pregnant women, including teenagers, mothers and newborns receive timely, safe, appropriate, and effective health services before, during, and after childbirth.

In order to achieve the above targets, it will be vital to have in place an up-to-date, aligned and comprehensive SRH-specific national policy with costed annual workplans and adequate institutional mechanisms in place to monitor implementation.

Reproductive Health Policy (2010)

The *Reproductive Health Policy* is the only policy solely dedicated to SRHR. This was developed in 2010 by the Ministry of Health (now Ministry of Health and Medical Services). In 2018, the Gutmacher-Lancet Commission released a comprehensive definition of SRH and an essential package of SRH interventions that included: family planning services, maternal and newborn care, and prevention and treatment of HIV, AIDS and STIs; post-abortion care; prevention, detection, and counselling for GBV; and prevention, detection, and treatment of cervical cancer (refer to Annex 4) (Starrs et al., 2018). Fiji's *Reproductive Health Policy* and related policies have also promoted a similar package of services. The key areas covered by the *Reproductive Health Policy* are:

1. Mobilising resources to support sexual and reproductive health
2. Safe motherhood—maternal and newborn care
3. Infant and child healthcare
4. Adolescent health
5. Family planning and fertility services
6. Sexually transmitted infections, HIV, and reproductive tract cancers.

Along with the *Reproductive Health Policy*, a comprehensive and costed Annual Work Plan for 2010-11 was developed to resource and monitor the implementation of targets. However, at the time of conducting this

review the authors could find no evidence of subsequent annual work plans having been developed. The authors are aware of a new RMNCAH Policy/ Strategy currently under development with the Ministry of Health and Medical Services. It is unclear what the projected timeline is on completion.

Ministry of Health and Medical Services Strategic Plan 2020-2025

The Ministry of Health and Medical Services Strategic Plan outlines a 'one system approach' to achieving universal health coverage with three strategic priority areas:

1. Reform public health services to provide population-based approach to diseases and the climate crises;
2. Increase access to quality, safe and patient-focussed clinical services;
3. Drive efficient and effective management of the health system (p. 4).

The strategy recognises reproductive, maternal, newborn, adolescent and child health as one of four population health themes central to the strategy. It broadly outlines outcomes relevant to SRH including:

- Improving the physical and mental well-being of all citizens, with particular emphasis on women, children and young people through prevention measures (p. 4).
- Improve patient health outcomes, with a particular focus on services for women, children, young people and vulnerable groups (p. 4).

As with the targets under the *National Development Plan*, it will be vital that there is a comprehensive and aligned SRH specific policy with accompanying costed annual work plans to ensure that these targets can be met.

National Gender Policy 2014

Developed by the MWCPA, the *National Gender Policy* (2014) sets out a general framework to promote gender sensitive approaches and policies across government ministries as well as in civil society, in order to address gender equality and eliminate discrimination in line with CEDAW.

The Policy includes provisions for reproductive health, HIV and AIDS, and education including family life education.

In particular, it commits to support the national reproductive health program to provide comprehensive and integrated reproductive health services and ensuring universal access to reproductive health care (including access to family planning) for women and girls across Fiji (p. 23).

It also seeks to ensure young people including adolescents have access to youth friendly services to assist them to make responsible choices to protect and safeguard their health, with particular reference to unplanned and early pregnancies, STIs and HIV, and sexual abuse.

The National Gender Policy has not been reviewed or updated since its development in 2014, however it is referenced in a number of more recent policies including the *5-year -20-year National Development Plan (2017-39)*.

Women's Plan of Action 2010-2019

There have been two iterations of the 'Women's Plan of Action' developed by the Ministry of Women Children and Poverty Alleviation: The *Women's Plan of Action 1999-2008*, and the *Women's Plan of Action 2010-2019*. Both plans have made gender equality and the prevention and elimination of gender-based violence key priority areas. The *Women's Plan of Action 2010-2019* (WPA) focuses on the following five areas:

1. Formal sector employment and livelihood;
2. Equal participation in decision-making;
3. Elimination of violence against women and children;
4. Access to basic services;
5. Women and the law (p. 23).

'Access to services' includes objectives to improve access to reproductive health services. Under the WPA, reproductive health implies the right to:

- 'be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice and further other methods of their choice for regulation of fertility which are not against the law' (p. 14); and
- access appropriate maternal and child health care (p. 15).

Another of the objectives of the WPA was to address HIV/AIDS through a legislative framework, which was successfully achieved with the *HIV/AIDS Act 2011*.

There has been some critique of the WPA out of an audit conducted by the Office of the Auditor General (OAG, 2019) examining efforts to eliminate violence against women in Fiji, which will be discussed further under Section 5 of this report.

National Strategic Plan on HIV and STIs (2016-2020)

In 2016, the Ministry of Health and Medical Services introduced the *National Strategic Plan on HIV and STIs (2016-2020)* to address the SDGs, as well as the WHO and UNAIDS's plans and initiatives. The plan involved significant community consultation and is based on the principles of "nothing about us without us", universal health coverage and gender equality", as well as government accountability and evidenced-based, human rights-based approaches (p. 6). Importantly, the *National Strategic Plan on HIV and STIs* also incorporates costing, monitoring and evaluation requirements. The plan seeks to address four priority areas: (1) prevention; (2) continuum of care; (3) system strengthening; and (4) monitoring and evaluation. A five-year budget of \$32 million dollars was set aside to achieve the plan. At the time of this review, it is unclear whether the strategic plan has undergone an evaluation and to what extent it has achieved its targets.

The remainder of Section 4 of this report explores Fiji's policies and legislation in relation to the key SRH domains developed for this review.

4.2. Sexual health

There are relatively high prevalence rates of certain STDs in Fiji, particularly chlamydia, gonorrhoea and syphilis (Cliffe et al., 2008; Gaunavinaka et al., 2014; Nishijima et al., 2020). In 2017, 3.89 per cent of the population were estimated to have active syphilis; 1.63 per cent gonorrhoea; and 24.1 per cent chlamydia (Nishijima et al., 2020). STIs have been found to be prevalent in key populations, such as sex workers, but also populations who tend to be less vulnerable to sexual risks, such as married, pregnant women (Ryan et al., 2009). A 2008 study testing prevalence levels of STIs in Fijian pregnant women found that 29 per cent of women tested positive for chlamydia (34 per cent for those under 25) and 1.7 per cent (3.1 per cent for those under 25) had gonorrhoea (Cliffe et al., 2008). In Fiji, HIV rates are relatively low, however, given the rates of transmission of other STDs, it remains a significant area of concern.

General knowledge regarding STIs, contraception, and reproductive health consequences has been found to be low among young people in the community (Mitchell, 2012). Several studies have highlighted that concerns regarding confidentiality and judgment are a barrier to accessing sexual health services. (Mitchell, 2012; Mitchell and Bennett, 2020; O'Connor et al., 2019).

Sexual health is largely legislated under the *Public Health Act 1935* and the *HIV/AIDS Act 2011*. Part 8 of the *Public Health Act 1935* sets out provisions that relate to 'venereal diseases'. Where a person is aware or has reason to believe that they have an STI, they are required to seek and undergo medical treatment, until they are 'cured' (s 84). Section 85 enables compulsory examination and treatment of venereal disease, potentially by use of force 'as may be necessary'. Failure to comply with either of these provisions is an offence.

Section 87 contains restrictions on employing persons with STIs:

Every person who while suffering from any venereal disease in a communicable form accepts or continues in employment in or about any dairy, factory, shop, hotel, restaurant, house or other place in any capacity entailing the care of children or the handling of food or food utensils intended for consumption or use by any other person, and any person who employs or continues to employ any such person, shall be guilty of an offence unless he or she proves that he or she did not know or suspect that he or she was so suffering or, in the case of an employer, that the employee was so suffering.

It is also an offence to wilfully or by culpable negligence infect any other person with 'venereal disease'.

The requirements set out in the *Public Health Act 1935* with respect to STIs are inconsistent with the rights and protections afforded to persons with HIV/AIDS contained in the *HIV/AIDS Act 2011* (discussed below in 4.2.1), such as the right to testing with informed consent and the right to be free from discrimination. The *HIV/AIDS Act 2011* has a provision stating that:

Where the provisions of any other written law are specifically inconsistent with the provisions of the Act, this Act prevails to the extent necessary for the purposes for the (s 4(1)).

Meaning that persons with HIV or AIDS would be protected from the restrictions under the *Public Health Act 1935*, however this would not extend to other types of STIs. Further, the contradiction provides the basis for confusion in interpretation and application of the law in practice, leaving both service providers and those suffering from HIV and STIs vulnerable.

It should also be noted that the *Crimes Act 2009* replaced the Penal Code and decriminalised male to male sex, which enabled increased access to sexual health services for men who have sex with men. This will be explored in greater detail later in the report.

4.2.1. HIV and AIDS

According to the Ministry of Health and Medical Services *National Strategic Plan on HIV and STIs 2016-2020*, the total number of confirmed HIV cases in 2014 was 610 (64 new cases), and the objective is to maintain under 1000 cases by 2020 (less than 32 new cases per year). In 2015, an estimated 0.14 per cent of the population had HIV (MoHMS, 2016a). HIV screening takes place through antenatal services, blood donor screening, and reproductive health clinics ('hubs'), and is now decentralised through sub-divisional clinics in order to improve access (MoHMS, 2016a).

Government funding accounts for 80 per cent of the HIV response funding (HIV/AIDS Board, 2017). UNICEF, UNAIDS and SPC, as well as private donors, also provide funding and technical assistance for programs.

Prior to 2011, entry, stay, and residence in Fiji were restricted based on HIV status; however, this restriction was lifted by the Bainimarama government (MoHMS, 2016a). A rights-based *HIV/AIDS Act 2011* was also introduced in 2011. The Act established the HIV and AIDS board in order to manage a coordinated approach to HIV and AIDS in Fiji. Much of Fiji's work in this area has been concerned with improving the lives of those living with HIV, particularly key populations at higher risk as well as women and people with disabilities (Akbar, 2016).

The *National Strategic Plan on HIV and STIs (2016-2020)* sets out 90-90-90 targets as follows: 90 percent of people living with HIV will know their HIV status; 90 percent of people who know their status will be receiving treatment, and 90 percent of people on HIV treatment will have a suppressed viral load so that their immune system remains strong and they are no longer infectious (MoHMS, 2016a, p. 36). A 'Test and Treat Strategy' is employed under the plan to meet these targets, which involves rolling out universal HIV testing in order to provide diagnosis and commence antiretroviral treatment. Comprehensive actions are proposed under the following key areas:

- **Prevention efforts:** focus on vulnerable populations; aim to change beliefs about condoms; address gender inequality; address stigma experienced by people with HIV and AIDS.
- **Continuum of care:** ensure up-to-date treatment guidelines; provide antiretroviral treatment and STI treatment; treat opportunistic infections; support treatment adherence; support palliative care; strengthen laboratory services.
- **System strengthening:** ensure governance and coordination; improve the management of procurement processes; strengthen laboratory systems; build HR capacity; ensure sustainable financing.
- **Monitoring, evaluation and research:** update routine surveillance system, strengthen the collection of information through operational research and evaluation; conduct population-based studies; use strategic information to inform programmes, policies and guidance; strengthen information systems; develop a monitoring and evaluation plan.

The *Reproductive Health Policy* (2010) also sets out strategies to increase testing and treatment for HIV (and other STIs), such as testing all pregnant women to screen for HIV and preventing (and managing where it occurs) transmission to babies.

Testing and confidentiality

Confidentiality is vital to ensure people feel comfortable seeking medical assistance and to avoid potential discrimination against those with HIV and AIDS. Concern about confidentiality was cited as a key barrier for sex workers in seeking sexual health services (Mossman et al., 2014), as well as adolescents (Mitchell, 2012).

Section 24(1) of the *Constitution* guarantees the right to personal privacy, which includes the right to '(a) confidentiality of their personal information; (b) confidentiality of their communications; and (c) respect for their private and family life'. However, pursuant to s 24(2), 'to the extent that it is necessary, a law may limit, or may authorise the limitation of, the rights set out in subsection (1)'.

The *HIV/AIDS Act 2011* guarantees the right to be tested for HIV only with voluntary and informed consent as well as the right to confidentiality regarding HIV screening results (ss 24(1), 29, 32, 34-36.). No person or authority may be notified about another person's results; however, the manager of the National HIV and AIDS Programme must be provided with a de-identified written report of all positive tests (s 32). Prior to testing, counselling is required to be provided about the nature of HIV and AIDS, the testing process, and possible consequences of a positive result, including regarding treatment and transmission (s 27).

Contravention of confidentiality or testing requirements can constitute a criminal offence, punishable by a maximum fine of \$50,000 and/or two years in prison for a person, or a maximum fine of \$100,000 for a corporation (s 41).

A review of laws that relate to SRH in the Asia-Pacific region found that Fiji could be commended for its laws which allow people, including adolescents, to be tested voluntarily and confidentially (UNESCO, 2013). Though the protections for persons who have or may have HIV are strong, the protections are inconsistent with provisions regarding 'venereal disease' in the *Public Health Act 1935* that have not been repealed.

Discrimination

The *Constitution* provides for the right to live free from discrimination on the grounds of a person's 'health status' (s 26(3)(a)). Fiji's HIV and AIDS legislation also incorporates anti-discrimination and anti-stigmatisation components. Under s 25, it is unlawful to stigmatise a person on the basis of their having HIV or AIDS. Section 21 further states that 'it is unlawful to discriminate, directly or indirectly, against a person having HIV or AIDS or affected by HIV or AIDS', and s 22 outlines various circumstances where discrimination is unlawful, such as in relation to: employment; business partnerships; organisations, clubs or sporting associations; education; prison; accommodation; freedom of movement and access to goods and services. This protection sits in direct contradiction with s 87 of the *Public Health Act 1935* which requires employers to discriminate against persons with STIs in certain industries. It should be noted that the *HIV/AIDS Act 2011* preserves the military's right to discriminate against persons with HIV/AIDS (s 22(2)) however, in addition to insurers' (s 23).

Contravention of the discrimination and stigmatisation provisions is also a criminal offence (s 41).

Notwithstanding these legal protections, concern has been raised about whether anti-discrimination protections have been translated into practice (Lui et al., 2012). There is evidence that those with HIV or AIDS are unfairly discriminated against by health-care workers, who pass negative judgment on their sexual behaviour (Lui et al., 2012).

4.2.2. HPV

Fiji has a relatively high incidence of cervical cancer (Global Cancer Observatory, 2019). A 2014 prevalence study found that 24 percent of the general female population had human papillomavirus (HPV) (Foliaki et al., 2014). When administered to girls between 9-13 years old, the cost effective HPV vaccine is highly effective in reducing the incidence of cervical cancer (Tabrizi et al., 2011). Failure to provide the vaccine can increase morbidity and mortality of cervical cancer in women of reproductive age and place additional economic pressure on countries' health systems (UNFPA, 2019a).

A three-dose schedule of quadrivalent HPV (4vHPV) vaccine was introduced for 9-14 year old girls in 2009 through a donation, and three-dose schedule of bivalent HPV (2vHPV) was introduced into the national immunisation program in 2013 (Toh et al., 2017). The HPV vaccine is also included on Fiji's Essential Medicines List 4th Edition (April 2015). Researchers estimate that the introduction of the vaccines could potentially reduce Fiji's incidence of cervical cancer by over 80 per cent, and reduce pre-cancers by a minimum of 60 per cent (Tabrizi et al., 2011).

While the HPV vaccine is included on the National Vaccination Schedule, there is no indicator or target related to HPV vaccination coverage in either the 2010 *Reproductive Health Policy* or the latest *National Development Plan* (NDP). The NDP does however include a target to increase cervical cancer screening coverage rate from 23 per cent in 2017 to 50 per cent by 2021.

4.3. Contraception and family planning

Contraception use in Fiji is estimated to be around 36.1 per cent according to the UN DESA database, however data disaggregated by method was not available (UN DESA, 2019). The 2016 Health Status Report states that 48.3 percent of women of reproductive age (aged 15-49 years) have their need for family planning satisfied with modern methods. Despite limited available data on contraceptive use, both estimates indicate a high level of unmet need for family planning (MoHMS, 2016b). In recent years, the Ministry of Health and Medical Services and UNFPA have provided training to medical practitioners in family planning methods, including the insertion and removal of subdermal contraceptive implants, such as Jadelle (Reece, 2018), which have become more available as a result. Male condoms, emergency contraception (Levonorgestrel 0.75 mg), implantable contraceptives –Etonogestrel (Implanon) & Levonorgestrel (Jadelle) and copper intrauterine contraceptive device (IUCD) are all included in the Fiji Essential Medicines List 4th Edition (April 2015). It should be noted that female condoms are not currently included on the Essential Medicines List (EML).

Legislation in Fiji does not fully guarantee access to contraceptive services or provision of full, free, and informed consent for contraceptive services. Despite this, there are some legislative provisions providing protections, as follows:

The *HIV/AIDS Act 2011* provides that a person cannot be denied access to contraception (barrier method); under s 26, it is illegal to knowingly deny a person the 'means of protection' of themselves or another from HIV, which includes:

- HIV/AIDS awareness materials;
- condoms, condom lubricant and any other means of reducing the risk of HIV transmission, including effective treatment of a pregnant woman to prevent mother to child transmission of HIV;
- exclusive personal use of skin penetrative instruments, including razors, needles and syringes; and
- means of disinfecting skin penetrative instruments.

Although negatively framed as an interdiction to deny, rather than a right to access, this right remains significant.

The *Constitution* s 38(1) also broadly upholds the right to health-care services, including reproductive health care.

Access to contraceptives is not subject to any legal prohibitions or restrictions on the basis of age, marital status, or need for third-party authorisation in Fiji. However, the absence of specific laws guaranteeing the right to access, and provision of full, free and informed consent may create confusion for family planning service providers and practitioners as well as consumers, particularly in relation to access to contraceptives for ‘minors’ without the need for parental consent. While there are multiple policy commitments around the provision of adolescent and youth friendly SRH services including contraceptives, there are currently no specific guidelines around consent to access contraceptives for this age group.

The *Reproductive Health Policy* includes strategies regarding contraception and family planning methods, specifically under the fifth priority area of the plan, ‘Family planning and post abortion services’, with four strategic areas that aim to:

1. Ensure availability of a wide range of contraceptives;
2. Ensure counselling of clients to utilise effective and appropriate methods of contraception thereby facilitating informed choice;
3. Ensure the provision of family planning services together with post-abortion and post-partum care; and
4. Ensure the adequate supply of contraceptives at all facilities as well as at the community level.

The policy sets out a range of projected actions which pertain to each strategic area. For example, strategic area 1, action 5 is to: ‘develop specific policy on providing a wide range of contraceptive methods (at least five kinds of methods at the facility level and three at the community distribution level), including emergency contraception (access and Scope of Practice [SOP]), Jadelle (SOP for nurses) and condoms (supply)’ (p. 23). At the time of review, the contraceptive SOP has not been sighted. Strategic area 1, action 8 is to: ‘increase service providers’ capacity for providing sterilization, IUD insertion and injectable/implant at the community and facility level, (including increasing service providers’ capacity to prevent, detect and respond to GBV, including referrals)’ (p. 23).

As discussed earlier in the report, the *Reproductive Health Policy* has not been reviewed or updated since 2014, nor is there a current detailed work plan available.

Despite the above policy targets and the inclusion of modern contraceptives in the essential medicines list, a Fiji Health Facility Readiness and Service Availability (HFRSA) Assessment conducted in 2019 found that only 19 per cent of facilities are family planning service-ready, 66 percent of 164 primary level health facilities had three or more methods of family planning, and only 44 percent of 18 secondary/ tertiary facilities had five or more methods of family planning available on the day of the visit (UNFPA, 2020). This would suggest that the above policy targets have not necessarily been achieved in practice and reinforces the need for sound monitoring frameworks and annual review of targets with subsequent evidence-based work plans in place.

Of particular relevance to this review are findings from the Fiji Women’s Crisis Centre: *Somebody’s Life, Everybody’s Business—National Research on Women’s Health and Life Experiences in Fiji* (2010/2011). This survey explored the prevalence, incidence, and attitudes to intimate partner violence in Fiji. The survey found that women who experienced intimate partner physical or sexual violence were more likely to have experienced an unintended pregnancy or one that they would have preferred to delay (50 per cent compared to 36 per cent of women who had never experienced intimate partner violence). The survey found that associations between intimate partner violence and women’s use of contraception were also highly

significant. Women living with intimate partner violence were far more likely to have ever used contraception to prevent or delay pregnancy (56 per cent compared to 44 per cent of those not living with violence) on the one hand, while on the other, women living with intimate partner violence were also significantly more likely to have had their partner prevent them from using contraception (10 per cent compared with 3 per cent of women not living with violence) (FWCC, 2013).

Reproductive coercion is a behaviour that restricts a woman's autonomous reproductive health decision-making. This could include, for example, sabotage of contraception or coercion around pregnancy or abortion (Grace & Anderson, 2018). Reproductive coercion is increasingly being recognised as a serious threat to sexual and reproductive health and rights and an insidious form of violence against women in its own right. Despite this, there has been very limited research on this issue in the Pacific. More needs to be understood about this issue in Fiji to ensure that there are appropriate legislative protections and policy responses in place.

4.4. Maternal health

4.4.1. Antenatal and maternal health care

Background

Between 2000-2017, Fiji saw a 33 per cent reduction in its maternal mortality rate (MMR), from an MMR point estimate of 51 down to 34 (WHO et al., 2019). Though progress has been made, Fiji's maternal morbidity rates have been linked to high rates of non-communicable diseases, such as diabetes, as well as premature birth and anaemia (MOH, 2010). Most infants in Fiji are born in hospital facilities (MOH, 2010). By 2010, the Ministry of Health reported that antenatal care coverage had surpassed 95 per cent; however, early antenatal care, particularly in the first trimester, was rare (MOH, 2010). The current neonatal mortality rate is estimated to be 10.8 per 1000 live births, and the infant mortality rate is 21.62 (UN IGME, 2019).

Legislation and policy

The *Constitution* provides for the right to equality and freedom from discrimination (both indirect and direct) based on 'health status... conscience, marital status or pregnancy' (s 26). Though there is a constitutional right to reproductive health services (discussed in section 2.2.2 above), there is no right under the *Constitution* or in legislation to access antenatal or maternal health care in particular. *The Private Hospitals Act 1979* details conditions under which a private hospital may offer maternity care. *The Public Hospitals and Dispensaries Act 1955* (s 37) entitles women attending the antenatal clinic to free accommodation, maintenance and other hospital services.

The *Reproductive Health Policy* includes 'Safe Motherhood' as a key focus area. One of its aims is to improve pregnancy and neonatal outcomes through the provision of quality antenatal care. The following activities are outlined in the policy to achieve this:

1. Promote the early booking of mothers before 12 weeks with emphasis on most at-risk populations, e.g., poor, adolescents, single mothers, women in remote rural areas
2. Advocate that mothers attend at least four ANC clinics before delivery
3. Prevent transmission of syphilis, HIV, and other STIs from parent to child during pregnancy
4. Promote increased male participation in antenatal, intra-partum and postnatal care
5. Standardise quality of antenatal care at all facilities
6. Revise policy for Pap smear screening in antenatal clinics
7. Provide basic laboratory and radiology services at all sub divisional hospitals (p. 14).

The *Fiji Essential Medicines List 4th Edition (2015)* includes 10 of the 11 commodities listed by the UN Commission into Life Saving Commodities for maternal, newborn and child health, including oxytocin, misoprostol, magnesium sulphate, injectable penicillin, dexamethasone and betamethasone (antenatal corticosteroid), and chlorhexidine. However, newborn resuscitation devices are not included on the EML. Reproductive health commodities were discussed under section 4.3.

Despite the policy commitments to provide comprehensive maternity care and inclusion of life saving maternal and newborn commodities on the EML, concerning, the recent Health Facility Readiness and Service Availability (HFRSA) Assessment found that 0 per cent of facilities providing deliveries comply with global safe delivery practices⁷, 0 per cent of facilities provide all signal functions of basic emergency obstetric and newborn care (BEmONC),⁸ and only 10 percent of facilities are antenatal care and postnatal care service ready (UNFPA, 2020).

In the 2018-19 budget, the government incorporated 'parenthood assistance payments' for low-income families, which consist of an allowance of \$1000. Mothers are provided the payment directly for the care of their infant in order to 'empower Fijian mothers and drive a cultural shift toward female-led financial stewardship in Fiji' (Fijian Government, 2018). Pregnant women living in rural areas can also access a monthly \$50 food voucher for the duration of their pregnancy (Boila, 2020).

4.4.2. Parental leave

The *Employment Relations Act 2007* incorporates fundamental principles and rights in the workplace, such as the right to equal employment opportunities and parental leave. The parental leave provisions are not gender neutral, but rather separate the rights of women on maternity leave from those of men on paternity leave.

Women are able to take 98 consecutive days of maternity leave if they are employed, regardless of how long they have been employed for (*Employment Relations Act 2007* s 101(1)). If they have been employed for at least 150 days within a certain time period (the nine months prior to the last three months of pregnancy) (s 101(4)), women are entitled to be paid maternity leave at their normal rate of remuneration for the first three births, and at half her normal rate of remuneration for the fourth and subsequent births (s 101(2)). Effective as of 2019, fathers may take paternity leave for a period of no less than five working days (s 101A(1)), and paid paternity leave if he has completed more than three months' continuous service (s101A(2)). Like maternity leave, paid parental leave is available at full pay for the first three births, and half pay for the fourth and subsequent births.

Women cannot be terminated from their employment on the basis of pregnancy and, where termination of the employment of a pregnant woman occurs, the burden of proof rests on the employer to demonstrate that it was not due to pregnancy (*Employment Relations Act 2007* s 104).

Employers are unable to contract out of the parental leave provisions contained in Part 11 of *the Employment Relations Act 2007* (s 105).

The *National Gender Policy (2014)* sets a target to "promote initiatives that support and strengthen domestic and family life and increase the participation of men and women in shared family responsibilities" (p17).

7 "These results are lower than expected due to the inclusion of calcium gluconate, which at the time of the assessment was stocked out nearly nationwide. When excluded, 15 per cent or 4 facilities, CWM, Lautoka, Navua, and Taveuni) meet the criteria" (UNFPA, 2020. pVI).

8 "These results are lower than expected due to the inclusion of calcium gluconate, which at the time of the assessment was stocked out nearly nationwide. When excluded 15per cent or 4 facilities, CWM, Lautoka, Navua, and Taveuni) meet the criteria" (UNFPA, 2020. pVI).

It should be noted that despite these provisions, there is no legislation guaranteeing childcare services or mandating early childhood education for children between 0-5 years old. A business case for employer-supported childcare in Fiji found that limited childcare options disproportionately impact women who are often the primary caregiver, particularly in relation to re-entry into the workforce (IFC, 2019).

4.4.3. Abortion

Abortion is illegal in Fiji unless there is 'serious danger to the physical or mental health of the woman concerned' (*Crimes Act 2009* s 234(5)). It is a criminal offence for medical practitioners to perform abortions (except where the pregnancy arises out of a case of rape or incest) and they are subject to a maximum period of 14 years' imprisonment (s 234). Women who cause their own miscarriage through any measure are also criminalised and subject to imprisonment for seven years (*Crimes Act 2009* s 235).

The *Crimes Act 2009* s 234(10)(a) states that a woman who is a dependent minor (under the age of 16) shall not be regarded as having given informed consent [to an abortion] unless a custodial parent has been informed. A dependent minor can apply to a magistrate for an order that a custodial parent should not be notified (s 234(11)).

Guaranteed access to post-abortion care is not mandated in legislation.

Section 5 of the *Reproductive Health Policy* (2010) includes a broad commitment to ensuring availability to post-abortion care including informing public policymakers about the magnitude and consequences of unsafe abortion for an informed discussion on laws, policies and services. While there are limited data available on abortion practices in Fiji, it is reported that illegal abortion services are available in Suva, but they can be expensive and unsafe (Mitchell & Bennett, 2019). Fijian women also use home methods of termination such as herbal substances or violent massage (Mitchell & Bennett, 2019).

The *Reproductive Health Policy* notes that rates of unsafe, illegal abortion demonstrate the 'lack of contraceptive use in the context of unmet needs for family planning' (MOH, 2010, p. 7). Measures to prevent abortion such as contraception initiatives are outlined in the policy, as is the right to post-abortion services; however, the provision of safe abortions is not discussed.

The *National Gender Policy* (2014) sets a target to "Ensure that in cases of abortion, doctors are trained and sensitised to ensure that women give informed consent to terminations of pregnancy in accordance with the *Crimes Act 2009* and subject to the conditions set out in that Act and are adequately and gender responsively counselled on the choices they make" (p. 22).

Research has found that unsafe abortion contributed to 30 maternal deaths per 100,000 live births in Oceania (excluding Australia and New Zealand) in 2008 (Ahman & Shah, 2011). Ahman and Shah (2011, p. 121) state that "death attributable to unsafe abortion can be prevented by effective contraception, safe abortion services, and post abortion services". Research has also indicated that there is an association between higher maternal mortality rates, unsafe abortion and restrictive abortion laws (Sedgh et al., 2016). Further, Ganatra et al. (2017) found that when grouped by legal status of abortion, the proportion of unsafe abortions was significantly higher in countries with highly restrictive abortion laws and analysis showed a positive association between safe abortions and less restrictive laws.

4.5. Comprehensive sexuality education

The *Constitution* protects all Fijians' right to early child, primary, secondary, and further education under s 23. The government is required to 'take reasonable measures within its available resources' to provide free education, including education to those who have not completed primary or secondary schooling (s 23(2)). The *Rights of Persons with Disabilities Act 2018* (s 43) also ensures the right to education for all persons with disabilities in the area in which they live, free of tuition fees. Schools are required to provide reasonable infrastructure to enable persons with disabilities to participate and develop their 'fullest potential'. Since 2014/15, all state-run primary and secondary schools are free of charge (Duke et al., 2015). Most Fijian schools are 'community schools' rather than government schools, and as such they are run directly by communities with government funding, but must still teach the government curriculum (UNHRC, 2016).

Section 31(4) of the *Constitution* gives the state the power to 'direct any educational institution to teach subjects pertaining to health, civic education and issues of national interest, and any educational institution must comply with any such directions made by the State', which provides a constitutional basis for requiring comprehensive sexual education as part of curriculum, where the government chooses to exercise such a right.

However, rights relating to freedom of religion under s 22 of the *Constitution* should also be borne in mind. Section 22(4) of the *Constitution* states that 'every religious community or denomination, and every cultural or social community, has the right to establish, maintain and manage places of education whether or not it receives financial assistance from the State, provided that the educational institutions maintain any standard prescribed by law'. What is more, under s 22(5), 'a religious community or denomination has the right to provide religious instruction as part of any education that it provides'.

Integration of comprehensive sexual education is not explicitly mandated in domestic legislation in Fiji.

Fiji is subject to international obligations to provide SRH education. The Convention on the Rights of the Child states that State parties are required to 'develop...family planning education and services' for all children under 18 years of age (art 24(2)(f)). However, Kishore Singh, Special Rapporteur on the right to education, in his mission to Fiji, found that the constitutional provisions and obligations under international law are not adequately incorporated into the *Education Act 1978* (UNHRC, 2016).

Research has found that due to sex being a taboo topic, adolescents and youth are unlikely to receive sexual education from their parents, which makes institutionalised forms of education vital (Bishwa, 2000; Naz, 2014; Ram & Mohammadenzhad, 2020). The directive for Fiji to provide comprehensive sexual education is found in policy. Fiji's *Reproductive Health Policy* (2010) sets out the requirement for revision and implementation of comprehensive sexual education in schools, referred to as family life education (FLE). The *National Gender Policy* (2014) also includes a target to support and continue the Family Life Programme in all schools and consider commencing the programme at Class 1 level. (p. 24)

FLE was first introduced in 1985 following media coverage concerning high numbers of teenage pregnancies, as well as increasing numbers of STDs (Kondo, 1992), and was revised and reintroduced in 2007-2008 (Ram et al., 2020). UNFPA has since been involved in developing Fiji's FLE program.

FLE is delivered in both primary and secondary schools in Fiji to children and adolescents aged 11-19 years (Ministry of Education, 2015; SRI, 2016). Fiji's FLE has high coverage in schools compared to other Pacific nations; in 2010, Fiji reported that FLE had been implemented in 90 per cent of its schools (Chetty & Faleatua, 2015). In primary schools, FLE education is taught as a component of Health Living. However, there have been calls to remove FLE from the primary school curriculum after complaints from parents on the content taught (FWRM, 2016).

Fiji's FLE curriculum was revised in 2015 (Ministry of Education, 2015), and is considered comparatively progressive in the context of the Pacific (Chetty & Faleatua, 2015). There are four key focus areas in the curriculum: (1) human growth and development; (2) building healthy relationships; (3) personal and community safety (4) personal and community health. Though Fiji has been comparatively proactive in relation to SRH education, abstinence remains a key message (Mitchell, 2012), and there have been calls to review the program (UNHRC, 2019a). The curriculum, for example, cites 'the influence of liberal views on sex' as one of the causes of teen pregnancy. However, failing abstinence, the curriculum does also detail the importance of using contraception and maintaining sexual health through regular testing. Indeed, Fiji's sexual education has been referred to as an ABC model where A ('abstinence') and B ('be faithful') are emphasised, with C ('condom') suggested if A and B fail (Mitchell & Bennett, 2020). Mitchell and Bennett (2020) note that ABC approaches have largely been unsuccessful in the Pacific region, as they fail to account for the social, economic and cultural realities, and in particular, gender inequality. The curriculum includes some discussion of gender roles (though gender roles are not critiqued) as well as gender discrimination (Ministry of Education, 2015). LGBTIQ sexualities and identities are avoided (Ministry of Education, 2015).

The implementation of the curriculum has been called into question as largely dependent on teachers' personal views which may be in conflict with topics recommended under the FLE Programme (Chetty & Faleatua, 2015). Fijian Minister for Education, Heritage and Arts, Rosy Akbar, notes that the effectiveness of the FLE has also been hampered due to the taboo nature of sex and sexuality in Fijian culture (Nanuqa, 2020), which has been borne out in research. O'Connor et al.'s (2018) study exploring how adolescents in Fiji understand sexual and reproductive well-being, found that the FLE was hindered by conflicting religious messages, as well as by embarrassment experienced by teachers. A 2019 paper arising from the study cites an iTaukei boy living in an urban area: 'We need more information at school because we don't get to do this stuff at school because people feel ashamed of saying all this stuff' (O'Connor et al., 2019, p. 376). This embarrassment, as well as concern regarding the preservation of religious values, was confirmed by teachers in the study (O'Connor et al., 2019).

It has been reported that although most schools provide FLE classes, there are no specific FLE teachers, and as such teachers of other subjects are required to teach the program, with many ill-equipped to do so (Turaga, 2019). Ram and Mohammadenzhad (2020) conducted focus groups with teachers and found that they lacked the necessary skills and training to deliver FLE and felt hesitant to discuss sensitive topics that relate to sexuality. The *Reproductive Health Policy* includes plans to develop and provide training to primary and secondary school teachers regarding FLE; however, there was limited budget for implementation.

A qualitative study of parents' perceptions of FLE in secondary schools (n=26) found that the parents did not feel confident in discussing matters that concern SRH with their children, due to lack of knowledge themselves and also cultural sensitivity around such topics (Ram et al., 2020). Parents were keen to highlight the importance of educating adolescents to avoid courtship, particularly girls. Both iTaukei and Indian Fijian parents approved of sexual and reproductive health education incorporating religious and moral teaching, otherwise students 'will start practicing what they are taught and pregnancies will go up' (Ram et al., 2020, p. 5). This study confirms findings from a larger study about parents' views, which employed a questionnaire (n=386), focus group discussions (n=54) and interviews (n=34), and found that religious views, particularly relating to homosexuality and contraception, led parents to be wary of, and undermine, sexual education (Varani-Norton, 2014). To counter this, the study recommended an education programme for parents be designed to operate alongside the FLE.

It should also be noted that outside of the school system, various NGOs provide sexual education through youth programmes, as do some faith-based organisations (Mitchell, 2012).

Based on situation analyses commissioned by UNFPA in 2019 and 2021, the existing school-based FLE is not aligned to international standards. Led by the Ministry of Education and technical support from UNFPA and partners, efforts are underway to update the FLE curriculum and align it to international standards.

5 Gender-based violence in law and policy

This section of the report follows the same structure as Section 4. Key national policy documents will be outlined, highlighting their relevance to GBV. Policies along with relevant legislation will then be explored further, according to key gender-based violence (GBV) domains developed for this review.

5.1. Background

Fiji's rates of gender-based violence are estimated to be approximately double the global average. In 2013, the Fiji Women's Crisis Centre (FWCC) published a national prevalence study (n=3193) which found that 71 per cent of women had experienced physical or sexual violence or at some point in their life since turning 15. Sexual abuse was found to be rife, with one-third experiencing sexual violence in their lifetime, and 82 per cent of those raped by their husbands or partners (FWCC, 2013). Of those surveyed, 16 per cent had been sexually abused before the age 15, mostly by male family members or friends. The prevalence of physical and sexual violence perpetrated by non-partners was 31 per cent for women and girls over the age of 15 years (FWCC, 2013). High rates of physical and sexual violence during childhood and adolescence have also been linked with negative sexual and reproductive health outcomes, such as unintended pregnancies and STIs (Duke et al., 2015; Mitchell and Bennett, 2019; UNFPA, 2013).

The prevalence study found iTaukei women were slightly more vulnerable to experiences of violence compared with Indo-Fijian women; 69 per cent of iTaukei women had experienced physical violence at the hands of an intimate partner, compared with 47 per cent of Indo-Fijian women (FWCC, 2013). The study also found that iTaukei women were more likely to experience more severe physical violence, such as being punched, kicked, struck with an object or weapon, threatened with a weapon, dragged, and beaten. As such, iTaukei women are more likely to be injured as a result of domestic violence.

Indo-Fijian women were more likely than iTaukei women to seek help from external services. However, three quarters of women surveyed had never sought help from an agency, and almost half had never disclosed experiences of violence to anyone at all (FWCC, 2013). Research has found that women and girls are often unlikely to disclose violence due to the perceived shame that this could bring upon her and her family, in both iTaukei communities (Newland, 2016; O'Connor et al., 2018) and Indo-Fijian communities (Adinkrah, 2001). Tonsing and Barn's (2020) research found that instead of relying on external agencies, Fijian women tend to employ a range of strategies to cope with violence, such as taking solace and support in their faith. Fiji Women's Rights Movement's (FWRM) 'Balancing the Scales' study (2017) surveyed women involved in the justice system and found that women lived with violence for an average of two years and four months before seeking help from the police. The study estimated that in 2016 only seven per cent of women experiencing physical or sexual violence reported violence to the police.

The report also highlighted particular issues accessing assistance in rural and remote areas. According to the findings, despite half of the Fijian population living in rural areas, only 116 criminal cases and two domestic violence cases were heard within Island Courts (circuit Magistrates' courts) in 2016 (FWRM, 2017). High Court hearings are only heard in Suva, Lautoka and Labasa, which can prevent women from accessing justice due to prohibitive court fees, accommodation and transport costs.

5.2. Domestic legislation and policy

Currently, there is no overarching governmental policy or strategy to address GBV, however, many plans and programs include GBV components. It is reported that the Ministry of Women, Children and Poverty Alleviation (alongside Ministry of Education, Heritage and Arts, Ministry of Health and Medical Services, Ministry of Employment, Productivity, Industrial Relations, and the Ministry of Youth and Sports) is committed to developing a five-year 'National Action Plan to Prevent Violence Against Women and Girls'; however, at the time of writing, this has not been finalised (Vuniwaqa, 2020).

The following table summarises the key legislation and policies with GBV-specific provisions:

Table 6: Domestic legislation and policies that relate to gender-based violence in Fiji

| Policies and legislation that relate to gender-based violence | |
|---|---|
| Legislation | <i>Domestic Violence Act 2009</i> |
| | <i>Child Welfare Act 2010</i> |
| | <i>Crimes Act 2009</i> |
| | <i>Sentencing and Penalties Act 2009</i> |
| | <i>Criminal Procedure Act 2009</i> |
| | <i>Juveniles Act 1973</i> |
| | <i>Bail Act 2000</i> |
| | <i>Police Act 1965</i> |
| | <i>Family Law Act 2003 (Family Law (Amendment) Act 2012; Family Law (Amendment) Act 2005)</i> |
| | <i>Human Rights Commission Act 2009</i> |
| | <i>Online Safety Act 2018</i> |
| | <i>Rights of Persons with Disabilities Act 2018</i> |
| | <i>Marriage Act 1968 (Marriage Act (Amendment) Decree 2009)</i> |
| Policies and guidelines | |
| Ministry of Women, Children and Poverty Alleviation | Women's Plan of Action (1999-2008); Women's Plan of Action (2010-2019) |
| | National Gender Policy (2014) |
| | National Service Delivery Protocol for Responding to Cases of Gender-Based Violence (2018) |
| | Inter-Agency Guidelines (IAG) on Child Abuse and Neglect (2015) |
| Ministry of Education | Child Protection Policy (2010; revised 2015) |
| Ministry of Labour, Industrial Relations, Tourism and Environment | National Policy on Sexual Harassment in the Workplace (2007) |

Policies and legislation that relate to gender-based violence

| | |
|---|--|
| Fiji Police Force | No Drop Policy (1995; 2013) |
| Ministry of Health and Medical Services | Responding to Intimate Partner Violence and Sexual Violence against Women and Girls (clinical guidelines) (2015) |
| | Child Protection Guidelines for Health Workers in Fiji (2012) |
| | Reproductive Health Policy (2010) |
| | National Strategic Action Plan on HIV and STIs (2016–2020) |
| | Fiji Disability Action Plan (2002) |

National Gender Policy 2014

As discussed, the *National Gender Policy* includes provisions for gender sensitisation training, disaggregated data collection, gender analysis, and applying a gender lens to legislation and government decision-making, be it policy planning or budget allocation (MoSWWPA, 2014). A central focus of the policy is addressing GBV by establishing the Gender-Based Violence Service Protocol to ensure better coordination of essential inter-agency services. The Protocol was successfully released in 2018 and is discussed further below. The policy outlines strategies around training, victim support, coordination and institutional strengthening and counselling services for perpetrators. The National Gender Policy has not been reviewed or updated since its development in 2014.

The 5-year -20-year National Development Plan (2017-39) incorporates implementation of the National Gender Policy and the Women’s Plan of Action as a focus, including review and revision of laws relating to elimination of violence against women.

Women’s Plan of Action (2010-2019)

Although elimination of GBV is a distinct priority in itself, it is clear that all the initiatives of the *Women’s Plan of Action* contribute to challenging inequalities faced by women, which underpin GBV.

The Department of Women, Children and Poverty Alleviation works in partnership with other ministries and agencies such as the Fiji Police Force and the Ministry of Education, through various arrangements and memoranda of understanding, to achieve the initiatives outlined by the *Plan of Action*.

In a performance review of Fiji’s efforts to eliminate violence against women under the *Women’s Plan of Action (2010-2019)*, the Auditor General (2019, p. xii) found that the plan failed to fully align with the Beijing Platform for Action 1995, and was focused more on responding to violence, rather than efforts to address primary and secondary prevention of violence. It was noted that ‘there is weak alignment between strategic objectives and the action plans due to the lack of effort by the DoW [Department of Women] in undertaking research work on the root causes of violence against women’.

In 2013, the Department set up the Elimination of Violence Against Women taskforce to help deliver the Women’s Plan of Action objectives, consisting of members from government, NGOs and development agencies. The purpose of the taskforce is to develop policy and programming for better service delivery and protections for victims of domestic violence. The Auditor General (2019) has also criticised the institutional set up of the taskforce, particularly in relation to its administration, monitoring and coordination and its lack of inclusivity, while noting that the taskforce had been challenged by significant financial and human resource constraints.

No Drop Policy

The *No Drop Policy* was first introduced with respect to domestic violence cases in 1995 and reaffirmed in 2013. The policy was developed in an effort to tackle the pressure that may be placed on victims by family members to withdraw their statements. The *No Drop Policy* is presently provided for in various policy documents, including the *Fiji National Service Delivery Protocol for Responding to Cases of Gender-Based Violence* (2018) and the *National Gender Policy* (2014). Though it does not refer explicitly to a no drop approach, the *Domestic Violence Act 2009* also requires that police pursue all matters and have a 'duty' to 'bring offenders to justice' (s 12).

Concerns have been raised regarding law enforcement and court officials' knowledge and implementation of the *No Drop Policy*. Advocates claim that police officers consistently fail to investigate and prosecute complaints and are likely to victim-blame and/or charge victims, as well as defer to traditional processes of reconciliation (UNHRC, 2019b). The Auditor General (2019) found that greater oversight of the effectiveness of the *No Drop Policy* is needed. A 2017 Fiji Women's Rights Movement (FWRM) study found that two-thirds of women surveyed who had been in contact with the justice system faced issues when reporting to police and were advised to resolve the conflict within the family. A refuge in Fiji, Homes for Hope, has also noted that there is a persistent need to monitor the implementation of the *No Drop Policy* (UNFPA, 2008). FWCC offers training sessions for police officers and other legal officers to attempt to change attitudes towards domestic violence and domestic violence proceedings (UN Women et al., 2019).

Zero Tolerance Violence Free Communities programme

The Zero Tolerance Violence Free Communities (ZTVFC) campaign was launched in 2008, initially funded by UN Women, and delivered in a partnership between the Ministry of Women, the Fiji Police Force and NGOs (Shamim, 2014). The programme is designed to be driven by communities themselves and involves the identification of a 'gatekeeper' committee of community members to lead the project. Communities take part in 10 phases of development and capacity building (CEDAW Committee, 2016). As part of the programme, stakeholders working in the communities, such as police, take part in training around gender awareness and best practice procedures for working with victims of violence (Kate, 2015). The programme also attempts to raise awareness through training with community members about the legislative protections available to women and children under the *Domestic Violence Act 2009* and *Child Welfare Act 2010*. The gatekeepers on the committee play a role in attempting to resolve domestic disputes without violence and refer the dispute to legal avenues when such attempts are unsuccessful. It has been noted that this process may result in women being encouraged to reconcile with violent partners (George, 2018).

Since 2008, 88 communities have signed up to take part in the programme and 60 have completed the programme to be declared a ZTVFC (OAG, 2019). The Fiji Police Force have reported anecdotally that communities which successfully take part in the programme tend to demonstrate decreasing rates of domestic violence as well as crime in general (CEDAW Committee, 2016). It has been suggested, however, that communities who wish to retain their positive status of 'violence free' may be more likely to try to reconcile disputes outside of the legal process, leading to an under-reporting of domestic violence (FWCC, 2013; George, 2018). An independent evaluation of the ZTVFC programme is currently underway.

Fiji National Service Delivery Protocol for Responding to Cases of Gender Based Violence (2018)

The Elimination of Violence Against Women taskforce (with technical support from UN Women) developed the Fiji National Service Delivery Protocol for Responding to Cases of Gender Based Violence (2018), an interagency service delivery protocol (SDP). The protocol sets out standard operating procedures and referral pathways for social services, the Fiji Police Force, health services as well as legal practitioners and the judiciary. The SDP is designed to improve service providers' coordinated response across agencies and outlines a common set of principles and guidelines, taking a 'survivor-centred approach'. The SDP is accompanied by a 'signature of understanding' adopted by key stakeholders committing to

the implementation of the protocol, including the Ministry of Women, Children and Poverty Alleviation, the Ministry of Health and Medical Services, Fiji Police Force, Legal Aid, Ministry of iTaukei Affairs, FWCC, Medical Services Pacific, Empower Pacific, Homes of Hope, and The Salvation Army. The signatories to the SDP also form the basis of the GBV working group under the Fiji Safety & Protection cluster during emergencies, discussed further under Section 8 of this report.

The protocol is comprehensive and in line with the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, a partnership by UN Women, UNFPA, WHO, UNDP and UNODC.

While it is emphasised in the 'signature of understanding' commitments that the protocol is a living document that will be updated annually, there is no evidence of any updates having taken place since 2018 nor a comprehensive evaluation of its implementation.

Concerningly, the recent Health Facility Readiness and Service Availability (HFRSA) Assessment (UNFPA, 2020) found that only four per cent out of the 212 facilities audited were considered to be 'GBV service ready'. The Assessment looked at factors such as staff training to respond to GBV (only 27 per cent of staff had received training across the facilities), and the specific ability to respond to sexual violence (less than half of the services reported providing emergency contraceptives and post-exposure prophylaxis, and only 27 per cent of facilities had the ability to collect forensic evidence).

Reproductive Health Policy 2010

Recognising the important links between sexual and reproductive health and GBV, the *Reproductive Health Policy* includes various sections concerned with violence. The policy includes a 'reduction in gender-based violence' as a performance indicator and sets out the following strategic objectives and outcomes:

- 'Review of current Gender Based Violence (GBV) response services and programmes for men to identify areas for improvement' (p. 12)
- 'Advocacy for the importance of gender equality in the health and development of Fiji' (p. 12)
- 'Capacity building and in-service training for all staff involved in the care of victims of GBV, including training on the forensic role of health workers' (p. 12)
- 'Establishment of a network for the care and support of women and girls who experience violence of GBV' (p. 12)
- 'Increasing service providers' capacity to prevent, detect and respond to gender-based violence, including referrals' (p. 23)
- 'Create advocacy groups against gender violence' (p. 33)
- 'Conduct research on gender-based violence issues' (p. 33)
- 'Create COMBI Plan for campaign against gender violence' (p. 33)

However, the *Reproductive Health Policy* set out a limited budget of \$20,000 to further these ambitious aims for 2010-2011. At the time of this review, there has been no more recent workplan or budget developed under the policy.

The remainder of Section 4 of this report explores Fiji's policies and legislation in relation to GBV key domains developed for this review.

5.3. Domestic violence

5.3.1. The Domestic Violence Act 2009

The *Domestic Violence Act 2009* does not draw a distinction between intimate partner violence and violence between family members; it applies 'in a family or domestic relationship'. The provisions are framed in gender neutral terms and so are capable of including same-sex relationships (s 2).

Violence is defined to include physical violence, sexual violence, property damage, threats or intimidating behaviour, stalking, as well as persistent behaviour that is cruel, abusive, inhumane, degrading, provocative or offensive (s 3(2)). The definition does not include economic abuse. Violence includes causing a child to witness any of these behaviours (s 3(2)(g)). Protection can be sought for violence that occurs in a single incident or through a pattern of behaviours (s 3(5)).

Under the Act, a Domestic Violence Restraining Order (DVRO) can be sought to protect victims of domestic violence. DVRO matters are civil in nature and subject to a civil burden of proof (i.e., on the balance of probabilities), unless the order is breached, which constitutes a criminal offence (s 46). Applications for DVROs to protect people from violence may be made by the police, the victim, or a carer, parent or guardian of the victim (s 14, s 19).

The Act requires police to apply for a DVRO to protect any person who is or may become a victim of violence where:

- the perpetrator will be charged with an offence in relation to domestic violence; or
- where they suspect violence has been or will be committed and the victim's safety is at risk.

This provision supports the Fiji Police Force's *No Drop Policy*. The *Domestic Violence Act 2009* also sets out other key responsibilities that are incumbent on police, such as duties to:

- Ensure that the victims are referred for medical treatment and can receive such treatment safely;
- Inform the victim of their rights to apply for protection; the police's duty to apply for an order to protect the victim; the police's duty to prosecute crimes if they have been committed; domestic violence services available; and the police complaints process.
- Assist the victim to stay in the home, or, where this is not possible, find suitable accommodation, as well as assist the perpetrator to find accommodation.

Notwithstanding these requirements, the Fiji Police Force has yet to include content on gender sensitivity, the *Domestic Violence Act 2009*, the *Child Welfare Act 2010*, or sexual violence offences in the Training Manual for the Police Academy, despite a memorandum of understanding with the Ministry of Women Children and Poverty Alleviation regarding this (August 2017- July 2018) (OAG, 2019). Indeed, the Auditor General has raised concerns with the general implementation of the Act (see Figure 1) (OAG, 2019).

In practice, it is reported that applications under the legislation are rarely made by women themselves (refer to Figure 1) (OAG, 2019). The Auditor General (2019) found that this is due to a lack of awareness of their rights, the law and legal processes; fear of social stigma; pressure to remain with their partners and families; fear of increased violence as a result of reporting; and the inappropriate use of law and legal systems to undercut women's ability to exercise their rights.

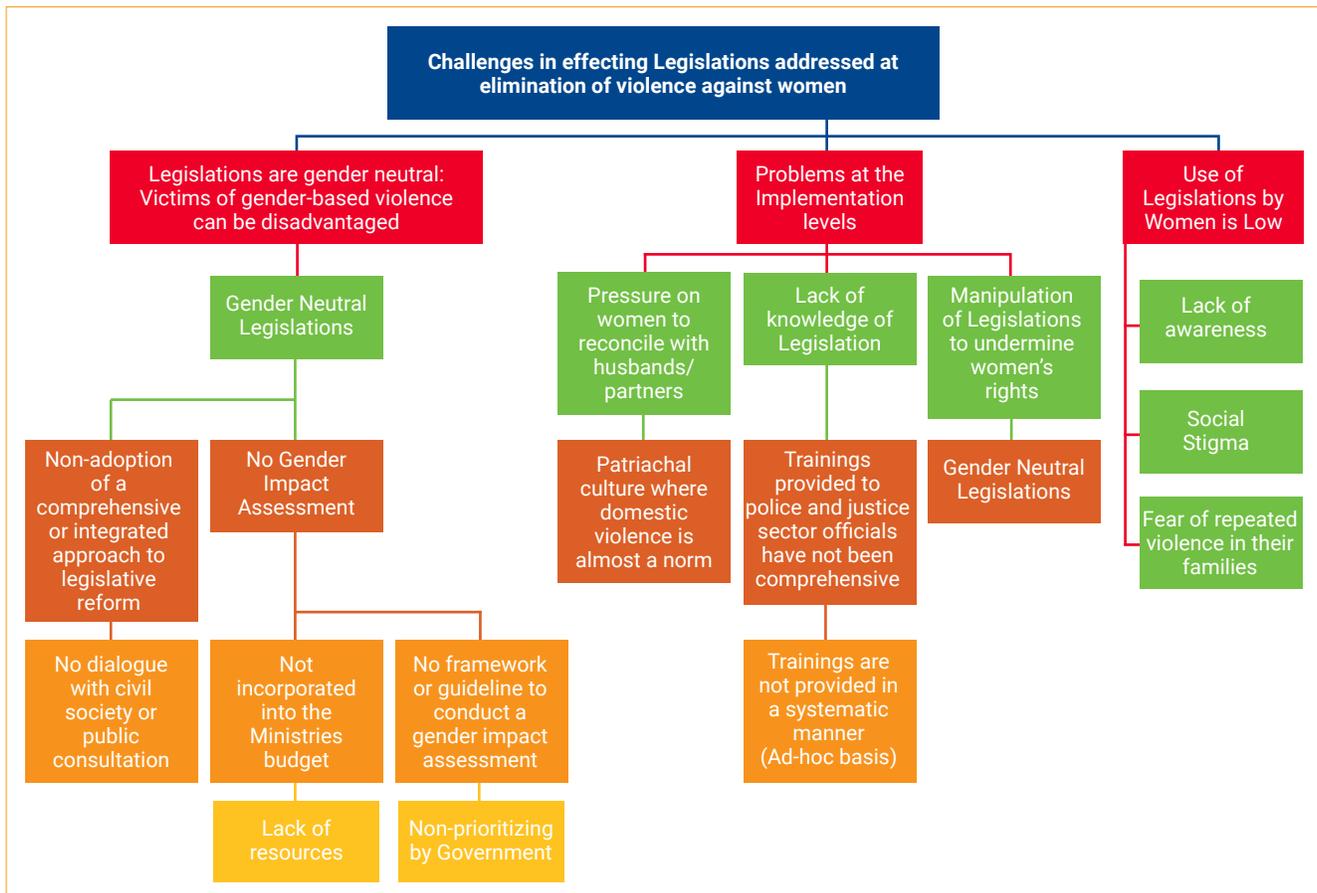
The Auditor General (2019) also raised concerns regarding the gender neutrality of the Act, as it fails to account for the unequal impact the legislation may have on women. As outlined in Figure 1, the gender

neutrality of provisions has reportedly led to manipulation of the legislation by men in order to victimise and disadvantage women. ‘Balancing the Scales: Improving Fijian Women’s Access to Justice’, a research project conducted by Fiji Women’s Rights Movement (FWRM) found that many men make their own applications for DVROs, despite the fact that it is women who are most often the victims of gendered violence (FWRM, 2017).

5.3.2. Family law

The *Family Law Act 2003* set up a family court in Fiji and deals with divorce, maintenance and matters relating to children. In addition to DVROs made under the *Domestic Violence Act 2009*, restraining orders can be also made in the form of injunctions under the *Family Law Act 2003*. An application for a restraining order can be made by an individual independently of other family law proceedings (*Family Law Act 2003* s 202). However, pursuant to the *Family Law (Amendment) Act 2005*, once a divorce or dissolution order has been made by the Court, applicants cannot bring further proceedings for an injunction in this jurisdiction. It is also open to the Court to make an order to protect a party where they see fit, regardless of whether an application has been made (ss 2(1)(f), 202(1)).

Figure 1: Office of Auditor General's (2019) assessment of challenges facing legislation that addresses violence against women



Source: Office of the Auditor General (2019) ‘Coordination of Actions on Elimination of Violence against Women: Performance Audit’ (Parliamentary Paper No.129 of 2019) Office of the Auditor General, Republic of Fiji: Suva.

The *Family Law Act 2003* importantly allows divorce on a ‘no fault’ basis, which can ease the process of separation, particularly in circumstances of domestic violence. *The Family Law Act 2003* also recognises the non-financial contributions that partners make to a marriage, enabling many women’s contributions (e.g., as homemakers) to be represented in financial settlements.

The *Family Law Amendment Act 2012* incorporated de facto relationships within the definition of marriage. However, 'de facto relationship' is defined as a relationship between a man and a woman who live with each other as spouses on a genuine domestic basis although not legally married to each other' (s 2) and so precludes LGBTIQ persons from accessing the family law system.

The *Family Law Act 2003* also has provisions which deal with the risk of family violence in relation to matters that concern children. Section 124 states:

1. In considering what order to make, the court must, to the extent that it is possible to do so consistently with the child's best interest being the paramount consideration ensure that the order-
 - a. is consistent with any family violence order; and
 - b. does not expose a person to an unacceptable risk of family violence.
2. For the purpose of subsection (1)(b) the court may include in the order any safeguards that it considers necessary for the safety of those affected by the order.

To file or defend a case in the Family Court requires payment of \$50 FJD filing fee, which amounts to approximately one week's average income (FWRM, 2019).

5.3.3. Child welfare

The *Child Welfare Act 2010* provides for mandatory reporting to child welfare authorities in cases where a professional becomes aware that a child has been or is likely to be harmed (s 4). Professionals who are required to report are defined as health professionals, teachers, police officers and legal practitioners (s 4). Failure to give notice to authorities is a criminal offence and subject to a fine of \$5,000.

In addition to involvement with child welfare authorities, corporal punishment of children in Fiji is considered assault, and persons can be charged under the *Crimes Act 2009*.

There are various child welfare policies at the ministry level:

- Fiji Ministry of Education has a Child Protection Policy (2010; revised 2015) (Ministry of Education, Heritage and Arts)
- Child Protection Guidelines for Health Workers in Fiji, (2012) (Ministry of Health (now Ministry of Health and Medical Services))
- Fiji Interagency Guidelines (IAG) on Child Abuse and Neglect.

Though Fiji is ahead of other Pacific countries in enacting mandatory reporting requirements in relation to children, it has been questioned whether these laws are implemented in practice (Duke et al., 2015). Literature also suggests that people may avoid seeking assistance from external services for fear that services may break up the family. Tonsing and Barn (2020, p. 7) found such apprehensions in their research; one participant noted:

I mean if I go to women crisis centre, they might do something to my husband, like put DVRO on him and this may separate the family . . . how will it look, I always think then the children will be bullied in school...'
(p. 7)

5.3.4. Criminal law

Domestic violence is not a crime in itself under Fijian law. Domestic Violence Restraining Orders (DVROs) or injunctions are civil in nature; however, as noted above, a breach of an order constitutes a criminal offence (*Domestic Violence Act 2009* s 77). Under the *Crimes Act 2009*, violence that takes place in domestic spaces can also be considered criminal where it falls under the ambit of other crimes. A non-exhaustive list of existing criminal offences that may be relevant in domestic violence incidents are outlined in Table 7. In criminal cases, the burden of proof falls upon the prosecution and the standard is beyond reasonable doubt (*Crimes Act 2009* s 58). In addition to the *Crimes Act 2009*, other criminal law processes and offences are set out in the *Criminal Procedure Act 2009*, *Juveniles Act* (n.d.), *Bail Act 2000*; *Online Safety Act 2018*; *Sentencing and Penalties Act 2009* and *Police Act 1965*.

Table 3: Criminal offences that may intersect with domestic violence incidents

| Charge | Legislation | Maximum sentence |
|--|--|---|
| Common assault | <i>Crimes Act 2009</i> , Part 15, Division 5, s.274 | 1 year |
| Assault causing actual bodily harm | <i>Crimes Act 2009</i> , Part 15, Division 5, s.275 | 5 years |
| Assault with the intent to commit rape | <i>Crimes Act 2009</i> , Part 12, s.209 | 10 years |
| Manslaughter | <i>Crimes Act 2009</i> , Part 15, Division 1, s.239 | 25 years |
| Murder | <i>Crimes Act 2009</i> , Part 15, Division 1, s.237 | Mandatory sentence of life imprisonment; however, there judicial discretion remains |
| Kidnapping | <i>Crimes Act 2009</i> , Part 15, Division 6, s.279. | 7 years |
| Rape | <i>Crimes Act 2009</i> , Part 12, s207 | Life imprisonment |
| Sexual assault | <i>Crimes Act 2009</i> , Part 12, s210 | 10 years |
| Causing harm by posting electronic communication | <i>Online Safety Act 2018</i> Part 4, s24 | 5 years |
| Posting an intimate visual recording | <i>Online Safety Act 2018</i> Part 4, s25 | 5 years |

Provocation

Provocation has historically been a problematic doctrine that has been relied upon by male perpetrators of violence to limit their criminal responsibility for killing their partners. Provocation remains a defence under the *Crimes Act 2009*; murder can be reduced to an offence of manslaughter under s 242(1):

When a person who unlawfully kills another under circumstances which, but for the provisions of this section would constitute murder, does the act which causes death in the heat of passion caused by sudden provocation as defined in sub-section (2), and before there is time for the passion to cool, he or she is guilty of manslaughter only.

Provocation is defined in section 242(2) as any wrongful act or insult which can ‘deprive him or her of the power of self-control and to induce him or her to commit an assault of the kind which the person charged committed’.

Sentencing

Sentencing in domestic violence matters is governed by the *Crimes Act 2009* and the *Sentencing and Penalties Act 2009*, as well as case law. There are particular matters the court must have regard to in sentencing cases of domestic violence, set out in the *Sentencing and Penalties Act 2009* s 4(3).

Concerns have been raised about inappropriate factors taken into consideration by the judiciary when sentencing in cases of GBV, such as gender stereotypes and traditional practices (e.g. *bulubulu*). In a study evaluating the considerations taken into account by the judiciary in sentencing in the Pacific, the ICAAD and Clifford Chance (2018) conducted a case study analysis of a rape case in Fiji (*Aisea Cabebula v State* (Criminal Case No: HAC 172/2011)). The case concerned a man who pleaded guilty to raping his 18-year-old daughter. Analysis of the sentencing judgement demonstrated that the judge prioritised the interests of the perpetrator over the victim's needs and referred to gender stereotypes in deciding upon the sentence. What is more, the perpetrator's sentence was reduced due to so called mitigating factors including the fact that he was married and was the sole breadwinner for his family. This confirms findings of the FWRM (2017) which in an analysis of rape cases heard in the High Court in 2016-2017, observed that the accused's sentence was reduced due to their role of sole breadwinner in approximately one in five cases in 2016.

5.4. Sexual violence

Sexual violence offences, including sexual assault, intent to commit rape, rape, incest, and defilement of a child under 13 or young person between 13-16 are set out in the *Crimes Act 2009*. Replacing the Penal Code, the *Crimes Act 2009* expanded the definition of rape to include penetration of the vulva, vagina or anus with anything, body part or penis; or penile penetration of the mouth. The Act increased the maximum sentence to life in prison. The rape provisions and sexual assault provisions are gender neutral and therefore incorporate same sex non-consensual relations.

Sections 206(1) and (2) define sexual consent as freely and voluntarily given by a person with the necessary mental capacity to give consent, and the submission without physical resistance by a person shall not alone constitute consent. Consent is not given if it is obtained

- a. by force; or
- b. by threat or intimidation; or
- c. by exercise of authority; or
- d. by false and fraudulent representations about the nature or purpose of the act; or
- e. by mistaken belief induced by accused person that the accused person was the person's sexual partner.

The *Crimes Act 2009* establishes that a person under the age of 13 years is incapable of giving consent (s 207 (3)).

However, the *Crimes Act 2009* s 215(2) also provides that

it shall be sufficient defence to any charge under subsection (1) [he or she unlawfully and carnally knows or attempts to have unlawful carnal knowledge of any person between 13 and 16 years of age] if it shall be made to appear to the court that the person charged had reasonable cause to believe, and did in fact believe, that the person was of or above the age of 16 years.

Note that concluding observations on the fifth periodic report of Fiji from the Committee on the Elimination of Discrimination Against Women recommends clearer legislative provision that the 'burden of proof regarding exculpating circumstances relating to the victims age lies with the perpetrator' (CEDAW Committee, 2018, p. 8). In reviewing legislation on consent and 'mistake as to age' laws, Warner (2012) suggests that a good

approach to achieve a greater onus on the defendant to ascertain age is the introduction of a 'reasonable steps' requirement. Warner (2012, p. 1038) used examples in Canadian and New Zealand legislation where the defence of mistake is not available for child-specific sex offenses 'unless the accused took all reasonable steps to ascertain the age of the complainant'. Age of consent will be discussed further under 'Adolescents and youth' in Section 6 of this report.

Key legislative changes made through the Criminal Procedure Act 2009, set out that:

- Corroboration is not required in sexual offence cases (s 129), affirming case law; and
- Evidence of past sexual history is not permissible (s 130).

Notwithstanding the legislative progress in this area, the way in which rape cases are dealt with in practice by authorities is not necessarily in line with best practice or policy. For example, 76 per cent of rape cases referred to Medical Services Pacific in 2015 and 2016 by the Fiji Police Force involved rape kits which were sent for pathological analysis. However, analysis of 67 rape cases heard in the High Court in 2016 demonstrated that pathology or forensic evidence was not presented to the court in a single case (FWRM, 2017).

Currently, sexual harassment is not an offence in Fiji and advocates have called for specific provisions concerned with sexual harassment to be added to the *Crimes Act 2009* (UNHRC, 2019a). Sexual Harassment is defined in the *Employment Relations Act 2007* s 76 which mandates employers to have in place a policy to prevent sexual harassment in the workplace. There is a *National Policy on Sexual Harassment in the Workplace* (2008), which sets out the various behaviours considered to be sexual harassment in employment contexts, as well as obligations on the part of employers and employees to address such harassment. Despite this provision, concern has been raised about implementation and appropriate mechanisms to monitor implementation of the policy within workplaces by the Ministry of Employment (UNHRC, 2019a).

5.4.1. Marital rape

Marital rape has been a key issue raised by advocates working in the GBV sector in Fiji (FWCC, 2005, 2010). Between January and June 2015, the FWCC assisted 67 women who sought help for marital sexual abuse issues (Moceituba, 2015). Like other common law jurisdictions, marital rape was historically legal in Fiji, even after separation. Under the *Crimes Act 2009*, rape is criminalised under the general sexual offenses contained in chapter 12; however, there is no express direction that the rape provisions apply to non-consensual sex within relationships, or any distinction made for marital rape or rape that occurs within relationships. The UN Women (2012) Handbook for Legislation on Violence Against Women recommends that rape within relationships such as marriage should expressly be criminalised in legislation, either by:

providing that sexual assault provisions apply 'irrespective of the nature of the relationship' between the perpetrator and complainant; or stating that 'no marriage or other relationship shall constitute a defence to a charge of sexual assault under the legislation' (p. 24).

Court decisions relating to rape within marriage make clear that rape is illegal in Fiji, regardless of relationship status. In a 2014 case concerning marital rape, Judge Janaka Bandara observed:

The law pertaining to 'Rape' is well settled in this jurisdiction. When the victim is over thirteen (13) years, 'consent' is an essential element to have sexual intercourse. In other words, what matters is the 'consent', but not the 'relationship' the perpetrator shares with the 'victim'. In the eyes of the Law, irrespective of their gender, everybody is equal and treated equally. A spouse is no exception. (*State v Ismail* [2014] FJHC 628 [25])

It should be noted however, that customary laws and religious institutions do not necessarily view marital rape as a crime, in contradiction with the legislation and case law (SRI, 2016).

Although prevalence data suggest sexual violence within marriage is common in Fiji (FWCC, 2013), victims of sexual violence within marriage are likely to experience shame and may be hesitant to seek help (UNFPA, 2008). A mixed methods study conducted by UNFPA Pacific (2008) found that police officers lacked awareness of the issue of sexual violence within marriage, and that they were likely to disregard reports of marital sexual violence when women reported such.

5.5. Other forms of gender-based violence

5.5.1. Trafficking and modern slavery

Section 10 of the *Constitution* protects against trafficking and forms of modern slavery, stating that '[a] person must not be held in slavery or servitude, or subjected to forced labour or human trafficking.' The *Crimes Act 2009* (Division 6) sets out provisions against sex trafficking and some labour trafficking with a penalty of 12-20 years imprisonment in relation to the trafficking of adults, and 25 years imprisonment for trafficking of children. These offences are movement-based: a person must be transported domestically or internationally for the offences to apply.

Division 5 of the *Crimes Act 2009* also prohibits slavery, sexual servitude, debt bondage and the deceptive recruitment of persons for the purposes of slavery or servitude. This includes providing finance for slavery or sexual servitude. Moreover, division 3 of the Act includes crimes that relate to "crimes against humanity" and includes provisions against enslavement, deportation, imprisonment, rape and sexual slavery, enforced prostitution, enforced pregnancy, enforced sterilisation and sexual violence, where 'the perpetrator's conduct is committed intentionally or knowingly as part of a widespread or systematic attack directed against a civilian population.'

Nevertheless, concerns have been raised about children being forced to work as sex workers in Fiji (Nacei, 2019b; UNHRC, 2019a), and calls have been made to strengthen legal frameworks that protect children by, for example, criminalising visiting a country with the intention of child sexual exploitation (UNHRC, 2019a).

On 19 September 2017, Fiji acceded to the 'Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children' (supplementing the United Nations Convention against Transnational Organized Crime). National action plans to address trafficking in Fiji are reported to have been drafted but not implemented (US Bureau of International Labor Affairs, 2018; US Department of State, 2019). In 2021, Fiji ratified the CRC optional protocol on the sale of children, child prostitution, and child pornography.

Though there is limited data on the true scope of the problem, it is acknowledged that human trafficking and slavery are issues for Fiji. The Minister for Women, Children and Poverty Alleviation, Mereseini Vuniwaqa recently noted that 'Fiji has an extensive porous border with a huge maritime space that makes it vulnerable for trafficking in persons as a transit and destination country for men, women and children' (Fijian Government, 2019, [4]).

The police have an anti-trafficking unit and provide anti-trafficking training to recruits; however, it has been reported in the media that an estimated 80 per cent of Fijian police officers are unable to identify and appropriately process a trafficking case (Nacei, 2019a). To the authors' knowledge, since the *Crimes Act 2009* was enacted there have been three successful prosecutions of trafficking (Pryde, 2014; U.S. Department of State, 2019). The Fijian Government has been criticised by members of the international community such as

the United States for failing to take active measures to screen for victims of trafficking in vulnerable groups, and for failing to comply with victim identification guidelines (U.S. Department of State, 2019).

Once identified, victims of trafficking into Fiji do not have legal rights to work or social benefits in Fiji. As such, they are generally dependent on NGOs for support and may even be detained in immigration detention centres after identification (Pryde, 2014).

5.5.2. Forced and early marriage

Prior to 2009, the *Marriage Act 1968* allowed for females to marry between the ages of 16-21 and males to marry between the ages of 18-21 with parental consent. After pressure from civil society organisations and international actors, Fiji amended the *Marriage Act 1968* to address early marriage (Lechuga Foundation & Sexual Rights Initiative, 2010). The *Marriage Act (Amendment) Decree 2009* adjusted the marriageable age to 18 for both males and females and abolished the requirement for consent from parents. The amendment also set out an offence for marrying a minor at s 29 (Marriage Act 1968):

Any person who -

- a. wilfully and unlawfully marries a person under the age of 18 years; or
- b. induces or endeavours to induce any marriage officer or other person to solemnize marriage between parties when the person so acting knows that one of the parties to the marriage is a minor; or
- c. abets or assists the principal offender in any such act or endeavour as is described in paragraphs (a) and (b), knowing that a party to the marriage or intended marriage is a minor.

shall be guilty of an offence and liable on conviction to a fine not exceeding five hundred dollars or to imprisonment for a term not exceeding two years.

This offence is therefore capable of applying to parents or other family members who may have facilitated the marriage of an underage person, as well as the person who is party to a marriage to an underage person.

The practice of early and arranged marriages is reportedly most prevalent in Indian-Fijian communities (UNHRC, 2019a), and also occurs in communities in rural areas (Prasad et al., 2009). As elsewhere, poverty and economic hardship play a key role in the occurrence of early marriage in Fiji. Families who are unable to adequately support their daughters may arrange marriage at an early age, and, in some instances, may marry their daughter into a wealthier family living overseas in the hopes of ongoing financial support (FWRM, 2010; Prasad et al., 2009). Anxiety about female sexuality outside of marriage in adolescence is also present in both i-Taukei and Indian-Fijian communities (O'Connor et al., 2018), which can act as an incentive for young women to be married at an early age.

In contrast with early marriage, forced marriage is not criminalised as an explicit offence.

6 Law and policy in relation to key populations

Section 6 of this report explores in greater depth the SRH and GBV legislative and policy implications for key population groups.

6.1. Adolescents and youth

Young people in Fiji experience high rates of early pregnancy and STIs, indicating an unmet need for family planning within this population. Rates of teen pregnancy in Fiji have been a cause of concern for policymakers for several decades. The adolescent (15-19-year-old) birth rate appears to be increasing slightly in recent years with 46 births per 1,000 women in 2010, 49 births per 1,000 in 2018, to 49 births per 1,000 women in 2019 (World Bank, 2019). Complications in pregnancy and birth represent the main cause of death in girls aged 15-19 globally (WHO, 2020). Adolescent mothers have higher risk of experiencing complications either themselves (such as eclampsia, puerperal endometritis, infections) or their babies (such as low birth weight, severe neonatal conditions and preterm delivery) (WHO, 2020).

As discussed earlier, a 2008 study testing prevalence levels of STIs in Fijian pregnant women found that 34 per cent of those under 25 tested positive for chlamydia (Cliffe et al., 2008). Though in Fiji HIV rates are relatively low, young people between the ages of 20-29 years have been found to account for 41 per cent of HIV notifications (MHMS, 2016 cited in Mitchell & Bennett, 2020). General knowledge regarding STIs, contraception, and reproductive health consequences has been found to be low among young people in the community (Mitchell, 2012).

The nexus between GBV and SRH for adolescents and youth has been long-established globally. This relationship with violence and SRH has been confirmed in Fiji (Mitchell & Bennett, 2019; Newland, 2016); Mitchell and Bennett's (2019) research demonstrated the connection between male coercion in intimate partner relationships and poor reproductive and sexual health outcomes for young women, over which they had little control. Prevalence research conducted by Fiji Women's Crisis Centre found that when comparing lifetime and current risk of violence, younger women aged 18-24 have a much higher current risk of experiencing physical partner violence (40 per cent or 2 in 5) compared with women across all age groups in Fiji (19 per cent or 1 in 5) in the 12 months before the survey (FWCC, 2013). A similar picture emerges for sexual violence, with 28 per cent of women under 24 years of age subjected to sexual violence by a partner compared with 19 per cent of women across all age groups in Fiji in the 12 months before the survey (FWCC, 2013). The survey also found that 16 per cent of women were sexually abused as children; and for 5 per cent of women (1 in 20), their first sexual experience was forced and for a further 24 per cent (almost 1 in 4) it was coerced.

Early marriage can also lead to poor maternal health outcomes due to its association with early pregnancy and reduced reproductive autonomy. Both early marriage and adolescent pregnancy have economic consequences, as girls may be prevented from continuing their education or employment (Wodon et al., 2017). While the *Constitution* (s 31) protects the right to primary and secondary education and the *Education Act 1966* mandates compulsory education for 6-15-year-olds, there is currently no legislation in place prohibiting the expulsion of girls from school on the basis of pregnancy.

As identified through this review, there are a number of protective legislative provisions in place for adolescents and youth in relation to SRH and GBV in Fiji. These include the established equal minimum age of marriage at 18 requiring full and free consent of both parties; explicitly criminalised early marriage; guaranteed access to HIV testing and treatment (including contraception) with clear provision for the full, free and informed consent of minors in line with the concept of the evolving capacity of adolescents; and the minimum age of sexual consent set at 16 balanced with a 'close in age gap' defence to protect the rights of mutually consenting adolescents to sexual autonomy.

There have also been a number legislative 'barriers' or gaps to adolescent and youth SRH and protection from GBV identified through the review. These include:

- the absence of legislation guaranteeing access to family planning (including contraception) and maternal health services, including mandating full, free and informed consent, factoring in the evolving capacity of adolescents;
- restrictive abortion laws requiring parental or judicial consent to access safe abortion;
- the absence of legislation protecting girls from school expulsion on the basis of pregnancy; and
- the absence of legislation mandating the inclusion of comprehensive sexuality education in the national school's curriculum.

Considering the high rates of child sexual abuse in Fiji, the issue of defence of mistaken age in the context of sexual assault in children aged 13-16 years old should also be further explored. Age of consent laws should seek to strike a balance between protecting children and young people from exploitation and preserving their right to privacy and healthy sexual development.

As indicated in this review, adolescent health is one of the five key focus areas of the *Reproductive Health Policy*. The policy calls for 'necessary resources to provide gender responsive and life-skills based information and education programmes, counselling services and youth-friendly services in a comprehensive and integrated manner', and aims to reduce 'sexual abuse, unplanned pregnancy and STIs including HIV among young people' (p. 20). The policy also includes plans to set up SRH resource centres at all primary and secondary schools (including supplies of contraception at secondary schools).

The *National Gender Policy* (2014) sets a target to "Ensure young people including adolescents have access to youth friendly services to assist them to make responsible choices to protect and safeguard their health, with particular reference to unplanned and early pregnancies, STI and HIV and sexual abuse" (p. 22).

While there has been no comprehensive evaluation as to whether these policy provisions have been implemented in practice, the HFRSA Assessment conducted in 2019 found that only three per cent of facilities audited provide adolescent and youth friendly (AYF) sexual and reproductive health services in line with global standards (UNFPA, 2020). Of the facilities audited, 35 per cent require consent from an adult for adolescents to receive SRH services (UNFPA, 2020).

Even in the absence of explicit legal or administrative prohibitions on access to SRH services including contraception, practitioners may still restrict access to adolescents or unmarried women due to social norms and beliefs (Starrs et al., 2018). Affirmative laws guaranteeing the right to access linked with policy and guidelines clearly addressing full, free and informed consent for adolescents, similar to provisions laid out in the *HIV/AIDS Act 2011*, can create an enabling environment for adolescent and youth friendly sexual and reproductive health services.

6.2. People with disabilities

The *Constitution* provides for the right to equality and freedom from direct and indirect forms of discrimination based on 'disability' (s 26). Members of the community with disabilities are entitled to the same constitutional rights to health, health care and reproductive health as everyone else (s 38). Section 42 of the *Constitution* further protects persons with disabilities' rights to reasonable access to 'all places' as well as 'reasonable access to necessary materials, substances and devices relating to the person's disability'.

Disabled persons' right to the 'same range, quality and standard of free or affordable health care... including in the area of sexual and reproductive health' is guaranteed in legislation under s 44 of the *Rights of Persons with Disabilities Act 2018*. Further, the Act expressly protects particular sexual and reproductive rights in provisions that relate to 'home and family':

42(1) All persons with disabilities have the right to be free from discrimination in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that—

- a. the rights of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognised;
- b. the rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided; and
- c. persons with disabilities, including children, retain their fertility on an equal basis with others.

Disability is incorporated in varying degrees within key national policies though notably not in the *Reproductive Health Policy* (2010).

The *Fiji Disability Action Plan* (2002) was prepared by the Fiji Human Rights Commission and draws on the rights set out in the ICESCR. Its focus cuts across a range of ministry portfolios. Among other key goals, the Action Plan aims 'to ensure the provision of adequate and appropriate health care for people with disabilities' and outlines strategies such as:

- delivering programs that aim at early recognition and intervention for people with disabilities (through government plans, policies and budgets);
- include rehabilitation services in health service delivery structures; and
- ensure health insurance is readily accessible for people with disabilities (para 15).

Notwithstanding the broad commitment to appropriate health care, SRHR is not addressed specifically within the *Disability Action Plan*.

Though the legal regime in relation to persons with disabilities' rights is relatively robust, advocates in the space have raised concerns about women living with disabilities' lack of access to adequate sexual and reproductive health services in practice, particularly in regard to maternal and child health services (UNHRC, 2019a).

Persons living with disabilities are particularly vulnerable to experiencing GBV. In addition to the constitutional protections already noted, the *Rights of Persons with Disabilities Act 2018* (s 35) provides that all people with disabilities should live free from violence, including GBV:

35(1) All persons with disabilities, both within and outside the home, have the right to be protected from all forms of exploitation, violence and abuse, including gender-based violence.

(2) All persons with disabilities who are victims of any form of exploitation, violence or abuse have the right to protective services which fosters the health, welfare, self-respect, dignity and autonomy of such persons and takes into account gender and age specific needs.

(3) All persons with disabilities who are victims of any form of exploitation, violence or abuse have the right to have the exploitation, violence or abuse investigated by the appropriate State authorities and, where relevant, prosecuted.

The *Disability Action Plan (2002)* acknowledges that women with disabilities may be subject to multiple forms of discrimination, including gendered discrimination. The plan does not propose any specific strategies concerning GBV or gendered discrimination, but focuses on education; access to public places; housing; access places of worship; access to information and communication; social security; health care; sports and recreation; support services and employment.

The *National Gender Policy 2014* also recognises that people with disabilities may be subject to multiple forms of discrimination and that their experiences of discrimination due to disability intersect with other forms of discrimination based on, for example, their gender or ethnicity. The policy thus aims to:

Promote policies and laws which are consistent with the UNCPRD, which recognise the intersection of discrimination which can arise from being a woman from a marginalised group and/or being a person living with disabilities, and which promote access to all services and amenities in Fiji (p. 16).

The *Fiji National Service Delivery Protocol for Responding to Cases of Gender Based Violence (2018)* requires service providers to be sensitive to the needs of people with disabilities and affirms their right to 'equal care and support'. Specific strategies that might enable service providers to be sensitive or responsive are not outlined in the policy in detail. Women with disabilities are referred to as 'extremely vulnerable' and may need 'support to take action' such as accompaniment to a service provider or leader.

The *Women's Plan of Action (2010-2019)* makes enhancing 'public awareness on violence against women and children with disabilities' a key direction for action, with the following indicators: (1) increase training (2) reporting on violence against women and children with disabilities. While there has been an audit conducted on the coordination of actions on elimination of violence against women under the *Women's Plan of Action (2010-2019)*, this did not look at the status of these particular indicators, or the broader impact of the Plan of Action on women with disabilities.

6.3. LGBTIQ communities

Sodomy was decriminalised in 2009 through the Crimes Act 2009, which replaced the Penal Code 1978 removing a significant legislative barrier to accessing SRH and protection from GBV. Fiji provides a constitutional right to equality and protection against discrimination based on 'sex, gender, sexual orientation, gender identity and expression' (s 26). Similar inclusive anti-discrimination provisions can be found in the *Employment Relations Act 2007* ss 1-4.

Despite this, George (2018) argues that LGBTIQ communities have been subject to discrimination and punitive treatment by the Fiji Police Force in the years that have followed. She highlights the role that church leaders have played in fuelling public anxiety around homosexuality as a form of deviance, which poses a challenge to the conjugal order. According to Nabulivou (2006, p. 31) "sexual orientation and gender identity are heavily and openly contested and politicized by faith-based organizations, 'State' and 'Vanua' (traditionalist political processes)".

Bavinton et al. (2011) conducted a questionnaire with men who have sex with men, and transgender people (n=212) in Fiji and found that 65.7 per cent of participants felt unsafe expressing their sexuality or their gender, and experienced high rates of verbal, physical and sexual abuse. More than a quarter of participants reported having been subject to rape (50 per cent of whom were transgender). There is also some evidence of cultural beliefs in corrective rape of lesbians to return them to heterosexuality (DFAT, 2017; George, 2018).

The position of transgender peoples in Fijian society is complex. There exists a concept of transgender in iTaukei culture through the term vakasalewalewa, the root words of which mean 'somewhat female', and denotes feminine appearance or gender presentation, but does not necessarily infer a particular sexuality (Varani-Norton, 2014). Transgender men are accepted as 'drag' performers or entertainers in the larger cities (DFAT, 2017). Despite this, transgender people have been subject to widespread stigma and discrimination (Bavinton et al., 2011).

It has been reported that LGBTIQ communities may have more difficulty accessing health services in certain areas (DFAT, 2017). Advocates have argued that healthcare workers require training in gender and sexuality diversity to reduce barriers experienced by LGBTIQ communities (UNHRC, 2019a). Though LGBTIQ communities (particularly transgender people and men who have sex with men) are considered a key population for HIV and AIDS prevention, heterosexual relationships remain the cause of the majority of HIV cases in Fiji (ibid).

The *Fiji National Service Delivery Protocol for Responding to Cases of Gender Based Violence* (2018) sets out that LGBTIQ people need to be provided with responsive support:

- Ensuring an inclusive response for diverse populations, including women and girls with disabilities, as well as lesbian, bi-sexual, and trans women.
- Services should be offered equally, without judgement or bias to all survivors, including lesbian, gay, bisexual, transgender, queer, and intersex (LGBTIQ) identified persons and people with disabilities.
- Providing sensitive and appropriate response to diverse populations including LGBTIQ and people with disabilities

Like women with disabilities, LGBTIQ women are referred to as 'extremely vulnerable' and may need 'support to take action', for example through escorting them to a service provider or community leader.

Those working in the space have argued that LGBTIQ people have not been protected under legislation and continue to be at heightened risk of discrimination and violence (UNHRC, 2019a). While the *Domestic Violence Act 2009* uses gender neutral language and thereby covers same sex relationships, the *Family Law Act 2003* does not apply to LGBTIQ relationships.

6.4. Sex workers

Sex work is illegal in Fiji; however, there is an active industry with a long history (McMillan and Worth, 2017). On 1 February 2010, the *Crimes Act 2009* was implemented, replacing the *Penal Code 1978*, and updating provisions that concern the sex work industry (referred to as 'prostitution' in the *Crimes Act 2009*). Under ss 230-233 of the legislation, it is illegal to:

1. Live wholly or partly on the earnings of prostitution (s 230(1)(a))
2. Solicit a person for 'immoral purposes' (s 230(1)(b))
3. Live with or be 'habitually in the company of a prostitute' (s 230(2))
4. Aid or abet a prostitute (s 230(2))
5. Solicit clients for sex work in public (s 231(1)(a)-(b))
6. Seek, use make arrangement regarding the services of a prostitute in public (s 231(1)(c)-(e))
7. Communicate at all with a person to 'solicit for an immoral purpose' (s 231(1)(f))

It is also a crime to keep, manage, or assist in the management of a brothel; to be a landlord to premises used as a brothel; or to be a tenant or occupier of a premise that is used in any part as a brothel (s 233). The provisions are intended to penalise pimping, but also apply to sex workers and clients themselves. Police also have powers to arrest on the street without need for a warrant (s 231(2)). Many of the offences relating to sex work were transferred from the Penal Code; however, key changes include the criminalisation of clients of sex services; a shift to gender-neutral language to capture prostitutes of all genders (rather than just women); and a significant increase in penalties (McMillan & Worth, 2011).

Commentators have criticised the harsh criminalisation and persecution of sex workers, particularly given that sex work in Fiji has been found to be connected with socio-economic marginalisation (McMillan & Worth, 2010, 2011, 2017; Mossman et al., 2014). There are reports that since the new legislation, sex workers have been increasingly subject to police surveillance, and have been detained and endured degrading physical punishment (George, 2018).

The Fijian sex work sector consists largely of transgender and female sex workers (McMillan & Worth, 2017). Mossman et al. (2014) conducted an integrated bio-behavioural survey exploring the nature of sex work and sexual health in Fiji (n=298) and found that there were approximately 857 female and transgender sex workers actively working in key areas in Fiji (Suva, Nausori, Lautoka, Ba, Labasa, Savusavu). Over a third of sex workers were transgender. Around 20 per cent were Indo-Fijian, 75 per cent were iTaukei, and the remainder were Chinese or migrant workers. Testing undertaken in the study only located three positive cases of HIV; however, other STIs, such as syphilis, were found to be more widespread than in the general population. Only 57 per cent of those questioned reported that they always used a condom with clients. Knowledge regarding the transmission of HIV was relatively low, and there was considerable demand for more information and access to health services, with 40 per cent reporting they had never had a sexual health test.

The criminalisation of sex work has significant impacts on sex workers' sexual and reproductive health as well as their access to safe working environments, and SRH services and support. McMillan and Worth's (2010) qualitative study with sex workers found that the risk of HIV was perceived to be less important than the risk of assault or brutality (perpetrated by clients and police), and so sexual health measures tended not to be prioritised by sex workers. In these circumstances, women felt unable to negotiate the use of contraceptives. The majority of sex workers operate publicly and informally, on the street, or in bars and restaurants, rather than through brothels or other private structures (Mossman et al., 2014). Sex workers may be at greater risk of sexual and gender-based violence due to such working conditions, with little recourse to police. Fear of engaging with police has limited sex workers' ability to negotiate terms with clients and preserve their safety (McMillan & Worth, 2010). Mossman et al. (2014) found that over a third of sex workers

reported being physically assaulted by clients during the preceding 12-month period, and 13 per cent had been raped. Violence of all types was reportedly more common for transgender sex workers, compared with female sex workers. Many sex workers reported that they would not feel comfortable seeking assistance; indeed 20 per cent of female sex workers and 30 per cent of transgender sex workers confirmed that they had been blackmailed by a person in authority. Only one per cent of sex workers reported that they would be comfortable reporting rape to the police (Mossman et al., 2014).

The study also found that fear of police brutality and harassment played a considerable role in decision-making; for example, women in Nadi were unwilling to carry more than one condom on their person due to fear of police harassment (McMillan & Worth, 2010). Concern regarding legal consequences has also led NGOs to move away from addressing contraceptive and sexual health of sex workers, in favour of initiatives that aim to encourage people to avoid or abandon sex work (e.g. through retraining and microfinancing programs) (McMillan & Worth, 2011, 2017). McMillan and Worth (2017, p. 42) note that while such initiatives 'may be politically palatable for many governments and NGO service providers, such efforts are ineffective both for HIV prevention and poverty reduction'.

Importantly, the National Strategic Action Plan on HIV and STIs (2016–2020) includes an action to undertake 'targeted advocacy to influence Parliamentary decision-making on the decriminalisation of sex work' (Action 1.4.2.1.1). However, barriers to legal reform in this area are thought to be significant. As George (2018, p. 265) writes:

In Fiji, sex work is also discussed in ways which suggest it is a powerful source of ontological insecurity. Debates on the legalisation of sex work, for example, are commonly resisted in ways which pathologise this activity or which suggest that decriminalisation will invite 'divine retribution' upon the country.

Lemisio (2008) similarly notes that sex work is not a topic open for discussion as it is framed as morally 'evil' rather than simply illegal, particularly in Christian communities. Sex workers may also face discrimination by health workers. Lui et al. (2012) conducted a cross-sectional survey exploring the attitudes of health care workers towards clients using sexual health services (n=369). They found that 35 percent of participants considered that HIV and other STIs were caused by their clients' immoral actions as retribution. Indeed, 46 per cent of participants reported that sex workers were responsible for the transmission of STIs, and nine per cent considered that those who participated in sex work should not be provided treatment by government services. Fourteen per cent of those surveyed reported observing a client who has or may have HIV receiving poorer quality of health care as a result in the last 12 months. This confirms reports of health worker discrimination against sex workers of McMillan and Worth's (2010) prior study.

7 Factors influencing sexual and reproductive health and gender-based violence law and policy

7.1. Gender roles and gendered inequality

On a policy level, the government has made efforts to combat gender inequality through its *National Gender Policy* (2014) and other policies concerned with gendered violence. In addition to addressing violence against women, the Fijian government has taken action regarding women's economic participation, leadership, and the gendered impact of climate change (UNHRC, 2019b).

However, despite improvements in certain domains such as education and employment, restrictive gender norms continue to be pervasive in Fiji (Chattier, 2013) and act as a barrier to both the development and implementation of laws and policies that seek to tackle gender-based violence (UNHRC, 2019b). Such norms are identifiable in both iTaukei and Indian Fijian communities, and have been both produced and reinforced by colonial structures (Mitchell & Bennett, 2019).

Fijian women experience economic, political, and social disparities (George, 2016) and Fiji was ranked 103 out of 153 countries in the Global Gender Gap Index 2020 rankings, which assesses inequalities across economic, educational, political, and health domains (World Economic Forum, 2019). Men retain greater access to land and resources through patrilineal titles (Mitchell & Bennett, 2019), and have much higher earning capacity. The 2017 census found that 76 per cent of men were participating in the labour force, compared with 37.4 per cent of women (Fiji Bureau of Statistics, 2018). The majority of working Fijian women operate in the informal economy (Bhagwan-Rolls, 2011; FWRM, 2017; McKinnon et al., 2016).

Socially, it has been observed that in many Fijian communities, men retain positions of superiority over women and are viewed as the heads of the household (Adinkrah, 2001; Newland, 2016). These patriarchal structures are embedded in both Indian-Fijian and iTaukei communities (Adinkrah, 2001; Mitchell and Bennett, 2019). Newland (2016) found that beliefs about males' rightful dominance within marriage were widespread, and violence within marriage was condoned. For this reason, it is often women who are blamed for the violence, for failing to give her partner appropriate respect or adequately fulfilling her role as wife:

'Customarily, women are considered to be responsible for relationships, whether affinal or consanguineal, and therefore are vulnerable to being blamed for their failure' (Newland, 2016, p. 59).

The survey conducted by FWCC (2013) found that 43 per cent of women agreed that there are legitimate justifications for husbands to beat their wives, such as to show 'who is the boss' or so that she submits to his will. Such internalised victim-shaming plays a role in women's help seeking behaviours, as well as institutional responses to women seeking help. Moreover, 58 percent of women surveyed considered that there should not

be any external intervention outside of the family where there had been conflict (FWCC, 2013). George (2018) argues that gendered notions of 'conjugal order' are deeply embedded in policing culture and undermine the implementation of legislation and policies aimed at addressing violence.

Importantly, Farran (2015) points out that there is limited evidence regarding local understandings of gender in Pacific countries. For example, there is evidence that in some Pacific societies, gender is understood as a fluid rather than binary concept; however, gendered binaries have been assumed in both research and policy (Farran, 2015).

Narrow expectations and descriptions of gender roles, particularly in relation to sexual behaviour, has implications for Fijian young people's sexual and reproductive health decisions. Mitchell and Bennett (2020, p. 510) found that young iTaukei women feel pressure to present an image that is 'restrained, devout and sexually innocent' and, as such, attempt to manage their reputations to minimise the risk of bringing shame upon herself and her family. This can lead young women to engage in clandestine sexual behaviour in locations away from their families and communities, such as in nightclubs, house parties or on campus (Mitchell & Bennett, 2020). Concern about reputation was also found to lead young women to feel apprehensive about being observed buying condoms or attending sexual health clinics (Mitchell & Bennett, 2020). This was confirmed in a qualitative study with iTaukei and Indo-Fijian youth, which found that women felt greater shame accessing services due to gender roles. In the words of one participant: 'in our community there's more stigma related when a female comes to a clinic' (O'Connor et al., 2019, p. 379). Mitchell and Bennett (2020) argue that public health initiatives in Fiji have prioritised physical risk through biomedical and behaviour change approaches, and failed to account for the social and relational dimensions of sexual and reproductive risk that women face.

Social and relational dimensions of sexual risk are not only related to cultural norms but also to gender inequality and power disparities. Gender inequality pervades key aspects of inter-personal relationships which shapes sexual and reproductive health. Due to gendered inequality, research has found that men are more likely to control decision-making regarding sexual and reproductive health (Mitchell & Bennett, 2019). Forms of controlling behaviour, like all forms of gender-based violence, reduce women's ability to negotiate consent and safe sex practices. The authors again emphasise the necessity of addressing domestic violence to promote women's sexual health.

7.2. Collective social norms

Traditionally in both iTaukei and Indian Fijian cultures, talking about sex is viewed as taboo and sexual relations are seen as only appropriate in the context of marriage (Naidu et al., 2019; O'Connor et al., 2018, 2019; Varani-Norton, 2014). Liberal ideas about sex and sexuality are strongly associated with Western and 'modern' influences, and there is a desire to protect the traditional values of Fijian culture (Naz, 2014). As such, discussing sexual and reproductive health, particularly among youth, can be viewed as delicate and contentious (Naz, 2014). O'Connor et al. (2018) found that young people from both Indo-Fijian and iTaukei backgrounds experienced embarrassment around sexuality and accessing sexual health services, regardless of whether they were from rural or urban areas.

Research has revealed that Fijian young people fear judgment for accessing sexual health clinics (Mitchell, 2012; O'Connor et al., 2019).

'Something about us here in Fiji is that when we go for these kinds of tests [HIV/STI test] people are not so open minded about it. They...are scared about what people think you know? Going through those kinds of clinics means um you are regularly having sex. So that is quite discouraging' (Mitchell, 2012, p. 10).

Concern regarding confidentiality was also found to strongly influence people's ability to seek health services (Mitchell, 2012; O'Connor et al., 2019).

Mitchell argues that an ecological approach to HIV and STI risk needs to be taken in Fiji. This would account for the intertwined relationships between individuals and their environment, incorporate the effects of colonialism, capitalism and globalisation as well as more local belief systems. The 'individual' here, needs to be 'anchored in social relations rather than existing as a disconnected individual' (p. 15).

Social norms regarding sex also impact people's experiences and practices in relation to reproductive health. In a study focusing on increasing involvement of men in antenatal care, Davis et al. (2016) note factors that prevent men and women from openly discussing matters relating to sexual and reproductive health include gender norms, taboos, stigma, gossip, and shyness to the extent that couples may avoid contact during particular periods, such as pregnancy and immediately postpartum. However, the study also highlights how culture evolves, particularly when the benefits of change are made apparent (Davis et al., 2016).

Examining violence in the Pacific context generally, Rankine et al. (2017) posit that individualistic approaches to GBV are likely to be ineffective, because they do not resonate with the value Pacific cultures place on the collective relation and responsibility. They argue that women experiencing GBV may view accepting individual support as causing further violence by harming community cohesion. This has also been noted by others working specifically in the Fiji context (FWCC, 2013).

Consequently, Rankine et al. (2017, p.2784) suggest that 'informal family, community, and spiritual' responses to GBV may be more effective in responding and preventing violence than the legal system.

Collectivist understandings may also be important in challenging individualistic notions of gender inequality that are implicit in human rights discourse. McKinnon et al. (2016, p. 1387) explored Fijian women's conceptions of economic empowerment and found that such understandings did not necessarily accord with international benchmarks or indicators:

'Understanding of gender equality seldom posited individual women's advancement as a central aim. Women's pursuit of an independent income was a desirable aim for gender equality that some women had put into practice. But this often ran alongside (and was in tension with), the desire for balanced and harmonious relationships with men, and greater respect and recognition of the different contributions made by women and men, as well as better leadership and role models to be provided by men for the benefit of the whole community'.

The authors assert the importance of developing indicators that are based on local values and ideas of gender in order to measure meaningful change (McKinnon et al., 2016).

7.3. Religion and faith-based organisations

Historically, the Methodist church and the Fijian State have been intertwined in Fiji (CEDAW Committee, 2016). Fiji was made a secular state under the 2013 *Constitution*, and the Bainimarama government has maintained the importance of this position in the face of persistent calls to return Fiji to a Christian state (Talei, 2018). Despite this, religious belief systems and institutions still play a pivotal role in Fijian culture and political life and, as a consequence, shape both structural and individuals' responses to violence and sexual and reproductive health.

The profound influence of religion in Fiji has connections with its colonial history. Presterudstuen (2016) contends that colonial, Christian ideas of masculinity are now intertwined with, and inextricable from, contemporary notions of 'traditional' masculinity in iTaukei culture.

It should be noted that some faith-based organisations are actively advocating for policy change that tackles gender inequality and violence in the Pacific and are challenging biblical constructions of gender that undermine equality (Forsyth, 2016). Religious institutions also supply considerable material support to women escaping violence and run most of the existing refuges in Fiji (Newland, 2016).

However, attitudes or descriptions of women as inferior to men, which underpin GBV, have been reinforced and reproduced by certain religious leaders, belief systems and interpretations of scripture. The exclusion of women from official religious leadership structures in the Pacific has also been found to perpetuate gender inequality (George, 2015).

Faith leaders are among the first people that women will turn to for help in the Pacific (Bull et al., 2019). Tonsing and Barn (2020) found that women who had experienced violence were much more likely to turn to faith leaders or fellow members of their faith, rather than seek assistance from violence services or the agencies, and that women's subsequent actions were greatly guided by the advice that they received in faith spaces. Where women were advised to simply pray and avoid divorce, they tended to heed this advice (Tonsing & Barn, 2020). The authors also found that women's personal relationships with their faith and belief system provided vital strength and solace to cope with their experiences of violence.

7.4. Plural legal systems

7.4.1. Bulubulu and traditional reconciliation customs

The conciliation practice of bulubulu takes place in many iTaukei villages and is a process through which community members can atone for wrongs and foster healing. In circumstances where a perpetrator wrongs a victim, the bulubulu custom typically involves the perpetrator and their family providing an apology to the victim's family, as well as presenting a gift, such as a whale's tooth (tabua), yaqona, kerosene, or cigarettes. If the victim's family accepts the apology the matter will be resolved. Some contend that the focus of bulubulu is to promote village cohesion, rather than provide reparations (Newland, 2016).

The CEDAW Committee has expressed concern about the practice of bulubulu, particularly insofar as it diverts sexual and gender-based violence cases from legal processes and reduces sentences in rape cases (Merry, 2006). Merry (2006, p. 71) takes issue with the Committee's condemnation of bulubulu, on the basis that such an approach essentialises culture, and fails to account for the role of cultural translation and transformation. She argues that '[a]s the nature of Fijian society has changed, the custom itself has begun to shift from a practice that focuses on preventing vengeance between clans to one that supports a victim and holds the offender accountable'. Further, she claims that the committee's concerns about bulubulu fail to

address how the legal system fails to meet the needs of victims of GBV.

At odds with Merry's view, findings from Newland's (2016) study demonstrated that bulubulu rarely leads to accountability for perpetrators or protection for victims. She emphasises the role of bulubulu in promoting village cohesion, over individual's safety and needs. She also discusses the role of the turaga ni koro (village head) and talatala (Methodist lay preacher) in resolving conflict, alongside bulubulu practices. The talatala is concerned with addressing marriage as a spiritual covenant, and the turaga ni koro is concerned with the law and cohesion of the village. According to Newland (2016), the talatala and the turaga ni koro will often aim to resolve the conflict together with the parties, with little reference to legislation or the national legal system, and it is only where village-based processes fail to reach reconciliation that the police or other services might be notified. Bulubulu could also preempt involvement of the police:

'In relation to child sexual abuse, a community in Ra, northern Viti Levu, went so far as to say that tradition was the line that stood between them and the law because when a bulubulu was held it was felt there was no longer any need to report the incident to the police. For example, one boy impregnated his 16-year-old cousin, but the girl's family did not feel they were able to report it after his family performed the bulubulu' (Newland, 2016, p. 61).

Despite police 'no drop' policies, Newland reported instances where victims had approached the police, only to be turned away to resolve the issue with the turaga ni koro. She also found that rape situations were at times resolved by the talatala and the turaga ni koro through negotiation of marriage between the parties. Notwithstanding this, the approaches taken by the turaga ni koro varied considerably, as could the responses of victims' families to bulubulu offerings (Newland, 2016).

Building on the work of Merry (2006), George (2016) argues that women's advocates in Fiji have done much work to challenge alleged incompatibilities between local traditional approaches and universal or rights-based approaches to GBV via processes of 'translation'. However, unlike Merry, George (2016) suggests this translation work between different cultural constructs has led to change at the legal and policy level but has had very little impact on women's experiences of violence on the ground. She argues that focusing on transforming culture alone has worked to obscure the political and economic structural factors which affect the security of women in Fiji.

In later work, George and colleagues (Bull et al., 2019; George, 2017, 2018) caution against integration of pluralised or 'hybridised' systems of law enforcement in Fiji. They suggest the failure to translate policy into practice is related to models of community policing that have been implemented in Fiji which place community social values above the objectives of policy and legislative schemes (Bull et al., 2019; George, 2017, 2018). From this view, the Fijian government and its agencies have been unable to act in accordance with their own policies regarding GBV, due to a deeply embedded culture of militarism and policing, which extends to the policing of gender and sex.

'Threats posed to conjugal and familial integrity are treated as a more serious source of ontological uncertainty than the physical insecurity that women might be exposed to within conjugal and familial settings and at the hands of police themselves' (George, 2018, p. 268).

Control of the traditional 'conjugal order' enacted by police and government agencies is considered to be connected with broader conceptions of community order and security that are tied to notions of gender and sex, rather than with beliefs about individuals' behaviour (George, 2017). As a consequence, the authors contend that pluralised or 'hybridised' systems which integrate traditional practices with systems of law enforcement can work to privilege particular gendered norms, at the cost of women's and other gendered groups' safety (Bull et al., 2019; George, 2018).

7.4.2. Reconciliation customs and sentencing

Currently, bulubulu may be taken into consideration as a mitigating factor in cases of common assault or assault occasioning actual bodily harm (ICAAD & Clifford Chance, 2018). It may also be taken into account in cases of domestic violence; the *Sentencing and Penalties Act 2009*, s 4(3)(e), states that, in sentencing perpetrators of domestic violence the court must also have regard to:

the conduct of the offender towards the victim since the offence, and any matter which indicates whether the offender –

1. accepts responsibility for the offence and its consequences;
2. has taken steps to make amends to a victim, including action to minimise or address the negative impacts of the offence on a victim.

Bulubulu should no longer be taken into account in sentencing in rape. In a recent rape case heard by the High Court, Judge Aruna Aluthge noted that ‘traditional bulubulu ceremonies play a crucial role in the families in sweeping the sex offence complaints under the carpet’ (State v Bebe [2019] FJHC 1064, [9]). FWRM (2017) conducted a judgment analysis of 89 rape cases heard in the High Court between 2016 and 2017. They found that bulubulu was not raised by any judicial officer in their sentencing judgement. However, bulubulu may still be referred to by the parties in the court, and it is unclear to what extent this may influence jury deliberation.

The *Sentencing and Penalties Act 2009* also contains provisions which allow for involvement of traditional and community leaders in identifying and reviewing sentences for those found guilty of offences. The types of offences for which this might be appropriate are not defined, but the legislation notes that regulations may be made which limit the range of circumstances where leaders’ involvement is allowed (s 54). Where no regulations are enacted, the judiciary may involve traditional leaders as they see fit in accordance with the act.

7.4.3. Codification of iTaukei custom in law and regulation

Provisions within the *iTaukei Affairs Act 1944* allow for the codification of iTaukei custom through the creation and upholding of by-laws that apply to iTaukei peoples within iTaukei provinces. The Act states:

‘A Provincial Council may, subject to the approval of the [iTaukei Affairs] Board, make such by-laws for the health, welfare and good government of, and, subject to the approval of the Minister, impose such rates or charge such fees to be paid by iTaukei residing in or being members of the community of the province’ (s 7(2))

The potential to codify iTaukei custom is more broadly supported in the *iTaukei Affairs (Provincial Council) Regulations 1996*, which allow that it shall be lawful for a Council to make and pass by-laws to provide ‘any other matter deemed by the Council to be of benefit to the iTaukei residing in the Province’ (reg 27(2)(d)).

However, the first by-law proposed since the colonial era failed to be passed. The proposed by-law (proposed in 2009 and reintroduced in 2016) was concerned with public health matters as well as legal matters such as minor criminal offences and child protection amongst other issues. The implementation of the by-law was purported to be consistent with national legislation, including the *Crimes Act 2009*, the *Domestic Violence Act 2009* and the *Child Welfare Act 2010*. However, significant concerns were raised about the regulation of women’s conduct and other gendered consequences of the by-law (Cokanasiga, 2018). In their review of the 2016 by-law, FWRM noted that ‘formalising indigenous traditional and customary structure of governance [w] as reinforcing patriarchal values and as such contravening national legislation that promotes gender equality’ (FWRM, 2017, Cokanasiga, 2018, p. 1). Though the by-law failed to move past the consultation stage, it demonstrates the potential for the existence of plural regulations in Fiji.

8 Humanitarian and disaster contexts

8.1. Background

Fiji is facing unprecedented challenges, including the compounded impacts of COVID-19, Tropical Cyclone (TC) Yasa and TC Ana, other recent cyclones and the ongoing impacts of climate change. Disaster, health, and GBV (preparedness, response, and recovery) policy and legislative frameworks exist in a context of high levels of gender inequality and social exclusion.

Already very high rates of violence against women and girls have reportedly increased in Fiji as a result of existing gender inequalities exacerbated by COVID-19 impacts, including unemployment related stress, lockdown related confinement with perpetrators and lack of access to the formal justice system. The findings from data analysis completed by FWCC, Fiji Police Force, Office of the Director of Public Prosecutions (ODPP) and Fiji Courts reflects that whilst women have experienced high levels of violence during the pandemic, they have not reached out to formal justice sector agencies for assistance (FWRM, 2020). The FWCC toll-free national helpline recorded a 300 per cent increase in domestic violence related calls after curfews and lockdowns were announced in 2020 (ADRA et al., 2021). Modelling completed to assess the potential impact of the COVID-19 pandemic on SRH in low- and middle-income countries projected that in the event of a 10 per cent decline in the use of short- and long-acting contraceptives due to disruptions in services, an additional 28,000 maternal deaths would result (Riley et al, 2020). The pandemic, alongside recent natural disasters and protracted emergencies, has shone a spotlight on SRH and GBV inequalities and vulnerability.

There are a range of government departments and offices involved in Fiji's disaster preparedness and response including the Fijian Climate Change and International Cooperation Division under the Ministry of Economy; the Ministry of Rural and Maritime Development; and the Ministry of Disaster Management, a key government agency housing the National Disaster Management Office (NDMO). Also key to the preparedness and response to disasters are the Ministry of Health for SRH and the Ministry for Women, Children and Poverty Alleviation for GBV along with Police, Courts and Justice. However key humanitarian actors have recommended that many more government departments need to mainstream gender-inclusive (SRH and GBV in this case) disaster preparedness and response into their policies, strategies and operating guidelines. This includes the Department of Planning, Ministry of Infrastructure and Public Works, Housing Authority, Department of Social Welfare and the Fiji Roads Authority (ADRA et al., 2021).

In Fiji, the disaster and humanitarian response is a collaborative effort with community, national and local government, civil society, INGOs, donors, UN agencies, regional partnerships, faith-based organisations and the diaspora. For example, the Pacific Humanitarian Team (PHT) is a network of humanitarian organisations that work together to assist the Pacific Island countries in preparing for and responding to disasters. During disasters, the PHT provides support to Pacific governments, NGOs and communities in delivering a fast, effective and appropriate disaster response.

8.2. International frameworks, commitments and guidelines

Fiji is a signatory to many international treaties and agreements that require it to uphold women's and children's rights alongside the rights of marginalised groups. This includes broad treaties and agreements focused on gender, LGBTIQ communities, disability and children's rights as already outlined in this report, as well as agreements specific to climate change and disaster. For example, the Paris Agreement, ratified in April 2016 and the Sendai Framework for Disaster Risk Reduction.

The Minimum Initial Service Package (MISP) for SRH in crisis situations is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis (IAWG, 2020). These needs are often overlooked with potentially life-threatening consequences. The MISP was developed by the Inter-Agency Working Group for Reproductive Health in Crisis (IAWG). UNFPA, in partnership with stakeholders, supports the implementation of the MISP to make sure that all affected populations have access to lifesaving SRH services. The key aims of the MISP are to ensure that there is no unmet need for family planning, no preventable maternal deaths and no GBV or harmful practices, even during humanitarian crises.

The six objectives of the MISP are to

1. Ensure the health sector/cluster identifies an organisation to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Planning for comprehensive services and their integration into existing services

A key partner in implementing the MISP in Fiji has been the International Planned Parenthood Federation (IPPF) SPRINT program, delivered through their local member association, the Reproductive and Family Health Association of Fiji (RFHAF). The recommended services are evidence-based interventions geared to be implemented at the onset of humanitarian crises. Following the acute emergency response and the implementation of the MISP objectives, a transition into comprehensive, integrated and ongoing SRH services is vital.

Two documents produced by the Inter-Agency Standing Committee (a forum of UN and non-UN humanitarian partners, aiming to strengthen humanitarian assistance) provide the foundational guidance on preventing and responding to GBV in emergencies (GBViE): the *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC, 2015) and the *Minimum Standards for Gender-Based Violence in Emergencies Programming* (IASC, 2020). The latter document outlines GBViE standards, a comprehensive set of 16 standards developed by UNFPA and providing practical guidance on how to prevent and respond to GBV in emergencies and facilitate access to multi-sector services (IASC, 2020). The GBViE standards also build on the *Essential Services Package for Women and Girls Subject to Violence* (UN Women, 2015). It is important to note that the Minimum Standards for SRH and GBViE are interrelated and interdependent. Both sets of standards should be explicitly incorporated into relevant disaster, gender, national development plans and health policy as a basis for preparedness, response, and recovery.

8.3. Regional agreements and networks

Fiji is a signatory to numerous disaster-related regional commitments. The Pacific Resilience Partnership (PRP) has a technical working group with a focus on climate smart Disaster Risk Management (DRM) legislation. Whilst gender equality is a stated goal of several agreements⁹ the only SRH specific agreement is the KAILA Strengthening Climate Change Resilience through Reproductive, Maternal, Newborn, Child and Adolescent Health (2015). Other regional climate and disaster agreements do not appear to have specific provisions or guidance regarding SRHiE or GBViE, however there are references to addressing gender equality and inequalities especially with vulnerable groups.

Examples of regional DRM commitments include;

- Framework for Resilient Development in the Pacific: An Integrated Approach to Address Climate Change and Disaster Risk Management [FRDP] 2017 – 2030
- The Boe Declaration on Regional Security and related action plan (2018)
- Framework for Pacific Regionalism endorsed by the Pacific Islands Forum (2014)
- Suva Declaration on Climate Change adopted in 2015 by the Pacific Islands Forum
- The Pacific Platform for Disaster Risk Management (2016)
- The Small Islands Developing States Accelerated Modalities of Action (SAMOA Pathway) (2014)
- KAILA PACIFIC VOICE FOR ACTION ON AGENDA 2030, Strengthening Climate Change Resilience through Reproductive, Maternal, Newborn, Child and Adolescent Health (2015)
- UNFPA's Regional Prepositioning Initiative has established hubs in Australia and Fiji that can quickly provide supplies to 11 countries.
- Pacific regional domestic violence working group (Pacific Community, 2018)

8.4. Domestic policy and legislation

In addition to laws already outlined, legislation relevant to disaster, climate and humanitarian response have been listed below.

- Climate Change Bill 2019 (Draft)
- *Natural Disaster Management Act 1998* to be replaced by the (Draft) Disaster Risk Management Bill (2020)
- *Public Health Act 1935*.
- *Town Planning Act 1946*
- *Local Government Act 1972*
- *Financial Management Act 2004*
- *Environment Management Act 2005*

Fiji's current disaster management framework is under review. The *Natural Disaster Management Act 1998* and the associated Plan will soon be replaced by the Disaster Risk Management Bill 2020, which at the time of this review has not been sighted by the authors.

9 For example, the Framework for Resilient Development in the Pacific: An Integrated Approach to Address Climate Change and Disaster Risk Management [FRDP] 2017 – 2030, "The FRDP also recognises the critical role of integrating gender considerations, and advocates for equitable participation of men and women in planning and implementation of resilience building activities.", see page 2, http://tep-a.org/wp-content/uploads/2017/05/FRDP_2016_finalResilient_Dev_pacific.pdf

A new Climate Change Bill was also drafted in 2019 and has been undergoing a phase of consultation in 2020. The Bill (s 5(h)) notes that:

there are inextricable links between gender equality and the Sustainable Development Goals, and when taking action to address climate change Fiji will respect, promote and consider gender equality and responsiveness, women’s human rights and the empowerment of women, including in the areas of formal sector employment and livelihoods, participation in decision-making and access to services, health, education, water, sanitation, housing and transport”.

The Bill also makes reference to the development and evaluation of the National Climate Change Policy with a specific provision to embed gender, human-rights, and social and cultural issues in Fiji’s approach to addressing climate change (s 24(4)(d)).

Whilst there are no direct references to SRHiE and GBViE in the draft Bill, the requirement to embed gender equality could be considered a mandatory requirement for action in SRHiE and GBViE as part of an effective response to promote gender equality in climate change as a form of a protracted emergency.

This provides a step towards an enabling legal environment for climate smart SRHiE and GBViE. At the time of this review, the progress on passing the Bill through parliament is unclear.

There is a draft Disaster Risk Management Bill 2020 which at the time of writing has not been sighted, however has been reviewed and critiqued by a recent report that recommends that *“Law and policies on CCA and/or DRR should promote gender and social inclusion as key elements for strengthening resilience to weather and climate-related hazards”* (Natoli, 2020).

It appears from a recent review by the International Federation of Red Cross and Red Crescent Societies (IFRC) in the Pacific that the current legal frameworks may also leave Fijians vulnerable to sexual exploitation, abuse and harassment, and other forms of exploitation relating to humanitarian relief. The report found that there appears to be no provision in Fiji’s current laws and policies outlining processes whereby international actors must have basic background, identity and competency checks (IFRC, 2021).¹⁰ The Government of Fiji does have in place a *Code of Conduct for all Workers in Emergencies*.

An overarching legal requirement to uphold and enact gender equality could be considered as jurisdictions which have adopted this approach have improved their ranking in relation to gender equality (World Economic Forum, 2021).

10 (See page 34, Legal Preparedness for Regional and International Disaster Assistance in the Pacific, https://disasterlaw.ifrc.org/sites/default/files/media/disaster_law/2021-02/IDRL-In-Pacific_Regional-Summary-LR.pdf)

8.5. Examples of policy relevant to SRH, GBV and disaster

In addition to policy already outlined in the report, examples of disaster, climate, and humanitarian response policies relevant to SRHiE and GBViE in Fiji are listed below.

- *Fiji National Health Emergencies and Disaster Management Action Plan 2013-2017* (MOH, 2013b) (HEADMAP)
- *Republic of Fiji National Adaptation Plan, 2018: A pathway towards climate resilience* (Government of Fiji, 2018)
- *National Climate Change Policy 2018 – 2030* (Ministry of Economy, 2019)
- *The National Humanitarian Policy for Disaster Management* (Ministry of Rural & Maritime Development & National Disaster Management, 2017)
- *The National Disaster Risk Reduction Policy 2018-2030* (Ministry of Disaster Management & Meteorological Services, 2018)
- *National Disaster Management Plan 1995* (NDMP) (National Disaster Management Council, 1995)
- *Climate Change and Health Strategic Action Plan 2016 – 2020* (MoHMS, 2016c)

Review of key health, GBV, disaster and climate policies reveal that explicit global standards such as MISP and Minimum Standards for GBViE and comprehensive guidance to address both SRHiE and GBViE have not been embedded into national policy. Notwithstanding this, SRHiE and GBViE has been recognised as an issue in some policies. This includes recognition of the impact of climate on health and GBV. Some key examples are outlined below.

The *Fijian National Adaptation Plan: A pathway towards climate resilience 2018*, includes health (though not specifically SRH) as a key priority and notes that

The Climate Change and Health Steering Committee and Climate Change and Health Advisory Working Group will establish and strengthen a formal link to the National Climate Change Coordinating Committee to support the incorporation of the health agenda in national, regional and global platforms (Government of Fiji, 2018).

Many of the suggested actions are relevant to SRH and SRHiE, however neither are explicitly addressed. The policy also requires gender issues to be considered and provides a brief checklist. The policy is silent on GBV and GBViE.

The *National Humanitarian Policy* (2017) outlines the Fiji Cluster system, a government-led humanitarian coordination mechanism in Fiji. It operates at the national strategic level throughout the disaster risk management cycle. This policy broadly outlines a sub-cluster system. Though not explicitly committed to in policy, this includes the Gender-Based Violence (GBV) Working Group, formed under the Fiji Safety and Protection Cluster, that is leading efforts to advance prevention and response to violence against women and girls during COVID-19. The GBV Working Group is led by Ministry of Women, Children, and Poverty Alleviation, the FWCC, and UN Women and works in partnership with frontline service providers, who are signatories to the *Fiji National Service Delivery Protocol for Responding to Cases of GBV*, and other key stakeholders to address GBV. In addition, there exists the *Fiji National GBV Sub Cluster Guidance on GBV Case Referral* prepared for responding to TC Winston (2016). To what extent this continues to be used in practice is unclear at the time of this review. There is also a *Code of Conduct for All Workers in Emergencies* (2016). However as noted earlier, there appear to be policy and legislative gaps in preventing sexual exploitation, harassment and abuse in relation to vetting international actors in emergencies. There is a Health and Nutrition sub-cluster led by Ministry of Health and Medical Services, which has its own standard operating procedures, however there are no SRHiE specific guidelines nor is SRH integrated into the sub-cluster guidelines.

The *National Disaster Risk Reduction (NDRR) Policy 2018-2030* also broadly incorporates health and mentions SRH and GBV considerations, requiring a rights-based approach to safety and protection, however it does not stipulate agreed minimum standards such as MISP or GBViE standards (Ministry of Disaster Management & Meteorological Services, 2018).

The Fijian Ministry of Health & Medical Services new *Strategic Plan 2020-2025* commits to:

- An increased number of health facilities that meet minimum standards for health emergency and disaster preparedness.
- Fiji's Emergency Medical Assistance Team (FEMAT's) role being strengthened as part of the overall response to outbreaks and disasters as well as deployment for outreach services, including a range of medical and emergency services
- Implementing cross-government strategic action plans for priority health issues, in particular the climate crisis, reduced sexual and gender-based violence, and improved access to services for people with disabilities.¹¹

While the Ministry of Health and Medical Services *Strategic Plan* does incorporate some broad health and disaster related targets, there appears to be no specific provision committing to minimum standards to respond to SRH and GBV in emergencies.

Given the frequency of disaster, the impact of climate change, and the role of all agencies in humanitarian responses, the need to link to long-term development is critical. This will require enhanced policy and legislative frameworks to enable all actors to continue to work together to avoid long term inter-generational inequality and exclusion

There is an opportunity for the forthcoming Disaster Management Framework to draw on existing international and regional commitments, such as KAILA, and explicitly commit to MISP, Essential Services standards and GBViE standards.

11 See Fijian Ministry of Health & Medical Services Strategic Pan, page 28, By the end of 2025 we want to have achieved the following: 20. Accessed at <https://www.health.gov.fj/wp-content/uploads/2020/05/Strategic-Plan-2020-2025-1.pdf> Implemented cross-government strategic action plans for priority health issues, in particular: well-being and lifestyles (NCDs), the climate crisis, reduced sexual and gender-based violence, and improved access to services for people with disabilities.

9 Conclusions and recommendations

The desk review indicates that Fiji has made solid progress towards creating an enabling legislative and policy environment towards universal access to SRH and protection from GBV.

It is important to recognise that the existence of a law or policy does not necessarily mean it will be implemented effectively. Ensuring accountability for the full implementation of laws and policies is as important as developing new legislation and policies to support SRHR and elimination of GBV. Accountability should be in the form of sound M&E frameworks and regular data collection, periodic review against indicators, and timely and comprehensive reporting on international commitments.

On the basis of this preliminary desk-review, several opportunities to strengthen policy and legislative responses were identified, and include:

9.1. General recommendations

- While there is precedence in Fiji for courts to consider and apply international legal commitments (such as the CRC and CEDAW) in justice and court proceedings (the *Constitution* s 7(b)), it is vital that Fiji continues to review and repeal old, and create new, national legislation in line with human rights obligations and international commitments. Any legislative reform should be approached in a comprehensive and integrated manner involving consultation with civil society and key population groups, including gender impact assessment to understand possible unintended consequences. This is in line with commitments under CEDAW and specific recommendations arising out of the Performance Audit Report on Coordination of Action for Elimination of Violence Against Women (OAG, 2019).
- Ensure institutional mechanisms are resourced to allow effective planning, monitoring and review such as the policy and planning units within the Ministry of Health and Medical Services and the Ministry of Women, Children, and Poverty Alleviation, inter-agency committees, and ERAW taskforce.
- Strengthen mechanisms for data collection to support monitoring and evaluation of policy and legislative implementation to ensure annual targets are met and allow evidence-based reform (HMIS information systems GBV AND SRH, interoperability of administrative data systems and collection of GBV service data).
- Further develop a national strategy to address harmful and discriminatory gender stereotypes in partnership with women's organisations, LGBTIQ groups, disabled people's organisations, community leaders, schools, faith-based organisations and the media. Part of this should include considering ways to strengthen the definition of discrimination against women in the *Constitution* and the possibility of a standalone Gender Equality law.

9.2. SRHR recommendations

- Considering the outdated Reproductive Health Policy and lack of a costed Reproductive Health National Plan, prioritise the finalisation of the new RNMCAH policy. This should include:
 - a clear definition of sexual and reproductive health and rights in line with the ICPD and an integrated essential service package (for example, based on the Guttmacher Lancet commission).
 - The accompanying workplan should set clear, measurable targets that are adequately costed, reviewed and updated annually.
 - Special provisions should be integrated for particularly vulnerable groups including adolescents and youth, people with disabilities, LGBTIQ communities, and sex workers, recognising the unique barriers they experience to accessing SRHR.
 - Ensure that the policy clearly links to SRHiE acknowledging the importance of prepositioning and long-term preparedness including the ability to pivot from ongoing integrated SRHR services to initial SRH services in emergencies (e.g., MISP) and back again.
 - Clearer directives for health providers on consent for access to contraceptives (including emergency contraception) for adolescents.
 - Evidence based resourcing (e.g., health readiness assessments).
 - Examine the private sector's role in health service provision to ease burden on government services in line with the NDP, recognising the important role of CSOs in community based SRHR.
- Consider legislating for guaranteed access to contraception, family planning and maternal health services with specific directives on ensuring access for adolescents and youth and marginalised population groups. Legislation should include provision for full, free and informed consent for services (including contraception) taking into consideration the evolving capacity of adolescents in line with international best practice. In the case of Fiji, new legislation could use the existing *HIV/AIDS Act 2011* as an example.
- Consider legislating that integration of Comprehensive Sexuality Education (CSE) into the national curricula be mandatory, and the CSE curriculum include a comprehensive range of topics (as outlined in the UN International Technical Guidance on Sexuality Education and the UNESCO Sexuality Education Review and Assessment Tool).
- Further research into the SRH needs of sex workers and barriers impacting on access to SRH services to inform advocacy, policy and possible law reform. Better understand legislative implications of SRH services for women in sex work (e.g., risk of prosecution) and multisectoral partnerships for referral into exit programmes and alternative income generating opportunities.
- Following the proposed action in the *National Strategic Action Plan on HIV and STIs (2016–2020)*, consider steps towards decriminalising sex work. In view of clear evidence that the criminalisation of sex work leads to poorer sexual and reproductive health outcomes for both sex workers and their clients, and to significant risk to the personal physical safety and health of sex workers, decriminalisation would decrease stigma and increase women's access to SRH information and services.
- Conduct further research into the impact, causes and consequences of unsafe abortion practices. Legislate for access to post-abortion care regardless of legality of abortion ensuring that women are not liable to prosecution.
- Consider development of a costed cervical cancer elimination policy aligned to the current WHO Cervical Cancer Elimination Strategy, in order to guide and evaluate programming and enable coordination of partner efforts.

- Further research should be conducted to understand how legal and policy provisions for the SRHR of persons with disabilities in Fiji are implemented and monitored in practice. This should include looking at the accessibility of services; service providers awareness and understanding of the CRPD and the Rights of *Persons with Disabilities Act 2018* and obligations therein in relation to SRH; and understanding the specific barriers experienced by people with disabilities themselves to accessing SRHR.

9.3. GBV recommendations

- Develop an overarching national policy/ plan/strategy on eliminating GBV and an aligned institutional mechanism to ensure its effective implementation. This should include resourcing and strengthening GBV data collection (both administrative service level data and population data); and ensuring adequate resourcing and allocation of budget.
- In consultation with community leaders, consider reforming the *Sentencing and Penalties Act 2009*, and related legal mechanisms, to ensure that *bulubulu*, or any other inappropriate reason, is no longer considered as a mitigating factor in sentencing rape or cases of domestic violence. Additionally, review the provisions which allow for the involvement of traditional and community leaders in identifying and reviewing sentences for those found guilty of offences, with a view to developing explicit guidelines and regulations, in consultation with community leaders, which limit the range of circumstances where leaders' involvement is allowed recognising the seriousness of domestic violence cases (s 54).
- Considering the feedback from the Auditor General, in future iterations of the Women's Plan of Action to give greater strategic priority and focus to primary and secondary prevention of violence outcomes that address the drivers of GBV, to align more closely with the Beijing Platform for Action 1995.
- In line with recommendations from the Auditor General, review the *Domestic Violence Act 2009*, with a view to addressing the ways that the gender neutrality of the provisions may unequally and unfairly impact women. This will require investment in exploring the unintended consequences of current legislation on key groups and ensuring a highly consultative approach to any further reforms.
- In addition to the protections in place with the minimum marriageable age, criminalisation of early marriage and the requirement of full, free and informed consent of both parties to marriage, consider criminalising forced marriage recognising that it is a serious breach of human rights and a form of GBV.
- Consider strengthening the legislative protections in place against intimate partner sexual assault by providing that sexual assault provisions apply 'irrespective of the nature of the relationship' between the perpetrator and complainant; or stating that 'no marriage or other relationship shall constitute a defence to a charge of sexual assault' under the legislation.
- Review the *Family Law Act 2003* with a view to expanding protections that apply to the LGBTIQ community.
- Review *Crimes Act 2009* with a view to criminalising and incorporating specific provisions for sexual harassment.
- Consider reviewing the provision in the *Crimes Act 2009* s 215(2) for mistaken age defence in cases of sexual relations with minors between the ages of 13 and 16 with a view to creating greater onus on the defendant to ascertain age, for example by adding a 'reasonable steps' requirement.

- Conduct further research on reproductive coercion (including integrating reproductive coercion questions into national VAW surveys) as a starting point to inform appropriate policy and legislative measures.
- Review GBV responses across ministries to ensure alignment with the 2018 national service delivery protocol for GBV.

9.4. Humanitarian and disaster recommendations

- Ensure that there are specific provisions in relevant health and related disaster policy and legislation to require the MISP for SRH objectives and related indicators to be embedded.¹² Ensure this is situated in a broader health policy that strengthens health systems as part of SRH preparedness and readiness.
- Ensure new policy such as the forthcoming *Fiji National Action Plan to Prevent Violence Against All Women and Girls* explicitly considers GBV in emergencies. Ensure GBViE standards are embedded in policy and legislative frameworks and national cluster guidance to specific actors providing ongoing lifesaving services. This should include government and non-government services.
- Consider integrating SRHiE and GBViE standards in policies relating to disaster as they are due for review. Include measures to prevent sexual exploitation, abuse and harassment. In particular, the forthcoming *Disaster Management Framework* provides an opportunity to draw on international and regional commitments, such as KAILA, already made and explicitly committed to MISP, Essential Services standards and GBViE standards.
- Ensure national fiscal and budget policy includes gender and emergencies responsive budgeting, especially SRHiE and GBViE budget disaster planning for the most marginalised communities and individuals.

¹² Consider assessing feasibility of embedding in policy a requirement for the Government of Fiji to periodically assess readiness for implementing the MISP.

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Annex 1: Desk review search terms

Fiji

| | | |
|------------------------------|----------------------------|--------------------------------|
| AND "fertility" | OR "SRH" | OR "Gender-based violence" |
| OR "Maternal mortality" | OR "Reproductive health" | OR "Violence against women" |
| OR "Matern* health" | OR "Sexual health" | OR "Domestic violence" |
| OR "Matern* leave" | OR "Contracept*" | OR "Intimate partner violence" |
| OR "Patern* leave" | OR "Abortion" | OR "Family violence" |
| OR "Pregnancy" | OR "Family planning" | OR "Trafficking" |
| OR "Childbirth" | OR "Sex* education" | OR "Sex work" |
| OR "Skilled birth attendan*" | OR "Sex* curriculum" | OR "Early marriage" |
| OR "Life-saving commodit*" | OR "Family Life education" | OR "Forced marriage" |
| OR "Life-saving medicine*" | OR "AIDS" | OR "Child marriage" |
| OR "HPV" | OR "HIV" | OR "Female genital mutilation" |
| OR "Discrimination" | OR "Gender" | OR "Female genital cutting" |
| OR "Plural legal system" | OR "Disability" | |

Annex 2: Relevant organisations and bodies—SRHR

| Organisations and bodies relevant to sexual and reproductive health | |
|---|--|
| Government ministries and agencies | Ministry of Women, Children and Poverty Alleviation (previously MoSWWPA) |
| | Ministry of Health and Medical Services (previously Ministry of Health) |
| | Ministry of Education, Heritage and Arts |
| | Fiji Police Force |
| Local and national non-government organisations working in SRH | Medical Services Pacific (MSP) |
| | National Advisory Committee on AIDS |
| | Rainbow Pride Foundation Fiji |
| | Pacific Society for Reproductive Health (PSRH) |
| International non-government organisations | Plan International |
| | Care |
| | Reproductive and Family Health Association of Fiji (Member association of the International Planned Parenthood Federation) |
| | IWDA |
| UN Agencies | UNAIDS |
| | UNICEF |
| | WHO |
| | UNFPA |
| Regional | Pacific Women (Aus Aid, DFAT) |
| | Pacific Islands Law Officer’s Network |
| | SPC Regional Rights Resource Team (RRRT) |

Annex 3: Relevant organisations and bodies—GBV

Organisations and bodies addressing GBV

| | |
|---|---|
| Government ministries and agencies | Ministry of Women, Children and Poverty Alleviation (previously MoSWWPA) |
| | Ministry of Health and Medical Services (previously Ministry of Health) |
| | Fiji Police Force |
| | Taskforce on the National Elimination of Violence against Women |
| | Ministry of Labour, Industrial Relations and Employment) in relation to the National Policy on Sexual Harassment in the Workplace (2007) |
| | Fiji Women’s Federation (made up of representatives from NGOs and faith-based organisations, and set up to liaise with the Ministry of Women, Children and Poverty Alleviation) |
| | Medical Services Pacific (MSP) (provides support for survivors of GBV, including a free one-stop-shop for rape survivor services (in Suva and Labasa), a rapid response team, and a kids’ helpline) |
| | Empower Pacific (counselling and social services) |
| | Fiji Women’s Crisis Centre (see below) |
| | Fiji Women’s Rights Movement (see below) |
| Local organisations active in GBV prevention, response, advocacy and survivor support | Rainbow Pride Foundation Fiji |
| | Fiji Muslim Women’s League (refuge) |
| | Homes of Hope (refuge) |
| | St Giles, (psychiatric hospital) |
| | The Salvation Army (refuge) |
| | Diverse Voices in Action for Equality (feminist LGBTQI activist group concerned with social justice and activism) |
| | Fiji Disabled Peoples Federation (an umbrella body for several organisations for disabled persons, 15 community branches, concerned with the realisation of the UNCPRD) |
| | Fiji Human Rights Commission |
| | Fiji Law Society |
| | Fiji Women Lawyers Association |
| Haus of Khameleon (group advocating for trans rights) | |

Organisations and bodies addressing GBV

| | |
|--|---|
| | UNFPA |
| | UNAIDS |
| | UNICEF |
| | WHO |
| | IWDA |
| International non- government organisations and regional bodies | Marie Stopes |
| | International Centre for Advocates Against Discrimination |
| | Pacific Women Shaping Pacific Development (Australia Aid, DFAT) |
| | Pacific Islands Law Officer's Network |
| | SPC Regional Rights Resource Team (RRRT) |
| | SPC the Pacific Community |
| | FemLINKPACIFIC |
| | Pacific Counselling and Social Services |

Annex 4: Integrated definition of sexual and reproductive health and rights

Guttmacher-Lancet Commission Integrated definition of SRHR

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health.

The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.

Source: Starrs, et al. (2018). Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. The Lancet Commissions. 391(10140) 2642-2692.

