

Teenage pregnancies in the Rewa medical sub-division, Fiji

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Abstract

To assess the magnitude of teenage pregnancies in the Rewa Medical Sub-division as well as the socio-demographic characteristics of the affected teenagers so as to provide a baseline for tackling the problem.

The study was a 5 year retrospective study (1994-1998) of the medical records of the Nausori Maternity Unit, the only unit for these purposes in the entire Sub-division. Pregnancies that were intentionally terminated were not included, as no such data was available from these our public health services.

An average of 11.1% of the 5319 obstetric patients attended to at the centre for the 5 years were teenagers. Their age range was 13 to 19 years. Proportionately more Fijians had such teenage pregnancies than their Indo-Fijian counterparts. The same was true of their being unmarried or being VDRL positive. A larger percentage of the Indian teenagers received assisted deliveries than the Fijians, but this was not statistically significant, being 6% and 4% respectively. Low birth weight was 19% among these teenagers (compared with 5.9% overall).

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Efforts are needed in the area of family life education to improve on aspects of teenage pregnancies. Since this is an area of education that has many conflicting values in the modern world, it is advocated that parents as well as many agencies as possible should be targets as well as join in this task in order meet the needs as due. Such education should cover and respect all the values concerned.

Introduction

Teenage pregnancy is a global problem with many local characteristics everywhere. It is stated that 19% of births worldwide each year are to women between the ages of 15 and 19 years¹. Infant mortality is significantly higher in teenage mothers, being 30% higher in them than in the older women². Obstructed labour and other obstetric risks are also higher in teenage pregnancies due to immature pelvis, etc³.

Some teenage pregnancies are planned while others are unplanned. The proportion of this latter is growing world-wide, especially since the different sexual revolutions of the 20th century. These latter have no doubt increased the overall problems of teenage pregnancies, including school dropouts, social stigma and other problems for the youths and society at large^{3,4}. For example, a 1995 study in Western Samoa showed that 81.3% of the teenage pregnancies were unplanned there⁴. Of these, 24% dropped out of school. There is as yet no community-based study of teenage pregnancies in Fiji that we can find in the literature. However, both local experiences here in Rewa Medical Sub-division and discussions at various health and school programmes suggest that the cases are rising.

In the Indian culture, to have children before marriage is totally unacceptable. Thus if such parents learn that their unmarried daughter is pregnant, they would quickly arrange for a quiet abortion. Secondly, a quick marriage arrangement may be made, preferably with the boy with whom the girl was involved, to avoid social stigma. Locally there are times the Indian girls are quietly sent away from their homes to the local orphanage home for

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Table 1. Teenage pregnancies for the study period

Year	Total no. of deliveries	Total no. of teenage deliveries	%
1994	1033	118	11.42%
1995	1053	129	12.25%
1996	1092	116	10.62%
1997	1021	126	12.34%
1998	1120	100	9%
Total	5319	589	11.07%

Table 2. Teenage pregnancies by age

Age	Frequency	Percent	Cummulative
13	1	0.2%	0.2%
14	1	0.2%	0.3%
15	6	1.0%	1.4%
16	28	4.8%	6.1%
17	81	13.8%	19.9%
18	202	34.3%	54.2%
19	270	45.8%	100.0%

Table 3. Teenage pregnancies by race

Race	Frequency	Percent
Fijians	348	59.1%
Indians	236	40.1%
Others	5	0.8%
Total	589	100.0%

Table 4. Teenage pregnancy by marital status

Race	Married (%)	Single (%)	Total (%)
Fijian	176 (50.6%)	172 (49.4%)	348 (100%)
Indian	223 (94.5%)	13 (5.5%)	236 (100%)
Others	2 (40%)	3 (60%)	5 (100%)
Total	401 (68.15)	188 (31.9%)	589 (100%)

172 (49%) of the Fijians were single mothers compared with 13 (6%) of the Indians

χ^2 test between the Fijians and Indians alone. $\chi^2 = 123.3$; $df 1$, $p < 0.001$

Table 5. Pattern of gravidity and parity among the teenage pregnancies

Gravida	a.		Parity	b.	
	Frequency	%		Frequency	%
1	504	85.6	0	2	0.3
2	80	13.6	1	504	85.6
3	4	0.7	2	80	13.6
4	1	0.2	3	3	0.5

Two pregnancies ended in stillbirth and abortion respectively

the pregnancy; and after delivery, the girl returns home, leaving the child for adoption. Such centres are now getting overcrowded on these accounts⁵.

Social stigma is an important consideration for Fijians, though they may not go to the lengths that Indians do to deal with unwanted pregnancies. Fijian girls do not find it very difficult to get married to the biological fathers after the children's births, which the Indians would rather never do. Even though teenage pregnancies without eventual marriage to the biological fathers of the children in the past have caused and are causing great social and legal problems among the Fijians, more and more of such pregnancies are now being observed.

While we have no access to the number of teenage pregnancies that were unwanted and so intentionally aborted, we decided to study those that presented for care at the only Sub-divisional maternity unit in the sub-division. The objectives of the study were to establish the magnitude of teenage pregnancies in the Rewa Medical Sub-division, to describe the socio-demographic characteristics of these pregnancies and to use these as a basis to propose measures that need to be taken to tackle the problems of teenage pregnancies.

Materials and methods

The study was descriptive and was conducted on the medical records of the Nausori Maternity Unit for the 5 years of 1994 to 1998 inclusively. All the desired socio-demographic and pregnancy outcome data of all the patients registered during the five years were collected in a data sheet. These were later entered into an Epiinfo 6 data file and analyzed.

Results

In the 5 year period, there were 5319 registered pregnancy outcomes, 589 (or 11.1%) of which were among teenagers. Thus there was a mean of 1063 pregnancies per year during that period, with the proportion of teenage pregnancies varying from 9% to 12.3%. - Table 1. No definite trend in incidence is discernible in the 5 years.

Table 6. Patterns of delivery of the major ethnic groups

Race	Assisted delivery (%)	Normal vaginal (%)	Total
Fijian	13 (3.74)	225 (96.26)	348
Indian	15 (6.35)	221 (93.65)	236
Others	1 (20)	4 (80%)	5
Total	29 (4.92)	560 (95.08)	589

38 (0.4%) were pre-term births

Tables 2 to 6 show the other data of the study. The earliest recorded age of teenage pregnancy was 13 years. 348 (59%) of the teenagers were Fijians while 40% were Indians. Compared with the 34,887 and 32,752 of these populations in the Sub-division in that year, there is statistically more Fijian teenage pregnancies than of the Indian teenagers ($\chi^2=146$; $p<0.001$). 32% of the teenagers were unmarried; again, with a statistically significantly greater proportion of the Fijian girls being in this category than the Indian girls (Table 4; $\chi^2=123$; $p<0.001$). For the purposes of this study, we take it that unmarried teenage pregnancies are indices of undesired or undesirable pregnancies. One of the teenagers was already gravida 4 at the time of this pregnancy. 5% of the pregnancies were assisted deliveries, with no statistical difference in the proportions between the two races, even though the rate was higher among the Indian population, 6% and 4% respectively - Table 5. 19% of the teenage pregnancies were low birth weight compared with 5.9% overall in the maternity unit ($\chi^2=69.3$; $p<0.0000$). Table 6 shows assisted vs unassisted deliveries and Table 7 shows the VDRL status of the teenagers. A statistically higher percentage of the Fijian teenagers were VDRL positive compared with the Indian girls ($\chi^2=6.9$; $p=0.008$).

Discussion

The population of Rewa Medical Sub-division was 68,944 in 1998, made up of 34,887 (50.6%) Fijians, 32,752 (47.5%) Indians and 1,305 (1.9%) others. It includes the South Eastern 1/3rd of Naitasiri, the Southern 1/2 of Tailevu and most of the indigenous villages of Rewa Province, excluding those on Beqa Island. The Nausori Maternity Unit is the only maternity unit in the Sub-division and all obstetric problems are brought, and deliveries take place, here.

The crude pregnancy rate in this community for the period was 15.9/1000 and 11.1% of the pregnancies were among teenagers. Bearing children before the age

of 18 years has many problems compared with having them between the prime child-bearing ages of 20 and 34 years.

As shown from this study, while the Indian community is apparently able to have most of teenage pregnancies within marriage, through mostly parentally arranged marriages for the children, the same degree of success is not reflected in the Fijian community. Not only does this show in the proportion of the unmarried teenagers but the higher VDRL positive status in the girls reflect the same problem. The data thus show two different problem patterns with teenage pregnancies. With increasing education in today's youths, early marriages are going to be a harder culture to maintain even by the Indian community. Liberal sexual attitudes as being experienced worldwide will only add to that problem. Legal (mostly related to native titles) and other social problems caused by teenage and unmarried child-bearing are being experienced in the Fijian communities. The other minority groups in the place are encountering similar problems as well. Therefore all the communities need to find solutions to the problem of teenage pregnancies and their related sex problems.

Three previous people had discussed the problem of teenage pregnancies or the need for sex education in the South Pacific third world countries. All three people talked about the use or involvement of different individuals and groups in the community in order to be able to do this well^{3,6,7}. These include the family (i.e., parents), the communities and other community value institutions. This would seem to be necessary in order to be able to healthily treat a subject as value-laden as sexual intercourse and behaviour in general.

However, in both Fijian and Indian cultures, parents find it hard to talk to their children on issues of sex, including contraception. The Christian, Hindu and Islamic cultural and religious values officially embraced by the vast

Table 7. VDRL status of the Fijian and Indian teenagers

Race	Positive	Negative	Total
Fijian	21 (6.0)	327 (94)	348
Indian	3 (1.3)	233 (98.7)	236
Total	24 (4.1)	560 (95.9)	584

majority of the communities in Fiji propose sexual self control as the way to go in these regards. This is to be lived out in teenage coital abstinence and coitus within marriage only, thereafter. But none of these groups teach this healthily, openly and practically. This creates the situation in which the youths learn about contraception at school or through other secular humanist media and have value conflict or confusion in applying the knowledge. Obviously, these are the reasons for the increasing rates of unwholesome teenage coitus, sexually transmitted diseases and teenage pregnancies as is being anecdotally claimed or experienced without proper scientific studies nationally. The problem will not go away as long as there is religion in the world; unless, of course, all the conflicting values are healthily addressed in the programmes relating to those subjects.

A recent School Principals Association meeting was informed that the way to overcome this problem of values confusion or conflict and the teenage sexual problems arising from it is to provide condom vending machines in schools⁸. It would appear that on the contrary, that exercise is more likely to reinforce the value confusion and conflict already being created. It would seem to us that a healthier way to approach the problem of teenage pregnancy is to introduce a comprehensive family life education which explores all the values in this regard and encourages the youths to freely embrace the values relevant to their home cultures. Two of the local writers in this regard had advocated this all-values-respecting approach to such sex education^{6,7}, while the third did not advocate any values-negating approach thereof either³. If the children have to change those original family values, they should be able to do so freely and maturely as well as take all the other necessary measures in that regard. Only properly designed educational programmes that respect and accommodate all the prevailing community values will be able to empower them to do so.

In this regard, the various value communities should be encouraged to develop appropriate family life education programmes covering all the facts as well as values in their communities in that regard^{9,10}. More importantly, financial support should be given to such programmes and not limited to only the secular humanist value-based ones. Individual groups may however thereafter give their own appropriate emphasis and practical support in their own value system to the desiring beneficiaries of such educational services. Public schools should do the same, and while elaborating all value systems in the given locality should avoid promoting any particular value base alone such as the free sex/secular humanist one¹¹. This latter is what sex behavioural information without (values) forma-

tion or the exploring of the value bases and problems in their adoption implies. It informs but does not truly educate; and that is where its problems begin. It invariably is a parochial, secular humanist religious agenda¹¹. A truly enlightened society or public institution should not promote it or especially do so at the expense of all the other value systems thereof whose destruction is its avowed objective¹¹.

Apart from the on-going confusion and conflict in values (i.e., lack of education), this continuing approach in public schools also involves an ethical violation. That is also what any pornography or the installation of condom vending machines in public schools involves. Only night clubs, brothels, sectarian schools meant for people who already profess or wish to explore the relevant secular humanist values and other non-captive or non-child-formative centres could install such machines without such ethical violations involved. This would be the way to reduce the problem of values confusion arising from past secular humanist sex education in schools which did not respect these principles as well as the rising problems associated with them.

As these local community groups and parents also need help in these regards, programmes should be developed to help them thereat. The target for this education should include the parent-teachers associations, the various men's and women's groups as well as the other social organizations. Family life education in schools should also teach and assist girls to avoid or resist unwanted sexual advances and to seek the appropriate enforcement of such protection or the punishment of boys or men who do so to

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them. The relevant laws should be enacted to enforce those protections. Parochial individuals and schools that fail to teach their students or youths what they themselves or other people profess to be their values or practices concerning such vital issues as sex should be helped to overcome their problems in doing so, healthily. The children will remain ill educated and most probably have problems later as a result thereof. As Schram observed⁶, sex education is a parental function, and other educators should be mainly valuable collaborators in this regard. Youths also indicate their preference of parents as primary educators for these purposes⁹.

Another community-based study is needed to establish the prevalence of induced abortions in Fiji and to find solutions that accommodate all the prevailing values in the community in their regard. This would seem to be the best way that the present clandestine approaches to the problem will be overcome and data on it become more easily accessible. Every society has a responsibility to

protect the values of its citizens and allow their change only by a natural evolution, rather than through ethical violations. In this regard, since secular humanism makes abortion (and not free sex alone) one of its official creeds, they have a right to have that value respected. In legalizing abortion so as to accommodate secular humanists in the society, doctors who adopt that value and perform such "services" need to be required to do so only to people who are of that creed¹¹. They may do so to other people only if they obtain a relevantly legislated proof that the avoidance of such an ethical violation has been fully satisfied in each individual case. The usual way to do this is to have obtained valid and certified counseling from an officially designated counselor of their religion or such other value base before being admitted to such a procedure.

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The command "Be fruitful and multiply" was promulgated according to our authorities, when the population of the world consisted of two people.

**W. R. Inge (1860 - 1954) in
'More Lay Thoughts of a Dean'**