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Visit to Fiji

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras*

Summary

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, visited Fiji from 28 November to 5 December 2019.

Fiji has a strong political will to realize the right to health. It has modernized outpatient and hospital care, invested in infrastructure and increased doctors' salaries. While Fiji has initiated public-private partnerships in the health sector, the delegation of State's duties to private providers does not absolve the State of its human rights obligations. Any public-private partnership should provide sufficient guarantees for the protection, respect and realization of the right to health, ensure transparency and participation and be backed by strong regulatory, monitoring and accountability mechanisms.

Fiji has the opportunity to develop modern rights- and evidence-based mental health care and to integrate mental health care in primary care, general health and social services. The actual realization of the right to physical and mental health will depend on addressing violence, discrimination and inequalities (through, inter alia, community-based psychosocial interventions) as much as on investments in the health-care system. Despite progress in many areas, paternalistic practices and attitudes among health-care workers continue to pose a challenge to the realization of the right to health on such issues as antenatal and postnatal depression, breast cancer and cervical cancer, teenage pregnancy, access to contraception and abortion services, and gender-based violence. More efforts will also be needed to address health care for diabetes and to improve health-care facilities.

* The summary of the report is being circulated in all official languages. The report itself, which is annexed to the summary, is being circulated in the language of submission only.

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Annex

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Fiji

Contents

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health visited Fiji from 28 November to 5 December 2019, at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the right to health was realized in the country, including progress and challenges.

2. During his visit, the Special Rapporteur travelled to Suva, Nadi, Taveuni, Qamea and Labasa. He was received by and met with the Attorney General, the Minister for Health and the Permanent Secretary of Health and Medical Services, with the Minister for Education, Heritage and Arts and the Permanent Secretary for Education, Heritage and Arts, and with the Director of the Human Rights and Anti-Discrimination Commission. He also held meetings with the HIV/AIDS Board, the Director of Climate Change and Development Cooperation and with officials from both the Ministry for Women, Children and Poverty Alleviation and the Fiji Corrections Service.

3. The Special Rapporteur visited the divisional hospital in Lautoka; subdivisional hospitals in Vunidawa and Taveuni; the St. Giles Psychiatric Hospital; the *Veivueti* hospital ship; health centres in Sawakasa, Nasau, Punja, Kamikamica and Seaqaqa; the new Makoi Maternity Unit in Suva; and nursing stations in Qamea, Bouma and Coqeloa. He also met with many representatives of civil society and grass-roots organizations everywhere he visited, and with representatives of the United Nations.

4. The Special Rapporteur thanks the Government of Fiji for its invitation and full cooperation during his visit, and for the crucial support provided by the Regional Office for the Pacific of the Office of the United Nations High Commissioner for Human Rights.

II. Right to health

A. Background

5. Fiji gained independence from the United Kingdom of Great Britain and Northern Island in October 1970. Between 1987 and 2013, the country experienced various periods of instability fuelled by ethnic tensions, including three coups d'état (in 1987, 2000 and 2006). During this time, it adopted different constitutions (in 1970, 1990 and 1997), left the Commonwealth (from 1987 to 1997), and was suspended from it twice (in 2000 and 2006). In 2013, after a two-year drafting process, a new Constitution was adopted, declaring Fiji a "parliamentary representative democratic republic", with a 51-member unicameral legislature, divided into four local administrative divisions (Central, Northern, Eastern and Western). Fiji was reinstated as a full member of the Commonwealth in September 2014.

6. Fiji is a multiethnic and multicultural country. The census conducted in 2017 found a total population of 884,887, although it did not feature reliable data on ethnicity. A government directive[1] has indeed prevented the gathering of data based on ethnicity on the grounds it might recall memories of the history of racial profiling in the country.[2] The Special Rapporteur reiterates the recommendations on the need to collect disaggregated data based on, inter alia, ethnicity, gender, age and economic status in order to implement effectively policies aimed at facilitating the right to health and that take into account existing gender and other inequalities and vulnerabilities.[3]

7. The territory of Fiji is spread over more than 300 islands and atolls, of which around 100 are inhabited. The islands consist mostly of small beaches and mountains, which explains why inhabited interior areas are sparsely populated. More than 80 per cent of national territory and the total population is concentrated in the two largest islands, Viti Levu and

[1] See www.statsfiji.gov.fj/index.php/census-2017/census.

[2] See CERD/C/FJI/18-20 and A/HRC/WG.6/34/FJI/1.

[3] See A/HRC/35/41/Add.3.

Vanua Levu. Many people residing on these islands, however, live in rural or remote locations (44.1 per cent), while only around 19.2 per cent of the total population lives in the main cities (Suva, Lautoka and Nadi).[4]

8. The country's geography and the dispersion of its population poses particular challenges to the accessibility of rights. The Special Rapporteur was able to experience the remoteness of certain villages when travelling by boat or vehicle inside the country to visit rural health centres.

9. Fiji has been consistently classified by the World Bank as an upper middle-income country since 2007.[5] It boasts the second largest economy in the Pacific, is industrially advanced and has substantial services and manufacturing sectors, with a major tourism industry.

10. Social and economic dimensions in-country show progress in accordance with the human development index, which assesses indicators such as longevity, health and standards of living. In Fiji, the index rose from 0.64 in 1990 to 0.724 in 2018. During the same period, life expectancy at birth increased by 2.1 years, and years of schooling by 2.5 years.[6] When viewed from a broader context, however, these values are still below the average for countries in the wider East Asia and Pacific region (0.741) and below the average for countries in the high human development group (0.75).

11. According to national estimates by the World Bank, the poverty rate dropped from 39.8 per cent in 2002/03 to 34 per cent in 2013/14.[7] Data gathered in the context of a household and income expenditure survey conducted in 2013/14 revealed, however, that the rate of poverty is still higher in rural areas (36.7 per cent) than in urban ones (19.8 per cent).[8] Estimates also indicate that urban poverty has slightly increased (from 18 to 19.8 per cent) since the previous survey,[9] suggesting that migration from rural to urban regions has increased and had a negative impact on overall well-being in urban areas.

12. With regard to the Sustainable Development Goals, Fiji has made progress in the right to health. The maternal mortality rate (Goal target 3.1) improved from 51 per 100,000 live births in 2000 to 34 in 2017,[10] which is already within the worldwide target of 70 for 2030. The neonatal mortality rate – currently 10.8 per 1,000 live births – has been relatively stable over the past 10 years. The child mortality has, however, been less stable: the child mortality rate reached its lowest in 2002, with 22.3 deaths per 1,000 live births. Since then, mortality of children under 5 years increased to 25.6 in 2018.[11] Despite these fluctuations, the rates for both neonatal and child mortality (comprising Sustainable Development Goal target 3.2) are on track for the relevant worldwide targets for 2030, namely 12 for neonatal and 25 for child mortality.

13. The Government of Fiji has consequently set more ambitious targets for Sustainable Development Goal targets 3.1 and 3.2, and has committed to a reduction in the maternal mortality rate to fewer than 8 deaths by 2021 and the neonatal and child mortality rate to less than 9 and 8, respectively, by 2030.[12]

14. Fiji is performing well in terms of Sustainable Development Goal target 3.8. It has reached close to universal coverage for almost all recommended vaccines. In 2017, following

[4] Estimations based on data available at https://worldpopulationreview.com/countries/fiji-population/.

[5] See https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2018-2019.

[6] UNDP, Human Development Report 2019, Inequalities in Human Development in the 21st Century, Briefing note for countries on the 2019 Human Development Report, Fiji.

[7] http://documents.worldbank.org/curated/en/531821528202548810/pdf/Fiji-PEB-Spring-2018.pdf.

[8] United Nations Children's Fund (UNICEF), *Situation Analysis of Children in Fiji*, Suva, 2017, p. 24.

[9] Anthony B. Atkinson, *Measuring Poverty around the World* (Princeton, New Jersey, Princeton University Press, 2019).

[10] www.who.int/gho/maternal_health/countries/fji.pdf?ua=1.

[11] https://data.unicef.org/country/fji/. According to data gathered by the World Bank, the child mortality rate reached 19 in 2003 and 21.6 in 2008; see https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=FJ.

[12] https://sustainabledevelopment.un.org/content/documents/25011Fiji_VNR_2019_final.pdf.

assessments that showed a decline in measles immunization coverage, the Ministry of Health and Medical Services, with the support of the World Health Organization (WHO) and UNICEF, provided vaccines for around 95 per cent of children between 12 months and 10 years.

15. Actions taken in 2017 showed their positive effects during the measles outbreak that hit the Pacific late in 2019; Fiji was in fact one of the least affected countries. The outbreak coincided with the visit of the Special Rapporteur, who observed first-hand the measures taken. At that point, further immunization was undertaken, targeting people who were not fully immunized or were most at risk of infection. Among other measures, large gatherings were discouraged, and a major women's rugby regional championship scheduled for November 2019 was postponed. The Special Rapporteur commended the authorities for the good coordination and containment of the outbreak.

16. Regarding other Sustainable Development Goal indicators relevant to the right to health, Fiji has not performed as well, in particular in terms of Goal target 3.7. According to the most recent data of the World Bank, in 2012, the proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods was 44 per cent, which is lower than the average of 76 per cent for the broader East-Asia and Pacific region (excluding high-income countries) and adolescent birth rate per 1,000 women in that age.[13] The infrequent use of contraceptives contributes to high rates of adolescent fertility and to sexually transmitted infections. The adolescent fertility rate in Fiji rose from 41 per cent in 2002 to 49 in 2018.[14]

B. Normative and institutional framework

17. Fiji is a State party to all core nine international human rights treaties, notably those enshrining the right to health, including the International Covenant on Economic, Social and Cultural Rights (ratified in August 2018), the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child.

18. Fiji plays an active role at the Human Rights Council – it was recently elected to the presidency of the Council for its fifteenth cycle – and is a role model in the Pacific. Strong political will has been publicly expressed to advance the human rights agenda. Fiji issued a standing invitation to the special procedures of the Human Rights Council in 2015, and since, mandate holders have officially visited the country once a year, with the exception of 2020, owing to the coronavirus disease (COVID-19) pandemic.

19. Fiji is also a key player in the Pacific, showing solid leadership in countering the negative impact of climate change. The State is a party to the WHO Framework Convention on Tobacco Control and to the main United Nations conventions relating to drug control.

20. In November 2019, Fiji was reviewed in the context of the third cycle of the universal periodic review, during which it committed to implement various recommendations relevant to the right to health, including expanding efforts to improve medical health services, their quality and accessibility by groups in vulnerable situation, and further investments in the training of health-care professionals in order to, inter alia, ensure that lesbian, gay, bisexual, transgender and intersex (LGBTI) persons have access to health-care services and HIV treatment in a non-discriminatory manner.

21. Recommendations have been addressed to Fiji on ratifying the optional protocols to the core human rights instruments, including the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights. While Fiji is currently focused on national implementation of recently ratified treaties, the Special Rapporteur looks forward to future consideration of ratification of the optional protocols to them.

[13] https://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations.

[14] The World Bank Data, Adolescent fertility rate (births per 1,000 women aged 15-19) Fiji, https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=FJ.

22. The Constitution of the Republic of Fiji of 2013 includes a comprehensive bill of rights and reflects the multi-ethnic and multicultural nature of its society, bestowing the title of "Fijian" on every citizen, regardless of ethnicity. The Constitution incorporates a comprehensive list of grounds on which discrimination is prohibited, and includes provisions regarding the rights of the child and of persons with disabilities, clarifying that courts, tribunals or other authorities may consider international standards and principles in the interpretation and application of the bill of rights.

23. The Constitution recognizes the right to health. According to article 38 (1), the State must take reasonable measures within its available resources to achieve the progressive realization of the right of every person to health, and to the conditions and facilities necessary to good health, and to health-care services, including reproductive health care. Article 38 (2) establishes that persons "must not be denied emergency medical treatment, while article 38 (3) indicates that, if the State claims that it does not have the resources to implement the right, it is the responsibility of the State to show that the resources are not available.

24. There are different laws governing the health sector, a key one being the Public Health Act (1935). The entity primarily responsible for managing the State's overall health-care system is the Ministry of Health and Medical Services. The Ministry is involved in the implementation of health-related laws, policymaking and in the delivery of health-care services across the country.

25. Fiji has a modern and bold vision towards health-related policies. The mission of the Ministry is to "empower people to take ownership of their health" and to assist people in achieving their full health potential by "providing quality preventative, curative and rehabilitative services through a caring sustainable health-care system". This has involved a shift from the usual focus on addressing and reducing certain diseases or infirmity through vertical programmes towards one addressing the determinants of health through a "wellness approach".

26. The "wellness approach" was specified in the 2015 National Wellness Policy, which laid the basis for multi-sectoral cooperation with stakeholders from outside the Ministry of Health and Medical Services to advocate and protect individuals' health and wellness. The policy goes beyond the usual dimensions of wellness, including its social, spiritual, environmental, occupational, psychological, physical and financial dimensions.

27. In March 2020, after the visit by the Special Rapporteur, the Ministry of Health and Medical Services launched the Strategic Plan 2020–2025, based on the National Wellness Policy. The plan aims at universal health coverage from a one-system approach to one that is more public health-oriented. The document considers the determinants of health to strengthen the continuum of care and to improve the health and well-being of the people in Fiji, especially those in the most vulnerable and isolated environments.

28. The strategic vision of the Ministry of Health and Medical Services, based on the "wellness approach" and its plan for 2020–2025, are all elements of a political will that suggests that Fiji is heading in the direction towards the full realization of the right to physical and mental health. The Special Rapporteur appreciates the clear focus of the documents on the determinants of health and on groups in vulnerable situations, and hopes that the same political will be shown during implementation, which will involve addressing not only inequalities but also violence and discrimination – determinants of health that, if not effectively addressed, would undermine the realization of the right to health.

C. National health-care system

29. Fiji inherited a subsidized health-care system from its British colonial past. The system is largely funded by the Ministry of Health and Medical Services, which is also the main provider of health care. Services are handled across the four geographical regions by three divisions: the Central/Eastern Division, the Western Division, and the Northern Division. Accordingly, there are three divisional hospitals, each supported by subdivisional hospitals, health centres and nursing stations.

30. While there is no public health insurance system, most services are provided free-of-charge in each facility. There is also private health expenditure from both, direct out-of-pocket payments and private health insurance policies, which are mostly used for prescriptions, over-the-counter medications and outpatient services. A study found that rises in out-of-pocket health expenditure in Fiji come predominantly from wealthier households in urban areas,[15] which may suggest that access to free health-care services by those in most vulnerable situations remains relatively stable.

31. In the 1970s, the primary health-care system underwent a decentralization process, which was made possible largely by the country's communal culture and the involvement of health workers with the community through home visits, the organization of village "health days" and their advisory role on public health issues. The public health-care system continues to rely on the strategic role played by more than 1,500 community health workers to extend the coverage of primary health care. These workers are members selected from the community, and usually do not have a formal health education. They receive training to advise community members on primary health care, such as nutrition and the early detection of health conditions. Through home visits, workers deliver key health messages and refer community members to essential health-care services, sometimes transporting themselves the community member to the health facility. They play an essential role in outreach, especially for persons living in remote locations when they miss a check-ups or need specific medical follow-up.

32. While the work of community health workers is performed on a voluntary basis, workers also receive an allowance in return for the submission of monthly health reports. Allowances are typically used for transportation or other expenses incurred when community health workers attend training or travel to nursing stations or health-care centres to perform their functions. At the time of the visit by the Special Rapporteur, the Ministry of Health and Medical Services had just reviewed and increased these allowances.

33. The Special Rapporteur met with many community health workers who travelled from their own villages and settlements to nursing stations exclusively to meet with him. He learned first-hand about their work, challenges, views and recommendations for strengthening the national health-care system. Community health workers expressed pride in their work. They also conveyed gratitude for the increase in their allowances, although some shared concerns about their timely distribution.

34. The next level of the Fijian health-care system includes nursing stations, currently 97 throughout the country. Nursing stations are the health-care facilities closest to the communities, mainly located in rural areas and generally staffed by one nurse, although on rare occasions they may also include a medical practitioner (such as in Coqeloa). Nursing stations, which deliver the most basic health-care services, like maternal and child health services, including immunization and family planning, serve communities with a population ranging from 100 to 5,000 people. They may refer individuals to higher level health facilities as required.

35. The Special Rapporteur visited three nursing stations, including the station on Qamea, an island only reachable by boat from Taveuni. The station temporary replaced the village health centre, underwater since a landslide in December 2016. The destruction of the centre was one of many examples illustrating the negative impact of climate change, including the right to health in general. Construction of a new health centre in Qamea was under way at the time of the visit by the Special Rapporteur, who hopes that it will be fully operational by the publication of the present report.

36. There are 86 health-care centres nationwide. Each one is staffed by either a doctor or a nurse practitioner, assisted by one or more nurses. The number of staff members may, however, actually range to up to 20, depending on the type of services, the location and the population covered. The centres, which are the first level of referral for nursing stations, deliver primary health-care services for communities with a population from 3,500 (in rural settings) to 10,000 (in urban areas). Centres (like the one in Seaqaqa) may have a pharmacy,

[15] See Asia Pacific Observatory on Health Systems and Policies, Health Systems in Transition, Fiji Living Hit Update, chap. 3.

a laboratory, an x-ray department or a dental unit, or be staffed also by a health inspector, a dietician, clinic nurses or other nurses responsible for conducting school visits and zone nurse activities. During his visits to some health centres, including those in remote locations (such as the one in Nasau), the Special Rapporteur was able to observe the equipment and services provided. He also held discussions with medical staff and users of services.

37. The Special Rapporteur observed and received information about the recording of health information on all clinical cases followed by each centre and nursing station, an activity that is done manually on white boards, with the keeping of respective files. While the medical information displayed on white boards is not usually confidential, it would be advisable that it be recorded in an automated system, in which it would be readily accessible.

38. Subdivisional hospitals, which constitute the next level of health-care services, provide secondary care. There are 10 such hospitals in the Central/Eastern Division, six in the Western Division and three in the Northern Division. Subdivisional hospitals provide inpatient care and outpatient services, while more complex cases are referred to the next health-care level, namely divisional or specialized hospitals. Fiji has three divisional hospitals: the Colonial War Memorial Hospital in Suva, covering the Central/Eastern divisions; Lautoka Hospital, for the Western Division; and Labasa Hospital, for the Northern Division. The country also has two specialized hospitals for mental health care (St. Giles) and for leprosy, tuberculosis and dermatology (PJ Twomey Hospital, in Tamavua). Divisional and specialized hospitals provide both secondary and tertiary health care. The Special Rapporteur visited several of these facilities.

39. As well as the public health-care system, Fiji has some 130 private general practitioner clinics and three private hospitals. Most private clinics provide outpatient services during the day, while private hospitals deliver secondary and tertiary health care, provided at the expense of the person receiving the care. While private facilities do not receive government funding as such, some schemes direct public funding to the private sector, such as public grants for kidney treatment or government payments to private pharmacies to provide individuals covered by the public health care with certain services free of charge.

Developments and challenges

40. The geography and population distribution of Fiji pose a significant challenge to the accessibility of health care. To meet that challenge, the Government has developed a number of initiatives, such as the *Veivueti*, the first hospital ship in the Pacific. Inaugurated in 2019 following a week-long trial test, the *Veivueti* is a full-fledged floating health facility, designed to provide medical services and rapid response during emergencies. The Special Rapporteur conducted a visit to the *Veivueti*, and was informed about the many surgeries performed during the trial and its upcoming visits to 10 islands over a 20-day period to deliver medical services. Shortly thereafter, the *Veivueti* was scheduled to visit the Western Division to help Lautoka Hospital to clear its patient waiting list.

41. The Emergency Medical Assistance Team and its surgical outreach constitute another commendable initiative. In May 2019, WHO accredited the Team as a type 1 Fixed Emergency Medical Team, ready for domestic and international deployment. Today it provides a broad range of medical and emergency services – including energy generation, a water treatment facility, desalination kits, waste incinerators, tents to accommodate the 20-member team and users as needed, and showers, among others – for up to 100 individuals a day. The Team is the first of its type in the Pacific.

42. The Team surgical capacity comprises surgeons, anaesthetist, nurses, health-care workers and logistics, which have been deployed to hospitals to perform surgical procedures. Team members at Vunidawa Hospital informed the Special Rapporteur about how some 60 surgeries had been performed in only one week.

43. The Special Rapporteur appreciated the existing political will to invest in all main components of the health-care system, including primary and specialized health care. He was also informed, however, that, in practice, there is a certain amount of mistrust in the public health system due to infrastructure perceived as insufficiently maintained, health-care workers and practitioners reportedly lacking experience, and recurring shortages in basic

equipment and medicines. Some people consequently resort to private health-care services or to those based overseas, a choice that can have a profound impact on household expenses.

44. The accessibility of specialist services is varied across the country, given that they are available only at divisional hospitals or in Suva. Some specialized clinical services, such as kidney transplants, neurosurgery or radiotherapy, are not routinely available, but rather provided through a reportedly cumbersome overseas medical referral programme that subsidizes patients below certain income level, subject to strict processes by the Overseas Treatment Committee. The limited treatment available for cervical and breast cancer is largely complemented by the programme. Other specialized services, such as treatment for rheumatic heart disease, are provided by visiting specialized medical teams from Australia and New Zealand; others, such as open-heart surgery, can be undertaken at the Colonial War Memorial Hospital.

45. Further efforts have been made to modernize hospital care, such as through investment in infrastructure, increases in salaries for doctors and public-private partnerships (particularly in the Ba and Lautoka hospitals to improve tertiary care, oncology services, kidney dialysis, maternity care and procedures for non-communicable diseases), and 24/7 availability of open-heart surgery. Any public-private partnership should, however, be deployed with clear and effective institutional policies and measures that put the public interest and human rights at the centre of all interactions. In such partnerships, the State detains its obligation to protect, respect and fulfil the right to health, and continues to bear responsibility for the performance of the private provider. Delegating a State's duty to a private provider does not absolve the State of its human rights obligations.

46. A number of studies show lessons learned from public-private partnerships in the health sector, including in the United Kingdom of Great Britain and Northern Ireland, Australia, Sweden and Lesotho, which should be considered in Fiji. Such partnerships may lack tangible benefits for the State, which may have limited control over quality, and may result in poor contracting management. Costs can often escalate or overrun, and there is a tendency for the quality of services to the public to decline.[16]

47. It should not be assumed that public-private partnerships will deliver on time, on budget and with a high-quality product. Strong regulatory, monitoring and accountability mechanisms are required to ensure respect for and the protection and realization of the right to health. Transparency should be ensured by participatory and accountable processes that target persons in the most vulnerable situations. Consultations are required throughout the negotiation process, including with meaningful participation of those most likely to be affected by the public-private partnerships. The State should guarantee accountability with adequate regulations that encourage responsible and accountable investments through, inter alia, regular reporting based on quality data and information.

48. Strong regulatory mechanisms should ensure non-discrimination and equal access by, for example, prohibiting the denial of access to affordable and adequate health services, goods and facilities, in particular to life-saving treatment in the event of inability to pay, or by combating corruption and providing guidance to private actors on how to respect human rights. Enforcement mechanisms must ensure that the right to health is realized and that any disproportionate impact on persons in a vulnerable situation is assessed and mitigated, including with respect to rural population, those living in poverty, women, children, older persons, LGBTIQ persons, persons with chronic illnesses and those who require palliative care. The State should further develop mechanisms to provide remedies against potential right-to-health abuses through judicial and non-judicial mechanisms that can settle grievances with impartial and transparent processes, safeguards for the protection of witnesses, victims and their legal representatives, as well as through the widespread dissemination of information about the remedies and support for organizations working with victims.

[16] See *Taking back control: a community response to privatisation*, www.peoplesinquiry.org.au, 2017; *History RePPPeated: How Public Private Partnerships are Failing*, Eurodad, October 2018; Joel Benjamin and Tim Jones, "The UK's PPPs disaster: Lessons on private finance for the rest of the world", Jubilee Debt Campaign, February 2017.

III. Right to mental health

A. Background and institutional framework

49. The issue of mental health has in Fiji historically relied on a traditional model of care based on psychiatric hospitalization and the idea that persons with mental health conditions could not be managed within the community. The model was introduced during British colonial times (1874–1970), with services centralized at the St. Giles Hospital, the country's only psychiatric hospital, located in Suva. Established in 1884 as the "Public Lunatic Asylum", it was renamed the "Suva Mental Asylum" in 1935, and again in 1960, as the St. Giles Hospital.

50. Mental health has often been associated with substantial stigma in Fiji. The St. Giles Hospital has itself had a reputation of discriminatory practices, and threats of being committed to the facility for misbehaviour were not uncommon.

51. Although health-care workers in divisional and subdivisional hospitals, health centres and nursing stations have also traditionally aimed at providing emergency and short-term mental health care, their training is so limited that they are often forced to refer individuals to St. Giles Hospital or to prescribe psychotropic medication.

52. Steps have been taken to shift this historical approach. Thanks also to the current "wellness approach", mental health is now included in a holistic, population-based delivery of health care. In October 2010, the Government endorsed a mental health decree, which in 2016, during the national process to consolidate laws, was proclaimed an "act", like all previous decrees and promulgations. The Mental Health Act aims at covering not only inpatient treatment but also mental health promotion, prevention, community-based services and rehabilitation. It includes some elements compatible with human rights, such as respect for and the maintenance of the rights of health-care workers (sect. 6.4 (a)); certain anti-discrimination provisions (sect. 7); respect for confidentiality (sect. 39); and access to medical records (sect. 40). It also refers to informed consent – "free, voluntary and in writing in the approved form and signed (or thumb printed) by the person giving consent" – for certain treatments.

53. The Mental Health Act is not, however, compliant with different provisions of the Convention of the Rights of Persons with Disabilities, which Fiji ratified on 7 June 2017. Its overall approach does not regard persons with intellectual, cognitive or psychosocial disabilities as holders of rights, but rather as mere recipients of care. An entire section (part 4) of the Act regulates detention in mental health facilities, allowing for forced treatment and forced hospitalization on the basis of "medical necessity" and "dangerousness for self or others" (sect. 17 (3); sect. 20; and part 4). Such an approach runs counter to article 14 of the Convention, which states that involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment, or other reasons tied to impairment or health diagnosis, is contrary to the right to liberty and amounts to arbitrary deprivation of liberty.

54. The Act includes a subsection on the use of seclusion and the exceptional use of restraints (sect. 37) in cases of "dangerousness". According to the terms of the Act, such uses should not exceed four hours without the approval of an authorized health-care professional, and should not follow immediately after another period of seclusion and restraint. Even with these provisions, the exceptional use of seclusion and restraints runs counter to article 14 of the Convention.

55. The Act also allows for the use of electroconvulsive therapy (sect. 72–76), with either the patient's free, voluntary and written consent or by decision of a tribunal, when the patient does not consent or is considered "incapable of giving [it]". The Act further allows for requests for a management order that cannot exceed 12 months, unless otherwise specified by the court, to manage the legal affairs of a person with "mental incapacity" (Part 10). Both provisions run counter to article 12 of the Convention protecting the right to equal recognition before the law, as does the existence of a mental health review board that examines decisions to refuse or approve the discharge of voluntary patients in a mental health facility; reviews

cases of persons detained in a mental health facility under a compulsory inpatient order; conducts inquiries with regard to consent for and the administration of electroconvulsive therapy; and decides whether to authorize surgery. Provisions of this type overrule the right to legal capacity of persons with disabilities who may wish to discharge themselves from the mental health facility or to exercise their informed consent by refusing treatment, including electroconvulsive therapy and surgery.

56. While the Mental Health Act provides for "the right to make a written statement (or) 'advanced directive'" regarding treatment and care (sect. 55 (1)), it also states that, when deciding how to treat a person, a health-care professional must consider – but is not bound by – the advance directive (sect. 55 (3)); when the advance directive is not followed, a written report explaining the reasons thereof must be submitted to the Permanent Secretary of Health and Medical Services and the Mental Health Review Board (sect. 55 (4)).

57. By not making directives binding on health-care workers, the Act effectively defeats the purpose of protecting the right to legal capacity, nullifying the option for persons with disabilities to express their preferences with regard to services, treatment and support while still capable of making such decisions. The Special Rapporteur stresses that any restraint, physical or chemical, even if allowed only in exceptional circumstances, may affect a person's physical safety and psychological well-being. Medical coercion in mental health-care settings must be radically reduced and eventually eliminated, measures should be developed to implement and use more widely non-coercive alternatives to restraints, and incentives should be created for such changes to be effected.

58. The Act has also paved the way for the incipient integration of mental health care at the primary level, a positive development. Stress management wards have been established in divisional hospitals, and mental health clinics have been put in place in some primary health-care facilities. The State is also implementing the WHO Mental Health Gap Action Programme, which should help to align mental health care further with the Convention on the Rights of Persons with Disabilities.

B. Main findings and the way forward

59. In Fiji, the traditional model of mental health care has often led to stigma, discrimination and the isolation of persons with mental health conditions and disabilities. The Special Rapporteur observed the limited and even total absence of mental health services in the outer island, and the lack of qualified counsellors in rural areas. Mental health survivors reported that they continued to feel disempowered and in a distinctly vulnerable situation. Such persons are often subjected to forms of violence that frequently go undocumented, and lack access to information about their rights and how to exercise them.

60. Overall, there is a lack of mental health support for pregnant women and new mothers, who may face antenatal or postnatal depression or have had a history of domestic violence. Depression is twice as common in women during childbearing age as in men and is closely linked to adversity, inequalities and violence, including gender-based. In Fiji, it is not uncommon for new mothers to be mistreated by health-care workers if they face difficulties in feeding their babies properly or struggle to lactate, disregarding whether they may be affected by a mental health condition. Risk factors, family dynamics, pre-existing mental health conditions or poor relations or interaction between the mother and the health-care worker are often ignored.

61. Increasing rates of bullying in Fijian schools may also be a cause of mental health issues. Virtually all stakeholders with whom the Special Rapporteur met recognized the existence of the practice; indeed, a recent report recorded more than 6,000 cases of bullying in 2019 alone.[17] The Special Rapporteur was pleased to learn about the plans of the Ministry of Education to carry out research into its causes and international best practices to address this issue.

[17] "Fiji records over 6,000 school bullying cases in 2019", Xinhuanet, 5 March 2020.

62. While there is no systematic reporting on suicide, the Ministry of Health and Medical Services reported that Fiji was considered to have one of the highest suicide rates in the world.[18] Student suicides are particularly alarming and currently considered the most common cause of death among teenagers and youths.[19] More than 90 per cent of those who died by suicide may have had clinical depression or another mental health condition. For children, home and school environments make a significant contribution to their emotional well-being; issues such as bullying and cyberbullying, unrealistic expectations, prejudices or pressure to overperform can push them to the edge. Drugs and alcohol use and abuse have also been linked to suicide in Fiji. In this regard, the Government informed the Special Rapporteur that it intended to develop a database on suicide.

63. The Special Rapporteur also learned about a lack in counselling services and of psychologists. Counselling services in Fiji are mainly provided by civil society organizations, like Empower Pacific and Medical Services Pacific; even the Ministry of Health and Medical Services and doctors refer users to them. These organizations play an important role and already have the trust of both health-care providers and users.

64. Recognition of the equal importance of mental and physical health is essential. All main elements should be addressed, including the prevention of mental health-related issues, such as depression, suicide, bullying and other forms of violence. Integrating mental health into primary health care is essential to reduce the stigma and discrimination still associated with mental health, to enhance access to integrated and continuing care and to improve social integration.

65. Mental health care should comply with the Convention on the Rights of Persons with Disabilities. Accordingly, the main targets of investment should be community-based rehabilitation, care and support with the engagement of all health-care workers, from community health workers to nurses and doctors, so they are able to provide care for people's mental health the same way they now care for their physical health. Equally important are the care and support for persons with psychosocial, cognitive and intellectual disabilities.

66. For most mild and moderate mental health conditions, cost-effective non-specialized interventions based on human interaction, talking and listening, starting from "watchful waiting", may be all that is required. Such interventions should be seen as frontline treatment; they can be provided without any need for psychiatric specialization. For that, all health-care workers should receive appropriate training to support anyone who may be facing emotional or social distress, such as women with newborns, new mothers, victims of gender-based violence, or children and adolescents facing bullying or suicidal thoughts.

67. Increasing the availability of psychosocial interventions and counselling services will help to reduce excessive reliance on psychotropic medications, including those used to treat depression and prevent suicide. While biomedical interventions remain important for severe conditions, they are not effective in addressing issues closely related to social problems, unequal power relations, violence and other forms of adversity that determine people's social and emotional environment.

68. Early intervention services for children with developmental disabilities and their families should also be developed. Child and adolescent mental health should be promoted through the support of parenting skills, preventing all forms of violence against children, reduction of poverty and all forms of discrimination. The education system should be involved and cooperate with the health and social welfare sectors to protect the mental health and well-being of children and adolescents effectively at the community level.

69. Health determinants such as inequality, discrimination and violence should be addressed with greater political will and more investments, so that the risk factors for poor mental health outcomes can be effectively mitigated. Given the detrimental impact of early childhood adversities and their correlation with a higher prevalence for different patterns of poor physical and mental health (including suicide), overcoming them is of key importance.

[18] See www.health.gov.fj/suicide/.

[19] Rosalie Muertigue and Kamala Naiker, "The Perceived Factors of Student Suicide in Fiji", *Edelweiss Psychiatry Open Access*, vol. 1, No. 1, 5 March 2018, pp. 21–24.

Awareness-raising programmes and campaigns are needed, together with effective preventive activities developed with the meaningful involvement of communities.

IV. Right to health of women and children

A. Rights to sexual and reproductive health

70. In 2014, Fiji developed a reproductive health policy that refers explicitly to the right of all women, men, couples and children to have access to curative and preventive reproductive health-care services and the right of young people to have access to youth-friendly services and information. According to WHO, in 2013, human papillomavirus vaccines became available to girls under 15 years of age, reaching a coverage of 50.5 per cent in 2018.[20]

71. Alongside the above-mentioned initiative, however, breast cancer and cervical cancer remain among the top five causes of death for women in Fiji, accounting for 30 per cent of all cancers registered in the country. This is partially the result of the fact that some women seek medical assistance only at a very late stage of the illness or who fail to follow up on treatment after testing positive. At the same time, however, there are obstacles stand in the way of equal access to cancer diagnosis and treatment across the country.

72. While free screening for cervical cancer is available at divisional and subdivisional hospitals, health centres and mobile clinics, there are no similar screening programmes for breast cancer as part of the core health-care system. Instead, women are encouraged to do breast self-examination regularly and to visit a doctor if they find any abnormality. The inconsistency of screening methods is compounded by a lack of technical skills and nurses to conduct tests, particularly in remote locations. Basic oncology units are available at the three divisional hospitals, but they have limited capacity to deliver chemotherapy, radiotherapy and surgery. Qualified women may be sent abroad for further treatment (mainly India) through a referrals programme, which, however, involves a cumbersome process requiring guidance and support.[21]

73. The Special Rapporteur observed efforts to increase capacity for maternal health, including through the new Makoi Maternity Unit, but also learned about the challenges that pregnant women living on islands (such as Taveuni or Qamea) face in reaching hospitals in the main centres of Labasa or Suva before they give birth. While some low-income women from rural areas are able to stay with relatives living near main centres prior to delivery and for the postpartum, many cannot, and travelling can involve transport conditions that expose mothers and their newborns to the risk of injury. To address these challenges, pregnant women could be offered transport by ambulance, or other options for out-of-hospital births, such as natural births. At present, home births, including with the assistance of a midwife, are not an option for women in Fiji.

74. Maternal health care seems to continue to be influenced by paternalistic and patriarchal attitudes. The Special Rapporteur received information about cases of obstetric violence in cases of procedures like C-sections and episiotomy being performed without the informed consent of the woman. In some cases, health-care workers do not share information or seek informed consent before procedures, and often fail to follow women's birthing plans and override their views and autonomy. The cultural perception is that health-care workers "know best" and that pregnant women are less knowledgeable and less capable of making decisions about themselves and their bodies. Depending on their race, socioeconomic status and disability, women are also subjected to hierarchical stratification, and feel intimidated and reluctant to question doctors or nurses, and fear retaliation through poor quality service or care.

[20] For WHO estimates of human papillomavirus immunization coverage (2010–2018), see www.who.int/immunization/hpv/monitor/en/.

[21] Fiji Women's Rights Movement, *Breaking the Barriers: Understanding Cancer Services, Screening & Treatment Available for Women in Fiji*, 2018.

75. Termination of pregnancy is provided for in the Crimes Act of 2009, part 14. Abortion is not unlawful if performed by a lawfully registered medical practitioner or if the pregnancy is the result of incest, rape or severe medical condition of the mother or the fetus. Various stakeholders reported, however, that, despite its legality, abortion is rarely performed because it is at the discretion and by decision of doctors, who often deny it on religious grounds. Some women and girls therefore resort to unsafe, clandestine and expensive abortions that put their health and integrity at risk; well-documented evidence in fact shows that unsafe abortion is a leading cause of maternal mortality and morbidity. Furthermore, there are no safe public spaces to openly discuss these and other related issues, such as further decriminalization.

76. Teenage pregnancies (number of births to girls from the ages of 15 to 19), are still high in Fiji and continue to increase annually,[22] with some exceptions, such as 2018, when the number of teenage pregnancies dropped to 97 from the 127 cases registered in 2017.[23] In 2019, however, cases rose again, reaching 104.[24] Teenage pregnancies in Fiji are the result of, inter alia, limited use of contraceptives and of sociocultural factors, lack of adequate and comprehensive sexuality education, and obstacles to access to sexual and reproductive health rights. Adolescents fear the stigma associated with seeking sexual and reproductive health care, particularly in rural areas. The confidentiality of female patients is often not respected by health-care workers, and even when a woman is married, the husband's consent is repeatedly sought before providing birth control, even though such consent is not required by law.

77. The limited use of contraception is also linked to paternalistic practices. While the age of consent for sex in Fiji is 16 years, a common practice in pharmacies and health centres is to provide over-the-counter contraceptives only to those who are 19 or older. Adolescents aged 16 to 19 usually require a parent to accompany them to obtain contraception. These obstacles put boys and girls at significant risk of unwanted pregnancies and of contracting sexually transmitted infections, including HIV.

78. Although HIV is not highly prevalent in Fiji,[25] its incidence, in terms of newly reported cases per year, disproportionately affects young people and indigenous iTaukei. The gender distribution of new cases of HIV has also changed, as more females are now more likely to be diagnosed than males. Furthermore, the incidence of sexually transmitted infections is extremely high among young women, who also face barriers to their access to effective treatment for them due to, inter alia, limited confidentiality in rural areas, the availability of drugs only at specialized centres and only through a doctor, and transportation costs from remote areas or outer islands.

79. Although Fiji is one of only two States in the Pacific to have developed a sexuality education ("family life education") programme. Recent studies have shown that its actual implementation is vague, not mandatory and not comprehensive.[26] While teachers may consider schools the ideal place for sexuality education, they lack adequate information and skills, continue to fear negative parental reactions and feel uncomfortable discussing sexuality issues.

80. Following up on a recommendation received in the context of the universal periodic review, Fiji indicated that an assessment of sexual and reproductive health rights had been completed, and a revised school curriculum would shortly provide comprehensive sex education, in accordance with international standards. The Special Rapporteur welcomes the announcement and looks forward to its realization.

[22] Ministry of Women, Children and Poverty Alleviation, Annual Report 2017–2018.

[23] See "Essay on Teenage Pregnancy" at www.123helpme.com/essay/Essay-On-Teenage-Pregnancy-483810.

[24] Fred Wesley, "The issue of teenage pregnancy", *The Fiji Times*, 7 March 2020.

[25] According to the Fiji Global AIDS Progress Report (www.unaids.org/sites/default/files/country/documents/FJI_narrative_report_2016.pdf2016), in 2014 there were fewer than 1,000 persons in Fiji with HIV, and the prevalence for 15–49 year-olds was 0.1 per cent.

[26] S. Ram and Masoud Mohammadenzhad, "Sexual and reproductive health in schools in Fiji: a qualitative study of teachers' perceptions", *Health Education*, vol. 120 (2020), pp. 57–71.

B. Gender-based violence

81. According to a study conducted in 2013, Fiji has one of the highest rates of violence against women and girls worldwide;[27] 64 per cent have experienced physical and/or sexual violence by a husband or intimate partner, 34 per cent have been sexually abused, and 16 per cent were sexually abused when they were less than 15 years old. Other sources reported an increase of 22 per cent in cases of child abuse across Fiji between 2018 and 2019.[28] These figures do not take into account an estimated 47 per cent of women and girls who do not report abuses owing to, inter alia, stigma, fear, shame and lack of trust in the police or legal services.[29] Hate speech against women has a high rate of prevalence in society and the media, including social media.

82. Victims of gender-based violence include lesbians, bisexual women, transgender men, transmasculine and gender non-conforming people. One study found that 83 per cent of persons between 25 and 34 years of age in this population had experienced physical and/or sexual violence by their intimate partners,[30] exacerbated by the trauma already experienced during frequent acts of abuse while growing up and stress linked to social stigmatization, isolation and lack of family support, among others. Sex workers, especially female and transgender ones, and men who have sex with men, avoid health care services because of stigma, discrimination, fear of poor treatment and a lack of confidentiality about their work or behaviour.[31] Calls to repeal laws criminalizing sex workers have not been successful. While Fiji has decriminalized homosexuality, LGBTIQ persons still do not enjoy certain rights in health, such as the right to donate blood.

83. In Fiji, gender-based violence is rooted in stereotypes and myths that place women in a position of inferiority. It is largely underreported owing to, inter alia, social pressure to resort to traditional reconciliation, like the *bulubulu*, a form of apology through gifts from the perpetrator's family to the victim's family. Such traditional practices also deters people from bringing cases to formal courts, where sentences for perpetrators have been reduced or condoned using *bulubulu* as a mitigating factor.

84. Fiji has made attempts to recognize this serious societal problem, such as through the Fiji National Service Delivery Protocol for Responding to Cases of Gender-Based Violence. The State has also recently launched consultations for the national action plan to prevent violence against women and girls (2021–2026). A next step is the review of the Delivery Protocol to substantively include inputs from the lesbian, bisexual, trans and gender non-conforming persons.

85. The Special Rapporteur welcomes the health guidelines developed by the Ministry of Health and Medical Services in 2015 on violence against women for comprehensive case management. He also notes, however, that discriminatory attitudes are still held by health-care workers, as reflected in their frequent incapacity to respond to the health needs of victims of gender-based violence, which is in part the result of a medical hierarchy that is deeply entrenched and upheld in the health-care system. Moreover, support services are limited and there is a lack of adequate shelters available for victims of gender-based violence, a problem compounded by the increases in gender-based violence during disasters and post-disaster situations. Further efforts should be made to stop the vicious cycle of violence, starting from gender-based violence as a priority.

[27] Fiji Women's Crisis Centre, *Somebody's Life, Everybody's Business*, 2013.

[28] Erin Thomas, "How data is improving justice for gender-based violence in Fiji", Open Global Rights, 7 April 2020.

[29] Asian Development Bank, Fiji: Country Gender Assessment 2015, 2016.

[30] Diverse Voices and Action (DIVA) for Equality Fiji, "Unjust, Unequal, Unstoppable: Fiji Lesbians, Bisexual women, Transmen and Gender Non-Conforming People tipping the scales toward justice", May 2019.

[31] See Fiji Country Factsheet on HIV and AIDS estimates and statistics (www.unaids.org/en/regionscountries/countries/fiji) and Integrated Biological Behavioural Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project 2014.

86. Changing rooted stereotypes and social and cultural patterns of behaviour is a long process. Although some worthy initiatives having been taken or are being planned, more effort is required in the health-care workforce. Doctors, nurses and other health-care workers should be trained not only on clinical skills and knowledge but also on how to communicate with users of health services and how to cope with difficult situations. At all levels of health care policies and services, priority ought to be given to developing a spirit of partnership and mutual respect and trust to replace paternalistic attitudes and the misuse of power asymmetries between health-care providers and users, including in mental health-care settings.

87. Training in human rights and medical ethics should be strengthened as an important part of medical and health education. Negative stereotypes and discriminatory attitudes around sexuality should be eliminated; adolescents should be ensured confidential access to contraception, while victims of rape, including women, children, and lesbian, bisexual, trans and gender non-conforming persons, should be provided with appropriate health-care services, including emergency contraception, post-exposure prophylaxis and adequate mental health care.

V. Additional challenges

A. Other groups in vulnerable situations

88. The incidence of non-communicable diseases is high in Fiji, with cardiovascular disease, stroke and diabetes the leading causes of death. The most pressing challenges relate to the latter. According to the Ministry of Health and Medical Services, one in three people in Fiji has diabetes.[32] Furthermore, very often the disease is not detected until amputation or even death is imminent. Some estimate that diabetes-preventable amputations constitute 40 per cent of all operations in hospitals.[33] Meanwhile, health centres regularly face a shortage or total lack of health goods, such as glucometer strips, lancets, insulin syringes, needles and functioning medical equipment.

89. Reportedly, public pharmacies very often run out of insulin, and testing strips are prohibitively expensive; in the outer islands, there are few or no pharmacies at all. Public health care is reportedly provided for type-1 diabetics free of charge to children up to the age of 14 years, which leaves children over that age at risk, in particular those from poor households. Health services for diabetes are furthermore frequently subject by climate shocks and natural disasters due to long power outages of the cooling systems required to store insulin. This situation is compounded by the lack of equipment among first medical responders to treat the disease.

90. It is reportedly not uncommon for husbands of diabetic women in remote locations to prevent them and their children from travelling to health centres to obtain the care they need. In addition, it has become common for diabetics to ask doctors not to mention the disease or hyper/hypoglycaemia in medical certificates owing to potential severe penalization by employers. A policy to better regulate such matters in the workplace is needed. The Special Rapporteur hopes that efforts by civil society organizations to develop a policy on diabetes in the workplace will succeed.

B. Impact of climate change on the right to health

91. The Pacific is one of the most disaster-prone and vulnerable regions in the world. Fiji is one of the 15 States worldwide with the highest risk of being adversely affected by climate change and natural disasters, with continuous risk of rapid-onset events, such as cyclones, floods, earthquakes, volcanic activity and tsunamis, not to mention slow-onset events, such as deteriorating marine ecosystems, rising sea levels and droughts.

[32] www.health.gov.fj/diabetes-2/diabetes/.

[33] See RNZ, “Diabetic amputations 40 percent of all Fiji surgery”, 10 July 2019.

92. Fiji has recently been affected by a wide range of issues created by climate change, including the world's first refugees caused by it. Owing to its small geographical size and its economy dependent on natural resources, Fiji is especially vulnerable to the adverse effects of the climate emergency on health and exposed to extreme climate events. Such climate change-related events have indeed resulted in a loss of revenue and affected its development and compliance with the Sustainable Development Goals, including Goal 3.

93. Overall, climate change has a negatively impact on health determinants, such as clean air, safe and sufficient water, and food and shelter, but also has a direct impact on human health, including injuries, disease and death from extreme heat and cold, cyclones, floods and droughts. Indirect effects include increases in vector-borne and water-borne cardiovascular, respiratory and renal diseases, also causing a psychosocial impact from the increase in the range and number of disease-spreading vectors, compromised food and water sources, livelihood losses and population displacement.

C. COVID-19

94. While the coronavirus disease (COVID-19) pandemic was declared only after his visit, the Special Rapporteur followed up on developments in Fiji. With the first case confirmed in March 2020, by 3 February 2021 there were only 56 cumulative cases and two deaths from COVID-19, including a 3-month period (19 April to 5 July 2020) where no new cases were reported. Containment measures included the closure of schools, workplaces and the international airport, community and home quarantines, limits to size of meetings and public gatherings, travel restrictions, stay-at-home orders for high-risk persons, teleworking, the closure of high-risk venues, temporary lockdowns of affected areas, nationwide curfews, fever clinics and contact tracing and supervision.

95. Concerns have nonetheless been expressed about the continuation of COVID-19 measures when there is de facto no community transmission. Measures should carefully take into account any public health benefits against any possible negative impact on health, such as lack of emergency access to health facilities during curfew hours, and they must be convincingly established in accordance with international standards of necessity, legality, proportionality and non-discrimination; otherwise, they should be lifted.

96. In June 2019, Fiji launched the smartphone application careFIJI, which all users of phones issued by the Government or government-funded bodies, and the armed forces, were required to download and install. Although the Government emphasized there were no privacy issues involved, various stakeholders expressed their concern at legislation governing the use of the application and safeguards in relation to data collection and storage.

97. The Special Rapporteur recalls that States have the responsibility to demonstrate that any use of technological surveillance as a response to COVID-19 is necessary and proportionate to achieve the objective pursued. Furthermore, States should not rely on generic provisions of other laws, but ensure that a specific law is in place to provide safeguards that are spelled out in sufficient detail, protecting data subject to privacy, transparency of processing, and access to portability, rectification, erasure and objection to the processing of health-related data. He recommends that Fiji be guided by the recommendations of the Special Rapporteur on the right to privacy on the protection and use of health-related data.[34]

98. With gender-based violence on the rise during the COVID-19 crisis worldwide, Fiji is one of few States to have considered services to address gender-based violence essential, and strengthened them. The services included two free national helplines: one to respond to child emergencies, established in 2015; and another to report incidents of domestic violence, established in 2017. Initially available for 12 hours a day, the helplines were upgraded in 2016 to be available 24 hours a day. Other services provide psychosocial support through information, education and communication materials and training for helpline staff. Training was also developed for health-care workers to identify and safely refer victims of violence, with a specific referral pathway for women with disabilities, among other measures.

[34] See A/74/277; see also A/75/147.

VI. Conclusions and recommendations

99. **Fiji has shown strong political will in realizing the right to health, with investments in all the main elements of health care, including primary and specialized care. The State has modernized outpatient and hospital care, invested in infrastructure and increased salaries for doctors. The actual realization of the right to health will also depend, however, on effectively addressing violence, discrimination and inequalities.**

100. **While continuous investments in a sustainable health-care system with a focus on primary care are important, it is equally important to seriously address the major health determinants that threaten the effective realization of people's right to health. The key to success is critical analysis, recognizing the current gaps and identifying the measures needed to close them.**

101. **Paternalistic practices and attitudes within the health-care system, and power asymmetries between health-care workers and users of services, continue to challenge the realization of the right to health in areas such as maternal care, including mental health care for pregnant women and child delivery, access to contraception and abortion services, health care for victims of gender-based violence, as well as women's and children's access to diabetes health care.**

102. **The Special Rapporteur recommends that the authorities of Fiji:**

(a) **Ensure that the right to health is protected, respected and fulfilled in all public-private partnerships in the health sector through participatory processes, strong regulatory, monitoring and accountability mechanisms, human rights guidance for private actors, and remedies;**

(b) **Develop modern rights- and evidence-based mental health-care services that integrate mental health into primary care, general health and social services, through the development of community-based support, care and rehabilitation, in accordance with the rights enshrined in the Convention on the Rights of Persons with Disabilities;**

(c) **Develop at the community level cost-effective psychosocial interventions for children and adults with mental health conditions, while empowering all health-care workers to be involved in mental health support and care through training in human rights and medical ethics;**

(d) **Strengthen financial support for civil society organizations providing counselling services and support to victims of violence;**

(e) **Support parenting skills to prevent all forms of violence against children, with the cooperation of education, health and social welfare systems;**

(f) **Develop a comprehensive public health policy that ensures psychosocial assessment and support in maternal and perinatal care, in close consultation with organizations advocating for feminist, women's and LGBTIQ persons' rights;**

(g) **Ensure equal access to services for cervical and breast cancer across the country, developing training and sensitization programmes for health-care workers in all facilities, particularly nursing stations;**

(h) **Increase accessibility to hospitals for pregnant women by improving road and water transport services, and, given the geographical challenges posed by the country, consider providing alternatives to hospital delivery, such as home births;**

(i) **Continue to review its health laws to address teenage pregnancy by ensuring the access of adolescents to sexual and reproductive health care, including contraceptive methods, and make abortion services and post-abortion care more accessible to women and girls;**

(j) **Conduct human rights and medical ethics training in medical and health education to eliminate negative stereotypes and discriminatory attitudes with regard to sexuality;**

(k) Continue to address gender-based violence, making full use of existing legislation and policies, providing adequate resources, and making sure that design and implementation are based on human rights and scientific evidence;

(l) **Strengthen efforts in the areas of diabetes prevention, early detection, health care and awareness through nutrition education, availability of medical supplies (glucometer strips, lancets, insulin syringes, needles and functioning medical equipment) and a policy focusing on diabetes in the workplace;**

(m) **Maintain a fiscal space for health care during COVID-19 times, prioritizing essential health-care services and medications, as well as contraceptive commodities, equipment and supplies in all hospitals;**

(n) **Regularly review legislation providing the basis for COVID-19-related restrictions, ensuring compliance with international human rights standards, particularly the principles of legality, necessity, proportionality and non-discrimination;**

(o) **Continue efforts to address the effects of the climate emergency and natural disasters that continuously undermine the country's effective response in providing for medical needs and services, especially for persons in the most vulnerable and isolated environments.**