

A Deeper Silence

The Unheard Experiences of Women with Disabilities
- Sexual and Reproductive Health and Violence against
Women in Kiribati, Solomon Islands and Tonga

MARCH 2013



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TABLE OF CONTENTS

Acknowledgements	6
Foreword – UNFPA	7
Executive Summary	10
Background	19
- About This Report	19
- UNFPA	20
- Structure of This Report	20
Overview	22
- Sexual and Reproductive Health and Rights	22
- Violence against Women	23
- Sexual and Reproductive Health	24
Disability	26
Situation Analyses Approach	29
- Purpose	29
- Approach	29
- Interviews with Women	30
- Use of Quotes and Names	31
- Challenges and Limitations	31
• Ethics	31
• Selection Bias	31
• Communication	31
• Triangulation	32
Regional Frameworks on Disability Issues in the Pacific	33
- Biwako Millennium Framework for Action and Biwako Plus Five	33
- Incheon Strategy to Make the Right Real for Persons with Disabilities in Asia and the Pacific	33
- Target 6.D: Increase measures to protect girls and women with disabilities from all forms of violence and abuse. Pacific Regional Strategy on Disability	34
Regional Entities Working on Disability and/or Sexual and Reproductive Health Issues in the Pacific	35
- International Planned Parenthood Federation’s Sub-Regional Office of the Pacific (IPPF SROP)	35
- Pacific Disability Forum (PDF)	36
- Pacific Islands Forum Secretariat (PIFS)	37
- Regional Rights Resource Team (RRRT)	38
Common Findings	39
- Common Strengths	39
• Skills and Talents of Women with Disabilities	39
• Disabled Persons Organizations	39
• Non-governmental Organizations	39

• Government Legislation, Policy and Services	39
- Common Areas to Address	40
• Regional Strategies and National Legislation, Policies and Services	41
• Family	41
• Community	41
• Sexual Identity	42
• Lack of Information and Understanding about SRHR	42
• Need for Improved Services	42
• Health Professionals and Other Social Service Staff	44
• Unplanned Pregnancies	44
• Women in Institutions	44
• Women with a Mental Illness or Intellectual Disability	44
• Involuntary Contraceptive Use or Sterilization	45
Recommendations	46
• Structure of Recommendations	46
• Specifically for Donors	46
• Regional Recommendations	46
• Recommendations for all Three Countries	49
• Kiribati Recommendations	53
• Solomon Islands Recommendations	54
• Tonga Recommendations	55



Kiribati Situation Analysis **56**

- About Kiribati	56
- Persons with Disabilities in Kiribati	57
- Kiribati Legislation, Policy and Services for Women with Disabilities	58
• Legislation	58
• Policies and Strategies	58
• Services/Programmes for Women with Disabilities	61
- Experiences of Women with Disabilities	63
• General Characteristics of Women Interviewed	64
• General Health Behaviours	65
• Sources of Support: The Family and Te Toa Matoa	66
• Community Attitudes	68
• Sexual and Reproductive Health Experiences	69
- Concluding Thoughts	79
- Kiribati Recommendations	81



Solomon Islands Situation Analysis **82**

- About Solomon Islands	82
- People with Disabilities in Solomon Islands	83
- Solomon Islands Legislative, Policy and Services for Women with Disabilities	84
• Legislation	84
• Policies and Strategies	85
• Services/Programmes for Women with Disabilities	89
- Experiences of Women with Disabilities	92
• General Characteristics of Women Interviewed	92
• General Health Behaviours	94

• Community Attitudes	96
• The Significant Role of the Family	98
• Sexual and Reproductive Health Experiences	100
- Concluding Thoughts	118
- Solomon Islands Recommendations	121



Tonga Situation Analysis	123
- A Note on Methodology	123
- About Tonga	123
- Persons with Disabilities in Tonga	124
- Tonga Legislation, Policy and Services for Women with Disabilities	126
• Legislation	126
• Policies and Strategies	127
• Services/Programmes for Women with Disabilities	131
- Family, Community and Sexual and Reproductive Health	135
• The Family	136
• Community Attitudes	137
• Sexual and Reproductive Health Experiences	139
Concluding Thoughts	148
Tonga Recommendations	150

Appendix One: Terms of Reference	152
- Proposal to conduct situation analyses in Solomon Islands	152
• Purpose	152
• Specific activities	153
• Methodology	154
• Output	154
• Timing	154
• Qualifications	154
- Proposal to conduct situation analyses Kiribati and Tonga	155
• Purpose	155
• Specific activities	155
• Methodology	156
• Output	156
• Timing	157
• Qualifications	157
• Details for the work to be delivered	157

Appendix Two: Lists of Interviews	158
- Kiribati List of Interviews	158
- Solomon Islands List of Interviews	158
- Tonga List of Interviews	159

Appendix Three: General Disability Issues and Recommendations Emerging from Situation Analyses	161
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General Disability Recommendations	164
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End Notes	166
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FOREWORD – UNFPA



DIRK JENA
Director and Representative,
UNFPA Pacific
Sub-Regional Office

UNFPA is guided by the idea “Everyone Counts”, and while this is often referred to with regard to work on population, it is equally true in the mandate of the Fund to ensure universal access to reproductive health. This is central to the spirit of the International Conference on Population and Development (ICPD), and the Programme of Action adopted by 174 countries in Cairo (1994) to realize the ICPD promise over 20 years. When the Millennium Development Goal (MDG) 5B was adopted in 2008, it included access to reproductive health care for all members of society, including those living with disabilities.

However, women with disabilities continue to be neglected and marginalized. Their reproductive health concerns are often ignored, sometimes in a way that dehumanizes them, and this compounds discrimination toward them and their families.

We hope that this publication will assist UNFPA to better address the needs and rights of women with disabilities in the new country programme cycle beginning in 2013, but that the findings and recommendations can also inform UN, government and development partners’ programming in years to come. Central to this will be in ensuring that policies and programmes for persons with disabilities are created and implemented with their meaningful engagement. This can be done through partnerships with organizations such as the Pacific Disability Forum and its country-based affiliate organizations.

The report findings are particularly urgent where they highlight the violence disabled women face. It is critical that the needs of persons with disabilities be integrated into legislative reform, policy and programme development and, most importantly, action that impacts positively on the lives of women with disabilities.

A handwritten signature in black ink that reads "Dirk Jena". The signature is written in a cursive, flowing style.

DIRK JENA
Director and Representative,
UNFPA Pacific Sub-Regional Office

ACRONYMS AND ABBREVIATIONS

AHD	Adolescent Health and Development Programme
AMAK	Aia Maea Ainen Kiribati
ANC	Antenatal Care
BCC	Behaviour Change Communication
BMF	Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights-based Society for Persons with Disabilities in Asia and the Pacific 2002-2012
CBR	Community-based Rehabilitation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CLA	Community Liaison/Advocates
CRPD	Convention on the Rights of Persons with Disabilities
DP	Depo Provera
DPO	Disabled Persons Organizations
ESCAP	Economic and Social Commission for Asia and the Pacific
EVAW	Elimination of Violence against Women
GLBTI	Gay, Lesbian, Bisexual, Transgender and Intersex
HCC	Honiara City Council
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICF	International Classification of Functioning, Disability and Health
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KFHA	Kiribati Family Health Association
LAM	Lactational Amenorrhea Method
MEHRD	Ministry of Education and Human Resource Development

MHMS	Ministry of Health and Medical Services
MWYCA	Ministry of Women, Youth and Children's Affairs
NATA	Naunau O'E' Alamaite Tonga Association
NEAP	National Education Action Plan
NGO	Non-governmental Organization
NHSP	National Health Strategic Plan
OP	Optional Protocol
PDF	Pacific Disability Forum
PIFS	Pacific Island Forum Secretariat
PNG	Papua New Guinea
PRSD	Pacific Regional Strategy on Disability, 2010-2015
PWDSI	People with Disabilities Solomon Islands
RH	Reproductive Health
RRRT	Regional Rights Resource Team
SH&FPA	Sexual Health and Family Planning Australia
SICHE	Solomon Islands College of Higher Education
SIPPA	Solomon Islands Planned Parenthood Federation
SPRHFTPT	South Pacific Reproductive Health and Family Planning Training Project
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SROP	Sub-Regional Office of the Pacific (IPPF)
STI	Sexually Transmitted Infection
SWIM	Short Workshops in Mission
TFHA	Tonga Family Health Association
TL	Tubal Ligation
TTM	Te Toa Matoa
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

In any particular country, on average about 15 per cent of the population is living with a disability. Women as a population group have a higher prevalence of disability, along with poor people and older people. Globally, there is evidence to show that women with disabilities experience significant barriers to realizing their sexual and reproductive rights. These include false beliefs that women with disabilities are asexual, unsuitable for marriage and unable to manage their fertility or raise children. These beliefs impact on the ability of women with disabilities to gain information and access services to enable them to enjoy safe and healthy sexual and reproductive lives, free from violence.

Women with disabilities have great talents, skills and experiences. They are frequently constrained from opportunities to use these through systemic discrimination. The norms that structure societies are usually prescriptive and restrictive in relation to sexual and reproductive health (SRH) issues. These norms intersect with inaccurate beliefs and attitudes about women with disabilities to create heavy burdens of discrimination for women to bear.

This report contains information gained in situation analyses exploring the SRH needs of women with disabilities in three Pacific Island countries: Kiribati, Solomon Islands and Tonga. This work was carried out over a four-month period spread out between October 2010 and September 2011. UNFPA undertook these situation analyses to gain greater understanding of the opportunities and needs experienced by women with disabilities in relation to their ability to realize their sexual and reproductive rights.

These situation analyses involved a desk review of literature, including regional frameworks, the work of key regional organizations and national legislation and policies. Complementing this desk review were interviews with stakeholders, service providers and women with disabilities in each country. These situation analyses are not representative of all women with disabilities in each country. They are the result of the collection of a wide range of information from different sources. This information has been gathered here to illustrate where women with disabilities may need greater assistance to realize their full range of SRH and rights.

Disability and Violence against Women

These situation analyses show that women with disabilities in Kiribati, Solomon Islands and Tonga have experienced physical and sexual violence. Some reported experiences of violence at the hands of intimate partners and even caregivers. Others reported rape by strangers or acquaintances, including during the critical developmental years of adolescence.

The consequences of violence can be severe. Some of those interviewed reported that violence increased during pregnancy, which puts the health and well-being of both the woman and the fetus in jeopardy. The situation analyses found that women with disabilities require more support when they experience violence and seek assistance.

Women with disabilities experience different forms of violence from women without disabilities. These include acts such as the withholding of medication and assistance, denial of food or water, and forced sterilization and medical treatment.

Studies show that women and girls with disabilities are two to three times more likely to be victims of physical and sexual abuse than women with no disabilities. This abuse can happen in the family, the community or in institutions where the perpetrators can be other patients or care givers. Their access to reproductive health (RH) care is minimal and as a result they suffer greater vulnerability to RH problems. There is a lack of awareness regarding women with disabilities and RH health needs. More often than not it is assumed that they do not form part of RH target groups because being disabled is associated with being sexless. The consequences are particularly severe for women with disabilities who are also subject to social, cultural and economic disadvantages due to gender discrimination.

There are at least four ways that consideration of violence against women could be better integrated in health care. First, health-care providers require more training and information to ensure delivery of quality services, a sound understanding of disability issues as well as of the issue of violence against women and girls, and the sensitivity to provide the relevant support for survivors of violence. Where services are available, training to manage care, provide counselling and follow-up should be included in pre-service curricula. Second, women with disabilities should be supported and guided in accessing health care, as well as in seeking referral to further counselling and legal action. Third, it is important that health-care providers liaise with displaced persons organizations (DPOs) and other services, including women's non-governmental organizations (NGOs) that may be providing services for survivors as well as conducting awareness programs.

Finally, health-care providers should have appropriate rights-based policies and guidelines, and workers should adhere to standards of practice. They should have a zero tolerance approach to violence against women and girls with disabilities.

There was a recurrent finding across all three countries that families and caregivers considered people with disability to be asexual. This contributed to not providing information on health and available health care. Women with disabilities reported that without information they did not feel confident to access health care. This cycle of discriminatory practice and belief and the resulting lack of access to health care must be broken.

Violence against women and RH can be mainstreamed in schools' health and education curricula, particularly in schools serving children with disabilities, to begin raising awareness at an early age. In all three countries, Family Life Education (FLE) programmes are being developed as part of the national curriculum. The FLE programmes include lessons and activities on sexuality education, RH and social relationships. These are currently being augmented with more material and resources on gender equality and gender-based violence. This school curriculum recognizes that there are students with disabilities in classrooms, and efforts have been made to address their specific needs. The use of FLE material may be used and adapted in schools for children with disabilities.

Considering the number of women interviewed who experienced sexual violence by a stranger or acquaintance, and women's beliefs that they were targeted because of their disability, these situation analyses indicate that women with disabilities may be more vulnerable than women in the general population. When discrimination based on disability combines with discrimination based on sex, disabled women can be more disadvantaged than not only able-bodied women, but also men with disabilities. Though women and girls with disabilities face similar discrimination and human rights abuses as other women and girls, their social isolation, exclusion and dependency increase the extent of their abuse and limit the actions they can take. Where poverty and disability are jointly manifest, they reinforce each other, leading to increased vulnerability and exclusion. In some cases rape resulted in marriage being arranged by the family, which only perpetuates the violence throughout a woman's life.

Around the world, "people with disabilities are at greater risk of violence than those without disabilities"¹. It is difficult to escape the cycle of violence: women with disabilities may not report violence to authorities, or may be unwilling to report a perpetrator who is a caregiver. Women can face challenges in even accessing the appropriate

authorities to lodge a complaint, and when they do report, in being treated appropriately by the authorities. Consideration should also be given for the specific needs of women with disabilities, such as specific communication needs that might arise when lodging a legal complaint. Their evidence can also be constrained by the lack of support in providing evidence.

Both Kiribati and Solomon Islands have new government-endorsed policies focussing on eliminating violence against women. These policies offer examples of promising practice in the region. While neither policy currently mentions women with disabilities specifically, there is the potential to address disability in the implementation phase. Implementation plans must mainstream women with disabilities and be implemented in liaison with the local DPO.

Governments, donors and development partners can make a significant contribution to the reduction of violence against women with disabilities through promoting health systems that strengthen and address women's access to justice. All have the potential to contribute to altering inaccurate, discriminatory and ultimately harmful beliefs, attitudes and practices related to women with disabilities.

Disability and Sexual and Reproductive Health and Rights

The Convention on the Rights of Persons with Disabilities (CRPD) specifies clear rights in relation to sexual and reproductive health. These include that persons with disabilities enjoy legal capacity on an equal basis with others, that they have the rights to marry, create a family and retain their fertility, and that they have a right to access SRH care. The CRPD also acknowledges that women and girls with disabilities are at greater risk of violence, abuse, neglect, maltreatment or exploitation, regardless of where they reside.

The *World Report on Disability* (2011) highlights that little information is available in relation to the SRH needs of persons with disabilities. Yet the evidence that is available indicates that persons with disabilities have “significant unmet needs” and experience discrimination in relation to their SRH and rights.

Studies show that the ability of persons with disabilities to enjoy safe and healthy sexual and reproductive lives is negatively influenced by prejudices, such as that people with disabilities are asexual and therefore not sexually active, or are unable to manage their own sexuality and fertility. A study by McKinistry et al. highlighted that “the traditional view in the Pacific is that persons with disabilities are to be looked after or cared for, and cannot be expected to take a full

and active part in village community life, thus marginalising them from mainstream life”. These sorts of prejudices (even if well-meaning) have far-reaching impacts for people with disabilities and contribute to the fact that:

- young people and adults with a disability are often excluded from sexuality and relationships education;
- health professionals are less likely to ask women with disabilities about contraception or to offer SRH services to people with disabilities;
- women with disabilities are less likely to get married than women without a disability;
- women with disabilities are less likely to receive information about SRH;
- women who acquire a disability at some time during their life are at a higher risk of divorce or separation.

It is not prejudice alone that erects barriers to people with disabilities accessing SRH care. “An Australian study on women with mental health conditions and physical, sensory, and intellectual impairment found that self-perceptions regarding sexuality, painful past experiences associated with reproductive screening, and memories of themselves before disability were all barriers to seeking health care”².

Evidence also indicates that persons with disabilities endure a higher risk of violence and abuse. This is for a variety of reasons, including situations whereby a person depends on a number of caregivers, social exclusion and the challenges people with particular impairments have in communicating with others. Persons with disabilities are more likely to experience sexual violence. This is particularly so for persons with an intellectual disability living in an institution, intimate partners and young people.

Women with disabilities living in residential institutions have particular SRH needs. They may reside in an institution due to high support needs the family or community find challenging to meet, or due to homelessness as a result of stigma. Women with disabilities may form consensual relationships with others within institutions; however, where institutions lack well trained staff, women with disabilities are at risk of judgement regarding their relationships, poor sexual health, engagement in risky behaviours or, sometimes, sexual abuse.

The *World Report on Disability* (2011) reports many cases of involuntary sterilization, predominantly of women, even when prohibited by the law. This is done to control the fertility of women, especially women with an intellectual disability. Involuntary sterilization is also unnecessarily used as a method for managing menstruation.

Sexual and reproductive health problems are not only a result of the discriminations experienced by people with disabilities and the health challenges their particular disability presents for each individual, but they can also be a cause of disability. Being HIV positive or having another sexually transmitted infection (STI) can contribute to disability. Poor health during pregnancy, such as having an STI or malaria, can cause disability in the newborn child. Maternal injury can also cause disability. For every woman who dies due to complications in pregnancy and childbirth, 20-30 experience short- or long-term illness or disability. Violence against women is also a significant cause of preventable disability.

There is a great deal to be done in order to remove societal barriers that prevent women with disabilities from enjoying a safe and healthy sexual and reproductive life. In 1994, governments recognized this when they agreed in the International Conference on Population and Development, Plan of Action (ICPD PoA) that they should:

- consider the needs of persons with disabilities in terms of ethical and human rights dimensions;
- recognize needs concerning, inter alia, reproductive health, including family planning and sexual health, HIV/AIDS, information, education and communication;
- eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights, household and family formation, and international migration, while taking into account health and other considerations relevant under national immigration regulations;
- develop the infrastructure to address the needs of persons with disabilities, in particular with regard to their education, training and rehabilitation;
- promote mechanisms ensuring the realization of the rights of persons with disabilities and reinforce their capabilities of integration; and implement and promote a system of follow-up of social and economic integration of persons with disabilities.

Yet, as these situation analyses show, much remains to be done.

While each country has a unique socio-economic, political and geographical context, similarities across all three countries emerged from these situation analyses.

- Women with disabilities make significant contributions to their communities. However while they have similar talents, skills and experience as other women, they may be more often under-recognized and have fewer opportunities.
- Each country has a committed and active disabled persons

organization: Te Toa Mataoa (TTM) in Kiribati, People with Disabilities Solomon Islands (PWDSI) and Naunau O'E' Alamaite Tonga Association (NATA).

- In the area of SRH, the Family Health Associations, Tonga Family Health Association (TFHA), Kiribati Family Health Association (KFHA) and Solomon Islands Planned Parenthood Association (SIPPA) are all local organizations that are in a good position to increase their focus on disability and sexuality.
- TFHA's popular past workshops on sexuality and disability were the only activity implemented in any of the three countries that specifically addressed issues of SRH for women with disabilities. People would like to see these workshops revived.
- Staff at the Red Cross schools in Solomon Islands and Tonga, San Isidro Rural Training Centre and Bethesda in Solomon Islands, the School for People with Disabilities in Kiribati and the Mango Centre in Tonga are great sources of expertise and experience which can contribute to efforts to improve the SRH of women with disabilities.
- At the level of government services, the community-based rehabilitation (CBR) programme in Solomon Islands is a solid Ministry of Health and Medical Services (MHMS) programme, spread throughout the country. This programme provides excellent opportunities to train staff to assist women with their SRH needs. The Tungaru Centre in Kiribati offers a quality service within its resource constraints and is a solid foundation from which to expand CBR services.
- In relation to national legislation and policy, Kiribati has a draft National Disability Policyⁱ and a strong policy addressing violence against women. Solomon Islands has a National Disability Policy, a draft Bill for the Rights of Persons with Disabilities and a solid policy addressing violence against women. Tonga has a robust reproductive health policy and a quality inclusive education policy, to which SRHR issues could be incorporated into implementation.
- At the regional level, there are robust organizations working in the area of disability and/or SRH that support governments and organizations at the country level. These include the Pacific Disability Forum (PDF), the Pacific Island Forum Secretariat (PIFS), the International Planned Parenthood Federation (IPPF) and the Regional Rights Resource Team (RRRT).
- The regional framework, "Biwako Plus Five: Further Efforts Towards an Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific" (2007) builds on the original Biwako Millennium Framework of 2002, providing a set of priority actions focussed specifically on women with disabilities. The Incheon Declaration to "Make the Right Real for Persons with Disabilities in Asia and the Pacific 2013 to 2022" specifically discusses SRH issues.

ⁱThis Policy remained a draft at the time of final editing, in September 2012, but there were concrete plans in place to get the government to adopt the Policy before the end of 2012.

- Solomon Islands and Tonga are both signatories to the CRPD.
- Family is central to the lives of the woman with a disability who were interviewed, providing the vast majority of support and assistance. Where families were less supportive or caring, women experienced significant hardship. Families require training, support and assistance.
- Community attitudes, in general, conform with stereotypical and prejudiced perspectives on people with disabilities. The women interviewed tended to feel that their closest community accepted them but often felt that the wider community ridiculed them, leading to feelings of shame and fear.
- The women with disabilities who were interviewed experienced a range of intimate relationships throughout their lives. Many were married and had children. Most enjoyed consensual sexual relations.
- The women interviewed did not have a good understanding of their full SRH, and need more education and easy access to services.
- The women interviewed tended to interact with health services most regularly when they were pregnant. Otherwise, there is a need for more engagement with health services, particularly for breast checks, cervical smears and testing for sexually transmitted infections. The quality of health services needs improvement.
- Health professionals and other social service staff require capacity building to enhance their skills and confidence in working with women with disabilities.
- Appropriate and accessible information, education and communication resources are required to meet the information needs of women with vision, hearing and/or intellectual impairments.
- Some of the women interviewed experienced violence, both physical and sexual. There are indications that women with disabilities may experience sexual violence perpetrated by acquaintances or strangers at a higher rate than other women.
- Several women interviewed became pregnant as a result of rape. They may have benefitted from the availability of the emergency contraceptive pill and access to safe abortion. Where the emergency contraceptive pill was available, women would have benefitted from knowing about it and being able to access it.
- Women with disabilities living in institutions have particular needs that do not appear to be adequately addressed. These women are at risk of abuse.
- Women with a mental illness or intellectual disability sometimes experience particularly severe discriminations, including multiple rapes, involuntary sterilization and the imposition of contraceptive use despite their inability to give informed consent.

The taboos and sometimes restrictive norms surrounding SRH intersect with the taboos and beliefs surrounding disabilities to create a heavy burden of discrimination for women to carry. This situation interacts with other identities that women with disabilities have, such as their age. Changes in social norms and attitudes can contribute to improvement in the SRH status of women with disabilities. This will take time, commitment and small steps, but with the significant strengths of individuals and organizations in these three countries, supported by regional stakeholders and donors, change can occur.

Three key sets of recommendations have been made: regional recommendations, recommendations for all three countries and specific country recommendations. These recommendations include to:

- do “nothing about us without us”, making sure that women with disabilities are included in action taken, right from the beginning;
- act as a regional advocate for the sexual and reproductive needs of women with disabilities;
- strengthen prevention and protection mechanisms to end violations of human rights and the denial of dignity that women with disabilities face;
- implement capacity building activities for social (particularly health) and justice sector professionals;
- design and implement a pilot programme of community liaison/advocates (CLAs) for women with disabilities;
- support and encourage regional organizations, governments and donors to take action on the findings of these situation analyses, including through legislative and policy discussions, reform and implementation.

A unique opportunity exists to take action on the information contained in these situation analyses. This action has the potential to shatter the pervasive silence surrounding the SRH experiences and needs of women with disabilities and build a global community where every voice is heard.

BACKGROUND

ⁱⁱ Throughout this document, when referring to women, the reader should also assume this word encompasses girls.

Globally, gradually, the status of womenⁱⁱ is improving. However, there is a long road to travel before all women, everywhere, are able to enjoy all their rights as equal human beings. Related to the low status of women in many countries, issues of SRH and rights tend to be neglected throughout the world. This neglect is particularly so in countries where there are socially conservative or fundamentalist cultures and religions, further compounding women's discrimination. This situation is a daily lived reality for many women across the Pacific.

In line with the situation of women in general and with globally prevalent negative attitudes about people with disabilities, women with disabilities are among the most "invisible" and discriminated people in the world. Women living with a disability endure a multitude of challenges in their lives. Most often these challenges emerge not from a woman's disability but from the environment within which she lives. A lack of understanding, fear, discrimination and stigma, or plain neglect and violence, mean that women with disabilities can carry multiple discriminatory burdens. The fact that women with disabilities still manage to contribute to society in a variety of ways is a testament to their talents, strength and fortitude.

About This Report

This report explores the SRH and rights experiences of women with disabilities in three countries: Kiribati, Solomon Islands and Tonga. This exploration involved using all available information sources to collate as much information as possible in an area where information is scarce. A general literature review set the scene for what is known globally about the SRH needs of women with disabilities, and violence against women with disabilities. The bulk of the work involved a review of country-based literature, interviews with women with disabilities and interviews with key stakeholders. This report is the summary of this work.

UNFPA

UNFPA works to promote and protect the SRH and rights of people everywhere. This has led UNFPA to explore how it can contribute to creating a world where all people with disabilities can enjoy their SRH and rights. In 2009, the World Health Organization (WHO) with UNFPA wrote a Guidance Note on “Promoting Sexual and Reproductive Health for Persons with Disabilities”. This Note recommended five key actions:

1. Establish partnerships with organizations of persons with disabilities.
2. Raise awareness and increase accessibility in-house.
3. Ensure that all SRH programmes reach and serve persons with disabilities.
4. Address disability in national SRH policy, laws and budgets. UNFPA, WHO and other reproductive health partner organizations’ staff should work with organizations of persons with disabilities to make sure that all legislation and regulations affecting SRH reflect the needs of persons with disabilities.
5. Promote research on the SRH of persons with disabilities.³

These situation analyses are part of the UNFPA Office of the Pacific’s contribution to fulfilling these recommendations. The aim of these situation analyses was to obtain a greater understanding of the situation for women with disabilities and their SRH and rights in the three particular countries. UNFPA will use the information emerging from the situation analyses, as well as ongoing programmes on violence against women, to work alongside other Pacific people in promoting and protecting the rights of women with disabilities.

Structure of This Report

This Report is divided into four sections.

- **An Overview.** This section sets the scene for the situation analyses and draws common conclusions from the three country situation analyses. Pertinent information in the separate areas of SRH and rights, and of disability, is summarized. Following this, the intersecting area of disability and SRH is outlined. Then the situation analyses approach is described. An analysis of regional frameworks follows this, as well as prominent regional stakeholders working in the area of disability and/or SRH. Next, common conclusions from the situation analyses are articulated. Recommendations conclude this section. These recommendations should be read with the short list of recommendations at the end of each of the next three sections of the report.

- **Kiribati, Solomon Islands, Tonga.** The next three sections of the report are devoted to each of the situation analyses in the three countries. These provide information about the country in general and people with disabilities in the country. Then the legal, policy and service provision context are analysed from the perspective of the SRH needs of women with disabilities. The experiences of women with disabilities are described, with use of country literature, and some analysis, before concluding thoughts lead into final recommendations. These recommendations complement the “Recommendations for all Three Countries” found in “An Overview” and should be read in conjunction with these.

AN OVERVIEW

Introduction

Both SRH and disability are areas that sit at the very core of what it means to be human. The significant human needs and fundamental human rights in these areas force us to question beliefs and norms that structure our societies. This contributes to the sensitivity and sometimes fear associated with talking about these issues. Changing beliefs and norms that discriminate against members of the human family takes long-term commitment and involves small steps. The first place to begin is to seek more information and start conversations. These situation analyses contribute to beginning that conversation.

It is important to ground the country situation analyses in the broader context of the two key sectoral areas of SRH and rights, and disability. Both of these “technical” areas of work are about human existence. Although we separate them out into different categories, we are talking about whole human beings, and their individual and collective experiences.

Sexual and Reproductive Health and Rights

Sexual and reproductive health and rights encompass several inter-related issues. These issues include:

- knowing about how our body works and understanding the way we feel, particularly in relation to our sexual feelings;
- understanding about healthy relationships and how we can communicate effectively with other people;
- being able to enjoy healthy sexual relationships;
- being able to express ourselves free from discrimination and in a way that respects the rights of others;
- the ability to plan when and how often we get pregnant and have children;
- getting good quality information and services for contraception and family planning, sexually transmitted infections (including HIV), pregnancy and parenting, antenatal and postnatal care, and skilled assistance during childbirth;
- being able to live free from violence and getting help to deal with violence when it happens to us.

Violence against Women

Reproductive rights are well articulated in international human rights law and policy. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, defines the right of women to be free from discrimination and sets the core principles to protect this right. It establishes an agenda for national action to end discrimination and provides the basis for achieving equality between men and women through ensuring women's equal access to, and equal opportunities in, political and public life as well as education, health and employment.

The CEDAW is the convention that provides the greatest protection for the range of women's SRH and rights. The CEDAW includes provisions that require States to ensure that women and men can equally access health services and education, including for family planning. It also provides for protection from discrimination due to pregnancy, including the provision of maternity leave and benefits, and protection from discrimination within the family and based on marital status. The CEDAW Committee has made recommendations to State parties on the basic right for women and adolescents to have access to safe and affordable SRH services, education and information; the issue of restrictive abortion laws and their contribution to the deaths of women; instructing State parties to enact and enforce legislation criminalizing violence against women; and to take measures to change social norms that perpetuate harmful and discriminatory traditional practices.⁴

The ICPD Plan of Action (1994) articulated that reproductive rights “rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of SRH. [This] also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, [couples and individuals] should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning”.⁵

Many reproductive rights are also sexual rights. However, due to the contention regarding the meaning of sexual rights, there is no explicit international agreement about what defines sexual rights. The Beijing Platform for Action is the only international human rights document

that offers what is widely regarded as a definition of sexual rights where it states that “the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence”.

The International Planned Parenthood Declaration of Sexual Rights articulates a set of specific sexual rights (many of which are already found in agreed international human rights law) based on the concept of non-discrimination, including on the basis of disability. These sexual rights are:

- the right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender;
- the right to participation for all persons, regardless of sex, sexuality or gender;
- the rights to life, liberty, security of the person and bodily integrity;
- the right to privacy;
- the right to personal autonomy and recognition before the law;
- the right to freedom of thought, opinion and expression; right to association;
- the right to health and to the benefits of scientific progress;
- the right to education and information;
- the right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children;
- the right to accountability and redress.⁶

Sexual and Reproductive Health

The landmark 1994 International Conference on Population and Development (ICPD) Programme of Action (PoA) defined reproductive health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes... It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases”.⁷

Each individual’s enjoyment of SRH, and their ability to realize their rights, is dependent on a wide range of factors. The socioeconomic determinants of health have a large impact on individual’s SRH and rights. These determinants include factors such as social inclusion, age, education, income, housing and gender. General health status also interplays with SRH and rights: poor mental or physical health can be

a cause and an effect of poor SRH. A woman's experience of violence has a significant impact on her SRH and rights, and can also cause disabilities. Every individual's needs change across their lifespan also, as people mature and experience different events at different stages of life.

Factors such as education and increased income play an important role in contributing to the improved SRH of women, including contraceptive use. There are intergenerational benefits, also, because children, particularly daughters, of women who are able to realize their sexual and reproductive rights are more likely to be healthier and to go to school. For young people, a good education, including comprehensive sex education, can delay their onset of sexual activity, reduce the number of sexual partners they choose to have and increase condom or contraceptive use.⁸

Women who are healthy in general and who practice health-conducive activities are more likely to enjoy good SRH. Good nutrition and healthy behaviours are vitally important to a woman who is trying to get pregnant, or who is already pregnant, as well as to her growing fetus during the pregnancy. Good nutrition will assist in preventing potential problems and reduce risks associated with pregnancy and birth for both the woman and her fetus. Activities such as smoking and drinking alcohol, particularly in large amounts, will reduce women's immunity to infections and disease, and if undertaken while pregnant can have an adverse impact on the developing fetus and future child. The consumption of alcohol in large amounts, particularly binge drinking, is a risk factor for unsafe sex. The national violence against women prevalence studies carried out in Tonga, Solomon Islands and Kiribati, clearly document the health consequences of intimate partner violence.

Access to safe water and sanitation facilities is a significant need for women, particularly when they are menstruating. This can become more significant for women with disabilities, particularly if they are incontinent of urine or faeces, or have to cover long distances to get to a toilet area.

The extent to which a woman is accepted by and included in family and community life is central to her sense of well-being. Social inclusion is important in building a sense of worth and self-confidence, which has significant consequences for being able to negotiate sexual relations and enter into healthy intimate relationships.

Multiple factors support and impinge on women's SRH and rights. In most societies, including in the Pacific, discussion of sexuality and sexual relations is often viewed as taboo, and people can find it difficult to seek out information and services for SRH problems. Fear of

judgement and ridicule, or of punishment and isolation, all play a role in hindering the realization of sexual and reproductive rights for all. For women with disabilities this situation is deepened by the fear and shame that can surround their disability, manifested by the prejudices and false assumptions other people make about the needs, wants and capabilities of women with disabilities.

Disability

It is estimated that 15 per cent of the global population have a disability⁹, “ranging from 11.8 per cent in higher income countries to 18 per cent in lower income countries”,¹⁰ based on World Health Survey data. Using data from both the World Health Survey and the Global Burden of Disease study, it is estimated that in 2010 “there were around 785 (15.6%) to 975 (19.4%) million persons 15 years and older living with disability”¹¹. Of these, somewhere between 2.2 and 3.8 per cent of the population have a severe or significant disability.¹² Women, the poor and older people all have a higher prevalence of disability than other population groups, and these rates are higher in developing countries. Many surveys and studies, including those in Kiribati, Solomon Islands and Tonga, find much lower prevalence rates of people with disabilities. This is due to the use of narrow definitions of disability, combined with the stigma attached with disability that inhibits peoples’ willingness to come forward.¹³

The concept of disability is an evolving one. The *World Report on Disabilities* (2011) uses the International Classification of Functioning, Disability and Health (ICF) to provide a standardized conceptual framework within which to discuss disability issues. “The ICF is a classification of health and health related domains that describe: body functions and structures, activities and participation, and environmental factors”¹⁴. The ICF dynamically combines medical and social approaches to functioning and disability to create a holistic lens through which to analyse disability issues. From this, the term “disability” is used as an “umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)”¹⁵.

The Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol (OP) have contributed to much greater attention being paid to the important and significant issues of women with disabilities. The CRPD and its Optional Protocol were adopted on 13 December 2006 and entered into force in May 2008. Solomon Islands signed the CRPD in September 2008 and the Optional Protocol in September 2009. Tonga

signed the CRPD in November 2007. Kiribati has not yet signed, and none of the three countries have yet ratified the CRPD.

The CRPD and OP mark a paradigm shift regarding attitudes and approaches to persons with disabilities — moving from perceptions that persons with disabilities are in need of charity, medical treatment and social protection towards seeing them as persons with rights like any other person. The CRPD has specific provisions related to access of persons with disabilities to SRH information and services. It recognizes the heightened risk that women and girls with disabilities face of exploitation, violence and abuse.

The CRPD and its OP adopt a broad categorization of persons with disabilities and reaffirm that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. The CRPD and OP clarify and qualify how all categories of rights apply to persons with disabilities, and identify areas where adaptations have to be made for persons with disabilities to effectively exercise their rights. In terms of rights violations, the CRPD states that the protection of rights must be reinforced and redress made available.

The CRPD recognizes in its preamble “that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others”. In Article One, the CRPD offers a description of what the term “disability” encompasses and this is increasingly used as a definition: “[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”¹⁶.

Persons with disabilities are some of the poorest and most socially excluded people in their countries. Along with their families, they face multiple discriminations, and subsequently have limited access to social services and employment opportunities,¹⁷ as well as constrained opportunities to contribute to social, economic and political life. In relation to support and care, as the *World Report on Disabilities* points out, often it is the family that provides the greatest support and assistance to persons with disabilities.

Persons with disabilities are not a homogenous group and societies’ perspectives of their disability, alongside their other “identities”, impact their ability to enjoy their full rights. As the *World Report on Disabilities* (2011) states: “[p]ersons with disabilities have diverse personal factors with differences in gender, age, socioeconomic status, sexuality, ethnicity, or cultural heritage”¹⁹.

Stubbs and Tawake (2009) articulate in their *Pacific Sisters with Disabilities* report that women with disabilities can experience multiple discriminations due to their different characteristics.²⁰ Three examples of this multiplicity are outlined below.

- Young people tend to experience barriers to SRH that stem from societal ideas that it is not acceptable for young people to engage in sexual relationships. The *State of Pacific Youth Report*²¹ describes how young people with disabilities are all but invisible in Pacific societies.
- Global research emphasises the double burden of discrimination that women with disabilities face due to their gender and their disability, which heightens their risk of experiencing abuse and violence.²²
- Most societies have strict norms related to sexual orientation (intolerance of non-heteronormative sexual orientations), the number of sexual partners an individual should have (often men are “allowed” more partners than women), sexual relations outside of marriage (not acceptable) and what it means about your conformity with these norms if you contract an STI. When these “rules” of sexual behaviour combine with the discriminatory attitudes towards people with disabilities, extraordinary barriers are erected for people with disabilities. As one study outlined, there remains deep-seated stigma and shame connected to both sexuality and disability.²³

Disability and gender can intersect to create double discrimination. The CRPD recognizes that women with disabilities experience multiple discriminations.²⁴ When other identity factors such as age and sexuality are added to the mix, a woman can experience deep discrimination which inhibits her ability to participate fully in the activities she chooses.²⁵

SITUATION ANALYSES APPROACH

Purpose

In each country, the purpose of the situation analysis was to assess the SRH situation and needs of women and girls with disabilities, including their vulnerability to violence, particularly sexual violence; identify critical issues and concerns which need to be addressed; and identify and document examples of good practice. Acknowledging a lack of published evidence, a visit to each country was incorporated to provide small-scale opportunities to talk with women with disabilities and civil society and government actors working on these issues.

Rather than gathering representative data, the intent of the situation analyses was to gain some basic understandings of the situation of women with disabilities and from this to draw out areas for further attention.

Approach

The three situation analyses were carried out between October 2010 and October 2011. A desk review considered published and grey literature. During country visits to Kiribati, Solomon Islands and Tonga the author worked with both the Ministry of Health and the local disabled persons organization (DPO). In Solomon Islands and Kiribati the interviews with women aged 15 years and over were the dominant form of collecting information. In Tonga the focus was on stakeholder and key informant interviews. Where obtainable, legislation, policies and services were explored through stakeholder interviews and desk-based analysis.

A generic question guide was developed for interviews with women, which covered several areas, as listed below. This question guide was modified between Solomon Islands and Kiribati, and it was translated into I-Kiribati. It was not used in Tonga because of translation issues and the inaccessibility of appropriate interview spaces. The key areas that the question guide explored were:

- age, place of residence, religion, education, water and sanitation;
- disability, care and support, including community attitudes and engagement;
- relationship status and sexual activity;
- use and knowledge of family planning and contraception;
- experiences during pregnancy, childbirth and parenting;

- knowledge of STIs and treatment-seeking behaviour;
- self-care behaviour in relation to breast cancer and cervical cancer;
- experiences of violence;
- experiences of health services and suggestions for improved health services.

Interviews with Women

Women and girls were identified for interview by working with the local DPO and MHMS. This meant that the women interviewed were known to an established organization. This proved to be an appropriate approach given the time and resource constraints.

When women were interviewed, each woman was interviewed separately and her full informed consent was obtained. Informed consent was obtained by: explaining the reason for the situation analysis and how the information would be used; outlining the types of questions in the interview, highlighting to the women that some questions were quite personal; assuring women of the confidentiality of their name and any details that would lead to their identification; and informing women that they could choose not to take part or answer any question, or stop the interview at any time. Following this explanation, women were invited to ask questions. Subsequent to this, their permission to carry out the interview was sought. Twice throughout the interview the woman's ability to choose not to answer or to stop the interview was re-emphasized, prior to questions on sexual activity and to questions on violence.

Women were predominantly interviewed alone, with the author and one other person from an established local organization. The author worked alongside the CBR team of the MHMS in Solomon Islands. In Kiribati and Tonga a volunteer from the local DPO — NATA or Te Toa Matoi — worked with the author. These individuals assisted in carrying out interviews with women, including translation. In some cases these individuals had an established professional relationship with the interviewee, contributing to the development of rapport for the interview. In some cases in Solomon Islands, a sign language or communication assistant assisted with the interviews. All interviewers signed confidentiality forms.

Compared to disability prevalence data, only a small number of interviews were carried out and selection was not randomized. Thus the findings of this situation analysis cannot be viewed as representative of all women with disabilities in the three countries.

Use of Quotes and Names

To bring the summarized information to life, stories and quotes from women have been included in the findings. Due to the challenges of translation, transcription and note taking, the quotes in the text are not always exact quotes as spoken by the respondents. However, the words capture the essence of what was conveyed, and are true to the information that was captured during the interviews. They have been written in quote form to differentiate them from the general text so as to highlight the voices of the women interviewed.

All names have been changed to ensure that specific individuals cannot be identified and any specific details that could only be attributed to one individual have not been included.

Challenges and Limitations

Ethics

While these situation analyses are not technically research studies, the fact that women with disabilities were being interviewed would have made it preferable to engage in an ethics approval process for the situation analyses in each country. Unfortunately, time and resource constraints did not allow this. To mitigate this, the author and colleagues in each country discussed ethical issues and did their best to balance the desire to give women with diverse disabilities the rare opportunity to share their thoughts and experiences, as well as ensuring that they could do this safely.

Selection Bias

The women interviewed for these situation analyses were known to established organizations and were generally easily accessible. Thus they are likely to experience greater access to information and services than those who are not known to organizations and who are more geographically or physically isolated.

Communication

Communication was a challenge, particularly when the team did not have access to the particular resources necessary to support communication (such as a sign interpreter). This was particularly pronounced when interviewing women with speech or hearing impairments, or a significant intellectual or mental health impairment. In Solomon Islands sign language teachers were available and assisted with some of the interviews. This was not possible elsewhere. In both Solomon Islands and Kiribati, in three or four cases, family members were interviewed rather than the woman herself due to the significant intellectual impairments of the women involved.

The questions were translated into I-Kiribati prior to interview but this did not occur in Solomon Islands or Tonga. Building time into the situation analyses to work in country with local people to devise the questions and discuss issues of translation prior to beginning the Situational Analyses would have been useful. Similarly, involving a person who knew sign language at the conception stages of the Situational Analysis design would have helped work through some of the potential challenges.

Triangulation

The opportunity to look at other sources of information, such as patient records, would have been useful to enable some cross-verification and clarification of what women were saying. For example, gaining clarification on how many antenatal visits women made during pregnancy and when these occurred. More interviews with reproductive health nurses could also have added a richness to the data.

REGIONAL FRAMEWORKS ON DISABILITY ISSUES IN THE PACIFIC

Biwako Millennium Framework for Action and Biwako Plus Five

In 2002, Asia and Pacific governments adopted a set of guidelines and actions to support disability-inclusive policy implementation entitled the “Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights-based Society for Persons with Disabilities in Asia and the Pacific (BMF), 2002-2012”. The BMF explicitly recognizes women with disabilities in Article 21 (section B) where it highlights the discrimination women and girls face “as they are exposed to greater risk of physical and sexual abuse, denial of their reproductive rights, and reduced opportunity to enter marriage and family life”²⁶. However, there are no explicit action areas in the BMF that specifically focus action on addressing women with disabilities’ extra discriminatory burdens, including for SRH.

In 2007 “Biwako Plus Five: Further Efforts Towards an Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific” was adopted at the high-level intergovernmental meeting where a midpoint review was undertaken for the Asian and Pacific Decade of Disabled Persons (2003-2012).²⁷ The BMF Plus Five outlines specific priority actions to be taken for women with disabilities and makes a marked improvement on the 2002 BMF. These actions include the mainstreaming of a gender approach in all policies, programmes, plans and laws, and the inclusion and participation of women with disabilities and organizations of women with disabilities in the development of these documents. Further, governments are advised to recognize that women and girls with disabilities are subject to multiple discrimination and therefore governments must support the empowerment of women with disabilities in all spheres. Governments are also advised to take action to address discrimination against women with disabilities, including in relation to marriage, family, parenthood and relationships.

Incheon Strategy to Make the Right Real for Persons with Disabilities in Asia and the Pacific

The Incheon Strategy was launched in 2012 at the Economic and Social Commission for Asia and the Pacific (ESCAP). The Incheon Strategy builds on the BMF and the CRPD, through focusing action on a set of priority goals and targets from 2013 to 2022.

The Incheon Strategy ²⁸ makes a robust contribution to improving the regional policy framework regarding the SRH of women with disabilities. It has specific targets on reproductive health and violence against women.

These are:

- Target 6.C: Ensure that all girls and women with disabilities have access to sexual and reproductive health services on an equitable basis with girls and women without disabilities. Target 6.D: Increase measures to protect girls and women with disabilities from all forms of violence and abuse. Pacific Regional Strategy on Disability

Pacific Island leaders adopted the *Pacific Regional Strategy on Disability 2010-2015* (PRSD) in 2009. The PRSD recognizes women's extra discriminatory burdens. The PRSD specifically mentions the need for including disability issues in all programmes "on gender, youth and other disadvantaged and vulnerable groups" and to "address the specific needs of youth, women, girls and children with disabilities"²⁹. This is under the thematic area "Enhancing the Central Role of Persons with Disabilities". However, under the thematic area "Strengthen Political Leadership and an Enabling Environment", there is no mention of women or of working with government agencies responsible for promoting and protecting the rights of women. In a region such as the Pacific, which has the second-lowest representation of women in parliament in any region of the world,³⁰ strengthening political leadership is absolutely crucial for women with disabilities. Action also needs to occur in the law and justice sector to build stronger legislative environment for women with disabilities, including methods for redress for the discriminations faced by women with disabilities. Yet there is no mention of these sorts of activities.

The PRSD does not discuss improving health information and services for women with disabilities (or people with disabilities in general). Finally, under "Strengthen Partnerships: Coordination and Collaboration", for the action area of "Preventing Avoidable Disability", malaria, violence against women and maternal injury are not highlighted as causes of disability. These three factors make a significant contribution to disability and it is vital that they are recognized as areas where more preventative action needs to be taken.

REGIONAL ENTITIES WORKING ON DISABILITY AND/OR SEXUAL AND REPRODUCTIVE HEALTH ISSUES IN THE PACIFIC

The original intent of these situation analyses was not to undertake a regional stakeholder analysis. These situation analyses were originally three discrete country reports. However, as the work evolved, the three reports were amalgamated into this single document. Comments from reviewers highlighted the need to recognize the work of key stakeholders at the regional level. Doing this in the absence of a regional stakeholder analysis may mean that some regional entities working in disability and/or SRH are omitted. If this is the case, we apologise for this omission. The entities included below have been included because they are clearly the dominant Pacific entities working regionally in this subject area.

International Planned Parenthood Federation's Sub-Regional Office of the Pacific (IPPF SROP)

The International Planned Parenthood Federation (IPPF) was formed in 1952 and is a global service provider and advocate of SRH and rights for all, working in over 172 countries throughout the world. IPPF is divided into six regions and the Sub-Regional Office of the Pacific (SROP) is part of the East, Southeast Asia and Oceania region (ESEAOR).

The IPPF SROP is the only regional NGO entity that works solely in the area of SRH advocacy and services (including information). SROP supports the nine Pacific organizations that are IPPF members in the Cook Islands, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. Australia and New Zealand also have organizations that belong to IPPF (Family Planning in New Zealand, and Sexual Health and Family Planning Australia). These SRH organizations work in the areas of advocacy, access to information and services, adolescents, safe and legal abortion, and HIV and AIDS. All IPPF member organizations serve their communities and function with the assistance of volunteers, and take rights-based, non-discriminatory approaches to their work. SROP and the other regional offices function to support and develop the capacity of the IPPF member organizations. Several of the national IPPF member associations have undertaken action on disability issues in the past, particularly the Tonga Family Health Association.

Pacific Disability Forum (PDF)

The Pacific Disability Forum (PDF) is the sole regional NGO entity that focuses in the area of disability. The PDF was established in 2002 and works towards inclusive, barrier-free, socially just and gender equitable societies that recognize the human rights, citizenship, contribution and potential of people with disabilities in Pacific Countries and territories. The PDF promotes and facilitates Pacific regional cooperation on disability-related concerns for the benefit of people with disabilities. PDF works with national-level partners and supports them both locally and regionally. PDF carries out advocacy and awareness raising — sharing resources, experiences and expertise, capacity building and training, especially of national DPOs, and promoting the equal participation of women.

The PDF has a strong commitment to women's rights, with a dedicated staff member working on women's rights issues, a specific strategy for women with disabilities and a women's committee. In April 2011, the PDF convened a "Pacific Regional Forum on Women with Disabilities", just prior to the two-yearly PDF "Pacific Regional Conference on Disability". At this regional forum, a call was made for:

- a representative from the PDF Women's Committee should participate on the Regional Working Group of UN Women;
- the linkages with the gender officers from the Pacific Island Forum Secretariat and the Secretariat of the Pacific Communities be strengthened;
- DPOs be supported to incorporate the CRPD, CEDAW, BMF, MDG and the Pacific Regional Strategy on Disability in strategic plans, programs, activities, funding proposals, and reporting;
- Pacific Governments that have not already done so, ratify CEDAW and CRPD and their respective Optional Protocols; and ensure that CRPD Article 6, *Women with disabilities* and CRPD Article 7, *Children with disabilities* and other CRPD Articles containing gender equity measures be given priority for implementation;
- Pacific Governments to ensure that their respective Ministries for disability, women's affairs and all other relevant portfolios need to include specific policies, programs and measures to address the rights of women and girls with disabilities;
- Pacific Governments adopt and implement the 28 recommendations directed at government that are contained within the UNDP report, *Pacific Sisters with Disabilities: at the Intersection of Discrimination*;
- DPOs are supported to act and report on implementation of the eight recommendations directed at DPOs contained in the *Pacific Sisters Report*.

Pacific Islands Forum Secretariat (PIFS)

The Pacific Islands Forum is a political grouping of 16 independent and self-governing states, and the Pacific Islands Forum Secretariat (PIFS) functions to action the decisions of the Pacific Island Forum leaders and ministers, and to coordinate the implementation of the Pacific Plan. The Pacific Islands Forum supports the development of disability as a regional policy issue, and the need to strengthen the capacity of governments and non-governmental organizations to integrate disability, as a rights-based issue, into development programmes. When Pacific Island leaders developed the Pacific Plan in 2005 disability progress and development were integrated into the plan, leading to the establishment of a disability coordination officer role at PIFS. The role of the disability desk includes managing a disability sub-working group within the health and population working group, which reports to the Council of Regional Organizations of the Pacific (CROP) agencies.

The PIFS disability coordination officer provides technical support and policy level guidance to governments in relation to the CRPD, such as ratifying the Convention and creating strategies for its full implementation. The disability desk also monitors the implementation of the PRSD, through bi-annual ministerial progress reports. PIFS has provided assistance to Kiribati, Solomon Islands and Tonga, among other countries, to develop national disability policies. PIFS also made a strong contribution to the development of the draft Incheon Strategy.

Pacific Island Forum leaders have also recognized sexual and gender-based violence as a human security issue, and have established a reference group to work to raise awareness of this issue and to maintain its prominence on regional and national political agendas. This reference group is made up of member countries and development partners.

Regional Rights Resource Team (RRRT)

The RRRT is a programme of the Secretariat of the Pacific Community (SPC) that provides human rights training, technical support and policy and advocacy services tailored specifically for the Pacific region. RRRT works with partners across the Pacific Island countries, including governments, and regional and civil society organizations. RRRT assists these partners with capacity building for human rights, including at the macro level with policy makers, parliamentarians, judges and magistrates; at the meso level with institutions like the police, social welfare workers and teachers; and at the micro community level with NGOs and communities.

RRRT has been active in the area of rights-based legislation reform relating to violence against women. In relation to the area of disability, RRRT supports disability organizations, as well as government agencies, through the provision of training and technical assistance to both lobby for, and comply with, the principles in the CRPD. RRRT provides assistance to DPOs on how to advocate for improved rights, including improved access to health care, employment and education. RRRT also provides training to government agencies on the rights contained in the CRPD, and how to plan to ensure that these rights are fulfilled. RRRT can provide assistance in ensuring that disability rights are mainstreamed into policies and legislation. Specific project areas where RRRT works to ensure that disability rights are mainstreamed include work on legislation to address violence against women and children, and legislative lobbying and advocacy skills training.

COMMON FINDINGS

Several similarities emerged across the three-country situation analyses, despite each country's unique socioeconomic, political and cultural context. In general these similarities included that women with disabilities:

- Make significant contributions to their communities, and have talents, skills and experience that are underutilized.
- Bear the burden of multiple discriminations and taboos. The societal rules surrounding contraceptive use, sexuality, youth sexual behavior and often-strict gender norms, discriminate against people who do not conform to these rules. This includes women with disabilities. On top of this, women with disabilities also experience the stigma and discrimination associated with their disability. This interacts with their other identities, compounding and deepening discrimination.
- Live in societies that are not equipped to support people with disabilities to contribute their skills and talents, particularly women with mental illness or an intellectual impairment.
- Engage in intimate relationships, are sexually active, enjoy consensual sexual relations and are parents, but have neglected SRH needs.
- Rely on their family for the majority of support and assistance.
- May be at risk of violence, particularly sexual violence, often perpetrated by an acquaintance or stranger.
- Are more likely to undergo involuntary contraceptive use and sterilization.

Common Strengths

Skills and Talents of Women with Disabilities

Women with disabilities have a range of knowledge, skills and talents, many of which are underutilized. Some of the women interviewed were employed at some time in their life, produced goods for sale or were engaged in volunteer work. The government, civil society and private sector could benefit much more from the knowledge, skills and talents of women with disabilities.

Disabled Persons Organizations

The DPOs in each country are working hard to promote and protect the rights of people with disabilities, and their skills, talents and commitment are a great strength to build on. It is crucial that these organizations be involved in any work to improve the SRH of women with disabilities. In particular, the women who worked with the

author for these situation analyses were driven to help all women with disabilities. Their experience and understanding will be central to the success of some of the recommendations of this report, as will the active involvement of the DPO to which they belonged.

Non-governmental Organizations

In the area of SRH, the family health associations, TFHA, KFHA and SIPPA, are all local organizations that are in a good position to increase their focus on disability and sexuality. In terms of activities that address women with disabilities' SRH and rights, TFHA's workshop on sexuality and disability was the only activity implemented in any of the three countries that specifically addressed issues of SRH for women with disabilities. TFHA's workshop was popular at the time and there is a desire to revive these. There is the potential to implement similar activities in all three countries.

Staff at the Red Cross schools in Solomon Islands and Tonga, San Isidro Rural Training Centre and Bethesda in Solomon Islands, the School for People with Disabilities in Kiribati and the Mango Centre in Tonga are a great source of expertise and experience who can contribute to efforts to improve the SRH of women with disabilities. In relation to the use of sign language, Solomon Islands has a strong pool of individuals who work with people with speech and hearing impairments. This group of people could be brought together to develop IEC/BCC materials for people with speech and hearing impairments, which could then be piloted elsewhere in the Pacific.

Government Legislation, Policy and Services

The CBR programme in Solomon Islands is a solid MHMS programme, spread throughout the country. This programme provides excellent opportunities to train staff in the area of SRH, so that they can have conversations with people with disabilities, provide basic advice and make referrals where necessary. As the Ministries of Health and Medical Services in Kiribati and Tonga begin to improve their rehabilitation services, and as Tonga develops a disability strategy, opportunities to learn from Solomon Islands experience would be of benefit. The Tungaru Centre in Kiribati offers a quality service within its resource constraints and is a solid foundation from which to expand CBR services.

In terms of national legislation and policy, at the time of writing (late 2011) Kiribati has the draft National Disability Policy and a solid policy addressing violence against women. Solomon Islands has a National Disability Policy, a draft Bill for the Rights of Persons with Disabilities and a strong policy addressing violence against women. Tonga has a robust reproductive health policy and a quality inclusive education policy that can form the basis for a national disability policy. These all provide opportunities for greater action on the SRH of women with disabilities.

Common Areas to Address

Regional Strategies and National Legislation, Policies and Services

Greater attention must be paid to women with disabilities in regional and national legislation, policies and services, including their SRH needs. With the exception of the BMF Plus Five, Incheon Draft Strategy and the draft Kiribati National Disability Policy, regional and national policies and strategies showed a lack of priority placed on action to improve the situation of women with disabilities, let alone their SRH needs. The CRPD can be utilized to underpin efforts in this area.

Family

These situation analyses showed that families and primary caregivers play a central and significant role in enhancing the ability of women with disabilities to enjoy their full rights. Families require much greater information, support and guidance to enable them to expand on their important role as caregivers and supporters of women with disabilities. There is little support and training provided for caregivers and the stories of overprotection, or violence and neglect, highlight the need for this.

Specific training in how to communicate with, support, guide and manage children or other female family members who have a disability would be of benefit as families, particularly parents and female relatives, can play an important role in educating women with disabilities about their SRH.³¹ Families and caregivers also need the opportunity to share their successes and challenges, as individual people in their own right, through mechanisms such as support groups.

Community

In general, these Situational Analyses found that community attitudes towards the sexual and reproductive lives of women with disabilities included a mistaken belief that women with disabilities are asexual beings who do not desire and are not capable of entering into intimate relationships, bearing or raising children. As one interviewee pointed out, community education is key to altering these attitudes.

Young women with disabilities face combined discriminations related to their disability and to their age. In general, many communities in Pacific countries expect that young people should not engage in sexual activity until married. Rates of teenage pregnancy indicate the reality is quite different.³² These attitudes can interact to cause young women with disabilities to be particularly excluded from information and services.

Sexual Identity

While the specific issue of GLBTI people with disability emerged only in Tonga, it is likely that women with disabilities who identify as lesbian, bisexual, transgender or intersex will find it difficult to express themselves free from discrimination in Kiribati or Solomon Islands. The stigmas associated with both disability and sexuality leave sexually non-hetero-normative women with disabilities completely isolated.

Lack of Information and Understanding about SRHR

Women with disabilities, particularly young women, have a significant need to receive more information and education about their bodies, SRH, and sexuality and relationships.

Health information received by the women with disabilities interviewed predominantly appears to be shared through family and friends. In relation to menstruation, the women interviewed overwhelmingly received information from their mothers or a female relative. Information and education does not necessarily have to be transmitted through the formalized means of health professionals and teachers, although these are important avenues for disseminating accurate information. Parents, friends and other female family members can also transmit important health information to women with disabilities. Research shows that when parents are equipped to talk to their children about SRH issues, they can have a marked positive effect.³³ The workshops run by TFHA for caregivers and women with disabilities are an example of good practice and should be revived and implemented elsewhere.

Given that many women who were interviewed had attended primary school or a school for children with disabilities, there is also a need to ensure that age-appropriate, evidence-based SRH education is taught at schools. Efforts are underway to do this in Solomon Islands and Kiribati, but they must be accelerated. As well as this, teachers require support and training to deliver this curriculum.

Need for Improved Services

The women interviewed in these situation analyses made use of SRH services most often when they were pregnant. Overall in Kiribati and Solomon Islands, with a few exceptions, women stated that they were treated well by health professionals. In Tonga the reports were more mixed.

Although women reported being treated well by health professionals, women did not always receive a high quality of care. The experiences of some of the women interviewed who received health care, but did not know what was done to them, highlights a need for more

comprehensive care to be provided. This includes health professionals being able to explain accurately, but in everyday language and a disability-friendly way, exactly what is being done to the woman and why. Similarly, the fact that several women were raped and became pregnant, but were not screened for STIs when they attended antenatal care, is an indicator that the quality of care provided could be improved. While women may not be willing to disclose rape, if the need for an STI check is explained well they may give consent without having to describe the circumstances through which they became pregnant. When health-care professionals screen for violence it does provide an opportunity for women to discuss their experience with somebody and, potentially, to receive further assistance.³⁴ The experience of women in institutions in Tonga who reported experiencing violence but did not receive appropriate care in response is another indication that the quality of health care provided needs to be improved.

Communication appears to be a key barrier to both women with disabilities to access care and for health professionals to provide information. Supporting health professionals through ongoing in-service learning and providing a range of information, education and communication materials may improve the quality of care provided to women with disabilities. Other general efforts to improve SRH services will also make an impact, including encouraging nurses to be non-judgemental and to respect confidentiality.

Given the fear and shame associated with attending SRH services expressed by some of the women interviewed, as well as the challenge of getting to health services, outreach and community engagement by reproductive health nurses could be a useful strategy. This approach may assist in increasing the currently low numbers of women who carried out breast self-examinations, obtained cervical Pap smear tests or sought assistance after unprotected sex with a stranger. There is obviously a high need here.

Alongside this outreach, training community advocates within the local DPO will provide women with disabilities with peer support, a liaison person with health services and ongoing education. This person will develop a relationship with women with disabilities and be able to provide case-specific support and care, making it more likely that women will be encouraged and supported to utilize health (and other) services.

Health Professionals and Other Social Service Staff

In general, health professionals and other social service staff appeared to have a poor understanding of disabilities. Providing training, mentoring and coaching on disability and issues for people with disabilities will assist those working in the social sector to provide improved services. Assisting social sector professionals by providing a range of information, education and communication materials that are accessible to people with disabilities will likely improve the quality of services provided to women with disabilities.

Unplanned Pregnancies

Several women had unplanned pregnancies, both through rape and through consensual sexual intercourse. These women would have benefited from being offered emergency contraception in the two to three days following sexual intercourse, or having access to legal and safe abortion. Although the vast majority of women who were raped did not attend health services, if they had known of the availability of emergency contraception they may have tried to get it, which could have provided nurses with an opportunity to offer other services.

In the social and legal settings in these three Pacific Island countries, safe and legal abortion is not available. This means women have no choice but to carry a potentially unwanted pregnancy through to childbirth. In many cases, this may be what the woman would choose regardless of other options. Currently, however, an informed choice is not an option. While it will take time, action must begin to expand women's reproductive choices to include safe and legal abortion.

Women in Institutions

These situation analyses raise questions about the quality of care that women with disabilities receive in institutions. The Alonga Centre in Tonga, in particular, requires much greater support and staff need training. Psychiatric services in all three countries also need to be engaged with in order to ensure that the SRH and rights of women in their care are given the attention they require.

Women with a Mental Illness or Intellectual Disability

These situation analyses highlight that women who have an intellectual disability or mental illness experience additional discrimination. Sexual violence was a common occurrence, often perpetrated by multiple men over time. Families struggled to know how to best care, support and maximize opportunities for their daughter, mother, sister or aunt.

There is a real need for specialized services for these women and their families, including the need for: appropriate education about their bodies, sexuality, sexual relations and how to keep themselves safe;

support and education for their caregivers and family; and greater assistance and support from health and social workers. There is also a need to take action to build a supportive and helpful community around women with mental health or intellectual impairments. Finally, there is also a need to talk to families and communities about the risk of violence against women and girls with disabilities.

Health professionals must ensure that when a woman with an intellectual disability or mental illness attends antenatal care, or any health service, time is taken to carry out a full SRH history, including appropriate screening for STIs and violence, and further action if necessary.

Involuntary Contraceptive Use or Sterilization

In all three countries it appears that involuntary sterilization or contraceptive use may be a common experience for women with an intellectual disability or mental illness. This was most often carried out on the instigation of families or medical professionals because of a genuine dilemma: women were repeatedly raped and becoming pregnant, and their families or medical professionals wanted to help them but felt unable to prevent rape and assumed the woman could not manage her own fertility. Nevertheless, involuntary contraceptive use and sterilization is a human rights violation, and each country needs to develop rights-based law that promotes and protects the rights of the woman.

Education of families and health professionals might assist in identification of solutions that do not violate the rights of women, and improve the system of gaining informed consent. The rape of women is an egregious human rights violation in and of itself, and much greater action is necessary to prevent this.

RECOMMENDATIONS

The following recommendations draw on the common findings above. As well as the recommendations presented here, a small number of country-specific recommendations are included under each of the country situation analyses. These should be read in conjunction with the recommendations below.

For any agency that wants to take action to support the sexual and reproductive well-being of women with disabilities, the one thing they need to do first and foremost is to walk the talk of “nothing about us without us”. These recommendations should be read with this in mind.

Structure of Recommendations

UNFPA requested that recommendations be made that other organizations could take on. For this reason, a broad range of recommendations has been included. Responsible organizations have not been assigned to particular recommendations. This is because the reader knows their organization best and whether or not they can take up a certain recommendation or work with another organization to implement it.

The three sets of recommendations provided in this report are:

- regional recommendations;
- recommendations for all three countries (i.e. those that need to be implemented in all three countries);
- specific country recommendations. These are included under each of the three country situation analyses below and need to be read in conjunction with the “recommendations for all three countries”.

Recommendations are listed in order of priority for UNFPA. Different organizations will have different priorities, according to their particular vision, mission and values.

Specifically for Donors

1. Donors need to increase support to organizations, programmes and projects that take action to harness the skills and talents of women with disabilities, provide support and education to expand their opportunities and build environments that do not discriminate against women with disabilities and that protect them from human rights abuses. Some of this support should be focussed on the specific SRH needs of women with disabilities, including prevention of sexual violence.
2. All support to SRH activities should encourage progressive inclusion of the specific needs of women with disabilities.
3. Local DPOs and NGOs, and MHMS, require more resources for taking action on disability issues, including SRH.
4. The allocation of resources needs to be coordinated with others, based on long-term commitments, well considered and accepting of current capacity constraints combined with a willingness to work with organizations “where they are at”.

Regional Recommendations

The Terms of Reference for these situation analyses requested recommendations for UNFPA to incorporate into its strategies and work with women with disabilities. For this reason, most of the “regional” recommendations listed below were written with UNFPA in mind. However, any organization or individual that wishes to improve the SRH situation for women with disabilities could (and should) take on these recommendations. In terms of policy engagement and advocacy, having many entities advocating for a particular action can be more powerful than one lone voice. Therefore, if several organizations took up some of the recommendations below, there may be a greater chance of success.

1. Discuss new initiatives with PDF and ensure that all action taken at a national level is done in collaboration with local DPOs.
2. Provide in-service training for all staff on the SRH and rights issues for women with disabilities, and ensure staff have a good understanding of general disability issues, including sexuality. This will ensure that staff are aware of disability issues and can better incorporate these issues into their programming.

3. Mainstream disability issues and gender through all work rather than separating these out, but ensure that action on disability and gender is specifically monitored. Ensure the needs of women with disabilities are integrated into all country work plans and in multi-year programme strategies.
4. Act as an advocate at the regional level to ensure that the particular issues of women with disabilities are integrated into the activities of other regional entities and donors, and regional activities, such as the adolescent sexual reproductive health, parliamentary activities and relevant technical working groups.
5. At the national level, engage with governments, civil society and the private sector to raise issues for women with disabilities, particularly in relation to their SRH.
6. Ensure that work on issues of disability is communicated clearly to other donors, multilaterals and development agencies working in the area of disability. This will enhance coordination, prevent duplication and ensure information is shared among all partners (such as lessons learned).
7. Continue to work with governments to encourage and support the availability and use of the emergency contraceptive pill.
8. Continue to work with governments to encourage and support the prevention of abortion and treatment of complications.
9. In line with the CRPD, engage with and support the law reform efforts of various governments, RRRT and other entities, particularly in the areas of disability, violence against women, and sexuality and reproduction, to ensure that bills are rights-based and that women with disabilities and their needs are included in the drafting process and final bills.
10. In all efforts to address violence against women, ensure that the voices and needs of women with disabilities are included, and take into account the greater risk of violence that women with disabilities are exposed to, and the different types of violence women with disabilities can experience in comparison to women without disability.
11. Implement the recommendations of previous documents, such as the Pacific Sisters report, as called for by the 2011 Pacific Regional Forum on Women with Disabilities.

12. Support DPOs and other services to better liaise with women's NGOs that may be providing services for survivors of violence against women and girls, as well as those who conduct awareness programs.

Recommendations for all Three Countries

1. **Nothing About Us Without Us.** Ensure that implementation of these recommendations includes women with disabilities and has input from the local DPO, from the very early stages and throughout.
2. **Community Liaison/Advocate for Women with Disabilities.** Fund the design and pilot implementation of a community liaison/advocate (CLA) role for women with disabilities. Several women with disabilities suggested this idea, and all stakeholders supported the idea during the final situation analysis feedback session in each country. As part of this, two CLAs should be trained and provided with ongoing mentoring/coaching support. Stakeholders felt that two CLAs could support each other. The design should explore the most appropriate operational structure for the CLAs and must include active involvement from the local DPO. Te Toa Matoa in Kiribati is a potential organization to undertake the pilot. The CLAs would need to be closely linked with the other key services for women with disabilities through functional referral networks, as outlined in each of the situation analyses.

CLAs will need to be trained in rights-based approaches, as well as the particulars of various disabilities. The role would involve providing assistance and support for women with disabilities in their engagement with various SRHR services, including health, justice, education and other social services. This role could also include policy advocacy with various ministries working on disability issues, to ensure the particular needs of women with disabilities are included. These individuals can also provide peer support and SRHR education to women and their families, linked up with the more formalized training outlined in Recommendation 4 below.

3. **Women with Intellectual and Mental Health Impairments.** Women with intellectual and mental health impairments experience discrimination, including sexual violence, and they require particular support. The author did not investigate deeply enough in this area to make recommendations for specific services required for women with intellectual and mental health impairments (as this was not in the TOR), apart from investing in specific information and education materials (see Recommendation 9c, below). Yet several of the recommendations in this report

contain substance that will assist women with these impairments, if implemented. Once these have been implemented, some momentum and clearer understanding of the local context will be built up and this can contribute to further work.

4. Training and Education.

- a. Train all RH, STI/HIV, psychiatric and community health professionals (particularly nurses and doctors) about disability and the rights of people with disabilities (including informed consent), sexuality and disability, screening for violence and abuse, and simple ways to improve communication with women with disabilities.
- b. Explore and implement mechanisms for ongoing mentoring or coaching of health professionals. This could involve TFHA and other IPPF associations as they grow expertise, or possibly New Zealand Family Planning or a member of Sexual Health and Family Planning Australia, as both these latter organizations have ready expertise in disability and sexuality, and in working with Pacific populations.
- c. Support a local NGO (TFHA, KFHA and possibly SIPPA) to run workshops on sexuality and disability for other health, education, social service and justice professionals working for government and civil society. These workshops should involve the local DPO.
- d. Support a local NGO (TFHA, KFHA and possibly SIPPA) to provide educational workshops for women with disabilities, and their relatives (particularly women) and caregivers, which cover sexuality and disability; understanding your body; relationships and how to negotiate sexual relations; pregnancy and contraception; sexual health and illness; and what to do if you experience violence. These workshops should involve the local DPO.

5. Regional Policy. Ensure the Pacific Regional Strategy on Disability (PRSD) includes specific action points for the SRH of women with disabilities at the time of its review in 2015.

6. Violence Against Women Policy. Both Kiribati and Solomon Islands have comprehensive policies on violence against women. Tonga does not yet. There needs to be greater recognition given to specific needs of women with disabilities in these policies and their action plans. This would include actions to address the challenges faced by women with disabilities in communication — both in reporting and in providing adequate evidence of violence. These actions could include recommendations from this report, such as training of key personnel in the justice sector, as well as

exploration of special provisions in the Evidence Act. The CLA programme can assist in this area by providing an advocate for women with disabilities reporting violence, who will there to support the woman.

- 7. Informed Consent Policy.** Given that legislation change will take time, work with the three governments, PDF, PIFs and local DPOs and other NGOs to develop and implement a rights-based policy for health professionals on informed consent and the use of involuntary sterilization and contraceptives.
- 8. Residential Care and In-patient Care.** Staff and volunteers working in residential care and in-patient psychiatric services require training, including in resident rights, informed consent and complaint mechanisms, and in the importance of taking action when women report violence, including referral to appropriate support services. There is a need for care facilities and in-patient care to have appropriate rights-based policies and guidelines and workers should adhere to standards of practice. A zero tolerance approach to violence against women and girls with disabilities is vital.
- 9. Information, Education, Communication (IEC) and Behaviour Change Communication (BCC).**
 - a. Promote the use of positive images of women with disabilities and reference to women with disabilities in any sexual and reproductive IEC or BCC materials that are produced.
 - b. Ensure IEC materials are accessible to women with a range of impairment types. Support the use of clear, everyday language and engaging pictures, and alternatives to leaflets and posters, such as tactile materials, audio-visual materials and mobile technology (such as text messages).
 - c. Invest in the development of IEC materials for people with intellectual disabilities (or contextualize and reproduce those that are already available).ⁱⁱⁱ
- 10. Routine Screening for Violence.**
 - a. Take steps to ensure that all women with disabilities who attend SRH services are routinely screened for violence, where there are services available, with appropriate action taken. These steps would include training health professionals, mentoring, guideline development, referral mechanisms and monitoring implementation.
 - b. When women have experienced sexual violence, ensure they receive the appropriate testing and treatment for STIs (including HIV) and are offered emergency contraception (if available), as well as referred to the local women's crisis centre.

ⁱⁱⁱ For example, Family Planning in New Zealand has a booklet on sexuality and relationships for people with a mild intellectual disability.

- c. Health professionals should have sensitivity training and a sound understanding of disability issues, as well as of the issue of violence against women and girls, as sensitivity can go a long way in providing the relevant support for survivors of violence.

11. Working with Men. Support country partners to mainstream gender and disability awareness into programmes for men, including programmes for men who have perpetrated violence against women. These should be rights-based, emphasising to men that women with disabilities are human beings with the same rights as everybody else.

12. Data Collection and Analysis.

- a. Include one or two questions on SRHR in nationwide disability surveys, or repeat surveys, to enable ongoing monitoring of the situation for and needs of women with disabilities. Analysis of data should include gender analysis.
- b. Similarly, in SRHR data collection activities, such as family health cards, ensure that there is a question on disability, so that reproductive health nurses are aware of women with disabilities who may require extra assistance.

13. Legislation.

- a. Work with other entities, such as RRRT and PDF, to support governments to sign and ratify the CRPD, and to ensure all legislation complies.
- b. Support governments to develop legislation on sterilization, including involuntary sterilization and contraceptive use. This could be in collaboration with PDF and RRRT.
- c. Conduct well-resourced research into the prevalence of abortion, in order to inform the case for abortion law reform, particularly in relation to instances of rape and incest.

14. Information and Education.

- a. Continue efforts to make accessible age-appropriate, evidence-based, comprehensive sexuality, relationship and SRH education both in and out of primary and secondary schools, including information on the SRH of people with disabilities.
- b. Take measures to ensure that teachers are also equipped to teach this curriculum and to identify behaviours that may signal abuse. Incorporate teaching methods that are suitable for children and young people with disabilities.

15. **Services.** Explore the feasibility of and potentially pilot an outreach SRH nursing service for women with disabilities (or perhaps all women). This could be done in collaboration with the local IPPF associations and/or the MHMS, and should include the local DPO.

Kiribati Recommendations

The recommendations below should be read in conjunction with the “Recommendations for All Three Countries” above.

1. Training and Education.

- a. In line with Recommendation 4 above, support KFHA to implement education and services for women with disabilities, including outreach services to their homes. TFHA’s experience in the area of disability and sexuality could be utilized to support KFHA, considering that they are both members of IPPF. This should be done in close liaison with TTM.
- b. In line with the above, engage with the MHMS to support them to include training and mentoring in their efforts to improve outreach services to outer islands, and reproductive and sexual health services. This should include rights-based education on disability, and disability and sexuality.
- c. Also provide training to Tungaru staff and staff from the School for Children with Disabilities.

2. Policy and Legislation Advocacy.

- a. Engage with Te Toa Matoa (TTM) and the Ministry of Internal and Social Affairs to support the government to sign and ratify the CRPD, and to approve the National Disability Policy and, when implemented, to include findings from this situation analysis into the Constitution for Women.
- b. Engage with the Ministry of Internal and Social Affairs and Te Toa Matoa to ensure that the implementation of the Action Plan on Sexual and Gender-based Violence includes women with disabilities (especially the mass media or educational campaigns) and that Te Toa Matoa is represented in any governance body overseeing implementation of the Action Plan.

Solomon Islands Recommendations

The recommendations below should be read in conjunction with the “Recommendations for All Three Countries” above.

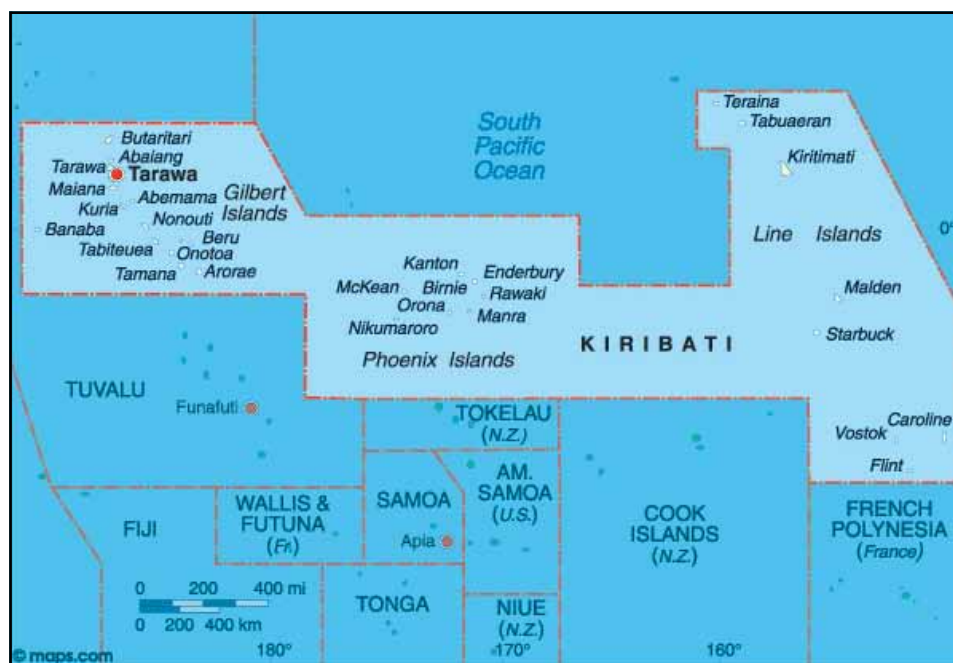
- 1. Educational Materials.** Building on the strengths in Solomon Islands in this area, fund and support PWDSI and the MHMS Reproductive Health Division, STI/HIV Section and CBR programmes, in liaison with the Red Cross school and San Isidro Rural Training Centre, to develop and pilot basic SRH information materials for people with speech and hearing impairments. These could then be piloted elsewhere in the Pacific.
- 2. CBR Services.**
 - a. Strengthen the SRHR components of the CBR Diploma course to equip future CBR staff with: knowledge of SRHR issues that their clients may encounter; an understanding of legal issues, particularly in relation to forced sterilization; and an ability to discuss SRHR issues with their clients and families, and know where to refer them to.
 - b. Create practice guidelines for CBR staff, including appropriate referral systems, to support them in addressing SRHR issues with their clients and families, and in making referrals to other health professionals, government agencies or civil society organizations.
 - c. Monitor the implementation of these CBR practice guidelines to assess whether CBR staff are discussing SRHR issues with clients and their families, and to identify areas for future training support.
- 3. Water and Sanitation Infrastructure.** Continue and potentially expand the water and sanitation programme for people with disabilities, giving priority to women and ensuring that facilities are designed to provide for the personal security of women with disabilities.
- 4. Legislation and Policy Advocacy.**
 - a. Engage with the CBR programme, PWDSI and the government to ensure that the draft Rights of Persons with Disabilities Bill incorporates the SRH and rights of people with disabilities, and is fully compliant with the CRPD.
 - b. Work with the Ministry of Women, Youth and Children’s Affairs to ensure that both the Women’s Policy and the Eliminating Violence Against Women Policy and Action Plan include women with disabilities (especially the education and mass media activities).

Tonga Recommendations

The recommendations below should be read in conjunction with the “Recommendations for All Three Countries” above.

- 1. Training and Education.** In line with Recommendation 4 in “Recommendations for all Three Countries”, fund TFHA to revive, improve and expand upon the disability and sexuality workshops that were conducted in the past. These workshops should be governed by a partnership between TFHA and NATA, to ensure that people with disability have oversight for how these educational sessions are run (at the governance level). Once established, TFHA staff could support KFHA in Kiribati to run similar workshops, and potentially expand to SIPPA in Solomon Islands, maximizing the benefits of their joint IPPF membership.
- 2. Alonga Centre.** Engage with the Government of Tonga and other stakeholders working in the area of disability in Tonga to explore how to support and improve the Alonga Centre.
- 3. Legislation and Policy Advocacy.**
 - a. When working with the Government of Tonga take all opportunities to encourage a whole-of-government approach to disabilities, rather than viewing it only as a health issue.
 - b. Engage with the Ministry of Education, Women Affairs and Culture, local NGOs and RRRT in the law reform efforts on violence against women and development of a disability bill to ensure women with disabilities are included and NATA is involved in the process.
 - c. Engage with the Ministry of Health as it develops a disabilities strategy, to ensure that the specific needs highlighted in this situation analysis are included.

KIRIBATI SITUATION ANALYSIS



About Kiribati

Kiribati is made up of 33 coral atolls that span the Equator. Spread over the largest exclusive economic zone in the Pacific, these low-lying atoll islands are divided into three groups: the Gilbert Islands, the Line Islands and the Phoenix Islands. The provisional population count from the 2010 Census data is approximately 103,000 people, about half of whom reside on South Tarawa, where the capital of Kiribati is situated.³⁵ Population density on South Tarawa is very high, leading to numerous social issues, such as poor health, crowded housing and violence.^{36,37} Life expectancy for men in Kiribati is 59 years and for women it is 63 years.³⁸ The population of Kiribati is youthful, with approximately 38 per cent of the population aged under 15 years, while 50 per cent are in the 15- to 49-year-old age group. People aged 50 years and over comprise 12 per cent of the population.³⁹

The official languages of Kiribati are I-Kiribati and English. In terms of religion, 55 per cent of people belong to the Roman Catholic Church, 36 per cent belong to the Kiribati Protestant Church and three per cent belong to the Church of Jesus Christ of Latter-day Saints (also known as Mormons). Apart from Baha'i, all other religions have less than two per cent of the population as members.⁴⁰

Kiribati is not ranked in the United Nations Development Programme's Human Development Index, but it is classed as a least-developed country. Kiribati has not yet signed the CRPD or its Optional Protocol.⁴¹

Persons with Disabilities in Kiribati

The Draft Kiribati National Disability Policy has estimated that there is most likely to be between 9,700 (10 per cent) and 19,400 (20 per cent) people with disabilities in Kiribati, with about half of these people residing on South Tarawa.⁴²

In 2004 the Kiribati National Disability Survey was carried out and this identified 3,840 persons with 4,358 disabilities, of whom 55 per cent were men and 45 per cent were women.⁴³

TABLE 1 | Disability by type and age group⁴⁴

	AGE IN YEARS							Total	%
	0-5	6-14	15-20	21-30	31-40	41-50	51+		
Physical Disability	61	108	57	90	171	197	713	1397	32%
Blind/Vision Impairment	29	69	44	64	92	219	663	1182	27%
Deaf/Hearing Impairment	29	179	94	138	145	131	303	1019	23%
Intellectual Disability	25	140	66	71	47	20	46	414	9.5%
Epilepsy	14	46	31	28	23	7	19	168	4%
Psychiatric / Mental illness	0	7	9	27	54	30	28	155	3.6%
Multi disabled	2	11	2	0	2	0	3	20	0.5%
Speech/ Language	0	3	0	1	1	0	1	6	0.1%
TOTAL	160	563	303	419	533	604	1776	4358	100%

As the table above shows, the survey found that physical disability accounted for 32 per cent of all disabilities reported, followed by visual impairment at 27 per cent, while people who had a hearing impairment represented 24 per cent.⁴⁵ The survey noted that there may be under-reporting of disabilities, such as mental health problems or intellectual impairments, due to a lack of understanding about disabilities. The survey does not provide a breakdown by sex and disability.

Other findings of the survey include:⁴⁶

- 40 per cent of all disabilities were found in the age group over 51 years.
- 23 per cent of disabilities were found in the under 20-year-old age group; hearing impairment accounting for 30 per cent of disabilities in this age group.
- Many people were unaware of the causes and treatments for disabilities, contributing to a lack of understanding and discrimination against people with disabilities.

Kiribati Legislation, Policy and Services for Women with Disabilities

Legislation

It was beyond the resources of this situation analysis to conduct a thorough examination of all Kiribati legislation. However, people with disabilities are not specifically mentioned in the Constitution under the section on “Fundamental Rights and Freedoms of the Individual” or under “Protection from Discrimination”, although “race, place of origin, political opinions, colour, creed or sex” are.⁴⁷ Abortion law is very restrictive, with the only reason abortion is permitted is to save a woman’s life.⁴⁸ There is no clear law on sterilization. A good deal of health-related legislation is over 30 years old, including mental health law, and there is a need to update this (recognized by the MHMS).⁴⁹

Policies and Strategies

Kiribati National Development Plan 2012-2015

At the time this situation analysis was conducted, the Kiribati National Development Plan 2008-2011 was drawing to an end, as the country geared up for the national election in late 2011. However, following the election of a new government in early 2012, the National Development Plan 2012-2015 was developed, which includes attention to gender-based violence as well as health (including reproductive health services and information) and governance issues. The governance matrix includes strengthened support services for particularly vulnerable women, as well as a specific goal of “improved empowerment and constructive involvement of special interest groups such as youth, elderly and disabled in decision making process”.

Draft National Disability Policy 2011-2014

The Draft Kiribati National Disability Policy 2011-2014 is a comprehensive and thorough policy, which has a vision of creating a society that “meets the needs of persons with disabilities through taking away barriers and ensuring that they have equality with all in society with access to employment, education, health, information and transportation”⁵⁰. The definition of disability that has been adopted for the policy emphasizes that disability is the result of an interaction between a person with an impairment and the environment within which they exist, moving the focus of disability from the individual to the responsibilities of society. The two key principles underlying the policy are partnership and inclusion.

The policy has nine strategic areas with 12 objectives, one of which is to “promote the equal participation of women and girls with disabilities and mainstreaming of their concerns at the national level”⁵¹. One of the key actions is to create a constitution for women with disabilities.

This provides great potential for the SRH needs of women with disabilities to be incorporated into action. The Cabinet has not yet endorsed this policy, which is why it is referred to here as “draft”.

Education

The Ministry of Education has signalled its intention to develop an inclusive education policy for children with disabilities and also to improve the focus on gender equality in policy development. Issues that are being consulted on include gender-based violence prevention and interventions (including sexual harassment), and the development of curricula on SRH. Currently schools do not have a comprehensive SRH curriculum.

National Policy and Action Plan on Eliminating Sexual and Gender-based Violence in Kiribati

Recently released, the Eliminating Sexual and Gender-based Violence Policy and Action Plan is based on the information gained in the *Kiribati Family Health and Support Study* (2010). This study showed very high levels of violence against women, particularly intimate partner violence, and highlighted the need for urgent action on violence against women in Kiribati. The policy is comprehensive but does not mention women with disabilities specifically. Nevertheless, if implemented, the policy and action plan could improve the situation of women with disabilities who experience violence. For example, one of the key actions is to review and update the Constitution to remove any legislation that discriminates against women.

The policy and action plan take a holistic, rights-based approach, working at the structural, societal, community and individual level. Women with disabilities are not specifically mentioned in the Policy or Action Plan. It would be useful to refer to their particular needs and greater vulnerability to violence, so that specific action to assist them can occur.

It is important that the government engage with TTM (the local DPO — see below) as a key stakeholder in the implementation of the Action Plan to ensure that the specific needs of women with disabilities are attended to. For example, there are clear challenges in communication which impact on women with disabilities’ ability to report violence and to provide useable evidence for prosecutions. This is important because of the violence that women with mental health and intellectual impairments experience because of their impairment.

Draft Strategic Plan 2008-2011, Ministry of Health and Medical Services

The Draft Strategic Plan for the MHMS is a comprehensive strategic plan and includes many important areas relevant to this situation analysis. A SWOT analysis highlighted key issues for the health sector. These are:

1. a declining health status in South Tarawa compared to the Outer Islands;
2. unsafe water supplies and poor sanitation;
3. an increase in infant mortality rate, with the main causes of mortality diarrhoea, pneumonia and neonatal conditions;
4. the high prevalence of TB, an increase in STIs and ongoing threat of HIV infections;
5. the increasing prevalence of non-communicable diseases (NCDs);
6. outdated laws and regulations that don't meet current and future health situations;
7. policies, guidelines and management decisions are not disseminated or followed by staff;
8. Ministry of Health Operational Plans (MOPs) based on outdated national strategies;
9. poor quality of health information;
10. lack of motivation among health staff;
11. significant level of untrained or unskilled staff;
12. poor communications;
13. lack of quality control and patient focus;
14. unclear management reporting line;
15. financial constraints to implementing MOPS.⁵²

From these key issue areas, six strategic objectives have been developed, which include a number of priority actions. Priorities related most closely to disability and to SRH include: improving maternal health; addressing HIV and other STIs; improving mental health; strengthening rehabilitation services; strengthening the care of chronically and terminally ill people; and improving medical and home-based medical services in outer islands. Updating legislation, including mental health legislation, is also prioritized. Along with these areas, there is significant emphasis on prevention of NCDs and other disability-causing diseases, such as trachoma and leprosy. If implemented, these areas have the potential to improve the situation of women with disabilities.

However, disability is specifically not mentioned anywhere in the Draft Strategic Plan.

The current Draft Kiribati National Health Strategic Plan (2012–2015) includes two strategic objectives that will address some issues that women with disabilities experience:

- Strategic Objective 6: Improve access to high quality, appropriate health care services for victims of gender-based violence, and services that specifically address the needs of youth.
- Strategic Objective 4: Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and consequently reduce morbidity, disability and mortality from NCDs.

Kiribati Population Policy Implementation Strategy 2009

The Kiribati Population Policy outlines a clear approach to managing the challenging population issues in Kiribati, particularly on South Tarawa. This policy is comprehensive and overarching, referring to all people of Kiribati. There is mention of youth and their special needs, but no mention of other vulnerable population groups that might need special support or attention, such as people with disabilities.

Services/Programmes for Women with Disabilities

Information, services and support for people with disabilities in Kiribati are scarce. The most active organizations are TTM, the School for Children with Special Needs and the Ministry of Health's Tungaru Rehabilitation Centre and the Ministry of Education.

Te Toa Matoa

Te Toa Matoa is the local DPO. It was established in 1999 and is run voluntarily by people with disabilities. TTM has a vision that:

- a person with a disability or disabilities is a person who is educated, socially secured, economically productive and happily living with his or her own family in a barrier-free environment;
- as an association TTM is an effective, democratic, self-reliant organization of men and women from all disability groups, able to work for the full participation and equalization of opportunities for persons with disabilities in Kiribati.

The government gifted the organization a piece of land where TTM has a *mwaneaba* (meeting house) and a small office. TTM has a performance and drama group, and many members, particularly on South Tarawa. The organization has been at the forefront of the development of the Draft National Disability Policy, which is awaiting government sign-off. TTM is also working to support the Government of Kiribati to sign and ratify the CRPD. TTM is an active organization and although they do not currently do any work in the area of SRH, they would like to in the future.

Tungaru Rehabilitation Centre, Ministry of Health

The Tungaru Rehabilitation Centre is situated at the hospital on South Tarawa. The Tungaru Centre provides inpatient rehabilitation support and conducts home visits and follow-up after people are discharged. People with disabilities living in the community are able to request assistance from the Tungaru Centre at any time and the Tungaru Centre also takes new referrals, although their resources are currently overstretched. The Tungaru Centre has six staff, three of whom have a diploma in physiotherapy. The Tungaru Centre also maintains a database of its patients, the majority of whom have experienced an amputation or a cerebral vascular accident (CVA), with a smaller number who have cerebral palsy or polio. The Tungaru Centre does not run any particular activities related to SRH.

Psychiatric Unit, Ministry of Health

Locally called the “mental ward”, the Kiribati Ministry of Health Psychiatric Unit is situated away from the main hospital, in a compound of its own. This unit appears to be significantly under-resourced. There are a total of five registered nurses and 19 orderlies (six women and 13 men) who staff the unit. Women orderlies work with the women, and men with the men. Currently, there are approximately 20 to 40 patients (there were different numbers provided by different interviewees) who live at the unit, but patients come and go so the exact number was not possible to ascertain. The unit has four lock-up rooms, which are used for very ill patients but also for managing “misbehaviour”. There are two dormitories — one for women and one for men. Interviewees gave conflicting reports as to whether or not these get locked at night. The main disorders that patients come to the ward for are schizophrenia, bipolar disorder and alcohol psychosis.

There is no psychiatrist in Kiribati, although a medical intern is currently training in this area. There are no occupational therapists either. The psychiatric unit staff try to involve patients in activities of daily living as a means of occupational therapy, but they would like to be able to do more. Staff have not received any training in calming and restraint, and the orderlies have received no training at all. Issues of sexual violence, relationships and pregnancy are not given great attention, although women are given depo provera (DP) as a pregnancy prevention method. This is discussed further below.

The School for Children with Special Needs

The School for Children with Special Needs was established in 1991. The school caters for about 70 to 96 students with a range of impairments. Sign language (Australian) and braille are taught. Where possible, the school uses the approved I-Kiribati educational curricula, but given the age ranges and variety of impairments, this can be challenging.

Teachers have not received any formal training. Some teachers educate their students about puberty (both boys and girls) but they have scarce support or resources to do so. Broader SRH issues are not taught, such as sexuality and sexual health, or keeping yourself safe from violence.

Kiribati Family Health Association

Kiribati Family Health Association (KFHA) provides a broad range of SRH services for people of all ages. Their focal areas are on access to information and services, advocacy, young people, HIV and STIs, and preventing abortion. The organization has a clinic, a youth drama group and KFHA creates and distributes educational materials. Currently, KFHA does not do any work in the area of disability and sexuality, but they would like to do more in this area in the future. One woman with a disability who was interviewed for this situation analysis reported using KFHA's services.

Other

The Kiribati Society of the Red Cross has historically engaged in working with people with disabilities but currently is not working in this area. The Kiribati Teachers College offers a Special Education Course for pre-service and in-service teachers. This has been in place since 2008 but it was not investigated as to how well this training is utilized.⁵³ The Kiribati Council of Churches has a 10-point moral framework that guides their work to ensure that all people with disabilities are included and embraced by churches.⁵⁴

TTM has recently become a member of Aia Maea Ainen Kiribati (AMAK). AMAK is the umbrella organization for I-Kiribati women's organizations, which form the National Council of Women. AMAK is very supportive of TTM's membership and they are keen to assist TTM in any way that they can. Several women with disabilities interviewed for this situation analysis benefitted from attending a workshop on cervical cancer that was run by AMAK.

Experiences of Women with Disabilities

The following section provides information from interviews with women, supplemented with information from other I-Kiribati data sources. Some information about all women in Kiribati is also included. This is to provide a point of reference for the information about women with disabilities. Due to the fact that the intent of this situation analysis was not to gather representative data, it is not accurate to compare the information gathered from interviews with women with information about all women in Kiribati.

The number of women with disabilities interviewed for this situation analysis does not allow for the information gained to be generalized to all women with disabilities. However, it is likely that the women interviewed in this situation analysis are more advantaged than those who were not interviewed, merely by the fact that they are known to TTM. This should be kept in mind while reading through the information below.

General Characteristics of Women Interviewed

Table 2 | Age, residence, disability type and religion of women interviewed

Age (years)	Number of Women
15-24	3
25-34	9
35-44	4
44 and over	4
Place of Residence	
South Tarawa	17
North Tarawa	3
Disability Type	
Physical	13
Sight Impairment	7
Intellectual	1
Religion	
Roman Catholic	12
Church of Jesus Christ of Latter-day Saints	4
Seventh Day Adventist	1
Kiribati Protestant Church	1
Baha'i	1
Assembly of God	1

As the table above shows, the women with disabilities who were interviewed were predominantly over the age of 25 years and resided on South Tarawa. Most women interviewed were Roman Catholic, which impacts on their SRH due to the position on contraception and sexual relations taken by the church. Apart from one, the women interviewed reported only one disability and these were mostly physical in nature. One woman had multiple disabilities.

The residence of women interviewed reflects the challenges associated with reaching women in non-urban areas of Kiribati. Almost half of the population of Kiribati reside in South Tarawa (47 per cent of women and 45 per cent of men⁵⁵) and this was where the majority of the women interviewed resided. One trip to North Tarawa was conducted but resource constraints prevented travel elsewhere. It is likely that women with disabilities on outer islands experience significant disadvantages and the interviews with women on North Tarawa indicated this.

The vast majority of the women interviewed had received some education, with several women attending secondary school for up to six years. One woman had attained a university qualification. Several women who were blind had learned how to read braille at the School for Children with Special Needs but unfortunately have scarce access to reading materials. The recent *Demographic and Health Survey* found that for all people in Kiribati, about 58 per cent of women had completed primary school and some secondary school (for men it is 60 per cent). About three per cent of people have attained some post-secondary education.⁵⁶

Almost all of the women interviewed were unemployed. For all people in Kiribati, 44% of women and 38% of men aged 15-49 years are classed as employed.⁵⁷

General Health Behaviours

Smoking, Alcohol and Drug Use

A reasonable number of women interviewed smoked, often traditional cigarettes, including three women who smoked during their pregnancies. Data gathered in the DHS show that about 33 per cent of all women are smokers and 24 per cent of these women smoke during pregnancy.⁵⁸

Some of the women interviewed drank kava (a relaxant and sedative, traditionally used in several Pacific countries but not in Kiribati) between once and three/four times a week, but the majority reported not using drugs other than those prescribed by a doctor. One woman had tried to commit suicide by overdosing on a range of pills (this was after her grandmother refused to allow the woman to marry her boyfriend). Answers to this question did not receive responses regarding traditional medicine, yet it appears through other conversations that traditional medicine is often used as a first port of call for women when they have a health problem. In relation to alcohol, almost all women said they did not drink apart from on special occasions. Some women stated that they used to drink when they were younger but no longer.

Diet

Locally grown, fresh food is scarce in Kiribati. Rice was the main component of the diet of every woman interviewed. Apart from this, women also reported consuming fish (tinned and fresh), shellfish, breadfruit and sometimes coconuts in the last 24 hours. A few women reported buying tinned fish. The *Demographic and Health Survey* found that for all mothers, the most common types of food consumed were high-protein foods, including meat, fish and shellfish (87 per cent), followed by grains (84 per cent), vitamin A-rich foods (58 per cent) and root crops (28 per cent).⁵⁹ The diets of the women interviewed seem broadly similar to the diets of all mothers in Kiribati, apart from

perhaps vitamin A-rich foods, which may be consumed even less in the women interviewed.

Water and Sanitation

Water and sanitation is a significant issue in Kiribati, particularly on South Tarawa. For all people in Kiribati, 90 per cent have access to an improved source of drinking water, that is, a piped source, a protected well or from rainwater. Those who live in urban areas have a greater access to an improved source of drinking water (96 per cent) compared to rural dwellers (87 per cent).⁶⁰ All of the women interviewed for this situation analysis had access to an improved source of drinking water, including those who lived in rural areas.

In relation to toilets, the majority of women interviewed used a water-seal toilet but these were often shared. Some women reported using the sea as the toilet. For all people in Kiribati, 35 per cent have access to an improved toilet, although this number includes toilets that are shared facilities and these are not generally classed as improved due to the hygiene issues of sharing with numerous other people.⁶¹ Almost 40 per cent of people used the sea or bush as a toilet.⁶²

Sources of Support: The Family and Te Toa Matoa

The family was the primary, and in some cases the only, source of support, care and assistance for the women with disabilities interviewed. Family members helped in a myriad of ways, from providing money and food to assisting with activities of daily living. The quote below is typical of what many women stated:

“I live with my family and they care for me — help me to cook, wash, carry water. But my mother does most of the work”.

The two women interviewed who had the most severe disabilities were both cared for by an older female relative: one woman by her mother and the other by her grandmother. This latter woman’s story is worth telling in full, to enable a full understanding of the situation of women with significant disabilities, particularly on outer islands where this woman resides.

“Life is very hard. Grandma adopted Taboneoa because her parents did not want her. She was born healthy but the next day she was shaking all over and became like she is now. [Appeared to be cerebral palsy.] She is now 25 years old and grandma is 58 years old. Taboneoa is totally dependent for her every need. Taboneoa is heavy and it is hard for her grandma to carry her and hold her when feeding her. Taboneoa’s grandma is the only person to provide care. She got some support from the hospital in the early days — some advice about stretching. But now she doesn’t receive any assistance, just medications when something is wrong.

Some people laugh at Taboneoa and make fun. Grandma worries about Taboneoa's future because grandma is getting older and there is no one to care for Tabonea".

Not all families were supportive. Several women shared stories of being neglected or hidden away by one or more members of her family. This most likely stems from parents' and family members' lack of understanding about disabilities, including feelings of shame and possibly guilt, in relation to a daughter's or family member's disability.

"Mother wanted me to stay at home. I was very lonely and stuck at home".

"When I was younger I lived with my family but my mother was unhappy to me but my father looked after me. My mother wouldn't let me play and one day, when I came back from playing, my mother hit me and threw a knife at me. My father was away then. I cried. My mother asked me not to tell my father, and I didn't. My mother got my sisters to look after me. My mother told my sisters that they should get married but not me. My mother looked down on me".

"My family did not care for me and were not friendly to me. I lived with them but sometimes they went to the neighbours for dinner and didn't cook for me — just leave me at home. I had nothing to eat. My mother left us and so my father raised me. One day he left me in the house and went and got another wife. So I lived with my uncle, who didn't look after me well either. He kicked me out when I was 28 so I went to live with a friend with a disability. Now I live with my mother's son to a different man. They are very helpful and supportive".

"My mother was not supportive — hid me away. Did not look after me and left her at home".

TTM was also mentioned as a source of support by many of the women interviewed, the majority of whom were members of TTM. Women saw TTM as a source of social engagement, providing an opportunity for acceptance and community belonging (see below). Some women had also received assistive equipment through TTM's relationships with other disability support organizations.

Community Attitudes

“Two ways — people who know and understand, and people who don’t want to help you, look down on you”.

This quote articulately sums up the responses from women in relation to whether or not they feel accepted in their communities. Most women interviewed felt accepted by their immediate community but often not by broader society or people who did not know them. As one interviewee stated, addressing people with disabilities is *“difficult for people in Kiribati — they stare at you. Very rude”*. Another woman stated, *“When I first had my disability I want to kill myself. Other people were not very helpful to me”*.

The two quotes below give an indication of the different experiences women have within themselves, with their village and with the wider community as they struggle to come to terms with their disability.

“Feel sad because all people when I go around, they say ‘Oh, she’s a blind woman’ and they laugh at me. But when at Te Toa Matoa I have no problem. At first I feel shy but when at Te Toa Matoa I feel like a free woman. But in my village, people are kind and friendly to me. Sometimes I go to church”.

“Very sad and lonely when disabled because people look down on me. That is also how I thought of people with disabilities before I developed my disabilities. At first I felt shy because I’m disabled — can’t go somewhere, like to the store or to church. Then Te Toa Matoa came and visited and asked me to join them. When I joined them I think I’m not a disabled woman”.

The women interviewed shared stories that highlighted that when people understood about a disability and what life was like with a disability, they were less likely to behave in a discriminatory manner.

“Kids my age laughed at me and said ‘stay away from here’. Then my mother went to talk to the children and explained how much they hurt me with their comments. Then the children were better”.

Sexual and Reproductive Health Experiences

Menstruation and Menopause

The majority of women interviewed were still menstruating. Generally, they had received information about menstruation from either their mother or grandmother. One or two women had figured it out for themselves after discovering blood on their skirt. Two young women had experienced the traditional ritual upon first menstruation — their grandmother took them away to a separate house where the girl was required to stay by herself for three days, using particular cloths for her menstrual blood.

In relation to menopause, a few women had heard about it by talking to other women but most had not received any information about it. One woman thought she had entered menopause because she had been menstruating for five years but had not become pregnant, although still menstruating. This indicates a lack of knowledge and education about menopause.

Intimate Relationships^{iv}

^{iv} For the purposes of these situation analyses, “intimate relationship” refers to an engagement between two people that is more than sexual intercourse but that is formed on the basis of sexual attraction. This is different from being sexually active and also from intimate relationships that are of different natures, such as parental or sibling relationships.

During the interviews with both women with disabilities and stakeholders, various perspectives were shared regarding relationships and marriage for women with disabilities. One prevalent perspective was that women with disabilities should get married to a man with a disability, preferably the same disability as the woman. As one stakeholder stated, “From our support, they marry each other”. Several women who were interviewed had indeed married a man with a disability, often a similar impairment to that which the woman experienced. In interviews with women who were not yet married, if they wanted a relationship, they stated that they would like to have a relationship with somebody who was like them. Most often this was because women assumed the man would be understanding if he experienced a similar disability. As one woman interviewed stated, “I want somebody like me to be my boyfriend”.

Another prevalent perspective, often held by parents or others, was that women with disabilities should not get married.

“People think that people with disabilities shouldn’t get married to each other and that it is a problem. They think that you are forced to get married. They think you can’t married because you are a disabled woman”.

“There were lots of boys interested but my mother told me not to get married”.

“Not normal for thinking about boys”.

“People laugh at me, when they hear that I have a boyfriend, they laugh at me. They are not happy I have a boyfriend”.

From the perspective of parents, this concern may be similar to what some women with disabilities feel, in that a man may be taking advantage of a woman with a disability if he marries her.

“I refused to have a relationship, even though some boys asked me, because I’m afraid that he might abuse me”.

“The man... he might abuse me or laugh at me”.

Despite perspectives that women with disabilities should not get married, the majority of the women interviewed were married. One woman was widowed and two women were in their second marriage. For all women in Kiribati, 52 per cent are married and 16 per cent identify themselves as living with a man, or being in a consensual union with a man — a total of 68 per cent of women.⁶³ Women are more likely to be widowed due to the shorter life expectancy of men.

Of the women interviewed who had ever been in a relationship and ever had sex, the majority had had more than one sexual partner over their life, ranging from one up to about ten. Of all antenatal women in Kiribati, the average lifetime number of partners was found to be 1.6 for women aged 15-24 years and 1.7 for women aged 25-46 years.⁶⁴

The women interviewed who had experienced sexual intimacy expressed their enjoyment of it, so long as it is consensual.

“When the idea comes to you, you want to do it”.

“Yes, I like it. But sometimes I stop feeling like it when man force me to have sex”.

“At other times you don’t like it but your husband force you. But when you don’t do it, he kick or slap you. The idea comes out that you have a boyfriend”.

Most women stated that their disability did not interfere with their enjoyment of sexual intimacy. One woman did experience discomfort during sexual intercourse due to her disability. She had not sought assistance from a health professional for this discomfort but rather came to an arrangement with her husband.

First Sexual Experience

The women interviewed who had engaged in sexual relations tended to have their first experience of sexual intercourse around 20 years of age. This is the same for all women in Kiribati aged 25 to 49 years.⁶⁵ The two women who had experienced sex before the age of 18 years had both been raped at the age of 10 and 12 years.

Just over half of women had consented to their first experience of sexual intercourse. For the remainder, their first sexual experience was either coerced or forced. For all women in Kiribati, the Family Health and Support Study found that 20 per cent of women had experienced coerced or forced first sexual experiences.⁶⁶ There is more discussion on this below, under the section on violence.

Contraceptive Knowledge and Use

Women's knowledge about contraception varied but was generally limited. Several women knew about various types of contraception that were available in Kiribati, such as DP, implants and pills. They had heard about these from other women, on the radio, at a workshop or from nurses. Several other women knew nothing or little about contraception.

Of the women interviewed who had been sexually active at some point throughout their life, only five had ever used a form of contraception and these were all married women. None of the currently single women had ever used contraception. The most popular forms of contraception were implants or injectables, while one woman had used pills once. Women used contraception because they wanted to stop or limit their children, or to space them. Some women actively sought out contraception while others took up an offer from a nurse. As one woman stated, *"Because of my disability I used the injection so I didn't have them [children] too close"*.

The majority of the women interviewed who did not want to get pregnant were also not currently using any form of contraception. Of these, two had sought contraception from their local clinic: one woman was thinking over her options, considering a tubal ligation, but she requested information from the author regarding other options; the other woman asked the nurse at the local clinic but the nurse said that the woman would have to ask her husband's permission. This latter situation was particularly poignant because the woman's husband had recently passed away and the reason the woman was seeking contraception was because now that she no longer had a husband she was *"afraid that men will try and have sex with me because of the way I am"* (she was blind).

Women didn't use contraception for several reasons. Some simply did not know about family planning and contraception, or were not concerned if they became pregnant. Others did not use contraception "because of religion — strict rule. Catholic, they tell women they can find another way to stop pregnancy but not the medicine, can use other ways [such as natural family planning]".

In relation to male condoms, few women had used them, although the majority of the sexually active women had had several partners throughout their lifetime. One woman said that she "was afraid to use them because I haven't used before. I trust my boyfriend". Another woman stated that she didn't use condoms "because I married and condoms are only for sex with another man". This comment quite possibly reflects the information available in Kiribati that condoms are to prevent STIs and the lack of information about how condoms are a useful form of preventing pregnancy also.

Unlike the women interviewed, among all people in Kiribati there is a generally high level of awareness of at least one form of contraception, with 93 per cent of all women knowing of a modern method of contraception and 78 per cent who know of a traditional method.⁶⁷ The most commonly known modern methods among women are injectables, male condoms, implants and the pill, while the most commonly known traditional method was the rhythm method.⁶⁸

This high level of knowledge does not translate into a high level of contraceptive use. Only about 39 per cent of all women in Kiribati had ever used a contraceptive at some point in their life: 35 per cent have used a modern method (injectables, the pill and implants are the most popular) and 13 per cent have used a traditional method (rhythm and withdrawal, followed by folk methods).⁶⁹ Of antenatal women, only 19 per cent had ever used a condom, most usually a male condom.⁷⁰ For married women, about 51 per cent have used a contraceptive method at some time: 46 per cent modern and 17 per cent traditional.⁷¹ The use of any contraceptive increases with a woman's age.

Involuntary Contraceptive Use or Sterilization

Women residing on the psychiatric unit had received DP in the past, but at the time of interview the unit had run out of supplies. In discussions with staff at the psychiatric unit it was shared that women were given DP as a way of preventing pregnancies. Some "don't want to" but "they have it in the end". It is not clear if full informed consent is obtained but it is highly unlikely, given the quote above and the general attitude towards women who "don't have their right mind to think by selves".

Termination of Pregnancy

None of the women interviewed reported ever trying to do something to end a pregnancy. One woman chose not to answer this question. Several women commented in response to this question that it was against the rule of their religion.

“When you deliver not in right time, when you make a wrong decision, the church not happy”.

“Can’t do that because of the rule, when you do that God’s very angry with you. It is an important thing that God has given you a child”.

Pregnancy, Antenatal Care, Delivery and Children

The average fertility rate in Kiribati is 3.8 births per woman aged 15 to 49 years of age. However, this varies according to the different socioeconomic circumstances of women: those who are less educated, poor and live rurally are more likely to have higher fertility rates (4.1, 5.0 and 4.1 respectively).⁷² The women interviewed had been pregnant and given birth between one and nine times each, with several being pregnant just once and several being pregnant between four and nine times.

Most of the women interviewed carried their pregnancies through to delivery and few had any problems along the way. However, two had experienced three miscarriages each: one woman blamed these on carrying heavy water, the other on the midwife pressing her stomach during an antenatal care visit. One woman had given birth to twins, who died within a year. The woman shared that this was because when she attended the hospital for her ultrasound scan, she was sent for an X-ray, which damaged the fetuses and the children were born with deformities.

Apart from one, all of the women interviewed attended antenatal care at least once during their pregnancies. For all women in Kiribati, over 70 per cent attend antenatal care at least four times during their pregnancy, and a nurse or midwife sees most of them.⁷³ However, many women do not attend health care until their fourth month of pregnancy, with only 36 per cent attending prior to their fourth month.⁷⁴ This means that opportunities for early screening and education are missed. While this was not discussed explicitly with the women interviewed, it is likely that they follow this pattern also, particularly if they only attend once.

Almost all of the women interviewed delivered their children in hospital. One woman living on an outer island had all her deliveries at home in the presence of a midwife, although for two deliveries the midwife was too late and the baby was delivered by the time the

midwife arrived. Many women interviewed reported their family supporting them to get to a health clinic prior to the birth of their child. For all women in Kiribati, 66 per cent deliver in a health facility, with the remainder delivering at home.⁷⁵ A skilled birth attendant assists almost 80 per cent of all pregnant women during delivery.⁷⁶ For the women interviewed in this situation analysis, skilled attendants were present at all their births by the mere fact that they gave birth in hospital. The one woman who gave birth at home, but with a midwife, is typical of the prevalence of home births for rural women in Kiribati: home births comprise 42 per cent of births in rural areas compared to 18 per cent in urban.⁷⁷

The women interviewed received information about pregnancy and childbirth from their female relatives or from nurses during antenatal care visits. One woman reported learning about pregnancy at school and another said she had read a book. One woman visited the nurse late in her pregnancy because she thought there was something wrong with her. She was unaware she was pregnant. *“Something moving in my tummy so I went to the nurse. She tell me I pregnant and sent me to Tarawa to wait”* to deliver.

The *Demographic and Health Survey* indicates that although all I-Kiribati women attend antenatal care at high rates, the care they are given during visits needs improvement. Less than half of all pregnant women in Kiribati could recall being informed of the signs of pregnancy complications and in rural areas women are much less likely to receive blood and urine tests.⁷⁸ Due to the communication challenges presented by some women’s disability, a lack of understanding by health professionals and women’s low level of knowledge (see below under Health Information and Services), it is likely that women with disabilities receive limited information during their attendance at antenatal care.

Breast Checks, Cervical Smears and STIs

None of the women interviewed practice regular breast self-examinations or had any knowledge of this. Some had experienced transitory lumps or sores on their breasts. Only two had lumps that were still present. Both had sought treatment but had not returned for follow-up (more on this below under Health Information and Services).

Similarly for cervical smears, few women had ever attended a health clinic for a cervical smear, even when they were sexually active. AMAK had run a workshop on cervical cancer and provided participants with the opportunity to have a cervical smear test. Of the women interviewed, three had taken up this opportunity. They each described a similar process, whereby they had been given medication as well as having a smear, and asked to return in six months time. These three

women did not know what the medication was for, although on further inquiry the author could make a guess at each of the woman's situation and what the medication was for. This is discussed further below, under Health Information and Services.

In relation to STIs, it is possible that the three women above were given treatment for some form of reproductive tract infection, which may have been an STI, but they did not seek out this treatment themselves. Apart from one woman interviewed, none of the woman had ever sought assistance for an STI, although some described possible signs or symptoms of STIs. Three of the women interviewed had received an HIV test when they attended antenatal care, but no woman sought an HIV test of her own volition. This situation is a concern, particularly when several women had had several sexual partners throughout their lives and several women had experienced rape, yet it is in line with all women in Kiribati.

The *Kiribati Demographic and Health Survey* (2009) found that 11 per cent of women aged 15-49 reported having an STI or a symptom of an STI in the 12 months prior, and that one third of them sought treatment.⁷⁹ The Second Generation Surveillance Survey (2008) found that less than one quarter of women who had potential STI symptoms sought health care assistance.⁸⁰ Chlamydia was the second most commonly detected STI at 11.2 per cent overall (15 to 24 years: 13 per cent, 25 to 46 years eight per cent). Hepatitis B was detected at approximately 15 per cent in each of the two age groups.⁸¹

Violence

Kiribati has benefitted from the recent *Kiribati Family Health and Safety Study*, undertaken in 2009. This study highlighted the high levels of gender-based violence against women in Kiribati. Significant findings include⁸²:

- 68 per cent of ever-partnered women aged 15 to 49 years reported violence by an intimate partner: 47 per cent of this was emotional; 60 per cent physical; 46 per cent sexual; and 68 per cent physical and/or sexual.
- 18 per cent of women aged 15 to 49 years experienced violence — physical, sexual or both — by someone other than an intimate partner:
 - for physical violence this was most likely perpetrated by a father, stepfather or other male relative;
 - for sexual violence this was most likely perpetrated by a male acquaintance or a stranger.
- 19 per cent of women aged 15 to 49 years had been sexually abused before the age of 15 years by male family members, acquaintances or strangers.

- 20 per cent of women's first sexual experience was forced or coerced.
- 23 per cent of ever-pregnant women reported being beaten during pregnancy. While the majority of these women had experienced the violence prior to their pregnancy, 37 per cent said it started during pregnancy and 10 per cent that it got worse during pregnancy.

The women with disabilities interviewed for this situation analysis reported experiencing a range of violence and this violence reflects the findings of the *Family Health and Safety Study* outlined above. Several women did not experience any violence whatsoever throughout their life. Of those who did report violence, two had been hit by a male relative (brother or uncle). The former was severe, with the woman's brother smashing her face into the ground, resulting in significant bruising and swelling. The woman told her father, who responded by beating her brother. Another three women had been beaten by their husbands: one only once, upon refusing to prepare her husband's food; another regularly until he was immobile so could no longer get to her; and the other was beaten throughout her pregnancy because her husband did not believe that the child was his, but this stopped once the child was born. These women did not tell anybody, as one explained, "*When you are married you can't go to ask for help from the police... because you are married, the man own you*".

The women with disabilities interviewed reported several instances of rape, usually by a stranger, a village man or a male relative. This was often the woman's first sexual experience, as outlined above under "First Sexual Experience". Village men had repeatedly raped one woman and she thought they treated her this way because of her disability. Combined with the concerns of health professionals for women with mental or intellectual impairments who wander the streets, there is an indication that men may target particular women with disabilities because of their disability. In response to the question about being forced to have sex, three women reported that their husbands had ever forced them to have sex.

Social pressure makes it difficult for disabled women to break free from violence. One woman interviewed had been raped by her husband as her first sexual experience, when they had only just met and were not yet married. This, along with comments such as the above about being "owned" by your husband, hint at the social pressure that women with disabilities carry with them even when experiencing violence. Findings from the *Kiribati Family Health and Safety Study* indicate that 76 per cent of women thought that they were obliged to have sex with their husbands, even if they didn't feel like it.⁸³

This social pressure may also contribute to the fact that few women interviewed who experienced violence reported it to anybody. Some women told a family member or friend, usually a woman, but this was rare. Nobody reported violence to the police. This should be considered in policy development, law reform and legal aid programmes.

Traditionally in Kiribati it was important for a woman to be a virgin upon marriage, with proof being the sight of blood on the wedding night. This tradition has subsided with time but is still an important concept in Kiribati society. This shaped the perspective of some of the women interviewed who had experienced rape and they did not want to tell anybody because they were afraid of what their family would think or do. The Family Health and Safety study supports this, stating that “young girls who are raped are particularly unlikely to report the crime to the police due to the emphasis on female virginity before marriage”.⁸⁴

Another tradition that has eroded over time is the acceptance of a man’s ability to “abduct” a woman and therefore marry her. One woman interviewed described her experience of this practice:

“The first time I had sex at 12 years. I was forced by a village man. He took me to his place and forced me to have sex with him. His family went to my family and tell them that I am OK. My uncle agree for me to go but my mother, my family not agree. The man beat me and forced me to have sex. But I divorce him after about one month and my family took me back home”.

Women with Mental Health or Intellectual Impairments

Women with mental health or intellectual impairments are vulnerable to violence, unwanted pregnancies and discrimination if they desire relationships and children. It was not possible to interview women with any of these impairments, but caregivers and health professionals were interviewed. Interviews with caregivers highlighted the high needs of both the woman with an impairment and the family. While the women were cared for and watched over closely by their primary caregivers, the potential exists for abuse by family members or by others, and the lack of time out for the primary caregiver makes life extremely difficult for her the carer.

Health professionals exhibited limited awareness about the SRH rights, issues and risks for women with mental health or intellectual impairments. Concern was expressed for women who “wander”, as they were believed to be at high risk of abuse by others. Health professionals also thought that family planning was a significant issue for women who “don’t have their right mind to think by selves...abused by others”. As outlined above, women were given DP and at times this may not involve informed consent.

One anecdote that was shared was that a few days before, when a woman with a mental illness was giving birth, she refused to push. In response, the health professionals present suffocated her until she pushed. This story is an indication of a lack of awareness of how to best support women with a mental illness when they are pregnant and giving birth. Without fully studying the case it is not clear what prior support the woman was given. But questions need to be asked, such as if the woman became pregnant as a result of rape, if she wanted the pregnancy and if she was given appropriate education and support throughout the antenatal period.

In relation to the psychiatric unit, the residential layout and conditions, as described above, give some concern for the safety and security of women residing on the ward. There is great potential for sexual abuse, both by other residents and by the orderlies. When asked about this, the health professionals did not think it was an issue. When asked about the development of relationships between residents, the response was that these were not encouraged and residents received “*discipline when we saw them*”.

Health Information and Services

The women with disabilities interviewed were most likely to go to health services when they were pregnant, for antenatal care or to give birth, and if their children are unwell. At other times, they will go when they think something is wrong with them, particularly if local medicine hasn't worked. One woman who reported visiting the nurse because she had felt lumps in her breast was sent away on the day she visited and asked to go back. She did not return because she was afraid. Another woman who had been referred to a specialist due to her breast lumps also did not attend because she was afraid.

None of the women interviewed had any knowledge of the signs or symptoms of STIs. Some women had some idea of how an STI can be contracted, including “*have lots of sex with many men*”, “*sleep with another man, you didn't know him*”, “*when you sex with another person*” or “*when you sex and didn't use condom*”. However, none of the women interviewed had a good understanding of how STIs were transmitted.

As outlined above, only three women had ever had a cervical smear and none knew about breast self-examination. Their knowledge of how to care for their bodies and what signs and symptoms to look out for was low.

The main barriers to accessing health care that women described were funds for the bus fare, challenges in physically getting onto the bus and having nobody else to care for their children when they went to the clinic. Almost every woman interviewed said that she wanted the nurse to visit her.

Given that women have a low awareness of contraceptives, little understanding of sexual health and challenges getting to health services, it may be useful for an outreach health service to be developed. The author's experience when interviewing women was that they were thirsty for knowledge on SRHR topics but had little understanding of how their bodies worked, how contraception worked and the issues surrounding STIs, sexual health, cervical and breast cancer. Women need support and encouragement on an ongoing basis.

Concluding Thoughts

There are individuals and organizations in Kiribati that stand out in terms of their commitment to people with disabilities and their drive for growing an I-Kiribati society that is inclusive. TTM is a strong organization. The gifting of land by the government has supported the people involved in TTM who are passionate, skilled and have a strong vision for people with disabilities. This land, as well as the TTM drama group, provides a unifying point for people with disabilities. One of TTM's volunteers has had training in women's rights. The School for Children with Special Needs and the Tungaru Centre at the MHMS are also strengths that Kiribati can build on to improve the SRH of women with disabilities.

In general, other organizations did not appear to think a great deal about the needs of women with disabilities, particularly in relation to SRH. Health professionals interviewed were often ignorant about disability issues and found it hard to answer questions about what might be particular issues women with disabilities would face. A lack of knowledge combined with negative attitudes about women with disabilities intersect with judgements attached to SRH issues, such as sexual relations outside of marriage, sexual violence and multiple sexual partners. These leave women with disabilities significantly discriminated and under-served in relation to SRH.

At the level of the general population, people with disabilities are discriminated against in Kiribati. People laugh at them and make incorrect assumptions about their capacities. However, at the village or family level, particularly when people understand the woman's disability, there are friends and family who are caring and supportive. Having said this, some women reported severe neglect and abuse by their families, which seemed to be underpinned by a sense of shame and ignorance.

The women interviewed stated that they enjoyed sexual relations when they were consensual and many were sexually active. Most of the women interviewed were married and had children, perhaps reflecting the large number of women interviewed in the over-25-year-old age group.

Despite this sexual and reproductive activity, women had low levels of knowledge in this area. The women interviewed made reasonably good use of antenatal care and hospital deliveries. Yet in relation to contraceptive use, sexual health, breast self-examination and cervical Pap smears, women need greater support, encouragement and assistance to practice behaviours that promote their health.

The need for support was expressed frequently in interviews, with a desire from women for health professionals to come to them, citing fear, transport barriers and finances as issues for getting to health services. The case of AMAK's workshop and Pap smear provision is illustrative. In this case, women were transported to a venue, given information and then had the immediate opportunity to have a cervical smear. All the women took this opportunity. But when they had to return for a six-month follow-up, none of the women had done this (at the time of interview). When women are sent away to come back some other time, they tend not to do so.

Women residing on outer islands are in particular need for improved access to information and services, as are those with significant disabilities. The liaison nurse in North Tarawa did not know the full definition of what a disability was, thinking at first that a disability was a physical one, such as a loss of sight or limb. After further discussion, other women were identified who had a disability, including a severely physically and intellectually disabled girl who was receiving limited professional input. This was despite great need. Similarly, back on South Tarawa, a woman with significant physical disability was receiving no professional support and her mother was her sole caregiver. The case of women with an intellectual or mental health disability is likely to be similar. They appeared to experience involuntary contraceptive use and comments by health professionals gave an impression of well-meaning but ignorant attitudes.

Many of the women interviewed experienced sexual violence and indications are that there is extreme social pressure around reporting or responding to violence at the hands of an intimate partner. This situation analysis suggests that further analysis of violence against women and girls with disabilities is required.

Kiribati Recommendations

The recommendations below should be read in conjunction with the “Recommendations for All Three Countries” above.

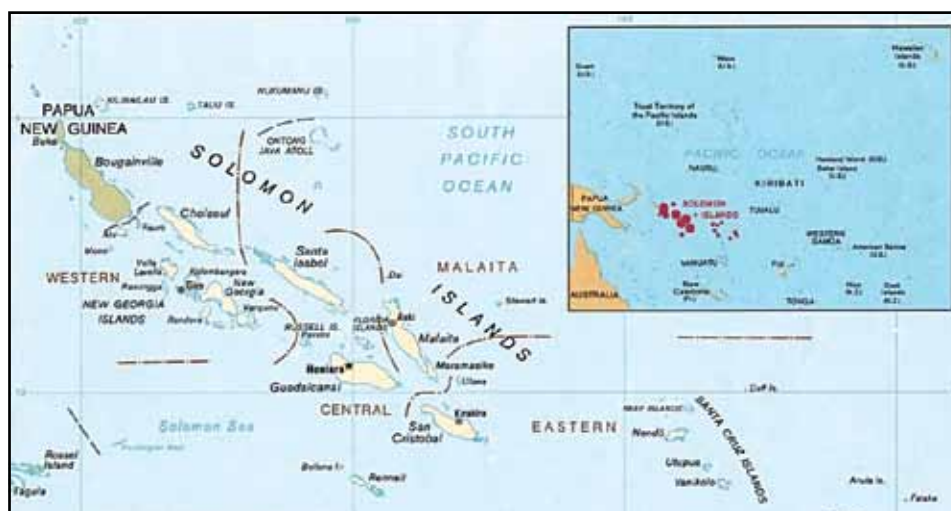
1. Training and Education.

- a. In line with Recommendation 4 above, support KFHA to implement education and services for women with disabilities, including outreach services to their homes. TFHA’s experience in the area of disability and sexuality could be utilized to support KFHA, considering that they are both members of IPPF. This should be done in close liaison with TTM.
- b. In line with the above, engage with the MHMS to support them to include training and mentoring in their efforts to improve outreach services to outer islands, and reproductive and sexual health services. This should include rights-based education on disability, and disability and sexuality.
- c. Also provide training to Tungaru staff and staff from the School for Children with Disabilities.

2. Policy and Legislation Advocacy.

- a. Engage with Te Toa Matoa (TTM) and the Ministry of Internal and Social Affairs to support the government to sign and ratify the CRPD, and to approve the National Disability Policy and, when implemented, to include findings from this situation analysis into the Constitution for Women.
- b. Engage with the Ministry of Internal and Social Affairs and TTM to ensure that the implementation of the Action Plan on Sexual and Gender-based Violence includes women with disabilities (especially the mass media or educational campaigns) and that TTM is represented in any governance body overseeing implementation of the Action Plan.

SOLOMON ISLANDS SITUATION ANALYSIS



About Solomon Islands

Solomon Islands is a Melanesian country made up of over 1,000 islands covering an area of 28,400 km². The country spans densely forested mountainous islands to low-lying atolls. It is divided into nine provinces — Malaita, Makira-Ulawa, Western, Choiseul, Temotu, Guadalcanal, Central, Isabel, Renbel, and one municipality — Honiara City Council. Honiara is the capital city. The most recent Census was completed in late 2009 and preliminary data released shows that the population of Solomon Islands is 515,870 people⁸⁵ and that it is a youthful population with a median age of 19.6 years.⁸⁶ There are more men than women: 264,452 males to 251,418 females.⁸⁷

Solomon Islands' people identified in the 1999 Census that they speak over 91 different languages⁸⁸ and the country also has its own pidgin sign language. Ethnically, Solomon Islands is predominantly made up of people of Melanesian descent; however, there are also small I-Kiribati, Polynesian, European and Chinese populations.⁸⁹ In terms of religion, there is a large variety of Christian denominations. The main Christian religions practised are Anglican, Roman Catholic, South Seas Evangelical, Methodist and Seventh Day Adventist, with smaller numbers of people belonging to Muslim, Baha'i and Jehovah's Witnesses faiths. In terms of human development, the Solomon Islands is ranked at 129 of 169 countries on the global Human Development Index.⁹⁰ This is situated just below Laos PDR and Swaziland, and just above Cambodia and Pakistan.

The Solomon Islands Government signed the CRPD in September 2008 and the Optional Protocol to the CRPD in September 2009.

People with Disabilities in Solomon Islands

The most comprehensive survey of people with disabilities in Solomon Islands was the 2005 *Solomon Islands Nationwide Disability Survey*, undertaken by the Solomon Islands MHMS, funded by the EU. As the table below shows,⁹¹ in 2005 there were 14,403 people living with a disability.⁹² The total number of people with at least one disability in the 2005 survey was an increase from the 1999 Census, which showed 11,107 people with disabilities (although different definitions may have been used, causing a difference in numbers).⁹³ Since 2005, the incidence of non-communicable diseases in the Solomon Islands has steadily increased. For this reason alone, it is highly likely that in 2010 there are even more people with disabilities, even taking into account deaths over this period. Light will be shed on this as the latest Census (2009) data is analysed and released, and through a revalidation of the 2005 Nationwide Disability Survey that is underway at present.

Table 3 | Population of people with disabilities in Solomon Islands, by region⁹⁴

Province	PWD Pop. (1999)	% of Total Provincial Pop. (1999)	PWD Pop. (2005)	% of Total Provincial Pop. (2005)
Malaita	3,571	32	5,161	36
Choiseul	559	5	1,376	10
Western	1,775	16	1,830	13
Isabel	479	4	590	4
Central	549	5	453	3
Renbel	131	1	134	1
Guadalcanal	1,624	15	2,427	17
Makira	807	7	1,209	8
Temotu	662	6	576	4
Honiara	950	9	647	4
Total	11,107		14,403	

In 2005, people with disabilities made up 3.52 per cent of the total population.⁹⁵ Some of these people have more than one disability, as there are 20,288 incidences of disability. Other key findings in the 2005 Survey are listed below.

- The most prevalent types of disabilities found in the 2005 survey are: vision (27 per cent); physical, such as leprosy, stroke, cerebral palsy or polio (20 per cent); and hearing (17 per cent).
- Most people experienced a moderate or severe impact on their lives due to their disability, with 82 per cent of those surveyed falling into this category.
- People over the age of 51 years comprised almost half of the people with disabilities at 48 per cent.

^vIn 2005, according to Solomon Islands' National Statistics Office, men comprised 52 per cent of the total population while women comprised 48 per cent. (<http://www.spc.int/prism/country/sb/stats/>, accessed on 20 December 2012)

- People aged 15 to 50 years comprised 26 per cent while people aged 60 to 70 years made up the final 26 per cent of people with disabilities.
- Of people with disabilities 45 per cent are women while 55 per cent are men.^{96,v}

Solomon Islands Legislative, Policy and Services for Women with Disabilities

Legislation

Draft Bill: Persons With Disability (Equal Opportunities, Protection of Rights and Full Participation) Bill 2006

The Draft Persons with Disability Bill (Draft Bill) is currently in its fifth draft. The draft bill requires a good deal more work, particularly to ensure it is consistent with the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child and the new, draft Solomon Islands Country Constitution.

In the draft bill, it would be useful to consider using a similar approach to defining disability as taken by the CRPD. That is, to recognize that disability is an evolving concept and is not only about an individual's disability, but also highly contingent on societies' attitudes and beliefs towards persons with disabilities. In line with this, the draft bill needs a strong section on the promotion of the rights of persons with disabilities, including public education. Finally, the draft bill will need to ensure that it incorporates the sexual and reproductive rights articulated in various other human rights treaties and conventions that Solomon Islands Government has signed, such as the International Convention on the Economic, Social and Cultural Rights.

Other Laws in Solomon Islands

This situation analysis did not have resources for a comprehensive and in-depth review of all Solomon Islands legislation; however, this would be a useful activity to conduct at some point in time. A brief review of Solomon Islands laws shows that, in general, the laws of Solomon Islands need to be reviewed to ensure that they are consistent with the CRPD. Overall, legislation appeared outdated and to exclude issues of disability. For example, the Penal Code refers to "imbeciles" and "idiots" and the Constitution does not refer to people with disabilities under grounds for protection from discrimination. While the Evidence Act has been updated, discussion with the coordinator of the sexual violence unit revealed that Solomon Islands needs a Victims Evidence Act as the current Evidence Act does not sufficiently provide for people

with disabilities. Also, there does not appear to be any legislation that covers the issue of sterilization, protection from enforced or nonconsensual sterilization or upon which (if any) grounds this could be acceptable.

Policies and Strategies

National Policy on Disability 2005-2010

The Solomon Islands National Policy on Disability 2005-2010 is about to be reviewed. Currently, it outlines a plan of action for Solomon Islands that, if fully implemented, could make a discernable difference for women with disabilities. There is a section devoted to women in the policy, although no specific mention of SRH issues. It would be timely to address this omission of SRH issues in the next review of the policy.

National Health Strategic Plan 2010-2015⁹⁷

The *National Health Strategic Plan* (NHSP) is a high-level document and does not include much detail regarding the delivery of health information and services. Having said this, it would be useful for the NHSP to recognize the specific needs of people with disabilities and that, consistent with the CRPD, their rights will be mainstreamed throughout the NHSP.

The NHSP situates itself on a foundation of principles for quality health information and service delivery, which implicitly relate to people with disabilities. The principle of “universality” outlines that all people residing in the Solomon Islands are entitled to the health services provided but recognizes that this does not equate to equal care. This acknowledges that potentially some people will require more care, such as women living with disabilities. The principle of “equity/ accessibility” recognizes that discrimination within the health services should not occur and lists some forms of discrimination, including “health status”, but does not list “disability”. Other principles, such as “quality and caring services” and “responsiveness”, if implemented, would assist in providing services and information that are good for women with disabilities.

The NHSP is heavily weighted towards a health promotion and population health approach, acting to reduce risk factors for and causes of disease. If effective, this approach will assist the long-term reduction in the number of people with disabilities due to preventative measures. However, there is little in the document that outlines the accessibility needs of people with disabilities, particularly in the area of health education and promotion, such as producing IEC that people who have visual or hearing disabilities can use. In the area of “do more rural water and sanitation systems”, there is no explicit recognition

of the needs of people with disabilities who, for example, are not able to carry water or who have special toilet needs. Similarly, there is no mention of the particular needs of women and girls with disabilities in the area of “do better reproductive health” or “do better HIV and AIDS prevention”.

The NHSP does include a reasonably strong focus on mental health. There is an explicit aim to “do better” in this area. This is important, as there does appear to be a current neglect of people with mental health issues. Prevention of domestic violence is also included in the document.

Community-based rehabilitation is also highlighted as a key strategy in the NHSP, although it is clearly stated that this will be a an uneven and under-resourced service. This is despite the fact that the CBR is essentially the only government programme doing anything in relation to disability, and because of this the CBR programme’s activities are extensive. Other programmes in the MHMS need to work to ensure that they are addressing the needs of women with disabilities, particularly health promotion, reproductive health and the HIV/STIs unit. The MHMS may need to review the mandate and resourcing of the CBR to ensure that it remains appropriate and has the capacity to carry out demands made of it.

Solomon Islands National Policy on Gender Equality and Women’s Development

The National Policy on Gender Equality and Women’s Development is implemented and monitored by the Ministry of Women, Youth and Children Affairs (MWYCA). The goal of this policy is to “advance gender equality and enhance women’s development, ensuring the active contribution and meaningful participation of both Solomon Islands women and men in all spheres, and at all levels, of development and decision-making”. The priority outcomes sought include:

1. improved and equitable health and education for all;
2. improved economic status of women/equal participation of women and men in decision-making and leadership;
3. elimination of violence against women and girls;
4. increased capacity for gender mainstreaming.

The policy makes no explicit mention of women and girls with disabilities as a group of women who experience a double burden of discrimination.

Having said this, listing all the different population groups of women and their individual experiences of discrimination would render the policy unworkable. Focussing on the five key priority areas will

assist in promoting and protecting the rights of all women, which if effective, could reduce some of the discrimination experienced by women with disabilities.

Yet, as one of the most marginalized and neglected groups of women, there is a need to explicitly recognize women with disabilities and ensure that a focus on their needs is mainstreamed throughout the implementation of the policy. It is highly likely that if action taken is “right” for women with disabilities, it will be “right” for other groups of disadvantaged women, such as older women, illiterate women and poor women.

National Policy on Eliminating Violence Against Women (EVAW)

^{vi} This Study was initiated and supported by UNFPA, co-funded by AusAID and implemented by SPC. It was the first-ever national representative study on violence against women in Solomon Islands.

The National Policy on Eliminating Violence against Women (Policy on EVAW) is a comprehensive response to the high levels of violence against women that were researched and exposed through the MWYCA and National Statistics Office’s *Family Health and Safety Study* in 2009.^{vi} The Policy on EVAW was approved by Cabinet in early 2010, and is subsidiary to the National Policy on Gender Equality and Women’s Development.

Women with disabilities are mentioned once in the National Policy on Eliminating Violence Against Women, recognizing their greater vulnerability, although the CRPD is not referred to. None of the five strategic priorities or the National Action Plan attached as an appendix to the Policy on EVAW outline any specific action for women with disabilities. As stated above, while action taken to improve the situation of all women may assist women with disabilities, it is important that the particular needs of women with disabilities are recognized in the Policy on EVAW. For example, discussion with the Royal Solomon Islands Police Sexual Violence Unit highlighted that often charges of sexual violence cannot be laid or taken to court for women with disabilities due to communication challenges, particularly related to gathering acceptable evidence. The need to address communication barriers highlights an area where women with disabilities may require specific responses and programmes.

Beyond this, it is important that any activity implemented under the National Policy on Eliminating Violence against Women and its National Action Plan include or mainstream women with disabilities. For example, in national advocacy and educational activities, images and stories of women with disabilities must be included so as not to marginalize women with disabilities further, and also to raise the awareness of the general population that women with disabilities have a right to live free from violence. Activities in schools need to include schools such as Bethesda, Red Cross and San Isidro. Action to analyse and reform laws must ensure that the rights of women with disabilities are included, and special needs, such as in the provision of evidence,

are well thought through. Law and justice workers need specific training on who they can contact to support women with disabilities who have experienced violence, and how to address their particular needs. Similarly, support services, such as the Christian Care Centre and Family Support Centre, need training and support to assist women with disabilities.

National Education Action Plan 2010-2012

The National Education Action Plan (NEAP) explicitly included an objective to “improve equal access to all levels of education for students and people with special needs”. The associated output for this was the “provision of education for people with special needs”. The two key activities planned to assist in achieving this output and objective were to “undertake an independent review of provision of education for people with special needs (especially children)” and “define special education in Solomon Islands context, following the independent review, and develop a national policy and an action plan for inclusive education”. A study on barriers to education carried out in 2010 also examined issues of disability and how this impacts on educational attainment of people with disabilities.

The NEAP outlines plans to upgrade school infrastructure, such as buildings, dormitories for girls and sanitation facilities. This is an excellent opportunity to ensure that schools have a built environment that enables people with disabilities to access the physical infrastructure, and that facilities promote the personal safety and dignity of people with disabilities.

School is one of the places identified in this situation analysis where women with disabilities learnt about SRH. The NEAP discusses introducing life skills into primary education and the ongoing development of a health curriculum. Without viewing the curriculum, it is difficult to say whether or not it includes comprehensive, evidence-based and age-appropriate components on sexuality, sexual and reproductive anatomy and physiology, relationships and SRH. However, an assessment carried out by the Regional Adolescent Health and Development programme indicated that it is unlikely that the health curriculum incorporates these important areas of health education and the capacity of the education sector to do so was low.⁹⁸ Positively, the same assessment highlighted a commitment within Solomon Islands to provide a curriculum that ensured that all young people could enjoy their right to sexuality education.

As increasing numbers of children and youth attend school, including girls with disabilities, it is vital that an age-appropriate, evidence-based health and life skills curriculum is developed. This should make use of simple language, pictures, models and other tactile materials,

and participatory learning, to ensure that girls (and boys) with disabilities in schools can learn about female and male bodies, changes in puberty, relationships and sexuality, reproduction and SRH. These sorts of learning materials and practices are also good for children and youth who do not have disabilities, catering for different learning styles and needs.

Services/Programmes for Women with Disabilities

There are two main entities in Solomon Islands that are at the centre of addressing disability issues in the country. These are the non-governmental organization (NGO) People with Disabilities Solomon Islands (PWDSI) and the Community-Based Rehabilitation (CBR) programme of the MHMS. There are three other key institutions: the Red Cross school, San Isidro Vocational and Sign School, and Short Workshops in Mission (SWIM). The Solomon Islands School of Higher Education is also implementing a course in CBR.

People with Disabilities Solomon Islands (PWDSI)

People with Disabilities Solomon Islands is a small NGO established primarily to act as an advocate for people with disabilities and their issues. One of the key issues PWDSI is working on is promoting the Convention on the Rights of Persons with Disabilities. PWDSI has self-help groups established in several provinces, which act as a localized community group to provide support and education for people with disabilities. PWDSI has a very important role to play in advocating for, protecting and promoting the rights of people with disabilities.

Community-Based Rehabilitation (CBR)

The CBR programme within the MHMS has a network of CBR coordinators, field workers and aides across the country (approximately 23 people). They work to carry out activities that ensure people with disabilities are rehabilitated within their own communities and assist people with disabilities to live healthy and productive lives in their communities. Further to this, it appears as though the CBR has become the key government focal point within the country for the coordination and implementation of activities for people with disabilities. For example, individuals within this programme are driving the development of the Draft Persons with Disabilities Bill. The CBR programme does not do any specific work in the area of SRH, and the subject was new to staff.

There are also other departments within the MHMS that provide basic and limited services for people with disabilities. These are the TB and Leprosy Unit, and the Rehabilitation Division at the National Referral Hospital in Honiara. These services are provided only in Honiara, Gizo and Auki, and are not accessible to the other provinces.

Diploma in Community-Based Rehabilitation, Solomon Islands College of Higher Education (SICHE)

The Diploma in Community-Based Rehabilitation is a new course that builds on the previously available Certificate, offered through the Solomon Islands College of Higher Education (SICHE). The diploma had not yet run at the time of the situation analysis but was planning its first intake in 2011, with priority given to individuals already working for CBR. The aim of this course is to develop a sustainable cadre of trained CBR aides and staff throughout the country, to raise the quality of service they provide for clients. The course content is comprehensive and includes reproductive anatomy in the anatomy and physiology section, and modules on community assessment and community awareness raising. The section on intra- and inter-personal skills includes a focus on the self-confidence and self-esteem of clients, which is central to good SRH. Overall, however, the course content could be strengthened in relation to the important issues of SRH.

There is scope to integrate information on SRH into the course content. In particular, areas that could be considered include:

- Training CBR aides to feel confident in discussing issues of sexuality, sexual relationships and SRH (including violence) with their clients. CBR aides do not need to be experts in this area — they could be making referrals to nurses working in SRH. However, CBR aides need to be aware of the issues, in particular that people with disabilities are sexual beings and have a right to enjoy healthy relationships just like anybody else, and CBR staff need to be able to discuss these areas with their clients to identify possible areas for assistance.
- CBR aides need to be trained to understand human rights and the law, and to assist their clients and their families in keeping themselves safe from abuse and violence, who to go to for assistance or help if they do experience violence of any sort, and negotiating condom use and sexual relations.
- CBR aides also need to be able to offer their clients and their families support in understanding how their bodies work, and managing menstruation and menopause.
- The full content of the course was not able to be viewed; however, the anatomy and physiology section should include human sexuality and relationships, and identifying sexual and reproductive pathophysiology so that the CBR aide can recognize potential problems and refer on for further assistance.

Short Workshops in Mission (SWIM) and Bethesda

SWIM is a faith-based organization based near Honiara that saw a need for people with disabilities and responded by giving resource support, as well as assisting some people with disabilities to access housing, toilet facilities and water tanks. SWIM has established a disability training and support centre, called Bethesda. This Centre is a residential training centre for people with disabilities who are interested in expanding their vocational and life skills. The centre also offers training for family members and disability workers in caring for people with disabilities. The primary focal population is people with physical disabilities. While the vocational course for people with disabilities includes a health education component there is currently no SRH component. The centre has a conservative Christian philosophy and while CBR have offered some education on SRH for the students, SWIM personnel have requested to view and vet the material that will be used in this education prior to giving permission. This request is reasonable and does not necessarily constitute a problem. It would be a problem in the instance that ideological reasons prevented the teaching of evidence-based, age-appropriate information to students who want to learn.

Red Cross

The Red Cross Special Development Centre based in Honiara is a school for children with a disability and teaches sign language. Students live locally. The school also carries out some outreach within its vicinity. One of the teachers runs a short session on SRH for the young women in her class. However, the school does not have any special resources or an established curriculum for this education.

San Isidro

San Isidro located in Aruligo, West Guadalcanal, is a church-based vocational residential school for young adults who have hearing and speech disabilities. Students come from around the country to attend the school. Here they learn sign language and also livelihood skills. The school does not have an established educational module on SRH but recognizes their students' needs for this.

Others

There is a wide range of civil society organizations working in Solomon Islands, both locally grown and international. Several of these were visited for this situation analysis. In terms of SRH, the Solomon Islands Planned Parenthood Federation is the main local NGO that offers clinical and education services throughout the country. They do not currently do any work with women with disabilities. In relation to working in the area of disability, one NGO offers a wheelchair placement programme, in collaboration with CBR. In general, other organizations do not have any specific programmes for people with

disabilities. However, all stakeholders interviewed had a desire to mainstream disability issues and were either working to find ways to include people with disabilities in their work, or beginning to grapple with how best to do this. The need to involve and include people with disabilities was well recognized. Agencies simply require more information, support and guidance on the best approaches, and support for action.

Experiences of Women with Disabilities

General Characteristics of Women Interviewed

The following section is a summary of the information received through the 39 interviews with women with disabilities. As the table below shows, the women interviewed spanned all age groups and disability types. Women resided in Honiara and Guadalcanal, Makira or Western Province, as these were the key areas visited for this situation analysis. Despite efforts to get out to rural women, the largest number of women interviewed resided in the area of Honiara City Council. In terms of disability, the number of women interviewed with a physical impairment, including polio, was the greatest. Women with a speech and/or hearing impairment comprised the second largest group of interviewees. Anglican, Seventh Day Adventist and Roman Catholic religions made up the majority of the religions of the women interviewed, with South Seas Evangelical and the United Church following behind.

Table 4 | Age, residence, disability type and religion of women interviewed

Age (years)	Number of Women	Percentage %
15-24	12	31
25-34	10	26
35-44	11	28
44 and over	6	15
Place of Residence		
Guadalcanal and Honiara City Council	19	49
Western	11	28
Makira	9	23
Disability Type		
Physical	20	48
Sight Impairment	2	5
Speech Impairment	3	7
Speech and Hearing Impairment	9	21
Intellectual	7	17
Mental Illness	1	2

Age (years)	Number of Women	Percentage %
Religion		
Anglican	9	23
Roman Catholic	7	18
South Seas Evangelical	4	10
Seventh Day Adventist	8	21
United Church	6	15
Christrian Fellowship Church	2	5
Jehovah's Witness	1	3
Baha'i	1	3
No response	1	3

Of the women interviewed for this situation analysis, the majority had attended some primary school: the average number of years attended was four. Of the women interviewed, six had attended secondary school, with an average number of years attended of four. Only three women had attended tertiary education: two of these women had trained to be teachers.

Attendance at primary school in Solomon Islands is not universal for all children. Rurally 38 per cent of girls had attended some primary school compared to 37 per cent of boys, and 17 per cent of both sexes had completed primary school.⁹⁹ In urban areas there is a larger difference, with girls attending and completing school at primary level slightly more than boys. Yet at secondary school level the numbers are reversed, with 30 per cent of girls completing some secondary, but 34 per cent of boys.

For girls and boys with a disability, the 2005 Disability Survey numbers show much greater disparities between boys and girls, with boys doing better. For primary school, 59 per cent of male respondents had attended compared to only 41 per cent of female. At secondary school the respective numbers were 70 per cent male and 30 per cent female. For other schools (presumably such as the Red Cross school and San Isidro), the gender difference remains with 64 per cent of males with disabilities attending other schools and only 36 per cent of females with disabilities.¹⁰⁰

These numbers clearly show disparity between boys and girls with disabilities in terms of educational attendance, at all levels, with girls faring much worse. Comparing the per centage of girls with disabilities to girls without disabilities, at first glance it appears that girls with disabilities have actually attended school more often. However, the statistics do not enable more detailed analysis due to the fact that for girls with disabilities the only measure available is whether or not they had attended at some point in time. This measure gives little information about completion or the quality of education received.

General Health Behaviours

Alcohol, Smoking and Betelnut

Very few women interviewed had ever drunk alcohol, with only four women drinking alcohol on the odd occasion but never during pregnancy. One woman reported occasionally binge-drinking at parties, and this tended to result in unsafe sexual behaviour. Similarly, very few women smoked. One woman was reported to “sit and smoke all day” and had smoked during pregnancy. One other woman smoked “a few cigarettes a day”. Both these women had significant intellectual disabilities. Four women had smoked a cigarette once or twice, just to see what it was like.

Most women had never chewed betelnut, with only nine women chewing regularly. The impact on SRH of chewing betelnut is not well documented. Betelnut is a known carcinogen and there is suspicion it may contribute to the development of cervical cancer, although this has not been thoroughly researched. Betelnut contributes to poor oral health, including ulcers. Speculative thinking proposes that chewing betelnut may be associated with an increased risk of oral infection of STIs, including HIV, through oral sex, due to the presence of mouth ulcers, although no documented research could be found to substantiate this claim.

Diet

It appeared that most of the women interviewed did not consume an adequate diet containing all the major food groups. This could be due to income and food availability, ease of preparation (as highly processed, carbohydrate-loaded foods are simpler to cook) or a lack of choice about what to eat. One woman commented:

“We are always told to go last when getting food or given the worst food”.

Without making a comparison with all women in Solomon Islands it is not possible to conclude whether the women with disabilities interviewed consume a poorer diet than other women. It did appear that the women interviewed ate what their family ate, so it is likely that in terms of composition of diet, women with disabilities eat similarly to their families, although the comment above highlights potential discrimination. General comments from various stakeholders, along with increasing rates of non-communicable diseases,¹⁰¹ indicate that nutrition among the general population is poor and it is possible that the women interviewed are generally consistent with the wider population in terms of low consumption of fruit and vegetables, and protein.

Water and Sanitation

In terms of access to running water, 12 (31 per cent) received water through a tap in their house. All but one of these women resided in Honiara. The remaining women either used a public standpipe or outside tap, or rainwater. Only one woman had to walk some distance (20 minutes) for water. The quality of this water was not assessed for drinking. In terms of hygiene, while it is good that women had access to water close by, the fact that they would have to fill containers and carry it to their homes for use presents challenges for women with physical disabilities. Having to wash in public places also presents safety issues (also see Sexual Violence).

Of the women interviewed, just under half did not have a toilet, so used a bush, the sea or a river, and two women had a pit toilet. Well over half of the women interviewed had a modern, plumbed toilet of some sort. This appears much better than the nationwide situation, where 60 per cent of households do not have access to an improved or non-shared sanitation facility.¹⁰² Even when separating out rural dwellers from urban dwellers, the women with disabilities interviewed do better than the general population. For all rural households in Solomon Islands, only 10 per cent have access to improved and not-shared sanitation facilities. Just over half of the women interviewed resided outside of Honiara, Gizo or Kira Kira. Of those women interviewed who live in rural locations, 20 per cent had a plumbed toilet. One of the activities of the CBR programme is to assist with water and sanitation, and is possible that this is why the women with disabilities interviewed have access to improved sanitation facilities more than others.

For women who did not have a toilet at close hand, it was a significant issue for them.

“Pikinini [children] go with me because it is a long way and I might fall”.

“I always go with her to the toilet because I am afraid of what might happen to her if she goes alone”.

The fear of assault or rape while women were visiting the toilet or washing was a concern expressed by several of the women interviewed or their family members. One woman had been raped while washing.

Community Attitudes

Most women interviewed stated that while they felt accepted and treated well among family and friends, in many instances the wider community did not respond to them in the same way. Several women reported being imitated or made fun of.

“Sometimes I feel like people look down on me because I am deaf”.

“I had a hard time when I went to secondary school. It was away from my village and the kids there gossiped about me and told stories. But my parents and relatives encouraged me. My dad talked to the teacher who talked to the students, and then it was OK”.

“...Some long term friends look at me differently now...the chair makes a huge difference — people look at me strangely. People treat me differently now — more negatively. But how you react is important to educating others — if they knew more they could be more understanding”.

From a positive perspective, what these comments imply is that if people knew or understood more, they may be less likely to make derogatory remarks and discriminate against women with disabilities. Nevertheless, until broader community attitudes change, women will continue to experience discomfort and the pain of feeling inferior or being made fun of.

Some of the women interviewed were engaged in community activities, such as attending church and/or youth groups. The most active women interviewed volunteered for a local persons with disabilities organization and almost half of the women had, at some point in time, had a job that earned them money. However, only three of these women were currently working and two were informally selling goods they had produced.

Several stakeholders interviewed had an understanding that women with disabilities have the same rights as any other individual, including the right to have sexual relationships and become a parent if they chose. However, at times this was accompanied by ideas that it is hard to be a parent and that the woman will need a good husband to help her. Some individuals told stories that highlighted a disapproval of women with disabilities who have children — that somehow this was not right. Yet for one older woman interviewed, she believed that having children changed how she was viewed in the village:

“People used to treat me badly and not include me. But it is different now. Now I am a grandmother and have two sons and six grandchildren. Now I am treated well”.

Overall, there was a general sense that emerged — both from the women interviewed and from stakeholders — either that women with disabilities should not get married or have sexual relationships, or that men would not want a woman with a disability. Several of the younger women interviewed said that they did not want to get married and have children. While this may be a normal attitude for women of their age, on further probing some responded that they felt this way because they had a disability and thought that nobody would want them. One young woman interviewed hinted at the influencing factors on feelings and thoughts women with disabilities have regarding relationships:

“People with disabilities, we have the same feelings as everyone else...We want to get married...only one thing is support from health workers and communities”.

Several parents certainly held the view that their child would not or should not get married, and needed to be protected from men.

“My parents told me not to get married because of my disability...but I found a nice man”.

Underlying this belief is likely an assumption that women with disabilities are asexual and do not have the same sexual feelings as other people, or the same desire for an intimate relationship. Reported comments from reproductive health nurses at a workshop on gender-based violence highlighted that at least some of them, too, held beliefs that women with disabilities either could not or should not have sexual relationships and have children. As outlined earlier in this report, global research supports the prevalence of this view, including that women with disabilities are asexual.^{103,104}

Yet this perspective was not held by all people interviewed. Some parents recognized that their children were, and are, in relationships with boys, and had been sexually active. This was particularly so for the younger women interviewed. One interview with a young woman who was deaf and mute, and her mother, showed their openness to discuss sexuality and sexual relationships with surprising frankness. The young woman shared her enjoyment of sex through her mother as a translator. In turn, her mother shared how after her daughter's first pregnancy she had requested the nurse insert an IUD into her daughter, without her daughter's knowledge, but this time, after the second pregnancy, mother and daughter had discussed the situation and agreed on the use of DP instead.

The Significant Role of the Family

Families appeared to be the most significant influence in the lives of the women interviewed, particularly immediate family (parents, siblings and/or husband). Almost every woman interviewed had a close relationship with at least one family member, usually a mother or husband, but sometimes both parents, a sister or an adult child. This relationship was central to the woman's support, feeling of acceptance and love, and access to resources, services and information. For women who were deaf and/or had speech disabilities, and for those with intellectual disabilities, this significant relationship was often their primary means of communicating with the world.

Esther and John have been together for over sixteen years, and became a couple in their late teens. Esther is not able to speak, although she has some ability to hear. They have their own form of communication, which is a mixture of body language, lip-reading and their personal sign language. Sometimes John finds it hard because he has to assist with everything. He is scared that people at the market will cheat Esther so he goes with her, and he always has to be with her to communicate with others, even though he works night shifts in his job. Esther has some friends and family in the village, but John is her main source of support, assistance and communication with others.

When this significant other was no longer with the woman, or if her family were not supportive, she tended to express feelings of isolation during the interview.

"I have six brothers and sisters but they have all got married and moved away. So I live with my niece. She works in the garden. I sell cigarettes and weaving, but sometimes I feel worried because my niece gets angry at me because I can't work. If I have a problem or feel sad I talk to the pikinini [children]. Sometimes I just wish I was dead".

"I come from a broken home. My mum has a new husband in Australia and she lives with him there. He pays for me to go to school. But I worry a lot, about who will feed us and help us — my brothers and sisters and I. We live with our cousin sister and her husband. I worry a lot and wish that my mother was with us because she would look after me. I feel very sad because I miss my mother".

Families of women interviewed in this situation analysis exhibited a protective character that spanned a continuum from over-protective to neglect — the latter appearing to stem from an inability to know what to do, rather than malign intent. Many families sat in the middle of this continuum. In interviews with young women who had hearing and speech disabilities, and who were attending school, their families

appeared to be giving the young women the space and freedom, as well as the opportunities, they needed to grow and develop. This was similar for several other young women who had mild physical disabilities.

Other families were more protective, sometimes based on a fear that the woman would be raped or harmed when alone. In several cases this fear was vindicated when women interviewed who were alone had ended up being raped or sexually abused — either in their home or when walking about the community. In most families this then resulted in a greater fear and worry for the main caregiver (see below under Sexual Violence).

While the tendency towards over-protection has no doubt resulted in a safer life for some of the women with disabilities, and may be appropriate in some cases, it also acts to prevent women from reaching their full potential and gaining equal opportunities in life. At times this protection is misplaced and may be based on underlying assumptions or a lack of knowledge about the abilities of women with disabilities, such as about their ability to engage in healthy intimate relationships or to function independently.

Christine is 17 years old but due to a congenital deformity her body has not grown or matured — she looks about 10 years old. However, she is menstruating, and her intellectual and mental development is consistent with her biological age. Yet she speaks with a baby voice and her parents talk about her playing with other children. Her mother stated that Christine was not fit to have a husband and babies.

Gertrude is now in her late 40s. She was born in a canoe and at about six or seven got sick. After this she felt weak and found it hard to get up. Diagnosed with polio, Gertrude is physically independent, but can collapse from time to time. Gertrude has never had a boyfriend or engaged in any sexual activity. For 10 years she has been living with her brother and his family, and works around the house cooking, cleaning and looking after the children. She has no friends where she lives and desperately wants to go home. But her mother says Gertrude should stay with her brother, so that he can keep an eye on her.

Older women interviewed who had not been married, or who were now widowed, relied on their children to assist them. In all cases this support was given, but it was sparse, particularly in terms of material items and assistance. This may be a symptom of impoverishment, possibly intergenerational with the loss or absence of a male breadwinner in the family (when men were traditionally the income earners). However, it could also be a symptom of neglect.

“I ask them [the son and daughter-in-law] to build a toilet for me but they won’t [she is blind and it is difficult to walk into the bush to use the toilet]. I have to ask them for everything. They feed me and give me a house to stay in, but if I want to wash my clothes I even have to ask them for soap”.

The families of women with a significant intellectual or mental disability who were interviewed appeared to struggle to know how to best support and maintain the safety of their relative (mother, daughter or sisters). They did their best, but were not equipped with the skills or resources to help promote their relative’s safety within a community where men rape with impunity. It is these situations where the woman is under-protected.

Sexual and Reproductive Health Experiences

Menstruation and Menopause

Of the women interviewed, six had gone through menopause. The vast majority of women learnt about their period from their mother, a female relative or a friend. The majority of women managed their own period, although one mother reported having to assist her daughter, who did not like wearing kalico (cloth) or pads.

Women who had gone through menopause tended to accept menopause as something that just happened, although they weren’t necessarily expecting it (i.e. they had not been given prior information about it). Two discussed their menopause with a nurse, while one read about it in a book and one discussed it with her sister.

Intimate Relationships

Well over half of the women interviewed, spanning all age groups, had never had an intimate relationship. Throughout the period of their lives, only eight had been married at some point. This contrasts with one study in Solomon Islands that found that 56 per cent of women attending antenatal care, aged 15-44 years, had been married at some stage in their lives. While not representative of all women with disabilities, or directly comparable, these numbers give some indication that women with disabilities in Solomon Islands may follow trends found elsewhere, in that women with disabilities are less likely to be married than other women.

Three women interviewed had acquired their disability while they were married. Of these three, two of them had their husband leave them after they acquired a disability and the women believed that this led to their husband’s departure.

“He’s healthy and I’m not...I think he is embarrassed of me”.

Of the women interviewed who were currently married or widowed, their husbands were generally a great source of support for them. Even for the women who were separated, their husbands were initially supportive in the early stages of rehabilitation. Having a supportive husband made life much easier for women with disabilities, and gave them support and resources they would not otherwise have.

However, not all relationships were easy. Of the two women who had attempted suicide (by taking chloroquine) both were due to relationship problems. One other woman requested advice from the interview team on how to nurture a healthy relationship with her boyfriend. This gives an indication of the challenges faced by women, and their need for more support and information on managing intimate relationships.

First Sexual Experience

Of all the women interviewed, 18 had sexual intercourse for the first time between the ages of 15 and 24 years. Five women had their first sexual intercourse under the age of 15. Twelve women had never had sexual intercourse and four women were not able to respond to the question but had been sexually active at some time in their lives. The average age of first sexual intercourse was 20 years. This is a little older than the average age of first sex of 17.3 years for women aged 15 to 24 years, and of 18.3 years for women aged 25 to 44 years, as found in 2008 in the *Second Generation Surveillance Study of Antenatal Women and Youths*.¹⁰⁶

Of the women interviewed who had experienced sexual intercourse 40 per cent (11 women) of women’s first sexual experience was by choice, while the remaining 60 per cent (16) had been coerced or forced. While representative only of the women with disabilities interviewed, this number is higher than that found in the 2009 *Family Health and Safety Study*, which found that for 38 per cent of women their first sexual experience was coerced or forced.¹⁰⁷ Separate from these numbers, two interviewees’ first and only sexual experience was sexual assault, but not involving penile penetration.

During the interviews, some of the women commented that for their first sexual experience, men asked them and asked them, and finally they said “yes”. These responses were classed as consensual, although they sit on a fine line between consent and coercion. It is not inconceivable that women get tired of being harassed, or are afraid that they may be forced, so the safest approach may be to simply consent, although they do not really want to.

Emotional blackmail was also used to coerce women:

“He asked me and said that if I loved him I would do it. So I said “yes”. It wasn’t much fun. I was scared. The whole time I was thinking “What are you really doing to me?” I was shaking...We didn’t use condoms. He didn’t want to. But I did ask him about whether he had anything [STIs]...I was scared of getting pregnant”.

There is further discussion below on sexual violence.

Consensual Sexual Relations

Several of the women interviewed (15) had experienced consensual sexual relations at some point in their life, and many of these women had had two or more consensual partners throughout their sexual life. This is not out of the ordinary for all women in Solomon Islands. The Second Generation Surveillance Survey of 2008 found that for antenatal women aged between 15 and 44 years, the mean number of partners across a woman’s lifespan was 3.8.^{vii,108}

^{vii} The Survey found a mean number of partners of 4.4 for women aged 15-24 years and for women aged 25-44 a mean of 3.8. However, the younger age group had one woman who reported 82 partners. When this is removed, both age groups have a mean of 3.8 partners.

Importantly, the majority of the women interviewed who had ever consented to sex at some point in their life enjoyed sexual relations. This highlights the well-known fact that women with disabilities can enjoy sex just like everybody else.

Contraception and Consensual Sexual Relations

The 2007 Solomon Islands Demographic and Health Survey found that of all currently married women aged between 15 and 49 years, 27.3 per cent were using a modern method of contraception. Options available in Solomon Islands include vasectomy, tubal ligation, contraceptive pill, DP, male and female condoms and intrauterine devices. Other options are lactational amenorrhea method (LAM), natural family planning and abstinence.

For all women in Solomon Islands, tubal ligation is the most popular form of family planning, with 13 per cent of women having undergone this operation.¹⁰⁹ The next most popular form of contraception is the DP injection at 9 per cent, followed by intrauterine devices (IUDs) and male condoms at 2 per cent.¹¹⁰ Traditional methods are used by 7 per cent of all Solomon Islands’ women, including natural family planning (also called “counting” by women).¹¹¹ For unmarried women in Solomon Islands, the most popular form of contraceptive is the male condom: 14 per cent of the 16 per cent of unmarried women who use a modern contraceptive, use condoms.

The women interviewed in this situation analysis made contraceptive choices that were somewhat similar to those of all women in Solomon Islands.

Among women interviewed the most common contraceptive used was tubal ligation, the same as for all Solomon Islands women. All four of these women had been, or were, married, and only one woman's husband had made the decision for her to have a tubal ligation before discussing it with her. The other three made the decision themselves, in discussion with their husbands. The use of this method was associated with a decision not to have any more children. Three of the four women who had a tubal ligation had previously used an alternative form of contraceptive to assist in spacing their children: one had used counting, one an IUD and one DP.

Of the remaining five ever-married women, three had not used contraception during their marriage — despite two of them not wanting to get pregnant — and two had used counting. One woman had sexual partners other than her husband but did not report using condoms. The majority of women discussed their family planning choices with their husbands. Only one woman had used DP, which is the most popular method of non-permanent contraception used in Solomon Islands (this was also found in a survey conducted in 2006¹¹²).

For the eight currently single women who were sexually active, three were using condoms, although not consistently. This is similar to the national data where unmarried women use condoms more than any other contraceptive. One woman interviewed had used an IUD and was about to commence on DP. One woman had used withdrawal, but had become pregnant as a result of this sexual encounter. Three women were using no form of contraception, despite having multiple partners throughout their lifetime and not necessarily wanting to get pregnant.

In general, there appeared to be a belief among women interviewed that contraception is only for married woman, presenting a barrier for young women. As one young interviewee put it when asked about family planning:

“That’s only for married women...husbands have a lot of sex and you never know when it is going to happen”.

Another barrier to the use of contraceptives is the fear of side effects.¹¹³ This is a common concern for women in Solomon Islands, which was also highlighted in this situation analysis:

“...heard about them from friends and that you can get bad bleeding...so I didn’t want to use them...”

Overall, for women who consented to sexual intercourse, their use of contraception was generally inconsistent and poorly informed. For women who were married, most were content having children but at some point in time had tried to space their pregnancies, although few women used a reliable method to achieve this.

“I was worried about getting pregnant during sex but was just ignorant of family planning. I didn’t really think about it”.

John and Esther used the injection (DP) for several years to delay and space their children. After their last child, which was an emergency case, they decided they had enough children and asked the doctor to do a sterilization.

Involuntary Contraceptive Use and Sterilization, Often Related to Rape

To be used ethically and without human rights violations, contraception requires the full and informed consent of a woman. In Solomon Islands it is a legal requirement that a husband must provide consent for his wife to undergo a tubal ligation, and at times this can effectively “coerce” a woman into having a tubal ligation, or prevent her from having one if she chooses to.^{viii} However, for five women interviewed, the scenario did not involve a husband. For these women, at some point in their life they had been “using” a contraceptive method without their full and informed consent.

Three of the women interviewed had undergone a tubal ligation by instigation of either a close female relative (sister and mother) or a doctor. One woman’s mother had arranged for an IUD to be inserted into her daughter without the daughter’s knowledge, while another woman had been given one dose of DP without giving her full informed consent. In all cases, the person taking this action did so because they perceived that the woman was not in a position to control whether or not she had sexual intercourse, assumed she was not able to give informed consent or did not seek her informed consent, and wanted to help her by ensuring she did not have unwanted pregnancies.

All five of these women had been raped, three, possibly four of them, repeatedly. Three of these five women had an intellectual disability. A fourth was not able to speak and was thought to also potentially have some degree of intellectual disability.

In this situation analysis, four women with an intellectual disability had become pregnant as a result of a rape, two of them multiple times. Rapes were generally not reported to the police, despite the fact that they are a severe violation of both women’s rights and the law (unless it is rape within marriage, which remains legal in Solomon Islands). (See the section on Violence below for further discussion.)

^{viii} This was reported to the author although the specific reference in Solomon Islands legislation could not be found. Yet the *Solomon Islands Evidence-Based Guidelines in Family Planning for Health Personnel, 2005*, state that “the Ministry of Health and Medical Services expects that a consent form for sterilization will be signed by both husband and wife” (p. 82).

The issue of involuntary use of contraceptives is a very challenging one. It came up in stories from nurses and stakeholders, revealing that the community believed that a woman with an intellectual disability who was regularly raped, or who was viewed as vulnerable to unwanted sexual relations, was in need of contraception. Families and communities did not seem to believe that they could take any action to prevent or stop the rape, or that the woman would be able to understand to consent, but this issue was not explored in depth.

Several stakeholders interviewed (separate to the individual women interviewed) related “stories” they had heard regarding a local woman with an intellectual disability who was regularly raped by local men, and had become pregnant as a result. In order to protect the woman, and presumably any potential future children, the family or community, or medical practitioner, had made the decision to give the woman a tubal ligation. In the case of the women interviewed, while this decision was sometimes conveyed to the women themselves, their level of understanding, and the potential subtle coercion involved, is likely to have prevented the women from giving informed and full consent.

Coerced or forced sterilization and/or use of contraception is a human rights violation. On the other hand, it can also be seen as a pragmatic response to a situation that is unlikely to change in the short term. Changing men’s violent sexual behaviour will require significant investment of resources in behaviour change campaigns and will take many years of sustained effort to achieve. As one interviewee said of her relative with an intellectual disability who was raped repeatedly by local men:

“She tells my auntie and then my auntie goes and yells at the men, but it doesn’t stop them”.

Compounding this problem is the challenge that both families and medical professionals appear to have in communicating with women who have significant intellectual disabilities. All people involved in the care of these women appeared to have a limited understanding of their developmental and cognitive abilities, appropriate ways of communicating with them and how to assist the woman or to manage her behaviour. This means that even if women were able to give their full and informed consent, it is possible that they are not given the opportunity to do so.

As stated above, one woman was not given a tubal ligation, but was instead given DP. This response, while still a violation of the woman’s right to give full and informed consent, is less of a violation of her rights than tubal ligation because it is not an invasive, permanent

method of contraception involving surgery. DP may be a better alternative to tubal ligation to protect the woman's rights in a society where men rape with impunity. Regular DP injections also mean that the woman will be making contact with a health professional regularly. A drawback of this approach is that the women would need to be taken to receive the injections regularly and this could be a challenge, unless the nurse visits her. It must also be noted that no non-barrier method of contraception will give any protection from STIs. Having said all of this, priority must be given to upholding the woman's rights and legislation is necessary.

Termination of Pregnancy

Termination of pregnancy is a taboo subject in Solomon Islands, although it is known to occur, as is suicide due to an unwanted pregnancy.¹¹⁴ During the interviews, only one woman responded that she had contemplated a termination when she discovered she was pregnant:

“When I got pregnant I was ashamed and thought about it [doing something to make the pregnancy go away], but I thought I would be punished later if I did anything...and other women encouraged me and said it would be alright [to have the baby]”.

Nine women had 13 pregnancies as a result of a rape. All of these women carried their pregnancies through to live births, with one exception. It was not possible to ascertain exactly what had happened in this exception, but it seems likely that the woman gave birth very prematurely and the baby died.

There is a strong case to be made to reform the law on termination of pregnancy. Currently, the law stipulates that an abortion can only be undertaken to preserve the mother's life. Furthermore, it appears that written consent is required from a spouse, next of kin or parents if the woman is a minor.¹¹⁵ Both the inability to obtain an abortion in the case of rape (and/or incest), and the requirement for permission from a spouse or parent, is a violation of women's rights, and contributes to further discriminations against women with disabilities who may have challenges in communicating their wishes (or in being appropriately listened to).

Pregnancy, Antenatal Care (ANC) and Children

Of the women interviewed, half had been pregnant at some stage in their life, with a total of at least 48 pregnancies. The vast majority of women interviewed reported giving birth in a clinic or hospital for most of their births. Eighty five per cent of all births in Solomon Islands are delivered in health facilities.¹¹⁶

Apart from one woman interviewed who received no antenatal care, and one unknown, almost all of the women interviewed who had been pregnant reported attending antenatal care as per the modern approach in Solomon Islands — once a month up until 32 weeks, then fortnightly and weekly. However, it is likely that this occurred from the second trimester onwards, often when the opportunity for early screening and prevention of problems has passed.¹¹⁷ For all women in the Solomon Islands, 95 per cent received antenatal care at some point, yet only 65 per cent made four visits.¹¹⁸

In general, it appeared that among the women interviewed, relatives and partners had made sure that women attended antenatal care and were close to a facility at the time of birth. Some women travelled a reasonable distance to ensure that they were at a health facility for their delivery.

There were few complications during pregnancy for the women interviewed. One woman had high blood pressure (pre-eclampsia) during her pregnancy, which saw her admitted to hospital. Another woman had a caesarean section for her first delivery and her second was a botched forceps delivery, during which the baby died. Only one woman experienced repeated difficult deliveries (her husband was her translator):

“All her deliveries were at No. 9 in Honiara. We got a medical evacuation every time [from an outer province]. Every delivery was a caesarean, our last one was twins. She got sick with malaria in one pregnancy, too”.

Four women had experienced a miscarriage at some point in their life. One of these desperately wanted a child but could not conceive following her first miscarriage.

Discussion below, under “Health Information and Services”, outlines women’s detailed responses about the amount of information they received from nurses during antenatal care. Women interviewed felt that they did not receive much useful information, raising the question of the quality of care received during antenatal visits. This issue also arose in the 2007 *Demographic and Health Survey*, where women, in general, reported a low quality of care provided during antenatal visits.¹¹⁹

Breast and STI Checks, and Cervical Smears

A very small number of women interviewed carried out breast checks, had received a cervical smear test or a sought treatment for STIs. Although breast self-examination is a controversial issue in high-income countries, in countries such as Solomon Islands where there is no mammography available, women need to be regularly carrying out breast self-examination. Yet, only four of the women interviewed

reported carrying out a breast check at some time. Three women, none of whom regularly checked their breasts, reported having a breast abscess or lump at some point in time. One woman had sought *kastom* (traditional) treatment with effect, one woman was about to have a mastectomy because an abscess had infiltrated her entire breast and another had a small lump that she was advised by the interview team to talk to a nurse about.

In relation to testing and treatment for STIs and cervical smears, while 27 of the women interviewed had had sexual intercourse, only five of these sexually active women respectively had ever had a cervical smear or a check for a STI. In some cases, the woman was not sure what had been done to her.

Mere recalled visiting a clinic and asking for a check “down below” because somebody had informed her that she should go and check to see if she was still a virgin. The nurse undertook some sort of observation and informed Mere that she was still a virgin. Mere didn’t know what the nurse really did or if any tests were taken at the time.

This occurrence indicates a general lack of knowledge and understanding about women’s bodies and sexual health issues — exhibited by the woman interviewed, her “advisor” and the nurse.

Of the five women who had gone for a STI check, three had experienced symptoms and subsequently tested positive, although one may have simply been a reproductive tract infection (again, the woman was not quite sure what had happened to her). Apart from the one woman who had been raped (and who received health care through the sexual violence unit of the police), none of these women received an HIV test. It should be noted, however, that two of them were in the over 45-year age group, and HIV tests would not have been available at the time they sought care.

Solomon Islands has high rates of STIs. In a 2008 study, 23 per cent of antenatal women aged 15 to 24 years and 14 per cent of women aged 25 to 44 years were found to have trichomonas. In the same study, 20 per cent of females and 10 per cent of males aged 15 to 24 years had chlamydia, 10 per cent of youth had active syphilis and 3 per cent gonorrhoea.¹²⁰

Cervical cancer, while slow growing, is the most prevalent cancer among women in the Solomon Islands¹²¹ and can be the result of infection with a very common STI — the human papilloma viruses (several strains of HPV cause cervical cancer). The fact that only five women interviewed had ever had a cervical smear is cause for concern, particularly in light of the number of women who were consensually sexually active or had experienced rape.

Violence

The next two sections on physical violence and sexual violence give an indication of some potentially significant differences in experience of violence between women with and without disabilities. It is important to note that the numbers provided from the interviews for this situation analysis are not representative of all women with disabilities, only those interviewed. A comparison is made with the *Family Health and Safety Study* to provide a reference point only. This exercise highlights the difference between the women interviewed (who are not representative of all women with disabilities) and a representative sample of women in the Solomon Islands in the *Family Health and Safety Study*. This exercise provides an indication that all women with disabilities may experience different rates and types of violence than women without disabilities, but until a representative study of women with disabilities is undertaken, the findings in this situation analysis can only be treated as potentially indicative. The questions used in this situation analysis were taken from the *Family Health and Safety Study*.

> Physical Violence

The women interviewed experienced physical violence most often at the hands of somebody other than an intimate partner — 18 per cent of women (seven women) experienced non-intimate physical partner violence. Compared with the *Family Health and Safety Study* this is the same per centage of all Solomon Islands women who experience non-intimate partner violence.¹²² However, women interviewed in this situation analysis reported a lower occurrence of intimate partner physical violence than what was shown as experienced by all women in the *Family Health and Safety Study* (remembering that the women interviewed are not representative of all women with disabilities).¹²³

This difference could reflect the fact that the majority of women with disabilities interviewed were not in an intimate relationship and never had been. However, out of the 15 women interviewed who had ever been in a relationship, only two had experienced physical violence by an intimate partner (not including sexual violence, which is discussed below). This represents 13 per cent of all women interviewed in this situation analysis who had ever been in a relationship and who experienced violence by an intimate partner. In comparison to the national population of women this is much lower than the 46 per cent reported in the *Family Health and Safety Study* for women who had ever been in a relationship and experienced violence by an intimate partner.¹²⁴

A close family member was the most common perpetrator of physical violence against women with disabilities interviewed in this situation analysis: mother, father, sister, auntie or brother-in-

law. This contrasts with the finding in the *Family Health and Safety Study* that the most common perpetrator of non-intimate physical violence was a woman's male family member.¹²⁵ Interviewees discussed being hit because their parent was "angry" or because their parent said they were "naughty". While one or two of the interviewees reported mild violence, such as a slap for being late home, several reported violence that was severe, at times resulting in injury.

Michelle was left to stay with her auntie when her family moved to Honiara. She was only young and could have been at school but her auntie forced her to work for her. When her auntie wasn't pleased or when she disobeyed, Michelle was beaten by a thick stick. She has scars on her hand and back as a result.

Mary has a significant intellectual disability. She has had three children and now lives with her extended family. Mary is regularly hit, slapped and pinched so that her skin blisters. Her brother-in-law does this to her. He is of some standing within the village and his violence is in response to Mary's apparent "misbehaviour" in front of important visitors, such as searching through their bags for cigarettes and embarrassing her brother-in-law.

Two other women told stories of being beaten regularly by their mothers, including the use of a stick and punching, and causing injury and loss of consciousness in one instance.

In general, the women who were able to comment on this issue thought that they were treated this way because they had a disability. For each of these women their disability meant that they had challenges communicating. They believed that the family member who hurt them did so because they were frustrated and angry with them.

> **Sexual Violence**

Out of the 39 women interviewed (who are not representative of all women with disabilities), 19 (49 per cent) had experienced sexual violence at some point in their life. The vast majority of these were rapes, most often by a stranger or acquaintance. A husband or boyfriend was the perpetrator in the experience of five women (26 per cent). Of women who had been in a relationship (15) this represents 33 per cent who had experienced sexual violence by an intimate partner. Five of the women interviewed were raped two or more times by different perpetrators. For two women interviewed, they experienced repeated rapes over time but by the same perpetrator.

Comparing this figure to the same one from the *Family Health and Safety Study*, the women with disabilities interviewed appear to be much more likely to be raped by a stranger than the general population of women.¹²⁶ The women interviewed who had ever been in a relationship were somewhat less likely to experience sexual violence by their partner than all women, as reported in the *Family Health and Safety Study*.¹²⁷

When asked, the majority of women thought that this happened to them because they had a disability, which implies that the perpetrator knew enough about them to single them out. It also signals that there may be different patterns in perpetration of rape between men who rape women that they do not know personally and deliberately “choose”, compared to men who rape their partners. This could be an area for further investigation to assist in finding ways to prevent this from happening.

Half of the women interviewed who had experienced sexual violence had told somebody about their experience of sexual violence. Only three women interviewed reported the violence to the police. This contrasts somewhat with the findings of the *Family Health and Safety Study*, which found that 70 per cent of women had not told anybody about violence they experience and only 1.1 per cent had told the police.¹²⁸ It may well be the protective nature of their families that contributed to the greater numbers of women with disabilities interviewed who told somebody, including the police, about the violence. Nevertheless, the numbers of women interviewed who reported violence to anybody remains lower than desirable. This is not unusual, as women often feel shame and confusion, and blame themselves for rape. An interviewee who was deaf and mute poignantly emphasized the isolation created by society’s inability to support her to communicate:

“I didn’t tell anybody because I didn’t know how to tell them” (emphasis added).

Reporting violence did not necessarily lead to the woman interviewed gaining support or assistance. For those women who did tell somebody, it was most likely to be a close female relative, usually a sister or mother. One woman interviewed had told her father, whose response was to go to discuss the issue with the man and arrange a “marriage”. The woman lived with this man and experienced rape on a regular basis for three years, until she became pregnant and left him. One girl interviewed, who had sustained vaginal injuries during rape, had told her sister, whose response was “Don’t do that, you’re too young”.

One mother, whose daughter with a disability had been repeatedly raped, had to pay compensation to her brothers when her daughter became pregnant. Two explanations were given for this. One was that compensation was given to prevent the brothers from pursuing the perpetrator and hurting him. The other explanation was to protect the girl from any harm the brothers may inflict on her, presumably for being sexually active, becoming pregnant and embarrassing the family.

In several instances (nine women and 13 pregnancies) the woman became pregnant as a result of rape. In all these instances she carried the pregnancy to full term and either she raised the child with the support of her family, or a female relative raised the child.

Women with an intellectual disability tended to be subject to multiple rapes. Out of the eight women with an intellectual disability who were interviewed, six were raped and four of these women were subjected to multiple rapes, three by multiple men spanning the women's lifetimes. One woman was raped at least once, but it was not possible to ascertain if this had been a regular occurrence.

The families' response to this violence, when it is known, is to become more protective. Women with disabilities were no longer left alone at any point, and were discouraged from walking around the community alone. In some instances, women were accompanied to the toilet, particularly when they had to walk a distance into the bush or to the sea. This places a huge burden on the primary caregiver, often the mother, who has other responsibilities as well.

"Me wari tumas. I worry a lot. I go to work in the mornings and rush home, always worried if something has happened to her".

Yet, in the case of women with significant intellectual disabilities or mental illness, often it was not possible to keep her at home. The women would wander off around the surrounding villages. The family had no skills, support or ability to keep their relative safe, or to assist the woman in keeping herself safe.

Three of the women who had experienced sexual violence gained support from their mother and reported it to the police.

Constance, who lives in Honiara, was raped twice by two different people in the space of four years. Both times she told her mother, who took her to the police. The second rape, the man paid compensation but they still went to the police. The police carefully interviewed Constance and took her clothes for evidence. A vaginal examination was carried out, with swabs and blood tests taken. Constance was given antibiotics to prevent any sexually transmitted infections. Neither Constance nor her mother knew if she had been given an HIV test but they did not think she was given emergency contraceptives. The police have been in touch and keep Constance and her mother up to date on progress, although in the second case the man has run away back to his home and can't be located. Constance's mother is sure Constance was raped because she has a disability.

Ethel reported her rape to the police in Honiara. They took her story down and that was it. She hasn't heard anything since. She thinks she is low priority because she has a disability.

A passing stranger sexually abused Angela. She immediately told her auntie. They went to their provincial police to report the crime. The police brought the man in and interviewed Angela in front of the man. When Angela's mother found out, they went back to the police and discovered that notes of the case had not been kept. Eventually; however, the case did go to court, where the judge claimed that it was "his word (the perpetrator's) against her word and without an eye-witness he could not prosecute". Angela and her mother think that all women are treated this way.

> [Justice and Support Services for Women Who Have Experienced Violence](#)

There has been a great deal invested in the Royal Solomon Islands Police Force through the Regional Assistance Mission to Solomon Islands. The country now has a sexual violence unit, and other police throughout the country have been on a sexual crimes course. However, it is highly likely that currently women in the provinces do not receive as good quality of care as those in and around Honiara, although with ongoing training and investment, hopefully this will change.

Discussions with the sexual violence unit coordinator highlight the challenges police have with prosecuting perpetrators of sexual violence against some women with disabilities. While the new Evidence Act no longer requires corroborating evidence (the situation Angela faced) to prosecute, there are still considerable challenges in getting evidence that conforms with the Evidence Act. For women who are deaf and mute, and illiterate, or who have a significant intellectual disability, the police experience great

challenges in obtaining an adequate statement of what happened. This is not simply because the police do not have the skills to communicate with these women, as they often call on assistance from Red Cross in cases of women who know sign language. It is because not all women have been taught sign language, some have invented their own or they are simply unable to communicate complicated, frightening and new experiences. This is particularly so if women have never been taught about their bodies or sex, or never experienced sexual activity before. These challenges with evidence have prevented prosecution at times. Changes that could assist include the development of a Victims Evidence Act and ensuring that the Penal Code includes provisions for people with disabilities.

The other area that the Sexual Violence Unit Coordinator was concerned about was the lack of support for women with disabilities in terms of legal proceedings and processes. While the Family Care Centre does offer this sort of support, they have no individual trained in sign language, or particular ways of communicating with women who have different disabilities. Additionally, the police do not necessarily refer women automatically to the Family Care Centre.

The Family Care Centre supports survivors of violence, offering counselling, legal referral and advice to women and their families. They reported having seen some women with disabilities, including having fought on behalf of one woman with a physical disability to be able to keep her children. They see the challenges for women with disabilities as the difficulty of identifying an advocate who can communicate with the woman, and on her behalf with various individuals and services, including law and justice, and health. This individual needs to understand the system and to be a strong advocate for the woman. Other challenges are transport and poorly built environments that prevent access for women with different disabilities.

The only shelter for women in Solomon Islands who have experienced violence is the Christian Care Centre. Discussion with the sisters who run this shelter highlighted that they have had some women with disabilities come to stay with them, including “a reasonable number who are deaf and dumb [sic]”. The sisters also highlighted that many women come to them with both physical and mental trauma, some of which will cause life-long disabilities for women.

Conflict and Disaster

Solomon Islands experienced a period of civil conflict between 1998 and 2003. The country also experienced an earthquake and tsunami in Western Province in 2007. It is well recognized that women with disabilities are likely to experience extra suffering and discrimination during disasters and the emergency response, predominantly due to their special needs not being met.¹²⁹

None of the women interviewed highlighted any particular discrimination that they had experienced during civil conflict or natural disasters, although it was not a specific question. However, the impacts of these events on the women's lives were apparent. One woman was not able to get the medical treatment she required, contributing to her disability. Another woman lost her job during the tensions because everything shut down in Honiara. In Western Province, people are now experiencing extra challenges because they have moved up the hill following the earthquake and tsunami. This made it more difficult for the women interviewed to access services and social networks, because it is further to go to reach them or because they no longer exist after the tsunami.

Health Information

Overall, the women with disabilities interviewed did not have a good understanding of their SRH, particularly young women. Women interviewed who had borne children tended to have greater knowledge of how their bodies worked and of contraception. This appeared to be acquired through experience and discussion with others, including health professionals. However, this knowledge often came too late to prevent unplanned pregnancies, violence or STIs, and was rudimentary.

Related to this, the women interviewed had received little information about SRH. This is consistent with research in other countries.¹³⁰ The women interviewed most often rated the information given as unhelpful. For women who had been pregnant, they got information from a nurse, a family member or another woman. One couple had sought information from a traditional birth attendant, as well as using other sources of information. One woman had learnt a little at school, and one had learnt from books. A total of eight women had not received any information about pregnancy. This is interesting, considering that with one exception all women who had been pregnant had attended antenatal care. In theory, perhaps the women interviewed cannot accurately remember what they were told at antenatal care, or it might have been so long ago that they could no longer isolate the specific information received and identify it as something that a nurse "taught" them. However, as stated above, it has been found that the quality of antenatal care tends to be poor for

all women in Solomon Islands, in general. For women with disabilities this will be exacerbated due to communication and access challenges, so it is likely that this is an accurate depiction of the situation.

In relation to family planning and sexual health, only a few women had received information from a nurse, while others had learnt from friends. Again, one person for each had, respectively, read a book, learnt something at school or heard information on the radio. The teacher at the Red Cross school provides a short lesson for women who attended there, and this was mentioned by five of the women interviewed.

“At first I learnt about family planning by talking to others, and my auntie gave me information as well. Then I went and talked to a nurse and she was helpful”.

“A nurse came and gave a talk in our village. I asked lots and lots of questions. Later my mother told me that I asked too many questions, but I just like to know things”.

“My geography teacher taught us about tourists and how you had to be careful because they could bring sexual infections with them...She also told us that we should use family planning so that we didn't have more children than we could afford. She talked about condoms, too, and that we should use them”.

Most of the women interviewed had received little or no information about sexual health and/or family planning. In one exceptional case, an older woman who had had polio described a relatively high quality of care:

“The nurse came and gave a talk in our village about family planning. That's how I got my cervical smear too — she came and did them here...I also had an STI test once. My parents took me to the clinic because something was wrong...Yes, it was a positive test”.

The 2007 Solomon Islands Demographic and Health Survey found that although 93 per cent of all women aged 15 to 49 years had heard of at least one form of contraception, this was not translated into contraceptive use, despite a desire to limit child-bearing. The survey found that “there were indications of numerous missed opportunities to inform and educate women about contraceptive options and choices, with over three quarters of women reporting that they had not discussed contraceptives with outreach workers or during previous visits to health centres”.¹³¹ This situation analysis highlighted similar missed opportunities for the sharing of information and education for the women with disabilities interviewed.

Health Services

Overall, apart from for antenatal care or to give birth, the women interviewed had not made great use of health services throughout their lives. The other main reason for attending health care was for an illness that required *hospitalization*. The latter sometimes related to a woman's disability — often at the time she had acquired her disability — but at other times attendance at health services was for a “fever” or “sore body”.

In general, women reported that when they did use health services, medical staff treated them well. During the interviews, it appeared that women tend to visit health services with their primary caregiver/significant other to give support and assist in communication. Again this highlights the importance of family support for the women interviewed.

Interview respondents struggled to answer the question of “what could be improved”. It is likely that people simply accept what they get, although some interview participants complained about the services they received.

“She had painful periods once and we went to the nurse. They didn't even look at her or explain anything. Just gave her Panadol and sent us away...I think we were treated that way because she has a disability”.

One couple had a lot to contribute about how health services could be improved. They were well qualified to comment through their significant interaction with SRH services throughout their relationship. They had used contraceptives and had three emergency deliveries. They also actively sought out as much information as they could on these issues, including talking to a traditional birth attendant:

“They need to do more, I'm not really satisfied about their treatment of Esther. They need to explain more about our own bodies and be able to address her specific needs [speech and hearing impairments]. They can't just rely on me — I don't know the information. They need more pictures and material figures — carvings and things you can hold. It is good to make a joke of these things, too — to have some humour so that it isn't all uptight. We've found it useful when they've used pictures. Transport would be helpful too”.

Another woman commented that:

“They use scientific words and I don't understand”.

Comments from people experienced in working with women with disabilities shed further light onto the subject. For example, one teacher of women who had hearing and speech disabilities said that the women she works with often found it challenging to communicate when using health services, so they tended to avoid them. The fact that none of the women who were raped sought health care assistance following the experience, regardless of whether they wanted to report the violence, also shows a lack of knowledge and/or a fear of health services.

A lack of information, as outlined above, may also contribute to poor use of SRH services. As one woman stated:

“We have the right to hear about what is important for our health...we need support, awareness talks”.

Several of the young women interviewed simply did not know where to go for information and services about contraception or sexual health. As well as this, particularly for young and single women, fear and shame appeared to be a significant barrier:

“If I had a boyfriend and I wanted to find out about how to stop getting pregnant and other things, I wouldn’t go to the school nurse... I’m afraid of her...what she might think”.

“I don’t want to go to the nurse...I’m ashamed of what she might think of me”.

In discussions with reproductive health nurses, they reported a desire to be able to communicate better with women with disabilities. They too recognize the challenges in providing a good quality of care for women with disabilities and want to do better.

Concluding Thoughts

The skills and talents of women with disabilities are being harnessed by PWDSI, and women are eager to do more to assist others. The CBR programme is also a great strength for Solomon Islands women with disabilities. This is predominantly because of its organized nature as a core institution of the MHMS and its reach out to the provinces. The implementation of a CBR-specific course at SICHE complements the commitment to build a professionalised CBR service for people with disabilities. Where up and running, PWDSI’s local support groups in provinces also provide a great opportunity for joining up with the CBR programme staff and extending the reach of services for people with disabilities. Alongside these two organizations, there are San Isidro,

Bethesda and the Red Cross school, all of which have been working for some time with people with disabilities and make an excellent contribution.

Most of the women interviewed stated that while they felt accepted and treated well among family and friends, in many instances the wider community did not respond to them in the same way. Several women reported being imitated or made fun of. A general sense emerged during the interviews with women and their families, and with stakeholders, that women with disabilities either should not get married or have sexual relationships, or that men would not want a woman with a disability. Underlying this is an assumption that women with disabilities are asexual, which is a globally prevalent, inaccurate, view of women with disabilities.

Family was a significantly important factor in supporting the women with disabilities interviewed. Family approaches ranged along a continuum from over-protective to neglect, with many situated in the middle, providing a stable support base for women. A lack of understanding, support and education for the family contributed to behaviour at the two extremes of this continuum. This shows the need for much greater focus on the family to enhance the nurturing, supporting and guiding strengths of the families of women with disabilities interviewed.

In terms of the SRH needs of women with disabilities, there is very little attention paid to this specific area by any entity in Solomon Islands. Yet the needs are high. The women with disabilities who were interviewed were sexually active. Encouragingly, sexual relations were enjoyable for 73 per cent of the 15 women interviewed who had ever consented to sex at some point in their life.

Although they are sexually active or experienced rape, the women interviewed did not have a good understanding of their SRH, particularly young women. Few women undertook breast self-examinations, were tested and treated for STIs or had a cervical Pap smear. The dominant event that led people to visit health services was pregnancy. This saw women with disabilities attending antenatal care and delivering in hospital, based on a strong community understanding that this was what was supposed to happen during pregnancy and birth. In general, the women interviewed reported that when they did use health services, medical staff treated them well.

One of the major challenges in using health services was the issue of communication. Often family members went with the woman to assist in communication. Nurses interviewed highlighted that they would like to be able to communicate better with women with disabilities.

Fear and shame, or simply a lack of knowledge, were other reasons for not using SRH services, especially for young and unmarried women.

In relation to sexual violence, the women interviewed experienced a high level of sexual violence, particularly rape. Over half of the women interviewed who had experienced sexual intercourse had been forced or coerced the first time they had sex. Sadly, this is not uncommon for women in Solomon Islands. Although it does appear that the women with disabilities interviewed experience greater rape by stranger/non-intimate partner than other women in Solomon Islands.

The women interviewed needed much greater support from social services when they do experience violence. Organizations and agencies such as the police, the judiciary and lawyers, the Family Support Centre and Christian Care Centre are doing their best to respond but require more training and/or support, particularly in the area of communicating with women with disabilities.

Women who had an intellectual or mental health disability experienced egregious human rights abuses, including, sometimes, repeated rape by local village men. While families tried to protect their daughter, auntie, mother or sister from rape, they were unable to. As a way of preventing the woman becoming pregnant, a family member or doctor instigated a tubal ligation for the woman, or use of a contraceptive, such as DP or an IUD. This was without the woman's informed consent. This issue is very challenging for all concerned and requires further action and investigation.

None of the women interviewed made specific mention of SRH challenges during conflict or disaster. However, following the tsunami in Gizo, women now experience extra challenges because they have moved up the hill to live and have further distance to cover to get to services and social networks.

There is little information available in Solomon Islands about SRH, and unless women seek this out they are unlikely to know what sorts of things they need to do to keep themselves healthy. This is particularly so for young women, when they are beginning to negotiate their sexual identity and relationships, and are particularly vulnerable. At the same time, young women experience the societal expectation that they are not to be sexually active until married. This does not happen in practice, either through sexual violence or consensual experimentation. This age-based discrimination and the generally taboo nature of SRH issues combines with the isolation and discrimination of having a disability.

The societal expectations of young people are somewhat reflected in the inaccurate beliefs of women with disabilities, that they are not interested in sex or cannot have sex. Also, the sense that others discriminate against them impacts on women's willingness to come forward and to demand support. This means their expectations of assistance are low. Altogether, the amalgamation of these various beliefs, norms and attitudes mean women have to negotiate a perilous path, often in the dark, to maintain their SRH and rights. Often they are not successful, through no direct fault of their own. There is a lot more that can be done in Solomon Islands to build inclusive communities so that women with disabilities can enjoy good SRH.

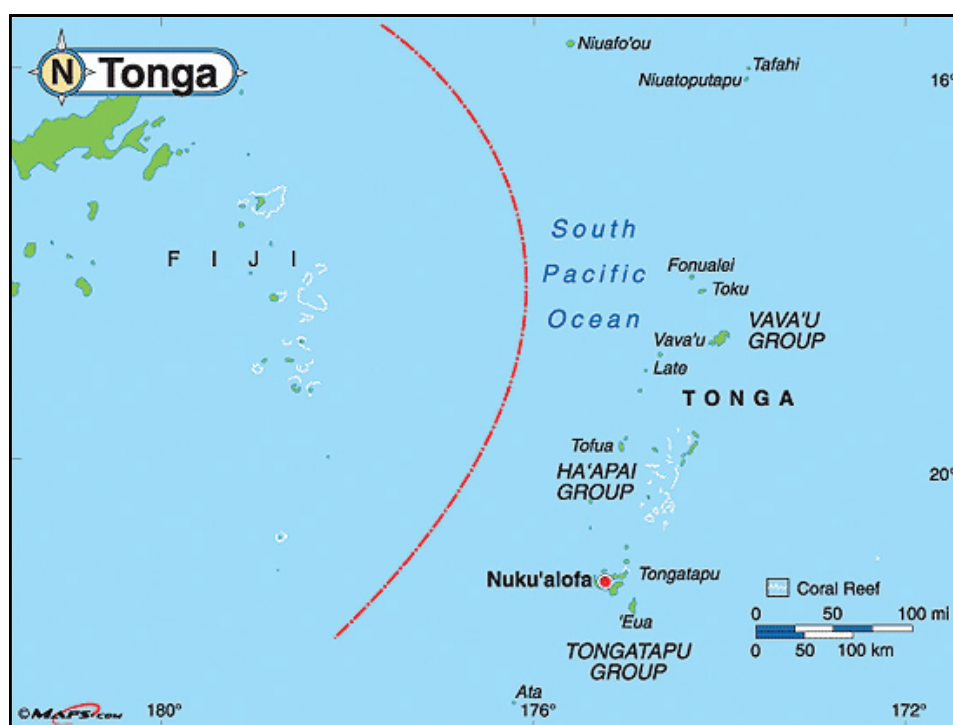
Solomon Islands Recommendations

The recommendations below should be read in conjunction with the "Recommendations for All Three Countries" above.

- 1. Educational Materials.** Building on the strengths in Solomon Islands in this area, fund and support PWDSI and the MHMS Reproductive Health Division, STI/HIV Section and CBR programmes, in liaison with the Red Cross school and San Isidro Rural Training Centre, to develop and pilot basic SRH information materials for people with speech and hearing impairments. These could then be piloted elsewhere in the Pacific.
- 2. CBR Services.**
 - a. Strengthen the SRHR components of the CBR diploma course to equip future CBR staff with knowledge of SRHR issues that their clients may encounter; an understanding of legal issues, particularly in relation to forced sterilization; and an ability to discuss SRHR issues with their clients and families, and know where to refer them to.
 - b. Create practice guidelines for CBR staff, including appropriate referral systems, to support them in addressing SRHR issues with their clients and families, and in making referrals to other health professionals, government agencies or civil society organizations.
 - c. Monitor the implementation of these CBR practice guidelines to assess whether CBR staff are discussing SRHR issues with clients and their families, and to identify areas for future training support.

3. **Water and Sanitation Infrastructure.** Continue and potentially expand the water and sanitation programme for people with disabilities, giving priority to women and ensuring that facilities are designed to provide for the personal security of women with disabilities.
4. **Legislation and Policy Advocacy.**
 - a. Engage with the CBR programme, PWDSI and the government to ensure that the draft Rights of Persons with Disabilities Bill incorporates the SRH and rights of people with disabilities, and is fully compliant with the CRPD.
 - b. Work with the Ministry of Women, Youth and Children's Affairs to ensure that both the Women's Policy and the Eliminating Violence against Women Policy and Action Plan include women with disabilities (especially the education and mass media activities).

TONGA SITUATION ANALYSIS



A Note on Methodology

The approach taken for this situation analysis in Tonga was conducted in the same way as those of Kiribati and Solomon Islands, with one exception: only seven women with disabilities were interviewed and most of the interviews were not in-depth, utilizing the questionnaire. This was because safe spaces for interviews were not available and translation was a significant issue. The bulk of the information for this situation analysis comes from stakeholder interviews and a literature review, particularly the 2006 *Tongan Survey on People with Disabilities*.

About Tonga

The Kingdom of Tonga is situated in Polynesia, and consists of 171 islands, 40 of which are inhabited. The country is divided into five administrative divisions: Tongatapu, Vava'u, Ha'apai, 'Eua and Ongo Niua. The capital city, Nuku'alofa, is situated on the island of Tongatapu. The population of 101,991 is predominantly youthful, with the median age of 21 years and 38 per cent of the population aged under 15 years.¹³² Just over 76 per cent¹³³ of the population reside rurally with the majority of people (71 per cent) residing on Tongatapu.¹³⁴ There are slightly more males than females in Tonga: 51,722 males and 50,219 females.¹³⁵

The main language spoken in Tonga is Tongan, but almost all of the population, particularly those younger than 44 years, are able to speak English well. According to interviewees for this situation analysis, there is a Tongan sign language that was recently created and officially launched. Tonga's population overwhelmingly comprises people identifying themselves as ethnically Tongan, with 97 per cent of people being of Tongan origin and another 1.6 per cent of part-Tongan origin.¹³⁶ The remaining people have an ethnicity of Chinese (1.1 per cent), European (0.8 per cent), other Asian (0.7 per cent) or other Pacific Island ethnicity.¹³⁷

Tonga is a strongly Christian country, with the Constitution mandating no work on the Sabbath Day.¹³⁸ The predominant religion in Tonga is Methodism. The Free Wesleyan Church attracts 37 per cent of the population, the Church of Jesus Christ of Latter-day Saints 17 per cent, the Roman Catholic Church 16 per cent, the Free Church of Tonga 11 per cent and the Church of Tonga seven per cent. The remaining three per cent of the population are made up of various denominations, including Anglican, Seventh Day Adventist, Baha'i, Buddhist, Hindu and Islam.¹³⁹

Tonga's Human Development Index is at 85, at the low end of countries in the high human development category. Tonga sits below Turkey (83) and Algeria (84), and above Fiji (86) and Turkmenistan (87), which are the first two countries in the "median human development" category.¹⁴⁰

Tonga signed the Convention on the Rights of Persons with Disabilities in November 2007 but not the Optional Protocol.¹⁴¹ Tonga has not signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Persons with Disabilities in Tonga

In 2006, two separate surveys were conducted that provide useful information about people with disabilities in Tonga. The 2006 Census included several questions on disability. The Census used the definition of disability as: "[A] disability includes any difficulties that affect vision, hearing, walking, remembering or concentrating properly".¹⁴² Using this definition it was found that five per cent of the total population reported a disability. (This is higher than the *Survey on People with Disabilities* — see below). The Census found that the proportion of the population with a disability increased with age and overall there was little difference in the proportion of males and females with disabilities. Of children aged five years or younger, about five per cent had a disability. This dropped down to almost zero at five years and remained there until 49 years of age, when the proportion

of the population with a disability increased continuously, reaching approximately 45 per cent in those aged 75 years and older.¹⁴³

The Tongan Red Cross Society carried out the most comprehensive Survey on People with Disabilities in Tonga, also in 2006. This was done in collaboration with a Disability Action Committee set up for the purposes of guiding the survey. The survey identified 2,782 people with disabilities, which was calculated to be approximately 2.8 per cent of the population at the time, a number that is likely to be a significant under-estimate due to the stigma attached to disability in Tonga and the exclusion of people with mild impairments from the survey¹⁴⁴ (and which is also lower than the 2006 Tongan Census finding and WHO estimates).

In contrast to the Census, the Survey on People with Disabilities found that the most common types of disability identified were physical disabilities (36 per cent of disabilities), vision impairments (24 per cent) and intellectual and learning disabilities combined (11 per cent). The Census found that the most common disabilities reported were vision impairments (total=2,326, male=1,043, female=1,283), followed by difficulties with walking (total=2,083, male=1,006, female=1,077) and hearing impairments (total=1,932, male=916, female=1,016). Problems with remembering or concentrating were reported in 930 people (male=460, female=470).¹⁴⁵ The difference between the two surveys is likely to be due predominantly to the different definitions used and the challenges of counting people with disabilities. What both surveys confirm is that there are a significant number of people living in Tonga who have a diverse range of disabilities.

Other key findings in the *Survey on People with Disabilities* include:

- After non-communicable diseases, ageing was the most common cause of disability. This is reflected in the ages of people with disabilities: 52 per cent of people with disabilities were over the age of 61 years; those aged 16 to 60 years comprised approximately 34 per cent, with youth aged 15-24 years making up nine per cent of all people with disabilities; those aged 5 to 14 years comprised nine per cent of people with disabilities; and infants made up the remaining one per cent.
- The most common disabilities in the youth age group (15-24 years) and the 5-14 year age group were physical disabilities, and learning and intellectual disabilities.
- An early age of onset of disability (age 15 and below) appeared to significantly reduce a person's access to education and marriage opportunities, and increased the likelihood that they would be a single parent.

- There were more females (51.5 per cent) than males (48.1 per cent) with a disability,¹⁴⁶ probably reflecting the fact that women live longer than men and are therefore at a higher risk of developing a disability through the aging process. (Females have a life expectancy at birth of 73 years, males 67 years.¹⁴⁷)
- Of the working age people with disabilities, only three per cent were in formal employment, with women being 10 per cent more likely than men to be unemployed or employed in the informal sector.
- Of the 254 children with a disability aged between 5 and 14 years, there were at least 100 (approximately 40 per cent) who were not receiving a full primary education. This does not include the children who were not captured by the survey.
- People with disabilities were found to be up to 23 times more likely to be living below recognized poverty indicators compared to the general population.

Tonga Legislation, Policy and Services for Women with Disabilities

Legislation

It was beyond the resources of this situation analysis to conduct a thorough examination of all Tongan legislation; however, a brief view highlights that Tongan legislation does not conform to the Convention on the Rights of Persons with Disabilities. There is little in the way of legislation that covers various aspects of SRH. For example, the Constitution does not outline the rights of citizens, including their right to live free from discrimination regardless of their sexual orientation or disability. The one place where the Constitution refers at all to issues of disability is article 35, where it is specified that no “idiot”, or person who is “insane or imbecile” will succeed to the Crown of Tonga.¹⁴⁸ The Criminal Offences Act outlines how assisting a woman to obtain a miscarriage (abortion/termination of pregnancy) carries a prison sentence of up to seven years, while for a woman procuring an abortion may be jailed for up to three years.¹⁴⁹ There is no law on involuntary contraceptive use or sterilization.

The Mental Health Act 1992 provides for the management of people with mental illness. This is a comprehensive Act that outlines the powers of the minister and provides guidelines for compulsory admission, detention and release of mentally ill patients.¹⁵⁰ This appears to be the only law pertaining to any specific area of disability (as of January 2005).

Policies and Strategies

[Tonga Strategic Development Framework 2011-2014](#)

The Tonga Strategic Development Framework (the Framework) is the overarching strategy guiding the Government of Tonga. The Framework has a vision “to develop and promote a just, equitable and progressive society in which the people of Tonga enjoy good health, peace, harmony and prosperity in meeting their aspirations in life”⁵¹. Beneath this are nine outcome objectives and four enabling themes.

The outcome objectives are:

1. strong inclusive communities;
2. dynamic public and private sector partnership as the engine of growth;
3. appropriate, well planned and maintained infrastructure that improves the everyday lives of the people and lowers the cost of business;
4. sound education standards;
5. appropriately skilled workforce to meet the available opportunities in Tonga and overseas;
6. improved health of the people;
7. cultural awareness, environmental sustainability, disaster risk management and climate change adaptation;
8. better governance;
9. safe, secure and stable society, by maintaining law and order.

The enabling themes are: continuing progress to a more efficient and effective government; improving coordination, service delivery and optimizing use of resources; ensuring a more coordinated whole-of-government approach in Tonga’s partnership with development partners; ensuring public enterprises are sustainable and accountable, and where appropriate moved into the private sector; and improving the macroeconomic environment and fiscal management.

The issue of disability is not mentioned in the document. Arguably this sort of document is not the place for specifics; however, an opening paragraph mentioning specific population groups that experience discrimination in Tonga, such as people with disabilities, would not be out of place in a strategic development framework. If the framework does not overtly recognize this fact, then people with disabilities may be overlooked in development efforts.

Disability Policy or Strategy

Through discussions with stakeholders it was apparent that there is no comprehensive national policy or strategy on disability. The National Inclusive Education Policy was written with this absence in mind and could be used as a beginning point to support the creation of a national disability policy in the future (Stakeholder comment). The Ministry of Health was thinking of starting work on a disability policy in October 2011 but it was not clear if this was only for the ministry or for the whole of government.

National Inclusive Education Policy, 2007

The Ministry of Education, Women Affairs and Culture implements this National Inclusive Education Policy. It is a carefully crafted policy with a vision that Tonga will have “an inclusive educational system where all children, including children with disabilities, are participating and treated equally. Where the educational system adapts its procedures and teaching modalities to ensure that all children, irrespective of their abilities, can learn, experience success, feel valued, and fulfil their potential”.¹⁵² The policy has 10 strategic policy priorities and objectives:

- awareness, collaboration and empowerment
- evaluation, assessment and information gathering
- inclusive education pilot classroom
- Teachers’ Institute of Education
- Tonga inclusive model for education
- early intervention, case management and statistics
- ongoing professional development
- access to educational built environments and educational transport systems
- early childhood education collaboration
- policy monitoring, review and implementation.

There is nothing in this policy regarding the needs of children to be educated about their bodies, or issues of abuse and discrimination. This is an important area to include in inclusive primary education, because research shows that it is more likely that people with disabilities will experience violence, particularly young people and people with an intellectual disability.¹⁵³ Teachers also need education and support to be able to identify behaviours that may signal children have experienced abuse. It was beyond the remit of this situation analysis to assess the implementation of this policy.

Family Life Education/Sexuality and Relationships Education

According to the Tongan Ministry of Health Reproductive Health Policy and Strategy, the Ministry of Education is still considering whether or not to introduce family life education into schools. Interviewees articulated that the issue is one of inadequate resources. Developing a comprehensive curriculum on sexuality and relationships education is a resource-intensive activity. The current situation is that aspects of family life education are incorporated into health and science subjects in a piecemeal way. For women with disabilities, given their low attendance at secondary school, it is unlikely that many of them will benefit from this curriculum.

It does not appear that teachers themselves gain any special support or education on how to teach the aspects of sexuality and relationships education that are in the curricula. Teachers also need support and education on how to detect behaviour that could signal that children are being abused, and how to manage the situation if it does occur.

Corporate Plan, Ministry of Health, 2008-2012

The mission of the Ministry of Health, as stipulated in its Corporate Plan is to “support and improve the health of the nation by providing quality, effective and sustainable health services and being accountable for the health outcomes”.¹⁵⁴ The vision is that “by 2020, we are the healthiest nation compared with our Pacific neighbours as judged by international determinants”. The core values of the Ministry of Health are:

- commitment to quality care
- professionalism and accountability
- care and compassion
- commitment to staff training and development
- partnership in health.

The Corporate Plan outlines six strategic key result areas:

1. Build capability and effectiveness in preventative health services to fight the non-communicable diseases (NCDs) epidemic and communicable diseases.
2. Improve the efficiency and effectiveness of curative health service delivery.
3. Provision of services in the other island districts and community health centres.
4. Build staff commitment and development.
5. Improve customer care.
6. Continue to improve the Ministry infrastructure and IT.

Under Key Result Area 2, strategy number 17 specifically relates to people with disabilities: “Expand clinical services to meet the needs of vulnerable groups of people such as the physically and mentally disabled in the community” with the key target being to develop a management plan by July 2010.¹⁵⁵ There are also targets for developing a national HIV/STI Strategic Plan and a strategy for strengthening reproductive health services.

On discussion with the director of health it was recognized that greater attention needs to be paid to people with disabilities. The head of the psychiatric ward had been nominated as the Ministry of Health’s focal person for disability issues and was recently sent to a forum in Fiji. The idea seemed to be for this person to lead the development of a plan for disabilities on his return from Fiji. It was not clear if this was a Ministry of Health plan or a whole-of-government plan (different stakeholders had different impressions). Unfortunately the focal person was still away during this situation analysis and could not be interviewed. There is an urgent need for improved health (and other) services and information for people with disabilities in Tonga. The prevention of NCDs is important, but this will take time to have effect. Meanwhile, there will be an increasing number of people with disabilities caused by NCDs and these people need assistance.

[Reproductive Health Policy 2008 and Reproductive Health Strategy 2008 — 2011](#)

There is no mention of disability issues in the Reproductive Health Policy or Strategy. The previous policy did include issues for people with disabilities but this was not carried through into the new Reproductive Health Policy or Strategy. The key thematic areas covered in the policy and strategy are:

- safe motherhood: antenatal, intrapartum, postpartum and neonatal care;
- family planning and reproductive health commodity security;
- adolescent SRH;
- reproductive tract infections, sexually transmitted infections and HIV;
- sexual violence;
- cervical cancer;
- men as partners in reproductive health.

All these areas are pertinent for women (and men) with disabilities and the particular needs of women with disabilities could be integrated into each of these thematic areas.

Services/Programmes for Women with Disabilities

Information, services and support for people with disabilities in Tonga are scarce. What is available is generally offered through non-governmental organizations or through charitable donations by churches and community groups.

Naunau O'E' Alamaite Tonga Association (NATA)

NATA is the local DPO. Established in 2003, volunteers run NATA, many of whom also have full-time work. Nevertheless, their employers are supportive and NATA is becoming increasingly busy as external actors are engaging more on disability issues in Tonga. The main focus for NATA is to raise the visibility of disability issues, including the CRPD, and to ensure that people with disabilities are involved in consultations on issues that impact on them.

National Disability Forum

The National Disability Forum was established during the consultative stage of the Inclusive Education Policy. It is unclear what role this entity currently plays or how active it is.

Red Cross

Red Cross has been running services for people with disabilities since 1976. These services consist of the 'Ofa Tui 'Amanaki Centre for Special Education and a school for children with hearing and speech impairments that is currently closed because there are no students of the appropriate age to attend (aged six to 16 years). The 'Ofa Tui 'Amanaki offers an education to children aged five to 18 years. These children are divided geographically and children from each geographical area of Tongatapu come to the school on allocated days. Red Cross picks the children up and drops them home. They currently have about 140 children attending. Red Cross also runs a home-visiting service for under-five-year-olds and in the past provided a wheelchair lending programme.

Red Cross does not integrate sexuality and relationships education into their curricula for the children attending their schools. The Red Cross has a separate educational programme on HIV and STIs, but this does not get integrated into the schools for children with disabilities, even though they cater for children up to 18 years of age. However, the teacher at the school for children with speech and hearing impairments refers young women to the Tongan Family Health Association for education on puberty and sexuality.

Psychiatric Ward, Vaiola Hospital, Ministry of Health

There is a psychiatric ward, which also has an intensive care unit. A psychiatric tribunal provides oversight of each patient's legal situation, set up under the Mental Health Act and comprised of a magistrate, the head psychiatrist and a theologian. Ten registered nurses and nine assistants staff the ward, with four registered nurses on each day shift and two at night. There are two psychiatrists. The police have trained the female registered nurses in calming and restraint, but the male registered nurses and assistants have received no training. Most of the patients have schizophrenia or bipolar disorder, but also people who have epilepsy or dementia are referred to the ward when they become "aggressive". During the day, men and women patients intermingle, but at night their sleeping quarters are separately locked.

The psychiatric ward appears to be significantly under-resourced but this would require further investigation to verify. During interviews comments were made that there are "supplies for staff but not patients" in relation to personal hygiene needs like toilet paper, soap and clothes. Food may also be scarce. One interviewee revised her comment regarding meals on the ward, stating that patients "settle" when they get a "decent meal, well, a meal" on the ward. There was also discussion of donated food, and food from the rehabilitation farm that gets brought in and cooked in the umu (earth oven) three or four times a week.

While it appears that very basic issues of safety are attended to for female patients on the ward, when women come onto the ward and complain of sexual assault they do not receive STI or pregnancy screening. According to interviewees, this only happens as part of antenatal care, if the woman is pregnant.

Community Reproductive Health Nurses, Ministry of Health

Community reproductive health nurses who took part in a participatory focus group had a basic understanding of the concept of disability, but used the comparisons "normal" and "abnormal" a good deal. When describing definitions of disability the concept of disabling environments was not articulated. When the nurses were given scenarios to work through they treated women with disabilities the same way that they would treat other women, showing they had an understanding of the basic rights of people with disabilities. For example, there were no comments that women with disabilities should not be sexually active because they had a disability. The nurses would like to learn more about disability issues and the challenges that women with disabilities face.

Alonga Centre

The Alonga Centre began in 1985 as a vocational workshop for people with disabilities. Currently the Red Cross supports the Alonga Centre with one staff member. The Queen of Tonga became the patron of the Alonga Centre and arranged for a long-term lease to provide land for a residential centre. This residential home was opened in 1991 and began as a week-stay centre, but has evolved into a full-time care provider. Volunteers staff the Alonga Centre, one of whom is the original staff member from Red Cross, and she provides the oversight and management of the centre. The volunteers receive no salary but in return for their work they receive a small stipend (from an annual government contribution of TOP4,000, although interviewees gave conflicting reports of the exact amount), food and accommodation. There appears to be somewhere between six and nine people who volunteer at the Centre. Volunteers have received no training.

The Alonga Centre has 20 beds for women and 20 beds for men, and currently there are 11 men and 14 women living there. (This number may include volunteers.) The Alonga Centre appears to provide residential care for almost any individual who is referred to them, from people with a mental illness to people with a physical disability or an intellectual disability, or a combination.

Originally a committee governed the Alonga Centre but this no longer functions. The manager runs the centre single-handedly. The Red Cross physiotherapist used to visit the residents but this no longer occurs. Similarly, there used to be a medical practitioner who would monitor the residents' health but this also no longer occurs. Discussion of the Alonga Centre continues later in this report.

The Mango Tree Centre

The Mango Tree Centre is a ministry of the Church of Nazarene. Originally set up in 2002 as a respite centre for children, it now offers home visits, rehabilitative therapy, a braille course, computer classes, an annual family camp, respite care and mobility aids and housing renovation. The Mango Tree Centre will help anybody with a disability and is the only service of this type in Tonga. The centre is small but welcoming, spotlessly clean and interviewees spoke highly of the centre's care. Two missionaries and two volunteers staff the Mango Tree Centre. One volunteer used to be a client at the centre but has gone on to assist them two days a week. Visiting physiotherapists and other professionals also assist on an ad hoc basis, and provide training for the staff at the centre. The centre staff were keen to learn more about the issues of sexuality and disability, and thought that women with disabilities would benefit from learning more about SRH.

Tonga Family Health Association

Tonga Family Health Association (TFHA) provides clinical and information services on SRH, as well as carrying out advocacy on these issues. TFHA is a youth-friendly service and has a youth drop-in centre. In 2005, TFHA worked with 'Ofa-Tui-'Amanaki to run a two-day workshop for the carers of people with disabilities, focussing on the issue of disability and sexuality. As this workshop was the first of its kind in Tonga, a radio programme was run and articles were put in the *Tongan Woman* magazine and another local newspaper. This received a positive response from the media and town officers.

The workshop covered topics that included values, facts and myths about disability, reflections on caring for a person with a disability, sexual assault and child abuse, disability and sexuality. Participants of the workshop were 15 mothers of children with a disability and two teachers from 'Ofa-Tui-'Amanaki. Participants commented positively on what they had learned at the workshop.

For the first time today have I realized the importance of knowing that disable people are still sexual being with the right to sexuality education like anybody else. So, thank you Mrs. Mafi for enlightening us on such an important issue. (Workshop Report, 2005, TFHA)

TFHA staff were enabled to run this workshop through the South Pacific Reproductive Health and Family Planning Training Project (SPRHFTTP), implemented by Sexual Health and Family Planning Australia (SH&FPA) and funded by AusAID. Through this project, a TFHA staff member received training on sexuality education, including for people with disabilities. TFHA drew from the quality disability and sexuality resources produced by Family Planning Queensland (a member of SH&FPA) in order to run this workshop. These include:

- Triple Taboo: HIV, Sexual Health and Intellectual Disabilities;
- Design and Deliver: a manual on delivering training for people with disabilities;
- Everybody Needs to Know — a set of flashcards and trainers manual.

Funding for this activity ceased but there is a real desire among interviewees for it to be revived, due to a perceived need and the positive reception the workshop received.

Other

There are other services in Tonga that have links with services for people with disabilities or who have worked in the area. The Salvation Army runs drug and alcohol assessments, counselling and home visits. At times they receive referrals from the psychiatric ward for these services. The Salvation Army has not worked with people with other disabilities but has a policy of non-discrimination. The NGO Tonga Human Rights and Democracy Movement has run workshops on the rights of people with disabilities in the past but is currently not working in this area, due to resource constraints. The Civil Society Forum offers support and assistance to Tongan civil society organizations, including NATA. The Para-Olympic Committee focuses on supporting people with disabilities to participate in the Para-Olympics. The ministry responsible for sports and youth is also beginning to work on disability issues, encouraging people with disabilities to engage in physical activity, particularly women.

Of note are the services provided by a volunteer of the Tongan Women and Children's Crisis Centre (TWCCC). This person was a former nurse and well known among hospital personnel. At TWCCC her role was essentially that of a community liaison cum advocate for families and individuals at risk, providing support and education for families, and representing them with the justice, health and social service system. Her work was respected and admired, and she provided a unique and much-needed service for vulnerable families. If appropriately designed and formalized, this is the sort of role that would benefit women with disabilities and is included as a recommendation of these situation analyses.

Family, Community and Sexual and Reproductive Health

The following section provides information from interviews with women and key stakeholders. Information from the literature supplements this information. Some information about all women in Tonga is also included. This is to provide a point of reference for the information about women with disabilities. Due to the fact that the intent of this situation analysis was not to gather representative data, it is not possible to compare the information gathered from interviews with women with information about all women in Tonga.

A total of seven women with disabilities were interviewed for this situation analysis. In all but two interviews, language, interview environment and other factors meant that it was difficult for women to freely share their perspectives. Due to this, the author asked generalized questions of the women interviewed, exploring their ideas experiences for all women with disabilities in Tonga. Interviews with

stakeholders focused on what they thought the key issues for women with disabilities were when it came to their SRH.

The Family

The family is of prime importance to the lives of people with disabilities in Tonga¹⁵⁶. In the absence of a safety net, such as a benefit or services, the family and charity are the main sources of support for people with disabilities, the latter mostly from the church. One interviewee clearly summed the situation up: *“People with disabilities have to rely on the family for everything. Some churches help out but not many”*. This situation is similar to that of people with disabilities globally, as discussed earlier in this report.

Not all families are supportive. The stigma and shame associated with having a family member who has a disability can mean that people with disabilities are hidden within their family home, treated poorly or cast out. One woman interviewed was unequivocal in how her family responded to her: *“They hated me”*.

The women interviewed for this situation analysis had had varied experiences. In some instances, the woman’s mother was caring and supportive but when she died, circumstances changed. For one woman:

“Mum was supportive...but then she died and father remarried. It was hard to stay with my stepmother, she was mean to me”.

For another woman interviewed, when her mother died (who had been her primary caregiver), another relative provided care, followed by this relative’s daughter. The woman interviewed was full of praise for the care and love she received: *“Hard to find this kind of unconditional love”*. Her two sisters in the United States support her financially, although this has become more difficult since the global financial crisis.

Another woman shared that her family *“serve me with the best, much better than other children”*.

Another interviewee was of the perspective that only disabled people cared for other disabled people: *“Disabled people are only one family”*.

When family members are not supportive or present, women are in a challenging situation. The Alonga Centre is one option for long-term residential care and several of the residents there had family who were overseas, had passed away or were unable to care for them.

The need for not only care but also companionship was apparent in interviews with women with disabilities and this sometimes caused them to make decisions that may not be optimal.

“When I was first blind I decided to get pregnant because I wanted somebody to help and care for me and thought that no man would want to marry me. So got pregnant to boyfriend”.

Community Attitudes

As the 2006 *Survey on People with Disabilities* found, “Tonga as a whole has a charitable view of disability which assumes that people with disabilities need only to be cared for by others, and not encouraged to gain greater independence and take a more empowered position in society”.¹⁵⁷ One interviewee for this situation analysis stated that people “underestimate person with disability”.

While the concept that people with disabilities need to be cared for can be viewed as a positive perspective, it also has a negative side. This concept can lead to a situation whereby people with disabilities are seen as victims who should be grateful for any small kindness that is extended to them. As some interviewees reported, they felt that unless others thought they could get something from them, or if they were part of a good family or had money, then others would help. But for most people, the attitude towards people with disabilities would be “What can I do about it, why care?” Sometimes charity is given only when the giver is in a position to give. Combined with the stigma, shame and fear attached to disabilities, this can lead to a situation whereby people with disabilities are at the bottom of the pile and only receive assistance once everybody else’s needs have been met.

This perspective of people with disabilities as charity recipients contrasts with a perspective that is grounded in rights, whereby people with disabilities have the same basic human rights as anybody else and are entitled to have these rights upheld, promoted and protected.

Overwhelmingly, interviewees for this situation analysis articulated that many people viewed people with disabilities with shame or embarrassment. This shame was sustained by a lack of understanding about disabilities and how they occurred. This is reflected in the community engagement of people with disabilities. The people with disabilities who had the lowest engagement in village and church activities were people with hearing and sight impairments, speech or language impairment, mental illness or epilepsy, or who had had a stroke. People with an intellectual disability had the lowest involvement in village activities (27 per cent).¹⁵⁸ This most likely reflects the fact that these disabilities are more “visible” and therefore more likely to be excluded. The 2006 *Survey on People with Disabilities* also found this. “The greatest identified need was for improvements in attitudes towards and the inclusion of people with disabilities into mainstream society (1,608 people)”.¹⁵⁹

The survey found that there was a general lack of understanding, particularly in mental and/or intellectual impairments and epilepsy. At times this was reflected in the words used to label or describe some impairments, such as epilepsy, for which the common term is “mahaki moa” meaning the “chicken illness”.¹⁶⁰

Fear also contributes to feelings of shame. This fear stems from beliefs that disabilities are a curse or punishment for a past transgression, and is fuelled by a lack of understanding. As one interviewee commented, “Some people view disabilities as a curse from the ancestors, in which case it shouldn’t be interfered with”.

During interviews for this situation analysis, the most common reply to a question about challenges for people with disabilities was that “it is under the carpet” or a hidden issue.

Discriminatory community attitudes have a significant impact on women with disabilities, and both women with disabilities and other situation analysis interviewees conveyed similar messages regarding their place in the community.

“My disability has been a scar on my life, no one accepts me for who I am. I got called crooked-eye at school and by family...Looking down on myself...[my disability] isolates me most of the time”.

“You look dumb and crazy (relating the confession of a previous employer of a woman with a disability)”.

“In Tonga we look down on people with disabilities”.

“No hope for people with disabilities”.

“Teacher he asked me bad questions — ‘Why you come to school when you can’t go to workplace?’...He didn’t come to encourage me he came to put me down”.

[Other children] “looked at me as a person not to be respected...they giving me a very sad time when I was little”.

“I want to use my knowledge but because they don’t accept me”.

Discrimination was not the only experience that women with disabilities had. As one interviewee stated when summing up community acceptance towards her, “About one third accept and two thirds don’t”. Positive experiences were shared, such as employers giving assistance at work and being

actively involved in church groups. Finding this acceptance and support has as greater positive impact on woman's lives than the discrimination has negative.

"It is the happiest time of life. I feel accepted for the first time...they treat me as a real family member...like a real person".

Sexual and Reproductive Health Experiences

All Women in Tonga

Regionally, Tonga has been ranked with an overall reproductive and sexual risk for women of 36.¹⁶¹ This puts Tonga just into the high-risk category, meaning that women have a high risk of complications or of death, due to sexual and reproductive issues. For comparison's sake, Papua New Guinea is the highest-risk for the region, at 68, while Samoa is in the moderate risk category of 34.¹⁶² Key areas of concern¹⁶³ for Tongan women include a very low use of modern contraceptives by women aged 15 to 49 years — only 23 per cent of women. The maternal mortality ratio is 139 deaths for every 100,000 live births and the incidence of chlamydia among women attending antenatal care was 13 per cent. Tonga has a highly restrictive abortion law, which has been mentioned as a possible problem in the Reproductive Health Strategy. Evidence from around the world is that where the abortion law is most restrictive, more women die from unsafe abortions.¹⁶⁴ This could be a contributor to Tonga's maternal mortality ratio, but further investigation is required in this area to make any definitive conclusions. Finally, the adolescent pregnancy rate of 24 teenage pregnancies for every 1,000 live births is of some concern. The majority of Tongan women make at least one antenatal care visit (99 per cent have at least one visit) and have skilled attendants at their births (98 per cent).

Noticeably, only 49 per cent of secondary school-age women were enrolled in secondary school.¹⁶⁵ As education is closely related to improved SRH, this is of some concern. This also means that young women are missing out on the family life education that is available at school.

Women with Disabilities

Intimate Relationships

People without disabilities can believe that sexual relationships and marriage are not feasible options for people with disabilities.¹⁶⁶ This may be the case in Tonga, as shared by interviewees. It appears that a general view of people with disabilities was that it is *"impossible for a person with a disability to get married and have children... from a Tongan perspective, you are married to a dying person"*. Other comments reflected this perspective:

“A good man never married a disabled woman”.

“...very difficult for disabled woman to get married”.

“We are not good to make friends because they won’t love us as normal people”.

“A husband would be an extra helping hand, a companion but my sister told me that getting married won’t do any good for me”.

“They do have relationships and we try to keep them in the hall. But they do reject us and we have to do screaming or send them home for a few days”.

The 2006 Survey on People with Disabilities provides some useful statistics on marital status for people with disabilities. This survey found that “people who acquired their disability before the age of 15 years are six times less likely to be or have been married than people who acquired their disability after the age of 15 years”.¹⁶⁷ This is shown in the table below.

Table 5 | Age of disability onset and relationship status¹⁶⁸

Age Acquired Disability	Sex	Single	Married	Divorced/ Separated	Widowed	Defacto	Total Ever in Relationship
Birth to 1 year	M	48%	8%	0%	1%	0%	9%
	F	52%	11%	0%	3%	1%	15%
1-5 years	M	38%	24%	0%	2%	0%	26%
	F	38%	23%	0%	4%	4%	31%
6-15 years	M	43%	25%	1%	1%	0%	27%
	F	35%	36%	0%	3%	0%	39%
16-30 years	M	41%	50%	3%	3%	1%	57%
	F	29%	58%	0%	11%	2%	71%
31 – 60 years	M	14%	71%	2%	12%	1%	86%
	F	8%	68%	1%	22%	0%	91%
61+ years	M	6%	68%	0%	24%	1%	93%
	F	8%	52%	1%	39%	0%	92%

For all people in Tonga aged 15 years and older, 53 per cent of males and 55 per cent of females were ever married.¹⁶⁹ Comparing this with eight per cent of males and 11 per cent of females who had lived with a disability from birth or infancy, shows that there is a significantly lower prevalence of marriage among people who have their disability from an early age. This difference begins to abate for people who have lived with their disability from the ages of 16 to 30 years, when 50 per cent of males and 58 per cent of females had been married.

Across all ages of disability onset, males with a disability have a higher per centage of never being in a relationship compared to females.

This is consistent with the data for all people in Tonga, which shows that there are a higher proportion of males who are never married.¹⁷⁰ Similar to data for all people in Tonga, the higher proportion of women with disabilities who are widowed may reflect the fact that women tend to live longer than men. The other reason why all women in Tonga experience widowhood more than men is because generally Tongan men marry at a later age compared to females, meaning that men are older and therefore more likely to die earlier than their wives.¹⁷¹ It is not possible to assess this for people with disabilities as the readily available data does not include the age of marriage for people with disabilities, only the age of acquisition of disability.

The belief that people with disabilities are not suitable for marriage is not universally held in Tonga, evidenced by the survey statistics and people's experience. As one woman explained:

*“Before I was married my biggest concern was that I would not be able to find a husband. I was so surprised when the man who is now my husband asked me to marry him. Now that we are married and we have children I barely feel like I have a disability at all”.*¹⁷²

Also, women with disabilities may seek out marriage for different reasons than other women, such as the need for support and assistance. In one interviewee's words *“This is why I have boyfriend like this. I need to married and someone who help me”*.

Sexual Activity, Childbearing and Child Rearing

It was not possible to obtain a great deal of information about sexual activity for women with disabilities. Yet it is clear that women with disabilities are sexually active. The 2006 Survey on People with Disabilities found that on average, people with disabilities have 5.8 children,¹⁷³ compared to a national total fertility rate for women of 4.2 in the 2006 Census.¹⁷⁴ The 2006 survey also found that the people with a younger age of disability onset were more likely:

- to have more children than people whose disability began at a later age;
- to be a single parent;
- for women, to be a single parent than men — up to three times more likely; and
- for women with disabilities onset of under five years, to be single mothers than the national average of single mothers.¹⁷⁵

Whether or not sexual activity is always consensual is a key issue. As interviewees stated, *“Some men treat disabled women as a sexual partner”*. The high rates of single parenthood among women with disabilities give some indication of the possibility that sexual relations may be coercive.

One interviewee stated that she thinks sometimes women with disabilities engage in sexual activity or consent to it when they otherwise wouldn't because it makes them feel valued: *"Even though I am a disabled woman he loves me"*, highlighting a conflation of engaging in sexual activity for love, as well as the desire to be valued as a human being.

The 2006 *Survey on People with Disabilities* accurately points out that it is possible that the statistics above represent a situation whereby women with disabilities suffer from a lack of education, either formal or informal, as well as a lack of access to SRH information and services, including contraception. The survey raises the possibility of sexual violence leading to unwanted pregnancies.

Some of the interviewees expressed the idea that a child may be somebody who can provide care and companionship to a woman with a disability (as articulated in an earlier quote) or also that having a child makes the person with a disability feel better about themselves. As one interviewee stated: *"if they have a baby, they feel they are a human being, are proud"*. This desire may also be a contributing factor in choices about pregnancy and childbirth.

Teenage Sexual and Reproductive Health

As the 2006 *Tonga Survey on People with Disabilities* outlined, early onset of disability increases the degree of discrimination experienced, in all areas of life.¹⁷⁶ For a young woman with a disability, this discrimination presents particular challenges for her SRH. The 2006 Tonga survey data shows it is likely that she will become pregnant, possibly as a single mother. Having a disability and being young will mean that a young woman with a disability is unlikely to receive the information she needs, including how her body works, how pregnancy can happen, how to enjoy a safe and respectful sexual relationship and how to prevent pregnancy and what to do if she becomes pregnant. As one young woman interviewed stated, *"People here in Tonga don't talk about it" but "now they see the consequences"*. Compounding this is that if she does reach out for help, a young woman may experience judgemental behaviour from health professionals.

While the reproductive health nurses interviewed all responded in supportive ways to scenarios involving young women with disabilities who were asking for contraception, there was a vague tone of judgement in the advice they would give to young women. This was because of their age, not their disability. Encouragingly, the nurses advised young women to use dual protection — both condoms and another contraceptive — DP (an injection) was the main recommendation from nurses. However, many also stated that they would inform a 16-year-old that she is *"too young to be using family*

planning” or to be having sex. While this may be strictly correct, as becoming pregnant when an adolescent presents particular physical risks, this may be interpreted as judgemental by the young woman asking for assistance, preventing her from returning again. Without fully understanding her circumstances, such as nonconsensual sexual relations, nurses may risk alienating young women who desperately need assistance and support.

Gay, Lesbian, Bisexual, Transgender, Intersex (GLBTI)

Another group of people who experience discrimination are those who have anon-heteronormative sexual orientation, such as being attracted to the same sex, gay, lesbian or bisexual, or who are transgender or intersex. This was an issue that emerged during the interviews for this situation analysis. One woman interviewed for this situation analysis who was same-sex attracted stated that issues such as this in Tonga were not discussed openly. *“Very closed — not very open here in Tonga. Most people here are hiding. But pretending — not real self”*.

As discussed earlier in this report, a woman with a disability who also identifies with another population group that experiences discrimination, such as being GLBTI, will experience a double burden of discrimination. There is a general lack of information and services for anybody who is GLBTI in Tonga, which is further compounded for women with disabilities.

Access to Sexual and Reproductive Health Services

The main barrier for women with disabilities accessing health services of any kind, including SRH services, was consistently reported as being the fact that disability issues are *“hidden”*, associated with shame. Interviewees articulated that this prevented women from coming forward to seek services. As one woman stated, one of the main barriers is people *“looking down, pride”*, in a perfect world everybody would have a *“humble heart and accept, not a proud heart — look and judge”*.

There are also other reasons reported, particularly in relation to the acceptability of services. The 2006 *Survey on People with Disabilities* highlighted that there is a sense of *“fear and distrust of the medical system by many people”*.¹⁷⁷ For women with disabilities, this combines with the fear of discrimination and feelings of shame regarding her disability, as well as bad experiences, to lead to a general avoidance of health services.

One woman reported going to the hospital to ask for assistance with her disability but was informed that there was nothing wrong with her, leading to her decision that she *“can’t go back there because they can’t help”*.

Other interviewees reported being treated last when they went to the hospital. “We sit, sit, sit, normal people go first, we get left till last” and “in the hospital they don’t accept me...only choose to serve friends or family”. One woman reported hearing health professionals making discriminatory comments about her. “After giving birth, some doctors treat me well but when I’m in my room, I heard some of them saying bad words about me”.

In one particularly concerning story, a woman interviewed conveyed her experience of giving birth:

“I went to the hospital after my waters broke, about two weeks before I had been recorded as due. I knew I was due about 10 May but the doctor’s thought I was due at the end of May. Anyway, they sent me away at this point. I went back the next day and saw a doctor who sent me straight away for a [caesarean section] because the baby’s heartbeat was weak. This doctor told the nurses off for sending me away. The nurses were not nice to me. I was very scared at that time”. When asked why she thought she was treated this way, she replied, disability “is the first judgement and then the others”.

The fertility rate for women with disabilities in the 2006 Tonga Survey highlights that women with disabilities have an average 5.8 children¹⁷⁸, compared to a national total fertility rate for women of 4.2 in the 2006 Census.¹⁷⁹ Women with disabilities may well be choosing to have more children, perhaps to provide future support. Although, as outlined above, it may also be because women with disabilities are not enjoying the benefits of the SRH information, education and services that they are entitled to. It is also likely that women with disabilities have low expectations of health services and are not aware of their entitlements.

When asked, most interviewees did not think there were any particular barriers or challenges for women with disabilities receiving contraception. This belief belies the challenges that women with disabilities describe above, in relation to accessing health services. As well as this, many interviewees also stated that women with disabilities had a need for more information and services about family planning, which can be interpreted as an admission that women with disabilities do not get this information and services now. The information they do get may also be tainted by inaccurate understandings of what is appropriate for a woman with a particular disability.

“I used the loop for a while but stopped because the nurses said it is dangerous for some people, and now use normal [name for non-penetrative sex], condoms or counting. But I keep busy at work and so am too tired for sex”.

Involuntary Contraceptive Use or Sterilization

Interviews for this situation analysis provide evidence that women experiencing mental illness or with an intellectual disability are being given contraceptives without their informed consent. The first issue that came up in discussion with staff at the psychiatric ward was that “*mentally retarded women get the family planning injection*” (DP). When the author inquired as to whether or not the women is asked if she wants this, the reply was that “we have to do it” because “*they’ve been around with men, boys...go on street...very dangerous people*” and that the authorities have to prevent them from getting pregnant or there will be “*more problems*”. The use of DP is more common than sterilization because it does not require an operation and many families will consent to their female relative having a contraceptive injection but do not want her to go through having an operation.

In another discussion with a staff member from obstetrics and gynaecology, the statement was made that for some women with disabilities, they tend to advise the parents that the woman should have a tubal ligation and the parents usually consent. This is “*because not absolutely normal like other women*”.

According to a magistrate interviewed for this situation analysis, there is no law regarding sterilization “*but desirable to look into it in relation to mentally affected*”. For women patients on the psychiatric ward who have made reports of sexual violence, the authorities are “*trying to figure out a way to help. Someone suggested giving them a mark*”, but this was rejected because it was thought that this would make them a target for male perpetrators of violence. As an alternative, “*sterilization was suggested*”.

These comments highlight two main factors. The first is that health professionals and other professionals involved in providing for the welfare of women with mental health impairments or intellectual impairments are not aware of women’s basic rights to informed consent. The second factor is that there seems to be a sense that it is not possible to protect women with disabilities from rape, leading to a desire to protect her from possibly unwanted, repeated pregnancies. Underlying these two factors are a multitude of assumptions being made about each individual woman and her capacity to be provided with information and understand it, as well as to engage in consensual sexual relations.

Involuntary contraceptive use and sterilization is a gross human rights violation. Every attempt must be made to discuss these issues with each individual woman and provide her with information, as well as taking every effort to keep her safe from violence. If this is not successful, then a carefully considered, rights-based law should govern involuntary contraceptive use and sterilization.

Violence

At the time of the research, there was scant data available about violence against women in Tonga. A national VAW prevalence study has since been completed by the Tonga Women and Children's Crisis Centre, and the Tonga National Women and Children's Centre, which highlights the significance of violence in Tongan women's lives.

Anecdotal information highlights that violence is most likely a common occurrence for women with disabilities in Tonga, but without broader information it is not possible to state whether this is at similar levels to women without a disability. The statistics from the 2006 survey on single-parenthood among women with disabilities, particularly those who acquire their disability at a young age, also indicate that sexual violence is occurring. Almost every interviewee referred to violence against women with disabilities, particularly sexual violence. One woman's story was particularly powerful, summarized below.

“She was adopted to her uncle when she was about five years old. During that period she was sexually abused by her first cousins. She went back to her parents when she was about nine years old. Then her older brother abused her too, when she was fourteen. Her half-brother too. Then when she was in New Zealand, one night she was drunk and her uncle abused her. She told her parents about the abuse by her first cousins. They did not accept it. She told her sister in New Zealand, who was OK about it. She has never told about her brother. When asked about the abuse, if she thought it was related to her disability, she said ‘took advantage of me because they think I have a disability and I won't talk. They think that I am dumb or something’. She just wanted to drink and get out of the house. During this period she met a man who she liked because he did things to her like a woman would. He found out that she was attracted to women and raped her”.

Comments made by stakeholders often referred to women “roaming the streets”, particularly women with intellectual or mental health impairments. Concerns were expressed that these women were engaging in sexual activity with multiple partners. This may well be transactional (for food or cigarettes), but it is likely some coercion is involved. The ability of women to give informed consent is also an area of concern here.

Women with Disabilities in Institutions

The two institutions in Tonga where women with disabilities reside are the Alonga Centre and the psychiatric ward at Vaiola Hospital. A full assessment of each institution was beyond the time constraints of this situation analysis. However, there are some areas for concern.

Alonga Centre

The Alonga Centre presented indications that neglect and abuse may be occurring. The centre appears dilapidated and unclean, with little obvious in the way of vocational or pleasurable activities for the residents to engage in. There was no toilet paper in the women's toilet, the toilet did not flush and only one out of four taps had running water in it. One man presented his prescription medication to the author. This had not been filled for eight months. Upon inquiring if he needed assistance with filling the prescription the response was that he could do it himself. One woman had a visible rash. Upon inquiring about this the author was informed that it was scabies and that the hospital did not have the cream for it. After a visit by a doctor was arranged this rash was diagnosed as a fungal infection. Several other staff and patients were also diagnosed with fungal skin conditions at the same time. (Treatment and follow-up visits were arranged.)

An inquiry about how much support residents required elicited the response, *"They are old enough to take care of themselves. We're just here to supervise"*. Yet upon observation of the equipment at the centre and the disabilities of some of the residents, it is difficult to see how these residents manage on their own.

There are no doors to individual rooms, just curtains, but the men's and women's wings are locked overnight. The author received reports of neglect and abuse of residents, including withholding of food, physical violence and failure to assist residents with personal hygiene needs, as well as theft of donations. These reports must be treated with caution, as they are not substantiated. Yet it is known that violence occurs in institutions where people with disabilities reside, particularly people with an intellectual disability.¹⁸⁰ Considering the stigma and discrimination associated with disabilities in Tonga, the lack of support and training for volunteers at the centre, and the absence of professional governance and oversight for the centre, it is probable that instances of abuse and neglect have occurred. These were discussed with various people in Tonga, but in the absence of a governing body or management committee for the Alonga Centre, there was uncertainty of how to address the issues.

The Psychiatric Ward

In relation to the psychiatric ward, the main concern for women with a mental illness is that it does not appear that a great deal of attention is given to reports of sexual violence, as outlined above. An indication of this is the reported absence of screening for STIs and pregnancy when a woman reports sexual violence. Staff may assume that women's reports of sexual violence are a delusion or hallucination associated with the woman's mental illness. Even so, these must be treated seriously and investigated appropriately, which may include offering the woman assistance in the form of STI and pregnancy testing.

A full assessment of whether patients were made aware of their rights and any existing mechanism for complaint was not undertaken during this situation analysis. The potential exists for women patients on the psychiatric ward to be at risk of abuse by both staff members and other patients. Precautions are taken at night by locking off the women's and men's sleeping quarters, but this does not prevent violence at other times of the day or by the staff. A mechanism for patients to file complaints against staff should be in place and fully utilized.

Concluding Thoughts

There are outstanding pockets of committed and motivated individuals in Tonga who are working hard to build a more inclusive society. NATA is at the forefront of these efforts with committed and skilled individuals working hard to improve the situation of people with disabilities. Alongside NATA, at the service provision level, is the Mango Tree Centre. TFHA's disability and sexuality workshops were successful and in demand, but are no longer running. TWCCC's model of community liaison and advocacy is also filling a significant community need, although not solely focused on women with disabilities. All four of these organizations are under-resourced in their work and would benefit from greater support, particularly that which is long term and thoughtful. They are contributing a great deal already to assist women with disabilities and are leaders in Tonga.

These organizations are working within an environment of structural discrimination. Population attitudes towards people with disabilities are generally negative and poorly informed. There is no cohesive whole-of-government approach to building a society that includes people with disabilities and respects them as people with the same rights as everybody else. The dominant approach to people with disabilities appears to be that of charity. While this is based somewhat on compassion, a charity approach contributes to the denial of basic human rights for people with disabilities.

Due to the constraints of this situation analysis it is not possible to draw a comprehensive picture of the SRH experiences of women with disabilities. Yet the 2006 survey, combined with the various interviews for this situation analysis, provides enough information to highlight areas for concern and strengths (as outlined above). What is certain is that due to the nature of discrimination, women with disabilities bear the burden of multiple discriminations and taboos. The societal rules surrounding contraceptive use, sexuality (such as same-sex attracted people and homosexuality), youth sexual behavior and strict gender norms, discriminate against people who do not conform to these rules, including women with disabilities. On top of this, women with disabilities also experience the stigma and discrimination associated with their disability. This interacts with their other identities, compounding and deepening discrimination. Where there are challenges in relation to SRH issues in Tonga, it is certain that women with disabilities feel these profoundly.

In general, interviewees (both women with disabilities and stakeholders) appeared to find it challenging to answer questions about what particular needs women with disabilities had when it comes to family planning, pregnancy, childbirth and sexual relations. This may well be because these issues are sensitive and not necessarily often discussed. It may also be because this is not an issue that much thought has been given to. Interviews with SRH professionals highlighted that few had experienced working with women with disabilities. When asked to consider potential challenges despite this lack of experience, most often the issue of stigma emerged. It is possible that combined with the general lack of awareness about SRH issues, and the discrimination faced by people with disabilities, women with disabilities' needs are not obvious. Alongside this, it is likely that women with disabilities have low expectations for information and services, contributed to by an unconscious acceptance of neglect as normal.

The indications are that the specific SRH issues that women with disabilities experience are issues that are not given much consideration by various stakeholders. These indications include the fact that women with disabilities appear to have had bad experiences with health services, the challenges discussing SRH openly, the high fertility levels among women with disabilities (particularly those who had an early onset of disability) and the very low contraceptive prevalence rate among all women in Tonga.

Specific areas that stand out are listed below.

- At the population level, community attitudes towards people with disabilities are discriminatory at worst and of a “charity” mindset at best.
- At the individual level, women with disabilities can experience acceptance, respect and dignity from other people, depending upon the people she comes across throughout her life.
- Family are the most important positive or negative factor for women with disabilities. In the absence of a government social safety net, if a woman with a disability does not have family (or friends) who are respectful, caring and supportive, life is very difficult.
- There is a significant lack of information and services for women with disabilities, both about their disability but also in relation to SRH issues.
- It appears likely that women with disabilities are more likely to experience sexual relations that are coercive and violent (research elsewhere shows this), and this relates specifically to their disability. It is likely that women with an intellectual or mental health impairment are at high risk.
- Involuntary sterilization occurs in Tonga, based on a desire to protect women with disabilities combined with a lack of understanding about both their rights, as well as the woman’s capabilities
- The Alonga Centre and the psychiatric ward require urgent support to create residential institutions that are rights based, well resourced, safe and supportive environments for the people with disabilities who live there.
- Research on abortion would be useful in Tonga, in order to assess its prevalence and possible impact on maternal health.

Tonga Recommendations

The recommendations below should be read in conjunction with the “Recommendations for All Three Countries” above.

- 1. Training and Education.** In line with Recommendation 4 in “Recommendations for all Three Countries”, fund TFHA to revive, improve and expand upon the disability and sexuality workshops that were conducted in the past. These workshops should be governed by a partnership between TFHA and NATA, to ensure that people with disability have oversight for how these educational sessions are run (at the governance level). Once established, TFHA staff could support KFHA in Kiribati to run similar workshops, and potentially expand to SIPPA in Solomon Islands, maximizing the benefits of their joint IPPF membership.

2. **Alonga Centre.** Engage with the Government of Tonga and other stakeholders working in the area of disability in Tonga to explore the how to support and improve the Alonga Centre.
3. **Legislation and Policy Advocacy.**
 - a. When working with the Government of Tonga, take all opportunities to encourage a whole-of-government approach to disabilities, rather than viewing it only as a health issue.
 - b. Engage with the Ministry of Education, Women Affairs and Culture, local NGOs and RRRT, in the law reform efforts on violence against women and development of a Disability Bill, to ensure women with disabilities are included and NATA is involved in the process.
 - c. Engage with the Ministry of Health as it develops a disabilities strategy, to ensure that the specific needs highlighted in this situation analysis are included.

APPENDIX ONE: TERMS OF REFERENCE

The below are excerpts from each of the two Terms of Reference for these three situation analyses. The whole Terms of Reference are not included as there is a good deal of background and context-setting information, which is not relevant.

Proposal to conduct situation analyses in Solomon Islands

APRO plans to conduct situation analyses in 3 countries in the Asia-Pacific region with a view to obtaining a better understanding of the actual situation of disabled women and girls vis à vis their rights to accessing RH information and services, including protection from GBV and support services.

It is proposed that a regional institution will be partnered to coordinate studies in the identified countries (possibly Thailand, Sri Lanka and Solomon Islands) to determine the extent to which government and civil society partners are addressing the RH needs of women and girls following adoption of the Convention on the Rights of People with Disabilities. The “coordinating institution” will be decided once the individual countries have been confirmed and partners identified. This TOR refers to Solomon Islands study, which is part of the regional study mentioned before.

Purpose

The purpose of the study in each country will be to:

1. assess the SRH situation and needs of disabled women and girls, including vulnerability to violence and sexual abuse;
2. identify critical issues and concerns which urgently need to be addressed (legislation, policy, practices and services);
3. identify and document examples of “good practice” that could perhaps be replicated in other countries.

Based on the findings, the final report will also make recommendations which will be used to help guide UNFPA Country Offices for 2011 and beyond, and which will also feed into UNFPA’s forthcoming Strategy.

Specific activities

Using a combination of literature search, key informant interviews and a selected number of focus group discussions:

- A. Review and document the extent to which the RH rights of women and girls with disabilities are being realized (covering, as possible, physical and mental disabilities, including sensorial, psycho-social and intellectual disabilities.) This will include:
- Reviewing the legal and policy environment, including the extent to which policy has been disseminated and implemented in sectors such as health, education and social welfare, etc.;
 - Assessing the extent to which women and girls with disabilities are able to access SRH information and services, with a particular focus on SRH information during adolescence, and family planning and STI services including HIV testing;
 - Assessing the vulnerability of disabled women and girls to sexual and physical abuse and exploitation (including of girls and women in institutions), and access to services for protection against GBV;
 - Exploring cultural attitudes towards women with disabilities, and analyzing how these may impact on access to services;
 - Reviewing the extent to which women and girls with disabilities are discriminated against with respect to their reproductive rights: particularly reviewing whether the State/ medical services advises/undertakes (forced) sterilization of disabled girls/women as a general practise, and in relation to the possible double burden of discrimination against those who may be infected with HIV;
 - Assessing the extent to which responsible national authorities, disabled people's associations and other social welfare/health groups are addressing the SRH needs of women and girls with disabilities, identifying gaps in terms of knowledge and capacity;
 - Assessing how women's agency has conducted advocacy, protection and support services for prevention and response to GBV for women and girls with disabilities;
 - Identifying the main issues for urgent policy and advocacy action, to be included as recommendations.
- B. Recommend ways in which UNFPA can support the rights of women and girls with disabilities to access SRH information and services, as well as protection from GBV and access to related services, through advocacy, knowledge sharing or capacity building of national level partners (govts and CSOs).

Methodology

A combination of literature review, key informant interviews, and focus group discussions and interviews with women and girls with disabilities, service providers and carers will be used. To the extent possible, a literature search will be the main methodology, but given the anticipated limited number of materials to review (particularly qualitative data), carefully selected key informant interviews and focus group discussions will be held to source additional material. Due to limitations of time and resources, in this respect it will not be possible to consult with disabled people representing all types of disabilities. In ensuring that there is provincial perspective to this undertaking, it is hoped that there will be provincial travel to meet with women with disabilities who are located at the sub national/provincial level.

Output

1. Dialogue and Consultation with Stakeholders (National and Provincial)
2. One Day Capacity Building workshop for MOH, PWDSI and MWYCA Partners (30 participants)
3. Situation Analysis Report and Recommendations (approximately 30 pages).

Timing

It is foreseen that the study will take 7 weeks to conduct and document and that the work will begin in October 2010. The fee will be paid on an output basis.

Qualifications

A relevant institution, NGO or consultant will be contracted to conduct the study with the following expertise:

- Formal social research expertise and experience
- Familiarity with disabilities; experience in working with and addressing the rights of disabled people
- Health sector experience, with a particular focus on reproductive health
- Gender analysis
- Excellent written and report writing skills in English

If a consultant is appointed, it is expected that that person would have a Master's degree in a Social Science or related discipline.

Proposal to conduct situation analyses Kiribati and Tonga

PSRO will conduct situation analyses in Kiribati and Tonga to obtain a better understanding of the actual situation of disabled women and girls vis à vis their rights to accessing RH information and services, including protection from GBV and support services.

Purpose

The purpose of the study in each country will be to:

1. assess the SRH situation and needs of disabled women and girls, including vulnerability to violence and sexual abuse;
2. identify critical issues and concerns which urgently need to be addressed (legislation, policy, practices and services);
3. identify and document examples of “good practice” that could perhaps be replicated in other countries.

Based on the findings, the final report will also make recommendations which will be used to help guide UNFPA programme support, and which will also feed into UNFPA’s forthcoming Strategy.

Specific activities

Using a combination of literature search, key informant interviews and a selected number of focus group discussions:

- A. Review and document the extent to which the RH rights of women and girls with disabilities are being realized (covering, as possible, physical and mental disabilities, including sensorial, psycho-social and intellectual disabilities.) This will include:
 - Reviewing the legal and policy environment, including the extent to which policy has been disseminated and implemented in sectors such as health, education and social welfare etc.;
 - Assessing the extent to which women and girls with disabilities, are able to access SRH information and services, with a particular focus on SRH information during adolescence, and family planning and STI services including HIV testing;
 - Assessing the vulnerability of disabled women and girls to sexual and physical abuse and exploitation (including of girls and women in institutions), and access to services for protection against GBV;
 - Exploring cultural attitudes towards women with disabilities, and analyzing how these may impact on access to services;
 - Reviewing the extent to which women and girls with disabilities are discriminated against with respect to their reproductive rights: particularly reviewing whether the State/

medical services advises/undertakes (forced) sterilization of disabled girls/women as a general practice, and in relation to the possible double burden of discrimination against those who may be infected with HIV;

- Assessing the extent to which responsible national authorities, disabled people's associations and other social welfare/health groups are addressing the SRH needs of women and girls with disabilities, identifying gaps in terms of knowledge and capacity;
- Assessing how women's agency has conducted advocacy, protection and support services for prevention and response to GBV for women and girls with disabilities;
- Identifying the main issues for urgent policy and advocacy action, to be included as recommendations.

- B. Recommend ways in which UNFPA can support the rights of women and girls with disabilities to access SRH information and services, as well as protection from GBV and access to related services, through advocacy, knowledge sharing or capacity building of national level partners (govts and CSOs).

Methodology

A combination of literature review, key informant interviews and focus group discussions and interviews with women and girls with disabilities, service providers and carers will be used. To the extent possible, a literature search will be the main methodology, but given the anticipated limited number of materials to review (particularly qualitative data), carefully selected key informant interviews and focus group discussions will be held to source additional material. Due to limitations of time and resources, in this respect it will not be possible to consult with disabled people representing all types of disabilities. In ensuring that there is provincial perspective to this undertaking, it is hoped that there will be provincial travel to meet with women with disabilities who are located at the sub national/provincial level.

Output

1. Dialogue and Consultation with Stakeholders (national and outer islands)
2. One Day Capacity Building workshop for MOH, PWDSI and MOW
3. Situation Analysis Report and Recommendations (approximately 30 pages)

Timing

It is foreseen that the study will take approximately 10 weeks (4 weeks for Kiribati and 4 weeks for Tonga, and 2 weeks desk work) to conduct and document. The consultancy work will be undertaken within the period June to November 2011. The fee will be paid on an output basis.

Qualifications

A relevant institution, NGO or consultant will be contracted to conduct the study with the following expertise:

- Formal social research expertise and experience
- Familiarity with disabilities; experience in working with and addressing the rights of disabled people
- Health sector experience, with a particular focus on reproductive health
- Gender analysis
- Excellent written and report writing skills in English

If a consultant is appointed, it is expected that that person would have a Master's degree in a Social Science or related discipline.

Details for the work to be delivered

2 week preparatory work will be undertaken during at the consultants home base, followed by **2 weeks visit to Tonga and 2 weeks to Kiribati** where the assessment will be undertaken by the consultant in close collaboration and consultation with UNFPA staff, various national counterparts (govt. and NGOs) as arranged by the UNFPA office and in country partners. **Travel to the various provinces and sites** will be undertaken in order to meet women with disabilities, caregivers, government/NGO and other agency representatives and conduct interviews and focus group discussions. At the end of the two week visit to each of Tonga and Kiribati, a capacity building/"sharing of main findings" workshop will be organized with relevant national counterparts by the consultant in collaboration with UNFPA. The main purpose of this event is to share "main RH and women with disability issues and concerns" and discuss some of the main findings, and draft recommendations for action. The final assessment report will be completed during the last 4 weeks of the consultancy at the consultant's residence.

APPENDIX TWO: LISTS OF INTERVIEWS

Kiribati List of Interviews

1. Twenty women with disabilities
2. President of AMAK
3. HIV and STI Team, Ministry of Health
4. Reproductive Health Coordinator, Ministry of Health
5. Obstetrician and Gynaecologist, Ministry of Health
6. Trainee Psychiatric Intern, Ministry of Health
7. Sister in Charge of the psychiatric unit, Ministry of Health
8. Mental Health Coordinator, Ministry of Health
9. Three Teachers at the School for Children with Special Needs
10. Te Toa Matoa
11. Gender-Based Violence Coordinator, Division for Women's Development, Ministry of Internal and Social Affairs
12. Education Programme Manager, AusAID
13. Adolescent Health and Development Programme Coordinator
14. Executive Director and Programme Officer, Kiribati Family Health Association.

Solomon Islands List of Interviews

1. People with Disabilities Solomon Islands
2. Save the Children: Honiara and Gizo
3. World Vision: Honiara and Kira Kira
4. Acting Director, Reproductive Health Division of the Ministry of Health and Medical Services
5. Coordinator, Sexual Violence Unit, Solomon Islands Royal Police Force
6. Bethesda Disability Training and Support Centre
7. Kastom Garden
8. Sisters, Christian Care Centre
9. Programme Manager, Bilateral Health and Gender, Development Cooperation; and Counsellor, Development Cooperation, AusAID
10. Ministry of Women, Youth and Children's Affairs,
11. Adventist Development Relief Agency (ADRA)
12. General Secretary, National Council of Women
13. Counsellor, Family Support Centre
14. National Coordinator, HIV/STI Division, Ministry of Health and Medical Services
15. Solomon Islands Council of Churches
16. Reproductive Health Nurse, Seghe

17. Reproductive Health Nurse, Lale, Ranongga
18. CBR staff members: Honiara, Makira, Western Province
19. Anglican Church, Gizo
20. SSED Church, Gizo
21. United Church, Gizo
22. Gizo Health Promotion Unit, Ministry of Health and Medical Services
23. President, Provincial Council of Women, Gizo
24. Parents (eight) of children with a disability in Gizo (separate from the interviews with women)
25. Officer-in-Charge, Solomon Islands Royal Police, Munda
26. Self-help Group, People with Disabilities Makira
27. Provincial Minister of Health, Makira
28. Secretary of Provincial Council of Women and Women's Centre, Makira
29. Seventh Day Adventist Church, Makira
30. Social Welfare Officer, Makira
31. Reproductive Health Nurse, Makira
32. Medical Director, Makira Hospital
33. Teacher, San Isidro

Tonga List of Interviews

1. Seven women with disabilities
2. Adolescent Health and Development Programme Coordinator, Tonga Family Health Association
3. AusAID, Staff Responsible for Health Systems Support Programme Oversight
4. Coordinator and Trainer Counsellor, Tonga National Women and Children's Centre
5. Country Focal Officer, VAW: Changing Laws, Protecting Women
6. Deputy Director and Head, Women Affairs, Ministry of Education, Women Affairs and Culture
7. Director of Health, Ministry of Health
8. Director, Civil Society Forum of Tonga
9. Executive Director and Teacher, Tonga Red Cross Society
10. Executive Director, Health Promotion Foundation
11. Executive Director, Tonga Family Health Association
12. Inclusive-Education Policy Author
13. Magistrate and President of Psychiatric Ward Tribunal, Magistrates Court
14. Manager, Alonga Centre
15. Mango Tree Respite Centre
16. Matron, Vaiola Hospital
17. Medical Officer, Communicable Disease Section, Ministry of Health, Vaiola Hospital

18. Nurse in Charge, psychiatric unit, Vaiola Hospital
19. Obstetrician at the Vaiola Hospital
20. President and Women's Focal Point, Naunau O'E' Alamaite Tonga Association (NATA)
21. Secretary, Langa Founua
22. Secretary, Para-Olympic Committee
23. Secretary, Tonga Human Rights and Democracy Movement
24. Several staff, Tonga Women and Children's Crisis Centre
25. Team Leader, Salvation Army Drug and Alcohol Services

APPENDIX THREE: GENERAL DISABILITY ISSUES AND RECOMMENDATIONS EMERGING FROM SITUATION ANALYSES

These situation analyses focus on a specific area of life for women with disabilities — that of their SRH. Inevitably, broader disability issues emerged that impact on the quality of life for women with disabilities, including their ability to enjoy healthy sexual and reproductive lives. An analysis of these issues is beyond the scope of this report, but it is important to refer to them briefly, as listed below.

- 1. Early assessment, diagnosis and intervention.** In each of the three countries there appeared to be few mechanisms for early detection and intervention of impairments, at all stages of life. This was particularly so in Kiribati and Tonga.
- 2. Quality/accurate diagnosis.** There were few health professionals in each country with specialist knowledge of disabilities, particularly in the area of intellectual and mental health impairments. This meant that often people were not given an accurate diagnosis and at times showed the potential of achieving greater activity than what they were currently achieving (this also relates to points below).
- 3. Education re. causes and diagnoses** — for both health professionals, and for people with disabilities and their families. Linked with the above, there was a general lack of awareness about what caused particular disabilities and what any particular diagnosis meant. This was prevalent in each of the three countries among non-specialist health professionals, families and women with disabilities.
- 4. Follow-up, care and support, including home-based/community-based.** In all three countries there were programmes to support people with disabilities in their communities. This was well established in Solomon Islands Community-Based Rehabilitation programme. But much greater resourcing is required to support women with disabilities, particularly for women with significant physical, intellectual and mental health impairments, or a combination.

5. **Maintenance of a database or register of people with disabilities.** Each of the three countries had carried out a *Survey on People with Disabilities* in the past. These provided a good beginning in terms of identifying people with disabilities in each country. In Kiribati and Solomon Islands, the Ministry of Health has maintained a register of some description yet there is no mechanism in place for maintenance of this register, such as adding new people with disabilities or removing people who have died. This process requires collaboration between government and local DPOs, allocation of responsibility to one organization and ongoing resourcing.
6. **A whole-of-government approach.** Building inclusive societies requires input from all sectors, including education, health, employment, transport and justice. While disability must be mainstreamed across the activities of governments, civil society and the private sector, there needs to be a collaborative mechanism for ongoing monitoring and promotion of this mainstreaming. Currently responsibility falls on the local DPO or a programme in the Ministry of Health. This does not show a whole-of-government commitment.
7. **Laws, strategies and policies.** These situation analyses highlight that, in general, regional frameworks and strategies, and country legislation and policies pay insufficient attention to the needs and contributions of women with disabilities. Legislators, policymakers and programme staff most likely do not understand or have an awareness of the significant challenges women with disabilities face, or how to go about taking appropriate action. Therefore, advocacy, training and ongoing support for legislators, policymakers and programme staff in government and civil society (and the private sector, where relevant) is important to ensure the specific needs and contributions of women with disabilities are considered and resourced.
8. **People with severe disabilities experience significant challenges.** These situation analyses found that women with intellectual and/or mental health impairments, or with severe physical impairments, experienced extreme discrimination.
9. **Families need more support.** As global research has found (see above) people with disabilities rely heavily on their families for support and care, and this was found in these situation analyses. Yet families received little education or support to carry out this important role, and nor did individual family caregivers receive respite or support for their own needs in providing care.

10. A need to prevent fragmentation. The area of disability is finally receiving the attention it requires in the global community. As more donors and agencies begin to fund work in this area there is the potential for fragmentation. It is important that funding agencies, whether they be donor governments, civil society organizations or multilaterals, understand the local context before providing funds and work collaboratively with other international agencies, as well as already established local organizations. Donors and international organizations must be aware of this in their activities and recognize how access to scarce funds can create competition and cause fragmentation among small populations, scattering already scarce resources.

GENERAL DISABILITY RECOMMENDATIONS

1. **Whole-of-government Coordination.** Establish a national coordinating group (or re-establish in the case of Solomon Islands) and ensure that all government, civil society and private sector groups working on disability issues are aware of this group and its function to share information and coordinate action on disability issues.
2. **Residential Care and In-patient Care**
 - a. Residential services must have a management committee or governance body to oversee the service and to ensure basic standards are enforced and that staff and volunteers are trained and supported.
 - b. Residential services and in-patient psychiatric services require adequate government resourcing: allocating inadequate funds to these services is discrimination and amounts to the abuse of the basic human rights of people who make use of these services.
 - c. Increasing the availability of occupational therapists would benefit people with disabilities in long-term care. This could be provided through various volunteer programmes.
3. **Service Provision.** Ensure that services reach people who are not in hospital and who do not live in the main urban area or island. People living with disabilities who are not near an urban centre experience greater neglect and isolation than those who do. Emphasis must be placed on reaching these people with good quality services.
4. **Database.** Establish and/or update and maintain a database of people with disabilities, including a database monitoring mechanism, within MHMS, for the purposes of future planning and programming for people with disabilities. Ensure that this database disaggregates individuals at least by sex, gender and age.
5. **Family Support.** Explore and implement mechanisms to provide families, friends and carers of people with disabilities with ongoing support and education, such as family support groups.
6. **Awareness Raising, Advocacy and Education.** Run a nation-wide educational radio campaign about the rights and experiences of people with disabilities, including on SRH issues, including violence against women.

- 7. Disaster Preparedness, Response and Rehabilitation.** Ensure that disaster preparation, response and rehabilitation activities cater to women with disabilities, particularly in relation to their personal safety, access to water, toilets and food, prevention of and treatment/support for survivors of sexual violence, prevention of excess maternal mortality, provision of cloth and pads for menstruation and ongoing provision of contraceptives, including condoms.
- 8. Information and Education.** Integrate pictures and stories of people with disabilities into activities that aim to inform, educate, communicate and change the behaviour of people, for example in the areas of nutrition, non-communicable diseases, voter education, HIV and malaria.
- 9. Climate Change.** Ensure that the specific needs of women with disabilities are incorporated into activities to mitigate and adapt to climate change.
- 10. Infrastructure, Services.** When building new clinics and schools, or renovating old ones, ensure that they enable access for and safety of women with disabilities, including ramps, rails in toilets and secure toilets and areas for washing.

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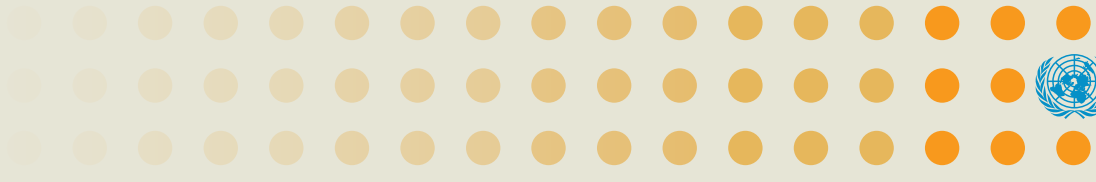
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