

Fertility and Family Planning in the South Pacific

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This paper discusses fertility and family planning in 18 countries of the South Pacific region, listed in Table 1 and shown in Figure 1. (As can be inferred from the table, the Australian dependency of Norfolk Island, with a population of around 1,900, and the British dependency of Pitcairn, with about 70 inhabitants, are excluded from the discussion.) Table 2 only hints at the diversity of the region. Compare, for example, the Trust Territory of the Pacific, which has more than 2,000 islands,¹ only 90 of which are inhabited, with phosphate-rich Nauru, which comprises one island of 21 square kilometers.

Perhaps in part because of their small populations (see Table 2), many of these countries are neglected in global or regional overviews of fertility and family planning. For example, Kirk gives the following explanation of why a Worldwatch Institute estimate of a crude birth rate of 17.4 per thousand for Oceania is lower than an AID estimate: "Through carelessness the former omitted the islands that constitute the less developed part of the region."²

A further reason for this neglect may be the difficulties involved in obtaining and comparing statistical data. For example, because six of the 18 countries are French or US territories, the information available from the United Nations, which deals largely with independent nations, tends to be limited. Even within a country, comparability over time presents problems. Thus, a reputable reference book has incorrectly suggested that Tonga's crude birth rate, as a consequence of the family planning program, fell from 25 per thousand in 1974 to 13 in 1976,³ whereas (as discussed below) improved vital registration suggests

that the rate may well have exceeded 30. Because many of the countries have incomplete vital registration combined with significant and fluctuating net migration rates, estimates of annual growth rates are often speculative.

Why, then, are these countries of interest? First, many have gained increased political autonomy in the last two decades, and this has influenced their strategic importance. Second, although the land area of the region is only 551,039 square kilometers, the 200-mile Exclusive Economic Area gives the region a total sea area of around 29 million square kilometers.⁴ Third, with high growth rates and, in some cases, very limited land area, the need for emigration or fertility control has become urgent. In addition, population changes in the region often have repercussions in other countries. The growth rates below 2 percent in Table 2 have largely been achieved by emigration, principally to Hawaii, the mainland United States, and New Zealand.

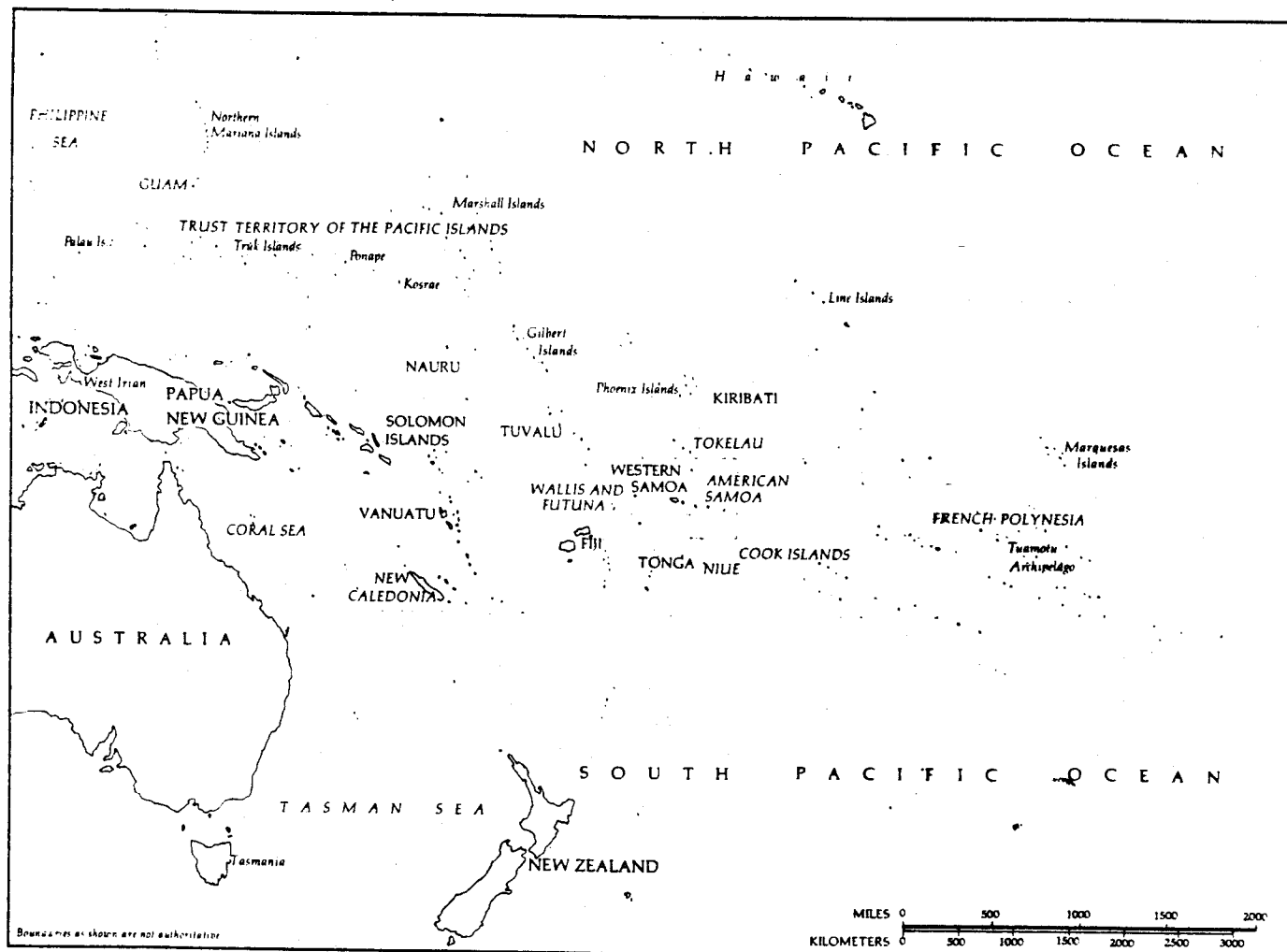
Fertility

As with growth rates, the estimates of total fertility rates are also quite variable, as indicated in Table 3. Many of the better estimates in this table are based upon complete or adjusted registered births and on an age distribution derived from a recent census. However, with small populations fluctuating from year to year because of sex-selective migration, the assumptions of a constant age-sex distribution may not always be fully valid.

Similarly, the base populations that form the denominator for the crude birth rates in Table 4 may also be subject to significant fluctuations. For example, Guam is experiencing immigration of Koreans and Filipinos, along with continuing movements of

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FIGURE 1 The South Pacific region



Guamanians and US military personnel and their dependents to and from other parts of the United States. In using these crude birth rates, caution must also be exercised because of the incorporation of "self-fulfilling prophecies" that bias the estimates downward. For instance, the existence of a family planning program may lead to an assumption of a significant downward trend in fertility.

Completed fertility (not shown in the tables) tends to reflect historically high fertility levels, with some areas and subgroups recording an average of seven or eight births to women aged 45-49.⁵ One exception is New Caledonia, where the relatively low fertility of the Europeans, who comprise about 38 percent of the population, depresses the average.

Factors Influencing Current and Completed Fertility

Apart from modern contraception, factors that tend to restrain fertility in the region include a relatively

high age at first marriage and a shortage of potential spouses in Tokelau and some other areas because of sex-selective emigration.⁶ Many traditional factors influencing fertility, such as sexual abstinence and breastfeeding, are now changing quite rapidly.

Sexual Abstinence

Although some ethnic groups in the Pacific traditionally resume sexual intercourse on the day of a child's birth,⁷ the most common pattern is for the mother to practice prolonged sexual abstinence during lactation until the child is weaned at 18 months or two years of age.⁸ Rigorously observed postpartum abstinence for four to six years has been recorded in Western New Guinea.⁹ Murdock's *Ethnographic Atlas* provides data on the duration of postnatal abstinence for certain Pacific Island societies: in five societies the conventional period was less than one month; in 13, it was between one month and one year; in 10, it was more than one year but less than two; and in as many as 9 societies abstinence for two years or more was customary.¹⁰

TABLE 1 Constitutional status of selected Pacific countries

Country	Status	Country	Status
American Samoa	United States Unincorporated Territory	Tonga	Independent monarchy. Ceased to be a British protectorate in 1970
Cook Islands	Self-governing in free association with New Zealand since 1965	Trust Territory of the Pacific Islands	United States Trust Territory (four governments in free association with the United States)
Fiji	Independent from Britain since 1970	Kosrae	Member, Federated States of Micronesia
French Polynesia	Overseas Territory of France, with a French governor and a local parliament; represented in the French Parliament	Marshall Islands	Self-governing-but also part of Trust Territory of the Pacific Islands
Guam	United States Unincorporated Territory	Northern Mariana Islands	Commonwealth state in association with US; also part of Trust Territory
Kiribati (formerly the Gilbert Islands)	Independent from Britain since 1979	Palau	Self-governing; also part of Trust Territory
Nauru	Independent from Australia since 1968	Ponape	Member, Federated States of Micronesia; also part of Trust Territory
New Caledonia	Overseas Territory of France, with a French governor who is also responsible for Wallis and Futuna; represented in the French Parliament	Truk	Member, Federated States of Micronesia; also part of Trust Territory
Niue	Self-governing in free association with New Zealand since 1974	Tuvalu (formerly the Ellice Islands)	Independent from Britain since 1978
Papua New Guinea	Independent from Australia since 1975	Vanuatu (formerly the New Hebrides)	Independent from Britain and France since 1980
Solomon Islands	Independent from Britain since 1978	Wallis and Futuna	Overseas Territory of France
Tokelau	New Zealand non-self-governing Territory	Western Samoa	Independent from New Zealand since 1962 (also known as Samoa)

SOURCE: Carter, cited in note 3, pp. 8-9.

TABLE 2 Population, density, and growth rates of selected Pacific countries

Country	Population (mid-1979 in '000s)	Area (km ²)	Density per km ²	Annual rate of population growth 1969-79 (percent)
American Samoa	31.4	197	159	1.7
Cook Islands	18.5	240	77	-0.9
Fiji	619.0	18,272	34	2.0
French Polynesia	144.6	3,265	44	2.9
Guam	100.0 117.0*	541	185	1.8 3.4*
Kiribati	57.3	690	83	1.7
Nauru	7.3	21	348	1.2
New Caledonia	139.0	19,103	7	3.1
Niue	3.6	259	14	-3.8
Papua New Guinea	3,079.0	462,243	7	2.7
Solomon Islands	221.2	28,530	8	3.4
Tokelau	1.6	10	160	-0.6
Tonga	95.8	699	137	1.6
Trust Territory of the Pacific Islands	132.5	1,832	73	3.0
Tuvalu	7.4	26	285	2.5
Vanuatu	114.5	11,880	10	3.5
Wallis and Futuna	10.2	255	40	1.8
Western Samoa	155.0	2,935	53	1.1
South Pacific region (including Norfolk Island and Pitcairn)	4,939.0	551,039	9	2.6

* Alternative population figure for Guam is from US Department of Commerce, Bureau of the Census, *World Population Statistics in Brief* (Washington, D.C.: Bureau of the Census, 1980).

SOURCE: South Pacific Commission, cited in note 4, Table 2. This source shows an annual growth rate for Vanuatu of 3.4 percent, which is apparently derived from rounding 3.45 percent.

TABLE 3 Estimates of total fertility rates for selected Pacific countries around 1966, 1970, and 1978

Country	Total fertility rates (per woman)		
	Around 1966	Around 1970	Around 1978
American Samoa	5.9	5.5 or 6.1	5.0
Cook Islands		6.2 or 6.1	4.2
Fiji	4.8	3.8 or 3.2	3.6 or 2.6
French Polynesia	6.3	5.6	
Guam	4.8	4.7	3.5
Kiribati		4.3 or 4.7	4.7
Nauru	7.1		
New Caledonia	5.6	4.3	
Niue		6.2	4.2
Papua New Guinea	6.5	7.1	
Solomon Islands		6.6	7.4
Tokelau		5.1	
Tonga	7.1		5.1
Trust Territory of the Pacific Islands	6.2	5.7 or 6.8	4.6 or 5.0
Tuvalu		2.5	2.8
Vanuatu	6.6		
Wallis and Futuna			
Western Samoa	7.4	6.7	6.4 or 3.7

NOTE: A distinction is made in Table 3 between estimates based on complete or adjusted registered births and other estimates (shown in italics) based on indirect estimation techniques or other approaches.

SOURCES: The main sources for Table 3 are US Department of Commerce, *A Compilation of Age-Specific Fertility Rates for Developing Countries* (Washington, D.C.: Bureau of the Census, 1979); United Nations Economic and Social Commission for Asia and the Pacific, *Demographic Trends and Policies in ESCAP Countries 1978* (Bangkok: United Nations, 1979).

Additional sources are as follows. For American Samoa and Fiji: World Health Organization, cited in note 8. For French Polynesia: Jean-Louis Rallu, "Situation démographique de la Polynésie Française," *Population* 35, no. 2 (March-April 1980): 385-416. For Guam: Guam Department of Commerce, cited in note 38. For Kiribati: Sheila Macrae, "Fertility," in *Report of the 1978 Census for Kiribati*, vol. 2 (forthcoming) for 1973 and 1978. For New Caledonia: for 1969, estimated from the mean number of children ever born to women aged 20-24 (P_2), 25-29 (P_3), and 30-34 (P_4). W. Brass, "Screening procedures for detecting errors in maternity history data," in Economic and Social Commission for Asia and the Pacific, *Regional Workshop on Techniques of Analysis of World Fertility Survey Data* (Bangkok, 1979), pp. 20-21. For Niue: Bakker, cited in note 75, vol. 2, pp. 75-96. For Papua New Guinea: M. Rafiq, "Some evidence on recent demographic changes in Papua New Guinea," *Population Studies* 33, no. 2 (July 1979): 307-312. For Solomon Islands: Solomon Islands Central Planning Office, cited in note 64, Table 3.46. For Tonga: for 1966, Bakker, cited in note 71, p. 27; for 1976, based on the mean number of children ever born to women aged 20-24 (P_2) and 25-29 (P_3). See Brass, cited above, p. 20. For Tokelau: based on the application of Arretx's method to data from Hooper and Huntsman, cited in note 74, pp. 366-411. For Tuvalu: Sheila Macrae, "Fertility," in *Report of the 1979 Census of Tuvalu* (in press). For Vanuatu: based on the formula

$$P_2 \left(\frac{P_4}{P_3} \right)^4 \text{ using 1967 census data.}$$

TABLE 4 Government position on population growth and family planning, around 1978

Government position	Estimated crude birth rates (per thousand)		
	20-29	30-34	40-49
A. Official policy to reduce the population growth rate	Fiji Tuvalu	Kiribati Tonga	Papua New Guinea Solomon Islands
B. Official support of family planning for other than demographic reasons (e.g., health)	Cook Islands Guam Nauru* New Caledonia* Niue*	American Samoa French Polynesia Western Samoa	Trust Territory of the Pacific Islands* Vanuatu
C. Government position unknown			Wallis and Futuna

NOTES: See Dorothy L. Nortman and Ellen Hofstatter, *Population and Family Planning Programs: A Compendium of Data through 1978*, tenth edition (New York: The Population Council, 1980), p. 29, for the categories used. The allocation of some countries into category A or B is tentative. Although placed in category B, the four starred (*) countries have implicit or explicit policies to increase or maintain the population growth rate. For example, according to the United Nations Fund for Population Activities, *Population Facts at Hand* (New York: United Nations, 1980), p. 50, Nauru perceived its current rate of natural increase as too low. Current fertility was considered satisfactory, but government policy was to maintain rates. At the same time, access to effective fertility control is not limited, and direct support for family planning services is provided.

SOURCES: The crude birth rates are from US Department of Commerce, Bureau of the Census, *World Population Statistics in Brief* 1979 (Washington, D.C.: Bureau of the Census, 1980), except for Tuvalu, where a lower census estimate by Sheila Macrae is preferred, and for Niue, where the source is M. L. Bakker, cited in note 75, vol. 2, p. 81. The government position was ascertained by reference to development plans and to the United Nations Economic and Social Commission for Asia and the Pacific, *Demographic Trends and Policies in ESCAP Countries 1978* (Bangkok: United Nations, 1979).

Among groups who consider sexual intercourse to be debilitating, sexual abstinence is often associated with the ritual of food production, as during the yam-growing season¹¹ or when the family pig has given birth.¹² At the other extreme are societies in which there is much playful enjoyment of sexual intercourse, especially among the unmarried, and adolescent sterility is still a puzzling phenomenon.¹³ Generally, modernization has resulted in a declining variety in sexual behavior among ethnic groups as

ionary influences have curtailed the freedom of young and the gradual disappearance of separate "men's houses" and polygyny has reduced the duration of abstinence.

Traditional Birth Control

In the nineteenth and early twentieth centuries, many of the Pacific Islands went through periods of varying duration in which they experienced a visible decline in total population numbers. There was much contemporary debate as to the causes of this depopulation. Mortality following from contact with introduced infectious diseases was certainly a major factor. The additional impact and relative importance of the spread of gonorrhea and the resort to induced abortion in reducing birth rates will probably never be fully established.¹⁴ It is clear, however, that many Pacific cultures both had access to effective mechanical means of inducing abortion and defined a limited number of exceptional circumstances in which abortion was socially sanctioned. Devereux was able to assemble anthropological data on abortion for 60 South Pacific cultures.¹⁵ Traditional methods of contraception appear to be much less common, although withdrawal is widely known.¹⁶

One distinctive feature of a number of Pacific cultures is the belief that women who are sterile have deliberately swallowed a concoction of leaves that has produced this effect.¹⁷ Often the accusation is that young girls take the medicine to avoid pregnancy before marriage and then find that its effects cannot be reversed because the woman who gave it to them has since died.¹⁸ Belief in this medicine makes Depo-Provera injections highly acceptable but also results in an excessive faith in the power of a single oral contraceptive tablet.

Breastfeeding

Current statistical data on breastfeeding in the South Pacific are not readily available, but the 1974 Fiji Fertility Survey indicated that breastfeeding for very long periods was not common. The median duration of lactation was 10.4 months among Fijians and 5.2 months among Indians, with a strong association between breastfeeding and postpartum abstinence.¹⁹

In some countries such as Western Samoa and Kiribati, maternal and child health services are encouraging longer breastfeeding.²⁰ In Papua New Guinea, feeding bottles and rubber teats were made available by prescription only under the Baby Feed (Control) Act of 1977.²¹ Although this measure was primarily intended to improve infant health, it was recognized that it could also result in reduced fertility.²²

Family Planning Services

In 1950, at the instigation of Prince Tungi, who is now the King of Tonga, the question of population was raised at the First South Pacific Conference. In 1952, the Fiji Legislative Council urged the appointment of a commission to consider the problems of overpopulation. It was not until 1957, however, that Sister Compton of New Zealand "made a start on the development of family planning in the islands of the Southern Pacific. The IPPF asked her to survey Fiji, Tonga, Niue, Eastern and Western Samoa and she returned to Tonga in 1958 to open the first clinic."²³

Today in most countries of the South Pacific region, family planning services are provided by the government, often (as in Fiji, the Cook Islands, Kiribati, and Tonga) as a part of a maternal and child health program. One recognized problem with the MCH approach is that the program tends to ignore women who are not mothers. Another is that men, who regard themselves as the decision-makers in the family, are not reached by the program.

Many of the countries also have private family planning associations and often an organization sponsored by the Catholic Church, usually founded in the 1970s and concentrating on the Billings and other natural methods (see Table 5). In countries such as Fiji and Western Samoa, the government health authorities tend to concentrate on the provision of services, while the private family planning associations are largely responsible for promotional activities.²⁴

The "Pacific way" of doing things stresses quiet cooperation and community consultation.²⁵ For this reason it is perhaps not surprising that at least two countries, Papua New Guinea and the Solomon Islands, have taken a cautious approach to family planning. In Papua New Guinea, the Population Action Program is currently at stage 1, research and education, which includes extending the awareness of family planning and motivation to use the services, and increasing the availability of family planning services. The second and third stages involve policy formulation and implementation.²⁶

Among the obstacles to family planning in Papua New Guinea were the beliefs that it promoted promiscuity, reduced a clan's fighting strength, and led to disputes between the Catholics and non-Catholics.²⁷ Similar obstacles were thought to have contributed to the decline in acceptance rates for Fijians between 1972 and 1977.²⁸

From the discussion of selected countries below, it can be seen that family planning often reflects an "urban bias" whereby services are more readily available in urban centers or on the main island. This

TABLE 5 The commencement of family planning in various South Pacific countries

Country	Government program or major involvement	Family planning association founded	Catholic Church-sponsored organization founded	International assistance from	Country	Government program or major involvement	Family planning association founded	Catholic Church-sponsored organization founded	International assistance from
American Samoa	1973	1973			Solomon Islands		1973	1973	UKODM WHO
Cook Islands				UNFPA	Tonga	1958	1969	1970	UNFPA IPPF, UNFPA, WHO, UNDP, New Zealand overseas aid
Fiji	1962	1963	1973	UNFPA, UNDP, WHO, UNICEF, WFP, USAID	Tuvalu	1968	1975		UNFPA
French Polynesia		1968?			Vanuatu		1974		IPPF, UNFPA, WHO, UNICEF
Kiribati	1968	1969		IPPF, UNFPA, WHO, UNICEF	Western Samoa	1971	1971		UNFPA, WHO/ UNICEF, WFP
Papua New Guinea	1968	1974	1974	IPPF, UNFPA, WHO, FPIA					

NOTE: Blank cells can mean either the lack of the relevant activity or that the date of its commencement is not known.

SOURCES: International Planned Parenthood Federation, cited in note 24, pp. 64-67. Additional sources are as follows. For Fiji: Bavadra and Kierski, cited in note 28, pp. 17-23. For Kiribati and Tuvalu: Pitchford, cited in note 47, p. 1, indicates that the Medical Department's program began "in earnest" in 1968. The date for the Tuvalu family planning association refers to "after separation" from Kiribati. For Papua New Guinea: O'Collins, cited in note 30, p. 3. For the Solomon Islands: Maev O'Collins, "Overview of social

welfare and family planning programmes in the Solomon Islands," report prepared for the United Nations Inter-Regional Technical Meeting on Social Welfare Aspects of Family Planning, Manila, 1978. O'Collins does not give the date when family planning was included in the Ministry of Health and Welfare's Family Health Programme. For Tonga: Mary Theresa, "Report of the Christian Family Life Programme, Catholic Diocese of Tonga" (mimeo, 1980). For Western Samoa: Stanley, cited in note 68, p. 4, indicates that the Family Planning Association was formed in 1971 but changed its name to the Western Samoa Planned Parenthood Association under the new constitution in 1973.

might result in part from a lack of trained manpower. To improve the delivery of services, the Cook Islands use paramedics and traditional midwives. Several other countries also use paramedics to fit IUDs or issue pills.²⁹

per capita income and various demographic indicators, the Solomon Islands, Tonga, and Western Samoa were designated as priority countries for UNFPA population assistance, while Kiribati and Tuvalu were designated as requiring special attention.³¹

International Agencies

International agencies have played a significant part in the development of family planning services in the South Pacific. For example, in Papua New Guinea a Family Health Project to integrate family planning into maternal and child health services was established in 1974 with the assistance of the World Health Organization and the United Nations Fund for Population Activities.³⁰ Details of the sources of international assistance are given in Table 5. On the basis of

Family Planning Methods

As far as can be ascertained, the following methods are available (albeit sometimes to a very limited extent) in all countries in the region: orals, the IUD, and female sterilization. Table 6 indicates that orals are widely used, particularly in the American territories and French Polynesia. The number of types of orals available varies from one in Kiribati and Tuvalu to six

TABLE 6 Contraceptive users, acceptors, and major methods among women aged 15-44 (around 1979)

Country	Number	Current users (percent)	Annual acceptors (percent)	Current users by major method (percent)
American Samoa	4,786	22	16	60% orals
Cook Islands	3,554	28	7	40% orals
Fiji	134,328	29	4	37% IUD 23% orals 42% female sterilization
French Polynesia	35,000		29	87% orals ^a
Guam	17,672	7	3	67% orals
Kiribati 1977	12,056	22	3	
1978		22	7	79% injectables
Nauru				
New Caledonia				
Niue	547	11		63% injectables
Papua New Guinea	494,860		3	44% orals ^a
Solomon Islands	37,351	23	3	42% injectables 25% orals
Tokelau				
Tonga	11,664	36	16	25% IUD 30% injectables
Trust Territory of the Pacific Islands	20,690	5	4	84% orals
Tuvalu	1,302	32	10	21% orals 26% IUD 46% injectables
Vanuatu	18,000	13	1	
Western Samoa	27,796	11	3	70% IUD

^aPercentage is based on methods used by annual acceptors.

NOTES: These statistics should be treated with extreme caution, and in many cases they provide only a rough guide to use of family planning in a particular country. In addition, there appears to be a lack of comparability between countries, particularly in respect to restarters, persons who change methods or clinics, and sterilization acceptors.

For Kiribati, restarters are definitely excluded from the annual acceptor figures. For Niue, Bakker (cited in note 75, p. 96) indicates that methods other than orals, IUD, injectables, and sterilization were not recorded at Alofi Hospital. For Western Samoa, reference to the *Annual Report 1978* of the Department of Health, Family Welfare Section, p. 6, indicates that if sterilization operations since 1980 were included, the proportion of current users would rise from 10 percent to 13 percent.

Perhaps because some of the figures in Table 6 are forecasts, reconciliation with other sources is sometimes difficult. For example, for Tonga the *Report of the Minister of Health for the Year 1978*, Table 11, shows that 53 percent of acceptors since 1966 are still practicing contraception.

SOURCES: World Health Organization, cited in note 8, Tables 12, 13, and 15, as adjusted. For Kiribati, reference to the *1978 Annual Report* of the Ministry of Health and Community Affairs, Appendix 12, indicates that the WHO figures relate to 1977. The 1978 figures are given in italics in Table 6.

in American Samoa. The IUD is an important method in some countries (notably Western Samoa) but has declined in popularity in some others.³²

Depo-Provera is unavailable in the American territories, which may reflect the unavailability of Depo-Provera on the mainland United States, where it is not licensed for contraceptive use. The widespread use of Depo-Provera in some other Pacific countries may therefore reflect the influence of New Zealand, which had 20,000 users of the method in 1974.³³

The legal status of abortion is not always clear but seems generally restrictive except where the

mother's life is at risk. In Vanuatu, the former British authorities apparently took a less restrictive view than the French. In New Zealand, the attitudes of Pacific Islanders are reported to be more conservative than those of Europeans or Maoris.³⁴

Family Planning in Selected Countries

The following section discusses family planning and population in the French Territories, in one American