IPPF/Rob Rickman

How religious, cultural, and traditional practices influence access to sexual and reproductive health and rights in Fiji: Research Brief

International Planned Parenthood Federation
Sub Regional Office for The Pacific

A QUALITATIVE STUDY

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EXECUTIVE SUMMARY

Fiji is at a critical juncture, confronting an escalating sexual and reproductive health (SRH) crisis that jeopardises the well-being of families, narrows opportunities for the next generation, and threatens national progress. The consequences are far-reaching, with annual economic losses from SRH gaps—due to lost productivity, rising healthcare costs, school dropout, and diminished workforce participation—estimated at FJD 300–700 million (World Bank, 2022; UNFPA, 2022; Vlassoff et al., 2004). These costs divert essential resources away from infrastructure, education, and development, undermining Fiji's prosperity and competitive standing in the Pacific region.

The rapid convergence of modern influences and deep-rooted cultural values compounds this crisis. Legal reforms, digital media, and evolving social norms are reshaping youth's expectations, but these changes often conflict with religious beliefs and traditional practices. Young people—especially girls—are left to navigate conflicting messages from online sources, schools, and families, frequently without the maturity, support, or accurate information needed to make safe decisions. In this void, they face isolation, vulnerability, and life-altering choices alone.

Yet Fiji's SRH challenges are also an opportunity for transformative change. Decisive action can safeguard the next generation, honour core Fijian values of family and community care, fulfil international commitments, and guarantee a healthier, more equitable, and prosperous future for all—urban and rural, iTaukei and Indo-Fijian, able-bodied and persons with disabilities. Advancing SRHR reform strengthens families, builds safer communities, and drives economic growth.

Despite a strong policy foundation , many frameworks fall short due to insufficient funding , weak enforcement, limited community engagement, and gaps in cross-sectoral collaboration. This brief leverages insights from community research conducted across urban, peri-urban, and rural Fiji, bringing forward the perspectives of youth, women, health workers, faith leaders, and others (UNFPA, 2022). Failure to act allows cycles of violence, illness, exclusion, poverty, stigma, and shame to persist. However, Fiji possesses dedicated local champions and effective, home-grown solutions—what is now required is greater support and sustained investment to drive real change.

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FIJI CONTEXT

Fiji has demonstrated substantial national, regional, and international commitments to advancing sexual and reproductive health and rights (SRHR) and gender equality. These commitments are embedded in legislative and policy frameworks anchored in global and regional agreements. The country's FP2030 Commitment (2025) pledges to expand access to family planning, reduce unmet contraceptive needs, and support comprehensive sexuality education, while the National Family Planning Policy 2025–2030 sets targets for universal access to modern contraception and adolescent-responsive services (Ministry of Health and Medical Services, 2025; FP2030, 2025). As a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Fiji is required to uphold women's reproductive autonomy and eliminate discrimination. SRHR targets also feature prominently in the Sustainable Development Goals (SDGs) and the National Development Plan, emphasising maternal health, reducing adolescent pregnancy, eradicating sexual and gender-based violence (SGBV), achieving health equity, reducing poverty, and promoting inclusive growth.

At the regional level, Fiji is bound by the Pacific Platform for Action on Gender Equality and Women's Human Rights (PPA), the Pacific Leaders Gender Equality Declaration (PLGED), and the MOANA Declaration, obligating the removal of discriminatory laws and practices affecting women, sex workers, and people of diverse sexual orientations, gender identities, expressions, and/or sex characteristics (SOGIESC) (UNFPA, 2025).

Despite a robust policy foundation, Fiji's SRHR indicators have deteriorated sharply in the past five years, representing a public health emergency that calls for urgent action. Recent statistics show 31–38 maternal deaths per 100,000 live births (WHO, 2025; World Bank, 2024), and in 2024 alone, 858 teenage pregnancies and adolescent birth rates of 21–38 per 1,000 girls aged 15–19—numbers that are especially pronounced among rural and marginalised youth, with alarming cases involving girls under 15 (Fiji Village, 2024; World Bank, 2024).

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Sexually Transmitted Infections (STIs) and HIV pose escalating threats. HIV prevalence has increased over thirteenfold since 2014, with approximately 5,900 people (0.6% of the population) living with HIV and 1,583 new cases in 2024, driven by drug use and high-risk sexual behaviour (UNAIDS, 2025 ; Fiji Ministry of Health, 2024). Syphilis prevalence is 3.9% among women, gonorrhoea 1.6%, and chlamydia a staggering 24.1%, placing youth at high risk and straining the health system (Nishijima et al., 2020). Youth STI rates have risen by 25%, with many infections unreported due to shame, confidentiality concerns, and a lack of youth-friendly services (UNFPA, 2022; WHO, 2017).

Sexual and gender-based violence remains widespread—61% of women aged 15–64 have experienced physical and/or sexual violence by an intimate partner. SGBV both drives and results from poor SRHR access, trapping women in cycles of coercion and abuse (World Bank, 2022; UNFPA, 2022). Its economic cost is huge: The World Bank estimates gender-based violence costs Pacific economies 2.6–3% of GDP annually, amounting to hundreds of millions of dollars in lost potential for Fiji (World Bank, 2022).

Alarmingly, suicide continues to claim young lives; in 2024, there were at least eight youth suicides under age 18, and suicide remains a leading cause of death for Fijian adolescents aged 15–24 (MaiTV Fiji, 2024; Fiji Ministry of Health and Medical Services, 2023; World Bank, 2024).

These challenges inflict economic losses—lower workforce participation, reduced educational attainment, higher healthcare costs, and declining productivity (World Bank, 2022; UNFPA, 2022) —and deep social costs, including family breakdown, intergenerational trauma, school dropout, and community fragmentation. Development setbacks hinder Fiji's progress on SDGs 3 (health), 4 (education), 5 (gender equality), 10 (reduced inequalities), and 16 (peace and justice). Furthermore, ongoing crises threaten Fiji's tourism, foreign investment, and reputation as a regional leader, signalling the urgent need for comprehensive, inclusive policy solutions.


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KEY MESSAGES

- Advancing SRHR reform strengthens families, builds safer communities, and drives national economic growth.
- Failure to act perpetuates cycles of violence, illness, exclusion, and intergenerational poverty, leaving teenagers alone to struggle with silence, stigma, and shame.
- Fiji already has local champions and effective, home-grown solutions—what's needed is greater support and sustained investment.
- Timely SRHR reforms will yield measurable improvements in health, social well-being, and economic prosperity.
- By embracing rights-based, culturally grounded SRHR policies, Fiji can position itself as a regional leader and role model.

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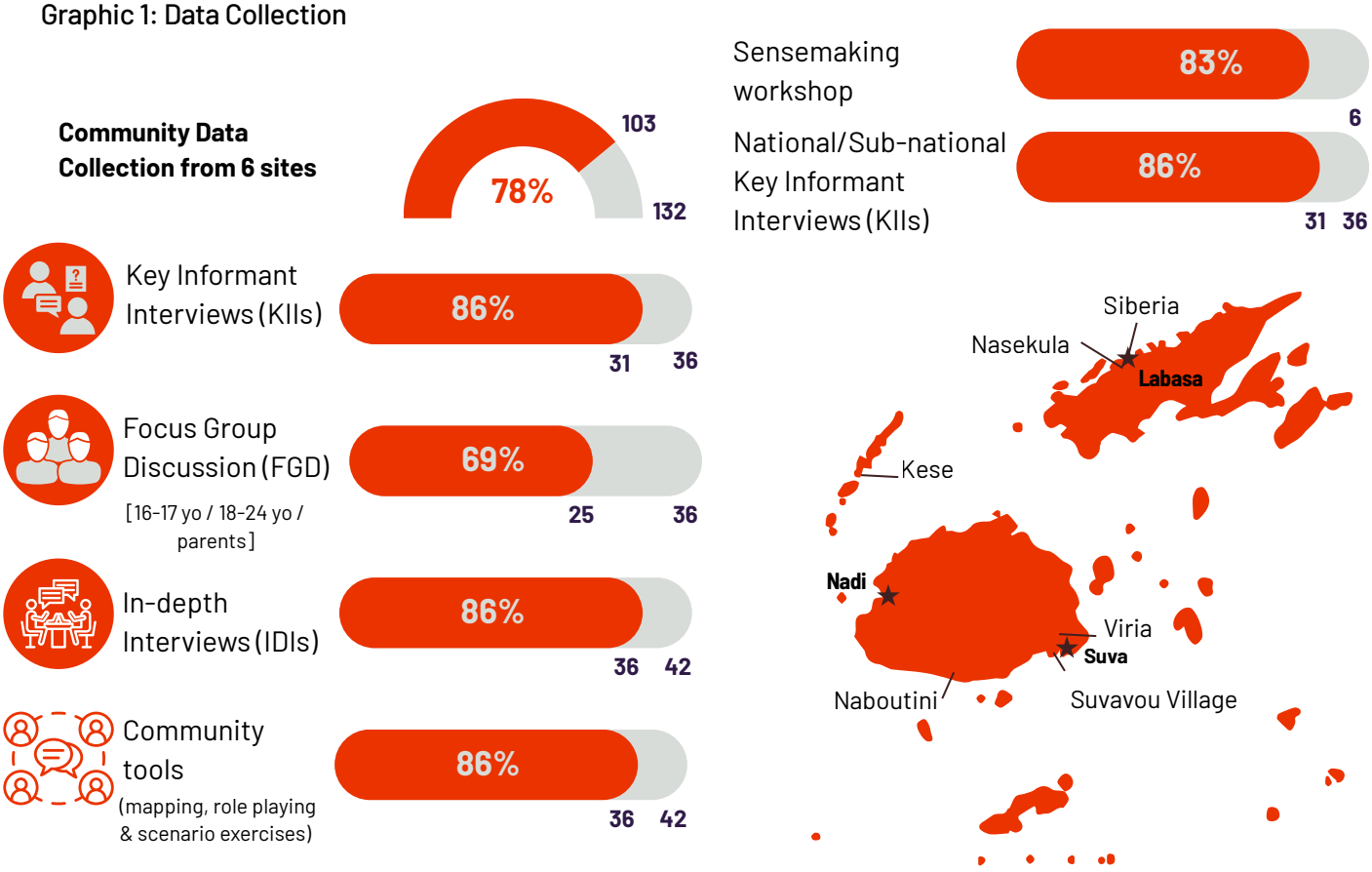
METHODOLOGY

This policy brief draws on qualitative research conducted in Fiji in 2025, using a community-based participatory research approach. A total of 103 participants from six communities across Fiji: Suvavou, Viria, Nasekula, Siberia, Naboutini, and Kese were included. Data collection involved a range of qualitative tools, including focus group discussions, key informant interviews, in-depth interviews, community mapping, scenario analysis, and sense-making workshops (Refer Graphic 1). Sample sizes varied by site, but the study aimed to cover diverse gender and age groups, prioritising youth and women. This diverse sample ensured that the findings reflected the voices of individuals from rural, remote, maritime, and urban areas, highlighting the real barriers and opportunities for SRHR access in Fiji.

The methodology prioritised participant safety, confidentiality, and cultural sensitivity. All interviews were conducted in accordance with the ethical guidelines approved by the Fiji Human Health Research and Ethics Review Committee, and informed consent was obtained from all participants (with parental consent for those under 18 years of age). Researchers followed safeguarding and data protection protocols throughout, and worked closely with community organisations to ensure respectful engagement and accurate representation of participant voices.

Graphic 1: Data Collection



FINDINGS

1 Entrenched Social and Gender Norms

Entrenched cultural taboos and rigid gender expectations in Fiji, often reinforced by patriarchal beliefs, stifle honest dialogue and perpetuate silence around sexual health. Parents, elders, and faith leaders may act out of care, but frequently serve as gatekeepers to vital information, unintentionally instilling shame and embarrassment in youth who most need support. Many young people grow up lacking the language and confidence to discuss their bodies and relationships. A young woman from Vanua Levu remarked, *"Talking about sex in the family is unheard of... you just get too ashamed to ask your parents anything."* Indo-Fijian youth echo this, with one girl sharing, *"My mother would never discuss these things. If I tried to ask, she would say 'that's not for you to know' or 'you'll learn when you're married.' But by then, how would I protect myself? My friends and I just share rumours and hope they're true."*

The Family Life Education (FLE) curriculum, Fiji's comprehensive sexuality education program, is considered inadequate. Youth and educators alike describe lessons as "boring and basic," and note that critical topics—consent, contraception, sexual pleasure, diverse sexualities, and healthy relationships—are often skipped. Students feel unprepared for real-life situations, as confirmed by a student in Labasa: *"Our teacher just read from the book and moved on quickly. We never talked about what happens when someone pressures you, or how to say no, or what to do if you're scared. The boys just laughed the whole time, and the teacher looked uncomfortable."* Many teachers lack training and institutional support, undermining the curriculum's impact.

Without guidance, misinformation flourishes: girls remain ill-equipped to refuse unwanted advances, boys may not grasp consent and respect, and youth of diverse SOGIESC are often excluded altogether. A generation thus faces elevated risks, lacking the knowledge and language to advocate for rights and safety. While girls are silenced, boys, too, are deeply affected, often seeking information from social media or pornography. *"My friends say if you don't know, watch a video online; but it's mostly wrong and confusing,"* explained a 16-year-old boy in Suva. Online sources spread damaging stereotypes—aggression as masculinity, stigma around women's sexual autonomy, and misconceptions about consent. *"We tell boys to be strong, to take what they want. No one teaches us about respect, listening, or what 'yes' really means. Then we're surprised when relationships turn violent,"* observed a youth leader in Nadi.

Intersecting factors—silence, shame, misinformation, and lack of adult guidance—deny both girls and boys essential knowledge, undermining their ability to make safe, respectful choices. Religious teachings also often promote abstinence and limit discussion of contraception or premarital sex, especially in Methodist and Catholic communities. As a youth in Viti Levu put it, *"The church says condoms are bad, but in school, we are told to use them to protect ourselves. My friends from the other church can talk about these things, but at home we're not allowed."* This conflict fosters confusion and anxiety, leaving young people fearful of judgment from both religious and secular authorities.

2 Critical SRH services access and quality gaps

Critical services access and quality gaps persist in Fiji, even for youth and women who courageously overcome cultural barriers to seek SRHR information or care. Stigma, discrimination, breaches of confidentiality, and the absence of youth-friendly protocols undermine trust and discourage care-seeking. At every research site, participants reported that clinic staff routinely violated confidentiality, openly discussing patients' SRHR concerns with colleagues, family members, and even community members. *"Young people go to the clinic for care, but the staff talk openly—'She's here again, wanting those pills.' Then the whole community knows. That's why a lot of women just stop going,"* explained a national disability advocate.

Such breaches of trust have dire consequences: youth avoid HIV testing even after risky behaviour due to fear of gossip, and women seeking contraception face exposure and judgment, resulting in many foregoing family planning or resorting to secret, informal channels. Negative provider attitudes further discourage care-seeking. Young people, unmarried women, sex workers, and individuals of diverse SOGIESC report being lectured, judged, or turned away. *"They may come for something else, like condoms. And then the nurse will tell them, 'Okay, you should get tested.' You know, in very judgmental ways, not in very good ways. That's why most of the girls don't want to go back there. They feel the discrimination,"* noted a male rural youth.

Sex workers endure especially harsh treatment—*"If you tell them you're a sex worker, they don't treat you well. They gossip or say you shouldn't be here."* Individuals of diverse SOGIESC face stares, intrusive questions, and even denial of care. Health workers, especially those in rural areas, often lack guidance on SRHR: *"I didn't realise it was my responsibility. No one told me to talk about sexual health with youth or families—so I just focused on general sickness and medicine,"* confessed a community health worker in Kese village. Systemic gaps in job descriptions, supervision, training, and accountability prevent even willing providers from effectively supporting SRHR.

When violence, coercion, or abuse occurs, survivors rarely receive holistic support. Schools, clinics, police, and social welfare agencies operate in silos, with minimal communication or formal referral protocols. *"When something bad happens at school, most teachers don't know what to do or just tell us to keep quiet and behave. There's no one to talk to if you need real help—they send you home or say talk to your parents, but at home, it's also taboo. So nothing really happens,"* shared a female peri-urban student. Health workers similarly noted that unmarried youth and sex workers rarely report violence—victim-perpetrator relationships discourage disclosure, and girls stay silent out of mistrust or fear of losing family support. The absence of survivor-centred, multisectoral responses leaves many without justice or healing, perpetuating cycles of harm.

Practical barriers further limit access, especially for rural and maritime populations, where travel distances are long and transport costs are prohibitive. *"The nearest health centre is too far and I can't afford the bus fare for a condom,"* said a young man in Viti Levu. In Viria, a young woman described having to *"ask someone else to get [contraceptives], steal it, through someone with connections—at a cost, but it will not stop him from getting contraception."*

Suicide and Unsafe Abortion: Extreme social pressure, stigma, and lack of support drive young people—especially girls facing unwanted pregnancies—toward dangerously harmful solutions. Multiple respondents described suicide as a perceived solution for girls facing unintended pregnancy or sexual violence. *"When a girl gets pregnant and the family finds out, sometimes they tell her she should just kill herself. Or she thinks that herself because she sees no way out,"* explained a youth worker. Several cases of attempted or completed suicide among adolescent girls followed the discovery of pregnancy or sexual activity, highlighting profound isolation and hopelessness.

Abortion is deeply taboo and highly restricted, but occurs often through unsafe, informal methods. *"We have pregnancies where a strong cup of tea will cause a miscarriage. Or they get a concussion to cause a miscarriage. So, there are quite a few strategies to miscarry,"* described a health provider. Girls resort to herbal medicines, plant concoctions, physical trauma and other methods without medical supervision, risking serious health consequences like haemorrhage, infection, infertility, or death. Fear of legal consequences, family punishment, and social judgment drives girls to these desperate measures. *"Girls who become pregnant out of wedlock are often advised simply to get married, run away, have an abortion, or end their own lives,"* summarised a community leader, reflecting the limited and often harmful options perceived as available.

3 Contraception access, preferences, SBGV and women's autonomy

Women and girls in Fiji encounter profound social, relational, and informational barriers to accessing and using contraception—barriers that stem from entrenched gender inequalities and severely limit their reproductive autonomy, exposing them to unintended pregnancy and poor health outcomes. In many relationships, women report having little agency over sexual and reproductive decisions; male partners often determine if and when contraception is used, if at all. *"If a woman says I want to use a condom, the man may think she is an expert now... that would lead to domestic violence,"* explained a woman from Viti Levu. Even the act of requesting protection can be seen as defiance or promiscuity, leading to verbal abuse, physical violence, or relationship breakdown.

Ample evidence of reproductive coercion was found, demonstrating that social attitudes and threats of violence routinely undermine women's autonomy over their reproductive health. Across sites, women report having no choice in reproductive decisions—*"she has no choice in saying yes or no... If you are married, it is your duty to fulfil your partner. So, it's your duty to sleep with your partner, even if he is having extramarital relationships. You cannot request to use a family planning method."* A woman from Viria highlighted the wider social acceptance of this control: *"GBV is wrong and not justified, but if a married woman takes contraception secretly and her husband beats her, the girl is wrong there because they are married. This is a common problem nowadays..."*. These accounts reveal the pervasive power imbalances and coercive practices limiting women's reproductive freedom in many Fijian communities.

The imbalance extends to decisions about childbearing and family size. Women wishing to delay or limit childbearing may face pressure to prove fertility or produce male heirs, with partners or in-laws holding decisive power: "My husband says we'll have children when he decides. If I go for family planning without his permission, he would be very angry." Male resistance to condoms and modern contraception, shaped by myths about pleasure, health, and morality, further hampers women's choices. "Condoms are for strangers or prostitutes," stated one male community member, reflecting anxieties over trust and masculinity.

Suspicion surrounds modern contraceptives like pills, injections, and implants, which are often blamed for infertility, cancer, and other health harms. "People say the injection makes you barren or gives you cancer. Even if the nurse says it's safe, you hear so many stories that you're afraid to try," shared a young woman in Lautoka. Contraception is widely believed appropriate only for married couples, and unmarried youth—mostly girls—who seek family planning face judgment and gossip, often accessing contraception covertly with support from mothers or sympathetic providers: "I used to say I was going for a check-up, but really my mum would take me for contraceptives," explained one young woman.

Choices around method often reflect community attitudes, fear of gossip, and circulating myths more than personal health needs or effectiveness. Poor, unreliable information about side effects leads many to rely on less effective traditional methods, withdrawal, or nothing at all. Secondary data reveals that the unmet need for modern contraception among married women approaches 20%, and a staggering 81% of sexually active adolescent girls report not using modern methods—placing them at high risk for unintended pregnancy and STIs.

Graphic 2: SRHR and SGBV, Fiji National Action Plan to Prevent violence Against All Women and Girls (2023-2028)

The 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:

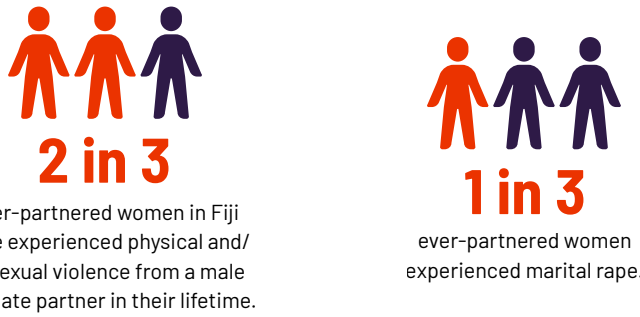
- have their bodily integrity, privacy, and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- 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.

SRHR and SGBV: A Vicious, Interconnected Cycle: Research highlights the strong link between poor SRHR access and sexual and gender-based violence (SGBV). Violence both prevents access and results from unmet SRHR needs, trapping women and girls in cycles of harm. Many cannot access contraception, seek STI testing, or refuse unwanted sex due to fear of partner violence. "Sometimes when I don't want to have sex, he beats me up," shared one survivor. Male community members often normalise this violence: "If your wife doesn't listen, give her a punch. That's the culture. That's the way we do it." Such normalisation enforces male authority and punishes female autonomy.

A significant proportion of teenage pregnancies in Fiji may result from situations where true consent is absent. Many girls lack the knowledge, confidence, or supportive networks required to refuse unwanted sexual advances, and the topic of consent is seldom addressed within families, schools, or community spaces. As one young woman who became pregnant at 16 explained, "No one ever taught me how to say no. I didn't even know I could say no. When it happened, I was scared and ashamed, and I thought it was my fault." Meanwhile, boys generally receive little or no education about respect, boundaries, or affirmative consent; instead, they are often socialised by peers and prevailing cultural norms to view male sexual aggression as normal or even desirable. Sexual coercion in these contexts constitutes a clear form of SGBV. These findings are strongly echoed by Mitchell and Bennett (2020), who document that many young Fijian women experience sexual coercion and pressure within premarital relationships.

Girls found to be sexually active before marriage, or who become pregnant, face severe consequences—often shamed, beaten, or expelled by their families. "If your parents find out you're pregnant, they will beat you and throw you out. That's why girls hide it until it's too late, or they try to end the pregnancy themselves," explained a health worker. Particularly within Indo-Fijian communities, female virginity and family honour are highly valued, and premarital pregnancy is seen as a source of profound family shame, damaging reputation and marriage prospects.

Graphic 3: Women and Violence, Fiji Women's Crisis Centre, 2013



4 Gendered leadership decision-making and information control

Traditional patriarchal structures continue to shape who holds power, whose voices are heard, and what information reaches families and communities. Male elders and leaders dominate decision-making spaces, controlling access to SRHR knowledge and resources.

Village councils, church committees, school boards, and family structures are predominantly male-led. Men decide which health programs are welcome, which educational materials are acceptable, and which community conversations take place. "Village decisions are made by the men; women can only speak if they are given permission," explained a female community member from Vanua Levu. "If you ask about these things, they say it's not for you to know," shared an adolescent girl, describing interactions with male elders. Boys may receive limited information within traditional masculine frameworks, but girls and women are more strictly silenced. This gatekeeping restricts the flow of SRHR information and limits youth and women's opportunities to participate in decisions that affect their lives.

Despite these barriers, courageous women are challenging conventions and advocating for change. Wives of pastors, widows, educated women, and grassroots activists speak out on issues like consent, gender-based violence, contraception, and reproductive rights—often facing backlash, gossip, or social exclusion. *"You get talked about if you challenge the men—some say you're trying to be like a man,"* shared a female community leader. Yet these women persist, creating safe spaces for dialogue, supporting survivors, and mentoring younger women to find their voices. When women are empowered to participate in leadership, convene community forums, and centre survivor experiences, they create vital openings for transformation. Their leadership demonstrates that SRHR reform is both possible and culturally grounded when approached with sensitivity, patience, and courage.

5 Religious and geographical diversity

SRHR challenges manifest differently across Fiji's diverse geographic and religious contexts, with rural and maritime communities facing particularly acute disadvantages. Urban youth generally have better access to health facilities, youth-friendly centres such as the SRH clinics, diverse information sources, and greater anonymity than their rural counterparts. However, they still contend with stigma, cultural taboos within families, peer pressure, and discrimination in some clinics or public spaces. Urban environments also concentrate sex work, diverse SOGIESC populations, and other groups with distinct needs that mainstream services often fail to accommodate.

In peri-urban communities, traditional rural values mix with urban influences, creating unique tensions and confusion for youth. Adolescents in these areas receive conflicting messages from conservative families, variable peers, progressive schools, and generally conservative churches. This inconsistency makes it difficult for young people to establish clear norms or reliably access support. *"In town, people say it's okay to use condoms. But when I come home to the village, everyone says it's wrong. I don't know what to do,"* shared a young man from a peri-urban settlement.

Rural and maritime communities contend with serious service gaps and compounded barriers. These include shortages of trained teachers and health workers, limited clinic hours, long travel distances, high costs for transport and services, increased social control from elders and faith leaders, minimal anonymity, and amplified gossip and stigma. Young people in these areas rely heavily on informal sources—peers, rumours, traditional healers—many of which perpetuate harmful misinformation. Parents and elders maintain near-total control over youth knowledge, reinforcing silence around bodies and relationships. "The nearest health centre is too far, so most people just don't go. If you have a problem, you try to fix it yourself or ask someone in the village—but they might not know either," explained a rural youth. Adolescents here are more likely to skip care, drop out of school if pregnant, experience early marriage, and remain especially vulnerable to SGBV and HIV/STIs.

Fiji's religious diversity also shapes SRHR experiences through conflicting messages and norms. Methodist and Catholic teaching in iTaukei communities generally extols abstinence until marriage and discourages abortion and contraception; religious leaders wield significant authority, with messages from the pulpit strongly shaping family and community attitudes. *"Our religion doesn't support abortion and premarital sex. We believe in sex after marriage. Even family planning—the church says it's not right to prevent God's will,"* explained a Methodist youth.

Other denominations—notably Assemblies of God and independent churches—are increasingly open to comprehensive sex education and modern contraceptive use, recognising the harm caused by silence and misinformation. Progressive pastors encourage healthy choices and responsible decision-making grounded in faith: *"At our church, the pastor talks about protecting yourself and being responsible. He says God wants us to be healthy and make good choices,"* shared a youth from Assemblies of God.

In Indo-Fijian Hindu and Muslim communities, the focus is more often on family reputation and honour than on specific religious doctrine, leading to mixed approaches. Some families prioritise girls' education and delay marriage; others impose strict controls on daughters' social interactions and behaviour.

These variations leave young people confused about what is "acceptable," whom to turn to for help, and how to navigate family, faith, and institutional expectations. "The church says condoms are bad, but in school, we are told to use them to protect ourselves," explained a youth in Viti Levu. "My friends from the other church can talk about these things, but at home we're not allowed." This underlying tension undermines effective SRHR education and fuels risky decision-making, as youth struggle to reconcile competing moral frameworks.

6 Marginalised populations

Fiji's SRHR landscape reflects deep inequities, complex social norms, and intersecting forms of discrimination. Marginalised populations—including people with disabilities, diverse SOGIESC individuals, and sex workers—face compounded barriers to accessing respectful, confidential, and appropriate health services. Their experiences reveal urgent gaps in information, care, and social support, underscoring the need to move beyond one-size-fits-all approaches and foster truly inclusive systems.

People with disabilities in Fiji face entrenched discrimination and multiple barriers in accessing SRHR. Common stereotypes paint them as asexual or undeserving of full rights, and judgmental attitudes are prevalent: *"You're a woman with disabilities, why do you need contraception?"* Clinics may lack accessibility, staff may breach confidentiality, and caregivers often make personal decisions for them.

Women with disabilities, especially in rural areas, are at heightened risk of SGBV and are frequently blamed or ostracised for its consequences: *"When a woman with disability is raped in the village, she becomes pregnant ... she's stigmatised by society or even by the church just because of getting pregnant, but it was not her fault."* Many are excluded from information and safe services, simply *"because of the way the community looks at them."* Nonetheless, self-advocates and allies are

challenging these narratives by demanding autonomy, accessible information, and judgment-free healthcare, supporting each other to lead and shape reforms that centre dignity and inclusion.

Individuals of diverse SOGIESC (LGBTQI+) face pervasive stigma and discrimination when seeking SRHR services. Reports highlight sexual violence, judgmental treatment by health workers, and unsafe clinic experiences: *"they get a different treatment, judged by the looks of health workers ... Just because of their SOGIESC identity."* Trans youth in Suva report being particularly targeted: *"They target us because we look different, especially trans girls. Sexual violence is common, even at parties or on the street."* Social exclusion, religious rejection, and family attitudes further compound barriers; some are expelled from homes and churches when their identities are discovered: *"My family found out I was gay, and they said, 'Leave the house, you are shaming us.' I had to start living with friends."* Many turn to peer support, NGOs, or carefully selected inclusive clinics: *"Whenever I go [to an inclusive clinic], I feel welcome and I go and get my test."* Their voices highlight the urgent need for safe, inclusive, and confidential services: *"we just don't go"* where acceptance is lacking.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"People of diverse SOGIESC (including lesbian, bisexual and transgender women, gay men, transgender men and gender non-conforming people) experience higher rates, and more severe forms of violence from partners, family members and communities with compounded barriers and discrimination within workplaces, schools, health care settings, public" - Fiji National Action Plan to Prevent violence Against All Women and Girls (2023-2028)

Sex workers in Fiji encounter persistent stigma, discrimination, and breaches of confidentiality despite policies claiming universal access. Many avoid clinics except in emergencies, citing humiliating treatment: *"It's one of the biggest challenges—the workers, when they look at you, they look differently."* The situation is especially acute for transgender sex workers. Structural barriers —limited clinic hours, routine privacy breaches, and nonconsensual disclosure of test results— further deter access.

Risks are intensified for those who are street-based, migrants, or transgender, who face harassment, police brutality, and family violence. *"Police don't take them [violence perpetrators] because we're transgender."* Yet sex workers persist in advocating for their needs, building networks of care and supporting outreach programs that distribute resources directly. As one sex worker expressed, *"We know our needs best—we don't want pity or hiding. We need respect, safety, and the chance to decide for ourselves."* These acts of solidarity and resilience illuminate a pathway towards SRHR that is genuinely accessible and shaped by those most affected.

HOME GROWN SOLUTIONS

Despite persistent social barriers, Fiji's communities are home to diverse locally driven solutions and champions advancing SRHR. Progressive faith leaders—including pastors and church elders—are increasingly reframing SRHR issues in a context that emphasises compassion, health, and responsible decision-making rather than judgment or prohibition. This shift enables more open dialogue within congregations, with some leaders publicly supporting contraception to prevent STIs and HIV and updating youth programs to include SRHR topics.

Women's leadership at the grassroots is a pillar of progress. Women's groups, church fellowships, and female community leaders offer safe spaces for mentorship, intergenerational conversation, and confidential support—including for survivors of violence. Many mothers quietly help daughters access contraception and clinical care, challenging harmful gender norms and breaking the silence within their families.

Youth advocates play a crucial role as peer educators and campaigners, organising awareness events, supporting each other, and engaging in informal networks that amplify youth voices. Their efforts create opportunities for young people to "learn best from each other" and navigate sensitive issues with greater confidence.

Trained and motivated health workers and teachers are champions on the frontlines; with institutional backing, clear protocols, and ongoing professional development, they can deliver quality, nonjudgmental care. Such investment promotes confidentiality and reduces shame and stigma for young people and marginalised groups seeking services.

A unique strength of Fiji is its tradition of community care, collective responsibility, and respect for elders. These cultural foundations can be harnessed to support SRHR efforts through inclusive dialogue, participatory leadership, and endorsement from trusted elders. Community suggestion boxes and SMS feedback lines offer avenues for client voices, enhancing service quality and accountability among providers.

The evidence shows multiple entry points for scaling positive change: strengthening comprehensive sexuality education, expanding youth-friendly clinics, supporting peer and parent engagement, investing in local leadership, and ensuring survivor-centred care. Media campaigns and storytelling in local languages further normalise SRHR conversations and help counter taboos. Through these home-grown approaches, Fiji can build on existing progress to ensure all people—particularly youth, women, and marginalised groups—receive the supportive, respectful, and informed care they deserve.

CONCLUSION

Fiji stands at the intersection of modernity and tradition, 'western' influences—whether through media, legal reforms, or new social norms—are rapidly reshaping the boundaries of what is possible and permissible for youth. Yet these changes often collide with deeply held religious and cultural values, creating a confusing, unspoken void. In this vacuum, girls and young women are left to navigate bewildering contradictions between what they see online, what is taught in school, and what their families or faith leaders expect of them—frequently before they have the maturity, knowledge, or support to do so safely. Without clear guidance, protection, or compassionate leadership, they are isolated, vulnerable, and forced to make life-altering decisions alone.

Real progress in SRHR depends on centring the voices and leadership of those most affected by exclusion and stigma. By ensuring services are welcoming, rights-based, and accessible—and by respecting the autonomy, dignity, and choices of all—Fiji can move closer to a future where sexual and reproductive health is a right enjoyed by everyone. Empowering marginalised groups to shape solutions is not just an act of justice, but a critical step towards healthier families, safer communities, and lasting social transformation.

Duty bearers should step boldly into this gap: not to erase tradition or faith, but to help preserve Fiji's social fabric by building bridges between old and new, ensuring every child is equipped, every family is supported, and every voice is valued in the journey toward a healthier, more resilient nation.

We have the power to:

- Protect adolescent girls from violence, coercion, and preventable harm
- Empower women to make autonomous reproductive decisions
- Ensure people with disabilities and individuals of diverseSOGIESC enjoy equal rights and dignity
- Strengthen families through access to information, services, and support
- Reduce healthcare costs and improve economic productivity
- Fulfil Fiji's national and international commitments on SRHR
- Build a healthier, more equitable, and more prosperous Fiji for all.


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Barriers vs Solutions for SRHR Norms Change in Fiji

Barriers	Solutions
Taboos on sex education/conversation	Culturally adapted FLE/CSE, family/youth forums, faith leader engagement
Girls are punished for contraception/refusal of sex	Legal protections, SGBV training, confidential services
Boys are not taught condom use/responsibility	Revised FLE/CSE curricula to include consent, peer and educator programs
Sex workers face discrimination	Decriminalisation, inclusive care, policy reform
Disabled persons excluded from SRHR knowledge	Disability-inclusive FLE/CSE, service accessibility audits
Reliance on unsafe abortion/remedies	Improved youth-friendly clinics, crisis response services
Leadership resistance to change	Investment in champions and quoted leadership

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