IPPF/Rob Rickman

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

International Planned Parenthood Federation
Sub Regional Office for The Pacific

A QUALITATIVE STUDY

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EXECUTIVE SUMMARY

This report documents findings from research which explored the factors that hinder access and the ones that facilitate access to sexual and reproductive health and rights (SRHR) in Fiji, focusing on the experiences of youth, women, sex workers, and people with disabilities. It reveals the powerful ways in which intersecting social norms, faith teachings, and gendered traditions reinforce silence, stigma, and exclusion, while also identifying pathways for positive change, anchored in lived realities and emerging community champions. It offers data-driven direction for policy and programming to advance SRHR transformation in Fiji.

Background: Fiji faces a deepening SRHR crisis, reflected in high rates of teenage pregnancy, rising youth suicide, a growing HIV epidemic, and pervasive sexual and gender-based violence (SGBV) (World Bank, 2024; UNFPA, 2022). In 2024, hospitals recorded 858 teenage pregnancies—almost double the previous year (Fiji Village, 2024). Youth suicide rates are among the highest in the region, driven by stigma, exclusion, SGBV, and poor access to mental health support (MaiTV Fiji, 2024; Fiji Ministry of Health and Medical Services, 2023). The country's HIV epidemic has accelerated, with cases rising from fewer than 500 a decade ago to nearly 5,900 by 2024; only 36% of people living with HIV know their status, and just 24% are on treatment (UNAIDS, 2025; Fiji Ministry of Health, 2024). SGBV affects 61% of women, with even higher rates among iTaukei women (World Bank, 2022; UNFPA, 2022). Marginalised populations—including sex workers, people with disabilities or diverse SOGIESC—face acute barriers to justice and care (UNFPA, 2022; WHO, 2025).

Despite robust national policy frameworks (Family Planning Policy, FP2030, CEDAW, Moana Declaration) and international commitments, major gaps persist in translating policy into practice, especially for marginalised groups and in rural and remote communities.

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Objectives: The research was designed to:

- Examine SRHR access challenges for young people and sex workers.
- Assess the influence of religion and culture on contraception, family planning, and comprehensive sex education.
- Analyse how traditional beliefs about gender roles, virginity, and marriage affect some women's informed choices about their bodies, health, and relationships.
- Document the effects of religious and cultural norms on attitudes toward sexuality and reproductive health, especially women's health and safety.
- Explore cross-cutting themes: women in leadership and decision-making, intergenerational dialogue, and violence against women and girls.

The Social Norms Framework: reveals how shared community beliefs and expectations—much more than individual preferences—shape sexual and reproductive health and rights (SRHR) in Fiji. It distinguishes between empirical expectations (what people believe others do) and normative expectations (what people believe others expect them to do), both of which powerfully influence behaviours around sexuality, agency, and relationships (Mackie et al., 2015). These norms are maintained through social mechanisms like gossip, exclusion, taboos, and deference to elders and faith leaders, all of which limit free discussion and personal choice (Bicchieri, 2017; Cislaghi & Heise, 2018).

In this study, the framework guided qualitative research design and analysis—interviews and coding focused on how local norms, sanctions, and reference groups govern SRHR choices and dialogue. Its relevance lies in helping identify not only barriers to SRHR but also practical strategies for change, such as supporting positive deviants (community members who successfully adopt healthier or more equitable behaviours despite prevailing norms) and targeting key reference groups to shift what is considered acceptable in the community (Bicchieri, 2017; UNFPA, 2022). This approach is particularly important for SRHR studies, where success depends on changing deeply entrenched attitudes and practices rather than simply increasing individual knowledge.

Methodology: The study was guided by a Community-Based Participatory Research (CBPR) approach and a social norms framework, involving six diverse communities across Fiji—Suvavou (urban, iTaukei, Methodist/SDA), Viria (urban, mixed iTaukei/Indo-Fijian, Christian/Hindu), Nasekula (urban, iTaukei, Methodist), Siberia (peri-urban, Indo-Fijian, Hindu), Naboutini (rural, inland, Indo-Fijian, Muslim), and Kese (rural, maritime, iTaukei, Christian). A group of community members from the Reproductive and Family Health Association of Fiji (RFHAF) and volunteer students were trained as enumerators and note takers. Ethical protocols emphasised informed consent, strong cultural sensitivity (including i sevusevu for iTaukei communities and council approval in Indo-Fijian settlements), safeguarding, and inclusive design.

Qualitative tools included focus group discussions, key informant and in-depth interviews, community mapping, role-playing, and scenario exercises, with the process encompassing draft tool development, advisory group review, site and enumerator selection, training, pilot testing, and both community and national data collection. Of the 132 proposed interviews/activities, 103 were completed (78% completion), with disruptions—primarily in

Labasa and Naboutini—stemming from local events such as funerals, church activities, domestic work, and migration. Several limitations affected the study and shaped the findings. RFHAF staff often juggled dual roles as service providers and researchers, which sometimes compromised research focus and data consistency. Volunteer data collectors, though enthusiastic, occasionally lacked confidence with sensitive SRHR topics or building rapport, leading to more superficial responses. Conversely, experienced staff sometimes struggled to maintain impartiality, potentially introducing bias. Recruiting some groups, particularly girls aged 18–24, was difficult due to migration and other commitments, resulting in gaps in their perspectives. In communities such as Labasa, sessions were often rushed or incomplete due to time constraints and participants' availability, limiting the depth and richness of the data.

To address these data quality concerns, the research team employed collective analysis techniques, regularly convening to discuss findings, identify gaps, and ensure a range of perspectives were considered in interpretation. In addition, sensemaking workshops were held with community members, allowing participants to reflect on and validate emerging themes, provide context, and address information gaps or areas of uncertainty. These collaborative approaches strengthened the rigour of analysis, supported transparent interpretation of results, and helped integrate community insights into the final findings—partially offsetting the effects of rushed sessions and participant gaps.

Key Findings:

SRHR Knowledge & Access: Comprehensive sexuality education (CSE) in Fiji is limited, taboo, and poorly resourced. The Family Life Education curriculum does not meet international CSE standards, with teachers and health workers lacking training and confidence. Responsibility for SRHR education is often deferred between home and school, with parents commonly silent—especially with daughters. Youth frequently rely on diverse sources such as social media, friends, and even pornography for information, rather than parents, leading to persistent myths and misinformation. Youth with diverse SOGIESC, sex workers, and individuals with disabilities face layered exclusion and discrimination.

Influence of Religion & Culture: Christian denominations, especially Catholic and Methodist, promote abstinence, oppose contraception before marriage, and restrict SRHR dialogue. Faith leaders sometimes serve as allies, but most uphold restrictive values. Indo-Fijian Hindu and Muslim communities are somewhat more accepting of family planning within marriage, yet maintain strong taboos regarding SRHR for unmarried youth. Faith and cultural leaders can act both as blockers and as champions for SRHR, with notable variation within and between faith groups.

Gender Norms & Barriers: Women's autonomy in SRHR is severely constrained by patriarchal norms, with decision-making dominated by men and violence frequently justified by tradition or faith. Virginity, marriage, and obedience remain central expectations for girls, while abstinence is the preferred solution for parents and faith leaders to unintended pregnancy or STIs. Early or forced marriage is sometimes used to resolve premarital pregnancy, thus perpetuating an unequal status quo, and survivors of violence face significant stigma and restricted support. Service access is especially limited for unmarried girls and marginalised groups due to shame, confidentiality concerns, and community judgment.

Violence & Exclusion: Sexual and gender-based violence (SGBV), emotional and psychological harm, and community exclusion are endemic, with service accessibility undermined by stigma, gossip, and lack of confidentiality in clinics. Sex workers are at heightened risk of SGBV due to the illegality of the profession. Economic dependence, mobility barriers and reduced autonomy are concerns for individuals with disabilities—physiological violence resulting from discrimination and mistreatment harms sex workers, and communities with diverse SOGIESC.

Change Pathways:Despite entrenched barriers, incremental change is emerging. Women's leadership in Fiji is now experiencing a visible shift, gradually moving beyond colonial-imposed boundaries. Community health initiatives, SRHR advocacy, and women's religious groups provide platforms for female leaders to drive change, champion taboo topics, and empower other women. Family dialogue, intergenerational peer education, and health worker outreach are also proving effective for shifting norms. Positive deviants are critical for promoting new models of agency and voice. Growing community awareness, faith-based partnerships, and advocacy networks are helping to build momentum for normative change and increase agency, particularly in selected communities.

Conclusion: The report reveals deep-rooted barriers embedded in Fiji's religious, cultural, and patriarchal structures, constraining SRHR access, knowledge, and agency—especially for women, youth, sex workers,people with diverse, and people with disabilities. While government policies increasingly affirm rights, implementation remains slow and uneven. Sustainable change depends on engaging across government sectors (e.g., Ministries of Health, Education, and Women, Children, and Social Protection), amplifying diverse voices, and dismantling systems of silence, shame, and exclusion. Moving forward will require robust commitment, multisector action, and the inclusive and meaningful participation of affected communities in design, delivery, and oversight of solutions.

Summary of Recommendations: This targeted set of recommendations aims to make SRHR services and education more accessible, inclusive, and community-led and dismantle restrictive norms. Section 8 outlines who is expected to take these recommendations forward:

Expand Comprehensive Sexuality and Family Life Education (FLE): Ensure that curricula in schools and out-of-school settings address consent, gender equality, contraception, diversity, respectful relationships, and SGBV prevention, with annual teacher training and active parent/caregiver engagement and monitoring.

Engage Religious and Community Leaders: Organise structured dialogues and build networks of SRHR champions among chiefs, faith leaders, and women's committees, using evidence-informed guides and real-life stories to foster acceptance and advocacy.

Promote Safe Intergenerational and Peer Dialogue: Fund "family talk" programs, support youth peer educators, and create safe spaces for open conversations about puberty, sex, relationships, and rights among adolescents and adults (parents and community leaders).

Strengthen Service Accessibility, Confidentiality, and Youth-Friendliness: Deploy mobile clinics, offer after-hours and confidential youth services, remove parental consent barriers, and routinely train health staff in nonjudgmental, inclusive care for all young people. Ensure that service accessibility strategies are developed in partnership with young people, so their needs and realities directly inform design and implementation.

Enhance Health Sector SGBV Response: Build 'service-ready' health facilities, implement survivor-centred case management in line with national protocols and international best practices, and coordinate multi-sectoral support for survivors through regular provider meetings and strengthened referral pathways.

Encourage Multi-Sector Responses: Integrate SRHR and gender-sensitive strategies in climate resilience, disaster response, and migration planning. Convene cross-sector groups, ensure SRHR is embedded in risk assessments and emergency protocols, and continually adapt with feedback from marginalised groups.

Promote Women's Leadership: Mandate women's representation in local governance, deliver leadership training, and fund women-led community organisations to advance SRHR, advocacy, and safe-space initiatives.

Advance Legal, Policy, and Service Reform for Sex Workers: Lead national dialogue on decriminalisation, improve health worker training and service integration, fund sex worker-led organisations, and tailor SRHR clinics and outreach to the needs of sex workers and marginalised communities.

Inclusive, Safe SRHR for Youth with diverse SOGIESC: Ensure services and education are affirming, confidential, and accessible for all people with diverse SOGIESC, including intersecting groups such as sex workers and youth with disabilities. Train health staff, resource peer support networks, and deliver survivor-centred violence response—challenge exclusion in families, faith, and mainstream settings.

Ensure Disability Inclusion: Introduce disability-focused values clarification and training, enable accessible SRHR facilities and materials, and create support networks co-led by people with disabilities.

Together, these recommendations foster openness, challenge stigma, and build the systems, leadership, and coalitions needed to achieve sustainable progress in sexual and reproductive health and rights for all Fijians.

Although the research for this report was conducted solely in Fiji, its findings are highly relevant to many Pacific countries that share similar religious, cultural, and traditional practices. The insights and lessons drawn from this report can provide valuable guidance and reflection for these countries as they navigate comparable social and community contexts.

ABBREVIATIONS

AOG: Assembly of God	OPD: Organisation of Persons with Disabilities
CBPR: Community-Based Participatory Research	SPC: Pacific Community
CSE: Comprehensive Sex Education	PWL: Pacific Women Lead
DFAT: Australian Government's Department of Foreign Affairs and Trade	RFHAF: Reproductive and Family Health Association of Fiji (the IPPF MA in Fiji)
FGD: Focus Group Discussion	SOGIESC: Sexual Orientation, Gender Identity, Expression, and Sex Characteristics
SGBV: Sexual and Gender-Based Violence	SROP: Sub-Regional Office for the Pacific
IDI: In-depth Interview	SRHR: Sexual and Reproductive Health and Rights
IPPF: International Planned Parenthood Federation	SRHRJ: Sexual and Reproductive Health, Rights, and Justice
KII: Key Informant Interview	STI: Sexually Transmitted Infection
MA: Member Association	VAWG: Violence Against Women and Girls
MYF: Methodist Youth Fellowship	NVII: Pacific Niu Vaka Strategy Phase II 2023-2028

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1. Introduction

The International Planned Parenthood Federation (IPPF) is a global healthcare provider and a leading advocate for sexual and reproductive health, rights, and justice (SRHRJ) for all, with Member Associations (MAs) and Collaborative Partners in 150 countries. The East and Southeast Asia and Oceania regional (ESEAOR) office includes the Sub-Regional Office for the Pacific (SROP), which supports MAs in 10 countries across the Pacific.

This IPPF research study is part of the project titled Advancing the sexuality agenda and shifting norms in the Pacific through improving access to sexual and reproductive rights and gender equality under the Australian Government's Department of Foreign Affairs and Trade (DFAT) funded Pacific Women Lead (PWL) at the Secretariat of the Pacific Community (SPC) and the IPPF's Pacific Niu Vaka Strategy Phase II 2023-2028i (NVII).

This study aimed to understand whether religious, cultural, and traditional norms and practices in Fiji affect access to sexual and reproductive health rights for young people, sex workers, and women. The study employed a Community-Based Participatory Research (CBPR) approach, involving the community in an active and participatory manner throughout the research process. Data was collected through interviews with key individuals and community members, focus groups, in-depth interviews, mapping exercises, and role-play activities. Participants and locations for the study were selected in partnership with the Reproductive and Family Health Association of Fiji (RFHAF), the IPPF Member Association in Fiji, to reflect a diverse range of experiences across Fiji's rural, remote, maritime, and urban communities.

1.1. Objectives of the research

The objective of the research was to gain a better understanding of how social norms, religious, cultural, and traditional practices in the Pacific influence access to SRHR among key populations, including young people in all their diversity and sex workers.

The research aimed to:

1. Examine SRHR access challenges faced by young people and sex workers
2. Examine the influence religion and culture have on contraception, family planning, and comprehensive sex education.
3. Analyse how traditional beliefs around gender roles, virginity, and marriage affect individuals' ability to make informed choices about their bodies, health and relationships.
4. Examine the influence of religion, cultural norms, and traditions on attitudes toward sexuality and reproductive health with a focus on enhancing women's health and safety.

Cross-cutting themes included women in leadership and decision-making, intergenerational dialogue, and ending violence against women and girls.

1.2. Anticipated Outcomes from the study

The study results are being disseminated to a broad audience, and the findings have been framed to align with the following outcomes, which were anticipated during the design phase:

- **Improved Access to SRHR Services:** By identifying cultural, religious, and traditional barriers, the study will provide policymakers, healthcare providers, and community organisations with evidence-based recommendations to enhance SRHR access, particularly for young people and marginalised groups.
- **Increased Community Engagement:** Empowering communities to take an active role in addressing SRHR challenges and influencing local practices creates a sustainable framework for long-term community engagement in SRHR initiatives.
- **Shift in Cultural Norms:** The study aimed to facilitate dialogue and change regarding traditional beliefs and practices that hinder access to SRHR, with a particular focus on women's health, safety, and rights.

1.3. Study Population and Stakeholders

IPPF identified the key population groups for this study as:

- **Young People (ages 15–24):** This group will include both men and women, with a specific focus on their access to sex education, family planning, and contraceptive methods.
- **Sex Workers:** Marginalised in many ways, sex workers face unique barriers to SRHR, and their voices will be integral to understanding the intersections of culture, religion, and service access.
- **Women (over 26):** Focus on women's health, with an emphasis on the challenges related to religious and cultural norms surrounding sexuality, marriage, and gender roles.

Several other stakeholders were included in the study because they hold prominent positions in communities and have access to specific knowledge, including:

- **Religious Leaders and Elders:** To gain insights into how religious beliefs and traditional practices shape attitudes toward SRHR.
- **Community Health Workers and Service Providers:** To explore service availability and accessibility, and understand institutional challenges.
- **Community Members:** Participants were selected from local communities, both rural and urban, to ensure a representative sample of Fijian society.

2. BACKGROUND

Despite a favourable policy environment, Fiji faces a deepening sexual and reproductive health and rights (SRHR) crisis, marked by high rates of teenage pregnancy, rising youth suicide, persistent outbreaks of HIV and sexually transmitted infections (STIs), and extremely high levels of sexual and gender-based violence (SGBV). The Constitution of Fiji (2013) guarantees fundamental rights, such as equality before the law and the right to health, and explicitly prohibits discrimination based on sex or gender, which underpins SRHR access and gender equality efforts.

Other key legislative and policy commitments include the National Family Planning Policy, FP2030 Commitments, Universal Periodic Review (UPR), CEDAW, and the Moana Declaration (See Box 1). The Crimes Act 2009 criminalises sexual violence, including rape and sexual assault, offering legal protection against GBV. Similarly, the Domestic Violence Act 2009 provides mechanisms such as Domestic Violence Restraining Orders (DVROs) to protect survivors. The Family Law Act 2003 governs marriage, divorce, and child welfare, setting the legal marriage age at 18 and addressing issues like early marriage, which is relevant to teenage pregnancy and reproductive rights challenges. However, cultural acceptance of early unions in some communities often overrides legal protections.

Additionally, the National Gender Policy 2014 promotes gender equality and women's access to SRHR services. The Public Health Act 1935 (and amendments) supports health service delivery, including STI prevention and maternal care. The Fiji National Action Plan to Prevent Violence Against Women and Girls (2021–2026) targets GBV prevention through coordinated responses. Furthermore, policies on Comprehensive Sexuality Education (CSE), such as the Family Life Education (FLE) module in schools, face resistance from parents and untrained teachers, aligning with community feedback on the need for culturally sensitive education.

In 2024, Fijian hospitals recorded 858 teenage pregnancies, nearly double the previous year's figures, with the majority among girls aged 15-19—a trend that signals ongoing gaps in sexual health education, contraception access, and safe family planning (Fiji Times, 2025). Teenage mothers face higher risks of maternal complications, social exclusion, interrupted education, and poverty. Fiji's troubling youth suicide statistics compound these vulnerabilities: between 2020 and 2024, there were 489 suicide deaths and 446 attempts, reflecting severe mental health pressures among youth aged 17–25 (FBC News, 2025; Ministry of Women, Children and Social Protection, 2025). Suicide ranks as one of the leading causes of death in young Fijians, driven by stigma, SGBV, limited mental health services, and a lack of safe support channels.

The health system also confronts a growing HIV epidemic. In 2024, there were 1,583 newly diagnosed cases (the highest ever recorded) and a 281% increase over 2023, with nearly a third of new infections reported among young people 15–24 (UNAIDS, 2025; IDEA International, 2025). Overall, the total number of cases has surged from fewer than 500 a decade ago to nearly 5,900 by 2024. Only 36% of people living with HIV in Fiji know their status, and just 24% receive treatment. High rates of untreated STIs further strain clinics, heighten the risk of HIV infection, and cause ongoing reproductive health complications.

Violence and discrimination are daily realities for women, girls, sex workers, individuals with diverse SOGIESC, and people with disabilities. Fiji ranks among countries with the highest SGBV prevalence globally: 61% of women report lifetime physical and/or sexual intimate partner violence (IPV), 24% have experienced recent IPV, and 16% have survived sexual abuse before age 15 (FWCC, 2013; UNFPA, 2014). Emotional and psychological violence affects 71% of women, while 1 in 5 have endured sexual violence from non-partners. Violence is most acute for marginalised groups—sex workers, young women, individuals with diverse SOGIESC, and those with disabilities—who face additional barriers to accessing justice and support. While 75% of facilities (n=212) reported providing services for SGBV, only 4% were able to offer the minimum services (UNFPA 2025), illustrating a significant gap between rhetoric and reality. The economic costs are immense, with violence estimated to cost Fiji FJD $300 million per year, or approximately 7% of the country's GDP (IFC, 2020).

While the government has adopted progressive national and international policy frameworks, significant gaps remain between legislative promises and on-the-ground practice. These interlinked challenges highlight critical gaps in SRHR services and education—and the consequences of inaction. Failure to address these issues perpetuates cycles of stigma, poverty, poor health, and exclusion for Fiji's most vulnerable, underscoring the importance of this study.

Box 1. Summary of Fiji's major SRHR commitments

Universal Periodic Review (UPR): Fiji made commitments to strengthen its legal and policy framework to eliminate all forms of gender-based violence, ensure comprehensive sexuality education, increase access to SRHR services for all (including marginalised populations), and address gaps in implementation and resourcing (see Fiji's UPR 2024/2025 reports and recommendations).

CEDAW (The Convention on the Elimination of All Forms of Discrimination Against Women): Fiji ratified CEDAW and has agreed to protect sexual and reproductive health rights, review discriminatory laws, decriminalize abortion, prevent and address gender-based violence, and prioritise access for the most marginalised—including individuals and communities with diverse SOGIESC and women with disabilities. The 2025 CEDAW Technical Cooperation in Fiji called for further steps to ensure SRHR and women's bodily autonomy.

Moana Declaration (2013 and reaffirmations): Fiji and other Pacific states signed the Moana Declaration, affirming commitments to:

- Universal access to sexual and reproductive health services
- Rights-based approaches and non-discrimination
- Adolescent-friendly services and prevention of early pregnancy
- Support for comprehensive sexuality education in schools
- Protection of marginalised groups such as young people, individuals with diverse SOGIESC, and people with disabilities.

FP2030 Commitments and National Family Planning Policy (2025–2030): Fiji launched its first National Family Planning Policy and FP2030 Commitment in July 2025, pledging to:

- Guarantee universal access to high-quality, rights-based family planning
- Expand services to rural, maritime, and vulnerable populations
- Prioritise the reduction of unmet need and adolescent pregnancy
- Integrate family planning into disaster preparedness
- Secure a dedicated national budget and robust monitoring
- Foster partnerships across agencies and sectors

Pacific Women Lead Formative Situational Analysis (2024, 2025): This regional gender analysis reaffirms Fiji's commitments to:

- Feminist leadership and inclusion
- Addressing intersecting discrimination in SRHR policy and programs
- Supporting community-based and survivor-centred action
- Ensuring women and girls, including those with disabilities or diverse SOGIESC, are central in policy design, delivery, and evaluation.

3. Literature Review

A literature review matrix, developed from grey literature from IPPF, mapped literature gaps to key research objectives during the inception phase. It identified significant gaps in the understanding and provision of SRHR in Fiji. Notably, while official statistics confirm low rates of contraceptive use and high adolescent pregnancy—particularly among married young women—there remains a lack of research into the specific barriers underlying these trends and into solutions tailored for different demographic groups (Ireland et al., 2025; Mahe et al., 2018). According to the 2025 Guttmacher report, the unmet need for modern contraception in Fiji is nearly 20% among married women, with many more adolescents (especially unmarried girls) facing even higher unmet needs. The unmet demand (those not covered but also open and willing to use modern contraception) is 81% for adolescent girls (Table 1). The iTaukei community and older rural women have particularly high unmet need and demand (Cammock et al., 2017).

Table 1: Contraceptive Statistics

Definition	Fiji Estimate (All Women, 15-49)	Fiji Adolescents (15-19)	Fiji Older Women (25+)
Unmet Need for Modern Methods	19.7% (married women)	Highest among unmarried girls; 81% of married girls 15-19 do not use contraception	25% (iTaukei women)
Unmet Need for Any Method	Not explicitly reported, but higher than modern needs	Similar pattern; much higher for adolescents	Higher for older, rural, poor women
Unmet Demand for Contraception	Implied: the majority of women want to avoid pregnancy and are open to using modern contraception in future	Only 19% of unmarried adolescent girls who want contraception have access (meaning unmet demand is 81%)	Not directly specified

Source: Guttmacher Institute (2025b)

Literature points to stigma, cultural taboos, and gender-based violence as persistent challenges, but there is little in-depth exploration of interventions that address these barriers effectively according to context (Yamin & Boulanger, 2013; McMillan & Worth, 2011). Fiji has among the highest rates of sexual and gender-based violence (SGBV) and intimate partner violence (IPV) in the world. The lifetime prevalence among iTaukei women was higher at 69% than the national average. In the previous 12 months, about 23% of iTaukei women and 17% of Indo-Fijian women reported experiencing physical assaults by a partner, and about 18% of iTaukei women and 14% of Indo-Fijian women reported sexual abuse by a partner (Fiji Women's Crisis Centre, 2013).

The literature further emphasises the significant impact of gendered social norms, religious teachings, and cultural beliefs on SRHR outcomes (Murphy et al., 2023; Ireland et al., 2025). However, there are limited studies that examine the intersection and variability of these factors across Fiji's ethnic (Indo-Fijian vs iTaukei) and geographical (urban vs rural) contexts (Mahe et al., 2018; Ireland et al., 2025). The role of male partners in family planning is increasingly acknowledged, but the mechanisms driving their involvement, and the barriers to effective support, remain underexplored (Mahe et al., 2018; Yamin & Boulanger, 2013).

The literature addresses the compounded difficulties faced by excluded groups such as sex workers and unmarried women, but few studies take an intersectional approach to map social, legal, and health-related obstacles (APTN, 2022; DIVA, 2020). Individuals with diverse SOGIESC receive scant attention, and despite transgender sex workers facing heightened risk of violence and discrimination, this reality is poorly documented in existing research (APTN, 2022). The literature does not clearly explain the causes of this violence and discrimination.

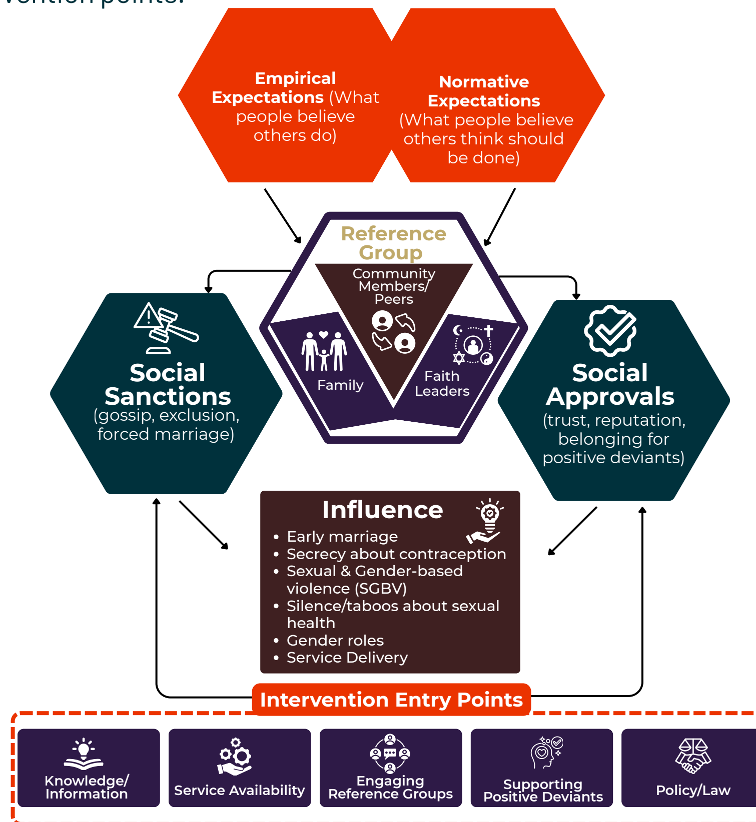
This review underscored the necessity for context-specific SRHR solutions and information, particularly for marginalised groups. This research aims to address the identified gaps by utilising a social norms framework to help unpack the underlying factors that may contribute to the literature findings and statistics. In particular, a social norms approach will address the lack of in-depth exploration of why unmet needs and demands vary across locations and religions. It builds on the literature to explain the tension between religious beliefs and personal desire, especially regarding virginity, premarital sex, and SRHR among youth (a recurring theme lacking deep sociocultural analysis)(Murphy et al., 2023; Ireland et al., 2025) and adopts an intersectional approach to illuminate the needs of marginalised groups. The study differs from previous literature in its approach to facilitating dialogue with communities and identifying appetite for change regarding traditional beliefs and practices that hinder access to SRHR.

4. Social Norms - a framework for SRHR research

Social norms are collectively held beliefs about what constitutes acceptable, expected, or appropriate behaviour within a particular group or society. They dictate both what people believe others in their community do (empirical expectations) and what people believe others in their community think they ought to do (normative expectations) (Bicchieri, 2006; Mackie et al., 2015).

Social norms differ from individual attitudes or preferences in that they rely fundamentally on shared expectations and the threat of social sanction or reward when those expectations are met or challenged. The social norms framework is a valid and powerful lens for studying SRHR challenges in contexts such as rural and peri-urban Fiji, where norms are often stronger determinants of behaviour than personal preferences (Cislaghi & Heise, 2018). Figure 1 illustrates how empirical and normative expectations, reference groups (family, community, faith leaders), and mechanisms of social sanction and approval interact to shape collective barriers to SRHR. Arrows indicate processes of enforcement and feedback, while highlighted intervention points show how SRHR outcomes (early marriage, secrecy about contraception, GBV, and silence around sexual health) can be effectively addressed by engaging reference groups, supporting positive deviants, and shifting community expectations.

Figure 1: Adapting the social norms framework for SRHR research in Fiji: key elements, pathways of influence, and intervention points.



It is a particularly effective approach for unpacking the collective processes that sustain taboos around sexuality, gendered control, and barriers to SRHR access. SRHR outcomes—such as early marriage, secrecy around contraception, gender-based violence, and silence about sexual health—are rarely explained fully by individual choices or institutional policy alone. Instead, they result from social processes of conformity, sanction, and reputation that operate at family, community, and faith levels (Heise & Manji, 2016; Cislaghi & Heise, 2020).

Social norms theory is particularly relevant in settings where traditions, religious teachings, and cultural expectations intersect, as in Fiji. For example, the norm that girls must maintain virginity before marriage is upheld not only by personal beliefs, but also by what parents, peers, and religious leaders expect and enforce through gossip, exclusion, or forced marriage when breached (known as sanctions). This interconnectedness helps explain why interventions focusing only on "knowledge" or "service availability" often struggle—change must engage both the reference groups who uphold and influence the norm and the mechanisms of social approval, fear, and belonging (Bicchieri, 2017; Mackie et al., 2015).

Recent research highlights the importance of distinguishing between empirical expectations (what people believe others actually do) and normative expectations (what people believe others think should be done), as different strategies are needed to influence each (Cislaghi & Heise, 2018). Effective SRHR programs, therefore, work to increase individual understanding while also shifting what is seen as normal behaviour and addressing the social consequences of breaking old norms (Kohler et al., 2015).

Given that social norms are collectively shaped and constantly evolving, the social norms approach provides a practical framework for designing and evaluating interventions that can change behaviour at scale. This approach recognises that change often begins with "positive deviants," individuals who quietly challenge existing norms and are protected by trust or status. This idea aligns with the pathways of change documented in many SRHR studies (Bicchieri & Mercier, 2014).

In summary, the social norms framework is uniquely positioned to address the intersecting, multilevel challenges of SRHR in Fiji, which are taboo and not openly discussed. The social norms framework guides analysis not only of barriers but also of entry points for change. It shows why addressing sanctions, reference groups, and collective expectations is crucial for sustainable impact.

5. Methodology

This study was conducted in phases, ensuring that the research is grounded in local contexts and empowering the Fijian community to address barriers to SRHR access in culturally and religiously sensitive ways.

5.1. Community-Based Participatory Research (CBPR) Approach

The research used the community-based participatory research (CBPR) approach, incorporating the social norms framework. A group of community members from RHAF and volunteer students were trained as enumerators and note takers. This meant people with knowledge of that specific context asked the questions. The study design process was iterative, involving continuous collaboration with RFHAF and IPPF Sub-Regional Office for the Pacific (IPPF SROP) team members at all stages, until RFHAF's involvement in the analysis was reduced due to internal issues. A core member of Includovate's team was Fijian and remained involved throughout the study, including the analysis, sense-making, report writing, and validation phases. This ensured that the research was grounded in local contexts and the recommendations addressed barriers to SRHR access in culturally and religiously sensitive ways.

5.2. Tools

The process began with the development of draft tools informed by the literature review. These draft tools were then presented to the research advisory group for feedback. Next, the research sites and data collectors were selected. Training sessions were conducted for the data collection team, followed by tool testing to identify and resolve any issues before fieldwork commenced. Following successful tool testing, data collection was conducted both within the communities and at the national level. The study used the following data collection tools:

- **Focus Group Discussions (FGDs):** Conducting separate FGDs with young people (16-17 and 18-24 year olds) and parents helped uncover how cultural, religious, and traditional practices influence their access to SRHR services.
- **Key Informant Interviews (KIIs):** Key informants (such as religious leaders, community elders, healthcare providers, sex workers and those who run OPD or SOCIESC councils or federations) were interviewed to explore the intersections of religion, culture, and SRHR and to understand institutional perspectives.
- In-depth Interviews (IDIs): Conducting longer in-depth interviews with young people, parents, and single mothers enabled a thorough exploration of topics and the gathering of insights that participants might have been reluctant to share in a Focus Group Discussion (FGD).
- **Community Mapping:** Participants engaged in mapping exercises to identify physical and social barriers to accessing SRHR services, including geographic isolation, religious or cultural prohibitions, and stigmatisation. Pictures of the maps are available to view in the community summary annexes.
- **Role-playing and Scenario Exercises:** These exercises explore real-life situations, enabling participants to act out and discuss responses to SRHR-related challenges within religious and cultural contexts. This tool helps surface community-level understanding and knowledge gaps about SRHR. The process of undertaking these exercises aimed to facilitate community dialogue, allowing participants to reflect on and discuss solutions to issues that surfaced.
- **Sensemaking workshops:** The results of community data collection, once analysed, were shared with communities along with draft recommendations for ways forward. This opportunity for community members to review and contribute to the final recommendations enhanced the study's effectiveness and legitimacy in local communities.

5.3. Sample size and study locations

Participants and locations for the community data collection were selected to represent a diverse range of experiences in Fiji, encompassing individuals from rural, remote, maritime, and urban communities. IPPF chose a total of six sites for their diversity, and the research teams were divided into three groups, each covering two sites:

- The Nadi (West) team undertook data collection in Kese village and Naboutini.
- The Suva (Central) team undertook data collection in Suvavou and Viria.
- The North travelled from Suva to Labasa and conducted data collection in Nasekula and Siberia, near Labasa.

Figure 2 shows the sites for community data collection on a map. Table 2 presents the demographics of each study site.

Figure 2: Location of community-level data collection

Table 2: Study Site Demographics

Community names	Urban/ Rural	Households	Ethnicity	Religion	Language
Suvavou	Urban	140 households	Traditional iTaukei village	Majority Methodist (church in village), second major religion Seventh-day Adventist (SDA) Methodist	iTaukei, English
Viria	Urban	180-200 households	Mixed - iTaukei and Indo-Fijians	Mixed: Christians and Hindus living together	iTaukei, English, Hindi
Nasekula	Urban	100 households	Traditional iTaukei village	Majority Christian, predominantly Methodist	iTaukei, English
Siberia	Peri - Urban	80-100 households	Indo-Fijian	Indo-Fijian Hindu Community	Hindi, English
Naboutini	Rural-Inland	23 households	Indo-Fijian	Indo-Fijian Muslim Community	Hindi, English
Kese village	Rural-Maritime	63 households	Traditional iTaukei village	Christian: Majority Methodist Assemblies of God (AOG), Christian Mission Fellowship (CMF), All Nations Christian Fellowship (ANCF)	iTaukei, English

Table 3 shows the proposed sample sizes for the communities and the final, actual samples given community availability. Table 4 shows the disaggregated sample size per community that was proposed and completed. There were 20 IDIs with female participants of different age group (four with people between 16-17 years, five with young people between 18-24 years, six with widows or divorced or single mothers, five with female parents of children over 15 years old), and 16 with male participants from the communities (five with people between 16-17 years, six with young people between 18-24 years and five with male parents of children over 15 years). In the case of FGDs, there were 12 FGDs with female participants and 13 FGDs with male participants. Table 5 presents the planned and actual sample sizes for key informant Interviews with national representatives across Suva and Nadi. These were conducted either in person or online, depending on the interviewee's location. Seventy-eight per cent of the proposed sample size was completed.

Table 3: Planned and Completed Sample Size by community data collection site

Communities	Proposed				Completed Sample			
	KII	IDI	FGD	Community tools	KII	IDI	FGD	Community tools
Suvavou	6	7	6	3	4	6	2	1
Viria	6	7	6	3	4	7	5	3
Nasekula	6	7	6	3	6	7	4	1
Siberia	6	7	6	3	6	6	6	3
Naboutini	6	7	6	3	6	5	4	
Kese	6	7	6	3	5	5	4	3
Subtotal	36	42	36	18	31	36	25	11
Total	**132**				**103**			

Table 4: Disaggregated sample per community

	Proposed in 6 locations						Completed in Six locations					
RESPONDENTS - per location X 6 locations	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Young people 16-17 (IDIs should be out of school)		6	6	6	6			4	5	4	4	
Young people 18-24		6	6	6	6			5	6	3	5	
Women (divorced/single, widow, never married)		6						6				
Parents with children over 15 years old		6	6	6	6			5	5	5	4	
Teachers / Head of school	6						5					
Religious Leaders, Muslim, Hindu and Christian	12						9					
SRHR service provider/health workers	6						6					
Local govt	6						5					
Other local leader	6						6					
Community tools						18						11
Total	**36**	**24**	**18**	**18**	**18**	**18**	**31**	**20**	**16**	**12**	**13**	**11**

Table 5: Suva and Nandi Respondents KII

	Proposed		Completed	
National/Suva	**F**	**M**	**F**	**M**
Ministry (Health, Youth, Women, Education)	2	1	1	1
Religious Leaders, Muslim, Hindu and Christian		3		1
IPPF service providers	1		1	
Gov service providers (SRHR service providers/health workers)	1		1	
OPD Federation	1		1	
SOGIESC Federation	1		1	
Sex Worker Federation	1		1	
Youth Council	1		1	
Sex Workers	2	2	2	2
Diverse SOGIESC	2	2	2	2
Total	**20**		**17**	
Nandi	**Proposed**		**Completed**	
Sex workers	4		3	
Diverse SOGIESC	1		0	
Religious Leaders	3		2	
SRHR service providers/health workers	2		2	
Total	**10**		**7**	

5.4. Ethical Considerations

Ethical clearance for the study was gained from the Fiji Human Health Research and Ethics Review Committee (see Annex 8.2 for clearance). The data collection teams received ethics training as part of their training. They took reasonable steps to ensure that the assessment was conducted in a manner that respects and protects the rights, welfare, and privacy of the people, communities, and other entities involved. Some examples include:

- **Informed Consent:** All participants were fully informed about the study's purpose, their roles, and the confidentiality of their contributions through written consent statements read aloud and signed, with copies provided to participants. Parental assent was obtained from respondents under 18 years of age.
- **Cultural Sensitivity:** The research process respected local customs, religious practices, and cultural norms, implementing specific protocols to build trust during data collection: for I Taukei communities, approval was secured through the Ministry of I Taukei Affairs and traditional 'i sevusevu' was presented to the Turaga ni Koro for acceptance in all visited areas, while for Indo-Fijian settlements, government procedures involved obtaining municipal council approval and engaging advisory councillors for access. Questions were carefully worded in sex- and gender-aware language, cross-checked and translated with local enumerators, and then pilot-tested with community members to ensure comprehension.
- **Safeguarding:** All data collectors and research team members were trained in safeguarding practices and were required to adhere to IPPF's safeguarding standards throughout the project. They also carried information on SRHR services, including for SGBV, that offer support.

5.5. Limitations

RFHAF did not have dedicated time for this study: RFHAF staff had to juggle their regular community work responsibilities alongside research duties, leading to significant challenges in allocating sufficient time and attention to data collection. Competing priorities—such as ongoing community activities and urgent tasks—often led to the research being deprioritised or interrupted, affecting the consistency and depth of the gathered information. In several instances, research activities were rescheduled or shortened due to overlapping village events, church services, or household obligations. In some cases, communication challenges arose between authorities and communities. For example, in Labasa, the authorities didn't pass the message to the community, so the community was surprised by the visit. As RFHAF was responsible for leading community engagement strategies, time constraints ultimately reduced the final sample size.

Volunteers/data collectors were not sufficiently confident/competent to build rapport and collect high-quality data: Many were new to conducting research and initially lacked the confidence and skills to establish rapport with participants, particularly when discussing sensitive and taboo topics such as SRHR. Building trust was particularly important in settings

where talking to a stranger—even about health—was uncommon. To address this, daily supervisor check-ins helped clarify questions and offer guidance, but challenges remained. Some strategies, such as walking with participants or sharing personal information, were used to encourage openness. Despite these efforts, data quality varied, as not all researchers consistently established trust and elicited candid responses. This likely limited the breadth and representativeness of data collection, potentially biasing findings toward more accessible or available participants.

More experienced RFHAF team members struggled to work as researchers, rather than educators. Experienced RFHAF staff, accustomed to advocacy and education roles, found it difficult to separate these responsibilities from their research roles. Instead of just gathering and recording participants' views, staff sometimes defaulted to providing education and advice during interviews. Training and pilot testing aimed to separate RFHAF staff roles as educators from researchers. Despite this, some staff defaulted to educational roles during interviews, potentially influencing participant responses and reducing neutrality. This could have introduced response bias, affecting the authenticity of qualitative data and possibly underrepresenting dissenting or sensitive viewpoints.

Uneven sample: Suvavou recorded the poorest sample collection, followed by Naboutini. Both villages had very few residents present during the visit, and cooperation from the village gatekeeper (village head or leader) was limited. Additionally, villagers' overall unavailability and low willingness to participate further constrained the process. This uneven coverage reduces generalisability and may overlook key perspectives from those communities, thereby affecting the comprehensiveness of the findings.

Reaching the required sample size proved difficult for several reasons. In many locations, girls aged 18 to 24 had relocated for work or study, leaving few eligible participants. Additionally, recruiting women for activities such as mapping was difficult, as their time was constrained by domestic work and other commitments. Despite strong initial community engagement, conflicts with local events (e.g., a funeral in Labasa or church services in other villages) often disrupted research activities, leading to postponements or shortened sessions. This contributed to a 78% completion rate for community-based data collection. Locations where community members were especially busy, or where events interrupted research sessions, were notably more challenging. For instance, in Labasa, the team had to return after a community funeral, which prolonged the timeline and limited opportunities for in-depth discussion. These challenges may have reduced opportunities for in-depth engagement and detailed data collection, affecting thematic saturation and the nuance of findings.

Overall, while mitigation strategies increased data quality and community involvement, unresolved limitations—particularly time constraints, volunteer variability, staff role confusion, and uneven sampling—may have restricted data representativeness and depth. To address these overall quality concerns, the research team employed collective analysis techniques, regularly convening to discuss findings, identify gaps, and ensure a range of perspectives were considered in interpretation. In addition, sensemaking workshops were held with community members , allowing participants to reflect on and validate emerging

themes, provide context, and address information gaps or areas of uncertainty (aside from Kese where a sensemaking workshop could not be held due to the death of the chief's wife). These collaborative approaches strengthened the rigour of analysis, supported transparent interpretation of results, and helped integrate community insights into the final findings—partially offsetting the effects of rushed sessions and participant gaps.

Nevertheless, the findings should be interpreted with caution, acknowledging potential biases that favour more accessible or engaged participants. Future research would benefit from more flexible field plans, repeated visits, enhanced training, and deeper community engagement to improve inclusivity and data robustness.

6. Findings and discussion

6.1. Part 1: Key SRHR Knowledge and Access Challenges

Across the Fiji communities studied, several persistent gaps and challenges shape the SRHR experience of male and female youth.

6.1.1. SRHR Knowledge and Education

Comprehensive sex education (CSE) in Fiji—delivered through the Family Life Education (FLE) curriculum—is limited by cultural taboos, shallow coverage, and a lack of trained teachers. Young people frequently describe the material as "boring" and "basic," noting that boys rarely learn about consent and girls aren't empowered to refuse unwanted advances. Teachers sometimes focus only on puberty or abstinence, as broader aspects of sexual health are avoided due to discomfort and the belief that open discussion could encourage sexual activity. As one participant warned, "modern knowledge is encouraging sexual intercourse in the adolescent years… teenage pregnancy will go up, HIV will rise." CSE often competes with exam subjects for attention, and some respondents argue the curriculum is "too Westernised," advocating for more localised content that avoids sensitive topics like adoption and abortion.

Many parents and teachers fear that such lessons might conflict with family or religious values, resulting in sex education being either skipped or restricted. Most parents and teachers agree youth should receive FLE/CSE "just before or after puberty," but recognise that, in practice, many children start learning before this from peers, the internet, or social media—sources that can be inaccurate or unsafe. Girls typically receive more instruction on menstruation and bodily changes, but are also cautioned that curiosity can bring shame, while boys' curiosity receives less overt guidance.

Teachers and health workers are themselves constrained by gaps in training and social norms. As one Kese community leader said, "Teachers feel uncomfortable, so it would be better to bring the people who actually work in this field." A teacher from Nasekula confirmed, "From the earlier days till now, openly discussing it is taboo. Sometimes we are shy because it

is taboo, but it is time we discuss this openly." Others acknowledge limited preparation: "Teachers don't have enough information about SRH... the curriculum needs to be reviewed." Health workers similarly feel SRHR is outside their usual remit: "We don't really look into sexual and reproductive health a lot... it's not something that we really focus on or are advised to look into... I've never done it."

Responsibility for sex education is often deferred between parents, elders, and schools, with widespread anxiety that lessons at school might "contradict the values taught at home or within faith settings." Some families find the curriculum "too fast and too much," fearing youth will "act on biological information without ethical guidance." There is a strong call for sex education that is more culturally sensitive and delivered in partnership with faith leaders, elders, and parents to ensure ethical grounding and community acceptance: "Everything starts at home... parents need to sit down and talk... to discuss these topics openly and with respect for tradition." Even so, few adults feel equipped or confident to lead these conversations.

Religious opposition to CSE is similarly strong. Many church leaders and religiously observant parents fear that teaching SRHR topics to adolescents may encourage sexual experimentation or conflict with faith principles. The notion that sex education should be limited, closely monitored, or taught only within a religious or abstinence-focused framework is widespread. In some cases, religious authorities actively lobby schools to restrict or reshape their curriculum to reflect church values—pushing for an emphasis on abstinence, modesty, and traditional moral standards over accuracy, inclusivity, or rights-based content. Persistent resistance from faith groups means progress on curriculum reform and open community discussion continues to be slow and contested: "Sex education is a taboo topic in religious spaces... religious leaders or community members will not accept sex education or awareness campaigns."

Religious teachings, particularly those of the Catholic Church, emerge as a significant barrier to accessing SRH information and services across the research sites. The Catholic faith's theological prohibition on contraception and family planning stands in stark contrast to other Christian denominations and faiths, creating distinct obstacles for young people seeking SRHR services: "For the Catholics, it's just because of their religious belief. They don't believe in contraception. And for us, we respect it, but we create awareness." One health worker explained: "Which religion teaches no contraception? Catholics. They talk about family planning, but it is the menstrual cycle, which is the natural method of contraception." The restrictive Catholic stance on contraception, combined with the church's emphasis on sex only within marriage and opposition to abortion, creates a multi-layered barrier that discourages Catholic community members—particularly young women—from seeking SRHR services, even when facing health risks or unplanned pregnancies.

The data shows faith-based and community leaders as both obstacles and potential allies. Many respondents emphasised the need for targeted training in sensitive approaches to SRHR and CSE, especially since these topics can make congregations deeply uncomfortable: "Some of them just stood up and left... children were just looking around left and right because they were feeling uncomfortable, him being at the pulpit and sharing about

sexual health matters." Health workers advocate for more education to prevent risks, but feel tradition limits their mandate; they often "respect both sides—traditional religious teachings and modern [messaging]—to remain effective." This perception of religion and culture as overriding factors can stand in tension with Fiji's commitments to international human rights treaties such as CEDAW, national legislation like the Fiji National Action Plan to Prevent Violence Against Women and Girls (NAP VAWG), and other policies that mandate inclusive, rights-based, and evidence-informed SRHR education for all.

Youth with diverse SOGIESC (Sexual Orientation, Gender Identity and Expression, and Sex Characteristics) face persistent and often heightened barriers to SRHR education and services. National interview and focus group data show that mainstream school curricula frequently ignore or deliberately stigmatise non-heterosexual and non-cisgender identities through heteronormative language, reinforcing feelings of alienation and invisibility. As one respondent reflected, "I think with Fiji we still have that stigma against the diverse gender identities and I don't think we have reached that stage where we are open to the different gender identities accessing SRH services and I think that in itself is a barrier…" This stigma is compounded by religious and school-based attitudes, where, "they always preach about abstinence… but just like a vulnerable community like I'm representing, we are the ones who are 'spreading HIV.' This kind of teaching actually contradicts and undermines the need to access these services. So it holds you back. Holds me, yeah."

Youth with diverse SOGIESC consistently report exclusion, judgment, and a lack of affirming information in mainstream, religious, and school settings, leading them to rely almost exclusively on rare, dedicated NGO- or peer-led spaces for SRHR education and care. As a youth with diverse SOGIESC declares, "I don't have any barriers [at RFHAF]. Whenever I want to go, I feel welcome and whenever I go and get my test." However, such inclusive and safe spaces are rare, and "most young people rely on peer support… they go where they're accepted," while others described being compelled to leave home or community due to their identity. Where inclusive peer groups and safe community spaces were available, youth with diverse SOGIESC expressed relief: "You go where you're comfortable… But when we are not accepted, we just don't go." The affirmation and safety found in these specialised spaces are deeply valued, yet remain the exception rather than the norm.

Similarly, young people with disabilities often face compounded barriers to information. Key informants described that decisions about what disabled youth learn or access are routinely made by adults, sometimes without consulting the young people themselves. Persistent stigma and myths about "asexuality" among disabled children are reflected in service provision as well; the value of dignity and respect for their choices is not always honoured, and disclosure of their health concerns can be a source of gossip, undermining privacy at clinics or homes. Box 2 summarises the findings from the study for people with disabilities, and Box 3 presents sex worker-specific findings.

Box 2: Spotlight on disability

People with disabilities in Fiji face significant barriers when accessing SRHR services:

- Discrimination and Stigma: People with disabilities experience multiple layers of discrimination, not only from the broader community but also from health workers. There are reports of negative attitudes, facial expressions, and comments from staff, such as "why do you need contraception?" or "why do you want to abort your baby?"—directly questioning the rights and choices of women with disabilities.
- Confidentiality Concerns: Breaches of confidentiality are a serious barrier. Instances are described where clinic staff talk openly about women with disabilities requesting SRHR services, leading to further exposure, stigma, and community gossip. As a national disability advocate explains, "In the clinic, sometimes the staff will talk openly — 'She's here again, wanting those pills.' Then the whole community knows. That's why a lot of women just stop going."
- Limited Information and Accessibility: There is poor access to written and spoken information about available family planning, contraception, SRHR choices, and potential side effects. Many people with disabilities are unaware of their rights and the available services, "...there are rights out there, but for persons with disabilities, they do not know that they have that right ... When we talk about contraception and family planning, we have a whole variety of contraception. And for persons with disabilities, getting that information, is it safe for them? Are the long-term or short-term benefits more important? What are the side effects? And on top of that, are they able to access the services?" (KII, female disability/SRHR advocate)
- Physical and Social Accessibility: Some physical clinics and service environments are not disability-friendly, meaning mobility, communication, or sensory barriers persist for those with disabilities.
- Power Dynamics and Lack of Autonomy: Caregivers or family members often make decisions on behalf of persons with disabilities, especially those with intellectual or psychosocial impairments, meaning they may not be able to make personal choices about contraception or family planning.
- Stigma about Sexuality: Negative community attitudes towards the sexuality of women and men with disabilities—including assumptions they should not be sexually active—result in policing their movements, restricting independence, and causing isolation.
- Taboos, Cultural, and Religious Factors: Cultural beliefs can dictate that talking about SRHR is taboo; these norms are even stronger for people with disabilities, compounding barriers to information and service access.

Some positive changes are occurring in policy and service delivery, including efforts to train health workers in disability sensitisation, promote youth-friendly and non-discriminatory approaches, and design family planning policies that are more inclusive. The Fiji Disabled Peoples Federation and other advocacy groups play a crucial role in raising awareness about SRHR for people with disabilities and advocating for policy change and improved practices.

National-level key informant interviews reveal that Fiji's approach to CSE is gradually shifting towards greater inclusivity, more localised and culturally relevant content, and calls for sensitive and respectful delivery. There is also an increasing demand for intergenerational dialogue and stronger institutional collaboration, as reflected in ongoing curriculum reforms, such as the Fiji Family Life Education (FLE) program, which is intended for both in-school and out-of-school (OOS) contexts. The OOS curriculum, piloted under initiatives such as Spotlight and now linked to the UNFPA Transformative Agenda Phase II (2025–2027) has reportedly seen limited implementation in Fiji to date.

Despite growing recognition of the value of partnership, parental attitudes remain sharply divided. Some parents express a readiness for closer cooperation with schools and more open communication about SRHR, wanting their children to have access to "modern information." Others, however, uphold strict silence, particularly mothers, when discussing sexuality with daughters, out of a desire to protect family honour. This results in many young people feeling lost and under-informed. Youth consistently describe longing for clear, practical knowledge but instead receive "mixed and usually prohibitive messages." As a result, some older girls admitted that their first exposure to contraception was after their sexual debut, with others reporting they only received proper information after becoming pregnant.

Box 3: Sex Worker-Specific SRHR Findings

Sex workers in Fiji encounter significant obstacles in accessing SRHR. Although government and NGO policies describe an environment where SRHR services—such as contraception, STI testing, family planning, and abortion—are available to all, the reality is complicated by widespread stigma, discrimination, and operational gaps. Many sex workers report delaying access to care or avoiding clinics entirely due to prior experiences of shaming and lack of confidentiality within health facilities. Public behaviours by healthcare providers, such as verbal abuse, mocking, judgment based on appearance, and open discussion of patients' health status, all contribute to an atmosphere of mistrust: "They look at you differently, as a sex worker... We can tell how they make fun of us." These experiences are exacerbated for transgender and street-based sex workers, who face even more acute levels of discrimination and violence, including from police and sometimes from family members.

Compounding these social barriers are structural and logistical challenges. Many clinic hours don't match sex workers' schedules, leaving services inaccessible when they are most needed. There are frequent shortages of essential supplies such as condoms and lubricants, and distribution often lacks privacy: "Sometimes when we go to collect condoms ... it's full of community members ... you just want to go there alone and get it." Some sex workers rely on outreach efforts from NGOs for both supplies and safe information, but these are not reliably available or adequately resourced.

Across settings, sex workers face heightened layers of stigma and exclusion. The layering of stigma from communities, faith leaders, and the legal system means that sex workers—particularly those who are transgender, migrant, or street-based—are often excluded from both protection and services. As one participant explained, "Sex workers are the ones taken in, and clients are ... rarely held accountable." Stigma is compounded by criminalisation and cultural norms, making it dangerous for sex workers to assert their rights or access health care openly.

The data confirms the United Nations Human Rights Council's (2021) Special Rapporteur on Fiji report. The report states "sex workers, especially female and transgender sex workers, and men who had sex with men, avoided healthcare services because of stigma, discrimination, fear of poor treatment and a lack of confidentiality about their work or behaviour" (A/HRC/47/28/Add.1, para. 40). Annex 9.2 elaborates further on sex worker findings.

6.1.2. Key Myths and Misinformation

"The old women always say to drink strong black tea if you think you might be pregnant. Or use roots and leaves—my aunties say they work."
—Rural village, female youth (iTaukei)

This section examines how location, social networks, and generational relationships continue to influence the emergence of SRHR misconceptions—and what this means for the effectiveness of health interventions and rights-based education in Fiji. To contextualise this section, it is important to understand that youth trust different sources of information to various degrees (Table 6).

Table 6: Youth Sources of SRHR Information

Source of Trust/Information	Younger Male Youth (16-17)	Older Male Youth (18-24)	Younger Female Youth (16-17)	Older Female Youth (18-24)
Parents (especially mothers)	Ranked among the most trusted (Kese, Naboutini)	Trusted, but boys are less likely to discuss with parents (Siberia)	Most trusted source (Viria, Naboutini)	Most trusted (Viria, Kese)
Health workers	Most reliable (Viria, Naboutini); confidentiality valued (Kese)	Trusted for accurate information (Siberia)	Most trusted (Viria, Nasekula); can explain properly	Most trusted (Viria, Kese); professional and confidential
Friends/ Peers	Common source, but least trusted for accuracy (Viria)	Frequently consulted (Siberia, Naboutini)	Most common source but least trusted for accuracy (Viria)	Common, but not most reliable (Nasekula)
Teachers	Trusted (Viria, Kese)	Trusted for formal education (Siberia)	Most trusted after parents (Viria)	Trusted (Viria, Nasekula, Savavou)
School/FLE programs	Most reliable (Viria)	Preferred for structured learning (Siberia)	Highly trusted (Viria, Nasekula)	Trusted (Viria, Nasekula, Savavou)
Church/ Religious leaders	Limited trust for SRHR (Viria)	Limited engagement (Siberia)	Limited trust (Viria, Kese)	Limited trust (Viria, Kese)
Internet/ Social media	Common source, least trusted (Viria, Naboutini)	Frequently accessed but viewed skeptically (Siberia)	Common but unreliable (Viria, Nasekula)	Common but not most trusted (Nasekula)
Porn	Accessed but recognised as unreliable (Viria)	Viewed but acknowledged as inaccurate (Siberia)	Least trusted (Viria)	Not mentioned as trusted

Traditional remedies and myths persist, undermining accurate sexual and reproductive health knowledge. While modernisation has brought fresh sources of confusion via the internet and social media, long-standing traditions and beliefs remain influential. This creates tension between prevailing practices and enduring myths, both of which are often shaped by convenience, fear, and the desire to avoid shame. Even as access to accurate information grows, many adults still pass down misconceptions—sometimes out of embarrassment, limited understanding, or a wish to uphold traditional values.

Myths and misinformation about SRHR/contraception are prevalent across all Fijian settings, but the specific context influences their expression and persistence. Traditional rural communities tend to hold onto inherited beliefs and home remedies more tightly. At the same time, urban and peri-urban youth are more exposed to (and must navigate) digital misinformation alongside modern health education. These myths were slightly more strongly held and sustained by elders in rural/remote communities. At the same time, urban youth experienced a faster churn of both myths and corrective information, as elaborated below.

Rural iTaukei (Indigenous) Communities: There is a stronger attachment to traditional beliefs and remedies, with many interviewees in rural and remote villages asserting that drinking strong black tea, taking herbal concoctions, or having hot baths could prevent pregnancy or induce abortion. Such practices are often handed down within families and reinforced by community elders: "The old women always say to drink tea, make it very strong, or use the plants after… some people say a hot bath can do it. I heard that from my grandmother." There is also a reluctance to use "Western" contraception, sometimes seen as unnatural or even harmful, with side effects exaggerated or misunderstood. For example, a rural iTaukei female parent explains, "They say the injection makes you barren or makes your periods stop forever." Several respondents felt that "Western" contraceptives are inappropriate, as this young man explains, "Our elders tell us that real Fijians don't use those pills, it's not for us, it will ruin you." When asked about preventing pregnancy, a young rural woman explained how traditional remedies prevent or end pregnancies: "You must have a hot bath straight after sex, or take a herbal drink, otherwise you will get pregnant."

Urban Communities: While traditional myths seem less deeply ingrained, misinformation thrives through peer networks, electronic media, and especially social media. Pornography, messaging apps, and internet searches often fill gaps left by incomplete or confusing school-based sex education. This can lead to both risky behaviours and confusion: "We learn from the internet and friends, but sometimes you don't know what is true and what isn't. Porn shows things that don't happen in real life…" An older male youth explained, "Most of the boys say they learned from porn, and they think that's what sex is supposed to be." Myths around condom use and double bagging were heard: "Some people use two condoms at once because they think it is extra safe, but I heard the health worker say it is not good" (Urban, female youth). Some urban respondents felt that learning about sex can lead to promiscuity: "Some friends say if you know too much, you will want to do it. But that's not true, some of us just want to be safe" (Urban FGD, mixed youth). The churn of misinformation is higher, but so too are the opportunities for correction from teachers, clinics, or better-informed peers.

Peri-urban and maritime communities sit at a crossroads: many youth and families still rely on herbal medicines and traditional practices, but are also exposed to modern SRHR messages through health workers, school programs, and online sources. Health professionals or youth leaders may challenge myths. Still, they often remain present, particularly in moments of uncertainty or mistrust in the healthcare system: "In town, you can see the posters and sometimes get condoms at the clinic, but at home the mothers or aunties still talk about using certain leaves or teas…" Herbal remedies and modern information co-exist: "We hear from mothers and aunties about bush medicine, but at the clinic we hear something different" (Peri-urban, female youth). Myths around the immediacy of pregnancy were heard: "If you touch a boy, you can get pregnant straight away—that's what the elders say. But our teacher explained otherwise" (Maritime school, female student).

Menstruation Myths

The strongest myths and taboos about menstruation and its links to sexuality were more commonly observed in rural and remote Fijian communities. In these areas, menstruation is often shrouded in silence, rituals, and warnings—reinforced by elders and community expectations. As one participant explained, "A teaching I got from my grandmothers back then was not to be with the boys because you'll get pregnant, yeah? Not to sleep with the boys. And secondly, when it's my first time for my menstruation to come, I have to protect myself, make sure I use the sanitary pads." Girls in rural villages reported that menstruation is sometimes hidden, or celebrated only symbolically, without open discussion of its health and sexual implications: "There's a big feast when a girl gets her first period, but after that they never talk about what it means for her, or about sex—just, 'welcome to womanhood.' That's it." Many described being told that appearing "too knowledgeable or curious could bring shame."

In contrast, while urban communities are not free from myths or stigma, there is a greater likelihood for girls to receive more accurate information about menstruation from a mix of sources, including school, friends, the internet, and some health workers. Urban youth more frequently reported learning about "bodily changes in class or from online," with one student saying, "We learn about it from school—sometimes they talk about periods and puberty." Even so, open discussion can remain limited, and some taboos persist alongside more modern health education.

Myths and Misinformation By Sex:

Myths and misunderstandings affect girls and boys differently, shaping norms around contraception, sexuality, masculinity, and menstruation, with adults and elders frequently sustaining these narratives within families and communities.

- **Girls/Young Women:** Myths affecting girls include the belief that taking contraception (especially at a young age) harms fertility, results in trauma or "opens the way" for immoral behaviour, or causes regret later in life. Girls are also told that virginity is directly tied to family reputation and that contraception is only for "bad" or "promiscuous" girls.
- **Boys/Young Men:** Boys face myths around masculinity and sexual invulnerability, including the idea that condoms weaken pleasure or are "not for real men," and that boys do not need contraception because "only girls get pregnant." In iTaukei communities, toughness and avoidance of health care are reinforced. In some Indo-Fijian communities, there are gendered expectations but also pragmatic discussions about contraception.

- **Adults:** Women, especially mothers and grandmothers, commonly deliver practical warnings to girls about menstruation and sexuality, often saying, "Not to be with the boys because you'll get pregnant." Men, including fathers and male elders, are more likely to reinforce silence and religious authority, with some male parents asserting, "If boys know too much, they will become wild. Better to keep those topics away." Overall, older adults of both sexes tend to favour traditional remedies, distrust "Western methods," and believe that sex education encourages sexual activity—all reflecting a deeper reliance on religious and cultural authority in adult discussions.

Myths and Misinformation By Age Group:

- **Younger Youth (12-16):** Myths are spread through peer groups (e.g., Facebook, Messenger), including false information about contraception, STI prevention, and sexual experiences. Younger youth are more likely to believe in the effectiveness of traditional remedies and less likely to seek adult guidance due to embarrassment.
- **Older Youth (17-24):** Older youth gain access to more diverse sources—including health workers, teachers, and sometimes online fact-based resources—but also encounter misinformation on social media/the internet and in peer settings. Traditional myths persist but may be challenged or reinforced by new information from schools or health outreach.
- **Adults (Parents & Elders):** Adults disseminate myths, especially regarding the dangers of modern contraception, the religious inappropriateness of abortion/condom use, and the sanctity of premarital virginity.

Across all settings, a mix of old and new sources drives a cycle of cognitive dissonance, with modernisation introducing new challenges while allowing some opportunities for correction.

6.1.3. STIs and HIV Prevention, Testing and Treatment

This section presents data on gaps in STI knowledge and timely access to professional services for the prevention and treatment of STIs, including HIV. The intersection of health, faith, and gender norms continues to influence choices and the ability of certain population groups to protect themselves across Fiji. Moreover, Fiji is experiencing an HIV outbreak (Table 7), underscoring the importance of this section.

Table 7: Fiji's HIV statistics

Indicator	Statistic/Trend
Estimated new HIV cases in 2024	*1,583*
Projected new HIV cases for 2025	*Over 3,000*
Increase in people living with HIV 2014-2024)	*10-fold (500 to 5,900)*
% people living with HIV aware of status 2024)	*36%1*
% new HIV cases (2024) among 10-19-year-olds	*10%*

Accessing sexual health services is highly stigmatised, including for STI testing, with widespread fears around confidentiality and judgment by healthcare workers: "People are afraid to go for HIV testing because everyone in the community will find out. They worry the nurse or someone at the clinic will gossip, so they just don't get tested—even if they know they've taken risks" (Male youth, rural FGD Nasekula). Such barriers discourage youth from seeking care, contributing to hidden unplanned pregnancies, unsafe abortions and the rising HIV rate.

Idle youth not attending school were identified as a key group at risk, contributing to higher rates of sexual activity and potential STI transmission—especially in rural communities like Nasekula. A male leader explained, "We must design and plan activities to take up their children's time and make them busy in the community. Because if they are left idle, then they will wander and get into these dangerous things like sex and drugs. Especially youths." He called for community-based projects to prevent young people from being "idle." Further, parent focus groups observed that early marriage and repeated pregnancies were more common among youth outside of school: "Nowadays... we get married at a very young age, where you were supposed to be in school, but you're married." Idle youth are perceived to be more at risk of STIs as they are more likely to engage in risky activities due to boredom.

The ability to negotiate contraceptive use or refuse unwanted sex is limited for girls, reinforcing cycles of SGBV and negative health outcomes: "Traditional expectations make it hard for girls to refuse unwanted sexual advances" (Siberia, rural, female youth FGD). Similarly, "If a woman says that I want to use a condom, [the man may] think that, oh, she is an expert now... that would... lead to domestic violence" (Naboutini, male policy officer). Another respondent from Kese said, "Women's role according to traditional belief is to listen to everything, so it's applied in SRHR decisions too" (Kese, rural, FGDs). These quotes confirm barriers to negotiation and autonomy for girls and women, with both sexual and safety consequences, particularly in rural and traditional settings.

Financial costs and distance to clinics are other reported obstacles, especially for those in rural or maritime areas. Participants note that while some clinics are physically nearby, financial challenges—such as costs for menstruation products, STIs or HIV testing, or transport—can deter access, particularly among youth, single parents, or those from poor households. A community health worker in Nasekula explains how proximity, cost, and transportation can create different challenges depending on how remote the community is: "Some people will not have the finances to travel, but the clinic is nearby, so they might walk", but "for remote communities, the cost and transport are severe barriers."

Prevention, testing, and treatment for STIs and HIV in Fiji are deeply shaped by religious messaging, which can both encourage moral behaviour and hinder uptake of medical interventions. Many young people, particularly in faith communities, acknowledge the importance of HIV prevention but experience conflicting guidance on the use of condoms and other biomedical strategies. As one Seventh Day Adventist youth reported, "HIV prevention is important, but using condoms is still discouraged by our church," reflecting a stance where abstinence and fidelity are promoted above protective methods. In some settings, respondents voiced reliance on religious faith as a safeguard against infection, as exemplified by a female participant in Viria: "Jesus is the only solution. Both girls and boys should turn to God because God knows he will bring you someone who is HIV free for you to marry. That's it." Such messaging can lead to stigma around condom use, reluctance to seek testing, and the expectation that marriage, rather than personal responsibility or medical advice, will ensure protection from HIV.

At the same time, anxiety about hidden HIV transmission and calls for criminalisation, public identification, or social punishment feed further stigma, fear, and avoidance of testing or care. Several respondents want more serious repercussions for those who spread HIV, as this male parent from Viria articulates, "They need to name and shame those spreading HIV—that will make people take it more seriously." Similar messages were heard in Savavou: "There should be a law that punishes people who know they have HIV and still infect others. That's not right—it's not fair for the rest of us." However, these attitudes seem to reduce testing: "Some say it's better not to know your status, because if the community finds out you are HIV positive, you'll be blamed for any new case that happens" (Female youth, Siberia). A Female rural health worker from Nasekula expressed concern about low testing rates, "I'm very concerned and scared... those who have HIV are not known, and they go around to spread HIV."

Peer and community advocacy are highlighted as effective ways to improve confidence and increase the uptake of testing: "After the HIV training, I gained enough confidence to go and get tested...It goes back to fear." Stigma especially affects access to services for marginalised groups such as individuals with diverse SOGIESC, sex workers, and people with disabilities. Some specifically mentioned preferring to be tested by specialised NGOs, such as RFHAF, for more respectful and confidential care. Thanks to NGO advocacy, provincial councils in Fiji are using HIV data in their planning and supporting the integration of SRHR into annual strategies: "When we presented on the HIV data to the provincial council, they took it on board and made part of the annual operational plan" (Female, national SRHR advocate).

Service gaps remain, but strategies such as mobile outreach, peer education, faith partnerships, and media campaigns (including radio, social media, and specialised educational apps) are mentioned to improve awareness, accessibility, confidentiality, and ultimately, STI outcomes for Fijian youth.

Churches and faith-based organisations are increasingly participating in SRHR information-sharing, playing a crucial role in normalising testing and prevention among young people. As a national SRHR advocate observed, "We work with faith-based organisations in providing information... sermons... radio programmes." In Nasekula, a Methodist pastor confirmed, "I believe in church, they are sharing this information a lot. During Youth Fellowship, we share this a lot with them." National-level program managers also described outreach through sermons and denominational networks: "...they talk to the members of the community... Why not use them to talk about SRH? Talk about a teenage pregnancy. Talk about HIV. So, it can be... a positive way in teaching about SRH." Individual youth advocates described feeling comfortable and supported in faith settings that address SRHR, such as Faith Harvest with Pastor Manasa Kolivuso: "He used that platform to advocate as well... He doesn't criticise." Another community leader in Nasekula highlighted the church's proactive involvement through events and collaboration: "...the church is doing its part... last week, we held a Junior MYF, so we invited Red Cross, Drugs, Labour and Health Services. They need to know about sex in marriage and sex before marriage... and the diseases that are spreading enormously in Fiji right now." Taken together, these quotes illustrate how faith leaders and church fellowships at both national and rural levels are becoming central actors in SRHR education and youth engagement across Fiji. Collaboration with faith leaders is seen as effective for outreach and awareness on HIV/STIs.

6.1.4. Contraception and Family Planning

Awareness about contraception and family planning is often limited. Many participants gave little response when asked about contraceptive options, or said they only became aware of methods for birth spacing after having children. Even where contraception was available, actual use remained low, hindered by embarrassment, misinformation, community scrutiny, and uncertainty about age and consent requirements. This was especially pronounced in smaller or rural communities. One respondent explained, "People will talk bad about you if you go to buy a condom... the mentality that they have is stopping them from coming. They are just ashamed." Confusion around whether parental consent is needed for those under 18 further discourages youth, prompting some to send friends, use disguises, or avoid services entirely to escape shame and potential family backlash. Table 8 shows differences in contraceptive knowledge, awareness, and attitudes between young males and young females.

Table 8: Differences in contraceptive knowledge, awareness, and attitudes between young males and young females.

Aspect	Young Males (Urban)	Young Females (Urban)	Young Males (Rural)	Young Females (Rural)
Knowledge of methods	Most aware of condoms. Some awareness of pills, but mainly view condoms as "for boys." Less familiar with implants or IUDs.	Often know about pills, injections, and sometimes emergency contraception from clinics or peers. Condoms are familiar, but usually associated with male use only.	Mostly know about condoms; less discussion of female methods. Sometimes learn of pills/implants after starting a family.	More likely to know about traditional remedies (herbal tea, hot baths) and pills/injections. Some learned about contraception only after childbirth.
Source of info	Friends, internet, social media, pornography, and school sometimes. Rarely from parents.	School, friends, social media (to a lesser degree); mothers or older sisters sometimes discuss it, but many say not until after marriage or pregnancy.	Friends, peers, social media (limited). Adult discussion is rare; mostly hearsay.	Mothers, aunties, clinics (but only when older/married or pregnant). Info before marriage is rare.
Attitudes/Barriers	Less embarrassed buying condoms, though often embarrassed if girls or adults are present. See condoms as affecting pleasure ("it doesn't feel as good").	Experience greater "shame" (madua) buying or accessing contraception– often disguise themselves or ask a friend to buy. See clinics as judgmental.	Feel peer pressure not to use condoms ("boys are tough"); accessing services is "shameful," especially if seen by elders.	Strong sense of shame and secrecy; parents often advise abstinence rather than contraception. Girls are more closely monitored by their families; buying contraception is especially stigmatised.
Consent & Autonomy	Believe contraception use is a personal choice, but often defer to partner's wishes. May send friends to buy condoms.	Fear of being seen as "promiscuous" if they seek contraception. Parental consent issues are common for those under 18.	Less likely to discuss contraception openly; some report not using condoms even if they wish.	Little autonomy; need parental or partner approval. Many girls use contraception without telling partners or families (injections, pills).
Other insights	May not connect contraception use to STI/HIV prevention—see it only as prevention for pregnancy.	More likely to connect with both pregnancy and illness prevention, but may not use unless already sexually active or after pregnancy.	Use traditional remedies as the main preventative method. Sex education is minimal.	Learn about body changes early, but not about contraception until after marriage/ pregnancy. Community gossip is a strong deterrent to accessing SRHR.

Resistance to family planning is pronounced among those with strong religious beliefs - even within marriage. Some female parents warn that seeking contraception will lead to "trauma and regret," with one expressing, "There are side effects if she takes contraception at a young age. If the mother allows the girl to take contraception, she is opening the door for the daughter to waste her life." Others invoke religious sanctions, stating, "God will punish you if you sin," and "If you are encouraging contraceptives, that means you are opening the door to Satan to destroy your life. It is in the bible." A female respondent in Viria explains, "There will be no need for us to visit SRHR services if my family learns the word of God." Despite these strong views, some mothers quietly assist their children in accessing contraception and care.

Some Christian leaders personally support family planning to protect maternal health and prevent STIs/HIV, but emphasise abstinence if unmarried. For Catholics in particular, contraception is viewed as "a big no-no." Community leaders report that awareness campaigns on contraception can be misinterpreted as promoting extramarital affairs or being incompatible with religious values. However, some church leaders are open to collaborating with external partners for awareness and information sessions, provided the message is sensitive to cultural and religious contexts.

6.1.5. Part 1 Conclusion

In conclusion, Part 1 highlights persistent and complex challenges affecting SRHR knowledge and access among youth in Fiji's diverse communities. Cultural taboos consistently constrain comprehensive sex education, limited teacher preparation, social stigma, and resistance from families and faith groups—leaving knowledge superficial and patchy, particularly for girls and youth with diverse SOGIESC. Adult discomfort means schools narrowly restrict content, while most youth rely on informal, often unreliable sources. Stigma and confidentiality concerns at clinics, especially for girls and marginalised groups, limit access to contraception, testing, and care, resulting in missed opportunities for prevention and early intervention. Financial barriers, community scrutiny, and unclear consent requirements further undermine effective use of SRHR services, especially in rural and remote areas.

While myths and misinformation flourish in all settings, rural youth face stronger traditional pressures, and urban youth grapple with rapidly spreading digital myths. Young people with disabilities and sex workers endure compounded discrimination and exclusion, confirming global concerns about stigma underlined by the UN Human Rights Council. Despite some promising efforts—such as emerging partnerships with faith leaders, provincial council planning, and peer-led and NGO outreach—progress is slow and fragile, with deeply rooted cultural, religious, and gender norms still limiting SRHR knowledge, confidence, and autonomy among Fiji's youth. The next section examines the role of religious teachings and cultural practices in shaping these dynamics.

Across Fijian communities, several entrenched gender norms present significant barriers to access to SRHR. These include expectations regarding female purity, silence and shame around sexuality, male authority in relationships, and strict controls over girls' bodies and choices. These have been structured to illustrate how they perpetuate the current situation

6.2. Part 2: Norms

Across Fijian communities, several entrenched gender norms present significant barriers to access to SRHR. These include expectations regarding female purity, silence and shame around sexuality, male authority in relationships, and strict controls over girls' bodies and choices. These have been structured to illustrate how they perpetuate the current situation of high teenage pregnancy and STIs.

6.2.1. Social and Gender Norms

Across Fijian communities, several entrenched gender norms present significant barriers to access to SRHR. These include expectations regarding female purity, silence and shame around sexuality, male authority in relationships, and strict controls over girls' bodies and choices. These have been structured to illustrate how they perpetuate the current situation of high teenage pregnancy and STIs.

Norm 1: Virginity and Female Purity Before Marriage

Normative: Girls are expected to remain virgins until marriage to "protect family honour"; virginity is not seen as equally necessary for boys.

Empirical: Many adolescents are sexually active before marriage, with the youth themselves acknowledging that sex before marriage is common despite the ideal. Girls' (15–19) pregnancy rate is high at 49 births per 1,000.

Sanctions: Girls risk public gossip, loss of marriage prospects, violence, forced marriage, or even suicide if they are found to be sexually active or pregnant before marriage. Boys, in contrast, are either ignored or quietly condoned.

SRHR barriers created or reinforced: This norm prevents open discussion, reduces girls' ability to access contraception, and enforces secrecy and risk-taking. Girls choose unsafe options and avoid seeking help or information.

Norm 2: Silence and Taboo Around Sex and SRHR

Normative: It is taboo to openly discuss sex, contraception, relationships, or menstruation with children and among community members.

Empirical: Many young people access information from peers, phones, social media, teachers, and health workers. Mothers often quietly advise their daughters, and some parents are starting to open up despite societal taboos.

Sanctions: Community gossip, shaming, backlash against parents/teachers who share information; fear of damaging reputation for "talking openly."

SRHR barriers created or reinforced: Lack of accurate, timely information contributes to myths, misinformation, early pregnancy, risky sexual behaviour, and limited use of services.

Norm 3: Gender Double Standards—More Surveillance for Girls

Normative: Girls must remain virgins until marriage; girls' sexuality is tightly controlled and policed. Boys' sexual activity is tolerated or seen as usual.

Empirical: Both girls and boys are sexually active before marriage, but only girls are sanctioned; girls secretly access contraception, but face a higher risk of expulsion from school, home and community, forced marriage, and disownment.

Sanctions: Gossip, loss of marriageability, family rejection, forced marriage, physical punishment (including violence), and social isolation for girls only.

SRHR barriers created or reinforced: Girls have less agency, greater fear in seeking SRHR services; families may block or refuse to support them; boys are not held accountable.

Norm 4: Male Authority in SRHR Decisions
Normative: Husbands and fathers are primary decision-makers in matters of contraception, pregnancy, healthcare, and sexual relationships.
Empirical: Some women and girls still defer, but increasing numbers make decisions secretly or independently, often hiding contraceptive use or seeking health services alone.
Sanctions: Reprimand, loss of relationship, domestic violence, community disapproval, accusations of being "disrespectful" or "disobedient" if women secretly take contraception.
SRHR barriers created or reinforced: Decreases women's bargaining power and limits uptake and effective use of contraception and services, especially for unmarried women.

Norm 5: Marriage as the Only Legitimate Setting for Sex and Childbearing
Normative: Sex, contraception, and pregnancy are only appropriate within marriage; early/forced marriage may be used to "resolve" premarital pregnancy.
Empirical: High rates of teenage pregnancy and premarital sex show that this ideal is not universally practised.
Sanctions: Girls are sometimes forced into marriage, expelled from school, or rejected by their families.
SRHR barriers created or reinforced: Promotes abstinence as a strategy for those who are unmarried and reduces CSE and informed decision making.

Norm 6: Elders as the Sole Authority and Reluctance to Share Power
Normative: Only elders/leaders (chiefs, pastors, male community heads) are permitted to speak or make decisions about sexuality, relationships, and health.
Empirical: Some younger leaders, wives of pastors, and health workers take initiative, and youth want more inclusion. Elders' authority is still strong in public settings.
Sanctions: Public discussions or innovations led by youth, women, or outsiders may be dismissed or not taken seriously.
SRHR barriers created or reinforced: Hampers youth-led outreach, peer-to-peer education, and open dialogue, thereby perpetuating the status quo.

Norm 7: Religious Doctrine as the Final Word on SRHR
Normative: Religious teachings define and limit acceptable sexuality and SRHR—"no sex before marriage," "contraception and abortion are a sin," and only God should decide the number of children.
Empirical: Many recognise the tension between doctrine and behavioural realities; some reinterpret or seek supportive religious champions, but official statements remain barriers.
Sanctions: Condemnation by church leaders, loss of standing in the faith community, and exclusion from church activities. Particularly for those that don't conform to the 'norm', e.g. people with diverse SOGIESC, sex workers and people with disabilities.
SRHR barriers created or reinforced: Restrict the introduction of comprehensive sexuality education, hamper contraception and SRHR messaging unless framed as compatible with faith.

Norm 8: Shame and Confidentiality—Seeking SRHR Services is Embarrassing and Risky
Normative: Approaching health services for contraception or SRHR raises suspicion, gossip, or ridicule; these services are "not for respectable people."
Empirical: Some youth and women navigate secrecy or use remote/anonymous services, but many avoid local clinics for fear of being seen.
Sanctions: Laughter, ridicule from pharmacy staff, gossip among peers and family members, and loss of privacy.
SRHR barriers created or reinforced: A major deterrent to accessing vital services, testing, or products.

Norm 9: Violence or Coercion in Sexual Relationships
Normative: Men have the right to demand sex in marriage; refusal may be met with violence or forced compliance, and marital rape is not recognised as a crime.
Empirical: Sexual and gender-based violence (SGBV) and sexual coercion are commonly linked to SRHR denial; some women report abuse for using contraception or refusing sex.
Sanctions: Physical and emotional violence, sometimes justified by tradition or faith narratives.
SRHR barriers created or reinforced: Acts as a silencing, controlling, and traumatising force for women and girls, daunting for change agents.

6.2.2. Shifting Cultural Norms that are Barriers

A combination of exposure to media and the internet, education programs, youth peer networks, women's leadership, urbanisation, intergenerational dialogue, and proactive health worker engagement can gradually weaken restrictive social expectations. These influences provide alternative perspectives, foster critical reflection, and offer safe spaces that support questioning and negotiation of norms over time. Change also depends on deliberate, locally grounded efforts. This section presents examples from Fijian communities that have begun to transform restrictive social expectations around SRHR:

- **Family dialogue and quiet acts of resistance:** Some mothers in both iTaukei and Indo-Fijian communities accompany daughters to clinics or maintain open communication about contraception despite prevailing taboos. These actions demonstrate that change can begin within families, often driven by personal experiences and challenges.
- **Intergenerational and peer education:** Progress occurs when older siblings, youth leaders, or young teachers facilitate discussions following NGO or Ministry of Health workshops. Serving as trusted information brokers, they help bridge generational gaps and normalise open debate.
- **Community awareness and outreach:** Health workers and NGOs—particularly in urban and peri-urban areas—have created safe spaces for youth dialogue, increased service use, and challenged silence and stigma around SRHR through awareness campaigns. Separate sex groups were also noted to be effective because they allow everyone to ask questions without the fear of judgment.
- **Female leadership and champions:** Training and support for women's leadership have enabled some to speak publicly about SRHR, redefining norms around authority and voice in community meetings.

- **Flexible responses to crisis:** Families who support daughters after premarital pregnancies —by helping them return to school or caring for grandchildren—show that compassion can coexist with cultural tradition, offering new pathways to acceptance.
- **Evolving teacher and school practices:** Educators trained by external partners rather than the education or health department are more confident in addressing SRHR topics. Some schools employ external facilitators or use gender-segregated sessions to create a comfortable environment for discussion.

These examples collectively demonstrate how small acts of defiance, peer education, community outreach, empowered female leadership, supportive family responses, and adaptive teaching practices work together to erode stigma and silence. They highlight how local leadership, relevant education, and supportive networks drive gradual shifts in norms that restrict SRHR.

6.2.3. Religion, Cultural Norms and Traditions: A Complex Relationship

In this study, we investigated whether the roles of religion, cultural norms, and traditions can be separated and discovered that in Fiji, they are so closely interconnected that it is nearly impossible to separate their influence when analysing barriers to SRHR. For example, the expectation of female virginity until marriage is shaped by Methodist and Catholic teachings in iTaukei communities, while also being reinforced through cultural practices tied to family reputation and honour. Likewise, the norm of male authority in relationships—and in decisions about contraception or sexual activity—is supported by church teachings that emphasise male leadership and by deeply rooted patriarchal traditions.

The taboo surrounding discussions of sexuality is not solely a product of religious prohibition —where subjects like premarital sex and contraception are framed as sinful—but is further sustained by cultural expectations around respect and modesty, which parents, elders, and community leaders enforce. In cases where restrictions on girls' movement or dress appear strictly traditional, religious justification is often invoked alongside appeals to cultural propriety. Indo-Fijian families add further layers of complexity, as religious diversity leads to varying barriers. Some Hindu and Muslim communities demonstrate pragmatic approaches to contraception, yet all groups reveal how faith and ethnic identity are entwined with cultural traditions.

Evidence consistently shows that barriers to SRHR stem from a system in which religion, norms, and traditions reinforce one another, creating layered obstacles to progress. Each element draws legitimacy from the others—whether in controlling sexuality, limiting female autonomy, or enforcing silence. Addressing SRHR challenges requires engagement with this entire matrix, rather than treating any component in isolation. The persistence of these barriers is due to their interdependence and sustained reinforcement. Religion may provide the moral foundation, but cultural practices and social realities determine everyday behaviours—sometimes amplifying, adapting, and occasionally overriding doctrine in favour of pragmatic solutions. Examples from community data indicate that families may privately support SRHR, despite publicly adhering to traditional or religious expectations, revealing nuances and adaptations that must be considered in intervention design.

6.2.4. Part 2 Conclusion

In conclusion, social and gender norms around sexuality and reproductive health in Fiji exert a powerful—often restrictive—influence on young people's beliefs, behaviours, and opportunities for SRHR. Descriptive and injunctive norms combine to sustain gendered double standards, the policing of female sexuality, silence around sex, and a hierarchy that privileges elders and religious authorities in decision-making. These expectations, deeply intertwined with faith and culture, perpetuate stigma and fear, leaving girls and other marginalised groups especially susceptible to shame, exclusion, and risk.

Yet, Fiji's experience also shows that small changes at family, peer, community, and institutional levels can begin to unravel these entrenched patterns. Supportive mothers, youth leaders, trained teachers, and pragmatic faith champions are quietly but steadily shifting norms—sometimes defying tradition to create new spaces for information, dialogue, and care. Change is slow and complex, as religion and tradition reinforce one another. Still, it is possible when strategies are grounded in local realities, responsive to context, and purposefully inclusive of those most excluded. The path forward for SRHR in Fiji depends on harnessing these emerging catalysts, working within and across cultural and faith boundaries, and fostering collective courage to reimagine—and realise—healthier, more just norms for all.

6.3. Part 3 Religious Teachings and Cultural Practice

Religious teachings in Fiji exert a strong and specific influence on attitudes toward family planning and sex education across all communities included in this study. The dominant narrative, rooted in both Christian and iTaukei traditions, promotes abstinence until marriage and frames sexual activity outside of wedlock as sinful. In most iTaukei and Christian communities, particularly those of Catholic and Methodist faiths, abstinence until marriage is framed as both a religious and social ideal. Clergy and parents regularly reinforce these expectations, emphasising the idea that "sex is only allowed when two are married; from God, premarital sex is not allowed, it is a sin." This framing leads many families and religious leaders to avoid open conversations about sexuality and contraception entirely, a silence that often results in confusion, shame, and a lack of accessible, accurate information—especially for girls.

Yet Fiji is changing rapidly in multiple ways, which is affecting how religious norms are practised. In focus group discussions, community members mention that "things are changing" with respect to marriage practices and that the "cost of getting married these days is so high—people just stay together or delay." In several interviews and FGDs from iTaukei communities, respondents comment on cultural shifts, noting that while marriage remains important, financial pressures and changing attitudes are leading some young couples to delay formal ceremonies or choose cohabitation until they are more established. This is sometimes linked to migration for work or education, as well as to the high cost of traditional ceremonies.

However, for marginalised groups—including people with disabilities, people with diverse SOGIESC, and sex workers—religious teachings can present particularly acute challenges in accessing nonjudgmental SRHR information and services. Faith leader discourse often reinforces stigma and shame; as one young person with diverse SOGIESC explained, "They always preach about abstinence… and say we [SOGIESC] are the ones who are spreading HIV." Transgender youth described feeling compelled to hide their true selves: "In church, they tell you it is not natural to be like that, so I do not talk about my true self. I just stay quiet or leave the group." For people with disabilities, exclusion is also pronounced: "In our congregation, people with disabilities are not expected to need contraception or talk about sexual health—so when you ask, people stare or whisper." Discourse from church leaders and elders often exacerbates exclusion and blame—"Most will not help, or they will blame you"—while many sex workers avoid church clinics entirely for fear of judgment and gossip. These lived experiences highlight how religious stigma can sharply limit access and confidence for vulnerable and marginalised populations within Fijian communities.

6.3.1. Differences by religion

Across all religions, the authority of religious doctrine and leaders significantly influences individual and community attitudes, with judgments about SRHR often intertwined with notions of family honour, gender roles, and community reputation. Yet, within each religion, there can be significant variation based on local custom, individual leaders' openness, and regional differences, particularly between urban and rural congregations, as summarised below and in Table 9.

Catholic doctrine strictly opposes premarital sex, modern contraception and abortion, permitting only natural family planning methods. This is reflected in community practice, where "family planning is about knowing the cycles, not using pills or injections," and any deviation brings strong resistance: "If you are young and unmarried and you go to the clinic for condoms, the community will say you are a sinner." A Catholic elder stated unequivocally, "Sex before marriage is not allowed, and contraception—unless you follow the rhythm method—is against the teachings of the church." Another Catholic parent reinforced, "We do not talk about abortion, it is a grave sin… even birth control pills are not accepted in our family unless you are married." Another explains, "No matter the reason, abortion is killing—you must face God."

Methodist and other Protestant church leaders often share these abstinence and anti-abortion views, though rules on contraception are somewhat less absolute. One Methodist pastor explained, "We prefer our young people to wait until marriage. Contraception is for husband and wife, not for the youth. Too much sex talk is not healthy." In practice, doctrinal teachings shape the limits of public and private conversation, with clergy and elders exerting a strong influence over youth: "In our youth group, the subject is purity and discipline, not about condoms or family planning," shared a Methodist youth leader.

Although most church communities maintain SRHR discussions within the boundaries of biblical teachings and spiritual purity, some isolated faith leaders are beginning to advocate for openness and dialogue. As one rural Methodist pastor reflected, "It is time we talk more openly—children need guidance, and churches must help." Even so, the dominant narrative remains conservative, emphasising biblical values and discipline over inclusive sexual health education.

Hinduism in Fiji presents a distinct approach to SRHR, differing from many Christian denominations. Traditionally, Hindu teaching is less prescriptive about contraception, with greater openness to family planning. One Indo-Fijian Hindu parent explained, "There is no problem if husband and wife use contraception—we talk about these things for the health of the mother and the welfare of the children." Historical emphasis on managing fertility and sex for pleasure (e.g the Kama Sutra) result in less doctrinal resistance: "Our religion does not tell us not to use these methods; it is our choice."

While cultural expectations around abstinence before marriage remain strong, sexuality is generally viewed as a natural part of life, especially within marriage. Parents sometimes cite traditional wisdom: "In our books, it is written that love and pleasure are part of marriage—it is not something we should be ashamed about." Open discussions about SRHR topics are more common in Indo-Fijian communities, as one adolescent shared, "My parents talk about menstruation and contraception—they want us to understand because it's better to be safe." However, stigma and silence can persist, especially in more conservative or traditional families: "Some homes are still very strict—you cannot talk about sex at all, and even mentioning family planning brings shame." These perspectives show both openness and ongoing barriers within Hindu communities in Fiji.

In Fiji's Muslim communities, SRHR norms and contraceptive use are guided by religious teachings that permit contraception within marriage but prohibit sex before marriage and abortion except to protect the mother's health. Family honour and modesty are paramount, so unmarried young women typically face restricted access to SRHR information and services. One Muslim parent explained, "We do not allow sex before marriage and contraception is only for the married—if you ask about these things in our house, it will bring shame." Another community leader noted, "It is not the right thing for girls to be given contraception before marriage. The family will be questioned and people will talk."

Open discussion about SRHR and contraception outside marriage remains rare, with families and mosques treating these as private and sensitive matters. "These topics are not discussed freely; you must talk quietly between mother and daughter," shared an Indo-Fijian Muslim mother. Even within marriage, some women report needing partner or family approval for contraception: "My husband must agree before I take any pills—he needs to understand why."

Data and interviews suggest that contraceptive use among unmarried Muslim women is very low, both due to cultural beliefs and real fear of stigma. As an unmarried Muslim youth recounted, "Even if I wanted to use contraception I would not dare ask—there is gossip and judgment if you do." Health workers supporting Muslim communities also describe reluctance: "Most unmarried Muslim girls are afraid to ask for contraception—they worry the nurse will know their family or it will get out." Within marriage, however, contraception is more

widely accepted, often valued for birth spacing and health reasons: "After my second child, I started using the injection because my health worker explained it is allowed—it is for my health."

While acceptance of contraception among married couples is growing, particularly for maternal health and family planning, pervasive stigma and silence mean unmarried women rarely seek information or services. Community norms prioritise protecting reputation and modesty over open dialogue or proactive care, leaving many young Muslim women under-informed and at risk. As one unmarried Muslim woman shared, "If you go to the clinic and ask for contraception before marriage, everyone will talk about you and say you have no respect. It is better to keep quiet and not shame your family."

Table 9: Religion & Location Contraceptive Preferences

Community / Ethnic & Religious Group	Contraceptive Methods Commonly Used	Key Distinctions and Attitudes
iTaukei/ Methodist (rural/ traditional villages)	Condoms, injectables (for married women), herbal/traditional methods, calendar/rhythm method	Condom use is highly stigmatised, especially for youth and unmarried; injectables/pills are mostly for married women; herbal methods are used for discretion; strong religious opposition to contraception outside marriage
Indo-Fijian/ Hindu (rural and urban)	Condoms, pills, injectables; some herbal/traditional remedies	Pills/injectables preferred for married women; condoms sometimes used by men; cultural emphasis on fertility, but access in urban areas can be easier. Herbal/traditional remedies are occasionally used for privacy
Muslim Communities	Pills, injectables, condoms; some natural/traditional methods	Preference for female-controlled methods in marriage; contraception outside marriage is taboo; herbal methods are used to avoid community scrutiny or when religious restrictions are strong
Catholic (rural and urban)	Rhythm/calendar, withdrawal method, limited condom/pill use	Strong religious discouragement of "artificial" contraception; natural methods favoured due to doctrine; limited acceptance of condoms and pills, mainly for health reasons and usually within marriage
Urban Mixed/Youth (all backgrounds)	Condoms, pills, emergency contraceptive pills, injectables, and traditional methods	Condom use is more common among urban youth, but they still use covert strategies (masks, friends buying for them); pills/injectables are popular for discretion; herbal/traditional methods are still present for confidentiality and privacy.

6.3.2. Views of religious leaders

Analysis of responses from religious leaders across the datasets reveals consistent patterns, as well as notable overlaps and contradictions between and within faith communities. Across Christian, Methodist, and Catholic leaders, there is a clear consensus that sex should be reserved for marriage, with strong concerns about premarital sexual activity and contraception outside marriage. A Methodist leader shared, "Sex before marriage is a sin, and contraception encourages young people to be promiscuous." Similarly, a Catholic respondent noted, "Family planning is important, but only within marriage—otherwise, it goes against our beliefs."

Among Muslim leaders, both overlap and contradiction are apparent. In some locations, leaders support women's decision-making and access to contraception: "If a woman wants to use contraception, that should be her right, especially for her health," said one Muslim leader. However, others discourage contraception for unmarried women or emphasise the need for partner approval: "Girls should not use birth control on their own; their husband needs to agree." This variability demonstrates that even within a single religion, attitudes can diverge geographically or by community tradition.

There is also significant overlap between Methodist and Catholic leaders, who both endorse family planning—but usually only within marriage and with a moralistic framing. One Catholic leader explained, "We talk about family planning because the mother's health is important, but we must remember it is a gift from God, and so there are boundaries." Methodists often share this perspective, warning, "Contraception is not for the unmarried; it is only to protect women within marriage."

Upon closer examination, the village and community context reveal further differences within faiths. Methodist and Muslim leaders from different locations express wholly opposing views regarding contraception before marriage and women's autonomy—one stating, "Girls must make their own choices," and another insisting, "That is not allowed here." Some Methodist and Catholic leaders in particular villages are open to discussing family planning and health: "We encourage families to talk with health workers about spacing children," said a village Methodist elder. Elsewhere, however, these same topics remain taboo: "In our community, we do not speak of these things," remarked another Methodist leader, highlighting intra-religion contradictions. Some of the most striking contradictions are found within religions themselves. These patterns highlight the complex, varied, and sometimes contradictory ways in which faith influences SRHR norms and guidance across Fiji.

6.3.3. Evidence of change among religious leaders

The data reveal a trend toward pragmatic support for SRHR initiatives and encouraging discussions on difficult SRHR topics. "Our talatala pastor is looking to introduce hard topics in church, like family values, pornography, all those things," shared one parishioner, inviting external organisations into church activities was positively received, showing how inclusive attitudes foster acceptance. Some Methodist and Assemblies of God (AOG) leaders now support comprehensive sexual health education for youth, recognising the value in preventing

teen pregnancies and STIs: "Modern education on sexual health over traditional knowledge... helps protect children from early pregnancy and other risks," said an AOG leader, who endorses awareness campaigns across churches, schools, and communities. The Methodist leader added, "I support the use of contraception, like condoms, to reduce STIs and HIV," revealing a personal openness. Still, faith leaders stress that SRHR initiatives must be delivered with respect and sensitivity, advocating for local language and culturally appropriate messaging to foster greater accessibility and acceptance.

Across the country, progressive faith leaders are increasingly making meaningful contributions to SRHR education and youth support. In Kese, church leaders stress the importance of family-based counselling and open, community-wide conversations: "Community leaders can have discussions... counselling from home, protecting youth and more family time, more awareness with the whole community." This openness, combined with nonjudgmental attitudes towards young people's health choices, empowers youth to feel in control: "He should not be embarrassed because it is his life... Religion (church) does not determine his health choices." Interfaith leaders in Siberia, spanning Imam, Pandit, and Christian clergy, demonstrate support for health education and broad community engagement: "Teachers, parents, pandits, and community leaders should be the champions... communities should talk openly about these things."

In Naboutini, Catholic and other church leaders are bridging generational divides, noting positive change over time: "Allow me to take us back to 2000... if someone started it up, it was not allowed to be spoken. Now, it can be talked about with leaders and youth." Faith leaders in Viria create safe spaces and train teachers, allowing youth to seek guidance and tackle stigma privately: "Youth come to the teacher privately to ask questions," and leadership training helps educators "address stigma and overcome the taboos and gain confidence." In Nasekula, pastors and elders advocate for sex education grounded in moral values and effective parent-child communication: "Everyone, including church leaders, is in favour of sex education... to open the minds of children and to be able to talk to them about sex and relationships."

On a national level, partnerships with faith-based organisations are increasingly driving inclusive discussions and supporting local champions: "We need more inclusive discussions... if there are local champions... they can be utilised in awareness programs to support young people who have this fear." Some faith leaders now embrace family planning to safeguard maternal health: "Family planning is important in protecting mothers from health issues associated with frequent childbirth," noted an AOG church leader, adding, "My church does not oppose family planning." Many are increasingly open to collaboration with the Ministry of Health and NGOs, seeking expert-led education sessions. A Methodist leader highlighted, "organisations like the Ministry of Health should provide information to prevent risky situations," and described inviting experts to church events as "a positive and effective step for reaching youth." Together, these shifts highlight the pivotal role faith leaders can play in normalising SRHR dialogue and expanding youth access to information and support.

6.3.4. Part 3 Conclusion

Religious doctrine in Fiji acts as both a direct and indirect barrier to SRHR, shaping individual attitudes, reinforcing community norms, and limiting open dialogue, policy development, and service delivery. Abstinence messaging dominates, and resistance to contraception and school-based sex education frequently stems from active religious teachings and their pervasive influence on family and social life. Silence and taboo around sexuality are systematically reinforced, with the most restrictive environments often found in iTaukei Methodist and Catholic communities. As one participant noted, "Girls and boys are treated differently. When a boy has sex before marriage, the community accepts it. If it is a girl, they will gossip about her."

The denominations differ in ways that affect advocacy and messaging. Catholicism maintains the strictest stance, rejecting modern contraception and abortion while discouraging sex education and unmarried youth's access to SRHR services. Methodist and other Protestant Christians are similarly conservative, though some allow contraception for married couples; premarital sex and abortion remain strongly taboo. Hindu communities tend to be more open to family planning and communication, maintaining conservatism around premarital sex yet allowing more space for parent-child discussion. Muslim communities prohibit premarital sex and abortion, emphasising marital sexual activity, but may offer nuanced acceptance of contraception within marriage. Notably, Indo-Fijian Hindu and Muslim families, while upholding abstinence, often approach reproductive health pragmatically, with mothers discreetly aiding their daughters' needs.

Encouragingly, a gradual change is evident as faith leaders adopt pragmatic, culturally sensitive approaches, collaborate with health authorities, and support open discussions. These efforts are helping create safer, more informed environments for youth and families, and advancing progress in sexual and reproductive health. To achieve SRHR for all, future programs in Fiji must address the complexities of religious doctrine and culture, equipping faith, community, and health leaders with the tools to provide empathetic, inclusive support. Only by fostering nuanced, culturally sensitive engagement can SRHR interventions gain widespread church support and drive meaningful, lasting change.

6.4. Part 4: Cross-Cutting Themes

This section explores what our research can tell us about the extent to which violence against women and girls, their lack of leadership and decision-making, play a role in SRHR access.

6.4.1. Sexual and Gender Based Violence

In Fiji, the prevalence of sexual and gender based violence is high, and the forms of violence are varied, affecting women, girls, sex workers, and people with diverse SOGIESC individuals across many levels: physical, emotional, sexual, and economic (Table 10).

Table 10: Violence Statistics for Fiji

Form of Violence	Statistic	Key Details/Notes
Lifetime physical and/or sexual IPV	61% of women	Fiji has one of the highest prevalence rates globally (FWCC, 2013).
Current IPV (last 12 months)	24% of women	Currently partnered women reporting recent violence (FWCC, 2013).
Child sexual abuse (before age 15)	16% of all women	Most prevalent form of sexual violence reported (FWCC, 2013; UNFPA, 2014).
Physical violence ever by a partner	66% of women	Fiji Women's Crisis Centre (FWCC, 2013).
Physical violence while pregnant	44% (of those abused)	Among women experiencing IPV (FWCC, 2013).
Emotional/psychological violence	71% of women	Most reported emotional violence from a partner or household (FWCC, 2013).
Domestic violence reported to police (2007)	457 cases	82% of victims were women; many unreported (FWCC, 2013; Fiji Police, 2007).
Sexual violence by a non-partner	1 in 5 women	Includes attempted and completed acts (FWCC, 2013; UNFPA, 2014).
Economic violence	Not quantified	Includes financial control, deprivation, and exclusion (FWCC, 2013).
Estimated cost to Fiji's economy	FJD $300 million/year	About 7% of GDP (IFC, 2020).
Acceptance of violence (attitudinal)	8% of women, 16% men	Justification for wife-beating in some scenarios (FWCC, 2013).

Participants describe intimate and family violence as "normalised," grounded in cultural and religious beliefs that reinforce patriarchal control, male entitlement, and the silencing of women's voices. A leader from Viria said, "Married women should submit to their husbands; it is in the Bible." A married woman explained, "Sometimes when I don't want to have sex, he beats me up." A married man explained: "If your wife doesn't listen, give her a punch. That's the culture. That's the way we do it," underscoring the normalisation of abuse within households and communities**.**

Violence is most often triggered when women attempt to assert autonomy—refusing sex, negotiating contraceptive use, or seeking SRHR services. Tactics include coercion, emotional abuse, threats, physical harm, forced or early marriage, and social exclusion. Several respondents explained that manipulation and non-consensual sex lead to teenage pregnancy. For girls and young women, mere suspicion of sexual activity outside marriage can result in severe psychological harm or even suicide attempts.

For sex workers, violence is exacerbated by legal barriers, stigma, and a lack of state protection. Sex work is illegal in Fiji under the Crimes Act 2009 and related provisions of the Laws of Fiji, which criminalise selling sexual services, solicitation, brothel-keeping, and living off the earnings of prostitution. For male and female sex workers, violence is not only routine but systematic, with stories of sexual assault, extortion, and targeted attacks. "Despite the criminalisation, it hasn't stopped any sex worker from accessing services, but stigma and abuse remain," one respondent emphasised. Some sex workers report that male clients or partners feel entitled to violence, and police protection is often unavailable or hostile. In the tourism sector, local girls engaging in sex work face increased risks of rape and exploitation, compounded by the "exchange of alcohol, drugs, and money for sex" and the absence of safe reporting channels. Physical and sexual violence, including rape, verbal abuse, and police harassment, was described as "common", with perpetrators rarely held accountable.

People with diverse SOGIESC experience heightened risk alongside pervasive stigma. An advocate reports: "There is a lot of sexual violence against lesbians and gay people ... they get a different treatment judging by the looks of health workers ... Just because of their SOGIESC identity." Another explains, "They target us because we look different, especially trans girls. Sexual violence is common, even at parties or the street" (Transgender youth, Suva). The respondents explain how common community violence is for them: "In my community, being out means risking violence—I have been beaten before for 'acting gay'" (Male, SOGIESC Kese). Some families reject individuals with diverse SOGIESC, even chasing them from their homes: "My family found out I was gay, and they said, 'leave the house, you are shaming us.' I had to start living with friends" (Lesbian youth, Labasa). Other "families are accommodating. It differs for different people. But it's the comments, how people judge them ... it may be a joke, but we are not seeing the psychological impact on the person," one key informant explained. An individuals with diverse SOGIESC explains the emotional impact arising from religious rejection: "When they found out that I was a lesbian woman, they sacked me from the church. I have never returned to church since that time until now. I just pray at home ..." Such exclusion from faith spaces magnifies isolation and mental health risks.

Women and girls with disabilities in Fiji face severe violence and deep stigma in communities. A health worker in Naboutini recounts, "People take advantage of disabled girls because they know they can't fight back or call for help, and sometimes, nobody wants to believe their story." Health workers and NGO staff across different communities recounted cases where women with disabilities are raped: "When a woman with disability is raped in the village, she becomes pregnant, she's stigmatised by society or even the church just because of getting pregnant, but it was not her fault." Another key informant from the Northern Division says, "If a disabled girl gets pregnant, they blame her or say she must have been careless, instead of treating her with care." A woman with a disability in Siberia explains why cases are not reported: "Reporting violence brings more problems. The family will blame you, and the community will gossip. Some just tell you to pray and forgive." A Disabled young woman, Naboutini, concurs, "Nobody wants the shame. If the police come, everyone finds out, and you are left alone and judged." These quotes show how violence, rape, stigma, blaming, and a lack of support deeply affect disabled women and girls within their home communities.

Survivor-centred care is rare, leaving many victim-survivors to return to abusive households out of economic necessity or fear. A Kese health worker explains, "Unmarried youth and sex workers experience violence, but rarely report it. The victim-perpetrator relationship discourages discussion." This resonates with a Sex worker from Suva, "I know some girls who went back to live with the abuser because they had nowhere else to go. The church tells them to forgive, but the violence doesn't stop." A Health worker from Kese explains that "We have heard about cases, but the girls stay silent—they do not trust the system or fear losing support from family." A Naboutini youth said, "If I complain, they will say I am lying or just want attention— it's better to keep quiet and stay safe." A young woman from Suva explains, "People say, 'you must have done something wrong'—it's always the girl's fault." Reports of rape are low due to shame (madua), fear of gossip, and the threat of increased violence if complaints are lodged. Barriers to justice and support are compounded by a lack of confidentiality at clinics, the absence of safe spaces, and persistent community and provider judgment.

Data linking teenage pregnancy to violence, a lack of autonomy and fear were found, along with forced or pressured sex, physical punishment, family rejection, and blame for violence or pregnancy: "Some boys try to force girls to have sex. The community may know but keeps quiet, blaming the girl for being 'bad' or 'asking for it'" (Female youth, Kese). This leads to situations where girls have sex with boys out of fear: "Some girls only say yes because they are pressured or scared. If they refuse, sometimes the boy or even the family will beat them" (FGD, Siberia). Families can physically hurt their daughters for having sex: "A girl gets scolded or even beaten by her father or brother if they find out she's been with a boy. For boys, nobody will say anything" (Parent IDI, Kese). Girls face additional violence if they get pregnant: "If a girl gets pregnant before marriage, the whole family is shamed, and sometimes the mother will say hurtful things or even send her away" (Female youth, Nasekula). Pregnant girls have also committed suicide because they are pregnant: "There are cases in the village where girls run away or even try to harm themselves because they are afraid of what will happen if their family finds out" (Health worker, Naboutini). These quotes illustrate the pervasive risks and real

consequences for girls when sex, violence, and social norms intersect—including forced or pressured sex, physical punishment, family rejection, and blame for violence or pregnancy.

The evidence presented in this section underscores the pervasive and multifaceted nature of SGBV in Fiji. High rates of intimate partner violence, child sexual abuse, and emotional harm affect women, girls, sex workers, people with diverse SOGIESC, and persons with disabilities, sustained by entrenched cultural, religious, and societal norms. Violence is often normalised or justified within families and communities, leaving victim-survivors isolated and fearful of reporting due to shame, stigma, and lack of safe, confidential support. The cycle of abuse is compounded by legal barriers, discriminatory attitudes, and insufficient survivor-centred care, with economic and social dependence limiting pathways to safety and justice. For those who challenge prescribed roles or seek autonomy—whether through asserting sexual and reproductive rights, rejecting violence, or claiming space as a person with diverse SOGIESC or disablities—the risks and consequences can be even greater. Across the data, participants consistently emphasise the urgent need for safe spaces, survivor-centred support, greater legal and social accountability, and decisive action to eliminate attitudes that justify or excuse violence.

6.4.2. Leadership Norms

Across both iTaukei and Indo-Fijian communities in Fiji, deeply embedded family structures and local governance consistently privilege male authority, sidelining women and youth from substantive participation. In iTaukei villages such as Siberia, Naboutini, and Kese, councils known as bose vaka koro and extended family arrangements visibly centre men as decision-makers. Women are often "relegated to the background" with only limited or supportive input. Male elders tightly control not just the meeting agendas, but also who is allowed to speak, particularly when addressing sensitive issues like sexuality, violence, and SRHR.

A pervasive silence also characterises Indo-Fijian communities, where—despite differences in social structure, with a greater emphasis on family gatherings and religious institutions—women are similarly expected to remain deferential or silent, especially in public and religious settings. As one participant noted, "elders maintain control," with "fathers or uncles mak[ing] the main decisions, and women support or keep quiet." The forums may differ—formal village councils for iTaukei, family or religious leadership for Indo-Fijians—but the exclusion of women and girls remains a common and persistent feature.

Rigid gender roles, enforced taboos, and the overarching power of elders are sustained through several explicit mechanisms: controlling speech, dictating the rules of engagement, upholding silence and secrecy, and restricting the flow of information. Young people, too, are marginalised: "Hardly any teenagers are present at community meetings." Elders often invoke religious and cultural traditions to justify their authority and resist reforms that could empower women or youth. One villager confessed, "Only males are allowed to talk on such occasions, and women's input is not considered."

Gatekeeping of information and public discourse on SRHR is a stark example: "Our elders don't usually share topics like sex on agendas." Community reluctance extends further—"In most village meetings, they don't talk about sexual and reproductive health, so it's only when someone commits a mistake or someone is raped or sexually abused, then they have like a meeting ... but otherwise, these topics are not raised." Village heads and leaders, including many elders, gatekeep the sharing of SRHR information. Excluding SRHR from the conversation profoundly limits access to crucial knowledge, perpetuating cycles of silence and risk.

Within households, religious beliefs reinforce patriarchal dominance. "Because of our religious context in the country and the biblical context where the man is the head of the house, that's also something that stays strong." Married women are expected to "listen, tow the line, once they get married into a family ... Women are often expected to be submissive in relationships. I think, generally, that's the belief." Stepping out of these roles brings stigma and often direct consequences: "Some women, when they voice out those rights—SRHR rights, right to education, right to health—GBV comes in again. You know, like, you keep quiet, you should be making babies. You should be having children. And women who don't have children are stigmatised."

Control over women's mobility and choices is maintained through family surveillance, economic dependence, threats, and—too often—physical violence. Women are sometimes unable to travel independently or must seek permission to leave home, reinforcing their invisibility in public life. The concept of madua (shame) and strong expectations of respect for elders create further internal barriers: "In Fiji, one of the things we're all taught across different cultural groups is that level of respect we give for elders ... but then we don't teach our children to speak out."

Through a combination of gatekeeping, exclusion, silence on taboo topics, and appeals to tradition, elders and senior male relatives entrench patriarchal privilege and limit shifts to more inclusive, equitable decision-making. These overlapping mechanisms curtail women's and youths' opportunities to influence community life—and, in some circumstances, may contribute to the enabling environment for more severe forms of abuse. However, direct data linking these exclusionary practices to child abuse is limited and would require further triangulation to substantiate any causal relationship**.**

6.4.3. How Women Display Leadership in Fiji

Women in Fiji display leadership most readily when they hold familial or religious ties to authority—such as being a chief's wife, a respected elder, a village nurse, or the daughter of an influential family. These connections facilitate acceptance in semi-public leadership or advisory roles. For example, a Kese woman shares, "The Soqosoqo Vaka Marama group, they're so important. Because they combine, they bring women together. And they talk at church, at our church, when there are women's conferences. They discuss issues. They discuss their heart issues, like even menopause right now is a topic of discussion, which is good." This reflects the role of the Soqosoqo Vaka Marama (women's committee) in fostering women's leadership and providing a forum for discussion and support within this iTaukei, Methodist community.

Similar references occur in the data for respected elders or nurses leading:" with our training and awareness that we did, we had a good team from reproductive and family health. Back then, it was with Sister Seriana, who had been part of the team. And so she had explained it to them since she was from the area, and she was telling them about the importance of women having to get their pap smear done..." These quotes illustrate how women's leadership and advisory roles are facilitated—and often legitimised—through familial or community ties and recognition as trusted, respected figures.

However, their inclusion is often conditional on adherence to accepted norms. This includes expectations of "respect" and not challenging existing authority structures, but usually in supporting rather than decision-making roles. A Kese woman explains, "We women can help with organising things for the church or the village, like cooking or making sure everything is ready, but for the main decisions, that is for the men and the elders to discuss." A woman shared similar examples in Naboutini: "Women are asked to take notes or prepare food for meetings, and sometimes we can share our thoughts, but the men in the council always make the final decision." As a result, leadership is most accessible to those with social capital and proximity to power. At the same time, true agency remains circumscribed by cultural taboos, patriarchal expectations, and the heightened risk of stigma for those who are young, unmarried, people with disablities or diverse SOGIESC, or outspoken.

Despite these constraints, women take on visible leadership positions in religious and community organisations—often serving in women's groups, on health committees, or at women's conferences. Here, they work to "create awareness within the churches" and promote SRHR in the spaces open to them. One informant described her strategic navigation of these structures: "I used to create awareness within the churches... I make sure to follow the channel and tell them, 'Okay, during the Bose Vakarau Methodist meeting...' I want to carry out this awareness to the Sunday school, or to the MYF, or to the Soqosoqo Vakamarama." This highlights how women use advocacy skills to reach youth and wider communities while respecting traditional boundaries.

Technical expertise further amplifies women's leadership in roles as village nurses, health workers, or NGO activists, enabling them to shape practices and policies from within. As one participant noted: "From the Pacific Feminist SRHR training, I learned that, you know, when you are a woman, you have a right to make a decision also, regarding your body, regarding your expression." Through such positions, women lead awareness campaigns, deliver technical advice, and facilitate access to SRHR information—often reaching even highly conservative households.

Chiefs' wives and other women of high rank may play behind-the-scenes advisory roles, acting as coordinators of information and services across provincial boundaries. One participant observed, "They are in a good position... to advocate, they arrange information and services from different communities, and we provide them... but they don't want to take ownership. They don't talk about SRH." This reflects both the strategic potential of these roles and the persistent reluctance—or social constraints—surrounding open advocacy, particularly on taboo matters.

The women who most actively push for change are often those who lead NGO programs, participate in feminist coalitions, or serve as peer educators. These bold, vocal leaders challenge silence and encourage dialogue, urging others to speak up. As a Kese female health worker explains, "I am actually encouraging women to be vocal, to share their problems... we're in 2025 and still, it really needs to change." In these ways, pioneering women are working to create safe spaces, dismantle taboos, and advocate for greater autonomy and rights for all.

Despite ongoing structural constraints, the determination of these women leaders is gradually shifting perceptions and expanding possibilities for others. Their advocacy, expertise, and willingness to speak out—particularly in challenging settings—are helping to build momentum for more inclusive leadership and meaningful participation. Ultimately, as more women assume visible, respected roles, they create new pathways for dialogue, support, and change within Fijian communities.

6.4.4. Intergenerational and cross-sector forums

While SRHR topics are often restricted or considered taboo in formal village councils, the data show they are becoming more common in community awareness sessions and follow-ups on local concerns such as teenage pregnancy, early marriage, or disaster recovery. Spaces like talanoa sessions, village meetings, and youth forums now bring together parents, elders, religious leaders, and health workers to discuss relationships, violence, and family dynamics as part of broader initiatives in health, safety, or climate resilience. These dialogues increasingly connect with discussions on vulnerability and the needs of women and girls during disasters. For example, a health worker in Naboutini shared, "During COVID, we had a lot of teenagers, so we ran sexual health reproductive sessions with them, helping them to understand the risks and safety and services available to them.... and mental health, recovery-oriented work." As a youth leader also observed, "We praise the NGOs that are doing the awareness. We also have programs in school like Drug Awareness Week, and invite people from health departments to come over, police, from Yellow Ribbon too, from ZAC, Ministry of Education, and other relevant offices." These community initiatives bridge intergenerational gaps, create new norms on gender roles and rights, and, as another community leader in KESE emphasised, promote much-needed awareness: "To overcome violence against women and girls, there should be more awareness on SRHR so that men can understand that women have every right to say no and forcing oneself is rape."

Across Fijian communities, challenges such as climate change and migration have distinct gendered impacts, underscoring the urgent need for gender-intentional approaches that integrate SRHR into development efforts. Rural and coastal participants describe how disasters like cyclones and flooding heighten vulnerability for women and girls by disrupting family structures, limiting access to health services, and increasing the risk of violence and economic hardship: "Women are totally dependent on men most of the time for their livelihood, even the social structures around them, and the financial needs. The moment the partner dies, the husband dies; they become very vulnerable..." explained a community leader in Naboutini. Migration further compounds these barriers, particularly for women and marginalized groups who lack information and support in new environments: "When we have migration, the women or young girls who move tend to get less information, fewer services they don't know where to find help, and if they're new, they keep quiet, which can lead to more problems," noted a local health worker in Naboutini.

The data shows that Intergenerational forums, when allowed and actively supported, have proven especially effective in fostering inclusive dialogue and advancing practical change around SRHR and gender equity in Fiji. These sessions purposefully bring together youth and elders to share insights, challenge harmful practices, and shift deeply held norms. For instance, discussions often focus on the realities facing young women and men, with participants reflecting: "I learned so much hearing from the older women and the church leaders—it helped me see why some rules exist but also why we need to change them" (Female Youth, Kese). Another participant added, "When young people and elders are together, we talk more honestly about violence and what needs to be done, not just what's always been done" (Male Parent, Savavou). These forums also create momentum for cross-sector collaboration, drawing in stakeholders from health, education, and community leadership, making awareness efforts more sustainable and relevant.

6.4.5. Part 4 Conclusion

Evidence from Part 4 reveals that SGBV, alongside strict gender norms, continue to undermine women's and girls' SRHR in Fiji. Cultural, religious, and legal barriers reinforce male dominance and silence marginalised voices—including women, girls, sex workers, people with diverse SOGIESC, and those with disabilities. Stigma, shame, social blame, and fear restrict access to protection, justice, and survivor-centred care. These voices underscore how shame, economic dependence, social blame, and the lack of safe survivor-centred services force many victims to remain silent, endure abuse, and return to unsafe environments throughout Fiji's communities.

Power-sharing and open dialogue about SRHR remain rare in a patriarchal system. Men and elders tightly control leadership and decision-making, with women's agency typically confined to supportive or advisory roles—especially for those outside established social or religious networks. Yet, women are increasingly finding ways to lead, educate, and advocate in restrictive environments, gradually breaking the silences and fighting stigma. Progress will require not only better services but also amplifying women's voices, confronting violence, and creating safe spaces so that all women and girls can access their rights without fear or shame.

7. Sensemaking workshops

Sensemaking workshops were held with all communities except Kese due to the chief's wife's death. The outcomes show broad agreement that parents and families are central to preventing early pregnancy and empowering girls, but approaches differ according to local culture, religious influences, and community structures. The following similarities across communities were found:

- **Role of Parents:** All communities emphasised the crucial influence parents have in empowering teenage girls to resist sexual pressure. Openness and guidance at home, including overcoming cultural taboos, are seen as essential across sites.
- **Community Support:** There was widespread agreement on the value of community-wide activities—such as awareness campaigns and health worker involvement—to tackle early pregnancies and promote SRHR. Participants in several communities suggested collaborative village meetings, women's club gatherings, and tapping into faith-based groups to increase awareness and support for parents and youth.
- **Cultural Barriers:** Each community noted cultural practices and gender roles, especially within iTaukei households, as barriers to open SRHR discussion. Traditional gender roles typically leave mothers responsible for educating their children while fathers are less engaged, a dynamic recognised across sites.
- **Importance of Family Time:** Spending quality time as a family is consistently highlighted as crucial for meaningful discussions and for building children's confidence in relationships and sexuality.

While cultural barriers persist—especially around gender roles and taboos—innovative, community-led strategies and multi-sector partnerships (involving schools, churches, sports, and health workers) are emerging as key mechanisms to strengthen SRHR education and support for both youth and parents. The following differences were observed during sensemaking:

- **Dialogue and Religious Values:** Communities like Suvavou, Viria, and Naboutini placed more emphasis on reinforcing religious values (purity, abstinence) as protective factors, with strong involvement of religious leaders in advocating for family guidance. In contrast, some communities (Naseakula) favoured open dialogue as a strategy to empower girls, especially overcoming taboos in iTaukei culture.
- **Innovative Strategies:** Suvavou suggested partnering with popular sports celebrities to boost attendance at SRHR forums. Viria and Naboutini proposed greater involvement of health workers and the integration of SRHR messaging into existing women’s and men’s groups.
- **Teacher and School Involvement:** Suvavou and Viria saw schools as key environments to fill gaps in SRHR education when parents are unable or unwilling to engage, while also noting resistance from some parents about the content and depth of school-based SRHR curricula.
- **Handling Violence and Risk:** Viria and Suvavou discussed community strategies to address SGBV, with Viria demonstrating stronger committee engagement in conflict mediation.

The sensemaking workshops revealed that while there is strong consensus across Fijian communities about the pivotal role of parents and families in preventing early pregnancy and empowering girls, the effectiveness of interventions depends on adapting to local cultural, religious, and structural realities. Meaning that solutions cannot be one-size-fits-all; successful SRHR strategies require both respect for, and adaptation to, diverse community values and practices. Community-wide cooperation, open family communication, and engagement of multiple actors—including schools, churches, sports, and health workers—are essential for overcoming deeply rooted gender norms and taboos.

The diversity in approaches, from leveraging religious leadership for family guidance to adopting open dialogue or innovative partnerships, demonstrates that communities are not only identifying barriers but also developing context-specific pathways for progress. Ultimately, strengthening SRHR education and support means meeting communities where they are and co-creating solutions that both honour tradition and enable change.

For a more detailed overview of the sensemaking workshops, see Annex 11.3.

8. Conclusion

This report highlights the deeply woven barriers to SRHR in Fiji, where religious, cultural, and patriarchal norms intersect to silence open dialogue, restrict autonomy, and entrench discrimination—particularly for women, girls, sex workers, young people, people with disabilities or diverse SOGIESC. Despite modernisation and gradual change in some families and communities, myths and misinformation persist, propelled by shame, stigma, and the need to protect family honour. The normalisation of sexual and gender-based violence, exclusion from decision-making, and lack of practical SRHR education continue to undermine health, safety, and equality.

Yet these realities often stand in stark contrast to Fiji's government commitments, legislative changes, and policy reforms that promise gender equality, SRHR, and violence prevention. While laws may affirm rights and international agreements may be signed, a significant gap remains between policy rhetoric and meaningful implementation. Many of the barriers experienced by women and marginalised groups reveal persistent failures in translating commitments into practical, adequately resourced programs—and into environments where rights can be safely exercised without fear of sanction or reprisal. Bridging this gap will require concerted action at all levels, robust accountability, and the inclusion of affected communities in both design and delivery of solutions.

The findings also reveal that progress is possible. Change accelerates when champions—whether committed parents, teachers, health workers, faith leaders, or youth advocates—actively foster trust, facilitate peer education, and create safer spaces for informed discussion and support. Culturally tailored interventions, disability inclusiveness, youth leadership, and policy reforms rooted in dignity, rights, and equity are essential to dismantling silence and stigma.

Ultimately, advancing SRHR and ending SGBV in Fiji is inextricably linked to broader struggles for social justice and gender equality. Sustained, community-driven efforts, along with meaningful participation by women and young people, are vital. Change may be slow, but it is necessary. By challenging the systems that enable violence and exclusion and empowering every individual to realise their rights, Fiji can move toward lasting solutions for health, autonomy, and respect for all.

9. Recommendations

These recommendations directly address and help to dismantle harmful social and gender norms that restrict SRHR in several targeted ways.

1. Expanding FLE/CSE and Outreach:

By normalising open, accurate discussions of sexuality, gender equality, and rights from a young age—in culturally relevant formats and spaces—these programs challenge the silence, stigma, and secrecy that underpin restrictive norms. Equipping parents, teachers, community leaders, etc, with the tools they need to lead culturally appropriate discussions helps shift entire family and community attitudes away from moral judgment and toward understanding and support. School-based curricula that teach consent, healthy relationships, and nonviolence actively counteract the norm that discourages inquiry and reinforces shame. More specifically:

1. Empower schools by ensuring every Family Life Education (FLE) curriculum includes explicit content on consent, contraception, puberty, gender equality, gender diversity and expression, respectful relationships, and SGBV prevention, adapted for diverse cultural and religious contexts.
2. Mandate annual teacher training on SRHR—partnering with NGOs to co-facilitate sessions, provide teaching guides, and ongoing mentoring (e.g., Viber/WhatsApp groups, peer teacher observations).
3. Conduct regular parent/caregiver education sessions in collaboration with faith-based organisations and local health clinics. Utilise drama groups, mothers' clubs, and village gatherings for open discussions on SRHR in the most common local languages.
4. Expand out-of-school FLE supported by peer education models and integrate community-wide SRHR days in church calendars or as part of village health outreach, with health staff, religious leaders, and youth presenting together to model dialogue.

2. Engaging Religious and Community Leaders:

By recruiting and supporting faith and traditional leaders to reflect on doctrine and speak publicly in favour of gender justice, bodily autonomy, and dialogue, these recommendations leverage social authority to reshape what is seen as morally acceptable or admirable. When sermons and village forums begin to model positive behaviour, the standard for what is normal shifts. More specifically:

1. Organise structured SRHR dialogue sessions for chiefs, faith leaders, women's committee heads, and youth in each district; Explore potential support systems that can be established to assist young people in various areas and use real-life stories and case studies for discussion.

2. Build an 'SRHR Champions' network of respected male and female community figures and have them publicly endorse women's leadership and equal SRHR access in sermons, radio shows, and village meetings.
3. Train selected pastors, imams, and priests (and their spouses) to serve as SRHR resource people, prepared to moderate family forums, answer confidential questions, and refer youth to appropriate resources.
4. Develop "Faith for Rights" guides that blend evidence with doctrine to support leaders in responding to faith-based concerns about SRHR and greater advocacy.

3. Promoting Safe Intergenerational and Peer Dialogue:

Structured forums are needed for parents, young people, and peers to share questions, beliefs, and experiences to break the "culture of silence" identified in the data. When communities provide space for open intergenerational conversation, it becomes easier for individuals to resist harmful 'madua' (shame) and 'rere' (fear) and challenge the pressures to conform. More specifically:

1. Establish "family talk" programs—facilitated by trained parent mentors—using narrative prompts to help parents and adolescents navigate discussions on puberty, sex, and relationships.
2. Create safe intergenerational spaces for discussing SRHR topics with key community leaders.
3. Support youth peer educator teams in every district, with incentives for club activities, mini-grants for youth-led health campaigns embedded in high-interest areas such as sports or arts, and recognition awards for impact.
4. Leverage women elders, female teachers, or older sisters as peer mentors for girls and young women; provide them with easy-to-use activity packs and referral cards.
5. Integrate SRHR topics and positive life skills into existing girls' and boys' sports leagues, school clubs, and Sunday school programs.

4. Strengthening Service Accessibility, Confidentiality, and Youth-Friendliness:

Making SRHR services more private, youth-focused, and stigma-free chips away at norms that equate seeking contraceptives or SRHR care with promiscuity or bad character. Removing parental consent requirements for adolescents empowers girls and young people to exercise agency despite social taboos, while training providers to act nonjudgmentally establishes new, positive expectations for how health professionals interact with youth, unmarried women, people with diverse SOGIESC, people with disabilities and survivors. More specifically:

1. Deploy mobile clinics to outer islands and remote areas at least quarterly, with advance scheduling through village leaders and school boards.
2. Expand selected clinics to offer after-hours services. Include youth-friendly spaces and services in health facilities and ensure separate waiting areas for confidentiality.
3. Make adolescent contraception and STI care available without requiring parental consent—communicate protocols via posters, radio, and school channels.

4. Train all frontline clinic staff using role-plays on non-judgmental service to unmarried girls, LGBTIQ+ youth, survivors of violence, and people with disabilities with quarterly refresherworkshops. Consider using the Values Clarification and Attitude Transformation (VCAT) training modules.
5. Set up confidential feedback mechanisms (community suggestion boxes, SMS feedback lines) to allow clients to report privacy breaches or poor treatment anonymously. Embed these in performance reviews.

5. Strengthen the health sector response to SGBV and ensure Survivor-Centred Care:

1. The health sector is an important entry point for survivors to access survivor-centred care and multi-sectoral referrals. When service providers work closely with communities, it sends a clear message that violence rooted in gender norms is not acceptable or inevitable. Training leaders and frontline workers to recognise and respond to abuse challenges the norm of survivor silence, victim-blaming, and the belief that SGBV is a private or family matter. More specifically:
2. Strengthen the health sector response to SGBV and SRHR by ensuring all health facilities are 'service ready' and adopting a survivor-centred, multi-sectoral approach aligned with Fiji NAP Strategy 3. This includes capacity building for health workers, implementation of case management guidelines and inter-agency protocols, the use of selective screening in line with IPPF/WHO best practices, and piloting innovative models such as ARCHES to address reproductive coercion and advance reproductive justice.
3. Multi-sectoral service coordination—across health, justice, protection, and community sectors—and operationalising the health guidelines and national service delivery protocols will ensure survivors have holistic access to care, safety, referrals and justice throughout Fiji.
4. Implement a comprehensive package of prevention interventions across the continuum of primary (prevent violence before it occurs), secondary (avoid the recurrence of violence), and tertiary prevention (prevent or limit impacts through short- and long-term care and support).
5. Multisectoral training that includes service providers (Social Services, Police, Health and Legal/Justice) with teachers, community and faith leaders to identify SGBV better, handle disclosures and build strong relationships to refer and link survivors to appropriate services while actively challenging victim-blaming.
6. Convene regular multisectoral meetings of SGBV service providers—bringing together church, community, and women's groups—to jointly review GBV administrative data, monitor trends, share best practices, and identify and address protection gaps in line with national protocols and Fiji's case management guidelines.

6. Promoting Multi-Sector Responses to Evolving Risks:

1. Proactively integrate SRHR and gender-sensitive strategies within climate resilience, disaster preparedness, and migration planning to support at-risk groups facing evolving risks. This approach ensures that SRHR is not delivered in isolation but as a core element of broader development, humanitarian, and adaptation efforts.

Convene cross-sector working groups at national and district levels, bringing together health, disaster management, environment, social welfare, women's organisations, faith leaders, and youth to identify vulnerable groups and design integrated, gender-just responses jointly.

- Systematically include SRHR, gender, and protection criteria in every climate adaptation and disaster risk reduction assessment and action plan, with special focus on women, girls, people with disabilities, people with diverse SOGIESC, migrants, and sex workers.
- Train disaster responders, climate and migration planners, and frontline community liaisons in SRHR basics, survivor-centred care, gender-based violence response, and referral pathways, with refresher modules offered after every major event.
- Embed SRHR services—mobile clinics, peer educator outreach, safe-spaces, and information materials—into emergency preparedness protocols and post-disaster response activities. Involve women, youth, and people with disabilities in the design and delivery of services.
- Monitor real-time impacts and gaps through participatory community feedback mechanisms; support iterative adaptation of strategies to address emerging risks for marginalised and at-risk populations.
- Create regular forums for intergenerational discussion on climate and migration challenges, ensuring space for women and youth voices to shape priorities and review action.
- Given the rising suicide rate, incorporate mental health across all approaches.

2. Integration of SRHR and gender justice into multi-sector action directly supports the health, safety, and agency of marginalised groups, enables communities to better withstand and recover from climate and migration shocks, and creates more resilient and equitable systems for the future.

7. Promote Women's Leadership:

Fostering a gender-equal society requires promoting women's leadership and empowerment, as well as sharing power between women and men. Mandating, training for, and financing women's participation in leadership upends the patriarchal hierarchy that keeps decision-making male-dominated. As women's voices and agency are routinely included in public life and SRHR discourse, entire communities witness alternative models of gender relations and see the value of women in guiding and shaping social change. This is in line with Fiji NAP Strategy 5, which "focuses on the strengthening of Fiji's societal systems and structures in a manner that enables and promotes gender equality, shared power between women and men, women's human rights and empowerment, women's leadership and transformative change against VAWG. More specifically:

1. Reserve at least one seat for women on every village council, school committee, church management group, and health governance board; track compliance annually.
2. Deliver leadership and SRHR advocacy training (with follow-up coaching) for women leaders, women's group heads, and female health workers—measured by number advancing to facilitation or public speaking roles.
3. Provide grant funding to women-led community organisations to run SRHR outreach, safe-space meetings, and peer-support circles.
4. Facilitate networking opportunities for women leaders to connect, share experiences, and collaborate across sectors and industries. Hold periodic women's action forums to connect, share experiences, and collaborate across sectors and industries. Hold periodic women's action forums to review local SRHR priorities, collect grassroots solutions, and present findings to local authorities.

8. Advancing Legal, Policy, and Service Reforms for Sex Workers:

By making laws and service protocols inclusive, rights-protecting, and sex worker-led, these actions directly contest the norm that certain people (sex workers, transgender individuals) are undeserving of dignity or support, setting new standards for equality and justice. More specifically:

1. Adapt SRHR service delivery to uphold the rights and dignity of sex workers by establishing mobile and fixed "one-stop" clinics in urban and peri-urban areas, providing anonymous care, condoms, and rapid referrals to legal and social support services. All services should be designed with sex worker-led organisations, integrated across sectors, and tailored to the diverse needs of sex workers.
2. Support and resource campaigns for community empowerment, ensuring that sex workers actively shape and access rights-protecting, inclusive laws and services.
3. Advance legal, policy, and service reforms for sex workers in line with international best practice and the IPPF IMAP statement.
4. Initiate a national dialogue on decriminalisation, with evidence-sharing sessions for policymakers and joint civil society-justice sector working groups aimed at repealing discriminatory laws and structural barriers.
5. Ensure all health worker orientation includes respectful engagement with sex workers, migrants, and transgender communities, as well as strengthened confidentiality protocols.
6. Formally support and fund sex worker organisations for outreach, clinical navigation, and awareness-raising roles, and guarantee their meaningful representation on SRHR planning committees.
7. Crucially, enforcement of these laws and policies must be prioritised: implementation should be systematically reinforced through ongoing supervision, transparent accountability mechanisms, and meaningful involvement of affected communities at every stage. Sufficient resourcing—both financial and human—is essential to translate legal and policy commitment.

9. Ensuring Inclusive, Safe SRHR Services for People with Diverse SOGIESC:

By making SRHR education, services, and community spaces inclusive, affirming, and confidential for youth with diverse SOGIESC —including those who are sex workers, disabled, or displaced—these actions directly challenge the norm that diversity is shameful or excluded, and set new standards for dignity, protection, and equal rights. More specifically:

1. Guarantee confidential, nonjudgmental SRHR services by training all health staff in SOGIESC inclusion; offer anonymous, affirming care and ensure privacy and non-discrimination. Remove parental consent for adolescent access.
2. Integrate SOGIESC content in all SRHR education by ensuring school and community programs positively represent sexual orientation and gender diversity and challenge stigma.

3. Support dedicated safe spaces and peer-led outreach by resourcing peer groups of people with diverse SOGIESC, drop-in centres, and safe events for education and care; partner with NGOs, youth networks and youth to reach marginalised groups.
4. Address intersectional needs (sex work, disability, migration): Design services and legal protections that respond to the complex risks faced by sex workers with diverse SOGIESC, disabled youth, and migrants.
5. Educate and train leaders and parent mentors to foster accepting environments, tackle harmful beliefs, and promote inclusion at home and in community forums.
6. Implement survivor-centred, multi-sector support for youth with diverse SOGIESC who face violence, discrimination, or family rejection.

10. Ensuring Disability Inclusion:

Targeted efforts to make SRHR services, information, and leadership accessible to people with disabilities challenge myths about their asexuality or lack of agency, affirming their equal rights and value within the community. More specifically:

1. Implement values clarification and attitude transformation (VCAT) training for all SRHR service providers in Fiji, with a focus on disability inclusion. VCAT workshops should be co-facilitated by persons with disabilities and local Organisations of People with Disabilities (OPDs), using participatory methods to challenge provider biases, increase empathy, and mainstream rights-based, person-centred care. This approach strengthens provider capacity to deliver accessible, welcoming, and equitable SRHR services, thereby reducing stigma and improving health outcomes for people with disabilities.
2. Protect decision-making autonomy in contraceptive and SRHR choices for all people with disabilities; include them in local and national policy dialogue forums.
3. Produce and distribute SRHR educational materials in Braille, sign language, audio, and plain language format.
4. Physical and information accessibility audits for all health facilities and FLE curricula; commit funding for reasonable accommodation modifications (e.g. ramps, signage, Braille, sign language interpretation, home visits, digital health interventions and easy-read materials).
5. Develop confidential networks (WhatsApp, community meetings, private SMS lines) for people with disabilities to support one another, ask questions, and raise concerns.
6. Each recommendation deliberately includes new voices, challenges restrictive taboos, and builds systems that reward openness, diversity, and active participation over silence, control, or exclusion—paving the way for sustainable normative change. A suggested timeframe and responsibilities for each recommendation appear in Table 11.

Table 11: Recommendation Action Plan

Recommendation	Key Actions/Details	Responsible Actors	Priority	Timeframe
Expanding CSE and Outreach	Integrate explicit FLE content on consent, gender, relationships, SRHR, SOGIESC, and SGBV; Mandate annual teacher training; Engage parents/caregivers; Peer-led outreach; Out-of-school/faith/church programs; Monitor implementation	Ministry of Education, Schools, NGOs, Faith-based Orgs	High	2025–2028 (annual review)
Engaging Religious & Community Leaders	Structured SRHR sessions for leaders; Build SRHR Champions network; Train faith leaders and spouses; Develop "Faith for Rights" guides	Faith orgs, Chiefs, Community leaders, NGOs	Medium	2025–2027
Safe Intergenerational & Peer Dialogue	"Family talk" programs; Safe intergenerational forums; District youth peer teams; Mentor networks for girls; SRHR in clubs, leagues, Sunday schools	Community orgs, Parents, NGOs, Youth groups, Women's groups	High	2025–2028 (annual review)
Strengthening Service Accessibility/Youth-Friendliness	Mobile clinics; After-hours services; Remove parental consent; Staff trained in inclusive care; Confidential feedback mechanisms	Ministry of Health, Clinics, NGOs, Youth orgs	High	2025–2028 (quarterly checks)
Survivor-Centred SGBV Response	Service-ready clinics; Survivor-centred care; Case protocols; Multi-sector prevention; Regular review meetings	Health, Justice, Police, Social Services, Community Orgs	High	2025–2027
Multi-Sector Response to Evolving Risks	SRHR/gender in climate/disaster/migration; Cross-sector working groups; SRHR in risk assessments; Embed services; Engage at-risk groups	Government, Disaster agencies, Health, NGOs, CSOs	Medium	2025–2028 (annual review)
Promoting Women's Leadership	Reserve seats for women; Leadership/SRHR advocacy training; Grants for women-led outreach; Women's networking/action forums	Government, Women's orgs, Community leaders, NGOs	Medium	2025–2028 (annual review)
Legal, Policy & Service Reform for Sex Workers	Inclusive laws/protocols; One-stop clinics; Campaigns; Legal reform; Health staff training; Fund orgs; Representation	Government, Justice sector, Health, NGOs, Sex worker orgs	Medium	2025–2028 (annual review)

Recommendation	Key Actions/Details	Responsible Actors	Priority	Timeframe
Inclusive, Safe SRHR for Youth with Diverse SOGIESC	Inclusive, confidential services; SOGIESC content in education; Safe spaces; Peer outreach; Address intersectional needs; Train leaders/parents; Survivor-centred violence response	Health, Education, NGOs, SOGIESC orgs, Social Services	High	2025-2028 (annual review)
Ensuring Disability Inclusion	VCAT/participatory training; Accessible services/materials; Autonomy safeguard; Inclusive formats; Audits & modifications; Peer networks	Ministry of Health, OPDs, NGOs, Social Services	Medium	2025-2028 (annual review)

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11. Annexes

11.1. Sex Worker Access to SRHR in Fiji: Key Findings, Challenges, and Solutions

Sex workers in Fiji face unique and considerable challenges in accessing SRHR services. While policy documents and some official perspectives suggest that services are readily available to all, substantial evidence indicates that these provisions often do not align with the lived experiences of sex workers, who continue to encounter stigma, discrimination, and operational gaps. This section synthesises first-person testimonies, service provider interviews, and civil society perspectives to analyse the key issues, interrogate structural causes of access gaps, and propose actionable solutions rooted in the realities of sex workers' lives.

SRHR access

Government and NGO representatives describe a public health system in which sex worker access to services is technically available, including contraception, STI testing, family planning, and abortion services. As one government respondent put it, "I feel that our service provision for sex workers is pretty good, despite it not being legal. Like, despite the legalisation not being there, it hasn't stopped any sex worker from accessing services." Nevertheless, sex workers themselves paint a much starker picture. Many highlight that formal availability does not equate to true accessibility, and significant barriers remain at the point of care.

Many sex workers delay accessing SRHR services or avoid clinics altogether until critically necessary, usually for childbirth or emergencies. According to one community leader,

“Our female sex workers felt that they had been stigmatised at the health centres. ...if they found out that they were pregnant, they couldn't continue their clinic due to the behaviour of the health providers. ...The only time they could access the hospital was when they had to go and deliver their babies.” This pattern is indicative of the depth of mistrust between sex worker communities and healthcare providers.

Discrimination, Stigma, and Breaches of Confidentiality

Discrimination remains the most consistent and damaging barrier to SRHR access for sex workers across Fiji. Reports abound of judgmental attitudes and outright mockery by medical staff, with service users stating, “It's one of the biggest challenges—the workers, when they look at you, they look differently. ...They look at you differently, as a sex worker.” Another sex worker described, “Very judgmental—the way they look at me...when a sex worker walks in, they don’t feel, like, appreciated, you know. So they are coming inside to ask for condoms, they give them this kind of discriminatory look.” The language of public shaming was echoed repeatedly, with multiple sex workers recounting experiences of being called names and judged for their appearance in front of peers or other clients. “We can just tell how they make fun of you.”

One sex worker emphasised the humiliation felt due to provider attitudes: “The treatment of health providers was very stigmatising, where they were verbally abused in the health premises in front of people. ...They found it so demeaning, and also they were called out names and [judged based on] how they dressed.” Appearance was frequently scrutinised: “She went to have her first clinic. She had hickeys on her neck, jeans that were ripped, and her top was very short...her belly was popping out. The nurse told her, ‘You know you’re pregnant and you're dressed like that.’ She was even told to go back home and change.”

Transgender sex workers face even greater levels of discrimination: “I have a lot of complaints that there has been a lot of discrimination coming out from health workers...Women do, but the majority, it comes from the trans community.” Another explained, “There is a lot of discrimination. But the majority of it comes against the trans community.”

The pressure to undergo HIV testing in a judgmental manner was especially discouraging: “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.”

The fear of exposure and humiliation is heightened by frequent breaches of confidentiality, with incidents reported of test results or personal health status being communicated to others without consent. “They share the results with the leader, without their consent. ...It's supposed to be confidential.” The lack of privacy further erodes trust: “During HIV testing, there's no privacy and, yes, there's no privacy for sex workers in terms of health check-up in all of these health centres around here.” One sex worker explained why they did not return for a second HIV test: “They go for a first check-in, like a first HIV testing, and there’s no privacy, so they never attend the second testing due to discrimination.”

Often, sex workers who lack a cell phone must provide NGO leaders' numbers to obtain test results. Instead of just notifying when results are ready, healthcare workers sometimes share actual results directly with the leader: "For me, it's okay, but what they're doing is a little bit over…instead of telling, just call and tell them to tell me to come and get my results, not to give the results. It's supposed to be confidential." Interpersonal provider dynamics, particularly among iTaukei women, are highlighted as a source of tension and breaches of privacy: "I think it's just the way we are. iTaukei to iTaukei women, we tend to have a tension there…there's more dictatorship."

These violations of dignity, privacy, and confidentiality, coupled with public shaming and discrimination, have deeply damaging effects on the willingness and ability of sex workers to seek care, resulting in avoidance of clinics and delayed treatment that puts their health and lives at risk.

Structural and Operational Barriers to Service Uptake

Systemic and operational gaps compound these interpersonal challenges. Service hours are often misaligned with sex workers' work patterns, with clinics closing before many can finish work or travel safely to access care. As one participant stated, "Health centres are often closed or inaccessible during the times sex workers are available to access them—when it's time to go …it's closing time for the health services… they either don't access the service, or they wait for someone to bring the services to them." Another contributor emphasised, "We even have the mobile clinics that came to stand, like they have the moonlight screening and so forth. But it's a one-and-done thing, you know? There should be something like, you have this one-stop shop where everything is there, and it's 24 hours, and anyone can access it."

Security concerns and logistics compound the difficulty of accessing SRHR services late at night: "St. Finch sometimes closes the gate at night. So, we can't go and get our supplies. So, staff from SPAN always drives out to other communities at night. So, it's convenient. And she just comes and brings it to you. So, you find it accessible."

Resource and supply chain inconsistencies further undermine the accessibility of SRHR services. Stockouts and inconsistent availability of condoms and lubricants are frequent: "…the condoms come to us in boxes, and in the next two to three months, the condoms expire. And also, it doesn't come with lubricants; most of the time, the lubricants are out of stock." Waiting for promised supplies can add stress and frustration: "We have focal points from the West who are still waiting and calling us, but we say we just have to wait for them until they deliver it to us."

Collecting supplies, even when available, can pose further barriers to privacy and dignity: "Sometimes when we go to collect condoms, it's like it's good, it's open. But the thing is, sometimes you can't collect. It's full of community members and even some big people from other offices doing the job. They can see us collecting the condoms because we don't know how they're going to feel. So, you know, you just want to go there alone and get it."

These logistical challenges reduce the effectiveness of both government programs and NGO-led outreach, which are especially critical for the most marginalised and mobile sex worker populations. As one outreach worker explained, "Most of my work that I do, I go around the streets and distribute condoms to the sex workers, to all, women and trans...I normally go down to the hub." These interventions are clearly valued, yet are insufficient and sporadic: "The thing is, when the Ministry [of Health] is actually not doing its work, like giving out information, giving out resources, giving out information, that's where you have blockages and barriers."

Intersecting and Compounded Vulnerabilities

Not all sex workers experience barriers equally. The intersection of sex work with gender identity, migrant status, and venue of work (street vs venue-based) results in compounded layers of vulnerability. Sex workers who are transgender, migrants, or street-based are particularly exposed to violence, discrimination, and service exclusion, with many reporting systematic abuse by both police and health workers. As one respondent noted, "Sex workers who face the most significant challenges and mistreatment are those who are street-based. These sex workers do not have proper shelters, who are just moving around compared to our sex workers, our call girls or the ones who are just going to hotels."

Transgender sex workers describe frequent discrimination in health centres: "I normally work with sex workers, transgender, here in Lautoka, and I have a lot of complaints that there has been a lot of discrimination coming out from the health workers ... Women, too, there is a lot of discrimination. But the majority of it comes to the trans community." Police violence is pronounced: "LGBTQ people do sex work as well ... and trans men, trans women, they face police brutality as well because of sex work. And, you know, the stigma just being a gay man or a trans woman. Moreover, there are cases of some of them being assaulted and police officers failing to help them —"they are being beaten up, they go to the station to report that they want to be taken to the hospital, the police do not take them because they're transgender, just because of who they are."

Street-based sex workers experience frequent harassment and violence on the streets, as described: "The police, even in Samambola, they're going just to park, and they wait for one car to come. As soon as you hop into that car, they're going to follow that car and chase you and start demanding the driver's money. ...But now they don't chase, they just come and collect money. If not, they'll remove you. They're going to keep on removing you. If not, they're going to take you to the police station." Another recalled, "Before, a long time ago, when we were standing in the street, we hopped in the car, the police took us somewhere, like the reservoir, and we got off there, and we took a walk from there. If not, they're going to take us to the sewer and get off, and you have to swim."

Violence is not limited to police and clients. It sometimes includes family: "Violence actually happens at home, and the perpetrators are actually inside that house. ... when they go back, things like this happen. It's either that some of your relatives are coming after you."

Transgender and street-based sex workers also face additional health system difficulties: "Some of the reasons behind this discriminatory attitude come from sex workers' involvement with drugs and alcohol. ...if you don't live in an environment where there are drugs, where there's violence and all sorts, and you are not getting drunk and turning up at the health facility, or drugged...", highlighting a cycle where marginalisation precipitates risky behaviours and further exclusion.

These stories reveal how compounded vulnerabilities—street status, gender identity, family exclusion, and exposure to violence—keep the most marginalised sex workers furthest from services and safety.

Legal, Religious, and Cultural Drivers of Gaps

The entrenched criminalisation of sex work forms a foundational barrier that exacerbates nearly all other problems. Criminalisation not only legitimises police harassment and perpetuates violence with little recourse but also emboldens discrimination within service settings. This creates a significant barrier for individuals in coming forward to report crimes: "We hardly see them come in and report, 'Hey, I'm a sex worker and I've just been forced into having sex by my partner.'" As a result, risk-taking is incentivised, and sex workers describe being unable to demand safer working conditions or fair treatment. "Sex workers are the ones taken in, and clients are ... rarely held accountable."

Religious and cultural drivers further sustain exclusion and shame. Many religious leaders actively preach against sex work, reinforcing a dominant narrative of sex workers as immoral or "dirty." Such messages trickle down through community networks, driving gossip, scrutiny, and the threat of family expulsion. "They have been monitoring the impact of [pastors'] speeches, describing sex workers as something ungodly, dirty and leading to when they're out on the streets, people are even going out and telling them off..." For sex workers who become pregnant outside of marriage, exclusion from families and social support is common.

The persistence of these gaps is rooted in the dynamic interplay among legal regimes, social stigma, and weaknesses in the health system. Firstly, the criminalisation of sex work directly incentivises secrecy, risk-taking, and avoidance of authorities, including health services. The very illegality of their work means sex workers are less able to assert their rights, report abuse, or seek recourse for injustices. Secondly, discrimination within health systems is fueled by the intersection of moral norms and insufficient professional training, resulting in provider attitudes that are often punitive and judgmental. Thirdly, service design and resource allocation frequently fail to reflect the lived realities and needs of sex workers, being constructed with limited consultation or involvement of the populations they intend to serve.

Deep-rooted societal stigma—sustained via religious dogma, community gossip, and cultural conservatism—frames sex workers as social outcasts, further legitimising their exclusion from mainstream services and support. These drivers, in combination, explain the chronic gaps in SRHR service uptake, health outcomes, and ultimately, the perpetuation of gender and social inequalities for sex workers in Fiji.

Solutions and Opportunities for Change

Resolving these entrenched issues requires a multi-pronged and sustained approach. First, legal reform—including decriminalisation of sex work—is fundamental. Legal recognition of sex work would enable safer practices, promote organisational representation, and transform relationships with public authorities and service providers. Second, health systems must prioritise meaningful and participatory engagement with sex worker communities. This includes involving sex workers in policy making, budgeting, program design and review, and ensuring that service delivery is responsive to their needs. Peer-led and community-based organisations should be core partners and resourced for stability and innovation.

Third, operational innovations such as expanding mobile, after-hours, and one-stop SRHR clinics are urgently needed. As several respondents suggested, "There should be something like a one-stop shop where everything is there, and it's 24 hours…" These hubs should guarantee privacy, non-judgmental care and confidentiality. Fourth, extensive sensitisation and professional training programs are needed for both health workers and police to dismantle stigma and instil accountability and respect for human rights.

Lastly, efforts to combat community-level stigma must engage religious and community leaders in new dialogues. Such efforts must move beyond awareness to create genuine accountability for discrimination and to foster supportive spaces for sex workers and their families.

Conclusion

Sex workers in Fiji are entitled to the full protection of their sexual and reproductive health and rights. Marginalisation is perpetuated not by a lack of health infrastructure, but by a complex interplay of legal, social, and institutional barriers. At the same time, interventions to advance these rights operate within communities shaped by strong social norms and sensitivities, particularly regarding sexuality, youth, and social change.

Protecting the rights and dignity of sex workers must be pursued with care and respect for context. Progress should be rooted in universal principles of non-discrimination, confidentiality, safety, and access to health care, ensuring that no group—including sex workers—is further marginalised or put at risk. However, efforts must be made to avoid unintended consequences, such as increasing stigmatisation, misunderstanding, or backlash within traditional communities. Reforms should balance the urgency of upholding sex workers' rights with a practical awareness of community anxieties and the need to safeguard adolescents and protect children from harm.

Achieving this balance requires listening, partnership, and building trust—ensuring that all reforms are community-owned, context-appropriate, and driven by shared values of dignity, protection, and equity.

Key recommendations include:

- Community-Centred Engagement: Engage faith leaders, parents, community leaders, youth representatives, and sex workers in open dialogue—grounding reforms in local values while affirming universal rights.
- SRHR for All: Approach SRHR improvements within a broad, inclusive framework that affirms the rights of sex workers alongside protections for youth and other marginalised groups.
- Confidential and Respectful Services: Prioritise the expansion of safe, non-judgmental, and confidential SRHR services for all—including sex workers—while ensuring privacy for those most likely to face stigma.
- Legal and Policy Reform—Cautious and Contextual: Advocate for policy changes that protect sex workers from violence and discrimination, considering careful, stepwise, and consultative approaches to law and policy to avoid backlash.
- Participation with Safeguards: Ensure sex workers have a voice in decision-making bodies, with parallel measures to uphold adolescent protection and community trust.
- Training and Accountability: Strengthen provider and police training to create a rights-based service environment—and establish accountability for abuse or discrimination.
- Partnerships for Change: Support grassroots and peer organisations to deliver both services and stigma-reduction initiatives, ensuring messages are tailored and delivered by trusted local voices.

In pursuing these pathways, Fiji can make progress on SRHR that protects sex workers' rights and dignity—while building the consensus and confidence needed for lasting, community-driven change. As one sex worker leader put it, "If you don't have the support, you can't do anything about it." The evidence is clear that with political will, participatory engagement, and sustained investment, these long-standing injustices can be challenged—and ultimately, transformed.

11.2. Community Synopsis

1. Viria

This section summarises the findings for one community to facilitate a nuanced understanding of each context studied.

I.1. Introduction to the study site

Viria Settlement, also known as Veidogo Informal Settlement, is located in Viria East, Vatuwaqa, covering approximately 4.5 hectares. The community comprises approximately 180-200 households and has faced significant challenges related to land tenure. Recently, the community received eviction notices affecting 155 families, despite having won the legal case and being advised to remain. These land tenure issues and ongoing relocations add socio-economic stress to the community, influencing the context of SRHR discussions and interventions. It has a mixed iTaukei and Indo-Fijian population, predominantly iTaukei.

Livelihoods in Suva rely on urban employment, often in low-income roles in government or the private sector, which are sufficient to meet basic needs. Houses are mainly tin structures,

reflecting a low standard of living. The community faces significant land tenure challenges, including past eviction notices affecting 155 families (as of 2024 court documents). However, a legal victory allows them to remain, with Cabinet plans to relocate 23 families to Makosoi Development Estate in Deuba and options for others under review (per news updates from May and August 2025).

The nearest health facility is Raiwaqa Health Centre, with access to Suva CWM Hospital, and a community health worker resides in the settlement. Located in an urban area, numerous primary and secondary schools are accessible within walking distance or via regular public transportation. Cultural taboos around discussing sex and menstruation contribute to limited parental engagement in SRHR education, with youth (aged 14–24) often relying on peers, schools, or social media for information, highlighting a need for community-driven education initiatives.

Table 12: Viria sample

	Viria Community - Proposed						Viria Community - Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Young people 16-17 (IDIs should be out of school)		1	1	1	1			1	1	1	1	
Young people 18-24		1	1	1	1			1	1	1	1	
Women (divorced/ single, widow, never married)		1						1				
Parents with children over 15 years old		1	1	1	1			1	1	1	0	

RESPONDENTS - per location	Viria Community - Proposed						Viria Community - Completed					
	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Religious Leaders, Muslim, Hindu and Christian	2						1					
SRHR service provider/health workers	1						1					
Local govt	1						0					
Other local leader	1						1					
Community tools						3						3
Total	6	4	3	3	3	3	4	4	3	3	2	3

1.2 Findings

I.2.1. Learning About SRHR and Sexuality

The most commonly mentioned way that young people learn about sex is through Family Life Education (FLE) in schools, and most people think that FLE being taught in school is good. The most common information sources for female parents include social media, the internet, and friends, while male parents mentioned health workers and the church. For older female youth, the most common sources are school, friends and social media. Male youth learnt about sex either from FLE in school or from friends, sharing short videos on Messenger. Female youth also learned from FLE, social media, and movies.

The older generation learnt about sex in secondary school or year 8 or 9. One male parent learnt only in church before entering marriage. Female parents mostly learnt at secondary school, but also from friends and social media, and agreed that they did not receive any information from their parents. While male and female parents, as well as religious leaders, state that the appropriate age is 10-12 years old, older male youth think it should be 12-13 years old (in class 7). All participants agreed that the age should be the same for boys and girls, which is quite different from other communities, where the ages differ for boys and girls.

Most respondents mentioned "taboo" as the primary concern regarding comprehensive SRHR education. The topic is rarely discussed, especially within the iTaukei population. A teacher mentioned that religious teachings confirm this topic as taboo. Other concerns expressed regarding SRHR education in schools are that it is taught too early, with a religious leader stating that kids make fun of the topic and need to be mature enough to understand it. Both female and male youth FGDs suggested separate classes for girls and boys, so that boys will not laugh at certain topics, and girls can gain more confidence to speak up and share.

According to female parents, what is taught at school in FLE is too fast and too much, and children are too young to practice it. They attribute the early FLE in schools to the increase in teenage pregnancy. Younger male and female youth voiced similar concerns: "If you learn about it, you want to practice it, it can cause a teenage pregnancy." Male parents think that parents should be the ones teaching children about sex.

Younger male youth believe that there is a plant whose leaves can be mixed and drunk for abortion. Some older female youth believe black tea can be used as contraception. Younger female youth also mentioned that herbal Fijian medicine, hot water, or strong tea can be used to prevent pregnancy. Trusted information sources differ among participant groups. For younger female youth, the most trusted are parents, teachers, and health workers. For older male youth, the most trusted are health workers because they have studied it and can give them condoms. Interestingly, female parents said they cannot trust social media, despite it being their most common source of information.

I.2.2. **Attitudes, Awareness, and Contraception**

Male and female parents are both heavily influenced by religious beliefs, believing that "HIV and STIs are happening because people are turning away from God." Similarly, female parents associate the cause of HIV and STIs with people not conforming to religious rules not to have premarital sex. Premarital sex is also wrong from the Catholic religious leader's view, but he confirms the option for people to choose contraceptives, as HIV is on the rise. A health worker confirmed that she advises young people to take contraceptives along with condoms to stop STIs.

A female parent confirmed that girls and boys are treated differently: "When a boy has sex before marriage, the community accepts it. If it is a girl, they will gossip about her." A teacher confirmed that when it comes to information sharing, girls are more hesitant to ask questions about SRHR than boys.

When comparing the perceptions of young girls and boys about what constitutes a healthy relationship, significant gender differences emerge. While girls describe it as respecting each other, listening to each other and having healthy communication, boys describe it as "having daily sexual intercourse" or "through visuals." While girls agree that if their partner did not want to use contraception but she did, she would still use it, all the boys disagreed with this statement.

An interview with a male parent revealed that he never used any contraception and only recently found out about it. Female parents suggested that their daughter will get trauma and regret if she seeks contraception, stating, "There are side effects if she takes contraception contraception for teenagers.

Although negative attitudes towards contraception prevail, especially among the older generation, health workers stated that they advise about contraception and despite religion, nobody completely rejected it. Regarding access pathways, both older and younger male youth usually have to hide that they want to buy contraception.

Similarly, younger female youth also hide when accessing contraception, either asking someone else to get it, stealing it, or getting it through someone with connections at a cost. The FGD revealed that girls under 18 need consent from their parents when accessing contraception, which can constitute a significant barrier.

Participants mostly said that no one influences them and that they make their own decisions. Most young people agreed that both women and men should be virgins when they marry. Interestingly, they were not sure when asked whether God would punish them if they had sex before marriage. They mostly agreed that if they were not punished or caught by their families, they would have sex before marriage.

When comparing responses from parents, all parents strongly agree that women should be virgins when they marry. Most parents also agreed that most adolescents in this community have premarital sex. Most parents disagreed that it is right to take their daughters to get contraception before marriage. This suggests that while parents acknowledge the prevalence of premarital sex among youth, they oppose practical measures to mitigate its potential consequences.

The need to obtain consent constitutes an administrative obstacle that can prevent children from finding out their HIV/STI diagnosis and starting treatment early enough. The distance to the hospital and cost do not constitute an obstacle, as it is nearby. However, healthcare workers' attitudes can constitute a barrier. A male youth mentioned that healthcare workers asked interrogative questions when trying to access contraception, sometimes making him run away. Interestingly, the health worker herself did not see this as a capacity gap, stating that she provides assurance and is never judgmental.

I.2.3. **Gender Roles, Virginity, and Marriage**

Parents seem influenced by religious beliefs in their views on virginity and marriage. According to male parents, sex is only allowed when married; according to God, premarital sex is not allowed, it is a sin. Similarly, female parents mention the need to reflect God's word - sex is sacred and only for after marriage. A health worker mentioned that, for married couples, the husband is traditionally expected to be the head of the family, though nowadays women often take on that role.

Traditional views encompass beliefs, customs, and social norms passed down through generations. It was difficult to distinguish them from religious views in this community, and they also overlapped, especially in views forbidding premarital sex and traditional beliefs about virginity.

An interesting view was expressed by a religious leader:
Traditional knowledge is rich, but the problem is how it is being interpreted in modern times. Some people interpret it to fit their own agendas."

Both younger female and male youths seem to be influenced by their parents' traditional and religious views. Younger female youth mentioned that their parents advise them to finish school first and only then find a boyfriend. Sometimes parents wrongly attribute the rise of teenage pregnancy and HIV to SRHR education.

Younger male youth mention that in religion, you are not supposed to have sex before marriage, it is like sinning: "Parents are required to keep our sisters like that, when they go out, you have to be aware where they go, what time they're coming back." Girls' agency is thus restricted by norms of "protection," with parents expected to control their actions. However, there is no mention of similar expectations for boys, nor any responsibility placed on them for their role in premarital sex, reinforcing gender inequality.

Various participants mentioned a conflict between what is expected of them and what they actually do. Examples include: "many adolescents in this community are having sex, although it is taboo and it is not allowed"; "there is a difference between what is taught at home, school and church and what they are practising"; "most adolescents have premarital sex, even though it is not allowed."

I.2.4. **Social Norms and Their Enforcement**

Interestingly, the parents' normative expectations towards what children should do were heavily influenced by religious and traditional beliefs. They strongly emphasised the need to obey religious norms. In contrast, a religious leader took a more permissive stance, acknowledging that young people have the will to make their own choices: "We teach them what is right, but God gave them the ability to make their own choices."

Participants state that although there is the norm expectation, people nowadays do things differently: "For the girls, they have to be virgins. But nowadays most have already lost their virginity before marriage."

Most of the sanctions mentioned were related to people gossiping. Religious beliefs influenced other sanctions: "God will punish you if you sin", or "Because you are opening the door to the power of darkness to destroy you." A male youth group surprisingly suggested the need to get corporal punishment back to prevent teenage pregnancy.

Most groups agreed that early marriage should be the best option in case a girl gets pregnant while not married. Abortion was suggested as a solution by two groups, even though they mentioned it is a sin. A case of unintended pregnancy in the community was mentioned, where the girl was allowed to attend school up to delivery and then got married.

I.2.5. Violence Against Women and Girls

Younger female youth think that if a girl gets married, a boy can abuse her. A teacher confirmed that some students were abused at home, but there is underreporting of GBV cases. As it is clear that some cases happened, this confirms the problem of underreporting. One young person out of three agreed that traditional expectations in the community make it difficult for girls to refuse unwanted sexual advances.

Participants were not sure how violence against women is related to SRHR. Female parents were of the view that SGBV is wrong and not justified, but if a married woman takes contraception secretly and her husband beats her, the girl is wrong because they are married. They attributed the drivers of violence only to those who do not believe in God: "This is a common problem nowadays, but only happens to those who are far from God." One parent mentioned that her daughter was beaten by her son-in-law, suggesting they need to forgive him and accept him because of a poor upbringing.

I.2.6. **Intergenerational Differences and Dialogue**

A female parent thinks that there is no intergenerational change, while a male parent thinks otherwise: "The Bible says no sex before marriage. But now people are not following it." Younger male youth confirmed: "Because of social media and porn, also peer pressure, people are doing it any time now." Teachers confirmed this: "Most youth are already having sex at the time of SRHR... now children are more open to talk than the older generation."

Elders believe that youth are increasingly exposed to social media nowadays and tend to be more open to exploring. There is a shift in attitudes towards more openness: "In these days it is important to tell them the truth because gone are the days that we kept them in the dark."

All categories of participants mentioned that change starts at home; thus, parents need to be role models for their children and are responsible for teaching their kids, as what they learn at school is not sufficient. Various participants think that times have changed, and it is no longer possible to sit back and wait. It is time to teach children about contraceptives and the use of condoms to protect them.

I.2.7. Leadership, Champions, and Blockers

Most participants replied that religious leaders are not really supportive of SRHR education. On the other hand, another participant mentioned a partnership with the church to organise youth meetings and hold prayer meetings to help them. The village headman is the primary person responsible for knowing what is happening and providing approval for SRHR activities.

Women's leadership was not mentioned by any participants, except one who contradicted himself: "We need equality to promote women to be part of men's jobs. But married women should submit to their husbands, it is in the Bible."

A good working solution to overcome the feeling of shame was mentioned: youth come to the teacher privately to ask questions. Another participant mentioned that the leadership training she attended helped her address stigma and overcome taboos. The community health worker believes that people are equal and that marginalised groups feel left out, but it is her duty of care towards all.

I.2.8. **Pathways to Change**

Religious teachings heavily influence proposed strategies: "Jesus is the only solution. Turn to God because God knows he will bring you someone who is HIV free for you to marry." Other proposed strategies include:

- Parental support: Most participants also highlighted the role of parents in teaching their children about SRHR. The primary norm that needs to be challenged is the overall lack of transparency regarding the topic. Some participants mentioned that this needs to change: "We need to be more open to talk to one another and be more educated."
- Improve capacity building: Most participants suggested that training can improve access to SRHR. Health workers should visit the community to raise awareness and train teachers in SRHR education. Teachers need to be trained by NGOs in SRHR education targeting the 13-19 age group to build capacity.
- Multi-lingual communication strategy: Various participants mentioned the need to translate educational materials into the Indian and iTaukei languages. Female parents suggested having classes in different dialects so they can better understand and take a holistic approach to SRHR.

1.3. **Conclusion**

The taboo nature of the topic, especially for the iTaukei population, hinders open discussion. Traditional and religious teachings heavily influence the elderly generation, and according to them, parents' role to teach children about sex is of utmost importance. However, there is a dissonance between what the norms prescribe and what actually happens in practice. Data showed that young people are breaking common norms and becoming more open to the topic, although stigma remains.

The key challenge, according to both elders and youth, especially among the young iTaukei population, is embarrassment, shyness, and fear of shame. Opportunities for collective action and cultural shifts include sports events, community awareness initiatives led by village nurses, and NGO involvement in schools and local communities.

I.3.1. Community Maps

Female participants from the Viria community have identified key locations, including those that provide SRHR information or services, such as the health centre. According to young women, accessing the health centre becomes challenging during heavy rains or high tide, as the bridge to the facility becomes difficult to cross. This issue is particularly problematic for the elderly, who struggle to walk or cross the bridge to reach the centre. Furthermore, the health centre is not open 24 hours a day, and health providers rarely conduct outreach activities within the community. The map also highlights the community hall, as well as the village nurse and community leaders' residences, where meetings are held. However, SRHR topics are seldom discussed in these meetings, and local leaders often lack sufficient information on the subject.

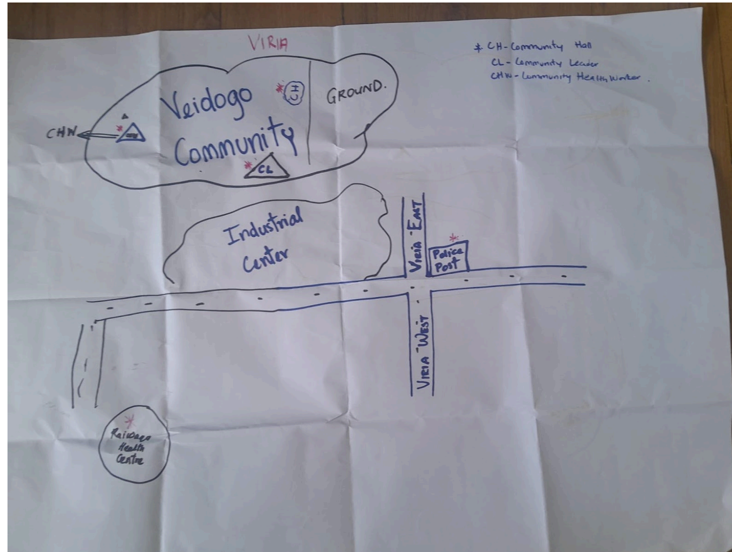

Figure 3: Viria - female participants' community maps

II. Suvavou

This section summarises the findings for Suvavou to facilitate a nuanced understanding of each context studied.

II.1. Introduction to the study site

Suvavou is a semi-urban village located on the outskirts of Suva, Fiji. Suvavou Village is a traditional iTaukei Fijian village located in the province of Rewa, within the urban area near Lami Town and approximately 2.8 km from Suva, the capital city of Fiji. As part of the Yavusa Nayavumata, it holds significant historical and cultural importance in the Rewa region, with a deep-rooted tribal structure documented in native land records (per historical research by Rokoua Mataiciwa, 2025). The village comprises approximately 140 households, with a predominantly iTaukei population. Most residents are employed in government and private-sector roles in the Suva urban area, reflecting a stable yet varied income base.

Dwellings are generally of good quality, including concrete and wooden structures, and the community infrastructure includes a large concrete community hall and a central Methodist-led church building. Some residents also attend the nearby Seventh-day Adventist (SDA) church on the village periphery. Suvavou has a significant youth population, many of whom are unemployed but actively engaged in sports clubs playing rugby and volleyball, fostering community cohesion. Health services are accessible through the nearby Lami Health Centre, private health facilities, and the main Suva CWM Hospital, with an active and engaged community health nurse supporting local needs.

Education is readily available, with easy access to primary, secondary, and tertiary institutions in the urban vicinity. Cultural taboos around discussing sex and menstruation contribute to limited parental engagement in SRHR education, with youth (aged 14–24) often relying on peers, schools, or social media for information, underscoring the need for community-driven education initiatives.

Data were collected through focus group discussions (FGDs), in-depth interviews (IDIs), community tools and key informant interviews (KIIs). The proposed data collection for Suvavou included six KIIs, seven IDIs, six FGDs, and three community tools. However, the actual data collected comprised four KIIs, six IDIs, two FGDs, and one community tool. Participants included youth (both male and female), community leaders, parents, local government officers, religious leaders, and health workers.

Table 13: Suvavou sample

	Suvavou Community - Proposed						Suvavou Community - Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Young people 16-17 (IDIs should be out of school)		1	1	1	1			1	0	1	0	
Young people 18-24		1	1	1	1			1	1	0	0	
Women (divorced /single, widow, never married)		1						1				
Parents with children over 15 years old		1	1	1	1			1	1	1	0	

RESPONDENTS - per location	Suvavou Community - Proposed						Suvavou Community - Completed					
	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Religious Leaders, Muslim, Hindu and Christian	2						0					
SRHR service provider/health workers	1						1					
Local govt	1						1					
Other local leader	1						1					
Community tools						3						1
Total	**6**	**4**	**3**	**3**	**3**	**3**	**4**	**4**	**2**	**2**	**0**	**1**

The following analysis will discuss key findings that highlight how religious, cultural, and traditional practices shape access to SRHR information and services.

II.2. **Findings**

II. 2.1 **Learning about SRHR and sexuality**

Most respondents reported that young people learn about sex and SRHR primarily through the Family Life Education program offered in schools. The main sources of SRHR information identified by young people include parents, teachers, media, social media, the internet, friends, and the radio. Of those who mentioned friends as their source of information, it was also noted that this information is often incomplete or inaccurate due to shyness and the taboo around discussing SRH issues openly.

We asked participants when young people should learn about SRHR vs. when they generally learn about it, and there was surprising consistency across all answers in this community. Almost all participants said that they learn about this in year 8, which is around 12-14 years old. Young women suggested that girls should start at 12, while boys should begin at 11. Female parents suggested girls should be taught SRHR when they have their first period and boys when they hit puberty, while a male parent suggested that girls should learn in high school and boys in year 10.

The difference between genders is based on the perception that boys' behaviours are more easily influenced by peer pressure than girls. One parent with children aged 25, 22, 15, 7, and 8 years noted that she had "not yet" discussed sex with her children, believing "it is not the time" and emphasising education and employment instead.

Parents were asked when they learned about sex themselves, and two parents mentioned that they only discovered when giving birth to their first child. As one mother explained, "The time I got married and had children, I went to the hospital where nurses give advice." Another male parent similarly shared, "When we have our first baby, when the hospital starts discussing family planning."

Most young people reported being more comfortable discussing SRHR with their mothers than with health service providers. It indicates their desire to be taught by their parents, despite the taboo surrounding this issue. Although most respondents acknowledged the significant influence that religious leaders have in their communities and their potential contribution to access to SRHR education, many highlighted the perceived conflict between faith and SRHR, which will be discussed in Section 2.2.

Feelings of shame, cultural taboos, conservative attitudes and beliefs are prevalent in the community. Misinformation and myths are present, and the myth that drinking plenty of water before and after sex prevents pregnancy was mentioned twice, as well as references to herbal medicine, traditional remedies and black tea. Trusted voices include health service providers, though the youth reported seeking advice outside their village to maintain confidentiality.

II. 2.2. **Attitudes, Awareness, and Contraception**

Overall, most participants had awareness of contraception and its role in family planning and HIV/STI prevention and emphasised its importance by noting that HIV/STIs are currently high in Fiji. While all male respondents agreed that they make their own decisions about health and relationships, young women and some female parents highlighted that women and girls in the community often have limited autonomy. Regarding pre-marital sex, most participants reported that girls face greater public humiliation and punishment compared to boys. As a result, boys tend to discuss SRHR matters more openly with their peers than girls. Furthermore, a female parent highlighted ethnic differences in the matter of early pregnancy by reporting that it is mostly iTaukei children who experience early pregnancy, whereas Indo-Fijians don't.

The most frequently mentioned contraceptives were condoms, tablets, and pills, which respondents got from the health centre, hospitals, and dispensers in schools. The discussions show that religion has a significant influence on how people in the Suvavou village approach contraception and family planning. Seventh-day Adventist (SDA) and Methodist respondents tended to be more supportive of using contraception because they have easier access to SRHR services and teachings. In contrast, some respondents pointed out that it is taboo for Catholic people to use contraceptives. However, respondents across all religions did not support pre-marital sex and abortion.

'For Catholics, it's a taboo for them to take contraception, unlike for us Methodists, we have freedom of choice.' (FGD Female Parents)

Barriers to accessing SRHR services include fear of public embarrassment or shame, peer pressure, provider discrimination, financial constraints, lack of information, and low literacy. Respondents also noted that confidentiality and stigma limit the access of youth and marginalised groups to SRHR services.

'So, if they walk in and we are already judging them with the look of our eyes, you know, they will never come back. And how we talk to them. It's still happening. I have seen it. That's why some of them would not access the health services.' (Community Leader)

II. 2.3. **Gender Roles, Virginity, and Marriage**

Traditional beliefs play a key role in how respondents viewed femininity, masculinity, virginity, and expectations around marriage. All respondents agreed that women and men should be virgins when they marry because it is taboo to have sex before marriage. Some participants discussed male control by noting that men often hold the authority to make decisions in their families.

'The male is always the prominent person who gets to decide and say whatever he wishes and expects his commands to be obeyed.' (Local Government Officer)

Although religion and traditional views can be differentiated in theory, in practice, they often overlap regarding contraception and family planning. As a result, they reinforce conservative attitudes towards SRHR and discourage open discussion about sexuality. Both belief systems significantly shape young people's choices around relationships and sexuality, often pushing them to hide their relationships from parents and limit their ability to make informed SRH decisions as they avoid being seen as sexually active in their communities. Furthermore, a respondent noted that the overlap of traditional practices and religious expectations leads to many people being confused about how to exercise their sexual and reproductive health and rights.

'In our culture and practice, we have our own line, and the church follows its own line, and one thing that has emerged and has come between the two is change. The problem now is that our culture and practices are perceived as wrong. The church has its own teachings, and if these are strictly followed, it will save and keep its people. The problem is that they don't follow; they're sitting on the fence between culture and religion, and then the problem arises. So when change is happening, it is important that our views and perceptions also change.' (Local Government Officer)

Most participants reported being sexually active and having access to contraception; however, all participants agreed that God would punish them if they had sex before marriage. This illustrates an internal conflict between faith and practice. Some respondents noted that even though discussing sexual issues is still taboo in their communities, they reject these values and acknowledge that it is about time people started an open discussion about SRHR.

'We should just openly talk about it and break the barrier of being taboo and the i-Taukei No-No issue to talk about. We just talk about it openly because, if you shut it out at this level, there are many avenues—gadgets, the internet—it is open and available freely. It's just best to talk about it and let the children learn about these issues.' (Teacher)

II.2.4. Social Norms and Their Enforcement

Strong social norms continue to influence how people in the village behave and make decisions around sexual and reproductive health. Normative expectations dictate that young people should remain virgins till marriage and should, therefore, not need to access SRHR services; however, empirical expectations suggest that respondents do not always follow these norms because they acknowledged that most young people have premarital sex and attempt to access SRHR information and services despite the societal expectations.

Sanctions and punishments for nonconformity with social norms remain significant, particularly for girls. Young females who engage in premarital sex or become pregnant outside of marriage face beatings from parents, gossip, public humiliation, and social exclusion. At the same time, boys often do not experience the same repercussions.

Myths and misconceptions continue to circulate in the community due to limited access to accurate sexual health information. Many young people do not conform to traditional expectations around virginity. Still, as a consequence, they live with shame and fear of judgment from families, churches, health workers, and the community. This discourages young people from having open discussions about contraception and safe sex, and this can prevent parents from having the opportunity to really know their children.

'That's why it's difficult for most of us to know about our own children, they will go to a person they trust the most, to share things with, rather than at home with mum and dad.' (Female Parent)

II.2.5. Violence against Women and Girls

Even though no respondent explicitly stated that there is sexual coercion and non-consensual behaviour, discussions revealed that traditional and religious norms emphasise female submission, which creates a gender power imbalance in intimate relationships. Some female participants supported the statement that they know many women use contraception without their partners knowing it. Additionally, a 23-year-old strongly agreed that traditional expectations in the community make it difficult for girls to refuse unwanted sexual advances. These scenarios reflect how many women do not have the power to negotiate contraception and to refuse sex.

Respondents reported that girls and women who disobey men and families, do not conform to traditional roles or threaten male honour, experience punishments such as gossip, public shaming and beating. Furthermore, discussions revealed that different ethnic groups punish differently when faced with these issues. Female parents' FGD shared that "for Indo-Fijians, they will end up killing" if a man finds out a woman is using contraception without his knowledge.

II.2.6. Intergenerational Differences and Dialogue

Findings highlight apparent intergenerational differences in attitudes toward contraception, CSE, and gender roles. Younger respondents expressed openness to learning and seeking SRHR information from friends, the internet, and social media, although they lacked depth in their understanding of the subject.

Most older respondents described learning about contraception and family planning at the time of the birth of their first child. Taboos and cultural norms limited SRHR education and awareness in earlier generations, and many of these taboos and cultural expectations remain in place today. However, they are not adhered to as strictly as in earlier generations. Older generations emphasised how girls nowadays do not stay at home and leave when they want. At the same time, during their time, they had to be accompanied, which demonstrates how girls do not conform to the restrictive gender roles.

'...girls will always stay home, not entering another house, or going outside. Or if we want to go somewhere, someone will accompany us. Now, if they want to go, they just go, they communicate through the use of the internet.' (Female Parent)
'Yes, because we follow our parents' instructions, whereas nowadays people get access anywhere they want.' (Male Parent)

Both young and older respondents highlighted the lack of intergenerational dialogue in the community. As a result, it pushes young people to hide their sexual activities from families and seek information from peers and social media, which is often inaccurate and can lead to negative consequences like STIs and early pregnancy. Many participants have identified entry points for intergenerational dialogue, including promoting open family discussions and building the capacity of village leaders and chiefs to advance SRHR within their communities. Utilising church and village gatherings as spaces for education and involving both youth and parents in SRH awareness programs to bridge understanding and build solidarity for change.
'...So, it starts from the home. We need to equip families so that they can talk to their children, especially to their daughters.' (Community Leader)

'For example, the females, if they talk about how this certain service- contraceptive has been useful to them, taking pills or injection, then they will be willing to share with the younger folks, younger mums. And sure enough, they will be willing to come forward to take the services, because the senior ones have evidence —their experience has been favourable. So, the younger ones can follow suit.' (Teacher)

'But I think it's time now that the leaders of the community, the chiefs – they need to be well informed. So, there is no silence about this. There's no culture of silence about this. And when they speak to the community, the leaders are comfortable discussing all issues, including SRHR. In a way, it will also help community members—the villagers—know that our leaders or chief is concerned about this. We need to do something.' (Community Leader)

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II.2.7. Leadership, Champions, and Blockers

Religious and traditional leaders remain key gatekeepers, as many continue to discourage young people's access to FLE. For instance, many respondents mentioned how religious expectations and traditional norms are barriers to them in seeking SRHR information and services, as both emphasise purity, virginity, and obedience. As a result, these beliefs often prevent young people from freely seeking the accurate SRHR information and services they need.

However, there are also emerging champions for change. Faith leaders from certain denominations, such as the Seventh-day Adventist Church, reportedly received support from their members, who acknowledged that it is easier to access their teachings and services. Some coaches, for example, on the rugby team, were reported to be supportive and helped young boys access accurate SRH information. Likewise, some parents and teachers recognised the need to start open SRHR discussions at home and improve the curriculum in schools to prevent early pregnancies and STIs, showing gradual shifts toward openness.

Furthermore, women were reported to be more active than men in influencing SRHR in the village. This was evident when many women in leadership positions in schools, health centres, and churches explained how they went the extra mile to facilitate SRHR discussions with young people while doing their duties.

'So, I talk to the students as if I am talking to my girls. Also, in church, if we have Adventist Youth programs, their issues with regards to family issues, I will talk about it because the consequences are real and it's happening there in society.' (Female Teacher)

However, cultural gatekeepers and healthcare providers often remain barriers, with judgmental attitudes and questions that discourage young people from seeking services. Despite these challenges, the presence of positive deviants – parents, faith leaders, coaches, and peers – who are breaking the silence and advocating for openness, signals a growing shift in community norms around SRHR.

II. 2.8. Pathways to Change

Respondents identified several pathways to change that could help to address SRHR barriers and harmful norms.

- **Educational and Communication Strategies:** Most of them emphasised the need to broaden the FLE curriculum in schools to include comprehensive SRHR education and to conduct awareness seminars, ensuring that boys and girls have access to accurate information. A community leader raised a concern about the SRHR education offered at schools, highlighting that the curriculum needs to be reviewed because teachers do not have comprehensive information, as the teachings are more about teenage pregnancy and the use of condoms. Young men recommended utilising sports as a platform to engage young people and create a safe space for dialogue on SRHR. Moreover, SRHR materials should be available in local languages to increase understanding and reach all people, especially those who may not have had the opportunity to complete their education.

- **Parental support:** Parents and youth suggested that SRHR education should start at home; therefore, they encouraged open family discussions involving not only mothers but also fathers. Promoting intergenerational dialogue will help build solidarity and create safe spaces for conversations without consequences for young people who go against traditional norms.
- **Engaging leaders:** Engaging faith and traditional leaders, such as pastors and chiefs, was seen as crucial to weakening restrictive norms. Respondents suggested utilising gender and village meetings to conduct awareness and outreach programs. Additionally, it was suggested that local institutions, such as the Women's Crisis Centre, be equipped to spread awareness to the village.
- **Improving inclusive and youth-friendly health services:** Provide training for providers to deliver services to young people and marginalised groups without bias, stigma, or breaches of confidentiality. Mobile clinics were suggested as another solution for helping marginalised groups and people who fear being seen accessing SRHR services. Participants requested that health centres and hospitals have unisex toilets to promote inclusiveness.

I.3. Conclusion

Findings illustrate that there are significant religious, social, and cultural barriers limiting young people's access to SRHR services and their ability to make informed decisions about their reproductive health. Girls and young women continue to be restricted by traditional expectations around virginity, marriage, and obedience. Parents and elders are often wary of FLE with the fear of pre-marital sex, early pregnancy and early marriage.

Religious and cultural norms strongly influence people's attitudes towards contraception, family planning, gender roles, and relationships. SDA and Methodist were reported to be more supportive of contraception than the Catholic denomination. Both religious and cultural norms emphasise abstinence teachings and silence around sexuality, which remains a key barrier. As a result, youth experience barriers such as inaccurate information, stigma, fear, shame, and provider discrimination.

Despite these gaps, opportunities exist for collective action, such as expanding SRHR education in schools, enhancing youth-friendly services, and engaging faith and community leaders to foster dialogue and challenge harmful norms. Building intergenerational and interfaith solidarity offers a pathway toward gradual cultural shifts that promote informed decision-making, gender equality, and well-being for all people in the village—similarly, empowering SRHR champions by providing them with the tools to deliver culturally safe and relevant SRHR information and raise awareness, while linking them to SRH services.

III. Nasekula

This section summarises the findings for one community to facilitate a nuanced understanding of each context studied.

III.1. Introduction to the study site

Nasekula Village is a traditional iTaukei Fijian village located in Macuata Province, Northern Division, situated in the urban area adjacent to Labasa Town, the largest town in Vanua Levu and the Northern Division of Fiji. The village is predominantly iTaukei, with most residents employed in government, private sector, and NGO roles within Labasa Town, reflecting a stable but varied income base. Housing in Nasekula consists primarily of substandard concrete and wooden houses with iron roofs, a shift from the traditional Fijian bures. The village benefits from proximity to numerous educational institutions, including primary, secondary, and tertiary facilities, and has access to the Labasa Divisional Hospital, the largest hospital in the Northern Division.

A community health nurse (nasi ni koro) serves the village, supporting local health needs. Nasekula enjoys good road infrastructure and accessible public transportation, including buses and taxis, which facilitate connectivity to urban amenities. The community has a strong historical connection to rugby, with the Nasekula Rugby Club founded in 1951, producing notable players who have represented Fiji.

Rugby serves as a significant outlet for youth energy and community cohesion, especially given the challenges faced by some village youth due to limited access to lease money and reduced incentives for education. Cultural taboos around discussing sex and menstruation contribute to limited parental engagement in SRHR education, with youth (aged 14–24) often relying on peers, schools, or social media for information, highlighting a need for community-driven education initiatives.

Data were collected through focus group discussions (FGDs), in-depth interviews (IDIs), community tools and key informant interviews (KIIs). The proposed data collection included six KIIs, seven IDIs, six FGDs, and three community tools. In practice, six KIIs, seven IDIs, four FGDs, and one community mapping were conducted. Participants included youth (both male and female), community leaders, parents, teachers, religious leaders, and health workers. Data collection for the FGDs and community tools was not completed due to difficulties mobilising participants during the first visit. The lack of data collection volunteers during follow-up visits also contributed to difficulties in collecting all the data.

Table 14: Nasekula sample

	Nasekula Community - Proposed						Nasekula community- Completed					
RESPONDENTS - per location	**KII**	**IDIs**		**FGD**		**Community Role Play + mapping**	**KII**	**IDIs**		**FGD**		**Community Role Play + mapping**
		Female	**Male**	**Female**	**Male**			**Female**	**Male**	**Female**	**Male**	
Young people 16-17 (IDIs should be out of school)		1	1	1	1			1	1	0	0	
Young people 18-24		1	1	1	1			1	1	1	1	
Women (divorced/single, widow, never married)		1						1				
Parents with children over 15 years old		1	1	1	1			1	1	1	1	
Teachers / Head of school	1						1					
Religious Leaders, Muslim, Hindu and Christian	2						2					
SRHR service provider/health workers	1						1					
Local govt	1						1					
Other local leader	1						1					
Community tools						3						1
Total	**6**	**4**	**3**	**3**	**3**	**3**	**6**	**4**	**3**	**2**	**2**	**1**

III.2. **Findings**

III.2.1. **Learning About SRHR and Sexuality**

Youth mostly learn about sex via social media (Messenger, Instagram), group chats, school, and friends, but not from parents. By comparison, parents learned from friends, their parents, school, phone, workshops, or on their own. The least common source of information is the church. The experiences differ significantly when comparing older and younger generations. Elderly people learned about sex at a later age (around 25), while youth mentioned learning at considerably younger ages (12 years old, class 8).

Parents mostly think that girls should be in primary school at class 6 or 7 when they should start learning about sex, or as soon as they start secondary school (14-15 years old). Most participants think that boys should learn at the same age as girls, except for two who suggested that boys should be one year older, since girls mature earlier.

The primary issue with access to SRHR education is the requirement to obtain parental consent for children to attend Family Life Education (FLE) in schools. Most participants in the role-play exercise agreed that there should be no consent form and that FLE should be taught without parental approval. Various participants identified that the topic is still taboo, and some people see the main risk as young people wanting to try sex once they learn about it. Another issue is the lack of proper training received by teachers, who may be uncomfortable sharing this sensitive topic due to feelings of shame (madua).

The opinions on who should teach about sex differ. Some participants think the church should teach, while others think parents or NGOs should. Most trusted information sources among girls are school and parents, while for boys, it is friends, teachers, the internet, and porn. Parents are the least common source of information for boys. Traditional methods of family planning or birth spacing were mentioned, including drinking strong tea after sex, though participants haven't tried these methods.

III.2.2. **Attitudes, Awareness, and Contraception**

Participants were mostly aware of the role that contraception plays in preventing HIV and STIs; however, their most recommended solution was abstinence. Three out of four youth participants agreed that abstinence is the best form of contraception, and all parents either agreed or strongly agreed with this statement. One parent had two sons who died from STIs, blaming the sons for not listening to advice to abstain from sex. Participants saw the key challenge in reducing STIs as the lack of family talk:

"The main difficulty is that parents don't talk with their children."

When asked about what a person diagnosed with HIV should do, participants in the role-play exercise suggested the person would consider suicide. Younger female youth confirmed that there are different expectations for girls and boys: girls should be more disciplined and suffer more than boys if people find out they had sex. A health worker thought that the majority of males don't use condoms despite advocacy efforts. Despite this, some participants confirm that they prefer condoms as contraception and strongly agree that youth should use them to prevent teenage pregnancy.

Strategies that youth implement to access contraception include wearing a disguise, such as a mask or hood, sending a friend, going to the hospital and asking a nurse not to tell anyone. Most youth participants either agreed or strongly agreed that girls in this community can access contraception before marriage; however, most still agreed that abstinence is the best form of contraception for adolescents.

The youth mostly stated that no one shapes their attitudes towards contraception; however, they seem influenced mainly by peer pressure. The older generation appeared to be heavily influenced by religion. Religious beliefs mostly create a barrier for access to contraception, with the Methodist religion not allowing condoms to be brought into the village.

Morality also intersects with religion - alcohol is seen as a trigger for STIs and HIV. A religious leader stated:

"This is my own view: the use of contraceptives should not be allowed at all. The Church is firm that you must not engage in sex before marriage."

A significant barrier is that a girl under 18 needs consent from her parents to access contraception. People with diverse SOGIESC, including lesbian, gay, bisexual, transgender and gender-diverse people, often face additional stigma when trying to access SRHR services Service providers' attitudes and lack of confidentiality also constitute barriers. Some of the main identified challenges include people's unwillingness to access SRHR services. The health worker admitted that they had not focused on SRHR at all in the last four years, stating that he had not been tasked with addressing SRH issues, such as distributing condoms or raising awareness.

III.2.3. Gender Roles, Virginity, and Marriage

Key traditional beliefs include that discussions about sex are shameful and that premarital sex is prohibited. When young people do not adhere to these traditional rules, it is often attributed to how parents raised them, which shames parents. Overall, conservative views prevail in the Nasekula community.

Religion, mainly Christianity, appears to play a significant role in shaping people's choices. Both male and female parents held the opinion that both females and males should be virgins when they marry, and that you are not supposed to use contraception due to religious beliefs. This was especially important for iTaukei. Interestingly, two out of three youth respondents disagreed with the statement that most adolescents in this community have premarital sex. At the same time, adults all either agreed or strongly agreed with the same statement.

The traditional coming-of-age rituals are still practised in Nasekula. It is difficult to differentiate traditional beliefs and religion in Nasekula. People's views on virginity, marriage and the use of contraception seem to be influenced by religious, rather than conventional beliefs. People cite the Bible, mention that marriage is God's covenant, and that having premarital sex is a sin.

All youth participants agreed or strongly agreed with the statement that both women and men should be virgins when they marry. Still, participants also think that premarital sex is very common today, although the church considers it to be a sin. The community still has patriarchal expectations towards girls in comparison to boys regarding dress code. Most young people agreed that they make their own decisions about their bodies; however, they also strongly agreed with the statement "God will punish me if I have sex before marriage," showing conflict between religious teachings and personal aspirations.

III.2.4. Social Norms and Their Enforcement

Some participants blame parents for not educating their children about sex. People are expected to follow religious teachings and place religious norms at the centre of their actions. A positive development is that both male and female youth participants agreed or strongly agreed with the statement.

"I think all women should decide about things that affect their bodies like sex and contraception."

Two out of four participants strongly agree that if they talk openly about sex, people will think badly of them. Most young people agree that their future in-laws will expect them to be virgins when married. Most parents agreed with the statement.

> "I know many women who use contraception that their partner is not aware of."

Responding to the question about what other people in the community would do if they found

out an adolescent had sex, the answer was that they do nothing at all for both girls and boys (no punishment, no gossiping, no shaming). However, another participant mentioned that people will talk badly about you if you go to buy a condom. The cause of teenage pregnancy was attributed to harsh upbringings and broken families. Suicide was suggested as one of the solutions in case an unmarried girl gets pregnant.

III.2.5. Violence Against Women and Girls

It is alarming that one participant still sees the cause of SGBV in the way a woman dresses, rather than holding the perpetrator responsible. Both SGBV and poor SRHR are rooted in harmful social norms, gender hierarchies, and patriarchy, which limit decision-making power and access to information and services.

The participants think that most commonly, SGBV happens inside a marriage regarding sex. Other participants reiterated that we must stop violence, but the woman is still to be blamed if she lied about contraception to her partner. Religious beliefs regarding jealousy and hiding things in marriage are another cause of violence. This reveals a pattern in which women are often seen as ultimately responsible for violence, while the role of the perpetrator is overlooked or justified.

Two out of four young people agree with the statement: "Other people in this community think boys can force girls to have sex." One out of two young girls stated that she does not know how to resist her boyfriend's request for premarital sex, suggesting that situations of sexual coercion are common, with girls feeling unable to assert their autonomy and highlighting a power imbalance in the relationships, where boys feel entitled to pressure or force girls into sex.

III.2.6. Intergenerational Differences and Dialogue

Various participants think the younger generation is now more open-minded and better educated about SRHR. One participant attributed the youth's changed perspectives to social media. A participant thinks that marriage was more important for the elderly generation than for young people now:

"Time has changed, and so have behaviours, norms have changed... even primary school students do this (sex)...in the past, they only had intercourse for the intention of trying to have a child." (IDI male and female parent, Nasekula)

The important role of parents in teaching about SRHR was highlighted. This is especially difficult for iTaukei homes, where this is still taboo:

"But our culture, our cultural value -it is very difficult for parents to tell their children." (KII teacher, Nasekula)

One participant believes that Indo-Fijians share more openly with their children, revealing cultural differences in how each ethnic group perceives and approaches SRHR.

III.2.7. **Leadership, Champions, and Blockers**
The church does not openly resist sex education; they organise awareness-raising sessions, however, they think that both school and parents need to be involved to teach their kids religious values along with SRHR. Village local leaders appear to be obstacles to expanding sex education. The village headman stated that in the town, people have no rights except to follow village rules.

There was very scarce information about women's leadership. Youth participants mostly agreed with the statement that women and girls in this community have little say in decisions about health and relationships. Religious leaders support youth SRHR education by arranging church youth camps during weekends and inviting NGOs to come and talk to youth about preventing teenage pregnancy.

Some positive examples can be seen in nurses' community-based awareness-raising sessions on family planning. One female parent showed willingness to challenge harmful norms, stating she wouldn't care about gossip if the community knew she taught her daughter about sex.

III.2.8. **Pathways to Change**
Various pathways to change were suggested, emphasising the importance of raising awareness and stretching parental support:

- Awareness Raising Activities: It was suggested that professionals be brought in to discuss with the youth in the absence of their parents. Awareness activities could be incorporated into village meetings.
- Enhance Capacity Building: To address the taboo and stigma, nurses and healthcare workers also require training to become more comfortable with SRHR topics.
- Parental Support: Strengthen the role of parents to teach their children about sex and living in sexual purity. Both female and male parents suggested that youth should come to church for education about safe sex.

The harmful norms that need to be addressed to strengthen SRHR include the belief that educating youth about sex increases sexual activity, as well as norms that consider discussions about sex shameful. Family time was recommended as a solution to prevent teenage pregnancy. However, it seemed more focused on controlling young girls' behaviour and movements than on fostering open discussion about the issue.

III.3. **Conclusion**

Key findings highlight that youth learn about sex from social media and friends rather than parents, and there are generational differences in the age at which sex education is deemed appropriate. Key challenges to comprehensive sexuality education include parental consent requirements, the topic being taboo, and a lack of teacher training.

Religious beliefs significantly influence attitudes towards contraception, family planning, and premarital sex, often creating barriers to SRHR services, while also offering opportunities better to address SRHR in a culturally safe and appropriate manner.

Gendered expectations and patriarchal norms also impact decision-making and access, with women having limited say in health and relationship matters.

Participants suggest that awareness-raising, intergenerational dialogue, and collaboration among community leaders, health officials, and the church are crucial pathways to overcoming these barriers and promoting positive change in access to and outcomes of SRHR.

III.3.1. **Community Maps**

Naseakula Village is located in the province of Macuata on Vanua Levu, approximately 1 kilometre outside Labasa Town. The village is large, to the extent that events or occasions happening on one side may not always be known to those on the other. Naseakula is a flood-prone area, as the creek separating the village from Labasa Town frequently overflows during heavy rain. During such times, participants shared that access to essential services, such as hospitals, police stations, and NGOs in town, becomes impossible. However, these floods usually do not last long, typically less than a day, and therefore have minimal impact on their SRHR services. Although the community is regularly visited by health professionals and NGOs, discussions about sexual and reproductive health remain taboo for many villagers.

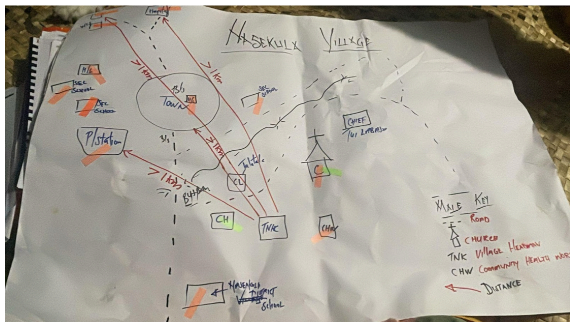


Figure 4: Nasekula male participants mapping (Labasa)

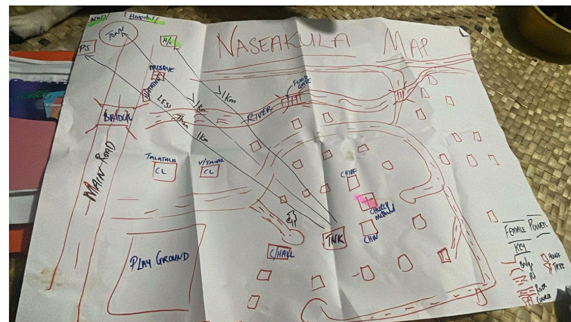


Figure 5: Nasekula female participants (Labasa)

IV. **Siberia**

IV.1. **Introduction to the study site - Siberia**

iberia is a peri-urban community settlement located just minutes away from Labasa Town, the largest town on Vanua Levu, in the Northern Division of Fiji. Labasa Town has a population of approximately 49,369, according to the 2017 census, with a majority being Indo-Fijians, descendants of indentured labourers brought to work on plantations. Siberia itself comprises about 40–50 households, with some community estimates suggesting over 100 houses, and is predominantly Indo-Fijian. Most residents are employed in government and private-sector roles, while others engage in farming and various skilled trades.

The community benefits from its proximity to Labasa Town, with access to a major hospital and primary, secondary, and tertiary educational institutions. Infrastructure within Siberia includes gravel feeder roads in some areas, while parts along the main road have good road infrastructure. The community also has access to reliable water and electricity services, though housing is generally simple and sub-standard, often constructed from concrete and wood.

The community is guided by a local advisory councillor who serves in a leadership role while also holding a full-time job and residing within the settlement. Cultural taboos and stigma around discussing sex and menstruation often limit parental engagement in SRHR education, with youth (aged 14–24) typically learning about these topics from school teachers, peers, family members, social media, or health workers, generally between ages 12–18, underscoring the need for accurate and culturally sensitive education initiatives.

This section summarises the findings for Siberia to facilitate a nuanced understanding of each context studied. Data were collected through focus group discussions (FGDs), in-depth interviews (IDIs), community tools and key informant interviews (KIIs). The proposed data collection included six KIIs, seven IDIs, six FGDs, and three community tools. The actual data collected comprised six KIIs, six IDIs, six FGDs, and three community tools. Participants included youth (both male and female), community leaders, parents, teachers, religious leaders (Muslim, Hindu, and Christian), and health workers.

Table 15: Siberia sample

	Siberia Community - Proposed						Siberia community- Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Young people 16-17 (IDIs should be out of school)		1	1	1	1			1	1	1	1	
Young people 18-24		1	1	1	1			0	1	1	1	
Women (divorced/ single, widow, never married)		1						1				
Parents with children over 15 years old		1	1	1	1			1	1	1	1	

	Siberia Community - Proposed						Siberia community- Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Religious Leaders, Muslim, Hindu and Christian	2						2					
SRHR service provider/health workers	1						1					
Local govt	1						1					
Other local leader	1						1					
Community tools						3						3
Total	**6**	**4**	**3**	**3**	**3**	**3**	**6**	**3**	**3**	**3**	**3**	**3**

IIV.2. Findings

IIV.2.1. Learning About SRHR and Sexuality

Young people across Siberia primarily learn about SRHR through schools (Family Life Education program), friends, and the internet. However, there is a significant gap in parent-child communication. Parents, particularly mothers, are expected to discuss sexual health with their children, but youth consistently report learning the least from them. This gap is deeply rooted in cultural taboos, especially within the Indo-Fijian community. A Hindu key informant estimated that only "5%" of Indo-Fijian community parents discuss SRH with their children, with parents describing traditional thinking as making it "very hard" to discuss sex with teenagers.

Male youth (18-24) reported accessing pornography via the internet to learn about sex, while younger male youth prioritised social media and friends. Female youth cited school as their primary source of information. Although health centres and pharmacies are available, young people struggle to access them due to embarrassment and fear of shame (madua). Religious institutions (Hindu and Muslim) largely treat sex education as taboo, reinforcing community avoidance of the topic.

Regarding when young people should learn about SRHR, views differ significantly. Young people confirmed that foundational learning begins in school between classes 5 and 8. However, younger female youth suggested a later start (17-18 years), while older male youth endorsed earlier education (Class 6, 11-12 years old), but worried that early sex education leads to experimentation. Female parents advocated for teaching by Class 6, stating that education should begin at a

"very early time, not when it is already too late."

Male parents and teachers suggested age 16 (puberty) for both sexes. The Muslim Religious Leader differentiated by puberty: girls should learn before menstruation (around 12) and boys around 14. One widow linked appropriate age to marriage norms, suggesting girls should learn at 16 and boys at 21 when they typically marry.

Family Life Education (FLE) in Fiji faces widespread resistance rooted in conservative beliefs. While all parents and young people recognise FLE's benefits—providing factual information, promoting awareness, and teaching protection—opposition stems from the assumption that FLE leads directly to sexual experimentation. Some female parents fear that once protection methods are taught, girls start "experimenting." Religious leaders, particularly Muslim leaders, oppose external sex education, and teachers feel constrained by community pressure, fearing parents would "take it negatively."

Schools and teachers are the most trusted sources for accurate information, particularly among younger adolescents. Older youth and adults also trust health workers and counsellors. However, inaccurate information proliferates through informal youth networks and digital platforms, with younger males accessing pornography to learn "styles" of sex. Traditional myths also circulate, such as drinking "very strong black tea" to prevent pregnancy. Access to accurate information is severely hindered by fear of confidentiality breaches and shame (madua), with young people fearing that local providers will gossip about their seeking STI testing or contraception.

IV.2.2. Attitudes, Awareness, and Contraception

Awareness of contraception is broad, driven primarily by school curricula and public health campaigns. Young people and service providers generally recognise contraception's dual protective role in preventing both unwanted pregnancies and diseases. However, one Muslim key informant stated it is irrelevant because people are forbidden to have sex before marriage, noting that condom use is "far, far behind" in the community.

Gendered differences severely limit female autonomy and lead to unequal sanctions for sexual activity. When girls engage in premarital sex, they face punishment and gossip, with losing their virginity before marriage bringing "shame." For boys, the community typically "do nothing" as the behaviour is viewed as "normal." Sexually active girls are called names like "prostitute" and "bitch," while there are no equivalent names for boys. Decision-making power is curtailed for women, with many letting male partners or elders control contraception choices. To cope with limited agency and avoid partner violence, some women resort to secretly using methods like Depo or Jadelle.

Condoms are the most frequently cited preferred method among youth, valued for being "cheap and readily available." Older female adults prefer hormonal or long-term methods. While access to contraception is generally good due to the proximity of pharmacies and health centres, it is severely restricted by social barriers, particularly embarrassment and fear of confidentiality breaches.

Contraceptive decisions are shaped by a complex interplay of personal and institutional influences, although religious prohibitions often serve as significant barriers. The Muslim faith is highly restrictive, with girls sometimes told they are "not allowed to use contraceptives." However, certain restrictions in the Muslim community are attributed to leaders rather than religious texts. Hindu and Christian teachings generally discourage sex before marriage, viewing it as a sin. Health workers' messaging is crucial for older adolescents, while peers, friends, and school curricula have a greater influence on younger adolescents. Parental authority remains paramount for many adult women, particularly Indo-Fijian women.

SRHR services are physically accessible, with the hospital located less than 1km away, yet social barriers severely restrict access. Shame (madua) and fear of confidentiality breaches are the most significant obstacles. Younger males report difficulty approaching female staff at pharmacies for condoms, and younger female youth are uncomfortable discussing sexual health with community providers due to fear of gossip. Most contraceptives are restricted for those under 18, creating an additional legal barrier. SRHR services are also recognised as "not accessible to people with disabilities."

IV.2.3. **Gender Roles, Virginity, and Marriage**

Traditional and patriarchal gender norms are deeply embedded within this community. The belief that virginity is mandatory for women before marriage is widespread, with elders viewing the loss of purity as "shame" and a "very big thing." Both Hindu and Muslim teachings prohibit sex before marriage, emphasising that marriage at the "right time" would prevent unwanted outcomes. However, premarital activity is considered "normal" for boys, while sexually active girls face severe stigma, reinforcing gender inequality.

Religion and traditional views are often conflated. While both share a fundamental position that sex before marriage is strictly prohibited, Indo-Fijian culture places particularly strong emphasis on female virginity for marriage eligibility. One leader admitted that people are "doing the opposite" of what religion teaches, leaving parents "torn between wanting to protect her daughter's future and her holding a cultural and religious expectation." This reveals a tension between religious teachings and cultural norms, as well as current social interactions and practices, with youth often acting in ways that contradict these teachings.

These strict, gendered norms profoundly shape young people's behaviour, compelling them toward secrecy and risky choices. Due to severe stigma against premarital sex (especially for girls), young people seek concealment methods. The lack of female agency and enforcement of male authority create conditions for violence and abuse, with women using contraception without their husband's knowledge facing potential "sexual violence." Teenage pregnancy creates a brutal conflict, often forcing girls to choose between education and family honour,

with consequences including dropping out of school, suicide, or considering abortion. One older male adolescent cited a real case where a girl "just kills herself" upon her father discovering the pregnancy.

Societal expectations curtail girls' agency, with women having limited "say in decisions about health and relationships." The normalisation of their sexual activity reinforces boys' agency. Cognitive dissonance is visible across age, gender, and ethnic groups when comparing strict normative expectations against personal desires and empirical reality.

IV.2.4. **Social Norms and Their Enforcement**

Normative expectations regarding SRHR are rigidly defined by traditional and religious frameworks, placing absolute value on sexual purity. The strongest expectation is that women should be virgins when they marry, though this is less vigorously enforced for males. While there is a belief that education "starts from home," the cultural and religious belief that talking openly about sex is "taboo" leads to a norm of silence, particularly among Indo-Fijian Hindu/Muslim communities.

Empirical expectations reveal profound cognitive dissonance between conservative normative ideals and observed reality. There is widespread agreement that "most adolescents in this community have premarital sex," and that "many women use contraception that their partner is not aware of."

Non-conformity to sexual norms is policed through strong, gender-unequal sanctions focused on shaming, gossip, and social exclusion. If a girl has had sex, community members "punish them" and use labels such as "prostitute" or "bitch." For boys, having sex is "normal," resulting in unequal treatment where negative commentary focuses on females. Fear of shame (madua) drives embarrassment when purchasing condoms or asking questions about sex. Parental authority also reinforces sanctions, with parents noting, "We can go against our kids' decisions."

IV.2.5. **Violence Against Women and Girls**

Cultural and religious norms create direct links to sexual coercion and Sexual and Gender-Based Violence (SGBV). Younger adolescent females face immense pressure, finding it "difficult for girls to refuse unwanted sexual advances." Violence Against Women and Girls (VAWG) is directly facilitated by harmful norms of male control, with women using hidden contraception risking reproductive coercion and sexual violence if discovered by partners.

Suicide is an extreme, gendered consequence of premarital pregnancy and resulting shame. Parents worry that excessive pressure might cause girls to "go and hang themselves" or "drink something." Early marriage is often forced by families to mitigate shame, typically resulting in girls dropping out of school. One parent reported rape and molestation against young children: "even the class one, two, three girls are molested... They are actually raped."

Community perspectives on violence drivers reflect deep-seated gender inequalities. Conflict escalates into violence when women exercise autonomy regarding contraception. A strong view exists with one leader linking violence to modernisation and claiming the “dressing of the girls nowadays" is "allowing violence to happen."

IV.2.6. **Intergenerational Differences and Dialogue**

Traditional taboos and established hierarchies severely limit intergenerational dialogue on SRHR, leading young people to primarily seek information outside the home through schools or the internet. Older parents observe a "complete breakdown of authority," recalling that their generation was "afraid of strict, traditional parents." Still, now teenagers dismiss older views, saying, "You people from the old thinking, we are in the new modern era."

Male youth state people now choose the "modern way," opting to use contraception instead of waiting for marriage. However, this openness is contextual, as the presence of elders can stop conversations. Muslim religious leaders describe a "big tension" between traditional religious knowledge and "modern education," fearing that young people "just want to live like Westerners."

Youth report choosing to use protective methods rather than adhering strictly to abstinence, while elders maintain that abstinence is the best form of contraception for teenagers. Younger female adolescents actively disagree with the expectation that men should control contraception decisions, asserting stronger individual stances on women's autonomy.

Entry points for intergenerational dialogue include peer solidarity, with young males advocating for specific groups to "remove the taboo and talk about it." Female parents suggested becoming "friends" with their children. Change requires "teamwork" and "responsibility for everyone to work hand in hand," with key partners including teachers, parents, religious leaders, and community leaders.

IV.2.7. **Leadership, Champions, and Blockers**

Resistance to sex education is frequently expressed through silence, maintaining taboos, and avoiding the subject in public or religious spaces. Religious leaders are definitive blockers, particularly Muslim leaders who stated, "for me, I don't accept that" regarding external sex education. Parents are perceived as the most significant barrier due to embarrassment and being too busy. Teachers often feel constrained by community pressure and fear parental backlash.

However, champions for SRHR progress exist across institutional and peer networks. Schools and teachers are the most frequently cited and highly trusted sources of information. Youth and peer networks are essential champions, especially in overcoming barriers to shyness. Health workers are active champions, and some parents advocate for becoming "friends" with children. Organisations such as Empower Pacific, the Red Cross, and BSP Life collaborate on SRHR outreach efforts.

Examples of positive deviants exist, with some Indo-Fijian Hindu adults recognising that outcomes often turn out well despite traditional condemnation. One mother "strongly agreed" that she knew of a girl who got pregnant and "everything turned out ok for her in the end."

IV.2.8. **Pathways to Change**

Pathways to change consistently emphasise cross-sector collaboration and capacity building. Key strategies include:

- Institutional and Policy Reforms: Lowering the age barrier for accessing contraception from 18; improving accessibility for people with disabilities; mandating government department leadership in awareness initiatives.

- Educational and Communication Strategies: Starting education early (around age 6-8 or primary school Class 6/7); integrating external experts like nurses and police officers in schools; using vernacular languages like Hindi for educational materials.

- Parental and Peer Support Systems: Fostering open parental dialogue by overcoming shame; utilising peer educators in community outreach; promoting women's autonomy in SRHR decisions.

- Engaging Leaders: Interfaith cooperation with all religious organisations working together to design programs; utilising traditional community gatherings and women's groups as forums; increased awareness and mobile clinics.

Strengthening SRHR requires weakening harmful norms such as gendered inequality and male control, cultural silence and taboo, and resistance to education from conservative religious leaders. To overcome these issues, mothers and female youth advocate that all women should have the autonomy to decide matters affecting their bodies. Parents can overcome silence by initiating open discussions and adopting friendly approaches with children. Introducing nurses and police officers into schools can legitimise comprehensive education, and promoting interfaith cooperation can normalise discussions.

IV.3. **Conclusion**

The SRHR landscape in Siberia is defined by profound conflict between youth's demand for information and deep-seated societal resistance rooted in conservative moral standards. Youth consistently rate schools and friends as their most trustworthy sources, while parents and religious leaders are identified as the primary sources of concern. A core challenge is gendered control of decision-making enforced by patriarchal gender norms, leading to severe social sanctions for girls engaging in premarital sex. Religious teachings and interpretations severely limit choices, and fears of confidentiality breaches exacerbate service-related barriers. Exclusion is high for people with disabilities, who face inaccessible services.

Progress demands cross-sector collaboration. Interventions must empower teachers and schools to deliver deeper FLE content. Health policy must address legal barriers, including the age at which adolescents can access contraceptives. Crucially, efforts must engage faith leaders to neutralise religious resistance. Parents must challenge cultural taboos and their own embarrassment, and communities need to foster solidarity among peer networks. Despite significant barriers, opportunities exist through institutional champions, emerging positive deviants, and youth advocates pushing for change.

IVIV. 3.1. **Community Maps**

The images below show the community maps developed by male and female participants. Siberia is a residential community situated within Labasa Town, in the province of Macuata, on the island of Vanua Levu. It is a semi-urban area with a mix of iTaukei and Indo-Fijian households.

Male participants highlighted several key locations where they access SRHR information, including the hospital, local NGOs like Empower Pacific, the Advisory Counsellor's house, Medical Services Pacific (MSP), the police station, and the school (marked in blue). These are considered places where they can easily obtain SRHR information. While they also mentioned religious temples as another potential source of information, they were quick to point out that "they don't talk about sex at all, they only tell you the good and the bad of its consequences."
All of these locations are considered close to the town and easily accessible to both males and females. However, while the community is not prone to flooding, poor road conditions worsen during heavy rain and can limit access to services.

Places marked in orange on the map are where participants feel shame when seeking information. Many of these places still provide SRHR information, but some individuals feel embarrassed about accessing it. As one participant shared: "Everyone can share. Go and seek this information...but some of us are ashamed."

Others related their sense of shame to having friends working in these places. For some, this connection is actually beneficial, while for others, it creates discomfort. As one participant explained: "For example, I go to the hospital to seek advice, and if my friend who works there isn't on shift, I'll have to talk to someone I don't know, and that's where the problem lies".
In contrast, places marked in pink are those they trust the most, such as the pharmacy, which they view as offering confidentiality. They also noted feeling safe to share and ask questions at school because, as one participant mentioned, "Teachers can't tell anything to anyone, it's your privacy."

Additionally, participants shared that they often gather to play soccer, which provides an opportunity to discuss and ask questions about SRHR issues among themselves.

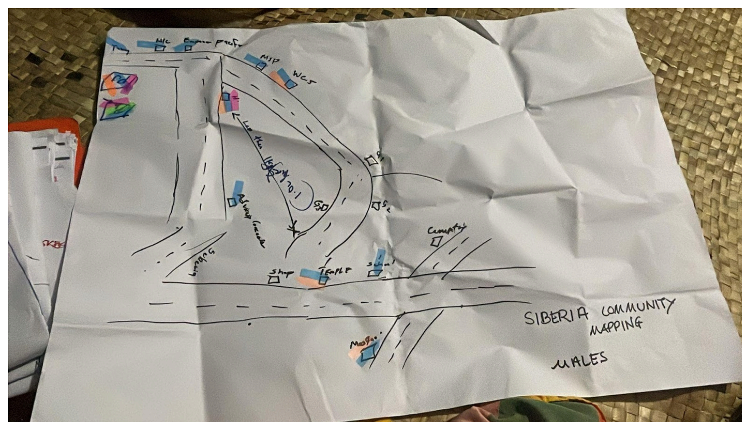


Figure 6: Siberia male participants - community mapping (Labasa)

The map below, created by female participants, includes key locations such as the hospital, religious centres, the MSP, and the NGO Empower Pacific. Participants noted that while these places are close and open 24 hours a day, heavy rains often cause the road to flood, making access difficult. They also highlighted that organisations' outreach services work well.
When discussing their comfort level visiting these places, one participant shared, "Mostly we go to Empower Pacific or MSP or Social Welfare or the hospital," and also mentioned feeling uncomfortable at home or religious temples, "because at church and temple, you can't talk about these things." Female participants also expressed that when they attend church meetings, "people are shy to talk about their sickness." Unlike male participants, they tend not to visit the Advisor Counsellor. Participants explained, "Madua" is very present, as they feel shy or ashamed to discuss issues related to SRHR.
When asked about the stigma surrounding unmarried girls, people with disabilities, or sex workers trying to access these services, one participant remarked, "Before no, but now, they have their own right… They encourage the Village Head Man… before it wasn't like that."

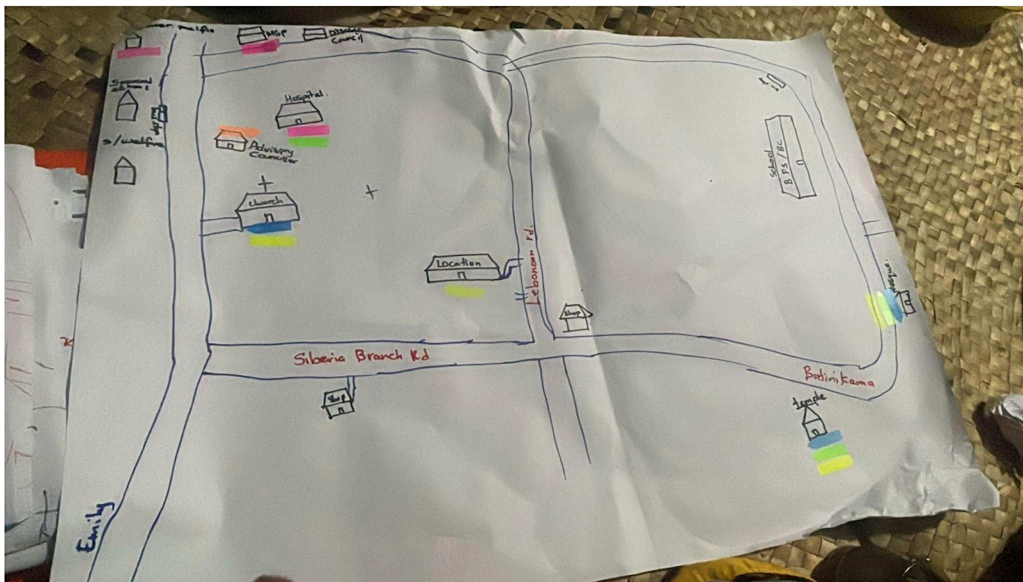


Figure 7: Siberia female participants - community mapping (Labasa)

V. Naboutini

This section summarises the findings for one particular community to facilitate a nuanced understanding of each context studied.

V.1. Introduction to the study site

Naboutini is a rural Indo-Fijian settlement located along Sabeto Road, approximately 12 kilometres from Nadi Town towards Lautoka, within the district of Sabeto under the provincial boundary of service in the Western Division of Fiji. The settlement comprises 23 households with a total population of 156 people: 45% are women, 30% are men, 25% are children, and 25% are elderly individuals. Situated beneath a prominent mountain, the area is surrounded by cane fields and farming settlements.

TThe nearest hospital is accessible in Nadi or Lautoka, while primary and kindergarten schools are located within the Sabeto boundary. The community has practised traditional coping mechanisms for over 100 years to address challenges, though modern influences and changing lifestyles are beginning to impact traditional knowledge and structures. Economically, the area is linked to agricultural initiatives focusing on high-value crops for local and export markets, benefiting rural farmers through innovative farming models.
Infrastructure developments, including processing and storage facilities, are emerging in the region to support agricultural growth. Cultural taboos and stigma around discussing sex and menstruation often limit parental engagement in SRHR education, with youth (aged 14–24) typically learning about these topics from school teachers, peers, family members, social media, or health workers, generally between ages 10–18, underscoring the need for accurate and culturally sensitive education initiatives.

The proposed sample for Naboutini included 22 data collection activities: six KIIs, seven IDIs, six FGDs, and three community mapping sessions. This write-up contains data from only 14 of these activities: six KIIs, four IDIs, and four FGDs.

There are significant gaps in the collected data due to challenges encountered during fieldwork, leading to shorter interviews. As a consequence, not all questions were asked, and the sensitive nature of some topics further limited responses. This means that the data provided from this community should be interpreted with caution.

Table 16: Naboutini sample

	Naboutini Community - Proposed						Naboutini community- Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Young people 16-17 (IDIs should be out of school)		1	1	1	1			0	1	0	0	
Young people 18-24		1	1	1	1			1	1	1	1	
Women (divorced/single, widow, never married)		1						1				
Parents with children over 15 years old		1	1	1	1			1	0	1	1	

	Naboutini Community - Proposed						Naboutini community- Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Religious Leaders, Muslim, Hindu and Christian	2						2					
SRHR service provider/health workers	1						1					
Local govt	1						1					
Other local leader	1						1					
Community tools						3						0
Total	**6**	**4**	**3**	**3**	**3**	**3**	**6**	**3**	**2**	**2**	**2**	**0**

V.2. **Findings**

V. 2.1. **Learning About SRHR and Sexuality**

The vast majority of participants were either not asked or did not respond to questions about where young people learn about sex and SRHR. Of the answers provided, participants mentioned school, social media, the internet, pornography and parents. The internet and social media are the primary sources of information for the youth. The community leader highlights how they can easily access information, including pornography, which may conflict with traditional teachings.

iTaukei youth learn between the ages of 14 and 15, while Indo-Fijian youth learn in classes 5 and 6 (ages 10-12). Indo-Fijian mothers note that both boys and girls should learn about SRHR from an early age, particularly girls. Both Muslim and Christian (Assembly of God) religious leaders also agree that SRHR education should begin early, before puberty, so young people are aware of what is happening when hormones are produced and the body is developing. According to the Christian religious leader, parents should take responsibility for teaching their children, even when it involves taboo subjects. iTaukei older youth believe that girls should start learning about SRHR at a later age, around 21, while boys should start at a younger age, around 15. This suggests that youth consider it acceptable for boys to learn about SRHR at an earlier age, while girls are expected to delay their sexual awareness.

The primary issue with access to SRHR education is the requirement to obtain parental consent for children to participate in school-based Family Life Education. Most participants in the role-play exercise agreed that there should be no consent form and that FLE should be taught in school without consent. Various participants identified that the topic remains taboo. Some people see the main risk associated with SRHR education as young people wanting to try sex. Another issue is the lack of proper teacher training, as teachers may be uncomfortable discussing this topic due to its sensitivity and taboo nature. It was suggested that the Ministry of Health conduct training workshops for teachers and that teaching materials use respectful language.

The opinions on who should teach about sex differ. Some participants believe that the church should teach them, while others think that parents or NGOs should be responsible for this task. Only one respondent was asked about sources of myths and misinformation. The Muslim religious leader reveals significant misinformation around SRHR linked to traditional herbal medicine: drinking strong tea to cause miscarriage, and warm baths to kill infections. Fathers and older male youth referenced the internet and social media as their most trusted sources. Some male parents highlighted the role of pornography as a source of information. In contrast, female parents underline the need for more controlled learning environments, such as schools or homes. Older girls specifically referred to their mothers as the most helpful source, but considered health workers the most trusted, since they can keep things confidential.

V.2.2. **Attitudes, Awareness, and Contraception**

There are different perspectives within the community on the use of contraception to prevent HIV and STIs. The community leader noted, "People have different views, depending on their level of understanding." According to the leader, more awareness of HIV and STIs would encourage the use of contraception. The Christian religious leader seemed open to having more awareness raised on HIV/STI prevention. The health worker noted that she provides HIV-related advice. Older girls showed some understanding of the role of family planning in HIV/STI prevention.

There are varying opinions on decision-making regarding contraception. While some older boys and women, both iTaukei and Indo-Fijian, agreed on consulting their partners regarding contraception use, others disagreed. Both Indo-Fijian and Muslim women expressed diverse views on women's autonomy regarding SRHR. The Muslim religious leader acknowledged that the community "has strong patriarchal values," which limit women's decision-making in many areas, including family planning. The leader also highlighted that many women are heavily dependent on men for financial and social support, which further limits their agency and underscores the extent of male authority and control.

None of the interviews includes information about preferred contraception. While there is no specific information on influences, the community leader pointed to how traditional ceremonies related to menstruation or youth's "coming of age" can influence boys' and girls' sexuality. These ceremonies can be seen as marking a transition into adulthood, giving them a sense that they can engage in behaviours that were previously restricted.

Religious institutions have a significant influence on community members' attitudes toward SRHR. Both interviewed religious leaders indicated that the topic is considered taboo, making open discussion challenging. The iTaukei Christian religious leader stated, "It is a taboo, but it is not right for us to stop them." The Indo-Fijian Muslim religious leader, while acknowledging that "things are changing now, people are more accepting of it," noted that some members of their religious community still believe that "they shouldn't be using family planning."

The concept of sin shapes the intersection of faith, morality, and SRHR decision-making: "From a religious point of view, it's not right for us to allow abortion, because it is a sin." Many participants acknowledge that youth are sexually active, despite this conflicting with religious teachings. An interviewed police officer highlighted that with today's wide access to SRHR information, youth face a challenge in deciding what to follow, whether it's sex before marriage or sex after marriage. This suggests they might feel confused about whether to follow traditional values and their families' expectations or adopt more contemporary views aligned with those of their peers.

The youth leader mentioned that taboos around contraception affect the ability to access SRHR. Additional barriers include embarrassment and fears about privacy, a lack of family support, including financial support to reach health centres, and a lack of confidentiality.

V.2.3. **Gender Roles, Virginity, and Marriage**

Strong beliefs exist around ensuring virginity before marriage. Both older male youth and women agreed that women should be virgins when they marry. Older male youth emphasised that marriage is seen as the appropriate way for young people to be in a relationship. Marriage is also a way to protect one's own or the family's reputation, particularly in relation to virginity. In the case of a daughter's unwanted pregnancy outside of marriage, supporting her is about shielding the family from shame. In the case of an unmarried woman who uses contraception and is beaten by her partner after he finds out, participants suggested that the solution would be "just to get married." Aligned with the importance given to marriage and virginity, abstinence as the safest contraception method is also supported.

According to the Muslim religious leader, while women may gain important knowledge at healthcare facilities, their lack of influence within the family limits their ability to shape decision-making. At the same time, the lack of male involvement or access to healthcare prevents them from sharing this information. Parents' attitudes also limit girls' and boys' agency since they cannot gather information from knowledgeable sources: "the parents are too shy. It's taboo. But they won't allow the children to go and talk to anyone." The interviewed community leader pointed out that the church is too strict about SRHR, hiding the fact that adolescents are having sex.

The taboo around SRHR contributes to a lack of understanding of a woman's reproductive health, leading to the issue being treated as something to be hidden or shameful, preventing open discussions and education about a woman's body. As a result, boys are unaware of the biological and health aspects of female reproductive health.

V.2.4. **Social Norms and Their Enforcement**

The collected data does not provide extensive information on normative expectations, empirical expectations, or specific sanctions and punishments. However, from the data available, we can observe that strong beliefs around virginity and marriage exist, and that discussion of SRHR topics remains taboo.

V. 2.5. **Violence Against Women and Girls**

Cultural and religious norms are linked to SGBV. These norms reinforce gender roles and expectations, particularly around women's availability and willingness to engage in sexual activities and male entitlement to sex within marriage. The interviewed police officer acknowledged that while handling cases of violence or abuse, he may face some contradictions due to his own cultural background. However, he emphasised, "The law is the law."

One participant highlighted the link between violence and health, noting that violence violates women's right to safety. Another participant pointed out the risk of contracting an STI due to male partners not using contraception, particularly condoms. If this happens, "she's the one who's bad. She's the one who is wrong," as it would be interpreted that she is promiscuous, which could then lead to violence. This reinforces the expectations on women's behaviours, highlighting the double standard in how sexual behaviour is judged.

V. 2.6. **Intergenerational Differences and Dialogue**

Male and female parents recognise the generational differences in how SRHR was addressed when they were younger compared to now. They recall that such topics were not openly addressed in schools or homes and were discussed only after they were married. Other interviewed adults also acknowledged that youth today have greater knowledge of SRHR issues, mainly around contraception. In contrast, the Christian religious leader states that it is now more challenging to share information on SRHR with youth. This is because youth are increasingly influenced by their peers rather than their parents, which can lead to behaviours that differ from the intended guidance.

The Christian religious leader emphasised the importance of intergenerational dialogue to prevent young people from falling into harmful situations. Similarly, despite recognising that SRHR is not discussed within the community, the Christian leader stated that this issue should be discussed within families. To address unwanted pregnancies, "the parents should sit together and discuss these matters so that it doesn't happen", suggesting that providing parents with tools to have the discussion could support intergenerational dialogue.

V. 2.7. **Leadership, Champions, and Blockers**

Religious leaders, including the youth leader, are described by the community leader as potential figures resisting discussions on SRHR issues. The community leader emphasised the need for these leaders to start incorporating SRHR into their teachings and to "step outside the box" and "have real discussions with the young people."

Champions in the community include community and religious leaders, as well as health workers, who are proactively engaging with youth on SRHR. The youth leader shares their personal experience to raise awareness about contraception and HIV testing. The Christian religious leader pointed to "the village headman" as a potential champion. The community leader praised health workers for their efforts and noted they are actively involved in delivering educational materials and conducting outreach activities.

Some examples of parents supporting their children, particularly daughters, through challenging situations include strengthening family bonds and offering better advice. In the case of an unwanted pregnancy, parents emphasised the need to "love and support her", without alienating their daughter.

V.2.8. **Pathways to Change**

Diverse strategies were mentioned:

- Awareness Raising Activities: It is important to focus on community-based awareness activities and outreach programmes to address issues like teenage pregnancy and sexual education.
- Educational and Communication strategies: The taboo preventing parents and their children from having open conversations about SRHR needs needs to be challenged by providing parents with the necessary tools to engage in these discussions. Community leaders, including religious figures, emphasise the importance of culturally relevant communication, particularly in iTaukei, to ensure the message resonates with local audiences.

Engaging Leaders: Religious leaders could increase their understanding of SRHR to help overcome barriers: "There should be more awareness from their side. They should know what the law says."

V.3. **Conclusion**

Findings illustrate that there are significant religious, social, and cultural barriers limiting young people's access to SRHR services and their ability to make informed decisions about their reproductive health. Girls and young women continue to be restricted by traditional expectations around virginity, marriage, and obedience.

Religious and cultural norms strongly influence people's attitudes towards contraception, family planning, gender roles, and relationships. Both religious and cultural norms emphasise abstinence teachings and silence around sexuality, which remains a key barrier. As a result, youth experience barriers such as inaccurate information, stigma, fear, shame, and the need for parental consent.

Despite these gaps, opportunities exist for collective action, such as expanding SRHR education in schools, enhancing youth-friendly services, and engaging faith and community leaders to foster dialogue and challenge harmful norms.

V.3.1. **Community Maps**

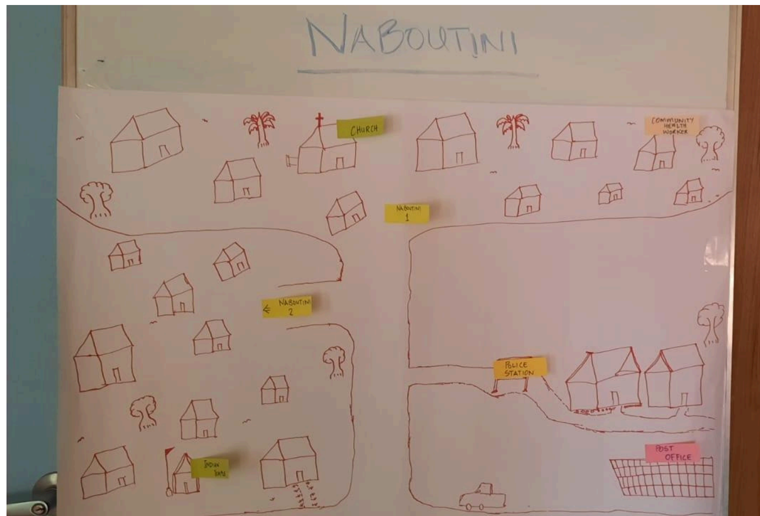


Figure 8: Naboutini, both male and female participants - mapping

VI. Kese

This section summarises the findings for one particular community to facilitate a nuanced understanding of each context studied.

VI.1. Introduction to the study site

Kese is a community in Fiji's Western Division, located on the island of Moro. This was the only maritime location that was included in the study sample.

Kese Village is a traditional iTaukei Fijian village located on the largest island in the Yasawa Group, Western Division of Fiji. The village has a total population of 219 people across 63 households and is situated in a cyclone-prone area, experiencing frequent natural disasters and prolonged dry spells that impact water availability. Main economic activities include tourism, fishing, and the cultivation of cash crops such as Chinese cabbage, cucumber, eggplant, lettuce, long bean, and tomatoes for family consumption and market sale, with many villagers also working in nearby hotels and resorts.
The village has access to a primary and high school, as well as a government health centre accessible to all on the island, which has recently been enhanced with solar power to support medical equipment and improve health service delivery for the surrounding population. Water management is a critical concern, with the community practising Solar Water Disinfection (SODIS) by exposing water in sealed plastic containers to sunlight for 6 hours to eliminate bacteria, and boiling water during overcast or rainy periods.
Additionally, a new water source was recently discovered on a hilltop, about two hours' walk from the village, benefiting both Kese and a neighbouring community, with a dam under construction to address shortages caused by dry weather.

Cultural taboos and embarrassment around discussing sex and menstruation limit parental engagement in SRHR education, with youth (aged 14–24) often learning about these topics from peers, school teachers, social media, or health workers, typically between ages 10–18, highlighting a need for accurate, community-driven education initiatives.
The proposed sample included 22 data collection activities: six KIIs, seven IDIs, six FGDs, and three community mapping sessions. This write-up contains data from 17 of these activities: five KIIs, five IDIs, four FGDs, and three community mapping sessions. The participants in the research were all iTaukei and Christians (most Methodists, some Assembly of God).

Table 17: Kese village sample

	Kese Community - Proposed						Kese community- Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Young people 16-17 (IDIs should be out of school)		1	1	1	1			0	1	1	1	
Young people 18-24		1	1	1	1			1	1	0	1	
Women (divorced/single, widow, never married)		1						1				
Parents with children over 15 years old		1	1	1	1			0	1	0	1	
Teachers / Head of school	1						0					
Religious Leaders, Muslim, Hindu and Christian	2						2					

	Kese Community - Proposed						Kese community- Completed					
RESPONDENTS - per location	KII	IDIs		FGD		Community Role Play + mapping	KII	IDIs		FGD		Community Role Play + mapping
		Female	Male	Female	Male			Female	Male	Female	Male	
Local govt	1						1					
Other local leader	1						1					
Community tools						3						3
Total	**6**	**4**	**3**	**3**	**3**	**3**	**5**	**2**	**3**	**1**	**3**	**3**

VI.2. Findings

VI.2.1. **Learning About SRHR and Sexuality**

iTaukei youth, regardless of gender, obtain information about sex and SRHR from a variety of sources, including social media/internet, peers/friends, health workers, church, school/teachers and parents. Both older (18-24 years old) and younger (16-17 years old) youth agree that peers and the internet, including social media, are their primary sources of information. For boys, both older and younger, pornography is also mentioned as a source of information because "it is a video" and shows "the best position, the style and any angle." School-based programmes (FLE) and parents are cited as additional sources of information. However, discussing sex and SRHR with parents appears to be challenging for some youth: "Last would be parents because it is more difficult to talk about sex at home."

Most respondents said that sexual education happens during the teenage years, between 14 and 17, for both boys and girls. iTaukei boys pointed out that girls and boys should learn about sex and SRHR when they are older (between 16 and 25 years old), with older male youth considering that boys can learn before girls since "boys are more curious about sexual relations at younger ages, compared to girls." An older female youth believes that girls should learn about SRHR at a younger age (10-11 years) "before they reach their teen era." Parents (fathers) and religious leaders agree with this, considering that girls "nowadays need to learn this at a young age due to the pace that we are moving in now."

Overall, there was a discrepancy between when people thought girls and boys should learn about these topics and when they were actually learning them. This was particularly stark for male respondents, with an older male respondent admitting that kids learn about sex at age 14, but that boys shouldn't learn until age 20 and girls not until age 25.

The main challenge with FLE is the belief among parents and religious leaders that it will encourage promiscuity, with youth becoming sexually active as a result: "one of the disadvantages would be that they will want to engage in sexual activities"; "the disadvantage part of it, maybe they will try and practice sexual activities with the use of contraceptives." Additionally, teachers often feel uncomfortable delivering this type of content. One respondent also noted that it is important to use "appropriate words that are not offensive" when developing educational materials.

Parents and elders are considered the ones who should teach children about sex, according to youth, community and religious leaders. There is a strong belief that "learning should start at home." However, while youth believe parents and elders should take on this role, both older and younger boys, as well as older girls, highlight that they do not discuss SRHR with their own parents or with other community members: "It is generally a taboo topic amongst families, communities and/or villages. People would shy away from topics related to sex." Male parents did not share the view that they should be the ones to educate young people about sex. Instead, they said health workers or community leaders should teach children. Overall, everyone thinks someone else should be responsible for teaching children about sex.

Myths/misinformation include the use of herbs and plant leaves as traditional methods to avoid unwanted pregnancies: drinking herbal medicines, having dark tea, or using Fijian plant leaves. Younger boys also mentioned lifting "heavy things" could be a way for a girl to induce an abortion. Pornography is a source of information mentioned by boys, with iTaukei boys (16-17) stating that adults have told them not to trust it and be cautious.

There is a discrepancy between which voices are trusted and where people commonly access information. For example, older youth access information online because it allows them to discover new content. However, both older and younger male youth consider pastors or church elders to be trustworthy, alongside their parents. Older girls share this view, recognising parents as the most trusted source of information. Parents (fathers) regard health workers and teachers as the most trusted voices, while also recognising the value of the internet for being "more detailed and accessible."

VI.2.2. Attitudes, Awareness, and Contraception

While there is awareness of the role of contraception in family planning and condoms in HIV/STI prevention, this awareness does not translate into effective use among youth. Older and younger male youth and older female youth recognise that the use of condoms prevents HIV and STIs. However, despite this awareness, none of the interviewed youth reported actually using contraception.

Religious and community leaders recognise the importance of contraception in preventing and reducing STIs and HIV, and acknowledge the need for youth to use them: "they have no choice, if they want to be safe, they have to use it"; "people will start using condoms because they are scared." Religious and community leaders also noted that reducing STIs is a challenge.

The barriers include limited understanding of STIs and how to use condoms properly, fear of being seen accessing SRHR services or purchasing condoms, and negative perceptions surrounding condom use.

There are noticeable differences in treatment, decision-making and information sharing related to contraception between boys and girls. Younger male youth consider that sex education should be separate because "some topics that girls should not know, they will know, some topics that us boys should not know, we will know." Older male youth disagree with this and believe boys and girls should receive the same information simultaneously. Younger male youth also see gender differences in the community's reaction to adolescent sexual activity: "the male is normally the root of the cause of the problem in engaging in sex," suggesting boys are typically seen as the ones initiating sex, while girls remain more passive.

In terms of decision-making around contraception, male youth agree that women should have a say about things that affect their bodies. However, despite acknowledging women's right to make decisions about their own bodies, all male youth are against girls accessing contraception before marriage, revealing that they still hold traditional beliefs that limit women and girls' access to contraception before marriage. Older female youth believe that women have the right to make decisions about their own bodies, but they also recognise that, in the community, women lack freedom of speech when it comes to health-related issues. As one health worker noted, "women's role, according to traditional belief, is to listen to everything, and this belief extends to SRHR decisions as well."

Both older and younger boys reported not using contraception. They specifically mentioned not using condoms due to negative perceptions about their effect on pleasure and comfort: "it gets in the way of feeling" and "I was not comfortable using a condom because it's plastic." Social narratives reinforce this preference: "based on what we hear, it feels better to do it without it." The older and younger girls who were interviewed also reported not using contraception. When asked about avoiding unwanted pregnancy, they mentioned using traditional methods such as herbs or tracking their menstrual cycle.

The data collected from the community did not mention much about who was influencing contraceptive decisions. Still, from answers to other questions, we can assume that members of this community are influenced by what they see or learn from pornography, social media, the internet or conversations with peers. Interviewed adults agree that youth are less influenced by their families and "nowadays children learn from the internet, peers and listening to others."

The Methodist Church recognises that community members use contraception. Still, it openly acknowledges that the topic remains taboo within the institution: "As for contraception, we know people are using it, but no one talks about it." Community leaders support this view, noting that the silence around contraception, driven by religious teachings, affects open discussion.

Even though contraception is used, it remains a taboo subject in the community, influenced by strong cultural and religious beliefs. The interviewed health worker supports this perspective, noting that "religious leaders will only view this issue from their religious beliefs and teachings, and this challenges the public's decision and view regarding family planning."

The intersection of faith, morality, and SRHR decision-making is shaped by the concept of sin and what is considered permissible behaviour: "everyone knows that sex before marriage is not ok." There is a disconnect between religious teachings and youth behaviour, at least in the eyes of religious leaders. Other community leaders also pointed out that their religion (Methodist) does not support premarital sex or abortion. Sex before marriage is frowned upon and not openly discussed. The fear of judgment keeps it hidden. Despite this, the reality is that unmarried young people are still engaging in sexual activity.

Barriers to accessing SRHR services for both male and female youth include limited availability of SRHR services or programs, the geographical location of health centres, financial constraints, shyness, fears about confidentiality and privacy, and service providers' attitudes. Adult respondents highlighted a lack of understanding of what the service is and who or how it is provided, as well as a lack of confidence and shyness. Additionally, the community leader pointed out fears around confidentiality since "the hospital is in the village. Everyone knows who goes to the hospital and why."

VI.2.3. Gender Roles, Virginity, and Marriage

Almost all respondents shared the view that virginity before marriage is a traditional practice in their community and that abstinence is the safest contraception method for adolescents. While the majority of the community acknowledges that adolescents are engaging in sexual activity, most, including male and female youth, hold the belief that boys and girls should practice abstinence so that they remain virgins until marriage. The strong belief in the traditional expectations of virginity is influenced by the lack of education and the isolation of the community: "We are living on the Island, and about 80% of the people here never finish school. They live and die here, so these traditional and cultural teachings are the only thing they hold dearly."

From a male youth's perspective, gender expectations around mothers and fathers are different: mothers are the ones responsible for ensuring their daughters are not engaged in sexual activities and avoid unwanted pregnancy. Male youth stated that mothers should be scolded by their family members in the event of an unwanted pregnancy outside of marriage, claiming, "it's her fault for causing all that, she didn't keep the daughter well and safe." This shows how girls' behaviour is expected to be policed by mothers. Similarly, suppose the daughter decides to continue with the unwanted pregnancy outside of marriage. In that case, the mother, older sister, or aunt is expected to take on the responsibility of caring for the baby. This reflects how gender roles are reinforced in the community, with the responsibility of an unwanted pregnancy falling on the female family members. Women are expected to bear the consequences of sexual activity, while male involvement is often overlooked.

Participants, particularly community and religious leaders, often use religious and traditional views interchangeably. They do not see any contradictions between these perspectives and the community's practices. Religious and traditional beliefs, which young people are expected to follow, prevent them from discussing issues related to relationships or sexuality with adults. This reluctance reflects a broader taboo, leaving young people navigating complex issues without guidance and creating a contradiction between their behaviours and the religious and traditional beliefs in their communities.

A key factor impacting youth's agency is a lack of guidance and information from trusted or qualified sources, including teachers who are "not comfortable in talking about SRHR" and health workers who are not sufficiently knowledgeable or engaged in SRHR discussions. Silence around SRHR affects young people and reinforces girls' limited agency. According to the interviewed health worker, "cultural norms say a woman has no choice over her body." This lack of open discussion leads to a general lack of understanding of SRHR among youth, with many resorting to the internet for information. This has larger consequences on women's bodily autonomy, GBV and gender inequality, as it reinforces traditional beliefs that limit women's control over their own health and decisions.

Main examples of cognitive dissonance are around virginity and premarital sex, and parents' personal choice of how to handle it outside their community's traditional beliefs. Examples include male fathers thinking that abstinence is the best form of contraception, but then saying, "I counsel my child to be selective and not to have sexual relations with just anyone who shows interest."

VI.2.4. **Social Norms and Their Enforcement**

The main sanction for both boys and girls in the community is shaming, which manifests in gossiping, spreading rumours, and looking down on them if they are known to be sexually active. However, when it comes to younger boys, there is an additional sanction: violence or punishment: "fellow peers would normally beat him." This is due to the belief that male youth are the main instigators of any sexual activity, reinforcing gender stereotypes of men being viewed as active and dominant in terms of their sexual behaviour. At the same time, women are perceived as passive or submissive.

Boys will continue to go at night to buy condoms or send someone else to do it for them, keeping this practice hidden. Girls might resort to or be advised to get an abortion or even contemplate suicide when given the scenario of an unwanted pregnancy: "Abort the baby", "Commit suicide, can hang herself." In some cases, girls may run away from home to escape the consequences of an unwanted pregnancy.

VI.2.5. Violence Against Women and Girls

Empirical data from many studies link gender inequality with high levels of SGBV and poor SRHR outcomes. In this research, respondents mentioned behaviours that lead to violence, such as *"infidelity, unfaithfulness, and multiple sex partners"*. Key community leaders reflected on how SGBV is related to SRHR: *"whenever we want sex, women should give in, and if not, we force them, or we abuse them"*; *"Because men never want women to say no to sex when he wants it."* These harmful norms contribute to women's lack of bodily autonomy and enable sexual coercion, reinforcing gender inequality and perpetuating SGBV.

"SRHR challenges, mainly the lack of guidance and information, affect women's and boys' health, leading to unwanted pregnancy and increasing STIs. Elements around control appear in the answers of some community members: "As for iTaukei, our traditional norm is, we own the women we marry."

VI.2.6. Intergenerational Differences and Dialogue

The data collected does not provide extensive information on intergenerational differences and dialogue. Still, the available data indicate generational differences in attitudes, and taboos limit communication across generations about SRHR topics.

VI.2.7. Leadership, Champions, and Blockers

There is cultural and religious resistance to change, and a strong value placed on traditional knowledge passed down through generations. There appears to be fear that new approaches to FLE may conflict with this. The emphasis is on the importance of tradition, with modern education often seen as a threat: "Traditional knowledge is the same from the start; it just passes down through generations. This is what we value as Fijians. We sometimes blame modern education for trying to change what we have." However, there is some recognition of the need for adaptation.

Institutions, such as the village's traditional governance system, do not address SRHR issues. The only one who mentioned women in leadership was the health care worker, who stated that women in leadership positions voice their opinions and can advocate for women's needs: "Once a woman has a say, she says it all."

One young man stated, about accessing condoms, "He should not be embarrassed because it is his life, it is for his well-being," relating contraception as a matter of personal well-being rather than something to be ashamed of.

VI.2.8. Pathways to Change

Respondents identified several pathways to change:

- **Awareness-Raising Activities**: All respondents believe there is a need for increased awareness and educational sessions on SRHR throughout the village. According to the Head of the Sunday School, "during our stay here for 2 years now, there hasn't been a programme or awareness done in the village." Awareness needs to include parents so they "understand their role because everything starts from home." The community leader highlighted existing support groups within the community, noting that while they are not currently focused on SRHR, "we can look into establishing one."
- **Educational and Communication Strategies:** Community leaders emphasise that understanding the importance of SRHR initiatives requires respect for cultural views, including the use of appropriate language. For SRHR programmes to respect cultural values while still promoting rights, they should be designed "by including iTaukei in the designing of programmes" and "by working together. Everyone." Male fathers and youth also suggest that more awareness sessions be held within the community, involving leaders and parents to engage directly with youth in spaces such as MYF, social groups, and village gatherings.

- Institutional Reforms: Increasing the number of health centres or establishing a dedicated community service in Kese could improve access to healthcare. The religious leader pointed out that there are not enough health services available, suggesting "having a village nurse with proper facilities will help." Similarly, improving outreach programmes was also mentioned.

VI.3. Conclusion

In iTaukei communities like Kese, discussions on SRHR are often controlled by a single figure in the village, limiting open conversations and access for youth. The key SRHR gaps and challenges include the taboo nature of the topic, lack of family communication, religious and cultural resistance to CSE, and limited access to youth-friendly services. Strong beliefs around virginity and abstinence persist, even though adolescents are acknowledged to be sexually active. This creates cognitive dissonance between normative expectations and actual behaviours.

Despite these gaps, opportunities exist for collective action through increased awareness programmes, engaging religious and community leaders, strengthening intergenerational dialogue, improving access to health services, and designing culturally appropriate SRHR interventions with community input.

VI.3.1. **Community Maps**

The community map below was developed by male participants, highlighting key locations such as the village hall, church, health centre, and police post. When discussing challenges in accessing SRHR information within the community, participants identified several barriers. One key challenge was the language barrier, as many medical professionals are not iTaukei. Another challenge was the distance for community members who live far from these services. Overall, there is a lack of services directly linked to SRHR. As one participant pointed out, "Medical professionals don't usually have awareness programs for our youths and the community as a whole."

Participants also mentioned receiving "general spiritual guidance" from the church, but not in-depth knowledge on issues faced by community members. Furthermore, male participants pointed to the lack of safe spaces for young women, youths, and teenagers to openly discuss topics like contraceptives, family planning, and sexual reproduction.

Figure 8: Community map by male participants in Kese Village

IIn the case of female participants who developed the map below, they highlighted that "once a year we get to access SRHR services." However, the main barrier they face is that "some of us are shy to seek medical assistance due to lifestyle diseases," and "medical staff at the health centres are not very friendly or helpful." Additionally, the health centre's location in the centre of the village makes them even more reluctant to seek care, as they fear a lack of confidentiality.

Figure 9: Community mapping by female participants in Kese village

11.3. Sensemaking Workshops

Key discussion points:

1. **Empowering Teenage Girls Against Sexual Pressure:**

    a. The role of parents: All participants across the communities emphasised the crucial role that parents play in empowering teenage girls to resist sexual pressure. A nurse from Naseakula Village highlighted the need for parents to overcome cultural taboos - especially within iTaukei culture - and create a safe space for open dialogue with their children. In contrast, in communities like Suvavou Village, Viria, and Naboutini, the focus is mainly on parents reinforcing religious values around purity, abstinence, and building resilience against sexual pressures. In Suvavou Village, a Methodist church leader described the family as the foundational "first school" for teaching Christian values related to relationships and family life. Continuous nurturing and guidance at home are essential for empowering girls to resist sexual pressure, particularly from boyfriends. Additionally, concerns were raised about the erosion of traditional family structures due to modern influences. In response, many participants called for renewed emphasis on fostering strong family bonds to promote mutual understanding between young girls and boys. In Viria, Naboutini, and Siberia, some parents argued that spending quality family time enables meaningful discussions. Mothers, for instance, can openly talk about the long-term consequences of early pregnancy, such as school dropout and economic dependency. At the same time, fathers have the opportunity to educate their sons on their role in preventing pressure on girls.

    b. Community support and innovative strategies: Participants from Suvavou Village, Viria, and Naboutini highlighted the need for community-based activities to raise awareness and address taboos, particularly within iTaukei communities where SRHR topics are often not openly discussed. This lack of open dialogue contributes to high rates of early pregnancy. Proposed solutions to tackle early pregnancies include community-wide visitations and awareness campaigns aimed at educating both parents and young people about the consequences of early pregnancies. In Viria and Naboutini, it was suggested that community health workers could play a key role in facilitating these important discussions. In Suvavou Village, an innovative approach to increasing attendance at SRHR awareness sessions was proposed: partnering with local sports celebrities, particularly from popular sports like rugby and volleyball, to attract more participants and engage the community.

    c. Addressing young girls' vulnerability: Participants from Suvavou Village and Viria raised several key issues, including the stigma of "madua" (shame), which prevents open discussions about sex within families, as well as the impact of peer pressure and overly sexual content on social media on what they perceive as "risky behaviours."

d. In the case of Suvavou Village:

- Both mothers and fathers were urged to take active roles in directly addressing issues of sex and relationships with their children to counteract harmful external influences such as movies and social media.
- Several speakers raised concerns about parental neglect or harmful guidance contributing to girls' vulnerability. The church leader (Speaker 1) shared a disturbing anecdote of a father encouraging his daughter to drink kava, alcohol, and smoke, leading to sexual encounters with boys and subsequent violence from the father when consequences emerged. Similarly, a female parent (Speaker 4) criticised mothers who are uneducated or frequently drunk, leaving children in grades seven and above at risk of sexual exploitation due to a lack of supervision in the village setting with extended family interactions.

2. **Supporting Parents to Educate Children on Sex and Pregnancy Prevention:**

a. Participants in Naseakula, Suvavou Village, Viria, Naboutini recognised parents often lack knowledge, feel shy due to cultural taboos and lack confidence, leading to inadequate education on contraception and pregnancy prevention.

- Proposed solutions: Using village meetings to advise parents on engaging with their children, shifting focus from trivial topics to SRHR awareness.
- Having women's club gatherings as a platform for the Ministry of Health or Women's Crisis groups to raise awareness and change parental mindsets.
- Leveraging existing community structures such as Soqosoqo Vakamarama (women's group), Soqosoqo ni Turaga (men's group), and Soqosoqo ni Tabagone (youth groups) to host awareness sessions.
- Having influential community leaders lead SRHR conversations can help parents, as well as having external partners, such as the Ministry of Health or NGOs like the Reproductive and Family Health Association of Fiji (RFHAF), frequently attend these gatherings, offering resources and expertise.
- Develop community-based SRH education sessions during existing meetings to reach parents who are uncomfortable discussing these topics at home, ensuring anonymity and cultural sensitivity in delivery.
- Strengthen family time through cultural campaigns that prioritise child-parent interaction over social distractions, involving community leaders to model and promote family bonding activities.
- Connect parents to women's and men's groups in Viria for peer support and information-sharing on SRH, creating safe spaces where they can share experiences and learn from one another.

b. Using religion/religious teachings to support SRHR discussion: In the case of Suvavou Village, the church (Methodist) acknowledged also lacking specialised knowledge to counsel on SRHR but expressed openness to inviting experts, NGOs, and government bodies like the Ministry of Health to speak during church-organized sessions or camps. In Viria, participants (health providers) suggested that parents could integrate practical SRH discussions into family devotionals, where spiritual teachings can be paired with real-life advice on contraception and pregnancy prevention.

c. Cultural Practices and Gender Roles: Some participants highlighted the barriers parents face due to cultural practices and gender roles, particularly in Suvavou Village, Viria and Siberia. They pointed out that in iTaukei households, parents often feel uncomfortable discussing sensitive issues, and traditional gender roles further exacerbate the problem. In these households, mothers typically bear sole responsibility for educating their children, while fathers are often absent due to social activities such as kava sessions. This was contrasted with the more structured family dynamics in Indo-Fijian households. In iTaukei households, these cultural aspects often lead to a disconnection between parents and children, with social obligations taking precedence over meaningful interactions between parents and children. As a result, children can become vulnerable to misinformation and risky behaviours.

3. **Encouraging Teachers to Improve Sex Education**
   a. Community acceptance of FLE:
   - Suvavou village: FLE is recognised as relevant to contemporary social challenges in Fiji. The Village Nurse (Speaker 3) explicitly concurred with its importance, while the church leader (Speaker 1) endorsed it as a government initiative that "matches with the social problems we are facing nowadays." Despite cultural sensitivities among iTaukei around the word "sex," which can evoke discomfort, there was consensus that FLE is a necessary tool to address issues like teen pregnancy and misinformation, aligning with broader societal needs.
   - Viria: Participants agree that FLE is needed since many iTaukei families lack the foundation to provide comprehensive SRH education at home. They viewed schools as critical spaces to bridge this gap, especially for children whose parents avoid these discussions due to cultural taboos, citing instances where school education prevented early pregnancies among informed students.
   - Teachers face resistance from parents, who view FLE as inappropriate. This was mentioned across communities. For instance:
   - Viria: Some parents expressed concern over the depth of FLE content delivered to younger students, particularly in primary school (e.g., Class 4). One participant felt that topics like detailed reproductive processes were too advanced and potentially harmful, risking early sexual curiosity or trauma. In-depth content should be for secondary school levels, where students are more emotionally and cognitively prepared.
   - Young men who recently completed schooling in the area criticised the delivery of FLE, describing it as a "boring" or "free" class often misused by teachers for other subjects or simply not prioritised. They recalled teachers appearing embarrassed or unprepared, lacking the training or confidence to engage students effectively, which diminished the module's impact and left students disengaged or misinformed.
   - Siberia: Teachers lack training and are unprepared to deliver the SRHR content.
   - Proposed solutions: The village headman and committees (e.g., education and health) support schools by discussing these topics in village meetings, explaining the government's intent to fill gaps left by parents.

- Advocate for Ministry of Education reviews of FLE curricula to ensure age-appropriate content, focusing on deeper topics on secondary levels while keeping primary content basic and focused on values and safety.
- Provide specialised training for teachers to build confidence and skills in delivering FLE effectively, incorporating cultural sensitivity and interactive teaching methods to engage students.
- Investigate teacher attitudes toward FLE through surveys or focus groups to address disengagement and ensure dedicated class time, potentially incentivising commitment through professional development credits.

4. **Addressing Resistance to Condom Use Among Men**
   a. Shyness, cultural beliefs or misinformation contribute to men's reluctance to use condoms.
   - Proposed solution: Having men's gatherings led by the village headman to encourage contraceptive use and village nurses distributing condoms to young men, as they are hesitant to buy them from pharmacies or hospitals.
   - Have expert-led sessions on contraceptive use, highlighting the availability of both male and female condoms. Many men are unaware of condom varieties and proper use, which contributes to misconceptions about reduced sensation, and suggests focused awareness efforts for men.
   - Increase awareness and support from the Ministry of Health to provide HIV education.
   - Increase community-led awareness campaigns on HIV/STI transmission risks, including needle use, by engaging health workers and local leaders to conduct regular informational sessions or distribute materials in accessible formats.

   b. Cultural differences: In iTaukei households, discussing condoms within families remains a significant taboo, while in Indo-Fijian communities, they are more open. In Siberia, participants agree that this is the case. In Suvavou village, one participant contrasted this with Western ease of family communication, highlighting that iTaukei tradition limits discussions to "wait for marriage" without deeper SRHR details, perpetuating high STI and pregnancy statistics due to communication barriers.
   c. HIV Concerns:
   - Suvavou village: Fear of unknowing transmission: "I'm very concerned and scared... those who have HIV is not known and they go around to spread HIV." Due to confidentiality laws, only the nurse and Turaga ni Koro know the identities, limiting direct intervention, though affected individuals attend monthly clinic check-ups (Speakers 1, 2, 3). This secrecy, while legally necessary, complicates community efforts to prevent spread, amplifying the urgency for youth-focused awareness sessions.
   - Viria: One participant stated that a bold community teaching stance of "no condom, no sex" to prevent HIV/STI transmission, viewing it as a straightforward message to encourage responsibility among youth and men. He also acknowledged emerging risks beyond sexual transmission, such as rising needle use for drugs in urban-adjacent areas like Viria, which exacerbates disease spread and requires broader community awareness efforts.

d. Religious Tensions with Awareness Messaging:

- Suvavou village: While contraception for HIV/STI prevention was supported, concerns were raised that it could encourage premarital sex, conflicting with Christian teachings. There's a need for culturally sensitive messaging that balances health education with moral values.
- Viria: One participant stressed relying on spiritual strength and church teachings to control sexual urges, viewing condoms as conflicting with faith. In contrast, a community nurse advocated for practical solutions, highlighting the importance of providing condoms and education to overcome stigma and ensure protection.
- Most respondents from Viria consider that a strong spiritual upbringing at home fosters better decision-making among youth, equipping them to resist peer pressure or societal norms that discourage condom use.
- Proposed solution: Promote dual messaging in Viria that combines spiritual guidance with practical health measures, ensuring condom availability through health clinics while respecting religious beliefs through church-led discussions.
- Reinforce family and community roles in guiding youth through consistent dialogue and correction, encouraging mentorship programs where respected elders or peers model responsible behaviour.

5. **Balancing Tradition with Modern SRH Needs**

a. Certain traditions (maintaining virginity until marriage and celebrating a girl's first period and boys' circumcision) are considered valuable for participants across communities: they can involve feasts, dancing, singing and joyful occasions and instil a sense of love and value in children, potentially deterring risky behaviours like premarital sex through reinforced communal bonds. However,

- Naseakula Village: These practices still need to be adapted. A participant criticised the influence of social media and lack of parental care as undermining traditions, advocating for family bonding and recognition of bodily changes to prevent negative outcomes like early sex. She suggested involving extended family (aunts, grandmothers) to reinforce cultural practices.
- Suvavou village: A retired school teacher pointed out disparities in how milestones are celebrated, noting that boys' circumcisions often receive more attention (e.g., mats and feasts prepared by families) than girls' first menstruation, for which "hardly anything is done." She and others called for equal recognition, with some ladies in the room admitting they celebrate only the eldest daughter's milestone as a proxy for younger siblings, while all boys receive individual attention.
- Proposed solution: Traditional events should include SRHR education. Mothers or grandmothers should use these occasions to advise girls on the risks of early sex and pregnancy, ensuring cultural practices serve as platforms for modern health messaging.
- Viria: Maintain the beneficial aspects of tradition, such as respect for elders and communal support systems, while advocating for changes to barriers like "madua" (shame) through family discussions and education.

b. Breaking Cultural Silence on SRHR (Suvavou village and Viria): Participants discussed how to address the taboos limiting SRHR discussion. A debate emerged around the cultural silence on SRHR in iTaukei communities in Suvavou village. One participant

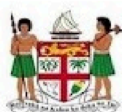
explained that the reluctance to discuss sex is based on respect ("veirokorokovi"), not shame ("madua"), and is tied to cultural norms about timing and appropriateness. However, others argued that in times of high disease rates, open communication should take priority. The discussion highlighted the need for a balance: respect guides the context of SRHR conversations but does not prevent them. It was agreed that a culturally sensitive approach is needed, where these discussions occur at the right time and in the right setting. In Viria, one participant noted that children are already exposed to explicit content online, making traditional silence on sex counterproductive and potentially harmful, as it leaves them without proper guidance to navigate these influences.
Proposed solutions: Expand awareness campaigns by health and NGO partners targeting rural villages to bridge urban-rural gaps in SRH openness, using mobile clinics or community outreach to deliver education and resources.
Encourage family-level discussions to adapt traditions, focusing on positive cultural elements like communal support and respect for elders that can bolster SRH initiatives without conflicting with modern needs.

c. Role of the church: The Methodist Youth Fellowship, prevalent in Viria, is a platform for SRH discussions and an example of successful church-led health talks that balanced spiritual teachings with practical SRH advice, suggesting this as a model for broader adoption.
Proposed solution: Partner with church groups in Viria to integrate SRH education into youth programs, respecting spiritual values by framing discussions within a faith-based context while addressing practical health needs.

6. **Promoting Healthy Relationships and Respectful Communication**

- Addressing violence: Participants, mainly in Viria and Suvavou village, discussed how to address gender-based violence in their communities. In Viria, they noted domestic violence is prevalent, ranging from verbal disputes to physical altercations within households. They said that community committees often step in to mediate, advising couples to resolve conflicts privately and respectfully to avoid public escalation. In Suvavou village, participants are unsure how to address these issues, although they acknowledge that they are prevalent.
- Parents as role models: Parents and elders must model respectful communication for children to learn healthy relationships, as credibility is key. In Viria, participants mentioned that children absorb behaviours from parental interactions, making it essential for couples to demonstrate mutual respect in daily life to set a positive example. The notion of strengthening family time to ensure children and youth have a more positive view of relationships is stressed in Viria, Suvavou village and Naboutini.

11.4. Ethical Clearance



Fiji Human Health Research and Ethics Review Committee

MINISTRY OF HEALTH AND MEDICAL SERVICES

Date: 10/06/2025

Dr Kristie Drucza
Washington DC.

Project Title: "Community-Based Participatory Research to better understand how religious, cultural, and traditional practices in Fiji influence access to sexual and reproductive health and rights (SRHR) among key populations, including young people, sex workers, and women. Implemented as part of the project "Advancing the sexuality agenda and shifting norms in the Pacific through improving access to sexual and reproductive rights and gender equality."

FNHRERC Number: 34/2025

Principal Investigator(s): Dr Kristie Drucza, Washington DC.

Co- Investigator(s):
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Kelly Durrant, Includovate team.
Mosese Qasenivalu, Includovate team.
Ramya Rajagopalan, Includovate team.

Dear Dr Kristie

This is to inform you that the Fiji Human Health Research Ethics Review Committee (FHHRERC) has granted scientific, technical and ethical **approval** to your proposal titled "*Community-Based Participatory Research to better understand how religious, cultural, and traditional practices in Fiji influence access to sexual and reproductive health and rights (SRHR) among key populations, including young people, sex workers, and women. Implemented as part of the project "Advancing the sexuality agenda and shifting norms in the Pacific through improving access to sexual and reproductive rights and gender equality*".

As the Principal Investigator, it is **your responsibility to ensure that all the people associated with this particular project area aware of the conditions of this approval and copy of the final report is also submitted to the Ministry of Health and Medical Services at the conclusion of your project for our records.**

The following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

1. **Further consultation:** Presentation to the specialist group; the CSNs for the Ministry of Health and Medical Services on the proposal.

2. **Seek the approvals of the Permanent Secretary for Health and Medical Services:** on the **advertisement** at birthing centres, hospitals and MCH Clinics which is the recruitment strategy.

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