Poverty, Health and Nutrition in Fiji

Fozia N. Razak
Biman C. Prasad

Abstract

Poverty is considered to be a multidimensional problem which progressively needs public attention at all levels. Health and poverty are intertwined and each impacts on the other. Poverty contributes towards ill-health as individuals strive to adequately meet nutritional requirements, whereas people with poor health are normally unable to work or earn well and gradually end up in chronic poverty. The purpose of this paper is to present an overview of poverty, health, and nutrition in Fiji, and in doing so, identify the implicit linkages amongst them. Trends in poverty and health indicators in Fiji are examined together with a discussion of what poverty does to health and nutrition.

Introduction

Poverty is a multidimensional problem and has several facets which need to be examined. Two of these are food insufficiency, and lack of access to health services and medicine. In the Millennium Development Goals (MDGs), these two issues are measured by a proportion of the population receiving less than the minimum level of dietary intake, and by the prevalence of underweight children.

Poverty has been on the rise in Fiji and appears to be gaining momentum in all aspects of it. However, there are many hidden aspects of poverty that can only be revealed at closer examination. Pain and disability, for instance, are associated with poverty. Similarly some older persons may have enough to eat but may not have medicine for sicknesses, or may be physically disabled and not have aid for mobility. Such phenomena are common even in marginally poor households. If all such conditions are accounted for in the measurement of poverty, then the poverty

rates for many developing countries would increase substantially. If such phenomena are measured for households already in poverty, then the depth of poverty (poverty gap measure) would increase substantially since certain individuals within households are often more severely affected by deprivation.

In Fiji, there is overwhelming evidence of increasing poverty (Narsey 2006). The number of people living in squatter settlements is rising which is evident both in rural and urban areas. The poor are normally deprived of adequate nutritional requirements and this gives rise to many health problems.

According to the Strategic Development Plan 2007-2011 (SDP), Government has a number of poverty alleviation programs in place. For example, in 2005, $62.7 million was allocated for poverty alleviation programs such as upgrading of squatter settlements, micro-finance schemes and the Family Assistance Scheme (FAS). Since 2001, the government has allocated about $284 million for social safety nets in Fiji (SDP 2006).

A review of health performance suggests that while inputs provided by governments have increased, the outcomes in terms of health indicators have not shown proportional improvement. This poses a challenge for the institutions engaged in the delivery of health-related services.

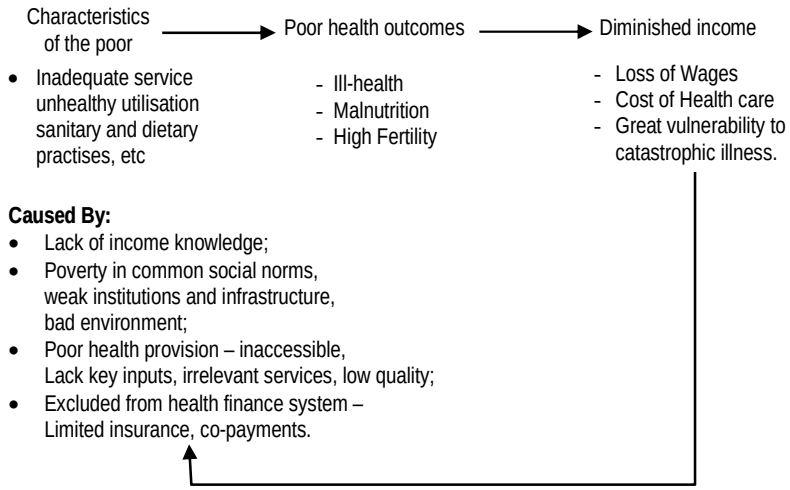
This paper discusses the linkages between poverty, health and nutrition in Fiji. Poverty contributes towards ill-health as individuals strive to adequately meet the nutritional requirements, whereas people with poor health are normally unable to work or earn well and gradually end up in poverty. Hence, poverty and health are intertwined, each impacting on the other. The next section looks at the linkage amongst poverty, health and nutrition. This is followed by an overview of poverty and health in Fiji, describing issues related to health expenditures. We then focus on nutrition and non-communicable diseases.

Poverty, Health and Nutritional linkages

Poverty is generally regarded as both a consequence and a cause of ill health. Hence, poverty and ill-health are intertwined (WHO 2002). Households end up in poverty or sink further into it if they are already poor and have health problems. As a result of this, they suffer from malnutrition and chronic poverty. For example, according to the 2002-04 SDP, more people fell ill and visited hospitals in 2000 than in 1999 due to reduced income and thus lack of nutritious food including stress and frus-

tration caused by unemployment.[1] Poor countries and consequently, poor people usually lack the resources to pay for health services, food, clean water, good sanitation, and other components needed for good health. Normally, apart from being deprived of resources, the poor people are also underprivileged in terms of knowledge about prevention from disease and timely healthcare. The communities in which they live usually have social norms that are not conducive to good health. In a nutshell, we can say that poor people are caught in a vicious cycle where poverty breeds ill-health and ill-health in turn plunges them deeper into poverty (see Figure 1).

Figure 1: Cycle of health and poverty



Source: WHO (2002:98)

Poverty and Health in Fiji

Strong relationship between poverty and health is recognized and acknowledged by health service and development organizations at all levels. Subsequently, three of the eight MDGs are focused on specific health improvements by 2015. The 4th MDG states that reducing child mortality

[1] This was due to the attempted terrorist coup of May 2000, which caused increased redundancies and unemployment, thereby increasing the number of people in poverty.

by two-thirds between 1990 and 2015 for children under the age of five should be achieved by all developing countries. The 5th MDG states that reducing maternal mortality rate by 75% between 1990 and 2015 should also be achieved by the developing countries. The 6th MDG states that HIV/AIDS, Malaria and other diseases are to be combated to halt their spread by year 2015. Further to this, it entails a commitment of reversing the spread of HIV/AIDS, as well as the incidence of Malaria and other diseases. G.H. Brundtland, the Director General of WHO in 1998 emphasized the interrelationship between health and poverty, and stated the following:

> We cannot allow health to remain a secondary item on the international health agenda…We know that the vast majority of human suffering and early deaths in the world are poverty related…Ill-health leads to poverty and poverty breeds ill-health. People in developing countries carry 90% of the disease burden yet have access to only 10% of the resources used for health.

In addition to this, health is increasingly viewed as fundamental to eradicating poverty and extreme hunger (OECD 2003). Two targets arising from this are that between 1990 and 2015, the proportion of people living on less than $1US per day and the number of people suffering from hunger, should be halved. Indicators for these targets basically include the proportion of those in poverty and the poverty gap ratio, which indicates the depth of poverty.

Poverty in Fiji has been increasing over the past three decades (see Prasad 1998; Kumar and Prasad 2004; Prasad and Asafu-Adjaye 1998; Barr 1991; MacWilliam 2002; Naidu et al. 1999; Gounder 2007; Chand 2007; Walsh 2001; Prasad and Tisdell 2006) and as a result a higher percentage of the population fell below the poverty line in Fiji (see Tables 1-3).[2] The data from last three Household Income and Expenditure Surveys (HIES) indicate that both the incidence and the severity of poverty have increased over time (Table 4; see also Walsh 2001). Studies have also shown that poverty gap and hence the cost of closing the poverty gap in Fiji over the years have also increased (see Table 5).

[2] Normally three household poverty lines are used: Food poverty – the inability to provide minimum dietary requirements), Basic needs poverty (income less than the costs of basic food and shelter); Relative poverty (under one-half of the average household income).

Narsey (2006) states that the cost of closing the poverty gap has risen from 11% of the total wage bill in 1984 to 27% in 1989 and 32% in 1999. The largest portion of these adjustments was required in the private sector (more than 95% of the required adjustment).[3]

Table 1: Urban Poverty line and the Estimates of Urban Poverty in Fiji

Year	Poverty Line (Weekly Household Earnings in $F)	Percentage of Population in Poverty as defined by income
1982	45.00	9
1989	63.10	12
1990	71.40	15-20
2002-03	128-132	31.4

Source: UNDP 1997:31; SDP (2007); HIES (2002/03); Barr (1991)

Table 2: Poverty Rates for Food, Basic Needs and Relative Poverty Lines (1990/91)

Groups	Food Poverty[a]	Basic Needs Poverty[b]	Relative Poverty[c]
Urban	7.9	27.6	29.0
Rural Village (Fijian)	12.2	22.4	35.2
Rural settlement (mainly Indo-Fijian)	10.1	26.2	24.9
Fijian	10.4	27.7	31.3
Indo-Fijian	9.2	31.0	34.5
Others	12.1	27.6	26.9
Total	9.9	25.5	32.7

Notes: [a] Income less than cost of basic food items; [b] Income less than costs of basic needs; [c] Income less than half average household incomes as defined by UNDP (1997).

Source: UNDP (1997); Kumar and Prasad (2004).

Table 3: Ethnic and Rural-Urban Distribution of Poverty Incidence in Fiji

	Rural			Urban			Total
	Fijians	Indians	Others	Fijians	Indians	Others	
Percentage of population by Group	38	43.1	41.3	27.2	29.1	17.3	34.4

Source: SDP (2007-11) from HIES (2002/03)

The report estimates the poverty gap to be $2616.64 per year for an average household. The gap is the difference between the national poverty line (estimated at $8062.6 in 2002) and the average income of a poor household ($5445.96 per year). This indicates the depth of poverty .

[3] For a detailed discussion on the costs of bridging the poverty gap amongst wage earners, see Narsey (2006: 27-44).

Table 4 Incidence of Poverty in Percent as per HIES (1977 1990/91 and 2002/3)

Incidence of poverty	1977)	1991	2002/3	Change in Poverty (1977-1991)	Change in Poverty 1991-2002/3	Change in Poverty 1977-2002/3
National	15.0	25.2	34.4	60.0	+9.2	+19.4
Urban	11.6	32.8	31.8	150	-1.0	+20.2
Rural	21.4	23.1	38.1	40	+15.0	+18.5
Settlement	19.6	29.0	..	5	..	..

(Source: Gounder 2007: 95)

Table 5: Poverty Gap and the Cost of Closing the Gap (in Fiji Dollars)

Income	1977 (all Groups)	1990/1991 (all groups)	2001 (Indo-Fijians)
National Household Income	5398	10364	8516.13
National Poverty Line	1480	4316	5845.32
Mean Income of the Poor	814	2939	3440.41
Poverty Gap	666	1377	2404.91
Cost of Closing the Gap (millions)	11.5	45.9	90.20

(Source: Kumar and Prasad 2004: 477).

The SDP (2007) points out three main reasons for the increase in poverty, which are as follows: 1) the increasing number of households and individuals receiving family assistance; 2) the increasing number of displaced families from the sugar industry; and 3) the continuing rural-urban migration. Other reasons as stated by the SDP (2002) are the effects of political crises, which have led to increasing unemployment and redundancies, leading to a reduction in income.

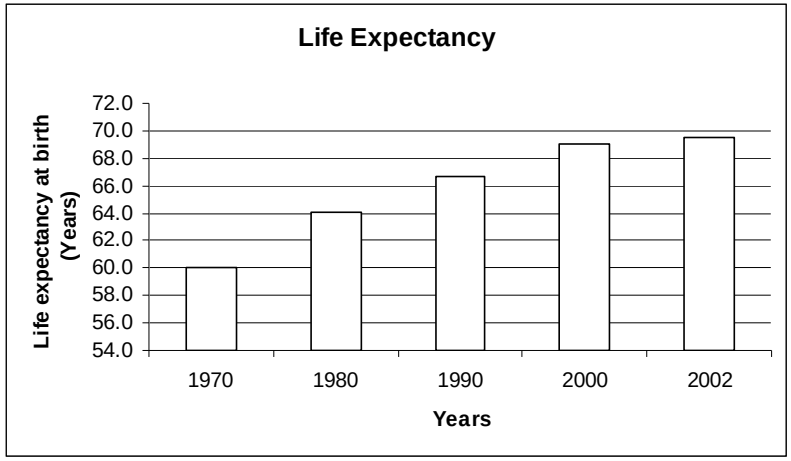
There has been an increase in urban poverty in Fiji as shown in Table 1. It is evident from the table that urban poverty increased from 9% in 1982 to 15-20% in 1990 and further to 31.4% in 2002-03. This has manifested into many obvious signs of increase in poverty such as increase in the number of street beggars and cases of prostitution. Also evident is the increase in criminal activities in urban areas. Another manifestation is the increase in the number of squatter settlements in many of the satellite towns around Fiji, which is a direct cause of increasing rural-urban migration. Rural to urban migration is generally seen as a solution to the problems of the rural poor. However, if this is not coupled with corresponding increases in urban economic activities, it results in proportional increases in the rate of poverty in urban centers where the migration takes place. When this trend continues for long periods of time, it inevitably

leads to deeper and more serious forms of deprivation.

Results of the 2002/03 HIES indicate that 34.4% of the population lived below the Basic Needs Poverty Line (BNPL). This indicates a 5% increase from the 1990/91 HIES report. According to the report, most of those in poverty are people living in rural areas particularly those from the Indo-Fijian community (see Table 3).

The UNDP (2003) reports that the Human Poverty Index (HPI) for Fiji has increased from 41 in 2001 to 49 in 2003, while the Human Development Report 2007/2008 states that Fiji ranked 50th among 108 developing countries in 2004. There, however, there has been an improvement in certain health indicators for the nation as a whole. For example, Fiji's life expectancy has improved gradually over the years (see Figure 2), a pattern that is consistent with the life expectancy achievements in other countries. At independence, life expectancy at birth was 60 while in 2002 it increased to 69 years (World Bank 2004).

Figure 2: Fiji Life Expectancy Rate

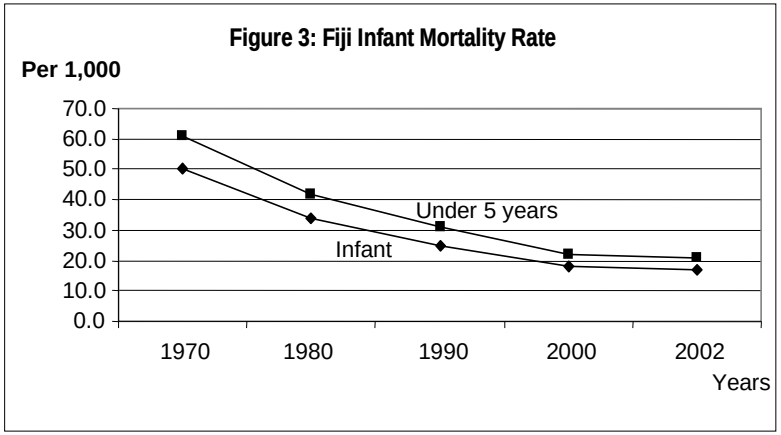


Source: World Bank (2004)

Fiji has also made significant improvements in mortality rate as shown in Figures 3 and 4. Both infant and under-five mortality rates have been halved since the 1970s and are now relatively low. Under-five mortality rate was 60 per 1,000 in 1970; this has fallen to about 20 per 1,000 in 2002. Similarly, infant mortality rate was 50 per 1,000 in 1970, which

declined to less than 20 per 1,000 by 2002 (World Bank 2004). Better childbirth facilities in hospitals, increases in the use of sterilised equipment during childbirth, and improvements in postnatal care, has contributed to this decline. More public awareness on childcare and increased vaccination and immunisation of children against diseases such as DPT and measles, including polio and tetanus, has helped improve child health generally and in reduction in infant mortality rates (Figure 5).

Figure 3: Fiji Infant Mortality Rate



Source: World Bank (2004).

Fig. 4: Mortality Rates (Adult), 1970-2000

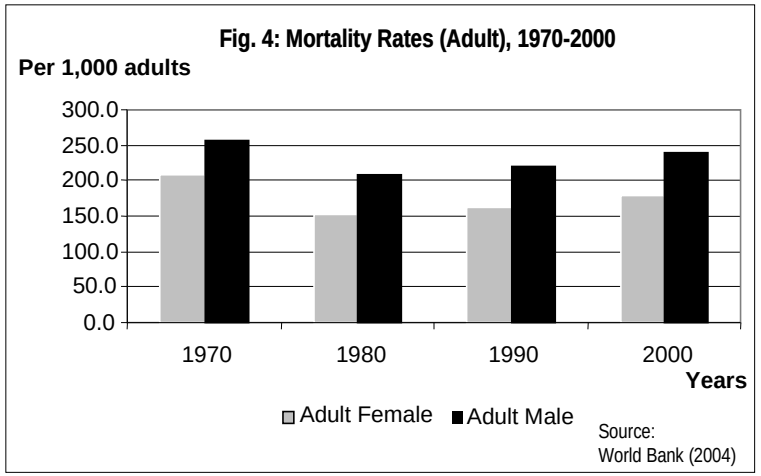
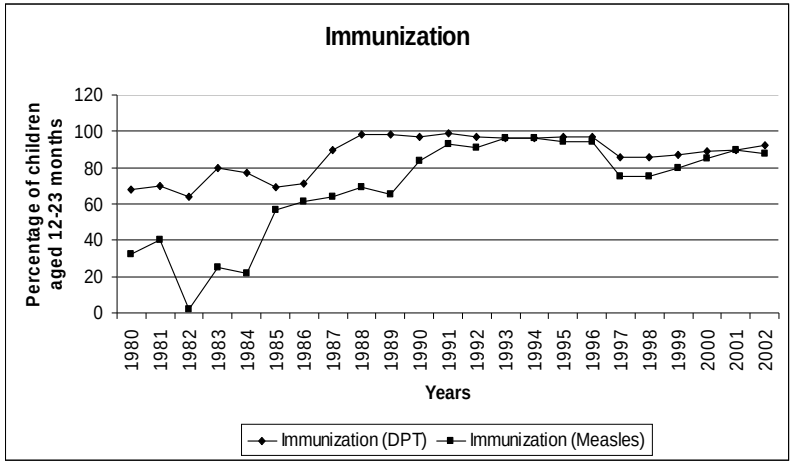


Figure 5: Immunization of 12-23 Month Old Babies (1980-2002)



Source: World Bank (2004).

According to Chand (2007), the simultaneous rise in the HDI for Fiji and the increasing poverty levels show evidence of failure of the many pro-poor policy pronouncements of the past.[4] Poor economic performance and policy failures of various governments since the mid 1980s are also a major reason why poverty in Fiji has been on the rise (Kumar and Prasad 2004; Sephere and Akram-Lodhi 2000; Walsh 2001; Prasad 1998).

Food and nutrition are critical factors in influencing the health of the poor. The OECD (2003) states that nearly 800 million people in developing countries are chronically undernourished. Undernourishment affects the immune system, increasing the incidence and severity of diseases, which is an associated factor in over 50% of all child mortalities (OECD 2003).

There have been rising concerns about Fiji's deteriorating healthcare services, with improving the services being given low priority. Despite improvements in the health indicators such as improving life expectancy and falling mortality rates, there is a growing concern that Fiji faces a serious challenge in terms of rising incidences of AIDS, and lifestyle diseases such as heart-attack and diabetes. Deterioration in Fiji's healthcare

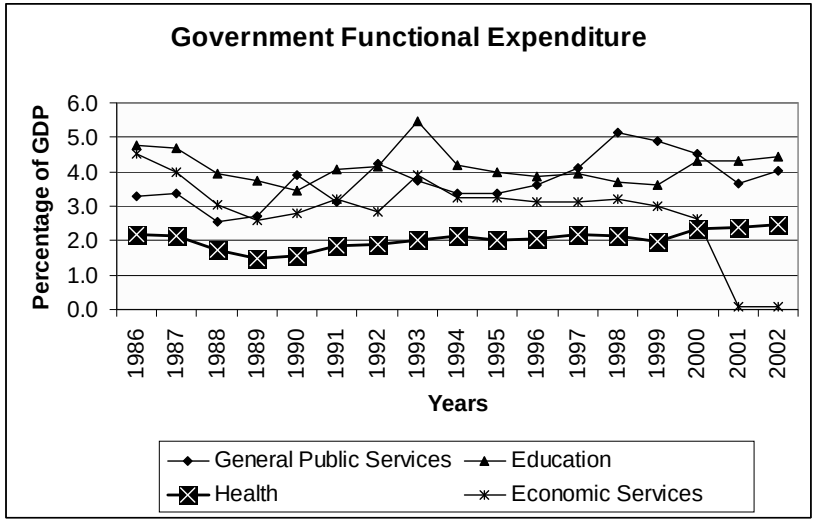
[4] According to UNDP (2006) the HDI for Fiji was 0.663 in 1975 and it rose to 0.758 in 2004 (Chand, 2007).

system is regarded as the main contributing factor in increasing incidences of these diseases. As the healthcare system deteriorates, the poor get affected the most since they depend mainly on public health services.

Health Expenditure in Fiji

Fiji's healthcare expenditure has ranged from 1.5 to 2.5 percent of GDP over the period 1986 to 2002 (Figure 6). Despite the gradual increase in budgetary allocations for healthcare during this period, the health expenditure in terms of percentage of GDP has not increased significantly. Available statistics indicate that the health expenditure was 1.5 percent of GDP in 1989 and 2.5 percent of GDP in 2002. This shows a significant increase over this 10 year period. The health expenditure as a percentage of GDP has averaged 2.0% over the period 1986-2002. Health expenditure as a percentage of GDP has remained far less than the expenditures on general public services, education and economic services. The trends depicted here make it clear that healthcare has been given a lower priority in terms of government funding relative to education.

Figure 6: Fiji Government Functional Expenditure 1986-2002.

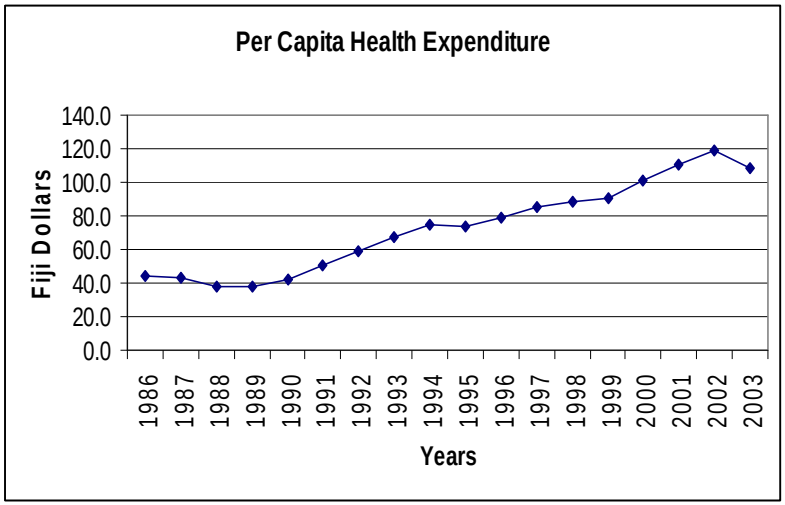


Source: World Bank (2004).

The political crises of 1987 had a detrimental effect on the economy (see Prasad 2003) and on the amount of money allocated for health. This declined from 2.1 percent of GDP in 1986 to 1.5 percent in 1989 (Figure 6). While health expenditure as a share of GDP remained around 2.2 percent in 1993 and 1997, it declined slightly to 2.0 percent of GDP in 1999. However, the crisis of 2000 did not affect health expenditure as it remained constant for the years 2000-2002.

Figure 7 shows per capita health expenditures between 1986 and 2003 showing a steady rise. Per capita expenditure was just over $F40 in 1986, which tripled by the year 2002. While such statistics are preferred and represent a good outcome in terms of per capita healthcare funding, the actual trickledown effect of per capita spending is more important and is an issue that needs further investigation.

Figure 7: Fiji's Per Capita Health Expenditure: 1986-2003.



Source: Asian Development Bank (2004).

A major problem regarding the healthcare sector in Fiji is the migration of skilled health professionals to other countries, like Australia, New Zealand, Canada, and America (see Gani, 2005; Seniloli, 2005 and Narsey, 2004). This is a fast growing problem and affects developing countries globally. For example, in 1999, the Fiji Ministry of Health estimated that 78% of all local doctors who had resigned in the previous 13

years had gone overseas (World Health Organisation 2004). As more and more healthcare staff emigrate overseas, there is a tendency for the health sector to face problems in the implementation of national strategies for health sector development. The loss of such skills is not only costly but also irreplaceable because of the enormity of resources required to training personnel in the healthcare sector. Recruitment in this area is often quite difficult as local training facilities are under-resourced and overseas recruited personnel require further training in language and culture. Pacific Island countries had had their health system marked by 'its vulnerability to workers and/or skill shortages' (World Bank. 1994). According to World Health Organisation (2004), Fiji had high medical personnel vacancy rates, averaging 9 percent of approved posts in the mid-1980s. In 1988-89, deteriorating pay prospects and ethnic tensions led to the resignation of over 100 doctors including many senior specialists, most of whom later emigrated. This has been a major setback from which the health care system in Fiji has not recovered fully despite various recruitment strategies.

Nutrition and Non-communicable Diseases

As pointed out earlier, Fiji has a relatively healthy population but life style diseases are increasing due to lack of primary healthcare facilities and information and advocacy. The main deficiencies are in the rural areas where basic sanitation and safe drinking water are in scarcity. Nutritional deficiencies are also common for poor households. Such problems in the rural areas normally cause people to migrate towards the urban centres. However, urbanisation in itself causes certain irreversible problems.

Urbanisation has been on the rise and has consequently led to many health problems over the past years. According to the Fiji Bureau of Statistics, urban population growth over the last census period (1986 to 1996) was 2.6 percent compared to 0.8 percent for the population as a whole.[5] A major consequence of rapid urbanisation has been health problems associated with poor housing, sanitation, diet and a sedentary life style. Other outcomes of urbanisation have been a loss of traditional food security for the two major ethnic groups, a lack of traditional familial support, congestion, pollution, and unhealthy life style. All these have detrimental impacts on the health of poor people which push them further into poverty (See Box 1). The expenditure on food items for poor house-

[5] Personal communication – statistics division

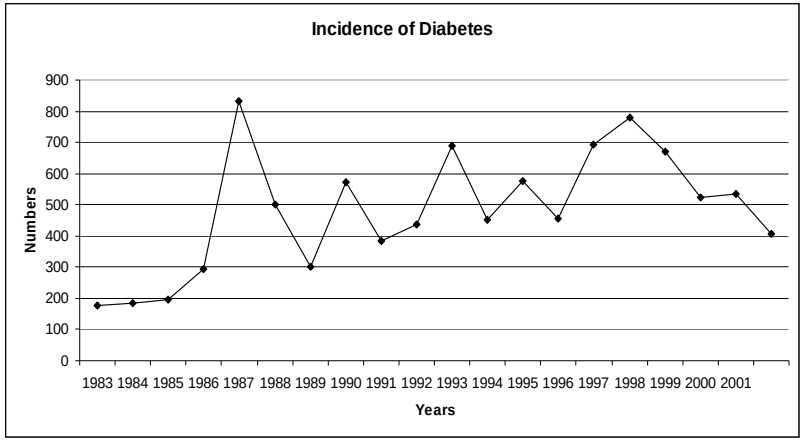
holds often determines the state of the health of the household members. Narsey (2006) argues that expenditure on food is the most critical component for households in poverty.

Box 1: A Story of a Squatter Indo-Fijian family.

Maizy (not the real name) is 40 years old and lives with her husband (45 years old) and two children, a 22 year son who is married and has a 1 year 3 month old son, and a 15 year old daughter who is schooling. Maizy works as a babysitter for five days a week in the neighbourhood and earns $50, while her husband is a taxi driver and earns about $80 per week. Her son is a casual worker and is occasionally out of job and was out of job for about 3 months at the time of the interview. According to Maizy, they have lots of difficulties in meeting ends since her husband spends most of his earnings smoking and drinking kava. Their meals comprise noodles, bread and rice which is often not enough. Maizy's daughter is suffering from severe anaemia. The family lives in a two-bedroom shack which is quite congested and the outside environment is polluted with household refuse and in unhygienic condition. The point to note was that although they were not able to spend much on food and health, Maizy saved money to watch movies. It appeared that the family was not giving much priority to nutrition and health and there was a major lack of corporation from Maizy's husband.

Generally, non-communicable diseases such as stroke and heart attacks and obesity have continued to rise in Fiji despite repeated campaigns to control them. The incidence of diabetes in Fiji was increasing in the past but has begun to decline since late 1990s (see Figure 8).

Figure 8: Fiji Incidence of Diabetes 1980-2001



Source: Unpublished data from Fiji Ministry of Health Headquarters.

The South Pacific Commission (2000) reports that diabetes has reached extremely high levels in the Pacific region, with Nauru standing at 35 percent of the adult population, Fiji at 20 percent, and Kiribati at 15 percent.

According to the Ministry of Health, respiratory, infectious and parasitic diseases continue to be the leading causes of admission to hospitals. The alarming trend could be largely attributed to lifestyle changes, poor diet, smoking and changing patterns in physical activity and lack of attention to nutritional needs, particularly for school-going children, women and elderly people. As pointed out earlier, there are increases in reported cases of HIV/AIDS and Sexually Transmitted Diseases (STD). Fiji Ministry of Health (various issues) states that it is rather difficult to get information on STDs due to unreported cases. WHO and UNAIDS (2004) report that Fiji has seen an increasing number of new HIV cases from 1989 to 1999. In 2001, an estimated 300 individuals were living with HIV/AIDS in Fiji (WHO and UNAIDS 2004). The 2007-11 SDP report states that the cumulative number of people with positive HIV/AIDS status was 229 as at September 2006. Fiji has passed the initial stages of the epidemic; the country now is in the explosive stage. If the HIV infection rate continues at the current pace, it is projected that 6500 people will have the HIV/AIDS virus by 2015. It is expected that these cases will mostly be from poor households.

A Non-Communicable Disease survey in 2002 showed an 11.9 percent prevalence rate for diabetes and 19.1 percent for hypertension. A third of all deaths and half of those in the 40-59 year-old age group are due to circulatory diseases. According to the Ministry of Health, the leading cause of death and serious illnesses in young children are acute respiratory infections, diarrhoea, parasitic infections, meningitis and anaemia. All these largely arise from poor or inadequate diet; the poor are mainly affected by this.

WHO and UNAIDS (2002) emphasise that Fiji has a high life expectancy at birth, which could be averaged at 72.5 years and lower infant and maternal mortality rates. Non-communicable diseases such as diabetes, cardio-vascular diseases, cancer and respiratory diseases, have been generally increasing over the years, which Food and Agriculture Organisation (2003) attributes to the changing lifestyle for most people and the continuing problems of overweight and obesity. In Fiji, people are generally moving away from their traditional diets and switching from nutritional local foods like taro, cassava, and rice, to canned and imported foods like mutton flaps and more recently, instant noodles and soft

drinks.[6] These substitutes provide far less nutrition than the local foods, and contribute towards nutritional problems. As a result, major nutritional problems in Fiji are anaemia among pregnant women and school-going children. Conditions such as iodine and vitamin deficiency disorders are rapidly increasing together with other diet-related non-communicable diseases (FAO-GIS/ESNA 2002). According to Bryant-Tokalau (1995) poor diets relate to inadequate incomes as well as a lack of knowledge about nutrition. Narsey (2006) argues that the most critical factor for households in poverty is the expenditure on food. He affirms that consumers in Fiji are consuming more imported foods rather than those that are domestically available and hence end up with lesser nutritional values. His report shows that a relatively small amount of income is spent on food per week amongst all ethnic groups. This pattern is the case in both urban and rural settlements. This is most evident in the lower 10% of the households. For example, food expenditure per week per adult equivalent for rural households ranges from $9.32 to $33.24 and for urban households it ranges from $7.31 to $31.61, from the lowest to highest deciles respectively. The lesser the allocations towards food, the more likely are the nutritional problems. Mainly the poor are unable to allocate sufficient income towards food and nutrition, which is evident from the data. These are the unfortunate ones who suffer from multiple health problems and very seldom have resources to meet healthcare expenditures. Poor nutrition triggers poor health and ill-health in return exacerbates poverty.

Conclusion

Poverty is a multidimensional problem. The nexus between nutrition, health and poverty is an important one. This is because even if measures of relative poverty in countries may suggest that families are above the poverty line, they could in reality have poor health and nutrition. This would cause their ability to remain above the poverty line to be temporary and unsustainable. The distribution of income and indeed consumption patterns at the household level could explain the nutritional and health problems of children and women who are the most vulnerable in households that are at the margins of income just above the poverty line. The assessment of health and nutrition aspects in Fiji suggests that many households who may officially not fall below the poverty line, but actually have very poor health due to nutritional deficiencies.

However, further studies about poverty at the intra-household level could shed more light on the relationship between health, nutrition and poverty. Who are the real poor? How do the spending patterns of people living in squatter settlements differ from average and high income earners? What importance is attached to health and nutrition in different households and how do they differ? Where do the spending priorities lie? The answers to these questions could produce interesting insights into the situations of poor households including those just above the poverty line. Such findings would provide a basis for appropriate national policies in the area of health and nutrition.

[6] According to Vatucawaqa (2001), Fiji has a low self-sufficiency (43% of energy derived from local foods in 1997) in terms of local production of major food commodities and this deems it necessary to meet the shortfall with imports.

References

Asian Development Bank (1990) *Key Indicators.* Manila.

Asian Development Bank (2004) *Key Indicators.* Manila.

Barr, K. (1991) *Poverty in Fiji' Fiji Forum for Justice, Peace and the Integrity of Creation.* Suva: ECREA.

Bayarsaikhan, D. (2003) Regional Overview on Health Care Financing, (Power Point presentation at the TAG meeting on Health Care Financing) WHO Regional Office for the Western Pacific, 17-19 February 2003, Manila: Philippines.

Bryant, J. J. (1993) *Urban Poverty and the Environment in the South Pacific*. Australia: The Department of Geography and Planning, University of New England.

Chand, S. (2007) '50/50 by 2020: Poverty and Redistributive Politics in Post-Independence Fiji'. *Pacific Economic Bulletin* 22(2): 22-35.

Fiji Ministry of Health (2003) *Annual Corporate Plan – 2003. Suva:* Government Printer.

Fiji Ministry of Health (2003) *Strategic Plan – 2003-2005.* Suva: Government Printer.

Fiji Ministry of Health (various issues) Annual Reports. Suva: Government Printer.

Food and Agriculture Organization (2003) *Nutrition Country Profiles – Fiji*. Italy: Rome.

Gani, A. (1999) 'An Economic Analysis of Factors Influencing Fertility in the Pacific Island Countries'. *International Journal of Social Economics* 26(1/2/3): 345-353.

Gani, A. (2000) 'Some Dimensions of Fiji's Recent Emigration'. *Pacific Economic Bulletin* 15(1): 94-103.

Gani, A. (2005) 'Fiji's Emigrant Transfers and Potential Macroeconomic Effects'. *Pacific Economic Bulletin* 20(2): 117-128.

Goundar, R. (2007) 'Strengthening Fiji's National Poverty Policies in the Context of Regionalism'. *Pacific Economic Bulletin* 22(2): 91-103.

Government of Fiji (2001) *Strategic Development Plan 2002-2004: Rebuilding Confidence, Stability and Growth, Ministry of National Planning*. Suva: Fiji.

Government of Fiji (2003) *Fiji Government Budget Estimates 2003*. Suva: Govern-

ment Printer.
Government of Fiji (2006) *Strategic Development Plan 2007-2011: Maintaining Stability and Sustaining Growth to Achieve a Peaceful, Prosperous Fiji*. Suva: Fiji, Ministry of Finance and National Planning,.
Kumar, S. and B. C. Prasad (2004) 'Politics of race and Poverty in Fiji'. *International Journal of Social Economics* 31(5/6):469-486.
MacWilliam, S. (2002) 'Poverty, Corruption and Governance in Fiji'. *Pacific Economic Bulletin* 17(1):129-45.
Naidu, V., K. Barr, R. Lee and K. Seniloli (1999) '*Fiji's Poverty alleviation and Eradication Strategy Framework*'. Suva: UNDP and Ministry of National Planning.
Narsey (2004) *Regional Integration or Remittances: What Options?* Paper presented at the Remittances, Microfinance and Technology Workshop, University of Queensland, 10-11 June 2004.
Narsey, W. (2006) *Just Wages for Fiji – Lifting workers Out of Poverty*. Suva, Fiji: Vanuavou Publications.
Narsey, W. (2006) *Report on the 2002-2003 Household Income and Expenditure Survey*. Suva, Fiji: Vanuavou Publications,.
New Zealand's International Aid and development Agency, 'Ending Poverty Begins with Health' available at: http://www.nzaid.govt.nz/library/docs/nzaid-ending-poverty-begins-with-health.pdf.
Organisation for Economic Co-Operation and Development Observer (2003) *Poverty and Health in Developing Countries: Key Actions*. Policy Brief, OECD.
Poverty Task-Force (1991) *The Report of the Poverty Task Force*, presented to the Economic Strategy Committee, Fiji Cabinet, October 1991
Prasad, B. C. (1998) 'The Woes of Economic Reform: Poverty and Income Inequality in Fiji'. *International Journal of Social Economics* 25(6/7/8):1073-1094.
Prasad, B. C. (2003) 'Merging Interests in Fiji: Essential Ingredients for Better Economic Performance'. *Pacific Economic Bulletin* 18(1): 121-130.
Prasad, B. C. and J. Asafu-Adjaye (1998) 'Poverty and Macroeconomic Policy in Fiji'. *Pacific Economic Bulletin* 13(1): 47-56.
Prasad, B. C. and C. Tisdell (2006) *Institutions, Economic Performance and Sustainable Development: A Case Study of the Fiji Islands.* Inc. New York: Nova Science publishers.
Saito, S. (1995) *1993 National Nutritional Survey Main Report*. Suva, Fiji: National Food and Nutrition Committee.
Savou, S., S. Saito and R. Murti (1995) *1993 National Nutritional Executive Summary Report*. Suva, Fiji: National Food and Nutrition Committee.
Scheffler, R. M. (2004) *Health Expenditure and Economic Growth: An International Perspective*. Occasional Papers on Globalization 1(10).
Seniloli, K. (2005) 'They are Digging Their Graves with Their Teeth'. *The Journal of Pacific Studies* 25(2): 163-91.
Sephere, A. and H. Akram-Lodhi (2000) 'Fiji's Economy: The Challenges of the Future', in H. Akram-Lodhi (Eds), *Confronting Fiji Futures.* Canberra: Asia Pacific Press.
Sharma, K. L. (2004) 'Growth Inequality and Poverty in Fiji Islands: Institutional Constraints and Issues'. USPEC Working Paper No. 2004/10. Suva: School of

Economics, The University of the South Pacific.
South Pacific Commission (2000) *Lifestyle Diseases in Pacific Communities*. New Caledonia: Noumea.
Szmedra, P. and K. L. Sharma (2005) 'Lifestyle Diseases and Economic Development: The Case of Nauru and Kiribati'. USPEC Working Paper No. 2005/13, Suva: School of Economics, The University of the South Pacific.
Szmedra, P., K. L. Sharma and C. L. Rozmus (2005) 'Managing Lifestyle Illnesses in Pacific Island States: The Case of Fiji, Nauru and Kiribati'. USPEC Working Paper No. 2005/14, Suva: School of Economics, The University of the South Pacific.
UNAIDS/WHO (2002) Fiji: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections 2002 Update, New York, available at:http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Fiji_en.pdf
United Nations Administrative Committee on Coordination (1997) 'Nutrition and Poverty'. Papers from the ACC/SCN 24th Session Symposium Kathmandu, March 1997, Nutrition Policy Paper # 16.
United Nations Development Programme (1997) *Fiji Poverty Report*. Suva: UNDP and Government of the Republic of Fiji islands.
United Nations Development Programme (2006) 'What is Poverty?'. *Concepts and Measures*, Brazil: UNDP International Poverty Centre.
Van Den Berg, H. (2001) *Economic Growth and Development*. Boston: McGraw-Hill Irwin.
Vatucawaqa, P. (2001) *Fiji Food Balance Sheet-1997*. Suva, Fiji: National Food and Nutrition Committee.
Walsh, C. (2001) 'Poverty in Fiji and the Pacific Islands'. Paper delivered at the Asia Pacific Forum on Poverty: Reforming Politics and Institutions for Poverty Reduction at the Asian Development Bank, Manila, 5-9 February, 2001.
WHO and UNAIDS (2004) Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections Update, Available at: http://www.who.int/hiv.
World Bank (2004) World Bank Indicators (CD Rom) Washington D.C.
World Bank (1994) *Health Priorities in the World Bank's Pacific Member Countries.* Washington D.C.
World Health Organisation (2004) *The Migration of Skilled Health Personnel in the Pacific Region*. A Summary Report, Philippines: Manila.
World Health organization (2002) 'Poverty and health Sector Inequalities', by Wagstaff, A. Bulletin of the World Health Organization 80(2):97-105.

Fozia Razak is an Assistant lecturer in the School of Economics at the University of the South Pacific. She teaches public finance, development and microeconomic theory. Email Contact: nisha_f@usp.ac.fj

Biman Prasad is Professor of Economic and the Dean of Faculty of Business and Economics at the University of the South Pacific. Email Contact: chand_b@usp.ac.fj

.