



**Family Planning in the Pacific Region: Getting the basics right**

*Paper presented at the international symposium “Population Change in Asia and the Pacific: Implications for Development Policy”, Australian National University*

Authors: Maggie Kenyon, Jennifer Power  
Australian Reproductive Health Alliance

## **Introduction**

An estimated 8.3 million people live in the Pacific,(SPC, 2002) inhabiting islands dispersed over nearly 30 million square kilometers of ocean. There is great diversity in the land area and geographic features. Papua New Guinea has the largest land area at 462 243 sq. km but much of this is impassable, mountainous terrain. In contrast, the atoll countries are very small and flat.

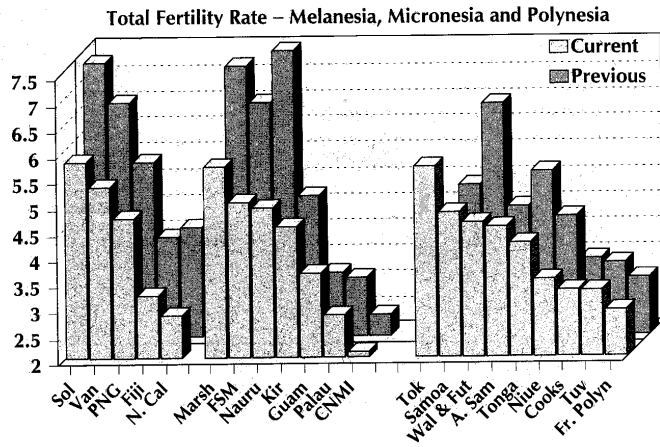
Populations vary from over five million in Papua New Guinea to Niue which has an estimated population of less than two thousand. There are at least twelve Pacific Island Countries whose population is less than 100 000. Population density, varies from 567 persons/km<sup>2</sup> in Nauru to 12 or less in Papua New Guinea (SPC, 2002) and Solomon Islands.

With less than 0.1% of the world's population, the Pacific is home to one third of the world's languages. Cultural practices, social norms and traditions vary considerably across the Pacific, both between and within countries. The political conditions are also markedly different from country to country – some being quite stable while others are politically volatile.

Such diversity makes it difficult to generalize in a discussion of Pacific family planning programs. Program features in one country may not be effective in other areas. This paper will try however to provide an overview of family planning in the Pacific, and identify key issues involved.

## **Fertility Rates and Population Growth in the Pacific**

Fertility rates and mortality rates have declined in the Pacific over the past twenty years. However, the total fertility rates (TFRs) are still high and there is still rapid population growth in parts of the Pacific. SPC data (Secretariat of the Pacific Community) in 2000, shows that TFRs exceed four in at least 12 Pacific countries. (Solomon Islands, Vanuatu, Papua New Guinea, the Marshall Islands, Kirribati, the Federated States of Micronesia,



Graph 1: TFR in the Pacific, past and present. (SPC, 1998)

Nauru, Tokelau, Samoa, American Samoa, Wallis and Futura and Tonga) As a point of comparison, the TFR in Australia for the same period was just under two.

Population growth rates vary across the Pacific from as high as 5.5% in the Northern Mariana

Islands to negative growth in parts of Polynesia (Tonga -0.5%, Niue -3.1%) which is due to out migration rather than low fertility rates. (SPC 2002) Tonga has a total fertility rate (TFR) of just over four, while the Northern Mariana Islands with a growth rate of 5.5 has a TFR of just over two (SPC 2002).

High fertility and lowering mortality rates means there is a young population plus a high dependency ratio. Solomon Islands now claims 65% of their population is under 25. This has obvious economic implications as well as creating a demographic profile in which the largest age cohorts are reaching childbearing age. As Paramanathan (1994) writes,

*“The extreme youthfulness of the population give the countries ‘demographic momentum’, because even if fertility rates fall significantly, the population will continue to grow rapidly because of the young age-structure.”*

This paper does not have space to discuss the impact of population growth in the Pacific, although the topic is certainly urgent. The issues of environmental pressure, degradation and poverty facing Pacific countries are similar to those of many developing countries in other regions - although the specifics may vary from island to island.

## **Fertility Reduction and Family Planning Programs**

There is some debate about the efficacy of family planning programs in reducing TFRs. For example, Pritchett (1994) argues that family planning programs have little, or no, effect on fertility rates. *“It is fertility desires and not contraceptive access that matter.”*(Pritchett 1994) He argues that the social desire for smaller families is created through improvements in social and economic conditions that effect improvements in the status of women.

Freedman, argues that FP programs may not influence preferences regarding the number of children couples seek to have, but they do help to overcome cultural and practical barriers once preferences are established.

*Studies indicated that, when women began to feel that they wanted no more children, they were often uncertain and hesitant about taking the steps necessary to halt conception. The evidence...was that the (family planning) worker's helped the women to overcome a series of obstacles presented by traditional institutions and values. The result was to convert latent into manifest demand, followed, in many cases, by the adoption of contraception. (Freedman 1997)*

Freedman's literature review suggests that family planning programs play a supportive role for women or couples who choose to space, or have fewer, children but are unlikely to create the impetus for a reduction in preferences for larger families, family planning programs may strengthen and quicken that process when it occurs. Given the diversity of the Pacific region, establishment of family planning programs is complex and not achieved quickly. Reduction in fertility rates is achieved through changes and cultural perspectives as well as providing the means for contraception.

While the role family planning programs plays in influencing fertility preferences is debatable, the positive role family planning programs play in meeting the unmet contraceptive needs of women is unquestionable. Contraceptive needs may not be met due to limited, inconvenient or inappropriate services or cultural factors or religious beliefs. (Bulatao 1998) While it is difficult to assess the extent to which continuing high fertility rates in the Pacific reflect 'wanted fertility' or inadequate service provision. (House 1999) There have been some attempts to gauge the extent of unmet need in the Pacific. Notably, House (1998) conducted a survey of women in Vanuatu which suggested that approximately 24% of women of child bearing age have an unmet need for contraception, defined by women who are sexually active but state they do not wish to bare any, or any more, children.

### **Contraceptive Use in the Pacific – Current Trends**

One of the stated goals of the ICPD (International Conference on Population and Development) Plan of Action is goal of achieving a minimum of 55% contraceptive prevalence rate (CPR) in all countries by 2010. (UNFPA) In terms of meeting this goal, Pacific countries have some advantages over other developing countries. Specifically, access to health services and trained medical personnel is comparable to many middle-income countries, universal education has been achieved in the majority of countries and annual average incomes are higher in the Pacific than many other developing countries.

Despite this, all 14 Pacific Island countries had failed by 1998 to meet the 55% target. It is likely that these data represent inaccurate and underreporting of CPR in the Pacific. This is suggested by declining fertility rates that have occurred despite no reported increase in CPR. For example, in Fiji CPR showed little change between 1982 and 1990 whereas the fertility rate dropped 20% in the same period. (Lee) William House uses data regarding the decline in fertility rates in each Pacific country to estimate more realistic figures for CPR. With these adjustments, House estimates that CPR in 1998 may have surpassed 55% in Fiji, Palau, Niue and Tuvalu. Rates still appear low, however, in the Solomon Islands, Vanuatu, Federated States of Micronesia, the Marshall Islands and Tokelau. (1999)

Cook Is	FSM	Fiji	Kiribati	Marshall	PNG	Samoa	Sol Is	Tokelau	Tonga	Van
34	28	40	26	37	20	31	20	8.9	33	22

Table 1: Contraceptive Prevalence rates as reported by UNFPA, 1998

In terms of contraceptive methods most commonly used, Depo-provera remains a favoured method spacing while tubal ligation is commonly used for family completion.

### **Elements of Successful Family Planning Programs**

Essential 'requirements' suggested by Berelson (Bulatao) and others includes:

- An effective logistics system for importing, storing and distributing contraceptive materials
- Accessible clinics, services and education programs
- Provision of a variety of contraceptive methods
- Adequate training of front-line workers
- Social marketing
- The adoption of a national population policy
- Political support and bureaucratic support for policy implementation at national, provincial and local levels.

Finally, appropriate social marketing is important. The population must receive the right message through the mass media, advertising and health promotion.

These elements provide a useful framework for assessment of Pacific family planning programs but Bulatao cautions,

*Rather than strict program requirements, a number of these items are alternatives that may be more or less important in particular settings. Few programs receive high scores across all these areas, and even some quite successful programs so little in some areas.*

### **Contraceptive Delivery, Distribution and Storage**

There are major practical barriers to adequate contraceptive supply in the Pacific - lack of funds, a weak supply chain, inadequate storage facilities and obvious geographical barriers.

The United Nations Population Fund (UNFPA) and the International Planned Parenthood Foundation (IPPF) had been responsible for providing 40% of contraceptive supplies for Pacific countries between 1992 and 1996. Since then support declined due to major funding cuts by the USAID. In 2000, donors met only 27% of the total estimated contraceptive requirements and Pacific governments have unable to make up for this shortfall. (New Zealand Press Association 2003)

Logistical or communication breakdowns are common in the chain of supply across the Pacific. For example, national pharmacies may only supply to distributors at the provincial or district level who then give priority to hospitals or larger health centers and do not necessary supply to smaller units.

### **Diversity of Available Contraceptive Methods**

Although non-government family planning organisations in the Pacific have shown a marked increase in clients if a wider range of methods was available, lack of staff training, lack of supply, religious teachings against particular methods all pose a barrier to diversifying available methods. For example, Norplant could be an excellent long term, reversible method but it is currently only available in Fiji, Marshall Islands and Palau. This may be due to the difficulty of training workers in insertion and removal techniques. It may also be due to the fact that it may, in some instances, be physically obvious that a woman is using the method. Each method has its advantages and disadvantages, plus specific logistics and training.

## **Access to Family Planning Services**

Traditionally, many Pacific health centers operate a once a week session at the health centre which is likely to be inconvenient for many clients. A bigger problem is the high visibility of the service. In small villages or regions, confidentiality is easily breached, not only in terms of people knowing a man or woman has sought family planning services, but also through discriminatory practices by workers. While clinic policies certainly do not advocate discrimination, there are numerous accounts of health workers being unwilling to supply contraceptives to young people, or people suspected or outside marriage. The belief among young people that family planning services are only for married people is also a particular barrier.(Burslem).

Outreach is one method for increasing access. A project in Solomon Islands increased CPR by 300% when health workers started house-to-house visiting introducing family health information cards.(Chevalier) Pacific NGO family planning organizations have incorporated community based distribution of contraceptive supplies into their outreach programs and utilise mobile clinics and peer educators. In Fiji community nurses take buses, bicycles and even horses to reach their communities. Geographical difficulties are highly problematical in Papua New Guinea where Burdon reports outreach patrol costs averaging K19600 (app A\$10 000) per patrol. (Burdon 1998) Funding is an ongoing barrier for development of outreach programs. Social marketing, recently started in Fiji, may overcome geographical isolation but is expensive for the consumer and provides a limited contraceptive range.

Encouraging staff to carry out mobile clinics or patrols has also been difficult. The culture and practice of patrol has almost ceased due to complex reasons that include financial cutbacks, nurses are more comfortable in their 'space' (the clinic) and the fear of violence which prevents female health workers moving into unprotected areas. Chevalier (1997) argues that within the 'bigman culture' and combined with professional position, health workers practice privileges the provider over the client. Simply put, the expectation is that the client comes to the clinic as for other curative services.

## **Training of Family Planning Workers**

Problems regarding adequate Family Planning training in the Pacific include:

- Health workers values and attitudes to Family Planning, sex and sexuality
- Underestimation of the amount of training, both basic and in-service required for adequate Family Planning services
- underestimating support systems for Family Planning workers
- lack of funding for training.

Anecdotal evidence suggests that many clients or potential clients are denied access to family planning services due to attitudes of health workers. Adolescents and unmarried clients, are often refused contraceptives if health workers disapprove of premarital or extramarital sexual practice. Some religious groups will not allow contraceptives to be given out through their clinics even when the population may have alternative beliefs. Other health workers enforce their own regulations of obtaining the husband's permission in writing before contraception is given. Similarly, emergency contraception is often only prescribed for 'rape cases' and not offered when usual contraception has failed. An essential, although often neglected, part of FP training involves creating awareness amongst health workers of how individual values and attitudes impact on their practice is.

John Hopkins Program for International Education in Reproductive Health (JHIEPGO) recommends that a FP trainer or supervisor should receive, at minimum, 8-10 weeks full-time training. This figure is based on findings from a program conducted in Papua New Guinea between 1991 and 1993. (Burdon 1997) Family Planning Australia, which supports projects in five Pacific countries, also relies on an extensive accredited training program for key FP educators. Training is conducted in Australia for 10 weeks, before educators return to their own countries for practical and final assessment. However, this level of training is not available to most FP educators and trainers. Generally a train-the-trainer model is utilised in which most people receive a maximum of two weeks FP education which is grossly inadequate given that FP educators are key personnel who

work as both trainers and supervisors and provide the main link between government policy and clinic implementation.

The cost of training presents another barrier to further implementation of FP training in the Pacific. For example, a major Child-Survival project in PNG focused on training over 7000 health workers with an average training time of 0.5 days per year. The cost for this exceeded US\$1700 000 (\$A2.8 million). (Burdon) Unless funded by donors many countries simply cannot afford continuing education programs. One option that has been successful in Solomon Islands is a Distance Education program offering five post basic certificates (including Family Planning) at a minimal cost to the government. (Kenyon)

### **Population Policies and Family Planning**

Of the 15 Pacific countries receiving financial assistance from UNFPA, three have official population policies, eight have policies in development and four have chosen to incorporate population issues into their development and sectoral plans. (UNFPA 2002) Policies are an important step because they legitimize the work of health workers. There are a number of sound population policies in the Pacific, for example, the PNG National Health Plan 2001-2010. It states that:

- All couples and individuals shall have access to information needed to decide freely and responsibly the number, spacing and timing of their children.
- All adolescents shall have access to information and advice on sexual health and family planning.

The Department of health in PNG has now introduced training sessions that take health workers through the policy and discuss how this can be implemented, the pitfalls that can be expected and discussion on the way to move ahead.

However, implementation of population policies is often far from smooth. In some instances policies have proved to be too cumbersome for an effective coordinating structure. In Solomon Islands the National Population Policy Council (NPPC) comprised all permanent secretaries of government ministries, forty co-opted members from the commissioner of Police, various non-government organisations, Lands and Labour

secretaries and undersecretaries not including a Technical Advisory Unit and multi-sectorial Implementation and Evaluation Committees at the provincial level. In a ten year period the NPPC were never able to meet.

Other population policies have proved ineffective because they lack detail and a coordinating structure. Chee et al (1999) point out that in countries such as the Marshall Islands and Papua New Guinea population policies developed in the late 1980s lacked detail in actual budgeting of the policy and accounting for human resources.

*Perhaps a major reason (for their limited success) was the seeming lack of political commitment to the allocation of scarce financial resources and high-level manpower to ensure that the implementation strategies were being carried out in a systematic and coordinated manner. In many instances, the population policy implied that there was a population program with overriding national goals and objectives. In reality the “program” often consisted of component parts or sectoral interventions which were implemented in an uncoordinated fashion with no assurance that they were not conflicting with the overriding national goals. (Chee)*

Some policies also emphasise approaches to FP that have been shown to be ineffective. For example, Margaret Chung (1992) argues that many Pacific population policies aim at recruiting new acceptors rather than reducing the drop out rate. This is because service providers define the main problem with low FP use to be the ‘traditional’ nature of their clients rather than an issue of quality service delivery.

Several countries have also shown a drop in fertility rates without a policy in place. Haberkorn (1995) reports a study from Guam where the TFR dropped from 7.3 in 1950 to 3.6 in 1977. This occurred in a 100% catholic country and in the absence of an official population policy.

### **Public and Political support**

Political, public and church support are required for family planning programs and activities to be given legitimacy and removed from the realms of secrecy and shame.

HRH Princess Nanasipau'u Tuku'aho of Tonga is a leading proponent for AIDS campaigns as well as the first lady of Fiji, her Excellency Adi Lady Lalabalavu Mara CF STJ. (PASA 1996) Many church leaders are at the forefront of AIDS campaigns but are less willing to publicly endorse sex education programs for youth.

It is vital to identify and engage at national, provincial and local level with the gatekeepers who can support or undermine Family Planning activities. Public servants direct policy and funds, individual teachers and headmasters can censor sex education in schools or give their own version. Parents may prevent sex education classes going ahead while church pastors are particularly influential. Health workers can discriminate in the contraceptive methods they promote and to which clientele they will provide. An example of working with gatekeepers is the Family Planning Australia program to develop a Year 6 Teacher's manual in Vanuatu. Advocacy and training programs were held with teachers and executive teachers before presenting the curriculum to be approved by the National Curriculum department.

### **Program activity**

Promotional activities can have substantial effect but have to be properly and sensitively done. Katz argues that knowledge attitude and practice studies (KAP) have improved our understanding of communities and cultures but also demonstrate the gap between knowledge and the way people practice. New knowledge, does not necessarily lead to new attitudes which leads to new practices. (Ritchie 1999) Religion and culture may pose powerful barriers to such fundamental areas as sexuality and reproduction.

A survey in Fiji by RHAFH in 2001 revealed that the majority of young people interviewed who were sexually active did not protect themselves from pregnancy or STIs. Many reported ignorance of the need to use condoms, while others expressed negative views towards them. Only 5% had experience of contraception other than condoms.

(Gibson 2001) The report also showed that there is inconsistency between belief systems and behavior. Most of the young people interviewed felt that there should be no sex before marriage, yet 69% were sexually active before the age of 20. Social and cultural attitudes and practices take time and sensitivity to changes as well as the means to change.

Since the ICPD, program activities are beginning to actively acknowledge the role of men in reproductive health decisions and practices and more awareness messages and programs are targeting men of all ages. Men are fathers, partners, husbands and community leaders and socially and personally responsible for the success of Family Planning programs.

The relationships between the Family Planning NGOs and Ministries of Health are varied and often dependent on personalities. Many government services are jealous of the speed and effectiveness of NGOs and the fact that they can access funds quickly. Some government bureaucracies feel that the NGOs are preaching a message of promiscuity or that the NGOs cannot be 'controlled'. Working with and through government agencies has advantages in terms of provincial coverage, permanence and core funding. Staffing and management are usually well established while technical assistance to government agencies can have critical impact on policy, management and programs.

## **Conclusion**

In summary, the Pacific region still has high population growth rate, high fertility rates and low contraceptive coverage. Getting the basics right, means that more training is required for senior supervisory levels and front line health staff. Raising and maintaining awareness of population related development problems is also key to long term changes in social and cultural attitudes. Public and political support are needed to legitimize and popularize family planning messages and concepts. Involving men, faith based organizations and community leaders are essential and a more community based approach to FP education to increase coverage and overall effectiveness.

The rest is a question of securing contraceptive supplies and ensuring distribution to some of the most remote places on earth.

## Sources

Brewis, A. *Structure of Family Planning in Samoa* Australia and New Zealand Journal of Public Health Vol 22, No. 4, 1998

Bulatao, R. 1998 *The Value of Family Planning in Developing Countries* RAND Santa Monica USA

Burden R. 1998 *Training Needs Assessment & Five year Training Plan*. Report for Women and Children's health Project. AusAID, Australia

Burslem F., Laohapensang, O. Young M. Larson, A. *Naked Wire and naked truths: Reproductive health risks faced by teenage girls in Honiara, Solomon Islands*. Pacific Health Dialog Vol 5 No 1.

Caldwell, J. Phillips, J. Barket-e-Khuda *The Future of Family Planning Programs* Studies in Family Planning Vol 33 March 2002

Chee (1998) *Overview of Population and Development Issues in the Pacific: Challenges and Opportunities in the Post-ICPD Era*. UNFPA Report to Ministerial Meeting on Pacific Response to the ICPD Programme of Action November 1998, FIJI

Chee, S. House, W. Lewis, L. 1999 *Population Policies and Programmes in the Post ICPD Era: Can the Pacific Island Countries Meet the Challenge?* Asia Pacific Population Journal v14 no1 pp3-20

Freedman, R. *Do Family Planning Programs affect fertility preferences?* Studies in Family Planning Vol 28, Number 1 March 1997

Haberkorn, G. *Fertility and Mortality in the Pacific Islands* Pacific Health Dialog Vol 2 Number 1 March 1995

House, W. 1999 *Reproductive Health and Family Planning in the Pacific Island Countries*. UNFPA (Development Bulletin January 1999)

Hardy, R. 1995 *Key Informant perceptions of family planning education in Vanuatu*. Pacific Health Dialog Vol 2. No 1

Katz, C. 1998 *Rhetoric to action: Putting the participant into the 'participation' in the Pacific*, unpublished Master of Public Health dissertation, University of New South Wales, Sydney.

Kenyon, M. (1999) *Going the distance: Lessons in family planning by distance education in Solomon Islands* Development Bulletin January 1999

Mendoza, O. 1988, *Technical report on the Ministry of Health Maternal and Child Health Programme and Services*, University of Manila, Manila

New Zealand Press Association 2003 *Pacific Nations Agree to Contraception Plan*, 24 January and Family Planning Association of New Zealand Press Release 20 January 2003 *Pacific Faces Condom and Contraceptive Crisis*

Paramanathan, K. *Population IEC in the Pacific Island Countries: Trends and Challenges*  
Discussion Paper No. 6 UNFPA Country Support Team

PASA 1996 Pacific AIDS Alert No 19 2000 SPC New Caledonia

*Pacific Response to the ICPD POA* UNFPA 1998

Papua New Guinea Department of Health *National Health Plan 2001-2010 Program Policies and Strategies Volume II*

Pope, S. 1997 *Tongan Family Planning practice: An ideographic study*, Taloua Press, Nuku'alofa.

Ritchie, J. *Education and Family Planning* Development Bulletin

SPC (Secretariat of the Pacific Community) 1998 *Pacific Island Populations* Noumea

SPC 2000 *Total Fertility Rates* SPC, Noumea

SPC 2002 *Pacific Island Population Projections* Noumea

Strachen, J. et al *Family Planning in Choiseul Province, Solomon Islands*. Journal of the Australian Population Association. Vol 12 1995

Sun-Hee Lee, *Reproductive Health and Family Planning in the Pacific: Current Situation and the Way Forward*. Discussion Paper No 14, UNFPA 1995

UNFPA *Asia and the Pacific: A region in transition* 2002 New York