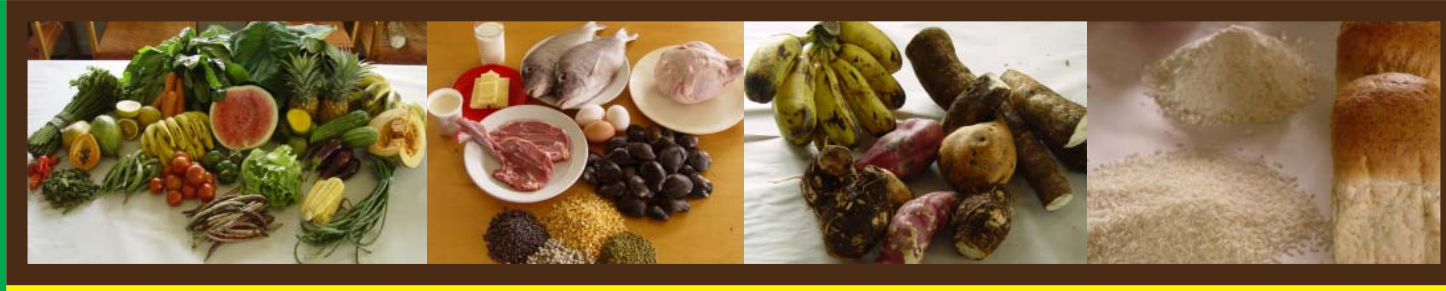

2008 FIJI FOOD AND NUTRITION POLICY

Vision: Good health and nutritional well-being for all citizens of Fiji

Mission: To improve the nutritional status and health of the population

Overall Goal: Nutritionally healthy communities

National Food & Nutrition Centre

MINISTRY of Health
Shaping Fiji's Health

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2008 FIJI FOOD AND NUTRITION POLICY

June 2010

ACRONYMS

CP	Cabinet Paper
DP7	Development Plan 7
DP8	Development Plan 8
FAO	Food and Agriculture Organization
FPAN	Fiji Plan of Action for Nutrition
JICA	Japan International Cooperation Agency
MoH	Ministry of Health
NCD	Noncommunicable Disease
NFNC	National Food and Nutrition Centre
NNS	National Nutrition Survey
UNDP	United Nations Development Plan
UNICEF	United Nations Children's Fund
USDRI	United States Dietary Reference Intake
WHO	World Health Organization

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1.0 INTRODUCTION

Nutrition is an integral part of people's basic needs and considered a human right. Food plays an important part in our cultures. Our choice of food and the amount we eat however have implications for our waistline and health. These food choices are influenced by factors such as food availability, food costs, cultural background and preferences.

Other influences known to impact on food choices include peers, food beliefs, media and advertising, education and our modern way of life such as eating out, casual eating, and transportation.

Food availability and access (food security) is essential for good health. Food security in totality includes nutrition security and is defined as adequate access to a variety of food that is affordable, safe and habitually eaten in the right amount at all times.

A growing body of literature suggests that nutrition increases returns on investments in education and health care. Consequently, nutrition interventions have been found to have a positive effect on welfare and economic growth. Thus good nutrition is increasingly perceived as an investment in human capital that yields returns today and in the future. Good nutrition impacts national development positively. Taken together, these findings provide strong evidence that public investment in improved nutrition should be a top priority for developing countries like Fiji (FAO, 2001).

2.0 FOOD AND NUTRITION DEVELOPMENTS IN FIJI

Since the mid 1970s, the Fiji Government has been cognisant of the positive effects of good nutrition on human capital and economic growth as outlined below. In 1976, Government decreed in Development Plan 7 (DP7) that "Food of adequate nutritional standards must be made available to every member of the community in order to maintain physical and mental health and enable people to realize their potential".

In 1976 also, the National Food and Nutrition Committee (NFNC) was formally 'conceived' to: i) help combat malnutrition, ii) advise Government on ways and means of utilizing the food resources of the country to the greatest advantage by the people, and iii) prepare a national food and nutrition policy with the necessary programmes and projects. Since NFNC lacked adequate financing and staff, technical and financial assistance was provided in a two-year project, called the National Food and Nutrition Development Programme, between UNDP/FAO and the Government of Fiji. As a result, the first National Nutrition Survey (NNS) was conducted in 1980 to assess the situation in the country.

In DP8 (1981) Government emphasized that meeting basic needs and nutrition was of paramount importance and indicated that a Food and Nutrition Policy would be prepared and submitted to Cabinet during the five-year plan period. The proposed National Food and Nutrition Policy as outlined in Cabinet Memorandum CP(82) 113 was approved in principle by Cabinet. The document became better known as the "1982 Food and Nutrition Policy"

A direct outcome of the policy was the establishment, by Cabinet subvention in 1982, of a multi-sectoral National Food and Nutrition Committee (a quasi-government organisation) and its secretariat to coordinate programmes and advise Government in all matters relating to the nutrition of the population. The Policy aims focused on increasing food availability while simultaneously reducing reliance on food imports; reducing low birth weight babies; reducing the level of undernutrition in children 0-5 years; reducing the incidence of goitre; reducing infantile diarrhoea, iron deficiency anaemia and obesity; improving disaster preparedness; promoting breastfeeding; promoting nutrition training and establishing a system to monitor not only the food and nutrition situation, but to assess actions which could have a major effect on food and nutrition whether positive or negative.

Fiji became a signatory to the World Declaration to eliminate hunger and poverty at the International Congress on Nutrition in 1992 and undertook to develop a national plan of action for nutrition.

Around the same period, Government conducted the second NNS (1993). The results of the survey were used to evaluate the 1982 policy goals. It also became the basis on which the Fiji Plan of Action for Nutrition (FPAN) was developed.

In 1997, the Fiji Plan of Action for Nutrition (FPAN) was completed, submitted to and endorsed by Cabinet in April 1998. The multi-sectoral National Food and Nutrition Committee established in 1982 was disbanded by the then Permanent Secretary of Health in 1998. However, the secretariat remained as the National Food and Nutrition Centre (the Nutrition Centre) under the Ministry of Health.

In 2000, Fiji committed itself to meeting the Millennium Development Goals (MDGs) of the Millennium Declaration adopted by the UN General Assembly. Out of the eight MDGs, four are directly related to Fiji: poverty and hunger, child mortality, maternal health and HIV/AIDS/other Communicable Diseases.

In 2002, the Fiji Noncommunicable Disease (NCD) STEPS Survey was conducted to determine the prevalence of key NCDs (hypertension, diabetes, obesity) and the major risk factors and their associations (smoking, physical activity, cholesterol level, consumption of alcohol, fruits and vegetables). The results showed an alarming increase in prevalence rates of a number of NCDs.

The Nutrition Centre had over the years compiled the Food Balance Sheet which reports national data on food availability or food supply in Fiji over a given period of time, based primarily on the Bureau of Statistics and the Ministry of Agriculture annual reports. While the information is useful as a proxy measure of national food and nutrient intake, its major limitation is that agricultural data used includes commercial

production only and does not include subsistence data due to unavailability of this information.

The third NNS was conducted in 2004. Areas for actions arising from the NNS 2004 report include increasing the proportion of healthy weight population, improving infant feeding practices and health, reducing levels of anaemia and micronutrient deficiencies, improving nutrient intakes, improving food and dietary patterns, increasing consumption of fruits and vegetables, improving household food security, reducing levels of NCD risk factors such as hypertension, smoking, alcohol consumption, kava consumption, and increasing physical activity levels.

A 1994 UNICEF iodine survey found that the majority of pregnant women and primary school children (8-12 years) surveyed were iodine deficient. Salt was identified as the ideal vehicle for fortification. Legislations were put in place in 1996 to have all salt imported for human consumption fortified with iodine. The national salt iodisation programme commenced in 1998.

Fiji has successfully commenced in January 2005 measures to address micronutrient deficiencies through flour fortification with iron, folic acid, zinc and B vitamins (riboflavin, niacin and thiamine). These vitamins and minerals are essential for normal growth and development especially in children. Although Vitamin A was also identified as a problem of public health concern by the NNS 2004, interventions are yet to be implemented.

Improving nutrition in school children at school is reflected in the Nutrition Policy for Schools that was developed by the Ministry of Education in 2006. It aims to provide a clear, manageable and comprehensive structure for the delivery of nutrition in all schools in Fiji. Other existing policies that highlight the importance of food and nutrition include the National Noncommunicable Diseases Strategic Plan 2004 – 2008 and the National Health Promotion Policy for Fiji Islands, 2007 and the Prevention of Mother to Child Transmission of HIV/AIDS, 2006.

3.0 BACKGROUND TO THE POLICY

This policy background is divided into four parts – i) food availability, ii) nutritional status, iii) nutrient intake and iv) other health and lifestyle indicators.

3.1 Food Availability

Fundamental to food choices is food availability and access. These are intrinsically linked to food self-sufficiency.

The most recent Food Balance Sheet for Fiji is for the year 2004 and shows that over half of Fiji's food supply in terms of macronutrients (calories, protein and fat) is imported (Table 1).

Table 1 Percent contribution of imported macronutrients to total energy (kilocalories), per capita per day, 1985 - 2004

Year	Total kilocalories per capita per day	Percent contribution of imported macronutrients		
		Calories %	Protein %	Fat %
1985	2819	42	52	46
1992	2879	57	60	64
2004	3421	53	60	58

The reliance of Fiji on food imports to feed its population is of concern. The situation leaves Fiji very vulnerable to outside forces. A number of factors contribute to this heavy reliance on imported food. Fiji needs to address the underlying causes.

Table 1 also shows that total kilocalories (kcals or calories) per capita per day have continuously increased from 2819 in 1985 to 2879 in 1992 and 3421 in 2004. The 2004 figure showed 1193 kilocalories in access of the Food and Agriculture energy requirement of 2228 kcals or a daily oversupply of 53% per person on average.

The significant oversupply of dietary energy as well as qualitative changes in the energy contribution of the macronutrients might help to explain the rapidly rising obesity and the incidences of non-communicable diseases in Fiji. For example, the total protein per capita per day was 65 grams in 1985, 73 grams in 1992 and 93 grams in 2004. Total fat per capita per day was 67 grams in 1985, 80 grams in 1992 and 101 grams in 2004.

For good heath, WHO recommends that 55-75% energy should come from carbohydrate, 10-15% from protein and 15-30% from fat. Table 2 shows that Fiji's diet appears to be within the range for carbohydrate and protein but is towards the top end for fat. The percent energy contribution from fat has continued to increase steadily since 1985.

Table 2 Percent contribution towards total energy supply per capita per day, 1985 - 2004

Percentage contribution towards total energy supply per capita per day				
Year	Total calories (kcal)	Carbohydrates %	Protein %	Fat %
1985	2819	69	9	21
1992	2879	65	10	25
2004	3421	62	11	27

The NNS 2004 showed that in dietary intake, carbohydrate contributed 53%, protein contributed 15% and fat contributed 28% to total energy per day. These results show a consistent trend in the qualitative change of the diet of Fiji's population.

3.2 Nutritional Status

This section primarily compares the National Nutrition Survey (NNS) results NNS 2004 and NNS 1993 with caution. It also refers to the Strategic Development Plan 2007 – 2011 (Ministry of Finance and National Planning), and the NNS 1980 where relevant.

The NNS 2004 found that only 54.4% of the population had "healthy" weights, which was similar to that found in 1993 (55.3%). Underweight was 19.6% in 1993 and had decreased to 9.8% in 2004. Overweight was 17.7% in 1993 but had increased to 23.4% in 2004. Obesity was 14.8% in 1993 and had also increased to 24.7% in 2004.

Low birth weight rates were similar for the two surveys (11.4% in 1993 and 10.2% in 2004). High birth weight was not reported in 1993 whereas it was highlighted as an emerging issue in 2004 at 10.5%.

The national prevalence of anaemia was 27.2% in 1993 and 32.4% in 2004 (27.4% males and 37.1% females). Children under 5 years with anaemia increased from 40% in 1993 to 49.9% in 2004. In women over 15 years the prevalence of anaemia was 32% in 1993 and 36.9% in 2004. For men, the corresponding prevalences were 16% in 1993 and 25.7% in 2004. Pregnant women with anaemia were 55.6% in 1993, decreasing to 43.5% in 2004 which could be attributed to the iron supplementation programme. Table 3 shows the cutoffs used in NNS 2004.

Table 3 WHO Anaemia cutoffs used in NNS 2004 and NNS 1993

<table>
<tr><th rowspan="2">Age</th><th colspan="2">Anaemia cut off points for Hb</th></tr>
<tr><th>2004</th><th>1993</th></tr>
<tr><td>6 months to under 5 years</td><td colspan="2">< 11 g/dl</td></tr>
<tr><td>5 - 11 years</td><td>< 11.5 g/dl</td><td rowspan="2">< 12 g/dl (6-14 years)</td></tr>
<tr><td>12 - 14 years</td><td>< 12 g/dl</td></tr>
<tr><td rowspan="2">> 15 years</td><td colspan="2">< 13 g/dl for males;
< 12 g/dl for non-pregnant females</td></tr>
<tr><td colspan="2"><11 g/dl for pregnant women</td></tr>
</table>

Note: NNS 1993 used the old cutoffs whereas NNS 2004 used the latest WHO cutoffs published in 2001

Micronutrients

In 2004, blood samples were collected for the first time for analysis of selected micronutrients in women of childbearing age (15 - <45 years). The prevalence of micronutrient deficiencies are shown in Table 4.

Table 4 Percent prevalence of micronutrient deficiencies

Micronutrient deficiencies	% prevalence
Iron deficiency	23
Vitamin A deficiency	13
Folate deficiency	5
Zinc deficiency	39

Early studies found that goitre had been endemic in the Sigatoka valley. In 1994, a UNICEF study found that 45% of pregnant women and school children surveyed had goitre. The Ministry of Health annual report 2004 indicated there were only 22 cases of goitre.

A Repeat Survey by MoH in 2006 looked at iodine levels in urine and also in household salt. It revealed that 88.4% of pregnant women and 83.6% of school children were found to have normal levels of iodine in urine. The salt samples tested showed that 98.4% contained normal levels of iodine (15ppm).

Breastfeeding and diarrhoea in children under 2 years

In 1993, 88% of mothers initiated breastfeeding within 24 hours, whereas in 2004, it was 85.1%. The proportion of babies who were exclusively breastfed increased from 25% in 1993 to 39.8% in 2004.

The 1993 survey showed that 7.8% of children less than 2 years had diarrhoea in the month before the NNS whereas the 2004 survey showed 4.8%.

Poverty and undernutrition

The UNDP 1996 Poverty Report indicated that almost 10% of households could not afford a minimum nutritious diet.

Underweight amongst children less than 5 years in Fiji was 15% in 1980, 10.5% in 1993 and 7.0% in 2004. Under nutrition in children under 5 years is an indicator of poverty and hunger. In line with the Millennium Development Goals (MDGs), the Government Strategic Development Plan (SDP 2007 –2011) focuses on poverty and hunger to address under nutrition.

The target is to halve between 1990 and 2015, the proportion of people who suffer from hunger.

3.3 Nutrient Intakes

For the first time in the history of national nutrition surveys in Fiji, the NNS 2004 collected quantitative dietary information from adolescents and adults (15 - <45 years) using a one-day 24-hour recall. To assess the adequacy of nutrient intake, the United States Dietary Reference Intake (USDRI) was used as the reference in the absence of a Pacific equivalent.

Nutrients were categorised as either meeting or not meeting USDRI levels as shown in Table 5.

Table 5 Percent population (15 - <45 years) meeting the USDRI

Nutrient	% of population meeting USDRI	% of population not meeting USDRI
Energy	39	61
Protein	61	39
Fat	37	63
Cholesterol	24	76
Carbohydrate	89	11
Dietary Fibre	20	80
Vitamin A (total)	20	80
Retinol	7	93
Beta carotene	57	43
Thiamine	34	66
Riboflavin	6	94
Niacin	52	48
Ascorbic acid	53	47
Iron	41	59
Calcium	13	87
Potassium	17	83
Zinc	38	62

Note: *i) A limitation of the 24-hour recall is under reporting of food intake, which may result in less than adequate nutrient intakes. ii) The USDRI are set at the top most levels for optimal nutrient use without any health risk – which may make it impossible to achieve*.

At face value, the table indicated that the Fiji diet fell well below the USDRI levels. In other words, Fiji diets were not meeting the recommended amount of nutrients for good health.

3.4 Other health and lifestyle indicators

The proportion of households with:

- access to safe water (piped water) was 82% in 1993 and 90% in 2004;
- no toilets was 5% in 1993 and 0.5% in 2004;
- pit toilets was 34% in 1993 and 17% in 2004;
- flush toilets was 61% in 1993 and 82% in 2004.

The prevalence of hypertension was 9.8% in 1993 and 17.1% in 2004.

The prevalence of diabetes was 16% in 2002.

82% of all deaths were from noncommunicable diseases (NCD Steps Survey 2002).

Daily consumption of tobacco was 35.2% in 2002 (NCD Steps Survey 2002) but was only 12.8% in 2004.

The population consuming alcohol more than 5 days a week was 7.2% in 1993 and 4% in 2004.

The population reported in moderate physical activity was 26.5% in 1993 and 29.8% in 2004.

The population consuming kava daily in 2004 was 11.2%.

4.0 POLICIES

The following nine policies and their strategies are being proposed to improve the current benchmarks of food availability, nutritional status, nutrient intake as well as other lifestyle and health indicators. The Food and Nutrition Policy will support food and nutrition related policies of Government ministries and departments such as the National Centre for Health Promotion, Agriculture & Fisheries, National Planning, Trade & Commerce, Education, Consumer Council of Fiji, Non-Government and other organisations. To implement the Fiji Food and Nutrition Policy 2007 effectively, it needs to be endorsed at the highest level of Government.

The nine policies are:

Policy 1 Advocate nutritional issues and mainstreaming into the Government decision-making system.

Policy 2 Promote and sustain household food security.

Policy 3 Improve national nutritional status.

Policy 4 Protect consumers through improved food and water quality and safety.

Policy 5 Improve nutritional status of the socio-economically disadvantaged and the groups that are nutritionally vulnerable (including children, mothers, the aged, differently-abled and those living with HIV/AIDS.

Policy 6 Support Nutrition Policy for Schools.

Policy 7 Promote healthy diets and lifestyles.

Policy 8 Establish and promote a nutrition surveillance and monitoring system.

Policy 9 Strengthen collaboration with development partners.

5.0 STRATEGIES

The nine policies and their strategies are outlined as follows.

Policies	Strategies	
[Policy 1] Advocate nutritional issues and mainstreaming into the Government decision-making system	1.1	Integration of FPAN into Government Strategic Plan
	1.2	Intersectoral collaboration for advocacy and mainstreaming
	1.3	Strengthening of stakeholder coordination through the National Food and Nutrition Centre for the implementation of the 2008 Food and Nutrition Policy
	1.4	Implementation and monitoring of the Food Safety Act
	1.5	Development and endorsement of the Marketing Controls: Food for Infants and Young Children
	1.6	Implementation and monitoring of the Food and Nutrition Policy for Schools
[Policy 2] Promote and sustain household food security	2.1	Advocacy for consistent nutritious food supply for households
	2.2	Local initiatives for increasing production and consumption of fish and seafods, poultry and livestock
	2.3	Community-based food production to increase consumption of vegetables, fruits and root crops
	2.4	Encourage proper processing of local food, fruits and vegetables
	2.5	Promote safe household food storage, preparation and preservation
	2.6	Advocate for proper usage of pesticides
	2.7	Incorporate appropriate and sustainable agricultural science technology in the school curriculum
	2.8	Promotion of local foods for family meals
[Policy 3] Improve national nutrional status	3.1	Promotion and maintenance of healthy weight
	3.2	Reduction of undernutrition including micronutrient deficiencies
	3.3	Reduction of overweight and obesity
	3.4	Reduction of low and high birth weight
	3.5	Development of new or strengthen existing intervention programmes to reduce protein-energy malnutrition, micronutrient deficiencies (iron, vitamin A and iodine), overweight, obesity, low and high birth weights in infants
	3.6	Monitoring and evaluation implemented programmes

Policies	Strategies	
[Policy 4] Protect consumers through improved quality and safety of food and water	4.1	Provision of safe and accessible water supply
	4.2	Promotion of safe food handling practices
	4.3	Enforcement and monitoring of the Food Safety Act
	4.4	Enforcement of hygiene & village by laws
[Policy 5] Improve nutritional status of the socio-economically disadvantaged and the groups that are nutritionally vulnerable (including children, mothers, the aged, differently-abled and those living with HIV/AIDS	5.1	Promotion of increased exclusive and continued breastfeeding
	5.2	Promotion of appropriate and timely complementary foods and proper feeding practices
	5.3	Initiatives to improve nutritional and health status among senior citizens (>60 years)
	5.4	Nutrition monitoring and counselling to mothers and caregivers
	5.5	Reduction of anaemia in women and children
	5.6	Promote backyard/food garden to improve family nutrition
	5.7	Provision of nutrition information for HIV/AIDS
	5.8	Promote nutrition in emergencies and times of national disasters
	5.9	Training initiatives for income generating food related activities
	5.10	Disaster Ration Scales reviewed
[Policy 6] Nutrition Policy for Schools	6.1	Support the implementation of the Nutrition Policy for Schools covering school children, school canteen operators and boarders
	6.2	Establish linkage between ministries of Education, Health, Agriculture and NFNC to improve the health and proper development of school children in Fiji
	6.3	Support planting of fruit trees in school compounds
	6.4	Promotion of gardening and enterprise education in all schools
	6.5	Implementation of health promoting schools programs
[Policy 7] Promote healthy diets and lifestyles	7.1	Strengthen community action
	7.2	Develop personal skills
	7.3	Create supportive environment
	7.4	Re-orient health service
[Policy 8] Establish and promote a nutrition surveillance and monitoring system	8.1	Establishment of a centralized database
	8.2	Develop appropriate well-targeted nutrition intervention programs with clear monitoring and evaluation components
	8.3	Monitoring of FPAN
	8.4	Evaluation of FPAN
	8.5	Develop appropriate risk-based assessment indicators
[Policy 9] Strengthen collaboration with development partners	9.1	Improve and strengthen collaboration and particpation of private sectors and NGOs in the delivery of food and nutrition intervention programmes and activities (FPAN)
	9.2	Strengthen collaboration with NCHP regarding the healthy settings approach
	9.3	Systematic coordination of activities amongst food agencies, international and regional bodies and donor institutions

6.0 SUMMARY

Good food and nutritional health is critical to national well-being and development. Government recognized its importance in Development Plan 7 (1976). Since then, a number of research studies related to food and nutrition have been carried out to determine what the real situation in the country is with the most recent being the National Nutrition Survey 2004.

This most recent available statistics provides the framework for the proposed evidence-based Fiji Food and Nutrition Policy 2008. The nine policies and their strategies were developed through a series of wide consultations of stakeholders. The next step is the revision of the Fiji Plan of Action for Nutrition and the determining of priorities, policy actions and timeframes for implementation.

It is recommended that the policy is endorsed at the highest level of Government.

Annex 1

Cabinet Decision on the Revised 2008 Fiji Food and Nutrition Policy

At the Cabinet meeting of 23 September 2008,

Cabinet with reference to IGCP(08)340 on the Revised 2008 Fiji Food and Nutrition Policy:

"

i) endorsed the new 2008 Fiji Food and Nutrition Policy to replace the 1982 version; and

ii) agreed that the 1998 Fiji Plan of Action for Nutrition be modified accordingly.

"

Development of the 2008 Fiji Food and Nutrition Policy

The Process

1. A Memorandum of Understanding (MoU) for the Food and Nutrition Policy ("the Policy") was signed on November 30, 2006 between the MoH, JICA, and witnessed by WHO and Secretariat of the Pacific Community.

2. The MoU identified the Permanent Secretary for Health as Project Director and the National Advisor for Dietetics and Nutrition as Project Manager.

3. A JICA short-term consultant was in Fiji from February 6 – March 8, 2007. Part of her terms of reference was to assist in the development of a draft Food and Nutrition Policy.

4. A small multi-sectoral Steering Committee was formed to assist with the policy development. A series of meetings was held by the Steering Committee and three drafts were produced before the JICA consultant departed.

5. A second working group was formed (from mid June 2007)) under the NCD Healthy Food Choice subcommittee (HFC) to complete the project under the chairmanship of Mrs. Jimaima Schultz, Study Manager - Obesity Prevention in Communities (OPIC).

6. The HFC working group met several times during the second half of the year. The group discussed ways of moving the work forward:
   - Examined several documents in terms of information and format that could be used -
     (i) Draft 3 of the Policy
     (ii) Food and Nutrition Policy 1982[1]
     (iii) Fiji Plan of Action for Nutrition (FPAN) 1998
     iv) Executive Summary results from the National Nutrition Survey 2004.
   - The working group agreed that the 1982 Food and Nutrition policy format be adopted and used because it was simple and easy to follow.
   - The Fiji Plan of Action for Nutrition (FPAN) 1998 was used as the basis as many issues in the FPAN are still current. New emerging issues could easily be added.
   - The working group agreed that the project could be done in two stages: Stage 1 – completion of the Policy and Stage 2 - the revision of the Fiji Plan of Action. The working group's number one priority was to complete Stage I.
   - The Policy - Stage 1
     - Identifying current issues and categorising these issues into potential areas for policy. These were refined further after consulting the FPAN document and other reports for confirmation of issues.
     - Policy components such as statements, goals, objectives and strategies were developed.
     - Actions/activities and targets were separated in successive drafts (at least seven).
     - To give direction to the Policy, targets based on the latest available statistics were elicited from the Fiji Food Balance Sheet 2002, National Nutrition Survey 2004,

[1] According to the Management Effectiveness Review of the National Food and Nutrition Committee prepared by Sarita Mani for the Public Service Commission in 1985, Cabinet approved in principle the proposals relating to a National Food and Nutrition Policy as outlined in CP (82) 113 and thus approved twelve policy goals for improving food and nutrition.

Micronutrient Status of Women 2004, the NCD Steps Survey 2002 and the latest MoH Annual Report.

- To ensure that the Policy objectives and strategies incorporated other line ministry's food and nutrition priorities, documents consulted included National Health Promotion Policy for Fiji Islands 2007, Nutrition Policy for Schools 2006, Ministry of Agriculture's Strategic Development Plan (2006-2008) and the National Planning's Strategic Development Plan 2007-2011.
- During the process of refining the Policy, consultations with a number of key sectors continued.
- The draft policy developed by the HFC working group was forwarded to the Director Public health for comments.
- Draft Policy was presented by the Director Public Health (DPH) – Dr. Tima Tuiketei - to the National Executives Committee of the MoH on September 26, 2007 for discussion and adoption. The "Policy" was endorsed with suggested and agreed amendments to be resubmitted to DPH for Cabinet submission endorsement.

ACKNOWLEDGEMENTS

Organisations involved in the development of the Policy were:
Ministry of Health (MoH), Japan International Cooperation Agency (JICA), OPIC Project of the Fiji School of Medicine, National Food and Nutrition Centre (NFNC), University of the South Pacific (USP), World Health Organisation (WHO), United Nations' Children's Fund (UNICEF), and the ministries of National Planning, Agriculture, Education and Fijian Affairs.

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