WOMEN AND YOUNG PEOPLE WITH DISABILITIES:

A needs assessment of sexual and reproductive health and rights, gender-based violence, and access to essential services

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A partnership of Pacific organisations of and for persons with disabilities

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List of acronyms

CEDAW Committee	UN Committee on the Elimination of Discrimination against Women
CRPD	Convention on the Rights of Persons with Disabilities
CRPD Committee	UN Committee on the Rights of Persons with Disabilities
DPOs	Disabled people's organizations
FAD	Fiji Association of the Deaf
FDPF	Fiji Disabled People's Federation
FWRM	Fiji Women's Rights Movement
GBV	Gender-based violence
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, and queer
MSP	Medical Services Pacific
NGO	Non-governmental organization
PDF	Pacific Disability Forum
PSA	Psychiatric Survivors Association of Fiji
RFHAF	Reproductive Family Health Association of Fiji
RMNCAH	Reproductive, maternal, neonatal, child and adolescent health
SPC	Social Development Division of the Pacific Community
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
UBP	United Blind Persons of Fiji
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNFPA Pacific	United Nations Population Fund – Pacific Sub-Regional Office
WEI	Women Enabled International

Executive summary

Women and young people with disabilities living in Fiji face significant barriers that hinder their full and effective participation in society on an equal basis with others. In particular, as this report reveals, they are prevented from fully realizing their sexual and reproductive health and rights (SRHR) and their rights to legal capacity and to be free of gender-based violence (GBV).

As a result of stigma and harmful stereotypes, many women and young people with disabilities only receive basic information about their SRHR and lack access to essential sexual and reproductive health (SRH) services, most of which are neither fully accessible nor disability inclusive. As a result, those who do seek SRH services report feeling judged or receiving unfair treatment by service providers. In particular, women and young people with disabilities usually find that, instead of receiving accessible information to make their own SRH decisions, service providers and family members make medical decisions on their behalf. These patterns of substitute decision-making and abusive medical care—coupled with stigma around SRH and widespread misconceptions about contraceptive methods and their risks, benefits, and potential side effects—deter many women and young people with disabilities from seeking SRH services and negatively impact their SRHR.

Women and young people with disabilities are also typically discouraged from talking about and/or reporting GBV, which is also highly taboo and extremely prevalent in Fiji. When women and young people with disabilities overcome these attitudinal barriers and report instances of violence, the police and members of the judiciary often disregard the complaints and/or refer them to informal reconciliation procedures, leading to high rates of impunity and perpetuating the cycle of violence. GBV survivors with disabilities also report significant challenges to accessing social and protective services, especially in more rural areas.

Summary of general recommendations

This report proposes general recommendations for the State to dismantle these barriers and advance the fundamental rights of women and young people with disabilities living in Fiji. These recommendations can be summarized as follows:

- Submit Fiji's initial report to the UN Committee on the Rights of Persons with Disabilities.
- Identify gaps in the implementation of the Rights of Persons with Disabilities Act of 2018, as well as national action plans and policies on reproductive health and violence against women.
- Conduct *talanoa* (dialogue and awareness raising) across government ministries about the rights of persons with disabilities, as well as common barriers and accessibility needs of persons with diverse disabilities.
- Invest adequate resources to ensure accessibility of SRH and GBV services for people with diverse disabilities.
- Invest in developing a network of accessible shelters and safe houses to facilitate better access to protective services outside of urban centers.

Summary of issue-specific recommendations

This report also describes specific legal, policy, social, attitudinal, physical, information and communication barriers impacting SRHR, legal capacity and GBV for women and young people with disabilities and includes a series of specific recommendations for addressing them. These recommendations can be summarized as follows:

Recommendations for addressing **legal and policy barriers**

- Ensure that the right to legal capacity, as recognized in the Rights of Persons with Disabilities Act (2018) is fully implemented.
- Invest in system-wide disability-inclusion capacity building for the justice sector.

Recommendations for addressing **social and attitudinal barriers**

- Develop Women and Young People with Disabilities Community Health Liaison/Advocate Program.
- Organize SRH and GBV workshops for women and young people with diverse disabilities and their family members.
- Provide disability-specific values clarification trainings for a wide range of SRH and GBV service providers and for police and justice sector personnel.

Recommendations for addressing **physical barriers**

- Strengthen and expand accessible and disability-friendly mobile clinic outreach by SRH and GBV service providers.
- Ensure access to refresher trainings for nurses staffing Ministry of Health and Medical Services' Nursing Stations in remote areas to retain skills for administering a range of contraceptive methods.
- Integrate disability-specific training sessions into existing SRH training for nurses and community health workers to strengthen integration of rights-based, disability-friendly practices.

Recommendations for addressing **information and communication barriers**

- Develop accessible SRH and GBV information, education and communication materials specifically targeting women and young people with disabilities to improve their awareness about SRH, GBV, and the services available to them.
- Prioritize increasing accessibility in the health care and the justice sectors through improving and developing access to sign language interpretation and other accessible formats.

1 Introduction and methodology

In 2020 the United Nations Population Fund Pacific Sub-Regional Office (UNFPA Pacific) engaged Women Enabled International (WEI)—in collaboration with the Pacific Disability Forum (PDF) and with the support of the Fiji Disabled People's Federation (FDPF) —to conduct needs assessment research to identify the barriers preventing women and young people with disabilities living in Fiji from fully realizing their sexual and reproductive health and rights (SRHR) and their rights to legal capacity and to be free of gender-based violence (GBV). This report summarizes research findings and priority recommendations for the State to eradicate those barriers and advance the fundamental rights of women and young people with disabilities.

Research for this report consisted of (1) **desk research,** reviewing laws and policies of Fiji and available reports published by United Nations (UN) agencies, human rights monitoring bodies, and non-governmental organizations (NGOs); (2) **interviews with key stakeholders,** including local disabled people's organizations (DPOs), organizations providing sexual and reproductive health (SRH) and GBV services, and UN agencies working in the country; and (3) **focus group discussions and interviews with women and young people with disabilities.** Due to COVID-19 travel restrictions, WEI was not able to conduct planned field research in Fiji, nor was WEI able to conduct site visits to independently verify information that we received from stakeholders as to facility accessibility.

Due to travel restrictions imposed by COVID-19, stakeholder interviews were conducted remotely by WEI staff, legal interns, and student attorneys with the Human Rights Clinic at the University of Texas School of Law via Zoom or Skype (depending on the platform preferred by the stakeholder). WEI conducted interviews with PDF, FDPF, UNFPA Pacific, United Nations Development Programme (UNDP), Reproductive Family Health Association of Fiji (RFHAF), Medical Services Pacific (MSP), Empower Pacific, Legal Aid Commission, Fiji Women's Crisis Centre, the Fiji Women's Rights Movement, and the Human Rights and Social Development Division of the Pacific Community (SPC). Attempts to secure an interview with the Ministry of Health and Medical Services were unsuccessful, largely due to the impact of the COVID-19 pandemic. The authors were also unable to secure interviews with the Ministry of Women, Children, and Poverty Alleviation, and the Fiji Human Rights and Anti-Discrimination Commission.

Focus group discussions and interviews were conducted by Naomi Navoce, an independent consultant with expertise on gender and disability, with assistance from PDF and FDPF. Four focus groups were conducted with a total of 31 female participants over the age of 18 and 8 male participants between the ages of 18 and 24: one with members of the United Blind Persons of Fiji (UBP) in the Central District, one with members of the Fiji Association of the Deaf (FAD) in the Central District, one with women with diverse disabilities in the Western District, and one with members of the Psychiatric Survivors Association of Fiji (PSA) in the Central District. Ms. Navoce and Ruci Senikula, Program Officer with PDF, also conducted individual interviews with 17 women with diverse disabilities between November 2020 and April 2021. No young men (under the age of 24) agreed to participate in the interviews or focus group discussions. Given that this research focuses on women and young people, we have omitted responses from the eight men over age 24 who participated in focus group discussions.

Women and girls were identified for interviews by PDF and FDPF and its affiliate DPOs. Informed consent was obtained by: explaining the reason for the research and how the information would be used; outlining the types of questions in the interview, highlighting to the women that some questions were quite personal; assuring women of the confidentiality of their name and any details that would lead to their identification; and informing women that they could choose not to take part or answer any question

or stop the interview at any time. The participants were informed that the research is critical to better understand the experiences that women and young people with disabilities have in their communities and in accessing essential services. They were also told that questions only ask about their opinion or experience; there is no right or wrong answer. After women were invited to ask questions, their permission to carry out the interview was sought. Twice throughout the interview participants were reminded that their participation is voluntary and that they could refrain from answering any questions and stop the interview at any time.

Focus groups and interviews were conducted in English and Fijian, depending on the preference of the interviewee. Where interviews were conducted in Fijian, the interview notes and quotations were translated into English. Quotes are as close to the original information communicated by the respondent as possible but are not verbatim in each instance. Nevertheless, they accurately capture the substance and information conveyed. They are included with quote marks to convey that the text has been taken directly from the interview notes. Where identifying information has been provided, such as the age, type of disability, and place of origin of the speaker, it is included with the express consent of the person interviewed.

While the focus groups and stakeholder interviews reflect a broad diversity of disabilities and service providers, there are some acknowledged gaps in this report, including the absence of interviews with young men with disabilities and women and young people with disabilities currently living in outer lying islands, as well as the limited number of interviews with women and young people with intellectual disabilities. Similarly, we were not able to secure interviews with government ministries and with service providers at public health care facilities, including St. Giles Hospital.

2 Priority issues at the intersection of gender and disability

This needs assessment research focuses on three priority issues impacting human rights at the intersection of gender and disability: SRH, GBV, and legal capacity. This section provides a brief overview of these issue areas and how gender and disability intersect to prevent women and young people with disabilities from fully realizing their fundamental rights with respect to these issues.

Sexual and reproductive health: Reproductive health refers to the "state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable, and acceptable methods of family planning, including methods for regulation of fertility, which are not against the law, and the right of access to appropriate healthcare services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[1] Sexual health, which is a component of reproductive rights, comprises of "the enhancement of life and personal relations, not merely counselling and care related to reproduction and sexually transmitted infections. It refers to the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love."[2]

Women and young people with disabilities have the same sexual and reproductive health rights as people without disabilities,[3] and they are just as likely to be sexually active as their peers without disabilities despite inaccurate stereotypical views to the contrary. Accordingly, they have the same SRH needs as women and young people without disabilities. Due to multiple and intersecting forms of discrimination on the basis of gender and disability—such as harmful stereotypes that people with disabilities do not have sex or are incapable of becoming parents—women and young people with disabilities face unique and pervasive barriers to accessing essential SRH services.

Legal capacity: Legal capacity is defined as "the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)."[4] Legal standing and agency entitles a person to the full protection of their rights without state inference and allows a person to engage in, create, modify, or end legal relationships.[5] In the SRH context, this might take the form of the right to consent to a medical procedure and withdraw that consent upon receiving further information; the exercise of this right for persons with and without disabilities is often referred to as the right to provide informed consent.[6]

Unfortunately, due to both gender and disability stereotyping, women with disabilities are often deemed incompetent or unreliable when making decisions or entering into a legal relationship, and as a result are subjected to substituted decision-making systems.[7] In these systems, such as guardianship regimes, someone other than the person with the disability can be authorized to make legally binding decisions that impact that person's life.[8] Often there are only limited safeguards for the person with a disability to challenge the loss of their legal capacity.

Similarly, in countries with and without substitute decision-making regimes, women with disabilities regularly experience substitute decision-making on an

informal basis. Informal substitute decision-making occurs when a person other than the individual with the disability is permitted to make a decision for the person with the disability without any formal authorization to do so.[9] An example of informal deprivation of legal capacity is when the parent of an adult with a disability is asked to consent to a medical procedure or medication rather than the person themselves. Common informal substitute decision-makers include spouses, family members, support persons, or medical providers. Informal deprivations of legal capacity are particularly insidious because of the lack of procedures and even limited safeguards in place to protect the person with the disability.

The alternative to a substituted decision-making system—both formal and informal—is a supported decision-making system.[10] Supported decision-making programming enables all persons with disabilities, regardless of their impairment, to understand the pertinent information required to make a decision and to access the assistance they require to make their own informed decision.[11]

Gender-based violence: GBV are acts "perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. The term 'gender-based violence' is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence. As agreed in the *Declaration on the Elimination of Violence against Women (1993)*, this includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life. The term is also used by some to describe some forms of sexual violence against males or targeted violence against LGBTIQ populations."[12] GBV can be perpetrated by intimate partners, family members, medical providers, educators, or employers and can take many forms, such as physical, emotional, sexual, and economic.[13]

Women with disabilities make up approximately one-fifth of the world's population of women and are two or three times more likely to experience certain types of GBV.[14] Despite the large number of women with disabilities affected, most laws and policies on GBV do not addresses the specific concerns of girls and women with disabilities.[15] The lack of disability-specific legal protections, coupled with inadequate accessibility mechanisms and lack of training across protective and preventative services and the justice sector—frequently prevent GBV survivors with disabilities from reporting the violence, seeking essential GBV services, and accessing justice.

3 Findings: Overview of the situation in Fiji

The Republic of Fiji is the second largest country in the South Pacific island region.[16] The country consists of more than 330 islands, of which 110 are permanently populated, though roughly 87 per cent of the population resides on the two largest islands—Viti Levu and Vanua Levu.[17] The 2017 census counted 884,887 people in Fiji, with women making up 49 per cent of the population.[18] Fiji's population is also quite young, with the median age being 27.5 years.[19] Forty-five per cent of Fiji's female population is between the ages of 15 and 44.[20]

3.1. Civil and human rights

The current Constitution of the Republic of Fiji was signed into law and went into effect in September 2013. Fiji's Constitution prohibits discrimination on the basis of sex, gender, disability, marital status, or pregnancy.[21] The Constitution protects the rights of persons with disabilities, including with respect to accessing places, transportation, information, assistive devices, and the use of sign language, Braille, or other alternative methods of communication.[22] The Constitution also protects the rights of children, including asserting a right to be protected from abuse, neglect, harmful cultural practices, and other forms of violence.[23] Notably, other than a general prohibition on discrimination on the basis of sex and gender, Fiji's Constitution does not explicitly protect women's rights, though the Constitution does commit to progressive realization of the right to health, including reproductive health.[24] The Constitution does recognize a right to be free from torture and other forms of cruel, inhumane and degrading treatment, and further recognizes that the right to personal security includes a right to be free from violence at home, school, and work.[25]

Fiji has ratified or acceded to all nine core international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CRPD), and the Convention on the Rights of the Child.

Fiji's first report to the Committee on the Rights of Persons with Disabilities (CRPD Committee) was due in July 2019, but the country has yet to submit its report. Accordingly, Fiji's compliance with the CRPD has not yet been reviewed.

3.2. People with disabilities

The 2017 census documented that 113,595 people over the age of 3 years—or 13.7 per cent of Fijians—has at least one "functioning challenge" or disability.[26] While data disaggregated by sex is available for some districts,[27] census data does not indicate the nationwide percentage of persons with disabilities who are women.

In 2018, Fiji enacted the Rights of Persons with Disabilities Act, aimed at domestic implementation of the CRPD. Importantly, this law codifies the rights protected in the CRPD, including the rights to legal capacity,[28] health (including SRH),[29] and freedom from violence.[30] It is worth noting that, while the CRPD itself acknowledges that women with disabilities encounter multiple forms of discrimination on the basis of both gender and disability and States Parties to the CRPD commit to taking "all appropriate measures to ensure the full development, advancement and empowerment of women" to fulfil the rights protected in the CRPD,[31] Fiji's Rights of Persons with Disabilities Act of 2018 contains no such provisions aimed at addressing the disproportionate and intersecting forms of discrimination encountered by women with disabilities.

While this law provides a crucial first step to bringing Fiji into compliance with the CRPD, it is important to

note that there is lack of clarity as to the extent to which this law has been implemented. The law itself does not contain any guidance on how to give effect to the rights protected in the Act, and no stakeholders interviewed could provide clarity on what steps are being taken to implement the law or to bring other legislation into compliance with the terms of the Rights of Persons with Disabilities Act.

Focus group discussion participants and interviewees report a wide range of experiences in Fiji due to their disability—ranging from kindness to paternalism to abuse—at both the family and community level.[32] Several people interviewed expressed particular concern about the lack of integration of children with disabilities into Fijian families and society, noting that parents of children with disabilities do not always accept their child's disability and sometimes even hide them away[33] and expressing concern about lack of accessibility of mainstream schools.[34] This lack of inclusion from an early age contributes to challenges in accessing education, securing employment later in life, and lack of empowerment to understand and exercise fundamental human rights, including sexual and reproductive rights and the right to be free from GBV.

In terms of disability-inclusive service provision, the FDPF collaborates formally and informally with several service providers, and FDPF has conducted disability awareness trainings and accessibility audits in some instances to strengthen access to essential services.[35] The Fiji Association of the Deaf also has a memorandum of understanding with the Fiji Women's Rights Movement (FWRM), which has strengthened both representation of—and FWRM's capacity to incorporate the experiences of—Deaf women into their advocacy. Service providers noted that they rely heavily on collaborations with DPOs for interpretation, particularly for Deaf patients.[36]

3.3. Sexual and reproductive health

In 2014, Fiji's Ministry of Health and Medical Services developed a Reproductive Health Policy with the overall goal of providing comprehensive and integrated health services for all women, men, and young people.[37] The policy outlines priority areas for reproductive health, including family planning and fertility, infant and child health, adolescent health, maternal and neonatal health, and sexually transmitted infections and reproductive tract cancers.[38] This policy is currently undergoing review, and Fiji will soon be implementing its new Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) policy.

In practice, geography plays a major factor in ensuring access to health services, including SRH services, with individuals in remote or outer lying islands having much less access to regular SRH services. Fiji's Ministry of Health and Medical Services has identified increased decentralization of health services—including in particular maternal, mental, and rehabilitative health services—as a strategic priority to allow for broader distribution across the country and ensure better access.[39]

Persons with disabilities experience heightened barriers to accessing health services in Fiji as compared to persons without disabilities,[40] and this holds true in the context of SRH services as well. A significant number of the women and young people with disabilities that participated in interviews and focus group discussions report that they have not accessed a full range of SRH services, nor is comprehensive SRH information widely available in accessible formats.[41] Of the women and young people with disabilities we spoke with who have accessed SRH services, they access services either at government-run clinics or through services provided by NGOs, and report a variety of experiences in terms of accessibility and quality of care.[42] The barriers that interview and focus group participants identified in accessing services—which range from significant attitudinal barriers to barriers accessing information and communicating effectively with providers to barriers with physical and geographic access to SRH clinics—are explored in depth in the following sections.

3.4. Legal capacity

Article 32 of Fiji's Rights for Persons with Disabilities Act of 2018 states, "All persons with disabilities have the right to enjoy legal capacity on an equal basis with others in all aspects of life."[43] While Fiji has recognized the legal capacity of persons with disabilities to make their own decisions, then, legal capacity can be curtailed under the determination of mental incapacity and through the use of management orders.[44] These two mechanisms can revoke legal capacity from persons with disabilities, though stakeholders interviewed were not certain whether such substituted decision-making formally extends to medical decisions, and they indicated that management orders and other formal deprivations of legal capacity were not common in Fiji.[45]

In practice, irrespective of the legality of substituted decision-making in the medical context, numerous participants in focus groups and individual interviews report that they do not make their own decisions with respect to medical decisions, including decisions around contraceptive methods (see *Legal and Policy Barriers: Issue 1*). Limited standardized guidance within the medical field, particularly when it comes to providing disability-inclusive health services, exacerbates the challenges in ensuring fully informed consent for medical decisions.

3.5. Gender-based violence

GBV is extremely prevalent in Fiji. Seventy-two percent of women who have had intimate partners have experienced some form of violence—physical, sexual, or emotional—from a partner.[46] The CEDAW Committee has noted that Fiji's rates of GBV are the highest in the region and expressed concern about underreporting of GBV (due to "stigma, social pressure to resort to traditional apology and reconciliation procedures … and distrust in the justice system"), impunity for perpetrators of GBV, and limited access to health and social support for survivors of gender-based and sexual violence.[47]

Fiji has a variety of laws and policies that work in tandem to address GBV. The National Gender Policy defines GBV as any act that results in, or is likely to result in physical, sexual, emotional or psychological harm to women, and which results from power inequalities that are based on gender roles in which a perpetrator gains power and exerts control over the other person.[48] The Domestic Violence Act of 2009 is aimed at preventing domestic and intimate partner violence,[49] while the Crimes Act of 2009 includes the criminal offences of rape, sexual assault, indecent assault, and the defilement of intellectually impaired persons.[50] Fiji is also in the process of launching a National Action Plan to Prevent Violence Against Women and Girls,[51] and has undertaken consultations to discuss how this five-year (2021-2026) plan will be executed.[52] These consultation plans are inclusive of women with disabilities, and FDPF is part of the technical working group.[53]

Advocates that we spoke with indicated that there are strong laws on GBV in Fiji, but that the biggest challenge is with ensuring implementation of these strong laws and policies.[54] For example, one advocate noted that the no drop policy—a policy that essentially eliminates police discretion in processing cases involving GBV—has been unevenly implemented across police stations, with limited follow through to ensure that the policy is taken seriously.[55] Stakeholders further noted that access to social, protective, and justice services is particularly challenging for survivors of GBV—and more so for survivors with disabilities—if they live outside of bigger cities or towns.[56] In particular, stakeholders underscored the need for more safe houses, including accessible safe houses, to be well distributed throughout the country,[57] as well as the physical inaccessibility of most courthouses throughout the country.[58]

> *"Women with disabilities don't feel safe in their own home and community too because they are faced with violence and abuse in their own home."*
> – 49-year-old woman with a physical disability from Nadi

Women with disabilities in Fiji report that GBV is a big concern in their communities.[59] Yet violence against women and girls with disabilities is typically underreported,[60] and participants in focus group discussions and individual interviews indicated that many women with disabilities are discouraged from reporting or that they do not feel comfortable talking about their experiences with violence.[61] Slightly more than half of the 19 women who participated in individual interviews reported experiencing physical

violence[62]—including at the hands of a spouse, parent, teacher, or stranger—but only two indicated that they reported the violence.[63] The majority of those interviewed similarly indicated that they had not received information about GBV; those who had, indicated that workshops provided by the Fiji Women's Crisis Centre and FDPF, as well as social media, were their main sources of information about GBV.[64]

3.6. COVID-19

Fiji responded swiftly to the COVID-19 pandemic, shutting down its international borders and instituting a nationwide lockdown in April 2020. Citizens and residents who were repatriated during this time entered into a mandatory quarantine, and until April 2021, Fiji was able to contain identified cases of COVID-19 and prevent community spread. At the same time, the steep decline in revenue from tourism, trade, and production has had a significant economic impact on Fiji.[65]

Women with disabilities and service providers indicated that the primary impact of COVID-19 on daily life has been felt in relation to restrictions on movement and resulting consequences for access to employment, essential goods and services, disability supports, and public transportation.[66] With respect to the provision of SRH services in Fiji, service providers indicated that lockdowns restricted access to services.[67]

Interviewees and focus groups participants generally indicated that they were able to access information about the virus, either through television, Internet, or family members, though a survey carried out by the Psychiatric Survivors Association found that 65 per cent of homeless persons with psychosocial disabilities in Suva were not aware of the virus.[68] At the same time, the quality of information provided—particularly where translated into sign language—created issues in ensuring access to essential health services. For example, a 35-year-old Deaf woman from Tailevu reported that the information available to the Deaf community underscored that you cannot leave your home; despite being pregnant, she was too scared to leave her home even to go to the hospital for maternity care.[69]

Several focus group participants reported significant impacts as a result of the lockdowns, particularly with respect to accessing essential health care services[70] and experiencing heightened rates of verbal and physical abuse.[71] One 20-year-old Deaf woman from Gau Island recounted her attempt to secure police authorization to travel to the hospital to deliver a baby. Despite being in labor with her water broken, her mother spent hours calling the police to secure the necessary pass to go to the hospital. As a result of this delay, she delivered her baby in the car on the way to the hospital—almost 18 hours after her mother had first contacted the police to try to secure a pass—and fainted during the delivery.[72] Interviewees with psychosocial disabilities also reported not having access to mental health services at St. Giles during COVID-19 lockdowns.[73]

> *"The violence between Deaf women and their husband has gotten worse because of no jobs or not enough money to support the family."*
> - 26-year-old Deaf woman from Naitasiri

Several participants interviewed reported challenges in accessing public transportation during COVID-19, including being denied entrance onto buses, which restricted their ability to get to work and to health care facilities.[74] Several participants also reported losing their job which led to financial hardships for some families.[75] Several women reported that financial hardships as a result of the pandemic have exacerbated the situation of GBV.[76]

4 General recommendations

Recommendation 1: Submit Fiji's initial report to the UN CRPD Committee to allow experts on disability rights to identify priority recommendations to bring Fiji into stronger compliance with the CRPD. The process of developing the State report should incorporate national consultations with DPOs and their members to identify priority human rights issues for people with disabilities.

Recommendation 2: Review status of implementation of the Rights of Persons with Disabilities Act of 2018, as well as national action plans and policies on reproductive health and violence against women, to identify gaps in implementation. In particular, conduct a review of national laws and policies, including those bearing on legal capacity and management orders; informed consent; and physical accessibility of public buildings (including court buildings) to determine where existing laws and policies conflict with the provisions of the Rights of Persons with Disabilities Act of 2018. Disaggregate national census data on disability by gender and age to strengthen monitoring of disability rights.

Recommendation 3: Conduct *talanoa* (dialogue and awareness raising) across government ministries about the rights of persons with disabilities, as well as common barriers and accessibility needs of persons with diverse disabilities, to foster stronger support for human rights-based disability-inclusion. Ensure adequate support for FDPF—including for human and financial resources—and its affiliate DPOs to meet high demands for their expertise on disability inclusion.

Recommendation 4: Invest adequate resources to ensure accessibility of SRH and GBV services—whether provided by public, private, or non-governmental entities—for people with diverse disabilities, including by:

- Ensuring that FDPF and its affiliate DPOs have sufficient support (including for human and financial resources) to carry out trainings for public and non-governmental entities, as well as people with disabilities, especially those from underserved disability communities and rural areas.

- Implement a clinical redesign program that is based on a mapping of patient journeys of patients with diverse disabilities to identify gaps in coordination of care (including with respect to information and communication between service recipients and providers) and to improve service delivery.

Recommendation 5: Invest in developing a network of accessible shelters and safe houses—distributed across the country to ensure access for survivors of GBV in rural areas—to facilitate better access to protective services outside of urban centers.

5 Legal and policy barriers

5.1. Issue 1: Formal and informal deprivations of legal capacity for women and young people with disabilities are permitted in Fiji.

> *"Only some Deaf women make their own decisions when seeing a doctor. … The doctors and nurses would make the decision for me what family planning method to take even though I choose another family planning method. However, the doctor would tell me to take the one they choose because it's better."*
> – 27-year-old Deaf woman from Sigatoka

Despite the Rights of Persons with Disabilities Act establishing the right to enjoy equal legal capacity, women and young people with disabilities can face obstacles when trying to exercise agency over their SRH decisions. The Mental Health Act of 2010 enables substitute decision-making for persons with disabilities who meet the definition of "mental incapacity,"[77] though it is not clear the extent to which management orders extend to medical decisions.

Denials of legal capacity, however, extend beyond formal substituted decision-making. Across focus group discussions and individual interviews, women with disabilities said that women should be able to make their own decisions when it comes to medical care, but that most often those decisions are made by family members.[78] This is particularly the case for women and young people with disabilities who have had less access to education, women with psychosocial disabilities, and women who have difficulty communicating directly with service providers, such as Deaf women and women with intellectual disabilities.[79] In these instances, family members or medical providers typically make medical decisions on their behalf, often without a formal recognition of authority to make legal decisions for that person.[80]

Substituted decision-making in the area of SRH services appears to be particularly common. A 32-year-old woman with a psychosocial disability from Suva reported that she was sterilized without her free and full informed consent: "I was tied and cut not to have a baby again. Therefore, I continue to face depressions, and it's affecting my marriage."[81] Anecdotal reports indicate that involuntary sterilizations are not uncommon—quite a few focus group participants were familiar with cases where women with disabilities had been sterilized without their consent.[82]

With respect to family planning methods, many women with disabilities do not have access to information they need in a form that they can understand to be able to make their own decisions.[83] For example, one young woman with a visual impairment reported being prescribed contraception for a medical condition without being told what the medication was; she only discovered that she had been taking contraceptives later, after being scolded and humiliated by her teacher for having contraceptive pills in her bag.[84] As one focus group participant stated, "How will medical doctors explain the different types of family planning to a woman with a visual impairment that is not well educated and living in the rural community. … At some point the doctor will just prescribe the medication and telling the woman the medicine is good for her without making her own decisions."[85]

5.2. Issue 2: Sexual and gender-based violence cases involving women with disabilities are seldom processed through formal justice system.

Women and girls with disabilities face significant challenges reporting experiences of GBV and ensuring that cases are processed through the justice system. In addition to facing pressure from family members not to report experiences of violence—or threats of retaliation from the perpetrator themselves, women with disabilities often find that police do not take complaints about GBV seriously.

Several focus group participants discussed that women with disabilities are typically encouraged by police to use reconciliation instead of continuing with their claim.[86] Deaf women and women with psychosocial disabilities, in particular, expressed that the police do not believe them or open files on their cases when they report experiences of GBV.[87] When cases do progress through the justice system, several women indicated that magistrates often take pity on the perpetrator and dismiss the case.[88]

Where women and girls with disabilities are accompanied by someone they trust, they are more likely to report the violence they experience and to pursue the complaint.[89] Similarly, where service providers have been able to take time and build trust and rapport with survivors with disabilities, they have seen an increased willingness in giving a statement and taking cases to trial.[90]

> *"When the violence happens, people or perpetrators use reconciliation as a tool against [women with disabilities]. After they reconcile, they continue with the crime abusing women with disabilities. If the matter is reported and taken to court, the perpetrator will give excuses [and] the court or the magistrate will feel sorry for the perpetrator and dismiss the case."*
> – 20-year-old woman with a visual impairment from Nakaroba Village

Recommendations for addressing legal and policy barriers

Recommendation: Ensure that the right to legal capacity, as recognized in the Rights of Persons with Disabilities Act (2018) is fully implemented, including by: (1) developing clear guidelines for securing informed consent for medical procedures and (2) bringing pre-existing laws and policies regarding legal capacity and substituted decision-making into compliance with the standards required by the CRPD. Train service providers on various types of force and coercion so they can understand how their actions, words, and power imbalances can affect informed decision-making for patients with disabilities.

Recommendation: Invest in system-wide disability-inclusion capacity building for the justice sector. Strengthen and fund effective referral pathways between counseling services, GBV service providers, and DPOs to ensure that women with disabilities who report experiences of violence have access to the supports they need to be able to communicate with service providers and the justice sector and to pursue their complaints.

6 Social and attitudinal barriers

6.1. Issue 1: Harmful stereotypes of women and young people with disabilities limit access to SRH and GBV services.

> *"The community laughs and makes fun of pregnant women with disabilities. They openly make comments—'look at her having a disability and being pregnant.'"*
> – Visually impaired woman from Lautoka (age not disclosed)

In Fiji, disability can be seen as evil or as a curse.[91] Families and communities also tend to think of women with disabilities as people that need to be taken care of.[92] Fijian society rejects the idea that women with disabilities can have sex, get married, or have a baby.[93] This stereotype contributes to many women with disabilities not knowing their rights or being able to access SRH services. Women with disabilities further lack awareness that their is a legal recourse for GBV.[94]

Women also feel pressure not to access health care services, including SRH services. In 2017, 39 per cent of Fijian women stated that they must ask permission from their partners before pursuing health care options.[95] Young people, in particular, battle stigma when trying to access SRH, and this is exacerbated in more rural areas.[96] In focus group discussions, several women shared that they were shamed by family members or teachers when it was discovered that they took contraceptive pills, even when the pills were prescribed for medical reasons separate from preventing pregnancies.[97] Others reported that they or their children experience bullying as a result of being disabled or having parents with disabilities.[98]

6.2. Issue 2: Women and young people with disabilities are socialized not to talk about SRH and GBV.

One of the primary barriers to promoting access to SRH and GBV services for women and young people with disabilities is that these issues are highly taboo in Fiji generally, and even more so for women and young people with disabilities; as a result, women and young people with disabilities are socialized not to talk about these issues. This posed a significant barrier to data collection, as many individuals did not feel comfortable participating in individual interviews—or declined to answer certain questions—due to a discomfort with the subject matter. One focus group participant underscored that women with disabilities are especially discouraged from talking about GBV because "[i]f the perpetrator is a family member or from an extended family within their community, it will bring about shame to the family and the community."[99]

Among focus group discussion and interview participants, there are some women with disabilities who have had access to more comprehensive sexuality education, including in particular, awareness raising sessions organized by RFHAF, FWCC, FDPF, and FAD, and thus felt empowered to make their own decisions and understand that they have a choice to use contraceptives and access SRH and GBV services. Women in this group were more likely to report using modern contraceptive methods, reporting GBV, and seeking out GBV services when experiencing violence.[100]

> *"Our cultural beliefs and traditions does not allow us to openly talk about sex, family planning and other sensitive topics. These are taboos in our culture. Therefore, persons with disabilities lack the information, knowledge and decision-making about their bodily autonomy. Especially women with disabilities."*
> - 25-year-old woman with visual impairment from Suva

The majority of women we spoke with, however, have been socialized not to talk about these issues, felt uncomfortable discussing their experiences with SRH and GBV, and lacked access to essential information about the services available to them. Indeed, a significant number of interviewees and focus group discussion participants report that they have not accessed a full range of SRH services. While the results from these interviews are not statistically significant, they do indicate widespread barriers to accessing SRH services. For example, fewer than half of the 19 women who participated in individual interviews had received a breast exam, pap test, or a test for sexually transmitted infections.[101] Interviews further exposed an unmet need for family planning for women with disabilities—less than a quarter of participants in individual interviews had ever used a family planning method, including several women of reproductive age who are sexually active, but who do not currently want to become pregnant.[102] Moreover, at least five of the 19 women interviewed reported experiencing unintended pregnancies.[103] Women in this latter group were also more likely to report that family members made medical decisions on their behalf.[104]

> *"I don't go to anybody [if I have a question about my health] because I am shy to talk about my health and my body."*
> – 37-year-old woman with a hearing impairment from Nadi

Accompaniment can go a long way to ensuring that women with disabilities seek out SRH and GBV services. Several women spoke of accessing services when accompanied by friends with disabilities or accompanying friends to seek such services.[105]

> *"Women with disabilities face violence every day in their lives. However, these women don't talk about the violence to other women's organizations but only talk about it amongst themselves as women with disabilities. Family members is a challenge and will not allow them to report."*
> – 35-year-old woman with visual impairment from Naitasiri

6.3. Issue 3: Negligence and stigma in health care and gender-based violence sectors impact quality of services.

Women with disabilities have reported feeling judged or receiving unfair treatment at health centers or hospitals when they do seek reproductive health services.[106] Numerous women interviewed reported experiencing humiliating and sometimes abusive treatment due to their disability when seeking health services.[107] These types of experiences deter women with disabilities from seeking health care services. At least one woman reported traveling further distances—with attendant costs and physical barriers—to access non-abusive medical care.[108]

It is worth noting that quite a few women reported positive experiences with health care services, including those provided by RFHAF and at the Namaka Health Centre in Nadi.[109] RFHAF has implemented disability-specific values clarification training with their staff, with a particular emphasis on respecting the capacity of persons with disabilities to make autonomous decisions and on dismantling harmful stereotypes about people with disabilities.[110] Patient reports of positive experiences with RFHAF's services suggest that such trainings have had a positive impact on the quality of care.

> *"After my accident, I gave birth to two sons. Compared to before I had the accident, I felt there was a big gap in terms of the services that was given to me. Before I lost my vision, the service was really, really nice … when I gave birth to my first son. … After my accident, … the truth I felt I was not treated in a way I deserved to be treated before. I was in the labor room alone... I had to call out to the nurses to come to the labor room. … I was not cleaned, and I had to help myself to get to the bathroom to clean myself."*
> – 39-year-old woman with visual impairment from Lautoka

As a consequence of negative treatment, some women with disabilities do not feel that service providers can understand their experiences or provide needed support. For example, one woman suggested "we should have our own disability helpline instead of going to another organization. Because persons with disabilities would understand another person with disability."[111]

Recommendations for addressing social and attitudinal barriers

Recommendation: Develop Women and Young People with Disabilities Community Health Liaison/ Advocate Program. Recruit and train women and young people with disabilities to serve as Community Health Liaisons to provide peer-to-peer education and accompaniment to SRH and GBV services. This role can help strengthen understanding among women and young people with disabilities about the availability and appropriateness of SRH and GBV services, as well as dismantle perceptions that SRH and GBV services are not for people with disabilities.

Recommendation: Organize SRH and GBV workshops for women and young people with diverse disabilities and their family members. Create and expand rights-based awareness-raising programs on disability rights and inclusion, with a particular focus on ensuring that such programs are made available and accessible to women with disabilities, young people with disabilities, Deaf and hearing-impaired people, people with intellectual disabilities, and family members (especially parents) of people with disabilities. Programming must be grounded in the CRPD framework, developed in consultation with DPOs, and led by people with disabilities whenever possible. Key topics to be addressed include: SRH and GBV rights and services for people with disabilities; legal capacity, including informed consent in healthcare settings; and family violence.

Recommendation: Provide disability-specific values clarification trainings for a wide range of SRH and GBV service providers and for police and justice sector personnel. Successful models of disability-specific values clarification trainings should be scaled up and expanded to reach a wider range of actors who provide essential SRH and GBV services.

7 Physical barriers

7.1. **Issue 1: Geographic barriers prevent women and young people with disabilities from accessing SRH and GBV services.**

Fiji is made up of many islands, many of which require long travel to reach from the other metropolitan areas. Currently, the Ministry of Health and Medical Services partners with NGO service providers, including both the RFHAF and MSP, to strengthen access to SRH and GBV services. RFHAF and MSP both have memoranda of understanding with the Ministry of Health and Medical Services and conduct mobile outreach clinics to bring their services to remote areas and outer lying islands. Both organizations indicated that ability to conduct mobile clinic outreach, particularly in more remote areas and outer lying islands like the Lau Islands, is resource contingent.[112] Between visits from NGO mobile clinics—which is typically a 12-18 month period for harder to reach islands—women must either seek health care through community health workers, Ministry of Health and Medical Services' Nursing Stations, or undertake expensive and onerous travel to urban centers.[113] Similarly, some remote islands lack police presence, which can make it virtually impossible to report GBV or access justice.[114]

Nurses and community health workers play an important role in providing essential health services and also help make arrangements for mobile clinics, but community health workers are not typically trained to administer contraceptive services themselves, and it is not clear if nurses or community health workers have received disability-specific training.[115] This can pose a significant challenge to contraceptive adherence. For example, many Fijian women chose injections as their preferred contraceptive method, as injectables are the easiest method to conceal.[116] Yet women need to receive an injection every three months for injectables to work effectively; without regular access to a provider trained to administer contraceptive services, women in rural and outer lying islands cannot adhere to this specific method.

Limited access to mobility aids can pose an additional barrier for women with disabilities to access SRH services, even when mobile clinics are visiting a given area. When MSP became aware that their mobile clinics were inaccessible for some women with disabilities who lacked adequate supports or mobility aids, they implemented a practice they refer to as "the walk," where the clinical team will visit homes of women with disabilities once the clinic closes for the day to provide care to those who are unable to access the mobile clinic.[117] This practice has been helpful in ensuring access to services for patients who otherwise lack access to even mobile clinics, but patient confidentiality, particularly for GBV and SRH services, would be strengthened if patients had better physical access to static and mobile clinics.

Recommendations for addressing physical barriers

Recommendation: Invest adequate resources to strengthen and expand accessible and disability-friendly mobile clinic outreach by SRH and GBV service providers, as well as adequate distribution of mobility aids to facilitate physical access to both static and mobile clinics. Consider integrating principles of universal design[118] in both static and mobile clinics to ensure physical accessibility of the built environment.

Recommendation: Ensure access to refresher trainings, for nurses staffing Ministry of Health and Medical Services' Nursing Stations in remote or outer lying areas to retain skills for administering a range of contraceptive methods, including injectables, to ensure better adherence to family planning methods between visits by mobile clinics. Train nurses to explain the pros and cons of various methods of contraceptives to women and young persons with disabilities, particularly people with intellectual disabilities, in an accessible way.

Recommendation: Integrate disability-specific training sessions into existing SRH pre- and post-service training for nurses and community health workers to strengthen integration of rights-based, disability-friendly practices. Trainings should be grounded in the CRPD framework to ensure that providers understand the rights of persons with disabilities, but also focus on skill development in providing quality and evidence based SRH services to persons with disabilities.

8 Information and communication barriers

8.1. Issue 1: Women and young people with disabilities lack accessible information on SRH and GBV.

> *"I feel spaces like this are important because the Deaf are not aware of the reproductive health. Most of my Deaf [friends] are not aware of this, and it's very important for us to know about this and what reproductive health means for us. At times we are not included in a lot of spaces or workshops that share this kind of topic."*
> – 27-year-old Deaf woman from Sigatoka

Access to accessible information is one of the biggest barriers for Fijian women with disabilities to receive SRH services. Women with disabilities report a wide variety of sources for SRH information, including family members, school programs, Internet sources, trainings by RFHAF and/or FDPF, and nurses at their local clinic,[119] though many indicated they had only received basic information about their health and bodies and very little information about GBV. Moreover, SRH and GBV information is not widely available in accessible formats, especially in Easy Read[120] and sign language.[121]

Awareness trainings can have a big impact on empowering women with disabilities to better understand what services are available and how to access these services.[122] Focus group participants expressed that the RFHAF trainings were very informative and simple to understand.[123] Women who had accessed the trainings offered by RFHAF felt much more empowered to talk about SRH issues, were more likely to make use of SRH services and to say they make their own decisions regarding their SRH.

> *"After I attended the … training on sexual and reproductive health and family planning. I was motivated to get checked. … I felt good because I got to know my internal organs. … I also find the clinic accessible for me because the nurses are very helpful when providing the test together with useful information are very useful for me. I had never had a pap smear test before, so I decided to have a test done by going to RFHAF clinic."*
> – 35-year-old woman with visual impairment from Naitasiri

8.2. Issue 2: Lack of sign language interpretation significantly inhibits communication with SRH and GBV service providers.

> *"It's so hard for me to communicate with the doctors and nurses when I get to the hospital. At times, I just write on a piece of paper to communicate with the doctor. However, this type of communication is still a barrier for me. I would prefer for an interpreter to come in and interpret for me so that the doctor can just attend to giving me advice what I am supposed to do as a patient"*
> – 24-year-old Deaf woman from Nausori

Sign language interpreters are not readily available in health care facilities.[124] While organizations that provide SRH services and labor and delivery care try to provide interpreters, there are still reports of women with disabilities in labor passing away in health care facilities because of their doctors' inability to communicate with them.[125] NGO service providers expressed that information and communication barriers are a big hurdle and that they must rely on partnerships with DPOs to ensure access to sign interpreters.[126] These organizations have admitted that this area needs the most improvement to better facilitate SRH services for women with disabilities in Fiji.[127]

Interviews and focus group discussions with Deaf women underscored this substantial barrier to accessing SRH services. In particular, Deaf women reported that they either cannot communicate effectively with their health care provider or that they have to compromise their confidentiality and be accompanied by a parent or another individual to assist with communication.[128] In some instances, providers did not even attempt to communicate directly with patients, communicating instead with family members, which may result in substituted decision-making in the provision of SRH services (see Legal and Policy Barriers: Issue 1).[129]

These communication barriers also extend to GBV services. A number of Deaf women interviewed expressed concern that the national helpline for GBV is inaccessible because it does not have text capabilities.[130] The lack of sign language interpreters and other accessible communication devices make it extremely difficult to report when they experience GBV or to seek out essential GBV services.[131]

> *"Because we are Deaf, sometimes we experience the violence in our home and community. It is very hard to ask for help when the violence happen because we are Deaf and [have] no sign language interpreter to help us."*
> – 26-year-old Deaf woman from Naitasiri

8.3. Issue 3: Women and young people with disabilities experience widespread misconceptions about contraception.

Based on the focus group discussions and individual interviews, women and young people with disabilities appear to lack access to essential information about contraceptive methods and their risks, benefits, and potential side effects. As a result, misconceptions that may deter women from starting or adhering to contraceptives seem commonplace. For example, a number of women reported significant concerns about side effects from contraceptive use—including extreme weight loss, hair loss, dizziness, and amenorrhea.[132] While some women sought a different contraceptive method, others were deterred from utilizing contraceptives.[133] At least one woman expressed concern that contraceptives would prevent future pregnancy.[134] Women with disabilities need to be able to communicate effectively with their providers in order to receive effective counseling around contraceptive methods and to dispel misconceptions that contraceptives have long-term adverse consequences for fertility.

> *"I told [my friend] 'you should stop taking those kind of things because in the future it's probably going to stop you getting pregnant or probably spoiled your chances of getting pregnant.'"*
> – 26-year-old Deaf woman from Suva

Recommendations for addressing information and communication barriers

Recommendation: Develop accessible SRH and GBV information, education and communication materials specifically targeting women and young people with disabilities to improve their awareness about their SRH, GBV, and the services available to them. Disseminate information, education and communication materials in a range of accessible formats, including digital and/or audio formats, simplified formats such as plain language and Easy Read, and sign language. Ensure that medical terms are simplified to allow women with disabilities with limited access to education to understand the information.

Recommendation: Prioritize increasing accessibility in the healthcare and the justice sectors through improving and developing access to sign language interpretation and other accessible formats, such as text-to-talk apps and text enabled GBV helplines. Plan for long-term investment in increasing the number of sign-language interpreters available in Fiji and the hiring of permanent sign language interpreters within the health care and the justice sectors. Develop safeguards to maintain and guarantee patient confidentiality when communicating with service providers.

Endnotes

1 UNFPA, Danish Institute for Human Rights, & OHCHR. *Reproductive rights are human rights: A handbook for national human rights institutions,* at 18 U.N. Doc. HR/PUB/14/16 (2014). http://www.ohchr.org/Documents/Publications/NHRI-Handbook.pdf

2 *Id.* at 19.

3 Convention on the Rights of Persons with Disabilities, art. 25, G.A. Res. 61/106, U.N. Doc. A/RES/61/106 (Dec. 13, 2006) [hereinafter CRPD].

4 CRPD Committee, *General Comment No. 1 (2014) Article 12: Equality Recognition Before the Law,* para. 13, U.N. Doc. CRP-D/C/GC/1 (May 19, 2014) [hereinafter CRPD Committee, *General Comment No. 1*].

5 *Id.,* para. 12.

6 For good practices on seeking informed consent from people with disabilities in SRH settings, see UNFPA & WEI: *Women and young persons with disabilities: Guidelines for providing rights-based and gender-responsive services to address gender-based violence and sexual and reproductive health and rights 16 – 19* (Nov. 2018), https://www.unfpa.org/featured-publication/women-and-young-persons-disabilities [hereinafter UNFPA &WEI, GBV and SRHR Guidelines].

7 Women Enabled International, Legal capacity of women and girls with disabilities 1 https://www.womenenabled.org/pdfs/Women%20Enabled%20International%20-%20Legal%20Capacity%20of%20Women%20and%20Girls%20with%20Disabilities%20-%20English.pdf?pdf=GBVEnglish.

8 *Id.*

9 See CRPD Committee, *General Comment No. 1, supra* at note 4, para. 52.

10 *Id*., para. 29.

11 UNFPA & WEI, *GBV and SRHR Guidelines, supra* note 6, at 20-21.

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14 USAID, United States Strategy to prevent and respond to gender-based violence globally 7 (Aug. 10, 2012), http://www.state.gov/documents/organization/196468.pdf. It is worth noting that no global data exists on the incidence of such violence, and studies draw on different sources of data.

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16 UNFPA Pacific Sub-Regional Office, *Population and Development Profiles: Pacific Island Countries,* 22 (April 2014), https://pacific.unfpa.org/sites/default/files/pub-pdf/web__140414_UNFPAPopulationandDevelopmentProfiles-PacificSub-Region-Extendedv1LRv2_0.pdf.

17 Fiji Bureau of Statistics, *Regional Training Workshop on SEEA EEA* (2015), https://unstats.un.org/unsd/envaccounting/workshops/Indonesia_2015_eea/41.%20Session%204%20-%20Fiji.pdf.

18 Fiji Bureau of Statistics, *2017 Population and Housing Census (Release 1)* 1 (January 2018), https://www.statsfiji.gov.fj/index.php/census-2017/census-2017-release-1 [hereinafter 2017 Population and Housing Census Pt. 1].

19 *Id*.

20 *Id.* at 3.

21 The Constitution of the Republic of Fiji, Sept. 9, 2013, art. 26(3)(a).

22 *Id.*, art. 42.

23 *Id*., art. 41.

24 *Id*., art. 38.

25 *Id.*, art. 11.

26 2017 Population and Housing Census Pt. 1, *supra* note 18, at 13.

27 Fiji Bureau of Statistics, *2017 Population and Housing Census (Release 2)*, 7 (September 2018), https://www.statsfiji.gov.fj/index.php/census-2017/census-2017-release-2 (noting that 54.8 per cent of persons with disabilities in the Central and Eastern Divisions of Fiji are female).

28 Fiji, Rights of Persons with Disabilities Act of 2018, art. 32(1).

29 *Id.*, art. 44.

30 *Id*., art. 35.

31 CRPD, art. 6.

32 Focus group discussion by Naomi Navoce with members of the United Blind Persons of Fiji, in Suva, Fiji (Sept. 25, 2020) [hereinafter UBP focus group discussion]; Focus group discussion by Naomi Navoce with members of the Fiji Association of the Deaf, in Suva, Fiji (Nov. 26, 2020) [hereinafter FAD focus group discussion]; Focus group discussion by Naomi Navoce with members of the Nadi and Lautoka Branches of the Fiji Disabled People's Federation, in Nadi, Fiji (Jan. 13, 2021) [hereinafter Nadi focus group discussion]; Focus group discussion by Naomi Navoce with members of the Psychiatric Survivors Association of Fiji, in Suva, Fiji (Jan. 15, 2031) [hereinafter PSA focus group discussion].

33 FAD focus group discussion, *supra* note 32; Nadi focus group discussion, supra note 32.

34 Nadi focus group discussion, *supra* note 32.

35 Zoom interview with Prem Singh, Empower Pacific (Nov. 11, 2020) [hereinafter Empower Pacific Interview]; Zoom Interview with Lanieta Tuimabu Fiji Disabled People's Federation (Apr. 30, 2020) [hereinafter FDPF Interview]; Zoom interview with Shamima Ali, Fiji Women's Crisis Centre (Nov. 11, 2020) [hereinafter FWCC Interview]; Zoom interview with Laisa Bulatale, Fiji Women's Rights Movement (Nov. 17, 2020) [hereinafter FWRM Interview]; Zoom interview with Ashna Shaleen, Medical Services Pacific (July 16, 2020) [hereinafter MSP interview]; Zoom interview with Matelita Seva-Cadravula, Reproductive and Family Health Association of Fiji (July 6, 2020) [hereinafter RFHAF interview].

36 *See, e.g.,* Empower Pacific interview, *supra* note 35 ("As an NGO, we have limited resources. So to meet the needs of people with disabilities, … we rely heavily on disabled people's organizations for interpretation.")

37 Fiji Min. of Health, *Reproductive Health Policy* 11 (2014).

38 *Id*. at 7.

39 Fiji Min. of Health, *Strategic Plan 2020-2025,* 22-23 (2019).

40 *See, e.g.*, Care International, et al., *Fiji Gender, Disability, and Inclusion Analysis COVID-19 and TC Harold* 10 (June 2020), http://careevaluations.org/wp-content/uploads/Fiji-GDIA_COVID19TCHarold_30Jun20-FINAL-signed-off.pdf.

41 *See, e.g.,* UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

42 FAD focus group discussion, *supra* note 32; UBP focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32.

43 Fiji, Rights of Persons with Disabilities Act of 2018, art. 32.

44 Fiji, Mental Health Decree 2010.

45 Skype interview with Angeline Chand, PDF (May 20, 2020); FDPF interview, *supra* note 35; RFHAF interview, *supra* note 35.

46 Care International, et al., s*upra n*ote 40, at 16.

47 Committee on the Elimination of Discrimination against Women, *Concluding observations: Fiji,* ¶ 27, U.N. Doc. CEDAW/C/FJI/CO/5 (2018).

48 Fiji Min. of Social Welfare, Women, and Poverty Alleviation, *National Gender Policy* 9 (2014).

49 Fiji, Domestic Violence Act of 2009, § 23.

50 Fiji, Crimes Act of 2009, §§ 207-216.

51 Fijian Government, *Fiji Starts National Consultations on Action Plan to Prevent Violence Against Women and Girls* (Nov. 25, 2020), https://www.fiji.gov.fj/Media-Centre/News/FIJI-STARTS-NATIONAL-CONSULTATIONS-ON-ACTION-PLAN.

52 Id.; FWCC interview, supra note 35.

53 FWCC interview, *supra* note 35.

54 FWRM interview, *supra* note 35; FWCC interview, s*upra* note 35; MSP interview, *supra* note 35.

55 FWRM interview, s*upra* note 35.

56 Empower Pacific interview, *supra* note 35; FWCC interview, supra note 35; Zoom interview with Julie van Dassen, United Nations Development Programme (May 6, 2020) [hereinafter UNDP interview].

57 FWCC interview, *supra* note 35; Empower Pacific interview, *supra* note 35; MSP interview, *supra* note 56.

58 UNDP interview, *supra* note 56.

59 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, s*upra* note 32; PSA focus group discussion, *supra* note 32.

60 FWRM interview, supra note 35 (noting that, when researching access to justice issues, their research team could only identify one or two cases of violence against women and girls with disabilities proceeding through the justice system).

61 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32; Interview by Naomi Navoce with K.T., in Suva, Fiji (Jan. 18, 2021).

62 Interview by Naomi Navoce with S.B., in Suva, Fiji (Nov. 26, 2020); Interview by Naomi Navoce with S.M., in Suva, Fiji (Nov. 26, 2020); Interview by Naomi Navoce with A.M., in Nadi, Fiji (Jan. 14, 2021); Interview by Naomi Navoce with R.C., in Nadi, Fiji (Jan. 14, 2021); Interview by Naomi Navoce with K.T., in Suva, Fiji (Jan. 18, 2021); Telephone interview by Naomi Navoce with N.C., (Jan. 20, 2021); Interview by Ruci Senikula with A.M., in Suva, Fiji (Apr. 6, 2021); Interview by Ruci Senikula with E.N., in Suva, Fiji (Apr. 6, 2021); Interview by Ruci Senikula with S.S., in Suva, Fiji (Apr. 6, 2021).

63 Interview by Naomi Navoce with R.C., in Nadi, Fiji (Jan. 14, 2021); Telephone interview by Naomi Navoce with N.C., (Jan. 20, 2021).

64 *See, e.g.*, Interview by Naomi Navoce with K.T., in Suva, Fiji (Jan. 18, 2021); Interview by Ruci Senikula with E.N., in Suva, Fiji (Apr. 6, 2021).

65 Care International, et al., *supra* note 40, at 2.

66 FAD focus group discussion, *supra* note 32; UBP focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32.

67 MSP interview, *supra* note 35; RFHAF interview, *supra* note 35.

68 Care International, et al., *supra* note 40, at 11.

69 FAD focus group discussion, *supra* note 32.

70 FAD focus group discussion, *supra* note 32; UBP focus group discussion, *supra* note 32; Interview by Naomi Navoce with R.C., in Nadi, Fiji (Jan. 14, 2021). See also, Care International, et al., *supra* note 40, at 10.

71 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

72 FAD focus group discussion, *supra* note 32.

73 PSA focus group discussion, *supra* note 32.

74 Nadi focus group discussion, *supra* note 32; Telephone interview by Naomi Navoce with N.C., (Jan. 20, 2021).

75 FAD focus group discussion, *supra* note 32; Interview by Ruci Senikula with A.M., in Suva, Fiji (Apr. 6, 2021).

76 FAD focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32; Telephone interview by Naomi Navoce with N.C., (Jan. 20, 2021).

77 Fiji, Mental Health Decree 2010.

78 *See,* e.g., UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32; Interview by Naomi Navoce with S.B., in Suva, Fiji (Nov. 26, 2020); Interview by Naomi Navoce with I.R., in Rewa Province, Fiji (Mar. 27, 2021).

79 RFHAF Interview, *supra* note 35; UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32; Interview by Naomi Navoce with S.B., in Suva, Fiji (Nov. 26, 2020); Interview by Naomi Navoce with I.R., in Rewa Province, Fiji (Mar. 27, 2021); Interview by Naomi Navoce with T.C., in Rewa Province, Fiji (Mar. 27, 2021).

80 Interview with RFHAF; UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, supra note 32.

81 PSA focus group discussion, *supra* note 32.

82 UBP focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

83 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32.

84 Interview by Ruci Senikula with D.N., in Suva, Fiji (Apr. 6, 2021).

85 UBP focus group discussion, *supra* note 32.

86 UBP focus group discussion, *supra* note 32.

87 FAD focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

88 UBP focus group discussion, *supra* note 32.

89 Empower Pacific interview, *supra* note 35; PSA focus group discussion, *supra* note 32.

90 Empower Pacific interview, *supra* note 35.

91 RFHAF interview, *supra* note 35; MSP interview, *supra* note 35; Empower Pacific interview, *supra* note 35; Interview with FDPF; PSA focus group discussion, *supra* note 32.

92 Empower Pacific interview, *supra* note 35; Nadi focus group discussion, *supra* note 32.

93 RFHAF interview, *supra* note 35; Nadi focus group discussion, *supra* note 32.

94 MSP interview, *supra* note 35.

95 Fiji NGO Coalition on CEDAW, *Submission to the Committee on the Elimination of Discrimination against Women* 11 (2017).

96 *Id.* at 12.

97 Nadi focus group discussion, *supra* note 32.

98 Nadi focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

99 UBP focus group discussion, *supra* note 32.

100 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

101 *See, e.g.* Interview by Naomi Navoce with S.B., in Suva, Fiji (Nov. 26, 2020); Interview by Naomi Navoce with I.R., in Rewa Province, Fiji (Mar. 27, 2021); Interview by Naomi Navoce with T.C., in Rewa Province, Fiji (Mar. 27, 2021).

102 Interview by Naomi Navoce with K.T., in Suva, Fiji (Jan. 18, 2021); Interview by Ruci Senikula with A.M., in Suva, Fiji (Apr. 6, 2021); Interview by Ruci Senikula with S.S., in Suva, Fiji (Apr. 6, 2021). Interview by Ruci Senikula with L.T., in Suva, Fiji (Apr. 6, 2021).

103 Interview by Naomi Navoce with R.K., in Nadi, Fiji (Jan. 14, 2021); Interview by Naomi Navoce with R.C., in Nadi, Fiji (Jan. 14, 2021); Telephone interview by Naomi Navoce with N.C., (Jan. 20, 2021); Interview by Ruci Senikula with L.T., in Suva, Fiji (Apr. 6, 2021); Interview by Ruci Senijula with L.O., in Suva, Fiji (Apr. 6, 2021).

104 *See, e.g.* Interview by Naomi Navoce with S.B., in Suva, Fiji (Nov. 26, 2020); Interview by Naomi Navoce with I.R., in Rewa Province, Fiji (Mar. 27, 2021).

105 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32.

106 RFHAF interview, *supra* note 35; FDPF Interview, supra note 35.

107 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, supra note 32.

108 FAD focus group discussion, *supra* note 32.

109 UBP focus group discussion, *supra* note 32; FAD focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32.

110 RFHAF interview, *supra* note 35.

111 UBP focus group discussion, *supra* note 32.

112 MSP interview, *supra* note 35; RFHAF interview, *supra* note 35.

113 MSP interview, *supra* note 35; RFHAF interview, s*upra* note 35.

114 UNDP interview, *supra* note 56.

115 MSP interview, *supra* note 35.

116 RFHAF interview, *supra* note 35.

117 MSP interview, *supra* note 35.

118 The 7 Principles of Universal Design include Equitable use, Flexibility in use, Simple and intuitive use, Perceptible information, Tolerance for error, Low physical effort, Size and space for approach and use http://universaldesign.ie/What-is-Universal-Design/The-7-Principles/.

119 FAD focus group discussion, s*upra* note 32; UBP focus group discussion, *supra* note 32; Nadi focus group discussion, *supra* note 32.

120 RFHAF interview, *supra* note 35; MSP Interview, *supra* note 35; FDPF interview, *supra* note 35.

121 FAD focus group discussion, *supra* note 32.

122 Nadi focus group discussion, *supra* note 32; UBP focus group discussion, *supra* note 32.

123 Nadi focus group discussion, *supra* note 32; UBP focus group discussion, *supra* note 32; PSA focus group discussion, *supra* note 32.

124 RFHAF interview, *supra* note 35; FAD focus group discussion, *supra* note 32.

125 RFHAF interview, *supra* note 35.

126 Id.; MSP interview, *supra* note 35; Empower Pacific interview, *supra* note 35.

127 RFHAF interview, *supra* note 35; MSP interview, *supra* note 35.

128 FAD focus group discussion, *supra* note 32.

129 *Id.*

130 *Id*.

131 *Id.*

132 *Id.*

133 *Id.*

134 *Id.*