

Solomon Islands

Demographic and Health Survey

2006-2007

by
the Solomon Islands National Statistics Office,
the Secretariat of the Pacific Community,
and Macro International Inc.

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PREFACE

The 2006/2007 Solomon Islands Demographic and Health Survey (2006/2007 SIDHS) was one of four pilot demographic and health surveys conducted in the Pacific under an Asian Development Bank ADB/ Secretariat of the Pacific Community (SPC) Regional DHS Pilot Project. The primary objective of this survey was to provide up-to-date information for policy-makers, planners, researchers and programme managers, for use in planning, implementing, monitoring and evaluating population and health programmes within the country. The survey was intended to provide key estimates of Nauru's demographics and health situation.

The findings of the 2006/2007 SIDHS are very important in measuring the achievements of family planning and other health programmes. To ensure better understanding and use of these data, the results of this survey should be widely disseminated at different planning levels. Different dissemination techniques will be used to reach different segments of society.

The Solomon Islands National Statistics Office would like to acknowledge the efforts of a number of organisations and individuals who contributed immensely to the success of the survey. Representatives of the Ministry of Health were members of the Steering Committee, which offered guidance on the implementation of the survey. The list of those involved in the 2006-2007 SIDHS appears in Appendix D.

Financial assistance was provided by ADB, UNFPA, UNICEF, and AusAID. Macro International Inc. and SPC are greatly appreciated for having offered important critical technical support.

We are grateful for the efforts of officials at international and local government levels who supported the survey. And finally, we are highly appreciative of all the field staff for their outstanding contributions reflected herein and, equally so, the respondents whose participation play a crucial role to the overall successful completion of this survey.

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ACKNOWLEDGEMENTS

The 2006/2007 Solomon Islands Demographic and Health Survey (2007 SIDHS) was one of four pilot DHSs in the Pacific under the ADB/SPC Regional DHS Pilot Project. The primary objective of the survey was to provide up-to-date information for policy-makers, planners, researchers and program managers to use in the planning, implementation, monitoring and evaluation of population and health programs in the country. The survey was intended to provide key estimates of the demographics and health of the country. In addition, the content of the survey was expanded to include questions on disability and gender-related violence.

The findings of the 2007 SIDHS are very important for measuring the achievements of family planning and other health programs. To ensure better understanding and use of these data, the results of the survey should be widely disseminated at different planning levels. Different dissemination techniques will be used to reach different segments of society.

The 2007 SIDHS is the result of an earnest effort put forth by different individuals and organizations. Conducted under the ADB/SPC Regional DHS Pilot Project, with technical assistance provided by Macro International Inc. and SPC, the survey was implemented by SISO. We acknowledge with much gratitude the generous financial support provided by the Asian Development Bank (ADB) and the Australian International Assistance Bureau, enabling the Solomon Islands National Statistics Office (SINSO) to undertake this survey, and we are particularly thankful to the Ministry of Health staff who offered guidance on the implementation of the survey from planning right through the preparation of this report.

SINSO would like to acknowledge the efforts of a number of organisations and technical experts in different fields of population and health for their valuable input into the various phases of this survey, including finalisation of survey questionnaires, training of field staff, assistance with data processing, reviewing of draft tables, and compiling this comprehensive report. We extend our deep appreciation to Macro International Inc and the Secretariat of the Pacific Community for their excellent technical support. We thank Dr Elizabeth Go, DHS Consultant, and Mr Han Raggars, Macro Data processing specialist for their efforts. We are equally appreciative of the support provided by SPC's Statistics and Demography programme, comprising Mr Graeme Brown, Dr Gerald Haberkorn, Mr Rick Baxter, Ms Leilua Taulealo, Ms Kaobari Matikarai and Mr Arthur Jorari. We also acknowledge the assistance provided by UNFPA (Dr Annette Robertson) and SPC's Public Health Programme (Dr Justus Benzler, Ms Kathryn Crouchley, Ms Karen Fukofuka Nemaia) for contributing and peer reviewing key chapters.

We appreciate the publication and layout work provided by SPC through Ms Gladys Beccalossi, Mr Jean-Pierre Le Bars, Ms Angela Templeton, Ms Kim Des Rochers, and Ms Jenny Drummond.

Special thanks go to the staff of SINSO both permanent and DHS temporary team listed in Appendix D. We particularly acknowledge those who contributed to the main report writing who are listed below.

We would like to extend our heartiest appreciation to survey respondents in Honiara and the provinces where the DHS took place. Their cooperation and assistance were critical to the successful completion of this important survey. We are grateful for the efforts of officials at national and local government levels who supported the survey.

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SUMMARY OF FINDINGS

The 2006/2007 Solomon Islands Demographic Health Survey (2006/2007 SIDHS) is a nationally representative survey of 3,823 women aged 15–49 and 2,056 men aged 15–54. The 2006/2007 SIDHS is the first for the country and one of the four DHS conducted in Pacific as part of the ADB/SPC Pacific Demographic and Health Surveys Pilot Project. The primary purpose of the SIDHS is to furnish policy-makers and planners with detailed information on fertility, family planning, infant and child mortality, maternal and child health and nutrition, and knowledge of HIV and AIDS and other sexually transmitted infections.

FERTILITY

Survey results indicate that the total fertility rate (TFR) for Solomon Islands is 4.6 births per woman. The TFR in urban areas (3.4 births per woman) is much lower than in rural areas (4.8 births per woman).

Education and wealth have a marked effect on fertility, with less educated mothers having more children (on average) than women with more than a secondary level education, and women in the lowest wealth quintile having two more children than women in the highest wealth quintile.

Childbearing starts early and is nearly universal. Women in Solomon Islands have an average of 2.1 children by the time they are in their late 20s and more than five children by the time they reach 50 years.

The initiation of childbearing in Solomon Islands has not changed much over time, although it seems that there is a slight increase in age at first birth in recent years. The median age at first birth in Solomon Islands is 21.6 years for women aged 25–29, the youngest cohort for whom a median age can be estimated. The findings further show that women in the highest wealth quintile, urban women, and women who have more than a secondary level education tend to have their first child at a later age than do other women.

Marriage patterns are an important determinant of fertility levels in a population. Age at first marriage for women appears to be slowly increasing in Solomon Islands. The median age at first marriage has increased from 19.1 years

among women aged 35–39 to 20.6 years among women aged 25–29. Women in Solomon Islands tend to initiate sexual intercourse about two years before marriage, as evidenced by the median age at first intercourse among women aged 20–49 of 18.2 years compared with the median age at first marriage of 20.3 years. Similarly, age at first sexual intercourse among women in Solomon Islands also shows a very slow increasing trend. For example, while the percentages of women who had sexual intercourse by exact age 15 are the same or similar among younger cohorts of women and older women except at ages 15–19 years, the percentage of women who first had sexual intercourse by exact age 18 is lower among younger cohorts of women than older women in the 35–44 age group.

Men, however, tend to marry several years later than women and initiate sexual activity around the same time as women. The median age at first marriage among men aged 20–49 is 25.6 years, while the median age at first intercourse is 18.3 years. Age at first sex for men has remained relatively constant over the years.

Almost one-quarter of non-first births in Solomon Islands (23%) occur at least 24 months after the birth of the previous sibling while 55% occur within 36 months. The overall median birth interval is 34 months. Birth intervals vary by place of residence: urban women have longer intervals between births (35.3 months) compared with rural women (33.4 months).

FAMILY PLANNING

Overall, knowledge of family planning is very high in Solomon Islands with 93% of all women and 99% of all men aged 15–49 having heard of at least one method of contraception. Pills, injectables, condoms and female sterilisation are the most widely known modern methods among both women and men.

About 58% of currently married women have ever used a family planning method at least once in their lifetime. Modern methods commonly ever used for family planning by married women are female sterilisation, injectables, and pills, with the rhythm method being the most commonly used traditional method.

Modern methods are more widely used than traditional methods, with 48% of currently married women using a modern method and 24% using a traditional method. The most popular modern method is injectables. About one out of three (35%) currently married women used any methods of contraception. Married women in urban areas are less likely to use contraception (29%) than women in rural areas (35%).

The majority of currently married women (83%) obtain contraceptive methods from public medical sources, while 6% obtain methods from other facilities, including private medical services where 9.2% obtain their contraceptive method from churches and non-governmental organisations.

Overall, 11% of currently married women have an unmet need for family planning services. The need for spacing (7%) is higher than the need for limiting (4%).

MATERNAL HEALTH

Ninety-five percent of women who had a live birth in the five years preceding the survey received antenatal care from a skilled health professional for their last birth. Over three in five (65%) of women make four or more antenatal care visits during their entire pregnancy. The median duration of pregnancy for the first antenatal visit is 5.6 months, indicating that Solomon Islands women start antenatal care at a relatively late stage in pregnancy.

Among women who received antenatal care, over half (55%) reported that they were informed about how to recognise signs of problems during pregnancy. Weight and blood pressure measurements were taken for 98.7% and 99% of women, respectively. Urine and blood samples were taken from 91% and 79% of women, respectively. Only 26% of women received two or more tetanus toxoid injections during their last pregnancy. An estimated 52% of births were reported to be protected against neonatal tetanus because of previous immunisations the mother had received.

Over eight in ten births occur in a health facility. Overall, 85% of births were delivered with the assistance of a trained health professional — a doctor, nurse, midwife, medical assistant, or clinical officer — while less 0.5% were delivered by a traditional birth attendant. About

4.4 percent of births were attended by other persons while 1.5 percent of births were delivered without any type of assistance at all.

Postpartum care is extremely high in Solomon Islands. Only 26% of women who had a live birth in the five years preceding the survey received no postnatal care at all, and 51% of mothers received postnatal care within the critical first two days after delivery. About 71% of women received first postnatal care from trained health professionals while about 2% were cared for by a traditional birth attendant.

Concern that no drugs were available, no care provider was available and getting money for treatment were the most commonly cited problems in accessing health care in Solomon Islands.

CHILD HEALTH

About 77% of children aged 12–23 months were fully vaccinated at the time of the survey. About 96% had received the BCG vaccination, and 81% had been vaccinated against measles. Because DPT and polio vaccines are often administered at the same time, their coverage rates are expected to be similar. A small difference in coverage of DPT and polio is the result (in part) of stock-outs of the vaccines.

Over 93% of children received the first doses of DPT and of polio, although 87% of children received the third dose of DPT and 86% received the third dose of polio.

The occurrence of diarrhoea varies by age of the child. Young children ages 12–23 months are more prone to diarrhoea than children in other age groups. Diarrhoea prevalence is more common among male children, among children who live in households with a non-improved drinking water and toilet facility. There are no differences among children by urban and rural residence. The pattern of diarrhoea prevalence declines as a mother's education level increases. Children in the lowest and fourth wealthiest households are more likely to have diarrhoea than children in other household quintiles.

Nearly four in five (78%) of children with diarrhoea were treated with some kind of oral rehydration therapy or increased fluids. About four in ten children (38%) were treated with oral rehydration salts prepared from an oral rehydration salts packet, 58% percent were given recommended home fluids, and 34% were given increased fluids.

ORPHANHOOD

Over two in ten households in Solomon Islands included one or more children who stayed with neither their natural father nor their natural mother. A higher percentage of households with foster children were found in urban areas (30%) than in rural areas (27%). Only one in ten households in Solomon Islands has orphans. More households have single orphans (5%) than double orphans (1%). No major variations exist between rural and urban areas regarding households with orphans.

In Solomon Islands, about seven out of ten (69.5%) children aged less than 18 years live with both parents, while 10% live with their mother but not with father even though the father is alive somewhere. Male children aged 0–9 years living in rural areas are more likely to be found living with their mothers.

About 14% of children do not live with either biological parent. These children are likely to be between the ages of 2 and 17 years living in both rural and urban areas and living in middle and fourth wealth quintile households. There is very little variation by sex.

Overall, about one-fifth (15%) of children do not live with biological parents, which is likely to increase as the age of the child increases and likely to take place in rural areas. The parents of about 4% of these children are dead.

BREASTFEEDING AND NUTRITION

Breastfeeding is nearly universal in Solomon Islands, with 93% of children born in the five years preceding the survey having been breastfed at some time. There is very little difference in whether children were ever breastfed by most background characteristics except place of residence and wealth status. There is an obvious difference in the proportion ever breastfed children between rural and urban where the practice is almost universal (93%) in rural areas compared with rural areas (89%). Similarly, the proportions of children being breastfed are likely to be higher among mothers in lower wealth quintile households compared with mothers in wealthier households.

The median duration of breastfeeding is 22.6 months, while the median duration for exclusive breastfeeding is 4.2 months, and the median duration for predominant breastfeeding is 4.9 months. The mean duration is shorter with overall mean duration of breastfeeding at

21.7 months, while the mean duration for exclusive breastfeeding is 5.1 months and the mean duration for predominant breastfeeding is 5.8 months. There is little difference in the duration of breastfeeding by sex of the child. Rural children are breastfed for a slightly longer duration (23 months) than urban children (18.3 months). Mothers with a secondary education breastfeed their children for a shorter duration than mothers with less education.

Between the ages of 6 and 23 months, children consume fruits and vegetables rich in vitamin A more often than any other food group. More than 84% of breastfeeding children and 86% of non-breastfeeding children in this age group ate fruits and vegetables in the day and night preceding the interview. The next most commonly consumed food group is food made from roots and tubers. Around 67% of breastfeeding and non-breastfeeding children ate food made from roots and tubers. The third commonly consumed food group is food made from grains, consumed by 42.4% of breastfeeding children and 49.4 percent of non-breastfeeding children).

About 85% of children aged 6–23 months who live with their mother received breast milk or other milk or milk products during the 24-hour period before the survey; 59% had a minimally diverse diet (i.e. they had been fed foods from the minimum number of food groups, depending on their age and breastfeeding status); and about 60% had been fed the minimum number of times appropriate for their age. In summary, only 37% of children aged 6–23 months in Solomon Islands met the minimum standard with respect to all three WHO Infant and Young Child Feeding practices

Ninety-one percent of youngest children aged 6–35 months who live with their mother consumed vitamin A-rich foods in the 24-hour period before the survey. Consumption of foods rich in vitamin A increases from 75% among children aged 6–8 months to 93% among children aged 12–35 months.

The staple diet of mothers of young Solomon Islands children consists of foods rich in Vitamin A (88%), food made from roots and tubers (78.5%), and food made from grains (61.7%). Almost three in five women (61.7%) consume food made from grains, whereas 47% of women consume other fruits and vegetables. Among mothers aged 15–49 with a child under age 3 years living with them, about 10% drink

milk while 41% drink tea and coffee, and 35% drink other liquids.

Observations made during the 2006/2007 SIDHS on thinness and wastage among children aged 0–5 years for whom wasting was observed for selected parts of their bodies show that more than one in ten children (11.8%) aged 0–5 years have low weight-for-age, and 2.4% are severely underweight. Underweight children are more common among children aged 9–11 months, children whose mothers have no education or only a primary education, and children living in the lowest wealth quintile households.

About 33% of children aged 0–5 years were stunted (i.e. low height-for-age). Stunting is more common among children aged 18–23 months, rural children, children whose mothers have no education or only a primary education, and children living in the second lowest wealth quintile. Only 4.3% of children aged 0–5 years in Solomon Islands were reported to be wasted (i.e. have low weight-for-height).

HIV AND AIDS AND STIs

Knowledge about AIDS is almost universal among the adult Solomon Islands population. A very high proportion of both women and men have heard of the disease; however men have a more comprehensive knowledge about AIDS (98%) than women (94%). The results also show that the level of knowledge is quite high for both women and men at different ages and marital status categories, place of residence, education levels and household wealth quintiles.

Men and women were specifically asked if it is possible to reduce the risk of acquiring HIV by consistently using condoms, limiting sexual intercourse to one uninfected partner who has no other sex partners, and abstaining from sexual intercourse. The results show that 61% of women and 69% of men agree that using a condom at every sexual intercourse can reduce the risk of getting AIDS, while 80% of women and 95% of men agree that limiting sexual intercourse to one uninfected partner is a way to avoid contracting HIV and AIDS.

Generally, most women and men are aware that the chances of getting HIV through these specified prevention methods can be prevented by limiting sex with one uninfected partner (80% women, 95% men), abstaining from sex (77% women, 89% men), using condoms (61% women, 69% men) and limiting sex to one uninfected partner (56% women, 68% men).

About 71% of women and 83% of men know that a healthy-looking person can have the AIDS virus. Knowledge that people cannot get AIDS by mosquito bites is lower among women (63%). On the other hand, knowledge that people cannot get AIDS by supernatural means is higher for men (71%).

More than one in four women (29%) and 39% of men have such a comprehensive knowledge. Women in urban areas are more likely to have comprehensive knowledge (38%) than rural women (27%). Women who have ever had sex, and who have more than a secondary level education, who live in Western Province, and who live in the highest wealth quintile are more likely to have a comprehensive knowledge about HIV than other women. Comprehensive knowledge is more common among men in urban areas who are currently married, those with a higher education level, those in higher wealth quintiles, and those who live in Guadalcanal Province.

About 69% of women and 53% of men know that HIV can be transmitted from a mother to her child by breastfeeding. A very low proportion of women and men (both 6.7%) know that HIV can be transmitted through breastfeeding and that the risk of transmission can be reduced by special drugs. Less than one in ten women and men (8% and 9%, respectively) aged 15–49 know that there are special drugs that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby.

Less women than men expressed positive attitudes and opinions toward family members with AIDS. For example, 66% of women and 72% of men report that they would not want to keep it a secret that a family member has AIDS while only 36% of women and 56% of men are willing to care for an HIV-infected family member. Only 30% of women and 55% of men report that they would buy vegetables from a shopkeeper who has AIDS.

More than 80% of both women and men in the 15–49 age group agree that a wife is justified in refusing to have sexual intercourse with her husband if she knows that he has a sexually transmitted disease. Almost the same proportion of women and men also agree that a wife is justified in refusing sexual intercourse or asking her husband to use a condom.

WOMEN'S EMPOWERMENT

Data for the 2006/2007 SIDHS show that 42% of currently married women and almost 87% of currently married men were employed at some time in the year prior to the DHS. Less than 60% of these women and men are likely to be paid in cash (33% and 52%, respectively). Women are more likely to work but not receive payment (56%) than men (22%). Similarly, women are less likely to be paid in-cash and in-kind than working men which 9% of women paid in-cash and in-kind as compared to 24% of men.

Overall, 16% of women decide by themselves how their husband's earnings are to be spent, while 56% of women make the decision jointly with their husband or partner. About 23% report that the decision is mainly made by their husband or partner.

About 40% of women make decisions regarding daily household purchases on their own, and 21% report that they make decisions about major household purchases by themselves. About 28% of married women independently decide on their own health care while over half of all women report that this decision is made jointly with their husband or partner.

About 46% of men think that mainly the wife should make decisions about purchases of daily household needs while 40% think that this decision should be made jointly by a wife and her husband or partner. Over half (56%) of men think that a joint decision is required to purchase major household items compared with about 20% of men with a view that this decision should be left entirely to the wife.

Over 20% of men think that wives should decide on how they wish to spend their earnings while 59% percent of men think that this should be a joint decision between husbands and wives.

Data show that most women find that wife beating is justified in certain circumstances. Over two-thirds of women (69%) agree that at least one of the reasons asked about during the SIDHS is sufficient justification for a wife to be beaten. This indicates that Solomon Islands women generally accept violence as part of male-female relationships, which is not surprising because traditional norms teach women to accept, tolerate and even rationalise battery.

Men were also asked about their opinions on the justification of wife beating under certain

circumstances. Almost six in ten men agree that wife beating is justified for at least one of the specified reasons. It is interesting to note that this is slightly lower than the percentage of women who agreed with at least one of the reasons (64% for men compared with 69% for women).

Interestingly, the DHS data also show that over seven in ten women and men (74% women, 75% men) believe that a woman has the right to refuse sex with the husband for all of the specified reasons.

MORTALITY

Evidence from the 2006/2007 SIDHS points to a much lower infant mortality rate (IMR) (i.e. 24 infant deaths per 1,000) than the IMR reported by the 1999 census (66).

Even allowing for significant sampling errors — which are reflected in the high relative standard error and wide confidence interval (14.4–34.2) — and for non-sampling errors — such as the under-recording of infant deaths in the survey operation — we can say with some confidence that improvements in infant and child health have taken place since 1999.

What we cannot say for certain, is that the current IMR actually equals 24.

We cannot ascertain the magnitude of this change because the years of civil unrest in the lead-up to the 1999 census caused an almost complete breakdown in government service provisions, including health, in many parts of Solomon Islands. All of this could have contributed to a much higher IMR in 1999 than one would have encountered under more peaceful circumstances.

The IMR in 1999 for Vanuatu (27 per 1,000) lends support to such reasoning as Vanuatu is a neighbouring Melanesian country that faces similar challenges as Solomon Islands with regard to health services provision as well as endemic malaria.

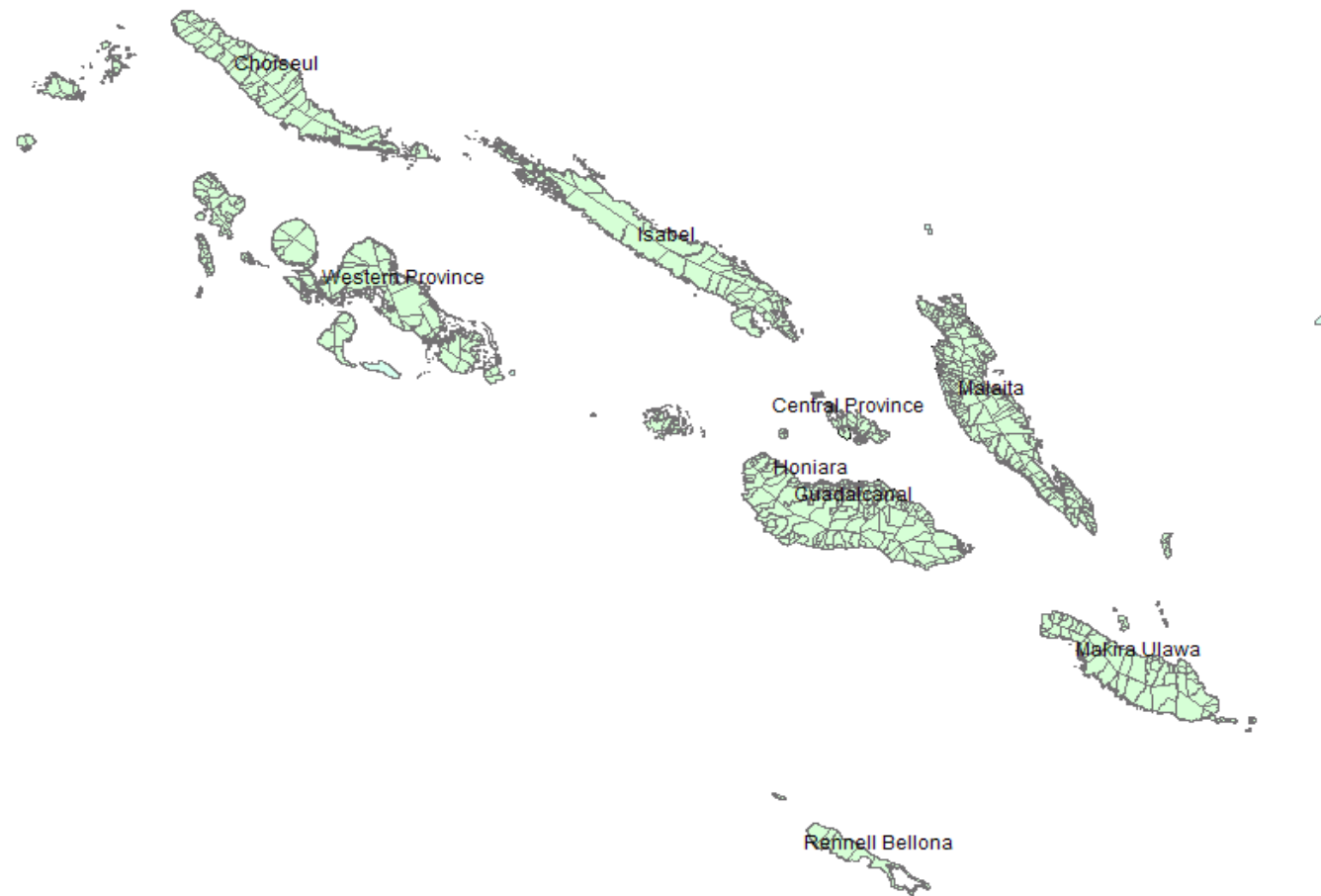
About 27% of births in Solomon Islands are not in any high-risk category. An additional 19% of births are first order births to mothers aged 18–34, which is considered an unavoidable risk category. The remaining 55% of births in Solomon Islands are in at least one of the specified avoidable high-risk categories, experienced by 63% of currently married women.

Over one-third of births (37%) are in only one of the high-risk categories: 1) in birth orders higher than 3 (24%) and 2) in short birth intervals of less than 24 months (9%). Meanwhile 18% of births are in multiple high-risk categories. Births in multiple high-risk categories are found mostly in two combinations: mother's age greater than 34, and birth orders higher than 3 (9% of births); and birth order higher than 3 with birth intervals less than 24 months (7% of births).

DHS INDICATORS REQUIRED BY INTERNATIONAL AGENCIES

Indicator	National	Differentials	
		Urban	Rural
MDG /UNFPA			
Net enrolment ratio in primary education (overall net attendance ratio)	65.4	72.1	64.5
Net enrolment ratio in primary education (net attendance ratio — males)	62.5	69.1	61.5
Net enrolment ratio in primary education (net attendance ratio — females)	68.7	76.0	67.8
Literacy rate of women aged 15–49	78.4	86.2	76.9
Literacy rate of men aged 15–49	88.4	95.0	86.9
Literacy rate of women aged 15–24	84.9	-	-
Literacy rate of men aged 15–24	86.5	-	-
Ratio of literate women to men aged 15–24	98.1	-	-
Ratio of literate women to men aged 15–49	88.7	90.7	88.5
Share of women in wage employment in the non-agricultural sector	52	-	-
Under-5 mortality rate (0–9 years before the DHS)	37	31	38
Infant mortality rate (0–9 years before the DHS)	26	23	27
Percent of 12–23 month-old children fully immunised (BCG, measles, etc.)	82.7	84.4	82.4
Percent of births attended to by skilled health personnel	84.5	94.4	83.1
Contraceptive prevalence rate (currently married women)	34.6	29.3	35.4
Percent of population cooking with solid fuels	92.3	59.8	97.6
Percent of population with sustainable access to an improved water source, urban and rural	84.2	94.0	82.6
Percent of population with access to improved sanitation, urban and rural	17.6	76.8	7.8

Solomon Islands



CHAPTER 1 INTRODUCTION

1.1 HISTORY, GEOGRAPHY AND ECONOMY

1.1.1 Geography

The Solomon Islands consist of nearly 1,000 islands that together, make up a land area of approximately 30,400 square kilometres within a sea area of roughly 1.5 million square kilometres. The country's six major islands are Choiseul, New Georgia, Isabel, Guadalcanal, Malaita and Makira. The largest island is Guadalcanal, which is 5,336 square kilometres. Most of the landmass consists of hills and rugged mountain ranges with tropical rainforests, while the remainder consists of coastal plains and low-lying atolls. The Solomon Islands have a tropical climate with little temperature change over the year. Rainfall, however, is concentrated between November and April.

Solomon Islands became an independent country in 1978. The country's form of government is a constitutional monarchy within the Commonwealth, in which the British monarch is represented by the Governor General. Executive power is in the hands of the national Cabinet headed by the Prime Minister. The Parliament consists of 50 members, each of whom is elected from a constituency. The second administrative level is formed by the nine provinces and the Honiara town council. The provinces and Honiara are further subdivided into wards, of which there are 183 in total.

Solomon Islands is part of the Melanesian cultural area, with close ties to Vanuatu, Papua New Guinea and Fiji. However, there are also influences from people of Micronesia (mainly Kiribati) and Polynesia, and small European and Chinese populations. Land ownership and land use are largely organised along tribal lines, and people maintain strong attachment with their islands of origin. Christianity has a large influence on Solomon Islands society and is represented by a large variety of denominations. The country is also characterised by a rich linguistic diversity: the 1999 census distinguished 91 different vernacular languages. English is the official language of the country, but Pidgin is widely used as the *lingua franca*. The majority of people live along the coast, but there are substantial population pockets in inland areas of Guadalcanal and Malaita.

The recent ethnic conflict has had far-reaching consequences for Solomon Islands' economy and society. Major companies in the country were closed down, and a large number of people were displaced, leading to a significantly different population distribution within the country. Primary social services were reduced and several major aid donors cut back their support in the wake of the policy pursued by the Solomon Islands government. At the time of writing this report, the country is still struggling to regain its former stability.

1.1.2 History

It is thought that people have lived in the Solomon Islands since at least 2000 BC. The islands were explored in 1568 by Alvaro de Mendana of Spain, but were not visited again for about 200 years. In 1886, Great Britain and Germany divided the islands between them, but later Britain was given control of the entire territory. The Japanese invaded the islands in the 1940s, and the islands were the scene of some of the bloodiest battles in the Pacific Islands region, the most famous being the battle of Guadalcanal. The British gained control of the island again in 1945. In 1976 the islands became self-governing and gained independence in 1978.

Since early 1999, the Isatabu Freedom Movement, a militia group made up of indigenous Isatabus from Guadalcanal, have expelled more than 20,000 Malaitans from the island. The Malaitans then migrated to Guadalcanal from nearby Malaita, and many had secured jobs in the capital, Honiara, stirring resentment among Isatabus that has grown steadily since independence. In response to the ethnic violence and expulsions, a rival Malaitan militia group was founded, the Malaita Eagle Force. In June 2000, the Malaita Eagle Force stole police weapons, forced the country's prime minister at the time to resign, and seized control of the capital. The rival groups agreed to a cease-fire in June 2000, barely averting a civil war. Although a peace agreement was signed and

elections took place, the country continued to suffer from lawlessness. In July 2003, at the request of the prime minister, a 2,250-strong international peacekeeping force led by Australia arrived on the island to restore order. Australia's intervention was highly successful, and two years after troops had arrived, the country remained relatively stable.

1.1.3 Economy

The bulk of the population depends on agriculture, fishing, and forestry for at least part of their livelihood. Most manufactured goods and petroleum products must be imported. The islands are rich in undeveloped mineral resources such as lead, zinc, nickel and gold. However, severe ethnic violence, the closing of key business enterprises, and an almost empty government treasury have led to serious economic disarray, indeed near collapse. Tanker deliveries of crucial fuel supplies (including those for electrical generation) have become sporadic due to the government's inability to pay and due to attacks against ships. Telecommunications are threatened by the non-payment of bills and by the lack of technical and maintenance staff many of whom have left the country.

A per capita GDP of US\$340 ranks Solomon Islands as a lesser developed nation. Over 75% of the country's labour force is engaged in subsistence farming and fishing. Until 1998, when world prices for tropical timber fell steeply, timber was Solomon Islands' main export product and, in recent years, Solomon Islands' forests were dangerously overexploited. Other important cash crops and exports include copra and palm oil. In 1998 Ross Mining of Australia began producing gold at Gold Ridge on Guadalcanal. Mineral exploration in other areas continued. However, in the wake of the ethnic violence in June 2000, exports of palm oil and gold ceased while timber exports fell.

Exploitation of Solomon Islands' rich fisheries offers the best prospect for further export and domestic economic expansion. However, a Japanese joint venture, Solomon Taiyo Ltd., which operated the only fish cannery in the country, closed in mid-2000 as a result of ethnic disturbances. The plant has reopened under local management.

Tourism, particularly diving, is an important service industry for Solomon Islands. Growth in that industry is hampered, however, by a lack of infrastructure, transportation limitations and security concerns. Solomon Islands' economy was particularly hard hit by the Asian financial crisis that occurred before the ethnic violence of June 2000. The Asian Development Bank estimated that the crash of the tropical timber market reduced Solomon Islands' GDP by between 15% and 25%. About one-half of all jobs in the timber industry were lost. The government has said that it will reform timber harvesting policies with the aim of resuming logging on a more sustainable basis.

The arrival of the Regional Assistance Mission to Solomon Islands (RAMSI) and the re-engagement of other donors provided Solomon Islands with an opportunity to rebuild and expand the struggling economy. The Solomon Islands Government was seen as the driving force of any fundamental reforms for long-term change. Clearing away the bureaucracy and inefficiencies of the past, and providing a stable environment for private business, were viewed at the time as fundamental to these reforms. Previous government domination of the small economy, both through state businesses and regulation, had hindered the development of a robust private sector.

With stability returning, the government can begin to tackle a range of medium-term problems that do not require increased expenditure, such as the removal of inefficient and costly regulations and licensing regimes. This should include regulations that discourage foreign investment. Efficient infrastructure and utilities are vital for economic and social welfare and, over the medium term, need to be improved. Greater government revenues and more targeted expenditure will enable the government to provide better services.

The key longer-term challenge will be that of land tenure. For Solomon Islands to prosper, the government must address this divisive and delicate issue. The size of Solomon Islands' market and the inherent difficulties and costs due to geography and relative isolation do not mean that Solomon Islands cannot be prosperous. Facilitating an open and flexible business-friendly economy will help Solomon Islands' economy grow and its businesses to compete in international markets.

1.2 POPULATION GROWTH

Population censuses have been carried out in the Solomon Islands since 1931 at various intervals, changing to decennial intervals. Table 1.1 provides a summary of the basic demographic indicators available for Solomon Islands from the census data for 1931–1999. Solomon Islands' population has increased four times since 1931, from around 94,066 in 1931 to over 409,042 in 1999. The population grew at a rapid rate between 1931 and 1986 from 1.0% to 3.4%, but the population growth rate has slowed since 1986 to 2.8% (Solomon Islands Government 1999). A recent projection (2008) estimated Solomon Islands' population to be over 521,100.¹

Table 1.1: Basic demographic indicators, selected indicators, Solomon Islands 1931–1999

	1931	1959	1970	1976	1986	1999
Total population	94,066	124,076	160,998	196,823	285,176	409,042
Intercensal growth rate (percent)	-	1.0	2.5	3.3	3.4	2.8
Density (population/kilometre ²)	3	4	6	7	10	14
Percent urban	-	-	-	9	13	16
Life expectancy						
Male	-	-	-	-	54.3	60.6
Female	-	-	-	-	55.0	61.6
Total	-	-	-	-	54.7	61.1

- equals unknown (not available)

Source: Solomon Islands Government National Statistics Office

The population density has greatly increased over the same period from three people per square kilometer in 1931 to 14 people per square kilometer in 1999. Solomon Islands is predominantly rural with the proportion of the urban population estimated at only 16% in 1999. Life expectancy for Solomon Islands women in 1999 was slightly higher than male life expectancy (61.6 years versus 60.6 years).

1.3 POPULATION AND REPRODUCTIVE HEALTH POLICIES AND PROGRAMMES

1.3.1 Evolution of population policy

In 1998, the Solomon Islands Government endorsed the country's National Population Policy (NPP). This policy provided the framework for all population and development activities, including externally funded projects in the country. It discussed the main policy issues, the population policy framework, and the overall goals of the government in the broad area of integrated population and development planning. It also provided specific objectives in some key areas such as responsible decision-making regarding family size and raising children, basic service provision, sustainable resource use, and employment in rural areas.

Implementing the NPP began in 1999 and has since gained momentum. The ethnic tension caused serious delays but most activities have already restarted. In order to implement the NPP, it was felt that a comprehensive NPP Implementation Plan should be developed. Work on a Plan of Action began in February 2000. The Technical Advisory Committee of the National Population Council reviewed the first drafts of the plan during its meetings in 2000. After all amendments were made, the final draft was endorsed during a meeting of the Technical Advisory Committee in February 2001.

That Implementation Plan contained a comprehensive set of sectoral objectives and strategies in all relevant areas of integrated population and development planning. Like the 1998 NPP, it cannot be expected that all strategies included in that plan could be implemented overnight.

¹ SPC Population Projections 2008.

However, that plan was considered as a statement of intent as well as a framework within which all population and development related activities in the country were to be planned and executed.

In that Implementation Plan, extensive use was made of existing sectoral policies and acts such as the Women's Policy, the draft Youth Policy, and the Forest Act. Furthermore, relevant objectives and strategies of the Plans of Action of some international conferences, especially the International Conference on Population and Development (ICPD) in Cairo in 1994 were also included.

This current policy document outlines the perspectives, policies, and strategies on population issues and problems adopted by the Solomon Islands Government to guide the country over the next 10 years. It incorporates most of the objectives and strategies under the 1998/2000 NPP Plan of Action. The purpose of the National Population Policy 2008–2017 is to:

- assist the donor community and other development partners to identify programmes that they may wish to support, either financially or by means of technical assistance;
- make clear to the public as a whole what the population situation in the country presently is, what the future is likely to be like, and how the problems the future is likely to bring will be managed or alleviated by the government;
- assist national departments to understand fully the functions that they are currently performing or expected to perform in implementing government policy on population issues;
- assist provincial administrations to prepare projects, plans and programmes to address their particular population circumstances and conditions;
- provide NGOs with a framework for identifying the specific roles that they can play — in partnership with the government — to implement the proposed policies and strategies; and
- provide the government, through the Department of Development Planning, a tool for coordinating, monitoring and evaluating all population and development efforts aimed at improving the quality of life of the population, and thereby progressing achievement of the Millennium Development Goals (MDGs) and other development goals.

The National Population Policy 2008–2017 represents a revision of Solomon Islands' last population policy (1998 National Population Policy for the period 2000–2004), which was based on outdated information from the 1986 population and housing census. It was recommended that the 1998 policy be revised as soon as the 1999 census results were available. Preparing the 2008–2017 policy began in July 2006 with stakeholder consultation meetings, followed by a workshop to discuss key population and development issues in Solomon Islands noted during the consultations. A number of international policy frameworks pertaining to population and related development issues continue to be promoted in the region, resulting in the adoption to incorporate them into national policy frameworks. Prominent among these are the MDGs. This also necessitated revision of the existing Solomon Islands population policy.

The 1998 population policy was prepared without the benefit of up-to-date statistics on population patterns and trends. Completing the 1999 census and the 2006 Household Income and Expenditures Survey facilitated the reformulation of policy approaches in the light of new evidence on population trends.

1.3.2 Rationale and role of the population policy

The rationale for an official government population policy rests on several grounds. First, the population of Solomon Islands, as with most developing countries, will continue to grow for several decades to come. An increasing population will in turn increase the demand for government services such as schools and health care. A population policy creates awareness of the probable future demand for government services, and this awareness makes it more likely that governments and other agencies will undertake advance planning to ensure that these demands will be met in the most cost-effective manner possible. Second, a population policy helps to identify population patterns and trends that threaten to undermine the pace or nature of socio-economic development. If current population trends are unacceptable from the perspective of

public welfare, government intervention to influence them is justified. A population policy identifies important population trends and issues and makes it transparent why government intervention is justified. A population policy can be justified if there is reason to believe that the desired welfare outcomes will not occur unless some government action takes place. The third basis for an official policy is that programmes and plans intended to influence population trends are more likely to be consistent and coherent if formulated within a unified framework and placed together in the same document.

Government intervention does not imply that the government or the state is attempting to take direct control of the private behaviour of individuals or families. 'Intervention' includes actions such as providing information and education, improving the quality and quantity of education or health services, or encouraging the involvement of the private sector or non-governmental organisations (NGOs). The National Population Policy should not be confused with a 'population control' policy. While Solomon Islands has population problems, these are not so serious as to justify the use of population control measures or restrict social rights and freedoms. The National Population Policy 2008–2017, like its 1998 predecessor, is firmly rooted in a human rights perspective that draws upon the Solomon Islands Constitution as well as international declarations.

The principal role of an official population policy, therefore, is to provide a coherent and transparent picture of the significance of population issues in the overall development process, and the measures that government proposes to address them. A population policy is not an end in itself but a means to other ends. A population policy is future oriented: it is based upon a perception of what the future would be like if nothing was done to make it otherwise and expresses a preferred future for the country.

The Solomon Islands Government prefers a future where:

- Population growth does not constrain sustainable economic growth and development;
- Women have a higher social status than they do today, and participate in economy and society;
- Births are spaced to enhance the health of both mothers and children;
- Violence against women is eliminated;
- Universal basic education is achieved before the end of the next decade;
- Adult illiteracy, especially among women, will be substantially reduced;
- Laws on marriage and family are in harmony with emerging social values;
- All new entrants into the labour force are able to find productive work and contribute to the economy;
- The environment is protected from degradation;
- Fewer infants and children die before they have had a chance to experience life;
- Fewer mothers die in childbirth from preventable causes;
- Women and men live longer and healthier lives;
- Migration, urbanisation, and population distribution patterns contribute to rather than detract from development

These changes cannot be expected to occur automatically or at the desired speed. Government intervention is an important catalyst for change, and government policies can make a difference. But government alone cannot bring about change. A population policy is a call for individual, community and government collaboration in a voluntary and public effort to bring about population outcomes that enhance the quality of life and level of living for all citizens of Solomon Islands.

1.3.3 The review and policy formulation process

The process of reviewing and revising the 1998 revised NPP was recommended to begin as soon as the policy was approved. However, this review did not take place mainly because of the ethnic unrest after the 1998 policy was drafted. The Solomon Islands Government only requested for the

review in 2006 under the auspices of a United Nations Population Fund (UNFPA)/ Secretariat of the Pacific Community (SPC) project on integrating gender and population issues into policy and development planning.

Detailed consultations with government departments were conducted in July 2006 to ensure that the policy approaches adopted were consistent with the current strategies being applied by national departments and sectoral agencies. The review process occurred from 17–28 July 2006 and consisted of two weeks of consultations with stakeholders at all levels of Solomon Islands society: government administrations, including line ministries such as planning, health, labour, education, home affairs and finance; as well as the National Statistics Office and provincial administrations. A meeting of all provincial representatives was organised and these representatives participated in the National Workshop on the National Population Policy with other stakeholders, held in Honiara on 27 July. Development partner institutions visited are the World Health Organization, the German Foundation for International Development and Oxfam among others. A meeting with donor agencies (e.g. the Australian Agency for International Development, New Zealand Agency for International Development, Japan International Cooperation Agency, European Union, and Taiwan/ROC) was organised on 28 July, as well as consultations with key NGOs and civil society organisations (e.g. Save the Children, National Council of Women, Kastom Garden, Solomon Islands Christian Association, and Christian Care Centre [Anglican Church]). A meeting with Honiara youth was also organised and some of these youth participated in the National Workshop on the National Population Policy.

The review results are incorporated into the population policy formulation process, into their respective topics or sectors. All stakeholders, including the Solomon Islands Christian Association, recognised that the current population growth and related structure was not sustainable, given the potential impact on the delivery of services, including rural-urban migration and urbanisation.

Key recommendations from the National Workshop on the National Population Policy included the following:

- Ensure that the links between goals, objectives, strategies and targets are clear by using a policy matrix framework;
- Include consideration of environment, employment and urbanisation;
- Ensure that demographic targets are realistic within the time frame specified;
- Incorporate the recommendations of the 1994 International Conference on Population and Development (Cairo 1994), the Port Vila Declaration on Population (1993) and other relevant international meetings;
- Strengthen the focus on reproductive rights and the empowerment of women;
- Place family planning in the context of reproductive health;
- Pay greater attention to the demographic and social variations between provinces and regions.

Revising the National Population Policy was the responsibility of the Department of National Planning. The membership of the Population Policy Review Team was made up of representatives of the National Planning and Health departments, together with the UNFPA and SPC.

It is acknowledged that greater consultation with the provinces would have been valuable given the importance of their role in implementing government programmes. While most of the provinces were able to provide input into the policy details during the National Workshop, others were left out until the final review. Nevertheless, the National Population Policy 2008–2017 explicitly acknowledges the substantial variations in conditions between provinces, and this is reflected in a number of policy goals and strategies.

1.3.4 The policy time frame

The National Population Policy 2008–2017 covers a 10-year period. The year 2017 has been selected as the terminal year because all MDG-related strategies and programmes in Solomon Islands are targeted towards 2015, and a review after that would provide the opportunity to assess the impact of various interventions.

1.3.5 Health policy

One of the major issues in a country consisting of several large, scarcely populated and remote islands is the delivery of health services, difficulty and cost of transport in regard to increasing demand, and stable or declining supply. Poverty and gender issues are also considered to be important factors affecting access to health services; while the increasing vulnerability to infectious diseases, notably sexually transmitted infections (STIs, including HIV and AIDS), and lifestyle diseases may place increased pressure on the health budget of households and governments beyond sustainability.

The way health services are operated and provided, linked to qualification and commitment of staff, is also an issue affecting rural populations in the use health services as opposed to the use of traditional healers whose services are considered to be of poor quality but less expensive in terms of medication and transport. A change in the health seeking behaviour of Solomon Islanders is necessary to reduce morbidity and mortality and increase life expectancy. While more people are seeking better treatment, population growth and access to most areas are the main reasons for the difficulty in coping with demand and supply. Slow fertility decline (hopefully the 2006/2007 DHS and the next 2009 census results will confirm this statement) associated with increasing cohorts of childbearing aged women results in larger birth cohorts, continuing population growth, and increased pressure on health services in both rural and urban areas, where positive net rural-urban migration adds to natural population growth.

The government health department has in its current development plan, strategies to increase access by all women in both rural and urban areas to reproductive health and rights by 2015, following the International Conference on Population and Development (ICPD) 1994 goal that was reiterated at the Beijing conference in 1995 and the ICPD +5.

The draft National Health Strategy (NHS) will be integrated into the framework of the Population and Development Policy. Sectors included in the NHS address child as well as maternal health, two sectors that are related to the MDGs. In particular, they include immunisation, reduction of child mortality, safe motherhood and family planning, including adolescent sexual and reproductive health. The NHS would address the main issue of population growth through access to extended health services, expanding services to provinces and upgrading staff qualification, developing information on rights and choices, to conform to youth as well as married couples' expectations to be able to choose contraception methods according to their needs. Both single youth and married couples have unmet contraceptive needs that result in teenage pregnancies and unwanted pregnancies. Information and behaviour change are important for increasing the use of services, and for involving men in family planning, and empowering women in decision-making about family life, including sexual behaviour.

1.4 DEMOGRAPHIC AND HEALTH SURVEY

This report presents the findings of the 2006/2007 Solomon Islands Demographic and Health Survey (SIDHS), which was carried out by the Solomon Islands Statistics Office from 9 October 2006 to 15 April 2007, using a nationally representative sample of over 4,000 households. All women aged 15–49 in these households were eligible to be individually interviewed, while men aged 15 and over in one-half of the households were eligible to be interviewed.

1.4.1 Survey objectives

The principal objective of the SIDHS was to provide current and reliable data on fertility and family planning behaviour, child mortality, adult and maternal mortality, children's nutritional status, the use of maternal and child health services, and knowledge of HIV and AIDS. Specific survey objectives were to:

- collect data at the national level, which will allow the calculation of key demographic rates;
- analyse the direct and indirect factors that determine the level and trends of fertility;
- measure the level of contraceptive knowledge and practice among women and men by method, urban-rural residence and region;
- collect high-quality data on family health, including immunisation coverage among children, prevalence and treatment of diarrhoea and other diseases among children under 5 years, and maternity care indicators, including antenatal visits, assistance at delivery, and postnatal care;
- collect data on infant and child mortality;
- obtain data on child feeding practices, including breastfeeding, and collect 'observation' information to use in assessing the nutritional status of women and children;
- collect data on knowledge and attitudes of women and men about sexually transmitted infections and HIV and AIDS, and evaluate patterns of recent behaviour regarding condom use; and
- collect data on support to mentally ill people as well as information on the incidence of suicides.

This information is essential for informed policy decisions, planning, monitoring, and evaluating programmes on health in general, and reproductive health in particular, at both the national level as well as in urban and rural areas. A long-term objective of the survey is to strengthen the technical capacity of government organisations to plan, conduct, process, and analyse data from complex national population and health surveys. Moreover, the 2006/2007 SIDHS provides national, rural and urban estimates on population and health that are comparable with data collected in similar surveys in other Pacific DHS pilot countries and other developing countries.

1.4.2 Survey organisation

The 2006/2007 SIDHS was carried out under the ADB/SPC Pacific Regional Pilot DHS Project, which was executed by the Solomon Islands National Statistics Office (SINSO) in collaboration with the Solomon Islands Ministry of Health (MOH). Macro International Inc provided technical assistance through its MEASURE DHS project. The survey was funded by ADB.

A steering committee was formed to be responsible for coordination, oversight, advice, and decision-making on all major aspects of the survey. The steering committee comprised representatives from various ministries, including MOH, and SINSO. A technical advisory committee and technical subcommittee were also formed.

1.5 SURVEY IMPLEMENTATION

1.5.1 Sample design

The sample SIDHS was designed to provide reliable estimates of total fertility and infant mortality rates at the national level, with urban and rural breakdown and relatively stable estimates for selected provinces. Although the design considered an urban-rural split, this was not carried out during the sample selection of the enumeration area (EA). The sample was not spread out geographically in proportion to the population; as a result, the SIDHS sample is not self-weighting at the national level and sample weighting factors have been applied to survey records in order to bring them into proportion.

The sample for the survey is a three-stage stratified, nationally representative sample of households. The sampling frame consisted of the estimated number of households in each EA by

province and was prepared by SPC from the 1999 population census data and estimated urban and rural population growth rates. Honiara, which is urban in its entirety and selected enumeration areas of Guadalcanal and other provinces, comprise the country's urban areas. The rest of Guadalcanal and all other provinces are rural. Five domains were identified: Honiara, remaining Guadalcanal, Western, Malaita, and the combined group of smaller provinces (Choiseul, Isabel, Central, Makira/Ullawa, Rennell/Bellona and Temuto). The primary sampling units, comprising 215 EAs, were selected in each province using systematic random sampling with probability proportional to the estimated number of households in the EA. It was not possible to cover several of the selected sample EAs: 5 EAs were damaged or destroyed during the tsunami of 1 April 2007; 5 EAs were refused permission to survey by village elders or the community; and 23 EAs (11 in Honiara, 7 in Western, 4 in Malaita and 1 in Guadalcanal) were not covered due to poor team leadership or poor field monitoring. In Western Province, 7 EAs were not covered due to internal migration of residents after the tsunami. Thus, the survey covered 182 EAs — 60 urban and 122 rural.

Mapping and listing households in each sample EA were undertaken by the interviewers. In each sample point, 20 households were selected by the team supervisor using systematic random sampling. The sample was designed to cover a target sample of 4,300 households with an expected household response rate of 95%. All women aged 15–49 who slept in the sample household on the night prior to the interview date were eligible to be interviewed for the Women's Questionnaire, and for the anthropometric (height and weight), blood pressure and haemoglobin measurements. Every second household was sub-selected for the male survey. All men aged 15 or over in the sub-selected households were eligible to be interviewed for the Men's Questionnaire, and for anthropometric and blood pressure measurements. All children aged 0–5 years were eligible for anthropometric measurement, and those aged 6 months to 5 years, for anaemia testing.

1.5.2 Questionnaires

Three questionnaires — a household questionnaire, a women's questionnaire and a men's questionnaire — were used in the SIDHS. The contents of these questionnaires were based on model questionnaires developed by the MEASURE DHS program at Macro International.

In consultation with MOH, SINISO and Macro, staff modified the DHS model questionnaires to reflect relevant issues in population, family planning, HIV and AIDS, and other health issues in the Solomon Islands. The questionnaires were translated into Pidgin and back-translated in order to check accuracy.

The household questionnaire was used to list all the usual members and visitors in the selected households. Some basic information was collected on the characteristics of each person listed, including age, sex, education, and relationship to the head of the household. The main purpose of the household questionnaire was to identify women and men who were eligible for the individual interview. The household questionnaire also collected information on characteristics of the household's dwelling unit, such as source of water, type of toilet facilities, materials used for the floor and roof of the house, ownership of various durable goods, and ownership and use of mosquito nets. In addition, this questionnaire was also used to record height and weight measurements of women aged 15–49, men aged 15 and above, and children under the age of 5 years, as well as consent from women, and children's parent or guardian to give blood samples for anaemia and blood pressure testing among women and men.

The women's questionnaire was used to collect information from all women aged 15–49 on:

- Background characteristics (education, residential history, media exposure, etc.)
- Reproductive history and child mortality
- Knowledge and use of family planning methods
- Fertility preferences
- Antenatal and delivery care
- Breastfeeding and infant feeding practices
- Vaccinations and childhood illnesses

- Marriage and sexual activity
- Woman's work and husband's background characteristics
- Infant and child feeding practices
- Awareness and behaviour about AIDS and other sexually transmitted infections.

The men's questionnaire collected similar information contained in the women's questionnaire, but was shorter because it did not contain questions on reproductive history, contraceptive calendar, and maternal and child health and nutrition.

Both informal and formal pre-tests of the questionnaires were undertaken. In July 2006, an informal pre-test was done through self-administration of the individual women's and men's questionnaires, respectively, by six female and four male SINSO staff members.

A more formal three-week pre-test was undertaken for the interviewers from 21 August to 2 September 2006, inclusive of Saturdays. The pre-test training for the nurses/health technicians started a few days later, and went from 25 August to 2 September. Twelve pre-test interviewers (seven males and five females) were expected to become team supervisors and field editors during the main enumeration. Four nurses/health technicians were trained for accuracy and reliability of the various measurements. Most pre-test interviewers had experience as interviewers in the 2006 Household Income and Expenditures Survey. Recruitment was done through radio advertisement and recommendation of SINSO staff.

Pre-test training for the interviewers consisted of classroom lectures, demonstration interviews, front-of-class interviews, mock interviews, quizzes and tests, and three days of field practice. Instructional materials included the household questionnaire, the women's questionnaire, the men's questionnaire, four field control forms, and various PowerPoint presentations. A whiteboard, an electronic projector and a laptop computer were also used during the pre-test training. The pre-test resulted in revising the translation of some questions and skip instructions.

1.5.3 Anaemia and blood pressure testing

All eligible women aged 15–49 who were interviewed were asked to voluntarily provide some drops of blood for anaemia testing, and the parents or guardians of children aged 6–59 months were asked for consent to test the child for anaemia. In addition, women aged 15–49 and men aged 15 and above who were interviewed were asked if they wanted to have their blood pressure taken as part of the survey.

The protocol for the anaemia and blood pressure testing was based on protocols developed by the DHS programme, and approved of by Macro International's Institutional Review Board. Each data collection team included one nurse/nurse aide/health technician who was responsible for taking the anthropometric (height and weight), blood pressure, and haemoglobin (anaemia) measurements.

For the blood pressure and anaemia testing, the team health technician described the procedure to eligible respondents in order to obtain informed consent. For the blood pressure measurement, respondents who agreed to the test were measured using the mercury-type sphygmomanometer.

Anaemia levels were determined by measuring the level of haemoglobin in the blood, a decreased concentration of which characterises anaemia. For haemoglobin measurement, capillary blood was taken from the finger (or heel of infants aged 6–11 months) using HemoCue safety lancets (i.e. sterile, single-use, spring-loaded instruments that allow a relatively painless skin puncture). Haemoglobin was measured in the blood using the HemoCue system.

1.5.4 Training

Interviewer training for the main enumeration was undertaken from 11–30 September, 2006. In total, 74 candidates (who comprised 12 teams plus 2 reserve interviewers) were trained. Each team consisted of three female interviewers, one male interviewer, one field editor and one team

supervisor and a nurse/health technician. Training was mostly done by Macro Inc's long-term consultant to the project.

A separate training for the 12 nurses/health technicians was conducted. However, due to the delayed delivery of the blood pressure measuring equipment and the weighing scales, training in how to use this equipment was delayed until the equipment was received in the first week of October.

A few days after the main training, a condensed training for five SINSO staff who would act as field supervisors or office editors/coders was carried out for 2.5 days. However, there was no actual practice on editing/coding due to time constraints.

Another condensed training for reserve interviewers was undertaken immediately after the training for field supervisors/office editors. This was a special training for eight (6 females and 2 males) newly recruited reserve interviewers to replace those not performing well in the field. All the questionnaires, forms and instructions were discussed thoroughly in five days as in the main training, with only one day of mock interviewing but no demonstration interviews.

For these trainings, the same techniques, materials, and equipment were used as in the pre-test training. In addition, a sound system was provided due to the large number of participants.

1.5.5 Fieldwork

As mentioned above, each of the 12 data collection teams comprised one supervisor, one field editor, three female interviewers, one male interviewer, and one nurse/health technician. Five senior staff from SINSO were designated as field coordinators. Data collection started on 9 October 2006. The field enumeration for Honiara and Guadalcanal were first, but without the measurement component of the survey. The teams had to make call backs for the measurements after the health technicians' training on the use of the weighing scale and sphygmomanometer. Data collection continued until April 2007.

The field teams faced several challenges:

1. A considerable number of households and individual respondents refused to be interviewed. The field editors and team supervisors had to make last attempt call-backs to interview problem households and respondents.
2. In Western Province, local health officials campaigned to residents not to cooperate because they were not informed about the survey. A SINSO senior staff visited the province to resolve the issue.
3. Tribal leaders of five EAs did not allow the interviewing team to conduct the survey, resulting in EA non-response.
4. Twelve EAs in Western Province were affected by the tsunami, resulting in missing questionnaires for the entire EA and non-coverage due to exodus of residents.

1.5.6 Data processing

The computer processing of SIDHS data began a few weeks after the fieldwork began. The Macro Inc data processing consultant held a training from 30 October 30 to 10 November 2006. A data processing specialist from SPC, the data processing head from SINSO, and two data processing staff from the Republic of the Marshall Islands attended. The training included how to set up the data entry system, data entry, and how to run the field check tables to monitor data quality and teams' and interviewers' performance.

Completed questionnaires were returned periodically from the field to the SINSO office in Honiara. Data processing began in the first week of November 2006 and was completed in the last week of June 2007. The data processing staff consisted of 2 supervisors from SINSO, 4 questionnaire administrators/coding clerks, and 14 data entry operators. Data were entered using the CSPro computer package. All data were entered twice (100% verification). The concurrent data processing was a distinct advantage for data quality, since SIDHS staff were able to advise

field teams of errors detected during data entry. Upon completion of data entry, final editing and preliminary tabulation were undertaken in the last week of June 2007. However, 33 of the 215 clusters were missing — either not enumerated, completed but destroyed by the tsunami, or refused by tribal leaders. Adjustment for non-response was done for the missing clusters. Sampling weights were then calculated and incorporated into the household and individual records.

1.6 RESULTS OF SURVEY INTERVIEWS

1.6.1 Response rates

Table 1 shows response rates for the 2006/2007 SIDHS. In total, 3,632 households were selected in the sample, of which 3,475 were found occupied at the time of the fieldwork. The shortfall is largely due to households that were away for an extended period of time. Of the existing households, 3,259 were successfully interviewed, yielding a household response rate of 94%.

Among the households interviewed in the survey, 4,409 eligible women were identified, of whom 3,823 were successfully interviewed yielding a response rate of 87%. With regard to male survey results, 2,598 eligible men were identified, of whom 2,056 were successfully interviewed, yielding a response rate of 79%. Response rates are lower in the urban sample than in the rural sample, especially for women. Response rates were lowest in Honiara and highest in Malaita.

The principal reason for non-response among eligible women and men was a failure to find individuals at home despite repeated visits to the household, followed by refusal to be interviewed. The substantially lower response rate for men reflects the more frequent and longer absence of men from the households.

Table 1.2: Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence and region, Solomon Islands 2006/2007

Result	Residence		Region					Total
	Urban	Rural	Honiara	Guadal- canal	Malaita	Western	Other provinces	
Household interviews								
Households selected	1,177	2,455	1,077	755	580	460	760	3,632
Households occupied	1,105	2,370	1,008	716	568	444	739	3,475
Households interviewed	1,008	2,251	917	666	555	412	709	3,259
Household response rate	91.2	95.0	91.0	93.0	97.7	92.8	95.9	93.8
Women's interviews								
Number of eligible women	1,844	2,565	1,715	752	644	467	831	4,409
Number of eligible women interviewed	1,463	2,360	1,363	673	610	400	777	3,823
Eligible women response rate	79.3	92.0	79.5	89.5	94.7	85.7	93.5	86.7
Men's interviews								
Number of eligible men	1,143	1,455	1,071	411	367	266	483	2,598
Number of eligible men interviewed	841	1,215	796	334	316	206	404	2,056
Eligible men response rate	73.6	83.5	74.3	81.3	86.1	77.4	83.6	79.1

CHAPTER 2 HOUSEHOLD POPULATION AND HOUSING CHARACTERISTICS

In the following chapters of this report, a number of demographic and health-related topics (e.g. respondent characteristics, fertility, contraceptive behaviour, infant and child mortality) are viewed across different sub-groups of the population. One focus of this chapter is to describe the environment in which survey respondents live. This description shows general characteristics of the population such as age-sex structure, literacy and education, household arrangements (e.g. headship, size) and housing facilities (sources of water, sanitation facilities, dwelling characteristics and household possessions). A distinction is made between urban and rural settings where many of these indicators usually differ.

Besides providing the background for better understanding of many social and demographic phenomena discussed in the following chapters, this general description is useful for assessing the level of economic and social development of the population.

2.1 HOUSEHOLD POPULATION BY AGE AND SEX

The 2006/2007 SIDHS included a household questionnaire that was used to elicit information on the socioeconomic characteristics of usual residents and visitors who had spent the previous night in the selected households. Table 2.1 shows the reported distributions of the household population in five-year age groups, by sex and urban-rural residence. Data show that there are just slightly more men (8,500) than women (8,365), with men constituting 50.4% of the population and women constituting 49.6%. The sex composition of the population does not show significant variation by urban-rural residence, in fact the proportions were same at 50.4% for men and 49.6 % for women.

Table 2.1: Household population by age, sex, and residence

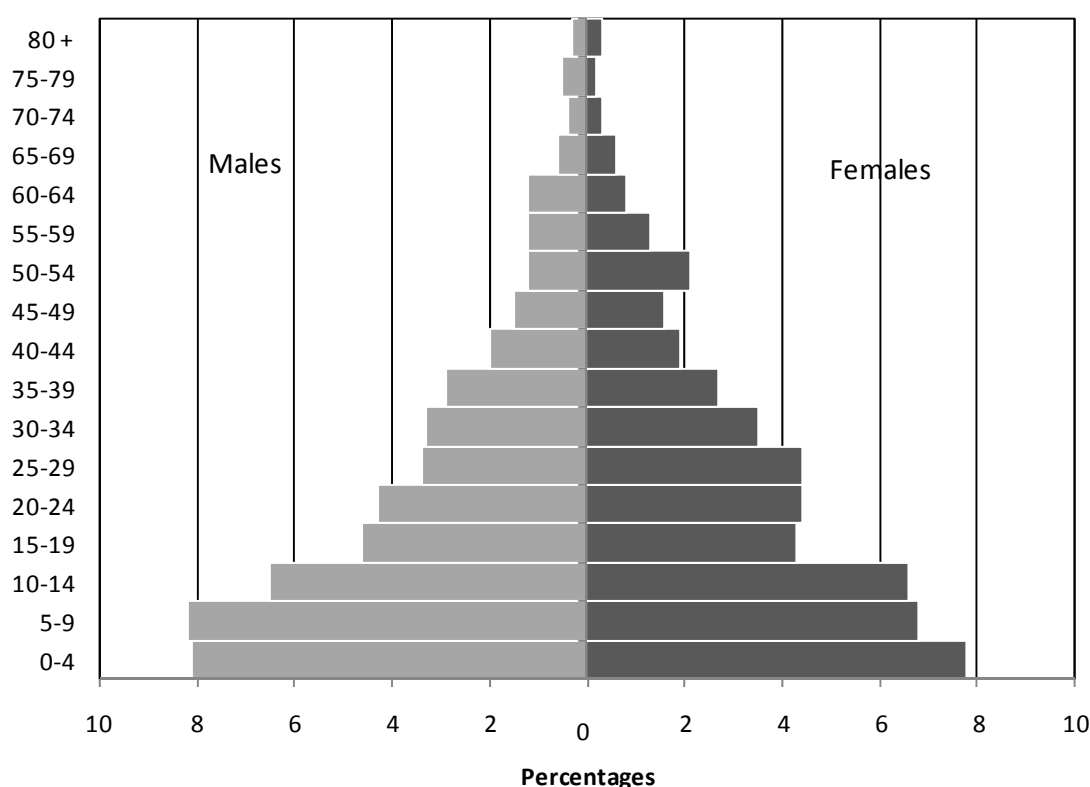
Percent distribution of the de facto household population by five-year age groups, according to sex and residence, Solomon Islands 2007

Age	Urban			Rural					
	Male	Female	Total	Male	Female	Total	Male	Female	Total
<5	12.3	13.8	13.0	16.7	16.0	16.4	16.1	15.7	15.9
5–9	13.8	12.0	13.0	16.6	13.9	15.3	16.2	13.7	14.9
10–14	9.8	11.2	10.5	13.5	13.5	13.5	13.0	13.2	13.1
15–19	10.4	11.2	10.8	8.9	8.3	8.6	9.1	8.7	8.9
20–24	12.8	13.0	12.9	7.7	8.2	8.0	8.4	8.9	8.7
25–29	9.6	9.8	9.7	6.3	8.6	7.5	6.8	8.8	7.8
30–34	8.8	8.7	8.8	6.1	6.8	6.5	6.5	7.1	6.8
35–39	7.1	6.2	6.7	5.5	5.4	5.4	5.7	5.5	5.6
40–44	4.2	3.8	4.0	4.0	3.9	3.9	4.0	3.9	4.0
45–49	3.2	2.7	3.0	3.0	3.2	3.1	3.0	3.2	3.1
50–54	2.9	3.7	3.3	2.3	4.3	3.3	2.4	4.2	3.3
55–59	1.7	1.6	1.6	2.5	2.7	2.6	2.4	2.6	2.5
60–64	1.5	0.9	1.2	2.6	1.7	2.2	2.4	1.6	2.0
65–69	0.5	0.4	0.5	1.4	1.3	1.4	1.3	1.2	1.2
70–74	0.3	0.2	0.3	1.0	0.8	0.9	0.9	0.7	0.8
75–79	0.0	0.0	0.0	1.1	0.5	0.8	0.9	0.4	0.7
80+	0.2	0.1	0.1	0.6	0.7	0.7	0.6	0.6	0.6
Don't know/missing	0.9	0.6	0.7	0.2	0.0	0.1	0.3	0.1	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	1,278	1,190	2,467	7,222	7,176	14,400	8,500	8,365	16,867

The table further depicts Solomon Islands as having a young population, with a large proportion of the population being in the younger age groups. The population under age 20 constitutes 53% of

the total population. The older age groups are very small in comparison, as can be seen in the population pyramid in Figure 2.1. In general, the population pyramid reflects a broad base pattern, characteristic of Solomon Islands and over half of its population being young. This type of age structure has a built-in momentum for the growth of the country's population. When the young population eventually reaches reproductive age, the result will be a high population growth rate for some years to come.

Figure 2.1: Population pyramid, Solomon Islands 2007



2.2 HOUSEHOLD COMPOSITION

Table 2.2 presents the headship and composition of households in Solomon Islands. Only one in ten households is headed by women while eight in ten households are headed by men. The proportion of female-headed households is the same in both urban and rural areas (i.e. 13%).

Close to 2 in every 10 households have one to two members. One- to two-member households are more likely to be found in rural areas (15.9% percent) than in urban areas (8.1%). Excluding household sizes of seven to nine (or more) members, rural areas have consistently higher percentages of households that contain between one to six members than urban areas. In urban areas, 20% of households have nine or more members, compared with about 9% in rural areas, indicating the need for housing in urban areas. Table 2.2 also shows that the mean household size is 5.3 people, which is slightly lower than the figure of 6.3 people obtained from the 1999 population and housing census (SINSO 1999). The mean household size is larger in urban areas (6.3 people) than in rural areas (5.2 people).

2.3 FOSTERHOOD AND ORPHANHOOD

In Solomon Islands, a person younger than age 18 years is defined as a child. Information on fosterhood and orphanhood of children is presented in Table 2.2. Nearly three in ten Solomon Islands households included one or more children who stayed with neither their natural father nor

their natural mother. A slightly higher percentage of households in urban areas (30%) have foster children than in rural areas (27%). Nearly one in ten (6.4%) Solomon Islands households have orphans. There are more households with single orphans (5%) than with double orphans (1%), and there are no major variations between rural and urban areas regarding households with orphans.

Table 2.2: Household composition

Percent distribution of households by sex of head of household and by household size; mean size of household, and percentage of households with orphans and foster children under age 18, according to residence, Solomon Islands 2007

Characteristic	Residence		Total
	Urban	Rural	
Household headship			
Male	86.7	87.4	87.3
Female	13.3	12.6	12.7
Total	100.0	100.0	100.0
Number of usual members			
1	4.8	6.7	6.5
2	3.3	9.2	8.5
3	9.5	11.4	11.2
4	11.7	13.7	13.5
5	13.3	15.5	15.3
6	14.7	14.9	14.9
7	12.6	11.4	11.6
8	10.0	8.3	8.5
9+	20.1	8.8	10.2
Total	100.0	100.0	100.0
Mean size of households	6.3	5.2	5.3
Percentage of households with orphans and foster children under age 18			
Foster children ¹	29.8	26.7	27.1
Double orphans	0.9	1.0	1.0
Single orphans	4.4	5.5	5.4
Foster and/or orphan children	32.2	29.6	29.9
Number of households	387	2,872	3,259

Note: Table is based on *de jure* household members (i.e. usual residents).

¹ Foster children are those under age 18 living in households with neither their mother nor their father present.

The distribution of *de jure* children under age 18 by living arrangements and survival status of parents and related information are presented in Table 2.3. About seven out of ten (69.5%) Solomon Islands children younger than age 18 years live with both parents, 10.0% live with their mother but not with father even though the father is alive somewhere. Both male and female children aged 0–9 years living in either rural or urban areas are more likely to be found living with their mothers. Moreover, children living with their mothers are almost equally distributed in all wealth quintiles from lowest to highest. In contrast, those children younger than age 18 years living with their fathers is only 1%, and these are likely to be in the age range of 10–14 years living in urban areas and from second and the highest household wealth quintiles. There is very little difference in the number of boys and girls in this living arrangement.

Table 2.3: Children's living arrangements and orphanhood

Percent distribution of *de jure* children under age 18 years by living arrangements and survival status of parents, the percentage of children not living with a biological parent, and the percentage of children with one or both parents dead, according to background characteristics, Solomon Islands 2007

Background characteristic	Living with mother but not with father			Living with father but not with mother		Not living with either parent					Total	Percentage not living with a biological parent	Percentage with one or both parents dead	Number of children
	Living with both parents	Father alive	Father dead	Mother alive	Mother dead	Both alive	Only father alive	Only mother alive	Both dead	Missing information on father/ mother				
Age														
0–4	72.3	15.5	1.0	0.5	0.5	8.3	0.1	0.0	0.1	1.6	100.0	8.5	1.8	2,677
<2	72.9	18.1	1.5	0.2	0.1	5.2	0.0	0.0	0.0	2.1	100.0	5.2	1.6	1,085
2–4	71.9	13.8	0.7	0.7	0.9	10.4	0.2	0.1	0.2	1.3	100.0	10.8	1.9	1,592
5–9	71.1	9.1	1.4	1.2	0.3	14.0	0.5	0.5	0.4	1.5	100.0	15.4	3.1	2,547
10–14	69.1	6.9	2.0	1.9	0.4	15.5	0.4	1.3	0.9	1.5	100.0	18.2	5.1	2,255
15–17	58.4	3.8	3.9	1.2	0.6	25.1	0.4	1.8	0.6	4.1	100.0	28.0	7.3	961
Sex														
Male	69.1	10.3	1.4	1.3	0.5	14.0	0.4	0.8	0.5	1.8	100.0	15.6	3.6	4,361
Female	69.9	9.6	2.1	1.1	0.3	13.8	0.2	0.7	0.5	1.8	100.0	15.1	3.8	4,078
Residence														
Urban	69.8	7.8	1.5	2.5	0.4	13.5	0.2	0.5	0.6	3.3	100.0	14.7	3.2	1,042
Rural	69.4	10.2	1.7	1.0	0.4	13.9	0.3	0.8	0.5	1.6	100.0	15.5	3.8	7,398
Region														
Honiara	72.0	7.5	1.1	2.3	0.6	11.5	0.3	0.6	0.4	3.7	100.0	12.8	3.1	732
Guadalcanal	77.1	7.1	2.5	1.4	0.3	9.0	0.5	0.5	0.2	1.5	100.0	10.1	3.9	1,504
Malaita	78.8	7.1	2.0	1.5	0.2	7.7	0.3	0.7	0.5	1.2	100.0	9.2	3.7	2,045
Western	58.5	15.1	1.1	1.1	0.8	19.1	0.0	0.2	0.8	3.2	100.0	20.1	3.1	999
Other provinces	62.7	12.1	1.4	0.7	0.5	19.1	0.4	1.1	0.5	1.5	100.0	21.1	3.9	3,160
Wealth quintile														
Lowest	73.0	10.8	1.4	0.9	0.2	10.6	0.4	0.9	0.5	1.3	100.0	12.3	3.3	1,837
Second	71.9	8.4	1.9	1.4	1.0	11.8	0.5	1.1	0.5	1.5	100.0	13.9	5.2	1,741
Middle	66.7	10.7	2.0	0.8	0.3	16.7	0.1	0.1	0.6	2.0	100.0	17.5	3.1	1,696
Fourth	66.0	10.5	1.7	0.9	0.3	16.5	0.2	0.9	0.6	2.4	100.0	18.2	3.6	1,601
Highest	69.3	9.2	1.5	2.0	0.3	14.2	0.4	0.7	0.3	2.1	100.0	15.6	3.2	1,565
Total <15	70.9	10.7	1.4	1.2	0.4	12.4	0.3	0.6	0.5	1.5	100.0	13.8	3.2	7,478
Total <18	69.5	9.9	1.7	1.2	0.4	13.9	0.3	0.7	0.5	1.8	100.0	15.4	3.7	8,440

Note: Table is based on *de jure* members (i.e. usual residents).

The 2006/2007 SIDHS results from Table 2.3 also shows that Solomon Islands children younger than age 18 years and not living with either parent constitute about one in seven (13.9%) of children. These are likely to be in the 2–17 years age range living in both rural and urban areas, and in the middle to highest wealth quintile households. There is very little variation by sex.

Overall, roughly one-sixth (15%) of children do not live with their biological parents. This figure is likely to increase as the age of the child increases and is equally likely to be the case in both rural and urban areas. The variation by region ranges from 9–21%. Meanwhile, about 4% of these children have either one or both parents' dead.

2.4 HOUSING CHARACTERISTICS

Increased access to safe drinking water results in improved health outcomes in the form of reduced cases of water-borne diseases such as dysentery and cholera. Information was collected in the 2006/2007 SIDHS about certain characteristics of household drinking water, including source of drinking water, time taken to collect water, household members who usually collect the water, water treatment prior to drinking, and type of sanitation facility.

Table 2.4 shows that 83% of households use improved water sources.² In urban areas, 9 in every 10 households have access to an improved water source while 8 in every 10 households have access to an improved water source in rural areas. Piped water into a dwelling/yard/plot (28%) and public tap/standpipe (28%) are the two major sources of drinking water (a combined total of 56%), while rainwater (18%) and non-improved water source (16%) are the next two important sources (with a combined total of 34%). These four sources combined are used by about 90% of households. Other water sources such as tube well or borehole, protected dug well and protected spring, unprotected dug well, unprotected spring and surface water accounts for only 25%. The percentage of households with access to piped water into a dwelling/yard/plot is much higher in urban areas (60%) than in rural areas (24%). However, public tap/standpipe water source is more popular in rural areas (30%) than in urban areas (11%). These results complement the findings of the 1999 Population and Housing Census.

Regarding the amount of time taken to draw water, findings show major urban-rural differences. In rural areas, 26% of households take less than 30 minutes to obtain drinking water, compared with only 8.1% of urban households. Similarly, most rural households (5.1%) still take 30 minutes or longer to make a round trip to and from a drinking water source compared with only 3.2% in urban areas. The above differences may have been determined by the result that 88% of households in urban areas have water on the premises compared with only 67% of households in rural areas.

The 2006/2007 SIDHS findings also show that most of the burden of fetching drinking water rests on women aged 15 and over. Solomon Islands children (girls and boys under age 15) are less likely to fetch water (only about 2.9% of households). It should be noted that households could report more than one person who usually collects water. In rural areas, women collect water in a higher percentage of households than other family members under age 15 (23%) compared with only 6.5% for urban women where most households have water on the premises.

Water from an improved source can be contaminated at collection, during transportation, and during storage. Information was collected on whether or not water was treated prior to drinking. The majority of households (84%) do not use any appropriate treatment method on their drinking water while only about 13% of households do use an appropriate treatment method. The most commonly reported treatment method is boiling. Only one in every ten households boiled water prior to drinking. This method is practiced more by urban households (29%) than by rural households (9%).

² Improved water sources include piped water, public tap, tube well or borehole, protected dug well, or spring and rainwater. It should be noted that the definition of improved water sources used in Solomon Islands differs from the international definition used here in that it excludes rainwater.

Table 2.4: Household drinking water

Percent distribution of households and de jure population by source, time to collect, and person who usually collects drinking water; and percentage of households and de jure population by treatment of drinking water, according to residence, Solomon Islands 2007

Characteristic	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Source of drinking water						
Improved source	93.7	81.7	83.1	93.7	82.6	84.1
Piped water into dwelling/yard/plot	60.3	23.8	28.2	61.0	24.4	29.6
Public tap/standpipe	11.1	30.2	27.9	10.6	30.9	28.0
Tube well or borehole	0.2	0.9	0.8	0.3	0.8	0.8
Protected dug well	0.2	4.2	3.8	0.3	4.4	3.8
Protected spring	2.2	5.1	4.7	2.0	4.7	4.3
Rainwater	19.7	17.5	17.7	19.5	17.4	17.7
Non-improved source	5.7	17.8	16.4	5.9	17.0	15.4
Unprotected dug well	0.1	1.2	1.1	0.1	1.3	1.2
Unprotected spring	3.0	7.7	7.1	3.3	7.5	6.9
Tanker truck/cart with small tank	0.7	0.5	0.5	0.5	0.5	0.5
Surface water	1.9	8.4	7.6	1.9	7.7	6.9
Bottled water, improved source for cooking/washing ¹	0.4	0.0	0.0	0.3	0.0	0.0
Other	0.2	0.2	0.2	0.1	0.2	0.2
Missing	0.0	0.3	0.2	0.0	0.2	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Percentage using any improved source of drinking water						
	94.1	81.7	83.2	94.0	82.6	84.2
Time to obtain drinking water (round trip)						
Water on premises	87.9	66.8	69.3	88.2	67.7	70.6
Less than 30 minutes	8.1	26.2	24.1	7.8	24.9	22.5
30 minutes or longer	3.2	5.1	4.9	3.5	5.8	5.5
Don't know/missing	0.8	1.8	1.7	0.5	1.6	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Person who usually collects drinking water						
Adult female 15+	6.5	23.0	21.0	6.3	23.5	21.1
Adult male 15+	1.6	5.5	5.0	1.4	3.2	2.9
Female child under age 15	0.6	2.1	1.9	0.6	2.6	2.3
Male child under age 15	0.1	0.8	0.8	0.1	1.2	1.0
Other	3.2	1.2	1.5	3.4	1.4	1.7
Water on premises	87.9	66.8	69.3	88.2	67.7	70.6
Missing	0.1	0.6	0.5	0.1	0.4	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Water treatment prior to drinking²						
Boiled	29.1	8.9	11.3	29.8	8.3	11.3
Bleach/chlorine	0.9	0.0	0.1	1.1	0.0	0.2
Strained through cloth	2.1	1.6	1.6	1.8	1.5	1.6
Ceramic, sand or other filter	0.4	0.0	0.1	0.3	0.0	0.1
Solar disinfection	0.2	0.1	0.1	0.3	0.0	0.1
Other	4.5	1.7	2.1	4.8	1.7	2.1
No treatment	64.8	86.8	84.2	64.1	87.4	84.1
Percentage using an appropriate treatment method³						
	31.2	10.3	12.8	31.8	9.7	12.8
Number	387	2,872	3,259	2,450	14,854	17,303

¹ Because the quality of bottled water is unknown, households using bottled water for drinking are classified as using an improved or non-improved source according to their water source for cooking and washing.

² Respondents may report multiple treatment methods so the sum of treatment may exceed 100%.

³ Appropriate water treatment methods include boiling, bleaching, straining, filtering, and solar disinfecting.

Poor sanitation coupled with unsafe water sources increases the risk of water-borne diseases and illnesses due to poor hygiene. This has contributed immensely to the disease burden in Solomon Islands. Households without proper toilet facilities are more exposed to the risk of diseases such as dysentery, diarrhoea, and typhoid fever than those with improved sanitation facilities. Table 2.5 shows that approximately two in ten households use improved toilet/latrine facilities compared with about eight in ten households that use non-improved toilet/latrine facilities. Households with improved toilet facilities of flush/pour flush to septic tank system account for only about 8% and mostly in urban areas (52%) while those with pit latrine with slab account for a little over 4% and are again more likely to be in the urban areas (13%). Overall, 66% of households in Solomon Islands have no toilet facilities of any kind. This problem is more common in rural areas, where a staggering 74% of households have no toilet facilities, compared with urban areas where only 5% of households have no facilities. The 2006/2007 SIDHS findings support what was found in the 1999 Population and Housing Census.

Table 2.5: Household sanitation facilities

Percent distribution of households and de jure population by type of toilet/latrine facilities, according to residence, Solomon Islands 2007

Type of toilet/latrine facility	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Improved, not shared facility						
Flush/pour flush to septic tank	51.7	1.9	7.8	56.1	1.7	9.4
Flush/pour flush to pit latrine	5.8	1.2	1.7	5.5	1.4	2.0
Ventilated improved pit (VIP) latrine	1.4	1.5	1.5	1.7	1.5	1.5
Pit latrine with slab	12.6	3.1	4.3	13.5	3.2	4.7
Non-improved facility						
Any facility shared with other households	16.8	6.0	7.3	12.7	6.2	7.1
Flush/pour flush not to sewer/septic tank/pit latrine	0.2	0.2	0.2	0.2	0.2	0.2
Pit latrine without slab/open pit	1.9	6.1	5.6	1.5	5.9	5.2
Bucket	3.4	0.9	1.2	3.3	0.7	1.1
Hanging toilet/hanging latrine	0.0	1.5	1.3	0.0	1.7	1.4
No facility/bush/field/beach	4.8	73.8	65.6	4.1	73.3	63.5
Other	0.1	3.4	3.0	0.1	3.8	3.3
Missing	1.2	0.4	0.5	1.2	0.4	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	387	2,872	3,259	2,450	14,854	17,303

Table 2.6 provides information that relates to other characteristics of dwellings, such as whether or not the household has electricity, the main construction materials used for the floor, the number of rooms used for sleeping, and information on type of power/fuel used for cooking and location of cooking.

Only 13% of households in Solomon Islands have access to electricity. The result is similar but just slightly lower than that of the 1999 Population and Housing Census (16%). As expected, access to electricity is much higher in urban areas (69%) than in rural areas (a mere 5%). Indeed, findings show that 9 in 10 rural households do not have access to electricity.

The type of material used for the floor may be viewed as an indicator of the quality of housing (a wealth dimension) as well as an indicator of health risk. Some floor materials such as earth and sand pose a health problem because they can act as breeding grounds for pests and may be a source of dust. They are also more difficult to keep clean.

Overall, over 5 out of every 10 households (55%) have floors made of wood/planks. Wood/planks are almost equally used by urban (54%) and rural (55%) households. Palm/bamboo is the next most commonly used flooring type, of which 2 in 10 households have floors made of this material and that this flooring type is more popular in the rural households (23%) than urban households (0.3%). On the other hand, only about 7% of households have earth or sand floors, with rural

households accounting for the majority of households (8%), compared with only 0.6% of the urban households.

The number of rooms used for sleeping gives an indication of the extent of crowding in households. Crowding in one sleeping room increases the risks of infection by diseases. In Solomon Islands, a room that sleeps more than two people is considered to be overcrowded. Overall, about one-fifth of all households (19.4%) use only one room for sleeping. A higher percentage of household members in rural areas (21%) sleep in one room than in urban areas (11%). Households in urban areas are more likely to use two or more rooms for sleeping than households in rural areas.

Smoke from solid fuels for cooking (e.g. charcoal, wood, and other biomass fuels) is a major cause of respiratory infections. The type of fuel used for cooking, the location where food is cooked, and the type of stove used are all related to indoor air quality and the degree to which household members are exposed to the risk of respiratory infections and other diseases. A little over 1 in 10 (13%) Solomon Islands households cook in the same house, about eight in ten (82%) use a separate building, while only 4% cook outdoors. Rural households are more likely (86%) than urban households (56%) to cook in a separate building, although cooking in a separate building is also still common in urban households (as was revealed by the DHS).

Cooking fuel affects air quality for household members. Clean fuel is not affordable in most cases and most households resort to using solid fuels that emit a lot of smoke. As a result, household members are likely to be exposed to air pollution. Reducing the proportion of the population relying on solid fuels is a Millennium Development Goal. In Solomon Islands, this proportion is 92%.

Table 2.6: Household characteristics

Percent distribution of households and de jure population by housing characteristics and percentage using solid fuel for cooking; and among those using solid fuels, percent distribution by type of fire/stove, according to residence, Solomon Islands 2007

Housing characteristic	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Electricity						
Yes	68.6	5.4	12.9	70.6	5.1	14.4
No	31.2	93.8	86.4	29.2	94.1	84.9
Missing	0.1	0.8	0.7	0.2	0.8	0.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Flooring material						
Earth, sand	0.6	7.6	6.8	0.4	7.0	6.0
Dung	0.0	3.0	2.6	0.0	2.6	2.3
Wood/planks	53.9	55.4	55.2	54.2	55.4	55.3
Palm/bamboo	0.3	22.9	20.2	0.4	22.9	19.7
Parquet or polished wood	15.9	4.8	6.2	15.4	5.3	6.8
Vinyl or asphalt strips	1.0	0.2	0.3	1.1	0.2	0.4
Ceramic tiles	1.0	0.1	0.2	0.7	0.1	0.2
Cement	20.9	3.4	5.5	21.1	3.4	5.9
Carpet	5.6	0.8	1.4	5.7	1.2	1.9
Other	0.7	1.4	1.3	0.9	1.4	1.3
Missing	0.1	0.4	0.3	0.1	0.3	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Rooms used for sleeping						
One	11.3	20.5	19.4	7.6	16.4	15.1
Two	43.6	38.8	39.4	41.6	38.3	38.8
Three or more	37.5	35.8	36.0	43.8	40.4	40.9
Missing	7.6	4.9	5.2	7.1	4.8	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 2.6 (continued)

Housing characteristic	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Place for cooking						
In the house	34.2	10.1	12.9	34.0	9.3	12.8
In a separate building	55.5	85.5	82.0	55.0	87.9	83.2
Outdoors	9.4	3.1	3.9	10.1	1.8	2.9
Other	0.3	0.2	0.2	0.4	0.1	0.2
Missing	0.6	1.1	1.0	0.4	1.0	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Cooking fuel						
Electricity	1.3	0.2	0.4	1.0	0.1	0.3
LPG/natural gas/biogas	41.4	2.5	7.2	39.0	1.9	7.1
Coal/lignite	1.6	2.3	2.2	1.5	2.5	2.4
Charcoal	47.4	93.9	88.4	49.5	94.5	88.1
Straw/shrubs/grass	7.9	0.5	1.4	8.6	0.6	1.8
Agricultural crop	0.2	0.0	0.1	0.2	0.0	0.0
No food cooked in household	0.1	0.3	0.2	0.0	0.1	0.1
Other	0.2	0.0	0.0	0.2	0.0	0.0
Missing	0.0	0.2	0.2	0.0	0.2	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Percentage using solid fuel for cooking ¹	57.0	96.8	92.1	59.8	97.7	92.3
Number of households/population	387	2,872	3,259	2,450	14,854	17,303
Type of fire/stove among households using solid fuel¹						
Closed stove with chimney	0.0	0.0	0.0	0.0	0.0	0.0
Open fire/stove with chimney	1.9	2.7	2.7	2.0	2.8	2.7
Open fire/stove with hood	1.9	2.1	2.1	1.2	2.2	2.1
Open fire/stove without chimney or hood	93.4	93.6	93.6	93.0	93.5	93.4
Other	0.1	0.0	0.0	0.1	0.0	0.0
Missing	2.7	1.5	1.6	3.7	1.5	1.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of households/population using solid fuel	221	2,780	3,000	1,465	14,510	15,975

LPG = liquid petroleum gas

¹ Includes coal/lignite, charcoal, wood/straw/shrubs/grass, agricultural crops, and animal dung [list categories included in the country questionnaire]

Findings in Table 2.6 also show that charcoal is the fuel used for cooking in 88% of all households, while LPG/natural gas/biogas is used in 7% of households. Electricity is used by only 0.4% of all households while coal/lignite is used in 2% of all households. Use of charcoal fuel in rural areas is almost universal with over 9 out of 10 households using it, while in urban areas nearly 5 out of 10 households (47%) use this type of fuel.

Chimneys help reduce the exposure of household members to cooking fire smoke. Results show that 94% of households use open fires/stoves without chimneys for cooking, which waste energy and expose household members to harmful smoke.

2.5 HOUSEHOLD ASSETS

The 2006/2007 SIDHS also collected information on household ownership of selected assets that are in themselves believed to have a strong association with poverty levels. Some of these can be used to measure household welfare when combined with other indicators to generate a wealth index. Information was collected on household ownership of a radio and television as a measure of access to mass media; telephone ownership (both mobile and non-mobile telephones) as an indicator of access to an efficient means of communication; refrigerator ownership as an indication of the capacity for hygienic storage of foods; and ownership of a means of transportation (bicycle, motorcycle, boat with or without a motor, or private car or truck) as a sign

of the household's level of access to public services and markets as well as exposure to developments in other areas. In addition, ownership of agricultural land shows a household's access to means of production. Ownership of farm animals such as local cattle, exotic/cross cattle, horses/donkeys/mules, goats, sheep, pigs, or chickens indicates the level of assets a household possesses that could be used to meet household demands.

Table 2.7 shows that 55% of households in Solomon Islands own a radio; urban households are more likely than rural households to own a radio (80% and 52%, respectively). Overall, 5% of all households own a television, and as expected, urban households are more likely than rural households to own a television set (38% and 0.9%, respectively). About 4% of households own a mobile telephone while 2% own a non-mobile telephone and almost all these telephones are likely to be owned by urban households. Regarding transport, about 9% of households own bicycles and these are more likely to be found in urban households (10%) than in rural households (8.5%). Meanwhile, 14% of urban households own a car or truck compared with less than 1% of rural households. In contrast, about 9% of rural households own a boat with a motor compared with 6% of urban households. Similarly, 7% of rural households own fishing gear compared with 3% of urban households.

Nearly 2 out of 10 households (18.4%) own agricultural land; 29% are owned by urban households while 17% are owned by rural households. A little over 4 out of 10 households (43%) own farm animals and, as expected, 48% of these households are in rural areas while 9% of households are in urban areas. Pigs, chickens and cattle were some of the most commonly owned types of livestock, each owned by 43% of all households.

Table 2.7: Household possessions

Percentage of households and de jure population possessing various household effects, means of transportation, agricultural land and livestock/farm animals by residence, Solomon Islands 2007

Possession	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Household effects						
Radio	79.9	51.7	55.1	81.4	54.7	58.5
Television	38.3	0.9	5.3	43.6	1.3	7.3
Mobile telephone	24.3	0.7	3.5	27.0	0.8	4.5
Non-mobile telephone	15.0	0.2	2.0	16.5	0.3	2.6
Refrigerator	35.9	0.6	4.8	38.0	0.5	5.8
Bed	70.8	45.1	48.2	71.8	45.9	49.6
Dining set	52.6	12.3	17.1	55.1	13.7	19.5
Dressing table	40.7	6.1	10.2	42.7	7.2	12.2
Lounge chair	41.9	6.7	10.9	46.2	7.2	12.7
Pressure lamp	20.7	19.6	19.7	22.7	19.7	20.1
Cooking gas	53.5	5.2	10.9	54.1	5.2	12.1
Microwave oven	8.2	0.3	1.2	9.2	0.2	1.5
Sewing machine	44.9	31.8	33.3	49.5	34.7	36.8
Freezer	23.1	0.2	3.0	23.5	0.2	3.5
Washing machine	5.1	0.5	1.0	5.0	0.6	1.2
Video set	46.8	3.0	8.2	51.4	3.4	10.2
Chainsaw	6.2	7.6	7.4	6.9	8.6	8.3
Carpet/floor rug	59.5	15.8	21.0	60.8	16.6	22.9
Fishing net	2.9	7.2	6.7	3.0	8.3	7.5
Means of transport						
Bicycle	10.0	8.5	8.7	11.1	9.4	9.6
Animal drawn cart	0.7	0.6	0.6	0.8	0.5	0.5
Motorcycle/scooter	0.7	0.2	0.3	0.6	0.1	0.2
Car/truck	14.1	0.7	2.3	16.7	0.8	3.1
Boat with a motor	6.2	8.6	8.4	7.0	9.1	8.8
Ownership of agricultural land						
	29.1	17.0	18.4	32.4	18.0	20.0
Ownership of farm animals¹						
	8.9	48.1	43.4	10.0	51.5	45.6
Number	387	2,872	3,259	2,450	14,854	17,303

¹ cattle, cows, bulls, horses, donkeys, goats, sheep or chickens

2.6 WEALTH QUINTILES

The 2006/2007 SIDHS did not collect information on household income or consumption. However, information on household assets is used to create an index representing the wealth of households interviewed. The wealth index is a proxy for long-term standard of living of the household. Household assets used to calculate the wealth index include consumer items such as a refrigerator, television and car; dwelling characteristics such as floor material; type of drinking water source; toilet facilities; and other characteristics that are related to wealth.

To construct the wealth index, each household asset for which information was collected is assigned a weight or factor score generated through principal components analysis. The resulting asset scores are standardised in relation to a standard normal distribution with a mean of zero and a standard deviation of one.

Each household is assigned a standardised score for each asset, where the score differs depending on whether or not the household owned that asset (or, in the case of sleeping arrangements, the number of people per room). These scores are summed by household, and individuals are ranked according to the total score of the household in which they reside. The sample is then divided into population quintiles (i.e. five groups with the same number of individuals in each). The 20% of the population with the lowest total asset scores become the individuals in the lowest wealth quintile; the next 20% become the members of the second wealth quintile, and so forth. At the national level, approximately 20% of the household population is in each wealth quintile.

In other words, the wealth index measures the standard of living of a household relative to other households in Solomon Islands. The wealth quintile of a household does not indicate whether or not the household lives in poverty according to a Solomon Islands poverty definition (an experience of hardship). Rather, it indicates that an individual living in a household in the second wealth quintile has better socioeconomic status than someone in the lowest wealth quintile and worse socioeconomic status than someone in the middle wealth quintile.

In defining the wealth quintiles, a single asset index is developed on the basis of data from the entire country sample and used in all the tabulations presented. Separate asset indices are not prepared for rural and urban population groups on the basis of rural or urban data, respectively.

Wealth quintiles are expressed in terms of quintiles of individuals in the population, rather than quintiles of individuals at risk for any one health or population indicator. Thus, for example, the quintile rates for infant mortality refer to the infant mortality rates per 1,000 live births among all people in the population quintile concerned, as distinct from quintiles of live births or newly born infants, who constitute the only members of the population at risk of mortality during infancy.

The assets index has been found to be highly comparable to both poverty rates and gross domestic product per capita for India, and against expenditure data from household surveys in Nepal, Pakistan and Indonesia (Filmer and Pritchett 1998) and Guatemala (Rutstein 1999).

Table 2.8: Wealth quintiles

Percent distribution of the de jure population by wealth quintiles, and the Gini coefficient according to residence and region, Solomon Islands 2007

Solomon Islands, Solomon Islands 2007							
	Wealth quintile						
Residence/region	Lowest	Second	Middle	Fourth	Highest	Total	Number of population
Residence							
Urban	0.6	1.1	3.4	13.0	81.9	100.0	2,450
Rural	23.2	23.1	22.7	21.1	9.9	100.0	14,854
Region							
Honiara	0.2	1.5	2.3	10.8	85.2	100.0	1,784
Guadalcanal	26.1	16.5	19.2	20.9	17.2	100.0	2,934
Malaita	21.2	22.8	23.6	20.4	12.0	100.0	3,969
Western	9.0	12.7	20.1	27.8	30.4	100.0	2,045
Other provinces	25.4	27.1	22.9	19.3	5.3	100.0	6,572
Total	20.0	20.0	20.0	20.0	20.1	100.0	17,303

Table 2.8 shows the distribution of the de jure household population into five wealth levels (quintiles) based on the wealth index by residence. These distributions indicate the degree to which wealth is evenly (or unevenly) distributed by geographic areas. The findings indicate that wealth is concentrated in urban areas. Among the population in urban areas, 82% is in the highest wealth quintile, compared with 10% of the household population in rural areas. About 95% of the urban population is in the top two (fourth and highest) household wealth quintiles compared with nearly 5 in 10 rural people likely to be found in the last second and lowest household wealth quintiles. These results further confirm other findings that the distribution of wealth is uneven and that poverty is more concentrated in rural areas than in urban areas.

2.7 BIRTH REGISTRATION

It is a human right for a child to know who its parents are and to have a nationality through registration. The registration system in Solomon Islands needs to be formalised with the Ministry of Home Affairs. Currently, only birth registration is done by the Ministry of Health but requires considerable quality control checks to improve proper recording and maintenance. Coverage is good in some provinces while in others more efforts are needed to improve the capture of vital demographic processes. Birth registration is being undertaken in all provinces countrywide. Apart from being the first legal acknowledgment of a child's existence, birth registration is fundamental to the realisation of a number of rights and practical needs, including but not limited to access to health care and immunisation. Birth registration in a well established and functioning system ensures that the country has an up-to-date and reliable database for planning. This is as useful for national level planning as it is for local government bodies that are responsible for maintaining education, health, and other social services for the community.

Table 2.9 shows that about 80% of children are registered in Solomon Islands. There is, in fact, a slight difference in the proportion of children registered in urban areas (70%) than in rural areas (81%). However, there is not much variation in birth registration within household wealth quintiles, ranging from 80% in the lowest quintile to 78% in the highest quintile.

Table 2.9: Birth registration of children under age 5 years

Percentage of de jure children under age 5 years whose births are registered with civil authorities, according to background characteristics, Solomon Islands 2007

Background characteristic	Percentage of children whose births are registered			Number of children
	Had a birth certificate	Did not have a birth certificate	Total registered	
Age				
<2	79.2	1.7	80.9	1,085
2–4	77.3	1.7	79.1	1,592
Sex				
Male	77.4	1.7	79.1	1,344
Female	78.8	1.7	80.4	1,333
Residence				
Urban	68.7	1.1	69.8	319
Rural	79.4	1.8	81.1	2,357
Region				
Honiara	61.9	0.6	62.5	232
Guadalcanal	75.9	2.4	78.3	475
Malaita	78.4	3.3	81.8	649
Western	66.4	2.5	68.9	304
Other provinces	86.1	0.4	86.5	1,016
Wealth quintile				
Lowest	79.5	0.3	79.8	645
Second	82.0	2.5	84.5	565
Middle	75.1	2.4	77.5	520
Fourth	76.6	1.7	78.3	502
Highest	76.3	1.9	78.1	445
Total	78.1	1.7	79.8	2,677

2.8 EDUCATIONAL LEVEL OF HOUSEHOLD POPULATION

Education affects many aspects of life, including individual demographic and health behaviour. Studies have shown that educational level is strongly associated with contraceptive use, fertility, and the general health status, morbidity, and mortality of children. In each household, for all members aged 6 years or older, data were collected on the highest level of education attended and the highest grade completed at that level. Table 2.10.1 shows the distribution of female household members and Table 2.10.2 shows the distribution for male household members aged 6 years and older by the highest level of education attained and the median number of years of education completed, according to background characteristics.

Table 2.10.1: Educational attainment of the female household population

Percent distribution of the de facto female household populations age 6 and over by highest level of schooling attended or completed and median grade completed, according to background characteristics, Solomon Islands 2007

Background characteristic	No education	Some primary	Completed primary ¹	Some secondary	Completed secondary ²	More than secondary	Don't know/missing	Total	Number	Median years completed
Age										
6–9	68.2	26.6	0.0	0.1	0.0	0.0	5.1	100.0	1,143	0.0
10–14	8.8	83.5	3.9	2.9	0.0	0.0	0.8	100.0	1,106	2.2
15–19	8.3	27.5	19.0	43.1	0.0	0.4	1.7	100.0	727	5.7
20–24	8.6	23.3	19.0	43.1	0.5	4.0	1.3	100.0	746	5.9
25–29	11.2	26.1	31.6	25.0	0.1	4.6	1.6	100.0	736	5.4
30–34	14.1	23.7	41.0	15.4	0.1	5.3	0.5	100.0	592	5.3
35–39	26.0	18.1	40.0	12.3	0.0	2.8	0.8	100.0	459	5.1
40–44	20.4	25.2	38.2	10.4	0.0	5.5	0.3	100.0	325	5.2
45–49	31.3	49.7	8.4	8.1	0.5	1.4	0.7	100.0	264	2.6
50–54	45.4	35.5	9.8	4.4	0.0	0.9	3.9	100.0	352	1.0
55–59	37.0	50.5	7.9	1.2	0.0	1.0	2.4	100.0	214	1.5
60–64	50.0	33.9	4.6	1.0	0.0	2.1	8.4	100.0	136	0.0
65+	62.2	30.1	3.2	0.4	0.0	0.6	3.4	100.0	243	0.0
Residence										
Urban	18.1	27.4	14.8	30.1	0.4	6.6	2.6	100.0	1,025	5.3
Rural	28.4	38.2	17.3	12.7	0.0	1.2	2.1	100.0	6,025	2.7
Region										
Honiara	17.9	26.9	14.8	30.6	0.5	6.5	2.8	100.0	745	5.4
Guadalcanal	30.8	37.8	13.2	14.1	0.0	0.7	3.2	100.0	1,210	2.5
Malaita	38.9	36.7	10.2	10.2	0.0	1.3	2.7	100.0	1,673	1.0
Western	10.2	35.1	29.4	20.5	0.1	2.1	2.6	100.0	844	5.2
Other provinces	25.3	39.3	19.6	12.9	0.1	1.8	1.1	100.0	2,578	3.2
Wealth quintile										
Lowest	38.1	39.9	13.1	7.9	0.0	0.0	1.1	100.0	1,331	1.3
Second	28.0	38.9	18.8	10.3	0.0	0.2	3.8	100.0	1,453	2.8
Middle	27.3	38.9	18.6	12.1	0.0	1.1	1.9	100.0	1,373	2.6
Fourth	25.8	35.6	19.0	15.8	0.0	1.6	2.1	100.0	1,394	3.3
Highest	16.4	30.5	15.1	29.0	0.4	6.7	1.9	100.0	1,499	5.2
Total	26.9	36.6	16.9	15.3	0.1	2.0	2.2	100.0	7,050	3.0

¹ Completed six grades at the primary level.

² Completed seven grades at the secondary level.

Note: Totals include nine women for whom age is missing.

As shown in Table 2.10.1 and Table 2.10.2, the majority of Solomon Islanders had attended school, although many did not complete primary school (about 30% for each sex). Among those who never attended school, slightly more females than males never attended; 26.9% of females aged 6 or older in Solomon Islands had never been to school, compared with 22.8% of males. According to these results, the gender gaps in educational attainment are obvious; favouring males more than females in all categories except for ‘completed secondary’ attainment level, where both are the same for each sex (0.1%). Females aged 20 and older are less likely to have no education and have attained some secondary education than males aged 20 and older. In contrast, the proportion of individuals aged 6–19 with no education is higher for males than for females.

Overall, levels of educational attainment in the primary level are higher in rural areas than in urban areas while in the secondary levels it is higher in urban areas than in rural areas. The median number of years of schooling is higher in urban areas (5 years) than in rural areas (3 years).

As a result of free education at the primary education level, there is little variation among the different levels of educational attainment in this category with the exception of secondary and

higher. The likelihood of completing secondary and ‘more than secondary’ level education increases as a household’s wealth quintile increases. For example, among females, only 7.9% of those from the poorest households would have some secondary education while 29% of females from the wealthiest households would have some secondary schooling. Similar differences by wealth are also large among males; only 8% of males from the poorest households have ‘some secondary’ compared with 32% from the wealthiest households.

Table 2.10.2: Educational attainment of the male household population

Percent distribution of the de facto male household populations age 6 and over by highest level of schooling attended or completed and median grade completed, according to background characteristics, Solomon Islands 2007

Background characteristic	No education	Some primary	Completed primary ¹	Some secondary	Completed secondary ²	More than secondary	Don't know/missing	Total	Number	Median years completed
Age										
6–9	74.8	21.8	0.2	0.0	0.0	0.0	3.2	100.0	1,375	0.0
10–14	10.6	81.5	4.6	1.7	0.0	0.0	1.5	100.0	1,104	2.0
15–19	5.5	33.9	19.9	39.3	0.1	0.7	0.5	100.0	776	5.5
20–24	6.1	16.8	18.7	53.1	0.8	3.5	1.0	100.0	718	7.3
25–29	6.7	13.6	29.3	37.4	0.4	9.8	2.8	100.0	579	6.0
30–34	3.4	19.4	39.2	23.7	0.2	11.8	2.3	100.0	554	5.7
35–39	9.4	15.7	35.0	26.6	0.2	12.2	0.9	100.0	486	5.7
40–44	8.6	20.3	31.0	28.4	0.1	8.9	2.7	100.0	341	5.9
45–49	10.6	41.1	19.7	20.8	0.1	5.5	2.2	100.0	258	5.7
50–54	12.0	57.4	11.8	7.6	0.0	8.7	2.5	100.0	202	5.5
55–59	16.3	49.2	12.1	12.9	0.0	6.7	2.8	100.0	200	5.1
60–64	19.7	49.5	20.4	5.7	0.0	3.9	0.7	100.0	207	4.0
65+	43.9	47.1	2.2	0.8	0.0	3.7	2.3	100.0	309	0.7
Residence										
Urban	14.9	23.8	14.2	33.6	0.8	9.5	3.2	100.0	1,120	5.8
Rural	24.3	36.9	16.5	16.9	0.0	3.4	1.9	100.0	6,013	3.6
Region										
Honiara	13.8	22.6	13.4	36.2	1.1	9.8	3.0	100.0	819	6.2
Guadalcanal	24.0	36.7	14.3	20.0	0.0	1.6	3.4	100.0	1,159	3.5
Malaita	28.8	39.0	12.3	15.3	0.0	2.9	1.7	100.0	1,605	2.4
Western	13.7	36.6	23.9	18.2	0.1	4.5	3.1	100.0	872	5.1
Other provinces	24.5	34.8	17.6	17.2	0.0	4.7	1.2	100.0	2,678	3.8
Wealth quintile										
Lowest	32.3	40.5	15.9	7.8	0.0	2.0	1.6	100.0	1,345	2.2
Second	26.4	37.0	17.3	15.4	0.0	2.3	1.5	100.0	1,352	3.2
Middle	22.9	37.8	15.1	19.2	0.1	3.4	1.4	100.0	1,439	3.6
Fourth	20.7	32.8	18.7	21.2	0.0	4.4	2.3	100.0	1,459	4.9
Highest	13.4	27.2	14.1	32.2	0.6	9.1	3.5	100.0	1,537	5.8
Total	22.8	34.9	16.2	19.5	0.1	4.3	2.1	100.0	7,133	4.0

¹ Completed six grades at the primary level.

² Completed seven grades at the secondary level.

Note: Total includes 23 men for whom age is missing.

The likelihood of reaching ‘more than secondary level of education’ is much greater among the wealthiest Solomon Islanders than those from poorer households. Nine percent of males from the wealthiest households have ‘more than secondary level of education’ compared with 2–4% of males from the remaining wealth quintiles. A similar pattern is observed for women, with 7% of females from the wealthiest households and just 0–2% of those from less wealthy households having attained ‘more than secondary level of education’.

2.8.1 Primary school attendance ratios

Solomon Islands uses a 6-6-4 formal education system, which means six years of primary school, a maximum of six years of secondary school, and four years of post secondary/university/tertiary. The official age ranges for these levels are 6–13 years, 14–17 years, and 18–21 years, respectively.

The net attendance ratio (NAR) for the primary level is the percentage of primary school-age population (aged 6–13) that is attending primary school. Overall, the primary school NAR is only 65.4% in Solomon Islands (see Table 2.11). In urban areas, 72% of children aged 6-13 attend primary school compared with 65% in rural areas. Interestingly, there is a slight difference in the primary NAR by sex, which is 69% for females and 63% for males.

Table 2.11: School attendance ratios

Net attendance ratio (NAR) and gross attendance ratio (GAR) for the de facto household population by sex and level of schooling; and the gender parity index (GPI), according to background characteristics, Solomon Islands 2007

Background characteristic	Net attendance ratio ¹				Gross attendance ratio ²			
	Male	Female	Total	Gender Parity Index ³	Male	Female	Total	Gender Parity Index ³
PRIMARY SCHOOL								
Residence								
Urban	69.1	76.0	72.1	1.10	91.9	113.4	101.2	1.23
Rural	61.5	67.8	64.5	1.10	101.6	103.1	102.3	1.02
Region								
Honiara	72.3	71.9	72.1	0.99	96.4	105.2	100.4	1.09
Guadalcanal	66.7	66.1	66.4	0.99	95.5	103.3	99.3	1.08
Malaita	56.0	59.5	57.8	1.06	96.0	88.9	92.5	0.93
Western	68.3	75.8	71.6	1.11	117.8	124.5	120.8	1.06
Other provinces	60.7	74.4	67.0	1.23	100.8	110.4	105.2	1.10
Wealth quintile								
Lowest	55.5	61.3	58.1	1.10	94.2	87.0	91.1	0.92
Second	61.0	66.5	63.9	1.09	99.4	111.3	105.6	1.12
Middle	61.7	61.0	61.4	0.99	106.2	97.6	102.3	0.92
Fourth	58.5	75.9	66.7	1.30	96.4	106.2	101.0	1.10
Highest	76.4	79.9	78.0	1.05	105.6	118.8	111.8	1.12
Total	62.5	68.7	65.4	1.10	100.4	104.3	102.2	1.04
SECONDARY SCHOOL								
Residence								
Urban	47.9	45.2	46.5	0.94	67.7	52.7	59.9	0.78
Rural	25.0	26.4	25.7	1.05	31.9	30.8	31.5	0.96
Region								
Honiara	47.0	47.1	47.1	1.00	68.0	55.7	61.6	0.82
Guadalcanal	34.3	30.1	32.3	0.88	48.6	37.2	42.7	0.77
Malaita	20.5	20.0	20.3	0.98	28.6	22.9	25.8	0.80
Western	23.3	34.5	28.8	1.48	27.5	38.6	32.9	1.40
Other provinces	27.5	27.5	27.5	1.00	32.9	31.7	32.4	0.96

Table 2.11 (continued)

Background characteristic	Net attendance ratio ¹				Gross attendance ratio ²			
	Male	Female	Total	Gender Parity Index ³	Male	Female	Total	Gender Parity Index ³
Wealth quintile								
Lowest	11.8	10.3	11.1	0.88	20.8	11.4	16.3	0.55
Second	25.2	26.6	26.0	1.06	29.0	28.9	28.9	0.99
Middle	25.2	24.0	24.6	0.95	32.5	30.3	31.5	0.93
Fourth	30.8	34.6	32.8	1.13	36.4	42.5	39.4	1.17
Highest	44.8	45.8	45.3	1.02	62.4	52.8	57.5	0.85
Total	28.5	29.6	29.1	1.04	37.4	34.6	36.0	0.92

Note: Attendance ratios are calculated using children's ages at the beginning of the school year to avoid underestimating rates of school participation by including children below the target age for each level.

¹ The NAR for primary school is the percentage of primary-school age (aged 6–11) population attending primary school. The NAR for secondary school is the percentage of the secondary-school age (aged 12–18) population attending secondary school. By definition, the NAR cannot exceed 100%.

² The GAR for primary school is the total number of primary school students, expressed as a percentage of the official primary school-age population. The GAR for secondary school is the total number of secondary school students, expressed as a percentage of the official secondary-school-age population. If there are significant numbers of overage and underage students at a given level of schooling, the GAR can exceed 100%.

³ The GPI for primary school is the ratio of the primary school NAR (GAR) for females to the NAR (GAR) for males. The GPI for secondary school is the ratio of the secondary school NAR(GAR) for females to the NAR(GAR) for males.

There is little variation in the NAR by wealth quintiles. The NAR is lowest among school-age children in the lowest wealth quintile households (58%) and the highest NAR is observed for children in the highest wealth quintile (78%). The NAR for children for all other wealth quintiles falls between 61% and 67%. Given that primary education is supposed to be free (although not compulsory), it is not surprising that the NAR does not increase with increasing wealth quintiles — from the poorest to the middle wealthiest households. However, some schools still charge some fees and that may have caused the trend in the fourth and highest wealth quintiles.

The gross attendance ratio (GAR) measures attendance irrespective of the official age at each level. The GAR for primary school is the total number of primary school students (aged 5–24), expressed as a percentage of the official primary-school-age population (aged 6–12). A major contributing factor to high GAR is children starting primary school later than the recommended age of 6 years. Overall, the primary school GAR is 102, with the highest GAR in the Western Province (121%) followed by 105% in the second wealth quintile. There are no notable differences by sex.

The gender parity index (GPI) is a measure of the ratio of females to males attending school, regardless of age. For primary school, the GPI is 1.04, indicating that the number of female and male students is almost the same, with females slightly outnumbering males. There is not much variation in the GPI for the primary school GAR by background characteristics; however, the ratios are below the national average for rural areas and for lowest and middle wealth quintiles.

2.8.2 Secondary school attendance ratios

The concept of the NAR at the secondary level is similar to that of the primary level, being the percentage of the secondary school-age population (aged 12–18) attending secondary school. Overall, only 29 out of 100 children of secondary school age in Solomon Islands attend secondary school. The secondary NAR for males is 29% and the NAR for females is 30%.

The secondary school NAR is better in urban areas than in rural areas (47% versus 26%). This pattern is the same for boys and girls in urban areas. As regards wealth quintile, ignoring the second wealth quintile (26%), the secondary school NAR rises with wealth from about 11% in the lowest wealth quintile to 45% in the wealthiest quintile. This finding suggests that poverty and factors related to poverty play an important role in whether children are sent to secondary school.

The secondary GAR is 36% for the nation as a whole and is higher in urban (60%) than in rural parts of the country (32%). This same pattern is observed for males and females. Similar to the

NAR, the secondary GAR increases as wealth increases: the GAR is 58% among youth in the wealthiest households and only 16% among youth in the poorest households.

The GPI for the secondary school GAR is 0.92, indicating that, the ratio of females to males attending schools is not quite the same, with males slightly outnumbering females. This ratio is lower than the GPI for the primary school GAR, and varies little by background characteristics. Male students are outnumbered by female students only in the fourth wealth quintiles while males outnumbered females in all background characteristics. The GPI for the secondary school is especially low in the lowest wealth quintile households (0.55) and to certain extent in urban areas (0.78), indicating a gender gap in favour of males. There was no perfect gender balance in the secondary school GAR observed for any of the background characteristics, however, we are close to achieving that in certain characteristics.

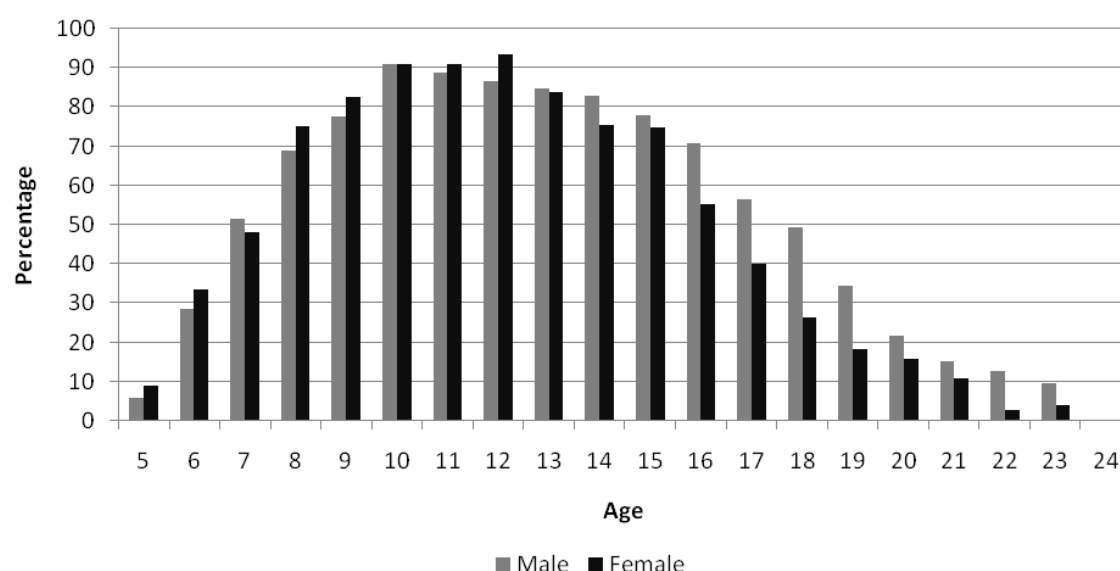
2.8.3 Age-specific attendance rates

Figure 2.2 presents information on school attendance among youth aged 5–24, by age. The figure includes students who attended primary school, secondary school, or higher education during the 2006 school year.

As Figure 2.2 shows, by ages 8 and 9 the vast majority of children in Solomon Islands attend school (approaching 80% and over). Rates of attendance range from 50–93% among males and females aged 7–12. Starting at age 13, attendance rates decline noticeably for all children. For instance, the attendance rate is 50% among males aged 18, and just 27% among females the same age. By age 21, only 15% of males attend school, compared with only 11% of females.

Figure 2.2 also shows that half (50%) of children aged 7 attend school, and attendance rates among children aged 8 and 9 are around 70% percent and 83%, respectively. These statistics show that most children in Solomon Islands enter into primary schools later than age 6. The age-specific attendance rate for Solomon Islands peaked between 10 and 12. For about 50% of children aged 7 and about 28% of the children aged 8, this was not the case; that is, they were not attending primary school (this is particularly important as education is free although not compulsory in Solomon Islands).

Figure 2.2: Age-specific attendance rates of the *de facto* population aged 5–24



2.9 KEY RESULTS

This section highlights the main findings related to general characteristics of the Solomon population, population structure, literacy and education, household arrangements, household composition, household facilities, sanitation facilities, dwelling characteristics and household possession. These findings are useful for policy decision-making in assessing the level of economic and social development of the population and to be able to make sound policy decisions to improve the current status of the economic and social development in the country. These findings are listed below.

1. Solomon Islands has a young population structure. The findings show that about half of the population is below the age of 20, an indication of rapid population growth and large population composition are in the dependent age groups. In contrast, a very small proportion of women and men are in the older age groups, indicating early death in the country.
2. The average household size in Solomon Islands is five, with urban households having more members than rural households, which indicates the need in urban areas for more housing.
3. Not all households (83%) use improved water sources and the majority of households (84%) do not apply any treatment to their drinking water, which is an implication of higher exposure of household members to water-borne diseases such as dysentery and cholera.
4. The results show that 6 out of 10 households have no toilet facilities and this is more common in the rural areas. Poor sanitation coupled with unsafe water sources increases the risk of water-borne diseases.
5. According to the wealth index, the distribution of wealth is uneven across all household in Solomon Islands: poverty is more concentrated in rural areas than in the urban area.
6. Even though education is provided free in Solomon Islands up to primary level, the results show that primary education does not reach the entire primary school-age population. The declining trend of females and males attaining secondary and higher education is associated with the cost of education at these levels.
7. The results also show that most children in Solomon Islands enter into primary school later than age 6 — the official primary age of primary education.

CHAPTER 3 CHARACTERISTICS OF RESPONDENTS

This chapter describes the situation of men and women of reproductive age in Solomon Islands, which is useful for understanding the context of reproductive and health of men and women. The following variables are discussed: age at the time of the survey, marital status, residence, education, literacy, and media access. In addition, this chapter explores factors that enhance women's empowerment, including employment, occupation, earnings, and continuity of employment. An analysis of these variables provides the socioeconomic context in which demographic and reproductive health issues are examined in subsequent chapters.

3.1 CHARACTERISTICS OF SURVEY RESPONDENTS

Table 3.1 presents background characteristics of the 3,823 women aged 15–49 and 2,056 men aged 15–54 who were interviewed in the 2006/2007 SIDHS, and show their distribution by background characteristics. The proportion of women and men decline with increasing age, reflecting the young population of Solomon Islands: 37% for both women and men in the 15–24 age group, 35% of women and 33% of men are aged 25–34, and the remaining respondents are women aged 35–49 and men aged 35–54.

About 62% of women are formally married compared with less than one-half (46%) of men. Men are much more likely than women to have never married (41% for men, 29% for women). Less than 20% of women and men (5% percent women, 12% men) declare themselves to be living together. Women are more likely in the divorced/separated and widowed status than men do (3.6% and 0.9%).

The distribution of men and women by residence is biased towards rural because a large proportion of Solomon Islands' population resides in rural areas: about 83% of women live in rural area while 17% of women are found in urban areas. These figures are similar for men where 81% reside in rural areas while only 19% live in urban areas.

Data in Table 3.1 show that there is some variation in educational attainment of women and men, where 14% of women and 6% of men have no formal education. Moreover, 45% of men have a secondary or higher education compared with only 31% of women.

Wealth quintiles for both women and men were evenly distributed across the quintiles.

In terms of religion, 76% of Solomon Islanders are Anglican, followed by 41% who are South Seas evangelical, 32% who are Roman Catholic, 20% who belong to the United Church, 17% who are Seventh-Day Adventists, and 13% who are in the 'other' category.

The majority of the population is Melanesian, followed by Polynesian and Micronesian.

Table 3.1: Background characteristics of respondents*Percent distribution of women and men aged 15–49 by selected background characteristics, Solomon Islands 2007*

Background characteristic	Women			Men		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age						
15–19	18.0	687	736	18.1	292	283
20–24	18.7	716	744	18.8	304	327
25–29	19.1	729	698	16.5	266	267
30–34	15.7	600	620	16.5	266	286
35–39	12.6	482	472	14.8	239	232
40–44	8.8	336	321	8.3	134	151
45–49	7.1	273	232	7.0	113	128
Marital status						
Never married	29.4	1,125	1,213	40.9	660	668
Married	62.0	2,368	2,294	46.1	744	785
Living together	5.0	191	188	12.1	195	200
Divorced/separated	2.5	95	81	0.6	9	13
Widowed	1.1	43	47	0.3	5	8
Residence						
Urban	16.6	636	1,463	18.6	301	731
Rural	83.4	3,187	2,360	81.4	1,313	943
Region						
Honiara	12.6	481	1,363	14.9	240	692
Guadalcanal	16.7	637	673	15.4	249	269
Malaita	22.0	840	610	21.4	345	245
Western	12.0	458	400	11.2	181	159
Other provinces	36.8	1,407	777	37.1	599	309
Education						
No education	13.6	520	481	5.5	88	80
Primary	55.3	2,114	1,908	49.2	794	719
Secondary	27.9	1,067	1,244	36.8	593	708
More than secondary	3.2	122	190	8.6	138	167
Wealth quintile						
Lowest	18.2	696	576	17.4	281	212
Second	19.8	755	526	18.0	291	223
Middle	19.3	738	551	20.0	323	229
Fourth	20.1	769	664	21.9	353	298
Highest	22.6	864	1,506	22.7	366	712
Religion						
Anglican	36.0	1,376	1,057	40.3	650	516
Roman Catholic	15.5	593	730	16.3	264	318
United Church	10.1	384	515	9.5	154	210
South Seas Evangelical	20.9	798	786	21.2	343	336
Seventh-Day Adventist	9.8	376	458	7.3	118	168
Other	7.7	296	277	5.2	84	123
Ethnicity						
Melanesian	96.7	3,698	3,659	97.0	1,566	1,595
Polynesian	2.1	81	108	1.6	26	50
Micronesian	1.1	42	48	1.0	17	22
European	0.0	0	1	0.0	0	0
Chinese	0.0	0	1	0.0	0	0
Other	0.0	1	4	0.2	3	4
Total 15–49	100.0	3,823	3,823	100.0	1,614	1,674
50+	na	na	na	na	442	382
Total men 15+	na	na	na	na	2,056	2,056

Note: Educational categories refer to the highest level of education attended, whether or not that level was completed.
na = not applicable

3.2 EDUCATIONAL ATTAINMENT BY BACKGROUND CHARACTERISTICS

Tables 3.2.1 and 3.2.2 show the distribution of respondents according to the highest level of schooling attended. Most respondents had some secondary education: 28% of women compared with 36% of men. Table 3.2.1 shows that the percentage of women with some primary education (27%) is slightly higher than that for men (21%). An equal proportion (28%) of both women and men completed primary education. More men (9%) than women (3%) have more than a secondary education.

Table 3.2.1: Educational attainment — Women

Percent distribution of women aged 15–49 by highest level of schooling attended or completed, and median grade completed, according to background characteristics, Solomon Islands 2007

Background characteristic	Highest level of schooling						Total	Median years completed	Number of women
	No education	Some primary	Completed primary ¹	Some secondary	Completed secondary ²	More than secondary			
Age									
15–24	7.4	24.9	18.1	46.9	0.3	2.4	100.0	6.0	1,404
15–19	7.9	27.3	17.1	47.3	0.0	0.5	100.0	5.9	687
20–24	6.9	22.6	19.2	46.5	0.7	4.2	100.0	6.3	716
25–29	10.3	28.8	31.3	25.3	0.0	4.3	100.0	5.3	729
30–34	14.0	24.4	40.2	15.7	0.1	5.5	100.0	5.3	600
35–39	23.3	20.7	41.0	12.8	0.0	2.2	100.0	5.1	482
40–44	19.7	24.4	40.9	12.5	0.0	2.5	100.0	5.2	336
45–49	29.1	54.0	7.2	7.7	0.3	1.7	100.0	2.8	273
Residence									
Urban	7.8	18.2	18.9	45.2	0.8	9.2	100.0	7.2	636
Rural	14.8	28.9	30.1	24.3	0.1	2.0	100.0	5.3	3,187
Region									
Honiara	8.4	18.4	19.4	44.5	0.9	8.4	100.0	7.0	481
Guadalcanal	15.7	34.7	23.2	25.1	0.0	1.3	100.0	5.0	637
Malaita	31.0	29.3	17.7	19.6	0.0	2.5	100.0	3.8	840
Western	0.8	11.3	46.8	37.6	0.2	3.4	100.0	5.9	458
Other provinces	8.3	30.4	33.7	24.9	0.1	2.6	100.0	5.4	1,407
Wealth quintile									
Lowest	21.3	38.0	24.3	16.2	0.0	0.1	100.0	4.1	696
Second	13.2	32.5	32.8	20.4	0.0	1.2	100.0	5.2	755
Middle	17.4	25.9	32.9	22.3	0.0	1.5	100.0	5.2	738
Fourth	11.8	24.8	32.4	28.7	0.0	2.2	100.0	5.5	769
Highest	6.1	16.6	19.6	47.3	0.8	9.8	100.0	7.7	864
Total	13.6	27.1	28.2	27.7	0.2	3.2	100.0	5.4	3,823

¹ Completed six grades at the primary level.

² Completed seven grades at the secondary level.

There is no significant difference in the median years of education completed by both women and men (5% women, 6% men). As expected, people in rural areas are less educated than those in urban areas.

Table 3.2.2: Educational attainment — Men

Percent distribution of men aged 15–49 by highest level of schooling attended or completed, and median grade completed, according to background characteristics, Solomon Islands 2007

Background characteristic	Highest level of schooling						Total	Median years completed	Number of men
	No education	Some primary	Completed primary ¹	Some secondary	Completed secondary ²	More than secondary			
Age									
15–24	4.9	21.6	18.9	50.4	1.0	3.2	100.0	6.5	596
15–19	3.3	25.8	20.6	48.6	0.2	1.4	100.0	6.0	292
20–24	6.5	17.5	17.2	52.1	1.8	4.9	100.0	7.4	304
25–29	4.8	20.0	24.6	37.4	0.4	12.8	100.0	6.4	266
30–34	2.3	21.0	41.7	19.8	0.1	15.1	100.0	5.6	266
35–39	6.6	13.5	36.4	31.9	0.1	11.4	100.0	5.8	239
40–44	9.0	14.7	38.7	28.4	0.0	9.1	100.0	5.8	134
45–49	10.8	41.4	26.7	16.7	0.0	4.5	100.0	5.7	113
Residence									
Urban	2.5	11.7	17.9	52.2	2.2	13.5	100.0	8.5	301
Rural	6.2	22.9	30.7	32.7	0.1	7.4	100.0	5.7	1,313
Region									
Honiara	2.8	10.6	15.7	55.4	2.7	12.7	100.0	8.7	240
Guadalcanal	4.6	27.0	30.4	35.5	0.0	2.6	100.0	5.7	249
Malaïta	16.9	24.9	21.8	30.2	0.0	6.2	100.0	5.5	345
Western	1.8	12.6	43.1	33.4	0.8	8.3	100.0	5.9	181
Other provinces	1.4	22.6	31.9	33.3	0.0	10.8	100.0	5.9	599
Wealth quintile									
Lowest	11.4	33.6	32.4	18.9	0.0	3.7	100.0	5.3	281
Second	2.7	23.5	33.1	34.6	0.0	6.0	100.0	5.8	291
Middle	10.7	22.0	26.6	31.9	0.5	8.3	100.0	5.7	323
Fourth	2.7	19.8	31.0	37.3	0.0	9.2	100.0	5.9	353
Highest	1.1	8.8	20.5	54.0	1.7	13.9	100.0	8.5	366
Total 15–49	5.5	20.8	28.4	36.3	0.5	8.6	100.0	5.9	1,614
50+	28.3	54.0	7.7	6.1	0.0	3.9	100.0	3.3	442
Total men 15+	10.4	28.0	23.9	29.8	0.4	7.6	100.0	5.7	2,056

¹ Completed six grades at the primary level.

² Completed seven grades at the secondary level.

3.3 LITERACY ACHIEVEMENT

The literacy level determines the individual's ability to read all, part or none of a sentence in the language that he/she is able to read. Questions assessing literacy were asked of each respondent who had not attended any school and who were attending primary school only. An additional approach in gaining more information on respondents' level of literacy is by getting respondents to read out loud a simple sentence. In the 2006/2007 SIDHS, the same method was applied to all respondents who had not attended school and had attended primary level only. The interviewer asked respondents to read out loud a simple sentence written on a card in Solomon Islands Pidgin. The interviewer then recorded whether the respondent could read all of the sentence, only parts of it, or could not read any of the sentence.

3.3.1 Literacy achievement: women and men

Data in Tables 3.3.1 and 3.3.2 show that 21% of women aged 15–49 and 11% of men aged 15–49 cannot read at all. As expected, the literacy level is often higher in urban areas than rural areas, for both men and women. For example, the percentage of literate men in urban areas is 95% compared with 87% for men in rural areas. The figures for women show a similar trend, where 86% of women in urban areas are literate compared with 77% of women in rural areas.

Table 3.3.1: Literacy — Women

Percent distribution of women aged 15–49 by level of schooling attended and level of literacy, and percentage literate, according to background characteristics, Solomon Islands 2007

Background characteristic	Secondary school or higher	No schooling or primary school						Total	Percentage literate¹	Number
		Can read a whole sentence	Can read part of a sentence	Cannot read at all	No card with required language	Blind/visually impaired	Missing			
Age										
15–19	47.7	25.5	11.8	13.0	0.3	0.0	1.8	100.0	85.0	687
20–24	51.4	20.2	13.2	15.0	0.0	0.0	0.2	100.0	84.8	716
25–29	29.6	27.4	22.9	20.1	0.0	0.0	0.0	100.0	79.9	729
30–34	21.3	36.2	25.1	17.2	0.2	0.0	0.0	100.0	82.6	600
35–39	15.0	35.6	19.2	29.4	0.4	0.0	0.4	100.0	69.8	482
40–44	15.0	34.0	23.6	27.4	0.0	0.0	0.0	100.0	72.6	336
45–49	9.7	24.4	19.9	45.6	0.1	0.1	0.2	100.0	54.1	273
Residence										
Urban	55.1	19.0	12.1	13.4	0.1	0.0	0.2	100.0	86.2	636
Rural	26.3	30.4	20.2	22.6	0.1	0.0	0.5	100.0	76.9	3,187
Region										
Honiara	53.8	17.5	13.5	14.7	0.1	0.1	0.3	100.0	84.8	481
Guadalcanal	26.4	30.8	17.6	24.9	0.1	0.0	0.2	100.0	74.8	637
Malaita	22.1	18.8	24.2	33.8	0.3	0.0	0.7	100.0	65.2	840
Western	41.1	36.1	20.0	2.7	0.2	0.0	0.0	100.0	97.2	458
Other provinces	27.6	34.5	17.6	19.8	0.0	0.0	0.5	100.0	79.6	1,407
Wealth quintile										
Lowest	16.3	27.5	26.6	29.4	0.1	0.0	0.1	100.0	70.4	696
Second	21.5	33.6	20.3	24.2	0.0	0.0	0.3	100.0	75.5	755
Middle	23.8	31.7	18.0	24.9	0.0	0.0	1.6	100.0	73.5	738
Fourth	30.9	30.3	20.0	18.4	0.3	0.0	0.0	100.0	81.3	769
Highest	57.8	20.4	10.9	10.6	0.2	0.0	0.2	100.0	89.0	864
Total	31.1	28.5	18.8	21.0	0.1	0.0	0.4	100.0	78.4	3,823

¹ Refers to women who attended secondary school or higher and women who could read a whole sentence or part of a sentence.

Table 3.3.2: Literacy — Men

Percent distribution of men aged 15–49 by level of schooling attended and level of literacy, and percentage literate, according to background characteristics, Solomon Islands 2007

Background characteristic	Secondary school or higher	No schooling or primary school						Total	Percentage literate ¹	Number
		Can read a whole sentence	Can read part of a sentence	Cannot read at all	No card with required language	Blind/visually impaired	Missing			
Age										
15–19	50.3	20.4	17.1	12.2	0.0	0.0	0.0	100.0	87.8	292
20–24	58.8	15.7	10.7	14.6	0.0	0.0	0.2	100.0	85.2	304
25–29	50.6	25.9	10.4	12.6	0.3	0.0	0.1	100.0	86.9	266
30–34	35.0	47.7	10.2	6.4	0.0	0.0	0.7	100.0	92.9	266
35–39	43.5	33.7	13.0	8.2	0.3	0.0	1.3	100.0	90.2	239
40–44	37.5	39.2	11.7	9.4	0.0	0.0	2.2	100.0	88.4	134
45–49	21.2	54.4	11.4	11.7	0.0	0.0	1.2	100.0	87.1	113
Residence										
Urban	67.9	19.4	7.7	4.7	0.0	0.0	0.3	100.0	95.0	301
Rural	40.2	33.5	13.2	12.3	0.1	0.0	0.7	100.0	86.9	1,313
Region										
Honiara	70.9	17.6	7.2	4.0	0.0	0.0	0.4	100.0	95.6	240
Guadalcanal	38.0	28.6	21.2	12.0	0.0	0.0	0.2	100.0	87.8	249
Malaita	36.4	25.9	14.9	22.2	0.0	0.0	0.5	100.0	77.3	345
Western	42.5	32.4	16.6	5.5	0.9	0.0	2.2	100.0	91.4	181
Other provinces	44.1	39.4	7.6	8.4	0.0	0.0	0.5	100.0	91.2	599
Wealth quintile										
Lowest	22.5	41.1	15.2	21.0	0.0	0.0	0.2	100.0	78.8	281
Second	40.6	33.6	13.7	10.4	0.3	0.0	1.4	100.0	87.9	291
Middle	40.7	28.9	14.2	15.8	0.0	0.0	0.5	100.0	83.7	323
Fourth	46.5	34.3	12.0	6.8	0.2	0.0	0.2	100.0	92.8	353
Highest	69.6	19.2	7.2	3.2	0.0	0.0	0.8	100.0	96.0	366
Total 15–49	45.3	30.8	12.2	10.9	0.1	0.0	0.6	100.0	88.4	1,614
50+	10.0	42.7	18.5	27.3	0.2	1.3	0.0	100.0	71.2	442
Total men 15+	37.7	33.4	13.6	14.4	0.1	0.3	0.5	100.0	84.7	2,056

¹ Refers to men who attended secondary school or higher and men who could read a whole sentence or part of a sentence.

3.4 ACCESS TO MASS MEDIA

Information access is essential to increasing people's knowledge and awareness of what is taking place around them, which may eventually affect their perceptions and behaviour about an issue. In the survey, exposure to media was assessed by asking how often a respondent reads a newspaper, watches television, or listens to a radio.

Most of the population is exposed to some form of media. In general, men are more likely than women to have access to mass media (this is true for all types of media). Tables 3.4.1 and 3.4.2 show the variation in media exposure by background characteristics of respondents. The results for both women and men indicate that more men in the 20–24 age group are exposed to any form of media at least once a week than other men and women in other age groups. Urban women and men are more likely to have access to mass media than rural residents. For example, 68% of men in urban areas read a newspaper at least once a week compared with 26% of rural men. In terms of television, 58% of urban men watch television once a week compared with 2% of rural men. For those listening to radio, 85% of urban men listen to radio at least once a week compared with 67% of rural men. Findings further show a gap in media access for all three media at least once a week, biased towards urban men 43% (compared with 2% for rural men). The proportion of the population that has access to all three media types (i.e. radio, newspaper and television) at least once a week is generally lower for women (4.4%) than men (9%). About 49% of women and 28% of men have no exposure to any media.

Data further reveal that exposure to media is positively associated with educational attainment. For example, 19% of women with more than a secondary level education are exposed to at least one form of media each week, compared with only 2% of women with no primary education or only a primary education. A similar pattern exists for men, where 16% of men with more than a secondary level education are exposed to at least one form of media each week compared with 4% of men with no primary education or only a primary education.

Data also show that media exposure is limited among Solomon Islands women and men in the lower household wealth quintiles. For instance, 1% of women from the poorest homes are exposed to at least one form of media each week, compared with 15% of women from the richest homes. This pattern is similar for men.

Table 3.4.1: Exposure to mass media — Women

Percentage of women aged 15–49 who are exposed to specific media on a weekly basis, by background characteristics, Solomon Islands 2007

Background characteristic	Reads a newspaper at least once a week	Watches television at least once a week	Listens to the radio at least once a week	All three media at least once a week	No media at least once a week	Number
Age						
15–19	24.6	11.8	45.8	5.2	45.7	687
20–24	24.7	11.3	48.8	6.3	45.7	716
25–29	18.1	9.5	49.5	4.5	45.5	729
30–34	14.6	9.2	40.0	3.9	54.7	600
35–39	14.6	8.3	44.7	3.3	50.9	482
40–44	17.4	8.2	38.2	2.9	55.8	336
45–49	9.7	3.9	40.9	1.3	53.8	273
Residence						
Urban	42.0	40.9	63.9	20.5	22.3	636
Rural	14.2	3.3	41.2	1.1	54.6	3,187
Region						
Honiara	42.2	49.9	61.5	24.7	21.9	481
Guadalcanal	28.0	11.0	64.1	5.5	31.8	637
Malaita	7.1	0.7	39.2	0.0	59.1	840
Western	24.1	2.8	40.0	1.8	52.8	458
Other provinces	12.1	2.6	35.8	0.3	59.3	1,407
Education						
No education	0.8	3.3	29.9	0.2	69.0	520
Primary	12.7	6.6	42.4	2.0	52.6	2,114
Secondary	36.0	16.5	54.6	9.4	35.9	1,067
More than secondary	52.9	26.1	70.3	19.5	21.9	122
Wealth quintile						
Lowest	8.1	2.2	24.5	0.7	73.5	696
Second	10.8	3.0	35.8	0.9	59.4	755
Middle	14.8	2.4	43.0	1.5	53.0	738
Fourth	19.2	4.5	54.1	1.5	41.0	769
Highest	37.7	31.7	63.2	15.3	24.8	864
Total	18.8	9.5	45.0	4.4	49.2	3,823

Table 3.4.2: Exposure to mass media — Men

Percentage of men aged 15–49 who are exposed to specific media on a weekly basis, by background characteristics, Solomon Islands 2007

Background characteristic	Reads a newspaper at least once a week	Watches television at least once a week	Listens to the radio at least once a week	All three media at least once a week	No media at least once a week	Number
Age						
15–19	39.4	13.8	65.2	8.3	29.0	292
20–24	32.9	15.2	74.9	12.5	21.0	304
25–29	36.8	12.6	77.4	9.2	16.7	266
30–34	32.0	10.6	68.9	8.2	27.5	266
35–39	29.8	9.1	71.6	6.9	22.4	239
40–44	36.9	12.4	70.9	9.1	25.6	134
45–49	23.6	11.8	59.2	9.9	38.1	113
Residence						
Urban	68.0	58.3	85.2	42.9	5.5	301
Rural	25.9	1.9	67.3	1.5	29.0	1,313
Region						
Honiara	68.4	65.8	83.6	49.0	6.2	240
Guadalcanal	36.9	10.3	72.4	8.1	22.5	249
Malaita	21.0	0.9	74.0	0.3	21.6	345
Western	32.0	2.9	55.8	1.3	37.2	181
Other provinces	26.6	1.4	67.3	1.2	30.8	599
Education						
No education	0.7	2.9	46.8	0.5	52.8	88
Primary	19.9	5.8	62.4	3.5	33.7	794
Secondary	53.8	21.1	83.5	16.5	11.0	593
More than secondary	48.5	19.0	78.2	16.2	12.8	138
Wealth quintile						
Lowest	12.8	1.0	51.7	0.4	45.0	281
Second	25.0	0.5	68.1	0.3	29.4	291
Middle	29.4	1.0	73.4	0.8	23.5	323
Fourth	29.8	4.4	73.6	3.2	22.8	353
Highest	64.7	48.5	82.0	36.2	7.9	366
Total 15–49	33.8	12.4	70.7	Total 9.2	24.6	1,614
50+	24.0	5.5	56.1	4.6	39.9	442
Men 15+	31.7	10.9	67.5	8.2	27.9	2,056

3.5 EMPLOYMENT STATUS

Like education, employment can be a source of empowerment for women, especially when leading them into a decision-making position and control of income. The measurement of women's empowerment is one of the more difficult tasks to undertake and is most often under-reported, especially women's work that deals with family or the home, which is almost always referred to as informal work or home duties.

To ensure complete coverage of women's empowerment, the 2006/2007 SIDHS provided questions about women's employment status in both the informal and formal sectors. All employed women are classified as those currently working for the last 7 days and the last 12 months prior to the survey. Some additional questions were also included to ask about any kind of payment respondents received in return for the service they provided.

Tables 3.5.1 and 3.5.2 show that 36% of women and 71% of men are classified as currently employed. The proportion currently employed increases with age and the number of living children among women. Data for men show a similar variation in employment status by age and number of children. Women who were classified as divorced/separated/widowed or who were married are the most likely to be employed (about 37% for both categories). Never-married women and men are the least likely to be employed (35% women, 57% men). Almost 81% of married men are currently employed.

There is little variation in the current employment level for women in rural areas (37%) and urban areas (35%), although there is some variation in employment level between men in rural areas (74%) and men in urban areas (57%).

Clearly, current employment levels for both women and men are positively associated with educational attainment.

Table 3.5.1: Employment status — Women

Percent distribution of women aged 15–49 by employment status, according to background characteristics, Solomon Islands 2007

Background characteristic	Employed in the 12 months preceding the survey		Not employed in the 12 months preceding the survey	Missing/ don't know	Total	Number of women
	Currently employed ¹	Not currently employed				
Age						
15–19	29.7	2.7	67.3	0.3	100.0	687
20–24	33.8	4.4	61.7	0.1	100.0	716
25–29	34.0	4.6	61.3	0.2	100.0	729
30–34	41.8	5.3	52.4	0.5	100.0	600
35–39	41.2	4.3	54.4	0.0	100.0	482
40–44	47.2	4.2	48.6	0.0	100.0	336
45–49	32.2	11.2	56.7	0.0	100.0	273
Marital status						
Never married	34.6	4.1	61.0	0.3	100.0	1,125
Married or living together	37.1	5.0	57.8	0.2	100.0	2,560
Divorced/separated/widowed	36.9	5.1	58.0	0.0	100.0	138
Number of living children						
0	33.9	4.3	61.5	0.3	100.0	1,213
1–2	34.2	4.4	61.3	0.1	100.0	954
3–4	39.7	4.3	55.8	0.2	100.0	885
5+	39.0	6.3	54.6	0.2	100.0	772
Residence						
Urban	34.6	2.9	62.1	0.3	100.0	636
Rural	36.7	5.1	58.1	0.2	100.0	3,187
Region						
Honiara	29.7	3.3	66.6	0.4	100.0	481
Guadalcanal	35.1	5.2	59.1	0.6	100.0	637
Malaita	29.0	3.1	67.9	0.0	100.0	840
Western	51.4	2.8	45.4	0.4	100.0	458
Other provinces	38.7	6.6	54.7	0.0	100.0	1,407
Education						
No education	23.1	4.7	72.2	0.0	100.0	520
Primary	34.6	5.1	60.1	0.2	100.0	2,114
Secondary	42.4	4.1	53.2	0.3	100.0	1,067
More than secondary	70.0	4.0	26.0	0.0	100.0	122
Wealth quintile						
Lowest	37.1	8.0	54.8	0.0	100.0	696
Second	37.9	6.0	55.9	0.2	100.0	755
Middle	27.3	4.9	67.7	0.1	100.0	738
Fourth	35.7	1.8	62.2	0.4	100.0	769
Highest	42.7	3.5	53.6	0.2	100.0	864
Total	36.3	4.7	58.7	0.2	100.0	3,823

¹ 'Currently employed' is defined as having done work in the past seven days, and includes people who did not work in the past seven days but who were regularly employed and were absent from work for leave, illness, vacation, or any other such reason.

Table 3.5.2: Employment status — Men

Percent distribution of men aged 15–49 by employment status, according to background characteristics, Solomon Islands 2007

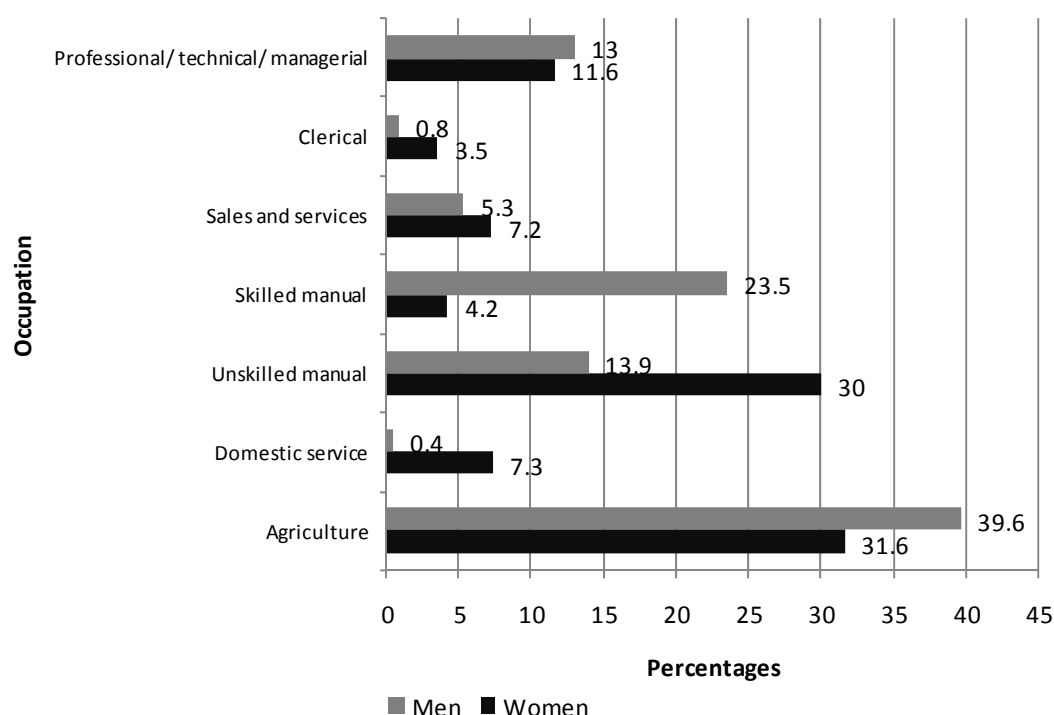
Background characteristic	Employed in the 12 months preceding the survey		Not employed in the 12 months preceding the survey	Missing/ don't know	Total	Number of men
	Currently employed ¹	Not currently employed				
Age						
15–19	42.0	12.3	45.6	0.0	100.0	292
20–24	64.2	3.3	32.4	0.0	100.0	304
25–29	73.8	8.2	18.0	0.0	100.0	266
30–34	88.6	2.7	8.7	0.0	100.0	266
35–39	79.4	8.7	11.9	0.0	100.0	239
40–44	87.2	3.4	9.4	0.0	100.0	134
45–49	78.7	6.9	14.1	0.3	100.0	113
Marital status						
Never married	56.6	7.3	36.0	0.1	100.0	660
Married or living together	80.9	6.2	12.9	0.0	100.0	939
Divorced/separated/widowed	83.3	9.5	7.2	0.0	100.0	14
Number of living children						
0	59.8	7.3	32.9	0.0	100.0	754
1–2	76.6	7.2	16.2	0.0	100.0	322
3–4	85.0	5.0	10.0	0.0	100.0	298
5+	81.3	6.3	12.4	0.0	100.0	240
Residence						
Urban	57.4	3.8	38.8	0.0	100.0	301
Rural	74.1	7.4	18.5	0.0	100.0	1,313
Region						
Honiara	54.8	2.2	43.1	0.0	100.0	240
Guadalcanal	76.8	13.5	9.5	0.1	100.0	249
Malaita	50.4	3.9	45.7	0.0	100.0	345
Western	80.1	4.1	15.8	0.0	100.0	181
Other provinces	84.2	8.1	7.8	0.0	100.0	599
Education						
No education	39.1	5.2	55.6	0.0	100.0	88
Primary	76.3	6.8	16.8	0.0	100.0	794
Secondary	66.3	8.0	25.8	0.0	100.0	593
More than secondary	80.8	1.5	17.7	0.0	100.0	138
Wealth quintile						
Lowest	74.0	7.4	18.6	0.1	100.0	281
Second	79.0	6.2	14.8	0.0	100.0	291
Middle	63.8	11.4	24.9	0.0	100.0	323
Fourth	74.1	4.7	21.2	0.0	100.0	353
Highest	65.6	4.4	30.0	0.0	100.0	366
Total 15–49	71.0	6.7	22.3	0.0	100.0	1,614
50+	68.6	3.6	27.8	0.0	100.0	442
Total men 15+	70.5	6.0	23.5	0.0	100.0	2,056

¹ Currently employed¹ is defined as having done work in the past seven days, and includes people who did not work in the past seven days but who were regularly employed and were absent from work for leave, illness, vacation, or any other such reason.

3.6 OCCUPATION

Respondents who were currently employed were asked to state their occupation. The results are presented in Figure 3.6.1, Tables 3.6.1 and 3.6.2. For women who are currently employed, 32% are engaged in 'agriculture' and 30% are engaged in 'unskilled manual'. About 12% are involved in professional, technical and managerial related occupations, while only 7% are engaged in both sales/services and domestic services. A similar situation was observed in men, where 40% are engaged in agriculture, 24% are involved in skilled manual, 13% are engaged in professional, and 14% in unskilled manual. This confirms that a large percentage of both men and women are engaged in agriculture.

Figure 3.6.1: Occupation by sex



Most women and men who are engaged in *non-agricultural* activities work in unskilled manual labour or sales and services, skilled manual labour or clerical-related occupations. Professional, technical, and managerial occupations, which require more skill and have higher income-earning potential, are occupied by 12% of women and 13% of men

Table 3.6.1 shows the distribution of women employed in the 12 months preceding the survey by type of occupation and according to background characteristics. Most women are engaged in agriculture (32%) and unskilled manual (30%). Obviously, women are more likely to work in professional/technical/managerial and skilled manual occupations unless they are urban residents, have more than a secondary level education or are from the richest homes.

Women in the 30–34 age group, those who are divorced/separated/widowed, who live in urban areas, have no education, and are in the fourth wealthiest households are more likely to be in skilled manual occupations. Women holding professional/technical and managerial occupations, those in the 20–29 age group, and those who are never-married, typically live in urban areas, have higher qualifications and are in the highest wealth households.

Table 3.6.1: Occupation — Women*Percent distribution of women aged 15–49 employed in the 12 months preceding the survey by occupation, according to background characteristics, Solomon Islands 2007*

Background characteristic	Professional/ technical/ managerial	Clerical	Sales and services	Skilled manual	Unskilled manual	Domestic service	Agriculture	Missing	Total	Number of women
Age										
15–19	1.7	0.6	5.4	2.1	41.9	7.8	26.0	14.5	100.0	222
20–24	17.5	3.9	6.8	3.6	28.4	12.5	22.3	5.0	100.0	274
25–29	16.9	5.4	7.2	3.3	29.9	4.7	30.4	2.3	100.0	281
30–34	10.6	5.3	8.7	6.5	29.5	7.7	27.9	3.8	100.0	283
35–39	9.2	4.4	11.7	4.1	22.2	2.2	44.3	1.9	100.0	220
40–44	13.3	1.0	5.6	4.6	30.7	2.6	40.5	1.8	100.0	172
45–49	8.6	1.3	1.2	5.3	26.2	15.8	39.4	2.3	100.0	118
Marital status										
Never married	15.5	2.9	5.2	2.3	31.1	12.8	20.6	9.5	100.0	436
Married or living together	9.9	3.8	8.1	4.7	29.6	4.9	36.4	2.7	100.0	1,077
Divorced/separated/widowed	14.4	2.3	4.3	9.4	29.5	10.3	25.3	4.5	100.0	58
Number of living children										
0	16.0	3.9	4.9	2.6	32.4	10.5	20.8	9.1	100.0	463
1–2	11.4	5.1	9.2	3.2	26.4	6.5	34.5	3.7	100.0	369
3–4	12.0	3.9	5.4	6.3	27.3	5.1	36.7	3.4	100.0	389
5+	5.6	0.8	10.0	5.0	33.6	6.4	37.3	1.2	100.0	349
Residence										
Urban	21.7	20.6	11.9	5.2	9.8	22.3	3.2	5.2	100.0	239
Rural	9.8	0.4	6.3	4.0	33.6	4.6	36.7	4.5	100.0	1,331
Region										
Honiara	22.1	17.7	12.3	5.1	8.5	25.3	3.1	6.0	100.0	159
Guadalcanal	6.1	1.8	3.6	4.2	23.1	6.2	47.4	7.6	100.0	257
Malaita	18.7	5.0	3.2	5.9	35.4	4.3	16.3	11.1	100.0	269
Western	12.3	2.4	12.6	6.6	8.6	4.8	50.8	2.0	100.0	248
Other provinces	7.9	0.4	6.9	2.3	44.2	5.5	31.4	1.4	100.0	637
Education										
No education	0.4	0.0	5.1	6.1	39.3	6.6	41.6	0.8	100.0	145
Primary	2.3	0.6	7.8	4.1	31.5	9.2	40.4	4.1	100.0	839
Secondary	22.0	6.6	7.8	4.2	27.7	5.5	18.9	7.2	100.0	496
More than secondary	59.3	19.1	0.5	1.6	14.1	0.6	3.7	1.1	100.0	90

Table 3.6.1 (continued)

Background characteristic	Professional/ technical/ managerial	Clerical	Sales and services	Skilled manual	Unskilled manual	Domestic service	Agriculture	Missing	Total	Number of women
Wealth quintile										
Lowest	0.6	0.0	4.5	1.5	41.6	5.4	44.7	1.7	100.0	315
Second	3.8	0.0	4.8	2.5	50.3	7.7	27.6	3.2	100.0	332
Middle	17.2	0.9	8.4	3.3	18.0	2.7	43.4	6.1	100.0	237
Fourth	14.0	0.9	8.4	9.0	20.7	7.1	31.6	8.4	100.0	288
Highest	21.7	12.6	9.6	4.7	17.8	11.3	17.7	4.6	100.0	399
Total	11.6	3.5	7.2	4.2	30.0	7.3	31.6	4.6	100.0	1,570

Likewise, Solomon Islands men with skilled manual jobs are more likely to be in the 20–24 age group, tend to be single men, reside in urban areas and live in the wealthiest households. Professional jobs are occupied more by men in the 35–39 age group, are married or living with a partner, live in urban areas, have a higher educational level, and live in wealthier households.

Table 3.6.2: Occupation — Men

Percent distribution of men aged 15–49 employed in the 12 months preceding the survey by occupation, according to background characteristics, Solomon Islands 2007

Background characteristic	Professional/ technical/ managerial	Clerical	Sales and services	Skilled manual	Unskilled manual	Domestic service	Agriculture	Missing	Total	Number of men
Age										
15–19	2.6	0.2	0.0	10.6	16.7	0.5	57.8	11.7	100.0	159
20–24	6.5	1.0	4.5	36.8	6.1	0.9	41.9	2.3	100.0	205
25–29	16.6	0.2	6.4	25.7	13.3	0.1	35.2	2.5	100.0	218
30–34	13.0	1.2	5.7	26.4	19.1	0.3	30.6	3.7	100.0	243
35–39	21.9	1.4	7.0	22.1	13.6	0.0	33.0	1.0	100.0	210
40–44	18.9	0.4	6.4	17.0	12.3	0.1	42.3	2.6	100.0	121
45–49	8.5	1.2	6.7	15.4	16.4	0.7	49.0	2.0	100.0	97
Marital status										
Never married	7.5	0.4	2.9	25.7	11.9	0.2	44.7	6.8	100.0	422
Married or living together	15.6	1.0	6.5	22.3	15.0	0.4	37.1	2.0	100.0	818
Divorced/separated/widowed	*	*	*	*	*	*	*	*	100.0	13
Number of living children										
0	11.1	0.6	3.5	23.2	14.1	0.4	41.5	5.6	100.0	506
1–2	14.4	0.6	7.4	29.7	11.1	0.3	33.4	3.1	100.0	269
3–4	19.6	1.3	4.5	21.1	10.2	0.3	41.3	1.8	100.0	268
5+	7.2	1.3	7.9	19.2	21.5	0.3	41.1	1.4	100.0	210
Residence										
Urban	22.9	5.7	23.6	33.7	1.1	1.2	7.9	3.9	100.0	184
Rural	11.2	0.0	2.1	21.7	16.1	0.2	45.1	3.5	100.0	1,069
Region										
Honiara	22.5	7.2	27.1	34.8	0.5	1.1	3.3	3.6	100.0	137
Guadalcanal	7.2	0.0	6.7	20.0	4.8	0.3	60.6	0.3	100.0	225
Malaita	21.8	0.0	4.0	23.7	10.4	0.0	33.2	6.8	100.0	187
Western	11.9	0.5	3.8	24.8	1.9	1.4	48.8	6.9	100.0	152
Other provinces	10.3	0.0	0.1	21.6	25.3	0.0	39.8	2.9	100.0	552

Table 3.6.2 (continued)

Background characteristic	Professional/ technical/ managerial	Clerical	Sales and services	Skilled manual	Unskilled manual	Domestic service	Agriculture	Missing	Total	Number of men
Education										
No education	(0.0)	(0.0)	(3.7)	(29.7)	(9.2)	(0.0)	(53.9)	(3.5)	100.0	39
Primary	3.6	0.0	3.3	24.8	15.9	0.4	48.6	3.4	100.0	660
Secondary	20.4	1.3	9.4	21.7	9.6	0.4	33.5	3.6	100.0	441
More than secondary	43.0	3.9	1.1	20.5	20.5	0.0	6.6	4.5	100.0	113
Wealth quintile										
Lowest	1.4	0.0	0.8	18.7	20.7	0.3	56.0	2.1	100.0	229
Second	8.4	0.0	1.1	19.7	28.2	0.0	39.9	2.8	100.0	248
Middle	12.1	0.1	1.3	25.2	12.8	0.3	46.2	2.0	100.0	242
Fourth	15.4	0.0	4.8	22.6	6.3	0.5	45.5	5.0	100.0	278
Highest	25.9	4.0	17.7	30.8	3.1	0.6	12.3	5.6	100.0	256
Total 15–49	13.0	0.8	5.3	23.5	13.9	0.4	39.6	3.6	100.0	1,253
50+	15.0	1.3	4.1	7.8	11.7	1.9	56.9	1.3	100.0	319
Total men 15+	13.4	0.9	5.0	20.3	13.4	0.7	43.2	3.1	100.0	1,573

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

3.7 EARNINGS, TYPE OF EMPLOYER, AND CONTINUITY OF EMPLOYMENT

Table 3.7 shows the distribution of women by their employment status. The data indicate that 44% of employed women receive payment in cash only, 6.7% are paid both in cash and in kind, 1.2% receive only payment in kind, while 47% receive no payment for their work.

The data on type of employer indicate that 76% of women are employed by family member, 21% are self-employed, and 3% are employed by a non-family member.

Table 3.7 also presents the distribution of women by the continuity of their employment. About four in every ten women work all year, 39% work seasonal and 19% work occasionally.

Table 3.7: Type of employment: Women

Percent distribution of women aged 15–49 employed in the 12 months preceding the survey by type of earnings, type of employer, and continuity of employment, according to type of employment (agricultural or non-agricultural), Solomon Islands 2007

Employment characteristic	Agricultural work	Non-agricultural work	Missing	Total
Type of earnings				
Cash only	13.9	44.1	36.9	34.2
Cash and in kind	9.6	6.7	3.3	7.5
In-kind only	1.8	1.2	0.4	1.4
Not paid	74.7	47.4	57.5	56.5
Missing	0.0	0.5	1.9	0.4
Total	100.0	100.0	100.0	100.0
Type of employer				
Employed by family member	75.6	53.8	39.1	60.0
Employed by non-family member	3.2	25.5	22.9	18.3
Self-employed	20.9	20.0	36.2	21.0
Missing	0.3	0.6	1.9	0.6
Total	100.0	100.0	100.0	100.0
Continuity of employment				
All year	40.3	58.7	82	53.9
Seasonal	39.1	27.3	9.9	30.2
Occasional	19.4	13.5	6.2	15.0
Missing	1.2	0.5	1.9	0.8
Total	100.0	100.0	100.0	100.0
Number of women	497	1,001	73	1,570

Note: Total includes women with missing information on type of employment who are not shown separately.

3.8 HEALTH INSURANCE COVERAGE: WOMEN

The 2006/2007 SIDHS asked respondents if they were covered by specific types of insurance schemes. These insurance schemes were categorised as: 1) government-run schemes such as the Social Security Scheme, 2) employer-based schemes, 3) mutual health organisation/community-based insurances, 4) privately purchased commercial insurances, and 5) other insurance arrangements. The distribution of respondents aged 15–49 by types of insurance coverage according to the respondent's background characteristics are presented in Table 3.8.1 for women and Table 3.8.2 for men.

These tables show the percentage of women and men covered by a health scheme or health insurance, by type of health insurance coverage. Overall, 99% of both women and men are not covered by any government and/or private insurance schemes. This means that less than one in ten respondents is covered by any insurance scheme in Solomon Islands. For example, social security covers slightly the same low proportion of women and men (0% women, 0.2% men). Obviously, there is an equal proportion of women and men (1%) who are covered by other employer-based insurance. Mutual health organization, community-based insurance, and privately purchased commercial insurance covers 0.1% respectively for both women and men. Other insurance covers 0.1% for women and 0.2% for men.

The overall trend shows that insurance coverage for both women and men in Solomon Islands is low, indicating that insurance is too expensive to afford.

A small proportion of both women and men aged 25 and over, living in urban areas and in the Western Province and have a higher education level, are more likely to be covered by other employer-based insurance.

Table 3.8.1: Health insurance coverage — Women*Percentage of women aged 15–49 with specific types of health insurance coverage, according to background characteristics, Solomon Islands 2007*

Background characteristic	Social security	Other employer-based insurance	Mutual health organisation/ community-based insurance	Privately purchased commercial insurance	Other	None	Number
Age							
15–19	0.0	0.1	0.0	0.1	0.0	99.9	687
20–24	0.0	0.1	0.5	0.4	0.2	98.8	716
25–29	0.0	0.8	0.0	0.0	0.1	99.1	729
30–34	0.0	1.7	0.0	0.1	0.0	98.3	600
35–39	0.1	1.5	0.1	0.0	0.0	98.3	482
40–44	0.0	1.0	0.2	0.0	0.4	98.3	336
45–49	0.0	0.6	0.3	0.1	0.0	99.0	273
Residence							
Urban	0.1	2.7	0.2	0.3	0.4	96.3	636
Rural	0.0	0.4	0.1	0.1	0.0	99.4	3,187
Region							
Honiara	0.1	2.8	0.1	0.4	0.2	96.4	481
Guadalcanal	0.0	0.0	0.3	0.0	0.1	99.6	637
Malaita	0.0	0.0	0.0	0.0	0.0	100.0	840
Western	0.0	3.4	0.3	0.0	0.3	96.0	458
Other provinces	0.0	0.0	0.1	0.1	0.0	99.7	1,407
Education							
No education	0.0	0.3	0.3	0.0	0.0	99.3	520
Primary	0.0	0.5	0.1	0.0	0.0	99.4	2,114
Secondary	0.0	1.0	0.3	0.1	0.2	98.4	1,067
More than secondary	0.3	5.3	0.0	2.1	0.8	91.6	122
Wealth quintile							
Lowest	0.0	0.1	0.3	0.0	0.0	99.7	696
Second	0.0	0.0	0.0	0.0	0.0	100.0	755
Middle	0.0	0.2	0.3	0.0	0.0	99.4	738
Fourth	0.0	0.3	0.0	0.0	0.1	99.6	769
Highest	0.0	2.9	0.1	0.4	0.4	96.1	864
Total	0.0	0.8	0.1	0.1	0.1	98.9	3,823

Table 3.8.2: Health insurance coverage — Men*Percentage of men aged 15–49 with specific types of health insurance coverage, according to background characteristics, Solomon Islands 2007*

Background characteristic	Social security	Other employer-based insurance	Mutual health organisation/ community-based insurance	Privately purchased commercial insurance	Other	None	Number
Age							
15–19	0.0	0.0	0.0	0.0	0.0	100.0	292
20–24	0.0	0.3	0.0	0.2	0.1	99.4	304
25–29	0.0	0.5	0.2	0.0	0.0	99.3	266
30–34	0.7	1.1	0.3	0.0	1.2	96.8	266
35–39	0.0	1.4	0.0	0.0	0.0	98.6	239
40–44	0.3	1.9	0.4	0.0	0.6	97.5	134
45–49	1.5	0.2	0.0	0.3	0.0	98.0	113
Residence							
Urban	0.0	1.9	0.4	0.1	1.4	96.4	301
Rural	0.3	0.4	0.0	0.0	0.0	99.2	1,313
Region							
Honiara	0.0	2.4	0.2	0.2	0.1	97.4	240
Guadalcanal	0.0	1.5	0.0	0.2	0.0	98.2	249
Malaita	0.0	0.0	0.0	0.0	0.6	99.4	345
Western	0.9	0.8	0.4	0.0	0.9	96.9	181
Other provinces	0.4	0.1	0.1	0.0	0.0	99.5	599
Education							
No education	0.0	0.0	0.0	0.0	0.0	100.0	88
Primary	0.2	0.2	0.1	0.0	0.2	99.3	794
Secondary	0.0	1.6	0.1	0.2	0.0	98.3	593
More than secondary	1.6	0.5	0.5	0.0	1.8	95.8	138
Wealth quintile							
Lowest	0.0	0.4	0.0	0.0	0.0	99.6	281
Second	0.0	0.0	0.2	0.0	0.0	99.8	291
Middle	0.0	0.0	0.0	0.0	0.0	100.0	323
Fourth	0.5	0.5	0.0	0.0	0.0	99.0	353
Highest	0.6	2.3	0.3	0.3	1.1	95.6	366
Total 15–49	0.2	0.7	0.1	0.1	0.3	98.7	1,614
50+	0.0	0.5	0.1	0.1	0.2	99.2	442
Total men 15+	0.2	0.6	0.1	0.1	0.2	98.8	2,056

3.9 KNOWLEDGE AND ATTITUDE TOWARD TUBERCULOSIS

Tuberculosis (TB) is a major killer of women, men and children in most developing countries. Knowledge about TB is critical to understanding how people deal with the disease. The 2006/2007 SIDHS asked questions about knowledge and attitude toward TB. Tables 3.9.1 and 3.9.2 show several indicators relating to respondents' knowledge and attitude concerning TB, including the percentages who have heard of TB, who know that TB is spread through the air by coughing, who believe that TB can be cured, and who would want to keep it a secret that a family member has TB.

Table 3.9.1: Knowledge and attitude concerning tuberculosis — Women

Percentage of women aged 15–49 who have heard of tuberculosis (TB), and among women who have heard of TB, the percentage who know that TB is spread through the air by coughing, the percentage who believe that TB can be cured, and the percentage who would want to keep secret that a family member has TB, by background characteristics, Solomon Islands 2007

Background characteristic	Among all women		Among women who have heard of TB:			
	Percentage who have heard of TB	Number	Percentage who report that TB is spread through the air by coughing	Percentage who believe that TB can be cured	Percentage who would want a family member's TB kept secret	Number
Age						
15–19	91.2	687	77.6	81.7	19.1	627
20–24	95.2	716	81.9	85.5	17.1	682
25–29	93.3	729	83.5	87.0	19.8	680
30–34	94.7	600	79.9	87.0	14.5	568
35–39	95.0	482	85.4	85.1	19.6	458
40–44	93.9	336	82.7	90.4	12.6	315
45–49	96.6	273	80.1	81.2	16.8	264
Residence						
Urban	97.3	636	91.1	88.6	15.0	619
Rural	93.3	3,187	79.5	84.8	18.0	2,975
Region						
Honiara	96.9	481	89.3	90.1	14.8	466
Guadalcanal	93.8	637	89.4	80.2	13.7	597
Malaïta	93.1	840	75.7	86.4	13.5	782
Western	96.5	458	96.4	87.9	18.6	442
Other provinces	92.8	1,407	73.6	84.8	22.1	1,306
Education						
No education	87.0	520	76.6	80.6	15.8	453
Primary	93.9	2,114	78.0	84.4	17.4	1,984
Secondary	97.0	1,067	89.4	88.4	18.1	1,035
More than secondary	100.0	122	89.4	94.6	18.8	122
Wealth quintile						
Lowest	91.0	696	74.4	79.8	16.3	634
Second	92.2	755	73.3	84.5	22.6	697
Middle	93.8	738	82.9	85.6	19.6	692
Fourth	95.6	769	84.5	86.9	14.5	735
Highest	96.7	864	90.0	89.0	14.9	836
Total	94.0	3,823	81.5	85.4	17.5	3,594

Knowledge of TB by both women and men is almost universal (94% and 98%, respectively). Slightly more Solomon Islands men (86%) than women (82%) reported that TB is spread through the air by coughing. About nine in ten Solomon Islands women and men believe that TB can be cured. This figure generally increases with age and educational attainment. More women in urban areas believe that TB can be cured than women in rural areas.

Table 3.9.2: Knowledge and attitude concerning tuberculosis — Men

Percentage of men aged 15–49 who have heard of tuberculosis (TB), and among men who have heard of TB, the percentage who know that TB is spread through the air by coughing, the percentage who believe that TB can be cured, and the percentage who would want to keep secret that a family member has TB, by background characteristics, Solomon Islands 2007

Background characteristic	Among all men		Among men who have heard of TB			
	Percentage who have heard of TB	Number	Percentage who believe that TB is spread through the air by coughing	Percentage who believe that TB can be cured	Percentage who would want a family member's TB kept secret	Number
Age						
15–19	93.7	292	80.2	94.5	27.1	273
20–24	99.3	304	87.3	93.2	16.7	302
25–29	97.2	266	85.9	90.2	14.8	258
30–34	98.0	266	87.3	94.5	22.5	261
35–39	99.5	239	88.5	96.8	30.7	237
40–44	95.8	134	87.9	93.8	17.4	128
45–49	99.4	113	87.6	98.6	19.6	112
Residence						
Urban	99.3	301	86.2	93.2	6.6	299
Rural	97.1	1,313	86.1	94.3	25.1	1,274
Region						
Honiara	99.1	240	89.1	91.8	5.8	238
Guadalcanal	98.4	249	94.8	98.8	16.8	245
Malaita	97.6	345	73.9	95.4	2.9	337
Western	99.6	181	86.3	94.9	13.7	180
Other provinces	95.7	599	88.2	92.1	43.5	573
Education						
No education	91.8	88	70.8	94.6	3.1	81
Primary	96.8	794	84.4	91.8	27.0	768
Secondary	98.8	593	88.7	96.7	16.8	587
More than secondary	99.2	138	93.4	96.0	22.0	137
Wealth quintile						
Lowest	98.5	281	83.3	98.4	26.4	277
Second	98.1	291	87.0	93.4	38.7	286
Middle	96.1	323	84.5	95.6	17.6	310
Fourth	95.8	353	88.5	92.6	21.0	338
Highest	99.0	366	86.6	91.5	8.2	362
Total 15–49	97.5	1,614	86.1	94.1	21.5	1,573
50+	97.1	442	83.0	93.4	22.6	429
Total men 15+	97.4	2,056	85.4	94.0	21.8	2,002

A small difference is observed for rural and urban women in terms of those who would want it kept secret that a family member had TB: 18% for rural women, 15% for urban women. In contrast, the proportion of men expressing a desire to keep it secret about a family member with TB was higher among rural men (25%) than urban men (7%).

3.10 TOBACCO USE

Tobacco is responsible for many deaths around the world including Solomon Islands.

The 2006/2007 SIDHS asked women and men aged 15–49 about whether they smoked cigarettes, a pipe or other tobacco products. Respondents were also asked how many cigarettes they smoked in the preceding 24 hours.

Tables 3.10.1 and 3.10.2 show the number of women and men aged 15–49 who smoked cigarettes, pipe or other tobacco products (including the number of cigarettes smoked) in the preceding 24 hours before the DHS survey.

A large proportion of women aged 15–49 (80%) do not use tobacco as compared with 42% of men. More men (45%) than women (14%) smoke cigarettes. Slightly more women in urban areas (20%) than in rural areas (13%) smoke cigarettes. The same pattern is observed for men, where 53% of men in urban areas smoke cigarettes compared with 43% of men in rural areas.

Some significant difference can be observed for women and men who use other tobacco. About 53% of men smoke other tobacco compared with only 9.2% of women.

The results also indicate that about 10% of pregnant women and those women who breastfeed smoke both cigarettes and other tobacco.

Table 3.10.1: Tobacco use — Women

Percentage of women aged 15–49 who smoke cigarettes or a pipe or use other tobacco products, and the percent distribution of cigarette smokers by number of cigarettes smoked in the preceding 24 hours, according to background characteristics and maternity status, Solomon Islands 2007

Background characteristic	Tobacco type			Does not use tobacco	Number of women	Number of cigarettes in last 24 hours						Number of cigarette smokers
	Cigarettes	Pipe	Other tobacco			0	1–2	3–5	6–9	10+	Total	
Age												
15–19	13.9	0.5	7.2	83.2	687	3.1	62.8	22.2	3.7	8.2	100.0	96
20–24	17.3	0.6	7.6	78.6	716	6.8	53.5	19.6	9.7	10.4	100.0	124
25–29	13.1	1.7	8.4	80.7	729	12.3	35.1	37.3	1.5	13.7	100.0	96
30–34	12.3	3.4	10.2	79.9	600	15.0	38.6	29.4	4.3	12.6	100.0	74
35–39	13.6	5.8	11.8	76.1	482	9.1	63.7	16.9	7.3	3.0	100.0	66
40–44	10.0	6.7	11.9	79.6	336	(8.7)	(48.1)	(32.2)	(3.1)	(7.9)	100.0	34
45–49	14.0	6.7	11.4	74.4	273	(31.0)	(9.7)	(38.2)	(3.2)	(18.0)	100.0	38
Residence												
Urban	19.7	0.0	7.1	78.8	636	4.1	32.0	28.9	13.6	21.3	100.0	125
Rural	12.6	3.4	9.7	79.7	3,187	12.4	52.3	25.7	2.5	7.0	100.0	401
Region												
Honiara	20.3	0.1	7.2	78.2	481	5.2	32.5	27.6	13.3	21.4	100.0	98
Guadalcanal	12.1	8.4	8.1	79.0	637	18.7	34.6	24.7	9.3	12.7	100.0	77
Malaita	10.6	1.4	6.9	85.5	840	3.8	45.3	41.6	6.8	2.5	100.0	89
Western	8.4	0.6	4.2	87.2	458	(9.1)	(43.0)	(25.8)	(2.7)	(19.5)	100.0	39
Other provinces	15.9	3.0	13.5	74.1	1,407	12.8	60.1	20.7	0.0	6.4	100.0	224
Education												
No education	12.8	6.7	11.2	76.4	520	9.8	36.6	48.1	1.0	4.5	100.0	67
Primary	12.5	3.3	9.7	80.3	2,114	14.9	50.6	23.0	4.0	7.4	100.0	265
Secondary	16.5	0.5	7.5	80.0	1,067	4.4	47.4	23.6	8.2	16.4	100.0	176
More than secondary	15.4	0.0	9.0	74.0	122	(6.1)	(43.8)	(24.8)	(7.8)	(17.5)	100.0	19
Maternity status												
Pregnant	9.5	4.4	10.2	81.7	228	*	*	*	*	*	100.0	22
Breastfeeding (not pregnant)	10.4	4.1	8.5	82.5	990	5.9	45.5	31.4	4.1	13.2	100.0	103
Neither	15.4	2.3	9.5	78.2	2,605	10.8	48.2	26.1	5.3	9.6	100.0	401
Wealth quintile												
Lowest	12.5	7.2	12.0	75.6	696	9.6	65.6	20.3	2.5	2.0	100.0	87
Second	10.6	4.7	8.1	79.1	755	(7.2)	(57.2)	(26.8)	(1.8)	(7.1)	100.0	80
Middle	14.9	2.9	11.1	79.7	738	18.5	44.2	28.2	5.1	4.1	100.0	110
Fourth	15.1	0.4	11.9	80.0	769	11.9	46.7	28.6	2.9	9.9	100.0	116
Highest	15.5	0.0	4.1	82.5	864	5.0	33.3	27.1	11.0	23.5	100.0	133
Total	13.8	2.9	9.2	79.5	3,823	10.4	47.5	26.5	5.2	10.4	100.0	526

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Tables 3.10.1 and 3.10.2 further show that a significant proportion of both women and men smoked several cigarettes in the 24 hours preceding the survey. For example, 48% of women reported that they smoke 1–2 cigarettes compared with 19% of men. In contrast, about 37% of men reported that they smoked 3–5 cigarettes in the preceding 24 hours compared with 27% of women. Tobacco use — in this case, cigarette smoking — for both women and men has a strong link with age and educational background. For example, cigarette smoking is more prevalent among women in the 20–24 age group (17.3%), while cigarette smoking among men is more prevalent in the 20–29 age group. This is further supported by educational attainment, where tobacco use among women increases with educational attainment, while the opposite is true for

men, where tobacco use decreases with educational attainment. In general, men use some form of tobacco more often than women.

Table 3.10.2: Tobacco use — Men

Percentage of men aged 15–49 who smoke cigarettes or a pipe or use other tobacco products, and the percent distribution of cigarette smokers by number of cigarettes smoked in the preceding 24 hours, according to background characteristics, Solomon Islands 2007

Background characteristic	Uses tobacco					Number of cigarettes in last 24 hours							Number of cigarette smokers
	Cigarettes	Pipe	Other tobacco	Does not use tobacco	Number of men	0	1–2	3–5	6–9	10+	Don't know/missing	Total	
Age													
15–19	34.7	0.3	32.5	59.8	292	2.4	43.9	37.7	3.7	11.9	0.3	100.0	101
20–24	52.5	0.8	55.7	36.5	304	2.2	15.4	33.0	7.7	40.8	0.9	100.0	160
25–29	58.1	0.8	64.3	29.7	266	3.9	14.9	38.2	14.3	28.2	0.5	100.0	155
30–34	49.5	2.0	64.3	33.6	266	6.6	18.2	35.8	7.5	31.0	0.9	100.0	132
35–39	38.0	1.2	50.7	45.0	239	6.2	15.4	43.7	7.1	26.5	1.2	100.0	91
40–44	31.8	2.0	49.0	47.5	134	12.1	13.7	28.2	4.1	41.9	0.0	100.0	43
45–49	37.2	3.3	55.5	40.2	113	18.0	7.9	36.6	11.7	23.7	2.2	100.0	42
Residence													
Urban	52.5	0.1	38.4	46.1	301	0.0	12.7	33.1	18.7	34.7	0.9	100.0	158
Rural	43.0	1.5	56.4	40.5	1,313	6.9	21.1	37.5	5.6	28.1	0.8	100.0	565
Region													
Honiara	52.0	0.1	38.1	46.2	240	0.0	11.7	30.8	19.3	37.1	1.1	100.0	125
Guadalcanal	42.8	7.7	51.6	42.4	249	12.2	17.6	39.5	13.6	14.0	3.1	100.0	107
Malaita	48.6	0.1	54.7	44.0	345	0.0	18.5	32.0	9.4	39.6	0.5	100.0	168
Western	47.9	0.0	54.1	38.2	181	29.9	18.0	29.1	5.3	17.6	0.0	100.0	87
Other provinces	39.6	0.0	58.3	38.9	599	0.0	24.9	44.2	0.9	29.8	0.1	100.0	237
Education													
No education	53.6	3.4	78.5	19.8	88	(4.7)	(11.0)	(32.4)	(3.2)	(48.7)	(0.0)	100.0	47
Primary	43.6	1.6	56.4	39.5	794	7.0	17.6	39.3	7.7	28.0	0.4	100.0	347
Secondary	47.4	0.7	49.2	43.1	593	4.4	23.6	33.8	9.8	26.9	1.4	100.0	281
More than secondary	34.6	0.0	33.7	60.4	138	0.0	13.5	36.8	10.9	37.8	0.9	100.0	48
Wealth quintile													
Lowest	41.8	2.8	60.0	39.3	281	4.8	21.4	38.7	6.2	27.7	1.2	100.0	117
Second	49.2	1.5	60.6	34.3	291	6.2	26.6	41.0	5.5	20.0	0.8	100.0	143
Middle	35.8	1.4	44.6	50.9	323	6.1	21.3	28.5	8.1	35.3	0.8	100.0	115
Fourth	49.1	0.5	62.7	34.1	353	7.2	16.4	43.8	6.3	25.8	0.5	100.0	173
Highest	47.4	0.3	39.8	47.9	366	2.9	13.2	29.5	14.9	38.6	0.8	100.0	173
Total 15–49	44.8	1.2	53.0	41.5	1,614	5.4	19.3	36.5	8.5	29.6	0.8	100.0	723
50+	29.0	4.0	43.0	50.2	442	8.5	27.9	31.1	6.9	23.3	2.3	100.0	128
Total men 15+	41.4	1.8	50.9	43.4	2,056	5.9	20.5	35.7	8.2	28.6	1.0	100.0	851

Note: Figures in parentheses are based on 25–49 unweighted cases.

3.11 KEY RESULTS

This chapter describes the situation of men and women of reproductive age in the Solomon Islands in terms of their age at the time of the survey, marital status, residence, education, literacy and health. Understanding the context of the reproductive health and overall health status of women and men is critical to understanding issues related to women's and men's health that are discussed in other chapters of this report. Such information also provides a solid foundation for planning and development. This section summarises the main findings in this chapter.

1. The population of women and men of reproductive age in Solomon Islands is concentrated in the 15–29 age group. About 50% of both women and men are in the 15–29 age group. Of these, around 30% are in the 30–39 age group, and less than 20% are in the 40–49 age group. The proportion of both women and men decline with increasing age, reflecting the young population and early death in Solomon Islands.
2. Women are more likely to be married than men, an indication that women are losing out on opportunities such as education and better jobs. A higher proportion of married women means that more women are exposed to getting pregnant and, thus, positively contributing to the increasing fertility level.
3. The distribution of women and men is more concentrated in rural areas because the majority of Solomon Islands' population reside in rural areas. The population residing in rural areas are less likely to have access to economic and social services.
4. More women in the reproductive age categories have no education compared with men. These uneducated women are more likely to be found in rural areas and in the lowest wealth quintile. More men are literate than women.
5. About 50% of women are not exposed to any media compared with 25% of men who are exposed. Most of these women reside in rural areas and have either no primary education or only a primary level education. Women who are less exposed to information and knowledge are less likely to change their perceptions and behaviour.
6. Far fewer women than men are currently employed (36% compared with 71%). Education is very much associated with employment because most employed women and men are those with higher educational levels.
7. Employed women in Solomon Islands are more engaged in occupations such as agriculture and unskilled manual, whereas men are more engaged in agriculture and skilled manual work. Slightly the same small proportion of employed women and men are in professional/technical and managerial occupations.
8. About one in every two employed women aged 15–49 receive payment in cash from non-agricultural work, 75% are not paid for doing agricultural work.

CHAPTER 4 FERTILITY

This chapter presents the analysis of fertility data obtained from the 2006/2007 SIDHS, and includes differences in fertility levels and trends, fertility by background characteristics, data on lifetime fertility (children ever born and living), age at first birth, and birth intervals. Adolescent fertility is also covered to indicate the incidence of early pregnancy among young women in Solomon Islands. These data are important because they indicate the beginning of a woman's reproductive life.

Fertility data were collected in the 2006/2007 SIDHS using the women's questionnaire. This questionnaire contained the birth history of every eligible woman. The birth history captures the total number of all living and dead children a woman has given birth to, the children's date of birth, current age (if alive) and age at death (if dead), and whether the children are living with the mother or not. Although birth history tries to capture all births, the data that are obtained might be subject to various types of errors such as:

- Under-reporting of births, particularly the omission of children living elsewhere and those births that died very young (at birth or several hours after birth), which could result in underestimating the number of births.
- Misreporting of date of birth and/or age, in particular, the tendency in rounding off dates of birth or ages, which could result in under- or over-estimating fertility at certain ages and/or certain periods of time.
- Selective bias: questions were posed only to women who survived. Assuming that the fertility level of women who died prior to the survey differed from the level of survivors, the fertility level obtained from the survey might be slightly biased.

Other types of possible data errors include:

- Very young women (teenagers) who did not state the birth of their child.
- Unmarried women who did not state the birth of their child.
- Women whose child died shortly after birth and who did not state the birth of the child.
- Women who did not state the birth of a child from a different father than their present husband.
- Women who had multiple births (either twins or triplets), or had two births during the 12-month period before the census, and only recorded 1 birth.
- Women who were temporarily absent from their permanent household were counted, but their fertility status was not recorded, and/or was wrongly assumed to be zero.
- Older women (who already had many children) who did not remember the exact date of birth of their last child.
- Inclusion of adopted or foster children as own biological child(ren).
- Errors during data recording and/or processing.

4.1 CURRENT FERTILITY

Measures of current and cumulative fertility for Solomon Islands for the three-year period preceding the survey are shown in Table 4.1. The age-specific fertility rate (ASFR) provides the age pattern at each different age group, and is the number of births to women in each specific age group. The total fertility rate (TFR) refers to the average number of births a woman would have had by the time she ended her childbearing years if she experienced the prevailing ASFR of a given year. The TFR sums the fertility of all women in a given point in time. Another refined measure of fertility is the general fertility rate (GFR). The GFR is the number of births to women in the 15–49 age group. The crude birth rate (CBR) is a crude measure of fertility because it relates to births of the whole population regardless of their sex and age.

According to the 2006/2007 SIDHS, the TFR for Solomon Islands is 4.6 as indicated in Table 4.1. This implies that on average a woman in Solomon Islands during her childbearing years would give birth to 4.6 children by the end of her reproductive period, if fertility levels remained constant at the observed level in the three-year period preceding the survey. Table 4.1 and Figure 4.1 show the current fertility level and pattern by urban-rural residence of women. The TFR of women residing in rural areas (4.8 births) is considerably higher than the TFR of women living in urban areas (3.4 births). Differences in fertility rates are observed for all age groups of women in rural and urban areas. For instance, among all young women aged 15–19 in rural areas, there are 75 births per 1,000 women compared with 41 births per 1,000 women in urban areas. The results show that the GFR in Solomon Islands is 160 per 1,000 women.

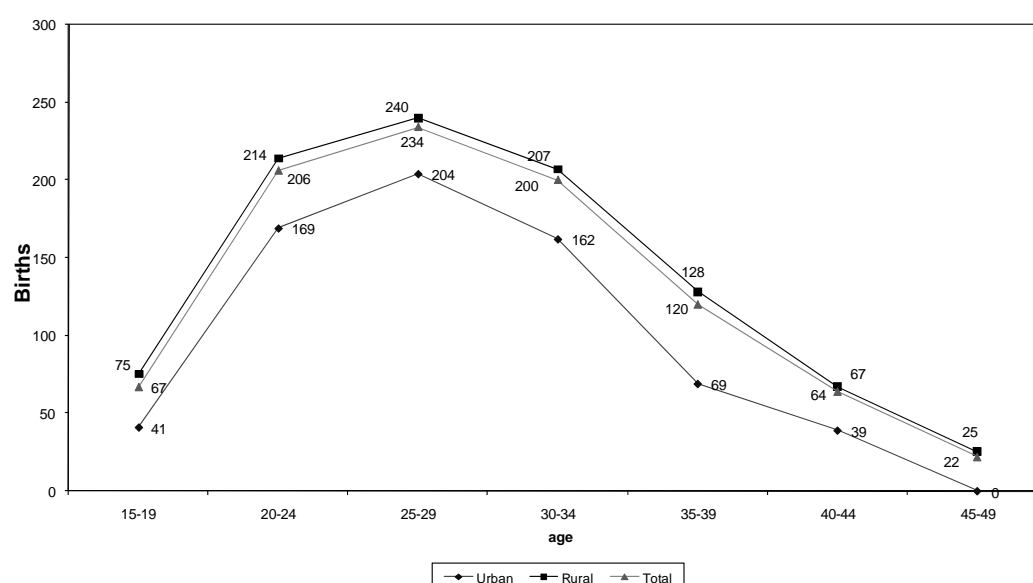
Table 4.1: Current fertility

Age-specific and total fertility rates, the general fertility rate, and the crude birth rate for the three years preceding the survey, by residence, Solomon Islands 2007

Age group	Residence		Total
	Urban	Rural	
15–19	41	75	67
20–24	169	214	206
25–29	204	240	234
30–34	162	207	200
35–39	69	128	120
40–44	39	67	64
45–49	0	25	22
TFR	3.4	4.8	4.6
GFR	124	168	160
CBR	31.9	34.4	34.1

Notes: Age-specific fertility rates are per 1,000 women. Rates for the 45–49 age group may be slightly biased due to truncation. Rates are for the period 1–36 months prior to interview.
TFR = total fertility rate expressed per woman
GFR = general fertility rate expressed per 1,000 women
CBR = crude birth rate, expressed per 1,000 population

Figure 4.1: Age-specific fertility rate by residence, Solomon Islands 2007



4.2 FERTILITY BY BACKGROUND CHARACTERISTICS

Fertility is known to vary with a woman's socioeconomic background characteristics. Table 4.2 indicates the TFR for the three-year period preceding the survey, the percentage of women aged 15–49 currently pregnant, and the mean number of children ever born to women aged 40–49, by background characteristic. The mean number of children ever born to women aged 40–49 is an indicator of complete fertility, which reflects the performance of childbearing of women who are nearly reaching the end of their reproduction period. Fertility level is known to be stable when the TFR and the number of children ever born (CEB) are almost the same. When the fertility level has been declining, the TFR will be lower than the mean CEB among women aged 40–49. The comparison between the two fertility measures of TFR and completed fertility provides an indication of fertility change in the country.

Table 4.2: Fertility by background characteristics

Total fertility rate (TFR) for the three-year period preceding the survey, percentage of women aged 15–49 currently pregnant, and the mean number of children ever born (CEB) to women aged 40–49 years, by background characteristics, Solomon Islands 2007

Background characteristic	TFR	Percentage women aged 15–49 currently pregnant	Mean CEB to women aged 40–49
Residence			
Urban	3.4	5.1	4.9
Rural	4.8	6.1	5.0
Region			
Honiara	3.4	5.1	4.7
Guadalcanal	(5.1)	8.2	5.2
Malaita	(5.5)	(5.5)	5.6
Western	*	(7.1)	4.6
Other provinces	4.2	(5.1)	4.8
Education			
No education	*	*	5.0
Primary	4.9	6.0	5.1
Secondary	3.8	7.1	4.9
More than secondary	*	*	*
Wealth quintile			
Lowest	(5.9)	8.6	5.0
Second	(5.1)	3.9	4.9
Middle	(4.2)	(5.1)	4.9
Fourth	(4.0)	(8.0)	5.4
Highest	3.6	(4.5)	4.6
Total	4.6	6.0	5.0

Note: With the exception of the TFR, figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed. For the TFR only, figures in parentheses are based on 500–750 unweighted cases. TFRs replaced with asterisks indicate a figure based on fewer than 500 unweighted cases and have been suppressed.

TFRs are for the period 1–36 months prior to interview.

Current fertility is higher in Malaita (5.5%) and Guadalcanal (5.1%) than the overall national level (4.6%) as shown in Table 4.2. As reported earlier, women in Honiara have fewer children (3.4%) than those in other provinces. Women with lower educational levels and in the lower wealth quintiles are likely to have more children than those women with higher education and in higher wealth quintiles. The table also indicates that the fertility level for women aged 40–49 who are almost reaching the end of their reproduction cycle in the Solomon Islands is estimated to be five births per woman.

4.3 FERTILITY TRENDS

Fertility trends and patterns are indicators of the availability, use and effectiveness of fertility control methods such as family planning, reproductive health programmes and policy intervention. Fertility decline is an indicator of women's empowerment and decision-making in controlling her fertility. The decline in fertility level also indicates customary and believes change in a society toward having small family size. Fertility decline is also the result of women's empowerment to make decisions in controlling the number of children they wish to have.

Fertility trends can be established using retrospective data from a single survey such as the 2006/2007 SIDHS. Women's birth history is the main source of data in producing fertility trends from the 2006/2007 SIDHS. The two main components of fertility trends — women's age at birth and the number of children ever born — are recorded for each woman in their respective birth history. Table 4.3 shows the ASFRs for the five-year period preceding the survey, by mother's age at the time of the birth. In interpreting the results, it is important to keep in mind some of the limitations in data capturing. For example, women can record adopted or foster children as their own children, which can lead to overstating the fertility trend. On the other hand, older women tend to under-report their fertility, especially children that died very young, which can lead to underestimating the fertility level.

Table 4.3: Trends in age-specific fertility rates

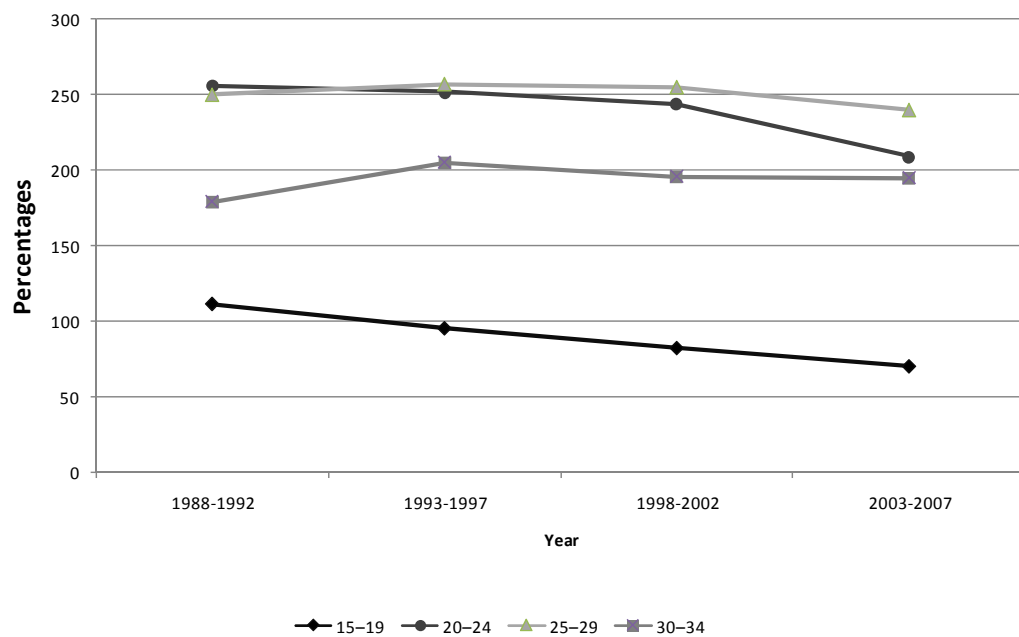
Age-specific fertility rates for the five-year period preceding the survey, by mother's age at the time of the birth, Solomon Islands 2007

Mother's age at birth	Number of years preceding survey			
	0–4	5–9	10–14	15–19
15–19	70	82	95	111
20–24	209	244	252	256
25–29	240	255	257	250
30–34	195	196	205	[179]
35–39	112	117	[129]	-
40–44	53	[54]	-	-
45–49	[22]	-	-	-

Note: Age-specific fertility rates are per 1,000 women. Estimates in brackets are truncated. Rates exclude the month of the interview.

Table 4.3 and Figure 4.2 show a declining trend of fertility level at each age category in Solomon Islands for the past 20 years (1988–2007). However, fertility rates decline fairly steadily between the earliest periods (15–19 years prior to the survey) and the most current period, especially for the youngest age groups (15–19 and 20–24). For example, adolescent fertility decreased from 111 births per 1,000 women in the last 20 years to 70 births per 1,000 women in the last five years. The ASFR for women in the 25–29 age group is reported to be 250 births per 1,000 women in the period 1988–1992, while the ASFR for women in the same age group for the period 2003–2007 is about 240 births per 1,000 women.

Figure 4.2: Trends in age-specific fertility rates



4.4. CHILDREN EVER BORN AND LIVING

Data on children ever born (CEB) comprises information on the number of children born alive (lifetime fertility) and should include all children born alive during the life of the woman, up to the current date. Lifetime fertility information is useful in examining the momentum of childbearing in a population and also for estimating the proportion of childless women in a population. The age-specific mean number of CEB provides fertility level comparisons between different age groups in a population.

Table 4.4: Children ever born and living

Percent distribution of all women and currently married women by number of children ever born, mean number of children ever born, and mean number of living children, according to age group, Solomon Islands 2007

	Number of children ever born														
Age	0	1	2	3	4	5	6	7	8	9	10+	Total	Number of women	Mean number of children ever born	Mean number of living children
ALL WOMEN															
Age															
15–19	90.1	8.2	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.00	687	0.12	0.11
20–24	47.6	26.3	16.1	7.0	2.8	0.1	0.0	0.0	0.0	0.0	0.0	100.00	716	0.91	0.90
25–29	17.9	18.1	27.7	17.1	10.4	6.2	2.3	0.3	0.0	0.0	0.0	100.00	729	2.14	2.05
30–34	10.3	6.3	13.3	15.2	23.5	15.8	11.0	3.7	0.6	0.2	0.0	100.00	600	3.51	3.39
35–39	4.4	5.2	5.8	14.0	23.5	15.8	14.3	7.0	6.9	0.9	2.3	100.00	482	4.53	4.36
40–44	4.5	2.0	4.8	13.7	15.5	20.6	19.0	9.8	6.1	1.7	2.3	100.00	336	4.89	4.62
45–49	6.2	6.7	4.2	6.1	13.0	13.8	20.6	13.7	8.5	4.6	2.7	100.00	273	5.12	4.85
Total	31.5	12.2	12.1	10.4	11.5	8.5	7.1	3.4	2.1	0.6	0.7	100.00	3,823	2.52	2.41
CURRENTLY MARRIED WOMEN															
Age															
15–19	53.6	32.7	13.4	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.00	86	0.60	0.58
20–24	22.3	33.0	26.4	13.2	4.9	0.3	0.0	0.0	0.0	0.0	0.0	100.00	383	1.46	1.43
25–29	8.0	17.5	30.4	20.4	12.6	7.7	2.9	0.4	0.0	0.0	0.0	100.00	588	2.49	2.40
30–34	4.9	5.3	13.9	16.0	26.3	16.2	12.3	4.2	0.7	0.3	0.0	100.00	533	3.78	3.66
35–39	3.8	3.4	5.0	13.4	24.1	17.6	15.6	7.8	5.9	1.0	2.5	100.00	433	4.68	4.50
40–44	3.9	1.7	4.2	12.8	15.0	21.7	20.5	10.0	6.0	1.7	2.5	100.00	311	5.00	4.71
45–49	4.0	4.5	1.0	6.5	13.8	13.4	22.8	16.3	9.1	5.4	3.2	100.00	226	5.55	5.29
Total	9.5	12.3	15.7	14.4	16.2	12.0	10.4	4.9	2.7	0.9	1.0	100.00	2,560	3.49	3.35

All women aged 15–49, regardless of their marital status, were asked questions about the total number of live births (CEB) they have had in their lifetime. Caution is required when interpreting the results for older age groups beyond 35 or 40 years as they could be less reliable than younger age groups. For instance, older women are more likely to exclude their children that died at a very young age. The inclusion of adopted and foster children can overestimate the CEB for all women.

Table 4.4 presents the percent distribution of all women and currently married women by number of children ever born, mean number of children ever born, and mean number of living children, by age group. The results indicate that among all married women, about 90% have children. Among all women, about nine in every ten women reported having a child.

Table 4.4 also shows that on average women in Solomon Islands have given birth to about one child by their early 20s, 3.5 births by their early 30s and 5.1 births at the end of their reproductive period. Overall, the mean number of CEB is 2.4 children for all women and 3.5 children for married women. The difference between the mean number of CEB with mean number of living children provides an indication of the level of childhood and adult mortality in the country.

4.5 BIRTH INTERVALS

A birth interval is the length of time between two successive live births. Information on birth intervals provides insight into birth spacing patterns, which affect fertility as well as infant and childhood mortality. Studies have proven that children born too soon after a previous birth are at increased risk of dying at an early age, particularly when the interval between births is less than 24 months.

Table 4.5 presents the percent distribution of non-first births in the five years preceding the survey by number of months since the preceding birth, and median number of months since the preceding birth, according to mother's demographic and socioeconomic background characteristics. The median birth interval is about 34 months. This means that half of all non-first births occur before and half occur after 34 months from a preceding birth. The shortest birth interval of 25 months is observed among children where the preceding birth died. The longest birth interval (52 months) is among children with mothers almost reaching the end of their childbearing years.

About one in every five children (23%) is born within less than 24 months after the preceding birth. Data show that the shortest birth interval is observed among mothers from Guadalcanal and Malaita, among children whose mothers attain secondary levels of education, and among children whose mothers are in the second wealth quintile.

Table 4.5: Birth intervals

Percent distribution of non-first births in the five years preceding the survey by number of months since preceding birth, and median number of months since preceding birth, according to background characteristics, Solomon Islands 2007

Background characteristic	Months since preceding birth						Total	Number of non-first births	Median number of months since preceding birth
	7–17	18–23	24–35	36–47	48–59	60+			
Age									
15–19	*	*	*	*	*	*	100.0	10	25.7
20–29	9.5	22.6	35.0	17.7	8.7	6.5	100.0	908	29.1
30–39	4.9	11.8	31.3	21.0	12.1	18.8	100.0	1,005	36.6
40–49	1.0	5.2	23.4	16.1	19.9	34.3	100.0	164	52.4
Birth order									
2–3	7.7	17.4	32.3	16.5	10.6	15.4	100.0	985	32.8
4–6	5.8	14.2	31.0	21.9	11.9	15.2	100.0	883	35.6
7+	4.5	16.9	39.1	19.6	11.5	8.5	100.0	218	30.8
Sex of preceding birth									
Male	7.0	14.1	29.9	19.7	12.9	16.5	100.0	1,083	35.6
Female	6.1	18.1	35.3	18.6	9.4	12.6	100.0	1,005	31.4
Survival of preceding birth									
Living	5.6	16.0	32.9	19.6	11.4	14.5	100.0	1,987	34.0
Dead	25.0	16.5	25.0	9.9	8.2	15.5	100.0	100	24.9
Residence									
Urban	8.3	18.7	24.7	20.8	10.7	16.8	100.0	234	35.3
Rural	6.4	15.7	33.5	18.9	11.3	14.3	100.0	1,853	33.4
Region									
Honiara	7.3	18.3	24.8	19.5	11.9	18.1	100.0	179	35.8
Guadalcanal	5.8	13.5	34.7	22.6	10.5	12.9	100.0	395	33.4
Malaita	9.5	17.5	35.0	15.7	11.1	11.2	100.0	522	30.2
Western	4.1	15.3	27.2	22.0	10.7	20.7	100.0	224	36.8
Other provinces	5.5	16.0	33.0	18.8	11.6	15.1	100.0	767	34.7
Education									
No education	6.8	14.5	34.9	17.9	12.8	13.0	100.0	318	33.8
Primary	5.1	16.7	30.9	20.7	10.9	15.6	100.0	1,398	34.6
Secondary	12.2	14.5	38.5	14.0	11.4	9.5	100.0	326	30.3
More than secondary	8.1	16.2	20.5	16.7	9.6	28.9	100.0	46	39.4
Wealth quintile									
Lowest	8.2	15.8	31.8	19.3	10.4	14.4	100.0	531	33.4
Second	3.8	17.4	37.5	17.3	12.0	12.0	100.0	432	31.1
Middle	5.5	10.9	36.1	21.3	9.7	16.4	100.0	381	35.1
Fourth	5.9	18.6	29.5	19.4	14.6	12.0	100.0	398	33.8
Highest	9.4	17.4	26.6	18.4	9.3	18.9	100.0	345	34.2
Total	6.6	16.0	32.5	19.1	11.2	14.6	100.0	2,087	33.6

Note: First-order births are excluded. The interval for multiple births is the number of months since the preceding pregnancy that ended in a live birth. An asterisk indicates a figure is based on fewer than 25 unweighted cases and has been suppressed.

Table 4.6: Age at first birth

Percentage of women aged 15–49 who gave birth, by exact ages, the percentage who have never given birth, and the median age at first birth, according to current age, Solomon Islands 2007

Current age	Percentage who gave birth by exact age					Percentage who have never given birth	Number of women	Median age at first birth
	15	18	20	22	25			
Age								
15–19	2.4	na	na	na	na	90.1	687	a
20–24	1.3	14.5	29.1	na	na	47.6	716	a
25–29	3.0	13.6	31.5	55.5	73.3	17.9	729	21.6
30–34	2.7	17.5	37.8	58.9	79.3	10.3	600	21.2
35–39	4.1	20.1	45.7	63.8	80.6	4.4	482	20.5
40–44	4.1	16.8	44.5	64.6	79.3	4.5	336	20.6
45–49	7.4	22.7	42.5	60.0	77.3	6.2	273	20.8
20–49	3.2	16.7	36.7	na	na	18.7	3,136	21.4
25–49	3.8	17.3	39.0	59.8	77.5	10.1	2,419	21.1

na = not applicable

a = Omitted because less than 50% of women had a birth before reaching the beginning of the age group

4.6 AGE AT FIRST BIRTH

Examining the age at first birth in the population is crucial because of its implications to fertility levels. Data on age at first birth also provide clear insights of women's first time to enter childbearing. Early age of childbearing provides women the opportunity to bear more children than those women who enter childbearing at later ages.

Table 4.6 shows the percentage of women aged 15–49 who gave birth, by exact age, percentage who have never given birth, and median age at first birth, according to current age at the time of the survey. The results show that the median age at first birth for women aged 20–49 is reported to be 21 years, and about 19% of these women stated not having given birth. The percentage of women aged 15–49 who reported to have given birth by their exact age increases from 3% at exact age 15 years to 37% at exact age 20 years. The results also show the close median age at first birth for each age group at about 21 years. Less than 10% of women in the 45–49 age category are childless.

Further insights into the onset of childbearing by exact age can be examined for various age groups of women by their different background characteristics. Table 4.7 shows the median age at first birth among women aged 25–49, according to their background characteristics. The median age at birth is slightly higher in urban areas than in rural areas, a difference of about 1.5 years. Across geographical regions, women's median age at birth is slightly lower in all regions compared with Honiara. The results also show that women's median age at birth increases with educational background.

Table 4.7: Median age at first birth

Median age at first birth among women aged 25–49, according to background characteristics, Solomon Islands 2007

Background characteristic	Age					Women aged 25–49
	25–29	30–34	35–39	40–44	45–49	
Residence						
Urban	23.6	22.6	22.1	21.3	22.8	22.5
Rural	21.4	20.9	20.3	20.5	20.6	20.9
Region						
Honiara	23.0	22.6	21.7	21.0	21.9	22.3
Guadalcanal	20.9	21.5	21.0	23.2	23.1	21.3
Malaita	23.1	22.1	21.1	20.0	21.7	21.8
Western	22.2	20.5	21.0	21.6	22.0	21.2
Other provinces	21.2	20.6	19.7	19.6	19.4	20.4
Education						
No education	21.4	22.0	19.3	20.6	21.7	20.7
Primary	20.7	20.8	20.3	20.5	20.4	20.6
Secondary	23.6	21.2	21.7	(20.0)	*	22.0
More than secondary	a	(24.5)	*	*	*	24.8
Wealth quintile						
Lowest	20.9	21.0	21.0	21.4	(20.8)	21.0
Second	21.8	20.7	20.2	(19.4)	(21.3)	20.9
Middle	21.4	20.7	19.3	(20.1)	(20.7)	20.6
Fourth	21.4	21.5	19.9	20.1	(19.1)	21.1
Highest	22.9	21.8	21.5	21.2	22.1	21.8
Total	21.6	21.2	20.5	20.6	20.8	21.1

a = omitted because less than 50% of the women had a birth before reaching the beginning of the age group.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

4.7 TEENAGE PREGNANCY AND MOTHERHOOD

Teenage pregnancy and motherhood refers here to young women becoming pregnant and becoming mothers at less than 20 years of age. Teenage pregnancy is a major health concern because of its association with higher morbidity and mortality for both the mother and child, and also its association with unprotected sex for young women, which leads to unwanted fertility and higher risk of sexual transmitted diseases. Childbearing during teenage years also frequently has adverse social consequences, particularly on female educational attainment because women who become mothers in their teens are more likely to curtail education. Early childbearing is also associated with higher fertility levels.

Table 4.8 presents the percentage of women aged 15–19 who have had a live birth or who are pregnant with their first child, and the percentage who have begun childbearing, by background characteristics. The percentage of women who have begun childbearing is the combination of those who have had a live birth and those who are pregnant with their first child at the time of the survey. In Solomon Islands, about 12% of women aged 15–19 have begun childbearing, almost 10% had a live birth at the time of the survey, and only 2% reported that they are pregnant with the first child at the time of the survey.

More women who have begun childbearing reside in rural areas, have only a primary education, and live in the fourth, second and lowest wealth quintiles. Across the region, women from Guadalcanal are more likely to have begun childbearing earlier than those women from other regions.

Table 4.8: Teenage pregnancy and motherhood

Percentage of women aged 15–19 who have had a live birth or who are pregnant with their first child and the percentage who have begun childbearing, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage who:		Percentage who have begun childbearing	Number of women
	Have had a live birth	Are pregnant with first child		
Age				
15	6.7	0.0	6.7	147
16	2.9	0.9	3.8	141
17	9.3	1.3	10.6	141
18	11.6	3.6	15.2	137
19	20.9	4.4	25.4	121
Residence				
Urban	7.8	1.3	9.0	135
Rural	10.5	2.1	12.6	552
Region				
Honiara	7.5	1.7	9.1	104
Guadalcanal	13.0	2.4	15.4	120
Malaita	5.6	0.0	5.6	134
Western	5.4	4.2	9.7	96
Other provinces	13.8	2.1	15.9	234
Education				
No education	(8.3)	(0.5)	(8.8)	54
Primary	12.7	2.0	14.6	305
Secondary	7.2	2.2	9.4	325
More than secondary	*	*	*	3
Wealth quintile				
Lowest	11.2	3.7	15.0	110
Second	13.0	2.5	15.5	157
Middle	10.1	0.0	10.1	125
Fourth	10.9	3.1	14.1	127
Highest	5.2	0.9	6.1	168
Total	9.9	2.0	11.9	687

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

4.8 KEY RESULTS

Fertility is one factor affecting the structure (size, growth and distribution) of the population in Solomon Islands. This section summarises the key findings of fertility levels and the differences that are important to consider in future development planning and policy decisions regarding population growth, distribution, and service delivery, including education and health, in Solomon Islands. Solomon Islands, like most Pacific Island countries, experiences high fertility levels, which is the main source of the country's high population growth. High population is always associated with socioeconomic problems, including high unemployment, urban growth with unplanned settlement practices, and poor sanitations among others.

The 2006/2007 SIDHS reported a fertility level of 4.6 births per woman, implying that on average a woman in Solomon Islands would have 4–5 children by the time she ended her childbearing years if she were to pass through her childbearing years conforming to the ASFRs observed during this period. This translates into a 4% decline in the overall fertility level of 4.8 children per woman, as estimated from the 1999 census. For the same eight-year period (1999 – 2007), the decline in teenage fertility was 15%, from 82 births to 70 births per 1,000 teenage girls. These results indicate a very slow fertility decline in Solomon Islands over this period. This indicates that Solomon Islands would continue to experience a high fertility level, which guarantees high population growth in the future.

The following findings are also highlighted to provide more insight into the fertility level, trend and pattern of fertility in Solomon Islands.

1. The fertility level is higher in rural areas (4.8 births per woman) than in urban areas (3.4 births per woman).
2. Women with a lower educational background are more likely to have higher fertility than those women with a higher educational background (4.9 births to 3.8 births).
3. The ASFRs show that teenage fertility is almost double in rural areas with about 75 births as compared with urban teenage fertility of 41 births.
4. Early childbearing occurs in Solomon Islands at the age of 15 years, with 7% of girls having begun childbearing. At age 17, teenage fertility peaks to 11%, and by age 19, about one in every four teenage girls have become mothers.
5. Age at first birth is lower in rural than in urban areas. Age at first birth increases with increased education level.
6. Birth intervals are shorter in rural areas than in urban areas. The interval between birth increases with increased education level.

The following are policy implications that could be considered to overcome and control the high fertility level in Solomon Islands:

1. Increasing public awareness on socioeconomic problems associated with high population, both in urban and rural areas. People should be well informed that high rates of fertility, which contribute to high population growth, can have several direct effects on a country's long-term development, such as contributing to a lower standard of living; reducing per capita land and resource availability; increasing under-employment; increasing pressure on social services such as education, health and housing among others. In this case, people should be well informed about their important role in planning the right number of their children for a better and healthy lifestyle.
2. Providing easy and free access to family planning services that can be accessed by every individual for use for birth control or birth limiting. To increase family planning use by providing advocacy and high-quality services of contraceptive methods at all levels.
3. Providing training and counselling to adolescents and youth on safe sex behaviour in order to assist them in protecting themselves from early and unwanted pregnancy, and also to protect them from sexually transmitted infections.

CHAPTER 5 FAMILY PLANNING

Family planning is recognised as a national priority in the Solomon Islands National Health Strategic Plan 2006–2010. The plan's objectives in Strategic Area 7 — Family Planning and Reproductive Health — include:

- improving health worker counselling skills to discuss sexual health issues, including family planning with men, women and young people;
- improving uptake of contraceptive methods by empowering men, women and young people to exercise free choice;
- reducing teenage pregnancy; and
- allowing women a choice in family planning.

The National Health Strategic Plan recognises the right of everyone to have knowledge about and access to contraceptives of their choice. Improving access and knowledge requires changes in health staff skills and attitudes to contraceptive availability. The National Family Planning Programme is aimed at ensuring that all women and men at the community level have information and access to appropriate contraceptives to plan the number and spacing of their children. National Family Planning Guidelines have been updated, and service providers in all provinces are being trained in various methods of contraception and in how to optimise all opportunities to promote family planning for the individual. Non-governmental organisations and churches have been encouraged to play a more effective role in family planning.

This chapter examines information on contraceptive knowledge; current, past and future use of contraception; and attitudes pertaining to contraception. While the results primarily focus on women, some results from the male survey are discussed, because men play an important role in the reproductive health decision-making and realisation of reproductive health goals. Data on exposure to family planning messages through the media, sources and costs of contraception, contact with family planning providers and husbands' knowledge about their wives' contraceptive use are also presented.

These topics are of practical use to policy and programme administrators in formulating effective family planning strategies. One of the important indicators resulting from this survey is the percentage of currently married women, aged 15–49, who are currently using any methods of contraception (referred to as the contraceptive prevalence rate (CPR)).

5.1 KNOWLEDGE OF CONTRACEPTION

A major objective of the 2006/2007 SI DHS was to assess the level of knowledge of contraception methods among women and men. Individuals who have adequate information about the available methods of contraception are better able to develop a rational approach to planning their families. The ability to spontaneously name or recognise a family planning method when it is described is a simple test of a respondent's knowledge, but is not necessarily an indication of the extent of knowledge. Information on knowledge of contraception was collected in the survey by asking women and men to name ways or methods by which a couple could delay or avoid pregnancy. If the respondent failed to mention a particular method spontaneously, the interviewer described the method and asked whether the respondent had heard of it. Contraceptive methods are grouped into two types. Modern methods included: female sterilisation, male sterilisation, contraceptive pill, intrauterine contraceptive device (IUCD), injectables, implants, male condom, female condom, lactational amenorrhea and emergency contraceptives. Traditional methods included rhythm method (periodic abstinence), withdrawal, and folk methods.

In Table 5.1, information about knowledge of contraceptive methods is presented for all women and men as well as for currently married and sexually active, unmarried women and men by specific methods. Findings from the 2006/2007 SIDHS show that knowledge of at least one modern method of family planning in Solomon Islands is almost universal among both women and men. The most widely known modern contraceptive methods among currently married women are: male condoms (89%); injectables (87%); female sterilisation (79%); contraceptive pill (75%); male sterilisation (62%). Over 14% of married women have heard of implants, 59% have heard of

the IUCD, and 16% have heard of emergency contraception. This pattern is similar for all, currently married, and sexually active unmarried men except that men are more likely than women to have heard of male and female condoms, male and female sterilisation, emergency contraception, and are less likely to have heard of IUCD, injectables and pills.

Effective use of the lactational amenorrhea method (LAM) means that a woman is exclusively or predominantly breastfeeding, is less than 6 months postpartum, is postpartum amenorrheic, and knows to use another contraceptive method when any of the previous criteria do not hold. LAM was reported as one of the lowest known methods for all groups of married and unmarried females and males, with unmarried males having the least knowledge (6%).

Table 5.1: Knowledge of contraceptive methods

Percentage of all respondents, currently married respondents, and sexually active unmarried respondents aged 15–49 who know any contraceptive method, by specific method, Solomon Islands 2007

Method	Women			Men		
	All women	Currently married women	Sexually active unmarried women ¹	All men	Currently married men	Sexually active unmarried men
Any method	92.6	94.4	97.4	99.3	99.6	100.0
Any modern method	92.4	94.0	97.4	99.2	99.6	100.0
Female sterilisation	75.3	79.4	80.3	79.5	89.5	66.8
Male sterilisation	57.0	62.0	64.5	67.5	78.8	49.3
Pill	69.4	75.1	66.5	66.6	76.3	65.3
IUCD	52.8	58.5	52.2	47.0	59.3	38.0
Injectables	82.0	87.4	83.5	74.9	85.2	57.9
Implants	13.1	14.2	22.6	13.4	17.3	11.9
Male condom	87.8	88.8	96.6	98.5	99.1	99.7
Female condom	42.5	42.0	49.3	53.7	52.3	56.7
Lactational amenorrhea	15.5	18.0	13.2	9.9	13.1	5.8
Emergency contraception	15.8	16.2	25.3	17.2	23.2	8.0
Any traditional method	63.7	68.0	73.8	88.1	93.3	92.5
Rhythm	50.5	54.8	56.7	45.9	53.4	37.6
Withdrawal	50.4	54.0	68.5	85.1	90.1	90.9
Folk method	11.2	11.2	22.1	6.8	8.9	2.2
Mean number of methods known by respondents 15–49	6.2	6.6	7.0	6.7	7.5	5.9
Number of respondents	3,823	2,560	163	1,614	939	195
Mean number of methods known by respondents 15+	na	na	na	6.5	7.1	5.9
Number of respondents	na	na	na	2,056	1,314	196

¹ Had last sexual intercourse within 30 days preceding the survey.
na = not applicable

Among sexually active unmarried women, higher percentages of respondents with knowledge about sterilisation, implants, male and female condoms and emergency contraception were reported than among married women. Whereas among sexually active unmarried men, knowledge of most contraceptives was lower than for sexually active unmarried women and currently married men, with the exception of condoms. Of note was a higher percentage of currently married men who reported having knowledge of emergency contraception than currently married females, and a higher percentage of sexually active, unmarried women who had knowledge of emergency contraception than married women.

A greater proportion of women and men reported knowing a modern method than a traditional method. Knowledge of any traditional method among all three groups of women ranges from 64–74%. Reported knowledge of traditional methods is much higher among men (88–93%). One of the reasons for the lower reported knowledge of traditional methods may be that these methods are not included in the government family planning programme and women may be reluctant to mention them because they are not widely accepted.

The mean number of known contraceptive methods varies by marital status of women and men, with the lowest number of methods estimated for unmarried men being six, while the highest number of methods was eight for married men.

The high level of knowledge could be attributed to the successful dissemination of family planning messages through the mass media and the revitalised family planning programme. The higher levels of knowledge of emergency contraception among married men and sexually active unmarried women may be attributed to the Male in Reproductive Health and Adolescent Health and Development activities³. Wide knowledge of condoms may be due to increasing the activities of the STIs and HIV prevention programme.

5.2 KNOWLEDGE OF CONTRACEPTIVE METHODS BY BACKGROUND CHARACTERISTICS

Table 5.2: Knowledge of contraceptive methods by background characteristics

Percentage of currently married women and currently married men aged 15–49 who have heard of at least one contraceptive method and who have heard of at least one modern method by background characteristics, Solomon Islands 2007

Background characteristic	Women			Men		
	Heard of any method	Heard of any modern method ¹	Number	Heard of any method	Heard of any modern method ¹	Number
Age						
15–19	83.4	81.8	86	*	*	1
20–24	93.0	92.9	383	99.3	99.3	75
25–29	94.3	93.9	588	99.3	99.3	171
30–34	95.8	95.1	533	99.7	99.7	226
35–39	95.4	95.0	433	100.0	100.0	230
40–44	94.2	94.2	311	98.8	98.8	129
45–49	96.3	96.3	226	100.0	100.0	107
Residence						
Urban	92.0	91.6	372	100.0	100.0	162
Rural	94.8	94.5	2,187	99.5	99.5	778
Region						
Honiara	89.2	88.7	278	100.0	100.0	124
Guadalcanal	97.6	97.3	445	98.9	98.9	180
Malaita	93.5	92.7	612	99.1	99.1	222
Western	98.3	98.3	303	100.0	100.0	94
Other provinces	93.7	93.6	922	100.0	100.0	320
Education						
No education	89.9	89.1	385	95.1	95.1	60
Primary	94.5	94.3	1,610	99.8	99.8	510
Secondary	97.2	96.7	493	100.0	100.0	268
More than secondary	97.1	97.1	72	100.0	100.0	102
Wealth quintile						
Lowest	93.7	93.1	499	98.7	98.7	185
Second	95.1	95.1	500	100.0	100.0	178
Middle	94.4	93.9	490	99.1	99.1	172
Fourth	94.9	94.3	546	100.0	100.0	209
Highest	93.9	93.7	524	100.0	100.0	196
Total 15–49	94.4	94.0	2,560	99.6	99.6	939
50+	na	na	0	96.4	95.3	375
Total men 15+	na	na	0	98.7	98.4	1,314

¹Female sterilisation, male sterilisation, pill, IUCD, injectables, implants, male condom, female condom, diaphragm, foam or jelly, lactational amenorrhea method, and emergency contraception.

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = not applicable

³ UNFPA country programmes and ongoing activities that support male and adolescents involvements in reproductive health programmes and also promote decision-making about the roles of men and adolescents in healthy reproductive health behavior.

Table 5.2 explores the level of knowledge about contraceptive methods for currently married women and men aged 15–49 who have heard of at least one contraceptive method or who have heard of at least one modern method, by background characteristics. The table is restricted to currently married women and men in order to facilitate comparison between subgroups, which may differ in their marital composition.

For all background characteristics subgroups, level of knowledge exceeded 80% for married women and men. However, the 15–19 age group of married women reported the lowest level of knowledge of any method or any modern method. Slightly lower levels of knowledge were reported for urban females and for females residing in Honiara. Females from Western Province reported the highest level of knowledge of at least one method. As expected those women and men with no education and those in the lowest wealth quintile had slightly lower levels of knowledge of at least one method.

5.3 EVER USE OF CONTRACEPTION: WOMEN AND MEN

Data on ever use of contraception has special significance because it reveals the cumulative success of programmes that promote the use of family planning among couples. Ever use refers to use of a method at any time, with no distinction between past and present use. In the 2006/2007 SIDHS, respondents who had heard of a method of family planning were asked if they had ever used a method.

Table 5.3.1 shows the percentage of all women and currently married women who have ever used family planning by specific method and age. Just under 59% of currently married women have used a method of contraception, and 48% have used a modern method. Among currently married women, less than one in three (29%) have ever used injectables, making it the most commonly used modern method. Approximately 13% of currently married women have had female sterilisation, about one in ten have used male condoms, 8% have used the pill in the past, and less than 1% reported male sterilisation. Negligible levels of use were reported for lactational amenorrhea, female condom and implants.

The 2006/2007 SIDHS collected information on ever use of contraception for men as well, but with respect to four male methods only: male sterilisation, condoms, rhythm method and withdrawal. As seen in Table 5.3.2, 77% of currently married men aged 15–49 have ever used a method in the past, with only 31% having used a modern method. Looking at specific methods, 68% of currently married men reported to have used withdrawal. Men are much more likely to report ever use of condoms than women. Slightly more than 1% of currently married men reported to have been sterilised. Ever use of any method among all men rises from 48% among those in the youngest age group, to a peak of 84% among men aged 25–29, and then steadily decreasing to 70% among men aged 40–49.

The proportion of currently married women aged 15–49 that have ever used any modern method is 48%, while the percentage for currently married men is 31%. Use of any traditional method was reported by 20% of all women and 68% of all men. About 41% of women who are categorised as sexually active unmarried women have ever used any modern family planning method compared with 62% of sexually active unmarried men.

Table 5.3.1: Ever use of contraception — Women

Percentage of all women, currently married women, and sexually active unmarried women aged 15–49 who have ever used any contraceptive method by method and according to age, Solomon Islands 2007

Age	Any method	Any modern method	Modern method										Any traditional method	Traditional method			Number of women
			Female sterilisation	Male sterilisation	Pill	IUCD	Injectables	Implants	Male condom	Female condom	LAM	Emergency contraception		Rhythm	Withdrawal	Folk method	
ALL WOMEN																	
15–19	17.2	12.4	0.0	0.2	0.0	0.1	2.2	0.0	10.2	0.1	0.1	0.0	10.1	4.2	7.3	0.1	687
20–24	42.1	28.2	0.2	0.2	2.1	1.1	11.5	0.0	15.7	0.2	0.1	0.0	25.7	15.9	19.6	2.6	716
25–29	48.2	38.0	2.8	0.1	5.6	1.8	23.5	0.0	14.4	0.1	0.2	0.1	22.8	13.4	11.4	2.7	729
30–34	59.6	49.5	11.8	0.6	8.3	4.3	33.4	0.1	11.0	0.1	0.5	0.0	25.4	18.6	13.7	0.8	600
35–39	61.2	51.6	21.0	1.0	8.1	2.4	32.3	0.0	7.7	0.4	2.8	0.0	21.1	13.0	11.6	1.8	482
40–44	61.9	54.0	20.7	1.0	12.8	2.1	33.4	0.3	7.8	0.0	0.0	0.0	19.3	14.1	9.6	0.1	336
45–49	59.9	55.8	33.8	0.8	9.8	4.5	21.5	0.0	2.3	0.0	0.0	0.0	14.6	11.4	4.1	1.3	273
Total	46.9	37.8	9.3	0.5	5.6	2.0	20.8	0.0	11.1	0.1	0.5	0.0	20.4	12.9	11.9	1.5	3,823
CURRENTLY MARRIED WOMEN																	
15–19	33.5	18.4	0.0	0.0	0.2	0.5	7.9	0.0	9.8	0.0	0.0	0.0	18.7	11.6	6.4	0.7	86
20–24	49.8	35.5	0.4	0.3	3.7	2.1	18.7	0.0	12.6	0.1	0.1	0.0	25.3	14.0	19.9	0.7	383
25–29	55.3	43.6	3.4	0.1	6.8	2.2	28.8	0.0	15.0	0.1	0.2	0.0	26.8	15.8	13.1	3.3	588
30–34	64.1	53.3	13.2	0.7	7.8	4.8	35.7	0.1	10.4	0.1	0.6	0.0	26.6	19.0	13.5	0.9	533
35–39	63.8	53.4	23.2	1.2	8.3	2.4	33.2	0.0	7.9	0.4	3.1	0.0	23.0	14.3	12.4	2.0	433
40–44	62.6	54.5	21.1	1.1	13.6	2.3	33.9	0.0	8.0	0.0	0.0	0.0	20.1	14.5	10.0	0.1	311
45–49	63.7	59.0	36.5	1.0	11.0	5.1	22.6	0.0	2.6	0.0	0.0	0.0	15.7	12.8	3.2	1.6	226
Total	58.7	47.9	13.3	0.6	7.8	3.0	28.8	0.0	10.4	0.1	0.7	0.0	23.8	15.4	12.6	1.6	2,560
SEXUALLY ACTIVE UNMARRIED WOMEN¹																	
Total	61.1	40.6	0.1	0.8	5.2	0.0	8.1	0.0	36.8	0.5	0.0	0.0	45.6	26.3	42.0	0.4	163

LAM = lactational amenorrhea method

¹ Women who had sexual intercourse within 30 days preceding the survey.

Table 5.3.2: Ever use of contraception — Men

Percentage of all men, currently married men, and sexually active unmarried men aged 15 and older who have ever used any contraceptive method by method and according to age, Solomon Islands 2007

Age	Any method	Any modern method	Modern method		Any traditional method	Traditional method		Number of men
			Male sterilisation	Male condom		Rhythm	Withdrawal	
ALL MEN								
15–19	47.7	32.8	0.6	32.2	41.4	6.1	40.9	292
20–24	78.3	47.0	0.1	46.9	73.0	17.4	69.3	304
25–29	83.5	41.5	1.7	41.5	78.9	19.9	76.2	266
30–34	78.5	35.7	1.6	35.3	74.8	28.1	71.0	266
35–39	78.0	27.7	1.4	27.7	74.5	27.2	69.9	239
40–44	70.0	31.9	1.2	31.5	67.3	35.5	59.0	134
45–49	70.7	25.3	0.9	24.4	65.7	23.1	59.9	113
Total 15–49	72.4	36.0	1.0	35.8	67.8	20.9	64.2	1,614
50+	61.5	11.4	1.8	9.8	58.9	18.7	50.6	442
Total men 15+	70.1	30.7	1.2	30.2	65.9	20.4	61.2	2,056
CURRENTLY MARRIED MEN								
15–19	*	*	*	*	*	*	*	1
20–24	69.9	41.7	0.0	41.7	63.1	22.6	57.8	75
25–29	82.2	34.0	2.1	34.0	77.9	17.7	75.2	171
30–34	78.9	30.9	0.6	30.5	75.6	26.5	71.9	226
35–39	78.9	27.1	1.4	27.1	75.4	26.9	70.6	230
40–44	71.4	31.9	1.3	31.5	68.6	36.0	60.5	129
45–49	69.8	24.1	0.9	23.2	64.5	22.0	58.4	107
Total 15–49	76.7	30.8	1.1	30.5	72.7	25.5	67.9	939
50+	61.1	12.6	2.1	10.7	58.1	19.4	48.9	375
Total men 15+	72.3	25.6	1.4	24.9	68.5	23.7	62.5	1,314
SEXUALLY ACTIVE UNMARRIED MEN ¹								
Total 15–49	88.7	61.7	0.6	61.7	83.5	27.4	78.5	195
Total men 15+	88.8	61.3	0.6	61.3	83.6	27.3	78.7	196

¹ Men who had sexual intercourse within 30 days preceding the survey.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Figure 5.1: Proportion of currently married women and men who reported ever use of any method of contraception by age

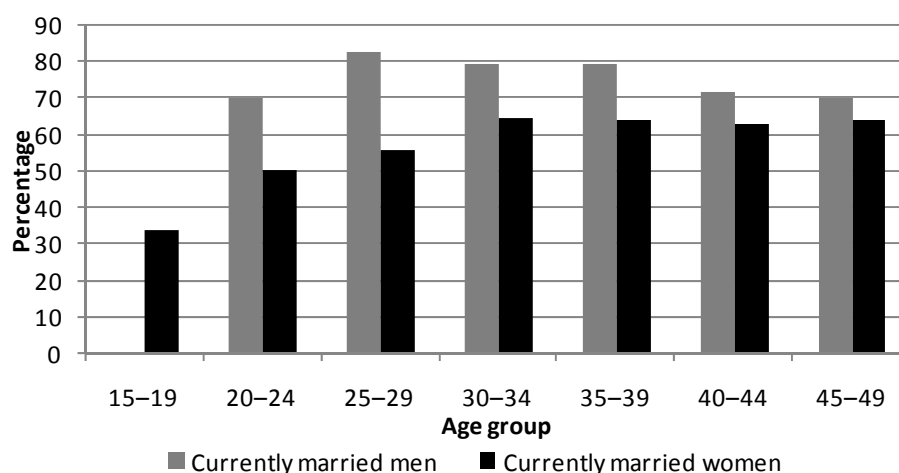


Figure 5.1 shows the proportion of currently married women and men who ever used any family planning method by age at the time of the 2006/2007 SIDHS. Generally a higher proportion of currently married men have ever used any family planning methods for all ages. Ever use of contraception varies with age for men and women. The pattern of ever use is curvilinear, with use being lowest among women in the youngest age group (15–19), and increasing with age to a plateau among women in their 30s and 40s. The level of ever use of any method among currently married women rises to a high of 64% among those aged 30–39 and 45–49. Ever use of any modern method by age follows a similar pattern, regardless of marital status. Among all women aged 15–19, only 12% reported having ever used any modern method while 18% of currently married women of this age group reported having used any modern method. For men aged 15–19, 33% reported use of any modern method and 48% for any method. Differences between age groups may reflect lifetime effects and/or genuine cohort change.

5.4 CURRENT USE OF CONTRACEPTION BY AGE

Current use of contraception is defined as the proportion of women who reported the use of a family planning method at the time of interview. The level of current use — usually calculated among currently married women — is the most widely used measure of the success of family planning programmes (contraceptive prevalence rate). Furthermore, it can be used to estimate the reduction in fertility attributable to contraception. To collect information on current use of contraception among Solomon Islands women, respondents in their childbearing ages were asked whether they were currently using any methods, and if so which methods they were using. All current methods which were used and reported from all women were then recorded. Table 5.4 shows the percent distribution of all women and currently married women who are currently using specific family planning methods by age. Similar information on current use was also collected for men.

Table 5.4 shows that approximately 35% of currently married women are using a family planning method, with 27% using a modern contraceptive method. The proportion of women who are using a modern method is substantially higher than the contraceptive prevalence rate (CPR) reported by the Solomon Islands Ministry of Health and Medical Services Health Information System (CPR 10% for 2006). Approximately 7% of currently married women of all ages reported using a traditional method. The most commonly used method among currently married women was reported to be female sterilisation (13%), followed by injectables (9%), rhythm (5%); and IUCD and withdrawal (both at 2%). Use of other methods was reported as negligible.

Contraceptive use varies by age. Use is lower among younger women (because they are in the early stage of family building). Among older women (some of whom are no longer fecund), higher rates of use of any modern method were observed than among those at intermediate ages. For example, current use of a modern contraceptive method is 13% among currently married women aged 15–19, rising to 35% among women aged 35–39, and further increasing to 44% among women aged 45–49.

Injectables are popular among women of all ages and IUCDs are particularly popular among women aged 30–34. As expected, male condoms are most popular among those women in the youngest age group.

Women aged 45–49 had the highest levels of female sterilisation. This may be due to a cohort effect because about 10 years ago, more tubal ligations were performed. Due to the lack of family planning providers capable of performing this procedure, a high turnover of medical staff and the deterioration of health facilities in the provinces in recent years subsequent to national ethnic tension, tubal ligations are not performed as frequently as they were in previous years.

Table 5.4: Current use of contraception by age

Percent distribution of all women, currently married women, and sexually active unmarried women aged 15–49 by contraceptive method currently used, according to age, Solomon Islands 2007

Age	Any method	Any modern method	Modern method								Any traditional method	Traditional method			Not currently using	Total	Number of women
			Female sterilisation	Male sterilisation	Pill	IUCD	Injectables	Male condom	Female condom	LAM		Rhythm	Withdrawal	Folk method			
ALL WOMEN																	
15–19	7.2	5.2	0.0	0.0	0.0	0.1	2.1	3.0	0.0	0.0	2.1	1.0	0.9	0.1	92.8	100.0	687
20–24	19.9	13.6	0.2	0.0	0.9	0.8	8.5	3.2	0.0	0.0	6.3	2.8	2.6	0.8	80.1	100.0	716
25–29	21.8	15.7	2.8	0.0	2.0	1.4	7.0	2.5	0.0	0.0	6.2	2.9	2.6	0.7	78.2	100.0	729
30–34	33.5	26.6	11.8	0.0	1.1	3.5	8.3	1.6	0.0	0.3	6.9	5.2	1.6	0.1	66.5	100.0	600
35–39	41.9	33.3	21.0	0.5	1.2	2.1	7.9	0.7	0.0	0.0	8.6	6.5	1.9	0.3	58.1	100.0	482
40–44	38.6	31.2	20.7	0.6	0.6	1.1	7.2	0.9	0.0	0.0	7.4	6.3	1.2	0.0	61.4	100.0	336
45–49	43.4	40.8	33.8	0.8	0.0	0.9	5.1	0.1	0.0	0.0	2.6	1.8	0.6	0.3	56.6	100.0	273
Total	26.2	20.5	9.3	0.2	0.9	1.4	6.6	2.0	0.0	0.1	5.7	3.6	1.8	0.4	73.8	100.0	3,823
CURRENTLY MARRIED WOMEN																	
15–19	19.5	12.8	0.0	0.0	0.2	0.5	7.9	4.2	0.0	0.0	6.7	3.1	2.9	0.7	80.5	100.0	86
20–24	25.0	18.2	0.4	0.0	1.4	1.5	13.7	1.3	0.0	0.0	6.8	2.9	3.9	0.0	75.0	100.0	383
25–29	25.8	18.6	3.4	0.0	2.4	1.7	8.6	2.4	0.1	0.0	7.2	3.5	2.8	0.9	74.2	100.0	588
30–34	37.0	29.5	13.2	0.0	1.3	4.0	9.1	1.6	0.0	0.4	7.6	5.7	1.7	0.2	63.0	100.0	533
35–39	44.4	35.1	23.2	0.5	1.3	2.3	7.0	0.7	0.0	0.0	9.3	7.3	1.8	0.3	55.6	100.0	433
40–44	40.0	32.4	21.1	0.6	0.7	1.2	7.8	1.0	0.0	0.0	7.6	6.4	1.2	0.0	60.0	100.0	311
45–49	47.1	44.0	36.5	1.0	0.0	0.8	5.5	0.2	0.0	0.0	3.2	2.1	0.7	0.3	52.9	100.0	226
Total	34.6	27.3	13.3	0.3	1.3	2.1	8.8	1.5	0.0	0.1	7.3	4.7	2.2	0.3	65.4	100.0	2,560
SEXUALLY ACTIVE UNMARRIED WOMEN ¹																	
15–19	21.5	14.1	0.0	0.0	0.0	0.0	0.0	14.1	0.0	0.0	7.4	2.6	4.8	0.0	78.5	100.0	75
20–24	28.4	16.4	0.0	0.0	0.0	0.0	2.1	14.3	0.0	0.0	12.0	5.9	6.1	0.0	71.6	100.0	59
25+	(27.4)	(21.2)	(0.7)	(0.0)	(0.0)	(0.0)	(7.3)	(13.2)	(0.0)	(0.0)	(6.2)	(0.0)	(6.2)	(0.0)	(72.6)	100.0	29
Total	25.0	16.2	0.1	0.0	0.0	0.0	2.1	14.0	0.0	0.0	8.8	3.3	5.5	0.0	75.0	100.0	163

Note: If more than one method is used, only the most effective method is considered in this tabulation.

Note: Figures in parentheses are based on 25–49 unweighted cases.

LAM = lactational amenorrhea method

¹ Women who have had sexual intercourse within 30 days preceding the survey.

5.5 CURRENT USE OF CONTRACEPTION BY BACKGROUND CHARACTERISTICS

The study of current contraceptive use by background characteristics is important because it helps identify subgroups of the population to target for family planning services. Table 5.5 presents the percent distribution of currently married women by their current use of family planning methods, according to background characteristics. This table allows comparisons of the level of current contraceptive use among major population groups. It also permits an examination of differences in the method mix among current users within the various subgroups.

Substantial differences in the use of contraceptive methods among subgroups of currently married women can be seen in Table 5.5. Women in rural areas are more likely to use a family planning method than urban women, reflecting the higher motivation of health providers in rural areas despite the higher accessibility to contraception in urban areas. The contraceptive prevalence rate for modern methods is 23% in urban areas, compared with 28% in rural areas. Female sterilisation and injectables are most popular in rural areas where 14% of currently married women have been sterilised and 10% use injectables. On the other hand, IUCD, male condoms and pills are most popular in urban areas.

Contraceptive use varies by region with much of the variation due to differences in female and male sterilisation and injectables. Use of a modern method among currently married women is highest in Western and other provinces (33%), followed by Malaita (25%) and Honiara and Guadalcanal (20%). Western and other provinces reported the highest levels of female sterilisation. Injectables are most common among currently married women living in Guadalcanal, Malaita and Western provinces (10%) and much less in Honiara than other provinces. IUCD use was most popular in Honiara and other provinces and least popular in Guadalcanal. The highest level of pill use was in Western Province (2%) but was negligible in all other provinces. There is less variation in the use of male condoms by provinces. The use of any traditional method was most popular in Guadalcanal and least popular in Honiara.

The effect of education on contraceptive use is mixed. Use of modern methods is highest among women with more than a secondary level of education (30%) and lowest among women with only some secondary education (22%). Contraceptive use is higher among women who have had more than a secondary education because a sizeable proportion of these women use IUCD, male condoms and injectables. The most popular modern method among women who have had more than a secondary education is injectables (12%), whereas the most popular modern method among women who have no education is female sterilisation (15%) followed by injectables (10%). In fact, female sterilisation and injectables are the most popular methods among all women who have less than a secondary level of education. In general, as women's level of education increases they are more likely to use modern contraceptive methods, especially injectables and IUCD.

There is a direct association between the use of modern family planning methods and the number of children women have. Only 3% of women with no living children use modern contraception; the percentage increases to 32% among women with three to four children, and to 38% among women with five or more children. As expected, permanent methods are popular among high-parity women. Use of female sterilisation increases with the number of living children a woman has. Approximately 27% of women with five or more children reported female sterilisation. Injectables, pills and IUCD are also more popular among women with one to four children. The popularity of injectables could be due to several reasons: injectables are more easily accessible because supplies are available at most health facilities; they work for a relatively longer duration; they are convenient to use; and their use can be kept private.

Contraceptive use varies with wealth quintiles. Women in the middle and fourth quintile reported highest use of a modern method. Women in the lowest quintile reported the highest use of any traditional method, especially the rhythm method. Women in the highest quintile reported the highest use of IUCDs and pills.

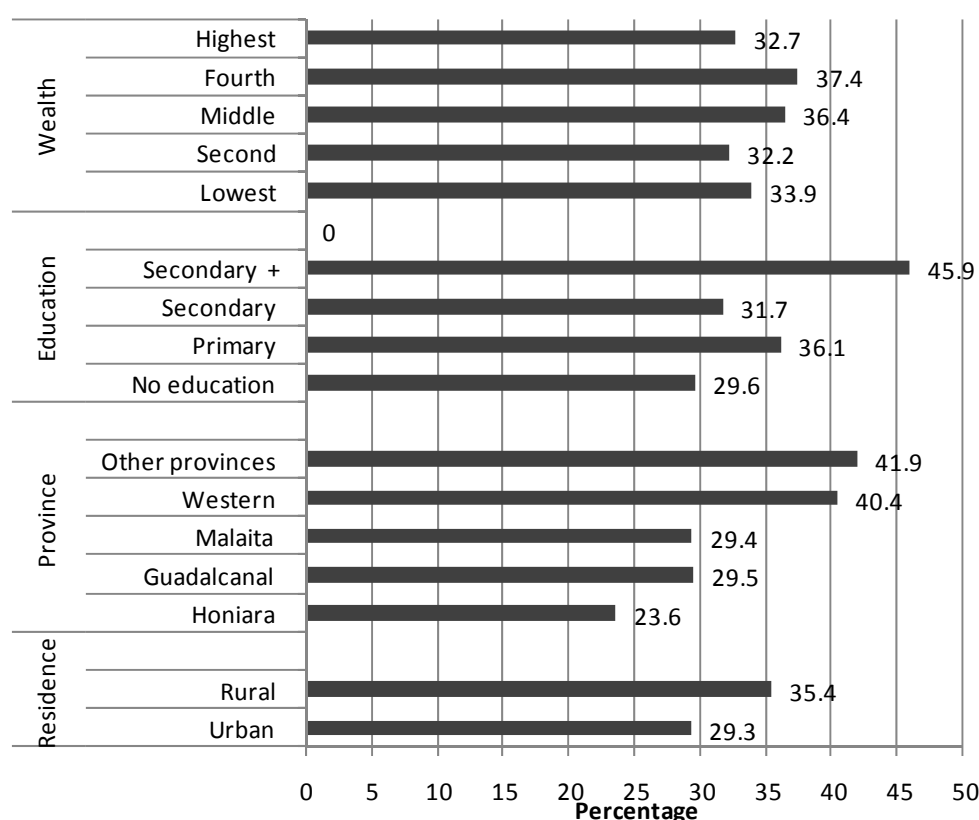
Table 5.5: Current use of contraception by background characteristics*Percent distribution of currently married women aged 15–49 by contraceptive method currently used, according to background characteristics, Solomon Islands 2007*

Background characteristic	Any method	Any modern method	Modern method								Any traditional method	Traditional method			Not currently using	Total	Number of women
			Female sterilisation	Male sterilisation	Pill	IUD	Injectables	Male condom	Female condom	LAM		Rhythm	Withdrawal	Folk method			
Residence																	
Urban	29.3	23.2	10.2	0.8	2.2	3.5	4.2	2.3	0.1	0.0	6.1	3.2	2.7	0.2	70.7	100.0	372
Rural	35.4	28.0	13.8	0.2	1.2	1.8	9.6	1.3	0.0	0.1	7.5	5.0	2.1	0.4	64.6	100.0	2,187
Region																	
Honiara	23.6	19.7	9.1	0.3	1.3	3.0	4.5	1.3	0.1	0.0	3.8	1.8	2.0	0.0	76.4	100.0	278
Guadalcanal	29.5	19.5	6.1	0.2	0.7	0.5	10.3	1.9	0.0	0.0	9.9	2.9	6.1	0.9	70.5	100.0	445
Malaita	29.4	24.6	10.5	0.8	0.9	1.4	10.1	0.9	0.0	0.0	4.8	2.0	2.6	0.2	70.6	100.0	612
Western	40.4	32.5	17.1	0.0	2.3	2.2	9.9	0.9	0.0	0.0	7.9	6.2	1.1	0.6	59.6	100.0	303
Other provinces	41.9	33.4	18.7	0.0	1.6	2.9	8.1	1.9	0.0	0.2	8.4	7.8	0.4	0.2	58.1	100.0	922
Education																	
No education	29.6	28.2	14.6	0.9	1.0	1.8	9.8	0.2	0.0	0.0	1.3	0.4	1.0	0.0	70.4	100.0	385
Primary	36.1	28.7	15.1	0.1	1.1	1.9	8.9	1.5	0.0	0.1	7.4	5.3	1.7	0.4	63.9	100.0	1,610
Secondary	31.7	21.7	7.5	0.2	2.3	2.1	7.4	2.2	0.0	0.0	10.1	5.7	3.8	0.6	68.3	100.0	493
More than secondary	45.9	29.5	6.1	0.0	0.3	7.3	12.1	3.6	0.0	0.0	16.4	8.9	7.6	0.0	54.1	100.0	72
Number of living children																	
0	11.7	3.4	1.6	0.0	0.0	0.0	0.0	1.8	0.0	0.0	8.3	3.5	4.8	0.0	88.3	100.0	247
1–2	24.5	19.4	1.9	0.0	2.3	2.5	10.5	2.2	0.0	0.0	5.0	2.5	2.5	0.1	75.5	100.0	742
3–4	42.5	32.4	14.9	0.3	1.4	2.8	11.1	1.5	0.0	0.2	10.1	7.3	1.9	0.9	57.5	100.0	837
5+	43.4	37.5	26.9	0.5	0.6	1.5	7.4	0.6	0.0	0.0	5.9	4.5	1.3	0.1	56.6	100.0	734
Wealth quintile																	
Lowest	33.9	23.8	10.0	0.0	1.9	0.5	9.7	1.6	0.0	0.0	10.1	7.4	2.4	0.2	66.1	100.0	499
Second	32.2	25.5	15.9	0.0	0.1	1.1	7.4	0.9	0.0	0.0	6.7	3.9	2.5	0.2	67.8	100.0	500
Middle	36.4	31.7	17.1	0.7	0.8	2.2	10.0	0.5	0.0	0.4	4.7	2.1	2.6	0.0	63.6	100.0	490
Fourth	37.4	30.0	11.7	0.1	1.6	2.5	11.3	2.9	0.0	0.0	7.4	5.8	0.8	0.8	62.6	100.0	546
Highest	32.7	25.4	12.1	0.5	2.2	3.8	5.6	1.3	0.1	0.0	7.3	4.2	2.6	0.4	67.3	100.0	524
Total	34.6	27.3	13.3	0.3	1.3	2.1	8.8	1.5	0.0	0.1	7.3	4.7	2.2	0.3	65.4	100.0	2,560

Note: If more than one method is used, only the most effective method is considered in this tabulation.

LAM = lactational amenorrhea method

Figure 5.2: Contraceptive use among currently married women by background characteristics



5.6 NUMBER OF CHILDREN AT FIRST USE OF CONTRACEPTION

To examine the timing of initial family planning use during the time when couples are having their children, the 2006/2007 SIDHS asked all women about the number of living children they had at first use of contraception. Table 5.6 shows the distribution of women aged 15–49 by age group and number of living children at the time of first use of contraception. This table permits an analysis of cohort changes in parity at first use of contraception.

Ten percent of all women first used a family planning method when they already had four or more children. Just over 12% of all women first used family planning at the time they had no children, and 11% first used contraception after the birth of their first child.

An important point of this table is to examine cohort change in parity at first use of contraception. Younger women reported first use of contraception at lower parities than older women, suggesting a shift toward the early use of contraception and the desire to delay childbearing among Solomon Islands women. For example, 23% of women aged 20–24 initiated use before having any children compared with 6% among women aged 35–39. This may be because young women are more likely to use contraceptives to space births, whereas older women use them to limit births after they have reached high parities (4+children).

Table 5.6: Number of children at first use of contraception

Percent distribution of women aged 15–49 by number of living children at the time of first use of contraception, according to current age, Solomon Islands 2007

Current age	Never used	Number of living children at time of first use of contraception						Total	Number of women
		0	1	2	3	4+	Missing		
Age									
15–19	82.8	14.1	2.9	0.1	0.0	0.0	0.0	100.0	687
20–24	57.9	23.0	12.0	3.8	2.0	0.7	0.6	100.0	716
25–29	51.8	11.0	16.4	12.8	4.7	2.9	0.4	100.0	729
30–34	40.4	8.7	16.4	14.8	9.0	9.9	0.8	100.0	600
35–39	38.8	5.5	6.4	11.9	9.1	27.7	0.7	100.0	482
40–44	38.1	7.2	10.0	10.6	8.6	25.0	0.6	100.0	336
45–49	40.1	8.4	14.3	3.5	4.5	28.7	0.5	100.0	273
Total	53.1	12.2	11.2	8.2	4.9	10.0	0.5	100.0	3,823

5.7 KNOWLEDGE OF FERTILE PERIOD

An elementary knowledge of reproductive physiology provides a useful background for the successful practice of coitus-associated methods such as withdrawal, condoms, and vaginal methods. As shown in Tables 5.1, 5.3.1 and 5.4, respectively, 51% of all women have heard of the rhythm method, 13% have ever used it in the past, and 4% are currently using the method. Table 5.7 shows respondents' knowledge about the time during the menstrual cycle when a woman is most likely to get pregnant.

Overall, only 16% of women correctly reported that the most fertile time during the menstrual cycle is halfway between two menstrual periods. Among users of the rhythm method, 33% were able to correctly identify when during a woman's cycle she is most likely to get pregnant and about 43% reported that a woman's most fertile period is right after menstruation has ended. About 46% of non-users did not know any specific time or about the fertile period, and 31% of them stated that a woman is most susceptible to becoming pregnant just after her period has ended. Approximately 16% of non-users reported the fertile period as being halfway between the two menstrual periods.

Table 5.7: Knowledge of fertile period

Percent distribution of women aged 15–49 by knowledge of the fertile period during the ovulatory cycle, according to current use of the rhythm method, Solomon Islands 2007

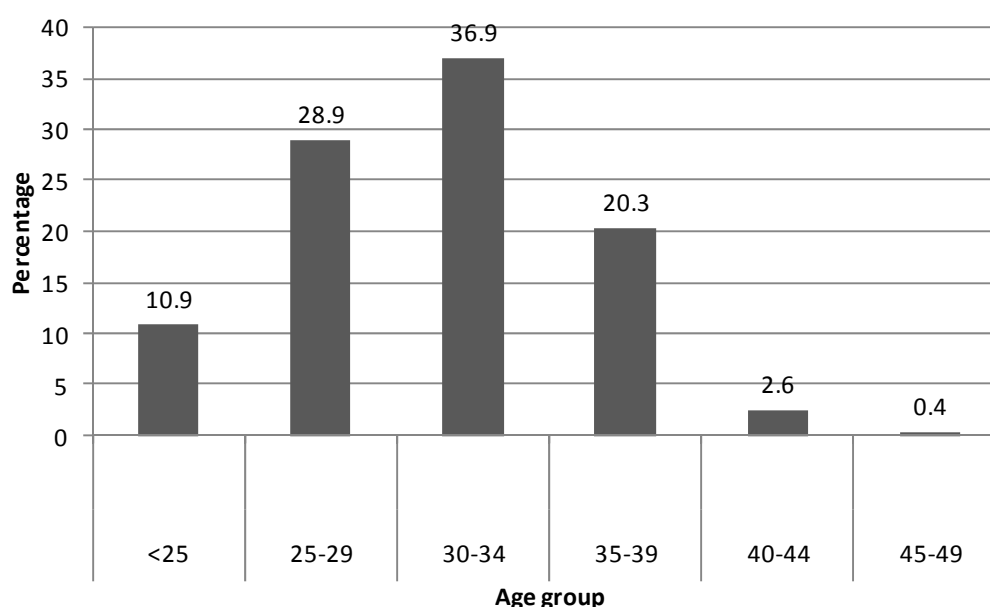
Perceived fertile period	Users of rhythm method	Non-users of rhythm method	All women
Just before her menstrual period begins	2.5	3.8	3.7
During her menstrual period	1.5	2.8	2.8
Right after her menstrual period has ended	43.0	31.1	31.5
Halfway between two menstrual periods	33.3	15.6	16.2
Other	0.0	0.2	0.2
No specific time	11.0	16.5	16.3
Don't know	8.3	29.8	29.0
Missing	0.3	0.3	0.3
Total	100.0	100.0	100.0
Number of women	137	3,686	3,823

5.8 TIMING OF FEMALE STERILISATION

Figure 5.3 shows the percent distribution of sterilised women aged 15–49 by age at the time of female sterilisation in Solomon Islands. In countries where female sterilisation is prevalent, there is an interest in the trends in adoption of the method and the age at the time of sterilisation. During the 2006/2007 SIDHS, to minimise the problem of censoring, the median age at the time of sterilisation is calculated only for women sterilised at less than 40 years of age. The median age at sterilisation was reported to be 30.9.

The results indicate that most women (77%) were sterilised before age 35, with 11% sterilized before age 25. Thus, female sterilisation in Solomon Islands occurs primarily between ages 25 and 35. The median age at sterilisation (for women sterilised before age 40) is 30 years.

Figure 5.3: Timing of female sterilisation



5.9 SOURCE OF CONTRACEPTION

Table 5.8 documents the main sources of contraception for users of different modern methods of contraception. Information on where women obtain their contraception is important for programme managers and implementers who design family planning policies and programmes. All current users of modern contraceptive methods were asked the most recent source of their contraception. The government sector remains the major source of contraceptive methods in Solomon Islands, providing methods to more than four in five current users. The share of the government sector has remained steady over the past two to three decades. Approximately 8% get their contraceptive supplies from the church hospital or rural health clinics. Only 2% of users reported getting their methods from the non-government sector, mostly from the Solomon Islands Planned Parenthood Association (SIPPA) Clinic and Save the Children Fund. Approximately 1% reported obtaining their methods from the private medical sector, mostly pharmacies.

However, only 50% of users reported obtaining condoms from the public sector, 10% reported obtaining condoms from private pharmacies, and 12% from SIPPA. It was notable that 20% of users reported obtaining condoms from other organisations and 12% from other private entities.

Table 5.8: Source of modern contraception methods

Percent distribution of users of modern contraceptive methods aged 15–49 by most recent source of method, according to method, Solomon Islands 2007

Source	Female sterilisation	Pill	IUCD	Injectables	Male condom	Total ¹
Public sector	91.8	(81.7)	79.2	81.8	50.1	82.9
Public government hospital	91.8	(16.7)	19.4	9.9	9.1	48.5
Rural health centre	0.0	(14.2)	15.5	5.7	2.8	3.8
Rural health clinic	0.0	(44.3)	33.8	56.4	37.8	26.3
Nurse aide	0.0	(0.0)	5.8	9.1	0.0	3.3
Satellite clinic	0.0	(3.3)	0.7	0.0	0.0	0.2
Other public	0.0	(3.2)	4.0	0.8	0.4	0.8
Private medical sector	0.0	(0.0)	3.1	0.2	9.7	1.3
Private hospital/clinic	0.0	(0.0)	3.1	0.0	0.0	0.2
Private pharmacy	0.0	(0.0)	0.0	0.0	9.7	1.0
Private doctor	0.0	(0.0)	0.0	0.2	0.0	0.1
Other private	0.0	(2.8)	1.9	0.6	12.0	1.6
Church	5.6	(7.0)	15.8	11.3	0.0	7.6
Church hospital	5.6	(3.5)	10.4	4.9	0.0	5.0
Church rural health clinic	0.0	(3.5)	5.4	6.5	0.0	2.6
Non-governmental organisations						
SIPPA clinic	0.0	(2.8)	1.9	0.6	11.8	1.6
Save the children fund	0.0	(0.0)	0.0	0.0	0.2	0.0
Other	0.9	(7.7)	0.0	1.0	20.1	3.1
Missing	1.7	(0.8)	0.0	5.2	8.2	3.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	355	35	53	252	78	782

¹ Total includes other modern methods but excludes lactational amenorrhea method (LAM).

Note: Figures in parentheses are based on 25–49 unweighted cases.

5.10 COST FOR MODERN CONTRACEPTIVE METHODS

Table 5.9: Cost of modern contraceptive methods

Percentage of current users of modern contraception aged 15–49 who did not pay for the method and who do not know the cost of the method and the median cost of the method by current method, according to source of current method, Solomon Islands 2007

Source of method/cost	Female sterilisation	Pill	IUD	Injectables	Male condom	Total
Total						
Percentage free	86.7	(100.0)	95.7	94.3	85.4	90.1
Do not know cost	5.1	na	4.3	4.7	10.0	5.3
Number of women	355	35	53	252	78	782

Note: Table excludes lactational amenorrhea method (LAM). Costs are based on the last time current users obtained method. Costs include consultation costs, if any. For condom, costs are per package; for pills, per cycle. For sterilisation, data are based on women who received the operation in the five years before the survey.

Note: Figures in parentheses are based on 25–49 unweighted cases.

As Table 5.9 shows, the vast majority of users (90%) in Solomon Islands do not pay for contraception. Approximately 5% of current users stated that they did not know the cost. In Solomon Islands, contraceptives are provided free of charge at all public sector facilities and at NGOs. UNFPA has provided contraceptives free of charge to the Solomon Islands Government for the past three decades. NGOs also receive contraceptives from UNFPA through MOH supplies or directly. The International Planned Parenthood Association also supplies contraceptives to

SIPPA. Female sterilisation is usually conducted at public hospitals at no costs to clients. Similarly, IUCD and injectables are provided at no cost to clients at all public facilities. Some IUCD and injectables are provided by doctors in private practice.

5.11 INFORMED CHOICE

Informed choice is an important tool for monitoring the quality of family planning services. Current users of modern methods who are well informed about the side effects and problems associated with methods, and know of a range of method options, are better placed to make an informed choice about the method they would like to use. All providers of sterilisation must inform potential users that the operation is a permanent, irreversible procedure; potential users also must be informed of alternate methods that could be used. Users of temporary methods also should be informed about choices they have and other available methods. Family planning providers also should inform all method users of potential side effects and what to do if they experience a problem. This information assists users in coping with side effects and decreases unnecessary discontinuation of temporary methods.

Table 5.10 presents information on informed choice by type and source of method. The data show that 66% of current users were informed about possible side effects or problems associated with use, about 61% of users were informed about what to do if they experienced side effects, and 59% were informed of other methods that could be used.

Table 5.10: Informed choice

Among current users of modern methods aged 15–49 who started the last episode of use within the five years preceding the survey, percentage who were informed about possible side effects or problems of that method, the percentage who were informed about what to do if they experienced side effects, and the percentage who were informed about other methods that could use, by method and initial source; and among sterilised women, the percentage who were informed that the method is permanent, by initial source, Solomon Islands 2007

Method/source	Among women who started last episode of modern contraceptive method within five years preceding the survey:				Among women who were sterilised:	
	Percentage who were informed about side effects or problems of method used	Percentage who were informed about what to do if experienced side effects	Percentage who were informed by a health or family planning worker of other methods that could be used	Number of women	Percentage who were informed that sterilisation is permanent ¹	Number of women
Method						
Female sterilisation	70.8	63.7	47.2	143	91.6	143
Pill	(50.1)	(46.9)	(61.1)	33	na	0
IUD	(85.4)	(75.4)	(76.9)	46	na	0
Injectables	60.7	57.6	62.9	223	na	0
Initial source of method²						
Public sector	64.6	58.6	59.1	375	95.1	129
Public govt hospital	65.7	56.0	53.6	160	95.1	129
Rural health centre	(49.6)	(47.3)	(58.0)	30	na	0
Rural health clinic	63.8	60.0	61.1	157	na	0
Church	(78.0)	(77.2)	(55.4)	47	*	7
Total	65.7	60.6	58.9	448	91.6	143

Note: Table excludes users who obtained their method from friends/relatives.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = not applicable

¹ Among women who were sterilised in the five years preceding the survey.

² Source at start of current episode of use.

It is encouraging to note that 92% of women who were sterilised were informed that the method is permanent. More than 95% of women who were sterilised at a public government hospital were informed that sterilisation is permanent, 65% were informed about side effects or problems of

method used, and 59% were informed about what to do if side effects were experienced or about other methods.

5.12 FUTURE USE OF CONTRACEPTION

An important indicator of the changing demand for family planning is the extent to which non-users of contraception plan to use family planning in the future. Currently, married women who were not using contraception at the time of the survey were asked about their intention to use family planning in the future. The results are shown in Table 5.11. Among currently married women who are not using contraception, 24% reported that they intend to use a family planning method in the future, 48% said that they do not intend to use a method in the future, and 25% were unsure of their future intention. There are minor differences in the percentage of women who intend to use family planning according to their number of living children. The proportion of women intending to use family planning peaks at 29% among non-users with one child, and declines to 21% among women with four or more children.

Table 5.11: Future use of contraception

Percent distribution of currently married women aged 15–49 who are not using a contraceptive method by intention to use one in the future, according to number of living children, Solomon Islands 2007

Intention	Number of living children ¹					Total
	0	1	2	3	4+	
Intend to use	27.1	28.5	25.7	26.9	20.6	24.4
Unsure	26.3	21.9	26.0	21.2	27.1	25.1
Does not intend to use	46.7	47.6	46.9	49.7	48.5	48.1
Missing	0.0	2.0	1.4	2.3	3.8	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	190	248	286	277	675	1,675

¹ Includes current pregnancy.

Intention to use contraception in the future provides a forecast of potential demand for services and acts as a convenient summary indicator of disposition toward contraception among current non-users. Respondents may or may not adhere to their intentions for future use.

5.13 REASONS FOR NON-USE OF CONTRACEPTION

An understanding of the reasons women give for not using family planning methods is critical to designing programmes that could improve the quality of services. Table 5.12 shows the percent distribution of currently married women who are not using a contraceptive method and who do not intend to use one in the future, by the main reasons for not intending to use.

Approximately 20% of women do not intend to use contraception in the future because of fertility-related reasons. A number of these women (15%) reported themselves to be subfecund or infecund. Fifteen percent of women do not intend to use because of opposition to use, with most respondents opposed to using any method. Just under 45% percent of women also cited method-related reasons; primarily fear of side effects (37%), as a major reason for non-use in the future. Over 9% of women reported a lack of knowledge as the reason for not intending to use contraception in the future; of which 7% cited lack of knowledge about methods.

Overall, these data suggest that there is substantial scope for family planning programmes to increase contraceptive use by providing advocacy and high-quality services. Improved information and educational activities will play an important role in dispelling fears and misconceptions about specific contraceptive methods and contraceptive use in general.

Table 5.12: Reason for not intending to use contraception in the future

Percent distribution of currently married women aged 15–49 who are not using contraception and who do not intending to use in the future by main reason for not intending to use, Solomon Islands 2007

Reason	Percent distribution
Fertility-related reasons	
Infrequent sex/no sex	1.8
Menopausal/had hysterectomy	1.0
Subfecund/ infecund	15.2
Wants as many children as possible	2.1
Opposition to use	
Respondent opposed	6.0
Husband/partner opposed	3.1
Others opposed	1.0
Religious prohibition	4.9
Lack of knowledge	
Knows no method	6.9
Knows no source	2.5
Method-related reasons	
Health concerns	5.7
Fear of side effects	37.2
Lack of access/too far	0.8
Cost too much	0.5
Inconvenient to use	0.3
Interfere with body's normal process	2.8
Other	2.2
Don't know	5.6
Missing	0.5
Total	100.0
Number of women	805

5.14 PREFERRED METHOD OF CONTRACEPTION FOR FUTURE USE

Future demand for specific family planning methods can be assessed by asking non-users who intend to use in the future which methods they prefer to use. Table 5.13 provides some indication of currently married women's preferences for the method they might use in the future. However, the information should be interpreted with caution since two conditions are implied here: intent to use and method preferred if intent is followed. Most currently married women would prefer to use injectables (39%) and periodic abstinence (13%) in the future. About 12% of women mentioned male condoms as a potential future method, and 8% mentioned female sterilisation.

Table 5.13: Preferred method of contraception for future use

Percent distribution of currently married women aged 15–49 who are not using a contraceptive method but who intend to use in the future by preferred method, Solomon Islands 2007

Preferred method	Percent distribution
Female sterilisation	8.2
Male sterilisation	0.3
Pill	6.9
IUCD	6.0
Injectables	38.6
Implants	0.3
Male condom	11.5
Female condom	1.0
Diaphragm	0.0
Lactation amenorrhea method (LAM)	0.1
Periodic abstinence	13.4
Withdrawal	2.1
Other	3.2
Unsure	8.1
Missing	0.1
Total	100.0
Number of women	409

5.15 EXPOSURE TO FAMILY PLANNING MESSAGES

Electronic media such as radio and television are important for communicating messages about family planning. Information on the level of exposure to such media is important for programme managers and planners to effectively target population subgroups for information, education and communication (IEC) campaigns. To assess the extent to which media serve as a source of family planning messages, respondents were asked if they had heard or seen a message about family planning on the radio, television or in the print media (e.g. newspaper, magazine, poster) in the months preceding the survey. The results are shown in Table 5.14.

In Solomon Islands, the most common media source is the radio. Television is mostly found in urban areas, while print media are accessed mostly by the educated. The majority of women (60%) and men (78%) aged 15–49 have heard a family planning message recently on the radio, whereas only 4% of women and men have heard family planning messages on television. Sixteen percent of women and 34% of men have read about family planning in the newspaper or a magazine. Approximately 38% of women and 19% of men have not been exposed to family planning messages in any of the specified media sources.

In general, respondents' exposure to media messages on family planning by various methods differ with age. Younger women and men aged 15–19 are least likely to have been exposed to family planning messages on the radio than other ages. On the other hand, older women aged 45–49 are less likely to get media messages through the newspaper or a magazine and television. Men aged 40–44 are more likely to get media messages through the newspaper or a magazine than men of other ages.

Table 5.14: Exposure to family planning messages

Percentage of women and men aged 15–49 who heard or saw a family planning message on the radio or television or in a newspaper in the past few months, according to background characteristics, Solomon Islands 2007

Background characteristic	Women					Men				
	Radio	Television	Newspaper/ magazine	None of these three media sources	Number of women	Radio	Television	Newspaper/ magazine	None of these three media sources	Number of men
Age										
15–19	50.3	3.2	16.8	47.7	687	69.9	3.3	23.6	26.2	292
20–24	63.1	3.7	20.7	33.7	716	70.1	3.6	28.0	27.5	304
25–29	62.9	3.5	14.9	35.6	729	83.2	4.7	38.0	12.3	266
30–34	57.5	3.9	14.5	39.8	600	84.0	4.7	35.5	13.8	266
35–39	60.5	2.4	15.5	38.6	482	79.7	3.5	40.0	17.2	239
40–44	61.7	5.1	16.0	37.0	336	83.2	3.8	43.8	14.1	134
45–49	67.4	2.1	8.6	31.9	273	81.4	4.0	35.9	18.6	113
Residence										
Urban	67.7	13.6	30.7	26.7	636	78.6	11.0	58.5	14.7	301
Rural	58.1	1.4	13.1	40.6	3,187	77.6	2.3	28.1	20.3	1,313
Region										
Honiara	63.5	14.6	28.8	31.0	481	78.2	10.5	57.4	15.2	240
Guadalcanal	72.8	3.9	16.5	26.6	637	80.1	9.2	36.2	18.3	249
Malaita	51.1	1.4	6.5	47.4	840	67.2	0.0	11.4	32.5	345
Western	74.1	1.0	37.9	23.4	458	72.6	1.9	56.1	20.5	181
Other provinces	53.0	1.5	10.0	45.6	1,407	84.4	2.0	29.3	13.2	599
Education										
No education	45.6	1.2	1.6	54.3	520	46.5	0.0	0.5	53.5	88
Primary	57.9	1.5	9.9	41.2	2,114	77.0	3.5	25.6	21.0	794
Secondary	69.4	7.7	31.0	26.6	1,067	81.3	4.5	47.1	14.1	593
More than secondary	68.6	11.0	52.2	22.6	122	87.2	6.8	44.2	9.3	138
Wealth quintile										
Lowest	44.4	0.5	7.8	54.8	696	67.8	2.8	13.2	31.5	281
Second	53.8	0.3	9.8	45.4	755	82.7	0.3	24.1	16.6	291
Middle	65.4	1.6	12.5	33.2	738	74.8	0.7	30.8	21.6	323
Fourth	62.3	2.4	13.7	35.9	769	83.6	4.8	34.5	14.0	353
Highest	70.2	11.1	33.1	25.4	864	78.7	9.8	59.1	14.8	366
Total 15–49	59.7	3.5	16.0	38.3	3,823	77.8	3.9	33.7	19.2	1,614
50+	na	na	na	na	0	66.5	4.1	26.4	31.8	442
Total men 15+	na	na	na	na	0	75.4	4.0	32.1	21.9	2,056

na = not applicable

Not surprisingly, women and men residing in urban areas are much more likely to have been exposed to family planning messages in any media than those in rural areas. This is especially true for messages on television and in the print media.

Female residents of Western and Guadalcanal provinces are more likely to have heard family planning messages on the radio than residents in Honiara, Malaita and other provinces. Men from Guadalcanal and other provinces are more likely to have heard family planning messages on the radio than men from Malaita and Western provinces. Residents of Honiara are more likely to report having heard family planning messages on the television than those of other provinces.

Education influences media exposure positively. For example, only 46% of uneducated women had exposure to family planning information on the radio compared with just 69% of women with a secondary and higher education. A similar pattern is observed for men. Not surprisingly, 52% of women and 44% of men in the highest education group reported receiving family planning information through the newspaper or a magazine compared with 2% of women and 1% of men in the uneducated group.

Similarly, exposure to family planning messages varies by wealth quintile. In general, the percent of women and men getting family planning messages through the media is highest among respondents in the wealthiest quintile.

5.16 CONTACT OF NON-USERS WITH FAMILY PLANNING PROVIDERS

When family planning providers visit women in the field or when women visit health facilities, family planning fieldworkers and health providers are expected to discuss family planning issues, to discuss contraception options available, and to motivate non-users to adopt a method of family planning. To get insight into the level of contact between non-users and health workers, women were asked if a family planning fieldworker had visited them during the 12 months preceding the survey and discussed family planning. In addition, women were asked if they had visited a health facility in the 12 months preceding the survey for any reason and whether anyone at the facility had discussed family planning with them during the visit.

Table 5.15 shows that fieldworkers discussed family planning with only 9% of non-users during the 12 months preceding the survey. At the same time, only 17% of non-users discussed family planning at a health facility. One of the reasons for the low exposure to family planning from field workers could be the lack of emphasis on home visits by family planning fieldworkers. This low level of contact of non-users with family planning providers varies by background characteristics. Higher percentages of older women, women residing in rural areas, women from Guadalcanal and other provinces, women with only a secondary education and women in the middle and lowest wealth quintiles were visited by a field worker who discussed family planning. The highest percentages of women who neither discussed family planning with fieldworkers nor at a health facility were noted among the youngest age group, women residing in urban areas or Honiara, women with no education and those in the highest wealth quintile.

Overall, 79% of women who could have been exposed to family planning information did not discuss family planning during a field visit or at a health facility, indicating numerous missed opportunities to inform and educate women about family planning. This situation is surprisingly more pronounced in urban (88%) areas than in rural areas (77%).

Table 5.15: Contact of nonusers with family planning providers

Among women aged 15–49 who are not using contraception, the percentage who during the last 12 months were visited by a fieldworker who discussed family planning, the percentage who visited a health facility and discussed family planning, the percentage who visited a health facility but did not discuss family planning, and the percentage who neither discussed family planning with a fieldworker nor at a health facility, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of women who were visited by fieldworker who discussed family planning	Percentage of women who visited a health facility in the past 12 months and who:		Percentage of women who neither discussed family planning with fieldworker nor at a health facility	Number of women
		Discussed family planning	Did not discuss family planning		
Age					
15–19	5.6	5.4	24.0	90.6	637
20–24	8.3	16.8	26.9	79.4	574
25–29	13.5	18.2	27.4	73.6	570
30–34	8.5	26.5	20.8	71.7	399
35–39	9.2	19.4	25.6	77.8	280
40–44	13.2	25.2	23.1	69.6	206
45–49	10.2	11.5	25.7	83.7	154
Residence					
Urban	3.9	9.8	15.4	88.1	509
Rural	10.5	17.9	27.1	77.0	2,311
Region					
Honiara	4.1	7.0	16.1	91.0	406
Guadalcanal	11.2	21.3	33.6	74.3	488
Malaita	5.4	12.1	22.3	85.4	655
Western	8.9	12.7	7.2	84.0	303
Other provinces	13.3	22.2	31.8	70.5	968
Education					
No education	7.7	11.1	20.8	84.3	394
Primary	9.0	18.0	26.9	77.8	1,481
Secondary	10.5	15.1	24.6	80.1	862
More than secondary	9.8	27.2	14.6	66.1	83
Wealth quintile					
Lowest	14.1	23.3	25.5	71.0	505
Second	7.0	23.2	28.3	73.0	556
Middle	11.9	11.2	29.1	82.6	543
Fourth	9.2	15.0	24.4	80.6	546
Highest	5.6	11.2	19.1	85.8	669
Total	9.3	16.5	25.0	79.0	2,820

5.17 HUSBAND'S KNOWLEDGE OF WIFE'S USE OF CONTRACEPTION

Use of family planning methods is facilitated when couples discuss and agree on the issue. To assess the extent to which women use contraception without telling their partners, the 2006/2007 SIDHS asked married women whether their husbands or partners knew that they were using a family planning method.

Table 5.16 shows that the vast majority of women (92%) say their husbands know that they are using contraception. Differences by background characteristics are not large.

Table 5.16: Husband/partner's knowledge of women's use of contraception

Among currently married women aged 15–49 who are using a method, percent distribution by whether they report that their husbands or partners know about their use, according to background characteristics, Solomon Islands 2007

Background characteristic	Knows ¹	Does not know	Unsure whether knows/missing	Total	Number of women
Age					
15–19	*	*	*	100.0	17
20–24	93.1	3.6	3.3	100.0	96
25–29	90.6	2.6	6.9	100.0	152
30–34	85.6	6.0	8.4	100.0	197
35–39	93.8	2.7	3.4	100.0	192
40–44	96.7	2.0	1.3	100.0	125
45–49	96.9	0.4	2.7	100.0	106
Residence					
Urban	89.7	3.1	7.2	100.0	109
Rural	92.6	3.1	4.3	100.0	775
Region					
Honiara	89.6	3.0	7.5	100.0	65
Guadalcanal	89.6	3.1	7.3	100.0	131
Malaita	88.4	4.9	6.6	100.0	180
Western	88.3	6.5	5.1	100.0	122
Other provinces	96.6	1.2	2.2	100.0	386
Education					
No education	93.9	2.6	3.5	100.0	114
Primary	91.9	3.7	4.4	100.0	582
Secondary	92.7	2.1	5.3	100.0	156
More than secondary	(91.0)	(0.0)	(9.0)	100.0	33
Wealth quintile					
Lowest	92.0	2.0	6.0	100.0	169
Second	92.8	4.5	2.7	100.0	161
Middle	94.9	2.8	2.3	100.0	179
Fourth	90.0	2.8	7.2	100.0	204
Highest	91.8	3.6	4.5	100.0	171
Total	92.2	3.1	4.6	100.0	885

¹ Includes women who report use of male sterilisation, male condoms or withdrawal.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

5.18 KEY RESULTS

Family planning is one factor that directly impacts on the fertility level and health of both mother and child. In Solomon Islands, family planning has been recognised as one of the national priorities as announced in the Solomon Islands National Health Strategic Plan 2006–2010. The main objective of the strategic plan is to promote free access to family planning services and to increase the use of family planning methods in the country. One of the important indicators presented here is the percentage of current married women, aged 15–49 who are currently using any methods of contraception — also known as the contraceptive prevalence rate. This indicator is the most widely used measure of the success and effectiveness of family planning programmes in the country. This section also summarises other key findings on family planning issues that are important to consider in future planning of family planning services.

The results from the 2006/2007 SIDHS show that the contraceptive prevalence rate of 35% — that is, about two in every five currently married women — reported using any family planning method at the time of the survey. This result shows an increasing level of family planning usage compared with only 10% in the 2006 Islands Ministry of Health and Medical Services Health Information System. This trend indicates that family planning services have been somehow improved, although considerably more effort is required to make family planning services universal to all users.

Below are other findings that may explain why the contraceptive prevalence rate is not as expected, and can be considered in future family planning strategies to help improve the use of family planning methods in Solomon Islands.

1. About 70% of currently married women not currently using any method of contraception.
2. Women with little education are more likely to not use any contraceptive method.
3. A lower proportion of currently married women in urban areas use any family planning method than those in the rural areas.
4. Approximately one in every two non-users (women) reported not knowing any specific time for the fertile period or knew about the fertile period.
5. The source of modern contraceptive methods is concentrated in public government hospital only, providing little access for rural women.
6. Among current users of modern methods, not all of them are informed about possible side effects and problems associated with use of any method.
7. The results show that 50% of currently married women are not intending to use any family planning methods in the future. About 40% of these women reported a fear of side effects as the reason for not intending to use contraception in the future.
8. There is also an indication of women having no knowledge of any family planning methods and the source of obtaining such methods.
9. Among modern contraception methods, injectables, male condoms and female sterilisation are the most preferred methods to be used in the future.

Policy implications for health services and especially family planning programmes are:

1. Increase contraceptive use by providing advocacy and high-quality services of family planning methods.
2. Improve information and education activities that will play an important role in dispelling fears and misconceptions about specific contraceptive methods and contraceptive use in general.
3. Expand free and easy access to family planning methods so that individuals can obtain them when required.
4. Maintain the supply of methods at all levels in order to meet current and future use of methods.
5. Provide training and counselling at the community and individual level on the importance and advantage of family planning.

CHAPTER 6 OTHER PROXIMATE DETERMINANTS OF FERTILITY

This chapter discusses factors other than contraception that affect a woman's risk of becoming pregnant. These proximate (or direct) determinants of fertility include marriage, sexual intercourse, breastfeeding, postpartum abstinence from sexual relations and menopause. Marriage and sexual behaviour mark a woman's exposure to the risk of childbearing, postpartum amenorrhea and postpartum abstinence affect the length of birth intervals, and menopause marks the end of a woman's reproductive period. These factors are important to examine because they help determine the length and pace of a woman's reproductive behaviour, and provide clear understanding of fertility level and trend.

6.1 MARITAL STATUS

The 2006/2007 SIDHS asked respondents about their marital status, whether they were currently married, living with a partner as if married, widowed, divorced, separated or never married. Married in this context refers to those couples who are formally married, while living together refers to informal marriages. Table 6.1 shows the percent distribution of women and men aged 15–49 by current marital status, according to age at the time of the survey. The proportion of those respondents who are currently in a union refers to those who are married and living together.

Marriage is more common among women than men in Solomon Islands. The proportion of women currently in a union is 67.0% compared with 58.2% of men. Among women who are currently in a union, the majority (62%) are legally married. For men currently in a union, only 46.1% consider themselves to be in a formal marriage. Data show that 9.7% of young women aged 15–19 are formally married.

The proportion of women and men who are never married declines as age increases. However, there are more men than women reported to be remain single. For example, 97% of never married men are in the 15–19 age group compared with 88% of women in the same age group. However, the proportion of men who are single drops sharply to 1.3% when they are in their late 40s compared with 9.0% of women.

Another interesting finding is that the proportion of widowed men aged 15–49 is much lower (0.3%) than for widowed women (1.1%). The discrepancy between the proportion of widowed men and widowed women at ages 35 and older increases. Between ages 35 and 44, less than 1% of males are widowed, compared with 2–3% of females. At ages 45–49, only 3.7% of men are widowed, compared with 5.7% of women.

The higher proportion of widowed women is explained by lower female mortality rates (and therefore longer life expectancies of female spouses), and men marrying at older ages than women.

Table 6.1: Current marital status

Percent distribution of women and men aged 15–49 by current marital status, according to age, Solomon Islands 2007

Age	Marital status						Total	Percentage of respondents currently in union	Number of respondents
	Never married	Married	Living together	Divorced	Separated	Widowed			
WOMEN									
15–19	87.5	9.7	2.8	0.0	0.0	0.0	100.0	12.5	687
20–24	45.6	45.6	7.8	0.2	0.7	0.0	100.0	53.5	716
25–29	14.2	74.7	6.0	1.7	3.0	0.4	100.0	80.7	729
30–34	8.0	85.4	3.4	0.6	2.3	0.2	100.0	88.8	600
35–39	2.8	85.3	4.5	1.2	3.0	3.2	100.0	89.8	482
40–44	2.4	87.4	5.4	1.3	1.3	2.2	100.0	92.8	336
45–49	8.8	78.3	4.3	1.3	1.5	5.7	100.0	82.6	273
Total	29.4	62.0	5.0	0.8	1.7	1.1	100.0	67.0	3,823
MEN									
15–19	99.6	0.0	0.4	0.0	0.0	0.0	100.0	0.4	292
20–24	74.7	17.0	7.8	0.0	0.5	0.0	100.0	24.8	304
25–29	35.3	50.3	13.9	0.0	0.5	0.0	100.0	64.2	266
30–34	13.5	65.9	19.1	0.6	0.8	0.1	100.0	85.0	266
35–39	2.8	81.8	14.6	0.6	0.2	0.1	100.0	96.4	239
40–44	3.1	77.7	18.7	0.0	0.2	0.2	100.0	96.4	134
45–49	1.3	74.2	20.2	0.3	0.3	3.7	100.0	94.4	113
Total 15–49	40.9	46.1	12.1	0.2	0.4	0.3	100.0	58.2	1,614
50+	2.9	68.9	15.8	0.1	2.1	10.1	100.0	84.8	442
Total men 15+	32.7	51.0	12.9	0.2	0.7	2.4	100.0	63.9	2,056

6.2 POLYGAMY

Polygamy is defined as any form of marriage in which a person has more than one spouse. Polygamy is not part of Solomon Islands custom, although some marriages are arranged in this way. The 2006/2007 SIDHS asked women who were currently married about whether their husband had any other wives besides them. If the husband had more than one wife, then women asked to rank themselves in that marriage (i.e. whether they are the first wife, second wife, etc.). Men were asked whether they had more than one wife or woman that they lived with.

Table 6.2.1 shows the percent distribution of currently married women aged 15–49 by number of co-wives, according to their background characteristics at the time of the survey.

Although the results indicate that polygamy is not very common in Solomon Islands, 4.2% of currently married women report that their husband has one more wife beside them. According to background characteristics, young, currently married women aged 15–19 and the older women aged 44–49 report that their husband has at least one more wife (11.3% and 5.6%, respectively). Women in Honiara and in the provinces, and those with a secondary education and living in the highest wealth quintile are more likely to be affected.

Table 6.2.1: Number of co-wives

Percent distribution of currently married women aged 15–49 by number of co-wives, according to background characteristics, Solomon Islands 2007

	Number of co-wives					Number of women
Background characteristic	0	1	2+	Missing	Total	
Age						
15–19	86.1	7.8	3.5	2.6	100.0	86
20–24	91.1	3.5	0.5	4.9	100.0	383
25–29	93.6	5.1	0.4	1.0	100.0	588
30–34	93.9	3.4	0.3	2.5	100.0	533
35–39	92.6	3.7	0.6	3.0	100.0	433
40–44	94.8	4.3	0.1	0.8	100.0	311
45–49	91.2	4.2	1.4	3.2	100.0	226
Residence						
Urban	91.0	6.5	0.9	1.5	100.0	372
Rural	93.1	3.8	0.5	2.6	100.0	2,187
Region						
Honiara	91.5	5.5	1.3	1.7	100.0	278
Guadalcanal	92.1	4.5	0.6	2.7	100.0	445
Malaita	92.4	4.5	0.2	2.9	100.0	612
Western	93.7	3.1	1.2	2.0	100.0	303
Other provinces	93.5	3.7	0.4	2.4	100.0	922
Education						
No education	92.1	4.4	0.7	2.9	100.0	385
Primary	93.9	2.8	0.5	2.8	100.0	1,610
Secondary	89.0	8.8	1.0	1.2	100.0	493
More than secondary	96.8	1.3	0.0	1.9	100.0	72
Wealth quintile						
Lowest	95.4	3.2	0.4	1.0	100.0	499
Second	93.5	4.0	0.4	2.2	100.0	500
Middle	91.7	3.8	0.0	4.5	100.0	490
Fourth	92.7	3.8	0.6	2.9	100.0	546
Highest	90.8	5.9	1.5	1.8	100.0	524
Total	92.8	4.2	0.6	2.5	100.0	2,560

Table 6.2.2 presents the percent distribution of currently married men aged 15–49 by number of wives, according to background characteristics. Overall, more than 2% of currently married men aged 15–49 claim that they have more than two wives. Of the proportion of currently married men with more than two wives, most reside in urban areas.

The results reveal some inconsistency in the data. For example, 4.8% of women report that their husbands have at least one more co-wife, while only 2.0% of men reported to have 2 or more wives. This could be due to the sample size of men in the survey.

Table 6.2.2: Number of men's wives

Percent distribution of currently married men aged 15–49 by number of wives, according to background characteristics, Solomon Islands 2007

Background characteristic	Number of wives		Total	Number of men
	1	2+		
Age				
15–19	*	*	100.0	1
20–24	98.5	1.5	100.0	75
25–29	99.4	0.6	100.0	171
30–34	99.0	1.0	100.0	226
35–39	95.6	4.4	100.0	230
40–44	98.5	1.5	100.0	129
45–49	97.2	2.8	100.0	107
Residence				
Urban	99.0	1.0	100.0	162
Rural	97.7	2.3	100.0	778
Region				
Honiara	98.7	1.3	100.0	124
Guadalcanal	96.8	3.2	100.0	180
Malaita	98.9	1.1	100.0	222
Western	100.0	0.0	100.0	94
Other provinces	97.0	3.0	100.0	320
Education				
No education	98.4	1.6	100.0	60
Primary	97.2	2.8	100.0	510
Secondary	98.8	1.2	100.0	268
More than secondary	98.9	1.1	100.0	102
Wealth quintile				
Lowest	98.4	1.6	100.0	185
Second	99.2	0.8	100.0	178
Middle	98.4	1.6	100.0	172
Fourth	95.7	4.3	100.0	209
Highest	98.3	1.7	100.0	196
Total 15–49	97.9	2.1	100.0	939
50+	98.3	1.7	100.0	375
Total men 15+	98.0	2.0	100.0	1,314

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

6.3 AGE AT FIRST MARRIAGE

Marriage marks a woman's exposure to childbearing especially in societies where childbearing is practiced within marriage. A woman's age at first marriage is crucial to examine because of its effect on fertility levels and patterns. When age at first marriage is observed to be early, then the probability of having many children is higher because women have a longer reproductive period before reaching menopause.

Table 6.3: Age at first marriage

Percentage of women and men aged 15–49 who were first married by specific exact ages and median age at first marriage, according to current age, Solomon Islands 2007

	Percentage first married by exact age:					Percentage never married	Number	Median age at first marriage
Current age	15	18	20	22	25			
WOMEN								
Age								
15–19	2.6	na	na	na	na	87.5	687	a
20–24	3.1	22.4	36.3	na	na	45.6	716	a
25–29	6.4	24.7	43.4	61.1	80.7	14.2	729	20.6
30–34	8.8	30.9	49.9	66.0	82.4	8.0	600	20.0
35–39	10.6	32.6	58.0	74.1	84.5	2.8	482	19.1
40–44	8.0	32.2	52.9	70.8	84.7	2.4	336	19.7
45–49	9.1	34.6	56.5	68.8	81.9	8.8	273	19.6
20–49	7.2	28.3	47.4	na	na	16.7	3,136	20.3
25–49	8.4	30.0	50.7	67.1	82.6	8.2	2,419	19.9
MEN								
Age								
15–19	0.0	na	na	na	na	99.6	292	a
20–24	0.0	3.9	9.6	na	na	74.7	304	a
25–29	0.0	6.2	9.5	23.3	48.5	35.3	266	a
30–34	0.0	7.8	15.2	30.4	47.5	13.5	266	25.3
35–39	0.0	12.3	20.6	31.6	58.6	2.8	239	24.0
40–44	0.0	8.1	22.8	38.3	57.2	3.1	134	23.8
45–49	0.0	3.5	16.1	28.4	59.3	1.3	113	23.8
20–49	0.0	7.1	14.6	27.4	46.6	27.9	1,322	25.6
25–49	0.0	8.0	16.1	29.7	52.9	14.0	1,018	24.5
20+	0.0	6.0	13.0	na	na	21.7	1,764	a
25+	0.0	6.5	13.8	26.7	49.3	10.6	1,460	a

Note: The age at first marriage is defined as the age at which the respondent began living with her/his first spouse/partner

na = not applicable due to censoring

a = omitted because less than 50% of women (and/or men) married for the first time before reaching the beginning of the age group.

Table 6.3 indicates the percentage of women and men aged 15–49 who were first married by specific exact ages and median age at first marriage, according to their current age during the time of the survey. The data show that women in the 20–49 age group marry earlier — at the exact age of 15 — than men. About 8% of these women report that they entered marriage at the exact age of 15. Less than 50% of women (47.4%) in the 20–49 age group are married by age 20 compared with 14.6% of men in the same age group. The median age of first marriage is higher for men (25.6) than for women (20.3) in the 20–29 age group.

6.4 MEDIAN AGE AT FIRST MARRIAGE

Table 6.4.1 presents the median age at first marriage among women 20–49 and 25–49, according to their background characteristics. The data show that the median age at first marriage among women aged 25–29 is 20.6, and among women aged 30–34 it is 20.0, and among women aged 45–49 it is 19.6. The results indicate an increase in the median age at first marriage in Solomon Islands.

Table 6.4.1: Median age at first marriage — Women

Median age at first marriage among women by five-year age groups, aged 20–49 and 25–49, according to background characteristics, Solomon Islands 2007

Background characteristic	Age						Women age	Women age
	20–24	25–29	30–34	35–39	40–44	45–49	20–49	25–49
Residence								
Urban	a	22.6	21.3	20.3	19.9	22.2	a	21.3
Rural	a	20.4	19.8	19.0	19.7	19.5	a	19.8
Region								
Honiara	a	22.0	21.3	20.6	19.6	21.1	a	21.0
Guadalcanal	a	20.6	19.4	19.3	21.0	(21.6)	a	20.3
Malaita	19.6	21.1	19.9	18.9	18.7	(19.8)	19.9	19.9
Western	a	22.0	20.2	20.4	21.3	(19.9)	a	20.9
Other provinces	a	19.9	19.8	18.7	18.9	19.1	19.9	19.3
Education								
No education	(19.7)	20.1	20.1	18.3	19.2	20.3	19.2	19.2
Primary	19.8	19.6	19.8	19.4	19.5	19.4	19.6	19.6
Secondary	a	22.4	19.5	19.8	(21.2)	*	a	20.9
More than secondary	a	(24.6)	(24.0)	*	*	*	a	23.7
Wealth quintile								
Lowest	19.7	20.3	20.0	19.5	20.8	(19.9)	20.0	20.1
Second	0.9	20.7	19.6	19.6	(18.3)	(20.2)	a	19.9
Middle	a	19.9	19.3	18.4	(19.4)	(18.8)	19.6	19.1
Fourth	a	20.4	20.2	19.0	20.2	(18.7)	a	20.0
Highest	4.9	21.6	21.0	19.4	19.4	21.1	a	20.6
Total	a	20.6	20.0	19.1	19.7	19.6	a	19.9

Note: The age at first marriage is defined as the age at which the respondent began living with her/his first spouse/partner

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

a = omitted because less than 50% of women married for the first time before reaching the beginning of the age group.

When looking at the median age at first marriage across women's socio-economic background characteristics, the age at marriage of married women in urban areas is higher than for women in rural areas. This applies to all women in all age groups, implying that urban women enter marriage later than the rural women. Median age increases with education level while wealth quintile does not show any consistency.

Table 6.4.2 present the median age at first marriage for men in different age groups. The results show that the median age at first marriage is higher in urban areas for men in the 25–39 age group, although a different pattern is seen for men in the 40–44 age group and those aged 50 and over.

Table 6.4.2: Median age at first marriage — Men

Median age at first marriage among men by five-year age groups, age 20–54 and age 25–59, according to background characteristics, Solomon Islands 2007

Background characteristic	Age							Men age
	20–24	25–29	30–34	35–39	40–44	45–49	50+	25+
Residence								
Urban	a	a	25.5	25.1	22.6	(24.5)	25.4	a
Rural	a	24.5	25.2	23.8	24.0	23.7	26.5	a
Region								
Honiara	a	a	25.5	25.3	(23.1)	(24.7)	25.8	a
Guadalcanal	a	(22.7)	25.2	(24.0)	(23.1)	(27.4)	26.6	24.7
Malaita	a	23.6	(24.5)	(23.7)	*	*	26.4	24.0
Western	a	a	(27.5)	*	*	*	(25.9)	a
Other provinces	a	a	24.8	(23.8)	(26.0)	(22.7)	26.6	a
Education								
No education	a	*	*	*	*	*	26.9	a
Primary	a	23.2	25.0	22.8	23.7	23.5	25.8	24.3
Secondary	a	a	25.6	25.3	(24.9)	(25.3)	(27.3)	a
More than secondary	a	a	(25.6)	(24.6)	*	*	(25.9)	a
Wealth quintile								
Lowest	(10.3)	(22.1)	(25.0)	(24.7)	*	*	25.7	23.9
Second	(10.4)	a	(25.3)	(22.4)	*	*	28.2	24.5
Middle	(5.0)	(4.4)	(25.3)	(25.5)	(24.0)	*	29.1	a
Fourth	8.5	a	25.2	(22.6)	(24.0)	*	25.6	a
Highest	12.1	a	25.6	25.1	24.0	(25.8)	26.3	a
Total	a	a	25.3	24.0	23.8	23.8	26.4	a

Note: The age at first marriage is defined as the age at which the respondent began living with her/his first spouse/partner

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

a = omitted because less than 50% of men married for the first time before reaching the beginning of the age group.

6.5 AGE AT FIRST SEXUAL INTERCOURSE

Marriage marks the beginning of sexual activity among married couples, sexual relations and behaviours are most common outside marriage in most societies as well as in Solomon Islands. The 2006/2007 SIDHS collected information about the age at first sexual intercourse, regardless of respondents' marital status. Table 6.5 shows the percentage of women and men aged 15–49 who had first sexual intercourse by specific exact ages, percentage who never had intercourse, and median age at first intercourse, according to their current age at the time of the survey.

The median age at first sexual intercourse is estimated at 18.2 years, lower than that the estimated median age at first marriage of 20.3 years, a difference of 2.1 years. Women are more likely than men to have had their first sexual intercourse at an early age (11.6% women and 6.4% men by exact age 15). About one in every two women have their first sexual intercourse by the age of 18, while 67% report that their first sexual intercourse occurred when they were at the exact age of 20.

By comparing the estimated mean age at first sexual intercourse with the mean age at first marriage (Table 6.3) it is noted that the age of women and men at first sexual intercourse is younger than that at marriage. However, in the context of marriage as a process, rather than a single event, the notion of 'premarital sexuality' is problematic. The median age of first sexual intercourse indicates that sexuality tends to precede formal marriage. This may be because the process of moving from the initial coupling through community recognition, and on to formal and/or religious recognition implies that there is no single 'age' of marriage, but rather a band of ages encompassing the whole process.

Table 6.5: Age at first sexual intercourse

Percentage of women and men aged 15–49 who had their first sexual intercourse by specific exact ages, the percentage who never had intercourse, and the median age at first intercourse, according to current age, Solomon Islands 2007

Percentage who had first sexual intercourse by exact age:						Percentage who never had intercourse	Number	Median age at first intercourse
Current age	15	18	20	22	25			
WOMEN								
15–19	14.9	na	na	na	na	46.9	687	a
20–24	9.9	49.0	69.3	na	na	13.3	716	18.1
25–29	11.3	43.9	64.8	75.6	86.0	4.3	729	18.5
30–34	12.6	47.1	65.7	78.2	84.1	2.8	600	18.2
35–39	12.7	52.2	72.1	82.5	86.7	0.1	482	17.8
40–44	11.5	49.5	66.3	77.8	83.6	0.4	336	18.0
45–49	12.3	44.1	58.0	70.9	78.6	1.2	273	19.0
20–49	11.6	47.6	66.7	77.9	84.0	4.7	3,136	18.2
25–49	12.1	47.1	65.9	na	na	2.2	2,419	18.2
15–24	12.3	na	na	na	na	29.8	1,404	18.3
MEN								
15–19	16.0	na	na	na	na	46.8	292	a
20–24	8.1	53.3	82.5	na	na	6.5	304	17.8
25–29	4.8	46.6	72.5	87.0	96.2	1.8	266	18.2
30–34	4.6	48.4	74.9	91.4	93.6	0.1	266	18.1
35–39	5.9	33.1	70.2	83.2	87.3	1.2	239	18.6
40–44	7.2	34.0	67.0	83.5	95.7	0.1	134	18.8
45–49	10.4	34.1	59.3	78.1	89.4	0.5	113	19.2
20–49	6.4	43.7	73.2	87.2	92.6	2.2	1,322	18.3
25–49	5.9	40.9	70.4	na	na	0.9	1,018	18.5
15–24	12.0	na	na	na	na	26.3	596	17.9
20+	6.0	37.2	64.1	na	na	1.8	1,764	18.7
25+	5.6	33.9	60.3	77.5	87.8	0.8	1,460	19.0

na = not applicable due to censoring

a = omitted because less than 50% of respondents had intercourse for the first time before reaching the beginning of the age group.

6.6 MEDIAN AGE AT FIRST SEXUAL INTERCOURSE

Table 6.6.1 presents the median age at first sexual intercourse among women by five-year age groups, 20–49 and 25–49, according to their background characteristics. Overall, the data show that there was not much difference in the median age at first sexual intercourse between age groups. However differences are obvious when looking at background characteristics. For example, the median age at first intercourse is earlier for women in rural areas than for women in urban areas. The median age at first intercourse is increasing with education level and wealth quintile for women aged 25–49.

Table 6.6.2 shows the median age at first intercourse is 19 years for men aged 25 and older. Overall, the median age at first intercourse is almost the same across all six given age groups. However, there are differences in the median age at first intercourse by men's background characteristics. For example, men aged 25 and over, residing in rural area have a slightly higher median age at first intercourse than men in urban areas. Men with no education are more likely to have a higher median age at first intercourse than men with a higher education level. The median age at first intercourse decreases with an increase in men's wealth quintile.

Table 6.6.1: Median age at first intercourse — Women

Median age at first sexual intercourse among women by five-year age groups, 20–49 and 25–49, according to background characteristics, Solomon Islands 2007

Background characteristic	Age						Women age	Women age
	20–24	25–29	30–34	35–39	40–44	45–49	20–49	25–49
Residence								
Urban	19.0	19.6	19.9	19.7	19.3	19.8	19.5	19.6
Rural	17.8	18.3	18.0	17.4	17.9	18.8	17.9	18.0
Region								
Honiara	19.6	19.2	20.2	19.5	19.1	18.9	19.5	19.5
Guadalcanal	17.4	17.5	18.1	18.0	18.1	(20.6)	18.0	18.1
Malaita	18.4	20.0	18.9	18.5	18.6	(18.9)	18.9	19.0
Western	16.9	18.8	18.5	18.0	18.3	(17.5)	18.0	18.2
Other provinces	17.8	18.1	17.5	16.6	17.6	19.0	17.5	17.5
Education								
No education	(19.6)	18.4	18.2	17.6	19.1	18.3	18.2	18.0
Primary	16.9	17.6	18.2	17.5	18.0	19.1	17.8	18.0
Secondary	18.6	19.7	17.8	18.5	(17.5)	*	18.7	18.8
More than secondary	(19.3)	(22.0)	(20.5)	*	*	*	a	20.9
Wealth quintile								
Lowest	17.1	17.6	17.2	17.6	18.8	(19.3)	17.7	17.8
Second	18.0	18.3	18.8	16.8	(17.8)	(18.2)	17.9	17.9
Middle	18.4	19.2	18.0	17.3	(17.0)	(19.0)	18.2	18.1
Fourth	17.6	18.1	18.4	18.1	18.0	(18.9)	18.0	18.1
Highest	18.8	19.9	19.4	18.7	18.8	19.0	19.1	19.2
Total	18.1	18.5	18.2	17.8	18.0	19.0	18.2	18.2

a = omitted because less than 50% of women had intercourse for the first time before reaching the beginning of the age group

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Table 6.6.2: Median age at first intercourse — Men

Median age at first sexual intercourse among men by five-year age groups, 20+ and 25+, according to background characteristics, Solomon Islands 2007

Background characteristic	Age							Men age	Men age
	20–24	25–29	30–34	35–39	40–44	45–49	50+	20+	25+
Residence									
Urban	17.7	18.1	18.6	18.7	19.0	(20.2)	20.5	18.7	18.9
Rural	17.8	18.2	17.9	18.6	18.7	19.0	20.9	18.8	19.0
Region									
Honiara	17.5	18.0	18.2	18.8	(19.0)	(20.4)	20.4	18.5	18.8
Guadalcanal	(16.5)	(16.8)	17.5	(18.4)	(17.2)	(18.8)	19.4	18.2	18.3
Malaita	(18.5)	18.2	(19.1)	(20.1)	*	*	23.4	a	20.3
Western	(17.5)	*	(18.6)	*	*	*	(20.5)	18.5	18.7
Other provinces	17.4	(19.1)	16.8	(18.6)	(19.4)	(18.3)	20.7	18.8	19.2
Education									
No education	a	*	*	*	*	*	22.5	a	21.6
Primary	18.1	18.1	18.0	18.5	18.6	18.7	20.2	18.6	18.8
Secondary	17.4	18.0	18.2	18.3	(18.7)	(19.4)	(23.1)	18.1	18.4
More than secondary	*	(19.5)	(18.5)	(20.2)	*	*	(21.6)	19.6	19.8
Wealth quintile									
Lowest	(18.0)	(17.1)	(16.9)	(19.0)	*	*	21.2	18.8	19.2
Second	(18.2)	(18.8)	(18.4)	(18.2)	*	*	21.1	19.0	19.2
Middle	(17.8)	(18.5)	(17.6)	(18.8)	(19.3)	*	21.3	18.8	18.9
Fourth	17.4	18.5	18.2	(18.6)	(19.2)	*	20.6	18.6	18.9
Highest	17.4	18.2	18.2	18.7	18.6	(19.9)	20.1	18.6	18.8
Total	17.8	18.2	18.1	18.6	18.8	19.2	20.8	18.7	19.0

a = omitted because less than 50% of men had intercourse for the first time before reaching the beginning of the age group.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

6.7 RECENT SEXUAL ACTIVITY: WOMEN

The 2006/2007 SIDHS collected information on past and recent sexual behaviours for all women and men aged 15–49 by asking them questions about the timing of their last sexual intercourse. This information is useful for determining women’s exposure to becoming pregnant, especially in societies where contraceptive use is low, and for designing programmes that deal with sexually transmitted infections and HIV and AIDS.

Respondents are considered sexually active if they report having sexual intercourse once during the four weeks preceding the survey.

Table 6.7.1 show the percent distribution of women aged 15–49 by the timing of their last sexual intercourse, according to their background characteristics. The result shows that one in every two women aged 15–49 (51.4%) had sexual intercourse within the four weeks preceding the survey. As observed, women in the 25–49 age group have a higher level of recent sexual activity than younger women. Recent sexual activity increases from age 15 to late 30s (20–69%) and then declines as women reach their 40s. About 5% women in the 25–29 age group report that they never have sex intercourse.

The majority of women who are married and in a living together relationship (70.4%) are sexually active. More than 70% of women who have been married for between 10 and 19 years had sexual intercourse within the four weeks preceding the survey. Women who are married more than once are more likely to have had sexual intercourse in the four weeks preceding the survey.

Women in rural areas are more likely to be sexually active (52.1%) than women in urban areas (47.9%). The findings indicate that recent sexual activity declines with an increasing level of women’s education. For example, 46% of women with a secondary and higher educational background are sexually active compared with more than 54% of women with a lower educational background.

Table 6.7.2 presents information on recent sexual activity among all men aged 15–49 according to their background characteristics. Overall, more than 52% of men are sexually active (i.e. have had sexual intercourse within the four weeks preceding the survey). The proportion of men who are sexually active increases with age, from 19% for men in the 15–19 age group to a peak of 86% for men in their late 30s. The proportion of sexually active men declines with age. Like women, married men are more likely to be sexually active (76.8%) than unmarried men (28.6%).

Recent sexual activity is more common among married men (77%), and among men who have been married for 15–19 years (87%), and is also more common among men with no educational background (65%) and for those in the poorest wealth quintile (60%).

Table 6.7.1: Recent sexual activity — Women

Percent distribution of women aged 15–49 by the timing of their last sexual intercourse, according to background characteristics, Solomon Islands 2007

Background characteristic	Timing of last sexual intercourse				Never had sexual intercourse	Total	Number of women
	Within the last 4 weeks	Within 1 year ¹	One or more years	Missing			
Age							
15–19	20.2	19.4	12.2	1.2	46.9	100.0	687
20–24	45.2	24.2	14.6	2.7	13.3	100.0	716
25–29	57.9	22.4	9.5	5.9	4.3	100.0	729
30–34	67.9	17.2	5.8	6.3	2.8	100.0	600
35–39	69.3	13.8	12.9	4.0	0.1	100.0	482
40–44	57.5	23.4	15.7	3.1	0.4	100.0	336
45–49	53.7	16.6	21.5	7.0	1.2	100.0	273
Marital status							
Never married	13.0	21.1	20.4	3.6	41.8	100.0	1,125
Married or living together	70.4	19.8	5.6	4.2	0.0	100.0	2,560
Divorced/separated/widowed	12.1	14.4	67.3	6.1	0.0	100.0	138
Marital duration²							
0–4 years	69.7	20.0	4.7	5.5	0.0	100.0	485
5–9 years	69.4	23.5	3.1	4.0	0.0	100.0	570
10–14 years	75.0	17.2	4.0	3.9	0.0	100.0	422
15–19 years	72.7	15.7	5.7	5.9	0.0	100.0	380
20–24 years	68.0	19.3	9.3	3.4	0.0	100.0	302
25+ years	60.9	22.3	13.4	3.4	0.0	100.0	235
Married more than once	76.9	19.4	3.1	0.7	0.0	100.0	165
Residence							
Urban	47.9	16.9	12.8	5.3	17.1	100.0	636
Rural	52.1	20.6	12.1	3.9	11.4	100.0	3,187
Region							
Honiara	47.5	14.9	12.7	5.9	19.0	100.0	481
Guadalcanal	52.4	21.3	9.9	3.6	12.8	100.0	637
Malaita	53.1	16.6	10.4	5.0	14.9	100.0	840
Western	46.7	25.5	13.6	5.2	9.0	100.0	458
Other provinces	52.8	21.3	13.7	2.9	9.3	100.0	1,407
Education							
No education	54.1	16.1	13.7	4.7	11.4	100.0	520
Primary	56.8	20.6	10.4	3.6	8.5	100.0	2,114
Secondary	40.1	20.5	15.0	3.9	20.5	100.0	1,067
More than secondary	45.9	20.6	11.1	11.5	11.0	100.0	122
Wealth quintile							
Lowest	56.4	21.0	12.5	2.6	7.5	100.0	696
Second	50.4	20.9	11.4	5.8	11.6	100.0	755
Middle	48.3	21.2	12.3	3.6	14.6	100.0	738
Fourth	55.2	18.7	12.2	2.9	11.0	100.0	769
Highest	47.6	18.4	12.6	5.4	15.9	100.0	864
Total	51.4	20.0	12.2	4.1	12.3	100.0	3,823

¹ Excludes women who had sexual intercourse within the four weeks preceding the survey.

² Excludes women who are not currently married.

Table 6.7.2: Recent sexual activity — Men

Percent distribution of men aged 15–49 by the timing of their last sexual intercourse, according to background characteristics, Solomon Islands 2007

Background characteristic	Timing of last sexual intercourse				Never had sexual intercourse	Total	Number of men
	Within the last 4 weeks	Within 1 year ¹	One or more years	Missing			
Age							
15–19	18.9	23.3	11.1	0.0	46.8	100.0	292
20–24	49.1	28.7	13.9	1.7	6.5	100.0	304
25–29	64.5	19.9	9.9	3.8	1.8	100.0	266
30–34	63.5	23.6	9.3	3.4	0.1	100.0	266
35–39	85.5	7.6	5.1	0.6	1.2	100.0	239
40–44	68.9	18.5	9.2	3.3	0.1	100.0	134
45–49	66.4	19.3	6.1	7.6	0.5	100.0	113
Marital status							
Never married	28.6	27.9	17.9	0.6	25.0	100.0	660
Married or living together	76.8	15.6	3.8	3.8	0.0	100.0	939
Divorced/separated/widowed	*	*	*	*	*	100.0	14
Marital duration²							
0–4 years	77.9	16.4	1.4	4.3	0.0	100.0	210
5–9 years	77.6	17.3	2.2	2.9	0.0	100.0	239
10–14 years	70.9	17.9	7.9	3.2	0.0	100.0	185
15–19 years	87.2	6.2	3.0	3.6	0.0	100.0	135
20–24 years	74.1	22.3	1.5	2.1	0.0	100.0	99
25+ years	66.8	9.9	11.6	11.7	0.0	100.0	55
Married more than once	(82.4)	(13.1)	(4.5)	(0.0)	(0.0)	100.0	17
Residence							
Urban	49.4	25.4	15.0	0.5	9.6	100.0	301
Rural	58.5	19.7	8.5	2.8	10.4	100.0	1,313
Region							
Honiara	45.2	26.4	17.4	0.7	10.3	100.0	240
Guadalcanal	67.2	20.9	6.6	1.0	4.2	100.0	249
Malaita	63.1	14.3	5.5	2.9	14.1	100.0	345
Western	57.8	19.6	12.5	3.9	6.2	100.0	181
Other provinces	53.2	22.6	9.6	2.9	11.7	100.0	599
Education							
No education	65.4	13.9	4.4	1.7	14.7	100.0	88
Primary	60.1	14.8	11.0	3.5	10.7	100.0	794
Secondary	49.3	27.7	10.4	1.7	10.9	100.0	593
More than secondary	64.6	30.1	3.3	0.0	2.0	100.0	138
Wealth quintile							
Lowest	60.9	13.9	9.4	3.1	12.7	100.0	281
Second	59.8	22.0	11.1	2.6	4.6	100.0	291
Middle	54.9	18.9	7.5	1.9	16.8	100.0	323
Fourth	58.8	24.2	7.0	2.7	7.3	100.0	353
Highest	51.0	23.6	13.6	1.9	9.9	100.0	366
Total 15–49	56.8	20.8	9.7	2.4	10.2	100.0	1,614
50+	35.5	17.8	43.4	2.7	0.6	100.0	442
Total men 15+	52.2	20.2	17.0	2.5	8.2	100.0	2,056

¹ Excludes men who had sexual intercourse within the four weeks preceding the survey.

² Excludes men who are not currently married.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

6.8 POSTPARTUM AMENORRHEA, ABSTINENCE AND INSUSCEPTIBILITY

Postpartum amenorrhea is the temporary absence of menstrual periods following childbirth. This is a period in which women are less like to become pregnant. The period of postpartum amenorrhea can be extended by prolonged breastfeeding. Thus, promoting breastfeeding is one way of reducing fertility as well as improving infant and maternal health. Abstinence is a family planning method that involves not having intercourse at times when a woman's risk of becoming pregnant is high. Women are considered insusceptible when they abstain from sex following childbirth and are thus amenorrheic.

Table 6.8 and Figure 6.1 presents the percentage of births in the three years preceding the survey for which mothers are postpartum amenorrheic, abstaining and insusceptible, by the number of months since birth. The median and mean durations for these indicators are also highlighted.

As is expected, the percentage of women who are amenorrheic, abstaining and/or insusceptible decreases with the length of time since childbirth.

In Solomon Islands, about 25% of women in the three years preceding the survey are amenorrheic, 54% are amenorrheic up to five months after childbirth; and 38% remain amenorrheic for 12 months after childbirth. The median duration for amenorrhea is estimated to be 5.1 months, while the mean is approximately 9.4 months.

Similarly, postpartum abstinence is practiced by 25% of women who gave birth in the three years preceding the survey. Nearly 80% of mothers who gave birth less than two months prior to the survey were abstaining from sexual intercourse. The median duration for postpartum abstinence is 4.2 months while the mean duration for postpartum abstinence is 9.6 months. For those mothers who are insusceptible (both amenorrheic and abstaining) the median duration is estimated to be 11.0 months.

Table 6.8: Postpartum amenorrhea, abstinence and insusceptibility

Percentage of births in the three years preceding the survey for which mothers are postpartum amenorrheic, abstaining, and insusceptible, by number of months since birth, and median and mean durations, Solomon Islands 2007

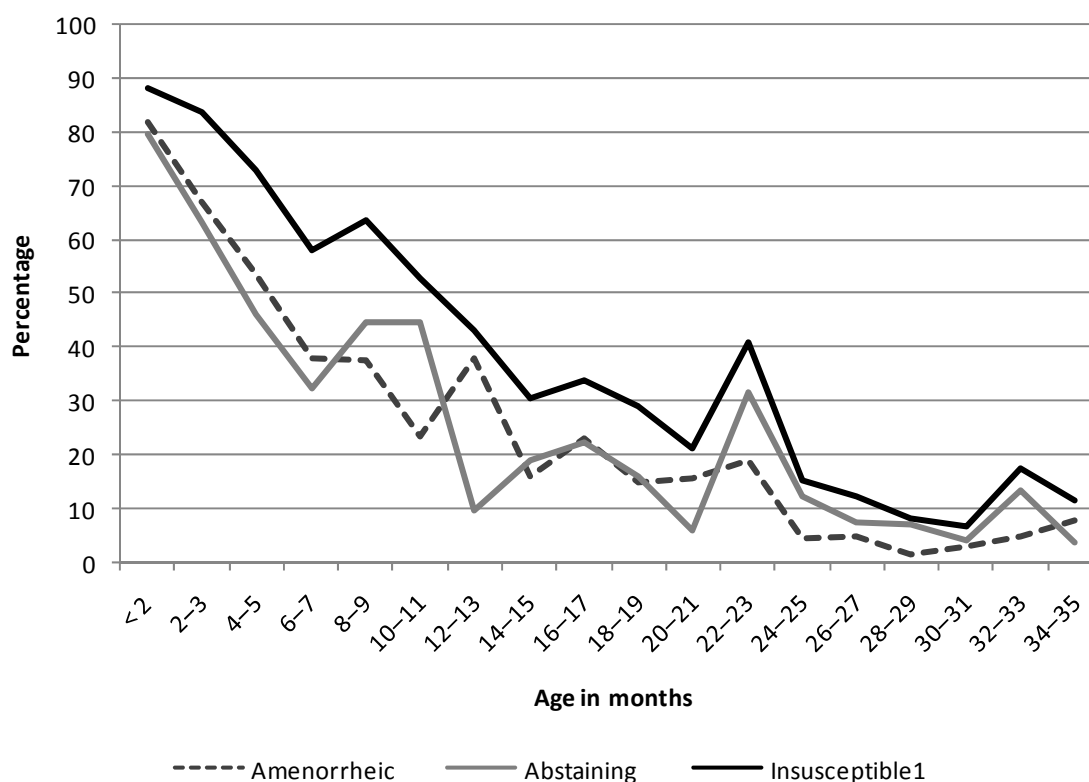
Months since birth	Percentage of births for which the mother is:			Number of births
	Amenorrheic	Abstaining	Insusceptible ¹	
< 2	81.8	79.7	88.3	55
2-3	67.0	63.4	83.9	126
4-5	53.5	46.2	73.1	93
6-7	37.8	32.4	57.9	113
8-9	37.4	44.9	63.7	75
10-11	23.5	44.6	52.9	73
12-13	37.9	9.7	43.0	88
14-15	15.9	18.9	30.3	80
16-17	23.0	22.4	33.9	82
18-19	14.8	15.9	28.9	124
20-21	15.5	6.2	21.0	83
22-23	19.0	31.8	41.0	81
24-25	4.2	12.2	15.1	88
26-27	4.8	7.5	12.2	92
28-29	1.4	7.0	8.0	95
30-31	2.9	4.2	6.5	96
32-33	4.7	13.4	17.3	77
34-35	7.7	3.8	11.4	94
Total	24.9	25.0	37.9	1,616
Median	5.1	4.2	11.0	na
Mean	9.4	9.6	14.1	na

Note: Estimates are based on status at the time of the survey.

na = not applicable

¹ Includes births for which mothers are either still amenorrheic or still abstaining (or both) following childbirth.

Figure 6.1: Percentage of births in the three years preceding the survey for which mothers are postpartum amenorrheic, abstaining, and insusceptible



Median duration of postpartum amenorrhea and postpartum abstinence is found to be higher for older mothers aged 30–49 years as compared to young mothers aged 15–29 years. More mothers living in rural areas are likely to be in a postpartum practices than mothers in urban areas.

Table 6.9: Median duration of amenorrhea, postpartum abstinence and postpartum insusceptibility

Median number of months of postpartum amenorrhea, postpartum abstinence, and postpartum insusceptibility following births in the three years preceding the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Postpartum amenorrhea	Postpartum abstinence	Postpartum insusceptibility ¹
Mother's age			
15–29	4.6	3.9	11.2
30–49	6.3	5.1	(10.2)
Residence			
Urban	(2.1)	(2.8)	(7.8)
Rural	5.5	4.3	11.7
Region			
Honiara	(2.5)	(2.3)	(8.6)
Guadalcanal	(9.2)	(6.4)	(11.5)
Malaita	(6.6)	*	(8.8)
Western	*	*	*
Other provinces	(4.2)	(6.2)	*
Education			
No education	*	*	*
Primary	5.8	3.6	11.9
Secondary	(2.3)	(8.5)	(10.1)
More than secondary	*	*	*

Table 6.9 (continued)

Background characteristic	Postpartum amenorrhea	Postpartum abstinence	Postpartum insusceptibility ¹
Wealth quintile			
Lowest	(11.9)	(4.8)	(15.1)
Second	(4.0)	(5.8)	*
Middle	(6.6)	(5.2)	*
Fourth	(2.6)	*	(3.6)
Highest	(3.2)	(5.5)	(9.1)
Total	5.1	4.2	11.0

Note: Medians are based on the status at the time of the survey (current status).

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Includes births for which mothers are either still amenorrheic or still abstaining (or both) following birth.

6.9 MENOPAUSE

Menopause literally means the permanent physiological or natural cessation of menstrual periods. It is important to examine menopause when studying fertility levels and patterns because this is the period that helps mark and monitor declining fertility within a population. Menopause is positively associated with a decline in fertility.

Table 6.10 indicates the percentage of women aged 30–49 who were menopausal (by age) at the time of the survey. Only 6% of women stated that they were menopausal. About 2% of women aged 30–34 reported being menopausal. As expected, more than 30% of women were menopausal by ages 48–49. The proportion of menopausal women increases with age as shown in Table 6.10.

Table 6.10: Menopause

Percentage of women age 30–49 who are menopausal, by age, Solomon Islands 2007

Age	Percentage menopausal ¹	Number of women
30–34	1.7	600
35–39	1.6	482
40–41	9.2	126
42–43	8.2	149
44–45	10.2	138
46–47	15.8	109
48–49	31.3	87
Total	6.0	1,691

¹ Percentage of all women who are not pregnant and not postpartum amenorrheic and whose last menstrual period occurred six or more months prior to the survey.

6.10 KEY RESULTS

The high fertility level in Solomon Islands contributes to the country's high population growth. This chapter examined factors other than contraception that affect a woman's risk of becoming pregnant (usually called proximate determinants of fertility). These factors include marriage, sexual intercourse, breastfeeding, postpartum abstinence from sexual relations, and menopause. For example, marriage and sexual behaviour marks a woman's exposure to the risk of childbearing, postpartum amenorrhea and postpartum abstinence affect the length of birth intervals, and menopause marks the end of a woman's reproductive period. Understanding these factors is important for helping to deter or support policies and programmes aimed at assisting in reducing the country's fertility level.

The 2006/2007 SIDHS data show that:

1. About 7.2% of women in the 20-49 age group are reported to be married at the exact age of 15 compared to 0.0% of men in the same age group. Men tend to marry later than women do; the median age at first marriage for men aged 20-49 is 25.6 years, compared with 20.3 for women.
2. Women living in rural areas, with very little education and in poor households marry at younger ages than women in urban areas, who have a higher education and live in wealthier households
3. The median age at first intercourse is lower than the median age at first marriage, implying that sexual intercourse occurs before marriage. A higher proportion of men than women have their first sexual intercourse at ages 15-19. The median age at first intercourse is lower among women in rural areas who have little education and live in the poorest households.
4. One in every two women (51%) aged 15-49 reported having had sexual intercourse within the four weeks prior to the survey. Among these, 20% were teenagers aged 15-19.
5. The median duration of amenorrhea is about 5.1 months and the median duration of abstinence is 4.2 months. About one in every four women in the three years preceding the survey are reported to be amenorrheic and practicing abstinence after giving birth. One out of two women are reported to be amenorrheic up to five months after giving birth.

CHAPTER 7 FERTILITY PREFERENCES

This chapter addresses three questions that help ascertain the need for contraception. Does the respondent want more children? If so, how long would she prefer to wait before the next child? If she could start afresh, how many children in all would she want? Two further issues are examined. To what extent do unwanted or mistimed pregnancies occur? What effect would the prevention of such pregnancies have on fertility rates? Bearing in mind that the underlying rationale of most family planning programmes is to give couples the freedom and ability to bear the number of children they want, and to achieve the spacing of births they prefer, the importance of this chapter is obvious.

The 2006/2007 SIDHS included questions to elicit fertility preferences. Women who were either not pregnant or unsure about their status were asked the question: *'Would you like to have (a/another) child or would you prefer not to have any (more) children?'* A different question was posed for women who were pregnant at the time of the survey. Pregnant women were asked: *'After the child you are expecting, would you like to have another child or would you prefer not to have any more children?'* The women who indicated that they wanted another child were asked how long they would like to wait before the birth of the next child. Finally, women were asked to state the total number of children they would like to have, as well as their sex preference for the child, if they were to start childbearing afresh.

Given the ongoing family planning programmes that address both men and women, and given that men play a vital role in realising reproductive goals, the 2006/2007 SIDHS included questions that elicited information on men's fertility preferences.

7.1 DESIRE FOR MORE CHILDREN

Data on the desire for more children can provide an indication of future reproductive behaviour provided that the required family planning services are available, affordable, and accessible to allow people to realise their fertility preferences. Table 7.1 presents the distribution of currently married women and men aged 15–49 by desire for children according to the number of living children. Overall, about 50% of currently married women and 41% of currently married men want no more children, and were sterilised, and about 17% of currently married women and 18% of currently married men want to have another child later, after two years, while 10% of currently married women and 8% of currently married men want to have another child soon, or within two years of the birth of their youngest living child. Only 4% of currently married women and 2% of currently married men are infecund.

Table 7.1 also shows that the proportion of both currently married women and men who want another child soon after the birth of their youngest living child declines with an increase in the number of living children. This result clearly shows that fertility preference in Solomon Islands diminishes as the number of living children increases. This finding is further supported by the pattern observed in the proportion of women and men wanting no more children, which increases with the increased number of living children. Considering the above result, there is obviously a need and/or desire for birth spacing and limiting in Solomon Islands.

Table 7.1: Fertility preferences by number of living children

Percent distribution of currently married women and currently married men age 15-49 by desire for children, according to number of living children, Solomon Islands 2007

	Number of living children									
Desire for children	0	1	2	3	4	5	6+	Total 15-49	50+	Total men 15+
WOMEN ¹										
Have another soon ²	40.5	16.4	11.6	6.5	6.1	4.9	0.6	10.1	na	na
Have another later ³	13.1	47.4	33.3	17.7	5.4	4.8	0.7	16.7	na	na
Have another, undecided when	4.9	6.0	5.0	4.3	1.8	1.3	0.4	3.2	na	na
Undecided	14.3	15.6	21.6	21.3	19.1	12.6	9.1	16.5	na	na
Want no more	12.3	6.8	22.0	39.2	41.6	47.1	58.0	34.9	na	na
Sterilized ⁴	1.8	0.8	2.9	7.8	21.5	24.7	27.6	13.6	na	na
Declared infecund	12.9	6.8	3.0	2.7	3.0	3.0	3.0	4.3	na	na
Missing	0.1	0.1	0.6	0.5	1.4	1.6	0.5	0.8	na	na
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	0.0
Number	219	315	400	423	440	320	442	2,560	0	0
MEN ⁵										
Have another soon ²	28.5	14.1	9.1	7.6	2.9	0.6	1.1	8.4	0.1	6.0
Have another later ³	2.9	38.3	34.5	22.2	9.4	9.0	0.5	17.8	0.3	12.8
Have another, undecided when	22.9	6.8	7.8	4.3	2.7	4.0	1.7	6.5	0.2	4.7
Undecided	10.4	30.0	23.5	25.5	13.8	19.3	18.4	20.6	4.7	16.1
Want no more	10.6	8.8	17.3	34.1	62.7	59.4	69.5	37.8	79.6	49.8
Sterilized ⁴	4.3	0.2	1.6	2.1	4.4	3.8	4.2	2.9	8.3	4.4
Declared infecund	12.7	0.0	0.7	1.1	0.3	1.2	1.0	2.0	4.5	2.7
Missing	7.7	1.8	5.5	3.1	3.9	2.7	3.7	4.0	2.4	3.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	98	129	163	154	148	116	132	939	375	1,314

NA=Not applicable

¹ The number of living children includes current pregnancy for women

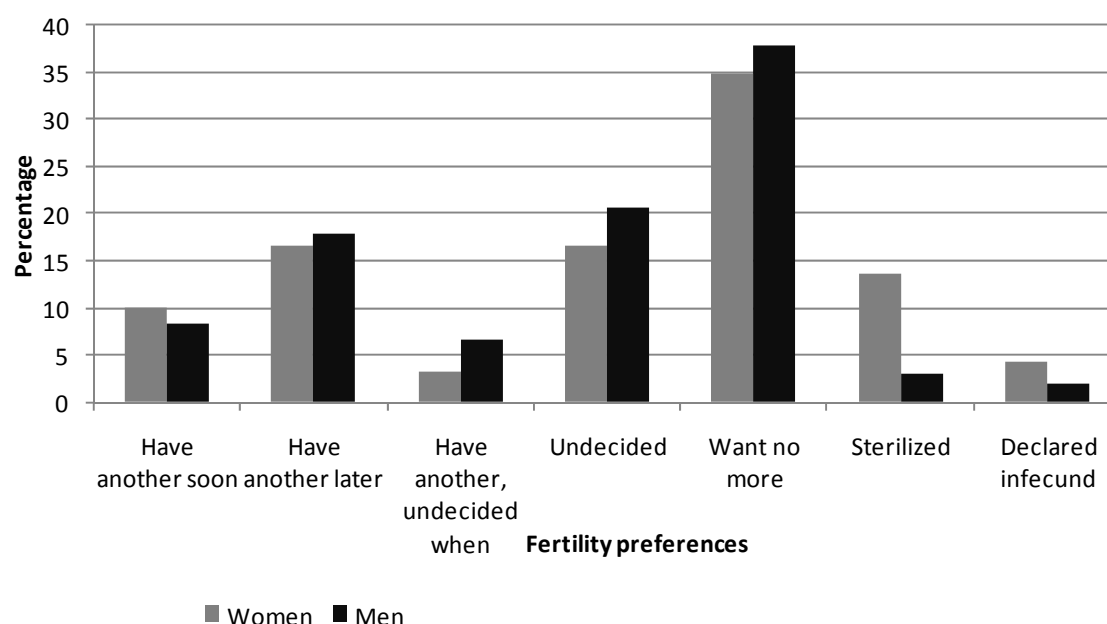
² Wants next birth within 2 years

³ Wants to delay next birth for 2 or more years

⁴ Includes both female and male sterilization

⁵ The number of living children includes one additional child if respondent's wife is pregnant (or if any wife is pregnant for men with more than one current wife).

Figure 7.1: Fertility preference among currently married women and men aged 15–19, Solomon Islands



7.2 DESIRE TO LIMIT CHILDBEARING BY BACKGROUND CHARACTERISTICS

Tables 7.2.1 and 7.2.2 present the percentage of currently married women and men who want no more children, by the number of living children they have and according to their background characteristics. As shown, more than four out of ten currently married women and men want no more children, and there is no substantial difference in the proportion of those wanting no more children or limiting the number of children by both sexes (48% women, 41% men). However, variation was observed in the proportion of desire to limit childbearing among urban and rural dwellers. Overall, the proportion of women and men who desire to limit childbearing is higher among rural dwellers than urban dwellers. For instance, 50% of women in rural areas want to limit the number of children, as opposed to 37% of urban women. Similarly, 42% of men in rural areas want to limit the number of children, as opposed to 37% of urban men. As also shown, the desire to limit childbearing increases with the number of living children, and the proportion is equally displayed in both currently married women and men.

Table 7.2.1: Desire to limit childbearing: Women

Percentage of currently married women age 15-49 who want no more children, by number of living children, according to background characteristics, Solomon Islands 2007

Background characteristic	Number of living children ¹							Total
	0	1	2	3	4	5	6+	
Residence								
Urban	5.4	12.8	20.0	39.3	56.1	72.4	71.5	36.7
Rural	16.4	6.2	25.8	48.2	64.3	71.7	87.1	50.4
Region								
Honiara	7.0	11.6	21.4	34.7	53.6	69.3	71.5	35.3
Guadalcanal	0.0	10.0	31.9	51.3	51.8	74.2	84.0	47.3
Malaita	0.0	10.7	24.0	28.3	55.8	(61.8)	77.4	41.4
Western	0.0	1.6	19.4	(49.9)	70.5	(82.7)	(79.6)	48.7
Other provinces	35.6	4.3	24.6	56.4	73.0	73.8	97.5	57.6
Education								
No education	23.4	(20.6)	(40.9)	30.1	58.1	56.2	81.5	53.6
Primary	13.9	5.7	21.9	48.7	66.4	72.9	86.9	51.2
Secondary	13.2	7.8	25.7	48.4	53.6	(89.9)	(87.5)	36.7
More than secondary	1.4	*	(21.4)	(62.9)	*	*	*	40.5
Wealth quintile								
Lowest	24.7	11.9	34.3	48.1	72.5	72.7	88.2	57.8
Second	31.5	3.3	19.2	62.9	72.8	(77.3)	86.6	55.1
Middle	21.1	7.1	26.6	42.7	58.5	(55.8)	84.5	45.6
Fourth	2.2	6.1	22.6	31.0	51.8	73.0	84.0	40.5
Highest	2.8	10.9	21.2	53.9	61.9	75.2	83.9	44.0
Total	14.1	7.6	24.9	47.0	63.2	71.8	85.6	48.4

Note: Women who have been sterilized are considered to want no more children.

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ The number of living children includes the current pregnancy.

Table 7.2.2: Desire to limit childbearing: Men

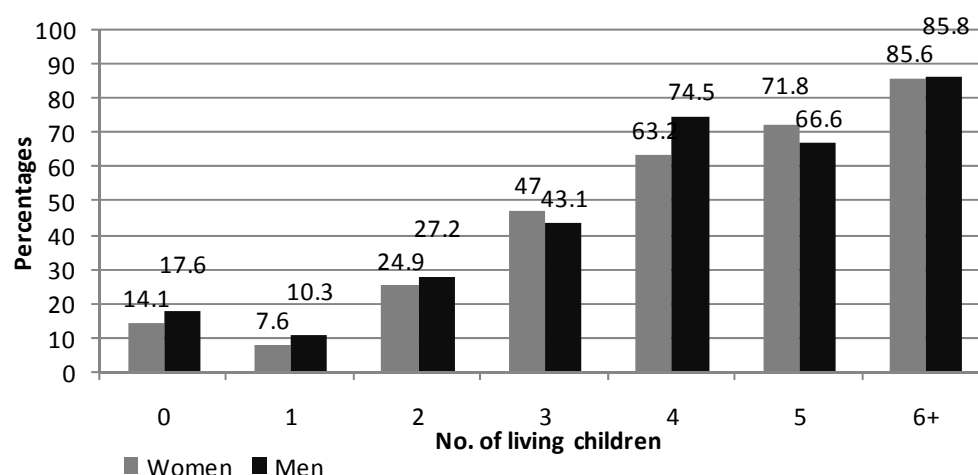
Percentage of currently married men age 15+ who want no more children, by number of living children, according to background characteristics, Solomon Islands 2007

Background characteristic	Number of living children ¹							Total
	0	1	2	3	4	5	6+	
Residence								
Urban	8.0	8.4	11.2	29.4	63.1	70.9	83.2	37.1
Rural	16.2	9.3	20.2	37.6	68.1	61.5	72.7	41.5
Region								
Honiara	10.6	4.5	13.1	36.3	58.2	67.1	79.8	35.9
Guadalcanal	13.2	(25.5)	(10.1)	(28.7)	(45.5)	(61.5)	90.1	38.3
Malaita	0.0	(0.0)	(21.1)	(13.1)	(53.5)	(51.0)	40.1	26.1
Western	17.4	*	*	*	*	*	(57.3)	45.2
Other provinces	22.6	*	(27.3)	(53.4)	(88.8)	(64.1)	95.0	52.7
Education								
No education	0.0	*	*	*	*	*	36.4	24.4
Primary	26.3	16.8	14.6	32.6	63.7	68.0	79.4	44.9
Secondary	10.8	1.9	24.7	35.4	73.8	(67.8)	(70.0)	36.8
More than secondary	0.0	*	*	(56.3)	(66.5)	*	*	39.8
Wealth quintile								
Lowest	10.2	*	(7.0)	(31.0)	(55.1)	(51.0)	68.9	35.1
Second	25.7	*	*	(12.1)	(86.2)	(76.3)	81.5	47.6
Middle	0.0	(20.6)	(31.6)	(47.9)	(71.8)	(30.8)	(50.5)	36.4
Fourth	18.4	(10.9)	(26.0)	(40.9)	(72.1)	(94.5)	85.4	45.9
Highest	11.4	7.1	10.6	41.0	57.2	70.4	76.5	38.0
Total 15-49	14.9	9.0	18.9	36.2	67.1	63.2	73.7	40.7
50+	*	*	*	(82.6)	(95.4)	72.8	94.0	87.9
Total men 15+	17.6	10.3	27.2	43.1	74.5	66.6	85.8	54.2

Note: Men who have been sterilized or who state in response to the question about desire for children that their wife has been sterilized are considered to want no more children.

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ The number of living children includes one additional child if respondent's wife is pregnant (or if any wife is pregnant for men with more than one current wife).

Figure 7.2: Percentage of currently married women and men aged 15–49 who want no more children by number of living children

A large proportion of women with no education or only a primary level of education expressed a desire to limit their family as opposed to the proportion of women with a secondary and higher level of education. This finding clearly indicates that there is a strong link between women's educational attainment and preference for family size, such that women with a higher educational attainment are more likely to meet their desire to limit childbearing, thus the proportion of women who desire to limit childbearing in this category is low. Conversely, women with low educational attainment or no education at all are less likely to meet their desire to limit childbearing, and thus their proportion, as illustrated in Table 7.2.1, is high. Furthermore, the findings of this survey may also reflect women's social status in Solomon Islands; the lower a women's educational attainment, the less likely she is to be able to meet her desire to limit the number of children.

A comparison across the provinces reveals that currently married women in other provinces collectively account for 58%, while 49% of women in Western Province, 47% in Guadalcanal Province, 41% in Malaita Province, and only 35% in Honiara expressed a need or desire to limit their childbearing. Again, this result may indicate that women in Honiara are more likely to meet their desire to limit their childbearing as opposed to women in other provinces, particularly Western, Guadalcanal and Malaita.

The results also reveal that there is a strong link between wealth and preference to family size. For instance, the proportion of women who wish to limit their childbearing is higher in the lower wealth quintiles than those in the upper wealth quintiles, where the proportion of women who desire to limit childbearing decreases as the wealth quintile increases. This result clearly shows that women in the lower wealth quintiles are less likely to meet their desire to limit their family size, thus their proportion is higher (see Table 7.2.1). On the other hand, women from the upper and/or highest wealth quintile are more likely to meet their desire to limit childbearing, thus few of them expressed their desire to do so.

7.3 NEED FOR FAMILY PLANNING SERVICES

In the 2006/2007 SIDHS, women who indicated that they either want no more children (limiters) or want to wait two or more years before having another child (spacers), but are not using contraception, constitute a group that has an *unmet need for family planning*. Women who are currently using a family planning method are considered to have a met need for family planning. Women with an unmet need for family planning and those currently using contraception form the total demand for family planning.

Table 7.3.1 presents the proportion of the unmet need, met need, and the total demand for family planning services for currently married women. Overall, 11% of currently married women have an unmet need for family planning services. Of these women, 7% were birth spacers and 4% for birth limiters, and about 35% are currently using contraceptive methods. This constitutes the overall met needs for family planning in Solomon Islands. The total demand for family planning on the other hand is estimated to be 46%, while the demand satisfied accounts for 76%.

A substantial difference was noted in the level of unmet need for family planning by age group. As shown, currently married women below the age of 35 are more likely not to meet their need for family planning as opposed to currently married women aged 35 and older. This is clearly demonstrated by the proportion of unmet needs that are higher in younger married women than in older women. The table also shows that the proportion of unmet needs is higher for birth spacing, particularly among younger married women (aged 15–29) as opposed to birth limiting; however, as women's age increases, the proportion of unmet need is higher in birth limiting as opposed to birth spacing. This result indicates that younger women are more likely to opt for birth spacing than for birth limiting, whereas older married women are more likely to opt for birth limiting than birth spacing. In other words, the demand for birth spacing is more common in younger women while demand for birth limiting is more common in older women.

A similar pattern was also observed for met needs. The proportion of met needs is higher for birth spacing than for birth limiting at younger age groups. For birth spacing, the proportion of met needs decreases with increased age, whereas for birth limiting, the proportion of met needs increases with women's age. This result reveals that the demand for family planning services, especially in younger married women, is for birth spacing, whereas older women use any form of

contraceptive methods for the purpose of birth limiting. It is also obvious from Table 7.3.1 that the proportion of met needs increases with women's age.

A substantial variation was also noted in the unmet needs of urban and rural dwellers. As shown, 12% of rural women expressed an unmet need for family planning as opposed to 8% of urban women. For rural women, the proportion expressing an unmet need for birth spacing is higher than for birth limiting, whereas for urban women, the proportion is higher for birth limiting than birth spacing. This result indicates that the demand for birth limiting is higher among women in urban areas than in rural areas, whereas the demand for birth spacing is higher among women in rural areas than in urban areas. For met needs, the demand for family planning is mostly used for birth limiting rather than for birth spacing. A similar pattern is also observed for both rural and urban men.

Across the provinces, Malaita has the highest (13%) proportion of unmet needs for family planning followed by Guadalcanal (12%), Western (9%) and Honiara (8%), while other provinces collectively account for 11%. Other than Honiara and Western Province, Malaita followed by Guadalcanal and then other provinces has the highest unmet need for birth spacing while the proportion for birth limiting is highest in Honiara and Western Province. This result indicates that birth spacing is mostly preferred by women in Malaita, Guadalcanal and other provinces, whereas birth limiting is mostly preferred by women in Guadalcanal and Honiara. Looking at the met need for family planning, Western Province had the highest proportion (40%), followed by Malaita and Guadalcanal (each about 29%) and Honiara 24%. Other provinces collectively account for 42%. Comparing the proportions of met need for family planning either for birth spacing or birth limiting, the proportion of met needs is higher for birth limiting than for birth spacing across the provinces. This result clearly indicates that family planning is used much more for birth limiting than for birth spacing, and the proportion is highest in Western (28%) followed by Malaita (19%), Guadalcanal 17% and Honiara 15%.

The proportion of unmet needs for family planning is highest in women with no education at all, with the proportion decreasing as the educational attainment of women increases. The proportion of unmet needs is also higher for birth spacing than for birth limiting. A similar pattern is also observed for met needs; however, the proportion of met needs is higher for birth limiting than for birth spacing for all levels of educational background. This result clearly illustrates that regardless of educational background, women are more likely to use any form of contraceptive method for birth limiting than for birth spacing. This is further supported by the small proportion of unmet needs for family planning for birth spacing than for birth limiting. It is evident that there is a high demand for family planning services and the demand is more obvious for birth limiting than for birth spacing.

Table 7.3.1 shows that the proportion of unmet needs for family planning was higher in the middle and lower wealth quintiles as opposed to the upper wealth quintiles. Additionally, the proportion of unmet needs was higher for birth spacing than for birth limiting. As for met needs for family planning, the proportion is highest in the middle to upper wealth quintiles. The table also reveals that regardless of the wealth quintile, the proportion of met needs is higher for birth limiting than for birth spacing. This result strongly indicates that most married women in Solomon Islands use a contraceptive method for birth limiting rather than for birth spacing.

Table 7.3.1: Need and demand for family planning among currently married women

Percentage of currently married women age 15-49 with unmet need for family planning, percentage with met need for family planning, the total demand for family planning, and the percentage for the demand for contraception that is satisfied, by background characteristics, Solomon Islands 2007

Background characteristic	Unmet need for family planning ¹			Met need for family planning (currently using) ²			Total demand for family planning			Percentage of demand satisfied	Number of women
	For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total		
Age											
15-19	11.7	3.2	15.0	19.0	0.4	19.5	30.8	3.7	34.4	56.6	86
20-24	10.5	4.2	14.8	19.5	5.5	25.0	30.0	9.7	39.7	62.9	383
25-29	11.3	4.0	15.3	17.2	8.6	25.8	28.5	12.6	41.0	62.8	588
30-34	7.8	7.3	15.1	10.7	26.4	37.0	18.5	33.7	52.1	71.0	533
35-39	3.9	4.6	8.5	6.6	37.8	44.4	10.5	42.4	52.8	84.0	433
40-44	0.6	1.6	2.3	3.1	36.9	40.0	3.8	38.6	42.3	94.6	311
45-49	0.0	0.7	0.7	2.1	45.0	47.1	2.1	45.7	47.8	98.5	226
Residence											
Urban	3.0	5.2	8.2	11.4	17.9	29.3	14.5	23.1	37.5	78.1	372
Rural	7.6	4.0	11.6	11.4	24.1	35.4	19.0	28.1	47.1	75.3	2,187
Region											
Honiara	3.3	4.8	8.1	8.7	14.8	23.6	12.0	19.7	31.7	74.4	278
Guadalcanal	6.8	5.8	12.6	12.4	17.0	29.5	19.2	22.9	42.1	70.0	445
Malaita	9.1	4.3	13.4	10.5	18.9	29.4	19.6	23.2	42.8	68.7	612
Western	4.0	4.5	8.5	12.8	27.5	40.4	16.8	32.0	48.8	82.7	303
Other provinces	7.6	3.1	10.7	11.8	30.0	41.9	19.4	33.1	52.6	79.6	922
Education											
No education	7.0	5.1	12.1	6.5	23.1	29.6	13.5	28.1	41.6	71.0	385
Primary	7.5	4.1	11.6	10.8	25.3	36.1	18.4	29.4	47.7	75.7	1,610
Secondary	5.5	4.5	10.1	15.6	16.2	31.7	21.1	20.7	41.8	75.9	493
More than secondary	2.5	0.5	3.0	21.8	24.1	45.9	24.3	24.6	48.9	93.8	72
Wealth quintile											
Lowest	9.3	5.2	14.5	8.5	25.4	33.9	17.8	30.6	48.4	70.0	499
Second	7.8	2.7	10.4	7.2	25.0	32.2	14.9	27.7	42.6	75.6	500
Middle	10.9	4.5	15.4	11.7	24.7	36.4	22.6	29.3	51.9	70.3	490
Fourth	4.5	5.3	9.8	16.4	21.0	37.4	20.9	26.4	47.3	79.2	546
Highest	2.7	3.2	6.0	12.7	20.0	32.7	15.4	23.2	38.6	84.6	524
Total women currently married	6.9	4.2	11.1	11.4	23.2	34.6	18.3	27.4	45.7	75.6	2,560
Total women not currently married	0.0	0.7	0.7	5.4	3.9	9.4	5.4	4.7	10.1	92.8	1,263
Total all women	4.6	3.1	7.7	9.4	16.8	26.2	14.1	19.9	33.9	77.3	3,823

¹ *Unmet need for spacing* includes pregnant women whose pregnancy was mistimed; amenorrheic women who are not using family planning and whose last birth was mistimed, or whose last birth was unwanted but now say they want more children; and fecund women who are neither pregnant nor amenorrheic, who are not using any method of family planning, and say they want to wait 2 or more years for their next birth. Also included in *unmet need for spacing* are fecund women who are not using any method of family planning and say they are unsure whether they want another child or who want another child but are unsure when to have the birth

Unmet need for limiting refers to pregnant women whose pregnancy was unwanted; amenorrheic women who are not using family planning, whose last child was unwanted and who do not want any more children; and fecund women who are neither pregnant nor amenorrheic, who are not using any method of family planning, and who want no more children

² *Using for spacing* is defined as women who are using some method of family planning and say they want to have another child or are undecided whether to have another child. *Using for limiting* is defined as women who are using and who want no more children. Note that the specific methods used are not taken into account here

7.4 IDEAL NUMBER OF CHILDREN

The 2006/2007 SIDHS asked women and men about the total number of children they would like to have in their lifetime. For respondents who already had living children, the question was posed hypothetically: *'If you could go back to the time when you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?'* Table 7.4 presents the distribution of women and men aged 15–49 by their preferred number of children.

Generally, the average ideal number of children expressed by currently married men and women aged 15–49 is 3.8 for men and 3.7 for women, and the mean ideal number increases with the number of living children. As also shown, 34% of currently married women preferred 4 as an ideal number of children. Equally so, 35% of currently married men expressed 4 as an ideal number of children.

Table 7.4: Ideal number of children

Percent distribution of women and men 15-49 by ideal number of children, and mean ideal number of children for all respondents and for currently married respondents, according to number of living children, Solomon Islands 2007

Ideal number of children	Number of living children							Total
	0	1	2	3	4	5	6+	
WOMEN ¹								
0	12.1	7.3	1.7	1.6	2.4	4.5	3.4	6.1
1	3.2	9.2	0.9	1.0	0.3	0.9	0.4	2.5
2	34.0	32.2	30.0	9.1	5.4	3.4	3.5	20.5
3	13.6	18.5	17.1	26.8	8.6	5.5	4.1	13.7
4	24.3	20.5	40.0	47.7	57.1	28.7	34.4	34.0
5	3.2	3.1	2.4	4.0	5.8	31.4	9.2	6.7
6+	2.1	1.9	1.6	2.2	12.2	10.9	26.8	7.0
Non-numeric responses	7.5	7.4	6.3	7.7	8.3	14.7	18.0	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	1,170	494	447	450	462	330	470	3,823
Mean ideal number children for: ²								
All	2.6	2.6	3.2	3.5	4.0	4.3	4.6	3.3
Number	1,082	458	419	415	424	282	385	3,464
Currently married	3.0	2.8	3.2	3.5	4.0	4.3	4.6	3.7
Number	208	304	376	392	402	271	359	2,312
MEN ³								
0	11.8	2.7	1.7	4.6	1.5	9.6	1.6	7.3
1	1.4	5.9	0.6	0.0	1.6	0.0	0.0	1.4
2	21.2	21.8	16.4	6.0	1.2	0.2	0.0	14.1
3	19.0	23.4	22.0	31.4	5.2	6.8	3.4	17.4
4	30.8	35.5	43.9	39.6	51.5	30.2	21.8	34.6
5	9.0	3.4	6.1	10.3	19.1	28.9	11.3	10.9
6+	1.8	1.5	2.3	1.1	16.2	17.6	40.4	7.4
Non-numeric responses	5.0	5.8	6.9	7.1	3.8	6.9	21.6	6.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	740	148	167	155	151	118	134	1,614
Mean ideal number children for men 15-49: ²								
All	3.0	3.1	3.4	3.5	4.4	4.3	5.4	3.5
Number	703	140	156	144	145	110	105	1,503
Currently married	3.2	3.0	3.4	3.5	4.4	4.2	5.4	3.8
Number	93	120	151	144	142	108	103	863

Table 7.4 (continued)

Ideal number of children	Number of living children							Total
	0	1	2	3	4	5	6+	
Mean ideal number children for men 15+ : ²								
All	3.0	3.1	3.5	3.6	4.6	4.3	5.1	3.7
Number	706.8	142.3	180.1	169.4	194.3	161.8	259.2	1,866.1
Currently married	3.2	3.0	3.5	3.6	4.6	4.2	5.1	4.0
Number	97.6	122.8	175.8	169.4	191.2	159.5	257.8	1,174.2

¹ The number of living children includes current pregnancy for women

² Means are calculated excluding respondents who gave non-numeric responses.

³ The number of living children includes one additional child if respondent's wife is pregnant (or if any wife is pregnant for men with more than one current wife).

7.5 MEAN IDEAL NUMBER OF CHILDREN

The mean ideal number of children among women aged 15–49 by background characteristics is presented in Table 7.5. As shown, the average ideal number of children increases steadily with women's age such that the mean ideal number of children expressed by married women aged 15–19 was 2.4, while it was 4.3 for women aged 45–49. The table also displayed little difference in the mean ideal number of children expressed by urban and rural women. As well, there were no substantial variations in the mean ideal number of children as expressed by currently married women across the provinces.

Table 7.5: Mean ideal number of children

Mean ideal number of children for all women age 15-49 by background characteristics, Solomon Islands 2007

Background characteristic	Mean	Number of women ¹
Age		
15-19	2.4	629
20-24	2.8	680
25-29	3.3	668
30-34	3.7	554
35-39	3.8	428
40-44	4.0	293
45-49	4.3	212
Residence		
Urban	3.0	606
Rural	3.4	2,858
Region		
Honiara	3.0	456
Guadalcanal	3.4	594
Malaita	3.5	709
Western	3.1	427
Other provinces	3.3	1,278
Education		
No education	3.5	452
Primary	3.5	1,885
Secondary	2.8	1,008
More than secondary	3.2	118
Wealth quintile		
Lowest	3.6	610
Second	3.3	689
Middle	3.3	668
Fourth	3.3	693
Highest	3.0	804
Total	3.3	3,464

¹ Number of women who gave a numeric response

Considering respondents' educational levels, there is very little variation noted; however, the mean ideal number of children declines with increasing education. Women with no education or only a primary education prefer 3.5 children, while those with a secondary and or higher education level preferred 2.8 and 3.2 children, respectively.

A similar trend was also noted for wealth quintile; that is, the mean ideal number of children declines as the wealth quintile increases. For instance, 3.6 is the mean ideal number of children for women in the lowest wealth quintile compared with 3.0 children for women in the highest quintile.

7.6 FERTILITY PLANNING

To measure the level of unwanted fertility during the 2006/2007 SIDHS, women were asked whether any birth in the preceding five years was wanted at the time, wanted but at a later time, or not wanted at all. For women who were pregnant at the time of the interview, this question was also asked with reference to the current pregnancy. The procedure required the respondents to recall accurately their wishes at one or more points in the last five years. Care must be taken when interpreting these results because an unwanted conception may have become a cherished child, leading to the rationalisation of responses to these questions.

According to Table 7.6, 42% of births in the five years preceding the survey were wanted then, 32% were wanted later (mistimed), and 25% were not wanted at the time they were conceived. This finding clearly indicates that there is a great demand for birth spacing and limiting, which is roughly consistent with the number of unmet need for birth spacing and limiting observed in Table 7.3.1 above.

Looking at fertility planning status by birth order and age of the mother at birth, the data show that little variation was noted in the proportion of births that were wanted then by birth order and age of mother at births. However, the proportion of wanted birth is highest in birth order 1, with the proportion decreasing as birth order increases. For instance, 50% of all first births (birth order 1) were wanted then, while 37% of all fourth or more births (birth order 4+) were wanted then. This result clearly indicates that wanted births diminishes with increased number of births, thus there is a clear need for birth spacing and limiting. As also shown, proportion of mistimed births was highest in birth order 2 followed by birth order 3, and the lowest proportion was demonstrated in birth order 1. About 34% of all fourth and or more births were not wanted.

Table 7.6 also shows that more than 40% of all births delivered by younger mothers (aged less than 35) were wanted then. However, as the mother gets older (35 years or more) the pattern changes; that is, the proportion of births is highest in unwanted births. Again, this result reveals the need for birth spacing — although more importantly birth limiting — in older women rather than in younger women.

Table 7.6: Fertility planning status

Percent distribution of births to women 15-49 in the five years preceding the survey (including current pregnancies), by planning status of the birth, according to birth order and mother's age at birth, Solomon Islands 2007

Birth order and mother's age at birth	Planning status of birth				Total	Number of births
	Wanted then	Wanted later	Wanted no more	Missing		
Birth order						
1	49.6	27.3	22.2	0.8	100.0	620
2	43.9	39.6	15.2	1.3	100.0	582
3	42.6	36.0	20.3	1.1	100.0	509
4+	37.0	28.4	33.9	0.7	100.0	1,185
Mother's age at birth						
<20	45.0	33.1	20.6	1.3	100.0	265
20-24	42.1	34.8	22.4	0.7	100.0	846
25-29	44.6	34.6	19.7	1.1	100.0	850
30-34	39.8	27.3	32.1	0.8	100.0	605
35-39	33.8	27.3	38.2	0.7	100.0	235
40-44	48.4	15.8	35.9	0.0	100.0	84
45-49	*	*	*	*	100.0	12
Total	42.1	31.8	25.3	0.9	100.0	2,896

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

7.7 WANTED FERTILITY RATES

The wanted fertility rate measures the potential demographic impact of avoiding unwanted births. It is calculated in the same way as the conventional total fertility rate, except that unwanted births are excluded. A birth is considered wanted if the number of living children at the time of conception was less than the ideal number of children reported by respondent. The gap between wanted and actual fertility shows how successful women were in achieving their reproductive intentions.

A comparison of the total wanted fertility rate and total fertility rate for the three years preceding the survey by background characteristics is presented in Table 7.7. The data reveal that if all unwanted births are eliminated, the total fertility rate in Solomon Islands would be 3.3 children per woman instead of the actual total fertility rate of 4.6 children per woman.

Table 7.7: Wanted fertility rates

Total wanted fertility rates and total fertility rates for the three years preceding the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Total wanted fertility rates	Total fertility rate
Residence		
Urban	2.8	3.4
Rural	3.4	4.8
Region		
Honiara	2.8	3.4
Guadalcanal	(3.8)	(5.1)
Malaita	(3.8)	(5.5)
Western	*	*
Other provinces	3.1	4.2
Education		
No education	*	*
Primary	3.7	4.9
Secondary	2.9	3.8
More than secondary	*	*
Wealth quintile		
Lowest	(4.5)	(5.9)
Second	(3.3)	(5.1)
Middle	(3.1)	(4.2)
Fourth	3.2	4.0
Highest	2.7	3.6
Total	3.3	4.6

Note: Rates are calculated based on births to women age 15-49 in the period 1-36 months preceding the survey. The total fertility rates are the same as those presented in Table 4.2.

Figures in parentheses are based on 500-750 unweighted cases. Asterisks indicate a figure based on fewer than 500 unweighted cases and have been suppressed.

Considerable variation is observed in the actual and wanted fertility rate by background characteristics. The overall gap between actual and wanted fertility ranges is 1.3 and the gap between actual and wanted fertility by background characteristics ranges from 0.6 to 1.4. The lowest gap of 0.6 was found in urban women as well as women in Honiara, followed by 0.9 in women with educational attainment of a secondary level and over. The biggest gap (1.4) on the other hand, was found in rural women. The results clearly indicate that urban women, including women in Honiara are more likely to succeed in achieving their reproductive intentions as opposed to women living in rural areas. Equally so, women with a higher educational attainment are also more likely to achieve the same as compared with women with a primary or no educational background at all.

7.8 KEY RESULTS

Unmet needs for contraception can lead to unintended pregnancies, which pose risks for both mother and child, and contributes to a high fertility level. Understanding the level or extent of unmet needs for contraception and the background of women with unmet needs for family planning methods can help strengthen health services and family planning programmes in targeting sub-groups of the population who are in need of such services. Woman's fertility preferences and desire for having the number of children they want are likely to be archived if the required family planning services are available, affordable and accessible. This section summarises the main findings that allow for an assessment of the need for contraception.

1. The desire for more children for both currently married women and men diminishes as the number of living children increases.
2. A higher proportion of those desiring to limit childbearing is higher among rural dwellers than urban dwellers. This is an indication that rural dwellers do not meet their desire to limit childbearing.
3. Women with a low educational background are less likely to meet their desire to limit childbearing, and therefore unwanted pregnancies occur.
4. Women in Western, Guadalcanal and Malaita provinces are less likely to meet their desire to limit their family size than women in Honiara.
5. The proportion of women who wish to limit their childbearing is higher in the lower wealth quintiles meaning that these women are less likely to meet their desire in limiting their childbearing.
6. The mean ideal number of children for all women aged 15–49 in Solomon Islands is reported to be 3.3 children. The mean ideal number of children increases with women's age.
7. About 32% of births in the five years preceding the survey were mistimed, while one in every four births were unwanted births. This indicates that there is a great demand for contraception for birth spacing and birth limiting.
8. The results show the gap of 1.3 births between wanted fertility and the actual fertility rates. This implies that if all women are able to achieve their reproductive intentions, then the total fertility rate in Solomon Islands would be 3.3 children instead of the actual fertility rate of 4.6 children per woman.
9. Unmet needs for family planning is 11%, which indicates the proportion of women who want no more children (limiters) or want to wait for two or more years before having another child but are not using any method of contraception.

CHAPTER 8 INFANT AND CHILD MORTALITY

This chapter presents estimates of levels, trends and differentials of neonatal, postneonatal, infant and childhood mortality, as well as perinatal mortality in Solomon Islands. The information presented in this chapter is important not only for a demographic assessment of the country's population, but also in the design and evaluation of health policies and programmes. According to the latest Solomon Islands Government health objectives and outcomes document, primary and preventative health services are key areas for improving the quality of life of Solomon Islanders, which includes the reduction of infant and childhood mortality and the incidence of high-risk pregnancies. Estimates of infant and child mortality serve as an input into population projections, particularly if the level of adult mortality is known from another source or can be inferred with reasonable confidence. These estimates also serve the needs of the health ministry by identifying populations within the country, particularly babies and their mothers, who are at high risk of mortality.

8.1 DEFINITIONS, METHODOLOGY AND ASSESSMENT OF DATA QUALITY

Childhood mortality measures or indicators presented in this chapter are defined as follows:

Neonatal mortality: the probability of dying within the first month of life

Infant mortality: the probability of dying between birth and the first birthday

Postneonatal mortality: the arithmetic difference between infant and neonatal mortality

Child mortality: the probability of dying between exact age one and the fifth birthday

Under-5 mortality: the probability of dying between birth and the fifth birthday.

The data used in estimating these mortality rates were collected in the birth history section of the 2006/2007 SIDHS women's questionnaire. The section begins with questions about the respondent's childbearing experience (i.e. the number of sons and daughters who live in the household, those who live elsewhere, and those who have died). Next, for each live birth, information on the name, date of birth, sex, whether the birth was single or multiple, and survivorship status was recorded. For living children, information about their age and whether they resided with their mother was obtained. For children who have died, the respondent was asked to provide the child's age at death.

A retrospective birth history, such as that included in the 2006/2007 SIDHS is susceptible to several data collection errors.

- First, only surviving women aged 15–49 were interviewed; therefore, no data are available for children of women who have died. The resulting mortality estimates will be biased if the child mortality rate of surviving and non-surviving women differs substantially.
- Another possible error in data collection is under-reporting of events (e.g. births and deaths), especially in cases where deaths occur early in infancy. If such deaths are selectively omitted, the consequence will not only be a lower infant mortality rate (IMR) and neonatal mortality rate, but also a low ratio of neonatal deaths to infant deaths and early neonatal death (within one week) to neonatal deaths.
- It is believed that under-reporting of early infant deaths may increase with the length of time since the child's death (e.g. an early infant death that occurred ten years before the survey may be more likely to be omitted than an early infant death two years before the survey). Thus, an examination of these patterns over time is critical.

8.1.1 Reporting children's birth dates

Mis-stating the date of birth and age at death of a child results in a distortion of the age pattern of death. This may affect the final indices obtained because of shifting ages above or below the borderline ages. Many DHS reports worldwide have reported evidence of age shifting or heaping to years outside of the required cut-off year to avoid administering lengthy birth-history related questions. Evidence from Appendix Table C.4 shows that there was no serious shift in the reporting of births during the operations. This is not to say that this was not the case, however; probably there were cases where interviewers shifted dates but not enough to show heaping in Table C.4, although the table also shows that date of birth of over 9 out of 10 babies born were recorded.

8.1.2 Reporting children's age at death

Another aspect that affects childhood mortality estimates is the accurate reporting of age at death. In general, these problems are less serious for periods in the recent past than for those in the more distant past. If ages are misreported then they will bias estimates, especially if the net effect of age misreporting results in the transfer of deaths from one age bracket to another. For example, a net transfer of deaths from under age 1 year to age 1 year and older will decrease the estimate of infant mortality and increase the estimate of childhood mortality. To minimise errors in the reporting of age at death, the 2006/2007 SIDHS interviewers were instructed to record the age at death in days if the death took place within one month after birth, in months if the child died within 24 months, and in years if the child was two years or older.

The distribution of child deaths by age of the child at death is shown in Appendix Table C.5. The table shows that age heaping at ages 7 days, 14 days, and 21 days — which are usually observed in other DHSs — are not a concern in the SIDHS results. Although age heaping at 14 days and 21 days may not bias any indicator, the heaping at 7 days usually leads to lower estimates of early neonatal mortality and perinatal mortality, but because this is not the case in Solomon Islands, the results can be used as indicators for policy and/or planning purposes. However, it must be stressed that caution must be exercised in using the mortality measures as indicators of levels of early age mortality because of possible under coverage of eligible DHS respondents. This is particularly important as the DHS based mortality indicators appear to be much lower than the estimates based on 1999 Population and Housing Census Data, considering the socioeconomic environment during the period 1999–2007.

Appendix Table C.6 presents the distribution of deaths of children aged less than 2 years by age at death in months over a 20-year period that is split into groups of 5 years. Neonatal deaths in the past 20 years constitute 63% of all infant deaths, and this is considered to be quite high. There is wide variation in the rates within a range (39–89%) over the 20 years prior to the survey, indicating possible misreporting or under-reporting. Similar to Table C.5, Table C.6 shows evidence of some heaping at age 12 months, which might have had an impact on estimates of infant mortality.

Finally, some caution should also be exercised when comparing early childhood mortality results from the 2006/2007 SIDHS to estimates from other data sources that have been calculated using a different technique. In Solomon Islands, childhood mortality rates have typically been computed using two approaches: direct and indirect. Direct mortality estimates have been computed from 2006/2007 SIDHS data using information collected using the birth history table. On the other hand, lacking the necessary information for producing estimates using direct methods, the population censuses give indirect estimates based on the number of children ever born and children surviving to women aged 15–49. The underlying assumptions used in indirect methods can introduce a potential bias (see 1999 census report for the defined assumptions) in the mortality estimates.

8.1.3 Sampling errors for child and infant mortality estimates

All estimates produced from the SIDHS are affected by two types of errors: non-sampling and sampling. While this issue is addressed in detail in Appendix B, it is worth mentioning sampling errors associated with estimates of child and infant mortality in this chapter, due to their significant impact. Unfortunately, for any sample survey, when collecting information for a variable where the number of cases is minimal (the situation with child and infant mortality), sampling errors can become significantly large, and as such, great care should be used when using this information.

A brief description of the key estimates produced in this chapter, along with information to assist in determining their reliability is provided in the table below.

Table 8.1.1: Five-year mortality rates in Solomon Islands (refers to zero to four years before the SIDHS, reflecting roughly 2003–2007)

Indicator	Estimate /1,000 births	Std error	95% CI		RSE (%)
			Lower	Upper	
Neonatal mortality	15.2	3.7	7.7	22.6	24.5
Postneonatal mortality	9.1	2.8	3.5	14.7	30.6
Infant mortality	24.3	4.9	14.4	34.2	20.3
Child mortality	13.0	3.7	5.6	20.4	28.5
Under-5 mortality	37.0	6.0	25.0	49.0	16.3

Table 8.1.2: Ten-year mortality rates in Solomon Islands (refers to zero to nine years before the SIDHS, reflecting roughly 1998–2007)

Indicator	Estimate /1,000 births	Std. error	95% CI		RSE (%)
			Lower	Upper	
Neonatal mortality	16.8	2.7	11.4	22.3	16.1
Postneonatal mortality	9.3	2.3	4.6	13.9	25.3
Infant mortality	26.1	3.9	18.2	34.0	15.0
Child mortality	11.4	2.2	6.9	15.9	19.7
Under-5 mortality	37.2	4.1	29.0	45.5	11.1

To help understand the reliability of the estimates in the second column, any one of the standard error (std. error), 95% confidence interval (95% CI) or relative standard error (RSE [%]) can be used, although the last two options can generally provide the quickest interpretation of an estimate's accuracy. To understand these, a brief description is provided below.

95% CI: For any given statistic calculated from a sample survey, the value of that statistic will fall within a range of plus or minus two times the standard error of that statistic in 95% percent of all possible samples of identical size and design (the larger this range, the less reliable the estimate).

RSE (%): This is simply the standard error expressed as a percentage of the estimate (the larger this value, the less reliable the estimate).

Generally speaking, estimates with RSEs above 10% are considered usable, but should be used with care, while estimates with RSEs above 25%, should not be considered reliable. Given nearly all the estimates above have RSEs falling between 15% and 30%, it strongly suggested that estimates provided in this chapter should be used with great care.

8.2 EARLY CHILDHOOD MORTALITY RATES: LEVELS AND TRENDS

The 2006/2007 SIDHS collected birth histories from roughly 3,823 women. Early childhood mortality rates for the 15-year period preceding the survey are presented below by 5-year periods in Table 8.2.

Table 8.2: Early childhood mortality rates

Neonatal, postneonatal, infant, child, and under-5 mortality rates for five-year periods preceding the survey, Solomon Islands 2007

Years preceding the survey	Neonatal mortality (NN)	Postneonatal mortality (PNN) ¹	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
0–4 (2003–2007)	15	9	24	13	37
5–9 (1998–2003)	17	9	26	11	37
10–14 (1993–1998)	9	13	23	8	30

¹ Computed as the difference between the infant and neonatal mortality rates.

For the most recent period (i.e. zero to four years before the survey, reflecting roughly 2003–2007), the infant mortality rate is 24 deaths per 1,000 live births. This means that 24 in every 1,000 babies born in Solomon Islands do not live to their first birthday. Of those who survive to the first birthday, 13 out of 1,000 would die before reaching their fifth birthday. The overall under-5 mortality rate is 37 deaths per 1,000 live births, which implies that 37 in every 1,000 Solomon Islands babies do not survive to their fifth birthday.

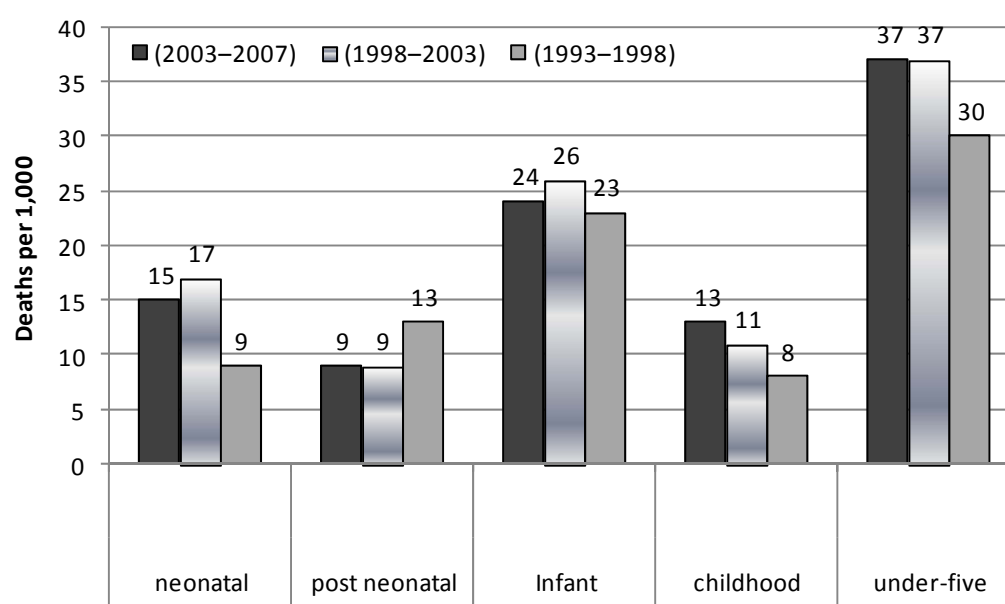
The first month of life is associated with the highest risk to survival. The neonatal mortality rate is 15 deaths per 1,000 live births, implying that 15 out of every 1,000 infant deaths occur during the first month of life. As childhood mortality declines, postneonatal mortality usually declines faster than the neonatal mortality because neonatal mortality is frequently caused by biological factors that are not easily addressed by primary care interventions. In Solomon Islands, postneonatal mortality is 9 per 1,000 births among infants.

The mortality estimates presented in Table 8.1 for the period 1998–2003 increased from low levels observed for period 1993–1998. For example, a high level increase is observed in neonatal deaths between 1993 and 1998 and between 1998 and 2003, from 9 deaths per 1,000 live births to 17 deaths per 1,000. This is nearly twice the number of deaths, and is the main reason for the increase in infant mortality in Solomon Islands babies during the same period.

Early age mortality estimates derived from the 1999 census data indicate an infant mortality rate of 66 deaths per 1,000 births for Solomon Islands. The 2006/2007 SIDHS estimated the IMR to be 24 infant deaths per 1,000 for the most recent period (0–4 years before the DHS), indicating a massive 64% decline in the IMR level from the 1999 level. Whether this decline is a direct result of interventions to reduce early age mortality in Solomon Islands or is a result of data errors needs to be investigated further. It is important for users of the SIDHS data to know that early age mortality, including IMR estimates, are based on an 87% response rate of all eligible women selected in the DHS sample.

Data from the 2006/2007 SIDHS also show that the situation of childhood mortality in Solomon Islands perhaps worsened in the period 1998–2003, compared with the earlier period 1993–1998. This worsened situation is observed in neonatal, infant, childhood and under-5 mortality. For example, IMR increased from 23 infant deaths per 1,000 live births during the period 1993–1998 to 26 infant deaths per 1,000, while the rate for under-5 mortality increased from 30 to 37 deaths per 1,000 births (Fig. 8.1).

Figure 8.1: Mortality trends



8.3 EARLY CHILDHOOD MORTALITY BY SOCIOECONOMIC CHARACTERISTICS

Table 8.3 presents early childhood mortality rates in Solomon Islands by socioeconomic characteristics. The rates refer to the 10-year period from 1998–2007. As evidenced from sources such as censuses, there are differences between mortality levels in urban populations and mortality levels in rural populations. For example, the IMR in rural Solomon Islands during the 10-year period before the 2006/2007 DHS is 27 deaths per 1,000 births compared with 23 deaths per 1,000 births in urban areas. This rural IMR of 27 is above the national average of 24 deaths per 1,000 births. In terms of differentials by province, Malaita Province has estimates that are consistently higher than those for other provinces. Interestingly, the average mortality levels estimated for all ‘other provinces’ combined follows closely behind Malaita compared with other provinces (Fig 8.2).

A mother’s education level is typically associated with child survival. In general, children born to mothers with a secondary or higher education have by far the lowest rates for all types of childhood mortality while the opposite is true for mothers with low levels of education. Table 8.3 generally confirms that as the level of a mother’s education increases, the level of early age mortality decreases. There are, however, indications that this view is not true and could be due to data error (e.g. in the analysis of IMR). For instance, the estimated IMR for mothers with no education is 32, while it is 25 for mothers with a primary education, and increasing to 28 for mothers who have completed a secondary level education. A similar pattern is observed for postneonatal mortality. Similarly, the childhood mortality rate is higher for mothers with a primary level education than for mothers with no education.

Table 8.3: Early childhood mortality rates by socioeconomic characteristics

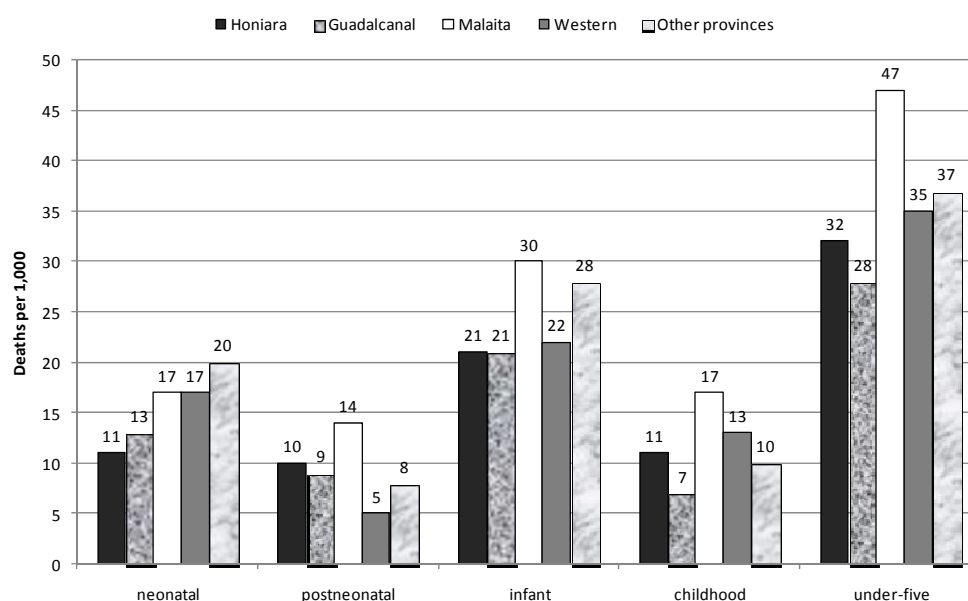
Neonatal, postneonatal, infant, child, and under-5 mortality rates for the 10-year period preceding the survey, by background characteristic, Solomon Islands 2007

Background characteristic	Neonatal mortality (NN)	Postneonatal mortality (PNN) ¹	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Residence					
Urban	15	8	23	8	31
Rural	17	9	27	12	38
Region					
Honiara	11	10	21	11	32
Guadalcanal	13	9	21	7	28
Malaita	17	14	30	17	47
Western	(17)	(5)	(22)	(13)	(35)
Other provinces	20	8	28	10	37
Mother's education					
No education	17	15	32	11	42
Primary	18	7	25	13	38
Secondary	15	13	28	5	33
More than secondary	*	*	*	*	*
Wealth quintile					
Lowest	8	8	16	10	26
Second	31	5	37	13	49
Middle	8	13	21	21	41
Fourth	21	14	35	3	38
Highest	17	6	23	11	33

Note: Figures in parentheses are based on 250–499 unweighted cases. An asterisk indicates that a figure is based on fewer than 250 unweighted cases and has been suppressed.

¹ Computed as the difference between infant and neonatal mortality rates.

It is generally observed that women's wealth status is inversely associated with childhood mortality. However, this general guide is not observed in the case of Solomon Islands as seen in Table 8.3. Children in the lowest wealth quintile households have the lowest mortality rates, while those in the second to fourth wealthiest quintile households have the highest mortality rates. As noted above, please use caution when interpreting these results due to under-coverage of respondents on which the rates are based.

Figure 8.2: Mortality levels by province

Similar to observations made in other DHSs and data from other sources, the mortality differentials observed by socioeconomic characteristics of the mother are greater for the neonatal period than for the postneonatal period. This is undoubtedly due to the fact that most causes of neonatal mortality are biologically related and are less amenable to socioeconomic interventions, whereas causes of postneonatal mortality are more related to standard of living factors. This means that efforts to reduce infant mortality in Solomon Islands will yield greater results if they are targeted at a mother's and household's behavioural factors. Thus, if the DHS data depict an accurate picture of the true level and trend of child mortality in Solomon Islands it then is safe to assume that besides education, the declining infant mortality could also be the result of government interventions that target issues related to a mother's and household's attitudes and practices.

However, evidence from the DHS standard error computation (see Appendix B on Estimates of sampling errors) shows that the childhood mortality decline is likely to be a result of data errors and therefore, users are urged to use caution when using the DHS derived indicators.

8.4 EARLY CHILDHOOD MORTALITY BY DEMOGRAPHIC CHARACTERISTICS

The demographic characteristics of both a mother and child have been found to play an important role in the survival probability of children. Table 8.4 presents early childhood mortality by a number of these characteristics, including the sex of the child, mother's age at birth, birth order, and previous birth interval for the 10-year period before the survey.

The IMR estimated from the 2006/2007 SIDHS for females is 14% higher than that for males (i.e. 28 deaths per 1,000 for females and 24 deaths per 1,000 for males). This contradicts the otherwise commonly observed pattern in most countries of the world of higher male than female child mortality rates.

The results in Table 8.4 do not agree with the traditional hypothesis of 'too early and too late increases child's mortality.' According to the 2006/2007 SIDHS findings, children born 'too early' (i.e. mothers who are less than age 20) are not disadvantaged compared with children born to mothers between the ages of 20 and 39. Given that the sample was too small, the hypothesis that 'too late increases child's mortality' could not be tested. The traditional view that children born to mothers who are less than 20 years of age have a higher risk of dying before one month of age compared with children born to mothers who are older does not appear to hold in Solomon Islands. *Caution must be used in interpreting these mortality measures as they are based on 87 out of 100 eligible women selected (87% response rate for women).*

Table 8.4: Early childhood mortality rates by demographic characteristics

Neonatal, postneonatal, infant, child, and under-5 mortality rates for the 10-year period preceding the survey, by demographic characteristics, Solomon Islands 2007

Demographic characteristic	Neonatal mortality (NN)	Postneonatal mortality (PNN) ¹	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Child's sex					
Male	18	6	24	13	36
Female	15	13	28	10	38
Mother's age at birth					
<20	13	6	18	5	23
20-29	15	9	24	13	37
30-39	23	13	36	9	45
40-49	*	*	*	*	*
Birth order					
1	23	5	28	4	32
2-3	12	10	21	18	39
4-6	18	14	32	8	40
7+	(19)	(0)	(19)	*	*

Table 8.4 (continued)

Demographic characteristic	Neonatal mortality (NN)	Postneonatal mortality (PNN) ¹	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Previous birth interval²					
<2 years	11	18	29	16	44
2 years	7	11	19	20	38
3 years	21	3	24	(10)	(34)
4+ years	25	6	31	6	37
Birth size³					
Small/very small	(30)	(2)	(32)	-	-
Average or larger	5	5	10	-	-
DK/Missing	*	*	*	-	-

Note: Figures in parentheses are based on 250–499 unweighted cases. An asterisk indicates that a figure is based on fewer than 250 unweighted cases and has been suppressed.

¹ Computed as the difference between the infant and neonatal mortality rates.

² Excludes first-order births.

³ Rates for the five-year period before the survey.

Birth order affects a child's chances of survival mostly during infancy, and for Solomon Islands the first birth is particularly at greater risk of mortality compared with higher order births. For example, in the case of neonatal mortality, the risk for a first order birth is 92% higher than the risk for birth orders 2–3. For those children surviving the neonatal period, the infant mortality rate increases for higher birth orders. In the case of under-5 mortality, there is little difference in mortality risks between second to sixth order births (39–40 deaths per 1,000) of dying before age 5 years. In Table 8.4, an asterisk in the column means these figures are based on fewer than 250 unweighted cases. The values for neonatal, postneonatal, and infant mortality for seventh and higher birth orders is in brackets because they are based on only 250–499 unweighted case, and should therefore be interpreted with caution.

The data in Table 8.4 also show that short birth intervals are associated with increased risk of mortality. For neonatal mortality, the shortest birth interval (i.e. less than two years) carries a high risk of mortality and the risk of mortality is generally observed to be high with each increase in the length of the birth interval. Again, this does not agree with the traditional view of decline in mortality risk for longer birth intervals. For infant and under-5 mortality, there appears to be little difference but this could be due to the very small sample size.

8.5 EARLY CHILDHOOD MORTALITY BY STATUS OF WOMEN

This section presents information on indicators of women's empowerment, presents three empowerment indices, and relates those indices to early childhood mortality outcomes. The Women's Questionnaire collected data on general background characteristics of female respondents (e.g. age, education, wealth quintile, employment status) and also data more specific to women's empowerment (e.g. household decision making and reasons for which wife-beating is justified). This section tabulates and presents early childhood mortality rates classified by two indicators of woman's empowerment: a woman's participation in household decision making, and her attitudes toward wife beating. That is, these measures of empowerment were developed based on the number of household decisions in which the respondent participates, and her opinion on the number of reasons that justify wife beating. These measures were used to cross-tabulate early childhood mortality indicators to determine the relationship between women's empowerment and childhood mortality outcomes as presented in Table 8.5.

Table 8.5: Early childhood mortality rates by women's status

Infant, child, and under-5 mortality rates for the 10-year period preceding the survey, by indicators of women's status, Solomon Islands 2007

Empowerment indicator	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Number of decisions in which women participate¹			
0	(50)	*	*
1–2	38	(12)	(49)
3–4	20	11	30
Number of reasons given for refusing to have sexual intercourse with husband²			
0	*	*	*
1–2	18	9	27
3	27	12	38
Number of reasons for which wife-beating is justified³			
0	29	18	47
1–2	16	6	23
3–4	26	8	34
5	(31)	(9)	(40)

Note: Figures in parentheses are based on 250–499 unweighted cases. An asterisk indicates that a figure is based on fewer than 250 unweighted cases and has been suppressed.

¹ Restricted to currently married women. See Table 14.5 for the list of decisions.

² See Table 14.7 for the list of reasons.

³ See Table 14.9 for the list of reasons.

With regards to participating in the decision-making process in the household, there is some correlation between a woman's empowerment and early childhood mortality. For example, Table 8.5 shows that the probability of babies dying before reaching their first birthday is high among babies born to mothers who have participate very little in decision making compared with babies born to mothers who participate in three to four decision-making opportunities. Whether the high levels of IMR observed are correlated to non-participation in decision making is uncertain.

The 2006/2007 SIDHS also gathered information on women's attitudes toward wife beating, a proxy for women's perception of their status. Women who believe that a husband is justified in hitting or beating his wife for any of the specified reason may believe themselves to be low in status, both absolutely and relative to men. Such a perception could act as a barrier to accessing health care for themselves and their children, affect their attitude toward contraceptive use, and impact their general well-being. Women were asked whether a husband is justified in beating his wife under a series of circumstances, including: if the wife burns the food, argues with him, goes out without telling him, neglects the children, and refuses sexual relations, among others. Cross-tabulation of early childhood mortality by this empowerment indicator (Table 8.5) shows no clear pattern, although the probability of babies dying before reaching their first birthday is high among babies born to mothers who provided zero or three or more reasons for husbands beating their wives compared with those born to mothers who provided one to two reasons for wife beating. This may suggest that there is very little or no correlation between wife beating and infant mortality.

8.6 PERINATAL MORTALITY

In the 2006/2007 SIDHS, women were asked to report all pregnancy losses in the five years before the survey. The duration of each such pregnancy was recorded. In this report, perinatal deaths include pregnancy losses occurring after seven completed months of gestation (stillbirths) and deaths to live births within the first seven days of life (early neonatal deaths). The distinction between a stillbirth and an early neonatal death may be a fine one, depending often on the observed presence or absence of some faint signs of life after birth. Causes of stillbirths and early neonatal deaths are overlapping, and examining just one or the other can understate the true level

of mortality around the time of delivery. For this reason, in this report, both event types are combined and examined together.

The perinatal mortality rate is the sum of the number of stillbirths and early neonatal deaths divided by the number of pregnancies of seven or more months' duration. The perinatal mortality rate is a useful indicator of the state of delivery services, both in terms of their use and their quality (i.e. the degree to which complications arising during childbirth and the immediate postpartum are prevented or managed effectively). Data in Table 8.6 show that overall, the survey recorded 38 perinatal deaths, of which 4 were stillbirths and 34 were early neonatal deaths, resulting in a perinatal mortality rate in Solomon Islands of 14 per 1,000 pregnancies.

Perinatal mortality is highest among women in the youngest age group, decreasing in the next age group and increasing as the age of mothers increases. Table 8.6 further demonstrates that the duration of the previous pregnancy interval is related to pregnancy outcome. Pregnancies occurring within 39 months of a previous birth and first pregnancies have the highest risk of pregnancy loss or early death (17 and 26 pregnancy losses or early deaths per 1,000 pregnancies, respectively). Contrary to best practice recommendations, a birth interval of 39 months and more does not appear to be the safest pregnancy interval, therefore, caution must be taken in interpreting DHS results.

The perinatal mortality rate in rural areas is low compared with urban areas (14 pregnancy losses or early deaths per 1,000, compared with 16 per 1,000 in urban areas). In other words, the risk of pregnancy loss in rural areas is 13% lower than the risk in urban areas. In terms of differential by provinces, Malaita and Western provinces had equally more early deaths per 1,000 births than the other provinces.

Table 8.6: Perinatal mortality

Number of stillbirths and early neonatal deaths, and the perinatal mortality rate for the five-year period preceding the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Number of stillbirths ¹	Number of early neonatal deaths ²	Perinatal mortality rate ³	Number of pregnancies of 7+ months duration
Mother's age at birth				
<20	0	5	21	253
20–29	2	17	12	1,567
30–39	2	10	16	757
40–49	0	1	18	95
Previous pregnancy interval in months⁴				
First pregnancy	2	13	26	572
<15	0	0	0	95
15–26	1	6	10	683
27–38	1	4	8	583
39+	1	11	17	739
Residence				
Urban	1	4	16	331
Rural	3	30	14	2,341
Region				
Honiara	1	2	13	250
Guadalcanal	0	3	6	483
Malaita	2	14	22	679
Western	0	6	22	289
Other provinces	1	10	12	970

Table 8.6 (continued)

Background characteristic	Number of stillbirths ¹	Number of early neonatal deaths ²	Perinatal mortality rate ³	Number of pregnancies of 7+ months duration
Mother's education				
No education	1	6	18	373
Primary	2	23	15	1,664
Secondary	2	5	11	573
More than secondary	0	0	7	62
Wealth quintile				
Lowest	0	5	8	647
Second	2	10	22	554
Middle	0	2	5	484
Fourth	1	13	26	514
Highest	1	5	11	473
Total	4	34	14	2,672

¹ Stillbirths are foetal deaths in pregnancies lasting seven or more months.

² Early neonatal deaths are deaths at age 0–6 days among live-born children.

³ The sum of the number of stillbirths and early neonatal deaths divided by the number of pregnancies of seven or more months' duration, expressed per 1,000.

⁴ Categories correspond to birth intervals of <24 months, 24–35 months, 36–47 months, and 48+ months.

Table 8.6 indicates that in Solomon Islands, a mother's education level determines the level of perinatal mortality as the differences of the perinatal mortality rate by level of education are big but do not show a consistent trend by level of education, for example, the rate for mothers with no education is higher (18 losses or early deaths per 1,000) than for those with more than secondary education (7 pregnancy losses or early deaths per 1,000). Similarly, there is no clear relationship between the wealth quintiles and the level of perinatal mortality, except that perinatal mortality is highest among the fourth and second quintile households.

8.7 HIGH-RISK FERTILITY BEHAVIOUR

The 2006/2007 SIDHS examined the relative importance of maternal fertility patterns associated with the increased risk of mortality. Generally, infants and children have a greater probability of dying if they are born to mothers who are too old or too young, if they are born after a short birth interval, or if they are of high birth order. In analysing the effects of high-risk fertility behaviour on child survival, a mother is classified as too young if she is less than 18 years, and too old if she is over 34 years at the time she gives birth. A short birth interval is defined as a birth occurring less than 24 months after the previous birth, and a child is of high birth order if the mother previously gave birth to three or more children (i.e. if the child is of birth order 4 or higher).

Table 8.7 shows the percent distribution of births in the five-year period before the survey according to these elevated risk factors. The table also examines the relative risk of children dying by comparing the proportion dead in each specified high-risk category with the proportion dead among children not in any high-risk category. Although first births are commonly associated with increased risk of mortality, they are not included in any high-risk category because they are considered an unavoidable risk.

Only 27% of births in Solomon Islands are not in any high-risk category. An additional 19% of births are first order births to mothers aged 18–34 (considered an unavoidable risk category). The remaining 55% of births are in at least one of the specified avoidable high-risk categories. Over one-third of births (37%) are in only one of the high-risk categories — mostly high birth orders greater than 3 (24%) and short birth intervals less than 24 months (9%) — while 18% are in multiple high-risk categories. Births in multiple high-risk categories are mostly found in two combinations: age more than 34 years and birth order higher than 3; and birth order higher than 3 with a birth interval less than 24 months (7% of births).

The second column of Table 8.7 shows that the risk of dying for a child who falls within an avoidable high-risk category is 1.09 times higher than that for a child who is not within a high-risk category. Children in a single high-risk category had a slightly higher (1%) mortality risk, while the mortality risk for children in multiple high-risk categories is almost 26% higher than the risk for children not in any high-risk category.

The single high-risk category associated with the highest risk ratio is a birth interval less than 24 months. Children born less than 24 months after a previous birth have a 90% higher risk of dying than children not in any high-risk category. It is important to note that the proportion of births that are first order births may be higher among women aged 34 and over than among younger women (because the level of fertility was high when these women had their first birth experience). The second highest risk is associated when a mother's age is greater than 34 (61% higher risk). While high birth order is generally considered a high-risk category, Table 8.7 shows that in Solomon Islands, children of birth order 3 or higher actually have a somewhat lower mortality risk (0.70) than children not in any high-risk category (1.00).

The category with the highest multiple risks is for births with the three risk factors combined; that is, children born to older women (aged 34 or older) with a short birth interval of less than 24 months, and of births order 3 and higher have a 81% higher risk of mortality than children not in any of these high-risk categories. However, this category involves only 3.3% of births. Among the multiple high-risk categories with the highest percentage of births, mothers who are aged 34 and over and higher birth orders increases the mortality risk by 11%.

Table 8.7: High-risk fertility behaviour

Percent distribution of children born in the five years preceding the survey by category of elevated risk of mortality and the risk ratio, and percent distribution of currently married women by category of risk if they were to conceive a child at the time of the survey, Solomon Islands 2007

Risk category	Births in the five years preceding the survey		Percentage of currently married women ¹
	Percentage of births	Risk ratio	
Not in any high risk category	26.6	1.00	29.9 ^a
Unavoidable risk category			
First order births between ages 18 and 34 years	18.5	1.03	7.5
Single high-risk category			
Mothers's age <18	3.3	0.55	0.3
Mothers's age >34	1.0	(1.61)	3.9
Birth interval <24 months	9.1	1.90	7.9
Birth order >3	23.6	0.70	13.8
Subtotal	36.9	1.01	26.0
Multiple high-risk category²			
Age <18 and birth interval <24 months	0.2	*	0.3
Age >34 and birth interval <24 months	0.0	*	0.2
Age >34 and birth order >3	9.3	1.11	23.2
Age >34 and birth interval <24 months and birth order >3	1.2	(1.81)	3.3
Birth interval <24 months and birth order >3	7.2	1.40	9.7
Subtotal	17.9	1.26	36.6
In any avoidable high-risk category	54.8	1.09	62.6
Total	100.0	na	100.0
Number of births/women	2,668	na	2,560

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed. Risk ratio is the ratio of the proportion dead among births in a specific high-risk category to the proportion dead among births not in any high-risk category.

na = not applicable

¹ Women are assigned to risk categories according to the status they would have at the birth of a child if they were to conceive at the time of the survey: current age less than 17 years and 3 months or older than 34 years and 2 months, latest birth less than 15 months ago, or latest birth being of order 3 or higher.

² Includes the category age <18 and birth order >3.

a = includes sterilised women

Table 8.7 also shows the potential for high-risk births among currently married women. A woman's current age, time elapsed since last birth, and parity are used to determine the risk categories in which any birth she conceived at the time of the survey would fall. In the final data processing, the criteria for placing women into specific risk categories are adjusted to take into account the gestation period.

Three in ten (30%) currently married women in Solomon Islands are not in any high-risk category, while over half (63%) have the potential of giving birth to a child exposed to a higher-risk of mortality, with over one-third (37%) of married women falling into multiple high-risk categories.

8.8 KEY RESULTS

Evidence from the 2006/2007 SIDHS points to a much lower IMR (24) than the situation reported by the 1999 census (66). Even allowing for significant sampling errors — which are reflected in the high relative standard error and wide confidence interval (14.4–34.2) — and for non-sampling errors — such as the under-recording of infant deaths in the survey operation — we can say with some confidence that improvements in infant and child health have taken place since 1999.

What we cannot say for certain, is that the current IMR actually equals 24. We cannot ascertain the magnitude of this change, as years of civil unrest in the lead-up to the 1999 census caused an almost complete breakdown in government service provisions, including health, in many parts of Solomon Islands. All of this could have contributed to a much higher IMR in 1999 than one would have encountered under more peaceful circumstances. The 1999 Vanuatu IMR of 27/1,000 lends support to such reasoning. Vanuatu is a neighbouring Melanesian country facing similar challenges in health services provision as well as endemic malaria such as in Solomon Islands.

The 2006/2007 SIDHS examined the relative importance of maternal fertility patterns associated with the increased risk of mortality. Generally, infants and children have a greater probability of dying if they are 1) born to mothers who are too old or too young, 2) born after a short birth interval, or 3) are of high birth order.

In the analysis of the effects of high-risk fertility behaviour on child survival, a mother is classified as being too young if she is less than 18 years of age, and too old if she is over 34 years of age at the time of birth. A short birth interval is defined as a birth occurring less than 24 months after the previous birth, and a child is of high birth order if the mother has previously given birth to three or more children (i.e. if the child is of birth order 4 or higher).

The 2006/2007 SIDHS findings show that:

- only 27% of births in Solomon Islands were not in any high-risk category;
- an additional 19% of births are first order births to mothers aged 18–34, which is considered an unavoidable risk category;
- the remaining 55% of births are in at least one of the specified avoidable high-risk categories:
 - a. Over one-third of births (37%) are in only one of the high-risk categories; mostly birth order 3 or higher (24%), and for birth intervals less than 24 months (9%); while 18% are in multiple high-risk categories.
 - b. Births in multiple high-risk categories are mostly found in two combinations: 1) age greater than 34 years and birth order higher than 3; and 2) birth order higher than 3 with birth intervals less than 24 months (7% of births).

Expected correlation	SIDHS confirms expected correlation (Yes/No/Partially)
Level of child mortality	
Early childhood mortality rates are higher for males than females	Yes
Early childhood mortality rates are higher in the rural than urban areas	Yes
Early childhood mortality rates decreases with increased level of education of mothers	Partially
Early childhood mortality rates decreases with increased level of wealth of women	No
Early childhood mortality rates is higher if mother is younger than age 20	No
Early childhood mortality rates is higher if mother is older than age 40	No
Early childhood mortality rates is higher at first birth	No
Early childhood mortality rates is higher if birth interval is less than 2 years	Partially
Early childhood mortality rates decreases with increased status of women	No
Perinatal mortality	
Perinatal mortality is higher among women in the youngest age group	Yes
Perinatal mortality is higher among women first pregnancy	Yes
Perinatal mortality is higher if pregnancy interval is within 39 months of previous birth	Partially
Perinatal mortality is higher in the rural than urban areas	Yes
Perinatal mortality is higher among women in the oldest age group	Partially
Perinatal mortality decreases with increased level of education of mothers	Yes
Perinatal mortality decreases with increased level of wealth of women	No

CHAPTER 9 REPRODUCTIVE HEALTH

Reproductive health is an important part of the healthcare system and is aimed at reducing pregnancy-related morbidity and mortality. The health care that a woman receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and well-being of both the mother and child. Solomon Islands is committed to the Millennium Development Goals (MDGs), and has developed various policies and strategies to this end. The MDGs call for a three-quarter reduction in maternal mortality, and for universal access to reproductive health services by 2015. This chapter presents findings on several aspects of maternal health for Solomon Islands: antenatal, delivery and postnatal care, as well as problems in accessing health care. The Ministry of Health and Medical Services is working toward better access and higher quality services to improve maternal health. The Ministry is trying to improve comprehensive and basic emergency obstetric care, facilitate human resource development, and upgrade the skills of skilled birth attendants.

Information on antenatal, delivery and postnatal care is of great value in identifying subgroups of women who do not use such services, and is useful in planning for improvements in service delivery. In this chapter, information on antenatal care (ANC) is shown according to the number of ANC visits made, the stage of pregnancy at the time of the first visit, the type of provider, and the specific services and information provided during ANC visits, including whether tetanus toxoid was received. Similarly, delivery services are described according to the place of the delivery, the type of person assisting the delivery, and the number of caesarean sections. Information on postnatal care is shown by whether a woman gave birth in a healthcare facility or elsewhere, and describes the time since delivery of the first postnatal care, and from whom it was received. This information helps identify population groups that are underserved by maternity care services, and highlights access and barriers to use of health services.

9.1 ANTENATAL CARE

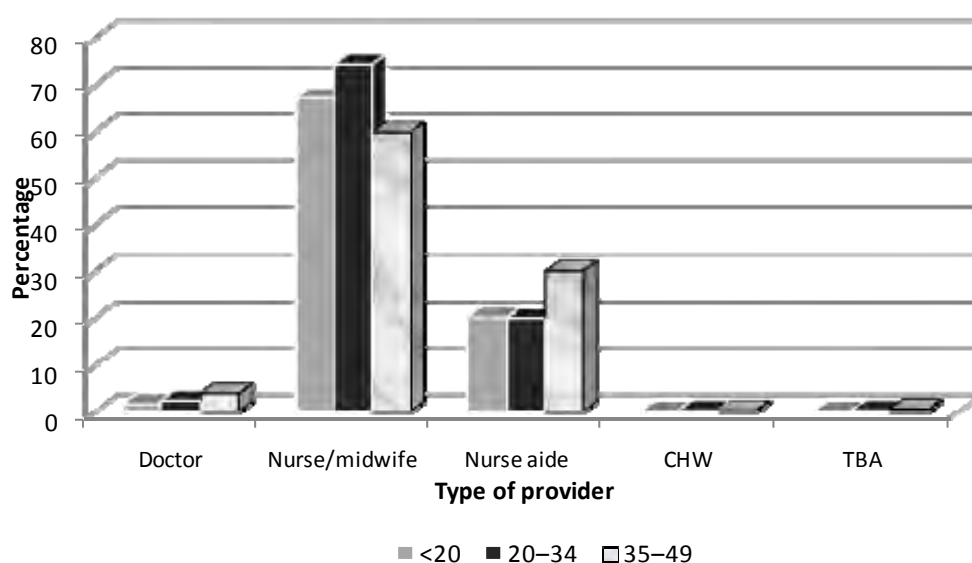
The major objective of ANC is to identify and treat problems during pregnancy, such as anaemia and infections. It is during an ANC visit that screening for complications, and advice on a range of issues, including place of delivery and referral of mothers with complications occur. In the 2006/2007 SIDHS, interviewers recorded the source of ANC and the person who provided that care for a woman's most recent births. If a woman received ANC from more than one provider, the provider with the highest qualifications was recorded.

Table 9.1 shows the background characteristics of women who had live births in the five years preceding the survey according to the type of ANC provider. The results indicate that 95% of women received ANC from a skilled provider. Most of these women (72%) sought care from a nurse or midwife, and 2% received care from a doctor. Less than 1% of women received ANC from a traditional birth attendant as their most qualified provider. About 3% of women who gave birth in the five years preceding the survey received no ANC.

Data in Table 9.1 and Figure 9.1 further indicate that the choice of ANC provider varies slightly by the mother's age. Mothers aged 20–34 are more likely than younger mothers to receive ANC from a skilled provider, particularly a nurse/midwife (96% compared with 89% of mothers aged less than 20).

Attendance at ANC did not differ substantially by birth order.

Figure 9.1: Percentage receiving ANC by provider according to age group



CHW=community healthcare worker
TBA=traditional birth attendant

Almost all women in urban and rural areas (95%) receive ANC from a skilled provider. Women in Honiara and Guadalcanal have a slightly lower percentage of delivery attendance by a skilled health provider than women in other provinces.

ANC coverage is associated with women's educational attainment. Better educated women are more likely to seek ANC and more likely to be attended to by a doctor than less educated women. Over 12% of women with a secondary level of education or higher received ANC from a doctor; the corresponding proportion for women with just a primary education is only 3%. In addition, % of women with no education received no ANC compared with only 2% who had a secondary level education and above.

Similarly, ANC is associated with wealth. Women in the highest wealth quintile were more likely to be attended to by a doctor than women in the lowest wealth quintiles. Less than 6% of women in the lowest quintile received no antenatal care compared with only 1–3% of women in the other wealth quintiles.

Table 9.1: Antenatal care

Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by an antenatal care (ANC) provider during pregnancy for the most recent birth, and the percentage receiving ANC from a skilled provider for the most recent birth, according to background characteristics, Solomon Islands 2007

Background characteristic	Doctor	Nurse/ midwife	Nurse aide	Community health worker	Traditional birth attendant	Other	No one	Missing	Total	Percentage receiving antenatal care from a skilled provider ¹	Number of women
Mother's age at birth											
<20	1.6	66.9	20.0	0.0	0.0	0.1	9.5	1.8	100.0	88.5	148
20–34	2.3	74.1	19.7	0.2	0.2	0.7	2.1	0.7	100.0	96.1	1,404
35–49	3.8	59.7	29.9	0.2	0.5	1.3	3.2	1.3	100.0	93.5	247
Birth order											
1	1.1	74.0	20.7	0.0	0.2	0.4	2.9	0.7	100.0	95.8	341
2–3	3.6	70.7	19.1	0.1	0.0	1.2	4.1	1.2	100.0	93.4	652
4–5	1.8	76.5	18.5	0.4	0.4	0.6	1.0	0.9	100.0	96.7	488
6+	2.4	63.2	29.9	0.3	0.4	0.3	3.0	0.7	100.0	95.5	318
Residence											
Urban	4.7	79.6	10.5	0.3	0.1	2.4	2.0	0.6	100.0	94.7	236
Rural	2.1	70.3	22.8	0.2	0.2	0.5	3.0	1.0	100.0	95.2	1,562
Region											
Honiara	3.9	79.9	9.7	0.4	0.1	3.1	2.2	0.7	100.0	93.4	178
Guadalcanal	4.0	63.0	26.7	0.4	1.1	0.1	4.1	0.6	100.0	93.7	323
Malaita	3.0	66.5	25.9	0.2	0.0	0.0	2.4	2.0	100.0	95.4	420
Western	5.6	75.4	13.6	0.0	0.0	0.0	4.0	1.5	100.0	94.5	208
Other provinces	0.0	75.4	20.9	0.1	0.0	1.1	2.3	0.3	100.0	96.3	671
Mother's education											
No education	3.2	59.3	31.3	0.0	0.5	0.1	4.8	0.7	100.0	93.8	243
Primary	2.1	73.5	20.0	0.2	0.1	0.5	2.9	0.8	100.0	95.5	1,104
Secondary	2.1	73.6	19.1	0.2	0.4	1.8	1.5	1.3	100.0	94.7	406
More than secondary	10.4	70.6	14.3	0.0	0.0	1.1	2.0	1.7	100.0	95.3	46
Wealth quintile											
Lowest	1.6	62.4	28.0	0.1	0.7	0.1	5.9	1.1	100.0	92.1	412
Second	1.4	71.3	24.2	0.3	0.0	0.5	1.9	0.4	100.0	96.9	367
Middle	1.8	71.3	24.5	0.0	0.2	0.0	1.2	1.1	100.0	97.6	326
Fourth	2.9	77.3	13.4	0.2	0.0	1.7	2.9	1.6	100.0	93.6	363
Highest	4.7	77.1	14.4	0.4	0.0	1.5	1.5	0.4	100.0	96.2	330
Total	2.4	71.5	21.1	0.2	0.2	0.7	2.8	0.9	100.0	95.1	1,799

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications was considered in this tabulation.

¹ Skilled provider includes doctor, nurse, midwife, and auxiliary nurse/midwife.

9.1.1 Number of antenatal care visits and timing of the first visit

In line with WHO guidelines, the Solomon Islands Ministry of Health and Medical Services recommends that a woman who is having a normal pregnancy should attend four ANC visits, the first of which should take place during the first trimester. Information on ANC visits and the stage at which pregnant women seek ANC is presented in Table 9.1.1. Almost two out of three women (65%) receive four or more visits for ANC, while almost 20% do not receive the recommended number of ANC visits.

Table 9.1.1 further shows that only 15% of pregnant women receive their first visit during the first three months of pregnancy. A high proportion of women (43%) make their first ANC visit during the fourth or fifth month of pregnancy, while 30% make their first visit during the sixth month of pregnancy or later. The median gestational age when women make their first visit is 5.6 months, when the opportunity may have passed to diagnose problems early, provide treatment, and prevent complications.

Table 9.1.1: Number of antenatal care visits and timing of first visit

Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by number of antenatal care (ANC) visits for the most recent live birth, and by the timing of the first visit, and among women with ANC, median months pregnant at first visit, according to residence, Solomon Islands 2007

Number and timing of ANC visits	Residence		Total
	Urban	Rural	
Number of ANC visits			
None	2.0	3.0	2.8
1	2.4	2.7	2.7
2–3	19.3	11.5	12.6
4+	58.8	65.5	64.6
Don't know/missing	17.6	17.3	17.4
Total	100.0	100.0	100.0
Number of months pregnant at time of first ANC visit			
No antenatal care	2.0	3.0	2.8
<4	11.2	15.8	15.2
4–5	33.9	44.4	43.0
6–7	42.7	28.5	30.4
8+	8.4	5.4	5.8
Don't know/missing	1.9	2.9	2.8
Total	100.0	100.0	100.0
Number of women	236	1,562	1,799
Median months pregnant at first visit (for those with ANC)	6.1	5.5	5.6
Number of women with ANC	230	1,501	1,731

Table 9.1.2: Components of antenatal care

Among women age 15-49 with a live birth in the five years preceding the survey, the percentage who took iron tablets or syrup and drugs for intestinal parasites during the pregnancy of the most recent birth, and among women receiving antenatal care (ANC) for the most recent live birth in the five years preceding the survey, the percentage receiving specific antenatal services, according to background characteristics, Solomon Islands 2007

Background characteristic	Among women with a live birth in the last five years, the percentage who during the pregnancy of their last birth:			Among women who received antenatal care for their most recent birth in the last five years, the percentage with selected services:					
	Took iron tablets or syrup	Took intestinal parasite drugs	Number of women with a live birth in the last five years	Informed of signs of pregnancy complications	Weighed	Blood pressure measured	Urine sample taken	Blood sample taken	Number of women with ANC for their most recent birth
Mother's age at birth									
<20	89.0	37.2	148	50.1	96.7	100.0	87.9	80.4	131
20-34	92.0	40.8	1,404	55.7	98.9	98.8	91.1	78.2	1,365
35-49	89.8	51.6	247	51.8	99.0	99.6	89.6	80.9	236
Birth order									
1	91.5	34.7	341	51.9	98.4	99.5	92.0	84.8	329
2-3	91.3	39.6	652	55.8	98.9	98.9	91.8	75.2	618
4-5	91.9	46.3	488	54.9	98.6	98.5	89.3	79.4	479
6+	91.3	48.2	318	55.4	99.1	99.2	89.1	78.1	306
Residence									
Urban	90.0	30.0	236	59.9	99.6	99.6	98.6	98.2	230
Rural	91.7	43.8	1,562	54.0	98.6	98.9	89.4	75.7	1,501
Region									
Honiara	87.9	27.9	178	56.6	99.5	99.5	99.3	98.1	172
Guadalcanal	91.6	50.9	323	73.1	98.2	97.7	95.7	89.6	307
Malaita	91.8	20.0	420	42.1	98.0	98.2	73.8	79.6	401
Western	89.3	63.6	208	60.0	99.3	99.6	96.6	84.3	197
Other provinces	92.8	48.4	671	51.9	99.2	99.7	94.6	66.2	654
Mother's education									
No education	89.7	27.0	243	48.5	98.5	98.2	81.2	79.2	230
Primary	92.1	45.8	1,104	55.3	98.6	99.1	90.4	77.0	1,064
Secondary	91.3	41.1	406	56.8	99.1	99.0	96.1	81.1	394
More than secondary	87.1	37.1	46	55.5	99.0	99.2	98.2	96.3	44
Wealth quintile									
Lowest	91.8	37.3	412	52.6	97.7	98.2	87.7	64.2	383
Second	90.6	50.1	367	62.8	98.9	99.5	94.8	80.7	358
Middle	90.3	40.1	326	48.3	99.2	98.1	84.4	80.8	319
Fourth	92.3	42.8	363	48.1	99.5	100.0	91.1	78.5	347
Highest	92.4	39.7	330	62.0	98.6	99.0	95.3	91.8	324
Total	91.5	42.0	1,799	54.8	98.7	99.0	90.7	78.7	1,731

9.1.2 Quality of Antenatal care

The Solomon Islands Obstetrics Guidelines (MOH 2007) provide details of what is to be done by a health service provider during antenatal care. Most health workers have been trained to offer the package.

Table 9.1.2 shows the percentage of mothers who receive ANC by content of ANC and background characteristics. The results show that the majority of women receive the minimum ANC. In general, 96% of women with a live birth in the last five years received some form of ANC for their most recent birth. The majority of women (92%) who gave birth in the five years preceding the survey took iron tablets or syrup during their last pregnancy. Almost all women (99%) who received ANC for their most recent birth in the past five years, had their weight measured during the pregnancy and their blood pressure taken. A urine sample was taken from 91% of women during an ANC, while a blood sample was taken from 79% of women. Only 55% of women received information on how to recognise signs of problems during pregnancy. Only 42% took drugs for intestinal parasites.

In summary, the results show that a full range of ANC is being provided. While the rate of coverage of four or more ANC visits is fairly high, concerted efforts are needed to improve the timing of visits and quality of ANC, especially education about early signs of pregnancy complications and the provision of antihelminthic drugs.

9.1.3 Tetanus toxoid immunisation

Neonatal tetanus is a leading cause of neonatal death in developing countries, where a high proportion of deliveries are conducted at home or in places where hygienic conditions may be poor. Tetanus toxoid (TT) immunisation is given to pregnant women to prevent neonatal tetanus. For full protection, a pregnant woman needs two doses of TT during pregnancy. However, if a woman was immunised before she became pregnant, she may require one or no TT injections during pregnancy, depending on the number of injections she has received and the timing of the last injection.

For a woman to have lifetime protection, a total of five doses are required. The 2006/2007 SIDHS collected data on whether or not women received at least two TT injections during pregnancy, and whether or not the pregnancy was protected against neonatal tetanus for women's most recent live birth in the five years preceding the survey. Table 9.1.3 shows that only 26% of pregnant women received two or more TT injections during their last pregnancy. However, 52% of women during their last pregnancy were protected against neonatal tetanus because of their previous immunisation. Younger women and women pregnant with lower order births are more likely to receive two TT injections during their pregnancy. However, the likelihood of having a pregnancy that is protected against neonatal tetanus does not appear to decline with mother's age at birth, and women who are pregnant with their first child are actually less likely to have their pregnancy protected against neonatal tetanus than women with 2–3 children. Previous pregnancies as well as increasing age may expose women to opportunities to receive TT injections that also contribute to protecting their later pregnancies.

Therefore, older and higher parity women may be less likely to require two TT injections during pregnancy in order for their pregnancies to be protected against neonatal tetanus.

Women in urban and rural areas are almost equally likely to have their last pregnancy protected against neonatal tetanus (48% urban, 53% rural). The proportion of women whose last pregnancy was protected against neonatal tetanus was highest in other provinces (67%). The proportion of women who had their last pregnancy protected against neonatal tetanus was lowest in Malaita and Western provinces. The likelihood of having the last pregnancy protected against neonatal tetanus increases with educational attainment but is variable across wealth quintiles.

Table 9.1.3: Tetanus toxoid injections

Among mothers aged 15–49 with a live birth in the five years preceding the survey, the percentage receiving two or more tetanus toxoid injections during the pregnancy for the last live birth, and the percentage whose last live birth was protected against neonatal tetanus, according to background characteristics, Solomon Islands 2007

Background characteristic	Percentage receiving two or more injections during last pregnancy	Percentage whose last birth was protected against neonatal tetanus ¹	Number of mothers
Mother's age at birth			
<20	31.7	46.8	148
20–34	25.7	53.1	1,404
35–49	23.7	48.6	247
Birth order			
1	41.5	51.3	341
2–3	26.5	54.9	652
4–5	20.6	51.0	488
6+	16.2	48.3	318
Residence			
Urban	26.4	47.6	236
Rural	25.9	52.6	1,562
Region			
Honiara	27.6	51.0	178
Guadalcanal	28.4	53.0	323
Malaita	19.2	29.4	420
Western	25.1	47.6	208
Other provinces	28.8	67.2	671
Mother's education			
No education	26.5	42.5	243
Primary	24.7	52.2	1,104
Secondary	29.2	56.8	406
More than secondary	23.2	54.6	46
Wealth quintile			
Lowest	22.1	59.3	412
Second	31.0	51.6	367
Middle	22.6	45.4	326
Fourth	26.7	47.2	363
Highest	27.6	54.9	330
Total	25.9	52.0	1,799

¹ Includes mothers with two injections during the pregnancy of her last birth, or two or more injections (the last within three years of the last live birth), or three or more injections (the last within five years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections prior to the last birth.

9.2 CHILDBIRTH CARE

Some of the factors associated with birth outcome include the place where a mother delivers her baby, the disinfection practices used there, the equipment available, and the skills and performance of those who assist the woman. Table 9.2 shows the percent distribution of live births in the five years preceding the survey by place of delivery and background characteristics of the mother.

Overall, 85% of births occurred at health facilities, and 14% of births took place at home. According to Table 9.2, births to younger women and lower order births are more likely to take place in a healthcare facility than births to older women and higher order births. For example, 81% of births to mothers aged 35–49 took place at a healthcare facility, whereas the corresponding figure for births to women under age 20 old is 88%. Similarly, 92% of first order births occurred at health facilities, compared with 82% of sixth and higher order births.

ANC attendance is related to place of childbirth. As expected, births to women who made four or more ANC visits are more likely to occur in a healthcare facility (88%) than births to women who did not attend antenatal care (53%).

The proportion of births occurring in a healthcare facility is much higher in urban areas (94%) than in rural areas (83%). Births in Honiara, Western and other provinces are more likely to take place in a healthcare facility (94%, 92% and 91%, respectively) compared with Guadalcanal (68%) and Malaita 80%) provinces.

Births to mothers with a secondary or higher education are more likely to occur in a healthcare facility (92%) than births to women with no education (67%). A woman's wealth status also has a direct correlation with the place where she gives birth to her baby. The proportion of births in a healthcare facility increases with increasing wealth quintile: 74% in the lowest wealth quintile to 94% in the highest quintile.

Table 9.2: Place of delivery

Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a healthcare facility, according to background characteristics, Solomon Islands 2007

Background characteristic	Healthcare facility					Total	Percentage delivered in a healthcare facility	Number of births
	Public sector	Private sector	Home	Other	Missing			
Mother's age at birth								
<20	82.8	5.0	10.1	0.0	2.0	100.0	87.8	253
20–34	78.9	5.8	14.1	0.1	1.0	100.0	84.7	2,107
35–49	75.6	4.9	18.0	0.0	1.5	100.0	80.5	308
Birth order								
1	85.1	6.6	7.1	0.1	1.2	100.0	91.7	577
2–3	79.1	6.6	12.7	0.2	1.4	100.0	85.7	989
4–5	73.6	4.9	20.4	0.0	1.0	100.0	78.5	680
6+	78.3	3.2	17.5	0.0	1.0	100.0	81.5	422
Residence								
Urban	91.7	2.6	3.9	0.4	1.3	100.0	94.4	330
Rural	77.0	6.1	15.6	0.1	1.2	100.0	83.1	2,338
Region								
Honiara	92.0	1.5	4.2	0.6	1.7	100.0	93.5	249
Guadalcanal	68.3	0.0	29.3	0.0	2.4	100.0	68.3	483
Malaita	77.3	3.0	18.3	0.2	1.3	100.0	80.2	678
Western	66.0	26.0	6.1	0.0	1.8	100.0	92.0	289
Other provinces	85.7	5.3	8.8	0.0	0.2	100.0	91.0	969
Mother's education								
No education	65.0	2.3	30.1	0.2	2.4	100.0	67.3	373
Primary	79.4	6.4	13.4	0.1	0.7	100.0	85.8	1,662
Secondary	85.3	5.9	7.3	0.0	1.5	100.0	91.2	571
More than secondary	88.6	3.7	3.2	0.2	4.3	100.0	92.3	62
Antenatal care visits ¹								
None	51.6	1.2	45.5	0.0	1.7	100.0	52.8	51
1–3	80.4	4.2	15.2	0.1	0.0	100.0	84.7	273
4+	82.9	5.3	11.6	0.1	0.0	100.0	88.3	1,162
Wealth quintile								
Lowest	72.0	2.1	24.0	0.0	1.8	100.0	74.2	646
Second	78.9	5.9	14.3	0.0	0.8	100.0	84.8	552
Middle	77.7	4.7	16.4	0.3	1.0	100.0	82.3	484
Fourth	81.3	8.9	8.5	0.0	1.2	100.0	90.2	513
Highest	86.8	7.5	4.5	0.3	0.9	100.0	94.3	472
Total	78.9	5.6	14.2	0.1	1.2	100.0	84.5	2,668

¹ Includes only the most recent birth in the five years preceding the survey.

Note: Total includes 313 cases with missing information on number of antenatal care visits.

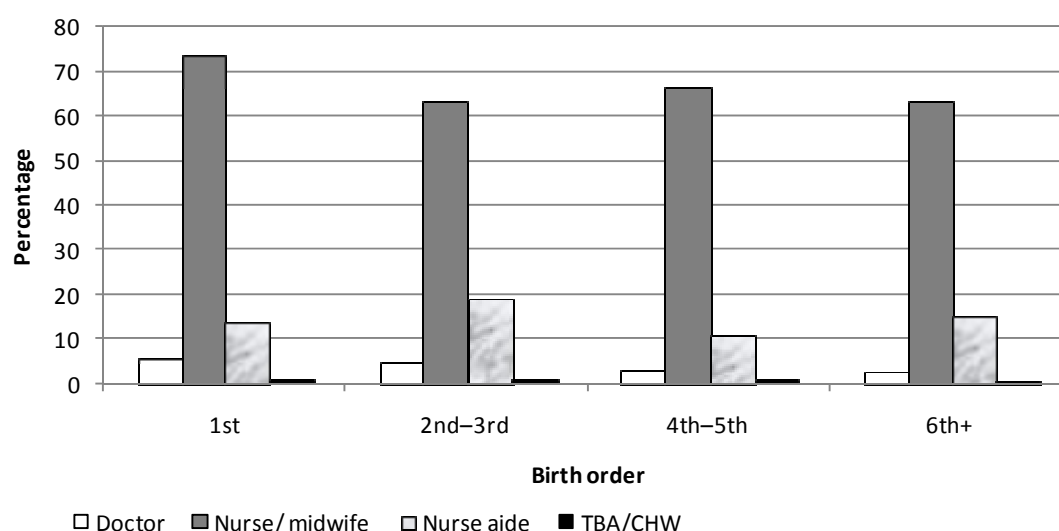
9.3 ASSISTANCE DURING CHILDBIRTH

In addition to place of birth, assistance during childbirth is an important variable that influences the birth outcome and the health of the mother and the infant. This is because the skills and performance of the birth attendant determine whether or not he or she can manage complications and observe hygienic practices. Table 9.3 shows the percent distribution of live births in the five years preceding the survey by person providing assistance, according to background characteristics of the mother.

Overall, 86% of births are assisted by a skilled provider during delivery. About 4% of births are delivered with the assistance of a doctor, 66% are assisted by a nurse/midwife, and 15% are assisted by a nurse's aide. Less than 1% of births are assisted by a traditional birth attendant or community healthcare worker. For 1.5% of births, the mother received no assistance during childbirth.

Younger women are more likely to receive assistance during childbirth from a skilled provider than are older women. In Figure 9.2 women are more likely to receive assistance from a nurse/midwife, particularly during the birth of their first infant. Women are also more likely to receive assistance from a doctor during delivery of their first infant than higher parity women.

Figure 9.2: Assistance during delivery by type of provider and birth order



CHW=community healthcare worker
TBA=traditional birth attendant

Approximately 95% of urban women are attended to by a skilled provider, compared with only 84% of rural women. By province, percentage of births attended to by a skilled provider ranges from 69% of births in Guadalcanal to 94% in Honiara. In Western Province, the percentages of births by skilled providers was 93% and in other provinces 92%. Approximately 82% of births in Malaita are attended to by a skilled provider.

Women who have attained a secondary education are more likely to be assisted at childbirth by a skilled provider (92%) than women with no education (69%). The likelihood of receiving skilled attendance at birth increases with wealth quintile, from 74% of births in the lowest quintile to 95% in the highest wealth quintile. Use of a traditional birth attendant is highest among births to women in the lower wealth quintiles.

Table 9.3 presents data on prevalence of births by caesarean section (C-section). Overall, 6% of births were delivered by C-section. C-sections are more common among first births, among births to younger women, births to women in urban areas, and births to women with a secondary or higher education. The results show inequity with regard to access to C-sections across the wealth

quintiles, with 4% of births to women in the lowest wealth quintile compared with 10% of births to women in the highest wealth quintile. Slightly less than 10% of births in Honiara are delivered by C-section compared with only 4% in Western Province. The low percent of deliveries by C-section in Western Province may reflect the limited number of medical doctors there.

Figure 9.3: Percentage delivered by a skilled provider by background characteristics

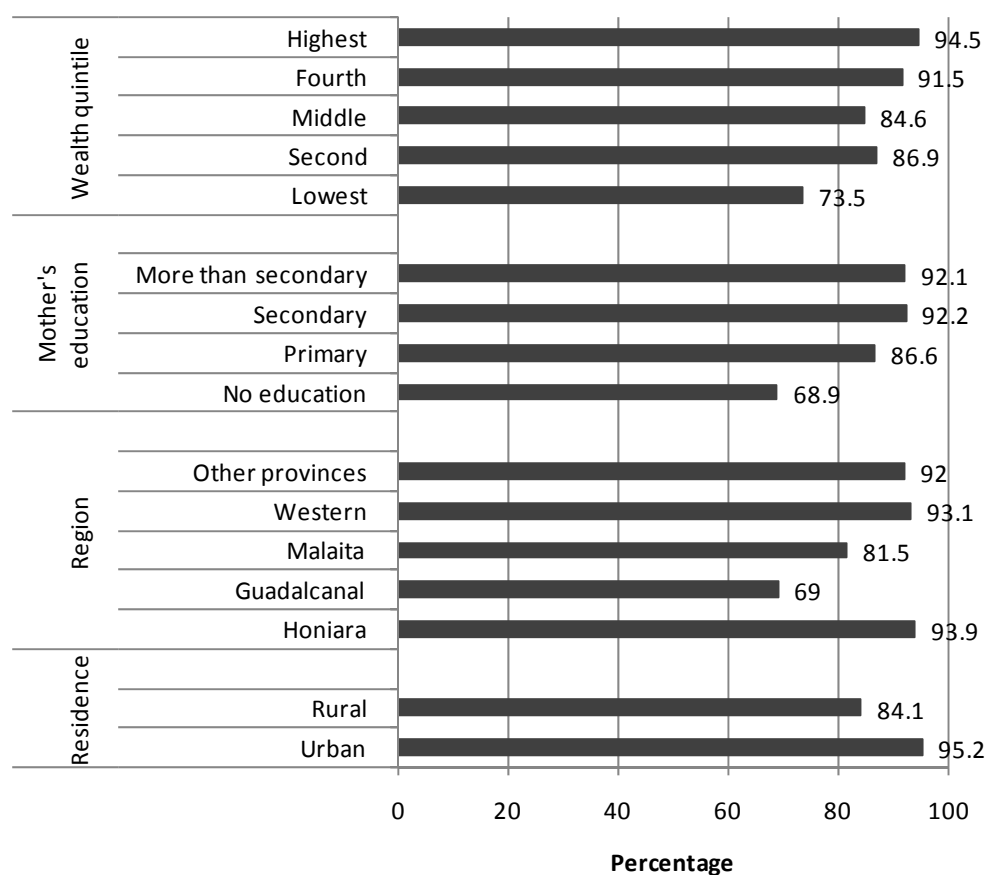


Table 9.3: Assistance during delivery

Percent distribution of live births in the five years preceding the survey by person providing assistance during delivery, percentage of birth assisted by a skilled provider and percentage delivered by caesarean-section, according to background characteristics, Solomon Islands 2007

Background characteristic	Person providing assistance during delivery:							Total	Percentage delivered by a skilled provider¹	Percentage delivered by C-section	Number of births
	Doctor	Nurse/ midwife	Nurse aide	Traditional birth attendant /Community healthcare worker	Other	No one	Don't know/ missing				
Mother's age at birth											
<20	4.5	64.5	19.0	1.3	3.0	0.9	6.8	100.0	88.0	11.4	253
20–34	4.2	66.3	15.3	0.5	4.5	1.5	7.7	100.0	85.9	5.6	2,107
35–49	3.1	65.5	12.0	0.2	4.4	2.2	12.6	100.0	80.6	5.8	308
Birth order											
1	5.4	73.2	13.9	0.6	3.0	0.1	3.9	100.0	92.4	13.7	577
2–3	4.7	63.1	19.2	0.6	3.3	1.2	7.9	100.0	87.0	4.6	989
4–5	2.9	66.1	11.0	0.5	6.8	1.8	10.9	100.0	80.0	2.8	680
6+	2.8	63.1	15.2	0.1	4.8	3.7	10.3	100.0	81.1	5.3	422
Place of delivery											
Health facility	4.8	76.7	17.6	0.0	0.4	0.0	0.5	100.0	99.1	7.3	2,255
Elsewhere	0.2	8.4	3.0	3.5	28.2	10.1	46.7	100.0	11.6	0.0	381
Residence											
Urban	8.6	81.2	5.4	0.3	0.5	0.3	3.7	100.0	95.2	8.1	330
Rural	3.5	63.9	16.7	0.5	4.9	1.7	8.8	100.0	84.1	5.9	2,338
Region											
Honiara	8.2	82.0	3.8	0.1	0.7	0.4	4.9	100.0	93.9	9.9	249
Guadalcanal	3.9	55.9	9.2	1.8	4.9	2.5	21.9	100.0	69.0	5.7	483
Malaita	4.8	55.8	20.9	0.3	8.3	3.4	6.5	100.0	81.5	7.6	678
Western	5.7	80.4	7.0	0.8	1.0	0.4	4.7	100.0	93.1	4.1	289
Other provinces	2.2	69.9	19.9	0.0	3.2	0.3	4.4	100.0	92.0	5.2	969
Mother's education											
No education	2.2	47.7	19.0	0.7	8.7	4.9	16.8	100.0	68.9	5.3	373
Primary	4.1	66.6	15.8	0.6	4.0	1.2	7.7	100.0	86.6	4.9	1,662
Secondary	3.9	76.0	12.4	0.3	3.1	0.2	4.2	100.0	92.2	10.6	571
More than secondary	17.1	68.7	6.3	0.0	0.0	0.7	7.2	100.0	92.1	6.4	62

Table 9.3: (continued)

Background characteristic	Person providing assistance during delivery:							Total	Percentage delivered by a skilled provider ¹	Percentage delivered by C-section	Number of births
	Doctor	Nurse/ midwife	Nurse aide	Traditional birth attendant /Community healthcare worker	Other	No one	Don't know/ missing				
Wealth quintile											
Lowest	2.7	52.8	17.9	0.6	8.3	2.3	15.3	100.0	73.5	3.7	646
Second	1.9	66.4	18.6	0.6	3.4	1.6	7.5	100.0	86.9	8.0	552
Middle	3.3	66.3	14.9	0.3	5.0	2.1	7.9	100.0	84.6	4.7	484
Fourth	4.6	70.0	16.9	0.5	2.6	1.0	4.4	100.0	91.5	5.1	513
Highest	8.8	79.1	6.6	0.5	1.3	0.2	3.6	100.0	94.5	10.2	472
Total	4.1	66.0	15.3	0.5	4.4	1.5	8.2	100.0	85.5	6.2	2,668

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation.

Total includes 32 cases with missing information on place of delivery.

¹ Skilled provider includes doctor, nurse, midwife and auxiliary nurse/midwife.

9.4 POSTPARTUM CARE

Postpartum care is important — both for the mother and for the child — for treating complications arising from the delivery as well as for providing the mother with important information on how to care for herself and her child. The postpartum period, also known as the puerperium, is defined as the time between delivery of the placenta and 42 days (6 weeks) following delivery. The timing of postpartum care is important. The first two days after delivery are critical, since most maternal and neonatal deaths occur during this period. The Solomon Islands Obstetrics Guidelines recommend that a mother should attend postpartum care during the puerperal period to check for possible complications. Through the provision of integrated services, the Ministry of Health and Medical Services recommends that mothers receive postpartum care immediately postpartum, and when they bring their infants for immunisation at 6 weeks.

Table 9.4: Timing of first postnatal check-up

Among women aged 15–49 giving birth in the five years preceding the survey, the percent distribution of the mother's first postnatal check-up for the last live birth by time after delivery, according to background characteristics, Solomon Islands 2007

Background characteristic	Timing after delivery of mother's first postnatal check-up					No postnatal checkup ¹	Total	Number of women
	Less than 4 hours	4–23 hours	2 days	3–41 days	Don't know/ missing			
Mother's age at birth								
<20	19.9	1.1	19.6	19.2	8.9	31.3	100.0	148
20–34	30.7	3.8	17.3	16.9	5.4	26.0	100.0	1,404
35–49	28.9	1.7	21.9	21.3	6.1	20.1	100.0	247
Birth order								
1	25.7	5.5	20.4	21.6	6.5	20.3	100.0	341
2–3	32.6	3.1	16.4	16.7	5.2	25.9	100.0	652
4–5	27.6	2.0	19.1	16.6	5.8	28.8	100.0	488
6+	30.4	3.1	17.3	17.2	6.0	26.0	100.0	318
Residence								
Urban	32.6	4.8	27.6	13.6	4.4	16.9	100.0	236
Rural	29.1	3.0	16.6	18.3	6.0	27.0	100.0	1,562
Region								
Honiara	25.7	5.1	28.9	16.9	4.1	19.3	100.0	178
Guadalcanal	47.1	3.1	16.7	7.1	3.3	22.6	100.0	323
Malaita	29.7	6.3	16.8	9.0	11.2	26.9	100.0	420
Western	31.2	1.8	24.6	17.3	5.7	19.4	100.0	208
Other provinces	21.5	1.4	14.6	28.6	4.0	29.9	100.0	671
Education								
No education	35.7	4.0	16.2	11.6	7.8	24.7	100.0	243
Primary	28.2	2.6	18.0	19.3	5.2	26.7	100.0	1,104
Secondary	30.0	4.1	19.2	16.5	5.9	24.2	100.0	406
More than secondary	25.2	8.0	19.5	23.5	6.6	17.2	100.0	46
Wealth quintile								
Lowest	29.9	1.5	9.4	16.6	6.0	36.6	100.0	412
Second	23.9	4.8	19.4	19.7	7.8	24.3	100.0	367
Middle	29.4	2.2	18.3	21.9	4.8	23.5	100.0	326
Fourth	30.0	2.0	20.9	17.7	4.9	24.5	100.0	363
Highest	35.0	6.3	24.1	12.7	5.2	16.7	100.0	330
Total	29.5	3.3	18.1	17.7	5.8	25.6	100.0	1,799

¹ Includes women who received a check-up after 41 days.

In the 2006/2007 SIDHS, the extent of postnatal care was determined by asking mothers whether they had received a phealth check after the delivery of their last birth in the five years preceding

the survey, when they received the first check, and what type of health provider they saw for postnatal care.

Table 9.4 shows the timing of the first postpartum check-up by background characteristics, and indicates that 26% of women did not receive postpartum care for their last birth, 30% received postpartum care within four hours after giving birth, and 18% received postpartum care within the first two days. Older women, women with first-order births, urban women, better-educated women, and those in the highest wealth quintile are more likely to seek postpartum care than other women.

A slightly higher proportion of women in Honiara, Western, and Guadalcanal provinces received a postpartum check-up. Women in Malaita and other provinces are less likely to receive a postpartum check-up.

9.4.1 Type of provider for the first postpartum check-up

The type of provider for postpartum care was assessed. This is important because the skills of a provider determine the ability to diagnose problems and to recommend appropriate treatment or referral. Table 9.4.1 shows that 57% of women received postpartum care from a doctor, nurse or midwife, while 14% received postpartum care from an auxiliary nurse/midwife, and less than 1% from other healthcare professionals. About 2% of women received postpartum care from a traditional birth attendant.

Women aged 35–49, those who gave birth to their first child, urban women, those with a secondary education and above, those in the highest wealth quintile, and women in Western Province and Honiara are more likely to receive postpartum care from skilled professionals. Use of a doctor, nurse or midwife for postpartum care in Malaita (52%) and other provinces (50%) are lower than the national average. Women from Guadalcanal were the mostly likely to use a traditional birth attendant (7%) compared with women from other provinces. Older women, women with six or more children, women with no education and women in the lowest wealth quintile were the most likely to use a traditional birth attendant for postpartum care. The highest proportions of women receiving postnatal care from an auxiliary nurse/midwife were those in rural areas, those from Malaita and other provinces, those with no education and those in the second lowest wealth quintile.

Table 9.4.1: Type of provider of first postnatal check-up

Among women aged 15–49 giving birth in the five years preceding the survey, the percent distribution by type of provider of the mother's first postnatal health check for the last live birth, according to background characteristics, Solomon Islands 2007

Background characteristic	Type of health provider of mother's first postnatal check-up:						No postnatal checkup ¹	Total	Number of women
	Doctor/ nurse/ midwife	Auxiliary nurse/ midwife	Nurse aide	Traditional birth attendant	Other	Don't know/ missing			
Mother's age at birth									
<20	52.6	13.5	0.0	0.4	1.2	0.9	31.3	100.0	148
20–34	57.1	13.8	0.1	1.6	0.9	0.5	26.0	100.0	1,404
35–49	61.9	12.5	0.0	3.9	1.2	0.4	20.1	100.0	247
Birth order									
1	65.4	11.7	0.0	0.4	1.8	0.4	20.3	100.0	341
2–3	55.6	15.7	0.1	1.5	0.5	0.7	25.9	100.0	652
4–5	57.8	10.3	0.1	1.8	0.9	0.2	28.8	100.0	488
6+	51.8	16.4	0.0	4.1	0.9	0.8	26.0	100.0	318
Residence									
Urban	75.8	4.9	0.0	0.1	1.3	0.9	16.9	100.0	236
Rural	54.6	14.9	0.1	2.1	0.9	0.5	27.0	100.0	1,562
Region									
Honiara	74.4	3.1	0.0	0.2	1.8	1.2	19.3	100.0	178
Guadalcanal	60.5	9.4	0.4	6.6	0.2	0.3	22.6	100.0	323
Malaita	51.5	19.4	0.0	0.4	0.4	1.3	26.9	100.0	420
Western	75.2	4.9	0.0	0.0	0.0	0.4	19.4	100.0	208
Other provinces	49.6	17.5	0.0	1.4	1.7	0.0	29.9	100.0	671
Education									
No education	49.6	20.3	0.0	5.3	0.2	0.0	24.7	100.0	243
Primary	56.0	14.2	0.1	1.7	0.7	0.6	26.7	100.0	1,104
Secondary	64.7	8.4	0.0	0.2	2.2	0.3	24.2	100.0	406
More than secondary	68.1	9.2	0.0	0.0	0.7	4.8	17.2	100.0	46
Wealth quintile									
Lowest	41.8	15.4	0.2	5.7	0.3	0.0	36.6	100.0	412
Second	57.2	16.7	0.0	0.6	0.6	0.5	24.3	100.0	367
Middle	61.7	12.1	0.0	0.8	1.1	0.7	23.5	100.0	326
Fourth	58.5	14.1	0.0	1.1	1.1	0.7	24.5	100.0	363
Highest	71.7	8.8	0.2	0.1	1.7	0.8	16.7	100.0	330
Total	57.4	13.6	0.1	1.8	0.9	0.5	25.6	100.0	1,799

¹ Includes women who received a check-up after 41 days.

9.5 PROBLEMS ENCOUNTERED IN ACCESSING HEALTH CARE

Many factors can prevent women from receiving medical advice or treatment when they are sick. Information on such factors is particularly important in understanding and addressing the barriers women may face in seeking care during pregnancy and at the time of delivery.

The 2006/2007 SIDHS assessed problems encountered in accessing health care. Table 9.5 shows the percentage of women who reported various types of serious problems in accessing health care.

Overall, 96% of women reported that they encounter at least one serious problem in accessing health care. About 89% of women reported that no available drugs is a serious problem in accessing health care.

Concern that no provider is available (85%) is the second most common problem, followed by getting money for treatment (62%) and the concern that there is no female provider (59%). Other reported problems include having to take transport (55%) and the distance to a healthcare facility (53%). The least reported problems related to not wanting to go alone to a health facility (44%) and getting permission (28%).

Looking at the results by age and birth order, older women and women with more children are the most likely to cite concern about the availability of providers and drugs as major problems in accessing health care. Younger women and those with fewer children, on the other hand, are more likely to cite getting permission, not wanting to go alone, and a concern that there would be no female provider as major problems in accessing health care. Divorced, separated, or widowed women are generally more constrained in getting money for treatment and having to take transport than currently married and never married women.

By employment status, unemployed women are most likely to report having problems in getting money for treatment, distance from the health facility, not wanting to take transport and having to go alone. Women who are employed — but not for cash — are usually more likely than other women to report getting permission to go for treatment, concern that there was no female provider, or no drugs available.

Rural women are more likely than urban women to report having each of the problems asked about in accessing health care. They are especially more likely to report that getting money for treatment, distance to a health facility and having to take transport are serious problems.

Over 97% of women in Guadalcanal, Malaita and other provinces reported that at least one of the items asked about was a serious problem in accessing health care. Women from Guadalcanal were most likely to report having at least one problem with access to health care, with distance to a healthcare facility, having to take transport and not wanting to go alone being the major concerns. By contrast, 87% of women in Honiara reported at least one serious problem in accessing health care. Getting money for treatment was a serious problem for more women in Western Province (69%) than in other provinces.

Less educated women are more likely to report at least one serious problem in accessing health care compared with other women. Women with only a primary level education had the highest level of concern for each problem in accessing health care. Women with a secondary education or higher had the lowest levels of concern about problems in accessing health care.

Wealth has an especially strong association with reporting all types of problems with access to health care. Table 9.5 shows that women in the lowest wealth quintile are much more likely than women in other wealth quintiles to report getting permission to go for treatment, distance to a healthcare facility, having to take transport, not wanting to go alone and concern that no female provider or drugs were available as serious problems in accessing health care. As expected, the proportion of women with problem of getting money to gain access to health care decreases as the increasing in their wealth quintile.

Table 9.5: Problems in accessing health care

Percentage of women aged 15–49 who reported that they have serious problems in accessing health care for themselves when they are sick, by type of problem, according to background characteristics, Solomon Islands 2007

Background characteristic	Problems in accessing health care									Number of women
	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Having to take transport	Not wanting to go alone	Concern no female provider available	Concern no provider available	Concern no drugs available	At least one problem accessing health care	
Age										
15–19	31.8	65.2	55.5	54.2	55.8	64.0	87.8	90.5	97.0	687
20–34	27.2	61.7	52.9	55.3	42.5	57.8	83.4	87.8	95.1	2,045
35–49	25.4	61.6	51.2	53.1	37.7	56.8	87.2	91.1	96.3	1,091
Number of living children										
0	29.0	61.9	52.3	51.3	50.7	59.2	83.9	88.2	95.1	1,213
1–2	27.6	64.9	52.6	52.7	39.9	60.4	84.5	87.5	95.4	954
3–4	27.5	60.0	56.1	61.1	41.6	59.5	85.6	89.6	96.2	885
5+	25.2	62.4	50.4	53.9	38.9	54.4	88.1	92.5	96.8	772
Marital status										
Never married	30.8	61.7	54.2	53.3	50.3	62.3	87.5	89.9	95.9	1,125
Married or living together	26.3	62.2	52.2	54.8	40.9	57.5	84.9	89.3	95.7	2,560
Divorced/separated/widowed	24.0	70.4	53.9	56.9	36.6	48.5	74.3	82.7	96.5	138
Employed last 12 months										
Not employed	28.4	65.6	56.4	59.2	46.6	59.9	85.5	89.0	95.6	2,253
Employed for cash	18.5	49.8	48.3	44.0	38.0	48.2	77.1	85.7	93.2	655
Employed not for cash	31.9	63.3	47.8	50.5	39.7	62.8	90.7	92.5	97.9	909
Residence										
Urban	17.0	47.7	38.1	36.0	39.0	51.2	76.2	80.1	88.6	636
Rural	29.6	65.2	55.8	58.1	44.4	60.1	87.1	91.1	97.2	3,187
Region										
Honiara	16.5	46.0	36.5	35.7	39.7	55.0	73.6	76.9	86.5	481
Guadalcanal	23.2	66.3	67.4	65.5	54.3	42.1	72.0	86.2	98.2	637
Malaita	12.7	58.9	45.0	45.4	34.5	53.4	89.1	92.2	97.0	840
Western	31.3	69.4	62.6	59.5	37.4	58.3	88.8	90.7	93.9	458
Other provinces	40.8	65.9	53.5	59.6	47.3	70.5	91.8	92.6	97.7	1,407

Table 9.5: (continued)

Background characteristic	Problems in accessing health care									Number of women
	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Having to take transport	Not wanting to go alone	Concern no female provider available	Concern no provider available	Concern no drugs available	At least one problem accessing health care	
Education										
No education	25.7	66.2	52.6	56.9	44.7	58.5	87.1	89.5	96.7	520
Primary	30.3	66.2	56.4	58.6	44.6	60.2	87.4	91.6	97.0	2,114
Secondary	23.5	55.3	48.1	47.4	42.2	56.7	81.8	85.7	93.9	1,067
More than secondary	23.3	40.7	35.1	34.5	30.5	46.9	70.7	78.8	86.4	122
Wealth quintile										
Lowest	38.7	77.1	65.3	69.6	52.5	68.8	92.3	95.6	98.7	696
Second	31.8	65.7	52.2	55.8	44.1	58.9	91.7	94.2	98.6	755
Middle	27.4	64.3	56.9	58.1	47.2	58.1	86.1	90.9	97.5	738
Fourth	23.4	60.3	51.1	53.1	38.0	55.7	81.7	85.3	94.8	769
Highest	18.5	47.5	41.6	39.2	37.6	53.0	76.7	81.9	90.3	864
Total	27.5	62.3	52.9	54.5	43.5	58.6	85.3	89.2	95.8	3,823

Note: Total includes seven cases with missing information on employment status.

9.6 KEY RESULTS

Ninety-five percent of women who had a live birth in the five years preceding the survey received ANC from a skilled healthcare professional for their last birth. Over three in five women (65%) make four or more ANC visits during their entire pregnancy. The median number of months of pregnancy when women seek their first ANC visit is 5.6 months, indicating that Solomon Islands women start ANC at a relatively late stage in pregnancy.

Among women who received ANC, over half (55%) reported that they were informed about how to recognise signs of problems during pregnancy. A weight measurement was taken for 98.7% of women and blood pressure was taken for 99% of women. Urine and blood samples were taken for 91% and 79% of women, respectively. Only 26% of women received two or more tetanus toxoid injections during their last pregnancy. An estimated 52% of births were reported to be protected against neonatal tetanus because of previous immunisations the mother had received.

Over eight in ten births occur in a healthcare facility. Overall, 85% of births were delivered with the assistance of a trained health professional — a doctor, nurse, midwife, medical assistant, or clinical officer — while 0.5% were delivered by a traditional birth attendant. About 4.4% of births were attended to by other people, while 1.5% of births were delivered without any type of assistance at all.

Postpartum care is reported to be high in Solomon Islands. Only 26% of women who had a live birth in the five years preceding the survey received no postnatal care at all, and 51% of mothers received postnatal care within the critical first two days after delivery. About 71% of women received first postnatal care from trained health professionals while about 2% were cared for by traditional birth attendant.

Concern that no drugs were available, no female care provider was available and getting money for treatment were the most commonly cited problems in accessing health care in Solomon Islands.

CHAPTER 10 CHILDREN'S HEALTH

This chapter presents the findings on several areas of importance to children's health. Information on birth weight and birth size is important for the design and implementation of programmes aimed at reducing neonatal and infant mortality. Many early childhood deaths can be prevented by immunising children against preventable diseases and by ensuring that children receive prompt and appropriate treatment when they become ill. Vaccination coverage information focuses on children aged 12–23 months. Overall coverage levels for this age group at the time of the survey are shown. Additionally, the source of the vaccination information (whether based on a written vaccination card or on the mother's recall) is shown. Differences in vaccination coverage between population subgroups assist in the planning of infant and child health programmes.

Information on treatment practices and contact with health services among children with the three most important childhood illnesses (acute respiratory infection-ARI, fever and diarrhoea) help in assessing national programmes aimed at reducing the mortality impact of these illnesses. Information is provided on the prevalence of ARI and its treatment with antibiotics, and the prevalence of fever and its treatment with antibiotics. The treatment of diarrhoeal diseases with oral rehydration therapy (including increased fluids) aids in assessment programmes that recommend such treatment. Because appropriate sanitary practices can help prevent and reduce the severity of diarrhoeal disease, information is also provided on the proper manner of disposing of children's faecal matter.

10.1 CHILD'S SIZE AT BIRTH

Birth weight and size at birth are important indicators of a child's vulnerability to the risk of childhood illnesses and their chances of survival. Children whose birth weight is less than 2.5 kg, or children reported to be 'very small' or 'smaller than average' are considered to have a higher than average risk of early childhood death. For births in the five years preceding the survey, birth weight was recorded in the questionnaire (if available) from either a written record or the mother's recall. Since birth weight may not be known for many babies, the mother's estimate of the baby's size at birth was also obtained. Even though it is subjective, it can be a useful proxy for the weight of the child. Table 10.1 presents information on children's weight and size at birth according to background characteristics.

Just over 8 in 10 children (81.3%) in Solomon Islands are weighed at birth, which is not surprising because the majority of births take place in a healthcare facility. Among children born in the five years before the survey with a reported birth weight, 12.5% weighed less than 2.5 kg at birth. Birth weight is lower among children born to younger women (mother's age at birth less than 20 years), first-born children, and children of women with no education. The data in Table 10.1 indicate that there is no association between lower birth weight babies and wealth quintile. The birth weight of a child has little variation by mother's place of residence: 12.1% of births in urban areas were reported to be less than 2.5 kg compared with 12.6% of births in rural areas. By region, Malaita reported the highest percentage (17.1%) of babies weighing less than 2.5 kg at birth, all other provinces reported less than 13%.

Table 10.1 also includes information on the mother's assessment of the baby's size at birth. In the absence of birth weight, a mother's subjective assessment of the baby's size at birth may be useful. About 4% of births were reported to be very small and almost 10% were reported as smaller than average. Around 20% of births to women under age 20, and around 20% of first-order births were small or smaller than average compared with births to older women and higher-order births. There is not much differences in the proportions of mothers with no education or only a primary education with birth being reported as very small or smaller than average. Mothers in the poorest households are more likely to report their birth as being very small.

Table 10.1: Child's weight and size at birth

Percent distribution of live births in the five years preceding the survey, with a reported birth weight by birth weight; percent distribution of all live births in the five years preceding the survey by mother's estimate of baby's size at birth, and percentage of all births with a reported birth weight, according to background characteristics, Solomon Islands 2007

Background characteristic	Percent distribution of births with a reported birth weight ¹		Total	Number of births	Percentage of all births with a reported birth weight	Percent distribution of all live births by size of child at birth					Total	Number of births
	Less than 2.5 kg	2.5 kg or more				Very small	Smaller than average	Average or larger	Don't know/ missing			
Mother's age at birth												
<20	20.5	79.5	100.0	211	83.5	5.6	15.9	75.3	3.3	100.0	253	
20–34	10.6	89.4	100.0	1,719	81.6	3.7	8.9	80.5	6.9	100.0	2,107	
35–49	19.0	81.0	100.0	240	77.9	5.2	9.9	76.8	8.1	100.0	308	
Birth order												
1	18.1	81.9	100.0	500	86.7	5.4	12.3	78.2	4.1	100.0	577	
2–3	10.8	89.2	100.0	813	82.2	3.4	9.6	80.1	6.8	100.0	989	
4–5	11.4	88.6	100.0	539	79.3	3.2	8.9	80.5	7.4	100.0	680	
6+	10.1	89.9	100.0	317	75.2	5.0	7.5	78.6	8.9	100.0	422	
Mother's smoking status												
Smokes cigarettes/tobacco	11.9	88.1	100.0	368	80.5	3.5	11.7	77.9	6.9	100.0	457	
Does not smoke	12.6	87.4	100.0	1,778	81.6	4.1	9.3	80.1	6.5	100.0	2,180	
Residence												
Urban	12.1	87.9	100.0	306	92.9	2.8	8.7	84.5	4.0	100.0	330	
Rural	12.6	87.4	100.0	1,863	79.7	4.2	9.9	78.9	7.1	100.0	2,338	
Region												
Honiara	11.4	88.6	100.0	227	91.3	1.8	10.4	82.9	5.0	100.0	249	
Guadalcanal	12.7	87.3	100.0	316	65.3	7.3	7.6	76.7	8.4	100.0	483	
Malaita	17.1	82.9	100.0	481	71.0	2.7	10.1	75.5	11.8	100.0	678	
Western	12.6	87.4	100.0	263	91.2	4.7	10.5	81.0	3.7	100.0	289	
Other provinces	10.2	89.8	100.0	882	91.0	3.7	10.1	82.6	3.6	100.0	969	
Mother's education												
No education	15.0	85.0	100.0	238	63.8	6.9	8.5	71.7	13.0	100.0	373	
Primary	12.4	87.6	100.0	1,358	81.7	4.1	10.9	78.9	6.1	100.0	1,662	
Secondary	11.6	88.4	100.0	516	90.2	2.3	7.0	86.1	4.6	100.0	571	
More than secondary	12.2	87.8	100.0	58	93.7	0.0	10.2	83.5	6.3	100.0	62	

Table 10.1: (continued)

Background characteristic	Percent distribution of births with a reported birth weight ¹		Total	Number of births	Percentage of all births with a reported birth weight	Percent distribution of all live births by size of child at birth				Total	Number of births
	Less than 2.5 kg	2.5 kg or more				Very small	Smaller than average	Average or larger	Don't know/ missing		
Wealth quintile											
Lowest	11.7	88.3	100.0	450	69.6	5.3	10.5	75.5	8.7	100.0	646
Second	15.5	84.5	100.0	444	80.4	3.3	10.9	79.0	6.9	100.0	552
Middle	9.8	90.2	100.0	399	82.5	4.1	8.4	82.6	5.0	100.0	484
Fourth	14.0	86.0	100.0	441	86.0	3.5	10.1	78.4	8.0	100.0	513
Highest	11.4	88.6	100.0	436	92.2	3.5	8.2	84.0	4.3	100.0	472
Total	12.5	87.5	100.0	2,169	81.3	4.0	9.7	79.6	6.7	100.0	2,668

Note: Total includes 30 cases with missing information on mother's smoking status.

¹ Based on either a written record or the mother's recall.

10.2 VACCINATION COVERAGE

Universal immunisation of children against the eight vaccine-preventable diseases (tuberculosis, diphtheria, whooping cough [pertussis], tetanus, hepatitis B, *Haemophilus influenzae*, polio and measles) is crucial to reducing infant and child mortality. Information on vaccination coverage among population subgroups is useful for programme planning and targeting resources to areas most in need. Additionally, information on immunisation coverage is important for the monitoring and evaluation of the Expanded Programme on Immunization (EPI)⁴.

The 2006/2007 SIDHS collected information on vaccination coverage for all living children born in the five years preceding the survey. According to World Health Organization guidelines, children are considered fully vaccinated if they have received BCG vaccinations (for tuberculosis), three doses each of DPT (diphtheria, pertussis and tetanus) and polio vaccines, and a measles vaccination by the age of 12 months. BCG should be given at birth or at first clinical contact, DPT and polio require three vaccinations at approximately 6, 10, and 14 weeks of age, and measles should be given at, or soon after reaching, 9 months of age.

Information on vaccination coverage was collected in two ways during the SIDHS: from vaccination cards shown to the interviewer and from mothers' verbal reports. If cards were available, the interviewer copied the vaccination dates directly onto the questionnaire. If there was no vaccination card for the child or if a vaccine had not been recorded on the card, the respondent was asked to recall the vaccine dates. Table 10.2 shows the percentage of children aged 12–23 months who received various vaccinations by source of information, that is, from a vaccination card or mother's recollection. This is the youngest cohort of children who have reached the age by which they should be fully vaccinated.

Table 10.2: Vaccinations by source of information

Percentage of children aged 12–23 months who received specific vaccines at any time before the survey, by source of information (vaccination card or mother's report), and percentage vaccinated by 12 months of age, Solomon Islands 2007

Source of information	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Measles	All basic vaccina- tions ¹	No vaccina- tions	Number of children
Vaccinated at any time before survey											
Vaccination card	85.4	84.2	82.6	80.3	83.8	82.1	79.6	78.1	75.2	0.1	457
Mother's report	10.3	9.2	8.6	7.9	10.2	9.0	7.9	9.2	7.5	4.2	78
Either source	95.7	93.4	91.2	88.2	94.0	91.1	87.4	87.3	82.7	4.3	535
Vaccinated by 12 months of age ²	95.7	93.2	90.8	87.1	93.8	90.7	86.3	80.6	76.6	4.3	535

¹ BCG, measles and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth).

² For children whose information was based on the mother's recollection, the proportion of vaccinations given during the first year of life was assumed to be the same as for children with a written record of vaccination.

Over 76% of children aged 12–23 months were fully vaccinated by 12 months of age at the time of the survey, about 96% had received the BCG vaccination, and 81% had been vaccinated against measles. Over 90% of children received the first doses of DPT and of polio. About 87% of children received the third dose of DPT and 86% received the third dose of polio.

⁴ The Expanded Program on Immunization (EPI) was initiated in 1974 by the World Health Organization (WHO) with the goal to make vaccines available to all children throughout the world.

Table 10.3 shows the vaccination coverage among children aged 12–23 months, according to information from the vaccination card or mother's report, by background characteristics. A vaccination card was seen for 86% of children aged 12–23 months. This information may give some indication of the success of the immunisation programme in reaching out to all population subgroups. Male babies are more likely to have a higher vaccination coverage rate (90%) for all basic vaccinations compared with female babies (75%).

Table 10.3: Vaccinations by background characteristics

Percentage of children aged 12–23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card, by background characteristics, Solomon Islands 2007

Background characteristic	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Measles	All basic vaccinations ¹	No vaccinations	Percentage with a vaccination card seen	Number of children
Sex												
Male	97.4	95.7	94.4	92.3	95.9	94.4	92.1	92.9	90.0	2.6	88.1	275
Female	93.8	90.9	87.9	83.8	92.0	87.7	82.4	81.4	75.0	6.2	82.7	260
Birth order												
1	99.7	96.7	94.3	87.5	98.4	96.2	87.4	90.2	80.5	0.3	80.9	94
2–3	96.3	95.2	93.6	92.8	95.2	93.6	92.4	88.7	87.5	3.7	91.0	202
4–5	93.0	92.6	90.9	87.0	91.2	88.8	84.5	83.6	77.9	7.0	79.5	126
6+	94.4	88.1	84.8	81.9	91.3	85.1	81.9	86.5	81.3	5.6	86.0	113
Residence												
Urban	97.0	94.3	92.3	89.7	95.7	93.2	87.2	93.3	84.4	3.0	77.0	73
Rural	95.5	93.2	91.1	88.0	93.7	90.8	87.4	86.3	82.4	4.5	86.8	462
Region												
Honiara	97.3	93.6	90.8	87.3	95.5	93.6	88.2	92.2	84.3	2.7	80.6	54
Guadalcanal	96.5	91.9	89.5	87.5	94.8	88.3	85.2	81.4	77.9	3.5	84.9	105
Malaita	99.4	95.1	89.9	84.5	95.1	89.9	84.5	82.3	73.8	0.6	97.0	130
Western	(86.2)	(86.2)	(86.2)	(77.2)	(86.2)	(84.5)	(72.7)	(79.4)	(69.9)	(13.8)	(71.1)	51
Other provinces	94.8	94.8	94.5	94.2	94.5	94.5	94.2	94.5	94.2	5.2	83.3	195
Mother's education												
No education	97.1	88.8	82.4	77.5	88.8	81.1	76.2	79.0	67.2	2.9	95.7	65
Primary	94.5	92.8	90.9	87.8	94.1	91.3	87.6	86.9	84.2	5.5	86.7	335
Secondary	97.8	96.4	95.8	93.5	95.8	94.9	91.9	92.2	86.0	2.2	75.5	119
More than secondary	*	*	*	*	*	*	*	*	*	*	*	16
Wealth quintile												
Lowest	98.6	96.0	93.3	88.5	94.9	92.6	87.4	91.0	84.0	1.4	89.9	161
Second	88.2	80.5	76.8	73.4	86.5	76.8	73.4	75.6	72.2	11.8	74.0	70
Middle	95.5	94.4	92.0	87.9	94.4	92.8	87.9	91.2	86.2	4.5	87.5	87
Fourth	94.2	93.4	93.4	93.0	93.4	93.4	93.0	81.1	80.6	5.8	84.5	112
Highest	98.0	97.0	94.6	92.6	98.0	94.6	90.3	92.6	87.0	2.0	85.8	105
Total	95.7	93.4	91.2	88.2	94.0	91.1	87.4	87.3	82.7	4.3	85.5	535

¹ BCG, measles and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth).

Second and third birth order children are more likely than children of other birth orders to be fully immunised, with 87.5% of all second and third birth order children having received all basic vaccinations. Urban-rural differences in vaccination coverage are minimal, with 84.4% of children in urban areas likely to be fully immunised compared with 82.4% of children in rural areas.

The percentage of children fully immunised varies by mother's education. Only 67% of children whose mothers have no education are fully immunised, compared with 84% of children born to mothers with a primary level education, and 86% born to mothers with a secondary level education. There is no relationship between households in the lowest wealth quintile and the likelihood of being fully immunised.

10.2.1 Trends in vaccination coverage

One way of measuring trends in vaccination coverage is to compare coverage among children of different ages covered by the 2006/2007 SIDHS. Table 10.4 shows the percentage of children who have received vaccinations during the first year of life by current age. This type of data can provide information on trends in vaccination coverage over the past four years.

Table 10.4: Vaccinations in first year of life

Percentage of children aged 12–59 months at the time of the survey who received specific vaccines by 12 months of age, and percentage with a vaccination card, by current age of child, Solomon Islands 2007

Age in months	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Measles	All basic vaccinations ¹	No vaccinations	Percentage with a vaccination card seen	Number of children
12–23	95.7	93.2	90.8	87.1	93.8	90.7	86.3	80.6	76.6	4.3	85.5	535
24–35	92.8	90.4	85.6	80.0	91.5	86.7	81.2	68.1	64.4	7.0	79.8	533
36–47	90.6	89.0	86.1	80.8	88.7	85.9	79.6	72.0	66.7	9.2	74.6	515
48–59	87.7	85.5	81.9	72.5	86.4	82.8	74.3	62.6	56.7	11.6	70.3	477
Total	91.8	89.7	86.2	80.4	90.3	86.7	80.6	71.4	66.6	7.9	77.8	2,059

Note: Information was obtained from the vaccination card or if there was no written record, from the mother. For children whose information was based on the mother's report, the proportion of vaccinations given during the first year of life was assumed to be the same as for children with a written record of vaccinations.

¹ BCG, measles and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth).

Vaccination coverage improved over the past four years. The percentage of children who have received no vaccinations at all by 12 months of age has declined from 11% among children aged 48–59 months at the time of the survey to 4% among children aged 12–23 months. Over the same period, the percentage fully immunised by age 12 months increased from 57% to 77%.

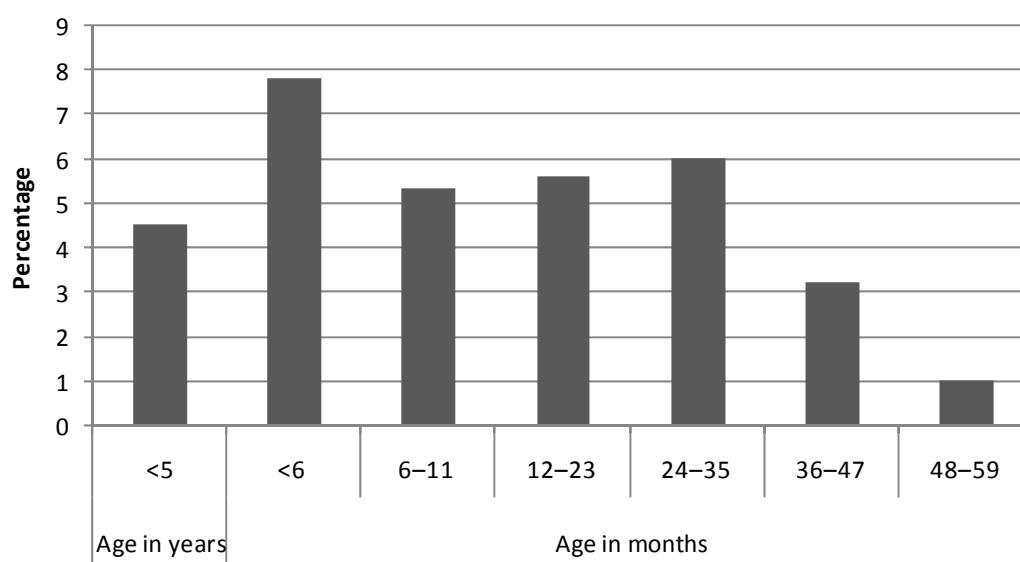
The data generally show that vaccination coverage in Solomon Islands has improved over the past five years. The percentage of children who received each vaccination has also increased in the past five years. As noted above, the percentage who received none of the six basic vaccinations decreased from 12% among children aged 48–59 months before the survey to 4% aged 12–23 months before the survey.

10.3 ACUTE RESPIRATORY INFECTION

Acute respiratory infection (ARI) is among the leading causes of childhood morbidity and mortality throughout the world. Early diagnosis and treatment with antibiotics can prevent a large proportion of deaths caused by ARI. In the 2006/2007 SIDHS, the prevalence of ARI was estimated by asking mothers whether their children under age 5 had been ill in the two weeks preceding the survey, with a cough accompanied by short, rapid breathing which the mother considered to be chest-related. These symptoms are compatible with ARI. It should be noted that the morbidity data collected are subjective in the sense that they are based on the mother's perception of illness (i.e. without validation by medical personnel).

Figure 10.1 shows that about 5% of children under age 5 years showed symptoms of ARI at some time in the two weeks preceding the survey. The prevalence of ARI symptoms varies by age of child. Children aged less than 6 months are more likely to show symptoms of ARI (8%) than children in other age groups.

Figure 10.1: Prevalence of symptoms of ARI among children under 5, Solomon Islands



10.4 FEVER

Fever is another symptom of an acute infection in children. Illnesses that cause fever contribute to high levels of malnutrition and mortality. Fevers can occur year-round, therefore factors that cause fevers must be taken into account when interpreting fever prevalence in Solomon Islands.

Table 10.5 shows the percentage of children under age 5 years with fever during the two weeks preceding the survey and the percentage receiving various treatments, by selected background characteristics. About 17% of children under age 5 years were reported to have had fever in the two weeks preceding the survey. The prevalence of fever varies by age of child. Children aged 6–11 months (23%) and 12–23 months (23%) are more commonly sick with fever than children of other age groups.

There are no significant variations in the prevalence of fever by sex of the child or between children in urban and rural areas. Malaita and Western provinces have higher proportions (16% and 18%, respectively) of children with fever than Honiara or Guadalcanal. The percentage of children with fever increases as the level of the mother's education increases. Mothers with more than a secondary level education are a small percentage and the proportion of children in this group with fever is 13%. The proportion of children with fever is highest in the highest and lowest wealth quintiles (19% and 18%, respectively); the quintiles in between show an increasing proportion of children with fever. All of this suggests that there is no relationship between wealth quintiles and fever prevalence in children.

Over 68% of children with fever were taken to a healthcare facility or provider for treatment. Children between 6 and 11 months of age were more likely to be taken to a healthcare facility or provider for treatment of fever than other children. There is no significant difference between the proportion of children in rural and urban areas seeking treatment for fever. There is no significant difference in the proportion of girls or boys being taken for treatment. The lowest percentage of children with fever taken for treatment is in Guadalcanal Province (46%). There is no correlation between a mother's education level and the proportion of fever children taken for treatment.

Children in lower wealth quintile households are more likely to be taken for treatment than those in the higher wealth quintile households.

Exactly 19% of fever children received antimalarial treatment and over 7% received antibiotics. There is little variation in the use of antibiotic drugs by background characteristics of mothers.

Table 10.5: Prevalence and treatment of fever

Among children under age 5 years, the percentage who had a fever in the two weeks preceding the survey; and among children with fever, the percentage for whom treatment was sought from a health facility or provider, the percentage who took antimalarial drugs, and the percentage who took antibiotic drugs, by background characteristics, Solomon Islands 2007

Background characteristic	Among children under age 5 years:		Children under age 5 years with fever			
	Percentage with fever	Number of children	Percentage for whom advice or treatment was sought from a health facility or provider ¹	Percentage who took antimalarial drugs	Percentage who took antibiotic drugs	Number of children
Age in months						
<6	11.8	266	(77.0)	(9.7)	(13.0)	32
6–11	23.0	259	78.2	14.4	10.9	60
12–23	23.4	535	65.5	10.6	8.5	125
24–35	16.9	533	63.3	17.5	7.1	90
36–47	15.0	515	64.5	34.0	2.8	77
48–59	9.2	477	(74.5)	(32.7)	(3.0)	44
Sex						
Male	16.4	1,269	68.7	20.0	7.9	208
Female	16.8	1,316	68.2	18.1	6.6	220
Residence						
Urban	16.4	319	69.5	12.2	16.9	52
Rural	16.6	2,266	68.3	20.0	5.9	376
Region						
Honiara	14.0	241	67.2	6.9	17.4	34
Guadalcanal	13.5	476	46.1	38.1	12.3	64
Malaïta	16.0	647	69.0	36.1	9.8	103
Western	17.7	276	(54.8)	(13.7)	(4.4)	49
Other provinces	18.9	945	80.0	6.1	2.9	178
Mother's education						
No education	14.1	359	(72.4)	(28.0)	(13.9)	50
Primary	15.9	1,603	66.0	17.3	3.9	254
Secondary	20.5	563	72.7	18.9	9.8	116
More than secondary	13.0	61	*	*	*	8
Wealth quintile						
Lowest	18.3	636	70.7	21.9	3.2	116
Second	12.9	528	82.2	12.7	4.5	68
Middle	15.1	468	63.0	26.4	12.1	71
Fourth	17.0	493	66.1	24.3	2.8	84
Highest	19.4	459	61.2	9.3	15.1	89
Total	16.6	2,585	68.4	19.0	7.3	428

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Excludes pharmacy, shop, and traditional practitioner.

10.5 DIARRHOEA PREVALENCE

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among young children, although the condition can be easily treated with oral rehydration therapy (ORT). Exposure to diarrhoea-causing agents is frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta. In interpreting the findings of the 2006/2007 SIDHS, it should be borne in mind that diarrhoea prevalence varies seasonally.

Table 10.6: Diarrhoea prevalence

Percentage of children under age 5 years who had diarrhoea in the two weeks preceding the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Diarrhoea in the two weeks preceding the survey		
	All diarrhoea	Diarrhoea with blood	Number of children
Age in months			
<6	0.9	0.0	266
6–11	12.3	0.7	259
12–23	21.1	0.6	535
24–35	8.8	1.5	533
36–47	6.7	0.2	515
48–59	3.1	0.5	477
Sex			
Male	11.1	0.8	1,269
Female	7.8	0.5	1,316
Source of drinking water¹			
Improved	9.3	0.5	2,179
Not improved	10.0	1.1	402
Toilet facility²			
Improved, not shared	8.4	0.4	390
Non-improved or shared	9.6	0.7	2,180
Residence			
Urban	9.4	0.0	319
Rural	9.4	0.7	2,266
Region			
Honiara	7.6	0.1	241
Guadalcanal	8.8	1.2	476
Malaita	5.8	1.0	647
Western	7.4	1.4	276
Other provinces	13.2	0.0	945
Mother's education			
No education	9.2	1.0	359
Primary	10.0	0.7	1,603
Secondary	8.1	0.3	563
More than secondary	7.1	0.0	61
Wealth quintile			
Lowest	13.8	1.5	636
Second	7.3	0.1	528
Middle	5.0	0.1	468
Fourth	12.5	0.9	493
Highest	6.9	0.4	459
Total	9.4	0.6	2,585

Note: Total includes 5 cases with missing information on source of drinking water and 15 cases with missing information on toilet facility.

¹ See Table 2.7 for definition of categories.

² See Table 2.8 for definition of categories.

Table 10.6 shows the percentage of children under age 5 years with diarrhoea in the two weeks preceding the survey according to selected background characteristics. Overall, 9% of all children under age 5 had diarrhoea; less than 1% had diarrhoea with blood.

The occurrence of diarrhoea varies by a child's age: it is least in the less than 6 months age group (less than 1%), rising steeply to a peak in children aged 12–23 months (21%), and then decreasing sharply in children aged 48–59 months (3%). Diarrhoea prevalence is higher in boys (11%) than in girls (8%). Diarrhoea is more common among children who live in households with a non-improved or shared toilet facility than among children who live in households with improved, unshared facilities and non-improved drinking water source. There is no urban and rural difference in diarrhoea prevalence, and there is no relationship between diarrhoea prevalence and household wealth quintile. Diarrhoea prevalence decreases with an increase in mother's education level.

The prevalence of diarrhoea with blood is minimal and shows no correlation with categories surveyed.

10.6 DIARRHOEA TREATMENT

In the 2006/2007 SIDHS, mothers of children with diarrhoea were asked what was done to treat the illness. Table 10.7 shows the percentage of children with diarrhoea who received specific treatments by background characteristics. Over 56% of children with diarrhoea were taken to a healthcare provider. Children of mothers living in rural households were more likely to be taken to a healthcare provider than other children. There is no significant difference in male or female children who had diarrhoea in the two weeks preceding the survey taken to a healthcare provider.

Table 10.7: Diarrhoea treatment

Among children under age 5 years who had diarrhoea in the two weeks preceding the survey, the percentage for whom advice or treatment was sought from a health facility or provider, the percentage given oral rehydration therapy (ORT), the percentage given increased fluids, the percentage given ORT or increased fluids, and the percentage who were given other treatments, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of children with diarrhoea for whom advice or treatment was sought from a health facility or provider ¹	Oral rehydration therapy (ORT)					Other treatments		Number of children with diarrhoea		
		ORS packets or pre-packaged liquid	Recommended home fluids (RHF)	Either ORS or RHF	Increased fluids	ORT or increased fluids	Antibiotic drugs	Home remedy/ other			
Sex											
Male	56.9	43.9	67.9	78.6	32.0	84.5	5.4	39.9	1.4	4.3	141
Female	56.4	29.4	45.4	60.7	35.8	68.2	1.8	39.5	0.0	8.8	103
Residence											
Urban	49.0	39.9	57.4	76.6	57.9	91.3	2.8	17.1	1.0	6.6	30
Rural	57.7	37.4	58.5	70.3	30.2	75.7	4.1	42.9	0.8	6.1	213
Total	56.7	37.7	58.4	71.1	33.6	77.6	3.9	39.7	0.8	6.2	243

Note: ORT includes solution prepared from oral rehydration salt (ORS), pre-packaged ORS packet, and recommended home fluids (RHF).

¹ Excludes pharmacy, shop and traditional practitioner.

More than 77% of children with diarrhoea were treated with some kind of oral rehydration therapy (ORT) or increased fluids. About 38% were treated with ORS prepared from an ORS packet, almost 60% were given recommended home fluids, and 34% were given increased fluids. The percentage of boys receiving ORT was greater than that of girls, except for therapy with increased fluids where the percentage is slightly higher than in boys.

Just under 4% of children with diarrhoea were given antibiotic drugs and 40% were given home remedies or other treatments. Over 6% of children with diarrhoea did not receive any treatment at all.

ORT and other treatments vary by urban and rural residence as observed in Table 10.8. More children in rural areas (58%) sought treatment for diarrhoea than those in urban areas (49%). Home remedies were more likely to be used in rural areas (43%) than in urban areas (17%). More children in urban areas were given ORT or increased fluids (91%) than children in rural areas (76%).

10.7 FEEDING PRACTICES

Mothers are encouraged to continue normal feeding of children with diarrhoea and to increase the amount of fluids. These practices help to reduce dehydration and minimise the adverse consequences of diarrhoea on the child's nutritional status. Mothers were asked whether they gave the child less, the same amount, or more fluids and food than usual when their child had diarrhoea. Table 10.8 shows the percent distribution of children under age 5 years who had diarrhoea in the two weeks prior to the survey by feeding practices, according to background characteristics.

About 41% of children who had diarrhoea were given the same amount of liquid as usual, 34% were given more, 11% were given somewhat less than the usual amount, and 10% were given much less than the usual amount.

Regarding the amount of food offered to children who had diarrhoea, 38% were given the same amount as usual, 12% were given more, 16% were given somewhat less than the usual amount of food, 22% were given much less than the usual amount of food, and 8% of children who usually ate solid foods did not receive food during their illness.

Children who live in urban areas are more likely to receive more than the usual amount of liquid during episodes of diarrhoea than children in rural areas. Regarding the amount of food offered during diarrhoea episodes, children in urban areas are more likely to receive more food during a diarrhoea episode (24%) than children in rural areas (11%).

Table 10.9 also shows that 20% of children were given increased fluids and continued feeding, while 76% of children who continued feeding were given ORT and/or increased fluids, with the largest differentials observed by place of residence.

Table 10.8: Feeding practices during diarrhoea episodes

Percent distribution of children under age 5 years who had diarrhoea in the two weeks preceding the survey by amount of liquids and food offered compared with normal practice, the percentage of children given increased fluids and continued feeding during the diarrhoea episode, and the percentage of children who continued feeding and were given ORT and/or increased fluids during the diarrhoea episode, by background characteristics, Solomon Islands 2007.

Background characteristic	Amount of liquids offered						Amount of food offered								Percentage given increased fluids and continued feeding ^{1,2}	Percentage who continued feeding and were given ORT and/or increased fluids ³	Number of children with diarrhoea
	More	Same as usual	Somewhat less	Much less	Don't know/missing	Total	More	Same as usual	Somewhat less	Much less	None	Never gave food	Don't know/missing	Total			
Sex																	
Male	32.0	37.9	16.8	10.9	2.4	100.0	8.2	34.3	15.7	24.4	12.0	3.0	2.4	100.0	20.3	83.3	141
Female	35.8	45.1	3.5	8.7	6.8	100.0	18.1	43.6	15.4	19.6	3.3	0.0	0.0	100.0	20.5	66.9	103
Residence																	
Urban	57.9	27.1	4.3	8.2	2.5	100.0	23.6	51.6	12.1	11.7	0.0	0.0	1.0	100.0	50.4	89.5	30
Rural	30.2	42.9	12.2	10.2	4.5	100.0	10.8	36.4	16.1	23.9	9.5	2.0	1.4	100.0	16.2	74.5	213
Total	33.6	40.9	11.2	10.0	4.3	100.0	12.4	38.2	15.6	22.4	8.3	1.7	1.4	100.0	20.4	76.4	243

¹ Equivalent to the UNICEF/WHO indicator "Home management of diarrhoea." MICS Indicator 34.

² Continue feeding practices includes children who were given more, same as usual, or somewhat less food during the diarrhoea episode.

³ Equivalent to UNICEF MICS Indicator 35.

10.8 KNOWLEDGE OF ORS PACKETS

A simple and effective response to dehydration caused by diarrhoea is a prompt increase in the child's fluid intake through some form of ORT, including the use of a solution prepared from packets of ORS. To ascertain how widespread the knowledge of ORS is in Solomon Islands, respondents were asked whether they know about ORS packets.

Table 10.9 shows that over three-quarters of women (79%) who gave birth in the five years preceding the survey knew about ORS packets. ORS knowledge is higher among urban women (86%) than among rural women (77%). Knowledge of ORS increases as the age of women increases, from 51% among the youngest age group to 85% in the oldest age group.

Similarly, knowledge of ORS packets increases as a mother's education level increases, from 67% among mothers with no education to 89% among mothers with more than a secondary education.

Table 10.9: Knowledge of ORS packets or pre-packaged liquids

Percentage of mothers aged 15–49 who gave birth in the five years preceding the survey who know about ORS packets or ORS pre-packaged liquids for treatment of diarrhoea by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of women who know about ORS packets or ORS pre-packaged liquids	Number of women
Age		
15–19	50.8	68
20–24	73.6	361
25–34	79.7	963
35–49	84.5	406
Residence		
Urban	85.8	236
Rural	77.3	1,562
Region		
Honiara	84.6	178
Guadalcanal	82.0	323
Malaita	72.0	420
Western	86.7	208
Other provinces	76.6	671
Education		
No education	66.5	243
Primary	79.0	1,104
Secondary	82.8	406
More than secondary	89.1	46
Wealth quintile		
Lowest	78.9	412
Second	72.2	367
Middle	78.6	326
Fourth	80.0	363
Highest	83.0	330
Total	78.5	1,799

ORS = oral rehydration salts

10.9 STOOL DISPOSAL

Table 10.10: Disposal of children's stools

Percent distribution of youngest children under age 5 years living with the mother by the manner of disposal of the child's last faecal matter, and percentage of children whose stools are disposed of safely, according to background characteristics, Solomon Islands 2007

Background characteristic	Manner of disposal of children's stools									Total	Percentage of children whose stools are disposed of safely	Number of mothers
	Child used toilet or latrine	Put/rinsed into toilet or latrine	Buried	Put/rinsed into drain or ditch	Thrown into garbage	Left in the open	Thrown into sea/river	Other	Missing			
Age in months												
<6	1.9	12.9	7.3	20.7	2.8	0.0	48.5	3.9	2.0	100.0	22.1	262
6–11	2.8	17.3	7.9	15.3	2.2	1.4	51.5	0.0	1.5	100.0	28.1	255
12–23	2.4	14.8	12.5	10.8	6.6	1.1	50.1	0.5	1.3	100.0	29.7	478
24–35	8.5	12.6	14.5	10.9	1.9	1.6	46.1	0.7	3.2	100.0	35.6	352
36–47	7.9	12.0	12.2	5.6	3.5	2.5	48.5	5.3	2.4	100.0	32.1	216
48–59	7.8	12.1	5.3	11.0	2.3	1.6	52.8	1.8	5.3	100.0	25.2	181
Toilet facility												
Improved, not shared ¹	18.1	58.0	4.1	7.7	0.6	1.0	8.8	0.2	1.5	100.0	80.2	267
Non-improved or shared	2.5	5.8	11.9	13.2	4.2	1.3	56.6	2.0	2.5	100.0	20.2	1,466
Residence												
Urban	19.3	58.4	2.9	10.9	0.1	0.0	6.0	0.5	1.8	100.0	80.6	217
Rural	2.8	7.5	11.8	12.5	4.1	1.5	55.5	1.9	2.4	100.0	22.1	1,527
Region												
Honiara	19.2	58.4	0.9	11.6	0.2	0.0	7.2	0.7	1.9	100.0	78.5	162
Guadalcanal	3.5	16.4	25.2	8.9	7.7	5.2	30.0	0.4	2.7	100.0	45.0	318
Malaita	4.1	10.5	9.5	22.1	5.7	0.2	45.3	0.3	2.3	100.0	24.1	415
Western	5.4	16.7	1.1	3.0	0.8	2.5	65.4	0.0	5.1	100.0	23.2	195
Other provinces	2.3	2.8	9.6	10.8	2.0	0.0	67.0	4.0	1.6	100.0	14.7	653
Education												
No education	4.4	12.2	10.6	15.0	9.1	2.2	39.0	2.4	5.2	100.0	27.2	238
Primary	4.2	10.5	10.1	12.4	3.3	1.5	54.7	2.1	1.2	100.0	24.7	1,075
Secondary	6.5	20.4	13.0	11.3	1.0	0.2	43.6	0.3	3.8	100.0	39.9	387
More than secondary	10.3	46.6	4.3	6.5	5.2	0.0	24.3	0.0	2.8	100.0	61.2	44

Table 10.10 (continued)

Background characteristic	Manner of disposal of children's stools									Total	Percentage of children whose stools are disposed of safely	Number of mothers
	Child used toilet or latrine	Put/rinsed into toilet or latrine	Buried	Put/rinsed into drain or ditch	Thrown into garbage	Left in the open	Thrown into sea/river	Other	Missing			
Wealth quintile												
Lowest	2.0	3.4	19.7	11.5	9.1	3.3	47.9	0.9	2.2	100.0	25.1	400
Second	3.7	3.3	11.7	10.5	2.3	0.6	61.8	4.2	2.1	100.0	18.7	362
Middle	1.6	8.5	7.0	14.6	2.7	1.8	63.3	0.6	0.0	100.0	17.1	324
Fourth	3.8	13.5	8.8	11.9	1.6	0.4	52.4	2.2	5.4	100.0	26.1	350
Highest	14.6	45.7	3.7	13.7	1.5	0.0	18.5	0.4	2.0	100.0	63.9	308
Total	4.9	13.8	10.7	12.3	3.6	1.3	49.3	1.7	2.4	100.0	29.4	1,744

Note: Total includes 11 cases with missing information on toilet facility.

¹ Non-shared facilities that are of the types: flush or pour flush into a piped sewer system/septic tank/pit latrine; ventilated, improved pit (VIP) latrine; pit latrine with a slab; and a composting toilet.

If human faeces are left uncontained, disease may spread by direct contact or by animal contact with the faeces. Hence, the proper disposal of children's stools is extremely important in preventing the spread of disease. Table 10.10 presents information on the disposal of the stools of children under age 5 years, by background characteristics.

About 67% of children's stools are left uncontained: over 12% are put or rinsed into a drain or ditch, over 3% are thrown into the garbage, while a massive 49% are thrown into a river or the sea. A little over 29% of children's stools are disposed of hygienically: A little less than 11% are buried, 14% disposed of in a toilet or latrine, and 5% of children under age 5 years use a toilet or latrine. There is some variation in containing children's stools by age, with 22% for children less than 6 months compared with 25% for children aged 48–59 months, the highest containment is observed for children aged 24–35 months.

There are pronounced differences by mother's level of education in the way stools are disposed of. Stools are disposed of hygienically (i.e. child uses a toilet, child's stools are thrown in toilet, or buried in yard) for 61% percent of children whose mothers have more than a secondary level of education, compared with 27% of children whose mothers have no education. Not surprisingly, 80% of children in households with improved toilets that are not shared with other households, have their stools contained compared with 20% of children in households using non-improved or shared toilet facilities. Children's stools are much more likely to be contained in wealthier households (64%) than in middle wealth quintile households (17%).

Children's stools are more likely to be contained in urban areas (81%) than in rural areas (22%). This marked difference could be attributed to the fact that toilet facilities are more available in urban areas.

10.10 KEY RESULTS

The main findings related to child health in Solomon Islands are highlighted below.

1. About 13% of live births with a reported birth weight in the five years preceding the survey weighed less than 2.5 kg at birth, indicating a prevalence of children underweight at birth. This is an important indicator of a child's vulnerability to the risk of childhood illnesses and the chances of their survival. Therefore, policies are needed to improve this area of child health.
2. Although vaccination coverage is found to be high in Solomon Islands (about 86%), differences in coverage show that mothers with low educational attainment and women in the lowest wealth quintile have low vaccination coverage for their children.
3. Data show that vaccination coverage in Solomon Islands improved over the past four years from 57% to 77%. However, further improvement in health programme planning is required for targeting subgroups of children who are not receiving immunisations.
4. Only 5% of children under age 5 years have symptoms of ARI, and 73% of these seek advice from a healthcare facility or provider. ARI symptoms in Solomon Islands is more common among children aged less than 6 months, children whose mothers smoke cigarettes or tobacco, children whose mothers have no education, and children with mothers in the lowest wealth quintile.
5. Among children under age 5 years, about one in every five (17%) had fever in the two weeks preceding the survey and 68% of these sought treatment from a healthcare facility. Fever is common among children aged 6–23 months, children whose mothers have a secondary level education, and those in the lowest and highest wealth quintiles.
6. Exposure to diarrhoea is related to the use of contaminated water and to hygienic practices in food preparation and the disposal of excreta. More than 9% of children under the age of 5 years had diarrhoea in the two weeks preceding the survey. Diarrhoea is higher among children aged 6–24 months, children drinking unimproved water and using non-improved or shared toilet facilities, those whose mothers have no education or only a primary education. Diarrhoea is also higher among children living in the lowest wealth quintile households. More than 78% of mothers have knowledge of ORS packets for diarrhoea treatment.
7. Disposal of children's stools is extremely important in preventing the spread of diseases. The results show that only 29% of children's stools are disposed of safely.

CHAPTER 11 NUTRITION

This chapter examines: 1) the nutritional status of men, women and children by assessing their anthropometric characteristics; 2) infant and child feeding practices; 3) micronutrient intakes of women and children; 4) food consumption patterns of mothers; and 5) the consequences of inadequate nutrition.

The prevalence of anaemia, as determined from haemoglobin testing of women and children, are discussed in this chapter.

Survey participants were invited to have their weight and height measured. These measurements were then used to calculate indicators of nutritional status, including body mass index (BMI)⁵, an indicator of thinness and fatness and short stature. A low BMI ($<18.5\text{kg/m}^2$) can be used as an indicator of chronic energy deficiency (CED), and the degrees of severity are defined as follows:

- mild CED is a BMI $17\text{--}18.5\text{ kg/m}^2$
- moderate CED is a BMI $16.0\text{--}16.9\text{ kg/m}^2$
- severe CED is a BMI $<16.0\text{ kg/m}^2$

CED is an indicator of chronic malnutrition, which can negatively impact productivity levels among adults, and is a risk factor for childhood morbidity and mortality. Causes of malnutrition include not eating enough nutritious food, poor food choices and feeding practices, parasitic infections, poor sanitation and other socio-cultural factors that influence food choices and feeding practices. Women and children are the most at-risk population groups. Women with CED are more likely to give birth to low weight babies who are more likely to experience poor health outcomes.

Short stature (defined as height $<145\text{ cm}$) can be used to identify women with an increased risk of poor delivery and childbirth outcomes. Short stature is associated with a small pelvic size, which makes delivering a baby difficult. The risk of delivering low birth weight babies is higher for women of short stature.

A high BMI ($>25.00\text{ kg/m}^2$), on the other hand, is an indicator of overweight (BMI $25.0\text{--}29.9\text{ kg/m}^2$) and obesity (BMI $>30\text{ kg/m}^2$), which is associated with an increased risk of developing of non-communicable diseases such as diabetes, heart disease and some cancers.

11.1 NUTRITIONAL STATUS OF MEN

Table 11.1 presents the percentage of Solomon Islands men with specific BMI levels by background characteristics. Overall, the mean BMI of men was 24.1 kg/m^2 . Although this figure is within the normal BMI range of $18.5\text{--}24.9\text{kg/m}^2$, it is near the upper limits of normal. From the survey, 66.5% of men have a BMI within the normal range. Men in the 15–29 age group, from rural areas within Malaita Province, and from low to moderate wealth quintile households are more likely to be in the normal range than other men. Most young men in rural areas are involved in daily physical labour and sports which contributes to reducing body fat and hence result in a lower BMI.

The overall prevalence of a low BMI among men was 2.2%, with less than 1% of men having a BMI of $<17\text{kg/m}^2$. This indicates that less than 3% of adult men are mildly to severely malnourished, which is mainly the case among men in rural areas, Guadalcanal Province, less wealthy households and among men aged 15–19. These men are less likely to have access to nutritious foods.

⁵ Is a measure of body fat based on heights and weights that applies to both adult men and women.

Table 11.1: Nutritional status of men

Among men aged 15+, the mean body mass index (BMI), and the percentage of men with specific BMI levels, by background characteristics, Solomon Islands 2007

Background characteristic	Mean BMI	BMI							Number of men
		<17 (Moderately and severely thin)	<18.5 (Total thin)	17.0–18.4 (Mildly thin)	18.5–24.9 (Total normal)	>=25.0 (Total over-weight or obese)	25.0–29.9 (Over-weight)	>=30.0 (Obese)	
Age									
15–19	22.1	3.4	5.5	2.1	81.7	12.8	12.3	0.5	233
20–29	23.3	0.1	0.5	0.4	80.0	19.5	17.0	2.5	465
30–39	25.1	1.0	2.1	1.1	56.0	41.9	33.8	8.1	423
40–49	25.4	0.0	0.1	0.1	56.5	43.4	32.4	11.0	203
Residence									
Urban	25.6	0.0	0.5	0.5	52.8	46.7	30.5	16.2	194
Rural	23.7	1.1	2.1	1.0	71.8	26.1	22.8	3.3	1,129
Region									
Honiara	25.7	0.0	0.6	0.6	53.9	45.5	27.5	18.0	152
Guadalcanal	23.6	2.4	3.8	1.4	67.8	28.4	24.6	3.8	198
Malaita	24.0	0.0	0.7	0.7	75.9	23.4	19.9	3.5	267
Western	23.8	1.4	3.2	1.8	64.3	32.5	28.4	4.1	148
Other provinces	23.8	1.1	1.7	0.6	71.5	26.8	23.4	3.4	559
Education									
No education	23.3	0.0	0.0	0.0	89.1	10.9	8.9	2.0	61
Primary	23.7	1.6	3.0	1.4	69.9	27.1	22.5	4.6	668
Secondary	24.1	0.4	0.9	0.5	69.5	29.6	24.3	5.3	480
More than secondary	25.5	0.0	0.0	0.0	51.4	48.6	38.6	10.0	115
Wealth quintile									
Lowest	23.3	1.5	2.6	1.1	72.3	25.1	24.4	0.7	238
Second	23.8	0.0	1.1	1.1	75.0	23.9	21.0	2.9	274
Middle	23.2	2.0	2.8	0.8	74.4	22.8	21.5	1.3	264
Fourth	24.0	1.0	2.1	1.1	70.0	27.9	22.2	5.6	295
Highest	25.7	0.3	0.6	0.3	52.6	46.8	31.2	15.6	253
Total 15–49	24.0	1.0	1.9	0.9	69.0	29.1	23.9	5.2	1,323
50+	24.3	0.2	3.7	3.4	59.4	36.9	29.0	7.9	369
Total men 15+	24.1	0.8	2.2	1.4	66.9	30.8	25.0	5.8	1,693

Note: BMI is expressed as the ratio of weight in kilograms to the square of height in meters (kg/m²).

The prevalence of a high BMI ($> 25 \text{ kg/m}^2$) was 30.8%, with the highest BMI levels observed among men in the 40+ age group from urban areas around Honiara, and among better educated men living in wealthier households. Figure 1 shows the differences in the mean BMI among men by region. Men with a high BMI were most likely to be professional men working in offices and so less likely to be engaged in regular physical activity. These men are also more likely to have access to more choices of food.

Figure 11.2 compares the differences between the prevalence of men identified as thin ($\text{BMI} < 18.5 \text{ kg/m}^2$) and those identified as overweight or obese ($\text{BMI} > 25 \text{ kg/m}^2$).

Figure 11.1: Mean BMI of men aged 15+ in Solomon Islands by region

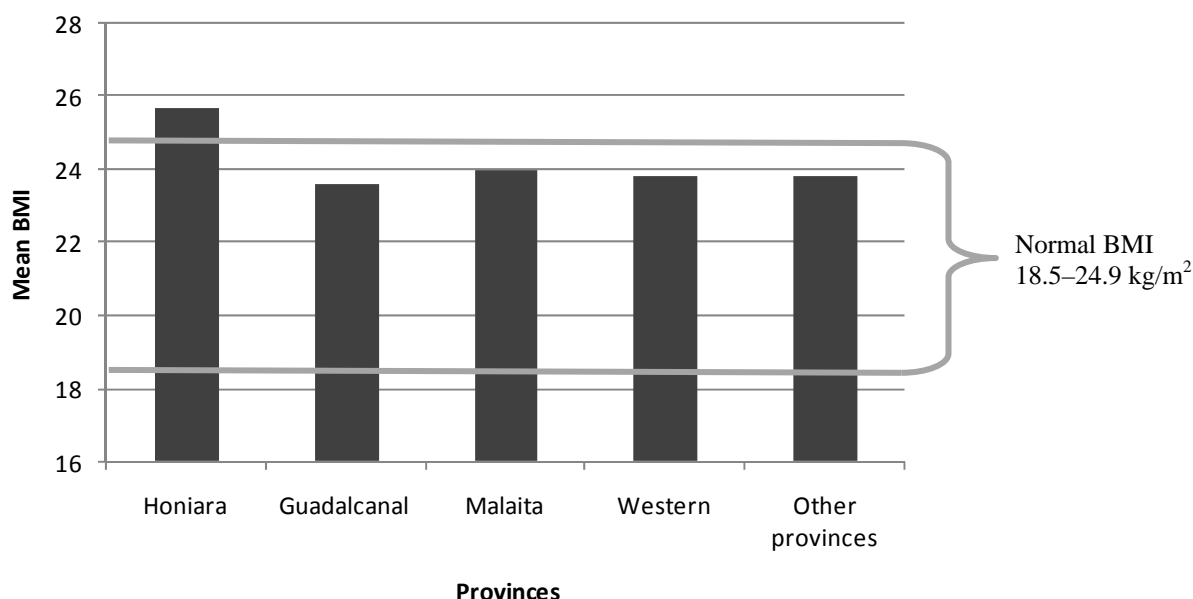
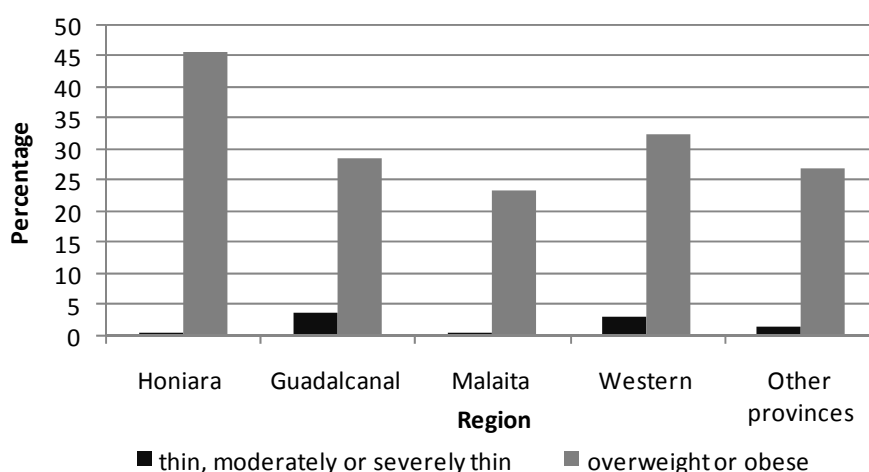


Figure 11.2: Prevalance of thin and overweight men aged 15 years and over by region, Solomon Islands



Although the mean BMI was within the normal range for men, Figure 11.2 clearly shows that a significant number of men were either overweight or obese in all regions, particularly Honiara.

11.2 NUTRITIONAL STATUS OF WOMEN

Table 11.2 presents the nutritional status of Solomon Islands women aged 15–49 who were not pregnant or had given birth over the preceding two months. Overall, only 3% of women are of short stature, observed mostly in younger women (aged 15–19 at 5.5%) from rural areas in Western Province and living in the least wealthy households.

The overall prevalence of low BMI (25.4 kg/m^2) is less than 2%, seen mostly in younger women (aged 15–19) from rural areas in Guadalcanal and Malaita provinces, and living in less wealthy households. Women in rural areas are less likely than women in urban areas to have access to adequate nutritious foods. The mean BMI for women is 25.4 kg/m^2 , which is in the overweight category. This is slightly higher than that observed for men (24.1 kg/m^2).

The overall prevalence of high BMI ($>25 \text{ kg/m}^2$) among women is 44%, with 29.9% being overweight (BMI $25\text{--}29.9 \text{ kg/m}^2$) and 14.5% being obese (BMI $>30 \text{ kg/m}^2$). Higher BMI is observed among older women (aged 30–49) from urban areas in Honiara and among women with a higher education living in wealthy households. Increasing BMI levels appear to be associated with increasing age and levels of maternal education and household wealth. Regional differences in the mean BMI among women is shown in Figure 11.3.

Table 11.2: Nutritional status of women

Among women aged 15–49, the percentage with height under 145 cm, mean body mass index (BMI), and the percentage with specific BMI levels, by background characteristics, Solomon Islands 2007

Background characteristic	Height		BMI ¹								Number of women
	Percentage below 145 cm	Number of women	Mean BMI	<17 (Moderately & severely thin)	17.0–18.4 (Mildly thin)	<18.5 (Total thin)	18.5–24.9 (Total normal)	>=25.0 (Total over-weight or obese)	25.0–29.9 (Over-weight)	>=30.0 (Obese)	
Age											
15–19	5.5	600	23.7	0.5	1.9	2.4	68.7	28.9	26.3	2.6	582
20–29	2.6	1,324	24.6	0.4	1.7	2.1	59.9	38.0	28.7	9.4	1,176
30–39	1.8	1,008	26.3	0.1	1.3	1.4	45.4	53.1	32.8	20.3	916
40–49	3.1	575	27.1	1.0	1.1	2.1	38.7	59.2	31.5	27.7	573
Residence											
Urban	1.5	526	27.2	0.3	1.3	1.6	41.2	57.2	32.5	24.7	491
Rural	3.2	2,980	25.0	0.5	1.5	2.0	55.9	42.1	29.5	12.6	2,756
Region											
Honiara	1.5	396	26.9	0.2	1.4	1.6	40.6	57.8	32.9	24.9	367
Guadalcanal	3.7	518	24.3	0.6	2.1	2.7	64.4	32.9	21.9	11.0	461
Malaita	3.5	786	25.4	0.5	1.8	2.3	55.4	42.2	30.3	12.0	727
Western	6.0	409	25.7	0.6	0.7	1.3	51.1	47.6	28.7	18.9	377
Other provinces	1.9	1,396	25.2	0.4	1.4	1.7	53.3	44.9	32.0	12.9	1,314
Education											
No education	2.9	474	24.9	0.7	1.7	2.4	58.4	39.2	26.5	12.7	450
Primary	3.6	1,988	25.5	0.4	1.4	1.8	53.0	45.2	29.2	16.0	1,837
Secondary	1.8	935	25.0	0.3	1.8	2.2	55.1	42.7	31.4	11.3	852
More than secondary	0.5	109	27.9	0.0	0.8	0.8	34.4	64.8	43.7	21.1	108
Wealth quintile											
Lowest	4.3	661	24.5	0.7	2.0	2.7	61.8	35.5	25.8	9.7	599
Second	3.2	711	24.7	0.4	1.2	1.6	58.8	39.7	30.7	9.0	672
Middle	3.4	681	25.3	0.6	2.9	3.4	54.2	42.4	28.0	14.4	638
Fourth	2.6	710	25.4	0.1	0.5	0.6	54.6	44.8	30.9	13.9	645
Highest	1.3	742	26.9	0.5	1.1	1.6	40.4	58.0	33.5	24.5	693
Total	3.0	3,506	25.4	0.4	1.5	1.9	53.7	44.4	29.9	14.5	3,247

Note: BMI is expressed as the ratio of weight in kilograms to the square of height in meters (kg/m²).

¹ Excludes pregnant women and women who gave birth in the two months preceding the survey.

Figure 11.3: Mean BMI among women aged 15–49 in Solomon Islands by region

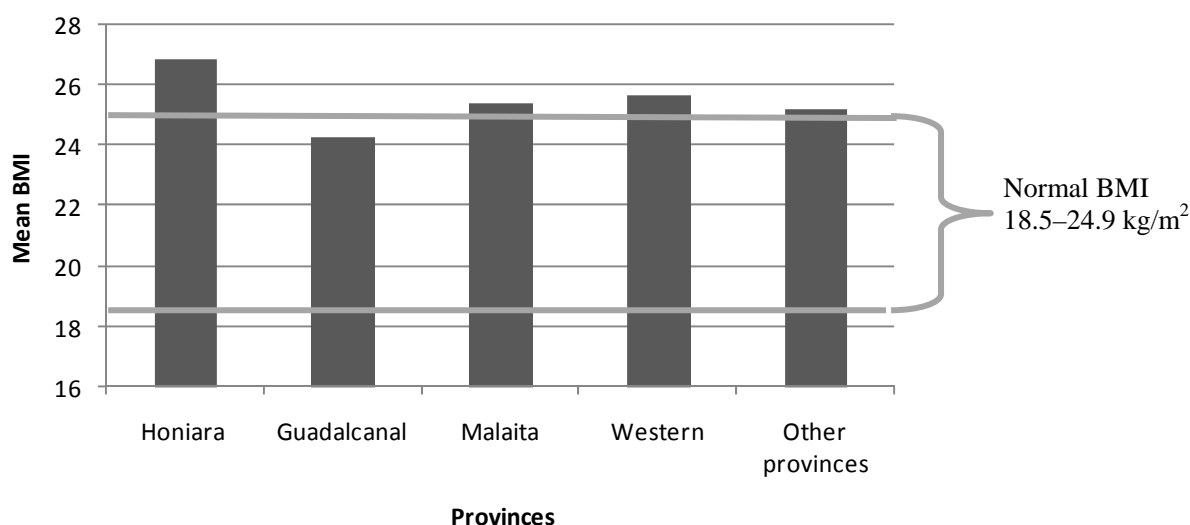


Figure 11.4: Differences in prevalence between thin and overweight or obese women aged 15–49 in Solomon Islands by region

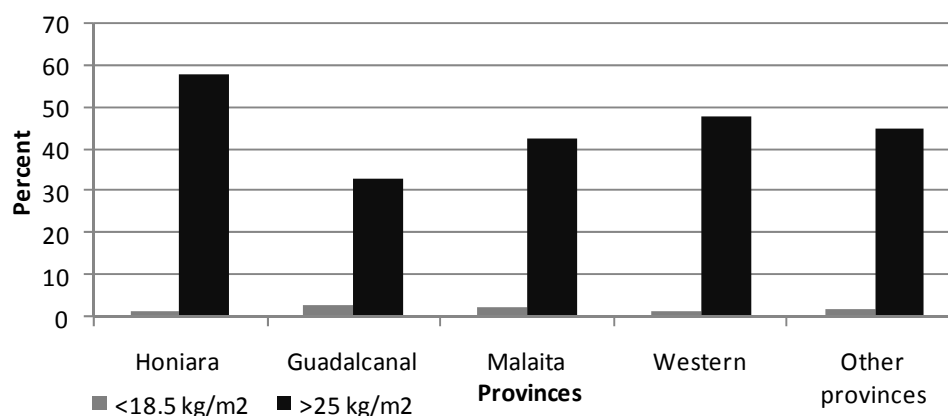


Figure 11.4 shows the distribution of women who are thin (BMI <18.5 kg/m²) and overweight or obese (BMI >25 kg/m²) by region, and illustrates that in all regions, a significant number of women are either overweight or obese. These results are similar for men (see Fig. 11.2).

11.3 NUTRITIONAL STATUS OF CHILDREN

The nutritional status of children is an important indicator of their health and well-being. Poor nutrition in children under age 5 five years is associated with an increased risk of morbidity and mortality. Usually there is a “catch-up” growth in older childhood or adolescent in children who experience growth retardation under age 3 years.

Malnutrition in children leads to short stature in adults, which is associated with reduced productivity and increased obstetrics risks for women.

Poor nutrition in children is related to maternal malnutrition, low birth weight, inadequate breastfeeding and weaning diets, and high levels of infectious disease morbidity. Improvements in

the nutritional status of children will reduce the severity of common childhood illnesses and reduce the risk of death.

In the 2006/2007 SIDHS,, the nutritional status of children was assessed by examining weight and height measurements using standardised methods. Weight was measured using a digital scale accurate to the nearest 100 g, and height was measured using a portable measuring board accurate to the nearest 1 mm. Children under age 2 years were measured lying down, while older children were measured standing upright.

Three anthropometric indicators were calculated using weight and height measurements:

1. **Height-for-age** reflects achieved linear growth and deficits, which indicates long-term cumulative inadequate nutrition and poor health. Low height-for-age or **stunting** is frequently associated with poor overall economic conditions, which result in long-term, inadequate calorie intake and/or repeated exposure to illness, and other adverse conditions. Height-for-age is the recommended indicator that best reflects failure of a child to reach linear growth potential. This indicator changes slowly over time and does not vary by season.
2. **Weight-for-height** reflects body weight relative to height. Low weight-for-height, or **wasting**, indicates a loss of weight or an insufficient weight gain relative to height. Wasting is generally associated with recent or ongoing severe weight loss. Weight loss in children resulting in low weight-for-height is usually due to recent illness and/or insufficient calorie intake (caused by food shortage, weaning practices or other events). This indicator can vary by season depending on the availability of food and the incidence of acute morbidity in the child population.
3. **Weight-for-age** is an indicator of body mass relative to chronological age. Weight-for-age is primarily a composite of weight-for-height and height-for-age, and fails to distinguish tall, thin children from short, well-proportioned children. Because it is influenced by both the height and the weight of the child, it is more difficult to interpret. Low weight-for-age or **underweight** can be used as a general indicator of child health and mortality risk.

These indices were calculated by comparing the weight and height measurements, or combinations of these measurements, with WHO international growth references. These references are based on the observation that well-nourished children from different countries and ethnic groups have a similar growth potential at least to age 7 years. Environmental factors such as infectious diseases, inadequate and unsafe diet, poverty and socioeconomic status, rather than genetic predisposition, account for any deviations from the references (WHO 1997).

The anthropometric indicators of the child nutrition status used in this survey are expressed as standard deviations (SD), the deviations of the individual anthropometric measurements from the median value of the WHO growth reference for that child's height or age divided by the SD for the reference population. Children who were more than 2 SD below the reference median of the international growth reference for their age or height (<2 SD) were considered **undernourished** and those more than <3 SD below were graded as **severely undernourished**.

Stunting in children

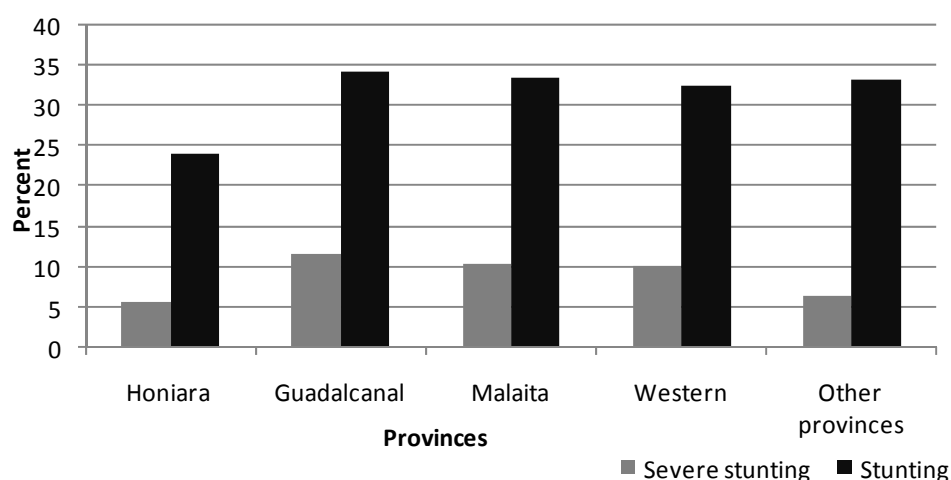
Low height-for-age, or stunted growth, reflects a failure to reach linear growth potential as a result of suboptimal health and/or nutritional conditions. On a population level, high level of stunting is associated with poor socioeconomic conditions and a high risk of frequent and early exposure to adverse conditions such as illness and/or inappropriate feeding practices. Childhood stunting leads to significant reduction in adult size. One of the main consequences of small adult size is reduced work capacity, which in turn has an impact on economic productivity. Maternal size is associated with specific reproductive outcomes. Short stature in women places an increased risk of delivery complications because of small pelvic size. Small maternal size also increases the risk of giving birth to low weight babies who themselves have an increased risk of becoming small sized adults.

Table 11.3 presents the prevalence of low height-for-age or stunting in children less than 5 years by gender and according to birth size and maternal characteristics. Overall, 32.8% of children under age 5 years are stunted (identified as <-2 SD below the mean), and 8.5% are severely stunted (identified as <-3 SD below the mean). The prevalence of stunting is slightly higher among boys (36.7%) than girls (28.8%), and also appears to be higher in children in rural areas in Guadalcanal, Malaita and Western provinces than in children in Honiara and other provinces (see Fig. 11.3). Stunting is more likely to be observed among children born of mothers with little or no education and living in less wealthy households. Stunting is also more likely to be observed among babies who are born very small or small.

Overall, the mean Z-score for height-for-age is -1.5, indicating a distribution shift below zero, the expected value of the reference distribution. This shows that on average, Solomon Islands children less than 5 years in age fail to achieve linear growth potential when compared with the WHO international growth references. Children are generally not able to achieve linear growth for age.

There are no observed differences between boys and girls. Both are equally shorter than children of similar age in the international reference population.

Figure 11.5: Prevalence of severe stunting among Solomon Islands children less than 5 years



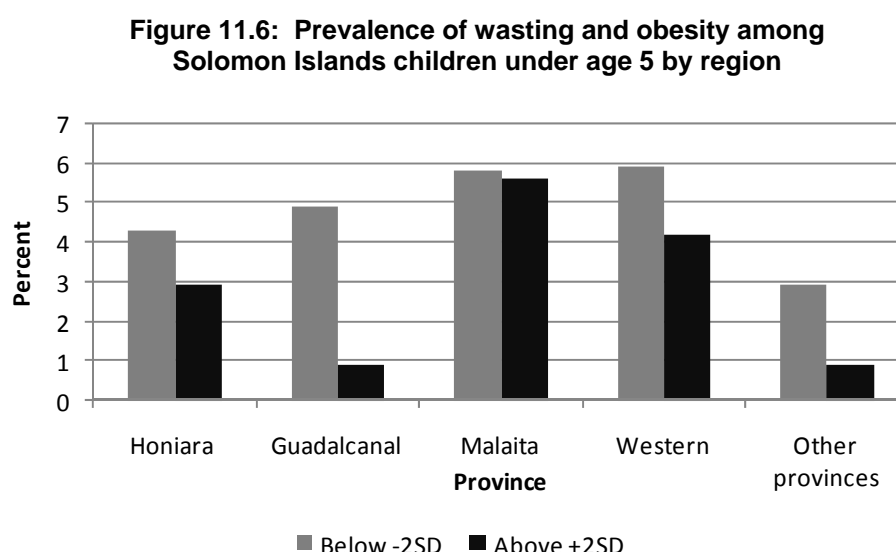
Wasting in children

Low weight-for-height or wasting or thinness indicates in most cases a recent or severe process of weight loss that is often associated with acute starvation and/or a severe disease. Wasting may also be the result of chronic unfavourable living conditions. Overall, the prevalence of wasting in Solomon Islands children is low, with 4.3% below -2SD and less than 1.4% severely wasted (below -3SD). The mean Z-score for weight-for-height is -0.1, which is slightly below zero, the expected reference value.

There is an observed peak in the prevalence of wasting in children between ages 9 and 17 months, which corresponds to the time of weaning and an age when acute infectious diseases are common. The prevalence of wasting is slightly higher among girls (5.7%) than boys (3.0%). It is also higher in rural areas in Guadalcanal and Western provinces. Children of educated mothers are less likely to be wasted. There does not seem to be any relationship between household wealth and wasting in children. Babies who are born small are more likely to be wasted (5.1% below -2SD) than children who are born of an average or larger size (4.1% below -2SD).

High weight-for-height can be considered an adequate indicator of obesity because the majority of individuals with high weight-for-height are obese. The overall prevalence of childhood obesity (>2 SD) is 2.5%. The prevalence of high weight-for-height peaks in less than 17-month-old babies, which reflects the high breastfeeding rates in these age groups (see Table 11.14.1), indicating that babies receive adequate nutrition from breast milk.

Figure 11.6 shows the prevalence of wasting and obesity by region. More children in Guadalcanal Province are wasted than children in Malaita Province where an equal proportion of children are wasted and obese.



Underweight in children

Table 11.3 shows the prevalence of low weight-for-age or underweight or being undernourished in children. Overall, 11.8% of children are underweight (below -2SD) and 2.4% are severely underweight (below -3SD). The mean Z score for weight-for-age is -0.9, which is less than zero, the expected value of the reference distribution. Solomon Islands children under age 5 years are slightly underweight when compared with the WHO growth reference.

Children in rural areas, in less wealthy households and born to less educated mothers are more likely to be underweight. The prevalence of underweight children is higher in children in Western Province than in other regions. Children of an average or large birth size are less likely to be underweight than children of a small birth size. Apathy, whether induced by inadequate nutrition intake or infection, places children at risk of developmental retardation.

Figure 11.7 shows that more children are underweight and undernourished than are overweight in all provinces.

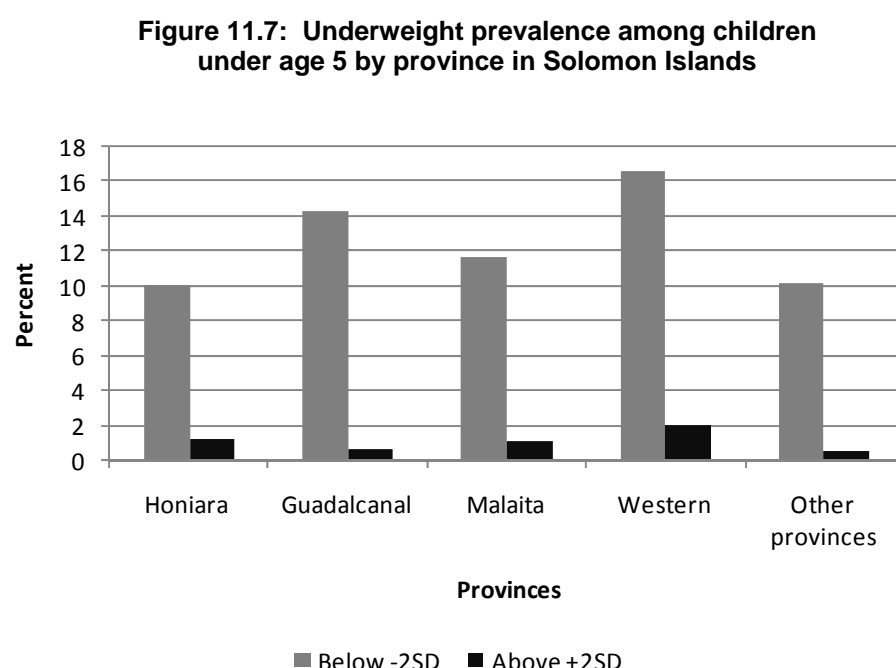


Table 11.3 Nutritional status of children

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Solomon Islands 2007

Background characteristic	Height-for-age			Weight-for-height				Weight-for-age				Number of children
	Percentage below -3 SD	Percentage below -2 SD ¹	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	
Age in months												
<6	3.7	10.0	-0.4	2.7	7.9	9.0	0.2	1.7	5.5	3.9	-0.2	159
6-8	4.6	13.0	-0.8	0.8	5.5	7.8	-0.1	1.0	7.7	3.7	-0.6	118
9-11	4.1	24.5	-1.1	3.5	9.4	5.0	-0.4	3.6	20.9	1.8	-0.9	85
12-17	9.7	31.5	-1.4	3.3	9.2	0.5	-0.4	3.5	15.6	0.1	-1.0	185
18-23	9.2	47.3	-1.7	0.0	2.9	1.1	-0.2	0.7	10.8	0.4	-1.0	243
24-35	11.1	33.6	-1.6	0.5	1.9	2.1	0.0	2.3	12.2	0.7	-0.9	430
36-47	12.4	43.7	-1.7	2.3	4.4	1.1	-0.2	5.0	16.4	0.0	-1.1	427
48-59	4.6	28.5	-1.5	0.4	2.5	1.5	-0.1	0.7	7.0	0.1	-1.0	382
Sex												
Male	9.4	36.7	-1.5	0.6	3.0	2.2	-0.0	1.8	10.4	0.5	-0.9	1,035
Female	7.6	28.8	-1.4	2.2	5.7	2.8	-0.3	3.1	13.4	1.2	-1.0	994
Birth interval in months²												
First birth ³	9.7	35.5	-1.5	0.8	2.7	3.6	0.0	2.6	14.3	0.3	-0.9	370
<24	9.4	37.2	-1.6	2.3	5.9	2.7	-0.1	3.2	11.9	0.7	-1.0	325
24-47	6.8	30.9	-1.4	1.3	4.2	2.7	-0.2	2.2	12.0	1.7	-1.0	751
48+	8.9	28.1	-1.4	1.6	6.1	1.6	-0.2	2.2	10.5	0.1	-0.9	384
Size at birth²												
Very small	7.2	45.2	-1.8	0.0	5.1	1.4	-0.3	1.0	20.7	0.0	-1.2	60
Small	17.2	46.1	-1.8	0.7	5.8	3.3	-0.2	5.2	19.5	0.9	-1.2	187
Average or larger	6.8	29.5	-1.4	1.5	4.1	2.5	-0.1	2.0	10.4	0.9	-0.9	1,490
Mother's interview status												
Interviewed	8.3	32.3	-1.5	1.4	4.6	2.7	-0.1	2.5	12.2	0.9	-0.9	1,829
Not interviewed but in household	4.1	16.2	-1.0	2.0	3.1	4.3	-0.2	2.0	7.4	0.5	-0.7	50
Not interviewed, and not in the household ⁴	12.9	43.8	-1.7	0.4	1.7	0.0	0.1	2.1	9.3	0.0	-0.9	149

Table 11.3 (continued)

Background characteristic	Height-for-age			Weight-for-height				Weight-for-age				Number of children
	Percentage below -3 SD	Percentage below -2 SD ¹	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	
Mother's nutritional status												
Thin (BMI<18.5)	(6.6)	(45.1)	(-1.9)	(2.0)	(10.6)	(6.4)	(-0.5)	(7.7)	(32.3)	(3.2)	(-1.4)	31
Normal (BMI 18.5-24.9)	8.3	32.8	-1.5	1.9	5.0	2.8	-0.2	3.3	13.2	0.6	-1.0	1,077
Overweight/obese (BMI ≥ 25)	8.4	30.7	-1.4	0.8	3.6	2.5	0.0	1.1	9.4	1.2	-0.8	724
Residence												
Urban	6.9	23.0	-1.1	0.5	3.4	2.4	-0.1	0.6	8.2	2.0	-0.7	209
Rural	8.7	33.9	-1.5	1.5	4.4	2.5	-0.1	2.6	12.2	0.7	-0.9	1,819
Region												
Honiara	5.7	24.1	-1.1	0.3	4.3	2.9	-0.1	0.4	10.0	1.2	-0.7	153
Guadalcanal	11.7	34.3	-1.4	1.8	4.9	0.9	-0.3	3.0	14.3	0.6	-1.0	322
Malaita	10.4	33.5	-1.5	2.9	5.8	5.6	0.0	3.3	11.7	1.0	-0.8	486
Western	10.1	32.6	-1.5	2.7	5.9	4.2	-0.3	4.1	16.6	2.0	-1.0	206
Other provinces	6.4	33.4	-1.5	0.2	2.9	0.9	-0.1	1.7	10.2	0.5	-0.9	861
Mother's education⁵												
No education	9.8	37.7	-1.4	2.4	4.7	3.4	-0.1	2.7	11.7	1.6	-0.9	277
Primary	8.6	32.8	-1.5	1.0	4.0	2.4	-0.2	2.3	11.7	0.5	-1.0	1,169
Secondary	5.2	25.4	-1.3	2.1	6.3	3.1	-0.1	2.5	13.4	1.3	-0.8	393
More than secondary	13.1	29.9	-1.1	0.9	2.6	1.0	-0.1	4.8	11.1	2.7	-0.7	40
Wealth quintile												
Lowest	11.3	34.2	-1.6	1.2	4.6	3.2	-0.0	3.6	13.7	1.1	-0.9	493
Second	13.1	39.4	-1.7	1.4	3.7	1.7	-0.1	2.7	12.3	0.0	-1.0	436
Middle	5.8	31.6	-1.3	1.9	5.1	4.1	-0.2	2.0	13.4	1.7	-0.9	383
Fourth	5.1	33.7	-1.5	1.2	3.7	1.5	-0.2	2.6	9.1	0.2	-1.0	396
Highest	5.5	22.0	-1.2	1.3	4.6	1.9	-0.2	0.6	9.8	1.1	-0.8	321
Total	8.5	32.8	-1.5	1.4	4.3	2.5	-0.1	2.4	11.8	0.8	-0.9	2,029

Note: Table is based on children who slept in the household the night before the interview. Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards.

Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight.

Totals include 82 cases with missing information on size at birth, 44 cases with missing information on mother's nutritional status, and 1 case with missing information on mother's education.

¹ Includes children who are below -3 standard deviations (SD) from the International Reference Population median

² Excludes children whose mothers were not interviewed

³ First born twins (triplets, etc.) are counted as first births because they do not have a previous birth interval

⁴ Excludes children whose mothers were not weighed and measured. Mother's nutritional status in terms of BMI (Body Mass Index) is presented in Table 11.10

⁵ Includes children whose mothers are deceased

11.4 INFANT AND YOUNG CHILD FEEDING PRACTICES

The survival, growth, development, health and nutritional status of children are closely linked to infant and young child feeding practices. The mother's nutritional status during pregnancy and lactation also has an important impact on the child's health and nutritional status. Exclusive breastfeeding until six months of age is the recommended and most appropriate way to feed newborn babies until age 6 months. It provides optimal nutrition for the growing child; reduces exposure to environmental pathogens, and provides protection from environmental contamination such as poor water quality.

WHO and UNICEF recommend that solid food should only be given after a child reaches 6 months of age, and that breastfeeding should continue into the second year of life. Prolonged breastfeeding also increases duration of postpartum infertility, thus breastfeeding acts as a natural contraceptive, impacting on the mother's fertility health and length of birth intervals.

11.4.1 Initial breastfeeding

Both the mother and child benefit from early initiation of breastfeeding. The suckling actions of the baby on the breast release the hormone oxytocin, which increases uterine contractions and improves the expulsion of the placenta and reduces the risk of haemorrhage following delivery. The infant benefits from the first breast milk called colostrums, which is rich in nutrients and immunoglobulin that help protect against infections.

Table 11.4 presents the prevalence of children born in the five years preceding the survey who were ever breastfed and the time of initiation of breastfeeding. Overall, the prevalence of children who are ever breastfed is 92.6%, with 75% of these beginning breastfeeding within one hour of birth; this figure increased to 96% within one day of birth. An overall 6.5% of children receive something other than breast milk.

The prevalence of breastfeeding is slightly higher in rural areas (93.2%) than in urban areas (88.5%). Overall, the results show that the prevalence of breastfed babies increases with a mother's level of educational attainment, but decreases with an increasing level of household wealth.

Figure 11.8: Prevalence of breastfeeding children by province

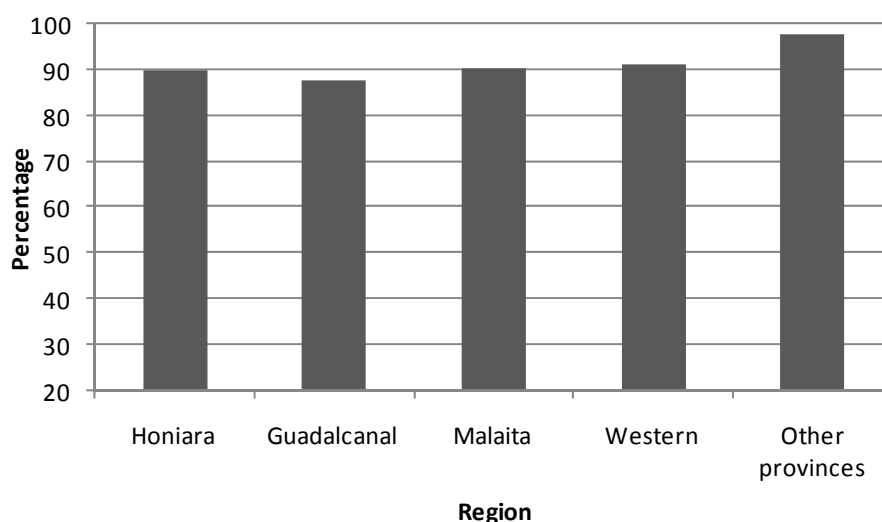


Table 11.4: Initial breastfeeding

Percentage of children born in the five years preceding the survey who were ever breastfed, and for the last children born in the five years preceding the survey ever breastfed, the percentage who started breastfeeding within one hour and within one day of birth, and the percentage who received a prelacteal feed, by background characteristics, Solomon Islands 2007

Background characteristic	Breastfeeding among children born in last five years		Among last-born children ever breastfed:			
	Percentage ever breastfed	Number of children born in last five years	Percentage who started breastfeeding within 1 hour of birth	Percentage who started breastfeeding within 1 day of birth ¹	Percentage who received a prelacteal feed ²	Number of last-born children ever breastfed
Sex						
Male	91.9	1,317	72.7	95.8	7.3	848
Female	93.3	1,351	77.2	96.3	5.7	859
Residence						
Urban	88.5	330	78.0	94.8	4.5	218
Rural	93.2	2,338	74.5	96.2	6.8	1,490
Region						
Honiara	89.8	249	76.6	93.1	5.5	165
Guadalcanal	87.9	483	69.9	95.3	2.8	297
Malaita	90.2	678	47.2	95.0	1.6	391
Western	91.0	289	80.0	97.4	7.2	189
Other provinces	98.0	969	91.7	97.3	11.1	665
Mother's education						
No education	91.7	373	64.8	97.2	2.6	227
Primary	93.3	1,662	74.8	95.7	7.8	1,056
Secondary	90.9	571	81.0	96.6	5.7	380
More than secondary	96.6	62	79.9	93.0	5.2	44
Assistance at delivery						
Health professional ³	93.2	2,280	76.9	96.5	6.3	1,492
Traditional birth attendant	90.4	194	66.2	95.8	12.3	120
Other	88.3	110	60.2	94.7	4.4	63
No one	*	*	*	*	*	18
Place of delivery						
Health facility	93.2	2,255	77.0	96.5	6.3	1,481
At home	89.0	379	64.4	96.5	8.1	217
Other	*	*	*	*	*	2
Wealth quintile						
Lowest	95.8	646	71.9	97.0	8.9	402
Second	94.3	552	79.1	97.0	6.8	352
Middle	92.1	484	76.1	95.5	6.1	311
Fourth	91.2	513	75.1	94.7	5.4	337
Highest	88.5	472	72.8	95.7	4.8	306
Total	92.6	2,668	75.0	96.0	6.5	1,708

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Table is based on births in the last five years whether the children are living or dead at the time of interview.

Total includes 15 cases with missing information on assistance at delivery and 8 cases with missing information on place of delivery.

¹ Includes children who started breastfeeding within one hour of birth.

² Children given something other than breast milk during the first three days of life.

³ Doctor, nurse/midwife, or auxiliary midwife.

11.4.2 Age of breastfeeding

One indicator of breastfed children is the percentage of children less than 6 months old who are exclusively breastfed.

Table 11.5 presents the prevalence of children less than age 3 years who are currently breastfed and/or receiving complementary foods at the time of the survey. The prevalence of exclusive breastfeeding declines rapidly between 4 and 8 months while the prevalence of consumption of complementary foods increases. This corresponds to the early introduction of complementary feed. Figure 11.8 shows this relationship very clearly. The practice of introducing complementary foods from 4 months onwards is common in Solomon Islands.

Plain water is given to children mostly during the weaning period. Non-milk liquids or juice are given mainly to children less than 4 months of age. Milk other than breast milk is not commonly given to babies because the cost of formula and powdered milk is very expensive. The use of a bottle with a nipple peaks between ages 6 and 12 months.

Figure 11.9: Relationship between exclusive breastfeeding and complementary feeding among Solomon Islands children less than 3 years old

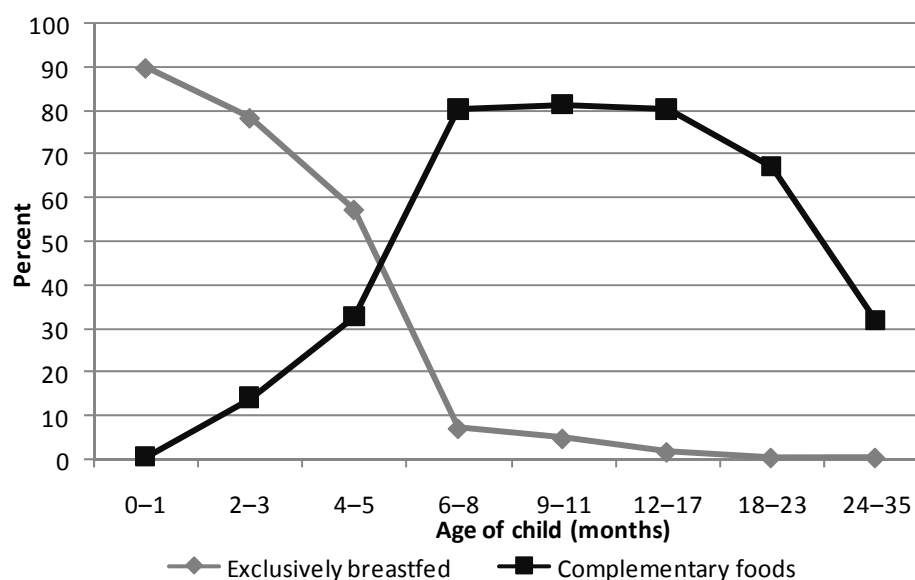


Table 11.5: Breastfeeding status by age

Percent distribution of youngest children under 3 years who are living with their mother by breastfeeding status and the percentage currently breastfeeding; and the percentage of all children under three years using a bottle with a nipple, according to age in months, Solomon Islands 2007

Age in months	Not breast-feeding	Exclusively breastfed	Plain water only	Non-milk liquids/ juice	Other milk	Complementary foods	Total	Percentage currently breast-feeding	Number of youngest child under three years	Percentage using a bottle with a nipple ¹	Number of children
0-1	3.5	90.0	0.0	3.1	2.7	0.7	100.0	96.5	53	3.4	55
2-3	1.0	78.5	3.0	3.1	0.3	14.1	100.0	99.0	121	1.8	121
4-5	0.8	57.4	2.5	6.6	0.0	32.6	100.0	99.2	89	8.1	90
6-8	3.2	7.0	3.3	6.2	0.0	80.3	100.0	96.8	153	12.4	154
9-11	10.8	4.7	0.8	1.9	0.6	81.3	100.0	89.2	101	27.0	106
12-17	18.2	1.6	0.0	0.0	0.0	80.2	100.0	81.8	227	10.3	245
18-23	31.5	0.3	1.1	0.0	0.0	67.2	100.0	68.5	251	11.2	290
24-35	68.0	0.3	0.0	0.0	0.0	31.7	100.0	32.0	352	5.1	533
0-3	1.7	82.0	2.1	3.1	1.0	10.1	100.0	98.3	174	2.3	176
0-5	1.4	73.7	2.2	4.3	0.7	17.7	100.0	98.6	262	4.3	266
6-9	3.7	5.8	3.2	6.0	0.0	81.4	100.0	96.3	186	15.6	187
12-15	15.7	1.1	0.0	0.0	0.0	83.2	100.0	84.3	150	10.4	165
12-23	25.2	0.9	0.6	0.0	0.0	73.4	100.0	74.8	478	10.8	535
20-23	32.6	0.0	0.0	0.0	0.0	67.4	100.0	67.4	141	7.2	167

Note: Breastfeeding status refers to a 24-hour period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, non-milk liquids/juice, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add up to 100%. Thus children who receive breast milk and non-milk liquids and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any child who receives complementary foods is classified in that category as long as they are breastfeeding as well.

¹ Based on all children under age 3 years.

11.4.3 Duration and frequency of breastfeeding

Table 11.6 presents the median duration of any breastfeeding, exclusive breastfeeding and predominantly breastfeeding among children born in the three years preceding the survey, and the mean number of feeds per day/night by background characteristics.

WHO and UNICEF recommend exclusively breastfeeding babies for the first 6 months and continued breastfeeding for at least 24 months. The median duration of any breastfeeding among Solomon Islands children born in the three years preceding the survey is 22.6 months. The mean duration for exclusive breastfeeding is 5.1 months and is 5.8 months for predominantly breastfeeding.

Children in rural areas are most likely to be breastfed more frequently than those in urban areas. There are no significant differences in the mean duration of exclusive breastfeed children (both 4.2%) by region, mother's educational attainment or residence.

Table 11.6: Median duration and frequency of breastfeeding

Median duration of any breastfeeding, exclusive breastfeeding, and predominant breastfeeding among children born in the three years preceding the survey, percentage of breastfeeding children under 6 months living with the mother who were breastfed 6 or more times in the 24 hours preceding the survey, and mean number of feeds (day/night), by background characteristics, Solomon Islands 2007

Background characteristic	Median duration (months) of breastfeeding among children born in the last three years ¹			Frequency of breastfeeding among children under 6 months ²			
	Any breast-feeding	Exclusive breast-feeding	Predominant breast-feeding ³	Percentage breastfed 6+ times in last 24 hours	Mean number of day feeds	Mean number of night feeds	Number of children
Sex							
Male	23.2	4.8	5.4	95.8	7.7	5.4	129
Female	22.1	3.7	4.4	98.0	8.0	4.8	121
Residence							
Urban	18.3	4.2	6.1	88.1	5.8	4.3	31
Rural	23.0	4.2	4.8	98.1	8.1	5.2	219
Region							
Honiara	18.4	3.3	5.2	93.9	6.1	4.5	24
Guadalcanal	24.4	3.9	4.6	100.0	9.1	8.3	48
Malaita	(19.2)	(3.5)	(3.7)	(90.8)	(6.5)	(4.5)	55
Western	*	*	*	*	*	*	23
Other provinces	25.1	4.9	5.5	98.7	8.3	4.2	100
Mother's education							
No education	(22.2)	(3.8)	(4.7)	(91.3)	(6.3)	(5.1)	32
Primary	23.3	4.5	5.1	98.7	8.5	5.2	142
Secondary	21.7	3.7	4.5	98.8	7.4	5.1	70
More than secondary	*	*	*	*	*	*	6
Total	22.6	4.2	4.9	96.9	7.8	5.1	250
Mean for all children	21.7	5.1	5.8	na	na	na	na

Note: Median and mean durations are based on current status. Includes children living and deceased at the time of the survey.

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = not applicable

¹ It is assumed that non-last-born children and last-born children not currently living with the mother are not currently breastfeeding.

² Excludes children without a valid answer on the number of times breastfed.

³ Either exclusively breastfed or received breast milk and plain water, and/or non-milk liquids only.

No categorisation by wealth due to low numbers.

11.4.4 Types of complementary foods consumed by children

UNICEF and WHO recommend introducing solid food to infants from the age of 6 months because the nutritional requirements of the child will not be adequately met by breast milk alone. In the transition to eating the family diet, children from the age of 6 months should be fed small quantities of solid and semi-solid foods (complementary foods) throughout the day. The risk of malnutrition during this transition period is very high due to improper and unsafe food handling practices.

Mothers whose youngest child is under 3 years of age were asked about the types of foods and liquids consumed by the child in the day or night preceding the interview. The results are presented in Table 11.7.

Liquids

Non-breastfed children are more likely to consume all other types of liquids and milks than breastfed children. The most commonly consumed liquid is 'other liquids', which does not include water. Coconut water was one of the selection items in the questionnaire as this was commonly given to very young children. Infant formula and other milks were not commonly consumed by all children but were slightly more consumed by non-breastfed children.

Solids or semi-solid foods

The introduction of semi-solid and solid foods increased rapidly between 4 and 9 months among all children. Vitamin A-rich foods such as foods such as pawpaw, sweet potatoes and pumpkin are the most common foods introduced to young children. These are very soft when cooked and thus easily mashed to the right consistency.

Other commonly consumed foods include those made from grains followed by foods made from tubers, roots crops and other vegetables.

Only 21% of breastfed children and 38.5% of non-breastfed children consume protein-rich foods, such as meat, fish, poultry and eggs. These foods are very expensive and not everyone can afford them.

The percentage of non-breastfed children consuming any solid or semi-solids foods is higher (95.2%) than those who are breastfed (73.7%).

A high percentage of non-breastfed children consume high fat foods (62.4%) as well as sugary foods (26.0%), while only 37.2% of breastfed children consume high fat foods and 12.6% sugary foods.

Table 11.7: Foods and liquids consumed by children in the day or night preceding the interview

Percentage of youngest children under age 3 years who are living with the mother by type of foods consumed in the day or night preceding the interview, according to breastfeeding status and age, Solomon Islands 2007

Age in months	Liquids				Solid or semi-solid foods								Sugary foods	Number of children	
	Infant formula	Other milk ¹	Other liquids ²	Fortified baby foods	Food made from grains ³	Fruits and vegetables rich in vitamin A ⁴	Other fruits and vegetables	Food made from roots and tubers	Food made from legumes and nuts	Meat, fish, poultry, and eggs	Cheese, yogurt, other milk product	Any solid or semi-solid food			Food made with oil, fat and butter
BREASTFEEDING CHILDREN															
0–1	2.8	1.8	4.1	0.0	0.0	0.7	0.0	0.7	0.0	0.0	0.0	0.7	0.0	0.0	51
2–3	3.1	3.4	16.1	0.3	3.3	10.5	4.0	4.0	1.7	2.5	1.2	14.3	2.9	0.7	120
4–5	1.8	2.0	21.8	2.0	2.7	29.5	5.7	13.5	1.6	3.3	4.5	32.9	4.4	2.6	88
6–8	4.6	6.7	56.2	2.4	11.4	75.6	25.7	49.1	3.0	14.2	2.7	82.9	24.5	4.4	149
9–11	7.4	10.3	67.7	2.5	38.1	85.4	46.4	67.5	6.8	23.3	10.7	91.1	40.8	9.2	90
12–17	3.4	5.7	81.3	2.8	57.7	88.0	44.2	73.0	12.2	30.9	6.9	98.1	56.2	21.1	186
18–23	3.0	6.8	69.2	1.7	55.0	87.1	37.9	76.1	24.3	32.3	4.9	97.3	68.1	20.7	172
24–35	4.5	7.4	83.6	3.2	75.0	92.5	44.2	86.9	20.9	37.1	10.9	98.9	51.8	25.6	113
6–23	4.2	6.9	69.5	2.3	42.4	84.3	38.1	67.1	12.6	26.0	5.9	93.0	49.4	15.0	597
Total	3.8	5.8	56.8	2.0	35.6	66.7	29.7	53.2	10.5	21.0	5.4	73.7	37.2	12.6	968
NON-BREASTFEEDING CHILDREN ⁵															
6–23	12.1	18.1	81.0	3.9	49.4	87.5	43.0	67.1	22.0	39.1	6.8	90.8	62.0	35.9	136
Total	6.8	12.4	79.3	2.8	60.9	91.4	46.1	76.2	21.9	38.5	8.6	95.2	62.4	26.0	379

Note: Breastfeeding status and food consumed refer to a 24-hour period (yesterday and last night).

¹ Other milk includes fresh, tinned and powdered cow or other animal milk.

² Doesn't include plain water.

³ Includes fortified baby food.

⁴ Includes pumpkin, carrots, squash, sweet potatoes, dark green leafy vegetables, ripe mangoes, and pawpaw.

⁵ There are too few non-breastfeeding children less than 12 months of age to show results by age in months.

11.4.5 Feeding practices according to the IYCF recommendations

The WHO Global Strategy on Infant and Young Child Feeding – IYCF (WHO 2005) recommends the timely introduction of solid and/or semi-solid foods from age 6 months, increasing the amount and variety of foods and frequency of feeding as the child gets older, while maintaining frequent breastfeeding as best practice.

Mothers with children aged 6–23 months living with them were asked about the kinds of foods and drinks they fed their children and how often children ate the food in the previous day or night. The list of foods in the questionnaire was categorised into seven groups. The minimum standards were defined with respect to food diversity (i.e. the number of food groups consumed) and feeding frequency (i.e. the number of times the child was fed), as well the consumption of breast milk or other milks or milk products. Breastfed children aged 6–8 months were considered to have met the minimum nutritional requirements if they consumed foods from at least three food groups⁶ as well as breast milk at least twice a day and at least three times per day for children aged 9–23 months. Non-breastfed children were considered to have met the minimum nutritional requirements if they consumed milk or milk products plus foods from at least four food groups (including milk products), and were fed at least four times per day.

Table 11.8 shows the percentage of children who are fed according to the IYCF practices. Overall, among all children aged 6–23 months, 85.1% consume breast milk or other milk products, while 56.2% consume a varied diet from the three to four main food groups a day, and only 36.9% meet all three IYCF practices.

Among non-breastfed children, only 2.7% meet the minimum IYCF requirements and these children are mainly from Honiara and among educated women and women living in wealthy households. Children in urban areas, born to educated mothers and living in wealthy households are more likely to meet the minimum IYCF.

⁶ Food groups used in the assessment of minimum standard of feeding practices include: infant formula, milk other than breast milk, cheese or yogurt or other milk products; foods made from grains, roots and tubers, including porridge and fortified baby food from grains; fruits and vegetables rich in vitamin A; other fruits and vegetables; eggs; meat, poultry, fish and shellfish (and organ meats); beans, peas and nuts; and foods made with oil, fat or butter.

Table 11.8: Infant and young child feeding (IYCF) practices

Percentage of youngest children aged 6–23 months living with their mother who are fed according to three IYCF feeding practices based upon number of food groups and times they are fed during the day or night preceding the survey by breastfeeding status and background characteristics, Solomon Islands 2007

Background characteristic	Among breastfed children 6–23 months, percentage fed:				Among non-breastfed children 6–23 months, percentage fed:					Among all children 6–23 months, percentage fed:				
	3+ food groups ¹	Minimum times or more ²	Both 3+ food groups and minimum times or more	Number of breastfed children 5–23 months	Milk or milk products ³	4+ food groups	4+ times or more	With 3 IYCF practices ⁴	Number of non-breastfed children 6–23 months	Breast-milk or milk products	3+ or 4+ food groups ⁵	Minimum times or more ⁶	With all 3 IYCF practices	Number of all children 6–23 months
Age in months														
6–8	32.8	68.0	23.3	149	22.3	13.5	0.0	0.0	5	97.5	32.2	65.8	22.5	153
9–11	62.3	57.8	37.7	90	33.0	21.1	21.3	4.8	11	92.8	57.9	53.8	34.2	101
12–17	68.5	68.0	51.8	186	14.7	56.4	48.6	4.1	41	84.5	66.3	64.5	43.2	227
18–23	74.9	67.3	59.0	172	20.6	59.0	25.7	1.9	79	75.0	69.9	54.2	41.0	251
Sex														
Male	61.4	62.5	44.8	273	23.5	52.9	38.1	1.8	73	83.8	59.6	57.4	35.7	347
Female	59.7	69.4	44.5	324	15.7	54.3	23.6	3.9	63	86.3	58.9	62.0	37.9	386
Residence														
Urban	71.7	71.8	55.5	71	53.1	67.5	43.7	14.0	20	89.5	70.7	65.5	46.2	92
Rural	59.0	65.5	43.2	526	14.0	51.1	29.2	0.7	116	84.5	57.6	59.0	35.5	641
Region														
Honiara	66.0	71.6	52.3	52	58.9	64.0	37.5	15.5	18	89.3	65.5	62.7	42.7	71
Guadalcanal	56.6	67.1	43.1	120	17.6	63.7	33.1	6.8	13	92.2	57.3	63.9	39.6	133
Malaita	65.1	64.1	46.9	151	0.9	64.3	33.1	0.0	43	78.1	65.0	57.2	36.5	195
Western	63.8	64.2	39.8	57	33.8	73.6	23.3	0.0	17	84.7	66.1	54.7	30.6	75
Other provinces	57.2	66.6	43.4	216	17.3	28.3	29.9	0.0	45	85.8	52.3	60.3	36.0	261
Mother's education														
No education	58.1	50.9	33.0	82	2.8	16.0	20.6	2.8	13	86.6	52.3	46.7	28.8	95
Primary	60.6	65.8	45.4	358	19.1	59.0	27.4	0.7	89	83.8	60.3	58.1	36.5	447
Secondary	60.1	77.2	48.8	139	29.5	55.5	49.1	8.7	31	87.0	59.2	72.0	41.5	170
More than secondary	(71.7)	(61.0)	(50.2)	(19)	(17.0)	(31.6)	(11.7)	(0.0)	(3)	(90.2)	(67.0)	(55.2)	(44.3)	22

Table 11.8 (continued)

Background characteristic	Among breastfed children 6–23 months, percentage fed:				Among non-breastfed children 6–23 months, percentage fed:					Among all children 6–23 months, percentage fed:				
	3+ food groups ¹	Minimum times or more ²	Both 3+ food groups and minimum times or more	Number of breastfed children 5–23 months	Milk or milk products ³	4+ food groups	4+ times or more	With 3 IYCF practices ⁴	Number of non-breastfed children 6–23 months	Breast-milk or milk products	3+ or 4+ food groups ⁵	Minimum times or more ⁶	With all 3 IYCF practices	Number of all children 6–23 months
Wealth quintile														
Lowest	69.4	67.6	47.6	165	10.4	46.6	40.4	0.0	32	85.4	65.7	63.2	39.8	197
Second	52.2	56.1	37.8	108	3.4	59.9	9.2	0.0	19	85.5	53.4	49.1	32.1	127
Middle	59.7	64.4	43.9	100	14.1	44.2	23.1	3.1	27	81.6	56.3	55.5	35.2	128
Fourth	45.7	68.4	36.5	101	27.3	56.9	30.7	0.0	35	81.5	48.6	58.8	27.2	135
Highest	68.8	73.0	54.0	122	42.7	64.0	48.4	12.5	23	91.0	68.0	69.2	47.5	145
Total	60.5	66.2	44.7	597	19.9	53.5	31.4	2.7	136	85.1	59.2	59.8	36.9	733

Note: Figures in parentheses are based on 25–49 unweighted cases.

¹ Food groups: a) infant formula, milk other than breast milk, cheese or yogurt or other milk products; b) foods made from grains, roots, and tubers, including porridge, fortified baby food from grains; c) vitamin A-rich fruits and vegetables (and red palm oil); d) other fruits and vegetables; e) eggs; f) meat, poultry, fish and shellfish (and organ meats); g) legumes and nuts; h) foods made with oil, fat butter.

² At least twice a day for breastfed infants aged 6–8 months and at least three times a day for breastfed children aged 9–23 months.

³ Includes commercial infant formula, fresh, tinned and powdered animal milk, and cheese, yogurt and other milk products.

⁴ Non-breastfed children aged 6–23 months are considered to be fed with a minimum standard of three IYCF practices if they receive other milk or milk products and are fed at least the minimum number of times per day with at least the minimum number of food groups.

⁵ 3+ food groups for breastfed children and 4+ food groups for non-breastfed children.

⁶ Fed solid or semi-solid foods at least twice a day for infants aged 6–8 months, 3+ times for other breastfed children, and 4+ times for non-breastfed children.

11.5 FOOD CONSUMPTION PATTERNS OF WOMEN

The nutritional status of a mother during pregnancy and lactation has an important impact on the health and nutritional status of her child.

Table 11.9 presents the types of foods consumed by mothers with young children in the day or night preceding the interview by background characteristics.

The most commonly consumed liquid mothers consume is tea and coffee followed by other liquids. The consumption of milk is very low because of its high cost.

The most commonly consumed solid or semi-solid food items are vitamin A-rich foods such as pawpaw, sweet potato, pumpkin and green leafy vegetables (consumed by 88% of women), followed by food made from root vegetables (78.5%), grains and cereals (61.7%) and other fruits and vegetables (47.0%).

The results show that 67.4% of women also consume foods high in fat, and 18.6% consume high sugar foods. Both of these have contribute to increasing obesity

Less than 50% of women consume protein-rich foods such as meat, fish and eggs. These foods are also good sources of iron, which is needed to prevent anaemia

Cheese and yogurt are the least commonly consumed foods, as not many people can afford to buy milk.

Mothers who were more likely to consume a more varied and healthy diet are those who live in urban areas in Honiara and Western Province and in more wealthy households.

Table 11.9: Foods consumed by mothers in the day or night preceding the interview

Among mothers aged 15–49 with a child under age 3 years living with them, the percentage who consumed specific types of foods in the day or night preceding the interview, by background characteristics, Solomon Islands 2007

Background characteristic	Liquids			Solid or semi-solid foods								Foods made with oil/ fat/ butter	Sugary foods	Number of mothers
	Milk	Tea/ coffee	Other liquids	Foods made from grains	Foods made from roots/ tubers	Foods made from legumes	Meat/ fish/ shellfish/ poultry/ eggs	Cheese/ yogurt	Vitamin A-rich fruits/ vegetables ¹	Other fruits/ vegetables	Other solid or semi- solid food			
Age														
15–19	7.3	48.0	32.1	46.9	63.5	11.4	20.8	5.6	83.5	39.9	30.7	66.9	8.1	64
20–29	8.7	41.5	37.0	65.2	77.7	21.0	39.2	11.0	86.3	46.4	37.1	64.7	21.4	721
30–39	11.0	39.1	31.3	59.9	83.3	22.5	42.1	12.6	91.1	49.9	38.6	71.6	16.8	491
40–49	9.0	41.3	34.5	52.8	67.5	18.0	41.8	6.7	88.3	40.6	37.2	65.8	12.0	71
Residence														
Urban	30.8	74.9	54.0	88.9	76.2	27.7	62.4	28.9	85.9	62.7	61.8	63.6	45.6	169
Rural	6.4	36.1	31.8	57.9	78.9	20.0	36.2	8.6	88.3	44.8	33.9	67.9	14.7	1,179
Region														
Honiara	33.2	70.4	51.4	87.6	73.1	24.4	56.8	27.2	84.3	57.0	56.1	57.8	36.3	129
Guadalcanal	8.4	43.8	38.7	65.6	78.0	28.7	34.0	19.1	87.6	50.4	49.0	56.9	19.9	256
Malaita	3.2	39.8	26.4	67.4	81.5	22.3	46.9	5.6	89.7	59.2	47.4	75.4	14.6	335
Western	30.6	67.2	51.9	80.8	76.2	48.0	59.2	26.9	86.1	61.0	46.9	80.3	41.9	139
Other provinces	2.0	25.0	28.6	43.5	78.9	7.4	27.2	1.9	88.6	30.3	16.7	66.2	9.2	488
Education														
No education	4.7	26.5	31.1	51.5	76.7	19.0	38.2	9.4	86.5	49.6	40.1	62.7	10.5	191
Primary	8.0	40.1	34.7	60.4	79.0	21.0	35.1	8.9	89.3	44.1	36.8	69.1	17.3	812
Secondary	13.2	47.5	35.1	67.9	78.9	20.9	49.0	15.2	85.7	50.8	35.6	65.3	22.9	309
More than secondary	35.8	81.5	44.6	95.5	73.7	32.0	66.8	33.7	88.1	69.1	50.3	70.9	54.6	35
Wealth quintile														
Lowest	4.6	23.6	28.5	38.2	87.6	19.7	34.8	8.2	92.9	39.0	32.2	70.1	8.4	338
Second	5.3	30.7	28.7	55.9	78.5	14.2	29.7	8.0	88.7	47.9	30.7	61.9	9.0	277
Middle	7.1	39.2	36.9	69.2	85.2	21.9	41.3	8.4	89.1	49.3	38.3	72.5	17.4	259
Fourth	9.3	50.2	35.9	71.5	65.2	22.8	35.3	9.9	80.7	48.5	36.5	63.8	22.6	234
Highest	23.8	70.3	46.1	84.1	71.6	27.8	59.7	22.9	86.3	53.6	52.2	67.7	41.4	239
Total	9.5	41.0	34.6	61.7	78.5	21.0	39.5	11.1	88.0	47.0	37.4	67.4	18.6	1,347

Note: Foods consumed in the last "24-hour" period (yesterday and last night).

¹ Includes [list fruits and vegetables included in the questionnaire such as pumpkin, red or yellow yams or squash, carrots, red sweet potatoes, green leafy vegetables, mangoes, papayas, and other locally grown fruits and vegetables that are rich in vitamin A].

11.6 MICRONUTRIENT INTAKE

11.6.1 Micronutrient intake among children

Micronutrient deficiencies are a consequence of malnutrition. Malnutrition is a key indicator for child health, and contributes to child morbidity and mortality. The causes of malnutrition include not eating enough nutritious food, poor feeding practices, parasitic infections, poor sanitation and other socio-cultural factors that influence feeding practices. Vitamin and mineral deficiencies are also consequences of malnutrition. Vitamin A and iron status were the key micronutrients that were selected as indicators for this survey.

Vitamin A is an essential vitamin for keeping tissues cells in a healthy condition and protecting the body against infections, and is important for healthy eyes and eyesight. It has two forms. Retinol, which is readily absorbed by the body and found in breast milk, fatty fish, eggs, milk and milk products; and carotene, which is a provitamin because it has to be converted into vitamin A by the liver before it can be used. Carotene is found in green leafy vegetables, and red and yellow fruits such as papaya, pandanus and pumpkin. Iron is a key mineral essential for proper brain function. Low iron intake can contribute to iron deficiency anaemia. Young children are at the highest risk for iron deficiency anaemia because they have very high requirements due to their rapid growth.

Mothers were asked whether they fed their children with vitamin A-rich and iron-rich foods the day or night before the survey. They were also asked whether their children had received vitamin A or iron supplements in the six months before the survey. The results are presented in Table 11.10

Overall, 90.6% of children consumed vitamin A-rich foods, but only 31.6% consumed iron-rich foods in the 24 hours preceding the survey. Children in urban areas in Honiara and Western Province were more likely to consume vitamin A-rich and iron-rich foods than children from other provinces.

The results suggest a very low uptake of the supplementation programme for vitamin A and iron, with only 7.4% of all children receiving vitamin A supplements and 4.2% receiving iron supplements. Children aged 24-59 months, children aged 6-59 months not breastfed, living in rural areas, residing in Malaita and Western province, children with mothers having no education and children with young mothers are least likely to be given vitamin A supplementary in the last 6 months.

Micronutrient deficiency problems among young children less than age 2 years is a serious concern that needs to be addressed. Some strategies for consideration may include dietary diversification through the promotion of locally grown foods, micronutrient supplements, food fortification and prevention and control of parasitic infections. It is unlikely that any one strategy will address this problem; an integrated approach is needed.

Table 11.10: Micronutrient intake among children

Among youngest children aged 6–35 months who are living with their mother, the percentages who consumed vitamin A-rich and iron-rich foods in the day or night preceding the survey, and among all children aged 6–59 months, the percentages who were given vitamin A supplements in the six months preceding the survey, who were given iron supplements in the last seven days, and who were given de-worming medication in the six months preceding the survey, and among all children aged 6–59 months who live in households that were tested for iodised salt, the percentage who live in households with adequately iodised salt, by background characteristics, Solomon Islands 2007

Background characteristic	Among youngest children aged 6–35 months living with the mother:			Among all children aged 6–59 months:			
	Percentage who consumed vitamin A-rich foods in last 24 hours ¹	Percentage who consumed foods rich in iron in last 24 hours ²	Number of children	Percentage given vitamin A supplements in last 6 months ³	Percentage given iron supplements in last 7 days	Percentage given de-worming medication in last 6 months	Number of children
Age in months							
6–8	75.1	14.2	153	6.2	7.6	5.9	154
9–11	89.1	23.5	101	12.4	2.0	14.1	106
12–17	93.6	31.6	227	13.1	3.2	13.7	245
18–23	90.0	36.4	251	11.3	5.3	21.7	290
24–35	96.2	38.1	352	4.9	3.6	24.7	533
36–47	na	na	na	7.6	4.7	26.6	515
48–59	na	na	na	4.1	3.8	24.0	477
Sex							
Male	90.9	34.1	523	7.0	5.0	23.7	1,135
Female	90.3	29.2	562	7.8	3.5	19.8	1,183
Breastfeeding status							
Breastfeeding	89.2	27.8	710	10.1	4.5	16.0	742
Not breastfeeding	93.2	37.9	356	6.2	4.1	25.2	1,387
Residence							
Urban	88.9	59.4	135	11.8	2.4	17.6	285
Rural	90.8	27.6	950	6.8	4.5	22.3	2,034
Region							
Honiara	86.2	52.9	102	9.6	3.2	16.0	214
Guadalcanal	90.0	30.1	202	20.7	1.7	14.2	422
Malaita	93.3	35.7	277	1.8	1.6	18.1	587
Western	92.0	52.8	117	4.2	6.2	30.4	253
Other provinces	89.7	17.3	386	5.0	7.1	26.8	843

Chapter 11.10 (continued)

Background characteristic	Among youngest children aged 6–35 months living with the mother:			Among all children aged 6–59 months:			
	Percentage who consumed vitamin A-rich foods in last 24 hours ¹	Percentage who consumed foods rich in iron in last 24 hours ²	Number of children	Percentage given vitamin A supplements in last 6 months ³	Percentage given iron supplements in last 7 days	Percentage given de-worming medication in last 6 months	Number of children
Mother's education							
No education	86.3	33.4	157	5.8	2.7	19.4	324
Primary	90.5	27.3	664	7.1	4.9	21.8	1,453
Secondary	94.0	39.2	236	9.5	3.5	22.9	488
More than secondary	(88.4)	(57.1)	29	7.0	1.2	22.0	54
Mother's age at birth							
15–19	90.7	29.4	86	4.7	6.0	20.9	216
20–29	90.2	31.8	616	6.9	3.6	22.8	1,363
30–39	91.7	32.9	340	9.3	4.7	19.1	659
40–49	(87.5)	(22.9)	44	8.0	7.3	26.2	81
Wealth quintile							
Lowest	92.8	29.6	286	8.4	6.3	22.5	585
Second	91.1	24.4	223	7.4	4.9	22.8	472
Middle	93.1	27.0	196	6.6	2.4	20.1	405
Fourth	83.7	30.3	186	5.6	4.1	23.7	443
Highest	90.7	48.7	193	8.8	2.4	18.8	413
Total	90.6	31.6	1,085	7.4	4.2	21.7	2,319

Note: Figures in parentheses are based on 25–49 unweighted cases.

Information on vitamin A and iron supplements and de-worming medication is based on mother's recall.

Totals include 189 children aged 6–59 months with missing information on breastfeeding status.

na = not applicable

¹ Includes meat (and organ meat), fish, poultry, eggs, pumpkin, red or yellow yams or squash, carrots, red sweet potatoes, dark green leafy vegetables, mango, papaya, and other locally grown fruits and vegetables that are rich in vitamin A, and red palm oil (if data are collected).

² Includes meat (including organ meat).

³ De-worming for intestinal parasites is commonly done for helminthes and for schistosomiasis.

11.6.2 Micronutrient intake of mothers

Table 11.11 presents the micronutrient intake patterns of mothers with young children.

Overall, 92% of women consume vitamin A-rich foods. Women living in rural areas and in Malaita and Western provinces are more likely to eat large amounts of vitamin A-rich foods. Vitamin A supplements are also provided to 15.9% of postpartum women as a matter of protocol. Given the very low percentage of women who have suffered from night blindness during their last pregnancy, and the very high consumption of vitamin A-rich foods, it is unlikely that vitamin A deficiency is a problem. Further studies are required to adequately determine the extent of the problem. It could be that although the consumption of vitamin A-rich foods is high, other factors such as infections may be limiting the absorption of the vitamin.

Mothers in Guadalcanal Province are more likely to be given a dose of vitamin A after childbirth. Women with a higher education level and those living in wealthy households are also more likely to be given a dose of vitamin A after childbirth.

Only 39.5% of women consumed iron-rich foods the day before the interview. Women in urban areas in Honiara and Western Province consumed iron-rich foods in the day before the interview.

The percentage of women who received iron supplements for <60 days is 26.2%, decreasing to 19.4% for those who received iron tablets for >90days. Iron tablets are provided as a matter of routine for all pregnant women, although a high percentage of women don't know or are unable to remember whether they had taken their iron tablet.

Vitamin A and iron supplements are given to women who are identified and diagnosed as being underweight and those with recurrent diarrhoea and respiratory health issues.

Table 11.11: Micronutrient intake among mothers

Among women age 15-49 with a child under age three years living with her, the percentages who consumed vitamin A-rich and iron-rich foods in the 24 hours preceding the survey; among women age 15-49 with a child born in the last five years, the percentage who received a vitamin A dose in the first two months after the birth of the last child; among mothers age 15-49 who during the pregnancy of the last child born in the five years prior to the survey, the percentage who suffered from night blindness, the percentage who took iron tablets or syrup for specific numbers of days, and the percentage who took de-worming medication; and among women age 15-49 with a child born in the last five years, who live in households that were tested for iodized salt, the percentage who live in households with adequately iodized salt, by background characteristics, Solomon Islands 2007

Among women with a child under three years living with her				Among women with a child born in the last five years										
				Percentage who received vitamin A dose postpartum ³	Percentage who suffered night blindness during pregnancy of last birth		Number of days women took iron tablets or syrup during pregnancy of last birth					Percentage of women who took de-worming medication during pregnancy of last birth ⁵		Number of women
					Reported	Adjusted ⁴	None	<60	60-89	90+	Don't know/missing			
Background characteristic	Percentage consumed Vitamin A rich foods ¹	Percentage consumed iron-rich foods ²	Number of women											
Age														
15-19	87.2	20.8	64	14.5	4.2	0.3	5.0	31.5	2.1	16.6	44.8		54.0	68
20-29	90.7	39.2	721	15.4	7.2	1.1	6.9	28.7	3.8	17.9	42.6		38.5	894
30-39	94.5	42.1	491	16.4	9.8	1.2	7.2	24.5	5.0	21.8	41.6		42.7	718
40-49	92.5	41.8	71	17.4	11.6	1.4	9.7	15.2	7.6	17.7	49.8		56.4	119
Residence														
Urban	89.5	62.4	169	18.0	10.8	2.0	9.3	30.5	4.1	14.6	41.5		30.0	236
Rural	92.4	36.2	1,179	15.6	8.1	1.0	6.8	25.6	4.5	20.1	43.0		43.8	1,562
Region														
Honiara	88.4	56.8	129	19.3	7.3	1.4	11.1	25.2	5.4	15.3	43.0		27.9	178
Guadalcanal	87.6	34.0	256	32.0	7.3	0.3	8.0	36.4	4.9	13.0	37.8		50.9	323
Malaita	96.6	46.9	335	12.0	8.7	1.7	5.3	23.9	4.5	18.4	47.9		20.0	420
Western	93.2	59.2	139	11.5	10.5	2.0	6.8	19.7	2.7	17.8	53.0		63.6	208
Other provinces	91.8	27.2	488	11.0	8.4	0.9	6.9	25.1	4.5	24.7	38.8		48.4	671
Education														
No education	90.9	38.2	191	14.4	8.8	1.0	8.6	26.6	1.9	15.2	47.6		27.0	243
Primary	92.3	35.1	812	15.1	9.0	1.0	6.6	26.6	3.8	20.0	43.1		45.8	1,104
Secondary	91.8	49.0	309	18.2	6.3	1.7	7.0	24.1	8.3	21.2	39.4		41.1	406
More than secondary	93.8	66.8	35	23.5	11.3	2.0	12.1	33.6	1.9	12.1	40.4		37.1	46

Table 11.11 (continued)

Among women with a child under three years living with her				Among women with a child born in the last five years										
				Percentage who received vitamin A dose postpartum ³	Percentage who suffered night blindness during pregnancy of last birth		Number of days women took iron tablets or syrup during pregnancy of last birth					Percentage of women who took de-worming medication during pregnancy of last birth ⁵		Number of women
					Reported	Adjusted ⁴	None	<60	60-89	90+	Don't know/missing			
Background characteristic	Percentage consumed Vitamin A rich foods ¹	Percentage consumed iron-rich foods ²	Number of women											
Wealth quintile														
Lowest	93.9	34.8	338	15.8	10.2	0.6	7.0	29.1	4.1	21.4	38.4	37.3	412	
Second	93.7	29.7	277	14.7	5.4	0.5	8.7	32.3	4.7	15.7	38.6	50.1	367	
Middle	97.1	41.3	259	18.2	10.0	1.6	7.4	28.2	1.1	19.5	43.8	40.1	326	
Fourth	84.4	35.3	234	11.2	5.5	0.8	5.7	16.9	6.4	23.2	47.8	42.8	363	
Highest	89.5	59.7	239	20.2	11.2	2.6	6.6	24.3	5.8	16.8	46.4	39.7	330	
Total	92.0	39.5	1,347	15.9	8.4	1.2	7.1	26.2	4.5	19.4	42.8	42.0	1,799	

¹ Includes meat (and organ meat), fish, poultry, eggs, pumpkin, red or yellow yams or squash, carrots, red sweet potatoes, mango, papaya, and other locally grown fruits and vegetables that are rich in vitamin A, and red palm oil [if data are collected]

² Includes meat (and organ meat), fish, poultry, eggs

³ In the first two months after delivery

⁴ Women who reported night blindness but did not report difficulty with vision during the day

⁵ Deworming for intestinal parasites is commonly done for helminthes and for schistosomiasis

11.7 ANAEMIA

Iron deficiency anaemia is a global problem and is the most common form of micronutrient malnutrition in the world. Anaemia in the developing world is mainly due to inadequate absorption of dietary iron. The resulting iron deficiency leads to reduced production of haemoglobin and anaemia. In pregnant women, folate deficiency also plays a role in causing anaemia but to a lesser extent than iron deficiency. Iron deficiency anaemia is more common in young children and women of reproductive age, especially pregnant and breastfeeding mothers. These population subgroups are more susceptible to anaemia because of their increased iron needs due to growth, pregnancy and lactation. Women of reproductive age also have increased iron losses from menstrual blood flow.

The 2006/2007 SIDHS directly measured haemoglobin levels of all ever-married women aged 15–49 and their children aged 5 years and below. Hemocue instruments, which are portable haemoglobinometers, were used to measure the haemoglobin level of consenting survey participants in their homes. Those identified with severe anaemia were referred to their local health centre for treatment.

11.7.1 Prevalence of anaemia in children

Iron anaemia in children impairs mental capacity, motor development and behaviour in children. Iron deficiency predisposes people to diseases through reduced immune functions. The apathy associated with anaemia in young children adversely affects their cognitive and social development. Children born to mothers who are iron deficient have reduced iron stores that may not be corrected by breastfeeding, which then leads to early onset of anaemia. Low birth weight babies are born with reduced iron stores and have additional requirements for catch up growth. These additional iron requirements cannot be met by breast milk and if iron supplements are not provided, these babies will also have an increased risk of early onset of anaemia.

Table 11.12 presents the prevalence of anaemia in children aged 6–59 months by background characteristics. Overall, 48.0% of children aged 6–9 months are anaemic: 29.0% of children have mild iron deficiency anaemia, 18.6% have moderate anaemia, and 0.5% have severe anaemia. The highest prevalence for any anaemia is in children aged 12–17 months. The prevalence is slightly higher among girls. Prevalence decreases with increasing wealth level.

Figure 9 presents the differences in the prevalence of anaemia by region. The prevalence of any anaemia is high in all regions but is particularly high in Guadalcanal and other provinces. The prevalence of any anaemia is also high throughout the Solomon Islands.

Figure 11.10: Prevalence of anaemia among children aged 6–59 months by haemoglobin level and by province

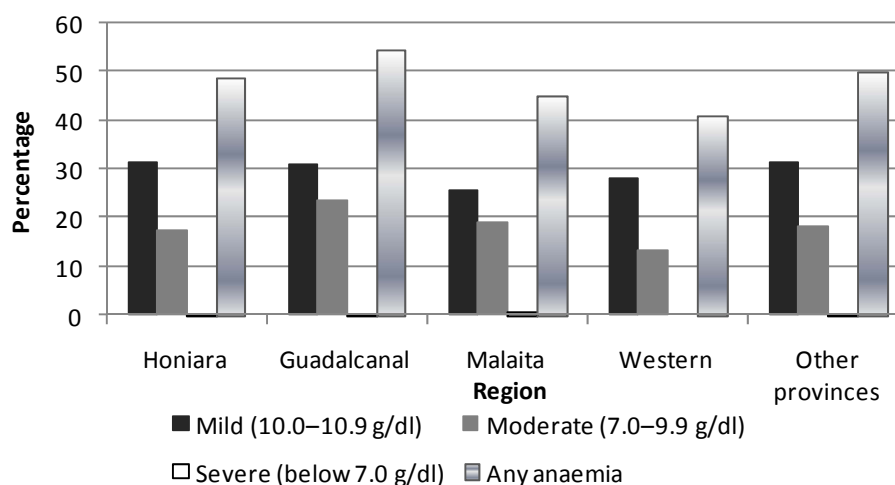


Table 11.12: Prevalence of anaemia in children

Percentage of children aged 6–59 months classified as having anaemia, by background characteristics, Solomon Islands 2007

Background characteristic	Anaemia status by haemoglobin level			Any anaemia	Number of children
	Mild (10.0–10.9 g/dl)	Moderate (7.0–9.9 g/dl)	Severe (below 7.0 g/dl)		
Age in months					
6–8	32.3	30.1	4.6	67.0	115
9–11	31.2	37.7	2.3	71.1	85
12–17	38.5	37.2	0.3	75.9	206
18–23	25.3	26.5	0.1	51.9	258
24–35	36.3	13.2	0.1	49.6	456
36–47	25.6	11.6	0.1	37.3	453
48–59	22.3	10.4	0.0	32.7	386
Sex					
Male	29.2	18.2	0.4	47.9	987
Female	29.6	19.0	0.5	49.1	973
Mother's interview status					
Interviewed	28.3	19.4	0.5	48.3	1,720
Not interviewed but in household	26.7	28.1	0.0	54.8	51
Not interviewed, and not in the household ¹	39.8	8.5	0.0	48.3	189
Residence					
Urban	29.2	20.4	0.3	49.9	193
Rural	29.4	18.4	0.5	48.3	1,767
Region					
Honiara	31.4	17.2	0.4	49.0	142
Guadalcanal	30.8	23.3	0.5	54.6	317
Malaita	25.4	19.0	0.9	45.2	513
Western	28.1	13.1	0.0	41.2	203
Other provinces	31.4	18.2	0.3	49.9	784
Mother's education²					
No education	24.5	23.2	0.7	48.4	274
Primary	28.1	20.3	0.2	48.5	1,094
Secondary	31.7	15.9	1.5	49.1	365
More than secondary	28.3	14.1	0.0	42.3	37
Wealth quintile					
Lowest	30.9	21.8	0.6	53.3	480
Second	32.6	18.9	0.3	51.8	423
Middle	25.9	18.1	0.9	44.9	372
Fourth	30.4	15.1	0.3	45.8	392
Highest	25.4	18.4	0.1	43.9	293
Total	29.4	18.6	0.5	48.5	1,960

Note: Table is based on children who slept in the household the night before the interview. Prevalence of anaemia, based on haemoglobin levels, is adjusted for altitude using formulas in CDC, 1998. Haemoglobin in grams per deciliter (g/dl).

Total includes one case with missing information on mother's education.

¹ Includes children whose mothers are deceased.

² For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

11.7.2 Prevalence of anaemia among women

The fatigue that results from anaemia impairs work performance and endurance even for tasks that require only moderate levels of activity. Thus, anaemia can result in reduced household productivity, especially where tasks require a high level of effort.

Severe anaemia in pregnancy has been shown to increase the risk of maternal mortality, low birth weight, preterm and low birth weight, and subsequent risk of anaemia in the infant.

Table 11.13 and Figure 11.11 present the prevalence of anaemia in women. Overall, 44.3% of women have anaemia, 36.0% have mild anaemia, 7.6% have moderate to severe anaemia, and 0.6% have severe anaemia. Table 11.13 also shows that the prevalence of anaemia is highest among pregnant women at 60.1%.

Figure 11.11: Prevalence of anaemia among women aged 15–49 by province, Solomon Islands

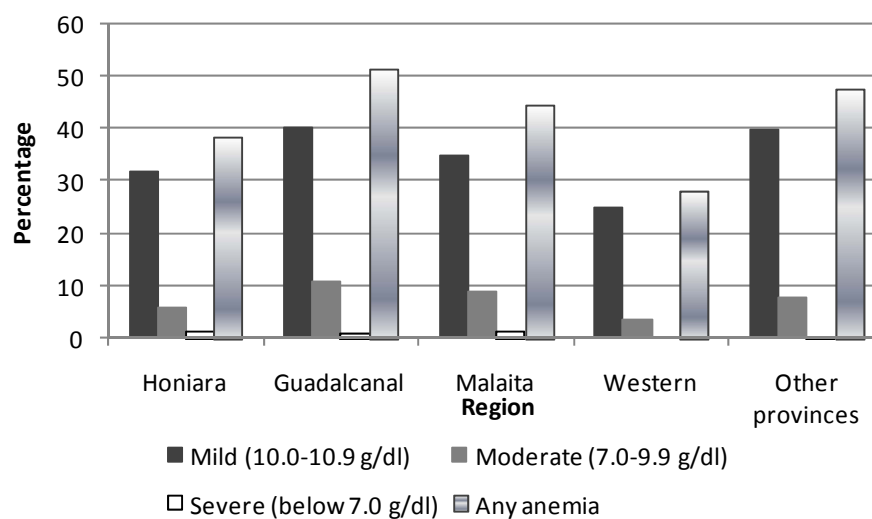


Table 11.13: Prevalence of anaemia in women*Percentage of women aged 15–49 with anaemia, by background characteristics, Solomon Islands 2007*

Background characteristic	Anaemia status by haemoglobin level				Number of women	
		Mild anaemia	Moderate anaemia	Severe anaemia		Any anaemia
	Not pregnant	10.0–11.9 g/dl	7.0–9.9 g/dl	<7.0 g/dl		<12.0 g/dl
	Pregnant	10.0–10.9 g/dl	7.0–9.9 g/dl	<7.0 g/dl	<11.0 g/dl	
Age						
15–19		32.3	3.1	0.1	35.5	576
20–29		37.9	8.0	0.6	46.5	1,299
30–39		33.3	9.2	0.3	42.8	997
40–49		40.5	8.6	1.8	51.0	559
Number of children ever born						
0		30.1	2.9	0.4	33.4	1,024
1		40.0	7.0	0.5	47.5	422
2–3		38.0	9.0	0.4	47.4	790
4–5		40.2	9.4	0.5	50.2	699
6+		35.8	13.1	1.7	50.7	497
Maternity status						
Pregnant		34.4	23.6	2.1	60.1	217
Breastfeeding		42.2	8.9	0.3	51.3	922
Neither		33.7	5.6	0.6	40.0	2,292
Using IUD						
Yes		(46.3)	(6.4)	(0.0)	(52.7)	48
No		35.9	7.6	0.6	44.2	3,383
Smoking status						
Smokes cigarettes/tobacco		38.6	9.4	1.1	49.1	663
Does not smoke		35.3	7.3	0.5	43.1	2,743
Residence						
Urban		31.8	4.9	0.9	37.6	503
Rural		36.8	8.1	0.6	45.4	2,928
Region						
Honiara		31.6	5.6	1.2	38.3	393
Guadalcanal		40.1	10.6	0.8	51.5	489
Malaita		34.9	8.6	1.2	44.7	779
Western		24.8	3.3	0.0	28.1	387
Other provinces		39.7	7.8	0.2	47.7	1,383
Education						
No education		40.0	6.9	1.5	48.4	480
Primary		37.0	9.3	0.5	46.8	1,949
Secondary		32.1	4.9	0.3	37.3	898
More than secondary		34.6	3.0	0.6	38.2	105
Wealth quintile						
Lowest		41.4	7.7	1.9	51.0	657
Second		42.6	8.2	0.1	50.9	705
Middle		32.3	8.7	0.6	41.5	672
Fourth		34.7	9.5	0.0	44.2	674
Highest		29.4	4.2	0.5	34.1	723
Total		36.0	7.6	0.6	44.3	3,431

Note: Prevalence is adjusted for altitude and for smoking status if known using formulas in CDC 1998. [Be sure to include this in the reference list]

Total includes 25 cases with missing information on smoking status.

Note: Figures in parentheses are based on 25–49 unweighted cases.

11.8 KEY RESULTS

Breastfeeding is nearly universal in Solomon Islands, with 93% of children born in the five years preceding the survey having been breastfed at some time. There is very little difference in whether children are ever breastfed by most background characteristics, except place of residence and wealth status. Differences in the proportion of children who were ever breastfed can be also seen between children living in urban and rural areas as 93% of children in rural areas have been breastfed as compared to only 89% of children in urban areas. Similarly, the proportions of children being breastfed are likely to be higher among mothers in lower wealth quintile households compared with mothers in wealthier households.

The median duration of breastfeeding is 22.6 months, while the median duration for exclusive breastfeeding is 4.2 months, and the median duration for predominant breastfeeding is 4.9 months. The mean duration is shorter, with the overall mean duration of breastfeeding is 21.7 months, the mean duration for exclusive breastfeeding is 5.1 months, and the mean duration for predominant breastfeeding is 5.8 months. There is little difference in the duration of breastfeeding by sex of the child. Rural children are breastfed for slightly longer (23.0 months) than urban children (18.3 months). Mothers with a secondary education breastfeed their children for a shorter duration than mothers with less education.

Between the ages of 6 and 23 months, children consume fruits and vegetables rich in vitamin A more often than any other food group. More than 84% of breastfeeding children and 86% of non-breastfeeding children in this age group ate fruits and vegetables in the day and night preceding the interview. The next most commonly consumed food group is food made from roots and tubers. Around 67% of breastfeeding and non-breastfeeding children ate food made from roots and tubers in the day and night preceding the survey. The third common food group is food made from grains, consumed by 42.4% of breastfeeding children and by 49.4% of non-breastfeeding children.

About 85% of children aged 6–23 months living with their mother received breast milk or other milk or milk products during the 24-hour period before the survey: 59% of these had a minimally diverse diet (i.e. they had been fed foods from the minimum number of food groups depending on their age and breastfeeding status), and about 60% had been fed the minimum number of times appropriate for their age. In summary, only 37% of children aged 6–23 months in Solomon Islands meet the minimum standard with respect to all three IYCF practices

Over 90% of children aged 6–35 months living with their mother consumed foods rich in vitamin A in the 24-hour period before the survey. Consumption of foods rich in vitamin A increases from 75% among children aged 6–8 months to 93% in children aged 12–35 months.

The staple diet of mothers of young Solomon Islands children consists of foods rich in vitamin A (88.0% and food made from roots and tubers (78.5%). and food made from grains (61.7%). Almost three in five women (61.7%) consume food made from grains, whereas 47.0% percent of women consume other fruits and vegetables. Among mothers aged 15–49 with a child under age 3 years living with them, about 10% drink milk, 41% drink tea and coffee, and 35% drink other liquids.

The results of observation made during the SI 2006/2007 SIDHS shows that 11.8% of children aged 0–5 years are considered underweight while 2.4% are considered to be severely underweight. Underweight children are more common among children aged 9–11 months, with mothers having no education or only a primary education and with children living in the lowest household wealth quintile households.

About 33% of children aged 0–5 years are stunted (have low height-for-age). This is particularly common among children aged 18–23 months, rural children whose mothers have no education or only a primary education, and children living in the second lowest wealth quintile households. Only 4.3% of children aged 0–5 years in Solomon Islands have a low weight-for-height.

CHAPTER 12 MALARIA

12.1 INTRODUCTION

Malaria continues to be a major public health concern in Solomon Islands, especially among pregnant women and children under age 5. Malaria is a leading cause of morbidity and mortality in Solomon Islands in both outpatient attendance and inpatient admissions. Most parts of the country report malaria transmission throughout the year, although it increases during and soon after the rainy season.

Malaria is caused by four species of parasites that are transmitted by *Anopheles* mosquitoes. *Plasmodium falciparum* is the most common of these parasites. It causes the most severe form of malaria, which often leads to death if not properly managed. However, the most severe cases are typically limited to patients who have an impaired immune function or who have developed little or no immunity to malaria through previous exposure. Children under age 5 are most at risk. Also at particular risk are pregnant women who are vulnerable because of their reduced natural immunity. Malaria is also perceived as another cause of pregnancy loss, low birth weight, and neonatal mortality.

Malaria continues to pose a high burden in both societal and economic terms in Solomon Islands, ranging from school absenteeism to low productivity at workplaces. This affects agricultural production and outputs from other economic sectors.

The Solomon Islands Government is committed to the control and prevention of malaria. A considerable amount of its limited health budget is allocated to addressing malaria and malaria-related disabilities. The Solomon Islands Government, through its Vector-Borne Disease Control Programme, endeavours to employ strategies that will:

- provide reliable and quality diagnosis and treatment, which is accessible for the total population;
- provide an increased and sustainable bed-net distribution system to achieve and maintain 100% bed-net coverage;
- reduce the transmission by reducing the survival of malaria vectors entering houses or sleeping units through an expanded indoor residual spraying (IRS) response;
- adopt malaria prevention measures and treatment for pregnant women; and
- eliminate malaria in at least one province by 2016.

The expenditure related to malaria is high and is expected to rise enormously after the introduction of artemisinin-based combination therapy (ACT) in conjunction with rapid diagnostic tests (RDTs) to assist in the diagnosis of malaria by detecting evidence of malaria parasites in human blood. ACT is a response to the emerging resistance of malarial parasites to monotherapy that uses antimalarials such as chloroquine, and was the first line treatment drug in Solomon Islands, at the time of the survey. RDTs supplement diagnostic services where microscopy is not feasible.

The 2006/2007 SIDHS collected basic information on malaria, which is summarised and presented in the following sections.

12.2 MOSQUITO NETS

The use of an insecticide-treated mosquito net (ITN) is a primary health intervention to reduce malaria transmission in Solomon Islands. Nets provide a protective physical barrier, reducing the number of bites from infective vectors. It is anticipated that the widespread use of ITNs reduces mosquito density and biting intensities.

This section presents the 2006/2007 SIDHS findings on household possession of mosquito nets and use, and the treatment of bed-nets by household members. Although the 2006 Household Income and Expenditure Survey (HIES) included questions about household mosquito net possession and usage, the questions were formulated differently, so comparison between the two surveys (i.e. DHS and HIES) is difficult and will not be discussed in this chapter.

12.2.1 Ownership of mosquito nets

All households at the time of the 2006/2007 SIDHS were asked whether they owned a mosquito net, and if so, how many. Table 12.1 shows household ownership of nets by degree of protection offered by the net and by selected background characteristics of respondents. It shows that three-quarters (75.4%) of all households own at least one mosquito net. However, ownership of ITNs is lower, with 48.5% having at least one ITN. Although ownership of mosquito nets is as high as 75.3% for urban households and 75.4% for rural households, only 50.3% of urban households and 48.3% of rural households own at least one ITN.

Ownership of ITNs is highest in Guadalcanal Province with 92.6% of households owning at least one mosquito net. Malaita Province has the lowest ITN ownership. Reasons for these variations include differences in mosquito density and biting intensity by provinces, and preferences in malaria control strategies by major donor partners in the province.

Households in the highest wealth quintile are the most likely to own a mosquito net. More than half (51.7%) of the households in the highest wealth quintile have at least one ITN as compared with 41.9% in the lowest wealth quintile.

A net that has been treated with insecticide repels and kills mosquitoes with somewhat greater effectiveness than a net that has never been treated, but not as effectively as a net that was treated within the last 12 months or was made with long-lasting insecticide. Table 12.1 also shows ownership of ever-treated nets separately. A greater proportion of households own at least one ever-treated net (74.6%) as compared with an ITN (48.5%). This indicates that some households do not re-treat their nets as often as recommended. The percentage of households that reported having at least one ever-treated net is higher than the percentage of households that own an ITN across all provinces. The differences are particularly large in Guadalcanal and Western provinces.

Table 12.1: Household possession of mosquito nets

Percentage of households with at least one and more than one mosquito net (treated or untreated), ever treated mosquito net and insecticide treated net (ITN), and the average number of nets per household, by background characteristics, Solomon Islands 2007

Background characteristic	Any type of mosquito net			Ever treated mosquito net ¹			Insecticide treated mosquito nets (ITNs) ²			Number of households
	Percentage with at least one	Percentage with more than one	Average number of nets per household	Percentage with at least one	Percentage with more than one	Average number of ever treated nets per household	Percentage with at least one	Percentage with more than one	Average number of ITNs per household	
Residence										
Urban	75.3	60.5	1.9	73.8	58.4	1.8	50.3	38.9	1.2	387
Rural	75.4	56.7	1.8	74.7	55.1	1.7	48.3	32.0	1.0	2,872
Region										
Honiara	72.9	56.4	1.8	71.1	54.6	1.7	50.2	36.9	1.2	268
Guadalcanal	92.6	74.7	2.3	92.0	72.2	2.2	55.6	41.3	1.3	546
Malaita	61.9	48.8	1.4	60.3	46.3	1.4	33.3	23.9	0.7	727
Western	77.2	54.7	1.8	75.9	51.9	1.7	44.4	30.7	1.0	406
Other provinces	75.7	55.4	1.8	75.5	54.9	1.7	55.0	34.1	1.1	1,312
Wealth quintile										
Lowest	69.4	44.1	1.4	68.9	43.1	1.4	41.9	21.3	0.7	718
Second	72.9	55.3	1.6	72.3	53.6	1.6	47.9	31.2	1.0	683
Middle	78.3	62.5	1.9	77.0	60.5	1.8	50.8	37.2	1.1	653
Fourth	82.1	65.9	2.1	81.5	64.1	2.0	51.4	37.1	1.2	638
Highest	75.2	59.8	2.0	73.9	57.9	1.9	51.7	39.6	1.3	567
Total	75.4	57.1	1.8	74.6	55.5	1.7	48.5	32.8	1.0	3,259

¹ An ever-treated net is a pre-treated net or a nonpre-treated net that has subsequently been soaked with insecticide at any time.

² An insecticide treated net (ITN) is: 1) a factory treated net that does not require any further treatment, 2) a pre-treated net obtained within the past 12 months, or 3) a net that has been soaked with insecticide within the past 12 months.

12.2.2 Use of mosquito nets

The 2006/2007 SIDHS asked about the use of mosquito nets by household members during the night before the survey. The Solomon Islands National Health policy recognises that children under age 5 and pregnant women are high-risk groups that should sleep under ITNs.

Because the prevalence of malaria-carrying mosquitoes varies seasonally, with a peak during and immediately following periods of rain, use of mosquito nets may be expected to follow a similar seasonal pattern. Despite the geographical variation in altitude, seasonality and humidity, malaria is endemic to all major islands in Solomon Islands.

Tables 12.2 and 12.3 show the percentage of children under age 5 and women who slept under a mosquito net on the night before the survey. Roughly two-thirds of children under age 5 slept under a mosquito net the night before the survey, and less than half (40.4%) of these slept under an ITN. Use of any mosquito net or ITN is associated with the age of the child. Younger children are more likely to have slept under a mosquito net than those closer to their fifth birthday. There is no gender preference between male and female children under five pertaining to net use.

A greater proportion of children under age 5 slept under a mosquito net compared with women (Table 12.3). Just under 35% of all women and 36.5% of pregnant women slept under an ITN the night before the survey.

Table 12.2: Use of mosquito nets by children

Percentage of children under age 5 who slept under a mosquito net (treated or untreated), an ever-treated mosquito net, and an insecticide treated net (ITN) the night before the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage who slept under any net last night	Percentage who slept under an ever treated net last night ¹	Percentage who slept under an ITN last night ²	Number of children
Age in months				
<1	73.5	73.1	48.8	528
1	67.7	65.1	38.5	545
2	63.3	63.0	38.4	566
3	64.9	63.7	37.9	556
4	61.9	61.1	38.5	480
Sex				
Male	64.1	63.3	37.5	1,357
Female	68.6	67.1	43.4	1,317
Residence				
Urban	62.8	62.0	43.7	323
Rural	66.8	65.6	39.9	2,351
Region				
Honiara	59.2	58.0	42.0	235
Guadalcanal	80.5	80.2	47.6	476
Malaita	58.7	56.2	33.3	665
Western	64.3	63.7	35.5	303
Other provinces	66.8	66.2	42.8	996
Wealth quintile				
Lowest	62.9	62.3	34.8	628
Second	70.0	68.4	43.2	560
Middle	67.1	65.1	37.5	514
Fourth	68.6	67.7	42.5	515
Highest	62.9	62.4	45.5	457
Total	66.3	65.2	40.4	2,674

¹ An ever-treated net is a pre-treated net or a nonpre-treated which has subsequently been soaked with insecticide at any time.

² An insecticide treated net (ITN) is a 1) factory treated net that does not require any further treatment, 2) a pre-treated net obtained within the past 12 months, or 3) a net that has been soaked with insecticide within the past 12 months.

Higher rates of net use are reported in rural households than in urban household for both children and women. Approximately two in three children in rural areas slept under a mosquito net compared with less than 65% of children in urban areas. By provinces, the highest rate of net use by children was in Guadalcanal, with 80.5%. However, only 47.6% reported to having slept under an ITN the night before the survey.

Table 12.3: Use of mosquito nets by women

Percentage of all women aged 15–49 and pregnant women aged 15–49 who slept under a mosquito net (treated or untreated), an ever treated mosquito net, and an insecticide treated net (ITN) the night before the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of all women aged 15–49 who:				Percentage of pregnant women aged 15–49 who:			
	Slept under any net last night	Slept under an ever treated net last night ¹	Slept under an ITN last night ²	Number of women	Slept under any net last night	Slept under an ever treated net last night ¹	Slept under ITN last night ²	Number of women
Residence								
Urban	44.8	43.8	29.0	658	61.6	61.6	47.0	27
Rural	58.3	57.5	36.1	3,190	59.4	58.4	34.9	182
Region								
Honiara	39.3	38.1	27.2	490	48.4	48.4	37.9	20
Guadalcanal	75.0	74.6	44.5	648	88.6	87.4	54.2	49
Malaita	47.7	46.3	27.6	848	(45.8)	(45.8)	(20.3)	44
Western	55.3	54.5	30.9	451	(74.4)	(70.2)	(47.1)	28
Other provinces	58.1	57.7	38.7	1,411	(45.0)	(45.0)	(29.3)	68
Education								
No education	52.6	51.4	30.5	512	(47.2)	(47.2)	(28.3)	28
Primary	57.2	56.6	35.8	2,157	63.1	61.8	37.3	131
Secondary	56.1	55.1	35.0	1,080	65.9	65.9	43.7	43
More than secondary	44.7	44.7	34.6	100	*	*	*	7
Wealth quintile								
Lowest	53.7	53.3	30.3	690	(43.7)	(42.7)	(19.1)	56
Second	63.0	61.6	38.6	748	(61.8)	(61.8)	(35.7)	27
Middle	56.7	55.9	34.9	735	(43.5)	(43.5)	(27.5)	35
Fourth	62.4	61.8	38.4	777	77.6	75.5	44.4	59
Highest	45.7	44.9	32.2	899	70.0	70.0	61.6	33
Total	56.0	55.2	34.9	3,849	59.7	58.8	36.5	209

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ An ever-treated net is a pre-treated net or a nonpre-treated, which has subsequently been soaked with insecticide at any time.

² An insecticide treated net (ITN) is (1) a factory treated net that does not require any further treatment, (2) a pre-treated net obtained within the past 12 months, or (3) a net that has been soaked with insecticide within the past 12 months.

12.3.1 Treatment of women during pregnancy

Table 12.4 show the percentage of women who took any antimalarial drugs, received SP/Fansidar and given IPT during pregnancy for their last live birth in the two years preceding the survey by background characteristics. The results show that the most common treatment for malaria prevention was antimalarial drug which was taken by the majority of women (93%). The use of SP/Fansidar and IPT were very low presenting of less than 2% of women receiving this treatment. This could indicate that the IPT is not common in the country.

Table 12.4: Prophylactic use of antimalarial drugs and use of Intermittent Preventive Treatment (IPT) by women during pregnancy

Percentages of women who took any antimalarial drugs for prevention, who took SP/Fansidar, and percentage who received Intermittent Preventive Treatment (IPT) during the pregnancy for their last live birth in the two years preceding the survey, by background characteristics, Solomon Islands 2007

Background characteristic	SP/Fansidar ¹			Intermittent Preventive Treatment ²		Number of women
	Percentage who took any antimalarial drug	Took SP/Fansidar	Took more than one dose	Received SP/Fansidar during ANC	Received more than one dose SP/Fansidar during ANC	
Residence						
Urban	91.1	4.1	2.3	4.0	2.3	138
Rural	93.1	1.2	1.0	1.0	0.8	900
Region						
Honiara	92.3	1.3	0.9	1.1	0.9	105
Guadalcanal	92.1	1.9	0.0	1.9	0.0	190
Malaita	90.5	3.3	3.3	2.7	2.7	257
Western	94.2	0.0	0.0	0.0	0.0	108
Other provinces	94.6	0.8	0.8	0.7	0.7	378
Education						
No education	91.9	0.3	0.3	0.3	0.3	134
Primary	95.1	2.1	1.5	1.8	1.2	615
Secondary	90.2	1.1	1.0	1.0	1.0	261
More than secondary	(74.2)	(1.0)	(0.0)	(1.0)	(0.0)	29
Wealth quintile						
Lowest	90.6	1.8	1.6	1.1	1.0	254
Second	94.7	1.6	1.6	1.5	1.5	186
Middle	94.1	0.0	0.0	0.0	0.0	192
Fourth	93.3	1.9	1.3	1.9	1.3	202
Highest	92.4	2.6	1.3	2.5	1.3	204
Total	92.9	1.6	1.2	1.4	1.0	1,038

Note: Figures in parentheses are based on 25-49 unweighted cases.

¹ SP = sulphadoxine pyrimethamine

² IPT: Intermittent Preventive Treatment is preventive intermittent treatment with SP/Fansidar during an antenatal care (ANC) visit.

12.3.2 Treatment of children with fever

Because fever is the major manifestation of malaria, mothers were asked whether their children under age 5 had had an episode of fever in the two weeks preceding the survey. If a fever was reported, the mother was asked whether treatment was sought and what medication the child was given, if any.

Table 12.5 shows the percentage of children under age 5 who had an episode of fever in the two weeks preceding the survey, the percentage who received antimalarial drugs among those sick with fever, and the percentage who received treatment soon after the onset of illness, by selected background characteristics.

Over 16% of children under age 5 had a fever in the two weeks preceding the survey. Among those sick with fever, 19% received antimalarial drugs, and 10.8% received drugs the same day or the day after the fever started.

Table 12.5: Prevalence and prompt treatment of fever

Percentage of children under age 5 with fever in the two weeks preceding the survey, and among children with fever, the percentage who took antimalarial drugs and the percentage who took drugs the same or next day following the onset of fever, by background characteristics, Solomon Islands 2007

Background characteristic	Among children under age 5:		Among children under age 5 with fever:		
	Percentage with fever in the two weeks preceding the survey	Number of children	Percentage who took antimalarial drugs	Percentage who took antimalarial drugs same or next day	Number of children
Age (in months)					
<12	17.4	526	12.8	3.0	91
12–23	23.4	535	10.6	6.7	125
24–35	16.9	533	17.5	12.7	90
36–47	15.0	515	34.0	16.9	77
48–59	9.2	477	(32.7)	(24.4)	44
Residence					
Urban	16.4	319	12.2	5.6	52
Rural	16.6	2,266	20.0	11.6	376
Region					
Honiara	14.0	241	6.9	2.7	34
Guadalcanal	13.5	476	38.1	20.0	64
Malaita	16.0	647	36.1	22.5	103
Western	17.7	276	(13.7)	(5.8)	49
Other provinces	18.9	945	6.1	3.7	178
Mother's education					
No education	14.1	359	28.0	11.7	50
Primary	15.9	1,603	17.3	10.9	254
Secondary	20.5	563	18.9	10.0	116
More than secondary	13.0	61	*	*	8
Wealth quintile					
Lowest	18.3	636	21.9	13.2	116
Second	12.9	528	(12.7)	(8.7)	68
Middle	15.1	468	26.4	11.9	71
Fourth	17.0	493	24.3	14.8	84
Highest	19.4	459	9.3	4.8	89
Total	16.6	2,585	19.0	10.8	428

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

The proportion of children under age 5 who had an episode of fever in the two weeks preceding the survey in those living in urban areas is similar to that of those living in rural areas. However, children living in urban areas are less likely to receive antimalarial drugs for fever than those living in rural areas. Children with fever in rural areas are more likely to receive antimalarial drugs as presumptive treatment of malaria than urban children. This can be attributed to the lower coverage for microscopy services for diagnosis in rural areas.

12.4 TYPE AND TIMING OF ANTIMALARIAL DRUGS

Table 12.6 shows the different antimalarial drugs that were received by children under age 5 with fever in the two weeks preceding the survey. Chloroquine, a component of the first line combination therapy in Solomon Islands, was the most frequently used antimalarial, and was received by 18.1% of children with fever. Fansidar, the partner drug for first line combination therapy, was received by 5.8% of children with fever. Less than 1% of children with fever received quinine, the second line treatment, or artemether. Solomon Islands will be introducing ACTs into its treatment guidelines, beginning in 2008.

12.5 KEY RESULTS

Malaria continues to be a major public health concern in the Solomon Islands, especially among pregnant women and children under age 5. Malaria is also a leading cause of morbidity and mortality in Solomon Islands. The use of an insecticide-treated mosquito net (ITN) is a primary health intervention to reduce malaria transmission in the country. The 2006/2007 SIDHS show findings on household possession of mosquito nets and use, and the treatment of bed-nets. The results show that three quarter (75.4%) of all households own at least one mosquito net with less than half of these households (48.5%) have at least one ITN mosquito net. Among children under age 5, 66% were reported to sleep under any net the night before the survey while only 40.4 percent used an ITN mosquito net. About 37% of pregnant women slept under ITN the night before the survey.

Because fever is the major manifestation of malaria, mothers of children with fever in the last two weeks were asked about the treatment they took for their children. This is important to identify children receiving appropriate treatment to prevent and eliminate malaria. Among 16% of children under age 5 who had fever in the two weeks preceding the survey, 19% received antimalarial drugs and 11% received drugs the same day or the day after the fever started. Similar proportions of children with fever are noted in both urban and rural areas. However, children in rural areas are more likely to receive antimalarial drugs than those children in urban areas.

The results also shows that about 18% of children with fever in the two weeks preceding the survey received a chloroquine antimalaria drug, about 6% were given fansidar while less than 1% received quinine.

Table 12.6: Type and timing of antimalarial drugs

Among children under age 5 with fever in the two weeks preceding the survey, percentage who took specific antimalarial drugs and the percentage who took each type of drug the same or next day after developing the fever, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of children who took drug:							Percentage of children who took drug the same or next day:			Number of children with fever
	SP/ Fansidar	Chloroquine	Primaquine	Quinine	Artametar	CBD anti-malarial	Other anti-malarial	SP/Fansidar	Chloroquine	Quinine	
Age (in months)											
<12	3.7	12.3	0.0	0.0	0.0	0.0	0.5	0.0	3.0	0.0	91
12–23	3.2	9.7	0.5	0.0	0.6	0.4	0.0	2.1	6.7	0.0	125
24–35	5.9	16.4	0.0	0.0	0.0	0.0	0.9	3.8	12.5	0.0	90
36–47	8.5	34.0	0.0	0.0	0.0	0.0	0.0	4.7	16.9	0.0	77
48–59	(12.7)	(29.6)	(0.0)	(3.2)	(0.0)	(0.0)	(0.0)	(10.1)	(21.3)	(3.2)	44
Residence											
Urban	0.4	9.6	0.0	0.0	1.4	0.0	0.8	0.4	5.2	0.0	52
Rural	6.6	19.3	0.2	0.4	0.0	0.1	0.2	3.7	11.2	0.4	376
Region											
Honiara	0.6	3.0	0.0	0.0	2.1	0.0	1.3	0.6	2.1	0.0	34
Guadalcanal	14.4	36.1	1.0	0.0	0.0	0.8	1.2	5.8	20.0	0.0	64
Malaita	12.8	34.7	0.0	1.3	0.0	0.0	0.0	7.8	21.2	1.3	103
Western	(0.0)	(13.7)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(5.8)	(0.0)	49
Other provinces	1.2	6.1	0.0	0.0	0.0	0.0	0.0	1.2	3.7	0.0	178
Mother's education											
No education	(4.0)	(28.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(2.8)	(11.7)	(0.0)	50
Primary	5.2	16.7	0.0	0.0	0.0	0.2	0.3	3.2	10.8	0.0	254
Secondary	8.3	17.0	0.5	1.2	0.3	0.0	0.4	4.1	8.8	1.2	116
More than secondary	*	*	*	*	*	*	*	*	*	*	8
Wealth quintile											
Lowest	7.9	21.2	0.0	0.0	0.0	0.0	0.7	4.6	13.2	0.0	116
Second	(4.1)	(12.7)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(1.1)	(8.7)	(0.0)	68
Middle	6.8	26.4	0.0	0.0	0.0	0.0	0.0	3.2	11.9	0.0	71
Fourth	5.6	23.7	0.7	0.0	0.0	0.6	0.0	5.0	14.8	0.0	84
Highest	3.7	6.2	0.0	1.6	0.8	0.0	0.5	1.8	3.1	1.6	89
Total	5.8	18.1	0.1	0.3	0.2	0.1	0.3	3.3	10.5	0.3	428

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

13.1 INTRODUCTION

Acquired immune deficiency syndrome (AIDS) is caused by a human immunodeficiency virus (HIV) that 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 contact, followed in magnitude by perinatal transmission in which a mother passes the virus to her child during pregnancy, delivery or breastfeeding. Other modes of transmission are through infected blood and unsafe injections⁷.

This chapter presents current levels of HIV and AIDS knowledge, attitudes and related behaviours for the general adult Solomon Islands population. It then focuses on HIV and AIDS knowledge and patterns of sexual activity among young people, because young adults are the main target of many HIV prevention efforts. Findings in this chapter will assist the HIV and STI control programme in Solomon Islands to identify particular groups of people who are most in need of information and services and who are most vulnerable to the risk of HIV infection. Overall, 3,823 women and 1,614 men aged 15–49 completed the HIV and AIDS related knowledge, attitudes and behaviours section of the 2006/2007 SIDHS. For men, an additional 442 people aged 50 years and older also participated.

13.2 KNOWLEDGE OF AIDS

The 2006/2007 SIDHS collected information on Solomon Islanders' knowledge of and behaviour related to AIDS and other diseases that are transmitted through sexual contact. All eligible respondents were asked whether they had heard about AIDS. Table 13.1 presents the proportions of women and men who have heard of AIDS according to their background characteristics.

Findings for the 2006/2007 SIDHS reveal that knowledge about AIDS in Solomon Islands is widespread but not universal: 94% of women aged 15–49 and 98% of men aged 15–49 have heard of AIDS (Table 13.1). For men, this finding is consistent across all other background characteristics, while knowledge of HIV is slightly lower for women with no education (84%), women who are divorced/separated/widowed (88.0%), and women in the lowest wealth quintile (89.7%). There is no substantial difference among women and men in their knowledge about AIDS.

Table 13.1 also shows that about 26% of women aged 15–49 and 37% of men in the corresponding age group knows where to get an HIV test. Knowledge of where to get an HIV test is lower among married women, women in rural areas and with women in lower educational background.

⁷ <http://www.who.int/features/qa/71/en/index.html>

Table 13.1: Knowledge of AIDS

Percentage of women age 15-49 and men age 15+ who have heard of AIDS, by background characteristics, Solomon Islands 2007

Background characteristic	Women			Men		
	Has heard of AIDS	Knows where to get an HIV test	Number of respondents	Has heard of AIDS	Knows where to get an HIV test	Number of respondents
Age						
15-24	94.7	27.6	1,404	98.4	33.2	596
..15-19	93.4	22.3	687	96.8	31.4	292
..20-24	95.9	32.6	716	99.9	35.0	304
25-29	93.7	28.8	729	98.0	47.5	266
30-39	94.1	24.3	1,082	97.4	44.1	505
40-49	94.2	22.3	609	98.8	32.4	247
Marital status						
Never married	95.0	28.1	1,125	97.3	35.5	660
..Ever had sex	95.6	28.0	655	99.1	38.7	495
..Never had sex	94.2	28.2	470	91.7	26.1	165
Married/Living together	94.2	24.8	2,560	98.6	41.2	939
Divorced/Separated/Widowed	88.2	31.9	138	*	*	14
Residence						
Urban	99.1	41.3	636	99.2	61.7	301
Rural	93.3	23.0	3,187	97.8	33.6	1,313
Region						
Honiara	99.0	37.3	481	99.6	64.8	240
Guadalcanal	95.7	24.1	637	99.9	29.5	249
Malaita	92.7	22.3	840	97.8	24.9	345
Western	93.9	35.0	458	98.8	36.9	181
Other provinces	93.0	22.3	1,407	96.7	41.0	599
Education						
No education	84.4	10.6	520	92.4	5.3	88
Primary	94.0	19.3	2,114	97.7	27.5	794
Secondary	98.8	42.0	1,067	99.0	51.2	593
More than secondary	100.0	69.9	122	100.0	72.6	138
Wealth quintile						
Lowest	89.7	14.6	696	98.7	23.2	281
Second	92.7	22.4	755	99.2	33.9	291
Middle	94.7	22.2	738	97.5	38.0	323
Fourth	94.4	25.9	769	96.3	38.0	353
Highest	98.8	41.7	864	98.9	56.6	366
Total 15-49	94.2	26.0	3,823	98.1	38.9	1,614
50+	na	na	na	83.4	16.8	442
Total men 15+	na	na	na	94.9	34.1	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
na = Not applicable

13.3 KNOWLEDGE OF HIV PREVENTION METHODS

HIV among adults is mainly transmitted through heterosexual contacts between an infected partner and a non-infected partner. Consequently⁸, the HIV prevention programme in Solomon Islands has mainly sought to reduce further sexual transmission through three programmatically important ways: 1) the promotion of sexual abstinence, 2) mutually faithful monogamy among uninfected couples, and 3) condom use by those that cannot abstain from sexual intercourse.

HIV and AIDS prevention programmes focus their messages and efforts on three important aspects of behaviour, often referred to as “ABC” messages: a) delaying sexual debut (i.e. **abstinence**), b) limiting the number of sexual partners, and **being faithful** to one uninfected partner, and c) using **condoms**. To ascertain whether programmes have effectively communicated these messages, respondents were asked specific questions about whether it is possible to reduce the chances of getting the AIDS virus by using condoms every time they have sexual intercourse, by having one sex partner who is not infected and has no other partners, and by abstaining from sexual intercourse.

Table 13.2 and Figure 13.2 present the proportion of women and men aged 15–49 who were aware about the various HIV and AIDS prevention methods by background characteristics. Findings of the 2006/2007 SIDHS indicate that, in general, more men are aware about various preventive methods to reduce HIV transmission compared with women, with a similar pattern observed for each preventative method.

Findings of the 2006/2007 SIDHS reveal that knowledge is highest for awareness that HIV can be prevented by limiting sexual intercourse to one uninfected partner (95% men, 80% women), followed by abstaining from sexual intercourse (89% men, 77% women), while using a condom is the least known way to prevent HIV from spreading (69% men, 61% women). Table 13.2 also shows that there is no substantial difference in the level of knowledge of prevention methods by age group. Lower proportions of never-married men and women who report that they have never had sex were found to have knowledge of prevention methods compared with those who have had sex, or are married/living together or divorced/separated/widowed.

Differences were noted among women from urban and rural areas regarding the level of knowledge about ways to prevent HIV from spreading. A higher proportion of women from urban areas have knowledge of the four methods of preventing HIV transmission than women from rural areas. Knowledge about ways to prevent HIV from spreading were similar for men in both settings.

Table 13.2 shows some differences in knowledge on the basis of region. The 2006/2007 SIDHS findings also show that less than 50% of men in Western Province are aware that using condoms and limiting sexual intercourse reduce the chances of getting HIV. Only 52% of women from Malaita Province know that using condoms can prevent transmission of the HIV virus.

The proportion of respondents who have knowledge about ways to prevent HIV from spreading increases with educational attainment. This pattern is evident among both men and women, and is most evident for women who have not attended any schooling. A similar pattern is also shown for wealth quintiles. The proportion of women who know methods of reducing the risk of HIV transmission is lowest for women from the lowest quintile, and increases with the level of relative wealth.

⁸ http://www.who.int/features/2004/hiv_aids/en/index.html

Table 13.2: Knowledge of HIV prevention methods

Percentage of women age 15-49 and men age 15+ who, in response to prompted questions, say that people can reduce the risk of getting the AIDS virus by using condoms every time they have sexual intercourse, by having one sex partner who is not infected and has no other partners, and by abstaining from sexual intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Women Percentage who say HIV can be prevented by					Men Percentage who say HIV can be prevented by				
	Using condoms ¹	Limiting sexual intercourse to one uninfected partner ²	Using condoms and limiting sexual intercourse to one uninfected partner ^{1, 2}	Abstaining from sexual intercourse	Number of women	Using condoms	Limiting sexual intercourse to one uninfected partner	Using condoms and limiting sexual intercourse to one uninfected partner	Abstaining from sexual intercourse	Number of men
Age										
15-24	61.4	81.2	57.4	79.4	1,404	67.9	94.4	65.9	89.0	596
..15-19	57.4	79.1	52.9	77.0	687	64.2	92.6	62.5	87.1	292
..20-24	65.3	83.2	61.8	81.8	716	71.5	96.2	69.1	90.7	304
25-29	58.4	79.3	54.7	75.3	729	64.0	94.3	62.3	88.9	266
30-39	61.6	79.6	57.5	75.4	1,082	70.9	95.3	69.9	88.1	505
40-49	59.7	78.1	54.0	73.5	609	74.2	95.7	72.5	90.3	247
Marital status										
Never married	60.8	80.4	56.4	77.2	1,125	67.1	92.7	64.7	87.4	660
..Ever had sex	65.5	83.2	60.5	78.8	655	68.8	94.7	66.7	88.3	495
..Never had sex	54.4	76.7	50.8	75.0	470	61.7	86.8	58.7	84.6	165
Married/Living together	60.6	79.7	56.3	76.2	2,560	70.5	96.4	69.4	89.9	939
Divorced/Separated/Widowed	59.2	79.1	58.1	77.8	138	*	*	*	*	14
Residence										
Urban	65.5	88.8	62.8	82.9	636	70.3	96.2	68.1	85.7	301
Rural	59.7	78.1	55.1	75.3	3,187	68.9	94.5	67.4	89.6	1,313
Region										
Honiara	63.8	86.5	61.2	79.6	481	72.7	97.4	70.9	90.8	240
Guadalcanal	55.2	90.8	54.1	78.7	637	77.8	98.2	77.1	89.5	249
Malaita	52.2	71.4	48.7	65.5	840	75.9	94.7	73.8	92.0	345
Western	63.9	77.6	61.6	74.5	458	47.2	85.4	43.1	74.1	181
Other provinces	66.0	78.5	58.7	81.9	1,407	66.9	95.4	66.1	90.5	599
Education										
No education	45.6	66.3	43.2	60.2	520	78.0	87.3	74.7	87.6	88
Primary	58.6	78.6	53.5	76.5	2,114	67.1	94.0	65.3	87.9	794
Secondary	70.5	87.5	66.9	83.5	1,067	70.4	96.2	69.1	89.5	593
More than secondary	73.0	93.3	70.3	87.0	122	70.2	98.8	69.0	92.7	138

Table 13.2 (continued)

Background characteristic	Women					Men				
	Percentage who say HIV can be prevented by					Percentage who say HIV can be prevented by				
	Using condoms ¹	Limiting sexual intercourse to one uninfected partner ²	Using condoms and limiting sexual intercourse to one uninfected partner ^{1,2}	Abstaining from sexual intercourse	Number of women	Using condoms	Limiting sexual intercourse to one uninfected partner	Using condoms and limiting sexual intercourse to one uninfected partner	Abstaining from sexual intercourse	Number of men
Wealth quintile										
Lowest	55.7	73.3	49.5	70.2	696	80.9	95.8	79.6	94.1	281
Second	57.9	76.7	54.2	73.6	755	61.0	95.0	59.7	91.5	291
Middle	58.6	76.7	53.4	76.5	738	67.7	95.1	66.2	90.4	323
Fourth	59.8	82.5	56.1	79.1	769	65.7	92.8	63.8	86.4	353
Highest	69.5	88.3	66.7	82.2	864	71.2	95.9	69.4	83.7	366
Total 15-49	60.6	79.9	56.4	76.6	3,823	69.2	94.9	67.6	88.9	1,614
50+	na	na	na	na	na	53.8	79.0	51.9	69.7	442
Total men 15+	na	na	na	na	na	65.8	91.4	64.2	84.7	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

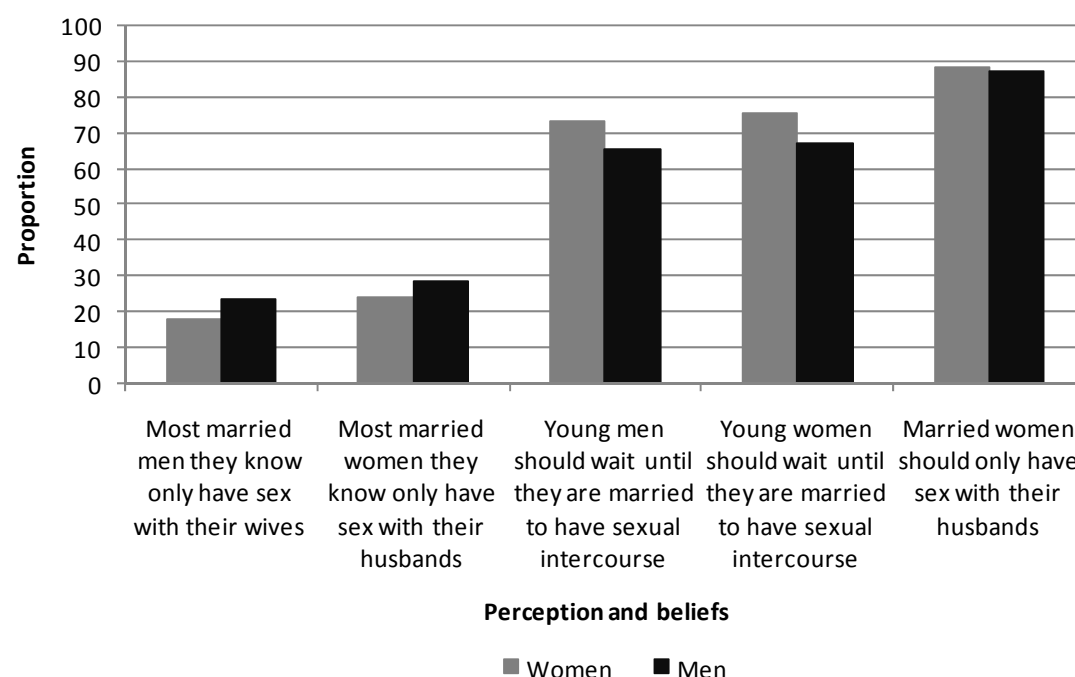
na = Not applicable

¹ Using condoms every time they have sexual intercourse

² Partner who has no other partners

Findings of the 2006/2007 SIDHS also indicate that there is a strong belief by women and men that both a husband and wife must be faithful to one another, yet only a small proportion of women and men aged 15–49 reported that most married men and women they know have sex only with their spouse (Fig. 13.1).

Figure 13.1: Proportion of all women and men aged 15–49 who believe in abstinence and faithfulness



13.4 REJECTION OF MISCONCEPTIONS ABOUT HIV AND AIDS

In addition to knowing about effective ways to avoid contracting HIV, the 2006/2007 SIDHS also included questions to assess the prevalence of common misconceptions about AIDS transmission and prevention, and knowledge about AIDS. Table 13.3.1 and Table 13.3.2 presents the percentage of women and men aged 15–49 who say that a healthy-looking person can have the AIDS virus and who, in response to prompted questions, correctly reject local misconceptions about AIDS transmission or prevention, and the percentage with a comprehensive knowledge about AIDS by background characteristics.

The results show that 71% of women and 83% of men are aware that a healthy-looking person can have the AIDS virus, and approximately two-thirds of women (63%) and men (67%) know that the AIDS virus cannot be contracted by mosquito bites or transmitted by supernatural means (66% women, 68% men). Nearly three-quarters of women (71%) and men (70%) are aware that the AIDS virus cannot be transmitted by sharing food with an infected person.

Tables 13.3.1 and 13.3.2 also show the proportions of respondents who reject common misconceptions about contracting HIV and AIDS. For both sexes, knowledge is highest for knowing that a healthy person can have the HIV virus (71% women, 80% men) and a person cannot become infected with the HIV virus by sharing food with a person who has the virus (71% women, 70% men). Approximately two-thirds of both sexes know that HIV cannot be transmitted by mosquito bites (63% women, 67% men).

While there are no definite trends for misconceptions on the basis of age group, there are some differences in areas of residence. Lower proportions of men and women from rural areas correctly responded to misconceptions about HIV transmission. In addition, lower proportions of women

from Malaita and 'other provinces', and men from Western and 'other provinces' correctly responded to misconceptions about HIV transmission than women and men from Honiara and Guadalcanal Province.

As might be expected, lower proportions of women and men with no education, correctly responded to misconceptions than did those who completed some schooling. Also, fewer people from the lowest wealth quintile correctly answered these questions than those from higher wealth quintiles.

13.5 COMPREHENSIVE KNOWLEDGE ABOUT HIV AND AIDS

As HIV epidemic changes with time, it is necessary for people to have more comprehensive knowledge of HIV and AIDS. An indicator of comprehensive knowledge about HIV and AIDS combines several individual indicators previously discussed. It is the percentage of respondents aged 15–49 who know that:

- (a) people can reduce the chances of getting the AIDS virus by using a condom every time they have sex;
- (b) people can reduce the chances of getting the AIDS virus by having sex with just one uninfected partner who has no other partners;
- (c) people cannot get the AIDS virus by sharing food with a person who has AIDS;
- (d) that a healthy-looking person can have the AIDS virus; and who
- (e) reject the two most common local misconceptions about AIDS transmission or prevention.

Tables 13.3.1 and 13.3.2 also show the proportions of women and men who have a comprehensive knowledge about HIV and AIDS. The 2006/2007 SIDHS reveals that very few people in Solomon Islands have a comprehensive knowledge about HIV and AIDS. This is clearly reflected in the small proportion of women (29%) and men (35%) who have a comprehensive knowledge about the ways in which HIV and AIDS can be contracted and or transmitted.

Although there is no substantial variation in the knowledge about HIV and AIDS among women by age group or marital status, the 2006/2007 SIDHS found that women with little and or no education and those from the lowest wealth quintile have a lower comprehensive knowledge level about the disease and how it can be prevented compared with those with higher levels of education and relative wealth.

Lower proportions of women and men from rural areas have a comprehensive knowledge than women and men from urban areas. In addition, lower proportions of women from Malaita and 'other provinces' and men from Western and 'other provinces' have a comprehensive knowledge than those from Honiara and Guadalcanal. This finding strongly suggests that if an awareness programme had been conducted prior to the survey then it was not as effective as it could have been. There is a need to increase HIV awareness programmes that target women in rural areas so that there is a widespread and universal understanding and knowledge in Solomon Islands about HIV.

Table 13.3.1: Comprehensive knowledge about AIDS: Women

Percentage of women age 15-49 who say that a healthy-looking person can have the AIDS virus and who, in response to prompted questions, correctly reject local misconceptions about AIDS transmission or prevention, and the percentage with a comprehensive knowledge about AIDS by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of respondents who say that:				Percentage who say that a healthy looking person can have the AIDS virus and who reject the two most common local misconceptions ¹	Percentage with a comprehensive knowledge about AIDS ²	Number of women
	A healthy-looking person can have the AIDS virus	AIDS cannot be transmitted by mosquito bites	AIDS cannot be transmitted by supernatural means	A person cannot become infected by sharing food with a person who has AIDS			
Age							
15-24	70.7	68.3	68.4	74.3	42.7	29.3	1,404
..15-19	67.7	66.4	68.0	73.6	41.8	28.6	687
..20-24	73.7	70.2	68.8	75.0	43.5	30.0	716
25-29	68.5	61.7	65.0	70.1	39.8	26.9	729
30-39	72.2	60.5	66.7	68.5	42.6	31.2	1,082
40-49	70.2	55.3	62.0	68.0	36.5	27.1	609
Marital status							
Never married	68.6	68.3	67.9	75.5	41.9	30.2	1,125
..Ever had sex	70.8	69.5	68.9	79.3	41.6	31.2	655
..Never had sex	65.5	66.5	66.4	70.4	42.2	28.7	470
Married/Living together	71.3	60.8	66.3	68.9	41.2	28.6	2,560
Divorced/Separated/Widowed	75.8	54.8	53.3	68.5	34.3	28.1	138
Residence							
Urban	85.8	77.4	75.2	79.1	55.6	38.1	636
Rural	67.6	59.9	64.5	69.2	38.2	27.2	3,187
Region							
Honiara	83.2	75.8	72.1	77.8	50.5	33.7	481
Guadalcanal	85.6	72.7	83.1	76.5	62.3	37.8	637
Malaita	64.0	49.1	56.7	57.2	30.8	22.5	840
Western	73.7	69.9	74.7	70.8	54.7	45.1	458
Other provinces	62.6	59.7	59.6	74.1	30.1	22.1	1,407
Education							
No education	57.6	41.1	49.9	47.3	24.8	16.2	520
Primary	69.2	57.2	65.8	68.0	37.9	26.0	2,114
Secondary	78.1	81.3	73.1	85.6	52.6	39.3	1,067
More than secondary	86.1	90.6	85.6	91.2	67.0	47.3	122

Chapter 13.3.1 (continued)

Background characteristic	Percentage of respondents who say that:				Percentage who say that a healthy looking person can have the AIDS virus and who reject the two most common local misconceptions ¹	Percentage with a comprehensive knowledge about AIDS ²	Number of women
	A healthy-looking person can have the AIDS virus	AIDS cannot be transmitted by mosquito bites	AIDS cannot be transmitted by supernatural means	A person cannot become infected by sharing food with a person who has AIDS			
Wealth quintile							
Lowest	62.6	51.6	61.7	63.7	30.0	19.5	696
Second	63.4	60.0	61.3	69.4	36.8	27.6	755
Middle	70.4	57.9	65.2	67.9	40.0	28.9	738
Fourth	73.4	65.9	67.1	71.8	43.1	28.1	769
Highest	81.3	75.6	74.5	79.5	53.1	38.9	864
Total 15-49	70.7	62.8	66.3	70.9	41.1	29.0	3,823

¹ Two most common local misconceptions: AIDS cannot be transmitted by mosquito bites and AIDS cannot be transmitted by supernatural means.

² Comprehensive knowledge means knowing that consistent use of 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.

Table 13.3.2: Comprehensive knowledge about AIDS: Men

Percentage of men age 15+ who say that a healthy-looking person can have the AIDS virus and who, in response to prompted questions, correctly reject local misconceptions about AIDS transmission or prevention, and the percentage with a comprehensive knowledge about AIDS by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of respondents who say that:				Percentage who say that a healthy looking person can have the AIDS virus and who reject the two most common local misconceptions ¹	Percentage with a comprehensive knowledge about AIDS ²	Number of men
	A healthy-looking person can have the AIDS virus	AIDS cannot be transmitted by mosquito bites	AIDS cannot be transmitted by supernatural means	A person cannot become infected by sharing food with a person who has AIDS			
Age							
15-24	82.8	67.5	73.3	74.3	47.3	35.1	596
..15-19	77.7	63.2	65.5	70.1	39.5	26.4	292
..20-24	87.6	71.6	80.7	78.4	54.7	43.5	304
25-29	82.3	77.8	70.4	73.6	54.5	37.5	266
30-39	84.3	76.4	70.9	73.1	56.2	42.6	505
40-49	84.6	69.7	68.5	71.2	50.6	40.4	247
Marital status							
Never married	82.7	69.6	71.7	76.1	49.1	35.3	660
..Ever had sex	84.8	74.8	75.6	79.0	53.2	38.1	495
..Never had sex	76.3	54.0	60.3	67.5	36.7	27.1	165
Married/Living together	84.3	74.1	70.8	71.7	53.7	40.9	939
Divorced/Separated/Widowed	*	*	*	*	*	*	14
Residence							
Urban	92.4	88.6	90.5	86.8	78.3	56.6	301
Rural	81.4	68.6	66.9	70.3	45.7	34.5	1,313
Region							
Honiara	93.8	91.2	92.0	86.2	82.8	60.1	240
Guadalcanal	94.1	86.3	92.9	75.7	79.6	62.4	249
Malaita	91.1	66.3	72.6	73.5	53.5	42.0	345
Western	77.6	67.7	56.9	67.8	33.6	21.0	181
Other provinces	72.2	63.8	57.7	68.8	32.3	23.6	599
Education							
No education	83.6	55.8	69.7	64.8	47.9	44.4	88
Primary	81.9	62.6	60.8	65.7	39.0	29.5	794
Secondary	84.7	82.6	83.4	81.4	64.5	46.5	593
More than secondary	86.8	94.3	80.6	87.7	73.0	53.5	138

Chapter 13.3.2 (continued)

Background characteristic	Percentage of respondents who say that:				Percentage who say that a healthy looking person can have the AIDS virus and who reject the two most common local misconceptions ¹	Percentage with a comprehensive knowledge about AIDS ²	Number of men
	A healthy-looking person can have the AIDS virus	AIDS cannot be transmitted by mosquito bites	AIDS cannot be transmitted by supernatural means	A person cannot become infected by sharing food with a person who has AIDS			
Wealth quintile							
Lowest	76.3	67.2	66.0	66.3	43.2	36.6	281
Second	77.8	67.5	54.8	68.5	31.8	24.6	291
Middle	86.4	67.4	69.9	75.1	48.1	34.6	323
Fourth	82.2	68.4	75.1	73.2	52.9	37.8	353
Highest	92.0	88.1	86.1	81.1	76.2	55.8	366
Total 15-49	83.4	72.3	71.3	73.3	51.8	38.6	1,614
50+	65.9	46.3	55.8	56.7	33.1	23.5	442
Total men 15+	79.7	66.7	68.0	69.8	47.7	35.4	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Two most common local misconceptions: AIDS cannot be transmitted by mosquito bites and AIDS cannot be transmitted by supernatural means.

² Comprehensive knowledge means knowing that consistent use of 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.

13.6 KNOWLEDGE OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Some preconditions for reducing mother-to-child transmission (MTCT) are knowing that HIV can be transmitted from mother to child, and knowing that the use of antiretroviral drugs by the mother can reduce the risk of transmission (WHO). The 2006/2007 DHS asked respondents about their knowledge of whether a mother who has AIDS can pass the disease on to her baby in any of three ways: 1) while she is pregnant with the baby, 2) during delivery of the baby, or 3) while she is breastfeeding the baby. This is an important indicator of respondents' knowledge of MTCT, and measures respondents' knowledge about whether MTCT can be prevented through antiretroviral therapy and by avoiding breastfeeding.

In the 2006/2007 SIDHS survey, respondents were asked if the AIDS virus can be transmitted from mother to child. If the answer was 'Yes', respondents were further asked about whether the virus could be transmitted during pregnancy, during delivery, and/or during breastfeeding. They were also asked if there are any special drugs that a doctor or nurse can give to an HIV-infected pregnant woman to reduce the risk of transmission to the baby. Table 13.4 presents the proportions of women and men who know that HIV can be transmitted from mother to child during breastfeeding, and that the risk of MTCT of HIV can be reduced by the mother taking special drugs during pregnancy, by background characteristics.

In Solomon Islands, over two-thirds of women (69%) and just over one-half of men (53%) are aware that HIV can be transmitted from a mother to her child through breastfeeding, while only 8% of women and 9% of men are aware that MTCT can be reduced by the mother taking special drugs during pregnancy. Very few women and men are aware that HIV can be transmitted by breastfeeding, and that the risk of transmission can be reduced by infected mothers taking special drugs.

The proportions of men who know that HIV can be transmitted by breastfeeding is particularly low among men from Malaita Province (27%) and among men with no education (29%).

Table 13.4: Knowledge of prevention of mother to child transmission of HIV

Percentage of women and men who know that HIV can be transmitted from mother to child by breastfeeding and that the risk of mother to child transmission (MTCT) of HIV can be reduced by mother taking special drugs during pregnancy, by background characteristics, Solomon Islands 2007

Background characteristic	Women				Men			
	Percentage who know that:			Number of women	Percentage who know that:			Number of men
	HIV can be transmitted by breastfeeding	Risk of MTCT can be reduced by mother taking special drugs during pregnancy	HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy		HIV can be transmitted by breastfeeding	Risk of MTCT can be reduced by mother taking special drugs during pregnancy	HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy	
Age								
15-24	70.6	6.4	5.4	1,404	50.4	9.0	7.2	596
..15-19	70.7	5.2	3.6	687	44.6	7.9	5.5	292
..20-24	70.6	7.6	7.2	716	55.9	10.0	8.8	304
25-29	68.8	12.0	9.7	729	56.6	12.9	8.2	266
30-39	68.8	6.8	5.9	1,082	54.6	7.5	6.0	505
40-49	65.4	8.8	7.3	609	52.8	9.0	5.5	247
Marital status								
Never married	68.7	8.1	6.9	1,125	51.2	9.0	6.6	660
..Ever had sex	67.5	8.5	6.8	655	56.7	11.1	8.1	495
..Never had sex	70.3	7.6	7.1	470	34.5	2.5	2.1	165
Married/Living together	69.4	8.3	6.9	2,560	54.6	9.1	6.6	939
Divorced/Separated/Widowed	62.4	1.5	1.3	138	*	*	*	14
Currently pregnant								
Pregnant	64.8	5.5	4.9	228	na	na	na	na
Not pregnant or not sure	69.2	8.1	6.8	3,595	na	na	na	na
Residence								
Urban	78.5	12.0	10.5	636	62.0	11.1	7.8	301
Rural	67.0	7.2	5.9	3,187	51.0	8.7	6.5	1,313
Region								
Honiara	79.0	11.5	10.2	481	61.0	10.6	7.6	240
Guadalcanal	75.3	8.9	8.0	637	81.8	13.7	12.4	249
Malaita	67.8	2.4	2.4	840	27.1	0.4	0.4	345
Western	56.6	4.5	3.0	458	63.4	18.8	15.1	181
Other provinces	67.3	10.8	8.6	1,407	49.8	8.8	5.1	599

Table 13.4 (continued)

Background characteristic	Women				Men			
	Percentage who know that:			Number of women	Percentage who know that:			Number of men
	HIV can be transmitted by breastfeeding	Risk of MTCT can be reduced by mother taking special drugs during pregnancy	HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy		HIV can be transmitted by breastfeeding	Risk of MTCT can be reduced by mother taking special drugs during pregnancy	HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy	
Education								
No education	59.4	4.9	4.5	520	28.7	0.8	0.5	88
Primary	68.4	6.1	5.4	2,114	51.6	7.7	6.3	794
Secondary	74.1	11.7	9.0	1,067	58.1	10.9	7.2	593
More than secondary	74.2	21.0	18.7	122	56.0	15.7	10.8	138
Wealth quintile								
Lowest	68.7	6.6	6.2	696	41.5	4.3	2.6	281
Second	64.4	7.3	6.6	755	47.8	7.6	4.5	291
Middle	69.6	6.4	5.6	738	49.2	12.3	9.2	323
Fourth	64.7	9.0	5.7	769	60.4	7.9	6.9	353
Highest	76.4	10.3	9.0	864	62.5	12.5	9.3	366
Total 15-49	68.9	8.0	6.7	3,823	53.1	9.2	6.7	1,614
50+	na	na	na	na	40.5	6.5	4.2	442
Total men 15+	na	na	na	na	50.4	8.6	6.2	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
na = Not applicable

13.7 STIGMA ASSOCIATED WITH AIDS, AND ATTITUDES TOWARD HIV AND AIDS

Knowledge about AIDS can affect people's opinions and attitude toward people with AIDS (UNAIDS 2008). To measure attitudes toward people with AIDS, a number of questions were asked about people's willingness to care for a family member with AIDS, perceived stigma associated with a family member being diagnosed with HIV and AIDS, and attitudes toward casual contact with someone who has AIDS. Respondents were also asked about their opinion on whether a female teacher who has AIDS but who is not sick should be allowed to continue teaching. Tables 13.5.1 and 13.5.2 show the proportions of women and men who expressed positive attitudes toward people with AIDS according to their background characteristics.

Overall, a higher proportion of men than women reported accepting attitudes. Accepting attitudes are highest for not wanting to keep it a secret about a family member being infected with AIDS (66% women, 72% men). About 57% of men report that they would be willing to care for a family member with AIDS in their own home compared with 36% of women. About 54% of men report that they would buy fresh vegetables from a shopkeeper with AIDS compared with only 30% of women. Only 20% of men and 16% of women agree that a female teacher infected with the AIDS virus should be allowed to continue teaching. Very few respondents (10% men, 5% women) expressed acceptance about all four indicators.

This finding clearly indicates that intervention strategies are needed to reduce the stigma associated with HIV and AIDS. Lower proportions of never married men who have never had sex reported that they would not be willing to accept a family member infected with the HIV and AIDS virus than other men. A similar trend was also observed among never married women who have never had sex.

Despite the low percentage of accepting attitudes toward people with HIV and AIDS, urban residents, and higher proportions of people in Honiara, have accepting attitudes toward people with AIDS than do rural residents and people from other provinces. Tables 13.5.1 and 13.5.2 also show that accepting attitudes increase with educational attainment and wealth quintile.

Table 13.5.1: Accepting attitudes toward those living with HIV/AIDS: Women

Among women age 15-49 who have heard of AIDS, percentage expressing specific accepting attitudes toward people with AIDS, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of respondents who:				Percentage expressing acceptance attitudes on all four indicators	Number of respondents who have heard of AIDS
	Are willing to care for a family member with the AIDS virus in the respondent's home	Would buy fresh vegetables from shopkeeper who has the AIDS virus	Say that a female teacher with the AIDS virus and is not sick should be allowed to continue teaching	Would not want to keep secret that a family member got infected with the AIDS virus		
Age						
15-24	36.2	31.6	17.5	66.7	4.4	1,329
..15-19	34.8	31.7	16.7	66.4	3.8	642
..20-24	37.5	31.4	18.2	67.0	5.0	687
25-29	31.1	26.6	16.7	66.1	4.7	683
30-39	33.8	30.3	13.2	65.6	4.7	1,018
40-49	42.6	27.6	15.4	65.9	5.2	573
Marital status						
Never married	37.7	35.4	19.4	65.1	5.3	1,069
..Ever had sex	43.7	38.8	21.4	64.0	5.6	626
..Never had sex	29.4	30.7	16.5	66.7	4.9	443
Married/Living together	34.6	27.5	14.2	66.9	4.5	2,412
Divorced/Separated/Widowed	36.4	21.8	14.7	61.2	3.9	122
Residence						
Urban	46.4	42.9	24.5	59.5	6.5	630
Rural	33.3	26.8	13.9	67.6	4.3	2,973
Region						
Honiara	49.6	44.4	28.6	58.3	7.3	476
Guadalcanal	26.6	30.8	13.4	67.7	4.8	609
Malaita	22.5	15.9	8.8	75.3	1.6	778
Western	32.6	27.1	15.5	67.9	8.1	430
Other provinces	43.5	32.8	16.5	62.3	4.4	1,309
Education						
No education	22.8	18.0	11.7	69.8	2.6	439
Primary	32.7	25.0	11.9	66.7	3.4	1,987
Secondary	43.6	40.5	22.8	64.3	7.5	1,055
More than secondary	58.9	54.3	33.2	61.1	9.2	122
Wealth quintile						
Lowest	27.1	23.3	13.6	64.5	0.8	624
Second	34.1	27.7	13.4	64.1	2.8	700
Middle	29.3	23.2	12.1	71.6	3.3	699
Fourth	38.3	31.0	14.2	65.6	6.7	726
Highest	45.9	40.1	23.7	65.1	8.4	853
Total 15-49	35.6	29.7	15.8	66.2	4.7	3,603

Table 13.5.2: Accepting attitudes toward those living with HIV/AIDS: Men

Among men age 15+ who have heard of HIV/AIDS, percentage expressing specific accepting attitudes toward people with HIV/AIDS, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of respondents who:				Percentage expressing acceptance attitudes on all four indicators	Number of respondents who have heard of AIDS
	Are willing to care for a family member with the AIDS virus in the respondent's home	Would buy fresh vegetables from shopkeeper who has the AIDS virus	Say that a female teacher with the AIDS virus and is not sick should be allowed to continue teaching	Would not want to keep secret that a family member got infected with the AIDS virus		
Age						
15-24	51.0	51.2	22.3	71.3	8.3	586
..15-19	39.8	46.3	18.0	75.3	7.9	282
..20-24	61.4	55.7	26.2	67.7	8.6	304
25-29	65.8	58.6	25.1	73.6	13.7	261
30-39	56.8	58.5	16.4	70.8	8.2	492
40-49	54.5	52.0	19.1	74.2	10.2	244
Marital status						
Never married	53.2	53.4	23.9	72.4	10.7	642
..Ever had sex	57.6	57.1	26.1	68.7	11.0	490
..Never had sex	39.1	41.7	16.8	84.6	9.7	152
Married/Living together	57.4	56.1	18.0	71.7	8.7	926
Divorced/Separated/Widowed	*	*	*	*	*	14
Residence						
Urban	72.5	61.4	40.9	75.3	18.8	298
Rural	51.9	53.3	15.7	71.2	7.3	1,284
Region						
Honiara	70.0	58.4	39.7	78.0	17.1	239
Guadalcanal	69.9	72.3	34.4	65.3	17.0	248
Malaita	54.4	38.4	9.4	94.3	5.4	337
Western	62.7	55.9	26.5	69.6	13.8	179
Other provinces	42.5	55.1	11.0	60.1	4.1	579
Education						
No education	44.2	32.3	4.0	85.6	2.4	82
Primary	50.3	47.6	13.9	73.7	6.9	775
Secondary	62.0	63.3	29.1	72.2	12.4	588
More than secondary	66.7	72.5	30.0	53.4	15.9	138
Wealth quintile						
Lowest	42.3	49.4	7.9	64.0	2.2	278
Second	54.1	54.0	13.0	62.7	2.7	289
Middle	57.1	56.7	21.5	76.5	13.7	315
Fourth	51.2	56.7	19.0	79.2	10.3	340
Highest	70.6	56.3	36.4	74.8	16.0	362
Total 15-49	55.8	54.8	20.4	72.0	9.5	1,583
50+	61.3	48.2	16.7	70.3	7.5	369
Total men 15+	56.8	53.6	19.7	71.7	9.1	1,951

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

13.8 ATTITUDES TOWARD NEGOTIATING SAFER SEX

Knowledge about preventing HIV and AIDS transmission is of limited value if women are unable to negotiate a safe sexual relationship with a husband or partner. The 2006/2007 SIDHS asked respondents whether it is justifiable for a wife to refuse sexual intercourse with her husband, or to request him to use a condom if she knows that he has an STI. Table 13.6 presents the percentage of women aged 15–49 and men aged 15 and older who believe that a woman is justified in refusing sexual intercourse or in negotiating for safer sex, by background characteristics.

The 2006/2007 SIDHS found that 83% of women and 86% of men believe that a woman is justified in refusing sexual intercourse or negotiating for safer sex with a husband or partner who has an STI.

Table 13.6 also shows that while there are no substantial differences in the proportion of men and women who believe that a woman is justified in negotiating for safer sex, less than 50% of men in Western Province agree with this statement. Additionally, a lower proportion of men aged 15–19 believe that a wife is justified in refusing sexual intercourse with an infected husband or negotiating for condom use during sexual intercourse compared with all other age groups. Never married and never had sex were least likely to believe that a woman is justified in refusing sexual intercourse or negotiating for safer sex with a husband or partner who has an STI.

Table 13.6: Attitudes toward negotiating safer sexual relations with husband

Percentage of women age 15-49 and men age 15+ who believe that, if a husband has a sexually transmitted disease, his wife is justified in refusing to have sexual intercourse with him or asking that they use a condom, by background characteristics, Solomon Islands 2007

Background characteristic	Women Woman is justified in:			Men Man is justified in:		
	Refusing to have sexual intercourse	Refusing sexual intercourse or asking that they use a condom	Number of women	Refusing to have sexual intercourse	Refusing sexual intercourse or asking that they use a condom	Number of men
Age						
15-24	82.9	82.9	1,404	81.2	81.2	596
..15-19	80.5	80.5	687	76.8	76.8	292
..20-24	85.3	85.3	716	85.4	85.4	304
25-29	83.9	83.9	729	87.4	87.4	266
30-39	83.2	83.2	1,082	89.9	89.9	505
40-49	82.8	82.8	609	84.6	84.6	247
Marital status						
Never married	79.4	79.4	1,125	80.6	80.6	660
..Ever had sex	79.2	79.2	655	81.9	81.9	495
..Never had sex	79.6	79.6	470	76.6	76.6	165
Married/Living together	84.7	84.7	2,560	89.0	89.0	939
Divorced/Separated/Widowed	86.0	86.0	138	*	*	14
Residence						
Urban	92.6	92.6	636	85.0	85.0	301
Rural	81.3	81.3	3,187	85.6	85.6	1,313
Region						
Honiara	91.3	91.3	481	87.5	87.5	240
Guadalcanal	89.2	89.2	637	96.4	96.4	249
Malaita	82.1	82.1	840	94.0	94.0	345
Western	78.2	78.2	458	49.1	49.1	181
Other provinces	79.9	79.9	1,407	86.2	86.2	599
Education						
No education	82.1	82.1	520	91.5	91.5	88
Primary	81.3	81.3	2,114	81.1	81.1	794
Secondary	86.8	86.8	1,067	88.8	88.8	593
More than secondary	89.0	89.0	122	92.2	92.2	138
Total 15-49	83.2	83.2	3,823	85.5	85.5	1,614
50+	na	na	na	83.2	83.2	442
Total men 15+	na	na	na	85.0	85.0	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = Not applicable

13.9 MULTIPLE SEXUAL PARTNERS AND HIGHER RISK SEXUAL INTERCOURSE IN THE PAST 12 MONTHS

Higher risk sex is defined as having sex with a person who is neither a spouse nor a cohabiting partner (UNGASS 2005). In order to assess indicators of multiple sexual partners and higher risk sex, the 2006/2007 SIDHS asked respondents who had sexual intercourse in the 12 months preceding the survey about the number of partners they had, and asked those who had higher risk sexual intercourse about whether a condom was used.

Tables 13.7.1 and 13.7.2 present the percentage of those who reported having sexual intercourse with more than one partner and who used a condom during their last sexual intercourse, and the percentage of who reported having higher risk sexual intercourse and used a condom during their last higher risk sexual intercourse. These tables also present the mean number of lifetime sex partners by background characteristics.

The result of the 2006/2007 SIDHS shows that 4% of women and 9% of men reported having sexual intercourse with more than one partner in the 12 months preceding the survey, and that 15% of women and 32% of men reported to have had higher risk intercourse in the 12 months preceding the survey.

Tables 13.7.1 and 13.7.2 further reveal that 16% of women aged 15–19 have had sexual intercourse with more than one partner, and 68% of women in the same age group have had higher risk sexual intercourse in the 12 months preceding survey. One-quarter of men (24%) aged 20–24 had sexual intercourse with more than one partner in the 12 months prior to the survey, and almost 100% of men aged 15–19 have had sexual intercourse with a partner who neither had a spouse nor lived with respondents (higher risk).

Looking at the marital relationship of respondents, the 2006/2007 SIDHS findings show that higher proportions of never married respondents had two or more partners in the 12 months prior to the survey compared with fewer partners for other groups. About 1 in every 4 never married men had sexual intercourse with more than one partner in the 12 months prior to the survey. About 19% of never married women have had sexual intercourse with more than one partner.

The prevalence of higher risk behaviours for both men and women was higher for urban areas than for rural areas. Women from Western Province have the highest prevalence of having had sexual intercourse with more than one partner (6%) as well as having had higher risk intercourse (25%) in the 12 months preceding the survey. About 17% of men from Honiara had sexual intercourse with multiple partners in the 12 months prior to the survey, and 41% had higher risk intercourse. Men from Western Province also have the second highest proportion (40%) of higher risk intercourse in the 12 months preceding the survey.

Tables 13.7.1 and 13.7.2 also show that men with a secondary level education had sexual intercourse with more than one partner as well as had higher risk intercourse, with a similar pattern observed for women with a secondary level education.

Table 13.7.1: Multiple sexual partners and higher-risk sexual intercourse in the 12 months preceding the survey: Women

Among women age 15-49 who had sexual intercourse in the 12 months preceding the survey, the percentage who had intercourse with more than one partner and the percentage who had higher-risk sexual intercourse in the past 12 months; and among those having more than one partner in the past 12 months, the percentage reporting that a condom was used at last intercourse; and among those having higher-risk intercourse in the past 12 months, the percentage reporting that a condom was used at last higher-risk intercourse; and the mean number of sexual partners during her lifetime for women who ever had sexual intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Among women who had sexual intercourse in the past 12 months:			Among women who had 2+ partners in the past 12 months:		Among women who had higher risk intercourse in the past 12 months:		Among women who ever had sexual intercourse	
	Percentage who had 2+ partners in the past 12 months	Percentage who had higher-risk intercourse in the past 12 months ¹	Number	Percentage who reported using a condom during last sexual intercourse	Number	Percentage who reported using a condom at last higher-risk intercourse	Number	Mean number of sexual partners in lifetime	Number
Age									
15-24	11.0	43.4	769	(18.0)	84	16.8	335	3.8	934
..15-19	15.6	68.3	272	(15.3)	42	12.7	186	3.1	349
..20-24	8.4	29.8	497	*	42	22.0	149	4.3	585
25-29	1.0	8.3	585	*	6	(12.6)	49	3.5	634
30-39	0.3	2.5	911	*	3	(44.3)	23	3.7	981
40-49	0.3	1.2	463	*	1	*	6	2.7	553
Marital status									
Never married	19.3	96.1	384	(20.5)	74	18.7	371	4.2	597
Married or living together	0.9	1.3	2,308	*	20	*	30	3.4	2,374
Divorced/separated/widowed	(0.0)	(33.3)	37	*	0	*	12	2.6	130
Residence									
Urban	3.1	19.6	412	*	13	9.6	82	2.8	473
Rural	3.5	14.3	2,317	(17.3)	81	20.1	331	3.6	2,628
Region									
Honiara	2.2	17.6	300	*	7	13.2	54	2.3	344
Guadalcanal	0.9	13.9	469	*	4	10.4	65	2.6	544
Malaita	1.2	6.5	585	*	7	(12.5)	38	2.0	651
Western	5.5	25.0	331	*	18	21.9	83	7.2	363
Other provinces	5.6	16.5	1,043	*	59	21.7	172	4.0	1,200
Education									
No education	0.8	5.4	365	*	3	*	20	2.1	420
Primary	3.2	11.5	1,636	*	52	9.8	188	3.8	1,817
Secondary	6.0	28.7	647	(22.5)	39	24.0	187	3.8	773
More than secondary	0.5	22.4	81	*	0	*	18	3.4	92

Table 13.7.1 (continued)

Background characteristic	Among women who had sexual intercourse in the past 12 months:			Among women who had 2+ partners in the past 12 months:		Among women who had higher risk intercourse in the past 12 months:		Among women who ever had sexual intercourse	
	Percentage who had 2+ partners in the past 12 months	Percentage who had higher-risk intercourse in the past 12 months ¹		Percentage who reported using a condom during last sexual intercourse	Number	Percentage who reported using a condom at last higher-risk intercourse	Number	Mean number of sexual partners in lifetime	Number
			Number						
Wealth quintile									
Lowest	3.9	13.9	539	*	21	(25.6)	75	3.7	612
Second	5.3	16.3	538	*	29	12.3	88	3.4	608
Middle	3.4	14.8	513	*	18	(29.9)	76	3.6	586
Fourth	1.2	10.6	568	*	7	16.4	60	3.8	633
Highest	3.5	19.7	571	*	20	10.3	114	3.1	662
Total	3.5	15.1	2,729	16.1	94	18.0	413	3.5	3,102

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Sexual intercourse with a partner who neither was a spouse nor who lived with the respondent

Table 13.7.2: Multiple sexual partners and higher-risk sexual intercourse in the past 12 months: Men

Among men age 15+ who had sexual intercourse in the past 12 months, the percentage who had intercourse with more than one partner and the percentage who had higher-risk sexual intercourse in the past 12 months; and among those having more than one partner in the past 12 months, the percentage reporting that a condom was used at last intercourse; and among those having higher-risk intercourse in the past 12 months, the percentage reporting that a condom was used at last higher-risk intercourse; and the mean number of sexual partners during his lifetime for men who ever had sexual intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Among men who had sexual intercourse in the past 12 months:			Among men who had 2+ partners in the past 12 months:		Among men who had higher risk intercourse in the past 12 months:		Among men who ever had sexual intercourse	
	Percentage who had 2+ partners in the past 12 months	Percentage who had higher-risk intercourse in the past 12 months ¹	Number	Percentage who reported using a condom during last sexual intercourse	Number	Percentage who reported using a condom at last higher-risk intercourse	Number	Mean number of sexual partners in lifetime	Number
Age									
15-24	21.6	78.9	360	39.1	78	25.6	283	8.2	420
..15-19	17.4	98.8	123	(54.2)	21	30.2	121	6.1	153
..20-24	23.8	68.5	237	33.3	56	22.0	162	9.3	266
25-29	7.6	32.9	224	*	17	32.8	74	11.0	251
30-39	3.2	8.3	454	(7.3)	15	17.0	38	11.9	455
40-49	1.3	2.3	214	*	3	*	5	10.3	212
Marital status									
Never married	24.8	97.9	373	42.3	93	26.1	365	9.3	469
Married or living together	1.7	3.1	869	(13.1)	15	27.8	27	10.7	858
Divorced/separated/widowed	*	*	10	*	5	*	9	*	11
Residence									
Urban	15.1	39.1	225	27.8	34	31.1	88	9.3	256
Rural	7.6	30.4	1,027	40.8	78	24.5	312	10.5	1,082
Region									
Honiara	16.5	40.7	172	23.4	28	28.2	70	9.6	200
Guadalcanal	4.2	22.0	219	*	9	(19.3)	48	8.2	232
Malaita	10.9	23.2	267	*	29	(33.4)	62	8.6	281
Western	8.3	40.0	140	*	12	(11.8)	56	17.8	140
Other provinces	7.5	36.1	454	(54.4)	34	29.1	164	10.5	484
Education									
No education	7.3	18.9	70	*	5	*	13	5.9	70
Primary	6.1	24.3	595	(17.7)	36	14.7	144	10.2	641
Secondary	13.5	46.4	457	48.5	62	31.5	212	10.9	501
More than secondary	7.2	23.5	131	*	9	(44.2)	31	10.7	126

Table 13.7.2 (continued)

Table 13.7.2 (continued)									
Background characteristic	Among men who had sexual intercourse in the past 12 months:			Among men who had 2+ partners in the past 12 months:		Among men who had higher risk intercourse in the past 12 months:		Among men who ever had sexual intercourse	
	Percentage who had 2+ partners in the past 12 months	Percentage who had higher-risk intercourse in the past 12 months ¹	Number	Percentage who reported using a condom during last sexual intercourse	Number	Percentage who reported using a condom at last higher-risk intercourse	Number	Mean number of sexual partners in lifetime	Number
Wealth quintile									
Lowest	6.6	22.8	210	*	14	(10.1)	48	8.7	224
Second	2.9	31.2	238	*	7	21.5	74	8.5	258
Middle	9.4	31.4	238	*	22	(34.2)	75	9.6	247
Fourth	11.4	34.2	293	(53.0)	33	29.7	100	12.3	316
Highest	13.0	37.8	273	26.2	36	27.0	103	11.5	293
Total 15-49	9.0	32.0	1,252	36.9	112	26.0	400	10.3	1,338
50+	0.6	1.1	236	*	1	*	3	6.2	395
Total men 15+	7.6	27.1	1,488	36.4	114	25.8	403	9.4	1,733

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Sexual intercourse with a partner who neither was a spouse nor who lived with the respondent

13.10 PAYMENTS FOR SEXUAL INTERCOURSE

The 2006/2007 SIDHS asked male respondents about whether they had paid money in exchange for sexual intercourse in the 12 months preceding the survey. Table 13.8 presents the percentage of men aged 15 and over who paid someone for sexual intercourse. These questions are important for determining the prevalence of commercial sex in Solomon Islands, which is considered to be a higher risk sexual behaviour.

Table 13.8 shows that overall, about 2% of men aged 15–49 paid money in exchange for sexual intercourse in the 12 months preceding the survey. Men aged 15–19 and in the second lowest wealth quintile are more likely to engage in commercial sex than men in other groups. There is also evidence that men in the fourth wealthiest quintile, men who have never married, men with only a primary level education, and men in urban areas (especially Honiara) and even Malaita Province are also involved in commercial sexual activities. Caution is emphasized when interpreting these results due to small number of cases.

Table 13.8: Payment for sexual intercourse: Men

Percentage of men age 15+ reporting payment for sexual intercourse in the 12 months preceding the survey, by background characteristics, Solomon Islands 2007

Background characteristic	Payment for sexual intercourse in 12 months preceding the survey	
	Percentage who paid for sexual intercourse	Number of men
Age		
15-24	2.8	596
..15-19	3.5	292
..20-24	2.1	304
25-29	2.2	266
30-39	1.0	505
40-49	0.4	247
Marital status		
Never married	2.5	660
Married or living together	1.3	939
Divorced/separated/widowed	0.9	14
Residence		
Urban	2.1	301
Rural	1.7	1,313
Region		
Honiara	2.3	240
Guadalcanal	1.0	249
Malaita	2.2	345
Western	0.4	181
Other provinces	2.1	599
Education		
No education	0.0	88
Primary	2.4	794
Secondary	1.4	593
More than secondary	0.6	138

Chapter 13.8 (continued)

Background characteristic	Payment for sexual intercourse in 12 months preceding the survey	
	Percentage who paid for sexual intercourse	Number of men
Wealth quintile		
Lowest	0.8	281
Second	3.3	291
Middle	1.2	323
Fourth	2.5	353
Highest	1.1	366
Total 15-49	1.8	1,614
50+	0.1	442
Total men 15+	1.4	2,056

13.11 MALE CIRCUMSION

Given that the risk for HIV and AIDS transmission is higher among men who have not been circumcised, the 2006/2007 SIDHS asked male respondents about their circumcision status⁹. This question is important for assessing the risk in which AIDS can be acquired and or transmitted in Solomon Islands. Table 13.9 presents the percentage of male respondents who are circumcised.

Overall, only 4.4% of men are circumcised. About 45% of Polynesian men are circumcised while only 3% of other Melanesian men are circumcised. This finding clearly indicates that the risk for acquiring HIV and AIDS is higher among Melanesian men than men from other ethnic groups.

There is also evidence that while there is a relatively high proportion of circumcised men in Honiara, the lowest proportion is observed among men with no education, among men from Guadalcanal and Malaita provinces, men in rural areas, and young men aged 15–19. However caution is emphasized in interpreting these results by background characteristics due to very small number of cases.

⁹ <http://www.cdc.gov/hiv/resources/factsheets/PDF/circumcision.pdf>

Table 13.9: Male circumcision

Percentage of men age 15-49 who report having been circumcised, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage circumcised	Number of men
Age		
15-24	4.3	596
..15-19	3.7	292
..20-24	4.8	304
25-29	4.2	266
30-39	3.9	505
40-49	6.3	247
Residence		
Urban	6.1	301
Rural	4.0	1,313
Region		
Honiara	7.7	240
Guadalcanal	1.4	249
Malaita	1.4	345
Western	3.0	181
Other provinces	6.5	599
Ethnicity		
Melanesian	2.9	1,566
Polynesian	44.5	26
Micronesian	(70.9)	17
Other	*	3
Education		
No education	0.8	88
Primary	3.0	794
Secondary	6.3	593
More than secondary	6.8	138
Total 15-49	4.4	1,614
50+	0.0	442
Total men 15+	3.5	2,056

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

13.12 SEXUALLY TRANSMITTED INFECTIONS (STI) PREVALENCE AND SYMPTOMS

Sexually transmitted infections (STIs) are a global cause of acute illness, infertility, long-term disability and death, with severe medical and psychological consequences for millions of men, women and infants. The impact of this disease is magnified by its potential to facilitate the spread of HIV.

The 2006/2007 SIDHS included questions to measure the extent to which STIs have been diagnosed among women and men who had sexual intercourse in the 12 months preceding the survey. All respondents who had ever had sex were asked if they had had an STI or symptoms of an STI (including a bad-smelling/abnormal genital discharge and a genital sore or ulcer) in the 12 months preceding the survey. Table 13.10 presents the percentage of women aged 15–49 and men aged 15 and over who have been diagnosed with an STI or have symptoms of an STI in the 12 months prior to the survey by background characteristics.

Overall, 1.3% of women and 2.5% of men had an STI in the 12 months preceding the survey. A further 1.7% of women and 2.4% of men reported a bad smelling and/or abnormal genital discharge in the 12 months prior to the survey, and a very small percentage of women (0.7%) and men (1.5%) reported a genital sore or ulcer in the 12 months preceding the survey.

Women aged 15–19 have the highest prevalence of STIs, followed by women aged 20–24. For men, STI prevalence is highest among those aged 15–25. This result clearly indicates that STIs are more likely to be prevalent among younger women and men than older age groups. STIs prevalence is more common among rural women and among urban men. Western men are more likely to report higher prevalence of STIs than men from other provinces. STIs and STIs symptoms are slightly higher among women and men with lower educational background.

Table 13.10: Self-reported prevalence of sexually-transmitted infections (STIs) and STIs symptoms

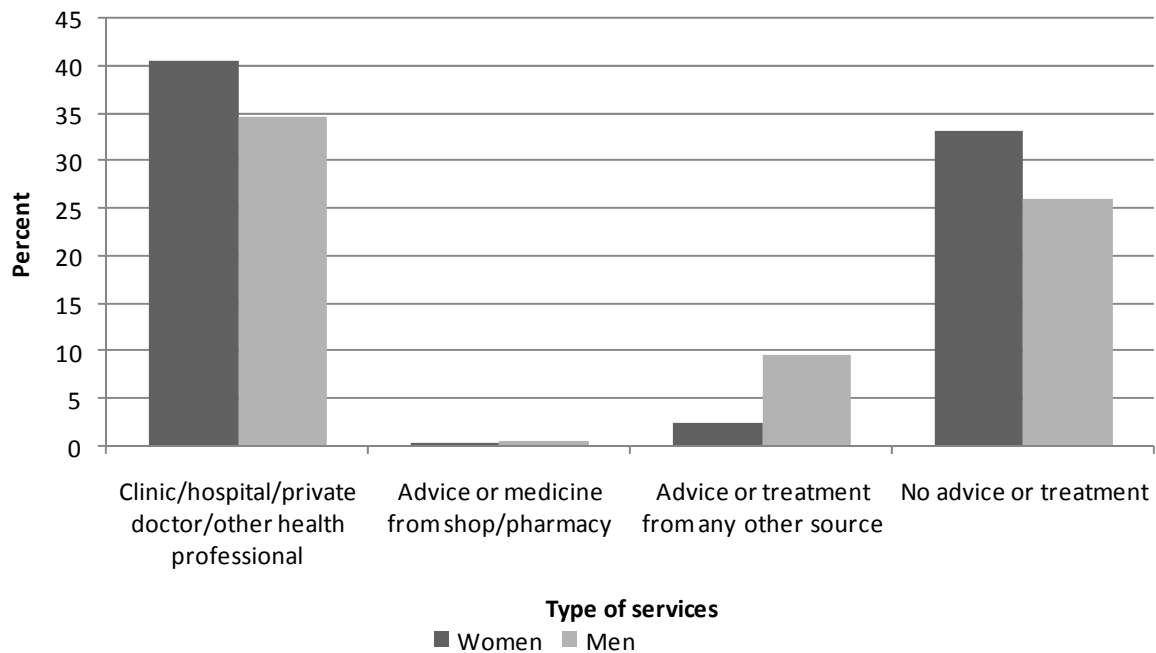
Among women age 15-49 and men age 15+ who ever had sexual intercourse, the percentage reporting having an STI and/or symptoms of an STI in the past 12 months, by background characteristics, Solomon Islands 2007

Background characteristic	Women					Men				
	Percentage of women who reported having in the past 12 months:					Percentage of men who reported having in the past 12 months:				
	STI	Bad smelling/ abnormal genital discharge	Genital sore/ulcer	STI/genital discharge/sore or ulcer	Number of respondents who ever had sexual intercourse	STI	Bad smelling/ abnormal genital discharge	Genital sore/ulcer	STI/genital discharge/sore or ulcer	Number of respondents who ever had sexual intercourse
Age										
15-24	2.0	3.3	1.6	4.5	986	4.5	4.0	2.3	5.3	439
..15-19	3.3	5.1	0.3	5.5	365	2.5	3.3	3.6	3.8	155
..20-24	1.2	2.2	2.4	4.0	621	5.6	4.4	1.5	6.1	284
25-29	1.5	1.6	0.4	2.7	698	3.7	3.8	2.2	5.1	261
30-39	0.9	0.9	0.3	1.5	1,065	1.2	1.1	1.3	2.1	502
40-49	0.5	0.9	0.2	1.3	604	0.4	0.7	0.0	1.1	246
Marital status										
Never married	2.4	2.8	0.2	3.7	655	5.1	4.6	2.5	6.0	495
Married or living together	1.0	1.2	0.7	2.1	2,560	1.1	1.0	0.9	2.0	939
Divorced/separated/widowed	0.6	6.6	1.9	6.6	138	*	*	*	*	14
Male circumcision										
Circumcised	na	na	na	na	0	1.7	3.4	2.8	4.0	70
Residence										
Urban	0.8	0.5	0.4	1.2	527	3.6	2.8	2.3	4.4	272
Rural	1.3	2.0	0.7	2.9	2,825	2.3	2.3	1.4	3.2	1,177
Region										
Honiara	1.1	0.7	0.6	1.6	390	2.7	1.6	1.0	3.6	215
Guadalcanal	1.5	1.4	0.1	2.3	555	1.6	1.6	1.6	1.6	238
Malaita	1.2	1.3	0.6	2.0	715	2.3	2.1	2.0	4.9	296
Western	1.4	0.0	0.0	1.4	417	5.1	5.7	4.8	6.9	170
Other provinces	1.2	3.0	1.3	3.8	1,276	2.2	2.2	0.4	2.3	529
Education										
No education	1.0	0.1	0.1	1.0	461	3.9	3.6	2.8	7.2	75
Primary	1.3	2.4	1.0	3.5	1,934	1.9	2.0	1.5	2.6	709
Secondary	1.3	1.2	0.5	1.5	849	3.2	3.2	1.7	4.2	529
More than secondary	0.7	1.0	0.3	1.0	108	2.5	0.4	0.2	2.9	135
Total 15-49	1.3	1.7	0.7	2.6	3,353	2.5	2.4	1.5	3.5	1,448
50+	na	na	na	na	0	0.5	0.0	0.0	0.5	440
Total men 15+	na	na	na	na	0	2.1	1.8	1.2	2.8	1,888

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed
na = Not applicable

Figure 13.2 shows the proportion of women and men who had a diagnosed STI or STI symptoms in the 12 months preceding the survey, and who also sought advice and or medical treatment. As shown, about 40% of women and 35% of men who had an STI or STI symptoms sought medical advice or treatment at a clinic/hospital/private doctor or some other healthcare facility, while 33% of women and 26% of men who also had an STI or STI symptoms did not seek medical advice or treatment.

Figure 13.2: Proportion of women and men aged 15–49 reporting an STI or STI symptoms who sought medical advice or treatment



13.13 PREVALENCE OF MEDICAL INJECTIONS

The 2006/2007 SIDHS asked all respondents of women aged 15–49 and men aged 15 and older who received at least one medical injection in the 12 months preceding the survey, the average number of medical injections per person in the 12 months preceding the survey, and among those who received a medical injection, the percentage of last medical injections for which the syringe and needle were taken from a new or unopened package by background characteristics. The results are shown in Table 13.11. About 26% of men and 12% of women received at least one medical injection, with an average of about 1.1 and 0.5 medical injections received by men and women, respectively, in the 12 months preceding the survey.

Table 13.11 shows that the prevalence of medical injections varies the most among men across all provinces. For instance, among men in Malaita who had an STI in the 12 months preceding the survey, only 9% received at least one injection, whereas 24% of men in Guadalcanal and Western provinces (equally) received at least one injection. Among women, prevalence is lowest in Honiara, followed by Western Province.

Rural residents are more likely than urban residents to have received at least one injection in the 12 months preceding the survey. Among the various age groups, there is no significant differences in the percentage of women and men receiving an injection, and there is no consistent pattern observed across the wealth quintiles.

Table 13.11 also shows that almost 100% of the needles used in all medical injections were taken from a new, unopened package, indicating that Solomon Islands continues to provide safe STI healthcare practices.

The majority of medical injections received by both women and men with an STI or STI symptoms in the 12 months preceding the survey were given at public healthcare facilities, most probably at a rural health centre (see Fig. 13.3).

Figure 13.3: Source of last medical injection

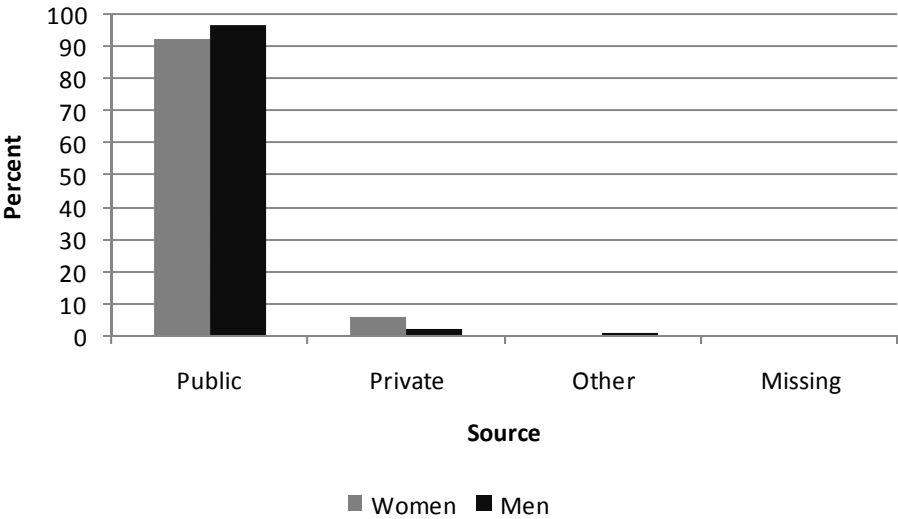


Table 13.11: Prevalence of medical injections

Percentage of women age 15-49 and men age 15+ who received at least one medical injection in the 12 months prior the survey, the average number of medical injections per person in the last 12 months, and among those who received a medical injection, the percentage of last medical injections for which the syringe and needle were taken from a new, unopened package, by background characteristics, Solomon Islands 2007

Background characteristic	Women					Men				
	Percentage who received a medical injection in the 12 months prior the survey	Average number of medical injections per person in the 12 months prior the survey	Number of women	For last injection, syringe and needle taken from a new, unopened package	Number of respondents receiving medical injections in the 12 months prior the survey	Percentage who received a medical injection in the 12 months prior the survey	Average number of medical injections per person in the 12 months prior the survey	Number of men	For last injection, syringe and needle taken from a new, unopened package	Number of respondents receiving medical injections in the 12 months prior the survey
Age										
15-24	10.9	0.5	1,404	96.4	154	23.4	0.9	596	99.4	139
..15-19	11.9	0.6	687	98.6	82	20.8	0.7	292	(100.0)	61
..20-24	10.0	0.4	716	94.0	72	25.8	1.0	304	98.9	79
25-29	11.1	0.5	729	93.5	81	23.8	1.0	266	99.8	63
30-39	13.6	0.5	1,082	96.8	147	27.5	1.1	505	97.7	139
40-49	10.1	0.5	609	100.0	61	33.1	1.5	247	99.6	82
Residence										
Urban	10.2	0.5	636	95.1	65	13.8	0.6	301	95.7	41
Rural	11.9	0.5	3,187	96.8	378	29.1	1.2	1,313	99.3	382
Region										
Honiara	8.3	0.4	481	92.1	40	16.3	0.7	240	95.4	39
Guadalcanal	11.7	0.6	637	97.5	74	24.0	1.1	249	100.0	60
Malaita	11.2	0.5	840	97.6	94	8.7	0.5	345	*	30
Western	9.5	0.3	458	(88.4)	44	24.1	1.0	181	(94.9)	44
Other provinces	13.5	0.6	1,407	98.4	191	41.9	1.5	599	99.8	251
Education										
No education	11.5	0.6	520	(100.0)	60	16.8	1.1	88	*	15
Primary	11.3	0.5	2,114	97.9	240	27.8	1.1	794	99.5	221
Secondary	12.2	0.6	1,067	92.3	131	26.8	1.1	593	98.2	159
More than secondary	10.3	0.4	122	*	13	20.5	0.7	138	(99.5)	28

Table 13.11 (continued)

Background characteristic	Women					Men				
	Percentage who received a medical injection in the 12 months prior the survey	Average number of medical injections per person in the 12 months prior the survey	Number of women	For last injection, syringe and needle taken from a new, unopened package	Number of respondents receiving medical injections in the 12 months prior the survey	Percentage who received a medical injection in the 12 months prior the survey	Average number of medical injections per person in the 12 months prior the survey	Number of men	For last injection, syringe and needle taken from a new, unopened package	Number of respondents receiving medical injections in the 12 months prior the survey
Wealth quintile										
Lowest	12.2	0.5	696	98.6	85	28.0	1.1	281	(100.0)	79
Second	15.4	0.7	755	97.2	116	31.8	1.3	291	100.0	93
Middle	9.0	0.4	738	99.3	66	24.9	0.9	323	99.2	80
Fourth	12.1	0.6	769	99.3	93	27.3	1.1	353	98.7	96
Highest	9.4	0.4	864	87.9	82	20.5	0.9	366	96.5	75
Total 15-49	11.6	0.5	3,823	96.5	442	26.2	1.1	1,614	98.9	423
Total men 15+	na	na	na	na	0	26.4	1.1	2,056	98.9	542

Note: Medical injections are those given by a doctor, nurse, pharmacist, dentist or other health worker.

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = Not applicable

13.14 COMPREHENSIVE KNOWLEDGE ABOUT AIDS AND SOURCES OF CONDOMS AMONG YOUTH

Comprehensive knowledge about AIDS is defined as knowing that: 1) people can reduce the chances of getting AIDS if condoms are used consistently during sexual intercourse or having just one uninfected faithful partner; 2) a healthy-looking person can have AIDS; and 3) HIV cannot be transmitted by mosquito bites, supernatural means or by sharing food with a person infected with the virus.

This section addresses HIV- and AIDS-related knowledge and behaviour among young adults aged 15–24. Special attention is paid to this group because of the high percentage of young people in Solomon Islands' population. In addition to knowledge about HIV transmission, data are presented on age at first sexual intercourse, condom use, age differences between sexual partners, forced sex, sex related to alcohol use, and voluntary counselling and testing for HIV.

Young respondents were asked the same set of questions as other respondents on facts and beliefs about HIV transmission. Information on the overall level of knowledge about major methods of avoiding HIV and rejection of major misconceptions are shown in earlier tables in this chapter. Table 13.12 presents the percentage of young adults aged 15–24 with a comprehensive knowledge about AIDS as well as knowledge about where to get condoms, by background characteristics.

Table 13.12 shows that overall, the proportion of young people who have a comprehensive knowledge of AIDS is higher for young men (35%) than for young women (29%). Overall, 81% of men stated that they knew of a source for condoms compared with only 46% of women. This suggests a need to increase awareness among young women on sources of condoms within the community.

Although there is no substantial difference in the level of knowledge about HIV by age characteristics, the level of knowledge among both young men and women increases with age, such that the proportion of comprehensive knowledge is higher among older youth than among younger youth.

Men in urban areas have the most comprehensive knowledge about AIDS whereas men in rural areas are more likely to know where to get condoms. Less than 50% of women in rural areas and about 2 in every 5 women in urban areas know where to get condoms. About 34% of women in urban areas and 28% of women in rural areas have a comprehensive knowledge about AIDS.

The level of knowledge for women does not vary although in Western Province, 49% of women are knowledgeable about AIDS and preventative measures compared with only 23% of women in Malaita Province. Men in Guadalcanal province are more aware about AIDS and how it can be prevented compared to only 14% of men in Western province.

As Table 13.12 shows, the level of knowledge about HIV and AIDS among women increases with educational attainment. Knowledge about HIV and AIDS is lowest among women with no education at all compared with women who have more than a secondary education.

13.14.1 Knowledge of condom source among young adults

Condom use among young adults plays an important role in preventing the transmission of HIV and other STIs, as well as unwanted pregnancies. Knowledge about where to go for condoms helps young adults to obtain and use condoms. Table 13.12 shows that 46% of young women and 81% of young men reported that they knew where to get condoms.

Table 13.12: Comprehensive knowledge about AIDS and sources of condoms among youth

Percentage of young women and young men aged 15–24 with a comprehensive knowledge about AIDS, and the percentage with knowledge of where to get condoms, by background characteristics, Solomon Islands 2007

Background characteristic	Women aged 15–24			Men aged 15–24		
	Percentage with comprehensive knowledge of AIDS ¹	Percentage who know a condom source ²	Number of women	Percentage with comprehensive knowledge of AIDS ¹	Percentage who know a condom source ²	Number of men
Age						
15–19	28.6	38.8	687	26.4	74.5	292
..15–17	29.2	36.5	429	25.0	69.0	181
..18–19	27.7	42.5	258	28.7	83.6	111
20–24	30.0	53.0	716	43.5	87.2	304
..20–22	28.6	51.1	415	44.6	86.0	194
..23–24	31.9	55.6	301	41.6	89.5	110
Marital status						
Never married	30.1	44.5	928	33.5	79.8	518
..Ever had sex	30.4	54.8	510	35.9	88.1	361
..Never had sex	29.9	31.9	418	28.1	60.5	156
Ever married	27.7	49.0	476	45.8	89.2	78
Residence						
Urban	34.3	37.3	281	52.4	76.1	114
Rural	28.1	48.2	1,123	31.0	82.2	482
Region						
Honiara	33.2	30.5	211	56.9	74.4	98
Guadalcanal	35.0	38.1	234	59.9	80.1	68
Malaita	22.7	42.5	286	38.9	79.8	130
Western	49.0	69.4	170	14.5	80.0	68
Other provinces	22.1	50.4	502	22.5	85.1	231
Education						
No education	16.1	17.0	103	(56.8)	(80.4)	29
Primary	22.3	39.8	604	24.1	73.0	241
Secondary	37.3	55.4	663	39.6	86.9	306
More than secondary	37.0	62.8	33	*	*	19
Wealth quintile						
Lowest	17.3	45.5	208	34.7	74.7	104
Second	29.1	46.9	268	18.9	88.9	102
Middle	31.3	45.5	280	33.2	83.4	130
Fourth	27.1	49.6	284	33.9	81.8	123
Highest	36.5	43.3	364	50.4	77.0	137
Total 15–24	29.3	46.0	1,404	35.1	81.0	596

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Comprehensive knowledge means knowing that consistently using condoms 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. The components of comprehensive knowledge are presented in Tables 13.2, 13.3.1 and 13.3.2.

² For this table, the following responses are not considered sources for condoms: friends, family members and home.

13.15 AGE AT FIRST SEXUAL INTERCOURSE AMONG YOUTH

Early engagement in sexual behaviour exposes young women to the risk of early pregnancy and exposes both young women and men to the risk of STIs, and HIV infection and transmission. Early pregnancy contributes to high fertility levels as well as maternal, infant and child deaths, while early age HIV infection contributes to high levels of mortality. Since HIV transmission occurs predominantly through heterosexual intercourse between an infected and non-infected person, age at first intercourse marks the time when most individuals are first exposed to the risk of acquiring HIV.

Table 13.13 shows the percentages of young women and men who had sexual intercourse before reaching age 15 and age 18, by background characteristics. Equal proportions of young women and men aged 15–24 (12%) reported that their first sexual intercourse occurred before they turned 15; 51% of young women and 55% of young men reported that their first sexual intercourse occurred before they turned 18.

Young women and men aged 15–19 (15% and 16%, respectively) were more likely to have had their first sexual intercourse before they turned 15 than women and men aged 20–24 (10% and 8%, respectively). The proportions of those who had their first sexual intercourse before age 18 were also higher in the lowest age group as compared with the upper age group. For example, 57% of women between the ages of 18 and 19 had their first sexual intercourse before age 18, compared with 49% of women aged 20–24. About 59% of young men aged 18–19 had their first sexual intercourse before age 18 compared with 53% of men aged 20–24. The findings clearly indicate a need for sex education for younger women and men aged 15–19 to enable them to protect themselves from sexual transmission infections including AIDS, given that a large proportion of young adults have been exposed to sexual behaviours before age 15 years.

Findings of the 2006/2007 SIDHS show that ever-married women are more likely to have had their first sexual intercourse before age 15 (17%) and before age 18 (63%) than never-married women. Men on the other hand demonstrated the opposite trend.

Table 13.13 shows a higher proportion of rural women reported sex before 15 years and 18 years compared with urban women and also indicates the low proportion of women from Honiara reported sex before age 15 compared to other areas.

Findings of the 2006/2007 SIDHS also reveal that the proportion of women who had their first sexual intercourse before age 15 and age 18 decreases as the wealth quintile increases, suggesting that young women from low wealth quintile households are more likely to engage in early sexual behaviours than young women from upper (and the highest) wealth quintile households. For men, the proportion who had their first sexual intercourse before age 15 and age 18 increases with wealth quintile, which may indicate that men in upper or higher wealth quintile households are more likely to engage early in sexual behaviour than men from lower wealth quintile households.

Table 13.13: Age at first sexual intercourse among youth

Percentage of young women and of young men age 15-24 who had sexual intercourse before age 15 and percentage of young women and of young men age 18-24 who had sexual intercourse before age 18, by background characteristics, Solomon Islands 2007

Background characteristic	Women				Men			
	Percentage who had sexual intercourse before age 15	Number of respondents (age 15-24)	Percentage who had sexual intercourse before age 18	Number of respondents (age 18-24)	Percentage who had sexual intercourse before age 15	Number of respondents (age 15-24)	Percentage who had sexual intercourse before age 18	Number of respondents (age 18-24)
Age								
15-19	14.9	687	na	na	16.0	292	na	na
..15-17	15.5	429	na	na	14.4	181	na	na
..18-19	13.9	258	56.8	258	18.7	111	59.1	111
20-24	9.9	716	49.0	716	8.1	304	53.3	304
..20-22	10.1	415	46.2	415	5.2	194	49.9	194
..23-24	9.5	301	53.0	301	13.3	110	59.3	110
Marital status								
Never married	10.1	928	40.5	522	12.8	518	56.2	337
Ever married	16.6	476	63.3	453	6.3	78	48.9	78
Knows condom source¹								
Yes	12.5	646	54.8	489	13.3	483	56.3	358
No	12.2	758	47.3	485	6.5	113	45.3	57
Residence								
Urban	6.5	281	38.5	199	12.0	114	55.1	79
Rural	13.8	1,123	54.3	776	12.0	482	54.8	335
Region								
Honiara	4.7	211	33.0	150	12.0	98	56.5	72
Guadalcanal	12.8	234	59.0	160	22.2	68	59.1	46
Malaita	8.9	286	47.2	211	5.0	130	38.8	95
Western	14.2	170	64.7	100	11.6	68	(64.6)	50
Other provinces	16.6	502	53.7	353	13.0	231	59.6	151
Education								
No education	7.5	103	37.7	75	(0.0)	29	*	23
Primary	20.0	604	62.9	406	10.0	241	53.6	136
Secondary	6.7	663	43.7	461	15.5	306	58.8	237
More than secondary	0.0	33	39.6	32	*	19	*	19

Table 13.3 (continued)

Background characteristic	Women				Men			
	Percentage who had sexual intercourse before age 15	Number of respondents (age 15-24)	Percentage who had sexual intercourse before age 18	Number of respondents (age 18-24)	Percentage who had sexual intercourse before age 15	Number of respondents (age 15-24)	Percentage who had sexual intercourse before age 18	Number of respondents (age 18-24)
Wealth quintile								
Lowest	16.8	208	61.8	143	8.5	104	(50.6)	69
Second	16.8	268	51.3	167	7.8	102	58.4	82
Middle	14.3	280	49.8	205	14.2	130	52.5	80
Fourth	8.4	284	55.6	204	13.7	123	57.7	89
Highest	8.0	364	42.4	256	14.1	137	54.2	95
Total	12.3	1,404	51.1	975	12.0	596	54.8	415

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = Not available

¹ For this table, the following responses are not considered a source for condoms: friends, family members and home

13.16 CONDOM USE AT FIRST SEXUAL INTERCOURSE AMONG YOUTH

In order to measure the extent to which condoms are used at first sexual intercourse among youth, the 2006/2007 SIDHS included questions that asked young women and men aged 15–24 about whether they used a condom the first time they had sexual intercourse. Results for this question are presented in Table 13.14.

Overall, only 14% of women and 15% of men aged 15–24 used a condom the first time they had sexual intercourse. Young women and men aged 15–19 are more likely to use a condom at first sex than those aged 20–24.

The prevalence of condom use at first sex was higher for never married women compared with ever married women. Data show that about 18% of never married women reported using condom at first sex as compared to about 11% of those ever married women.

Findings also show that condom use is lower among women (8%) and men (10%) aged 15–24 who do not know where to get condoms, and higher among women (20%) and men (15%) who do know where to get condoms. This clearly indicates that there is a need to increase the availability and accessibility of condoms to young adults.

Table 13.14 shows that the proportion of young adults aged 15–24 who used a condom at first sex intercourse increases with educational attainment, indicating that the higher the education level, the greater is the knowledge about ways to reduce the risk of getting HIV and AIDS.

Table 13.14: Condom use at first sexual intercourse among youth

Among young women and young men age 15-24 who have ever had sexual intercourse, percentage who used a condom the first time they had sexual intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Women age 15-24		Men age 15-24	
	Percentage who used a condom at first sexual intercourse	Number of respondents who have ever had sexual intercourse	Percentage who used a condom at first sexual intercourse	Number of respondents who have ever had sexual intercourse
Age				
15-19	19.0	365	21.7	155
..15-17	7.7	178	22.7	79
..18-19	29.7	187	20.8	76
20-24	11.3	621	11.1	284
..20-22	11.0	346	10.0	177
..23-24	11.7	276	12.9	107
Marital status				
Never married	17.5	510	17.0	361
Ever married	10.5	476	4.7	78
Knows condom source¹				
Yes	19.5	513	15.4	388
No	8.3	473	10.3	51
Residence				
Urban	7.5	180	13.5	87
Rural	15.6	805	15.2	352
Region				
Honiara	10.6	128	13.0	76
Guadalcanal	15.1	156	8.9	58
Malaita	6.7	180	16.1	82
Western	9.8	130	(2.0)	57
Other provinces	19.7	391	21.5	167
Education				
No education	11.0	57	*	22
Primary	12.5	450	7.8	158
Secondary	16.2	454	19.6	243
More than secondary	(12.3)	25	*	17
Wealth quintile				
Lowest	25.2	164	(2.7)	69
Second	11.8	184	31.0	90
Middle	14.0	187	12.4	78
Fourth	12.2	213	10.6	100
Highest	10.2	238	14.9	103
Total	14.1	986	14.8	439

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ For this table, the following responses are not considered a source for condoms: friends, family members and home

13.17 PREMARITAL SEXUAL INTERCOURSE AND CONDOM USE

Premarital sexual intercourse in this section refers to a sexual relationship that occurs among never married women and men. Table 13.15 shows the proportion of never-married women and men aged 15–24 who have never had sexual intercourse, and the proportion of never-married women and men who had sexual intercourse in the 12 months preceding the survey (premarital sexual intercourse). The table also presents the proportion of those who had premarital sexual intercourse but used a condom at their last sexual intercourse.

Overall, 45% of never-married women and 30% of never-married men had never had sexual intercourse, and about 36% of never-married women and 55% of never-married men had sexual intercourse in the 12 months preceding the survey. Of the never married women and men who had sexual intercourse in the 12 months preceding the survey, 17% of women used a condom at their last sexual contact while more than one-quarter of never-married men used a condom at their last sexual contact.

The proportion of never-married women who had sexual intercourse in the 12 months preceding the survey decreases as the wealth quintile increases, with more than 50% of never-married women in the lowest wealth quintile having had sexual intercourse compared with one-third of never-married women from the highest wealth quintile. Men in the corresponding marital status did not show any association with their wealth quintiles.

Condom use at last sexual intercourse is very low across all other groups, with the lowest proportion being among women and men aged 18–19, among men aged 23–24, and among men with more than a secondary education.

Table 13.15: Premarital sexual intercourse and condom use during premarital sexual intercourse among youth

Among never-married women and men age 15-24, the percentage who have never had sexual intercourse, the percentage who had sexual intercourse in the past 12 months, and, among those who had premarital sexual intercourse in the past 12 months, the percentage who used a condom at the last sexual intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Never-married women age 15-24					Never-married men age 15-24				
	Percentage who have never had sexual intercourse	Percentage who had sexual intercourse in the past 12 months	Number of never married women	Among women who had sexual intercourse in the past 12 months		Percentage who have never had sexual intercourse	Percentage who had sexual intercourse in the past 12 months	Number of never married men	Among men who had sexual intercourse in the past 12 months	
				Percentage who used condom at last sexual intercourse	Number of women				Percentage who used condom at last sexual intercourse	Number of men
Age										
15-19	53.6	32.5	601	11.9	195	47.0	41.9	291	30.1	122
..15-17	61.9	27.8	406	15.5	113	56.5	35.7	181	43.0	65
..18-19	36.4	42.2	196	7.1	83	31.2	52.3	109	15.6	57
20-24	29.2	41.1	326	23.9	134	8.8	72.3	227	22.0	164
..20-22	30.7	44.3	227	24.4	101	11.4	65.6	152	25.1	100
..23-24	25.7	34.0	99	(22.1)	34	3.3	85.9	75	17.1	64
Knows condom source¹										
Yes	32.3	44.8	413	19.3	185	22.9	63.0	413	26.5	260
No	55.2	28.1	515	13.5	145	59.0	24.5	105	(15.4)	26
Residence										
Urban	48.8	30.2	205	10.3	62	26.1	54.2	102	29.9	55
Rural	44.0	37.0	722	18.3	268	31.2	55.5	416	24.4	231
Region										
Honiara	53.4	25.6	155	14.2	40	25.9	52.6	87	26.9	46
Guadalcanal	53.3	33.3	146	(10.5)	49	18.9	66.5	53	(25.3)	35
Malaita	66.5	19.2	160	*	31	46.4	41.2	105	*	43
Western	30.9	52.4	128	21.2	67	18.1	67.6	62	(11.9)	42
Other provinces	32.9	42.4	338	18.8	143	30.3	56.8	211	27.8	120
Education										
No education	71.3	18.8	65	*	12	39.1	*	20	*	10
Primary	46.1	41.0	334	11.3	137	40.1	44.4	207	9.3	92
Secondary	41.4	33.1	504	23.3	167	23.2	62.2	272	31.1	169
More than secondary	(35.5)	(54.8)	25	*	14	13.1	*	19	*	15

Table 13.5 (continued)

Background characteristic	Never-married women age 15-24					Never-married men age 15-24				
	Percentage who have never had sexual intercourse	Percentage who had sexual intercourse in the past 12 months	Number of never married women	Among women who had sexual intercourse in the past 12 months		Percentage who have never had sexual intercourse	Percentage who had sexual intercourse in the past 12 months	Number of never married men	Among men who had sexual intercourse in the past 12 months	
				Percentage who used condom at last sexual intercourse	Number of women				Percentage who used condom at last sexual intercourse	Number of men
Wealth quintile										
Lowest	36.4	51.1	120	(26.5)	62	38.0	(44.5)	90	*	40
Second	41.7	36.8	202	14.5	74	13.9	67.0	91	(24.5)	61
Middle	54.0	31.5	173	(24.8)	54	48.9	37.5	107	(29.4)	40
Fourth	44.5	30.5	159	10.6	48	22.3	71.9	102	32.6	74
Highest	46.0	33.2	274	10.6	91	26.9	56.0	127	26.0	71
Total	45.0	35.5	928	16.8	330	30.2	55.2	518	25.5	286

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ For this table, the following responses are not considered a source for condoms: friends, family members and home

13.18 HIGHER-RISK SEX AMONG YOUTH

HIV is commonly transmitted through higher-risk sex, which involves sexual relationships with partners who are neither a spouse nor a cohabiting partner. Youth are more likely to engage in temporary sexual relationships than are older adults, which expose them to STIs and HIV infection. Condom use among young adults plays an important role in preventing the transmission of HIV and other STIs, as well as unwanted pregnancies. Knowing where to get condoms helps young adults obtain and use them.

Table 13.16.1 shows the percentage of young women aged 15–24 who either had sexual intercourse or higher-risk sexual intercourse in the 12 months preceding the survey, and among them, the percentage who used a condom at last high-risk intercourse, by background characteristics.

More than 40% of young women aged 15–24 who had sexual intercourse in the 12 months preceding the survey had higher-risk sexual intercourse, and only 17% of these women used a condom during their last higher-risk intercourse. Table 13.16.1 shows that 38% of women aged 15–24 who had sexual intercourse in the 12 months preceding the survey did not know where to get a condom.

Table 13.16.1 also shows that condom use among young women aged 15–24 who have been involved in higher-risk intercourse in the 12 months preceding the survey is generally very low, with the lowest proportion of condom use at last higher-risk sex being among women aged 18–19. Overall, higher proportions of young men aged 15–24 had higher-risk sex compared with young women.

Table 13.16.2 shows that nearly 80% of young men aged 15–24 who had sexual intercourse in the 12 months preceding the survey had higher-risk intercourse. Of those young men who were involved in higher-risk behaviour, only 26% used a condom during their last higher-risk intercourse. Higher-risk sexual behaviour is widespread among young men aged 15–24 but is universal among young teenage men aged 15–17.

Table 13.16.1: Higher-risk sexual intercourse among youth and condom use at last higher-risk intercourse in the past 12 months: Women

Among young women age 15-24 who had sexual intercourse in the 12 months preceding the survey, the percentage who had higher-risk sexual intercourse in the past 12 months, and among those having higher-risk intercourse in the past 12 months, the percentage reporting that a condom was used at last higher-risk intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Among women age 15-24 who had sexual intercourse in the 12 months preceding the survey:		Among women age 15-24 who had higher risk intercourse in the 12 months preceding the survey:	
	Percentage who had higher-risk intercourse in the 12 months preceding the survey ¹	Number of women	Percentage who reported using a condom at last higher-risk intercourse ¹	Number of women
Age				
15-19	68.3	272	12.6	186
..15-17	87.2	129	15.5	113
..18-19	51.1	143	8.0	73
20-24	29.8	497	21.4	148
..20-22	38.7	276	23.0	107
..23-24	18.6	221	(17.5)	41
Marital status				
Never married	96.0	330	17.4	317
Ever married	3.9	440	*	17
Knows condom source²				
Yes	47.9	403	18.5	193
No	38.4	366	13.7	141
Residence				
Urban	47.6	129	9.9	61
Rural	42.5	640	18.0	272
Region				
Honiara	44.4	90	13.5	40
Guadalcanal	38.1	129	(10.5)	49
Malaita	19.8	155	*	31
Western	65.3	104	21.1	68
Other provinces	50.1	292	18.4	146
Education				
No education	(17.4)	48	*	8
Primary	37.9	386	10.6	146
Secondary	52.9	315	23.4	166
More than secondary	(60.4)	21	*	13
Wealth quintile				
Lowest	42.1	143	(27.0)	60
Second	53.1	136	(14.9)	72
Middle	38.6	152	(23.1)	58
Fourth	30.5	163	10.3	50
Highest	53.0	175	10.1	93
Total 15-24	43.4	769	16.5	334

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Sexual intercourse with a partner who neither was a spouse nor who lived with the respondent

² For this table, the following responses are not considered a source for condoms: friends, family members and home

Table 13.16.2: Higher-risk sexual intercourse among youth and condom use at last higher-risk intercourse in the past 12 months: Men

Among young men age 15-24 who had sexual intercourse in the 12 months preceding the survey, the percentage who had higher-risk sexual intercourse in the past 12 months, and among those having higher-risk intercourse in the 12 months preceding the survey, the percentage reporting that a condom was used at last higher-risk intercourse, by background characteristics, Solomon Islands 2007

Background characteristic	Among men age 15-24 who had sexual intercourse in the 12 months preceding the survey:		Among men age 15-24 who had higher risk intercourse in the 12 months preceding the survey:	
	Percentage who had higher-risk intercourse in the 12 months ¹	Number of men	Percentage who reported using a condom at last higher-risk intercourse ¹	Number of men
Age				
15-19	98.8	123	30.2	121
..15-17	100.0	65	43.0	65
..18-19	97.4	58	15.7	57
20-24	68.5	237	22.0	162
..20-22	68.8	138	25.0	95
..23-24	68.1	98	17.8	67
Marital status				
Never married	97.6	286	25.5	279
Ever married	5.9	73	*	4
Knows condom source²				
Yes	79.1	326	26.4	258
No	(76.1)	34	(16.6)	26
Residence				
Urban	85.7	66	30.4	57
Rural	77.3	293	24.3	227
Region				
Honiara	83.1	56	28.0	47
Guadalcanal	63.3	50	(22.7)	32
Malaita	(62.8)	69	*	43
Western	(87.2)	48	(11.9)	42
Other provinces	88.0	137	28.3	120
Education				
No education	*	20	*	10
Primary	74.9	124	9.8	93
Secondary	82.7	200	31.2	166
More than secondary	*	15	*	15
Wealth quintile				
Lowest	(74.5)	53	*	40
Second	(87.6)	70	(24.8)	61
Middle	(61.9)	63	(30.4)	39
Fourth	76.9	93	31.5	72
Highest	89.7	80	26.7	72
Total 15-24	78.9	360	25.6	283

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Sexual intercourse with a partner who neither was a spouse nor who lived with the respondent

² For this table, the following responses are not considered a source for condoms: friends, family members and home

13.19 AGE-MIXING IN SEXUAL RELATIONSHIPS

To examine age differences between sexual partners — the so-called cross-generational sexual partners — women aged 15–19 who had high-risk sex in the 12 months preceding the survey were asked about their partner's age. In the event that they did not know a partner's exact age, they were asked if the partner was older or younger than they were, and if older, whether the partner was 10 or more years older. Table 13.17 presents the age-mixing in sexual relationships among women aged 15–19.

Overall, 6% of teenage women aged 15–19 who had high-risk intercourse in the 12 months prior to the survey stated that their partner was a man who 10 years older than them.

Table 13.17: Age-mixing in sexual relationships among women age 15-19

Percentage of women age 15-19 who had higher-risk sexual intercourse in the last 12 months with a man who was 10 or more years older than themselves, by background characteristics, Solomon Islands 2007

Background characteristic	Percentage of women who had higher-risk intercourse with a man 10+ years older ¹	Number of women who had higher-risk intercourse in the last 12 months ¹
Age		
15-17	5.3	113
18-19	7.6	73
Marital status		
Never married	6.3	185
Ever married	*	1
Knows condom source²		
Yes	5.8	98
No	6.7	88
Residence		
Urban	3.6	31
Rural	6.8	155
Total 15-19	6.2	186

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Sexual intercourse with a partner who neither was a spouse nor who lived with the respondent

² For this table, the following responses are not considered a source for condoms: friends, family members and home

13.20 DRUNKENNESS DURING SEXUAL INTERCOURSE AMONG YOUTH

Engaging in sex under the influence of alcohol can impair judgment, compromise power relations, and increase risky sexual behaviour. Respondents who had sex in the 12 months preceding the survey were asked if they or their partner drank alcohol the last time they had sex with that partner, and whether they or their partner was drunk. Table 13.18 presents the percentage of young women and men aged 15–24 who had sexual intercourse in the 12 months preceding the survey while they were drunk or with a partner who was drunk, by background characteristics.

Overall a very small proportion (0.6%) of young women aged 15–24 were drunk during their last sexual intercourse while 5% of young men aged 15–24 were drunk during their last sexual intercourse in the 12 months preceding the survey. Approximately 5% of both young women and men aged 15–24 had sexual intercourse while drunk or with a partner who was drunk in the 12 months prior to the survey.

Table 13.18 also shows that women in urban areas, as well as women from the wealthiest quintile were more likely to have sexual intercourse under the influence of alcohol than other women. Although there is no substantial variation across all other groups, having sex under the influence of alcohol or with a partner who is also drunk is highest among young women from the lowest wealth quintile (10%), young women from Western Province (7.3%), young women with only a primary education (6.5%), and young women who know where to get condoms (6.2%).

The proportion of men having sexual intercourse under the influence of alcohol or with a partner who is also drunk is more common among young men in Honiara (12%), young men from the wealthiest quintile and from urban areas (equally account for 11%), and young men aged 20–24 (8%). Furthermore, the proportion of young adults having sexual intercourse under the influence of alcohol is also common among young women (7.1%) and men (5.4%) who know where to get condoms.

Table 13.18: Drunkenness during sexual intercourse among youth

Among all young women and young men age 15-24, the percentage who had sexual intercourse in the past 12 months while being drunk and percentage who had sexual intercourse in the past 12 months when drunk or with a partner who was drunk, by background characteristics, Solomon Islands 2007

Background characteristic	Women age 15-24			Men age 15-24		
	Percentage who had sexual intercourse in the past 12 months when drunk	Percentage who had sexual intercourse in the past 12 months when drunk or with a partner who was drunk	Number of respondents	Percentage who had sexual intercourse in the past 12 months when drunk	Percentage who had sexual intercourse in the past 12 months when drunk or with a partner who was drunk	Number of respondents
Age						
15-19	0.3	5.4	687	1.8	2.1	292
..15-17	0.1	3.8	429	1.5	1.5	181
..18-19	0.6	8.0	258	2.3	3.0	111
20-24	1.0	5.2	716	8.1	8.1	304
..20-22	1.2	7.0	415	7.9	7.9	194
..23-24	0.7	2.6	301	8.4	8.4	110
Marital status						
Never married	0.8	6.2	928	4.6	4.7	518
Ever married	0.4	3.6	476	7.9	7.9	78
Knows condom source¹						
Yes	1.2	7.1	646	5.2	5.4	483
No	0.2	3.7	758	4.1	4.1	113
Residence						
Urban	2.2	5.3	281	10.0	10.7	114
Rural	0.2	5.3	1,123	3.8	3.8	482
Region						
Honiara	2.0	3.8	211	11.6	11.6	98
Guadalcanal	0.9	4.5	234	4.1	4.1	68
Malaita	0.0	3.5	286	5.1	5.1	130
Western	1.4	7.3	170	2.1	3.4	68
Other provinces	0.0	6.6	502	3.3	3.3	231
Education						
No education	0.0	1.4	103	(2.1)	(2.1)	29
Primary	0.4	6.5	604	5.2	5.2	241
Secondary	1.0	4.9	663	3.7	4.0	306
More than secondary	0.0	2.2	33	*	*	19

Table 13.18 (continued)

Background characteristic	Women age 15-24			Men age 15-24		
	Percentage who had sexual intercourse in the past 12 months when drunk	Percentage who had sexual intercourse in the past 12 months when drunk or with a partner who was drunk	Number of respondents	Percentage who had sexual intercourse in the past 12 months when drunk	Percentage who had sexual intercourse in the past 12 months when drunk or with a partner who was drunk	Number of respondents
Wealth quintile						
Lowest	0.0	9.5	208	0.0	0.0	104
Second	0.0	8.0	268	1.1	1.1	102
Middle	0.0	1.5	280	3.7	3.7	130
Fourth	0.6	3.3	284	8.1	8.1	123
Highest	1.9	5.3	364	10.2	10.8	137
Total 15-24	0.6	5.3	1,404	5.0	5.2	596

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ For this table, the following responses are not considered a source for condoms: friends, family members and home

13.21 KEY RESULTS

Knowledge about AIDS is nearly universal among adult Solomon Islanders. A very high proportion of both women and men have heard of the disease; however, men are more knowledgeable about it than women (98% and 94%, respectively). The results show that the level of knowledge is quite high for both women and men at different ages and marital status, place of residence, education levels and household wealth quintiles.

Men and women were specifically asked if it is possible to reduce the risk of acquiring HIV through consistently using condoms, limiting sexual intercourse to one uninfected partner, and abstaining from sexual intercourse. The results show that 61% of women and 69% of men agree that using a condom at every sexual intercourse can reduce the risk of getting the AIDS virus, while 80% of women and 95% of men agree that limiting sexual intercourse to one uninfected partner is a way to avoid contracting HIV and AIDS. Generally, most women and men know that abstaining from sex (77% women, 89% men) and using condoms (56% women, 68% men) are other ways to avoid contracting HIV and AIDS.

About 71% of women and 83% of men know that a healthy-looking person can have the AIDS virus. Knowledge that people cannot get the AIDS virus by mosquito bites is higher among men (72%) than women (63%), and knowledge that people cannot get AIDS by supernatural means is higher for men (71%) than for women (66%).

Women in urban areas are more likely to have a comprehensive knowledge about HIV and AIDS (38%) than women in rural areas (27%). Women who have ever had sex, have more than a secondary education, who live in Western Province, and who live in the wealthiest quintile households are more likely to have a comprehensive knowledge about HIV and AIDS than other women. Comprehensive knowledge is more common among men in urban areas who are currently married, who have more than a secondary education, who live in higher wealth quintile households, and who live in Guadalcanal Province than other men.

About 69% of women and 53% of men know that HIV can be transmitted from a mother to her child by breastfeeding. A very low proportion of women and men (each 6.7%) know that HIV can be transmitted through breastfeeding and that the risk of transmission can be reduced by special drugs. Less than one in ten women and men (8% and 9%, respectively) aged 15–49 know that there are special drugs that a doctor or nurse can give to an HIV-infected pregnant woman to reduce the risk of transmitting the virus to the baby.

Less women than men expressed positive attitudes and opinions toward a family member with AIDS. For example, 66% of women and 72% of men would not want to keep it a secret that a family member has AIDS while only 36% of women and over half of men (56%) are willing to care for an HIV-infected family member. Meanwhile, only 30% of women and 55% of men reported that they would buy vegetables from a shopkeeper who has the AIDS virus.

Almost the same proportion of women and men (more than 80%) in the 15–49 age group agree that a wife is justified in refusing to have sexual intercourse with her husband if she knows that he has an STI. Nearly the same proportion of women and men also agree that a wife is justified in refusing sexual intercourse or asking her husband to use a condom.

CHAPTER 14 WOMEN'S EMPOWERMENT AND DEMOGRAPHIC AND HEALTH OUTCOMES

The 2006/2007 SIDHS Women's Questionnaire collected data on the general background characteristics (e.g. age, education, wealth quintile and employment status) of female respondents, and also data that are more specific to women's empowerment, such as receipt of cash earnings, the magnitude of a woman's earnings relative to those of her husband or partner, and control over the use of her own earnings and those of her husband or partner.

The Women's Questionnaire also collected data on women's participation in household decision-making, on the circumstances under which a woman is justified in refusing to have sexual intercourse with her husband or partner, and women's attitudes towards wife beating. For this report, three separate indices of empowerment were developed based on the number of household decisions in which the respondent participates, her opinion on the number of circumstances for which a woman is justified in refusing to have sexual intercourse with her husband or partner, and her opinion on the reasons that justify wife beating. The ranking of women on these three indices is then related to selected demographic and health outcomes, including contraceptive use; ideal family size and unmet need for contraception; the receipt of healthcare services during pregnancy, childbirth and the postnatal period; and survivorship of children.

14.1 EMPLOYMENT AND FORM OF EARNINGS

Like education, employment can also be a source of empowerment for both women and men. It may be particularly empowering for women if it puts them in control of income. Currently married respondents were asked whether they were employed at the time of the survey and if not, whether they were employed in the 12 months preceding the survey. Table 14.1 shows that 42.1% of currently married women aged 15–49 were employed during the last 12 months. In comparison, 87.1% of currently married men in the same age group were employed in the last 12 months. This indicates that there is still significant gender disparity in the employment sector. Women's vulnerable economic position is exacerbated by the fact that more than half (56.1%) of employed women are not paid for their work. On the other hand, only 21.7% of employed men aged 15–49 are not paid for their work. Men are much more likely than women to be paid in cash and in-kind. The high proportion of women who are not paid for their work is particularly concerning because domestic work — including caring for children, cooking and cleaning — is unpaid work. This creates a double burden for women.

Table 14.1: Employment and cash earnings of currently married women and men

Percentage of currently married women aged 15–49 and men aged 15+ who were employed at any time in the last 12 months, and the percent distribution of currently married women and men employed in the last 12 months by type of earnings, according to age, Solomon Islands 2007

Age	Currently married respondents:		Percent distribution of currently married respondents employed in the last 12 months, by type of earnings					Total	Number of respondents	
	Percentage employed	Number of respondents	Cash only	Cash and in-kind	In-kind only	Not paid	Missing			
WOMEN										
15–19	26.2	86	*	*	*	*	*	100.0	22	
20–24	33.7	383	37.3	11.3	1.7	49.6	0.0	100.0	129	
25–29	36.9	588	34.6	10.4	1.4	53.3	0.4	100.0	217	
30–34	48.6	533	36.6	5.7	0.5	57.1	0.0	100.0	259	
35–39	45.8	433	30.6	13.4	1.2	54.5	0.3	100.0	198	
40–44	51.6	311	31.0	6.1	3.1	59.8	0.0	100.0	161	
45–49	40.0	226	27.7	1.4	1.8	69.2	0.0	100.0	90	
Total 15–49	42.1	2,560	33.4	8.9	1.4	56.1	0.1	100.0	1,077	
MEN										
15–19	*	1	*	*	*	*	*	100.0	1	
20–24	70.8	75	65.9	7.1	3.8	23.2	0.0	100.0	53	
25–29	84.7	171	62.9	23.6	0.7	11.2	1.5	100.0	145	
30–34	91.1	226	52.7	23.4	0.9	23.0	0.0	100.0	206	
35–39	88.9	230	49.6	29.5	1.0	19.2	0.7	100.0	205	
40–44	90.3	129	50.7	17.9	1.7	28.5	1.1	100.0	117	
45–49	86.3	107	32.6	32.8	3.0	31.7	0.0	100.0	92	
Total 15–49	87.1	939	52.1	24.2	1.4	21.7	0.6	100.0	818	
50+	76.5	375	39.6	26.5	2.0	31.9	0.0	100.0	287	
Total men 15+	84.1	1,314	48.8	24.8	1.6	24.4	0.4	100.0	1,105	

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

14.2 CONTROL OVER HUSBAND'S EARNINGS

Table 14.2 shows who decides how men's cash earnings are spent, by background characteristics. The data show that nearly 16% of women aged 15–49 take the main responsibility for how their husband's earnings are spent. About 56% of women report that it is a joint decision between the husband and the wife, and about 22.5% report that the husband has control over how his earnings are spent. These results seem to show that women have quite a significant amount of control over how earnings are spent even if those earnings are the husband's. It is encouraging that the majority of women make financial decisions together with their husbands.

Table 14.2: Control over men's cash earnings

Percent distribution of currently married women aged 15–49 whose husbands receive cash earnings, by person who decides how men's earnings are used, according to background characteristics, Solomon Islands 2007

Background characteristic	Women					Total	Number
	Mainly wife	Husband and wife jointly	Mainly husband	Other	Missing		
Age							
15–19	*	*	*	*	*	100.0	13
20–24	13.1	63.8	16.8	0.0	6.2	100.0	63
25–29	13.5	63.7	20.4	0.2	2.2	100.0	95
30–34	16.4	51.2	26.9	0.0	5.4	100.0	110
35–39	17.0	53.6	18.2	0.0	11.3	100.0	84
40–44	16.3	52.4	27.0	0.0	4.3	100.0	60
45–49	(16.0)	(66.5)	(13.8)	(0.0)	(3.8)	100.0	26
Number of living children							
0	13.9	62.4	16.3	0.3	7.0	100.0	59
1–2	19.0	52.6	26.2	0.0	2.1	100.0	116
3–4	10.9	58.8	26.8	0.0	3.5	100.0	165
5+	20.7	51.1	15.7	0.0	12.5	100.0	110
Residence							
Urban	8.8	65.3	21.0	0.1	4.8	100.0	133
Rural	18.7	51.8	23.2	0.0	6.3	100.0	317
Region							
Honiara	10.1	60.8	21.5	0.2	7.4	100.0	86
Guadalcanal	21.9	45.6	32.4	0.0	0.0	100.0	116
Malaita	(9.7)	(76.8)	(11.8)	(0.0)	(1.6)	100.0	78
Western	17.1	51.0	24.2	0.0	7.7	100.0	74
Other provinces	17.3	50.1	19.0	0.0	13.6	100.0	95
Education							
No education	(12.5)	(54.8)	(30.3)	(0.0)	(2.4)	100.0	31
Primary	18.6	52.0	21.7	0.0	7.7	100.0	227
Secondary	13.3	61.0	23.6	0.1	2.0	100.0	141
More than secondary	12.1	58.9	18.9	0.0	10.1	100.0	51
Wealth quintile							
Lowest	(22.6)	(40.6)	(34.7)	(0.0)	(2.1)	100.0	56
Second	(28.9)	(46.8)	(23.4)	(0.0)	(0.9)	100.0	42
Middle	16.0	43.6	23.7	0.0	16.8	100.0	72
Fourth	11.7	64.7	20.5	0.0	3.0	100.0	103
Highest	12.8	62.6	19.2	0.1	5.3	100.0	176
Total 15–49	15.8	55.8	22.5	0.0	5.8	100.0	450

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = not applicable

Women in the youngest age group are the most likely to take joint responsibility with their husband. At first this seems counter intuitive because older women usually develop more power within the household over time; however, there may be a generational shift in attitudes and that younger married couples are taking a more collaborative approach to financial decision making.

Urban women are slightly more likely than rural women to be in control of their husband's earnings either on their own or jointly. Women who have a secondary education level or higher are more likely to share in the decision-making responsibility with their husbands than those who have a lower education level. This indicates that the education of women can contribute to their empowerment and decision-making ability within the home. Couples that have a higher income also seem to share the responsibility more.

14.3 WOMEN'S EMPOWERMENT

In addition to educational attainment, employment status and control over earnings, the 2006/2007 SIDHS collected information on some direct measures of women's autonomy and status. Specifically, questions were asked about women's participation in household decision making, their acceptance of wife beating, and their opinions about the conditions under which a wife should be able to deny sex to her husband. Such information provides insight into women's control over their environment and their attitudes toward gender roles, both of which are relevant to understanding women's demographic and health behaviour.

The first measure — women's participation in decision making — requires little explanation because the ability to make decisions about one's own life is of obvious importance to women's empowerment. The other two measures derive from the notion that gender equity is essential to empowerment. Responses that indicate a husband is justified in beating his wife, reflect a low status of women, and signify acceptance of norms that give men the right to use force against women, which is a violation of women's human rights. Similarly, beliefs about whether and when a woman can refuse to have sex with her husband reflect issues of gender equity regarding sexual rights and bodily integrity¹⁰. Besides yielding an important measure of empowerment, information about women's attitudes toward sexual rights is useful for improving and monitoring reproductive health programmes that depend on women's willingness and ability to control their own sexual lives.

14.3.1 Women's participation in household decision making

To assess women's decision-making autonomy, questions were asked about women's participation in four different types of household decisions: 1) the respondent's own health care, 2) making major household purchases, 3) making household purchases for daily needs, and 4) visiting her family or relatives. Having a final say in decision-making processes is the highest degree of autonomy. Women are considered to participate in a decision if they alone or jointly with their husband or partner have the final say in that decision. Table 14.3 shows the percent distribution of currently married women according to the person in the household who usually makes decisions concerning these matters.

Women most often reported that these household decisions were made jointly. However, 28.8% of women reported that decisions about major household purchases are primarily made by their husbands. On the other hand, 40.0% of women reported that they make decisions regarding purchases for daily household needs. It is concerning that only 28.1% of women reported that they have exclusive control over their own health care. This indicates that women do not have full rights over their own bodies. Furthermore, only 19.8% of women reported that they have the main decision-making power with regards to visits to their family and friends. Table 14.4 shows that only 7% percent of men aged 15–49 reported that their wife has the primarily responsibility for this decision. This is significant because when men control women's behaviour, it often results in limiting a woman's access to her sources of support (i.e. family and friends), thus isolating her. This can make women particularly vulnerable if they are experiencing abuse in the home.

In all other areas, men's understanding of women's participation in decision making is relatively similar to that of women's.

¹⁰ The ownership of one's own body and ability to determine what happens to it, how it happens, and even why it happens.

Table 14.3: Women's participation in decision making

Percent distribution of currently married women aged 15–49 by person who usually makes decisions about four kinds of issues, Solomon Islands 2007

Issue	Who makes the decision?					Missing	Total	Number of women
	Mainly wife	Wife and husband jointly	Mainly husband	Someone else	Other			
Own health care	28.1	54.4	16.6	0.1	0.2	0.5	100.0	2,560
Major household purchases	21.0	49.3	28.8	0.1	0.1	0.6	100.0	2,560
Purchases of daily household needs	40.0	43.3	15.8	0.2	0.3	0.4	100.0	2,560
Visits to her family or relatives	19.8	60.8	18.5	0.0	0.1	0.8	100.0	2,560

Table 14.4: Women's participation in decision making according to men

Percent distribution of currently married men aged 15–49 by person who they think should have a greater say in making decisions about five kinds of issues, Solomon Islands 2007

Issue	Who should make the decision?				Missing	Total	Number of men
	Wife	Wife and husband equally	Husband	Don't know/depends			
Major household purchases	19.5	55.7	23.2	1.3	0.3	100.0	939
Purchases of daily household needs	46.5	40.4	11.0	1.9	0.3	100.0	939
Visits to wife's family or relatives	7.0	70.2	18.3	3.9	0.6	100.0	939
What to do with the money wife earns	20.7	58.8	12.8	7.1	0.6	100.0	939
How many children to have	1.7	92.3	3.7	1.7	0.6	100.0	939

14.3.2 Women's participation in decision making by background characteristics

Table 14.5 shows the percentage of women who reported that they alone, or jointly, participate in specific household decisions, according to background characteristics. Generally speaking, the percentage of women who usually make specific decisions, either by themselves or jointly with their husband, increases as women get older. This reflects that women tend to gain more power within the home over time.

Women who are employed are also more likely to participate in household decision making, confirming that employment is a source of empowerment for women. In addition, 70.3% of women in urban areas participate in all four categories of household decision making compared with only 55.2% of women in rural areas. This is because patriarchal family ideology, which limits women's participation in household decision making, is often more deep-seated in rural areas. Furthermore, women in urban areas tend to have higher levels of employment and education, other factors that contribute to their empowerment within the home.

Table 14.5: Women's participation in decision making by background characteristics

Percentage of currently married women aged 15–49 who usually make specific decisions either by themselves or jointly with their husband, by background characteristics, Solomon Islands 2007

Background characteristic	Specific decisions				Percentage who participate in all four decisions	Percentage who participate in none of the four decisions	Number of women
	Own health care	Making major household purchases	Making purchases for daily household needs	Visits to her family or relatives			
Age							
15–19	75.8	77.6	77.2	70.8	58.2	11.8	86
20–24	81.0	70.2	81.4	77.4	53.8	5.0	383
25–29	82.7	70.1	83.7	82.0	56.2	6.1	588
30–34	82.5	69.5	84.4	79.6	58.3	6.4	533
35–39	85.3	72.8	88.2	83.3	61.2	5.7	433
40–44	82.0	69.2	79.9	81.1	62.1	8.7	311
45–49	83.2	67.0	81.0	82.3	50.5	5.9	226
Employment (last 12 months)							
Not employed	80.1	67.5	80.4	78.0	56.3	9.4	1,479
Employed for cash	88.7	82.1	91.0	88.9	70.3	1.4	456
Employed not for cash	84.3	68.3	84.8	80.6	50.9	3.1	620
Number of living children							
0	70.6	68.6	74.5	77.4	50.9	8.5	247
1–2	82.1	69.1	83.4	79.7	57.8	7.2	742
3–4	86.4	75.3	86.8	82.4	61.8	4.5	837
5+	82.7	66.4	82.3	80.5	54.2	7.1	734
Residence							
Urban	85.5	78.8	85.6	84.9	70.3	7.7	372
Rural	82.1	68.9	83.0	79.8	55.2	6.2	2,187
Region							
Honiara	84.2	78.2	85.3	83.6	70.9	10.0	278
Guadalcanal	88.6	69.1	88.4	88.1	58.9	0.8	445
Malaita	86.7	76.3	83.8	81.6	65.6	6.0	612
Western	88.4	77.2	89.4	90.4	68.5	2.5	303
Other provinces	74.5	62.3	78.1	72.1	43.5	9.7	922

Table 14.5 (continued)

	Specific decisions				Percentage who participate in all four decisions	Percentage who participate in none of the four decisions	Number of women
Background characteristic	Own health care	Making major household purchases	Making purchases for daily household needs	Visits to her family or relatives			
Education							
No education	84.6	71.1	77.9	81.2	60.1	8.9	385
Primary	81.7	68.3	84.5	79.7	55.6	6.4	1,610
Secondary	83.2	74.3	83.0	82.8	59.3	4.3	493
More than secondary	87.1	83.5	90.3	81.6	71.8	8.1	72
Wealth quintile							
Lowest	85.3	71.7	85.3	82.1	57.4	3.0	499
Second	80.7	66.5	81.6	84.7	52.1	5.7	500
Middle	80.9	74.3	84.8	78.4	60.0	6.9	490
Fourth	83.3	65.1	83.7	77.4	54.7	8.3	546
Highest	82.6	74.4	81.5	80.5	63.0	8.0	524
Total	82.6	70.3	83.4	80.6	57.4	6.4	2,560

Total includes five cases with missing information on employment.

Table 14.6: Men's attitude toward wives' participation in decision making

Percentage of currently married men aged 15–49 who think a wife should have the greater say alone, or equal say with her husband, on five specific kinds of decisions, by background characteristics, Solomon Islands 2007

Background characteristic	Specific decisions					All five decisions	None of the five decisions	Number of men
	Making major household purchases	Making purchases for daily household needs	Visits to her family or relatives	What to do with the money the wife earns	How many children to have			
Age								
15–19	*	*	*	*	*	*	*	1
20–24	71.9	88.4	75.3	80.5	92.8	39.5	0.0	75
25–29	82.0	87.0	85.1	82.9	97.2	54.6	0.0	171
30–34	71.7	89.0	73.8	81.5	94.5	42.2	0.0	226
35–39	73.4	83.8	80.1	73.9	96.0	36.3	0.6	230
40–44	78.1	86.0	73.1	85.2	90.8	47.7	0.0	129
45–49	75.0	87.7	72.2	75.1	88.1	34.9	1.4	107
Employment (last 12 months)								
Not employed	80.6	90.4	91.2	58.1	98.4	39.7	0.0	121
Employed for cash	78.2	88.0	78.4	80.6	93.8	46.7	0.3	624
Employed not for cash	61.3	80.3	64.9	89.1	91.6	30.6	0.6	189
Missing	*	*	*	*	*	*	*	5
Number of living children								
0	76.1	92.0	76.2	79.7	96.5	46.8	0.0	113
1–2	76.2	86.4	81.1	79.2	94.5	44.7	0.5	297
3–4	81.1	85.6	74.0	83.0	96.2	46.1	0.4	293
5+	66.2	86.3	77.1	75.4	89.4	34.1	0.1	236
Residence								
Urban	80.6	88.0	72.2	93.9	96.0	44.5	0.2	162
Rural	74.1	86.6	78.3	76.5	93.6	42.3	0.3	778
Region								
Honiara	77.2	91.2	66.1	93.6	96.4	38.5	0.2	124
Guadalcanal	90.7	87.1	72.8	90.5	98.5	52.8	0.0	180
Malaita	62.6	87.7	93.9	76.4	98.3	38.3	0.0	222
Western	64.1	78.8	74.9	79.0	85.8	39.8	2.8	94
Other provinces	77.6	86.7	73.3	70.1	89.9	42.6	0.0	320

Table 14.6 (continued)

Background characteristic	Specific decisions					All five decisions	None of the five decisions	Number of men
	Making major household purchases	Making purchases for daily household needs	Visits to her family or relatives	What to do with the money the wife earns	How many children to have			
Education								
No education	67.1	82.8	79.6	66.3	93.8	28.5	0.0	60
Primary	74.0	88.2	75.3	80.8	93.0	40.9	0.0	510
Secondary	75.4	84.0	79.5	78.4	95.6	44.0	0.6	268
More than secondary	85.1	89.5	80.2	83.8	94.7	56.5	1.2	102
Wealth quintile								
Lowest	76.1	85.2	77.6	83.0	95.7	46.7	0.0	185
Second	71.8	88.0	85.1	80.0	93.7	48.9	0.0	178
Middle	68.5	85.3	70.4	72.5	94.8	32.3	0.8	172
Fourth	79.3	89.1	77.5	73.9	89.1	43.0	0.6	209
Highest	79.1	86.1	75.8	87.9	97.2	42.1	0.1	196
Total 15–49	75.2	86.8	77.3	79.5	94.0	42.7	0.3	939
50+	74.0	89.1	75.1	80.3	92.1	43.2	1.4	375
Total men 15+	74.9	87.4	76.7	79.7	93.5	42.8	0.6	1,314

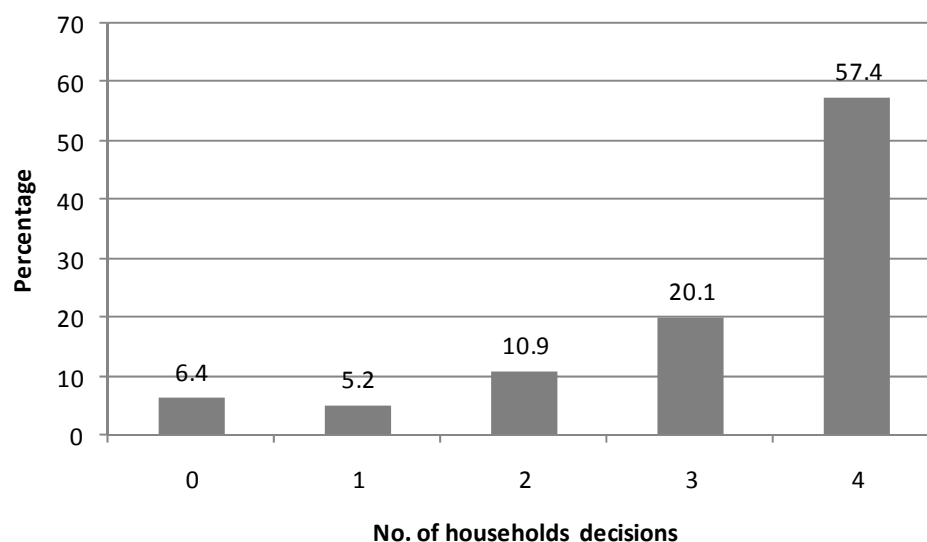
Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

14.3.3 Men's attitude towards their wife's participation in decision making

Table 14.6 shows men's attitudes towards their wife's participation in decision making, and indicates that 42.8% of men aged 15 and older support women's participation in five areas: making major household purchases; making purchases for daily household needs; visiting family and friends; deciding how to spend her own income; and how many children to have. Of all five decisions, men most supported women's participation in deciding how many children to have, and least supported women's involvement in decisions about major household purchases. In general, men with a higher education level are more likely to support their wife's involvement in household decision making, demonstrating that men's education helps to promote gender equality and women's empowerment. In most cases, men in urban areas are more likely to support their wife's participation in decision making more than men in rural areas. If the husband has not employed in the last 12 months he is significantly less likely to support his wife's participation in deciding how to spend her own earnings. That is, if household earnings are only made up of the wife's earnings then the husband is more likely to expect to have more control over it.

Figure 14.1 shows the distribution of currently married women according to the number of decisions in which they participate, either alone or in conjunction with their husband or partner. The majority of women in Solomon Islands participate in all specific decisions regarding her own health care, making major household purchases, making purchases for daily household needs and visits to her family or relatives that were asked about in this survey. Only 6.4% of women in Solomon Islands do not participate in any of the four survey questions regarding household decisions. Although this is encouraging, there is clearly still room for improvement because more than 40% of women do not participate in all household decisions.

Figure 14.1: Number of decisions in which currently married women participate in the final say



14.3.4 Attitudes toward wife beating

Violence against women has serious consequences for women's mental and physical well-being, including their reproductive and sexual health (WHO 1999). One of the most common forms of violence against women worldwide is abuse by a husband or partner (Heise et al. 1999).

The 2006/2007 SIDHS gathered information on women's attitudes toward wife beating, a proxy for women's perception of their status. Women who believe that a husband is justified in hitting or beating his wife for specified reasons may believe themselves to be low in status, both absolutely and relative to men. Such a perception could act as a barrier to accessing health care for themselves and their children, affect their attitude toward contraceptive use, and impact their general well-being. Women were asked whether a husband is justified in beating his wife under a series of circumstances: if the wife burns the food, argues with him, goes out without telling him, neglects the children and refuses to have sexual intercourse with him. Table 14.7 summarises women's attitudes toward wife beating in these five specific circumstances.

Just under 70% of women agreed with at least one justification for a husband beating his wife. It is significant that the majority of women believe that intimate partner violence is justified under some circumstances. Such findings are of concern because they indicate that the subordinate status of women within the marital relationship is generally accepted by women. Women seem to make distinctions about the specific circumstances under which beating is justifiable. The most commonly accepted justification for wife abuse — according to women — is if she neglects the children. The justification considered least acceptable was if she refuses sex with her husband.

The attitudes of women do not vary significantly across different demographical and social characteristics, although women with some education are less likely to justify violence than those who have no education. Also, women who are divorced, separated or widowed are less likely to agree that violence is justified under some circumstances. There is some evidence that women who are divorced or separated have a higher prevalence of partner violence than other women. This suggests that violence may be an important cause of marriage breakdowns (Garcia-Moreno, 2005). It is possible that divorced or separated women are less likely to justify violence because they are more likely to have experienced the impact first hand.

Men were also asked about their opinions on the justification of wife beating under certain circumstances. As shown in Table 14.8, 65.1% of men aged 15–49 agreed with at least one justification for wife beating. This is similar to, but slightly less than, the percentage of women in the same age group who agreed with one or more justifications for wife beating. For men, the most commonly accepted justification for beating a wife is if the wife neglects the children; the least accepted justification is if she refuses sex with her husband. This consistency between men and women's attitudes indicates a cultural and social understanding of partner violence that cuts across genders.

A very interesting observation from Table 14.8 is that men with no education are much less likely to believe that violence is justified than those who are educated. For example, 24.8% of men with no education agree with one or more justifications for wife abuse while 69.4% of men who have a tertiary level education agree with one or more justifications for wife abuse. Other research suggests that male education usually helps to promote women's empowerment and, therefore, this result needs to be analysed further. Younger men are also more likely to justify partner violence against women than older men, perhaps indicating a conservative revival among younger generations. Both of these findings highlight the importance of including gender equality and women's rights in educational programmes, particularly those that involve boys.

Men in urban areas are also more likely to justify violence, with the highest percentage in Honiara and Western Province. Interestingly, 29.6% of men from Malaita Province agree with one or more justifications for wife abuse. More research should be conducted to ascertain whether Malaita Province has a particular culture that is less violent, or recognises women's rights more than other provinces in Solomon Islands.

Table 14.7: Attitude toward wife beating — Women

Percentage of all women aged 15–49 who agree that a husband is justified in hitting or beating his wife for specific reasons, by background characteristics, Solomon Islands 2007

Background characteristic	Husband is justified in hitting or beating his wife if she:					Percentage who agree with at least one specified reason	Number of women
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses to have sexual intercourse with him		
Age							
15–19	31.1	36.3	51.2	64.4	13.3	71.6	687
20–24	26.0	35.0	55.9	55.2	13.0	72.2	716
25–29	23.6	30.1	45.6	52.0	11.7	64.4	729
30–34	31.9	34.8	49.3	59.3	18.3	67.8	600
35–39	26.9	32.4	46.8	55.7	14.4	68.8	482
40–44	26.8	37.3	49.8	66.1	8.2	71.8	336
45–49	27.3	35.3	44.1	50.8	13.9	63.2	273
Employment (last 12 months)							
Not employed	26.6	35.5	52.5	57.5	13.9	67.9	2,245
Employed for cash	25.5	29.1	43.3	55.9	10.2	68.7	655
Employed not for cash	31.3	34.0	47.5	59.5	14.9	70.9	909
Marital status							
Never married	30.4	34.8	52.1	61.2	13.9	69.9	1,125
Married or living together	27.1	34.7	49.0	56.5	13.5	69.1	2,560
Divorced/separated/widowed	15.8	19.5	38.8	47.6	9.1	54.8	138
Number of living children							
0	28.6	31.8	52.2	57.6	12.7	69.8	1,213
1–2	25.7	35.4	49.4	58.1	13.4	67.8	954
3–4	24.7	36.1	50.3	57.4	12.4	69.3	885
5+	32.0	34.1	44.7	57.2	16.0	67.8	772
Residence							
Urban	20.4	32.9	49.6	53.4	15.8	65.1	636
Rural	29.1	34.4	49.5	58.4	13.0	69.5	3,187

Table 14.7 (continued)

Background characteristic	Husband is justified in hitting or beating his wife if she:					Percentage who agree with at least one specified reason	Number of women
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses to have sexual intercourse with him		
Region							
Honiara	18.6	31.6	51.6	58.3	15.1	65.7	481
Guadalcanal	42.8	40.7	54.5	58.6	27.1	69.9	637
Malaita	18.2	42.0	50.7	58.4	9.7	67.3	840
Western	32.4	25.7	41.5	66.6	15.7	76.5	458
Other provinces	28.0	30.2	48.5	53.5	8.2	67.8	1,407
Education							
No education	22.2	38.1	48.8	57.9	12.1	63.2	520
Primary	31.6	35.3	51.0	57.4	14.8	70.8	2,114
Secondary	23.2	30.4	48.0	58.1	11.0	67.7	1,067
More than secondary	22.1	30.0	40.7	54.1	16.0	67.3	122
Wealth quintile							
Lowest	32.4	31.9	45.6	49.5	17.6	65.5	696
Second	32.5	40.1	49.4	60.6	12.9	70.7	755
Middle	23.3	34.5	47.7	58.3	11.0	68.3	738
Fourth	26.9	33.4	54.7	61.6	12.5	71.4	769
Highest	24.0	31.2	49.8	57.4	13.6	67.9	864
Total	27.7	34.2	49.5	57.6	13.4	68.8	3,823

Total includes 14 cases with missing information on employment.

Table 14.8: Attitude toward wife beating — Men*Percentage of all men aged 15–49 who agree that a husband is justified in hitting or beating his wife for specific reasons, by background characteristics, Solomon Islands 2007*

Background characteristic	Husband is justified in hitting or beating his wife if she:					Percentage who agree with at least one specified reason	Number of men
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses to have sexual intercourse with him		
Age							
15–19	35.2	42.6	52.7	61.1	10.3	72.9	292
20–24	30.8	39.0	40.9	52.1	10.6	64.1	304
25–29	34.1	32.4	49.0	56.1	16.3	69.9	266
30–34	31.1	28.3	33.7	55.4	14.9	62.7	266
35–39	35.8	28.9	32.9	48.8	15.9	61.2	239
40–44	29.9	33.5	43.9	55.2	19.8	58.9	134
45–49	34.2	40.5	40.5	52.5	21.3	57.6	113
Employment (last 12 months)							
Not employed	27.7	33.6	38.4	40.0	16.0	50.5	360
Employed for cash	38.1	39.1	48.9	63.0	16.8	74.4	893
Employed not for cash	26.2	26.6	28.4	48.4	6.8	56.0	354
Marital status							
Never married	32.7	40.9	47.2	56.9	12.5	69.2	660
Married or living together	33.7	30.8	38.8	53.5	15.8	62.6	939
Divorced/separated/widowed	*	*	*	*	*	*	14
Number of living children							
0	32.4	39.2	46.5	57.4	11.7	69.2	754
1–2	36.4	34.6	43.4	54.5	15.4	65.1	322
3–4	30.0	28.1	34.5	53.1	16.9	59.9	298
5+	34.8	30.5	36.9	48.6	19.2	58.8	240
Residence							
Urban	43.4	47.1	55.6	65.3	20.9	76.1	301
Rural	30.7	32.2	39.2	52.3	13.0	62.6	1,313
Region							
Honiara	46.6	55.4	56.8	66.9	20.7	77.4	240
Guadalcanal	16.3	22.8	28.6	40.5	9.0	54.7	249
Malaita	11.1	18.0	19.0	22.3	15.6	29.6	345
Western	43.2	20.5	52.9	63.5	28.6	79.1	181
Other provinces	44.3	46.0	52.2	71.7	9.4	80.7	599

Table 14.8 (continued)

Background characteristic	Husband is justified in hitting or beating his wife if she:					Percentage who agree with at least one specified reason	Number of men
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses to have sexual intercourse with him		
Education							
No education	9.5	16.8	14.7	18.2	7.0	24.8	88
Primary	37.8	37.8	46.4	56.9	15.9	66.8	794
Secondary	31.3	36.7	42.0	55.7	14.7	67.8	593
More than secondary	28.7	22.8	37.0	61.0	10.8	69.4	138
Wealth quintile							
Lowest	40.7	35.4	38.1	52.8	10.7	62.1	281
Second	35.3	40.8	51.6	62.2	12.4	68.5	291
Middle	22.5	28.8	32.5	46.0	13.3	60.2	323
Fourth	32.6	27.4	39.3	52.6	18.0	62.3	353
Highest	35.3	42.8	49.4	59.9	16.8	71.9	366
Total 15–49	33.1	35.0	42.2	54.7	14.5	65.1	1,614
50+	27.6	30.5	42.8	51.9	11.1	58.4	442
Total men 15+	31.9	34.0	42.4	54.1	13.8	63.7	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
Total includes seven cases with missing information on employment.

14.3.5 Attitudes toward refusing sex with husband

The extent of control women have over when and with whom they have sex has important implications for outcomes such as the transmission of HIV and other STIs. To measure women's beliefs about sexual empowerment, female respondents were asked whether it is justifiable for a wife to deny her husband sex in the following circumstances: when she knows her husband has an STI, when she knows her husband has had sex with other women and when she is not in the mood.

Table 14.9 shows that the majority of women report a relatively high level of sexual autonomy in Solomon Islands: 74.3% of women agree that a woman is justified in refusing to have sex with her husband for all three reasons, while only 6.4% of women do not agree that a woman has the right to refuse sex with her husband for any of these reasons. The most commonly accepted reason among women was if she knows that her husband has had sex with other women. Older women, women in higher wealth quintiles, women with a higher education, women in urban areas, and women who are employed for cash are more likely to believe that wives are justified in refusing sex under all circumstances. This confirms that the extent of control women have over their own sexuality is related to other sources of empowerment such as employment and education.

Table 14.9: Attitudes toward refusing sexual intercourse with husband — Women

Percentage of all women aged 15–49 who believe that a wife is justified in refusing to have sexual intercourse with her husband in specific circumstances, by background characteristics, Solomon Islands 2007

Background characteristic	Wife is justified in refusing intercourse with her husband if she:			Percentage who agree with all of the specified reasons	Percentage who agree with none of the specified reasons	Number of women
	Knows husband has a sexually transmitted disease	Knows husband has intercourse with other women	Is tired or not in the mood			
Age						
15–19	80.5	86.1	80.2	69.0	8.3	687
20–24	85.3	88.1	86.3	76.1	6.0	716
25–29	83.9	87.5	84.2	74.7	6.0	729
30–34	81.9	89.5	83.7	74.9	6.8	600
35–39	84.8	87.7	87.8	76.1	5.4	482
40–44	84.6	88.6	86.5	76.1	5.8	336
45–49	80.5	88.2	89.7	75.5	5.7	273
Employment (last 12 months)						
Not employed	81.7	87.0	83.9	73.3	7.2	2,245
Employed for cash	86.6	89.5	89.5	79.6	4.7	655
Employed not for cash	84.3	88.7	83.8	73.0	5.6	909
Marital status						
Never married	79.4	84.4	79.9	68.4	9.3	1,125
Married or living together	84.7	89.0	86.9	76.5	5.3	2,560
Divorced/separated/widowed	86.0	94.4	86.1	81.3	2.9	138
Number of living children						
0	82.8	86.4	80.9	72.0	8.3	1,213
1–2	83.7	89.5	87.5	76.0	4.3	954
3–4	82.8	88.0	87.6	75.1	5.3	885
5+	83.5	87.8	84.5	74.8	7.4	772
Residence						
Urban	92.6	93.8	91.9	85.7	2.4	636
Rural	81.3	86.6	83.4	72.0	7.2	3,187

Table 14.9 (continued)

Background characteristic	Wife is justified in refusing intercourse with her husband if she:			Percentage who agree with all of the specified reasons	Percentage who agree with none of the specified reasons	Number of women
	Knows husband has a sexually transmitted disease	Knows husband has intercourse with other women	Is tired or not in the mood			
Region						
Honiara	91.3	94.5	90.7	84.7	2.9	481
Guadalcanal	89.2	93.6	91.4	84.0	2.6	637
Malaita	82.1	86.2	82.5	72.2	7.6	840
Western	78.2	81.3	78.7	72.8	15.2	458
Other provinces	79.9	86.1	83.2	68.1	5.7	1,407
Education						
No education	82.1	86.3	83.4	74.0	6.9	520
Primary	81.3	86.9	84.7	71.5	6.1	2,114
Secondary	86.8	90.1	85.5	79.3	7.0	1,067
More than secondary	89.0	90.1	87.9	81.3	3.9	122
Wealth quintile						
Lowest	82.6	85.3	83.3	71.3	7.3	696
Second	80.6	85.8	85.0	71.4	6.8	755
Middle	79.2	85.6	83.0	71.0	7.9	738
Fourth	83.3	89.7	83.0	73.8	6.1	769
Highest	89.1	92.0	89.1	82.5	4.2	864
Total	83.2	87.8	84.8	74.3	6.4	3,823

Total includes 14 cases with missing information on employment.

Table 14.10 shows the percentage of men who believe that a wife is justified in refusing sex with her husband under specific circumstances. The data show that 75.5% of men aged 15–49 agree with all three justifications for a wife refusing sex with her husband. Only 4.1% believe that women are not justified in refusing sex under any of the specified circumstances. This percentage is even less than for women indicating that men have greater respect for women’s sexual autonomy than do women. Like women, men who were older, employed for cash, and had a secondary or higher education were more likely to believe that women are justified in refusing sex under all circumstances. The association with income and rural-urban settings among men, however, was not clear.

Table 14.10: Attitudes toward refusing sexual intercourse with husband — Men

Percentage of all men aged 15–49 who believe that a wife is justified in refusing to have sexual intercourse with her husband in specific circumstances, by background characteristics, Solomon Islands 2007

Background characteristic	Wife is justified in refusing intercourse with her husband if she:			Percentage who agree with all of the specified reasons	Percentage who agree with none of the specified reasons	Number
	Knows husband has an STI	Knows husband has intercourse with other women	Is tired or not in the mood			
Age						
15–19	76.8	83.1	82.6	63.7	7.1	292
20–24	85.4	82.9	84.6	75.0	8.0	304
25–29	87.4	83.1	91.6	75.9	1.5	266
30–34	89.9	91.0	89.7	82.8	3.4	266
35–39	89.9	90.3	89.0	77.7	1.5	239
40–44	87.1	89.2	91.0	80.4	4.2	134
45–49	81.7	89.9	92.7	78.9	1.7	113
Employment (last 12 months)						
Not employed	82.0	87.1	87.1	75.2	6.8	360
Employed for cash	84.1	84.2	88.1	72.9	3.9	893
Employed not for cash	92.7	91.2	88.9	82.5	2.8	354
Marital status						
Never married	80.6	82.3	83.8	69.3	7.4	660
Married or living together	89.0	89.3	91.0	79.9	2.1	939
Divorced/separated/widowed	*	*	*	*	*	14
Number of living children						
0	81.4	83.3	84.5	69.2	6.3	754
1–2	88.4	86.3	90.8	78.5	3.7	322
3–4	91.6	93.1	92.4	85.9	2.1	298
5+	86.7	88.2	89.8	78.6	1.6	240
Residence						
Urban	85.0	86.1	89.1	76.1	4.8	301
Rural	85.6	86.5	87.7	75.4	4.2	1,313

Table 14.10 (continued)

Background characteristic	Wife is justified in refusing intercourse with her husband if she:			Percentage who agree with all of the specified reasons	Percentage who agree with none of the specified reasons	Number
	Knows husband has an STI	Knows husband has intercourse with other women	Is tired or not in the mood			
Region						
Honiara	87.5	83.6	87.9	76.7	5.0	240
Guadalcanal	96.4	97.1	95.2	92.4	0.6	249
Malaita	94.0	94.8	92.0	89.1	2.3	345
Western	49.1	84.6	79.2	44.2	9.3	181
Other provinces	86.2	78.9	85.4	69.6	5.2	599
Education						
No education	91.5	91.3	89.6	87.1	4.6	88
Primary	81.1	85.3	85.6	71.6	5.1	794
Secondary	88.8	87.2	89.9	77.6	3.4	593
More than secondary	92.2	86.6	92.6	81.8	3.3	138
Wealth quintile						
Lowest	92.9	89.8	92.1	82.5	1.1	281
Second	82.6	90.8	89.2	78.5	4.5	291
Middle	86.9	88.5	88.3	74.1	1.4	323
Fourth	81.4	76.5	81.2	67.0	9.1	353
Highest	84.7	88.2	90.2	77.3	4.5	366
Total 15–49	85.5	86.4	88.0	75.5	4.3	1,614
Total 50+	83.2	88.0	89.2	72.5	3.6	442
Total men 15+	85.0	86.8	88.3	74.9	4.1	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Total includes seven cases with missing information on employment.

STI = sexually transmitted infection

Table 14.11: Men's attitudes toward a husband's rights when his wife refuses to have sexual intercourse

Percentage of men aged 15–49 who believe that a husband has the right to certain behaviours when his wife refuses to have sex with him when he wants her to, by background characteristics, Solomon Islands 2007

Background characteristic	When a wife refuses to have sex with her husband, he has the right to:				Percentage who agree with all of the specified reasons	Percentage who agree with none of the specified reasons	Number
	Get angry and reprimand her	Refuse her financial support	Use force to have sex	Have sex with another woman			
Age							
15–19	12.8	11.2	5.1	5.3	0.0	77.2	292
20–24	16.6	10.4	8.8	6.5	1.5	74.3	304
25–29	13.0	10.3	5.9	7.8	1.5	75.5	266
30–34	12.5	9.3	7.4	4.7	2.2	81.2	266
35–39	8.2	8.4	5.6	4.8	0.0	84.6	239
40–44	23.7	14.3	16.1	9.4	5.9	73.2	134
45–49	20.8	8.0	4.2	5.1	0.0	74.5	113
Employment (last 12 months)							
Not employed	10.2	12.6	6.1	6.2	1.0	78.6	360
Employed for cash	14.2	11.3	7.8	7.7	2.1	77.2	893
Employed not for cash	19.0	5.1	7.0	1.5	0.1	77.7	354
Marital status							
Never married	15.7	11.1	6.8	6.3	0.7	74.2	660
Married or living together	13.2	9.3	7.5	6.0	1.9	80.1	939
Divorced/separated/widowed	*	*	*	*	*	70.6	14
Number of living children							
0	14.5	10.8	6.3	5.9	1.1	75.9	754
1–2	12.6	10.2	8.4	5.3	1.2	79.6	322
3–4	12.3	9.9	6.7	5.8	1.3	80.4	298
5+	18.4	8.6	9.2	7.9	2.6	76.8	240
Residence							
Urban	12.2	16.6	4.5	5.4	0.2	71.8	301
Rural	14.8	8.7	7.9	6.2	1.7	79.0	1,313

Table 14.11 (continued)

Background characteristic	When a wife refuses to have sex with her husband, he has the right to:				Percentage who agree with all of the specified reasons	Percentage who agree with none of the specified reasons	Number
	Get angry and reprimand her	Refuse her financial support	Use force to have sex	Have sex with another woman			
Region							
Honiara	9.7	17.4	3.8	3.2	0.2	73.7	240
Guadalcanal	13.7	7.7	6.3	5.8	3.0	81.7	249
Malaita	7.2	3.7	2.6	0.8	0.0	90.1	345
Western	35.8	32.2	37.7	33.1	6.1	38.3	181
Other provinces	14.0	5.5	2.4	2.2	0.6	82.2	599
Education							
No education	4.9	4.6	2.7	1.7	0.4	90.9	88
Primary	18.9	11.0	8.8	6.4	2.1	74.9	794
Secondary	11.1	10.1	7.0	6.4	0.7	77.9	593
More than secondary	7.5	9.6	2.0	5.4	1.1	83.7	138
Wealth quintile							
Lowest	16.9	3.6	6.0	4.1	1.1	80.8	281
Second	10.9	9.5	7.0	6.2	2.3	83.3	291
Middle	15.5	10.8	6.4	8.6	1.8	76.0	323
Fourth	13.3	10.8	8.6	4.0	1.0	77.0	353
Highest	14.8	14.7	7.8	7.3	0.9	72.7	366
Total 15–49	14.3	10.2	7.2	6.1	1.4	77.6	1,614
Total 50+	12.5	10.2	7.2	5.0	2.1	82.9	442
Total men 15+	13.9	10.2	7.2	5.8	1.5	78.8	2,056

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
Total includes seven cases with missing information on employment.

Table 14.11 shows the percentage of men who believe that a husband has the right to certain behaviours when his wife refuses to have sex with him. These behaviours include: getting angry and reprimanding her; refusing her financial support; using force to have sex; and having sex with another woman. A significant majority (77.6%) of men aged 15–49 do not agree with any of these behaviours, which is encouraging. Only 1.5% of men agree that a husband has the right to do all of these things if his wife refuses him sex. Nevertheless, 7.0% of men aged 15–49 believe that a husband has the right to force his wife to have sex if she refuses him. Marital rape is never justified and so this is an area where need further research. Men who have no education are less likely to support these behaviours than men who have some education, and further research is needed to understand why this is the case.

14.3.6 Women's empowerment indicators

The three sets of empowerment indicators — women's participation in making household decisions, their attitude toward wife beating, and their attitude toward a wife's right to refuse sexual intercourse with her husband/partner — can be summarised into three separate indices. The first index shows the number of decisions (see Table 14.5 for the list of decisions) in which women participate alone or jointly with their husband or partner. This index ranges in value from 0 to 4 and is positively related to women's empowerment. It reflects the degree of decision-making control that women are able to exercise in areas that affect their own lives and environments.

The second index, which ranges in value from 0 to 5, is the total number of reasons (see Table 14.7 for the list of reasons) for which the respondent feels that a husband is justified in beating his wife. A lower score on this indicator is interpreted as reflecting a greater sense of entitlement and self-esteem and a higher status of women.

The final index, which ranges in value from 0 to 3, is the number of circumstances (see Table 14.8 for the list of the circumstances) in which the respondent feels that a woman is justified in refusing sexual intercourse with her husband or partner. This indicator reflects perceptions of sexual roles and women's rights over their bodies and relates positively to women's sense of self and empowerment.

Table 14.12 shows how these three indicators of women's empowerment relate to each other, and how a higher level of empowerment or sense of entitlement or control in one indicator relates to a higher level of empowerment in another. For example, women who participate in making household decisions are also more likely to have gender-egalitarian beliefs. That is, women who participate in more household decisions are more likely to disagree with all justifications of wife-beating and agree with all justifications for refusing sex. Similarly, women who support fewer justifications for wife beating are more likely to participate in household decision making and are more likely to accept all justifications for refusing sex. This is important because it indicates that if we can affect change in one area of women's empowerment, this change can have additional effects in other areas of women's lives.

Table 14.12: Indicators of women's empowerment

Percentage of women aged 15–49 who participate in all decision making, percentage who disagree with all reasons for justifying wife-beating, and percentage who agree with all reasons for refusing sexual intercourse with husband, by value on each of the indicators of women's empowerment, Solomon Islands 2007

Empowerment indicator	Currently married women		Percentage who disagree with all the reasons justifying wife-beating	Percentage who agree with all the reasons for refusing sexual intercourse with husband	Number of women
	Percentage who participate in all decision making ¹	Number of women			
Number of decisions in which women participate ¹					
0	na	na	24.6	68.1	165
1–2	na	na	27.6	71.4	412
3–4	na	na	32.2	78.3	1,983
Number of reasons for which wife-beating is justified ²					
0	59.3	792	na	70.8	1,193
1–2	58.8	870	na	75.6	1,276
3–4	53.7	713	na	75.6	1,061
5	57.1	185	na	78.3	293
Number of reasons given for refusing to have sexual intercourse with husband ³					
0	68.7	136	45.8	na	245
1–2	48.1	464	32.1	na	737
3	58.8	1,959	29.7	na	2,841

¹ Restricted to currently married women. See Table 15.5.1 for the list of decisions.

² See Table 15.6.1 for the list of reasons.

³ See Table 15.7.1 for the list of reasons.

na = not applicable

14.4 CURRENT USE OF CONTRACEPTION BY WOMEN'S EMPOWERMENT STATUS

A woman's ability to control her fertility and choose a contraceptive method is likely to be affected by her status, self-image, and sense of empowerment. A woman who feels that she is unable to control other aspects of her life may be less likely to feel she can make decisions regarding fertility. She may also feel the need to choose methods that are easier to conceal from her husband or partner, or which do not depend on his cooperation.

Table 14.13 shows the relationship of each of the three indicators of women's empowerment with current use of contraceptive methods by currently married women aged 15–49 in Solomon Islands. It is evident from the data that women who do not participate in any household decisions are less likely to use contraception. Of the women who do not participate in making any household decisions, 22.6% use a contraceptive method compared with 38.7% of women who participate in making 1–2 household decisions, and 34.7% of women who participate in making 3–4 household decisions. In particular, women who do not participate in household decision making are much less likely to use condoms as a contraceptive method and instead use modern female methods that do not depend on her husband's or partner's cooperation.

The association between whether a woman agrees with any justifications of wife beating and her contraceptive use is less clear. Women who accepted all justifications of wife beating had a higher rate of contraceptive use (38.7%) than women who did not agree (32.9%) with any justifications of wife abuse. Similarly, the association between the number of justifications for refusing sex that a woman accepts and her use of family planning methods is also unclear. Women who reported 1–2 justifications for refusing sex had a higher contraceptive rate than women who reported all three justifications, which is not what is expected. However, the rate of condom use is significantly lower among women who do not agree with any justifications for refusing sex with

her husband. This indicates that a lack of control over when a woman has sex also contributes to her lack of control over condom use, which has implications for the transmission of HIV and STIs.

Table 14.13: Current use of contraception by women's status

Percent distribution of currently married women aged 15–49 by current contraceptive method, according to selected indicators of women's status, Solomon Islands 2007

Empowerment indicator	Any method	Modern methods					Any traditional method	Not currently using	Total	Number of women
		Any modern method	Female sterilisation	Male sterilisation	Temporary modern female methods ¹	Male condom				
Number of decisions in which women participate ²										
0	22.6	21.8	4.9	0.0	16.5	0.4	0.8	77.4	100.0	165
1–2	38.7	29.8	15.3	0.7	10.5	3.3	8.9	61.3	100.0	412
3–4	34.7	27.2	13.6	0.2	12.3	1.2	7.5	65.3	100.0	1,983
Number of reasons for which wife-beating is justified ³										
0	32.9	27.2	12.7	0.1	13.5	1.0	5.7	67.1	100.0	792
1–2	39.3	29.4	15.9	0.0	11.4	2.1	9.9	60.7	100.0	870
3–4	29.5	23.7	11.4	0.8	10.7	0.8	5.8	70.5	100.0	713
5	38.7	31.9	11.4	0.0	17.3	3.2	6.8	61.3	100.0	185
Number of reasons given for refusing to have sexual intercourse with husband ⁴										
0	36.5	34.2	17.3	0.0	16.9	0.0	2.3	63.5	100.0	136
1–2	42.6	33.1	17.1	0.4	13.8	1.9	9.4	57.4	100.0	464
3	32.5	25.4	12.1	0.2	11.6	1.5	7.1	67.5	100.0	1,959
Total	34.6	27.3	13.3	0.3	12.3	1.5	7.3	65.4	100.0	2,560

Note: If more than one method is used, only the most effective method is considered in this tabulation.

¹ Pill, IUD, injectables, implants, female condom, diaphragm, foam/jelly and lactational amenorrhea method

² See Table 15.5.1 for the list of decisions.

³ See Table 15.6.1 for the list of reasons

⁴ See Table 15.7.1 for the list of reasons

14.5 IDEAL FAMILY SIZE AND UNMET NEED FOR FAMILY PLANNING

As a woman becomes more empowered to negotiate fertility decision making, she has more control over contraceptive use and, thus, her chances of becoming pregnant and giving birth is lower. Table 14.14 shows how women's ideal family size and their unmet need for family planning vary by the three indicators of women's empowerment.

According to the table, the mean number of ideal children does not vary significantly with women's participation in household decision making, and is, in fact, slightly higher for women who do participate in decision making (3.7) compared with those who do not (3.6). However, women who participate in less household decisions have a greater unmet need for family planning for the spacing of children, although not for limiting children.

Table 14.14: Women's empowerment and ideal number of children and unmet need for family planning

Mean ideal number of children for women aged 15–49 and the percentage of currently married women aged 15–49 with an unmet need for family planning, by indicators of women's empowerment, Solomon Islands 2007

Empowerment indicator	Mean ideal number of children ¹	Number of women	Percentage of currently married women with an unmet need for family planning ²			Number of women
			For spacing	For limiting	Total	
Number of decisions in which women participate ³						
0	3.6	152	8.6	3.8	12.4	165
1–2	3.7	368	7.0	3.8	10.8	412
3–4	3.7	1,791	6.8	4.3	11.1	1,983
Number of reasons for which wife-beating is justified ⁴						
0	3.2	1,088	8.1	5.3	13.4	792
1–2	3.3	1,157	5.9	3.8	9.7	870
3–4	3.3	946	7.2	3.6	10.8	713
5	3.4	273	5.4	4.1	9.5	185
Number of reasons given for refusing to have sexual intercourse with husband ⁵						
0	2.8	200	10.7	5.8	16.5	136
1–2	3.2	633	12.1	2.4	14.5	464
3	3.4	2,632	5.4	4.5	10.0	1,959
Total	3.3	3,464	6.9	4.2	11.1	2,560

¹ Mean excludes respondents who gave non-numeric responses.

² See Table 7.3.1 for the definition of unmet need for family planning.

³ Restricted to currently married women. See Table 14.5 for the list of decisions.

⁴ See Table 14.7 for the list of reasons.

⁵ See Table 14.9 for the list of reasons.

The mean ideal number of children is positively correlated to the number of justifications that a woman supports for wife abuse. That is, as the number of justifications for wife beating goes up, so does the ideal number of children. However, the percentage of women who do not agree with any justification for wife beating who have unmet family planning needs is higher than those who do justify wife beating in some circumstances. This challenges the assumption that women who support violence have less control over family planning. However, it will be more significant to determine whether women who actually experience partner violence have less control over their reproductive health decisions.

The relationship between unmet family planning needs and women who believe that they are justified in refusing sex with their husband under certain circumstances is more expected. Women who support refusing sex under all three circumstances have the lowest unmet family planning need, indicating again that sexual autonomy has a significant impact on reproductive health.

14.6 WOMEN'S STATUS AND REPRODUCTIVE HEALTH CARE

Table 14.15 examines whether women's use of antenatal, delivery and postnatal care services from health workers varies by their level of empowerment as measured by the three indicators of empowerment. In societies where health care is widespread, women's empowerment may not affect their access to reproductive health services; in other societies, however, increased empowerment of women is likely to increase their ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe motherhood.

Table 14.15 indicates that the relationship between reproductive health care and women's participation in decision making is not clear or not what we would expect. For example, women who do not participate in any household decisions receive the highest percentage of postnatal care

within the first two days after delivery. The lowest proportion of women who receive delivery assistance from health personnel is among women who participate in the most household decisions. Because antenatal and delivery assistance are provided to most women in Solomon Islands, it's possible that the effect of indicators of empowerment are not so pronounced.

Women who are less likely to justify wife beating are more likely to receive antenatal care and receive delivery assistance from health personnel, although the differences are not significant. Probably the most significant difference is that women who support all three reasons for refusing sex with their husband are much more likely to receive postnatal care within the first two days after delivery.

Table 14.15: Reproductive health care by women's empowerment

Percentage of women aged 15–49 with a live birth in the five years preceding the survey who received antenatal care, delivery assistance and postnatal care from health personnel for the most recent birth, by indicators of women's empowerment, Solomon Islands 2007

Empowerment indicator	Received antenatal care from health personnel	Received delivery assistance from health personnel	Received postnatal care from health personnel within the first two days since delivery ¹	Number of women with a child born in the last five years
Number of decisions in which women participate²				
0	94.9	87.9	55.1	100
1–2	96.2	89.6	45.9	259
3–4	95.4	86.3	49.6	1,257
Number of reasons for which wife-beating is justified³				
0	96.7	89.4	46.8	594
1–2	94.7	89.6	52.7	566
3–4	93.8	83.2	44.6	490
5	94.7	81.6	53.8	149
Number of reasons given for refusing to have sexual intercourse with husband⁴				
0	88.3	86.7	35.9	104
1–2	94.8	87.7	35.9	342
3	95.7	87.0	52.9	1,352
Total	95.1	87.1	48.7	1,799

Note: 'Health personnel' include doctors, nurses, midwives, or auxiliary nurses or auxiliary midwives.

¹ Includes deliveries in a health facility and not in a health facility.

² Restricted to currently married women. See Table 14.5 for the list of decisions.

³ See Table 14.7 for the list of reasons.

⁴ See Table 14.9 for the list of reasons.

14.7 KEY RESULTS

The following details the main findings of the 2006/2007 SIDHS Women's Questionnaire.

- There is still significant gender disparity in the employment participation rates of men and women in Solomon Islands, with women working less than men and also not being paid for the work that they do more often than men.
- Most household decisions are made jointly by the husband and wife, however, between 15.8% and 28.8% of women do not participate in certain household decisions.
- The majority of women and men agree with at least one justification for a husband beating his wife. Such findings are of concern because they indicate that the subordinate status of women within the marital relationship is generally accepted.
- Community education and advocacy should promote an understanding that violence against women is not justifiable under any circumstances. In order to promote this ideal, laws also need to be changed.
- The majority of women have a relatively high level of sexual autonomy, however a number of women also believe that they cannot refuse sex with their husband under certain circumstances.
- About 7% of men aged 15–49 believe that a husband has the right to force his wife to have sex if she refuses him. This is of concern because marital rape is never justified, and this is an area where education efforts should be targeted.
- Interestingly, men with no education are much less likely to believe that violence is justified, and less likely to support men's right to beat their wives if they refuse to have sex. Younger men are also more likely to justify partner violence against women than older men, perhaps indicating a conservative revival among younger generations. Both of these findings need to be examined in greater detail because they challenge our expectations. They highlight the importance of including gender equality and women's rights in the educational programmes of boys in particular.
- The three indicators of women's empowerment are found relate to each other. A higher level of empowerment or sense of entitlement or control in one area relates to a higher level of empowerment in another. This is important because it indicates that if we can affect change in one area of women's empowerment, this change can have additional effects in other areas of women's lives.
- Women who do not participate in any household decisions are less likely to use contraception than women who do. In particular, women who do not participate in household decisions are much less likely to use condoms as a contraceptive method and instead use modern female methods that do not depend on their husband's or partner's cooperation. This has significant implications for women's reproductive health and, in particular, the transmission of STIs. Women's empowerment within the home should therefore be promoted in programmes that target reproductive health.
- Older women, women who are employed, women who are more educated, and women living in urban areas are more likely to have higher indicators of empowerment such as participating in household decisions.
- Policies should focus on improving women's livelihoods, increasing women's education and providing educational and advocacy programmes in rural areas where patriarchal ideologies appear to be stronger.

REFERENCES

- Australian Government, 2004. Solomon Islands – Rebuilding an Island Economy; www.dfat.gov.au/eau, Canberra, Commonwealth of Australia
- de Onis, Mercedes, A.W. Onyango, E. Borghi, C. Garza, and H. Yang. 2006. *Comparison of the WHO*
- Child Growth Standards and the National Center for Health Statistics/WHO International Growth Reference: Implications for Child Health Programs*. Public Health Nutrition 9 (7).
- Filmer, D. and L. Pritchett. 1998. Estimating wealth effects without expenditure data – or tears: An application to educational enrollments in states of India. World Bank Policy Research Working Paper No. 1994. Development Economics Research Group (DECRG), World Bank, Washington, DC.
- Garcia-Moreno C, Jansen HEF, Ellsberg M., Heise L, Watts CH (2005) The Who multi-country study on women's health and domestic violence against women: initial findings on prevalence, health consequences and women's responses WHO/WHD.
- Government of Papua New Guinea. 1997. 1996 Papua New Guinea demographic and health survey: Final report. National Statistical Office, Port Moresby.
- Government of Solomon Islands, 1999 Census Analytical Report, Honiara, Solomon Islands.
- Heise L, Raikes A, Watts CH and Zwi AB (1994) Violence against women: a neglected public health issue in less developed countries Social Science and Medicine 39(9) 1165–1179.
- JS Garrow, WPT James & A Ralph. *Human Nutrition and Dietetics*. 10th edition . 2000. Church Livingston, UK
- L Kathleen Mahan & Sylvia Escott-Stump. *Krause's Food, Nutrition and Diet Therapy*. 10th Edition. 2000. WB Saunders Company, Philadelphia, USA.
- Ministry of Health and National Statistics Office, Timor Leste (Indonesia) and the University of Newcastle, the Australian National University, and ACIL Australia Pty Ltd, Australia. 2004. Timor-Leste 2003 Demographic and Health Survey. Newcastle, Australia: University of Newcastle.
- Ministry of Health and Population Nepal, 2006. Nepal Demographic and Health Survey Report 2006. Kathmandu, Nepal: New ERA, and Macro International
- National Statistical Service (Armenia), Ministry of Health (Armenia), and ORC Macro. 2006. Armenia Demographic Health Survey 2005. Claverton, Maryland, USA: National Statistical Service, Ministry of Health, and ORC Macro.
- RG Hughes et al. *Environmental influences on helminthiasis and nutritional status among Pacific school children*. International Journal of Environmental Health Research 2004: 14(3); 163–177
- Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. Uganda Demographic and Health Survey 2006. Maryland, USA: UBOS and Macro International Inc.
- UNAIDS/07.12E/JC1318E. 2005. Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2008 reporting. Geneva, Switzerland. UNAIDS.
- UNAIDS/07.15E/JC1338E. 2007. A framework for monitoring and evaluating HIV prevention programs for most-at-risk populations. Geneva, Switzerland. UNAIDS.
- WHO. *Iron deficiency anaemia assessment, prevention and control. A guide for programme managers*. 2001. WHO, Geneva.

- WHO-UNICEF. *Global Strategy on Infant and Young Child Feeding*. 2003. www.unicef.org www.who.org
- World Health Organization Multicentre Growth Reference Study Group. 2006. WHO Child Growth Standards: Length/height-for-age, Weight-for-age, Weight-for-length, Weight-for-height, and Body Mass Index-for-age: Methods and Development. Geneva: WHO.
- World Health Organisation, 2006. Second Generation Surveys of HIV, other STI's and risk behaviours in 6 Pacific Island Countries (2004-2005).
- World Health Organization (WHO). 2005. Guiding principles for feeding non-breastfed children 6–24 months of age. Geneva: World Health Organization.
- World Health Organization 2006. *WHO Child Growth Standards*. <http://www.who.int/childgrowth/en/>

APPENDIX A: SAMPLE IMPLEMENTATION

Table A.1: Sample implementation — Women

Percent distribution of households and eligible women by results of the household and individual interviews, and household, eligible women and overall response rates, according to urban-rural residence and region, Solomon Islands 2007

Result	Residence		Region					Total
	Urban	Rural	Honiara	Guadalcanal	Malaita	Western	Other provinces	
Selected households								
Completed (C)	85.6	91.7	85.1	88.2	95.7	89.6	93.3	89.7
Household present but no competent respondent at home (HP)	2.6	2.6	2.5	4.2	1.0	4.6	1.3	2.6
Postponed (P)	0.1	0.2	0.1	0.7	0.0	0.0	0.0	0.2
Refused (R)	5.5	2.0	5.8	1.7	1.2	2.4	2.6	3.1
Household absent (HA)	3.2	2.5	3.2	3.0	1.7	2.6	2.6	2.8
Dwelling vacant/address not a dwelling (DV)	0.3	0.1	0.3	0.0	0.2	0.4	0.0	0.2
Dwelling destroy (DD)	0.2	0.0	0.2	0.1	0.0	0.0	0.0	0.1
Other (O)	2.5	0.8	2.7	2.0	0.2	0.4	0.1	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of sampled households	1,177	2,455	1,077	755	580	460	760	3,632
Household response rate (HRR) ¹	91.2	95.0	91.0	93.0	97.7	92.8	95.9	93.8
Eligible women								
Completed (EWC)	79.3	92.0	79.5	89.5	94.7	85.7	93.5	86.7
Not at home (EWNH)	5.6	2.4	5.4	4.4	0.9	5.1	1.1	3.7
Postponed (EWP)	0.3	0.3	0.3	0.5	0.0	0.0	0.5	0.3
Refused (EWR)	9.5	2.2	9.4	1.6	2.2	4.5	2.9	5.3
Partly completed (EWPC)	0.2	0.2	0.1	0.4	0.0	0.4	0.2	0.2
Incapacitated (EWI)	0.4	1.2	0.3	0.7	0.8	1.7	1.6	0.8
Other (EWO)	4.7	1.7	5.0	2.9	1.4	2.6	0.2	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1,844	2,565	1,715	752	644	467	831	4,409
Eligible women response rate (EWRR) ²	79.3	92.0	79.5	89.5	94.7	85.7	93.5	86.7
Overall response rate (ORR) ³	72.4	87.4	72.3	83.2	92.6	79.5	89.7	81.3

¹ Using the number of households falling into specific response categories, the household response rate (HRR) is calculated as:

$$100 * C$$

$$C + HP + P + R + DNF$$

² Using the number of eligible women falling into specific response categories, the eligible woman response rate (EWRR) is calculated as:

$$100 * EWC$$

$$EWC + EWNH + EWP + EWR + EWPC + EWI + EWO$$

³ The overall response rate (ORR) is calculated as:

$$ORR = HRR * EWRR/100$$

Table A.1.1: Sample implementation — Men

Percent distribution of households and eligible men by results of the household and individual interviews, and household, eligible men and overall response rates, according to urban-rural residence and region, Solomon Islands 2007

Result	Residence		Region					Total
	Urban	Rural	Honiara	Guadalcanal	Malaita	Western	Other provinces	
Selected households								
Completed (C)	87.8	91.9	86.8	88.9	96.6	89.6	93.4	90.5
Household present but no competent respondent at home (HP)	2.2	2.7	2.4	4.0	1.4	3.9	1.3	2.5
Postponed (P)	0.0	0.2	0.0	0.8	0.0	0.0	0.0	0.2
Refused (R)	4.8	2.1	5.0	1.9	0.7	3.0	2.9	3.0
Household absent (HA)	2.7	2.1	3.0	2.1	1.4	2.2	2.4	2.3
Dwelling vacant/address not a dwelling (DV)	0.3	0.2	0.4	0.0	0.0	0.9	0.0	0.2
Dwelling destroy (DD)	0.0	0.1	0.0	0.3	0.0	0.0	0.0	0.1
Other (O)	2.2	0.7	2.4	2.1	0.0	0.4	0.0	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of sampled households	589	1,227	539	377	290	230	380	1,816
Household response rate (HRR) ¹	92.7	94.8	92.1	93.1	97.9	92.8	95.7	94.1
Eligible men								
Completed (EMC)	73.6	83.5	74.3	81.3	86.1	77.4	83.6	79.1
Not at home (EMNH)	10.5	6.8	9.5	8.5	3.3	13.2	7.2	8.4
Postponed (EMP)	0.3	0.2	0.4	0.2	0.5	0.0	0.0	0.3
Refused (EMR)	8.5	3.1	8.8	1.5	3.5	3.4	4.1	5.5
Partly completed (EMPC)	0.2	0.0	0.2	0.0	0.0	0.0	0.0	0.1
Incapacitated (EMI)	1.0	2.4	0.9	1.9	2.7	2.6	2.3	1.8
Other (EMO)	5.9	4.0	5.9	6.6	3.8	3.4	2.7	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of men	1,143	1,455	1,071	411	367	266	483	2,598
Eligible men response rate (EMRR) ²	73.6	83.5	74.3	81.3	86.1	77.4	83.6	79.1
Overall response rate (ORR) ³	68.2	79.2	68.5	75.6	84.3	71.9	80.0	74.5

¹ Using the number of households falling into specific response categories, the household response rate (HRR) is calculated as:

$$\frac{100 \times C}{C + HP + P + R + DNF}$$

² Using the number of eligible women falling into specific response categories, the eligible woman response rate (EWRR) is calculated as:

$$\frac{100 \times EWC}{EWC + EWNH + EWP + EWR + EWPC + EWI + EWO}$$

³ The overall response rate (ORR) is calculated as:

$$ORR = HRR \times EWRR/100$$

APPENDIX B: ESTIMATES OF SAMPLING ERRORS

Estimates of sampling errors

The main objective of a DHS survey is to provide estimates of a number of basic demographic and health variables through interviews with a scientifically selected probability sample chosen from a well-defined population: women of reproductive age (15–49). Estimates from a sample survey are affected by two types of errors: non-sampling and sampling. Non-sampling errors are the results of mistakes made in implementing data collection and data processing, such as failure to locate and interview the correct household, misunderstanding of the questions on the part of either the interviewer or the respondent, and data entry errors. Although numerous efforts were made during the implementation of the 2006/2007 Solomon Islands Demographic and Health Survey (SIDHS) to minimise this type of error, non-sampling errors are impossible to avoid and difficult to evaluate statistically.

Sampling errors, on the other hand, can be evaluated statistically. The sample of respondents selected in the 2006/2007 SIDHS is only one of many samples that could have been selected from the same population, using the same design and expected size. Each of these samples would yield results that differ somewhat from the results of the actual sample selected. Sampling errors are a measure of the variability between all possible samples. Although the degree of variability is not known exactly, it can be estimated from the survey results.

Sampling errors are the errors that result from taking a sample of the covered population through a particular sample design. Non-sampling errors are systematic errors that would be present even if the entire population was covered (e.g. response errors, coding and data entry errors, etc.).

For the entire covered population and for large subgroups, the SIDHS sample is generally sufficiently large to provide reliable estimates. For such populations the sampling error is small and less important than the non-sampling error. However, for small subgroups, sampling errors become very important in providing an objective measure of reliability of the data.

Variables for reporting sampling error

Sampling errors will be displayed for total, urban and rural and each sample domain only. No other panels should be included in the sampling error table. The choice of variables for which sampling error computations will be done depends on the priority given to specific variables. However, it is recommended that sampling errors be calculated for at least the following variables.

Table B.1: List of selected variables for sampling errors, Solomon Islands 2007

Variable	Estimate	Base population
Urban	Proportion	All women
Literate	Proportion	All women
No education	Proportion	All women and all men
Secondary education	Proportion	All women and all men
Net attendance ratio	Ratio	Children aged 7–12 years (modify age according to country)
Never married	Proportion	All women and all men
Currently married	Proportion	All women and all men
Married before age 20	Proportion	Women aged 20–49 and men aged 20–54
Had sexual intercourse before age 18	Proportion	All women and all men
Currently pregnant	Proportion	All women
Children ever born	Mean	All women and all men
Children surviving	Mean	All women
Children ever born to women aged 40–49	Mean	Women aged 40–49
Total fertility rate (three years)	Rate	All women
Know any contraceptive method	Proportion	Currently married women and currently married men
Ever used any contraceptive method	Proportion	Currently married women
Currently using any contraceptive method	Proportion	Currently married women
Currently using pill	Proportion	Currently married women
Currently using IUD	Proportion	Currently married women
Currently using female sterilisation	Proportion	Currently married women
Currently using periodic abstinence	Proportion	Currently married women
Used public sector source	Proportion	Current users of modern methods
Want no more children	Proportion	Currently married women and currently married men
Want to delay birth at least twoyears	Proportion	Currently married women and currently married men
Ideal family size	Mean	All women and all men
Perinatal mortality (0–4 years)	Ratio	Number of pregnancies of 7+ months
Neonatal mortality (0–4 years)	Rate	Children exposed to the risk of mortality
Post-neonatal mortality (0–4 years)	Rate	Children exposed to the risk of mortality
Infant mortality (0–4 years)	Rate	Children exposed to the risk of mortality
Infant mortality (5–9 years)	Rate	Children exposed to the risk of mortality
Infant mortality (10–14 years)	Rate	Children exposed to the risk of mortality
Child mortality (0–4 years)	Rate	Children exposed to the risk of mortality
Under-5 mortality (0–4 years)	Rate	Children exposed to the risk of mortality
Mothers received tetanus injection for last birth	Proportion	Women with at least one live birth in five years before survey
Mothers received medical assistance at delivery	Proportion	Births occurring 1–59 months before interview
Having diarrhoea in two weeks before survey	Proportion	Children age 0–59 months
Treated with oral rehydration salts	Proportion	Children with diarrhoea in two weeks before interview
Taken to a health provider	Proportion	Children with diarrhoea in two weeks before interview
Vaccination card seen	Proportion	Children aged 12–23 months
Received BCG	Proportion	Children aged 12–23 months
Received DPT (3 doses)	Proportion	Children aged 12–23 months
Received Polio (3 doses)	Proportion	Children aged 12–23 months
Received measles	Proportion	Children aged 12–23 months
Height-for-age (-2SD)	Proportion	Children aged 0–59 months
Weight-for-height (-2SD)	Proportion	Children aged 0–59 months
Weight-for-age (-2SD)	Proportion	Children aged 0–59 months
Anaemic	Proportion	Children aged 6–59 months
Anaemic	Proportion	All women
BMI <18.5	Proportion	All women
Had 2+ sexual partners in past 12 months	Proportion	All women and all men
Had higher-risk intercourse (with a non-marital, non-cohabitating partner) in past 12 months	Proportion	All women and all men who had sexual intercourse in past 12 months
Condom use at last higher-risk intercourse	Proportion	All women and all men who had higher-risk intercourse in past 12 months

Condom use at last higher-risk intercourse (youth)	Proportion	All women and all men aged 15–24 who had higher-risk intercourse in past 12 months
Abstinence among youth (never had intercourse)	Proportion	Women aged 15–24 and men aged 15–24
Sexually active in past 12 months among never-married youth	Proportion	Women aged 15–24 and men aged 15–24
Paid for sexual intercourse in past 12 months	Proportion	All men
Had an injection in past 12 months	Proportion	All women and all men
Had HIV test and received results in past 12 months	Proportion	All women and all men
Accepting attitudes towards people with HIV	Proportion	All women and all men who have heard of HIV/AIDS
HIV prevalence (15–49)	Proportion	All women and all men who were tested for HIV
HIV prevalence (15–54) (15–59)	Proportion	All men aged 15–54 who were tested for HIV

For the 2006/2007 SIDHS, report, sampling errors for selected variables have been presented in a tabular format. The sampling error tables should include:

Variable name:

- R: Value of the estimate;
- SE: Sampling error of the estimate;
- N: Un-weighted number of cases on which the estimate is based;
- WN: Weighted number of cases;
- DEFT: Design effect value that compensates for the loss of precision that results from using cluster rather than simple random sampling;
- SE/R: Relative standard error (i.e. the ratio of the sampling error to the value estimate);
- R-2SE: Lower limit of the 95% confidence interval;
- R+2SE: Upper limit of the 95% confidence interval (never >1.000 for a proportion).

Sampling errors are usually measured in terms of the *standard error* for a particular statistic (mean, percentage, etc.), which is the square root of the variance. The standard error can be used to calculate confidence intervals within which the true value for the population can reasonably be assumed to fall. For example, for any given statistic calculated from a sample survey, the value of that statistic will fall within a range of plus or minus two times the standard error of that statistic in 95% of all possible samples of identical size and design.

If the sample of respondents had been selected by simple random sampling, it would have been possible to use straightforward formulas for calculating sampling errors. However, the 2006/2007 SIDHS sample was the result of a multistage stratified design, and, consequently, it is necessary to use more complex formulae. The computer software used to calculate sampling errors for the 2006/2007 SIDHS is the ISSA Sampling Error Module. This module uses the Taylor linearisation method of variance estimation for survey estimates that are means or proportions. The Jackknife repeated replication method is used for variance estimation of more complex statistics such as fertility and mortality rates.

The Taylor linearisation method treats any percentage or average as a ratio estimate, $r = y/x$, where y represents the total sample value for variable y , and x represents the total number of cases in the group or subgroup under consideration. The variance of r is computed using the formula given below, with the standard error being the square root of the variance:

$$SE^2(r) = \text{var}(r) = \frac{1-f}{x^2} \sum_{h=1}^H \left[\frac{m_h}{m_h - 1} \left(\sum_{i=1}^{m_h} z_{hi}^2 - \frac{z_h^2}{m_h} \right) \right]$$

in which,

$$z_{hi} = y_{hi} - rx_{hi}, \text{ and } z_h = y_h - rx_h$$

where h represents the stratum which varies from 1 to H ,
 m_h is the total number of clusters selected in the h^{th} stratum,
 y_{hi} is the sum of the weighted values of variable y in the i^{th} cluster in the h^{th} stratum,
 x_{hi} is the sum of the weighted number of cases in the i^{th} cluster in the h^{th} stratum, and
 f is the overall sampling fraction, which is so small that it is ignored.

The Jackknife repeated replication method derives estimates of complex rates from each of several replications of the parent sample, and calculates standard errors for these estimates using simple formulae. Each replication considers all but one cluster in the calculation of the estimates. Pseudo-independent replications are thus created. In the 2006/2007 SIDHS, there were 182 non-empty clusters. Hence, 182 replications were created. The variance of a rate r is calculated as follows:

$$SE^2(r) = \text{var}(r) = \frac{1}{k(k-1)} \sum_{i=1}^k (r_i - r)^2$$

in which,

$$r_i = kr - (k-1)r_{(i)}$$

where r is the estimate computed from the full sample of 182 clusters,
 $r_{(i)}$ is the estimate computed from the reduced sample of 181 clusters (i^{th} cluster excluded), and
 k is the total number of clusters.

In addition to the standard error, Integrated Sample Survey Analysis (ISSA) Software Program computes the design effect (DEFT) for each estimate, which is defined as the ratio between the standard error using the given sample design and the standard error that would result if a simple random sample had been used. A DEFT value of 1.0 indicates that the sample design is as efficient as a simple random sample, while a value greater than 1.0 indicates the increase in the sampling error due to the use of a more complex and less statistically efficient design. ISSA also computes the relative error and confidence limits for the estimates.

Sampling errors for the 2006/2007 SIDHS are calculated for selected variables considered to be of primary interest for the women's survey and for men's surveys, respectively. The results are presented in this appendix for the country as a whole, and for urban and rural areas. For each variable, the type of statistic (mean, proportion, or rate) and the base population are given in Table B.1. Tables B.2 to B.9 present the value of the statistic (R), its standard error (SE), the number of unweighted (N) and weighted (WN) cases, the design effect ($DEFT$), the relative standard error (SE/R), and the 95% confidence limits ($R \pm 2SE$), for each variable. The $DEFT$ is considered

undefined when the SE considering simple random sample is zero (when the estimate is close to 0 or 1). In the case of the total fertility rate, the number of unweighted cases is not relevant, as there is no known unweighted value for woman-years of exposure to childbearing.

The confidence interval (example, as calculated for *children ever born to women aged 40–49*) can be interpreted as follows: the overall average from the national sample is 4.993 and its SE is 0.145. Therefore, to obtain the 95% confidence limits, one adds and subtracts twice the standard error to the sample estimate (i.e. $4.993 \pm 2 \times 0.145$). There is a high probability (95%) that the *true* average number of children ever born to all women aged 40–49 is between 4.703 and 5.283.

Sampling errors are analysed for the national woman sample and for two separate groups of estimates: 1) means and proportions, and 2) complex demographic rates. The SE/R for the means and proportions range between 0.9% and 27.5%; the highest SE/Rs are for estimates of very low values (e.g. *currently using IUD*). So in general, the SE/R for most estimates for the country as a whole is small, except for estimates of very small proportions. However, for mortality rates, the averaged SE/R for the five-year period mortality rates is generally higher than those related to the 10-year estimates. There are differentials in the SE/R for the estimates of sub-populations. For example, for the variable *want no more children*, the SE/Rs as a percent of the estimated mean for the whole country, and for the urban areas are 3.9% and 6.2%, respectively.

Table B.2 Sampling Errors for total women, Solomon Islands 2007

Variable	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
Urban residence	0.166	0.02	3823	3823	3.346	0.121	0.126	0.207
Literate	0.784	0.017	3823	3823	2.609	0.022	0.749	0.819
No education	0.136	0.015	3823	3823	2.694	0.11	0.106	0.166
Secondary education or higher	0.311	0.016	3823	3823	2.201	0.053	0.278	0.344
Net attendance ratio for primary school	0.606	0.013	4023	3862	1.619	0.022	0.58	0.633
Never married	0.294	0.016	3823	3823	2.17	0.054	0.262	0.326
Currently married/in union	0.67	0.016	3823	3823	2.119	0.024	0.637	0.702
Married before age 20	0.474	0.019	3087	3136	2.104	0.04	0.436	0.512
Had sexual intercourse before age 18	0.476	0.023	3087	3136	2.533	0.048	0.43	0.521
Currently pregnant	0.06	0.005	3823	3823	1.368	0.088	0.049	0.07
Children ever born	2.516	0.084	3823	3823	2.11	0.033	2.349	2.683
Children surviving	2.414	0.075	3823	3823	1.966	0.031	2.264	2.563
Children ever born to women age 40-49	4.993	0.145	553	609	1.446	0.029	4.703	5.283
Knows any contraceptive method	0.944	0.01	2482	2560	2.264	0.011	0.923	0.965
Knowing any modern method	0.94	0.011	2482	2560	2.221	0.011	0.919	0.962
Ever using contraceptive method	0.587	0.028	2482	2560	2.868	0.048	0.53	0.643
Currently using any contraceptive method	0.346	0.021	2482	2560	2.249	0.062	0.303	0.389
Currently using modern method	0.273	0.018	2482	2560	1.964	0.064	0.238	0.308
Currently using pill	0.013	0.004	2482	2560	1.576	0.273	0.006	0.021
Currently using condom	0.015	0.004	2482	2560	1.548	0.255	0.007	0.022
Currently using injectables	0.088	0.008	2482	2560	1.427	0.092	0.072	0.104
Currently using IUD	0.021	0.006	2482	2560	1.99	0.275	0.009	0.032
Currently using female sterilization	0.133	0.018	2482	2560	2.69	0.138	0.096	0.17
Currently using rhythm method	0.047	0.012	2482	2560	2.765	0.249	0.024	0.071
Obtained method from public sector source	0.829	0.027	635	782	1.833	0.033	0.774	0.884
Want no more children	0.484	0.019	2482	2560	1.898	0.039	0.446	0.522
Want to delay birth at least 2 years	0.167	0.014	2482	2560	1.934	0.087	0.138	0.196
Ideal family size	3.294	0.053	3473	3464	1.994	0.016	3.188	3.4
Mothers received tetanus injection for last birth	0.259	0.018	1750	1799	1.732	0.069	0.224	0.295
Mothers received medical assistance at delivery	0.701	0.023	2594	2668	2.192	0.033	0.655	0.748
Had diarrhoea in two weeks before survey	0.094	0.015	2513	2585	2.49	0.157	0.064	0.124
Treated with oral rehydration salts (ORS)	0.377	0.037	206	243	1.151	0.097	0.304	0.451
Taken to a health provider	0.598	0.056	206	243	1.745	0.093	0.487	0.71
Vaccination card seen	0.822	0.025	548	557	1.568	0.031	0.771	0.872
Received BCG	0.947	0.014	548	557	1.456	0.015	0.919	0.975
Received DPT (3 doses)	0.867	0.023	548	557	1.62	0.027	0.82	0.914
Received polio (3 doses)	0.858	0.023	548	557	1.559	0.027	0.811	0.904
Received measles	0.888	0.022	548	557	1.675	0.025	0.843	0.932
Fully immunized	0.832	0.025	548	557	1.578	0.03	0.781	0.882
Height-for-age (below -2SD)	0.328	0.017	2078	2029	1.577	0.053	0.293	0.363
Weight-for-height (below -2SD)	0.043	0.006	2078	2029	1.386	0.15	0.03	0.056
Weight-for-age (below -2SD)	0.118	0.014	2078	2029	1.772	0.117	0.091	0.146
Use condom at last high risk sex	0.177	0.033	391	411	1.717	0.187	0.111	0.244
Use condom at last high risk sex - 15-24	0.165	0.039	310	334	1.85	0.237	0.087	0.243
Two or more sexual partners	0.035	0.011	2594	2728	3.161	0.328	0.012	0.057
Had High risk Intercourse	0.151	0.018	2595	2729	2.496	0.116	0.116	0.186
Abstinence among youth (never had sex)	0.45	0.042	1011	928	2.655	0.092	0.367	0.533
Sexually active last 12 months never married youth	0.356	0.032	1011	928	2.111	0.089	0.292	0.42
Had injection last 12 months	0.116	0.009	3823	3823	1.73	0.077	0.098	0.134
Has heard of HIV	0.942	0.009	3823	3823	2.295	0.009	0.925	0.96
Accepting attitudes to people with HIV	0.047	0.008	3639	3603	2.161	0.162	0.032	0.062
HIV test and result in last 12 months	0	0	3823	3823	-	-	0	0

Table B.3: Sampling errors for urban women sample, Solomon Islands 2007

Variable	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
Urban residence	1	0	1463	636	-	0	1	1
Literate	0.862	0.017	1463	636	1.929	0.02	0.827	0.897
No education	0.078	0.01	1463	636	1.403	0.126	0.058	0.098
Secondary education or higher	0.551	0.031	1463	636	2.397	0.057	0.489	0.613
Net attendance ratio for primary school	0.652	0.022	1186	452	1.475	0.033	0.609	0.695
Never married	0.372	0.024	1463	636	1.859	0.063	0.325	0.419
Currently married/in union	0.585	0.024	1463	636	1.882	0.041	0.537	0.634
Married before age 20	0.368	0.031	1147	500	2.141	0.083	0.307	0.429
Had sexual intercourse before age 18	0.312	0.024	1147	500	1.743	0.076	0.265	0.36
Currently pregnant	0.051	0.008	1463	636	1.307	0.147	0.036	0.066
Children ever born	1.868	0.072	1463	636	1.273	0.038	1.725	2.012
Children surviving	1.819	0.073	1463	636	1.331	0.04	1.673	1.965
Children ever born to women age 40-49	4.855	0.228	161	71	1.268	0.047	4.398	5.312
Knows any contraceptive method	0.92	0.019	842	372	2.026	0.021	0.882	0.958
Knowing any modern method	0.916	0.02	842	372	2.068	0.022	0.876	0.955
Ever using contraceptive method	0.486	0.033	842	372	1.886	0.067	0.421	0.551
Currently using any contraceptive method	0.293	0.033	842	372	2.126	0.114	0.227	0.36
Currently using modern method	0.232	0.018	842	372	1.227	0.077	0.197	0.268
Currently using pill	0.022	0.007	842	372	1.359	0.313	0.008	0.036
Currently using condom	0.023	0.01	842	372	1.949	0.44	0.003	0.043
Currently using injectables	0.042	0.007	842	372	1.08	0.178	0.027	0.057
Currently using IUD	0.035	0.007	842	372	1.136	0.207	0.02	0.049
Currently using female sterilization	0.102	0.013	842	372	1.241	0.127	0.076	0.128
Currently using rhythm method	0.032	0.011	842	372	1.814	0.344	0.01	0.054
Obtained method from public sector source	0.765	0.066	207	103	2.222	0.086	0.633	0.896
Want no more children	0.367	0.023	842	372	1.371	0.062	0.321	0.412
Want to delay birth at least 2 years	0.154	0.012	842	372	0.934	0.076	0.131	0.177
Ideal family size	3.029	0.054	1389	606	1.278	0.018	2.92	3.138
Mothers received tetanus injection for last birth	0.264	0.023	551	236	1.19	0.085	0.219	0.309
Mothers received medical assistance at delivery	0.898	0.015	768	330	1.172	0.016	0.869	0.928
Had diarrhoea in two weeks before survey	0.094	0.02	743	319	1.767	0.214	0.054	0.134
Treated with oral rehydration salts (ORS)	0.399	0.053	64	30	0.809	0.132	0.294	0.505
Taken to a health provider	0.49	0.082	64	30	1.256	0.167	0.327	0.654
Vaccination card seen	0.743	0.039	156	66	1.103	0.053	0.665	0.821
Received BCG	0.982	0.009	156	66	0.848	0.009	0.964	1
Received DPT (3 doses)	0.866	0.036	156	66	1.308	0.042	0.794	0.938
Received polio (3 doses)	0.833	0.032	156	66	1.05	0.038	0.769	0.896
Received measles	0.941	0.018	156	66	0.947	0.019	0.905	0.977
Fully immunized	0.798	0.042	156	66	1.283	0.052	0.714	0.882
Height-for-age (below -2SD)	0.23	0.021	591	209	1.159	0.091	0.188	0.272
Weight-for-height (below -2SD)	0.034	0.01	591	209	1.264	0.284	0.015	0.054
Weight-for-age (below -2SD)	0.082	0.016	591	209	1.349	0.195	0.05	0.114
Use condom at last high risk sex	0.081	0.026	173	81	1.248	0.32	0.029	0.133
Use condom at last high risk sex - 15-24	0.099	0.033	135	61	1.281	0.333	0.033	0.166
Two or more sexual partners	0.031	0.008	926	411	1.469	0.269	0.014	0.048
Had High risk Intercourse	0.196	0.03	927	412	2.265	0.151	0.136	0.255
Abstinence among youth (never had sex)	0.488	0.042	484	205	1.865	0.087	0.403	0.573
Sexually active last 12 months never married youth	0.306	0.038	484	205	1.816	0.125	0.23	0.382
Had injection last 12 months	0.102	0.016	1463	636	2.008	0.156	0.07	0.133
Has heard of HIV	0.991	0.003	1463	636	1.041	0.003	0.986	0.996
Accepting attitudes to people with HIV	0.065	0.011	1444	630	1.643	0.164	0.043	0.086
HIV test and result in last 12 months	0	0	1463	636	-	-	0	0

Table B.4: Sampling errors for rural women sample, Solomon Islands 2007

Variable	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
Urban residence	0	0	2360	3187	-	-	0	0
Literate	0.769	0.021	2360	3187	2.397	0.027	0.727	0.81
No education	0.148	0.018	2360	3187	2.486	0.123	0.111	0.184
Secondary education or higher	0.263	0.018	2360	3187	1.951	0.067	0.228	0.299
Net attendance ratio for primary school	0.6	0.015	2837	3410	1.51	0.024	0.571	0.63
Never married	0.279	0.019	2360	3187	2.04	0.068	0.241	0.316
Currently married/in union	0.686	0.019	2360	3187	1.99	0.028	0.648	0.724
Married before age 20	0.494	0.021	1940	2635	1.862	0.043	0.452	0.537
Had sexual intercourse before age 18	0.507	0.025	1940	2635	2.207	0.049	0.457	0.557
Currently pregnant	0.061	0.006	2360	3187	1.248	0.101	0.049	0.074
Children ever born	2.645	0.098	2360	3187	1.919	0.037	2.449	2.841
Children surviving	2.532	0.088	2360	3187	1.791	0.035	2.357	2.708
Children ever born to women age 40-49	5.011	0.161	392	537	1.346	0.032	4.689	5.333
Knows any contraceptive method	0.948	0.012	1640	2187	2.154	0.012	0.924	0.972
Knowing any modern method	0.945	0.012	1640	2187	2.102	0.013	0.921	0.968
Ever using contraceptive method	0.604	0.032	1640	2187	2.64	0.053	0.54	0.667
Currently using any contraceptive method	0.354	0.024	1640	2187	2.04	0.068	0.306	0.403
Currently using modern method	0.28	0.02	1640	2187	1.808	0.072	0.24	0.32
Currently using pill	0.012	0.004	1640	2187	1.526	0.344	0.004	0.02
Currently using condom	0.013	0.004	1640	2187	1.412	0.301	0.005	0.021
Currently using injectables	0.096	0.009	1640	2187	1.293	0.098	0.077	0.115
Currently using IUD	0.018	0.007	1640	2187	1.968	0.357	0.005	0.031
Currently using female sterilization	0.138	0.021	1640	2187	2.474	0.153	0.096	0.18
Currently using rhythm method	0.05	0.014	1640	2187	2.529	0.272	0.023	0.077
Obtained method from public sector source	0.839	0.03	428	678	1.659	0.035	0.78	0.898
Want no more children	0.504	0.021	1640	2187	1.699	0.042	0.462	0.546
Want to delay birth at least 2 years	0.17	0.017	1640	2187	1.824	0.1	0.136	0.204
Ideal family size	3.35	0.063	2084	2858	1.847	0.019	3.225	3.476
Mothers received tetanus injection for last birth	0.259	0.02	1199	1562	1.578	0.079	0.218	0.299
Mothers received medical assistance at delivery	0.674	0.026	1826	2338	1.94	0.038	0.622	0.725
Had diarrhoea in two weeks before survey	0.094	0.017	1770	2266	2.262	0.177	0.061	0.127
Treated with oral rehydration salts (ORS)	0.374	0.042	142	213	1.065	0.111	0.291	0.457
Taken to a health provider	0.614	0.061	142	213	1.561	0.1	0.491	0.736
Vaccination card seen	0.832	0.028	392	490	1.44	0.034	0.776	0.889
Received BCG	0.942	0.016	392	490	1.269	0.016	0.911	0.973
Received DPT (3 doses)	0.867	0.026	392	490	1.46	0.03	0.815	0.919
Received polio (3 doses)	0.861	0.026	392	490	1.423	0.03	0.809	0.913
Received measles	0.88	0.025	392	490	1.48	0.029	0.83	0.931
Fully immunized	0.836	0.028	392	490	1.43	0.033	0.78	0.892
Height-for-age (below -2SD)	0.339	0.019	1487	1819	1.442	0.057	0.301	0.378
Weight-for-height (below -2SD)	0.044	0.007	1487	1819	1.271	0.162	0.03	0.059
Weight-for-age (below -2SD)	0.122	0.015	1487	1819	1.63	0.126	0.092	0.153
Use condom at last high risk sex	0.201	0.039	218	331	1.421	0.193	0.123	0.278
Use condom at last high risk sex - 15-24	0.18	0.046	175	272	1.574	0.255	0.088	0.271
Two or more sexual partners	0.035	0.013	1668	2317	2.937	0.377	0.009	0.062
Had High risk Intercourse	0.143	0.02	1668	2317	2.338	0.14	0.103	0.183
Abstinence among youth (never had sex)	0.44	0.051	527	722	2.369	0.117	0.337	0.542
Sexually active last 12 months never married youth	0.37	0.039	527	722	1.83	0.104	0.293	0.447
Had injection last 12 months	0.119	0.01	2360	3187	1.546	0.087	0.098	0.139
Has heard of HIV	0.933	0.011	2360	3187	2.044	0.011	0.912	0.954
Accepting attitudes to people with HIV	0.043	0.009	2195	2973	2.091	0.211	0.025	0.061
HIV test and result in last 12 months	0	0	2360	3187	-	-	0	0

Table B.5: Sampling errors for total men, Solomon Islands 2007

Variable	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
Urban residence	0.167	0.02	2056	2056	2.404	0.118	0.128	0.207
No education	0.104	0.019	2056	2056	2.821	0.183	0.066	0.142
Secondary education or higher	0.377	0.018	2056	2056	1.677	0.048	0.341	0.413
Never married	0.327	0.02	2056	2056	1.962	0.062	0.287	0.368
Currently married/in union	0.639	0.017	2056	2056	1.603	0.027	0.605	0.673
Had first sex before 18	0.372	0.025	1773	1764	2.139	0.066	0.323	0.421
Knows any contraceptive method	0.987	0.004	1322	1314	1.245	0.004	0.979	0.995
Knowing any modern contraceptive method	0.984	0.005	1322	1314	1.317	0.005	0.974	0.993
Ever used condom	0.256	0.026	1322	1314	2.149	0.101	0.204	0.308
Want no more children	0.542	0.021	1322	1314	1.56	0.039	0.499	0.584
Want to delay birth at least 2 years	0.128	0.011	1322	1314	1.239	0.089	0.106	0.151
Ideal family size	3.652	0.081	1863	1866	1.775	0.022	3.489	3.815
Accept attitudes towards people with HIV	0.095	0.013	1648	1583	1.825	0.139	0.068	0.121

Table B.6: Sampling errors for total urban men sample, Solomon Islands 2007

Variable	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
Urban residence	1	0	841	344	-NaN	0	1	1
No education	0.037	0.008	841	344	1.169	0.206	0.022	0.052
Secondary education or higher	0.639	0.03	841	344	1.816	0.047	0.579	0.699
Never married	0.393	0.024	841	344	1.421	0.061	0.345	0.441
Currently married/in union	0.588	0.024	841	344	1.434	0.041	0.539	0.636
Had first sex before 18	0.383	0.028	707	288	1.539	0.074	0.326	0.439
Knows any contraceptive method	1	0	478	202	-NaN	0	1	1
Knowing any modern contraceptive method	1	0	478	202	-NaN	0	1	1
Ever used condom	0.509	0.044	478	202	1.903	0.086	0.422	0.596
Want no more children	0.474	0.022	478	202	0.964	0.047	0.43	0.518
Want to delay birth at least 2 years	0.167	0.022	478	202	1.307	0.134	0.122	0.211
Ideal family size	3.396	0.187	829	339	3.164	0.055	3.022	3.77
Accept attitudes towards people with HIV	0.188	0.018	727	298	1.254	0.097	0.152	0.225

Table B.7: Sampling errors for total rural men sample, Solomon Islands 2007

Variable	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
Urban residence	0	0	1215	1712	-NaN	-NaN	0	0
No education	0.117	0.022	1215	1712	2.425	0.191	0.072	0.162
Secondary education or higher	0.325	0.019	1215	1712	1.411	0.058	0.287	0.363
Never married	0.314	0.024	1215	1712	1.822	0.077	0.266	0.363
Currently married/in union	0.65	0.02	1215	1712	1.479	0.031	0.609	0.69
Had first sex before 18	0.37	0.029	1066	1477	1.949	0.078	0.313	0.428
Knows any contraceptive method	0.984	0.005	844	1112	1.095	0.005	0.975	0.994
Knowing any modern contraceptive method	0.981	0.005	844	1112	1.16	0.006	0.97	0.992
Ever used condom	0.21	0.028	844	1112	1.982	0.132	0.155	0.266
Want no more children	0.554	0.024	844	1112	1.43	0.044	0.505	0.603
Want to delay birth at least 2 years	0.121	0.013	844	1112	1.147	0.106	0.096	0.147
Ideal family size	3.709	0.089	1034	1527	1.401	0.024	3.532	3.886
Accept attitudes towards people with HIV	0.073	0.015	921	1284	1.712	0.201	0.044	0.102

Table B.8: Sampling errors for 5 years mortality rates, Solomon Islands 2007

Variable	R	SE	N	WN	DEFT	CV	R-2SE	R+2SE
Neonatal mortality (last 0-4 years)	15.161	3.707	2617	2684	1.473	0.245	7.747	22.576
Post-neonatal mortality (last 0-4 years)	9.138	2.794	2615	2687	1.256	0.306	3.549	14.726
Infant mortality (last 0-4 years)	24.299	4.931	2620	2688	1.357	0.203	14.437	34.161
Child mortality (last 0-4 years)	13.007	3.705	2515	2607	1.676	0.285	5.597	20.417
Under-five mortality (last 0-4 years)	36.990	6.019	2627	2695	1.391	0.163	24.953	49.027

Table B.9: Sampling errors for 10 years mortality rates, Solomon Islands 2007

Variable	R	SE	N	WN	DEFT	CV	R-2SE	R+2SE
Neonatal mortality (last 0-9 years)	16.841	2.712	4924	5098	1.515	0.161	11.416	22.265
Post-neonatal mortality (last 0-9 years)	9.260	2.342	4907	5081	1.640	0.253	4.577	13.944
Infant mortality (last 0-9 years)	26.101	3.926	4926	5099	1.712	0.150	18.249	33.952
Child mortality (last 0-9 years)	11.413	2.249	4779	4982	1.475	0.197	6.914	15.912
Under-five mortality (last 0-9 years)	37.216	4.119	4931	5102	1.473	0.111	28.977	45.455

APPENDIX C: DATA QUALITY TABLES

Table C.1: Household age distribution

Single-year age distribution of the de facto household population by sex (weighted), Solomon Islands 2007

Age	Women		Men	
	Number	Percent	Number	Percent
0	294	3.5	234	2.7
1	276	3.3	286	3.4
2	243	2.9	284	3.3
3	278	3.3	310	3.6
4	224	2.7	254	3.0
5	222	2.6	252	3.0
6	284	3.4	338	4.0
7	212	2.5	285	3.4
8	194	2.3	273	3.2
9	231	2.8	227	2.7
10	254	3.0	238	2.8
11	207	2.5	194	2.3
12	215	2.6	255	3.0
13	192	2.3	203	2.4
14	238	2.8	215	2.5
15	148	1.8	142	1.7
16	171	2.0	173	2.0
17	137	1.6	137	1.6
18	151	1.8	194	2.3
19	119	1.4	129	1.5
20	157	1.9	179	2.1
21	123	1.5	128	1.5
22	138	1.6	145	1.7
23	148	1.8	120	1.4
24	180	2.2	146	1.7
25	162	1.9	117	1.4
26	182	2.2	95	1.1
27	111	1.3	118	1.4
28	159	1.9	128	1.5
29	122	1.5	121	1.4
30	139	1.7	187	2.2
31	118	1.4	79	0.9
32	117	1.4	103	1.2
33	102	1.2	86	1.0
34	116	1.4	100	1.2
35	122	1.5	122	1.4
36	98	1.2	70	0.8
37	78	0.9	83	1.0
38	105	1.3	123	1.4
39	54	0.7	88	1.0
40	94	1.1	123	1.5
41	40	0.5	36	0.4
42	75	0.9	85	1.0
43	57	0.7	41	0.5
44	59	0.7	55	0.7
45	80	1.0	57	0.7
46	54	0.6	44	0.5
47	50	0.6	33	0.4
48	58	0.7	74	0.9
49	23	0.3	50	0.6
50	115	1.4	63	0.7

Table C.1 (continued)

Age	Women		Men	
	Number	Percent	Number	Percent
51	50	0.6	27	0.3
52	65	0.8	38	0.4
53	51	0.6	37	0.4
54	71	0.9	38	0.4
55	47	0.6	52	0.6
56	44	0.5	52	0.6
57	28	0.3	34	0.4
58	64	0.8	34	0.4
59	30	0.4	29	0.3
60	46	0.6	80	0.9
61	12	0.1	43	0.5
62	22	0.3	19	0.2
63	23	0.3	9	0.1
64	32	0.4	55	0.6
65	47	0.6	24	0.3
66	7	0.1	14	0.2
67	10	0.1	27	0.3
68	13	0.2	23	0.3
69	24	0.3	20	0.2
70+	141	1.7	201	2.4
Don't know/missing	9	0.1	23	0.3
Total	8,365	100.0	8,500	100.0

Table C.2a: Age distribution of eligible and interviewed women

De facto household population of women aged 10–54, interviewed women aged 15–49, and percentage of eligible women who were interviewed (weighted), by five-year age groups, Solomon Islands 2007

Age group	Household population of women aged 10–54	Interviewed women aged 15–49		Percent of women
		Number	Percent	
10–14	1,106	na	na	na
15–19	727	624	17.9	85.9
20–24	746	655	18.8	87.8
25–29	736	667	19.2	90.7
30–34	592	550	15.8	92.8
25–39	459	425	12.2	92.5
40–44	325	309	8.9	95.0
45–49	264	248	7.1	93.8
50–54	352	na	na	na
15–49	3,849	3,477	100.0	90.4

Note: The *de facto* population includes all residents and non-residents who stayed in the household the night before the interview. Weights for both household population of women and interviewed women are household weights. Age is based on the household schedule.

na = not applicable

Table C.2b: Age distribution of eligible and interviewed men

De facto household population of men aged 10–64, interviewed men aged 15–59 and percent of eligible men who were interviewed (weighted), Solomon Islands 2007

Age group	Household population of men aged 10–64	Interviewed men aged 15–59		Percentage of eligible men interviewed
		Number	Percent	
10–14	565	na	na	Na
15–19	382	273	14.4	71.3
20–24	355	281	14.9	79.2
25–29	301	241	12.7	80.0
30–34	283	241	12.7	85.2
25–39	251	219	11.6	87.2
40–44	154	119	6.3	77.1
45–49	126	109	5.8	86.7
50–54	103	89	4.7	86.5
55–59	102	88	4.7	86.4
60–64	108	na	na	Na
15–59	2,058	1,891	92.5	91.9

Note: The *de facto* population includes all residents and non-residents who stayed in the household the night before the interview. Weights for both household population of men and interviewed men are household weights. Age is based on the household schedule.

na = not applicable

Table C.3: Completeness of reporting

Percentage of observations missing information for selected demographic and health questions (weighted), Solomon Islands 2007

Subject	Percentage with missing information	Number of cases
Month Only (births in last 15 years)	2.47	7,015
Month and Year (births in last 15 years)	0.28	7,015
Age at Death (deceased children born in the last 15 years)	0.36	256
Age/date at first union (ever married women) ¹	1.79	2,698
Age/date at first union (ever married men)	2.68	1,383
Respondent's education (all women)	0.01	3,823
Respondent's education (all men)	0.08	2,056
Diarrhoea in last two weeks (living children aged 0–59 months)	3.99	2,585
Height (living children aged 0–59 months from Household Questionnaire)	19.85	2,685
Weight (living children aged 0–59 months from Household Questionnaire)	17.67	2,685
Height or weight (living children aged 0–59 months from Household Questionnaire)	20.25	2,685
Anaemia (living children aged 6–59 months from Household Questionnaire)	18.68	2,410
Anaemia (all women from the Household Questionnaire)	17.70	3,849
Anaemia (all men from the Household Questionnaire)	100.00	4,631

¹ Both year and age missing.

Table C.4: Births by calendar years

Number of births, percentage with complete birth date, sex ratio at birth, and calendar year ratio by calendar year, according to living (L), dead (D), and total (T) children (weighted), Solomon Islands 2007

Calendar year ¹	Number of births			Percentage with complete birth date ²			Sex ratio at birth ³			Calendar year ratio ⁴		
	L	D	T	L	D	T	L	D	T	L	D	T
0	28	0	28	100.0	na	100.0	111.8	na	111.8	na	na	na
1	516	11	527	100.0	100.0	100.0	76.0	184.8	77.4	na	na	na
2	524	14	538	100.0	100.0	100.0	111.4	110.2	111.4	99.9	108.5	100.1
3	534	15	548	100.0	100.0	100.0	92.5	122.2	93.2	101.8	79.9	101.0
4	524	23	547	100.0	98.4	99.9	113.9	59.4	110.9	104.1	121.0	104.7
5	474	23	497	100.0	100.0	100.0	97.1	337.4	102.2	97.3	128.2	98.4
6	450	13	463	100.0	90.5	99.7	97.0	123.4	97.6	87.2	42.3	84.7
7	558	38	596	96.9	94.9	96.8	122.5	65.2	117.7	122.8	250.4	127.0
8	458	17	475	95.3	91.5	95.2	135.1	124.6	134.7	92.6	61.8	90.9
9	431	18	450	96.2	60.9	94.7	147.1	71.9	142.7	99.7	97.1	99.6
0-4	2,126	63	2,189	100.0	99.4	100.0	97.5	99.4	97.5	na	na	na
5-9	2,371	109	2,480	97.7	89.1	97.3	117.8	108.9	117.3	na	na	na
10-14	1,966	80	2,046	94.9	92.4	94.8	99.4	94.3	99.2	na	na	na
15-19	1,347	39	1,386	93.3	84.8	93.0	110.6	262.3	113.1	na	na	na
20+	1,417	101	1,518	93.3	90.9	93.1	127.4	229.0	132.2	na	na	na
All	9,227	392	9,619	96.3	91.5	96.1	109.0	135.5	110.0	na	na	na

NA = Not applicable

¹ Replace with calendar years in stub. For example, if survey takes place in 2000, 0 becomes 2000, 1 becomes 1999, etc.

² Both year and month of birth given

³ $(B_m/B_f) \times 100$, where B_m and B_f are the numbers of male and female births, respectively

⁴ $[2B_x/(B_x + 1 + B_{x+1})] \times 100$, where B_x is the number of births in calendar year x

Table C.5: Reporting of age at death in days

Distribution of reported deaths under one month of age by age at death in days and the percentage of neonatal deaths reported to occur at ages 0–6 days, for five-year periods of birth preceding the survey (weighted), Solomon Islands 2007

Age at death (days)	Number of years preceding the survey				Total 0–19
	0–4	5–9	10–14	15–19	
<1	14	11	3	2	30
1	14	13	6	9	42
2	3	9	3	0	15
3	1	9	0	1	12
4	1	0	0	0	1
5	1	0	0	1	3
7	2	2	2	4	9
8	0	0	0	7	7
9	0	0	0	0	0
10	1	0	0	0	1
12	1	0	0	0	1
14	0	0	1	0	2
Total 0–30	40	45	15	24	124
Percent early neonatal ¹	86.3	95.7	79.9	55.4	82.8

¹ = 6 days / = 30 days

Table C.6: Reporting of age at death in months

Distribution of reported deaths under two years of age by age at death in months and the percentage of infant deaths reported to occur at age under one month, for five-year periods of birth preceding the survey, Solomon Islands 2007

Age at death (months)	Number of years preceding the survey				Total 0–19
	0–4	5–9	10–14	15–19	
<1 ^a	40	45	15	24	124
1	2	3	0	1	7
2	1	1	1	0	2
3	1	2	5	1	8
4	1	2	0	0	3
5	2	4	0	0	6
6	5	3	5	0	12
7	0	12	0	0	12
8	0	0	11	0	12
9	6	2	1	0	9
10	0	0	0	1	1
12	7	6	0	1	14
15	2	0	0	0	2
17	0	0	0	0	0
18	0	0	0	1	1
21	0	1	0	0	1
1 Year	0	3	3	0	6
Total 0–11	58	71	39	29	196
Percent neonatal ¹	69.1	62.6	38.7	84.6	63.0

^a Includes deaths under one month reported in days.

¹ Under one month / under one year.

Table C.7: Nutritional status of children

Percentage of children under age 5 years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Solomon Islands 2007

Background characteristic	Height-for-age			Weight-for-height				Weight-for-age				Number of children
	Percentage below -3 SD	Percentage below -2 SD ¹	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	
Age in months												
<6	1.4	4.1	-0.2	0.8	2.5	10.7	0.5	0.0	1.7	9.8	0.3	156
6–8	0.8	7.5	-0.8	0.1	3.5	7.5	0.1	1.1	6.0	3.8	-0.5	117
9–11	2.4	19.3	-1.1	3.9	8.2	4.0	-0.4	3.5	26.5	2.5	-1.2	85
12–17	8.7	32.2	-1.5	1.4	9.1	0.1	-0.6	3.3	22.7	0.1	-1.4	182
18–23	7.8	41.8	-1.7	0.0	6.0	1.0	-0.6	0.9	22.5	0.4	-1.4	243
24–35	6.6	22.8	-1.3	0.3	1.8	0.9	-0.3	3.2	20.8	1.1	-1.1	434
36–47	7.9	36.6	-1.5	1.3	4.5	0.2	-0.4	5.5	19.3	0.0	-1.3	426
48–59	4.6	26.1	-1.4	0.0	2.0	1.0	-0.3	0.7	12.3	0.1	-1.1	382
Sex												
Male	5.6	28.9	-1.3	0.5	2.5	2.1	-0.3	1.8	13.7	0.8	-1.0	1,038
Female	6.2	24.9	-1.3	0.9	5.6	1.9	-0.4	3.4	20.8	2.0	-1.1	986
Birth interval in months ²												
First birth ³	8.2	29.4	-1.4	0.3	3.0	2.9	-0.2	2.1	17.9	1.0	-1.0	370
<24	6.6	32.3	-1.4	1.7	4.4	2.3	-0.3	4.1	16.8	0.8	-1.2	327
24–47	4.7	24.7	-1.3	0.5	3.4	1.6	-0.4	2.5	18.6	2.5	-1.1	746
48+	5.4	24.5	-1.2	0.7	6.5	2.6	-0.4	2.4	15.6	0.8	-1.0	385
Size at birth												
Very small	4.5	39.3	-1.6	0.0	7.4	0.9	-0.6	1.0	24.4	0.0	-1.4	60
Small	7.9	36.5	-1.6	0.6	4.5	2.4	-0.4	4.3	25.7	1.1	-1.3	185
Average or larger	5.3	24.6	-1.3	0.8	3.8	2.3	-0.3	2.3	15.8	1.6	-1.0	1,490
Missing	10.3	37.9	-1.4	0.0	6.3	1.7	-0.5	6.4	24.4	1.7	-1.2	82
Mother's interview status												
Interviewed	5.9	27.0	-1.3	0.7	4.1	2.2	-0.3	2.7	17.5	1.5	-1.1	1,828
Not interviewed but in household	2.9	13.0	-0.9	2.1	5.5	0.0	-0.5	2.1	10.9	0.5	-1.0	48
Not interviewed, and not in the household ⁴	7.3	31.4	-1.5	0.0	1.5	0.0	-0.2	1.7	15.0	0.0	-1.1	149

Table C.7 (continued)

Background characteristic	Height-for-age			Weight-for-height				Weight-for-age				Number of children
	Percentage below -3 SD	Percentage below -2 SD ¹	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD ¹	Percentage above +2 SD	Mean Z-score (SD)	
Mother's nutritional status⁵												
Thin (BMI<18.5)	4.6	43.2	-1.7	0.0	8.4	6.5	-0.6	5.8	34.5	3.3	-1.5	31
Normal (BMI 18.5–24.9)	6.0	26.9	-1.3	1.0	4.4	1.9	-0.4	3.6	17.6	1.1	-1.1	1,073
Overweight/obese (BMI ≥ 25)	5.6	26.2	-1.2	0.5	3.7	2.4	-0.2	1.3	16.3	2.1	-1.0	724
Missing	4.3	14.3	-1.0	0.0	3.9	1.1	-0.4	0.0	14.2	0.5	-1.0	45
Residence												
Urban	6.2	19.2	-1.0	0.0	3.2	1.6	-0.3	0.1	11.6	2.6	-0.9	208
Rural	5.9	27.9	-1.3	0.8	4.1	2.0	-0.3	2.9	17.8	1.3	-1.1	1,817
Region												
Honiara	4.7	19.2	-1.0	0.0	2.9	1.7	-0.3	0.1	13.8	1.9	-0.9	152
Guadalcanal	8.7	30.0	-1.3	0.8	4.0	0.9	-0.5	3.1	20.1	0.6	-1.2	320
Malaita	7.4	27.8	-1.3	1.3	6.3	3.1	-0.3	3.8	16.2	1.6	-1.0	484
Western	6.1	29.6	-1.3	2.4	6.0	3.8	-0.4	5.0	23.0	3.3	-1.1	208
Other provinces	4.2	26.1	-1.4	0.0	2.3	1.4	-0.3	1.6	15.8	1.1	-1.1	861
Mother's education⁶												
No education	7.5	31.4	-1.3	0.9	3.7	1.8	-0.2	3.3	16.7	2.2	-1.0	275
Primary	6.0	27.6	-1.3	0.7	4.1	1.4	-0.4	2.8	18.1	1.0	-1.1	1,167
Secondary	3.4	20.6	-1.1	0.9	4.6	4.9	-0.2	2.1	15.4	2.4	-0.9	393
More than secondary	12.4	24.5	-0.9	0.0	6.3	0.0	-0.3	0.0	17.9	2.7	-0.9	40
Missing	0.0	46.2	-1.4	0.0	0.0	0.0	-0.5	0.0	46.2	0.0	-1.2	1
Wealth quintile												
Lowest	8.7	27.9	-1.4	0.7	3.9	3.5	-0.2	4.3	17.3	1.5	-1.1	496
Second	7.3	34.0	-1.5	0.2	4.2	0.6	-0.3	3.2	19.8	0.0	-1.2	434
Middle	3.6	24.7	-1.2	1.4	3.2	2.6	-0.4	1.6	21.3	3.5	-1.0	379
Fourth	4.0	26.2	-1.3	0.8	4.1	1.1	-0.4	2.4	13.1	0.3	-1.1	395
Highest	4.8	19.6	-1.0	0.3	4.6	1.8	-0.4	0.5	13.4	2.1	-0.9	321
Total	5.9	27.0	-1.3	0.7	4.0	2.0	-0.3	2.6	17.2	1.4	-1.1	2,025

Note: Table is based on children who slept in the household the night before the interview. Each of the indices is expressed in standard deviation units (SD) from the median of the NCHS/CDC/WHO Child Growth Standards.

Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight.

¹ Includes children who are below -3 standard deviations (SD) from the International Reference Population median.

² Excludes children whose mothers were not interviewed.

³ First born twins (triplets, etc.) are counted as first births because they do not have a previous birth interval.

⁴ Includes children whose mothers are deceased.

⁵ Excludes children whose mothers were not weighed and measured. Mother's nutritional status in terms of BMI (body mass index) is presented in Table 11.10.

⁶ For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

**APPENDIX D: LIST OF PEOPLE INVOLVED IN THE
2006/2007 SIDHS**

DEMOGRAPHIC HEALTH SURVEY FINAL LISTING – Interviewers and Supervisors

Person No.	NAME	Comment	Reserves
Choiseul			
01	Blaize Noqe		
02	Melinda Dixie		
03	Dimymah Kimata		
04	Mazilyn Diadonga		
05	Larisah Kimata		
06	Job Sasabule		
	Roselyn Konaki		
Western 1			
07	William Talasasa		
08	Enda P Naule		
09	Molia Naru		
10	Elsie Galokesa		
11	Elaine B. Darcy		
12	Raynald Mamu		
	Aron Jani Levo (Technician)		
Western 2			
13	Treva A. Lianga		
14	Iatali Ringi		
15	Ronnette Paul		
16	Cynthia Napthalai		
17	Judy Sasapitu		
18	Edward Sasapitu		
	Madeline Kimasaru		
Honiara 1			
19	Pricilla Ma'au*		
20	Alice Ratu		
21	Melaine Tafeasu		
22	K. Andrea Kiriau		
23	Gwenneth Gulu		
24	Aziz		
	Margarette Hetaia		
Honiara 2			
25	Diana Noda		
26	Deann Ghuena		
27	Loretta Rembi		
28	Rosemary Ota'alo		
29	Babra Aipaina*		
30	Peter Rahemanu		
	Mavis Kwainarara		
Honiara 3			
31	Patricia Gegeu		
38	Joylyn Paurana		
33	Margaret Taupongi		
34	Joan Sotokera		
35	Anna Gafui		
36	Calvin G. Vana		
	Merilyn Roy (Technician)		

Person No.	NAME	Comment
Honiara 4		
37	Richard Ben	
32	Agnes Rumo	
39	Webster Asagolomo	
40	Martha Sterward	
41	Sharon Panda	
42	Endross Ragoso	
	Kendrick Solodi (Technician)	
Honiara 5		
43	Mathias Marau	
44	Babra Nanauoha	
45	Josephin Ibuna	
46	Cynthia Ouou	
47	Yancy Agosi	
48	John Tao	
	Wendy Tealiklava (Technician)	
Guadalcanal 1		
49	Richard Rasile	
50	Ellyna Charcha	
51	Muleletiti Daniel	
52	Jinah Rachel Baku	
53	Rose Toke	
54	Willie Newman	
	Annette Soma	
Guadalcanal 2		
55	Joseph Mari	
56	Tina Memua	
57	Stella Lee	
58	Jane Beri	Toba Theresa Haeo
59	Milcah Luvusia	
60	Simon Basi	
	Joshua Bulolo (Technician)	
Malaita 1		
61	Everest Edgar Kairi	
62	Lisa Bibimauri	
63	Linda Sui	
64	Veronica Koibinu	
65	Salome Gelisae*	
66	Eddie Maela	James Lee
	Jessy Bobby	
Malaita 2		
67	John M. Haihuru	
68	Jane Toli	
69	Hellen Baeoro	
70	Trinner Sinahanuakeni	
71	Georgina Lyn Awaohu	
72	John G. Sinahanua	
	Everlyn Rapu	