

Fertility Patterns of Adolescent and Older Women in Pacific Island Countries: Programme Implications

*By William J. House and Nasiru Ibrahim **

** William J. House, Adviser on Population Policies and Development Strategies, UNFPA Country Support Team for the South Pacific, and Nasiru Ibrahim, United Nations Volunteer Statistician, both of whom are assigned to Suva, Fiji. The views expressed in this article are those of the authors and do not necessarily reflect the views of the United Nations Population Fund (UNFPA) or the United Nations.*

Compared with some regions of the world, adolescent fertility in the Pacific island countries is certainly not high, but unmet need for contraception among older women is significant

Following the International Conference on Population and Development (ICPD) in Cairo in September 1994, much concern has been expressed about the importance of the life-cycle stage of adolescence, the powerfully formative time of transition to adulthood. What happens to the individual during this period shapes how they will live their adult lives, in the reproductive arena as well as in the social and economic realm. ICPD was especially concerned over the vulnerable reproductive health status of adolescents, particularly females between the ages of 15 and 19 years, partly due to their changing demographic and sexual behaviour. Indications are that, while the mean age at menarche has been falling, both the mean age at first marriage and age at first intercourse have been rising, but the increase in age at marriage is greater, resulting in an extended period of possible exposure to adolescent pregnancy (Bongaarts and Cohen, 1998). Adolescents, especially those aged 15 to 19 years, are believed to engage in high levels of unprotected sexual activity both within and outside marriage, leaving them exposed to the risk of unplanned and unwanted pregnancy, and contracting sexually transmitted diseases (STDs) including HIV/AIDS. Such behaviour, often resulting in early out-of-wedlock pregnancy, constitutes a major threat to the health of these adolescents, as well as retarding their potential educational, career and economic development.

Recently, organizations in many countries have created a wide range of programmes to respond to the reproductive health needs of adolescents, although it is fully recognized that existing programmes are too few and too limited to meet the global need. This need is reflected in the approximately 1 billion persons who are adolescents, 85 per cent of whom live in developing countries. Very many adolescents are sexually active and at risk of numerous reproductive health dangers, such as unsafe abortion and sexually transmitted diseases. It should be mentioned that 40 per cent of all new HIV infections occur among persons 15-24 years old.

Clearly, adolescents are a sizeable, vulnerable group. The global community, and UNFPA in particular, is justified in highlighting their specific problems. Adolescents often lack basic reproductive health information, skills in negotiating sexual relationships, and access to affordable, confidential reproductive health services. Concerns about privacy or the ability to pay, and real or perceived disapproval by service providers further limit access to services where they exist, as do legal barriers to information and services in some countries. Many adolescents lack strong stable relationships with parents or other adults with whom they can talk about their reproductive health concerns.

This increased concern for the health and welfare of young people is to be welcomed and it has been echoed repeatedly in recent years in the Pacific island countries. Indeed, much of the rationale for UNFPA's current programme in the region is premised on the belief that adolescents are increasingly sexually active, often exposed to early pregnancy and infections from sexually transmitted diseases, and frequently by-passed by the institutions and personnel responsible for the provision of reproductive health services, including family planning.

The adverse social and economic consequences for an adolescent girl who becomes pregnant and delivers a baby will depend on her particular marital, cultural, familial and community situation. However, the physical and health consequences for the mother and her child are universally recognized as problematic (Singh, 1998). From the societal and familial viewpoint, the consequences of adolescent pregnancy and childbirth, especially that of very young adolescents, are profound. In less developed countries, where health conditions are poor and anaemia and malnutrition are common, and where access to health care is inadequate, adolescent pregnancy can bring forth very high risks to the immediate and long-term health status of the mother and child.

No doubt, the adverse social, economic and personal repercussions of adolescent childbearing are inversely related to the age of the teenage mother. The young mother will invariably drop out of school and any opportunities for further education will be curtailed; she is very likely to be unmarried and to become overly dependent on her family for economic support. Her lifetime opportunities for self-advancement will have been seriously damaged by the act of early motherhood.

While accepting, unequivocally, that adolescent reproductive health, particularly the deleterious consequences for the subjects of unprotected sexual activity and teenage pregnancy, should be a prime concern of UNFPA and other development agencies, the purpose of this article is to bring an element of circumspection to the often seemingly alarmist popular perceptions about trends in adolescent sexual behaviour which are widely portrayed in the local media.¹ We wish to

investigate whether adolescent birth rates are high and rising over time in the Pacific island countries, as is widely believed, and whether they are high relative to past years and to other developing regions in the world. We conclude by examining the merits of also focusing financial and technical assistance on another vulnerable group of women, those exposed to pregnancy over the age of 35 years, whose claims for special treatment seem to have been subordinated by the perception of rising rates of teenage pregnancy in the subregion in recent years.

Patterns of adolescent fertility in the Pacific island countries

No doubt the societal consequences of an early age at initial childbearing are profound and can be especially adverse if the mother is unmarried. They will vary according to the timing of childbirth during the adolescent years as well as the proportion of women who start childbearing at different ages. The level of, and changes over time in, adolescent childbearing are examined here, to the extent possible, using various measures. The overall rate is best captured by the age-specific fertility rate (ASFR), particularly for females aged 15-19 years. Another indicator is the proportion of all births in a year attributable to adolescents, or more definitively, to those aged 15-19. On the other hand, the timing of childbearing is better measured by the proportion who have had a child by selected ages within the period of adolescence, say by the age of 20.

ASFR measures the annual number of live births per thousand women in each of seven age groups (15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49) and is a valuable measure of current childbearing performance by these cohorts. Very few Demographic and Health Surveys (DHS) have been conducted in the Pacific island countries and the development of a registration system of vital events (births, deaths and marriages) remains in its infancy in the great majority of the countries. Reliance on registered births from incomplete hospital records would produce very misleading results as coverage rates vary from year to year. Therefore, in most cases, we must rely on decennial population censuses for information on childbearing to trace the evolution of changing patterns of adolescent fertility.

These data are taken from the demographic analyses of past censuses. While we cannot vouch for the reliability of the data, they are likely to be the best available. It is also likely that, over time, their reliability has improved as national statistical offices have gained experience and built national capacity, often through the support of donor organizations. For the Pacific island countries, how high is current adolescent fertility, and what has been happening to the ASFR of adolescents over time? The only available source and most reliable evidence comes from national censuses. Table 1 provides the annual number of births per thousand females aged 15-19 at various times over the last 30-40 years in the Pacific island countries and major regions of the world.

Table 1. Age-specific fertility rates for females 15-19 years old, by country, for selected years

Country or area	1960s	1970s	1980s	1990s
Melanesia				
Fiji:				
Fijians	55	42	-	-
Indians	96	53	-	-
All	-	-	65	54
Papua New Guinea	69	63	41	77
Solomon Islands	-	142	101	-
Vanuatu	102	91	60	-
Micronesia				
Federated States of Micronesia	-	90	68	54
Kiribati	109	76	51	44
Marshall Islands	171	155	162	-
Palau	91	81	53	45
Polynesia				
Cook Islands	128	89	83	76
Tonga	-	32	28	28 ^a
Tuvalu	-	17	-	39
Samoa	-	41	-	22
Niue	-	-	-	32
Elsewhere				
World total	-	-	-	60

Africa	-	-	-	136
Asia	-	-	-	45
Europe	-	-	-	27
Latin America and Caribbean	-	-	-	79
North America	-	-	-	60
Oceania	-	-	-	28

Source: National censuses and United Nations (1995). World Population Prospects: The 1994 Revision, New York.

a Latu, R. (1996). "Reproductive health and family planning: sectoral review for the Kingdom of Tonga". UNFPA Country Support Team, Suva, mimeographed.

While the longevity of the data series differs across countries, what can we conclude from table 1 about general patterns of change in childbearing of adolescents? With a few exceptions (Marshall Islands, Papua New Guinea and Tuvalu) it can be concluded that adolescent fertility has fallen over the years in the Pacific island countries at a time when overall fertility was generally declining for all women. The lowest rates of adolescent fertility are found in Polynesia (Samoa 22 and Tonga 28) with some of the highest rates being found in Micronesia (Marshall Islands 162 in 1988) and Melanesia (Papua New Guinea 77 in 1996 and Solomon Islands 101 in the period 1984-1986). The apparent increase in adolescent fertility in Papua New Guinea and Tuvalu seems implausibly high, underlining the difficulty of monitoring demographic trends in small island populations.²

How does the level of adolescent fertility in the Pacific island countries compare with other major regions of the world for the most recent period for which we have data, the 1990s? The world average for adolescents in the period 1990-1995 was 60 births per thousand females, which is only exceeded by Papua New Guinea and Cook Islands of the countries in the subregion for which data are available for this period. In all likelihood, the level in Marshall Islands and Solomon Islands would currently also exceed 60 per thousand if data were available. Indeed, compared with most of the developing regions of the world, Africa, Asia, Latin America and the Caribbean, and indeed North America, adolescent fertility in the Pacific island countries appears to be relatively low.

In the Pacific island countries, where data allow, it is also of interest to contrast the proportionate decline over time in adolescent childbearing compared with overall fertility. In only a few countries can we make such comparisons over any length of time; in three of them, adolescent fertility appears to have fallen faster than adult fertility: Solomon Islands (-30 per cent for adolescents compared with -18 per cent for adults), Kiribati (-53 compared with -45 per cent) and Vanuatu (-20 compared with -19 per cent). The opposite is the case in Cook Islands (-40 per cent for adolescents compared with -58 per cent for adults) and the Federated States of Micronesia (-40 compared with -43 per cent).

From the current estimates of fertility that we have, how "high" is adolescent fertility according to the ASFR in the Pacific island countries compared with numerous other countries around the world? In table 2, we restrict the countries to data from the 1990s and again compare ASFRs for various countries with those from South Pacific countries. The comparisons are very revealing and confirm once more that adolescent fertility is relatively low in the Pacific island countries compared with some of the individual countries from other developing regions.

Table 2. Age-specific fertility rates of females 15-19 years old for South Pacific countries and selected countries in other regions

Age-specific fertility rates of females 15-19 years old	<30	30-50	51-100	100+
South Pacific	Samoa (22)	Kiribati (44)	Cook Islands (76)	
	Tonga (28)	Niue (32)	Federated States of Micronesia (54)	
	Tokelau (0)	Palau (45)	Papua New Guinea (77)	
		Tuvalu (39)	Fiji (54)	
Sub-Saharan Africa			Rwanda (60)	Burkina Faso (149)
			Zimbabwe (99)	Cameroon (164)
				Ghana (116)
				Kenya (110)
				Madagascar (157)
				Malawi (161)
				Namibia (109)

			Niger (215)
			Nigeria (146)
			Senegal (127)
			Tanzania (144)
			Zambia (156)
Asia	Philippines (50)	Indonesia (61)	Bangladesh (140)
		Pakistan (84)	India (121)
		Turkey (55)	
Latin America and Caribbean		Bolivia (94)	
		Columbia (89)	
		Dominican Republic (88)	
		Paraguay (97)	
		Peru (61)	
		Trinidad (82)	

Source: For the Pacific island countries: national censuses and United Nations (1995). World Population Prospects: The 1994 Revision, New York. For other countries, see Singh, S. (1998). "Adolescent childbearing in developing countries: a global review" Studies in Family Planning 29(2), June, table 2.
a Restricted to data for the 1990s.

This is not to deny, of course, that the rate of adolescent pregnancy might have risen in the Pacific island countries, only to be offset by a high rate of induced abortion. Since abortion in the Pacific island countries is illegal as a means of terminating a pregnancy, other than to save the life of the mother, it is impossible to bring hard evidence to bear on the hypothesis. We would argue, however, that while such illegal abortions may be taking place, they are not so widespread as to contradict our overall conclusion. Nor is it obvious that, where induced abortion takes place, it is more prevalent among younger than older women.

Furthermore, while adolescent fertility generally has been declining at the same time as the mean age at first marriage has been rising, it could well be that the proportion of adolescent births attributable to unmarried teenagers has been rising. Such a phenomenon may well have led to the popular perception that overall adolescent fertility has been rising. However, no data are available to confirm or reject this hypothesis.

Alternative measures

While the overall level of adolescent fertility is best captured by the ASFR for females aged 15-19, the timing of childbearing is better measured by the proportion of women aged 20-24 who have had a birth by a certain age, say 18, 19 or 20. Very few estimates for the Pacific island countries are available and these are compared with recent data for the 1990s for selected countries from around the world and reported in table 3. While the reference periods are often slightly different, it would seem that the percentage of women 20-24 years old who had given birth to a child by age 20 were already relatively low in earlier years in the few Pacific island countries for which data are available compared with more recent estimates for other regions of the world.

Table 3. Percentage of women 20-24 years old who have had a child before age 20

Country or area	(Per cent)
Pacific islands	
Papua New Guinea (1996)	34.6
Vanuatu (1995)	38.1
Fiji:	
	30.6 (1956)
Fijians	28.2 (1966)
	20.8 (1976)
	68.5 (1956)
Indians	45.2 (1966)
	23.3 (1976)

Kiribati (1978)	29.4
Sub-Saharan Africa	
Burkina Faso (1992-1993)	62.4
Cameroon (1991)	66.8
Ghana (1993)	48.5
Kenya (1993)	52.2
Madagascar (1992)	52.9
Malawi (1992)	63.3
Namibia (1992)	41.6
Niger (1992)	75.0
Nigeria (1990)	53.5
Rwanda (1992)	24.6
Senegal (1992-1993)	51.7
Tanzania (1991-1992)	56.8
Zambia (1992)	61.3
Zimbabwe (1994)	46.9
Mean:	54.1
Asia	
Bangladesh (1993-1994)	66.0
India (1992-1993)	48.6
Indonesia (1994)	32.7
Pakistan (1990-1991)	30.5
Philippines (1993)	21.5
Turkey (1993)	25.3
Mean:	37.4
Latin America and Caribbean	
Bolivia (1993-1994)	37.7
Colombia (1995)	36.0
Dominican Republic (1991)	33.1
Paraguay (1990)	37.1
Peru (1991-1992)	26.9
Mean:	34.2

Source: Various census reports for Pacific island countries and House, W.J. (1998). "Prospects for demographic change in Vanuatu: results of a KAP survey". UNFPA Country Support Team for the South Pacific, Discussion Paper No. 17, December; for other countries, Singh, S. (1998). "Adolescent childbearing in developing countries: a global review" *Studies in Family Planning* 29(2), June, table 2.

Table 4. Absolute number of births and share of total number of births attributable to adolescents aged 15-19 in selected Pacific island countries and elsewhere over time

Country or area	Absolute number of births			Percentage share of births to adolescents in total annual births		
	1970s	1980s	1990s	1970s	1980s	1990s
Melanesia						
Fiji	-	2,375	2,190	-	11	11
Papua New Guinea	6,517	5,618	14,197	6	5	11
Solomon Islands	-	-	-	-	-	-
Vanuatu	553	412	-	12	8	-
Micronesia						

Federated States of Micronesia	303	257	314	10	8	10
Kiribati	262	-	161	13	-	7
Marshall Islands	-	321	-	-	15	-
Palau	-	58	30	-	13	9
Polynesia						
Cook Islands	91	93	58	17	20	11
Tonga	-	143	117 ^a	-	6	5 ^a
Tuvalu	9	-	11	5	-	4
Samoa	373	-	204	9	-	5
Niue	-	-	3	-	-	4
Elsewhere (1990-1995)						
World total	-	-	-	-	-	11
Africa	-	-	-	-	-	17
Asia	-	-	-	-	-	9
Europe	-	-	-	-	-	8
Latin America and Caribbean	-	-	-	-	-	16
North America	-	-	-	-	-	13
Oceania	-	-	-	-	-	6

Source: National censuses and United Nations (1995). World Population Prospects: The 1994 Revision, New York.

^a Latu, R. (1996). "Reproductive health and family planning: sectoral review for the Kingdom of Tonga". UNFPA Country Support Team, Suva, mimeographed.

Alternatively, it may be that heightened concern about adolescent fertility reflects concern over a growing proportion of annual total births being attributable to women under the age of 20 years. Indeed, what has happened to the absolute number of births to teenagers over time, as well as their contribution to, or share of, the total number of births annually? Table 4 shows patterns of change and compares the Pacific island countries with other regions of the world.

The direction of change in the Pacific island countries in table 4 is fairly clear. Only in Papua New Guinea is there any significant increase in the absolute number and share of total births attributable to adolescents.⁴ Elsewhere, particularly in Cook Islands, Fiji, Kiribati, Palau, Samoa, Tonga and Vanuatu, the absolute number of births annually to adolescents has declined, often accompanied by a decline or constancy in their share of total annual births in their country.

Still, this evidence should not detract from the need to address the emerging reproductive health problems of adolescents, many of which are not necessarily related to childbearing per se, but which are a consequence of sexual activity, the nature and extent of which has not been measured.

Childbearing by older women -- a forgotten issue?

Patterns of fertility and infant and maternal mortality are closely interrelated. Relatively high rates of infant and maternal mortality occurring in some of the Pacific island countries can be attributed to many factors.⁵ One important determinant is the pattern of fertility depending, in turn, on the age of the mother, the number of children she has had, and the length of the interval between births. Children born to teenage mothers and to mothers over the age of 35 have a reduced chance of surviving. Older mothers who have already had a number of children are also likely to be at greater risk together with their newborn child, because they are less able to withstand the stress of pregnancy, delivery and breastfeeding.⁶

How significant is childbearing among older women in the Pacific island countries relative to younger women in those countries? Table 5 brings evidence to bear on this issue.

Table 5. Age-specific fertility rates for women aged 35 and older

Country and area	1970s	1980s	1990s
Melanesia			
Fiji	-	38	35
Papua New Guinea	119	98	86

Solomon Islands	-	-	-
Vanuatu	123	98	-
Micronesia			
Federated States of Micronesia	154	170	102
Kiribati	73	91	82
Marshall Islands	-	120	-
Palau	142	82	31
Polynesia			
Cook Islands	71	56	-
Tonga	-	75	85 ^a
Tuvalu	21	-	94
Samoa	78	-	98
Niue	-	-	77

Source: National censuses.

^a Latu, R. (1996). "Reproductive health and family planning: sectoral review for the Kingdom of Tonga". UNFPA Country Support Team, Suva, mimeographed.

Table 6. Age-specific fertility rates of females 15-19, 35-39 and 40-44 years old in selected Pacific island countries and elsewhere in the world in the 1990s

Country and area	Age-specific fertility rates		
	15-19 years	35-39 years	40-44 years
Melanesia			
Fiji	54	61	25
Papua New Guinea	77	122	82
Micronesia			
Federated States of Micronesia	54	153	91
Kiribati	44	138	60
Palau	45	54	20
Polynesia			
Tuvalu	39	135	39
Samoa	22	153	86
Tonga	22	126	67
Niue	32	159	40
Elsewhere			
World total	60	59	24
Africa	136	149	82
Asia	45	56	22
Europe	27	23	5
Latin America and Caribbean	79	66	28
North America	60	32	5
Oceania	28	53	20

Source: National censuses and United Nations (1995). World Population Prospects: The 1994 Revision, New York.

Along with the overall total fertility rate and the age-specific fertility rate for adolescents, the rate of childbearing among older women has generally declined throughout the Pacific island countries over the last three decades. However, fertility among women aged 35 and older still remains very significant and appreciably higher than among adolescents in these countries. During the 1990s, the ASFR for women over 35 years of age, as reflected in tables 1 and 5, exceeded that for adolescents by a significant margin in Federated States of Micronesia, Kiribati, Niue, Papua New Guinea, Samoa and Tuvalu.

Given the reported differences in fertility behaviour between these cohorts in earlier years, this pattern is likely to hold also in Tonga and Vanuatu in the 1990s.

A comparison is made in table 6 of the most recently estimated ASFRs for adolescents 15-19 years old with women 35-39 and 40-44 years old in the Pacific island countries and other regions of the world. It is evident that older women in the former continue to experience relatively high fertility compared with adolescents, while the stark opposite generally holds in many other regions of the world. Such high-risk behaviour by older women can be the cause of profound life-endangering reproductive health problems for such women and their families, and particularly for their children. Yet the persistently higher fertility of older women in the Pacific island countries does not appear to attract anywhere near as much attention from planners, policy-makers, donors and the media as the fertility behaviour of adolescents in the current post-ICPD era with its heightened concern about adolescent reproductive health and sexuality.

Table 7. Absolute number of births and share of total number of births attributable to women aged 35+ in selected Pacific island countries and elsewhere over time

Country and area	Absolute number of births			Percentage share of births to women 35+ in total annual births		
	1970s	1980s	1990s	1970s	1980s	1990s
Melanesia						
Fiji	-	1,957	2,362	-	9	12
Papua New Guinea	22,908	19,305	20,473	22	21	16
Solomon Islands	-	-	-	-	-	-
Vanuatu	722	779	-	15	16	-
Micronesia						
Federated States of Micronesia	785	639	732	25	19	22
Kiribati	280	-	481	14	-	20
Marshall Islands	-	256	-	-	12	-
Palau	101	57	36	23	18	11
Polynesia						
Cook Islands	76	64	37 ^a	14	14	7 ^a
Tonga	-	400	476 ^b	-	17	19 ^b
Tuvalu	12	-	58	7	-	22
Samoa	693	-	920	17	-	22
Niue	-	-	13	-	-	17
Elsewhere (1990-1995)						
World total	-	-	-	-	-	11
Africa	-	-	-	-	-	15
Asia	-	-	-	-	-	10
Europe	-	-	-	-	-	9
Latin America and Caribbean	-	-	-	-	-	11
North America	-	-	-	-	-	10
Oceania	-	-	-	-	-	10

Source: National censuses and United Nations (1995). World Population Prospects: The 1994 Revision, New York.

a From registered births; see Katoanga, S.K. (1996). "Sectoral review of reproductive health in the Cook Islands". UNFPA Country Support Team, Suva, mimeographed.

b Latu, R. (1996). "Reproductive health and family planning: sectoral review for the Kingdom of Tonga". UNFPA Country Support Team, Suva, mimeographed.

Table 7 replicates the structure of table 4 while examining patterns of change and the relative importance of childbearing among older women. Following the overall decline in fertility, childbearing among older women, as well as adolescents, has indeed fallen over the last 30 years or so in the majority of the Pacific island countries. Yet there are exceptions in table 7. Over some part of the period, the absolute number of births to older women has increased, for example, in Federated States of

Micronesia, Fiji, Kiribati, Papua New Guinea, Samoa, Tonga, Tuvalu and Vanuatu, partly reflecting an increase in the ASFR of women over 35 (Federated States of Micronesia, Kiribati, Samoa and Tuvalu) and an increase in the number of women in these age groups. Indeed, table 7 demonstrates that the share of total annual births attributable to women over 35 years of age has risen over time in some countries (Federated States of Micronesia, Fiji, Kiribati, Samoa, Tonga and Tuvalu) while still invariably far exceeding the share contributed by adolescents. Moreover, the share of total births of older women in many of the Pacific island countries exceeds the share of their peers in the world at large, and even in high fertility regions such as Africa and Latin America.

Older women: a special target group?

Given that family planning programmes in the past were concentrated on dealing with the "maternal and child health" (MCH) problems of mothers and their offspring, an issue arises as to whether the high fertility of older women in the Pacific island countries may have been inadequately addressed. Or, perhaps this relatively high fertility is wanted fertility? Where it is unwanted, a strong case can be made for public sector and NGO interventions to address the problems of those women experiencing an "unmet need" for family planning as a group deserving of priority concern. Unmet need is usually defined on the basis of women's responses to survey questions. Those fecund and sexually active women who indicate that they would like to postpone or avoid further childbearing, but also report that neither they nor their partners are using any method of contraception, are said to have an unmet need. The standard formulation was developed by Westoff (1988a, 1988b) who defined the group with unmet need as all fecund women who are married or living in union -- thus presumed to be sexually active -- who are not using any method of contraception but they either do not wish to bear any more children or wish to postpone their next birth for at least two more years. Those who wish to bear no more children are said to have an unmet need for limiting births; those who do not want another child for at least two more years are considered to have an unmet need for spacing births.

Some of the common causes of unmet need include inconvenient or unsatisfactory services, ignorance and lack of information about their fecund state and the need to use reliable contraception and about what services are available, fear of the side-effects of contraceptive methods, a lack of long-term methods for couples who have completed their family formation, and opposition from husbands and other members of the extended family. Other important reasons include lack of access, high cost and fatalism (Bongaarts and Bruce, 1995).

Obviously, the identification of the nature and characteristics of unmet need could help the family planning programme to respond better to the demands of these women. A programme strategy focusing on such women as a distinct audience and clientele requires a comprehension of the reasons underlying the unmet need; the determination of the size and composition of sub-groups classified according to their socio-economic characteristics; the prioritizing of certain sub-groups which the programme would be capable of reaching; and the design of a strategy to deliver information and services to meet the essential and specific needs of the various sub-groups.

Only two recent surveys are available from the Pacific island countries which attempt to gauge the size of the unmet need of women, and then only the unmet need for limiting births. From a 1995 knowledge, attitude and practice (KAP) survey in Vanuatu, House (1998) estimated that at least 24 per cent of all adult women of childbearing age and 30 per cent of women with a husband or partner have an unmet need for contraception for limiting the size of their families because they claim they do not want another child but are not using any form of family planning.

Since our concern in this section of the article is with the status of older women, it is revealing to note that 47 per cent of women in the age group 35-49 years in Vanuatu are estimated to have an unmet need for family planning. This would suggest about 4,800 ni-Vanuatu women in this age category had an unmet need in 1995. Of course, some of the oldest women in this group may have experienced, or were in the process of experiencing, menopause and would not need contraception. And some, perhaps, were not sexually active. Nevertheless, despite these reservations, we can assert that the unmet need of older women for limiting additional births in Vanuatu is significant and worthy of special consideration by planners, policy makers and donors in the family planning sector.

It is also very revealing to note that over 63 per cent of the older women in Vanuatu with an unmet need for limiting further childbearing have already had five children or more. Evidently, an additional pregnancy -- especially when they did not want it -- would place their health and their families' socio-economic status in grave danger. The scope for information dissemination and education on family planning is large since 20 per cent of this group have not heard of family planning and only 36 per cent have ever used family planning before.

In contrast, the estimated number of females aged 15-19 in Vanuatu in 1995 was about 7,800, the largest possible female target group for interventions in adolescent reproduction health, including IEC and family planning services. Even if as many as half of them were sexually active and in need of reproductive health services, the resulting size of the target group would be exceeded by the number of older women having an unmet need for family planning.

The 1996 Papua New Guinea DHS generated conceptually similar estimates of the extent of unmet need and demonstrated that the proportion of currently married women not using contraception and wanting no more children increased consistently from 27 per cent for those aged 30-34 to 37 per cent for those aged 35-39, to 47 per cent for those aged 40-44 and to 66 per cent for those aged 45-49. For the group of women aged 35-49, almost half (48 per cent) had an unmet need for limiting future childbearing, almost the same proportion as in Vanuatu. They would represent just over 27,000 females in

Papua New Guinea in 1996, a sizeable group of women worthy of special programmes to address their particular service needs. These scenarios may reflect the situation in many of the other island countries of the Pacific, whereby perhaps one out of every two women between the ages of 35 and 49 has no wish to bear another child but, for one reason or another, is not using a family planning method. Thus, there is a sizeable group of women who need to be the focus of researchers, health authorities and donors for interventions but who currently receive no special attention and priority and who are overshadowed by the aforementioned concern with "adolescent reproductive health".

Conclusions and recommendations

Maternal and child health and family planning programmes (MCH/FP), and more recently reproductive health programmes, have been established in many countries of the Pacific with UNFPA assistance, but with only limited success. Fertility and population growth rates remain high, reflecting perhaps a lack of access to high quality family planning services and poor conviction on the part of the population concerned as to the health and livelihood benefits to be derived from family planning and child spacing. On the other hand, while desired family size has no doubt fallen in recent years, the desire to bear four or more children appears to be widespread. No doubt this is a reflection of the set of incentives facing the typical household, including the need for adequate family labour, the old-age support benefits to be derived from large families, some of whom migrate out of the household but continue to contribute to its welfare through regular remittance flows, and in those countries where infant mortality rates continue to be high (Federated States of Micronesia, Kiribati, Marshall Islands, Papua New Guinea, Solomon Islands, Vanuatu), the need to replace children who, it is anticipated, are likely to die before reaching maturity.

In the subregion, great reliance is still placed on the decennial population censuses, the principal source of demographic data in all the countries. Analysis of these data is very often delayed such that the information is out of date for planning purposes by the time it is made available. While demographic and KAP-type surveys have not been widely undertaken in the subregion, it is strongly recommended that such surveys be conducted more often, and in more of the island countries, if policies are to be formulated to induce a decline in fertility rates from their current high levels and if services are to be improved. Vital registration systems remain grossly underdeveloped, contributing to the poor quality of key demographic indicators. Information also needs to be generated on the current quality of services provided both from the providers' and users' perceptions. Indeed, basic information is lacking on the extent of service delivery since the age-specific modern contraceptive prevalence rate in most countries is known only with great uncertainty and is estimated usually from poorly kept service statistics. Because public sector budgets are inadequate, and national capacity for data collection and analysis remains low, we recommend that donors be prepared to invest much more in improving statistical systems which are capable of generating the requisite data and information on which to construct well-designed programme interventions.

More research is necessary in this whole area of reproductive health, gauging the extent and socio-economic characteristics of those with an unmet need for family planning services, including the prevalence of sexually transmitted diseases and reproductive tract infections, in order to generate data and information with which to design and improve services to address such problems. The overall impression is, however, that the quality of services, especially on the outer islands and in rural areas, has much room for improvement.

Using data from recent population censuses, this article has challenged the "conventional wisdom" that adolescent fertility and teenage pregnancy is high and rising in the Pacific island countries. While adolescent fertility still remains high in a few countries, the overall trend over the past 30 years has been for both a decline in the age-specific fertility rate of females 15-19 years old and for a fall in the share they contribute to the total number of annual births. Compared with many of the regions in the world, adolescent fertility in the Pacific island countries is certainly not high and, indeed, by some standards, might well be considered to be relatively low. This does not deny, however, that adolescent reproductive health, particularly morbidity resulting from reproductive and sexual behaviour, is an important policy issue that should be addressed by government planners, service providers, NGOs and donor agencies, including UNFPA. Nor can we confirm or reject the suggestion that the number of induced abortions by pregnant adolescents has risen in recent years in response to their increased sexual activity and consequent increased rate of pregnancies. Since abortion is illegal in the Pacific island countries, other than to save the life of the mother, it is impossible to gauge the extent to which such an illegal activity is taking place.

The article has concluded by bringing firm evidence to bear on the existence of relatively high fertility among women over the age of 35 in many of the Pacific island countries. Like adolescents, their fertility has declined in recent decades but still is high by world standards and, in the two countries for which data are available, they appear to have a large "unmet need" for family planning services to limit further childbearing.

In conclusion, while applauding the objective of raising the reproductive health status of adolescents, we would recommend that governments, NGOs and donor agencies not overlook the special reproductive health needs of older women in current and future reproductive health and family planning programmes. Heightened awareness-raising campaigns are required to publicize the deleterious physical, mental and economic consequences for those high parity women who continue to bear children beyond the age of 35. Public policies which raise the costs of extended childbearing of older women, for example, the waiving of school fees only for the first two or three children born, or the granting of paid maternity leave for a limited number of pregnancies for those women in formal employment, need to be considered for incorporation in comprehensive population and development policies.

Acknowledgements

The authors wish to thank Barney Cohen of the Committee on Population, National Research Council, Washington DC, John May of the World Bank, Washington DC, Chris McMurray of the Secretariat of the Pacific Community, Geoff Hayes, UNFPA/ILO Technical Adviser, National Planning Office, Papua New Guinea, and UNFPA Country Support Team colleagues for comments received on an earlier draft.

Endnotes

1. The popular press contributes to the growing public concern over supposedly irresponsible teenage sexual behaviour, often in alarmist tones. For example, while teenage pregnancy is believed to be everywhere on the rise, sexually transmitted diseases are portrayed to be out of control. At a recent workshop on community education in Fiji, a health official is reported in the Fiji national press to have said: "...the rise in the number of teenagers contracting sexually transmitted diseases was alarming...in 1997, 77 per cent of Fijians, 16 per cent of Indians and 7 per cent of others contracted an STD...(the speaker said)...there was a need to make people aware that sexually transmitted diseases and teenage pregnancies were on the rise" (Fiji Times, 25 March 1999). Surely, quoting such unbelievably high figures is not the way to enlighten the general public!

2. The estimate for the 1990s for Papua New Guinea comes from the 1996 Demographic and Health Survey (DHS) while estimates for the earlier years for this country are derived from population censuses.

3. Booth (1994) reported that both the mean age at marriage and mean age at first birth increased for women in Fiji and Kiribati over the period from 1946 to 1986.

4. Again, the estimate for 1990 for Papua New Guinea is derived from the ASFR from the DHS and the number of adolescents reported in the 1990 population census.

5. Infant mortality is estimated by the 1996 DHS to be 69 per thousand live births in Papua New Guinea (Papua New Guinea, 1997). While recent estimates are not available, data from the late 1980s and early 1990s suggest that the infant mortality rate remains significant in Solomon Islands (38 in 1986), Vanuatu (45 in 1989), Federated States of Micronesia (46 in 1994), Kiribati (65 in 1990), Marshall Islands (63 in 1988) and Tuvalu (51 in the period 1991-1995); see South Pacific Commission (1997). Estimated rates of maternal mortality are more difficult to measure, particularly in such small populations. However, Papua New Guinea heads the list in the Pacific island countries with a maternal mortality rate of 370 per 100,000 (Papua New Guinea, 1997).

6. While data are scarce on the characteristics of maternal deaths, it is revealing that Cook Islands reported one maternal death during the period 1994-1998 and Tuvalu four such deaths between 1993 and 1998. These women were in their thirties at the time of death. Fiji recorded 36 maternal deaths during the period 1995-1998. Of the total, only two were adolescents, but fourteen of the dead women were aged at least 30.

References

Bongaarts, J. and J. Bruce (1995). "The causes of unmet need for contraception and the social context of services" *Studies in Family Planning* 26(2), June.

Bongaarts, J. and B. Cohen (1998). "Introduction and overview" *Studies in Family Planning* 29(2) June.

Booth, H. (1994). "The estimation of levels and trends in age at first marriage in the Pacific islands". Australian National University, Working Papers in Demography No. 45.

Fiji Times (1999). "Sexually transmitted diseases", an article published on 25 March 1999.

House, W.J. (1998). "Prospects for demographic change in Vanuatu: results of a KAP survey". UNFPA Country Support Team for the South Pacific, Discussion Paper No. 17, December.

Katoanga, S.K. (1996). "Sectoral review of reproductive health in the Cook Islands". UNFPA Country Support Team, Suva, mimeographed.

Latu, R. (1996). "Reproductive health and family planning: sectoral review for the Kingdom of Tonga". UNFPA Country Support Team, Suva, mimeographed.

Papua New Guinea (1997). Demographic and Health Survey 1996; National Report (Port Moresby, National Statistical Office).

Singh, S. (1998). "Adolescent childbearing in developing countries: a global review" *Studies in Family Planning* 29(2), June.

South Pacific Commission (1997). Population Data Sheet, Noumea.

United Nations (1995). World Population Prospects: The 1994 Revision, New York.

Westoff, C.F. (1988a). "Is the KAP-gap real" Population and Development Review 14(2), June.

_____ (1988b). "The potential demand for family planning: a new measure of unmet need and estimates for five Latin American countries" International Family Planning Perspectives 14(2), June.

Asia-Pacific Population Journal, www.unescap.org/appj.asp

Print this page