

Individual Deprivation Measure

Knowing who is poor, in what way and to what extent



EXPLORING MULTIDIMENSIONAL POVERTY IN FIJI: KEY FINDINGS FROM A STUDY USING THE IDM

BACKGROUND

Currently, poverty data in Fiji (and elsewhere) is derived from household income and expenditure data. Given gender inequality within households can be significant, assessing individual poverty by using household data and then assuming all household members have the same access to resources and opportunities is problematic. Household-level measurement also means accurate disaggregation is impossible. This makes the work of policy makers and advocates harder, hiding differences rather than revealing them so they can be addressed. Individual-level measurement is essential to fully understand poverty and inequality, and the relationship between gender and poverty.

In September 2015, 193 countries agreed to the Global Goals for Sustainable Development, committing to leave no one behind in achieving the Goals by 2030. We need data about individuals, to see how factors such as sex, age, disability, geography and more effect outcomes.

The Individual Deprivation Measure (IDM) is a new, gender-sensitive and multidimensional measure of poverty. The measure assesses deprivation at the individual level, in relation to 15 key dimensions of life, making it possible to see who is poor, in what way and to what extent. It resulted from a four-year, three-phase

multidisciplinary international research collaboration involving thousands of participants across 18 sites in six countries: Angola, Fiji, Indonesia, Malawi, Mozambique and the Philippines.

For any new measure to gain traction, it needs to be tested and learning documented to inform refinement and subsequent use. This requires initial users who recognise that potential can only be realised by taking a first step.

In 2014, the Australian Government funded the first IDM study beyond an initial proof of concept trial in the Philippines, to explore what additional insights could be gained by individual-level, gender-sensitive poverty measurement. This work was undertaken by the International Women's Development Agency (IWDA), working with the Fiji Bureau of Statistics (FBoS).

In 2016, the Australian Government made a further investment in the IDM as part of a wider focus on closing the gender data gap, supporting a four-year program to ready the IDM for global use by 2020. The IDM Fiji Study has ensured that the current IDM Program, implemented in partnership with the Australian National University (ANU) and IWDA, is informed by circumstances in the Pacific.

THE STUDY

The Fiji Bureau of Statistics (FBoS) designed the study sample, conducted enumerator training, piloted the survey, and collected and cleaned the data. Preparatory work and implementation of the survey was undertaken between February and September 2015. Data was analysed by IWDA.

Participants at a stakeholder workshop in Suva in February 2016 reviewed the initial data analysis, and urged a focus on the IDM's ability to reveal how deprivation varies - within households, by sex, across social groups and settlement type, and by Tikina. This brief focuses on this information. Stakeholders considered that the process of aggregating dimension data into an overall IDM score hid the differences that were of most interest and policy relevance.

The initial scaling, weighting and aggregation of data in Fiji revealed some reliability issues. For this reason, overall IDM scores are not reported here. When the aggregation process is finalised we will calculate and report overall IDM scores for Fiji.



IDM FIJI SAMPLE (2015)

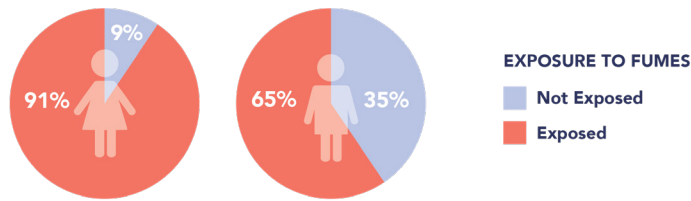
- 1125 Households; 2966 individuals
- Men = 1481; Women = 1485
- Age range 18-97; mean age 42.91
- Rural = 2054; Urban = 757; Informal = 155

GENDER SENSITIVITY

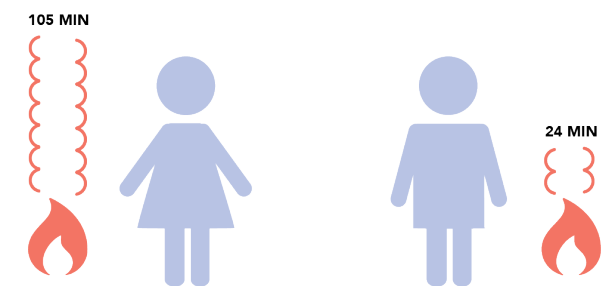
ENERGY/FUEL

The IDM Fiji study confirmed the measure’s potential to reveal gender differences within the household.

Some 91% of women reported exposure to fumes related to cooking and heating, compared to 65% of men.



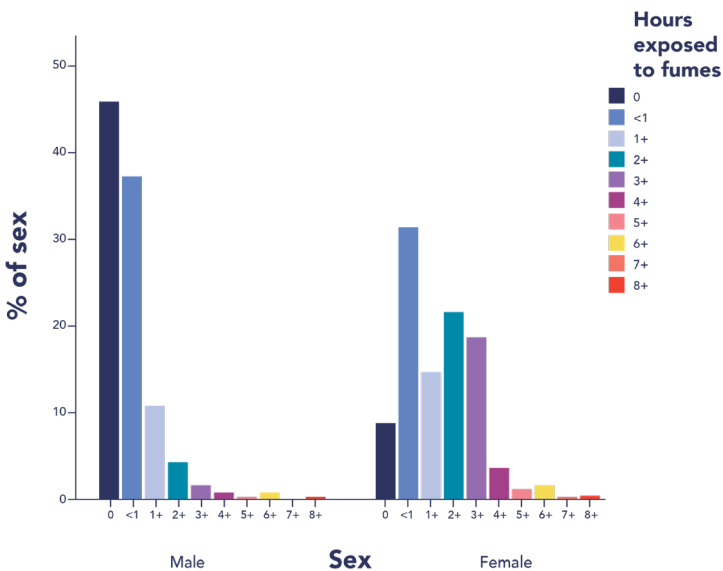
Women on average were exposed to 1 hr 45 minutes per day of fumes related to cooking and heating, compared to an average of 24 minutes per day for men.



More women than men suffered health problems linked to unclean cooking and heating fuel (25% cf 12%). Of those who suffered health problems, women were more likely to suffer more severe consequences (see table below).

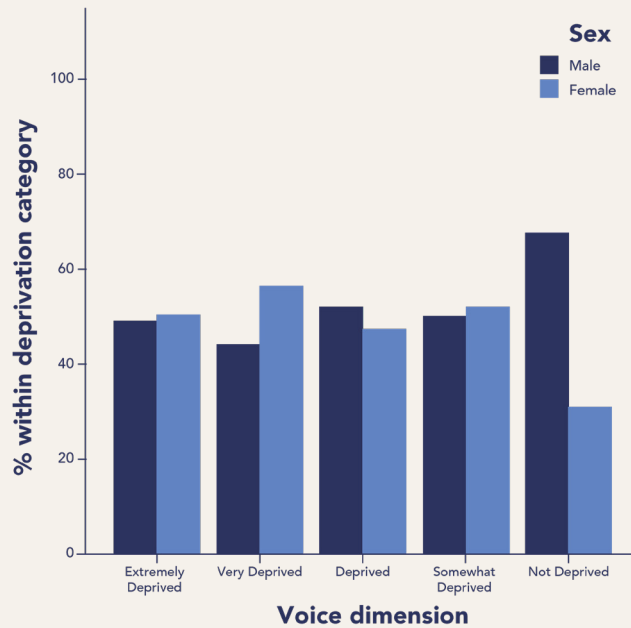
Severity of health problems related to exposure to harmful fumes			
	Minor	Moderate	Severe
Women	33%	43%	24%
Men	58%	33%	9%

These findings reflect not just household variables such as location/type of kitchen and fuel used, but also the implications of a **gendered and unequal distribution of household responsibilities**, with women having primary responsibilities for domestic work.



VOICE

Women were more likely than men to be extremely deprived and very deprived in **Voice** (the ability to raise concerns and effect change in their community). Men were twice as likely to be not deprived at all in this dimension. The gender difference in Voice was largest in urban areas.



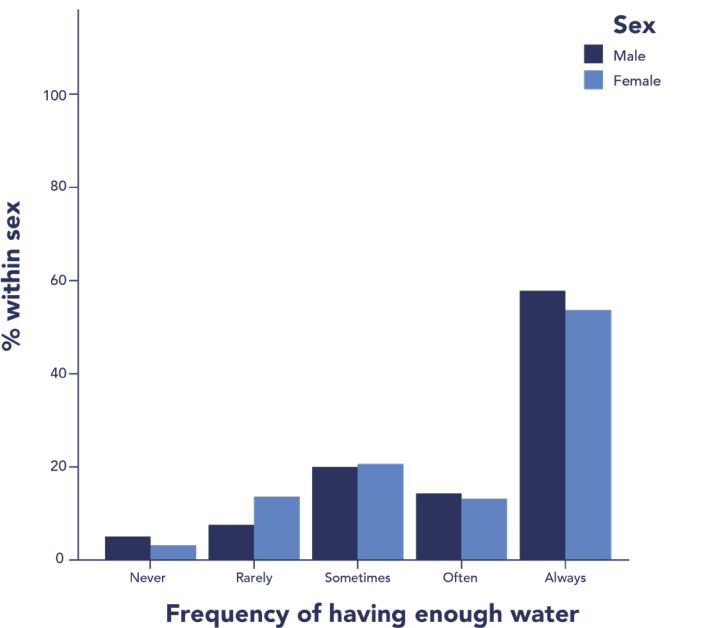
INTRAHOUSEHOLD MEASUREMENT

Overall, the majority of study participants (72%, or over 2000 people) had **Water** piped into their dwelling, and travelled less than 10 minutes to their water source. Looking inside the household, individuals may have different needs for water, linked to different responsibilities and requirements. Assessing water access at the household level cannot reveal the full extent of individual deprivation. Intrahousehold measurement enables assessment of who has enough water to meet their needs.

Respondents in informal settlements struggled most with having sufficient water; **nearly 40% reported that they ‘rarely’ or ‘never’ had enough water to meet their personal needs**. There was a statistically significant difference between men and women, with **women more likely to report that they did not have enough water to meet their needs**.

This difference likely reflects women’s primary responsibility for cooking, cleaning, and washing, which require water beyond that needed for drinking and bathing. Men were more likely than women to report that they ‘always’ (57% cf 52%) or ‘often’ (12.5% cf 11%) had enough water. Almost double the number of women

reported ‘rarely’ having enough water (12.2% cf 6.1% of men); however, slightly more men (4%) than women (3%) reported ‘never’ having enough water.



INEQUALITY

The IDM measures the intensity of deprivation in each dimension and overall. This makes it possible to capture information about inequality, which can inform policy.

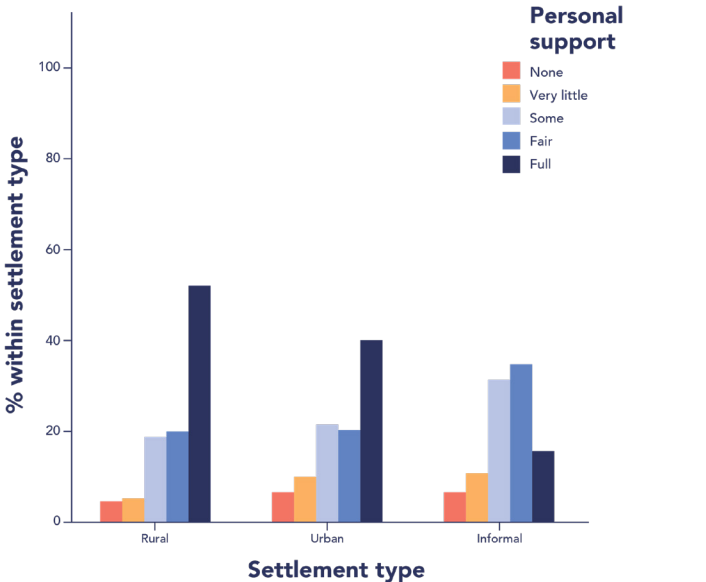
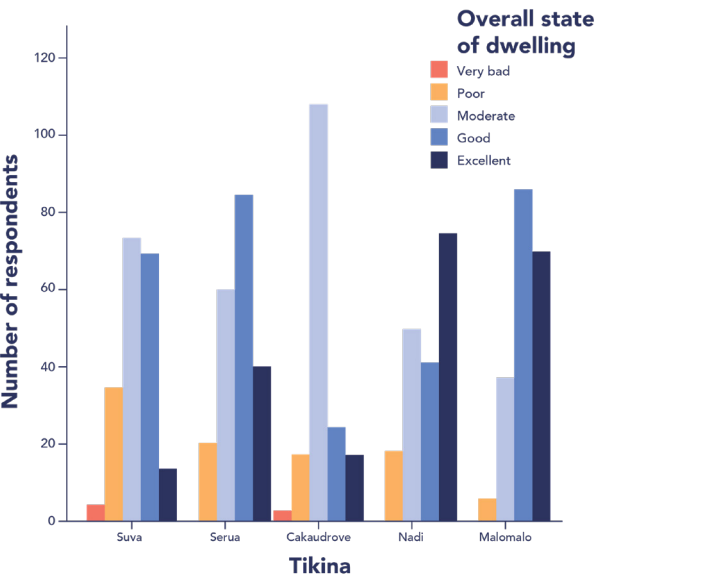
Any deprivations in **Shelter** materials and quality are shared by a household, and therefore gender differences in shelter were not observed in this study. However, **differences in shelter were observed by settlement type, Tikina, and sociocultural background**.

The study found more low quality materials and quality of dwellings in Suva and Rakiraki, and more high quality in Nadi and Malomalo. **Data about condition of dwellings in urban areas was more polarised:** dwellings were more likely to be rated as ‘excellent’, and more likely to be rated as ‘poor’, than houses in

rural areas, reflecting greater inequality in urban areas. Housing in rural areas was more consistent, with over 40% rated as ‘good’.

This inequality was also found in social dimensions such as personal support. Respondents in informal settlements experienced less average support than those in either urban or rural areas – but respondents in urban areas were more likely to report both full personal support and no personal support, indicating more inequality in personal support for individuals living in urban areas.

Unless we measure the scale of deprivation, we miss information about inequality – and consistently moderate deprivation requires a different policy response than high levels of both extreme deprivation and advantage.



MULTIDIMENSIONALITY

Participants in the IDM Fiji stakeholder workshop in February 2016 highlighted that results in many IDM dimensions were related.

The **Water** and **Sanitation** dimensions were correlated at 0.25, a statistically significant correlation indicating that citizens who were deprived in the water dimension were also likely to be deprived in the sanitation dimension.

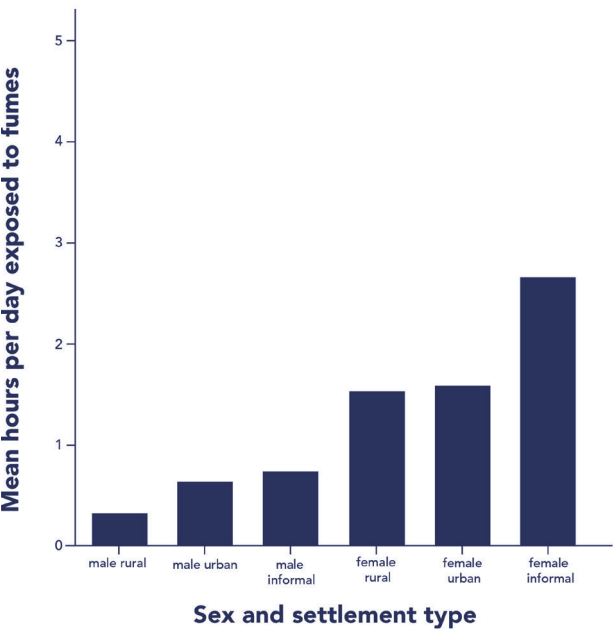
Each IDM dimension is measured using multiple indicators. At the indicator level, **citizens with rudimentary water sources were also more likely to use rudimentary toilet facilities.**

Over 80% of citizens who had water piped into their dwelling also used a private flush toilet, whereas only 45% of those who used unprotected surface water had a private flush toilet.

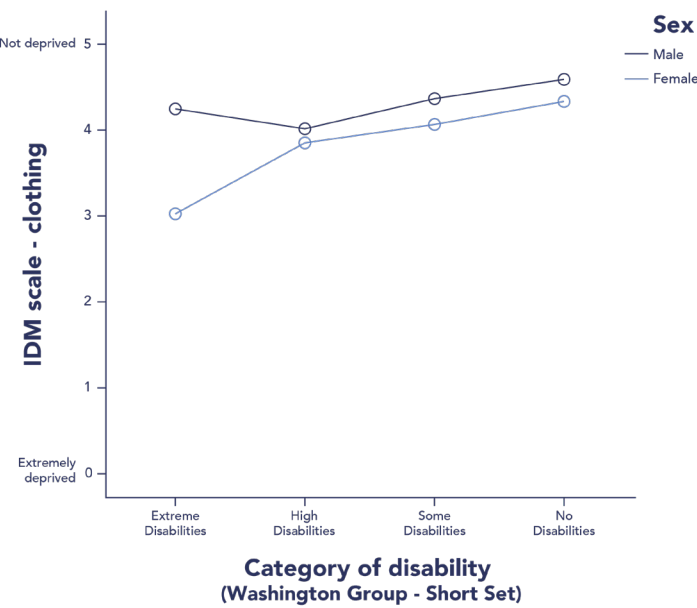
Water access was also linked to **Time-use** in a way that is gendered. Primary responsibility for water collection in Fiji (and elsewhere) rests with women and children. **In rural settlements, distance travelled to access water was up to 90 minutes each day.** Walking a longer distance to a water source takes time away from other productive activities, and potentially exposes an individual to increased risk of violence.

INTERSECTIONALITY

Gender difference in **exposure to fumes** intersected with settlement type to influence the amount of time an individual was exposed. Women in informal settlements spent most time exposed to fumes.



The IDM assesses deprivation in **Clothing** in terms of social acceptability (the ability to meet the dress standards of the community) and physical protection from elements. Results were influenced by disability and gender: **women with high levels of disability were most deprived in the clothing dimension.**



The intersection of disability and deprivation is well noted in poverty literature. The IDM Fiji study provides initial evidence that disability, in the form of general functional and cognitive difficulties, is related to more severe deprivation across many of the 15 IDM dimensions and indicators, and that sex and disability appear to interact to produce varying levels of deprivation.

There was a strong correlation between functional difficulty and age in this sample. The majority of respondents who reported higher levels of disability were in the oldest age group sampled (66+). Further clarity about the relationship between disability, age and deprivation may be addressed by a larger sample or working with disability organisations in implementing an IDM survey.

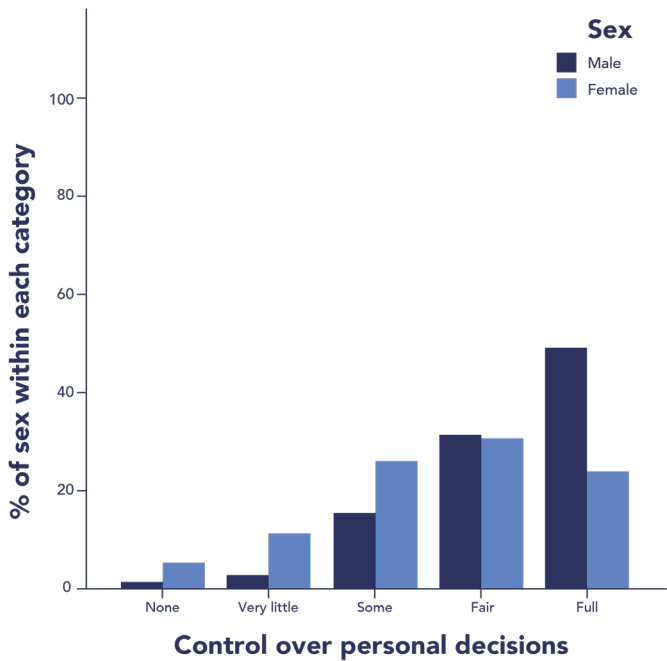


SOCIAL DEPRIVATION

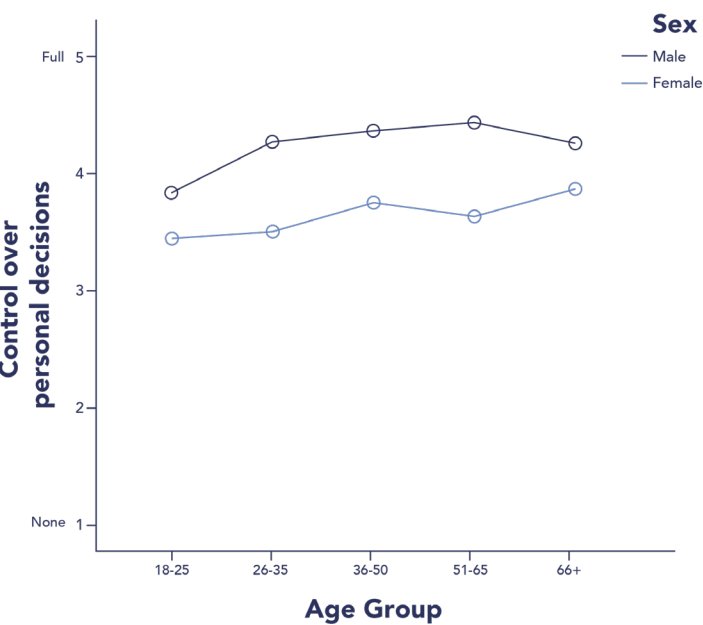
Poverty is not just material deprivation, but relational. Social dimensions of poverty include the ability to control personal decisions (whether to leave the house, seek health care, and freely associate with others); connectedness and social support (being able to depend on others, and being depended on); the ability to present to the standards of one’s community; and voice – the ability to make changes and influence decisions in one’s community or society.

Some 37% of the sample considered they had full control over personal decision-making, and 47% perceived full support from friends and family. However, further disaggregation reveals that **social deprivation was highly gendered**.

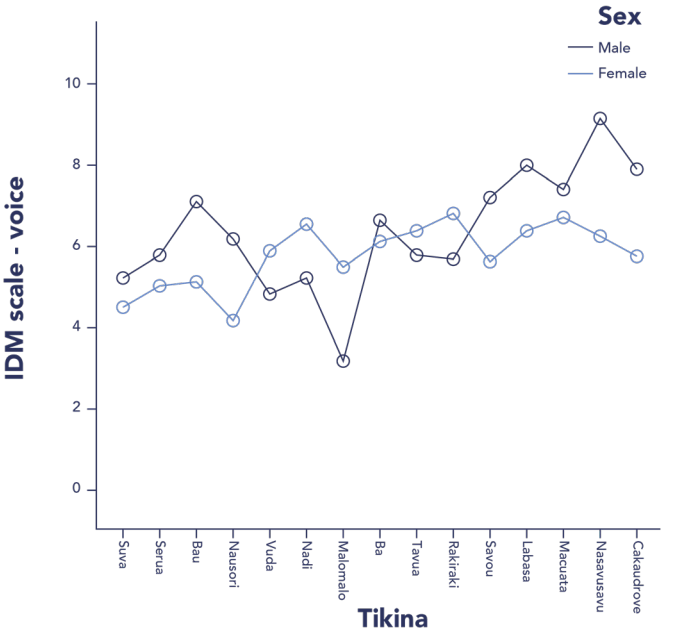
Nearly half the men in the sample (48%) reported full control over personal decisions, compared to only 25% of women. Women were more likely than men to report no control over personal decisions (5% cf to 1.4%).



Young people, and young women in particular, perceived the least control over their personal decision making.

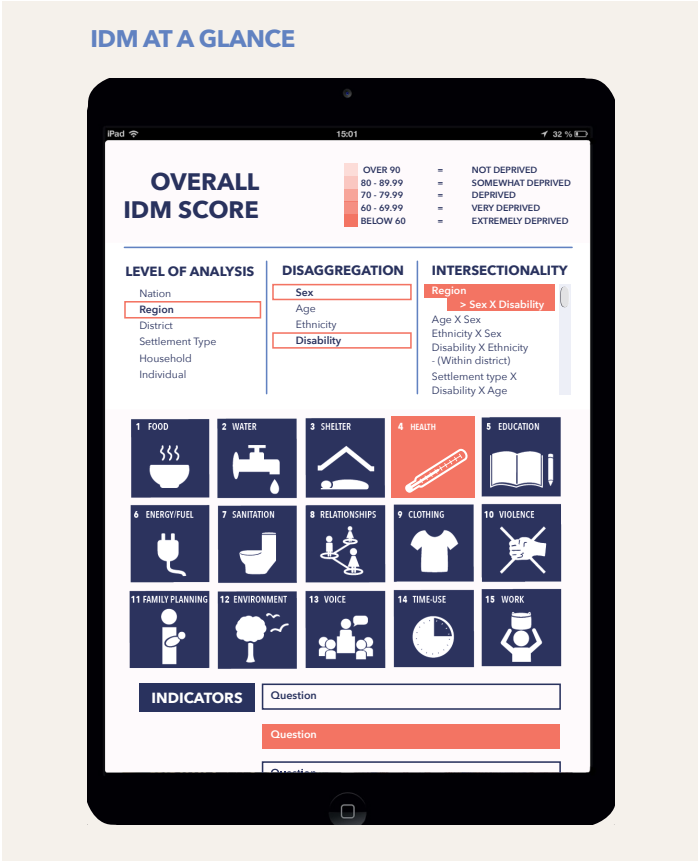


In response to the question 'If you were in trouble, how much support could you count on from friends and family', men were more likely to anticipate full personal support from friends and family (50% of 45%), and were also more likely to anticipate no personal support (6% of men compared to 3.6% of women). Women were more likely to anticipate moderate amounts of personal support.



Voice also varied by geographic location, with **gender inequality in Voice** markedly higher in Bau, Malomalo, and Cakaudrove.

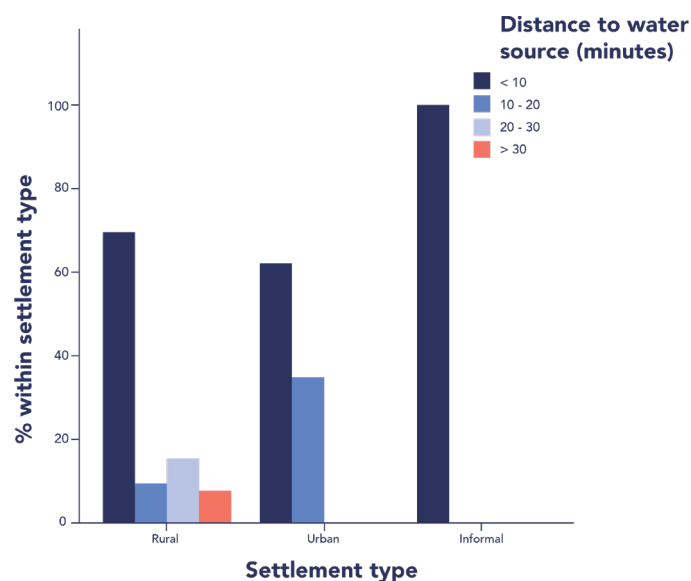
Overall, participants perceived having more control over decisions and support at the familial and immediate social group level than ability to raise issues and affect change at the community level.



DECOMPOSITION

Each IDM dimension is measured using multiple indicators. Analysing results at the indicator level shows what is driving dimension results, and the value of using multiple indicators.

Looking at **Water**, urban settlements were the least deprived because the majority of residents had water piped into their dwellings, individuals always or often had enough water to meet their needs, and if travel was required to water sources, it was not far. However, the nature of deprivation in rural and informal settlements differed: **residents in informal settlements struggled with water reliability, and residents of rural areas struggled with travelling long distances to access water.**



Women were more deprived overall in the **Health** dimension. Examining results at the indicator level helps to understand why. Approximately 50% of participants experienced an illness in the last year. Of these, 60% of men and 50% of women reported that their last injury or illness made it difficult or impossible for them to perform their usual paid or unpaid activities.

Men were more likely than women to have received health care the last time they experienced an injury or illness that required it (70% cf 60%). There were also differences by sex and age, with younger women less likely to access health care than both younger men and older women. In contrast, men's reported rate of health care utilisation did not vary by age.

Of those who sought medical care, 92% of men saw a doctor compared to 84% of women. More women than men saw a nurse (12% cf 4%). This difference was particularly pronounced between younger men and women.

The most common problem with health care quality was waiting time; 30% of respondents indicated a problem in this area. Few gender differences were observed in health care quality, although women were more likely than men to report problems with the skill of the provider (7.4% cf 3.4%).

NEXT STEPS

The current IDM Program will continue to explore and resolve technical aspects of the IDM through to 2020, alongside data collection in additional countries, contexts and populations (for example, people living with disability and LGBTI communities).

Following completion of work on weighting, sampling and aggregation, guidance will be published, enabling further analysis of IDM Fiji data, including generation of aggregate IDM scores. Stay connected and learn more about this global program at:

individualdeprivationmeasure.org

The current IDM Program (2016-2020) is a partnership between the Australian Government through the Department of Foreign Affairs and Trade, the Australian National University and the International Women's Development Agency. The original research that developed the IDM was a four-year, international, interdisciplinary research collaboration, led by the ANU, in partnership with IWDA and the Philippine Health and Social Science Association, University of Colorado at Boulder, and Oxfam Great Britain (Southern Africa), with additional support from Oxfam America and Oslo University. It was funded by the Australian Research Council and partner organisations (LP 0989385).

THE IDM FIJI STUDY (2014-2017) WAS A PARTNERSHIP BETWEEN THE AUSTRALIAN GOVERNMENT, THE INTERNATIONAL WOMEN'S DEVELOPMENT AGENCY AND THE FIJI BUREAU OF STATISTICS.

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