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LESSONS FROM THREE PACIFIC ISLAND STATES RESPONSES TO THE COVID-19 PANDEMIC

Strengths, Impacts and the Experiences of Vulnerable Groups

Fiji Women's Rights Movement (FWRM)

FEMINISTS
FOR A PEOPLE'S
VACCINE

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ACRONYMS

NGO	Non- Government Organization
WHO	World Health Organization
TWN	Third World Network
FPV	Feminists for a People's Vaccine Campaign
DAWN	Development Alternatives for Women for a New Era
EDI	Equality, Diversity and Inclusion
FGD	Focus Group Discussions
CSO	Civil Society Organizations
HIV	Human Immunodeficiency Virus
SRHR	Sexual and Reproductive Health and Rights
PWD	Persons with Disabilities

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INTRODUCTION

The coronavirus (COVID-19) pandemic is considered to be one of the defining moments in modern history. A susbstantial number of cases and deaths occurred in many Pacific Island countries. For the purpose of this study, we are focusing on Fiji, Vanuatu and Samoa. In Fiji, there were 71,040 COVID-19 cases and 949 fatalities. Vanuatu recorded 19,789 cases with 22 fatalities, and Samoa recorded 29, 621 cases with 60 deaths (Bell et al, 2022).

During the Covid pandemic, the poor were pushed into further poverty with insufficient income to pay for basic needs. The COVID-19 pandemic illuminated existing frailties in our society, but more importantly, it illustrated clear distinctions between the rich and the poor and between those in the mainstream and those on the margins. The measures taken by governments across the world had unprecedented impacts on people and led to multifaceted outcomes, specifically loss of employment, food insecurity, poor healthcare services, and increases in gender-based violence.

In the Pacific, the COVID-19 pandemic posed immense dangers to already ailing public healthcare systems, affecting access to usual outpatient services, including for checkups and treatment of chronic medical conditions. Although there were fewer Covid cases reported in the Pacific region compared to other parts of the world, the danger of widespread transmission became a serious concern of all Pacific governments. Measures to contain the spread of COVID-19 infections were gender blind/neutral, ignoring or failing to consider the gendered needs for healthcare services, with women, girls, and other vulnerable groups in society, including those living in poverty, being more acutely affected.

The roll-out of vaccine programmes in the Pacific was challenging as gender played a significant role in vaccine uptake. Vaccine policies, programmes and their subsequent implementation were also gender blind which directly or indirectly played a role in undermining efforts to ensure vaccine equity.

Across the Pacific, access to public healthcare systems already crippled by under-funding and shortage of health workers was further limited by restrictions on public health systems and services during lockdowns. Such restrictions meant that women and girls had limited access to essential sexual and reproductive health services which included contraceptive supplies, maternal health services, pap smears and

pre natal care (DIVA et al, 2020). Breast and cervical cancers remain the highest causes of death for Pacific women and during COVID-19 access to medication, surgery and post-recovery treatment, palliative care and the management of cancer patients were further affected. Additionally, many women in the healthcare system became frontline workers in the response to COVID-19, placing them at increased risk of exposure to infection. This had physical, mental and psychological impacts, and being away from family, children and loved ones was especially hard as family and community support are central to wellbeing in Pacific communities.

The pandemic took a severe toll on those already living in poverty. There is a heavy income reliance on the tourism industry in Pacific Island states. The Pacific Islands are popular tourist destinations. Tourism is the largest revenue-earner for many Pacific countries and its multiplier effects benefit the local economy, sustaining small businesses, and various informal employment opportunties, as well as supporting agriculture, transport and the arts sector. Women comprise a third of the tourism workforce which was especially impacted by COVID-19. With border closures, curfews and lockdowns in place, the tourism industry came to a standstill, rendering 115,000 employees across the entire industry, including in the national airline, unemployed. Women workers in this sector were hard hit, subjected to wage reductions, being sent home on leave without pay, or being laid-off work completely. With strict public curfews and restrictions on movement, women could not find alternative income sources to support their families.

The impact of any global pandemic requires thorough analysis to ensure that we learn lessons from the experiences and are prepared for future emergencies. This paper employs a Equality, Diversity and Inclusivity (EDI) framework in its approach to analysing the impacts of and responses to the pandemic, especially in terms of accesss to health by marginalized populations, specifically sex workers, transgender women (fa'afafine), and women with disabilities, with a focus on equitable treatment, and creating a foundation of respect, support and fair access in both policy and healthcare.

The research paper documents the challenges women reported facing during the pandemic, specifically sex workers, transgender women (fa'afafine) and women with disabilities. Additionally, the paper analyses the laws, policies, programmes and accountability mechanisms that comprised the legal and institutional frameworks put in place, as well as the roles of the media, civil society groups and social movements during the pandemic.

METHODOLOGY AND DATA SOURCES

Two research tools were employed for data gathering: Literature review and Focus Group Discussions (FGDs).

a. The Review of literature aimed to delve into the specific regulations which were implemented in the Pacific Islands, and the strengths and the challenges faced in fighting the COVID-19 pandemic. The review scope encompassed newspaper and online articles and other publications, and available data related to the issue.

b. FGDs: Focus group discussions were conducted in Fiji, Samoa and Vanuatu. Doris Tulifau of *Brown Girl Woke*, an initiative which empowers youth in all levels of schooling in rural Samoa by investing in their education, aspirations and success, organized the FGDs in Samoa with transgender women (*fa'afafine*) from the Samoa Fa'afafine Association and Malu o Aiga to obtain primary data. In Vanuatu, FGDs with sex workers from Erakor Bridge Youth Association and Seaside Community Association, as well as with women with disabilities from Vanuatu Young Women for a Change, were arranged by Anne Pakoa, the Founder of the Vanuatu Human Rights Coalition. In Fiji, the FWRM arranged FGDs with sex workers of the Survivor Advocacy Network and the Strumphet Alliance Network. Women with disabilities participants were members of the Fiji Disabled Peoples Federation. A breakdown of the participants in the FGDs held in the three countries is shown below:

FIJI	**18 WOMEN ENGAGED IN SEX WORK AND 6 WOMEN WITH DISABILITIES**
SAMOA	**6 TRANSGENDER WOMEN (*FA'AFAFINE*)**
VANUATU	**6 WOMEN ENGAGED IN SEX WORK AND 7 WOMEN WITH DISABILITIES**

Questions based on thematic areas were used during the FGDs to collect disaggregated data. Individual consent forms were not distributed but participants were advised of the objectives and assured of the confidentiality of the research, and the non-disclosure of names or any information that might identify them. They were also informed that the sessions would be recorded with the identities of all participants anonymized.

LITERATURE REVIEW

LEGISLATIVE RESPONSES DURING THE COVID-19 PANDEMIC FIJI

Fiji implemented several legislative measures to contain the spread of COVID-19. The most controversial one garnering a lot of public scrutiny was the "No Jab, No Job" Policy, introduced in 2021 through the Health and Safety at Work (General Workplace Conditions) Regulations (Part 14A). This was a mandatory vaccination policy that required all employers and employees in both the public and private sectors to be vaccinated as a preventative strategy. **Part 14A** made it unlawful for employers and workers to enter workplaces unless they had received the prescribed doses of an approved COVID-19 vaccine. It also allowed workers to be dismissed if they were not vaccinated (https://www.munroleyslaw.com/no-jab-no-job-ends/). This policy was enforced in other service sectors, as a requirement for accessing supermarkets and shops (Bell et al., 2022). Wilson et al (2023) stress that the "No Jab No Job" Policy's implementation accelerated Fiji's vaccination program; by October 20, 2021, 95.9 per cent of the eligible adult population had received their first dose, and 84.4 per cent had received their second dose.

This policy was viewed by many Fijians, however, as a violation of an individual's right to make decisions about their own body. Forcing employees to receive a vaccine against their will was seen as infringing their bodily autonomy and personal freedom. Denying employment to individuals who refused vaccination impacted their right to work with potentially severe economic and social consequences, especially in contexts where unemployment benefits and alternative job opportunities are limited or non-existent. The human rights implications of this policy needs further analysis.

The Public Health Order enforced lockdowns and curfews on all Fijians – exceptions were given for medical emergencies (KPMG, 2021). This policy had a direct impact on access to healthcare services, treatment, medication and other essential services in situations that were not necessarily a "medical emergency" but were nonetheless concerning (Dean, 2020). In Suva, diabetic patients needing daily testing and treatment did not turn up to the health center and missed half of their required visits due to the lockdown. These records are not easy to quantify and it was different for those who could test and treat themselves at home. Those who missed the health centre services would also have been affected by the police

passes required for emergency hospital runs. Furthermore, the Public Health Order enforced a nationwide curfew from 11:00pm-4:00am daily. Towns, cities, housing suburbs, villages and outer islands were heavily patrolled by the Fiji Police Force, which led to significant human rights violations. Due to prolonged restricted movement, people were unable to find employment in order to buy food, water and daily essentials.

The curfews particularly affected those who relied on daily jobs or informal work to purchase food supplies. Without being able to work they experienced food insecurity. To address the growing food issue, food rations were distributed to houses in designated lockdown zones and to those living under home isolation on a needs basis. Requests for food rations could be made via a toll free number and/or by email. The food rations were a motivating factor for people to get vaccinated as well, as rations were only provided to those who were vaccinated.

Through an agreement with the Government, unemployment relief was provided to eligible workers by the Fiji National Provident Fund, by permitting FNPF members to make withdrawals of $1,000.00 from savings in their own accounts. Where members savings were insufficient they were topped up by the government. FNPF is Fiji's national superannuation and retirement savings fund. It is a compulsory savings scheme that requires both employers and employees to contribute a mandatory percentage of wages to provide retirement benefits for employees. FNPF's COVID-19 Unemployment Relief was provided in several phases for members who were on leave without pay, unemployed, or on reduced working hours and pay (Fiji National Provident Fund, 2021).

COVID-19 UNEMPLOYMENT RELIEF PHASES:

1. Phase 1:

- **Eligibility:** Members who lost their jobs or experienced reduced hours/ wages due to the pandemic.
- **Assistance:** Provided financial support directly from members' General Account balances.

2. Phase 2 (8 Rounds):

- **Eligibility:** Members unemployed from October 2019, or on leave without pay.
- **Assistance:** Allowed withdrawals from members' General Accounts, with specific rounds reopening as needed.

3. Phase 3 (6 Rounds):

- **Eligibility:** Members experiencing reduced wages or hours.
- **Assistance:** Offered partial withdrawals to compensate for income loss.

4. Phase 4 (5 Rounds):

- **Eligibility:** Members unemployed between January 2010 and September 2019.
- **Assistance:** Provided financial relief to long-term unemployed members.

5. Voluntary Members' Relief (3 Rounds):

- **Eligibility:** Voluntary members with sufficient General Account balances.
- **Assistance:** Enabled withdrawals to support those without formal employment.

6. Lockdown Relief (2 Rounds):

- **Eligibility:** Members affected by specific lockdown measures.
- A**ssistance:** Offered immediate financial support during lockdown periods.

7. SMEs, Taxi/Minibus Drivers (1 Round):

- **Eligibility:** Small and Medium Enterprises (SMEs) and registered taxi/minibus drivers.
- **Assistance:** Provided targeted relief to these sectors.

These relief measures were active for more than two years, concluding in February 2022. During this period, a total of $366.3 million was disbursed across 27 rounds of COVID-19 relief, with $185.5 million contributed by the Government and $180.8 million from FNPF (members own contributions). As the relief provided throough FNPF were permitted withdrawals of funds from FNPF members' own individual accounts, this had the disadvantage of diminishing funds for workers' eventual pensions. Most domestic workers and other informal sector workers did not benefit from this relief measure as they are not FNPF members.

Employers in Fiji were the main beneficiaries of The Fiji National Provident Fund (COVID-19 Response) (Amendment) Act 2020, passed by the Fiji Parliament on 27 March 2020, which halved the mandatory employer contributions for each of their employees from 10% to 5% of their wages. This, together with the reduction of worker contributions from 8% to 5% over the same extended period, significantly diminished contributions towards all workers' retirement savings.

Non-legislative responses to Covid by the Fiji government included an "Agriculture Response Package for COVID-19" which upscaled several initiatives which were

already in place to ‘ensure [people had] access to adequate food of acceptable quality and nutritional value’ thoughout the crisis (Sherzad, n.d.). The response included a home gardening program , which involved the provision of gardening seed packs to all urban and peri urban areas around Fiji by agriculture extension officers, with laid off corporate employees also being targeted for seed distribution; and a Farm support package ‘to boost production of short -term crops’ (Sherzad,n.d.).

VANUATU

Vanuatu took a different approach to Fiji. Although the ‘No Jab, No Job’ policy was discussed by the government, it was not implemented because the country did not have a single case in the early stages of the pandemic. The “No Jab, No Job” policy was also viewed by Vanuatu lawmakers as illegal and non-compulsory. Instead, people were encouraged to have the vaccinations (Tarianga, 2021). Vanuatu enforced curfews from 8pm to 6am and public gatherings were prohibited. Violations of COVID-19 regulations carried fines of up to VUV 100,000 for individuals and VUV 500,000 for businesses (Crisis24, 2022). A lockdown was only enforced when Vanuatu had it’s first COVID-19 case, and strict measures were then implemented. Similar to Fiji, accessing food became a significant problem and the government employed different strategies to respond to the food crisis. The people were encouraged to take the government’s advice on restricted movement seriously, and regulations were seen as a successful measure in this regard. For lockdown affected areas, Vanuatu’s “COVID-19 Food Security Response Plan” which promoted “stay at home and grow your own food” through backyard gardening, was supported by the production of root crop and vegetable seedlings for sale (Sherzad, n.d). Interested households were sold vegetable and root crop seedlings for self- sufficiency.

The COVID-19 Food Security Response Plan developed by the Government of Vanuatu to address the immediate and long-term food security challenges brought on by the COVID-19 pandemic, was a broadly-conconceived response that sought to address dietary and health as well as economic and food security vulnerabilities exposed by the pandemic. The plan aimed to ensure, first of all, that households had access to sufficient, nutritious food, particularly during border closures, economic downturns, and disruptions to the supply chain.

Its immediate key objectives included i) Strengthening local food production systems to reduce reliance on imported food; ii) Supporting vulnerable households by providing food relief and resources for subsistence farming; and iii) Promoting

sustainable agriculture to ensure long-term food security; and mitigating the economic impacts of COVID-19.

However, as detailed below, the 5 key components of the Response Plan went beyond those immediate objectives:

1. IMMEDIATE FOOD RELIEF:

The government provided emergency food distributions to communities most affected by the economic impacts of the pandemic, particularly in urban areas where many people lost their jobs. Priority groups included households in quarantine or isolation; vulnerable communities with limited access to food and remote islands that faced supply chain disruptions.

2. STRENGTHENING LOCAL FOOD PRODUCTION:

The plan emphasized self-sufficiency through subsistence farming and home gardening programs. Households were encouraged to grow their own food and support was provided through distribution of seeds and farming tools, training programs on sustainable farming practices and promoting traditional crops well-suited to local conditions.

3. SUPPORT FOR FARMERS AND FISHERS:

To ensure food availability in local markets, the government provided assistance to local farmers and fishers through subsidies for agricultural inputs like seeds, fertilizers, and livestock feed; financial assistance to farmers and fishers affected by the pandemic; and transport support to help move produce from rural areas to urban markets.

4. ENHANCING MARKET ACCESS:

The plan addressed supply chain disruptions caused by COVID-19 by improving local market access and transport logistics. Key initiatives included mobile markets to bring fresh produce directly to urban areas; supporting local food vendors to ensure continuous food supply and encouraging food processing and preservation to reduce waste.

5. PROMOTING NUTRITION AND FOOD DIVERSITY:

The plan emphasized the importance of nutritious and diverse diets to improve the overall health of communities. It promoted the consumption of locally grown fruits and vegetables and, importantly, raised awareness about healthy eating habits and addressed malnutrition and dietary deficiencies, especially in children.

Vanuatu's Food Security Response Plan had significant impacts in improving household food security during the pandemic; increasing local food production and reduced reliance on imports; strengthening the resilience of rural communities to future food security shocks; improving access to fresh, nutritious food for vulnerable populations; and empowering farmers and fishers to sustain their livelihoods. The "Stay at Home and Grow Your Own Food" initiative was a well-thought out and intentionally transformative policy response to a major challenge posed by the COVID-19 pandemic – ensuring food supply for people in lockdown areas. It sought to have longer term beneficial effects. The program encouraged citizens to cultivate home gardens to enhance their food security through self-sufficiency, and reduce household dependence on imported goods during periods of restricted movement and economic uncertainty. By growing their own food, households could ensure a steady supply of fresh produce for themselvces, reduce their reliance on external food sources and become resilient to supply chain disruptions. Engaging in gardening activities was also seen as providing a constructive outlet during lockdowns, benefiting both mental and physical health.

The strategies of distributing seeds, seedlings, and basic gardening tools to kickstart home gardens; running workshops and disseminating informational materials to teach effective gardening techniques, pest management, and crop selection suitable for Vanuatu's climate; promoting organic farming; and encouraging local communities to share resources, knowledge, and experiences to foster a collective approach to home gardening, indicated recognition that the pandemic presented an opportunity to bring about needed change in the way of life of ni-Vanuatu in urban areas.

Vanuatu has a long tradition of subsistence farming, principally carried out by women, on customary land, with families in rural areas living on homegrown produce. The initiative sought to revive and modernize these practices in urban and peri-urban backyards, aligning with the nation's cultural heritage of subsistence livelihoods. In the aftermath of natural disasters in Vanuatu like Cyclone Pam in 2015, leaders had urged citizens to "plant their own gardens and survive," emphasizing the importance of self-reliance in times of crisis. The Covid crisis was not an environmental disaster, and therefore presented an opportunity to bring about more sustainable and healthy living practices, while ensuring better chances of surviving the impacts of Covid.

SAMOA

Samoa declared a state of emergency and mandated that all citizens be vaccinated, and take the necessary precautions to contain the virus. Immunization was considered a preventive measure, but it was optional even though vaccinations against a measles outbreak were required. After the country's first positive case of COVID-19 was discovered, there was a clear lockdown for four days, with only emergency services being opened (Vaha, 2021). Following the discovery of COVID-19 cases among international arrivals under quarantine, all unnecessary travel and activities were prohibited. Unless they were seeking or offering necessary or emergency services, citizens were expected to stay at home. There was a curfew and large-scale gatherings were forbidden. US$360k, was set aside to boost local food production by the Ministry of Agriculture and Fisheries in Samoa. Fruit, vegetables, and other short-cycle crop seeds were distributed to farmers and households, including those in urban areas. In order to boost food production in the nearby villages, planting materials such taro, sweet potatoes, and cassava were also provided (Sherzad, n.d).

Additionally, in August 2021, the Samoan government launched a nationwide door-to-door COVID-19 vaccination campaign to increase immunization coverage and protect its population from the virus (Vaha, 2021).

KEY FEATURES OF THE CAMPAIGN:

House-to-House Vaccinations: Healthcare teams visited households across the country to administer vaccines, ensuring accessibility for all residents, including those in remote areas.

Identification System: Families with unvaccinated members were encouraged to tie red-colored cloth in front of their homes, signaling health officials to provide vaccinations.

Community Engagement: The campaign emphasized the critical role of village leaders and community participation in promoting vaccination and ensuring public health safety.

IMPACTS

Samoa's proactive approach significantly boosted vaccination rates, contributing to the country's progress towards its immunization coverage goals. By September 28, 2021, 94.4% of the eligible population had received their first dose, and 52.4% had received their second dose. The success of this campaign demonstrated the effectiveness of community-based strategies in enhancing public health initiatives, particularly in increasing vaccine uptake during the COVID-19 pandemic.
Key Challenges in Accessing Healthcare during COVID-19

1. THE IMPACT OF CURFEWS AND LOCKDOWNS

The lockdowns and curfews especially affected marginalised groups. For example, curfews limited the hours during which sex workers could move freely. Many sex workers operate during night-time hours and the curfews affected their ability to earn income. The impact of not earning an income was multifaceted. Moreover many health centers and clinics that provide SRHR services, reduced their operating hours or closed entirely due to the pandemic. This was problematic for sex workers who rely on continuous STI testing, access to contraceptive products , and other SRHR needs to ensure full protection when engaged in sex work.

Women with disabilities faced similar challenges in accessing SRHR services. There was no accommodation made for women who needed this service. The curfews increased dependence on caregivers, potentially leading to increased vulnerability to abuse or neglect. Limited mobility and transportation options during curfews meant that women were unable to access resources or escape unsafe situations. For transgender women, the COVID-19 measures affected the accessibility of hormones and gender affirming health care services as doctors solely focussed on fighting COVID-19. This resulted in an increase in mental health issues such as anxiety and depression (Asia Pacific Transgender Network, 2024).

2. THE IMPACT OF MISINFORMATION

Many Fijians were reluctant to receive vaccinations because of the high volume of misinformation about COVID-19, the government and the intentions of global healthcare service providers and experts. There were a lot of fears around the vaccine itself and its impact of people's health, and some Fijians refused to be vaccinated and were prosecuted for this. Two doctors were detained by the authorities and questioned over disseminating false information regarding vaccines. The Fiji Police Force detained a religious leader for allegedly disseminating

misinformation about the vaccines being "evil". Such misconceptions created vaccination hesitancy among some people. Ministry of Health and Medical Services (2022) clarified that the vaccines were medically safe for usage.

3. THE USE OF HERBAL MEDICINES

Traditional herbal medicine is commonly used as an alternative treatment option to pharmaceutical products in the Pacific. During the COVID-19 era, pawpaw leaves and ginger were consumed as alternative herbal remedies for the blood, muscles, and immune system to help reduce the symptoms of the virus. This became problematic as many opted for herbal medicine as a preventative measure, instead of getting vaccinated.

4. THE INFLUENCE OF RELIGIOUS VIEWS

Wilson et al. (2023) shed light on the strong correlation between religious beliefs and vaccine reluctance. After poll data was examined, it was discovered that 16.2 per cent of Fijian participants said they would not vaccinate their child. The information revealed that a small percentage of people thought their faith would be enough to improve their overall health and well-being. Religious leaders who disseminated conspiracy theories about vaccines asserted that the shots were unnatural and, therefore, immoral (Kant, Varea & Titifanue, 2021). In Fiji, vaccine reluctance or rejection was amplified by the impact of radical religious doctrines that 'prioritized the preservation of the natural body over the intentions of a grand creator of humanity' (Kant, Varea & Titifanue, 2021). Religious bodies could have instead motivated their members to acknowledge the significance of vaccinations in the eradication of infectious diseases and improvements in health worldwide, and of COVID-19 vaccines specifically, emphasizing that WHO information and advice about COVID-19 vaccines should not be ignored.

Samoa showed relatively high levels of vaccination compared to some other Pacific nations, partly due to effective communication and the integration of cultural and religious values into public health messaging. The majority of Samoa's population identifies as Christian, with denominations such as Congregationalist, Methodist, Catholic, and others having significant influence. Churches are central to Samoan community life and church leaders played an important role in encouraging vaccine uptake. Many church leaders supported vaccination campaigns, promoting vaccines as a way to protect the community and adhere to biblical principles of caring for others (Feagaimaali'i, 2021). Traditional healing practices coexist with modern

medicine, and this dual approach can sometimes affect health-related decision-making. Despite general support, some individuals or small groups expressed hesitancy based on religious or cultural beliefs, sometimes fueled by misinformation about the vaccines.

In Vanuatu, the intersection of religion, culture, and the COVID-19 response—including vaccination efforts—was shaped by the nation's unique social and spiritual landscape. Christianity is the predominant religion in Vanuatu, with several denominations including Presbyterian, Anglican, Catholic, and Seventh-Day Adventists forming the majority. Churches play a central role in community life, influencing opinions and behaviors. Many religious leaders supported COVID-19 vaccination campaigns, promoting health and safety as expressions of faith and love for others (Vaccine Confidence Project, n.d). Sermons and community gatherings were used to address vaccine hesitancy and misinformation. Traditional beliefs and practices coexist with Christianity in many parts of Vanuatu. Some individuals rely on customary healers or view illnesses like COVID-19 through a spiritual lens. Some religious or spiritual groups expressed skepticism or opposition to vaccines, citing misinformation or spiritual beliefs that conflict with modern medicine.

STRENGTHS

1. SENSE OF RESPONSIBILITY AND AN ETHIC OF CARING FOR OTHERS

A sense of responsibility during the COVID-19 pandemic in Samoa and Vanuatu was deeply rooted in communal values, cultural traditions, and the influence of religious and traditional leadership.

Fa'a Samoa, or "The Samoan Way," emphasizes community, respect, and mutual care. This cultural ethos strongly influenced individuals to prioritize the collective well-being over personal preferences. Decisions were often guided by what was best for the family and village, leading to widespread support for health measures such as vaccination and mask-wearing. The government partnered with village councils and church leaders to ensure compliance with health directives. Local chiefs (*matai*) reinforced the importance of collective responsibility within villages (Fruean, 2021). Samoa's tragic experience with the 2019 measles epidemic heightened awareness of the importance of vaccination, creating a stronger sense of urgency during COVID-19.

In Vanuatu, *kastom* (traditional customs and practices) emphasizes the well-being of the group over the individual. This principle guided communities to follow health measures, even in remote areas. Village chiefs were instrumental in ensuring that their communities adhered to quarantine protocols, social distancing, and vaccination campaigns. Churches were central to spreading accurate information and fostering trust in COVID-19 measures (Williams & Laboukly, 2020). Leaders framed vaccination as a moral obligation to protect others, reinforcing community solidarity. Prayer gatherings were used as platforms to discuss health issues and encourage responsible behavior. With its dispersed islands, Vanuatu faced significant logistical challenges. Community members took on responsibilities such as delivering supplies to remote areas and assisting in vaccine distribution. The sense of duty to protect their isolated communities led many villagers to comply with public health measures, even if it required significant adjustments to daily life.

In Fiji, the sense of responsibility during COVID-19 was shaped by the country's communal culture, strong religious values, and the government's public health messaging. In Fijian culture, vanua refers to the interconnectedness of the land, people, and customs. This collective worldview encourages individuals to prioritize the well-being of the community over personal interests. Fijians traditionally live in close-knit communities where decisions are made with the group's welfare in mind. During the pandemic, this sense of interdependence motivated many to follow health guidelines to protect their families, villages, and elders. National prayer days and religious gatherings (adapted to adhere to restrictions) helped maintain morale and unity during challenging times. The government worked with traditional chiefs, religious leaders, and village councils to ensure public health measures were understood and respected in urban and rural areas. Villages organized checkpoints, distributed food, and ensured adherence to lockdown protocols to protect their members (RNZ, 2020). Urban Fijians organized food drives and supported those in quarantine, reflecting a strong sense of social responsibility.Young Fijians played a key role in spreading awareness through social media campaigns, highlighting their responsibility to protect the vulnerable.

Special mention should be made of the introduction of online bartering through Facebook groups during the pandemic. A creative strategy established to promote non-cash trading in Fiji that began early in 2020 and was the brainchild of community activist, Marlene Dutta, it was almost immediately emulated elsewhere in the region. Not only did it help financially struggling families, it put people and

particularly women in touch with one another, encouraged solidarity and a spirit of being able to offer what you had and seek what you need, with dignity. In just a few weeks, the Facebook page, *Barter for Better Fiji*, gained close to 200,000 members. People widely used the page to barter food, needed supplies and services, from grass-cutting, gardening, house painting, agricultural produce, cooked or baked foods, household goods, and necessities like diapers and babies clothes. Some people in extreme need even bartered their jewelry like wedding rings for needed supplies. Similar Facebook pages were set up in 2020 in Vanuatu (*Barter for Nambawan Life*), Tonga (*Barter for Change*), and Samoa (Barter for Better Samoa and *Le Barter*) (Pacific Islands Forum Secretariat, 2021).

The efforts of the Fijian government and of public sector workers during this trying period were remarkable with comprehensive daily televised updates, advisories and sharing of statistics by senior Health officials. Field hospitals were set up to cater for increased cases and frontline workers made admirable sacrifices throughout 12-hour shifts to limit COVID-19 cases (McLennan, Maude & Movono, 2023). This demonstrated a clear feeling of duty to assist the general public in preventing infections, as well as a deeply felt ethic of care. Health care personnel were provided with Personal Protective Equipment (PPE) including gloves, gowns, masks and aprons, because they faced the danger of contracting the virus and passing it on to their family and the communities they served. This protection improved their overall well-being and ability to perform duties effectively although Fiji lost some doctors and nurses amongst its Covid casualities.

Despite the success of the government's early COVID-19 containment efforts, however, and due to a quarantine breach in April 2021, Fiji went from having a small number of Covid cases to joining countries with the highest number of new infections by July/August 2021, and by the end of 2021 suffering the highest number of Covid deaths in the Pacific region (McLellan, Maude & Movono, 2023).

2. HOME VISITS

Samoa conducted a nationwide house-to-house immunization campaign to boost immunization numbers (Vaha, 2021). Home visits played a significant part in this outreach. The approach reflected Samoa's communal culture and the government's commitment to reaching all citizens, including those in remote and underserved areas. Village councils (*fono*) and traditional leaders (*matai*) played a crucial role in organizing and facilitating home visits. Chiefs worked with government health teams to ensure residents trusted the process and cooperated with health workers

(World Health Organization, 2020). Home visits contributed to Samoa achieving high COVID-19 vaccination coverage, helping to protect vulnerable populations.

Home visits during the COVID-19 pandemic in Vanuatu were a key aspect of the country's health response, particularly given its geographic challenges and dispersed population The purposes of home visits were to provide health education in local languages and dispel myths, for vaccination outreach to rural and remote areas, and to monitor and support individuals in isolation. Traditional leaders (*kastom* chiefs) played a pivotal role in facilitating access to communities and encouraging participation (Williams & Laboukly, 2020). Chiefs often coordinated visits and ensured community members trusted health workers.

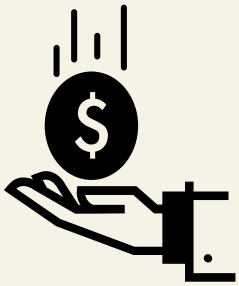
Medical Services Pacific (MSP), an NGO in Fiji which provides women, youth and children with quality health care and social services developed a practice known as "the walk," where the clinical team visited homes of women with disabilities after the clinic closed for the day to provide care to those who were unable to access the mobile clinic. This was done after MSP learned that some women with disabilities were unable to access their mobile clinics because they lacked adequate support or mobility aids (United Nations Population Fund, 2021). For patients who would not otherwise have had access to even mobile clinics, this approach was beneficial in guaranteeing their access to services. Frontline workers were also tasked with doing routine check-ups on patients who had previously contracted the virus, and visiting homes, particularly for elderly and disabled individuals who could not get vaccinated at hospitals.

FOCUS GROUP DISCUSSIONS – KEY FINDINGS AND ANALYSIS

The series of focus group discussions conducted with different groups of women in Fiji, Samoa and Vanuatu provides primary data for this research. A majority of sex workers and women with disabilities among the Fiji participants were of I-Taukei (indigenous Fijian) descent and only a few were Indo-Fijian partcipants from urban areas. Transgender (*fa'afafine*) Samoan women were from both peri-urban and rural localitities. The sex workers and women with disabilities among the Vanuatu participants were from rural, peri- urban and urban locations.

HEALTHCARE SERVICES AND RECOVERY

Many Pacific people are dependent on public transportation for daily travel because it is a cheaper option. However, this was restricted to manage the spread of COVID-19. This restriction directly affected women in Fiji and Vanuatu who needed to access reproductive healthcare services and treatment by public transport. Additionally, the hospitals and health centers had a restriction on the number of patients attending clinics, which affected women who needed healthcare treatment in Vanuatu. In Fiji, many women were laid off work and faced prolonged unemployment. Without any other income source, women could not access public healthcare services, nor had the means to seek help from a private healthcare provider. The absence of a daily income affected many women's access to medical care and services, especially those who did not have FNPF.



"We sex workers do not have any FNPF so there was no help provided to us from anywhere. We could not get customers and this affected us badly because we had no food so forget about having money for going to the doctor when any of my children or I got sick".

Women in Fiji and Vanuatu used steam or vapour therapy (inhalation) and herbal medicines such as mangrove leaves, pawpaw leaves, ginger, lemon and lemon grass as an additional remedy to recover from the COVID-19 virus. Over the counter medicines like Panadol which were readily available at home were also taken for COVID-19 virus symptoms and basic illnesses like migraine, leg pain and sore throat by the women.

Additionally, women relied on prayers by religious pastors to recover from COVID-19 whilist others relied on painkillers to cope with the pain and fever. The Ministry of Health and Medical Services also provided quarantine centers where some women were being kept for treatment and recovery. Managed isolation as well as home quarantine was compulsory for infected people.

Below are some of the responses from women with disabilities,:

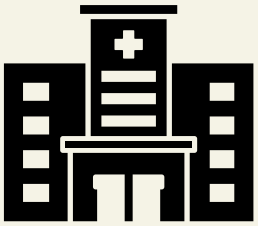
• A blind Fijian woman and two deaf Fijian women reported that they did not have carers and interpreters to take them to the nearest health clinic due to lockdown restrictions.

• One woman with psychosocial disability said that she could not go to the hospital to get her medicinal refills as her nearest health center in her village was not disability friendly. For some women, a health care facility was accessible, but they did not feel safe going to the hospital for fear that they would get the virus and die. For a small number of women, healthcare accessibility was not an issue as their doctors used to conduct home visits for diabetes.

• A ni-Vanuatu woman with eighty percent speech impairment, and a wheelchair-user said that the phone was slammed down on them when they made a call to the nurse. Another participant revealed that she did not have a mobile phone to call the hospital to request for a home visit.

"I went to the hospital only to find a big notice and a security guard at the entrance of the hospital saying the hospital was closed so I came back home and just steamed myself and had plenty of warm water. I was scared to die because I was so sick, but the hospital could not help me".

On the other hand, the urban and rural *fa'afafine* group had completely opposite experiences in healthcare access. Precautions were taken by them following the lockdown of the country due to the measles outbreak, and it made sense to them to stay home, sanitize and eat healthy. The women stated that COVID-19 vaccinations and tests could only be done at hospitals. But hospital visits were not allowed unless someone had signs of COVID-19. Non COVID-19 health services and treatments (such as dental and cardiology services) were not available at the hospitals as the sole focus was on the treatment of COVID-19.



"We did not have any problems accessing healthcare because there was a lot of fa'afafine in the nursing field so that made sure our community was up to date by calls to Samoa Fa'afafine Association to get the word out".

VACCINATIONS

The first nation in the Pacific islands to receive doses of the COVID-19 vaccine sent through the COVAX (COVID-19 Vaccines Global Access) Facility was Fiji (World Health Organization, 2021). In Fiji, the vaccination rate was fairly good. The total number of adults who received the first dose of the immunization was 644,228; (95.9 percent) those who received the second dosage totalled 590,623 (84.4 percent). (MHMS, 2023).

The majority of Fijian women participants engaged in sex work had received two COVID-19 vaccinations – their own safety and that of their children was the determining factor in getting vaccinated. The women were worried about the welfare of their children should they die from the COVID-19 virus. Additionally, the women got vaccinated to access public transportation and supermarkets and to get government assistance in terms of food rations and financial assistance.

A small proportion of the women in the FGDs emphasised that they chose not to get vaccinated as information on the vaccines was not sufficient – most were advised by their families living abroad that the vaccines were deadly. One woman shared that she decided not to get vaccinated because one of her friends passed away after getting the vaccinations. Furthermore, a handful of women said that they chose not to get vaccinated because their faith disallowed them to do so. They did not trust getting vaccinated as they believed that people had died after being vaccinated and that their faith is enough.

"I chose to get vaccinated so I could access government assistance such as the food rations because I wouldn't get anything without getting vaccinated...I did not want to get vaccinated....I was forced to get vaccinated".

Most of the Fijian women participants with disabilities shared that they took both doses of the vaccination. The women shared that they did not really understand the importance of being vaccinated nor did their family members. The women blamed the media for not providing updated vaccination information.The determining factor that influenced the women in getting vaccinated was the "No Jab No Job" government policy.

"I did not want to get vaccinated because it had to do with my body, I was worried about the side effects, but I feel like I had no choice with the no jab no job policy, so to have a job I had to get vaccinated. Some of our members refused to take the shot because the was so much information that it led to confusion. I tried my best to give the correct information which I got from Facebook so everyone in my deaf community can get vaccinated. I took interpreters with me to help tell about vaccinated and why it is important to get vaccinated".

Samoa also obtained 24,000 doses of AstraZeneca vaccines via the COVAX Facility (World Health Organization, 2021). By September 28, 2021, 94.4% of eligible Samoan individuals had received their first dose of the vaccine and 52.4% had received their second dose. (World Health Organization, 2021). The Samoan women participants said that they all chose to get both of their vaccinations. The women were aware of the need to get vaccinated as it was the best thing to do because it was not just for their own safety but for the whole of community's safety. The vaccinations meant people being shielded from getting the COVID-19 virus and spreading it to others.

"We got vaccinated to be COVID-19 free. We were tired and got vaccinated as we felt that we had to keep healthy to take care of everyone to keep them safe. That's how our community works. It feels like the fa'afafines have genes to take the vaccinations and look after everyone which did not allow us to get the virus".

While 93% of ni-Vanuatu received their first dose, 84% of the population received both doses of the immunization (Ministry of Health, 2022). 24,000 doses of the AstraZeneca COVID-19 vaccine were supplied to Vanuatu via the COVAX Facility. (Ministry of Health, 2021).

However, in Vanuatu, only a small proportion of women participants who were engaged in sex work got vaccinated. Those who did not get vaccinated made their decision out of fear and a strong belief that it was harmful for the body. Rumors about the side effects of the vaccinations on social media resulted in vaccination hesitancy. There was no public education or informative advertising which conveyed facts about the vaccinations.

"There was a push from the Government for us to get vaccinated. We need to read and understand information about the vaccinations. We took the vaccinations but we were not provided with much information about it".

All women with disabilities who participated in the FGD got vaccinated for the 1st and 2nd dose by force, saying that they had zero understanding about the vaccination's side effects but decided to get vaccinated anyway out of fear of death. They felt that people who should have provided them with the right information about the vaccinations such as the doctors, nurses and the public media did not do their job well.

CHALLENGES FACED IN ACCESSING HEALTHCARE

The majority of sex worker participants faced similar challenges in accessing healthcare during the pandemic in Fiji and Vanuatu. There was an absence of family planning and SRHR services such as STI tests in both countries. All resources were directed towards COVID-19, mainly vaccinations, and healthcare facilities did not prioritise condoms, HIV testing and SRHR services. Transportation was a major hindrance in accessing health care. A few women said that they could not access any healthcare facility as they chose to not get vaccinated while some women had issues with waiting in long queues at the healthcare facility and seeing the nurses just talking, having tea and not attending to them. The women additionally did not feel safe at the hospital due to derogatory remarks directed at them by the police and army personnel who were continuously starring at them.

> **"Ministry of Heath forgot about condoms which led to a spike in HIV for some women in our group. Some clients knew we were desperate for money during the pandemic. They'd refuse to pay us and would violently snatch our money after the job was done which we never encountered pre-Covid".**

In Vanuatu, there was also confusion about the availability of walk-in patients with disabilities. The women claimed that it was difficult to access health care from operating public health facilities and at the same time some of the private clinics increased their consultation and treatment fees, which also added to the hardship of accessing healthcare. A ni-Vanuatu woman living with disabilities expressed concerns about the technical words used in the information leaflets on the vaccinations, saying that understanding about vaccinations was difficult.

“For people with disabilities, services provided were not adequate. The private clinics raised their fees, the Ministry of Health put new rules for sick patients to go to the private clinics if they are sick. The Vila Central Hospital did not allow walk-ins”.

Most women in the disability group in Fiji did not have carers and interpreters to take them to the health clinic at first, as they had travel issues due to the unavailability of transportation. The attitude of the nurses towards them was also bad. A hearing-impaired participant said that the doctor was rude, and behaved aggressively.

“When I was admitted, the nurse woke me up to take medicine and did not tell me which medicine to take and they introduced a new medicine. When I ask another nurse, they investigated and found out that the nurse who came to me in the first place was giving me extra medicine. Even if I am deaf, I am a visual learner so I could pick out that I was being given extra medicine”.

A Samoan *fa’afafine* woman was placed in the male ward upon being tested for COVID-19, which was not safe at all. Many women said that there were no major challenges except that the community and healthcare workers blamed the *fa’afafines* for the pandemic and termed it as the “transgender community disease”. Healthcare workers made nasty jokes that it was the *fa’afafines* who were spreading the COVID-19 virus by sleeping with everyone. Additionally, they were not informed about the closure of pharmacies and would only find out about it when they drove down to buy their medicines.

"We were not told about the closing hours of the pharmacy on Facebook, TV or radio. Travelling to pharmacies was not cheap. It cost us money which went down the drain as we were not able to buy our much needed medicines. Blaming us for spreading COVID-19 virus was not good".

IMPACTS OF LAWS AND POLICIES IN ACCESSING HEALTH CARE

The impacts of lockdowns and curfews were acutely experienced by women participants living with disabilities in both Fiji and Vanuatu. Women with disabilities in rural Vanuatu localities could not visit health centers for treatment as they did not have money to travel to the town to seek medical assistance. Mobility was hard as carers were not available as usual to assist. A woman in a wheelchair bitterly mentioned that drivers were more discriminatory considering that they demanded extra money for the wheelchair. Likewise, women with disabilities in Fiji were very affected by the 'No Jab, No Job Policy' stating that they did not have bodily autonomy. Lockdowns and curfews resulted in zero access to family planning services.

"The laws were forced on us. We feel like we had no freedom of choice so we could not refuse to get vaccinetad or go out when we wanted. The 'No Jab No Job Policy' left us with no choice. What could we do?"

"Accessing contraceptives for women with disabilities during covid was hard. We could not access all the different forms of family planning. All the focus on covid made everyone forget about SRHR for women with disabilities. Women with disabilities during crisis times like covid are very vulnerable. Not everyone feels comfortable with all health facilities and attitudes of healthcare workers. SRHR access to women with disabilities is very poor so women just don't go".

Women engaged in sex work emphasized that the national lockdown and curfews prevented them from accessing healthcare services. The lockdown made the women jobless hence there was no money to use to access healthcare services. Fees for private hospitals were higher and there was no money to make a public hospital run.

"Me too I face many difficulties because life was so hard then. The lockdown caused many issues and especially for me, I could not go out but stayed at home and do nothing. My regular clients did not have money so I could not make any money from them. Other people were not walking around so it was hard to make business so I had to struggle by myself. This was a huge challenge for me that I will never forget".

Two Fijian women engaged in sex work said that the "No Jab, No Job" policy heavily impacted their healthcare access as entry to healthcare clinics was prohibited. Choosing not to get vaccinated left them jobless. Hence they made food and tried to sell parcels to those they knew with the hope to get money to cater for their food and travel costs for medical care. But they were chased away by the people. It was difficult to get a pass from the police to make hospital runs as well.

"I went out fishing trying to find food for my children and even the Police would come around to harass me and tell me to go home. I was fishing by myself with no other human beings around, only the fish and prawns. Who was I hurting? Police just wanted to chase me away. Yes it was a lockdown but I was only fishing, not roaming around".

In Samoa, there was a lockdown but the women waited for health care workers to come door to door for COVID-19 testing. This was an advantage as testing services were provided by the health workers at home. Mass vaccination was also provided in the country. However, while the aging *fa'afafine* group said that the lockdown made it hard for them to travel to towns to seek healthcare, the young *fa'afafine women* `claimed that the lockdown was not so bad. There was no need to travel in the lockdown as medical care for COVID-19 was provided at home.

CONCLUSION

COVID-19 had a significant impact on marginalized groups in the Pacific. The findings from the FGDs clearly indicate an unfavorable experience for the marginalized groups in the three Pacific Island countries. While healthcare access was accessible to the transgender (*fa'afafine*) women in Samoa, sex workers as well as women with disabilities did not find it easy to get healthcare access during the pandemic.

'Whilst the *fa'afafine* group in Samoa faced very little challenges when it came to accessing healthcare services in the country during the pandemic, sex workers and women with disabilities in Fiji and Vanuatu had to endure a lot of hardship to access healthcare services. With the never-ending challenges, most women found it best to resort to using herbal medicines which were readily available at home with over-the-counter medications and home remedies such as steam or vapour therapy (inhalation) to get better. The research additionally indicated an absence of SRHR services with priority given to only COVID-19 patients and vaccinations. Through the FGDs, this research revealed the women's hesitancy in getting the COVID-19 vaccinations due to the absence of adequate public information about the immunization being disseminated.

The findings further reveal that the laws and policies implemented in the country to tackle COVID-19 were strategic, but were not rights-based, gender-responsive or non-discriminatory, as experienced by the three groups of women who faced heightened vulnerabilities and multilayered discrimination and impoverishment. Additionally, it was seen as the responsibility of the media to disseminate current and accurate information about COVID-19 vaccines, treatment and care so that women could make informed decisions about being vaccinated.

Integrating an Equality, Diversity and Inclusion (EDI) framework into healthcare policies is essential for building equitable systems that can address the unique needs, challenges and rights of persons in marginalized groups such as sex workers, transgender people, and women with disabilities. Data on the experiences of women in these groups is needed to inform government policies and practice.

Development of anti- discrimination policies and frameworks which explicitly protect vulnerable groups of people from discrimination is needed. Such policies have to hold the Government, healthcare providers and institutions accountable for discriminatory practices or neglect. An essential element which such policies need to include is a rights-based approach based on the human rights principle of respect for human dignity, and practices of fairness, equality and non- discrimination to ensure healthcare centers prioritize dignity and equality for all marginalized groups of women.

Nurses and doctors pledge to look after the health needs of people from different backgrounds but in the FGDs, it was reported that healthcare workers tended to not adhere to the pledge which they make upon appointment. Health care providers' need training on gender sensitization and EDI principles to ensure that a non-stigmatizing environment in healthcare settings is promoted.

The government can provide accessible services to ensure physical, informational and communication accessibility especially for women with disabilities. Dedicated services to address the needs of marginalized groups of women need to be considered, such as hormonal treatments for transgender patients, reproductive health care for women with disabilities, and mental health services for sex workers facing stigma and violence. Stakeholders must also do regular audits and reviews of healthcare policy frameworks and practice to assess EDI compliance, identify gaps and make the much needed changes.

RECOMMENDATIONS

This paper shines a light on the lived realities and struggles that three categories of marginalized women in the Pacific region experienced during the COVID-19 pandemic. Based on their experiences, the following recommendations to key stakeholders are highlighted:

ENSURE CONTINUED HEALTHCARE ACCESS IN TIMES OF CRISIS AND EMERGENCIES

1. Pacific governments must employ an efficient system to ensure that the poor and marginalised groups are provided transportation to healthcare services in times of crisis and emergencies. Through collaboration with public transportation companies, free or subsidized rides to vaccination sites and healthcare facilities would help marginalized groups, especially those who come from poor socio-economic backgrounds. Sexual and reproductive health care for women like pregnancy and abortion need to be treated as essential services during a pandemic.

2. Pacific governments must invest in healthcare infrastructure in rural and maritime areas so that marginalized groups are able to access services for treatment and care in times of crisis and emergencies. This can be done by establishing home delivery of prescriptions which would ensure timely access to medicines for people living in more remote areas. Healthcare providers can equally coordinate a sustainable approach for medicine distribution.

PRIORITISE DECENTRALIZATION OF HEALTHCARE SERVICES

3. Pacific governments should prioritise decentralisation of healthcare services in densely populated areas and in rural areas so that there is a one-stop-shop for all healthcare needs. This reduces travel time bringing medical services closer to such areas and would ensure underserved communities have access to healthcare.

IMPROVE THE ACCESS TO QUALITY AND ACCURATE HEALTHCARE INFORMATION FROM RELIABLE SOURCES

4. Pacific government and the media sector to develop standardised policies and procedures in times of crisis and emergencies to ensure dissemination of quality, accurate and accessible healthcare information to the public. To prevent stigma and discrimination of groups like transpersons and sexworkers, adequate training to front-line health workers and doctors should be given. Health services should be designed in a way that there are accountability systems and mechnisms for discriminatory attitudes and behaviours.

5. The media sector must adhere to codes of ethics and conduct when reporting crucial healthcare information in times of crisis and emergencies. This is to ensure that there is no false information, rumors and misinformation that create public fear and distrust.

RECOGNISING THE ROLE OF CIVIL SOCIETY AND NON-GOVERNMENTAL ORGANISATIONS

6. CSOs and NGOs play a critical role in ensuring government's accountability by giving voice to issues and concerns from people on the ground. Pacific governments must recognise CSOs and NGOs as key stakeholders who can help provide technical advice on law, policy and resource interventions that align with EDI principles in future crisis and emergencies.

PRIORITISE INCLUSIVE LAWS, POLICIES, PROGRAMME AND RESOURCE INTERVENTIONS FOR ALL HEALTHCARE SERVICES IN TIMES OF CRISIS AND EMERGENCIES

7. PWDs need to be included in all programmes, decision making and policies by the government during crises like a pandemic, to ensure consultation on compulsory laws like 'no jab no job policy'. This would ensure inclusivity of PWDs in all programs, policies, projects by the governments, NGOs and anyone working in the research, advocacy, healthcare and crisis response space.

8. All health facilities to be disability-orientated such as through the provision of ramps, braille, tactile drawings, visual display of services etc to ensure that people with disabilities enjoy the right to attaining the highest standard of health without discrimination.

9. Governments need to ensure that people can access help through calls with medical professionals for medical advice. Such an initiative would allow people to consult medical professionals, reduce physical interactions, and lower the spread of infectious viruses like COVID-19.

10. The government must provide health services for free and 24 hour emergency services and health facilities, seven days a week. Marginalized groups face financial barriers to accessing healthcare and having a free medical center would remove the main barrier and provide necessary care, ensuring that no one is left behind.

11. Healthcare workers should provide pap smear and HIV tests, as well as regular testing and special clinics for sex workers at home, as such services are not comfortable for the women to access at public health care facilities.

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APPENDIX

Focus Group Discussion
Situational analysis on access to health care during the COVID-19 pandemic: Sex Workers and Women with Disabilities in Fiji, Samoa and Vanuatu.

Fiji Women's Rights Movement (FWRM) is part of the Feminists for a People's Vaccine Campaign (FPV). The campaign began in 2020 after the COVID-19 pandemic revealed gaps in distribution and access to vaccines in third world countries in comparison to more developed nations. Together with other feminist groups and organizations from around the world, FWRM has participated in the campaign, sharing available research and reports, media stories and social media updates on COVID-19 related information on our social media platforms. The FPV campaign brings together feminist groups and organizations across the globe with their unique perspectives and opinions.

Development Alternatives for Women for a New Era (DAWN) is facilitating the Feminists for a People's Vaccine Campaign for equitable, accessible, and affordable COVID-19 vaccines, drugs, therapeutics, and equipment. The campaign challenges the causes and consequences of inequalities in access to medicine and vaccinations. This research will be getting an insight into the experiences of marginalized women (specifically women with disabilities and sex workers) in the Pacific when they were accessing health care during COVID-19 pandemic.

The purpose of this research study is to document the challenges marginalized women and girls experienced in accessing public healthcare services during the
You are humbly invited to take part in this research study to help address several important questions. Your participation is completely voluntary, and you are free to withdraw at any time.

QUESTIONS
A. Personal Information:
1. Location:
• Urban
• Peri Urban
• Rural
• Maritime

2. Division:

• Western
• Central
• Northern
• Eastern

3. Age:

• Under 18
• 18 –30
• 30 – 45
• 45 – 55
• 55 – 65
• 65+

4. Ethnicity:

• Fijian of i-Taukei descent
• Fijian of Indian descent
• Fijian of Chinese descent
• Fijian of Rotuman descent
• Fijian of Banaban descent
• Fijian of mixed descent
• Others: _____

5. Education level:

• Primary level
• Secondary level
• University (Please specify) _____
• Prefer not to answer

6. Religion:

• Christian
• Hindu
• Muslim
• Others _____

7. Sex

• Male
• Female
• Intersex

8. Gender, gender identity, and expression

Gender, identity and expression is about each person's deeply felt sense of being man, woman, trans-person, intersex or another gender identity. What is your gender identity and or expression?

• Man
• Woman
• Transgender/ trans woman / trans feminine
• Transgender / trans man / trans masculine
• Gender non-conforming / gender non-binary / gender diverse
• Additional _____
• Prefer not to answer (NA)

9. Sexual orientation

Sexual orientation is about each person's capacity for attraction to other individuals. What is your sexual orientation?

• Lesbian
• Gay
• Bisexual
• Heterosexual/Straight
• Queer questioning
• Additional _____
• Prefer not to answer (NA)

B. Disability assessment

1. Do you have difficulty seeing, even if you wear glasses?

• No - no difficulty
• Yes – some difficulty
• Yes – a lot of difficulty
• Cannot do at all

2. Do you have difficulty hearing, even if you use a hearing aid?

• No - no difficulty
• Yes – some difficulty
• Yes – a lot of difficulty
• Cannot do at all

3. Do you have difficulty walking or climbing steps?

• No – no difficulty
• Yes – some difficulty
• Yes – a lot of difficulty
• Cannot do at all

4. Do you have difficulty remembering or concentrating?

• No – no difficulty
• Yes – some difficulty
• Yes – a lot of difficulty
• Cannot do at all

5. Do you have difficulty with self-care such as washing all over or dressing?

• No – no difficulty
• Yes – some difficulty
• Yes – a lot of difficulty
• Cannot do at all

6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

• No – no difficulty
• Yes – some difficulty
• Yes – a lot of difficulty
• Cannot do at all

7. Do you live:

• Alone
• With wife/husband
• With a partner
• With family
• Other

8. What was your situation during the COVID-19 pandemic?

• I am financially self-sufficient
• I am dependent on my parents or other people
• I am partially dependent on my parents or other people

9. How much was your monthly income during the COVID-19 pandemic?

• Below the national average
• Equal to the national average
• Above the national average
• I don't have any income

C. Key Questions

1. Did you have COVID-19?

• Yes
• No

2. Did you seek any medical assistance or services during the COVID-19 pandemic? If so, please state for what.

• Cardiology
• General practice
• ENT / laryngology
• Psychiatric
• Psychological
• Dermatological
• Pulmonary
• Neurological
• Orthopedic
• Obstetrics and gynecological
• Urological
• Endocrine
• Oncology
• Ophthalmic
• Dental
• Nursing
• Physiotherapeutic
• Aesthetic medicine
• Other (please specify which): _____

3. From a scale of 1 to 5, 5 being very satisfied and 1 being unsatisfactory, how would you rate your access to:

• (a) medication: _____
• (b) services: _____
• (c) vaccinations: _____
• (d) others (please specify): _____

4. Did you face any challenges in accessing health care during the COVID-19 pandemic? If so, then please state your challenges.

• Closure of clinics: _____

• No transportation: _____

• Economic hardship due to loss of jobs or reduced hours: _____

• Others (please specify): _____

5. Did you have any positive experience in accessing health care during the COVID-19 pandemic? If so, then please explain your positive experience (s)?

6. Did you feel neglected while accessing health care during COVID-19 pandemic?

• Yes: _____

• No: _____

7. The Fijian Government implemented a few laws, policies and programmes to prevent the spread of COVID-19 virus. How did the following laws, policies and programmes affect you and your access to health care during COVID-19 pandemic?

• No Job, No Jab Policy (please explain)

• National lockdown (please explain)

• Curfews (please explain)

• Social distancing (please explain)

8. Were the healthcare services provided to you in a timely manner upon accession?

• Yes

• No

9. What could have the health care providers or government done better to make the services better to assist you during COVID-19 pandemic?

10. Do you think that your rights were respected during the COVID-19 pandemic?

• Yes

• No

• Not sure

BIOGRAPHY

The **Fiji Women's Rights Movement** is a multiethnic and multicultural non-governmental organisation committed to removing discrimination against women through institutional reforms and attitudinal changes. By means of core programmes as well as innovative approaches, the Movement practices and promotes feminism, democracy, the rule of law, good governance and human rights. It strives to empower, unite and provide leadership opportunities for women in Fiji, especially for emerging young leaders.

FEMINISTS
FOR A PEOPLE'S
VACCINE

Feminists for a People's Vaccine
Research Paper

DAWN
FEMINIST

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Third World Network