

Key Vanuatu DHS Indicators



	Residence				
	Urban	Rural	Rural 1	Rural 2	National
Marriage and fertility					
Total fertility rate per women aged 15–49 years (children per woman)	3.3	4.7	4.3	4.8	4.2
General fertility rate per 1,000 women	115	162	147	166	146
Crude birth rate per 1,000 population	30.2	33.1	31.4	33.5	32.5
Age at first marriage (Median)					
Women aged 25–49 years	21.4	20.6	20.8	20.5	20.8
Men aged 25+ years	25	24.2	24.1	24.2	24.4
Young women aged 15–19 years who have begun childbearing	12.8	17.3	17.1	17.3	15.7
Median age at first birth for women aged 25–49 years	21.7	20.9	21.3	20.9	21.2
Median age at first sexual intercourse					
Women age 25–49 years	19.5	18.5	19.0	18.9	19.1
Men age 25+ years	18.9	19.6	19.3	19.7	19.4
Family planning (% of currently married women aged 15–49 years)					
Contraceptive prevalence rate (%)	50.9	48.1	53.9	47	47
Current use (%)					
Any method	50.9	48.1	53.9	47	47
Any modern method	42.5	34.6	36.8	34.2	34.2
Female sterilisation	13.6	9.8	10.1	9.7	9.7
Male sterilisation	0.2	0.8	0.7	0.8	0.8
Injectables	9.1	10	10.1	9.9	9.9
Pill	10.8	10.4	10.9	10.3	10.3
Male condom	2.5	1.9	2.1	1.9	1.9
Any traditional method	8.4	13.5	17.2	12.8	12.8
Unmet need for family planning					
Total unmet need (%)	23.5	24.6	25.7	24.4	24.4
Unmet need for spacing (%)	11.3	11.6	13.4	11.3	11.3
Unmet need for limiting (%)	12.2	12.9	12.3	13.1	12.7
Infant and child mortality (0-9 years before DHS)					
Neonatal mortality (NN)	16	13	12	13	12
Infant mortality (1q0)	25	28	20	29	28
Under-five mortality (5q0)	28	35	22	37	31
Maternal and child health					
Maternity care (births in the last three years)					
Mothers who had at least one antenatal care visit for their last birth (%)	1.7	2.3	1.5	1.6	1.4
Mothers who had at least four antenatal care visits for their last birth (%)	46.4	54.1	55.8	53.8	51.8
Births attended by skilled health personnel (%)	95.7	87.0	95.4	85.6	89.4
Mothers receiving antenatal care from skilled provider (%)	80.9	73.3	85.4	71.1	75.6
Births delivered in a hospital or health facility (%)	98.1	84.9	96.2	83.1	88.5
Mothers having at least one problem accessing health care (%)	82	91.4	92.7	94.4	89.9
Child immunisation and health care					
Children 12–23 months fully immunised (BCG, measles and three doses each of polio and DPT) (%)	44.3	28.5	25.2	29	32.7
Children 12–23 months who have received BCG (%)	80.8	70	78.6	68.4	72.9
Children 12–23 months who have received three doses of polio vaccine (%)	63.1	47.9	53.8	46.8	52
Children 12–23 months who have received three doses of DPT/Penta vaccine (%)	70.9	49.4	57	48	55.1
Children 12–23 months who have received measles vaccine (%)	68.7	46.7	51.9	45.8	52.6
Children 12-23 months with no vaccination	11.2	23.3	12.9	25.1	20
Children 12-23 where vaccination card seen	57.1	57.4	67	55.7	57.3
Children aged 6–35 months given vitamin A dose in the last six months (%)	24.6	24.9	26.6	24.6	24.8
Children 6–35 months given de-worming medication in the last six months (%)	49	48.9	54.6	48	49
Prevalence of underweight children under five years of age (less than 2.5 kg) (%)	13	10.1	10.1	10.1	10.9
Treatment of childhood diseases					
Children under five with diarrhoea in the last two weeks who received ORS (%)	38	51.6	40.6	53.9	47.6
Children under five with diarrhoea in the last two weeks who seek advice from a health facility or provider (%)	39.5	45.9	48.5	45.4	44
Home management of diarrhoea (%)	32.4	30.3	23.9	31.6	30.9
Received ORT or increased fluid and continued feeding (%)	39.9	40.9	40.2	41	40.6
Children with fever in the last two weeks who seek advice/treatment from a health facility or provider (%)	47.9	61.1	55.7	62.1	57
Nutritional status of adults and children					
Women aged 15–49 years who are overweight or obese (%)	59.0	45.3	49.3	44.6	49.5
Men aged 15–49 years who are overweight or obese (%)	51.3	28.4	37.5	26.7	35.8
Women aged 15–49 years whose body mass index is below normal (%)	3.6	2.8	2.4	2.9	3

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	Residence				
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Nutritional status of adults and children (cont')					
Children under five years ever breast-fed (%)	91.2	96.3	92.5	96.9	94.9
Children under five years breast-fed within one hour of birth (%)	83.1	86.4	88.0	86.1	85.4
Children under five years who received a pre-lacteal feed (%)	4.1	6.8	3.0	7.4	4.1
Children under five years who are stunted (%)	19.1	31.5	28.6	31.9	28.5
Children under five years who are wasted (%)	2.0	5.2	4.9	5.3	4.4
Children under five years who are underweight (%)	5.0	12.5	9.1	13.0	10.7
Households with adequately iodised salt (%)	69.4	42.0	52.8	40.0	50.7
Malaria					
Household ownership of mosquito nets					
Household owns at least one mosquito net (any type)	70.4	93.4	85.7	94.7	86.5
Household owns at least one ITN	65.8	90.3	81.2	91.9	83.0
Children under five who slept under an ITN the night before the survey (%)	25.6	61.0	53.9	62.2	51.0
Women aged 15–49 years who slept under an ITN the night before the survey (%)	19.1	59.4	44.1	62.4	44.6
Pregnant women aged 15–49 years who slept under an ITN the night before the survey (%)	27.5	47.4	38.3	49.0	40.5
Children under five treated with anti-malarial drugs (%)	5.8	4.8	3.7	5.0	5.1
Women's empowerment					
Share of women in wage employment in the non-agricultural sector	95.4	67.9	90.4	63.6	78.3
Women's cash earnings compared with husband's cash earnings					
More (%)	33.5	29.1	29.9	28.9	31.3
Less (%)	50.8	42.1	42.4	42.1	46.5
Women's participation in decision-making (%)	61.1	68.9	62.9	69.9	66.4
Child labour and child discipline					
Child labour (Children aged 5–11 years engaged in child labour activities)					
Male children (%)	na	na	na	na	20.0
Female children (%)	na	na	na	na	22.0
Children aged 12–14 years engaged in child labour activities	0.5	0.6	1.4	1.7	0.7
Male children (%)	na	na	na	na	1.3
Female children (%)	na	na	na	na	0.1
Child discipline (children aged 2–14 years [%]) by methods and severity of punishment					
Psychological aggression	74.4	78.4	79.6	78.2	77.3
Any physical punishment	70.0	72.0	74.5	71.6	71.5
Severe physical punishment	31.6	37.2	33.7	37.8	35.7
Any violent discipline method	82.9	83.7	87.7	83.0	83.5
HIV and AIDS (women and men aged 15–49 years)					
Women who have heard of AIDS (%)	96.4	87.6	94.7	86.2	90.7
Men who have heard of AIDS (%)	95.8	90.5	93.1	90.0	92.4
Women who know where to get an HIV test (%)	77.9	56.7	69.6	54.1	64.0
Men who know where to get an HIV test (%)	82.7	69.4	75.7	68.1	74.3
Attitudes towards people with HIV/AIDS (no discrimination) - Women 15–49 years (%)	15.2	7.4	10.4	6.8	10.3
Attitudes towards people with HIV/AIDS (no discrimination) - Men 15–49 years (%)	28.3	13.6	13.9	13.5	19.1
Mean number of sexual partners in lifetime, women 15–49 years (%)	2.3	2.0	2.1	2.0	2.1
Mean number of sexual partners in lifetime, men 15–49 years (%)	5.6	4.6	6.0	4.3	5.0
Comprehensive Knowledge of HIV and AIDS					
Women 15–49 years (%)	23.3	19.7	18.1	20.0	20.9
Men 15–49 years (%)	26.8	19.7	17.2	20.3	22.3
Young women 15–24 years (%)	17.7	18.4	14.5	19.2	18.1
Young men 15–24 years (%)	19.3	18.6	(15.0)	19.4	18.9
High-risk sex in the past 12 months among young population					
Young women who had high-risk sex (%)	43.8	32.8	34.3	32.5	36.5
Young women who used a condom during last high-risk sex (%)	43.2	31.9	36.0	31.1	36.5
Young men who had high-risk sex in the past 12 months (%)	82.5	64.2	84.3	59.5	71.6
Young men who used a condom during last high-risk sex (%)	50.0	40.3	39.1	(40.7)	44.8
Other respondent characteristics					
Birth registration					
Total registered (children under five) (%)	75.1	75.7	81.6	74.7	75.5
Had a birth certificate (children under five) (%)	60.8	36.7	49.7	34.5	43.4
Anaemia among children and adults					
Children aged under five who are anaemic (%)	32.3	25.3	37.9	23.3	27.0
Women aged 15–49 years who are anaemic (%)	19.4	23.9	20.5	24.5	22.5
Pregnant women aged 15–49 years who are anaemic (%)	na	na	na	na	24.7
Environment					
Households with sustainable access to an improved water source (%)	98.9	87.6	91.8	86.9	91.0
Households with access to improved sanitation (%)	45.8	52.7	53.9	52.6	50.8
Households with solid fuel use (%)	68.3	98.7	93.5	99.6	89.6
Households using an appropriate treatment method (%)	34.4	17.8	24.7	16.7	22.8

NOTE: Figures in parentheses are based on 25–49 unweighted cases. na: not available

Population characteristics



With population characteristics and processes both the drivers and results of social and economic development processes and outcomes, it is imperative that a good understanding of a country's population dynamics provide the basis for informed decision-making, policy development and planning.

Population and housing censuses provide the backbone of this information in most countries. But these 'snapshots' are taken only every five to ten years and so are not enough to inform policy and allow regular monitoring of development progress.

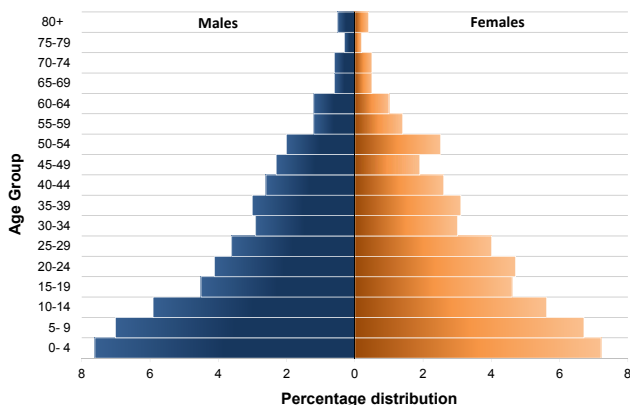
Regular household surveys, such as the 2013 Vanuatu DHS, address this data and information gap by providing high quality, up-to-date statistics and information in their own right, as well as providing the basis for the calculation of important development indicators. This survey provided more than a hundred such indicators, covering many development features of relevance to both national and international development agencies and conventions such as the Millennium Development Goals (MDGs), the International Conference on Population and Development (ICPD), the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), the United Nations General Assembly Special Session (UNGASS) and the United Nations Children's Fund (UNICEF), to name but a few that are included in this development snapshot.

The population of Vanuatu

A census is held in Vanuatu every ten years; the most recent Census was in 2009.

Vanuatu has a youthful population with about 40% of the population surveyed younger than 15 years of age (Fig. 1). The youthful population is a result of a continued high fertility rate, which also reflects a high population growth rate of 2.5% per year.

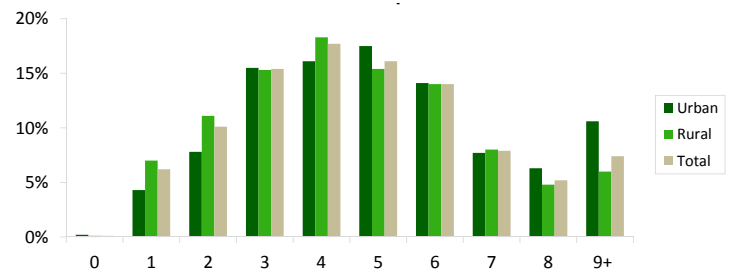
Figure 1: Percentage distribution of de facto household population by age and sex



Household composition

The average household size comprises of about five members (4.9) (Fig. 2) which corresponds to the figure shown by the 2009 population and housing census; 6% of households are headed by women. In urban areas, some 11% of households have nine or more members compared to 6% for rural households.

Figure 2: Household composition – number of usual members



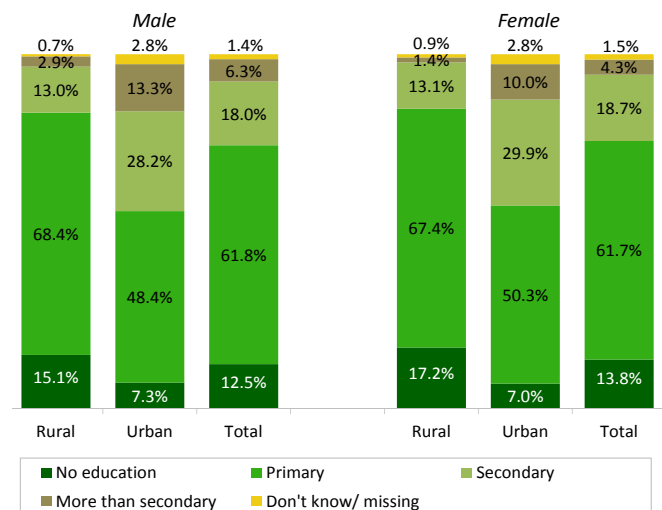
As elsewhere throughout the Pacific, fosterhood is common in Vanuatu, with equal proportions of rural (26%) and urban households (26%) including foster and/or orphaned children. Seventeen per cent of children aged less than 18 years of age do not live with a biological parent.

The 2013 Vanuatu DHS provides useful information concerning socio-economic background characteristics, which may provide important contextual information for key demographic and health outcomes. These include education (such as attainment levels), economic well-being (illustrated through wealth quintiles) and basic household amenities, such as access to safe water, sanitation and household characteristics, such as household size. All of these factors are of critical importance, especially to infants and young children.

Educational level

Education is provided free in Vanuatu for primary education in government schools for children aged 6–13 years, and some schools allow enrolment from five years of age (Fig. 3).

Figure 3: Educational achievement of males and females in Vanuatu - Highest educational attainment



Most people in Vanuatu do not progress past primary education, with 13.8% of females and 12.5% of males never having attended school; the latter is more pronounced in rural than urban areas. Furthermore, of those referring to primary education as their highest level of educational attainment, only 24.5% of men and 24.1% of women actually completed primary



school. Urban Vanuatu also has a much higher concentration of women (39.9%) and men (41.5%) with secondary education or higher, compared to rural areas (15.9% of males; 14.5% of females). Overall, there appear no major differences between the educational achievement of males and females in Vanuatu.

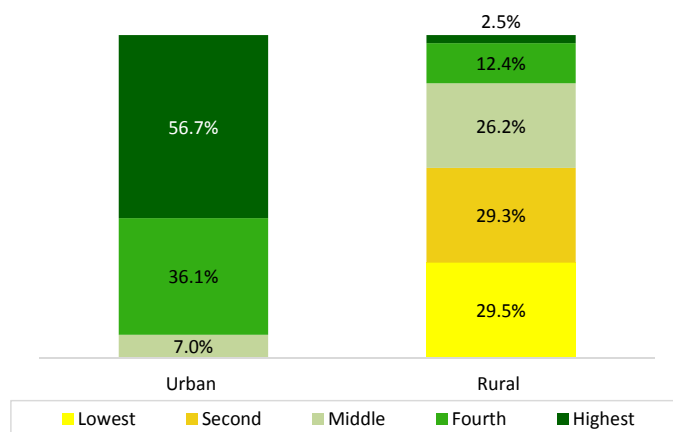
Net attendance ratio (NAR) measures the number of school-age children who attend school. According to the 2013 Vanuatu DHS, the primary school NAR is 77%, while the secondary school NAR is only 24%.

Economic well-being

DHS Household information on assets allows the calculation of a wealth index, which provides a useful proxy measure describing the long-term standard of living of a household. It is not an absolute measure that can tell us if a household suffers hardships or lives in poverty. What it can tell us, however, is that a person living in a household in the second highest wealth quintile, for example, has a better socio-economic status than someone in a lower quintile, and a worse socio-economic status than someone in the highest wealth quintile.

Wealth is distributed very unevenly throughout the country, with wealth concentrated largely in urban areas. About 57% of the urban population are in the highest wealth quintile compared to just under 3% of the rural population. In contrast, 30% of rural households are in the lowest wealth quintile compared to none in urban areas (Fig.4).

Figure 4: Wealth quintiles



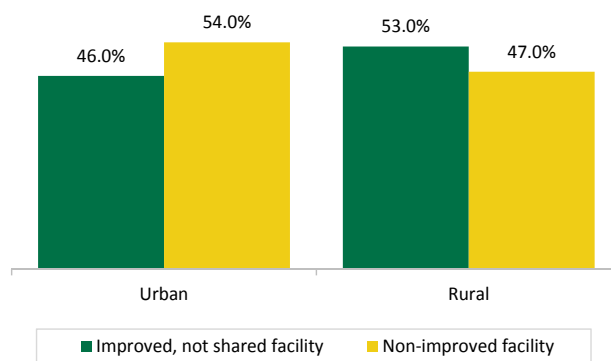
Access to safe water and sanitation

Poor sanitation, coupled with unsafe water sources, can increase the risk of waterborne diseases and illnesses due to poor hygiene. Households without proper toilet facilities are more exposed to the risk of diseases like dysentery, diarrhoea, and typhoid fever than those with improved sanitation facilities.

Just under half (46%) of urban households have access to improved (and not shared) sanitation facilities, with the majority having to make do with non-improved facilities (shared facilities, flush or pour but not sewers/septic tanks/pit latrines, pit latrines without slab, no facility/bush). The picture is almost reversed in

rural households, where access to improved sanitation facilities is much higher than in urban Vanuatu. This is because a major proportion of rural households (46%) has access to improved pit latrines (ventilated, and/or with slab) compared to only 7% in urban Vanuatu. The fact that 54% of urban households have access only to non-improved sanitation facility has some serious personal and environmental health implications, particularly in crowded urban environments (Fig. 5).

Figure 5: Household sanitation facilities



Access to safe drinking water

Overall, 91% of households have access to an improved source of drinking water. Urban households have greater access to piped water sources (99%) than rural households (88%).

Access to electricity

Around 32% of Vanuatu households have access to electricity; 86% in urban and 14% in rural Vanuatu.

Policy note

The broad base population referred to earlier is indicative of continued high fertility in Vanuatu, which translates into high population growth. A youthful population means continued and growing pressure on the government to provide education and employment opportunities, which will be outside the formal sector for most.

With many health outcomes determined by factors outside the health sector, and related to people's social and economic environment, their housing, and access to services and infrastructure (e.g. water and sanitation), it is worth remembering when comparing demographic and health patterns across the country, that 57% of the population in urban areas are in the top wealth quintile, compared to only 3% in rural Vanuatu; three out of every ten rural ni-Vanuatu people are represented in the lowest wealth quintile, compared to zero in the two urban centres.

While there appear to be no major differences between the educational achievement of males and females in Vanuatu, it is worth noting that while three out of every four men and women do not progress beyond primary education as their highest level of educational achievement, 50% of males and 51% of females have had none or incompleting primary education.

*For more detailed information on population characteristics see chapters 2 and 3 in the 2013 Vanuatu DHS report.

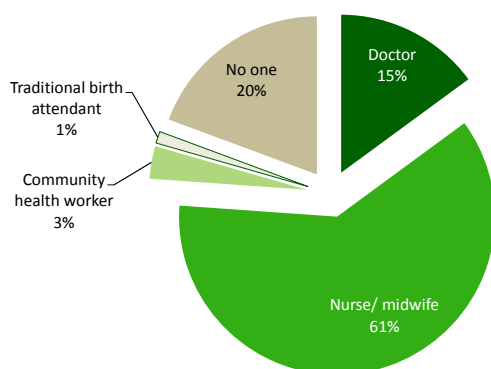


Providing adequate care during pregnancy and childbirth is important for the health of mother and baby. Reproductive health covers antenatal, childbirth and postnatal care, in addition to access to general health care services. Gathering reproductive health information will help identify problems with the level of care provided and groups of the population whose health needs are underserved throughout pregnancy and childbirth.

Antenatal care

Most pregnant women in Vanuatu receive antenatal care. Regardless of whether a woman lives in an urban area or in a rural area that is difficult to access, she has over 70% chance of accessing a health professional during a pregnancy. The 2013 Vanuatu DHS indicates that a doctor or a nurse/midwife most commonly provides antenatal care (76%) (Fig. 1).

Figure 1: Providers of antenatal care



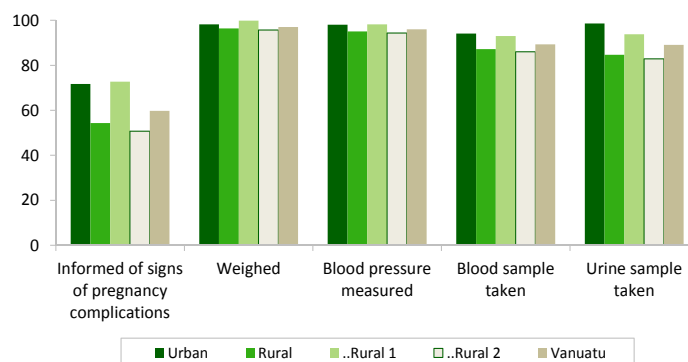
The reassuring findings concerning the widespread access to antenatal care are carried through into the findings about how many antenatal visits a pregnant woman receives. Almost 50% of women in urban and over 50% in rural areas received more than four antenatal visits, the minimum number recommended by the World Health Organization. Most women have their first antenatal visit in the fifth month of their pregnancy. A higher proportion of women in urban than rural areas was reported to access antenatal care in their first trimester.

Quality of antenatal care

The 2013 Vanuatu DHS confirms that the quality of antenatal care provided in Vanuatu is high, with almost all women reporting they had been weighed (97%) and had their blood pressure (96%) and urine (89%) checked. However, only 60% reported they had been informed about the signs and symptoms of pregnancy complications (Fig. 2).

Tetanus toxoid (TT) immunisation is given to pregnant women to prevent neonatal tetanus – a leading cause of neonatal death in developing countries. For full protection, a pregnant woman needs two injections of TT during pregnancy. If a woman was immunised before her pregnancy, she may require one or no TT injections, depending on when she had that pre-pregnancy immunisation.

Figure 2: Selected services received by women attending antenatal care for their most recent birth (Women aged 15–49 who had a live birth in the 5 years preceding the survey)



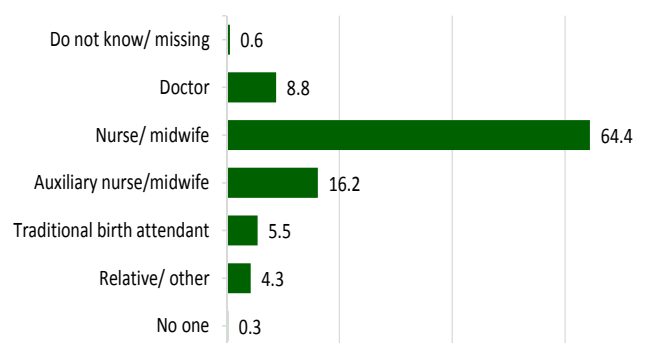
The survey results show that less than a third (30%) of expectant women received two or more TT injections during their last pregnancy and that 13% were already protected by virtue of prior injections. This meant that only 43% of women were protected, a matter of concern for Vanuatu, which is trying to improve immunisation rates.

Childbirth care

According to the 2013 DHS, the majority of births take place in a public health facility (87%), mostly an urban facility. Ten per cent of women deliver at home and 1.5% deliver in a private facility. This homebirth delivery rate is high compared to many other Pacific Island countries, but low compared to Papua New Guinea and Solomon Islands.

Most women who delivered in Vanuatu (89%) were attended by a skilled professional (Fig. 3). Regardless of their background, where they lived, or their age, the majority (64%) are more likely to be attended by a nurse/midwife rather than a doctor. The number of deliveries attended by a traditional birth attendant was a low at 5%.

Figure 3: Assistance during childbirth (%)



With the national rate of caesarean sections reported at 12% in the 2013 Vanuatu DHS, the corresponding estimate for young mothers (less than 20 years) was slightly higher at 14%.

Postpartum care

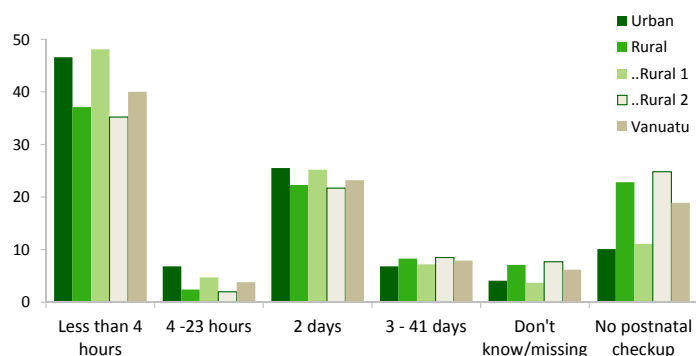
Postpartum care is important. It checks on possible



complications after delivery and provides mothers with important information on caring for herself and her child. The crucial period is the two days after delivery when most complications arise. During that period, 40% of women reported having been attended to by a skilled health worker within four hours after delivery, an additional 3.8% within 24 hours, and a further 23.2% reported having received such attention during the second day (Fig 4).

Notwithstanding these high coverage rates, it should not be ignored that 19% of women reported not having had any post-natal check-up at all. This affected 1 in 4 women in the remote rural areas (24.8%), compared to 10% and 11% of urban women and women residing in peri-urban areas; it also affected women with none or only primary education, and those in the lowest wealth quintile to a larger extent than more educated women and those in higher wealth quintiles.

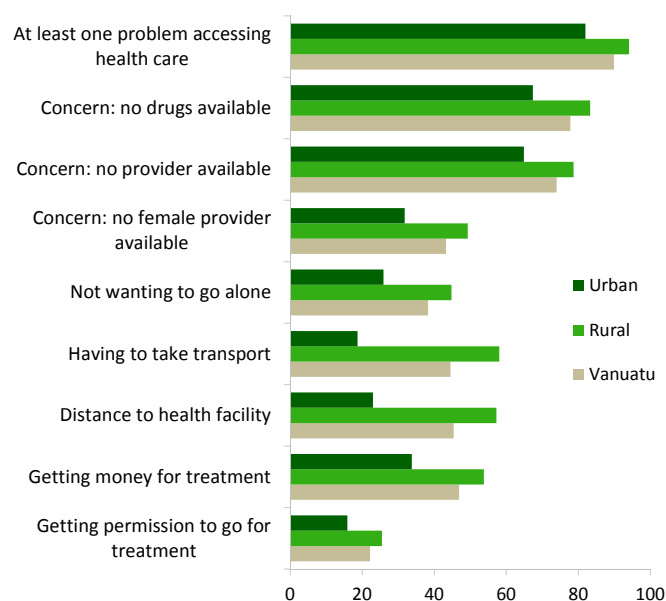
Figure 4: Timing of first postpartum check-up



General problems accessing health care

Nine in ten ni-Vanuatu women (90%) reported at least one problem experienced with accessing health care (Fig. 5). The most common concerns raised were that no drugs or no provider would be available when needed. Getting money for treatment and distance to health services were two other problems commonly raised by many women, but particularly by younger women with no children, never married, not employed, living in remote rural areas, with low education and most likely to live in the lowest to middle wealth quintile households.

Figure 5: General problems accessing health care



Policy note

Survey results indicate that Vanuatu's public health system is providing comprehensive maternal care, as illustrated in the high number of women reported receiving good quality care during their pregnancies.

About 50% of urban and rural women reported to have benefitted from the full recommended four antenatal visits, while 19% have never taken up this opportunity. This should be of concern to Vanuatu health authorities.

A further reproductive health policy challenge would be to ensure that most women have their first antenatal visit earlier than half-way through their pregnancy to allow antenatal providers to carry out appropriate screening and discuss ways that can have a positive impact on a healthy pregnancy, such as diet.

Despite a reported high quality antenatal care (over 90% of women reporting were weighed, had their blood pressure checked and urine tested), only 60% of women reported having been informed about signs and symptoms of pregnancy complications. This is an area RH providers might wish to have a closer look at.

The same might be said regarding improving tetanus coverage, and addressing the current situation where 57% of women are not completely protected against tetanus.

*For more detailed information on reproductive health, see chapter 9 in the 2013 Vanuatu DHS report.

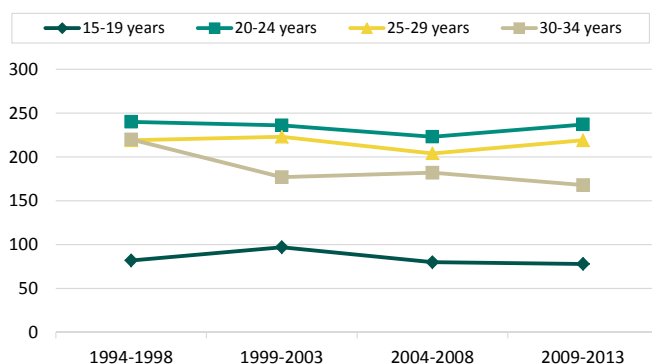


The 2013 Vanuatu DHS results suggest that, on average, a ni-Vanuatu woman will have 4.2 children during her reproductive life, with rural women (4.7) showing a higher total fertility rate than urban women (3.3); fertility is higher (4.8) in the remote rural areas than in villages adjacent to Port Vila and Luganville (4.3), which have easy access to urban services. There are no conclusive variations in terms of educational status of mothers, but marked differences when considering economic circumstances, with women in the lowest wealth quintile (5.5) having on average two children more than women in the highest wealth quintile (2.9). It is also worth noting that teen-age fertility amongst rural women is nearly twice as high (97 births by 1000 women in this age group), as that of young urban women (52).

Trends in age-specific fertility rates

After declining significantly between the 1960s and the late 1980s, fertility rates have remained relatively steady over the past 20 years across major age-groups, with only women in their early thirties showing a decline in fertility (Fig. 1). The survey results indicate a tendency for women in urban areas to have children between the ages of 25 and 34 years, while women in rural areas are more likely to spread out the time they have children between the age ranges of 20 and 34. The slightly delayed childbearing age of women in urban areas may result from women undertaking further education or taking advantage of a greater range of employment opportunities than do women in rural Vanuatu.

Figure 1: Trends in age specific fertility rates



Family planning

Knowledge of contraceptive methods is high in Vanuatu, with 91% of all women and 98% of all men knowing at least one contraception method. More people reported knowing about modern contraception methods than traditional methods, and the most commonly known method was the male condom, with 84% of women and 95% of men reporting that they knew this method.

In contrast to this widespread knowledge, contraceptive use is low, with approximately two out of three women reporting that they have used contraception at some time in their life. Married women are more likely than unmarried women to have used contraception (78%). Men are more likely (73%) than women to have used contraception at some time. The male condom is the most popular male modern method, being used by 58% of all men.

Married ni-Vanuatu men and women expressed a desire to have some control over the number of births they have and the timing of

those births, with 41% of women and men reporting that they do not want another child.

The survey results also highlight that not everyone's family planning needs are being met. Overall, 24% of married ni-Vanuatu women have an unmet need for family planning, with no major contrasts emerging between women in urban (23%) and rural areas. Forty-nine per cent of the total demand for family planning is currently met.

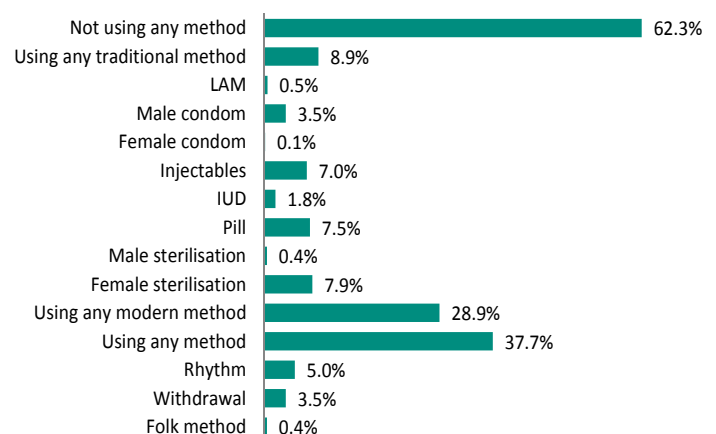
Regarding the notion of an ideal family size, men expressed a desire to have slightly larger families than women, with men's mean ideal number of children being 3.1, compared with 2.6 for women. Both these preferred family sizes are lower than the total fertility rate of 4.2 children per woman. It is perhaps a surprise to some, that one in ten ni-Vanuatu men and women said they wanted no children at all.

Current use of modern contraceptives by women (15-49 years)

The current use of contraception is low in Vanuatu and large families are the norm. Almost three out of ten women reported that they were using contraception at the time of the 2013 Vanuatu DHS (Fig. 2). Women are most likely to use a contraceptive method if they are currently married and aged between 25 and 29 years (54%). The most common method is female sterilisation.

A variation in the use of modern contraceptives is observed between urban (42%) and rural (35%) women, but use varies most noticeably in relation to numbers of children had: 7% of married women with no children, 36% of married women with one or two children, 42% of married women with three or four children, and 40% of women with five or more children. Contraceptive use is less prevalent amongst married women in the lowest wealth quintile (29%) than among women in the higher wealth quintiles, ranging from 32% in the middle quintile to 45% in the fourth quintile.

Figure 2: Current use of contraceptives by women aged 15-49 years



About 16% of women reported that they had used a form of contraception prior to having children. Around 20% of women start using a contraceptive method after they have their first child. The survey results suggest that there is an rise in contraceptive use amongst women, with 14% of women aged 45-49 years using contraception after the birth of their first child compared with more than 24% of women aged 20-24 years. Younger women have never used any form of contraception, with more than one in three



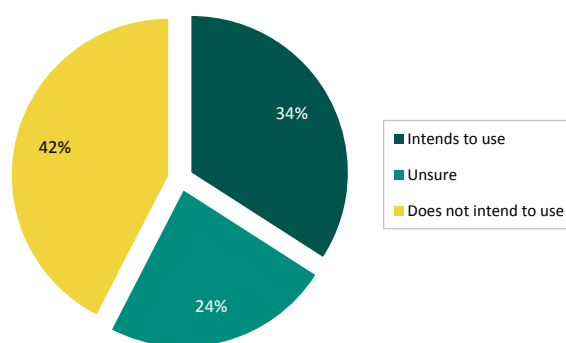
women aged 20–24 years reporting that they have never used a contraceptive method. Female sterilisation is one of the most common forms of contraception used by ni-Vanuatu women. The median age for sterilisation is 31 years.

The majority of people using contraception obtain it from the public sector, mainly from government hospitals (55%), health centres (25%) and family planning clinics (4%). Respondents indicated that contraceptives are generally available free of charge.

Intended future use of contraception

Over 40% of women in Vanuatu not currently using contraception do not intend to start using contraception in the future (Fig. 3), while one out of three women intend to start using contraception in the future. This slightly lower number of women who intend to start using contraception in the future can be attributed to issues such as fear of side effects (20%), health concerns (16%), and being opposed to using contraception (16%), among the main reasons. The reasons for not wanting to use contraception do not appear to be much related to a lack of knowledge or access issues.

Figure 3: Intended future use of contraception by married women not currently using contraception



Amongst women who expressed a desire to use contraception in the future, the three preferred methods of contraception are the pill (37%), injectable (31%), and male condom (7%).

The media are currently being used to disseminate family planning information in Vanuatu and 23% of women and 37% of men reported that they had heard family planning messages on the radio. Television and newspapers are also a common source of family planning messages.

Throughout the world, field workers have proven to be an effective means of providing family planning information. However, more than four out of five women (82%) reported that they had not discussed family planning with a field worker or health care worker at a health facility in the twelve months prior to the survey. Only around one in ten women reported that they had been visited by a health worker who discussed family planning with them in the twelve months prior to the survey.

Median age at first childbearing

The median age for a ni-Vanuatu woman to have her first child is 21.2 years, which means, 50% of women delay childbearing until after 21 years of age. No substantial differences emerge between urban and rural Vanuatu.

*For more detailed information on fertility and family planning see chapters 4 and 5 in the 2013 Vanuatu DHS report.

Age at first sexual intercourse

The median age at first sexual intercourse for both ni-Vanuatu women and men is 19 years, which is relatively young compared with worldwide norms. And with the median age for first marriage around 21 years of age for women and 24 years for men, this points to an onset of sexual activity well before marriage. Having said this, marriage at a very young age does happen, with 5% of women reported to have married by age 15, and 6% of men at age 18.

Birth intervals

The median birth interval among ni-Vanuatu women is 36 months. Wealthier women tend to have longer birth intervals than women in lower wealth quintiles. About one in four women (28%) in the lowest wealth quintile had birth intervals of less than the recommended 24 months. This suggests that women in the lowest wealth quintiles have more children, and that they tend to have their children in quick succession.

Teenage pregnancy and motherhood

Pregnancies among women aged 15–19 years are common in Vanuatu, with about 12% of women in this age-group having reported a live birth, and 4% being pregnant at the time of the survey. Almost one in three teenage women (30.4%) who have had a live birth were 19 years old. As indicated in Figure 1, teen-age fertility has remained both high and unchanged over the past twenty years, with figures for rural Vanuatu twice as high as for young women in town.

Policy note

As contraceptive use is quite low, and most women (three out of four) not currently using contraception and not intending to start using contraception in the future, a review of reproductive health policy and programmes might be timely, particularly with a focus on reproductive and sexual health education.

Reproductive and sexual health initiatives would do well to assess women's concerns about perceived implications of contraceptive use on their health (2%) or other side effects (16%), as well as emphasise the positive spin-off on sexual health (protection from STIs). The latter seems to be particularly relevant, with sterilisation representing the most commonly used contraception by women aged 15–49 years, but which provides no protection against STIs, whereas current contraceptive use of the male condom (which offers protection against STIs) is very low at just 1%.

The survey results suggest that there is a need for more family planning messages to be targeted at young people, with close to half of all females aged 15–19 years reporting that they had neither seen nor heard any family planning messages on radio, television or in the newspaper.

The use of health fieldworkers could be stepped up to provide reproductive and sexual health education; with four out of five women reporting never having discussed family planning with a field worker or staff at a health facility in the twelve months prior to the survey, there seems to be an obvious need to address the lack of reproductive and sexual health information.



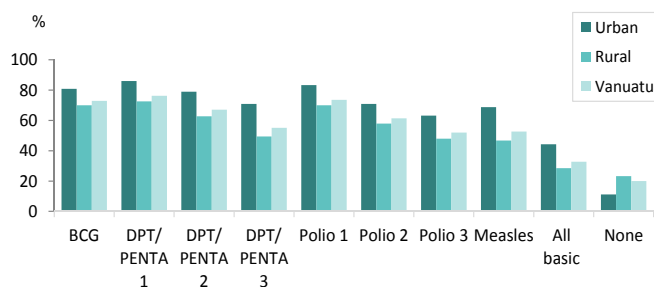
Many childhood deaths can be prevented by immunising children against certain diseases and ensuring that they receive prompt and appropriate treatment when they become ill.

Universal immunisation of children against the eight vaccine-preventable diseases (tuberculosis, diphtheria, whooping cough [pertussis], tetanus, hepatitis B, haemophilus influenza, polio and measles) is crucial in reducing infant and child mortality.

Vaccinations

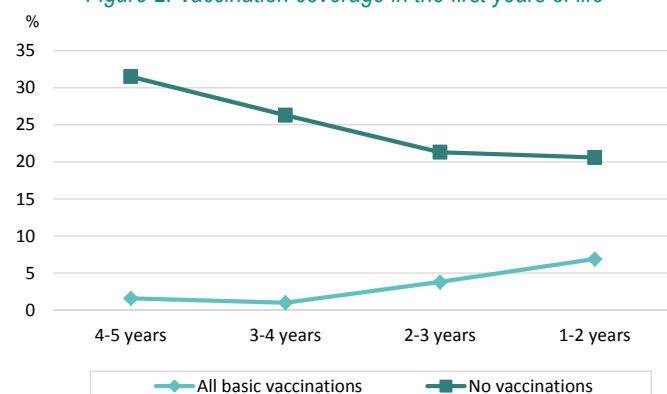
According to the 2013 Vanuatu DHS, one in every three (33%) children aged 12–23 months was fully vaccinated at the time of the survey (Fig. 1). Male babies are more likely (35%) than female babies (30%) to have received all basic vaccinations. Children living in urban areas are more likely to be fully immunised (44%) than children in rural areas (28%), perhaps reflecting easier access to services in town. And a mother's education appears to affect immunisation rates, with 47% of children whose mothers have secondary education being fully immunised, compared with 25% of children whose mothers have only primary level education.

Figure 1: Coverage by type of vaccination, Children aged 12–23 months



DHS results indicate that vaccination rates have improved over the past four years. This is reflected in the proportion of children who had received no vaccinations by 12 months of age; this proportion has declined from 31% among children aged 4–5 years at the time of the survey, to about 21% among children 1–2 years of age at the time of the survey (Fig. 2).

Figure 2: Vaccination coverage in the first years of life



According to World Health Organization guidelines, children are considered fully immunised when they have been vaccinated against BCG, received three doses of DPT and polio, and one measles vaccination by the age of twelve months. Despite the higher trends in BCG, DPT and polio immunisation rates, only one in ten children aged 12–23 months had been vaccinated against measles (12%). And unlike solid BCG, DPT and polio immunisation coverage in the first years of a child's life, measles vaccination had not improved much in the five years before the DHS.

Birth weight

With most births taking place in a health facility, most babies are weighed at birth (87%). About 11% of children born in the five years prior to the survey had a birth weight of less than 2.5 kg. Factors contributing to children being more likely to have a low birth weight include being their mother's first child, the mother being younger than 20 years old, the mother being a smoker of cigarettes or tobacco, and the mother having no education.

Acute respiratory infections (ARI)

Acute Respiratory Infection (ARI) is a leading cause of child morbidity and mortality worldwide, and early diagnosis and treatment can prevent many of the deaths caused by ARI. The good news for Vanuatu is that the ARI incidence is very low, with only 3% of children under age five having shown symptoms in the two weeks preceding the survey.

Fever

Around one in ten children under five years was reported to have experienced a fever in the two weeks prior to the survey. Children living in urban areas were more likely (15%) to have had fever in the two weeks preceding the survey than children in rural areas (12%). The number of children taken to a health facility or provider to receive treatment for a fever is higher in rural areas (61%) than in urban areas (48%). About 23% of children reported to have had a fever received antibiotic drugs.

Diarrhoea

During the two weeks prior to the survey, around 12% of children in Vanuatu under five years were reported to have had diarrhoea. This rate is a little higher than the incidence recorded in the 2007 DHS for Solomon Islands, Marshall Islands and Tuvalu, and the 2010 DHS survey in Kiribati (around 10%). The incidence of diarrhoea with blood was very low, affecting only 1% of 1,517 children.

The highest incidence of diarrhoea was amongst children between 6 and 11 months (15.6%) and between 12 and 23 months (15.5%), with young boys slightly more affected than girls. Forty-four per cent of the children with diarrhoea were taken to a health care provider and most were treated with oral

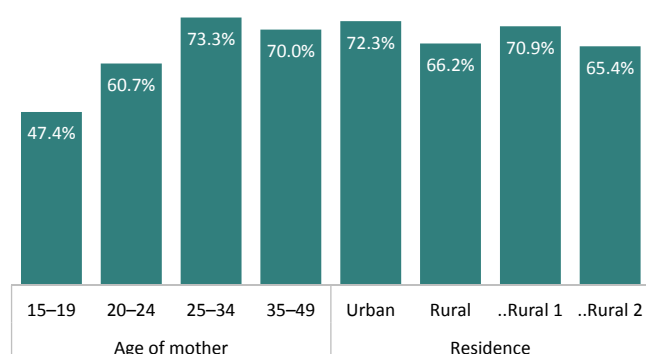


rehydration salts (ORS), or a mix of ORS and recommended home fluids.

Oral rehydration salts

There is common knowledge of ORS packets in Vanuatu and 68% of women who gave birth in the five years preceding the survey know about them. A woman is more likely to know about ORS as she gets older, with only just under half of all women aged 15–19 years knowing about them, compared with 70% of women aged 35–49 years (Fig. 3).

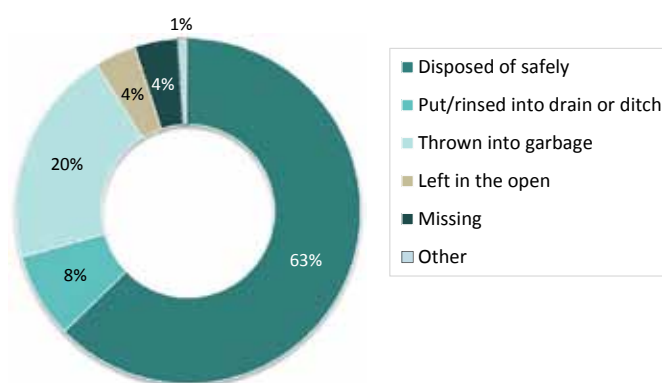
Figure 3: Percentage of women who know about ORS packets or pre-packaged liquids



Disposal of excreta

Proper disposal of human faeces is extremely important in preventing diseases from spreading. Sixty-three per cent of children’s stools are disposed of hygienically in Vanuatu. Most frequently, stools are thrown directly into the garbage, rinsed in a ditch or drain or left out in the open. As a child gets older, it is far more likely that their stools will be disposed of safely (35% for children aged less than six months, compared with 88% for children aged 48–59 months). Children living in the poorest households are more likely (74%) to have their stools disposed of safely than those living in the wealthiest households (39%) – perhaps a reflection of a greater use of disposable nappies amongst the latter.

Figure 4: Disposal of children’s stools



Policy note

As in many other Pacific countries where Demographic and Health Surveys have been carried out, the vaccination rate for measles is lower than the other basic vaccinations. Further information needs to be sought about why so few babies are being vaccinated against measles in the first 12 months of their life.

With diarrhoea incidence markedly higher than in many other Pacific Island countries where DHS have been carried out, having affected 12% of children in the reference period prior to the survey, and rehydration knowledge as high as 68%, more attention might be given to younger mothers, with only just under half of all 15–19 years old, and 60% of 20–24 years old able to report correct knowledge of using ORS packets and how to reduce the incidence of diarrhoea.

There could also be some stepped-up public health guidance on the hygienic disposal of nappies, particularly in densely populated urban areas, where the use of disposable nappies is higher than in rural areas.

*For more detailed information on child health see chapter 10 in the 2013 Vanuatu DHS report.

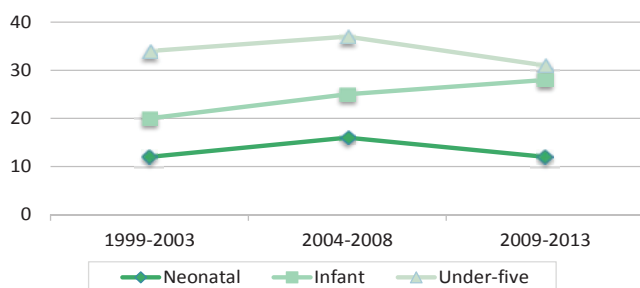


Infant and child mortality data are important not only for demographic assessment but also for design and evaluation of health programmes and policies. Primary and preventive health services target improving the quality of life for Ni-Vanuatu people; this includes the reduction of infant and childhood mortality and the incidence of high-risk pregnancies.

Neonatal mortality	The probability of dying within the first month of life (12/1000)
Post-neonatal mortality	The probability of dying between 2–12 months (16/1000)
Infant mortality	The probability of dying before the first birthday (28/1000)
Child mortality	The probability of dying between age 1 and before the fifth birthday (3/1000)
Under-five mortality	The probability of dying before the fifth birthday (31/1000)

For the five years preceding the 2013 Vanuatu DHS, the estimated infant mortality rate was 28 deaths per 1000 live births (Fig. 1). This means, about three of every 100 children born in Vanuatu died prior to their first birthday. Of those who survived until their first birthday during this period, three of 100 died before reaching their fifth birthday. This results in an estimated under-five mortality rate of 31 deaths per 1000 live births.

Figure 1: Childhood mortality trends



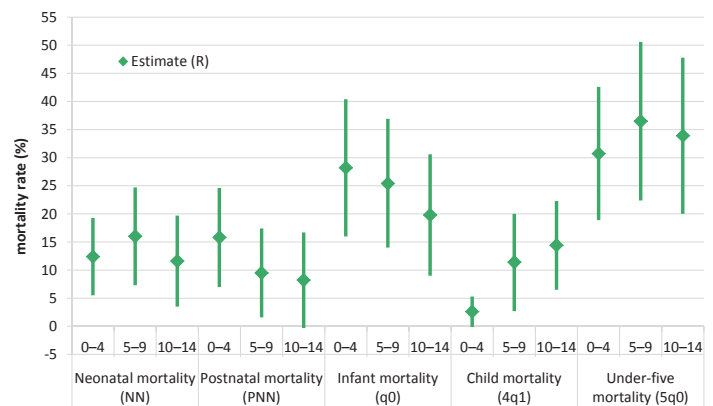
While under-five mortality has remained quite stable over the past fifteen years (34/1000 → 31/1000), this 'stability' is the result of two opposing developments: an increase in infant mortality (20/1000 → 28/1000), and a marked decrease (14/1000 → 3/1000) in child mortality.

Notwithstanding these trends, these various mortality indicators need to be interpreted in connection with their standard errors, to ascertain the probability of these trends reflecting a true development. Figure 2 shows that, apart from improved child mortality, all other values lie in overlapping confidence intervals. This means that the true mortality value of each period could be located anywhere in the confidence interval and, as such, the true trend could theoretically be the opposite of what the mortality indicators suggest.

Comparing 2013 DHS estimates with similar statistics derived from the 2009 census shows identical values in child mortality

(3/1000), but a higher infant mortality rate (IMR) (28/1000) compared with the corresponding figure from the census (21/1000). This translates into a slightly higher under-five mortality (31/1000) compared to the 2009 census based estimate of 24/1000.

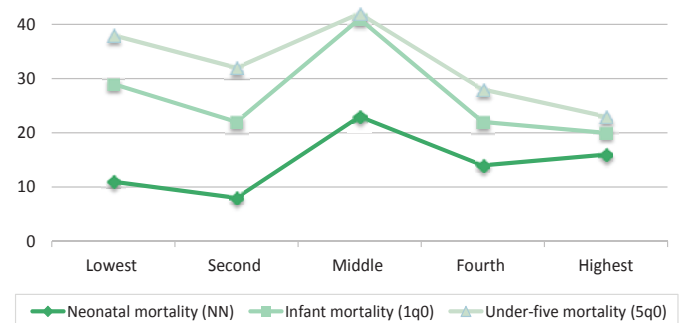
Figure 2: Childhood mortality rates and 95% confidence intervals



Infant and child mortality by socio-economic characteristics

Better health outcomes of children, including child survival, are associated with higher education outcomes of their mothers and their overall socio-economic status. Survey data could not show conclusive evidence of such a relationship regarding the education of mothers in Vanuatu, whereas the household economic status seemed to have more of an impact. Children growing up in households in the highest wealth quintile have lower post neonatal, infant, child and under-five mortality rates than those in the lowest wealth quintiles, with neonatal deaths showing no conclusive evidence for such a pattern (Fig. 3).

Figure 3: Infant and child mortality by wealth quintile



Lower urban than rural post-neonatal, infant, child and under-five mortality rates, with neonatal mortality the only exception to this pattern, reflect the positive impact easier access to better health facilities and services may have on child survival; the same can be said regarding marked differences in socio-economic conditions between urban and rural Vanuatu, as illustrated in the relative distributions of populations across wealth quintiles, illustrating a distinct socio-economic rural-urban divide in Vanuatu. These patterns become even more pronounced when combining the data from



peri-urban villages (Rural 1) and the corresponding urban estimates, particularly in the case of much better post-neonatal and child mortality outcomes in the combined urban areas, relative to rural Vanuatu.

Table 1: Urban-rural variations in infant and child mortality (2003–2012)

Residence Characteristics (Location)	Neonatal mortality (NN)	Post-neonatal mortality (PNN)	Infant mortality (1q0)	Child mortality (4q1)	Under-five mortality (5q0)
RESIDENCE					
Urban	16	9	25	3	28
Rural	13	14	28	8	35
... Rural 1	12	8	20	2	22
... Rural 2	13	15	29	9	37

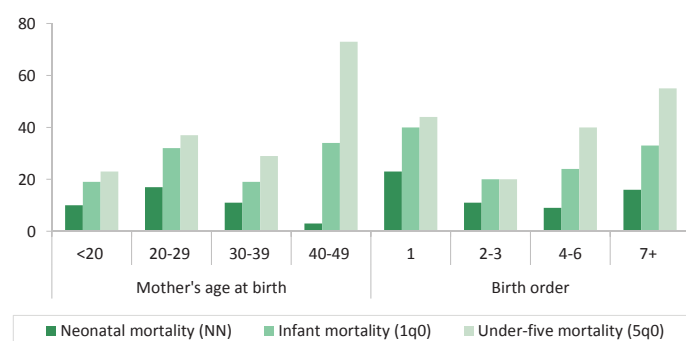
Infant and child mortality by demographic characteristics

Vanuatu 2013 DHS results point to a higher female than male neonatal, infant and under-five mortality. This contrasts with the higher male than female post-neonatal deaths, with no gender differences reported for child mortality (1–4 years old).

An old saying that ‘too early and too late increases child mortality’ applies only in the case of older mothers; while showing the smallest incidence of neonatal mortality, women in their forties are more than twice as likely to lose a child between 28 days and the child’s fifth birthday than women in any other age-group (Fig. 4).

Similarly, short birth intervals (< 2 years) generally have a negative impact on a child’s chances of survival. This holds true for Vanuatu, particularly with respect to neonatal, infant and under-five mortality rates. The child mortality rate is highest among children born after a short birth interval (< 24 months after a previous birth).

Figure 4: Early childhood mortality rates by demographic characteristics

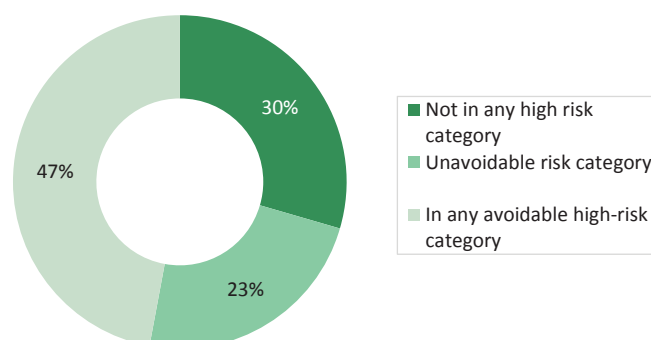


High-risk fertility behaviour

Generally, infants and children have a greater probability of dying if they are born to mothers who are over 34 years old or under 18 years old, born after a short birth interval (< 24 months after a previous birth) or of high birth order (i.e. the

mother has previously given birth to three or more children). Vanuatu 2013 DHS data show that about 30% of births were not in any high-risk category; an additional 23% of births were first-order births to mothers aged 18–34, which is considered an unavoidable risk category, whereas 47% are in at least one of the specified avoidable high-risk categories.

Figure 5: High-risk births



Policy note

With overall under-five mortality having remained relatively stable over the past ten years (modest change from 34/1000 → 31/1000), the only truly significant change occurred in child mortality, improving from 14 deaths per 1000 live births to just three since the period 1999–2003. This positive development is counter-balanced by an increase in infant mortality (20/1000 → 28/1000) during the same period. Although not statistically significant, any reversal in past achievement in child survival should alert Vanuatu health authorities, as this increase in IMR is largely the result of post-neonatal mortality doubling (8/1000 → 16/1000), whereas neonatal mortality remained constant over this period.

The results also indicate that high levels of infant and under-five mortality are more common among children with mother’s having low levels of education and living in the lowest wealth households. Furthermore, about half of all births are associated with at least one avoidable high-risk category. Specific health policy and associated public awareness and prevention programmes targeting specific population groups might be considered in stepped up Maternal and Child Health (MCH) activities and the overall health development plan.

*For more detailed information on infant and child mortality, see chapter 8 in the 2013 Vanuatu DHS report.



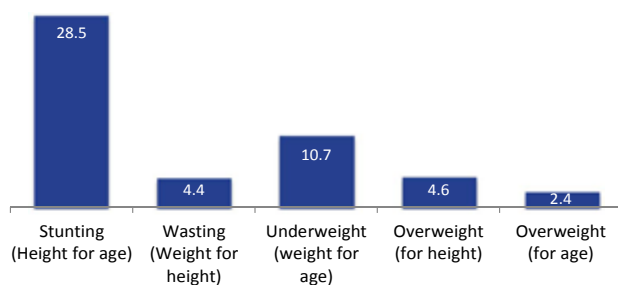
Adequate nutrition is essential to good health. Poor nutrition can affect productivity, and places an extra burden on health systems as a result of non-communicable diseases. Concerns about the type of food that is generally being consumed in a country relate not only to people not eating enough, but also to the amount of sugary and high-fat foods consumed. Overconsumption of these foods can result in a diet that is high in energy but lacking in essential nutrients.

Nutritional status of children

Poor nutrition among children is associated with maternal malnutrition, low birth-weight, inadequate breast-feeding and weaning diets, and morbidity related to high levels of infectious diseases. Improving children's diets can reduce the severity of childhood illnesses and reduce the risk of death.

The 2013 Vanuatu DHS shows that of all children younger than five years of age, 28.5% are underweight relative to height for age, 10.7% are underweight relative to weight for age, and 4.4% relative to weight for height (Fig. 1). This illustrates that the prevalence of stunting among children under five years of age is high, relative to World Health Organization (WHO) guidelines. The prevalence of stunted, wasted and underweight children was considerably higher in rural than urban areas, with the reverse applying to being overweight. Having said this, the overall prevalence of wasting, underweight for height and overweight for age is of low public health significance, according to the WHO guideline.

Figure 1: Nutritional status of children under age five



Micronutrient intake by children

Vitamin and mineral deficiencies are consequences of malnutrition. Overall, 88% of children were reported to have consumed foods that are rich in vitamin A, and nearly seven out of ten children had consumed food rich in iron in the 24 hours preceding the survey.

About 25% of children had received vitamin A supplements during the six months prior to the survey, and 50% of children had been given de-worming medication during the same period; most commonly this medication is administered to children aged between 18 and 59 months.

Foods consumed by mothers

The type of food a mother eats has a significant impact not

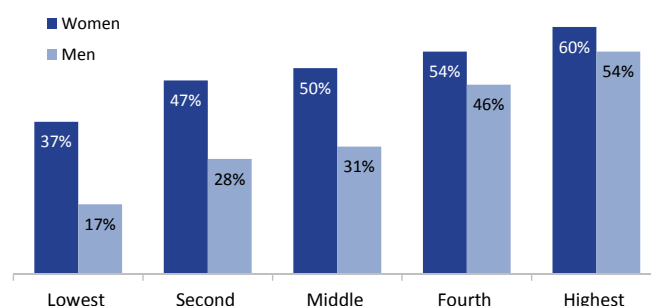
only on her own health, but also on the health of her children. A healthy, varied and low-fat diet is especially important to women who are pregnant and breast-feeding.

Most women with children under three years of age reported eating vitamin A-rich foods (90%), high protein foods (76%), root crops (76%) and grains (76%). Just over half of all women (53%) reported consuming high-fat foods, with 45% reporting eating sugary food. Consumption of high-fat food was as pronounced in urban as in rural Vanuatu, with no marked variations across wealth quintiles; intake of sugary food, however, was marginally higher in towns (52%) than in rural Vanuatu (42%), and highest among women in the highest wealth quintile (60%), compared to values in the low 40s for the other four wealth quintiles.

Nutritional status of mothers

With malnutrition not representing a major health issue affecting adults in Vanuatu (3% of women and less than 3% of men), obesity and being overweight should be of greater concern to the Vanuatu Ministry of Health. About 50% of women aged 15–49 years (and 40% of men aged 15 years and over) were reported to be obese and overweight, and both these conditions were more pronounced among people in the highest wealth quintile. Women and men residing in urban areas were also more likely to be obese and overweight than people living in rural areas (Fig. 2).

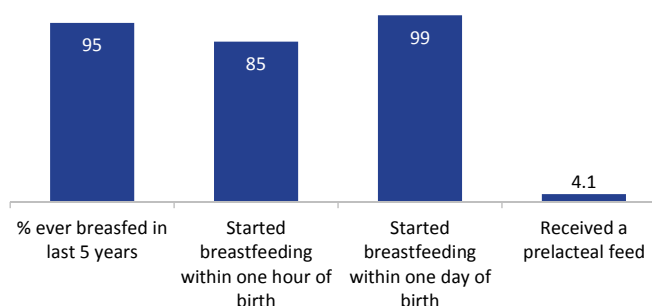
Fig.2: Proportion of overweight and obese adults



Infant and young children feeding practices (IYCF)

Almost all (95%) children born in Vanuatu in the five years preceding the survey were breast-fed at some time, with 99% receiving their first breast-feed within one day after birth (Fig. 3).

Figure 3: Breast-feeding practices





Although WHO and United Nations Children's Fund (UNICEF) recommend exclusive breastfeeding, the survey results show that plain water, other liquids and complementary foods are being introduced to some babies less than six months of age in Vanuatu.

The mean duration of breast-feeding among Vanuatu children born in the three years preceding the survey is 18.7 months. The mean duration of exclusive breast-feeding is 4.3 months, and 5 months for predominant breast-feeding.

Regarding frequency of feeds, survey results show that babies are being breast-fed at frequencies in line with the WHO and UNICEF recommendations. The mean number of feeds during the night and day is 10.2.

Young ni-Vanuatu children tend to have a diet that is high in vitamin A, grains and root vegetables, with fruits and vegetables being the most common food consumed by breast-feeding children (82%) and non-breast-feeding children (90%). However, the survey results show that non-breast-fed children are more likely to eat sugary foods (45%) and foods made with oil, fat and butter (50%), than breast-fed children (36% and 39% respectively).

The Global Strategy on Infant and Child Feeding recommends that breast-fed children aged 6–23 months receive foods from at least three specified food groups per day. This recommendation rises to four specified food groups for children who are not breast-fed. The Vanuatu DHS survey shows that only 29% of children aged 6–23 months are fed according to recommended IYCF feeding practices. This low percentage is usually due to children not being fed as frequently as required, contributing to two-thirds of children not being fed the recommended dietary requirements for good health.

Anaemia

Young children who are growing rapidly have the highest iron requirements, and thus are at highest risk for iron deficiency anaemia. Survey results show one in four children (27%) aged 6–59 months having a form of anaemia: 19% have mild anaemia, 8% have moderate anaemia and less than 1%, severe anaemia. The prevalence of anaemia does not differ much by sex, but it is higher in urban than in rural areas. Surprisingly, the prevalence of anaemia increases with mother's educational level and wealth quintile.

Policy note

The survey highlights several malnutrition issues amongst children under five and adults, which, if unattended, have the potential to turn into serious health challenges.

The data illustrate the prevalence of malnutrition among children under five years of age (28.5% stunting, 10.7% underweight and 4.4% wasting) as a result of poor nutrition among this young population. In terms of health policy, parents may need to be better informed about the importance of nutritious food for their children's physical and intellectual development.

Data also show that plain water, other liquids and complementary foods were being introduced to children under six months old, which is against WHO and UNICEF recommendations on exclusive breast-feeding. This is an area where significant positive health outcomes could be achieved, with Vanuatu health authorities stepping up their efforts to promote longer and exclusive breast-feeding, and undertaking a policy review to encourage and facilitate breast-feeding for working mothers at the workplace.

Amongst adults, malnutrition manifests itself in the form of being overweight and affects nearly half of women, particularly mothers with children under three years of age. Although most women reported eating vitamin A-rich foods (90%), high protein foods (76%), root crops (76%) and grains (76%), just over half (53%) reported consuming high-fat foods, with 45% reporting eating sugary food. Vanuatu health authorities are invited to take note of the reported figures on being overweight and obesity in the context of its NCD policy and programmes.

*For more detailed information on nutrition see chapter 11 in the 2013 Vanuatu DHS report.



Employment can act as a source of empowerment for both men and women. This is particularly important for women's empowerment, as employment gives them some control over their income.

Regarding the type of work undertaken by men and women, the 2013 Vanuatu DHS survey showed no differences, with near equal proportions of men and women undertaking paid and unpaid work, and work for cash and in-kind, and for in-kind remuneration only (Fig. 1).

Figure 1: Type of earnings of currently married respondents aged 15-49 employed in the past 12 months



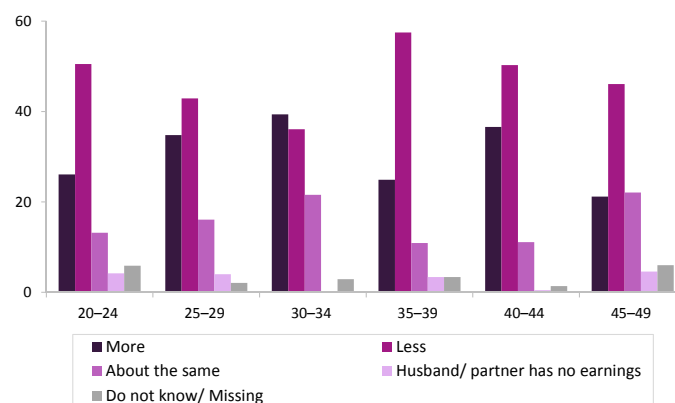
Regarding decision-making on how their respective incomes are spent, Table 1 shows that most married women (50%) and men (61%) refer to joint decision-making. One in four women (26%) report they are the principal decision-maker on how their own income is spent, whereas one in five claims her husband makes that decision. With a near equal proportion of men reporting they make the decision on how their own income is spent (23%), only one in ten (12%) refers to his wife as making that decision. Women and men tend to be largely in agreement on how men's salary is spent, except perhaps for a marginally larger proportion of women (29%) than men (23%) crediting men with making these decisions.

Table 1: Decision-making about women's and men's income (%)

WOMEN's INCOME		MEN's INCOME		MEN's INCOME	
WOMEN reporting		WOMEN reporting		MEN reporting	
Wife	26.2	Wife	12.1	Wife	12.1
Joint	50.3	Joint	57.3	Joint	61.2
Husband	21.1	Husband	29.3	Husband	23
Missing	2.4	Missing	1.3	Missing	3.7

Women earn less than their husbands or partners in most age groups except in the 30-34 years age group. The proportion of women who earn less than their husbands or partners is significantly lower in three age groups: 20-24, 35-39 and 45-49 years (Fig. 2).

Figure 2: Women's earnings compared with those of their husbands or partners



Participation in household decision-making

Women were asked about their participation (i.e. having the final say either jointly or solely) in decisions on both major and minor household purchases, their own health care and visits to their family or relatives (Table 2).

Table 2: Participation in household decision-making

Questions asked of men and women about key decision-making issues	WOMEN reporting			MEN reporting		
	Mainly wife	Joint wife/husband	Mainly husband	Mainly wife	Joint wife/husband	Mainly husband
Major Household purchases	13.6	58.7	26.2	4.9	75.8	19.2
Purchases of daily household needs	17.8	57.9	22.8	25.1	64.4	9.3
Visits to wife's family or relatives	13.6	63.2	21.8	5.3	80.6	13

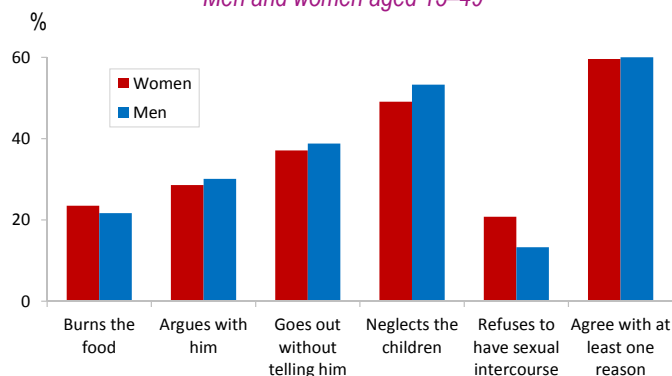
In Vanuatu, the majority of men and women tend to make household decisions together across the three standard DHS household scenarios. Having said this, some interesting contrasts do emerge; a greater proportion of men than women make reference to joint decisions across all three scenarios, and both male and female respondents report more men than women making more decisions by themselves, except in the purchase of daily household needs.



Attitudes towards violence against women

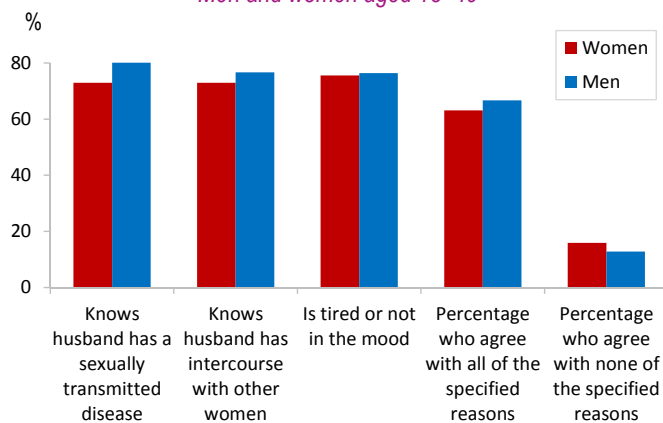
Regarding both male and female attitudes towards violence against women, a worrying picture emerges from the survey, indicating that the majority of women (59.6%) and men (60.2%) aged 15–49 years think that wife beating is justified in certain circumstances (Fig. 3).

Figure 3: Justification of violence against women
Men and women aged 15–49



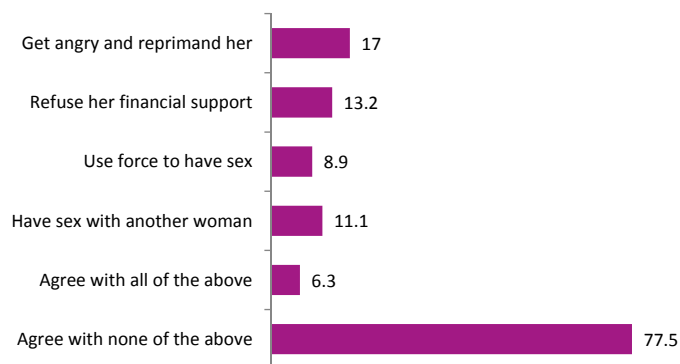
Referring to standard DHS survey scenarios, the majority of ni-Vanuatu men and women accept the fact that women are justified in refusing to have sex with their husbands or partners. Women who currently are or have been married or divorced, and /or have children, with higher education and are employed, are most likely to accept that a woman can refuse sex with her husband (Fig. 4).

Figure 4: Attitude toward women's right to refuse sex with her husband,
Men and women aged 15–49



Responding to a final DHS scenario, of what men might consider appropriate responses to wives refusing to have sex with their husbands, the vast majority of men did not agree with the sentiment of the four scenarios. One in ten men, however, thought 'refusing her financial support' (13%) or 'having sex with another women' (11%) were acceptable responses (Fig. 5).

Figure 5: Men's attitude towards a husband's right to certain behaviour when his wife refuses sex



Policy note

With most men and women reporting they make household decisions together, a greater proportion of males than females made reference to joint decision-making across three standard DHS scenarios, whereas more women credit their husbands rather than themselves with main decision-making.

The vast majority of women and men aged 15–49 years think that wife-beating is justified in certain circumstances, pointing to a high level of community acceptance of this behaviour. Given the severe impact on women's health, overall well-being, and empowerment, as well as sending the wrong message to young boys and girls, these findings should be of great concern to the government and communities at large.

*For more detailed information on women's empowerment, see chapter 15 in the 2013 Vanuatu DHS report.



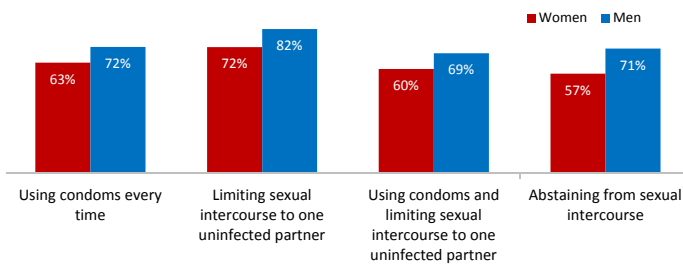
Human Immunodeficiency Virus (HIV) is a virus that causes Acquired Immune Deficiency Syndrome (AIDS) and weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that lead to death through these secondary infections.

The predominant mode of HIV transmission is through heterosexual sexual contact, followed in magnitude by perinatal transmission, where the mother passes the virus to the child during pregnancy, delivery or breastfeeding. Other modes of transmission are through homosexual contact, infected blood and unsafe injections.

Vanuatu has a low reported HIV prevalence with 9 people having been diagnosed with HIV as of the end of 2012. Of those people, six remain living in Vanuatu.

2013 Vanuatu DHS data show that about the same proportion of women (91%) and men (92%) have heard of AIDS, but knowledge of how to prevent HIV infection was less pronounced across different answer categories: these range from 57% of females referring to “abstaining from sexual intercourse”, to 82% of males making reference to “limiting sexual intercourse to one uninfected partner” (Fig. 1). Young people display a similar level of knowledge about how to prevent HIV.

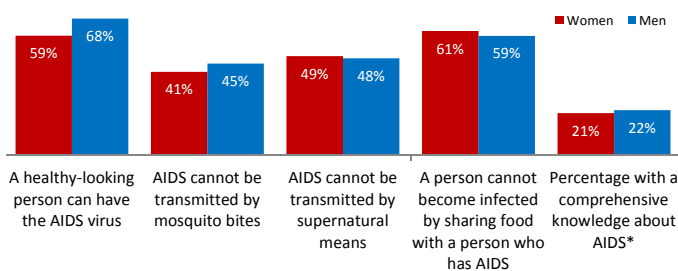
Figure 1: Knowledge of HIV and AIDS prevention methods, Men and Women aged 15–49



Percentage of respondents who correctly answered that each method could reduce their chances of getting AIDS.

Despite most people reporting some knowledge about HIV and AIDS, only one in five people (21% of women and 22% of men) had a comprehensive knowledge about AIDS. The survey reveals prevailing misperceptions about the transmission of HIV and acquiring AIDS, with less than half of all men and women knowing that AIDS could not be transmitted through mosquito bites or supernatural means (Fig. 2).

Figure 2: Rejection of misconceptions about HIV transmission, and comprehensive knowledge, Men and Women aged 15–49



* Comprehensive knowledge means knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention - mosquito bites and sharing food.

Comprehensive knowledge of AIDS was lowest amongst the youth population, at just 18% of women and 19% of men aged 15–24 years.

Stigma and attitudes associated with HIV and AIDS

Survey results indicate a strong stigma and negative attitudes towards people living with HIV. Only 10% of women and 19% of men aged 15–49 expressed overall tolerance and acceptance of people living with HIV. Although many people would be willing to care for a family member with HIV at home (63% of women and 75% of men), one in three people did not think a female teacher with HIV should be allowed to keep teaching (30% of women and 34% of men).

Knowing where to obtain HIV test

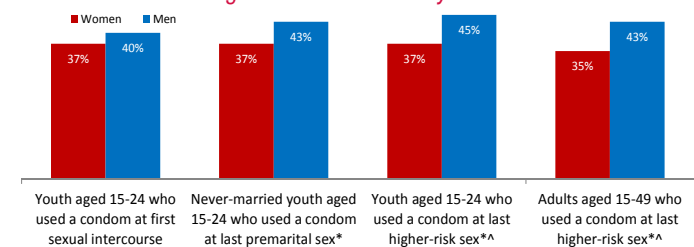
About two-thirds of women and three quarters of men knew where to obtain an HIV test. The incidence of people knowing where to get an HIV test increased with level of education, and urban respondents also were more likely to know where to obtain HIV test compared to rural respondents.

Multiple partners and condom use

Among adults aged 15–49, ni-Vanuatu men reported to have had on average 5 sexual partners in their lifetime compared to women’s reference to 2 partners over their lifetime. Such a male-female difference is also reflected among those who had sexual intercourse during the 12 months prior to the survey, with three times more men (7%) than women (2%) reporting to have had 2 or more sexual partners. Of this group, 30% men and 13% women had high-risk sexual intercourse. Although the actual numbers are small, it is important to note that amongst these men and women, less than half had used condoms (35% women and 43% men) (Fig. 3).

The incidence of high-risk sex is high among young adults engaging in sex (36% of young women; 72% of young men). Looking at overall low condom use rates amongst those engaged in high-risk sex, clearly puts these young people, especially young men, at greater risk of contracting and transmitting STIs and HIV.

Figure 3: Condom use by sex



* Among respondents who had sex in the previous 12 months.

** Higher risk sex was defined as sexual intercourse with a partner who neither was a spouse nor who lived with the respondent.

Payment for sex

Male respondents aged 15–49 years were asked if they had paid for sexual intercourse during the 12 months preceding the survey, and whether a condom had been used at the time of last paid intercourse. The results show that at the national level, 3% had had paid for sex, with similar figures emerging for never married (4%) and married males (3%). Because the proportion of males reporting to have recently engaged in paid sexual intercourse is quite small, it is difficult to draw meaningful conclusions about the use of condoms.



Sexually transmitted infections (STIs)

The number of people who reported having had an STI was low at about 4% of men and women, with only marginal differences across age-groups and other socio-economic and locational variables, to draw meaningful conclusions.

Table 1: HIV and AIDS prevention among young people

HIV and AIDS knowledge and prevention among young people aged 15–24 years old				
	Women		Men	
	Primary education	Secondary education	Primary education	Secondary education
Has comprehensive knowledge about AIDS	12%	25%	13%	26%
Knows a condom source	58%	74%	80%	89%
Had sex before age 15	8%	5%	7%	8%
Had sex before age 18	52%	34%	58%	53%
Used a condom at first sexual intercourse	29%	47%	32%	52%
Used condom at last sexual intercourse	30%	45%	36%	51%
Used a condom at last higher-risk intercourse	30%	44%	42%	50%

Age at first sexual intercourse (15–24 year olds)

A small proportion of adolescents aged 15–24 had sexual intercourse before age 15 (6% of women and 7% of men), but by age 18, this increased markedly to 41% of women and 53% of men. Ever-married women were more likely to have had sex by age 18 (52%) than never married women (29%). Comparatively, a higher percentage of young women have had sex by age 18 in rural areas (46%) compared to urban women (34%). Women with just a primary level of education were more likely to have had sex before age 15 (8%) and before age 18 (52%) compared to women with a secondary level education (5% before age 15 and 34% before age 18). Less than half of these sexually active young people (37% women and 40% men) used condoms at their first sexual intercourse, with a similar pattern also (37% women and 43%) reported for their last sexual intercourse.

Premarital sex and condom use (15–24 year olds)

The survey results show that of the 96% of unmarried young women who had higher risk sex in the past 12 months, only 38% used a condom compared to 44% of unmarried young men out of the 94% who had higher risk sex. The low condom use rate could be a reflection of young people not knowing where to obtain condoms, or where to obtain them anonymously.

Alcohol consumption and sexual intercourse among youth

The influence of alcohol can impair judgment, compromise power relations and increase risky behaviour. It is worth noting, that only a small percentage of young people (15–24) in Vanuatu reported having had sex when drunk, with less than 1% of young women compared to 5% of young men aged 15–24 reporting to have engaged in such activity. Approximately 6% of young women and 5% of young men reported having had sex when their partner was drunk.

*For more detailed information on HIV/AIDS see chapter 13 in the 2013 Vanuatu DHS report.

Policy note

While most Ni-Vanuatu women and men have heard about HIV and Aids, knowledge about prevention, and safe sex practices do lag somewhat behind, with only one in five women (21%) and men (22%) reporting a comprehensive HIV knowledge. Of particular concern are prevailing misconceptions about transmission, with only 1 in 2 men and women reporting that Aids cannot be transmitted by mosquito bites or supernatural means. Despite many years of HIV/Aids education, such figures suggest that key messages have not been absorbed by half the population, and that continued and more intensive education and health promotion ought to be considered.

The incidence of high-risk sex (36% women and 72% men) is high among young adults (15–24). Together with condom use rates of 36% for women and 45% for men puts those young people, especially the young men at greater risk of contracting and transmitting STIs and HIV. As indicated above, stepped-up efforts to advocate STI prevention methods ought to be considered, with a particular focus on young people.

With higher rates of condom usage at last higher-risk intercourse among young men (45%) than young women (36%), usage shows distinct variations which ought to be considered when devising stepped-up health education and advocacy measures:

- a higher proportion of women in urban areas (43%) used a condom at last higher-risk sex compared to women in rural areas (32%), with similar contrasts also prevailing amongst urban (50%) and rural (40%) males.
- Similar differences emerge when considering levels of education attainment: only 30% of women and 42% of men with a primary level education used a condom at last higher-risk sex, compared to 44% of women and 50% of men with a secondary level education. While providing a basis for more targeted health education initiatives, the key challenge is that condom use still remains below 50%, which ought to call for a greater sense of policy urgency to address this situation.



Malaria represents a major public health concern in Vanuatu, especially among those who are particularly vulnerable, such as pregnant women and children under five years of age. It is a leading cause of morbidity in Vanuatu, and places a heavy burden on the country in both social and economic terms, ranging from school absenteeism to low productivity. Most parts of the country report transmission throughout the year, although it increases during and soon after the rainy season.

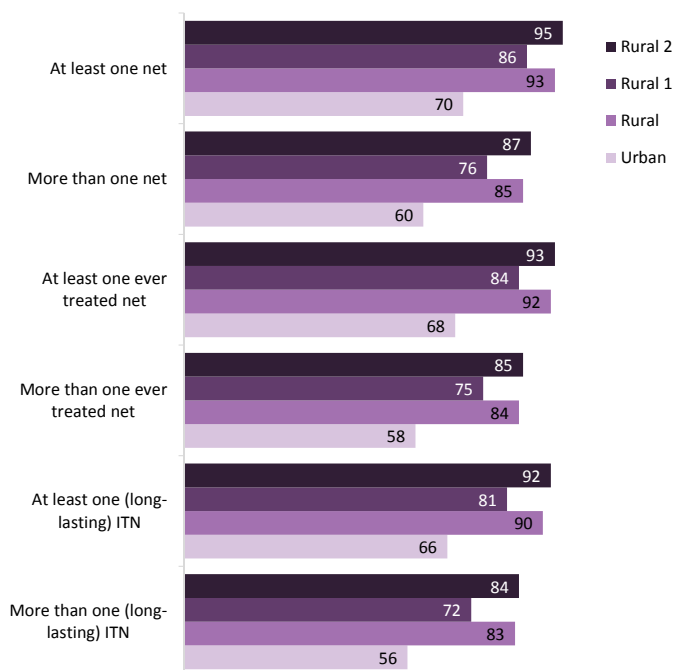
Mosquito nets

The use of long-lasting insecticide-treated mosquito nets (ITNs) is a key component of the Vanuatu Government's primary health care program, which is committed to controlling and preventing malaria. An ITN kills and repels mosquitoes with greater effectiveness than a net that has never been treated; however, a net that was treated within the last 12 months or was treated with a long-lasting insecticide is the most effective.

Ownership of mosquito nets

Ownership of ITNs is slightly lower (83%), compared to 'ever treated nets' (85%) or 'nets of any kind' (87%); ownership is highest in Rural-2 (92%), with only two out of three urban households (66%) having access to at least one ITN (Fig. 1). Ownership of ITNs is higher amongst households in the lowest wealth quintiles (93%) and lowest in the highest quintile (61%), and rural households have a higher number of ITNs per household (three) than urban households (two).

Figure 1: Household ownership of mosquito nets (%) by region

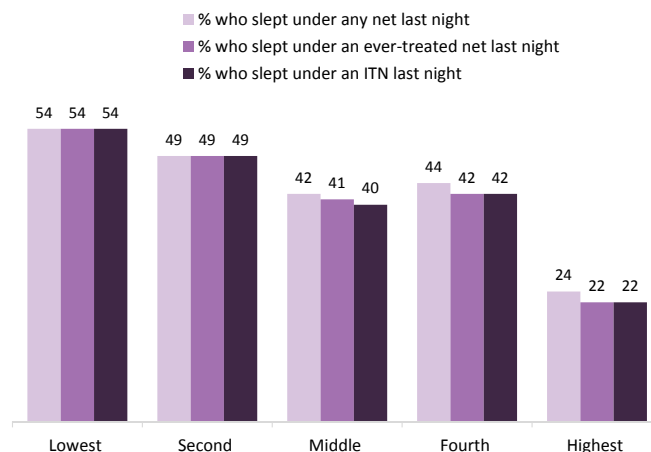


Use of mosquito nets

On the night before the survey, 53% of all children under five years of age slept under a mosquito net (51% slept under an ITN net), with net-use of any kind more than twice as high in

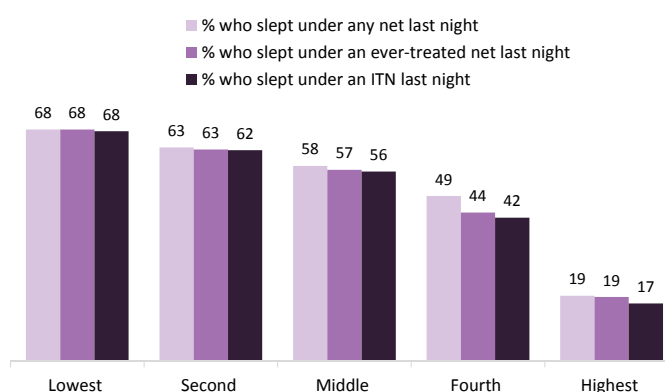
rural Vanuatu (62%) than in the more densely populated urban areas (29%). The corresponding coverage for ITN use was 61% for rural and 26% for urban Vanuatu. A similar contrast emerges across wealth quintiles, with net-use by children in the lowest wealth quintile more than three times higher (68%) than that by children in the highest wealth quintile (19%) (Fig. 2). Not much variability occurs between different age groups.

Figure 2: Use of mosquito nets by children by wealth quintiles



Only 42% of pregnant women slept under a mosquito net, with 41% using an ITN (Fig. 3). Pregnant women living in urban areas (28%) and in households in the highest wealth quintile (22%) were less likely to sleep under an ITN the night before the survey, compared to pregnant rural women (48%), and pregnant women in the lowest wealth quintile (54%).

Figure 3: Use of mosquito nets by pregnant women by wealth quintile



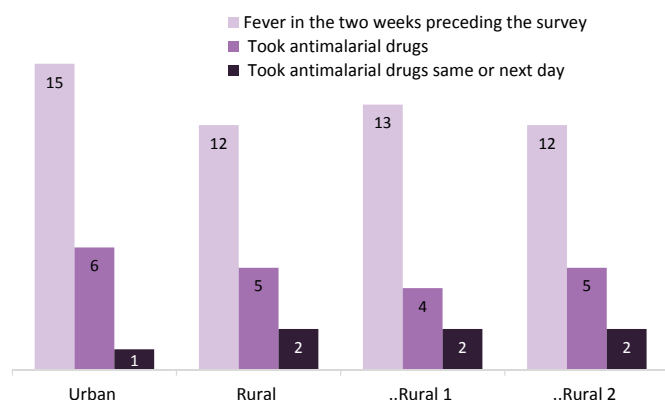
Treatment of children with fever

During the two weeks preceding the survey, 13% of children under five years old had a fever, with only a marginal difference emerging between urban (15%) and rural (12%) Vanuatu (Fig. 4). With access to anti-malarial drugs very low, provided to only 5% of children who had experienced a fever, there is no difference in the availability of, or access to such drugs between urban (6%) and rural (5%) Vanuatu; and the number of children having had access to these drugs the same



day or the day after their fever started is equally low in urban (1%) and rural (2%) Vanuatu. The small number of overall cases (N=10) prevents any meaningful further disaggregation.

Figure 4: Prevalence and prompt treatment of fever



Policy note

Malaria remains a leading cause of morbidity in Vanuatu, with bed nets, particularly long-lasting insecticide-treated nets (ITNs) representing a proven and cost-effective way of preventing malaria. While continued distribution of ITNs and perhaps a re-treatment programme remain important components of Vanuatu's vector-borne diseases control programme, notable discrepancies in the use of bed nets between urban and rural areas and between different population groups, as well as a far from universal uptake by particular population groups at risk (young children and pregnant women), highlight the importance of complementing primary health care measures with stepped-up efforts in comprehensive community education and awareness programmes.

Survey findings highlight some key areas of possible policy attention:

- Improve bed-net use amongst vulnerable populations, such as infants and pregnant women. Universal coverage may be more aspirational than realistic, but current rates of people sleeping under an ITN – 54% of children under one year old and 41% of pregnant women – put one out of two infants and 60% of future mothers at unnecessary risk.
- Improve bed-net use among urban populations. While policy attention and service coverage often favours urban populations over their rural counterparts, survey results point to substantially lower numbers of urban infants (26%) and pregnant women (28%) who receive protection from ITN bed nets, compared to 61% of rural infants and 47% of pregnant women. This highlights the importance of stepped-up primary health care measures in urban Vanuatu, particularly in high-density neighbourhoods, including informal urban settlements.
- Consider improving treatment rates for children with fever, from a current low 5% access to drugs, and 2% access to drugs the same day or day after a fever started.

*For more detailed information on malaria see chapter 12 in the 2013 Vanuatu DHS report.





Article 32 of the Convention on the Rights of the Child says: 'States parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development'. The 2013 Vanuatu DHS survey included several questions pertaining to child labour, which is defined as 5–14 year-old children being engaged in various forms of paid or unpaid labour activities. A child is considered to be involved in child labour if, during the week preceding the survey, it undertook the following activities:

- ▶ was involved in at least one hour of economic work or 28 hours of domestic work (children aged 5–11 years)
- ▶ was involved in at least 14 hours of economic work or 28 hours of domestic work (children aged 12–14 years).

A note of caution is advisable when describing different child labour activities, given the substantial contrast in working hours of economic work undertaken by children of different ages.

Child labour

Survey results show that one in every five children aged 5–11 years falls into the category of child labour, having undertaken at least one hour of paid or unpaid economic activity or 28 hours of household activities (Fig. 1). The report also highlights that there are a few differences between young boys (20%) and girls (22%), with near equal proportions of boys and girls undertaking household chores below (73.9%) and above (0.3%) 28 hours per week (Table 16.1). The lack of gender disparities is not surprising, as regular help at home is part and parcel of growing up in Vanuatu: helping out around the house and garden, fetching water or collecting firewood, and looking after younger siblings while parents work in the food gardens

or plantations. Only a very small proportion of these young children were engaged in paid work – 2.3% in urban Vanuatu, and 3.4% in rural areas.

Looking at the situation of 12–14 year old children, a similar pattern emerges across most work activities highlighted above, except for the fact that less than one per cent of children was engaged in child labour, that is, was involved in at least 14 hours of economic work, or 28 hours of domestic work. As stated above, this contrast is a reflection of a longer reference time for "hours worked" for 12–14 year old children (14 hours versus 1 hour), as illustrated in the sizeable proportion of these children (26.3%), who worked between 1 and 14 hours.

Child discipline

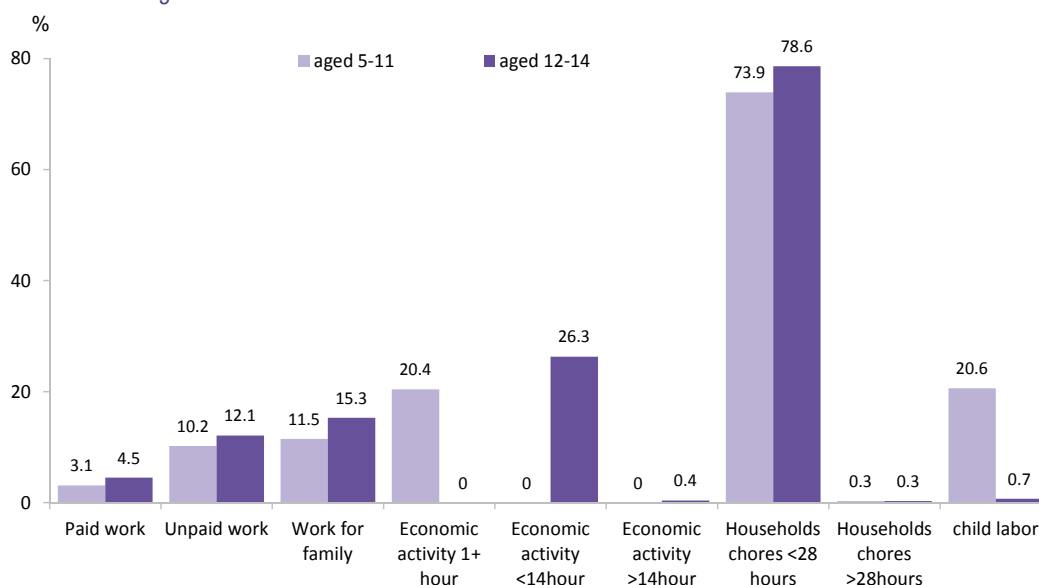
The UN Millennium Declaration calls for the protection of children against any acts of violence, abuse and exploitation. In the 2013 DHS, mothers/caretakers of children aged 2–14 years were asked a series of questions on the ways parents discipline their children when they misbehave. From these questions, two child discipline indicators are derived:

1. Proportion of children aged 2–14 years who experience either psychological aggression as punishment, or minor or severe physical punishment;
2. Proportion of parents/caretakers of children 2–14 years old, who believe that in order to 'raise their children properly', they need to physically punish them.

For the child discipline module, one child aged 2–14 years per household was selected randomly during fieldwork.

In Vanuatu, the majority (84%) of children aged 2–14 were subjected to some form of forceful child discipline (Fig. 2). More than 70% were subjected to at least one form of psychological

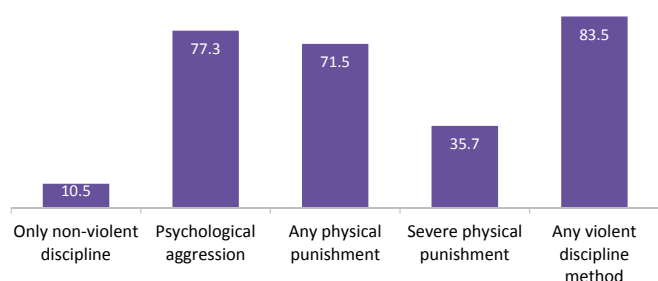
Figure 1: Household children aged 5–14 involved in child labour and other activities





or physical punishment by their mothers/caretakers or other household members, with one in three children (36%) subjected to severe physical punishment, and one in ten children exposed to non-physical punishment. Apart from a slightly higher proportion of young boys (38%) being subject to severe physical punishment than young girls (34%), being exposed to forceful or violent disciplining does not discriminate between boys (83.3%) and girls (83.6%). Prevalent across Vanuatu society, there appear no real differences between socio-economic groupings (wealth quintiles), ranging from a 'low' 80% amongst the poorest wealth quintile to 86% in the middle quintile. And there are also only marginal differences between rural and urban Vanuatu, with a slightly higher incidence of physical aggression (78% vs 74%) and severe physical punishment (37% vs 32%) in rural Vanuatu..

Figure 2: Percentage of children aged 2–14 years exposed to different types of punishment



Policy note

The survey showed that one in five children aged 5-11 were undertaking child labour activities during the two-week survey reference period. While most of these activities related to undertaking household chores and other forms of unpaid work, a small number of children (3%) reportedly undertook some form of paid work, which could impact on their health, education and general development.

Although representing only a small proportion, it could be argued that 3 percent is still too many, given Vanuatu's ratification of the Convention of the Rights of Children (CRC), with Article 19 quite explicit that "governments should protect children from work that is dangerous or that might harm their health or education".

The Convention of the Rights of Children is equally explicit on governments ensuring that "children are properly cared for and protected them from violence, abuse and neglect by their parents, or anyone else who looks after them" (Article 32). Given the rather high prevalence of forceful or violent disciplining, including physical punishment young ni-Vanuatu children are exposed to by their parents or caretakers, Vanuatu authorities associated with justice and community services might wish to have a close look at these statistics, which are incompatible with the spirit of the Vanuatu's support of the CRC.

*For more detailed information on child labour and discipline see chapter 16 in the 2013 Vanuatu DHS report.