Key Kiribati DHS indicators

	Residence			Educational level			
	Total	Urban	Rural	No education/ primary	Primary and some secondary	Secondary level 1	Secondary level 2 and higher
Marriage and fertility							
Women aged 20–24 married by age 18 (%)	20.3	na	na	na	na	na	na
Men aged 20–24 married by age 18 (%)	5.0	na	na	na	na	na	na
Total fertility rate (children per woman)	3.8	3.5	4.1	4.1	4.1	3.9	3.3
Women aged 15–19 already mothers or pregnant at the time of the survey	10.2	8.4	12.7	*	8.0	10.5	*
Median age at first birth for women aged 25–49	22.1	22.6	21.8	20.7	21.1	24.1	*
Married women with 2 living children wanting no more children (%)	36.1	30.7	40.0	*	35.1	31.7	*
Family planning (% currently married women aged 15–49)							
Current use							
Any method	22.3	19.1	24.6	16.9	25.1	19.1	15.1
Any modern method	18.0	15.9	19.5	10.9	20.6	14.9	13.4
Female sterilisation	4.0	4.2	3.9	3.4	4.7	2.6	3.8
Male sterilisation	0.5	0.3	0.7	1.2	0.7	0	0
Injectables	7.6	6.7	8.2	2.2	8.9	6.8	4
Pill	1.3	1.1	1.4	0	1.5	1.2	0.8
Male condom	0.4	0.1	0.5	0	0.4	0	1.8
Unmet need for family planning							
Total unmet need (%)	28.0	31.4	25.5	21.1	26.3	31.9	32.7
Unmet need for spacing (%)	14.4	17.8	11.9	15	15.9	8.8	11.3
Unmet need for limiting (%)	13.6	13.6	13.6	6.1	10.5	23	21.4
Infant and child mortality (0–9 years before DHS)							
Neonatal mortality rate	27	20	31	9	28	29	23
Infant mortality rate	46	44	47	29	52	37	23
Under-five mortality rate	72	72	72	67	77	69	36
Maternal and child health							
Maternity care (births in the last 3 years)							
Mothers who had at least 4 antenatal care visits for their last birth (%)	72.8	72.5	69.5	na	na	na	na
Births delivered in a hospital or health facility (%)	65.9	79.9	56.5	(76.6)	61.4	70.8	75.9
Mothers who received post-partum care from a doctor/nurse/midwife for their last birth (%)	54.5	59	51.4	(55.3)	49.6	58.7	74.6
Mothers who received their first post-partum checkup within 2 days of delivery of their last birth (%)	48.1	52.2	45.2	44.0	43.3	53.6	65.7
Child immunisation							
Children aged 12–23 months fully immunised (BCG, measles, and 3 doses each of polio and DPT) (%)	28.7	30.2	27.6	*	23.9	39.5	*
Children 12–23 months who have received BCG (%)	(89.4)	90.9	88.4	*	87.0	89.7	*
Children 12–23 months who have received 3 doses of polio vaccine (%)	48.1	47.1	48.8	*	45.5	54.1	*
Children 12–23 months who have received 3 doses of DPT vaccine (%)	61.4	62.6	60.6	*	55.6	66.5	*
Children 12–23 months who have received measles vaccine (%)	69.1	72.1	66.9	*	68.5	68.0	*
Children aged 6–59 months given de-worming medication in the last 6 months (%)	33.9	23.3	41.0	(34.8)	35.5	30.9	32.8
Treatment of childhood diseases							
Children under 5 with diarrhoea in the last 2 weeks who received oral rehydration salts (%)	61.5	(75.5)	54.6	*	60.2	(51.7)	*
Children under 5 with diarrhoea in the last 2 weeks taken to a health facility or provider (%)	65.9	(78.4)	59.9	*	63.9	(51.7)	*
Children with fever in the last 2 weeks taken to a health facility or provider (%)	23.3	21.4	24.6	(26.2)	24.5	20.5	23.6

NOTE: Figures in parentheses are based on 25–49 unweighted cases.
* Indicates a figure based on fewer than 25 unweighted cases.
na: not available

	Residence			Educational level			
	Total	Urban	Rural	No education/ primary	Primary and some secondary	Secondary level 1	Secondary level 2 and higher
Nutritional status of children							
Children under 5 years breastfed within 1 hour of birth (%)	79.9	78.2	80.9	(85.1)	82.2	76.7	72.2
Children aged 0–5 months exclusively breastfed (%)	69.0	na	na	na	na	na	na
Children aged 6–9 months breastfed and receiving complementary foods (%)	65.7	na	na	na	na	na	na
Children under 5 years who are underweight (%) (-2 and -3 SD weight/age)	23.1	21.4	24.3	*	28.4	21.7	13.1
Children under 5 years who are overweight for their age (%)	5.7	8.5	3.7	*	6.0	6.1	7.8
Knowledge of HIV and AIDS (women and men aged 15–49)							
Women who have heard of AIDS (%)	97.3	97.3	97.3	91.3	96.5	99.5	100
Men who have heard of AIDS (%)	98.7	99.7	97.9	99.2	98.1	99.6	100
Women who know where to get an HIV test (%)	83.3	82.8	83.8	70.2	80.3	90.0	91.3
Men who know where to get an HIV test (%)	85.6	80.6	89.3	82.2	83.7	89.2	91.2
Women who know that consistent condom use can reduce the chances of getting HIV and AIDS (%)	82.8	82.0	83.5	71.5	82.3	85.3	85.8
Men who know that consistent condom use can reduce the chances of getting HIV and AIDS (%)	91.2	91.9	90.6	88.9	90.8	91.7	96.1
Women with comprehensive knowledge of HIV and AIDS (%)	45.8	45.2	46.3	24.6	42.1	53.4	61.8
Men with comprehensive knowledge of HIV and AIDS (%)	51.7	51.1	52.2	40.9	50.9	54.3	66.2
Women who know that HIV can be transmitted from mother to child via breastfeeding (%)	87.5	85.7	89.1	81.6	86.1	90.1	92.0
Men who know that HIV can be transmitted from mother to child via breastfeeding (%)	83.8	81.0	86.0	79.6	83.2	86.0	86.8
Women who had high-risk sex in the past 12 months (%) (had sex in past 12 months with a person who was neither their husband nor who lived with them)	4.6	4.5	4.6	4.9	4.3	4.1	7.9
Men who had high-risk sex in the past 12 months (%) (had sex in past we months with a person who was neither their wife nor who lived with them)	34.8	42.4	29.0	33.4	30.6	47.2	29.2
Women who used a condom during last high-risk sex (%)	3.5	(8.7)	(0)	*	(2.1)	*	*
Men who used a condom during last high-risk sex (%)	29.1	32.7	25.1	*	27.1	34.2	*
Women's empowerment							
Currently married women who usually participate in household decisions (own health care, making purchases for daily household needs, making major household purchases)	47.1	56.5	40.3	46.1	46.1	46.7	57.3
Women who agree that at least one of the reasons for violence against women is justified (burns the food, argues with him, goes out without telling him, neglects the children, or refuses sex)	75.6	74.5	76.5	78.0	77.7	73.6	65.4
Men who agree that at least one of the reasons for violence against women is justified (burns the food, argues with him, goes out without telling him, neglects the children, or refuses sex)	59.7	51.1	66.7	60.0	61.1	59.6	46.0

NOTE: Figures in parentheses are based on 25–49 unweighted cases.
* Indicates a figure based on fewer than 25 unweighted cases.
na: not available

Population characteristics

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

While population and housing censuses provide the backbone of this information in most countries, the provision of a snapshot – often only every 10 years – is clearly insufficient to inform policy and allow a regular monitoring of development progress.

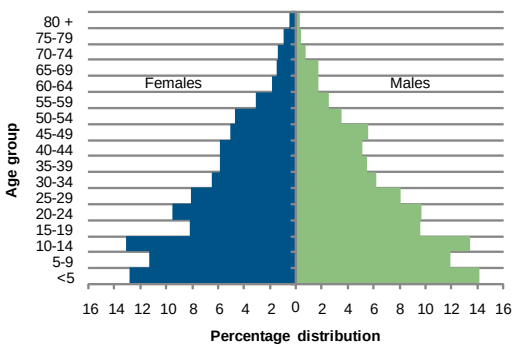
Regular household surveys, such as the Kiribati 2009 DHS, address this data and information gap by providing high quality and up-to-date statistics and information in their own right, as well as providing the basis for the calculation of important development indicators. This survey provided more than a hundred such indicators, covering many development features of relevance to both national and international development agencies and conventions such as Millennium Development Goals (MDGs), International Conference on Population and Development (ICPD), Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), United Nations General Assembly Special Session (UNGASS) and United Nations Children's Fund (UNICEF), to name but a few that are included in this development snapshot.

The population of Kiribati

A census is held in Kiribati every five years, and as the most recent census was in 2005, the 2009 Kiribati DHS provides a rich, up-to-date account of how the country is progressing in key areas of social and human development.

Kiribati has a young population, with 38% of the population younger than 15 years. The broad population base pattern, illustrated in the population pyramid, indicates that the population is growing rapidly and this trend will continue when those currently aged younger than 15 years enter into their reproductive years. More females than males are over 70 years old. This fact can be partly explained by the sex ratio of just 95 men for every 100 women.

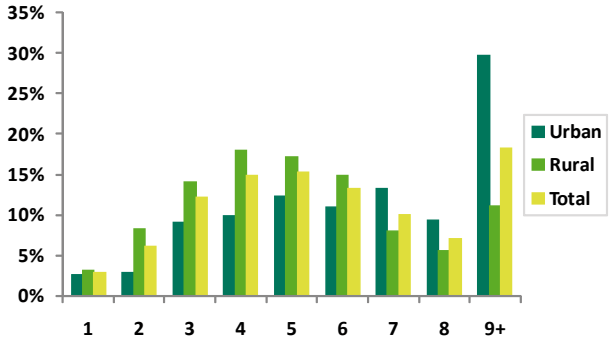
Percentage distribution of de facto household population by age and sex, Kiribati 2009



Household composition

The average household in Kiribati comprises six members and households are generally headed by men (76.5%). As a result of urbanisation in South Tarawa, vacant land is becoming scarce and new housing is needed. In urban areas an average of seven people share a household, compared with only five in rural areas. One in three households has more than nine people living together.

Household composition
Number of usual members



Another factor increasing household size is the high incidence of fosterhood in Kiribati. Forty per cent of households in Kiribati have foster children. This practice is slightly more common in urban than rural households. Survey results indicate that 22% of Kiribati children under 18 years of age do not live with their biological parents.

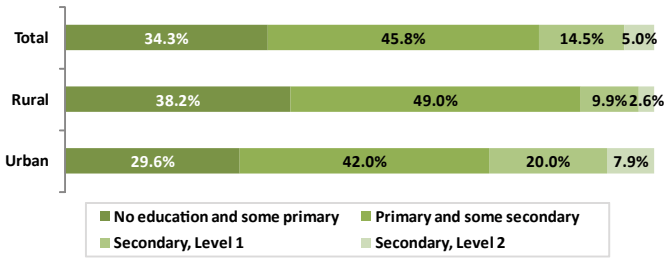
The Kiribati 2009 DHS provides useful information concerning socio-economic background characteristics which may explain key demographic and health outcomes. These include education (such as attainment levels), economic well-being (illustrated through wealth quintiles) and basic household amenities, such as access to safe water, sanitation and household characteristics. All of these factors are of critical importance, especially to infants and young children, with reference made to the contextual variations right throughout the various fact sheets.

Educational level

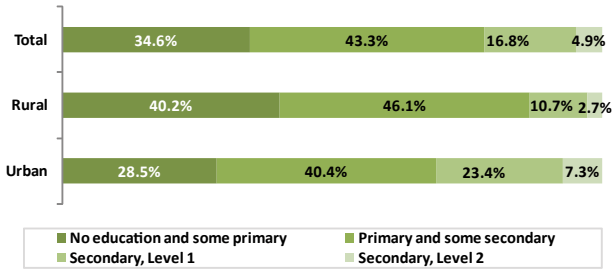
Education is provided free in Kiribati and is compulsory for children aged 6–15. Nevertheless, the Kiribati 2009 DHS indicates that many children do not, in fact, start primary school at age six and continue until age 15. For example, all children aged seven and eight should have attended primary school during the 2009 school year, but more than 10% did not.

Although most people in Kiribati have some primary education, only 5% of people completed secondary and higher education. Around 1 in 3 people have no education or only some years of primary education. People with the highest education levels tend to live in urban areas, in households in high wealth quintiles. There is little difference between the educational achievement of males and females in Kiribati.

Highest male educational attainment



Highest female eduational attainment



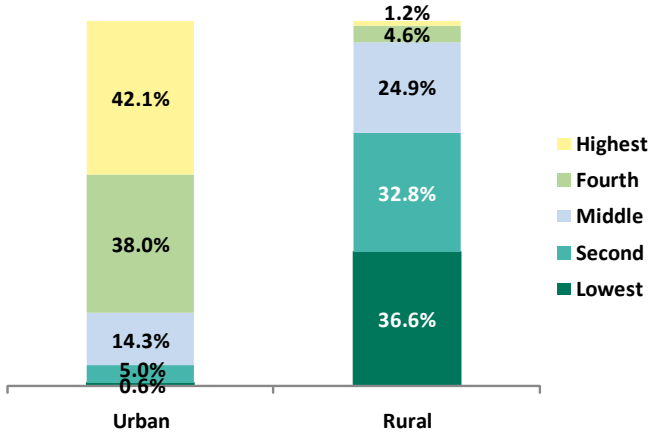
Net attendance ratio (NAR) measures the number of school age children who attend school. According to the Kiribati 2009 DHS, the primary school NAR is 84%, while the secondary school NAR is much lower at 59%. The gender parity index (GPI) indicates that there are slightly more females than males at secondary school.

Economic well-being

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

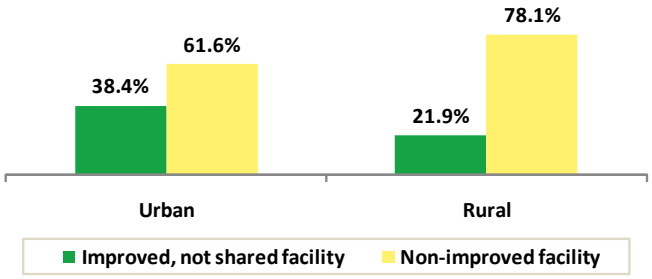
Wealth is distributed unevenly throughout Kiribati, with wealth very clearly concentrated in urban areas (South Tarawa). Forty two per cent of people in the highest quintile live in urban areas, compared with just 1% in rural areas. One third of the population in rural areas are in the lowest quintile while almost no urban households are found in this category.

Wealth quintiles



Access to safe water and sanitation

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



The lack of proper toilet facilities in Kiribati is striking, with the majority of people in Kiribati not having access to improved, not shared toilets. This situation is most pronounced in rural Kiribati, where four in every five households have to make do with non-improved toilet facilities.

Access to safe drinking water

Ninety per cent of respondents reported having access to an improved water source for drinking water, with access more common in urban (96%) than rural (87%) Kiribati.

Access to electricity

90% of urban households and only 20% of rural households have access to electricity.

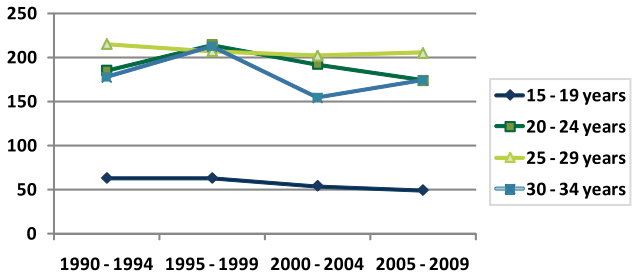
Fertility and family planning

The 2009 Kiribati DHS results suggest that on average, a Kiribati woman will have 3.8 children. Although this represents a slight increase from the total fertility rate (TFR) recorded in the 2005 Kiribati Census, the actual difference between 2005 and 2009 may well be significantly less when sample size and standard errors are taken into consideration, as the latter point to a probability of 95% that the true TFR lies between 3.6 and 4.1.

This range should also be taken into consideration when comparing rural (4.1) and urban (3.5) fertility rates, as the lowest point of the rural estimate and the highest point of the urban estimate overlap, so the true difference between urban and rural TFR may be much smaller.

Trends in age-specific fertility rates

Fertility rates have not changed dramatically in the past 20 years. Fertility has declined slightly overall, with a modest but steady decrease in the fertility rates of teenage women. Women between 25 and 29 years of age had the highest fertility rates in the five years prior to the 2009 Kiribati DHS.



Family planning

Knowledge of at least one method of contraception is high in Kiribati, with 93% of all women and 97% of all men knowing of at least one contraceptive method.

Fewer women in urban areas use contraception than women in rural areas. This finding is consistent with survey questions about women's desire to limit childbearing, as women in rural areas (45%) were more likely than those in urban areas (37%) not to want any more children. Given the current overcrowding and lack of housing in South Tarawa, this trend should be of some concern to Kiribati's planners and policy-makers.

Twenty-eight percent of currently married I-Kiribati women have reported an unmet need for family planning, with slightly more women living in urban areas (31%) expressing an unmet need for family planning compared to women in rural areas (26%).

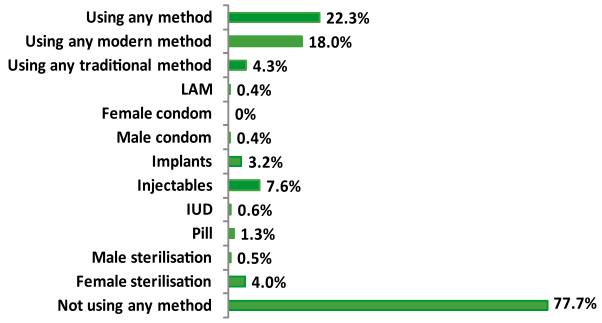
Family planning: knowledge versus practice

Despite widespread knowledge of contraception, actual use is low and many survey respondents expressed a desire for large numbers of children. Approximately 61% of all women aged between 15 and 49 years have never used a contraceptive method. This trend is even more pronounced among young women, with 97% of 15–19 year olds and 78% of 20–24 year olds having never used any contraception.

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

Less than a quarter of married I-Kiribati women were using any method of family planning at the time of the Kiribati 2009 DHS. Injectables and female sterilisation were the most commonly used forms of contraception, but given the low use of contraception these two methods were only used by around 12% of married women. Condom use was very low, with less than 0.5% of married and unmarried women using condoms.

Current use of contraceptives by married women aged 15–49



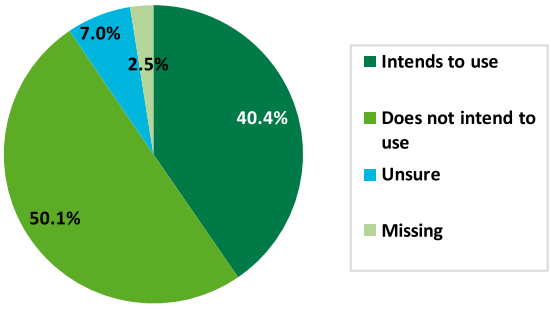
The survey results suggest that around 15% of I-Kiribati women start using a modern contraception method after they have their first child. First use of contraception varies according to age: 12% of women aged 20–24 started using contraception after their first child was born compared with 20% of women aged 30–34, 40–45 and 45–49. This suggests a decline in contraceptive use in recent years among young people.

The majority of women using contraception obtain it from the public sector, mainly from government hospitals (54%), health centres (23%) and family planning clinics (9%).

Intended future use of contraception

Half of all married women who are not currently using contraception do not intend to start using it in the future. Women who have not yet started having children are more likely to intend to use contraception in the future than women who have four children or more (29%). The most common reason given for why women did not intend to use contraception in the future was religious prohibition. Around 11% of women were concerned about possible side effects.

Intended future use of contraception by married women age 15–49 not currently using modern contraception



Of those women who expressed a desire to use contraception in the future, the most popular methods were injectables (34.4%) and implants (18.4%).

These findings indicate that more family planning messages – in particular messages targeted at certain groups such as women with four or more children – should be considered to increase contraceptive use in Kiribati. Currently, the most effective media channel for conveying family planning messages is the radio; however, far more men (75%) than women (58%) had heard a family planning message on the radio. A family planning programme should give special consideration to youth as half of all female respondents aged 15–19 had not been exposed to family planning messages through any of the media sources. Fieldworkers can be an effective means of disseminating contraception messages; however, 88% of women had not discussed family planning with a fieldworker or health professional in the past 12 months. Women in rural areas are more likely than those in urban areas to have discussed family planning with a health worker.

Median age at first childbearing

The median age for an I-Kiribati woman to have her first child is estimated to be 22.1 years, which means that by the time they reach this age, 50% of I-Kiribati women will have had their first child. Education seems to have a direct impact on the age women begin childbearing, as women with secondary education have their first birth more than three years later than women with the lowest educational level.

The 2009 Kiribati DHS also indicates that women are having children later. Women aged 45–49 tended to have their first child at 20.9 years while women aged 25–29 had their first child when they were around 23 years old. Women living in urban areas generally had their first child slightly later (22.6 years) than women in rural areas (21.8 years).

Birth intervals

Children born too soon after a previous birth (less than 24 months), have an increased risk of health problems and infant mortality. The median birth interval in Kiribati is 35 months, and a quarter of births occur less than 24 months after the previous birth. Birth intervals are shorter for women in the lowest wealth quintile (33.5 months) than for women in the highest wealth quintile (40.8 months).

Teenage pregnancy and motherhood

About 10% of women aged between 15–19 years reported that they were either pregnant or had a child at the time of the survey, and 28% of 19 year old women had begun childbearing. Socio-economic factors seem to have some influence on early childbearing, with 19% of teenage women in the lowest wealth quintile having begun childbearing, compared to just 5% of teenage women in the highest wealth quintile.

Policy note:

DHS results underline that there have been few changes in fertility over the past 20 years, a surprising picture considering the growing pressure on land and other natural resources, particularly in South Tarawa.

Effectively addressing this issue poses a serious policy challenge for Kiribati authorities, given the complexity of key underlying issues, as illustrated by:

- a continued desire by many i-Kiribati people for large families notwithstanding resource pressures all around;
- prevailing low contraceptive prevalence rates, despite one in four women expressing an unmet need for family planning; and
- the classic knowledge-attitude-behaviour disconnect of having widespread knowledge of family planning (93% of all women and 97% of men), yet two in three women aged 15–49 reporting never having used a contraceptive method.

A different policy and strategy is in order, as low contraceptive prevalence is not merely a family planning issue, it presents a serious sexual and public health challenge.

For more detailed information on fertility and family planning, see chapters 4, 5, 6 and 7 in the Kiribati 2009 DHS Report.

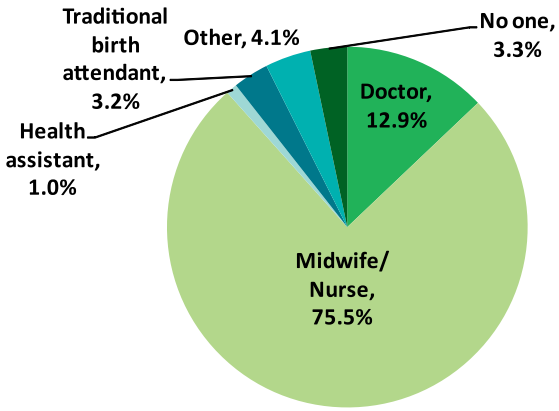
Reproductive health

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

Antenatal care

Almost all women in Kiribati received care from a skilled provider during their last pregnancy. Most women's care was provided by a nurse or midwife.

Providers of antenatal care



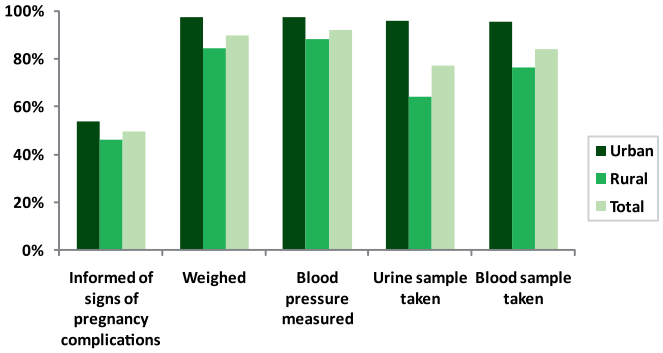
More than 70% of women are seen by a skilled health attendant at least four times during their pregnancy. In most cases, women are seen by a midwife or a nurse. This result accords well with the World Health Organization recommendation of at least four antenatal visits. There is some room for improvement around the timing of these visits, however, as only 36% of pregnant women are seen by a health professional before the fourth month of their pregnancy. I-Kiribati women living in rural areas tend to have their first antenatal visit later than urban women.

Quality of antenatal care

Although many women receive antenatal care, the survey results suggest that there is room for improvement in the type of care given. Fewer than half of all pregnant women reported being informed of the signs of pregnancy complications. It is important that women are aware of these signs in order for them to seek urgent assistance when a problem arises. There is a significant difference in the number of urban (96%) and rural (64%) women who have a blood and urine sample taken and tested during pregnancy.

Selected services received by women who received antenatal care for most recent birth

(Women aged 15–49 who had a live birth in the five years preceding the survey)



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

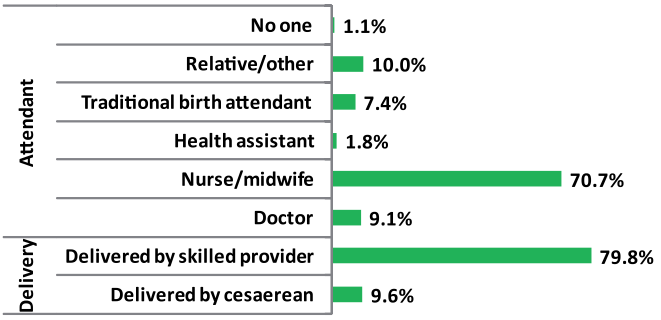
Survey results show that close to 44% of women had two or more tetanus toxoid injections during their last pregnancy and 48% of women reported that their last pregnancy was protected against neonatal tetanus due to previous immunisations.

Childbirth care

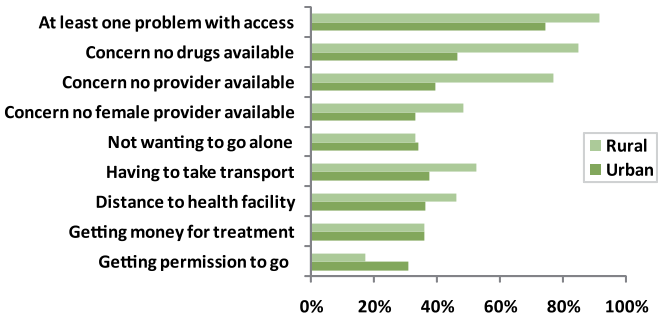
The vast majority of women (66%) deliver their babies in a public health facility. Home births account for the rest, and are most prevalent in rural (42%) compared to urban areas (18%). Women who deliver at home are likely to be older, have higher-order births and belong to lower wealth quintile households.

Close to 80% of pregnant women are assisted by a skilled birth attendant during delivery; in most cases, women receive assistance from a nurse or midwife. The figures are slightly higher in urban (84%) than in rural areas (77%), where traditional birth attendants and midwives play a more prominent role. In rural areas, 21% of women are assisted by a traditional birth attendant or relative, compared with 13% of women in urban areas.

Assistance during childbirth



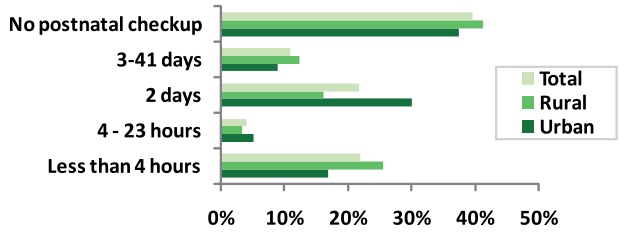
General problems accessing health care



Postpartum care

Postpartum care is important to follow up on any complications following the delivery as well as to give the mother important information on caring for herself and her child. The crucial period is during the two days following delivery, when most complications arise. Although close to half of all mothers and babies are seen within two days of delivery in Kiribati, nearly 40% of women in both urban and rural areas do not report any postnatal checkups. A higher proportion of rural than urban women have postpartum checkups within 4 hours of giving birth, with little differentiating both groups having their first postnatal checkups within 24 hours. Yet, twice as many urban (30%) than rural women (16%) have their first postnatal checkups only after 2 days.

Timing of first postpartum check-up



General problems accessing health care

Most women reported at least one problem accessing health care. The most common concerns referred to the unavailability of drugs or providers (in particular, of female providers). As is common throughout the Pacific, I-Kiribati women expressed a clear preference for female health professionals, with 41% of I-Kiribati women concerned that no female health provider would be available.

Rural women were far more likely than those in urban areas to report problems accessing health care. In contrast to all other concerns raised, twice as many urban as rural women referred to the need to seek permission to visit a health facility as a problem when accessing health care.

Policy note:

While 9 out of 10 women access antenatal care during their pregnancy and 7 out of 10 see a health care professional at least four times during their pregnancy, only 1 in 3 women has the first visit before the fourth month of pregnancy, which shows there is considerable room for improvement.

There is also considerable room for improvement in the quality of antenatal care in rural areas, as virtually all women in urban South Tarawa have blood and urine samples taken, compared to just 64% of rural women.

Given the importance of postpartum care to ensure mother and child health, it is worth noting that only half of all mothers reported that they were attended to within two days of delivery (52% of urban and 45% of rural women), but with nearly twice as many urban (30%) than rural women (16%) having to wait for 2 days; a further 9% of urban and 13% of rural women had to wait between 3 and 41 days for their first post natal check, and a staggering 38% of urban and 41% of rural women experienced no postnatal check-up at all. This reported lack of post-partum care deserves urgent policy attention by Kiribati health authorities, not only for obvious child health/survival and reproductive health considerations, but also because postpartum care provides a unique opportunity for intensive child health and sexual/reproductive health education, including advice and information on family planning.

Women, particularly those in rural areas, highlighted many general problems with accessing health care, with lack of drugs (85% urban, 47% rural) and unavailability of health care providers (77% urban, 39% rural) topping the list. Note that twice as many rural as urban women expressed such concerns.

*For more detailed information on reproductive health see chapter 9 in the Kiribati 2009 DHS report.

Child health

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

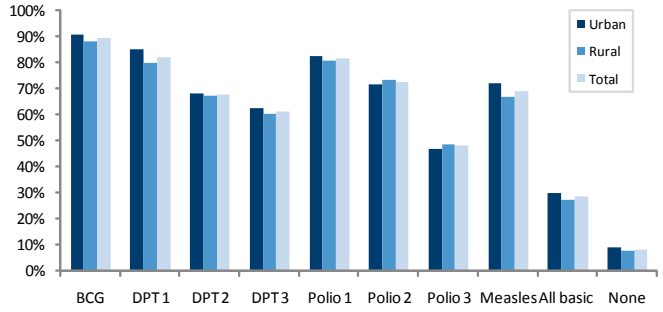
Universal immunisation of children against the eight vaccine-preventable diseases (tuberculosis, diphtheria, whooping cough [pertussis], tetanus, hepatitis B, haemophilus influenzae, polio and measles) is crucial in reducing infant and child mortality.

Vaccinations

According to the 2009 Kiribati DHS, less than one third (29%) of I-Kiribati children aged 12–23 months were fully vaccinated at the time of the survey. There is only minor variation in the vaccination rates of children living in urban and rural areas.

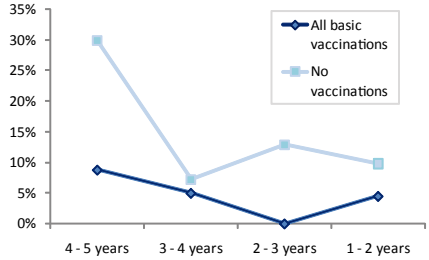
More boys (35%) than girls (22%) are reported to be fully immunised. A mother's education appears to have a significant impact on the likelihood that a child will be fully immunised, as around 40% of children whose mothers have a secondary level 1 education are fully immunised compared with 24% of children whose mothers have less education.

Coverage by type of vaccination
Children aged 18–29 months



Although overall vaccination rates are low in Kiribati, the 2009 Kiribati DHS suggests that the situation is improving. The number of children who had no vaccinations by the age of 12 months has dropped from 30% to 10% in the past four years. According to World Health Organization guidelines, children are considered fully immunised when they have received a BCG vaccination, three doses of DPT and polio vaccine, and a measles vaccination by the age of 12 months. For children aged between one and five years, the number of children with all basic vaccinations is now increasing. While measles vaccination rates have increased markedly, currently standing at 69%, it is disturbing to note that only one in ten children have been fully vaccinated at 12 months.

Vaccination coverage in the first years of life



Birth weight

Nearly eight in ten I-Kiribati children are weighed at birth. Nine percent of children born in the five years prior to the survey weighed less than 2.5 kg at birth. About 12% of children born in rural areas have a birth weight of less than 2.5 kg compared with 5% of children born in urban areas.

Acute respiratory infections (ARI)

The incidence of ARI in Kiribati is low, with only 7% of children under age five having shown symptoms in the two weeks preceding the survey. A higher rate of ARI was observed in children whose mothers have little education, those who live in rural areas, and those in the lowest wealth quintile households.

Acute respiratory infection (ARI) is a leading cause of child morbidity and mortality worldwide. Early diagnosis and treatment can prevent many of the deaths it causes.

Fever

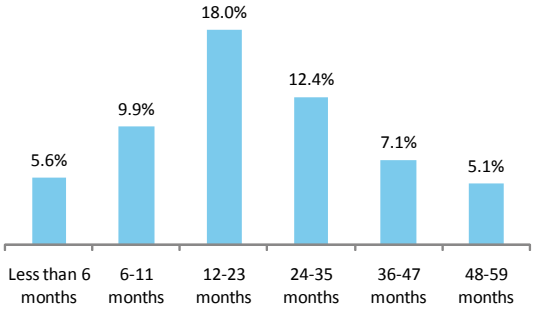
Less than one in four children under age five were reported to have had a fever in the two weeks prior to the survey. Overall, 27% of children with a fever were taken to a health facility or health provider for treatment. About 17% of children with fever were treated with antibiotics.

Diarrhoea

During the two weeks prior to the survey, around 10% of children in Kiribati under age five were reported to have had diarrhoea. This rate is similar to the incidence recorded in the 2007 demographic and health surveys (DHSs) for Solomon Islands, Marshall Islands and Tuvalu.

As shown in other DHSs, the prevalence of diarrhoea is highest amongst the 12–23 month age group. This is not surprising as infants of this age interact much more with other children and they tend to explore by putting all new objects into their mouths. Male children are more prone to diarrhoea than female children in Kiribati.

Prevalence of diarrhoea by age



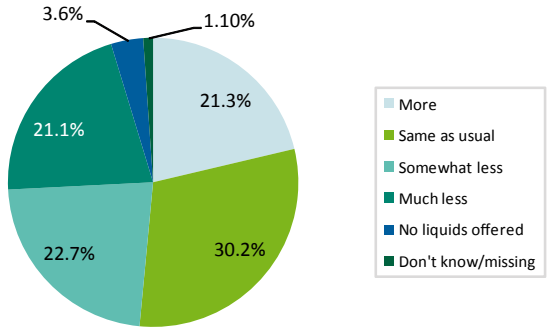
About two thirds of the children who have diarrhoea are taken to a healthcare provider and treated with oral rehydration salts (ORS), while 76% are treated with ORS and increased fluids.

Feeding practices during diarrhoea

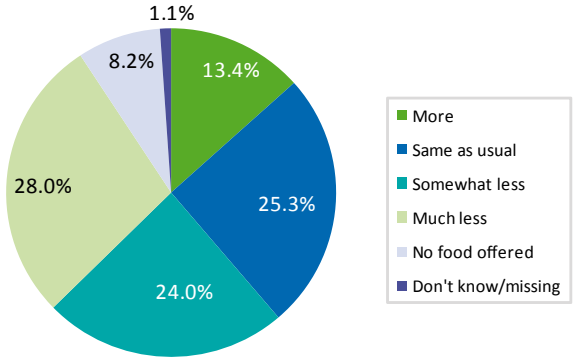
When children have diarrhoea, mothers are encouraged to continue feeding children as they would normally, and to increase the amount of fluids in order to reduce dehydration and minimise the adverse consequences of diarrhoea on the child's nutritional status.

More than half of all children were offered more or the same amount of fluids during diarrhoea. Forty four percent were given less fluid than usual.

Amount of liquids offered during diarrhoea

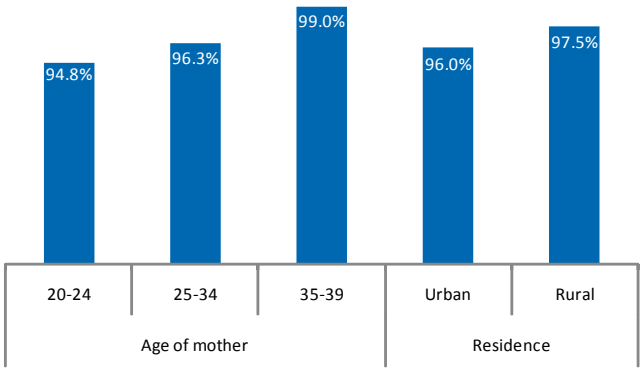


Amount of food offered during diarrhoea



Oral rehydration salts (ORS)

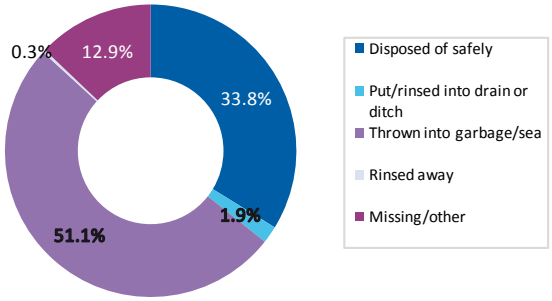
There is comprehensive knowledge of ORS packets in Kiribati and 97% of women who gave birth in the five years preceding the survey knew about them.



Disposal of excreta

Proper disposal of human faeces is extremely important in preventing diseases from spreading. Around one third of children's stools are disposed of safely in Kiribati. Most frequently, stools are thrown directly into the garbage or the sea. Wealth and a mother's education have a direct impact on the way stools are disposed of and the stools of children who live in poorer households and whose mothers have little education are less likely to be disposed of safely. As many households, particularly those in rural areas, do not have improved toilet facilities it is not surprising that only 30% of children's stools are properly disposed of in rural areas.

Disposal of children's stools



Policy note:

The overall rate of complete vaccination is rather low (28%), with male babies more likely to be fully vaccinated. Authorities need to leverage the progress that has already been made in improving vaccination rates in recent years. The importance of timely vaccination needs to be emphasised, as many children are not fully vaccinated by one year of age.

Although most children receive the first of the three polio and DPT vaccinations, immunisation rates decline with subsequent doses.

Low overall complete vaccination coverage and prevailing poor sanitation conditions (safe disposal of excreta) could well explain some of the childhood mortality rates and differentials outlined in other chapters of the the Kiribati 2009 DHS Report.

*For more detailed information on child health see chapter 10 in the Kiribati 2009 DHS Report.

Infant and child mortality

Infant and child mortality data are important not only for demographic assessment but also for design and evaluation of health programmes and policies. Primary and preventative health services aim to improve the quality of life for I-Kiribati people; this includes the reduction of infant and childhood mortality and the incidence of high-risk pregnancies.

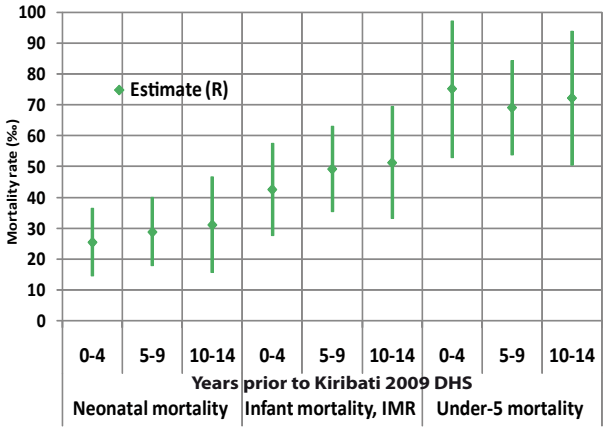
Neonatal mortality	The probability of dying within the first month of life
Infant mortality	The probability of dying before the first birthday
Under-five mortality	The probability of dying before the fifth birthday

The Kiribati 2009 DHS Report provides estimated early childhood mortality rates with standard errors to a 95% confidence rate. The estimated mortality indicators shown in this fact sheet represent the midpoint of the range, and the actual value could fall anywhere within the range.

For the period measured during the Kiribati 2009 DHS, the estimated infant mortality rate was 43 deaths per 1000 live births. This means that 43 of 1000 children born in Kiribati do not live until their first birthday. Of those who survive until their first birthday, another 32 out of 1000 will die before reaching their fifth birthday. This results in an estimated under-five mortality rate of 75 deaths per 1000 live births.

These indicators must be interpreted with some caution given the relatively wide range of possible values. The ranges overlap from one period to the next, so trends are difficult to ascertain with precision. Nevertheless, mortality rates have stayed rather stable. The infant mortality rate shows a slight decrease over the past 15 years, while overall there was a slight increase in child mortality (1–4 year olds) during this period.

Childhood mortality trends

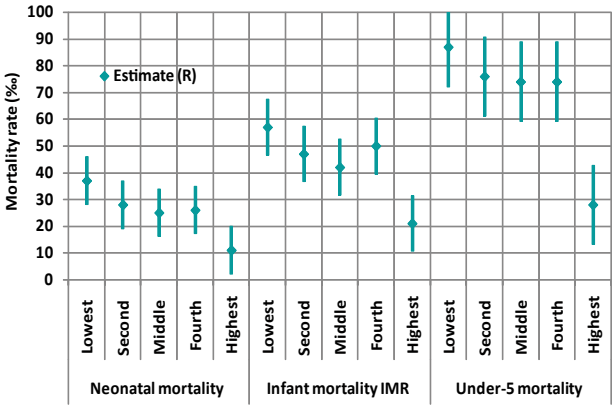


Childhood mortality by socio-economic characteristics

There tends to be a strong correlation between the level of a mother's education and a child's chances of survival. Kiribati certainly follows this trend and children born to mothers with a secondary level 2 education appear almost twice as likely to live to age five as those born to women with less education.

Residence has an impact on survival rates but the trends are not consistent across the different age ranges. Infant mortality and neonatal mortality rates seem lower in South Tarawa, while post-neonatal rates appear lower in rural areas. The difference in urban and rural neonatal mortality rates is most likely linked to two factors: medical services are easier to access in South Tarawa than in rural areas; and there is a higher prevalence of households in the higher wealth quintiles in South Tarawa.

Childhood mortality by wealth quintile

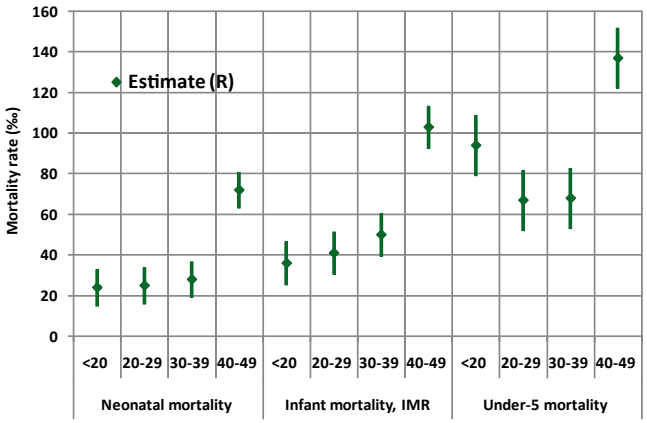


Childhood mortality by demographic characteristics

In general, the Kiribati 2009 DHS results suggest that child mortality rates are slightly higher for males (32) than females (24). In contrast to general trends worldwide, the neonatal mortality rate is higher for females than males. This is peculiar given that the biological disadvantage of boys versus girls is normally most pronounced during the first month of life.

In most countries the hypothesis 'too early and too late increases child mortality' holds true. In Kiribati, mortality rates are consistently higher for women aged 40–49; however, the results are mixed for younger mothers. Although child mortality and under-five mortality rates are higher among mothers younger than age 20, there are no such differences with neonatal mortality, and overall early mortality rates were slightly lower among the younger age groups, a picture somewhat different from what is generally observed worldwide.

Mother's age at birth

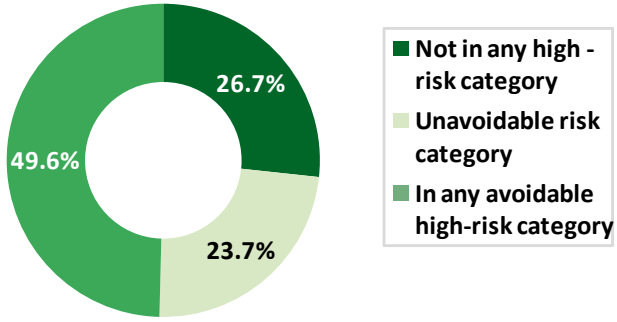


High-risk fertility behaviour

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

Only 27% of births in Kiribati were not in any high-risk category. An additional 24% of births are first-order births to mothers aged 18-34, which is considered an unavoidable risk category. The remaining 50% of births in Kiribati are in at least one of the specified avoidable high-risk categories. The results of the Kiribati 2009 DHS suggest that a child who falls within an avoidable risk category is twice as likely to die as a child not in any high-risk category. A child who: was born to a mother older than 34; was born after a birth interval of less than 2 years; or is the fourth child or more, is four times more likely to die than a child not in any high-risk category.

High-risk births



Policy note:

A key finding of the Kiribati 2009 DHS is that under-five mortality has remained reasonably stable over the past 15 years. This is the result of a modest improvement in infant mortality, which is offset by a slight increase in child mortality (1–4 year olds). An analysis of the causes of death is a matter of urgency, to better target future interventions.

Location (whether a person lives in an urban or a rural setting), combined with socio-economic status and well-being also play a major defining role. Childhood mortality levels were higher in the outer islands and lowest in the highest wealth quintiles and amongst mothers with higher levels of education. Effective intervention programmes need to acknowledge such clear socio-economic differences.

In terms of key risk factors, the age of the mother (too young, and more importantly, too old) plays an important role, with mortality levels highest amongst mothers over age 40.

*For more detailed information on infant and child mortality see chapter 8 in the Kiribati 2009 DHS report.

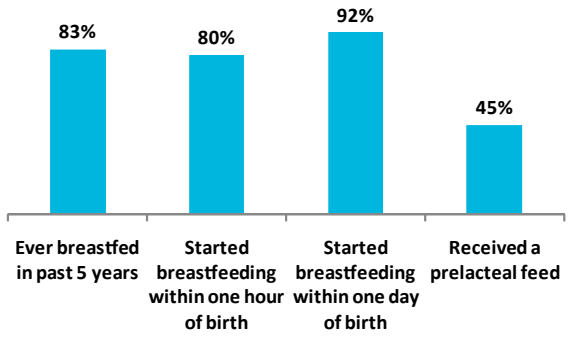
Child and maternal nutrition

Adequate nutrition is essential to good health. The period from birth to two years of age is particularly critical for optimal growth, health and overall development. In subsequent years, poor nutrition can impact on productivity and places an extra burden on health systems as a result of non-communicable diseases. Poor nutrition can be attributed to not eating enough nutritious food, eating too much food that is high in fat and sugars, and other socio-cultural factors.

Infant and young child feeding practices (IYCF)

Breastfeeding in Kiribati is widespread, but less common than in neighbouring Tuvalu (90%) to the south or Marshall Islands to the north (95%), with 83% of children born in the five years preceding the survey having been breastfed at some time.

Breastfeeding practices



However, the number of children who are exclusively breastfed declines well before age six months, the age recommended by WHO and UNICEF for introduction of solid foods. Seventy nine percent of children are exclusively breastfed in the first month of life, but this number declines to just 23% by six months. This means that three out of four infants' diets are supplemented by water, other milk and food products before they reach six months of age. This practice may be contributing to the high prevalence of underweight children in Kiribati as children may not be receiving the nutrients necessary for healthy development.

The mean duration of breastfeeding among I-Kiribati children born in the three years preceding the survey is 23.8 months. The mean duration of exclusive breastfeeding is 4.8 months and that of predominantly breastfeeding is 5.7 months. At age six months, 94% of children are at least partially breastfed.

About two-thirds of all children do not consume the recommended dietary requirements for good health. Slightly less than half of children aged 6–23 months are not fed frequently enough according to ICYF feeding recommendations and slightly more than half are not fed a sufficient variety of foods.

Nutritional status of children

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

Close to one quarter (23%) of children in Kiribati are considered underweight or severely underweight, with little difference reported between the number of underweight children in urban and rural areas. In contrast to many other Pacific Island nations, a low prevalence of obesity was observed, with 6% of children considered obese.

This high proportion of underweight children places Kiribati well above the WHO threshold (10%), making the prevalence of underweight children a significant public health issue. Although more children are underweight in poor than in wealthier households, around 14% of children in the highest wealth quintile are reported to be underweight, showing that this problem cuts across all economic sectors.

Micronutrient intake

Malnutrition can result in micronutrient deficiencies such as a lack of vitamin A and iron. Most children were fed vitamin-A rich foods and 66% were reported to have received vitamin A supplements. Slightly less than 13% of children received iron supplements in the seven days before the survey.

Foods consumed by mothers

Eating the right amount of good quality food has a positive impact on mothers' health and the health of their children. Healthy eating habits are particularly important during pregnancy and breastfeeding.

Most women with children under age three years reported having eaten foods rich in protein and grains such as fish and rice, during the 24 hours preceding the survey. More than half of the women surveyed indicated that they had eaten foods such as pumpkin, sweet potato or mango, which are rich in vitamin A.

Women's diets vary according to where they live. Women in South Tarawa are far more likely to eat dairy products than rural women and are less likely to eat root vegetables, such as taro. Although around one third of women ate foods high in fat in the 24 hours prior to the survey, this type of food was consumed more by women in wealthier households (44%) than by women in lower wealth quintile households (24%).

Micronutrient intake among mothers

Almost all mothers (94%) consume vitamin-A rich foods and most (87%) consume iron-rich foods.

As iron deficiency anaemia can cause perinatal and maternal mortality, iron deficiency has been pinpointed as one of the top ten risk factors in developing countries for 'lost years of healthy life'. Iron supplements are reasonably common during pregnancy in Kiribati, with 61% of women reporting having taken iron supplements during their last pregnancy.

Severe vitamin A deficiency can cause night blindness in pregnant women. Around 15% of women reported that they suffered from night blindness. This may be attributable, at least in part, to the fact that only 40% of women receive a vitamin A postpartum supplementation.

Policy note:

As in most Pacific Island countries, breastfeeding in Kiribati is widespread, but less pronounced than in neighbouring Tuvalu (90%) to the south or the Marshall Islands to the north (95%), with 83% of children born in the five years preceding the survey having been breastfed at some time. The mean duration of breastfeeding amounted to 23.8 months, and at age of six months, most children (94%) are at least partially breastfed.

Given this widespread acceptance and practice of breastfeeding, it does come as a surprise, however, that only one in four children is exclusively breastfed at the age of six months (down from 79% in the first month of life), which is the recommended WHO standard to achieve optimal growth and development. Considering the DHS findings on child health, it seems that more concerted policy attention has the potential to increase this percentage, to contribute to both child health and household well-being (by saving on food supplements, including expenditure on milk formula), with minimum implications on the health budget.

More concerted efforts could also be made to improve the amount and type of food children are fed as ICYF feeding recommendations are not met for around half of I-Kiribati children.

Although the survey provides a generally healthy nutritional picture for women in terms of food consumption and micronutrient intake by mothers, the same cannot be said for children, with close to one quarter of all children (23%) considered underweight or severely underweight. This is well above the WHO threshold (10%), making it a significant public health challenge.

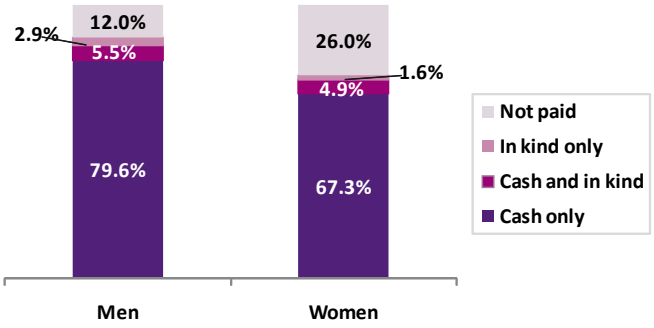
*For more detailed information on nutrition see chapter 11 in the Kiribati 2009 DHS report.

Women's empowerment

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

The number of working men and women was very similar, with slightly more than 55% of currently married men and 54% of currently married women employed in the year prior to the Kiribati 2009 DHS. Most people were paid in cash. Women were more than twice as likely as men to work but not receive payment.

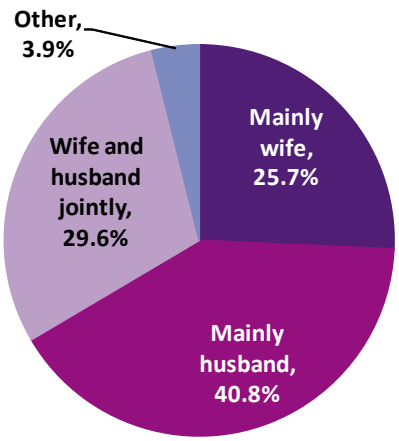
Type of earnings of currently married respondents aged 15–49 employed in the past 12 months



Around two in ten married women who have their own cash earnings decide by themselves how their earnings should be spent. Close to half of the married women surveyed indicated that they make this decision jointly with their partner.

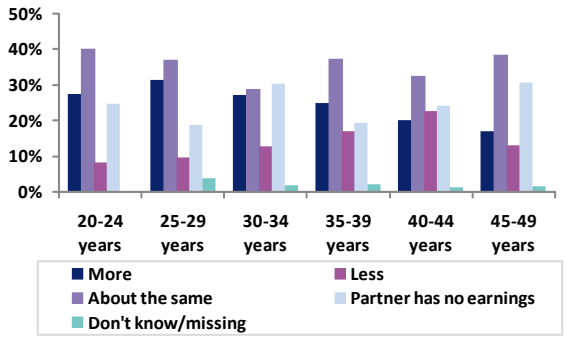
Younger women are generally more independent than older women in making decisions on how to spend their earnings; however, the group with the most autonomy over how their income is spent is women aged 45–49. Couples living in urban areas were more likely to make decisions jointly about how the wife's earnings are spent than couples in rural areas.

Person with control over husband's earnings Currently married women aged 15–49



More than one third of all working married women reported earning less than their husband or partner and one quarter of working married women reported that their partner does not bring in any money. As a woman gets older and has more children, her likelihood of earning more money than her husband decreases.

Women's earnings compared with their husbands'



Participation in household decision-making

Both men and women were asked about their participation (i.e., having the final say either jointly or solely) in decisions on major and minor household purchases, their own health care and visits to the wife's family or relatives.

Most currently married I-Kiribati women do not make household decisions themselves. One quarter of the women surveyed reported that they have no say in any of the decisions related to household purchases, visits to their family or their own health care. Women in rural areas are less likely than those living in urban areas to participate in decision-making.

Whether or not men or women make decisions, or make them jointly, depends largely on what is being decided, and to some extent on who is doing the reporting. For example, 20% of women reported making daily household decisions independently, yet only 7% claimed to make an independent decision on a major household purchase. Five times as many (34%) women claimed such decisions are made by their husbands, while just under half (47%) see these as joint decisions. Comparing these views with male reports on who they believe should have a greater say in decision-making illustrates some interesting contrasts in self-perception versus perception of others. Thirty nine per cent claim women should have a greater say in making daily household decisions independently, and only 22% see major household purchases as a male domain. The majority (71%) expressed the view that major household purchases ought to be joint decisions.

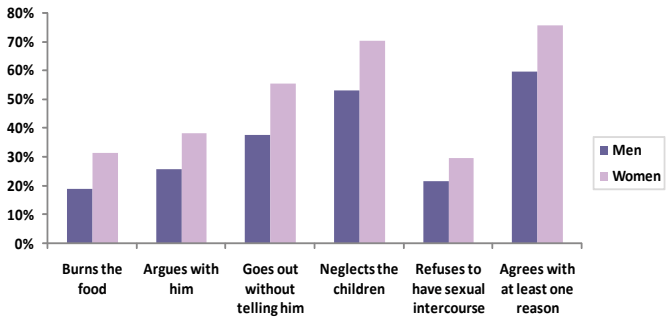
Attitudes towards violence against women

The majority of people surveyed consider that violence against women is justified in certain circumstances. Considerably more women (76%) than men (58%) agree that violence against women is justified for at least one of the reasons specified in

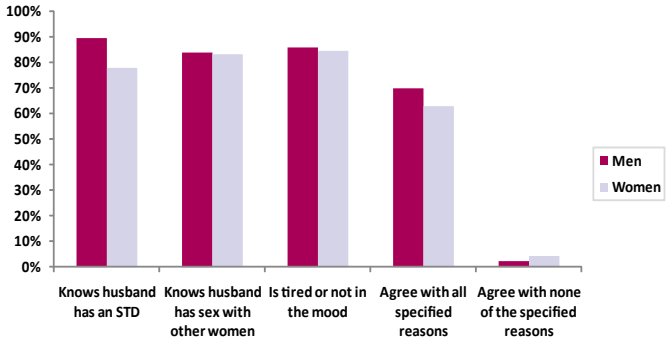
the survey. These results indicate that I-Kiribati women are even more likely than men to consider violence a part of normal relationships. Although traditional norms teach women to accept, tolerate and even rationalise violence, it is surprising that women appear even more accepting of violence directed at them than men.

The most commonly accepted justification for violence against women was neglecting the children. The trend noted above, with women being more accepting of violence than men, is reflected in a much higher rate of acceptance by women that violence in the case of child neglect is justified (70%), compared to men (52%). However, this and other common justifications are somewhat less prevalent amongst men and women with higher levels of education and general socio-economic status.

Justification of violence against women
Men and women aged 15–49



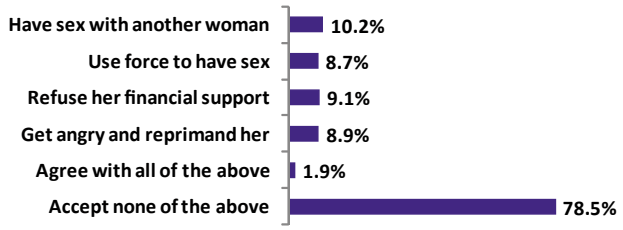
Attitudes towards a woman's right to refuse sex with her husband
Men and women aged 15–49



As with the results on attitudes to violence against women, more men (69%) than women (63%) consider that a woman is justified in refusing to have sex with her husband in certain circumstances. A person's background has a significant impact on attitudes towards sexual autonomy in Kiribati. The survey results show that people with higher education, a job, and who live in wealthier households are more likely than other groups to accept that a woman can refuse sex with her husband. The survey results consistently suggest that men in Kiribati are less accepting of spousal or partner violence than women.

Nearly 80% of men do not feel that if a wife refuses to have sex with her husband he is justified in responding in one of the negative ways suggested in the survey.

Men's attitude towards a husband's right to certain behaviours when his wife refuses sex



Policy note:

While the DHS revealed no difference in the number of working men (55%) and women (54%), more pronounced contrasts emerge in remuneration: one in four women receives no pay for her work compared to 12% of males, 80% of whom are paid in cash compared to 67% of women. An obvious area of policy intervention would focus on redressing such imbalances.

Some gender differentials were reported regarding decision-making across standard DHS categories. Whether or not men or women make decisions, or make them jointly, was shown to depend largely on what is being decided on, and to some extent also on who was being asked, with men making more pronounced reference to joint decision-making than women.

Respondents' attitudes to violence against women are disconcerting, not only with the majority of men and women accepting such violence as justified under specific circumstances (wife burning food, arguing with husband, going out without telling him, neglecting children, refusal of sex with him), but with many more women (76%) than men (58%) doing so.

Whether or not this reflects a low sense of self-esteem and resignation amongst I-Kiribati women, different levels of honesty in male responses or perhaps an indication that attitudes might be changing with men realising that domestic violence is wrong, can only be speculated on in this context. But these findings do corroborate earlier findings of a gender-based violence survey which highlighted the widespread nature of this problem across society and the tendency to accept domestic violence as a given.

Both studies provide substantive evidence of the magnitude of this problem, and can assist in pointing government, communities and non-governmental organisations (NGOs) in the right direction to make concerted efforts in developing and implementing unambiguous policy measures to help bring about a change to a 'culture of domestic violence'.

*For more detailed information on women's empowerment see chapter 13 in the Kiribati 2009 DHS report.

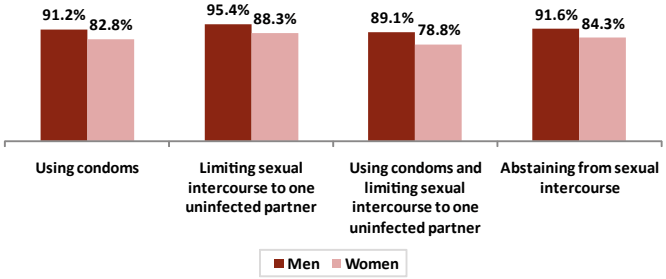
HIV and AIDS

Human immunodeficiency virus (HIV) is a virus that causes acquired immunodeficiency syndrome (AIDS) and weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that lead to death through these secondary infections. The predominant mode of HIV transmission is through heterosexual sexual contact, followed in magnitude by perinatal transmission, where the mother passes the virus to the child during pregnancy, delivery or breastfeeding. Other modes of transmission are through homosexual contact, infected blood and unsafe injections.

Kiribati is considered to have a low HIV prevalence, with a total of 52 people diagnosed with HIV as of the end of 2009. Transmission is most likely to occur via heterosexual contact, and those considered most at risk are seafarers, their wives and children, and people providing sexual services, often to seafarers.

Almost all women (97%) and men (99%) in Kiribati have heard of AIDS. More comprehensive knowledge of how to prevent HIV infection was somewhat less widespread but still reasonably high. Men appear to have a slightly better knowledge of HIV and AIDS than women.

Knowledge of HIV/AIDS prevention methods Men and women aged 15–49

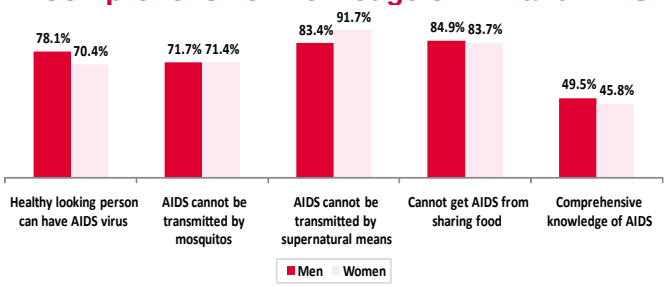


Despite most people having some knowledge of HIV and AIDS, there appear to be some widespread misconceptions about how HIV is transmitted. Around three quarters of men and women know that HIV cannot be spread via mosquito bites and most people know that it cannot be transmitted by supernatural means. When the various beliefs are analysed together, however, the survey results indicate that only half the respondents have good, comprehensive knowledge of how HIV is transmitted.

Mother-to-child transmission

Slightly more women than men were aware that HIV can be transmitted by breastfeeding (88% of women and 84% of men). The number of people who were aware that the risk of mother-to-child transmission can be reduced if an infected mother takes retroviral drugs during pregnancy was much lower (39% of women and 38% of men). People educated to at least secondary level tend to have more knowledge of mother-to-child transmission than people with little education, but other factors such as age and residence do not appear to have any impact on people's knowledge.

Comprehensive knowledge of HIV and AIDS



Stigma and attitudes associated with HIV and AIDS

Most men and women reported that they would be willing to care for a family member with AIDS in their home. Far fewer people (49% of women and 54% of men) reported that they think a female teacher with HIV should be allowed to continue teaching. Overall, around three in ten respondents expressed tolerant and accepting attitudes on all four indicators used in the survey.

Previous HIV testing

The majority of women (83%) and men (85%) know where to obtain an HIV test.

Attitudes toward negotiating safer sex

More men (89%) than women (78%) consider that a wife is justified in refusing to have sexual intercourse with her husband or asking her husband to use a condom if she knows he has a sexually transmitted disease. The fact that more men than women agreed with this statement illustrates the differing attitudes between a woman's perception of her right to protect herself and the views of I-Kiribati men around a woman's right to refuse sex.

Multiple partners and condom use

More men (9%) than women (2%) reported having two or more sexual partners during the 12 months preceding the survey. Men in the higher wealth quintiles are more likely than men in lower wealth quintiles to have had multiple sexual partners.

Of those people who reported having two or more sexual partners, condom use was higher among male (29%) than female respondents (4%).

Overall, I-Kiribati men reported having many more sexual partners (7.6) during their lifetime than women (1.6).

As observed in many other recent DHSs in the Pacific region, there appears to be a disconnect between stated ideals concerning marital fidelity and actual practice. Although around two thirds of respondents believed that married men should only have sex with their wives, only 40% of men and 22% of women reported that most married men they knew only had sex with their wives. Likewise, despite 85% of men surveyed considering that women should only have sex with their husband, only around half stated that most of the women they know actually are faithful.

Around three quarters of survey respondents agreed that women should wait until marriage to have sex, but fewer agreed that young men should wait until marriage (49% of women and 56% of men).

Payment for sex

Five per cent of men aged 15–49 had paid for sex in the 12 months prior to the survey. Men who paid for sex tended to be young, unmarried, and in either the highest or lowest income brackets. Fewer than one in four men used a condom when they last purchased sex.

Sexually transmitted infections (STIs)

With 11% of women and 6% of men aged 15–49 reporting having had an STI or having shown symptoms of an STI in the 12 months preceding the survey, the STI rate in Kiribati is likely to be reasonably high. As many STIs are asymptomatic the 2009 Kiribati DHS is likely to under-represent actual STI prevalence. The fact that one third of men and women who either had an STI or had symptoms of an STI in the 12 months preceding the survey did not seek any treatment represents an additional cause of concern, as does the reported very low condom use amongst men and women (see also Fertility and Family Planning factsheet).

HIV/AIDS prevention among young people 15–24 years old

	Women	Men
Comprehensive knowledge of AIDS	44.4%	48.6%
Knowledge of condom source	73.8%	76.1%
Used condom during first sex	3%	13%
Percentage who had sex in the past 12 months and had higher risk sex	73.1%	11%
Percentage who reported using a condom during higher risk sex	2.4%	29.6%

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

Around 19% of young women and 56% of young men had sexual intercourse before they turned 18. Women who start having sex before 18 years of age tend to have low education levels and low income. More than two thirds of men aged 18–24 who had sexual intercourse before age 18 reported that they did not know where to get condoms.

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

The survey results show a significant difference between the sexual practices of unmarried women and unmarried men aged 15–24. Only three per cent of young, unmarried women (N=14) reported having sex in the 12 months preceding the survey, compared with 63% of young men (N=177).

Less than one third of young males having premarital sex reported using a condom the last time they had sex. Two in three of these men knew where to obtain a condom, yet only one in three reported using one the last time they had sex.

Alcohol consumption and sexual intercourse among youth

Alcohol can impair judgment, compromise power relations and increase risky behaviour. Among young people aged 15–24 years, 2% of women and 24% of men reported having sex while they or their partner were drunk.

Policy note:

Although most I-Kiribati people have heard of AIDS and many know about how it is transmitted, there are still gaps apparent in people's knowledge of HIV and AIDS. Comprehensive knowledge is most prevalent amongst the more educated men (65%) and women (62%), and least pronounced amongst men (40%) and women (24%) with either no or only a few years of primary education, again highlighting the importance of education.

The stigma that exists around people with HIV appears to be driven by fear and misunderstanding of how HIV is transmitted. Therefore, health communication and education strategies should focus on reassuring the public that provided certain types of behaviour and exposure are avoided, it is safe to live with and care for people living with HIV. As long as unfounded fears remain and HIV stays a hidden threat in the community, people are unlikely to be tested or seek treatment, which will result in more people unknowingly infecting others.

While three out of four unmarried male and female youth reportedly know where to obtain a condom, condom use is very low throughout Kiribati. With a high proportion of men having sex at a young age, and only 13% of them – and even fewer young women (3%) – using a condom during first sex, there is obvious room for more effective and better targeted communication strategies to increase condom use to prevent STI and HIV infections.

Although I-Kiribati women start having sex later than men, with many waiting for marriage, the survey results suggest that women are still at risk of infection. Many women report that they would not protect themselves if their husband had an STI, and less than one quarter stated that most married men they know are faithful. The STI prevalence rate is higher among women than men, and one third of people showing symptoms do not seek treatment. Future health education and communication strategies should aim to remove the stigma around STIs so people can recognise and avoid risk, and feel confident seeking treatment when symptoms occur.

*For more detailed information on HIV/AIDS see chapter 12 in the Kiribati 2009 DHS Report.