FIJI

A SITUATION ANALYSIS OF CHILDREN, YOUTH & WOMEN

GOVERNMENT OF FJII
with the assistance of UNICEF

2007

Fiji Islands. A Situation Analysis of Children, Youth and Women.
UNICEF Pacific Office, Fiji. 2007

Copies of this publication are available from
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Acronyms

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
AIDA	Accessible information on development activities
ALTA	Agricultural Landlord and Tenant Act
ANC	Antenatal care
ART	Anti-retroviral treatment
AusAID	Australian Agency for International Development
BCG	Bacillus Calmette-Guerin (anti-tuberculosis vaccine)
CBR	Crude birth rate
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CFCs	Chloro-fluorocarbon
CPR	Contraceptive prevalence rate
CRC	Convention on the Rights of the Child
CSEC	Commercial sexual exploitation of children
CSOs	Civil society organisations
DPT/Hib3	Diphtheria, Pertussis and Tetanus/Haemophilus influenzae type B
DPT-HepB+Hib	Diphtheria, Pertussis and Tetanus/Hepatitis B
ECE	Early childhood education
ECREA	Ecumenical Centre for Research, Education and Advocacy
EPI	Expanded Programme on Immunisation
FCA	Fiji College of Agriculture
FCOSS	Fiji Council of Social Services
FEYE	Fiji Eight Year (Secondary School) Entrance Examination
FIT	Fiji Institute of Technology
FNCDP	Fiji national council for diasabled persons
FRCS	Fiji Red Cross Society
FRIEND	Foundation for Rural Integrated Enterprise 'N' Development
FSEG	Family Support and Education Group
FSM	Fiji School of Medicine
FTUC	Fiji Trades Union Council
FWCC	Fiji Women's Crisis Centre
FWRM	Fiji Women's Rights Movement
GDP	Gross Domestic Product
GOAL	Grassroots Opportunities for Action and Leadership
HART	Housing Assistance Relief Trust
HBW	High Birth Weight
HDI	Human Development Index
HIES	Housing Income and Expenditure Survey
HIV	Human immunodeficiency virus

IDA	Iodine Deficiency Anaemia
IDD	Iodine Deficiency Disease
ILO	International Labour Office
IMCI	Integrated Management of Childhood Illnesses
IUCD	Intra-uterine contraceptive device
JICA	Japan International Co-operation Agency
LBW	Low Birth Weight
MDGs	Millennium Development Goals
MLGHSSE	Ministry of Local Government, Housing, Squatter Settlements and Environment
MOH	Ministry of Health
MOE	Ministry of Education
NCCC	National Coordinating Committee on Children
NCD	Non communicable disease
NGO	Non-governmental organisation
NNC	National Nutrition Centre
NNS	National Nutrition Survey
NZAID	New Zealand Agency for International Development
ODA	Official development assistance
PAFCO	Pacific Fishing Company
PMTCT	Prevention of Mother To Child Transmission
SCF	Save the Children Fiji
SDA	Seventh Day Adventist
SDL	Soqosoqo Ni Duavata Ni Lewenivanua (political party)
SHSM	Order of Sisters of Sacred Heart
SOPAC	South Pacific Applied Geo-Science Commission
SPC	Secretariat of the Pacific Community
STI	Sexually transmitted infections
UN	United Nations
UNAIDS	United Nations AIDS (agency)
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Council for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USP	University of the South Pacific
VCT	Voluntary counselling and testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

As part of its country programmes, UNICEF assists governments to produce and update a report on development trends within each country that describes how these changes affect the well-being of children, youth and women. These reports help to direct UNICEF's programmes and they also provide a useful reference for national bodies, the public and other development partners. This report presents an overview of the situation of children and women in Fiji in the first decade of the 21st century. It was drafted with help from many people in Fiji and draws upon both published and unpublished information and reports.

Political instability and associated economic difficulties over the past twenty years have put the Fiji Government's commitment to equitable development under increased pressure. The current development plan focuses on opportunities for economic growth, in the expectation that this is the precursor to social development. But government's budget has grown faster than the national economy, its debt has grown rapidly, and civil service salaries take up a large part of government spending, despite a recent pay cut. There is little left over for capital costs, and social services are under growing strain to maintain their quality in the face of this declining investment. Progress in sectors such as health, education and social services, which has taken so much to achieve, is in jeopardy.

Since the late 1990s, Fiji's progress has stalled on basic development indicators, including the Human Development Index (HDI). Infant, child and maternal mortality rates have halved since the 1960s and are now low, and life expectancy at birth is high at 70.7 years for women and 66.5 years for men. In the early 1990s Fiji's child mortality rate was the second lowest among Pacific island countries. Since then, child mortality has dropped in every other country in the region – particularly in countries with higher rates – but Fiji remained static. There is a high level of adult literacy, almost universal primary school enrolment, and around 40 per cent of adolescents remain at school to the age of 18 years, up from a much smaller number a generation ago. Partly because these education indicators were already good, Fiji has made less recent improvement on them than most other Pacific island countries.

The last national population census was held 11 years ago in 1996. Population projections compensate for the lack of recent figures but much is uncertain about the present situation. Because there are no firm population counts, important questions that cannot be properly answered include the proportions of children in or out of school, vocational skills in the working population, the extent of unemployment, the growth of towns, and the number of families living in squatter-like housing. It is nonetheless evident that there is now: a very high rate of emigration from Fiji, particularly of skilled and professional people; an outflow of rural residents to the towns and more generally people from Vanua Levu to Viti Levu, because of the expiration of agricultural land leases; an upsurge in informal settlements where people

must live with poor living conditions and insecure tenure; and generally a growing breadth and depth of poverty.

Health concerns include problems of access to good quality care, especially for people in remote rural areas; the expense of health care for low-income people, despite the low user fees at government facilities; deteriorating national nutrition standards; the increased prevalence of chronic diseases, reproductive health problems, especially for young people; and the risks posed by HIV and AIDS. Progress has stalled on lowering the infant mortality rate, to the point where it appears to have recently increased. Possible causes for this include a decline in the quality of health services, a decline in their use, or the worsening health of women of child-bearing age. To contain this problem will require both persistence with traditional strategies – immunisation, nutrition education, and so on – and the adoption of new ones, particularly the identification of sub-national patterns of child illness and death, and targeting children with special health risks and families living in poverty.

School enrolments in Fiji are high, with a Net Enrolment Ratio of around 100%. Entry to primary education is almost universal, equally so for boys and girls. This significant national achievement has come about through the joint efforts of the Ministry of Education and the many NGOs, local communities, churches and private organisations that operate schools, or programmes to assist under-privileged children. Since the early 1990s, the Ministry of Education has worked towards making basic education compulsory – although not entirely free – for children aged 6-15 years by extending tuition fee-free grants to schools, increasing the number of civil servant teacher posts, helping to extend early childhood education, establishing more rural schools and providing transport assistance to children in remote rural areas, improving the quality of teaching staff and school management through training programmes, promoting community support for education, and increasing education opportunities for children with disabilities. Nonetheless, the survival ratio from primary school classes 1 to 5 appears to have fallen since the early 1990s, possibly indicating the difficulty faced by low-income families in keeping their children at school – but the full extent of this will only be evident after the forthcoming census is completed.

Post-secondary education is available through several Government-run or private institutions, but all forms of adult and vocational education are limited and entry is competitive, advantaging the best qualified students or those who can afford the often high fees. Females constitute only 30% of enrolments in technical and vocational education, indicating their continuing disadvantage. Non-formal education remains poorly organised and little supported by government.

The youth population is the fastest growing segment of Fiji's population. A lot of attention has been given to the problems faced by young people, and to improving their prospects

through training in life skills and employment generation, provision of youth-friendly reproductive health services, and projects to address issues such as substance abuse. A National Youth Policy was developed in 2004 with the assistance of the National Youth Council and other youth organisations, and incorporated into the national development planning process.

People with special needs include disabled children and adults, people living in poverty , and children and women at risk of abuse. The terms 'poverty', 'hardship' and 'disadvantage' now occur frequently in government planning and policy documents. Many NGOs working in this area nevertheless believe that there is insufficient political will to fully address these problems. There is a close connection between disability and poverty. The Fiji Government allocates a very small proportion of its budget to social welfare. The main official welfare programme, the Family Assistance Scheme, provides small payments to the most destitute households, but even these payments were severely cut in the last budget.

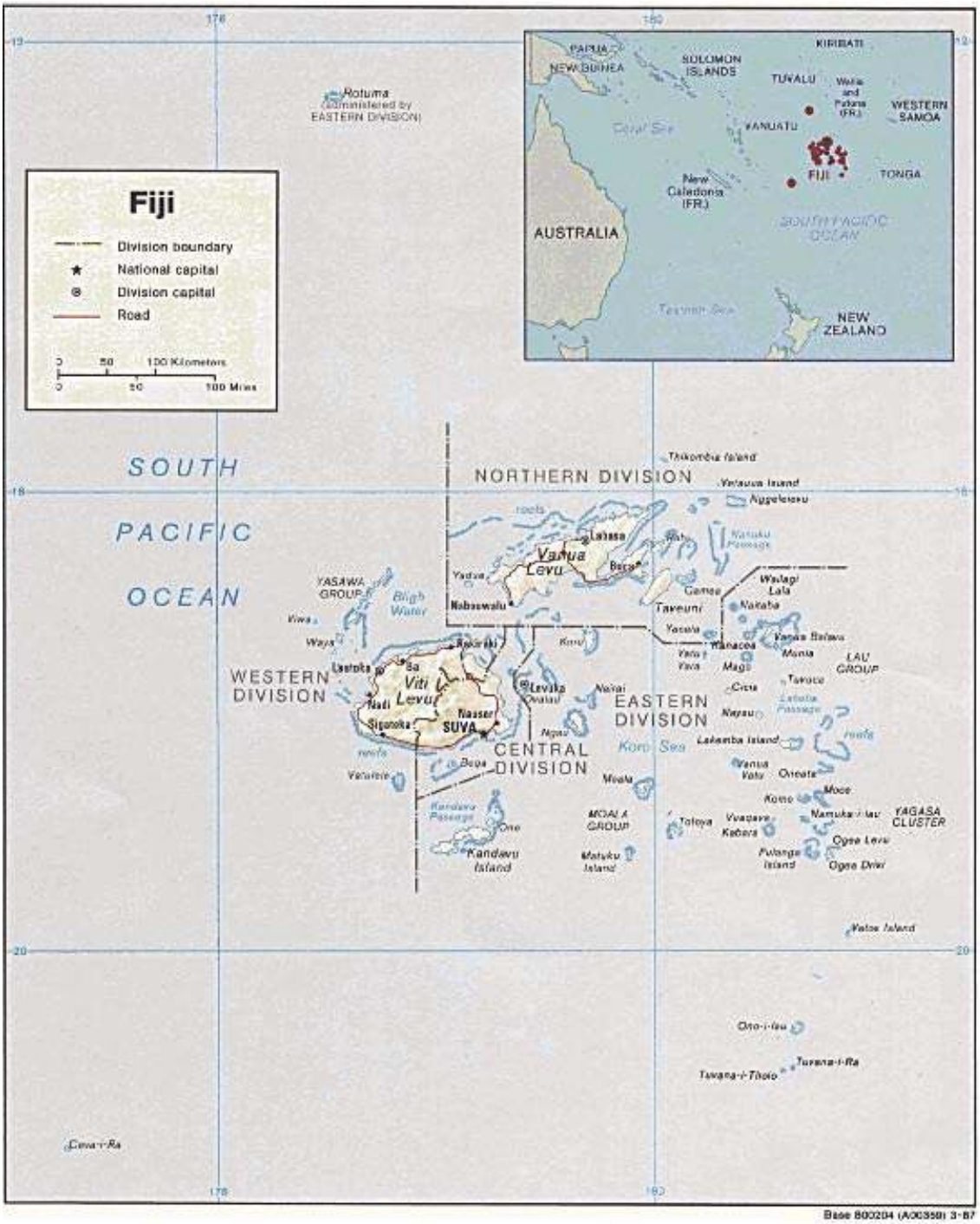
Domestic violence is an issue that is now receiving more of its due attention, and the past decade has seen a real change in official attitudes. Other areas of discrimination against women remain, partly because legislative changes have yet to be made in, for example, legal provisions for various sexual offences, or sufficient action yet taken to counter *de facto* discrimination against females in the education system and workforce.

Physical abuse of children remains a problem even in the schools, and their sexual abuse and exploitation may be on the increase, aided by new electronic media, more extensive tourism, and poverty. Work is underway to educate the community, including children, about child rights and children's development. The commitment of the Fiji Government to child protection is demonstrated through the policies of various ministries, particularly the Police. The National Coordinating Committee on Children coordinates and facilities advocacy about the Convention on the Rights of the Child, and monitors and reports on related activities of the government.

In its Strategic Plan 2007-2010, the Fiji Government reaffirmed its responsibility to put in place policies that will achieve prosperity, especially for the poorest, disadvantaged and most vulnerable citizens. However, pro-poor planning is not strong in Fiji. National plans emphasize the need to address poverty and hardship, yet the major upheavals of recent years – the termination of thousands of agricultural leases, the periods of economic malaise that have followed periods of political unrest, the loss of factory employment for thousands of workers, particularly women, the large out-flow of people from Vanua Levu, stagnation of the low-income urban housing market, and the visible growth of poverty – have not been sufficiently mitigated by well designed or implemented programmes.

Non-government organisations have for many years made a large contribution to education, health and social services in Fiji. They now need to be able to scale up their activities, to widen and deepen their coverage, and this requires that more resources are channelled into supporting effective programmes. The potential role for NGOs in development has been talked about for more than a decade, but many of these organisations in Fiji believe that this potential is still far from being realised.

MAP OF FIJI



Introduction

As part of its country programmes, UNICEF assists governments to produce and update a report on development trends within each country that describes how these changes affect the well-being of children, youth and women. These reports help to direct UNICEF's programmes and they also provide a useful reference for national bodies, the public and other development partners. This report presents an overview of the situation of children and women in Fiji in the first decade of the 21st century. It was drafted with help from many people in Fiji and draws upon both published and unpublished information and reports.

In 1993, the Fiji Government ratified the Convention on the Rights of the Child (CRC) and in 1995, produced their first CRC Implementation Report. The CRC is central to the work of UNICEF and forms an important backdrop to this report. The second guiding document for this report is UNICEF's Medium Term Strategic Plan 2006-2011, which sets out the organisation's priorities for the next four years. The goal of UNICEF's Pacific Programme is, together with regional and country partners, to ensure a better outcome for Pacific island children as reflected in more accurate data for planning and monitoring, improved policies and legislation, and greater access to quality services. The results sought are:

1. Increased country ownership of the principles of the Convention on the Rights of the Child (CRC) and the Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW);
2. Improved infant and child health and development and education of children under 12 years of age;
3. Greater resiliency of adolescents;
4. Greater participation of children in society and their protection from abuse and discrimination.

A third, more general background is the Millennium Development Goals, which inform the work of all United Nations agencies and which are very pertinent to the status and conditions of children, youth and women.

The Definition of a Child

Under Fiji's Constitution, all people irrespective of age, sex, ethnicity or religion have equal rights. As a signatory to the Convention on the Rights of the Child, Fiji recognises that people under the age of 18 years are entitled to particular rights and protection as children, but the laws are not consistent about this. Most provisions in the Fiji Constitution suggest that a person reaches adult status at the age of 21 years, when, for example, they become eligible to vote. But in other respects, the age of legal responsibility is younger:

- Under the Juveniles Act, no child under the age of 10 years can be guilty of any offence. All other children up to the age of 17 years are dealt with in juvenile courts. A child between ten and twelve can be found guilty only if the child knows the crime he or she committed was wrong. Children under 14 can be placed in prison if they are considered hardened juvenile criminals. Under the Penal Code (Section 25), a sentence of death cannot be pronounced on a person under the age of 18 years.

- There is no prescribed age at which a child can give testimony in Court or at which parental consent does or does not apply. Under the Juveniles Act, a child can give sworn evidence if he or she understands the nature of an oath. If they do not understand the oath but understand the duty of speaking the truth (described as "any child of tender years") their evidence is admissible but must be corroborated.

- Under the Juveniles Act, it is an offence to assault, ill-treat, neglect, abandon, or expose a juvenile to suffering or injury to health. The Penal Code includes other measures to safeguard and protect children from the offences of abduction, defilement, and infanticide, again up to the age of 17 years.

- The Marriage Act provides a minimum age for marriage of 16 years for women and 18 years for men, but parental consent is needed from the father for persons under the age of 21. If he has died, the mother or a magistrate can give consent.

- In regard to property, the Wills Act provides that a person can make a will once they reach the age of 18 years. There is no specific legislation as to the minimum age at which people can contract or acquire and transfer land but the English Minors Act is followed, which again is 18 years.

- Under the Liquor Act, it is illegal to sell or supply alcohol to people under the age of 18 years.

- The Employment Act defines children as people under the age of 15. It prohibits employment of children under the age of 12 and protects older children from long hours, night work and hard or heavy work. A child can only be employed on a daily basis for six hours or less, and must return home each night.

- A young person must be at least 18 to be recruited into the army.

- The health services have no clear legal definition of the age at which children need parental consent for outpatient care or contraceptive use[1].

- Under the Family Law Act, if parents have separated, the parent having the care of any children of the marriage can apply to the Court for maintenance for the children.

[1] Government of Fiji, 1995. Fiji CRC Implementation Report.

This Act applies to children up to the age of 18 years, or older if special circumstances apply.

Cabinet established the National Coordinating Committee on Children in 1993, the year in which Fiji ratified the UN Convention on the Rights of the Child. The Committee consists of representatives from various government ministries and non-government organisations whose work relates to children. The Committee considers ways to incorporate the provisions of the Convention into Fiji's laws and practices and coordinates national efforts in matters relating to children.

Part 1
The National Situation

PART 1: THE NATIONAL SITUATION

1. The Economic and Political Situation

Fiji is a small island state lying 15 to 22 south of the equator in the southern Pacific Ocean. The country has approximately 300 islands with a total area of 18.2 thousand sq. km. of land, spread over 906 thousand sq. km. of ocean. Tourism, remittances, sugar production, and to a lesser degree manufacturing, are the main supports of the economy. The population of around 750,000 is growing slowly, if at all, due to a moderately slow rate of fertility and a fast rate of out-migration. Just over half of the population are indigenous Fijians. The other large ethnic group are Indo-Fijians, mostly descendants of indentured labourers who came from India in the late nineteenth and early twentieth centuries. Other ethnic groups (officially known as 'Others') have never made up more than 10 per cent of the population. They include Chinese, Europeans and other Pacific Islanders, and a growing number of people of mixed ethnicity or other origins.

One of the larger countries of the South Pacific island region, The Fijian Islands have a relatively well-developed infrastructure, on average a moderately good standard of living, and a high but static level of human development. Internationally, Fiji is listed on UNDP's development scales among the medium developed countries, ranking 90th of 177 countries on the 2006 Human Development Index (HDI). This ranking on the HDI reflects high adult literacy, school enrolments and life expectancy, which together compensate for a somewhat lower Gross Domestic Product (GDP).

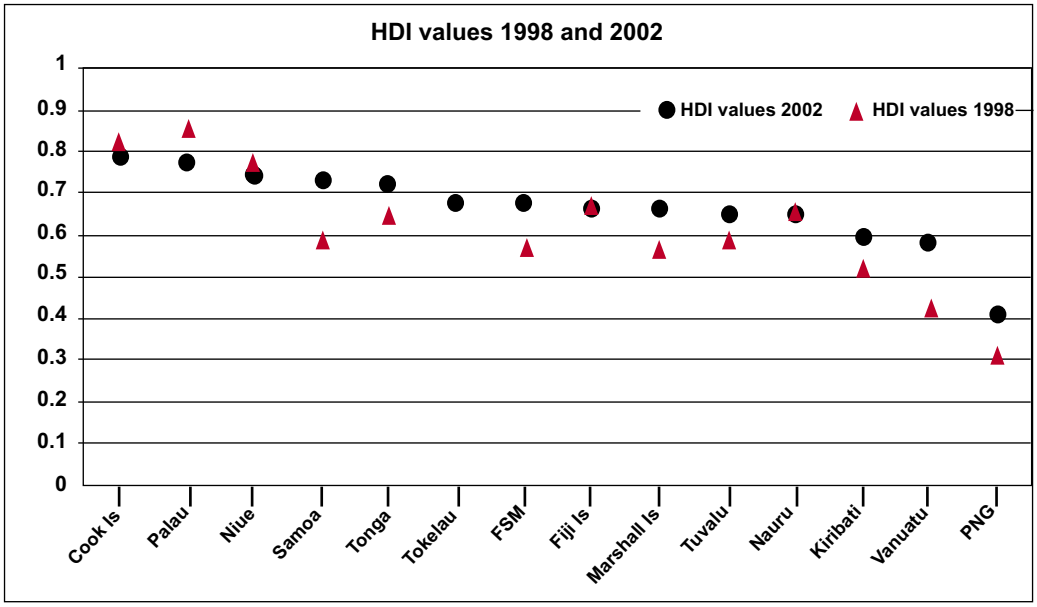
Since Independence in 1970, successive governments have given priority to equal development, economic growth, expanding health and education services, and developing human resources. NGOs, church organisations and other community bodies have also made large contributions to national development. They operate most of the schools and many of the welfare and community development organisations.

Table 1.1 Fiji's Ranking on the Human Development Index (HDI), 1990-2006

Year	HDI	International ranking
1990	0.724	71 Medium HDI
1995	0.741	46 High HDI
2000	0.769	66 Medium HDI
2005	0.752	92 Medium HDI
2006	0.758	90 Medium HDI

Source: UNDP Human Development Reports, various years.
Note: The lower the international ranking number, the better the score.

Figure 1.1 The HDI for Pacific Island Countries, 1998 and 2002



Source: UNDP (forthcoming)

Over the past two decades, political instability has taken its toll on Fiji. It has held back economic growth, which has contributed to a widening gap between the rich and the poor. A recent economic survey estimated that each of the four coups over the past twenty years has cost Fiji three years of economic growth, a total of 12 years of stagnation, and the impact has been greatly affected on the poor[2]. This has eroded the sense of national community and diminished the quality of life for many people[3].

While the exercise of measuring development standards has tightened the focus on practical achievements towards meeting national commitments, the current emphasis on international yardsticks such as the HDI and the MDGs has had one unfortunate effect, that of focussing attention on crude national averages. In this, a most elementary feature of statistics is easily overlooked: averages tell very little about the range. National averages show nothing of the extent of inequality within a country and can camouflage deep pockets of disadvantage. By international comparisons, Fiji may appear moderately well off but the extent of inequality is large and growing.

Since the late 1990s, Fiji's progress on the HDI has stalled (Figure 1.1). Infant, child and maternal mortality rates have halved since the 1960s and are now low, and life expectancy at birth is high at 70.7 years for women and 66.5 years for men. However, even a decade ago, in the 1996 census, there were signs that life expectancy numbers were no longer increasing and could instead be falling back[4]. There is a high level of adult literacy, almost universal primary school enrolment, and around 40 per cent of adolescents remain at school to the age of 18 years, up from a much smaller number a generation ago. Largely because these education indicators were already good, in recent years Fiji has made much less improvement on them than many of its neighbouring countries. But there is also growing pressure on the quality of education and other basic services, for while government expenditure on services has increased, so too has the proportion of funds that must go solely to operating costs.

Political instability and civil disorder in 2000 shocked the Fiji economy almost to a standstill out of which it was slowly drawn by the recovery of the tourism sector. This in turn brought

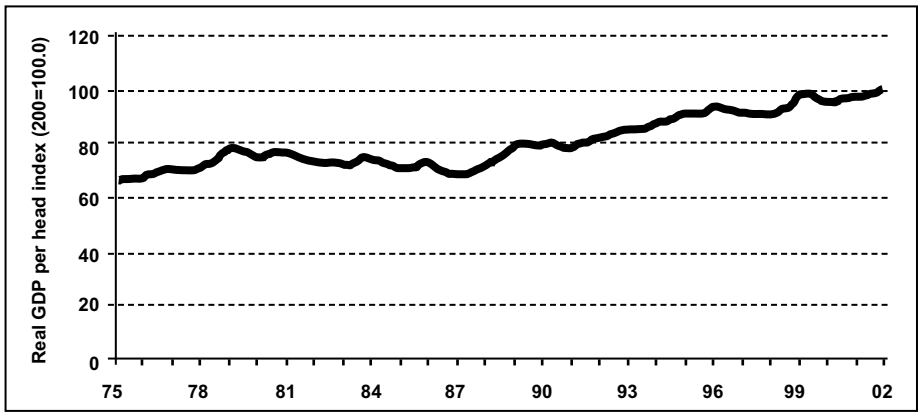
[2] Chand, 2007.
[3] Government of Fiji, MDG Report, 2004
[4] Bakker, 1998

growth in related areas such as restaurants and construction.[5] Political instability, the expiry of tax holidays for some garment factories and loss of export quotas contributed to a decline in clothing manufacturing and the loss of approximately 6,000 jobs, most held by women.[6] As qualified and skilled citizens emigrated, skill shortages hampered both the public and private sectors, however remittances from workers abroad now make a significant contribution to the national and household incomes. The rural sectors – agriculture, forestry and fisheries – have continued to shrink in importance since the 1990s. A sharp drop of cane production in the early 2000s and its poor quality, transportation problems, uncertainty over land-leases, poor mill performance, all contributed to a decline in sugar production, and thereby to export earnings and Fiji's balance of payments.[7] The viability of the sugar and clothing industries is in doubt, and with them most prospects for economic growth, employment, and tax revenues.[8] Government efforts to stimulate the economy have been held back by a low level of private investment and continuing concerns over the security of land tenure and political stability. Another political crisis in late 2006 brought on another economic downturn.

These have been difficult times for many families in Fiji. Narsey (2006a) reported that average wages stayed below the growth line of per capita GDP from the early 1990s, caught up briefly in 1996, and then went into a deep and widening slump. People earning salaries generally did not do well unless they worked for Government or statutory authorities where strong unions could protect real incomes. Wage earners – generally people at the lower end of the income scale – were worse off in 2002-3 than in 1991.[9]

Despite the economic problems, GDP has continued to grow, but the benefits of this growth have not been well distributed. While there was little growth in real GDP per head from 1975 to 1987, it increased substantially since 1987, growing 23% from 1990 to 2002. The fact that poverty also grew over that period suggests that the development process has not been inclusive and calls into question the quality of both economic and social policies.[10]

Figure 1.2 Real GDP per head since 1975



Source: Focus Economics, 2005, derived from Fiji Islands Bureau of Statistics (2004) and World Development Indicators 2003

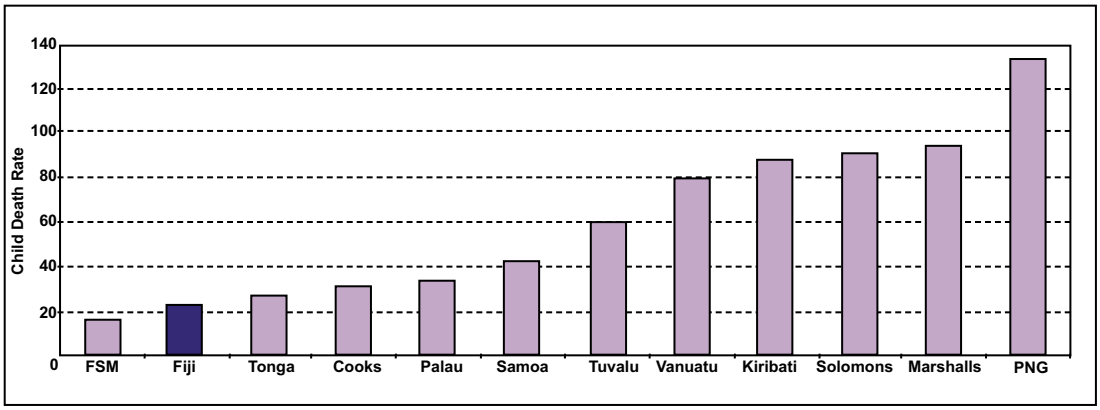
5, 7 ADB, 2003.
6, 8 ADB, 2006.
9 Narsey, 2006b.
10 Focus Economics, 2005

The Fiji Government's stated commitment to equitable development has come under increased pressure. The present development plan is to focus upon opportunities for economic growth and to get the economy moving as a precursor to social development. But in recent years, government's budget has grown faster than the national economy and its level of debt has grown rapidly. Civil service salaries take up a large part of government spending, and the 2007 budget introduced a 5% pay cut for civil servants. There is little left over for capital costs, and social services are under growing strain to maintain their quality in the face of this declining investment.

Fiji's stalled progress on human development

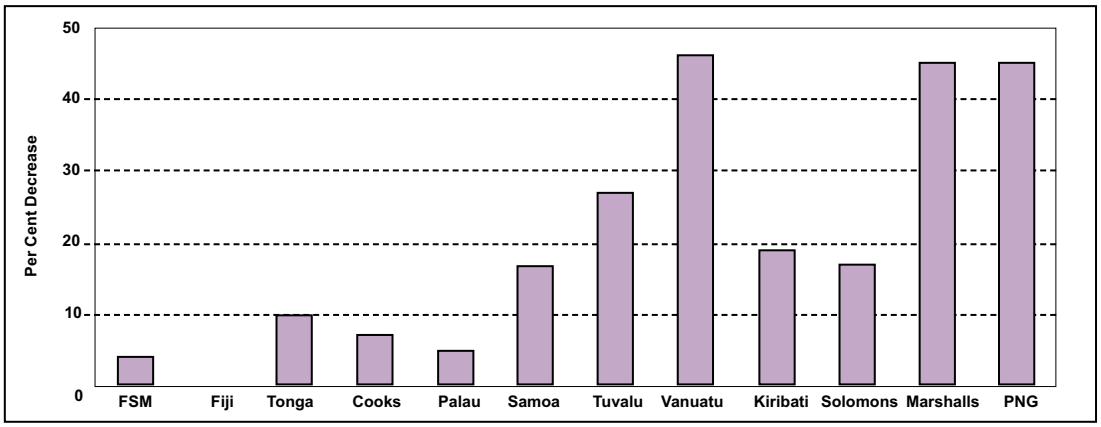
Child mortality is an important indicator of human development. Fiji has a relatively low mortality rate for children. In the early 1990s it was the second-lowest among Pacific Island countries. Over the past decade, child mortality dropped in every other country in the region – particularly in countries with higher rates – but Fiji remained static.

Figure 1.3 Child mortality rates in Pacific Island countries, early 1990s



Source: UNDP, 1999

Figure 1.4 Per cent decrease in child mortality in Pacific Island countries, early 1990s to 2000s



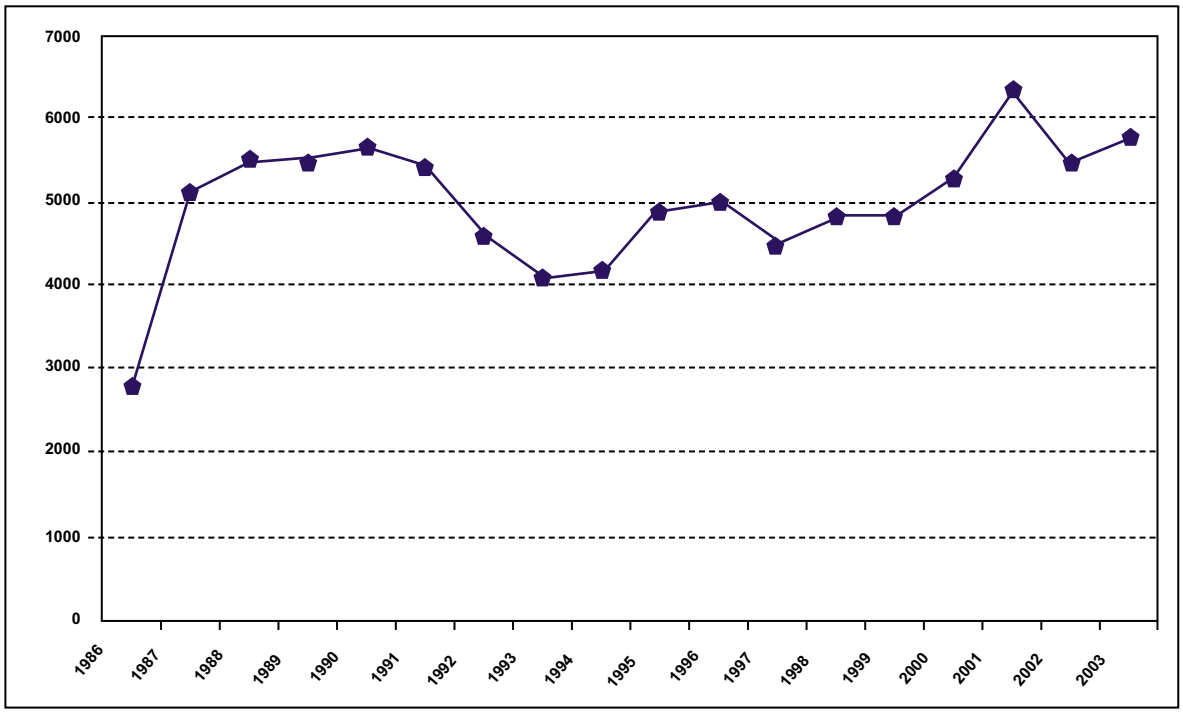
Source: UNDP, forthcoming

3. Population trends

The last national population census was held 11 years ago in 1996. Population projections partly compensate for the lack of recent figures but much is uncertain about the present situation. Because there are no firm population counts, important questions that cannot be properly answered include the proportions of children in or out of school, vocational skills in the working population, the extent of unemployment, the growth of towns, and the number of families living in squatter-like housing.

Since Independence, Fiji has had a slow but steady exodus of professional and skilled workers, but emigration accelerated in the 1980s. Soon after the military coups of 1987, emigration rates more than doubled. In the early 1990s, the outflow dropped back to around 4,000 people per year, partly because of long waiting times for visas, and then steadily rose again. By 2000, emigration was almost back to its post-1987 height, but after the attempted coup that year it surged upwards again, to a net loss of 6,300 people in 2001, 5,500 in 2002 and 5,700 in 2003.[11] Most migrants are skilled workers or professionals and their families. This 'brain drain' has had serious repercussions on the staffing of schools, health facilities, businesses and government administration.

Figure 1.5 Net Emigration from Fiji, 1986-2006

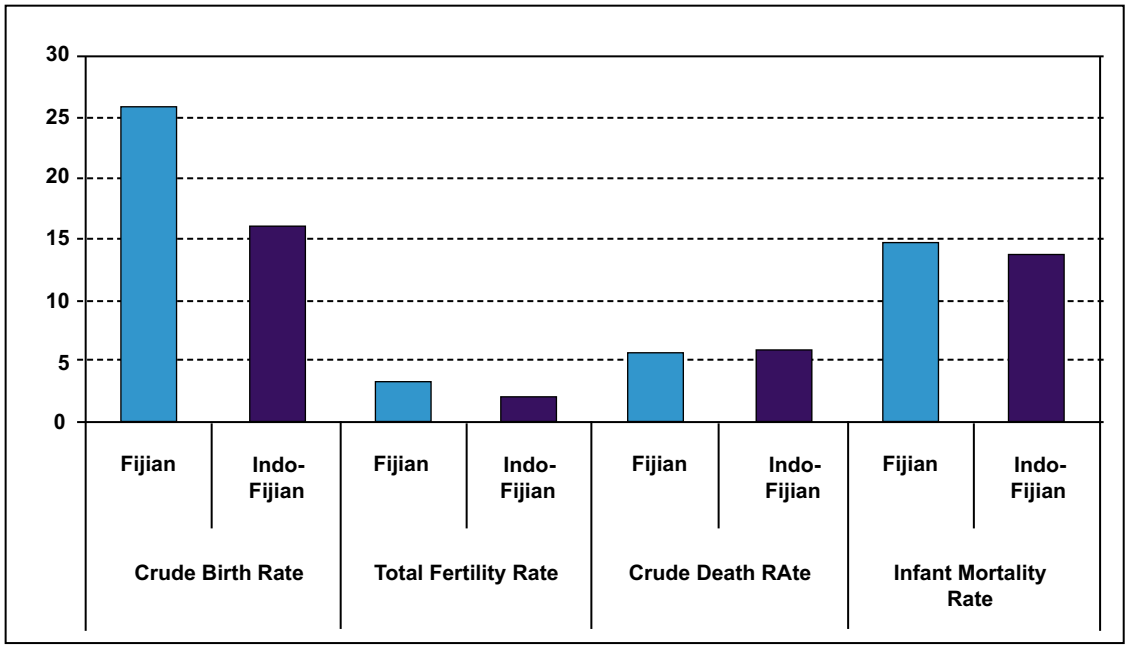


Source: Bureau of Statistics, 2007

Because emigration rates have been higher for Indo-Fijians than Fijians, the remaining population is more heavily Fijian, and this has an effect on other demographic characteristics. The crude birth rate, total fertility rate and infant mortality rate for several decades have been higher for Fijians than Indo-Fijians (Figure 1.6). As the population becomes more Fijian, these rates will likely rise – but as an artefact of the changing population composition rather than a deterioration of national health standards.

[11] Fiji Islands Bureau of Statistics, 2007.

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



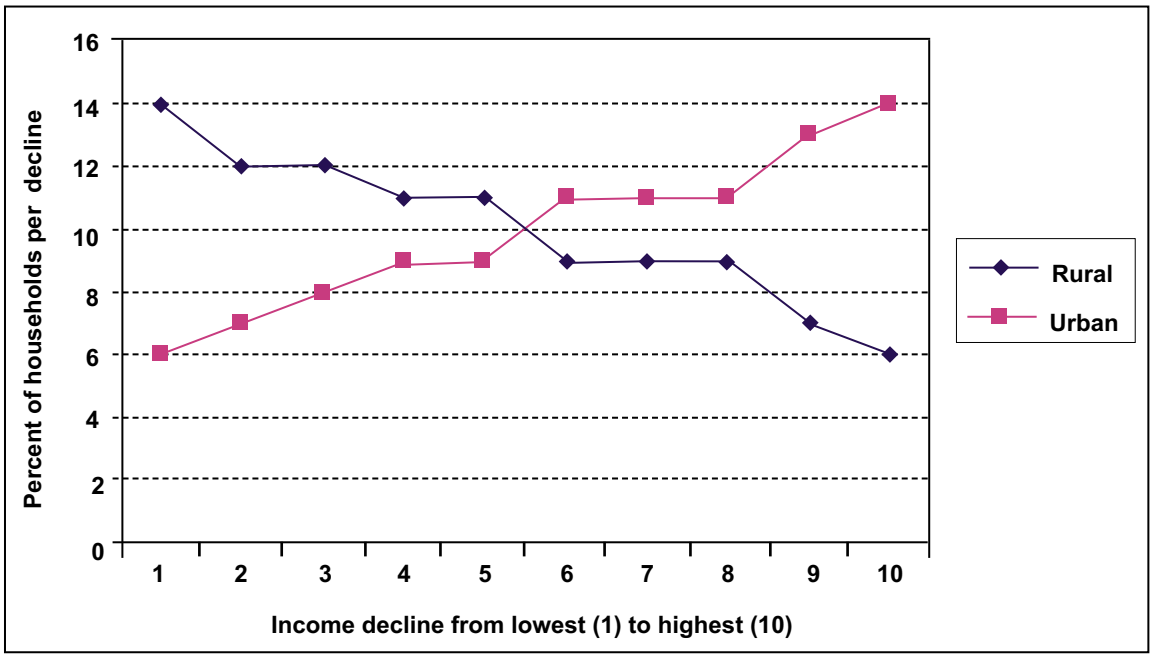
Source: Fiji Islands Bureau of Statistics, 2007

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 House hold 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)

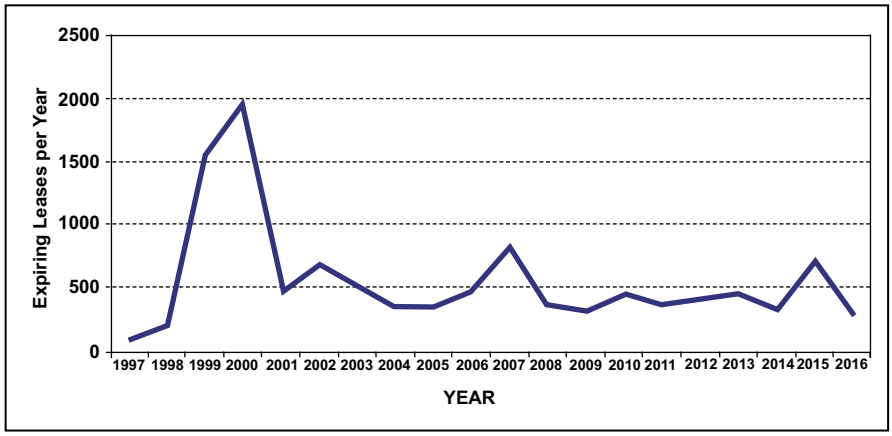
[12] Narsey, 2006b: 48.

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

[13] Lingam, 2006.

[14] ADB, 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.

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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 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 sanitation[21] - 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.

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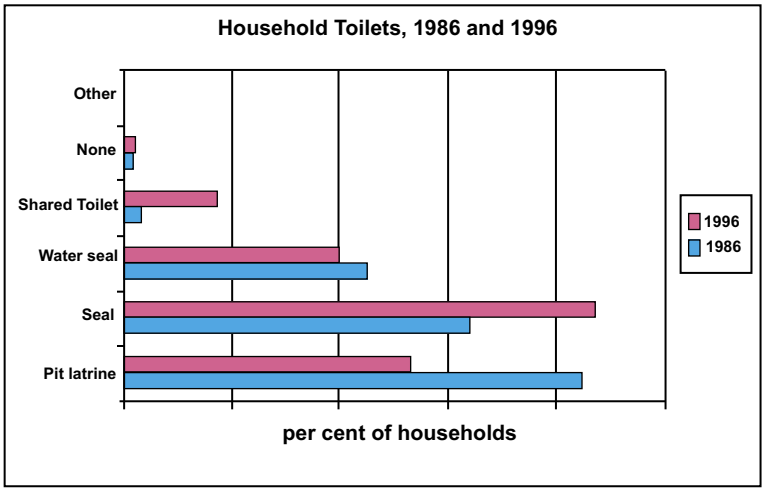
21 ADB, 2003.

22 Fiji Government 2004. National data on water supply and sanitation mostly come from the Censuses and House hold 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]

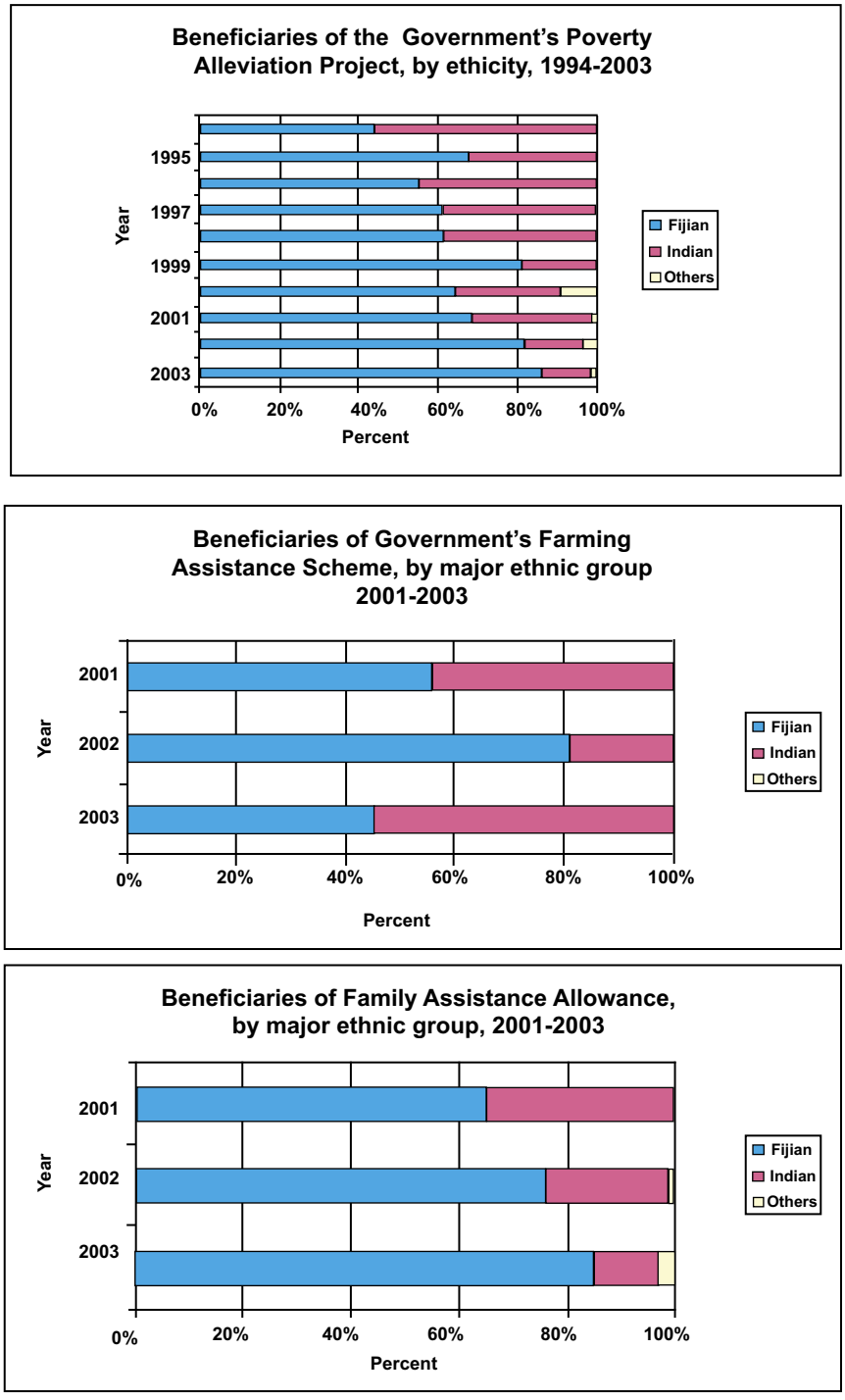
4. National development priorities

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 polices 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

[24] ADB, 2003.
[25] National 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



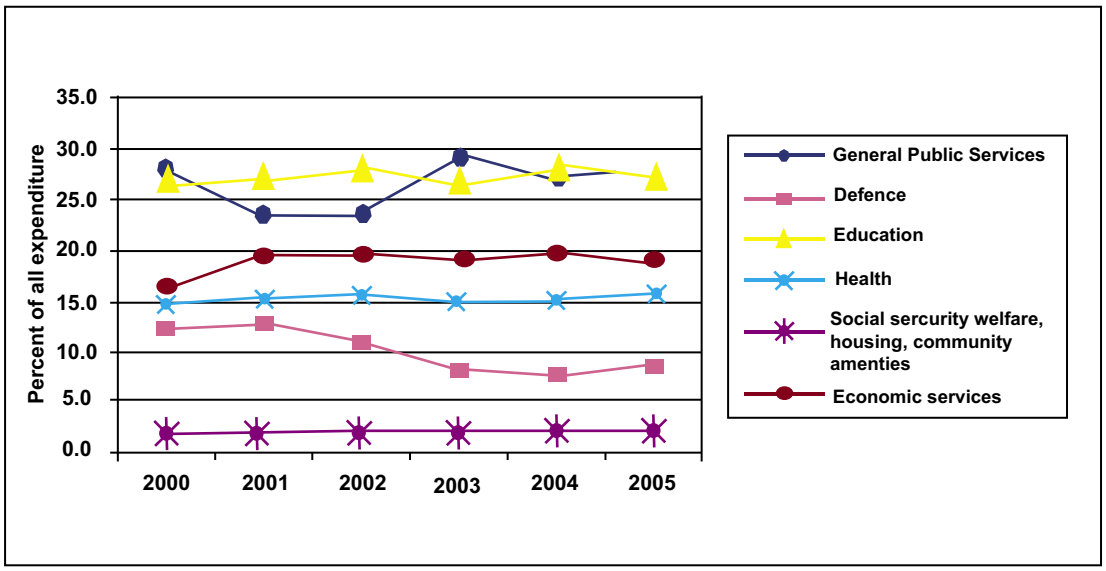
Sources: Unpublished data from Department of Social Welfare and Ministry of Agriculture, as in Kaitani, 2005

[26] Fiji 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.

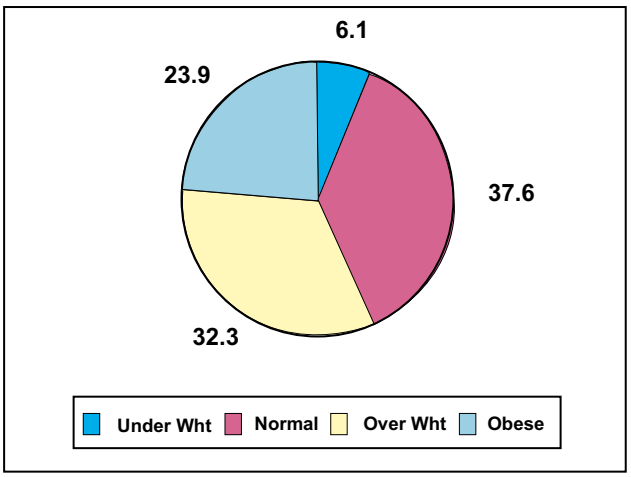
One writer has noted the coincidence of decreased immunisation rates and a reported increase in the infant mortality rate since 2001, and suggested that they both reflect falling health service standards.[32] Infant mortality (Number of infant deaths per 1,000 live births) has risen steadily from 15.40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

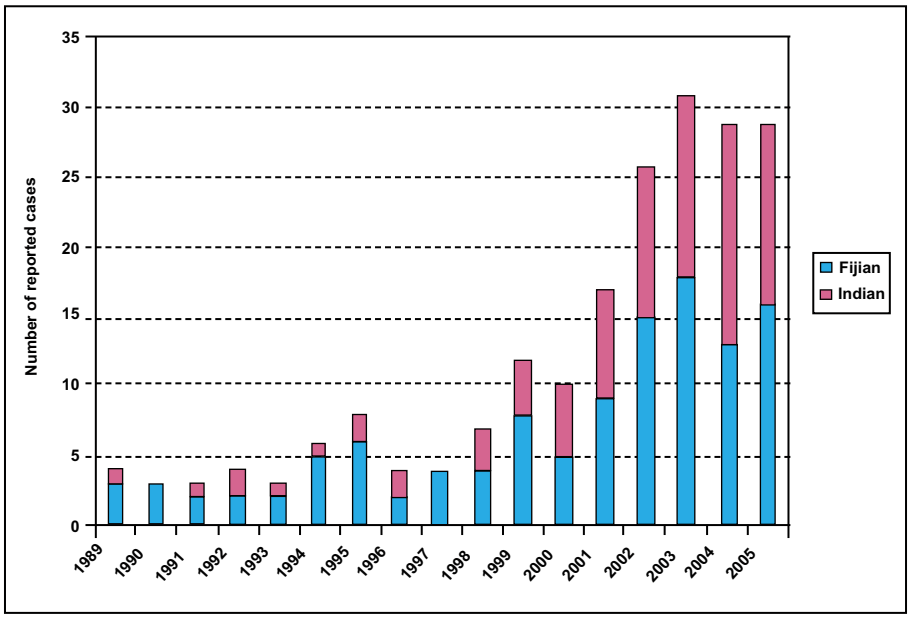
The Ministry reports HIV and AIDs cases separately by age, sex and race, and acts to protect the identity of individuals living with HIV. Of the known infections, 62 per cent are male, and 82% are in the indigenous Fijian population. The main route of infection is sexual activity; there has been only 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,

[38] Whiteside 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-retro viral 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

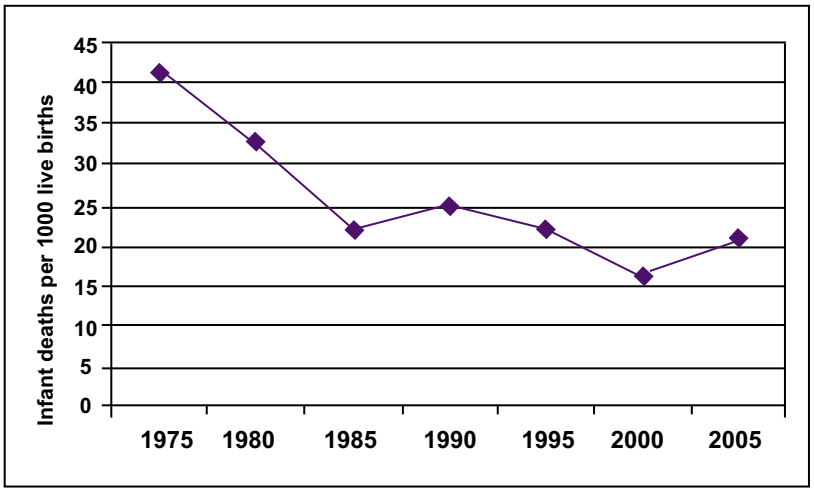
(a) Infants and children

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.

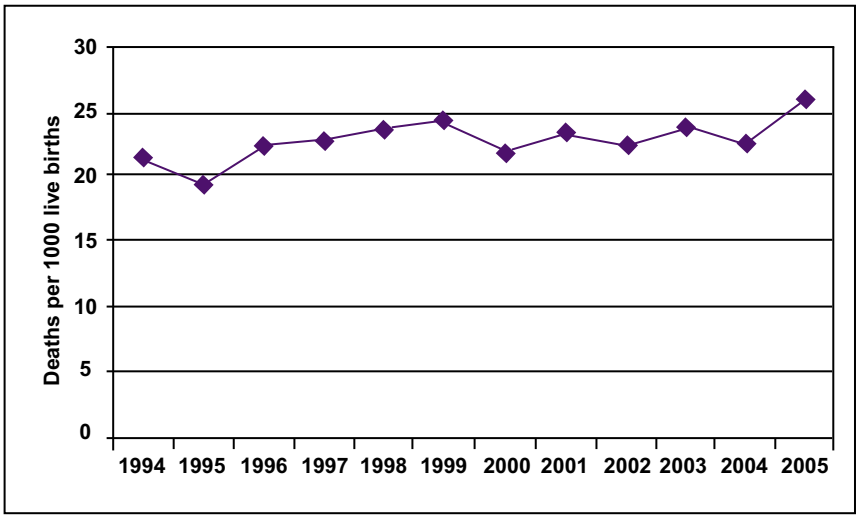
40 Ministry of Health, 2006.
41 Without a recent census, there is no source of data with which to check the accuracy of Ministry of Health records.
42 Fiji Government and UNICEF, 1996.
43 National Nutrition Centre, 2007.
44 Low-birth weight and anaemia are both generally associated with poor nutrition, 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

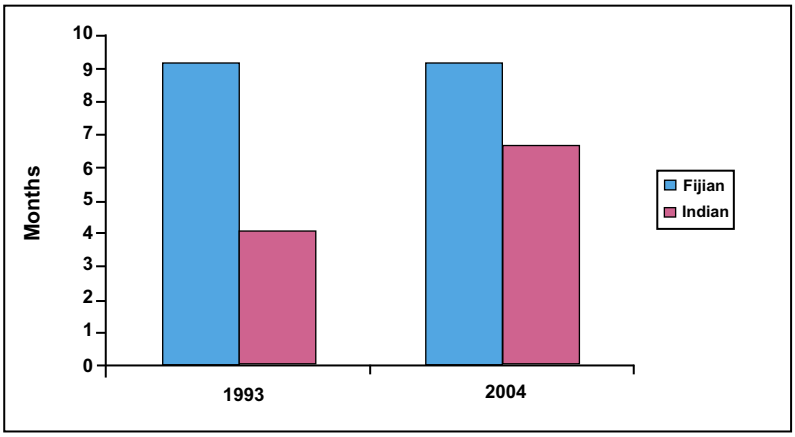
Breastfeeding was initiated by ***85% of mothers*** within 24 hours after giving birth, with higher rates for Fijians than Indo-Fijians. ***In children aged 6 months or less, 40% were exclusively breastfed but there was a sharp drop-off after that age. Only 2.3% of children aged 7 - 12 months were still 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

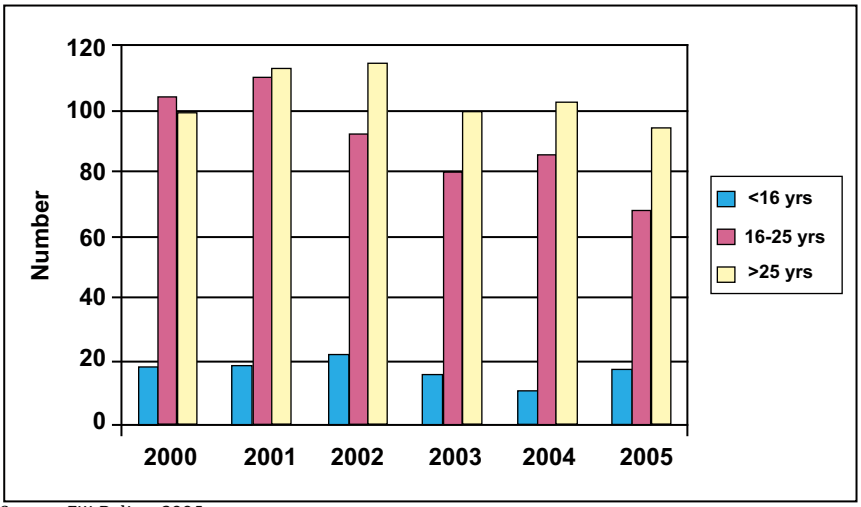
Source: Ministry of Health, 2006

[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

	Gonorhoea		Syphilis	
Age group	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

Table 2.9 Births to teenagers, as a percentage of all live births, 2002-2005

	2002	2003	2004	2005
Under 15 yrs	0.1	0.2	0.2	0.1
15-19 yrs	2.8	4.6	7.3	7.5

Source: Ministry of Health, 2006

A high and rising teenage pregnancy rate is another consequence of restricted access for young people to reproductive and sexual health services and information. The rate is higher for Fijian than Indo-Fijian women. The Ministry of Health is trying to address this problem through awareness programmes and by expanding reproductive health services.

Condoms should be the most readily available prophylactic against STI infection or unintended pregnancy, but studies by WHO (2002) and UNFPA (2003) have confirmed that condoms are still hard to get in rural communities and young people can be embarrassed to seek them in pharmacies. Condom use is being encouraged by the Ministry of Health and various NGOs and agencies that are working to prevent HIV transmission. The number of condoms distributed has risen steadily but while it can be assumed that some are being used in situations of high-risk sex, this progress cannot be quantified.

Substance abuse is now a general problem in the Fiji population, and young people are in the forefront of the associated behavioural changes. The 2004 NNS found that one quarter of Fiji's adult population now smoked, more males than females (38% and 13% respectively) and more Fijians than Indo-Fijians (29% and 17% respectively) - although more Indo-Fijians smoked heavily. Five per cent of 12-17 year olds regularly smoked. Despite all public education programmes, there had been a small overall increase in the overall proportion of smokers – up 1.4% since 1993 – and in the proportion of young adolescents who smoked – up 3.7% for males and 4.3% for females since 1993.

Alcohol use has also become more widespread. The 2004 NNS found that 51% of the adult population reported drinking alcohol, again more males than females (58% and 32% respectively). Alcohol use was widespread among young adolescents, with 46% of 12-17 year-old males and 17% of females regularly drinking, and 50% of these young people reporting binge drinking. Drinking was more common among Fijians than Indo-Fijians. In 2004, however, fewer people reported drinking more than 5 days a week than in 1993, when the previous National Nutrition Survey was conducted. Risks associated with alcohol use include accidents, high risk sexual behaviour, domestic violence, crime, and depletion of family budgets. Marijuana use is widespread, including among school children, despite mandatory prison sentences for possession and use. Yaqona (kava) consumption is also greater and more widespread than in 1993. Again, more males than females and more Fijians than Indo-Fijians regularly drink yaqona. Sixty-nine percent of adults surveyed in the 2004 NNS drank kava 2-6 days per week, and 11% did so daily.

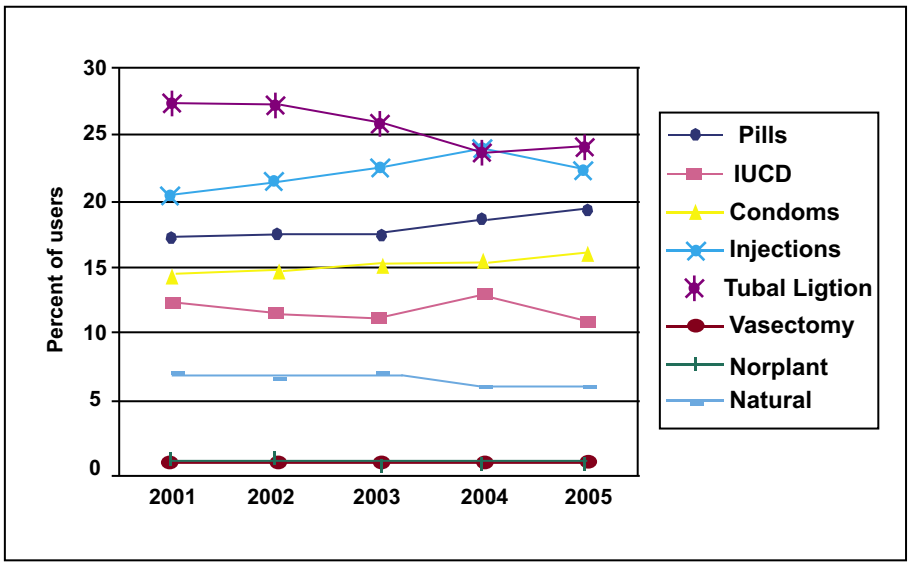
(c) Women

Maternal and child health services are available in government clinics and with private practitioners throughout Fiji. Since the early 1990s, a steady 97% of women have given birth in hospitals equipped with at least basic essential emergency obstetric care. The maternal mortality rate in Fiji's relatively small population fluctuates widely and this limits its usefulness as a general measurement of health.[56] In 2005, the maternal mortality rate was 50.49 per 100,000 live births, while the overall average for 2001-2005 was 31.85. Complementary indicators are the Crude Birth Rate (20.9/1000, 2005) and the Contraceptive Prevalence Rate (42.5%, 2005). Maternal mortality and morbidity is now less related to the

[56] With an annual average in Fiji of around 17,700 births, one maternal death would raise the maternal mortality rate by 5.6. Anything more than 18 deaths in a year would place Fiji among the countries with the worst conditions in the world for reproductive health.

conditions of delivery and more to long-term health risks such as rheumatic heart disease, obesity, diabetes and anaemia which exacerbate complications of pregnancy and child-bearing. The leading cause of maternal deaths in 2005 was ruptured ectopic pregnancy (28%).[57] Complications of pregnancy are still a major reason for women to be hospitalised. Reducing maternal deaths and pregnancy-related illness will again require sub-national differences in maternal health conditions to be better identified and addressed.

Figure 2.7 Main contraceptive methods, 2001-2005

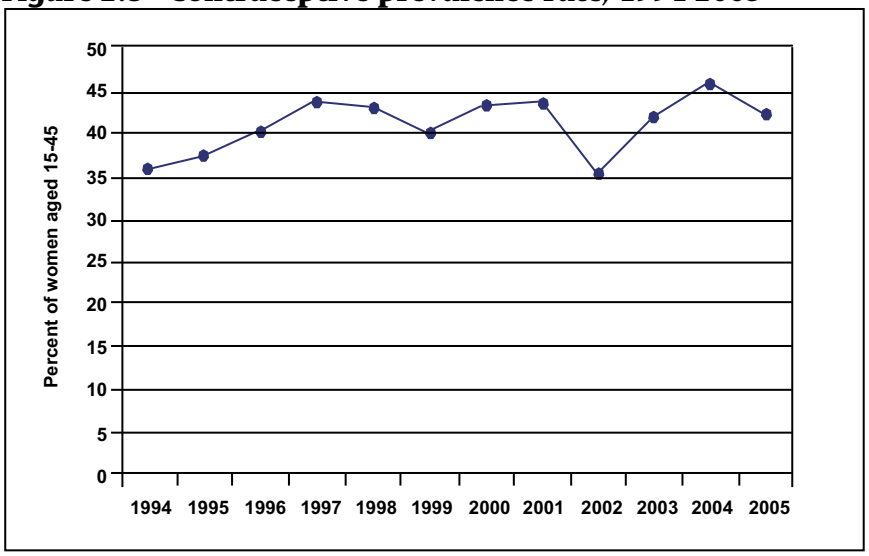


Source: Ministry of Health, 2005

Family planning services have been widely available in Fiji for the past 30 years, and are provided free in all Government medical stations throughout Fiji. From 1994 to 2005 the contraceptive prevalence rate has ranged between 35 and 45 per cent of women of child-bearing age, which is moderately high. The emphasis is on the health benefits of well-spaced births and, while a 'cafeteria' choice of methods has been championed, most promotion has been given to long-acting methods, such as pills, depo-provera and sterilisation. Vasectomy is still little used. Birth control is more widely practiced than the official contraceptive prevalence rate suggests, for this figure is compiled only from government health services and misses out the many people who use private health services, traditional methods (including rhythm and withdrawal, used particularly by Fijian couples), or poorly counted methods (condoms), used particularly by Indo-Fijian couples.[58]

[57] Ministry of Health, 2006.
[58] Government of Fiji, 2004 MDG Report.

Figure 2.8 Contraceptive prevalence rate, 1994-2005



Source: Ministry of Health, 2005

The most common cancers in females are cervical, breast and uterine.[59] Cancers of the female reproductive organs make up almost 40% of cancers in both males and females, giving women a much higher incidence of cancer than men. The incidence of cancer is also much higher in Fijians than Indo-Fijians.[60] The particularly high incidence of cervical cancer in Fiji, which alone accounts for 37% of cancers in women,[61] is related to the prevalence of STIs. The death rate from cancer is related to the minimal pap test screening available for women, although this test is now promoted by the Ministry of Health.

Obesity is more prevalent in women than men. The 2004 NNS found that 32.3% of women were overweight and 23.9% were obese. Although Fijian females had the highest rate of obesity (41.7%), the rate was increasing quickly for Indo-Fijian women also. Overweight and obesity are major risk factors for NCDs and linked to the high incidence rates of diabetes and heart diseases.

1.5 Addressing health needs

The 2004 NNS summarised the main nutrition related issues that need to be addressed in order to improve the general health of the Fiji population:

- Reduce the prevalence of anaemia, by increasing consumption of iron-rich foods, including fortification of commonly eaten processed food, and better monitoring of pregnant women children and adolescents

- Reduce the prevalence of overweight and obesity in children and adults, by better education, school-based programmes, promoting of physical activity, lower consumption of sugar, fat and salty foods, and higher consumption of fruits and vegetables.

- Reduce the incidence rates of LBW babies by better maternal health programmes and promotion of early prenatal clinic and regular check-ups.

[59,60] Ministry of Health, 2006.

[61] UNGASS Report, 2005

- Improve growth and reduce underweight children by promoting better infant and child feeding practices, exclusive breastfeeding, expansion of the 'baby friendly hospital and work place initiatives', legislation on the Fiji Code for Marketing Breastmilk Substitutes, better infant growth monitoring programmes

- Reduce the prevalence of high birth weight (HBW) by monitoring weight gain in pregnant women, public education, and promotion of health living.

- Reduce the incidence of diarrhoea, skin infections, parasitic infestation and other infections by promoting hygiene and sanitation, expanded safe water supply, better immunisation coverage, and more promotion of the use of oral re-hydration for diarrhoea.

- Reduce prevalence rates of NCD risk factors by increasing taxes on alcohol and tobacco, health promotion activities especially for young people, better monitoring of anti-smoking laws; and promoting physical activities, healthy diets and regular health check-ups,

- Improve food consumption patterns by promoting healthy diets, local production of nutritious foods, and controls on the importation of foods to meet minimum nutritional standards.

- Improve family food production and household food security by encouraging family food production, enactment and monitoring of food standards legislation, better environmental management and poverty alleviation programmes.

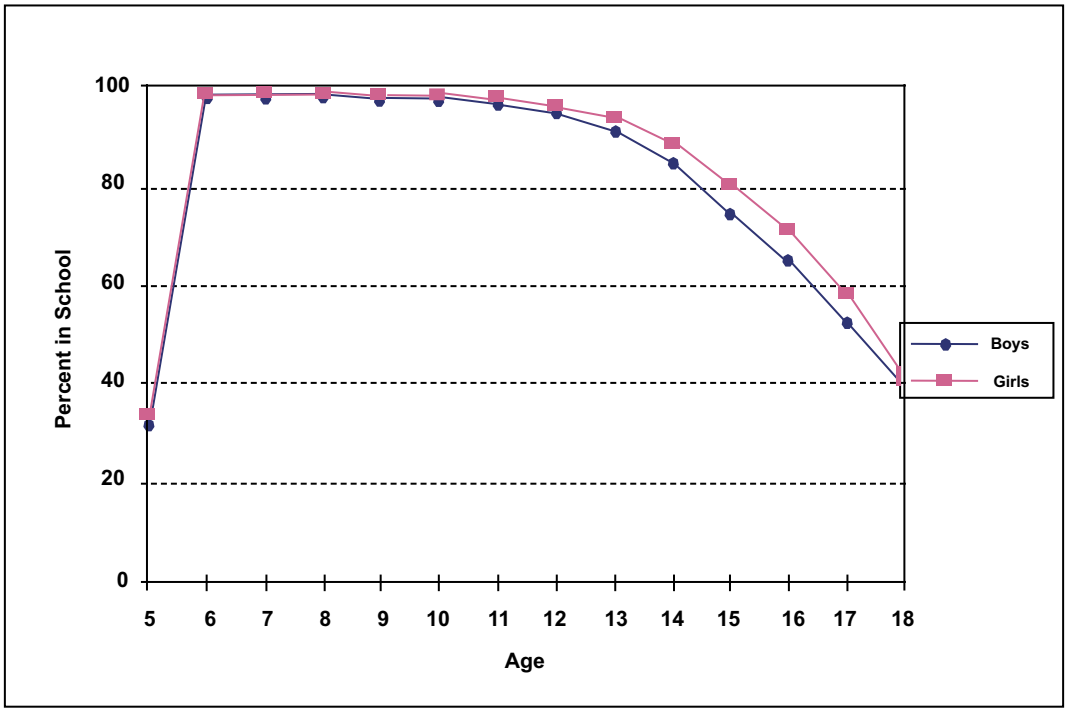
- Formulate a policy and plan of action for nutrition to address improved household food security, promotion of better dietary patterns, food quality standards and control; poverty alleviation; and strengthened public health services.

2. Education

2.1 Primary and Secondary Education

School enrolments in Fiji are high, with a Net Enrolment Ratio of around 100%. Entry to primary education is almost universal in Fiji, equally so for boys and girls (Figure 2.9). It is important to note, however, that these figures are based on the Ministry of Education's estimations of the total child population and in the absence of a recent census, it is impossible to confirm these figures. The most recent data on school enrolments by age comes from the 1996 census (Figure 2.9)

Figure 2.9 School enrolments by age, 1996



Bureau of Statistics: 1996 Census

This significant national achievement has come about through the joint efforts of the Ministry of Education and the many NGOs, local communities, churches and private organisations that operate schools or programmes to assist under-privileged children. Over the past decade, a strong push to widen access to school by the Ministry of Education and the many NGOs that operate schools or programmes to assist under-privileged families has considerably reduced the number of children who never attend school or do not complete basic education.[62]

Community involvement in school management is encouraged by the Ministry of Education, which concentrates on providing material and technical support and supervision to schools and teachers. From 2001 to 2005, the Fiji Government has spent around 20% of its annual budget on education.[63]

Since the early 1990s, the Ministry has worked towards making basic school education compulsory - although not fully free - for children aged 6 to 15 years by progressively extending fee-free education to cover all basic education years, increasing the amount of

[62] Fiji Government, 2004.

[63] Ministry of Education, 2006. Annual figures were: 2001: 19.3%; 2002: 20%; 2003: 19.8%; 2004: 21.5%; 2005: 21.3%.

tuition fee-free grants to schools,[64] increasing the number of civil servant teacher posts,[65] helping extend pre-school education, establishing more rural schools and providing transport assistance to children in remote areas, improving the quality of teaching staff and school management through pre-service and in-service training, and promoting community support for education.[66] (There has also been a considerable increase in education opportunities for children with disabilities throughout Fiji.) As Table 2.10 shows, there has been a net decrease in primary school enrolments and a fall in enrolments at schools close to urban areas (possibly because of increased inability to afford schooling) but a large increase in very remote school enrolments.[67]

Table 2.10 Primary school enrolments, 1999 and 2003

	Number of children		Average annual change (%)
	1999	2003	
All schools	142,728	142,148	-0.1
Urban schools	74,398	76,313	0.6
Rural schools	68,330	65,835	-0.9
- close to urban areas	25,146	17,174	-9.1
- remote	27,393	27,751	0.3
- very remote	15,791	20,910	7.3

Source: Focus Economics, 2006

Table 2.11 Special Schools for Disabled Children, 2005

	Fijian	Indian	Others	Total
Ba School for Special Education	7	18	-	25
Fiji School for the Blind	14	13	4	31
Gospel School for the Deaf	29	6	9	44
Hilton Special School	59	28	6	93
Labasa School for the Disabled	64	43	-	107
Lautoka School for Special Education	27	21	64	112
Lautoka Sunshine School	75	41	4	120
Levuka School for Special Education	9	1	1	11
Nadi Centre for Special Education	56	14	-	70
Nausori Special Education School	9	-	25	34
Ra Society School for Disabled	49	4	-	53
Savusavu Handicapped School	32	5	4	41
Sigatoka School for Special Education	35	7	1	43
Suva Intellectually Handicapped School	44	71	10	125
The Early Intervention Centre	42	24	3	69
Veilomani Rehabilitation Workshop	23	12	-	35
Vocational Training Centre - Suva	26	48	8	82
TOTAL	600	356	139	1007

Source: Ministry of Education, 2006.

[64] Only 2 of the 719 primary schools and 12 of the 162 secondary schools are run by Government. (2005) Most are operated by community or church organisations.
[65] The reason that basic education is not fully free is that almost all schools are operated by non-government organisations, and government cannot control any other costs than tuition fees.
[66] Coordinating Committee on Children, 1995; Ministry of Education, all recent years.
[67] Focus Economics, 2006.

Many children in Fiji must travel a long distance to school, as shown in Table 2.12, including almost one third of urban students who travel more than 3 km to and from school daily, often passing other schools in order to attend one with a more desirable ethnic focus, religion, or quality.[68] In remote parts of Fiji, even very young children often board at school during the week for school would be too far away otherwise. In these often poor communities, feeding and maintaining children at boarding facilities can be difficult.

There is concern that there has been a significant decline in the quality of education and the standards achieved, both in basic numeracy and literacy. Students in remote and very remote schools are most disadvantaged in terms of their pass rates in national examinations (Table 2.12). The government's response has largely been to increase funding for schools, although there has been little research into the most effective targeting of these resources.[69] Narsey (2004) noted that differences in education quality mirrored significant differences in the capacities of schools to generate their own funds. For every dollar provided by government, urban schools spent an additional $1.41, rural schools an additional 75 cents, remote schools 33 cents, and very remote schools 53 cents.[70] Poorer communities generally have less extra money to invest in the schools their children attend, and therefore lower-income students generally attend poorer quality schools. Improving the quality of schools is a pro-poor policy that has wide potential benefits for disadvantaged groups.

The Fiji Education Sector Programme provides infrastructure support to 300 of the most disadvantaged schools in the country. School selection was undertaken using baseline data from the Ministry of Education's database and merging it with a specially designed Schools Infrastructure Disadvantage Indices. The needs of these schools were confirmed through detailed questionnaires and site visits. The targeted schools are drawn from all fourteen provinces, all nine education districts, all four education divisions, and are spread across 44 islands. Over 80% of the schools are in remote or very remote locations.

Source: Ministry of Education, 2006

Table 2.12 Indicators of access to education, 1999

	Urban	Rural	Remote	Very Remote	Total
Books per pupil	3.5	5.3	5.3	5.5	4.5
Desk places per pupil	0.8	0.8	0.8	0.8	0.8
Percentage boarding	0.1	1.5	7.9	7.9	2.9
Percentage repeating	1.1	1.8	4.3	4.7	2.3
Percentage travelling >3 km	30	23	23	11	25
Percentage walking > 3 km	1.8	5.2	9.6	5.4	4.4
Failure rates: English *	11	18	23	23	16
Failure rates: Mathematics *	11	12	17	18	13
Failure rates: Basic science *	11	12	20	22	14

Source: Narsey, 2004 *Fiji secondary school entrance examination (FEYE)

The SDL Government's affirmative action policies for indigenous Fijians and Rotumans were especially applicable to education, and continue to direct the policies of the Ministry of Education. In the name of social justice, school development programmes aimed to particularly improve education and training opportunities for Fijian and Rotuman

[68,69,70] Narsey, 2004.

students and focus school improvement programmes on these communities. To this end, a Fijian Education Board was established to provide advice to the Minister of Education and schools with predominantly Fijian students were designated Centres of Excellence and provided higher standard facilities and equipment.

These policies for education were influenced by the government's political manifesto, the 2000 Fiji Islands Education Commission, which expanded upon the conventional (that is, for Fiji) analysis of ethnic differences in educational outcomes, and the Ministry of Education's own long preoccupation with ethnicity.[71] Other evidence points to gender[72] or urban-rural differences[73] being significant factors in educational outcomes, but these issues have received much less attention. Furthermore, Narsey (2004) found no significant relationship between higher per pupil funding or expenditures and better academic performance, suggesting that the affirmative programmes could have been misdirected. A principal outcome, however, has been a requirement for Indo-Fijian households to spend a larger proportion of their incomes on education.[74]

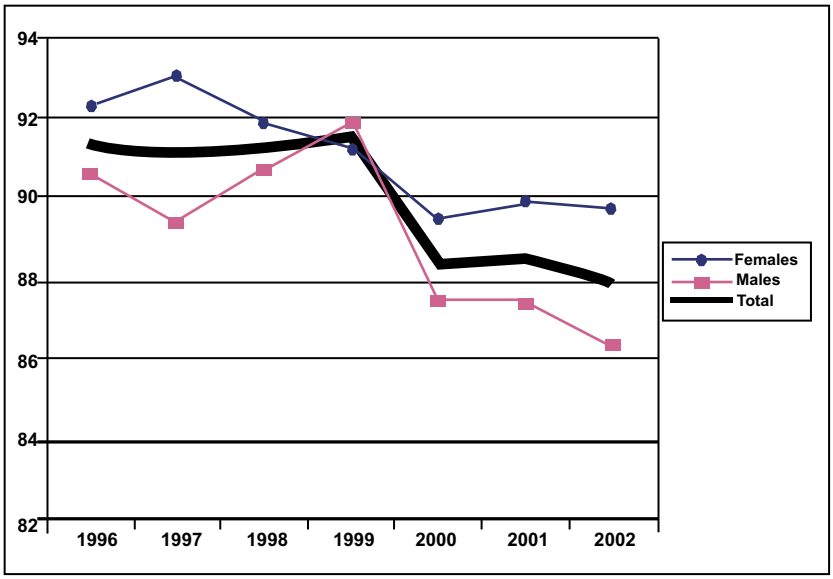
2.2 School drop-outs

With Government's imbursement of tuition costs, other assistance for disadvantaged children and at least nominal compulsory school attendance, a 2005-6 household survey found that even in urban informal settlements, few children did not attend primary school.[75] However, for those children who do not complete primary school, the principal reason that they leave school early is the inability of their families to afford school costs.[76] While schools are now free of tuition costs up to senior secondary classes, schools levy other fees, and other essential expenses include uniforms, books, and transport. Annually, this amounts to around F$200 per primary pupil and F$350 per secondary student a cost that is high for low-income families.

The survival ratio (ie. the proportion of children who stay at school from Class 1 to the end of Class 5) has fallen since the early 1990s, possibly indicating the difficulty faced by of low-income families in keeping their children in school (Figure 2.10, next page). Without a recent census, it is not possible to measure how many children are now out of school. Anecdotal evidence suggests that the number has risen considerably, brought up by increasing economic pressure on many households.

[71]Even today, the Ministry's annual reports more often present information by ethnicity than by gender.
[72,76]Save the Children Fiji, 1998.
[73,74]Narsey, 2004.
[75]M. Chung with ECREA, 2006.

Figure 2.10 Survival rates to Class 5, by sex, 1996-2002



Source: Ministry of Education annual reports, various years

2.3 Early Childhood Education

Preschool education assists children to adjust to school and may improve their academic attainment. There has been a great expansion of access to early childhood education (ECE) in the past decade. By 2005, 315 ECE centres were operating throughout Fiji, established and operated by local communities. The Ministry of Education licenses and monitors preschools and assists with some training, but responsibility for the operation of preschools and kindergartens falls to community groups, and their facilities and programmes are of varying standards.

In 2005, 19 ECE centres benefited from a total $100,000 in government building grants,and the first 25 ECE teachers graduated from Lautoka Teachers College with an Advanced Certificate in Early Childhood Education. Other organisations that assist ECE in Fiji include the Fiji Early Childhood Education Association, the University of the South Pacific, UNICEF, and Save the Children Fiji.

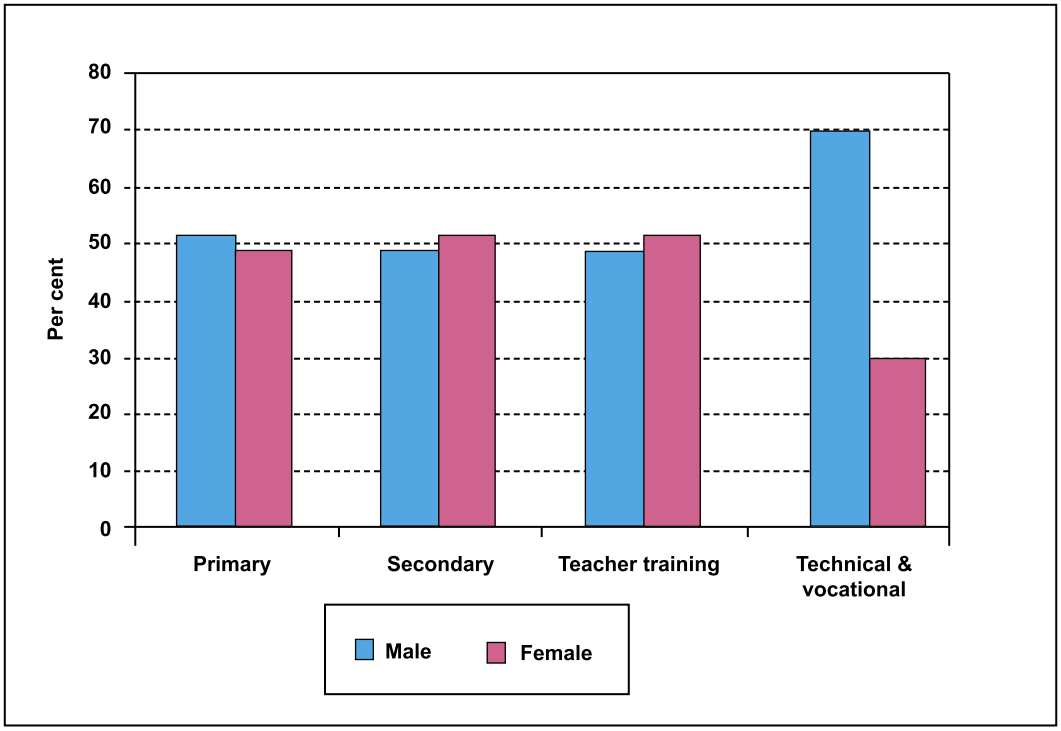
Save the Children Fiji has assisted low-income communities in Suva and Labasa to establish and run ECE centres through its Mobile Kindergarten. This project, which operates in disadvantaged communities, including informal urban settlements,demonstrates the potential of preschools to go beyond early childhood education to also assist in building and empowering communities.

2.4 Post-secondary and Vocational Education

Post-secondary education is available through several Government-run or private institutions, such as the Fiji Institute of Technology, and regional tertiary institutions such as the University of the South Pacific, the University of Fiji, and the Fiji College of Agriculture, but entry into these institutions is competitive and restricted. Once out of school, there are very few opportunities for young people to gain livelihood skills or qualifications. All forms of adult and vocational education are limited and entry is competitive, advantaging either the best qualified students or those who can afford the high fees charged by private agencies. With international donor assistance, the Government plans to make a large investment in vocational education.

It is at this level that a clear disadvantage appears for females, who make up only 30% of all enrolments in technical and vocational education courses (Figure 2.11). This figure has changed very little over the past decade.

Figure 2.11 Enrolments at Education levels and Gender, 2005



Source: Ministry of Education, 2006

Non-formal education, which would cater for a much larger population, is poorly organised and receives much less government attention. There has been no national assessment of the demand for adult education but almost certainly there are far too few opportunities for people youth, adults, men or women to participate in non-formal education programmes of any kind. Most adult education programmes cater for young men but, even there, access to these courses is very restricted in the number of places available, the high cost, and in the range of skills offered. There is almost no public advocacy for women's participation in adult education.

A 1998 survey found that the eight major non-formal vocational programmes received 10,950 applications that year for a total of 4,850 places, providing a place to less than half of the applicants.[77] But neither number represented the real demand for this training, for many people did not know about these courses or how to apply. Most people learn about them by word of mouth for there is no public listing of training opportunities. Sometimes this information hardly enters the public domain at all because the organisations themselves select people to train, rather than give individuals the opportunity to apply for themselves or assess their own needs. There has been very little review of the non-formal education programmes that do exist, or of formal vocational programmes for that matter. No tracer studies have been conducted to document what graduates of these programmes have achieved.

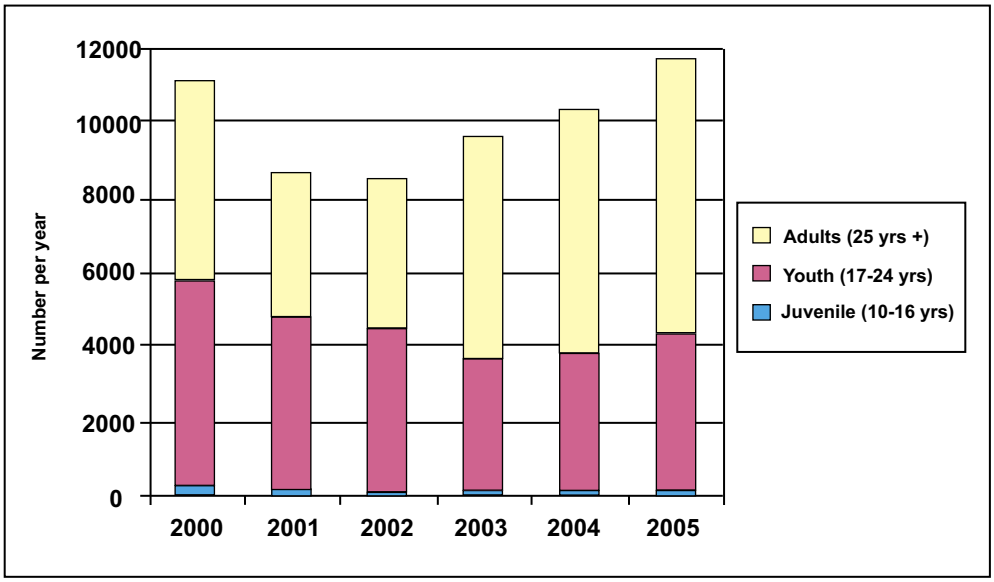
[77] Barr 1990.

3. Youth Development

3.1 Policies and Programmes for Youth

The youth population is the fastest growing segment of the Fiji population. In 1996, the median age in Fiji was 21.2 years and 19.6% of the population was aged between 15 and 24 years. Many social problems cluster around youth, including crime (Figure 2.12). A lot of attention has been given to the problems faced by young people, and to improving their prospects through training in life skills and employment generation, provision of reproductive health services specifically for youth and projects to address issues such as substance abuse. Fiji participated in the development of the Pacific Youth Strategy. Youth delegates contributed to regional strategies of the Pacific Plan and the Pacific Millennium Development Goals.[78] The Fiji Government recognises that the issues facing children and youth are multi-faceted and need to be addressed in a coordinated way. Key issues are employment, teenage pregnancy and sexual and reproductive health, the latter issues covered elsewhere in this report.

Figure 2.12 Reported Offenders by age-group, 2000-2005



Source: Fiji Police, 2005

A National Youth Policy was developed in 2004 with the assistance of the National Youth Council and representatives of other youth organisations, and incorporated into the national development planning process. Key elements of the policy were youth development and employment; leadership and decision-making; physical education, sports and recreation; youth health; life skills training; youths at risk; youth networking and partnership; cultural, religious, values and virtues, youth rights, and environmental sustainability. In 2005, Cabinet endorsed a 20 year Strategic Development for Youth Plan 2006-2025 of which core areas were health and social services, non-formal education and training, employment and sports.[79]

3.2 Expanding livelihoods

There is a shortage of wage employment in Fiji and young people are disadvantaged by their lack of work experience and often limited employable skills. The link between limited education and restricted livelihood opportunities in Fiji is well documented.[80] Nationally, there is a marked drop-off in school enrolments after the age of 15 (Figure 2.9 see page 38).

[78] UNICEF, 2005.
[79] Fiji Government, 2006.
[80] Fiji Government and UNDP, 1997.

There has been an expansion of vocational education in the schools but most of it is pitched at higher secondary forms. Many students who could benefit most therefore miss out, and what is available is too limited to meet the demand.[81]

Youth employment is being addressed by Government through the Youth Employment Policy Framework and the Labour Administration and Productivity Improvement Sub-Programme under the Ministry of Employment and Productivity. The problem of finding employment for young people, however, cannot be separated from the overall difficulties of creating livelihoods in Fiji. Over the past two decades, the low level of business investment has depressed the demand for labour and restricted the growth of the job market. There has been a progressive erosion of the value of real incomes, especially for waged workers.[82] The most disadvantaged workers are those in the informal sector, employed domestically, or outside of the main industries, occupations that are entirely unprotected in Fiji.

For both men and women, the proportion of people who are economically active rises with each level of formal education. The proportion of economically active people who earn a wage or salary also rises with each level of formal education, and wage and salary earners predominate in the higher earning deciles of the population.[83] The fact that overall this generation of young people have had more access to education that older generations widens their potential livelihood opportunities. Without economic growth, however, there are not enough jobs being created to meet the demand. The decline in livelihoods is greatest in rural areas. Jobs and income are concentrated in the towns, and so is the population of young adults.

4. People with special needs

4.1 Disabled children and adults

Disabled or chronically ill people in Fiji are at high risk of living in poverty.[84] Although education opportunities for disabled children have recently widened, many older youths and adults had only a chance to attend primary school at most. Many disabled people cannot therefore get good paying jobs and they often face discrimination in the work place.[85]

The number of disabled adults is growing with the increased prevalence of chronic illnesses such as diabetes and hypertension. If the family is unable to pay for the costs of medicine or for looking after the disabled family member, the household will be poor. Because of the burden of care, some mentally or physically disabled or elderly people are neglected or excluded by their families. Many permanently disabled people are left to the mercy of their relatives and their needs may be ignored. This is especially so in areas where there are no facilities for the disabled. The Disabled Persons Association works to empower disabled people, principally by providing them referral services to other government and NGO programmes.

4.2 People living in poverty

Stories abound in Fiji's news media of people facing hard times, and all surveys into incomes or living standards confirm that many households now live on a very thin margin. Political and economic troubles in Fiji have had serious consequences for families and children, particularly through an upsurge in unemployment. Many families have been left for varying lengths of time unable to buy sufficient food, pay for housing or send their children to school. Natural disasters, such as hurricanes, can also be very disruptive to communities. The Government's Natural Disaster Coordination Committee attempts to quickly provide relief and rehabilitation to communities in emergencies.

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[81] Pers comm., AusAID Review Team, 2006, on vocational education.

[82] Narsey, 2006.

[83] Fiji Government and UNDP, 1996.

[84] Fiji Government and UNDP, 1996; Chung with ECREA, 2006.

[85] UNDP and Fiji Government, 1996; Pers comm. Fiji Red Cross

Poverty is the main cause of child labour in Fiji. Children who leave school early mostly do so because their families cannot afford the cost.[86] Most children who work do so in informal ways, for families as domestic workers, labourers, or farm workers, often being passed from one family to the next with little consideration for their care. Some become 'street children' in the towns, working as wheelbarrow boys in the markets, shoe-shiners, or prostitutes.

The broken lives on our streets

The Suva Market is both home and place of employment for Pita and John. They are the wheelbarrow boys, earning a living by carting produce for farmers, stall holders and shoppers. Pita and John are both 16 years old. They have been fending for themselves since they were 14. Pita comes from a family of five. He was orphaned when only a year old. An aunt took in Pita and two of his siblings. But things started to go wrong for them as they grew older. "In 1995, when I was in class one, I never had any lunch to take to school," says Pita. "I could go without lunch for weeks." "This happened right until class eight, and I missed school a lot. I and some other boys would climb mango and guava trees to feed ourselves."Pita's world came crashing down one day in 2003 when he returned home to find all his belongings by the roadside. He could hear his aunt and uncle arguing. "I knew right away it was about me because my older brother had run away two weeks before. When my aunt told me to look for some place else to live I could feel my heart breaking…"

Pita said he was so depressed that he even thought of killing himself. "Where I was to go, I didn't know." He ended up at the bus stand, hungry and tired. "I wanted to sleep but I couldn't because I was so embarrassed. I waited for nightfall so no one could see me."

It was at the market that Pita met John. John had been an only child, living in Toorak with his parents. He said his was a happy family until his parents separated. Then the heated arguments started. "Every time this happened I would stand and watch, feeling very helpless." John's mother left when he was studying for the Fiji Junior Examination. "I just couldn't concentrate at school," he said. When his father brought in a new woman, John decided to run away. "I couldn't live there because no one loved me."

He came to the market and got into the wheelbarrow business. "At first I thought the *bara boys* would harass and beat me but later I came to understand that we had one thing in common – survival."

John remembers his first encounter with Pita at the market. He felt an immediate connection because he knew at once Pita's story was the same as his. Both boys lament the lost opportunity to get an education.

Source: Fulori Turaga and Shobna Goundar, Wansolwara, June 2005

The Fiji Government allocates only a small proportion of its budget to social welfare, on the basis that it cannot afford a welfare state nor wants to create a 'handout' mentality. Their view has been that families should take responsibility to protect all their members – although there is good evidence that many poor people cannot rely on family support. The main official welfare programme, the Family Assistance Scheme, provides small cash payments to the most destitute households. There have always been more eligible applicants than the programme could cater for, payments have remained very small, and even these payments were cut drastically in the government's last budget.

Other assistance provided by government to disadvantaged groups has included small grants provided through the Department of Social Welfare to assist with housing and help people (principally ex-prisoners) develop livelihoods; capital and recurrent grants provided through CSOs to fund social services; micro-credit services provided through the Ministry

[86] Save the Children Fiji, 1999.

of Commerce, public legal services provided by the Department of Social Welfare and the Attorney-General's Office on the basis of a means test; provision of tuition fees for all school-children through the Ministry of Education; health services provided for everyone at little or no cost through the Ministry of Health; and special assistance to Fijian and rural people.

The terms 'poverty', 'hardship' and 'disadvantage' now occur frequently in government planning and policy documents. Since 2000, national plans have emphasised the need to address poverty and hardship. Many NGOs working in this area believe nevertheless that there is insufficient political will to fully address the problems. There also are evident contradictions in policies. For example, the Social Welfare Department provides $5000 grants to Family Assistance recipients to enable them to build houses, at which price the only affordable sites would be in informal settlements. Meanwhile, the stated policy of the Squatter Unit - a department within the same ministry - is to discourage squatter growth through the regular patrolling of squatter settlements, issuing of eviction notices to new entrants, pulling down shacks that have been erected, withholding consent for water and electricity from new squatters, and giving low priority to development of new squatter settlements. The Unit says it uses these strategies with some constraint, being aware that they violate human rights.[87]

Civil society organisations play a very important role in social welfare and development in Fiji. They provide by far the largest part of welfare assistance to poor and needy people in the community, and this has been their traditional focus. Even though many of these organisations are small, have a limited range, and cannot meet all demands on their services, the contribution of CSOs to welfare in particular far out-weighs that of government.

Workers and their families at Vatukoula Gold Mine

Many communities in developing countries have complained of human rights abuses and environmental degradation perpetuated by mining companies. Often these communities have no institution that they can address to seek fair and equitable redress and mining companies have been able to disregard their concerns. The gold-mine at Vatukoula is no exception to this sorry story.

Since operations began in 1935 by Emperor Gold Mining Company[88], working conditions in the mine and living conditions for workers and their families have been the subject of many reviews, most of them silenced by the company through successful court actions. In 1991, miners went out on strike alleging low pay, negligent health and safety conditions and substandard company housing. This dispute has never been resolved despite an official commission of inquiry, a Senate inquiry and a series of court cases. Many of the strikers have remained out of work for 17 years, although some returned to work for lack of another livelihood. Some of the ex-workers were served with eviction orders from their company-owned housing. The stress of being on strike for so long has led to family breakdown, alcohol and substance abuse, and sometimes domestic violence. The children of strikers could be distinguished from other children by their poor health, lack of food, lack of shoes and proper school uniforms.

Working conditions never improved. An Oxfam inquiry in 2004 found that hazardous working conditions in the mine had caused deaths and injuries. After salary deductions, including costs of safety gear, damaged machine parts and rent for sub-standard company housing, workers complained they had barely enough to feed their families. (Emperor was given special exemptions to basic employment standards in Fiji under the Employment Act.) Women workers were discriminated against by the company refusing to grant them housing, requiring them to work long hours in excruciating conditions sometimes late into the night, and then providing them no transport to safely return home. Workers complained they received no sickness benefits from the company and alleged they were pressured to work when injured and unwell.

87 Lingam, 2007:29

88 Emperor Gold Mine was formed in 1986 from the assets and holdings of the Emperor Gold Mining Company. The new company was first domiciled on the Isle of Man for tax purposes but listed on the Australian stock exchange, until 2002 when it was fully transferred to Australia (Macdonald et al., 2004).

Living conditions in the workers' quarters remain grim. Drinking water is drawn untreated from the Nasivi River, despite confirmed unsafe levels of mercury, cadmium and e-coli in the water, despite a 1981 UNESCAP report that recommended the company's lease not be renewed until they had satisfactorily monitored their environmental impact, and despite a 1995 official review report that said that "Vatukoula might be one of the last mining towns in the world where untreated water is drawn from taps that is freely available to children." When the mine was working, rainwater tanks and the air were polluted from sulphur clouds emitted from the roaster stacks, causing children to have respiratory problems such as asthma, bad headaches, bleeding noses and itchy eyes. The sulphur plumes regularly affected the local primary school causing children to run inside and close the windows to avoid the white clouds. Air pollution also spoiled food crops. Company housing, which was rented or purchased by workers or illegally occupied by striking workers, was in very poor condition. Families occupied single-room barracks originally built for single male workers, with ten or more families sharing a toilet or shower, and all now in very dilapidated condition. Houses built of corrugated iron were impossibly hot during the day and lacked kitchen or bathroom facilities. Children played around the open drains.

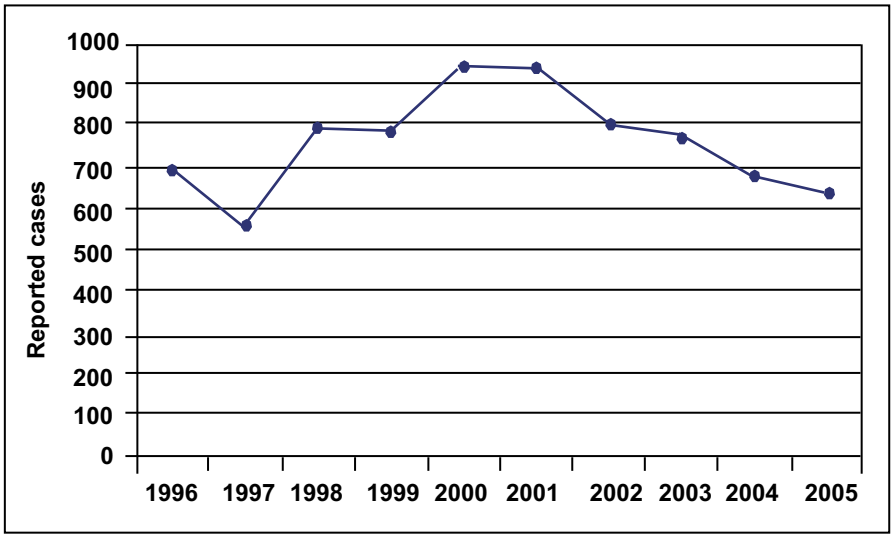
In 2006, Emperor Gold Mine was sold to another Australian company, of which the original company held a large share, but the sale process was delayed. By July 2007, the mine had been closed for 6 months but no resolution was expected for at least another 4 months. Some workers had found seasonal work away from Vatukoula as cane-cutters or forestry workers and sent what money they could back to their families. Many families were left with no income at all. A poor community was now in crisis. Schools in the area were trying to assist children who had no bus fares or meals, but school attendance was dropping. Community leaders had appealed to the National Disaster Management Office for disaster relief but no government assistance had been provided. Families of the 1700 miners who lost their jobs were pleading for assistance from any possible direction.

Sources: MacDonald et al., 2004, and discussions at Vatukoula with Josefa Salau, President of the Fiji Mine Workers Union, Kavakini Navuso, General Secretary of the Fiji Mine Workers Union and Industrial Relations Advisor, and laid-off workers and their families, July 2007.

4.3 Women and children at risk of abuse

Domestic violence is an issue about which there was both community and official denial, and a strange assumption that this particular form of violence could and should be dealt with by families themselves. Led by the Fiji Women's Crisis Centre and the Fiji Women's Rights Movement, over the past decade or so there has been a real change in official attitudes to domestic violence in Fiji. The Government recognises it as a pervasive social problem across all communities and the Fiji Police have put in place mechanisms such as a 'no-drop' policy to better report and deal with it. The problem itself, however, remains.

Figure 2.13 Reported cases of domestic violence, 1996-2005



Source: Fiji Police Force, 2005

Physical abuse of children is common in Fiji because it is often considered an acceptable form in discipline. A survey conducted in 2006 found that the great majority of punishments experienced by children were direct assaults, and that younger children received more than older children. These assaults (in the words of the children) included being beaten, hit, slapped or lashed, smacked, whacked, given a hiding, spanked, punched, "donged" (on the head) and pinched. Most of the children reported the school and the home as the places were most punishments were administered and the people who most dealt out punishment were teachers. However, if all immediate family members were added together, the home was where most punishment was meted out. Children were punished for disobedience, poor academic performance and misbehaviour.[89]

Sexual abuse also occurs, with a high number of incest and sexual exploitation cases reported in the media and dealt with in the courts. It appears that both boys and girls are equally involved in prostitution and pornography, and exploited both by locals and foreign abusers.[90] Children who are at risk for sexual exploitation also tend to be at risk for commercial sexual exploitation, which takes five common forms: prostitution, pornography, child sex tourism, adoption and early marriage. Sexual exploitation can include rape, incest, molestation, domestic sexual and physical abuse, sodomy, paedophilia, and witnessing third party involvement.[91] A study conducted in 2006 found that perpetrators of child commercial sexual abuse included a small number of foreigners resident in Fiji's towns, who were assisted by 'middle-men' (sometimes taxi drivers) or women who worked as 'local agents' by arranging meeting points for young girls with men for monetary exchange. The study concluded that commercial sexual exploitation was becoming more organised, lucrative and complex, and the risk to children was rising.[92]

In 1997, the Juveniles Act was amended in regard to the prevention of child pornography and in 1998, Cabinet passed a motion implementing tougher sentences for perpetuators of child sexual abuse. Those found guilty now face a minimum sentence of 14 years imprisonment and a $25,000 fine, or a maximum sentence of life imprisonment and fine of $50,000.[93]

[89] Save the Children Fiji, 2006a
[90] AusAID, 1999; Carling, 2004; Save the Children Fiji, 2006b.
[91,92] Save the Children Fiji, 2006b.
[93] Carling, 2004.

It is difficult to know from the increased number of reports of domestic violence or child abuse whether the problems are growing or their reporting has become more thorough. There are five approved children's homes providing emotional and psychological care to children who have been removed from their homes under Court Order, but child victims of abuse live there together with child offenders, or else they must live with other relatives or even back with the person accused of abuse. This problem is often compounded by a long delay between an incident of abuse and it going to trial. There is a great shortage of skilled child counsellors, however this training is now offered as part of the Certificate in Social Work offered by the University of the South Pacific.

Fiji's Plan of Action against the commercial sexual exploitation of children calls for:

- Development of child-sensitive laws essential to preventing CSEC or the exploitation of children or young people through information technologies and other channels of communication such as videos or the internet;
- Integration of the issue of CSEC into both formal and informal education, to encourage more young people to be involved in combating CSEC through local task forces or children's task forces;
- Strengthening of the National Youth Council to become an independent advisory and consultative body to the government on legislation and other issues;
- Development of greater capacity among government, NGO and CSO bodies, including training on child-friendly services and community training on the CRC and other international legal instruments, parenting, communication, peer counselling, and the training of trainers for teachers, parents, young people and community leaders;
- Greater provision of services for child victims of CSEC, which are gender and culture sensitive, and include peer counselling, hot-line, shelters, medical treatment and psycho-social counselling;
- Establishment of community-based surveillance and monitoring of CSEC to strengthen the social protection of children and to involve the participation of children and young people;
- The linkage of government monitoring of the Stockholm Declaration and agenda for action to other monitoring efforts, such as for the CRC.

4.4 Children and youth in trouble with the law

Although Fiji has a special juvenile justice system and specific legislation, Fiji's 1995 CRC report pointed out the short-comings of the system. The Fiji Law Reform Commission has proposed legislative reform that relate specifically to children and aim to harmonise legislation with the principles of the CRC and CEDAW. However, most of these problems are yet to be resolved.

The Juvenile Courts are held only in Suva and Lautoka, in a normal Magistrate's Court. Children and youth can still be victims of punitive behaviour by the Police or be detained with adults in over-crowded or sub-standard prisons and detention centres.[94] Child maintenance payments are mostly inadequate to cover a child's needs or are insufficiently

[94] Carling, 2004.

enforced. There is no specific legislation to adequately address commercial sexual exploitation of children, trafficking and abduction. The few existing provisions consider commercial sexual exploitation of children to be a misdemeanour liable for convictions of 2 years imprisonment. The minimum age of criminal responsibility is 12 years, or 10 years if it can be proven that the person had the capacity to know if was a wrongful act.[95] There are very few trained legal representatives or counsellors for children. The Women's Crisis Centre is the only agency that provides counselling to child victims of sexual abuse. Welfare officers do not accompany children to court and are usually only called in at the stage of a social inquiry report.[96]

Young people are often poorly informed about their rights and legal issues, including the Legal Aid service. Juvenile offenders are often imprisoned in a detention home or regular prison instead of being given rehabilitative punishment, often because of the difficulty of finding suitable supervisors. A survey of juvenile offenders found that none had had legal representation in court.[97] However, the Police follow a national standard to caution a juvenile for minor offences without resorting to judicial proceedings and practice pre-trial diversion. No juvenile can receive corporal punishment but although the words 'conviction' or 'sentence' cannot be used, they still get a criminal record. The Police also have a Juvenile Bureau that collects information about juvenile justice issues, efforts are being made to improve the standards of prisons and detention centres for juveniles, and a number of training programmes have been held for Police to deal with sexual offences against children and women.

The Geneva Committee on the Rights of the Child has recommended the revision of laws, policies, programmes and practices pertaining to the juvenile justice system, to fully integrate the CRC and other international conventions. It also recommended a review of provisions for legal counselling for children in care centres, that detention should be used as a last resort, and that conditions of detention centres be improved. Other potential partners identified to raise awareness of juvenile justices issues are the Pacific Judicial Education Programme, the Regional Rights Resource Team, National Council on Substance Abuse, the Ministry of Youth, Employment Opportunities and Sports, Women's Action for Change, Salvation Army, Fiji Red Cross Society, Save the Children Fiji, Young Women's Christian Association, Chevalier Hostel, Fiji Women's Crisis Centre, Young Lawyers Association and the National Coordinating Committee on Children.[98]

The Australia/Fiji Law and Justice Sector Programme has refurbished juvenile court facilities, conducted a study into community attitudes on juvenile justice, conducted community and professional training workshops on various aspects of law and order, provided a community volunteer probation officer, and undertaken various other initiatives on juvenile justice.

5. Recognition and protection of human rights

5.1 Children

Most Pacific island countries have long had laws and procedures to protect children from harm or neglect but it is only quite recently, particularly after ratification of the CRC, that wider attention has been given to the implementation of these laws and procedures and to their limitations. However, the CRC proposes more than simply focusing on children in need of special protection with reaction-oriented measures, rather it calls for a holistic approach that focuses on the whole protective environment for all children, to ensure that there are back-up support systems when regular safety nets fail to provide adequate protection for children against violence, exploitation, abuse or discrimination.[99]

[95,96,97,98,99] Carling, 2004.

Fiji ratified the CRC in 1993 and presented its first implementation report in 1995. The Department of Social Welfare has a child protection unit and is responsible for addressing most child protection issues, but the unit is very understaffed and lacks transport in rural areas. The Ministries of Education, Youth and Health also have responsibilities for child protection. Fiji has ratified ILO conventions regarding the Minimum Age for Admission to Employment and the Elimination of the Worst Forms of Child Labour, acceded to the Hague Convention on the Civil Aspects of International Child Abduction, and adopted the Stockholm Agenda for Action to prevent the commercial exploitation of children.[100]

UNICEF and other development partners have been helping the Fiji Government to strengthen their capacity to support child rights. The commitment of government to child protection as demonstrated through the policies of various ministries and the police is driving this process onwards. The National Coordinating Committee for Children coordinates and facilitates advocacy about the CRC and monitoring and reporting activities to be carried out by the government.

An important part of this process is to educate the public about child rights and children's development. This knowledge helps to build capacity to budget for and develop necessary services for children, and to make people aware of what types of actions constitute child abuse and are unacceptable. The Ministry of Education, for example, has had a policy in place for more than a decade, that head-teachers alone could physically punish children and then only in controlled ways. The fact that teachers still strike children is evident from the number of newspaper reports and court cases against them, but these reports and cases also show that the community is becoming less tolerant of this behaviour.

One of the difficulties in better addressing child protection is the lack of consolidated and disaggregated data on issues such as juvenile justice, child labour, abuse and exploitation, leaving people in key political, administrative and judicial roles reliant on media reports and anecdotes.[101] Efforts to develop common reporting databases nevertheless go back to the early 1990s.[102] Another problem in better developing child protection is the little financial resources directed towards this, particularly the limited resources of the Department of Social Welfare, the police, children's homes and detention centres.[103]

[100,101,103] Carling, 2004.
[102] Fiji Government, CRC Report 1995.

Table 2.13 Missing information on child protection

Issue	Source	Data available
Reported cases of sexual abuse of children and young people	Police	Reported cases of rape, attempted rape, defilement of girls under 13 yrs, defilement of girls 14-16 yrs, unnatural offences, indecent exposure, incest, indecent assault
	Department of Social Welfare	Sexual abuse
Reported cases of child physical abuse	Police	Murder, manslaughter, assault with intent to cause grievous bodily harm, assault occasioning actual bodily harm, abduction, criminal intimidation,common assault, others
	Department of Social Welfare	Child neglect, abandonment,lost/ orphaned, beyond control (removal of child), child available for adoption, victims of parental conflict, truancy
Violence against children in the school		No data available
Violence against children in conflict with the law		No data available
Violence against institutionalised children		No data available
Violence against children in work situations		No data available
Violence against children in the street/community		No data available
Violence against children in the cyberspace		No data available

Source: Ministry for Women, Social Welfare and Poverty Alleviation, 2005.

Note: There are protocols for information sharing between the Dept of Social Welfare and the police, but no legal requirements.

Birth registration is an important right for all children. Compared with other Pacific island countries, Fiji's registration system is comprehensive. Registration of births within two months is a legal requirement under the 1975 Births, Deaths and Marriages Act. Birth registries are available in all government centres. About 70% of all births are registered within the correct time period, 28% are late registrations (ie. after 12 months) and an estimated 2% of births are not registered for some reason.[104]

[104] L. Matadigo, Register General, in UNICEF, 2005.

UNICEF's Programme to Recognise and Protect Human Rights

Rights Advocacy: This project aims to ensure that all partners understand and embrace the CRC and CEDAW and its implications; legislation is closer to compliance with the CRC and implemented by relevant authorities in all 14 Pacific Island countries; and monitoring and reporting on the CRC is conducted in a timely basis. All self-governing Pacific Island countries have now signed the CRC and their governments have the obligation to prepare initial and periodic reports on its implementation.

Protection: This project aims to ensure that services for relief, rehabilitation and reintegration for children in need of special protection are known to caretakers and made accessible to children in 5 Pacific Island countries. In the Pacific Island countries there are increasing numbers of children and young people living on the streets, or involved in pornography and prostitution. In most countries legislation to protect children is inadequate although some improvements have been made in areas such as adoption and juvenile justice.

Communication: This project aims to develop information and communication strategies to increase awareness of children's and women's rights and enable rightsholders to adopt attitudes and practices that will support the implementation of the rights, and to create opportunities for child participation to ensure that Pacific children participate and have a voice in matters of direct relevance to them.

5.2 Women

Fiji ratified CEDAW in 1995, which obliged the government to work on modifying the Constitution and legislation to accord with the articles of CEDAW. A survey of legislative compliance conducted in 2006 found that Fiji has achieved full compliance with 49 of 113 indicators, partial compliance with 26 indicators, and is non-compliant with 38 indicators. However, by the end of 2006, some important areas relevant to CEDAW were the subject of draft legislation before Parliament or were being investigated.[105]

The Constitution of Fiji guarantees the rights and freedoms of citizens in most of the areas required by CEDAW, but while equality is guaranteed before the law, it does not guarantee equal benefits or outcomes as required by CEDAW. The Constitution also establishes a Human Rights Commission which is empowered to implement affirmative action programmes, a capacity which could be used to accelerate the advancement of women. The Ministry with responsibility for women also plays a part in the advancement of women, although as it was not established by legislation, its powers could possibly be curtailed.

Areas of discrimination against women remain. Sexual assault laws give inadequate protection for the range of sexual violations against women and girls, for they require penile penetration. The Sexual Offences Report 1999 prepared by the Fiji Law Reform Commission recommended widespread changes to these laws. While sexual violence is treated seriously in the courts, with mandatory prosecution and minimum sentences, sexual assault offences are less rigorously pursued in the courts. Fiji's Penal Code does not contain offences for domestic violence and women must instead rely on the general assault provisions which are insufficient to encompass the breadth of situations in which women experience domestic violence in their daily lives.[106]

Article 4 of CEDAW requires special measures to be introduced into national constitutions and legislation for the advancement of women. The provision in the Fiji Constitution is however limited to education and training, land and housing, participation in commerce and in all levels of the public service. Even in these areas. However, some *de facto* discrimination

[105,106] CEDAW Legislative Compliance Report, 2006

is evident. For example, Fiji has few female members of parliament (only 8 of 71 seats in 2006) and no quota systems to ensure their better representation. As well, although Fiji has compulsory education for both males and females aged 6-15 years, discrimination is still prevalent in schools where, for example, girls and women face expulsion because of their pregnant status.[107] Although women have in law the same employment rights as men, several aspects of employment law discriminate against women, such as minimum standard pay rates for maternity leave and lack of provision for nursing mothers in the workplace. Although the law requires that women have access to health services including family planning, abortion is still criminalised and unsafe abortion often occurs.

Fiji has a number of NGOs that actively promote women's rights and CEDAW. The most prominent of these are the Fiji Women's Rights Movement, which effectively advocates for the advancement of women and gender equality, and the Fiji Women's Crisis Centre, which assists women and children who experience domestic violence or family break-up and has effectively sensitised the Fiji public and government about the prevalence and nature of sexual violence.

[107] CEDAW Legislative Compliance Report, 2006

Part 3
Strategies

PART 3: STRATEGIES

1. National policies and programmes

This report has assessed the current status of children, youth and women in Fiji with particular reference to health, education and other services that most directly impact on their well-being. In its Strategic Development Plan 2007-2010, the government reaffirmed its social responsibility to its citizens to put in place policies that will achieve prosperity, especially for the poorest, disadvantaged and most vulnerable citizens. Notable progress has been achieved in certain areas for children, youth and women since UNICEF's last report on Fiji in 1996, but other problems have remained or emerged.

Fiji's ranking in the Human Development Index has dropped from a ranking of 46th in 1995 to 90th in 2006. Both urban and rural poverty have grown in extent and depth. Economic and political problems underlie this situation. The negative repercussions on the poor and disadvantaged are evident in a series of knock-on effects resulting from reduced working hours, loss of jobs, rising prices of essential items, reduced frequency of transport to remote communities and so on. Government has also had to introduce budgetary restrictions that have further reduced its ability to provide essential services, including critically needed welfare payments to the increasing number of individuals, families and communities in need of support.

The practice of pro-poor planning is not strong in Fiji. National plans have emphasised the need to address poverty and hardship, yet the major upheavals of recent years – the termination of thousands of agricultural leases, the periods of economic malaise that have followed episodes of political unrest, the loss of factory employment for thousands of workers, particularly women; the large out-flow of people from Vanua Levu, stagnation of the low-income urban housing market; and the visible growth of poverty – have not been sufficiently mitigated by well designed or implemented programmes. Progress in sectors such as health, education and social services, which has taken so much to achieve, is in jeopardy.

Non-government organisations have for many years made a large contribution to education, health and social services in Fiji. They provide almost all welfare services and most education services and as well make significant contributions to health and other social services. Local communities, faith-based organisations and other NGOs operate almost 95% of schools, including all that cater for people with special needs. NGOs also provide by far the largest part of welfare assistance to poor and needy people in the community, and this has been their traditional focus. Even though many of these organisations are small, have a limited range, and cannot meet all demands on their services, the contribution of NGOs to welfare in particular out-weighs that of government.

NGOs need to be able to scale up their activities, to widen and deepen their coverage, and this requires that more resources are channelled into supporting effective programmes. Local fundraising is restricted not only by the small sise of the population but also by the requirements of the Act under which NGOs are registered. These organisations mainly depend on small grants from government and international donors, and usually these grants are provided for activities and not for organisational needs. Without the capacity and physical structure, NGOs struggle to deliver services with any efficiency. It is for this reason that some organisations fail in their programmes, and that most organisations fail to evolve into professional institutions. The potential role for NGOs in development has been talked about for more than a decade but many of these organisations in Fiji feel that their potential has not yet been realised.[108]

[108] Personal communication: NZAID roundtable meetings with NGOs, February-March 2007.

Table 3.1 Major NGOs working in social development fields

General purpose	Organisation	Activities
Empowerment	Ecumenical Centre for Research, Education and Advocacy (ECREA)	Works with informal settlements and other groups that lack security in terms of land and employment through regular community visits and training programmes to empower people, such as economic and legal literacy, and to assist them to lobby government or work with agencies to better their lives. A recent initiative is development of a national Squatter Network as advocacy group for settlers and to help fund land purchases.
	Fiji Council for Social Services (FCOSS)	Advocates for social justice and operates various development programmes for community groups.
	Fiji Trades Union Council (FTUC)	Works to improve workers' conditions, welfare concerns and wage levels.
	Fiji Women's Crisis Centre (FWCC)	Provides counselling and other assistance to women and children who are victims of abuse or face family problems.
	Fiji Women's Rights Movement (FWRM)	Advocates for the empowerment of women and gender equality and conducts programmes to advance these goals.
Skills and livelihoods	Foundation for Rural Integrated Enterprises 'N' Development (FRIEND)	Main activities focus on income-generation for disadvantaged, low-income groups, namely the Income Generating Scheme which operates in Lautoka, Ba and nearby villages and produces and sells chutney and other items, and the Rural Banking Scheme. FRIEND is also heavily involved in empowerment, working with communities and groups with special needs, such as ex-prisoners and prisoners.
	Save the Children Fiji (SCF)	SCF assists disadvantaged children and their families through their programmes, including the Mobile Playgroup Programme that provides early childhood education in low-income communities and empowers these communities through education and mobilisation. SCF also provides assistance to victims of natural disasters.
Housing and basic services	Habitat for Humanity	Assists disadvantaged people to improve their housing. It promotes community empowerment by using community resources to build their own houses, training community members to build future houses, works with Social Welfare Department to identify people in need of better housing.

	Housing and Relief Trust (HART)	Established in 1970 by the Fiji Council of Churches, HART provides apartments for destitute families. Government provides financial support for administration, maintenance, construction of new dwellings and purchase of land.
	Rotary Club (Rotahomes)	Since 1985, Rotahomes, has built over 800 houses for destitute families and has developed a model community, Koroipita at Naikabula Road, outside Lautoka.
Welfare	Arya Pratinidhi Sabha of Fiji	Assists destitute people with monthly food rations and meets school costs for needy children.
	Bayly Welfare	Assists the elderly, the destitute without relief, the chronically ill, widows, wives whose husbands are in prison, etc. with food rations, medicine, clothing etc., and assists disadvantaged children through their educational assistance scheme.
	Counterstroke Fiji	Provides assistance to people who are disabled by strokes and their families, and conducts public education activities.
	Dorcas Society (Seventh Day Adventist Church)	Each SDA church has a Dorcas group that identifies and assists disadvantaged people in their district, providing for family disasters (such as fire) with basic items such as utensils, bedding, clothing, etc.
	Family Support & Education Group (FSEG)	Funded by the Ministry of Health, this organisation provides counselling services, including for HIV/AIDS at Western Division hospitals and education programmes in communities, and networks with other organisations such as Bayly and HART to assist clients to seek assistance.
	Lifeline Wesley Church	Provides a referral service for people with various social and economic problems.
	Lions Club	Pays school costs for needy children, including boarding fees for those who stay far away from schools. Provides some welfare assistance to other people in special need.

	Fiji Muslim League	Engaged in a wide range of social, welfare, and cultural activities.
	Missionary Sisters (SHSM)	Assists destitute people with monthly food rations and meets school costs for needy children.
	Fiji National Council for Disabled Persons (FNCDP)	An umbrella body for organisations working with disabled people, and inevitably involved in poverty issues. Member organisations assist disabled people to access assistance for suitable housing, specialised transportation and mobility aids, and advocates for their better access to medical services, education, vocational training, employment, recreational activities and other basic needs. They direct children with disabilities to welfare organisations that can assist with school costs.
	The Poor Relief Society	Provides material support to destitute people.
	Fiji Red Cross Society (FRCS)	Principally involved in disaster relief, the Red Cross Society has broadened its operations to include a Medical Welfare programme to assist poor people to find organisations that will cater for their needs or to navigate the government bureaucracy. The Fiji Society has 15 branches throughout Fiji.
	Saint Vincent De Paul	Works through Catholic Church parishes throughout Fiji and identifies families or individuals who need assistance through the local conferences, the priests and home visitations. The Society provides food and housing for the especially needy, identifies their skills and gives training to enable them to be self-sufficient and not dependant on welfare.
	Salvation Army	Helps disadvantaged people with school fees, food and other welfare items such as clothing, and runs programmes catering for single mothers, the elderly, young people, ex-prisoners and their families. Provides training and job placement for young people with limited education and works with the court system to assist prisoners, ex-prisoners and their families.

	Satya Sai Service Organisation of Fiji	Provides some material assistance to the poor, including food, clothing, shelter, educational assistance. Also involved in community and youth development and disaster relief.

Fiji benefits from assistance from many international donor organisations. Multilateral organisations include the United Nations agencies and the European Union. Major bilateral donors to Fiji in the areas of health, education, social services and civil society are Australia, Japan and New Zealand.

Table 3.2 Major bilateral donors to social services

Sector	Donor	Type of assistance
Education	Australia	Supports the Fiji Education Sector Support Programme.
	Japan	Supports: advanced technology training; basic life skills for young people and adults; education policy, administration and management; higher education; programme formulation in secondary education and human resources; participation of Japanese citisens in education; teacher training; and vocational training.
	New Zealand	Supports: kindergartens; cyclone rehabilitation; early childhood education; SCF's Mobile Playgroup; in-country training; Nabua Secondary School; scholarships and study awards; and computers for schools.
Health	Australia	Supports: the Fiji Health Sector Improvement Programme; health personnel development; and the UNICEF Pacific Programme.
	Japan	Supports: advanced laboratory technology for care and management of HIV; basic health care; construction of Pharmaceutical Service Centre; health policy, administration and management; and medical education/ training.
	New Zealand	Supports: the Fiji School of Medicine; dietary survey; distant learning; medical treatment scheme; Fiji Dental Association; Psychiatric Survivors Association.

Social services and civil society	Australia	Supports electoral assistance and strengthening civil society.
	Canada	Supports NGOs to reach women at the grassroots level.
	European Union	Supports Grassroots Opportunities for Action and Leadership (GOAL); democratisation, human rights and ethnic group reconciliation; and governance.
	Japan	Supports economic and development policy and planning and programme formulation and public sector financial management.
	New Zealand	Supports: up-grading of Champagnat Institute; cyclone rehabilitation; Fiji Council of Social Services; Habitat for Humanity squatter settlements; Children's Library at Suva City Library; Fiji Women's Crisis Centre, civil education; Elections Office; Fiji Law Reform Commission; Legal Aid; Fiji Human Rights Commission; Fiji Women's Crisis Centre.

Source: Development Gateway Foundation Accessible Information on Development Activities (AIDA).

2. UNICEF's regional and national programmes

UNICEF's Medium-Term Strategic Plan 2006-2009 focuses upon the following areas:

i. Young Child Survival and Development, to provide support in regular, emergency and transitional situations for essential health, nutrition, water and sanitation interventions, and for young child and maternal care at the policy, provider, family and community levels.

ii. Basic Education and Gender Equality, specifically to improve developmental readiness for schools; access, retention and completion, especially for girls; improved educational quality; education in emergency situations and continued leadership of the UN Girls' Education Initiative.

iii. HIV&AIDS and Children with emphasis on increased care and services for children orphaned and made vulnerable by HIV/AIDS, and on preventing infections among children and adolescents; and a continued strong participation in UNAIDS.

iv. Child Protection to strengthen country environments, capacities and responses to prevent and protect children from violence, exploitation, abuse and conflict.

v. First Call for Children in Policies, Laws and Budgets by generating and disseminating high quality, child focused data and analysis: support emergency preparedness capacity and leverage resources and results through partnerships for investing in children to reach the MDGs and foster children's and young people's participation.

UNICEF's Multi-Country Programme for the Pacific Island Countries for the period 2008-2012 follows the following strategies:

i. Evidence-based advocacy to influence the development and implementation of laws and policies that recognise children's rights and address clearly evident sub-national inequalities.

ii. Systematic capacity building of duty bearers at national and sub-national levels through promotion of human-rights based programming, gender and youth mainstreaming and results-based planning and management.

iii. Enhancements to basic service delivery through participatory evaluation of models and approaches (e.g. essential package of health interventions; Child-Friendly Schools; strengthening social service response capacity; emergency preparedness and response).

iv. Partnerships with and for children and young people at sub-national, national and regional levels.

v. Intensified community engagement, social mobilisation and communication for behaviour change and social change.

vi. Partnerships with, and leveraging of, financial and/or technical resources of major development partners and regional organisations and institutions.

vii. Strengthened monitoring and evaluation of results.

viii. Enhanced Pacific Island Countries national and sub-national capacities for emergency preparedness and response in a coordinated and integrated manner to mitigate impact on children, women and vulnerable members of the population and ensure rapid return to normalcy.

At the Fiji country level the UNICEF Pacific Country Programme Document 2008-2012 identifies the following priorities and goals:

i. Health and Nutrition: To increase childhood immunisation coverage (all vaccines) from the regional mean of 80% to 90% with a special focus on low-performing districts.

ii. HIV and AIDS: To reduce vulnerability to and impact of HIV and AIDS among the most at risk populations with a special focus on children and women through strengthened integration of maternal and child health services and community-based initiatives.

iii. Child Protection: To establish legislative and regulatory environments that increasingly protect children from violence, exploitation and abuse, and to ensure that children are better served by a well informed and coordinated child protection social service and justice system.

New programmes are also planned to develop synergies across core elements of Integrated Child Health and Development, Education, HIV and AIDS, and Child Protection. A more integrated, community-driven approach will be used to assist marginalised and vulnerable populations that will be identified through consultation with partners.[109]

[109] UNICEF Pacific Country Programme Document 2008-2012 (Draft).

3. Strategic approaches for UNICEF

a) Greater coordination and partnership with local organisations and donors

There is scope for an increased emphasis on a community-based approach to addressing the needs of children, women and youth. NGOs in Fiji play an essential role in providing welfare services to the needy and poor in the community but often they require additional support and resources so as to be able to expand their activities. Greater coordination with NGOs, including community or faith-based organisations, will facilitate the identification of key community needs, a more thorough understanding of their origin and nature, and a more accurate determination as to how best these needs can be met. It will also further foster partnerships with those at the community level who are most likely to be committed to, and best positioned to guarantee that activities are implemented in ways that meet community needs. Working with communities is often easier to identify and address needs in a more holistic manner, than often is the case at a more central level, where organisational compartmentalisation can frustrate efforts to address issues in integrated and synergistic manner. A greater emphasis on a community-based approach is also likely to appeal to many donors who have indicated their increased interest in providing assistance at this level through partnerships with NGOs

b) A balance of structural assistance and community level practical assistance

Specific problems, particularly at the community level, can have a large negative impact on the delivery of essential services, yet there are often relatively simple and inexpensive solutions. Addressing these obstacles not only presents a cost-effective way of enhancing the actual delivery of services, but also has an important role in raising the morale of the service providers upon which these services critically depend. When these problems are found to be widespread or systemic, then additional larger scale structural assistance may be also required.

4. Addressing UNICEF's regional priorities

Young Child Survival and Development

In order to further reduce both infant and child mortality it is necessary to identify and address sub-national patterns in maternal health conditions, pregnancy-related illnesses, child illnesses and death. This will assist a more specific and effective targeting of mothers and children with special health risks, particularly those in families living in hardship or poverty.

There is a pressing need to further strengthen aspects of the Expanded Programme on Immunisation, particularly in its delivery in remote areas.

The 2004 National Nutrition Survey identified a wide range of health and nutrition related issues in which UNICEF can productively collaborate with its various partners. Additional emphasis also needs to be given to the early identification, correct diagnosis and appropriate treatment of children with various disabilities, to ensure that their special needs are not neglected or delayed, for this can cause further complications to the children and their families.

The NCCC has recommended that a comprehensive analysis be undertaken of the impact on children and their families of the current and predicted economic situation. UNICEF's experience of working in countries that have experienced similar problems could be useful in identifying ways and means to mitigate against the consequences of an economic downturn on the most vulnerable people.

Basic Education and Gender Equality

Further improvement of schools, especially those in remote areas, would particularly benefit poor and disadvantaged communities.

There is a need to undertake a national assessment of the demand for non-formal education and to review existing non-formal education, both in terms of its effectiveness and its availability, particularly for women and young people.

In the interest of gender equity, ways should be explored to increase the enrolment of females in technical and vocational education courses from the current level of 30% of all students. To address the social and economic needs of youths, greater focus needs to be placed upon the provision of youth-specific life skills and vocational training, and employment generation activities.

HIV&AIDS and Children

Much work has been undertaken in STIs and HIV awareness and education programmes, but research is required to assess the effectiveness and impact of these activities. Further improvements could be made to the reproductive health services, especially to make them more youth-friendly

Child Protection

This report noted the progress that has been achieved in the area of child protection, but it also noted areas where far more must be done, including the need to address the lack of reliable and accurate data on the subject.

Progress has been achieved in exposing and dealing with domestic violence, but its nature and prevalence are still subjects of considerable denial. Greater emphasis needs to be given to various issues related to child protection both at the family and community levels, including the prevention of physical punishment both in the home and at school, greater vigilance to prevent various forms of sexual exploitation of children and juvenile justice.

First Call for Children in Policies, Laws and Budgets

There is a recognised need for the adoption of a National Plan of Action for Children. In order to remove existing ambiguities, particularly with regard to various laws, further clarification is required concerning the definition of a child

The NCCC provides an essential mechanism for coordinating the work and experiences all the various agencies involved with children in Fiji, but its work warrants additional support. There remains a chronic need to generate and disseminate high quality child-focused data and analysis, and to ensure that this is disaggregated beyond crude national averages that fail to provide a sound basis for either policy or necessary interventions. There is also a need for additional disaggregated data on key issues related to unemployment, urban growth, squatter settlements, etc.

In the context of human rights programming, key duty bearers, in particular government, need to be encouraged to recognise and more effectively fulfil their responsibilities in regard to the provision of health, education, welfare and other services, in particular to the most marginalised, disadvantaged, vulnerable and poorest communities.

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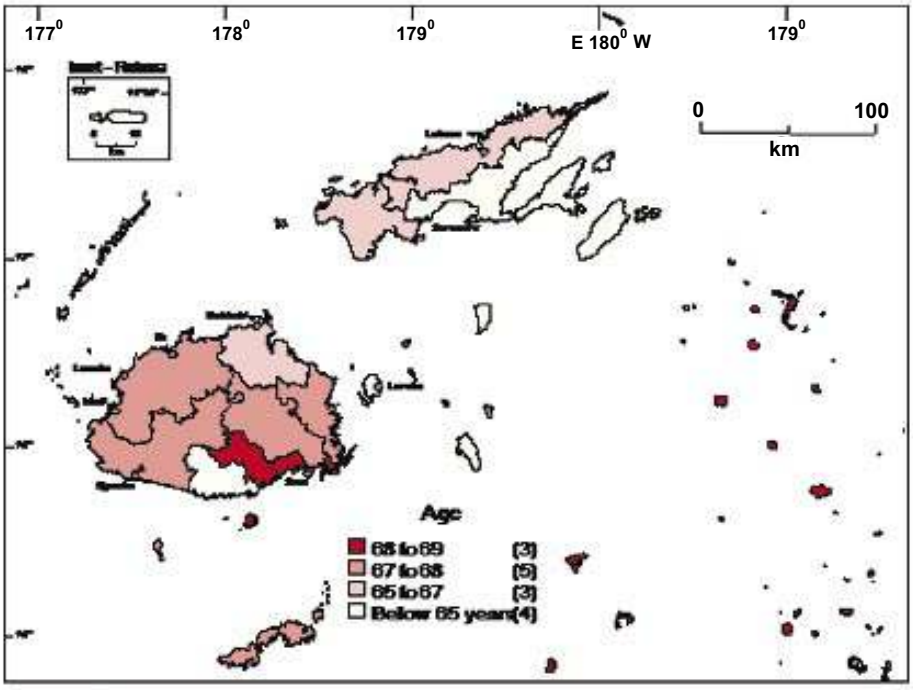
Annexes

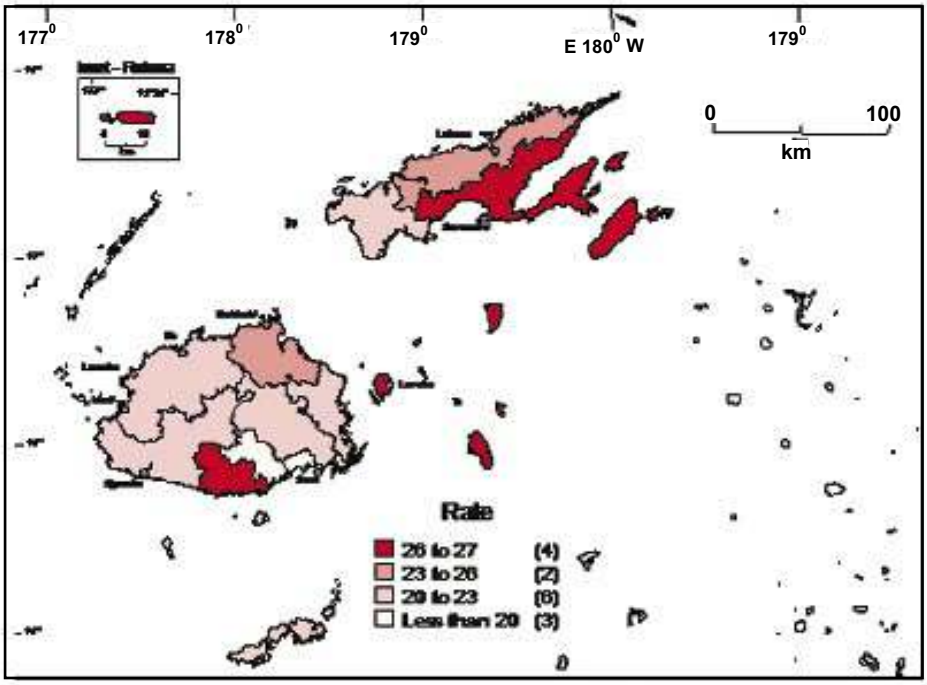
ANNEX 1: GEOGRAPHICAL PATTERNS OF DISADVANTAGE

Life expectancy at birth in 1996 (years)



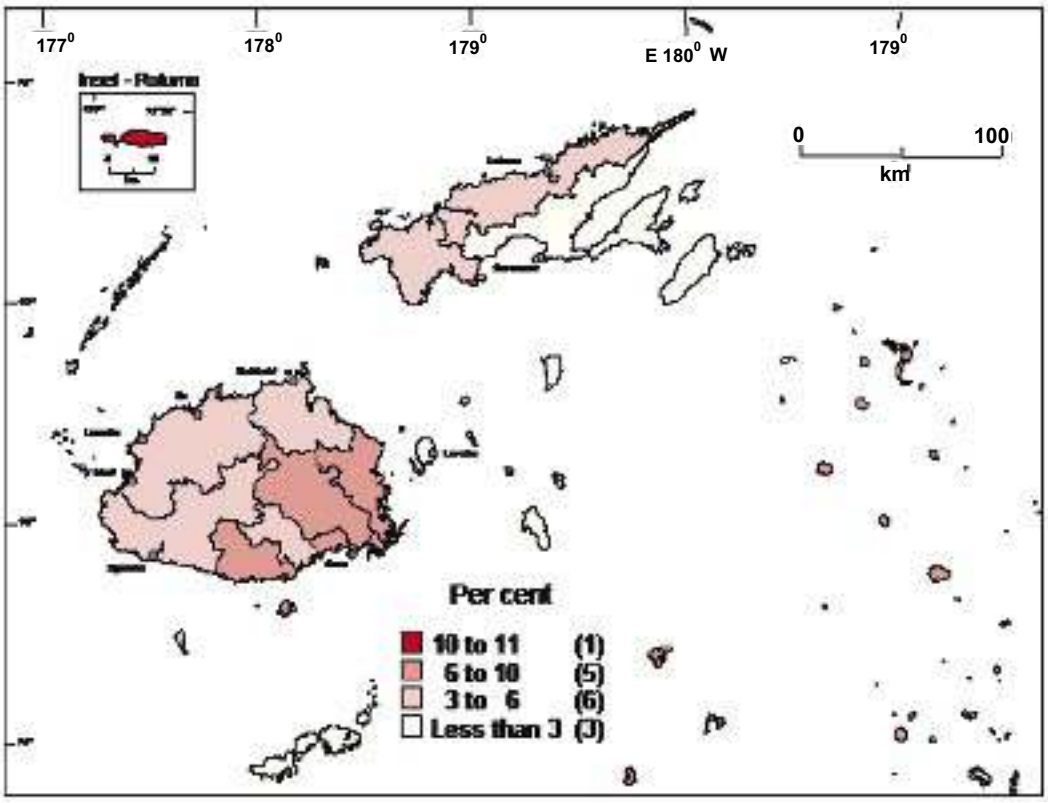
Source: Fiji Islands Bureau of Statistics (2000b)

Infant mortality rate in 1996 (deaths per 1,000 live births)



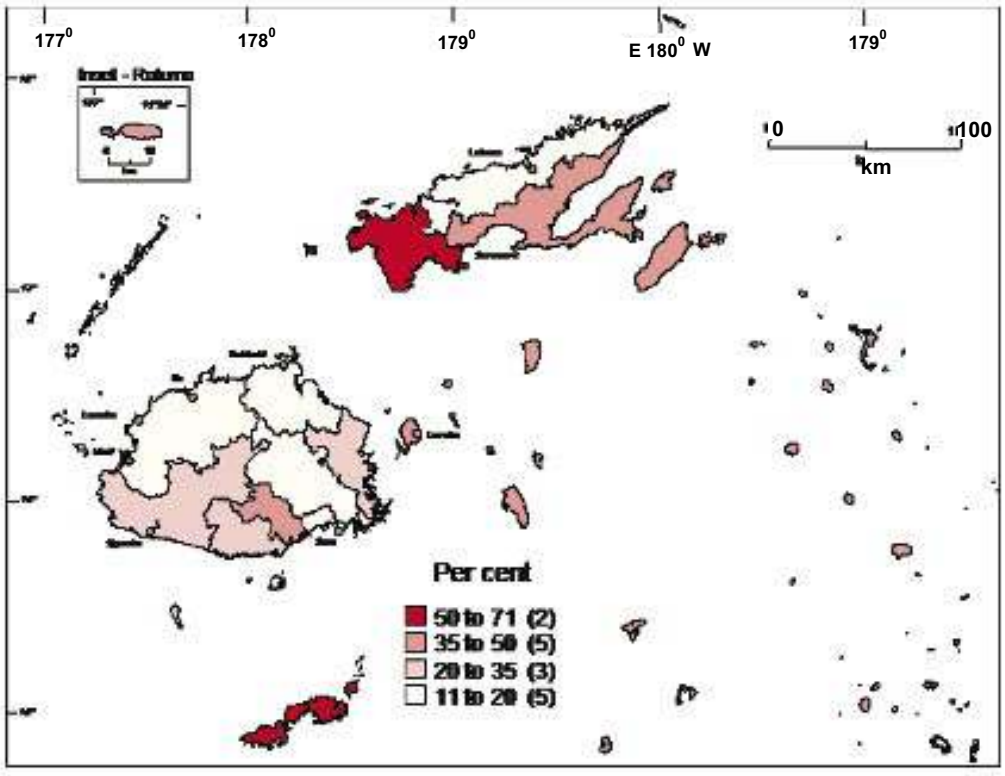
Source: Fiji Islands Bureau of Statistics (2000b)

Unemployment rate in 1996 (% of economically active population)



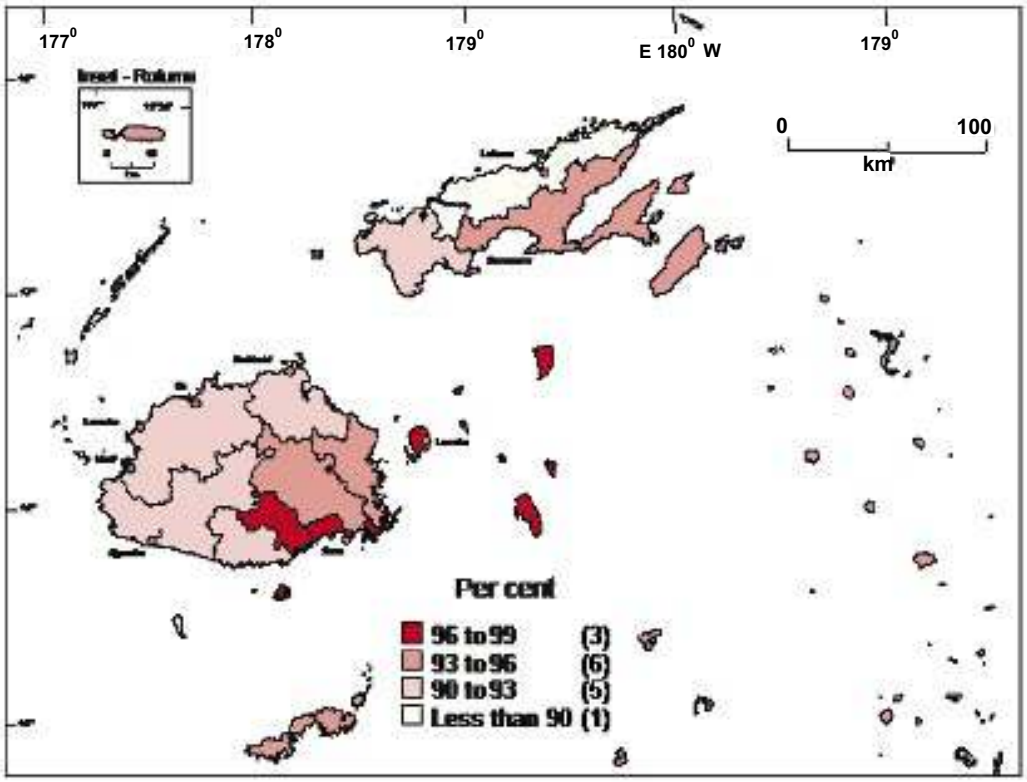
Source: Fiji Islands Bureau of Statistics (2000b)

Subsistence lifestyles in 1996 (% of economically active population)



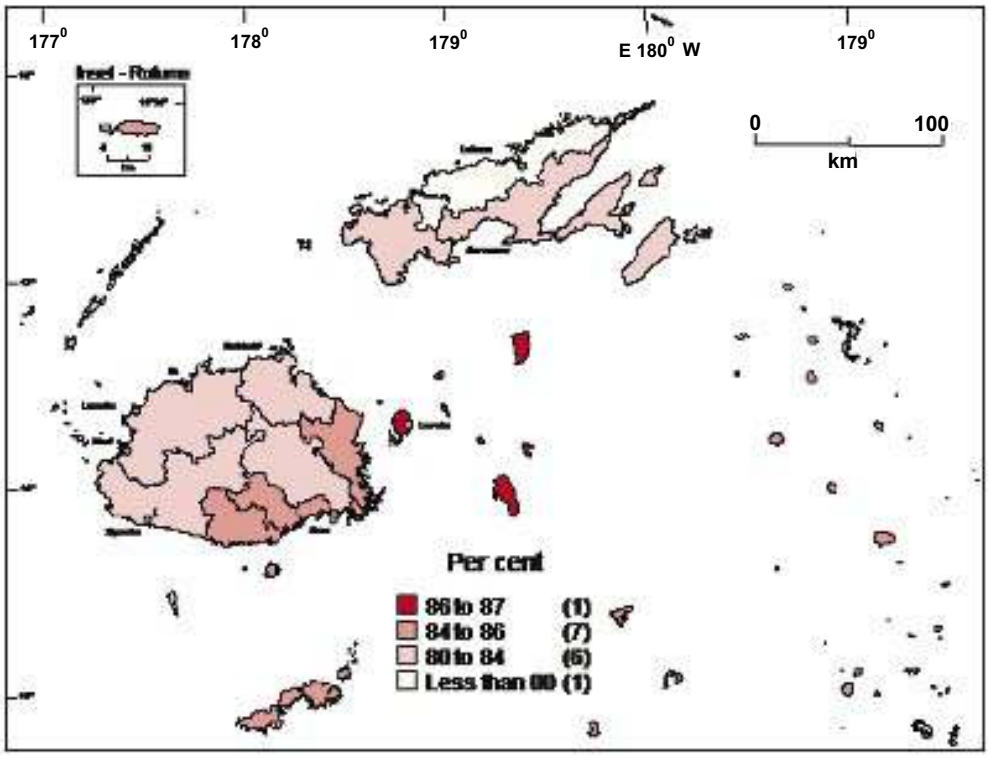
Source: Fiji Islands Bureau of Statistics (2000b)

Adult literacy in 1996 (% of population aged more than 15 years)



Source: Fiji Islands Bureau of Statistics (2000b)

School attendance in 1996 (% of population aged 6yrs to 19yrs)



Source: Fiji Islands Bureau of Statistics (2000b)

ANNEX 2: FIJI'S PROGRESS ON MILLENNIUM DEVELOPMENT GOALS

1. ERADICATE POVERTY

Target	Indicator	Status of Progress			
		± 1990	± 1995	± 2000	Latest
1. Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below $1 per day (PPP values)	n.a	n.a	n.a	n.a
	1a. Poverty head-count ratio	n.a	National 25.5%; Urban 27.6% Rural 24.3%[1]	n.a	n.a
	2. Poverty gap ratio	n.a	0.31 [1]	n.a	n.a
	3. Share of poorest quintile in national consumption	n.a	2% [1]	n.a	n.a
2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of under-weight children (under 5 yrs of age)	15% [2]	n.a	n.a	n.a
	5. Proportion of population under minimum level of dietary energy consumption	n.a	9.9%[1]	n.a	n.a

Sources: [1] Calculations from 1990-91 HIES for Fiji Poverty Report, 1996; [2] Fiji National Food and Nutrition Committee, 1994.

2. ACHIEVE UNIVERSAL PRIMARY EDUCATION

Target	Indicator	Status of Progress			
		± 1990	± 1995	± 2000	Latest
3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education	6. Net enrolment ratio in primary, secondary & tertiary education	Primary: Total 92%[4] Boys: 91.7% Girls: 92.4% (1986)	Total: 97.1%[2] Boys: 96.7% Girls: 97.6% (1996)	Total 94.7%[4] Boys: 94.9% Girls: 94.6%	Total 102%[1**] Boys:102% Girls:102% Boys:102% Girls:102%

		Secondary Total: 44.2% [4] Boys: 44.1% Girls: 44.2% (1986)	Total: 67.1%[2] Boys: 64.7% Girls: 69.6% (1996)	Total: 71.0%[4] Boys: 67.7% Girls: 74.4%	n.a.
		Tertiary 4%[5]	1.2%[2]	n.a.	n.a.
	7. Proportion of pupils starting grade 1 who reach grade 5		Total: 91.4% [1] Boys: 90.6 % Girls: 92.3 % (1996)	Total: 88.4% [1] Boys: 87.4 % Girls: 89.5 %	Total: 88.0% [1] Boys: 86.3% Girls: 89.8% (2002)
	7a. Primary completion ratio	n.a.	n.a.	n.a.	64.3% (2003) [1]
	8. Literacy rate of 15-24 year olds	Total: 97.5% Males: 97.6% Females: 97.4% (1986) [2]	Total: 99.3% Males: 99.1% Females: 99.4% (1996) [2]	n.a.	Total: 99.2% (2002) [3]

Sources: [1] Ministry of Education, various dates; [2] Bureau of Statistics, various dates; [3] ADB, 2003 (from UNESCO Statistical Yearbook); [4] Calculated from Ministry of Education, 2000 and Bureau of Statistics, 2004; [5] World Bank, 1992.

3. PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Target	Indicator	Status of Progress			
		± 1990	± 1995	± 2000	Latest
4. Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	9. Ratio of girls to boys in primary, secondary & tertiary education	Primary: 0.94 Secondary: 1.05[1] Tertiary: 0.72[5]	Primary 0.94 Secondary 1.04 Tertiary: 0.82 [5]	Primary 0.98 Secondary 1.07 Tertiary: 0.87 [5]	Primary: 0.93 Secondary: 1.0[1] Tertiary: 0.99 [5] (2003)
	10. Ratio of literate females to males of 15-24 year olds	1.000[3]	1.003 [2]	n.a	n.a

	11. Share of women in wage employment in the non-agricultural sector	27.1%[3]	44.6[2]	38.1% (1999) [3]	31 [4]
	12. Proportion of seats held by women in national parliament	House of Represen--tatives: 0 Senate: 0 Total: 0	House of Represent--atives: 4.2% Senate: 9.4% Total: 5.8%	House of Represen--tatives: 11.3% Senate: 25% Total: 15.5%	House of Represent--atives: 7% Senate: 12.5% Total: 8.7% (2004)

Sources: [1] Ministry of Education, various years; [2] National Census; [3] Bureau of Statistics, 2004; [4] ADB 2004 from 2002 Urban HIES; [5] USP.

4. REDUCE CHILD MORTALITY

Target	Indicator	Status of Progress			
		± 1990	± 1995	± 2000	Latest
5. Reduce by 2/3 between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate (per 1000 live births)	27.8[1]	19.4[1]	21.8[1]	22.35 (2002) [1]
	14. Infant mortality rate (per 1000 live births)	16.8[1]	14.7[1]	16.2[1]	17.8 (2002)[1]
	15. Proportion of 1 year old children immunised against measles	86% (1991)[1]	75% [11]	73.6%[1]	76.4% (2002)[1]

Sources: [1] Ministry of Health; [2] UNDP, 1994; [3] ADB, 2003;

5. IMPROVE MATERNAL HEALTH

6. Reduce, by three-quarters, between 1990 and 2015, the maternal mortality rate	16. Maternal mortality rate (per 100,000 live births)	41.1 (1989)[3]	60.4[1]	57.6 [1]	35.3 (2002)[1]
	17. Proportion of births attended by skilled health personnel	98[1]	99[1]	99[1]	98.6 (2003)[1]

6. COMBAT HIV&AIDS AND OTHER DISEASES

7. Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	18. HIV prevalence among 15-24 yr old pregnant women	0	< 0.01	< 0.01	< 0.01
	19. Condom use rate of the contraceptive prevalence rate	9.8% (1989)[1]	13.1%[1]	14.6%[1]	14.8% (2002)[1]

	19a. Condom use at last high-risk sex	n.a.	n.a.	n.a.	n.a.
	19b. Percentage of the population 15-24 yrs with comprehensive correct knowledge of HIV/AIDS	31%[1]	38%[1]	44%[1]	35%[1]
	20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 yrs	0	0	0	0
8. Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	21. Prevalence & death rates associated with malaria	Not relevant to Fiji	Not relevant to Fiji	Not relevant to Fiji	Not relevant to Fiji
	23. Prevalence & death rates associated with tuberculosis	n.a.	Prevalence: 21.1/ 100,000 Death rate: 0.37/ 100,000 (1997)[3]	Prevalence: 18/ 100,000 Death rate: 0.37/ 100,000[3]	Prevalence: 22/ 100,000 Death rate: 0.73 (2001)[3]
	24. Proportion of TB cases detected and cured under DOTS	Programme not yet introduced	40%[3]	85.5%[3]	80%[3]

Sources: [1] Ministry of Health, annual reports; [2] ADB, 2003; [3] WHO, 2004 .

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Target	Indicator	Status of Progress			
		± 1990	± 1995	± 2000	Latest
9. Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources	25. Proportion of land area covered by forest	48.9 %[4]	n.a.	44.6 %[3]	n.a.
	26. Ratio of land area protected to maintain biological diversity to surface area	9136.4 ha[7]	9256.4 ha[7]	9256.4 ha[7]	9306.4 ha[7]
	27. Energy use (kg oil equivalent) per $1 GDP (PPP)	n.a	n.a	9.3	n.a
	28a. Carbon dioxide emissions per capita	1.52 [9]	n.a.	1.02 [9]	n.a.
	28b. Consumption of ozone-depleting CFCs (ODP tons)	38[9]	n.a.	9 (1999)[9]	n.a.

	29. Proportion of population using solid fuels	80% rural 30% urban[8]	48% [5]	n.a.	n.a.
10. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	30. Proportion of the population with sustainable access to an improved water source, urban and rural	n.a	National: 92.7% Urban: 97.5% Rural: 65-82%[5]	n.a	96.1% (urban) (2002)[3]
	31. Proportion of the population with access to improved sanitation, urban and rural	93% (1993)[6]	National: 98.8%[5] Urban: 99.8% Rural: 97.9[5]	n.a	National: n.a Urban 75 Rural 12[3]
11. By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	32. Proportion of people with access to secure tenure	n.a	National- 83.5% Urban - 86.7% Rural - 80.7%	n.a	n.a

Sources: [1] UNDP, 1994; [2] Urban HIES, 2002; [3] ADB, 2003; [4] Dept Forestry, 1989; [5] Bureau of Statistics, from 1996 Census; [6] National Nutrition Survey, 1993; [7] D. Watling; [8] SOPAC estimations;[9] SPC, 2004.

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target	Indicator	Status of Progress			
		±± 1990	± 1995	± 2000	Latest
13. Address the special needs of developing countries	37. ODA received in small island developing countries as a proportion of their gross national incomes	3.75%[7]	n.a.	1.78%[7]	n.a.
15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.	44. Debt service as a percentage of exports of goods and services	12%[7]	5.9%[7]	2.1%[7]	n.a.
16. In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	45. Unemployment rate of 15-24 yr olds, each sex and total	Male: 12.9% Female: 34.3% Total: 18.3% (1986)[6]	Male: 11.3% Female: 16.7% Total: 13.1% (1996)[6]	n.a.	14.1% adult rate [2]

17. With cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis	100%	100%	100%	100%
18. In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	47. Telephone lines and cellular subscribers per 100 people			106 (2001)[3]	
	48a. Personal computers per 100 population	n.a	n.a	n.a	n.a
	48b. Internet users per 100 population	0	n.a	n.a	0.1 (2004)[8]

Sources: [1] Fallon & King, 1995, from Reserve Bank data; [2] Urban HIES, 2002; [3] ADB, 2003; [4] Ministry of Finance, various dates; [5] Reserve Bank, various dates; [6] Censuses; [7] SPC, 2004; [8] Estimate based on number of dial-ups in September 2004 through the single ISP.