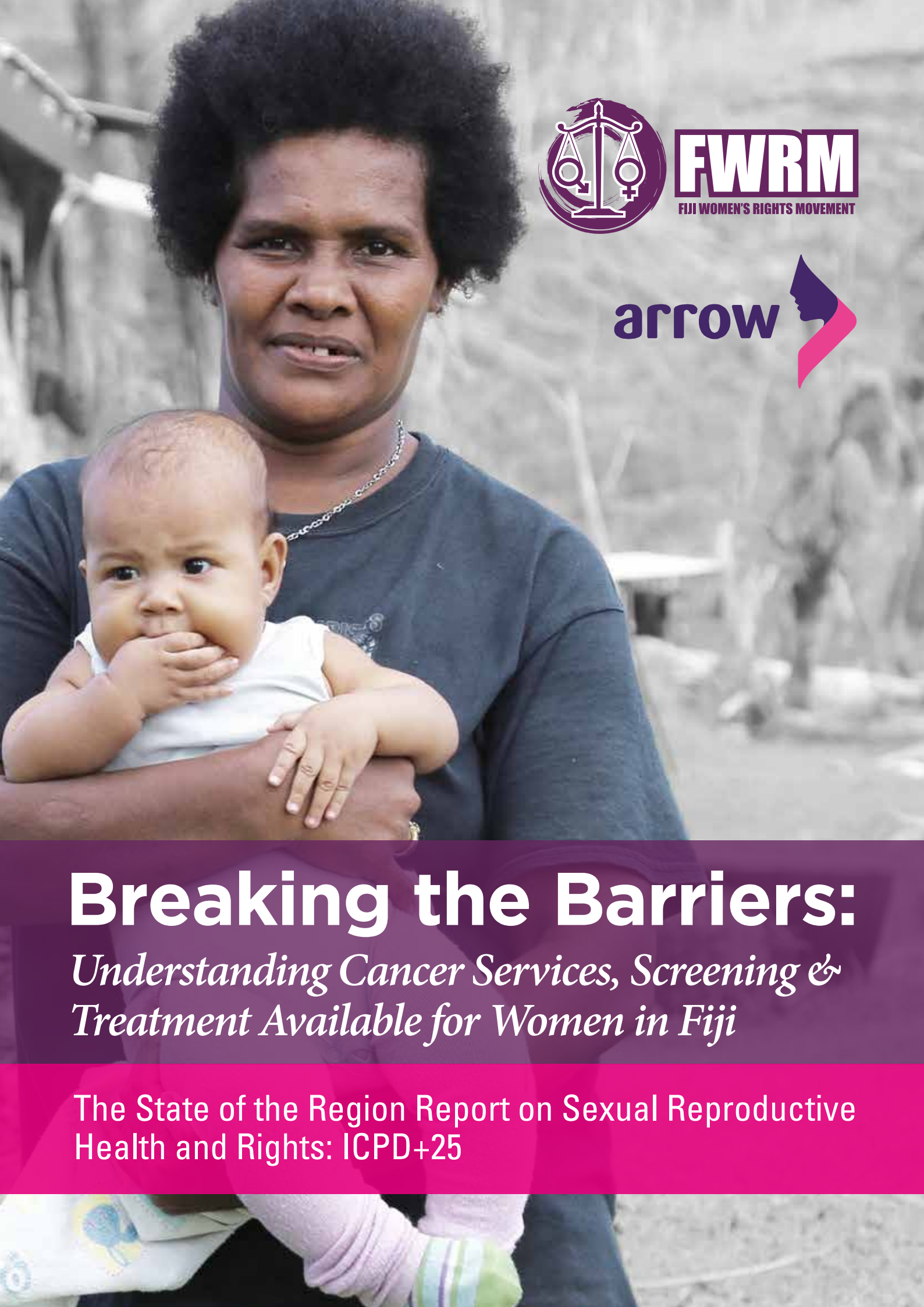

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Breaking the Barriers:

Understanding Cancer Services, Screening & Treatment Available for Women in Fiji

The State of the Region Report on Sexual Reproductive Health and Rights: ICPD+25

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GLOSSARY OF ACRONYMS

ABR	Adolescent birth rate
ARROW	Asian – Pacific Resource and Research Centre for Women
ANC	Antenatal care coverage
AusAID	Australian Agency for International Development
CCESCR	Committee on Economic, Social and Cultural Rights
CSW	Commission on the Status of Women
CPR	Contraceptive Prevalence Rate
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CWM	Colonial War Memorial Hospital
FBS	Fiji Bureau of Statistics
FCS	Fiji Cancer Society
FNHRERC	Fiji National Health Research Ethics Review Committee
FNPF	Fiji National Provident Fund
GTJ	Gender Transitional Justice Team
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IARC	International Agency for Research on Cancer
ICPD	International Conference on Population and Development
ICPD PoA	ICPD Programme of Action
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
MDGs	Millennium Development Goals
MOH	Ministry of Health and Medical Services
NGO	Non-Governmental Organisation
PICs	Pacific Island countries
PICTs	Pacific Island countries and territories
TC Winston	Tropical Cyclone Winston
RH	Reproductive Health
RFHAF	Reproductive & Family Health Association of Fiji
SRHRs	Sexual reproductive human rights
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNOHCHR	United Nations Office of the High Commissioner for Human Rights
VIA	Visual Inspection with acetic acid
WHO	World Health Organisation

EXECUTIVE SUMMARY

The review of the International Conference on Population and Development (ICPD) in 2019 will mark the twenty-fifth anniversary of the ICPD Programme of Action (PoA), a historic consensus document where 179 countries stood in solidarity to advance women's sexual and reproductive health and reproductive rights everywhere. Much has been achieved since the adoption of the ICPD PoA but more needs to be done to ensure that the commitments adopted in Cairo remain at the heart of the global agenda. Monitoring the implementation of this international commitment is a vital way of holding governments accountable and transparent.

In our bid to ensure that the Fiji Government remains committed and accountable towards the promises made in Cairo, the Fiji Women's Rights Movement (FWRM) decided to carry out a research study that focussed on the state of cancer services, screening and treatment in Fiji because of the high prevalence rate of reproductive cancers affecting women to date. As it stands, breast and cervical cancer remain among the top five causes of death in women around the country. Given these statistics, the need for FWRM to investigate the state of cancer services and treatment available for women became apparent, as well as the intersectional barriers that women face in accessing these services.

The introductory section of the research study aims to set the context of the selected research topic, providing an interlinking narrative on the significance of the ICPD PoA and other international and regional commitments; the overall health of women in the world and in the Pacific; the status of implementation of the ICPD PoA since Cairo; and the prevalence rate of reproductive cancers globally and in the Pacific. Linking our research area to these areas is FWRM's approach in keeping the Fiji Government accountable to the promises pledged at the world stage.

In a nutshell, the findings of the main research topic provide a snapshot of existing gaps within Fiji's public healthcare system in terms of basic cancer screening coverage and methods; the accessibility of proper information; the increasing rate of late presentation; and the limited treatment available locally. Additionally, the findings of the research included the lived experiences of women who have gone through Fiji's public healthcare system during their journey with cancer.

The research comprised informant interviews with key stakeholders and women who are cancer survivors; and a stakeholder meeting.

INTRODUCTION

The Fiji Women's Rights Movement (FWRM), established in 1986, is a multi-ethnic and multicultural non-governmental organisation committed to removing all forms of discrimination against women through institutional reform and attitudinal change. Being a feminist organisation, FWRM uses feminist analysis in the work we do to address gender inequality.

Some of the early advocacy work that FWRM carried out under sexual and reproductive health and rights (SRHR) centered on women's health; the knowledge and use of contraceptives and female condoms; and empowering women to take control of their own sexuality[1]. We note that these areas have also been of concern to diverse women that FWRM has worked with through our outreach programmes particularly for the Fiji Young Women's Forum (FYWF)[2]. In 2017, FWRM conducted a scoping study on women and ageing where key findings revealed that the progression of age had a direct impact on health and that there were significant gaps in accessing adequate healthcare services for ageing women[3]. Additionally, FWRM has been involved with various stakeholders in drafting a Pacific SRHR manual in its efforts to contextualise the articles of the ICPD PoA so it makes sense to Pacific contexts[4].

While numerous works have centred around the health aspects of reproductive cancers affecting women; FWRM acknowledges that little research has been done to explore the intersecting SRHR challenges that women face in their battle with cancer; as well as the state of cancer services and treatment available in the country.

Setting the context

A state of a woman's sexual and reproductive health and rights (SRHRs) intersects with multiple human rights including the right to health, the right to education, the right to not be discriminated against, the right to be free from any form of violence, and the right to life. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Article 16(e) recognises these intersecting human rights and envisions a world where all women can truly decide responsibly and freely on the number and spacing of their children; and to have access to better reproductive health services so women can fully exercise these rights without discrimination or violence[5]. And in Article 10(h), State parties are called upon to ensure that the rights of women in accessing information and services on family planning and the wellbeing of the family are protected[6].

Over the past century, increased efforts from the international community on global health issues has seen a shift in the allocation of resources to more health-related interventions aimed at improving the overall health status of women in the developing world. In particular, the 1994 passage of the International Conference on Population and Development (ICPD) marked the beginning of a new era of global recognition by governments, nongovernmental organisations and civil groups of the need to specifically address reproductive health concerns of women in the developing world. The ICPD Programme of Action (ICPD PoA) serves as a comprehensive guide for government in ensuring that sexual and reproductive health and rights, safety in pregnancies and childbirth, the potential of young people, women's empowerment and gender equality remains a national priority in population and development programmes[7].

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1 FWRM. (1999). Retrieved from Balancing the Scales : http://www.fwrm.org.fj/images/fwrm2017/publications/balance/pdf/1999_BalanceOctober_December.pdf

2 Fiji Young Women's Forum outcome statement; http://www.fwrm.org.fj/programmes/intergenerational-womens-leadership/fiji-young-women-s-forum

3 Women & Ageing: Scoping Study on Perceptions of Ageing Among Women in Fiji: http://www.fwrm.org.fj/images/May-24-2017-Women--Ageing-Scoping-Study-on-Perceptions-of-Ageing-Among-Women-in-Fiji.pdf

4 Pacific's first Sexual and Reproductive Rights Manual Launched: http://rrrt.spc.int/news/item/620-pacific-s-first-sexual-and-reproductive-rights-manual-launched

5 (United Nations Office of the High Commissioner of Human Rights (UNOHCHR) 1979)
In the CEDAW Committee's General Recommendation 24 asks States to prioritize the prevention of unwanted pregnancy through family planning and sex education: (UNOHCHR, 1999) http://www.ohchr.org/EN/HRBodies/CEDAW/Pages/Recommendations.aspx
Additionally, in the General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) it was recognised that maternal health services was paramount and that States were strongly encouraged to take proactive steps to effectively address the right to health of women in the context of maternal health: (UNOHCHR, 2000) http://www.refworld.org/pdfid/4538838d0.pdf

6 Ibid,1

7 (United Nations Population and Development (UNFPA) 2018)

A year after the ICPD saw the unanimous adoption of the Beijing Declaration Platform for Action by 189 countries at the Fourth World Conference on Women; an extraordinary moment in history with unprecedented solidarity by world leaders, NGOs, women movements and activists, unified with a common message that human rights are women's rights and women's rights are human rights. The Platform for Action envisions a world where women and girls can truly live freely without discrimination or violence; a world where women and girls can exercise their freedom of choice and have equal opportunities in all spheres in life like men and boys. It calls for increased resources in research on women's health concerns; better family planning services and information; and rights to SRHR without discrimination or violence[8]. Marking this year's sixty-second session of the Commission on the Status of Women (CSW) held in New York, member States were urged to improve access to healthcare and family planning services; improve access to healthcare information; and decrease the rate of maternal deaths, infant mortality and morbidity rates for rural women[9].

Between the 1990s and early 2000s, the overall health of women around the world had improve to some extent. These key improvements were noted at the end of the Millennium Development Goals (MDGs) era in 2015 which stated that;

- maternal mortality rate (MMR) fell by 45 per cent since 1990;
- contraceptive prevalence rate (CPR) increased from 55 per cent in 1990 to 65 percent in 2015;
- the Human Immunodeficiency Virus (HIV) infections fell by approximately 40 per cent between 2000 and 2013; and
- more than 71 per cent of births were assisted by skilled health personnel globally in 2014, an increase from 59 per cent in 1990[10].

At the end of the MDG era came the Sustainable Development Goals (SDGs)[11] which goes beyond the MDGs. Both the SDG 3 and SDG 5 targets highlight the need to ensure universal access to SRH services for women; the integration of reproductive health into national strategies; and the accessibility to reproductive health information as embedded in the ICPD PoA, Beijing Platform for Action and the outcome documents of their review conferences.

The SDGs is also a part of the 2030 sustainable development agenda that looks to achieve effective policy and funding; and channeling targeted development to areas set out in the 2030 Agenda[12]. Particularly for women and girls, the 2030 Agenda commits governments to ensure that effective measures are implemented to end discrimination and eliminate violence against women and girls, reduce maternal mortality, end preventable deaths of newborns and children under five years, provide better universal health coverage, and mainstream gender equality across all goals and targets set out in the Agenda with disaggregated data provided for effective monitoring.

What is evident from the promises of Cairo; the vision of the Beijing Platform for Action; the SDGs and the 2030 Agenda is the common recognition that we must all do more to ensure that the rights of women and girls are protected so that we can live in a world where women and girls have control over their own bodies, where women and girls can exercise the freedom of choice and to do so without any form of discrimination or violence, and where gender equality is at the very heart of national commitments.

But while there is no denial on the progress made thus far, challenges remain in implementing these commitments at the national level. In many countries, the commitment of the ICPD PoA has regressed in varying degrees because governments have changed and policy makers are unaware of the significance of integrating gender equality and women's SRHRs to population and development programmes.

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8 (Fourth World Conference on Women: Beijing, China - September 1995 1995)
9 (United Nations 2018)
10 (United Nations Development Programme (UNDP) 2015)
11 (United Nations Development Programmes (UNDP) 2016)
12 (The United Nations Department of Economic and Social Affairs (UNDESA) 2015)

After the MDG era, the gap between the rich and the poor remains huge in many countries leaving millions in poverty[13]. Many women still face complications in pregnancies and childbirth, and challenges regarding their reproductive health[14]. It is estimated that in 2015, about 830 women died as a result of pregnancy and childbirth complications. Most of the deaths occurred in low-resource settings and the main causes of death were haemorrhage, hypertension, infections, and indirect causes, mostly due to interaction between pre-existing medical conditions and pregnancy. The risk of a woman in a developing country dying from a maternal-related cause during her lifetime is about 33 times higher compared with a woman living in a developed country[15]. Additionally for contraception, almost a quarter of married women or in-union women lacked access to modern contraception in 2016[16].

Reproductive health issues are reported to be responsible for one third of health issues for women between the ages of 15 and 44 years; and maternal health complications still remain a challenge. Furthermore, the prevalence rate of sexually transmitted infections (STIs) and sexual violence against women also remains at the very top of the global health agenda for women[17]. Furthermore, global health statistics reported that breast and cervical cancer were among the top five types of cancers affecting women as of 2015, accounting for half a million deaths respectfully. Majority of these deaths occur in low- and middle-income countries where proper screening and detection, prevention and treatment are almost non-existent[18]. It is worth noting here that the narrative around sexual rights has not developed or gained significant recognition thus far to influence laws and policies despite many global agreements and many governments stating that they recognise the right to one's sexual orientation free from coercion, discrimination and violence. This hinders emerging definitions of sexual and gender identities and preferences that the human rights aspects that come with it; and the access to basic healthcare and SRH services[19].

That being said, while much has been achieved since Cairo 1994, more still needs to be done to address the SRHR of marginalised and vulnerable groups within societies so we can all exercise our freedom and rights without stigmatisation, discrimination or violence.

Pacific regional SRHR status post-Cairo 1994

The Pacific is home to many island nations and small ssland territories with uniquely diverse cultures, languages, geographical locations, societal norms, socioeconomic status and religious values. With these diversities come a shared recognition of the intersectional challenges existing among many Pacific island countries (PICs) when committing to global agendas; unique challenges which often remain unaddressed during negotiations on global indicators. But despite this, many of the founding leaders in the Pacific recognised the significance of the ICPD and ICPD PoA as a map to help plot strategies that address key SRHR issues facing women in the Pacific.

Most in the Pacific have committed to the ICPD PoA, ICPD+5, +10 and +15, the Beijing Declaration, Beijing+5, +10 and +15, and the Millennium Development Goals (MDGs). At the regional level, further commitments were pledged during the Pacific Conference of Parliamentarians for Advocacy. The Moana Declaration (2013) calls for better recognition of SRHR for all people without discrimination, incorporating sexual and reproductive health-related issues in development strategies and increasing participation of women and young people in decision-making processes[20]. Also in 2013, the Pacific SRHR Coalition adopted an outcome statement which was used as a lobby tool in the 2014 Pacific Leaders Triennial

13 (United Nations Development Programmes (UNDP) 2018)
14 (The World Bank 2017)
15 (World Health Organisation (WHO) 2018)
16 (World Health Organisation (WHO) 2016)
17 (World Health Organisation (WHO) 2015)
18 (World Health Organisation (WHO) 2018)
19 (General Assembly 30 January 2015)
(Asian-Pacific Resource & Research Centre for Women (ARROW) 2012)
20 (Secretariat of the Pacific Community (SPC) 2015) Page 12
(Moana Declaration: Outcome Statement of Pacific Parliamentarians for Population & Development August 2013)

and the 2017 Pacific Women Leaders Triennial. Some of the immediate issues centered around action to ensure the right to legal and safe abortion for all Pacific women and girls; the repeal of laws and legislations that discriminate against LGBTI women and girls; ratification of the CEDAW convention; removal of gender-based violence; and to ensure and protect the human rights of women and girls in the Pacific region overall.

Implementing such commitments has been slow and uneven across the region given the diversities existing[21]. Tracking progress of implementation among the Pacific region will depend upon the availability of consistent disaggregated data; an area that all island nations fall short of. There needs to be additional work on gathering contextual evidence-based data across the region. The outcome of the Pacific Regional ICPD Review 2014 saw a number of challenges in ensuring the complete protection of the rights of women, girls, persons with disabilities (PWDs) and other vulnerable groups in society. A lack of comprehensive sex education integrated into the school-education curriculums was common throughout the region[22]. Existing still was the uneven participation of women and girls in political and economic life[23]; and the prevalent gender-based violence reported by most[24] in many island nations.

The Review reported that maternal deaths occurred most in Melanesian countries with significant regression rates recorded in Papua New Guinea (PNG); and slow progression in Solomon Islands and Vanuatu. In some countries, the actual number of maternal deaths is so low, often being in the single digits if there are any at all therefore using the percentage rate is not the best way to measure maternal mortality in these contexts. Better monitoring of maternal morbidity is crucial in capturing the true state of maternal deaths in the Pacific region[25].

When assessing antenatal care for the Pacific region, the difficulty lies in the use of different indicator values in many countries; and this impacts upon acquiring reliable data to measure progress. Despite this, some countries have been able to report rates above 90 percent such as Cook Islands, Fiji, Nauru, Niue, Samoa, Tonga and Tuvalu.

The Review reported that:

- the contraceptive prevalence rate (CPR) showed that most island countries remained below the 50 per cent target with some countries showing stagnant results. Cook Islands, Vanuatu, FSM and Fiji have recorded CPRs in the 40 per cent range[26] while other countries have recorded lower rates;
- the high prevalence rate of STIs and teenage pregnancies remain a challenge for most countries as well[27];
- most countries have only draft forms of an SRH policy[28];
- SRH services remain inaccessible to women and young people living in rural, remote and outer islands;
- young people face particular barriers accessing services because the services are less receptive to younger people. While some countries have already begun implementing 'youth friendly' services prior to Review, there is still a disproportionate number of young people unable to access basic SRH services; and
- most countries indicated that SRH was part of primary healthcare with clinical and emergency guidelines in place, however, the Review found that it was unused either because there was a lack of knowledge that these guidelines existed; and a lack of expertise and capacity to implement it.

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21 (United Nations Population Fund (UNFPA) 2013)

22 Ibid.21 (pages 67, 81 and 12)

23 Ibid.21 (pages 9, 48)

24 Ibid.21 (pages 7, 28, 41, 43 and 48)

25 Ibid.21 (page 20)

26 (National Minimum Development Indicators 2013)

27 Ibid.16

28 Most countries reported to have implemented policies to improve SRH issues concerning women with institutional structures in place to implement these policies. But in reality, some countries do not have an SRH policy; only existing in draft form. Samoa's health policy has integrated SRH; and Fiji, Tonga and Vanuatu have adopted and are implementing a SRH policy and strategy. Solomon Islands, Tuvalu, the Marshall Islands and the Cook Islands have only draft SRH strategies existing; while the Federated States of Micronesia has a family planning policy being developed (United Nations Population Fund (UNFPA) 2013)

The prevalence rate of reproductive cancers is equally alarming in the Pacific with breast and cervical cancers being the top two cancers affecting Pacific women to date. Many island nations have indicated that they have cancer screening programmes however, there is a lack of capacity and resource commitment towards implementing nationwide screening programmes for high risk groups except for a few countries[29]. Additional data sources reveal that the mortality rate for breast cancer was reported the highest in Fiji (26.6) and 12.2 for Papua New Guinea (PNG); and a mortality-incidence ratio of 0.5 recorded for PNG. For cervical cancers, the mortality rate was also the highest in PNG and Fiji[30].

Furthermore, the narrative around sexual rights has not developed at all or gained significant recognition in the Pacific thus far despite some island governments recognising the right to one's sexual orientation free from coercion, discrimination and violence at the global level. In particular, the rights of LGBTQI people remain extremely marginalised, discriminated and stigmatised in the Pacific because of the entrenched and engraved patriarchal values integrated with culture, religion and societal norms; deep-rooted values and norms that hinder basic access to healthcare and SRH services[31].

29 Cook Islands, Niue and Tokelau conduct breast and cervical screening programmes nationally with the technical support of New Zealand. Eight USA-affiliated states and NZ-affiliated countries provide HPV vaccination to young girls in late primary school level. Fiji also conducts vaccination of Class 8 girls with assistance from AusAID (United Nations Population Fund (UNFPA) 2013)

30 Asian – Pacific Resource and Research Centre for Women (ARROW 2018)

31 (UNOHCHR 2015)

NATIONAL SRHR STATUS IN FIJI POST-CAIRO

Country demographics

Coined the hub of the Pacific, Fiji has a total landmass of 18,333 square kilometres with more than 330 islands of which a third are permanently inhabited. There are two main islands in Fiji - Viti Levu and Vanua Levu - with other main islands including Taveuni, Kadavu, Gau and Koro. Fiji's total population stands at 884,887 as of 2017 with more people living in the urban centres. The urban population has increased from 50.7 per cent to 55.9 per cent as of 2017 while the rural population has declined from 49.3 per cent in 2007 to 44.1 per cent[32].

The 2017 Fiji Census data indicates that the population of the country increased by 5.7 per cent from 837,271 persons in 2007. The average annual rate of population growth sits at 0.6 per cent . Data trends show that population growth decreased in 1986, 1996 and 2017 due to lower birth rates and migration. The average rate of the population is 27.5 years which means that there are more young people in the country.

There are more females living in the urban centers compared to rural areas; and slight differences in the 0-4 and 10-14 age category that indicate a larger number of females living in rural areas *(see appendix A for reference)*. In terms

32 (Fiji Bureau of Statistics 2017)

of population by province, the province of Ba had the highest number of residents accounting 28.0 per cent of Fiji's population. Additionally, there are more females living in the urban areas within the various provinces than rural provinces *(see appendix B for reference).*

The unemployment rate is significantly high in the Central Division for females living in the urban centers. Rural women in the Western Division had the highest unemployment rate. The unemployment age category ranges from 15 years and above *(see appendix C for reference).* Also, the census data shows a significant gender gap in paid and unpaid work - 234,059 for males and 106,680 for females *(see appendix D for reference)*. This dataset released by the Fiji Bureau of Statistics (FBS) is collated and reported into one category, therefore there is no clear distinction in data between paid and unpaid work.

Fiji context

Well before the 1994 ICPD in Cairo, key population issues concerning the country were already at the forefront of Fiji's development goals. The establishment of the National Population and Family Planning Control Unit in 1987 came at a time when Fiji's population growth had progressively increased while the economy was still relatively young. The focus for government was limiting population growth in order to improve and sustain the standard of living[33]. Additionally, Fiji became one of the few low- to middle-income countries in the world to implement cytology-based cervical cancer screening, including the first in the Pacific island region in the 1990s[34].

Now two years shy of the 50th anniversary of our independence, Fiji has improved in some areas but more needs to be achieved and it can be. Since 2013, the MOH has administered HPV vaccines to Class 8 female students for cervical cancer prevention. The HPV vaccine coverage stands at 55.7 for 2016. During the first quarter in 2017, the Central Division recorded the highest coverage rate for HPV1 followed by the Western, Northern and Eastern divisions. HPV2 was also administered but lacked significant coverage than HPV1. In the third quarter the Northern Division recorded the highest coverage rate followed by the Central and Western divisions – there were no figures reported for the Eastern Division.

In 2014, the MOH adopted the Reproductive Health Policy in its effort to improve reproductive health programmes and strengthen health service delivery. The Reproductive Health Policy explicitly supports the rights of all women, men, couples and children to have access to curative and preventive RH services. It also takes note of the rights of young people to have access to youth-friendly services, access to RH information that will help them make responsible choices, and in particular prevent unplanned early pregnancies, STIs, HIV and sexual abuse[35].One of the criticisms of the RH Policy is that it reflects the perception that women are just birthing factories and that such views contribute further to the existing gender roles of women in Fiji[36].

Also in 2014 was the adoption of the National Gender Policy formulated to promote women's rights in all aspects of Fiji's development in compliance with CEDAW which the country has ratified. It calls for a system of gender mainstreaming in all sections of government; and in all other areas of public life. It provides a framework that policy-makers and key actors involved in societal development can use as a guide in addressing gender concerns including the evaluation of the social division of labour[37].

33 (Hon. Minister for Health 1999)
34 (Law 2013)
35 (Ministry of Health and Medical services n.d.)
36 (Fiji 2018)
37 (Ministry of Social Welfare, Women and Poverty Alleviation 2014)

The Policy calls for:

1. Greater accessibility to quality services during pregnancy, labour and delivery; encouraging women and family friendly hospital practices that involve both parents in prenatal, birthing and postnatal care;
2. For doctors to be efficiently trained and sensitised when dealing with cases of abortion, and to ensure women give informed consent to terminations of pregnancy in accordance with the Fiji Crimes Act 2009;
3. The availability of male and female condoms in public toilets, universities, hotels and bars in order to protect against STIs, HIV and unplanned pregnancies; and sanitary products in public women's toilets;
4. Comprehensive and integrated reproductive health services to ensure universal access to reproductive health care (including access to family planning) for women and girls across Fiji;
5. Better social protection measures and policies that address the differential experiences of older persons; and
6. The right to information about family planning and reproductive health.

Fiji's progress

Table 1: Table shows selected SRHR indicators and data taken from MOH Health Status Report 2016

	SRHR INDICATOR	2015	2016	2017
Level 1	General Fertility Rate	|	90.6	21.7
	Maternal Mortality Rate	|	20.9	0.0
	Maternal Mortality Ratio (MMR) 20 per 100,000]\live births	29	42.0	|
Level 2	Contraceptive Prevalence Rate amongst population of child bearing age increased from 46% to 56% (Females 15-49 yrs.)	47.1	49.3	|
	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	|	48.3%	|
	Percent of Births Attended by Skilled Health Personnel	|	99.8	|
	Adolescent birth rate per 1000 girls aged 15-19	30.3	28.4	|
	Antenatal care coverage (one visit)	|	Between 10% – 20%	|
	Antenatal care coverage (4 visits)	|	76.9	|
Level 3	HPV vaccine coverage among adolescents	|	55.7	|
	Prevalence rate for STI for men and women	90.04	|	-
	HIV prevalence among population aged 15-24 years (MDG 6.1)	|	|	|
	STI (Chlamydia) prevalence among women receiving antenatal care	|	|	|

Source: Health status report 2016 MOH

Reference

- **Health Statistics Report 2016**
- **HealthInformation Unit 3rd Quarter, Bulletin 2017**
- **MDG indicator**
- **Sustainable Development Goals**
- **Healthy island indicators-Public Health Information System, MOH**
- **| = No data**

The MOH Health Status report 2016 recorded that the provision of antenatal and postnatal services has improved since Cairo 1994, with new and exciting recommendations put forward by the WHO to increase the number of antenatal care visits from 4 to 8, a recommendation that will take some time to be implemented in the country.

The antenatal care coverage (ANC) had a 76.9 coverage rate and more women were making their first booking in their second and third trimesters, with the highest number of visits recorded in the 20-34 age category. For maternal health, Fiji is doing quite well in increasing skilled birth attendance to 99/8 per cent with additional renovations of a few birthing facilities in Suva, Makoi and Labasa to increase access to birthing facilities for women. The CPR coverage rate is at 40 per cent; and ABR has decreased from 30.3 per cent to 28.4 per cent as of 2016. Particularly for the latter, the Western Division reported the highest number in adolescent pregnancy in the Health Information Unit 3rd Quarter, Bulletin 2017. For MMR, the figures stand at 29 per cent in 2015 and 42.0 per cent in 2016. These figures were released by the Obstetrics & Gynaecology Unit accounts for both direct and indirect causes of maternal death, however, an independent breakdown of the figures was not provided.

Raising awareness on sexual reproductive health and reproductive rights is still a challenge in Fiji. More work is needed to demystify the perception that comprehensive reproductive health education and SRH concepts increase sexual promiscuity among young people.

Abortion is only delivered in three major hospitals (Labasa, CWM and Lautoka) and not in sub-divisional hospitals. This becomes problematic as women have to travel long distances which could take an hour or more. Furthermore, there is a lack of services available in Fiji for women such as fertility clinics for those trying to conceive, for HIV-positive women, and hormonal replacement therapy and specific SRH services for menopausal women.

National development plans on SRHR

Fiji's 20+ year national development plans aim to provide better quality family planning services, better maternal-child health services, efficient reproductive health information, services and resources, and improved adolescent health and services[38]. Furthermore, the government looks to implement policies encouraging shared decision-making in relationships, family planning, child care, economic independence and choices of paid work in line with SDG 5. The 2018-2019 national budget allocation for cancer services is $F50,000 for cervical cancer under Public Health service, however, the budget does not mention other new initiatives funded by government particularly for cancer treatment, services and outreach programmes.

38 (Ministry of Economy 2017) Page 4-6, 13

OBJECTIVES

Purpose of the research

The ICPD review in 2019 will mark the twenty-fifth anniversary of the ICPD PoA, a historic consensus document which governments have committed to, to safeguard women's sexual and reproductive health and reproductive rights. Monitoring the implementation of these international commitments pledged in Cairo 1994 is a vital way of holding governments accountable and transparent.

That being said, the overall purpose of this research is to review the commitments made by the Fiji Government under the ICPD PoA agenda with a specific focus on the state of cancer services and treatment available for women in Fiji. This research area was chosen by FWRM because of the increasing rate of female reproductive cancers in Fiji. As of 2017, breast and cervical cancer were among the top five causes of death among women overall. Given these statistics, the need for the FWRM to investigate the state of cancer services and treatment available for women became apparent, as well as the intersectional barriers that women face in accessing these services.

Findings of the research presented in the report is FWRM's effort to ensure that existing challenges in cancer services are addressed, that the intersectional challenges women face in accessing these services are highlighted and documented, and that the promises made in Cairo remain at the forefront of Fiji's national agenda.

Research questions for the report

The research had three main research questions:

- What is the state of female reproductive cancers in Fiji?
- What are the cancer services and treatment available for women in Fiji?
- What are some of the barriers that women face in accessing these services?

Further research questions

(a) What is the state of female reproductive cancers in Fiji?

- What are some of the reproductive health programmes and services provided by the Fiji Government and other organisations?
- What are the common types and causes of female reproductive cancers in Fiji?
- What is the common age category of women who are diagnosed with a reproductive cancer?
- Which ethnic background/race are female reproductive cancers the most common?
- Which geographical location are female reproductive cancers the most common? Rural? Urban? Central, Eastern, Northern or Southern?

(b) What are the cancer services and treatment available for women in Fiji?

- What are some of the cancer services and treatment available in Fiji for women?
- Are these cancer services and treatment available to all women across all divisions in Fiji?
- What are some of the challenges faced in the delivery of these services and its accessibility to women?
- What is the number of early detection cases? How many early detection cases weren't successful? How is this data captured? Where is it captured?

- What are some of the recommendations for service providers in the delivery of cancer services and treatment for women?
- What are some of the recommendations for women regarding reproductive cancers and accessing services?

(c) What are some of the barriers that women face in accessing these services?

- Personal information i.e. age, marital status, ethnicity, no. of children, location
- Cancer information i.e. type of cancer, stage of the cancer when first diagnosed, year when first diagnosed
- What were some of the barriers you faced from diagnosis, to treatment, recovery, and post-recovery?
- Were you/are you satisfied with the services you received? If not, please indicate your reasons

(d) Overseas referral treatment

- What are the application processes for cancer patients who seek government assistance for overseas treatment in India?
- Is there any other country, besides India, that the Fiji Government is providing funding for cancer treatments?
- Why India?
- If a cancer patient, her spouse/partner, and their children are all unemployed; would the ministry approve funding assistance?
- If the cancer patient, her spouse/partner, and their children earn below $30k, would the ministry approve funding assistance?
- What is the purpose of submitting financial documents such as loans, hire purchase, and rent as listed in the general requirement form? Does this have some significant impact on the application being approved/not approved?
- For successful applications, are cancer patients required to repay funding provided to them by the ministry?
- We've been informed that patients seeking overseas treatment in India must fundraise money for their accommodation, food, etc. How much is specifically required for patients to fundraise? And how much is the ministry actually funding for?
- At which stage during cancer would the ministry approve funding? And at what stage during cancer would the ministry not approve funding? (stage 1, 2, 3?)
- How many applications from cancer survivors does the ministry receive in a year? Additionally, for 2017 – 2018, how many applications have been approved? How many haven't?

(e) Data collection and reporting

- What is the purpose of the cancer registry?
- How effective is the cancer registry?
- What sort of data is collected in the cancer registry?
- What percentage of data collected in the registry are female reproductive cancers?
- What is the rate of early detection cases for female reproductive cancers in Fiji?
- What are some of the limitations and challenges of the cancer registry?
- What is being done to improve data collection for the cancer registry?
- For NGOs/CSO, what are some of the data collection mechanisms and processes implemented? What are some of the limitations and challenges of the data collection mechanism used?

Data sources for this research report

Data sources for this research report are: the Ministry of Health's health status reports 2015-2017, health information quarterly bulletins 1st and 3rd quarter; Ministry of Economy 5-Year & 20-Year National Development Plan report, outcome documents of the Beijing Platform for Action, Moana Declaration, CSW 2018, National Minimum Development Indicators 2013, the Pacific SRHR Toolkit, World Bank 2017 datasets on women's health, United Nations Development Programmes 2016 fact sheets, Millennium Development Goals 2015 report, United Nations Population Fund (UNFPA) fact sheets on the ICPD, Pacific Regional ICPD Review: Review of the Implementation of the International Conference on Population and Development Programme of Action Beyond 2014, Review, Word, Health Organisation fact sheet on cancer and women's health, Global Health Observatory (GHO) data: Maternal and reproductive health, and need for family planning satisfied, and United Nations Department of Economic and Social Affairs (UNDESA). Other additional data sources are noted in the reference section of this report.

METHODOLOGIES

Desk and Literature review

The purpose of the desk & literature review is to gauge Fiji's progress in implementing the ICPD PoA under the SRHR research topic area chosen for this monitoring report. The scope of the review covers the health status report published in 2016 and subsequent health bulletins released by the MOH for 2017; these were used as primary sources of information in tracking the progress of implementing of the ICPD indicators.

Preliminary findings of the review revealed that the MOH had used several health indicators from MDGs and SDGs to report under while also using their own health indicators; this made it difficult for the research team to track specific SRHR indicators. Given this, the research team decided to select specific SRHR indicators as indicated in the table below:

Table 1: Table shows selected SRHR indicators from MOH Health Status Report 2016

	SRHR INDICATOR
Level 1	General Fertility Rate
	Maternal Mortality Rate
	Maternal Mortality Ratio (MMR) 20 per 100,000]\live birt
Level 2	Contraceptive Prevalence Rate amongst population of child bearing age increased from 46% to 56% (Females 15-49 yrs.)
	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
	Percent of Births Attended by Skilled Health Personnel
	Adolescent birth rate per 1000 girls aged 15-19
	Antenatal Care Coverage
	Antenatal care coverage (one visit)
	Antenatal care coverage (4 visits)
Level 3	HPV vaccine coverage among adolescents
	Prevalence rate for STI for men and women
	HIV prevalence among population aged 15-24 years (MDG 6.1)
	STI (Chlamydia) prevalence among women receiving antenatal care

Source: Health status report 2016 MOH

The review of local and international documents was also conducted and it included ICPD documents, global health status documents, Human Papillomavirus reports, and related health research publications on cancer-related issues and services. Local documents reviewed included health status reports, female reproductive cancer trends in Fiji and cancer services, screenings and treatments available.

Preliminary findings of the review led to further investigation on the prevalence rate of reproductive cancers affecting women in Fiji. The review found that as of 2017, reproductive cancers remained among the top five causes of deaths in women around Fiji. It was identified that the prevalence rate of breast and cervical cancer was the most common type of cancer affecting women. Given these statistics, the next step in the review was to assess the types of cancer services, screenings and treatment available for women. It became apparent to review the types of cancer services provided by the Fiji Government to identify intersectional barriers women face in accessing these services.

The UNFPA publication on the Pacific Regional ICPD Review of Action Beyond 2014 provided substantive content for the research team in developing a narrative around the interlinkages between international, regional and local commitments such as the ICPD PoA, MDGs and SDGs. From this, the research was able to gauge the SRHR issue(s) concerning the Pacific region and the challenges that exist. The report was used as a framework in developing the concept note for this research.

Additionally, the MOH reports published online provided substantive information and content when assessing the burden of female reproductive cancers in Fiji. This helped form and development the basis of this research.

Data methods

Key informant interviews

The purpose of the key informant interviews is to have in-depth interviews with stakeholders who work in the area of women's health, community awareness programmes, cancer screening services and cancer treatment. Furthermore, the interviews aimed to collect valuable information on the intersectional barriers women face accessing cancer services in the country.

The scope of the key informant interviews covers the following area:

- The state of female reproductive cancers in Fiji?
- The types of cancer services and treatment available for women in Fiji?
- The barriers women face in accessing these services?

Key informants from relevant stakeholders were carefully selected for the research. The first step was identifying and collating a list of key potential informants from government offices, non-governmental organisations (NGOs) specialising in cancer services, patient support, reproductive clinics and mobile screenings, and international organisations that oversee the ICPD mandate. Creating a list helped to assess potential key informants so that the research incorporated diverse voices and perspectives.

The next step was narrowing the list to include relevant stakeholders who would provide the best information needed for this research. Of the nine stakeholders identified, only five were available to be interviewed. Face-to-face conversations were used to carry out the interviews, with audio taped and transcribed. At maximum, the interviews lasted an hour and were conducted in English.

The interviews followed a semi-structured format where a series of topics were listed and covered including follow-up and open-ended questions. Information obtained from the interviews incorporated both quantitative and qualitative data. A standard questionnaire format was used to obtain basic information such as age, residential location, ethnicity, type of cancer, stage of cancer upon diagnosis and treatment used, and open-ended questions were incorporated when the participants shared their stories with the interviewer.

The research aimed to include lived experiences from women who are reproductive cancer survivors. A list of potential participants was created and majority of the women were contacted by the research team in an effort to interview as many women as possible. Both face-to-face and telephone conversations were used to interview the women, and the inputs were transcribed. Majority of the interviews were conducted in the iTaukei language and later translated to English.

A total of 10 women were interviewed for this research, of which eight were interviewed at the Oncology Unit. One woman preferred to be interviewed in her own office while another preferred being interviewed at the FWRM office. Additional women were approached and had initially agreed to be interviewed but ended up declining the invitation. One woman who was identified as a potential participant unfortunately lost her battle with breast cancer in August 2018.

The researcher conducting the interviews took notes as women shared their journey with cancer. Interviews were not audio taped but translated from the iTaukei language to English.

National Policy dialogue (NPD)

The purpose of the NPD is to present the findings of the research to key stakeholders. This dialogue will ensure FWRM's commitment in transparency in the work we do, and also to give stakeholders an opportunity to provide collective recommendations in addressing the findings of the research. A separate report will also be consolidated after the NPD with key stakeholders.

Ethical consideration

A formal research proposal was drafted and uploaded onto the MOH health portal to be reviewed by the Fiji National Health Research Ethics Review Committee [FNHRERC] before the researcher can begin scheduling and conducting interview sessions with MOH doctors, nurses and other health officials.

The Ethics Committee required the following information:

- Detailed procedure(s) for participants i.e. type of questions that will be asked during the interview; as well as how the interview session(s) will be conducted;
- Detailed information on who is carrying out the research?
- Who the study participants are
- How will the study participants be selected
- Potential risks for study participants
- Confidentiality
- What information and/or data will be collected
- Where will the information gathered from the interview be kept
- When will the personal information collection, use and access stop?
- Estimated outcomes
- Participation and withdrawal
- Who will collect and have access to the information?
- Identification of principal investigator
- Detailed informed consent sheet

The review process took a couple of months because the Ethics Committee was not satisfied with the research proposal submitted. Despite numerous email conversations and follow-ups, the research proposal was finally approved and endorsed by the Committee on June 26th 2018 and preliminary interviews were able to be scheduled and conducted. A sample of the FWRM's research proposal and approval letter is provided in the *Appendix E.*

DESK & LITERATURE REVIEW FINDINGS

The prevalence rate of reproductive cancers of Pacific women

Reproductive cancer is a cancer that infects the reproductive organs of both men and women, particularly for the latter. The common types that affect women are cervical, breast, ovarian, uterine, vaginal and vulvar cancers. In 2012, the International Agency for Research on Cancer (IARC) reported that reproductive cancers were the common cancers affecting women in 2012. For breast cancer, the incident rate was at 65 cases per 100,000 women, with a mortality rate of 28.4 cases per 100,000 women. Cervical cancer was second with 37.8 cases per 100,000 women, and mortality rate was at 20.9 per 100,00 women.

Here in the Pacific, the incidence rates are equally alarming for breast and cervical cancer. Data shows that breast and cervical cancer are the two most common reproductive cancers affecting Melanesian women. Breast cancer is at a rate of 41.0 cases per 100,000 with a mortality rate of 19.8 cases per 100,000 women, while cervical cancer has a rate of 3 –33.3 cases per 100,000 with a mortality rate of 20.7 cases per 100,000 women.

For Micronesian women, breast cancer is more common with a rate of 48.8 per 100,000 women; and a mortality rate of 10.5 cases per 100,000 women. For Polynesian women, breast cancer is the more common reproductive cancer with an incident rate of 68.9 per 100,000 women; and a mortality rate of 15.4 per 100,00 women.

The cancer burden for women in Fiji

In the 1990s, some progress was made to address the high incident rate of reproductive cancers affecting women in Fiji. A cancer registry software was set up to record and track the cancer burden and rate in the country and Fiji also became one of the few low-middle income countries in the world to implement a cytology-based cervical cancer screening[39].

The prevalence rate of reproductive cancers for women in the country has increased over the years. Between 2002-2005, breast, uterine and cervical cancers were the most common types of cancers registered for women. Of the 3112 cases recorded in the Cancer Registry, 1,547 cases were breast, uterine and cervical cancers which is close to half of the registered cancers[40].

Research between 2003-2009 revealed that cervical cancer had a higher incident rate of 27.6 cases per 100,000 women compared to cancers affecting women. The median age at diagnosis was 50 years and iTaukei women were significantly younger at diagnosis than Fijian women of Indian descent. Between the ages of 20 and 69 years, the relative risk of iTaukei women developing cervical cancer compared with Fijian women of Indian descent was 1:4[41]

The MOH Health Status 2016 report recorded seven types of cancers affecting women, and reproductive cancers were reported to be affecting women. As it stands, breast and cervical remain among the top five causes of death in women. For breast and cervical, 41.5% (329 cases) for breast and 35.1% (278 cases) for cervix[42]. Furthermore, according to the world health ranking by WHO data 2017, Fiji is ranked 8th in the world for breast cancer death rate; and ranked 28th for deaths caused by cervical cancer.

39 (Law 2013)
40 (Best1, et al. 2011)
41 iBid.32
42 (Ministry of Health and Medical services 2016) (Page 8)

Fiji's top 10 causes of death: Age standardised death rate per 100,000 population

	TOP 50 CAUSES OF DEATH	Rate	World Rank
1.	Diabetes Mellitus	187.90	1
2.	Coronary Heart Disease	161.57	39
3.	Stroke	73.71	111
4.	Kidney Disease	53.51	3
5.	Influenza and Pneumonia	40.02	83
6.	Breast Cancer	29.89	8
7.	Asthma	24.96	7
8.	Hypertension	24.26	40
9.	Cervical Cancer	21.48	28
10.	Lung Disease	15.86	146

Source: World Health Rankings

KEY INFORMANT INTERVIEW FINDINGS

The prevalence rate of reproductive cancers in Fijian women

- Globally, Fiji rates for breast, cervix and ovary are significantly high
- The breast and the cervix are the two common registered cancers in the Fiji cancer registry; making up 30 per cent of cancers listed
- The cancer registry records breast and cervix are the organs most affected, and that women have the organs most affected.
- More women are dying young with reproductive cancer; for some women it's the basic fear of the outcome of cancer and being unsure of where to seek help.
- Most women diagnosed with reproductive cancers are generally between the 30-50 age category.
- iTaukei women have the worst health-seeking behaviour than others and are not enthusiastic about seeking services, care and treatment, and have higher chances of dying than a Fijian women of Indian descent.
- 50 percent of women will not seek further medical assistance, treatment or follow-ups after testing positive. More research is needed to try and understand how to improve the health-seeking behaviour of women.
- Many women are still presenting themselves very late with stage three cervical and breast cancer which the oncology unit cannot provide effective treatment for. Palliative care can only be provided to women at this stage.

Overview of cancer screenings, treatment and support services in Fiji

Fiji's healthcare system operates on a three-levelled model covering the four main divisional centers in the country. There are three main divisional hospitals in the Central, Western and Northern divisions with 19 sub-divisional hospitals and two specialist and private hospitals.

A total of 86 health centers and 97 nursing stations are located across the country. Fiji also has a number of privately-run clinics operated by general practitioners[43]. The health system is divided into two strategic pillars: preventive, curative, and rehabilitative health services, and health systems strengthening, and under these pillars are various areas that make up the organisational structure and operation of the ministry. There are also various committees and councils that provide support to specific health services[44].

Much of Fiji's cancer treatment includes a limited level of chemotherapy, radiotherapy and surgery. Treatment(s) will depend on the type of cancer, its stage at diagnosis and availability in Fiji. Basic oncology units are available at the three divisional hospitals with nurses provided to inpatients. To address the shortcomings in chemo-and radiotherapy, the Oncology Unit has the overseas referral system to send qualified patients abroad for treatment, but this process requires much guidance and support for patients.

Another treatment available under the Oncology Unit is palliative care with the support of the Fiji Cancer Society (FCS). However, accessing high-level and good quality palliative care requires a lot of development in Fiji because it is not consistently available. There is also the need to improve on patient navigation i.e. helping the patient to navigate through the health system where they are given support either through chemotherapy, surgery or palliative care support. For the

43 (Ministry of Health , 2016) http://www.health.gov.fj/wp-content/uploads/2018/03/MoHMS-Jan-July-Report-2016.pdf (Page 44)

44 National Food and Nutrition Centre; http://www.nutrition.gov.fj/
National Advisory Committee on AIDS; http://www.aidsdatahub.org/fiji-national-composite-policy-index-2010-national-advisory-committee-on-aids-secretariat-fiji-2010
National Health Promotion Council; https://pdfs.semanticscholar.org/79b6/6ca1a9f268afbb8262ea3753eb1788a8acdb.pdf (Page 1)

vulnerable groups in society, formal government structures and funding assistance are in place to help patients seeking local or overseas treatment.

With regards to cancer screenings, the ministry provides free screenings for women at divisional and sub-divisional hospitals, including health centres. For cervical cancer, the screening methods available are Pap smear tests, liquid-based cytology (LBC), and visual inspection with acetic acid (VIA). Other screening services are available independently in accredited health clinics including mobile clinics targeting women living in rural and remote parts of the country and have difficulties accessing a health centre or nursing station.

The human papillomavirus (HPV) vaccinations are part of cervical screenings conducted by the Fiji Government targeting all female students in Class 8 for cervical cancer prevention and HPV awareness. We will not know for sure if the vaccinations have worked until the cohort of females that have been vaccinated reach the age where cervical cancer is more prevalent. That being said, continuous screening is recommended as HPV vaccination does not guarantee complete protection from HPV infections.

For breast cancers, the MOH does not have a screening programme within the core healthcare delivery system. Women are encouraged to do their own breast self-examination regularly and if any abnormalities are found, women are recommended to visit a doctor for medical advice. There are also home and workplace screenings conducted by the Fiji Cancer Society (FCS) in collaboration with the MOH. Included in the screenings are information sessions on breast and cervical cancer, signs and symptoms, proper breast self-examination techniques, and treatment available. Women are referred to the Oncology Unit if abnormalities are found. During the interview with key informants, strong emphasis was expressed on the inconsistency of screening methods available in health centres and nursing stations, particularly for remote areas in Fiji. The lack of technical skills and capacity of nurses to conduct screening methods was also raised.

The MOH has a specialist training programme for internal medicine, surgery, paediatrics and ONG & Oncology. For the latter, the ministry is progressively developing the nursing Oncology Unit with a doctor now trained to specialise in oncology. Furthermore, the Oncology Unit is in the process of seeking ways to support more doctors intending to specialise in oncology. More cases are being diagnosed now given the programme in ONG and surgical for breast cancers.

Cancer registry

The cancer registry helps notify when a patient is being diagnosed. The registry has been fairly efficient in diagnosing close to 1,600 new cases each year - 1,000–2,000 is the expected burden of cancers expected in Fiji every year given the characteristics of the country. Before 2010, the registry was diagnosing 800 new cases with a lot more cancer cases not being captured in the registry. Now there is better data-capturing of diagnosed patients.

The cancer registry is useful when assessing disease burden and tracking trends, however, planning effective services means going beyond the registry. The NoHNS has seedling structures for a functional database that allows the registration and tracking of patients; additional funding is needed for the registry to operate efficiently.

The Overseas Referral System

For cancer patients seeking overseas treatment and upon the recommendation of an oncology specialist, the Fiji Government will step in to provide financial support. Most cancer patients seek assistance for chemo-radiation treatment because the chemo-palliative is available in Fiji. Cancer patients are referred to India because the government is able to meet the cost of treatment there.

Like any other government assistance scheme, there is a standard application process and requirement when applying for assistance. Furthermore, the government does not provide financial support for the entire trip but for treatment only. Very rarely will the government provide full funding for patients unless there is substantial need to approve such assistance.

As per criteria, the MOH has stated that it does not provide financial assistance to patients diagnosed with stage three cervical cancer because the treatment is expensive. Despite this standard criterion, women are still encouraged to lodge an application with the Committee because all applications are reviewed independently and approved applications are a case by case basis.

Patient or family member applying for financial support	
Step 1:	A full written and signed medical report by a specialist or local consultant will only be accepted. The report should contain the diagnosis of the patient, the type of treatment required for the patient that is not available in Fiji, the required overseas treatment is recommended, and the potential outcome or health condition of the patient after the recommended treatment. Sometimes the oncology specialist will send the full medical report of the patient to the overseas referral office with assurance that the patient has been counselled on the treatment and additional requirements needed from the patient. If the medial report submitted is not written by a specialist or local consultant, then the report is forwarded to one who can vet the report before it is considered. Full medical reports written and compiled by an oncology specialist costs $57.70 FJD.
Step 2:	The application requires that the following financial documents be submitted if the patient is working: recent payslip, 3 months bank statement, recent FNPF statement, and a health insurance statement. If the patient is married and has children who are working, then the above financial documents are also required from a patient's spouse and children. If there are financial commitments such as loans, hire purchases or rent then the patient or applicant will be required to submit evidence of these commitments.
Step 3:	A formal request from the patient or applicant is required which will include the family history, marital status, number of children, occupation and if the employment status is permanent or casual work, income status of the patient and family members, and whether the family members are able to provide support towards the treatment cost or related costs. The residential address, phone contact and postal address is also part of the required information.
Step 4:	A statutory declaration is required to ensure that the financial and personal information lodged with the application are true. A copy of the passport biodata page of both the patient and the person accompanying the patient are required to be submitted with the application.
Overseas Referral Committee	
Step 6	All documentations are collated and submit it to the review committee for vetting. The vetting process will depend upon the availability of the specialists and the time taken to vet applications varies. Once an application is approved for the specified treatment, the office will then review the overall status of the patient to see if he/she is fit to travel. Once this process is done, the application is then approved and a potential date is scheduled with the patient to travel.
Step 7:	The office will contact the patient or applicant to discuss logistical and financial requirement. Because the treatment and airfares are paid by government, the onus is on the patient or applicant to cover costs for accommodation and meal amounting to $F10,000. If a patient requests that their spouse accompany them to India, then the application and decision made is appealed. At times the government has had to cover airfare costs for both the patient and spouse.

Support services

a) Fiji Cancer Society

Established in 1993, the Fiji Cancer Society is the national cancer centre providing educational awareness, health promotion and patient support services. FCS facilitates and helps cancer patients navigate their journey within the public healthcare system.

Transportation, medicines and home visits for patients in palliative care are provided by the FCS. Particularly for the latter, a qualified nurse from the MOH accompanies the home visits to assess the women in palliative care, Purchasing of basic food items and assisting with social welfare applications for the patient's family.

FCS also conducts bra-fitting programmes post-mastectomy, in addition to counselling to help women cope post-surgery, regain self-confidence and a sense of normality when being fitted with the new bras. Outreach roadshows are also done by the FCS targeting all family members in a household, including children. Free VIA screenings are also provided to women who attend the information session. In the sessions women are informed of the free healthcare services offered at the hospitals such as chemotherapy and surgery. If there is a need to travel to India for treatment, the family is informed of the application processes and requirements under the MOH.

In the month of June, the FCS concluded their free screening programme across Viti Levu where 300 women were screened. From this, 15 cases were referred to the Oncology Unit in Suva for further examination. The FCS maintained contact with the 15 women, scheduling appointments with the available oncology doctor, providing the women with travel reimbursements, and providing support in following-up on results. Out of the 15 women, three tested positive, however, theyhave opted to take a step back to rethink things. The FCS provides patient support to ensure the women are able to travel to Suva or Lautoka for treatment without any significant barriers, should the women continue engaging with the FCS.

FCS is also targeting children in efforts to raise awareness on the implications of cancer using simple English, with the idea of learning about cancer with their mothers, aunties, grandmothers etc. – a strategic approach it hopes to introduce into the school system.

b) Reproductive & Family Health Association of Fiji (RFHAF)

Inaugurated in June 1996, the Reproductive and Family Health Association of Fiji (RFHAF) has contributed significantly towards advancing SRHRs in Fiji, advocating for better reproductive health programmes and policies. Their involvement in SRHR has seen the formulation of Fiji's national family planning policy and promoting comprehensive sexual reproductive health education with young people and communities. Demystifying the perception that comprehensive reproductive health education and SRH concepts increase sexual promiscuity among young people is challenge that RFHAF tries to address continuously.

The reproductive health services provided by RFHAF include cervical screenings, breast self-examination contraceptives, STI management and counselling services. Through its mobile clinics, RFHAF is able to carry out SRHR awareness to rural and remote parts of the country, targeting women who are unable to go to a health centre. Teams that conduct mobile clinics are accompanied by MOH nurses when available on their day-off.

RFHAF also has a static clinic in Suva and programme officers stationed at the Nausori and Wainibokasi health centres. In Lautoka and Labasa hospitals, an officer is present to provide family planning counselling for mothers. The clinic in Suva is also accessible to vulnerable groups in society such as persons with disabilities (PWDs) and LGBTQI persons. Condoms and contraceptives are also provided to sex workers when they visit the clinics.

In 2011, RFHAF partnered with Family Planning New South Wales and the MOH in introducing VIA screening in Fiji. This has since been implemented. The organisation will be able to conduct free VIA screenings once the equipment is made available to the clinic. In the meantime, the clinic conducts Pap smears and once tested positive, cases are referred to the Oncology Unit for treatment, chemotherapy or surgery;

The organisation also conducts a programme called "Future She Deserves" which educates girls on sex-related topics such as menstruation, puberty, etc. The girls' parents are also part of the programme.

CHALLENGES

Unequal cancer services available across Fiji

The MOH reports and information obtained from their website states that basic oncology units are available at the three divisional hospitals with nurses provide to inpatients. Much of the cancer treatment includes a limited level of chemotherapy and surgery, and the treatment will depend on the type of cancer, its stage at diagnosis and availability in Fiji. The Fiji Government can only provide a limited level of chemotherapy because there is not enough funding to purchase all types of chemotherapy drugs available. Palliative care is also provided by the Oncology Unit with the support of the Fiji Cancer Society .

The realities on the ground, though, paint a different picture; a picture that depicts the true state of cancer services in the country. From the interviews conducted, a common message echoing from the key informant interviews was the unequal services across all divisional and sub-divisional hospitals, and sometimes this inconsistently included the unavailability of medical personnel. Ensuring that cancer services are available to all women across all locations is the first big step to fighting the prevalence of cancer in this country; a fight which is unfortunately already at a disadvantage. The trickle-down effect of the inconsistency of services can be seen in the coverage rate of the screening programmes under the MOH. As of 2018, the coverage rate was 10-20 per cent of highrisk women. Improving these statistics require extensive funding.

Accessibility of cancer services

There are health centres and nursing stations located throughout the country yet some women still have to walk five kilometres to get to a health centre or nursing station to seek medical help. Also in terms of accessibility, the nurses at the nursing stations lack the technical skills and capacity on SRH to provide medical help to women who visit them.

There are attitudinal barriers from the service providers that hinder women's access to health centres.

Health seeking behaviour of women

Late presentation has become a significant challenge for the MOH not only for cancers but across other diseases and related health issues. Very little is done to unpack and understand the health seeking behaviours of women in Fiji, an area that needs further research.

Key informants from the interviews conducted state that 50 percent of women will not seek further medical assistance, treatment or follow-up after testing positive for cancer. Therefore, providing high-end medicine and treatment for women will not cease to succeed if women themselves do not access these services. Many women are still presenting themselves very late with cancer, and as late as stage three cervical or breast cancer. Unfortunately, the Oncology Unit cannot provide effective treatment at this stage other than palliative care to which is provided to patients to offer some level of quality life. Furthermore, many women still resort to traditional herbal medicine when diagnosed with cancer and will only return to the hospital when the families themselves cannot handle the physical deteriorating state of patient; or if the pain threshold has intensified to an extent that morphine is needed for relief.

The MOH also provides funding assistance to cancer patients seeking overseas treatment in India. One of the challenges that the MOH faces is finding women who have had their applications for treatment successfully approved. At times the contact details provided are unavailable and the ministry has had to wait for months to get responses from women who have requested financial assistance. Another issue identified by the Committee is that despite applications being approved, some women refuse treatment and prefer the chemo-palliative care provided by the public healthcare system.

Lack of awareness of services available

There is still a lack of awareness on cancer and reproductive services available for women in Fiji and very rarely will women visit a health facility and demand a HPV test or other preferred screening methods. If women knew about the services and demand it,the Fiji Government would be on its toes to ensure it delivers the service.

Experiences and challenges that women face in their journey with cancer survivor

While inputs from the key healthcare service providers in this research is important and appreciated, it was imperative for the research to also incorporate the lived first-hand experiences of women who are cancer survivors and have gone through the public healthcare system in Fiji.

The Oncology Unit stationed at the CWM Hospital was approached by the research team to assist in finding women cancer survivors to interview for this report. Furthermore, additional women were also approached using the contacts of friends, family and work colleagues but these women declined our invitation. One potential participant that the research team was hoping to interview sadly passed away from breast cancer in August 2018.

The interview followed a semi-structured format where a series of topics were listed and covered during the interview – including follow-up questions. Information obtained from the interview incorporated both quantitative and qualitative data. A standard questionnaire format was used to obtain basic information such as age, residential location, ethnicity, type of cancer, stage of cancer upon diagnosis and treatment used; and open ended questions were incorporated when the participants shared their stories with the interviewer.

(a) Demographics of the women being interviewed

A total of 10 women were approached and they voluntarily agreed to be interviewed for this research. Of the 10, three were Fijians of Indian descent, one was a Fijian of Chinese descent, and 6 were iTaukei. The women were in the 30-50 age category, with one in her late 60s. The lived experiences of the participants reported in this research comprises of women surviving cancer more than 10 years to less than the 10 year mark as indicated in the table 1.

Table 1: Number of women surviving reproductive cancer by years

Year	No. of participants	No. of years surviving
1999	1	19
2010	1	8
2013	1	5
2015	2	3
2016	2	2
2017	2	1
2018	1	three months awaiting overseas treatment

Table 2: Participant demographics

Participant	Type of cancer	Stage	Year of diagnosis	Age as of 2018	Marital status	Ethnicity	Children? (Yes/ No)	Location
1	Cervical	3B	2016	37	Married	iTaukei	Y	Tailevu
2	Vaginal	1	2013	48	Married	Fijian woman of Indian descent	Y	Narere
3	Endometrial	2	2015	58	Married	Fijian woman of Indian descent	Y	Suva
4	Cervical	2B	2015	41	Married	iTaukei	Y	Suva
5	Breast & Cervical	2	2016	65	Widow	iTaukei	Y	Nausori
6	Cervical	2	2017	39	Married	Fijian woman of part – Chinese descent	Y	Suva
7	Cervical	3	2017	43	Married	iTaukei	Y	Suva
8	Cervical	2B	2018	57	Married	iTaukei	Y	Korovou village
9	Breast	3	1999	57	Separated	iTaukei	Y	Suva
10	Breast	2	2010	52	Widow	Fijian woman of Indian descent	Y	Suva

- Of the 10 participants, four were iTaukei women diagnosed with cervical cancer between stage 2B and 3B; one iTaukei woman diagnosed with both breast and cervical cancer and was at stage two upon diagnosis.
- The remaining participants included a Fijian woman of Chinese descent diagnosed with stage two cervical and cancer; and the three Fijian women ofs Indian descent were diagnosed with stage two breast cancer, stage one vaginal and stage two endometrial cancer.
- The participant diagnosed with vaginal cancer was the only participant diagnosed with stage one cancer upon diagnosis.

"I felt disheartened, sad, depressed to be leaving my husband and 4 children behind who at the time were still young (Class 8, 5, 3 and 2 years old) and with a newborn baby"

"I was really fearful of telling my daughter who had accompanied me to the hospital where I found out the news"

"I had given birth to my child and for one year I bled continuously but did not seek medical help because I was still breast feeding my newborn baby and did not want to disturb that"

(Quotes taken from three participants)

(b) Emotional challenges

During the interview, all the participants expressed a degree of depression, sadness, and were disheartened when first diagnosed with cancer. Majority feared dying of cancer given their perceptions of the disease.

Seven of the 10 participants recalled being anxious and sad thinking about their children growing up without them. The remaining three did not feel as depressed as the others because their children were adults.

Three of the seven participants had very young children that they were still nurturing and the thought of the child growing up without a mother had made one participant extremely depressed while the other participant was concerned about the welfare of her child. The third participant had refused seeking medical help because doing so would disturb the breast feeding schedules of her new-born baby.

(c) Financial challenges

Eight of the 10 participants expressed their frustration over the financial requirement under the overseas treatment assistance being overly burdensome to them and their family. With the government only funding treatment, the onus was on the participants to raise between $F10,000 - $F31,000 to cover additional costs like meals, airfare tickets, accommodation etc. and that was particularly stressful for most of the participants.

Other challenges included medical examination, medicine and drugs, and post-recovery stages being expensive; and raising younger children while battling cancer was extremely difficult. One participant stated that with her husband gone, she had to use her entire FNPF funds to support her children.

Table 3: Number of women opting for local vs overseas treatment

Participant	Type of cancer	Ethnicity	Overseas treatment	Location
1	Cervical	Itaukei	Overseas	India
2	Vaginal	Fijian woman of Indian descent	Local	Fiji
3	Endometrial	Fijian woman of Indian descent	Overseas	India
4	Cervical	iTaukei	Overseas	India
5	Breast & Cervical	iTaukei	Local	Fiji
6	Cervical	Fijian woman of part – Chinese descent	Overseas	India
7	Cervical	iTaukei	Local	Fiji
8	Cervical	iTaukei	**Still fundraising**	
9	Breast	iTaukei	Overseas	United States of America (USA)
10	Breast	Other	Overseas	Australia

- Of the 10 participants, six were able to travel abroad for overseas treatment, three had local treatment, and the remaining participant is scheduled to go abroad in September this year after fundraising enough money for the trip.
- Three of the six participants sought financial assistance from family members and the FCS in fundraising for their trip to India, two participants paid for their treatment without government assistance and the sixth used her husband's life insurance policy to cover costs.

- Of the three participants that opted for local treatment, one was not able to go to India because she did not have family support to help her financially.
  The second did not go abroad for treatment because she was a stage one cancer patient when first diagnosed and was treated at the Oncology Unit at the CWM Hospital.
- Lastly, the third participant opted for local treatment because she could not fundraise enough funds to go abroad. This case is particularly interesting as the participant further recalls being told that the Fiji Government can only provide funding for overseas treatment if the cancer is at stage two when diagnosed. For this participant, she was a stage three cervical cancer patient when diagnosed and could not apply for government assistance.

"I was told by the doctors that I have to go to India for operation but I couldn't go because none of my children want to help me pay for the trip… I feel very disheartened. I need help like social welfare support to help support myself because I don't like to live like this. Since my husband died, I took out all my FNPF funds to support my children…and now they don't support me"

(Quotes taken from one of the participants)

"I did not have money to fund for the trip to India. The Ministry for Health will only help pay for stage two cancer. Patient will have to pay for stage three. My husband said that we were going to try to get some assistance from the company, the one he works for, but we had to wait for the board meeting where the company will discuss this request. It took long"

"Daily expenses is challenging but I try to take it one step at a time"

"I trusted in God and decided not to go to India and just get treated at the CWM Hospital"

(Quotes taken from one of the participants – transcribed from Itaukei to the English language)

(d) Family support

Majority of the participants expressed their appreciation towards their families for their support both financially and emotionally, and looking after them post-treatment and recovery. Despite feeling depressed leaving their young children behind, most of the participants were thankful to their husbands for holding the fort in the home while they underwent treatment and recovery.

One of the participants particularly expressed her disappointment at the lack of support from her children. Diagnosed with stage two cervical cancer, she was qualified to apply for government assistance for treatment in India, however, none of her children wanted to pay for her trip. Furthermore, she is currently living with her youngest daughter and has expressed sadness at the way her daughter has disregarded her daily medical needs. Being vulnerable and at the mercy of her daughter was not the life this participant foresaw and seeing the lack of support from her children has made her extremely disheartened.

"I experience some pain from time to time but I choose not to tell my daughter so that I can keep the peace in the home. She often growls at me and I don't want to ask her for things"

(Quotes taken from one of the participants– transcribed from Itaukei to the English language)

Another participant in the interview shared her story of seeing her husband leave her and their young children when she was diagnosed with breast cancer. Although life was difficult for her, juggling her responsibilities towards her children, food and rent expenses, no husband for seven years, and battling breast cancer, her mission was her children and it it is what has kept this participant going.

"I've discovered for myself what builds me up, and I focus on that. It is also very therapeutically for me to find time for myself and stay away from city life. And I believe that it is good to forgive and it's a way I've been able to heal. My husband thought that he could leave me and the family, and find another woman with beautiful breasts and be satisfied? He never found it. No satisfaction so he came back to us"

(Quotes taken from one of the participants– transcribed from Itaukei to the English language)

(e) Satisfaction with the cancer services provided by MOH

Of the 10 participants in the interview, only three expressed some degree of dissatisfaction with the services provided by the MOH. The first participant stated she would always take a Pap test and for eight years the results remained negative and nothing was detected. This same participant was diagnosed with stage two cervical cancer in 2017 and within a period of three months after arriving in India for treatment, the cancer had advanced to stage four. She called for better detection capabilities and upgrading the Pap smear system in Fiji.

"I was aware of the inaccessibility of mammograms, mastectomies and chemotherapy due to the cost factor but I was also surprised to learn about the link between early detection and radiation treatment and how it's just not available! Why talk about detection if we are not giving the information about the lumpectomy options?…We need to talk about the access and affordability to good surgical options if needed but also treatment via radiation following a lumpectomy or any other early cancer detection"

(Quotes taken from the participants)

The next participant expressed her frustration on the inaccessibility of good affordable surgical options, unavailability of essential drugs, inadequate counselling services for cancer patients, the lack of information on lumpectomy options, and the unavailability of radiotherapy treatment in the three divisional hospitals in Fiji. Particularly for the latter, this participant feels that Fiji has yet to provide radiotherapy because there are no trained radiologist and that the Fiji Government lacks investment in this area.

The third participant felt that the most important cancer service needed in Fiji is radiotherapy, not only for female reproductive cancers, but for all cancers. She recalls that this was the agenda of the MOH strategic plans post-Tropical Cyclone Winston (Post-TC Winston), however, the progress of setting up such treatment has since remained stagnant.

Another issue raised by the third participant was the lack of awareness of doctors when dealing with a cancer patient. Being a strong advocate on cancer services, she recalls that when women are diagnosed with tennis ball sized tumours they're advised to go home and wait for the tumour to mature. And when the women do return to the hospital, the tumour has matured drastically. For her, there is a complete disconnect with the standard treatment protocols; and the actual practices on the ground.

She also expressed some frustration over the limited level of chemotherapy available in the country for women, the lack of sufficient medical equipment, inadequate information, advice and counselling for women when diagnosed, to treatment options, recovery stage to post-recovery period. There is also a delay in diagnosis because of the lack of training to do a

proper medical examination and detection. For instance, she has worked with some women who are given antibiotics and Panadol instead of being diagnosed with cancer and given the correct treatment for it.

There is also a delay of treatment when women need chemotherapy treatment i.e. the drugs are either expired or has been administered to another patient and the woman scheduled to get her next cycle of chemotherapy is made to wait.

"In terms of the access to services there is an issue with delay and diagnosis – when it's a breast lump, women are given anti-biotics and Panadol but in actual fact its cancer. Some children would take their mothers out from the public hospitals and get them admitted into the private hospitals where a thorough investigation is done to get accurate diagnosis – that in itself is like $1k. Surgery is $7.5k, so in total it is $8.5k. Sometimes women are admitted back into the public hospitals because it is too expensive but for those that can afford, they travel to India for example to get their surgery done"

"Sometimes the delay in services also extents to the chemo drugs being expired by the time they get to the hospitals; and in other cases when the women come to the hospitals to get checked and get their chemo-drugs administered; they are made to wait because the nurses had already given their administered drugs to someone else. So that's another delay"

(Quotes taken from one of the participants during the interview session.)

The remaining seven participants were satisfied with the services they received from diagnosis to treatment received locally and in India, the recovery and post-recovery check-ups. Majority of the women stated that the team of oncology doctors and nurses at CWM hospital were professional and provided the standard of care and efficient advice that they needed.

(f) Satisfaction with the cancer support services

Of the 10 participants, two participants expressed dissatisfaction with the support services for women because of the lack of follow-up with women-cancer survivors, the inadequate counselling services, the lack of proper health and nutrition advice, and the poor data collection of women post treatment and recovery. Attitudinal barriers of nurses at health centres was also raised by one of the two participants.

The remaining eight participants expressed their appreciation for the support services they received such as taxi reimbursement, patient support before and after treatment, mobilising to help fundraise for overseas treatment, counselling services before and after treatment, and making their journey with cancer less daunting.

RECOMMENDATIONS

A. Ministry of Health and Medical Services & Ministry of Women, Children and Poverty Alleviation

- Late presentation has become a significant challenge for the MOH not only for cancers but across other diseases and related health issues. Very little is done to unpack and understand the health seeking behaviour and perceptions of diseases among women from different ethnic groups in Fiji; an area that needs further research which can strengthen MOH and MOW's strategic plans in addressing the prevalence of cancer among women and strengthen the Wellness Programme under the ministry.
- More funding is needed towards efficient patient navigation structures in order to help patients navigate through the public healthcare system. Patient navigation is basically helping the patient to navigate through the health system where they are given support. The feedback from key informant interviews is that 50 per cent of women, after testing positive for a reproductive cancer, will drop out completely from healthcare system and will fail to follow up. It is a significant challenge for the Oncology Unit to ensure that women who test positive will follow through and get treated.
- Promoting better health-seeking behaviour with a good screening programme, and patient navigation are three crucial components that need to be in existence. The three-tier system allows the patient who needs the services to be pushed to the surface.
- More effort is needed to increase cervical cancer programmes that emphasises on active recruitment and follow-ups. What this means is that when medical or health officials go into a community or village to conduct screenings; the details of the woman are recorded and registered, including their contact details. Women are then asked to visit the nearest hospital or health centre to get screened, an appointment date is issued and women are ticked off the list once she is screened. And then there is an active follow-up with the women right towards treatment.
- More effort needs to be put into strengthening the oncology-cancer care network so that it is able to provide efficient cancer care especially before bringing in high-end treatment. Strengthening the cancer care network will help in establishing a radiotherapy clinic.
- Setting up and operating a radiotherapy clinic is expensive for the country, costing the F10 million at a minimum - an estimated quotation that was provided to the MOH almost 10 years ago.
- There is a need for more nurses conducting community awareness within their own districts because some women are still unaware of signs and symptoms of cancers and the services available to them to seek medical help. The FCS cannot reach all the places in Fiji to raise awareness on reproductive cancers hence the onus is on MOH and MOW to equally take proactive action and do a bit more community awareness so that women are properly informed.

B. Civil Society organisations in partnership with the MOH and MOW

- There is an identified need for more professional development of service providers with SRH awareness to change the perceptions of women as just baby factories but to also recognise them as human beings; and SRH services to have a more holistic approach when providing services to women.
- Additionally, there is a need to review the essential drug list so women living in rural areas are able to access these essential drugs without having to travel far to get the help needed.
- There is a lack of comprehensive sexuality education integrated into the school-education curriculum. CSOs in partnership with government need to conduct more evidence-based research studies in this area.

C. Fiji Cancer Society and other support services

- There is an identified need to have more professional development in cancer screening detection methods and types because of the inconsistencies in screening results. Increasing the upskilling of frontline service providers in screening methods is needed to improve and ensure higher quality screening services for women.

- Improve the counselling services provided within the support services so that it empowers women to cope during treatment and post-recovery stages. This can include implementing an integrated counselling component that provides advice on health and nutrition for women during treatment and post-recovery stages - a crucial aspect lacking within the counselling services.

LIMITATIONS OF THE RESEARCH

1. Scheduling interviews with women who are cancer survivors was extremely difficult given the sensitivities around it. Some women who had initially agreed to be interviewed unfortunately declined while others simply refused to be interviewed. Several stakeholders were approached to assist in finding women for the research, however, there were no responses. One potential participant who the research team was hoping to interview had regrettably passed away in early August 2018 before the intended interview session.

2. Another limitation to this research is the number of women who were available to be interviewed. Only 10 women had agreed to be interviewed; and the research team could not interview more women for the research given the approaching deadline for the research report.

3. Any health- related research has to be approved by the Fiji National Health Research Ethics Review Committee [FNHRERC] with understandably rigid approval progresses. A full detailed proposal of FWRM's research was submitted and uploaded on to the Fiji Health Research portal. It took a couple of months and resubmission of the proposal for the research to finally be approved. The research proposal was finally approved and endorsed by the Committee on June 26th 2018. However, FWRM had written a formal letter to the MOH requesting datasets recorded in the cancer registry from 2015-2017 to be able to independently track the prevalence rate of reproductive cancers for women in the country but the request was not granted. Therefore, the research lacks comprehensive data analysis of the reproductive cancer burden for women in Fiji.

APPENDICES

APPENDIX A: Age category of urban and rural female population as of 2017

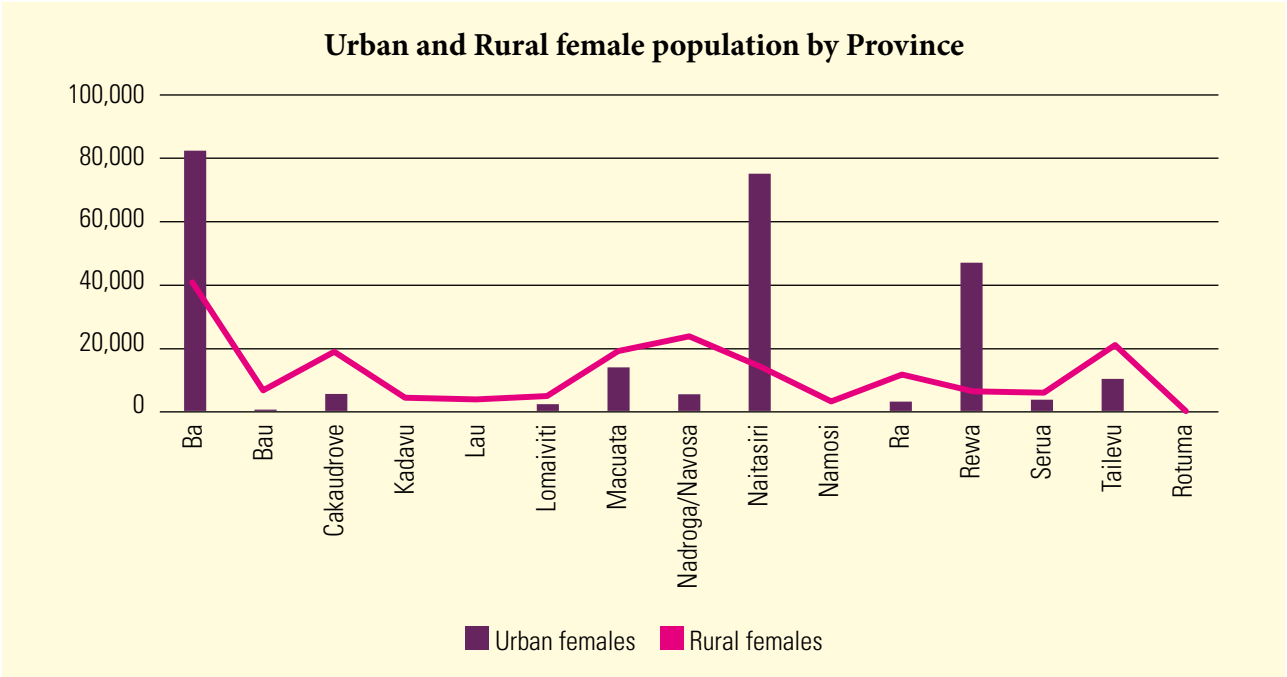
Age group	Urban females	Rural females
15-19	50.7	46
20-24	50.2	47.3
25-29	49.6	48.4
30-34	49.4	47.8
35-39	49.8	47.3
40-44	49.4	46.7
45-49	49.8	47.7
50-54	50.2	48.2
55-59	51.3	47
60-64	53.4	48.9
65-69	55.2	49.9

Source: Census 2017, Fiji Bureau of Statistics

Analysis

There are more females living in the urban centers compared to rural areas; and slight differences in the 0-4 and 10-14 age category that indicate a larger number of females living in rural areas *(see appendix)*

APPENDIX B: Female population by province as of 2017 – Urban and Rural

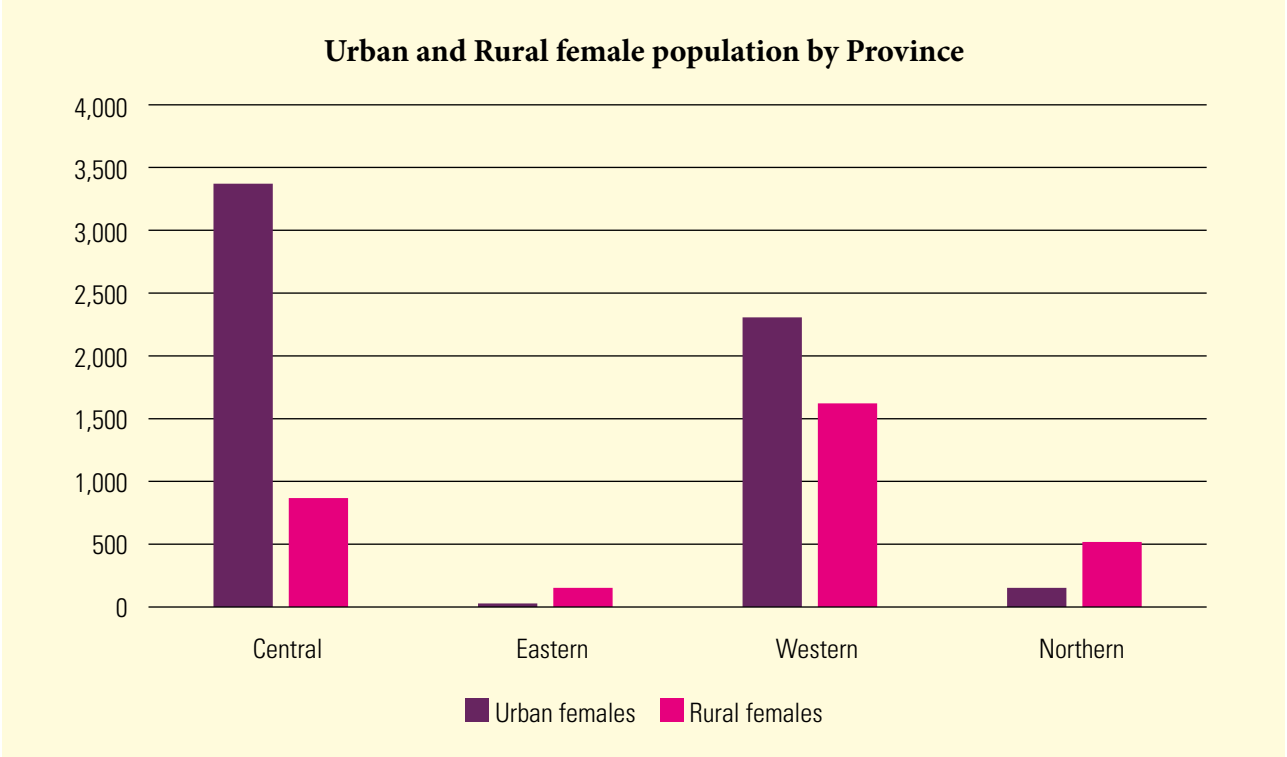


Source: Census 2017, Fiji Bureau of Statistics

Analysis

In terms of population by province, the province of Ba had the highest number of residents accounting 28.0 per cent of Fiji's population. Additionally, there are more females living in the urban areas within the various provinces than rural provinces.

APPENDIX C: Unemployment rate of urban and rural women by location as of 2017

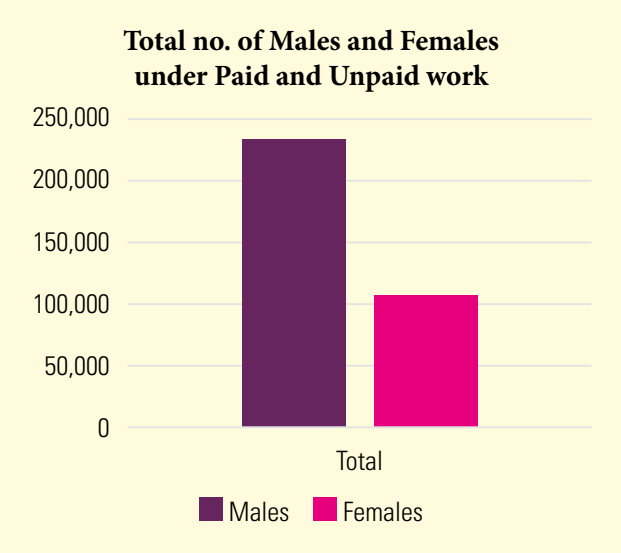


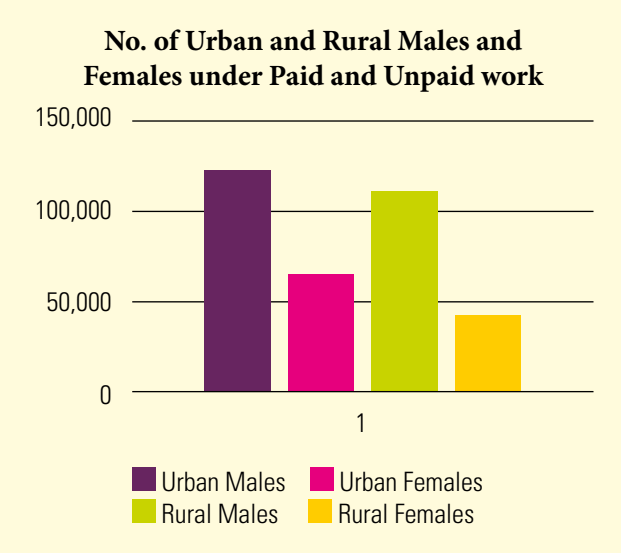
Source: Census 2017, Fiji Bureau of Statistics

Analysis

The unemployment rate is significantly high for the Central Division for females living in the urban centers. Rural women in the Western Division had the highest unemployment rate. Unemployment age category is from 15 years and above *(see appendix C for reference).* Also, the census data shows a significant gender gap in paid and unpaid work - 234,059 for males and 106,680 for females.

APPENDIX D: No. of male and females under paid and unpaid work; and urban v rural as of 2017



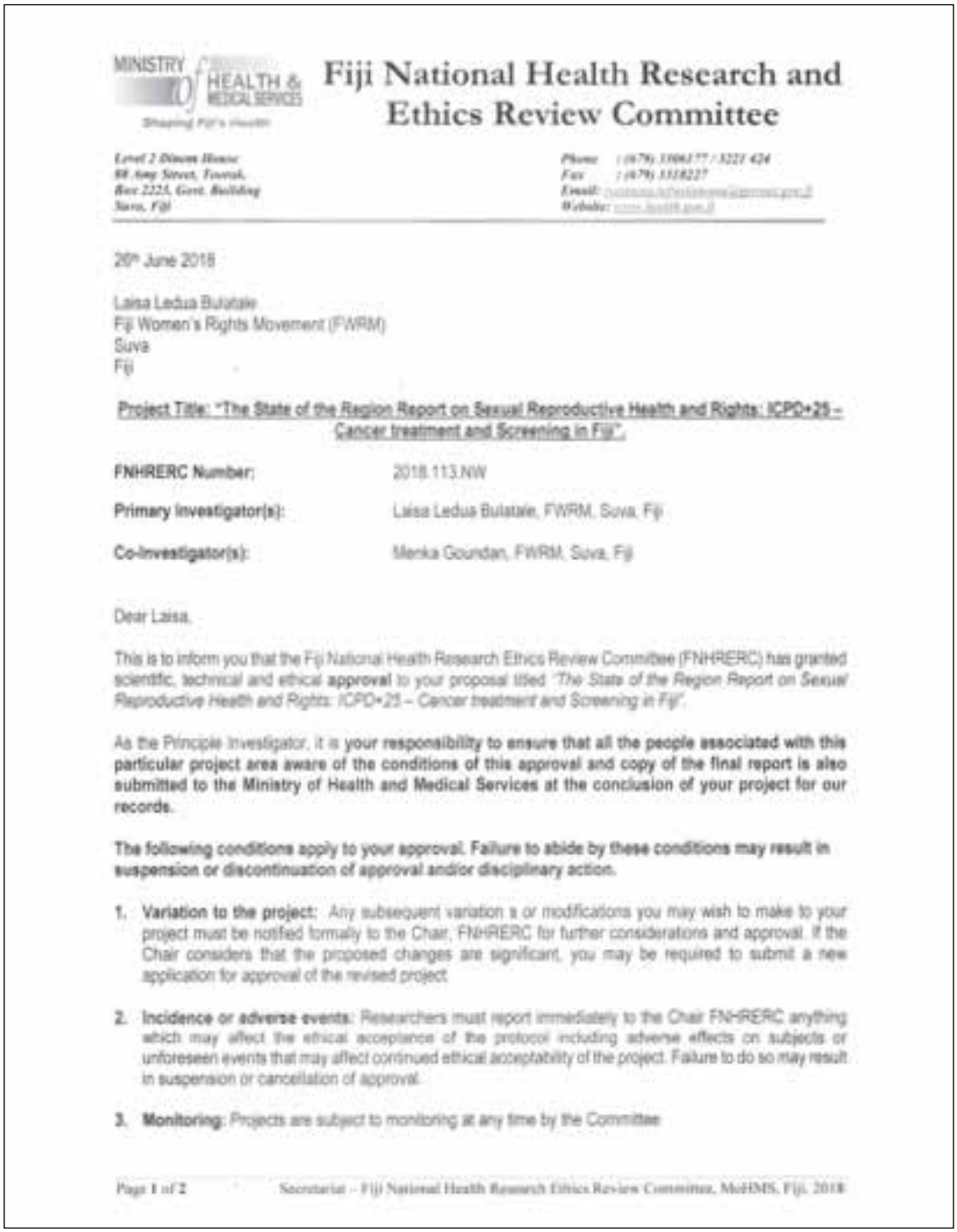


Source: Census 2017, Fiji Bureau of Statistics

Analysis

This dataset released by the Fiji Bureau of Statistics (FBS) is collated and reported into one category therefore there is no clear distinction in data between paid and unpaid work.

APPENDIX E: Fiji National Health Research Ethics Review Committee [FNHRERC]



MINISTRY OF HEALTH & MEDICAL SERVICES
Shaping Fiji's Health

Fiji National Health Research and Ethics Review Committee

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28th June 2018

Laisa Ledua Bulatale
Fiji Women's Rights Movement (FWRM)
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Fiji

Project Title: "The State of the Region Report on Sexual Reproductive Health and Rights: ICPD+25 – Cancer treatment and Screening in Fiji".

FNHRERC Number: 2018.113.NW

Primary Investigator(s): Laisa Ledua Bulatale, FWRM, Suva, Fiji

Co-Investigator(s): Menka Goundan, FWRM, Suva, Fiji

Dear Laisa,

This is to inform you that the Fiji National Health Research Ethics Review Committee (FNHRERC) has granted scientific, technical and ethical **approval** to your proposal titled *"The State of the Region Report on Sexual Reproductive Health and Rights: ICPD+25 – Cancer treatment and Screening in Fiji"*.

As the Principle 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. **Variation to the project:** Any subsequent variation s or modifications you may wish to make to your project must be notified formally to the Chair, FNHRERC for further considerations and approval. If the Chair considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

2. **Incidence or adverse events:** Researchers must report immediately to the Chair FNHRERC anything which may affect the ethical acceptance of the protocol including adverse effects on subjects or unforeseen events that may affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

3. **Monitoring:** Projects are subject to monitoring at any time by the Committee.

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