The Evolution of Primary Heath Care in Fiji: Past, Present and Future

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Abstract
Health policy initiatives are under-analysed in the Pacific region. Understanding how health policies develop and evolve is a first step towards improving their quality and contextual appropriateness. Through a document review and key informant interviews, this paper examines the evolution of primary health care in Fiji from 1975 to 2009 focusing on priority-setting, funding, implementation, political economy, the cultural context and interactions among communities, government and donors. Lessons learned from more than 30 years of experience with community health in Fiji are highlighted and reveal high levels of contestation over health policy processes. The paper identifies factors for consideration in renewed primary health interventions and calls for greater government ownership of priority-setting processes, more clarity on the links between policy and funding, more focus on evidence-based policy, greater awareness by development partners of the risks of policy imposition, and a deeper analysis of political economy and culture in relation to health sector policies. (PHD 2011; Vol. 16(2): p13-23).

Introduction

Primary Health Care (PHC) has been a central concept in global health for more than 30 years since its inception at Alma-Ata in 1978. The Alma Ata Declaration defined primary health care as 'the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process' (WHO 1978). The Declaration affirmed health as a fundamental human right and strongly linked it to national development. Over the past two years, there has been a renewed interest in PHC, culminating in the 2008 World Health Report, 'Primary Health Care: Now More Than Ever' (WHO 2008).

Alma Ata emphasised a community-focused health system that 'addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly' and initiatives that require and promote 'community and individual self-reliance and participation in the planning, organization, operation and control of primary health care' (WHO 1978). Even so, the emphasis on PHC 'was not a "how to" manual, but rather a philosophy of holistic health' (Lawn et al 2008). PHC has been variously defined as an overarching health system philosophy (to attain the goal of Health for All), as a level of care (first point of contact with health system) and as a health systems approach emphasising a horizontal manner of addressing health challenges (Lawn et al 2008).

With the renewed push to realise Alma Ata's principles, it is important to examine the strengths and weaknesses of past approaches to PHC implementation. Carden (2009) asserts that in order to maximise policy effectiveness 'the best first step is to assess how that policy is actually made'. Despite its importance, health policy analysis remains neglected, under-researched and under-funded (Gilson and Raphaely 2008). This is particularly true for the Pacific where there has been a paucity of analysis of the development of health policies.

This paper examines the evolution of PHC in Fiji during the period 1975 to the present

aiming to understand how health policies developed over time, noting how various actors influenced health policy and the dynamics between national and international stakeholders; and also seeks to inform current debate in Fiji on the direction of PHC policy. A recent overview of the Fiji health sector cited the 'need for [a] stronger evidence based approach to policy and planning' (Sutton et al 2008) to which this paper aims to contribute.

Methods

The case study commenced with a thorough document review, including bilateral and multilateral agency reports, Ministry of Health (MoH) documents and the published literature. A PubMed literature search using terms including 'pacific and islands and primary health care' and 'Fiji and primary health care' revealed a limited number of papers, demonstrating the relative lack of published analysis of PHC in the region. Fourteen semi-structured key informant interviews were conducted by phone and in-person with representatives of government agencies, multilateral and donor agencies, academic institutions and experienced health consultants to the region, including ten with national actors and four with representatives of bilateral or multilateral agencies. The focus of the interviews was on the interviewees' perceived changes to PHC over time, emphasising influences, language and the social construction of ideas. Ethics approval was received through the University of Sydney, while the Permanent Secretary of the MoH Fiji approved interviewing of staff.

The study used Walt and Gilson's (1994) health policy analysis triangle to structure the interviews and analysis, and to focus on decision-making processes and the relationship dynamics among key actors. However, the framework does not sufficiently capture some of what Pollard (2008) calls the Pacific's 'below the iceberg' factors of beliefs, culture and values; power, authority and politics; organizational culture & norms of behaviour; and social patterns and relationships'. Therefore, in looking to develop a policy analysis framework for the Pacific, we sought to integrate cultural and contextual issues specific to the Pacific (Capstick et al 2009).

The study is limited by attempting to cover more than 30 years of history in a limited number of qualitative interviews. Many of the key actors involved in PHC in the 1970s and 1980s are no longer in Fiji or no longer living. Additionally, those willing to be interviewed were likely to be interested in the topic thus introducing a degree of selection bias. Lastly, through a sense of nostalgia for the 'good old days' some recollections of health policy development might not represent the full spectrum of issues of the time.

Findings

The origins of PHC in Fiji

As the global community declared its health goals at Alma Ata, the newly independent nation of Fiji, in responding to its own health challenges, was already practicing much of what the Alma Ata Declaration proposed, leading one interviewee to state that 'PHC has always been here'. Interviewees agreed that at least some elements of PHC existed in Fiji before 1976 although not institutionalised, funded or formalised.

One described starting work in 1962 in the interior of Vanua Levu, Fiji's second largest island, where as a medical officer (MO), he conducted outreach to remote villages on horseback, to discuss hygiene and health issues with the community, to train headmen's wives and give basic medications to treat minor ailments. He noted that many other MOs conducted these types of services too 'based on intuition' to reach the dispersed population in more than 130 inhabited islands. Most graduating doctors served in rural health centres providing services close to where people lived (Sutton et al 2008). Health centres and nursing stations provided family planning information and services,

maternal and child health services, first-aid, health education and outreach; and nurses were holding village clinics and training Traditional Birth Attendants and Traditional Medicine Practitioners. From the early 1970s, domiciliary visits and demographic information collection became part of the nurses' role along with their clinical responsibilities at their posts. They would visit every home in their nursing zone, discuss health issues with community members and find collaborative ways to overcome health challenges, such as protecting water sources or building latrines. Fiji's communal culture facilitated a high degree of community engagement and participation.

Alma Ata

In 1976, WHO held a regional Pacific meeting to introduce the concept of PHC. The Government of Fiji followed in 1977 with the First National Conference on Primary Health Care (Asuzu et al 2004) and in the same year WHO started providing substantial funding for PHC implementation in Fiji. Interviewees remembered hearing the term PHC for the first time that year.

Although the existing health system structure incorporated a number of PHC concepts, a 'major reorganization of the administrative structure was made to the health system in the build up to and the period immediately after Alma Ata. At the national level, a new division of Primary and Preventive Health was set up with all community based health institutions placed under its jurisdiction' (Waqatakirewa 2001); and PHC was embraced quickly by health workers.

With significant new funding, Fiji implemented a broad-based PHC approach in 1978 highlighting six pillars: expanded access to health services, community engagement, environmental health, multi-sectoral engagement, establishment of village health committees and training of village health workers, with the view to community members seeing health as their own responsibility. A major component was the training of Community Health Workers (CHW) in mixed Indo-Fijian communities and Village Health Workers (VHWs) in every Fijian village. Communities nominated a local person to become the CHW/VHW and they were trained by the MoH through an intensive 6 week program followed by organised in-service training (MoH 1994). The MoH would provide equipment and drugs, the community would provide a working location and, in many cases, the community committed to supporting the CHW/VHW either with cash or with in-kind contributions, such as planting or fishing on their behalf. Interviewees affirmed that the CHW/VHW were 'the backbone of PHC, the interface between health and the community.'

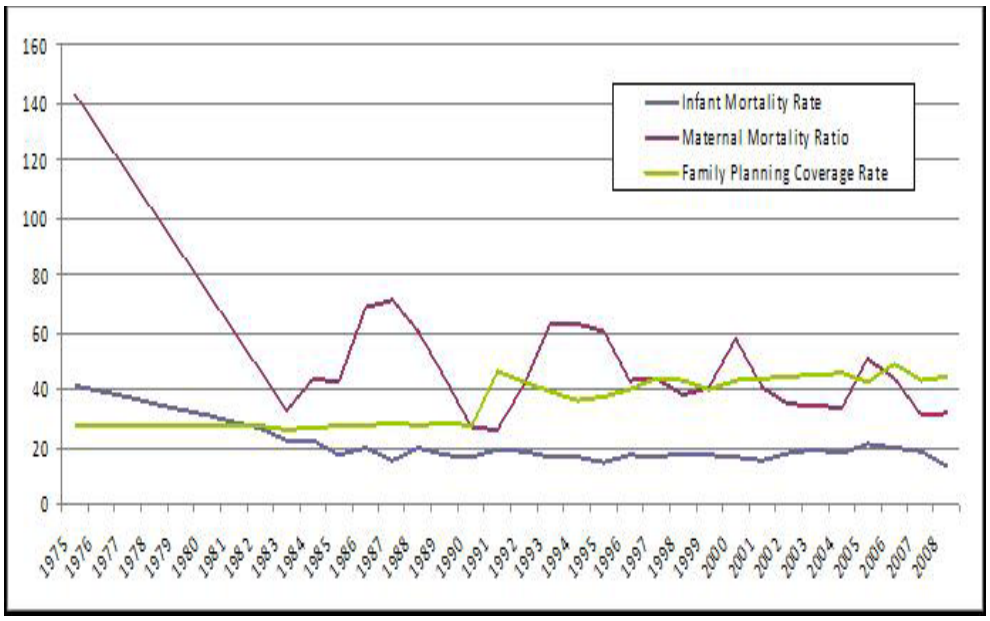
Challenges and Successes in PHC Implementation

Along with a generally positive experience in the early days of PHC, a number of challenges also arose. The top-down approach, in which health professionals took the main role, meant that PHC was successful mostly where the sub-divisional MO pushed it. Tembon (1988) identified that the 'training of CHWs depends on the enthusiasm and energy of the medical officer of that area'. While one interviewee stated that 'at the time, I would eat and sleep PHC,' this level of commitment was unlikely to be true for all doctors and nurses working in rural areas.

Another noted that while implementation of PHC was successful, it 'required a lot of sacrifice from the health workers' in time conducting outreach and working with communities. The level of personal commitment needed to fully implement PHC was perhaps unsustainable without continued external funding. A similar sustainability challenge existed with CHW/VHWs. Though most agreed that the trained CHW/VHWs did a good job, some were not supported by their communities for the basic operational costs, and village dispensaries were not consistently supplied by the MoH, leading to a drop in the number and commitment of CHW/VHWs.

Asuzu et al (2004) reported that, based on progress during the first decade of PHC, many thought Fiji 'could be the first in the developing world to achieve health for all'. Key health indicators supported this expectation. Critical indicators improved significantly from 1975 to 1986 (Figure 1): the infant mortality rate and maternal mortality ratio declined dramatically and immunisation coverage increased from below 50% to over 80% (Asuzu et al 2004). Waqatakirewa (2001) noted that while 'it is true that other positive factors affecting the health system could claim credit for the improvement the single most important event happening around that period was the introduction of the PHC concept'.

Figure 1: Key Primary Health Indicators in Fiji 1975-2008



Notes: Infant Mortality Rate per 1000 live births; Maternal Mortality Ratio per 100,000 live births. Data for some years was not available and was estimated by the authors. Sources: World Bank 1994; MoH 1994; MoH 1996; MoH 1998; MoH 1999; MoH 2000; MoH 2006; MoH 2008; Sutton et al 2008.

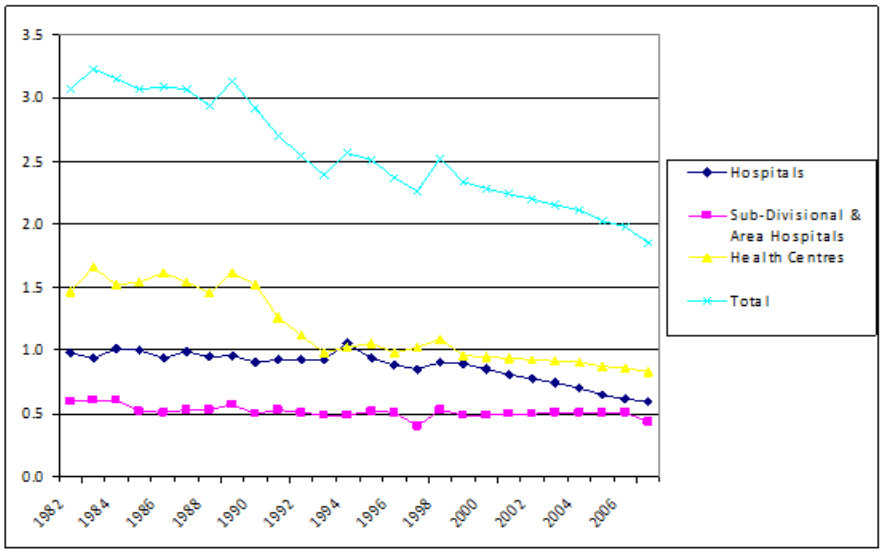
Overall, PHC was seen by interviewees as a powerful and positive galvanising force towards better health. It was generally agreed that through the early 1980s, the PHC approach seemed entrenched in MoH health systems, policy and implementation.

The Decline of PHC in Fiji

Despite the prominence of PHC in the late 1970s and early 1980s all interviewees agreed that this momentum did not last, and that PHC in Fiji suffered a steady decline from the late 1980s, leading one to assert that, at this time, 'PHC withered on the vine'. The decline of PHC is reflected in the declining use of primary health centres. Data from MoH annual reports indicates a marked drop in per capita health centre outpatient utilisation rates from 1989 as well as a later drop in urban hospital utilisation (Figure 2). Though some of the observed change in utilisation patterns may be explained by urban migration and changes in demand for health services, interviewees confirmed that people began to bypass lower level health services.

A number of different reasons were posited as the cause of decline in PHC. These explanations are by no means mutually exclusive but most interviewees highlighted only one explanation as dominant, while acknowledging that

Figure 2: Per Capita Outpatient Utilisation Per Annum by Facility Type and Total, 1982-2007



Note: Data for 1992 and 2001 to 2005 was not available and was estimated by the authors. Population data from SPC 2009 and United Nations Population Division 2008. Sources: World Bank 1994; MoH 1994; MoH 1996; MoH 1998; MoH 1999; MoH 2000; MoH 2006; MoH 2008.

acknowledging that others might have had a more limited role. These explanations are also not necessarily comprehensive and other factors including changes in demand might have contributed to weakened PHC implementation.

Explanation #1: Success

Some interviewees suggested that there was a general feeling that PHC had been accomplished successfully and it was simply time to move on. PHC had been pursued for a number of years, communicable disease rates were down, workshops had been held, CHW/VHWs had been trained and 'it was time for the next thing.'

Explanation #2: The End of WHO Funding

The end of WHO funding for community seminars in 1985 (WHO 1987) was cited by a few interviewees as the primary reason for the decline of PHC. One interviewee noted that he and colleagues ran 14 seminars in one year with the funding covering food, transport and expenses.

Ministry of Finance Budget Reports show that, from 1981 to 1985, donors provided a total of FJ$863,800 to 'rural health services' (World Bank 1994). This funding abruptly disappeared in the 1986 budget. Interviewees stated that fewer seminars were held and the push on PHC died out as sub-divisional health teams did less outreach to villages; and MoH funding to replace WHO funds was not provided.

Explanation #3: Lack of Explicit Government-Driven PHC Policy and Budget

The lack of MoH policy to guide PHC resulted in no strategic or operational planning for its implementation, no line item for PHC in the MoH budget and no national funding allocation.

Real per capita government health expenditure peaked in 1984 and has declined since. At FJ$25.80 in 1962, it rose steadily to FJ$51.00 in 1984 and then declined to FJ$35.10 in 1992 (prices at 1985 FJ$, World Bank 1994), representing a fall of 35% over the period. By the early 1990s, Fiji government expenditure on rural and public health was markedly lower than that for other Pacific Islands Countries (World Bank 1994).

Although the World Bank (1994) asserted that Fiji 'had been the most successful in grafting

primary health care facilities and outreach activities on to its existing system, with spending on rural services averaging more than 10 percent of total recurrent health outlays in the early 1980s' it states also that the budgetary share allocated to rural facilities and preventive services fell by half between 1983 and 1991.

Explanation #4: Domestic Instability

A number of interviewees stated that the decline of PHC started with the 1987 coup de etat, after which a large number of skilled health workers who had been instrumental in the development of PHC emigrated. The coup also led to an economic downturn which was reflected in the health budget.

Explanation #5: Cultural Changes in Fijian Villages

A number of interviewees cited changes in community culture as leading to the weakening of PHC implementation in communities. As Roberts (1997) writes, 'while a strong tradition of communal action exists in Fijian villages, systems for mobilising it have partly broken down with the introduction of Western values centred on improving the lot of the individual'. As a result, over time, there was a lower level of community engagement in both Fijian and Indo-Fijian communities.

Explanation #6: Short Attention Span of Global Actors

One interviewee noted that the concept of PHC itself was diluted by the global community in the mid to late 1980s. While the original notion comprised comprehensive PHC, by the mid-80s a selective approach to PHC had emerged globally, (e.g. UNICEF's application of the GOBI model of growth monitoring, oral rehydration, breastfeeding and immunisation). Various accounts describe this shift from comprehensive to selective PHC (Hall and Taylor 2003; Brown et al 2006; Haines et al 2007).

Health Promotion, Healthy Settings and Disease Focus

From the late 1980s through to the early 2000s, a number of different community health concepts were implemented in Fiji including health promotion, the Kadavu and Taveuni models, and disease focused projects. Together, these affected the way that PHC was conceived and implemented in Fiji over this time period.

Health Promotion

While the 1993-94 MoH annual report described PHC as 'the focus for the delivery of health care services', the 1995-96 report replaced this with a separate section on health promotion (MoH 1994; MoH 1996). The 2000 MoH annual report states that health promotion aims to ensure that 'each village, each settlement, each school, each health facility is trained to look at their own problems, issues and factors that influence health, list down issues, look at what can be done, develop an action plan and implement it' (MoH 2000).

The Yanuca Island Declaration, which resulted from the first Pacific Island Ministers of Health Conference in Fiji in 1995 (WHO 1995) and which proposed a 'truly ecological model of health promotion,' emphasised the environment and advanced the concept of 'Healthy Islands' (Nutbeam 1996). Despite an emphasis on environmental health and integrated development, the language of PHC is missing from the declaration.

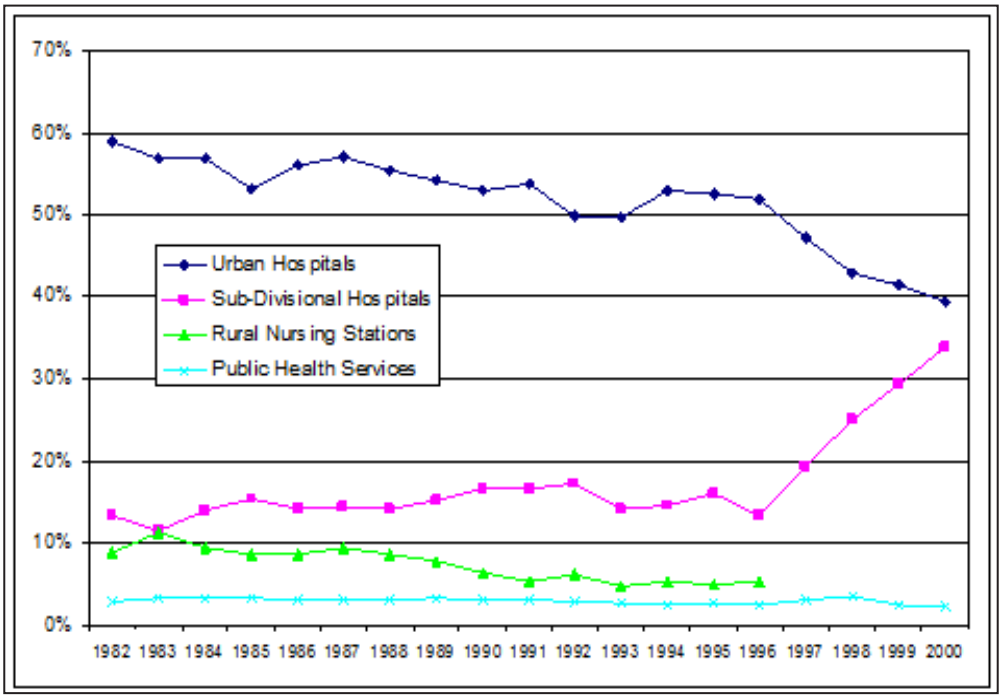
Debate continues about whether the emergence of health promotion represented a weakening of PHC concepts, the fulfilment of the PHC ideal or the continuation of PHC. Some interviewees saw the Yanuca Declaration as sounding the 'death knell for PHC as a guiding concept in Fiji' while others saw the Healthy Islands concept 'as a way of redirecting PHC.' One interviewee noted that while health promotion generally continued the PHC concepts, promotion was emphasised at the expense of protection, and that health

promotion focuses mainly on behaviour change and not sufficiently on such activities as building of latrines and improving water supply. Similarly, interviewees noted that health promotion was but one piece of the whole puzzle and that health care was needed as well as health promotion.

Funding for Community Health Activities

Public health programs remained under-funded in Fiji. The World Bank estimated that 'in most Pacific island countries around 70 per cent of recurrent health budgets are devoted to curative care and treatment overseas, leaving little for preventative services' (AusAID 2009). This is confirmed by Fijian data which shows that the funding for public health has been only 2-3% of budget provision since 1982 (Figure 3). Importantly, the budget line item for Rural Nursing Stations, which was included in MoH annual reports from 1982 to 1996, was not included in reports in subsequent years. As noted above, government funding for rural nursing stations was cut in half between 1983 and 1991. Despite the marked increase in funding for sub-divisional hospitals between 1996 and 2000, utilisation rates for those hospitals did not increase during that time period (see Figure 2 above). The reduction in funding for urban hospitals did coincide with reduced utilisation in those facilities.

Figure 3: Government Budget Provision for Health by Category, Fiji 1982-2000



Note: Data for 1997 was not available and was estimated by the authors using data from 1996 and 1998.
Source: MoH 1994; MoH 1996; MoH 1998; MoH 1999; MoH 2000

AusAID and JICA inputs to support Health Promotion

Another element of the transition to health promotion was the commitment of additional external resources. In 1994 AusAID, JICA and the MoH developed the National Centre for Health Promotion, equipped with media resources and with processes for supporting community health initiatives. In addition, AusAID funded two sub-divisional hospital building and health projects (Kadavu 1994 and Taveuni 1997). The Kadavu health promotion model (Roberts1997) endorsed some of the core elements of PHC: environmental health, community outreach, training VHWs and forming community health committees. Roberts writes that the community component of the Kadavu project

emphasised 'providing information to assist communities to make sensible decisions to protect their own health'. The projects were widely seen to be successful and post-project interviews with senior MoH officers indicated 'that the projects had influenced MoH to place a greater emphasis on preventive' activities (AusAID 2001).

Disease Focus

Starting in the early 2000s, the global health arena saw a substantial increase in disease focussed funding from the Global Fund for AIDS, Tuberculosis and Malaria, other disease-focused initiatives and activities targeted to achieve the Millennium Development Goals. The significant and often detrimental impact of these disease specific global health initiatives on PHC implementation and on national policy and priority setting has recently been highlighted (Biesma et al 2009).

Health Status and Service Delivery

Major health policy changes during the last 30 years have not been paralleled by a consistent improvement in health status. On the contrary, in some key areas health status has declined. The maternal mortality ratio has increased since 1990 (Figure 1) while progress against other key health indicators has stagnated since the end of the PHC era.

A number of challenges confront the Fiji health system. The migration of health professionals (Sutton et al 2008; Negin 2008) has resulted in a significant reduction in services available in sub-divisional health facilities over the past decade. By 2008, 25% of the total medical workforce was in private practice (Sutton et al 2008). Interviewees also agreed that VHWs were no longer very active with some estimating that only 60-70% of communities have an active VHW in place.

Health financing also remains a challenge. Despite annual increases in health spending in dollar terms, the proportion of GDP allocated to the Ministry of Health has fallen from 4% to 2.6% over the last 15 years placing it among the lowest in the region (Lingam and Roberts 2009). Recognition of these health system challenges has led to some recent positive changes. AusAID funded the Fiji Health Sector Improvement Program (FHSIP) during 2004-2009 which contributed to a recent strengthening of primary care delivery through an emphasis on community development and outreach.

Revitalising Primary Health Care in Fiji

Publication of the 2008 World Health Report indicated a return to the ideas of PHC and a new commitment by WHO to revitalising community health care. WHO's 62nd World Health Assembly (WHA) in Geneva in May 2009 reaffirmed the Alma Ata principles and called for a renewed push on PHC and health system strengthening. This has been seconded by regional partners such as AusAID, which recently stated that 'involving communities in service delivery can help services providers be more responsive and accountable to local needs and provide additional resources for service delivery' (2009). These global trends, coupled with increasing realisation of local needs, provide a critical opportunity for the revitalisation of PHC in Fiji.

A number of issues emerge if a return to PHC principles is to be successful in the Fijian context:

Domestic Political Ownership

Most interviewees agreed that some return to community health principles was needed. Many interviewees emphasised the political aspects, arguing that the MoH needs to drive the dialogue towards the model it wants rather than simply respond to inappropriate external models.

Integrating Urban and Non-Communicable Diseases into PHC

A number of interviewees argued that the

new approach to PHC should be adapted to changed disease patterns and to other circumstances, including urbanisation and high rates of non-communicable diseases (NCD) (MoH 2008). PHC should now move beyond being a rural health mechanism to include urban health issues. As one interviewee said, 'this isn't just about village health care.' Recently AusAID (2009) noted that the 'level of poverty in urban centres is considerably higher than in rural areas'. The concern to include NCD risk factors in PHC reflects international opinion. Frenk (2009) has highlighted how the new PHC needs to address both acute and chronic care: 'Primary health care should also move from episodic to continuous care, going beyond the simplicity implied in the original notion of first level of care.'

Resources – Human and Financial

The new approach to PHC will require additional resources and the harmonisation of agency, donor and MoH approaches to maximise resource efficacy. Despite current difficulties, more health workers and improved deployment will be required for a revitalised PHC program. The Fiji School of Medicine (FSMed) and the Fiji School of Nursing (FSN) have recently emphasised rural placements and community health in their curricula. Sufficient funding for PHC activities is needed and should be included in the preparation of national health budgets. Within the MoH, one interviewee noted that while there is the impression that 'curative is expensive and preventative is cheap,' 'this is not true anymore … preventative is also expensive.'

Conclusions

This case study provides important lessons for Fiji, the region and the wider health policy community on how health policy develops and evolves over time. It challenges the notion that an important and successful approach to population health could only be delivered for an 'era' and then be replaced by an untested approach. Health policy decision-making at the global and national levels is often short-sighted and focused on short-term targets, and lessons from past experiences are often not fully considered in the development of new policies. This analysis of PHC in Fiji from the mid-1970s serves as a microcosm of health policy challenges. It highlights the importance of the political economy context to health policy development and provides emphasis on a greater understanding of community and political culture. It shows that there is often a one-sided relationship between development partners (including multilateral organisations) and national governments in which policies brought from outside are often imposed without due attention to the evidence base and local country conditions. This trend of coercive policy convergence is a global phenomenon (Ogden et al 2003).

The basic tenets of the Paris Declaration and Pacific Aid Effectiveness Principles, which call for greater government ownership of development priorities and place the impetus for decisions in the hands of domestic government, need to be fully taken into account in developing a new model of PHC implementation in Fiji and the wider region. The MoH and partners should come together and design a new Fiji-specific PHC to ensure access to quality health services for the Fijian people.

References

Asuzu MC, Ram BP, Salusalu M, Lal M, Tuqa S (2004). Participatory operational research of the dynamics of the primary health care programme in Fiji. Pacific Health Dialogue 11(1):31-7.

AusAID (2001). Developing Integrated Rural Health Care Systems: An Evaluation of the Kadavu Rural Health Project in Fiji. Quality Assurance Series No. 24, 2001.

AusAID (2009). Tracking development and governance in the Pacific. Canberra: Commonwealth of Australia, August 2009.

Biesma RG, Brugha R, Harmer A, Walsh A, Spicer N, Walt G (2009). The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control. Health Policy and Planning 24:239-252

Brown T, Cueto M, Fee E (2006). The World Health Organisation and the transition from international to global public health. Public health then and now. American Journal of Public Health 96: 62-72.

Capstick S, Norris P, et al. (2009). Relationships between health and culture in Polynesia - a review. Social Science and Medicine 68: 1341-1348.

Carden F (2009). Knowledge to Policy: Making the Most of Development Research. International Development Research Centre, Ottawa, Canada 2009.

Frenk J (2009). Reinventing primary health care: the need for systems integration. Lancet 374:170-173.

Gilson L, Raphaely N (2008). The terrain of health policy analysis in low and middle income countries: a review of published literature 1994–2007. Health Policy and Planning 23:294–307.

Haines A, Horton R, Bhutta Z (2007). Primary health care comes of age. Looking forward to the 30th anniversary of Alma-Ata: call for papers. Lancet 370: 911-3.

Hall J, Taylor R (2003). Health for all beyond 2000: the demise of the Alma-Ata Declarations and primary health care in developing countries. Medical Journal of Australia 178: 17-20.

Lawn J, Rohde J, Rifkin S, et al. (2008). Alma-Ata 30 years on: revolutionary, relevantand time to revitalize. Lancet 372: 917-27.

Lingam D, Roberts G (2009). Forty- six years of Health Financing in Fiji 1962 to 2008, Pacific Health Dialogue 15(2):45-53.

Ministry of Health [MoH] (1994). Fiji Ministry of Health Annual Report 1993 and 1994. Suva, Fiji: Ministry of Health, 1994.

Ministry of Health [MoH] (1996). Fiji Ministry of Health Annual Report 1995 and 1996. Suva, Fiji: Ministry of Health, 1996.

Ministry of Health [MoH] (1998). Fiji Ministry of Health Annual Report 1997 and 1998. Suva, Fiji: Ministry of Health, 1998.

Ministry of Health [MoH] (1999). Fiji Ministry of Health Annual Report 1999. Suva, Fiji: Ministry of Health, 1999.

Ministry of Health [MoH] (2000). Fiji Ministry of Health Annual Report 2000. Suva, Fiji: Ministry of Health, 2000.

Ministry of Health [MoH] (2006). Fiji Ministry of Health Annual Report 2006. Suva, Fiji: Ministry of Health, 2006.

Ministry of Health [MoH] (2008). Fiji Ministry of Health Annual Report 2008. Suva, Fiji: Ministry of Health, 2008.

Negin J (2008). Australia and New Zealand's Contribution to Pacific Island Health Worker Brain Drain. Australian and New Zealand Journal of Public Health 32:507-511.

Nutbeam D (1996). Healthy Islands—a truly ecological model of health promotion. Health Promotion International 11:263–264.

Ogden J, Walt G, Lush L (2003). The politics of 'branding' in policy transfer: the case of DOTS for tuberculosis control. Social Science & Medicine 57:179-188.

Pollard S (2008). How can aid help build capacity in the Pacific? Asian Development Bank Brownbag seminar. 28 February 2008.

Roberts G (1997). The Kadavu health promotion model, Fiji. Health Promotion International 12;4:283-290.

Secretariat of the Pacific Community [SPC] (2009). Population Data. http://www.spc.int/demog/en/stats/2006/Pacific%20Island%20Populations%202006-2015%20-%2030%20Oct%2006.xls (Accessed on February 10, 2010).

Sharma N (2009). Opening remarks for the launch of EPI/RH Symposium. April 1, 2009. http://www.fiji.gov.fj/publish/printer_14605.shtml (Accessed on August 10, 2009).

Sutton R, Roberts G and Lingam D (2008). A situational analysis of the Fiji health sector. AusAID discussion document. Suva, Fiji: Fiji School of Medicine, 2008.

Tembon AC (1988). Suggestions for Primary Health Care Improvement on an Island in Fiji using Results from a Utilization Survey. Public Health 102:493-500.

United Nations Population Division (2008). World Population Prospects: The 2008 Revision. Population Database. http://esa.un.org/unpp/index.asp (Accessed on October 20, 2009).

Walt G, Gilson L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning, 9(4): 353-370.

Waqatakirewa L (2001). Primary Health Care Review on Fiji., World Health Organization, Manila, Philippines, 2001.

World Bank (1994). Health Priorities and Options in the World Bank's Pacific Member Countries. Report No. 11 620-EAP. October 1994.

World Health Assembly (2009). Primary health care, including health system strengthening. May 22, 2009. http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R12-en.pdf

World Health Organization. [WHO] (1978). Declaration of Alma-Ata. http://www.who.int/publications/almaata_declaration_en.pdf (Accessed on May 5, 2009).

World Health Organization [WHO] (1987). Development of Primary Health Care in the South Pacific. Agency Terminal Report. Regional Office for the Western Pacific, Manila, Philippines, 1987.

World Health Organization [WHO] (1995) Yanuca Island Declaration. Regional Office for the Western Pacific, Manila, Philippines.

World Health Organization [WHO] (2008). The World Health Report 2008. Primary health care: now more than ever. Geneva: WHO. http://www.who.int/whr/2008/whr08_en.pdf (Accessed on May 8, 2009).

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