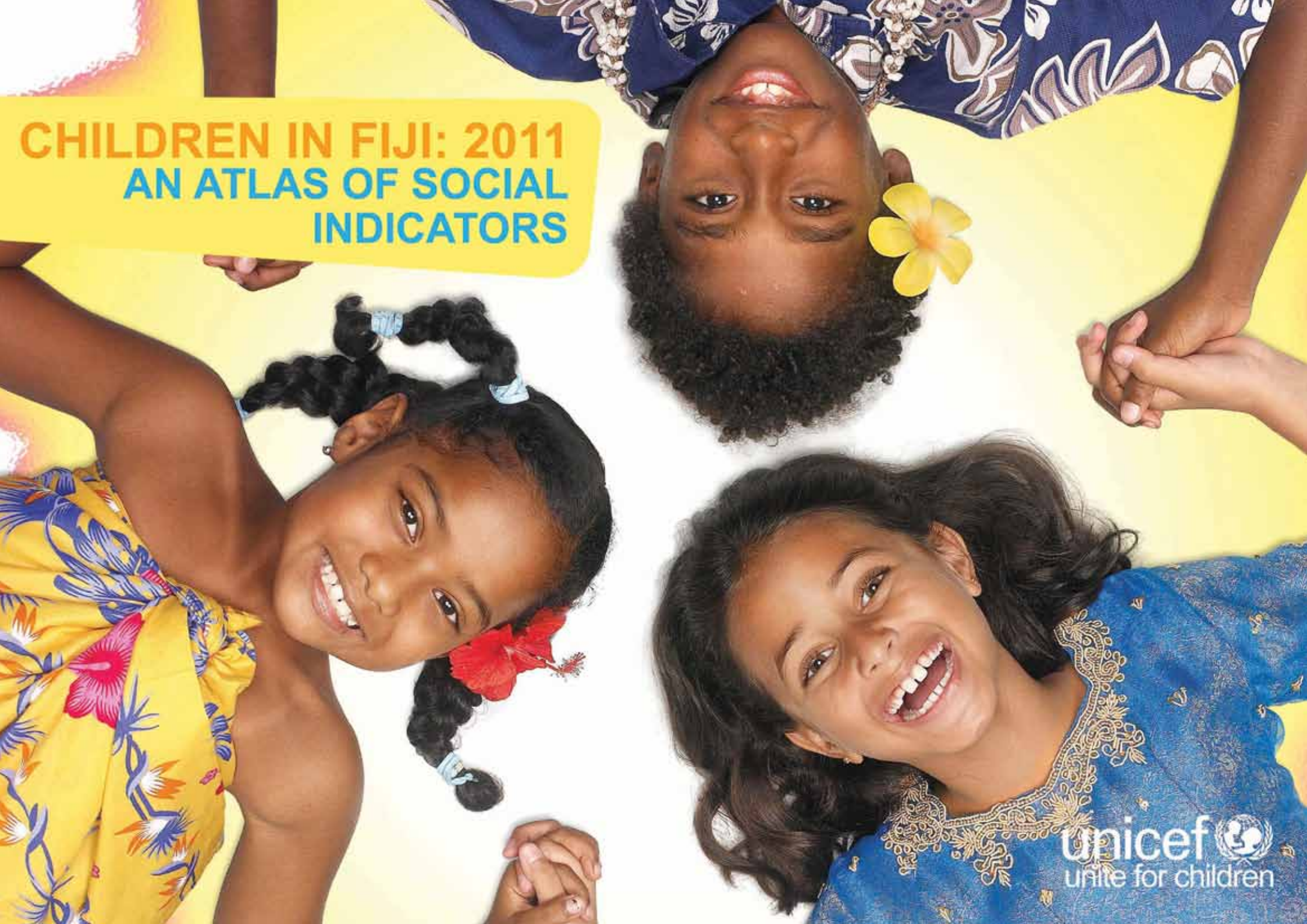


CHILDREN IN FIJI: 2011
AN ATLAS OF SOCIAL
INDICATORS



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Foreword

Children are our greatest resource. They are not just the link to tomorrow. They are the link to today.

This Atlas of Social Indicators provides a snapshot of children in Fiji today. It highlights progress in providing all children access to health, education, protection and economic security, and identifies areas of inequities.

The Government is grateful to UNICEF Pacific for the technical assistance provided in producing this Atlas. It will help the government and partners to make informed decisions in resource allocation and policy priorities for children's development. We are now able to better address inequities effectively and Fiji can accelerate progress towards the Millennium Development Goals and the Convention on the Rights of the Child.

While Fiji has made significant progress in the areas of poverty reduction, children's access to education, as well as the reduction of infant and child mortality rates, focused and concerted action is needed for a better environment for our children.

We will use this Atlas to ensure that every child in Fiji has the best opportunity to grow and develop holistically, through their experiences of education, family and community life.

This requires us to examine our priorities at all levels – from household to public policy, because focusing on children presents great opportunity to change our world. By investing in our children we are building a great family, community and country.

Let us accept that challenge.



Pita Wise

Permanent Secretary for Strategic Planning, National Development and Statistics

Introduction

Children in Fiji: An Atlas of Social Indicators provides a snapshot of the situation of children throughout the nation, with a particular emphasis on the most vulnerable children and sub-national patterns of equity. The report also examines progress made towards achieving the UN Millennium Development Goals (MDGs), in particular those goals and targets with special relevance to children.

The Atlas is based on core social indicators provided by UNICEF and Government partners and builds on a range of survey and administrative data sources, such as the Fiji Census 2007, Household Income and Expenditure Surveys (HIES), national MGD reports, annual reports from the Ministries of Education and Health, UNGASS and UNICEF Child Protection baselines.

In mapping areas of deprivation and disparity for children and women, the Atlas lays the foundation for an effective response to such inequities. The information it contains is designed to inform the choices made by decision-makers in allocating resources and determining policy priorities.

Ongoing research and analysis confirms that impoverished child populations suffer from the highest concentrations of disease, ill health, illiteracy and abuse and face a much higher risk of dying before the age of five. In this context, a recent UNICEF study found that an equity-based approach to improving the situation of children and women could move us more quickly and cost-effectively towards meeting MDGs 4 and 5 by the 2015 MDG deadline.¹

An equity-based model focuses on strengthening services for all children; removing barriers that prevent the poorest from using services; and making greater use of community-based workers to deliver essential services.

It is hoped that the Government of Fiji, civil society and development partners will use the information brought to light in this Atlas to inform policies and programmes that reduce child disadvantage and give all children an equal opportunity to grow and develop their full potential, no matter where they live.

¹ UNICEF, *Narrowing the Gaps to Meet the Goals*, 2010.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome	MARP	Most-At-Risk Populations
BNPL	Basic Needs Poverty Line	MDGs	Millennium Development Goals
CWD	Children with Disabilities	MoE	Ministry of Education
EA	Equity Atlas	MoH	Ministry of Health
EFE	Education for All	MSPNDS	Ministry of Strategic Planning, National Development & Statistics
ECE	Early Childhood Education	NCCC	National Coordinating Committee on Children
EPI	Expanded Programme on Immunization	NFPL	Non-Food Poverty Line
FBOS	Fiji Bureau of Statistics	PWD	People With Disabilities
FJC	Fiji Junior Certificate	SGS	Second Generation Surveillance Survey
FPL	Food Poverty Line	TRB	Teacher Registration Board
FSLC	Fiji School Leaving Certificate	UN	United Nations
FSFE	Fiji Seventh Form Examination	UNCRC	United Nations Convention on the Rights of the Child
FWCC	Fiji Women's Crisis Centre	UNESCO	United Nations Educational Scientific and Cultural Organisation
GDP	Gross Domestic Product	UNGASS	United Nations General Assembly Special Session
HIES	Household Income and Expenditure Survey	UNICEF	United Nations Children's Fund
HIV	Human Immunodeficiency Virus	WHO	World Health Organisation
ILO	International Labour Organisation		

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1 DEMOGRAPHY

Demography

Overview

Fiji is situated in the South Pacific Ocean and comprises 330 islands, about 110 of them inhabited. Most of the population is on the two main islands of Viti Levu and Vanua Levu. The country has four administrative divisions, which are subdivided into 14 provinces. Central division (capital Suva) contains the provinces of Naitasiri, Namosi, Rewa, Serua and Tailevu; Northern (capital Labasa) has Bua, Cakaudrove and Macuata; Eastern (capital Levuka) covers Kadavu, Lau and Lomaiviti and Western (capital Lautoka) covers Ba, Nadroga-Navosa and Ra.

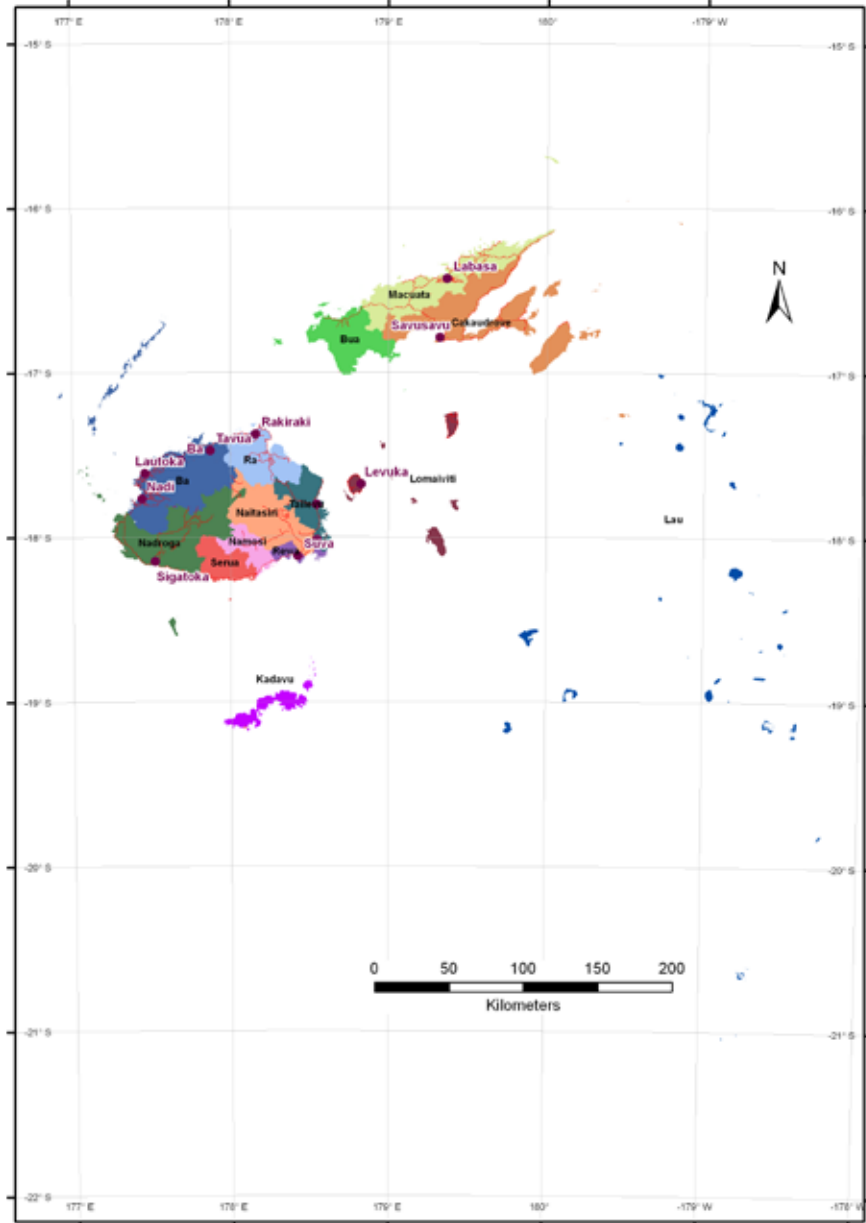
Fiji has a relatively young population, with children 0-18 years constituting nearly 40 per cent of the entire population (Census 2007). The total population of 837,271 comprises iTaukei (57 per cent), Indo-Fijians (37 per cent) and other ethnic groups (6 per cent).

Fifty-one per cent of the population lives in urban areas and 49 per cent in rural areas. In the past two decades, Fiji's ethnic composition has changed significantly. Between 1996 and 2007, the iTaukei population increased by 82,164 persons, while the Indo-Fijian population decreased by 25,020. This decrease has been attributed to high emigration rates and declining fertility in the Indo-Fijian community (FBOS, 2008).

The national population growth rate stands at about 0.7 per cent per year. Despite this low growth, it is projected that Fiji's population "will reach the one million mark in 2030" (FBOS, 2008:2).

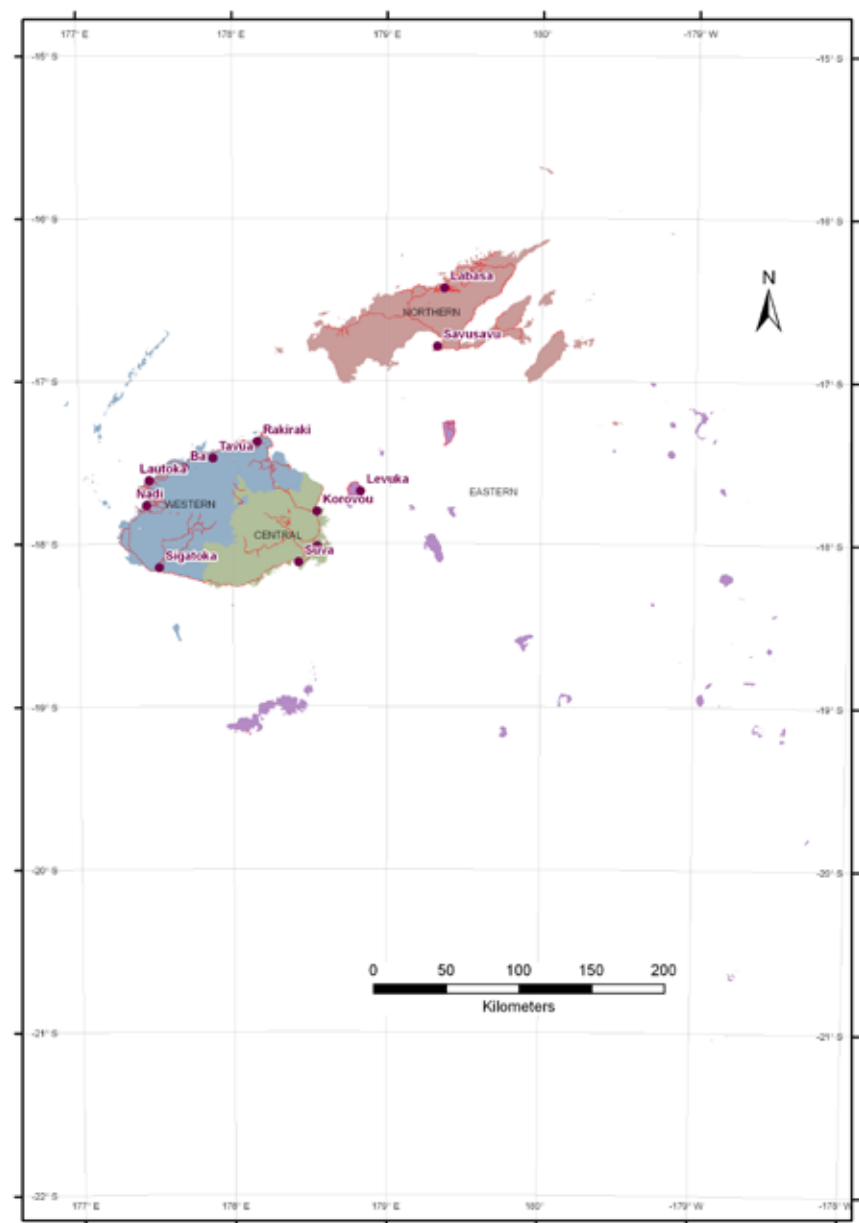
The province of Naitasiri, in particular the urban area of Nasinu and parts of the Suva-Nausori corridor, were identified in the 2007 Census as areas of major growth for both iTaukei and Indo-Fijian populations. This growth has been attributed largely to movement from rural to urban areas and changes in urban and town boundaries (FBOS, 2008). The rapid rate of urbanisation will continue to place pressure on the Government to provide resources and educational and health infrastructure to cater for families, in particular, children and women. In 2008, the life expectancy at birth was 66 years for males and 72 years for females (WHO, 2008).

Map 1.1 Fiji by provinces



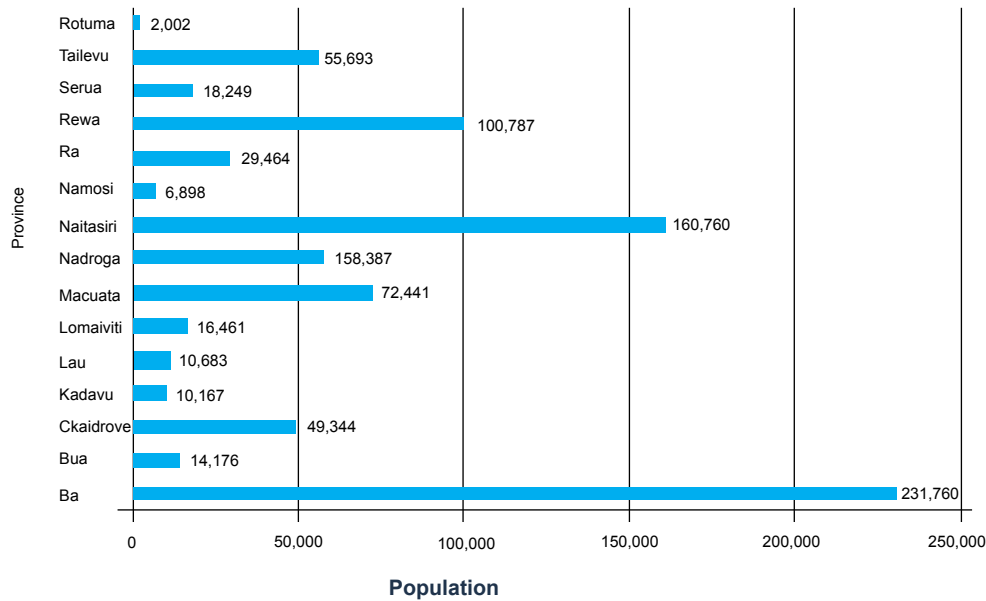
Source: Fiji Bureau of Statistics, Key Statistics 2011

Map 1.2 Fiji by divisions



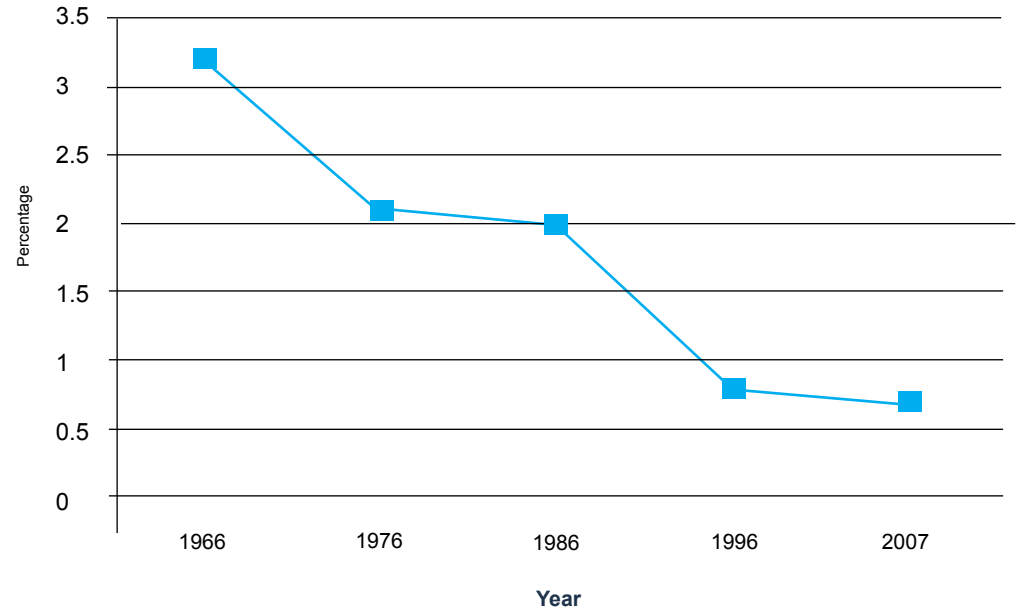
Source: Fiji Bureau of Statistics, Key Statistics 2011

Figure 1.1 Population by province (2007)



Source: FBOS, Key Statistics 2011

Figure 1.2 Population Growth Rate (%), 1996-2007



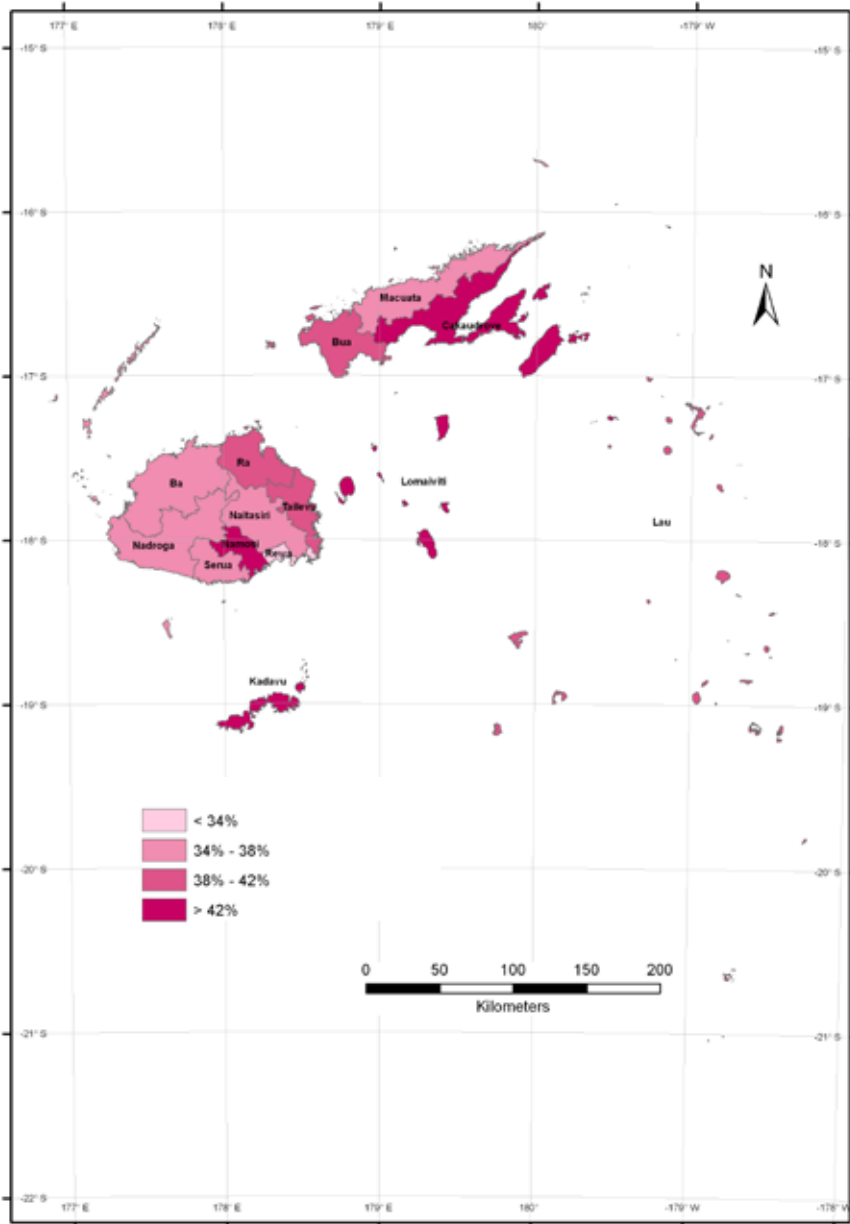
Source: FBOS, Key Statistics 2011

Fiji's population is concentrated in the provinces of Ba, Naitasiri and Rewa, which are also home to the main urban centres of Nadi, Lautoka, Nasinu, and Suva. The maritime provinces of Rotuma, Lau, Kadavu and Lomaiviti have lower populations than those on the two main islands, Viti Levu and Vanua Levu. In the remote, less populated areas, geographic barriers, limited and costly transportation and a lack of resources tend to reinforce deprivation and inequity.

More than 180 squatter or informal settlements exist in Fiji and they are home to an estimated 125,000 people or about 15 per cent of Fiji's population. The largest concentration of squatter settlements (about 100,000 people) can be found along the Suva-Nausori corridor. These settlements generally lack the basic amenities of clean water, electricity and sewerage systems. Poverty, inadequate housing, crime and related social issues are rife in these areas (NZAID, 2011).

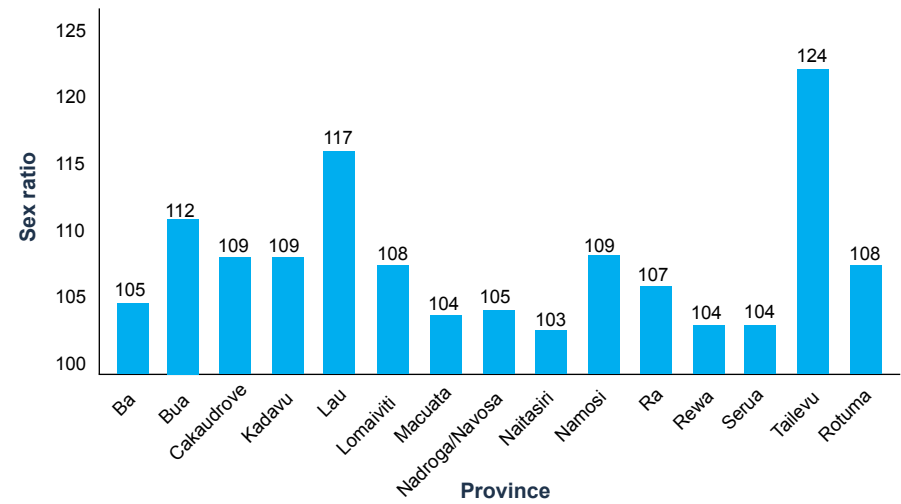
An estimated 15 per cent of Fiji's population lives in squatter or informal settlements

Map 1.3 Children (0-18 years) as a percentage of the total population (2007)



Source: Fiji Bureau of Statistics, Key Statistics 2011

Figure 1.3 Number of male children per 100 female children by province (2007)



Source: Fiji Bureau of Statistics, Key Statistics 2011

The 2007 Census recorded that Fiji had a population of 322,639 children, which is close to 40 per cent of the total population. Almost half of all children nationwide live in two provinces, Ba and Naitasiri, where Fiji's main urban centres are situated. The large population of children in these provinces presents the Government with a continuing challenge to meet the growing demand for education and health resources.

In human populations, it is normal for more boys to be born than girls and the sex ratios at birth typically range between 103 and 107. Nationwide, Fiji had 107 male children per 100 female children in 2007, ranging from a low of 103 in Naitasiri to a high of 123 in Taillevu.

Almost half of the child population is concentrated in Ba and Naitasiri

Figure 1.4 Rural population pyramid - Proportional age-sex structure of the rural population (% , 1996-2007)

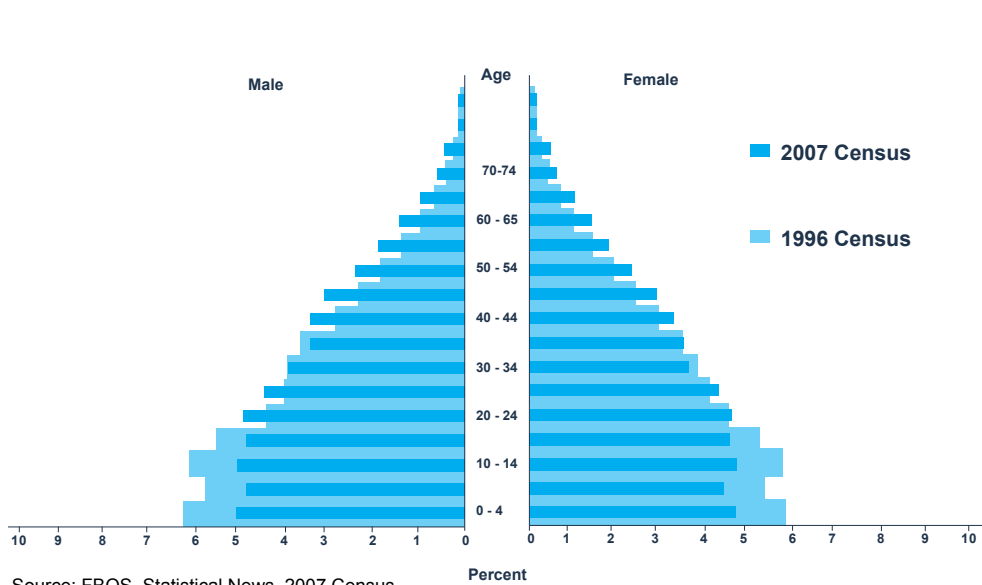
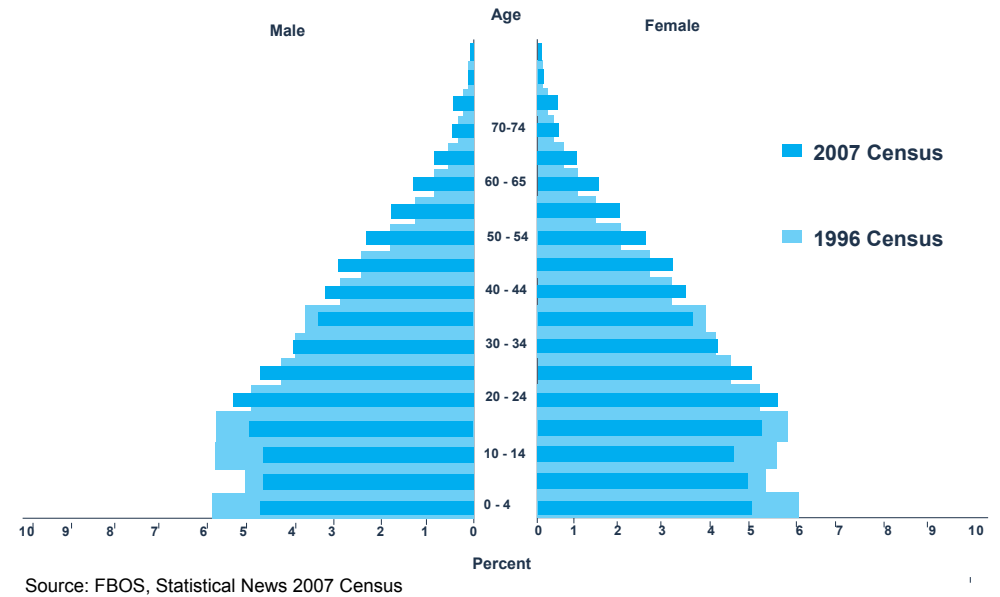


Figure 1.5 Urban population pyramid - Proportional age-sex structure of the urban population (% , 1996-2007)



The Fijian age-sex pyramid has gradually narrowed at the base as a result of a general decline in fertility (FBOS, 2008). The relative size of the child population to the total population has declined both in urban and rural areas. Fiji is slowly going through a demographic transition with relatively low mortality rates while birth rates are coming down too. These changes in the country's age structure have important socioeconomic consequences. For example, a growing number of youth is entering the labour market every year.

Fiji is going through a demographic transition with declining mortality and fertility rates



2 SOCIO - ECONOMIC DEVELOPMENT

Socio-economic development

Overview

The success of Fiji's development initiatives is dependent on the country's economic performance. During the past two decades, Fiji shifted from an import-substitution approach to one of trade liberalisation yet this has not been translated into strong economic growth.

In fact, the country recorded nine years of negative growth between 1970 and 2006. Economic growth over the past few years has fluctuated, ranging from 3.6 per cent in 2006 to 2.5 per cent in 2009 (MSPNDS, 2008). The poor economic growth has reduced income and work prospects and the resulting financial and emotional strains have had an adverse effect on families. Fiji's lagging economy has been attributed to "intermittent political instability, poor economic and financial management and the expiry of land leases since 1997" (MSPNDS, 2010:2).

The Government is committed to stimulating the economy and meeting its social development obligations. Economic measures include encouraging foreign investment; reforming and supporting traditional sectors such as tourism, sugar, mining, textile production and agriculture, declaring tax-free regions in underdeveloped parts of Fiji and creating employment opportunities (Ministry of Finance and National Planning, 2008; Ministry of Strategic Planning, National Development & Statistics, 2010).

In terms of health, higher priority has been given to infant and maternal health and to the delivery of preventative services. The Government is focusing on improving the quality of education delivery and ensuring accessibility for disadvantaged groups such as people with disabilities and those living in remote areas (Ministry of Strategic Planning, National Development & Statistics, 2010).

**Fiji's economic growth has been
weak and highly volatile**

Table 2.1 GDP per capita (US\$, 2006-2009)

Year	2006	2007	2008	2009
GDP per capita	3,724	4,030	4,224	3,326

Source: World Bank

Fiji's Gross Domestic Product (GDP) per capita puts the country into the 'middle-income' category. While there were notable increases in 2007 and 2008, GDP per capita declined in 2009.

Table 2.2 Government allocations for health and education (FJ\$, 2005-2009)

Government Allocation	2005	2006	2007	2008	2009
Health	136.8	136.8	155.3	139.5	152
Education	260.4	301.1	320.6	296.4	NA

Source: MoH and MoE Annual Reports

Government allocations for health and education vary. The health budget remained constant in 2005 and 2006, but fluctuated between 2007 and 2009. The education budget, on the other hand, increased from 2005 to 2007 then declined in 2008. The percentage allocation of the national budget for these sectors has remained constant - from 9-10 per cent for health and 19-20 per cent for education.

The percentage budget allocation for health and education remained constant from 2005-2009

Table 2.3 Pacific Island Countries Human Development Index and rank

Pacific Island Countries	HDI	Rank
Tonga	0.704	90
Samoa	0.688	99
Fiji	0.688	100
Solomon Islands	0.510	142
Vanuatu	0.617	125
PNG	0.466	153
Federated States of Micronesia	0.636	116

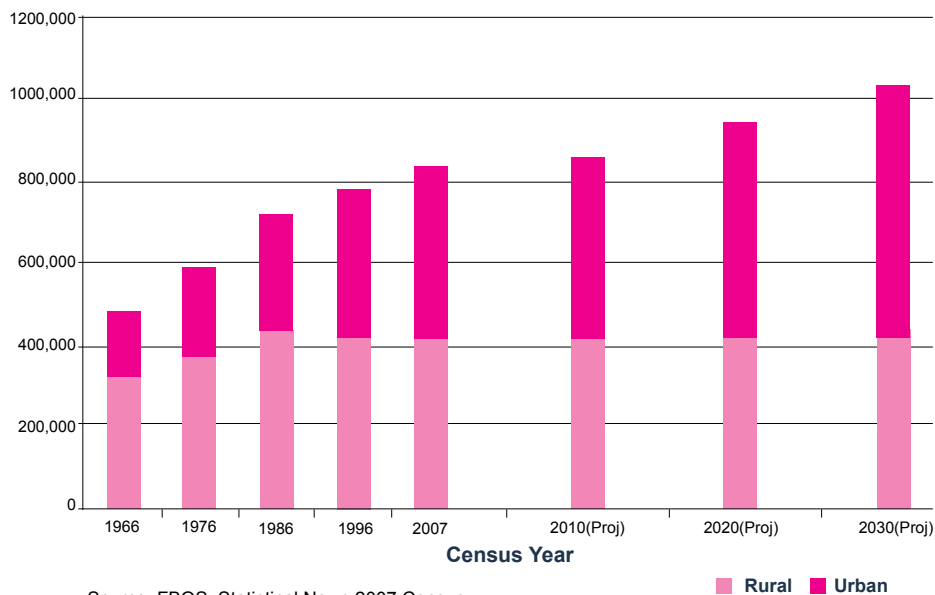
Source: UNDP Human Development Report 2011

The UN's Human Development Index (HDI) is a composite statistic used to rank countries on a number of development indicators. It measures the average achievements in a country in three basic dimensions of human development: a long and healthy life (health), access to knowledge (education) and a decent standard of living (income).

Fiji is ranked 100th of 187 countries on the 2011 Human Development Index – ahead of Solomon Islands, Vanuatu, Papua New Guinea (PNG) and Federated States of Micronesia (FSM), but below Tonga and Samoa. Fiji's HDI value is 0.688, which places it in the 'medium human development' category.

Urbanization

Figure 2.1 Change in the rural-urban composition of the population between 1966 and 2007 and projected until 2030



Source: FBOS, Statistical News 2007 Census

Population projections to 2030 show continuing growth in urban areas. Fiji's urban population grew significantly between 1966 and 2007. Several factors contributed to this trend: rural-to-urban migration and a concomitant growth in squatter settlements; the expansion of Nadi and Lautoka town boundaries; and the incorporation of Nasinu as a town.

About 40 per cent of Fiji's urban population live in Nasinu (FBOS, 2008). It will be vital to assess the impact of decreasing 'personal space' on living conditions, in particular, access to water, proper sanitation and personal and food security for children. Lack of personal space for children can be detrimental to their development as well as increasing their vulnerability to a range of risks.

The challenge for Government will be to make decisions and policies on rural and urban development that are informed by evidence-based research.

Table 2.4 Urban growth rates (1995-2010)

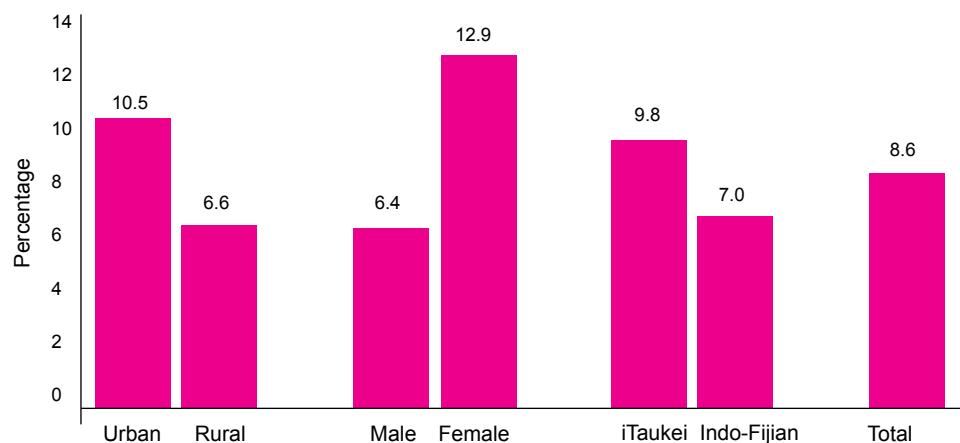
	1995-2000	2000-2005	2005-2010
World	2.19	2.07	1.98
Least Developed Countries (LDC)	2.96	2.68	2.53
Fiji	2.07	1.66	1.60

Source: FBOS

Children's access to food, water and sanitation is challenged by rapid urban growth

Income and Employment

Figure 2.2 Unemployment rate by socio-demographic characteristics (2007)



Source: Fiji Bureau of Statistics, Census 2007.

Fiji's overall unemployment rate has increased from 3.7 per cent in 1996 to 8.6 per cent in 2007 (FBOS, 2009). Rural unemployment was significantly lower at 6.6 per cent than urban unemployment at 10.5 per cent. Gender disparities remain strong with female unemployment twice as high as male unemployment. Moreover, unemployment was somewhat higher among iTaukei (9.8 per cent) than Indo-Fijians (7.0 per cent).

Table 2.5 Shares of income sources in total household income (2002-2008)

Income source	2002	2008	%-change
Wages from permanent employment	43	44	4
Wages from casual employment	11	10	-15
Agricultural business	10	7	-28
Commercial business	7	4	-43
Subsistence (home production)	8	5	-32
Foreign remittances	2	4	134
Local remittances	1	1	39
Gifts received	2	4	99
Other	17	25	25
Total	100	100	-

Source: Narsey (2012) based on HIES 2002/03 & 2008/09

In 2008, paid employment comprised 54 per cent of all household income, while income from the productive sectors (agricultural business, commercial business and subsistence production) accounted for 16 per cent (Narsey, 2012). Transfers (remittances and gifts received) comprised another 9 per cent. Between 2002 and 2008, the relative share of transfers in household income has doubled, while the share of productive sectors has decreased dramatically.

Unemployment is higher in urban than rural areas
Females are twice as likely to be unemployed as males

Poverty

Poverty in Fiji is measured using a Basic Needs Poverty Line (BNPL), estimated to be about \$175 per week for a household of four (FBOS, 2010:10). Based on this threshold, 31 per cent of the national population was classified as being poor in 2008/09, down from 35 per cent in 2002/03.

While poverty in urban areas dropped dramatically from 28 to 18 per cent (a reduction of 34 per cent) over this period, poverty in rural areas increased by 6 per cent from 40 to 43 per cent. Moreover, children are disproportionately affected by poverty, with half of all families with two or more children living in poverty.

According to the Ministry of Strategic Planning, National Development & Statistics (2010), the high incidence of rural poverty is compounded by increasing rural-to-urban migration due to expiring land leases and growth in the number of people living in squatter and informal settlements, about 45,000 people in 1999 to about 125,000 people in 2011(NZAID, 2011).

Based on the current scenario, it is unlikely that Fiji will be able to 'Eradicate Extreme Poverty and Hunger' (MDG 1) by 2015. The government is, however, committed to strengthening the economy and putting in place employment-generation policies.

Addressing the challenges will benefit those caught in the cycle of poverty, particularly children for whom the early experience of deprivation can have a lifelong impact on development and opportunities. Children experience poverty differently from adults, with deprivations in nutrition, health, water, shelter and education affecting not only their current well-being, but also their future prospects.

**Between 2002/03 and 2008/09
urban poverty dropped by 34 per cent while
rural poverty increased by 6 per cent**

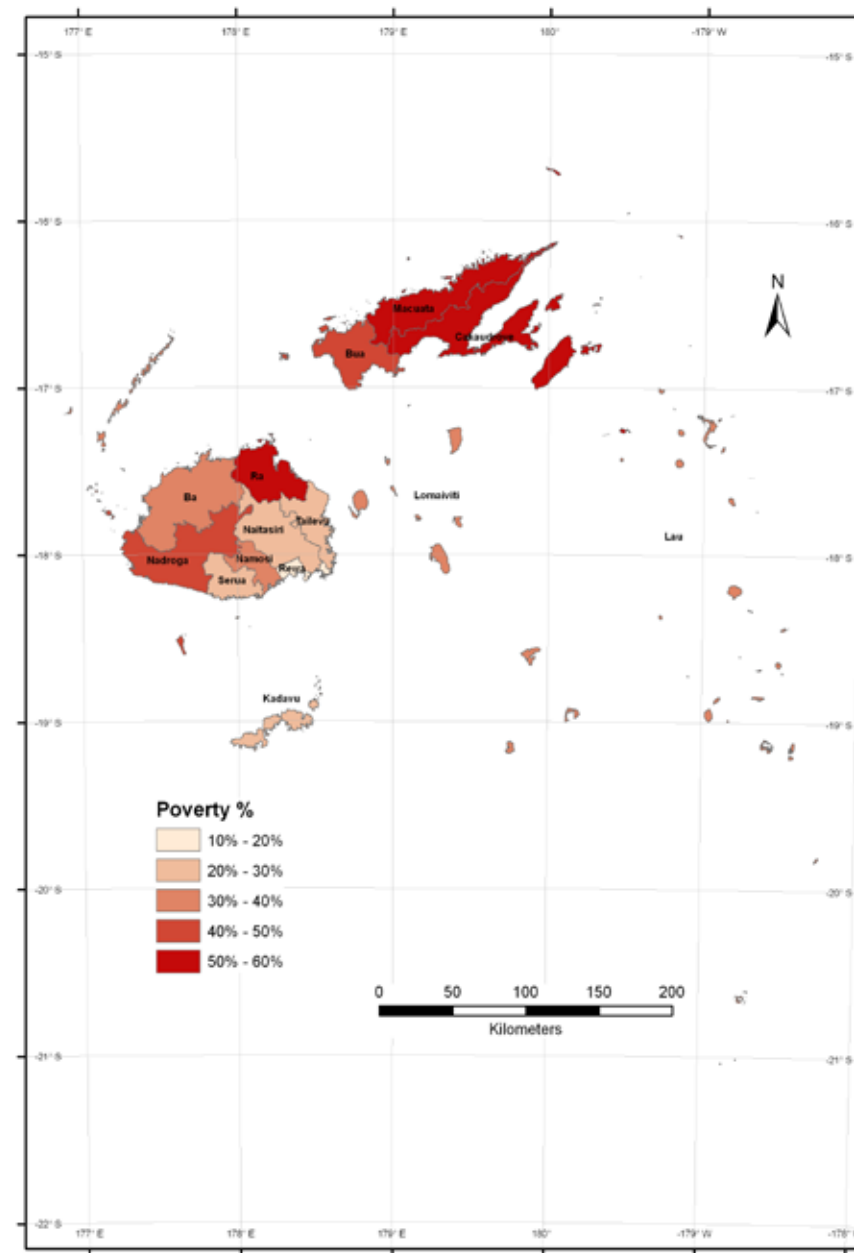
Table 2.6 Provincial-level poverty rate and gap based on national Census (%)

Region	Province	Proportion of population below the Basic Needs Poverty Line	Poverty gap	Number of poor
Western	Ba	37	10	83,579
Northern	Bua	47	16	6,566
Northern	Cakaudrove	55	20	26,470
Eastern	Kadavu	26	7	2,468
Eastern	Lau	31	8	3,215
Eastern	Lomaiviti	34	9	5,272
Northern	Macuata	51	18	35,181
Western	Nadroga / Navosa	42	12	23,054
Central	Naitasiri	25	6	38,665
Central	Namosi	32	8	2,131
Western	Ra	56	19	17,157
Central	Rewa	17	4	16,530
Central	Serua	26	6	4,619
Central	Tailevu	30	7	16,368
Rotuma	Rotuma	15	3	298

Source: World Bank (2011) based on HIES 2008/09 and Census 2007

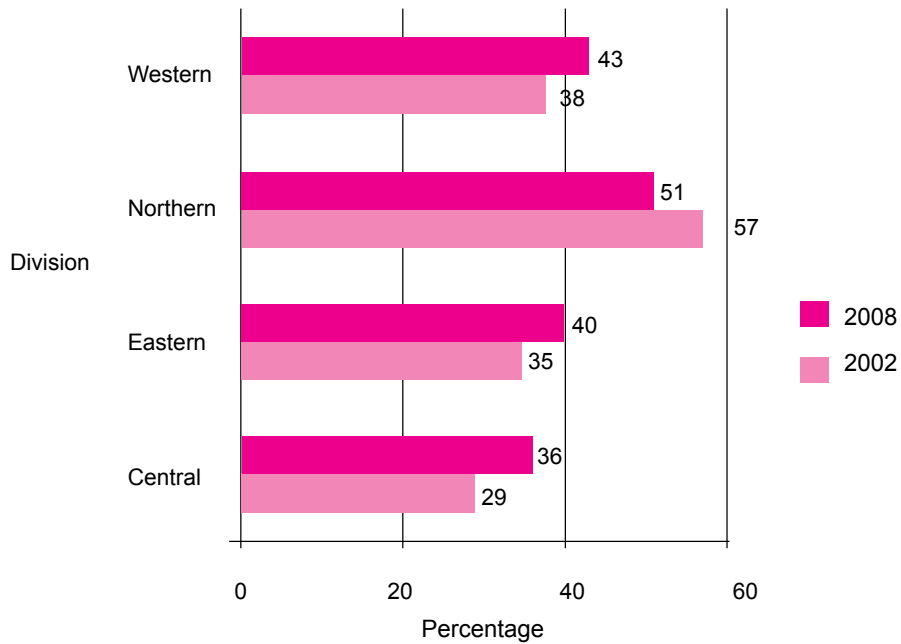
Of the four divisions in Fiji, the Northern division is the poorest, with 48 per cent of its population living below the BNPL. This is followed by the Eastern division with 38 per cent and the Western and Central divisions on 33 and 21 per cent respectively. There are also substantial differences in poverty rates across provinces. For instance, in the Central division, where the overall poverty rate is 24%, there are provinces with substantially higher poverty, such as Tailevu (30%) and Namosi (32%). The poverty rate ranges from 15% in Rotuma to 56% in Ra.

Map 2.1 Population below the Basic Needs Poverty Line by province (%)



Source: World Bank (2011) based on HIES 2008/09 and Census 2007

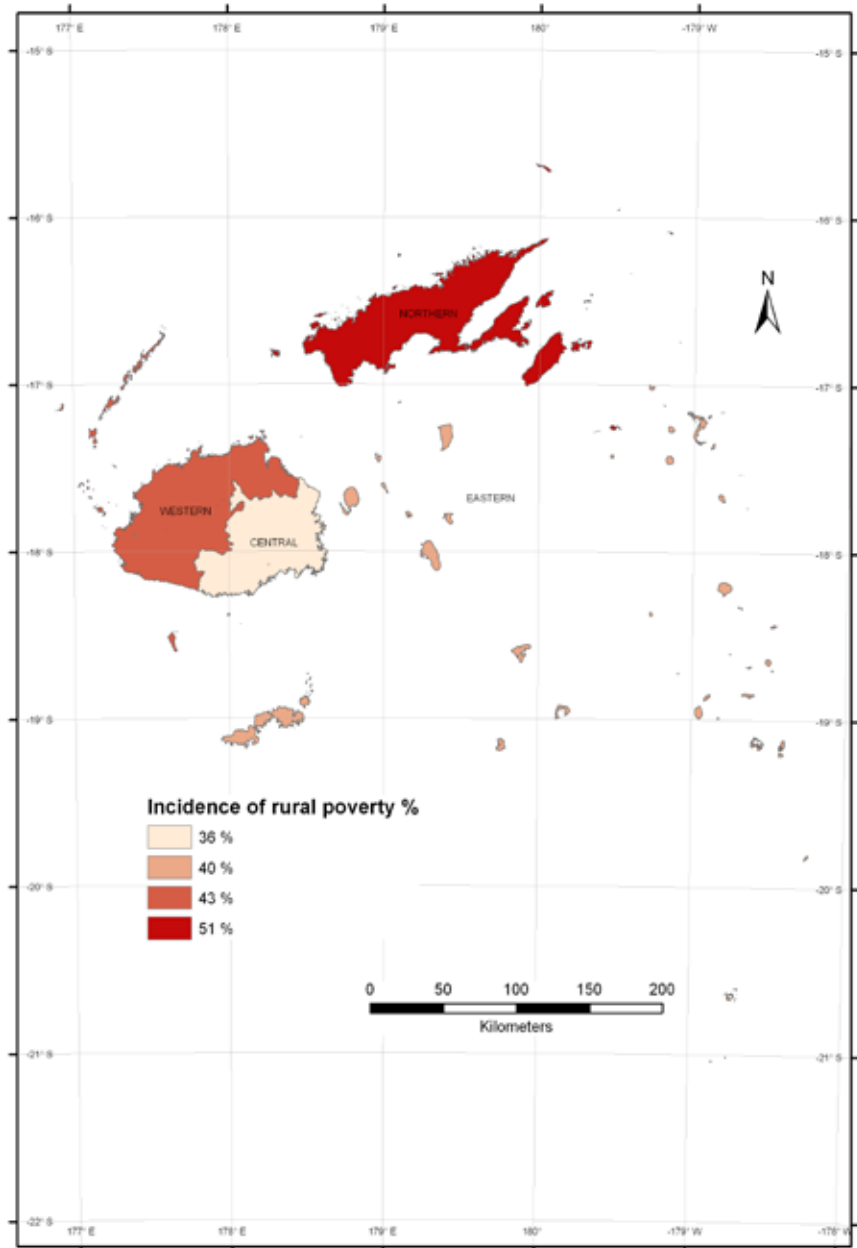
Figure 2.3 Percentage of population below the Basic Needs Poverty Line by rural division (% , 2002-2008)



Source: Fiji Bureau of Statistics, HIES Report 2010

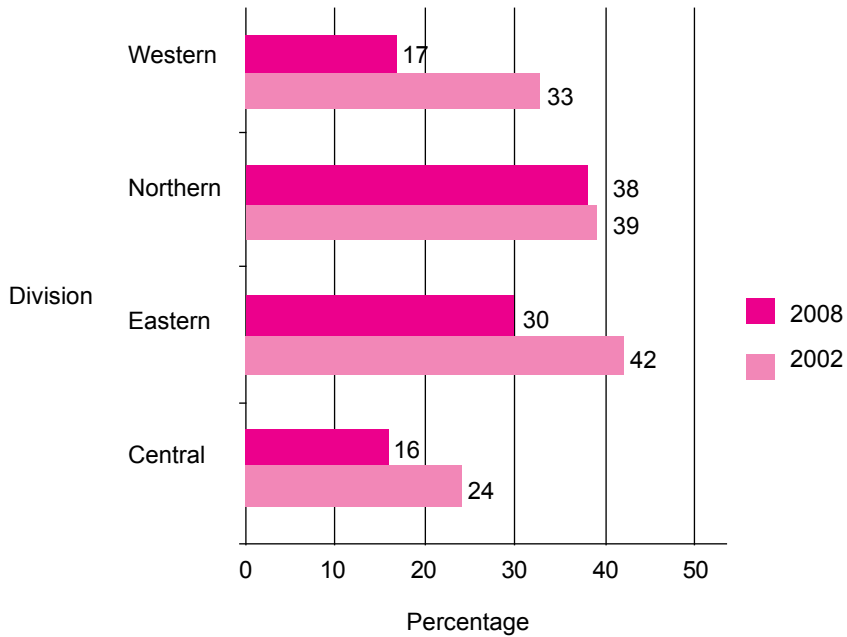
On the whole, rural children experience poverty more than their urban counterparts. Rural poverty in Fiji increased from 40 per cent in 2002, to 43 per cent in 2008. With the exception of the Northern division, all divisions experienced an increase in poverty. The 2008 HIES Report observed that the increase could be due to the “decline in the sugar industry and declining proportions and amounts of loans to agriculture” (FBOS, 2010:12). These factors, together with declining income opportunities, place children at risk of discontinuing school and having diminished opportunities in life.

Map 2.2 Percentage of population below the Basic Needs Poverty Line by rural division (% , 2002-2008)



Source: Fiji Bureau of Statistics, HIES Report 2010

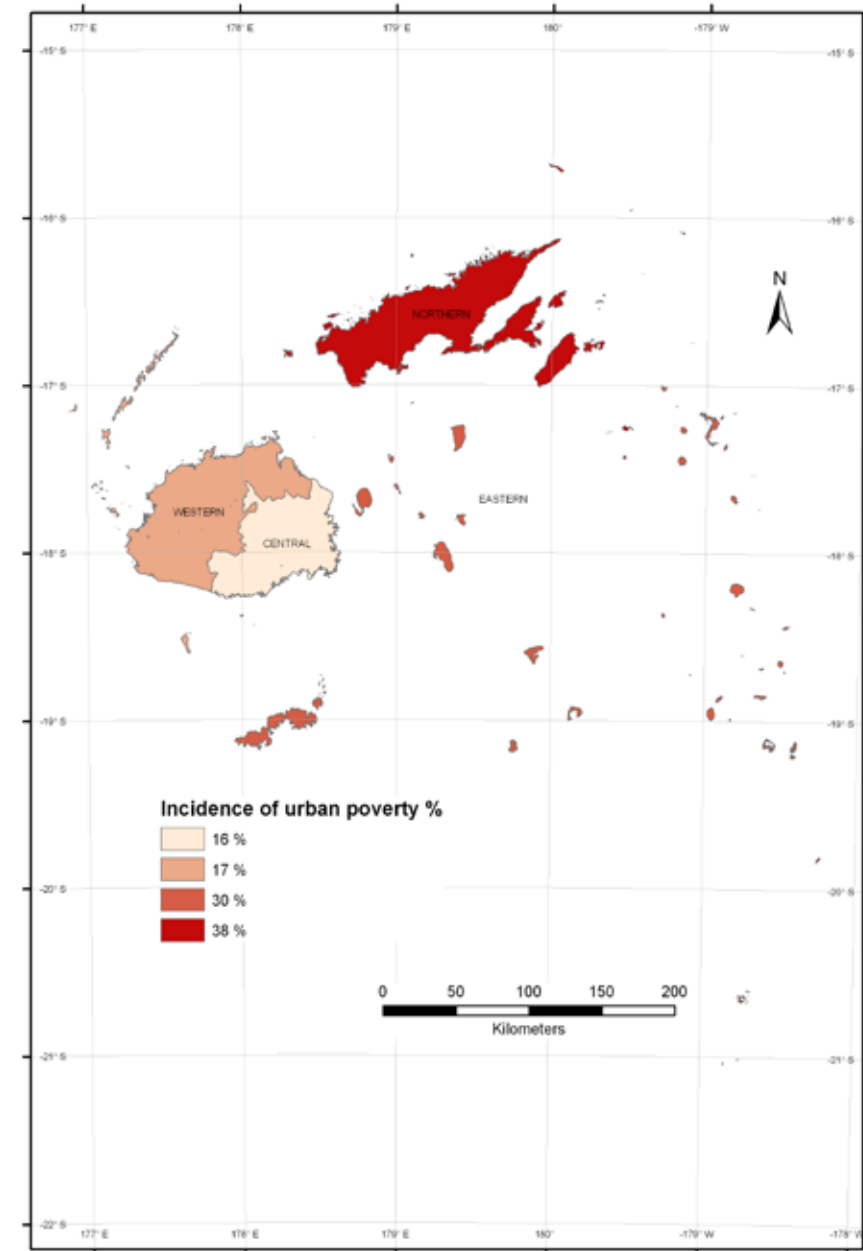
Figure 2.4 Percentage of population below the Basic Needs Poverty Line by urban division (% , 2002-2008)



Source: Fiji Bureau of Statistics, HIES Report 2010

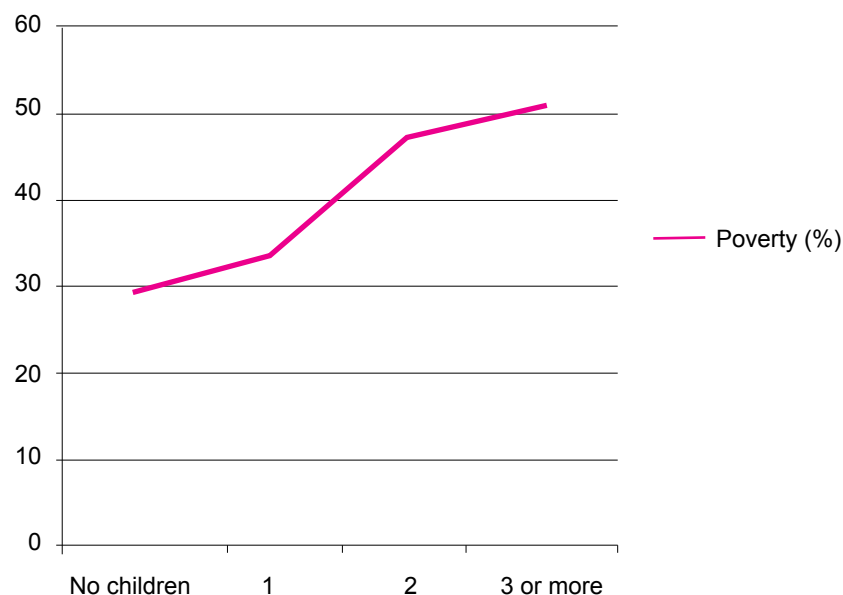
In contrast to the rural trend, the incidence of poverty across all urban divisions in Fiji decreased between 2002 and 2008. In the Western Division, the incidence of poverty almost halved. Income and economic opportunities are increasing in urban areas and as a result, children are more likely to experience improved life chances.

Map 2.3 Percentage of population below the Basic Needs Poverty Line by urban division (% , 2002-2008)



Source: Fiji Bureau of Statistics, HIES Report 2010

Figure 2.5 Household poverty by number of children in the household (2008/09)



Source: World Bank (2011) based on HIES 2008/09

Fijian households on average have two children and larger households with more children have higher poverty rates, which remains an important concern in the country. Almost half of households with two or more children are living below the basic needs poverty line. Households with both elderly and children are the poorest, with a poverty headcount of 52 per cent, while households with no elderly and children have a poverty headcount of 22 per cent. The high percentage of families with children living in poverty indicates the need for direct actions to raise children's wellbeing.

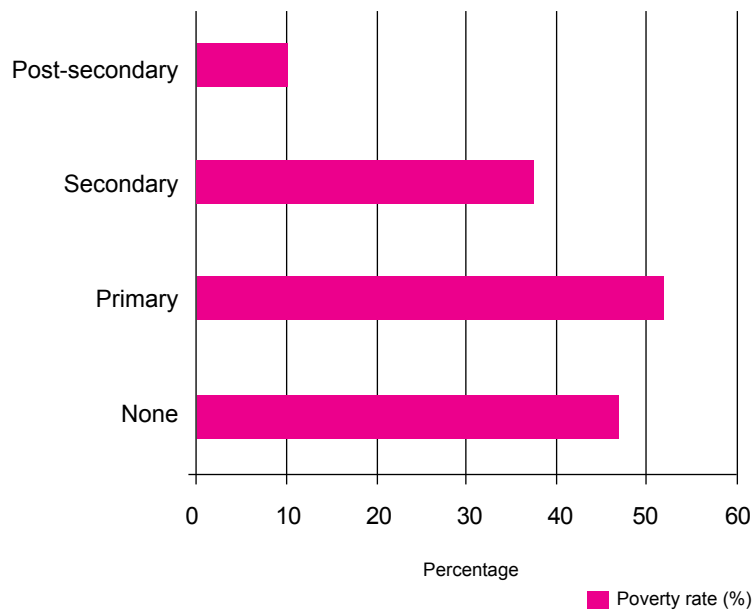
Table 2.7 Household poverty by presence of children (< 14 years) and elderly (+65 years) by rural-urban status (2002/03-2008/09)

Type of household	2002-03	2008-09	Change
National			
Households with elderly only	48%	45%	-3%
Households without elderly	38%	33%	-5%
Households with children only	43%	39%	-4%
Households without children	27%	24%	-3%
Households with both children and elderly	53%	52%	-1%
Households without children and elderly	25%	22%	-3%
Urban			
Households with elderly	44%	32%	-12%
Households without elderly	33%	25%	-8%
Households with children	38%	29%	-8%
Households without children	24%	18%	-6%
Households with both children and elderly	50%	42%	-7%
Households without children and elderly	23%	19%	-5%
Rural			
Households with elderly only	51%	54%	3%
Households without elderly	42%	41%	-2%
Households with children	47%	47%	0%
Households without children	30%	32%	2%
Households with both children and elderly	54%	58%	4%
Households without children and elderly	27%	28%	1%

Source: World Bank (2011) based on HIES 2008/09

Half of all families with two or more children live in poverty

Figure 2.6 Poverty rates and head of household education level (2008/09)



Source: World Bank (2011) based on HIES 2008/09

Education is an important determinant of poverty. The poverty rates in Fiji are higher for households where the head of the household does not have secondary education – at around 50 per cent versus 35 per cent overall poverty rate. Fiji has a well educated population and as such only 18 per cent of the population lives in households where the household head has less than secondary education. However, in the most populous group of secondary education, poverty is still quite high, as 40 per cent. Poverty is significantly lower for households with heads who have attained post-secondary education (10 per cent).

**Low levels of education
dramatically increase the
risk of poverty**

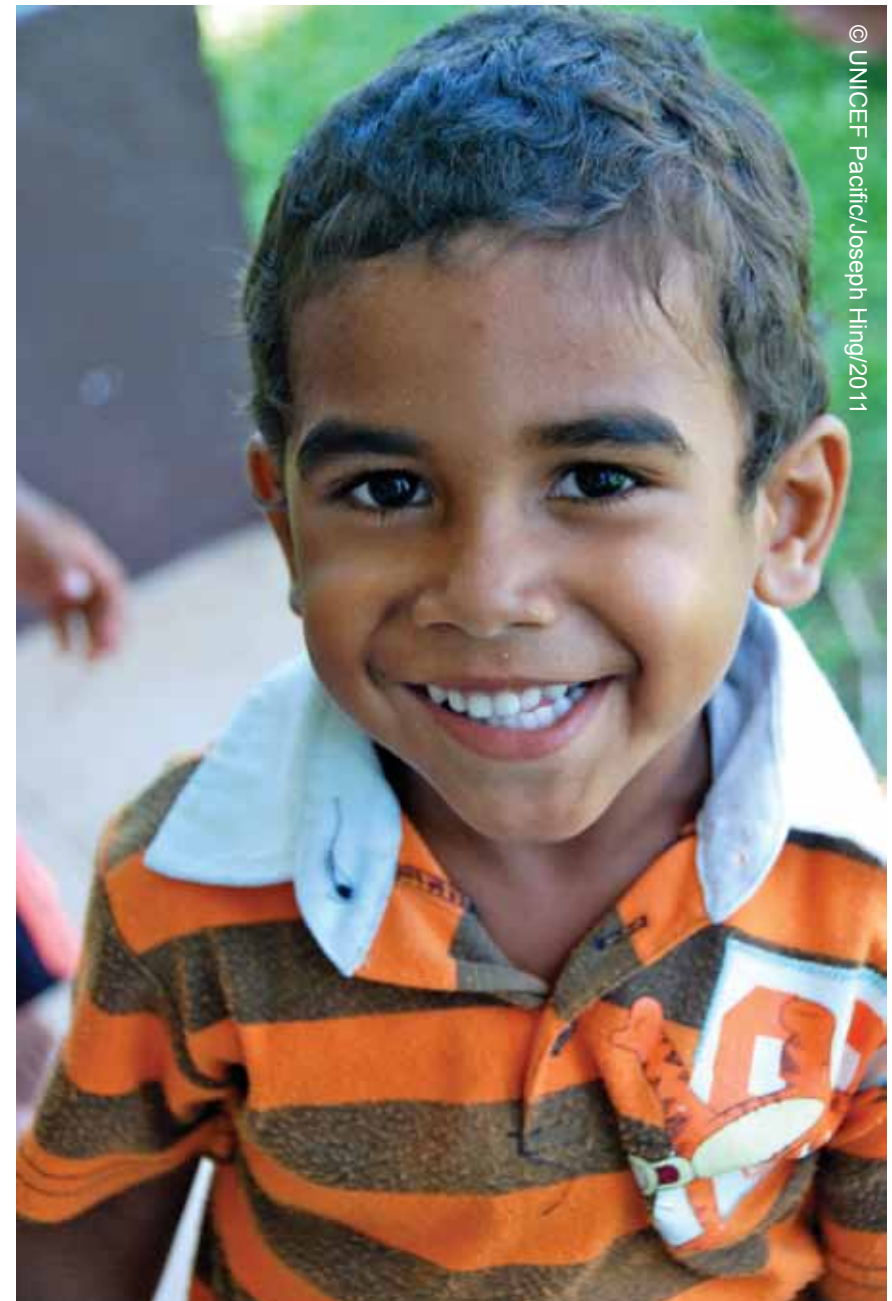
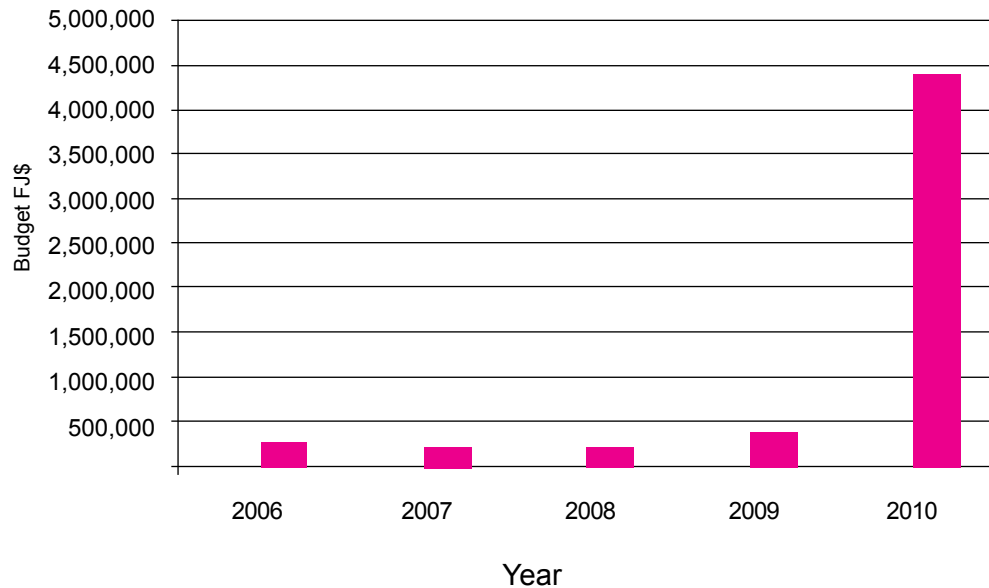


Figure 2.7 Government budget allocation for child allowances (2006-2010)



Source: MSPNDS, 2011

The Ministry of Social Welfare, Women and Poverty Alleviation, through its Care and Protection Allowance, gives parents and caregivers financial assistance for vulnerable children in their care. Families receive monthly payments of \$30 to \$100. Payment depends on criteria such as the number of children needing assistance, their age and educational status and whether the child has a disability (NCCC, 2011).

The marked increase in funds allocated in 2010 is the result of the Government's decision to transfer 4,000 recipients from the Family Assistance Programme (FAP) to that of Care and Protection. This reallocation of resources does indicate a stronger focus on the needs of children. However, only a small proportion of vulnerable families are benefitting from state support. World Bank estimates suggest that in 2008/09, only 3 per cent of the population benefitted from FAP. Taking into account the fact that resources are shared within household, it is estimated that about 13% of the population directly or indirectly benefited from the FAP.

It is estimated that only 3 per cent of the population benefited directly from the Family Assistance Programme in 2008/09



Monday
Yesterday
Tuesday
Today
Wednesday
Thursday
Friday
Saturday
Sunday

TERM 3
Week 8



NUMBERS

COLOURS

B	C	D	E	F	G
I	J	K	L	M	N
P	Q	R	S	T	U
V	W	X	Y	Z	

3 4 5 6 7 8 9 10

NUMBERS

one	two
three	four
five	six
seven	eight
nine	ten

Education

Overview

Fiji's current education theme, "Education for change, peace and progress" is guided by documents such as the Government's People's Charter for Change and Progress, UNESCO's Education for All (EFA) and the MDGs (MoE, 2008). Since independence in 1970, the education sector has made a great deal of progress. A significant milestone has been the achievement of MDG 3 'Achieve Universal Primary Education' (MSPNDS, 2010). The Government, through the Ministry of Education, is steadfast in its commitment to building an educated and informed nation and continues to work closely with national, regional and bilateral² partners in this process.

According to Fiji's second MDG Report, there are many continuing challenges for children in the education system. One challenge relates to the reality of non-completion at the primary school level due to socio-economic challenges faced by many families. For example, families in the poorest 30 per cent of Fiji's population spend the least on children's education in comparison to expenditure on other items (Narsey, 2008). Moreover, a recent study on child labour in Fiji (ILO, 2010) found that the majority of the 170 children living on the street who were interviewed, had left school at Class 8. The main reason (44 per cent) given for not completing school was lack of money for school fees.

Children with disabilities belong to one of the most disadvantaged groups when it comes to access to formal education. Many do not attend schools because they are restricted by school management while others are kept at home by parents and guardians. In such cases where children with disabilities do attend school, many do not make it beyond the primary level because of inadequate support and the absence of teachers with experience in working with special needs children (Tavola and Whippy, 2010). While special education falls within the ambit of the Ministry of Education's primary division, much needs to be done to achieve the aims of EFA and an all-inclusive education sector.

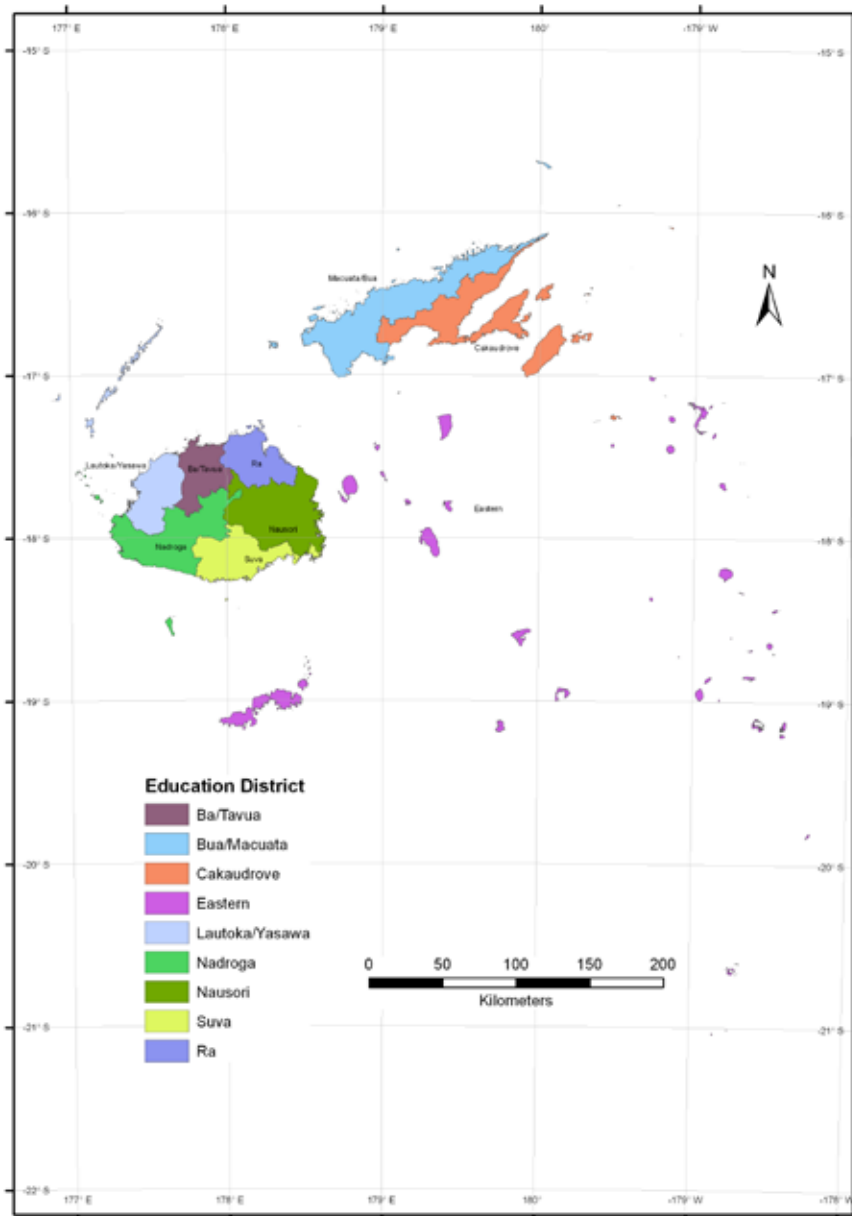
Fiji's commitment to improving the education of children is reflected in the development of the first ever 'Education Sector Strategic Development Plan 2008-2011'. The equitable allocation of resources to schools, in particular, highly disadvantaged schools, has been assisted by the development of a disadvantage index³ (MOE, 2008). In addition, the current government is focusing on accessibility to education and ensuring that students remain in school. To achieve this, it is progressively introducing targeted policies. These include the phasing out of external examinations until sixth and seventh forms and the introduction of a bus fare subsidy scheme.

There are plans to mainstream early childhood education and efforts to improve the quality of education delivery have seen the establishment of a Teacher Registration Board (TRB) in 2008. Students with special needs have been integrated progressively into the mainstream education system. For example, 200 students experienced this transition between 2006 and 2008 (MoE, 2008). In addition, Fiji now has 22 secondary schools that enrol students with disabilities.

² Some of these partners include AusAID, the European Union (EU) and UNESCO.

³ The index "classifies schools according to their level of disadvantages as determined by their location, water supply, electricity supply and conditions of utilities" (MoE, 2008:25).

Map 3.1 Overview of Education Districts



Source: Ministry of Education Website

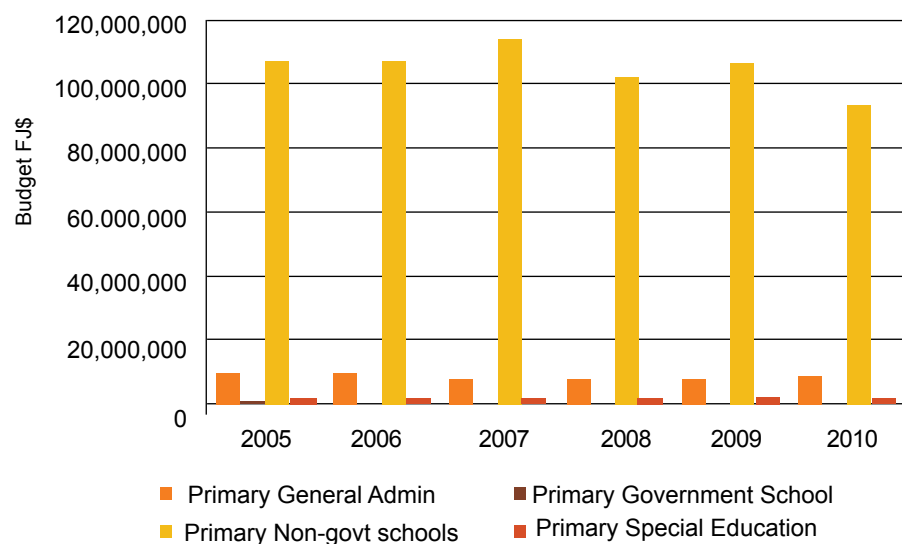
Fiji has four education divisions and each division is managed by a divisional Education Officer. A division consists of one or more education districts. There are nine education districts in total and each district is administered by a Principal Education Officer.

In terms of physical access, schools in remote areas, the interior of the large islands and small isolated islands are particularly disadvantaged because they are difficult to reach by roads and shipping services (MoE, 2008).

School zoning was implemented in urban primary and secondary schools in 2011. It involves the defining of catchment areas for schools at different levels by the Ministry of Education. Students who live within a school's home zone have absolute right to be enrolled in that school. The Ministry provides full transport assistance to eligible students attending schools within their school home zone, while costs for transport outside the zone have to be borne by the student's family. According to the Minister for Education, "zoning will lead to improvement of quality performance... as there will be an equal distribution of high, average and low achievers... will [also] remove social stratifications such as parents' occupation, socio-economic status, ethnicity and religious affiliations" (Fiji Government Online, 2011).

The newly introduced school zoning policy is expected to increase equitable access to quality education

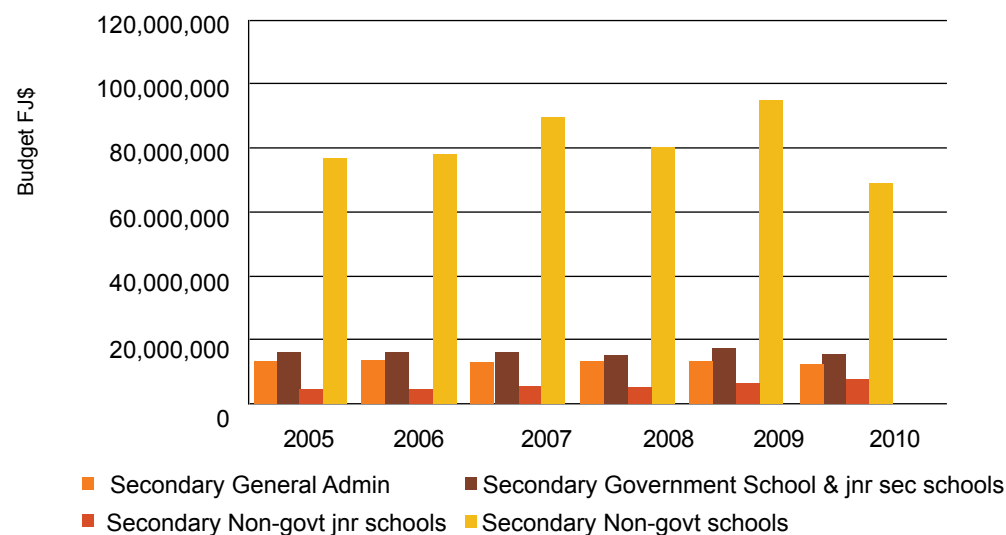
Figure 3.1 Budget allocation for primary education (2005-2010)



Source: MSPNDS, 2011

Primary education receives the greatest share of financial support from the education budget. From 2005 to 2010, the primary education sector received the most financial resources in 2007 and the least in 2010. While non-government schools received the most resources, funding for special education increased in 2009 and 2010. Non-government schools feature more prominently in funding statistics at primary and secondary levels. This is because less than 2 per cent of schools in Fiji are Government-owned (two primary and 13 secondary). The Government, however, subsidises most of the education costs, including tuition (Class 1 to Form 7) and salary grants (MoE, 2008).

Figure 3.2 Budget allocation for secondary education (2005-2010)



Source: MSPNDS, 2011

The highest budget allocation for secondary education in the 2005-10 period was recorded in 2009. The most significant budget increase in the secondary sector allocation was for non-government junior secondary schools. This reflected the government's commitment to supporting rural education in recognition of the fact that the majority of the junior high schools are situated in rural areas.

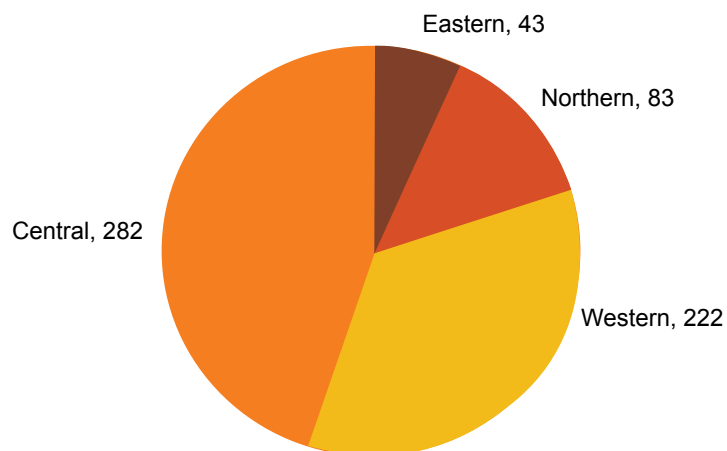
Public funding for primary and secondary education has decreased between 2005 and 2010

Early Childhood Education (ECE)

Early childhood education has grown in Fiji since the first pre-school opened in 1961 and there are now 630 recognised ECE Centres in the country. These centres are assisted by the Government through salary grants, building funds and materials such as teaching and learning resources. In 2007, the MoE developed an ECE policy and plans are underway to integrate ECE centres with primary schools within the same vicinity.

It is estimated that only 12 per cent of young children under the age of five eligible for EC programmes are accessing them (Waqanisau and Tuicama, 2009). Due to the absence of ECE data management systems, the average age of ECE enrolment cannot be ascertained. Moreover, available information on the number of ECE centres shown does not give an indication of issues related to access, delivery and the quality of programmes. It is clear, however, that provision of ECE centres is heavily skewed toward urban areas.

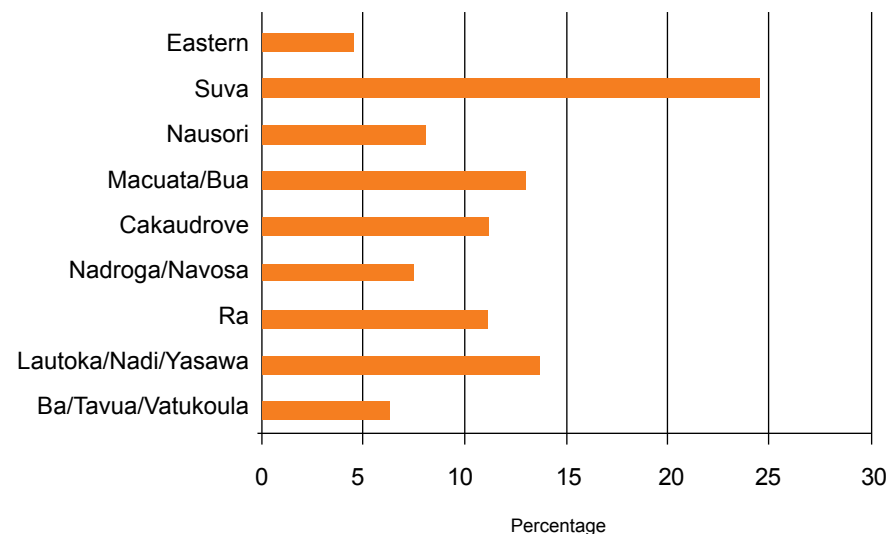
Figure 3.3 Distribution of ECE centres by division¹⁵



Source: MOE Strategic Development Framework 2009-2011, 2008

¹⁵ These figures were not dated. They were produced in the MoE's Strategic Development Framework 2009-2011.

Figure 3.4 Percentage distribution of children attending pre-school by geographic region (% , 2011)



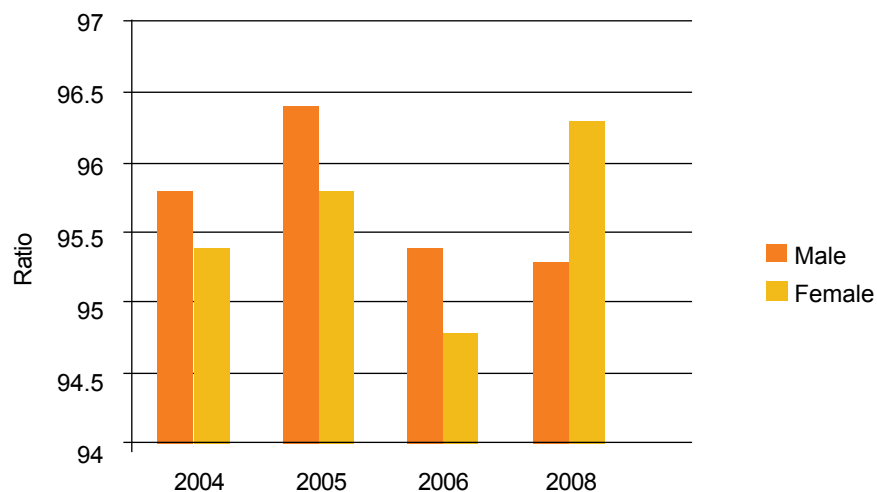
Source: Ministry of Education SIMS, October 2011.

Out of all five-year-old children attending pre-school nationwide, one in four (24 per cent) is located in Suva while less than five per cent are from the Eastern division. There is a clear disparity in ECE between Fiji's main islands (Viti Levu/ Vanua Levu) as compared to the outer, smaller remote islands in the Eastern division (Lau/Lomaiviti/Kadavu). This points to a need for government to provide more support to ECE in the outer islands and to ensure that children are not deprived of essential quality primary education preparedness.

Provision of ECE is skewed towards urban areas and mostly benefits urban children

Primary Education

Figure 3.5 Primary school net enrolment ratio by gender (2004-2008)

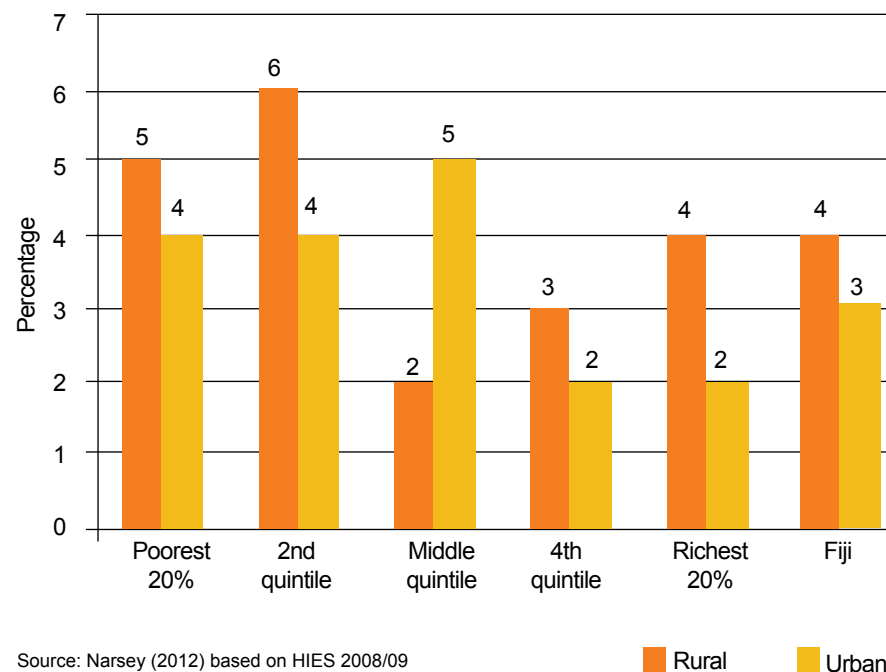


Source: Fiji Ministry of Education Annual Reports (Various issues)

Net Enrolment Ratio in Primary School refers to the proportion of children of the official age for primary education who are enrolled in primary schools. For male children, the ratio decreased slightly from 95.8 per cent in 2004 to 95.3 per cent in 2008. For female children, the ratio increased slightly from 95.4 per cent to 96.3 per cent over the same period. In absolute numbers, more female children are enrolled than male children.

Survey data on school attendance present a similar picture. Nationwide, 3 to 4 per cent of children aged 6-13 years in urban and rural areas were not at school during the time of the HIES 2008/09. The poorest children are most likely to be deprived of primary education. Some 5-6 per cent of rural children and 4 per cent of urban children in the poorest two quintiles were not at school.

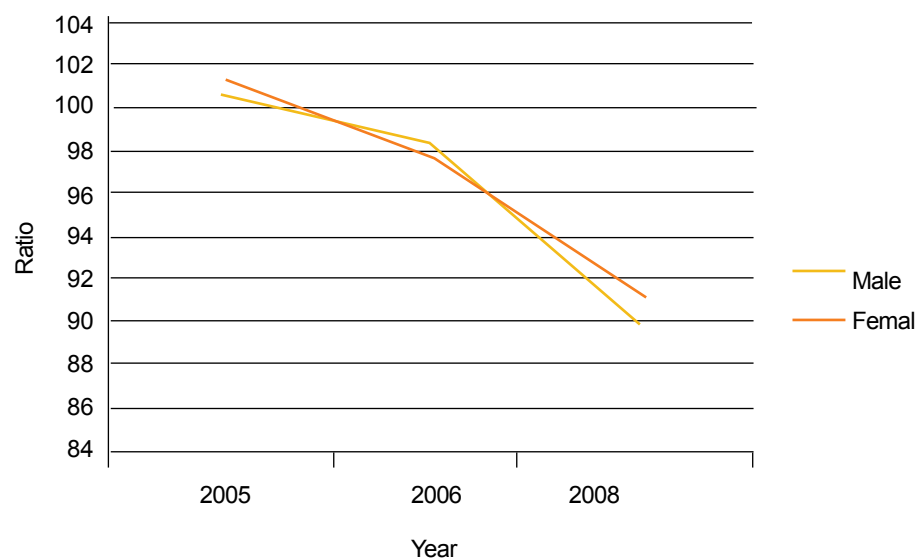
Figure 3.6 Percentage of children aged 6-13 years not attending school by quintile and urban-rural status (2004-2008)



Source: Narsey (2012) based on HIES 2008/09

Rural and urban children living in poverty are most at risk of being deprived of primary education

Figure 3.7 Basic primary completion ratio by gender (2005-2008)



Source: MDG 2nd Report for the Fiji 1990-2009, 2010

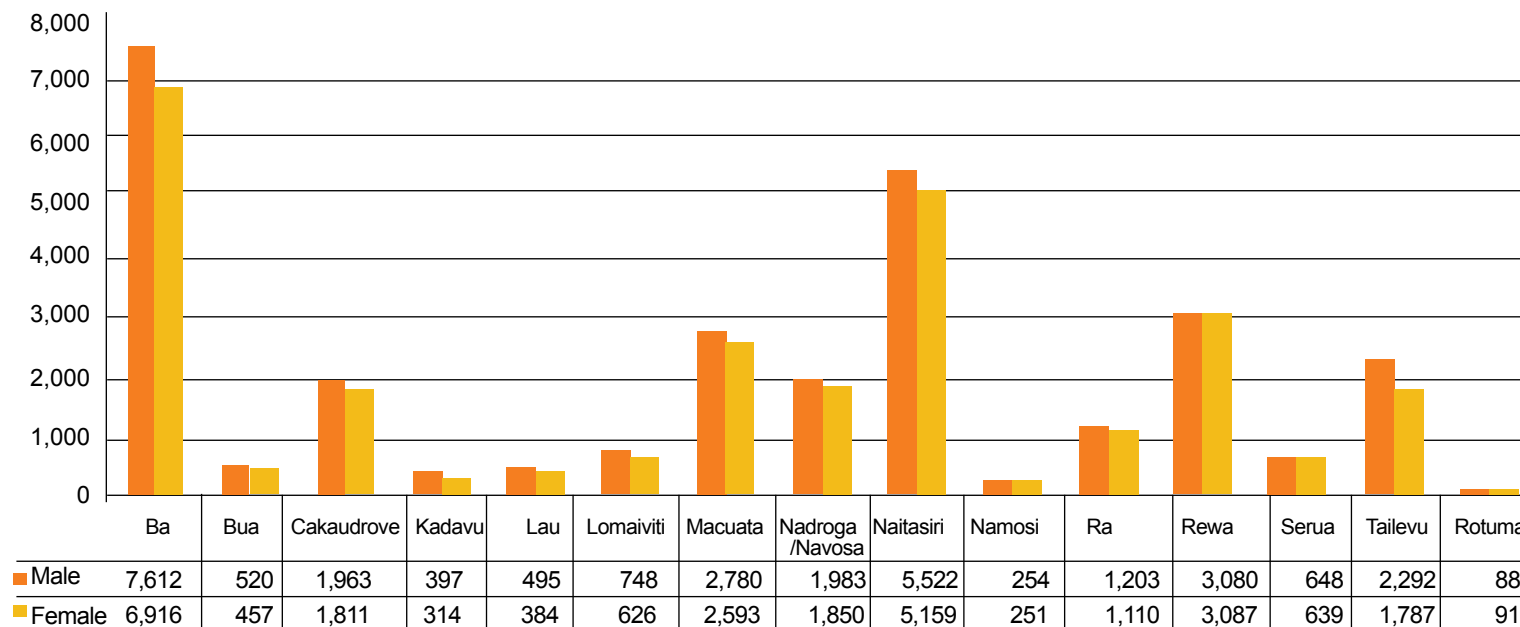
The primary completion rate is the ratio of the total number of students successfully completing the last year of primary school in a given year to the total number of children of official graduation age in the population. Fiji's primary school completion rate decreased from 100 per cent in 2005 to 90 per cent in 2008. This drop may be attributed to poverty and the impact of the sudden decline in the tourism industry in 2007. Reduced income from labour as well as marked increases in the cost of fuel and basic food items such as rice and flour, reduced many family's ability to pay for their children's education (Narsey, 2008). In response, the Government recently introduced free education and transport for children to improve school retention and to achieve MDG 2 (Universal Primary Education). More female than male children are completing primary school and though this augurs well for the empowerment of girls, it points to the need to examine the implications for male children.



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Junior Secondary and Secondary Education

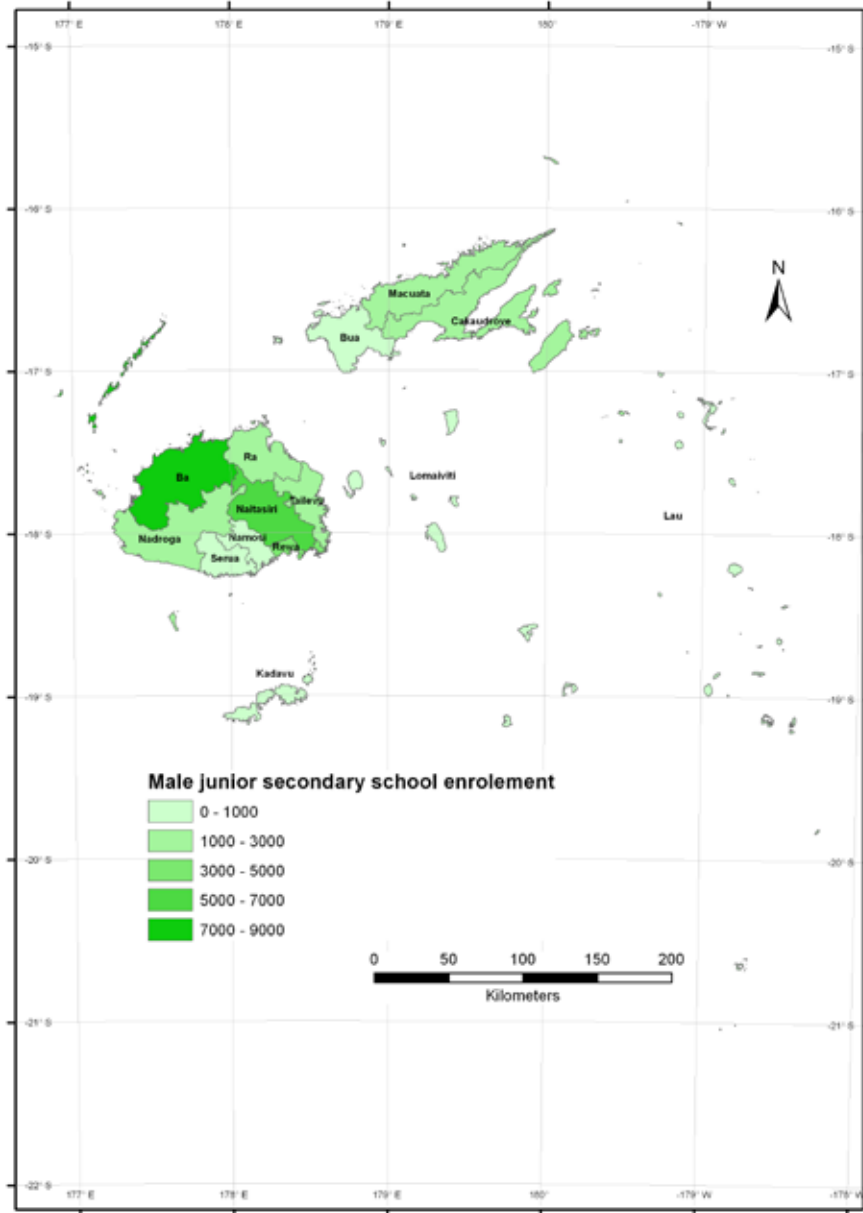
Figure 3.8 Number of children enrolled in junior secondary schools by gender and province (2007)



Source: Fiji Bureau of Statistics, Census 2007

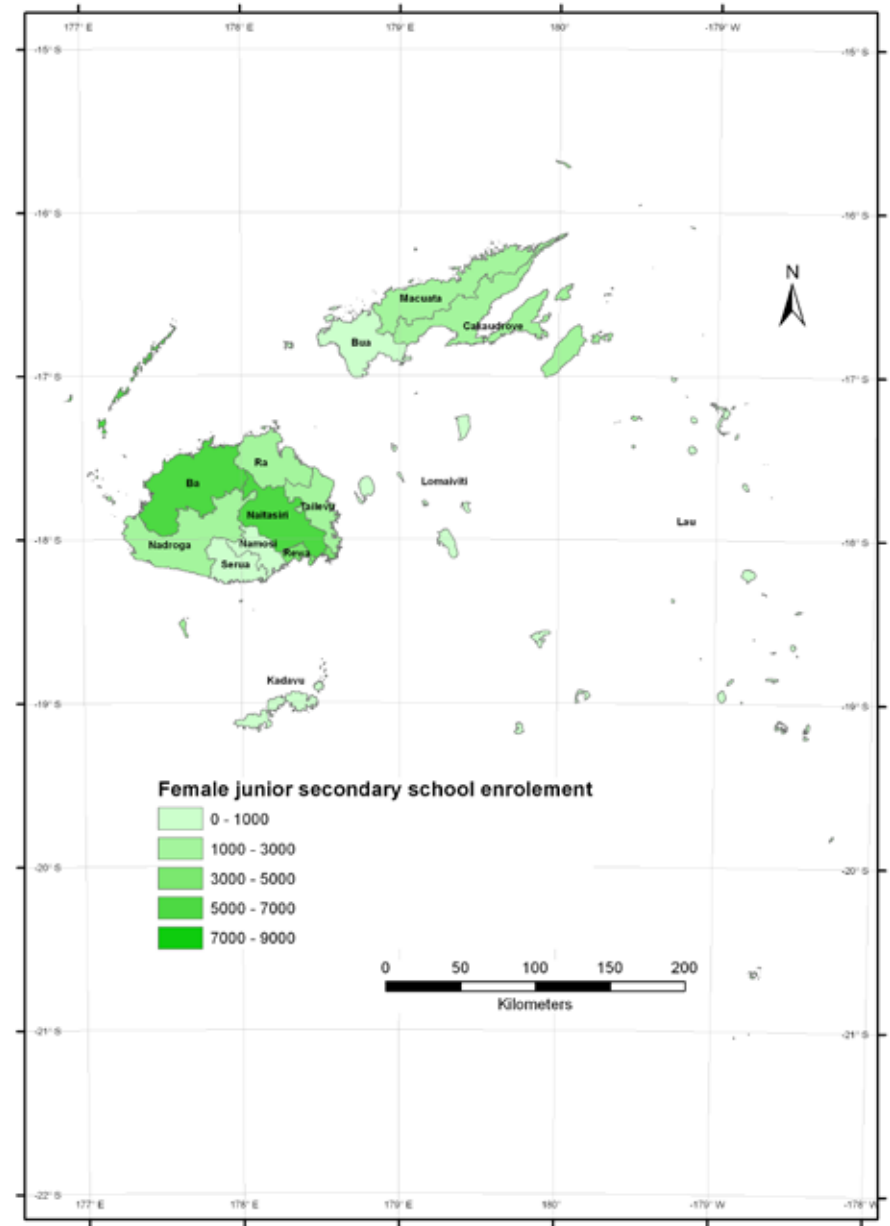
Junior secondary schools were established, particularly in rural areas, to ensure that all children had access to secondary education (MoE, 2008). Enrolment at junior secondary schools is proportionate to the population of children in the different provinces. This means that many children of junior secondary school age are attending schools within their own localities. On the whole, more males than females are enrolled at these schools. Only in Rewa and Rotuma did females outnumber males.

Map 3.2 Male junior secondary school enrolment



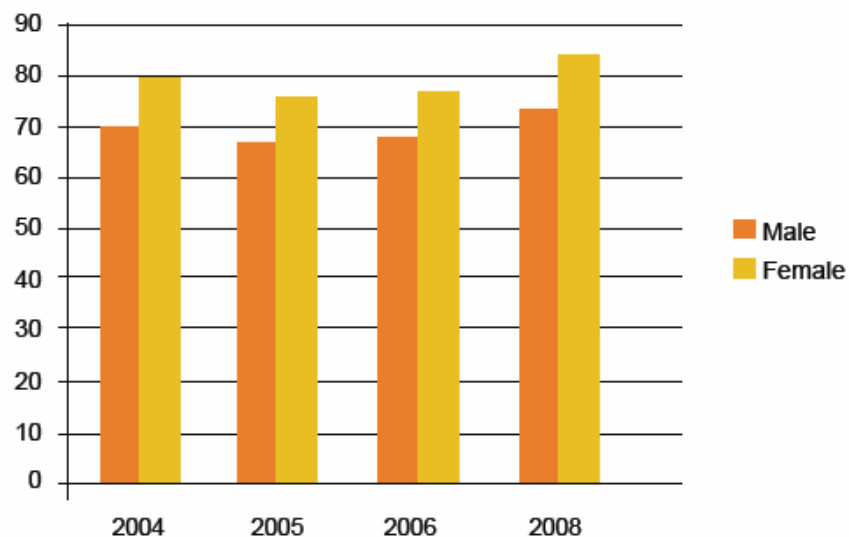
Source: MDG 2nd Report for the Fiji 1990-2009, 2010

Map 3.3 Female junior secondary school enrolment



Source: MDG 2nd Report for the Fiji 1990-2009, 2010

Figure 3.9 Secondary school net enrolment ratio by gender (2004-2008)

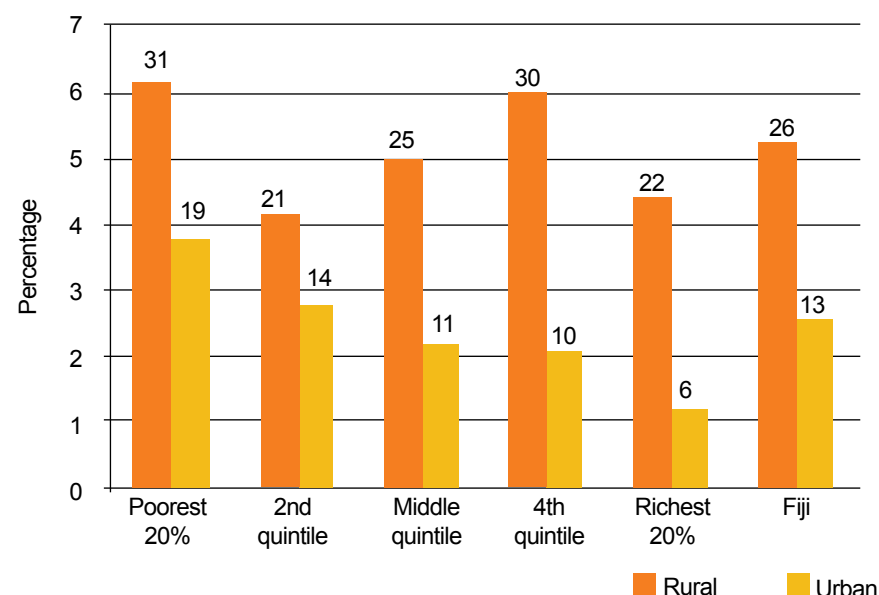


Source: Fiji Ministry of Education Annual Reports (various issues)

Fiji's net enrolment ratio in secondary school has increased steadily since 2005. For males, the ratio decreased from 69.8 per cent in 2004 to 74.1 per cent in 2008. For females, the ratio increased from 79.6 per cent to 84.4 per cent over the same period. The number of females enrolled in secondary school is much higher than the number of males.

Despite steady progress, approximately one in five children of secondary-school-age were not attending school in 2008/09. Non-attendance is twice as high in rural areas (26 per cent) than urban areas (13 per cent). There are also strong disparities across quintiles in urban areas, with urban children in the poorest quintile three times less likely to attend secondary school than children in the richest quintile. An ILO report on child labour in Fiji (2010) found that urban children not in school were often involved in child labour doing jobs such as shoe-shining, pushing wheel barrows, collecting scrap metal and other exploitative work.

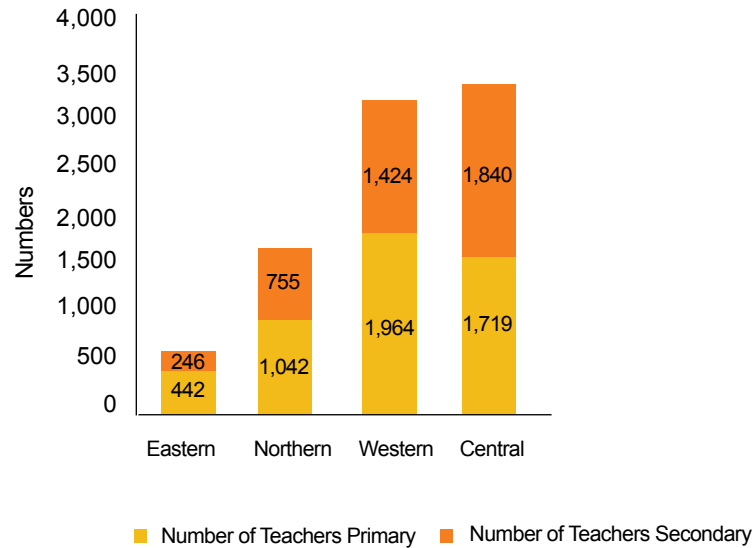
Figure 3.10 Percentage of children aged 14-18 years not attending school by quintile and urban-rural status (2008/2009)



Source: Narsey (2012) based on HIES 2008/09

One in five children of secondary-school-age are out of school. Non-attendance is twice as high in rural than urban areas

Figure 3.11 Number of trained teachers by division (2008)

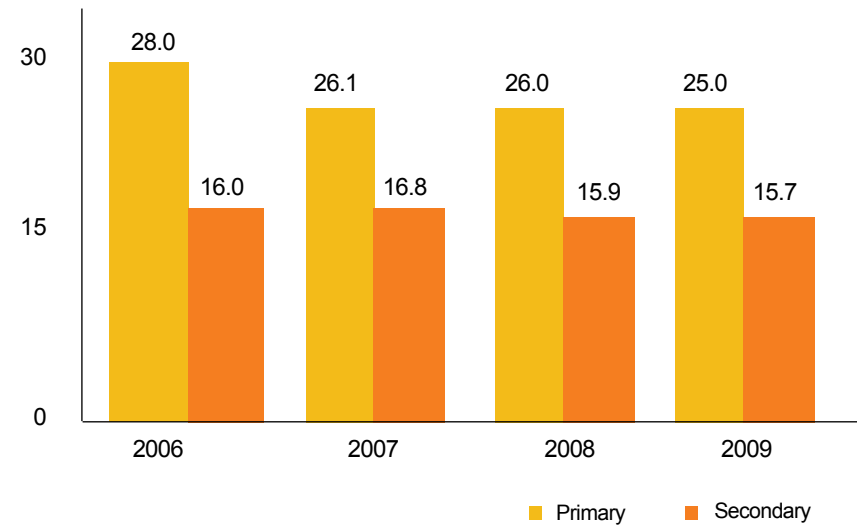


Source: MoE Strategic Development Plan 2008-2011

In an effort to develop a “professional teaching force”, the Ministry of Education has established a Teacher Registration Board (TRB) and implemented professional development programmes for teachers (MoE, 2008:16). Most of the trained teachers are in the Western and Central divisions, as compared to the Eastern and Northern divisions. It is estimated that approximately 98 per cent of Fiji’s primary teachers were trained teachers (World Bank, 2008).

The student-teacher ratio in primary schools is higher compared to secondary schools

Figure 3.12 Student-teacher ratio (2006-2009)



Source: FBOS, Key Statistics, 2011

The student-teacher ratio and class size in Fiji schools exists at a manageable level. The student-teacher ratio in primary schools is higher compared to secondary schools but they are both well below the existing student-teacher ratio policy of 30:1 (FBOS, 2011). Due to the population distribution the student-teacher ratio for both primary and secondary schools is higher in urban areas compared to rural areas (NCCC, 2011). Better learning outcomes can be attained with quality teachers and more dedicated time spent per student (MoE, 2007).

4

HEALTH



Health

Overview

Fiji's health sector has made significant progress since the country became independent in 1970. This has been achieved despite the fact that the sector caters for a population that is dispersed through its many islands. The 2010 MDG report asserts that the country is well on its way towards achieving a two-thirds reduction in child mortality (MDG 4) and an improvement in maternal health (MDG 5) between 1990 and 2015. The infant mortality rate fell from 16.8 deaths per 1,000 live births in 1990 to 13.1 in 2008 and the under-five mortality rate fell from 27.8 in 1990 to 23.6 in 2008. In addition, the proportion of infants under the age of one year who have been vaccinated increased from 86 per cent in 1990 to 93.9 per cent in 2008 (MSPNDS, 2010). Immunization remains high on the agenda, with the Ministry of Health making a commitment to ensure that by 2015, all children starting primary school are fully immunised (MoH, 2011).

The data show that children who die in the first 28 days of life (neonatal mortality) account for 60 per cent of children who die under one year of age (infant mortality rate) and 50 per cent of children who die under five years of age. In order to improve the survival chances for newborns, pregnant women should attend ante-natal clinics that are staffed by health workers, with close follow up for the first 28 days of a baby's life and further contact during the first year of life. There needs to be broader coverage of preventive and curative interventions for newborns and infants. This should include a stronger focus on water and sanitation, the prevention of pneumonia, diarrhea and malnutrition and ensuring a high rate of Expanded Immunization Programme coverage.

Maternal mortality has shown substantial improvement since 1990. It has dropped from 41.1 maternal deaths per 100,000 live births in 1990 to 31.7 in 2008. A major contributing factor in this improvement could be the high proportion (99 per cent) of births now attended to by trained personnel. While work continues in this area, the Government places equal emphasis on pregnancy related illnesses linked to diabetes, anaemia and premature birth. Reporting of pregnancy related illnesses is suggested as a way of accurately identifying causal factors and working towards solutions (MSPNDS, 2010).

Despite these achievements, much work is needed to address the health sector's limitations and to meet the targets set for 2015. The 2010 MDG Report identifies some of these limitations as being the result of "poor equipment and consumables ... [and the] shortage of general practitioners in rural areas" (MSPNDS, 2010: 40). Additional challenges identified in the MoH's Strategic Plan 2011-2015 include the poor assessment of pregnancy related illnesses and the inability of low-income earners to access medical facilities and services (MoH, 2011).

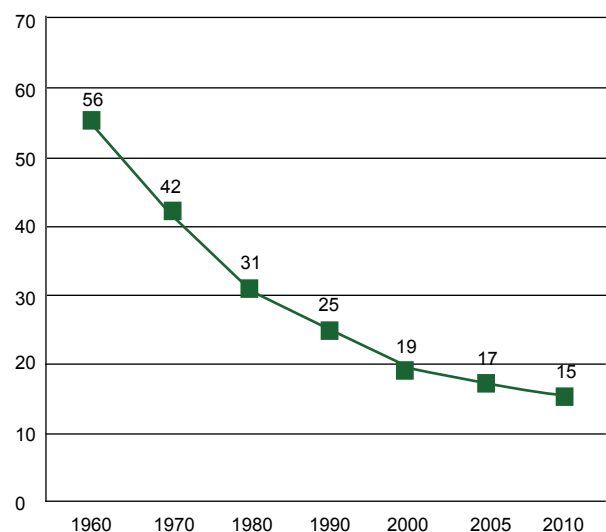
The health sector is proactive in working to meet the complex health needs of Fiji's population. The Ministry of Health is guided by documents such as the Strategic Plan 2011-2015 and the MDGs, particularly Goals 4, 5 and 6 (MoH, 2011).

Child Mortality

According to global UN estimates,⁴ the Infant Mortality Rate (IMR) in Fiji decreased substantially over the past decades, from 56 deaths per 1,000 live births in 1960 to 19 in 2000 and 15 in 2010. Despite this progress, the declining trend is not sufficient to meet the MDG 4 target of achieving a two-third reduction in child mortality over the period 1990-2015 (MSPNDS, 2010).

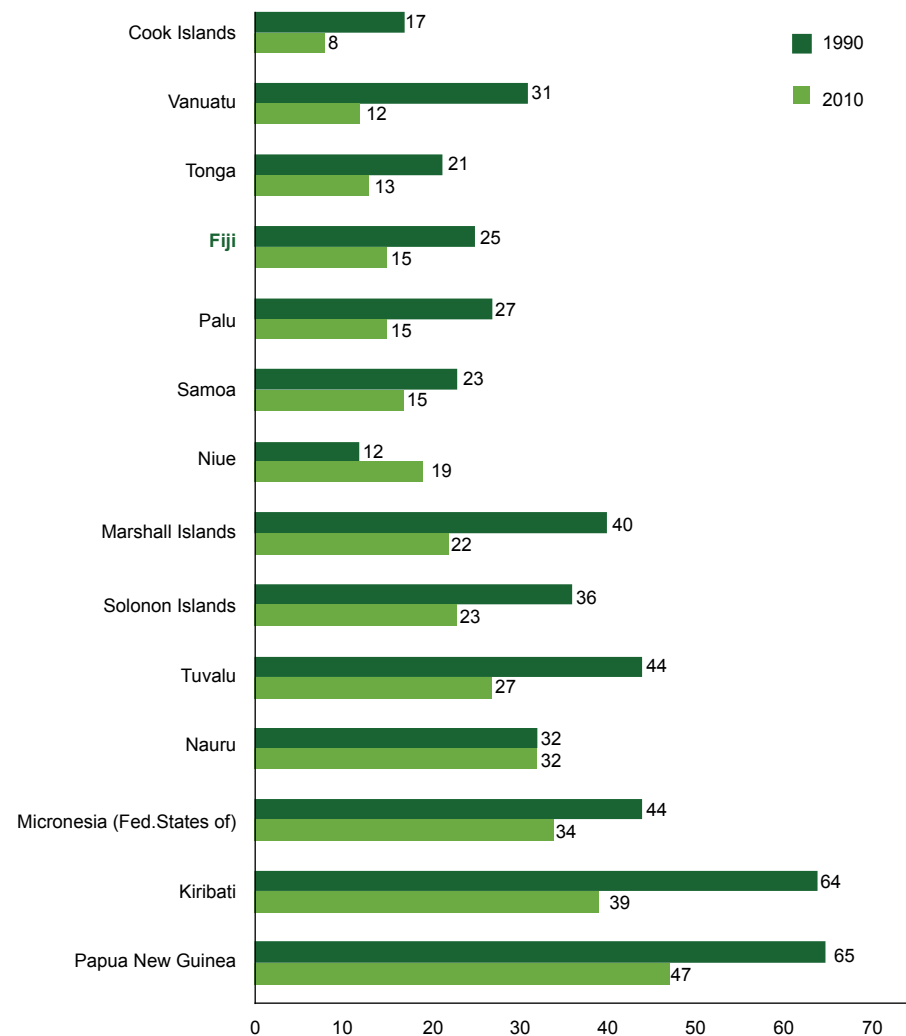
Fiji performs relatively well in comparison to other Pacific Island Countries. Only Cook Islands, Vanuatu and Tonga achieved lower infant mortality rates in 2010 than Fiji.

Figure 4.1 Trend in Fiji's infant mortality rate (UN estimates, 1960-2010)



Source: UN Inter-agency Group for Child Mortality Estimation (2011)

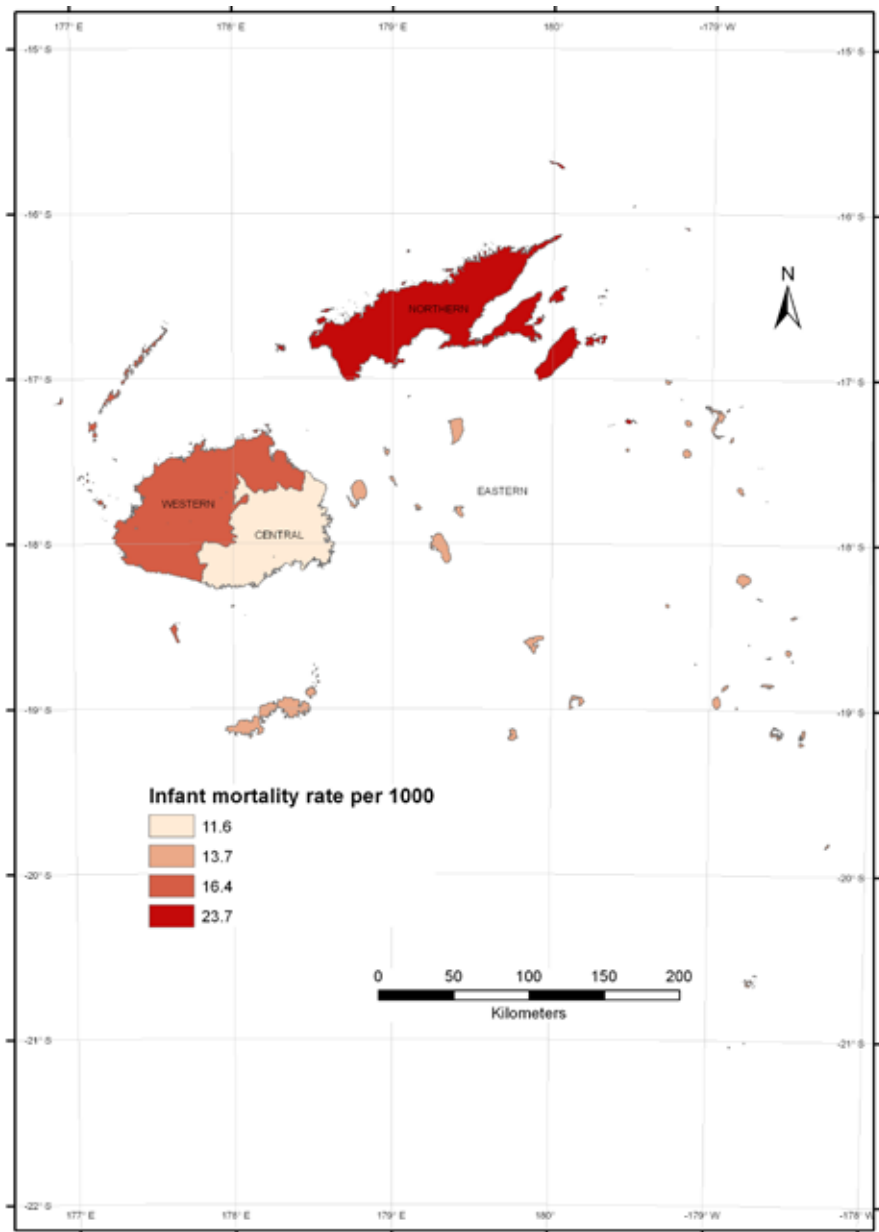
Figure 4.2 Infant mortality rates in Pacific Island Countries (UN estimates, 1990-2010)



Source: UN Inter-agency Group for Child Mortality Estimation (2011)

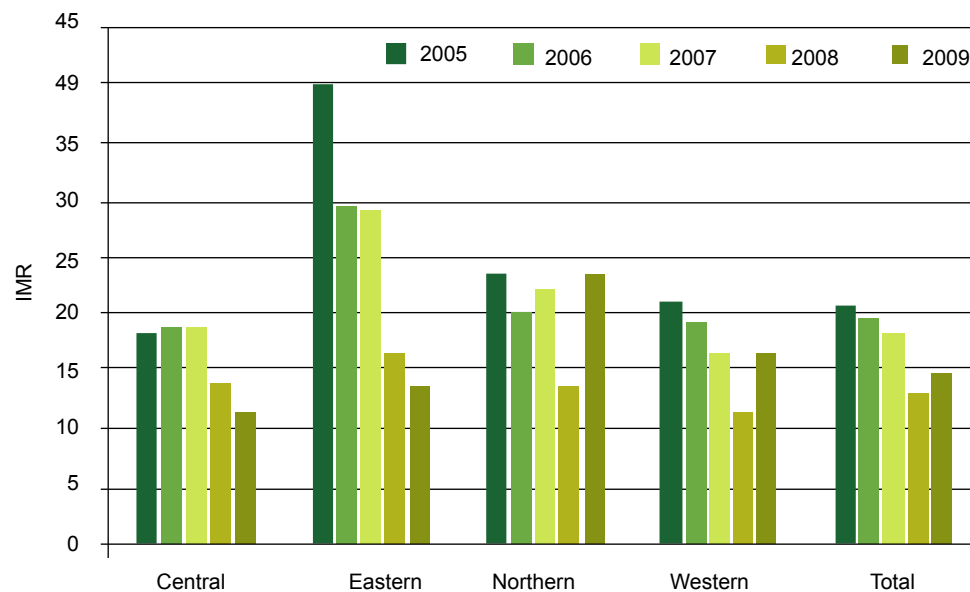
⁴ The UN estimates of child mortality - produced by the IGME - differ slightly from data produced at the country level because of methodological differences. The IGME compiles all available national-level data on child mortality, including data from vital registration systems, population censuses, household surveys and sample registration systems. It then applies a smoothed trend curve to the set of observations and extrapolates that trend to a defined time point. The fitted trend line is based on the entire time series of data available for each country.

Map 4.1 Infant Mortality Rate by division (deaths per 1,000 live births, 2009)



Source: Public Health Information System, Ministry of Health

Figure 4.3 Infant Mortality Rate by division (deaths per 1,000 live births, 2005-2009)



Source: Mortality Database, Public Health Information System Database at Health Information Unit, Ministry of Health

Between 2005 and 2008, the highest Infant Mortality Rate was in the Eastern division. This rate dropped significantly in 2009 and in that year, the Northern division recorded the highest number of infant deaths.

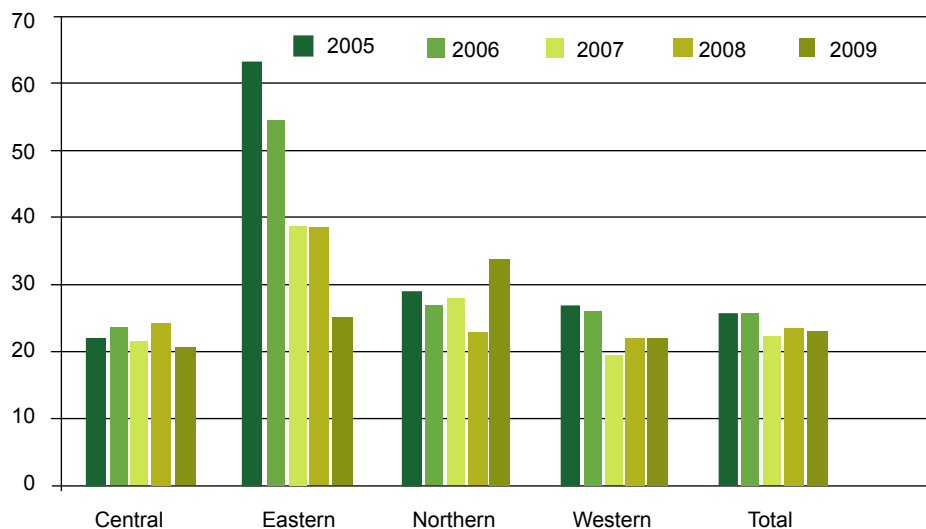
According to the MoH, the major causes of infant mortalities “include perinatal conditions such as birth asphyxia (inadequate supply of oxygen to a baby at birth), congenital malformations (birth defects), sepsis (blood poisoning), being underweight and congenital syphilis (MoH, 2010:8). Geographic location is a critical factor in newborn survival rates as it determines how quickly medical assistance can be reached when there are complications during pregnancy and childbirth. In order to reduce mortality further, there is a need for local skilled health workers who can attend to such emergencies quickly. Low-cost transport is needed in order for mothers and babies to easily access health services.

Table 4.1 Under-five Mortality Rate (deaths per 1,000 live births, 2005-2009)

Year	2005	2006	2007	2008	2009
Under-five Mortality Rate	25.8	25.8	22.4	23.6	23.2

Source: MoH Annual Reports 2008 and 2009

Figure 4.4 Under-five Mortality Rate by divisions (deaths per 1,000 live births, 2005-2009)



Source: Mortality Database, Public Health Information System Database at Health Information Unit, Ministry of Health

To achieve the MDG 4 target on child mortality, Fiji's Under-Five Mortality Rate (U5MR) should drop to 9.2 by 2015. The Ministry of Health, however, recorded only a slight decline in U5MR in recent times, from 25.8 in 2005 to 23.2 deaths per 1,000 live births in 2009. Children in the Eastern and Northern divisions are most at risk of dying before the age of five. A significant factor could be the remoteness of villages in these regions and lack of easily accessible health services. In addition, greater investment is needed in preventative health to improve progress on reaching MDG 4.

Between 2005 and 2008, Eastern division had by far the highest mortality rate in the under-five group while the Northern division had a similar rate to the other three divisions. This changed dramatically in 2009, however, when the Northern division rate peaked at more than 30 and the Eastern dropped from 40 to below 30.

Under-five mortality is significantly higher in the Eastern and Northern divisions

Maternal Health

Table 4.2 Maternal Mortality Rate (maternal deaths per 100,000 births, 2005-2009)

Year	2005	2006	2007	2008	2009
Maternal mortality ratio	50.5	43.5	31.1	31.7	27.5

Source: MoH Annual Report (2008, 2009)

The Maternal Mortality Rate for Fiji has been declining steadily since 2005. In 2009, the percentage stood at 27.5 (per 100,000 births). Annually, the Ministry of Health aims to reduce the MMR by 6 per cent. The target for 2015 is 10.3 percent.

Table 4.3 Trained attendant at birth (% , 2005-2009)

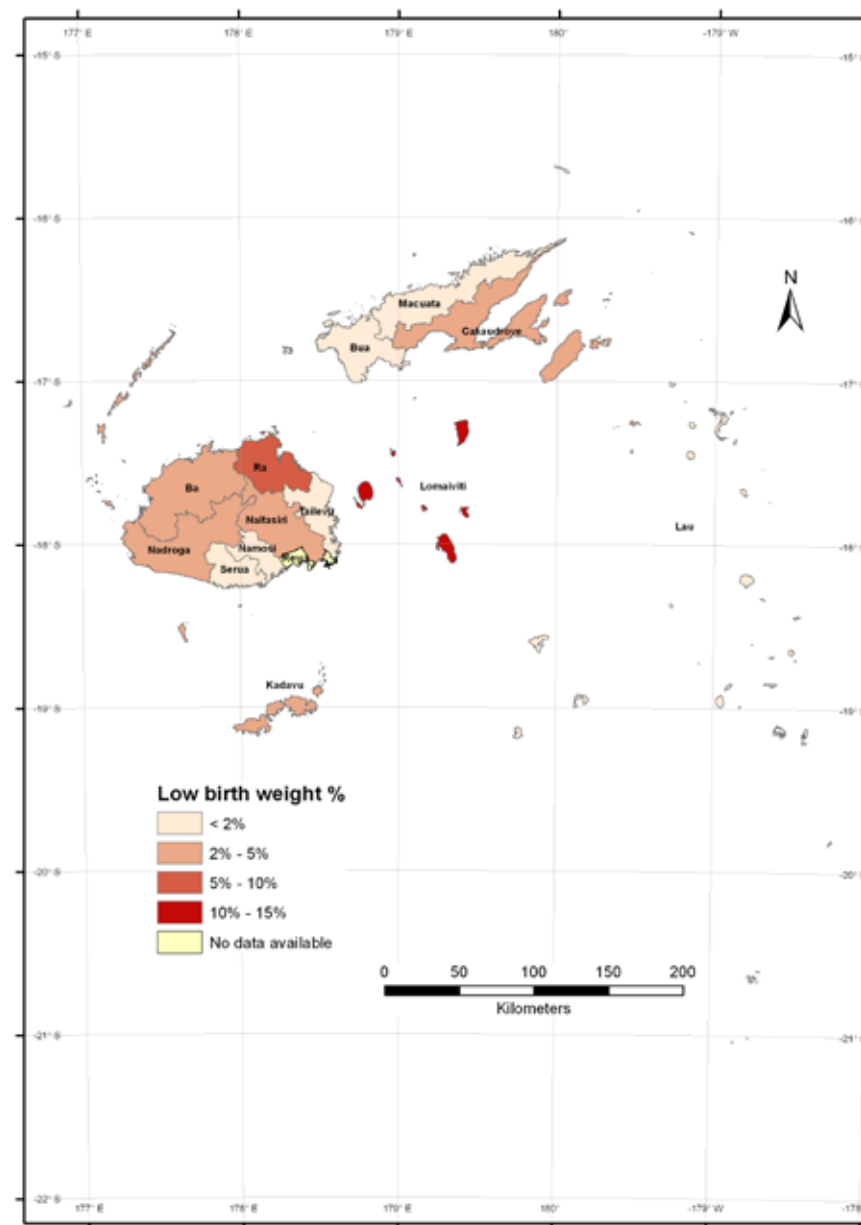
Year	2005	2006	2007	2008	2009
Trained attendant at birth	98.9	99.3	99.9	98.8	N/A

Source: MDG 2nd Report for the Fiji 1990-2009 (2010)

Women who give birth in Fiji are well attended by trained health workers. The current investments in the health sector should see Fiji record a 100 per cent attendance rate in the percentage of trained attendants at birth.

Birthweight is a strong indicator of a birth mother's health and nutritional status as well as a newborn's chances for survival, growth, long-term health and psychosocial development. A low birthweight (less than 2,500 grams) raises grave health risks for children. In 2010, the prevalence of low birth weight was highest in the Central division with 8.2% and lowest in the Northern division with 1.8%

Map 4.2 Prevalence of low birth weight by province (% , 2010)



Source: Public Health Information System Database at Health Information Unit, Ministry of Health

Immunisation

Table 4.4 Administrative data on immunisation coverage of infants 0-1 years by type of vaccine (2010)

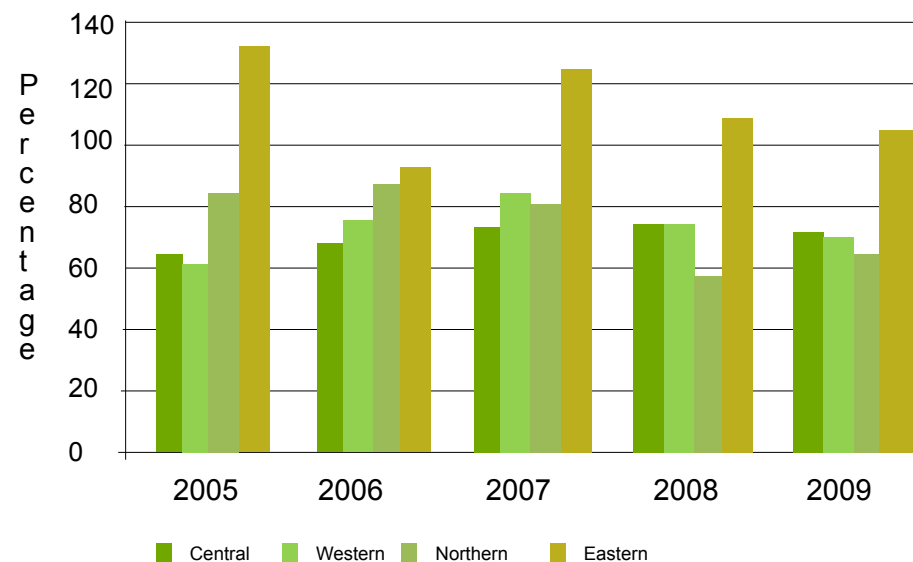
Immunisation Coverage (%) 0-1yr	%
BCG	98.7
OPV0	98.6
HBV0	101.9
OPV1	80.7
Pentavalent 1	80.8
OPV2	80.3
Pentavalen 2	80.5
OPV3	76.7
Pentavalent 3	77.2
MR1	71.8

Source: Ministry of Health (2011) Annual Report 2010

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. Ministry of Health figures for 2010 – collected through the Public Health Information System (PHIS) – indicate that coverage rates for most vaccines were well below the 90 per cent rate needed for effective high population immunity. Only reported coverage for BCG, OPV and HBV was well above 90 per cent. Coverage rates for all other vaccines hovered between 70-80 per cent.

Immunisation rates for measles reported through the PHIS have consistently been about 71% in 2009 and 2010. However, data collected through the National Immunisation Coverage Surveys suggest much higher coverage (e.g. 94 per cent in 2008). The significant gaps between administrative data from the Ministry of Health and coverage detected through surveys point to an urgent need to improve routine reporting.

Figure 4.5 Administrative data on measles immunisation coverage for children under one by division (2005-2009)



Source: Ministry of Health Annual Reports - 2005-2007; Health Information Unit, Public Health Database, 2008-2009

Immunisation of young children against measles and other deadly diseases should be strengthened

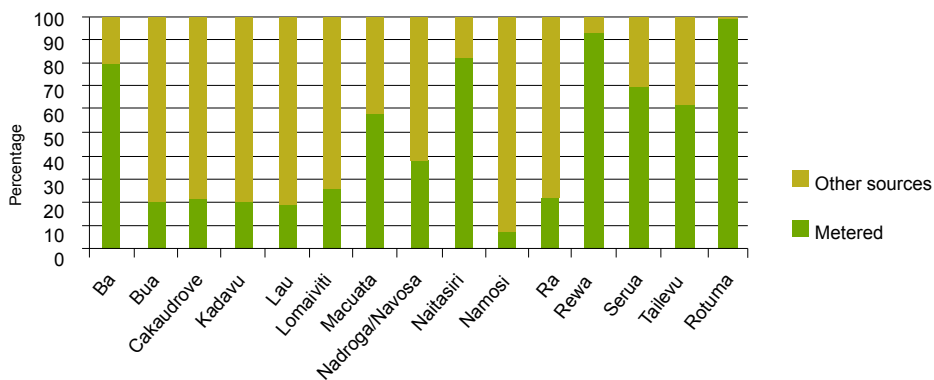
Water and Sanitation

One of the key targets under MDG 7 is to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. Equitable access to adequate water supply and sanitation is of fundamental importance to health, and will speed the achievement of all eight MDGs. Lack of adequate water contributes to diarrheal diseases and illness, especially in children.

Use of metered water has increased since 1986 in both urban and rural areas. In 2007, 65 per cent of children had access to metered water in their household. There are, however, important differences between urban and rural areas and provinces. Only 37 per cent of the rural population had access to metered water compared to 95 per cent of the urban population. Children's access to metered water ranged from a low of 8 per cent in Namosi to nearly 100 per cent in Rotuma.

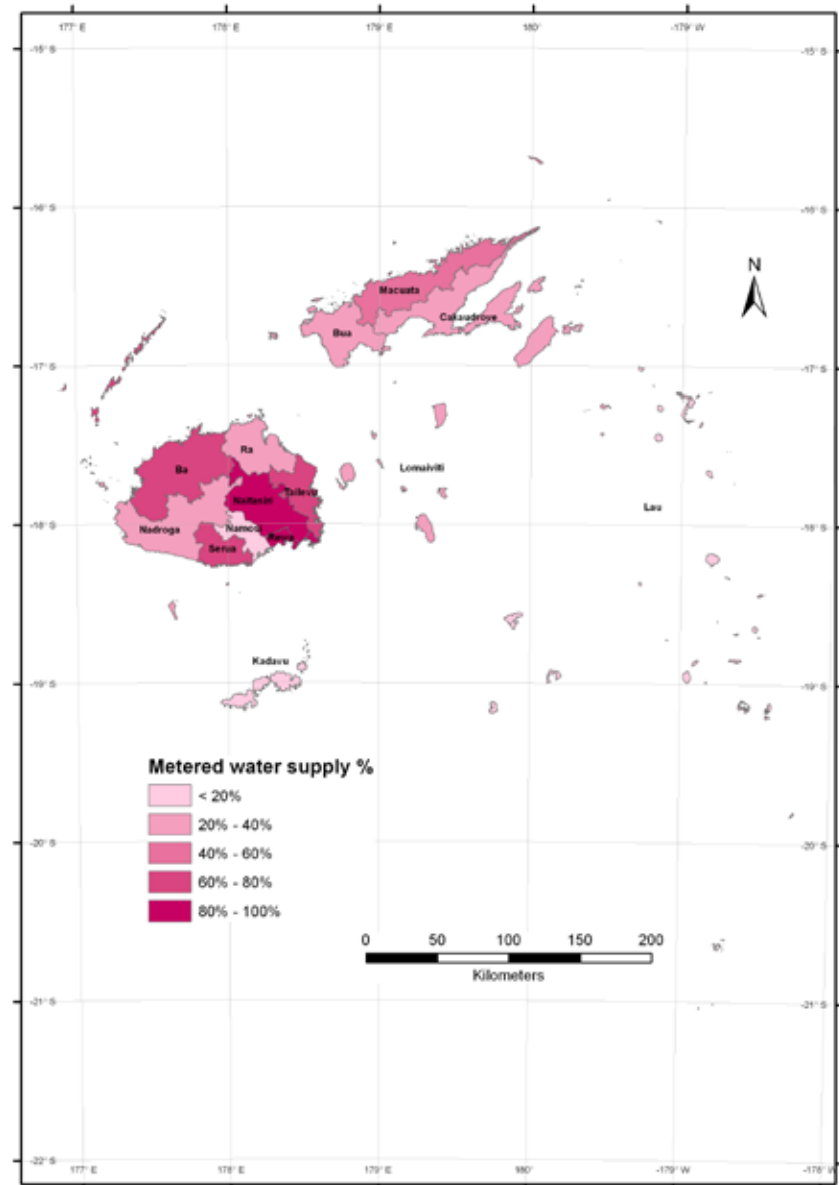
Only four out of ten people in rural areas have access to metered water supply

Figure 4.6 Children's water source by province (% , 2007)



Source: FBOS, Census 2007

Map 4.3 Metered water supply by province (2007)

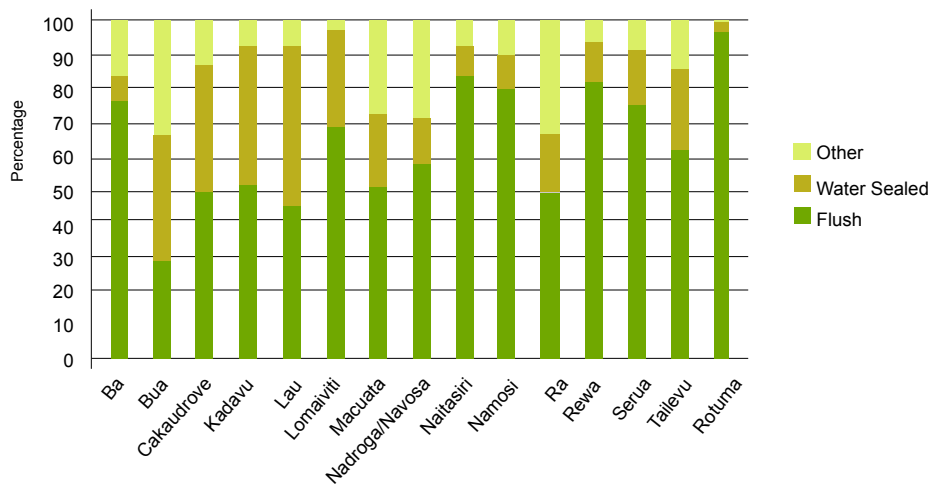


Source: FBOS, Census 2007

Nationwide, 70 per cent of children had access to a flush toilet in their household in 2007. There are, again, important disparities across provinces. Access to a flush toilet ranges from a low of 29 per cent in Bua to a high of 98 per cent in Rotuma. An increasing number of rural households are constructing flush toilets, but the functioning of these depends on local conditions, water availability and resources.

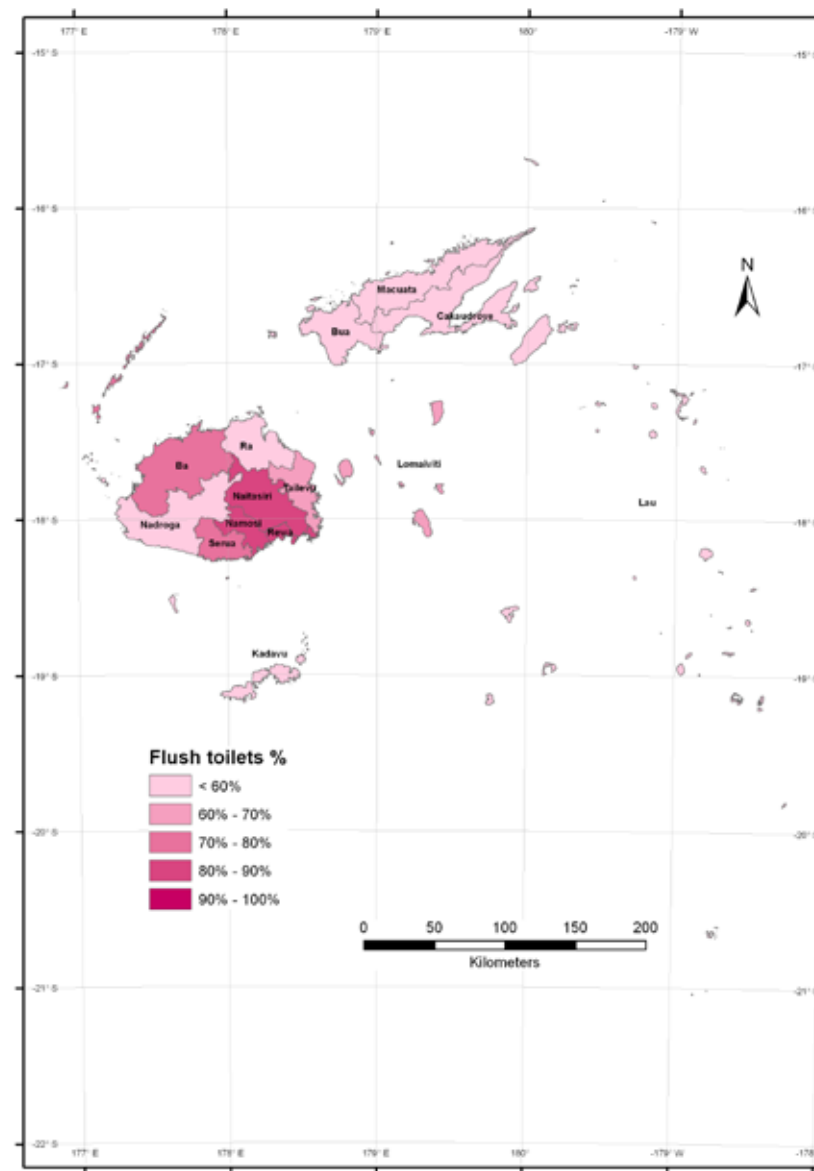
Seven out of ten children have access to a flush toilet in their household, but large provincial disparities remain

Figure 4.7 Children's access to toilet facilities by province (2007)



Source: FBOS, Census 2007

Map 4.4 Flush toilets by province (2007)



Source: FBOS, Census 2007

Nutrition

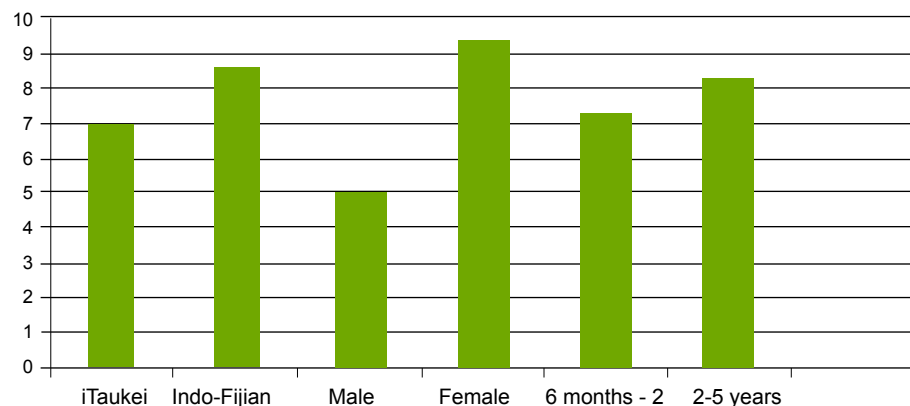
Table 4.5 Proportion of under-five children with malnutrition (2005-2009)

Year	2005	2006	2007	2008	2009
Under-5 malnutrition	7	7	7	7	6

Source: MoH Annual Reports (2006-2009)

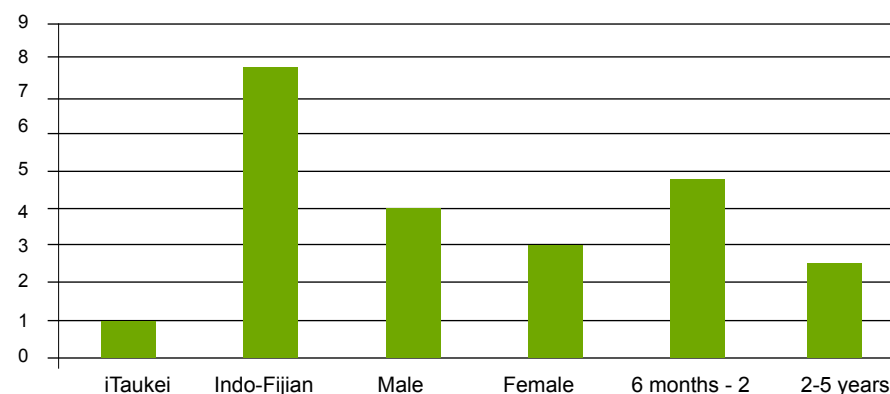
Under-five malnutrition exists as an “indicator of poverty and hunger” (MoH, 2008b:7). The rate of undernourished children in Fiji has declined from 15 per cent in 1980, to 6 per cent in 2009. Reducing the prevalence of under-five malnutrition continues to be a priority of the Government through its poverty and hunger eradication policy. Specific policies aimed at addressing underweight among children include the Fiji Nutrition Policy for Schools 2006 and the Fiji Food and Nutrition Policy 2008 (MoH, 2008b).

Figure 4.8 Stunting (height for age) by ethnic group, gender and age



Source: Fiji National Nutrition Council, 2008 'Micronutrient status of children 6 months to 2 years.

Figure 4.9 Wasting (weight for height) by ethnic group, gender and age



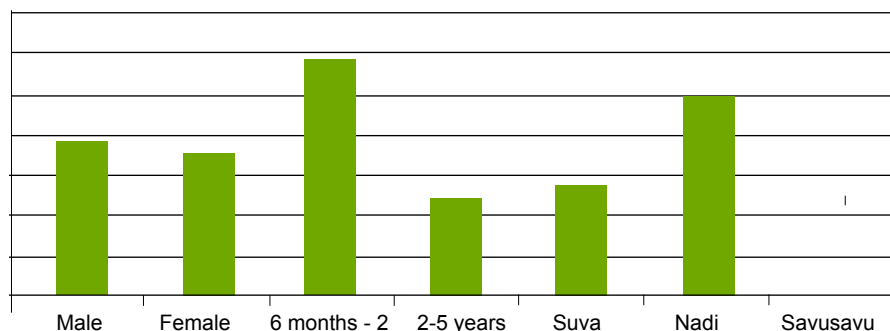
Source: National Food and Nutrition Council, 2008 Micronutrient status of children 6 months to 5 years

Stunting, or low height for age, is caused by long-term insufficient nutrient intake and frequent infections. Stunting generally occurs before age two, and effects are largely irreversible. These include delayed motor development, impaired cognitive function and poor school performance. Data from the Fiji National Nutrition Council (2008) shows that prevalence of stunting is nearly twice as high in young girls than boys. Stunting is only slightly higher among Indo-Fijian than iTaukei children.

Wasting, or low weight for height, is a strong predictor of mortality among children under five. It is usually the result of acute significant food shortage and/or disease. Prevalence of wasting is highest in young children under two as compared to children aged 2-5 years. Wasting is also markedly higher among Indo-Fijian than iTaukei children.

Young girls are nearly twice as likely to be stunted as boys as a consequence of long-term insufficient nutrient intake

Figure 4.10 Anaemia by gender, age group and location

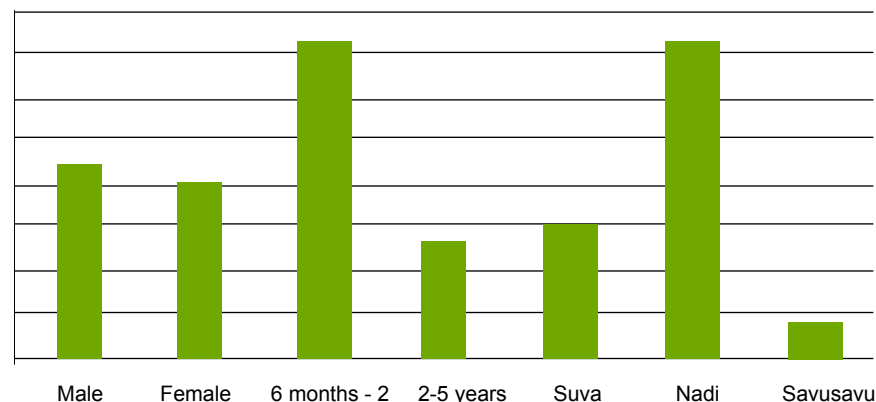


Source: National Food and Nutrition Centre, 2008 Micronutrient status of children 6 months to 5 years.

Micronutrient deficiencies are a serious public health problem and result primarily from diets lacking essential vitamins and minerals, such as iron, vitamin A, and zinc. Micronutrient deficiencies can occur even when people have enough to eat, but lack the resources to buy fresh fruits and vegetables, meat, milk products, and other foods rich in vitamins and minerals. Diets poor in micronutrients cause illness, blindness, premature death, impaired mental development, and susceptibility to infectious diseases, particularly among children.

Anaemia, usually caused by insufficient intake of iron, remains widespread among women and young children. Prevalence of anaemia affected about half of all children under five (NFNC, 2007). While there was no marked difference in the prevalence of anaemia by gender, it was higher among Indo-Fijians (39 per cent) compared to iTaukei (36 per cent). Consistent with global trends, anaemia was more prevalent in aged children 6-23 months compared to children 2-5 years old. Nadi also recorded a significantly higher prevalence rate compared to Suva and Savusavu.

Figure 4.11 Vitamin A deficiency by gender, age group and location



Source: National Food and Nutrition Council Centre, 2008 Micronutrient status of children 6 months to 5 years

While there is no marked difference in the prevalence of Vitamin A deficiency by gender, there is a significant difference by age group showing a high prevalence (15 per cent) in children 6 months to 2 years compared to 5 per cent in children 2-5 years. Ethnic differences were also seen, with iTaukei children showing an 11 per cent prevalence rate compared to 4 per cent among Indo-Fijian children. High prevalence was also noted in Nadi, representing the Western division, compared to Suva and Savusavu, representing the Central and Northern divisions respectively. Of concern is the high prevalence of children at risk of Vitamin A deficiency estimated at 34 per cent. More children in Savusavu (54 per cent) were at risk of Vitamin A deficiency compared to Suva (32 per cent) and Nadi (28 per cent).

Micronutrient deficiencies are a major public health problem affecting up to half of all children under five years

HIV and AIDS

Fiji is considered a low HIV prevalence⁹ country, however, the cumulative number of confirmed cases is a major concern; “from four in 1989 to 333 in 2009¹⁰ (MSPNDS, 2010: 50). According to the Fiji 2010 MDG Report, two age groups are most prominent in this increasing trend; 30-39 and 40-49 years (MSPNDS, 2010). Higher numbers of iTaukei are being diagnosed HIV-positive compared with other ethnic groups in the country (Republic of the Fiji, 2010). Reliable baseline data is lacking in Fiji and this presents a challenge to understanding HIV and its implications for children and pregnant women.

The most recent HIV study in Fiji was the Second Generation Survey (SGS) in 2008. The survey showed that the risk of HIV was greater for individuals who have multiple sex partners, those engaging in ‘high-risk sex¹¹ and those having sexual encounters with ‘Most-At-Risk-Populations’ (MARPs). Mother-to-child transmission remains low in Fiji, however, 29 per cent of pregnant women (303) who were part of the 2008 SGS survey tested positive for chlamydia (Republic of the Fiji, 2010). This figure is worrying as the presence of chlamydia indicates a higher risk of HIV infection and transmission.

Fiji has been progressive in terms of developing a national response to HIV and AIDS. Preventative strategies have included community awareness campaigns, peer education and condom distribution. Voluntary testing and counselling services have also been increased (Republic of the Fiji, 2010). According to the UNGASS Fiji 2010 Country Progress Report, there are 95 centres where blood samples can be taken for HIV testing. Numbers of people testing for the virus have been intermittent, with the highest proportion, 6.59 per cent recorded in 2005

⁹“Prevalence is a measure of the occurrence of a condition in the population: i.e. the number of cases divided by the population (usually 15-45 yrs old)” (MSPNDS, 2010:48)

¹⁰ ‘High risk sex’, “is where one or both sexual partners have had more than one partner in the past 12 months” (Republic of the Fiji, 2010:7).

¹¹ ‘Most-At-Risk-Populations’ (MARPs), “normally defined in the Fijian context as sex workers, uniformed services, youth, seafarers and Men who have Sex with Men (MSM)” (Republic of the Fiji, 2010:11).

Table 4.6 Number of new HIV infections in children 0-9 years (2005-2009)

Year	2005	2006	2007	2008	2009
0-9 years new HIV infections	2	1	0	2	5

Source: MoH Annual Report, 2009

The Government’s HIV and AIDS Decree passed in February 2011, ensures the confidentiality of those diagnosed and affected by HIV, allows for and encourages voluntary testing and related counselling and empowers affected individuals to seek compensation should their rights be violated (Ministry of Information, 2011).

Data for HIV infections in children is only available for those aged 0-9 years. The first known HIV infection in this age group was diagnosed in 1991 (MoH,2009). The small number of new infections could be attributed to the low incidence of mother-to-child transmission. No HIV-positive babies were born to five HIV-positive mothers who gave birth in 2008 nor to six HIV-positive mothers in 2009 (Republic of the Fiji, 2010).

Fiji is in the early stages of a possible HIV epidemic. The known number of people living with HIV and AIDS is rising steadily

Table 4.7 Selected indicators of STIs and sexual behaviour among 303 pregnant women in Fiji (2008)

Key indicators	Total (N=303)
Syphilis prevalence (%)	2.6
Chlamydia prevalence (%)	29.0
Gonorrhoea prevalence (%)	1.7
Median age at first sex (years)	19 (12-30)
Commercial sex in last 12 months (%)	0
Median number of sex partners in life	2 (1-16)
No incorrect beliefs about mother to child transmission (%)	70.6

Source: SPC SGS Survey 2008.

Although Fiji is classified as a low HIV prevalence country, available data indicates that its population is vulnerable to HIV due to various risk factors. Specifically, surveys show low levels of HIV knowledge, high levels of commercial sex and multiple sexual partners, and low levels of condom use among those who engaged in higher-risk sex. Additional evidence of sexual risk is the repeatedly high prevalence of Sexually Transmitted Infections (STIs) found among antenatal care attendees at surveillance sites: according to Second Generation Sentinel Survey (SGSS) of 2004, the prevalence rates of Chlamydia and Gonorrhoea among pregnant women were as high as 29 per cent and 1.7 per cent respectively; a similar study conducted in 2008 revealed that Chlamydia prevalence has decreased slightly (27 per cent), whereas Gonorrhoea prevalence increased to 2.2 per cent.

Only half of youth have comprehensive correct knowledge of HIV

Table 4.8 Proportion of youth participants with correct knowledge of HIV prevention (2008)

Questions	Male		Female	
	15-19 years N=103	20-24 years N=183	15-19 years N=107	20-24 years N=150
Having sex with only one, faithful uninfected partner can reduce the chance of getting HIV	76.7 %	82.0%	80.4%	86.7%
Using condoms correctly can reduce the chance of getting HIV	81.6%	84.2%	80.4%	80.7%
A healthy looking person can be infected with HIV	84.5%	86.3%	86.9%	88.0%
A person can get HIV from mosquito bites	61.2%	68.3%	76.6%	74.7%
A person can get HIV from sharing a meal with someone who is infected with HIV	74.8%	84.7%	85.0%	86.7%
All answers correct	41.2%	54.1%	55.1%	54.0%

Source: Republic of Fiji, 2010

The Fiji 2008 SGSS also surveyed young people drawn from three tertiary institutions. While the results cannot be generalised across Fiji's entire youth population, they do provide a snapshot of young people's knowledge of HIV prevention. Overall, around 50 per cent of surveyed youth had comprehensive, correct knowledge of HIV. Both males and females aged 20-24 years were more knowledgeable about HIV prevention than their peers in the 15-19 years category.

Only one in four female tertiary students and 63 per cent of male tertiary students aged 15-24 years in the SGS 2008 survey reported ever having sex. Young people scored highly in terms of having had a HIV test and receiving their results.

5 DISABILITY



Disability

Overview

People with disabilities (PWD) in Fiji face many obstacles that prevent them from having an adequate quality of life. Though a lot has been done in this sector by both Government and non-governmental organisations, PWD lack opportunities for employment and education and often have limited access to adequate health care and support services. The lack of awareness and understanding of disability in the general community means PWD and their families face prejudice, discrimination and rejection.¹⁶ This is often more severe for women and girls. People with disabilities often face extreme poverty. Disability adds to the risk of poverty and conditions of poverty increase the risk of disability.

While conditions and life opportunities for PWD in Fiji are far from adequate, particularly for people living in remote and rural areas, Government and Non-Governmental Organisations have been active in addressing their plight. Fiji has a national disability policy and signed the Convention on the Rights of Persons with Disabilities (CRPD) in June 2010. It is the only Pacific island country with disability specific legislation – the 1994 Fiji National Council for Disabled Persons (FNCDP) Act. The FNCDP is the key co-ordinating body on disability matters. Its functions include formulating disability policies and plans, incorporating disability into Government functions and promoting disability prevention measures. The council shares its premises in Suva with vocational training and early intervention centres.

About 60 children, aged from 18 months to eight years, attend the early intervention centre, which aims to prepare students to attend mainstream schools. In the late 1990s, students with disabilities began to attend secondary schools and are now enrolled in 22 schools. All of those students had attended special school during primary years.¹⁷ Fiji has 17 segregated special schools. The Ministry of Education has a Special Education Action Plan and a draft IE policy that is awaiting approval. The Ministry supports the special schools, all of which are run by NGOs, by providing grants and paying teacher salaries. In addition, the Government pays for teacher aides and sign language interpreters in secondary schools.¹⁸ Since the mid-80s, the Ministry of Health has had a system of community based rehabilitation assistants (CRAs) who work in most parts of Fiji. The CRAs' role is to detect and identify disabilities, manage disabilities and the rehabilitation of PWD. There is a need to upgrade training for CRAs, however, no funding is available for this purpose. Physical impairment is the main type of disability and affects 41 per cent out of all people with disabilities. People who are deaf and blind make up the smallest group with 0.2 per cent.

¹⁶ Fiji National Council for Disabled Persons, 'Making Women with Disabilities Visible', September 2010

¹⁷ UNICEF, 'Pacific Children with Disabilities: A report for UNICEF Pacific's mid-term review', 2010

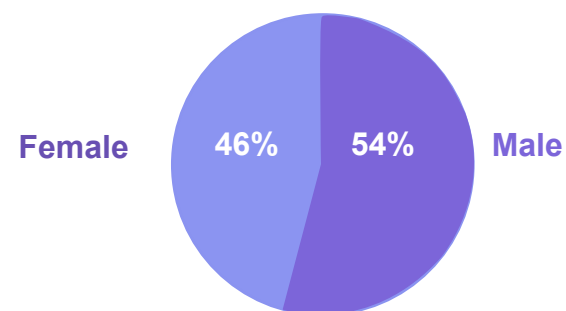
¹⁸ FNCDP, 2010

Table 5.1 Percentage of the population with reported disabilities (2010)

District	Total population	Total disability population	% total disability
Macuata	72,441	1,846	2.55
Suva	89,202	1,647	1.85
Lautoka	94,873	1,130	1.19
Nadi	63,651	822	1.29
Kadavu	10,167	707	6.96
Ba	80,852	636	0.79
Sigatoka	58,387	617	1.06
Levuka	16,461	576	3.50
Savusavu	49,344	523	1.06
Taveuni	2,545	490	19.25
Rakiraki	29,464	468	1.59
Tavua	29,545	434	1.47
Bua	14,176	263	1.66
Nausori	100,787	257	0.25
Vinidawa	160,760	446	0.28
Tailevu	55,692	193	0.35
Navua	25,147	167	0.66
Rotuma	2,002	90	4.50
Lau	10,683	70	0.66

Source: FNCDP, 2010

Figure 5.1 Percentage distribution of people with disabilities by gender (2010)

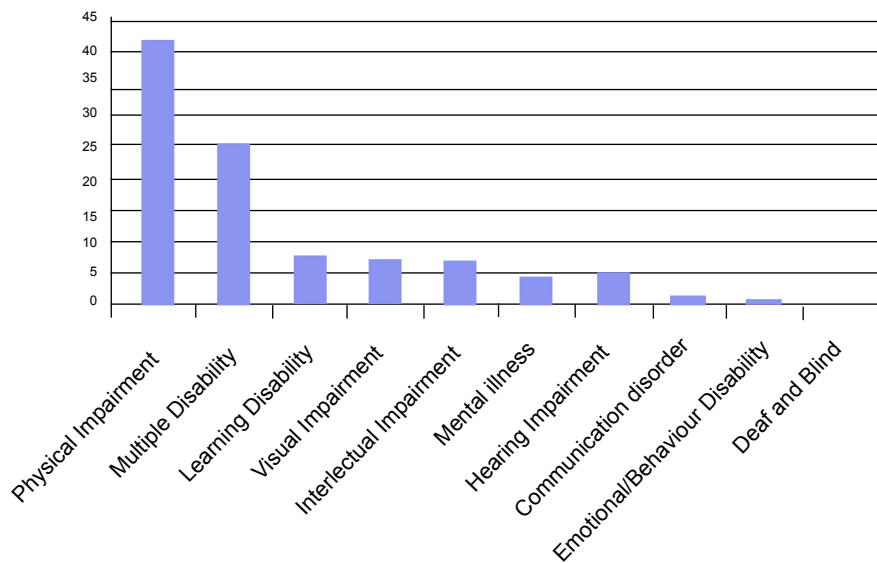


Source: FNCDP, 2010

Nationwide, an estimated 1.4 per cent of the total population or 11,402 people are living with a disability (FNCDP, 2010). There are more male than female persons with disabilities (with 54 per cent of people with disabilities being male). Prevalence of reported disability varies widely across districts, from a low of 0.25 per cent in Nausori to a high of 19.25 per cent in Taveuni. These percentage differences between areas in the country might reflect the general development level of an area, access to nutritious food, exposure to environmental or infectious agents, or other risk factors for disability, as well as unique social cultural perceptions and inhibitions with regard to reporting on disability (UNICEF, 2008). In absolute numbers, Macuata, Suva and Lautoka have the largest population of people with disabilities.

People with disabilities often lack opportunities for education and employment and have limited access to adequate health care and support services

Figure 5.2 Percentage distribution of types of disability among people with reported disabilities (2010)

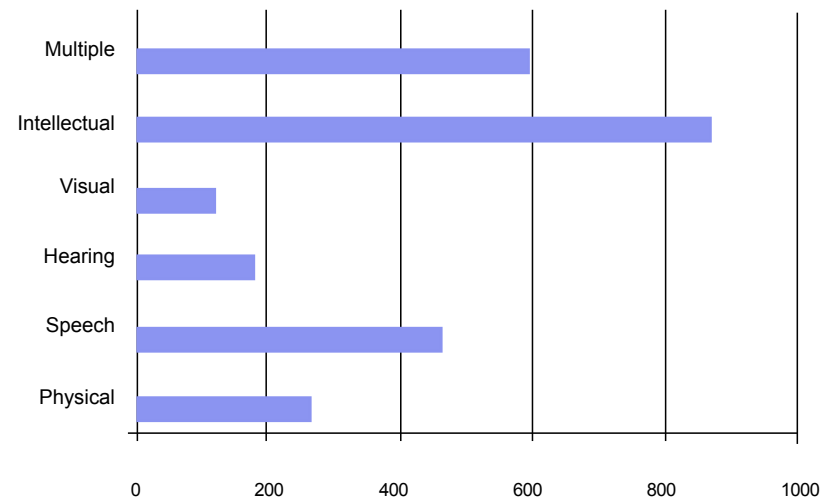


Source: FNCDP, 2010

People with different types of disabilities generally need different types of specialised services (physical rehabilitation, assistive devices, etc.). Overall, disabilities related to physical impairment were most frequently reported, affecting 42 per cent of all people with disabilities. Disabilities related to being deaf or blind were least frequently reported. In addition, around one in four people with disabilities are reported to have multiple disabilities.

There are 17 special schools in the country for children with disabilities. In 2010, intellectual disability was the main type of disability among children in special schools, followed by multiple disabilities and speech impairment.

Figure 5.3 Number of children attending special schools by type of disability (2010)



Source: Ministry of Education Annual Report 2010.

Physical impairment is the most frequently reported type of disability in the population

6 CHILD PROTECTION



Child Protection

Overview

Children in Fiji face a range of perils arising from economic difficulties, shortfalls within current legislations and precarious social behaviours and attitudes. For example, many children discontinue school because their parents cannot afford the high costs associated with education.

The FBOS (2010) reported a decline in child physical abuse cases from 232 cases in 2008 to 170 in 2009. However, there was a sharp increase in reporting of child sexual abuse cases, from 292 in 2008 to 542 in 2009.

A baseline survey conducted by the Fiji Government and UNICEF in 2009 found that the majority of adults (72 per cent) are confident about what to do if a child in their care were badly hurt.¹⁹ Yet, while highly aware of formal protection services available to them (the police and healthcare professionals), one in two respondents trust the police services least and would rather seek 'informal' assistance if needed.

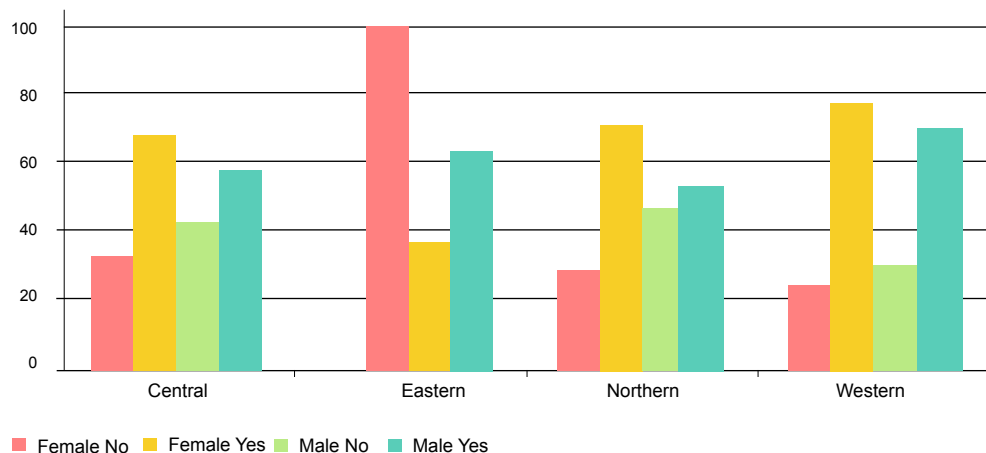
Birth registration is generally high in Fiji, though the exact number of children registered is unknown. Registration grants one the right to citizenship and other privileges. For example, registration for iTaukei children "entitles them to access land and apply for certain scholarships" (NCCC, 2011:41).

The Fiji Government is party to the United Nations Convention on the Rights of the Child (UNCRC) and has put in place legislations and institutional provisions for the care and protection of children, particularly the vulnerable and those who come into contact with the law. In April, 2011, the Government endorsed Fiji's 2nd, 3rd and 4th CRC report. The CRC report outlines "achievements, challenges and the administrative, judicial and legislative processes adopted by the State" in relation to the implementation of the UNCRC (Fiji Government Online, 2011).

The protection of children has also been enhanced through inter-agency collaboration between the Government and UNICEF on initiatives such as the Fiji Baseline Research on Child Protection (2008) and the signing of a Child Protection Multi-Year Work Plan (Fiji Government Online, 2011).

¹⁹ Source: Protect me with love and care: Baseline report for Fiji (2008: 187)

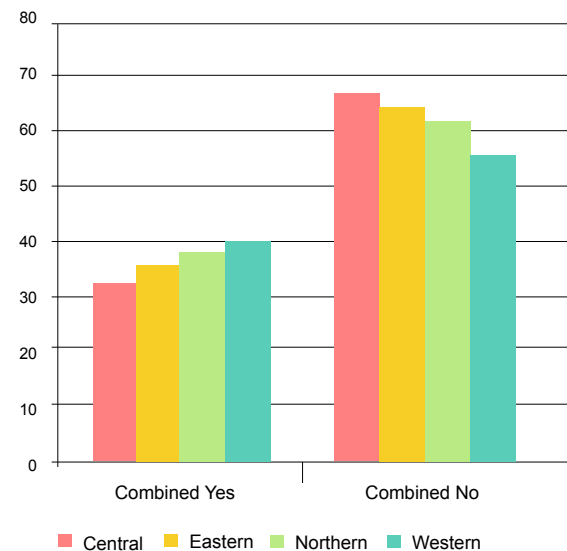
Figure 6.1 Proportion of adults who physically hurt children in their care by division (%), 2008



Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

The 2008 baseline research revealed that 72 per cent of adults physically hurt children in their care. While information pertaining to where this happened is unknown, this reveals children’s continuing vulnerability in the presence of adults, either in their immediate families or when living with relatives.

Figure 6.2 Children who state they have been physically hurt by an adult in the household in the past one month by division (%), 2008

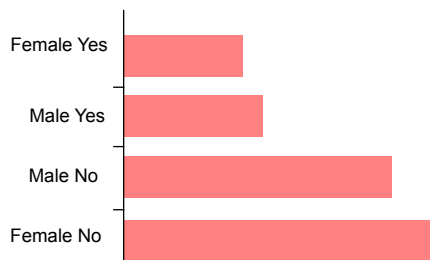


Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

Some 37 per cent of children aged 16-17 said they had experienced physical abuse from an adult in the home in the past month. The percentage was slightly higher in the Western division, where there was also a striking contrast between rural and urban areas. The incidence of household violence reported by children was twice as high in villages as in urban areas.

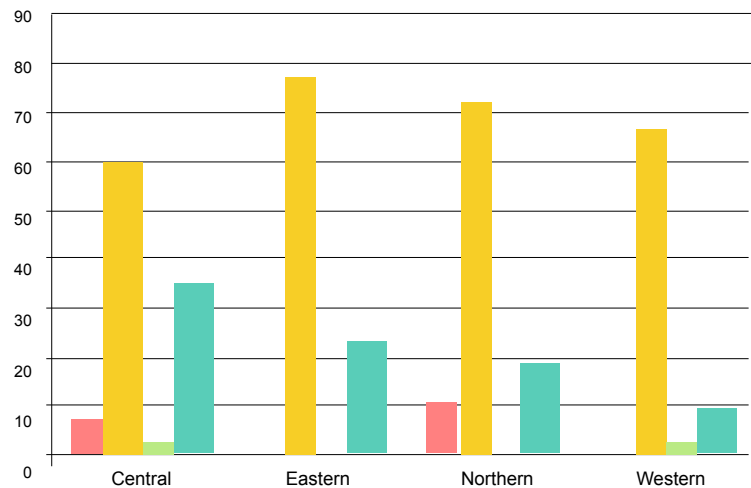
**Seven out of ten adults admitted to physically hurt children in their care
Almost one in three boys and girls confirmed having experienced violence from teachers**

Figure 6.3 Children who state they have been hit, smacked, pinched, knocked or flicked or had their ears pulled by a teacher at school in the past one month by gender (% , 2008)



Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

Figure 6.4 Children who state they have been hit, smacked, pinched, knocked or flicked or had their ears pulled by a teacher at school in the past one month by division (% , 2008)



Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

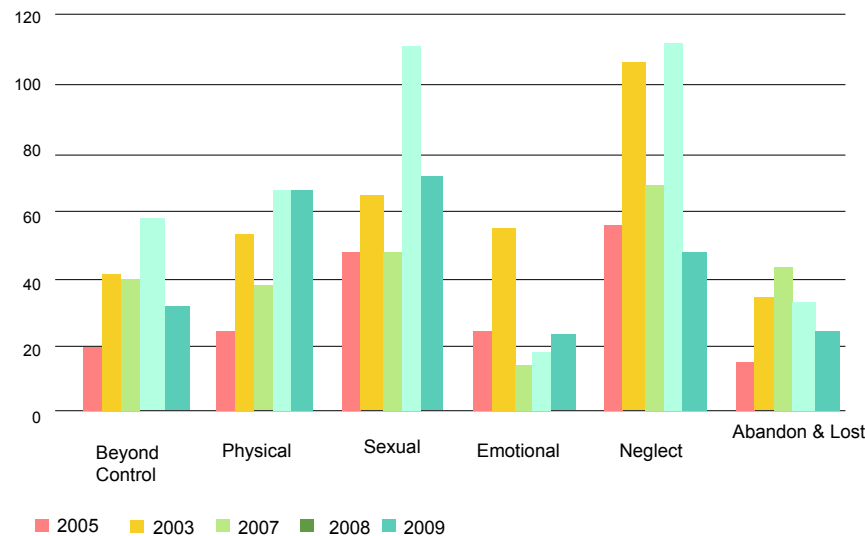
■ Combined do not go to school
 ■ Combined No
 ■ Combined Refused
 ■ Combined Yes

Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

Nationwide, 27 per cent of children aged 16-17 years in the survey confirmed having experienced violence from teachers. Boys were more likely than girls to have experienced violence from teacher violence (32 versus 27 per cent). Western and Central divisions had above-average percentages with 31 per cent and 34 per cent respectively.

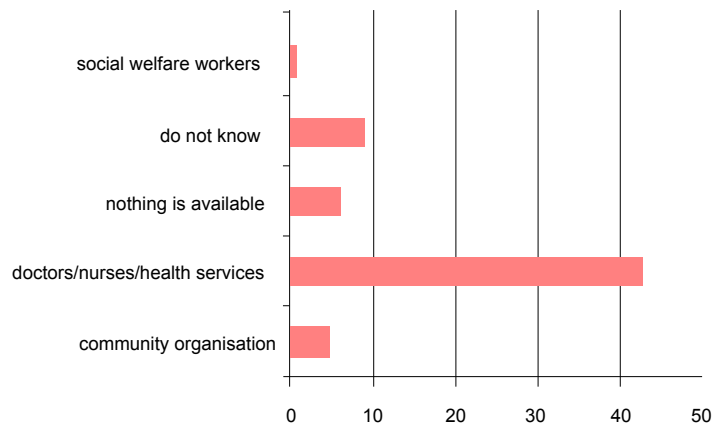
Child abuse in Fiji can be reported to the police, at hospitals, the Department of Social Welfare and the Women’s Crisis Centre. Most of the reported cases relate to neglect and sexual and physical abuse respectively. Not all cases of abuse are reported and the actual number of cases attended to is unknown. In addition, the profile of child victims is not available, making it difficult to identify vulnerable children and those at most risk of abuse.

Figure 6.5 Child abuse cases reported to Social Welfare Department by type of abuse (2005-2009)



Source: Ministry of Women, Social Welfare and Housing 2011 (from NCCC draft pg 60-61)

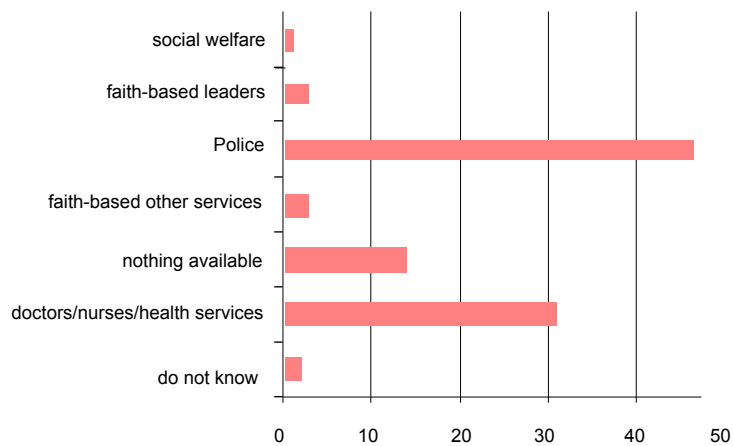
Figure 6.6 Services available in respondents' areas to help them if their child was badly hurt by someone, Rural



Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

In urban areas, 47 per cent of respondents identified police as a service available when a child was badly hurt and 31 per cent listed doctors, nurses and health services. In rural villages, however, only 17 per cent listed police as being available. Rural respondents mostly identified teachers, village traditional healers and community organisations as services available for a badly hurt child. The availability of social welfare services appears to be very low both in urban and rural areas (identified as available by less than 1 per cent of respondents). Some 15 per cent of adult respondents living in urban neighbourhoods indicated there were no services available at all for badly hurt children.

Figure 6.7 Services available to help respondents if their child was badly hurt by someone, Urban



Source: Protect me with love and care: Baseline report for Fiji (2008: 192)

15 per cent of adult respondents in urban neighbourhoods indicated there were no services available for badly hurt children

Table 6.1 Residential care admission at three children's homes

Year	St Christopher's Home	Dilkusha Home	Veilomani Boys Home	Ethnicity		
				iTaukei	Indo-Fijian	Others
2008	24	39	9	18	47	7
2009	22	32	9	15	42	6
2010	22	26	7	-	-	-
Total	68	97	25	33	89	13

Source: Social Welfare Department Statistics (from NCCC draft report pg 54)

Children in Fiji may be placed in seven child welfare residential facilities. Five of these are in the Central division; the Boys Centre; Mahaffy Girls Home, Happy Home; Dilkusha Girls Home and St Christopher's Home. Two child welfare facilities are in the Western division, they are Treasure Home and Veilomani Boys Home. The Eastern and Northern divisions do not have specific residential care facilities for children (NCCC, 2011). The majority of children in residential care are in the Central division and are of Indo-Fijian descent. No information is available about the children's gender composition, their place of origin or family backgrounds. UNICEF is working with the Department of Social Welfare to strengthen alternatives to residential care such as foster parenting.

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Annex 1

Definition of indicators

Socio-Economic Development

GDP per capita

Gross Domestic Product (GDP) is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output. GDP per capita is gross domestic product divided by mid-year population (UNICEF, The State of the World's Children 2009, Maternal and Newborn Health).

Percentage of Government budget allocated for education

Public expenditure on education consists of current and capital public expenditure on education and includes Government spending on educational institutions (both public and private), education administration, as well as subsidies for private entities (students/households and other private entities) (World Bank, 2011).

Percentage of Government budget allocated for education

Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning and nutrition activities and emergency aid designated for health, but does not include provision of water and sanitation (World Bank, 2011).

Children living below the national and sub-national Basic Needs Poverty Line

Basic Needs Poverty Line is taken to be the cost of foods that are part of the Food Poverty Line Basket, plus a value that represents essential non-food costs (FBOS, 2010).

Education

Number of trained teachers by province and by gender

Trained teachers are the percentage of school teachers who have received the minimum organised teacher training (pre-service or in-service) required for teaching in their country (World Bank, 2011).

Primary education completion rate (class 6) at sub-national or by provinces

Primary completion rate is the percentage of students completing the last year of primary school (World Bank, 2010).

Net enrolment in Junior Secondary Schools by gender and by province

Net enrolment ratio is the number of children enrolled in junior secondary school who are of the official school age group, expressed as a percentage of the whole population of the official age for that level of school in a given year (UNESCO, 2000).

ECE enrolment by province

Percentage of children under five years enrolled in ECE.

Exam pass rate by province

Percentage of students who scored above the minimum in external examinations.

Teacher/student ratio

The number of pupils enrolled in primary and secondary school divided by the number of primary and secondary school teachers regardless of their teaching assignment (World Bank, 2011).

Health

Infant mortality rate

Probability of dying between birth and exactly one year of age, expressed per 1,000 live births. (UNICEF, The State of the World's Children 2009, Maternal and Newborn Health)

Under-five mortality rate

Probability of dying between birth and exactly five years of age, expressed per 1,000 live births. (Ibid, 2009).

Maternal Mortality Ratio

Annual number of deaths of women from pregnancy related causes per 100,000 live births (United Nations Children's Fund, The State of the World's Children 2009, Maternal and Newborn Health).

Trained attendant at birth

The percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on their own and to care for newborns (MSPNDS, 2010).

Measles immunisation coverage rate

The percentage of children under one year of age who received the measles vaccine. A child is considered adequately immunised against measles after receiving one dose of vaccine (Ministry of Strategic Planning, National Development & Statistics, 2010).

Proportion of boys and girls one-year-old who are fully immunised with potent vaccines as per national schedule.

Access to hygiene sanitation facility

Hygiene sanitation facilities include the use, in home/compound of flush/pour-flush to piped sewer system, septic tank and pit latrine, pit latrine with slab, composting toilet and *Ventilated Improved Pit (VIP) latrine*. (UNICEF/WHO Joint Monitoring Programme).

Access to safe drinking water

Access to an improved water source refers to the percentage of the population with reasonable access to an adequate amount of water from an improved source such as

a household connection, public standpipe, borehole, protected well or spring and rainwater collection. Unimproved sources include vendors, tanker trucks and unprotected wells and springs. Reasonable access is defined as the availability of at least 20 litres a person per day from a source within one kilometre of the dwelling (World Bank, 2011).

Prevalence of under-five malnutrition

The percentage of children under age five whose weight for age is more than two standard deviations below the median for the international reference population ages 0-59 months (World Bank, 2011).

HIV and AIDS

Number of new HIV infections <nine years

The number of children under nine years who are infected with HIV

Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject misconceptions about HIV transmission

This is defined as having an understanding of the main methods of HIV prevention and knowledge about HIV transmission.

Percentage of sexually active young women and men aged 15-24 who received an HIV test in the last 12 months and know their results

Percentage of pregnant women who were tested for HIV and know their results

Child Protection

Percentage of parents and caregivers who know what to do/who to turn to in case of violence, exploitation and abuse of children in their care.

Knowing what to do refers to parents' and caregivers' confidence level to do something when a child in their care was badly hurt by someone.

Proportion of adults who physically hurt children

Physically hurting children involves hitting, smacking, kicking, donging or pulling or twisting children's ears.

Number of children placed in residential care

Children under the age of 17 years deprived of a family environment and taken under the care of the Director of Social Welfare.

