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Fertility and family planning in Fiji

Kesaia Seniloli

Résumé
Fécondité et planning familial à Fiji.

En vue de réduire le taux de natalité de la population, le gouvernement de Fiji a mis en place depuis vingt ans des programmes de maîtrise de la fécondité. En dépit de ces efforts, le taux est resté quasiment stable depuis 1977, augmentant même dans la population d'origine indienne. Les raisons tiennent autant à la résistance des valeurs traditionnelles qu'aux effets indirects de la modernisation : raccourcissement de l'abstinence post partum et déclin de l'alimentation au sein. Mais elles tiennent aussi à l'imperfection du message délivré et du suivi des programmes du planning familial.

Abstract
In order to reduce the birth rate, Fijian government has set up fertility control programmes 20 years ago. In spite of these efforts, the birth rate has not changed since 1977, it has even increased among Indians, because of the resistance of traditional values and of indirect results of modernisation: erosion of the periods of postpartum abstinence, and decreasing of breastfeeding, but also because of the imperfections of the family planning.

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Kesaia SENILOLI

Population Studies Programme
School of Social and Economic Development
University of the South Pacific
P.O. Box 1168
Suva
Fiji

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1. INTRODUCTION

In Fiji, both of the major ethnic groups, Fijians and Indians, recorded fertility declines between 1966 and 1986. However, the pace and scale of fertility decline was different for the two communities, a substantial decline of about 48 per cent in Total Fertility Rate (TFR) recorded by the Indian component of the population in the last two intercensal periods, 1966-1988 and a relatively slow decline of 27 per cent in the TFR in the Fijian community in the same period.

In the decade, 1976-1986 Fijian fertility stalled. Although stalls, slow declines or modest rises in fertility are not forecast by the demographic transition theory, they are not peculiar to Fiji alone : Korea, Costa Rica, Sri Lanka and the Malay community in Malaysia's plural society have also experienced such fertility deflections. Even though it has been argued that fertility rises precede fertility decline in developing countries most of the countries that experienced a deflection from the general pattern of the classical demographic transition had previously experienced approximately a decade of initial fertility decline. The question for Fiji is whether the recent stall in Fijian fertility represents a new trend or only a temporary retardation of fertility decline.

The relatively high fertility has contributed to the rate of population growth of 1.97 per cent and is higher than economic growth. This results in the government investing a significant proportion of national product on social services such as health and education without any further advancement in the socio-economic levels. In addition because of the moderately high fertility rate the population is young and consequently has a potential for further growth. This has significant and worrying socio-economic, political, cultural and environmental implications for Fiji.

The prevailing demographic situation in Fiji calls for sustainable population growth rate through population policies incorporating behavioural and attitudinal changes. The Fiji Government planned to reduce the CBR to 25 per 1000 first by 1975 and now by 1994. Failure to reach this target and statistical evidence of the favourable effects of the declining birth rate of the 1960s on the number entering the workforce in the 1980s has increased Government commitment to the fertility regulation programme. Despite these efforts relatively low contraceptive prevalence level and moderately high fertility

have persisted in Fiji particularly among Fijians.

Further despite significant investment in family planning in Fiji the impact of family planning on fertility decline has been rather limited. The Fijian protection rate of between 15-20 per cent has remained quite static since 1977 while the Indian protection rate increased from 29 per cent in 1977 to 33 per cent in the 1980s.

This paper therefore examines the socio-economic and cultural factors influencing fertility and family planning in Fiji. It first focuses on female education, women's work status which are important background variables, then examines the socio-cultural factors influencing fertility and family planning services in Fiji. Data presented in the discussion come from the 1956, 1966, 1976 and 1986 censuses and a micro-level study conducted in South-east Viti Levu in 1989-1990.[1]

2. BRIEF OVERVIEW OF FERTILITY TRENDS IN FIJI

The Indian fertility level (TFR) began to decline in the late 1950s and early 1960s and the decline was consistently rapid throughout the period 1956-1986 (Figure 1).

The Fijian fertility level (TFR), however, rose slightly between 1956 and 1966 and then began to edge downward moderately at first, then slowly, in the last intercensal period 1976-1986.

Table 1 shows that fertility of Fijian women between the ages of 15-44 years rose between the years 1956 and 1966 whereas the fertility of Indian women across all ages declined in the same period. In the intercensal period 1976-86, the fertility of Fijian women between the ages 20-34 years and Indian women between the ages 20-44 years continued to decline. Fertility of Fijian women in the youngest age group 15-19 years and the oldest age groups 40-44 and 45-49 years and fertility of Indian women in the youngest 15-19 years rose in the last intercensal period, 1976-1986.

Table 1. Age specific and total fertility rate (TFR) by ethnicity for selected years, Fiji 1956-1986.

Age group	1956	1966	1976	1986
Fijians				
15-19	53	55	42	62
20-24	274	287	237	211
25-29	285	323	257	227
30-34	206	238	174	171
35-39	142	148	99	106
40-44	62	59	37	40
45-49	19	7	4	11
TFR	5.2	5.6	4.3	4.1
Indians				
15-19	161	95	53	62
20-24	350	329	244	207
25-29	325	299	218	162
30-34	240	203	113	80
35-39	176	122	49	29
40-44	78	48	14	10
45-49	33	6	1	5
TFR	6.8	5.5	3.5	2.8

Source: McArthur, 1959: 211; Zwart, 1979: 279, 280; Bureau of Statistics, 1989: 66.

3. SOCIO-CULTURAL CONTEXT OF FERTILITY AND FAMILY PLANNING

The persistence of moderately high fertility in Fiji particularly among the Fijian component of the population appears deep-rooted in Fijian culture. When resistance to change lies at the social and cultural level, policy focusing mainly on service delivery is not likely to bring about any significant change. An understanding of the socio-economic and

[1] The micro-level data was collected during fieldwork undertaken between September 1989 and February 1990 in two ethnically different communities, one Fijian and the other Indian, situated adjacent to each other in SE Viti Levu, Fiji.

A qualitative approach with field notes, in-depth interviews and case studies yielded insights into the socio-cultural context of reproductive practice.

The unit of analysis is all Fijian women aged 15-49 years not attending the format school system and all ever married Indian women except where it was otherwise stated.

Table 2. Mean number of children ever born to all women 15 -49 years by educational level and ethnicity, Fiji 1986.

Educational level	Reported	Standardised	N
No education			
Fijians	2.5	2.0	925
Indians	4.2	2.7	9611
Primary education			
Fijians	3.5	2.4	13893
Indians	3.5	2.6	17251
Secondary education			
Fijians	2.0	2.2	58432
Indians	1.7	2.0	56688
Tertiary			
Fijians	2.1	1.7	1761
Indians	1.3	1.3	3294

Source: 1986 Population Census Data Tape

Table 3. Mean number of children ever born to all women 15-49 years by economic activity status and ethnicity, Fiji 1986.

Educational level	Reported	Standardised	N
Active			
Fijians	2.1	1.8	19239
Indians	1.8	1.7	13331
Homemaker			
Fijians	2.8	2.4	45359
Indians	2.9	2.5	60974
Inactive			
Fijians	0.3	1.3	10813
Indians	0.2	1.0	12907

Source: 1986 Fiji Population Census Data Tape.
Note: * Inactive included students, the disabled and women not looking for work. Active women included working women and those looking for work.

cultural context in which people live seems a possible approach to revealing why fertility is levelling off among Fijians and consistently declining among the Indians in Fiji. In addition it can elucidate why family planning is not widely accepted among Fijians and why fertility has consistently fallen among Indians in the face of very slow increase in contraceptive use.

3.1. Education and fertility

The census data revealed that fertility was higher among Fijian women with some and completed primary education compared with those with no schooling (Table 2). Fertility declined among Fijian women with secondary and tertiary education. The relatively high fertility of the primary educated could be attributed to lower contraceptive prevalence and decline in duration of breastfeeding and postpartum abstinence, increased fecundability and lower foetal loss. The Indian pattern shows the negative effects of education on fertility. Fertility declined consistently with increasing education.

3.2. Women's economic activity

The WFS study of relationship between work status and fertility showed that women engaged in work outside the home in non-familial activities had lower fertility than women who were full-time home-makers and those not engaged in wage employment (Cleland and Singh, 1980 : 215). The 1986 census data indicated that women who were

Table 4. Mean number of children ever born to all women 15-49 years by occupational status and ethnicity, Fiji 1986.

Occupation	Reported	Standardised	N
Professional and technical workers			
Fijians	2.4	1.7	2791
Indians	1.7	1.3	3011
Clerical workers			
Fijians	1.8	1.7	2485
Indians	1.1	1.2	3188
Sales workers			
Fijians	2.3	1.9	1545
Indians	1.8	1.7	1577
Service workers			
Fijians	1.6	1.4	4272
Indians	2.0	1.6	1751
Agricultural and forestry workers			
Fijians	2.3	2.2	6390
Indians	3.1	2.6	1723
Production workers			
Fijians	2.2	2.0	1630
Indians	1.8	1.6	1923

Source: 1986 Fiji Population Census Data Tape.

economically active had lower fertility than the homemakers in the two ethnic groups (Table 3). It must be pointed out that less than 20 per cent of women in the childbearing age are engaged in non-agricultural occupations. Evidence from a micro-level study conducted in South-east Viti Levu indicated that women in paid employment were current users of modern reversible contraception. It appears that there is some support for the notion of the marked depression of fertility due to work status of women in Fiji. There is also some support for the hypothesis that homemakers who are totally economically dependent tend to have many children to provide both economic and emotional support.

The 1986 census divided women into six broad categories the professional and technical workers, comprising mainly primary school teachers and nurses; clerical workers comprising largely typists; sales workers most of whom were shop assistants; service workers comprising mainly maids and househelpers; agriculture and forestry workers were largely subsistence farmers: and production workers mostly factory workers. The high fertility of agriculture and forestry workers of both communities (Table 4) could be explained by the nature of work in these activities which could accommodate childbearing activities. These activities in most cases were undertaken close to the family home which accommodated childbearing and nursuring roles. In addition, children or relatives cared for younger siblings allowing women to undertake agricultural activities.

4. PROXIMATE DETERMINANTS OF FERTILITY

The focus here is on some proximate determinants of fertility. These factors directly affect fertility. An examination of these proximate determinants is imperative to understanding the reasons for fertility variations.

4.1. Family formation: Age at marriage

In many societies, marriage is the point at which a woman is first exposed to the risk of socially accepted childbearing. At the aggregate level, there is a tendency for fertility to decline with rising age at marriage. In Fiji there is indication of the rising age at marriage because of greater education and employment opportunities. Data from both the microlevel study and the 1986 census indicate that Indian women married earlier than Fijian women. Among Fijians, the institution of marriage which began with elopement and/or pregnancies broke the commonly assumed linkage between age at marriage and the point of entry into sexual union. Among Fijians age at marriage therefore was a weak proximate determinant.

Among Indians most marriages were still parentally arranged and many women marry at an average age of 21 years. Mean age at marriage increased from 18 years in 1956 to 21 years in 1976 resulting in fertility decline. A consequence of rising age at marriage in both communities is the longer exposure to the risk of having premarital births which is a matter of concern to the government.

The micro-level study showed strong relationship between lower fertility and those married at 23 years or older among both Fijians and Indians. Among Fijians those married between the ages of 20-22 years have higher fertility which could be explained by the presence of pre-marital births, or that women who married before the age of 20 years had lower fertility due to physical immaturity. The Indian pattern showed a decline in fertility with increasing marriage age in both the age groups reflecting the exposure to the risk of childbearing and the almost total absence of ex-nuptial births.

4.2. Breastfeeding

Breastfeeding has an inhibiting effect on ovulation, thus increasing the birth interval. The micro-level data revealed that mean and median breastfeeding durations of ever-married Fijian women and those currently cohabiting who gave birth within the five years prior to the survey were approximately eight months whereas for Indians they were approximately four months. These were less than what was recorded in the Fiji fertility survey (Bureau of Statistics, 1976) Both mean and median durations of breastfeeding

were somewhat less than what was deemed as adequate in both societies.

4.3. Postpartum abstinence

Postpartum abstinence has a significant impact on fertility only if its duration exceeded the period of postpartum amenorrhoea. The micro-level study undertaken in South-east Viti Levu showed that the mean duration of postpartum abstinence was four months for Fijian women and two months for Indian women. These were much less than the perceived ideal.

The onset of modernisation has encouraged the erosion of both periods of postpartum infecundability and postpartum abstinence. There is a need for the Ministry of Health to encourage the use of contraception to compensate for the shorter durations in postpartum abstinence and postpartum infecundability.

4.4. Abortion

Induced abortion is the expulsion of the foetus prior to viability with deliberation or intent. Social definition of abortion varies, for instance a post-conception method may not be considered as an abortion but the regulation of a late period. Differences in perceptions on what constituted an abortion between the medical profession and the women themselves created problems of measurement. Abortions are generally under-reported, as exemplified by a Venezuelan study which, even though conducting a month by month probing of recent events, still experienced under-reporting and the reluctance of women to discuss the issue (Gaslonde and Carrasco, 1982). Induced abortion is also often omitted intentionally because of the sensitivity, secrecy and the stigma associated with it.

The doctors in the Suva-Nausori urban complex who provided abortions reported that most (60-70) of the patients were Indian women, particularly working women who had been liberated from the safety and near-total seclusion of the home. Many of these women were single or had been deserted by their spouses. The other large group comprised married women over the age of 35 years or those with close birth intervals. A new trend observed by the doctors was an increase in numbers of young single Indian women working in the new garment factories and also an increase in the number associated with inter-ethnic (Indian-Fijian) relationships. Like the clients of the doctors in urban areas, those seeking the services of the woman who provided the service in the study area (micro-level study) showed similar characteristics.

It appeared that fertility decline of Indians in Fiji had been achieved through some recourse to abortion.

5. FAMILY SIZE PREFERENCES

Family size preferences are influenced by societal norms and they are pointers for childbearing limitation. The micro-level data showed that there was no difference between the number of children desired and mean children ever born of both Fijian and Indian women implying no significant potential for further fertility decline. Most Fijian women regardless of age or educational attainment desired between three or four children. Hence purely medical approaches to population policy which focus on overcoming problems of use of modern contraceptives may make the achievement of the desired number of children more efficient, but would not necessarily alter completed family size. Further, the Indian data showed more younger women wanting smaller families.

6. GENDER PREFERENCE

There is a persistent tendency for couples to increase the number of children desired if the preferred sex composition has not been attained. In most less developed countries a strong preference for sons is attributed to the desire for old age insurance and the perpetuation of lineage. It is also suggested that as the family nucleates children's economic value depreciates and gender preference becomes unimportant.

Data from the micro-level study indicate that women in both communities (85 per cent of Fijians and 81 per cent of Indians) showed strong verbal preference for sons. Son preference is defined here as the desire for at least one son in the family sex composition. An interesting development among Indian women is that a few younger women even though having two female older children, while pregnant with the third child decided to have tubal ligation after childbirth regardless of the sex of the last child. It appears that attaining the sex composition desired has become less important as it has been overridden by costs of raising children. This is also bourne out by the proportion (12 per cent) of Indian women indicating satisfaction with having a child of any gender. This suggests that gender preference was gradually becoming unimportant in the Indian community. This was not evident at all in the Fijian community.

7. THE VALUE OF CHILDREN

Children are recognised as satisfying a variety of value which can also be satisfied by other activities such as paid employment and the acquisition of durable goods. In addition social, economic and cultural circumstances can influence the pattern of and the variation in the attachment to children.

Old age insurance

There is no doubt that the most widely recognised benefit of having children in Fiji among people of both communities is the role of children as old age insurance. Drawing from micro-level data in South-east Viti Levu the importance of old age support cuts across age, family size, education and employment status categories. Fiji has no old age security system. However, there is a superannuation fund for everyone in paid employment. According to the Bureau of Statistics (1989: 122) 55 per cent of the population were economically active in 1986.

The economically active included those looking for work, subsistence farmers and unpaid family workers, who did not contribute to the Provident Fund. Consequently only a small proportion of the working and mostly urbanised population benefited from the scheme. This could explain the wide recognition of old age support as an important benefit of having children.

8. FAMILY PLANNING

Government commitment to family planning is reflected in most development plans which have integrated population policy as part of socio-economic development plans. Today family planning are available at all government health facilities throughout the country while contraceptives are provided free by the Government. However, the Ministry of Health has indicated that the family planning programme has lagged behind other components of the maternal child health services since 1978. The lull in the implementation of the family planning programme in the late 1970s was attributed to the utilisation of resources on the launching of the Primary Health Care Approach at the expense of the family planning programme. The effectiveness of the family planning programme in Fiji remains the subject of controversy. The Fijian protection rate of between 15-20 per cent has remained static since 1977 while the Indian protection rate increased from 29 per cent in 1977 to 33 per cent in 1983. There is a need for an evaluation of the family planning programme in Fiji.

The parity progression ratios could be used to measure the effect of family planning programmes to determine the parities at which fertility was changing. For Fijian women 45-49 years the probability of advancing to the next birth was high at lower parities up to the fifth birth in 1966 and 1976. In 1986 advancing to the next birth was high at lower parities up to the third and fourth parities. By contrast, among Indian women aged 45-49 years in 1966 and 1976 the progression to the next birth was high but up to parity two. It appears that Indians were limiting their fertility earlier than Fijians.

9. FAMILY PLANNING SERVICE DELIVERY

Studies (Mendoza, 1988; Seniloli, 1992) have shown the lack of commitment of service providers. Doctors were found not to be committed to family planning. The task of identifying and motivating village couples to accept family planning lay in the hands of village health workers. The micro-level study conducted in South-east Viti Levu found that the volunteer village health worker lacked motivation, confidence and adequate training in the area of family planning. The village health worker needed to be from the village where she was working and she must have the cooperation of the older generation whose support was needed for a family planning programme to be effective in the village.

Often the family planning programme ignored the quality of the service provided as exemplified by the microl-level study. Women in the micro-level study in South-east Viti Levu, explained the reason for contraceptive use was that they were consistently persuaded by Medical personnel before and after childbirth only to abandon it after the stock ran out. A number of women who were cajoled by medical personnel used contraceptive surreptitiously and abandoned them after developing side effects or after subsequent discovery and displeasure by their husbands. Women were usually polite and had respect for authority, they felt obliged to accept contraceptive use particularly after receiving an important service at the hospital. The Ministry of Health had very poor follow-up system because most of these women who discontinued contraceptive use were never followed-up. Should women return for more contraceptive supplies often there supply problems. Moreover, older and higher parity women indicated that their verbal treatment during childbirth particularly for high order births bordered on vulgarity and rudeness. Hence women were often not allowed to accept family planning with dignity.

There was a tendency to use contraception only after achieving the number of children desired because an impediment to family planning is the apprehension regarding the use of modern reversible methods of contraception. The micro-level study revealed half the women discontinued using contraception because of experienced side-effects and a further six per cent were reluctant to use contraception because of anticipated side effects making contraceptive use a risk-taking endeavour. Unfortunately the medical profession are rather too cavalier and arrogant to address this problem adequately and there is fair amount of misinformation distributed by the medical profession as well. Too often, the Medical profession have dismissed these women as misinformed or incompetent practioners of contraception. However, Fijians place high value on health of the mother but the experienced and anticipated side effects from contraceptive use and the failure of the Ministry of Health to deal with this adequately and with sensitivity has not made contraceptive use widely accepted among Fijians.

Fijians place importance on adequately spaced pregnancies. The long durations of breastfeeding duration and postpartum abstinence were mechanisms by which women maintained long birth intervals. The decline in duration of breastfeeding and postpartum abstinence have turned these factors to fertility enhancing factors. Rapid social change has contributed to the erosion of traditional values particularly the reproductive norms that contributed to long periods between births. The micro-level study found that women still place importance on two year period between births. There is a need to offset the fertility enhancing effects of the short durations of breastfeeding and postpartum abstinence. This is where the family planning programme has failed in promoting contraceptive use for birth spacing.

10. CONCLUSION

In Fiji particularly among Fijians, modernisation has contributed to the erosion of traditional values particularly the decline in duration in postpartum abstinence and breastfeeding which were means of maintaining long birth intervals resulting in increasing fertility. The effects of these must be offset by an increase in use of modern contraceptives.

Levelling off in fertility particularly among Fijians could be explained by the preference of family size of between 3-4 children and the importance of the traditional values such as the continued importance of lineage, vital for the perpetuation of the family unit and old age support. The preferred family size reflected the importance of adhering to group norms and the importance of group solidarity. The large family size was sustained by the continued importance of traditional benefits of having children such as lineage which has been vital for the perpetuation of the family unit and old age support. These values showed no differential by education and suggesting that traditional values were quite entrenched among women regardless of education.

A major factor that has caused the non-acceptance of contraception is the lack of commitment of family planning officers and the very poor quality of the service provided. In Fiji where there is evidence of young couples articulating the importance of a small family and where there is an unmet need for family planning there is the problem of finding an acceptable means to achieve this objective.

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