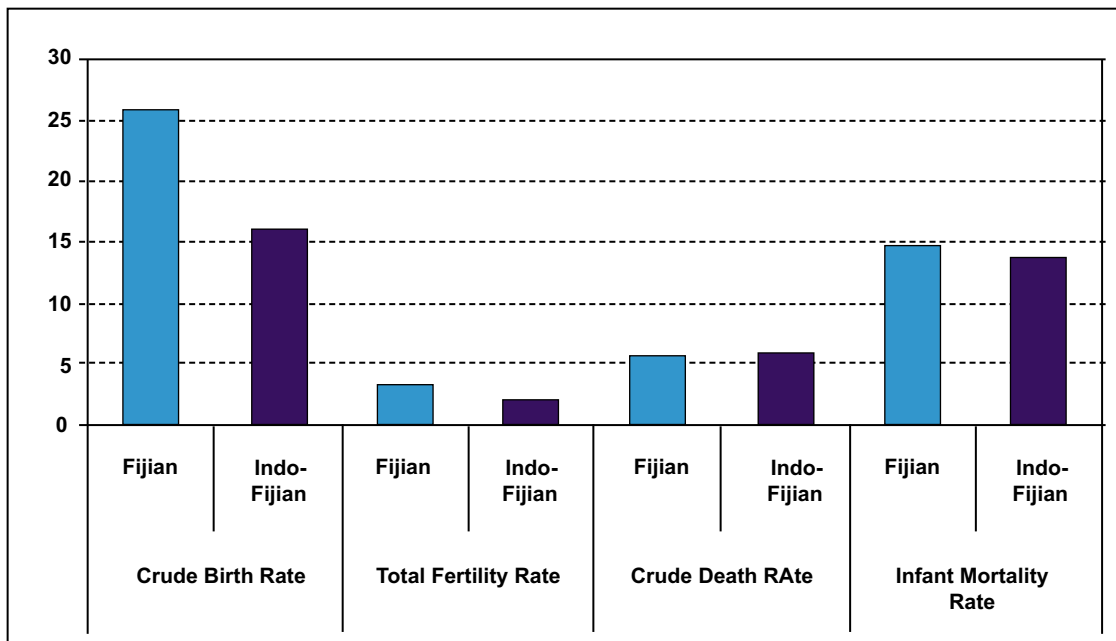


Figure 1.6 Ethnic differences in fertility and mortality: average rates, 1996-2003



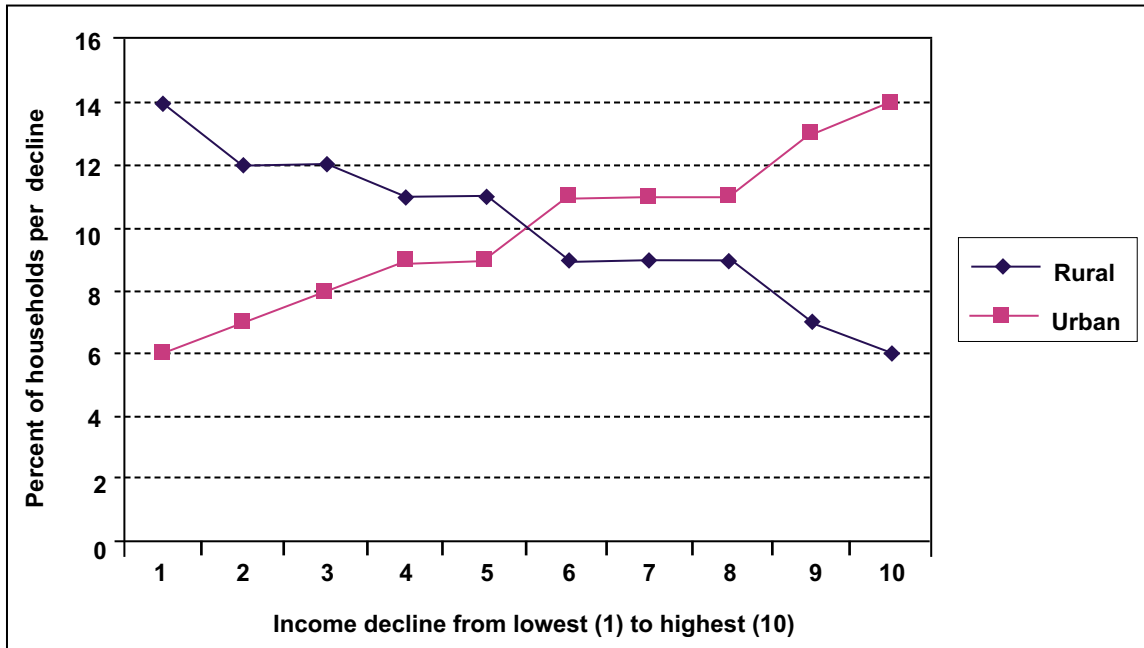
Source: Fiji Islands Bureau of Statistics, 2007

Other than the higher rate of emigration, the past decade has seen three other significant demographic changes in response to changing economic and political conditions:

- Over the past decade thousands of households, almost all Indo-Fijian, have lost their agricultural leases and livelihoods. Between 1997 and 2007, 3519 Agricultural Landlord and Tenants Act (ALTA) leases expired and most were not renewed. The recent Household Income and Expenditure Survey (HIES) noted there had been a massive change in the rural-urban distribution of Indo-Fijian households over the past decade since the 1990-91 HIES. The rural-urban distribution of Fijian households remained virtually the same (66:34 changing to 65:35) but the Indo-Fijian distribution had reversed, changing from 59:41 to 43:57.¹² The HIES also showed a marked income difference between rural and urban areas. Rural households were over-represented among poor households, and urban households among the rich (Figure 1.7)

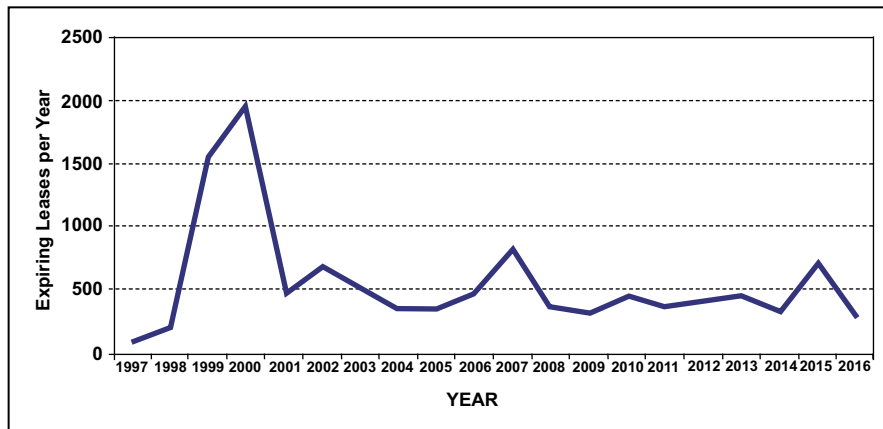
¹² Narsey, 2006b: 48.

Figure 1.7 Rural and urban households by income decile, 2002-3



Source: Fiji Islands Bureau of Statistics, 2007.

Figure 1.8 Expiry of agricultural land leases, 1997-2016



Source: Native Land Trust Board, Fiji, 2007

- An outflow of people from Vanua Levu to Viti Levu in response to the expired land leases and the downturn in the sugar industry and local economy. This flow cannot yet be quantified but there is much anecdotal evidence, including a huge drop in house rents in Labasa. It is particularly evident in the recent growth of the town of Nasinu, now Fiji's second largest and fastest growing town, dubbed the Squatter Town as an area of predominantly low-cost housing.¹³ With about 21% of the total urban population, Nasinu is about equal in size to Suva, although Suva is larger when its peri-urban areas are included.¹⁴

The Cabinet Sub-Committee on Poverty reported in 2002:

The psychological problems [associated with loss of farm land leases] are massive. Losing the capacity to take care of the family affects self-esteem for men. Debt takes

¹³Lingam, 2006.

¹⁴ADB, 2004

them further into helplessness. For women, fears of physical violation have increased since the year 2000. There is fear inside the house as well as outside. Many of them would prefer to work instead of staying in unprotected houses. Increasing numbers of them suffer abuse as a result of tension in family life. Children suffer because of distressing situations in the homes. Primary education has become a problem even though it is free. Many displaced families cannot afford school uniforms, lunches, textbooks and bus fares. Children are increasingly exposed to drug peddlers and sexual abuse.¹⁵

- The loss of rural livelihoods has contributed to urban growth, but mainly of informal or 'squatter' settlements. Without a recent census it is difficult to measure this precisely, but the best estimates are that urban growth is somewhere less than 2% per year, a low rate but higher than the national population growth rate of around zero.¹⁶ Urban growth is kept low by the outflow of people migrating abroad, but bolstered by the inflow of mostly poor rural households.
- Urban growth is increasingly haphazard and informal because neither the town councils nor the government's Housing Authority have been able to meet the demand for affordable housing. Poor families have little option but to live in informal settlements with insecure tenure and poor living conditions. Estimates of the number of squatter households range from 16% to 24% of all urban households.¹⁷ The fastest growth is outside the formal town boundaries where approximately 30% of the urban population lives, and where town infrastructure and services are substandard.¹⁸ Efforts by the Ministry of Local Government, Housing, Squatter Settlement and Environment (MLGHSSE) to upgrade these settlements covers only half of the annual growth of squatter houses.

3. Poverty and Inequality

Poverty has become a national issue of increasing urgency. Over the past decade, both urban and rural poverty have grown. The recent (2002-3 and 2003-4) HIES found that 34.4% of households were living in poverty, up from 29% in 1991.¹⁹ In urban areas, 27% of Fijian households and 29% of Indo-Fijian households were living under the poverty line. Rural poverty is more widespread, affecting 38% of Fijian households and 43% of Indo-Fijian households. Urban poverty, however, is more acute, for housing is expensive, wage levels for unskilled or low-skilled workers are low, and, particularly for women, jobs have recently been made more scarce by the closure of factories and the general effects of political disruption.

Surveys conducted for the Asian Development Bank in 2004 and UNDP in 2005-6 asked people throughout Fiji what they considered poverty to be and whom it involved.²⁰ According to most urban respondents, poverty meant being unable to access basic services or afford basic needs such as housing and food. It could be seen in the number of young people who drop out of school because education is unaffordable and in their increased involvement in criminal activities because of their lack of income opportunities. Rural communities defined poverty as poor housing, being unable to afford school for their children, a lack of farming or fishing tools and equipment, being in debt 'all the time', and being excluded from government programmes or economic opportunities by which they could improve their situation. Three forms of hardship noted by all communities were: an insufficient means of income, insufficient access to basic services, in particular water supply, electricity, and education; and increased social problems such as broken marriages, crime and community disputes due to the weakening of family and community structures. The UNDP study asked people across Fiji to describe unacceptably bad living conditions, and surveyed urban informal settlements to find the number of interviewed households that lived in these unacceptable conditions.

¹⁵ National Advisory Council Cabinet Sub-Committee on Poverty, 2002.

¹⁶ Ministry of Local Government, Housing, Squatter Settlement and Environment (MLGHSSE), 2004.

¹⁷ The MLGHSSE estimated 16% in 2003; Walsh estimated 24% in 1996.

¹⁸ MLGHSSE, 2004

¹⁹ Narsey found errors in the calculation of the 1991 poverty line, and suggested that the correct figure for the early

²⁰ 1990s was not 25% but 29% of the population living under the poverty line.

²⁰ Chung with ECREA, 2006 and ADB, 2004.

Table 1.2 Living conditions in urban informal settlements and squatters

Feature of house	Unacceptable characteristics	Households living in these conditions (%)
Facilities:		
Toilet	Shared with other households, or none	17%
Water supply	River or creek, community tap, borrowed or bought from neighbours, no regular supply	30%
Source of lighting	Firewood, candle, no regular light	4%
Cooking fuel	Firewood on open fire	17%
Electricity supply	None	44%
Construction:		
Walls	Wood in poor condition; makeshift or improvised materials	17%
Floor	Makeshift or improvised materials, bare concrete, wood in poor condition, earth	43%
Roof	Makeshift materials	4%
Household waste	Burnt, disposed in backyard, or in river or sea	83%
Household tenure		100%
Household possessions	Lacking refrigerator, telephone, stove, and television or radio.	15.4%

Source: Chung with ECREA, 2006

Inadequate living conditions extend well beyond the urban squatter settlements - a 2003 ADB survey found that rural villages and settlements were disadvantaged in regard to water supply and sanitation²¹ - but the situation has improved. The 2002 urban HIES showed that 96.1 per cent of urban households had access to safe water, down from 96.4 per cent twenty years previous in 1986, a decline that reflects growing population pressure on infrastructure.²² In rural settlements over one-third of households were without safe water, for they relied on rivers or open wells, and almost three-quarters had no improved sanitation system. Altogether, 7.3 per cent of households in 1996 had inadequate access to clean water for drinking. Other recent data on household water supply comes from the 2004 National Nutrition Survey (NNS) which showed that 90% of the survey sample had access to safe water (ie individual or communal piped). Roof tanks, boreholes, wells, rivers or creeks and other sources supplied the other 10% of households (Fiji Food and Nutrition Committee 2007).

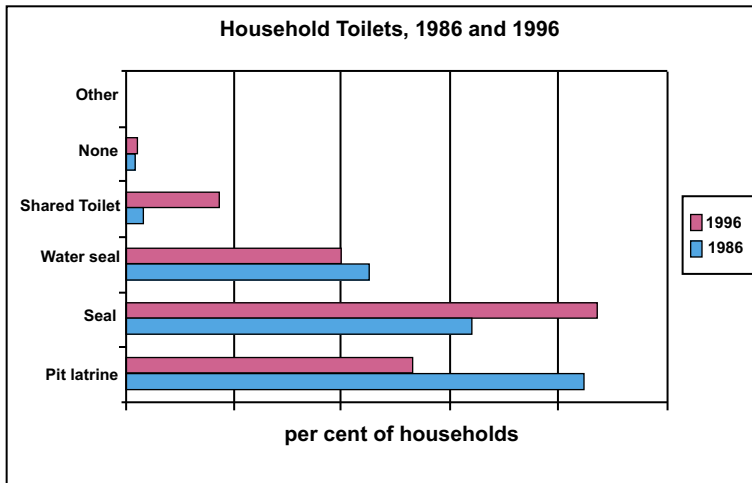
Almost all households have access to adequate sanitation. At the 1996 census, only 1.2 per cent of households lacked sanitation, a figure similar to the 1.3 per cent in 1986. However many households still use basic pit toilets, and in urban squatter settlements, households often must share toilets, a situation that Fiji people find difficult.²³ The 1993 and 2004 NNS showed that over the past decade there has been a big increase in the number of households using flush or water sealed toilets (82% in 2004 compared to 61% in 1993) and many fewer using pit latrines (17% in 2004 compared to 34% in 1993) or having no toilet (0.5% in 2004 compared with 5% in 1993). The 2004 NNS concluded that these changes reflected the greater availability of piped water and marked an improvement in community health.

²¹ ADB, 2003.

²² Fiji Government 2004. National data on water supply and sanitation mostly come from the Censuses and Household Income and Expenditure Surveys. Until 1997, the Ministry of Health was reporting annual figures on access to safe water and improved sanitation but discontinued this since, as there was no clear source for this information. The census reports only on the type of toilet or water supply used by each household, not their quality.

²³ Chung with ECREA, 2006.

Figure 1.9 Household toilets, 1986 and 1996



Source: National censuses, 1986 & 1996

The MDGs define ‘secure tenure’ as households that own or are purchasing their own homes, are renting privately, or are in social housing or sub-tenancy. According to the 1996 census, 83.5 per cent of households had secure tenure, including 86.7 per cent of urban households and 80.7 per cent of rural households. However, this definition does not fully reflect the nature of tenure security in Fiji. Although many households own or rent their home, many live in insecure conditions in that they do not own the land on which they live. Surveys conducted for the Fiji Poverty Report in the mid-1990s found that around 20 per cent of urban households lived on land without legal title, often with inadequate sanitation and water supply. There are very limited provisions for public housing for low-income families. According to the 2002 HIES, 26.5 per cent of the urban population lived in settlements and a further **10.3 per cent** lived in squatter areas.²⁴ Many rural households in Fiji also face insecure tenure, as discussed earlier in regard to the expiry of farm leases.

The 2004 NNS found that 81% of surveyed households owned their house, 6% were renting and 12% were ‘not paying’ for their accommodation (i.e. lived with relatives or friends without paying, or were ‘squatting’). The greater Suva area had the lowest home ownership rate (67%), with 20% being ‘non-paying’ residents. Other research in the Suva urban area has shown that households with ‘non-paying’ members are also typically ‘overcrowded’, more likely to contain unemployed members and more likely to spend money on non-food items (e.g., cigarettes, kava, beer, etc.). The National Nutrition Centre concluded the 2004 survey showing the percentage of households with ‘non-paying’ members might be interpreted as an indirect indicator of overcrowding, poor nutrition and associated negative health outcomes.²⁵

4. National development priorities

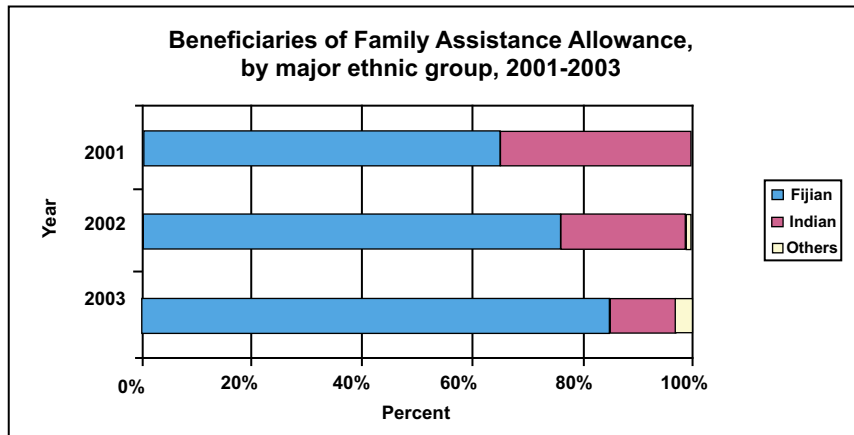
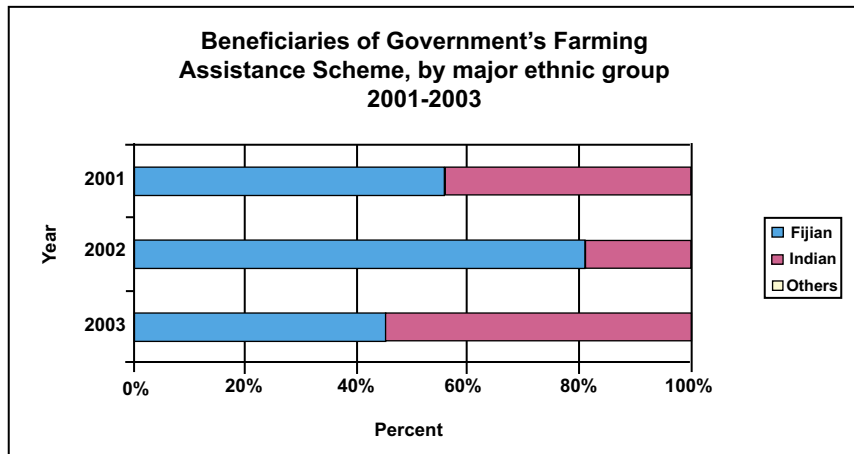
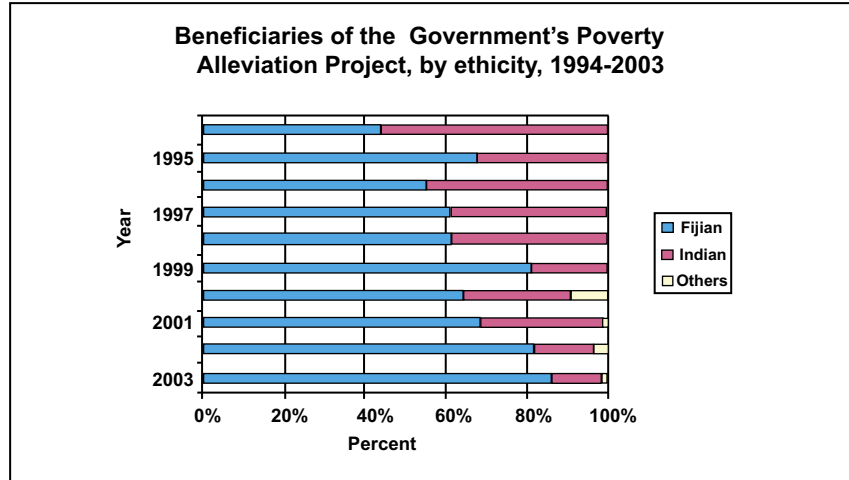
The SDL Government (2001-2006) aimed to both reactivate economic growth and implement affirmative action policies to enable indigenous Fijians and Rotumans to benefit from a greater proportion of the benefits of development programmes and economic growth. These policies were contained in a series of national development plans, with the affirmative policies explicitly developed in the 2020 Plan for Indigenous Fijians and the Blue Print. Affirmative policies were especially directed to education and training, resource-based industries, tourism, commerce and finance, and rural development. In practice, however, they extended even to areas where there was very weak, if any, evidence of an ethnic concentration of disadvantage. For example, Government welfare and poverty reduction programmes predominantly assisted

²⁴ADB, 2003.

²⁵National Nutrition Centre, 2007, citing Tunidau, 1983.

Fijians, disregarding all evidence that the poorest of the poor were more often Indo-Fijian (Figure 1.10).²⁶ Although the government changed following a military coup in December 2006, these affirmative policies are still written into ministry programmes and work-plans.

Figure 1.10. Distribution of Government welfare and poverty reduction programmes



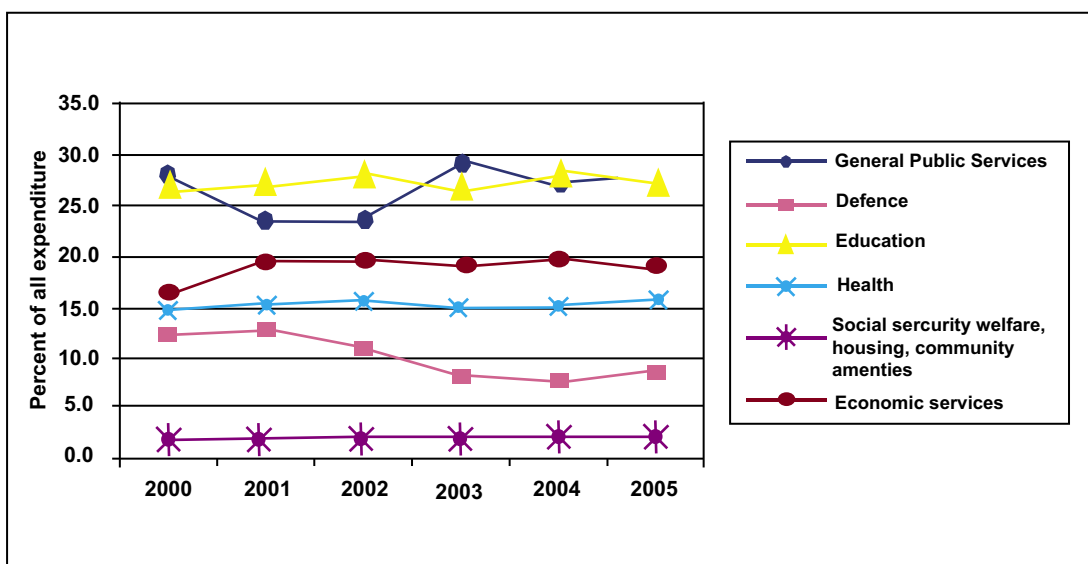
Sources: Unpublished data from Department of Social Welfare and Ministry of Agriculture, as in Kaitani, 2005

²⁶Fiji Government and UNDP, 1997.

Government's Strategic Development Plan 2007-2011 is sub-titled '*Maintaining Stability and Sustaining Growth to Achieve a Peaceful, Prosperous Fiji.*' It was designed through wide consultation with government, the private sector and NGOs and built upon the national consensus represented by the political parties then in power. It also aims to pursue progress on the MDGs. The main goals are to:

- Continue public service reform, particularly the reduction of the civil service and increase revenue from public enterprises and services;
- Alleviate poverty, by reducing income inequality and reducing the number of elderly people in state care;
- Develop rural and outer island communities by improving infrastructure and livelihood opportunities;
- Increase the supply of affordable housing for low-income families;
- Improve social justice and affirmative action by allocating more shares and licences to indigenous Fijians and Rotumans and providing them special education opportunities;
- Increase gender equality by increasing employment opportunities for women;
- Improve security, law and justice, including child and youth protection;
- Improve health services;
- Provide more resources for education, livelihood development, and sports development;
- Improve environmental sustainability.

Figure 1.11 Government has maintained education as a major priority



Source: Fiji Islands Bureau of Statistics, 2007

PART 2

THE ISSUES

PART 2: THE ISSUES

1. Health

1.1 Access to good quality care

The Government provides health services throughout Fiji, either free or at minimal cost to users. All health centres and nursing stations provide routine services, antenatal and post-natal care, family planning, and developmental screening for children. In a multi-island country like Fiji, the level of health services inevitably varies across the country, from well-equipped hospitals in the larger towns to more basic services in remote communities, where emergencies are more difficult to manage. Whenever possible, the Ministry of Health airlifts emergency cases to one of the main hospitals. The quality of rural health services particularly has deteriorated with the loss of many nurses, doctors and other medical workers through emigration.²⁷ Statistics such as the number of health professionals per population do not fully reflect this. They imply that a population is evenly served, but communities in remote places and small islands often depend on one health professional. If that person is away or cannot cope with a particular health situation, then 'access to health care' counts for very little.²⁸

Health services in remote Fiji

It is easy to forget from Fiji's towns and the more developed parts of the country just how far away from health care some people still are. In eastern Vanua Levu, for example, there is a network of nursing stations but they are sometimes understaffed or under supplied. Getting to them – or to higher-level services in an emergency – is often difficult because of limited transport and bad road conditions. People from the small settlements and nursing stations of Udu Point in the north of the island must travel to the health centre at Wainikoro or the hospital in Labasa by small boat, a long and sometimes risky trip of four hours or more. People in Fiji's other remote rural areas and small islands face similar difficulties. Nursing stations are staffed by a single nurse who usually must contend with limited radio telephone contact with the nearest doctor and very limited transport, requiring them to walk or hitch rides to visit patients and to depend heavily on their own resourcefulness and dedication.



Dogotuki Nursing Station (Cakaudrove, Vanua Levu) was upgraded in 2006 but while there are light bulbs there is no electricity. At night, the sole nurse must attend to emergencies or deliveries using a kerosene light. Her only way to contact medical help is by a fitful radio telephone and her main means of transport is by foot.

²⁷ Fiji Government, 2003.

²⁸ UNDP, 1999.

Many urban residents also have limited access to health services. Although user fees are still low at Government-run health facilities, low-income households find health care to be very expensive. A 2005-6 survey of urban squatter settlements found that almost everyone used the heavily subsidised public services but together with the cost of travel to health facilities and medicines, health care was considered very expensive and took a large chunk out of household incomes.²⁹ Analysis of the 2002-4 Household Income and Expenditure Survey found that the lower 60% of households on the income scale restricted their spending on health care.³⁰

Meanwhile, the Ministry of Health has noted the tight budget with which they must work. The government's allocation to **health is less than 3% of GDP** and the Ministry has limited opportunities to extend this through its own revenue collection, collecting only the equivalent of 1% of its annual budget (2002-2005). Expenditure on health totalled just over \$160 per head of population in 2005. The Ministry commented that, 'the low financial outlay is reflected in the numerous service inadequacies people frequently and somewhat vehemently complain about'.³¹ Fiji's primary health system, once among the best in the Pacific island region, is showing the strain of limited investment.

One writer has noted the coincidence of decreased immunisation rates and a reported increase in the infant mortality rate since 2001, and suggested that they both reflect falling health service standards.³² Infant mortality (Number of infant deaths per 1,000 live births) has risen steadily from 15.40 in 2001 to 20.76 in 2005.³³

1.2 The increased prevalence of chronic diseases

There has been an enormous rise in diseases associated with nutrition, tobacco use and lifestyle in Fiji over the past two to three decades. This adds a considerable burden to the cost of health care, at both a national and household level. Obesity and anaemia are prevalent among adults and increasingly among children. Epidemic-like rises in diabetes and heart diseases wreak an enormous economic and social toll with a general loss of health and productivity and specific consequences such as kidney failure, blindness and amputations. The 2001-2 Non-Communicable Disease (NCD) Survey found the prevalence of diabetes in adults aged 26-64 years to be 16% in Fijians and 21.2% in Indo-Fijians, and 24.7% among urban residents and 12.7% among rural residents. NCDs now contribute to 82% of all deaths.³⁴ The 2004 National Nutrition Survey (NNS) found there had been a 4% increase in hypertensive rates and a 7% increase in rates of borderline hypertension since the 1993 NNS, and that **56.2 % of the population surveyed was overweight and obese**. When combined with the number of underweight people, 62.3% of Fiji's adult population was unhealthy, a picture that the report described as alarming.³⁵

²⁹ Chung with ECREA, 2006.

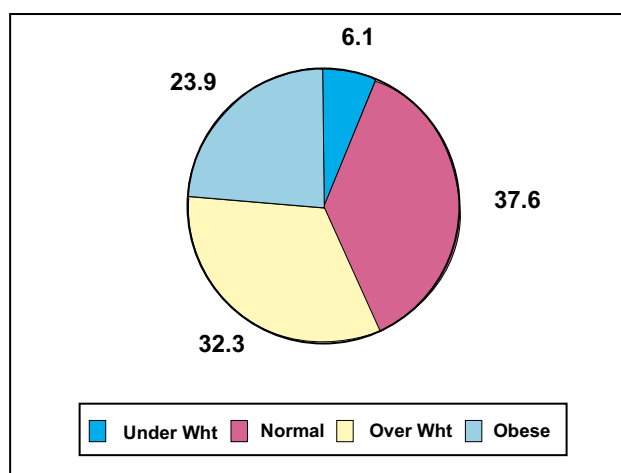
³⁰ Narsey, 2006b.

^{31,33,34} Ministry of Health, 2006.

³² Focus Economics, 2006.

³⁵ National Food and Nutrition Centre, 2007.

Figure 2.1 Adults 18 yrs and over by Body Mass Index (as percent of total adults), 2004



Few people other than those in secure, well-paying jobs have access to health insurance. The 1996 Fiji Poverty Report described how chronic diseases therefore contribute to poverty in Fiji, especially when they cause the loss or incapacity of a family breadwinner.³⁶ With approximately 35% of the population living in poverty in 2003-4, the unaffordable cost for many households of a basic nutritious diet in turn contributes to rising disease rates. The Ministry of Health is trying to encourage people to adopt healthy diets and lifestyles, but education programmes can go only so far. Many households base their diets on cost, and affordable food often is not the healthiest.³⁷ Other causal factors for these diseases are obesity and tobacco consumption.

Table 2.1 Major causes of illness, 1998-2005 (figures as percent of all reported illness)

	1998	1999	2000	2001	2005
Infection & parasitic disease	9.9	9.4	7.7	5.4	5.9
Respiratory system disease	9.1	8.6	7.7	9.0	8.1
Circulatory system disease	7.7	7.3	7.7	7.3	7.0
Injury & poisoning	6.8	6.9	7.4	5.9	
Genitourinary system disease	4.9	5.5	5.2	4.7	4.4
Perinatal conditions					6.4

Source: Ministry of Health, 2006

³⁶ Fiji Government and UNDP, 1996.

³⁷ Fiji Association of Women Graduates,

Table 2.2 Major causes of death, 2001-2005 (figures as percent of all deaths)

	1998	1999	2000	2001	2005
Circulatory system disease	39.3	43.6	47.7	40.3	26.4
Infection & parasitic disease	10.6		5.8	10	13.4
Neoplasm	9.3	7.6	6.2		10.6
Endocrine, metabolic, nutritional		7.3			9.3
Genitourinary system disease	6.5				
Respiratory system disease		7.5	6.1	8.1	8.5
Injury & poisoning		5.5	5.9	6.4	
Ill defined conditions		14.7			
Perinatal conditions					8.9

Source: Ministry of Health, 2006

1.3 The risk posed by HIV and AIDS

Fiji is in the early stages of a possible HIV epidemic. As the main transmission mode evidently is heterosexual contact (86% of known cases) (The known number of infected people is rising steadily and in October 2007 totalled 249). International experience shows that heterosexual-driven epidemics have the most potential for explosive growth.³⁸

Given the limited surveillance in Fiji, this is almost certainly an under-count. HIV is not routinely screened at ANC clinics and only around 85 per cent of pregnant women attend these clinics. Many of the people now recorded as HIV positive were first tested after their sexual partner, parent or child tested positive, and had been living unknowingly for some time with HIV. The Ministry of Health obtains information about HIV positive cases from laboratory test results. Efforts are being made to increase coverage of voluntary and confidential counseling and testing services (VCCT) at ANC clinics as part of Prevention of Mother To Child Transmission (PMTCT).

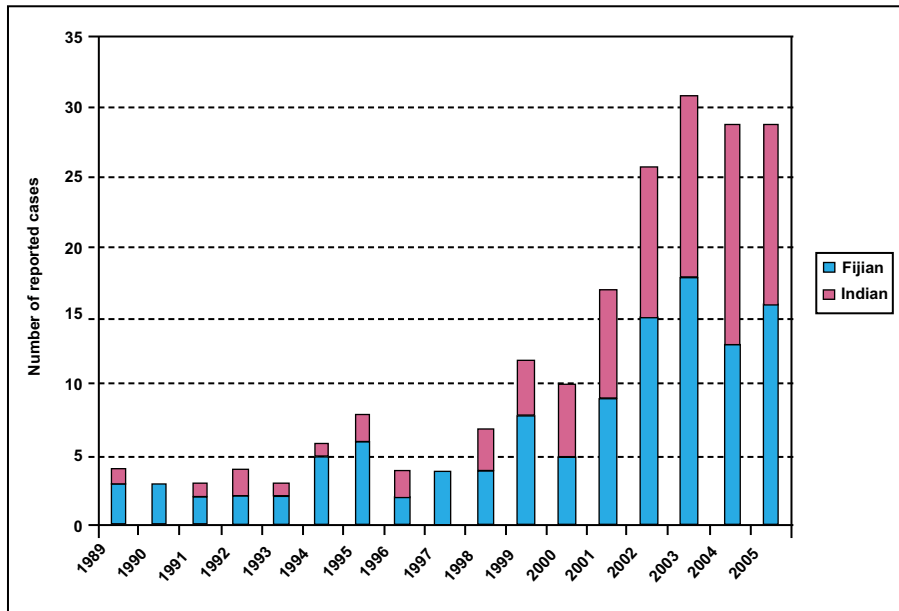
The Ministry reports HIV and AIDs cases separately by age, sex and race, and acts to protect the identity of individuals living with HIV. Of the known infections, 62 per cent are male, and 82% are in the indigenous Fijian population. The main route of infection is sexual activity; there has been only one known case of intravenous transmission. Although the first confirmed HIV positive person was infected through blood (a transfusion done abroad), blood supply in Fiji is considered safe, although there is some doubt among doctors that this is so. As at the end of 2005, 17 HIV positive pregnancies had been recorded, of which 8 children were born HIV positive, 4 HIV negative, and 5 with unknown HIV status. Eight of the ten known cases of mother-to-child transmission have occurred since 1999. Young people are generally at risk. Ten per cent of known infections have been to people under the age of 20, and 50 per cent were aged 20-29 years. To date, few children in Fiji have been orphaned by AIDS but if the number of infections continues to grow, this situation may deteriorate.

The predominance of cases among Fijians possibly reflects health seeking and protective behaviours, level of awareness of HIV, access to or acceptability of condoms, and opportunities to seek VCCT services in Fiji or abroad. Other risk factors in Fiji for a fast growing HIV epidemic include the high incidence of sexually transmitted infections, a considerable level of homosexual and male bisexual activity, high incidence of unprotected sex among teenagers, a high incidence of drug and substance abuse, a mobile population,

³⁸Whiteside et al., 1998.

many people working abroad, a large tourism industry, and cultural behaviour that includes a considerable degree of extramarital sex and sexual violence.³⁹ Data on known infections suggest that women are a large and growing group at risk, for they have little control over the sexual behaviour of their partners and little opportunity to protect themselves from infection.

Figure 2.2 Annual reported cases of HIV by sex, 1989-2005



Source: Ministry of Health, 2006.

The Fiji National AIDS Strategy aims to:

- Improve diagnostic and surveillance capacity, by establishing 'second generation' surveillance systems; strengthening infrastructure and human resources; providing diagnostic and monitoring services; improving blood screening and safety; and better monitoring of the epidemic.
- Improve access to treatment, care and support for people living with HIV and AIDS, especially vulnerable groups, and the general population, by providing voluntary counselling and testing (VCT) services, client-friendly clinics, improving clinical management and treatment of AIDS, and supporting anti-retroviral treatment (ART).
- Improve access to prevention, including heightened public awareness, through peer education programmes; building local capacity, such as training health workers; and giving more attention to human rights concerns.
- Strengthen national mechanisms to manage the epidemic, by revitalizing the National Advisory Council on AIDS (NACA), improving coordination between the Ministry of Health and NGOs working in this field, and developing a coordinated multi-sectoral response.

³⁹ United Nations, 1996

The PMTCT approach calls for a well coordinated health system to track and diagnose those at risk of HIV through improved referrals in outpatient clinics, STI and reproductive health services, and improved tracking of sexual partners and children of those at risk. Capacity for counselling of safe sex behaviours, especially those people who test positive, and the encouragement of their partners and others with high-risk behaviours to come for VCCT will help reduce the likelihood of them later infecting others.

1.4 Patterns of illness and death by age and sex

(a) Infants and children

Fiji's infant mortality rate fell from around 71 per 100,000 live births in 1960 to around 16 in 2000. As noted earlier, it has since increased each year to 21/1,000 live births in 2005.⁴⁰ The Ministry's records on infant deaths are reliable because trained medical personnel attend an estimated 98% of births, leaving a possibility of a few births or infant deaths going unrecorded.⁴¹ The overall drop in infant mortality since the 1970s reflects widening access to infant and maternal care throughout Fiji and improvements in the quality of these services over recent decades. The high rate of trained care at delivery has reduced both deaths and the birth injuries that once commonly caused life-long disability and suffering.⁴² Training in basic emergency obstetric care and midwifery through the Fiji School of Nursing and post-graduate training in obstetrics and child health at the Fiji School of Medicine has improved the quality of birth deliveries, including in remote health centres.

The infant mortality rate is nevertheless still relatively high and effective strategies are needed to decrease it. There is no firm explanation for its recent increase. Possible causes are a decline in the quality of health services, a decline in their use, or the worsening health of women of child-bearing age. Regular check-ups for pregnant women is an effective way to reduce the number of underweight babies but many working women cannot make the time to attend clinics, and many poorer women may have difficulty affording transport to the clinics, or there may not be adequate services in their area.⁴³ The increasingly high prevalence of anaemia in pregnant women has increased the proportion of infants underweight at birth (11% in 2004), which is a key indicator of risk for infants.⁴⁴ The rising incidence of diabetes contributes to gestational diabetes mellitus and the condition of macrosomia in infants (very over-weight at birth). Sexually transmitted infections (STI) pose another serious risk to babies at birth.



⁴⁰ Ministry of Health, 2006.

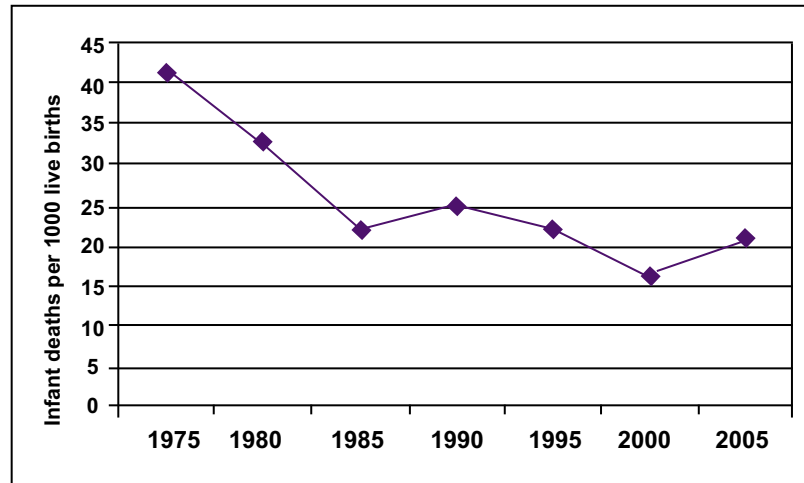
⁴¹ Without a recent census, there is no source of data with which to check the accuracy of Ministry of Health records.

⁴² Fiji Government and UNICEF, 1996.

⁴³ National Nutrition Centre, 2007.

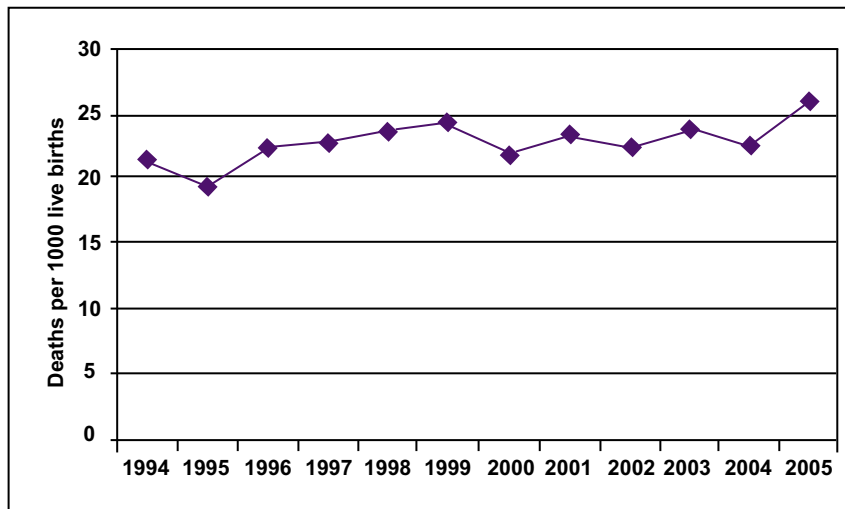
⁴⁴ Low-birth weight and anaemia are both generally associated with poor nutrition, poor environmental health, and other hall-marks of poverty, but also lifestyle choices such as smoking, and there is also an evident difference between Fijians and Indo-Fijians.

Figure 2.3 Infant Mortality Rate, 1975 – 2005



Source: Ministry of Health, Annual Reports, various years.

Figure 2.4 Child Mortality Rate 1994-2005



Source: Ministry of Health, Annual Reports, various years.

The Integrated Management of Childhood Illnesses (IMCI) Strategy by WHO and UNICEF in its pilot phase in 2003 – 2004 was seen to improve the management of the main causes of death in young children, and the programme was adopted nationally in 2004. However, the annual number of deaths among children 1-4 of age per 1,000 live births, has remained fairly steady for the past two decades, in the low 20s.

There is an evident difference between Fijians and Indo-Fijians, with a higher rate of child deaths for Fijians, which the 2004 NNS attributed to poor complementary feeding. The main causes of death in children are acute respiratory infection, communicable diarrhoeal diseases, rheumatic heart diseases, malnutrition, meningitis, and asthma. Other contributing factors are poverty, inadequate sanitation, low education level, poor water supply, and poor living and environmental conditions, particularly in rural areas.

To further reduce the number of child deaths will again require both persistence with old strategies – immunisation, nutrition education, fortification of flour – and new ones, particularly the identification of sub-national patterns in child illness and death, and targeting children with special health risks and families living in hardship or poverty.

Table 2.3 Leading causes of deaths for children under the age of five years

Medical conditions	2001	2002	2003	2004	2005
Perinatal conditions	25.8	41.5	65.9	49.1	55.0
Respiratory	17.2	12.3	7.5	14.0	8.9
Circulatory	12.1	6.4	6.1	6.0	5.0
Infectious/parasitic	10.1	11.8	4.2	13.0	11.7
Congenital	9.3				
Injury/poisoning		9.5	3.3	4.0	5.9
Nervous system					

Source: Ministry of Health, 2006

The Ministry of Health operates a child immunisation programme through primary health care clinics and rural nursing stations. There are however problems in maintaining the cold chain system, particularly in remote areas, and children there are most often disadvantaged. Ministry of Health figures for 2001-2005 show that for most years and vaccines, coverage rates hovered below or barely above the 90% rate needed for high population immunity. Only BCG coverage averaged above 90% in these five years. Coverage rates for the other vaccines all averaged in the mid-70 percents, far too low to be effectual.

The National Immunisation Coverage Survey, 2005, confirmed that Fiji needed to strengthen its Expanded Programme of Immunisation (EPI) in order to adequately protect infants from outbreaks of measles, meningitis and other preventable illnesses. The survey also showed a significant gap between the administrative coverage and the actual field coverage, which reflects poor quality reporting.⁴⁵

The DPT-HepB + Hib vaccine was tested in the Western Division in 2005 and introduced nationally in 2006. Cold chain equipment is being systematically replaced and upgraded – a slow process due to financial constraints. Trained technicians are now stationed in all health divisions.⁴⁶

Table 2.4 Immunisation coverage rates, 2001-2006

Vaccine	2001	2002	2003	2004	2005	2006
BCG	96.6	96.2	91.6	93.2	88.5	93.4
HBV3	78.3	83.9	73.3	75.4	75.1	81
OPV4	92.2	90.9	52.4	79.3	75.4	82.2
DPT/HiB3	91.2	85.1	61.9	74.5	75.5	80.6
Measles/Rubella	85.3	76.4	66.4	68.8	68.0	100

Source: Ministry of Health, 2006

National Nutrition Surveys conducted in 1980, 1993 and 2004 show that there is a small but growing problem of child malnutrition. The main causes of under-weight and stunting in children aged less than 5 years are maternal nutritional and health status, low birth weight, acute respiratory infection, diarrhoeal diseases, meningitis, asthma and malnutrition. These problems are mostly associated with poverty and poor living conditions but there are also general differences between the main ethnic groups, with Indo-Fijian children on average being smaller and lighter. A UNICEF study conducted in two sub-divisions (Suva and

^{45,46} Ministry of Health, 2006.

Macuata) found that infants were missing out on energy-dense foods, which put them at heightened risk for nutritional deficiencies.⁴⁷

The 2004 NNS found around 75% of infants were born at standard weight for age, 10.2% were of low birth weight (LBW), most of whom were Indo-Fijians; and 10.5% were born with high birth weight (HBW), most of whom were Fijians. Both LBW and HBW are now recognised to pose risks to infant health. There was an overall 1% reduction in LBW in 2004 compared with 1993. By sex, the birth weights of boys improved, but they declined for girls. The proportion of LBW had worsened in Fijian children by 3.3% but improved in Indo-Fijians children by 2.4%. LBW was more common in rural areas (54.8%) than urban areas (45%).

Table 2.5 Mean birth weights of children under 2 years by ethnicity and gender, 1993 and 2004

Ethnic group	Gender	Mean birth weight (g)		Gram difference	% change
		1993	2004		
Fijian	Male	3,440	3,515	+74	2.2
	Female	3,400	3,241	-159	- 4.7
Indo-Fijian	Male	2,930	3,054	+124	4.2
	Female	2,770	2,760	-10	- 0.4
'Others'	Male	3,600	3,760	+160	4.4
	Female	3,550	3,550	0	0

Source: National Nutrition Survey, 2004

Breastfeeding was initiated by **85% of mothers** within 24 hours after giving birth, with higher rates for Fijians than Indo-Fijians. **In children aged 6 months or less, 40% were exclusively breastfed but there was a sharp drop-off after that age. Only 2.3% of children aged 7 - 12 months were still exclusively breastfed, and none after the age of 12 months.**⁴⁸ **By 6 months of age, 39.8% of children were still exclusively breastfed in 2004, up from 25% in 1993.**

However, the overall rate of exclusive breastfeeding of children under the age of 2 declined slightly over the past decade, from 11.5% in 1993 to 10.9% in 2004. The overall duration of breastfeeding, however, increased. The mean duration of exclusive breastfeeding in 2004 was 9 months among Fijians and 6.8 months for Indo-Fijians. Interestingly, the average duration declined slightly over the decade 1993-2004 in rural areas (from 7.3 to 6.8 months) but rose in urban areas (from 5.8 to 9 months) The NNS report noted that the reasons for this difference were not clear but could be due to the success of the baby-friendly hospital initiative and the exclusive breastfeeding programme.

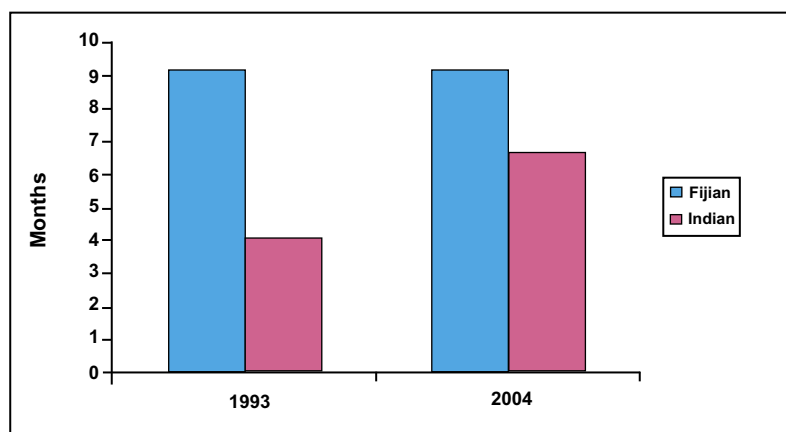
The most common reason given for not breastfeeding was 'no breastmilk'. By 6 months of age, 43% Fijian and 56% Indo-Fijian children were receiving breastmilk substitute; 79% of children were given other types of fluid including sweetened water; 31% were given fruits, 44% were receiving solid food and 25% were given solid/mushy food. The introduction of fluid supplementation before 6 months and sweetened drinks at an early age is not only unnecessary, it can also be a dangerous source of infection or the cause of tooth decay. It also interferes with proper feeding of infants and lowers the chances of breastfeeding success, as sweetened drinks are likely to replace milk.⁴⁹

⁴⁷ UNICEF, 2001.

⁴⁸ National Nutrition Centre, 2007. 'Exclusive breastfeeding' was defined in this survey as infants fed with only breast milk for the first six months without any other fluid (not even water).

⁴⁹ National Nutrition Centre, 2007.

Figure 2.5 Mean duration of breastfeeding by ethnicity, 1993 and 2004



Source: National Nutrition Survey, 2004

Under weight and stunting is common among Indo-Fijian children: less than 20% in the under 5 years; almost 30% in the 5-9 years; and around 37% in late adolescents. Fijian children were more prone to growth faltering after 3-5 months, which coincides with the weaning period and suggests poor feeding practices of infants and young children.⁵⁰

Obesity in both children and adults was more prevalent in urban areas. In some areas, 20-30% of children less than 5 years of age were classified as overweight and obese, while 20-25% in the same age group was classified as mild to moderately under-nourished. This was attributed to changes in food consumption patterns and dietary habits. Urban diets were typically made up of a moderate to high intake of energy foods, fat, protein, sugar and salt, but low in complex carbohydrates and fibre and probably low in antioxidants, potassium and trace minerals.⁵¹ Protein intake for Indo-Fijians remained unchanged. Urban Fijians consumed more cassava and bread, and rural Fijians more cassava, dalo, rice and dhal. Changes in Fijian food choice were attributed to food costs and ease of preparation; while changes amongst Indo-Fijians were to food costs and personal preference. The 2002 NCD Survey also reported low consumption of fruits and vegetables, with 66% of adults eating less than one serving of fruit a day.⁵²

Micronutrient deficiencies are also significant problems. No national representative survey has been conducted but small studies suggest that Iodine Deficiency Disease (IDD) is prevalent, especially in areas where few sea foods are consumed. A 1994 survey of 15-45 year old females found the prevalence of goiter in Suva and Sigatoka was 25% and 29%, respectively, and 39% in 6-12 year old children in Ba, Sigatoka Valley and Sigatoka Town. In 1996, legislation on exclusive import of iodised salt was introduced to improve the situation.⁵³ Iron Deficiency Anaemia (IDA) is another common problem in children and adults and contributes to the high rates of low-birth weight in Indo-Fijian infants, poor learning performance in school children, and low productivity in adults. A 1995 survey found that 29% of Fijian and 36% of Indo-Fijian children under 5 years were anaemic, as well as approximately 80% of pregnant women. In 1998, a survey of Ba Sub-division by the Ministry of Health found that 34% of women of child-bearing age were anaemic.⁵⁴ Anaemia is generally more common among Indo-Fijians but the 2004 NNS found that rates among Fijians had increased and that anaemia was more prevalent among young boys than girls.

^{50, 52, 53, 54} National Nutrition Centre, 2007.

⁵¹ Coyne, 2001.

Table 2.6 Nutritional problems in Fiji children, 1980, 1993 and 2004

Condition	1980	1993	2004
Low birth-weight babies (less than 2,500g)	n.a.	11%	10.2%
Children severely malnourished	5.8%	1 % rural children	n.a.
Children moderately malnourished	21.2%	15%	n.a.
Under-weight children (0-4 yrs)	16.4%	10.5%	7%
Over-weight children (0-4 yrs)	n.a.	4.5%	13%
Over-weight children (5-9 yrs)	n.a.	5.9%	15%
Anaemic children (6 mths - <5 yrs)	n.a.	40%	49.3%

Sources: National Nutrition Surveys, various dates

Dental caries is a growing public health problem, especially in children. The 2004 National Oral Health Survey showed that oral diseases are prevalent in Fiji and have become a serious public health problem. Dental services are available at health clinics throughout Fiji as well as mobile clinics to serve primary schools. The Ministry of Health however reports that because of inadequate supplies of dental supplies and equipment, there is a large unmet need for dental treatment.⁵⁵

Table 2.7 Prevalence of dental caries, by age group, 2004 (figures in %)

	6 yr olds	12 yr olds	15-19 yr olds	35-44 yr olds
Had caries experience	88.3	52.3	67.5	98.1
Had untreated caries	85.2	34.7	54.5	68.8
Had 4 or more decayed teeth in mouth	49.1	4.1	12.5	21.8

Source: Ministry of Health, 2006

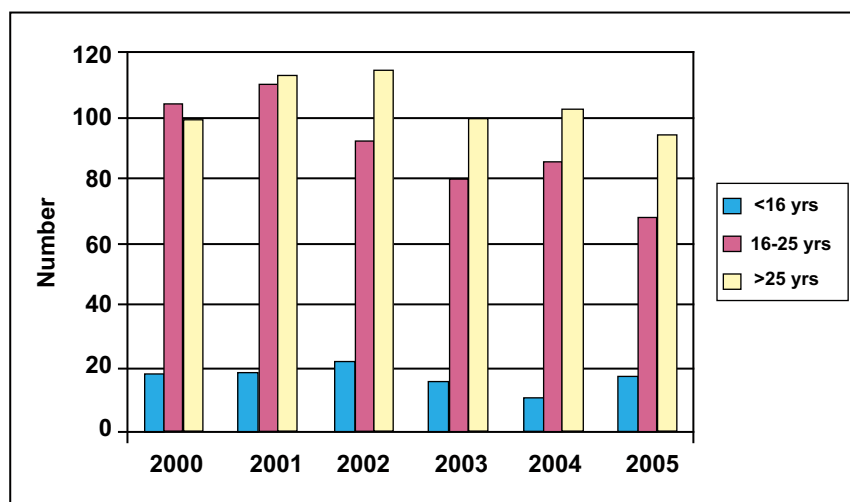


⁵⁵ Ministry of Health, 2006

(b) Older children and youth

Accidents are a significant cause of injury or death to older children and adults. Fiji has a high road toll, particularly of pedestrians, and also a high drowning rate. The suicide rate is also high, particularly for young men. Paraquat poisoning and hanging are common methods.

Figure 2.6 Suicides and attempted suicides, by age group, 2000-2005



Source: Fiji Police, 2005

Sexually transmitted infections (STIs) are prevalent in Fiji and pose risks to the whole population, but young people are particularly vulnerable. Many education programmes have been conducted on STIs and HIV but few resources have gone towards measuring their impact. Young people still generally have restricted access to reproductive and sexual health services and information, sometimes because the services are unavailable near to where they live, sometimes because health personnel are reluctant to serve young unmarried people and sometimes because young people are embarrassed or otherwise reluctant to use these services because of the stigma of being associated with promiscuous behaviour.

Table 2.8 Reported Sexually Transmitted Infections, by age, 2005

Age group	Gonorrhoea		Syphilis	
	Reported cases	%	Reported cases	%
10-19	133	15.9	76	9.2
20-29	569	66.7	530	63.7
30-39	111	13.2	175	21.0
>40	35	4.2	51	6.1
Total	838	100	832	100

Source: Ministry of Health, 2006