Solomon Islands

Demographic and Health Survey 2015

Final Report

Solomon Islands National Statistics Office,
Solomon Islands Ministry of Health and Medical Services and
the Pacific Community

Pacific Community
Communauté du Pacifique

Australian Aid

unicef

Solomon Islands Government

Solomon Islands

Demographic and Health Survey

2015

Prepared by Solomon Islands National Statistics Office,

Solomon Islands Ministry of Health and Medical Services (SIMoHMS),

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ABOUT THIS REPORT

This report summarises the findings of the Solomon Islands Demographic and Health Survey 2015 (DHS 2015) implemented by the Solomon Islands National Statistics Office (SINSO) in collaboration with the Solomon Islands Ministry of Health and Medical Services (SIMoHMS). The Solomon Islands Government (SIG) through the SINSO undertook project planning, recruitment of enumerators and executed the field-enumeration including undertaking data-entry operations, in coordination with the SIMoHMS. The SINSO and SIMoHMS in collaboration with other SIG ministries, the Pacific Community (SPC) and the Solomon Islands Resource Facility (SIRF) undertook the analysis of the various chapters of the report.

The Pacific Community (SPC) was the technical assistance partner to the DHS 2015 project. SPC provided technical support in the areas of survey planning and budgeting, sample and questionnaire design, pretesting and training, data processing and overall coordination and collating of the final analysis of the report.

The DHS 2015 project was funded jointly by the Australian Department of Foreign Affairs and Trade (DFAT)-Aid Program, SIG and the United Nations Children's Fund (UNICEF). DFAT provided program management support to the SINSO, and direct statistical technical assistance and data processing support through the Solomon Islands Resource Facility (SIRF). UNICEF provided specific medical supplies for the project.

Additional information about the survey can be obtained from:

Solomon Islands National Statistics Office, Ministry of Finance and Treasury (PO Box G6, Honiara, Solomon Islands; Tel: 677-21427; Fax: 677-23775; Email: STATS-Management@sig.gov.sb; Web: http://www.statistics.gov.sb); and by contacting the Statistics for Development Division, Secretariat of the Pacific Community, BPD5, 98848, Noumea Cedex, New Caledonia. (Tel: 687-262000; Fax: 687-263818; Email: spc@spc.int; Web: www.spc.int/sdd)

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DISCLAIMER

TABLE OF CONTENTS

TABLES AND FIGURES

MINISTER'S FOREWORD

On behalf of the Solomon Islands Government and as Minister responsible for Official Statistics and the Solomon Islands National Statistics Office, I welcome the findings of this report, *Solomon Islands Demographic and Health Survey 2015 Final Report*, that provides new information and an insightful analysis about the changing demographic and health related development challenges facing our country. This report is another significant statistical and development milestone for the nation.

The Solomon Islands Demographic and Health Survey 2015 (SIDHS 2015) is a nationwide survey of men and women of reproductive age that was designed to provide up-to-date data on fertility and child mortality, family planning, maternal health, breastfeeding practices, nutrition, anaemia and the presence of iodine in cooking salt. Information about the knowledge and attitudes of HIV/AIDS and other sexually transmitted infections (STI), disability, gender-based violence and other community-level data such as accessibility and availability of health, and family planning services were also collected in the SIDHS 2015.

The SIDHS 2015 is the second DHS to be conducted in the Solomon Islands. The first was conducted in 2006/2007. Recently in November 2016, the Solomon Islands Cabinet endorsed the implementation of the country's first ever National Statistics Development Strategy (NSDS) 2015–16 to 2035. The NSDS recognises the importance of conducting DHSs within a 5 to 10 years interval, and on a regular basis. This means that any other government endorsed DHS including other surveys and censuses will now be undertaken as an integral part of the NSDS going forward.

The NSDS provides the guiding strategy that brings together all key stakeholders in the production, dissemination and use of statistics for policy, development planning, and decision making. More specifically, this report underpins the goals of the NSDS in the provision of timely, relevant and vital statistics that are critical for the effective monitoring and implementation of the government's national development strategy (NDS), the national heath strategic plan, the fiscal (budgetary) policy and the medium term development plan (MTDP).

I congratulate the SINSO of the Ministry of Finance and Treasury (MOFT), and the Ministry of Health and Medical Services (SIMoHMS) for collaborating in implementing this project on behalf of the government. I also congratulate the Pacific Community (SPC) for partnering with the government and supporting the implementation of this project. This gratitude is also extended to our key development partner, the Australian Department of Foreign Affairs (DFAT)-Aid Program for on-going funding and programme support, including technical support provided through the Solomon Islands Resource Facility. The same words of commendation go to the United Nations Children's Fund (UNICEF) for the provision of key medical supplies for the project.

Lastly, I commend the people of the Solomon Islands particularly those households who have participated in making the SIDHS 2015 project a success.

Honourable Snyder Rini, MP
Minister for Finance and Treasury

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The Solomon Islands National Statistics Office (SINSO) acknowledges the earnest efforts put forth by different individuals and organisations towards the successful completion of the SIDHS 2015 and the release of this final report.

The SIDHS 2015 was implemented by the SINSO in collaboration with the Solomon Islands Ministry of Health and Medical Services (SIMoHMS) with technical assistance provided by the Pacific Community (SPC). The Australian Department of Foreign Affairs and Trade (DFAT) - Aid Program provided counterpart funding and programme support including technical support provided through the Solomon Islands Resource Facility (SIRF). UNICEF provided specialist medical support for the project.

The success of the SIDHS 2015 reinforces SINSO's efforts in progressing the implementation of the Solomon Islands National Statistics Development Strategy (NSDS) 2015–16 to 2035 through the provision of up-to-date statistical information and in progressing efforts towards the revitalising of national statistics system so as to respond effectively to the growing demand for data and information for policy, planning and decision making.

SINSO extends its deep appreciation to SPC through the Statistics for Development Division (SDD) for its excellent technical support provided by senior technical staff namely: Arthur Jorari, Kaobari Matikarai, Bertrand Buffière and Toga Raikoti. SPC provided technical assistance in various phases of this survey, including sampling, finalisation of survey questionnaires, training of field staff, assistance with data processing, reviewing of draft tables, and compiling this report. SINSO also acknowledges SPC's country office through Mia Rimon and various specialists for peer reviewing certain chapters of this report. The layout and formatting of publication by SPC's Publication Section is also acknowledged.

The SINSO also recognises the program management support provided by DFAT's Aid Program through the Health and Education Program by staff: Moses Tongare, Jane Bastin-Sikimeti and Kirsten Hawke. SINSO also appreciates the technical support provided through the Solomon Islands Resource Facility (SIRF) directly to the SINSO through Dr. Willie Lahari, Statistics Adviser, and Rubén Hume, CSPRO Data Processing Consultant. The support from UNICEF through the Country Representative, Dr. Yun Jong Kang, is also highly appreciated.

Specials thanks goes to staff of the SIMoHMS, SINSO and other ministries who participated as contributors to the various chapters, reviewers, resource persons and those engaged as enumerators, supervisors and nurses. Your names are acknowledged in the lists of: contributors to the report, reviewers and resource persons, including persons listed in Appendix D. The Permanent Secretary, Dr. T. Dalipanda and Undersecretary (Policy), Dr. C. Becha of the SIMoHMS are commended for their leadership and support for the SIDHS 2015.

Special recognition must go to the SIDHS 2015 Project Director, late Ms. Irene Kalauma, whose excellent leadership led to the successful completion of the field enumeration and the final collations of the various chapters of this report. Special gratitude also goes to the Deputy Director, Michael Dimola and SINSO provincial coordinators namely: Raphael Aipaina, Joseph Naesol, Anterlyn Tuzakana, Anna Pitaboe, Josephat Tako, Loyce Pabulu, Moffat Sanau, Alfred Palo, Florence Walekwate, Eleni Tasia and Clera Sa'ohu. SINSO also thanks the Permanent Secretary, Mr. Harry Kuma, Undersecretary (Eco.), Mr. McKini Dentana of MOFT, and our Minister, Honourable Snyder Rini, for top level support.

Finally, we extend our heartiest appreciation to the survey respondents throughout the country, whose participation was vital to the successful completion of this important survey.

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The Solomon Islands Demographic and Health Survey 2015 (SIDHS 2015) is a nationally representative survey of 6,266 women aged 15–49 and 3,591 men aged 15–54. The SIDHS 2015 was the second such survey for the country. The first one was conducted in 2006–2007. 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. The SIDHS 2015 is a follow up of the SIDHS 2006–2007 and is designed to provide updated data to monitor the population and health situation in Solomon Islands.

Chapter 2 provides a descriptive summary of some demographic and socioeconomic characteristics of Solomon Islands' population in 2015. For the purposes of the SIDHS 2015, a household was defined as a person or a group of people, related or unrelated, who live together and eat together. Information on basic demographic and socioeconomic characteristics for all usual residents and visitors (e.g. age, sex, educational attainment and current school attendance) was collected using a household questionnaire. This data collection method allows for the analysis of results for either the *de jure* (usual residents) or *de facto* (those who were there at the time of the survey) populations. The household questionnaire also obtained information on housing facilities (e.g. sources of water, sanitation facilities) and household possessions. Information collected from the household questionnaire provides a snapshot picture of household characteristics in Solomon Islands.

FERTILITY

Survey results indicate that the total fertility rate (TFR) for Solomon Islands is 4.4 births per woman compared with 4.6 per woman in the SIDHS 2006–2007 and 4.7 births per woman in the 2009 Solomon Islands census. TFR is marginally higher for rural women (4.7) than for urban women (3.4). The marginal difference between total and rural values reflects the fact that most of Solomon Islands' population live in rural areas (the proportion living in urban areas is 20%, according to the 2009 population census).

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 three 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 children by the time they are in their late 20s and more than four children by the time they are 50.

The initiation of childbearing in Solomon Islands has not changed much over time. The median age at first birth in Solomon Islands is 22.6 for women aged 25–29, the youngest cohort for whom a median age can be estimated. In addition, women in the highest wealth quintile, urban women, and women with more than a secondary level education tend to have their first child at a later age than other women.

Marriage patterns are an important determinant of fertility levels in a population. Age at first marriage for women shows no change over time in Solomon Islands, with the median age being 21.9 for women in the 25–29 age group and older women aged 40–44. Women tend to marry earlier than men in Solomon Islands. Women in Solomon Islands also tend to initiate sexual intercourse about three years before marriage, as evidenced by the median age at first intercourse among women aged 25–49 of 18.5, compared with the median age at first marriage of 21.3. Men initiate sexual activity around the same time as women.

About 29% of non-first births in Solomon Islands occur at least 24 months after the birth of the previous sibling, while 16% occur within 36 months. The overall median birth interval is 32 months and the same figure is also recorded for both urban and rural women.

To measure the level of unwanted fertility during the SIDHS 2015, 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. In general, more than two-thirds (67%) of births to women aged 15–49 in the five years preceding the survey were wanted, 20% were wanted but at a later time, and 12% were not wanted or planned at all.

FAMILY PLANNING

Overall, knowledge of family planning is high in Solomon Islands, with 94% of women and 98% of all men aged 15–49 knowing at least one contraceptive method. The most common known modern methods among all women include the male condom (90%), followed by an injectable (87%), female sterilisation (85%) and birth control pills (79%). Emergency contraception, which is an emergency measure of contraception, is one of the two least known contraceptives, with only 34% of all women knowing about the method. These findings are similar with those of the SIDHS 2006–2007.

About one in three (29%) married women are currently using any contraceptive method as opposed to 35% of currently married women currently using any method in the SIDHS 2006–2007. Female sterilisation and injectable are the most commonly used methods at 6% and 5.8%, respectively among all women. About 4% of all women use traditional methods of contraception: the rhythm method is the most commonly used traditional method, used by 2% of women. Contraceptive use among all women increases with age, peaking around the mid-30s and declining thereafter. The two most commonly used methods of contraception among currently married women are female sterilisation and injectables currently used by 9% and 8.2% of these women.

Women in rural areas are more likely to use contraceptive methods (30%) than women in urban areas (26%). In general, contraceptive use among women does differ significantly by women's education or wealth.

In Solomon Islands, 88% of current users of modern contraceptive methods obtained the methods from public places , and about 5% sourced the methods from private and other service providers.

One in five women aged 15–49 (20%) who started an episode of contraceptive use, discontinued its use within 12 months for any reason; 5% discontinued because of side effects or health concerns, and 5% discontinued because of other reasons. Wanting to become pregnant or wanting a more effective method of contraception were the next most common reasons for discontinuing a contraceptive method, with both reasons comprising about 3% of women. About 2% of women stopped using a contraceptive method due to method failure and another 5% switched to another method.

About 35% of currently married women have an unmet family planning need, 20% have unmet need for spacing births, and 15% have an unmet need for limiting births. Fewer women reported that their family planning needs were currently being met (29%). Younger married women have a high unmet need for spacing births while older women have an unmet need for limiting births. Unmet spacing and limiting needs were similar between urban women (21% and 14%, respectively) and rural women (20% and 15%, respectively).

MATERNAL HEALTH

About 94% of women aged 15–49 who had a live birth in the five years preceding the survey received antenatal care (ANC) from a skilled provider; this is similar to the findings of the SIDHS 2006–2007. Most of these women (87%) received 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 5% of women who gave birth in the five years preceding the survey received no ANC. Only 17% of women visited an ANC clinic for the first time before the fourth month of pregnancy, an increase of 2% from the SIDHS 2006–2007.

Overall, 85% of births occurred at health facilities, 76% occurred at public health centres, and 8% took place in a private health centre. More than 80% of deliveries were assisted by a skilled provider, of which nearly 4% were delivered with the assistance of a doctor, 72% were assisted by a midwife or registered nurse, and 10% were assisted by a nurse aid, while 2% were assisted by a traditional birth attendant or community healthcare worker. Less than 1% of births received no assistance during childbirth.

About 69% of women had their postnatal check up within the first two days of giving birth, of which, 44% received postpartum care within less than four hours of giving birth and another 20% of women received postpartum care within one to two days after giving birth. Another 21% of women claimed they did not receive any postpartum care after their last birth.

CHILD HEALTH

The majority of children (86%) born in Solomon Islands were weighed at birth. Birth weight is

generally lower among children born to younger women (women's age at birth less than 20) and older women (aged 35–49), first-born children, children of women with no education, children whose mothers smoke cigarettes or tobacco, and surprisingly, among babies in urban areas and babies whose mothers belong to the fourth highest wealth quintile households.

Overall, 73% of children aged 18–29 months were reported to be fully vaccinated at any time before the survey. This is a decline from 83% coverage of children 12-23 months reported in the SIDHS 2006–2007. Furthermore, the proportion of children aged 18–29 months that were fully vaccinated at exactly age 18 months at the time of the SIDHS 2015 was 71%, indicating a drop from 77% reported for children 12-23 months in the SIDHS 2006–2007.

Immunisation coverage for children increases with mothers who have a secondary level education, with coverage at 79% compared with 70% for children whose mother had only a primary school education. A vaccination card was seen for 78% of children aged 18-29 months.

ORPHANHOOD

In Solomon Islands, 63% of children aged less than 18 years live with both parents, while 15% live with their mother but not with their 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 17% of children do not live with either biological parent. These children are likely to be between the ages of 2 and 17 years and living in both rural and urban areas, and living in the fourth and highest wealth quintile households. Either one or both parents of 4% of these children were dead.

NUTRITION

In Solomon Islands, 79% of babies were breastfed within one hour of being born and 94% were breastfed within one day of birth. However, only 59% were still breastfed at 24 months, and 29% of children aged 6–23 months were fed according to the recommended infant and young child feeding practices. About 21% of children were given complementary foods before the recommended six months of age.

A woman's nutritional status has important implications for her health as well as the health of her children. Malnutrition in women results in reduced productivity, increased susceptibility to infections, slow recovery from illnesses, and heightened risks of adverse pregnancy outcomes. About 39% of children and 41% of women have iron deficiency anaemia.

The mean BMI for women in Solomon Islands aged 15–49 is 25.7 kg/m^2; of them, 50% are within normal, 3% are short in nature, and 2% are classified as being underweight. Furthermore, 3% of women have low BMI, with younger women, rural women, and women from the lowest wealth quintile households are more likely to be in this category.

The prevalence of high BMI among women aged 15–49 is 47%, of which, 30% are overweight and 18% are obese. The prevalence of obesity is higher in urban areas.

Moreover, 32% of children are stunted, 8% are wasted, and 16% are underweight.

HIV, AIDS AND STIS

About 91% of women and 97% of men aged 15–49 in Solomon Islands has heard of HIV, and almost every person in the country understands what HIV is and sexually transmitted infections (STIs) are, but the fact that STIs are rapidly increasing, increases the threat to the country as a whole. A comprehensive knowledge of HIV is reported to be much lower among men and women aged 15-49 years (41% and 31%). Comprehensive knowledge is defined as knowing: that consistently using a condom during sexual intercourse and having just one uninfected, faithful partner can reduce the chance of getting AIDS; that a healthy-looking person can have AIDS; and rejecting the two most common local misconceptions about AIDS transmission or prevention.

The SIDHS 2015 findings indicate that, in general, more men are aware about various preventive methods to reduce HIV transmission compared with women, with a similar pattern is observed for each preventative method. This is similar to what was reported in the SIDHS 2006–2007. Knowledge is highest for awareness that HIV can be prevented by limiting sexual intercourse to one uninfected partner (79% women, 87% men). This response has declined slightly among men (89%) but increased slightly among women (77%) since the SIDHS 2006–2007. Slightly more than 62% of women and 70% of men are aware that HIV can be prevented by using condoms every time they have sexual

intercourse, while another 58% of women and more than 65% of men are aware of both prevention methods.

The 2015 results also show that 31% of women and 41% of men aged 15–49 have a comprehensive knowledge about AIDS. About 61% of women and 73% of men agree that the AIDS virus cannot be transmitted by mosquito bites; 71% of women and 77% of men agree that a healthy-looking person can have HIV; 75% of women and 85% of men say that the AIDS virus cannot be transmitted by supernatural means; and 71% of women and 77% of men report that a person cannot become infected by sharing food with a person who has AIDS.

More men than women are likely to express their support of each specific attitude towards people living with HIV or AIDS. For example, 61% of men are willing to care for a family member with AIDS living in the same house as opposed to only 42% of women; 56% of men would buy fresh vegetables from shopkeeper who has the AIDS virus as opposed to only 33% of women; and 30% of men and 19% of women agree that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching. About the same percentage of women (67%) and men (66%) agree that they would not want to keep secret the fact that a family member was infected with the AIDS virus.

About 66% of women and 62% of men know that HIV can be transmitted by breastfeeding. About 29% of women and 32% of men know that the risk of mother-to-child transmission can be reduced through the use of certain drugs during pregnancy. Another 24% of women and 23% of men know that HIV can be transmitted by breastfeeding and that the risk of mother-to-child transmission can be reduced by the mother taking special drugs during pregnancy.

WOMEN'S EMPOWERMENT

About 52% of currently married women and nearly 91% of currently married men aged 15–49 were employed in the 12 months prior to the SIDHS 2015. Men are more likely to receive cash payment for work (50%) than women (39%). More women than men are involved in unpaid work.

Overall, 27% of women decide for themselves how their earnings are spent, 56% make the decision jointly with their husband or partner, and 10% report that the decision is mainly made by their husband or partner. In comparison, about 50% of wives earned less than their husband. However, only 7% of currently married women who work report that their husband or partner does not bring in any money.

About 29% of women report that their husband or partner is the main decision-maker on the use of his cash earnings, while 18% of married men aged 15 and older report that they are the main decision-maker with regard to the use of their cash earnings. Over half of men (61%) and women (55%) report that decision-making is a joint process between a husband and a wife.

About 29% of married women report that mainly the wife should make decision concerning their own health care compared with 14% of men. About 66% of married men think that the decision regarding health care should be a joint decision. About 15% of men think husbands should have a greater say in decisions about major household purchases, while 70% of men think these should be joint decisions.

Women's participation in all three decisions (i.e. about a woman's own health care, making major household purchases, and visiting her family or relatives) increases with age, from 58% among women aged 15–19 to 68% among women aged 45–49. About 76% of women who are employed for cash participate in making all household decisions, compared with 62% of unemployed women. Most women (66%) participate in all three household decisions, 20% participate in two decisions, while 7% participate in only one decision. Another 8% of women do not participate in any of the three household decisions.

INFANT AND CHILD MORTALITY

An infant death is the death of a child under age 1 year. The infant mortality rate (IMR) is defined as the number of deaths of babies under 1 year of age in a given year for every 1,000 live births in the same year. It is one of the key measures of the health and wellbeing of a country. The SIDHS 2015 showed that 19 infants out of 1,000 live births will die before their first birthday.

Neonatal death is the death of a child under 1 month of age. A child's risk of dying is highest in the neonatal period, which is the first 28 days of life. The neonatal mortality rate is the number of deaths of babies under 1 month of age in a given month for every 1,000 live births in the same month. It is another key measure of the health and

wellbeing of a country. The SIDHS 2015 revealed that 9 infants out of 1,000 live births will die during their first month of life.

Yet another key measure of the health and wellbeing of a country is the number of 'under 5' deaths. An under 5 death is defined as the death of a child before the child reaches age 5 years. The 'under 5' mortality rate is the number of deaths of babies under the age of 5 years in a given year for every 1,000 live births in the same year. The SIDHS 2015 found that 24 children out of 1,000 live births will die before their fifth birthday.

Interestingly, the data also indicate no differences between IMR in urban and rural areas (19 deaths per 1,000 live births for both areas), but the variability in other early childhood mortality is noticeable. For instance, the neonatal mortality rate is slightly higher in urban areas, 11 deaths per 1,000 live births compared with 9 deaths per 1,000 in rural areas. Rural populations on the other hand experienced higher post-neonatal mortality, childhood mortality, and under 5 mortality than urban populations.

The SIDHS 2015 also shows that the level of neonatal mortality increases with age of mothers (6 deaths per 1,000 live births at mother's age less than 20 years increased to 32 deaths per 1,000 for older mothers). The Under 5 mortality rates are relatively higher for children born to young mothers under age 20 and over age 30, than children born to mothers aged 20–29. IMR and under 5 mortality rate indicates a strong relationship between mother's age and childhood mortality, whereby childhood mortality is higher among children born to young and older mothers.

CHILD LABOR AND CHILD DISCIPLINE

A child was considered to be involved in child labour activities at the time of the survey if during the week preceding the survey the following was observed:

Children aged 5–11 were involved in at least 1 hour of economic work or 28 hours of domestic work per week; and

Children aged 12–14 were involved in at least 14 hour of economic work or 28 hours of domestic work per week.

In Solomon Islands, nearly 62% of children aged 5–11 are involved in child labour; 2% of these children engage in paid and/or economic work; and most of these are girls in rural areas. About 64% of girls aged 5–11 engage in 1 to more hours of work per week. Furthermore, 12% of children aged 12–14 are also reported to be involved in child labour.

In terms of child discipline, the most common discipline method used by mothers or caretakers is psychological aggression. More children received this disciplinary method (78%), which includes being shouted at, yelled or screamed at, or given something else to do, while 68% received some form of physical punishment. Children living in rural areas, those living in lowest wealth quintile households, and those with mothers or caretakers who have little education are the most likely to experience or receive these forms of discipline.

DISABILITY

The definition of disability in this survey is in line with the definition from the International Classification of Functioning, Disability refers to any difficulties encountered in any or all areas of functioning as follows:

- **impairments** – are problems in body functions or alterations in body structure;
- **activity limitations** – are difficulties in executing activities (e.g. walking or eating); and
- **participation restriction** – are problems with involvement in any area of life (e.g. facing discrimination in employment or transport).

The module questions on disability included in the 2015 SIDHS were adopted from the Washington Group, and asked whether the person had any difficulties due to health problems in seeing, hearing, walking or climbing steps; remembering or concentrating; self-care (e.g. washing or dressing, communicating and understanding); or being understood. The questions were asked of persons aged 5 years and above but in cases where the individual was not available, the interviewers were advised to use the head of the household or the most senior household member as proxies.

Overall, 10% of all people aged 5 years and older reported having difficulty in seeing. Difficulty in remembering or concentrating is reported to be the second highest problem, at 8%, followed by difficulty in climbing at 7%. Difficulty in walking and hearing accounted for 6% of disabilities, another 4% reported difficulties with self-care (washing and dressing) and the least common

difficulty reported at about 3% is with communication. The difficulties across these seven domains included those with some difficulty (mild), a lot of difficulty (moderate), and cannot do at all (severe).

Out of the total population aged 5 years and older with a disability and of those with a mild to severe disability, 17% never attended school; and 34% of those with a moderate to severe disability never attended school, while 45% of those with a severe disability never attended school. Another 10% with no disability never attended school.

MALARIA

About 87% of all households had at least one mosquito net of any kind, and 86% had at least one long-lasting insecticidal net (LLIN). Ownership of any type of mosquito net is highest in rural areas at 89%, and is 72% in urban areas. Furthermore, 56% of all households had one LLIN for every two people who stayed in the household the night before the survey.

About 70% of children under age 5 years slept under some type of mosquito net the night before the survey. High rates of net use are reported in rural households, where 73% of children slept under some type of mosquito net compared with 57% of children in urban areas. The use of an LLIN is the same as for other types of nets, with 70% of children sleeping under an LLIN.

The data indicate that 64% of pregnant women slept under some kind of mosquito net the night before the survey.

Solomon Islands DHS Key Indicators

Key Indicators	Residence		
	National	Urban	Rural
Marriage and fertility			
Total fertility rate per women aged 15-49 (children per woman)	4.4	3.4	4.7
General fertility rate per 1,000 women	154	122	164
Crude birth rate, per 1,000 population	32.6	30.8	32.9
Age at first marriage (Median)			
Women age 25-49	21.9	22.4	20.9
Men age 25+	a	a	a
Young women aged 15–19 who have begun childbearing	12.3	9.7	12.9
Young women aged 15-19 currently married/in-union	11.4	na	na
Median age at first birth for women aged 25–49	22.1	23.3	21.7
Median age at first sexual intercourse			
Women age 25-49	18.5	19.4	18.3
Men age 25+	18.8	19.0	18.7
Mean number of children ever born			
All Women	2.3	na	na
Married Women	3.3	na	na
Mean number of living children			
All Women	2.3	na	na
Married Women	3.2	na	na
Family planning (% currently married women aged 15–49)			
Contraceptive prevalence rate (%)	29.3	25.9	30.2
Current use (%)			
Any method	29.3	25.9	30.2
Any modern method	24.3	21.6	25.0
Female sterialisation	9.0	8.2	9.2
Male sterialisation	0.6	0.1	0.7
Injectables	8.2	6.8	8.5
Pill	1.1	0.9	1.2
Male condom	1.0	1.1	0.9
Any traditional method	5	4.3	5.2
Unmet need for family planning			
Total unmet need (%)	34.7	3.5	34.5
Unmet need for spacing (%)	20.0	21.4	19.6
Unmet need for limiting (%)	14.7	14.1	14.8
Infant and child mortality (0-9 years before DHS)			
Neonatal mortality (NN)	10	11	9
Infant mortality (1q0)	20	19	19
Under-five mortality (5q0)	28	23	26
Maternal and child health			
Maternity care (births in the last 3 years)			
Mothers who had at least 1 antenatal care visits for their last birth (%)	2.8	1.5	3.1
Mothers who had at least 4 antenatal care visits for their last birth (%)	68.9	72.3	68.1
Births attended by skilled health personnel (%)	86.2	96.0	84.1
Mothers receiving antenatal care from skilled provider (%)	94.0	95.0	93.8
Births delivered in a hospital or health facility (%)	84.5	95.4	82.2
Mothers having at least one problem accessing health care (%)	89.8	79.3	92.9
Child immunisation and health care			
Children aged 18–29 months fully immunised (BCG, measles, and 3 doses each of polio and DPT) (%)	73.4	82.5	71.4
Children 18–29 months who have received BCG (%)	90.4	94.9	89.4
Children 18–29 months who have received 3 doses of polio vaccine (%)	81.2	88	79.7
Children 18–29 months who have received 3 doses of DPT/Penta vaccine (%)	83.1	88.3	81.9
Children 18–29 months who have received measles vaccine (%)	85.1	89.1	84.2
Children 18-29 months with no vaccination	7.1	4.7	7.6
Children 18-29 where vaccination card seen	77.6	70.2	79.2
Treatment of childhood diseases			
Children under 5 with diarrhoea in the last 2 weeks who received ORS (%)	36.6	44.9	35.0
Children under 5 with diarrhoea in the last 2 weeks who seek advice form a health facility or provider (%)	54.8	62.3	53.3
Home management of diarrhoea (%)	40.0	24.9	43.0
Received ORT or increased fluid and continued feeding (%)	73.4	84.2	71.2
Children with fever in the last 2 weeks who seek advice/treatment from a health facility or provider (%)	61.3	69.7	59.4

Solomon Islands DHS Key Indicators

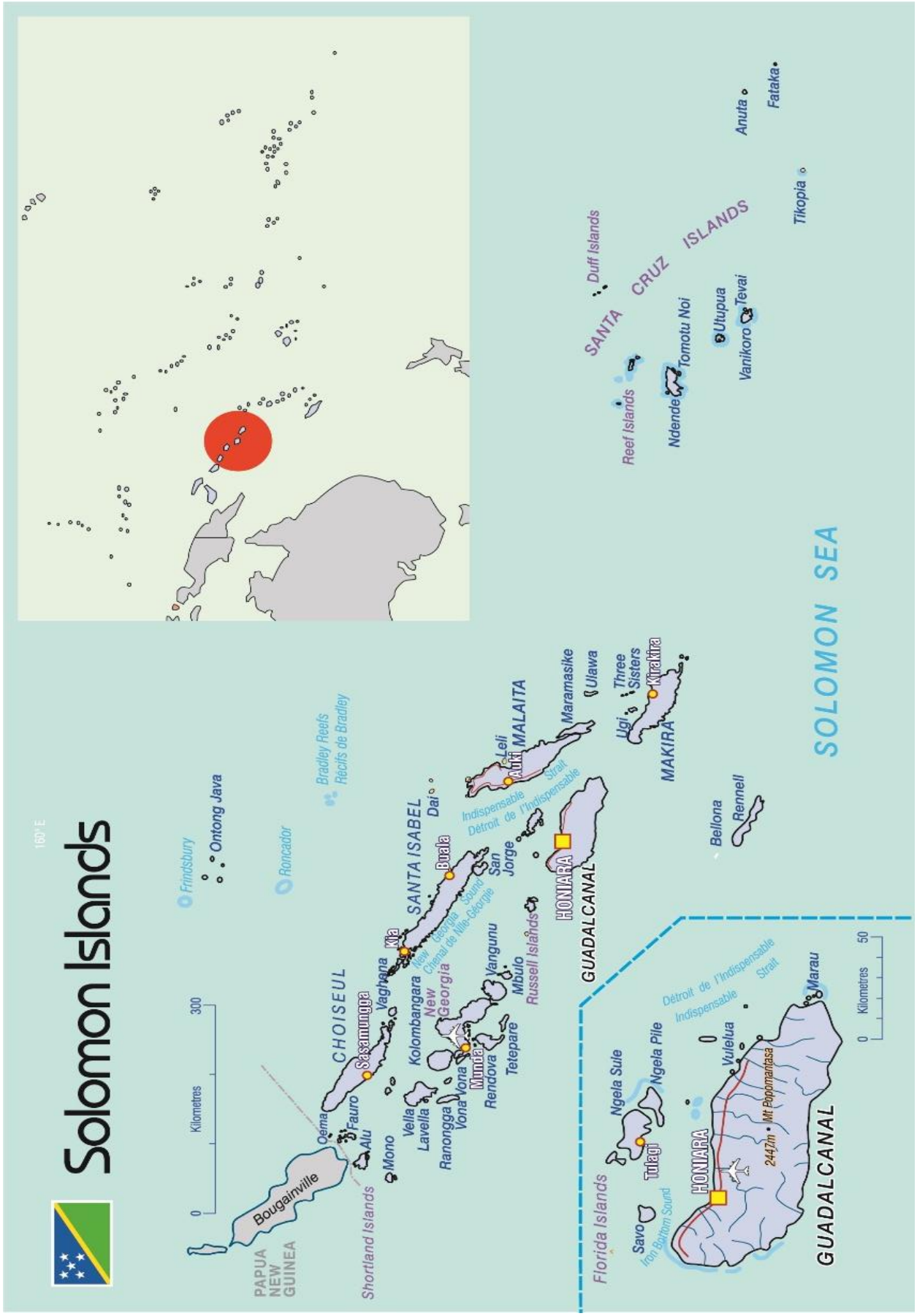
Key Indicators	Residence		
	National	Urban	Rural
Birth Registration			
Total registered (Children under 5) - %	88.0	88.8	87.9
Had a birth certificate (Children under 5) - %	26.2	30.8	25.3
Education			
Net attendance ratio in primary education (National)	66.2	72.4	65.1
Net attendance ratio in primary education (males)	64.5	70.7	63.4
Net attendance ratio in primary education (females)	68.0	74.2	66.9
Net attendance ratio in secondary education (National)	33.7	54.0	28.4
Net attendance ratio in secondary education (males)	33.5	53.2	28.5
Net attendance ratio in secondary education (females)	33.9	54.7	28.2
Literacy rate of women aged 15–49	82.4	91.2	79.8
Literacy rate of men aged 15–49	90.0	95.1	88.3
Ratios of girls to boys in primary (Gender Parity Index)	1.04	1.02	1.04
Ratios of girls to boys in secondary (Gender Parity Index)	0.93	0.90	0.94
Nutritional status of adults and children			
Women aged 15–49 who are overweight or obese (%)	47.4	60.5	43.6
Men aged 15–49 who are overweight or obese (%)	36.1	49.6	29.7
Women aged 15–49 whose body mass index is below normal (%)	2.2	1.5	2.5
Men aged 15–49 whose body mass index is below normal (%)	2.6	1.6	2.8
Children under 5 years ever breast feed (%)	97.9	96.5	98.2
Children under 5 years breastfed within 1 hour of birth (%)	78.9	78.8	78.9
Children under 5 years who received a prelacteal feed (%)	3.5	8.1	2.5
Children aged 0–5 months exclusively breastfed (%)	76.2	na	na
Children aged 6–9 months breastfed and receiving complementary foods (%)	69.0	na	na
Children under 6 months who are breast fed 6 or more times in the last 24hr (%)	93.0	(89.0)	94.6
Children under 6 months by mean number of days fed	6.4	(5.4	6.8
Children under 6 months by mean number of nights fed	3.8	(4.1)	3.7
Children under 5 years who are stunted (%)	31.6	27.3	32.4
Children under 5 years who are wasted (%)	7.9	6.3	8.3
Children under 5 years who are underweight (%)	15.5	12.0	16.2
Households with adequately iodized salt (%)	82.7	87.1	81.8
Anaemia among children and adults			
Children aged under 5 who are anaemic (%)	39.0	41.1	38.6
Women aged 15–49 who are anaemic (%)	40.7	41.5	40.5
Pregnant women aged 15–49 who are anaemic (%)	54.1	na	na
Environment			
Households with sustainable access to an improved water source (%)	82.5	94.6	80.1
Households with access to improved sanitation (%)	29.7	89.1	17.7
Households with Solid fuel use (%)	91.4	57.7	98.2
Households using an appropriate treatment method (%)	6.9	18.2	4.6
HIV and AIDS (women and men aged 15–49)			
Women who have heard of AIDS (%)	91.2	97.4	89.4
Men who have heard of AIDS (%)	96.8	99.1	96.1
Women who know where to get an HIV test (%)	36.7	56.7	30.8
Men who know where to get an HIV test (%)	46.9	68.7	41.9
Attitudes towards people with HIV/AIDS (no discrimination) - Women 15-49 (%)	6.0	9.5	4.9
Attitudes towards people with HIV/AIDS (no discrimination) - Men 15-49 (%)	15.9	28.2	11.8
Mean number of sexual partners in lifetime, Women 15-49 (%)	3.9	4.1	3.9
Mean number of sexual partners in lifetime, Men 15-49(%)	8.6	9.4	8.9
Comprehensive Knowledge of HIV and AIDS			
Women 15-49 (%)	31.0	39.0	28.7
Men 15-49 (%)	41.1	61.2	34.6
Young women 15-24 (%)	28.8	36.0	26.6
Young men 15-24 (%)	33.6	57.6	25.8

Solomon Islands DHS Key Indicators

Key Indicators	Residence		
	National	Urban	Rural
High-risk sex in the past 12 months amoung Young Population			
Young Women who had high-risk sex (%)	4.0	3.9	4.0
Young Women who used a condom during last high-risk sex (%)	20.5	15.5	21.9
Young Men who had high-risk sex in the past 12 months (%)	10.7	17.3	8.6
Young Men who used a condom during last high-risk sex (%)	24.5	28.2	22.1
Malaria			
Household ownership of mosquito nets			
Household owns at least one mosquito net (any type)	86.5	72.2	89.4
Household owns at least one ITN	86.0	71.6	88.9
Children under 5 who slept under an ITN the night before the survey (%)	69.6	56.6	72.1
Women aged 15–49 who slept under an ITN the night before the survey (%)	44.6	19.1	59.4
Pregnant women aged 15–49 who slept under an ITN the night before the survey (%)	63.5	41.7	68.6
Children under 5 treated with anti-malarial drugs (%)	10.3	5.7	11.4
Women Empowerment			
Share of women in wage employment in the non-agricultural sector	58.9	94.6	49.1
Women's cash earnings compared with husband's cash earnings			
More (%)	22.3	24.7	21.1
Less (%)	46.1	47.8	45.2
Womens's participation in Decision making (%)	65.5	68.8	64.7
Disability			
Disability Prevalence 'At least some difficulty' by fuctional domain:			
Vision	10.2	na	na
Hearing	6.1	na	na
Mobility (Walking)	7.1	na	na
Remembering/concentrating	10.2	na	na
Self-care	7.3	na	na
Communicating	5.3	na	na
Child labour and child discipline			
Child labour			
Children aged 5-11 engaged in child labour activities	61.6	35.4	66.2
Male children (%)	59.6	na	na
Female children (%)	63.8	na	na
Children aged 12-14 engaged in child labour activities	11.7	4.5	13.1
Male children (%)	10.4	na	na
Female children (%)	13.0	na	na
Child discipline			
Child discipline (children aged 2-14(%)) by methods and severity of punishment			
Phsycological aggresion	77.9	65.7	80.1
Any physical punishment	68.3	59.5	69.9
Severe physical punishment	22.0	15.2	23.3
Any violent discipline method	85.5	75.7	87.3

NOTE: Figures in parentheses are based on 25-49 unweighted cases
'na': not available

MAP OF SOLOMONS:



CHAPTER 1 INTRODUCTION

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1.1 GEOGRAPHY, HISTORY AND ECONOMY

1.1.1 Geography

Solomon Islands consists of nearly 1,000 islands that together make up a land area of approximately 30,400 square kilometres (km^2) within a sea area of roughly 1.5 million km^2. The country's six major islands are Choiseul, New Georgia, Isabel, Guadalcanal, Malaita and Makira. The largest island is Guadalcanal at 5,336 km^2. Most of Guadalcanal's landmass consists of hills and rugged mountain ranges with tropical rainforests, while the remainder consists of coastal plains and low-lying islets. Solomon Islands has a tropical climate with little temperature change throughout 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. 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 Melanesia, with close cultural ties to Vanuatu, Papua New Guinea and Fiji. However, there are also influences from Micronesia (mainly Kiribati) and Polynesia, and small populations of Europeans and Chinese. 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 country's official language, 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 ethnic conflict of 1999 to 2003 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.

1.1.2 History

It is thought that people have lived in the Solomon Islands around 30,000 BC with the arrival of Papuan-speaking settlers. 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.

In 1999, the Isatabu Freedom Movement, a militia group made up of indigenous Isatabus from Guadalcanal, expelled more than 20,000 Malaitans from the island. Malaitans have been migrating to Guadalcanal over the years from nearby Malaita, and many have 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 — the Malaita Eagle Force — was founded. In June 2000, the Malaita Eagle Force stole police weapons, forced the country's prime minister at that 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 (in which a new

prime minister was elected), 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 was relatively stable.

1.1.3 Economy

Most Solomon Islanders depend predominantly on agriculture, fishing, and forestry for at least part of their livelihood. Because the country's economy is small and depends on imports, it is often vulnerable to external shocks such as the volatility in world commodity prices and extreme weather patterns. The islands are rich in undeveloped mineral resources such as lead, zinc, nickel and gold. During 1998 to 2003 the country experienced severe ethnic violence, resulting in the closure of key business enterprises, and an almost empty government treasury that led to serious economic disarray, and near collapse. Tanker deliveries of crucial fuel supplies have become sporadic due to the government's inability to pay for the fuel 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. Post-tension stability has meant that many of these activities have recovered and are now in operation.

A per capita gross domestic product of USD 1,612 ranks Solomon Islands as a lesser developed nation. Two-thirds of the country's labour force is engaged in the primary sector, which consists of subsistence crop and animal production, hunting and related service activities, 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 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. It was later in 2010 when Allied Gold Ltd took over the mine and started production. In 2012, St Barbara Limited acquired the operations from Allied Gold until 2014 when the mine ceased due to severe weather and flooding.

With the economy growing at 2% (in 2014), prospects for sustaining growth remains a challenge. Exploitation of Solomon Islands' rich fisheries offers potential 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 and is currently in full operation.

Tourism, particularly diving, is an important industry for Solomon Islands. Growth in that industry is, however, hampered by a lack of infrastructure, transportation limitations and security concerns. Solomon Islands' economy was particularly affected by the Asian financial crisis that occurred before the ethnic violence and immediately after by the Global Financial Crisis, affecting exports particularly timber and other primary commodities. The government continues to progress timber harvesting policies with the aim of reforming the industry so that it is sustainable.

The arrival of the Regional Assistance Mission to Solomon Islands (RAMSI) in mid-2003 and the re-engagement of other donors provided Solomon Islands with an opportunity to rebuild and expand its struggling economy. The Solomon Islands government was seen as the driving force of any fundamental reforms for long-term change. Reforming the bureaucracy and inefficiencies of the past, and providing a stable environment for private business was an integral part of 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 continues to progress structural reforms through fiscal policy reforms (e.g. the Pubic Finance and Audit Act of 2013) and the National Development Strategy to tackle a range of medium- to long-term challenges, especially in the areas of improving rural service delivery, alleviating poverty, improving health and education, and driving economic growth.

The key longer-term challenge will continue to be in the area 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 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 1931–2009. Solomon Islands' population has increased five-fold since 1931, from around 94,066 in 1931 to over 515,870 in 2009. 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 2.3% (Solomon Islands National Population and Housing Census, 2009)[1]. A recent projection (2016) estimated Solomon Islands' population to be over 639,157.[2]

Table 1.1: Basic demographic indicators and selected indicators, Solomon Islands 1931–2009

	1931	1959	1970	1976	1986	1999	2009
Total population	94,066	124,076	160,998	196,823	285,176	409,042	515,870
Intercensal growth rate (%)	-	1	2.5	3.3	3.4	2.8	2.3
Density (population/km^2)	3	4	6	7	10	14	17
Percent urban	-	-	-	9	13	16	19.8
Life expectancy							
Males	-	-	-	-	54.3	60.6	66.2
Females	-	-	-	-	55	61.6	73.1
Total	-	-	-	-	54.7	61.1	69.6

- equals unknown (or unavailable)

Source: Solomon Islands National Statistics Office

Population density has greatly increased over the same period from 3 people/km^2 in 1931 to 17 people/km^2 in 2009. Solomon Islands is predominantly rural with the proportion of the urban population estimated to make up only 20% of the population in 2009. Life expectancy for Solomon Islands women in 2009 was slightly higher than male life expectancy (73.1 for women versus 66.2 for men).

1.2.1 Fertility

Data from the 2009 Census of Population and Housing suggests that Solomon Islands' annual population growth rate of 2.3% is still relatively high compared with other countries within the region; only Papua New Guinea and Vanuatu have much higher growth rates. A contributing factor to Solomon Islands' high natural growth rate is the high fertility rate. Although the average number of children per woman dropped marginally from 5 in 1999 to 4.7 in 2009, Solomon Islands still has a relatively high fertility rate.[3]

1.2.2 Mortality

Estimates of the level of mortality based on data from the 2009 Census of Population and Housing suggest that the infant mortality rate (IMR) declined by 6 deaths per 1,000 births, and that life expectancy at birth improved by 4.0 years for males and 3.7 years for females during the census period 1999–2009.

1.2.3 Migration

International migration is at an all-time low since the mid-1990s. A recent population census also indicated an annual migration rate of 0.0% (SINSO, 2009 Census of Population and Housing). Internal migration, on

[1] The 2009 Census reported an undercount of 8.3% at the national level; this should be noted when assessing the growth rate and making population projections especially at the provincial level.

[2] Solomon Islands National Statistics Office, Population Projections 2016.

[3] Solomon Islands National Statistics Office, 2009 Census of Population and Housing.

the other hand, is considerably high, with Honiara on Guadalcanal Province being target destinations because of employment opportunities and developments in Honiara.

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 provides the framework for all population and development activities, including externally funded projects in the country. It includes 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 provides 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 contains 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 the plan will be implemented overnight. However, the plan is considered as a statement of intent as well as a framework within which all population and development-related activities in the country are to be planned and executed.

In the 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 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 NPP 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 NPP 2008–2017 represents a revision of Solomon Islands' last population policy (1998 NPP for the period 2000–2004), which was based on outdated information from the 1986 Census of Population and

Housing. 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 Expenditure 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 NGOs. The NPP 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 NPP 2017–2026, like its 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 the 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 (or create job to) 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; and
- 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, therefore, 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 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 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, Oxfam and 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 NPP 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; and
- Pay greater attention to the demographic and social variations between provinces and regions.

Revising the NPP was the responsibility of the Department of National Planning. The membership of the Population Policy Review Team consisted 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 policy details during the national workshop, others were left out until the final review. Nevertheless, the NPP 2008–2017 explicitly acknowledges the substantial variations in conditions among the provinces, and this is reflected in a number of policy goals and strategies.

By 2008, the 2008–2017 revised Solomon Islands NPP, a very comprehensive multi-sector policy, had been produced and was ready for ratification. This was delayed and ultimately suspended due to the approaching census in 2009. It was believed that the 2009 census might reveal significant changes in population patterns and trends that could potentially disprove the policy measures that were proposed in the 2008 policy. However, that appears not to have been the case because most of the trends apparent in the 1990s have continued up to 2009 and possibly beyond. But this continuity did not become apparent until the 2009 census results had been analysed thoroughly, a process that took until 2014.

In September 2014, the process of re-formulating, revising and updating the 2008 draft population policy commenced under the management of the Ministry of Development Planning and Aid Coordination. It should be noted that the present policy (2017–2026) is the culmination of a long process lasting almost 10 years. This long period, along with the experience of developing the 1998 policy, has guaranteed that the idea of a population policy is well known to many of the agencies and groups with an interest in population, ranging from government ministries to national and international NGOs and churches, and has already been accepted in the community as an important component of development policy.

Through this policy, the Solomon Islands government has reaffirmed its commitment to population and development issues as previously manifested in the NPP developed in 1998 for the period 2000–2004 and the draft policy of 2008. Many of the critical development issues identified then remain relevant today.

1.3.4 2017–2026 Policy issues and timeframe

While a population and development-related agenda can cover a wide scope of sectors, it has been decided (being mindful of many other existing policies and plans currently in place) that the following key features form the basis of the current policy in the next 10 years.

- Certain shortcomings in the quality of population data make it difficult to determine the population situation accurately. Examples include the total fertility rate, the current population estimate, and the current growth rate.
- While the growth rate appears to be declining, the annual population increment is still climbing and this will remain the case for many years to come.
- The fertility transition has been slow relative to the decline in the death rate leading to persistently high population growth. It is possible that the fertility transition has stalled, although this is not certain due to the wide range of estimates of the present fertility level.
- Fertility ranges widely between provinces and between rural and urban areas.
- Adult male mortality appears to have been increasing in recent years.
- Maternal mortality remains an urgent issue.
- Adolescent fertility is high by Pacific regional and international standards and there is also wide variation between provinces.
- The population remains young, with 41% of the population in 2009 below the age of 15. This will contribute to population ‘momentum’ in the future, even if fertility rates decline quickly.
- An urban population growth rate of 4.7% per year, if it were to continue, would result in a doubling of the urban population by 2025.
- A significant population increase will occur over the next 30 years, with at least 400,000 people likely being added to the 2015 population by 2045. In the event of a continuing, slow fertility decline, the

number to be added over the next generation could reach 600,000 (giving a total population of 1.2 million).

These features constitute the key population issues that the 2016–2026 NPP will address.

The 2017–2026 NPP covers a 10-year period. The year 2026 has been selected as the terminal year because it will have been a decade of implementation and will be an appropriate time (neither too short nor too long) to take stock of progress. At mid-point (2021), a review of the policy should take place. This will happen two years after the next anticipated national census in 2019.

It should also be noted that the timeframe of the 2017–2026 NPP is in the first 10 years of the country's 20-year National Development Strategy (NDS) for the period 2016–2035, under which the NPP was referred to and is linked under objective two: Medium Term Strategy (MTS 7) of the NDS.

Recently in Novermber 2016 the government endorsed the implementation of the country's first ever National Statistics Development Strategy (NSDS) 2015-16 to 2035. With clear linkages and synegies to the NDS, the NSDS encompases the issues and key statistical priorities of the NPP such as the regular conduct of population censues and related surveys in the country.

This makes the current NPP policy well linked to the current NDS and should be implemented in alignment with the 2016–2035 NDS and also the NSDS 2015-16 to 2035.

An implementation monitoring matrix will be developed along with the current NPP to assist in monitoring and ensuring that issues are addressed.

1.3.5 Health policy

The Solomon Islands Ministry of Health and Medical Services (SIMoHMS) is responsible for delivering preventative and curative health services in the country, and caters to diseases of both children and elderly people. In 2011, SIMoHMS launched its five-year National Health Strategic Plan for 2011–2015, which forms the basis of all healthcare programmes for partners to embark on.

SIMoHMS's mission is to protect and promote the health of all people in Solomon Islands. Its vision is an integrated and decentralised health system that promotes an effective, efficient and equitable health services for the good health and general well-being of all people in Solomon Islands. It is with genuine conviction that steps to improving the health status of the people must be based on direct measures taken to: 1) ensuring access to health services at all levels, 2) improving the quality of services delivered at all levels, and 3) promoting good management and effective use of resources.[4]

In response to the Solomon Islands government's Priority Action Agenda, the MDGs, declarations by the Pacific Islands Ministers of Health (e.g. Healthy Island Declaration), and international obligations, SIMoHMS has developed a National Health Strategic Plan framework of key indicators to monitor and evaluate its development.

Most primary healthcare services are provided through health facilities such as health centres, dispensaries and aid posts. Likewise, hospitals and public health programmes also provide primary healthcare services. Tertiary care is mostly provided by the Honiara National Referral Hospital. This is the only referral hospital in the country.

Infectious diseases were prominent in the country. Now, due to rapidly changing lifestyles, non-communicable diseases (NCDs) are acquiring prominence. NCDs are a leading cause of death in Solomon Islands, and it is anticipated that this change in mortality trends will continue. Communicable diseases and NCDs remain the main diseases in Solomon Islands, with malaria and tuberculosis being the major public health concerns along with sexually transmitted infections, acute respiratory tract infections, diarrhoea and viral hepatitis. Dengue fever and measles are other major health concerns among communicable diseases.

The government will improve the provision of preventative and curative healthcare services across Solomon Islands, with an emphasis on promoting healthy lifestyles as stated in the Healthy Islands Policy and Strategy. The efficiency and effectiveness of preventing and encouraging healthy lifestyles is by reducing the main

[4] SIMoHMS National Health Strategic Plan 2011–2015

NCD risk factors of tobacco smoking, alcohol abuse, physical inactivity, and unhealthy eating, in order to reduce the incidence of NCDs.

Healthcare services are decentralised in accordance with the government's commitment to primary healthcare provision. However, there are inequities in the standard of service delivery between urban and rural areas that need to be addressed to ensure that the National Health Strategic Plan's objective of improving the quality of services delivered at all levels is achieved. In addition, many communities and health facilities are located in remote locations in Solomon Islands, which makes communication and transportation difficult. Many people living in these remote areas are deprived of access to medical care.

1.4 DEMOGRAPHIC AND HEALTH SURVEY

This report presents the findings of the Solomon Islands Demographic and Health Survey (SIDHS) 2015, which was carried out by the Solomon Islands Statistics Office from 6 April to 18 September 2015, using a nationally representative sample of over 5,000 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 main objective of the SIDHS 2015 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 healthcare services, knowledge of HIV and AIDS, and other health-related issues. Specific objectives were to:

- collect data (at the national level) that will allow the calculation of key demographic rates;
- analyse the direct and indirect factors that determine the fertility level and trends;
- 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 age 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, HIV and AIDS, and evaluate patterns of recent behaviour regarding condom use;
- collect data on knowledge and attitudes of women and men about tuberculosis; and
- collect poverty information to determine levels of hardship among children and adults.

This information is essential for making informed policy decisions, and for planning, monitoring and evaluating programmes on health — both with respect to general health, and reproductive health in particular — at the national level, and 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 SIDHS 2015 provides national, rural and urban estimates regarding population and health that are comparable with data collected in similar surveys in other developing countries, including those in the Pacific, where DHS pilot studies have been carried out.

1.4.2 Survey organisation

The SIDHS 2015 was carried out with funding support from the Department of Foreign Affairs and Trade, the United Nations Children's Emergency Fund (UNICEF), and Solomon Islands government, while technical supports throughout different phases of the survey was provided from various bodies such as the UNICEF, SPC's Statistics for Development Division (SDD), and Bristol University in London. The survey

was carried out by the Solomon Islands National Statistics Office (SINSO) in collaboration with the SIMOHMS.

A steering committee was formed, and was responsible for the 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 design for the SIDHS 2015 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. The sample design closely followed the SIDHS 2006–2007 to allow data comparisons between the two surveys.

The sample for the survey is a two-stage stratified, nationally representative sample of households. The sampling frame consisted of the estimated number of households in each enumeration area (EA) by province. It was prepared by SPC and based on the 2009 population census data, and estimated urban and rural population growth rates. Honiara, which is urban in its entirety, including selected urban EAs from the other provinces, comprised the country's urban areas. The selected rural EAs of Guadalcanal and other provinces comprise the country's rural areas. Five domains were identified: Honiara, remaining Guadalcanal Province, Western Province, Malaita Province, and the combined group of smaller provinces (Choiseul, Isabel, Central, Makira/Ulawa, Rennell/Bellona and Temotu). The primary sampling units, comprising the 211 EAs were selected in each province using systematic random sampling with probability proportional to the estimated number of households in the EA.

Mapping and listing households in each sample EA were undertaken by interviewers. In each sample point, 24 households were selected by the team supervisor using systematic random sampling. The sample was designed to cover a target sample of 5,064 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 were 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 2015. The development of these questionnaires closely followed the SIDHS 2006–2007. The contents of these questionnaires were based on module questionnaires developed by the MEASURE DHS program. The modules were then modified to reflect the country's requirements in consultations with government departments and agencies, NGOs and other data users within and outside the country. To respond to other data needs, other additional modules were incorporated in the questionnaires. The questionnaires were translated into Pidgin and back-translated into English in order to check the accuracy of the translation.

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 age 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 (e.g. education, residential history, media exposure);
- 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;
- conditions of bones and muscles; and
- other health issues

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 January 2015, an informal pre-test was done through self-administration of the individual women's and men's questionnaires, respectively, by nine female and seven male SINSO staff members.

1.5.3 Training

SINSO organised and delivered three types of training at different levels for the SIDHS 2015:

- Training of trainers (TOT);
- Pilot trainings;
- Main training of all fieldworkers

TOT – This training was conducted from 14 to 31 January 2015 inclusively of one week fieldwork practice. In total, 15 SINSO permanent staff participated in this training. The training served two purposes: to test the first draft of the questionnaires – testing the suitability of various aspects of the questionnaires such as the question's content, question's translation, skip procedures and filtering instructions; and to train the staff about their important role as trainers and how to carry out their role efficiently. Field work logistics and management, fieldworkers' workloads, transportation, and other field issues were all tested.

Pilot training – The pilot training was conducted in one centralised training venue in Honiara from 9 to 27 February 2015. Out of the total recruited SIDHS fieldworkers, 70 came from the 5 selected provinces (Honiara, Guadacanal, Malaita, Western, and other provinces). The main objective of this training was to train and identify future team supervisors. The training was also another opportunity to test the questionnaires after further revisions during the TOT as well as testing and confirming all fieldwork logistics and management preparations. The selected best trainers from the TOT assisted during the training while the other trainers were given another opportunity to attend the pilot training.

Main training – The main training of the SIDHS 2015 fieldworkers was conducted in three separate training rooms all located in one place (Red Mansion). There were 145 candidates (comprising 14 teams, plus 10 reserve interviewers and 9 data entry clerks were recruited and trained for about 3 weeks (2 weeks of classroom training and one week of fieldwork practice) from 9 to 27 March 2015. All participants were part

of this training, including those who attended the pilot training. There were 50 participants in each room, and 3 trainers were allocated in each training room with 1 main trainer each.

All training was conducted according to the standard DHS training procedures. The training consisted of class presentations, mock interviews, exercises, quizzes and role playing. The training also included further explanation of the questions, how to ask the questions, and how to record them in the questionnaire.

A separate training, conducted by UNICEF, was provided for 14 nurses and health technicians on how to take accurate measurements and readings.

Another condensed training for reserve interviewers (11 females and 2 males) was undertaken immediately after the teams were deployed in the field. This was a special training for newly recruited reserve interviewers to replace those who were not performing well in the field. All questionnaires, forms and instructions were discussed thoroughly in five days (as in the main training), with only one day of mock interviews but no practice interviews.

1.5.4 Listing

Household listing was implemented by survey teams two days prior to data collection. All private households within the selected village or EA were listed and recorded along with the head of the household and total number of household members. From the total updated household list, 24 households were randomly selected to be interviewed. Supervisors and field editors assisted their teams with updating the listing of households on the forms and maps. The maps and list of households used in the SIDHS 2015 were prepared by SINSO from the 2009 Census of Population and Housing.

All women aged 15–49 who slept in the sample household on the night prior to the interview were eligible to be interviewed using the women's questionnaire. Every second household was sub-selected for the men's survey. All men aged 15 or over in sub-selected households were eligible to be interviewed.

1.5.5 Fieldwork

All trained fieldworkers were put on a team to undertake the survey fieldwork. Fourteen data collection teams were deployed for the fieldwork, comprising of one supervisor, one field editor, four female interviewers, two male interviewers, and one nurse or health technician. Nine senior staffs from SINSO were designated as field coordinators. Data collection started on 6 April 2015 and ended on 18 September 2015.

From 19 October to 5 November 2015, a re-visit exercise was conducted for non-response respondents for Honiara alone. Former enumerators of DHS teams who resided in Honiara were recalled to do the re-visits for three weeks. Two teams of nine members were formed, and the re-visit was a success.

The field teams faced several challenges:

- 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.
- In Choiseul Province, one of the selected EAs has to be replaced because there was fighting and arguing among the tribes with a logging company.
- In Rennell-Bellona Province the selected EA had to be replaced because of the tenseness of the way the land in that EA was acquired by one of the mining companies.
- In Guadalcanal, men and women in one selected EA refused to participate in the men's and women's questionnaire, resulting in a low response rate, especially for men.

1.5.6 Data processing

The computer processing of SIDHS data began a few weeks after the fieldwork began. A data processing specialist from SPC held a training workshop from June 21 to 11 July 2015. 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 SINSO in Honiara. Data processing began in the third week of May 2015 and was completed in the last week of December 2015. The data processing staff consisted of two supervisors from SINSO, four questionnaire administrators and/or coding clerks, and nine 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 because SIDHS staff members 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 first week of January 2016.

1.6 RESPONSE RATES

Table 1.2 shows response rates for the SIDHS. In total, 5,064 households were selected in the sample, of which 5,054 were found occupied at the time of the fieldwork. In total, 5,042 households were successfully interviewed, yielding a household response rate of 99.8%.

Among the households interviewed in the survey, 6,657 eligible women were identified, of whom 6,266 were successfully interviewed yielding a response rate of 94.1%. With regard to male survey results, 3,920 eligible men were identified, of whom 3,591 were successfully interviewed, yielding a response rate of 91.6%. Response rates were lower in the urban sample than in the rural sample, especially for women. Response rates were lowest in Guadalcanal and highest in Honiara.

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 response rate for men reflects the more frequent and longer absence of men from the households.

Table 1.2: Results of household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), Solomon Islands 2015

Result	Residence		Region					Total
	Urban	Rural	Honiara	Guadalcanal	Malaita	Western	Other provinces	
Household interviews								
Household selected	1,632	3,432	696	1,080	1,080	1,080	1,128	5,064
Household occupied	1,627	3,427	693	1,079	1,077	1,077	1,128	5,054
Household interviewed	1,625	3,417	691	1,073	1,076	1,076	1,126	5,042
Household response rate[1]	99.9	99.7	99.7	99.4	99.9	99.9	99.8	99.8
Interviews with women age 15-49								
Number of eligible women	2,713	3,944	1,303	1,311	1,334	1,352	1,357	6,657
Number of eligible women interview	2,513	3,753	1,259	1,221	1,255	1,271	1,260	6,266
Eligible women response rate[2]	92.6	95.2	96.6	93.1	94.1	94.0	92.9	94.1
Interviews with men age 15+								
Number of eligible men	1,597	2,323	752	746	739	894	789	3,920
Number of eligible men interview	1,461	2,130	729	641	693	811	717	3,591
Eligible men response rate[2]	91.5	91.7	96.9	85.9	93.8	90.7	90.9	91.6

[1] Households interviewed/households occupied

[2] Respondents interviewed/eligible respondents

1.7 DATA DISAGGREGATION

Data are disaggregated and presented in the following important geographical divisions:

- **Urban**: households living in Honiara and all provincial centres of all other provinces.

- **Rural**: covering the rest of Solomon Islands households living in traditional rural areas.
- **Regions/Provinces**: all households in all selected five provinces of Honiara, Guadalcanal, Malaita, Western and other provinces.

Because of the way the sample was designed, the number of cases may in some instances appear small because they are weighted to make the regional distribution nationally representative. Throughout this report, numbers in the tables reflect weighted numbers. To ensure statistical reliability, percentages based on 25–49 unweighted cases are shown within parentheses, and percentages based on fewer than 25 unweighted cases are suppressed.

In the tables in this report, the category 'married' includes both those women and men who are in a formal or official marriage and those who are living together. The exception to this rule is in tables where 'married' and 'living together' are disaggregated as separate categories, in which case, the category 'married' refers only to those women or men who are in a formal or official marriage.

CHAPTER 2 HOUSEHOLD POPULATION AND HOUSING CHARACTERISTICS

by Josephat Tako, Statistician and Gloria Kila, Senior Information Officer, SINSO

KEY FINDINGS

- 83% of households have an improved source of water for drinking and 17% have a non-improved source of drinking water. Only 7% of households use an appropriate method of water treatment prior to drinking.
- About 23% of households have improved, non-shared toilet facilities, while 7% have shared toilet facilities. 70% of households have non-improved toilet facilities and 58% have no toilet facilities at all.
- 55% of households have access to electricity, and most of these households (68%) are in the urban area.
- 91% of households use solid fuel (e.g. wood, sawdust, shrubs) as their main source of cooking fuel.
- There is an uneven distribution of wealth across all households in Solomon Islands. Poverty is more prevalent in rural areas than in urban areas.
- Solomon Islands has a young population structure. Approximately 43% of the population is below 15 years of age, 45% is aged 15–49, and 12% is aged 50 and over.
- The average Solomon Islands household size is five people. The average household size in urban areas is six people and is 5 people in rural areas.
- More households (82%) are headed by males than females (18%).
- 17% of *de jure*, or usually resident, children aged less than 18 years do not live with a biological parent.
- Overall, the school national attendance ratio is 66% for primary school children and 34% for secondary school children.
- The majority of Solomon Islanders have attended school, although many have not completed primary school (35% of women, 34% of men). Among those who never attended school, slightly more females than males never attended; 22% of females aged 6 and older have never been to school, compared with 18% of males.

INTRODUCTION

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 subgroups of the population. One focus of this chapter is to describe the environment in which women and children live. This description includes housing facilities (sources of drinking water, sanitation facilities, dwelling characteristics and household possessions), household arrangements (headship, size), and general characteristics of the population (age-sex structure, literacy and education). A distinction is made between urban and rural settings where many of these indicators usually differ.

Besides providing the background for better understanding many of the 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 ENVIRONMENT

The household environment, which includes dwelling characteristics and housing facilities, is an important determinant of the socioeconomic and health status of household members. The SIDHS 2015 included questions about the household environment, including sources of drinking water, sanitation facilities used,

access to electricity, and other environmental-related factors. The results are presented by household and by the usual household resident population.

2.1.1 Drinking water

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 SIDHS 2015 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 2.1 shows that 83% of households use an improved water source[5]. In urban areas, more than 9 in 10 households have access to an improved water source. This is not the case in rural areas where 8 in 10 households have access to an improved water source. Rain water and a public tap (or standpipe) are the two most common sources of drinking water, used by 28% and 20% of households, respectively. After these, water piped to the yard (or plot) and non-improved water sources were listed as being used by 18% and 17% of households, respectively. This was a change from the SIDHS 2006–2007, where piped water to the dwelling, yard or plot was the second most common water source, used by 28% of households, and rainwater was used by only 18% of households. Public tap (or standpipe) water sources are more common in rural areas (22%) than in urban areas (9%). The highest percentage of non-improved water sources are in rural areas (20%) compared with urban areas (5%). These results are consistent with the findings of the 2009 Solomon Islands Population and Housing Census.

With regard to the amount of time taken to draw water, the SIDHS 2015 findings show that there are major urban–rural differences. Households in urban areas are much more likely to have drinking water on the premises (87%) than households in rural areas (64%). In rural areas, 9% of households take 30 minutes or longer (round trip) to obtain drinking water compared with 3% of households in urban areas.

[5] Improved water sources include piped water, a public tap, a tube well or borehole, a protected dug well (i.e. a well that is covered from pests and dust), or spring and rainwater. It should be noted that the definition of 'improved water sources' used in Solomon Islands differs from the international definition in that it excludes rainwater.

Table 2.1: Household drinking water

Percent distribution of households and de jure population by source of drinking water, time to obtain drinking water, and treatment of drinking water, according to residence, Solomon Islands 2015

Characteristic	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Source of drinking water						
Improved source	**94.6**	**80.1**	**82.5**	**94.9**	**79.6**	**82.5**
Piped into dwelling	31.6	5.2	9.7	34.9	4.7	10.6
Piped to yard/plot	19	18	18.2	19	17.9	18.1
Public tap/standpipe	9.4	21.9	19.8	9.1	22	19.5
Tube well or borehole	1.6	0.8	1	1.4	1	1
Protected well	1.2	1.6	1.5	1.2	1.6	1.5
Protected spring	1.9	4.2	3.8	1.9	4.2	3.8
Rain water	28.9	28.3	28.4	26.7	28.2	27.9
Bottled water	1	0	0.2	0.7	0	0.1
Non-improved source	**5.1**	**19.6**	**17.1**	**4.8**	**20.1**	**17.1**
Unprotected well	1.2	2.2	2	1	2.4	2.2
Unprotected spring	2.1	10.4	9	2.1	10.8	9.1
Tanker truck/cart with small tank	0.3	0.1	0.1	0.5	0.1	0.2
Surface water	1.5	6.9	6	1.4	6.7	5.7
Other	0.2	0.2	0.2	0.1	0.2	0.1
Missing	0.1	0.2	0.2	0.1	0.2	0.2
Total	100	100	100	100	100	100
Time to obtain drinking water (round trip)						
Water on premises	86.7	64.4	68.1	88	63.7	68.4
Less than 30 minutes	9.2	25.4	22.6	8.3	25.6	22.2
30 minutes or longer	3.1	9.3	8.3	2.7	9.9	8.5
Don't know/missing	1	0.9	1	1	0.8	0.9
Total	100	100	100	100	100	100
Water treatment prior to drinking[1]						
Boiled	15.1	4.1	5.9	16	4.5	6.7
Bleach/chlorine added	2.3	0.4	0.7	2.3	0.3	0.7
Strained through cloth	2.9	1.9	2.1	2.7	1.9	2.1
Ceramic, sand or other filter	1	0.1	0.3	1.1	0.1	0.3
Other	3.4	2.7	2.8	3.3	2.9	3
No treatment	**75.6**	**91.8**	**89.1**	**75**	**91.6**	**88.4**
Percentage using an appropriate treatment method[2]	**18.2**	**4.6**	**6.9**	**19.3**	**4.8**	**7.6**
Number	**850**	**4,192**	**5,042**	**5,207**	**21,652**	**26,859**

[1] Respondents may report multiple treatment methods so the sum of treatment may exceed 100%.

[2] Appropriate water treatment methods include boiling, bleaching, filtering, and solar disinfecting.

2.1.2 Household sanitation facilities

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 2.2 shows that approximately 2 in 10 households use improved toilet or latrine facilities compared with almost 8 in 10 households that use non-improved toilet or latrine facilities or shared facilities. These findings are consistent with the SIDHS 2006–2007. Households with improved toilet facilities using a flush or pour flush system to the septic tank account for 9% of all households, and most of these in urban areas (35% compared with 4% in rural areas), while those with pit latrines with a slab accounted for 4%. Overall, 58% of all households in Solomon Islands have no toilet facilities of any kind. This problem is more common in rural areas, where 68% of households have no toilet facilities, compared with urban areas where only 6% of households have no toilet facilities. The SIDHS 2015 findings are consistent with those found in the 2009 Solomon Islands Population and Housing Census.

Table 2.2: Household sanitation facilities

Percent distribution of households and de jure *population by type of toilet/latrine facilities, according to residence, Solomon Islands 2015*

Type of toilet/latrine facility	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Improved, not shared facility						
Flush/pour flush to piped sewer system	17	1	3.7	18.5	1	4.4
Flush/pour flush to septic tank	34.9	3.5	8.8	37.8	3.3	10
Flush/pour flush to pit latrine	6.5	2.9	3.5	6.4	2.6	3.4
Ventilated improved pit (VIP) latrine	2.4	1.9	2	2.2	1.9	1.9
Pit latrine with slab	6.8	4	4.4	6.9	3.6	4.3
Composting toilet	0.2	0.1	0.1	0.3	0.1	0.1
Total	**67.8**	**13.4**	**22.6**	**72.1**	**12.6**	**24.1**
Shared facility[1]						
Flush/pour flush to piped sewer system	3	0.4	0.8	2.4	0.3	0.7
Flush/pour flush to septic tank	7.6	1.2	2.2	6	0.8	1.8
Flush/pour flush to pit latrine	5.4	0.9	1.7	5.5	0.9	1.8
Ventilated improved pit (VIP) latrine	1.8	0.9	1.1	1.4	0.8	0.9
Pit latrine with slab	3.5	0.9	1.3	3	0.9	1.3
Composting toilet	0.1	0.1	0.1	0.1	0.1	0.1
Total	**21.3**	**4.3**	**7.1**	**18.4**	**3.7**	**6.6**
Non-improved facility						
Flush/pour flush not to sewer/septic tank/pit latrine	0.9	0.2	0.3	0.7	0.2	0.3
Pit latrine without slab/open pit	3.1	9.7	8.6	2.6	9.7	8.3
Hanging toilet/hanging latrine	0.2	2.5	2.1	0.3	2.5	2.1
No facility/bush/field/sea/ocean/beach	6	68.4	57.9	5.4	69.6	57.2
Other	0.5	1.4	1.3	0.5	1.6	1.4
Missing	0.1	0.1	0.1	0.1	0	0.1
Total	**10.9**	**82.3**	**70.3**	**9.6**	**83.7**	**69.3**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Number	**850**	**4,192**	**5,042**	**5,207**	**21,652**	**26,859**

[1] Facilities that would be considered improved if they were not shared by two or more households.

2.1.3 Household characteristics

Table 2.3 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, information on the type of power or fuel used for cooking, and the location of cooking facility.

The SIDHS 2015 found that 55% of households in Solomon Islands have access to electricity. This result shows a major change from the SIDHS 2006–2007, when only 13% of households in Solomon Islands had access to electricity. As expected, access to electricity is much higher in urban areas (68%) than in rural areas (53%). The result shows that one in two 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.

The type of flooring material most commonly used by households in Solomon Islands is wood planks (35%). More residences in rural areas (36%) have floors made of wood planks than residences in urban areas (33%). Parquet, or polished wood, is the second most commonly used flooring material in Solomon Islands, used in 32% of all households. This type of flooring is more common in urban areas (35%) than in rural areas (32%). According to the SIDHS 2006–2007, palm and/or bamboo was the second most common flooring material used in households (20%). In the SIDHS 2015, the use of palm and/or bamboo for flooring had decreased to 8%. The third most common material for flooring was earth or sand, used in 18% of rural households and 10% of 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 (18%) use only one room for sleeping. This is more common in rural households (19%) than in urban households (13%).

Smoke from solid fuels used 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. About 12% of Solomon Islands households cook in the same house, 83% use a separate building, and only 5% cook outdoors. Rural households are more likely than urban households to cook in a separate building (89% compared with 51%), while cooking in the house and outdoors was more common in urban households (40% and 9%) than in rural households (7% and 4%).

Clean cooking fuel is not affordable for many households, and most resort to using solid fuels that emit a considerable amount of smoke. As a result, household members are likely to be exposed to air pollution. Ensuring access to affordable, reliable, sustainable and modern energy for all is Sustainable Development Goal 7[6]. In Solomon Islands, 91% of households still use solid fuel for cooking.

[6] http://www.un.org/sustainabledevelopment/energy/

Table 2.3: Household characteristics

Percent distribution of households by housing characteristics, percentage using solid fuel for cooking, and percent distribution by frequency of smoking in the home, according to residence, Solomon Islands 2015

Housing characteristic	Residence		Total
	Urban	Rural	
Electricity			
Yes	67.6	52.6	55.1
No	32.4	47.3	44.7
Missing	0.1	0.1	0.1
Total	100	100	100
Flooring material			
Earth/sand	9.5	17.8	16.4
Coral/pebbles	0.5	1.4	1.3
Wood planks	33.4	35.6	35.2
Palm/bamboo	0.5	9.9	8.3
Parquet or polished wood	34.9	31.6	32.2
Ceramic tiles	4.4	0.1	0.8
Cement	14.6	2.9	4.9
Carpet	2.1	0.4	0.7
Other	0	0.1	0.1
Missing	0.1	0.2	0.2
Total	100	100	100
Rooms used for sleeping			
One	12.6	18.6	17.6
Two	47.5	42.5	43.3
Three or more	39.3	37.4	37.7
Missing	0.6	1.5	1.3
Total	100	100	100
Place for cooking			
In the house	39.8	6.6	12.2
In a separate building	50.6	89.1	82.6
Outdoors	8.8	3.7	4.5
No food cooked in household	0.2	0	0.1
Other	0.5	0.5	0.5
Missing	0.1	0.1	0.1
Total	100	100	100
Cooking fuel			
Electricity	3.1	0.1	0.6
LPG	37.3	1.5	7.5
Kerosene	1.6	0	0.3
Charcoal	0.3	1.1	1
Wood	52.3	96.9	89.4
Straw/shrubs/grass/sawdust	5.1	0.2	1
Other	0	0	0
No food cooked in household	0.2	0	0.1
Missing	0.1	0.1	0.1
Total	100	100	100
Percentage using solid fuel for cooking1	57.7	98.2	91.4
Frequency of smoking in the home			
Daily	48.7	59	57.3
Weekly	3.6	5.7	5.3
Monthly	0.5	0.8	0.7
Less than monthly	1.5	1.3	1.3
Never	45.5	33.1	35.2
Missing	0.2	0.1	0.1
Total	100	100	100
Number	**850**	**4,192**	**5,042**

LPG = Liquid petroleum gas

[1] Includes coal/lignite, charcoal, wood/straw/shrubs/grass/sa dust, agricultural crops, and animal dung

The SIDHS 2015 found that wood is the most common fuel for cooking, used in 89% of households, while LPG is used in 8% households. Electricity is used by only 0.6% of households. Other cooking fuels such as kerosene, charcoal, straw, shrubs, grass or sawdust are used in 2% of households. The use of wood fuel in rural areas is almost universal with well over 9 out of 10 households using it, while in urban areas 5 out of 10 households use this type of fuel.

Table 2.3 shows the frequency of residents smoking in the home, categorised in terms of daily, weekly, monthly, less than monthly, and never smoked in the home. Frequent smoking in the home can cause health and respiratory problems to household members. Daily smoking in the home occurs in 57% of Solomon Islands households, with most occurring in rural households (59%), but also in almost half of all urban households (49%). Urban households are also more likely to have residents who have never smoked in the home, with 46% of households stating that this was the case, compared with 33% of households in rural areas. Smoking in the house weekly, monthly or less than monthly occurred less frequently.

2.1.4 Household possessions

The SIDHS 2015 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 phones) as an indicator of access to an efficient means of communication; refrigerator ownership as an indication of the capacity for the 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 or cross cattle breed, horses, donkeys or mules, goats, sheep, pigs, or chickens indicates the level of assets a household possesses that could be used to meet household demands.

Table 2.4 shows the percentage of households owning certain goods and means of transportation, and land and farm animals. The most commonly owned items household items include, a bed, mobile phone, dining set[7], radio and sewing machine, whereas the least commonly owned items include a washing machine and microwave. Data from the SIDHS 2015 show that 26% of households in Solomon Islands own a radio. Owning a radio is more common (44%) in urban households than in rural households (23%). Approximately 9% of all households own a television, and as expected, urban households are more likely than rural households to own a television (42% urban, 2% rural). About 78% of all households own a mobile phone, including 97% of urban households. A refrigerator, microwave, fan, freezer, washing machine, chainsaw and pressure lamp were each owned by less than 10% of all households.

With regard to transport, 8% of all households own a bicycle and these households are more likely to be in urban areas (20%) than in rural areas (6%). In urban areas, 23% of households own a car or truck compared with 2% of rural households. In contrast, 10% of both rural households and urban households own a boat with a motor.

As expected, ownership of agricultural land and farm animals[8] was more common in rural areas than in urban areas. Approximately 63% of all Solomon Islands households own agricultural land; 26% of urban households own land in contrast to 70% of rural households. About 52% of households own farm animals, which again is more common in rural areas (60%) than in urban areas (17%).

[7] A dining set constitutes basic furniture such as a table and chairs.

[8] Farm animals include cattle, cows, bulls, horses, donkeys, goats, sheep or chickens.

Table 2.4: Household possessions

Percentage of households possessing various household effects, means of transportation, agricultural land and livestock/farm animals by residence, Solomon Islands 2015

Possession	Residence		Total
	Urban	Rural	
Household effects			
Radio	44	22.8	26.4
Television	41.6	2.2	8.9
Mobile telephone	97.2	73.7	77.7
Refrigerator	22.1	0.5	4.1
Bed	92.2	86.8	87.7
Sewing machine	36.5	23.2	25.4
Microwave	9.4	0.2	1.7
Fan	41.4	1.2	8
Freezer	26.1	0.6	4.9
Washing machine	5.3	0.1	1
Video set	45.6	8.3	14.6
Chainsaw	9.4	10	9.9
Dining set	60.4	27.3	32.9
Pressure lamp	3.9	2.2	2.4
Means of transport			
Bicycle	20.2	5.5	7.9
Motorcycle/scooter	1.3	0.4	0.6
Car/truck	22.9	1.8	5.4
Boat with a motor	10.2	9.6	9.7
Ownership of agricultural land	25.7	69.9	62.5
Ownership of farm animals[1]	16.5	59.5	52.3
Number	**850**	**4,192**	**5,042**

[1] Cattle, cows, bulls, horses, donkeys, goats, sheep or chickens

2.2 WEALTH QUINTILES

In addition to standard background characteristics, the SIDHS 2015 collected information on the country's various wealth quintiles, an indicator of the economic status of a household. Although surveys under the DHS programme do not collect data on consumption or income, they do collect detailed information on dwelling and household characteristics, and access to a variety of consumer goods and services and assets, which are used as a measure of economic status. The wealth index is a measure that has been used in many DHS and other country-level surveys to indicate inequalities in household characteristics, regarding the use of health and other services, and in health outcomes (Rutstein et al. 2000). The resulting wealth index is an indicator of the level of wealth that is consistent with expenditure and income measures (Rutstein 1999).

The wealth index was constructed using household asset data via principal components analysis. In its current form, which takes better account of urban–rural differences in the scores and indicators of wealth, the wealth index is created in three steps. In the first step, a subset of indicators common to both urban and rural areas is used to create wealth scores for households in both areas. Categorical variables to be used are transformed into separate dichotomous (0–1) indicators. These indicators and those that are continuous are then analysed using principal components analysis to produce a common factor score for each household. In a second step, separate factor scores are produced for households in urban and rural areas using area-specific indicators. The third step combines the separate area-specific factor scores to produce a nationally applicable combined wealth index by adjusting the area-specific score through regression on the common factor scores. This three-step procedure permits greater adaptability of the wealth index in both urban and rural areas. The resulting

combined wealth index has a mean of zero and a standard deviation of one, and once it is obtained, national-level wealth quintiles are obtained by assigning the household score to each *de jure* household member, ranking each person in the population by their score and then dividing the ranking into five equal parts, from quintile one (lowest-poorest) to quintile five (highest-wealthiest), each having approximately 20% of the population.

Table 2.5 shows the distribution across the five wealth quintiles of the population of urban and rural areas and in each region in Solomon Islands. These distributions indicate the degree to which wealth is evenly (or unevenly) distributed by geographic areas. The distribution of households by quintiles is not exactly 20% due to the fact that members of households, not households, were divided into quintiles.

Among the population in urban areas, 72% are in the highest wealth quintile, compared with 8% of the household population in rural areas. About 90% of the urban population is in the top two (fourth and highest) household wealth quintiles compared with 28% of the rural population. Almost half of the rural population is in the second to last and lowest household wealth quintiles. These results further confirm other findings that the distribution of wealth is uneven in Solomon Islands and that poverty is more concentrated in rural areas than in urban areas. This is consistent with results of the 2013/2014 Household Income and Expenditure Survey Poverty Profile.

Honiara has the highest percentage of residents in the highest wealth quintile (81%). In contrast, other provinces had the highest percentage of people in the lowest two quintiles. According to the Gini coefficient[91], wealth in Honiara and in urban areas is most evenly distributed (0.26).

Table 2.5: Wealth quintiles

Percent distribution of the de jure population by wealth quintiles, and the Gini coefficient, according to residence and region, Solomon Islands 2015

Residence/region	Wealth quintile					Total	Number of persons	Gini coefficient
	Lowest	Second	Middle	Fourth	Highest			
Residence								
Urban	0.8	2.2	6.7	18.3	72	100	5,207	0.26
Rural	24.6	24.3	23.2	20.4	7.5	100	21,652	0.31
Region								
Honiara	0	0.7	3.9	14.5	80.8	100	3,294	0.26
Guadalcanal	29.1	16.9	16.6	18.6	18.8	100	4,724	0.42
Malaita	21.5	28.3	22.8	19.8	7.6	100	7,218	0.35
Western	7.2	16.5	27.7	29.5	19.1	100	4,018	0.35
Other provinces	28.3	24.3	22.4	18.5	6.5	100	7,606	0.32
Total	**20**	**20**	**20**	**20**	**20**	**100**	**26,859**	**0.35**

2.3 HAND WASHING

Hand washing is important for health and hygiene and preventing the spread of disease. Table 2.6 shows the percent distribution of households where a place for washing hands was observed to have water, soap and other cleansing agents, by household background characteristics. In total, 70% of households had a place for washing hands. Of these households, soap and water were available for washing hands in 64% of all households; 25% had only water available, and 8% had no water, no soap and no other cleansing agent available.

A place for washing hands was more common in urban households (80%) than in rural households (68%). Urban households that had a place for washing hands were more likely to have soap and water available, while rural households were more likely to have water only or no water at all, no soap and no other cleansing

[9] The Gini coefficient is a measure of statistical dispersion intended to represent the income distribution of a country. It is the most commonly used measure of inequality. (See also: http://siteresources.worldbank.org/INTPA/Resources/tn_measuring_inequality.pdf)

agent. Western Province and Honiara had the higher percentage of households with a place for hand washing (84% and 83%, respectively). There was a fairly linear relationship between wealth quintile and a place for washing hands, with only 58% of households in the lowest quintile reported as having one, compared with 87% of households in the highest wealth quintile. Similarly, households with a hand washing place in higher wealth quintiles were more likely (90%) to have soap and water available than lower quintile households (33%).

Table 2.6: Hand washing

Percentage of households in which the place most often used for washing hands was observed, and among households in which the place for hand washing was observed, percent distribution by availability of water, soap and other cleansing agents, Solomon Islands 2015

Background characteristic	Percentage of households where place for washing hands was observed	Number of households	Among households where place for hand washing was observed, percentage with:								Number of households with place for hand washing observed
			Soap and water[1]	Water and cleansing agent[2] other than soap only	Water only	Soap but no water[3]	Cleansing agent other than soap only	No water, no soap, no other cleansing agent	Missing	Total	
Residence											
Urban	79.7	850	84.7	0.5	7.8	2.3	0.1	4.2	0.3	100	677
Rural	67.7	4,192	58.5	1.5	28.8	2.2	0.1	8.7	0.3	100	2,840
Region											
Honiara	83.2	496	88.3	0.3	5.2	2.4	0	3.5	0.2	100	413
Guadalcanal	65.6	948	58.6	3.8	26.3	0.9	0.2	10	0.1	100	622
Malaita	68.1	1,349	51.3	0.3	35.5	1.8	0	10.6	0.5	100	919
Western	83.5	760	71.7	0.5	16.4	3.8	0	7.2	0.3	100	635
Other provinces	62.4	1,488	62.3	1.5	27.4	2.3	0.2	6	0.4	100	928
Wealth quintile											
Lowest	58.4	1,026	33.4	2.1	45.3	1.8	0.5	16.4	0.5	100	600
Second	63	1,010	47.9	1.9	35.2	3.1	0	11.7	0	100	636
Middle	67.7	1,029	60.5	1.8	27.1	1.6	0	8.5	0.5	100	696
Fourth	74.3	1,055	75.2	0.7	17	3.1	0	3.9	0.3	100	784
Highest	86.9	922	89.7	0.3	6.5	1.5	0	1.6	0.4	100	801
Total	**69.8**	**5,042**	**63.5**	**1.3**	**24.7**	**2.2**	**0.1**	**7.8**	**0.3**	**100**	**3,517**

[1] Soap includes soap or detergent in bar, liquid, powder or paste form. This column includes households with soap and water only as well as those that had soap and water and another cleansing agent.

[2] Cleansing agents other than soap include locally available materials such as ash, mud or sand.

[3] Includes households with soap only as well as those with soap and another cleansing agent.

2.4 HOUSEHOLD POPULATION BY AGE AND SEX

The SIDHS 2015 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 2.7 shows the reported distributions of the *de facto* household population in five-year age groups, by sex and urban–rural residence. Data show that there are slightly more women (13,585) than men (13,408), with women constituting 50.3% of the population and men constituting 49.7%. The sex composition of the population does not show significant variation by urban–rural residence, with slightly more men living in urban areas (50.9%) than women (49.1%).

Table 2.7 further depicts Solomon Islands as having a young population, with a large proportion of people in younger age groups. Those aged less than 24 constitute 52% of the total population. Older age groups are very small in comparison, as seen in Figure 2.1 and Figure 2.2. Those aged over 50 make up less than 12%

of the total population. The population pyramid shows a broad base, reflective of the young age structure of the Solomon Islands. This type of age structure has a built-in momentum for the growth of the country's population, subject to migration and mortality trends. When the young population eventually reaches reproductive age, the potential result will be a high population growth rate for some years to come, assuming other contributors to population change hold constant (i.e. trends in fertility, mortality and migration).

Table 2.7: 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 2015

Age	Urban			Rural			National		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
<5	13	12.8	12.9	16.7	15.4	16	16	14.9	15.4
5–9	11.4	10.9	11.2	16.5	14	15.2	15.5	13.4	14.4
10–14	10	10.7	10.4	13.7	13.9	13.8	13	13.3	13.1
15–19	10.9	12	11.5	8.4	8.2	8.3	8.9	9	8.9
20–24	10.8	11.7	11.2	5.7	7	6.4	6.7	7.9	7.3
25–29	9.9	9.3	9.6	5.9	7.6	6.7	6.7	7.9	7.3
30–34	7.2	7.8	7.5	6.3	6.6	6.4	6.5	6.8	6.6
35–39	7.1	7.1	7.1	5.9	6.1	6	6.1	6.3	6.2
40–44	6.1	5.1	5.6	4.6	4.7	4.7	4.9	4.8	4.9
45–49	3.9	3.6	3.8	4.1	3.8	3.9	4	3.7	3.9
50–54	3.5	3.7	3.6	3	4.7	3.9	3.1	4.5	3.8
55–59	2.2	1.8	2	2.5	2.4	2.4	2.4	2.3	2.4
60–64	1.5	1.6	1.5	2.4	1.9	2.1	2.2	1.8	2
65–69	1	0.9	1	1.6	1.5	1.6	1.5	1.4	1.4
70–74	0.7	0.5	0.6	1.3	1	1.1	1.2	0.9	1
75–79	0.4	0.2	0.3	0.8	0.6	0.7	0.7	0.5	0.6
80+	0.3	0.2	0.2	0.6	0.6	0.6	0.6	0.5	0.5
Don't know/missing	0	0	0	0	0	0	0	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number	**2,691**	**2,596**	**5,287**	**10,716**	**10,989**	**21,705**	**13,408**	**13,585**	**26,993**

Figure 2.1: Solomon Islands population pyramid, 2015

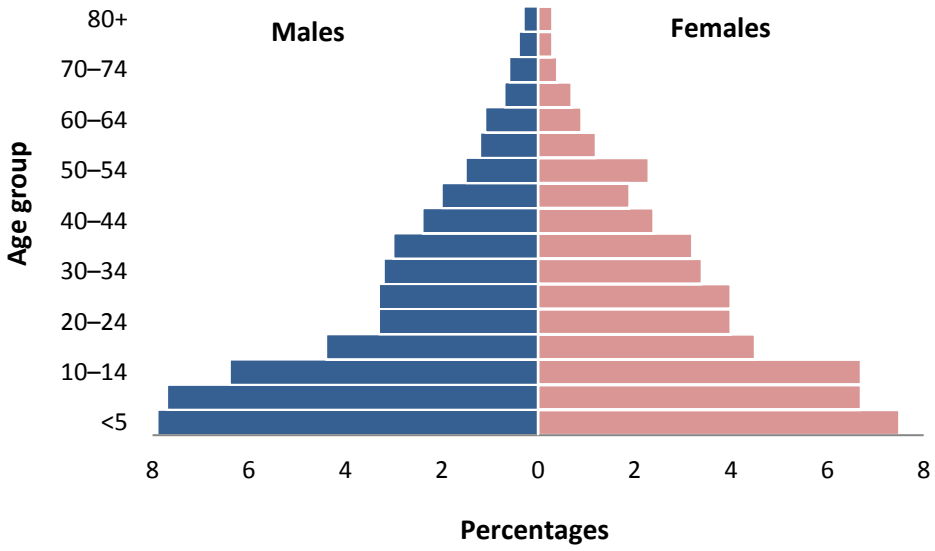
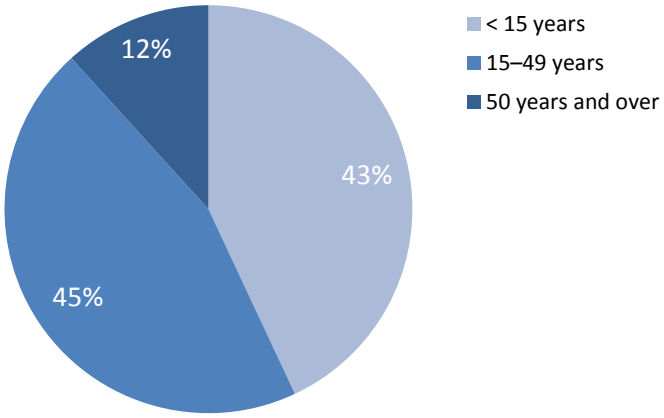
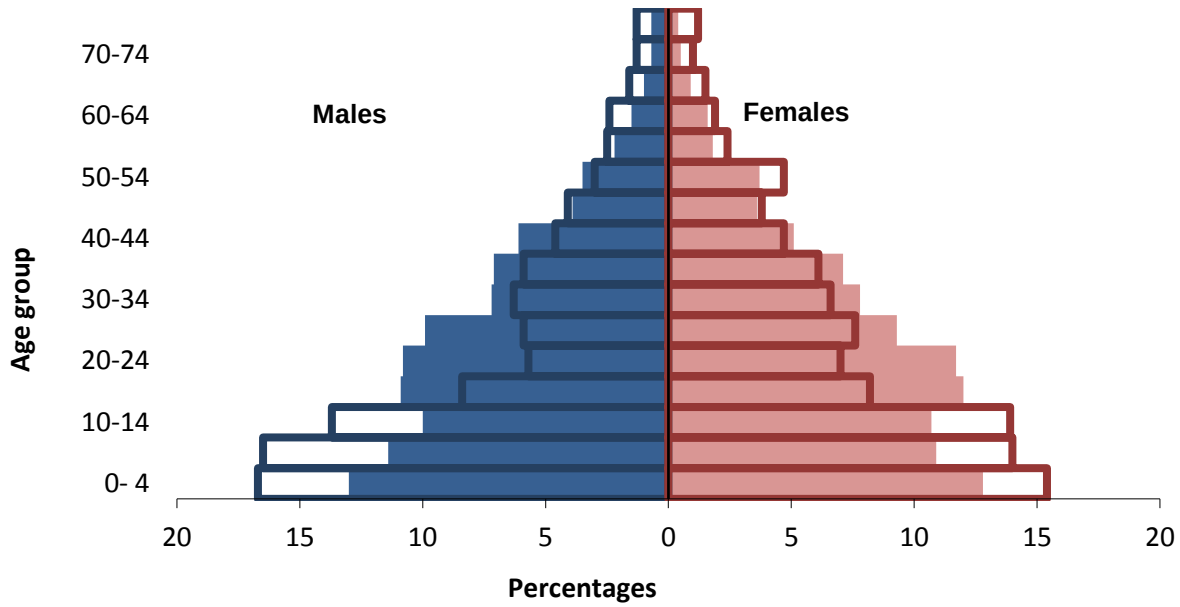


Figure 2.2: Solomon Islands broad age population (in percentages), 2015



There are differences in age structure between rural and urban areas. In urban areas, 35% of the population is aged less than 15 compared with 45% of the rural population. However, there are more working age people between ages 15 and 49 in urban areas than in rural areas, where they comprise 56% of the population as opposed to 42% of the population.

Figure 2.3: Urban (shaded) and rural (outlined) population pyramid, Solomon Islands 2015



2.5 HOUSEHOLD COMPOSITION

Information on other key aspects of household composition (e.g. sex of head of household and household size) are presented in Table 2.8. These characteristics are important because they provide information on the welfare of a household and its members. Economic resources are often more limited in larger households than in smaller households. Moreover, in larger households, crowding can lead to health problems. A household's size and composition influence the allocation of limited resources and affect the living conditions of household members.

Data from the SIDHS 2015 indicate that about 18% of households are headed by women, with little difference between urban and rural areas. The mean household size is 5.3 people, similar to the mean household size of 5.5 people reported in the 2009 population census. In urban areas, the average household size is 6.1 people, whereas in rural areas, the average household size is 5.2 people. About 19% of urban households reported having more than 9 members as compared with 10% of rural households. Where the size of the household is large, crowding can lead to social and health problems in the family, community and country. However, it is important to understand that measuring household size and whether it is crowded has two aspects. One is the

dwelling's physical measurements: more members can comfortably live in bigger houses. The other is the number of people living in the household.

Table 2.8: 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 18 years of age, according to residence, Solomon Islands 2015

Characteristic	Residence		
	Urban	Rural	Total
Household headship			
Male	83.5	82	82.3
Female	16.5	18	17.7
Total	**100**	**100**	**100**
Number of usual members			
0	0.3	0.1	0.1
1	3.6	4.4	4.2
2	5.5	8.7	8.2
3	10.2	12.6	12.2
4	15	16.9	16.6
5	12.9	17	16.3
6	13.7	14.6	14.4
7	10.8	10.6	10.6
8	9.1	5.6	6.2
9+	18.9	9.6	11.1
Total	**100**	**100**	**100**
Mean size of households	6.1	5.2	5.3
Percentage of households with orphans and foster children under 18 years of age			
Foster children[1]	28.7	28.6	28.6
Double orphans	0.9	0.7	0.7
Single orphans[2]	5.1	4.7	4.8
Foster and/or orphan children	31.1	30.6	30.7
Number of households	850	4,192	5,042

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.

[2] Includes children with one dead parent and an unknown survival status of the other parent.

2.6 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, birth registration is only 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 this demographic data. Birth registration is 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 that ensures 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 88% of births of children under age 5 years are registered in Solomon Islands, although only 26% of those registered have a birth certificate. This indicates an improvement from 80% as found by the SIDHS 2006–2007. There is little difference in the proportion of children registered in urban areas and rural areas, although those in urban areas were more likely to have a birth certificate. This is a noticeable

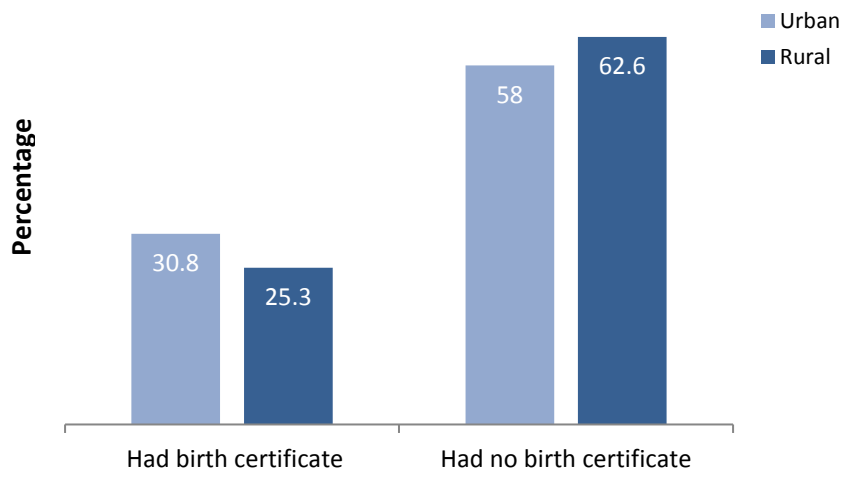
change from the SIDHS 2006–2007, where 70% of births in urban areas were registered compared with 81% in rural areas. There is little variation in birth registration across household wealth quintiles, ranging from 87% in the lowest wealth quintile to 89% in the fourth wealth quintile. Similarly, the number of registered births was consistent across regions with more than 80% births registered reported from each region. Children in Honiara and Malaita whose births were registered were the most likely to have birth certificates.

Table 2.9: Birth registration of children under 5

Percentage of de jure children under five years of age whose births are registered with the civil authorities, according to background characteristics, Solomon Islands 2015

Background characteristic	Children whose births are registered			Number of children
	Percentage who had a birth certificate	Percentage who did not have birth certificate	Percentage registered	
Age				
<2	27.3	63.3	90.6	1,642
2–4	25.4	60.9	86.3	2,490
Sex				
Male	26.3	60.9	87.2	2,133
Female	26.1	62.9	89	1,999
Residence				
Urban	30.8	58	88.8	672
Rural	25.3	62.6	87.9	3,460
Region				
Honiara	32.9	54.8	87.7	426
Guadalcanal	25.9	60.2	86.1	750
Malaita	39.1	48.6	87.8	1,130
Western	25.9	62.7	88.6	599
Other provinces	12.2	77.1	89.3	1,227
Wealth quintile				
Lowest	25.4	61.7	87	953
Second	24.4	64.2	88.7	862
Middle	26.2	61	87.1	864
Fourth	27.1	62.3	89.4	798
Highest	28.5	59.8	88.3	655
Total	**26.2**	**61.9**	**88**	**4,132**

Figure 2.4: Percent of birth registration of children under age 5 by urban and rural area, Solomon Islands 2015



2.7 FOSTERHOOD AND ORPHANHOOD

In Solomon Islands, a person younger than 18 years is defined as a child, as is the case in most other Pacific Island countries. Information on fosterhood and orphanhood of children is presented in the previous Table 2.8. The percentage of households with foster and/or orphan children is roughly the same in rural and urban areas, at about 31%. About 4.8% of all households have a single orphan, which refers to children living in the household with just a father or just a mother.

Table 2.10 shows: 1) the percent distribution of *de jure* children less than 18 years old by living arrangements and parental survival status, 2) the percentage of children not living with a biological parent, and 3) the percentage of children with one or both parents dead, according to background characteristics. Overall, 17% of *de jure* or usual resident children aged less than18 years do not live with a biological parent, which is more common with children in the 15–17 age group, and with children living in the highest wealth households. About 4% of children aged less than 18 years had one or both parents dead, and there is little difference when comparing urban and rural areas. Of the regions, 5% of children under age 18 in Malaita had lost one or both parents compared with 2% in other provinces. This was also more common among children living in the fourth wealth households (5%). Moreover, 63% of children aged less than 18 years were living with both parents while the remaining 37% of children aged less than 18 years were living with only one parent (father or mother) or with no parents at all. It was more common for children aged less than 18 and living with only one parent to be living with their mother (16%) than their father (3%).

Table 2.10: Children's living arrangements and orphanhood

Percent distribution of de jure children under age 18 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 2015

Background characteristic	Living with both parents	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[1]	Number of children
		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	69.2	19.6	0.8	1.2	0.1	8.2	0.3	0.1	0.1	0.4	100	8.8	1.4	4,132
..<2	70.9	23.3	0.7	0.5	0	3.6	0.1	0.1	0.2	0.6	100	3.9	1	1,642
..2–4	68.1	17.2	0.8	1.6	0.2	11.3	0.4	0.2	0.1	0.2	100	11.9	1.6	2,490
5–9	64.5	14.6	1.3	2.6	0.5	15.2	0.2	0.4	0.3	0.3	100	16.2	2.8	3,869
10–14	59.3	11.7	2.2	3.1	0.7	19.8	0.6	1.2	0.6	0.8	100	22.1	5.4	3,530
15–17	49.7	9.6	2.7	3.3	1	26.5	0.8	1.4	1.1	3.9	100	29.8	7.1	1,522
Sex														
Male	62.9	15.1	1.7	2.3	0.6	15.1	0.5	0.6	0.4	0.7	100	16.7	3.9	6,711
Female	62.8	14.6	1.4	2.5	0.3	16	0.3	0.6	0.4	1	100	17.4	3.1	6,342
Residence														
Urban	64.1	11	2.1	4	0.3	15.4	0.4	0.8	0.4	1.6	100	17	4	2,121
Rural	62.6	15.6	1.4	2.1	0.5	15.6	0.4	0.6	0.4	0.7	100	17	3.5	10,932
Region														
Honiara	64.8	10.9	1.8	4.6	0.2	15	0.1	0.7	0.3	1.6	100	16.2	3.2	1,303
Guadalcanal	74.6	11	1.6	0.8	0.7	9.3	0.6	0.5	0.2	0.7	100	10.6	3.6	2,311
Malaita	60.4	16.6	1.7	3.3	0.5	14.4	0.5	1.1	0.5	0.8	100	16.6	4.5	3,733
Western	53	19.7	1.8	2.8	0.5	19.2	0.6	0.5	0.8	1.1	100	21.1	4.2	1,894
Other provinces	62.4	14.3	1.1	1.5	0.4	18.8	0.2	0.3	0.4	0.7	100	19.6	2.4	3,813
Wealth quintile														
Lowest	69.9	13.3	2.2	1.3	0.3	11.3	0.4	0.6	0.1	0.6	100	12.4	3.5	2,857
Second	59.6	16.1	1.7	3.8	0.4	15.7	0.6	0.5	0.6	0.9	100	17.5	4	2,763
Middle	61.8	17.6	0.5	1.2	0.6	16.2	0.4	0.7	0.3	0.7	100	17.7	2.6	2,682
Fourth	61.1	15.3	2.1	1.6	0.9	16.3	0.4	0.5	0.7	1.1	100	17.9	4.6	2,531
Highest	61.1	11.2	1.2	4.3	0.2	19.2	0.2	0.9	0.4	1.3	100	20.7	3	2,220
Total <15	**64.6**	**15.5**	**1.4**	**2.2**	**0.4**	**14.1**	**0.4**	**0.5**	**0.3**	**0.5**	**100**	**15.3**	**3.1**	**11,531**
Total <18	**62.9**	**14.8**	**1.6**	**2.4**	**0.5**	**15.5**	**0.4**	**0.6**	**0.4**	**0.9**	**100**	**17**	**3.5**	**13,053**

Note: Table is based on de jure members, i.e., usual residents.

[1] Includes children with father dead, mother dead, both dead and one parent dead but missing information on survival status of the other parent.

2.8 EDUCATION OF THE HOUSEHOLD POPULATION

Education affects many aspects of life, including individual demographic and health behaviour. Studies have shown that education 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 2.11.1 shows the distribution of female household members and Table 2.11.2 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.

2.8.1 Educational attainment

As shown in Tables 2.11.1 and 2.11.2, the majority of Solomon Islanders attended school, although many did not complete primary school (35% of women, 34% of men). Among those who never attended school, slightly more females than males never attended; 22% of females aged 6 or older had never been to school, compared with 18% of males, which suggests a gender gap in educational attainment. Higher percentages of males are represented in the categories of 'some secondary' and 'more than secondary' education, while slightly higher percentages of women had 'some primary' education and 'completed primary' education as their highest level of educational attainment. Similar percentages of males and females had 'completed secondary' as their highest level of attainment (0.3%). Females in all age groups over age 20 are more likely to have no education. Women aged 20–49 are most likely to have some secondary education, and those aged 25–49 are most likely to have more than a secondary education. This is reflective of the age at which most people would undertake further education. The same was also true for men, although the percentages of men who had achieved these levels of education were higher than for women in all age groups. In contrast, the proportion of individuals aged 6–9 with no education is higher for males (76%) than for females (72%).

Overall, a primary level education is the highest educational attainment achieved in rural areas. Secondary level education attainment is higher in urban areas than in rural areas. The median number of years of schooling is higher in Honiara (8 years for males, 6 years for females) than it is in rural areas (4 years for both males and females). Secondary and more than secondary educational attainment is most common in Honiara for both men and women, while Malaita had the highest percentage of people who received no education.

Table 2.11.1: Educational attainment of the female household population

Percent distribution of the de facto female household population age 6 and over by highest level of schooling attended or completed and median years completed, according to background characteristics, Solomon Islands 2015

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	72.4	26	0.1	0	0	0	1.5	100	1,448	0
10–14	10	83	3.9	2.8	0	0	0.3	100	1,810	2.3
15–19	2.9	27.6	15	54	0.1	0.2	0.3	100	1,216	6.3
20–24	5	18.6	12.8	56.7	1.1	5.5	0.2	100	1,073	7.9
25–29	8.5	19	14.4	47.7	1	8.8	0.5	100	1,073	7.5
30–34	11.4	23.7	23	33.3	0.2	8.3	0.1	100	930	5.6
35–39	12	26.1	38.2	15.2	0.2	7.7	0.6	100	857	5.3
40–44	15	21	39.8	15.9	0.2	7.9	0.2	100	653	5.3
45–49	21.9	24.4	34.4	11.6	0	7.4	0.3	100	507	5.1
50–54	33.8	34.1	19.2	9	0	2.5	1.3	100	614	3
55–59	36.6	39.8	13.9	5.7	0	2.9	1	100	312	2.4
60–64	43.7	36.7	9	6.1	0	2.9	1.6	100	247	1.2
65+	49.4	38.7	7.2	0.8	0	1.7	2.2	100	449	0
Don't know/missing	0	0	0	0	0	0	100	100	1	0
Residence										
Urban	13	25.3	14.5	35.2	1	10.4	0.7	100	2,209	5.8
Rural	24.4	37.5	15.8	19.4	0.1	2.2	0.6	100	8,980	3.5
Region										
Honiara	13.2	23.9	13.5	35.6	1.3	12	0.5	100	1,386	6
Guadalcanal	22.7	38	13.1	22.6	0.2	2.8	0.5	100	1,905	3.8
Malaita	32.8	39.4	10.3	15.2	0.2	1.3	0.8	100	3,048	2
Western	10.5	32.8	25.6	26.2	0.1	3.8	1	100	1,656	5.3
Other provinces	21.5	35.1	17.6	22	0.1	3.2	0.4	100	3,194	4.1
Wealth quintile										
Lowest	32.7	40.6	13.9	11.6	0	0.4	0.7	100	2,179	2.1
Second	28.8	37.9	14.2	17.4	0.1	1.1	0.5	100	2,203	2.9
Middle	19	37.6	17.7	22.7	0	2.2	0.8	100	2,230	4.3
ourth	19.1	33.6	17.9	24.8	0.2	3.7	0.7	100	2,254	4.7
Highest	11.9	26.1	13.9	35.4	0.9	11.3	0.5	100	2,323	5.9
Total	**22.1**	**35**	**15.5**	**22.5**	**0.3**	**3.8**	**0.6**	**100**	**11,189**	**4.1**

[1] Completed grade 6 at the primary level

[2] Completed form 5 or form 6 or form 7 at the secondary level

Table 2.11.2: Educational attainment of the male household population

Percent distribution of the de facto male household population age 6 and over by highest level of schooling attended or completed and median years completed, according to background characteristics, Solomon Islands 2015

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	76.1	22.8	0	0.2	0	0	0.9	100	1,666	0
10-14	10.4	82.1	4.6	2.5	0	0	0.2	100	1,739	2.1
15–19	3.9	32.4	15.1	47.7	0.2	0.7	0.1	100	1,198	5.9
20–24	4.1	13.1	12.7	59.6	1.5	7.7	1.2	100	901	8.4
25–29	4.2	16.2	13.4	51.5	1.5	12.4	0.7	100	899	8.3
30–34	4.9	17.5	19.2	43.1	0.7	14.4	0.3	100	865	8
35–39	6	18	28.3	33.4	0	13.6	0.7	100	823	5.9
40–44	5.9	17.1	32.6	26.5	0.1	16.9	0.9	100	658	5.8
45–49	5.4	21.2	38.2	20.4	0	14	0.8	100	542	5.6
50-54	9.6	28	31	18.7	0.1	11.4	1.1	100	417	5.6
55-59	11.4	44.5	15.7	18.4	0.2	9.2	0.6	100	325	6
60-64	11.4	54.4	12.2	10.9	0	9.9	1.2	100	294	5.5
65+	22.3	52	10.5	7.7	0	6.7	0.9	100	529	3.6
Don't know/missing	0	0	55.8	0	0	44.2	0	100	4	5.9
Residence										
Urban	9.7	22.9	11.4	37.8	1.1	16.2	0.8	100	2,279	7.5
Rural	20.3	36.8	15.5	22.1	0.1	4.5	0.6	100	8,581	4.2
Region										
Honiara	9.2	21.6	10	38.5	1.4	18.4	0.8	100	1,442	8.2
Guadalcanal	19.4	34.2	14.7	25.9	0.1	5.2	0.5	100	1,906	4.5
Malaita	23.7	40.5	12.9	19.9	0.2	2.4	0.3	100	2,836	3.2
Western	12.7	30.2	20.6	26.5	0.4	8.6	1.1	100	1,648	5.5
Other provinces	19	35.5	15.3	23.5	0	6	0.7	100	3,028	4.6
Wealth quintile										
Lowest	27.7	40.5	14.1	15.4	0	1.7	0.6	100	2,082	2.8
Second	21.6	40.4	15.8	19.4	0.1	2.3	0.4	100	2,118	3.5
Middle	17.8	35.4	17.8	23.6	0.1	4.5	0.8	100	2,139	4.9
Fourth	14.6	32.2	14.4	29.8	0.4	7.7	0.8	100	2,195	5.4
Highest	9.6	22.4	11.4	37.3	1	17.6	0.7	100	2,326	7.6
Total	**18**	**33.9**	**14.7**	**25.4**	**0.3**	**7**	**0.6**	**100**	**10,860**	**5**

[1] Completed grade 6 at the primary level

[2] Completed form 5 or form 6 or form 7 at the secondary level

The likelihood of an individual never receiving an education decreases as the household's wealth quintile increases, just as the likelihood of the individual completing secondary or more than secondary level education increases. Among females, only 12% of those from the poorest households have some secondary education, while 35% of females from the wealthiest households have some secondary schooling. Similar differences by wealth are also evident among males: only 15% of males from the poorest households have some secondary education compared with 37% from the wealthiest households.

The likelihood of an individual reaching more than a secondary level of education is much greater among the wealthiest Solomon Islands households than individuals from poorer households. Some 18% of males from the wealthiest households have more than a secondary level of education as compared with 2–8% of males from the remaining wealth quintiles. A similar pattern is observed for women, with 11% of females from the wealthiest households and just 0–4% of females from less wealthy households having attained more than a secondary level of education.

2.8.2 School attendance ratios

Solomon Islands use 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 education, or university or tertiary education. 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 primary school is the percentage of the primary school-age population (aged 6–13) that is attending primary school. Overall, the primary school NAR is only 66% in Solomon Islands (see Table 2.12). 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 65% for males and 68% for females.

There is little variation in NAR by wealth quintiles. NAR is lowest among school-age children in the lowest wealth quintile households (56%) and is highest among children in the highest wealth quintile (77%). NAR for children of all other wealth quintiles falls between these two percentages. Because primary education is free (although not compulsory), it is not surprising that NAR at the primary school level does not increase with wealth quintile. However, some schools still charge some fees and this may have an impact on the trends observed.

The gross attendance ratio (GAR) measures attendance irrespective of the official age at each level. 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 105%, with GAR being higher for females (108%) than males (103%), and higher in rural areas (106%) than in urban areas (102%). GAR was consistent across wealth quintiles (107–109%), with the exception of the lowest quintile (96%).

The gender parity index (GPI) is a measure of the ratio of females to males attending school, regardless of age. It should be noted that the natural global sex ratio at birth (males born per 100 females) is between 103 and 107 males per 100 females[10]. Combined with differing morbidity and mortality patterns for males and females, this affects the gender structure of the population. For primary school, GPI is 1.05, indicating that the number of female and male students is almost the same, with females slightly outnumbering males. This is the same result that was found in the SIDHS 2006–2007. There is little variation in GPI for the primary school GAR between rural and urban areas (1.04 and 1.02, respectively); however, the ratios are above the national average in Guadalcanal, Malaita and Western provinces, and the third to fifth wealth quintiles.

The concept of NAR at the secondary level is similar to that of the primary level, that is, the percentage of the secondary school-age population (aged 12–18) attending secondary school. Overall, only 34 out of 100 secondary school-age children in Solomon Islands attend secondary school. The secondary NAR for both males and females is 34% (Table 2.12).

[10] United Nations. 2015. Population, households and families: Demographic composition of the population. Gender Statistics Manual, United National Statistics Division, updated 22 May 2016, accessed 31 May 2016. <http://unstats.un.org/unsd/genderstatmanual/Demographic-composition-of-population.ashx>

Table 2.12: School attendance ratios

Net attendance ratios (NAR) and gross attendance ratios (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 2015

Background characteristic	Net attendance ratio[1]				Gross attendance ratio[2]			
	Male	Female	Total	gpi[3]	Male	Female	Total	gpi[3]
PRIMARY SCHOOL								
Residence								
Urban	70.7	74.2	72.4	1.05	100.7	103.1	101.9	1.02
Rural	63.4	66.9	65.1	1.05	103.7	108.3	106	1.04
Region								
Honiara	72.7	72.7	72.7	1	99	97.5	98.3	0.98
Guadalcanal	59	68.3	63.4	1.16	97.9	111.8	104.4	1.14
Malaita	60	64.5	62.2	1.07	104.6	112.4	108.3	1.08
Western	68.4	67.7	68.1	0.99	97.1	102.4	99.7	1.05
Other provinces	67.7	69.8	68.7	1.03	109.3	106.1	107.7	0.97
Wealth quintile								
Lowest	54.1	57.9	55.9	1.07	94.4	98.1	96.2	1.04
Second	61.2	63.6	62.3	1.04	110	106.8	108.4	0.97
Middle	67.2	72.8	69.8	1.08	101.8	112.9	107	1.11
Fourth	69.2	70.1	69.7	1.01	107.2	108.6	107.9	1.01
Highest	74.6	79.1	76.8	1.06	104.4	113.7	108.9	1.09
Total	**64.5**	**68**	**66.2**	**1.05**	**103.3**	**107.5**	**105.3**	**1.04**
SECONDARY SCHOOL								
Residence								
Urban	53.2	54.7	54	1.03	73.2	66	69.5	0.9
Rural	28.5	28.2	28.4	0.99	35.2	32.9	34.1	0.94
Region								
Honiara	52.6	54.9	53.8	1.04	78	67.6	72.6	0.87
Guadalcanal	33.5	33.7	33.6	1.01	43.6	40.7	42.1	0.93
Malaita	26.3	24.9	25.6	0.94	34.5	30.8	32.6	0.89
Western	40.1	42.1	41.1	1.05	45.2	45.9	45.6	1.02
Other provinces	29.6	28.7	29.2	0.97	34.8	32.5	33.7	0.93
Wealth quintile								
Lowest	17.1	18.4	17.7	1.08	22.2	21.5	21.8	0.97
Second	18.7	23.1	20.9	1.23	22.8	25.7	24.2	1.12
Middle	35.6	31.2	33.4	0.88	43.8	37.8	40.8	0.86
Fourth	39.8	35.9	37.9	0.9	49.7	41.5	45.7	0.84
Highest	55.1	55.4	55.2	1.01	73.9	67.1	70.3	0.91
Total	**33.5**	**33.9**	**33.7**	**1.01**	**42.9**	**40**	**41.5**	**0.93**

[1] The NAR for primary school is the percentage of the primary-school age (6–11 years) population that is attending primary school. The NAR for secondary school is the percentage of the secondary-school age (12–18 years) population that is 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 gender parity index for primary school is the ratio of the primary school NAR(GAR) for females to the NAR(GAR) for males. The gender parity index for secondary school is the ratio of the secondary school NAR(GAR) for females to the NAR(GAR) for males.

Secondary school NAR is higher in urban areas (54%) than in rural areas (28%), and this pattern is the same for boys and girls. NAR rises with wealth from about 18% in the lowest wealth quintile to 55% in the highest wealth quintile.

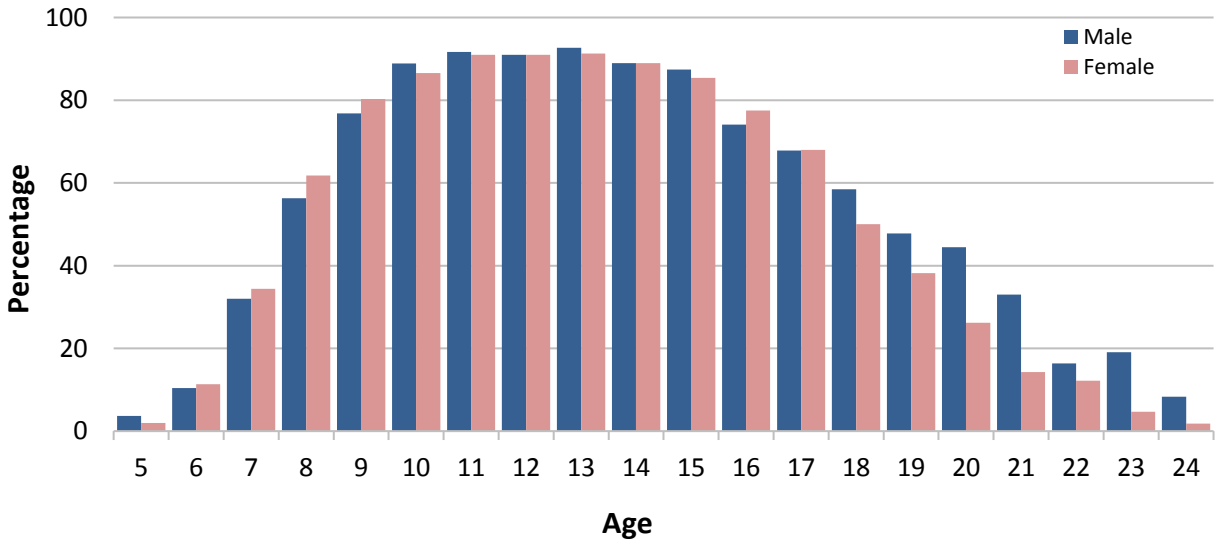
Secondary school GAR is 42% for the nation as a whole, and is higher in urban areas (70%) than in rural areas (34%). This same pattern is observed for males and females. Similar to NAR, secondary school GAR increases as wealth increases: GAR is 70% among youth in the wealthiest households and only 22% among youth in the poorest households.

GPI for the secondary school GAR is 0.93, 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 primary school GAR, and varies little by background characteristics. Male students are outnumbered by female students only in the second wealth quintile and in Western Province, while males outnumbered females in all background characteristics. GPI for secondary school is especially low in the fourth wealth quintile households (0.84) and to a lesser extent in urban areas (0.9), 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 2.5 shows that one-third (33%) of children aged 7 attend school. Attendance rates among children aged 8 are 60% and are 80% for children aged 9. These statistics show that most children in Solomon Islands enter into primary school later than age 7. The age-specific attendance rate for Solomon Islands peaked between 11 and 13 years. This was not the case for 40% of children aged 8 and about 20% of children aged 9 who did not attend primary school. This is particularly important because education is free, although not compulsory, in Solomon Islands. The percentage attendance overall was higher for girls in the younger age groups (6–9) and higher for boys in the older age groups (18–24).

Figure 2.5: Age-specific attendance rates of the de facto population aged 5–24, Solomon Islands 2015



The above graph 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 (2015) school year.

CHAPTER 3 CHARACTERISTICS OF SURVEY RESPONDENTS

by Anna Pitaboe, Senior Statistician, SINSO

KEY FINDINGS

- Solomon Islands has a young, predominantly Christian and Melanesian population. The majority of men and women aged 15–49 (77%) reside in rural areas and over half are married.
- More than half of all men and women aged 15–49 have achieved a primary level education, less than half have completed a secondary level education, and about 9% of women and 3% of men have had no formal education.
- Of those Solomon Islanders aged 15–49, 82% of women and 90% of men are literate. In contrast, 16% of women and 8% of men cannot read at all.
- Over half of all men (60%) and women (74%) aged 15–49 have no access to the three main media sources — radio, newspaper and television — at least once a week. Radio is the most popular media source.
- Approximately 37% of women and 70% of men are classified as currently employed. More women in urban areas (41%) are currently employed than women in rural areas (36%), while the opposite is true for men: 72% of men in rural areas are currently employed compared with 63% of men in urban areas.
- The largest industry of employment for both women and men aged 15–49 is agriculture (41% of women, 54% of men). This has increased from the 2006/2007 SIDHS, where 32% of women were employed in agriculture and 40% of men were.
- 41% of employed women between the ages of 15 and 49 receive payment in cash only and 49% of women receive no payment for their work.
- 41% of women aged 15–49 are self-employed and 35% are employed by a family member.
- Most women and men aged 15–49 are not covered by any health plan or insurance scheme (98% of women, 96% of men).
- 20% of women and 58% of men aged 15–49 are tobacco users. Cigarette smoking is more common than the use of pipes or other tobacco for both men and women aged between 15 and 49.
- 92% of women and 97% of men have heard of tuberculosis, and 83% of women and 88% of men reported that tuberculosis is transmitted through the air by coughing.

INTRODUCTION

This chapter describes the situation and characteristics of men and women of reproductive age in Solomon Islands, which is useful for contextualising data on reproductive and general health. 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 6,226 women aged 15–49 and 3,591 men aged 15 and above who were interviewed in the SIDHS 2015, and shows their distribution by background characteristics. The proportion of women and men declines with increasing age, reflecting the young population of Solomon Islands: 38% of both women and men are aged 15–24, 32% of women and 31% of men are aged 25–34, and the remaining respondents are women aged 35–49 and men aged 35 and above.

In terms of religion, more women and men belong to Anglican church (32% and 34%), followed by Roman Catholic church and the South Seas Evangelical Church (19% of women and 18% of men). Another 12% of women and men who are Seventh-Day Adventists while 10% of both women and men stated that they belong to the United Church. Very few women and men (8%) belong to other churches.

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

About 56% of women and 50% of men aged 15–49 are formally married. Men are much more likely than women to have never married (43% of men compared with 31% of women). Far fewer women (9%) and men (6%) said they were living together without being formally or traditionally married. More women (3.9%) than men (1.2%) said they were divorced, separated or widowed.

A large proportion of the Solomon Islands' population resides in rural areas. About 77% of women and 76% of men aged 15–49 live in rural areas, whereas 23% of women and 24% of men in the same age group reside in urban areas.

Data in Table 3.1 show that there is some variation in educational attainment between women and men, where 9% of women and 3% of men aged 15–49 have no formal education. Moreover, 56% of men in this age group have a secondary or higher level of education compared with only 46% of women.

Representation in the different wealth quintiles is fairly consistent between women and men.

Table 3.1: Background characteristics of respondents

Percent distribution of women and men aged 15–49 by selected background characteristics, Solomon Islands 2015

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15–19	19.8	1,241	1,240	20.5	605	563
20–24	18.3	1,146	1,101	17.6	519	475
25–29	17.4	1,091	1,068	16.2	479	459
30–34	14.9	933	910	14.8	436	414
35–39	12.8	803	818	13.4	394	381
40–44	9.2	576	627	9.5	280	328
45–49	7.6	476	502	8	236	270
Religion						
Anglican	32.1	2,013	1,780	33.6	990	868
Roman catholic	19	1,189	1,169	18.2	538	493
United church	10.2	640	791	10.1	299	366
Southseas evangelical	18.9	1,183	1,162	17.5	515	513
Seventh day adventist	11.9	748	842	11.9	352	388
Other	7.8	488	516	8.4	249	256
Missing	0.1	5	6	0.2	6	6
Ethnic group						
Melanesian	96.4	6,040	6,031	96.1	2,833	2,771
Polynesian	2.2	136	137	1.9	56	63
Micronesian	1.3	81	85	1.7	50	45
European	0.1	4	4	0.1	2	3
Chinese	0	2	4	0.1	3	3
Other	0	2	4	0.1	3	3
Missing	0	1	1	0.1	2	2
Marital status						
Never married	30.9	1,936	1,981	42.8	1,261	1,226
Married	55.8	3,495	3,417	50.3	1,484	1,463

Living together	9.4	591	607	5.7	168	161
Divorced/separated	2.8	173	191	1	28	31
Widowed	1.1	70	70	0.2	7	9
Residence						
Urban	22.8	1,427	2,513	24.4	720	1,248
Rural	77.2	4,839	3,753	75.6	2,229	1,642
Region						
Honiara	14.8	925	1,259	16.1	475	626
Guadalcanal	18.2	1,140	1,221	18.6	547	526
Malaita	25.7	1,608	1,255	24.1	710	542
Western	14.4	902	1,271	15.3	451	632
Other provinces	27	1,690	1,260	25.9	765	564
Education						
No education	9.2	576	491	3.1	92	80
Primary	45	2,820	2,651	40.8	1,202	1,073
Secondary	39.5	2,476	2,638	45.7	1,348	1,362
More than secondary	6.3	394	486	10.4	307	375
Wealth quintile						
Lowest	18.5	1,158	880	17.9	529	374
Second	18.7	1,172	904	19.1	565	421
Middle	19.5	1,223	1,083	17.9	528	466
Fourth	20	1,253	1,294	21.1	621	624
Highest	23.3	1,460	2,105	24	706	1,005
Total 15–49	**100**	**6,266**	**6,266**	**100**	**2,948**	**2,890**
50+	na	na	na	na	643	701
Total 15+	**na**	**na**	**na**	**na**	**3,591**	**3,591**

Note: Education 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. The largest percentage of respondents aged 15–49 fell into the category of having some secondary education: 39% of women and 45% of men. Table 3.2.1 shows that the percentage of women in this age group with some primary education (23%) is slightly higher than that for men (19%). A nearly equal proportion of women (22%) and men (21%) have completed primary education. More men (10%) than women (6%) have more than a secondary level education.

Most women and men in the younger age groups have achieved some secondary education as compared with women and men in older age groups. More than half of the youth population (aged 15–24) have achieved some secondary education (56% of women, 53% of men). There was a decline in the percentage of men and women with no education from the SIDHS 2006–2007.

Of the people aged 15–49 living in rural areas, 11% of women had received no education compared with only 3% of men who had received no education. Similar percentages of men and women had received some primary education (26% of women, 23% of men), but more men (43%) than women (36%) have some secondary education. Many more men and women in urban areas have some secondary education, have completed secondary school, or have a level of education above secondary than those men and women in rural areas. In urban areas, 15% of women and 21% of men have a level of education above secondary compared with 4% of women and 7% of men in rural areas.

The median number of years of education completed by both women and men increased from the SIDHS 2006–2007, and was 5.8 years for women and 7.0 years for men in 2015.

Table 3.2.1: Educational attainment – Women

Percent distribution of women aged 15–49 by highest level of schooling attended or completed, and median years completed, according to background characteristics, Solomon Islands 2015

Background characteristic	Highest level of schooling							Median years completed	Number of women
	No education	Some primary	Completed primary[1]	Some secondary	Completed secondary[2]	More than secondary	Total		
Age									
15–24	4.0	22.8	13.8	56.1	0.5	2.9	100	6.9	2,387
15–19	2.5	26.1	14.4	56.8	0.1	0.2	100	6.5	1,241
20–24	5.6	19.2	13.1	55.4	0.9	5.8	100	7.8	1,146
25–29	7.8	19.2	13.8	49.2	1.0	9.1	100	7.8	1,091
30–34	10.9	24.8	22.7	33	0.1	8.7	100	5.6	933
35–39	11.1	26	39.3	15.5	0.2	7.9	100	5.3	803
40–44	16.0	21.3	38.8	15.4	0.3	8.3	100	5.3	576
45–49	23.8	23.0	34.7	11.2	0.0	7.2	100	5.1	476
Residence									
Urban	4.9	13.1	16.3	49.2	1.4	15.1	100	8.4	1,427
Rural	10.5	25.6	24.0	36.1	0.1	3.7	100	5.6	4,839
Region									
Honiara	4.7	13	14.6	48.7	1.7	17.2	100	8.6	925
Guadalcanal	11.3	27.9	19.1	36.9	0.2	4.5	100	5.6	1,140
Malaita	18.3	33	16.5	29.5	0.2	2.6	100	4.9	1,608
Western	1.4	12.5	34.8	45.2	0.1	5.9	100	6.1	902
Other provinces	5.7	20.3	27.4	41.2	0.1	5.2	100	5.9	1,690
Wealth quintile									
Lowest	17.8	35.5	22.6	23.3	0.0	0.8	100	4.7	1,158
Second	12.8	28.7	23	33.4	0.3	1.8	100	5.4	1,172
Middle	7.1	23.1	24.7	41.5	0.0	3.7	100	5.8	1,223
Fourth	6.3	18.0	26.2	43.6	0.3	5.6	100	6.0	1,253
Highest	3.7	11.6	16.1	50.4	1.3	17	100	8.5	1,460
Total	**9.2**	**22.7**	**22.3**	**39.1**	**0.4**	**6.3**	**100**	**5.8**	**6,266**

[1] Completed 6 grade at the primary level

[2] Completed form 5 or form 6 or form 7 at the secondary level

Table 3.2.2: Educational attainment – Men

Percent distribution of men aged 15–49 by highest level of schooling attended or completed, and median years completed, according to background characteristics, Solomon Islands 2015

Background characteristic	Highest level of schooling							Median years completed[3]	Number of men
	No education	Some primary	Completed primary[1]	Some secondary	Completed secondary[2]	More than secondary	Total		
Age									
15–24	2.3	23.3	16.7	53.4	0.9	3.3	100	6.7	1,124
15–19	2.1	30	17.8	49.2	0	0.8	100	6	605
20–24	2.5	15.6	15.5	58.4	1.9	6.2	100	8.2	519
25–29	1.8	12.9	16.2	55	1.2	12.9	100	8.5	479
30–34	3.4	17.7	18.1	47.4	0.5	12.9	100	8.1	436
35–39	4	18	27.6	34.7	0	15.6	100	6.1	394
40–44	5.3	17.7	32.9	27.2	0	16.9	100	5.8	280
45–49	4.9	21.8	35.3	19.6	0	18.3	100	5.7	236
Residence									
Urban	2.2	9.3	13.8	52.2	1.8	20.7	100	9.7	720
Rural	3.4	22.7	23.8	42.8	0.2	7.1	100	6	2,229
Region									
Honiara	1.8	9	11.7	52.1	2.1	23.2	100	10.2	475
Guadalcanal	5.2	20.9	20.3	45.3	0.3	8.1	100	6.6	547
Malaita	4.8	29.8	22.4	38.5	0.3	4.4	100	5.7	710
Western	1.4	13.1	28.1	45.4	0.6	11.4	100	7.2	451
Other provinces	1.9	19	23.1	46.6	0.2	9.3	100	6.9	765
Wealth quintile									
Lowest	6.5	34	23.4	33.9	0	2.2	100	5.4	529
Second	2.5	27.3	25.8	40.1	0.3	3.9	100	5.8	565
Middle	2.7	16.6	26.8	45.5	0.1	8.4	100	6.5	528
Fourth	2.7	16.2	20.4	47.9	0.7	12.1	100	7.9	621
Highest	1.7	7.2	12.9	54.7	1.6	21.8	100	9.7	706
Total 15–49	**3.1**	**19.4**	**21.3**	**45.1**	**0.6**	**10.4**	**100**	**7**	**2,948**
50+	11.8	49.8	16.5	11.6	0	10.3	100	5.2	643
Total 15+	**4.7**	**24.9**	**20.5**	**39.1**	**0.5**	**10.4**	**100**	**6.3**	**3,591**

[1] Completed 6 grade at the primary level

[2] Completed form 5 or form 6 or form 7 at the secondary level

3.3 LITERACY

An individual's level of literacy refers to their ability to read all, part or none of a sentence in the language that he/she is able to read. One method of gauging a respondent's level of literacy is to ask them to read aloud a simple sentence. In the SIDHS 2015, this was asked of all respondents who had not attended school or had attended primary school only. The interviewer asked respondents to read out loud a simple sentence written on a card in English or Solomon Islands Pidgin. The interviewer then recorded whether the respondent could read the whole sentence, only parts of it, or could not read any part of the sentence.

Of the Solomon Islanders aged 15–49, 82% of women and 90% of men are literate. Tables 3.3.1 and 3.3.2 show that of this age group, 16% of women and 8% of men cannot read at all. Literacy levels are higher in urban areas than rural areas for both men and women. The percentage of literate men aged 15–49 in urban areas is 95% compared with 88% in rural areas. The figures for women show a similar trend, where 91% of women in urban areas are literate compared with 80% in rural areas.

The lowest wealth quintile had the highest proportions of men and women who could not read (15% of men, 34% of women). Correspondingly, a small proportion of men (3%) and women (6%) in the highest wealth quintile could not read. Of the regions, Honiara had the largest proportions of men and women who had a secondary education or higher level of education (78% of men, 68% of women) and the lowest proportions who could not read (4% of men, 7% of women). The reverse is the case in Malaita, which, of all the regions, had the lowest proportions of men and women who had a secondary education or higher (43% of men, 32% of women) and the highest proportions who could not read (15% of men, 27% of women).

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 2015

Background characteristic	Secondary school or higher	No schooling or primary school							Percentage literate[1]	Number of women
		Can read a whole sentence	Can read part of a sentence	Cannot read at all	No card with required language	Blind/ Visually impaired	Missing	Total		
Age										
15–24	59.5	12.7	14.5	10.6	0.1	0	2.7	100	86.6	2,387
15–19	57	15.7	14.3	8	0.2	0	4.8	100	87	1,241
20–24	62.1	9.4	14.7	13.4	0	0	0.4	100	86.2	1,146
25–29	59.2	11.9	13	15.1	0.1	0	0.6	100	84.2	1,091
30–34	41.7	16.8	22	18.6	0.3	0	0.6	100	80.5	933
35–39	23.6	32.4	24.2	19.2	0.5	0	0	100	80.2	803
40–44	23.9	30.1	24.8	20.5	0.2	0.2	0.4	100	78.7	576
45–49	18.4	26.1	24.1	30.5	0.3	0	0.6	100	68.6	476
Residence										
Urban	65.7	12.1	13.4	7.5	0.1	0.1	1	100	91.2	1,427
Rural	39.9	20.1	19.7	18.6	0.2	0	1.4	100	79.8	4,839
Region										
Honiara	67.7	11.6	12.3	7.2	0.1	0.2	0.8	100	91.6	925
Guadalcanal	41.7	16.3	21.5	18.9	0	0	1.6	100	79.6	1,140
Malaita	32.3	18.1	20.4	27.2	0.6	0	1.4	100	70.9	1,608
Western	51.2	28.7	14.7	4.2	0.2	0	0.9	100	94.7	902
Other provinces	46.5	17.8	19.2	14.9	0.1	0	1.5	100	83.6	1,690
Wealth quintile										
Lowest	24.1	18.1	22.3	33.5	0.3	0	1.7	100	64.5	1,158
Second	35.5	21	21.5	20.4	0.2	0	1.4	100	78	1,172
iddle	45.1	20.3	19.5	13.4	0.4	0	1.2	100	85	1,223
Fourth	49.5	19.7	19	10.7	0.1	0.1	1.1	100	88.2	1,253
Highest	68.6	13.4	10.9	5.7	0.2	0	1.2	100	92.9	1,460
Total	**45.8**	**18.3**	**18.3**	**16.1**	**0.2**	**0**	**1.3**	**100**	**82.4**	**6,266**

[1] Refers to women who attended secondary school or higher and women who can 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 2015

Background characteristic	Secondary school or higher	No schooling or primary school							Percentage literate[1]	Number of men
		Can read a whole sentence	Can read part of a sentence	Cannot read at all	No card with required language	Blind/ Visually impaired	Missing	Total		
Age										
15–24	57.6	17.1	13.6	8.5	0.1	0	3.1	100	88.3	1,124
15–19	50.1	20.9	15.5	8.5	0	0	4.9	100	86.5	605
20–24	66.4	12.5	11.3	8.5	0.2	0	1	100	90.3	519
25–29	69.2	14.2	8.6	7.3	0	0	0.8	100	91.9	479
30–34	60.8	18.7	11.7	8.6	0	0	0.2	100	91.2	436
35–39	50.3	25.1	14.9	9.4	0	0	0.4	100	90.2	394
40–44	44.1	32.9	14	8.4	0	0.3	0.2	100	91.1	280
45–49	37.9	38.9	13.5	8.2	0	0	1.4	100	90.4	236
Residence										
Urban	74.8	13.4	7	3.8	0	0	1.1	100	95.1	720
Rural	50.1	23.7	14.5	9.9	0	0	1.7	100	88.3	2,229
Region										
Honiara	77.5	12.2	5.4	3.6	0	0	1.3	100	95.1	475
Guadalcanal	53.7	21.7	12.8	10.2	0	0	1.6	100	88.2	547
Malaita	43.1	23.2	17.2	14.5	0	0	2	100	83.5	710
Western	57.4	24.4	10.1	6	0.2	0.2	1.7	100	91.9	451
Other provinces	56	22.6	14.5	5.8	0	0	1.1	100	93.1	765
Wealth quintile										
Lowest	36.1	24.7	22.2	15.3	0	0	1.7	100	83.1	529
Second	44.3	26.8	15.7	10.9	0	0	2.3	100	86.9	565
Middle	54	23.9	13.2	8.3	0	0.2	0.5	100	91.1	528
Fourth	60.7	22.2	9.2	6.6	0	0	1.3	100	92.1	621
Highest	78.1	11.1	5.8	3	0.1	0	1.9	100	95	706
Total 15–49	**56.1**	**21.2**	**12.7**	**8.4**	**0**	**0**	**1.5**	**100**	**90**	**2,948**
50+	21.9	43.2	18.8	15.3	0.3	0	0.5	100	83.8	643
Total 15+	**50**	**25.1**	**13.8**	**9.6**	**0.1**	**0**	**1.4**	**100**	**88.9**	**3,591**

[1] Refers to men who attended secondary school or higher and men who can read a whole sentence or part of a sentence

3.4 EXPOSURE 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 of, and behaviour towards, 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 all three forms of media at least once a week than women in this age group.

Urban women and men are more likely to have access to mass media than rural residents. Among men aged 15–49 in urban areas, 61% read a newspaper at least once a week compared with 15% of men in rural areas. In terms of television, 46% of men in urban areas watch television once a week compared with 4% of men in rural areas. For those listening to the radio, 53% of men in urban areas listen to the radio at least once a week compared with 23% of men in rural areas. Consequently, more men in urban areas (30%) could access all three types of media at least once a week compared with men in rural areas (3%).

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 lower for women (5%) than men (9%). Approximately 74% of women and 60% of men have no exposure to any media.

When comparing the results of the SIDHS 2006–2007 with those of the SIDHS 2015, there has been a decrease in the use of radio as a form of media. Among men aged 15–49, listening to the radio at least once a week has decreased from 71% to 31%, and among women in the same age group, from 45% to 17%.

A larger proportion of people with higher educational attainment have access to media. Of women aged 15–49 with a more than a secondary level of education, 15% are exposed to all three forms of media each week, compared with only 2% of women with no primary education or only a primary level education. For women with primary or no education, access to media has decreased over the last eight years since the SIDHS 2006–2007. A similar pattern exists for men, where 25% of men with more than a secondary level of education are exposed to all forms of media each week compared with 5% of men with no primary education or with only a primary education.

Data also indicate that media exposure is limited among Solomon Islands women and men in the lower wealth quintile households. Less than 1% of women from the poorest homes are exposed to all forms of media each week, compared with 16% of women from the wealthiest homes. This pattern is similar for men (1% in the lower household wealth quintiles, and 29% in the higher wealth quintiles). Correspondingly, 92% of women and 82% of men in the lowest wealth quintiles did not have access to any form of media once a week, compared to 39% of women and 27% of men in the highest wealth quintiles.

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 2015

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	Accesses all three media at least once a week	Accesses none of the three media at least once a week	Number of women
Age						
15–19	17	9.6	16.7	4	72.3	1,241
20–24	18.5	12.1	17.8	6	70.9	1,146
25–29	17	10.8	17.1	5.6	72.9	1,091
30–34	14.9	8.9	17.6	3.7	74.1	933
35–39	15.8	8.6	16.2	3.5	73.3	803
40–44	10.4	7.6	13.7	4	80.3	576
45–49	12.7	7.6	14.5	3.5	78	476
Residence						
Urban	40.4	37.1	34.1	16.8	41.2	1,427
Rural	8.6	1.6	11.4	0.9	83.3	4,839
Region						
Honiara	47.9	45.3	40.6	21.8	32	925
Guadalcanal	18.1	7.9	21.9	4.9	71.1	1,140
Malaita	13.1	2.5	9.8	1	79.7	1,608
Western	6	5.7	7.2	0.5	85.8	902
Other provinces	4.7	0.4	11.3	0.2	86.1	1,690
Education						
No education	0.4	1.7	7.6	0	91.6	576
Primary	8.2	4.6	11.9	1.7	82.6	2,820
Secondary	22.9	14.2	21.3	7.1	64.9	2,476
More than secondary	49.3	29.4	33.6	14.8	38.9	394
Wealth quintile						
Lowest	4.3	0.7	5.5	0.3	91.6	1,158
Second	5.8	0.2	6.3	0	89.8	1,172
Middle	8.3	1.4	12.2	0.7	82.4	1,223
Fourth	14.3	4.3	18.3	2.5	73.6	1,253
Highest	40.8	36	35.8	16.4	39.4	1,460
Total	**15.9**	**9.7**	**16.6**	**4.5**	**73.7**	**6,266**

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 2015

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	Accesses all three media at least once a week	Accesses none of the three media at least once a week	Number of men
Age						
15–19	23.3	14	24.1	6.9	63.5	605
20–24	27.5	15.4	32.5	9.9	59	519
25–29	28.6	13.4	32.8	8.4	58.1	479
30–34	25.6	15.4	28.8	10.3	61.3	436
35–39	26.9	13.5	36.4	10.1	56	394
40–44	26.1	11.8	26.8	8.3	62.5	280
45–49	29.6	16.9	35.2	11.9	56.5	236
Residence						
Urban	61.2	45.7	53.2	29.8	24.8	720
Rural	15.3	4.2	23.1	2.5	71.2	2,229
Region						
Honiara	71.9	54.5	63.2	38.3	15.5	475
Guadalcanal	21	4.6	23	3	68.3	547
Malaita	16.2	13.3	27.7	8.5	67.3	710
Western	19	8.2	18.4	2.2	67.7	451
Other provinces	16.1	0.8	25.2	0.2	69.8	765
Education						
No education	3.6	11.7	15	1.3	80.8	92
Primary	12.6	7.7	22.1	3.7	73	1,202
Secondary	34.3	16.3	34.6	10.8	52.4	1,348
More than secondary	53.1	32.1	49.7	25.4	34.9	307
Wealth quintile						
Lowest	9.9	2.6	16	1	81.8	529
Second	11	2.1	22.7	1.7	73.5	565
Middle	16.9	6	22.3	2.7	70	528
Fourth	26.8	8.2	31.8	5.3	57.7	621
Highest	58.1	44.5	52.5	29.4	26.9	706
Total 15–49	**26.5**	**14.3**	**30.5**	**9.1**	**59.9**	**2,948**
50+	17.7	7.7	27.8	4.5	65.6	643
Total 15+	**24.9**	**13.1**	**30**	**8.3**	**60.9**	**3,591**

3.5 EMPLOYMENT

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 difficult to do, 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 SIDHS 2015 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 or those who worked in the 12 months prior to the survey. Some additional questions were also included regarding any kind of payment that respondents received in return for the service they provided.

Tables 3.5.1 and 3.5.2 show that 37% of women and 70% of men are classified as currently employed. The proportion of women currently employed increases with age and the number of living children. Data for men show a similar trend. Women who are classified as divorced/separated/widowed, or who are married, are the most likely to be employed (about 54% for women who are divorced/separated/widowed, and 41% who are married). Never-married women and men are the least likely to be employed (27% of never-married women, 50% of never-married men). More than 85% of married men are currently employed.

Table 3.5.1: Employment status – Women

Percent distribution of women aged 15–49 by employment status, according to background characteristics, Solomon Islands 2015

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	16.3	6	77.5	0.1	100	1,241
20–24	28.8	9.9	61.2	0.2	100	1,146
25–29	43.8	8.9	47.3	0	100	1,091
30–34	42	11.7	46.2	0.1	100	933
35–39	48.3	10.1	41.6	0	100	803
40–44	49.5	10.8	39.5	0.3	100	576
45–49	52.4	12.6	35	0	100	476
Marital status						
Never married	26.8	6.9	66.2	0.2	100	1,936
Married or living together	41	10.8	48.2	0.1	100	4,086
Divorced/separated/widowed	53.8	10.7	35.5	0	100	244
Number of living children						
0	28.2	7	64.6	0.2	100	2,077
1–2	39	9.2	51.7	0	100	1,692
3–4	44.4	13	42.5	0.1	100	1,423
5+	41.5	10.3	48.1	0.1	100	1,073
Residence						
Urban	40.9	3.3	55.6	0.2	100	1,427
Rural	35.9	11.4	52.6	0.1	100	4,839
Region						
Honiara	36.3	1.7	61.9	0.2	100	925
Guadalcanal	43.4	5.5	51	0.1	100	1,140
Malaita	24.7	7.1	68.1	0.1	100	1,608
Western	31.9	5.8	62	0.2	100	902
Other provinces	47.8	20.9	31.3	0	100	1,690
Education						
No education	31.6	11.8	56.5	0	100	576
Primary	35.8	11.3	52.8	0.1	100	2,820
Secondary	35.1	7.6	57.2	0.1	100	2,476
More than secondary	66.4	6.2	27.4	0	100	394
Wealth quintile						
Lowest	32.6	15.6	51.7	0	100	1,158
Second	34.9	13.1	51.9	0.2	100	1,172
Middle	35.4	9.4	55.2	0.1	100	1,223
Fourth	39.6	8.2	52.1	0.1	100	1,253
Highest	41.7	3.2	55	0.1	100	1,460
Total	**37.1**	**9.6**	**53.3**	**0.1**	**100**	**6,266**

Table 3.5.2: Employment status – Men

Percent distribution of men aged 15–49 by employment status, according to background characteristics, Solomon Islands 2015

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	33.4	5.2	61.1	0.3	100	605
20–24	62	8.1	29.9	0	100	519
25–29	81.2	4.3	14.3	0.2	100	479
30–34	85.4	3.8	10.8	0	100	436
35–39	84.7	4.2	10.7	0.4	100	394
40–44	87.2	5.4	7.3	0	100	280
45–49	85.2	7.3	7.6	0	100	236
Marital status						
Never married	49.7	5.6	44.6	0.2	100	1,261
Married or living together	85.4	5.3	9.3	0.1	100	1,652
Divorced/separated/widowed	(76.3)	(6.6)	(17.1)	0	100	35
Number of living children						
0	53.4	5.7	40.7	0.2	100	1,411
1–2	84.5	5	10.5	0	100	681
3–4	85.3	4.9	9.8	0	100	510
5+	86.4	5.7	7.5	0.5	100	347
Residence						
Urban	62.7	4.9	32.2	0.1	100	720
Rural	72.3	5.6	22	0.2	100	2,229
Region						
Honiara	59.5	3.7	36.7	0.2	100	475
Guadalcanal	59.5	6.5	34	0	100	547
Malaita	74	1.8	24.2	0	100	710
Western	70.4	11.3	18.3	0	100	451
Other provinces	80	5.7	13.9	0.5	100	765
Education						
No education	77.7	4.2	18.1	0	100	92
Primary	70.9	6	22.9	0.3	100	1,202
Secondary	65.8	5.5	28.6	0.1	100	1,348
More than secondary	82.4	3.1	14.6	0	100	307
Wealth quintile						
Lowest	69.5	6.8	23.7	0	100	529
Second	71.2	5.6	23.2	0	100	565
Middle	74.5	6.2	19	0.3	100	528
Fourth	73.5	5	21.2	0.3	100	621
Highest	62.8	4	33	0.1	100	706
Total 15–49	**70**	**5.4**	**24.5**	**0.1**	**100**	**2,948**
50+	69.2	6.7	24.1	0	100	643
Total 15+	**69.8**	**5.6**	**24.4**	**0.1**	**100**	**3,591**

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

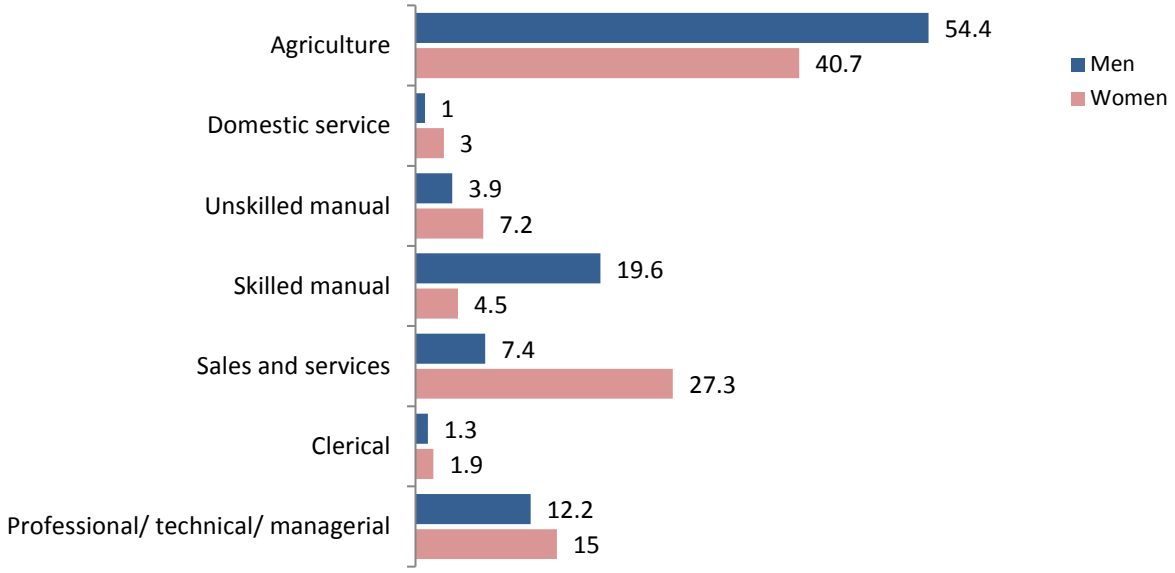
[1] 'Currently employed' is defined as having done work in the past seven days. Includes persons who did not work in the past seven days but who are regularly employed and were absent from work for leave, illness, vacation, or any other such reason.

There is little variation in the current employment level for women, with fewer women in rural areas currently employed (36%) than in urban areas (41%). The reverse is true for men, where 72% of men in rural areas are currently employed compared with 63% of men in urban areas. Current employment is highest among men and women with more than a secondary level of education (82% for men, 66% for women).

3.6 OCCUPATION

Respondents who were currently employed were asked to state their occupation. The results are presented in Figure 3.1 and Tables 3.6.1 and 3.6.2. For women who are currently employed, 41% are engaged in agriculture and 27% are involved in sales and services. Approximately 15% are involved in professional, technical and managerial related occupations, while only 3% are employed in domestic services and 2% in clerical occupations. Some similarities can be observed for men, where 54% are engaged in agriculture, 20% are involved in skilled manual work, 12% are engaged in professional, technical and managerial related occupations, while only 1% work in clerical or domestic service occupations. Large proportions of men and women continue to be engaged in agriculture, more so than in the SIDHS 2006–2007 (43% of men, 32% of women).

Figure 3.1: Occupation by sex, Solomon Islands 2015



Most men who are engaged in non-agricultural activities work in skilled manual labour (20%) or professional, technical, and managerial (12%) occupations. For women working in non-agricultural industries, most work in sales and services (27%) or professional, technicsal, and managerial (15%) occupations. The latter occupations, which require more skill and have higher income-earning potential, are the third largest industry of employment for both men and women.

Women aged 25–34 had the highest proportions of any age group employed in professional, technical and managerial roles and some of the lowest proportions in employed in agriculture. Employment in sales and services was fairly consistent from ages 20 through to 39 (between 27% and 28%), but the highest proportions of women working in agriculture were in the younger and older age groups, with 51% of 15–19 year-olds and 49% of 45–49 year-olds employed in these occupations. Women aged 15–19 were much more likely to work in domestic service than any other age group (8% compared with 3% or less for every other age group). Women are more likely to work in professional, technical and managerial occupations if they are urban residents, have more than a secondary level of education, have four children or less, or are from the highest wealth quintile. Employment in professional, technical and managerial occupations, clerical work, sales & services, unskilled manual labour, clerical and domestic services were higher for women in Honiara than in all other regions.

Employment in agriculture was highest for 15–19 year-old men (69%) and this declined with age to less than half of men aged 45–49. Skilled manual jobs were most common among males in the 35–39 age group. Men

aged 15–19 were much more likely to work in domestic service than any other age group (5% compared with 1% or less for every other age group).

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 2015

Background characteristic	Professional/ technical/ managerial	Clerical	Sales and services	Skilled manual	Unskilled manual	Domestic service	Agriculture	Missing	Total	Number of women
Age										
15–19	1.3	0	32.1	1.2	5.5	8.3	50.5	1.2	100	277
20–24	11.4	2.8	28.2	3.6	8	3.1	42.3	0.6	100	443
25–29	21.1	2.5	27.2	3.9	4.5	3.1	37.5	0.3	100	575
30–34	21.4	1.4	27.3	3.2	6.6	1.9	37.7	0.4	100	501
35–39	15	2.7	27.9	7.3	9.5	2.2	35	0.5	100	469
40–44	15.3	1.8	25.4	5.4	8.8	2.2	41.1	0	100	347
45–49	10.2	1.1	23.3	6.8	8.1	1.7	48.8	0	100	309
Marital status										
Never married	14.9	2.9	28.5	2.1	6.5	5.9	38.5	0.8	100	651
Married or living together	15.2	1.7	26.5	5	7.2	2	42.1	0.3	100	2,114
Divorced/separated/ widowed	12.2	1.2	34	8.5	9.4	3.9	30.8	0	100	157
Number of living children										
0	18.1	2.8	29.1	2.8	6.3	5.3	34.9	0.7	100	732
1–2	19.8	2.1	24.7	5.2	5.8	3.3	38.7	0.3	100	817
3–4	14	1.4	27.9	4.6	7.7	1.4	42.6	0.4	100	818
5+	5.2	1.2	27.9	5.6	9.6	1.8	48.5	0.2	100	556
Residence										
Urban	26.2	6.4	39.9	5.3	10.6	6.2	5.3	0.1	100	631
Rural	11.9	0.7	23.8	4.3	6.2	2.1	50.4	0.5	100	2,291
Region										
Honiara	30.4	8.1	40.9	4.3	9.6	5.7	1	0	100	351
Guadalcanal	12.3	0.9	25.9	4.1	7.2	3.5	45.5	0.7	100	558
Malaita	15.7	0.8	42.3	3.7	3.1	1.9	32.3	0.3	100	511
Western	14.3	2.6	20.5	13.9	5.1	3	39.7	0.9	100	341
Other provinces	11.5	0.9	19.3	2.4	8.9	2.4	54.4	0.3	100	1,161
Education										
No education	1	0	30.4	2.4	8.7	3.3	54	0.2	100	250
Primary	1.8	0.4	28.8	5.8	8.4	4	50.4	0.3	100	1,329
Secondary	20.6	2.6	29.4	3.8	6.5	2.2	34.4	0.6	100	1,057
More than secondary	67.8	8.3	9.9	3.1	2.9	0.4	7.3	0.3	100	286
Wealth quintile										
Lowest	2.3	0	23	3.5	6.2	3.7	60.6	0.6	100	559
Second	7.8	1	21.6	3.7	6.9	1.1	56.9	0.9	100	562
Middle	14.6	0.4	26.7	5.6	8.2	2.9	41	0.6	100	547
Fourth	18	1.1	30.5	5.8	6.5	2.5	35.5	0	100	599
Highest	29.5	6.3	33.4	4	8	4.4	14.3	0	100	656
Total	**15**	**1.9**	**27.3**	**4.5**	**7.2**	**3**	**40.7**	**0.4**	**100**	**2,923**

Like women, men are more likely to work in professional, technical and managerial occupations if they are urban residents, have more than a secondary level of education, or are from the highest wealth quintile. Employment in skilled manual labour, professional, technical and managerial occupations, sales and services, clerical work were higher for men in Honiara than in all other regions.

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 2015

Background characteristic	Professional/ technical/ managerial	Clerical	Sales and services	Skilled manual	Unskilled manual	Domestic service	Agriculture	Missing	Total	Number of men
Age										
15–19	1.6	0.5	6.4	12.7	4.2	5.1	68.5	1.1	100	234
20–24	5	0.6	7.3	18.3	5.9	0.9	62	0.1	100	363
25–29	9.5	1.9	9.1	21.9	5.2	0	52.2	0.2	100	409
30–34	14.8	1	5.4	19	3.6	0.9	55.4	0	100	389
35–39	14.1	1.7	7.8	24.9	2	0.4	48.8	0.3	100	350
40–44	20.5	2.6	8.5	19.6	3.2	0.6	44.9	0.2	100	259
45–49	22.5	0.8	6.9	18	2.4	0.2	49.2	0	100	218
Marital status										
Never married	6	1.1	7.7	17.9	4.9	2.3	59.6	0.5	100	697
Married or living together	14.7	1.4	7.2	20.6	3.4	0.4	52	0.1	100	1,497
Divorced/separated/ widowed	(28.6)	0	(6.5)	(12.3)	(3)	0	(49.7)	0	100	29
Number of living children										
0	7.3	1.2	8.3	16.7	5	1.9	59.3	0.3	100	834
1–2	14	1.4	7.5	21.6	3.5	0.4	51.4	0.3	100	609
3–4	15.9	1.7	6.2	20.2	2.1	0.8	52.9	0.1	100	460
5+	15.8	1.1	6.3	22.7	4.4	0.2	49.4	0.1	100	319
Residence										
Urban	24.8	4.9	20	35	6.1	2.2	6.5	0.6	100	487
Rural	8.6	0.3	3.8	15.3	3.3	0.7	67.8	0.2	100	1,736
Region										
Honiara	28.9	7	18.3	36.4	4.5	1.8	2.6	0.5	100	300
Guadalcanal	9.6	0.8	9	21.8	4.6	0.5	53.5	0.2	100	361
Malaita	8.6	0	5.1	13.8	1.9	0.7	69.5	0.3	100	538
Western	9.8	1	6.3	21.9	5.3	0.9	54.4	0.3	100	368
Other provinces	10.1	0.3	3.9	14.3	4.1	1.2	66.2	0	100	655
Education										
No education	4.4	0	5.6	19.5	5.5	2	63.1	0	100	75
Primary	3.4	0.7	6.5	19.5	3.5	0.4	65.9	0	100	924
Secondary	10.8	1.6	8.7	19.3	4.7	1.7	52.8	0.4	100	961
More than secondary	50	2.9	5.8	21.2	1.9	0.3	17.3	0.6	100	263
Wealth quintile										
Lowest	2.1	0	1.3	10.3	4.8	0.8	80.7	0	100	404
Second	5.7	0.3	5.6	13.5	3.5	0.1	71	0.4	100	434
Middle	10	0.6	6.6	19.5	3.3	0.9	58.8	0.3	100	426
Fourth	13	1	8.2	23.1	3.6	1.1	49.8	0.1	100	487
Highest	27.6	4.3	14	29.8	4.4	2	17.4	0.4	100	472
Total 15-49	**12.2**	**1.3**	**7.4**	**19.6**	**3.9**	**1**	**54.4**	**0.2**	**100**	**2,223**
50+	11.9	0.7	8	11.4	5	1	61.9	0	100	488
Total 15+	**12.1**	**1.2**	**7.5**	**18.2**	**4.1**	**1**	**55.7**	**0.2**	**100**	**2,711**

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

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 41% of employed women receive payment in cash only, 7% are paid both in cash and in-kind, 3% receive only payment in-kind, while 49% receive no payment for their work.

The data on type of employer indicate that 35% of women are employed by a family member, 41% are self-employed, and 23% are employed by a non-family member.

Table 3.7 also presents the distribution of women by the continuity of their employment. About six in ten women work all year, and two in ten work seasonally or occasionally.

Most women working within the agriculture sector are not paid (80%), and are commonly employed by family members or are self-employed. In contrast, women who do non-agricultural work mostly receive cash only (60%) and are employed by non-family members or self-employed.

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 nonagricultural), Solomon Islands 2015

Employment characteristic	Agricultural work	Nonagricultural work	Missing	Total
Type of earnings				
Cash only	13.1	60.1	21.3	40.8
Cash and in-kind	3.3	9.8	0.0	7.1
In-kind only	3.5	2.8	0.0	3.1
Not paid	80.1	27.2	41.6	48.8
Missing	0.0	0.1	37.0	0.2
Total	**100**	**100**	**100**	**100**
Type of employer				
Employed by family member	45.8	28.3	36.5	35.4
Employed by nonfamily member	4.5	36.4	12.4	23.3
Self-employed	49.8	35.1	14.1	41.0
Missing	0.0	0.2	37.0	0.2
Total	**100**	**100**	**100**	**100**
Continuity of employment				
All year	52.6	62.2	60.6	58.3
Seasonal	25.0	18.6	0.0	21.1
Occasional	22.1	18.9	2.4	20.1
Missing	0.3	0.3	37.0	0.5
Total	**100**	**100**	**100**	**100**
Number of women employed during the last 12 months	1,190	1,721	12	2,923

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

3.8 HEALTH INSURANCE COVERAGE

The SIDHS 2015 asked respondents if they were covered by specific types of insurance schemes. These insurance schemes were categorised as: 1) government-run schemes such as social security, 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 health insurance, by type of health insurance coverage. Insurance coverage in the Solomon Islands is low, with 98% of all women and 96% of all men not covered by any government and/or private insurance schemes. This means that only one in fifty women and two in fifty men are covered by an insurance scheme in Solomon Islands. Social security covers only 0.1% of men and 0 % for women. Women and men aged 15–49 are covered by other employer-based insurance, 1.2% and 1.1%, respectively. Mutual health organisation, community-based insurance, and privately purchased commercial insurance covers 0.3% of women and 2.7% of men.

Employer-based insurance is the most common type for women (1%) and privately purchased commercial insurance is the most common type for men (3%). Those with more than a secondary education are more likely to have insurance (6% of women, 12% of men). People aged 30 and over who reside in Honiara or Western Province, live in urban areas, have a higher level of education or are in the highest wealth quintile, are more likely to be covered by 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 2015

Background characteristic	Social security	Other employer based insurance	Mutual health organisation/ community based insurance	Privately purchased commercial insurance	Other	None	Number of women
Age							
15–19	0	0.4	0	0.1	0.1	99.4	1,241
20–24	0.1	0.9	0.1	0	0.2	98.8	1,146
25–29	0	1.3	0.3	0.1	0	98.3	1,091
30–34	0	1.4	0.4	0.3	0.1	97.8	933
35–39	0.1	1.8	0.3	0.2	0.1	97.6	803
40–44	0	2.2	0.2	0	0.3	97.3	576
45–49	0	1.2	0.1	0	0.1	98.7	476
Residence							
Urban	0.1	3.6	0.3	0.3	0.1	95.6	1,427
Rural	0	0.5	0.2	0	0.1	99.2	4,839
Region							
Honiara	0.2	3.2	0.2	0.4	0	96.1	925
Guadalcanal	0	0.6	0.3	0.1	0.1	99.1	1,140
Malaita	0	0.3	0	0.1	0	99.6	1,608
Western	0	3.4	0.4	0	0.7	95.5	902
Other provinces	0	0.2	0.3	0	0	99.5	1,690
Education							
No education	0	0.4	0	0	0	99.6	576
Primary	0	0.6	0.2	0.1	0.1	99.1	2,820
Secondary	0.1	1.5	0.2	0.1	0.1	98	2,476
More than secondary	0	4.2	0.9	0.4	0.4	94.1	394
Wealth quintile							
Lowest	0	0	0.1	0	0	99.9	1,158
Second	0	0	0.1	0	0	99.8	1,172
Middle	0	0.5	0.3	0	0.1	99.1	1,223
Fourth	0.1	1.5	0.1	0.1	0.3	97.9	1,253
Highest	0	3.4	0.3	0.3	0.1	95.8	1,460
Total	**0**	**1.2**	**0.2**	**0.1**	**0.1**	**98.4**	**6,266**

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 2015

Background characteristic	Social security	Other employer based insurance	Mutual health organisation/ community based insurance	Privately purchased commercial insurance	Other	None	Number of men
Age							
15–19	0	0	0.3	2.4	0	97.3	605
20–24	0	1.5	0	3	0	95.5	519
25–29	0	1	0.2	3.7	0	95.1	479
30–34	0	1.2	0	3.1	0	95.9	436
35–39	0.2	1.2	0.2	3	0.1	95.2	394
40–44	0.4	1.5	0.2	1.1	0	96.8	280
45–49	0	2.5	0.1	0.4	0.5	96.6	236
Residence							
Urban	0.1	2.2	0.3	10.7	0.1	86.8	720
Rural	0.1	0.8	0.1	0	0	99	2,229
Region							
Honiara	0.2	1.6	0.4	16	0	81.9	475
Guadalcanal	0	0.5	0	0	0.1	99.4	547
Malaita	0	0	0	0	0.2	99.8	710
Western	0	3.9	0.1	0.2	0	95.8	451
Other provinces	0.2	0.5	0.3	0.1	0	99	765
Education							
No education	0	1.2	0	1.8	1.2	95.8	92
Primary	0	0.5	0	1.4	0	98.1	1,202
Secondary	0.1	1	0.1	2.8	0	95.9	1,348
More than secondary	0	3.8	0.7	7.1	0.2	88.5	307
Wealth quintile							
Lowest	0	0	0	0	0	100	529
Second	0	0.4	0	0.6	0	99	565
Middle	0	0.9	0.4	0.5	0	98.2	528
Fourth	0.2	0.9	0	1.6	0.2	97.1	621
Highest	0.1	2.8	0.3	8.7	0.1	88.1	706
Total 15–49	**0.1**	**1.1**	**0.1**	**2.6**	**0.1**	**96**	**2,948**
50+	0	1.6	0.1	1.5	0	96.7	643
Total 15+	**0.1**	**1.2**	**0.1**	**2.4**	**0**	**96.2**	**3,591**

3.9 TOBACCO USE

Tobacco is responsible for many deaths around the world, including in Solomon Islands. The SIDHS 2015 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 had smoked in the preceding 24 hours.

Tables 3.9.1 and 3.9.2 shows tobacco use among respondents. A large proportion of women aged 15–49 do not use tobacco (80%) compared with men in the same age group (43%). More men (50%) than women (17%) smoke cigarettes, and male smokers were more likely to have smoked a larger number of cigarettes in the 24 hours preceding the survey than women.

Table 3.9.1: Use of tobacco – 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 24 hours preceding the survey, according to background characteristics, Solomon Islands 2015

Background characteristics	Uses tobacco			Does not use tobacco	Number of women	Percent distribution of women who smoke cigarettes by number of cigarettes smoked in the 24 hours preceding the survey						Total	Number of cigarette smokers
	Cigarettes	Pipe	Other tobacco			0	1–2	3–5	6–9	10+	Don't know/ missing		
Age													
15–19	10.7	0.1	4.7	88.5	1,241	4	36.5	29.6	7.3	18.2	4.5	100	132.1
20–24	19.9	0.3	8.1	79.1	1,146	1.1	30.8	36.8	8	21.9	1.5	100	228.2
25–29	21.4	0.1	11.2	76.4	1,091	2.2	28.7	28.9	9.9	30.3	0	100	233.7
30–34	19.6	0.7	14.2	76.8	933	4.5	26.3	33.6	8.9	26.1	0.6	100	182.8
35–39	17.9	1.4	11.1	78.8	803	2	19.9	31.3	11.8	34.1	1	100	144
40–44	14.6	2.5	11.6	78.2	576	1.5	20.5	36.3	7.4	32.8	1.4	100	84.2
45–49	12.5	4.4	13.3	79	476	0.5	17.4	25.6	21.6	32.1	2.8	100	59.3
Maternity status													
Pregnant	13.6	0.6	7.3	84.3	399	2.9	26.1	29.5	8.9	32.6	0	100	54.5
Breastfeeding (not pregnant)	14.3	0.6	8.9	83.4	1,492	3.2	28.4	32	8.9	27	0.5	100	213.3
Neither	18.2	1.1	10.6	78.5	4,374	2.1	27	32.5	10	26.7	1.7	100	796.6
Residence													
Urban	24.4	0.2	7.2	75.1	1,427	0.4	19.9	30.4	8.8	39.4	1.2	100	347.9
Rural	14.8	1.2	10.8	81.5	4,839	3.4	30.8	33.1	10.1	21.1	1.5	100	716.5
Region													
Honiara	25.9	0.1	7	73.8	925	0.3	18.6	30.7	8.5	41.3	0.6	100	239.8
Guadalcanal	12.4	3.1	8.4	82.4	1,140	2.3	19	36.1	5	33.6	3.9	100	141.3
Malaita	14.1	0.7	8.2	83.6	1,608	1.4	32.3	34.1	17.3	14.2	0.7	100	226.3
Western	13.8	0.1	8.6	84.7	902	0	34.7	24.3	6.4	34.3	0.3	100	124.9
Other provinces	19.6	0.6	15.1	75.9	1,690	5.5	30.8	33.3	8.6	20.1	1.7	100	332
Education													
No education	16.1	4.8	14.2	74.4	576	1.6	26.8	36.5	9.5	24.9	0.6	100	92.5
Primary	16.1	0.9	11.1	80.2	2,820	3.7	28.5	32	9.1	24.6	2	100	455
Secondary	18.5	0.2	8.4	80.5	2,476	1.6	27.2	31.6	10.5	28.1	1.1	100	457.4
More than secondary	15.1	0.2	5.7	84.1	394	0	18.2	31.9	8.6	41.4	0	100	59.5
Wealth quintile													
Lowest	12.4	2.7	12.5	80.9	1,158	3.1	27.1	36.2	17.4	13.6	2.6	100	143.8
Second	14.7	1	11.5	81.6	1,172	2.7	30.5	39.4	8.5	16.7	2.2	100	172.4
Middle	15.8	0.3	11.1	81.9	1,223	5.2	32.8	29.1	6.2	25.9	0.6	100	193.4
Fourth	20	0.6	9.9	77.9	1,253	1.9	30	30	10.1	27	0.9	100	250.5
Highest	20.8	0.4	5.9	78.4	1,460	0.4	19.6	30	8.6	40	1.3	100	304.3
Total	**17**	**0.9**	**10**	**80**	**6,266**	**2.4**	**27.2**	**32.2**	**9.7**	**27.1**	**1.4**	**100**	**1,064.4**

Slightly more women in urban areas (24%) than in rural areas (15%) smoke cigarettes. The difference is less marked for men, where 52% of men in urban areas smoke cigarettes compared with 49% of men in rural areas. A greater proportion of men and women with more than a secondary level of education do not use tobacco (48% and 84%). Higher proportions of men and women in the two highest wealth quintiles smoked cigarettes

rather than pipes or other tobacco (20% for women in the fourth wealth quintile and 21% for women in the highest wealth quintile; 49% for men in the fourth wealth quintile; 50% for men in the highest wealth quintile).

Differences can be observed for women and men who use other tobacco products. About 45% of men smoke other tobacco products compared with only 10% of women. The results also indicate that about 14% of both pregnant women and breastfeeding mothers smoke cigarettes.

Table 3.9.2: Use of tobacco – 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 24 hours preceding the survey, according to background characteristics, Solomon Islands 2015

Background characteristics	Uses tobacco			Does not use tobacco	Number of men	Percent distribution of men who smoke cigarettes by number of cigarettes smoked in the 24 hours preceding the survey							Number of cigarette smokers
	Cigarettes	Pipe	Other tobacco			0	1–2	3–5	6–9	10+	Don't know/ missing	Total	
Age													
15–19	27.8	0	24.6	69.1	605	9	23.4	37.7	12.3	17.2	0.5	100	168
20–24	58.3	0.3	51.3	34.1	519	5.4	19.8	31.7	17.6	24.4	1.1	100	302
25–29	58.2	0	52.7	32.8	479	10.9	12.6	27	15.5	33.5	0.5	100	279
30–34	63.1	0.4	57.4	28	436	4.2	12.9	28.3	17.7	36.7	0.1	100	275
35–39	50.4	1.4	46	40.6	394	6.1	13	23.5	14.7	41.2	1.5	100	199
40–44	51.5	0.4	48.5	37.4	280	4.1	6.9	34	16.1	38.9	0	100	144
45–49	42.5	0.8	43.4	47.9	236	9	12.3	22.4	13.9	40.6	1.8	100	100
Residence													
Urban	51.8	0.1	29.5	46.7	720	0.6	5.5	20.4	17.9	54.9	0.7	100	373
Rural	49.1	0.5	50.5	41.1	2,229	9	18	32.4	15.1	24.8	0.8	100	1,095
Region													
Honiara	52.7	0	25.9	45.9	475	0.6	3.9	19.9	18.6	56.7	0.3	100	250
Guadalcanal	40.9	2	46.5	43.6	547	3.3	7.4	18	21.4	48.2	1.8	100	224
Malaita	48.3	0	47.9	44.3	710	3.9	23.9	38.1	13.8	19.9	0.4	100	343
Western	44.2	0.2	49.2	45.7	451	3.3	17.2	25.8	20.5	33.3	0	100	199
Other provinces	58.9	0	51.9	35.9	765	15.9	16.7	35.1	11.1	20.2	1	100	451
Education													
No education	(63)	0	(65.2)	(24.7)	(92)	(11.2)	(20.3)	(25.6)	(8)	(32.4)	(2.5)	100	58
Primary	47.9	0.9	50	40.6	1,202	8.9	15.4	29.9	14.9	30.3	0.6	100	576
Secondary	51	0.1	43	43.9	1,348	5.9	15.2	30.8	17.3	30.1	0.7	100	687
More than secondary	47.9	0	31.5	48.4	307	1.5	8.8	21.6	15.9	51.5	0.6	100	147
Wealth quintile													
Lowest	50.5	1.3	60.5	34.1	529	17.9	18.8	33.7	12	16.4	1.2	100	267
Second	51.4	0.4	54	37.9	565	10.3	20.9	31.1	11.4	25.4	0.9	100	290
Middle	47.6	0.4	47.3	43.4	528	4.5	16.3	29.5	18.1	30.9	0.7	100	251
Fourth	49	0.1	40.5	46.3	621	2.6	13.3	30	18.4	35.2	0.5	100	304
Highest	50.2	0	29.9	48.4	706	1	7.3	23.8	18.5	48.9	0.5	100	355
Total 15–49	**49.8**	**0.4**	**45.3**	**42.5**	**2,948**	**6.8**	**14.8**	**29.3**	**15.8**	**32.4**	**0.7**	**100**	**1,468**
50+	34.5	2.6	38.2	52.9	643	7.5	11.6	33.3	15	31.6	0.9	100	222
Total 15+	**47**	**0.8**	**44.1**	**44.3**	**3,591**	**6.9**	**14.4**	**29.8**	**15.7**	**32.3**	**0.8**	**100**	**1,689**

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

3.10 KNOWLEDGE OF AND ATTITUDE TOWARDS 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 SIDHS 2015 asked questions about peoples' knowledge of and attitude towards TB. Tables 3.10.1 and 3.10.2 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 3.10.1: 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 percentages 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 2015

Background characteristic	Among all respondents		Among respondents who have heard of TB, the percentage who:			
	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	87.9	1,241	80.9	79.8	23	1,091
20–24	92.6	1,146	82.7	87.7	19.1	1,062
25–29	94.5	1,091	84.8	90.2	16.6	1,031
30–34	91.7	933	83.5	91.8	15.4	855
35–39	92.7	803	82.1	90.5	13.4	744
40–44	95.6	576	81.1	91.6	14.6	551
45–49	93.6	476	85.7	90.7	15.9	445
Residence						
Urban	98	1,427	90.3	92.2	16.5	1,398
Rural	90.5	4,839	80.5	87	17.7	4,381
Region						
Honiara	98.6	925	91.1	93.3	16	912
Guadalcanal	86.5	1,141	89	88.2	12.9	986
Malaita	91	1,608	82.8	88.7	15.8	1,463
Western	96.7	902	81.7	87	31.5	873
Other provinces	91.4	1,690	74.7	85.5	14.7	1,545
Education						
No education	81.1	576	74.3	82.8	9.5	467
Primary	91	2,820	77.9	86.1	16.3	2,567
Secondary	95	2,476	88	90.2	20.1	2,352
More than secondary	99.8	394	94.2	96.6	18.4	393
Wealth quintile						
Lowest	85.8	1,158	76.1	82.9	13.1	994
Second	88.7	1,172	80.3	86.2	17.3	1,039
Middle	93.6	1,223	80.4	89	22.1	1,145
Fourth	94.7	1,253	84.1	88.9	16.6	1,187
Highest	96.9	1,460	90.4	92.4	17.5	1,414
Total	**92.2**	**6,266**	**82.8**	**88.2**	**17.4**	**5,779**

Knowledge of TB of among women and men is very high (92% for women, 97% among men). Adolescents aged 15–19 were the most likely to have not heard of TB. Slightly more Solomon Islands men (88%) than women (83%) 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. More men and women in urban areas believe that TB can be cured than men and women in rural areas. Little difference is observed for rural and urban women in terms of those who would want it kept secret that a family member has TB: 18% for rural women and 17% 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 (17%) than urban men (11%).

Men and women in Honiara, who had a secondary level of education or more than a secondary level of education, or were in the highest wealth quintile, were most likely to report that TB is transmitted through the air and believe it can be cured. Those with no education or in the lowest wealth quintile are the least likely to report this.

Table 3.10.2: 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 percentages 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 2015

Background characteristic	Among all respondents		Among respondents who have heard of TB, the percentage who:			
	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	93.9	606	87.7	85.1	19.1	569
20–24	95.8	519	87.5	93.1	14.1	497
25–29	98.2	479	87.4	93.6	14.8	470
30–34	98.9	436	87.8	93.6	17.2	431
35–39	97.6	394	90.1	93.4	14	385
40–44	99	280	89.7	95.3	12.2	277
45–49	98.9	236	89.5	97.5	14.9	233
Residence						
Urban	98.6	720	96.2	97.2	11	709
Rural	96.5	2,229	85.7	90.7	17	2,152
Region						
Honiara	98.3	475	97.2	98.7	5.7	467
Guadalcanal	94.1	547	92.9	93.8	3.2	515
Malaita	98.8	710	74.3	92.9	19.6	702
Western	97.2	451	92.6	87.6	33.7	438
Other provinces	96.7	765	90.2	89.4	15.7	739
Education						
No education	88.4	92	70.6	85	13.8	81
Primary	96.6	1,202	83.1	90.3	18.2	1,162
Secondary	97.6	1,348	92	93.4	14.3	1,315
More than secondary	98.9	308	96.8	97.1	11.2	304
Wealth quintile						
Lowest	94.9	529	80.4	88.3	14.4	502
Second	96.4	565	81.5	91.2	17.4	544
Middle	98.2	528	87.6	89.7	17.2	518
Fourth	97.4	621	92	93.9	18	605
Highest	97.9	706	96.6	96.5	11.5	692
Total 15–49	**97**	**2,948**	**88.3**	**92.3**	**15.5**	**2,861**
50+	98.2	643	88.6	94.5	17.5	631
Total 15+	**97.3**	**3,591**	**88.4**	**92.7**	**15.9**	**3,493**

CHAPTER 4 MARRIAGE AND SEXUAL ACTIVITY

by Loyce Pabulu, Principal Statistician and Eleni Taisia, Statistician, SINSO

KEY FINDINGS

- More women (65%) than men (56%) aged 15–49 in Solomon Islands were reported to be currently in union status (married or living together) at the time of the survey.
- About 7% of women aged 25–49 are reported to have married at the exact age of 15 compared with no men in the same age group. Men tend to marry later than women do and are more likely to never marry (16% of men versus 10% of women).
- Education, wealth and urban living influence an individual's decision to get married. Women living in rural areas, with very little education, or in poor households marry at younger ages than women in urban areas, who have more education or live in wealthier households.
- The proportion of women aged 15–49 in a polygamous union increased from 5% in 2006–2007 to 6% in 2015. An increase in the number of men in a polygamous union was also observed, going from 2% in 2006–2007 to 3% in 2015.
- Age at first marriage among women aged 20–49 has increased from 19.9 years in 2006–2007 to 21.3 years in 2015.
- Over half of all men and women aged 20–49 had their first sexual intercourse by age 20 (71% of men, 67% of women).
- Median age at first sexual intercourse for women aged 20–49 is 18.4 years, and is 18.3 years for men in the same age group.
- The median age at first intercourse is lower than the median age at first marriage, indicating that sexual intercourse occurs before marriage. The median age at first intercourse is lower among women in rural areas who have little education or live in poorer households.
- Six in every ten women and men (56%) aged 15–49 had sexual intercourse in the four weeks preceding the survey, including 16% and 18% of teenagers aged 15–19.

INTRODUCTION

This chapter addresses factors other than contraception that affect a woman's likelihood of becoming pregnant. These factors are marriage, polygamy, and sexual activity. Marriage is a primary indication of a women's risk of pregnancy; therefore, it is important to understand fertility. Populations in which women marry at a young age tend to have high fertility rates and early childbearing. For this reason, there is an interest in age at marriage. In addition to marriage patterns and age at first marriage, this chapter includes information on two other measures of likelihood of pregnancy, age at first sexual intercourse and frequency of intercourse.

4.1 MARITAL STATUS

The SIDHS 2015 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 or unions in which a man and a woman live together but a formal civil or religious ceremony has not taken place. In some of the tables in this report, however, these two categories are combined and referred to collectively as 'currently married' or 'currently in a union-living together'. Respondents who are widowed, divorced, or not living together (separated), make up the remainder of the 'ever married' or 'ever in a union' category. Table 4.1 and Figure 4.1 show the percentage distribution of women and men aged 15–49 by current marital status, according to age at the time of the survey.

The percentage of married men and women increases with age as the percentage of never married men and women decreases. The proportion of women in a union is 65% compared with 56% of men. Among women who are currently in a union, the majority (56%) are formally married. For men currently in a union, 50% consider themselves to be in a formal marriage. Data show that 9% of young women aged 15–49 are not formally married compared with only 6% of men.

The proportion of women and men who have never married decreases as age increases. However, more men than women are single. Results of the SIDHS 2015 indicate that 98% of men aged 15–19 have never married compared with 88% of women in the same age group. The proportion of single men in the 45–49 age group (2%) is lower than that of single women (4%).

Another interesting finding is that the proportion of widowed men aged 15–49 is lower (0.2%) than for women (1%). The difference between the proportions of widowed men and widowed women at ages 35 and older increases. Between ages 35 and 44, the proportion of widowed men increases from 0.4% to 2%, whereas the percentage of widowed women increases from 1% to 3%. At ages 45–49, only 0.2% of men are widowed compared with 6% of women who are widowed.

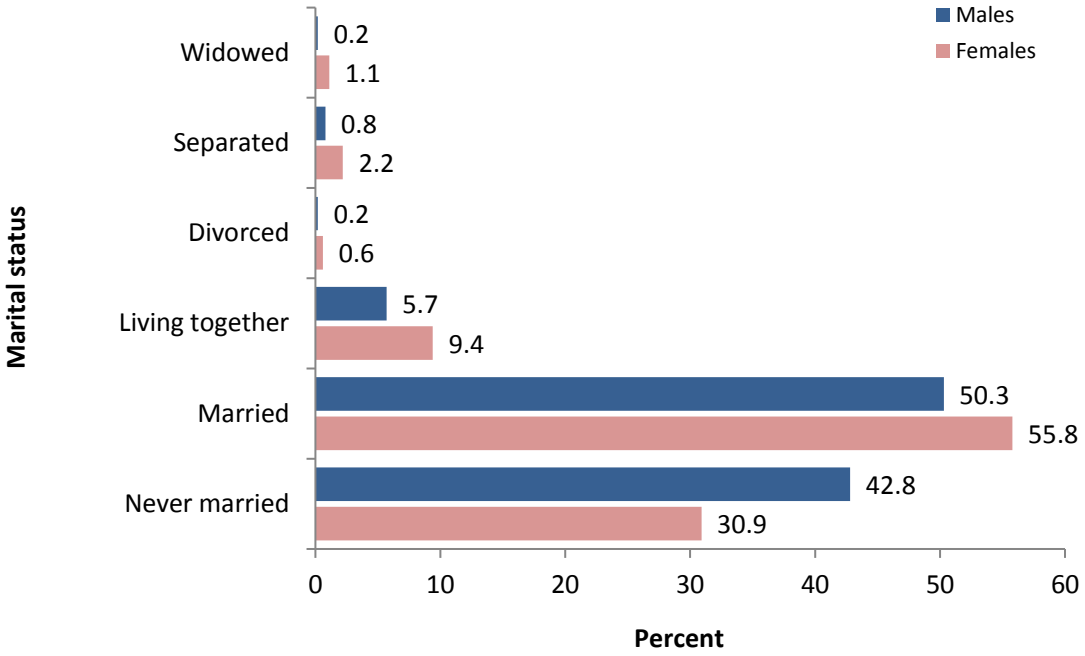
The higher proportion of widowed women is explained by lower female mortality rates and, therefore, longer life expectancies of female spouses, as well as men marrying at older ages than women.

Table 4.1: Current marital status

Percent distribution of women and men aged 15–49 by current marital status, according to age, Solomon Islands 2015

Age	Marital status						Total	Percentage of respondents currently in union	Number of respondents
	Never married	Married	Living together	Divorced	Separated	Widowed			
WOMEN									
Age									
15–19	88	9.2	2.1	0	0.5	0	100	11.4	1,241
20–24	41.3	46.4	9.9	0.2	2.3	0	100	56.3	1,146
25–29	18.5	63.9	14	0.8	2	0.8	100	77.9	1,091
30–34	7.5	79	9.3	0.5	2.6	1.1	100	88.3	933
35–39	5.5	76.8	12.3	0.9	3.3	1.2	100	89	803
40–44	5.9	75.1	12.4	0.9	3.1	2.5	100	87.5	576
45–49	4.3	76.8	8.7	2.1	2.7	5.5	100	85.5	476
Total 15–49	**30.9**	**55.8**	**9.4**	**0.6**	**2.2**	**1.1**	**100**	**65.2**	**6,266**
50+	-	-	-	-	-	-	0	-	0
Total 15+	**-**	**-**	**-**	**-**	**-**	**-**	**0**	**-**	**0**
MEN									
Age									
15–19	98.3	1.6	0	0	0	0	100	1.7	605
20–24	71.4	24.5	4	0.1	0	0	100	28.5	519
25–29	34.3	56.2	7.8	0.2	1.5	0	100	64.1	479
30–34	17.4	71.8	9.6	0.3	0.9	0	100	81.4	436
35–39	9.5	81.6	7.2	0.6	0.8	0.4	100	88.7	394
40–44	4.6	82.2	9.8	0	1.7	1.7	100	92	280
45–49	2.2	90.7	5.1	0	1.8	0.2	100	95.8	236
Total 15–49	**42.8**	**50.3**	**5.7**	**0.2**	**0.8**	**0.2**	**100**	**56**	**2,948**
50+	2.6	81.1	9.9	0.3	0.6	5.5	100	91	643
Total 15+	**35.6**	**55.8**	**6.5**	**0.2**	**0.7**	**1.2**	**100**	**62.3**	**3,591**

Figure 4.1: Marital status of women and men aged 15–49, Solomon Islands 2015



4.2 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 SIDHS 2015 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 were asked to rank themselves in that marriage (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 4.2.1 shows the percent distribution of currently married women aged 15–49 by the number of co-wives, according to their background characteristics at the time of the survey. The results show that 6% of currently married women report that their husband has one or more wives beside themselves compared with 5% who reported this in the SIDHS 2006–2007. According to background characteristics, adult women, women living in urban areas, women living in Malaita Province and other provinces, women with higher education, and women living in the middle wealth quintile households are more likely to report their husbands having more than one co-wives.

Table 4.2.2, presents the percent distribution of currently married men aged 15–49 by the number of wives, according to background characteristics. Overall, 3% of currently married men aged 15–49 claim that they have two or more wives compared with 6 of married women aged 15–49 who report that their husband has two or more wives. There is some inconsistency in the data, but the same trend was observed in the SIDHS 2006–2007, where 5% of women report that their husbands have at least one or more co-wives, while only 2% of men reported to have two or more wives. This may be due to the survey sample size of men in the survey.

In urban areas, 5% of currently married men have two or more wives compared with 2% in rural areas. Among the regions, Honiara has the highest percentage of men with multiple wives (6%), with other regions ranging from 4% in Western Province to 2% in other provinces. The proportion of currently married men with more than two wives increases with increasing level of wealth, while interestingly, men with no education claim to have more wives compared with men in other educational categories.

Table 4.2.1: Number of women's co-wives

Percent distribution of currently married women aged 15–49 by number of co-wives, according to background characteristics, Solomon Islands 2015

Background characteristic	Number of co-wives					Total	Number of women
	0	1	2+	Don't know	Missing		
Age							
15–19	96.6	1.6	0.7	1.1	0	100	141
20–24	92.6	4	1	2	0.4	100	645
25–29	92.4	4.5	1.2	1.7	0.2	100	850
30–34	91.6	5.2	0.5	2.7	0	100	824
35–39	94	4.1	0.7	0.8	0.4	100	715
40–44	92	5.6	1.2	1.1	0.1	100	504
45–49	91	6.1	0.6	1.8	0.5	100	407
Residence							
Urban	90.2	5.3	1.1	3	0.3	100	835
Rural	93.1	4.5	0.8	1.4	0.2	100	3,251
Region							
Honiara	91.6	4.4	1	2.8	0.3	100	529
Guadalcanal	91.6	3.9	0.8	3.4	0.3	100	772
Malaita	93.4	5.2	0.9	0	0.4	100	1,064
Western	94	4.2	0.6	0.9	0.3	100	581
Other provinces	92	5.1	0.8	2	0	100	1,141
Education							
No education	95.4	3	1	0.3	0.3	100	454
Primary	92.5	4.7	1	1.6	0.2	100	2,018
Secondary	91.9	4.8	0.6	2.4	0.3	100	1,340
More than secondary	91	6.6	0.5	1.5	0.3	100	275
Wealth quintile							
Lowest	93.2	3.7	1	1.6	0.5	100	813
Second	95.1	3.4	0.7	0.8	0	100	800
Middle	91.5	6.1	1.1	1.2	0.2	100	824
Fourth	91.8	5	0.7	2.4	0.1	100	831
Highest	91.1	5.3	0.8	2.5	0.4	100	818
Total	**92.5**	**4.7**	**0.9**	**1.7**	**0.2**	**100**	**4,086**

Table 4.2.2: Number of men's wives

Percent distribution of currently married men aged 15–49 by number of wives, according to background characteristics, Solomon Islands 2015

Background characteristic	Number of wives		Total	Number of men
	1	2+		
Age				
15–19	*	*	*	10
20–24	98.8	1.2	100	148
25–29	97.9	2.1	100	307
30–34	96.9	3.1	100	355
35–39	98.4	1.6	100	350
40–44	96.6	3.4	100	258
45–49	95.7	4.3	100	226
Residence				
Urban	95	5	100	360
Rural	98	2	100	1,292
Region				
Honiara	94.3	5.7	100	229
Guadalcanal	98.3	1.7	100	327
Malaita	98	2	100	397
Western	95.9	4.1	100	236
Other provinces	98.5	1.5	100	462
Education				
No education	95.9	4.1	100	63
Primary	96.9	3.1	100	698
Secondary	98	2	100	664
More than secondary	97.5	2.5	100	228
Wealth quintile				
Lowest	98.7	1.3	100	322
Second	97.7	2.3	100	315
Middle	97.8	2.2	100	320
Fourth	96.7	3.3	100	350
Highest	96.3	3.7	100	345
Total 15–49	**97.4**	**2.6**	**100**	**1,652**
50+	96.6	3.4	100	585
Total 15+	**97.2**	**2.8**	**100**	**2,237**

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

4.3 AGE AT FIRST MARRIAGE

Marriage influences a woman's likelihood of childbearing, especially in societies where having children is quite common within a marriage. A woman's age at first marriage is important to examine because of it affects fertility levels and patterns. When age at first marriage is early, then the probability of having many children is higher because women have a longer reproductive period before reaching menopause. Information on age at first marriage was obtained by asking all ever-married respondents the month and year they started living together with their first spouse.

Table 4.3 shows 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. Although the minimum legal age for marriage is 18 years in Solomon Islands, women and men can legally marry with parental consent at age 15. Among

women aged 20–49, 7% were married by age 15, 23% were married by age 18, and 40% were married by age 20. The median age at first marriage among women aged 25–49 is 21.3. This means that half of the women were married before they reached age 21 years 4 months.

The results also suggest that some younger women are delaying marriage. For instance, approximately 21% of women aged 20–24 were married by age 18, compared with 29% of women aged 45–49.

Among men aged 20–49, 4% were married by age 18 and 12% were married by age 20. The median age at first marriage for men has been omitted because of the small number of married respondents in these age groups.

Table 4.3: 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 2015

Current age	Percentage first married by exact age:					Percentage never married	Number of respondents	Median age at first marriage
	15	18	20	22	25			
WOMEN								
Age								
15–19	1.8	na	na	na	na	88	1,241	a
20–24	5.6	21.3	40	na	na	41.3	1,146	a
25–29	5.7	18	34.7	50.5	71.6	18.5	1,091	21.9
30–34	7.6	25.9	41.6	57	73.6	7.5	933	21.1
35–39	6.6	22.3	40.2	56.2	73.9	5.5	803	21.2
40–44	7.6	26.1	41.8	58.2	74.8	5.9	576	20.9
45–49	8.6	29.3	44.6	62.2	76.1	4.3	476	20.7
20–49	6.7	22.9	39.8	na	na	16.8	5,025	a
25–49	7	23.4	39.8	55.8	73.6	9.6	3,879	21.3
20+	-	-	-	na	na	-	0	a
25+	-	-	-	-	-	-	0	a
MEN								
Age								
15–19	0	na	na	na	na	98.3	605	a
20–24	0	4.4	11.7	na	na	71.4	519	a
25–29	0	4.3	11	23.2	47.9	34.3	479	a
30–34	0	5.2	12.9	21.3	41.8	17.4	436	26.3
35–39	0	3.6	12.4	24.6	48	9.5	394	25.3
40–44	0	2.2	7.3	22.2	40.9	4.6	280	26.1
45–49	0	6.2	16.3	29.8	52.4	2.2	236	24.5
20–49	0	4.3	11.8	na	na	28.4	2,343	a
25–49	0	4.3	11.9	23.7	46	16.2	1,824	a
20+	0	4.4	11.8	na	na	22.9	2,986	a
25+	0	4.4	11.9	23.8	45.4	12.7	2,467	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 the women or men began living with their spouse or partner for the first time before reaching the beginning of the age group.

4.3.1 Median age at first marriage

Table 4.4 and Figure 4.2 present the median age at first marriage among women and men, by background characteristics. The results suggest that education, wealth and urban living are factors related to delayed marriage. Women aged 25–49 living in urban areas marry about one and a half years later (at age 22.4 years)

than rural women in the same age group (who marry at age 20.9). By region, the lowest median age at marriage among women is observed in Malaita Province (20.4 years), while the highest is in Honiara (22.7 years).

The median age at first marriage for women aged 25–49 is higher among better educated and wealthier women than for women who are less educated and in lower wealth quintile households. Data show that the median age at first marriage among women aged 25–49 with no formal education is 19.9 years, and increases 4.6 years to 24.5 years among those with more than a secondary education. Women from the poorest households are likely to marry almost two and a half years earlier (at age 20.2) than women from wealthier households (at age 22.6).

Data for the median age at first marriage among men aged 25–49 have been omitted because of sample limitations.

Table 4.4: Median age at first marriage by background characteristics

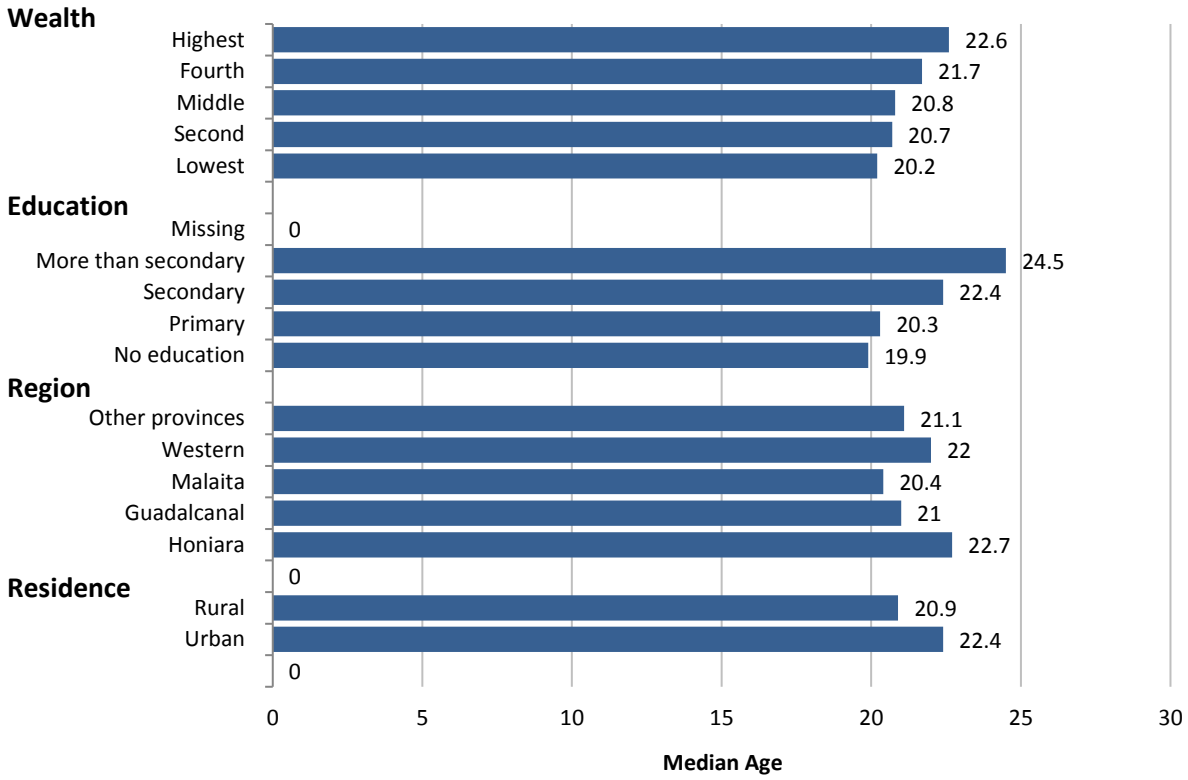
Median age at first marriage among women aged 20–49 and aged 25–49 , and median age at first marriage among men aged 20+ and 25+, according to background characteristics, Solomon Islands 2015

	Women age		Men age	
Background characteristic	**20–49**	**25–49**	**20+**	**25+**
Residence				
Urban	a	22.4	a	a
Rural	a	20.9	a	a
Region				
Honiara	a	22.7	a	a
Guadalcanal	a	21	a	24.8
Malaita	a	20.4	a	a
Western	a	22	a	a
Other provinces	a	21.1	a	a
Education				
No education	a	19.9	a	a
Primary	a	20.3	a	a
Secondary	a	22.4	a	a
More than secondary	a	24.5	a	a
Missing	a	a	a	a
Wealth quintile				
Lowest	a	20.2	a	24.8
Second	a	20.7	a	a
Middle	a	20.8	a	a
Fourth	a	21.7	a	a
Highest	a	22.6	a	a
Total	**a**	**21.3**	**a**	**a**

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

a = omitted because less than 50% of the respondents began living with their spouse/partners for the first time before reaching the beginning of the age group.

Figure 4.2: Median age at first marriage among women aged 25–49 by background characteristics, Solomon Islands 2015



4.4 AGE AT FIRST SEXUAL INTERCOURSE

Although age at first marriage is often used as a proxy for first experience of sexual intercourse, the two events do not necessarily coincide. In the SIDHS 2015, interviewers asked women and men how old they were when they first had sexual intercourse.

Table 4.5 shows the percentages of women and men aged 15–49 who first had sexual intercourse by specific exact ages, the percentage who had never had intercourse, and the median age at first intercourse, according to their current age at the time of the survey. As is the case with age at first marriage, men tend to initiate sexual activity later in life than women. Women in the age group 25-49 years are more likely than men to have had their first sexual intercourse at an early age (11% of women and 8% of men by exact age 15). Almost the same proportion of women and men (44% of women and 43% of men) initiated sex at the exact age of 18. For this same age group, 85% of women and 88% of men report that their first sexual intercourse occurred when they were at the exact age of 25. The median age at first sexual intercourse for women aged 25–49 is 18.5 years compared with the median age at first marriage of 21.3 years, a difference of almost three years. The median age at first sexual intercourse was similar to that in the SIDHS 2006–2007, which was 18.2 years.

The median ages at first intercourse among the different age cohorts suggest no significant change in age at first sexual intercourse for men and women between the two DHSs.

A comparison of the estimated mean age at first sexual intercourse with the mean age at first marriage on (Table 4.5) indicates 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 4.5: Age at first sexual intercourse

Percentage of women and men aged 15–49 who had first sexual intercourse by specific exact ages, percentage who never had sexual intercourse, and median age at first sexual intercourse, according to current age, Solomon Islands 2015

Current age	Percentage who had first sexual intercourse by exact age:					Percentage who never had intercourse	Number	Median age at first intercourse
	15	18	20	22	25			
WOMEN								
Age								
15–19	10.2	na	na	na	na	55.6	1,241	a
20–24	12.0	49.7	74.2	na	na	11.1	1,146	18.0
25–29	10.5	44.0	66.5	77.6	86.6	3.4	1,091	18.5
30–34	11.1	43.6	63.8	77.2	84.0	1.4	933	18.5
35–39	10.4	45.4	66.2	80.1	87.8	1.0	803	18.4
40–44	10.0	40.9	63.5	78.8	84.4	1.4	576	18.6
45–49	10.1	44.9	64.5	75.1	82.5	1.6	476	18.4
20–49	10.8	45.2	67.2	na	na	4	5,025	18.4
25–49	10.5	43.8	65.1	77.9	85.4	1.9	3,879	18.5
15–24	11.0	na	na	na	na	34.2	2,387	a
20+	-	-	-	na	na	-	0	a
25+	-	-	-	-	-	-	0	a
MEN								
Age								
15–19	10.6	na	na	na	na	55.9	605	a
20–24	11.8	54.0	78.7	na	na	12.4	519	17.7
25–29	10.1	52.2	74.7	85.6	89.4	3.0	479	17.9
30–34	8.8	48.2	72.8	88.7	91.0	1.3	436	18.1
35–39	5.6	38.6	64.5	82.5	86.7	1.8	394	18.6
40–44	6.4	32.3	63.5	79.6	85.6	0.7	280	18.9
45–49	4.4	33.8	63	77.9	87.3	0.7	236	18.9
20–49	8.5	45.3	71	na	na	4.1	2,343	18.3
25–49	7.5	42.9	68.8	83.8	88.4	1.7	1,824	18.4
15–24	11.2	na	na	na	na	35.9	1,124	a
20+	7.2	40.3	65.3	na	na	3.3	2,986	18.6
25+	6.3	37.4	62.5	78.4	83.5	1.4	2,467	18.8

na = not applicable due to censorin.

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

4.4.1 Median age at first sexual intercourse by background characteristics

Table 4.6 and Figure 4.3 present the median age at first sexual intercourse for women aged 20–49 and 25–49, and the median age at first sexual intercourse among men aged 20+ and age 25+ according to their background characteristics. Overall, the data show that there was not much difference in the median age at first sexual intercourse between these two age groups. However, differences are evident when looking at background characteristics. The median age rises from 17.8 years among women aged 20–49 with no education, to 19.9 years among women with more than a secondary education in the same age group. Similarly, median age at first sexual intercourse among women increases from 17.5 years in the lowest wealth

quintile to 19.0 years in the highest quintile. The median age at first intercourse for women aged 20–49 in rural areas is one year earlier (18.1) than for women in urban areas (19.0).

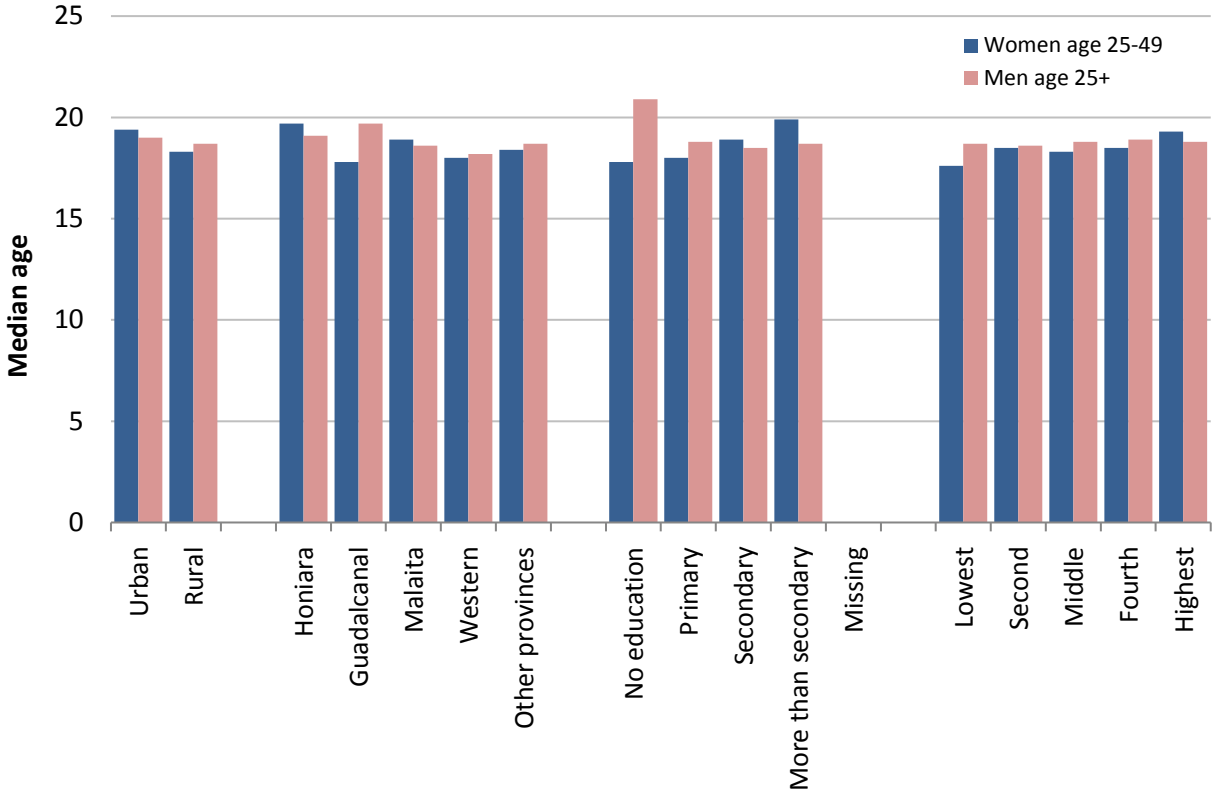
The table also shows the median age at first intercourse for men aged 20 and older is 18.6 years. The median age at first intercourse is almost the same for men 20+ and 25+ (18.6 and 18.8 years, respectively). Similarly, there is little difference between the median age at first intercourse between men aged 20 years and over in urban areas (18.7 years) and rural areas (18.5 years). Men aged 25 years and over with no education are more likely to have a higher median age at first intercourse (20.9 years) than men with more than a secondary level education (18.7 years). The median age at first intercourse was stable across wealth quintiles, ranging from 18.6 to 18.9 years. Men in the Western Province aged 20 have the lowest median age at first intercourse of all regions, 18.0 compared with Guadalcanal Province, where the highest median age is 19.1.

Table 4.6: Median age at first sexual intercourse by background characteristics

Median age at first sexual intercourse among women aged 20–49 and aged 25–49 , and median age at first sexual intercourse among men aged 20+ and age 25+, according to background characteristics, Solomon Islands 2015

Background characteristic	Women age		Men age	
	20–49	25–49	20+	25+
Residence				
Urban	19.2	19.4	18.7	19
Rural	18.1	18.3	18.5	18.7
Region				
Honiara	19.4	19.7	18.8	19.1
Guadalcanal	17.6	17.8	19.1	19.7
Malaita	18.8	18.9	18.6	18.6
Western	17.9	18	18	18.2
Other provinces	18.3	18.4	18.5	18.7
Education				
No education	17.8	17.8	a	20.9
Primary	17.8	18	18.7	18.8
Secondary	18.6	18.9	18.2	18.5
More than secondary	19.9	19.9	18.6	18.7
Missing	a	a	a	a
Wealth quintile				
Lowest	17.5	17.6	18.5	18.7
Second	18.2	18.5	18.5	18.6
Middle	18.3	18.3	18.7	18.8
Fourth	18.4	18.5	18.7	18.9
Highest	19	19.3	18.6	18.8
Total	18.4	18.5	18.6	18.8

Figure 4.3: Median age at first sexual intercourse among women aged 25–49 and men aged 25+, Solomon Islands 2015



4.5 RECENT SEXUAL ACTIVITY

In the absence of effective contraception, the probability of pregnancy is highly dependent on the frequency of intercourse. Therefore, information on sexual activity can be used to refine measures of the likelihood of pregnancy. Men and women who have had sex were asked how long ago their most recent sexual intercourse occurred. Tables 4.7.1 and 4.7.2 show the distribution of women and men by timing of last sexual intercourse, according to background characteristics. Respondents are considered sexually active if they had sexual intercourse once during the four weeks preceding the survey.

Just under 6 in 10 women (56%) aged 15–49 were sexually active during the four weeks preceding the interview. This is higher than the 51% in the SIDHS 2006–2007. Another 20% reported that their last sexual intercourse was in the 12 months preceding the survey (excluding the past month), 10% said that they had not been sexually active for one or more years, and 14% reported that they had never had sex.

The proportion of women who were sexually active in the four weeks preceding the survey increases with age, peaking in the late 30s at 73% and decreases slightly thereafter. As expected, the frequency of sexual activity among teenagers and women who are not currently in a union is lower than that among older women and women who are married or living with a man. About 16% of women aged 15–19 were sexually active in the four weeks preceding the survey (Fig. 4.4), and 13% of never-married women were sexually active during the same period. Women in urban areas were slightly less likely to be sexually active during the four weeks preceding the survey (54%) than women in rural areas (56%).

By region, the proportion of women who were sexually active during the four weeks preceding the survey was highest in Guadalcanal (57%) and lowest in Honiara (52%). The results further show that women with no education are more likely to have been sexually active in the four weeks preceding the survey (63%) than better educated women (58%) with more than a secondary level education). Women with a secondary education are least likely to have been sexually active in the weeks preceding the survey (49%).

Table 4.7.1: Recent sexual activity – Women

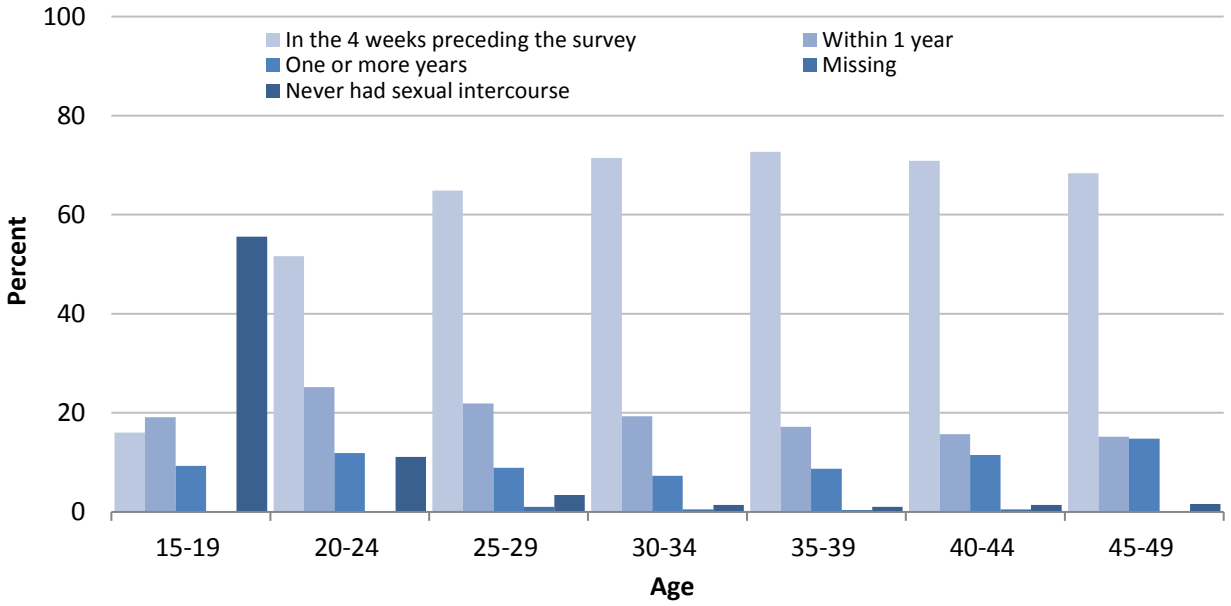
Percent distribution of women aged 15–49 by timing of last sexual intercourse, according to background characteristics, Solomon Islands 2015

Background characteristic	Timing of last sexual intercourse				Never had sexual intercourse	Total	Number of women
	In the 4 weeks preceding the survey	Within 1 year[1] of the survey	One or more years before the survey	Missing			
Age							
15–19	16.0	19.1	9.3	0.0	55.6	100	1,241
20–24	51.6	25.2	11.9	0.1	11.1	100	1,146
25–29	64.9	21.9	8.9	1.0	3.4	100	1,091
30–34	71.5	19.3	7.3	0.5	1.4	100	933
35–39	72.7	17.2	8.7	0.4	1.0	100	803
40–44	70.9	15.7	11.5	0.5	1.4	100	576
45–49	68.4	15.2	14.8	0.0	1.6	100	476
Marital status							
Never married	13.1	23.1	17.7	0.1	46	100	1,936
Married or living together	78.1	18.1	3.4	0.5	0.0	100	4,086
Divorced/separated/widowed	15.5	25.2	59	0.3	0.0	100	244
Marital duration[2]							
0–4 years	74.7	21.3	3.3	0.7	0.0	100	959
5–9 years	79.1	17.4	3.0	0.5	0.0	100	860
10–14 years	78.3	18.4	2.6	0.6	0.0	100	629
15–19years	80.1	16.7	2.8	0.4	0.0	100	633
20–24 years	82.8	12.1	4.9	0.3	0.0	100	404
25+ years	73.4	20.4	5.8	0.4	0.0	100	363
Married more than once	81.4	16.3	2.1	0.0	0.3	100	239
Residence							
Urban	53.6	20.6	10.7	0.9	14.2	100	1,427
Rural	56.2	19.7	9.7	0.2	14.2	100	4,839
Region							
Honiara	52.4	20.5	11.8	0.7	14.6	100	925
Guadalcanal	57.3	18.2	9.7	0.9	14	100	1,140
Malaita	54.9	17.5	8.9	0.1	18.6	100	1,608
Western	56.1	23.3	9.0	0.3	11.3	100	902
Other provinces	56.6	21.1	10.7	0.1	11.5	100	1,690
Education							
No education	63.2	16.2	12	0.5	8.1	100	576
Primary	59.6	17.2	9.5	0.2	13.4	100	2,820
Secondary	48.8	23.1	9.8	0.5	17.7	100	2,476
More than secondary	57.9	23.9	10.8	0.7	6.7	100	394
Wealth quintile							
Lowest	56.5	19.4	10.1	0.3	13.7	100	1,158
Second	55.2	20.9	9.0	0.1	14.9	100	1,172
Middle	58.9	18.2	10	0.4	12.5	100	1,223
Fourth	57.2	19.1	9.9	0.3	13.5	100	1,253
Highest	51.0	21.6	10.6	0.7	16.2	100	1,460
Total	**55.6**	**19.9**	**10.0**	**0.4**	**14.2**	**100**	**6,266**

[1] Excludes women who had sexual intercourse in the 4 weeks preceding the survey

[2] Excludes women who are not currently married

Figure 4.4: Women aged 15–49 by timing of last sexual intercourse, according to background characteristics, Solomon Islands 2015



For men aged 15–49, 58% reported having had sexual intercourse in the four weeks preceding the interview. About 20% of men had been sexually active within the 12-month period prior to the survey but not in the month prior to the interview, 7% had not been sexually active for one or more years, and 15% of men reported never having had sexual intercourse. The proportion of men who were sexually active in the four weeks preceding the survey increases with age, peaking in the 40–44 age group (81%) and declines as men reach 50 and over (Table 4.7.2 and Fig. 4.5). Men who are in a union are more likely to have been sexually active in the four weeks preceding the survey (82%) than men who have never been married or are not living with a woman (27%).

The percentage of men in urban areas who were sexually active in the four weeks preceding the survey increased from 49% in the SIDHS 2006–2007 to 61% in SIDHS 2015. The change was smaller change in rural areas, where 59% were sexually active in the four weeks preceding the SIDHS 2006–2007 and 57% in SIDHS 2015. Recent sexual activity among men is highest in Honiara (63%) and lowest in Malaita (50%).

Recent sexual activity is more common among men with more than a secondary education (78%), but is fairly even across wealth quintiles, ranging from 57% to 59%.

Table 4.7.2: Recent sexual activity – Men

Percent distribution of men aged 15–49 by timing of last sexual intercourse, according to background characteristics, Solomon Islands 2015

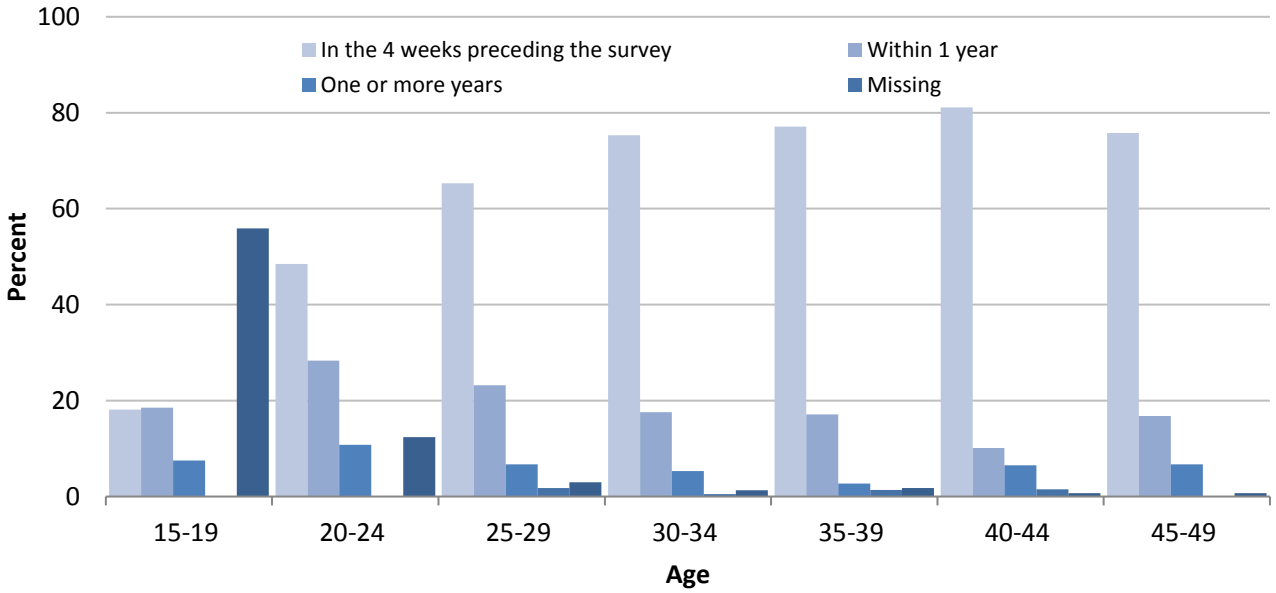
Background characteristic	Timing of last sexual intercourse				Never had sexual intercourse	Total	Number of men
	In the 4 weeks preceding the survey	Within 1 year[1] of the survey	One or more years before the survey	Missing			
Age							
15–19	18.1	18.5	7.5	0.0	55.9	100	605
20–24	48.5	28.3	10.8	0.0	12.4	100	519
25–29	65.3	23.2	6.7	1.8	3.0	100	479
30–34	75.3	17.6	5.3	0.5	1.3	100	436
35–39	77.1	17.1	2.7	1.4	1.8	100	394
40–44	81.1	10.1	6.5	1.5	0.7	100	280
45–49	75.8	16.8	6.7	0.0	0.7	100	236
Marital status							
Never married	26.6	26.5	12.2	0.3	34.4	100	1,261
Married or living together	82.1	14.7	2.1	1.0	0.0	100	1,652
Divorced/separated/widowed	(54.8)	(10.4)	(34.7)	0.0	0.0	100	35
Marital duration[2]							
0–4 years	80.1	17.4	1.5	1.0	0.0	100	464
5–9 years	84	12.4	2.3	1.3	0.0	100	370
10–14 years	78.4	18.3	2.2	1.1	0.0	100	274
15–19years	86.2	11.2	1.4	1.2	0.0	100	263
20–24 years	86.7	10.6	2.7	0.0	0.0	100	126
25+ years	72.4	21.9	5.6	0.0	0.0	100	75
Married more than once	86.6	9.2	2.5	1.8	0.0	100	81
Residence							
Urban	61.4	19.8	7.4	1.0	10.4	100	720
Rural	56.9	19.7	6.7	0.6	16.1	100	2,229
Region							
Honiara	63.1	20.6	5.8	0.4	10.0	100	475
Guadalcanal	59.9	14.9	6.6	1.1	17.5	100	547
Malaita	50.2	17.9	11.6	0.8	19.6	100	710
Western	55.3	24.2	7.2	0.5	12.9	100	451
Other provinces	62.6	21.6	3.0	0.6	12.2	100	765
Education							
No education	58.5	17.4	12.1	0.7	11.2	100	92
Primary	56.6	16.3	6.4	0.5	20.2	100	1,202
Secondary	54.8	24.0	7.5	0.7	13.0	100	1,348
More than secondary	77.6	14.8	4.4	1.5	1.8	100	307
Wealth quintile							
Lowest	58.7	18.9	4.9	0.9	16.6	100	529
Second	57.3	18.1	6.1	0.4	18.0	100	565
Middle	58.0	19.8	6.5	0.4	15.3	100	528
Fourth	56.7	19.7	8.7	1.1	13.8	100	621
Highest	59.4	21.5	7.5	0.7	11.0	100	706
Total 15–49	**58.0**	**19.7**	**6.8**	**0.7**	**14.7**	**100**	**2,948**
50+	44.9	22.5	31.0	0.9	0.7	100	643
Total	**55.7**	**20.2**	**11.2**	**0.7**	**12.2**	**100**	**3,591**

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

[1] Excludes men who had sexual intercourse in the 4 weeks preceding the survey.

[2] Excludes men who are not currently married.

Figure 4.5: Men aged 15–49 by timing of last sexual intercourse, Solomon Islands 2015



CHAPTER 5 FERTILITY

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KEY FINDINGS

- The estimated total fertility rate for Solomon Islands women aged 15–49 for the three years preceding the survey is 4.4 births per woman. Total fertility rates have been reasonably constant between the SIDHS 2006–2007 and SIDHS 2015 (4.6 births per woman in 2006–2007).
- Fertility level is higher in rural areas (4.7 births per woman) than in urban areas (3.4 births per woman). Women with less education are more likely to have higher fertility than women with greater education (4.7 births compared with 3.1 births).
- Age of the mother at first birth is lower in rural areas (21.7) than in urban areas (23.3). Age at first birth increases with wealth quintile: 21.0 for the lowest wealth quintile and 23.6 for the highest wealth quintile.
- Almost half of all Solomon Islands women aged 25–49 have given birth by age 22 (49.5%).
- Adolescent fertility among women aged 15–19 has decreased over the last 20 years, from 88 births per 1,000 women during 1996–2000 to 77 births during 2011–2015. There was, however, a small increase in the most recent four-year period (74–77 births per 1,000 women).
- The average number of children ever born during a woman's reproductive life is 2.31 for all women and 3.26 for married women.
- The median birth interval for Solomon Islands women is 32.3 months.
- Women aged 15–19 have the shortest median birth interval of 20.5 months.
- The median duration of postpartum amenorrhoea for women aged 15–49 in the three years preceding the survey is 3.9 months. It is higher for women in rural areas (4.1 months) than in urban areas (3.2 months).
- The percentage of women experiencing menopause increases with age from 2% of women aged 30–34 to 34% of women aged 48–49.

INTRODUCTION

This chapter presents fertility indicators and an analysis based on the results of the SIDHS 2015. The analysis includes differences in fertility levels and trends, fertility by background characteristics, data on lifetime fertility (children ever born and living), percentage of births and median duration for which mothers are postpartum amenorrhoea, abstinence and insusceptibility, menopause, age at first birth, and birth intervals. Adolescent fertility, which is also covered, has significant health and socioeconomic consequences for women and communities in Solomon Islands. These data are important because they indicate the beginning of a woman's reproductive life.

Fertility rates presented in this report are based on the reproduction section of the survey that uses a questionnaire for women. This section captures whether a woman has ever given birth, the total number of children living with her, number of children living elsewhere, and number of children who have died. A complete birth history was collected, including the child's sex, date of birth, current age and survival status. Although birth history tries to capture all births, the data 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 the date of birth and/or age of a child, in particular, the tendency to round off dates of birth or ages, which could result in under-reporting or overestimating 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 report the birth of their child;
- women whose child died shortly after birth and who did not report the birth of the child;
- women who did not report 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 one 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); and
- errors during data recording and/or processing.

5.1 CURRENT FERTILITY

Measures of current and cumulative fertility for Solomon Islands for the three-year period preceding the survey are shown in Table 5.1. The total fertility rate (TFR), age-specific fertility rate (ASFR), and general fertility rate (GFR) are cohort measures that represent the current situation. The crude birth rate (CBR) is a crude measure of fertility because it relates to births of the whole population regardless of sex and age.

CURRENT AND CUMULATIVE FERTILITY MEASURES

- ASFR provides the pattern for different age groups, and is the number of births to women in each specific age group.
- 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. TFR sums the fertility of all women at a given point in time.
- Another refined measure of fertility is GFR, which is the number of births to women in the 15–49 age groups.

According to Table 5.1, the estimated TFR for Solomon Islands women is 4.4 children per woman, compared with 4.6 children in the SIDHS 2006–2007. This means that on average Solomon Islands women are expected to have 4.4 children during their reproductive life.

Women in rural areas have a higher TFR (4.7) than women in urban areas (3.4). Fertility rates vary according to age group, with Figure 5.1 showing that ASFR is highest among women aged 20–24 in rural areas, with 251 births per 1,000 women for the three years preceding the survey. In urban areas, women aged 25–29 years have more births (196 births per 1,000 women) than women in other age groups. In the SIDHS 2006–2007, fertility peaks among women aged 24–29 (234 births per 1,000 women in this age group), whereas in the SIDHS 2015, the highest fertility peak is among younger women in the 20–24 age group (227 births per 1,000 women). This indicates the likelihood that more younger women are having more children than older women.

GFR for women aged 15–49 is 154 births per 1,000 women and CBR is 32.6 births per 1,000 population.

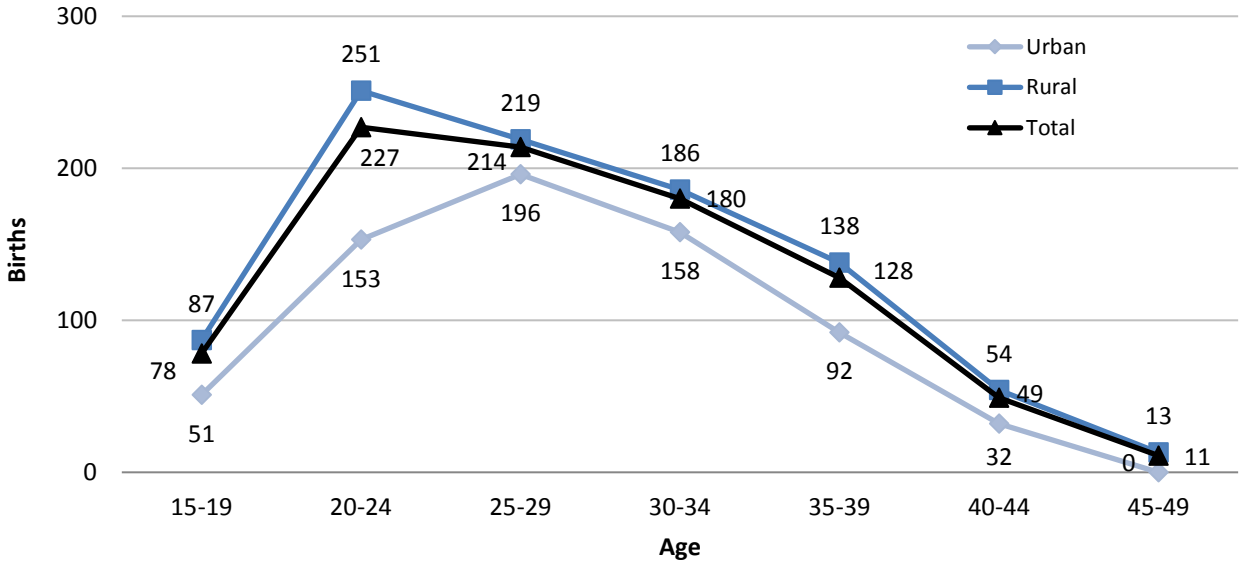
Table 5.1: Current fertility

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 2015

Age group	Residence		Total
	Urban	Rural	
15–19	51	87	78
20–24	153	251	227
25–29	196	219	214
30–34	158	186	180
35–39	92	138	128
40–44	32	54	49
45–49	0	13	11
TFR (15–49)	**3.4**	**4.7**	**4.4**
GFR	122	164	154
CBR	30.8	32.9	32.6

Notes: Age-specific fertility rates are per 1,000 women. Rates for age group 45–49 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 aged 15–44
CBR: Crude birth rate, expressed per 1,000 population

Figure 5.1: Age-specific fertility rate by residence, Solomon Islands 2015



5.1.1 Fertility by background characteristics

Fertility is known to vary with a woman's socioeconomic background characteristics. Table 5.2 indicates 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 characteristics.

The mean number of children ever born to women aged 40–49 is an indicator of complete fertility, which reflects the number of children women who are nearing the end of their reproductive period have had. The fertility level is known to be stable when TFR and the number of children ever born (CEB) are almost the same. When the fertility level has been declining, 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 5.2: Fertility by background characteristics

Total fertility rate for the three years preceding the survey, percentage of women aged 15–49 currently pregnant, and mean number of children ever born to women aged 40–49 years, by background characteristics, Solomon Islands 2015

Background characteristic	Total fertility rate	Percentage of women aged 15–49 currently pregnant	Mean number of children ever born to women aged 40–49
Residence			
Urban	3.4	5.2	4.1
Rural	4.7	6.7	5
Region			
Honiara	3.3	5	4
Guadalcanal	4.6	5.6	4.9
Malaita	4.6	6.6	5.3
Western	4.4	8.3	4.3
Other provinces	4.8	6.4	5
Education			
No education	4.7	(5.7)	5.4
Primary	4.9	6.1	4.9
Secondary	4.3	7.1	4.4
More than secondary	3.1	(4.9)	3.7
Wealth quintile			
Lowest	5.7	8.8	5.4
Second	5.1	6.7	5.4
Middle	4.4	5.5	5.2
Fourth	4	5.8	4.3
Highest	3.2	5.4	4
Total	**4.4**	**6.4**	**4.8**

Note: Total fertility rates are for the period 1–36 months prior to interview. Figures in parentheses are based on 25–49 unweighted cases.

A TFR above the national level was observed in Guadalcanal and Malaita provinces, with a TFR of 4.6 children per woman. Honiara has the lowest TFR (3.3 births per woman), which represent the largest urban town in the country.

TFR by educational background of women aged 15–49 shows that the higher the education level of women, the lower the number of children she has. According to Figure 5.2, women with no education have a TFR of 4.7 births per woman compared with a TFR of 3.1 births per woman with more than a secondary education. Although more education is generally associated with lower fertility, the magnitude of differential among educational levels varies. For example, TFR for women completing a primary level of education is higher (4.9 births) than for women with no education (4.7 births). The percentage of women aged 15–49 who are currently pregnant is highest among those with a secondary level education. Women in the highest wealth quintiles had lower TFRs than those in the lower wealth quintiles.

Table 5.2 also indicates that the mean number of CEB to women aged 40–49 who are nearing the end of their reproduction cycle is 4.8. This is slightly more than the national TFR of 4.4 births per woman, and suggests a small decline in fertility levels in Solomon Islands.

5.2 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 fertility, and the number of children they wish to have. The decline in fertility level also indicates a change in custom and beliefs in a society toward having a smaller family.

Fertility trends can be established using retrospective data from a single survey such as the SIDHS 2015. Women's birth history is the main source of data in producing fertility trends. The two main components of fertility trends — a woman's age at childbirth and the number of children ever born — are recorded for each woman in their respective birth history. Table 5.3 shows 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 5.3 and Figure 5.2 show an overall decrease in ASFRs for young women aged 15–19 and 20–24 over the past 20 years, although both age groups have increased over the last 5 years. Adolescent fertility (women aged 15–19) decreased from 88 births per 1,000 women during 1996–2000 to 77 births per 1,000 women during 2011–2015. ASFR for women aged 20–24 also declined from 220 births per 1,000 women during 1996–2000 to 196 during 2006–2010. ASFR increased again to 217 during 2011–2015. A slow decrease in ASFR was observed for women aged 25–39 over the last 15 years.

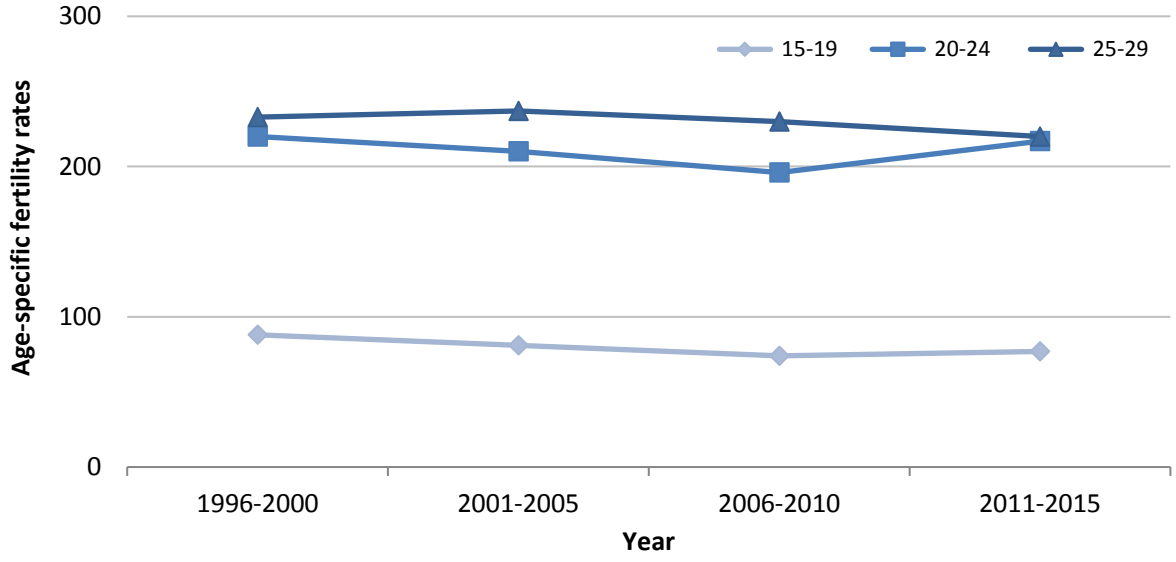
Table 5.3: Trends in age-specific fertility rates

Age-specific fertility rates for five-year periods preceding the survey, by mother's age at the time of the birth, Solomon Islands 2015

Mother's age at birth	Number of years preceding survey			
	0–4	5–9	10–14	15–19
15–19	77	74	81	88
20–24	217	196	210	220
25–29	220	230	237	233
30–34	182	187	209	[231]
35–39	133	133	[177]	-
40–44	50	[53]	-	-
45–49	[12]	-	-	-

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

Figure 5.2: Trends in age-specific fertility rates, Solomon Islands 2015



5.3 CHILDREN EVER BORN AND LIVING

Data on CEB comprise 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 5.4: Children ever born and living

Percent distribution of all women and currently married women aged 15–49 by number of children ever born, mean number of children ever born and mean number of living children, according to age group, Solomon Islands 2015

Age	Number of children ever born											Total	Number of women	Mean number of children ever born	Mean number of living children
	0	1	2	3	4	5	6	7	8	9	10+				
ALL WOMEN															
Age															
15–19	90.9	7.2	1.4	0.3	0.1	0	0	0	0	0	0	100	1,241	0.11	0.11
20–24	43.2	29.3	18.3	6.9	1.4	0.8	0.1	0	0	0	0	100	1,146	0.97	0.95
25–29	21.3	21.9	22.9	18	10.1	4.3	1.1	0.3	0	0	0	100	1,091	1.93	1.88
30–34	10.7	11.4	16.1	21.6	17.9	9.8	7.5	2.9	1.5	0.6	0	100	933	3.11	3.04
35–39	6.9	5.4	11.7	17.7	20.2	16.1	10.6	6.4	3	1.1	0.9	100	803	3.94	3.86
40–44	6	4.9	8.7	14.1	17.1	18	13.6	6.8	4.3	3.9	2.5	100	576	4.48	4.33
45–49	3.5	2.6	5.7	8.9	21.2	16.3	12.4	10.8	9.4	2.9	6.4	100	476	5.25	4.99
Total	**32.9**	**13.7**	**12.7**	**11.9**	**10.5**	**7.3**	**4.9**	**2.8**	**1.7**	**0.8**	**0.8**	**100**	**6,266**	**2.31**	**2.25**
CURRENTLY MARRIED WOMEN															
Age															
15–19	46.7	39.8	11.2	1.5	0.8	0	0	0	0	0	0	100	141	0.7	0.68
20–24	18.7	36.7	28.6	11.9	2.4	1.4	0.2	0	0	0	0	100	645	1.48	1.45
25–29	11.4	21.2	26.6	21.7	12.2	5.1	1.4	0.4	0	0	0	100	850	2.25	2.2
30–34	7.1	10.4	15.9	23.1	18.8	10.9	8.3	3.3	1.5	0.6	0	100	824	3.32	3.24
35–39	4.9	4.3	10.6	18.1	21.3	16.8	11.6	7	3.3	1.2	1	100	715	4.15	4.06
40–44	2.3	4.2	7.9	14.7	17.4	19.5	14.9	7.3	4.6	4.5	2.8	100	504	4.78	4.62
45–49	1	1.5	5.6	7.7	22.6	16.6	12.5	11.9	10.6	3.2	6.7	100	407	5.52	5.24
Total	**9.6**	**15.1**	**17.1**	**16.8**	**14.9**	**10.5**	**7.1**	**4**	**2.5**	**1.2**	**1.2**	**100**	**4,086**	**3.26**	**3.16**

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 because they could be less reliable than younger age groups. For instance, older women are more likely to exclude children that died at a very young age. The inclusion of adopted and foster children can overestimate the CEB for all women.

Table 5.4 presents the percent distribution of all women and currently married women by number of CEB, mean number of CEB, and mean number of living children, by age group. The results indicate that 90.4% of currently married women have given birth. On average, women aged 20–24 in Solomon Islands have given birth to one child (0.97 births), to two children by age 25–29 (1.93 births), three children by age 30–34 (3.11 births), four children by age 35–39 (3.94 births), and five children by age 45–49 (5.25 births). Overall, the mean number of CEB is 2.31 children for all women, and 3.26 children for married women. The mean number of living children is 2.25 for all women and 3.16 for married women. The difference between the mean numbers of CEB with mean number of living children provides an indication of the level of childhood and adult mortality in the country.

Out of all women aged 15–49, 33% reported that they have no children and 10% of currently married women did not have any children.

5.4 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. The World Health Organization (WHO) (recommends an interval of 24 months after a live birth before attempting the next pregnancy in order to reduce the risk of adverse maternal, perinatal and infant outcomes. These include risk of maternal, infant, neonatal and perinatal mortality; low birth weight; small size for gestational age; and pre-term delivery[11].

Table 5.5 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 32.3 months. This means that half of all non-first births occur before and half occur after 32.3 months from a preceding birth. The median birth interval recorded from the SIDHS 2006–2007 was 33.6 months.

The median number of months since preceding birth increases with age. Adolescent mothers aged 15–19 have the shortest birth interval of 20.5 months, which is lower than the WHO recommendation of 24 months. This figure increases to 47.6 months for older women aged 40–49 who are reaching the end of their childbearing years. Children whose preceding sibling died had a shorter median birth interval of 26.2 month than those whose sibling is living (32.4 months).

Data show that among regions, the shortest birth interval is observed among mothers in Malaita (29.3 months) compared with Western Province, which had the longest median birth interval of 36.6 months. By educational background, mothers who have more than a secondary level of education had the longest median birth interval of 36.7 months. Median birth interval increased with wealth quintile, from 30.9 months in the lowest wealth quintile to 34.2 months in the highest.

[11] World Health Organization. 2005. Report of a WHO technical consultation on births spacing. Geneva, Switzerland, 13–15 June 2007. 48 p. http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf?ua=1.

Table 5.5: 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 2015

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	27	20.5
20–29	14.5	23	31.9	14.2	8.4	8	100	1,268	27.9
30–39	7.8	14.1	28.2	17.8	10.6	21.4	100	1,463	35.9
40–49	6.1	9.2	20.3	14.7	9.1	40.6	100	308	47.6
Sex of preceding birth									
Male	10	16.4	30.3	16.3	9	17.9	100	1,579	32.6
Female	11.2	18.6	27.4	15.6	9.9	17.3	100	1,486	31.9
Survival of preceding birth									
Living	10.2	17.5	29.1	15.8	9.6	17.7	100	2,997	32.4
Dead	29	14.1	17.6	25	2.3	12.1	100	68	26.2
Birth order									
2–3	11.8	18.3	27.9	14.9	8.8	18.4	100	1,616	31.6
4–6	9.5	16.6	27.5	16.4	11.1	19	100	1,178	34
7+	8.1	16.5	41.1	20.4	6.8	7.2	100	272	30.4
Residence									
Urban	12.3	16	26.9	15.5	9.5	19.7	100	498	32.6
Rural	10.3	17.7	29.3	16.1	9.5	17.2	100	2,567	32.3
Region									
Honiara	12	17	26.3	15.8	9.4	19.5	100	313	32.9
Guadalcanal	10.4	19.7	29.3	15.3	9	16.3	100	592	31.3
Malaita	13	19.3	31.9	15.5	8.2	12.1	100	838	29.3
Western	10.2	15	23.5	16.4	9.9	24.9	100	400	36.6
Other Provinces	8.3	15.6	29.0	16.7	10.7	19.7	100	922	34.7
Education									
No education	10	13.4	34.7	14.7	9.6	17.6	100	340	31.8
Primary	9	18	28.7	15.6	9.3	19.4	100	1,618	33.1
Secondary	13.7	18.1	28.3	17	9.1	13.9	100	960	31
More than secondary	9.9	16.7	21.5	15.9	13.5	22.5	100	146	36.7
Wealth quintile									
Lowest	9.3	20.8	29.6	14.3	9.6	16.4	100	760	30.9
Second	9.4	17.5	32.6	15.8	10	14.8	100	652	31.4
Middle	12.5	15.3	29.1	18	7.5	17.7	100	617	32.9
Fourth	10.1	15.7	27.3	18.2	9.6	19	100	576	34
Highest	12.7	16.9	24.2	13.6	10.9	21.8	100	460	34.2
Total	**10.6**	**17.5**	**28.9**	**16**	**9.5**	**17.6**	**100**	**3,065**	**32.3**

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 that a figure is based on fewer than 25 unweighted cases and has been suppresed.

5.5 POSTPARTUM AMENORRHOEA, ABSTINENCE, AND INSUSCEPTIBILITY

Postpartum amenorrhoea is the temporary absence of menstrual periods after the birth of a child. During this period, women are less likely to become pregnant. The period of postpartum amenorrhoea can be extended by prolonged breastfeeding. Therefore, 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.

Table 5.6.1 and Figure 5.3 show the percentage of births in the three years preceding the survey for which mothers were postpartum amenorrhoeic, abstaining and insusceptible, by number of months since births. The table also shows the median and mean durations.

The overall percentage of women in Solomon Islands who gave birth in the three years preceding the survey and were amenorrhoeic is 19%. This shows a decline from 25% in the SIDHS 2006–2007. The percentage of women who are amenorrhoeic declines as the month since childbirth increases. The majority of women are amenorrhoeic up to three months after childbirth (76% for less than two months and 60% for two to three months). Less than 10% of women are amenorrhoeic for more than 17 months. The median duration for amenorrhoea is 3.9 months while the mean is 7.1 months. The SIDHS 2006–2007 recorded the median duration for amenorrhoea as 5.1 months and the mean as 9.4 months.

Likewise, 20% of women who gave birth in the three years preceding the survey practised postpartum abstinence. Around 85% of mothers who gave birth less than two months prior to the survey were abstaining from sexual activity compared with 5% of mothers who gave birth 34–35 months prior to the survey. Women are abstaining for a median of 2.6 months, or an average of 7.5 months.

Women who are either still amenorrhoeic, abstaining from sexual activity, or both, comprise 30% of women who gave birth in the three years preceding the survey.

Table 5.6.1: Postpartum amenorrhoea, abstinence and insusceptibility

Percentage of births in the three years preceding the survey for which mothers are postpartum amenorrhoeic, abstaining, and insusceptible, by number of months since birth, and median and mean durations, Solomon Islands 2015

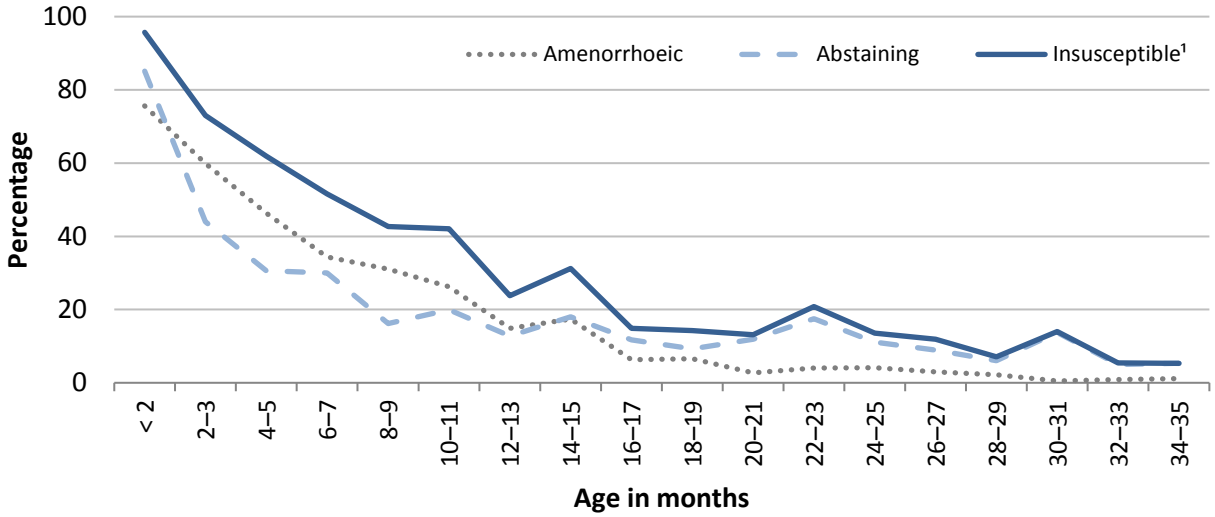
Months since birth	Percentage of births for which the mother is:			Number of births
	Amenorrhoeic	Abstaining	Insusceptible[1]	
< 2	75.6	85.1	95.7	113
2–3	59.9	44	73	135
4–5	46.3	30.6	61.9	146
6–7	34.4	30	51.6	166
8–9	31	16.2	42.7	141
10–11	26.2	19.9	42.1	152
12–13	14.9	12.8	23.8	176
14–15	17.4	18	31.2	156
16–17	6.3	11.7	14.9	107
18–19	6.6	9.3	14.3	134
20–21	2.7	11.9	13.1	146
22–23	4	17.5	20.8	117
24–25	4.1	11.1	13.6	138
26–27	3	8.9	11.9	150
28–29	2.2	6	7.1	103
30–31	0.5	13.7	14	138
32–33	0.9	5	5.4	128
34–35	1.1	5.3	5.3	143
Total	**18.8**	**19.5**	**30.3**	**2,491**
Median	3.9	2.6	7.2	na
Mean	7.1	7.5	11.1	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 amenorrhoeic or still abstaining (or both) following birth

Figure 5.3: Percentage of births in the three years preceding the survey for which mothers are postpartum amenorrhoeic, abstaining and insusceptible, Solomon Islands 2015



[1] Includes births for which mothers are either still amenorrhoeic or still abstaining (or both) following birt.

Table 5.6.2 indicates the median duration of postpartum amenorrhoea, postpartum abstinence and postpartum insusceptibility following births in the three years preceding the survey, by background characteristics.

Table 5.6.2: Median duration of amenorrhoea, postpartum abstinence and postpartum insusceptibility

Median number of months of postpartum amenorrhoea, postpartum abstinence, and postpartum insusceptibility following births in the three years preceding the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Postpartum amenorrhoea	Postpartum abstinence	Postpartum insusceptibility[1]
Mother's age			
15–29	3.5	3.1	7
30–49	5.4	2.3	8.5
Residence			
Urban	3.2	2.4	5.1
Rural	4.1	2.7	8.2
Region			
Honiara	3	2.2	4.1
Guadalcanal	3.8	2.3	8.8
Malaita	5.9	2.3	7.2
Western	3.2	3.4	9.7
Other provinces	3.7	3.1	8.7
Education			
No education	3.9	2.5	9
Primary	4.5	2.8	6.6
Secondary	3.6	2.5	7.7
More than secondary	0.7	3	5.3
Wealth quintile			
Lowest	4	2.4	6.4
Second	6.7	3	8.2
Middle	4.3	2.4	8.9
Fourth	4.3	2.9	8.4
Highest	2.8	2.8	4.6
Total	**3.9**	**2.6**	**7.2**

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

[1] Includes births for which mothers are either still amenorrhoeic or still abstaining (or both) following birt.

The median duration of postpartum amenorrhoea is found to be higher for older women aged 30–49 (5.4 months) than for younger women aged 15–29 (3.5 months), and is also higher for women who reside in rural areas (4.1 months) than in urban areas (3.2 months). Across the regions, women in Malaita have the highest median duration of postpartum amenorrhoea (5.9 months), while Honiara has the lowest (3.0 months). Women with more than a secondary education or from the highest wealth quintile had the shortest median periods of postpartum amenorrhoea (0.7 and 2.8 months, respectively).

Slightly more young mothers aged 15–29 engage in postpartum abstinence practises than older mothers aged 30–49 (for a median of 3.1 and 2.3 months, respectively). Women with more than a secondary education or from the fourth and highest wealth quintile had the longest median periods of postpartum amenorrhoea (about 3 months, respectively). Postpartum abstinence was practiced for a median of 2.4–3.0 months across wealth quintiles and education levels.

The median duration for postpartum insusceptibility was high in rural areas (8.2 months) compared with urban areas (5.1 months), and was also found to be highest for women with no education (9.0 months) or in the middle wealth quintiles (8.9 months).

5.6 MENOPAUSE

Menopause means the natural physiological 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 associated with a decline in fertility.

Table 5.7 presents the percentage of women aged 30–49 who are menopausal at the time of survey. Out of the total women aged 30–49, 7% were menopausal. As expected, the proportion of menopausal women increases with age. Of women aged 30–34, 2% were menopausal compared with 34 of women aged 48–49.

Table 5.7: Menopause

Percentage of women aged 30–49 who are menopausal, by age, Solomon Islands 2015

Age	Percentage menopausal[1]	Number of women
30–34	2	933
35–39	1.9	803
40–41	4.8	250
42–43	6.4	230
44–45	16.5	223
46–47	15.5	154
48–49	34.2	196
Total	**6.7**	**2,788**

[1] Percentage of all women who are not pregnant and not postpartum amenorrhoeic whose last menstrual period occurred six or more months preceding the survey.

5.7 AGE AT FIRST BIRTH

Age at first birth is an important indicator for determining the level of fertility in a population. Early age of childbearing provides women the opportunity to bear more children than those women who enter childbearing at older ages. However, this can also have implications for women's educational attainment and consequent ability to make empowered and informed decisions.

Table 5.8.1 shows the percentage of women aged 15–49 who gave birth, by exact age, the percentage that have never given birth, and the median age at first birth, according to women's current age at the time of the survey.

The results show that the median age at which women aged 25–49 had their first child was 22.1 years as compared with 21.1 years reported in the SIDHS 2006–2007. A higher percentage of women aged 20–49 reported that they have never given birth (19%) compared with 11% of women aged 25–49. Of women aged 25–49, 3% gave birth at exact age 15. This increased to 32% at exact age 20, and 71% by age 25.

Table 5.8.1: Age at first births.

Percentage of women aged 15–49 who gave birth by exact ages, percentage who have never given birth, and median age at first birth, according to current age, Solomon Islands 2015

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	0.8	na	na	na	na	90.9	1,241	a
20–24	3.3	14.9	32	na	na	43.2	1,146	a
25–29	2.3	13.5	27.7	44.2	67.4	21.3	1,091	22.6
30–34	3.1	17.8	33.4	49.8	69	10.7	933	22
35–39	3	13.9	30.8	51.8	73	6.9	803	21.8
40–44	3.8	15.5	33.4	50.4	74.3	6	576	21.9
45–49	3.9	21.1	39.5	56.2	75.9	3.5	476	21.2
20–49	3.1	15.6	32	na	na	18.6	5,025	a
25–49	3	15.8	32	49.5	71	11.3	3,879	22.1

na = not applicable due to censoring.

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

Table 5.8.2 shows the median age at first birth among women aged 25–49, according to their background characteristics. Rural women had their first birth at the median age of 21.7 compared with women in urban areas who delayed childbearing until a median age of 23.3. A higher median age was identified for woman residing in Honiara (23.7 years) than for women in the other regions.

Table 5.8.2: Median age at first birth

Median age at first birth among women aged 20–49 (25–49) years, according to background characteristics, Solomon Islands 2015

Background characteristic	Women aged 20–49	Women aged 25–49
Residence		
Urban	a	23.3
Rural	a	21.7
Region		
Honiara	a	23.7
Guadalcanal	a	21.8
Malaita	a	22
Western	a	21.8
Other provinces	a	21.8
Education		
No education	a	21.2
Primary	a	21.1
Secondary	a	22.9
More than secondary	a	a
Missing	a	a
Wealth quintile		
Lowest	a	21
Second	a	21.7
Middle	a	21.6
Fourth	a	22.2
Highest	a	23.6
Total	**a**	**22.1**

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

Median age at first birth increases with a woman's level of education and wealth quintile. Women's median age at first birth increased from 21.2 for women with no education to 22.9 for women with a secondary level education. Similarly, women in the lowest wealth quintile had a median age at first birth of 21.0, compared to 23.6 for women in the highest wealth quintile.

5.8 TEENAGE PREGNANCY AND MOTHERHOOD

Teenage pregnancy and motherhood refers 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 sexually 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 5.9 shows the percentage of women aged 15–19 who have had a live birth or who are pregnant with their first child, and the percentage of women who have begun childbearing, by background characteristics. The percentage of women who have begun childbearing is the combination of those who had a live birth and those who were pregnant with their first child at the time of the survey.

Table 5.9: 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 percentage who have begun childbearing, by background characteristics, Solomon Islands 2015

Background characteristic	Percentage of women aged 15–19 who:		Percentage who have begun childbearing	Number of women
	Have had a live birth	Are pregnant with first child		
Age				
15	0.6	0	0.6	299
16	1.8	2.8	4.6	248
17	8.6	1.7	10.3	222
18	15.7	4.3	20	224
19	21	7.7	28.7	248
Residence				
Urban	7.5	2.2	9.7	271
Rural	9.5	3.4	12.9	970
Region				
Honiara	6.6	2.6	9.2	173
Guadalcanal	9.3	1	10.3	226
Malaita	10	1.9	11.8	336
Western	11.5	4.9	16.4	187
Other provinces	7.9	5.4	13.2	319
Education				
No education	32.1	0	32.1	30
Primary	10.9	2.1	12.9	503
Secondary	6.8	4.1	11	705
More than secondary	*	*	*	2
Wealth quintile				
Lowest	9.9	5.2	15	221
Second	12.1	4	16.1	254
Middle	8.9	3.4	12.3	233
Fourth	8.1	1	9.1	226
Highest	6.8	2.5	9.3	306
Total	**9.1**	**3.2**	**12.3**	**1,241**

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

In Solomon Islands, 12% of women aged 15–19 have begun childbearing, with 9% of women having had a live birth and 3% pregnant with their first child. The percentage of young women who have begun child bearing has slowly declined for women aged 15 (7%) and women aged 17 (11%) in the SIDHS 2006–2007 compared with 0.6% of women aged 15, and 10% of women aged 17 according to the SIDHS 2015.

More adolescent women who have begun childbearing reside in rural areas (13%) than in urban areas (10%). Across the regions, 16% of adolescent women from Western Province have begun childbearing earlier than 9% of young women in Honiara.

The percentage of women who had begun childbearing at ages 15–19 decreased with level of education, from 32% of those with no education, to 7% of those with secondary education. Similarly, the proportion of young women who had begun childbearing was lowest in the two highest wealth quintiles (9% for the highest quintile and the fourth) compared with women in the lowest two wealth quintiles (15% for the lowest quintile, 16% for the second).

CHAPTER 6 FERTILITY PREFERENCE

by Baakai Kamoriki, Chief Medical Statistician, SIMoHMS

KEY FINDINGS

- The desire for more children for both currently married women and men diminishes as the number of living children increases.
- A higher proportion of those men and women desiring to limit childbearing are rural dwellers rather than urban dwellers.
- Women with little education are more likely to want to limit childbearing.
- Women in Western, Malaita and other provinces are less likely to meet their desire to limit their family size than women in Honiara and Guadalcanal.
- The proportion of women who wish to limit their childbearing is higher in the middle and lower wealth quintiles.
- The mean ideal number of children in Solomon Islands for all women aged 15–49 is 3.2 children, and is 3.3 children for men in the same age group. The mean ideal number of children increases with women's age.
- About 20% of births in the five years preceding the survey were mistimed, while one in every ten births were unwanted births, a decrease from one in four from the SIDHS 2006–2007.
- There is a gap of 1.0 births between wanted fertility and the actual fertility rate, compared with 1.3 found in the SIDHS 2006–2007. This implies that if all women are able to achieve their reproductive intentions, then the total fertility rate in Solomon Islands would be 3.4 children instead of the actual fertility rate of 4.4 children per woman.

INTRODUCTION

This chapter addresses a number of questions asked in the SIDHS 2015 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 were 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 SIDHS 2015 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 SIDHS 2015 also included questions that elicited information on men's fertility preferences.

6.1 DESIRE FOR MORE CHILDREN

Data on the desire for more children can provide an indication of future reproductive behaviour that requires family planning services that are available, affordable, and accessible in order for people to realise their fertility preferences.

Table 6.1 presents the distribution of currently married women and men aged 15–49 by desire for children according to the number of living children. Overall, 36% of currently married women and currently married men want no more children, while 22% of currently married women and 29% of current married men want to delay the next birth of a child by two years or more after the birth of the current baby. A further 11% of currently married women and 15% of currently married men want to have another child soon.

Table 6.1: Fertility preferences by number of living children

Percent distribution of currently married women and currently married men aged 15–49 by desire for children, according to number of living children, Solomon Islands 2015

Desire for children	Number of living children[1]								
	0	1	2	3	4	5	6+	Total 15–49	Total 15+
WOMEN									
Have another soon[2]	48.9	15.2	10.6	8.3	3.8	2.5	1.1	10.7	na
Have another later[3]	19.2	52.1	34.7	22.3	8.2	4.9	0.9	21.5	na
Have another, undecided when	3.2	3.2	2.2	1.7	1.5	0.6	0.4	1.8	na
Undecided	9.4	16.1	19.2	17.5	11.4	11.4	6.6	13.7	na
Want no more	1.5	6.8	24.5	38.4	53.8	54.1	61.9	35.7	na
Sterilised[4]	0	0.5	3.6	6.5	15.9	19.7	21	9.6	na
Declared infecund	16.3	4.4	3.5	2.7	2.5	5.3	5.4	4.9	na
Missing	1.4	1.6	1.7	2.6	2.9	1.6	2.7	2.1	na
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**na**
Number	335	613	730	731	619	450	608	4,086	na
MEN									
Have another soon[2]	46.7	25	12.7	12.9	6.9	1.9	3.1	15.1	11.5
Have another later[3]	16.4	55.1	44.6	29.9	12.6	10.8	2.6	28.8	21.4
Have another, undecided when	9.2	5.3	5	3.8	3.2	1.7	1.8	4.3	3.3
Undecided	5.9	4.3	9.1	10.6	12.3	6.8	7.7	8.2	6.5
Want no more	3.9	7	25.4	40.4	55	67.7	69.8	36.2	44.4
Sterilised[4]	1.4	0.8	1.2	1.2	7.8	8.7	10.3	3.8	5.2
Declared infecund	15.1	1.7	1.3	0.4	1.1	1.1	3.3	2.7	6.7
Missing	1.4	0.7	0.7	0.9	1.1	1.3	1.5	1	1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number	149	300	328	303	210	152	210	1,652	2,237

na=not applicable

[1] The number of living children includes the current pregnancy

[2] Wants next birth within two years

[3] Wants to delay next birth for two or more years

[4] Includes both female and male sterilisation

[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).

The table also shows that sterilisation among both currently married women and currently married men is somewhat low, accounting for only 10% of women and 4% of men. Additionally, the proportion of those declared infecund among the same age group is also low, accounting for 5% of women and 3% of men. This result clearly indicates that fertility among currently married women and currently married men in Solomon Islands is very high.

Figure 6.1 shows the percentage of currently married women and currently married men aged 15–49 who want to have another child soon after the birth of their youngest living child. The desire to have another child soon is highest among both women and men who do not have any living children (49% of women, 47% of men) and declines as the number of living children increases (1% of women with six or more children, and 3% of men with six or more children). Correspondingly, the proportion of men and women who want no more children increases with the number of living children they have, from 2% of women and 4% of men without living children, to 62% of women and 70% of men with six or more children. This indicates that there is a close link between the desire to have another child soon and the number of living children.

Figure 6.1 also shows that the desire to have another child soon is slightly higher among men except where a woman does not have any living children or has five children.

Figure 6.1: Percent distribution of currently married women and men aged 15–49 who desire to have another child soon, Solomon Islands 2015

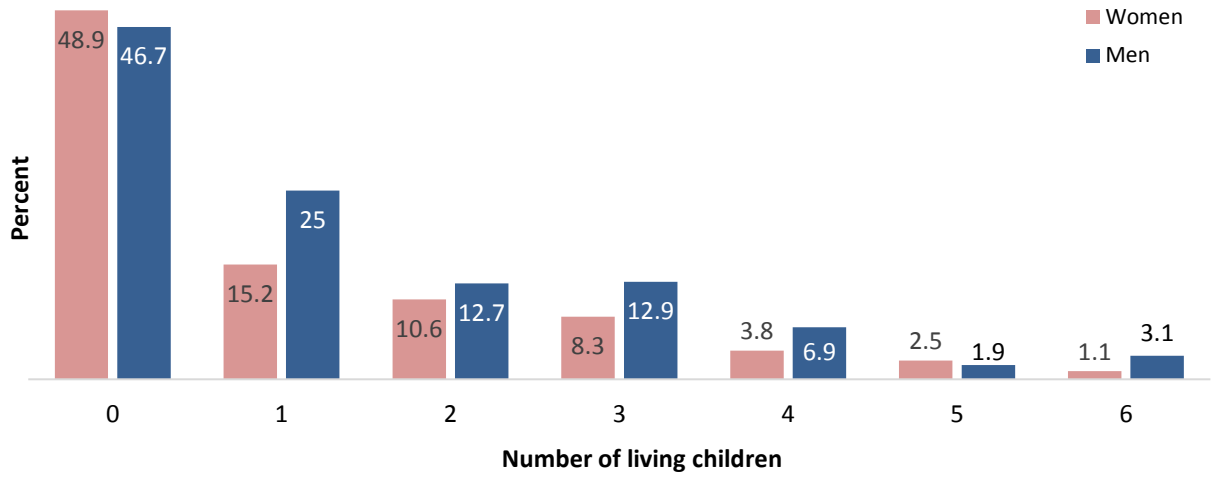
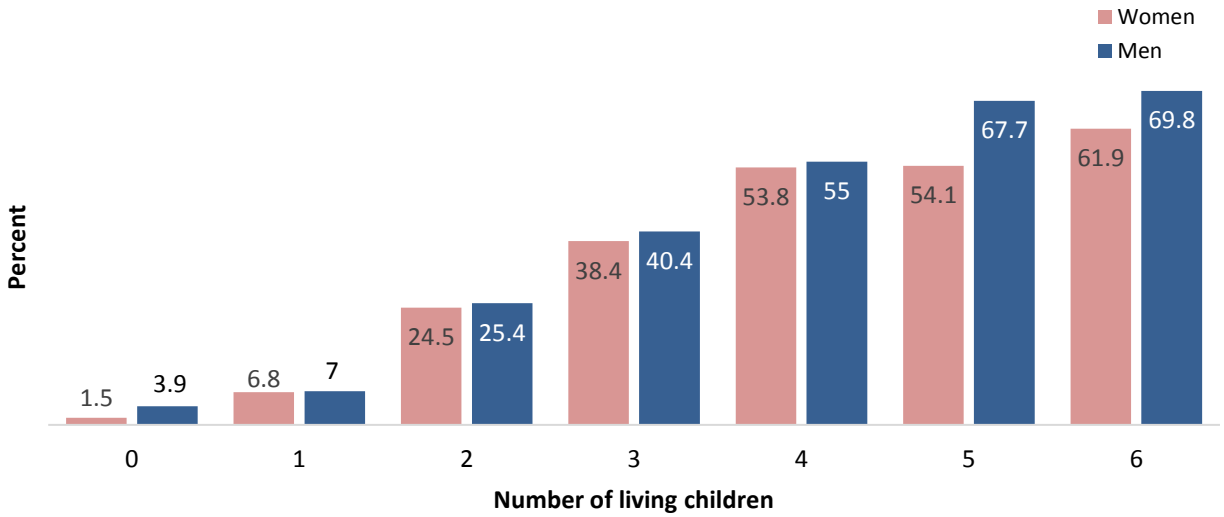


Figure 6.2: Percent distribution of currently married women and men aged 15–49 who want no more children, Solomon Islands 2015



6.2 DESIRE TO LIMIT CHILDBEARING BY BACKGROUND CHARACTERISTICS

Tables 6.2.1 and 6.2.2 present the percentage of currently married women and currently married men aged 15–49 who want no more children by the number of living children and their background characteristics. The tables indicate that about 45% of women and 40% of men do not want more children.

The tables also reveal that the desire to have no more children is highest among rural dwellers as opposed to urban dwellers (see also Fig. 6.3). For women in rural areas, 47% do not want more children, compared with 41% of women in urban areas. A similar pattern was observed for men, whereby 41% of men in rural areas and 37% of men in urban areas do not want more children).

Of all of the regions, the proportion of women who desire to have no more children is highest in Western Province at 49%, followed by other province at 48%, Malaita at 47% and Honiara at 41%. Guadalcanal demonstrated the lowest proportion of women wanting no more children (39%).

Table 6.2.1: 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 2015

Background characteristic	Number of living children[1]							Total
	0	1	2	3	4	5	6+	
Residence								
Urban	1.2	8.7	35.1	46.4	73	72.2	85.6	40.7
Rural	1.6	6.8	26	44.6	69.1	74.1	82.5	46.5
Region								
Honiara	1.2	9	38.2	50.8	71	74.6	84.7	41.2
Guadalcanal	0.7	3.2	22.6	39.9	61.2	63.9	74.8	38.5
Malaita	3.2	9	23.2	46.5	72.2	74.5	81.9	47.4
Western	2.1	6.8	34.6	53.8	71.5	72.4	90.1	48.8
Other provinces	0	8.2	28.4	40.5	71.2	78.6	87.7	48
Education								
No education	0	18.7	22.7	39.9	55.5	73.7	81.6	53.2
Primary	3.9	8.9	31.4	44.7	73	74.3	81.4	52.7
Secondary	0	5.1	23.4	45.3	70.2	72.1	91.4	32.7
More than secondary	0	4.6	39.3	50.4	70	71.3	90.3	38.6
Wealth quintile								
Lowest	0	8.7	26.8	37.1	54.7	71.1	81.1	45.5
Second	3.3	8.9	19.2	45.3	73.3	71.6	84.5	47.6
Middle	1.1	5.1	30.4	50.9	75.1	80.4	84.2	49.1
Fourth	3.3	5.4	27.9	42.6	73.1	72.9	78.6	42.7
Highest	0.4	8.5	34.4	48.1	74.4	73.8	88	41.7
Total	**1.5**	**7.3**	**28.1**	**44.9**	**69.7**	**73.8**	**82.9**	**45.3**

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

[1] The number of living children includes the current pregnancy.

A similar pattern in the provinces was observed among currently married men aged 15–49 who also wanted no more children. Western Province had the highest proportion of men wanting no more children (46%), followed by Malaita (41%), other provinces (40%), Guadalcanal (39%) and Honiara (33%).

Table 6.2.2: Desire to limit childbearing – Men

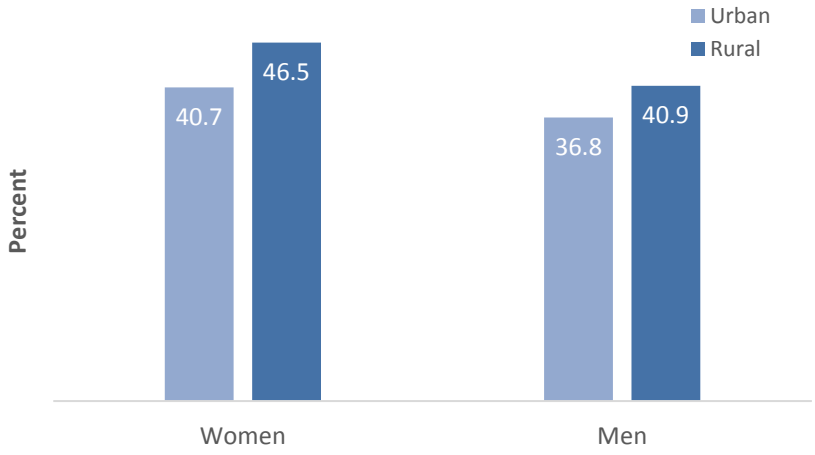
Percentage of currently married men age 15–49 who want no more children, by number of living children, according to background characteristics, Solomon Islands 2015

Background characteristic	Number of living children[1]							Total
	0	1	2	3	4	5	6+	
Residence								
Urban	3.5	6.7	26.5	48.5	63	82	77.8	36.8
Rural	5.9	8.2	26.6	39.8	62.7	74.8	80.5	40.9
Region								
Honiara	3.3	2.5	19.8	47.5	57.1	83.5	80.1	32.6
Guadalcanal	9.8	9.3	19	48.8	59.6	83	74.8	39.2
Malaita	0	6.3	27.7	36.2	59.1	80.4	80.6	40.7
Western	7.1	12.2	34.1	47.7	60.3	91.5	90.1	46.3
Other provinces	6.8	9.8	30.4	35	71.1	57	79.2	40.3
Education								
No education	0	0	30.3	22.9	78	84.6	63	47.7
Primary	7.3	13	35.3	45.9	63.7	74.5	84.1	49.3
Secondary	5.9	5.4	21.4	39.6	64.8	72.3	73.4	30.4
More than secondary	0	5.2	22.3	37.4	49.4	89.3	83.1	37.2
Wealth quintile								
Lowest	4.9	7.8	24.6	38.1	73.1	53.9	82.6	42.4
Second	0	7.3	29	48.4	65.2	74.4	72.5	42.1
Middle	10	7.4	27.1	34.9	59.2	84.4	89	40.1
Fourth	2.5	6.8	22.9	34	52.4	82.1	82.2	36.9
Highest	6.5	9.4	28.7	49.9	64.8	84.4	74.1	38.9
Total 15–49	**5.2**	**7.8**	**26.6**	**41.6**	**62.7**	**76.4**	**80.1**	**40**
50+	60.6	43.9	70.9	71.5	76.8	85.5	76.6	76.5
Total	**7.6**	**9.4**	**29.6**	**45.4**	**67.1**	**80**	**78**	**49.5**

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

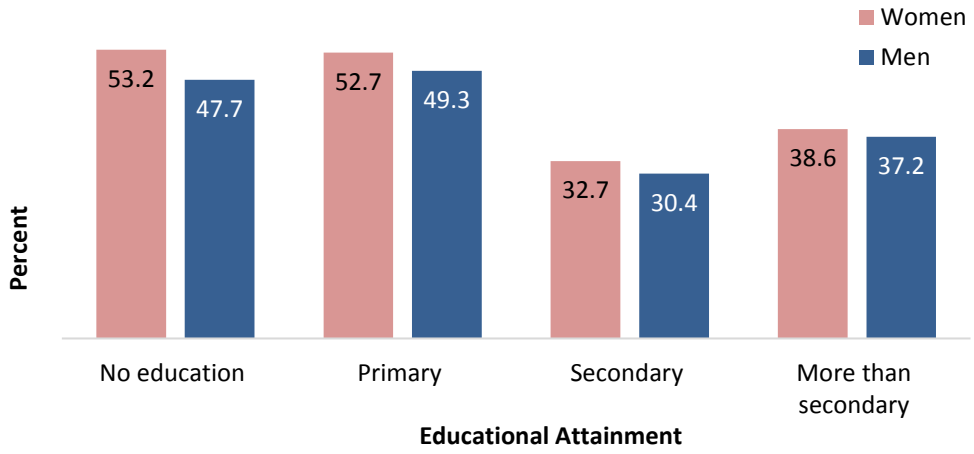
[1] The number of living children includes one additional child if respondent's wife is pregnant (or if any wife is pregnant for men with more than one current wife).

Figure 6.3: Percent distribution of currently married women and currently married men aged 15–49 who want no more children, by residence, Solomon Islands 2015



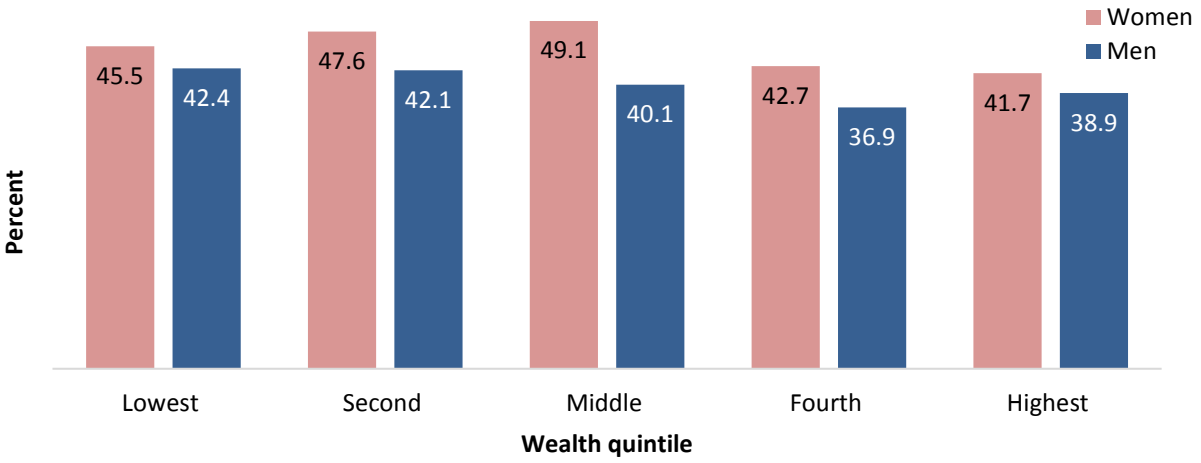
The desire to limit childbearing can also be affected by the level of educational attainment of both sexes. The proportion of both currently married women and currently married men aged 15–49 not wanting any more children is high among those with less education than those with a secondary and higher level of education. Slightly higher proportions of women wanted no more children than men at all education levels.

Figure 6.4: Percent distribution of currently married women and currently married men aged 15–49 who do not want any more child by education level, Solomon Islands 2015



The desire to limit the total number of children can also be influenced by the wealth status of both sexes. As with education level, higher proportions of women and men in the lower wealth quintiles do not want more children compared with women and men in the higher wealth quintiles. Across wealth quintiles, slightly more women than men do not want more children.

Figure 6.5: Percent distribution of currently married women and currently married men aged 15–49 who want no more children by wealth quintile, Solomon Islands 2015



6.3 IDEAL FAMILY SIZE

The SIDHS 2015 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 6.3.1 presents the percentage of currently married women and currently married men aged 15–49 with their preferred number of children.

Ideally the average number of children desired by all women and men aged 15–49 is very similar, 3.2 children for women and 3.3 children for men. This increases with the number of living children. The mean ideal number of children was slightly higher for married women and married men, increasing to 3.6 children for married women and 3.7 children for married men. The largest proportion of married women (32%) and married men (31%) listed 4.0 as the ideal number of children. A further 26% of women and 21% of men preferred two children, while 15% of women and 20% of men preferred 3.0 as an ideal number of children. This shows that most married couples in Solomon Islands would preferred to have two to four children. It is interesting to note that this pattern has not changed much from the last SIDHS in 2006–2007.

Table 6.3.1: Ideal number of children by number of living children

Percent distribution of women and men aged 15–49 by ideal number of children, and mean ideal number of children for all respondents and for currently married respondents, according to the number of living children, Solomon Islands 2015

Ideal number of children	Number of living children							Total
	0	1	2	3	4	5	6+	
WOMEN								
0	13.2	4.2	2.4	2.6	2.2	2.4	3.2	6.1
1	3.8	7.5	1.4	1.4	1.5	0.7	0.2	2.9
2	40.2	41.1	32.3	12.2	7.3	3.8	4.7	25.8
3	15.7	19.3	18.6	24.9	6.8	10.4	5.2	15.3
4	16.1	20.1	39.2	46	63.7	35	33.5	31.8
5	2.4	2.3	2.8	7.7	8.8	28.3	11.4	6.7
6+	1	0.9	1.2	2.7	4.8	14.3	31.4	5.7
Non-numeric responses	7.6	4.5	2.2	2.5	4.9	5.2	10.4	5.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number	**1,981**	**877**	**832**	**788**	**675**	**479**	**634**	**6,266**
Mean ideal number of children for[2]								
All	2.3	2.6	3.1	3.5	3.8	4.3	4.7	3.2
Number	1,830	837	814	768	642	455	568	5,914
Currently married	2.6	2.7	3.1	3.5	3.9	4.3	4.7	3.6
Number of currently married	321	600	718	714	588	427	547	3,916
Mean ideal number of children for men aged 15+[2]								
All men	-	-	-	-	-	-	-	-
Number of men	0	0	0	0	0	0	0	0
Currently married men	-	-	-	-	-	-	-	-
Number of currently married men	0	0	0	0	0	0	0	0
MEN								
0	10.2	3.5	3.2	2.1	4.4	7	11	7.2
1	1.7	3	1	0.4	0	0	0.6	1.3
2	28.1	34.6	19	8.6	6.5	3.4	1.6	21
3	20.6	23.7	25.5	25.7	8.6	10.2	4.7	19.5
4	23.8	26.3	39.8	47.5	50.1	27.6	26.9	30.8
5	7.3	5.7	7.1	10.1	15.6	31.6	9.8	9.4
6+	4.2	1.7	2.6	4.3	12.4	19	42.4	7.9
Non-numeric responses	4	1.4	1.8	1.3	2.2	1.2	3	2.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number	**1,380**	**341**	**341**	**309**	**214**	**153**	**210**	**2,948**
Mean ideal number of children for[2]								
All	2.9	2.9	3.3	3.7	4	4.3	4.8	3.3
Number	1,324	336	335	305	209	152	204	2,865
Currently married	2.9	3	3.3	3.7	4	4.3	4.8	3.7
Number of currently married	146	296	324	299	205	150	204	1,623
Mean ideal number of children for men aged 15+[2]								
All men	2.9	2.9	3.3	3.7	4.1	4.4	5.2	3.6
Number of men	1,348	356	362	347	304	257	491	3,467
Currently married men	3	2.9	3.3	3.7	4.1	4.5	5.2	3.9
Number of currently married men	152	310	348	337	296	250	477	2,171

[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).

Figure 6.6: Percent distribution of currently married women and currently married men aged 15–49 by ideal number of children, and by wealth quintile, Solomon Islands 2015

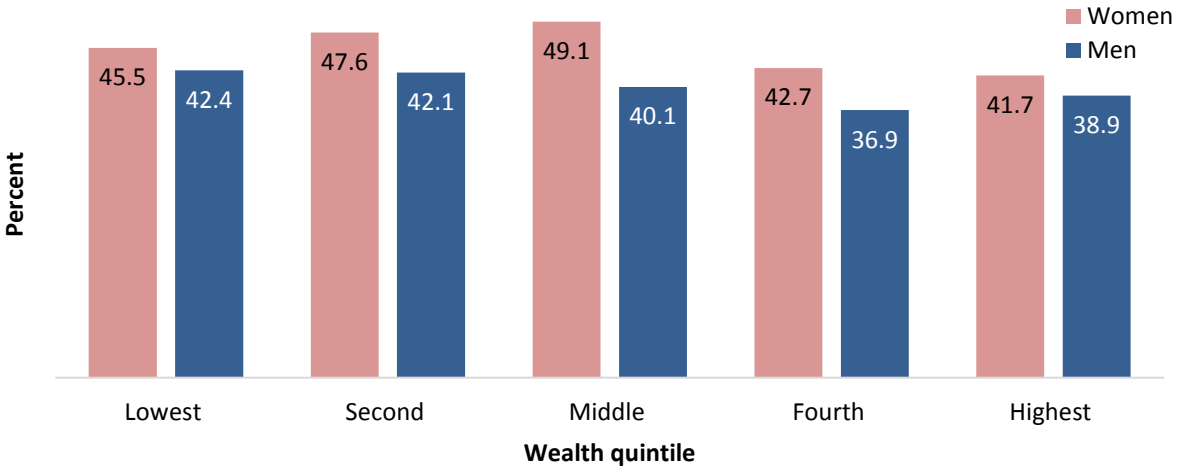
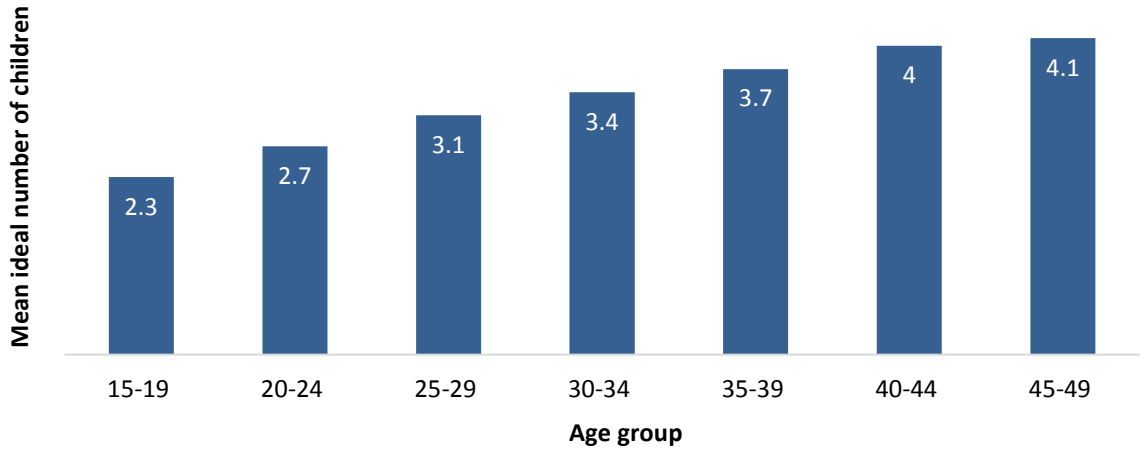


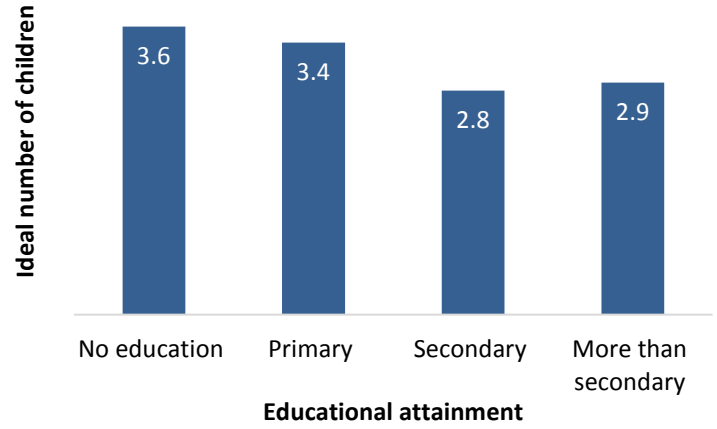
Table 6.3.2 presents the mean ideal number of children for all women aged 15–49 by background characteristics. As shown, the overall mean ideal number of children for women aged 15–49 is 3.2. The mean ideal number of children increases with the age of a woman, going from 2.3 for women aged 15–19 to 4.1 for women aged 45–49 (Fig. 6.7).

Figure 6.7: Mean ideal number of children by all women aged 15–49, Solomon Islands 2015



The mean ideal number of children is lower among women living in urban areas (2.6 children) than for women residing in rural areas (3.3 children) (Fig. 6.8).

Figure 6.8: Mean ideal number of children by all women aged 15–49 by educational attainment, Solomon Islands 2015



Among the regions, women in Malaita had the highest mean ideal number of children (3.4), particularly when compared with Honiara, which had the lowest (2.5).

The mean ideal number of children declines as the educational attainment of a woman increases, going from 3.6 children for women with no education to 2.8 children for women with a secondary education and 2.9 for women with more than a secondary education. This may suggest that education can also influence the fertility preference of women (see Fig. 6.9).

Table 6.3.2: Mean ideal number of children

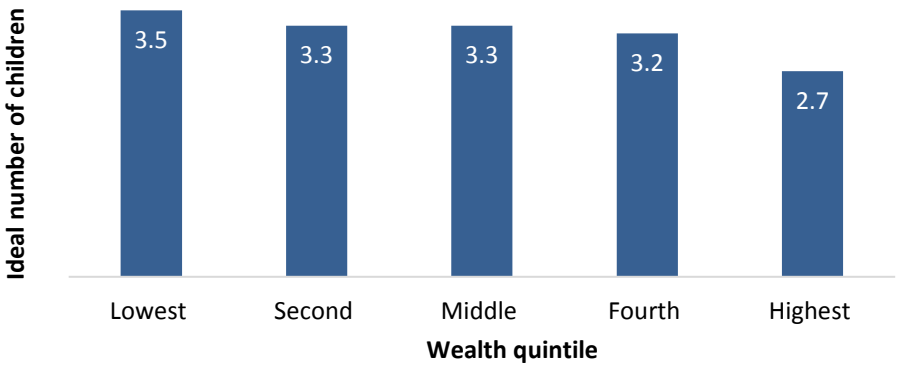
Mean ideal number of children for all women age 15–49 by background characteristics, Solomon Islands 2015

Background characteristic	Mean	Number of women[1]
Age		
15–19	2.3	1,133
20–24	2.7	1,096
25–29	3.1	1,057
30–34	3.4	889
35–39	3.7	762
40–44	4	546
45–49	4.1	431
Residence		
Urban	2.6	1,353
Rural	3.3	4,561
Region		
Honiara	2.5	881
Guadalcanal	3.1	1,052
Malaita	3.4	1,530
Western	3.1	880
Other provinces	3.3	1,571
Education		
No education	3.6	530
Primary	3.4	2,623
Secondary	2.8	2,382
More than secondary	2.9	380
Wealth quintile		
Lowest	3.5	1,076
Second	3.3	1,103
Middle	3.3	1,158
Fourth	3.2	1,197
Highest	2.7	1,379
Total	**3.2**	**5,914**

[1] Number of women who gave a numeric response

The mean ideal number of children declines as women's wealth status increases. Women in the lowest wealth quintile had a mean desire for 3.5 children, which did not vary greatly across the second to fourth quintiles, but decreased noticeably to 2.7 children for women in the highest wealth quintile.

Figure 6.9: Mean ideal number of children for all women aged 15–49 by wealth quintile, Solomon Islands 2015



6.4 FERTILITY FAMILY STATUS

To measure the level of unwanted fertility during the SIDHS 2015, 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 that respondents were able 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.

Table 6.4 and Figure 6.10 shows the percent distribution of births to women aged 15–49 in the five years preceding the survey (including current pregnancy) by planning status of the birth according to birth order and mother's age at birth.

In general, more than two-thirds of births to women aged 15–49 in the five years preceding the survey were wanted at the time of birth (67%), 20% of births were wanted but at a later time, and 12% were not wanted or planned at all.

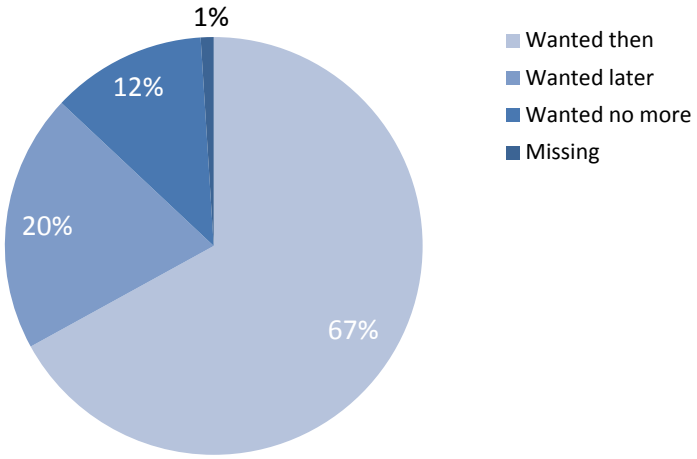
Table 6.4: Fertility planning status

Percent distribution of births to women aged 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 2015

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	71.3	20.4	7.8	0.5	100	1,147
2	69.3	21.5	8.5	0.7	100	988
3	66.2	21.1	11.4	1.3	100	801
4+	61.9	18.8	18.6	0.7	100	1,582
Mother's age at birth						
<20	66.5	23.6	9.4	0.5	100	505
20–24	66.5	22.7	10.1	0.7	100	1,265
25–29	69.3	20.1	9.8	0.9	100	1,256
30–34	65.1	19.9	14.3	0.7	100	829
35–39	64.6	14.5	19.6	1.3	100	508
40–44	62	10.3	27.3	0.5	100	143
45–49	*	*	*	*	*	14
Total	**66.7**	**20.2**	**12.4**	**0.8**	**100**	**4,519**

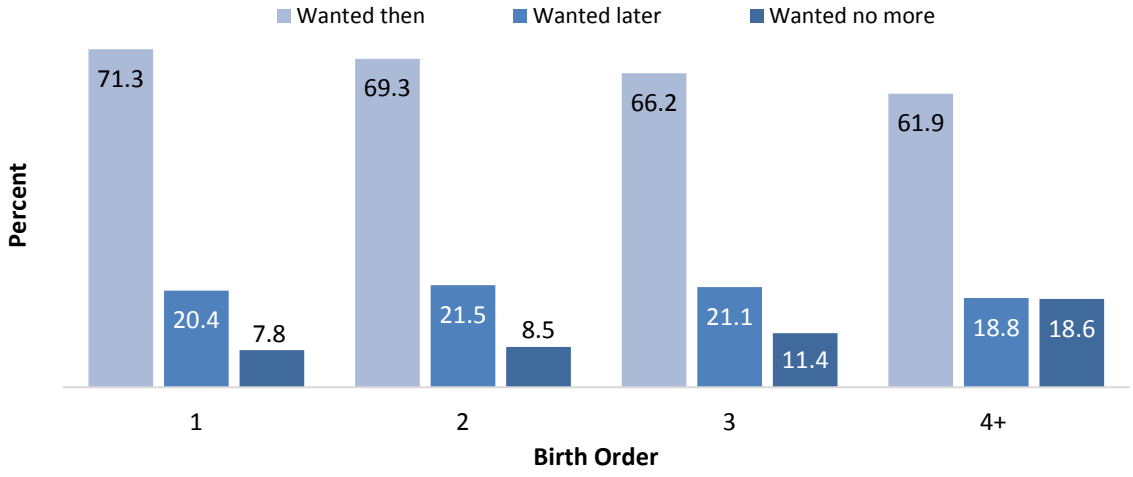
Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Figure 6.10: Percent distribution of births to women aged 15–49 in the five years preceding the survey by planning status, Solomon Islands 2015



Looking at fertility planning status by birth order and age of the mother at birth, the data show that the proportion of wanted births is highest in birth order 1, with the proportion decreasing as birth order increases (Figs. 6.11). Of all first births (birth order 1), 71% were wanted then, while 62% of all fourth or more births (birth order 4+) were wanted then. The proportion of mistimed births was reasonably consistent across birth order, ranging from 22% to 19%. However, births that occurred when no more children were planned increased with birth order, from 8% of first births to 19% of all fourth and more births. This indicates that wanted births diminish with increased number of children, and highlights the need for birth spacing and limiting options. About 19% of all fourth and or more births were not wanted.

Figure 6.11: Percent distribution of births to women aged 15–49 by planning status and by birth order, Solomon Islands 2015



By age of mother, the percent distribution of 'wanted then' births was highest among women aged 25–29 (69%). The proportion of births that were wanted later decreased steadily with age, just as the proportion of births women did not want increased. Births that were wanted later decreased from 24% of births to women under age 20, to 10% of births to women aged 40–44.

6.5 WANTED FERTILITY RATE

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 the extent to which women were able to achieve 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 6.5. The data reveal that if all unwanted births are eliminated, the total fertility rate in Solomon Islands would be 3.4 children per woman instead of the actual total fertility rate of 4.4 children per woman.

Considerable variation is observed in the actual and wanted fertility rate by background characteristics. The gap between actual and wanted fertility rates is slightly higher in rural areas (1.1) than in urban areas (0.9), implying that women residing in urban areas are more likely to achieve their desired family size than women living in rural areas.

Variations are also observed in the fertility gaps among the regions. Malaita Province demonstrated the biggest gap between its actual fertility rate and desired fertility rate (1.2), while Western Province demonstrated the lowest (0.7). Honiara had the lowest total wanted fertility rate of all regions and the only wanted fertility rate below 3 (2.3), in contrast to other provinces, which had the highest (3.8).

Table 6.5: Wanted fertility rates

Total wanted fertility rate and total fertility rate for the three years preceding the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Total wanted fertility rate	Total fertility rate
Residence		
Urban	2.5	3.4
Rural	3.6	4.7
Region		
Honiara	2.3	3.3
Guadalcanal	3.5	4.6
Malaita	3.4	4.6
Western	3.7	4.4
Other provinces	3.8	4.8
Education		
No education	3.5	4.7
Primary	3.6	4.9
Secondary	3.4	4.3
More than secondary	2.3	3.1
Wealth quintile		
Lowest	4.0	5.7
Second	4.0	5.1
Middle	3.3	4.4
Fourth	3.4	4.0
Highest	2.4	3.2
Total	**3.4**	**4.4**

Note: Rates are calculated based on births to women aged 15–49 in the 36 months preceding the survey. The total fertility rates are the same as those presented in Table 5.2.

In terms of educational attainment, the gap between the total wanted fertility rate and the total fertility rate is highest among women with less education (1.2–1.3) in contrast to women with more education (0.8–0.9).

This suggests that women with more education are more likely to achieve their desired family size as opposed to women with less education.

The results also indicate that wealth has a significant impact on a woman's ability to achieve her desired family size, with the gap between wanted and total fertility rates being twice as large for women in the lowest wealth quintile (1.7) as for women in the highest wealth quintile (0.8). Women in the highest two wealth quintiles were close to meeting their wanted fertility rates (0.6 and 0.8).

CHAPTER 7 FAMILY PLANNING

by Nancy Pego, National Adolescent Health and Development Program Coordinator, SIMoHMS; Anterlyn Tuzakana, Senior Statistician, SINSO; Kaobari Matikarai, Census and Survey Technical Officer, SPC

KEY FINDINGS

- Knowledge of contraception is almost universal in Solomon Islands, with 94% of women and 98% of men knowing at least one method.
- The reported contraceptive prevalence rate of currently married women is 29%, a decline of about 17% from the contraceptive prevalence rate recorded in the SIDHS 2006–2007 (35%).
- Female sterilisation and injectable contraceptives are the most popular modern contraceptive methods, used by 9% and 8%, respectively, of currently married women. The rhythm method is used by less than 3% of women.
- The public sector is the main provider of contraceptive methods with the national referral hospital, provincial health centres and rural health centres leading providers catering for the need of over two-thirds (68%) of modern contraceptive users aged 15–49.
- One in five women aged 15–49 years (20%) discontinued an episode of contraception within 12 months of starting; 5% of these women discontinued using contraception because of side effects and health concerns.
- About 35% of currently married women aged 15–49 have an unmet need for family planning, with 20% having unmet need for spacing and 15% having an unmet need for limiting. This was even higher for sexually active unmarried women (83%).

Most men and women aged 15–49 had not been exposed to family planning messages via radio, television or newspaper and/or magazine (59% of men, 69% of women).

INTRODUCTION

Family planning is recognised as a national priority, as reported in the 2016–2020 Solomon Islands Strategic Health Plan, and is also reflected in the National Reproductive and Child Health Strategic Plan 2016–2020.

One of the key results areas of the Reproductive Child Health and Nutrition Strategy 2016–2020 is family health, and the strategy's goal is to reduce unintended pregnancy by providing family planning services and information.

Family planning is a priority agenda for Solomon Islands because it not only benefits health but contributes to global education, gives power to women, prevents sexually transmitted infections (STIs) and HIV especially though condom usage, reduces poverty, and aids in environmental sustainability. Family planning and reproductive health includes:

- improving health worker counselling skills to discuss sexual health issues, including family planning with men, women and young people;
- improving the 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 Reproductive and Child Health National Strategic Plan 2015–2020, which was merged from the National Health Strategic Plan, recognises the right of everyone to have knowledge about, and access to, contraceptives of their choice. Improving access to and knowledge of family planning 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 in order to plan the number and spacing of their children. National Family Planning Guidelines have been updated, and service providers in all provinces are trained in various methods of contraception and in how to

optimise all opportunities to promote family planning for each individual. Non-governmental organisations and churches have been encouraged to play a more effective role in family planning.

This chapter presents the SIDHS 2015 findings on contraceptive knowledge; current, past and future use of contraception; and attitudes pertaining to contraception. Data are also presented on exposure to family planning messages through the media, sources and costs of contraception, and contact with family planning providers. Although the focus here is on women, some results from the men's survey are also presented because men play an important role in realising women's reproductive goals.

The information is particularly useful for policy-makers, programme managers, and researchers in population and family planning, and provides a means of assessing the success of Solomon Islands' family planning programme. One of the important indicators resulting from this survey is the percentage of currently married women, aged 15–49, who are currently using any method of contraception (referred to as the contraceptive prevalence rate, or CPR).

7.1 KNOWLEDGE OF CONTRACEPTIVE METHODS

One of the major objectives of the SIDHS 2015 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 in a better position 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 their 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 (IUD), injectable contraceptives, implants, male condom, female condom, lactational amenorrhea and emergency contraceptives. Traditional methods included rhythm method (periodic abstinence) and withdrawal method.

Table 7.1 presents information about knowledge of contraceptive methods for all women and men as well as for currently married and sexually active, unmarried women and men. Findings from the SIDHS 2015 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 women aged 15–49 are: male condoms (90%), injectable contraceptives (87%), female sterilisation (85%), contraceptive pill (79%), and male sterilisation (74%). Over 51% of women have heard of implants, 68% have heard of the IUD, and 34% have heard of emergency contraception. This pattern is similar for all currently married and sexually active unmarried men aged 15–49, 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 the IUD, injectable contraceptives and pills.

Effective use of the lactational amenorrhoea method (LAM) means that a woman is exclusively or predominantly breastfeeding, is less than six months postpartum, is postpartum amenorrhoeic, and knows another contraceptive method when any of the previous criteria do not hold. LAM was reported as one of the least known methods for all groups of married and unmarried females and males, with sexually active unmarried males having the least knowledge (24%); this is an improvement from 6% from the SIDHS 2006–2007.

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 82% to 88%. Reported knowledge of traditional methods is very similar among men (81–88%). 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. Of the traditional methods reported, withdrawal is the most common method known.

In contrast to the SIDHS 2006–2007, married women are more likely to have heard of each different type of contraception than sexually active unmarried women, with the exception of female condoms. Married women know a mean of 9.3 methods of contraception, while sexually active unmarried women know a mean of 8.4 methods. This was an increase from 6.6 and 7.0, respectively, since the SIDHS 2006–2007. The same is true for men. More married men have heard of each different method of contraception than single sexually active

men, with the exceptions of male and female condoms and withdrawal. Married men know a mean of 8.5 methods while sexually active unmarried men knew a mean of 7.7. This was also an increase from 7.5 and 5.9, respectively, from the SIDHS 2006–2007.

Table 7.1: Knowledge of contraceptive methods

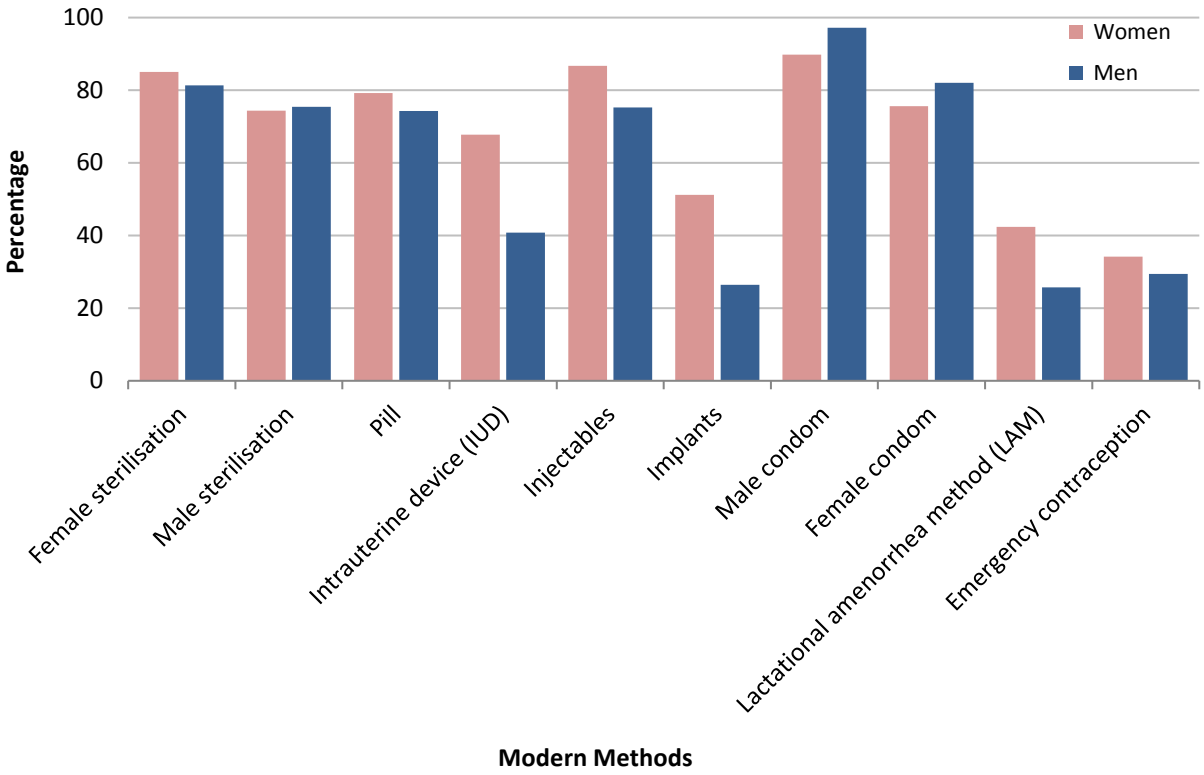
Percentage of all respondents, currently married respondents and sexually active unmarried respondents aged 15–49 who know any contraceptive method, by specific method, Solomon Islands 2015

	Women			Men		
Method	All women	Currently married women	Sexually active unmarried women[1]	All men	Currently married men	Sexually active unmarried men[1]
Any method	**94.1**	**97**	**96.4**	**98.1**	**99.2**	**99.6**
Any modern method	**93.8**	**96.7**	**96.1**	**97.9**	**99.1**	**99.6**
Female sterilisation	85	90.8	86.6	81.3	88.5	82.6
Male sterilisation	74.4	82.6	68.6	75.4	83.5	77.5
Pill	79.2	86.5	78.3	74.3	83.1	76.9
Intrauterine device (IUD)	67.8	77.6	65.7	40.8	50.5	37.4
Injectables	86.7	92.9	84.1	75.3	86	70
Implants	51.2	58.6	45.5	26.4	33.4	24.9
Male condom	89.8	93.6	91.8	97.2	98.3	99
Female condom	75.6	79.7	83.1	82	85.5	86.3
Lactational amenorrhea method (LAM)	42.4	50.5	36.4	25.7	33.2	24
Emergency contraception	34.2	38.1	36.5	29.4	35.1	30.7
Any traditional method	**81.8**	**88.4**	**83.8**	**80.5**	**88**	**88.4**
Rhythm	68.6	75.2	69.1	57.8	66.5	62.9
Withdrawal	73.2	81.3	76.2	76.4	84.1	86
Other	20.2	21.8	17.3	19.2	22.6	12.3
Mean number of methods known by respondents 15–49	8.5	9.3	8.4	7.6	8.5	7.7
Number of respondents	6,266	4,086	292	2,948	1,652	354
Mean number of methods known by respondents 15+	na	na	na	7.6	8.3	7.7
Number of respondents	na	na	na	3,591.00	2,236.90	356.2

na = not applicable.

[1] Had last sexual intercourse within 30 days preceding the survey.

Figure 7.1: Percentage of all women and men aged 15–49 with knowledge of any modern contraceptive method, Solomon Islands 2015



7.2 KNOWLEDGE OF CONTRACEPTIVE METHODS BY BACKGROUND CHARACTERISTICS

Table 7.2 shows the percentage of currently married women and currently married men aged 15–49 who have heard of at least one contraceptive method or who have heard of at least one modern contraceptive method by background characteristics. The results show that there is very little variation in knowledge of contraception by background characteristics.

For all background characteristic subgroups, level of knowledge exceeds 90% for married women and married men. However, of all age groups, married women aged 15–19 have the lowest level of knowledge of any method or any modern method. Women and men in urban areas have higher knowledge about contraceptive methods than women and men in rural areas. By region, women in Western Province have the highest level of knowledge of any method of contraceptive (99%) and whereas women in Malaita have the least amount of knowledge (93%). Men in Honiara, Malaita and Western provinces have the highest level of knowledge (100%) while men in Guadalcanal have the least amount of knowledge (96%).

Education has an impact on people's knowledge of contraceptive methods. Among married women aged 15–49 with no education, 91% have heard of a method of contraception compared with more than 99% of women in that age group with more than a secondary level education. Similarly, 96% of married men aged 15–49 with no education have heard of a method of contraception compared with 100% of men in the same age group with more than a secondary level education. The difference across wealth quintiles was more noticeable for women than men, with 94% of women in the lowest quintile having heard of a method of contraception compared to 97 % men. In the highest wealth quintile 99% of women compared to more than 99% of men have heard of any contraceptive method. Among men, there are few differences of contraceptive knowledge by wealth quintile although men in the lower wealth quintile are least likely to have knowledge about contraceptive methods.

Table 7.2: 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 2015

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	92.9	92.3	141	100	100	10
20–24	93.5	93	645	98	98	148
25–29	97.1	96.7	850	99.3	99.3	307
30–34	97.9	97.6	824	100	100	355
35–39	99	99	715	98.8	98.8	350
40–44	97.9	97.8	504	98.7	98.7	258
45–49	97.2	97.1	407	99.6	99.1	226
Residence						
Urban	98.8	98.6	835	100	100	360
Rural	96.5	96.3	3,251	99	98.9	1,292
Region						
Honiara	98.7	98.4	529	100	100	229
Guadalcanal	97.1	96.9	772	96.4	96.4	327
Malaita	93.3	92.9	1,064	100	100	397
Western	99.4	99.2	581	100	100	236
Other provinces	98.3	98.2	1,141	99.7	99.4	462
Education						
No education	90.8	90	454	95.9	95.9	63
Primary	97	96.7	2,018	98.8	98.6	698
Secondary	98.4	98.4	1,340	99.6	99.6	664
More than secondary	99.7	99.7	275	100	100	228
Wealth quintile						
Lowest	94.2	93.8	813	97.4	97.4	322
Second	97.1	97.1	800	100	100	315
Middle	96.6	96.1	824	99.2	99.2	320
Fourth	98.4	98.1	831	99.6	99.3	350
Highest	98.7	98.5	818	99.7	99.7	345
Total 15–49	**97**	**96.7**	**4,086**	**99.2**	**99.1**	**1,652**
50+	na	na	na	97.3	96.7	585
Total 15+	**na**	**na**	**na**	**98.7**	**98.5**	**2,237**

na = not applicable

[1] Female sterilisation, male sterilisation, pill, intrauterine device (IUD), injectables, implants, male condom, female condom, diaphragm, foam or jelly, lactational amenorrhoea method (LAM), and emergency contraception

7.3 CURRENT USE OF CONTRACEPTION

Current use of contraception is defined as the proportion of women who was using a family planning method at the time of the 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. Furthermore, it has been used to estimate the reduction in fertility that is attributable to contraception. The contraceptive prevalence rate (CPR) is usually defined as the percentage of all women of child bearing age (i.e. 15–49) that are currently using a method of contraception at the time of the survey.

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. Table 7.3.1 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 7.3.1 shows that approximately 21% of all women, 29% of currently married women, and 10% of sexually active unmarried women are using a family planning method. About 18% of all women use any modern method while 4% used any traditional method. The most common methods used among all women are female sterilisation (6%), injectable contraceptives (6%) and rhythm (2%).

The CPR of currently married women reported from the SIDHS 2015 is 29%, a decline of 17% from the reported CPR of 35% in the SIDHS 2006–2007. About one in four currently married women use any modern method, compared with one in ten sexually active unmarried women. Only 2% of sexually active unmarried women use traditional methods compared with 5% of married women. The most commonly used contraceptive methods among currently married women are female sterilisation (9%), injectable contraceptives (8%) and rhythm (3%). However, among sexually active, unmarried women, male condoms (4%), injectable contraceptives (2%), and rhythm (1%) are the most common contraceptive methods.

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 women of intermediate ages. Contraceptive use of any modern method is lowest for younger women, peaking at 28% among all women aged 45–49. Women aged 35 and over are more likely to use female sterilisation. The use of male condoms is most common for women under 35. The use of injectable contraceptives is most prevalent among women aged 20–34.

Table 7.3.1: 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 2015

Age	Any method	Modern method										Traditional method					Total	Number of women
		Any modern method	Female sterilisation	Male sterilisation	Pill	IUD	Injectables	Implants	Male condom	Female condom	Other	Any traditional method	Rhythm	Withdrawal	Other	Not currently using		
ALL WOMEN																		
Age																		
15–19	3.6	2.3	0	0	0	0	0.4	0.4	1.3	0.2	0	1.3	0.9	0.2	0.2	96.4	100	1,241
20–24	16.3	13.8	0	0	0.9	1.4	7	2.3	2.2	0.1	0	2.5	1.2	1.3	0	83.7	100	1,146
25–29	22.6	17.8	2.5	0	1	1.9	9.4	1.6	1.4	0	0	4.8	3.2	1.4	0.3	77.4	100	1,091
30–34	29.4	25.3	7.6	0.8	1.7	1.9	9	2.6	1.6	0	0.1	4.1	2	1.6	0.5	70.6	100	933
35–39	32.3	27.6	14.1	1	0.8	2	6.7	2.5	0.5	0	0.1	4.6	2.1	1.9	0.7	67.7	100	803
40–44	28.5	22.5	13.4	0.2	0.3	2.2	4.4	1.4	0.6	0	0	6	2.8	2.8	0.5	71.5	100	576
45–49	32.8	28.4	22.1	1.2	0.8	1.3	2	0	0.9	0	0	4.4	3	1.2	0.2	67.2	100	476
Total	**21.3**	**17.6**	**6.3**	**0.4**	**0.8**	**1.4**	**5.8**	**1.6**	**1.3**	**0**	**0**	**3.6**	**2**	**1.3**	**0.3**	**78.7**	**100**	**6,266**
CURRENTLY MARRIED WOMEN																		
Age																		
15–19	11.2	7.1	0	0	0	0	2.6	3.7	0.7	0	0	4.1	1.9	1.5	0.8	88.8	100	141
20–24	22.6	19	0	0	1.4	1.9	10.9	3.8	1	0	0	3.6	1.3	2.3	0	77.4	100	645
25–29	26.8	21	3	0	1.2	2.4	11.2	2.1	1.1	0	0	5.8	3.9	1.6	0.4	73.2	100	850
30–34	31.7	27.2	8.2	1	1.9	2.1	9.7	2.9	1.5	0	0	4.5	2.1	1.8	0.6	68.3	100	824
35–39	33.8	28.8	14.7	1.1	0.9	2	7.1	2.7	0.4	0	0	5	2.1	2.1	0.8	66.2	100	715
40–44	31.8	25.2	14.9	0.3	0.3	2.5	5	1.5	0.7	0	0	6.6	3.2	2.9	0.5	68.2	100	504
45–49	36.1	30.9	23.6	1.4	0.9	1.6	2.3	0	1.1	0	0	5.2	3.6	1.4	0.2	63.9	100	407
Total	**29.3**	**24.3**	**9**	**0.6**	**1.1**	**2**	**8.2**	**2.4**	**1**	**0**	**0**	**5**	**2.6**	**2**	**0.4**	**70.7**	**100**	**4,086**
SEXUALLY ACTIVE UNMARRIED WOMEN[1]																		
Age																		
15–19	6	5	0	0	0	0	0	0	5	0	0	1	1	0	0	94	100	96
20–24	9.5	8.1	0	0	0	1.6	1.9	0	4.6	0	0	1.4	1.4	0	0	90.5	100	105
25–29	10.7	9.2	0	0	0	0.6	7.9	0	0.7	0	0	1.6	1.6	0	0	89.3	100	50
30–34	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	18
35–39	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	12
40–44	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	6
45–49	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	5
Total	**9.6**	**8**	**0.9**	**0**	**0**	**0.7**	**2.4**	**0**	**4**	**0**	**0**	**1.6**	**1.1**	**0.4**	**0.1**	**90.4**	**100**	**292**

Note: If more than one method is used, only the most effective method is considered in this tabulation. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
na = not applicable. IUD = Intrauterine device. [1] Women who have had sexual intercourse within 30 days preceding the survey.

7.4 CURRENT USE OF CONTRACEPTION BY BACKGROUND CHARACTERISTICS

Table 7.3.2 shows data on current use of contraception among currently married women aged 15–49 according to their background characteristics. Knowledge of contraception methods by background characteristics is important for identifying targets and goals for family planning services. There is a strong association between current use of family planning and the number of children a woman has. The current use of family planning methods increases with the number of children, from 5% among women with no children to 23% among women with one to two children, and 39% among women who have five or more children. One out of ten women (10%) with more than three children have become sterilised and the use of female sterilisation doubled (20%) among women with five or more children. This indicates that these women might have completed their family size and do not want to have more children.

Married women in rural areas are more likely to use any method of contraception (30%) than married women in urban areas (26%). This trend is consistent with the SIDHS 2006–2007 although the percentage has decreased (35% of women in rural areas to 29% of women in urban areas). There is no substantial difference in the use of any traditional method among married women in urban and rural areas although slightly more women in rural areas used a modern method (25%) than women in rural areas (22%). A higher proportion of women in rural areas use all methods of modern contraception than those in urban areas, with the exceptions of IUDs, male condoms and the rhythm method.

By region, women in Honiara have the lowest level of current use of contraception at 21% while women in the other provinces and Western province have a higher use of contraception at 35%. The highest use of modern contraception was in Western Province (30%) and the highest use of any traditional method was in the other provinces (8%).

Currently married women with no education are less likely to use modern contraceptive methods (20%) or traditional contraceptive methods (3%) than those with more than a secondary level education (27% us modern methods, 6% using traditional methods). The trend is less marked for those with a primary and secondary education. Female sterilisation is the most popular form of modern contraception for all education levels, with the exception of those with a secondary education where injectable contraceptives are more commonly used.

There is no correlation between wealth and contraceptive use. For example, CPR is highest among mothers in middle quintile households, and is lowest in the highest and lowest wealth quintile households. Most women in the middle and fourth wealth quintile households use female sterilisation and injectable contraceptives.

Table 7.3.2: 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 2015

Background characteristic	Any method	Modern method								Traditional method				Not currently using	Total	Number of women
		Any modern method	Female sterili-sation	Male sterili-sation	Pill	IUD	Injectables	Implants	Male condom	Any tradi-tional method	Rhyth m	With-drawal	Other			
Number of living children																
0	4.7	2.3	0	0	0.4	0.3	0.4	0	1.2	2.5	1.2	1.3	0	95.3	100	403
1–2	23.2	17.5	2.2	0	0.9	1.7	9.1	2.5	1.1	5.7	3.2	2.2	0.3	76.8	100	1,349
3–4	36	30.1	10.3	0.8	1.4	3.3	10.6	2.9	0.7	5.9	3.3	2	0.5	64	100	1,316
5+	38.6	34.5	20.1	1.2	1.3	1.6	6.9	2.6	0.9	4.1	1.6	1.9	0.7	61.4	100	1,019
Residence																
Urban	25.9	21.6	8.2	0.1	0.9	2.8	6.8	1.6	1.1	4.3	2.8	1.1	0.4	74.1	100	835
Rural	30.2	25	9.2	0.7	1.2	1.8	8.5	2.6	0.9	5.2	2.6	2.2	0.4	69.8	100	3,251
Region																
Honiara	21.4	19.1	7.4	0	0.7	2.2	6.3	1.6	0.9	2.3	1.7	0.3	0.3	78.6	100	529
Guadalcanal	23.4	18.5	4.2	0.1	0.4	1.1	9.3	2.8	0.6	4.8	1.6	2.7	0.5	76.6	100	772
Malaita	28.2	24.5	10.3	0.4	1.7	1.5	7	2.7	0.8	3.7	1.8	1.7	0.2	71.8	100	1,064
Western	35	29.6	14.5	0.2	1	2.8	9.5	0.5	1.1	5.4	3.6	1.3	0.6	65	100	581
Other provinces	35.3	27.7	9.1	1.4	1.3	2.7	8.8	3.1	1.4	7.5	4	2.9	0.7	64.7	100	1,141
Education																
No education	23.3	20	10.7	0.4	0.7	1	4.6	2.3	0.4	3.3	0.9	2.1	0.2	76.7	100	454
Primary	30.9	26.3	11.6	0.7	0.8	1.7	8.3	2.5	0.7	4.6	1.9	2.1	0.6	69.1	100	2,018
Secondary	28.3	22.2	4.3	0.5	1.7	2.7	9.4	2.2	1.4	6.1	3.9	1.8	0.4	71.7	100	1,340
More than secondary	32.9	26.9	10.3	0	1.3	3.1	7.4	3.1	1.6	6	4.7	1.3	0	67.1	100	275
Wealth quintile																
Lowest	27.6	23.7	7.3	0.9	1.3	1.7	9.2	2.8	0.5	3.9	1.3	2.3	0.4	72.4	100	813
Second	30.5	24.3	8.6	0.2	0.9	1.4	8.5	3.6	1	6.2	2.8	2.7	0.7	69.5	100	800
Middle	31.8	26.3	10.8	0.7	1.6	1.6	9.4	1.3	0.9	5.5	3	2.2	0.3	68.2	100	824
Fourth	29.2	24.6	10.5	0.7	1.1	2.1	6.8	2.2	1.1	4.7	2.9	1.5	0.3	70.8	100	831
Highest	27.6	22.7	7.9	0.3	0.7	3.3	7.1	2.1	1.2	4.9	3.1	1.3	0.5	72.4	100	818
Total	**29.3**	**24.3**	**9**	**0.6**	**1.1**	**2**	**8.2**	**2.4**	**1**	**5**	**2.6**	**2**	**0.4**	**70.7**	**100**	**4,086**

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

7.5 TIMING OF STERILISATION

Table 7.4 shows the percentage of sterilised women aged 15–49 by age at the time of sterilisation and median age at sterilisation. In countries where female sterilisation is prevalent, it is important to understand the trend in which adoption of the method occurs and the age at the time of sterilisation for better development plans to improve services and supports in this field. Out of 394 sterilised women, three-quarters (75%) were sterilised before age 35. The most common age group for sterilisation was between 30 and 34 (40%), with less than one in ten women being sterilised before reaching 25 (9%). The median age at sterilisation among women in Solomon Islands is 31.7. This is higher than was reported in the SIDHS 2006–2007, where the median age was 30.9. The median age is higher among women who were sterilised within two years of the survey.

Table 7.4: Timing of sterilisation

Percent distribution of sterilised women aged 15–49 by age at the time of sterilisation and median age at sterilisation, according to the number of years since the operation, Solomon Islands 2015

Years since operation	Age at time of sterilisation						Total	Number of women	Median age[1]
	<25	25–29	30–34	35–39	40–44	45–49			
<2	0	25.9	42.5	25.3	2.4	3.9	100	60	33.2
2–3	7.4	22.2	35.1	19.9	14.3	1.1	100	64	32.1
4–5	6.5	17.3	46.2	22.1	7.8	0	100	59	32.3
6–7	(4.8)	(18.2)	(43)	(25.5)	(8.5)	0	100	46	32.6
8–9	5.8	47	25.1	20.3	1.8	0	100	46	29.8
10+	17.6	28.5	42.2	11.8	0	0	100	118	a
Total	**8.7**	**26.4**	**39.8**	**19.3**	**5.1**	**0.8**	**100**	**394**	**31.7**

a = not calculated due to censoring.

[1] Median age at sterilisation is calculated only for women sterilised before age 40 at less than 40 years of age to avoid problems of censoring.

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

7.6 SOURCE OF CONTRACEPTION

In the SIDHS 2015, women aged 15–49 who reported using any contraception were asked the source of the contraception the last time they obtained it. Information on the source of contraception is vital for planners and programme managers who provide contraceptive services for management and logistics purposes. The results are shown in Table 7.5.

The majority of users of any modern contraception source their methods from the public sector, which supplied contraceptive methods to over four in five current users. The share of the government sector has remained steady over the past two to three decades. The proportion of users who source their contraceptives from the public sector ranges from 68% to 92%, depending on the method used. Very few users obtained the methods from the private sector or other sources (5%).

Most men and women who are sterilised had the procedure done in a provincial hospital (47% of women) and users of implants (26%) also received these at a provincial hospital. Rural health centres were the main source for injectable contraceptives (47%), IUDs (38%) and male condoms (37%). About one in two users of all these methods sourced their methods from a rural health centre or a provincial hospital (25%).

The main providers of contraception from the private sector are church hospitals and private hospitals or clinics (2%). More women use other sources than the private sector, such as the church and the Solomon Islands Planned Parenthood Association (2%).

Table 7.5: 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 2015

Source	Female sterili-sation	Male sterili-sation	Pill	IUD	Injectables	Implants	Male condom	Female condom	Total
Public sector	91.5	*	(86.2)	90.5	88.8	83.3	68.2	0	87.6
National referal hospital	43.8	*	(5.1)	2.2	1.8	7.4	0.5	0	17.8
Provincial hospital	47.2	*	(9.2)	14.1	6	26.4	10.8	0	24.9
Urban area health centre	0	0	(6.6)	10.1	9.8	2.5	7.6	0	5.1
Area health centre	0	0	(9.8)	16.3	14.8	15.9	6.2	0	8.5
Rural health centre	0	0	(28.5)	37.6	46.8	26.1	37	0	24.8
Family planning clinic	0	0	(7.7)	2.7	0.8	0	1.2	0	0.9
Nurse aide post	0	0	(19.4)	7.4	8.1	4.3	4.9	0	4.9
Statellite clinics	0	0	0	0	0.9	0	0	0	0.3
Other public sector	0.5	*	0	0	0	0.7	0	0	0.4
Private sector	7.3	*	(1.4)	1.1	2.3	1.1	11.1	0	4.6
Private hospital/clinic	1	0	(1.4)	1.1	2.3	1.1	3.5	0	1.6
Pharmacy	0	0	0	0	0	0	6.7	0	0.5
Private doctor	0	*	0	0	0	0	0	0	0.1
Church hosptial	6.3	0	0	0	0	0	0	0	2.2
Other private medical sector	0	0	0	0	0	0	0.9	0	0.1
Other sources	0	0	(7.8)	8.4	6.6	7.4	9.7	*	4.9
SIPPA clinic	0	0	(6.2)	6.3	1.6	2	5.6	*	2
Save the children fund	0	0	0	0	0	0	0.7	0	0.1
Church	0	0	(1.7)	2.1	5	5.5	0	0	2.4
Shop	0	0	0	0	0	0	1.7	*	0.3
Friend/relative	0	0	0	0	0	0	1.7	0	0.1
Other	0	*	0	0	0.2	0.3	4.7	0	0.5
Missing	1.2	0	(4.5)	0	2.1	7.8	6.3	0	2.5
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of women	394	23	48	89	361	102	83	3	1,102

Note: Total includes other modern methods but excludes lactational amenorrhoea method (LAM). Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cased and has been suppressed.

IUD = Intrauterine device.

SIPPA = Solomon Island Planned Parenthood Association.

7.7 INFORMED CHOICE

Informed choice is an important tool for monitoring the quality of family planning services. Current users of modern methods who are informed of potential side effects and problems associated with different methods are best able 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.

Current users of various modern contraceptive methods who started the last episode of use within the five years preceding the survey were asked whether, at the time they adopted the particular method, they were informed about possible side effects or problems they might have with the method and what to do if they experienced side effects.

Table 7.6 presents information on informed choice by type and source of method. The data show that 70% of modern contraceptive users were informed about potential side effects or problems of the method by a

health or family planning worker, 66% were informed about what to do if they experienced side effects, and 71% were informed of other methods that they could use instead. Women who had used an IUD in the previous five years were more likely to have been told about the possible side effects or problems (76%), what to do if these were experienced (74%) and what their other family planning options were (88%) than any other contraceptive method.

Current users are more likely to be informed about the potential side effects or problem and what to do if they experience side effects if they sourced their contraceptive method from the public sector. They are less likely to be informed about what to do if they experienced side effects when using the methods.

Table 7.6: 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, the 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 they could use, by method and initial source, Solomon Islands 2015

Method/Source	Among women who started last episode of modern contraceptive method within five years preceding the survey:			
	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
Method				
Female sterilisation	71	71.2	58.4	152
Pill	(66.1)	(68.9)	(71.6)	46
IUD	75.5	74.1	87.8	61
Injectables	68.6	63.1	72.6	336
Implants	72.5	62.5	75.6	102
Initial source of method[1]				
Public sector	71.6	67.8	72.8	613
National referal hospital	78.1	74.1	55.9	85
Provincial hospital	73.3	72.3	74.6	129
Urban area health centre	74	72.7	77.9	51
Area health centre	62	55.2	80	79
Rural health centre	70.6	65.5	73.1	217
Family planning clinic	*	*	*	9
Nurse aide post	(75.3)	(74.5)	(77.9)	39
Statellite clinics	*	*	*	2
Private sector	(83.2)	(79.7)	(63.9)	24
Private hospital/clinic	*	*	*	8
Pharmacy	*	*	*	1
Church hosptial	*	*	*	16
Other private medical sector	*	*	*	0
Other sources	(75.5)	(65)	(84.6)	37
Sippa clinic	*	*	*	12
Church	*	*	*	25
Other	*	*	*	*2*
Missing	*	*	*	21
Total	**70.1**	**66.1**	**71.2**	**697**

Note: Table includes users of only the methods listed individually. 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] Source at start of current episode of use.

7.8 CONTRACEPTION DISCONTINUATION RATES

All women aged 15–49 who participated in the SIDHS 2015 were asked about their reproductive history, including the use of any family planning methods, timing of first use of methods, duration of use, and discontinuation of contraceptive method(s). For those using any method who then stopped using the method were further asked the reason for not continuing the use the method. The woman's calendar section in the woman's questionnaire recorded all contraceptive use from 3–62 months prior to the survey. A one-year contraceptive discontinuation rate based on the calendar data are presented in Table 7.7. One of the major concerns of family planning providers and planners is the discontinuation of contraceptive use among users. The information presented in this section will assist family planning managers and planners to further understand whether the discontinuation of contraceptive use is voluntarily or due to method failure or other reasons.

Table 7.7 shows that one in five women aged 15–49 years (20%) who started an episode of contraceptive use discontinued within 12 months; 5% discontinued because of side effects or health concerns, and another 5% discontinued for other reasons. Wanting to become pregnant or wanting a more effective method of contraception were the next most common reasons for discontinuation, both comprising 3% of women. About 2% stopped because the method failed and another 5% switched to another method.

Injectable contraceptives were associated with a higher rate of discontinuation, with more than 1 in 4 women (26%) dropping this method within 12 months of use.

Table 7.7: Twelve-month contraceptive discontinuation rates

Among women aged 15–49 who started an episode of contraceptive use within the five years preceding the survey, the percentage of episodes discontinued in the 12 months preceding the survey, by reason for discontinuation and specific method, Solomon Islands 2015

Method	Method failure	Desire to become pregnant	Other fertility related reasons[1]	Side effects/health concerns	Wanted more effective method	Other method related reasons[2]	Other reasons	Any reason[3]	Switched to another method[4]	Number of episodes of use[5]
Female sterilisation	(0)	(0)	(0)	(0.9)	(0)	(0)	(0)	(0.9)	(0)	159
Injectables	1.1	2.8	0.6	11.4	1.1	3	6.2	26.3	4.3	493
Rhythm	(1.4)	(2.9)	(0)	(0.5)	(2.3)	(0)	(4.0)	(11.1)	(2.6)	150
All methods	1.8	2.8	0.7	5.2	2.8	1.8	4.8	19.8	4.6	1,293

Note: Figures are based on life table calculations using information on episodes of use that began 3–62 months preceding the survey.

[1] Includes infrequent sex/husband away, difficult to get pregnant/menopausal, and marital dissolution/separation.

[2] Includes lack of access/too far, costs too much, and inconvenient to use.

[3] Reasons for discontinuation are mutually exclusive and add to the total given in this column.

[4] The episodes of use included in this column are a subset of the discontinued episodes included in the discontinuation rate. A woman is considered to have switched to another method if she used a different method in the month following discontinuation or if she gave 'wanted a more effective method' as the reason for discontinuation and started another method within two months of discontinuation.

[5] Number of episodes of use includes both episodes of use that were discontinued during the period of observation and episodes of use that were not discontinued during the period of observation.

7.9 REASONS FOR DISCONTINUATION

Table 7.8 shows the percent distribution of discontinuation of contraceptive methods in the five years preceding the survey by main reason for discontinuation. Across contraceptive methods, wanting to become pregnant was the most common reason among women for discontinuation (24%), followed by side effects and health concerns (17%). The most commonly stated reason for discontinuing using the pill, rhythm method and withdrawal method was wanting to become pregnant (26% pill, 31% rhythm method, 30% withdrawal method). For IUD and injectable contraceptive users, side effects and health concerns were the most likely cause for stopping (37% for IUD, 33% for injectables). The main reason listed for discontinuing the use of male condoms was wanting to become pregnant (29%).

Table 7.8: Reasons for discontinuation

Percent distribution of discontinuations of contraceptive methods in the five years preceding the survey by main reason stated for discontinuation, according to specific method, Solomon Islands 2015

Reason	Female sterilisation	Pill	IUD	Injection	Implants	Male condom	Female condom	Lactation amenorrhea	Rhythm	Withdrawal	Other	All methods
Became pregnant while using	0	14.3	(12.5)	4.3	0	(29.3)	0	0	20.2	24.1	*	13.4
Wanted to become pregnant	0	26	(25.4)	20.4	0	(16.8)	0	0	30.9	30.4	*	24.2
Husband disapproved	0	4.9	(1.1)	3	0	(3.7)	0	0	0	1.7	0	2.3
Wanted a more effective method	0	6.7	(5.1)	2.5	*	(4.2)	0	*	7.1	19.5	*	8.1
Side effects/health concerns	*	15.5	(36.7)	33.3	0	0	0	0	0.6	0	0	17.3
Lack of access/too far	0	0	0	8.7	0	(6.5)	0	0	0	0	0	3.9
Cost too much	*	2.5	0	0.6	0	0	0	0	0	0	0	0.8
Inconvenient to use	0	4.8	0	2.7	0	(2.7)	0	0	1.9	0	0	2.1
Infrequent sex/husband away	0	5	(4.9)	1.8	0	(7.9)	0	*	10.4	5.1	*	5.1
Marital dissolution/separation	0	1.2	0	0.1	0	0	0	0	0	0	0	0.2
Other	0	2.3	(1.1)	7	0	(10.5)	0	0	4.5	1.9	*	5.1
Don't know	0	2.5	0	5.1	0	(2.1)	0	0	0.4	0	*	2.8
Missing	0	14.3	(13.3)	10.5	0	(16.4)	*	0	24.1	17.3	*	14.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of discontinuations	3	65	32	242	2	41	0	6	107	85	21	604

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.

IUD = Intrauterine device.

7.10 KNOWLEDGE OF FERTILE PERIOD

An elementary knowledge of reproductive physiology provides a useful background for the successful practice of coitus-associated methods of family planning such as withdrawal, condoms, and vaginal methods. As shown in Tables 7.1 and 7.3.1, 69% of all women and 58% of all men have heard of the rhythm method, and 3% of all currently married women are using the method. Table 7.9 shows respondents' knowledge about the time during the menstrual cycle when a woman is most likely to get pregnant.

Overall, one in four women aged 15–49 (26%) correctly reported that the most fertile time during the menstrual cycle is midway between two menstrual periods. Among users of the rhythm method, 37% were able to correctly identify when during a woman's cycle she is most likely to get pregnant and about 26% of non-users of the rhythm method had the correct knowledge of the women's fertile period. About 35% reported that a woman's most fertile period is right after menstruation has ended and this was higher among users of the rhythm method (46%) than non-users (34%). One in four women (27%) stated that there was no specific time a woman was more fertile or that they did not know when this fertile period was.

Table 7.9: 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 2015

Perceived fertile period	Users of rhythm method	Nonusers of rhythm method	All women
Just before her menstrual period begins	8.6	9.2	9.2
During her menstrual period	0.6	2.8	2.7
Right after her menstrual period has ended	45.8	34.3	34.5
Halfway between two menstrual periods	37.1	25.6	25.8
Other	0	1	1
No specific time	4.7	14.1	13.9
Don't know	3.1	12.9	12.7
Missing	0	0.1	0.1
Total	**100**	**100**	**100**
Number of women	125	6,141	6,266

7.11 NEED AND DEMAND FOR FAMILY PLANNING SERVICES

Data in this section provide information on the extent of need and potential demand for family planning services in Solomon Islands. An unmet need for family planning refers to fecund women who are not using contraception but who wish to postpone their next birth (spacing) or stop childbearing altogether (limiting). Specifically, women are considered to have an unmet need for spacing if they are:

- at risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next two years or are unsure if or when they want to become pregnant;
- pregnant with a mistimed pregnancy; or
- postpartum amenorrhoeic for up to two years following a mistimed birth and not using contraception.

Women are considered to have an unmet need **for limiting** if they are:

- at risk of becoming pregnant, not using contraception, and want no (more) children;
- pregnant with an unwanted pregnancy; or
- postpartum amenorrhoeic for up to two years following an unwanted birth and not using contraception.

Women who are classified as infecund have no unmet need because they are not at risk of becoming pregnant. Women who are using contraception are considered to have a met need. Women using contraception who say they want no (more) children are considered to have a met need for limiting, and women who are using contraception and say they want to delay having a child or are unsure if or when they want a(another) child are considered to have a met need for spacing.

Unmet need, total demand, percentage of demand satisfied, and percentage of demand satisfied by modern methods are defined as follows:

- **Unmet need**: the sum of unmet need for spacing and unmet need for limiting
- **Total demand for family planning**: the sum of unmet need and total contraceptive use
- **Percentage of demand satisfied**: total contraceptive use divided by the sum of unmet need and total contraceptive use (any method)
- **Percentage of demand satisfied by modern methods**: total modern contraceptive use divided by the sum of unmet need and total contraceptive use (any method)

Table 7.10.1 shows the unmet need, met need, total demand, demand satisfied and demand satisfied to space or limit the number of children among currently married women aged 15–49. The results show that 35% of currently married women have unmet family planning needs; 20% have unmet needs for spacing births, and 15% have unmet needs for limiting the number of births. Fewer women reported that their family planning needs were currently being met (29%). Approximately 11% reported that their need for spacing births had been met, and 18% reported that their need for limiting births had been met. The total demand for family planning is 64%, which reflects the actual CPR among currently married women if those currently married women with unmet need of family planning (35 percent) were to use any methods for spacing and limiting their children.

The unmet need for family planning declines with increasing age of currently married women. More than 40% of young women aged 15–24 have an unmet need for family planning and the percentage decreases to 38% among women aged 25–34, and drops to only 13% among women aged 45–49. Younger married women have a high unmet need for spacing births while older women have an unmet need for limiting the number of births. Unmet spacing and limiting needs were similar between women in urban areas (21% for spacing, 14% for limiting) and those in rural areas (20% for spacing, 15% for limiting).

Results were mixed by educational attainment, where women with a secondary education reported the highest unmet demand for family planning (39%), particularly for spacing births (28%), but those with more than a secondary education reported the lowest unmet demand for family planning (27%). There was little difference in the level of unmet need for family planning among currently married women by wealth quintile, with the exception of the lowest wealth quintile, which was slightly higher than the other quintiles (37%). By region, the highest percentages of total unmet family planning needs are in Honiara and Guadalcanal (39%), unmet need for spacing (23%) and for limiting (16%).

The total demand for family planning is highest among currently married women aged 20–24 (71%) and 30–34 (70%) followed by women in the 25–29 age group (66%) and 35–39 age group (64%). The lowest demand for family planning is among older women aged 45–49 (49%) who correspondingly have the highest levels of satisfied demand for family planning (74%). Rural women have a higher total demand for family planning (65%) and higher levels of satisfied demand (47%) than urban women (61% and 42%, respectively).

The total demand for family planning generally increases with education: for example, from 57% among currently married women with no education to 64% for women with a primary education, reaching a high of 68% for women with a secondary level education, and then decreasing to 60% for those with more than a secondary education. Women with more than a secondary education also have the highest proportion of satisfied family planning demand (55%).

Across the regions, married women living in Western and other provinces have the highest total demand (67% Western Province, 69% other provinces) and the highest satisfied demand (53% Western Province, 51% other provinces). Total demand and satisfied demand were lowest in Honiara (60% and 36%, respectively).

Table 7.10.1: Need and demand for family planning among currently married women

Percentage of currently married women aged 15–49 with unmet need for family planning, percentage with met need for family planning, the total demand for family planning, and the percentage of the demand for contraception that is satisfied, by background characteristics, Solomon Islands 2015

Background characteristic	Unmet need for family planning			Met need for family planning (currently using)			Total demand for family planning[1]			Percentage of demand satisfied[2]	Percentage of demand satisfied by modern methods[3]	Number of women
	For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total			
Age												
15–19	39.5	4.9	44.4	9.7	1.5	11.2	49.2	6.4	55.6	20.1	12.7	141
20–24	40.3	7.7	47.9	17.5	5.1	22.6	57.8	12.7	70.5	32	27	645
25–29	26.9	12	38.9	15.8	11	26.8	42.6	23.1	65.7	40.8	31.9	850
30–34	21.2	17.1	38.3	12.7	19	31.7	33.9	36.1	70	45.3	38.8	824
35–39	8.7	21.3	30	8.4	25.4	33.8	17.1	46.7	63.8	53	45.1	715
40–44	5.7	20.3	26	3.1	28.7	31.8	8.8	49	57.8	55	43.6	504
45–49	1.9	11.1	13	2.6	33.5	36.1	4.4	44.6	49	73.6	63	407
Residence												
Urban	21.4	14.1	35.5	11.3	14.6	25.9	32.7	28.7	61.4	42.2	35.2	835
Rural	19.6	14.8	34.5	11	19.2	30.2	30.6	34.1	64.7	46.7	38.7	3,251
Region												
Honiara	22.9	15.5	38.5	8.5	12.8	21.4	31.5	28.3	59.8	35.7	31.9	529
Guadalcanal	23	16.2	39.3	12.5	10.8	23.4	35.6	27.1	62.6	37.3	29.6	772
Malaita	19.1	13.4	32.6	9	19.2	28.2	28.2	32.6	60.8	46.4	40.3	1,064
Western	18	13.7	31.7	10.5	24.5	35	28.5	38.2	66.7	52.5	44.4	581
Other provinces	18.4	14.8	33.2	13.3	21.9	35.3	31.8	36.7	68.5	51.5	40.5	1,141
Education												
No education	17.8	16.2	34	6.1	17.2	23.3	23.9	33.4	57.2	40.6	35	454
Primary	15.8	16.9	32.7	9	22	30.9	24.8	38.8	63.6	48.6	41.4	2,018
Secondary	27.7	11.6	39.4	15.1	13.2	28.3	42.8	24.8	67.6	41.8	32.8	1,340
More than secondary	16.6	10.7	27.3	14.8	18.2	32.9	31.4	28.9	60.2	54.6	44.6	275
Wealth quintile												
Lowest	22.2	15.2	37.4	9.8	17.9	27.6	31.9	33.1	65.1	42.4	36.4	813
Second	18.7	15.1	33.8	13	17.5	30.5	31.7	32.6	64.2	47.5	37.8	800
Middle	17.5	15.7	33.1	11.4	20.4	31.8	28.8	36.1	65	49	40.5	824
Fourth	21.6	12.9	34.5	9.9	19.3	29.2	31.5	32.2	63.7	45.9	38.6	831
Highest	20.1	14.4	34.5	11.2	16.3	27.6	31.3	30.8	62.1	44.4	36.6	818
Total	**20**	**14.7**	**34.7**	**11**	**18.3**	**29.3**	**31**	**33**	**64**	**45.8**	**38**	**4,086**

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al., 2012.

[1] Total demand is the sum of unmet need and met need.

[2] Percentage of demand satisfied is met need divided by total demand.

[3] Modern methods include female sterilisation, male sterilisation, pill, IUD, injectables, implants, male condom, female condom, and lactational amenorrhoea method (LAM).

Table 7.10.2 shows the need and demand for family planning among all women and sexually active unmarried women aged 15–49 to space or limit the number of children. Many of the above-mentioned trends for currently married women hold true for all women. Unmet demand is lowest among older age groups, while satisfied demand is also highest for these age groups. There is little difference between unmet demand for all women in rural areas and urban areas (28%), although total demand and satisfied demand are highest in rural areas. Honiara and Guadalcanal also have the highest unmet demand for family planning (29% and 30%, respectively) and the lowest satisfied demand (33% and 36%, respectively). The trend is not constant among education levels and wealth quintiles, although women with more than a secondary education and in the highest wealth quintile have the lowest unmet demand (24% and 26%, respectively).

Unmarried women who are sexually active have a far higher total demand for family planning (93%) and a much greater unmet demand (83%) than married women (64% who have a total demand, and 35% who have an unmet demand). This unmet demand is particularly high for 15–19 year olds at 91%. Only one in ten sexually active unmarried women have their family planning demand satisfied (10%) compared with almost five in ten married women (46%).

Table 7.10.2: Need and demand for family planning for all women and for women who are not currently married

Percentage of all women and women not currently married aged 15–49 with unmet need for family planning, percentage with met need for family planning, the total demand for family planning and the percentage of the demand for contraception that is satisfied, by background characteristics, Solomon Islands 2015

Background characteristic	Unmet need for family planning			Met need for family planning (currently using)			Total demand for family planning[1]			Percentage of demand satisfied[2]	Percentage of demand satisfied by modern methods[3]	Number of women
	For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total			
ALL WOMEN												
Age												
15–19	12.5	1.2	13.7	3.4	0.2	3.6	15.9	1.4	17.3	20.7	13.4	1,241
20–24	31.1	6.2	37.2	13	3.3	16.3	44.1	9.5	53.6	30.5	25.8	1,146
25–29	24	10.3	34.4	13.5	9.2	22.6	37.5	19.5	57	39.7	31.2	1,091
30–34	19.8	16	35.7	11.6	17.8	29.4	31.4	33.7	65.1	45.1	38.8	933
35–39	8.4	20.1	28.5	7.6	24.7	32.3	16	44.8	60.8	53.1	45.4	803
40–44	5.4	17.9	23.3	2.7	25.8	28.5	8.1	43.7	51.8	55.1	43.4	576
45–49	1.6	10.1	11.7	2.2	30.6	32.8	3.8	40.7	44.5	73.7	63.8	476
Residence												
Urban	18.3	9.4	27.6	8.2	9.7	17.9	26.4	19.1	45.5	39.2	33	1,427
Rural	16.6	10.9	27.5	8.6	13.6	22.3	25.2	24.5	49.7	44.8	37	4,839
Region												
Honiara	19.4	9.6	29	6.2	8.3	14.5	25.6	17.9	43.5	33.4	30	925
Guadalcanal	18.8	11.7	30.4	9.2	8	17.2	28	19.6	47.6	36.1	28.8	1,140
Malaita	14.7	9.6	24.3	6.5	13.3	19.8	21.2	22.9	44.1	45	39.1	1,608
Western	16.1	11	27	8.6	16.8	25.4	24.7	27.8	52.4	48.5	40.3	902
Other provinces	17.1	11	28.1	11.2	15.7	26.8	28.3	26.6	54.9	48.9	38.6	1,690
Education												
No education	14.9	14.1	29.1	4.8	15.4	20.2	19.7	29.5	49.3	41	35.4	576
Primary	13.7	13.2	26.9	7.2	16.6	23.8	20.9	29.8	50.7	47	40.2	2,820
Secondary	21.4	7	28.4	10.1	7.6	17.6	31.5	14.6	46.1	38.3	29.7	2,476
More than secondary	15.8	8	23.8	13.6	13.5	27.1	29.4	21.5	50.9	53.3	44.2	394
Wealth quintile												
Lowest	18.3	11.6	29.8	7.7	13.6	21.4	26	25.2	51.2	41.7	35.8	1,158
Second	15.5	11.5	26.9	9.7	12.5	22.1	25.1	23.9	49.1	45.1	35.7	1,172
Middle	16.1	11.7	27.9	9.1	14.4	23.6	25.3	26.1	51.4	45.8	38.4	1,223
Fourth	18.1	9.5	27.6	7.8	13.3	21.1	25.9	22.8	48.7	43.4	35.9	1,253
Highest	16.9	8.9	25.8	8.3	10.4	18.7	25.2	19.2	44.4	42	34.8	1,460
Total	**17**	**10.5**	**27.5**	**8.5**	**12.7**	**21.3**	**25.5**	**23.3**	**48.8**	**43.6**	**36.1**	**6,266**
SEXUALLY ACTIVE UNMARRIED WOMEN[4]												
Age												
15–19	87.8	3.4	91.3	6	0	6	93.8	3.4	97.3	6.2	5.2	96
20–24	78.8	6.5	85.3	8.6	0.9	9.5	87.4	7.4	94.8	10	8.5	105
25–29	64.5	14.7	79.2	5.5	5.2	10.7	70	20	89.9	11.9	10.2	50
30–34	50.2	21.2	71.3	4.4	7.5	11.8	54.6	28.6	83.2	14.2	14.2	18
35–39	28.2	31.8	60	0	18.9	18.9	28.2	50.7	78.9	24	24	12
40–44	40.2	13.6	53.8	0	25.9	25.9	40.2	39.6	79.7	32.5	0	6
45–49	0	64.6	64.6	0	18.2	18.2	0	82.9	82.9	22	22	5

Residence												
Urban	70.6	9.6	80.2	4.6	3	7.6	75.2	12.5	87.7	8.6	7.9	106
Rural	74.9	10.2	85.1	7.2	3.5	10.7	82.2	13.6	95.8	11.2	8.9	186
Region												
Honiara	77.6	6.6	84.1	3.4	1.2	4.6	81	7.8	88.8	5.2	5.2	68
Guadalcanal	68.4	7.9	76.3	6.6	6	12.6	75	13.8	88.8	14.2	9.4	53
Malaita	73.9	16.8	90.7	3.9	5.4	9.3	77.8	22.2	100	9.3	9.3	39
Western	71.5	11.9	83.4	6.8	7.3	14	78.3	19.1	97.4	14.4	9.1	48
Other provinces	74	9.8	83.7	9.2	0	9.2	83.2	9.8	92.9	9.9	9.9	84
Education												
No education	37.7	32.1	69.8	0	18.2	18.2	37.7	50.3	88	20.7	11.9	14
Primary	62.8	19.4	82.2	5.6	5.9	11.6	68.4	25.3	93.7	12.3	11.9	93
Secondary	83.7	2.7	86.3	5.7	0.9	6.6	89.3	3.6	93	7.1	4.9	163
More than secondary	64.7	9.8	74.5	17.6	0	17.6	82.3	9.8	92.1	19.1	19.1	22
Wealth quintile												
Lowest	71.2	7.6	78.8	4.7	6.3	11.1	76	14	89.9	12.3	8.8	34
Second	74.8	11.9	86.7	3.6	4.7	8.3	78.4	16.6	95	8.7	6.1	32
Middle	72.2	14.4	86.6	7.8	1.4	9.2	80	15.8	95.8	9.6	8.2	69
Fourth	74.8	7.6	82.4	10.8	2.3	13.1	85.6	9.8	95.5	13.7	10.4	59
Highest	73.6	8.4	82	3.9	3.7	7.6	77.5	12.1	89.6	8.5	8.5	98
Total	**73.4**	**10**	**83.3**	**6.3**	**3.3**	**9.6**	**79.7**	**13.2**	**92.9**	**10.3**	**8.6**	**292**

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al., 2012.

[1] Total demand is the sum of unmet need and met need.

[2] Percentage of demand satisfied is met need divided by total demand.

[3] Modern methods include female sterilisation, male sterilisation, pill, IUD, injectables, implants, male condom, female condom, and lactational amenorrhoea method (LAM).

[4] Women who have had sexual intercourse within 30 days preceding the survey.

7.12 FUTURE USE OF CONTRACEPTION

The 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 nonusers. It should be realised though that respondents may or may not adhere to their intentions for future use. In the SIDHS 2015, currently married women who were not using any contraceptive method were asked about their intention to use any contraceptive method in the future, according to their number of living children. The results are presented in Table 7.11.

The data show that out of every ten currently married women, five (51%) have no intention to use any family planning method in the future, four (37%) intend to use any methods in the future, and one is unsure of their future intention to use any method (10%). About 42% of women with one child intend to use a method in the future and drops to 29% when women have four or more children. The proportion of women who do not intend to use any contraceptive method in the future increases with the increasing number of children a woman has, and by the time these women have four or more children, 59% have no future intention to use any family planning method.

Table 7.11: Future use of contraception

Percent distribution of currently married women aged 15–49 who are not using a contraceptive method by intention to use in the future, according to number of living children, Solomon Islands 2015

Intention	Number of living children[1]					Total
	0	1	2	3	4+	
Intends to use	39.7	41.8	40.4	41.1	29.2	36.7
Unsure	13.4	12.5	11.6	7.5	8.4	10.1
Does not intend to use	45.1	43.5	46.3	50.5	59.2	51.1
Missing	1.8	2.2	1.7	0.8	3.1	2.1
Total	**100**	**100**	**100**	**100**	**100**	**100**
Number of women	316	512	518	498	1,043	2,887

[1] Includes current pregnancy.

7.13 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 so that they can effectively target population subgroups for information, education and communication campaigns. To assess the extent to which the media serves 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 7.12.

Table 7.12: Exposure to family planning messages

Percentage of women and men aged 15–49 who heard or saw a family planning message on radio, on television or in a newspaper or magazine in the past few months, according to background characteristics, Solomon Islands 2015

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	19.9	2.6	13.2	74.6	1,241	24.7	3.6	16	69.6	605
20–24	28.7	5.1	16	68.3	1,146	31.8	5.4	20.8	63.4	519
25–29	29.3	4.1	17.4	67.1	1,091	36.4	5.6	21.9	57.6	479
30–34	30.6	3.5	13.7	66.7	933	39.8	6.2	20.2	55.5	436
35–39	33.3	4.6	15.6	63.1	803	47	5.4	26.7	48.9	394
40–44	27.9	3.7	14.3	69	576	38.2	5.4	24.5	55.4	280
45–49	29.6	3.8	13.3	68.4	476	42.4	7.4	24.1	52.3	236
Residence										
Urban	41.5	13.4	32.1	49.2	1,427	40.8	14.1	35.9	49.8	720
Rural	24	1.1	9.9	74.2	4,839	34.2	2.5	16.6	61.9	2,229
Region										
Honiara	43.1	15.6	32.9	47.9	925	40.7	14.9	37.7	49	475
Guadalcanal	34.7	2.9	19.2	61.6	1,140	36.6	3.5	20.7	62.1	547
Malaita	15.9	1.4	8.1	82.5	1,608	36.2	5.4	17.2	59.1	710
Western	20.4	3	8.7	76	902	20.6	4.5	18	69.8	451
Other provinces	30.6	1	12.1	67.1	1,690	40.6	1.1	17.3	56.4	765
Education										
No education	14.6	1	2.4	84.9	576	17.6	1.6	4.2	82.4	92

Primary	23.4	2.1	8.5	74.9	2,820	31.3	3.5	14.6	65.4	1,202
Secondary	32.7	5	20.9	62	2,476	37.4	5.5	23.9	56.1	1,348
More than secondary	50.5	13.9	42.4	39.9	394	51.7	13	41.3	39.7	307
Wealth quintile										
Lowest	16.1	0.5	4.6	83.5	1,158	31.7	1.5	10.7	66.5	529
Second	19	0.5	6	79.6	1,172	32.6	2.3	14.9	64.8	565
Middle	25.9	1.2	11.4	71.8	1,223	35.5	2.1	17.2	60.9	528
Fourth	30.6	2.5	16.7	65.8	1,253	35.5	4.3	24.2	57.8	621
Highest	44	12.7	31.7	47.3	1,460	41.7	14	34.9	48.4	706
Total 15–49	**28**	**3.9**	**14.9**	**68.5**	**6,266**	**35.8**	**5.3**	**21.3**	**59**	**2,948**
50+	na	na	na	na	na	41.4	5.1	23.2	53.4	643
Total 15+	**na**	**na**	**na**	**na**	**na**	**36.8**	**5.3**	**21.7**	**58**	**3,591**

na = not applicable

In Solomon Islands, most women and men had not heard or seen a family planning message on the radio, television or in a newspaper or magazine (69% of women, 59% of men). Of those who had heard or seen a message, the most common media source is the radio: 28% of women and 36% of men. Women in the 30–39 age group are the most likely to obtain family planning messages from the radio, and this is similar to men in the age groups 35–49 and 45–49. Both women and men living in urban areas are much more likely to hear about family planning messages through any of the three media listed than those living in rural areas.

The proportion of men and women who heard or saw a family planning message on the radio, a television or newspaper and/or magazine increases with educational attainment and the living standard of the household. Over half of all men and women with more than a secondary level of education have heard a family planning message over the radio.

Across the regions, men and women in Honiara are most likely to have been exposed to a family planning message through any of the three media. Approximately 43% of women and 41% of men in Honiara have received a family planning message over the radio while the lowest exposure was recorded in Malaita Province for women (16%) and Western Province for men (21%).

About 15% of women and 21% of men were exposed to family planning messages by reading a newspaper or magazine, while very few women (4%) and men (5%) used television as a media for family planning messages.

7.14 CONTACT OF NON-USERS WITH FAMILY PLANNING PROVIDER

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, discuss available contraceptive options, and motivate non-users of contraception to adopt a method of family planning. To gain 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 to discuss family planning issues. 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 7.13 shows that in the 12 months preceding the survey, three out of four women aged 15–49 currently not using contraception did not discuss family planning with either a fieldworker or with a health provider. These are missed opportunities to inform and educate women about family planning options. This was more common among adolescent and older women than those aged 24–39 in their prime child bearing years. Slightly more non-users of contraception in urban areas (77%) than in rural areas (74%) did not discuss family planning with either a fieldworker or at a health facility. Among regions, Malaita has the highest instance of this (79%). Women not currently using contraception and with more than a secondary education are the most likely to have discussed family planning (although 69% still have not).

Fieldworkers discussed family planning with only 14% of non-users during the 12 months preceding the survey, while 19% of non-users discussed family planning at a health facility. However, this has increased since the SIDHS 2006–2007, from 9% and 17%. This low level of contact with non-users by family planning providers varies by background characteristics. Higher proportions of women aged 30–39, women in Western Province, women with more than a secondary education, and women in the fourth wealth quintile were visited by a field worker who discussed family planning options. The highest percentages of women who discussed family planning with fieldworkers at a health facility were women in the 30–39 age group, women residing in rural areas, women in other provinces, women with a high level of education, and women living in the fourth wealth quintile.

Table 7.13: Contact of nonusers with family planning providers

Among women aged 15–49 who are not using contraception, the percentage who during the past 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 did not discuss family planning either with a fieldworker or at a health facility, by background characteristics, Solomon Islands 2015

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 did not discuss family planning either with fieldworker or at a health facility	Number of women
		Discussed family planning	Did not discuss family planning		
Age					
15–19	8.6	6.3	24.2	88	1,196
20–24	14.7	20.2	26.8	74.4	959
25–29	14.9	25.1	29	69.2	844
30–34	17.1	29.6	27.1	65.3	659
35–39	19.4	26.8	26.6	67.5	544
40–44	14.5	21.3	26.9	73.9	412
45–49	13.9	14.2	27.3	78	320
Residence					
Urban	13	16.6	23.1	77.2	1,172
Rural	14.4	20.2	27.7	74.3	3,762
Region					
Honiara	12.6	17	22.2	77.3	791
Guadalcanal	12.7	20.7	21.6	74.3	944
Malaita	13.2	15.8	24.7	79	1,289
Western	16.4	21.7	34	71.5	673
Other provinces	15.5	22.3	31.2	71.9	1,236
Education					
No education	8.6	15.9	27.8	81.3	459
Primary	14.9	20.7	27.3	73.6	2,148
Secondary	13.8	18.2	25.6	76	2,039
More than secondary	18.4	23.5	26.5	68.7	287
Wealth quintile					
Lowest	13.7	21.2	30.1	75	911
Second	13.1	20.6	24.9	74.4	912
Middle	12.1	17.8	29	77.3	934
Fourth	16.7	21.4	25.6	71.7	988
Highest	14.3	16.6	24.2	76.5	1,188
Total	**14**	**19.4**	**26.6**	**75**	**4,934**

CHAPTER 8 INFANT AND CHILD MORTALITY

by Kaobari Matikarai, Census and Survey Technical Officer, SPC

KEY FINDINGS

- The infant mortality and under-5 mortality rates in the five years preceding the survey (2011–2015) are 19 and 24 deaths per 1,000 live births, respectively. Using these mortality rates, 1 in every 53 Solomon Islands children dies before reaching age 1 and 1 in every 42 Solomon Islands children do not survive to their fifth birthday
- Neonatal mortality, infant mortality, childhood mortality and under-5 mortality levels declined during the 10-year period preceding the survey by 11%, 5%, 33% and 17%, respectively
- Child survival data do not show any clear association with mother's socioeconomic characteristics and background. The infant mortality rate is the same for urban and rural areas at 19 deaths per 1,000 live births; mothers with no education and higher education have higher child mortality than mothers with only a primary and secondary education. Similarly, there was no clear trend in the infant mortality rate according to the mother's wealth status.
- Infant mortality and under-5 mortality rates are higher among young mothers (aged less than 20 years) and older mothers (aged 30 and over). Mothers with short birth intervals and more than six previous births are more likely to experience higher early childhood mortality. There is no clear correlation between a woman's empowerment and early childhood mortality.
- About 53% of births in the five years preceding the survey are in an avoidable high-risk fertility behavior category, 23% fall into an unavoidable risk category, and 25% are considered to not be in any high-risk category.

INTRODUCTION

This chapter presents estimates of levels, trends and differentials of neonatal, post-neonatal, infant and childhood mortality, and perinatal mortality in Solomon Islands. The information presented here 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 Solomon Islands government national health strategic plan 2011–2015, the primary and preventative health services are key areas for improving the quality of life of Solomon Islanders, and include 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

8.1.1 Terms and definitions

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
- **Post neonatal 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 SIDHS 2015 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 SIDHS 2015, 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 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 10 years before the survey may be more likely to be omitted than an early infant death 2 years before the survey). Thus, an examination of these patterns over time is critical.

8.1.2 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 deaths within a population. 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. The cut-off year for the SIDHS 2015 was January 2010 and although all SIDHS 2015 interviewers were trained and advised on how to record all births of the mother as accurately as possible in the birth history table, there would still be cases where interviewers accidentally or intentionally shift the children's birth dates outside the cut-off dates.

However, evidence from Appendix Table C.4 shows that there was no serious shift in the reporting of births during the operations. For instance, the overall percentage with complete birth date (year and month) that was reported is almost 100% for both children who are alive and children who have died. This is considered very high and reliable. Furthermore, the distribution of living children in 2010 in relation to 2009 and 2011 does not show any deficit as shown in the calendar year ratio. However, the data do show an apparent deficit among dead children in 2009, which could lead to the underestimation of child mortality during this period.

8.1.3 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 SIDHS 2015 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. Early infant deaths were not severely underreported in the SIDHS 2015 in the five years preceding the survey, as denoted by the high ratio of deaths in the first seven days of life to all neonatal deaths (85% in the five years preceding the survey). This is also apparent in the high ratio of deaths in the seven days of life to all neonatal deaths reported in the last 20 years (86%). However the table also shows some age heaping at age 7 days, which could impact the estimates of early neonatal mortality and perinatal mortality.

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 periods of five years. Neonatal deaths in the past 20 years are 55% lower than reported in the SIDHS 2006–2007, which could indicate possible misreporting or under-reporting. Table C.6 also shows evidence of some heaping at age 12 months, which might have had an impact on estimates of infant mortality.

8.2 LEVELS AND TRENDS IN INFANT AND CHILD MORTALITY

8.2.1 Early childhood mortality rates

Table 8.1 shows neonatal, post-neonatal, infant, child and under-5 mortality rates for successive five-year periods preceding the SIDHS 2015. The survey collected birth histories from roughly 6,266 women.

Table 8.1: Early childhood mortality rates

Neonatal, post-neonatal, infant, child, and under-5 mortality rates for five-year periods preceding the survey, Solomon Islands 2015

Years preceding the survey	Neonatal mortality (NN)	Post-neonatal mortality (PNN)	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
0–4 (2011–2015)	9	10	19	6	24
5–9 (2006–2010)	10	9	20	8	28
10–14 (2001–2005)	10	7	17	5	22

[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 2011–2015), the IMR is 19 deaths per 1,000 live births. This means that 19 in every 1,000 babies born in Solomon Islands do not live to their first birthday. Of those who survive to the first birthday, 6 out of 1,000 would die before reaching their fifth birthday. The overall under-5 mortality rate is 24 deaths per 1,000 live births, which implies that 24 in every 1,000 live births 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 in the five-year period preceding the survey is 9 deaths per 1,000 live births, implying that 9 out of every 1,000 infant deaths occur during the first month of life. As childhood mortality declines, post-neonatal 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, post-neonatal mortality is 10 per 1,000 births among infants.

8.2.2 Trends in early childhood mortality

Mortality trends for Solomon Islands can be examined and presented by comparing:

- mortality rates for the last three consecutive five-year periods preceding the survey; and
- mortality rates obtained from other sources such as the SIDHS 2006–2007 and Solomon Islands censuses, 1999 and 2009.

Figure 8.1 presents the level of early childhood mortality for the 15-year period preceding the survey. IMR, child mortality and under-5 mortality were high in the period 2006–2010 as compared with the earlier period 2001–2005. For example, IMR increased from 17 infant deaths per 1,000 live births during the period 2001–2005 to 20 infant deaths per 1,000 live births in 2006–2010, while the rate for under-5 mortality increased from 22 to 28 deaths per 1,000 live births. A situation of high mortality is observed during this period.

There is an improved outcome in the most recent period from 2011 to 2015; for instance, the neonatal mortality rate decreased by about 11% (from 10 to 9 deaths per 1,000 live births) (Fig. 8.1 and Table 8.1). The corresponding declines in IMR, child mortality and under-5 mortality over the same period are 5%, 33% and 17%, respectively.

Figure 8.1: Mortality trends, Solomon Islands 2015

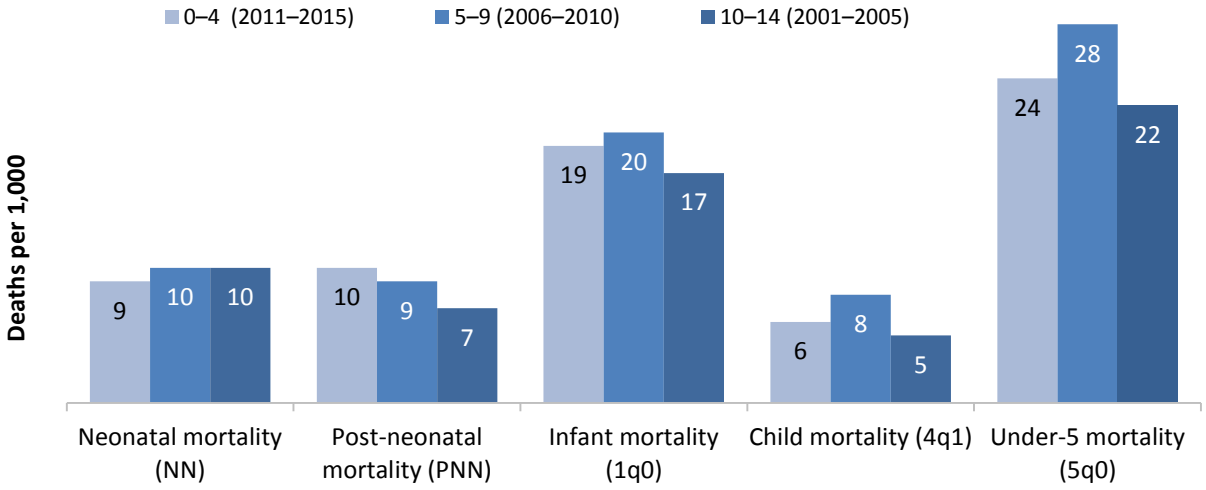
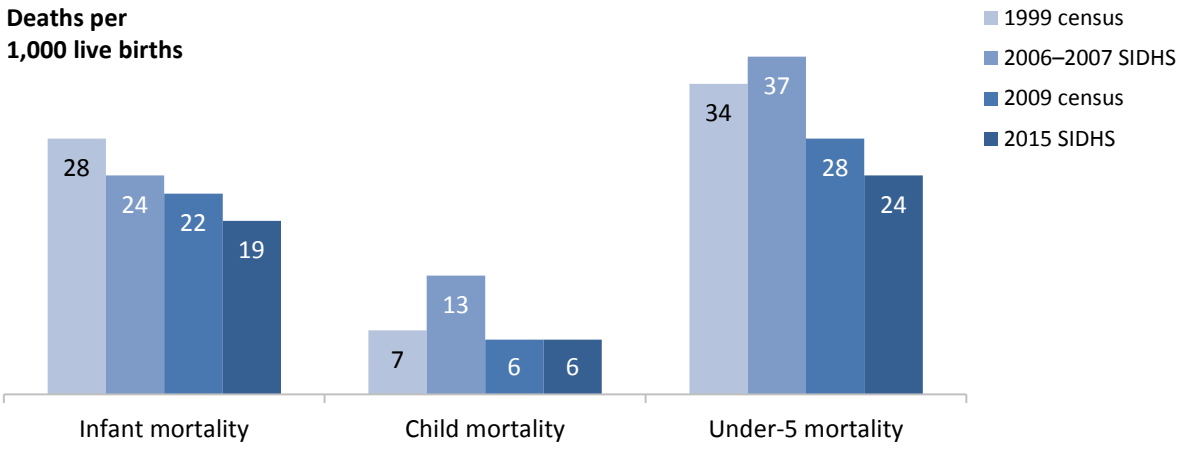


Figure 8.2 presents trends in some of the childhood mortality indicators based on: the 1999 census, SIDHS 2006–2007, 2009 census, and the SIDHS 2015. Although the methodology used to calculate the mortality indicators differs, the results are consistent, particularly with the level of IMR.

The IMR reflects a declining trend from 28 deaths per 1,000 during the 1999 census to 19 deaths per 1,000 reported in the SIDHS 2015 (a drop of about 47% over this period). Many factors contribute to the declining trend in IMRs, although the detailed analysis of these factors is beyond the scope of this report. The results from the two surveys (SIDHS 2006–2007 and SIDHS 2015), however, show a high proportion of women giving birth in the five years preceding the survey receiving antenatal care, which could be associated with the decline in childhood mortality. For example, among women who gave birth in the five years preceding the survey, the percentage receiving antenatal care from a doctor was the same (94% in both surveys), the percentage of deliveries assisted by doctors and skilled health workers was unchanged (86%, see Chapter 11 — Reproductive Health).

Figure 8.2: Trends in childhood mortality, 1999–2015, Solomon Islands 2015



8.3 EARLY CHILDHOOD MORTALITY BY SOCIOECONOMIC CHARACTERISTICS

Table 8.2 presents early childhood mortality rates in Solomon Islands by socioeconomic characteristics. The rates refer to the 10-year period from 2006 to 2015. A 10-year period is used to calculate early childhood mortality in order to minimise large sampling errors of the indicators.

Interestingly, the data show no differences between IMR in urban and rural areas (19 deaths per 1,000 live births for both areas) but variability in other early childhood mortality categories is noticeable. For instance,

the neonatal mortality rate is slightly higher in urban areas (11 deaths per 1,000 live births) than in rural areas (9 deaths per 1,000 live births). Rural areas, on the other hand, experienced higher post-neonatal mortality, childhood mortality and under-5 mortality than urban areas.

In terms of differentials by province, Malaita Province has estimates that are consistently higher than those of other provinces with under-5 mortality being the highest at 37 deaths per 1,000 live births. This is the same pattern for Malaita in the SIDHS 2006–2007, and although there is a declining trend between the two surveys, Malaita is still reporting high levels of early childhood mortality compared with other provinces.

A mother's education level and wealth status are typically associated with child survival. However, according to SIDHS 2015 data, child survival does not show clear association with the mother's level of education and wealth status. In general, children born to mothers with no education have by far the highest mortality rates for all types of childhood mortality except for neonatal mortality. Childhood mortality level data drops with mothers having primary education but then increases as mothers education increases to secondary or more than secondary. The same pattern for childhood mortality level was also cited with mother's wealth quintile status.

Table 8.2: 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 characteristics, Solomon Islands 2015

Background characteristic	Neonatal mortality (NN)	Post-neonatal mortality (PNN)[1]	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Residence					
Urban	11	7	19	4	23
Rural	9	10	19	7	26
Region					
Honiara	11	5	16	6	22
Guadalcanal	11	10	20	4	25
Malaita	15	12	27	10	37
Western	6	6	12	6	18
Other provinces	5	10	15	6	21
Mother's education					
No education	14	21	35	13	47
Primary	8	9	17	4	21
Secondary	9	7	16	10	26
More than secondary	14	6	19	8	27
Wealth quintile					
Lowest	7	9	16	6	23
Second	14	13	27	10	38
Middle	4	8	12	6	18
Fourth	14	11	25	6	31
Highest	8	6	14	4	18

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

Similar to observations made in other DHS reports and data from other sources, the mortality differentials observed by socioeconomic characteristics of the mother are less significant for the neonatal period than for the post-neonatal 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 post-neonatal mortality are more related to standard of living factors. The data reflect the fact that child survival is not strongly influenced by any socioeconomic characteristic as in the case of Solomon Islands. For example, the level of IMR is the same for urban and rural areas while mother's education and wealth is not associated with the level of early childhood mortality. 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, then it is safe to assume that besides education, the declining IMR could also be the result of government interventions that target issues related to a mother's and household's attitudes and practices.

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 8.3 and Figure 8.3 present 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.

Similar to most populations in the world, male children in Solomon Islands have higher child mortality rates than female children and are more likely to die before reaching the age of five years (31 male deaths per 1,000 live births compared with 21 female deaths per 1,000 live births).

Table 8.3 also provides evidence that the level of neonatal mortality increases with the age of the mother: 6 deaths per 1,000 live births for mothers aged less than 20 years increases to 32 deaths per 1,000 live births for older mothers. The under-5 mortality rate indicates a U-shaped pattern, being relatively higher for children born to young mothers under age 20 and over age 30, than children born to mothers aged 20–29. IMR and under-5 mortality rate indicates a strong relationship between maternal age and childhood mortality, whereby childhood mortality is higher among children born to young and older mothers (Fig. 8.3).

Table 8.3: 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 2015

Demographic characteristic	Neonatal mortality (NN)	Post-neonatal mortality (PNN)[1]	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Child's sex					
Male	10	11	21	10	31
Female	9	8	17	4	21
Mother's age at birth					
<20	6	11	17	11	28
20–29	7	9	16	6	22
30–39	14	9	24	8	31
40–49	32	9	40	0	40
Birth order					
1	10	10	20	6	26
2–3	7	7	14	8	22
4–6	10	10	20	8	28
7+	22	19	41	2	43
Previous birth interval[2]					
<2 years	14	13	27	15	41
2 years	6	8	13	4	17
3 years	7	10	16	6	22
4+ years	10	8	18	4	22
Birth size[3]					
Small/very small	16	6	22	–	–
Average or larger	6	8	14	na	na
Don't know/Missing	53	28	81	na	na

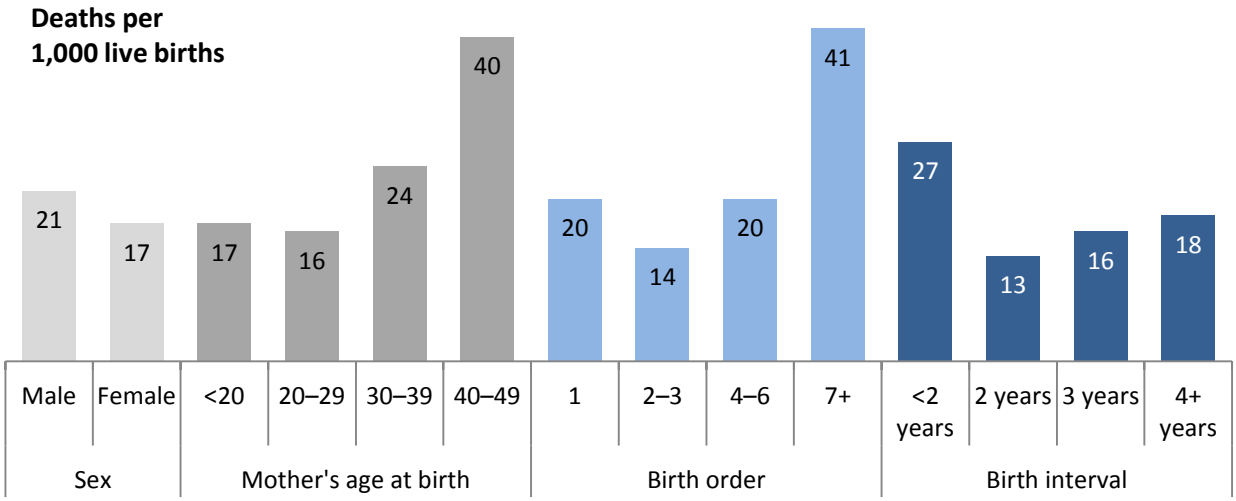
na = not available.

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.

Figure 8.3: IMR for the 10-year period preceding the survey by selected demographic characteristics, Solomon Islands 2015



Birth order affects a child's chances of survival mostly during infancy. The data from SIDHS 2015 indicates that birth order 7 and higher is particularly at greater risk of mortality compared with lower order births. For instance, in the case of neonatal mortality, the risk for a birth order 7 and higher is 22 deaths per 1,000 compared to 10 deaths per 1,000 for birth order 1. Figure 8.3 also indicates a high risk of infant mortality for birth order 7 and higher for those children surviving the neonatal period with 41 deaths per 1,000 live births.

Short birth intervals are always associated with an increased risk of mortality and data from the SIDHS 2015 also supports this view. In all the early childhood mortality categories presented in Table 8.3 and Figure 8.3, the shortest birth interval (i.e. less than two years) carries the highest risk of mortality. For example, the shortest birth interval for infant mortality carries a high risk of mortality with 27 deaths per 1,000 as compared to other birth interval. The risk of mortality is also observed to be quite high at the longest birth interval of four years and more.

8.5 EARLY CHILDHOOD MORTALITY BY STATUS OF WOMEN

This section presents information on indicators of women's empowerment, using 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 seen as 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 8.4.

Table 8.4: 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 empowerment, Solomon Islands 2015

Empowerment indicator	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
Number of decisions in which women participate[1]			
0	11	2	13
1–2	25	9	33
3	18	6	23
Number of reasons for which wife beating is justified[2]			
0	21	9	30
1–2	18	6	24
3–4	19	6	25
5	20	7	27

[1] Restricted to currently married women. See Table 15.6.1 for the list of decisions.

[2] See Table 15.7.1 for the list of reasons.

With regards to participating in the decision-making process in the household, there is no clear correlation between a woman's empowerment and early childhood mortality. For example, Table 8.4 shows that the probability of babies dying before reaching their first birthday is high among babies born to mothers who participate in one to three household decisions (25 deaths per 1,000 and 18 deaths per 1,000) compared with babies born to mothers who did not participate in any household decision-making (11deaths per 1,000).

The SIDHS 2015 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 reasons asked about, 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 women 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 8.4) also 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 pattern was also seen in the SIDHS 2006–2007. This may suggest that there is very little or no correlation between wife-beating perception and infant mortality.

8.6 PERINATAL MORTALITY

In the SIDHS 2015, women were asked to report all pregnancy losses in the five years preceding 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 8.5 show that there were 59 perinatal deaths, an increase of about 55% between

the two surveys (38 perinatal deaths were reported in SIDHS 2006–2007). Out of the total 59 perinatal deaths, 27 were stillbirths and 32 were early neonatal deaths, resulting in a perinatal mortality rate in Solomon Islands of 14 per 1,000 pregnancies according to the SIDHS 2015. Although the perinatal mortality rate in Solomon Islands between the two surveys is stable, it is important to note that there was an increase in the number of stillbirths recorded in the SIDHS 2015.

The perinatal mortality rate is found to be higher among older mothers with the rate increasing with age from 7% among young mothers, 20% among mothers aged 30–39, to 51% among older mothers aged 40–49. Likewise, perinatal mortality is also higher among births that occur more than 39 months after the previous birth. Although perinatal mortality generally decreases among mothers with more education and greater household wealth, the pattern is not always consistent, particularly with regard to household wealth.

Table 8.5 further demonstrates that the interval since the previous pregnancy is related to pregnancy outcome. Pregnancies occurring within 39 months of a previous birth have the highest risk of pregnancy loss or early infant death followed by pregnancies occurring within 27–38 months of a previous birth (21 and 15 pregnancy losses or early deaths per 1,000 pregnancies, respectively). The results contradict best practice recommendations because a birth interval of 39 months and more does not appear to be the safest pregnancy interval; therefore, caution must be taken in interpreting these results.

The perinatal mortality rate in rural areas is slightly low (14 pregnancy losses or early deaths per 1,000) compared with urban areas (15 per 1,000). Western Province has a higher perinatal mortality rate (22 per 1,000 live births) than the other provinces.

Table 8.5: 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 2015

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	2	1	7	465
20–29	12	12	11	2,317
30–39	10	14	20	1,218
40–49	3	5	51	146
Previous pregnancy interval in months[4]				
First pregnancy	5	7	12	1,006
<15	2	9	14	779
15–26	7	1	9	818
27–38	3	5	15	539
39+	11	10	21	1,005
Residence				
Urban	4	8	15	741
Rural	24	25	14	3,405
Region				
Honiara	2	4	13	467
Guadalcanal	4	8	15	803
Malaita	9	12	18	1,118
Western	8	5	22	568
Other provinces	4	5	7	1,192
Mother's education				
No education	0	4	10	402
Primary	15	13	14	1,973
Secondary	11	13	15	1,564
More than secondary	1	3	18	207
Wealth quintile				
Lowest	4	8	13	961
Second	3	7	12	860
Middle	8	3	14	835
Fourth	4	7	13	799
Highest	8	7	22	692
Total	**27**	**32**	**14**	**4,147**

[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 8.5 also indicates that in Solomon Islands perinatal mortality increases with a mother's education level, from 10 perinatal deaths per 1,000 among births born to mothers with no education to 18 deaths per 1,000 among births born to mothers with a secondary and higher education. Similarly, perinatal mortality appears to increase with wealth quintiles with the highest early deaths of 22 occurred among births born from mothers who live in households in the highest wealth quintile. However, caution should be used when interpreting these data due to the sample size and possible errors in reporting.

8.7 HIGH-RISK FERTILITY BEHAVIOUR

The SIDHS 2015 examined the relative importance of maternal fertility patterns associated with an 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 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 more than three children (i.e. if the child is of birth order 4 or higher).

Table 8.6 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.

Table 8.6: 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 2015

Risk category	Births in the 5 years preceding the survey		Percentage of currently married women[1]
	Percentage of births	Risk ratio	
Not in any high risk category	24.9	1	25.3
Unavoidable risk category			
First order births between ages 18 and 34 years	22.6	1.37	7.7
Single high-risk category			
Mother's age <18	3.2	2.55	0.4
Mother's age >34	2.3	3.35	6
Birth interval <24 months	11.3	1.48	10.3
Birth order >3	15.9	1.45	12.3
Subtotal	32.7	1.7	28.9
Multiple high-risk category			
Age <18 and birth interval <24 months[2]	0.5	0	0.2
Age >34 and birth interval <24 months	0.2	0	0.3
Age >34 and birth order >3	10.2	1.12	24.5
Age >34 and birth interval <24 months and birth order >3	2	2.35	4.4
Birth interval <24 months and birth order >3	7	2.79	8.6
Subtotal	19.9	1.79	38
In any avoidable high-risk category	52.5	1.74	66.9
Total	**100**	**na**	**100**
Number of births/women	4,119	na	4,086

Note: 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.

Almost 25% of births in Solomon Islands are not in any high-risk category, which indicates a drop of 7% in this category since the SIDHS 2006–2007. Another 23% of births are first order births to mothers aged 18–34 and are considered to be an unavoidable risk category. This group has increased by 21% since the SIDHS 2006–2007. The remaining 52% of births are in at least one of the specified avoidable high-risk categories: 33% fall in the single avoidable high-risk category and 20% are in the multiple avoidable high-risk categories. The most common births in the single avoidable high risk include those for birth orders over 3 (16%) and births with short intervals of less than 12 months (11%). Births in multiple high-risk categories are mostly found among: 1) mothers aged 34 and older and birth orders higher than 3 (10% of births), and 2) in birth intervals of less than 24 months and in birth orders higher than 3 (7% of births).

The second column of Table 8.6 presents the relative risk of dying (risk ratio) for children born in the five years preceding the survey by comparing the proportion dead in each risk category with the proportion dead among children with no risk factors. Overall, the risk ratio is higher for a child who falls within any avoidable high-risk category (single high-risk and multiple high-risk) than for a child who is within an unavoidable risk category (1.74 compared with 1.37). Moreover, the data show little difference between the risk of dying among births in the single high-risk category and births in the multiple high-risk categories, with both categories having a risk ratio of 1.7.

The SIDHS 2015 found that the risk of dying among births for both the unavoidable risk category and in any avoidable high risk-category has increased since the SIDHS 2006–2007. For example, the risk ratio in any avoidable high-risk category in the SIDHS 2006–2007 was 1.1 compared with 1.7 in the SIDHS 2015. It is important to note that in the SIDHS 2015, the highest single high-risk is for births from older mothers aged 34 and over with a risk ratio of 3.4 higher than the 1.6 risk ratio reported in the SIDHS 2006–2007. The highest multiple high-risk category is for births with combined factors, such as children born to mothers reporting a short birth interval of less than 24 months, and mothers having had three previous births, both having a ratio of 2.8.

The last column in Table 8.6 shows the potential for high-risk births among currently married women. A woman's current age, the time elapsed since her last birth, and parity are used to determine the risk categories in which any birth she conceived at the time of the survey will fall. In the final data processing, the criteria for placing women into specific risk categories are adjusted to take into account the gestation period.

Two-thirds of currently married women in Solomon Islands have the potential of a high-risk birth, with 29% of these falling within the single high-risk category and another 38% falling into multiple high-risk categories. Another one out of four married women are not in any high-risk category while about 8% of married women have the potential of giving birth to a child exposed to any unavoidable risk.

CHAPTER 9 REPRODUCTIVE HEALTH

by Kathleen Gapirongo, National Program Manager, SIMoHMS, and Betty Manehanitai, National Maternal and Safe Motherhood Coordinator, SIMoHMS

KEY FINDINGS

- 94% of women who had a live birth in the five years preceding the survey received antenatal care from a skilled healthcare professional for their last birth.
- Antenatal care attendance was slightly lower in 2015 than it was in 2007.
- About 7 out of 10 women (69%) made four or more antenatal care visits during their entire pregnancy.
- The median number of months of pregnancy before a woman seeks her first antenatal care visit is 5.6 months, indicating that Solomon Islands women start antenatal care at a relatively late stage in their pregnancy.
- The majority of women (88%) took iron tablets or syrup during their last pregnancy.
- Almost all women (98%) who received antenatal care for their most recent birth had their blood pressure taken during their pregnancy.
- Urine and blood samples were taken for 94% and 85% of women, respectively.
- Only 23% of women received two or more tetanus toxoid injections during their last pregnancy.
- An estimated 54% of births were reported to be protected against neonatal tetanus because of previous immunisations the mother had received.
- Postpartum care is reported to be high in Solomon Islands. Only 21% of women who had a live birth in the five years preceding the survey received no postnatal care at all, and 69% of mothers received postnatal care within the critical first two days after delivery.
- About 61% of women received first postnatal care from trained health professionals while about 32% did not receive the service in the first two critical days.
- Concerns that no drugs were available, no provider was available, and taking transport were the most commonly cited problems in accessing health care in Solomon Islands.

INTRODUCTION

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 and the Sustainable Development Goals, and has developed various policies and strategies to this end. The Millennium Development Goals 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 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 when the first ANC visit was made, the type of ANC 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 using health services.

9.1 ANTENATAL CARE

The major objective of antenatal care is to ensure optimal health outcomes for mothers and their babies. Antenatal care from a trained provider is important for monitoring the pregnancy and reducing morbidity risks for the mother and child during pregnancy and delivery. It is during an ANC visit that screening for complications, and advice on a range of issues, including place of delivery and referring mothers with complications to a doctor or healthcare specialist occur. In the SIDHS 2015, interviewers recorded the source of ANC and the person who provided that care for a woman's most recent birth. If a woman received ANC from more than one provider, the provider with the highest qualifications was recorded.

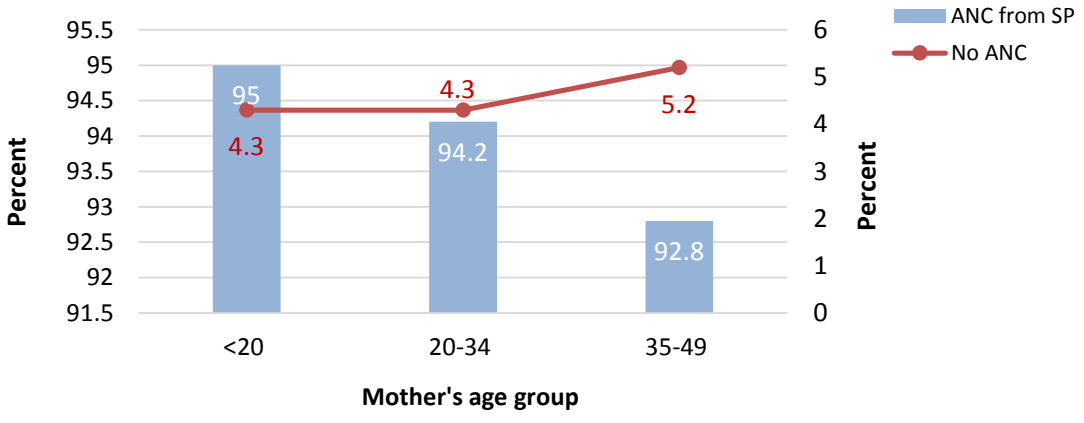
Table 9.1 shows the background characteristics of women who had live births in the five years preceding the survey according to the type of ANC provider. The results indicate that 94% of women received ANC from a skilled provider. Most of these women (87%) sought care from a nurse or midwife, and 2% received care from a doctor. Less than 1% of women received ANC from a traditional birth attendant as their most qualified provider. About 5% of women who gave birth in the five years preceding the survey received no ANC.

The percentage of women who gave birth in the five years preceding the survey and who received antenatal care from a skilled provider was 94%, which is similar to the percentage in the 2006–2007 DHS (95%). However, the percentage of these women who sought health care from a nurse or midwife increased from 72% in SIDHS 2006–2007 to 87% in the 2015 DHS. The percentage of women who received ANC from a doctor remained at 2% and the percentage of women who received ANC from a traditional birth attendant also remained unchanged at 1%. The percentage of women who gave birth in the five years preceding the survey who did not receive ANC increased from 3% (SIDHS 2006–2007) to 5% (2015 DHS).

The results show that there is a high proportion of women aged 15–49 who had a live birth in the five years preceding the survey and who received ANC from a skilled provider. The results, however, also show that the proportion of ANC received varied by women's background characteristics.

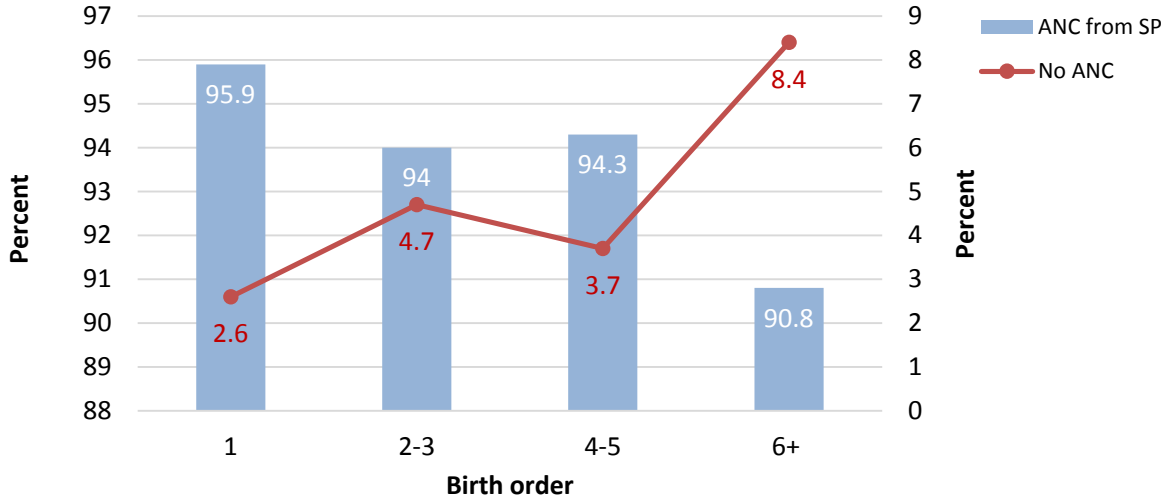
Data shown in Table 9.1 and Figure 9.1 on mother's age at birth are important because they help explain the quality of decisions the mother makes toward her reproductive health. Mothers who give birth at age less than 20 are more likely than older mothers, aged 20–49 to receive ANC from a skilled provider (95% compared with 93% of mothers giving birth at age 35–49), particularly receiving ANC from a nurse or midwife. Mothers giving birth at older ages (35–49) are the least likely to receive ANC from a skilled provider and they are more likely to report receiving no ANC (5%).

Figure 9.1: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey and who received antenatal care from a skilled provider and those who received no antenatal care, by mother's age at birth, Solomon Islands 2015



There are also some differences in the proportion of mothers receiving ANC by birth order. Mothers with highest birth order are least likely to receive ANC (Table 9.1 and Fig. 9.2). Mothers are more likely to receive ANC during their first birth (96%). As the birth number increases to more than 6 births, the very critical time for mothers to receive ANC, the proportion of mothers receiving ANC declines to 91%.

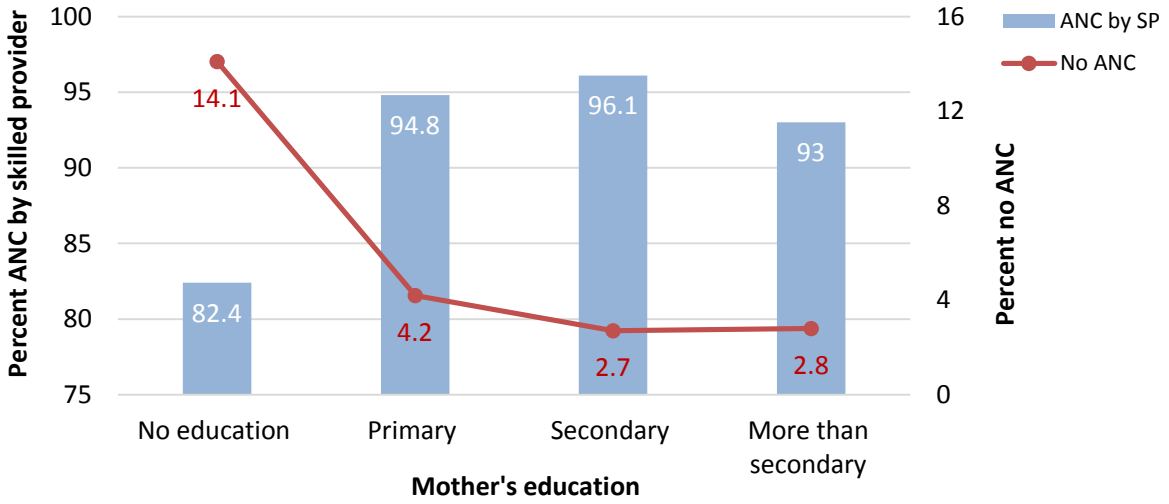
Figure 9.2: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey who received antenatal care (ANC) from a skilled provider (SP) and those had no antenatal care by birth order, Solomon Islands 2015



Urban women are marginally more likely to receive ANC than their rural counterparts (95% compared with 94%) with 5% of rural women stating that they did not receive ANC for their live birth in the five years preceding the survey. By region (province), women in Guadalcanal are the least likely to receive ANC (89%) compared with women in other provinces.

The survey results also indicate a positive relationship between ANC coverage and the woman's educational attainment as shown in Table 9.1 and Figure 9.3. Well educated women are more likely to seek ANC and are more likely to be attended to by a health worker than less educated women. Over 90% of women with a higher education received ANC compared with 82% of women with no education. Furthermore, 14% of women with no education did not receive any ANC compared with 3% women with a higher education who did not receive ANC.

Figure 9.3: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey and who received antenatal care (ANC) from a skilled provider (SP), and those women who received no ANC, by mother's education level, Solomon Islands 2015



Similarly, ANC is also linked with a woman's living status. Women living in households in the highest wealth quintile are more likely to receive ANC (97%) than women living in households within the lowest

wealth quintile (89%). Nearly 9% of women living in households in the lowest wealth quintile received no antenatal care compared to only 1–5% of women living in other wealth quintile households.

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 antenatal care (ANC) provider during pregnancy for the most recent birth and the percentage receiving antenatal care from a skilled provider for the most recent birth, according to background characteristics, Solomon Islands 2015

Background characteristic	Antenatal care provider							No ANC	Total	Percentage receiving antenatal care from a skilled provider[1]	Number of women
	Doctor	Nurse/ midwife	Auxiliary midwife	Community/ village health worker	Traditional birth attendant	Other	Missing				
Mother's age at birth											
<20	1.8	87.8	5.4	0.7	0	0	0	4.3	100	95	272
20–34	1.5	87.2	5.5	0.7	0.1	0.1	0.5	4.3	100	94.2	2,039
35–49	3.1	84.3	5.3	0	0	0.1	1.9	5.2	100	92.8	497
Birth order											
1	1.6	89.7	4.6	0.7	0	0	0.8	2.6	100	95.9	660
2–3	1.9	87.1	5	0.6	0.2	0.1	0.5	4.7	100	94	1,092
4–5	1.5	86.9	5.8	0.8	0.1	0.2	0.9	3.7	100	94.3	673
6+	2.7	80.3	7.7	0	0	0	0.8	8.4	100	90.8	382
Residence											
Urban	3.1	89.2	2.8	1.2	0	0.1	1.2	2.6	100	95	530
Rural	1.5	86.2	6.1	0.4	0.1	0.1	0.6	4.9	100	93.8	2,276
Region											
Honiara	3.6	90.6	1.1	1.8	0	0	1.6	1.3	100	95.2	336
Guadalcanal	4.5	76.9	7.7	1.2	0.4	0.5	0.4	8.4	100	89.1	543
Malaita	0.5	84.1	9.4	0.2	0	0	0.4	5.3	100	94	713
Western	0.6	92.1	5.4	0	0.2	0	0.4	1.3	100	98.1	405
Other provinces	1.1	91.4	2.4	0.2	0	0	0.9	4	100	94.9	810
Education											
No education	1.2	75.6	5.6	1.3	0.8	0.2	1.2	14.1	100	82.4	261
Primary	1.6	87	6.1	0.3	0	0.1	0.7	4.2	100	94.8	1,309
Secondary	1.5	89.6	5	0.7	0.1	0.1	0.3	2.7	100	96.1	1,084
More than secondary	6.6	82.9	3.6	1	0	0	3.1	2.8	100	93	152
Wealth quintile											
Lowest	1.5	82.3	5.1	0.6	0.3	0.2	1.2	8.8	100	88.9	616
Second	0.4	88.6	5.5	0.4	0	0.3	0	4.8	100	94.5	575
Middle	1.4	87.1	6.1	0.4	0	0	1.1	3.8	100	94.6	563
Fourth	1.7	87.4	6.9	0.8	0.2	0	0.3	2.8	100	96	556
Highest	4.5	89.1	3.5	0.6	0	0	0.9	1.3	100	97.1	496
Total	**1.8**	**86.7**	**5.5**	**0.6**	**0.1**	**0.1**	**0.7**	**4.5**	**100**	**94**	**2,807**

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications is considered in this tabulation.

[1] Skilled provider includes doctor, nurse/midwife, and auxiliary midwife.

9.1.1 Number and timing of antenatal care

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 or during the first 1–12 weeks of pregnancy. Information on ANC visits and the stage at which pregnant women should seek ANC is presented in Table 9.2.

The results of the survey shows that about seven in ten women (69%) received four or more ANC visits in their last pregnancy before the survey, while about 20% had less than the recommended number of ANC visits before delivery and about 5% never visited an ANC clinic in 2015. Comparing this result to the SIDHS 2006–2007, one may conclude that there has been minimal improvement in the level of ANC services provided in the last eight years. In the SIDHS 2006–2007, about 65% of women aged 15–49 had four or more ANC visits during their most recent birth before the survey (Fig. 9.4).

Figure 9.4: Percent distribution of women aged 15–49 who had a live birth in the five years preceding a survey according to the number of ANC visits, SIDHS 2006–2007 and SIDHS 2015

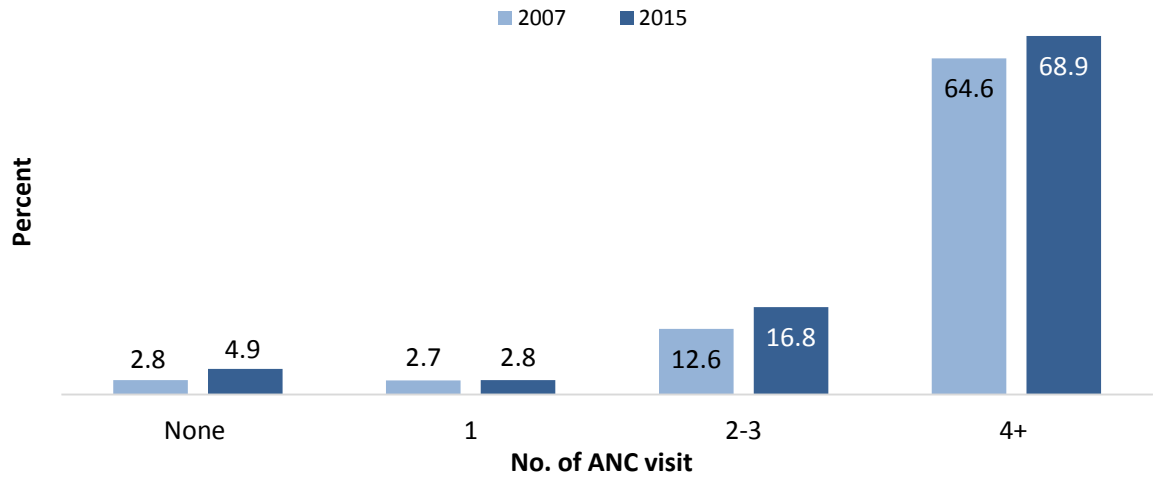


Table 9.2 also shows the distribution of women by urban and rural areas and by the total number of ANC visits, with women in urban areas more likely to make four or more ANC visits during their pregnancy than women in rural areas. As illustrated, 72% of women in urban areas had four ANC visits compared with 68% of women in rural areas. Those women who did not visit an ANC clinic during their pregnancy stage coupled with those who had less than four ANC visits accounted for about 26% of rural women but only 18% of urban women.

It is recommended that ANC visit for pregnant women should take place as early as or during the first trimester (i.e. the first 1–12 weeks or in the first to third month of pregnancy). Table 9.2 indicates late ANC visits among Solomon Island women, with the majority of them making their first ANC visit between the fourth and seventh month of pregnancy, 40% visiting an ANC while they were four to five months pregnant and another 34% of women visiting an ANC for the first time when they were six to seven months pregnant.

The median gestational age when women made their first ANC visit is 5.6 months, indicating that most women were at risk during their pregnancy because the opportunity for early diagnosis was lost and proper treatment and protection from having further complications would be provided late. In comparing these data with the 2006–2007 DHS, it is quite obvious that very little progress has been made in terms of provision of ANC services in the country.

Table 9.2: 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 2015

Number and timing of ANC visits	Residence		Total
	Urban	Rural	
Number of ANC visits			
None	3.3	5.3	4.9
1	1.5	3.1	2.8
2–3	12.8	17.8	16.8
4+	72.3	68.1	68.9
Don't know/missing	10.2	5.7	6.6
Total	**100**	**100**	**100**
Number of months pregnant at time of first ANC visit			
No antenatal care	3.3	5.3	4.9
<4	14	17.4	16.7
4–5	40.8	40	40.2
6–7	37	32.9	33.7
8+	4	3.9	3.9
Don't know/missing	0.9	0.5	0.6
Total	**100**	**100**	**100**
Number of women	530	2,276	2,807
Median months pregnant at first visit (for those with ANC)	5.7	5.6	5.6
Number of women with ANC	513	2,156	2,670

9.1.2 Components of antenatal care

In Solomon Islands, it is recommended that every pregnant woman receive the following services: height and weight measurements, blood pressure measurement, iron tablets, tetanus toxoid immunisation, abdominal examination, and pregnancy consultation and/or counselling. As part of her antenatal care, a woman also should be informed of the signs of pregnancy complications and give blood and urine samples.

Similar to the SIDHS 2006–2007, the SIDHS 2015 also collected information from women aged 15–49 about the type of ANC care they received during pregnancy with their recent live birth. Table 9.3 presents the percentage of women who had a live birth in the five years preceding the survey who took iron tablets and intestinal parasite drugs. The table also shows the percentage of women who were informed about signs of pregnancy complications as well as those receiving the selected routine ANC services. The SIDHS 2015 results show that, with the exception of intestinal parasite drugs, the majority of women received the minimum ANC during their most recent live birth before the survey as illustrated in Figure 9.3. Among women who received ANC for their most recent birth in the five years preceding the survey, the majority (more than 90%) had their blood pressure measured and urine sample tested; another 81% were informed of signs of pregnancy complications, while 85% had their blood tested. Among women with a live birth in the five years preceding the survey, 88% took iron tablets or syrup. Only 49% took intestinal parasite drugs. Islands.

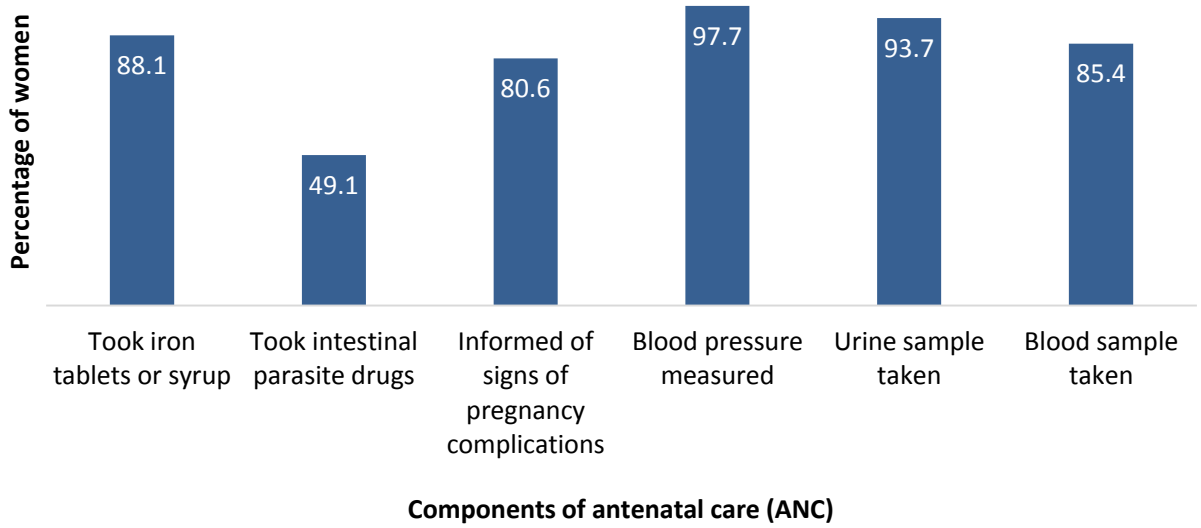
The SIDHS 2015 results show that, with the exception of intestinal parasite drugs, the majority of women received the minimum ANC during their most recent live birth before the survey as illustrated in Figure 9.3. Among women who received ANC for their most recent birth in the five years preceding the survey, the majority (more than 90%) had their blood pressure measured and urine sample tested; another 81% were informed of signs of pregnancy complications, while 85% had their blood tested. Among women with a live

birth in the five years preceding the survey, 88% took iron tablets or syrup. Only 49% took intestinal parasite drugs.

There is evidence that the components of ANC services are not equally received by all women when looking at the distribution of ANC by women's background. Among women who took iron tablets or syrup, women aged 35–49 while pregnant, women with two to three or more than six births, women living in Guadalcanal and Malaita, women with no education or only a primary education, and women living in the lowest wealth quintile households were the least likely to take iron tablets or syrup. This pattern is similar among women who took intestinal parasite drugs, with Malaita Province reporting the lowest percentage of women taking intestinal parasite drugs (30%) of all the provinces.

Among women who were informed of signs of pregnancy complications, the most disadvantaged group of women were those living in rural areas, women residing in other provinces, women with no and little education, and women in the lowest and second lowest wealth quintile households. Furthermore, women with high birth order children, women in rural areas, women from other provinces, women with lower education and from the lowest wealth quintile are less likely to have their urine and blood tested. There was little difference among women having their blood pressure measured by background characteristics.

Figure 9.5: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey and who received specific antenatal care (ANC) services, Solomon Islands 2015



In summary, the survey results show that a full range of ANC services is being provided. However, while the coverage of at least four ANC visits made during pregnancy is fairly high, concerted efforts are still needed to improve the timing of first ANC visits and the quality of ANC services being provided, particularly in educating women about the early signs of pregnancy complications and the importance of taking anti-helminthic drugs. Weight is an important component of an ANC visit because it measures foetal growth; however, because this was not included in the SIDHS 2015 ANC components questionnaire, no data are available.

Table 9.3: Components of antenatal care

Among women aged 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 2015

Background characteristics	Among women with a live birth in the past 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 past 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 past five years	Informed of signs of pregnancy complications	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	90.4	41	272	80.1	98.1	94.3	87.7	260
20–34	88.1	48.9	2,039	80.5	97.5	93.4	84.8	1,944
35–49	87	54.3	497	81.6	98.1	94.8	86.3	466
Birth order								
1	91.7	47.3	660	80.9	98.3	94.4	88.4	639
2–3	87.4	46.8	1,092	80.6	97.6	93.9	84.6	1,038
4–5	89.1	53.4	673	80.8	97.5	94.1	85	644
6+	82.1	51.4	382	79.9	97	91.2	82.8	349
Residence								
Urban	91.7	56.2	530	87.5	99.5	98.5	96.9	513
Rural	87.3	47.5	2,276	79	97.3	92.6	82.6	2,156
Region								
Honiara	93.2	55.7	336	88.2	99.8	99.5	98.1	329
Guadalcanal	82	57.2	543	77.7	97.5	96.7	89.2	497
Malaita	85	30.3	713	83.3	97.7	94.6	84.8	672
Western	96	60.3	405	85.4	98.6	97.8	94.1	398
Other provinces	88.9	51.9	810	74.4	96.4	86.6	73.5	774
Education								
No education	77.9	33.9	261	77.2	95.5	87.5	77.5	224
Primary	88.5	49.4	1,309	79	97.1	92.5	84.5	1,248
Secondary	90.1	51.1	1,084	82.7	98.6	96	87.3	1,052
More than secondary	88.9	59.6	152	85.2	99	97.7	90.8	145
Wealth quintile								
Lowest	81.3	44	616	74.8	96.1	89.9	78	557
Second	88.7	47.9	575	78.1	96.9	92.6	81.4	547
Middle	88.6	45.3	563	80.1	97.5	93.6	85.8	538
Fourth	91.6	51.2	556	84.2	98.3	94.5	87.7	540
Highest	91.5	58.9	496	86.8	99.8	98.6	95.2	487
Total	**88.1**	**49.1**	**2,807**	**80.6**	**97.7**	**93.7**	**85.4**	**2,670**

9.1.3 Tetanus toxoid injections

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 the baby from neonatal tetanus. For full protection, a

pregnant woman needs two doses of TT during her first pregnancy and one dose of TT in each of her subsequent pregnancies. However, if a woman was immunised before she became pregnant, she may require one or no TT injections during that pregnancy, depending on the number of injections she has received and the timing of the last injection.

For a woman to have lifetime protection, five doses of TT are required, two of which should be taken in the first pregnancy while one dose must be taken in each of the subsequent pregnancies until the fourth pregnancy. The SIDHS 2015 collected data on whether or not women received at least two TT injections during pregnancy, and whether or not the last live births before the survey were protected against neonatal tetanus.

Table 9.4: 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 2015

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	29.8	47.1	272
20–34	22	53.7	2,039
35–49	22.5	58.2	497
Birth order			
1	34	43	660
2–3	19.6	58.1	1,092
4–5	20.7	59.3	673
6+	16.7	50.9	382
Residence			
Urban	23.6	53.2	530
Rural	22.7	54	2,276
Region			
Honiara	20	49.1	336
Guadalcanal	25.2	53.3	543
Malaita	17	44.3	713
Western	29.4	64	405
Other provinces	24.3	59.4	810
Education			
No education	20.2	46.1	261
Primary	21.9	55.8	1,309
Secondary	24.6	52.6	1,084
More than secondary	23.1	58.7	152
Wealth quintile			
Lowest	20.2	51.7	616
Second	21.7	52.5	575
Middle	26.6	56.3	563
Fourth	23.7	55	556
Highest	22.1	53.8	496
Total	**22.8**	**53.8**	**2,807**

About 23% of women aged 15–49 received two or more injections of TT in their last pregnancy in the five years preceding the survey, while 54% of women reported that their most recent live birth was protected against neonatal tetanus. This result clearly shows that TT coverage in Solomon Islands is very low, signifying that a significant portion of babies are born without being protected against neonatal tetanus.

The proportion of mothers aged 15–49 who received two or more TT injections shows some variation by background characteristics. For instance, older mothers, mothers with 6 or more births, mothers from rural areas, and mothers living in Malaita are the least likely to receive two or more injections of TT during their last pregnancy. The proportion of mothers receiving two or more TT injections appears to be increasing with the increasing level of a mother's education while wealth status does not show any clear pattern. The proportion of women receiving two or more TT injections is lowest among mothers in the lowest quintile households while the highest proportion of women receiving TT injections is reported among women in the middle wealth quintile households.

Comparing the results of SIDHS 2015 with those of the SIDHS 2006–2007, it is evident that there was little change in the overall TT coverage and/or coverage of the most recent birth from neonatal tetanus. Again, this further supports the argument that ANC services in Solomon Islands have been stable for the past eight years.

9.2 DELIVERY

9.2.1 Place of delivery

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 9.5 shows the 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, 76% occurred at a public health centre, 8% took place in a private health centre, and another 14% of births were reported to take place at home. According to Table 9.5, younger mothers are more likely to give birth in a health facility than older women. For example, 88% of women aged less than 20 gave birth at a health facility compared with 82% of women aged 35–49. As such, the reverse pattern was observed for the percent distribution of births occurring at home, with the proportion of women giving birth at home increasing from 12% among young mothers to 15% among older mothers.

Women with fewer previous children are more likely to give birth at a health facility than women with many children. The percentage of births occurring at home increases with children's birth order, ranging from 6% of mothers with one child giving birth at health facilities to 29% of mothers with more than five children (Table 9.5 and Fig. 9.7).

The SIDHS 2015 also found that the proportion of women giving birth at a health facility increases with the number of ANC visits a woman completed before she gave birth. The percentage of women who gave birth at home decreases as the number of ANC visits completed before delivery increases. This finding clearly indicates that women who never attended ANC clinics are more likely to give birth at home than women who were able to attend more ANC clinics; 44% of women who had no ANC visits and who delivered at home, and 90% of women completing the recommended number of ANC visits and who delivered at health facilities (Table 9.5 and Fig. 9.8).

The proportion of births occurring in a health facility is higher in urban areas (95%) than in rural areas (82%). As such, home births are higher in rural areas and are more common among rural women living in Guadalcanal, Malaita and other provinces with the corresponding percent of 19%, 18% and 16%.

The SIDHS 2015 also reveals that women's educational attainment may have a direct influence on where she would deliver her baby. The proportion of women giving birth at a health facility increases along with the woman's education level, from 68% of women with no education giving birth at a health facility to 96% of women with more than a secondary education. The proportion of women giving birth at home decreases with a woman's education level, with 29% of women with no education delivering at home compared with only 2% of women with a higher education delivering at home (Table 9.5 and Fig. 9.9). A similar pattern is noticeable among women living in different wealth quintile households.

When comparing the results of the SIDHS 2006–2007 to those of the SIDHS 2015, it was observed that there was no significant change in the overall percentage of births occurring both at home and at the health facility.

Table 9.5: Place of delivery

Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a health facility, according to background characteristics, Solomon Islands 2015

Background characteristic	Health facility		Home	Other	Missing	Total	Percentage delivered in a health facility	Number of births
	Public sector	Private sector						
Mother's age at birth								
<20	78.7	9	11.5	0	0.7	100	87.8	463
20–34	76.3	8.2	13.5	0.3	1.6	100	84.5	3,051
35–49	73.3	8.8	15.3	0.7	1.9	100	82	606
Birth order								
1	82.8	9.1	6.2	0.1	1.8	100	91.9	1,054
2–3	77.4	8	12.9	0.3	1.4	100	85.4	1,616
4–5	74.3	8.8	14.8	0.3	1.8	100	83.1	941
6+	61.4	7.9	28.7	1.1	1	100	69.2	509
Antenatal care visits[1]								
None	47.3	3.8	43.9	0	4.9	100	51.2	137
1–3	70.2	11.6	17.2	0.8	0.2	100	81.8	552
4+	81.7	8.4	9.3	0.3	0.3	100	90.1	1,933
Don't know/missing	83.4	8.7	7.3	0.6	0	100	92.1	185
Residence								
Urban	91.5	3.9	2.3	0.2	2.1	100	95.4	738
Rural	72.8	9.4	16	0.4	1.4	100	82.2	3,382
Region								
Honiara	95.5	0.2	1.8	0.2	2.4	100	95.7	464
Guadalcanal	64.1	15.4	19.1	0.3	1.1	100	79.5	798
Malaita	70.1	10	17.8	0.7	1.4	100	80.1	1,109
Western	76.4	19.4	2.9	0.1	1.2	100	95.8	560
Other provinces	82.1	0.3	15.5	0.4	1.8	100	82.4	1,187
Mother's education								
No education	58.5	9.6	28.6	0.7	2.6	100	68.1	402
Primary	72.7	8.9	16.4	0.3	1.7	100	81.5	1,958
Secondary	83.2	7.8	7.6	0.3	1.1	100	91	1,553
More than secondary	89.6	6.4	2.2	0.3	1.5	100	96	206
Wealth quintile								
Lowest	63.8	5.5	28.7	0.2	1.7	100	69.3	957
Second	76.8	8.4	12.9	0.6	1.2	100	85.2	857
Middle	75.7	12.5	9.5	0.5	1.8	100	88.2	827
Fourth	78.3	10.2	9.8	0.2	1.5	100	88.4	795
Highest	90.5	5.6	2.4	0.2	1.4	100	96.1	684
Total	**76.1**	**8.4**	**13.6**	**0.4**	**1.5**	**100**	**84.5**	**4,119**

[1] Includes only the most recent birth in the five years preceding the survey

Figure 9.6: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by place of birth and by mother's age at birth, Solomon Islands 2015

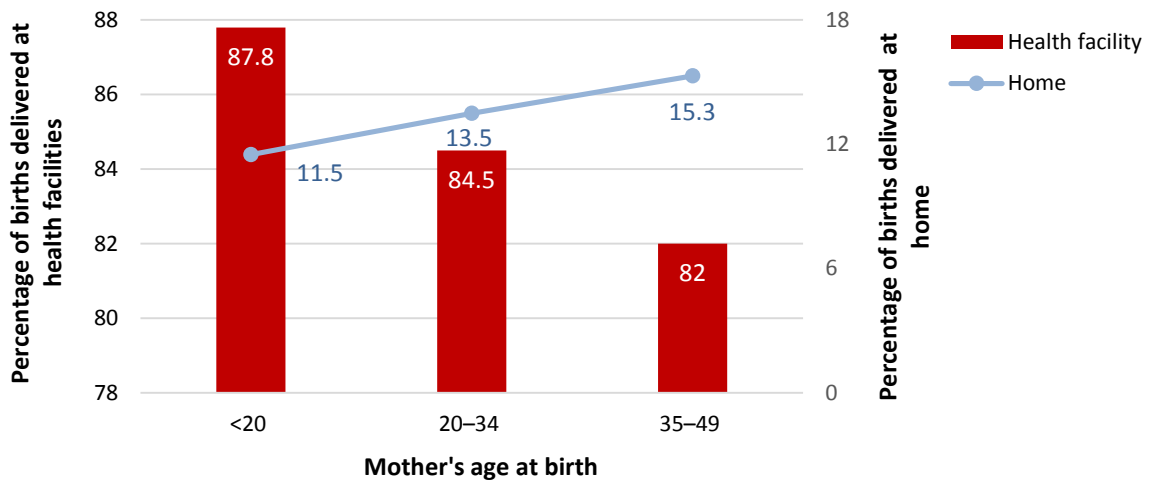


Figure 9.7: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by place of birth and by birth order, Solomon Islands 2015

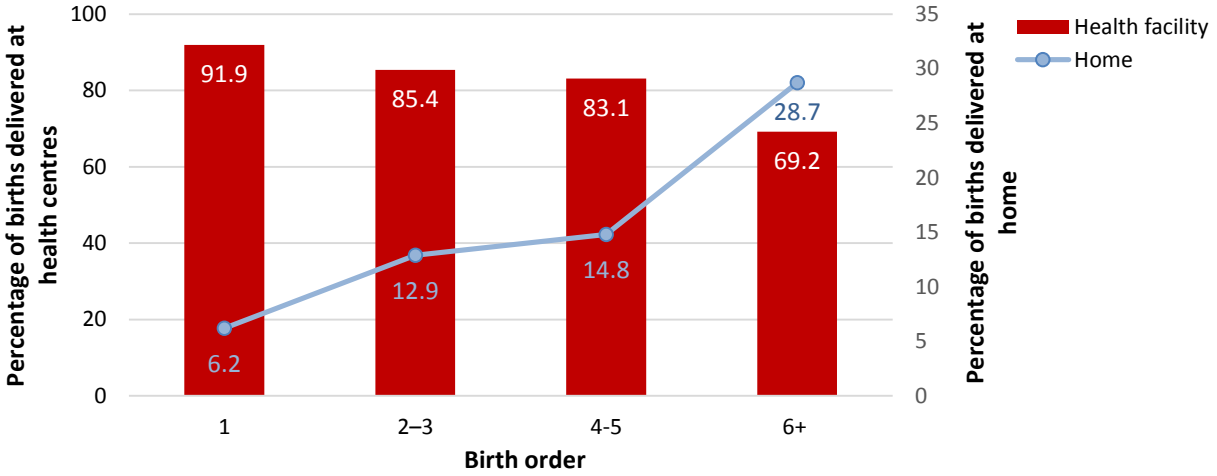


Figure 9.8: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by place of birth and by number of antenatal care visits, Solomon Islands 2015

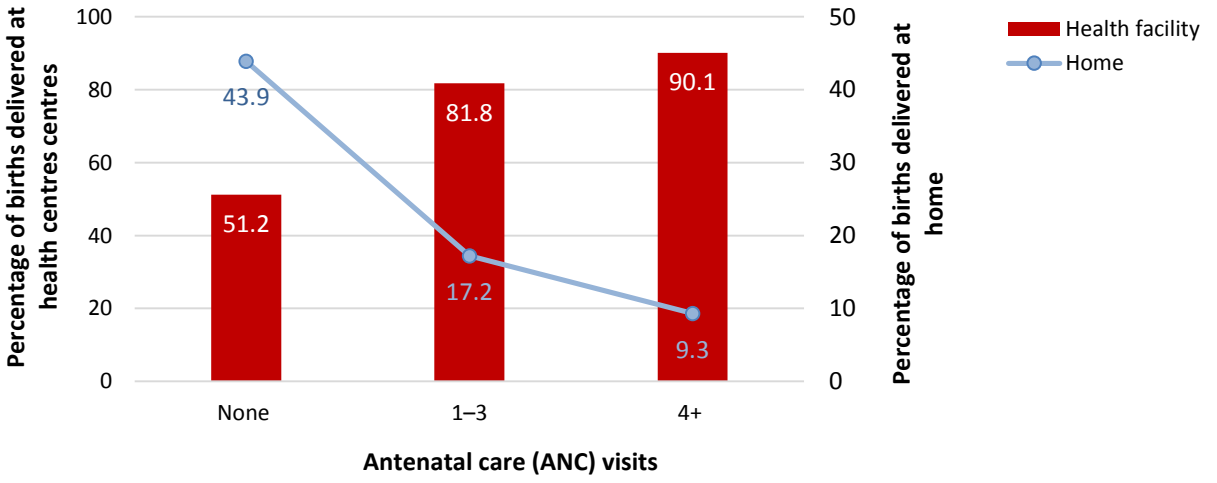
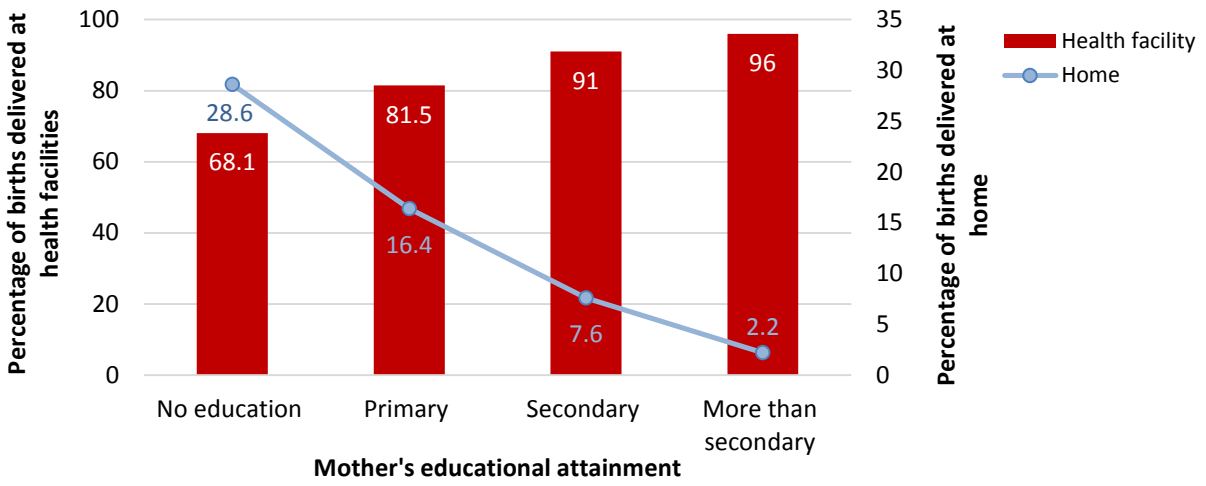


Figure 9.9: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by place of birth and by mother's educational attainment, Solomon Islands 2015



9.2.2 Assistance during delivery

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 infant. The skills and performance of the birth attendant determine whether or not he or she can manage complications and observe hygienic practices. Table 9.6 and Figure 9.10 show the distribution of live births in the five years preceding the survey by the person providing assistance, according to background characteristics of the mother.

Overall, about 86% of deliveries were assisted by a skilled provider. About 4% of births were delivered with the assistance of a doctor, 72% were assisted by a nurse or midwife, and 10% were assisted by a nurse aid, while 2% of births were assisted by a traditional birth attendant or community healthcare worker. Less than 1% of mothers received no assistance during childbirth. Only 6% of births were delivered by caesarean section.

Women giving birth elsewhere than the health centres, mothers living in rural areas, mothers from other provinces, mothers with no or low education, and mothers residing in the lowest wealth quintile households are less likely to receive assistance by a skilled provider.

Moreover, Figures 9.11 and 9.12 further illustrate the percent of births assisted by skilled attendants by mother's age at birth and by birth order. Younger women are more likely to give birth in a health facility where either a doctor, registered nurse or midwife, or nurse aide will attend them as opposed to older women who are more likely than younger women to give birth at home with the help of a relative, a traditional birth attendant, or give birth by themselves.

Mothers with fewer children are more likely to be assisted by a skilled provider than mothers with six or more children. Mothers with more than 6 children are more likely to opt for traditional birth attendants or a relative to assist them during delivery. This indicates that seeking assistance from a skilled birth provider during delivery diminishes as a woman's parity increases, putting women in this category at greater risk of having complications during delivery. This may contribute to more maternal deaths and/or stillbirths in the country.

Furthermore, births assisted by skilled providers are more common among mothers who have had more than four ANC visits (91%), mothers in urban areas (96%), mothers living in Honiara (97%) and Western Province (97%), mothers with more than a secondary education (97%) and women living in the highest wealth quintile households (96%).

Table 9.6: 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 2015

Background characteristic	Person providing assistance during delivery								Percentage delivered by a skilled provider[1]	Percentage delivered by C-section	Number of births
	Doctor	Midwife/ Registered nurse	Nurse aid	Traditional birth attendant	Relative/ other	No one	Don't know/ missing	Total			
Mother's age at birth											
<20	3.7	72.7	11.8	1	9.4	0.4	1	100	88.2	6.6	463
20–34	3.5	72.6	10.1	2	9.5	0.5	1.9	100	86.1	5.7	3,051
35–49	5.6	68.3	11.2	3.1	8.2	0.9	2.7	100	85.1	6.4	606
Birth order											
1	4.4	78.1	10.3	1.2	3.8	0	2.2	100	92.8	8.3	1,054
2–3	3.6	73.8	9.7	1.7	9.7	0.1	1.4	100	87.1	5.3	1,616
4–5	3.9	68.6	12.7	1.7	10.5	0.4	2.2	100	85.2	4.6	941
6+	3.1	59.7	8.8	5.7	17.3	3.1	2.3	100	71.6	5.1	509
Antenatal care visits[1]											
None	3.5	40.5	9.7	10.9	30.5	0	4.9	100	53.7	6.9	137
1–3	3.3	70.9	10.4	3	11.2	0.3	1	100	84.6	6.9	552
4+	4.3	76.8	10	1	6.8	0.6	0.6	100	91.1	6.9	1,933
Don't know/ missing	5.9	75.4	12.8	4	1.9	0	0	100	94	3.3	185
Place of delivery											
Health facility	4.3	82.8	11.8	0	0.5	0	0.6	100	98.9	7	3,482
Elsewhere	1.1	13.1	3.1	14.6	63.5	3.8	0.8	100	17.4	0	574
Missing	2.9	10.2	1.7	0	2.4	0	82.8	100	14.8	0	63
Residence											
Urban	7	86.2	2.8	0.2	1.5	0	2.3	100	96	7.9	738
Rural	3.1	68.8	12.1	2.5	11	0.6	1.8	100	84.1	5.4	3,382
Region											
Honiara	6.5	88.6	1.9	0.2	1	0	1.8	100	97	7.1	464
Guadalcanal	7.8	64.1	8.2	5.4	11.6	0.1	2.8	100	80.1	5.4	798
Malaita	1.5	67.8	11.8	1.4	15.5	0.6	1.3	100	81.1	6.6	1,109
Western	2.1	79.5	15.1	1	0.7	0.2	1.4	100	96.7	7.5	560
Other provinces	3	71	11.8	1.7	9.2	1.1	2.1	100	85.9	4.3	1,187
Mother's education											
No education	2.5	53.6	13	4.7	23.7	0.3	2.2	100	69	3.6	402
Primary	3.1	70	11	2.3	10.4	1	2.2	100	84.1	4.5	1,958
Secondary	4.3	77.5	10	1.3	5.4	0	1.5	100	91.8	7.7	1,553
More than secondary	9.3	84.4	3.1	0.7	0.7	0	1.7	100	96.9	10.3	206
Wealth quintile											
Lowest	2.7	54.6	14.8	4.1	20.6	1	2.3	100	72	3.2	957
Second	2.7	72.4	11.6	2.4	9.3	0.4	1.2	100	86.7	6.1	857
Middle	3.5	75.3	11.2	1.6	5.6	0.1	2.6	100	90	6.3	827
Fourth	3.5	79.3	7.6	1.3	6	0.9	1.4	100	90.4	7.4	795
Highest	7.7	83.2	5.3	0.3	1.7	0	1.9	100	96.2	7.1	684
Total	**3.8**	**71.9**	**10.4**	**2.1**	**9.3**	**0.5**	**1.9**	**100**	**86.2**	**5.9**	**4,119**

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation.

[1] Skilled provider includes doctor, midwife, registered nurse, nurse aid.

[2] Includes only the most recent birth in the five years preceding the survey.

Figure 9.10: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by the type of person providing delivery assistance, Solomon Islands 2015

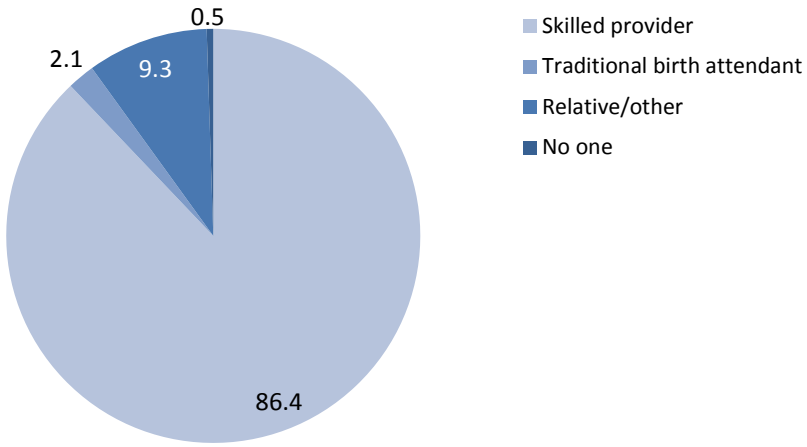


Figure 9.11: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey with the birth attended to by a skilled provider, by mother's age at birth, Solomon Islands 2015

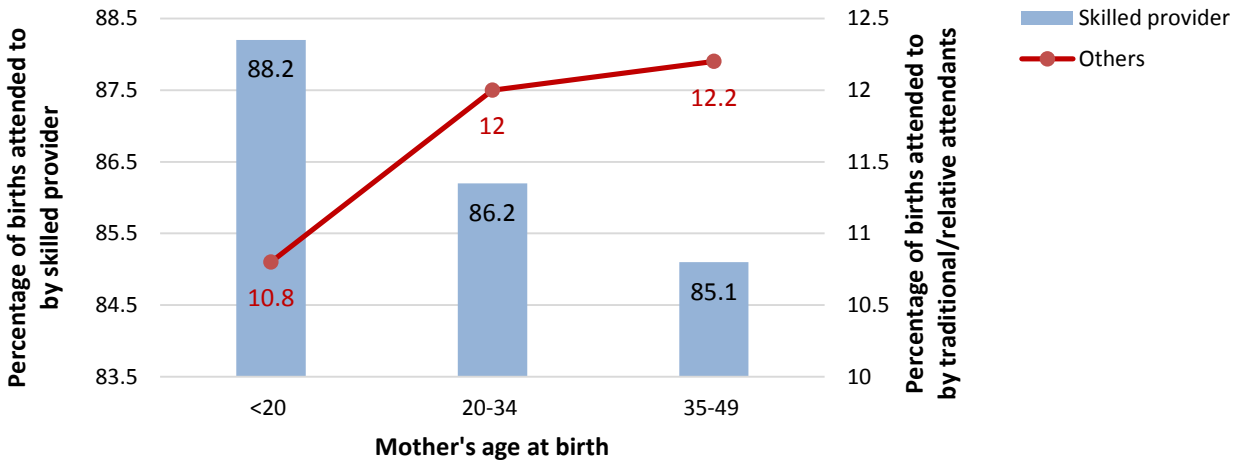
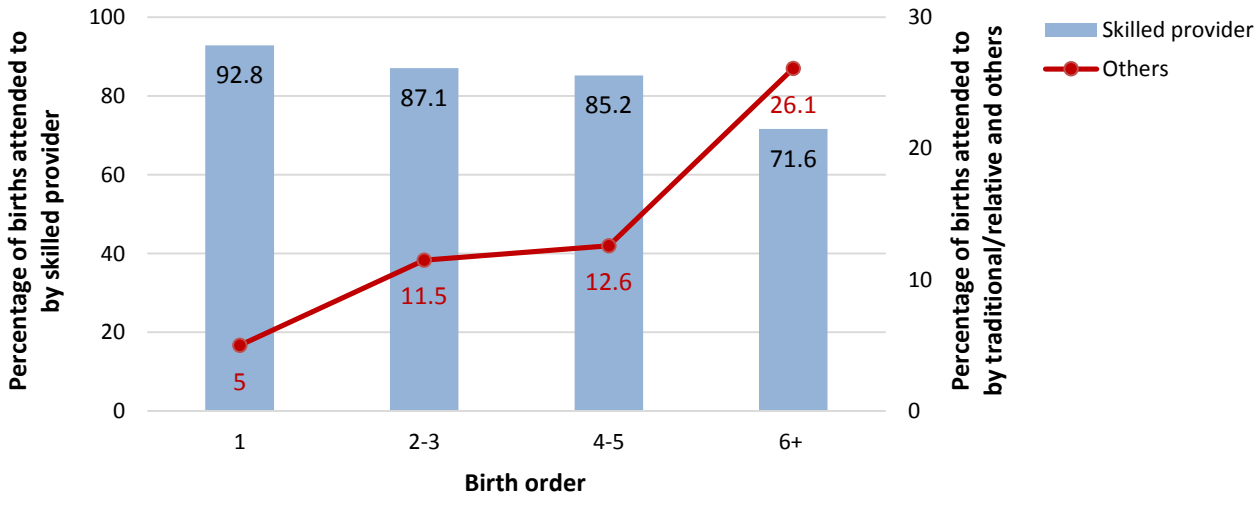


Figure 9.12: Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey with the birth attended to by a skilled provider, by birth order, Solomon Islands 2015



9.3 POSTNATAL CARE

Postpartum care is important for both the mother and the child for treating any complications arising from the delivery as well as for providing the mother with important information on family planning, personal hygiene, nutrition and breast feeding and, how to care for her child. The postpartum period, also known as the puerperium, is defined as the time between delivery of the placenta and 42 days (or 6 weeks) following delivery. The timing of postpartum care is important. The first two days after delivery are critical because most maternal and neonatal deaths occur during this period. The Solomon Islands Obstetrics Guidelines and the WHO 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, and when they bring their infants for immunisation at six weeks.

In the SIDHS 2015, the extent of postnatal care was determined by asking mothers whether they had received a health check after the delivery of their last birth that occurred in the five years preceding the survey, when they received the first postnatal checkup, and what type of health provider they saw for postnatal care.

9.3.1 Timing of first postnatal checkup for mother

Table 9.7 shows the timing of the first postpartum checkup by background characteristic and the percentage of women with a postnatal checkup in the first two days after birth. About 69% of women had their postnatal check up in the first two days after birth, out of which 44% received postpartum care within less than four hours after birth and another 19% of women received postpartum care within one to two days after delivery. Another 21% of women claimed they did not receive any postpartum care after their last birth.

Younger women, women with four to five children, urban women, better-educated women, and women in the highest wealth quintile households were more likely to receive postpartum care.

Comparisons across the provinces also show that postpartum care is highest among women in Honiara (90%) and Western Province (73%), and very low among women in Guadalcanal (62%) and other provinces (61%). In comparison to the SIDHS 2006–2007, postpartum checkup services in Solomon Islands show some improvement, with more women receiving postpartum services in 2015.

Table 9.7: Timing of first postnatal checkup

Among women aged 15–49 giving birth in the two years preceding the survey, the percent distribution of the mother's first postnatal checkup for the last live birth by time after delivery, and the percentage of women with a live birth in the two years preceding the survey who received a postnatal checkup in the first two days after giving birth, according to background characteristics, Solomon Islands 2015

Background characteristic	Time after delivery of mother's first postnatal checkup:						No postnatal checkup[1]	Total	Percentage of women with a postnatal checkup in the first two days after birth	Number of women
	Less than 4 hours	4–23 hours	1–2 days	3–6 days	7–41 days	Don't know/ missing				
Mother's age at birth										
<20	45.5	6.7	18.1	2.6	4.3	1.3	21.4	100	70.4	166
20–34	43	5.8	20	4.8	3.7	2.2	20.4	100	68.9	1,205
35–49	46.4	4.8	13.8	1.9	6.3	2.2	24.6	100	65	244
Birth order										
1	42.7	7.6	18.7	4.7	4.6	1.5	20.2	100	68.9	400
2–3	45.5	5.4	18.5	4.3	3.3	2.5	20.5	100	69.5	641
4–5	46.6	4.4	20.7	4.2	4.8	2.6	16.7	100	71.7	381
6+	34.7	6.1	17	2.2	4.7	1.6	33.6	100	57.8	193
Place of delivery										
Health facility	48.4	6.7	20	3.8	4.4	2.2	14.5	100	75.2	1,380
Elsewhere	16.7	0.5	12.8	6.4	2.7	2	58.9	100	30	227
Missing	0	0	0	0	0	0	100	100	0	8
Residence										
Urban	46.7	13.4	22.6	2.5	4.1	1.9	8.8	100	82.7	291
Rural	43.1	4.1	18.1	4.5	4.2	2.2	23.8	100	65.3	1,324
Region										
Honiara	50.7	15.9	23.1	1.7	1.2	1.7	5.6	100	89.7	182
Guadalcanal	37.5	3.2	20.8	5.2	7.1	1.1	25.1	100	61.5	301
Malaita	51	7.2	12.1	1.2	1	0.7	26.8	100	70.3	420
Western	49.5	3.6	19.2	3.1	9.3	3.8	11.5	100	72.6	238
Other provinces	35.8	3.3	22	7.6	3.6	3.4	24.3	100	61	474
Education										
No education	40.1	3	14.5	2.6	4.7	2.7	32.4	100	57.6	145
Primary	42.9	5.6	17.9	4.2	2.7	2.5	24.1	100	66.5	699
Secondary	44.4	6.4	20.8	4.1	5.3	1.9	17.1	100	71.6	680
More than secondary	52	6.3	18.9	6	6.1	0.5	10.1	100	77.2	90
Wealth quintile										
Lowest	30.5	4.2	16.2	8.1	4.6	2.7	33.7	100	50.8	378
Second	42.4	5.6	19.7	3.3	3	1.9	24	100	67.7	337
Middle	52.5	4.7	15.4	2.6	4.6	2	18.3	100	72.5	305
Fourth	48.3	4.8	20	4.4	4	2.8	15.8	100	73.1	318
Highest	48.7	10.4	24.2	1.3	4.7	1	9.7	100	83.6	277
Total	**43.8**	**5.8**	**18.9**	**4.1**	**4.2**	**2.1**	**21.1**	**100**	**68.5**	**1,615**

[1] Includes women who received a checkup after 41 days.

9.3.2 Provider of first postnatal checkup for mother

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 9.8 shows that 61% of women received postpartum care from a doctor, nurse or midwife, while 6% received postpartum care from a nurse aide, and less than 1% from other healthcare professionals, including traditional birth attendants. About 32% of women did not have a postpartum check up in the first two days after birth.

Table 9.8: Type of provider of first postnatal checkup for the mother

Among women aged 15–49 giving birth in the two years preceding the survey, the percent distribution by type of provider of the mother's first postnatal health check in the two days after the last live birth, according to background characteristics, Solomon Islands 2015

Background characteristic	Type of health provider of mother's first postnatal checkup				No postnatal checkup in the first two days after birth	Total	Number of women
	Doctor/midwife/ registered nurse	Nurse aid	Community/village health worker	Traditional birth attendant			
Mother's age at birth							
<20	61.7	8.7	0	0	29.6	100	166
20–34	61.3	6.1	0.1	1.4	31.1	100	1,205
35–49	58.5	6.5	0	0	35	100	244
Birth order							
1	61.8	6.4	0	0.7	31.1	100	400
2–3	63.4	5	0	1.1	30.5	100	641
4–5	59.4	10.5	0.3	1.5	28.3	100	381
6+	54	3.1	0	0.8	42.2	100	193
Place of delivery							
Health facility	68.2	6.9	0	0.1	24.8	100	1,380
Elsewhere	19.1	3.6	0.5	6.8	70	100	227
Missing	0	0	0	0	100	100	8
Residence							
Urban	80.3	2.2	0	0.1	17.3	100	291
Rural	56.7	7.3	0.1	1.3	34.7	100	1,324
Region							
Honiara	87.7	2.1	0	0	10.3	100	182
Guadalcanal	55.8	4.5	0.4	0.7	38.5	100	301
Malaita	60.3	8.7	0	1.3	29.7	100	420
Western	65.2	7.4	0	0	27.4	100	238
Other provinces	52.3	6.7	0	2	39	100	474
Education							
No education	48.2	8.4	0	1	42.4	100	145
Primary	58.4	6.2	0.2	1.8	33.5	100	699
Secondary	64.2	6.9	0	0.4	28.4	100	680
More than secondary	76.3	1	0	0	22.8	100	90
Wealth quintile							
Lowest	38.5	9.2	0	3.1	49.2	100	378
Second	59.2	7.5	0	1	32.3	100	337
Middle	67.6	4.9	0	0	27.5	100	305
Fourth	66	6.5	0	0.6	26.9	100	318
Highest	80.5	2.7	0.4	0	16.4	100	277
Total	**60.9**	**6.4**	**0.1**	**1**	**31.5**	**100**	**1,615**

Women aged less than 20 years, women who gave birth to their second and third child, urban women, women with a secondary education and higher, women in the highest wealth quintile, and women in Honiara are more likely to receive postpartum care from skilled professionals.

A comparison across the provinces shows that postpartum checks by a skilled health provider varies but is lowest in Guadalcanal (56%) and other provinces (52%). These two provinces also account for the highest proportion of women with no postnatal checkup in the first two days after birth. The proportion of women with no postnatal checkup is also higher among older women, women with six or more children, women who delivered somewhere other than a health centre, women with no education or just a primary education, and women in the lowest wealth quintile households.

Women aged 20–34, women with four to five children, women in rural areas, women with only a primary education, and women in the lowest wealth quintile households were the most likely to seek postpartum care from a traditional birth attendant. Also, women from the lowest wealth quintile households, women with no formal education, and women in Malaita, Western and other provinces and women in rural areas were most likely to seek postpartum care from the nurse aide.

9.4 NEWBORN CARE

9.4.1 Timing of first postnatal checkup for newborn

Newborn care is very important for a newborn infant because it is a crucial period for improving the child's chances for survival and to lay the foundation for a healthy life. Early essential newborn care is the initial care provided by a healthcare service at birth for the prevention of infections and treating complications arising from delivery. The WHO states that a newborn infant or neonate is a child that is less than 28 days old. These first 28 days represent the highest risk of dying for the child. Therefore, it is critical that proper care is provided at the appropriate time during the postpartum checkup to look for possible complications. Through the provision of integrated services, the Ministry of Health and Medical Services recommends that newborns receive neonatal care immediately after delivery and at the first postnatal checkup.

Table 9.9 shows the distribution of last births in the two years preceding the survey by time after birth of first postnatal checkup, and the percentage of births with a postnatal checkup in the first two days after birth, according to background characteristics.

Overall, 82% of neonates did not receive postnatal newborn care (this includes newborns that received care after the first week) while only 15.6% of births did receive newborn care as part of a postnatal checkup within the first two days after birth. Of the total births receiving newborn care, 8% received postnatal newborn care within four hours and a further 8% received postpartum newborn care in the first or second day.

Neonates of women aged 20–34, women with four or five children, urban women, better-educated women, and those in the fourth and highest wealth quintile households are more likely to receive postnatal newborn care within an hour after birth.

The proportion of neonates who do not receive postnatal newborn care checkup is highest among young and older mothers, women who have six or more children, women living in rural areas, women living in Western Province, women with a low level of education, and women in the lowest wealth quintile households.

Table 9.9: Timing of first postnatal checkup for the newborn

Percent distribution of last births in the two years preceding the survey by time after birth of first postnatal checkup, and the percentage of births with a postnatal checkup in the first two days after birth, according to background characteristics, Solomon Islands 2015

Background characteristic	Time after birth of newborn's first postnatal checkup									
	Less than 1 hour	1–3 hours	4–23 hours	1–2 days	3–6 days	Don't know/ missing	No postnatal checkup[1]	Total	Percentage of births with a postnatal checkup in the first two days after birth	Number of births
Mother's age at birth										
<20	2.1	4.8	2	5.1	2.2	0	83.9	100	14	166
20–34	2.9	5	1.4	6.7	1.9	0.5	81.6	100	16	1,205
35–49	1.8	5.6	0.7	6.8	1.5	0.6	83	100	14.9	244
Birth order										
1	2.9	5.5	2.2	7.1	2.1	0	80.1	100	17.7	400
2–3	2.8	4.5	1.3	6.8	1.6	0.4	82.6	100	15.4	641
4–5	3.1	5.4	0.9	5.7	2.3	1.2	81.5	100	15.1	381
6+	0.8	5.4	0.4	6.3	1.2	0.6	85.4	100	12.8	193
Place of delivery										
Health facility	3	5.7	1.4	6.6	1.2	0.5	81.6	100	16.8	1,380
Elsewhere	0.4	1.5	0.7	6	6.1	0.6	84.8	100	8.5	227
Missing	0	0	0	10.8	0	0	89.2	100	10.8	8
Residence										
Urban	3.3	11	3.4	10	1.5	0.2	70.5	100	27.7	291
Rural	2.5	3.8	0.9	5.8	1.9	0.5	84.6	100	12.9	1,324
Region										
Honiara	4.7	13.1	4.3	11.3	2.1	0	64.5	100	33.5	182
Guadalcanal	0.2	4.9	0.9	7.3	2.6	0.8	83.3	100	13.3	301
Malaita	0.4	4.6	1.1	8.4	1.9	0.5	83.1	100	14.6	420
Western	4.8	2.1	0.6	2	1.6	0	88.9	100	9.5	238
Other provinces	4.3	4	1	4.9	1.4	0.7	83.8	100	14.2	474
Mother's education										
No education	0	6	1.9	4.5	1.5	0	86.1	100	12.4	145
Primary	1.8	3.5	0.7	6.9	1.7	0.4	85	100	12.9	699
Secondary	3.9	5.8	1.7	6.9	2.3	0.7	78.7	100	18.3	680
More than secondary	4.2	10.7	2.4	4.1	0	0	78.6	100	21.4	90
Wealth quintile										
Lowest	1.2	2	1.4	4.3	2.8	0	88.3	100	8.9	378
Second	2.8	3.2	0	6	2.6	1.6	83.9	100	12	337
Middle	2.7	4.9	1.7	7	1	0.4	82.3	100	16.3	305
Fourth	3.6	7.3	1.7	7.7	0.9	0	78.8	100	20.3	318
Highest	3.1	9.1	2.1	8.6	1.8	0.5	74.8	100	22.8	277
Total	2.6	5.1	1.3	6.5	1.9	0.5	82.1	100	15.6	1,615

[1] Includes newborns who received a checkup after the first week.

9.4.2 Provider of first postnatal checkup for newborn

The type of provider of the first postnatal checkup is crucial given that failure to detect complications could potentially be fatal in this important period. Again, the ability to detect such complications, and to recommend appropriate treatment or referral, depends on the knowledge and skills of the provider undertaking the checkup.

Table 9.10 shows the distribution of births in the two years preceding the survey by type of provider of the newborn's first postnatal health checkup during the two days after the last live birth, according to background characteristics.

Table 9.10: Type of provider of first postnatal checkup for the newborn

Percent distribution of last births in the two years preceding the survey by type of provider of the newborn's first postnatal health check during the two days after the last live birth, according to background characteristics, Solomon Islands 2015

Background characteristic	Type of health provider of newborn's first postnatal checkup			No postnatal checkup in the first two days after birth	Total	Number of births
	Doctor/midwife/ registered nurse	Nurse aid	Traditional birth attendant			
Mother's age at birth						
<20	13	1	0	86	100	166
20–34	14.7	1	0.2	84	100	1,205
35–49	12.7	2.2	0	85.1	100	244
Birth order						
1	16.4	1.3	0	82.3	100	400
2–3	13.8	1.2	0.3	84.6	100	641
4–5	14.5	0.5	0	84.9	100	381
6+	10.7	2.1	0	87.2	100	193
Place of delivery						
Health facility	15.5	1.1	0.1	83.2	100	1,380
Elsewhere	6.7	1.8	0	91.5	100	227
Missing	10.8	0	0	89.2	100	8
Residence						
Urban	27.6	0	0.1	72.3	100	291
Rural	11.3	1.5	0.1	87.1	100	1,324
Region						
Honiara	33.5	0	0	66.5	100	182
Guadalcanal	12.2	1.1	0	86.7	100	301
Malaita	13.2	1.3	0.1	85.4	100	420
Western	8.8	0.7	0	90.5	100	238
Other provinces	11.9	1.9	0.4	85.8	100	474
Mother's education						
No education	11.7	0.7	0	87.6	100	145
Primary	11.8	1.1	0	87.1	100	699
Secondary	16.6	1.4	0.3	81.7	100	680
More than secondary	19.7	1.7	0	78.6	100	90
Wealth quintile						
Lowest	7.2	1.7	0	91.1	100	378
Second	10.7	1.3	0	88	100	337
Middle	13.5	2.1	0.7	83.7	100	305
Fourth	19.6	0.7	0	79.7	100	318
Highest	22.8	0	0	77.2	100	277
Total	**14.3**	**1.2**	**0.1**	**84.4**	**100**	**1,615**

Of the total births receiving newborn care (16%), 14% received postnatal newborn care from a doctor, nurse or midwife, while 1% received postnatal newborn care from a nurse aide. Less than 1% of neonates received their postnatal checkup from a traditional birth attendant. The data also show that the majority of births (84%) did not receive any postnatal newborn checkup during this critical time period.

Neonates of women aged 20–34, women with one child, women in urban areas, women with a secondary education and higher, women in the highest wealth quintile households, and women living in Honiara are more likely to receive postnatal newborn care from skilled professionals. Having neonates checked by a doctor, nurse or midwife is lowest and below the national average in Malaita, Guadalcanal and other provinces. The proportion for receiving postnatal care for new-born baby from skilled professionals is also low among mothers with more than six children (11%), births from older mothers aged 35–49 (13%), births that occurred outside health facilities (7%), births from mothers with no education (12%) and birth from mothers living in the lowest wealth quintile (7%).

9.5 PROBLEMS 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 their pregnancy and at the time of delivery. The SIDHS 2015 included questions that asked women and men whether or not each of the following factors would be a serious problem for them in seeking medical care: getting permission to go for treatment, getting money for advice or treatment, distance to a health facility, not wanting to go alone, health workers' attitudes, and weather. The information collected from these questions provides a good framework for assessing problems encountered in accessing health care in Solomon Islands. The results are shown in Table 9.11.

Overall, about 90% of women reported that they encounter at least one serious problem in accessing health care. The two major problems stated by women in accessing health care are: no drug(s) available (80.3%) and no healthcare provider at facilities (73%). Comparing these results to those of the SIDHS 2006–2007, there has been a decline in the proportion of women reporting at least one problem in accessing healthcare services. In the SIDHS 2006–2007, that proportion was 94% whereas in 2015 it had dropped slightly to 90%.

Table 9.11 also shows that more than 40% of women find it difficult to access health care due to transport issues, distance to a health facility, cost of treatment, and no female provider available. Another 39% of women say that going alone to a health facility is a problem for them while some women (18%) report that getting permission to go for treatment is a serious problem.

Younger women are slightly more likely than older women to report at least one problem in accessing health care. The women who have the most trouble accessing health care (but claim that distance and taking transport are not a problem) are those in the 15–19 age group. As such, it is likely that this group of women may not seek medical care for themselves when they are sick. The table also shows that women with five or more living children are more likely to encounter at least one problem in accessing health care than women with fewer living children. Their access to health services has been hindered by inadequate money for treatment, distance to health facility, no drugs, and no provider.

The marital status of a woman also influences her ability to access healthcare services. Never-married women face difficulties in getting permission to go for treatment, not wanting to go alone, not finding a female provider or finding no provider at all. Married women encountered problems mostly with distance to the health facility and taking transport, while the problems encountered by divorced, separated or widowed women were mostly about getting money for treatment.

Employment status can also affect a woman's access to healthcare services. Women who are not employed for cash and women who are not employed at all tend to encounter many problems in accessing health care services when they are sick compared with women who are employed in a cash earning job.

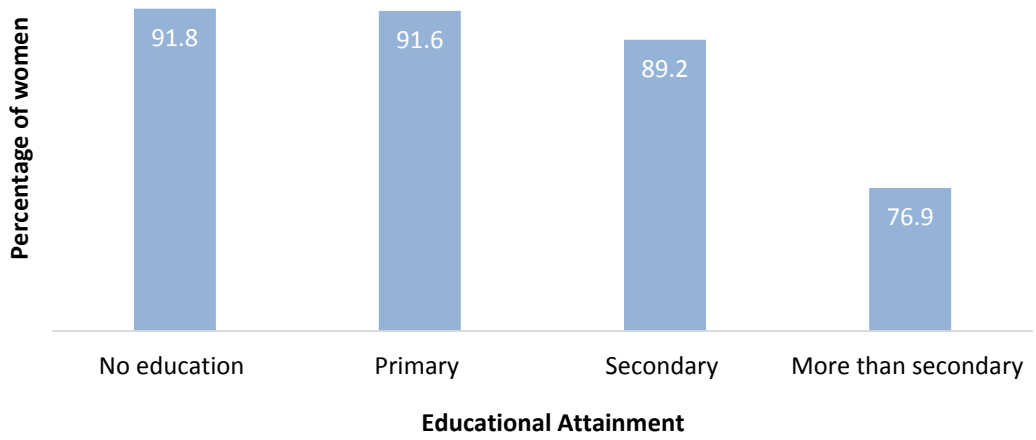
Table 9.11 also shows that women in rural areas are likely to encounter more problems in accessing healthcare services than women in urban areas. A comparison across the provinces shows that Malaita and Honiara account for the lowest proportions of women with at least one problem in accessing health care,

while women in other provinces account for the highest proportion, with at least one problem accessing health care, the exception being getting money for treatment.

The data illustrate that more than half the population in the provinces encountered problems in seeking health treatment, mostly with distance to a health facility and related transport issues. The majority of women from Western Province and other provinces stated that no provider and no drugs available are the major problems in getting treatment in their provinces.

Less educated women are more likely to have at least one serious problem in accessing health care and are more likely to experience all of the listed problems in accessing heath treatment. Educational attainment has a direct link to a woman's ability to access health care, such that the higher the educational attainment of a woman, the less likely it is she will encounter many problems when trying to access healthcare services (Table 9.11 and Fig. 9.13).

Figure 9.13: Percent distribution of women aged 15–49 who reported at least one problem in accessing health care, by women's educational attainment, Solomon Islands 2015



There is a strong correlation between a woman's wealth status and her ability to access health care. The proportion of women with at least one problem in accessing health care decreases as women's wealth status increases. About twice the number of women in the lower wealth quintiles had problems in accessing health centres for treatment than women in the higher wealth quintiles, mostly due to getting permission to go for treatment (27% of women in lowest wealth quintile vs 11% of women in the highest wealth quintile); getting money for treatment (65.0% of women in lowest wealth quintile vs 26% of women in the highest wealth quintile); distance to health facility (71% in the lowest wealth quintile vs 19% in the highest wealth quintile); and taking transport (71% in the lowest wealth quintile versus 18% in the highest wealth quintile).

Table 9.11: 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 2015

Background characteristic	Problems in accessing health care									Number of women
	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Taking transport	Not wanting to go alone	No female provider	No provider	No drugs	At least one problem accessing health care	
Age										
15–19	25.4	53.1	48.7	49.3	55	54.6	76.1	82.6	92.8	1,241
20–34	17	44.4	49	49.9	37.1	42.8	71.3	79	89.4	3,170
35–49	16.3	43.7	48.7	48.6	32.9	39.9	73	81.1	88.5	1,855
Number of living children										
0	21.1	46.2	44.6	45	46.8	48.5	71.6	78.9	89.4	2,077
1–2	15.9	43.9	47.6	48.4	34.9	41.4	72.5	79.4	88.7	1,692
3–4	16.3	45.7	53.1	53.9	36.1	41.8	74.5	82	90.5	1,423
5+	20.2	48.9	53.6	53.4	36.8	43.8	73.2	82.4	91.3	1,073
Marital status										
Never married	21.9	49.6	46.3	47.2	48.9	50.2	74.2	80.1	90.9	1,936
Married or living together	17.2	43.9	50.3	50.6	35.5	42	72.2	80.4	89.4	4,086
Employed last 12 months										
Not employed	17	45.7	48.5	48	43.5	44.1	71.9	79.7	89.3	3,343
Employed for cash	16.7	32.8	36.9	39	28.4	41.3	71.3	77.2	85.1	1,400
Employed not for cash	23.1	58.4	60.6	61.8	40.4	47.2	76.1	84.6	95.3	1,516
Missing	45.2	45.2	69.9	69.9	69.9	69.9	85.8	85.8	85.8	6
Residence										
Urban	11.7	22.5	17.7	18.8	22.5	32.3	64.3	69.3	79.3	1,427
Rural	20.4	52.8	58	58.4	44.4	47.8	75.3	83.6	92.9	4,839
Region										
Honiara	7.6	15.4	9.1	11.3	17.8	28.3	66.1	69.1	77.1	925
Guadalcanal	23.8	61.2	63.4	61.4	50.2	47.6	69.1	78.9	92.4	1,140
Malaita	11	39.7	42.7	44.3	35.5	37	51.7	69.3	83.6	1,608
Western	12.1	53.5	54.4	52.3	38.3	42.8	91.3	92.8	95.7	902
Other provinces	31.3	54.1	63.7	65.4	48.4	58.4	89	91.3	97.7	1,690
Education										
No education	19	54.6	55.3	59.6	42.5	47.4	67.1	79.8	91.8	576
Primary	21	52.9	55.4	55.7	42.2	46.3	73.8	81.5	91.6	2,820
Secondary	17	40.6	43.6	43.7	38.8	43.5	74	80.6	89.2	2,476
More than secondary	8.4	16.8	25.8	24.8	19.3	30.4	65.5	70.9	76.9	394
Wealth quintile										
Lowest	26.6	65	70.5	71.2	50.9	55.4	76.9	84.3	94.3	1,158
Second	22.4	56.9	62.7	64.2	49.4	48.1	73.7	84.3	93.8	1,172
Middle	17.9	46.4	53.4	54	42.2	45.7	74.3	82.8	92.7	1,223
Fourth	16.2	40.8	46.6	47.1	35.5	42.1	73.2	79.7	89.9	1,253
Highest	11.2	25.9	18.8	18.2	23.4	33	67.2	72.4	80.5	1,460
Total	**18.4**	**45.9**	**48.9**	**49.4**	**39.4**	**44.3**	**72.8**	**80.3**	**89.8**	**6,266**

CHAPTER 10 CHILDREN'S HEALTH

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KEY FINDINGS

- Among all live births in the five years prior to the SIDHS 2015 with reported birth weights, 10% of newborns weighed less than 2.5 kilograms and were considered underweight.
- 73 % of children aged 18–29 months were fully vaccinated prior to the SIDHS 2015, a decline from about 83% reported in the SIDHS 2006–2007. Another 71 % of children aged 18–29 months were fully vaccinated by 18 months of age as opposed to 77% reported in the SIDHS 2006–2007.
- Among children aged 18–29 months, 83% received the third doses of pentavalent while 81% completed the three doses of the polio vaccine.
- 4% of children under age 5 showed symptoms of acute respiratory infection in the two weeks preceding the survey, and for 79% of these children, advice and treatment were sought from a health facility.
- 19% of children under age 5 had a fever in the two weeks prior the survey, 61% received advice and treatment from a health facility or provider, 10% took antimalarial drugs, while 28% took antibiotics for treatment.
- 8% of children under age 5 had diarrhoea in the two weeks prior the survey, 55% received advice and treatment from a health facility or provider, 66% were treated with oral rehydration therapy by applying fluid from an oral rehydration salts packet and recommended home fluids. Another 12% of children with diarrhoea were not treated at all.
- About 39% of children under age 5 had their stool disposed of safely, either by using the toilet or latrine, rinsing the stool into the toilet or latrine, or by burying the stool. In contrast, 58% of children's stools were not disposed of safely and the most common unsafe method of stool disposal was throwing or leaving the stool into the sea or river.

INTRODUCTION

This chapter presents the findings of 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 18–29 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, or 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 fevers and their treatment with antibiotics. The treatment of diarrhoea diseases with oral rehydration therapy (including increased fluids) aid in assessing programmes to recommend such treatment. Because appropriate sanitary practices can help prevent and reduce the severity of diarrhoeal diseases, information is also provided on the proper manner of disposing of children's faecal matter.

10.1 CHILD'S SIZE AND WEIGHT AT 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. Because 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.

About 9 in 10 children (86%) in Solomon Islands are weighed at birth because the majority of births take place in a healthcare facility. Among children born in the five years preceding the SIDHS 2015, 10% weighed less than 2.5 kg at birth. Birth weight is lowest among children born to young women aged less than 20, first-born children, and children of women with no education. The data in Table 10.1 indicate that there is no correlation between low birth weight babies and wealth quintile. The birth weight of a child has little to do with the mother's place of residence, and there is no substantial difference between low birth weight (i.e. < 2.5kg) and urban vs rural areas, with 11% of low birth weights occurring in urban areas and 10% occurring in rural areas. By region, a birth weight of less than 2.5 kg ranged from 10% of all births in Malaita to 11% in Honiara. Low birth weight in other provinces reported 11% as well.

Table 10.1 also includes information on the mother's assessment of the baby's size at birth. In the absence of a child's birth weight record, a mother's subjective assessment of the baby's size at birth is useful. Accordingly, mothers reported 3.3% of all live births in the five years preceding the survey to be very small and 11% reported to be smaller than average. About 21% of babies born to women under age 20 and 19% of first-order births were small or smaller than average compared with babies born to older women and higher-order births. There is no clear relationship between the percentage of mothers having no or limited education and the size of the baby, although mothers in the poorest households are more likely to report their baby as being very small.

Table 10.1: Child's size and weight at birth

Percent distribution of live births in the five years preceding the survey by mother's estimate of baby's size at birth, percentage of live births in the five years preceding the survey that have a reported birth weight, and among live births in the five years preceding the survey with a reported birth weight, percentage less than 2.5 kg, according to background characteristics, Solomon Islands 2015

Background characteristic	Percent distribution of all live births by size of child at birth					Percentage of all births that have a reported birth weight[1]	Number of births	Births with a reported birth weight[1]	
	Very small	Smaller than average	Average or larger	Don't know/ missing	Total			Percentage less than 2.5 kg	Number of births
Mother's age at birth									
<20	5.2	15.3	76.2	3.3	100	88	463	14.3	407
20–34	3.1	11	81.3	4.6	100	85.8	3,051	9.3	2,618
35–49	2.9	9.5	83.3	4.4	100	84.1	606	11.4	509
Birth order									
1	4.4	14.4	77.6	3.6	100	91.2	1,054	13.8	961
2–3	3.2	10.2	82.5	4	100	86.3	1,616	8.9	1,394
4–5	2	10.9	82.6	4.5	100	84.9	941	9	799
6+	3.6	8.6	80.6	7.2	100	74.8	509	8.4	381
Mother's smoking status									
Smokes cigarettes/tobacco	2.9	13.5	78.2	5.5	100	82.9	788	11	653
Does not smoke	3.4	10.6	81.8	4.2	100	86.5	3,328	10	2,879
Missing	0	67.5	32.5	0	100	72.8	4	72.3	3
Residence									
Urban	2.4	9.6	84.8	3.2	100	92.9	738	10.7	685
Rural	3.5	11.6	80.2	4.7	100	84.3	3,382	10.1	2,850
Region									
Honiara	1.5	7.8	87.7	3	100	94.3	464	10.7	438
Guadalcanal	3.9	12.7	77.2	6.2	100	78.4	798	9.7	626
Malaita	3.4	10.2	84.3	2	100	79.8	1,109	9.5	885
Western	2.9	15.3	79.9	1.8	100	96.7	560	10.6	542
Other provinces	3.6	10.6	78.4	7.3	100	88	1,187	10.7	1,045
Mother's education									
No education	4.7	12.1	76.1	7.1	100	67.6	402	12.8	272
Primary	3.5	11.3	80.2	5	100	84.2	1,958	9.5	1,649
Secondary	2.8	11.4	82.5	3.2	100	91.1	1,553	10.9	1,416
More than secondary	2.7	7.5	87.2	2.7	100	96.1	206	7.5	198
Wealth quintile									
Lowest	4.5	11.3	75.6	8.6	100	73.1	957	11.1	699
Second	2.8	11.2	82.9	3.1	100	84.4	857	7.6	723
Middle	3.5	12.1	80.7	3.8	100	89.3	827	11.7	739
Fourth	2.6	11	83.3	3.2	100	92.3	795	10.6	733
Highest	2.9	10.4	84	2.6	100	93.7	684	10	641
Total	**3.3**	**11.2**	**81**	**4.4**	**100**	**85.8**	**4,119**	**10.2**	**3,535**

[1] Based on either a written record or the mother's recall

There is a decline in the percentage of very small babies born to mothers during the current survey compared to the SIDHS 2006–2007, from 4% to 3%.

10.2 VACCINATION COVERAGE

Universal immunisation of children against vaccine-preventable diseases which include— tuberculosis, diphtheria, tetanus, pertussis (also called whooping cough), hepatitis B, *Haemophilus* influenza type b, polio, pneumococcus, measles and rubella — is crucial in reducing infant and child mortality. The measles rubella vaccine was introduced into Solomon Islands in 2012; replacing the measles only vaccine and the pentavalent vaccine (Diphtheria, pertussis, tetanus vaccine plus hepatitis B and *Haemophilus* influenza type b vaccine) was also introduced in 2008. Generally vaccination coverage shows the level of protection against specific vaccine preventable diseases among the selected age groups of the population. Information on vaccination coverage among population subgroups is useful for effective programme planning and allocation of limited resources to areas most in needs. Additionally, information on immunisation coverage is important for the monitoring and evaluation of the Expanded Programme on Immunization (EPI)[12]. Various patterns of vaccination coverage among different social classes, gender and wealth quintiles can give an indication of equitable service delivery and alert any marginalized group to be better targeted in the subsequent programme cycle. Surveys may aim to estimate the levels of immunization coverage at either national or sub-national levels. They aim to either establish baseline information and to provide a comparison with administrative coverage (to verify administrative data), while efforts to improve routine reporting systems are ongoing. They can also be used to respond to specific questions regarding factors associated to low coverage or to satisfy information demands.

The SIDHS 2015 collected information on vaccination coverage for all living children born in the five years preceding the survey. According to WHO guidelines, children are considered fully vaccinated if they have received BCG vaccinations (for tuberculosis), three doses each of pentavalent and polio vaccines, measles and measles rubella by the age of 12 months. BCG should be given at birth or at first clinical contact, and hepatitis B should be given within the first 24 hours (hepatitis B vaccine birth dose) or in the first two weeks of birth. Pentavalent and polio vaccinations should be given at approximately 6, 10 and 14 weeks of age, while measles containing vaccines (MCV) such as measles rubella vaccinations should be given at either 9 or 12 months of age, or soon after. In the Solomon Islands, Measles Rubella is given at 12months. Although recent introductions of the new vaccines such as pneumococcal conjugate vaccine have changed the current EPI schedule, but these can only be assessed in the next DHS.

Information on vaccination coverage was collected in two ways during the SIDHS 2015: from vaccination cards shown to the interviewer and from mothers' recall or 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 vaccination dates. Table 10.2 shows the percentage of children aged 18–29 months who received 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 age 18–29 months who received specific vaccines at any time before the survey, by source of information (vaccination card or mother's report), and percentage vaccinated 18 months of age, Solomon Islands 2015

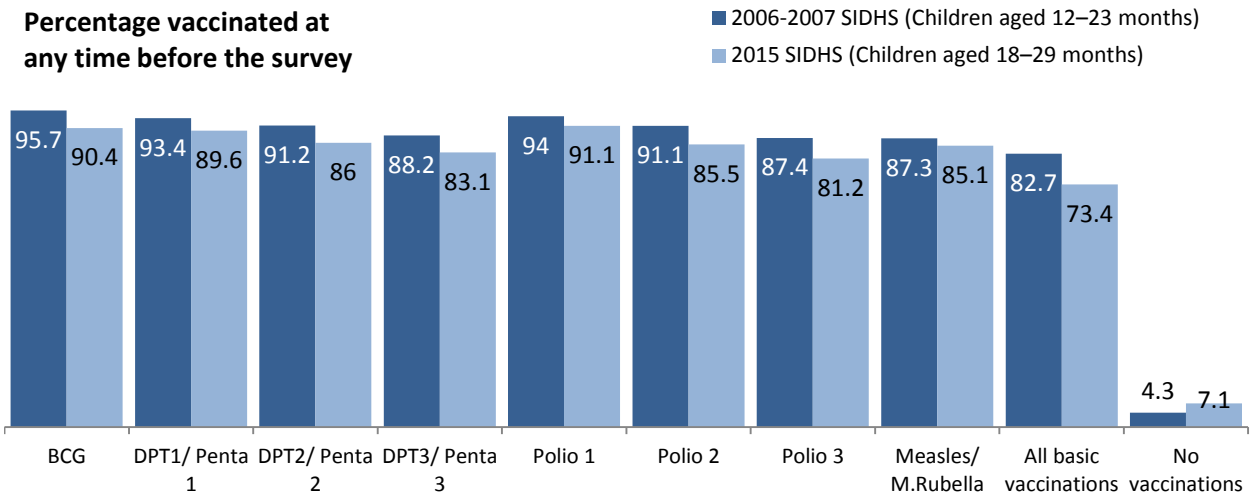
Source of information	BCG	Penta 1	Penta 2	Penta 3	Polio 1	Polio 2	Polio 3	Measles/ Rubella	All basic vaccina-tions[1]	No vaccina-tions	Number of children
Vaccinated at any time before survey											
Vaccination card	75.1	75.8	73.3	71.4	75.8	73.1	70.4	70.5	63.2	0	596
Mother's report	15.3	13.7	12.7	11.6	15.3	12.4	10.7	14.5	10.2	7.1	172
Either source	90.4	89.6	86	83.1	91.1	85.5	81.2	85.1	73.4	7.1	767
Vaccinated by 18 months of age[2]	90.2	89.1	85.6	82.7	90.6	85.1	80.4	81.5	70.5	7.1	767

[1] BCG (Bacille calmette guerin) , measles (or measles/rubella) and three doses each of penta and polio vaccine (excluding polio vaccine given at birth).

[2] For children whose information is based on the mother's report, the proportion of vaccinations given during the first year of life is assumed to be the same as for children with a written record of vaccination.

[12] The Expanded Program on Immunization (EPI) was initiated in 1974 by the World Health Organization with the goal to make vaccines available to all children throughout the world.

Figure 10.1: Vaccination coverage of children aged 12–23 months (SIDHS 2006–2007) and children aged 18–29 months (SIDHS 2015) with specific vaccinations



Overall, 73% of children aged 18–29 months at the time of the survey were reported to be fully vaccinated at any time before the survey. This is based on records from the vaccination cards and the mother's recall. This is a decline from 83% of vaccination coverage of children aged 12–23 months, which was reported in the SIDHS 2006–2007 (Table 10.2 and Fig. 10.1). Similarly, the proportion of children aged 18–29 months that were fully vaccinated at exactly age 18 months at the time of the SIDHS 2015 (71%) was lower than the 77% of children aged 12–23 months that were fully vaccinated at exactly age 12 months at the time of the SIDHS 2006–2007.

About 85% of children aged 18–29 months received a measles or measles rubella vaccine at any time before the survey, which is equivocal to the 87% that was reported in the SIDHS 2006–2007. However, there was a supplementary immunization activity in response to a measles outbreak, which may have increased SIDHS 2015 coverage. The first dose of pentavalent was received by 89% of children aged 18–29 months. The percentage, however, dropped to 86% for the second dose, and dropped to 83% for the third dose of pentavalent. A similar pattern was seen with polio vaccinations, with 91% of children receiving their first dose, 85% receiving a second dose and another 80% receiving the three doses of polio by 18 months of age. Another 7% of children aged 18–29 months did not receive any vaccinations at all.

10.2.1 Vaccination coverage by background characteristics

Table 10.3 shows the vaccination coverage among children aged 18–29 months, according to information from the vaccination card or mother's recall, by background characteristics. A vaccination card was seen for 78% of children aged 18–29 months. This information may give some indication of the success of the immunisation programme in reaching out to all population subgroups.

Female babies are slightly more likely to have a higher vaccination coverage rate (74%) for all basic vaccinations than male babies (73%). Children who are birth order six and higher are less likely to receive all vague vaccinations. Moreover, children living in rural areas, children living in the lowest and fourth wealth quintiles are more likely to be disadvantaged with regard to receiving all basic vaccinations.

Table 10.3: Vaccinations by background characteristics

Percentage of children age 18–29 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 2015

Background characteristic	BCG	Penta 1	Penta 2	Penta 3	Polio 1	Polio 2	Polio 3	Measles/ M.Rubella	All basic vaccina-tions[1]	No vaccina-tions	Percen-tage with a vaccina-tion card seen	Number of children
Sex												
Male	91.3	91.1	87.5	83.4	92.4	85.8	81.3	85.7	73.1	6.1	78.3	405
Female	89.4	87.8	84.3	82.6	89.5	85.1	81	84.3	73.7	8.2	76.8	363
Birth order												
1	95.1	90.7	88.6	85.2	95.2	89.3	85	90	77.6	3.1	76.1	196
2–3	91.7	91.5	88.1	84.1	92	88.7	83.4	86.2	75.2	5.9	81.3	302
4–5	87.4	87.2	83	81.9	86.8	79.7	77.5	82.2	72.7	11.2	74.8	182
6+	81.5	85.1	78.8	77.1	87.4	77.9	72.7	75.7	59.3	11.7	74.3	87
Residence												
Urban	94.9	91.3	90.7	88.3	92.8	91	88	89.1	82.5	4.7	70.2	137
Rural	89.4	89.2	85	81.9	90.7	84.3	79.7	84.2	71.4	7.6	79.2	631
Region												
Honiara	94.6	92.2	92.2	90.6	93.7	92.1	89.7	90.4	85.4	5.4	64.4	86
Guadalcanal	91.2	92.6	88	86.1	94.4	90.2	86	85.2	75.5	4.6	80.5	144
Malaita	87.9	86.2	79.7	74	88.6	79.9	74	81.1	65.6	9.8	81.2	200
Western	84.8	86.3	83.8	81.2	88.9	84.9	79.8	81.8	66.2	9.8	66.5	126
Other provinces	94	91.6	89.3	87.6	91.3	85.3	82	88.5	78.8	5.2	84.3	210
Mother's education												
No education	86.9	81.6	79.7	77.2	84.2	80.6	74.3	77	72.5	13.1	69.3	59
Primary	88	89.7	85.2	82	89.7	83.8	78.8	83.2	69.5	7.8	79.5	377
Secondary	93.4	90.5	87.5	84.9	93.6	88.4	85.7	89.2	78.7	5.4	77.7	300
More than secondary	97.7	94.2	93.1	88.2	96.7	87	78.4	83.4	71.4	2.3	70.6	31
Wealth quintile												
Lowest	87	89.1	82.8	79.3	90.3	83.2	77.7	81.9	66.8	7	86.4	182
Second	92.2	89.5	85.7	84	92.3	86.9	81.3	88.7	76.5	5.9	80.2	173
Middle	88.1	88.1	85.7	82.9	88.7	82.4	81.6	81.5	75	11.3	76.5	146
Fourth	90.1	87.5	84.3	81.4	89.7	83.4	78.4	85.6	70.7	7.4	71	130
Highest	95.4	93.8	92.4	88.6	94.3	92.1	87.7	87.9	79.2	3.8	70.3	137
Total	**90.4**	**89.6**	**86**	**83.1**	**91.1**	**85.5**	**81.2**	**85.1**	**73.4**	**7.1**	**77.6**	**767**

[1] BCG, measles (or measles/rubella) and three doses each of Penta and polio vaccine (excluding polio vaccine given at birth).

10.2.2 Trends in vaccination coverage

One way of measuring trends in vaccination coverage is to compare coverage among children of different ages. Table 10.4 shows the percentage of children aged 18–59 months who received specific vaccinations during their first 18 months of life by current age. These types of data can provide information on trends in vaccination coverage over the past five years.

From the table below in comparing different age cohorts, it can be seen that the younger cohorts are more likely to be vaccinated than the older ones showing an improvement in service reach. More significantly, the coverage of almost all vaccines during this period showed an improvement trend except for Penta 2, Polio 2 and Polio 3. The coverage of Penta 2, Polio 2 and Polio 3 was recorded to be lower in 18–29 months

compared to 42–59 months cohorts. The difference in vaccination coverage in the SIDHS 2006–2007 and the SIDHS 2015 is minimal.

The percentage of children who received no vaccinations at all by 18 months of age has declined from 9% among children aged 42–59 months at the time of the survey to 7% among children aged 18–29 months. Over the same period, the percentage of fully immunised children by age 18 months increased from 65% to 71%.

In summary, the data show that out of the total children aged 18–59 receiving specific vaccines by 18 months old, there is a minority group that were been missed out . For instance, 89% of all children aged 18–59 received BCG by 18 months. The other remaining 11% are those children whom they did not receive the BCG vaccine or been administered late. This pattern is seen in each specific vaccines.

Table 10.4: Vaccinations in the first 18 months of life

Percentage of children aged 18–59 months at the time of the survey who received specific vaccines by 18 months of age, and percentage with a vaccination card, by current age of child, Solomon Islands 2015

Age in months	BCG	Penta 1	Penta 2	Penta 3	Polio 1	Polio 2	Polio 3	Measles/ Rubella	All basic vaccina-tions[1]	No vaccina-tions	Percen-tage with a vaccina-tion card seen	Number of children
18-29	90.2	89.1	85.6	82.7	90.6	85.1	80.4	81.5	70.5	7.1	77.6	767
30-41	88.6	88.7	86.4	81.7	89.7	86.4	81.3	74.2	66	8.6	70.6	855
42-59	87.8	87.9	86.4	82.3	88.9	86.1	80.2	73.6	64.6	9.4	67	1,129
Total	**88.7**	**88.5**	**86.2**	**82.3**	**89.6**	**85.9**	**80.7**	**76.1**	**66.9**	**8.5**	**71.1**	**2,751**

Note: Information was obtained from the vaccination card or if there was no written record, from the mother. For children whose information is based on the mother's report, the proportion of vaccinations given during the first 18 months of life is assumed to be the same as for children with a written record of vaccinations.

[1] BCG, measles (or measles/rubella) and three doses each of Penta and polio vaccine (excluding polio vaccine given at birth)

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 prevents a large proportion of deaths caused by ARI. In the SIDHS 2015, the prevalence of ARI was estimated by asking mothers whether their children under age 5 years 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 linked 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).

Table 10.5 shows that 4% 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 the child. Children aged 6–11 months are more likely to show symptoms of ARI (7%) than children in other age groups. Children with mothers smokes cigarettes/tobacco, mothers with no education and living in the lowest quintile are more likely to have symptoms of ARI.

Among children less than age 5 years with symptoms of ARI, 79% sought advice and treatment from a health facility or provider and 51% of these children were given antibiotics for treatment.

Table 10.5: Prevalence and treatment of symptoms of ARI

Among children under age 5, the percentage who had symptoms of acute respiratory infection (ARI) in the two weeks preceding the survey and among children with symptoms of ARI, the percentage for whom advice or treatment was sought from a health facility or provider and the percentage who received antibiotics as treatment, according to background characteristics, Solomon Islands 2015

Background characteristic	Among children under age 5:		Among children under age 5 with symptoms of ARI:		
	Percentage with symptoms of ARI[1]	Number of children	Percentage for whom advice or treatment was sought from a health facility or provider[2]	Percentage who received antibiotics	Number of children
Age in months					
<6	3.1	391	*	*	12
6–11	6.7	455	*	*	30
12–23	4.9	826	(81)	(57)	41
24–35	4.7	786	(87)	(52.7)	37
36–47	4.3	856	(73.7)	(57.1)	37
48–59	2.7	720	(82.3)	(45.6)	19
Sex					
Male	4.4	2,084	84.9	58.4	91
Female	4.4	1,949	72.8	43.1	85
Mother's smoking status					
Smokes Cigarettes/tobacco	5.3	766	(92.6)	(57.3)	40
Does not smoke	4.2	3,263	75	49.1	136
Missing	0	4	–	–	0
Cooking fuel					
Electricity or gas	4.5	301	100	61.2	13
Kerosene	*	6	*	*	1
Charcoal	(3.6)	30	*	*	1
Wood/straw[3]	4.3	3,694	78.1	50.6	161
Missing	0	1	–	–	0
Residence					
Urban	5.1	720	86.8	54.8	37
Rural	4.2	3,313	77	50	140
Region					
Honiara	5	455	(89.3)	(53.5)	23
Guadalcanal	2.9	778	(80.2)	(49)	23
Malaita	5.2	1,080	(75.1)	(55.6)	57
Western	4	553	(65.9)	(43.2)	22
Other provinces	4.5	1,167	(83.9)	(49.1)	52
Mother's education					
No education	3.3	390	*	*	13
Primary	4.4	1,921	80.7	55.8	84
Secondary	4.7	1,521	79.7	45.7	71
More than secondary	4.2	201	*	*	8
Wealth quintile					
Lowest	3.7	939	(76.8)	(46.1)	35
Second	4.6	833	(76.1)	(62.8)	39
Middle	4.5	818	(72.4)	(44.7)	37
Fourth	4.5	773	(88)	(41)	35
Highest	4.6	670	(83.1)	(60.6)	31
Total	**4.4**	**4,033**	**79**	**51**	**176**

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.

[1] Symptoms of ARI (cough accompanied by short, rapid breathing which was chest-related and/or by difficult breathing which was chest-related) is considered a proxy for pneumonia.

[2] Excludes pharmacy, shop, friend/relative and traditional practitioner.

[3] Includes shrubs, grass, saw dust, agricultural crop.

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. Fever can occur year-round, and therefore, factors that cause fever must be taken into account when interpreting fever prevalence in Solomon Islands.

Table 10.6 shows the percentage of children under age 5 years who had a fever in the two weeks preceding the survey and the percentage receiving various treatments, by selected background characteristics. Among children under age 5 years, 19% had a fever during the two weeks preceding the survey. Of these children, 61% received advice and treatment from a health facility or provider; 10% received antimalarial drugs and 28% received antibiotic drugs for the treatment of their fever.

Table 10.6: Prevalence and treatment of fever

Among children under age 5, the percentage who had a fever in the two weeks preceding the survey; and among children with fever, the percentage for whom advice or treatment was sought from a health facility or provider, the percentage who took antimalarial drugs, and the percentage who received antibiotics as treatment, by background characteristics, Solomon Islands 2015

Background characteristic	Among children under age 5:		Among children under age 5 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	13	391	(55.4)	(3.2)	(32.6)	51
6–11	23.5	455	63.1	4.9	31.1	107
12–23	24.8	826	65.7	11	22.4	205
24–35	21.4	786	61	15.5	30.1	168
36–47	17	856	59.7	7.6	32	146
48–59	14	720	56.4	13.6	20.8	101
Sex						
Male	21.6	2,084	60.2	10.6	29.4	451
Female	16.8	1,949	62.8	9.9	25	327
Residence						
Urban	20.5	720	69.7	5.7	32.8	148
Rural	19	3,313	59.4	11.4	26.3	630
Region						
Honiara	20.4	455	67.3	4	33.1	93
Guadalcanal	13.7	778	67.2	14.4	29.5	106
Malaita	19.8	1,080	54.2	12.9	22.2	214
Western	15.1	553	64.4	3.3	29.6	84
Other provinces	24.1	1,167	61.7	11	28.3	281
Mother's education						
No education	14.4	390	(51.5)	(13.8)	(6)	56
Primary	18.7	1,921	61.1	9.9	28.2	359
Secondary	21.4	1,521	64.1	10.1	30.2	326
More than secondary	18.2	201	54	11.2	30.5	37
Wealth quintile						
Lowest	20.7	939	59.2	13.4	24.8	194
Second	18.2	833	59.3	6.7	26.1	151
Middle	17.1	818	51.4	10.1	29.9	140
Fourth	20	773	62.8	9	23.6	155
Highest	20.5	670	74.9	11.7	34.8	137
Total	**19.3**	**4,033**	**61.3**	**10.3**	**27.5**	**778**

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.

[1] Excludes pharmacy, shop, friend/relative, and traditional practitioner.

The prevalence of fever varies by age of the child. Children aged 6–11 months (24%) and 12–23 months (25%) are more commonly sick with fever than children of other age groups. There are also variations in the prevalence of fever by sex, with male children tending to be more often sick with fever (22%) than female children (17%). There is little variation in the prevalence of fever between children in urban and rural areas. Other provinces have a higher percentage of children with fever (24%) as opposed to children with fever in Guadalcanal (14%), Honiara (20%), Malaita (20%) and Western provinces (15%). 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 of all women and the proportion of their children with a fever in the two weeks preceding the survey was 18%. The percentage of children with fever is highest in the highest wealth quintile and in the lowest wealth quintile (21%); the quintiles in between show an increasing proportion of children with fever. All of this suggests that there is no relationship between wealth quintile and fever prevalence among children.

Children aged 12–23 months are more likely to be taken to a healthcare facility or provider for treatment of fever than other children. There is a difference between the proportion of children in rural and urban areas seeking treatment for fever, with 59% of rural children receiving treatment compared with 70% of urban children. The lowest percentage of children with fever taken for treatment is in Malaita Province (54%). Children in the highest wealth quintile households are more likely to be taken for treatment than those in the lowest wealth quintile households.

10.5 DIARRHOEA

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 SIDHS 2015, it should be borne in mind that diarrhoea prevalence varies seasonally.

10.5.1 Prevalence of diarrhoea

Table 10.7 shows the percentage of children under age 5 years with diarrhoea in the two weeks preceding the survey, according to selected background characteristics. Overall, 8% of all children under age 5 years had diarrhoea, and 1% had diarrhoea with blood.

Table 10.7 also shows that all cases of diarrhoea at <6 months are low at 1% because feeding is solely administered by mothers. From 6–23 months, the percentage of diarrhoea cases is high with a peak (13%) at 12–23 months. This is expected because children in this age group are very active in terms of 'hand to mouth' feeding actions if not properly guided. Generally, the prevalence of all diarrhoea is high in children under 59 months. Furthermore, a much severe form is diarrhoea with blood, which is found in 1% of children aged 6–59 months. This suggests that proper feeding techniques and the necessary essential information need to be provided to mothers with children in these vulnerable age groups.

Diarrhoea prevalence is higher in boys (9%) than in girls (8%). Diarrhoea is more common among children who live in households with a non-improved drinking water source. There is no urban–rural difference in diarrhoea prevalence, and there is no relationship between diarrhoea prevalence and household wealth quintile. Diarrhoea prevalence among children by toilet facilities show no differences at all.

Table 10.7: Prevalence of diarrhoea

Percentage of children under age 5 who had diarrhoea in the two weeks preceding the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Diarrhoea in the two weeks preceding the survey		Number of children
	All diarrhoea	Diarrhoea with blood	
Age in months			
<6	1.3	0	391
6–11	7.2	1	455
12–23	13.1	1.7	826
24–35	9.5	1.4	786
36–47	7.7	1.5	856
48–59	5.3	1	720
Sex			
Male	8.5	1.1	2,084
Female	7.6	1.3	1,949
Source of drinking water[1]			
Improved	7.9	1.3	3,289
Not improved	8.8	0.8	739
Other/missing	0	0	5
Toilet facility[2]			
Improved, not shared	8	1	800
Shared[3]	8.4	0.4	297
Non-improved	8	1.4	2,925
Missing	13.9	0	11
Residence			
Urban	7.5	0.9	720
Rural	8.2	1.3	3,313
Region			
Honiara	7.1	0.8	455
Guadalcanal	7.4	0.8	778
Malaita	6.8	1.5	1,080
Western	8.8	1.9	553
Other provinces	9.6	1	1,167
Mother's education			
No education	9.8	2.5	390
Primary	7.6	1.1	1,921
Secondary	8.2	1.1	1,521
More than secondary	7.4	0.9	201
Wealth quintile			
Lowest	8.7	1.6	939
Second	8.1	0.8	833
Middle	8.6	1.6	818
Fourth	6.9	0.9	773
Highest	7.9	1.2	670
Total	**8**	**1.2**	**4,033**

[1] See Table 2.1 for definition of categories.

[2] See Table 2.2 for definition of categories.

[3] Facilities that would be considered improved if they were not shared by two or more households.

10.5.2 Treatment of diarrhoea

In the SIDHS 2015, mothers of children with diarrhoea were asked what was done to treat the illness. Table 10.8 shows the percentage of children under age 5 years with diarrhoea who received specific treatments by background characteristics. Among children under age 5 with diarrhoea, 55 % sought treatment and advice from a health facility or provider. Children of mothers living in urban households were more likely to be taken to a healthcare provider than other children. More male children (56%) than female children (53%) had diarrhoea in the two weeks preceding the survey and were taken to a healthcare provider.

The results also shows that 66% of these children were treated with either some kind of oral rehydration therapy (ORT) or recommended home fluids (RHF), with 37% treated with (oral rehydration salt (ORS) from a prepared ORS packet, and 46% were given recommended home fluids. Another 25% were given increased fluids while the majority of children with diarrhoea were treated by ORT or increased fluids (73%). Furthermore, 40% were given home remedies or other treatments and few children were treated by antibiotics drugs and zinc supplements (7% given antibiotics drugs, 2% given zinc supplements), and 12% of children with diarrhoea received no treatment at all.

The percentage of girls receiving ORT was greater than that of boys, except for increased fluids, where the percentage is slightly higher with boys.

ORT and other treatments vary by urban and rural residence. Urban mothers of children were more likely to seek treatment for their child's diarrhoea (62%) than those in rural areas (53%). Home remedies were more likely to be used in rural areas (43%) than in urban areas (25%), and more children in urban areas were given ORT or increased fluids (84%) than children in rural areas (71%).

Table 10.8: 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 2015

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							
		Fluid from ORS packets or pre-packaged liquid	Recommended home fluids (RHF)	Either ORS or RHF	Increased fluids	ORT or increased fluids	Anti-biotic drugs	Zinc supple–Ments	Home remedy / other	Missing	No treatment	Number of children with diarrhoea
Age in months												
<6	*	*	*	*	*	*	*	*	*	*	*	5
6–11	(50)	(20.8)	(40)	(53)	(19.2)	(64.2)	(4.2)	(2.5)	(30.2)	0	(16.7)	33
12–23	46.1	32.3	44.6	63	26.5	71.9	7.8	2.2	41.6	0	13.5	108
24–35	65.6	45.3	51.5	73.6	19.9	80.5	9	2.9	34.7	1.6	7.2	75
36–47	54.1	36.1	38.2	62.9	29	66.4	8.9	1.3	39	2.3	16.2	66
48–59	(66.5)	(49.2)	(51.1)	(75.9)	(28.3)	(84.9)	0	(2.9)	(52.7)	0	(1.6)	38
Sex												
Male	56.1	36.5	43.2	63.4	25.5	72	8.5	1.4	36.9	0	12.6	177
Female	53.1	36.8	48.2	68.9	24.7	75	4.9	3.3	43.7	1.8	10.9	148
Type of diarrhoea												
Non-bloody	51.8	35	42.6	62	23.6	70.5	5.2	2.1	36.8	0	14.2	258
Bloody	(67)	(41.7)	(67.4)	(86.7)	(36.7)	(91.2)	(15)	(2.2)	(50.9)	0	(3.1)	49
Missing	63.2	45.7	26.2	65.2	14.8	65.2	9.1	4.3	55.3	15.1	1.4	18
Residence												
Urban	62.3	44.9	46.5	78.1	36.2	84.2	13.2	4.8	24.9	0	11.6	54
Rural	53.3	35	45.3	63.5	22.9	71.2	5.6	1.7	43	1	11.9	271
Region												
Honiara	(63.3)	(37.3)	(50.2)	(78.2)	(26.3)	(82.9)	(18.5)	(2.6)	(21.5)	0	(12.5)	32
Guadalcanal	55.7	49.8	41.4	75.9	42.9	84.7	3.2	5.1	36.2	2	3.9	57
Malaita	57	40.9	56.9	72.2	29.4	81.4	4.7	0	46.8	2	7.7	74
Western	55.5	38.1	55.2	68.9	34.2	84.3	5.8	3.2	36.8	0	13.9	49
Other provinces	50	26.2	34.5	51.9	9	54.9	7.4	1.8	44.1	0	17.5	112

Note: Oral rehydration therapy (ORT) includes fluid prepared from oral rehydration salt (ORS) packets, pre-packaged ORS fluid, and recommended home fluids (RHF). Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases.

[1] Excludes pharmacy, shop, friend and traditional practitioner.

Table 10.8: Diarrhoea treatment (cont')

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							
		Fluid from ORS packets or pre-packaged liquid	Recommended home fluids (RHF)	Either ORS or RHF	Increased fluids	ORT or increased fluids	Anti-biotic drugs	Zinc supple-ments	Home remedy / other	Missing	No treatment	Number of children with diarrhoea
Mother's education												
No education	(38.2)	(35.2)	(60.3)	(71.8)	(18.5)	(75.8)	(4.2)	0	(65.6)	0	(4.3)	38
Primary	55.8	38	40.8	66.2	20.1	73.4	3.9	1.5	34	1	15.7	147
Secondary	58.8	34.4	47.5	63.8	32.1	73.2	10.5	3.3	39.8	0.9	8.6	125
More than secondary	*	*	*	*	*	*	*	*	*	*	*	15
Wealth quintile												
Lowest	48.5	37.3	41.7	61.7	20.4	69.5	4	0	59.1	1.9	3.1	81
Second	51.1	32.7	36.9	61.8	20.8	70.1	1.6	2.5	28.6	0	25.3	67
Middle	48.2	34.4	51.9	69.6	23.1	70.8	3.5	0	54.4	0	11.5	70
Fourth	63.7	41.7	55.2	70.7	33.3	79.5	14.2	2.7	24.4	0	10.9	53
Highest	68.8	38.5	43.8	68.1	32.3	80.8	15.3	8	21.5	2.2	9.6	53
Total	**54.8**	**36.6**	**45.5**	**65.9**	**25.1**	**73.4**	**6.9**	**2.3**	**40**	**0.8**	**11.8**	**325**

Note: Oral rehydration therapy (ORT) includes fluid prepared from oral rehydration salt (ORS) packets, pre-packaged ORS fluid, and recommended home fluids (RHF). Figures in parentheses are based on 25 – 49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases.

[1] Excludes pharmacy, shop, friend and traditional practitioner.

10.5.3 Feeding practices during diarrhoea

Mothers are encouraged to continue normal feeding of children with diarrhoea and to increase the amount of fluid they intake. 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 10.9 shows the percent distribution of children under age 5 years who had diarrhoea in the two weeks preceding the survey by feeding practices and according to background characteristics.

Among children under age 5 years with diarrhoea, 50% were given the same amount of liquid as usual, 25% were given more liquid than usual, 13% were given somewhat less than the usual amount, and 12% were given much less than usual.

Those children who had diarrhoea and were given food, 45% had the same amount of food as usual, 8% had more, 26% were given somewhat less than the usual amount of food, 15% were given much less than usual, and 2% of children who usually ate solid foods did not receive any 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 than children in rural areas.

Table 10.9: Feeding practices during diarrhoea

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 oral rehydration therapy (ORT) and/or increased fluids during the episode of diarrhoea, by background characteristics, Solomon Islands 2015

Background characteristic	Amount of liquids given						Amount of food given								Percentage given increased fluids and continued feeding[1]	Percentage who continued feeding and were given ORT and/or increased fluids[1]	Number of children with diarrhoea
	More	Same as usual	Some-what less	Much less	Don't know/ missing	Total	More	Same as usual	Some-what less	Much less	None	Never gave food	Don't know/ missing	Total			
Age in months																	
<6	*	*	*	*	*	100	*	*	*	*	*	*	*	100	*	*	5
6–11	(19.2)	(65.8)	(7.6)	(7.3)	0	100	(7.8)	(46.2)	(19)	(9.3)	0	(17.7)	0	100	(11.1)	(44.3)	33
12–23	26.5	49.3	12.3	11.9	0	100	6	52.5	23.9	14.3	2.4	0.8	0	100	17.5	54.3	108
24–35	19.9	53.7	13.3	13	0	100	7.3	47.8	26.4	16.5	2	0	0	100	17	66.2	75
36–47	29	41.5	12.4	14.8	2.3	100	14.7	37.5	22	18.1	5.4	0	2.3	100	20.7	45.6	66
48–59	(28.3)	(49.9)	(11.6)	(10.2)	0	100	(5.9)	(34.5)	(42)	(13.3)	(4.3)	0	0	100	(18.8)	(67.3)	38
Sex																	
Male	25.5	51.4	11.5	11.6	0	100	10	46.3	22.9	16.5	1.8	2.6	0	100	18	53.9	177
Female	24.7	48.3	13.8	12.3	1	100	6.4	43.6	30	12.7	4.1	2.1	1	100	17.6	58.4	148
Type of diarrhoea																	
Non-bloody	23.6	53.6	12.1	10.7	0	100	7.9	50.1	23.9	13.5	1.7	3	0	100	17.3	55.3	258
Bloody	(36.7)	(32.5)	(10)	(20.8)	0	100	(9.9)	(20.6)	(35.6)	(23.6)	(10.2)	0	0	100	(21.9)	(58.9)	49
Missing	14.8	45.4	26.7	4.5	8.6	100	10.4	40.3	32.7	8.1	0	0	8.6	100	14.8	57.2	18
Residence																	
Urban	36.2	36	8.8	18.9	0	100	13.3	37	21.9	25.9	0	1.9	0	100	30.3	58.4	54
Rural	22.9	52.7	13.3	10.5	0.6	100	7.4	46.7	27	12.5	3.4	2.5	0.6	100	15.4	55.5	271

Note: It is recommended that children should be given more liquids to drink during diarrhoea and food should not be reduced. Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases.

[1] Continued feeding practices includes children who were given more, same as usual, or somewhat less food during the diarrhoea episode.

Table 10.9: Feeding practices during diarrhoea (Cont')

Background characteristic	Amount of liquids given						Amount of food given								Percentage given increased fluids and continued feeding[1]	Percentage who continued feeding and were given ORT and/or increased fluids[1]	Number of children with diarrhoea
	More	Same as usual	Some-what less	Much less	Don't know/ missing	Total	More	Same as usual	Some-what less	Much less	None	Never gave food	Don't know/ missing	Total			
Region																	
Honiara	(26.3)	(45.7)	(6.8)	(21.3)	0	100	(9.3)	(40.4)	(16.9)	(30.9)	0	(2.6)	0	100	(18.8)	(52.1)	32
Guadalcanal	42.9	36.3	12.6	8.1	0	100	20	29.9	27.6	22.5	0	0	0	100	33.5	64	57
Malaita	29.4	42.8	16	9.8	2	100	7.2	52.4	23.5	10.1	2	2.8	2	100	20.7	66.7	74
Western	34.2	44.6	7.2	14	0	100	15.4	37.5	30	6.7	3.5	6.9	0	100	30.8	70.5	49
Other provinces	9	65.1	14.3	11.7	0	100	0	52.6	28	12.6	5.4	1.3	0	100	2.1	39.6	112
Mother's education																	
No education	(18.5)	(40.5)	(23.7)	(17.3)	0	100	(3.4)	(28.2)	(39.6)	(22.7)	(4)	(2.2)	0	100	(12.4)	(53.1)	38
Primary	20.1	51.2	14.8	12.9	1	100	9.9	51.2	21.6	11.3	3.1	1.8	1	100	15	60.5	147
Secondary	32.1	51.1	7.4	9.3	0	100	7.7	41	29.8	15.5	2.6	3.4	0	100	22.3	52.5	125
More than secondary	*	*	*	*	*	100	*	*	*	*	*	*	*	100	*	*	15
Wealth quintile																	
Lowest	20.4	56	14	7.9	1.9	100	3.9	41.7	35.1	13.3	1.9	2.3	1.9	100	10.4	57	81
Second	20.8	57	12.8	9.4	0	100	8.2	50.4	22.5	7.4	8.1	3.4	0	100	12.5	51.2	67
Middle	23.1	51.1	12.4	13.3	0	100	6.8	57.9	17.3	15.7	2.3	0	0	100	15.9	55.1	70
Fourth	33.3	44.7	15.3	6.7	0	100	10.3	38.1	34.8	10.6	1.4	4.8	0	100	28.6	65.7	53
Highest	32.3	35.3	7.5	24.8	0	100	15.7	33.3	19.8	29.2	0	2	0	100	27.8	51.6	53
Total	**25.1**	**49.9**	**12.6**	**11.9**	**0.5**	**100**	**8.4**	**45.1**	**26.1**	**14.7**	**2.9**	**2.4**	**0.5**	**100**	**17.8**	**56**	**325**

Note: It is recommended that children should be given more liquids to drink during diarrhoea and food should not be reduced. Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases.

[1] Continued feeding practices includes children who were given more, same as usual, or somewhat less food during the diarrhoea episode.

10.6 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 10.10 shows that 73% of women who gave birth in the five years preceding the survey knew about ORS packets. ORS knowledge is higher among urban women (82%) than among rural women (71%), and knowledge about ORS is higher among older women than younger ones, with 78% of women in the oldest age group having knowledge compared 62% women in the youngest age group.

Similarly, knowledge of ORS packets increases as a mother's education level increases, from 60% among mothers with no education to 84% among mothers with more than a secondary education.

Table 10.10: Knowledge of oral rehydration salts (ORS) packets or pre-packaged liquids

Percentage of women aged 15–49 with a 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 2015

Background characteristic	Percentage of women who know about ORS packets or ORS pre-packaged liquids	Number of women
Age		
15–19	61.5	113
20–24	68	625
25–34	73.2	1,380
35–49	78.1	690
Residence		
Urban	81.6	530
Rural	70.7	2,276
Region		
Honiara	80.5	336
Guadalcanal	71.2	543
Malaita	68.8	713
Western	75.1	405
Other provinces	72.9	810
Education		
No education	59.5	261
Primary	70.6	1,309
Secondary	77	1,084
More than secondary	84.3	152
Wealth quintile		
Lowest	66.9	616
Second	70.5	575
Middle	70	563
Fourth	76.6	556
Highest	81.6	496
Total	**72.8**	**2,807**

10.7 TOOL DISPOSAL

If human faeces are left uncontained, disease can spread through direct contact or by transmission via flies and animals that had contact with the stool. Hence, the proper disposal of children's stools is extremely important in preventing the spread of diseases. Table 10.11 presents information on the disposal of stools of children under age 5 years, by background characteristics.

Table 10.11: 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 2015

Background characteristic	Manner of disposal of children's stools									Total	Percentage of children whose stools are disposed of safely[1]	Number of children
	Child used toilet or latrine	Put/ rinsed into toilet or latrine	Buried	Put/ rinsed nto drain or ditch	Thrown into garbage	Left in the open	Thrown/ left into sea/river	Other	Missing			
Age in months												
<6	2.5	12	6.5	30.7	9.6	1.2	28.3	4.6	4.4	100	21.1	380
6–11	2.7	9.2	14.9	24.4	12.2	0.8	27.8	4.3	3.8	100	26.8	443
12–23	4	10.8	24.6	13.1	7.9	1.3	32.8	2.3	3.2	100	39.5	732
24–35	10.1	12.5	23.5	10.1	4.5	2.6	32	0.8	3.9	100	46.1	481
36–47	18.5	11	21.7	6.5	3.6	1.9	34.2	1	1.7	100	51.1	386
48–59	26.2	10.4	14.6	5	3.1	1.6	35.4	1.2	2.6	100	51.2	249
Toilet facility[2]												
Improved, not shared	26.1	28.2	6.7	11.9	12	1.6	6.2	3.7	3.6	100	61	554
Shared[3]	19.3	28.9	14.7	16.8	11.3	0.6	3.4	1.4	3.5	100	63	189
Non-improved or shared	2.9	4.2	22.8	16.1	5.4	1.6	41.6	2.1	3.2	100	29.9	1,923
Missing	0	24.8	12.4	12.4	0	0	50.5	0	0	100	37.2	6
Residence												
Urban	27.6	28.4	7.3	8.1	16.7	0.7	4.6	4.3	2.2	100	63.3	489
Rural	4.6	7.1	21.5	16.8	5	1.7	37.6	2	3.6	100	33.2	2,184
Region												
Honiara	35.3	26	4.6	4.4	22	0.5	0.8	5	1.5	100	65.9	312
Guadalcanal	5.9	8.8	33.1	12.9	8.7	4.3	15	1.5	9.8	100	47.9	523
Malaita	5.8	11	18.7	22.6	5.9	0.2	33	1.4	1.2	100	35.6	680
Western	6.8	14.3	9.3	4.2	0.7	2.5	56.2	3.3	2.7	100	30.4	381
Other provinces	3.9	4.8	19.8	20.2	4.4	0.8	41.9	2.4	1.9	100	28.5	777
Mother's education												
No education	5.7	10.8	19.1	13.6	4.6	1.8	38.1	3.1	3.2	100	35.6	248
Primary	7.6	8.1	21.5	14.3	6.1	1.7	35.4	2.3	3.1	100	37.2	1,258
Secondary	9.7	12.9	17.1	17.4	7.8	1.3	28.1	2	3.6	100	39.8	1,024
More than secondary	19.3	23.6	7.4	10.9	16.2	2.2	12.4	4.7	3.3	100	50.4	142
Wealth quintile												
Lowest	2.6	2.9	24.8	14.6	6.8	1	40.5	2.1	4.7	100	30.3	595
Second	2.7	5.8	19.8	15	4.1	2.1	45.6	2.6	2.3	100	28.3	547
Middle	4.6	9.6	21.9	21.2	5.3	1.3	32.7	1.4	2	100	36.1	546
Fourth	11.8	12.6	18.6	16.7	4.2	2.4	28.1	2.1	3.5	100	43	529
Highest	26.1	27.7	6.6	7.4	16.9	0.9	6.1	3.9	4.2	100	60.4	457
Total	**8.9**	**11**	**18.9**	**15.2**	**7.2**	**1.5**	**31.6**	**2.4**	**3.3**	**100**	**38.7**	**2,672**

[1] Children's stools are considered to be disposed of safely if the child used a toilet or latrine, if the fecal matter was put/rinsed into a toilet or latrine or if it was buried.

[2] See Table 2.2 for definition of categories

[3] Facilities that would be considered improved if they were not shared by two or more households

The survey showed that only 39% of children had their stools disposed of safely, with 9% of children able to use a toilet or latrine to dispose of their stools, 11% of children's stool rinsed into a toilet or latrine and 19% of children's stool being buried. In contrast, 58% of children's stools were disposed of unsafely with 32% of stools being thrown into or left in the sea or river, 15% were rinsed into a drain or ditch, 7% were thrown into the garbage, 2% was left in the open, and another 2% were disposed of in other ways.

There are pronounced differences in the disposal of children's stools by background characteristics. For instance, children living in urban areas are more likely to have their stools disposed of safely than children living in rural areas. Children whose mother have more than a secondary education and lives in the highest wealth quintile are more likely to have their stools disposed of safely than other children.

CHAPTER 11 NUTRITION

by Josephine Maelaua and Salome Diatalau, Nutritionists, SIMoHMS

KEY FINDINGS

- 32% of children under age 5 years are stunted in growth (<-2 SD), with 10% being severely stunted (<-3 SD). Mean z score for height-age was 1.3.
- 8% of children under age 5 years are wasted, with 4% being severely wasted. Mean z score was 0.2.
- 16% of children under age 5 years are underweight, with 4% being severely underweight. Mean z score for weight-age was 0.9
- 76% of children less than 6 months old are exclusively breastfed.
- The mean duration for exclusive breastfeeding is 4.5 months.
- Initial breastfeeding within one hour of giving birth occurs among 79% of mothers.
- 39% of children less than 5 years old are anaemic.
- 37% of children aged 6–59 months receive vitamin A supplements.
- 35% of children receive deworming medication.
- 11% of children less than 5 years old receive iron supplements.
- 88% of households use salt, and of these, 98% use iodised salt.
- 47% of women aged 15–49 have a high body mass index (BMI): 30% are overweight, and 18% are obese.
- 41% of women aged 15–49 and 54% of pregnant women are anaemic.
- 33% of women aged 15–49 receive vitamin A supplements after childbirth.
- 36% of men aged 15–49 have a high BMI: 26% of men are overweight, and 10% are obese.

INTRODUCTION

This chapter describes the nutritional status of children under age 5 years; infant and young child feeding practices, including breastfeeding and feeding with solid and/or semisolid foods; diversity of foods fed and the frequency of feeding; and micronutrient status, supplementation, and fortification. The discussion also covers the nutritional status of adults 15–49 and the prevalence of iodized salt in households. Finally, children aged 6–59 months and all women aged 15–49 were eligible to provide a finger prick drop of blood that was tested to determine the prevalence of anaemia.

11.1 NUTRITIONAL STATUS OF CHILDREN

The nutritional status of children is an important indicator of their health and wellbeing. Poor nutrition in children under age 5 years is associated with an increased risk of morbidity and mortality. Usually there is a 'catch-up' growth period in older children or adolescents who experience growth retardation when they are less than three years old.

Poor nutritional status in children is related to maternal malnutrition, low birth weight, inadequate breastfeeding and weaning diets, and high levels of infectious disease morbidity. Malnutrition in children leads to short stature in adults, which is associated with reduced productivity and increased obstetrics risks for women. Improvements in the nutritional status of children will reduce the severity of common childhood illnesses and reduce the risk of death.

Similar anthropometrical standards and measurements were used in the 2015 and SIDHS 2006–2007s. 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 grams (g), and height was measured using a portable measuring board accurate to the nearest 1 millimetre (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 their 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 World Health Organization (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).[13]

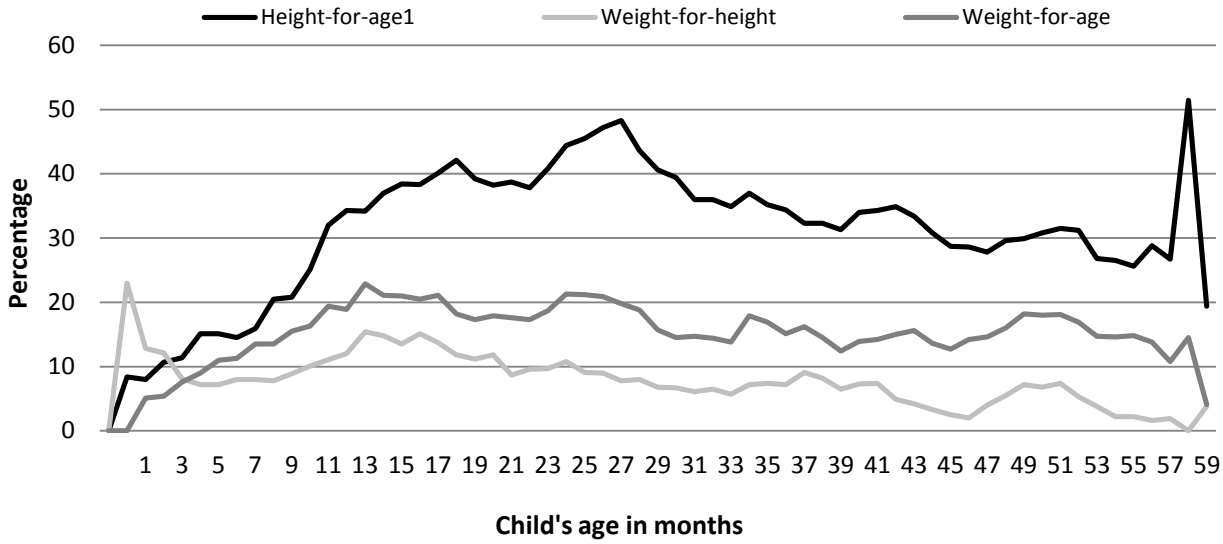
The anthropometric indicators of a child's nutritional status used in this survey are expressed as standard deviations (SD), the deviations of the individual anthropometric measurements from the median value of the WHO growth reference for that child's height or age divided by the SD for the reference population. Children who are more than 2 SD below the reference median of the international growth reference for their age or height (<-2 SD) are considered to be **undernourished** and those who are more than 3 SD (<-3 SD) below the reference median are considered to be **severely undernourished**.

Z-score means are also calculated as summary statistics representing the nutritional status of children in a population. These mean scores describe the nutritional status of the entire population without the use of a cut-off. A mean Z-score of less than 0 (i.e. a negative mean value for stunting, wasting or underweight) suggests that the distribution of an index has shifted downward and that most, if not all, children in the population suffer from undernutrition relative to the reference population.

Figure 11.1 illustrates the percentage of children under age 5 years who are classified as being malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by the child's age in months. In general, stunting, wasting, and underweight remain a nutrition problem in children less than 5 years of age. About 50% of stunting occurs in children aged 28 and 58 months, while over 20% of wasting occurs in children aged 1 month, and 20% of underweight occurs in children aged 12 and 24 months.

[13] WHO. 1997. WHO Global Database on Child Growth and Malnutrition. See: http://apps.who.int/iris/bitstream/10665/63750/1/WHO_NUT_97.4.pdf

Figure 11.1: Nutritional status of children by age, Solomon Islands 2015



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 11.1 presents the nutritional status of children including the prevalence of low height-for-age or stunting in children aged less than 5 years by gender and according to birth size and maternal characteristics. Overall, 32% of children under age 5 years are stunted (identified as <-2 SD below the mean), a 1% point decline compared with 33% reported in the SIDHS 2006–2007. According to the SIDHS 2015, 10% of children are severely stunted children (identified as <-3 SD below the mean), an increase of 1% point who were severely stunted in the SIDHS 2006–2007 (9%). The prevalence of stunting is slightly higher among boys (34%) than in girls (30%). A similar trend was reported in the SIDHS 2006–2007, in which the prevalence of stunting was 37% for boys and 29% for girls. Despite an 9% decrease among boys compared with a 3% increase among girls, stunting is still prevalent among boys.

Table 11.1: 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 2015

	Height-for-age[1]			Weight-for-height				Weight-for-age				Number of children
	Percentage		Mean Z-score (SD)	Percentage			Mean Z-score (SD)	Percentage			Mean Z-score (SD)	
Background characteristic	**below -3 SD**	**below -2 SD[2]**		**below -3 SD**	**below -2 SD[2]**	**above +2 SD**		**below -2 SD**	**below -2 SD[2]**	**above +2 SD**		
Age in months												
<6	4.8	11.4	-0.2	3.5	9.2	7	0.1	1.3	7.2	3.9	-0.2	275
6–8	6.5	16	-0.5	2.1	9.2	6.7	-0.2	2.2	11.7	2.4	-0.6	185
9–11	8.3	28.4	-1.2	3.8	7.9	4.3	-0.3	4.9	18	0.5	-1	185
12–17	15.6	37.2	-1.5	6	14.4	4.6	-0.5	7.1	20.6	2.5	-1.1	381
18–23	16.8	38.8	-1.5	4.4	11.1	4.7	-0.4	6.5	18	1.4	-1	338
24–35	12.4	40.4	-1.6	3.3	7.7	4	-0.3	3.9	17.3	0.9	-1	700
36–47	8.6	31.6	-1.5	2.2	5.9	3.2	-0.2	2.9	14	0.2	-1	762
48–59	7.8	28.9	-1.4	1.5	4.4	1.6	-0.3	2.6	15.1	0.3	-1	658
Sex												
Male	11.7	33.5	-1.4	3.2	7.9	4.3	-0.2	3.3	15.7	1	-0.9	1,778
Female	9	29.6	-1.3	3	8	3.5	-0.3	4.3	15.4	1.4	-0.9	1,705
Birth interval in months[3]												
First birth[4]	10	29.9	-1.3	3.2	8.1	3.8	-0.2	2.9	13.9	0.8	-0.9	744
<24	12.8	33.2	-1.4	2	6.4	4.3	-0.2	3.5	17.3	1.2	-0.9	649
24–47	10.5	32.1	-1.3	3.4	7.7	4.9	-0.2	3.2	14.1	1.5	-0.9	1,061
48+	7.3	28.7	-1.2	3.5	9.2	2.7	-0.4	4.3	15.9	1.3	-1	652
Size at birth[3]												
Very small	24.6	52.5	-2	6.5	10.8	1.5	-0.5	9.3	32.8	1.1	-1.5	91
Small	15	40.1	-1.6	4.7	12.9	4.1	-0.6	6.5	24.9	0.6	-1.3	333
Average or larger	9	28.8	-1.3	2.7	7.1	4.1	-0.2	2.8	13.1	1.3	-0.8	2,554
Missing	10.7	38.6	-1.5	4.4	7.5	3.8	-0.3	4.7	17	1.2	-1.1	125
Mother's interview status												
Interviewed	10.2	31.1	-1.3	3.1	7.8	4	-0.2	3.4	15.1	1.2	-0.9	3,106
Not interviewed but in household	9.3	35.6	-1.4	6.8	12.4	3.1	-0.6	9.1	17.6	0	-1.2	76
Not interviewed and not in the household[5]	12.3	35.6	-1.3	2.7	7.8	2.6	-0.3	6.1	19.5	0.8	-1	301
Mother's nutritional status[6]												
Thin (BMI<18.5)	(14.8)	(50.5)	(-1.8)	(6.4)	(14.1)	(1.9)	(-0.8)	(6.4)	(41.7)	0	(-1.6)	52
Normal (BMI 18.5–24.9)	11.1	33.2	-1.4	3.7	8.6	3.8	-0.3	4.2	16.6	1.3	-1	1,380
Overweight/ obese (BMI >= 25)	8	26.3	-1.2	1.6	5.5	4.3	-0.1	2	12.2	1.3	-0.7	1,270
Residence												
Urban	8.2	27.3	-1.1	2.1	6.3	4.4	-0.1	1.5	12	1	-0.7	562
Rural	10.8	32.4	-1.4	3.3	8.3	3.8	-0.3	4.2	16.2	1.2	-1	2,921
Region												
Honiara	9	26.6	-1.1	1.3	4.6	4.4	0	1	11.3	1.3	-0.6	375
Guadalcanal	14.3	36	-1.4	3.3	6.3	8.2	-0.1	3.8	13.9	1.7	-0.8	564
Malaita	10.3	34	-1.4	2.4	5.3	3.1	0	3.6	11.6	0.9	-0.8	995
Western	11.4	31	-1.3	5.7	14.6	2.8	-0.7	4.4	22.5	0.3	-1.2	494

Other provinces	8.3	29	-1.3	3.1	9.4	2.7	-0.5	4.6	18.3	1.4	-1.1	1,055
Mother's education[7]												
No education	11.2	34.6	-1.5	4.6	10.6	3.4	-0.3	5	17.7	0.7	-1.1	327
Primary	10.2	33	-1.4	2.9	7.1	3.5	-0.2	3	14.7	1.3	-0.9	1,536
Secondary	10.6	29.3	-1.3	3.3	8.3	5	-0.2	4.1	15.1	1.4	-0.9	1,166
More than secondary	4.3	21	-0.9	1.3	8.6	2.8	-0.2	2.2	15.4	0	-0.7	151
Missing	0	27.9	-1.8	0	0	0	-0.5	0	0	0	-1.2	2
Wealth quintile												
Lowest	12.8	36.2	-1.5	4.5	10	3	-0.4	6.8	21.2	1.5	-1.1	837
Second	7.7	32.1	-1.3	1.8	6.5	3.3	-0.2	3.2	13	0.8	-0.9	758
Middle	12.2	33.2	-1.5	3.4	7.8	3.9	-0.3	3.6	16.2	0.7	-1	694
Fourth	9.9	29.1	-1.3	2.7	7.5	3.9	-0.1	2.7	12.7	0.5	-0.8	664
Highest	8.3	24.6	-0.9	3	7.5	6	-0.1	1.5	12.9	2.6	-0.6	530
Total	**10.3**	**31.6**	**-1.3**	**3.1**	**7.9**	**3.9**	**-0.2**	**3.8**	**15.5**	**1.2**	**-0.9**	**3,483**

Note: Table is based on children who stayed in the household on 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 adopted in 2006. The indices in this table are NOT comparable to those based on the previously used NCHS/CDC/WHO reference. Figures in prentheses are based on 25-49 unweighted cases.

Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight.

[1] Recumbent length is measured for children under age 2, or in the few cases when the age of the child is unknown and the child is less than 85 cm; standing height is measured for all other children.

[2] Includes children who are below -3 standard deviations (SD) from the WHO Child Growth Standards population median.

[3] Excludes children whose mothers were not interviewed.

[4] First-born twins (triplets, etc.) are counted as first births because they do not have a previous birth interval.

[5] Includes children whose mothers are deceased.

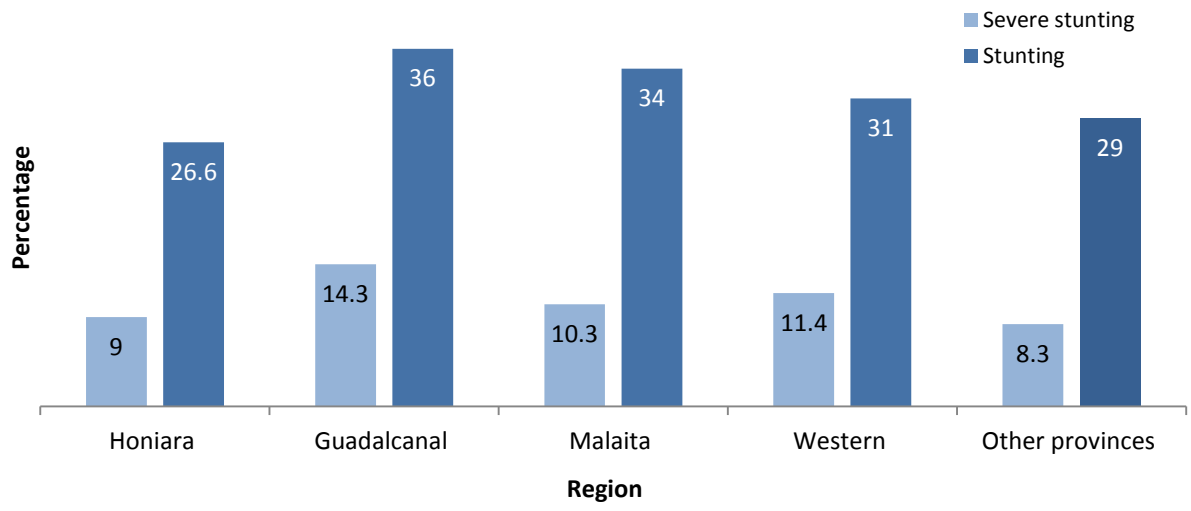
[6] Excludes children whose mothers were not weighed and measured, children whose mothers were not interviewed, and children whose mothers are pregnant or gave birth within the preceding 2 months. Mother's nutritional status in terms of BMI (body mass index) is presented in Table 11.10.1.

[7] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

Stunting also appears to be higher among children in rural areas of Guadalcanal, Malaita and Western provinces than among children in Honiara and other provinces (see also Fig. 11.2). Stunting is more likely to be observed among children born to mothers with little or no education and living in less wealthy households, and is more likely to be observed among babies who are born very small or small.

There are no observed differences between boys and girls: both are equally shorter than children of similar age in the international reference population.

Figure 11.2: Prevalence of severe stunting among children aged less than 5 years, Solomon Islands 2015



WASTING IN CHILDREN

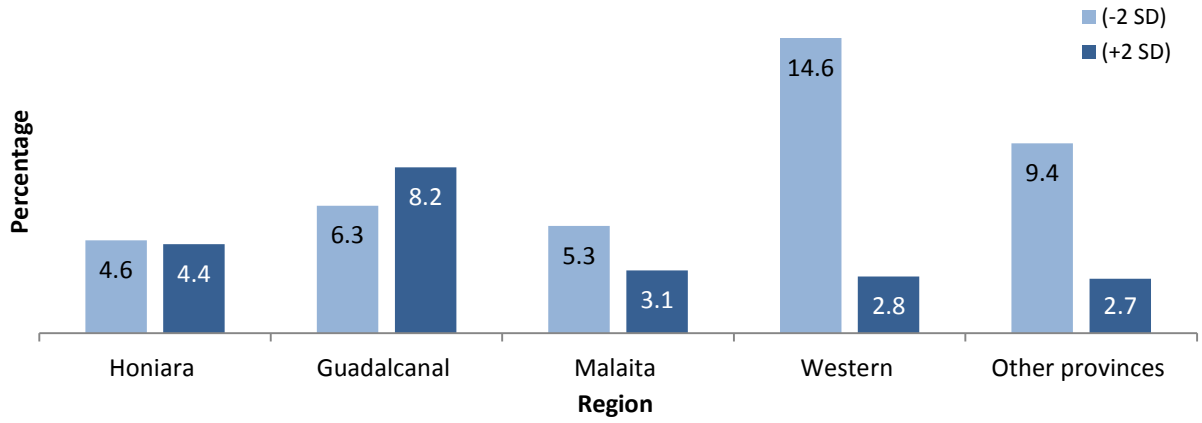
Low weight-for-height, or wasting or thinness, indicates in most cases, a recent or severe process of weight loss that is often associated with acute starvation and/or a severe disease. Wasting may also be the result of chronic unfavourable living conditions. Overall, the prevalence of wasting in Solomon Islands children is fairly low, with 8% below -2 SD and 3% severely wasted (below -3 SD) (Table 11.1) compared with 4% and 1%, respectively, as reported in the SIDHS 2006–2007. This is an increase of 4% points for wasting and a 2% points increase in severe wasting. The mean Z-score for weight-for-height is -0.2, which is slightly below zero, the expected reference value.

There is an observed peak in the prevalence of wasting in children between ages 12 and 23 months, which corresponds to the time after completing immunisation at 1 year of age and an age when acute infectious diseases are common. The prevalence of wasting is among both genders, with girls and boys at 8%. Wasting is higher in rural areas (8%), in Western (15%) and other provinces (9%). Children of educated mothers are less likely to be wasted, and the prevalence of wasting decreases as household wealth increases. Furthermore, there is evidence that babies who are born very small are more likely to be severely wasted (7% below -3 SD) than children who are born of an average or larger size (3% below -3 SD); a similar pattern was observed in the SIDHS 2006–2007.

High weight-for-height is considered an indicator for obesity because the majority of individuals with high weight-for-height are physically obese. The overall prevalence of childhood obesity (>2 SD) is 4%, an increase from 3% as reported in the SIDHS 2006–2007. Obesity among children under the age of 5 years has increased by 1% point since the SIDHS 2006–2007. The current prevalence of high weight-for-height peaks in babies that are less than 11 months old, a similar pattern as reported in the SIDHS 2006–2007.

Figure 11.3 shows the prevalence of wasting and obesity by region. More children in Western Province are wasted than children in other provinces and Guadalcanal Province. Obesity among children under age 5 years is observed in Guadalcanal Province, while Honiara reports a slightly equal proportion of wasted and obese children, which was also the case for Malaita Province in the SIDHS 2006–2007.

Figure 11.3: Prevalence of wasting and obesity among children aged less than 5 years by region, Solomon Islands 2015

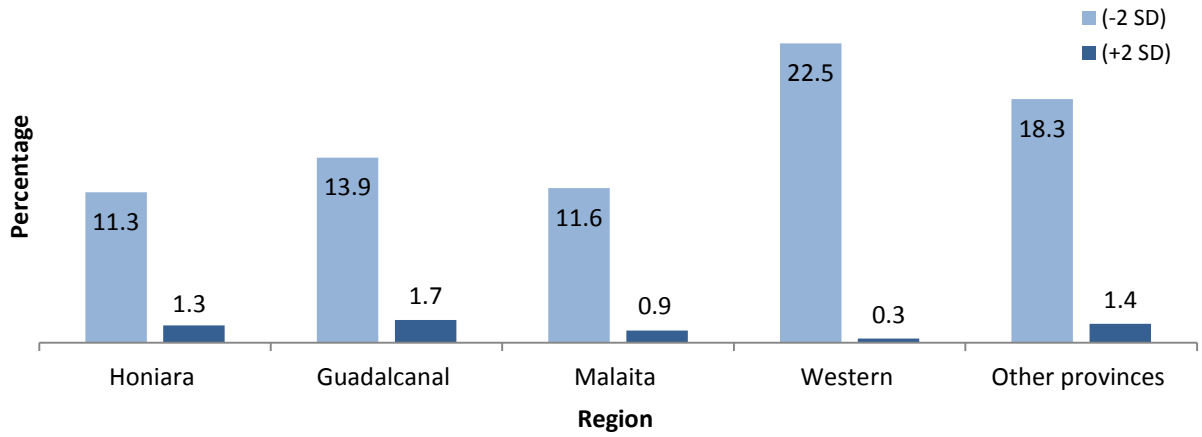


UNDERWEIGHT IN CHILDREN

The prevalence of low weight-for-age, or underweight, or being undernourished in children is shown in Table 11.1. Overall, 16% of children are underweight (below -2 SD), a 4% point increase compared with 12% reported in the 2006–2006 SIDHS. Furthermore, 4% are severely underweight (below -3 SD), a 2% point decrease compared with 2% as reported in the SIDHS 2006–2007. The mean z-score for weight-for-age is -0.9, which is below zero, the expected value of the reference distribution.

Children in rural areas, those in less wealthy households, and those born to less educated mothers are more likely to be underweight themselves (Table 11.1). 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 or infection, places children at risk of developmental retardation. The prevalence of underweight children is higher in Western Province than in other regions (Table 11.1 and Fig. 11.4).

Figure 11.4: Prevalence of underweight children aged less than 5 years by region, Solomon Islands 2015



11.2 BREASTFEEDING AND COMPLEMENTARY FEEDING

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 as important impact on the child's health and nutritional status. Exclusive breastfeeding until 6 completed months of age is the recommended and most appropriate way to feed newborn babies until age 6 completed 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 the United Nations Children's Emergency Fund (UNICEF) recommend that solid food should only be given after a child reaches 6 completed 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.

11.2.1 Initiation of breastfeeding

Both the mother and child benefit from early initiation of breastfeeding. The suckling action of the baby on the breast releases 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 colostrum, which is rich in nutrients and immunoglobulin that help protect infant against infections.

Table 11.2 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 98%, a 5% points increase (from 93%) from the SIDHS 2006–2007. Of these children, 79% began breastfeeding within one hour of birth; this figure increased to 95% of children who began breast feeding within one day of birth. Overall, 4% of children receive food other than breast milk. Both increase in the prevalence of children ever breastfed, and early initiation of breastfeeding favourably decreases the percentage of children who receive food other than breast milk by less than 2%.

Figure 11.5 visually shows the prevalence of breastfeeding by province. Overall, the prevalence of breastfed children is more than 95% in all provinces, with the highest prevalence in Guadalcanal (99%) followed by other provinces (98%). The prevalence of breastfeeding is slightly higher in rural areas (98%) than in urban areas (97%), with an increase of 5% points in rural areas and 8% points in urban areas, compared with 93% (rural) and 86% (urban) from the SIDHS 2006–2007. Overall, the results show that the prevalence of breastfed babies continues to increase with a mother's level of educational attainment. Results from the SIDHS 2015 indicate that there is no difference in the wealth of a household wealth and the prevalence of breastfed babies. In the SIDHS 2006–2007, however, there was an inverse pattern where the prevalence of breastfeeding decreased with an increase in household wealth. This is an indication that all mothers can

successfully breastfeed their children, provided that they receive adequate family support and access to complete and accurate breastfeeding information.

Table 11.2: Initial breastfeeding

Among last-born children who were born in the two years preceding the survey, the percentage who were ever breastfed and the percentages who started breastfeeding within one hour and within one day of birth; and among last-born children born in the two years preceding the survey who were ever breastfed, the percentage who received a prelacteal feed, by background characteristics, Solomon Islands 2015

Background characteristic	Among last-born children born in the past two years:				Among last-born children born in the past two years who were ever breastfed:	
	Percentage ever breastfed	Percentage who started breastfeeding within 1 hour of birth	Percentage who started breastfeeding within 1 day of birth[1]	Number of last-born children	Percentage who received a prelacteal feed[2]	Number of last-born children ever breastfed
Sex						
Male	98.2	77.9	94.6	824	4.4	809
Female	97.6	80	94.5	791	2.5	772
Assistance at delivery						
Health professional[3]	98	79.2	94.9	1,404	3.2	1,376
Traditional birth attendant	(100)	(68.3)	(92.8)	44	(10.2)	44
Other	97.7	81.2	93.7	147	5.1	144
No one	100	100	100	7	0	7
Missing	78.6	46.5	59.7	12	0	9
Place of delivery						
Health facility	98.2	79.7	94.9	1,380	3.2	1,355
At home	97.1	74.4	93	221	4.7	215
Other	100	71.2	100	6	28.8	6
Missing	66.8	66.8	66.8	8	0	5
Residence						
Urban	96.5	78.8	92.6	291	8.1	280
Rural	98.2	78.9	95	1,324	2.5	1,301
Region						
Honiara	97	81.1	93	182	9.1	176
Guadalcanal	98.5	73.3	95.9	301	1.3	296
Malaita	97.7	80.3	95.5	420	2.6	410
Western	98.1	90.9	96.6	238	4.3	234
Other provinces	98	74.4	92.3	474	3.1	465
Mother's education						
No education	98	85.5	95	145	1.1	142
Primary	98.1	80.5	94.7	699	3	686
Secondary	97.6	75.6	94.1	680	4.1	664
More than secondary	99.1	81.1	95.4	90	6.7	89
Wealth quintile						
Lowest	97.3	78.3	92.8	378	5.2	368
Second	98.1	77.1	94.6	337	0.4	330
Middle	98.4	77.1	95	305	2.5	300
Fourth	98.6	80.2	96.7	318	2.1	313
Highest	97.2	82.5	93.8	277	7.6	269
Total	**97.9**	**78.9**	**94.5**	**1,615**	**3.5**	**1,581**

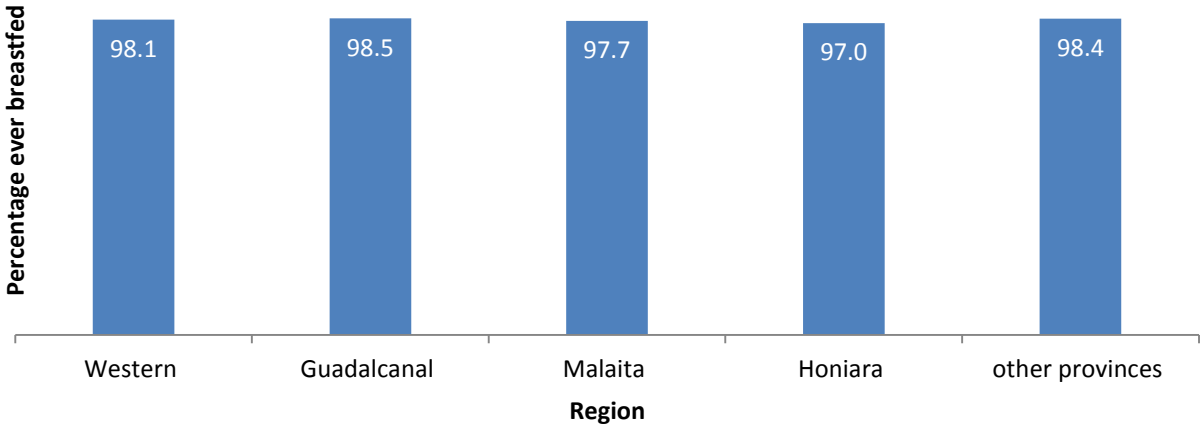
Note: Table is based on last-born children born in the two years preceding the survey regardless of whether the children are living or dead at the time of interview. Figures in parentheses are based on 25-49 unweighted cases.

[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, midwife, registerd nurse, nurse aid.

Figure 11.5: Prevalence of breastfeeding by province, Solomon Islands 2015



11.2.2 Breastfeeding status by age

One indicator of breastfed children is the percentage of children less than 6 months old who are exclusively breastfed.

Table 11.3 presents the prevalence of children less than age 2 years who are currently breastfeeding and/or receiving complementary foods at the time of the survey. There has been a 7% points decrease in the number of children less than age 2 years currently breastfeeding from 67% at the time of the SIDHS 2006–2007 to 60% reported in the SIDHS 2015. The prevalence of exclusive breastfeeding declines rapidly between 4 and 7 months, indicating that most (65%) breastfed children started complementary feeds at 6 completed months of age. Figure 11.6 shows this relationship very clearly. The introduction of the newly integrated WHO/UNICEF Infant Young Child Feeding (IYCH) practice in 2010 in Solomon Islalnds, which addressed exclusive breastfeeding and starting complementary feeds at 6 completed months of age (along with continued breastfeeding for up to two years) has had a positive impact. As illustrated in Figure 11.6, there has been improved adherence to the WHO/UNICEF IYCF practice, even though the practice of introducing complementary foods at age 4 months onwards is still a common practice in some areas of Solomon Islands.

According results of the SIDHS 2015, plain water is given to children mostly prior to the weaning period while at the time of the SIDHS 2006–2007, it was introduced during the weaning period. Breastfed children are being introduced to mainly non-milk liquids or juice earlier 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 prevalence of children who are given a bottle with a nipple peaks when children are between ages 12 and 17 months, compared with 9 and 11 months at the time of the SIDHS 2006–2007.

Figure 11.6: Relationship between exclusive breastfeeding and complementary feeding among children aged less than 2 years, Solomon Islands 2015

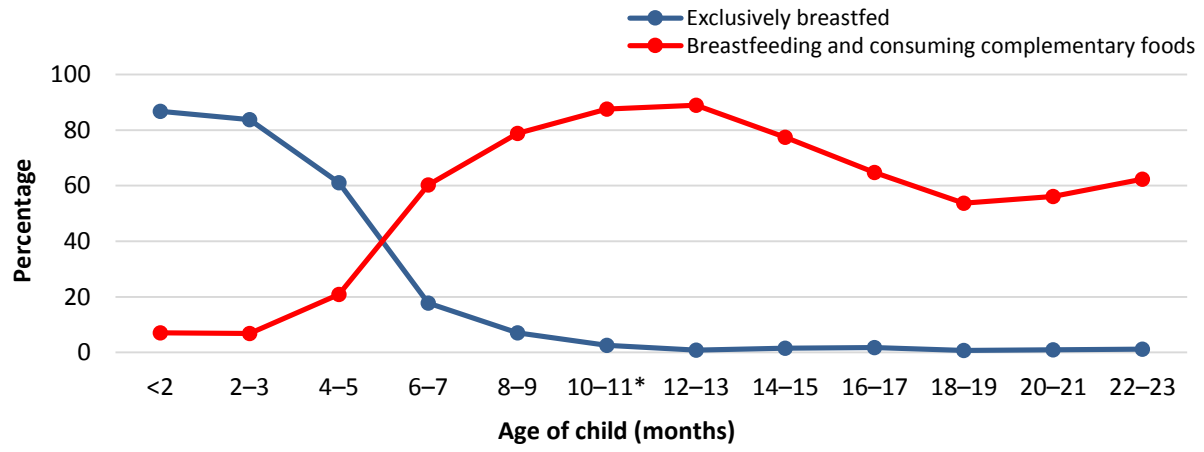


Table 11.3: Breastfeeding status by age

Percent distribution of youngest children under two years who are living with their mother by breastfeeding status and the percentage currently breastfeeding; and the percentage of all children under two years using a bottle with a nipple, according to age in months, Solomon Islands 2015

Age in months	Breastfeeding status						Total	Percentage currently breast-feeding	Number of youngest child under two years living with their mother	Percentage using a bottle with a nipple	Number of all children under two years
	Not breast-feeding	Exclusively breastfed	Breastfeeding and consuming plain water only	Breastfeeding and consuming non milk liquids[1]	Breastfeeding and consuming other milk	Breastfeeding and consuming complementary foods					
0–1	1.4	86.8	0	4.2	0.7	7	100	98.6	109	0.7	114
2–3	1.6	83.8	1.2	5.6	0.9	6.8	100	98.4	130	5.2	132
4–5	5	61.1	4.3	6.6	1.9	20.9	100	95	141	11	145
6–8	5.1	16.4	2	10.5	0.8	65.1	100	94.9	225	20.9	230
9–11	5.5	2.1	2.6	3.4	0.8	85.6	100	94.5	219	22.9	224
12–17	18.7	1.3	0.4	0.4	0	79.3	100	81.3	413	24.4	436
18–23	41.5	0.9	0.6	0	0	57	100	58.5	319	15.5	390
0–3	1.5	85.1	0.7	5	0.8	6.9	100	98.5	239	3.1	246
0–5	2.8	76.2	2	5.6	1.2	12.1	100	97.2	380	6	391
6–11	6.1	12.7	2.4	8.5	1.3	69	100	93.9	296	21.1	303
12–15	14.2	1.1	0.5	0.5	0	83.6	100	85.8	317	24.6	332
12–23	28.6	1.1	0.5	0.2	0	69.6	100	71.4	732	20.2	826
20–23	40	1	0	0	0	58.9	100	60	204	14.6	258

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, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100%. Thus children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.

[1] Non-milk liquids include juice, juice drinks, clear broth or other liquids.

11.2.3 Duration and frequency of breastfeeding

Table 11.4 presents the median duration of any kind of breastfeeding, exclusive breastfeeding and predominantly breastfeeding among children born in the three years preceding the survey, and the mean number of feeds per day or night by background characteristics.

WHO and UNICEF recommend exclusively breastfeeding babies for the first 6 completed months of age and continued breastfeeding for at least 24 months. The median duration of any kind of breastfeeding among Solomon Islands children born in the three years preceding the survey is 18.8 months, a decline from 22.6months at the time of the SIDHS 2006–2007. The mean duration for exclusive breastfeeding is 5.3 months and is 6.3 months for predominantly breastfeeding, representing a slight increase from 5.1 months and 5.8 months, respectively, from the SIDHS 2006–2007.

Children in rural areas are more likely to be breastfed more frequently than those in urban areas. There are no differences in the mean duration of exclusive breastfeeding among children in rural areas (5%) and urban areas (4%) or by region, mother's educational attainment or residence.

Table 11.4: Median duration of breastfeeding

Median duration of any breastfeeding, exclusive breastfeeding, and predominant breastfeeding among children born in the three years preceding the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Median duration (months) of breastfeeding among children born in the three years preceding the survey[1]		
	Any breastfeeding	Exclusive breastfeeding	Predominant breastfeeding[2]
Sex			
Male	18.2	4.6	5.3
Female	20.9	4.4	5.7
Residence			
Urban	16.5	4.4	4.9
Rural	19.9	4.5	5.6
Region			
Honiara	16.2	4.5	5
Guadalcanal	24.7	3.3	4.9
Malaita	17.8	4.3	5.1
Western	20.1	5.7	6.3
Other provinces	18.5	4.5	5.9
Mother's education			
No education	18.3	4.1	5
Primary	21.3	4.8	5.5
Secondary	18	4.3	5.5
More than secondary	15.4	4.5	5.9
Wealth quintile			
Lowest	21.8	4.2	5.8
Second	21.1	4.2	5.5
Middle	18.2	4.4	5.5
Fourth	19.5	5.3	5.7
Highest	16.4	4	4.6
Total	**18.8**	**4.5**	**5.5**
Mean for all children	21.1	5.3	6.3

Note: Median and mean durations are based on the distributions at the time of the survey of the proportion of births by months since birth. Includes children living and deceased at the time of the survey.

[1] It is assumed that non-last-born children and last-born children not currently living with the mother are not currently breastfeeding.

[2] Either exclusively breastfed or received breast milk and plain water, and/or non-milk liquids only.

11.2.4 Types of complementary foods consumed by children

UNICEF and WHO recommend introducing solid food to infants from the age of 6 completed 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 completed months should be fed small quantities of solid and semi-solid foods (referred to as 'complementary foods') throughout the day. The risk of malnutrition during this transition period is very high due to improper and unsafe food handling and inappropriate feeding practices.

Mothers whose youngest child is less than 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 11.5

LIQUIDS

Non-breastfed children are more likely to consume all other types of liquids and infant formula than breastfed children. The most commonly consumed liquid is 'other liquids', which does not include water consumed by 65% of non-breastfed children less than 2 years and by 49% of breastfed children in the same age group. The introduction of other liquids began early with one in ten breastfed children (11%) aged 0–3 months consumed other liquids and the number increased to 1 out of 2 among breastfed children (56%) aged 6–8 months who consumed other liquids. By age 9–11months, more than half of these children were given other liquids (65%).

Infant formula consumption has declined among breastfed children from 4% as reported in the SIDHS 2006–2007 to 2% in the SIDHS 2015. A similar pattern is also seen among non-breastfed children. Non-breastfed children are more likely to be given liquids (infant formula, other milk, other liquids) other than breastfed children. Overall, the consumption of all types of liquids among breastfed children less than 2 years has declined by 8 percentage points from the SIDHS 2006–2007 while consumption of other milk showed only a small decline of 0.2%.

SOLID OR SEMI-SOLID FOODS

Overall, 89% of breastfed children aged 6–23 months received solid and semi solid complementary food in addition to breast milk. Moreover, 97% of non-breastfed children in the same cohorts received the same type of feeding. The introduction of semi-solid and solid foods increased rapidly between ages 4 and 9 months among all breastfed children. Vitamin A-rich foods such as pawpaw, sweet potatoes, pumpkin, and dark green leafy vegetables are the most common foods introduced to young children. These are very soft when cooked and easily mashed to the right consistency.

Other commonly consumed foods include those made from grains especially for non-breastfed children followed by foods made from tubers and root crops.

Only 26% of breastfed children and 49% of non-breastfed children consume protein-rich foods such as meat, fish and poultry. Consumption of eggs was 19% in breastfed children and 26% in non-breastfed children. The low percentage of consumption could possibly be due to the high cost of these foods and not all households can afford them. Another 60% of breastfed children and 84% of non-breastfed children consumed fruits and vegetables rich in vitamin A. Food made from roots and tubers were consumed by 47% of breastfed children and 69% of non-breastfed children.

The percentage of non-breastfed children consuming any solid or semi-solids foods is higher (93%) than those who are breastfed (68%), a decline of about 3% and 6%, respectively.

Table 11.5: Foods and liquids consumed by children in the day or night preceding the interview

Percentage of youngest children under two years of age 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 2015

Age in months	Liquids			Solid or semi-solid 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	Eggs	Cheese, yogurt, other milk product	Any solid or semi-solid food	
BREASTFEEDING CHILDREN														
0–1	0	3	11.3	0	5.7	7.1	4.3	7.1	1	7.1	5.4	0	7.1	107
2–3	0.9	1.2	11	0.3	3.8	4.9	1.7	3.7	0.6	2.1	2.1	0.6	7	128
4–5	1.5	1.5	26.9	0	5.2	16.9	5	10.8	1.2	1.9	2.4	0.8	22	134
6–8	3.9	3.9	55.6	0.9	14.4	58.1	21.4	41.6	3.9	12.4	14.8	2.7	68.7	213
9–11	1.3	10.1	65.3	1.3	48.2	80.3	43.2	57.9	9.1	31.3	22.8	2.9	90.5	207
12–17	1.5	7	63.7	4.4	73.9	88.1	54.8	67.4	25	43.1	32.1	8.7	97.5	336
18–23	0.7	7.2	57	3.7	73.5	86.4	56.7	80.1	22.7	47.9	27.9	8.5	97.4	187
6–23	1.8	7	60.9	2.8	54.7	79.3	45.1	62	16.3	34.5	25.3	6	89.4	943
Total	**1.6**	**5.6**	**48.5**	**2**	**40.7**	**59.7**	**33.4**	**46.6**	**12**	**25.8**	**19.1**	**4.5**	**67.7**	**1,312**
NON-BREASTFEEDING CHILDREN														
0–1	*	*	*	*	*	*	*	*	*	*	*	*	*	1
2–3	*	*	*	*	*	*	*	*	*	*	*	*	*	2
4–5	*	*	*	*	*	*	*	*	*	*	*	*	*	7
6–8	*	*	*	*	*	*	*	*	*	*	*	*	*	12
9–11	*	*	*	*	*	*	*	*	*	*	*	*	*	12
12–17	2.9	11.7	66.1	1.5	71.3	83.7	47.1	66.8	25.9	39.2	27.7	7.2	95.1	77
18–23	0	5.7	69.4	4.6	80.7	91.8	60.9	75.5	25	56.4	28	9.9	100	132
6–23	2	8.1	66.9	3.9	74.6	87.9	54.8	72	23.1	50.9	27.1	8.3	96.5	233
Total	**2.6**	**7.8**	**64.8**	**3.7**	**71.3**	**84.4**	**52.4**	**69.2**	**22.1**	**48.7**	**25.9**	**7.9**	**92.6**	**244**

Note: Breastfeeding status and food consumed refer to a 24–hour" period (yesterday and last night). An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[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 [list fruits and vegetables included in the questionnaire such as pumpkin, red or yellow yams or squash, carrots, red sweet potatoes, dark green leafy vegetables, mangoes, papayas, and other locally grown fruits and vegetables that are rich in vitamin A]

11.3 INFANT AND YOUNG CHILD FEEDING PRACTICES

The WHO Global Strategy on Infant and Young Child Feeding – IYCF (WHO 2005) recommends the timely introduction of solid and/or semi-solid foods beginning at age 6 completed months, and 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 milk 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 groups[14] 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 11.6 shows the percentage of children who are fed according to IYCF practices. Among all children aged 6–23 months, 82% consume breast milk, milk, or other milk products, which is a decline from 85% as reported in the SIDHS 2006–2007. This is due to a significant decrease in the percentage of non-breastfed children who consume milk and milk products since the SIDHS 2006–2007. Furthermore, only 37% of children aged 6–23 months consume a varied diet from the three to four main food groups a day, a substantial fall of 22% points from 59.2% at the time of the SIDHS 2006–2007. A further 15% points decline is observed among children who meet all three IYCF practices with only 22% compared with 37 at the time of the SIDHS 2006–2007. There has been a drastic decline in the percentage of children aged 6–23 months who are fed according to IYCF recommendations.

Among non-breastfed children, only 3% meet the minimum IYCF requirements, a very slight improvement of 0.3% point from 2.7% reported in the SIDHS 2006–2007. Furthermore, most of these children are children aged 12–17 months, children with more educated mothers and children living in wealth households. Similar observations were reported in the SIDHS 2006–2007.

[14] 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 11.6: 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 on breastfeeding status, number of food groups, and times they are fed during the day or night preceding the survey, by background characteristics, Solomon Islands 2015

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:				
	4+ food groups[1]	Minimum meal frequency[2]	Both 4+ food groups and minimum meal frequency	Number of breastfed children 6–23 months	Milk or milk products[3]	4+ food groups[1]	Minimum meal frequency[4]	With 3 IYCF practices[5]	Number of non-breastfed children 6–23 months	Breast milk, milk, or milk products[6]	4+ food groups[1]	Minimum meal frequency[7]	With 3 IYCF practices	Number of all children 6–23 months
Age in months														
6–8	13.3	57.2	10.4	213	*	*	*	*	12	95.2	14.5	54.6	9.8	225
9–11	31.1	61.6	24.8	207	*	*	*	*	12	96.4	32.4	59.8	24.6	219
12–17	43.9	64.9	32.6	336	8.9	44.6	31.7	3.2	77	83	44	58.7	27.1	413
18–23	44.9	70.9	35.5	187	4.5	49.9	30.1	1.4	132	60.4	47	54	21.4	319
Sex														
Male	35.1	64.6	29.1	479	7.6	46	29.3	3.3	119	81.6	37.3	57.6	24	598
Female	33.5	62.7	23.7	464	7.6	49.5	29.5	2.7	114	81.8	36.7	56.1	19.5	578
Residence														
Urban	43.4	64.9	32.9	155	(23.7)	(59.1)	(41.1)	(9.8)	44	83.3	46.9	59.7	27.9	199
Rural	32.6	63.4	25.2	787	3.9	45.1	26.7	1.4	189	81.4	35	56.3	20.6	977
Region														
Honiara	38.5	68.8	31.6	96	(28.4)	(64.9)	(46.5)	(10.8)	29	83.3	44.6	63.6	26.7	125
Guadalcanal	25.2	56.8	15.7	199	(5.9)	(38.6)	(31.1)	(3.7)	28	88.3	26.9	53.6	14.2	227
Malaita	26.5	72.8	24.5	240	0.4	30	14.2	0	79	75.3	27.4	58.3	18.4	320
Western	50.6	71.9	42.9	134	(10.3)	(61.8)	(32.1)	(5.6)	37	80.7	53	63.4	34.9	170
Other provinces	38.5	54.8	26.1	274	6.1	58.5	38.6	1.2	60	83.2	42	51.9	21.7	333
Mother's education														
No education	31.7	68.9	26.3	86	*	*	*	*	20	80.8	28.4	57.7	21.2	106
Primary	29.7	64	22.8	407	8.4	46.6	34.2	2.3	102	81.6	33.1	58	18.7	509
Secondary	38.8	63.5	30	398	7.6	52.7	23.1	3.8	100	81.5	41.6	55.4	24.8	498
More than secondary	41	53.7	28.1	52	*	*	*	*	11	85	47	57.5	24.5	63
Wealth quintile														
Lowest	30.7	61.3	25.3	235	(4)	(34.5)	(29.7)	(0)	52	82.7	31.4	55.6	20.8	287
Second	31.7	63	24	204	(4.9)	(48)	(20.1)	(1.6)	50	81.4	34.9	54.6	19.6	254
Middle	31.9	68.3	23.9	175	(2.9)	(47)	(29.1)	(0)	43	80.9	34.9	60.6	19.2	218
Fourth	40.9	62.7	29.4	170	(3.9)	(47.7)	(22.7)	(2.4)	51	77.7	42.5	53.4	23.1	221
Highest	39	63.8	31	158	26.6	66.5	50.6	13.2	37	86	44.2	61.2	27.6	196
Total	**34.4**	**63.6**	**26.5**	**943**	**7.6**	**47.7**	**29.4**	**3**	**233**	**81.7**	**37**	**56.9**	**21.8**	**1,176**

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] Food groups: a. infant formula, milk other than breast milk, cheese or yogur or other milk products; b. foods made from grains, roots, and tubers, including porridge and 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. [2] For breastfed children, minimum meal frequency is receiving solid or semi-solid food at least twice a day for infants 6–8 months and at least three times a day for children 9–23 months. [3] Includes two or more feedings of commercial infant formula, fresh, tinned, and powdered animal milk, and yogurt. [4] For non-breastfed children aged 6–23 months, minimum meal frequency is receiving solid or semi-solid food or milk feeds at least four times a day.

[5] Non-breastfed children aged 6–23 months are considered to be fed with a minimum standard of three Infant and Young Child Feeding Practices if they receive other milk or milk products at least twice a day, receive the minimum meal frequency, and receive solid or semi-solid foods from at least four food groups not including the milk or milk products food group. [6] Breastfeeding, or not breastfeeding and receiving two or more feedings of commercial infant formula, fresh, tinned and powdered animal milk, and yogurt.

[7] Children are fed the minimum recommended number of times per day according to their age and breastfeeding status as described in footnotes 2 and 4.

11.4 MICRONUTRIENTS IN CHILDREN

11.4.1 Vitamin A and iron intake among children

Micronutrients are vitamins and minerals vital for life. They are needed in very small amounts but play significant roles in the body. Even though all micronutrients are crucial, vitamin A and iron are the most common nutrient deficiencies in the developing world. The SIDHS 2015 included questions regarding vitamin A and iron intake in order to examine the nutritional intake from food and supplements among children aged 6 months to 5 years and among women aged 15–49.

Children need vitamin A and iron from foods after age 6 months because their vitamin A and iron stores start to deplete and breast milk alone is not adequate to provide sufficient amounts of these nutrients. The WHO/UNICEF global IYCF strategy clearly outlines specific feeding recommendations to ensure children get enough vitamin A and iron to achieve their full growth and potential.

Vitamin A is vital for supporting normal growth in children and protecting them against infections and blindness. Vitamin A enters the body as retinol from animal food sources and β-carotene as plant sources. The main sources of vitamin A (retinol) include: breast milk, fatty fish, eggs, milk and milk products. Food providing β-carotene consists mainly of green leafy vegetables and coloured fruits such as papaya, pumpkin, yellow banana and pandanus. Children need vitamin A for proper growth and fighting infections such as pneumonia and diarrhoea. The severity of illness is often associated with the degree of vitamin A deficiency.

Iron is an essential mineral important for many cell activities. It helps with haemoglobin production and transportation of oxygen in the body as part of haemoglobin. Children require iron for proper growth and development. Foods such as red meat, fish, and green leafy vegetables are high in iron and should be included in their daily diet. An inadequate intake of iron from food sources (and low absorption) may lead to iron deficiency anaemia.

Table 11.7 and Figure 11.7 present the intake of vitamin A and iron among children aged 6 months to 5 years who were living with their mother at the time of the survey. Overall, 84% of children consumed vitamin A-rich foods, a decrease of 6% points (from 90%) from the SIDHS 2006–2007. Children from Honiara, Malaita and Western provinces are more likely to consume vitamin A-rich foods than children from other provinces. There is a minimal difference between regions and residences but the rate of vitamin A intakes increases with age. A higher consumption rate is found among children aged 1–2 years, which is similar for both the 2006–2007 and 2015 surveys. The consumption rate of iron-rich food is 46% compared with 32% at the time of the SIDHS 2006–2007. The consumption rate increases with household wealth and education, and high among children living in urban areas.

Although the consumption rate for vitamin A is high and the rate for iron has increased since the last SIDHS, anaemia and undernutrition are still high. High rates of undernutrition indicate that vitamin A deficiency is high in children. WHO and UNICEF have made recommendation for routine vitamin A supplementation for all children in areas with high numbers of children who are undernourished, and where the death rate from measles and where vitamin A deficiency is a problem. Solomon Islands is currently implementing routine vitamin A supplementation in children aged 6 months to 5 years.

Vitamin A supplements protect against complication of other life threatening infections such as malaria. Supplementing children with a large dose of vitamin A reduces the risk of dying from these infections.

Results from the SIDHS 2015 show that 37% of children receive vitamin A supplements, which indicates a massive increase of about 30% points when compared with only 7% during the SIDHS 2006–2007. Iron supplement intake was 11%, an increase of 7% points (from 4%) from the SIDHS 2006–2007. This indicates that the intake of vitamin A and iron supplements is improving. Figure 11.8 shows that supplements of vitamin A, iron, and de-worming tablets is high in Honiara and other provinces, followed by Malaita and Guadalcanal provinces.

Overall, 35% of children aged 6–59 months received deworming medication in the last 6 months preceding the survey while the majority of these children in the same age (98%) lived in households with iodised salt.

Figure 11.7: Among children aged 6 months to <5 years who consumed vitamin A-rich and iron-rich foods in the 24 hours before the survey by region, Solomon Islands 2015

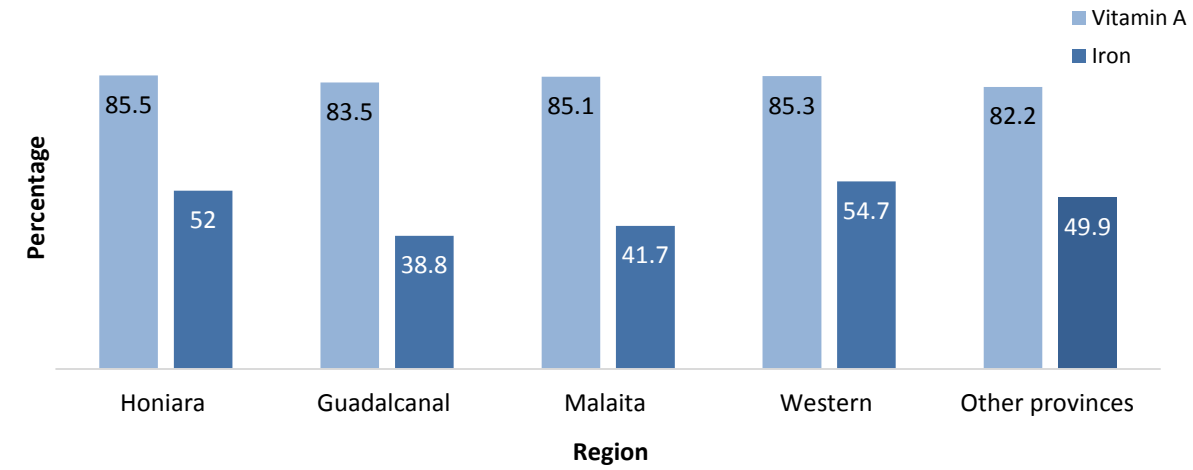


Figure 11.8: Among children aged 6 months to <5 years given vitamin A supplement, iron supplement and deworming tablets by region, Solomon Islands 2015

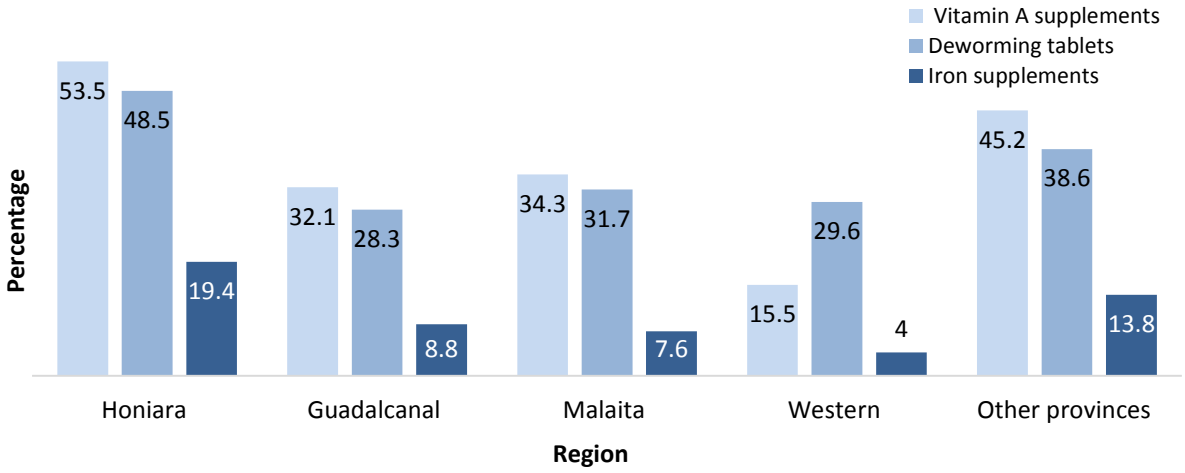


Table 11.7: Micronutrient intake among children

Among youngest children aged 6–23 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 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 prior the survey, and who were given deworming 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 iodised salt, by background characteristics, Solomon Islands 2015

Background characteristic	Among youngest children aged 6–23 months living with the mother:			Among all children aged 6–59 months:				Among children aged 6–59 months living in households tested for iodized salt	
	Percentage who consumed foods rich in vitamin A in last 24 hours prior the survey[1]	Percentage who consumed foods rich in iron in last 24 hours prior the survey[2]	Number of children	Percentage given vitamin A supplements in last 6 months	Percentage given iron supplements in the 7 days prior the survey	Percentage given deworming medication in last 6 months[3]	Number of children	Percentage living in households with iodised salt[4]	Number of children
Age in months									
6–8	58.8	22.9	225	36.2	8	9.1	230	98.4	212
9–11	83.8	43.8	219	41.6	13.7	16.8	224	97.6	187
12–17	90.3	51.7	413	44	12.7	28.4	436	98.9	394
18–23	93.8	58.1	319	37.9	8.3	37.3	390	97.9	336
24–35	na	na	na	38.1	10.5	40	786	99	688
36–47	na	na	na	36.3	10.1	39.6	856	98.3	763
48–59	na	na	na	28.6	10.4	38.7	720	98.1	634
Sex									
Male	86.1	48.3	598	37.9	10.1	36.4	1,880	98.6	1,645
Female	81.9	44.5	578	35.2	10.9	32.7	1,762	98.2	1,568
Breastfeeding status									
Breastfeeding	81.8	43.7	943	42.7	10.6	27.1	1,173	98.7	1,021
Not breastfeeding	93	57.8	233	34.2	10.4	39	2,316	98.4	2,054
Missing	0	0	0	25.8	9.4	25.5	153	95.6	139
Mother's age at birth									
15–19	76.6	42.4	58	31.2	7.2	31	90	99.2	81
20–29	84.6	45.4	660	38.2	11	34	1,846	99.1	1,598
30–39	83.5	48.2	405	34.1	9.7	34.9	1,420	97.5	1,269
40–49	89.8	50.8	52	40.6	11.2	38	286	98.2	265
Residence									
Urban	87.1	55.9	199	49.3	16.3	44.1	644	96.9	616
Rural	83.4	44.5	977	33.9	9.2	32.6	2,998	98.8	2,598
Region									
Honiara	85.5	52	125	53.5	19.4	48.5	408	95.4	398
Guadalcanal	83.5	38.8	227	32.1	8.8	28.3	714	99.9	658
Malaita	85.1	41.7	320	34.3	7.6	31.7	990	99.7	883
Western	85.3	54.7	170	15.5	4	29.6	492	99.6	438
Other provinces	82.2	49.9	333	45.2	13.8	38.6	1,038	96.7	837
Mother's education									
No education	79.2	37.6	106	25.7	9.5	22.3	358	100	294
Primary	84.7	45.4	509	35.5	10	35.7	1,753	98.6	1,505
Secondary	85.4	48.8	498	40.7	11.3	36	1,355	98.3	1,241
More than secondary	75.7	51.4	63	38.3	10.6	37.6	176	94.9	173
Wealth quintile									
Lowest	80.2	37.2	287	30.4	8	26.2	862	99.6	673

Second	83.9	50.5	254	35.5	8.2	34.9	756	99.5	654
Middle	82.5	46.7	218	37.7	9.8	35.5	737	96.7	662
Fourth	86.9	48.3	221	37.3	12.3	38.8	680	99.3	636
Highest	88.2	52.3	196	44.7	15.5	40.4	607	96.8	588
Total	**84**	**46.4**	**1,176**	**36.6**	**10.5**	**34.6**	**3,642**	**98.4**	**3,213**

Note: Information on vitamin A is based on both mother's recall and the immunization card (where available). Information on iron supplements and deworming medication is based on the mother's recall.

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), fish, poultry and eggs.

[3] Deworming for intestinal parasites is commonly done for helminthes and for schistosomiasis.

[4] Excludes children in households in which salt was not tested.

11.5 NUTRITIONAL STATUS OF ADULTS

The nutritional status of adults is an important indicator for health and wellbeing. Nutritional status is determined by calculating the body mass index (BMI), or weight in kg/height in m². BMI is classified as follows: ≤18.5 kg/m^2 = underweight, 18.5–24.9 kg/m^2 = normal, ≥25–29.9 kg/m^2 = overweight and ≥30 kg/m^2 = obese. Reaching and maintaining a healthy weight are important for overall health and control of some diseases, including non-communicable diseases (NCDs). Eating a healthy diet, being physically active, not abusing alcohol, and not using tobacco are key behaviours for staying healthy. A high BMI can lead to NCDs such diabetes, high blood pressure, heart disease and some forms of cancers. A low BMI is strongly associated with low bone mineral density, a mineral used for critical functions throughout the body. It is also strongly associated with decreased immune functions.

11.5.1 Nutritional status of women

Table 11.8.1 shows the nutritional status of women according to their BMI and by their background characteristics. The mean BMI for women aged 15–49 is 25.7 kg/m^2 compared with 25 reported in the SIDHS 2006–2007. While 50% of women are within the normal weight limit, 3% are classified as being of short stature (<145 cm) and 2% as underweight. Short stature was mainly observed in the 15–19 age group (4%) and those living in least wealthy households. A higher proportion (3%) of short-statured women resides in rural areas, mostly in Malaita Province.

The prevalence of low BMI (<18.5 kg/m²) was 2%. Younger women aged 15–19 (4%) tend to have very low BMIs than other women. A higher proportion of women with a BMI <18.5 are from rural areas, live in the least wealthy households, and are mostly from Guadalcanal and other provinces.

The overall prevalence of high BMI (≥25 kg/m$^{2)}$ among women is 47%, of which, 30% are overweight and 18% are obese. High BMI is observed among older women aged 30–49 from urban areas, particularly in Honiara and Malaita.

BMI tends to increase with age, education level and household wealth. Increasing BMI with age can possibly be explained by a combination of biological and sociocultural roles, where these females are in their reproductive years. Urban women with a higher level of education are more likely to have access to food. The types of foods consumed were not compiled in this survey.

Table 11.8.1: Nutritional status of women

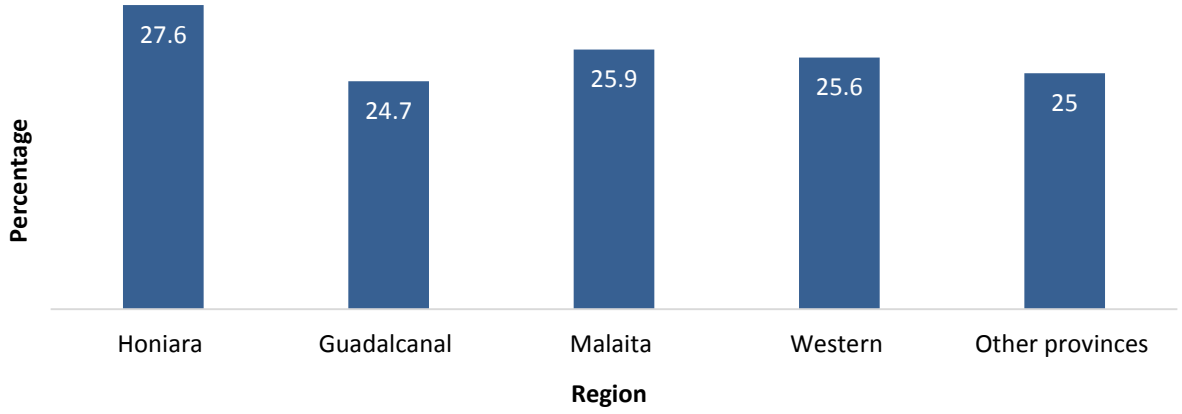
Among women aged 15–49, the percentage with height under 145 cm, mean body mass index (BMI), and the percentage with specific BMI levels, by background characteristics, Solomon Islands 2015

Background characteristic	Height		BMI[1]								
	Percentage below 145 cm	Number of women	Mean BMI	18.5–24.9 (Total normal)	<18.5 (Total thin)	17.0–18.4 (Mildly thin)	<17 (Moderately and severely thin)	>=25.0 (Total over-weight or obese)	25.0–29.9 (Over-weight)	>=30.0 (Obese)	Number of women
Age											
15–19	3.9	1,177	23.4	69.7	4	3	1	26.3	22.6	3.7	1,113
20–29	2.8	2,135	25.1	54.4	2	1.6	0.4	43.7	29.8	13.9	1,871
30–39	2.5	1,678	26.7	42.9	1.7	1.1	0.6	55.4	31.4	24	1,525
40–49	2	1,005	27.7	32.3	1.7	1.6	0.1	66	34.1	31.9	988
Residence											
Urban	1.5	1,333	27.3	38	1.5	1	0.4	60.5	31.6	28.9	1,238
Rural	3.2	4,663	25.2	53.9	2.5	1.9	0.5	43.6	28.9	14.7	4,258
Region											
Honiara	0.8	869	27.6	35.8	1.4	0.9	0.5	62.8	31.7	31.1	805
Guadalcanal	3.1	1,070	24.7	59.2	3	2.3	0.8	37.8	25.1	12.7	989
Malaita	4.4	1,577	25.9	48.7	0.7	0.6	0.1	50.6	33.5	17.1	1,456
Western	2.3	851	25.6	50.5	2.5	1.9	0.5	47.1	29.7	17.4	760
Other provinces	2.3	1,630	25	53.9	3.5	2.9	0.7	42.5	27.4	15.2	1,486
Education											
No education	3.8	552	25.3	51.3	2.5	1.5	0.9	46.2	29.1	17.1	505
Primary	3.3	2,724	25.9	48.6	2.2	1.8	0.4	49.2	29.5	19.8	2,516
Secondary	2.2	2,352	25.2	54.2	2.4	1.8	0.6	43.4	29.3	14.1	2,134
More than secondary	0.7	369	27.2	38.1	1.1	1.1	0	60.8	32.1	28.7	341
Wealth quintile											
Lowest	4.4	1,117	24	63.3	3.8	2.9	0.9	32.9	24.3	8.6	996
Second	1.7	1,141	24.9	55.9	2.2	1.9	0.4	41.8	28.8	13	1,042
Middle	3.5	1,187	25.6	50.2	2.3	2.1	0.2	47.5	30.1	17.4	1,106
Fourth	3.4	1,195	26.3	46.5	1.2	0.7	0.5	52.3	30.8	21.6	1,097
Highest	1.3	1,356	27.1	39	1.9	1.3	0.6	59.1	32.7	26.4	1,256
Total	**2.8**	**5,996**	**25.7**	**50.4**	**2.2**	**1.7**	**0.5**	**47.4**	**29.5**	**17.9**	**5,496**

Note: The body mass index (BMI) is expressed as the ratio of weight in kilograms to the square of height in meters (kg/m^2).

[1] Excludes pregnant women and women with a birth in the 2 months preceding the survey.

Figure 11.9: Regional differences in mean body mass index (BMI) among women aged 15–49, Solomon Islands 2015



11.5.2 Nutritional status of men

Table 11.8.2 shows the nutritional status of men aged 15–49 by background characteristics. The mean BMI for men is 24.6 kg/m^2, a slight increase of 0.2% point since the SIDHS 2006–2007. According to the SIDHS 2015, 63% of men are classified as having a normal BMI, 26% are overweight, 9% are obese and 3% of men are moderately to severely underweight (2.2% are mildly thin and 0.3% are moderately to severely thin).

Table 11.8.2: Nutritional status of men

Among men aged 15–49, mean body mass index (BMI), and the percentage with specific BMI levels, by background characteristics, Solomon Islands 2015

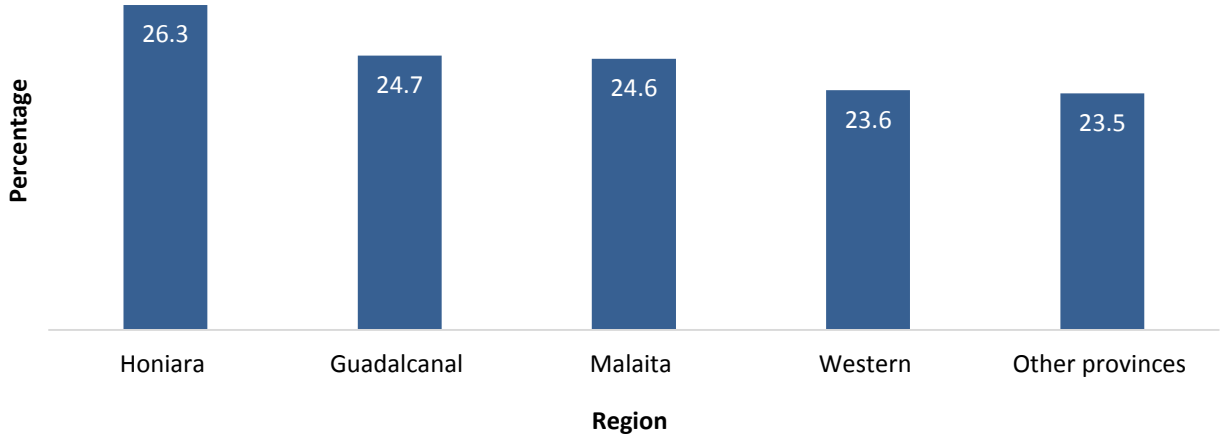
Background characteristic	BMI								
	Mean BMI	18.5–24.9 (Total normal)	<18.5 (Total thin)	17.0–18.4 (Mildly thin)	<17 (Moderately and severely thin)	>=25.0 (Total over-weight or obese)	25.0–29.9 (Over-weight)	>=30.0 (Obese)	Number of men
Age									
15–19	22.2	81	8.7	7.9	0.8	10.3	8.4	2	542
20–29	23.9	70.2	1.3	1.3	0	28.5	23.9	4.6	893
30–39	25.4	53.5	0.7	0.4	0.3	45.8	33.7	12.1	764
40–49	26.4	45.1	0.6	0.4	0.1	54.3	34.9	19.5	471
Residence									
Urban	25.9	48.8	1.6	1.4	0.2	49.6	31.9	17.7	619
Rural	24	67.5	2.8	2.5	0.3	29.7	23.6	6.1	2,051
Region									
Honiara	26.3	45.2	1.1	1	0.1	53.6	34.1	19.5	411
Guadalcanal	24.7	65.6	2.6	2.3	0.3	31.8	23.2	8.6	490
Malaita	24.6	61.4	1	1	0	37.6	31.2	6.4	681
Western	23.6	68.8	4.3	3.5	0.8	26.9	20.9	6	396
Other provinces	23.5	70.7	3.6	3.4	0.3	25.6	19	6.6	692
Education									
No education	24.4	60	5	4.4	0.6	35	27.3	7.7	77
Primary	24.2	64.3	3.3	2.9	0.4	32.4	25	7.5	1,087
Secondary	24.2	67.5	2.1	1.9	0.2	30.4	22.8	7.6	1,232
More than secondary	26.6	40.4	0.4	0.4	0	59.2	39.5	19.7	274
Wealth quintile									
Lowest	23.1	78.8	3.5	3.2	0.3	17.8	15	2.8	486
Second	24.2	67.3	2	1.8	0.3	30.7	24.1	6.5	529
Middle	24.2	62	2.8	2.8	0	35.3	27.6	7.6	491
Fourth	24.7	59.8	3.3	2.7	0.5	36.9	28.2	8.7	544
Highest	25.7	51.4	1.2	0.9	0.3	47.3	30.8	16.5	620
Total 15–49	**24.4**	**63.2**	**2.5**	**2.2**	**0.3**	**34.3**	**25.5**	**8.8**	**2,670**
50+	25.3	53.3	2.6	1.4	1.2	44.2	30.4	13.8	591
Total 15+	**24.6**	**61.4**	**2.5**	**2.1**	**0.4**	**36.1**	**26.4**	**9.7**	**3,262**

Note: The body mass index (BMI) is expressed as the ratio of weight in kilograms to the square of height in meters (kg/m^2).

A higher percentage of men (81%) with a normal BMI is observed among younger men aged 15–19. The majority of these men reside in rural areas, mainly from Other Province and Western. The prevalence of low BMI is 3%. A higher percentage of low BMI (<17 kg/m^2) is also found among the 15–19 age group, and among those men who live in rural areas, generally from Western Province.

The overall prevalence of high BMI among men (>=25 kg/m²) is 36%, with 26% of these men classified as being overweight and nearly 10% as obese. High BMI among men occurs mainly in the 40–49 age group, and among men living in urban areas, particularly Honiara. This can be explained by the fact that men in this age group begin to decrease their physically activity while their waist circumference increases.

Figure 11.10: Regional differences in mean body mass index (BMI) among men aged 15–49, Solomon Islands 2015



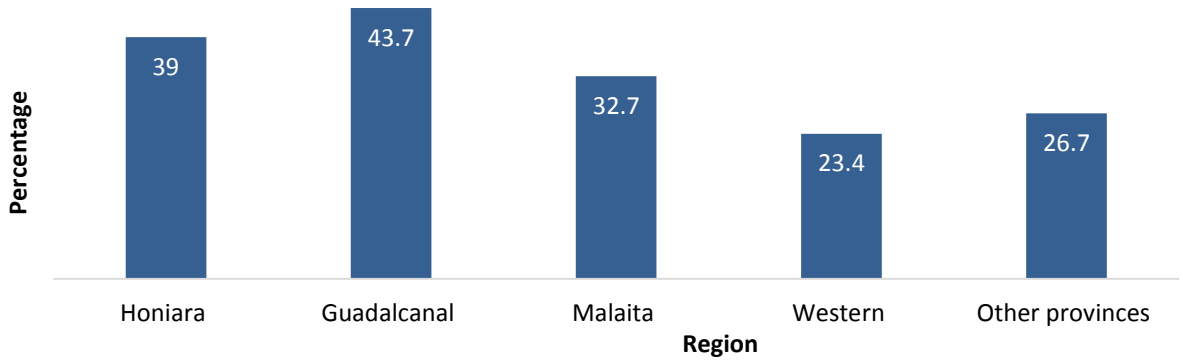
11.6 MICRONUTRIENT INTAKE AMONG MOTHERS

Vitamin A plays a number of key functions in the body, including promoting good vision, maintaining epithelia tissues, and supporting reproduction in women. An inadequate intake of vitamin A increases a person's susceptibility to infections. It is a requirement for postpartum mothers to take vitamin A for protection against infections and blindness.

Iron is important for red blood cell production, oxygen transport throughout the body, and immune system support. Women require more iron than men because they have menstrual cycles where they lose blood. During pregnancy, women need more iron to support the increase of red blood cell production to meet placental and foetal needs and particularly during childbirth when blood is lost. An inadequate intake of iron from food sources and low absorption may lead to iron deficiency such as anaemia.

Table 11.9 and Figure 11.11 show the percentage of women who receive vitamin A supplements during the postpartum period. About 33% of women receive vitamin A supplements after childbirth, an increase of from 16% reported in the SIDHS 2006–2007. Higher percentages of these are women from Guadalcanal Province (44%), women with higher educational backgrounds, and those living in wealthy households.

Figure 11.11: Percentage of women aged 15–49 who receive vitamin A supplementation during the period of postpartum, by region, Solomon Islands 2015



Iron tablets are provided routinely for all pregnant women although a higher percentage of women are unable to remember whether they had taken their iron tablet. Results of the SIDHS 2015 show that 31% of women took iron tablets for less than 60 days during the pregnancy of their most recent birth and 25% took iron tablets for more than 90 days, particularly women in Western Province. In the SIDHS 2006–2007, 26% of women took iron tablets for less than 60 days, while only 19% took iron tablets for more than 90 days. Another 7% of women did not take iron tablets during pregnancy of last birth as opposed to 11% reported in SIDHS 2015. Iron and vitamin A intake from foods was not compiled for this survey. Over 98% of women live in households where iodised salt is used and another 49% took deworming medication during pregnancy of last birth.

Figure 11.12: Percentage of pregnant women taking iron supplements by region, Solomon Islands 2015

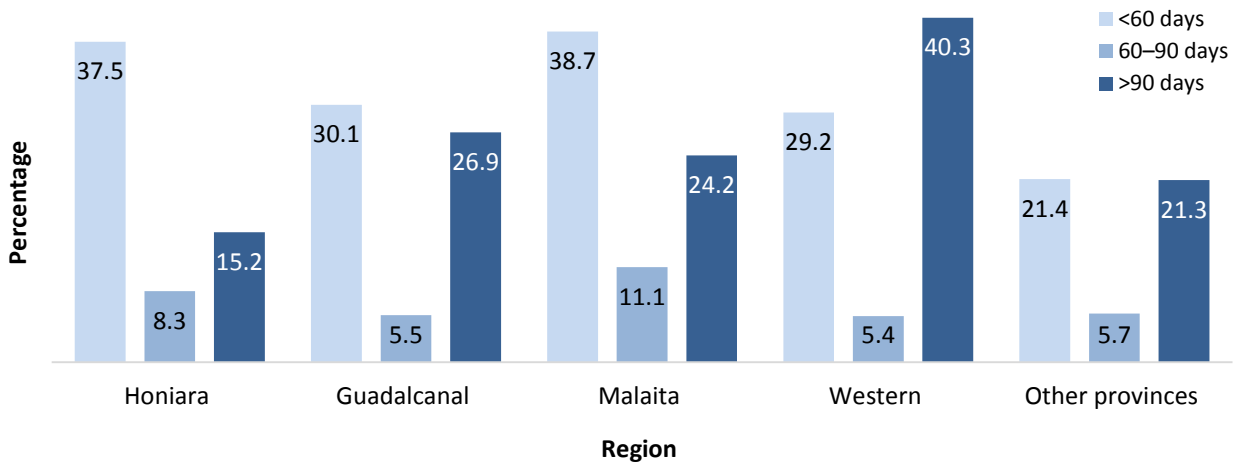


Table 11.9: Micronutrient intake among mothers

Among women aged 15–49 with a child born in the past five years, the percentage who received a vitamin A dose in the first two months after the birth of the last child, the percent distribution by number of days they took iron tablets or syrup during the pregnancy of the last child, and the percentage who took deworming medication during the pregnancy of the last child; and among women aged 15–49 with a child born in the past five years and who live in households that were tested for iodised salt, the percentage who live in households with iodised salt, by background characteristics, Solomon Islands 2015

Background characteristic		Number of days women took iron tablets or syrup during pregnancy of last birth								Among women with a child born in the last five years, who live in households that were tested for iodised salt	
	Percentage who received vitamin A dose postpartum[1]	None	<60	60–89	90+	Don't know/ missing	Total	Percentage of women who took deworming medication during pregnancy of last birth	Number of women	Percentage living in households with iodised salt[2]	Number of women
Age											
15–19	30	10.7	30.6	6.2	33.8	18.7	100	38.8	113	99.4	102
20–29	33.1	11.1	32.5	6.6	23.5	26.4	100	47.2	1,379	99	1,194
30–39	31.6	11.4	29.1	7.8	26.2	25.5	100	51.9	1,072	97.6	959
40–49	34.3	12.2	25.7	10	25.8	26.4	100	52.6	243	97.9	224
Residence											
Urban	39.5	7	32.1	6.9	17.8	36.2	100	56.2	530	97.3	504
Rural	30.9	12.3	30.2	7.4	26.8	23.3	100	47.5	2,276	98.7	1,974
Region											
Honiara	39	5.2	37.5	8.3	15.2	33.7	100	55.7	336	96	326
Guadalcanal	43.7	17.7	30.1	5.5	26.9	19.7	100	57.2	543	99.9	500
Malaita	32.7	14.5	38.7	11.1	24.2	11.5	100	30.3	713	99.5	635
Western	23.4	3.5	29.2	5.4	40.3	21.5	100	60.3	405	99.8	364
Other provinces	26.7	10.5	21.4	5.7	21.3	41.1	100	51.9	810	96.5	653
Education											
No education	27.9	21.8	29.2	8	16.4	24.6	100	33.9	261	100	213
Primary	31.9	11	31.1	6.7	25.3	25.9	100	49.4	1,309	98.5	1,134
Secondary	34.1	9.4	30.3	8	27.8	24.5	100	51.1	1,084	98.2	986
More than secondary	34	9	30	6.2	19.7	35.1	100	59.6	152	96.2	146
Wealth quintile											
Lowest	29.3	17.9	31.7	5.6	19.8	25	100	44	616	99.4	483
Second	32	11.3	29	7	27.2	25.6	100	47.9	575	99.1	489
Middle	32.4	10.8	29.6	8.1	28.8	22.8	100	45.3	563	96.7	508
Fourth	33.9	8.1	32.3	7.6	28.4	23.5	100	51.2	556	99.4	523
Highest	35.7	7.2	30	8.5	21.6	32.7	100	58.9	496	97.3	476
Total	**32.5**	**11.3**	**30.5**	**7.3**	**25.1**	**25.7**	**100**	**49.1**	**2,807**	**98.4**	**2,478**

[1] In the first two months after delivery of last birth.

[2] Excludes women in households where salt was not tested.

11.7 ANAEMIA

Iron deficiency such as anaemia is a global problem and affects mostly children as well as women of reproductive age. It occurs because of a lack of mineral iron in the body; a pre-requisite for producing haemoglobin, part of the red blood cell that transports oxygen to body organs. This type of anaemia is prevalent in the developing world and is a result of an iron-poor diet.

Iron deficiency 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 can lead to early onset 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 alone, and if iron supplements are not provided, these babies will also have an increased risk of early onset anaemia.

11.7.1 Prevalence of anaemia in children by background characteristics

Table 11.10 presents the prevalence of anaemia in children aged 6–59 months by background characteristics. Overall, 39% of children aged 6–59 months are considered to be anaemic compared with 49% reported in the SIDHS 2006–2007, a decrease of 10% points. In the SIDHS 2006–2007, 29% of children had mild iron deficiency compared with 24% in SIDHS 2015. Furthermore, 14% of children have moderate anaemia compared with 19% as reported in the SIDHS 2006–2007. The prevalence of severe anaemia remains static at 0.5% in both the SIDHS 2006–2007 and SIDHS 2015.

The highest prevalence for any anaemia is in children aged 12–17 months, with 63% in SIDHS 2015 compared with 78% as reported in the SIDHS 2006–2007. Currently, the prevalence of anaemia is slightly higher among boys than girls, which is in contrast to the SIDHS 2006–2007 where prevalence was higher in girls. The prevalence of anaemia decreases with increasing household wealth.

Figure 11.13 presents differences in the prevalence of anaemia by region. In general, the prevalence of any anaemia is high throughout the Solomon Islands but is particularly high in Western Province, Honiara, and other provinces.

Figure 11.13: Prevalence of anaemia among children aged 6–59 months by haemoglobin level and by region, Solomon Islands 2015

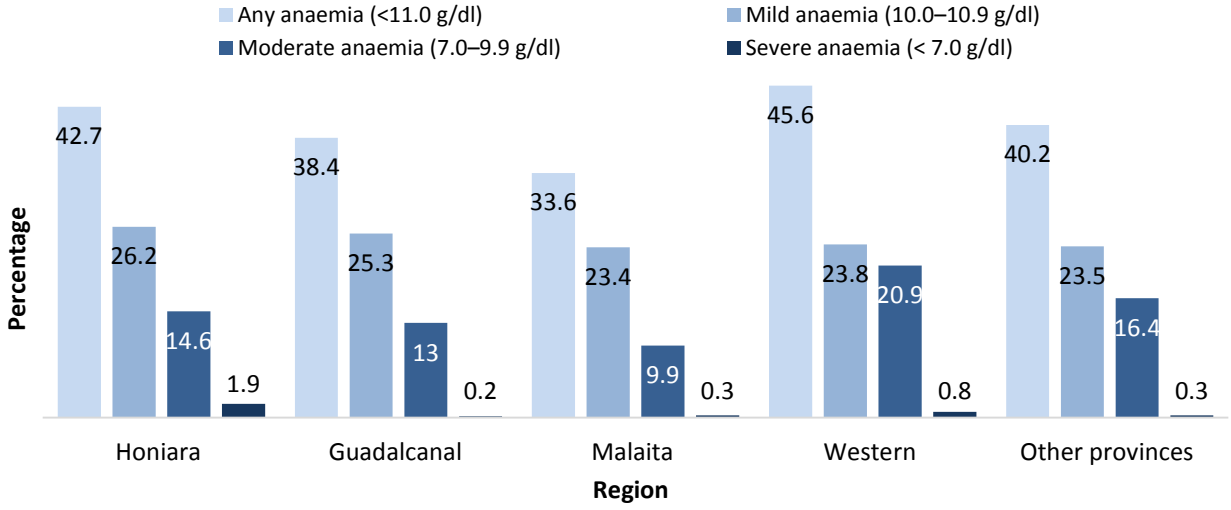


Table 11.10: Prevalence of anaemia in children

Percentage of children aged 6–59 months classified as having anaemia, by background characteristics, Solomon Islands 2015

Background characteristic	Anaemia status by hemoglobin level				
	Any anaemia (<11.0 g/dl)	Mild anaemia (10.0–10.9 g/dl)	Moderate anaemia (7.0–9.9 g/dl)	Severe anaemia (< 7.0 g/dl)	Number of children
Age in months					
6–8	60.7	35.7	23.5	1.6	192
9–11	59.5	28.4	28.4	2.6	194
12–17	62.7	33.1	28.5	1.1	414
18–23	48	29	18.9	0.1	359
24–35	35.2	21.6	13.3	0.4	768
36–47	29.2	20.9	8.3	0.1	814
48–59	24	18.2	5.7	0.1	690
Sex					
Male	40.1	23.4	15.9	0.7	1,730
Female	37.9	24.7	12.9	0.3	1,701
Mother's interview status					
Interviewed	39.3	24.2	14.6	0.5	2,968
Not interviewed but in household	45.1	26	17.9	1.2	88
Not interviewed and not in the household[1]	35.4	22.8	12.4	0.2	376
Residence					
Urban	41.1	25.3	14.5	1.3	531
Rural	38.6	23.9	14.4	0.4	2,901
Region					
Honiara	42.7	26.2	14.6	1.9	343
Guadalcanal	38.4	25.3	13	0.2	601
Malaita	33.6	23.4	9.9	0.3	981
Western	45.6	23.8	20.9	0.8	491
Other provinces	40.2	23.5	16.4	0.3	1,014
Mother's education[2]					
No education	39.5	26.3	13.2	0	310
Primary	37.5	22.7	14.3	0.5	1,503
Secondary	41.8	25.5	15.6	0.7	1,102
More than secondary	40.4	25.7	13.6	1.1	138
Missing	100	55.7	44.3	0	2
Wealth quintile					
Lowest	40.3	25.9	14.4	0	818
Second	42	25.7	15.8	0.4	740
Middle	35.2	22.4	12.5	0.4	716
Fourth	39.5	22.2	16.7	0.6	636
Highest	37.3	23.5	12.3	1.5	522
Total	**39**	**24.1**	**14.4**	**0.5**	**3,431**

Note: Table is based on children who stayed in the household on the night before the interview and who were tested for anemia. Prevalence of anemia, based on haemoglobin levels, is adjusted for altitude using formulas in CDC, 1998. Haemoglobin in grams per deciliter (g/dl).

[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

Iron deficiency is the most common and widespread nutritional disorder worldwide. It affects a large number of women in reproductive age, particularly pregnant women. Iron deficiency may be due to inadequate absorption of dietary iron, and frequently manifests as an impairment of increased risk of maternal mortality, low birth weight, preterm and low birth weight, and subsequent risk of anaemia in the infant and other infectious diseases. Iron deficiency can lead to a decrease in haemoglobin production causing iron deficiency anaemia.

Anaemia is more common in developing countries, affecting large numbers of women of reproductive age particularly, pregnant and lactating mothers. These stages of life demand more iron, and providing less makes women more susceptible to iron deficiency. Women need more iron due to repeated blood loss during menstruation.

Pregnancy demands extra iron to support the added blood volume, growth of foetus, and blood loss during childbirth. Severe anaemia has been shown to increase the risk of maternal mortality, low birth weight, preterm childbirth, and subsequent risk of anaemia (to the child) during infancy. Developing babies depend on their mother's iron stores; therefore, anaemic mothers are more likely to have anaemic babies.

Table 11.11 presents the prevalence of anaemia in women aged 15–49 by background characteristics. The overall prevalence of any anaemia is 41% among women aged 15–49 years. This is a decrease of 3% points from that reported in the SIDHS 2006–2007 (44%). In terms of severity, 33% of women are classified as having mild anaemia, 7% has having moderate anaemia, and 1% as having severe anaemia.

Anaemia in pregnant women has decreased from 60% as reported in the SIDHS 2006–2007 to 54% in the SIDHS 2015. This may indicate that women are becoming more compliant with taking iron supplements during pregnancy.

The highest proportion of anaemia occurs among women with little education, those living in rural areas, those living in the least wealthy households, and those from Guadalcanal Province. Women with children are more likely to be anaemic.

Figure 11.14: Prevalence of anaemia among women aged 15–49 by region, Solomon Islands 2015

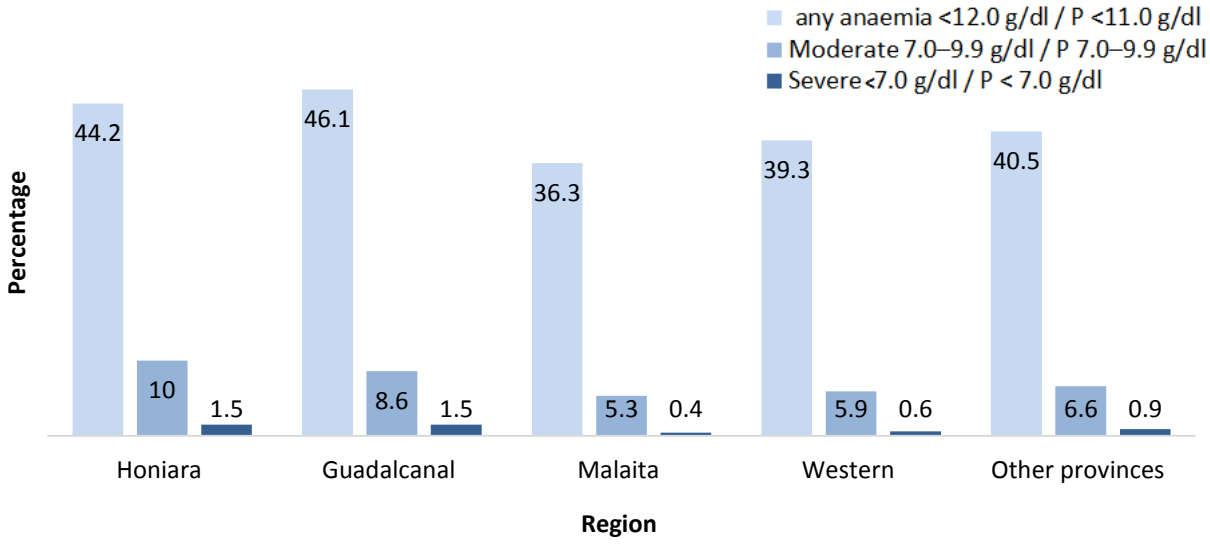


Table 11.11: Prevalence of anaemia in women

Percentage of women aged 15–49 with anaemia, by background characteristics, Solomon Islands 2015

Background characteristic	Anaemia status by hemoglobin level				
	Any (NP <12.0 g/dl / P <11.0 g/dl)	Mild (NP 10.0–11.9 g/dl / P 10.0–10.9 g/dl)	Moderate (NP 7.0–9.9 g/dl / P 7.0–9.9 g/dl)	Severe (NP < 7.0 g/dl / P < 7.0 g/dl)	Number of women
Age					
15–19	36.2	30	5.6	0.6	1,151
20–29	43	33.7	8.3	1	2,128
30–39	40.9	32.9	7.1	0.9	1,667
40–49	41.1	34	6	1.1	1,007
Number of children ever born					
0	35	29.1	5.2	0.7	1,911
1	45.7	35.5	9.4	0.8	821
2–3	42.2	33.9	7.6	0.8	1,487
4–5	43.6	35.2	7	1.4	1,073
6+	43.1	33.9	8.1	1.1	661
Maternity status					
Pregnant	54.1	27.7	23.8	2.6	384
Breastfeeding	49.3	40.2	8.3	0.8	1,439
Neither	36.5	30.7	5	0.8	4,130
Using IUD					
Yes	39.7	29.8	7.8	2	84
No	40.8	32.8	7	0.9	5,870
Smoking status					
Smokes cigarettes/ tobacco	45.7	34.9	9.2	1.6	1,184
Does not smoke	39.5	32.3	6.5	0.7	4,766
Missing	66	66	0	0	3
Residence					
Urban	41.5	31	9.1	1.3	1,321
Rural	40.5	33.3	6.4	0.8	4,633
Region					
Honiara	44.2	32.7	10	1.5	868
Guadalcanal	46.1	36	8.6	1.5	1,054
Malaita	36.3	30.6	5.3	0.4	1,566
Western	39.3	32.8	5.9	0.6	843
Other provinces	40.5	32.9	6.6	0.9	1,622
Education					
No education	44.5	36.4	6.5	1.5	551
Primary	40.4	32.8	6.8	0.8	2,701
Secondary	40.8	32.4	7.4	0.9	2,334
More than secondary	37.3	29.9	6.9	0.5	366
Wealth quintile					
Lowest	45.3	36.7	7.8	0.7	1,096
Second	41.1	33.1	6.9	1.1	1,142
Middle	37.5	30.2	6.5	0.7	1,191
Fourth	41.1	34	6.3	0.8	1,189
Highest	39.4	30.6	7.6	1.2	1,335
Total	**40.7**	**32.8**	**7**	**0.9**	**5,953**

Note: Prevalence is adjusted for altitude and for smoking status if known using formulas in CDC, 1998.
IUD = intrauterine device

11.8 PRESENCE OF IODISED SALT IN HOUSEHOLDS

The SIDHS 2015 included testing for iodine in household salts. Adding iodine to salt is a global strategy to eradicate iodine deficiency. Iodine is a trace element that is important for making thyroid hormones. These hormones control the body's metabolism and many other functions. In pregnancy, iodine is important for proper foetal bone and brain development. Children also require enough iodine for proper growth and development.

Seafood are rich sources of iodine. Iodine is also present in root vegetables grown in non-mountainous areas where iodine exists naturally in the soil. Nowadays, most of the top soil has leached out due to deforestation and flooding. As a result, people are not able to obtain enough iodine from their diet and this can result in iodine deficiency.

A lack of iodine in the diet can cause goitres in adults and can delay growth and development in children. Severe iodine deficiency in pregnant and lactating mothers can lead to brain damage in foetuses and infants. Although there is no available data on iodine deficiency in Solomon Islands, a few goitre cases have been observed.

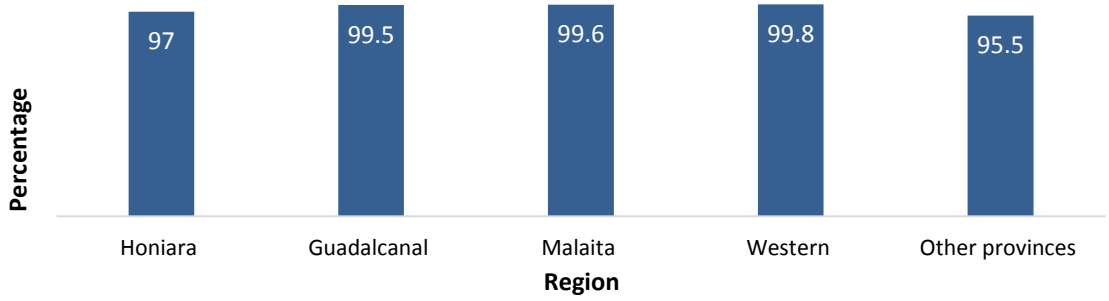
Table 11.12 and Figure 11.15 show that iodised salt is widely available and used by most households in Solomon Islands. Out of almost 88% of households with salt tested at the time of SIDHS 2015, 98% use iodised salt, with minimal variation by residence, region and wealth quantile.

Table 11.12: Presence of iodised salt in household

Among all households, the percentage with salt tested for iodine content and the percentage with no salt in the household; and among households with salt tested, the percentage with iodised salt, according to background characteristics, Solomon Islands 2015

Background characteristic	Among all households, the percentage			Among households with tested salt:	
	With salt tested	With no salt in the household	Number of households	Percentage with iodised salt	Number of households
Residence					
Urban	93.4	6.6	850	97.6	793
Rural	86.7	13.3	4,192	98.4	3,634
Region					
Honiara	96.5	3.5	496	97	479
Guadalcanal	89.9	10.1	948	99.5	852
Malaita	89.1	10.9	1,349	99.6	1,202
Western	89.7	10.3	760	99.8	682
Other provinces	81.5	18.5	1,488	95.5	1,213
Wealth quintile					
Lowest	78.3	21.7	1,026	98.9	804
Second	87	13	1,010	99	878
Middle	89.2	10.8	1,029	97.7	918
Fourth	91.1	8.9	1,055	98.4	961
Highest	94	6	922	97.2	866
Total	**87.8**	**12.2**	**5,042**	**98.2**	**4,428**

Figure 11.15: Percentage of households using iodised salt by region, Solomon Islands 2015



CHAPTER 12 MALARIA

by Dr Hugo Bugoro, Technical Advisor for National Vector Borne Disease Control Program, SIMoHMS

KEY FINDINGS

- 87% of households have at least one mosquito net of any kind, and 86% have at least one insecticide-treated net (ITN) and one long-lasting insecticidal net (LLIN).
- 56% of households have at least one LLIN for every two people who stayed in the household the night before the SIDHS 2015.
- 28% of households have received indoor residual spraying (IRS) against mosquitoes in the 12 months prior to the SIDHS 2015.
- 66% of households have at least one ITN for every two people and/or have received IRS in the 12 months prior to the SIDHS 2015.
- 71% of the household population had access to an ITN on the night prior to the SIDHS 2015, 57% slept under an ITN on the night prior to the survey, and 67% of household members who have access to at least one ITN slept under it.
- 70% of children under age 5 years slept under any kind of mosquito net on the night prior to the SIDHS 2015, and 76% slept under an ITN or in a dwelling sprayed with IRS in the 12 months prior to the survey.
- 80% of children under age 5 years in households with at least one ITN, slept under an ITN on the night prior to the SIDHS 2015. The use of an ITN among younger children is lower in: urban areas, children living in Malaita Province, and among children living in the second and highest wealth quintile households.
- 64% of pregnant women in all households slept under any kind of mosquito net on the night prior to the SIDHS 2015, and 75% of pregnant women in household with at least one ITN slept under an ITN on the night prior to the survey. The use of ITNs among pregnant women is lower: in urban areas, in Honiara, among pregnant women with a high level of education, and among women living in the highest wealth quintile.
- About one in five children under age 5 years had a fever in the weeks preceding the survey, 62% for whom advice and treatment were sought, for which the majority (84%) sought advice and treatment from the public sector.

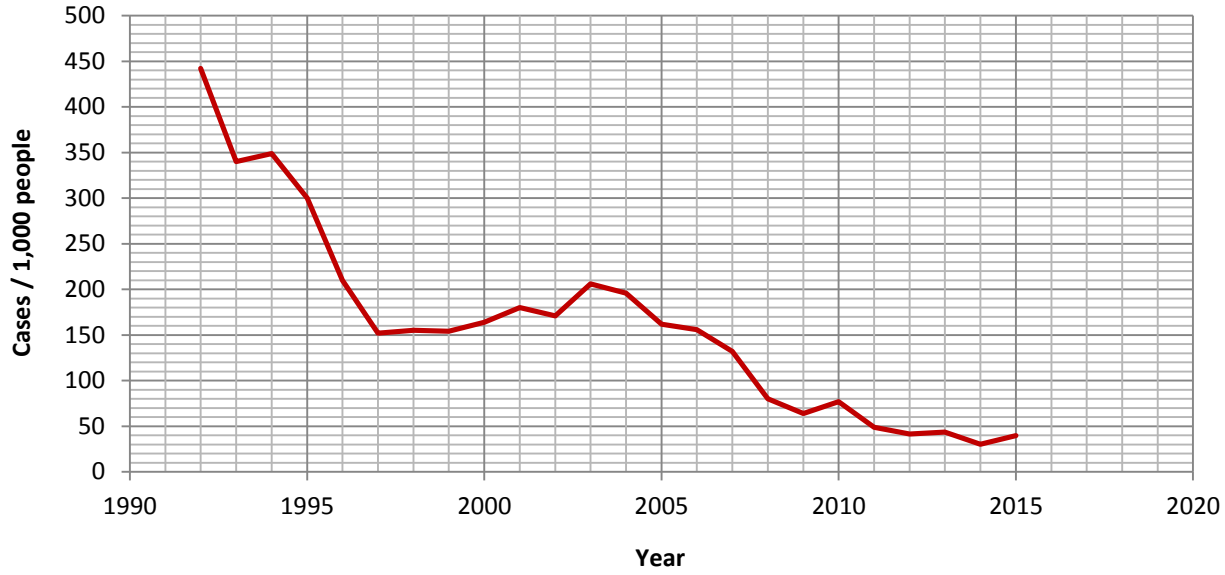
INTRODUCTION

Malaria continues to be a major public health concern in Solomon Islands, especially among pregnant women and children under age 5 years. 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 incidences increase 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 it is 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 years are most at risk. Also at particular risk are pregnant women who are vulnerable because of their reduced natural immunity. Malaria is also considered to be the cause of pregnancy loss, low birth weight, and neonatal mortality.

The burden of malaria, as measured by the number of confirmed cases per 1,000 people, has been significantly reduced in the last 24 years, from 442 cases per 1,000 people in 1992 to a little over 40 cases in 2015 (Fig. 12.1).

Figure 12.1: Annual incidence rate (AIR) of malaria in Solomon Islands since 1992

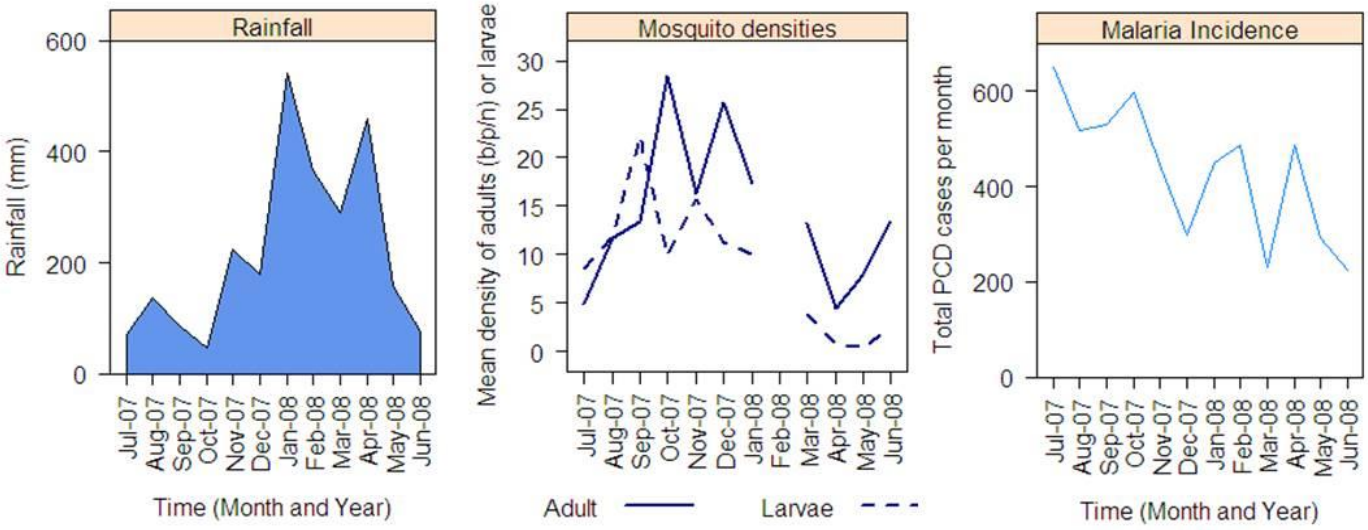


Source: National Vector Borne Disease Control Programme, 2015 annual report

With renewed interest from the government, communities and donor partners, these successes have been realised through the implementation of intensified control and elimination strategies. Among the strategies, is the use of long-lasting insecticidal nets (LLIN). LLINs are essential for the control and elimination of malaria and are supplemented by indoor residual spraying (IRS) in selected areas.

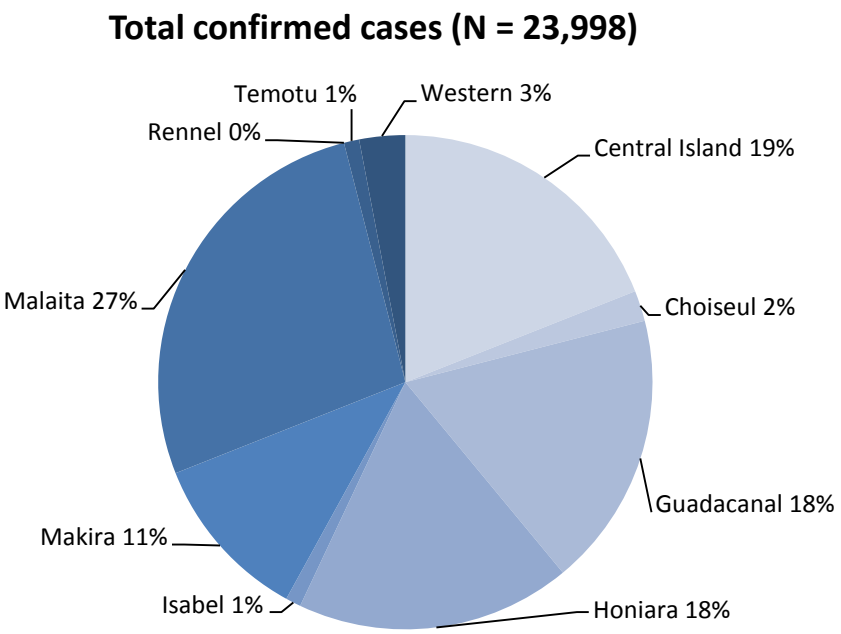
Despite this achievement, malaria is still an important public health issue and will continue to present challenges to individuals and the government's social and economic developmental plans if existing control efforts — including supplies, logistics and an increase in current key activities — are not sustained. It is important to note that in most parts of the country, malaria transmission occurs throughout the year; malaria is also seasonal, hence the differences in the number of malaria cases during the wet and dry seasons (Fig. 12.2). As well, the burden varies between and within provinces (Fig. 12.3).

Figure 12.2: Seasonality of malaria in Solomon Islands



Source: Bugoro et al. 2014. Malaria Journal 13:56.

Figure 12.3: The burden of malaria in the Solomon Islands by province in 2015



Source: 2015 National Vector Borne Disease Control Programme annual report.

Plasmodium knowlesi has recently been added to the current list of malaria parasites, making it the fifth species of parasite to cause human malaria. All malaria parasites are transmitted by infected female *Anopheles* mosquitoes. *Plasmodium falciparum* (*Pf*) is the most common of these parasites, however. The prevalence of *Plasmodium vivax* has slowly replaced *Pf* in Solomon Islands. *Plasmodium vivax* may not be as severe as *Pf* but can be fatal if left untreated. *Pf* causes the most severe form of malaria, which often leads to death if it is not properly managed; such cases, however, are typically limited to vulnerable individuals, in particular, children under the age of five years, pregnant women, people with impaired immunity, or those who have not been exposed to malaria and, therefore, have not developed an adequate immune response. Malaria during pregnancy can result in pregnancy loss, low birth weight, and early neonatal death.

In addition, 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 and outputs from other economic sectors.

The Solomon Islands government, in alliance with regional governments, through its Vector-Borne Disease Control Programme, is committed to intensifying malaria control efforts in order to eliminate malaria by 2030. This will and can be achieved by:

- providing reliable and quality diagnosis and treatment of both *Plasmodium falciparum* and *Plasmodium vivax*, which is accessible for the total population;
- distributing LLINs to every person (universal coverage of LLINs) in Solomon Islands;
- reducing malaria transmission by reducing the survival of malaria vectors entering houses or sleeping units through use of LLINs and supplemented by IRS;
- adopting malaria prevention measures and treatment for pregnant women; and
- allowing for additional preventative measures that target the other life stages of the mosquito through the application of integrated vector management to complement LLINs and IRS.

The cost related to reducing cases of malaria is expected to be high, especially as the government programme is going through the malaria elimination phase in some provinces. Further, the recent detection of a potentially insecticide-resistant form of malaria in Solomon Islands in addition to the current behaviouristic resistance expressed by the vector is a new challenge. The prevalence of *Plasmodium vivax* is high and its control has brought yet another challenge for the current programme Hence, quests to improve the quality of diagnosis with the rapid diagnostic tests, treatment adherence to artemisinin-based combination therapy and primaquine are ongoing.

The SIDHS 2015 collected basic information on malaria that is useful for assessing the implementation of malaria control strategies, including IRS of dwellings with insecticides, the availability and use of mosquito nets, the prophylactic and therapeutic use of antimalarial drugs, and the collection of blood for diagnostic tests for children with fever. The results are summarised in the following sections.

12.1 MOSQUITO NETS

Data collected during the SIDHS 2015 were also used to assess the proportion of households with mosquito nets, treated or untreated (any mosquito nets), those with insecticide-treated nets (ITNs), and those with LLINs. An LLIN is a mosquito net that has been impregnated with insecticide by the manufacturer and which does not require further treatment. An ITN is either an LLIN or a pre-treated mosquito net obtained less than 12 months before the survey, or a mosquito net that has been soaked in an insecticide less than 12 months before the survey.

Table 12.1 shows the percentage of households with at least one type of mosquito net, those with more than one net, and the average number of nets per household. The same information is provided for the possession of ITNs and LLINs.

12.1.1 Bed nets of any kind

Table 12.1 shows that on average, 87% of households own at least one bed net of any kind. The percentage is higher in rural areas than in urban areas. Western, Malaita and Guadalcanal provinces report over 80% of households having at least one bed net, with Western Province at 92%, Malaita Province at 87%, and Guadalcanal Province at 85%. Honiara is the exception, reporting only 62% of households with at least one bed net. The average for other provinces is 92%. The percentage of households with at least one bed net is interestingly lowest among households in the highest wealth quintiles at 75% whereas other wealth quintile households report more than 87% coverage. This may demonstrate a significant knowledge gap in understanding the benefit of using the LLIN to protect household members from potential malaria transmission.

Each household in Solomon Islands has an average of 2.6 bed nets of any kind, with households in rural areas having more bed nets (2.7) than households in urban areas (2.1). Western and Malaita provinces have the most bed nets per household at 3.0 and 2.7, respectively, followed by Guadalcanal with 2.3 and Honiara averaging 1.7 per household. Other provinces have 2.8 nets per household.

12.1.2 ITNs and LLINs

The percentage of households with at least one ITN is 86%, with rural households having more (89%) than urban households (72%). The majority of households in Western and other provinces (about 92% each) had at least one ITN. Households in Honiara have the lowest number of ITNs. The average household has 2.5 ITNs, with 56% of households possessing at least one ITN for every two people who stayed in the household the night before the survey.

The same pattern is also found with the possession of LLINs. Households owning at least one LLIN account for about 86% of all households, indicating that the majority of mosquito nets in Solomon Islands are ITNs or LLINs. Household possession of LLINs is highest in: rural areas, households in Western and other provinces, and households from the middle wealth quintile. Middle wealth quintile households are most likely to own a mosquito net. About 90% of middle wealth quintile households have at least one LLIN compared with over 74% of households from the highest wealth quintile.

On average, households possess 2.5 LLINs, with households in Honiara owning the fewest number at 1.7 LLIN per household. Furthermore, 56.3% of households possess at least one LLIN for every two people staying in the household the night before the survey, with more in rural areas (60%) than in urban areas (38%). The percentage of households possessing one LLIN for every two people was lowest in Honiara at 29%, with other provinces ranging from 54–65%.

Table 12.1: Household possession of mosquito nets

Percentage of households with at least one mosquito net (treated or untreated), insecticide/treated net (ITN), and long-lasting insecticidal net (LLIN); average number of nets, ITNs, and LLINs per household; and percentage of households with at least one net, ITN, and LLIN per two people who stayed in the household the night prior to the survey, by background characteristics, Solomon Islands 2015

Background characteristics	Percentage of households with at least one mosquito net			Average number of nets per household			Number of households	Percentage of households with at least one net for every two persons who stayed in the household the night prior to survey[1]			Number of households with at least one person who stayed in the household on the night before the survey
	Any mosquito net	Insecticide/ treated mosquito net (ITN)[2]	Long-lasting insecticidal net (LLIN)	Any mosquito net	Insecticide/ treated mosquito net (ITN)[2]	Long-lasting insecticidal net (LLIN)		Any mosquito net	Insecticide/ treated mosquito net (ITN)[2]	Long-lasting insecticidal net (LLIN)	
Residence											
Urban	72.2	71.6	71.4	2.1	2	2	850	40.6	37.9	37.9	849
Rural	89.4	88.9	88.8	2.7	2.6	2.6	4,192	61.7	60.2	60.1	4,191
Region											
Honiara	62.4	61.4	61.2	1.7	1.7	1.7	496	31	28.8	28.8	496
Guadalcanal	84.8	83.9	83.7	2.3	2.2	2.2	948	56.4	53.6	53.5	947
Malaita	87.4	87.1	87.1	2.7	2.6	2.6	1,349	57.8	56.8	56.8	1,349
Western	92.2	91.8	91.7	3	2.9	2.9	760	66.3	65.1	65	760
Other provinces	91.9	91.5	91.5	2.8	2.7	2.7	1,488	64.4	62.7	62.5	1,488
Wealth quintile											
Lowest	87.2	86.8	86.8	2.5	2.5	2.5	1,026	56.7	55	55	1,025
Second	89.9	89.8	89.7	2.6	2.6	2.6	1,010	57.9	56.7	56.6	1,010
Middle	90.8	90.5	90.5	2.8	2.7	2.7	1,029	63	61.9	61.9	1,029
Fourth	88.6	87.2	87.1	2.7	2.6	2.6	1,055	63	60.4	60.2	1,055
Highest	74.9	74.4	74.3	2.3	2.2	2.2	922	49	47	46.9	921
Total	**86.5**	**86**	**85.9**	**2.6**	**2.5**	**2.5**	**5,042**	**58.1**	**56.4**	**56.3**	**5,041**

[1] *De facto* household members.

[2] An insecticide-treated net (ITN) is: 1) a factory-treated net that does not require any further treatment (LLIN) or 2) a pretreated net obtained within the 12 months preceding the survey, or 3) a net that has been soaked with insecticide within the 12 months preceding the survey.

12.2 INDOOR RESIDUAL SPRAYING

IRS is another component of efforts to control malaria transmission in Solomon Islands. To obtain information on coverage of IRS, all households interviewed in the SIDHS 2015 were asked whether the interior walls of their dwelling had been sprayed against mosquitoes during the 12 months before the survey, and if so, who had sprayed the dwelling. Households are considered to be covered if they own at least one ITN and/or the dwelling has been sprayed at any time in the 12 months prior to the survey.

Table 12.2 presents results of the SIDHS 2015 with regard to IRS. About 28% of all households received IRS in the 12 months prior to the survey, and the number of households having received IRS is similar between urban areas (29%) and rural areas (28%). Households in Western and Malaita provinces report 34% and 31%, respectively, followed by Honiara at 25%, Guadalcanal Province at 22%, and other provinces at 26%.

Table 12.2: Indoor residual spraying against mosquitoes

Percentage of households in which someone has come into the dwelling to spray the interior walls against mosquitoes (IRS) in the12 months preceding the survey, the percentage of households with at least one ITN and/or IRS in the 12 months prior to the survey, and the percentage of households with at least one ITN for every two people and/or IRS in the 12 months preceding the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Percentage of households with IRS[1] in the 12 months prior to survey	Percentage of households with at least one ITN[2] and/or IRS in the 12 months prior to survey	Percentage of households with at least one ITN[2] for every two persons and/or IRS in the 12 months prior to survey	Number of households
Residence				
Urban	28.9	76.6	53.1	850
Rural	27.5	90.3	69	4,192
Region				
Honiara	24.6	67.7	44.3	496
Guadalcanal	22.4	85.9	62.9	948
Malaita	30.9	89.5	67.6	1,349
Western	33.7	92.9	76.1	760
Other provinces	26.2	92.3	69.7	1,488
Wealth quintile				
Lowest	23.7	88.1	63.6	1,026
Second	27.4	90.6	66.4	1,010
Middle	29.7	92.1	71.1	1,029
Fourth	30.8	90.2	71.4	1,055
Highest	26.8	78.1	58.2	922
Total	**27.7**	**88**	**66.3**	**5,042**

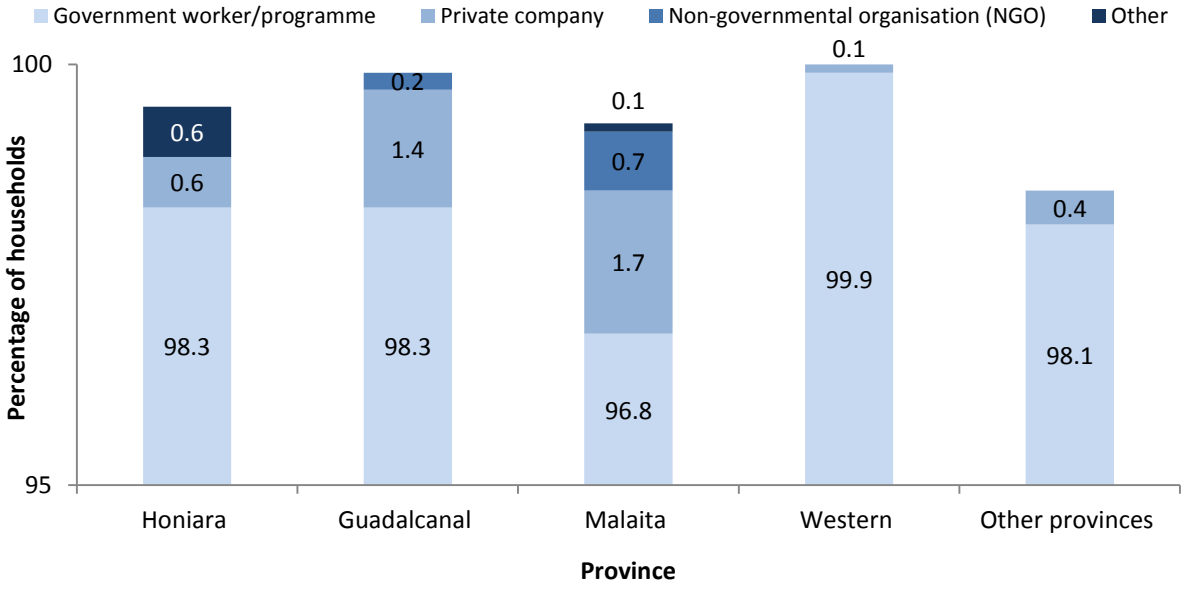
[1] Indoor residual spraying (IRS) is limited to spraying conducted by a government, private or non-governmental organisation

[2] An insecticide-treated net (ITN) is: 1) a factory-treated net that does not require any further treatment (LLIN), or 2) a pretreated net obtained within the12 months preceding the survey, or 3) a net that has been soaked with insecticide within the 12 months preceding the survey.

The combined coverage of households with at least one LLIN and/or having had IRS in the 12 months prior to the survey is estimated to be 88%, with higher coverage in rural areas (90%) than in urban areas (77%). The data also show higher coverage of IRS (in the 12 months prior to the survey) among households with at least one LLIN in Guadacanal, Malaita, Western and other provinces, and also among households in the second, middle and fourth wealth quintiles.

Figure 12.4 shows that 98% of spraying operations are carried out by government workers. Very few IRS operations are carried out by non-governmental organisations.

Figure 12.4: Percentage of households receiving indoor residual spraying operations provided by various organisations by province, Solomon Islands 2015



12.3 ACCESS TO AN INSECTICIDE-TREATED NET

An average of 71% of households in Solomon Islands have access to an ITN, if each ITN in the household is used by up to two people. The proportion of households with access to an ITN varies with the household's *de facto* size, ranging from a low of 57% of households with eight or more members, to a high of 86% of households with two members staying in the household the night before the survey (Table 12.3).

Table 12.3: Access to an insecticide-treated net (ITN)

Percent distribution of the de facto household population by number of insecticide-treated nets (ITNs) the household owns, according to number of persons who stayed in the household the night before the survey, Solomon Islands 2015

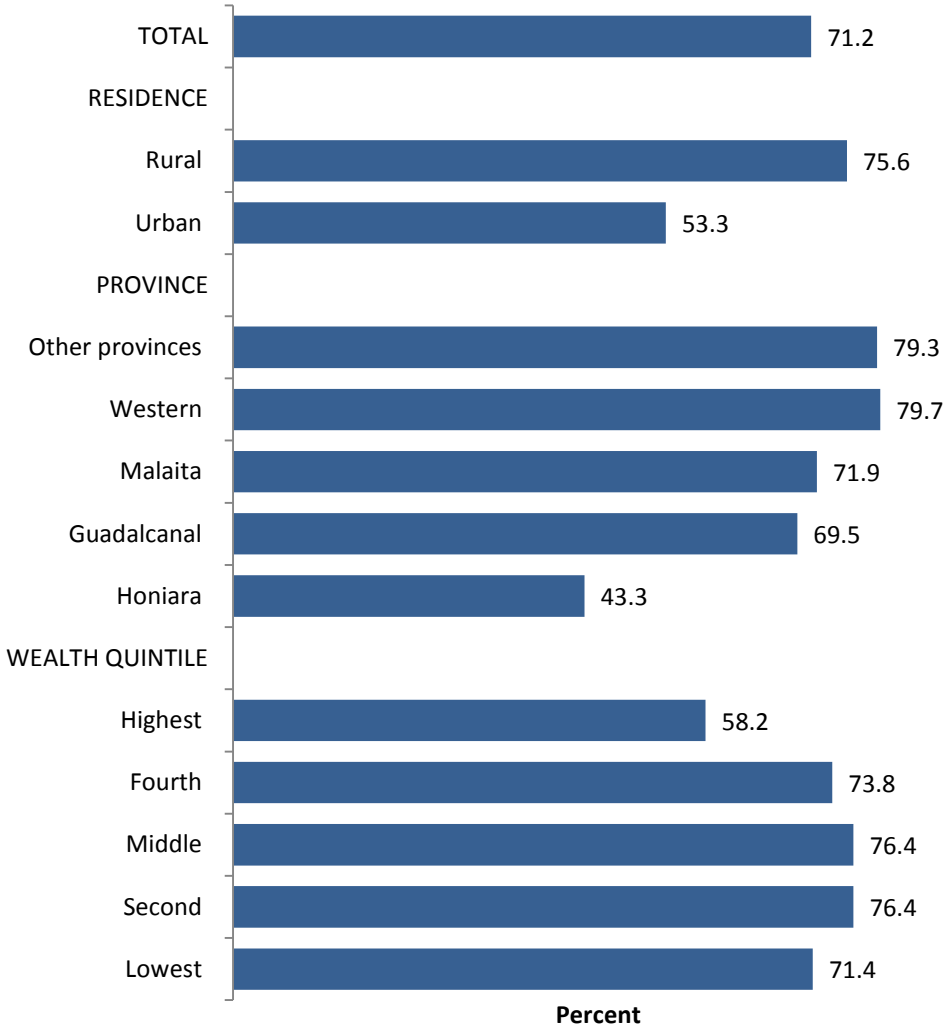
Number of ITNs	Number of people who stayed in the household the night before the survey								Total
	1	2	3	4	5	6	7	8+	
0	21.7	14.4	10.4	12.6	12.4	11.7	15.5	18.9	14.8
1	41.5	27.1	19.1	12	6.1	6.3	6.8	5	8.4
2	15.5	36.4	29.4	29.5	26.6	18.7	12.4	11.5	19.3
3	15.9	15.3	32.7	34.6	37.6	39	40.2	29.3	33.9
4	1.9	2.9	2.9	4.9	7.8	7.8	10.7	9.6	7.9
5	3.2	3.2	2.6	2.5	4.8	6	4.5	7.4	5.3
6	0.2	0.4	2.4	2.3	3.3	8.1	7.3	13.1	7.5
7+	0	0.4	0.7	1.7	1.3	2.3	2.6	5.3	2.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number	**212**	**821**	**1,878**	**3,319**	**4,074**	**4,418**	**3,592**	**8,679**	**26,993**
Percent with access to an ITN[1]	78.3	85.6	83.3	81.4	78.6	77.8	68.5	57.4	71.2

[1] Percentage of the *de facto* household population who could sleep under an ITN if each ITN in the household was used by up to two people

Figure 12.5 presents the percentage of *de facto* households with access to an ITN by background characteristics. A higher percentage of rural *de facto* households have access to an ITN (76%) than urban households (53%).

Across the five province groups, Western and other provinces account for the highest proportion of *de facto* households with access to an ITN. Honiara has the lowest proportion, at 43%. There is no clear relationship between household wealth, although interestingly, the highest wealth quintile households have the lowest percentage of ITNs.

Figure 12.5: Percentage of de facto households with access to an insecticide-treated net, Solomon Islands 2015



12.4 USE OF MOSQUITO NETS BY PEOPLE WITHIN THE HOUSEHOLD

The SIDHS 2015 included questions that asked respondents whether they had slept under a mosquito net the night before the survey. The results are presented in Table 12.4.

About 67% of household members with access to at least one ITN slept under an ITN the night before the survey. The same proportion of the household population (67%) slept under an ITN the night before the survey or in a dwelling that received IRS in the 12 months prior to the survey. Another 57% slept under any kind of mosquito net the night before the survey.

Table 12.4 also shows that 70% of people who slept under a mosquito net of any kind the night before the survey were children aged less than 5 years, and about 70% of them slept under an LLIN. The survey also showed that in the 12 months prior to the survey, 76% of the people who slept under a treated bed net and/or in a dwelling sprayed with IRS were children less than 5 years of age.

Table 12.4: Use of mosquito nets by people in the household

Percentage of the de facto household population who slept the night before the survey under a mosquito net (treated or untreated), under an insecticide-treated net (ITN), under a long-lasting insecticidal net (LLIN), and under an ITN or in a dwelling in which the interior walls had been sprayed against mosquitoes (IRS) in the 12 months preceding the survey; and among the de facto household population in households with at least one ITN, the percentage of people who slept under an ITN the night before the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Household population					Household population in households with at least one ITN[1]	
	Percentage who slept under any net the night before survey	Percentage who slept under an ITN[1] on night before survey	Percentage who slept under an LLIN on night before survey	Percentage who slept under an ITN[1] last night or in a dwelling sprayed with IRS[2] in the 12 months preceding survey	Number	Percentage who slept under an ITN[1] on the night before survey	Number
Age (in years)							
<5	70.3	69.6	69.5	75.6	4,156	80.3	3,602
5–14	56.6	56.1	56.1	66.8	7,451	65.3	6,400
15–34	52.7	52.2	52.2	64	8,154	62.5	6,809
35–39	57.6	57.2	57.1	67.1	4,042	67	3,450
50+	54	53.5	53.5	64.2	3,186	62.5	2,731
DK/Missing	18.4	18.4	18.4	50.4	5	27.1	3
Sex							
Male	54.3	53.9	53.9	65.2	13,408	63.4	11,391
Female	60.3	59.8	59.7	68.9	13,585	70	11,605
Residence							
Urban	42.8	42.2	42.2	55.6	5,287	60.2	3,711
Rural	60.9	60.4	60.4	69.8	21,705	68	19,285
Region							
Honiara	33.5	32.8	32.8	46.4	3,328	54.3	2,014
Guadalcanal	61.6	60.9	60.8	68	4,715	73.1	3,930
Malaita	52.1	51.8	51.8	64.6	7,241	59.5	6,299
Western	65.5	65.2	65.1	76.5	4,020	70.2	3,730
Other provinces	65.7	65.2	65.2	72.8	7,690	71.4	7,022
Wealth quintile							
Lowest	57.4	56.9	56.9	64.8	5,404	66	4,663
Second	60.5	60.3	60.3	70.5	5,363	66.4	4,871
Middle	62.7	62.5	62.5	72.4	5,393	69.2	4,866
Fourth	61.1	60	59.9	71.9	5,408	69.6	4,663
Highest	45.1	44.6	44.5	55.8	5,425	61.5	3,932
Total	**57.3**	**56.8**	**56.8**	**67**	**26,993**	**66.7**	**22,995**

[1] An insecticide–treated net (ITN) is: 1) a factory-treated net that does not require any further treatment (LLIN), or 2) a pretreated net obtained within the 12 months preceding the survey, or 3) a net that has been soaked with insecticide within the 12 months preceding the survey.

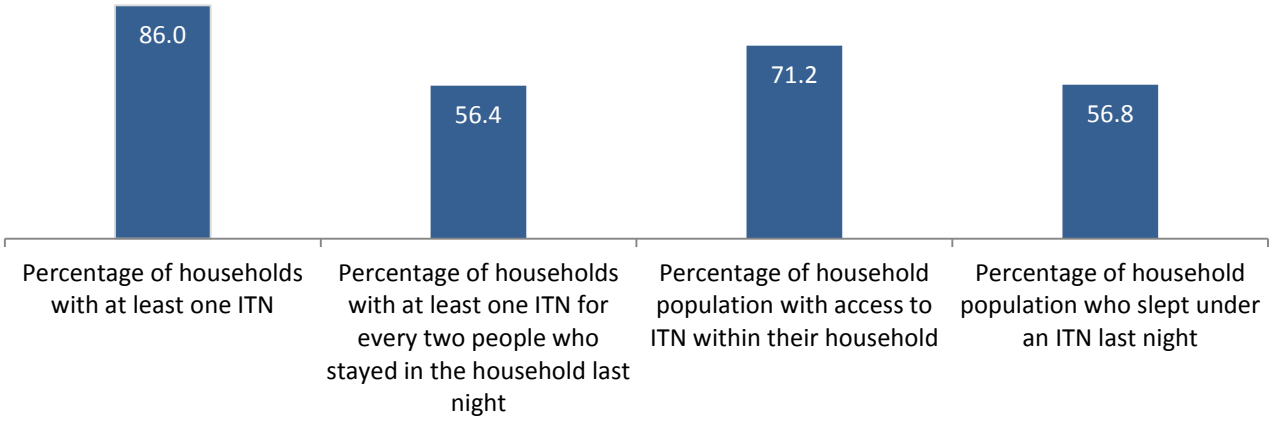
[2] Indoor residual spraying (IRS) is limited to spraying conducted by a government, private or non-governmental organisation.

Children less than 5 years old are more likely to have slept under a mosquito net than children over the age of 5. With regard to net use, there is no difference between male and female children aged less than 5 years, although the SIDHS 2015 did reveal a general tendency for more female children (60%) to sleep under any kind of net than male children (54%). With regard to other age groups, the percentage of people sleeping under a bed net of any kind was lower than for children aged 0–4 years.

More people of all age groups slept under a bed net of any kind in rural areas (61%) than in urban areas (43%). About 66% of people slept under any kind of bed net in Western Province followed by Guadalcanal and Malaita provinces at 62% and 52%, respectively. Honiara had the fewest number of people who had slept under any kind of bed net.

Figure 12.6 shows that 86% of households own at least one ITN. About three out of five households (56%) have at least one ITN for every two people who stayed in the household the night before the survey. Over 70% of households have access to an ITN and 57% of the household population slept under an ITN the night before the survey.

Figure 12.6: Ownership of, access to, and use of an insecticide treated bed net (ITN), Solomon Islands, 2015



12.5 USE OF EXISTING ITNS

Table 12.5 shows that overall, 66% of existing ITNs (or ITNs owned by households) were used the night before the survey. The use of existing ITNs is reported to be higher in urban areas (74%) than in rural areas (65%). Among the provinces, the use of ITNs is lowest in Malaita (59%), with Guadacanal reporting the highest proportion of ITN use. No differences were observed across household wealth quintiles regarding the use of ITNs.

Table 12.5: Use of existing ITNs

Percentage of insecticide-treated nets (ITNs) that were used by anyone the night before the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Percentage of existing ITNs[1] used the night before survey	Number of ITNs[1]
Residence		
Urban	74	1,660
Rural	64.9	11,047
Region		
Honiara	72.2	821
Guadalcanal	76.3	2,093
Malaita	59.3	3,548
Western	64.4	2,219
Other provinces	66.5	4,025
Wealth quintile		
Lowest	64.5	2,530
Second	66.5	2,612
Middle	66	2,794
Fourth	65.5	2,744
Highest	68.6	2,026
Total	**66.1**	**12,707**

[1] An insecticide-treated net (ITN) is: 1) a factory-treated net that does not require any further treatment (LLIN), or(2) a pretreated net obtained within the 12 months preceding the survey, or 3) a net that has been soaked with insecticide within the 12 preceding the survey.

12.6 USE OF MOSQUITO NETS BY CHILDREN AND PREGNANT WOMEN AGED 15-49

The use of mosquito nets by vulnerable populations, particularly children and pregnant women, in highly endemic countries is one of the major indicators collected during the SIDHS 2015. Table 12.6 presents data on the extent to which children under age 5 years slept under any kind of mosquito net on the night before the interview. Overall, the majority of children under age 5 years (80%) in households with at least one ITN slept under an ITN the night before the survey. The proportion of children who slept under any kind of net, under an ITN, or under an LLIN on the night prior to the survey accounted for almost the same percentage (70%).

A greater proportion of children aged less than 2 years slept under a mosquito net of any kind than children aged 3 and 4 years (Table 12.6). High proportions of children sleeping under any bed net are reported in rural households, among children in Western and Guadacanal provinces, and among children living in the second, third and fourth wealth quintile households.

Table 12.6: Use of mosquito nets by children

Percentage of children under 5 years of age who, the night before the survey, slept under a mosquito net (treated or untreated), under an insecticide-treated net (ITN), under a long-lasting insecticidal net (LLIN), and under an ITN or in a dwelling in which the interior walls have been sprayed against mosquitoes (IRS) wthin the 12 months preceding the survey; and among children under 5 years of age in households with at least one ITN, the percentage who slept under an ITN the night before the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Children under age 5 in all households					Children under age 5 in households with at least one ITN[1]	
	Percentage who slept under any net the night before survey	Percentage who slept under an ITN[1] the night before survey	Percentage who slept under an LLIN last night	Percentage who slept under an ITN[1] last night or in a dwelling sprayed with IRS[2] in the 12 months preceding survey	Number of children	Percentage who slept under an ITN[1] the night before survey	Number of children
Age (in years)							
<1	76.9	75.2	75.1	79.5	827	86.8	717
1	73.8	73.1	73.1	78.2	834	83.8	728
2	71.4	71	71	77.3	819	81.7	712
3	64.6	64.5	64.5	71.1	892	74.5	773
4	64.7	64.1	64.1	72	784	74.6	673
Sex							
Male	71.1	70.2	70.2	76.2	2,131	80.4	1,862
Female	69.4	68.8	68.8	75	2,025	80.1	1,741
Residence							
Urban	57.3	56.6	56.5	65.5	679	78	493
Rural	72.8	72.1	72.1	77.6	3,477	80.6	3,109
Region							
Honiara	49.1	48.1	47.9	56.8	427	74.9	274
Guadalcanal	73.2	72.2	72.2	75.9	749	86.3	627
Malaita	65	64.6	64.6	73	1,136	73.4	1,000
Western	76.2	75.8	75.8	83.6	597	81.4	556
Other provinces	77.7	76.9	76.9	80.4	1,247	83.7	1,145
Wealth quintile							
Lowest	69.7	69.2	69.2	73.7	966	80.3	833
Second	72	71.7	71.7	77.6	862	77.8	795
Middle	74.1	73.5	73.5	80	864	81.5	780
Fourth	74.7	73	73	78.6	801	82.7	707
Highest	58.5	57.9	57.8	66.3	663	78.6	489
Total	**70.3**	**69.6**	**69.5**	**75.6**	**4,156**	**80.3**	**3,602**

Note: Table is based on children who stayed in the household the night before the interview.

[1] An insecticide-treated net (ITN) is: 1) a factory-treated net that does not require any further treatment (LLIN), or 2) a pretreated net obtained within the 12 months preceding the survey, or 3) a net that has been soaked with insecticide within the 12 months preceding the survey.

[2] Indoor residual spraying (IRS) is limited to spraying conducted by a government, private or non-governmental organisation.

Table 12.7 shows the percentage of pregnant women who slept under any type of mosquito net the night before the interview. About 75% of pregnant women in households with at least one ITN slept under an ITN the night before the interview, while 64% slept under any kind of mosquito net. The other 70% of pregnant women slept under an ITN the night prior to the survey, or in a dwelling sprayed with IRS in the 12 months preceding the survey.

The data show that the lowest percentage of pregnant women using any kind of net the night before the interview were from urban areas and those living in Honiara. Interestingly, the results reveal that the lowest proportion of pregnant women sleeping under any mosquito net the night prior to the survey were those living in the highest wealth quintile households (46%).

Table 12.7: Use of mosquito nets by pregnant women

Percentages of pregnant women aged 15-49 who, the night before the survey, slept under a mosquito net (treated or untreated), under an insecticide-treated net (ITN), under a long-lasting insecticidal net (LLIN), and under an ITN or in a dwelling in which the interior walls have been sprayed against mosquitoes (IRS) within the 12 months preceding the survey; and among pregnant women aged 15-49 in households with at least one ITN, the percentage who slept under an ITN the night before the survey, by background characteristics, Solomon Islands 2015

Background characteristic	Among pregnant women aged 15-49 in all households					Among pregnant women aged 15-49 in households with at least one ITN[1]	
	Percentage who slept under any net the night before survey	Percentage who slept under an ITN[1] the night before survey	Percentage who slept under an LLIN the night before survey	Percentage who slept under an ITN[1] last night or in a dwelling sprayed with IRS[2] in the 12 months preceding survey	Number of women	Percentage who slept under an ITN[1] the night before survey	Number of women
Residence							
Urban	41.7	41.7	41.7	52.8	72	58.3	51
Rural	68.6	68.6	68.3	74.1	306	77.9	269
Region							
Honiara	(29)	(29)	(29)	(38.7)	45	(45)	29
Guadalcanal	64.5	64.5	62.8	73.1	59	81.8	47
Malaita	66.7	66.7	66.7	71.5	103	76.4	90
Western	71.8	71.8	71.8	77.4	72	76.9	68
Other provinces	69	69	69	75.5	99	77.6	88
Education							
No education	*	*	*	*	31	*	22
Primary	64.8	64.8	64.8	69.2	164	75.5	141
Secondary	64.3	64.3	63.7	71.7	165	75.1	141
More than secondary	*	*	*	*	18	*	16
Wealth quintile							
Lowest	68.8	68.8	68.8	71.4	96	80.4	82
Second	76.8	76.8	76.8	82.6	74	83.3	68
Middle	64.5	64.5	64.5	70.4	64	74.8	55
Fourth	60	60	58.6	68.7	69	72.8	57
Highest	46.2	46.2	46.2	57.1	76	59.3	59
Total	**63.5**	**63.5**	**63.2**	**70.1**	**378**	**74.8**	**321**

Note: Table is based on women who stayed in the household the night before the interview. 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 insecticide-treated net (ITN) is: 1) a factory-treated net that does not require any further treatment (LLIN), or 2) a pretreated net obtained within the 12 months preceding the survey, or 3) a net that has been soaked with insecticide within the 12 months preceding the survey.

[2] Indoor residual spraying (IRS) is limited to spraying conducted by a government, private or non-governmental organisation.

12.7 PREVALENCE AND PROMPT TREATMENT OF FEVER IN CHILDREN UNDER AGE 5 YEARS

Fever is the symptom that most frequently presages the onset of an episode of malaria. Especially in malaria-endemic areas, it is important that children experiencing fever receive prompt testing for malaria parasites, either by rapid diagnostic tests or by microscopy. Children testing positive for infection should be given an effective antimalarial medication according to national recommendations. The main objective of this protocol for rapid diagnosis and treatment of malaria in children is to reduce morbidity and mortality; however, a secondary benefit should be a reduction in the rate of antimalarial drug resistance as treatment becomes more specific.

Table 12.8 shows the percentage of children experiencing an episode of fever during the two weeks preceding the survey, the percentage having had a finger or heel stick (presumably for diagnostic purposes), the percentage having a fever receiving antimalarial drugs, and the percentage treated with antimalarial drugs the same or next day following the onset of fever.

Table 12.8 also shows that 19% of children under age 5 years had a fever in the two weeks prior to the survey. The data further indicate that fever is more common among young children aged less than 3 years, is higher among boys (22%) than girls (17%), among children living in Honiara and Malaita Province, among children whose mothers having a secondary education, and among children living in the lowest and highest wealth quintile households. No obvious differences with regard to fever were observed between urban areas (21%) and rural areas (19%).

Among children under age 5 years with fever, 62% sought advice and treatment. Seeking advice and treatment is less likely among older children, children in rural areas, children in Malatia Province, and children whose mothers live in the middle wealth quintile households.

Table 12.8: Prevalence, diagnosis, and prompt treatment of children with fever

Percentage of children under age 5 with fever in the two weeks preceding the survey; and among children under age 5 with fever, the percentage for whom advice or treatment was received, the percentage who had blood taken from a finger or heel, the percentage who took artemisinin, the percentage who took artemisinin the same or next day following the onset of fever, the percentage who took antimalarial drugs, and the percentage who took the drugs the same or next day following the onset of fever, by background characteristics, Solomon Islands 2015

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 for whom advice or treatment was sought[1]	Percentage who had blood taken from a finger or heel for testing	Percentage who took artemisinin	Percentage who took artemisinin same or next day	Percentage who took antimalarial drugs	Percentage who took antimalarial drugs same or next day	Number of children
Age (in months)									
<12	18.6	846	60.6	32.4	0	0	4.3	2.6	158
12–23	24.8	826	65.7	39.3	0.2	0.2	11	7.3	205
24–35	21.4	786	61	44	0	0	15.5	13.6	169
36–47	17	856	60.3	43.5	0	0	7.6	5.4	146
48–59	14	720	57.2	29.7	0	0	13.6	12.3	101
Sex									
Male	21.6	2,084	60.4	37.2	0	0	10.6	8.6	451
Female	16.8	1,949	63.1	40.3	0.1	0.1	9.9	7.2	327
Residence									
Urban	20.5	720	70.8	56.1	0.3	0.3	5.7	4.4	148
Rural	19	3,313	59.4	34.4	0	0	11.4	8.9	630
Region									
Honiara	20.4	455	69	61.2	0	0	4	2.2	93
Guadalcanal	13.7	778	67.2	52.6	0	0	14.4	11.4	107
Malaita	19.8	1,080	54.2	29.5	0	0	12.9	12.2	214
Western	15.1	553	64.4	40.9	0	0	3.3	2.4	84
Other provinces	24.1	1,167	61.7	31.8	0.1	0.1	11	7.2	281
Mother's education									
No education	14.4	390	(51.5)	(34.4)	0	0	(13.8)	(13.8)	56
Primary	18.7	1,921	61.1	31.8	0.1	0.1	9.9	7	359
Secondary	21.4	1,521	64.6	45.8	0	0	10.1	8.3	326
More than secondary	18.2	201	54	45.5	0	0	11.2	6.7	37
Wealth quintile									
Lowest	20.7	939	59.2	29.7	0	0	13.4	11.8	194
Second	18.2	833	59.3	33.7	0	0	6.7	3.7	151
Middle	17.1	818	51.4	29	0	0	10.1	7.5	140
Fourth	20	773	62.8	40	0	0	9	8	155
Highest	20.5	670	76.1	64.2	0.3	0.3	11.7	7.9	137
Total	**19.3**	**4,033**	**61.5**	**38.5**	**0**	**0**	**10.3**	**8**	**778**

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

[1] Excludes friend, relative and traditional practitioner.

Furthermore, 39% of those children experiencing fever in the two weeks prior to the survey had their blood tested for malaria. It was observed there was a slight difference between boys (37%) and girls (40%) and for urban areas (56%) and rural areas (34%) settings. Furthermore, blood testing is reported to be more common among children in Honiara and Guadalcanal Province, children whose mothers have a secondary and higher education, and children of mothers living in the highest wealth quintile households.

Among children with fevers, 10% received antimalarial drugs, and 8% of them received drugs the same day or the day after the fever started.

12.8 SOURCE OF ADVICE OR TREATMENT FOR CHILDREN WITH FEVER

Table 12.9 presents information on sources from which advice or treatment for fever was sought for children under age 5 years with fever in the two weeks preceding the survey. Among children under age 5 with a fever in the two weeks preceding the survey (19.3%), 54% of them seek advice from any public sector health clinic, mostly from rural health centres. Very few cases seek advice and treatment from a private sector source (8%) or any other source (4%).

Table 12.9: Source of advice or treatment for children with fever

Percentage of children under age 5 with fever in the two weeks preceding the survey for whom advice or treatment was received from specific sources; and among children under age 5 with fever in the two weeks preceding the survey for whom advice or treatment was received, the percentage for whom advice or treatment was received from specific sources, by background characteristics, Solomon Islands 2015

Background characteristic	Percentage for whom advice or treatment was received from each source:	
	Among children with fever	Among children with fever for whom advice or treatment was received
Any public sector source	54.2	83.5
..National referal hospital	0.9	1.4
..Provincial hospital	6	9.2
..Urban area health centre	6.7	10.3
..Area health centre	11.1	17
..Rural health centre	22.5	34.7
..Nurse aid post	7	10.7
..Satellite clinics	0.4	0.6
Any private sector source	7.9	12.2
..Private clinic	1.5	2.4
..Pharmacy	0.2	0.3
..Private doctor	0.8	1.3
..Church: Hospital	2.9	4.5
..Church: Rural health clinic	2.1	3.2
..Church: nurse aide post	0.4	0.6
Any other source	3.9	6
..SIPPA clinic	0.1	0.2
..Friend/relative	2.8	4.3
..Traditional practitioner	1.5	2.4
Number of children	778	505

Among children with a fever for whom advice or treatment was sought, the majority (84%) had consulted a public sector source and received advice or treatment. Consultations were high at rural health centres (35%) followed by area health centres (17%). Another 12% of cases received advice from the private sector and 6% received advice from other sources.

12.9 ANTIMALARIA DRUGS USED FOR CHILDREN WITH FEVER

Most malaria-endemic countries recommend the use of artemisinin-based combination therapy (ACT) as the first-line treatment for malaria. An ACT is defined as an antimalarial drug that contains an artemisinin component as well as a second antimalarial drug. WHO recommends five types of ACT drugs. Table 12.10

shows the types of antimalarial drugs used among children under age 5 years with a fever in the two weeks preceding the survey.

It is interesting to note the variety of antimalarial drugs taken by children at the different health settings. Coartem is the current drug of choice and is the first line treatment for malaria in Solomon Islands; 48% of children have been administered with it followed by SP/Fansidar (22%), Chloroquine (18%) and other anti-malaria (12%). The use of artemisinin and artametar are less commonly used among children with fever in Solomon Islands (0.5% and 6%, respectively).

Mothers' knowledge has minimal influence on drug preference for their children, in relation to the use of coartem and fansida; most probably because of the availability of these drugs at the health facility. The high consumption of chloroquine among children of uneducated mothers suggests the possibility that the drug is available within the household and, therefore, the SIMoHMS treatment guideline is ignored. It may also suggest limited coartem stock in health facilities and, hence, a resort to the available antimalarial drugs at home. Drugs that are only available from private clinics and drug stores are reportedly used by children with fever.

Table 12.10: Type of antimalarial drugs used

Among children under aged 5 with fever in the two weeks preceding the survey, the percentage who took any antimalarial medication, the percentage who took specific antimalarial drugs, by background characteristics, Solomon Islands 2015

Background characteristic	Percentage of children who took drug:								Number of children with fever who took anti-malarial drug
	Artemisinin	Quinine	SP/ Fansidar	Chloro-quine	Primaquine	Artametar	Coartem	Other anti-malarial	
Age (in months)									
<12	*	*	*	*	*	*	*	*	7
12-23	*	*	*	*	*	*	*	*	23
24-35	*	*	*	*	*	*	*	*	26
36-47	*	*	*	*	*	*	*	*	11
48-59	*	*	*	*	*	*	*	*	14
Sex									
Male	0	(4.6)	(19.1)	(16.4)	(12.3)	(5.4)	(59.1)	(2.7)	48
Female	(1.2)	(2.3)	(26.1)	(20.1)	(3.3)	(7.3)	(32.2)	(24.8)	32
Residence									
Urban	*	*	*	*	*	*	*	*	8
Rural	0	1.5	24.5	17.9	9.3	6.9	47.9	12.5	72
Region									
Honiara	*	*	*	*	*	*	*	*	4
Guadalcanal	*	*	*	*	*	*	*	*	15
Malaita	*	*	*	*	*	*	*	*	28
Western	*	*	*	*	*	*	*	*	3
Other provinces	(1.2)	(1.1)	(18.9)	(1.1)	(10.7)	(4.2)	(66.9)	(6.4)	31
Mother's education									
No education	*	*	*	*	*	*	*	*	8
Primary	(1.1)	(7.3)	(10.9)	(6.2)	(19.7)	(6.1)	(62)	0	35
Secondary	0	0	(30.5)	(22.2)	0	(8.5)	(37.4)	(14)	33
More than secondary	*	*	*	*	*	*	*	*	4
Wealth quintile									
Lowest	*	*	*	*	*	*	*	*	26
Second	*	*	*	*	*	*	*	*	10
Middle	*	*	*	*	*	*	*	*	14
Fourth	*	*	*	*	*	*	*	*	14
Highest	*	*	*	*	*	*	*	*	16
Total	**0.5**	**3.7**	**21.9**	**17.9**	**8.7**	**6.2**	**48.3**	**11.6**	**80**

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

CHAPTER 13 HIV AND AIDS RELATED KNOWLEDGE, ATTITUDES AND BEHAVIOUR

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KEY FINDINGS

- Knowledge of AIDS is widespread in Solomon Islands, with 91% of women and 97% of men aged 15–49 having heard of AIDS. However, the percentage of women and men who have heard about AIDS has declined slightly since the SIDHS 2006–2007.
- HIV awareness is almost universal among urban women and men (97% and 99%, respectively), while awareness among rural women and men is lower (89% and 96%, respectively).
- Among women and men who have knowledge of HIV prevention methods, 79% of women and 87% of men know that limiting sexual intercourse to one uninfected partner can reduce the chances of contracting HIV.
- About three in ten women and four in ten men have comprehensive knowledge about AIDS. That is, they know that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chances of getting HIV. They also know that a healthy-looking person can have the AIDS virus, and they reject the two most common local misconceptions about HIV transmission or prevention.
- Overall, 24% of women and 23% of men know that HIV can be transmitted by breastfeeding and that the risk of mother-to-child transmission can be reduced if the mother takes special drugs during her pregnancy.
- Among those who have accepting attitudes towards those living with HIV/AIDS, 6% of women and 16% of men express accepting attitudes in four situations: they would care for a family member with HIV/ AIDS in their own home, they would buy fresh vegetables from shopkeeper who has the AIDS virus, agree that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching, and that they would not want to keep it a secret that a family member is infected with the AIDS virus.

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 injections.[15] Globally, and in Solomon Islands, AIDS is one of the most serious public health and development challenges because it affects all aspects of socioeconomic livelihood.

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. Information gathered from the SIDHS 2015 will also assist all stakeholders and development partners in taking up the challenge to tackle the ongoing threat of HIV/AIDs in the country. The survey respondents comprise 6,266 women and 2,948 men aged 15–49 years who participated in the HIV

[15] http://www.who.int/features/qa/71/en/index.html

and AIDS-related knowledge, attitudes and behaviours section, including HIV counselling and testing. An additional 643 men aged 50 years and over also participated.

13.1 KNOWLEDGE OF AIDS

The SIDHS 2015 asked respondents whether they had heard of AIDS. For those respondents who reported having heard of AIDS were further asked a number of questions about whether and how HIV can be prevented.

The results in Table 13.1 show the percentage of women and men aged 15–49 who have heard of AIDS, by background characteristics. In Solomon Islands, 91% of women and 97% of men have heard of AIDS. The percentage of both women and men who have heard of AIDS has slightly declined since the SIDHS 2006–2007 (94% and 98%, respectively). There are minor differences in awareness according to background characteristics. Young women, women and men who have never been married, and never had sex are less likely to have knowledge of AIDS.

Awareness about AIDS is almost universal among urban women (97%) and men (99%), and rural men (96%), while awareness among rural women is slightly lower (89%). Women in Guadalcanal and Malaita provinces are less likely to be well aware about AIDS.

On the other hand, awareness and knowledge about AIDS is increasing with women's and men's level of education and living status. For example, women and men with no and lower education are less likely to have knowledge about AIDS compared with women and men with more education. This pattern is also observed with household wealth.

Table 13.1: Knowledge of AIDS

Percentage of women and men aged 15–49 who have heard of AIDS, by background characteristics, Solomon Islands 2015

Background characteristic	Women		Men	
	Has heard of AIDS	Number of respondents	Has heard of AIDS	Number of respondents
Age				
15–24	89.6	2,387	93.5	1,124
..15–19	87.2	1,241	90.4	605
..20–24	92.2	1,146	97.2	519
25–29	94.2	1,091	99	479
30–39	91.7	1,736	98.7	830
40–49	90.8	1,052	99	516
Marital status				
Never married	89.7	1,936	94.2	1,261
..Ever had sex	94.3	1,043	97.1	825
..Never had sex	84.3	893	88.6	436
Married/Living together	92	4,086	98.8	1,652
Divorced/Separated/Widowed	90.5	244	100	35
Residence				
Urban	97.4	1,427	99.1	720
Rural	89.4	4,839	96.1	2,229
Region				
Honiara	97.8	925	98.9	475
Guadalcanal	85.3	1,140	92.8	547
Malaita	87.3	1,608	99.8	710
Western	94.9	902	95.8	451
Other provinces	93.3	1,690	96.2	765
Education				
No education	71.9	576	86.2	92
Primary	89.5	2,820	95.2	1,202
Secondary	96.2	2,476	98.4	1,348
More than secondary	99.8	394	99.4	307
Wealth quintile				
Lowest	83.1	1,158	93.6	529
Second	88	1,172	97	565
Middle	91.4	1,223	97	528
Fourth	95.2	1,253	97.3	621
Highest	96.6	1,460	98.6	706
Total 15–49	**91.2**	**6,266**	**96.8**	**2,948**
50+	na	na	93.8	643
Total 15+	**na**	**na**	**96.3**	**3,591**

na = not applicable

13.2 KNOWLEDGE OF HIV PREVENTION METHODS

HIV among adults is mainly transmitted through heterosexual contact between an infected partner and a non-infected partner. Consequently[16], 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 presents the proportion of women and men aged 15–49 who are aware about the various HIV and AIDS prevention methods, by background characteristics. Findings of the SIDHS 2015 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. This is similar to what was reported in the SIDHS 2006–2007.

Findings of the SIDHS 2015 reveal that knowledge is highest for awareness that HIV can be prevented by limiting sexual intercourse to one uninfected partner (79% women, 87% men). This response (percentage) has slightly declined among men but has slightly increased among women (77% women, 89% men,) since the SIDHS 2006–2007. Slightly more than 62% of women and 70% of men are aware that HIV can be prevented by using condoms every time they have sexual intercourse, while another 58% of women and more than 65% of men are aware of both prevention methods. Table 13.2 also shows that there is no substantial difference in the level of knowledge of prevention methods by age group. Never-married men and women who report that they have never had sex were found to have less knowledge of prevention methods compared with those who have had sex, or are married and/or living together or divorced, separated or widowed.

Differences are noted among women and men from urban and rural areas regarding the level of knowledge about ways to prevent HIV from spreading. Women and men in urban areas are more knowledgeable about ways to prevent HIV from spreading than women and men in rural areas.

The data also show some differences in knowledge of HIV prevention methods on the basis of region. Women in Guadalcanal Province are the least knowledgeable about HIV prevention methods. Men from Malaita and Guadalcanal provinces are the least knowledgeable about using condoms and limiting sexual intercourse to one uninfected partner.

The proportion of respondents who have knowledge about ways to prevent HIV from spreading increases with educational attainment and wealth quintile for both women and men. For example, women and men with less education and living in lower wealth quintile households have less knowledge about HIV prevention methods than those women and men with more education and living in higher wealth quintile households.

[16] http://www.who.int/features/2004/hiv_aids/en/index.html; http://www.who.int/hiv/en/

Table 13.2: Knowledge of HIV prevention methods

Percentage of women and men aged 15–49 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, and by having one sex partner who is not infected and has no other partners, by background characteristics, Solomon Islands 2015

Background characteristic	Women				Men			
	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of women	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of men
Age								
15–24	62	77.2	57.7	2,387	64.6	80.9	59.5	1,124
..15–19	58.3	74.3	54.6	1,241	62.1	75.4	55.4	605
..20–24	66	80.3	61.1	1,146	67.6	87.3	64.4	519
25–29	66.2	82.4	62.1	1,091	68.7	89.6	64.8	479
30–39	62.8	80.4	59.1	1,736	75.9	89.6	70.9	830
40–49	57.7	78.6	54.2	1,052	73.5	91.1	68.8	516
Marital status								
Never married	59.7	77.2	55.7	1,936	66.6	82.2	61.7	1,261
..Ever had sex	64.5	83.4	60.5	1,043	72.8	87.1	68.4	825
..Never had sex	54	70	50.1	893	54.9	72.8	49.1	436
Married/Living together	63.1	80.1	59.2	4,086	72.7	89.7	67.8	1,652
Divorced/Separated/ Widowed	67.9	79.8	64.5	244	69.3	95	69.3	35
Residence								
Urban	65.9	89.7	63.3	1,427	77.9	94.9	76.2	720
Rural	61.2	76.1	56.8	4,839	67.5	83.8	61.7	2,229
Region								
Honiara	68.4	92.9	66.6	925	79.5	95.4	78.5	475
Guadalcanal	51.3	69.7	47	1,140	62.9	87.6	60.8	547
Malaita	61.8	78	58.7	1,608	63.7	82.7	58.5	710
Western	66.4	82.7	63.8	902	69.1	92	67.5	451
Other provinces	64.4	77.4	58.1	1,690	75.7	80.6	65.1	765
Education								
No education	42.2	55.1	39.6	576	51.4	61.2	42.7	92
Primary	59.3	75.3	54.5	2,820	67.8	83.3	62.2	1,202
Secondary	68.8	87.1	65.4	2,476	71.3	88.9	67	1,348
More than secondary	70.9	93.2	68.2	394	78.5	96.3	76.1	307
Wealth quintile								
Lowest	56.4	66.3	50.9	1,158	68.3	78.6	60.1	529
Second	60.4	75.4	56.3	1,172	64.5	82.3	58.9	565
Middle	62.9	78.3	57.9	1,223	67.8	85.3	61.9	528
Fourth	63.5	83.6	60.1	1,253	69.2	88.9	65.4	621
Highest	66.7	89.4	64.5	1,460	78.1	94.8	76.5	706
Total 15–49	**62.2**	**79.2**	**58.3**	**6,266**	**70**	**86.5**	**65.2**	**2,948**
50+	na	na	na	na	62.3	81.4	58.8	643
Total 15+	**na**	**na**	**na**	**na**	**68.6**	**85.6**	**64.1**	**3,591**

na = not applicable

[1] Using condoms every time they have sexual intercourse

[2] Partner who has no other partners

13.3 REJECTION OF MISCONCEPTIONS ABOUT HIV AND AIDS

As part of the effort to assess HIV and AIDS knowledge, the SIDHS 2015 collected information on common misconceptions about HIV transmission in Solomon Islands. Respondents were asked whether they think it is possible for a healthy-looking person to have HIV and whether they believe HIV can be transmitted through mosquito bites, transmitted by supernatural means, or sharing food with a person who has HIV or AIDS. Comprehensive knowledge is defined by a combination of measures that includes: 1) having knowledge about HIV prevention methods that relate to: the knowledge that consistent use of condoms during every sexual intercourse can reduce the change of getting the AIDs virus; having just one HIV-negative and faithful partner can reduce the chances of getting the AIDS virus; 2) knowing that a healthy-looking person can have the AIDS virus; and 3) rejecting the two most common local misconceptions about AIDS transmission and prevention: that HIV can be transmitted by mosquito bites and by supernatural means. The same questions were also asked during the SIDHS 2006–2007.

Tables 13.3.1 and 13.3.2 present the percentage of women aged 15–49 and men aged 15 years and older with a comprehensive knowledge about AIDS. The results show that 31% of women and 41% of men aged 15–49 have a comprehensive knowledge about AIDS. About 61% of women and 73% of men agree that the AIDS virus cannot be transmitted by mosquito bites; 71% of women and 77% of men agree that a healthy-looking person can have HIV; 75% of women and 85% of men say that the AIDS virus cannot be transmitted by supernatural means; and 71% of women and 77% of men report that a person cannot become infected by sharing food with a person who has the AIDS virus.

The data also indicate low comprehensive knowledge about AIDS among young women, women who never married, women who have never had sex, and women living in rural areas. Comprehensive knowledge of AIDS increases with increasing level of education and wealth quintile among women. The same pattern is also observed among men in this same age group and with the same background characteristics. For instance, about 34% of young men have a comprehensive knowledge about AIDS compared with adult men; only 35% of rural men have a comprehensive knowledge compared with 61% of urban men, and only 15% of men with no education have a comprehensive knowledge about AIDS compared with 60% of better educated men.

More women and men in Honiara are more knowledgeable about AIDS than women and men living in the other regions and provinces. For instance, more than 41% of women in Honiara have a comprehensive knowledge about AIDS while less than 35% of women in Guadalcanal, Malaita and Western provinces have a comprehensive knowledge of AIDS. Women residing in other provinces have the least amount of knowledge (25%) about AIDS, and the same pattern is observed among men in other provinces.

Table 13.3.1: Comprehensive knowledge about AIDS – Women

Percentage of women 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 transmission or prevention of the AIDS virus, and the percentage with a comprehensive knowledge about AIDS by background characteristics, Solomon Islands 2015

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 miscon-ceptions[1]	Percentage with a compre-hensive knowledge about AIDS[2]	Number of women
	A healthy-looking person can have the AIDS virus	The AIDS virus cannot be transmitted by mosquito bites [CS]	The AIDS virus cannot be transmitted by supernatural means [CS]	A person cannot become infected by sharing food with a person who has the AIDS[CS]			
Age							
15–24	67.3	57.8	72.9	67.7	41.1	28.8	2,387
..15–19	62.2	54	70.8	63.8	36.5	25.1	1,241
..20–24	72.9	61.8	75.2	72.1	46	32.8	1,146
25–29	75.6	67.1	79.7	75.7	50.8	36	1,091
30–39	73.9	63.4	76.4	74.8	49.5	33.7	1,736
40–49	70.3	56	71.9	68.5	43.1	26.7	1,052
Marital status							
Never married	68.1	59.1	73.9	68.2	42.8	28.6	1,936
..Ever had sex	73.7	62.8	79.8	74.2	46.6	31.5	1,043
..Never had sex	61.6	54.9	67	61.2	38.4	25.3	893
Married/Living together	72.6	61.2	75.6	72.5	46.4	31.8	4,086
Divorced/Separated/ Widowed	68.8	63	70.3	74.2	50.1	37.6	244
Residence							
Urban	80.2	70.8	80.3	80.3	57.2	39	1,427
Rural	68.4	57.7	73.3	68.5	42	28.7	4,839
Region							
Honiara	81.3	69.7	85.8	81.8	57.6	41.3	925
Guadalcanal	67	66.7	62.5	68.8	50.2	30.7	1,140
Malaita	71.3	57.5	73.7	67.7	44.8	30.1	1,608
Western	77.1	60.7	76.3	75.1	47.4	34.6	902
Other provinces	64.8	54.6	77.7	68.4	35.2	24.7	1,690
Education							
No education	49.3	36.5	53	42.7	24.1	15.2	576
Primary	67.1	52.7	69.9	65	36.7	23.7	2,820
Secondary	77.5	70.9	83.1	81.6	54.9	39.2	2,476
More than secondary	90.9	88.7	90.9	91.8	79.7	55.6	394
Wealth quintile							
Lowest	57.5	49.7	63.2	57.3	32.2	22.1	1,158
Second	66.9	53.1	71.5	64.8	36.1	24.3	1,172
Middle	70.1	60	77.2	72	44.6	30.8	1,223
Fourth	77.2	63.8	79.2	76.9	50.2	33.8	1,253
Highest	80.8	73.3	81.3	81.9	60.1	41.4	1,460
Total 15–49	**71.1**	**60.7**	**74.9**	**71.2**	**45.4**	**31**	**6,266**

[1] Two most common local misconceptions: it is possible to get HIV from mosquito bites and it is possible to get HIV by sharing food with a person who has AIDS.

[2] Comprehensive knowledge means knowing that consistent use of 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.

Table 13.3.2: Comprehensive knowledge about AIDS – Men

Percentage of 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 transmission or prevention of the AIDS virus, and the percentage with a comprehensive knowledge about AIDS by background characteristics, Solomon Islands 2015

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 miscon-ceptions[1]	Percentage with a compre-hensive knowledge about AIDS[2]	Number of men
	A healthy-looking person can have the AIDS virus	The AIDS virus cannot be transmitted by mosquito bites	The AIDS virus cannot be transmitte d by supernatur al means	A person cannot become infected by sharing food with a person who has the AIDS			
Age							
15–24	71.4	65.1	80.7	70.4	46.3	33.6	1,124
..15–19	65.5	62.1	76.8	67.4	41.9	31.4	605
..20–24	78.3	68.7	85.3	74	51.3	36.1	519
25–29	80.5	80.8	88.3	78.6	62.4	45	479
30–39	81.1	78.5	87	82.7	59.9	46.2	830
40–49	80.9	75	85.6	81.8	60.4	45.4	516
Marital status							
Never married	72.8	68.2	81.2	72.5	49.8	37.4	1,261
..Ever had sex	78.2	73.8	86.5	75.9	54.3	42.5	825
..Never had sex	62.6	57.6	71.1	65.9	41.3	27.8	436
Married/Living together	80.5	76.8	87	80.4	58.9	43.6	1,652
Divorced/Separated/ Widowed	(88.2)	(82.3)	(91.2)	(97.1)	(71.6)	(51.2)	35
Residence							
Urban	85	89.5	95	90.9	75.1	61.2	720
Rural	74.8	67.9	81.2	72.8	48.8	34.6	2,229
Region							
Honiara	89.2	93.6	96.8	93.1	83	68.9	475
Guadalcanal	71	72	80.4	77.7	52.8	36.6	547
Malaita	79	76.3	85.4	80.8	57.7	38	710
Western	72.6	62	72.3	69.4	46.6	39	451
Other provinces	75.5	64.9	86.4	68.2	42.4	31	765
Education							
No education	48.7	53.5	65.5	55.3	33.9	15.3	92
Primary	71.9	63.2	78.7	69.1	44.3	32.9	1,202
Secondary	81.4	79.9	89.4	83.8	62	45.9	1,348
More than secondary	88.5	88.7	92.1	86.5	74	59.3	307
Wealth quintile							
Lowest	69.5	60.8	77.7	66.3	41.9	29.2	529
Second	74.6	67.4	83.7	73.3	47.4	32.8	565
Middle	75.7	68.6	82.4	74.7	50.3	36.8	528
Fourth	78.8	77.2	84.2	79.4	56.8	41.8	621
Highest	85.1	86.9	92.3	88.5	73.6	59.1	706
Total 15–49	**77.3**	**73.2**	**84.6**	**77.2**	**55.2**	**41.1**	**2,948**
50+	74.2	63.9	79.8	71.2	49.3	34.9	643
Total 15+	**76.7**	**71.5**	**83.7**	**76.1**	**54.1**	**40**	**3,591**

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

[1] Two most common local misconceptions: it is possible to get HIV from mosquito bites, and it is possible to get HIV by sharing food with person who has AIDS.

[2] Comprehensive knowledge means knowing that consistent use of 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.

Table 13.4: Knowledge of prevention of mother-to-child transmission of HIV

Percentage of women and men aged 15–49 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 the mother taking special drugs during her pregnancy, by background characteristics, Solomon Islands 2015

Background characteristic	Women				Men			
	HIV can be transmitted by breast-feeding	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	Number of women	HIV can be transmitted by breast-feeding	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	Number of men
Age								
15–24	63.6	26.9	23	2,387	56.3	28.6	20.7	1,124
..15–19	59.3	26.5	23	1,241	50.7	26.1	17.7	605
..20–24	68.3	27.3	23.1	1,146	62.9	31.6	24.1	519
25–29	66.4	32.5	24.7	1,091	66.5	31.9	23.4	479
30–39	66.9	30.5	24.7	1,736	64.8	35.7	25.6	830
40–49	67.1	27	23.2	1,052	64.9	34.3	25.1	516
Marital status								
Never married	61.6	26.7	22.3	1,936	56.4	29	20.8	1,261
..Ever had sex	66.7	26.7	22.1	1,043	62	31.6	23.3	825
..Never had sex	55.6	26.6	22.5	893	46	24.1	16.3	436
Married/Living together	67.4	29.9	24.6	4,086	65.8	34.2	24.8	1,652
Divorced/Separated/ Widowed	66.8	28.6	23.6	244	(70.4)	(47.7)	(39.7)	35
Currently pregnant								
Pregnant	65.5	26.8	22.6	399	na	na	na	na
Not pregnant or not sure	65.6	29	23.9	5,867	na	na	na	na
Missing	–	–	–	0	na	na	na	na
Residence								
Urban	71.1	35.7	29.5	1,427	65.9	39.3	27.9	720
Rural	63.9	26.9	22.1	4,839	60.6	29.8	21.7	2,229
Region								
Honiara	72.1	32.8	28	925	61	41.7	27.2	475
Guadalcanal	55.7	23.6	16.7	1,140	64.8	25.2	19.6	547
Malaita	70.4	31.4	28.3	1,608	53.9	41	22.1	710
Western	69.6	30	26	902	65.5	25.5	24.2	451
Other provinces	61.9	27.3	21	1,690	65.6	26.8	23.9	765
Education								
No education	51.1	18.7	17.7	576	45.1	20.3	12.7	92
Primary	64	27.3	22.9	2,820	58.9	31.4	21.6	1,202
Secondary	68.8	30.9	24.5	2,476	63.5	31.1	22.9	1,348
More than secondary	77.9	42.1	35.3	394	71.3	43	34.7	307
Wealth quintile								
Lowest	56.9	24.2	20.6	1,158	59	23.6	17.3	529
Second	64.9	26.9	23.5	1,172	59	29.3	20.5	565
Middle	64.9	27.9	21.9	1,223	60.7	30.9	21.9	528
Fourth	70.5	31.5	25.9	1,253	63.9	34.1	25.5	621
Highest	69.4	32.8	26.5	1,460	65.4	39.9	29	706
Total 15–49	**65.6**	**28.9**	**23.8**	**6,266**	**61.9**	**32.1**	**23.3**	**2,948**
50+	na	na	na	na	57.7	29.1	20.5	643
Total 15+	**na**	**na**	**na**	**na**	**61.1**	**31.6**	**22.8**	**3,591**

Note: Figures in parentheses are based on 25–49 unweighted cases
na = not applicable.

Although more women and men agree that a healthy-looking person can have the AIDS virus, that virus cannot be transmitted by mosquito bites, that AIDS cannot be transmitted by supernatural means, and that a person cannot become infected by sharing food with a person who has AIDS, the data also show that there is a subpopulation with different characteristics and with misconceptions about the disease. In particular, women and men in rural areas, women and men with no and little education, and women and men living in low wealth quintile households are more likely to have misconception about AIDS and have less knowledge on how it is transmitted from one person to another.

Despite government efforts to increase awareness of HIV prevention and treatment, overall awareness among women and men has not increased substantially since the SIDHS 2006–2007. The proportion of women and men aged 15–49 with comprehensive knowledge increased only 2% and 6% points, respectively.

13.4 KNOWLEDGE OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Educating people about the ways in which HIV can be transmitted from mother to child during pregnancy, delivery, and breastfeeding is critical to reducing mother-to-child transmission (MTCT) of HIV. To obtain information on these issues, respondents were asked whether the AIDS virus can be transmitted from a mother to a child during pregnancy, delivery, or breastfeeding and whether a mother who is infected with HIV can reduce the risk of transmission of the virus to the baby by taking certain drugs (antiretroviral) during pregnancy.

Table 13.4 shows that, overall, 66% of women and 62% of men know that HIV can be transmitted by breastfeeding. About 29% of women and 32% of men know that the risk of MTCT can be reduced through the use of certain drugs during pregnancy. Another 24% of women and 23% of men know that HIV can be transmitted by breastfeeding and that the risk of MTCT can be reduced by the mother taking special drugs during pregnancy.

Knowledge of MTCT in Solomon Islands is likely to be lower among women and men living in rural areas, those living in Guadalcanal Province, and among women and men with less education and living in lower wealth quintile households.

13.5 STIGMA ASSOCIATED WITH AIDS, AND ATTITUDES RELATED TO HIV AND AIDS

Knowledge and beliefs about HIV infection affect how people treat those that they know to be living with HIV or AIDS. The level of progress in reducing stigma and related attitudes such as discrimination against people living with HIV or AIDS is an important measure in supporting strategies and programmes aimed at preventing and controlling infection. In the SIDHS 2015, a number of questions were posed to respondents to measure their attitudes towards HIV-infected people. These questions concerned their willingness to buy vegetables from an infected produce seller, to let others know the HIV status of family members, and to take care of relatives who have AIDS in their own household. They were also asked whether an HIV-positive female teacher who is not sick should be allowed to continue teaching. Tables 13.5.1 and 13.5.2 show the percentages of women and men who have heard of HIV and AIDS, and who express positive attitudes towards people with HIV, by background characteristics.

Accepting attitudes with regard to all four indicators among women and men are very low, with women indicating less acceptance towards individuals with HIV or AIDS (6%) than men (16%). Only a very low proportion of women in rural areas, with no education or just a primary education, and living in lowest wealth quintile have positive attitudes towards people living with HIV or AIDS.

The results also show that more men than women are likely to express their support to each specific attitudes toward those people living with HIV or AIDS. For example, 61% of men are willing to care for a family member with AIDS living in the same house compared with 42% of women; 56% of men would buy fresh vegetables from shopkeeper who has AIDS compared with only 33% of women; and 30% of men and 19% of women would agree to allowing a female teacher who has AIDS but is not sick to continue teaching. About the same percent of women and men (67% and 66%) agree that they would not want to keep it a secret that a family member was infected with the AIDS virus.

Table 13.5.1: Accepting attitudes toward those living with HIV/AIDS – Women

Among women aged 15–49 who have heard of AIDS, the percentage expressing specific accepting attitudes toward people with HIV/AIDS, by background characteristics, Solomon Islands 2015

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 AIDS in the respondent's home	Would buy fresh vegetables from shopkeeper who has the AIDS virus	Say that a female teacher who has the AIDS virus but 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	38.8	31.1	19.5	64.2	5.1	2,139
..15–19	39.6	31.6	21	62.3	5.2	1,082
..20–24	37.9	30.6	17.8	66.1	5	1,057
25–29	42.9	36.1	20.3	66.2	7.1	1,028
30–39	43.8	32.2	17.7	68.8	6	1,591
40–49	45.5	34	19.4	70.2	6.9	956
Marital status						
Never married	42.5	33.6	22.2	62.6	6.3	1,736
..Ever had sex	45.5	35.1	21.8	60.5	6	983
..Never had sex	38.7	31.6	22.6	65.3	6.8	753
Married/Living together	41.4	31.8	17.4	68.9	5.7	3,757
Divorced/Separated/ Widowed	49.3	42.7	24.7	65.3	9	220
Residence						
Urban	48	40.4	26.6	62.2	9.5	1,389
Rural	40.1	30.3	16.7	68.3	4.9	4,325
Region						
Honiara	49.9	38.2	28.2	64.2	10.2	905
Guadalcanal	34	29.4	12.4	66.6	4.4	973
Malaita	39.4	32.3	18.4	75.1	6.3	1,404
Western	44.7	36.3	16.7	47.4	3.6	856
Other provinces	43.4	30.2	20	71.5	5.7	1,577
Education						
No education	27.8	20.2	8.2	76.6	2.3	414
Primary	37.2	25.3	13.7	69.1	3.5	2,525
Secondary	46	39.2	23.1	63	7.2	2,383
More than secondary	64.3	54.7	40.9	65.3	19.1	393
Wealth quintile						
Lowest	33	22.8	12	72.7	3.3	962
Second	36.4	26.8	13.3	73	4.2	1,032
Middle	42.6	32	16.9	64.9	4.1	1,118
Fourth	40.8	33.8	19	66.9	5.9	1,193
Highest	53	43.8	30.1	59.8	10.8	1,410
Total 15–49	**42**	**32.8**	**19.1**	**66.8**	**6**	**5,714**

Table 13.5.2: Accepting attitudes toward those living with HIV/AIDS – Men

Among men aged 15–49 who have heard of HIV/AIDS, the percentage expressing specific accepting attitudes toward people with HIV/AIDS, by background characteristics, Solomon Islands 2015

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 AIDS in the respondent's home	Would buy fresh vegetables from shopkeeper who has the AIDS virus	Say that a female teacher who has the AIDS virus but 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	57.5	47.2	26	62.5	12.6	1,051
..15–19	56.6	45.8	22.6	60	10.5	547
..20–24	58.5	48.7	29.7	65.3	14.8	504
25–29	60	58.4	31.2	64.1	17.4	474
30–39	62.7	61.8	32.1	69.7	17.4	819
40–49	65.7	59.6	33.2	70.5	18.9	511
Marital status						
Never married	58.6	50.7	28	61.5	13.4	1,188
..Ever had sex	60.9	54.3	32.5	65.3	15.8	801
..Never had sex	53.9	43.1	18.5	53.5	8.5	387
Married/Living together	62.3	58.7	31.2	70.1	17.6	1,632
Divorced/Separated/ Widowed	(73)	(68)	(39.2)	(51)	(22)	35
Residence						
Urban	54.6	67	49.7	73.3	28.2	713
Rural	63	51.6	23.4	63.9	11.8	2,142
Region						
Honiara	55.1	70.5	59	76.9	37.5	470
Guadalcanal	53.1	50.8	20.6	86	13.3	508
Malaita	59.4	44	20.6	59.1	9.4	709
Western	70.8	55.7	27.5	48.8	5.8	432
Other provinces	65.4	60	28.2	63	16.1	736
Education						
No education	45.3	36.5	16	67.4	10.3	79
Primary	58.1	43.8	19.6	63.2	9	1,144
Secondary	62.1	61.9	34.2	66.3	17.9	1,326
More than secondary	69.8	76.1	54	77.5	34.7	306
Wealth quintile						
Lowest	62.4	45.9	19.5	66.4	13.1	495
Second	56.8	44.3	20.7	60.7	9	548
Middle	64.2	51.9	22.2	61.8	9.6	512
Fourth	60.7	61.5	32	69.6	18	604
Highest	60.7	68.4	48.4	70.9	26.1	697
Total 15–49	**60.9**	**55.5**	**29.9**	**66.3**	**15.9**	**2,855**
50+	63.1	51	25	65.6	12	602
Total 15+	**61.2**	**54.7**	**29.1**	**66.1**	**15.2**	**3,457**

13.6 ATTITUDES TOWARD NEGOTIATING SAFER SEX

Knowledge about HIV transmission and ways to prevent it is not useful if people are not able to negotiate safer sex practices with their partners. To gauge attitudes towards safer sex, respondents in the SIDHS 2015 were asked whether they think a woman is justified in refusing to have sex with her husband if she knows he has sex with other women. These women were also asked whether they think that a woman in the same circumstance is justified in asking her husband to use a condom if she knows that her husband has a sexually transmitted infection (STI). The results from these questions are shown in Table 13.6.

The findings show that the majority of women and men aged 15–49 years (89% women, 88% men) believe they are justified to refuse having sexual intercourse with the husband if the wife knows he has sex with other women. Most women and men with different background characteristics believe that a woman is justified in refusing to have sexual intercourse with her husband if she knows he has sex with other women.

Table 13.6: Attitudes toward negotiating safer sexual relations with husband

Percentage of women and men aged 15–49 who believe that a woman is justified in refusing to have sexual intercourse with her husband if she knows that he has sexual intercourse with other women, and the percentage who believe that a woman is justified in asking that they use a condom if she knows that her husband has a sexually transmitted infection (STI), by background characteristics, Solomon Islands 2015

Background characteristic	Women			Men	
	Refusing to have sexual intercourse with her husband if she knows he has sex with other women	Asking that they use a condom if she knows that her husband has an STI	Number of women	Refusing to have sexual intercourse with her husband if she knows he has sex with other women	Number of men
Age					
15–24	86.3	0	2,387	84.7	1,124
..15–19	83.8	0	1,241	82.3	605
..20–24	89	0	1,146	87.4	519
25–29	90.1	0	1,091	89.6	479
30–39	91.2	0	1,736	90	830
40–49	90.2	0	1,052	89.5	516
Marital status					
Never married	85.5	0	1,936	84.9	1,261
..Ever had sex	89.5	0	1,043	87.5	825
..Never had sex	80.8	0	893	79.8	436
Married/Living together	90.4	0	4,086	90.2	1,652
Divorced/Separated/ Widowed	92	0	244	(82)	35
Residence					
Urban	91.6	0	1,427	87.3	720
Rural	88.2	0	4,839	88	2,229
Region					
Honiara	94	0	925	88.3	475
Guadalcanal	85.7	0	1,140	90	547
Malaita	94.2	0	1,608	90.3	710
Western	88.2	0	902	86.1	451
Other provinces	83.9	0	1,690	84.5	765
Education					
No education	89.4	0	576	78.1	92
Primary	87.8	0	2,820	87.2	1,202
Secondary	89.6	0	2,476	88.4	1,348
More than secondary	92.8	0	394	90.4	307
Wealth quintile					
Lowest	86.7	0	1,158	86.9	529
Second	89.5	0	1,172	90.9	565
Middle	86.1	0	1,223	85.6	528
Fourth	88.9	0	1,253	87	621
Highest	92.9	0	1,460	88.4	706
Total 15–49	**89**	**0**	**6,266**	**87.8**	**2,948**
50+	na	na	na	89.9	643
Total 15+	**na**	**na**	**na**	**88.2**	**3,591**

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

na = not applicable.

13.7 MULTIPLE SEXUAL PARTNERS

To support counter policy measures against the spread of the epidemic, sensitive information about the sexual behaviour of women and men were collected to assess the extent of multiple sexual partners and higher risk sexual behaviour. Higher risk sex is defined as having sex with a person who is neither a spouse nor a cohabiting partner (UNGASS 2005).[17] The SIDHS 2015 collected responses from women and men who had sexual intercourse with more than one sexual partner in the 12 months preceding the survey. The specific responses included the actual number of partners the women or men had intercourse with; for those who had higher risk sexual intercourse, whether a condom was used in sexual intercourse; and the average number of sexual partners during the women's or men's lifetime.

13.7.1 Multiple sexual partners and condom use

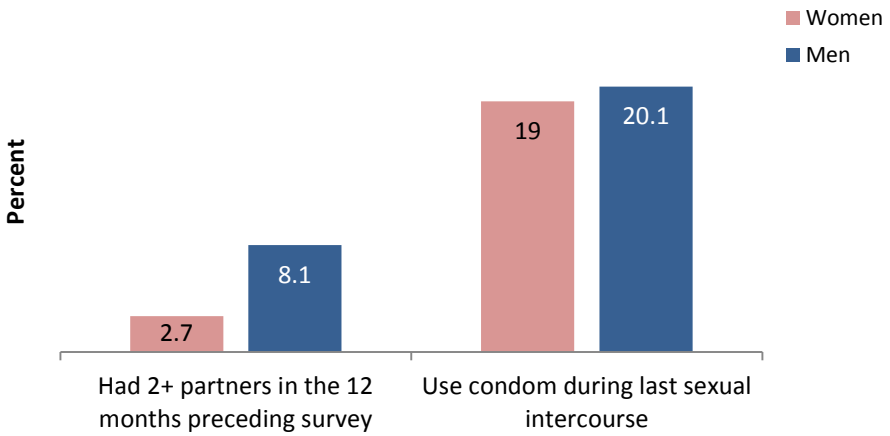
Tables 13.7.1 and 13.7.2 show the percentages of women and men that had two or more partners in the 12 months preceding the survey. The tables also show the percentages of women and men with two or more partners who used a condom during their last sexual intercourse. Finally, the tables provide information on the mean number of lifetime sexual partners among those who have ever had sexual intercourse.

A much larger proportion of men than women reported having two or more sexual partners in the 12 months preceding the survey (8% for men vs 3% for women). This trend has slightly declined since the SIDHS 2006–2007 findings (9% for men vs 4% for women). Among people aged 15–49, men had a greater number of sexual partners during their lifetime (mean number 9) than women (mean number 3.9). The mean number of lifetime sexual partners for women and men is highest in Western Province (8.2 for women, 11.9 for men) and other provinces (3.9 for women, 12.2 for women). Although the mean number of lifetime sexual partners increases with increasing education and wealth, for women, this trend slows down beyond post-secondary education, as is the case beyond the fourth-wealthiest group among both sexes.

The results further show that slightly over 5% of never-married women and 9% of women who were divorced, separated, or widowed reported having two or more sexual partners, as compared with 1% of married women.

Condom usage appears to be slightly higher among men (20%) than women (19%). The results show that close to one in four never-married women and men reported condom use during their last sexual intercourse (22% for women, 24% for men).

Figure 13.1: Among respondents aged 15–49, those who had multiple sex partners and those who used a condom during their last sexual intercourse, Solomon Islands 2015



[17]UNAIDS 2005. United Nations General Assembly Special Session on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. UNAIDS. Geneva, Switzeland.

Table 13.7.1: Multiple sexual partners – Women

Among all women aged 15–49, the percentage who had sexual intercourse with more than one sexual partner in the 12 months preceding the survey; among those having more than one partner in the12 months preceding the survey, the percentage reporting that a condom was used at last intercourse; and the mean number of sexual partners during their lifetime for women who ever had sexual intercourse, by background characteristics, Solomon Islands 2015

Background characteristic	All women		Among women who had 2+ partners in the 12 months preceding survey:		Among women who ever had sexual intercourse[1]:	
	Percentage who had 2+ partners in the 12 months preceding survey	Number of women	Percentage who reported using a condom during last sexual intercourse	Number of women	Mean number of sexual partners in lifetime	Number of women
Age						
15–24	4	2,387	20.5	95	3.4	1,552
..15–19	3.8	1,241	20.5	47	2.6	549
..20–24	4.2	1,146	20.5	48	3.9	1,004
25–29	2.5	1,091	16.4	28	4	1,042
30–39	2.3	1,736	18.3	39	4.3	1,686
40–49	0.8	1,052	14.5	8	3.9	1,022
Marital status						
Never married	5.4	1,936	22.3	105	3.7	1,033
Married or living together	1.1	4,086	14.6	44	3.9	4,029
Divorced/Separated/ Widowed	8.8	244	12.4	22	5.1	240
Residence						
Urban	3.1	1,427	15.3	45	4.1	1,195
Rural	2.6	4,839	20.4	126	3.9	4,107
Region						
Honiara	2.7	925	12.1	25	3.4	773
Guadalcanal	2.5	1,140	21.4	29	3.4	965
Malaita	1.9	1,608	24.7	31	2.1	1,299
Western	1.7	902	20.3	15	8.2	776
Other provinces	4.2	1,690	17.7	70	3.9	1,489
Education						
No education	1.2	576	0	7	1.9	520
Primary	2.4	2,820	17.4	67	4.1	2,410
Secondary	3.1	2,476	21.5	76	4.2	2,013
More than secondary	5.1	394	21.6	20	3.8	358
Wealth quintile						
Lowest	2.5	1,158	19.2	29	3.2	993
Second	2	1,172	18.5	24	3.4	992
Middle	2.9	1,223	22.8	35	4	1,056
Fourth	3	1,253	15.7	37	4.5	1,070
Highest	3.1	1,460	18.9	45	4.3	1,191
Total 15–49	**2.7**	**6,266**	**19**	**171**	**3.9**	**5,302**

[1]Means are calculated excluding respondents who gave non-numeric responses.

Table 13.7.2: Multiple sexual partners – Men

Among all men age 15–49, the percentage who had sexual intercourse with more than one sexual partner in the past 12 months; among those having more than one partner in the past 12 months, the percentage reporting that a condom was used at last intercourse; and the mean number of sexual partners during their lifetime for men who ever had sexual intercourse, by background characteristics, Solomon Islands 2015

Background characteristic	All men		Among men who had 2+ partners in the 12 months preceding survey:		Among men who ever had sexual intercourse[1]:	
	Percentage who had 2+ partners in the 12 months preceding survey	Number of men	Percentage who reported using a condom during last sexual intercourse	Number of men	Mean number of sexual partners in lifetime	Number of men
Age						
15–24	10.7	1,124	24.5	121	6.5	708
..15–19	6.5	605	28.6	39	3.9	262
..20–24	15.7	519	22.5	81	8	446
25–29	11.2	479	19.9	53	10.4	450
30–39	6.2	830	12.7	52	10.7	773
40–49	2.5	516	9.2	13	8.7	470
Marital status						
Never married	13.4	1,261	24	169	7.3	807
Married or living together	3.5	1,652	11.7	58	9.7	1,558
Divorced/Separated/ Widowed	(32.6)	35	*	11	(18.4)	34
Type of union						
In polygynous union	14.8	43	*	6	(17.2)	39
In non-polygynous union	3.2	1,609	13.2	52	9.5	1,519
Not currently in union	13.9	1,296	22.8	181	7.8	841
Residence						
Urban	11.9	720	25.1	86	9.4	612
Rural	6.9	2,229	17.3	153	8.9	1,788
Region						
Honiara	12.3	475	23.5	59	9.1	408
Guadalcanal	6.6	547	35	36	5.6	429
Malaita	2.9	710	14.1	21	6	557
Western	8.4	451	14.6	38	11.9	379
Other provinces	11.1	765	15.3	85	12.2	627
Education						
No education	4.9	92	12.5	4	4.5	79
Primary	5.5	1,202	17.8	66	8.2	915
Secondary	10.1	1,348	22.2	136	9.3	1,124
More than secondary	10.7	307	17	33	11.6	282
Wealth quintile						
Lowest	6.7	529	22.7	35	7.6	429
Second	6.6	565	22.8	37	7.7	445
Middle	5.6	528	12	30	8.7	428
Fourth	9.2	621	10.3	57	11.2	503
Highest	11.1	706	27.8	79	9.4	595
Total 15–49	**8.1**	**2,948**	**20.1**	**239**	**9**	**2,400**
50+	1.3	643	18.2	8	6.8	601
Total 15+	**6.9**	**3,591**	**20**	**247**	**8.6**	**3,001**

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

[1] Means are calculated excluding respondents who gave non-numeric responses.

13.8 PAYMENT FOR SEXUAL INTERCOURSE

In the SIDHS 2015, men who had sexual intercourse in the 12 months preceding the survey were asked if they had paid anyone for sexual intercourse during that time. Those who had engaged in paid sexual intercourse in the prior 12 months were asked if they used a condom the last time they paid for sexual intercourse. Such information provides insights into understanding the prevalence of commercial sex practices and its linkages to higher risk sexual behaviour where those involved have a high risk of contracting HIV and related STIs.

Table 13.8 shows that among males aged 15–49, about 3% reported ever paying for sexual intercourse and 2% reported having paid for sex in the 12 months preceding the survey. A similar percentage of men reported paying for sex in the SIDHS 2006–2007. The practice of paid sex in the 12 months preceding the survey was most common among men who were divorced, widowed, or separated (6%) in contrast to the SIDHS 2006–2007 where never-married men were the most predominant; among regions, the percentage of those who pay for sex ranges from slightly over 1% of men living in other provinces to slightly over 2% of men living in Guadalcanal Province.

The absolute number of men who use condom at last paid sexual intercourse in the 12 months preceding the survey compared with men who paid for sex was very low; hence, it is difficult to make conclusions about the variation of condom use. However, condom used by men aged 15–49 at last paid sex is 21%.

Table 13.8: Payment for sexual intercourse and condom use at last paid sexual intercourse

Percentage of men aged 15–49 who ever paid for sexual intercourse and the percentage reporting payment for sexual intercourse in the 12 months preceding the survey, and among them, the percentage reporting that a condom was used the last time they paid for sexual intercourse, by background characteristics, Solomon Islands 2015

Background characteristic	Among all men:			Among men who paid for sex in the 12 months preceding the survey:	
	Percentage who ever paid for sexual intercourse	Percentage who paid for sexual intercourse in the 12 months preceding survey	Number of men	Percentage reporting condom use at last paid sexual intercourse	Number of men
Age					
15–24	2.2	1.7	1,124	*	19
..15–19	1.1	1.1	605	*	7
..20–24	3.5	2.5	519	*	13
25–29	2.9	1.9	479	*	9
30–39	3.4	2.1	830	*	17
40–49	3.4	1.2	516	*	6
Marital status					
Never married	2.9	2.2	1,261	(17.6)	28
Married or living together	2.7	1.3	1,652	(27.7)	22
Divorced/Separated/ Widowed	9.5	6	35	*	2
Residence					
Urban	2.5	2.2	720	(36.5)	16
Rural	3	1.6	2,229	(14.3)	36
Region					
Honiara	2	2	475	*	10
Guadalcanal	3.2	2.4	547	*	13
Malaita	2.4	1.9	710	*	14
Western	2	1.6	451	*	7
Other provinces	4.2	1.2	765	*	9
Education					
No education	9.2	4.7	92	*	4
Primary	2.4	1.4	1,202	*	17
Secondary	2.8	2	1,348	(24.8)	27
More than secondary	3	1.2	307	*	4
Wealth quintile					
Lowest	2.9	0.6	529	*	3
Second	1.6	0.9	565	*	5
Middle	3.2	1.9	528	*	10
Fourth	4.6	3.3	621	*	21
Highest	2.2	1.9	706	*	13
Total 15–49	**2.9**	**1.8**	**2,948**	**21.1**	**52**
50+	2.8	0.7	643	20.9	5
Total 15+	**2.9**	**1.6**	**3,591**	**21.1**	**57**

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.

13.9 COVERAGE OF HIV COUNSELLING AND TESTING

Knowledge about one's HIV status has implications for motivating behavioural change and establishing linkages to care, treatment, and support services. Knowledge of HIV status is important for helping

individuals make specific decisions about adopting safer sex practices to reduce their risk of contracting or transmitting HIV. For those who are HIV positive, knowledge of their HIV status allows them to take actions to protect their sexual partners and to access treatment services.

To assess awareness of HIV testing services, respondents were asked whether they knew where to get an HIV test and whether they had ever been tested for HIV. Respondents who reported that they had been tested for HIV were asked whether they received the results of their last test. The findings for women and men aged 15–49 are presented in Tables 13.9.1 and 13.9.2, respectively.

Overall, 37% of women and 49% of men know where they can get an HIV test (see also Fig. 13.2). Knowledge of a place for HIV testing is highest among women and men who have divorced, separated and widowed (48% of women in this category, 58% of men) and among urban women and men (57% of urban women, 69% of urban men). Knowledge of where to get HIV testing among women and men increases with increasing level of education and wealth.

By marital status, never-married women and men who have not yet initiated sexual activity are least likely to know a place to obtain an HIV test (22% of never-married women, 28% of never-married men). Among the regions, women's and men's knowledge of a place to get tested for HIV is lowest in the Guadalcanal and Malaita provinces.

Tables 13.9.1 and 13.9.2 also show respondents' experience with prior HIV testing and whether they received their results. Among women and men tested for HIV in the 12 months preceding the SIDHS 2015, only 2% of women and 1% of men received their results.

Urban women are more likely (3%) than rural women (1%) to have been tested for HIV in the 12 months preceding the survey, and to have received their test results.

Figure 13.2: Knowledge of a place for HIV testing among women and men aged 15–49 by sex, Solomon Islands 2015

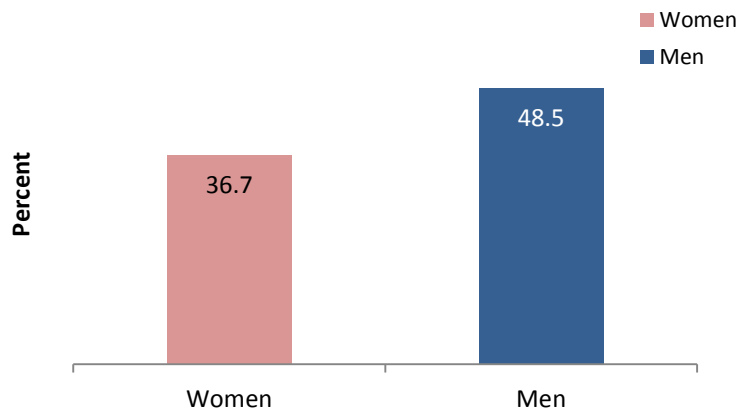


Table 13.9.1: Coverage of prior HIV testing – Women

Percentage of women aged 15–49 who know where to get an HIV test, the percent distribution of women aged 15–49 by testing status and by whether they received the results of the last test, the percentage of women ever tested, and the percentage of women aged 15–49 who were tested in the 12 months preceding the survey and received the results of the last test, according to background characteristics, Solomon Islands 2015

Background characteristic	Percentage who know where to get an HIV test	Percent distribution of women/men by testing status and by whether they received the results of the last test			Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of women
		Ever tested and received results	Ever tested, did not receive results	Never tested[1]				
Age								
15–24	29.4	3.8	1.2	95	100	5	1.6	2,387
..15–19	22.8	1.2	1	97.8	100	2.2	0.7	1,241
..20–24	36.6	6.6	1.5	92	100	8	2.7	1,146
25–29	46.2	10.3	3.7	86.1	100	13.9	2.5	1,091
30–39	40	6.2	1.8	92	100	8	1.1	1,736
40–49	38	5.3	0.9	93.8	100	6.2	0.6	1,052
Marital status								
Never married	30.7	2.9	0.8	96.4	100	3.6	1.5	1,936
..Ever had sex	38.3	4.5	1.1	94.4	100	5.6	2.5	1,043
..Never had sex	21.7	1	0.3	98.6	100	1.4	0.4	893
Married/Living together	38.9	7.1	2.1	90.8	100	9.2	1.5	4,086
Divorced/Separated/ Widowed	47.6	9.1	2.8	88.1	100	11.9	0.7	244
Residence								
Urban	56.7	11.9	1.2	86.9	100	13.1	3.3	1,427
Rural	30.8	4	1.9	94.1	100	5.9	0.9	4,839
Region								
Honiara	56.3	12.4	0.8	86.8	100	13.2	3.4	925
Guadalcanal	27.4	2.8	0.6	96.7	100	3.3	0.8	1,140
Malaita	29.7	4.3	2.4	93.2	100	6.8	0.9	1,608
Western	40.8	8.6	1.9	89.5	100	10.5	2.1	902
Other provinces	36.8	4.3	2.3	93.4	100	6.6	1.1	1,690
Education								
No education	15.6	1.5	1.5	96.9	100	3.1	0.6	576
Primary	28.2	4.3	1.7	94	100	6	1	2,820
Secondary	45.8	7	1.7	91.3	100	8.7	1.7	2,476
More than secondary	71.4	16.3	2.6	81.1	100	18.9	4.5	394
Wealth quintile								
Lowest	20.5	2.3	0.9	96.9	100	3.1	0.4	1,158
Second	27.7	3.4	2.3	94.3	100	5.7	0.5	1,172
Middle	31.2	3.9	1.5	94.6	100	5.4	0.9	1,223
Fourth	42	7.3	2.4	90.2	100	9.8	2.3	1,253
Highest	56.9	11	1.6	87.4	100	12.6	2.9	1,460
Total 15–49	**36.7**	**5.8**	**1.7**	**92.4**	**100**	**7.6**	**1.5**	**6,266**

[1] Includes 'don't know/missing'

Table 13.9.2: Coverage of prior HIV testing – Men

Percentage of men aged 15–49 who know where to get an HIV test, the percent distribution of men aged 15–49 by testing status and by whether they received the results of the last test, the percentage of men ever tested, and the percentage of men aged 15–49 who were tested in the 12 months preceding the survey and received the results of the last test, according to background characteristics, Solomon Islands 2015

Background characteristic	Percentage who know where to get an HIV test	Percent distribution of women/men by testing status and by whether they received the results of the last test			Total	Percentage ever tested	Percentage who have been tested for HIV in the 12 months preceding survey and received the results of the last test	Number of men
		Ever tested and received results	Ever tested, did not receive results	Never tested[1]				
Age								
15-24	39.8	2.2	1.1	96.7	100	3.3	0.5	1,124
..15-19	32.6	1.4	0.8	97.8	100	2.2	0.6	605
..20-24	48.2	3.3	1.4	95.3	100	4.7	0.4	519
25-29	53.0	5.2	1.9	92.9	100	7.1	1.1	479
30-39	55.7	6.0	2.5	91.5	100	8.5	1.3	830
40-49	51.6	5.5	1.6	93.0	100	7.0	1.0	516
Marital status								
Never married	42.0	3.0	1.1	95.9	100	4.1	1	1,261
..Ever had sex	49.3	4.2	1.4	94.4	100	5.6	1.4	825
..Never had sex	28.1	0.8	0.5	98.7	100	1.3	0.4	436
Married/Living together	53.2	5.3	2.2	92.5	100	7.5	0.8	1,652
Divorced/Separated/ Widowed	(57.9)	(6.3)	0.0	(93.7)	100	(6.3)	0.0	35
Residence								
Urban	68.7	3.9	1.2	94.9	100	5.1	1.2	720
Rural	41.9	4.5	1.9	93.6	100	6.4	0.8	2,229
Region								
Honiara	71.4	3.4	0.7	95.9	100	4.1	1	475
Guadalcanal	44.3	3.1	0.9	96.0	100	4.0	0.6	547
Malaita	38.4	5.9	1.8	92.4	100	7.6	1.3	710
Western	42.6	3.5	1.4	95.1	100	4.9	0.5	451
Other provinces	50.0	4.9	3.1	92.0	100	8.0	0.9	765
Education								
No education	23.8	1.0	0.0	99.0	100	1.0	0.0	92
Primary	37.2	4.2	1.0	94.8	100	5.2	0.8	1,202
Secondary	54.1	4.0	1.8	94.2	100	5.8	0.7	1,348
More than secondary	75.1	7.5	4.4	88.1	100	11.9	2.4	307
Wealth quintile								
Lowest	38.8	3.9	1.7	94.5	100	5.5	0.0	529
Second	40.1	4.8	1.0	94.2	100	5.8	1.2	565
Middle	41.1	4.3	1.1	94.6	100	5.4	0.4	528
Fourth	50.3	3.8	2.4	93.8	100	6.2	1.2	621
Highest	66.2	4.9	2.1	93.0	100	7.0	1.4	706
Total 15-49	**48.5**	**4.3**	**1.7**	**93.9**	**100**	**6.1**	**0.9**	**2,948**
50+	39.5	3.1	0.9	96	100	4.0	0.5	643
Total 15+	**46.9**	**4.1**	**1.6**	**94.3**	**100**	**5.7**	**0.8**	**3,591**

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

[1] Includes 'don't know' or 'missing'

13.10 MALE CIRCUMCISION

Evidence from studies such as Bailey et al. (2007) shows that male circumcision is correlated with lower vulnerability to transmission of STIs, including HIV. Because men who are not circumcised have a higher risk of HIV and AIDS transmission, the SIDHS 2015 asked male respondents about their circumcision status. Table 13.10 shows the results of men who report having been circumcised by background characteristics.

About 6% of men aged 15–49 reported that they are circumcised. This trend has increased marginally from 4%, as reported in the 2006–2007. Among men who are circumcised, urban men are more likely to be circumcised (8%) than rural men (5%).

By region, Malaita has the lowest percentage of circumcised men (2%) and among religious groups, the United Church has the highest percentage of circumcised men (14%).

Table 13.10: Male circumcision

Percentage of men aged 15–49 who report having been circumcised, by background characteristics, Solomon Islands 2015

Background characteristic	Percentage circumcised	Number of men
Age		
15–24	4.2	1,124
..15–19	3.8	605
..20–24	4.7	519
25–29	5	479
30–39	7.5	830
40–49	7.6	516
Residence		
Urban	8.2	720
Rural	5.1	2,229
Region		
Honiara	8.5	475
Guadalcanal	3.3	547
Malaita	1.8	710
Western	7.3	451
Other provinces	9.1	765
Religion		
Anglican	5.8	990
Roman catholic	5.4	538
United church	14.1	299
Southseas evangelical	2.5	515
Seventh day adventist	6	352
Other	4.3	249
Missing	*	6
Ethnic group		
Melanesian	4	2,833
Polynesian	32.4	56
Micronesian	77.2	50
European	*	2
Chinese	*	3
Other	*	3
Missing	*	2
Total 15–49	**5.9**	**2,948**
50+	8.7	643
Total 15+	**6.4**	**3,591**

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

13.11 SELF-REPORTING OF SEXUALLY TRANSMITTED INFECTIONS

In the SIDHS 2015, respondents who had ever had sexual intercourse were asked if in the past 12 months they experienced a disease acquired through sexual contact or if they experienced either of two symptoms associated with STIs: a bad-smelling, abnormal discharge from the vagina or penis, or a genital sore or ulcer. Table 13.11 shows the self-reported prevalence of STIs and STI symptoms among women and men. Overall, 5% of women and 4% of men reported having had an STI or experiencing STI symptoms in the 12 months preceding the survey.

Among both women and men, the prevalence of STIs and STI symptoms is higher among the 20–29 age group for women (6%) and the 20–24 age group for men (7%). By region, the prevalence is relatively high among women living in Honiara (5%) and men living in Guadalcanal Province (5%). By wealth, women living in middle and fifth wealth quintile households are slightly more likely than others to have reported an STI infection or STI symptoms. Women with a higher education (4%) and women who are married or living with a partner (4%) have the lowest prevalence of STIs or STI symptoms. Among men, those living in rural areas are more likely to have an STI or STI symptoms (4%) compared with urban men and (3%). Men with a higher education have the lowest prevalence of STIs or STI symptoms.

Table 13.11: Self-reported prevalence of sexually transmitted infections (STIs) and STI symptoms

Among women and men aged 15–49 who ever had sexual intercourse, the percentage reporting having an STI and/or symptoms of an STI in the 12 months preceding the survey, by background characteristics, Solomon Islands 2015

	Percentage of women who reported having in the 12 months preceding the survey:					Percentage of men who reported having in the 12 months preceding the survey:				
Background characteristic	**STI**	**Bad smelling/ abnormal genital discharge**	**Genital sore/ ulcer**	**STI/ genital discharge/ sore or ulcer**	**Number of women who ever had sexual inter-course**	**STI**	**Bad smelling/ abnormal discharge from penis**	**Genital sore/ ulcer**	**STI/ abnormal discharge from penis/ sore or ulcer**	**Number of men who ever had sexual inter-course**
Age										
15–24	1.9	4.3	0.9	5.2	1,568	4.1	5.3	3.3	6.4	720
..15–19	1.6	3.1	1.2	3.5	551	4.3	5	2.9	5.9	266
..20–24	2.1	5	0.8	6.1	1,017	3.9	5.4	3.6	6.6	454
25–29	1	5.2	1.1	6	1,050	4.2	3.8	1	5.3	462
30–39	0.5	3.2	0.5	3.5	1,709	2.1	1.4	0.6	2.6	811
40–49	0.9	2.7	0.6	3.5	1,035	0.3	0.5	0.4	0.7	508
Marital status										
Never married	2	3.8	1.5	4.7	1,043	4.7	5.8	2.9	7	825
..Ever had sex	2	3.8	1.5	4.7	1,043	4.7	5.8	2.9	7	825
Married/Living together	0.8	3.6	0.6	4.2	4,075	1.7	1.3	0.7	2.3	1,641
Divorced/Separated/ Widowed	2.4	7.4	0.3	8.4	244	(0.5)	(0.5)	(0.5)	(0.5)	35
Male circumcision										
Circumcised	–	–	–	–	0	7.9	8	4.2	9.4	160
Not circumcised	na	na	na	na	na	2.2	2.4	1.2	3.3	2,290
DK/Missing	na	na	na	na	na	8.4	4.8	4.1	8.4	51
Residence										
Urban	1.7	4.9	1	5.8	1,216	2.2	2.4	0.9	3.2	642
Rural	0.9	3.5	0.7	4.1	4,146	2.9	2.9	1.6	4	1,859
Region										
Honiara	1.4	4.4	0.9	5.4	784	1.7	1.8	0.7	2.1	426
Guadalcanal	1.2	2.4	0.3	2.8	978	2.9	4.5	1.7	5.1	447
Malaita	0.9	4.6	0.7	4.9	1,306	2.6	1.8	1.9	3.3	571
Western	1.2	3.5	1.3	4.7	799	2.5	2.8	1.5	3.9	391
Other provinces	1.1	3.9	0.8	4.6	1,495	3.4	3.1	1.3	4.5	666
Education										
No education	0.7	4.7	1.1	5	527	2.1	2.8	2.1	2.8	80
Primary	1.1	3.6	0.6	4.2	2,439	1.9	2.5	1.7	3.1	954
Secondary	1.2	4	0.9	4.7	2,030	3.8	3.4	1.4	4.9	1,168
More than secondary	1.1	3	0.7	3.6	366	1.4	1.2	0.4	2.3	299
Wealth quintile										
Lowest	0.9	4.7	0.7	5	999	3.5	3.1	2.6	4.1	439
Second	1.2	2.7	0.5	3.8	998	3.4	2.6	0.6	4	460
Middle	1.2	4.2	1.3	4.8	1,068	2.1	2.7	1.9	4.2	445
Fourth	0.8	3.7	0.6	4.2	1,081	2.9	3.1	1.7	4.2	531
Highest	1.4	3.8	0.8	4.5	1,216	1.9	2.4	0.6	2.9	626
Total 15–49	**1.1**	**3.8**	**0.8**	**4.5**	**5,362**	**2.7**	**2.8**	**1.4**	**3.8**	**2,501**
50+	na	na	na	na	na	1.5	1.6	0.4	2.6	634
Total 15+	**na**	**na**	**na**	**na**	**na**	**2.5**	**2.5**	**1.2**	**3.6**	**3,135**

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

na = not applicable.

13.12 PREVALENCE OF MEDICAL INJECTION

The prevalence of unsafe practices relating to the use of medical injections such as the reuse or overuse of injection equipment has implications for the quality of the healthcare service and is likely to contribute to the transmission of blood-borne infections with the potential risk of transmission of HIV through these medical injections. Table 13.12 shows that women are more likely to report receiving medical injections in the 12 months preceding the survey (23%) than men (16%). The percentage of women who received a medical injection in the 12 months preceding the SIDHS 2015 is highest among those aged 25–29 (25%), most likely because of injections given to women during antenatal care or family planning visits. Women aged 30–39 and women aged 40–49 have relatively fewer medical injections.

For women, a high proportion of those that are never married report having received a medical injection in the 12 months preceding the survey, in contrast to men where the ever had sex represent a high proportion of those that report having received a medical injection in the 12 months preceding the survey. By region, a high proportion of women in Western Province (33%) received medical injection in the 12 months preceding the survey while men living in Western Province and other provinces (17% each) received a medical injection. Injection prevalence for women increases with education and wealth in contrast to the injection prevalence for men where there is no strong pattern observed by education and wealth status.

Table 13.12: Prevalence of medical injections

Percentage of women and men aged 15–49 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, unopened package, by background characteristics, Solomon Islands 2015

Background characteristic	Women					Men				
	Percentage who received a medical injection in the 12 months preceding survey	Average number of medical injections per person in the 12 months preceding survey	Number of respond-ents	For last injection, syringe and needle taken from a new, unopened package	Number of respondents receiving medical injections in the 12 months preceding survey	Percentage who received a medical injection in the 12 months preceding survey	Average number of medical injections per person in the 12 months preceding survey	Number of respond-ents	For last injection, syringe and needle taken from a new, unopened package	Number of respondents receiving medical injections in the12 months preceding survey
Age										
15–24	23	1	2,387	91.8	550	18.2	0.5	1,124	98.3	205
..15–19	24.1	1.2	1,241	94.3	299	18.3	0.5	605	99.1	111
..20–24	21.9	0.9	1,146	88.8	251	18.1	0.4	519	97.3	94
25–29	25.1	1.3	1,091	92	273	14.5	0.5	479	96	69
30–39	21	1.2	1,736	93.8	365	15.7	0.5	830	96.6	130
40–49	21.2	1.5	1,052	93.7	223	11.6	0.4	516	96.1	60
Marital status										
Never married	23.2	1.1	1,936	92.8	450	17.9	0.5	1,261	97.8	226
..Ever had sex	23.1	1.2	1,043	92.2	241	20.5	0.5	825	98.7	169
..Never had sex	23.4	0.9	893	93.5	209	13	0.3	436	95	57
Married/Living together	22.3	1.2	4,086	92.4	911	13.8	0.5	1,652	96.5	228
Divorced/Separated/ Widowed	21.1	2	244	95.1	51	*	*	*	*	10
Residence										
Urban	27.8	1.9	1,427	95	396	17.5	0.5	720	93.9	126
Rural	21	1	4,839	91.7	1,016	15.2	0.5	2,229	98.4	338
Region										
Honiara	24.6	0.6	925	96.7	228	15.9	0.3	475	91.5	76
Guadalcanal	14.7	0.4	1,140	95.1	168	12.9	0.5	547	96.8	71
Malaita	18.7	0.9	1,608	97.8	301	16.1	0.4	710	97.1	114
Western	32.6	4	902	93.9	294	16.8	0.5	451	98.7	76
Other provinces	24.9	0.9	1,690	85	421	16.8	0.6	765	100	128

Education										
No education	17.1	0.6	576	90.9	99	*	*	*	*	12
Primary	20.2	1	2,820	93	568	12.8	0.4	1,202	96.7	153
Secondary	26	1.6	2,476	92.8	644	18.7	0.6	1,348	98.1	252
More than secondary	25.8	1.4	394	92	101	15.2	0.5	307	93	47
Wealth quintile										
Lowest	17.3	0.9	1,158	89.9	200	15.9	0.4	529	100	84
Second	19.9	0.8	1,172	90.7	234	14.7	0.5	565	97.8	83
Middle	22.5	1.1	1,223	93.7	275	18.4	0.6	528	96.7	97
Fourth	24.8	1.8	1,253	91	311	13.2	0.4	621	100	82
Highest	26.8	1.4	1,460	95.8	392	16.7	0.5	706	93.3	118
Total 15-49	**22.5**	**1.2**	**6,266**	**92.7**	**1,412**	**15.7**	**0.5**	**2,948**	**97.2**	**464**
50+	na	na	na	na	na	13.8	0.5	643	98.9	89
Total 15+	**na**	**na**	**na**	**na**	**na**	**15.4**	**0.5**	**3,591**	**97.5**	**553**

Note: Medical injections are those given by a doctor, nurse, pharmacist, dentist or other health worker. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = not applicable

13.13 COMPREHENSIVE KNOWLEDGE ABOUT AIDS AND SOURCES OF CONDOMS AMONG YOUTH

This section addresses HIV- and AIDS-related knowledge and behaviour among young adults aged 15–24. The youth of today face enormous challenges, especially during the period between their first sexual encounter and marriage, where this is often seen as a time of sexual experimentation. Faced with the very day threat of HIV/AIDs, it is a time that may involve risky behaviour. Special attention is paid to this group because of the high percentage of young people in Solomon Islands' population. Solomon Islands has a relatively high population of young people, with 41% of the population younger than 15 years, according to 2009 Population and Housing census. The world's attention on youth is also because the youth population account for half of all new HIV infections worldwide (e.g. Ross et al, 2006).

Young participants in the SIDHS 2015 were asked the same set of questions as the other participants on facts and beliefs about HIV transmission. As mentioned earlier in Section 13.3, 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. Information on the overall level of knowledge about major methods of avoiding HIV, and the rejection of major misconceptions, are shown in earlier tables in this chapter. Table 13.13 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. Condom use among young adults plays an important role in preventing the transmission of HIV and other STIs, and unwanted pregnancies. Knowledge about where to go for condoms helps young adults to obtain and use condoms

Table 13.13 shows that 34% of young men aged 15–24 have comprehensive knowledge of AIDS compared with 29% young women in the same age category. This result is similar to those of the SIDHS 2006–2007, indicating no significant change in comprehensive knowledge among the sexes since the last DHS. However, the percentage of young women who know of a source for condoms has increased from 46% in SIDHS 2006–2007 to 56% in 2015. Young men have a higher comprehensive knowledge on where to access condoms (82%) than young women (56%).

The percentage of young women and men who have widespread knowledge of AIDS and know where to get condoms increases with age, although this pattern slowly declines for women aged 23–24. Young men aged 18–19 have a greater comprehensive knowledge about AIDS (43%) than young women in the same age range (28%).

Table 13.13 also shows that the percentage of young women who have never had sex and who have a comprehensive knowledge of AIDS declined from 30% in SIDHS 2006–2007 to 28% in the SIDHS 2015. Young women and men in urban areas have a relatively a higher comprehensive knowledge about AIDS (36% for young women, 58% for young men) than rural women and men (27% for rural women, 26% for rural men). The findings also reveal that men and women in rural areas are less likely to know where to get condoms.

There is a positive correlation between the level of knowledge about AIDS among women and men and educational attainment, where the percentage of responses on comprehensive knowledge increases as educational attainment increases. Knowledge about AIDS is lowest among women with no education (12%) compared with women who have attended postsecondary education (56%).

Table 13.13: Comprehensive knowledge about AIDS and of a source of condoms among youth

Percentage of young women and young men aged 15–24 with comprehensive knowledge about AIDS and the percentage with knowledge of a source of condoms, by background characteristics, Solomon Islands 2015

Background characteristic	Women			Men		
	Percentage with comprehensive knowledge of AIDS[1]	Percentage who know a condom source[1]	Number of respondents	Percentage with comprehensive knowledge of AIDS[1]	Percentage who know a condom source[1]	Number of respondents
Age						
15–19	25.1	44.7	1,241	31.4	76.9	605
..15–17	23.6	37.6	768	24.7	71.2	381
..18–19	27.7	56.1	472	42.8	86.7	224
20–24	32.8	68.7	1,146	36.1	88.5	519
..20–22	33.9	69.5	743	35.3	88.3	317
..23–24	30.7	67.1	403	37.3	88.7	201
Marital status						
Never married	28.1	51.5	1,565	34	80.8	966
..Ever had sex	30.5	66.9	749	39	90.5	563
..Never had sex	25.9	37.4	817	27	67.2	403
Ever married	30.2	65.1	822	31.1	91.5	158
Residence						
Urban	36	66.1	567	57.6	92.1	274
Rural	26.6	53.1	1,820	25.8	79.1	850
Education						
No education	12.1	30	95	*	*	26
Primary	20	42.1	873	23.1	76.8	450
Secondary	34.3	65.4	1,351	40.2	86.8	611
More than secondary	56.1	89	69	(67.8)	(92.7)	37
Total	**28.8**	**56.2**	**2,387**	**33.6**	**82.3**	**1,124**

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

[1] Comprehensive knowledge means knowing that consistent use of 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 of the AIDS virus. 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 a source for condoms: friends, family members, and home.

13.14 AGE AT FIRST SEXUAL INTERCOURSE AMONG YOUTH

Early engagement in sexual behaviour exposures 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. Because 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 13.14 shows the percentage of young women and young men aged 15–24 who had sexual intercourse before age 15 and who had sexual intercourse before age 18. (See also Fig. 13.13) There is almost an equal proportion of young women and men who had sexual intercourse before reaching age 15 and age 18 (11% for young women, 11.2% for young men). Slightly more young men (55%) had sexual intercourse before age 18 than young women (52%).

Among young women aged 15–24, those aged 20–22 are more likely to have their first sexual intercourse before they turn 15 than women in the other age groups (e.g. 15–19 and 23–24). This is indicated by the highest percentage (13%) of women in this age group (20–22) who had sexual intercourse before age 15. For men, those in the 18–19 age category have a higher likelihood (14%) of having sexual intercourse before age 15 than young men in other age groups.

The percentage of women who have sexual intercourse before age 15 increases in the three upper age groups compared with the results observed from the SIDHS 2006–2007. Among women who had their first sexual intercourse before age 18, a higher percentage in the lowest age group when compared with the upper age group. For example, 58% of women aged 18–19 had their first sexual intercourse before age 18, compared with 48% of women aged 23–24. The increasing proportion of young adults who have sexual intercourse before age 15 and 18 clearly indicates a need for sex education in order to enable them to protect themselves from STIs, including AIDS, given that a large proportion of young adults have been exposed to sexual behaviours before age 15.

Ever-married women and men are more likely to have had their first sexual intercourse before age 15 and aged 18 (20% before age 15, 13% before age 18) compared with never-married young women and men (7% never-married young women, 11% never-married young men).

Table 13.14 also shows that a higher proportion of rural women reported having sex before age 15 and 18 (12% and 55%, respectively) compared with urban women (7% and 42%, respectively).

Table 13.14: Age at first sexual intercourse among young people

Percentage of young women and young men aged 15–24 who had sexual intercourse before age 15 and the percentage of young women and young men aged 18–24 who had sexual intercourse before age 18, by background characteristics, Solomon Islands 2015

Background characteristic	Women				Men			
	Percentage who had sexual intercourse before age 15	Number of respondents (15–24)	Percentage who had sexual intercourse before age 18	Number of respondents (18–24)	Percentage who had sexual intercourse before age 15	Number of respondents (15–24)	Percentage who had sexual intercourse before age 18	Number of respondents (18–24)
Age								
15–19	10.2	1,241	na	na	10.6	605	na	na
..15–17	9.5	768	na	na	8.5	381	na	na
..18–19	11.3	472	57.5	472	14.1	224	56.7	224
20–24	12	1,146	49.7	1,146	11.8	519	54	519
..20–22	13	743	50.3	743	13.3	317	53.5	317
..23–24	10.1	403	48.4	403	9.5	201	54.6	201
Marital status								
Never married	6.6	1,565	42.4	852	10.8	966	51.4	584
Ever married	19.5	822	62.5	767	13.2	158	67.2	158
Knows condom source[1]								
Yes	11.5	1,341	54.8	1,052	12.8	925	57	653
No	10.4	1,046	46.6	567	3.7	199	38.3	89
Residence								
Urban	7.4	567	42.2	422	13.6	274	54.3	207
Rural	12.2	1,820	55.4	1,197	10.3	850	55	535
Education								
No education	14.4	95	47.1	77	*	*	*	21
Primary	14.8	873	61.8	506	8.8	450	49.5	229
Secondary	8.8	1,351	48.8	967	12.7	611	56.7	455
More than secondary	3.6	69	29.1	69	(15.8)	(37)	(60.3)	37
Total	**11**	**2,387**	**51.9**	**1,619**	**11.2**	**1,124**	**54.8**	**743**

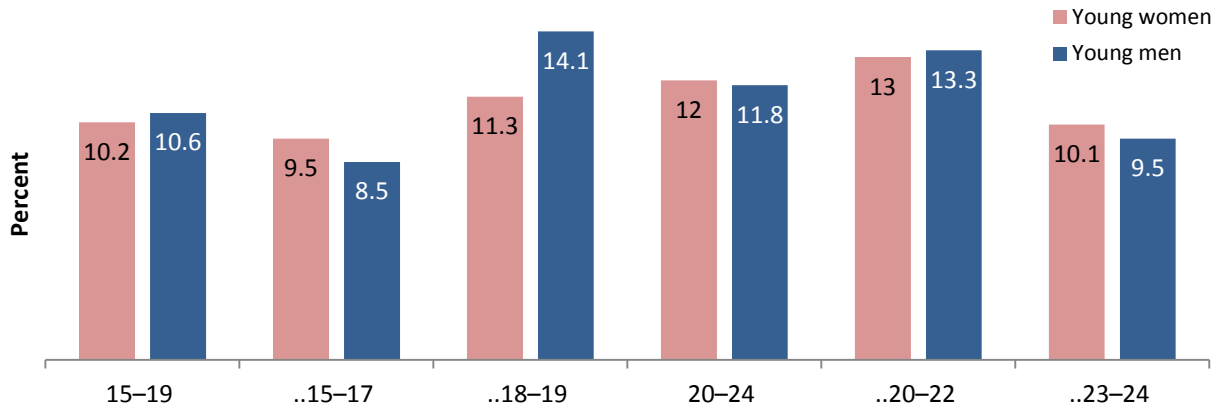
Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

na = not available

[1] For this table, the following responses are not considered a source for condoms: friends, family members and home.

Findings of the SIDHS 2015 also reveal that young women who have attended primary education account for a higher proportion of women who have had sexual intercourse before age 15 and age 18. As educational attainment increases beyond primary education, sexual intercourse before ages 15 and 18 declines among women. This indicates that increasing educational status has a positive impact on sexual intercourse before ages 15 and 18. This is in contrast to men where the opposite results are observed, which suggests that education has no significant impact on sexual intercourse before ages 15 and 18.

Figure 13.3: Percentage of young women and men aged 15–24 who had first sexual Intercourse by age group, Solomon Islands 2015



13.15 PREMARITAL SEXUAL INTERCOURSE AND CONDOM USE

Premarital sexual intercourse in this analysis 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. The table also presents the proportion of those who had premarital sexual intercourse but used a condom at their last sexual intercourse.

Among women aged 15–24 who have never married, 52% report that they did not have sexual intercourse in the 12 months preceding the survey. This is in contrast to 42% of never-married men who say they did not have sexual intercourse in the 12 months prior to the survey. This finding shows an increase from 45% of women and 30% of men in 2006–2007 who have never had sex in the 12 months before the survey.

Of the 34% of never-married women who have had sexual intercourse, only 18% used a condom during their last sexual contact. And, 25% of never-married men state that they have had sexual intercourse and used a condom at their last sexual intercourse.

According to Table 13.15, never-married women within the 20–24 age group account for the highest percentage (51%) of women who had sexual intercourse in the 12 months preceding the survey, while never-married women within the 18–19 age group account for the lowest percentage (12%) of never-married women who used a condom at their last sexual intercourse.

Higher proportions of never-married women and men (67% and 71%, respectively) never had sexual intercourse and lack the knowledge on where to obtain condoms. It is important to strengthen the coverage of family planning awareness targeting these higher percentages of women and men who are at high risk of early pregnancy, STIs, and HIV infection and transmission.

Women and men in both urban and rural areas do not show significant variations in their access to and use of a condom at the last sexual intercourse: 18% each of urban and rural women compared with 27% of urban men and 24% of rural men.

Although educational attainment is likely to show a positive role with safe sexual intercourse, the number of cases and results presented in the table are too few for discussion.

Table 13.15: Premarital sexual intercourse and condom use during premarital sexual intercourse among youth

Among never-married women and men aged 15–24, the percentage who have never had sexual intercourse, the percentage who had sexual intercourse in the 12 months preceding the survey, and, among those who had premarital sexual intercourse in the 12 months preceding the survey, the percentage who used a condom at the last sexual intercourse, by background characteristics, Solomon Islands 2015

Background characteristic	Women					Men				
	Percentage who have never had sexual intercourse	Percentage who had sexual intercourse in the 12 months preceding survey	Number of never married respond-ents	Percentage who used a condom at last sexual intercourse	Number of respond-ents	Percentage who have never had sexual intercourse	Percentage who had sexual intercourse in the 12 months preceding survey	Number of never married respond-ents	Percentage who used a condom at last sexual intercourse	Number of respond-ents
Age										
15–19	63.2	27.2	1,092	16.3	297	56.9	35.5	595	23.2	211
..15–17	76.1	18.6	714	21.3	133	71.5	23.8	381	28.4	91
..18–19	38.8	43.3	378	12.3	164	30.7	56.2	214	19.3	120
20–24	26.8	50.8	473	19.6	241	17.4	68.6	370	25.6	254
..20–22	26.7	51.7	377	19.9	195	18.6	67.5	259	24.9	175
..23–24	27.2	47.2	96	18.5	45	14.7	71.2	111	27.2	79
Knows condom source[1]										
Yes	37.9	45.2	806	21.9	364	34.7	54.7	780	25.2	427
No	67.3	22.8	759	9.1	173	(71.1)	(20.8)	(186)	(17.4)	39
Residence										
Urban	44	42.8	415	18.2	177	27.7	62.4	250	26.6	156
Rural	55.1	31.3	1,151	17.6	360	46.6	43.2	716	23.5	310
Education										
No education	*	*	*	*	12	*	*	*	*	6
Primary	66.3	23.7	533	15.8	126	59.6	33.3	384	21.5	128
Secondary	44.7	39.9	940	18.4	375	30.7	57.5	530	26.4	305
More than secondary	(37.1)	(49.5)	(49)	(27.6)	24	(10.7)	(82.8)	(32)	(20.9)	27
Total	**52.2**	**34.3**	**1,565**	**17.8**	**537**	**41.7**	**48.2**	**966**	**24.5**	**465**

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.

13.16 MULTIPLE SEXUAL PARTNERS AMONG YOUTH

HIV is commonly transmitted by having multiple sexual partners, which involves sexual relationships with partners who are neither a spouse nor a cohabiting partner. Young people are more likely to engage in temporary sexual relationships than older adults, which may expose them to STIs and HIV. 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 had multiple sexual partners in the 12 months preceding the survey, and among them, the percentage who used a condom at last intercourse, by background characteristics. Among all young women who had multiple sexual partners in the 12 months preceding the survey, 21% used a condom during their last intercourse. Women in the 18–19 and 23–24 age groups show the lowest percentages (19% for each age group) of women who used a condom at their last intercourse. Ever-married women with multiple partners account for only 4% of all women who have used a condom during their last intercourse, compared with 24% of never-married women.

According to Table 13.16.1, young women aged 15–24 in urban areas account for 16% of all women who reported using a condom during their last sexual intercourse compared with 22% of women in rural areas.

Table 13.16.1: Multiple sexual partners in the 12 months preceding the survey among young people – Women

Among all young women aged 15–24, the percentage who had sexual intercourse with more than one sexual partner in the 12 months preceding the survey, and among those having more than one partner in the 12 months preceding the survey, the percentage reporting that a condom was used at last intercourse, by background characteristics, Solomon Islands 2015

Background characteristic	Women aged 15–24		Women aged 15–24 who had 2+ partners in the 12 months preceding the survey	
	Percentage who had 2+ partners in the 12 months preceding the survey	Number of women	Percentage who reported using a condom at last intercourse	Number of women
Age				
15–19	3.8	1,241	(20.5)	47
..15–17	2.1	768	*	16
..18–19	6.7	472	(19.4)	32
20–24	4.2	1,146	(20.5)	48
..20–22	4.8	743	(21.1)	36
..23–24	3.1	403	*	12
Marital status				
Never married	5.1	1,565	23.6	80
Ever married	1.9	822	*	15
Knows condom source[1]				
Yes	5.7	1,341	21	76
No	1.8	1,046	*	19
Residence				
Urban	3.9	567	(15.5)	22
Rural	4	1,820	21.9	73
Education				
No education	2.8	95	*	3
Primary	3.4	873	(13.1)	30
Secondary	4.3	1,351	23	59
More than secondary	5.7	69	*	4
Total 15–24	**4**	**2,387**	**20.5**	**95**

Note: Figures in parethenses 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.

Table 13.16.2 shows that 11% of young men aged 15–24 had two or more partners in the 12 months preceding the survey, compared with 4% of young women in the same age group. Among all young men who had multiple partners in the 12 months preceding the survey, 25% reported that they used a condom at their last intercourse.

Although the percentage of young men in the 20–22 and 20–24 age groups who had multiple sexual partners in the 12 months preceding the survey is high (17% and 16%, respectively), they account for the lowest percentage of young men who used a condom at their last intercourse.

The findings also show that only 26% of never-married men used a condom at their last sexual intercourse. In terms of men's knowledge about a source of condoms, 25% of young men who use a condom have knowledge of where to get them.

Table 13.16.2: Multiple sexual partners in the 12 months preceding the survey among young people – Men

Among all young men aged 15–24, the percentage who had sexual intercourse with more than one sexual partner in the 12 months preceding the survey, and among those having more than one partner in the 12 months preceding the survey, the percentage reporting that a condom was used at last intercourse, by background characteristics, Solomon Islands 2015

Background characteristic	Men age 15–24		Men age 15–24 who had 2+ partners in the 12 months preceding the survey	
	Percentage who had 2+ partners in the 12 months preceding survey	Number of men	Percentage who reported using a condom at last intercourse	Number of men
Age				
15–19	6.5	605	(28.6)	39
..15–17	3.8	381	*	14
..18–19	11.1	224	(31)	25
20–24	15.7	519	22.5	81
..20–22	16.6	317	18.9	53
..23–24	14.2	201	*	29
Marital status				
Never married	11.6	966	25.7	112
Ever married	5.2	158	*	8
Knows condom source[1]				
Yes	12.3	925	25.2	114
No	3.6	199	*	7
Residence				
Urban	17.3	274	28.2	47
Rural	8.6	850	22.1	73
Education				
No education	0	26	*	0
Primary	6.2	450	33.5	28
Secondary	13.4	611	23.9	82
More than secondary	(30.4)	37	*	11
Total 15–24	**10.7**	**1,124**	**24.5**	**121**

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 AGE-MIXING IN SEXUAL RELATIONSHIPS

In a small, open society such as Solomon Islands, one is generally aware that young women are having sexual relationships with older men. Such relationships can lead to the spread of HIV and other STIs, especially in cases where an infected older partner introduces the virus to the uninfected younger partner, thereby introducing the virus into the younger, uninfected population. To examine age differences between sexual partners — so-called 'cross-generational sexual partners' — women aged 15–19 who had sexual intercourse 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 shows the percentage of men and women aged 15–19 who had sexual intercourse in the 12 months preceding the SIDHS 2015 with a partner who was 10 or more years older, by background characteristics. Overall, 11% of teenage women who had sexual intercourse in the 12 months prior to the survey stated that their partner was a man who was 10 years older than them; this is in contrast to 1% of teenage men.

In addition, 29% of ever-married young women and 3% of never-married women had intercourse with a partner 10 years older than themselves. Young women in rural areas and with primary education are more likely to have intercourse with a male partner who is 10 years older than them.

Table 13.17: Age-mixing in sexual relationships among women and men aged 15-19

Among women and men aged 15–19 who had sexual intercourse in the 12 months preceding the survey, the percentage who had sexual intercourse with a partner who was 10 or more years older than themselves, by background characteristics, Solomon Islands 2015

Background characteristic	Women aged 15–19 who had sexual intercourse in the 12 months preceding survey		Men aged 15–19 who had sexual intercourse in the 12 months preceding survey	
	Percentage who had sexual intercourse with a man 10+ years older	Number of women	Percentage who had sexual intercourse with a woman 10+ years older	Number of men
Age				
..15–17	12.1	183	0	91
..18–19	10.3	253	1.2	130
Marital status				
Never married	2.8	297	0.8	211
Ever married	28.7	139	*	10
Knows condom source[1]				
Yes	12	251	0.8	203
No	9.7	185	*	19
Residence				
Urban	8.1	108	2.7	60
Rural	12	328	0	161
Education				
No education	*	14	*	8
Primary	13.5	144	1.1	71
Secondary	9.3	277	0.6	139
More than secondary	*	1	*	3
Total	**11**	**436**	**0.7**	**221**

Note: 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 RECENT HIV TESTS

Having knowledge about one's HIV status is crucial in motiving oneself to take control over his or her sexual behaviour to avoid transmitting the virus to others. The focus on measuring the coverage of HIV testing among youth is crucial because youth are often faced with many challenges and obstacles to testing and counselling, and many are vulnerable to the threat of infection.

This section discusses vital information based on survey questions that asked respondents whether they have ever been tested for HIV, the timing of the most recent HIV test (within the previous 12 months), and whether the respondent received the results of their most recent HIV test. The intent was not to learn the results of the recent HIV test, but to capture the responses on whether the respondent received the results after their most recent HIV test.

Table 13.18 shows the percentage of young women and men aged 15–24 who had sexual intercourse in the 12 months preceding the survey. The table also presents the percentage of those young women and men who have been tested for HIV and received the results of their last test.

Among young women aged 15–24 who had sexual intercourse in the 12 months preceding the survey, 2% had been tested for HIV and had received the result of their last test; this is in contrast to 1% of young men in a similar age category.

Overall, the number of young women and men who were tested for HIV and who also received their test results is very low. Young urban women who are never married, have knowledge of where to get condoms, and have a post-secondary education are the most likely to be tested for HIV and are more likely to receive the results of their HIV test.

Table 13.18: Recent HIV tests among youth

Among young women and young men aged 15–24 who had sexual intercourse in the 12 months preceding the survey, the percentage who were tested for HIV in the 12 months preceding the survey and received the results of the last test, by background characteristics, Solomon Islands 2015

Background characteristic	Women aged 15–24 who had sexual intercourse in the 12 months preceding the survey:		Men aged 15–24 who had sexual intercourse in the 12 months preceding the survey:	
	Percentage who have been tested for HIV in the 12 months preceding survey and received the results of the last test	Number of women	Percentage who have been tested for HIV in the 12 months preceding survey and received the results of the last test	Number of men
Age				
15–19	1.4	436	0.9	221
..15–17	2.5	183	0.9	91
..18–19	0.6	253	0.9	130
20–24	2.8	881	0.2	398
..20–22	4	550	0.1	231
..23–24	0.8	330	0.4	167
Marital status				
Never married	2.6	537	0.6	465
Ever married	2.2	779	0	154
Knows condom source[1]				
Yes	2.9	876	0.5	568
No	1.3	441	0	51
Residence				
Urban	3.6	325	1.6	180
Rural	1.9	992	0	439
Education				
No education	0	58	*	13
Primary	1.9	443	0.1	191
Secondary	2.7	774	0.7	385
More than secondary	(3.6)	42	0	30
Total	**2.3**	**1,317**	**0.5**	**619**

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.

CHAPTER 14 DISABILITIES

by Elsie Taloafiri, National Community Base Reabilitation Coordinator, SIMoHMS

KEY FINDINGS

- Difficulties in seeing, hearing, walking or climbing stairs were the most common types of disabilities reported during the SIDHS 2015.
- About 10% of all people aged 5 years and older have some difficulties in seeing, 6% reported having some difficulties in hearing, the same percentage (6%) reported having some difficulties in walking, 7% reported having some difficulties in climbing stairs, 8.4% reported having some difficulties in cognition (remembering or concentrating), 4% reported having some difficulties in self-care (washing or dressing), and 3% reported having some difficulties in communication.
- The prevalence of disability increases with age, with those aged 60 and over showing higher percentages of disabilities compared with those aged 5–59.
- The prevalence of disability is higher among rural populations than urban populations.
- About 16% of males and 17% of females have a mild to severe disability.
- One-half of people aged 60 and older reported having a mild to severe disability, with about 24% within the same age group indicating that they have a moderate to severe disability.
- Nearly 17% of people living in rural areas have a mild to severe disability, compared with 15% of people in urban areas.
- Of those with a mild to severe disability, about 54% have primary level education; those with moderate to severe disability, 46% have primary level and from those with severe disability only 28% claimed to have primary level of education.
- Secondary level among the population with mild to severe disability accounted for 6% while only 3% among the population with severe disability.
- 66% of the population with a mild to severe disability are legally married; of those with severe disability only 28% are in the same married status.

INTRODUCTION

People with disabilities are disadvantaged in schools, workplaces and in other public places and are, therefore, considered to be vulnerable in Solomon Islands. As a signatory to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Solomon Islands agrees to uphold the rights of people with disabilities, and is, therefore, obliged to: 'Promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity'.

The government of Solomon Islands has developed a Solomon Islands National Disability Inclusive Development Policy and Plan of Action to promote effective service delivery to people with disabilities. This policy, together with the Plan of Action, incorporates many of the provisions in both the Incheon Strategy Making the Rights Real Framework for Action, and the UNCRPD, which is an indication of a government's commitment to advancing the status of people with disabilities. These two documents provide the government with a solid framework from which to work together to build a society that is inclusive, barrier-free and rights-based for all its people. The government has called on donor partners, regional agencies, disability organisations, non-governmental organisations and businesses, to work with the government to ensure that the strategies identified in the policies are achieved.

The definition of disability in this survey is in line with the definition from the International Classification of Functioning, Disability and Health, and refers to any difficulties encountered in any or all areas of functioning as follows:

- **impairments** – are problems in body functions or alterations in body structure;
- **activity limitations** – are difficulties in executing activities (e.g. walking or eating); and
- **participation restriction** – are problems with involvement in any area of life (e.g. facing discrimination in employment or transport).

The module questions on disability included in the SIDHS 2015 were adopted from the Washington Group, and asked whether the person had any difficulties due to health problems in seeing, hearing, walking or climbing steps; remembering or concentrating; self-care (e.g. washing or dressing, communicating and understanding); or being understood. The questions were asked of persons aged 5 years and above but in cases where the individual was not available, the interviewers were advised to use the head of the household or the most senior household member as proxies.

14.1 DISABILITY BY FUNCTIONAL DOMAIN AND DEGREE OF DIFFICULTIES

Table 14.1 and Figure 14.1 present the distribution of all people aged 5 years and over with disabilities by functional domain, degree of difficulties, and by social background characteristics. Overall, 10% of all people aged 5 years over reported having difficulty in seeing. Difficulty in remembering or concentrating is reported to be the second highest problem, with 8% of people falling into this category, while 7% reported difficulty in climbing stairs. Difficulty in walking and hearing accounted for 6% of difficulties, with self-care being the least common difficulty at 3%.

The results also indicate that people are more likely to report having some difficulties (mild) in all of the seven functional domains of seeing (8%), hearing and walking (5% each), climbing stairs (5%), cognition (7%), self-care (3%) and communication (2%) as opposed to other moderate and severe difficulties.

Similarly, the data also show that people are more likely to report having some difficulties (mild) regardless of their different background characteristics. However, older people aged 60 and above and those people living in rural areas are more likely to have some difficulties than their counterparts in urban areas. There is little difference in reported difficulties among men and women.

Figure 14.1: Percent distribution of all people aged 5 and above with difficulties, by functional domain, Solomon Islands 2015

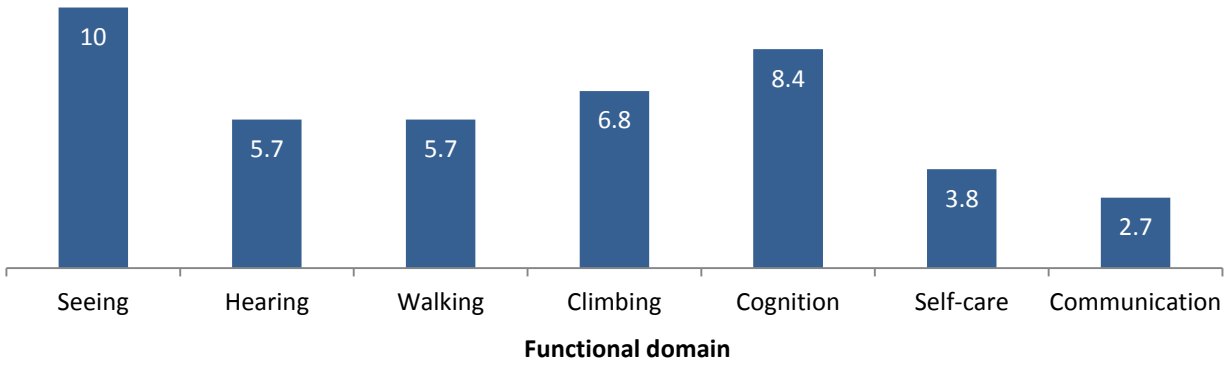


Table 14.1: Disability by functional domain

Percentage distribution of the population aged 5 years and older with disabilities by functional domain and degree of difficulty, Solomon 2015

Functional domain / Severity	Sex		Residence		Age group			Total
	Male	Female	Urban	Rural	5–17 years	18–59 years	60+ years	
Seeing								
Some difficulty (mild)	8.3	8.5	6.1	9	0.8	9.7	42.8	8.4
A lot of difficulty (moderate)	1.4	1.6	0.7	1.7	0.1	0.9	14.5	1.5
Cannot do at all (severe)	0.1	0.1	0	0.1	0	0	0.8	0.1
Total	**9.8**	**10.2**	**6.8**	**10.8**	**0.9**	**10.6**	**58**	**10**
Hearing								
Some difficulty (mild)	4.5	4.8	3	5.1	2.4	3.8	24.5	4.6
A lot of difficulty (moderate)	1	0.9	0.5	1.1	0.3	0.5	8	0.9
Cannot do at all (severe)	0.1	0.1	0	0.1	0	0.1	0.6	0.1
Total	**5.6**	**5.8**	**3.5**	**6.2**	**2.7**	**4.4**	**33.1**	**5.7**
Walking								
Some difficulty (mild)	4.1	5	3.4	4.9	0.6	4.3	30.6	4.6
A lot of difficulty (moderate)	0.9	0.9	0.5	1	0.1	0.4	9.6	0.9
Cannot do at all (severe)	0.3	0.2	0.1	0.3	0.1	0.1	1.8	0.2
Total	**5.3**	**6.1**	**4**	**6.1**	**0.8**	**4.8**	**42**	**5.7**
Climbing								
Some difficulty (mild)	4.5	6	3.9	5.6	0.8	5.2	31.8	5.3
A lot of difficulty (moderate)	1.2	1.3	0.9	1.3	0.2	0.6	12.7	1.2
Cannot do at all (severe)	0.3	0.3	0.1	0.4	0.1	0.1	3.2	0.3
Total	**6**	**7.7**	**5**	**7.3**	**1.1**	**6**	**47.7**	**6.8**
Cognition (Remembering or Concentrating)								
Some difficulty (mild)	6.8	7.6	5.4	7.7	2.6	7.4	33	7.2
A lot of difficulty (moderate)	1	1.1	0.5	1.2	0.3	0.8	7.9	1.1
Cannot do at all (severe)	0.1	0.1	0	0.1	0.1	0	0.7	0.1
Total	**7.9**	**8.8**	**6**	**9**	**2.9**	**8.2**	**41.6**	**8.4**
Self-care (washing or dressing)								
Some difficulty (mild)	3	2.6	3.5	2.6	2.5	1.7	13.2	2.8
A lot of difficulty (moderate)	0.7	0.5	0.9	0.5	0.7	0.3	2.7	0.6
Cannot do at all (severe)	0.6	0.3	0.4	0.5	0.6	0.2	1.7	0.4
Total	**4.2**	**3.4**	**4.8**	**3.6**	**3.8**	**2.1**	**17.6**	**3.8**
Communication								
Some difficulty (mild)	1.9	1.9	4	1.4	2.2	1.3	5	1.9
A lot of difficulty (moderate)	0.5	0.4	0.8	0.4	0.6	0.2	1.7	0.5
Cannot do at all (severe)	0.4	0.3	0.3	0.3	0.4	0.2	0.5	0.3
Total	**2.8**	**2.6**	**5.1**	**2.1**	**3.1**	**1.8**	**7.2**	**2.7**
Total	**11,395**	**11,627**	**4,632**	**18,390**	**9,039**	**12,450**	**1,533**	**23,022**

Table 14.2 shows the prevalence of disabilities for those aged 5 years and older having 'at least some difficulty, a lot of difficulty and unable to do at all'. The prevalence rate of disability among the population aged 5 years and above is calculated as follows:

- **at least some difficulty** – scores at least one in mild to severe difficult in each different domain;
- **at least a lot of difficulty** – scores at least one in moderate and severe difficulty in each different domain; and
- **unable to do all** – scores at least one in severe difficulty only for each domain.

The results show a low prevalence rate for disabilities in the category 'unable to do at all' for all functional domains. This is the group of people stating that they are unable to do any of the functional domains listed. Self-care and communication are reported to be the two leading difficulties as opposed to other functional domains at 2.2% and 1.5%, respectively.

The prevalence rate for disabilities in the category of 'at least a lot of difficulty' ranges from a low of 1% of people having at least a lot of difficulty with hearing, to the highest percentage of 3% among people having difficulties with self-care.

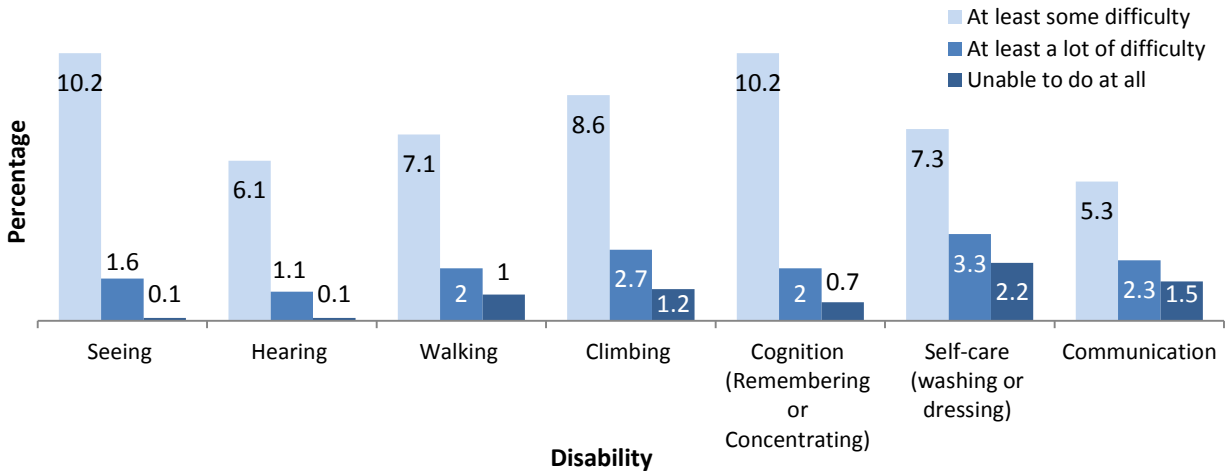
As expected, the disability prevalence is much higher in the category 'at least some difficulty' because this category includes all people with mild, moderate and severe difficulties in all domains reported. The highest rate of difficulty is with seeing and cognition (remembering and concentrating) with a rate of 10% for each.

Table 14.2: Disability by functional domain and degree of difficulty

Prevalence of disability among the population aged 5 years and older by domain and degree of difficulty, Solomon 2015

Background characteristic	At least some difficulty (%)	At least a lot of difficulty (%)	Unable to do at all (%)
Functional domain			
Seeing	10.2	1.6	0.1
Hearing	6.1	1.1	0.1
Walking	7.1	2	1
Climbing	8.6	2.7	1.2
Cognition (Remembering or Concentrating)	10.2	2	0.7
Self-care (washing or dressing)	7.3	3.3	2.2
Communication	5.3	2.3	1.5

Figure 14.2: Prevalence of disabilities among the population aged 5 years and older by functional domain, Solomon Islands 2015



14.2 DISABILITY BASED ON THREE THRESHOLDS BY BACKGROUND CHARACTERISTICS

Tables 14.3 and 14.4 show the prevalence of disabilities among the population aged 5 years and older based on three thresholds by background characteristics. The three thresholds are calculated as:

- mild to severe disability – at least one of the six domain is scored 'some difficulty or higher';
- moderate to severe disability – at least one of the six domain is scored 'a lot of difficulty or higher'; and
- severe disability – at least one of the six domains is scored 'cannot do it at all'.

The results show that the prevalence of disabilities among the population aged 5 years and older was reported higher for the threshold 'mild to severe disability' across all functional domains, with 16% of people having a mild to severe disability compared with a moderate to severe disability (4%), or a severe disability (1%). About 78% of the total population aged 5 years and older reported no disability at all across all functional domains.

Females are slightly more likely to have a mild to severe disability (17%) and moderate to severe disability (4%) than males. Older population aged 55 and above are more likely to have a moderate to severe disability and severe disability. The data show that as people age, the likelihood of becoming disabled increases.

Table 14.3: Disability based on three thresholds

Prevalence of disability among the population aged 5 years and older based on three thresholds, Solomon 2015

Background characteristic	Percentage of population aged 5 years and older with:					Total
	No disability	Mild to severe disability	Moderate to severe disability	Severe disability	Not applicable or missing	
Sex						
Male	78	15.9	3.4	1.1	1.5	11,264
Female	77.7	16.6	3.5	0.9	1.5	11,561
Age group						
5–17 years	87.6	7.7	1.5	0.9	2.4	8,987
18–59 years	77.7	18.4	2.4	0.5	1	12,318
60+ years	21.6	49	23.5	5.4	0.4	1,520
Age						
5 to 9	84.4	9.3	2.3	1.3	2.7	3,894
10 to 14	89.8	6.4	1	0.6	2.2	3,549
15 to 19	90.7	6.3	0.9	0.6	1.6	2,415
20 to 24	91.2	6	0.7	0.6	1.6	1,973
25 to 29	88.1	9.5	0.8	0.3	1.3	1,972
30 to 34	84.3	13	1.4	0.5	0.7	1,795
35 to 39	78.8	18.5	1	0.5	1.2	1,679
40 to 44	70.2	26	2.5	0.8	0.6	1,310
45 to 49	63.3	32.2	3.1	0.6	0.7	1,050
50 to 54	53	38.5	7.4	0.2	1	1,030
55 to 59	42.7	45.5	10.7	0.9	0.3	637
60+	21.6	49	23.5	5.4	0.4	1,520
Residence						
Urban	79.8	14.6	3.1	0.7	1.8	4,605
Rural	77.3	16.6	3.5	1.1	1.4	18,219
Wealth index quintile						
Poorest	77.2	16.8	4	0.8	1.3	4,440
Poorer	78	15.7	3.9	1.3	1.1	4,496
Middle	76.7	16.9	3.7	1.1	1.6	4,522
Richer	77.5	17	3	0.8	1.7	4,605
Richest	79.6	14.8	2.7	1.1	1.8	4,761
Total	**77.8**	**16.2**	**3.5**	**1**	**1.5**	**22,825**

Rural populations have a higher prevalence of disability in all three thresholds than urban populations. The population aged 5 years and above with no disability was slightly lower in rural areas at 77% than in urban areas at 80%.

Mild to severe disability is less common among people living in the richest wealth quintile households.

Table 14.4 presents the percentage of the population aged 5 years and older by their disability status and by their educational attainment and marital status. Of the total population aged 5 years and older with a mild to severe disability, 17% have never attended school, 34% of those with a moderate to severe disability also claimed to have never attended school, while 45% of those with a severe disability also stated that they have never attended school. About 10% of those with no disability have never attended school.

Table 14.4: Disability by educational attainment, marital status and degree of difficulty

Educational attainment and marital status among population aged 5 years and above by disability status based on three thresholds, Solomon 2015

Background characteristic	Total	Percentage of population aged 5 years and above with:				
		No disability	Mild to severe disability	Moderate to severe disability	Severe disability	Not applicable or missing
Never attended to school	12.6	10.4	17	33.6	45.1	9.9
Education						
No education	22.5	21.2	22	40.6	53.5	30.5
Primary	47.9	47.1	53.7	46.2	27.9	46.7
Secondary	23.4	25.7	17	8.5	10.4	18
More than secondary	5.2	5.2	6	2.8	3.1	3.8
Marital status						
Married legally	43.4	38.8	66.4	51.7	27.7	22.7
Defacto	1.3	1.3	1.5	2.1	0.3	0.5
Divorced	3	1.2	7	19.6	17.9	1.5
Separated	19.4	22	8.8	9.7	21.6	21.8
Not applicable (< 15 years)	32.6	36.4	15.9	16.1	31.1	53.2
Total	**22,825**	**17,764**	**3,702**	**788**	**229**	**342**

Note: Percentage total may not equal to 100 due to rounding off or missing category.

Educational attainment and marital status among population aged 5 years and above by disability status based on three thresholds, Solomon 2015

The data also show that the proportion of the population with a disability declined with an increasing level of education. For instance, of the population with a mild to severe disability, 54% have only a primary education compared with only 6% who have more than a secondary education. Similarly, of those with a moderate and severe disability, 46% have a primary education as opposed to 3% who have more than a secondary education. Of those with a severe disability, 54% have no education compared with 3% who have more than a secondary education.

Among the population aged 5 years and older with a disability, 66% of those with a mild to severe disability are legally married, 52% with a moderate to severe disability and 28% in the severe disability status are also legally married. Divorced and separated among the disability population is also evident. About 20% of those with a moderated to severe disability, and 18% of those with severe disability, are divorced. Within the severe disability status, about 22% of people are separated.

Figure 14.3: Prevalence of disability by educational attainment, Solomon Islands 2015

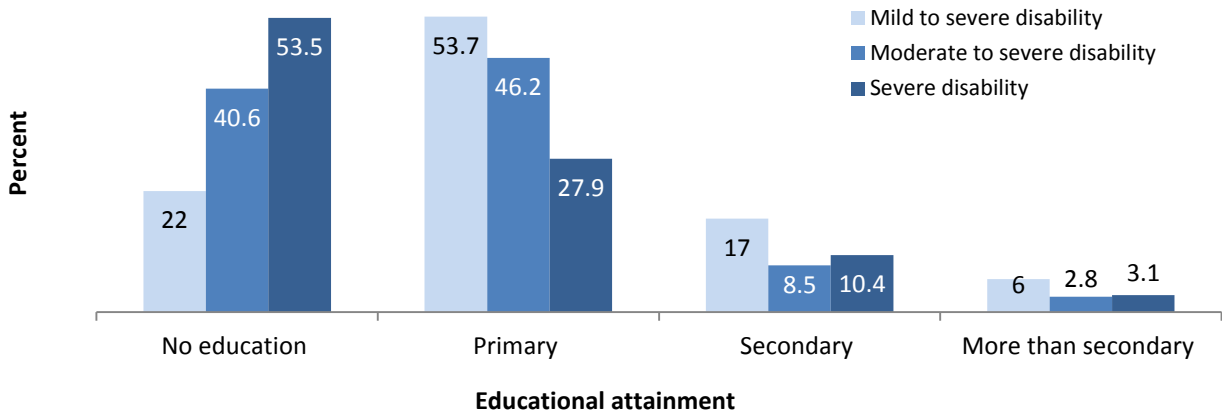
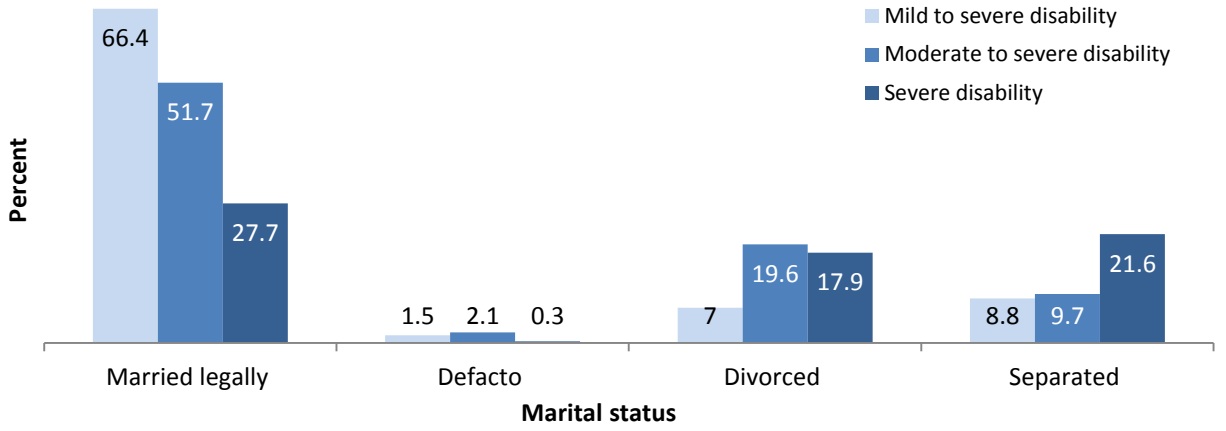


Figure 14.4: Prevalence of disability by marital status, Solomon Islands 2015



CHAPTER 15 WOMEN'S EMPOWERMENT AND DEMOGRAPHIC AND HEALTH OUTCOME

by Hugo Hebala, Under-Secretary, and Simon Dolaiano, Research Officer (Gender), Solomon Islands Ministry of Women Youth Children and Family Affairs; and Willie Lahari, Statistics Advisor, Solomon Islands Resource Facility

KEY FINDINGS

- Nearly 52% of currently married women and 91% of currently married men are employed. The percentage of currently employed married women and men increased from 42% and 87% respectively in the SIDHS 2006–2007.
- About 39% of women are engaged in paid (cash) employment (versus 33% in 2006–2007) compared with 50% of men (versus 52% in 2006–2007).
- The percentage of unpaid working women declined slightly from 56% in 2006–2007 to 50% in 2015.
- Only 27% of women who earn cash decide on how their own earnings are spent. The majority of women (56%) who earn cash make joint decisions with their husband or partner about the use of their earnings.
- About 66% of currently married women participate in all three decisions regarding: their own health care, making household purchases, and visits to their family or relatives. This is an improvement from 57% in 2006–2007.
- About six in ten women own a house and about four in ten women own land, mostly in joint ownership with their husbands. Ownership of assets is less influenced by background demographic characteristics.
- Close to eight in ten women agree with at least one of the specified justifications for wife beating, an increase from about seven in ten women in 2006–2007. This indicates that the majority of women still believe that violence against women is justified under certain circumstances. Close to six in ten men agree with at least one specified justification for wife beating.
- The use of contraception is lower among women who do not participate in any household decisions than those who do. A similar finding was observed in 2006–2007.

INTRODUCTION

This chapter examines the relationship between women's empowerment, and demographic and health outcomes in order to gain insights into the status of women in Solomon Islands. It focuses on analysing selected measures of women's empowerment by their background socioeconomic characteristics against selected gender-based, reproductive and family planning outcomes.

The analysis of women's empowerment is also about the issue of gender; where socially constructed roles, behaviours and attributes of women and men, over time have implications on gender inequalities in regard to access to opportunities, resources and services. In the SIDHS 2015, the selected measures of women's empowerment comprise two empowerment measures: 1) women's participation in household decision-making, and 2) women's attitude towards gender-based violence (GBV).[18] Some of the women-based questions (e.g. wife beating) are directly compared with those of men, particularly husbands and partners.[19] Data used in this analysis are sourced from the women's questionnaire. Data collected on general

[18] In the SIDHS 2006–2007, three sets of empowerment measures was analysed: 1) women's participation in household decision-making, 2) their attitudes towards wife beating, and 3) their attitudes towards a wife's right to refuse sexual intercourse with her husband or partner. The latter is excluded in view of the international revisions to the SIDHS 2015 women's questionnaire.

[19] The term 'husband' and/or 'wife' is based on women's responses to the question if she is 'currently married with a man', and not necessarily obtained or ascertained from any formal evidence such as a marriage certificate or certification by custom. Similarly, the term 'partner' refers to women's responses for 'living with a man' as if married.

background characteristics include: age, number of living children, residence, region or province, education, and wealth quintile. Specific data collected to assess the degree of women' status and empowerment include: employment and cash-earnings of women and men, control over women's and men's cash-earnings, ownership of assets by women and men, participation in decision-making, attitude towards wife beating, current use of contraception, family planning and reproductive health care.

A significant number of questions that were asked in the SIDHS 2006–2007 were asked in the SIDHS 2015. This allows for direct comparison of results between the surveys. The new inclusions in the SIDHS 2015 include questions on control over women's cash-earnings, the relative magnitude of women's cash earnings, and women's control over their own earnings and over those of their husband. Additional background questions such as main economic activity, sector of employment, occupation, and the inclusion of income quintile are collected to supplement future research and comparisons about women's empowerment.[20]

15.1 EMPLOYMENT AND FORM OF EARNINGS

Employment status, particularly employment for cash, is an important determinant of empowerment for women as well as men. Employment enables women to participate in household decision-making and empowers women by placing them in control of financial matters.

Table 15.1 shows the percentage of currently married women and men aged 15–49 who were employed at any time in the 12 months preceding the survey, and the percent distribution of employed women and men by the type of earnings they received (cash only, cash and in-kind, in-kind only).

Findings of the SIDHS 2015 show that about five in ten women (52%) compared with nine in ten men (91%) are employed. In the SIDHS 2006–2007, about four in ten women (42%) compared with nearly nine in ten men (87%) were employed. These findings show that although gender disparities in employment remain significant, in terms of progress since the 2006–2007, the results indicate a progressive shift in attitudes and the narrowing of the gender-based employment gap, with improvements in women's employment (paid and unpaid) growth since 2006–2007.[21]

Women engaged in paid employment (cash only) account for 39% of all currently employed married women as opposed to 33% in 2006–2007. This is in comparison to 50% of men engaged in paid employment as opposed to 52% in 2006–2007. The percentage of male paid employment (cash only) has slightly declined while women's has slightly increased since 2006–2007. In terms of unpaid employment, men are more likely to be paid for their work than women. However, results of the SIDHS 2015 also show the decline in the proportion of unpaid women from 56% in 2006–2007 to 50% in 2015. A direct relationship between age and paid employment (cash only) is observed; as age increases among both sexes up to age 44, paid employment (cash only) also increases. This is the opposite of what was observed in 2006–2007.

[20] Such data, although not fully analysed in this chapter, will supplement analysis and comparisons with similar data from the census and household income and expenditure surveys. Future analysis using these data will provide further insights about women's empowerment, particularly with regard to economic empowerment.

[21] The 2012–2013 Solomon Islands Household Income and Expenditure Survey found that although female heads of households earn less than their male counterparts in most wage-earning categories, they earn more than their male counterparts in income bracket of SBD 10,000 to SBD 30,000. Also, although men earn three times more than females in annual wages/salaries, in terms of their average (median) wages/salaries per capita, the gap in earnings show that women earn less than 10% of men's average earnings (men: SBD19,700; women: SBD17,680).

Table 15.1: Employment and cash earnings of currently married women and men

Percentage of currently married women and men aged 15–49 who were employed at any time in the 12 months preceding the survey, and the percent distribution of currently married women and men employed in the 12 months preceding the survey by type of earnings and according to age, Solomon Islands 2015

Age	Among currently married respondents:		Percent distribution of currently married respondents employed in the 12 months preceding survey, by type of earnings:						
	Percentage employed in the 12 months preceding survey	Number of respondents	Cash only	Cash and in-kind	In-kind only	Not paid	Missing/ don't know	Total	Number of respondents
WOMEN									
Age									
15–19	30.7	141	(32.3)	(3.5)	(2.6)	(61.6)	0	100	43
20–24	37.3	645	34.4	8.4	2.9	53.8	0.4	100	241
25–29	50.2	850	37.7	7.5	1.9	52.4	0.4	100	426
30–34	52.9	824	42.7	4.8	3	49.3	0.2	100	435
35–39	57.2	715	43.1	7.5	2.6	46.5	0.2	100	409
40–44	59.5	504	41.1	7.3	3.1	48.5	0	100	300
45–49	63.7	407	34.8	10.9	4.6	49.7	0	100	259
Total 15–49	**51.7**	**4,086**	**39.4**	**7.4**	**2.9**	**50.1**	**0.2**	**100**	**2,114**
50+	–	0	–	–	–	–	–	0	0
Total 15+	**–**	**0**	**–**	**–**	**–**	**–**	**–**	**0**	**0**
MEN									
Age									
15–19	*	10	*	*	*	*	0	100	9
20–24	87.2	148	40.5	9.4	4.4	45.7	0	100	129
25–29	89.5	307	49.1	8.1	2.3	40.4	0	100	274
30–34	91	355	49.2	11.8	3.2	35.8	0	100	323
35–39	88.9	350	51.4	7.7	3.5	37.5	0	100	311
40–44	93.4	258	54.2	11.7	3	31.1	0	100	241
45–49	93.4	226	53.1	7.1	2	37.8	0	100	211
Total 15–49	**90.6**	**1,652**	**50.2**	**9.3**	**3**	**37.5**	**0**	**100**	**1,497**
50+	76.8	585	34.3	11.1	4.1	50.6	0	100	449
Total 15+	**87**	**2,237**	**46.5**	**9.7**	**3.2**	**40.5**	**0**	**100**	**1,947**

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.

15.2 CONTROL OVER AND RELATIVE MAGNITUDE OF A WOMEN'S HUSBAND'S EARNINGS

Control over household and other resources, particularly income (cash earnings) is a key measure in the overall empowerment of women and men. Women's active participation in economic activities reflects the productive capacity of women and portrays women's autonomy and the extent of their control over their own productive earnings within and outside of the household setting. Access to cash earnings by women can become a significant instrument in transforming perceptions of and traditions on gender relations in decision-making, and over time bringing about social and economic changes to women's status in society. This section examines the control over a wife's and husband's earnings, and control over a wife's earnings and the relative size of a husband's and wife's earnings.

15.2.1 Control over wife's earnings

The SIDHS 2015 asked currently married women aged 15–49 who received cash earnings from employment about the nature of control over who used the wife's cash earnings by whether the wife earned more or less than her husband, according to background characteristics. The data provide useful insights from wives that were not previously collected in the SIDHS 2006–2007.

According to Table 15.2.1, less than a third (30%) of all currently married women have control over the use of their own cash earnings, indicating that women still do not have total control over their earnings. About half (56%) of all currently married women stated that decisions about the use of the wife's cash earnings are made jointly by both the wife and husband or partner.

Table 15.2.1: Control over women's cash earnings and relative magnitude of women's cash earnings

Percent distribution of currently married women aged 15–49 who received cash earnings for employment in the 12 months preceding the survey by person who decides how wife's cash earnings are used and by whether she earned more or less than her husband, according to background characteristics, Solomon Islands 2015

Background characteristic	Person who decides how the wife's cash earnings are used:						Wife's cash earnings compared with husband's cash earnings:						Number of women
	Mainly wife	Wife and husband jointly	Mainly husband	Other	Missing	Total	More	Less	About the same	Husband has no earnings	Don't know/ Missing	Total	
Age													
15–19	*	*	*	*	*	100	*	*	*	*	*	100	16
20–24	30.1	53.6	12	0	4.2	100	18.1	48.8	17.6	10.5	5	100	103
25–29	33.2	55	7.6	0.4	3.8	100	24.3	45.4	19.3	5.4	5.6	100	193
30–34	22.6	56.9	13.8	0	6.8	100	22.7	48.7	16.4	4.5	7.7	100	207
35–39	25.8	59.3	9.4	0	5.5	100	21.5	51.1	13.9	7.1	6.4	100	207
40–44	26	58.7	7.6	0	7.7	100	22.8	44.2	16.8	6.3	9.8	100	145
45–49	25.9	54.6	10.5	0	9	100	24.3	36.2	21.1	7.9	10.5	100	118
Number of living children													
0	26.8	50.1	14.4	0.7	8	100	24.2	35.8	23.4	7	9.7	100	123
1–2	28.6	55.4	10.7	0	5.3	100	18.8	49.5	17.9	7.3	6.5	100	335
3–4	25.2	61.1	8.5	0	5.2	100	24.9	45.2	16.5	6.5	7	100	319
5+	26.8	54.2	10.1	0	8.9	100	22.7	48	14.4	5.5	9.4	100	213
Residence													
Urban	35	51.8	10.5	0	2.7	100	24.7	47.8	16.6	6.2	4.6	100	327
Rural	22.9	58.5	10.2	0.1	8.2	100	21.1	45.2	17.7	6.8	9.2	100	663
Region													
Honiara	37	55	6.2	0	1.8	100	26.4	46.3	16.9	6.3	4.2	100	197
Guadalcanal	28.5	48.7	17.6	0	5.1	100	16.8	44.4	25.2	6.4	7.1	100	170
Malaita	39.3	47.3	7.1	0	6.4	100	23.2	38.4	24.9	6.1	7.4	100	175
Western	11.9	57.6	16.3	0.6	13.6	100	18.1	49.3	15.9	1.8	14.9	100	124
Other provinces	19	65.5	8.5	0	7	100	23.7	49.8	10	9	7.4	100	324
Education													
No education	40.6	46.7	9.3	0	3.4	100	24.3	44.6	22.4	3.9	4.7	100	61
Primary	21.5	58.2	10.9	0.2	9.2	100	15.4	48	17.3	8.6	10.7	100	389
Secondary	26.6	57.2	10.5	0	5.6	100	27.7	45.2	15	5.6	6.6	100	354
More than secondary	34.3	53.8	9.1	0	2.9	100	25.7	44.4	20.5	5.1	4.3	100	186
Wealth quintile													
Lowest	27.1	55.9	10.9	0	6.1	100	16.7	43.3	14.8	17.6	7.6	100	101
Second	25.7	57.9	8.2	0	8.1	100	23.2	43.7	18.5	4.7	9.8	100	134
Middle	21.4	60.7	10.4	0	7.6	100	24.3	46.1	15.9	5.3	8.5	100	203
Fourth	28.6	53.1	9.1	0.4	8.9	100	20.1	45.3	19.5	5.7	9.4	100	224
Highest	29.5	55.3	11.8	0	3.3	100	23.9	48.5	17.1	5.4	5.1	100	327
Total	**26.9**	**56.3**	**10.3**	**0.1**	**6.4**	**100**	**22.3**	**46.1**	**17.4**	**6.6**	**7.7**	**100**	**989**

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

As women get older, especially from ages 20–39 and the number of their living children increases (especially from 0–4), over half of all decisions about the use of the wife's cash earnings are made jointly. This trend declines after age 40, especially among women with more than 4 living children. This indicates the generational shifts in attitudes, especially when more young married couples are jointly making financial decisions. These findings further reveal the effect of aging and children's welfare in decision-making over the wife's earnings. Joint decisions are more frequent among women in Western Province and Honiara, excluding all other individual provinces.

Although education is a key driver of women's empowerment, the overall results are mixed and there is no significant variation. The findings show that the majority of currently married women with an education are jointly involved in decision-making over the wife's cash earnings, while women with no education are almost divided in the control over the wife's earnings: 41% report that the wife has control and 48% report joint control over wife's earnings.

In terms of the relative magnitude of the wife's cash-earnings to those of her husband or partner, the majority (46%) of currently married women stated that they earned less than their husband's cash-earnings; close to half of these women are aged 20-39. Despite earlier evidence of improvements in women's cash-employment, income (cash-earnings) inequality by gender appears biased against women and widens as wealth increases. In urban areas, women are more likely to earn more than their husband; this is in contrast to rural women. In addition, these women are likely to live in Western Province and Honiara. These findings further suggest that although education appears to have an influence on gender inequality with regard to cash earnings, the percentage of women with no education who earned the same, less or more than the husbands was similar to that for women with more than a secondary education. This suggests that the impact of education on gender inequality with regard to cash earnings is not significantly different for women with no education and those with more education.

15.2.2 Control over husband's or partner's earnings

This section examines the decisions by men (husband or partner) and women (wife) over who decides how the husband's cash earnings will be used, by selected background characteristics. While the SIDHS 2006–2007 posed a similar question as that asked in the SIDHS 2015 to currently married women aged 15–49, in 2015 the same question was also asked to currently married men in a similar age category.

Table 15.2.2 shows that 14% of currently married women (compared with 16% in 2006–2007) state that they decide on how the husband's cash earnings are to be used. This slight decline in attitude suggests that the progressive status of women in influencing decisions regarding the use of their husband's earnings has not improved. The results of the SIDHS 2015 indicate that women have a somewhat lesser degree of control over the use of their husband's earnings. About 29% of women report that their husband is the main decision maker in the use of his cash earnings. However, the 2015 findings tend to support the predominant view among both men (61%) and women (55%) that control over the use of the husband's earnings is jointly decided on by the couple. A similar observation was seen in the SIDHS 2006–2007 results.

Although the 2015 findings show, for the first time, that close to six in ten (58%) younger women, especially those in the 15–19 age category, make joint decisions regarding their husband/partner's cash earnings, older women continue to make joint decisions on how their husband's cash earnings are used. This suggests changing attitudes especially among younger women regarding their husband's earnings.

The 2015 responses among both women and men, compared with those of just women in 2006–2007, show evidence that as education increases (up to secondary level), the percentage of joint decisions also increases. This may not necessarily be less empowering for women alone to control their husband's earnings, but indicates that women's participation with their husbands empowers household decision-making even where it relates to the use of the husband's earnings.

Urban women and men appear likely to support the view of the wife having joint control of her husband's earnings than rural women, and these women are likely to live in Guadalcanal and Western provinces. While it is observed that wealthier women, especially those in the fourth wealth quintile, show predominance in the joint control over the use of the husband's earnings, responses from men show men in middle wealth

quintiles have a predominant say in joint decisions. This reflects differences in attitudes, especially among men when wealth is considered.

Table 15.2.2: Control over men's cash earnings

Percent distributions of currently married men aged 15–49 who receive cash earnings and of currently married women aged 15–49 whose husbands receive cash earnings, by person who decides how husband's cash earnings are used, according to background characteristics, Solomon Islands 2015

Background characteristic	Men							Women						
	Mainly wife	Husband and wife jointly	Mainly husband	Other	Missing	Total	Number	Mainly wife	Husband and wife jointly	Mainly husband	Other	Missing	Total	Number
Age														
15–19	*	*	*	*	*	*	4	8	57.6	32.8	0	1.6	100	133
20–24	10	64.5	19.8	2.3	3.5	100	64	14.1	54.6	29.3	0.2	1.8	100	598
25–29	13.4	65.5	17.5	0	3.7	100	157	15.3	54.1	29.2	0	1.4	100	813
30–34	13.7	64.1	12.6	0.5	9	100	197	15.1	50.5	32.3	0.1	2	100	785
35–39	12.9	57.4	23	0	6.7	100	184	13.6	58.1	27.1	0	1.2	100	686
40–44	14.8	57.1	18.3	0.7	9.1	100	159	12.6	58.1	28.2	0.2	1	100	478
45–49	16.5	59.7	18.7	0	5.1	100	127	15.5	58.4	25.7	0	0.5	100	388
Number of living children														
0	11.1	59.1	19.1	0	10.8	100	91	12.2	55.2	30.5	0.2	2	100	376
1–2	12	64.6	18.3	0.7	4.4	100	338	14.3	55.4	28.3	0	2	100	1,266
3–4	13.1	62.6	16.6	0	7.6	100	272	14.2	54.3	30.6	0	0.9	100	1,257
5+	19.1	53.7	19.5	0.6	7.1	100	190	14.9	55.9	27.9	0.2	1.2	100	981
Residence														
Urban	16.4	61.7	18.9	0	3	100	295	11.6	57.7	28.5	0.1	2	100	794
Rural	12.4	60.8	17.7	0.6	8.4	100	596	14.9	54.5	29.3	0.1	1.3	100	3,086
Region														
Honiara	16.6	62.2	17	0	4.2	100	192	13.6	59.3	24.7	0.1	2.3	100	503
Guadalcanal	11.6	67.1	17.2	1.6	2.5	100	232	9.6	55.1	34.2	0	1.1	100	727
Malaita	19.3	57.5	15.6	0	7.6	100	156	21.6	50.4	27	0	1	100	1,007
Western	10.1	65	17.7	0	7.3	100	155	11.5	64.3	22.9	0.3	1	100	569
Other provinces	11.5	50.7	23.9	0	13.9	100	157	12.2	52.9	33.1	0	1.8	100	1,074
Education														
No education	(9.9)	(54.7)	(22.2)	(0)	(13.2)	100	29	13.4	51.9	33.8	0	1	100	433
Primary	14.1	60.2	19.6	0.3	5.8	100	324	14.5	54.3	30	0.1	1.1	100	1,909
Secondary	13.5	63.2	16.6	0.7	6	100	360	13.9	57.3	26.8	0	2	100	1,277
More than secondary	14.3	59.7	17.9	0	8.1	100	178	15.5	56.4	26.4	0	1.7	100	261
Wealth quintile														
Lowest	18.4	59	11.9	1	9.7	100	104	18.3	49.2	31.7	0	0.7	100	758
Second	12.1	59.9	18.7	1.1	8.2	100	132	17.3	48.8	32.1	0	1.9	100	760
Middle	11.8	64.4	16.2	0	7.6	100	165	12.3	57.3	28.7	0.1	1.5	100	787
Fourth	10.4	58.8	22.4	0.5	7.9	100	218	12.8	63.2	22.4	0.1	1.5	100	792
Highest	16.6	62.3	17.9	0	3.1	100	273	10.7	56.9	30.9	0.1	1.4	100	784
Total 15–49	**13.7**	**61.1**	**18.1**	**0.4**	**6.6**	**100**	**891**	**14.2**	**55.2**	**29.1**	**0.1**	**1.4**	**100**	**3,880**
50+	13.4	64.7	16.4	0	5.6	100	204	na	na	na	na	na	na	na
Total 15+	**13.7**	**61.8**	**17.8**	**0.3**	**6.4**	**100**	**1,095**	**na**	**na**	**na**	**na**	**na**	**na**	**na**

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.

15.3 CONTROL OVER WOMEN'S EARNINGS AND RELATIVE SIZE OF HUSBAND'S AND WIFE'S EARNINGS

Among currently married women aged 15–49 years who earned cash and whose husband's earned cash in the 12 months before the survey, Table 15.3 shows who decides how the wife's or the husband's cash earnings are used, according to the relative magnitude of the wife's and the husband's cash-earnings. These findings provide further insight about the degree of control by the respective sexes with respect to cash-earnings and its connection to women's empowerment.

Overall, the 2015 results show that in view of the varying magnitudes of a woman's earnings relative to those of her husband, joint decisions over the use of either the wife or husband's cash earnings appear predominant (55–56%) among women. The argument that often those who earn the money are more likely to be the decision-maker is evident from the responses following joint decisions. Although a third of currently married women earn more than their husbands, it is less likely that they have more autonomy and bargaining power over the use of their husband's earnings, than their own earnings.

It is obvious that other factors apart from the relative size of a wife and husband's earnings also have influence over the control over the wife or husband's earnings. Such results show that even in the case where women work with no earnings or do not work at all, they participate in household decision-making with their husbands over the husbands earnings. This confirms that other sociological, cultural or economic factors have a say in the couple's financial decision-making within or outside the household.

Table 15.3: Women's control over their own earnings and over those of their husbands

Percent distribution of currently married women aged 15-49 with cash earnings in the12 months preceding the survey by the person who decides how the wife's cash earnings are used, and the percent distribution of currently married women aged 15-49 whose husbands have cash earnings by the person who decides how the husband's cash earnings are used, according to the relationship between wife's and husband's cash earnings, Solomon Islands 2015

Women's earnings relative to husband's earnings	Person who decides how the wife's cash earnings are used:							Person who decides how husband's cash earnings are used:						
	Mainly wife	Wife and husband jointly	Mainly husband	Other	Missing	Total	Number	Mainly wife	Wife and husband jointly	Mainly husband	Other	Missing	Total	Number of women
More than husband	31.6	60.5	7.9	0	0	100	221	13.7	63.4	23	0	0	100	221
Less than husband	31	57	12.1	0	0	100	456	11.8	58	30.2	0	0	100	456
Same as husband	16.2	69.8	14	0	0	100	172	8.4	68.8	22.4	0	0.4	100	172
Husband has no cash earnings or did not work	35.6	56.5	7.8	0	0	100	65	na	na	na	na	na	na	0
Woman worked but has no cash earnings	na	na	na	na	na	na	0	16.3	51.1	31.5	0.1	1.1	100	1,094
Woman did not work	na	na	na	na	na	na	0	14.4	54.1	29.4	0	2	100	1,863
Don't know/ Missing	5.5	9.6	0.7	1.1	83.2	100	76	9.3	68	14.3	2	6.3	100	76
Total[1]	**26.9**	**56.3**	**10.3**	**0.1**	**6.4**	**100**	**989**	**14.2**	**55.2**	**29.1**	**0.1**	**1.4**	**100**	**3,880**

na = not applicable

[1] Includes cases where a woman does not know whether she earned more or less than her husband.

15.4 OWNERSHIP OF ASSETS

Ownership and control over assets such as property and land by women and men have implications on gender relations within the family unit as well as broader implications on livelihoods within communities. When women have limited access to or are generally denied ownership and control of assets, their ability to engage actively in decision-making within the family is weakened. While the challenges of cultural norms and related

ideologies against women's ownership of assets may limit women's bargaining power and autonomy, the benefits often lead to improved economic status and livelihoods within and outside the household.

Tables 15.4.1 and 15.4.2 present the ownership of assets for women and men, respectively. According to Table 15.4.1, the overall responses of women aged 15–49 show that the majority of women neither own a house (43%) nor own land (50%). As age increases, the percentage of women neither owning a house nor land decreases, while solely owning a house increases. This reflects a shift in behaviour among older women towards solely owning and jointly owning a house and land. Moreover, as a woman's level of education increases from no education to post-secondary education, the percentage of women who do not own a house or land increases, accounting for over half of all responses from women with a secondary level education. This suggests that education does not have a significant impact on women's ownership of assets. The majority of these women reside in urban areas, do not own a house (66%), and do not own land (64%).

Table 15.4.1: Ownership of assets – Women

Percent distribution of women aged 15–49 by ownership of housing and land, according to background characteristics, Solomon Islands 2015

Background characteristic	Percentage who own a house:						Percentage who own a land:						
	Alone	Jointly	Alone and jointly	Percentage who do not own a house	Missing	Total	Alone	Jointly	Alone and jointly	Percentage who do not own land	Missing	Total	Number
Age													
15–19	5.2	18.7	6.4	69.5	0.2	100	2.4	23.1	6.8	66.5	1.1	100	1,241
20–24	8.1	21	15.3	55.5	0.1	100	6.2	22.4	11.8	59.2	0.4	100	1,146
25–29	13	29.2	15	42	0.8	100	8.3	26.9	13.5	50.1	1.2	100	1,091
30–34	16.8	32.2	19.4	31.3	0.3	100	10.1	28.9	15.3	44.5	1.2	100	933
35–39	19.1	32.8	22.9	24.8	0.4	100	14.8	28.2	19.4	37.2	0.4	100	803
40–44	19.8	34.9	21.8	23.3	0.2	100	14.7	33.2	15.2	36	0.9	100	576
45–49	23.1	35.1	22.1	19.4	0.3	100	15.5	31.2	21.8	30.7	0.9	100	476
Residence													
Urban	10	13.3	10	66.4	0.4	100	7.9	18.2	9	63.9	1	100	1,427
Rural	14.3	31.7	18	35.7	0.3	100	9.3	29.2	15	45.6	0.8	100	4,839
Region													
Honiara	8.4	9.9	9.5	71.9	0.4	100	8.1	13.1	8.1	69.9	0.8	100	925
Guadalcanal	18.6	25.8	19.5	35.8	0.3	100	8.6	37.5	15.8	36.3	1.9	100	1,140
Malaita	10.4	27.9	22	39.5	0.2	100	5.2	18.3	10.8	65	0.7	100	1,608
Western	14.4	36	11.3	37.9	0.4	100	11	34.6	14.7	38.9	0.8	100	902
Other provinces	14.6	33.4	14.7	36.9	0.5	100	12.3	30.7	17.4	39.1	0.5	100	1,690
Education													
No education	17.4	32.9	24.4	25.3	0	100	9	29.8	14.2	46.4	0.4	100	576
Primary	15.2	31	17.7	35.7	0.4	100	10.1	27.7	15.2	46	0.9	100	2,820
Secondary	11	24.1	12.9	51.6	0.3	100	7.6	25.8	12.2	53.3	1	100	2,476
More than secondary	8.3	16	13.4	61.9	0.5	100	9.3	20.6	10.9	58.8	0.4	100	394
Wealth quintile													
Lowest	15.2	36.8	19.8	27.8	0.4	100	9.5	32.4	14.4	42.8	0.9	100	1,158
Second	14	34.1	17	34.7	0.2	100	8.3	29.3	14.9	46.3	1.2	100	1,172
Middle	15.4	29.4	18.3	36.5	0.4	100	9.4	26.3	14.2	49.2	0.9	100	1,223
Fourth	14.9	27	17.8	40.1	0.2	100	10.6	27.6	16.4	44.6	0.8	100	1,253
Highest	8	13.7	9.5	68.3	0.5	100	7.4	19.7	9.2	63	0.7	100	1,460
Total	**13.3**	**27.5**	**16.2**	**42.7**	**0.3**	**100**	**9**	**26.7**	**13.7**	**49.8**	**0.9**	**100**	**6,266**

na = not applicable

The majority of the wealthiest women neither own a house (68%) nor land (63%). In contrast, ownership of house and land appear mainly among women in the poorest wealth quintile (36.8%). These results imply that other factors such as customary belief and practises are likely to have an influence over the ownership of assets than the socioeconomic status of women.

Table 15.4.2 presents responses of men regarding house and land ownership. As can be seen, ownership varies considerably from those of women, with some exceptions — education and wealth — although the effect of these characteristics on men's overall ownership of assets is varied, as is the case for women. The overall findings show that more men than women aged 15–49, own a house solely (35% men, 13% women). About 37% of men have joint ownership of land compared with 27% of women.

Table 15.4.2: Ownership of assets – Men

Percent distribution of men aged 15–49 by ownership of housing and land, according to background characteristics, Solomon Islands 2015

	Percentage who own a house:						Percentage who own a land:						
Background characteristic	**Alone**	**Jointly**	**Alone and jointly**	**Percent-age who do not own a house**	**Missing**	**Total**	**Alone**	**Jointly**	**Alone and jointly**	**Percent-age who do not own land**	**Missing**	**Total**	**Number**
Age													
15–19	9.7	28	7.5	54.4	0.3	100	5.7	36.4	10.6	45.9	1.4	100	605
20–24	19.9	25.5	10	44.6	0	100	8.1	35.7	13.4	40.7	2.1	100	519
25–29	33.8	25.5	8.3	31.9	0.6	100	11.4	42.5	12.6	31.1	2.4	100	479
30–34	51	16.8	6.5	25.8	0	100	16.5	40.2	14.6	25.4	3.3	100	436
35–39	52	11.9	9.9	25.8	0.4	100	15.2	35.3	17.7	29.8	2	100	394
40–44	49.6	16.4	11.4	21.2	1.3	100	17.5	35.4	17.5	24.5	5	100	280
45–49	60.8	12.8	6.7	19.3	0.4	100	22.1	34.4	15.9	25.2	2.4	100	236
Residence													
Urban	15.9	7.1	5.9	71	0	100	8.9	10.9	4.9	73.1	2.2	100	720
Rural	41.2	25.5	9.4	23.4	0.5	100	13.5	46	17	21	2.6	100	2,229
Region													
Honiara	7.4	6.4	7.4	78.8	0	100	3.8	7.7	3.1	84.7	0.7	100	475
Guadalcanal	50.3	22.7	4.4	22	0.6	100	23.3	42.2	4	27.4	3	100	547
Malaita	44.7	28.3	18.4	8.6	0	100	12.4	52.8	22.8	9.8	2.2	100	710
Western	25.5	19.1	1.5	53.9	0	100	15.9	33.4	5.2	45.1	0.4	100	451
Other provinces	37.9	23.3	7.3	30.5	1	100	7.7	40.6	25.1	22	4.7	100	765
Education													
No education	39.3	22.2	12.7	25.8	0	100	10.5	37.8	13.4	38.4	0	100	92
Primary	42.6	23	8.6	25.3	0.5	100	14.4	43.4	14	25.5	2.7	100	1,202
Secondary	29.1	21.6	8.4	40.5	0.4	100	10.2	36.1	14.3	37.1	2.3	100	1,348
More than secondary	30.2	10.4	8	51.5	0	100	14.2	20.1	13	49.6	3.2	100	307
Wealth quintile													
Lowest	44.6	29.8	11.9	12.8	0.9	100	9.7	51.2	20.4	14.8	3.9	100	529
Second	40.3	32.7	9.9	17.1	0	100	12.4	51.4	17.4	17.6	1.1	100	565
Middle	44.6	17.9	9.9	27.4	0.3	100	15.2	40.2	18.2	22.8	3.6	100	528
Fourth	35.4	20.1	6.6	37.4	0.5	100	16.3	37.6	11.7	31.7	2.6	100	621
Highest	16.3	8.3	5.6	69.6	0.2	100	8.6	13.7	5.5	70.7	1.5	100	706
Total 15-49	**35**	**21**	**8.6**	**35**	**0.4**	**100**	**12.3**	**37.4**	**14**	**33.7**	**2.5**	**100**	**2,948**
50+	60.1	13.9	11.8	13.9	0.4	100	23.2	38.2	21.5	14.9	2.2	100	643
Total 15+	**39.5**	**19.7**	**9.1**	**31.2**	**0.4**	**100**	**14.3**	**37.6**	**15.4**	**30.3**	**2.4**	**100**	**3,591**

As with women, similar behaviour is observed among men: as age increases, sole ownership of a house and land also increases. However, in the case of men over 29, there is a shift in attitude as those who jointly own

a house and do not own a house are likely to move towards solely owning a house. The majority of those men who own a house solely are found in rural areas and in Guadalcanal Province. In urban areas, the majority of men do not have a house or land, which is similar to situation with women.

15.5 WOMEN'S PARTICIPATION IN DECISION-MAKING

Decision-making is a process that is essential to and integrated part of women's empowerment. Whether the context of this process is political, socioeconomic or cultural, involving women enhances their ability to participate in making decisions on issues that affect their personal and collective circumstances. Issues and challenges affecting women such as gender-based violence impinge on gender roles and women's choices in decision-making. In Solomon Islands, the government adopted a policy on the elimination of violence against women based on the recommendation of the United Nations to protect women and children from such violence. Inadequate representation of women at all levels of decision-making is seen as a major obstacle against collective action to tackle the prevalence and impact of such violence within families and communities. Information drawn from the 2006–2007 and SIDHS 2015s provides insights to the current status and progress of women's engagement in decision-making, and its relationship to women's demographic and health behaviour.

In both the 2006–2007 and SIDHS 2015s, specific questions were asked to gather information about women's autonomy and status specific to their participation in decision-making at the household level. Information was collected on three types of decision-making: 1) their own health care; 2) making major household purchases; and 3) visits to family or relatives. In the SIDHS 2006–2007, an additional type of decision-making question ('purchases of daily household needs') was asked. In 2015, this specific information was obtained in a supplementary table including, for the first time, responses from men. Table 15.5 shows information about currently married women and currently married men aged 15–49 by the person who usually makes decisions about the three aforementioned issues, by background characteristics. According to Table 15.5, if women make final decisions alone, or jointly with their husbands or partners, they are considered to participate in a decision-making process with some degree of autonomy.

Table 15.5: Participation in decision-making

Percent distribution of currently married women and currently married men aged 15–49 by the person who usually makes decisions about various issues, Solomon Islands 2015

Decision	Mainly wife	Wife and husband jointly	Mainly husband	Someone else	Other	Missing	Total	Number of respondents
WOMEN								
Own health care	29.3	57.4	12.1	0.2	0.1	0.9	100	4,086
Major household purchases	22.3	53.2	23.2	0.3	0.1	0.8	100	4,086
Visits to her family or relatives	16.3	64.3	18.2	0.2	0.2	0.8	100	4,086
MEN								
Own health care	14.1	66.3	19.2	0.1	0	0.4	100	1,652
Major household purchases	14.7	69.9	14.8	0.2	0	0.4	100	1,652
Visits to her family or relatives	–	–	–	–	–	–	0	0

The majority of all currently married women in 2015 reported that all three household decisions are made jointly between the wife and husband (or partner). A similar finding was observed in the SIDHS 2006–2007. However, up to 23% of women do not participate in certain household decisions, a decline from 29% in 2006–2007. In terms of decisions regarding spending on major household purchases, 23% of women in 2015 (compared with 29% in 2006–2007) stated that this decision is predominantly made by men. This shows that attitudes have not changed significantly although there has been a slight decline in women's participation in deciding about household purchases. When a similar question was introduced for men in 2015, the majority of men agreed with women that household decisions regarding women's health care and

household purchases are made jointly. This suggest that men are more likely to accept their wives' opinions in making decisions, and are likely to show that they are less controlling in decisions regarding spending on major household purchases.

When examining women's control over their own health care, both the 2006–2007and SIDHS 2015 show no significant variation in attitudes, with close to a third of women reportedly making the decision. This indicates that the majority of women still have limited rights over their bodies. Between the 2006–2007 and SIDHS 2015s, the percentage of women who reported making decisions solely concerning visits to their family and friends declined (20% and 16%, respectively). This reflects the risks posed to women's freedom of movement, especially towards those who may be experiencing violence at home where men are controlling their choices and their participation in decision-making.

15.6 PARTICIPATION IN DECISION-MAKING BY BACKGROUND CHARACTERISTICS

Table 15.6.1 shows the distribution of currently women aged 15–49 who participate in three types of decisions — woman's own health care, making household purchases, and visits to her family or relatives — by background characteristics. In 2015, additional background information was collected on income, economic activity, sector of employment and occupation in order to further gain insights into women's decision-making. Slightly over 65% of women participate in all three decisions compared with just over 57% in 2006–2007, despite the fact that there were four types of decisions that were asked about in the SIDHS 2006–2007. These findings suggest positive changes in attitudes, with women gaining influence and power over time.

Table 15.6.1: 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 2015

Background characteristic	Specific decisions			All three decisions	None of the three decisions	Number of women
	Woman's own health care	Making major household purchases	Visits to her family or relatives			
Age						
15–19	82.6	75.8	72.3	57.9	10	141
20–24	87.1	70.6	78.8	63.1	9.1	645
25–29	85.9	74.7	77.8	63.7	9.1	850
30–34	86.3	75.7	79.4	64.8	7.7	824
35–39	86	78.2	83	68.3	6.6	715
40–44	87.4	79.2	83.8	69.4	6.9	504
45–49	90.1	75.7	86.6	67.5	4.7	407
Employment (last 12 months)						
Not employed	84	72.5	76.3	62.1	10.7	1,970
Employed for cash	89.8	84.4	86.2	76.1	5.5	989
Employed not for cash	88.8	73.3	83.4	62.3	4.2	1,120
Missing	65.6	65.6	65.6	65.6	34.4	7
Number of living children						
0	85.4	77.9	78	66.7	9.3	403
1–2	86.9	74.2	80.6	65.8	8.5	1,349
3–4	86.1	74.6	81.1	64.4	7.4	1,316
5+	87.6	77.7	81	66.1	6.4	1,019
Residence						
Urban	83.3	76.5	79.1	68.8	11.9	835
Rural	87.5	75.3	81	64.7	6.6	3,251
Region						
Honiara	84.3	80.4	81	73.7	11.5	529

Guadalcanal	85.8	71.3	82.4	60.6	5.1	772
Malaita	88.3	78.3	76.1	65.5	7.2	1,064
Western	82.9	72.6	81.7	67.3	13.6	581
Other provinces	88.8	75.2	82.9	64.2	5.2	1,141
Education						
No education	85.3	72.7	76.4	57.9	7.7	454
Primary	86.4	73.9	80.7	63.8	7.5	2,018
Secondary	87	76.6	80.9	67.9	8.2	1,340
More than secondary	89.5	87.7	86	79.5	7	275
Wealth quintile						
Lowest	89.7	72.5	79.8	59.7	4.3	813
Second	86.6	74.5	80.6	63	7.3	800
Middle	84.3	75.4	77.8	64.9	9.4	824
Fourth	88.3	77.6	84.1	69.7	6.6	831
Highest	84.6	77.7	80.7	70.1	10.9	818
Income quintile						
Lowest	82.1	76.3	78.2	67.5	9.5	218
Second	94	86.7	90.3	79.5	2.4	215
Middle	91.8	79.9	86.4	71.3	5.1	179
Fourth	90.8	87.6	85.1	79.3	6.9	176
Highest	91.8	92	92.8	83.8	2.9	178
Missing	83.9	89.7	76.7	76.7	10.3	22
Main activity						
Agriculture	87.8	71.7	83.9	63.1	5.5	819
Industry	83	76.4	79.3	69	11.7	91
Services	90.8	83.2	85.6	72.6	3.8	1,197
Missing	91	100	100	91	0	8
Working sector						
Public sector	92.6	88.1	89.1	79.6	3.6	273
Private sector	86.6	81.4	85	74.5	8.5	495
Religious organisation	(91.7)	(95.9)	(89.5)	(84.1)	(1.3)	30
Other	94.8	84.4	83.7	74.2	1.5	153
Missing	89.6	86.9	87.5	72.5	0	38
Occupation						
Legislators, senior officials and managers	(88.3)	(91.8)	(91.8)	(85.4)	(5.3)	29
Professionals	91.8	86.2	87.6	77.8	4.5	247
Technicians and associate professionals	98.2	92.4	87.5	83.3	1.8	46
Clerks	90.1	87.4	85.7	81.9	8.8	35
Service workers, shop and market sales workers	87.3	81.2	82.3	68.2	4.9	559
Skilled agricultural and fishery workers	89.3	74.4	85.4	65.3	4.2	857
Craft and related workers	94	75.8	87.2	71.1	4.7	98
Plant and machine operators and assemblers	*	*	*	*	*	7
Elementary occupation	87	74.2	82.1	65	7.3	229
Missing	94.3	78.8	94.3	78.8	5.7	7
Total	**86.7**	**75.6**	**80.6**	**65.5**	**7.7**	**4,086**

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 2015 results show a positive relationship between women's age and decision-making. As age increases, particularly from age 15–44, participation in all three decisions increases. This reflects changes in attitudes since the SIDHS 2006–2007. Similar to earlier results, women's responses by educational status, household wealth, and employment status appear mixed with regard to participation in decision-making. However,

slight progress in attitudes was observed since 2006–2007 regarding cash employment and decision-making. In the SIDHS 2015, 76% of women (compared with 70% in 2006–2007) who are employed for cash, participate in all three decisions. In addition, the 2015 results show that women whose main economic activity is in the services industry, and those who work in the public sector and/or occupy positions as technicians and associate professionals, are more likely to participate in all three decisions. When assessing the effect of women's wealth on decision-making between the SIDHS 2006–2007 and SIDHS 2015, we observe that women in the highest wealth quintile are more likely to participate in all three decisions than women in the lowest wealth quintile.

While the effect of education on women's decision-making varies, the data show that nearly eight in ten (80%) women with a post-secondary education dominated in making all decisions in 2015. However, the results also show that close to six in ten (60%) women with no education made all decisions, a slight improvement since 2006–2007. Furthermore, women in rural areas are more likely to participate in all three decisions than urban women since 2006–2007. This indicates, to some extent, the loosening of strong patriarchal family and cultural attitudes often found in more isolated rural areas.

Table 15.6.2 presents information regarding decision-making among men aged 15–49, according to decisions about their own health care and about major household purchases by background characteristics. About 8 in 10 (80%) men report making the vast majority of decisions about both their own health care and major household purchases. Making all decisions is more predominant among men aged 20–24 and 35–39 (13% and 11%) compared with men in other age category. Moreover, men with more living children are more likely to make all decisions compared with women. The difference is less significant difference by urban and rural areas; the highest age of men who made all decisions live in Western Province.

Similar to the women's findings, the effect of employment, wealth and education is less clear on men's decision-making behaviour. The responses from men who are employed and men who are not employed do not vary significantly; similarly, responses from men by wealth quintile vary little. When looking at educational status, the data show that 82% of all decision-making emanates from men with a post-secondary education (highest level) compared with 79% of men with no education.

Figure 15.1: Number of household decisions in which currently married women participate, Solomon Islands 2015

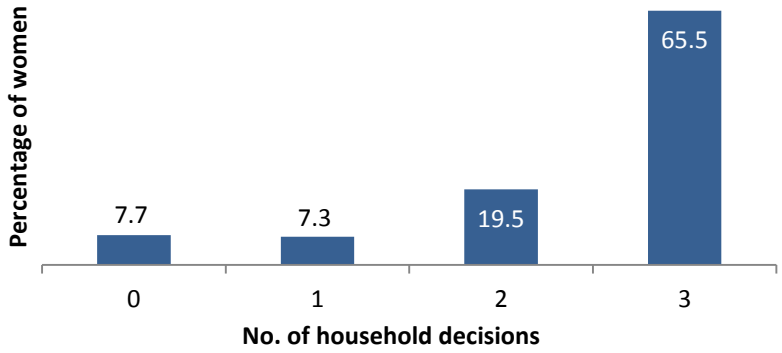


Figure 15.1 shows the distribution of currently married women by the number of household decisions in which they participate, either alone or with their husband or partner. The majority of women participate in all three decisions, specifically regarding their own health care, making major household purchases, and visiting family and relatives. Only 8% of women do not participate in any of the three decisions. Although this has slightly increased from 6% in 2006–2007, it indicates that there are more women (in absolute terms) who are not participating in all three decisions, even if the 2015 results show a higher percentage of women participating in all decisions compared with 2006–2007.[22]

[22] Also, noting the differences in sample size between the two surveys.

Table 15.6.2: Men's participation in decision making by background characteristics

Percentage of currently married men aged 15–49 who usually make specific decisions either alone or jointly with their wife, by background characteristics, Solomon Islands 2015

Background characteristic	Specific decisions		Both decisions	Neither of the two decisions	Number of men
	Man's own health	Making major household purchases			
Age					
15–19	*	*	*	*	10
20–24	86.1	82.2	81	12.7	148
25–29	88.5	84.1	81.4	8.8	307
30–34	82.8	85.7	77.1	8.7	355
35–39	85	83.9	80.2	11.3	350
40–44	85	84.7	79.6	9.9	258
45–49	85.6	86.9	81.4	8.9	226
Employment (last 12 months)					
Not employed	77.8	81.9	77.1	17.4	153
Employed for cash	85.5	85.4	79.9	9	891
Employed not for cash	87.5	84.7	80.9	8.7	606
Missing	0	0	0	100	2
Number of living children					
0	86.6	85.6	80.9	8.7	180
1–2	84.9	82.3	78.5	11.3	627
3–4	85.8	86.1	80.6	8.6	499
5+	85.4	86.7	81.2	9.2	346
Residence					
Urban	83.4	83.4	77.8	10.9	360
Rural	86	85.1	80.5	9.5	1,292
Region					
Honiara	86.7	86	82.1	9.4	229
Guadalcanal	80.8	81.3	77	14.9	327
Malaita	88.2	86.5	79.6	4.9	397
Western	88.9	91.9	87.1	6.2	236
Other provinces	83.9	81.4	77.6	12.3	462
Education					
No education	86.3	87.5	78.6	4.8	63
Primary	84.1	84.4	79	10.4	698
Secondary	86	84.1	80.4	10.2	664
More than secondary	87.4	86.7	82	7.9	228
Wealth quintile					
Lowest	87.5	88.4	83	7.1	322
Second	88.3	83.6	80.5	8.6	315
Middle	80.6	80.2	73.4	12.7	320
Fourth	84.5	84.9	80.6	11.2	350
Highest	86.4	86.4	82	9.2	345
Total 15–49	**85.4**	**84.7**	**79.9**	**9.8**	**1,652**
50+	83.8	82.6	77.7	11.4	585
Total 15+	**85**	**84.2**	**79.4**	**10.2**	**2,237**

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

15.7 ATTITUDES TOWARD WIFE BEATING

Solomon Islands reinforced its efforts to tackle violence against women when it joined other countries of the world in signing the 1993 United Nations Declaration on the Elimination of Violence against Women. Violence against women is a term used to collectively refer to violent acts that are primarily or exclusively perpetrated against women. It is a form of gender-based violence (GBV) and is often the consequence of imbalances in power between women and men. GBV is also a violation of human rights. It is a cross-cutting issue and concern, imposing on socioeconomic statuses, culture and religion. It has negative consequences on the mental and physical wellbeing of women, including their reproductive and sexual health (WHO1999). In Solomon Islands, abuse by a husband or partner is a common form of GBV and is a complex issue that requires understanding from various perspectives.

The SIDHS 2015, similar to the SIDHS 2006–2007, collected information on both women's and men's attitudes toward wife beating by background characteristics. More specifically, data were collected about the percentage of all women and men aged 15–49 who agree that a husband is justified in hitting or beating his wife for five specific reasons, by background characteristics. These specific reasons include: 1) she burns the food, 2) she argues with him, 3) she goes out without telling him, 4) she neglects the children, and 5) she refuses to have sexual intercourse with him.

15.7.1 Women's attitude towards wife beating

According to Table 15.7.1, over three quarters (77%) of women agree with at least one specific reason for wife beating. This rate has increased from 69% in the SIDHS 2006–2007, and is concerning because it indicates that a high proportion of women still believe that violence against women (wife beating by her husband or partner) is justified under some circumstances. A similar finding is observed in the 2009 Solomon Islands Family Health and Safety Study, where the majority of women (73%) believe that a man is justified in beating his wife under some circumstance, particularly for reasons of infidelity and disobedience. These results further confirm the subordinate status of women in marital relationships, which is generally accepted by women in Solomon Islands.

Table 15.7.1: 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 2015

Background characteristic	Husband is justified in hitting or beating his wife if she:					Percentage who agree with at least one specified reason	Number
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses to have sexual intercourse with him		
Age							
15–19	34.1	36.2	59.4	68.9	22	77.7	1,241
20–24	33.2	42.5	62.3	69.3	25.1	79.3	1,146
25–29	29.5	35.7	59.8	65.7	19	75.9	1,091
30–34	33.3	38.9	61.7	68.6	23.7	79.4	933
35–39	29.7	34.2	56.7	63.6	21.2	73.3	803
40–44	30.9	38.2	60.6	67.2	23.9	76.2	576
45–49	30.8	35.9	54.8	60.2	24.9	70.3	476
Employment (in 12 months preceding survey)							
Not employed	34.3	39	61.9	69.4	23.2	77.9	3,338
Employed for cash	23.6	30.3	53.9	60.3	17.9	71.2	1,400
Employed not for cash	34.6	41.3	60.7	67.4	25.7	79	1,516
Missing	3.2	16	36.5	43.8	15.6	56.2	12
Number of living children							
0	32.7	35.5	58.6	66.3	20.3	76.2	2,077
1–2	30.7	38.6	61.5	68.2	23.8	77.7	1,692
3–4	32.5	38.6	59.6	67.5	22.2	76.3	1,423
5+	31.5	38.4	59.4	65	25.6	76.4	1,073
Marital status							
Never married	32.4	35.5	58.4	67.4	20.7	76.8	1,936
Married or living together	31.8	38.5	60.6	67	23.6	77	4,086
Divorced/separated/widowed	31	38.3	57.2	59.9	21.3	69.5	244

Residence							
Urban	28.6	30.9	53.3	62.5	18.6	71.5	1,427
Rural	32.9	39.5	61.7	68.2	23.7	78.2	4,839
Region							
Honiara	29.8	27.2	47.8	59.1	15.4	66.9	925
Guadalcanal	38.9	49	60.8	67.9	31.4	78.3	1,140
Malaita	37.8	49.2	73.3	75.1	27.6	85.3	1,608
Western	29.5	25.1	54.2	65.2	20.1	72.5	902
Other provinces	24.1	31.1	55.6	63.5	17.1	74.8	1,690
Education							
No education	39.3	45	66.4	70.9	28.5	80.1	576
Primary	35.6	41.3	61.1	68.5	26	79	2,820
Secondary	27.9	34.3	58.7	66.5	19.1	75.5	2,476
More than secondary	20.3	21	47	51.7	11.4	61.9	394
Wealth quintile							
Lowest	39.6	44.9	61.9	68.2	26.1	78.5	1,158
Second	35	40.1	63.5	68.6	24.7	78	1,172
Middle	33.9	36.5	60.9	68	25.2	77.8	1,223
Fourth	27.3	38.4	62.4	69.2	20.5	79.7	1,253
Highest	25.6	29.8	51.9	61.6	17.8	70.5	1,460
Income quintile							
Lowest	24.7	36.8	62.9	66.2	21.1	74.6	327
Second	24.3	30.3	55.5	61	19.9	73.9	307
Middle	27.8	35.2	57.8	66.7	18.3	77.7	251
Fourth	20	21.2	46.3	56.2	14.9	68.6	240
Highest	19.8	22.8	40.8	47.2	14.8	57.2	230
Missing	24.9	43.8	63	66.9	10.7	77.2	45
Main activity							
Agriculture	32.6	40.4	60.6	66	25.4	77.5	1,073
Industry	28.6	34.6	55	65	22.3	75.1	114
Services	27.4	33.5	55.7	62.8	19.9	74	1,720
Missing	14.8	18.2	46.3	61	8.6	61	16
Working sector							
Public sector	16.7	21.8	44.2	51.2	11	63.3	377
Private sector	25	33.3	54.6	60.8	19.4	71.4	750
Religious organisation	(15.6)	(26.3)	(51.9)	(55.5)	(19.3)	(63.3)	38
Other	33.2	33.9	68.7	75.5	25.6	86.1	181
Missing	25	40.1	63.1	71	17.7	79.4	55
Occupation							
Legislators, senior officials and managers	(7.8)	(20.7)	(28.2)	(35.3)	(12)	(44.6)	37
Professionals	16.9	22.8	48.7	52.5	11.8	65.7	338
Technicians and associate professionals	24.9	31.3	53.8	55.4	20	67.9	63
Clerks	15.5	16	31	44	8.4	48.6	56
Service workers, shop and market sales workers	31.1	40.1	62.1	69.3	25.4	80.3	798
Skilled agricultural and fishery workers	32.7	38.5	57	64.5	23.6	76.4	1,134
Craft and related workers	34.2	38.4	62.5	63	20.4	78.3	124
Plant and machine operators and assemblers	*	*	*	*	*	*	8
Elementary occupation	28.8	36.4	62.8	69.5	22	76.9	352
Missing	28.5	24	53.5	60.8	12.4	60.8	12
Total	**31.9**	**37.6**	**59.8**	**66.9**	**22.6**	**76.7**	**6,266**

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 SIDHS 2015 shows that the most widely accepted justification for wife beating is neglecting the children. This is similar to the SIDHS 2006–2007 finding. This perception among women has increased from 58% in the SIDHS 2006–2007 to 67% in the current survey. The least acceptable justification is the wife refusing sexual intercourse with her husband, but this view has increased substantially from 13% in 2006–2007 to 23% in 2015. Moreover, although it is less likely that women who are divorced, separated or widowed will justify wife beating for any specific reason, it is often argued (see SIDHS 2006–2007 report) that these women would have either experienced higher incidences of abuse than other women, or that they have experienced the impact first hand.

The 2015 results show an increase in the number of women's responses justifying wife beating by the background characteristics of education, employment and wealth, compared with 2006–2007. Evidence shows that as a woman's educational status increases from no education to the highest educational level, her views on the justification for wife beating across all five reasons declines. This reflects the positive impact of education on violence against women, even though the proportions of responses remain relatively high. Moreover, the majority of women who justify wife beating under any circumstance are those who are predominately employed in the agriculture industry. This is expected given that the majority of these women are based in rural areas and predominantly occupy positions as skilled agricultural and fishery workers. Also, wealthier women are the least likely to justify wife beating under any circumstance compared with the 2006–2007 findings.

Both the 2015 and SIDHS 2006–2007 findings show that rural women are more likely to justify wife beating than urban women. At the provincial level, the 2015 findings show changing attitudes, with women from Malaita Province becoming more accepting of wife beating for neglecting children and refusing sexual intercourse than women in other provinces.

15.7.2 Men's attitudes toward wife beating

Similar to women, men aged 15–49 were asked about their views on the justification for wife beating under certain circumstances. According to Table 15.7.2, the overall attitude of men in 2015 appears generally similar to those of women in a number of certain justifications, although men's views are relatively lower in proportion. It is also evident that men's attitudes on a number of justifications for wife beating are changing since 2006–2007. Overall, 57% of men — compared with 77% of women — agreed with at least one specific justification for wife beating. The perceptions of men have declined from 65% since 2006–2007. This is one interesting findings from the survey however the reasons for the change in men's perceptions toward wife beating is beyond this survey and further research in this area is being encouraged.

Although the most predominant and least accepted views by women and men regarding justification for wife beating are similar to those of the wife neglecting the children and the wife refusing sexual intercourse with the husband, the trend in views differs from those in 2006–2007. Women's views have increased (67% compared with 58%), while men's views have declined (45% compared with 55%). The observed similarity in views between men and women reflect an entrenched cultural and social acceptance of marital or partner violence across the sexes and within society.

While men's perceptions by background characteristics such as employment, education, wealth and place of residence (region) are relatively lower in proportion than those of women, men's attitudes have shifted since 2006–2007. In 2015, men who are predominantly unemployed and employed (not for cash) are more likely to agree with at least one specific reason for wife beating than they were previously in the 2006–2007, where this view was predominant among men who were employed for cash. Educational status has also affected men's views regarding the justification of wife beating for at least one reason since 2006–2007; men's views decrease as educational status increases from no education to post-secondary education in contrast to men's views in 2006–2007. In contrast to perceptions in 2006–2007, men with no education are more likely to justify violence for any specific reason. The 2015 results also show changes in the trend of men's responses according to wealth. There is a shift in attitude where the poorest men (lowest quintile) account for the highest response in favour of wife beating for at least one reason, in contract to the same wealth quintile reporting the lowest response in 2006–2007.

Table 15.7.2: Attitude toward wife beating – Men

Percentage of all men age 15–49 who agree that a husband is justified in hitting or beating his wife for specific reasons, by background characteristics, Solomon Islands 2015

Background characteristic	Husband is justified in hitting or beating his wife if she:					Percentage who agree with at least one specified reason	Number
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses to have sexual intercourse with him		
Age							
15–19	19.8	34	42.4	46.2	16.5	59.7	605
20–24	21.9	33.7	41.4	46.7	11.6	60.5	519
25–29	21.9	34	40.5	46.8	12.2	61	479
30–34	17.4	32.1	37.2	44.2	8.6	54.4	436
35–39	19.5	37	36.9	45	12.5	55.7	394
40–44	15.5	26.4	32.3	38.4	7.4	48.5	280
45–49	15.1	28.9	36.1	40.5	8.9	49.1	236
Employment (last 12 months)							
Not employed	16.6	37.1	37.5	43.2	12.3	57.4	721
Employed for cash	16.1	29.4	36.4	42.3	8.5	56	1,233
Employed not for cash	25.5	34.5	43.3	48.9	15.6	57.6	990
Missing	0	0	17.7	17.7	0	17.7	4
Number of living children							
0	20.1	33.2	41	45.8	14	58.6	1,411
1–2	19.4	32.8	38.6	45.1	8.5	57.6	681
3–4	19.2	32	36.5	43.7	9.5	53.7	510
5+	16.4	33.4	34.7	41.2	12.4	53	347
Marital status							
Never married	20	33	41.2	46.2	14.4	59.3	1,261
Married or living together	18.8	32.8	37.2	43.7	9.9	55	1,652
Divorced/Separated/Widowed	(18.5)	(35.3)	(41.4)	(40.5)	(5.7)	(55.9)	35
Residence							
Urban	7.6	33.1	37.9	33.8	8.2	51	720
Rural	23.1	32.9	39.3	48.2	12.9	58.7	2,229
Region							
Honiara	2.8	32.7	40.7	33.1	6.3	51	475
Guadalcanal	24.7	50.2	41.4	60.4	15	73.9	547
Malaita	30.3	28.7	51.7	50.6	7.1	61.5	710
Western	9.1	18.7	22.2	23	10.1	34.2	451
Other provinces	21.6	33.1	34.1	48	18.3	57.2	765
Education							
No education	22.1	44.8	37.2	51.5	12.2	62.7	92
Primary	25.5	36.3	43.6	50.8	13.7	61.4	1,202
Secondary	15.7	30.8	36.8	41.1	11.1	55.4	1,348
More than secondary	10.5	25.7	30.9	35	7.1	43.8	307
Wealth quintile							
Lowest	23.2	40.1	40.2	54	16.6	65	529
Second	27.3	33.8	43.7	49.4	11.5	60.2	565
Middle	22.6	27.9	35.6	42.8	11.4	53.2	528
Fourth	19.2	32.3	37.8	43.6	12.6	55.8	621
Highest	7.9	31.2	37.8	36.5	8	51.6	706
Total 15–49	**19.3**	**32.9**	**39**	**44.7**	**11.8**	**56.8**	**2,948**
50+	18	25.9	31.6	38.5	9.8	46.8	643
Total 15+	**19.1**	**31.7**	**37.6**	**43.6**	**11.4**	**55**	**3,591**

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

Similar to rural women, rural men are more likely to justify wife beating than urban men. However, compared with the 2006–2007 findings, this view has changed. Rural men, in contrast to urban men are now more likely to justify at least one specific reason for wife beating. This relates specifically to cases where the wife neglects the children, wife burns the food, wife goes out without telling the husband, and wife refuses sexual intercourse. The only case where views have not changed is where the wife argues with the husband. By region or province, men from Guadalcanal and Malaita provinces show relatively higher responses, a shift in attitude from the dominance of men from Honiara and other provinces in 2006–2007.

The justification for wife beating, a form of GBV, remains high. The above information, including earlier discussions, clearly shows the power imbalances and changing attitudes over time, particularly among men. This kind of power imbalance is recognised as a determinant of GBV and impacts on women's basic human rights; it is rooted in customary and related beliefs, and in intimate marital and partner relationships. Given that this is a society-wide issue, prevention cannot be limited to a singular approach, but requires a more holistic process.

15.8 WOMEN'S EMPOWERMENT INDICES

In the 2015 Women's Questionnaire, specific data were collected to measure women's empowerment. The indicators derived for women's empowerment were then analysed with selected health outcomes such as contraceptive use, family planning, and reproductive health care. These analyses examine the degree of women's ability to have control over decisions regarding their own body and the family; in general, a woman's health decisions impact on her status, self-image and sense of empowerment. These topical analyses follow subsequently from this analysis.

Women's empowerment in this analysis is measured by two sets of empowerment indicators: 1) women's participation in making household decisions, and 2) women's attitude towards wife beating. These two indicators are summarised in two separate indices.[23] The first index shows the list of decisions in which women participate alone or jointly with their husband or partner. The value of this index ranges from 0 to 3, signifying the positive relationship to women's empowerment. It reflects the degree of control in decision-making among women, and their capacity to engage in matters that affect their own lives and circumstances. The second index ranges in value from 0 to 5 and represents the total number of reasons for which the respondent feels that wife beating by the husband or partner is justified. A score from low to high indicates the degree of sense of entitlement, self-esteem and status of women.

Table 15.8 shows the percentage of currently married women aged 15–49 who participate in all forms of decision-making, and the percentage who disagree with all of the reasons justifying wife beating by the value on each of the indicators of women's empowerment. The information pertaining to these indices show the relationships among these indicators. The results show that the percentage of women who disagree with all justifications for wife beating slightly increases as the number of household decisions that women participate alone or jointly in increases; from 22% of women who participate in no household decisions to 25% who participate in all three decisions. Although a similar trend was observed in 2006–2007, it is concerning that the percentage of women who disagree with all reasons justifying wife beating according to the number of decisions women participate in, has decreased since 2006–2007. For example, the percentage of women who disagree with all of the justifications for wife beating declined from 28% in 2006–2007 to 18% in 2015 for women who participate in one to two household decisions.

[23] In the SIDHS 2006–2007, an additional empowerment indicator – women's attitudes toward a wife's right to refuse sexual intercourse with her husband or partner — was included. In the revised SIDHS 2015, this question is omitted following revisions to international standards of the model questionnaire.

Table 15.8: Indicators of women's empowerment

Percentage of currently married women aged 15–49 who participate in all decision-making and the percentage who disagree with all of the justifications for wife beating, by the value of each of the indicators of women's empowerment, Solomon Islands 2015

Empowerment indicator	Percentage who participate in all decision-making	Percentage who disagree with all the reasons justifying wife beating	Number of women
Number of decisions in which women participate[1]			
0	na	21.5	315
1–2	na	17.8	1,094
3	na	25.3	2,677
Number of reasons for which wife beating is justified[2]			
0	72	na	939
1–2	65	na	1,425
3–4	63.2	na	1,196
5	60.6	na	526

na = not applicable

[1] see Table 15.6.1 for the list of decisions.

[2] see Table 15.7.1 for the list of reasons.

The percentage of women who participate in all household decisions decreases as the number of reasons justifying wife beating increases, from 72% of women who disagree with any of the reasons justifying wife beating to 61% of women who agree with all five reasons justifying wife beating. While this trend is similar to those of 2006–2007 results, it is disturbing to find that the percentage of women who participate in all decisions has increased from 57% in 2006–2007 to 61% for women who agree with all five reasons for wife beating.

The 2015 findings show that the higher the level of empowerment or sense of entitlement, or control in one indicator the more likely it is to lead to a higher level of empowerment in other indicators, as observed in 2006–2007.[24] Recognising the former relationships aid in supporting women's empowerment actions, especially in the case where if one has to effect change in one area of women's empowerment, this will impact on other areas of women's lives.

15.9 CURRENT USE OF CONTRACEPTION BY WOMEN'S STATUS

The extent of a woman's empowerment is also dependent on her ability to control or negotiate decisions about her fertility and choice of contraceptive methods. When a woman feels that she is limited in or incapable of controlling other matters affecting her life such as abuse, she may be less likely to feel that she can make decisions about fertility. It is also likely that she may feel the need to decide on contraceptive methods that are easier to conceal from her husband or partner, or choose those that are not dependent on his cooperation.

The relationship of the two empowerment indicators with the current use of contraception of currently married women aged 15–49 by selected background characteristics is shown in Table 15.9. The results show that the use of a contraceptive method is relatively lower among women who do not participate in any household decisions (23%) than among women who are involved in at least one household decision. Similar findings were observed in 2006–2007. This confirms the expectation that the use of contraception is positively related to participation in household decisions. In addition, about a third of women who

[24] As noted in the SIDHS 2006–2007 report, in relation to such relationships, when women participate more in making household decisions, it is likely that they have strong gender-egalitarian views. This implies that women who participate in more household decisions are more likely to disagree with all justifications for wife beating. The same can be argued for women who support fewer justifications for wife beating where they are more likely to participate in household decision-making.

participate in at least one household decision are currently using a contraceptive method. This trend has slightly declined since 2006–2007. It is argued and proven by the data that women who do not participate in household decisions are much less likely to use a certain contraceptive method (e.g. a condom) and more likely to decide to use modern female methods that are not dependent on their husband's or partner's cooperation.

The association between the use of contraceptives and the justification of wife beating appears mixed and unexpected. Similar observations were made in 2006–2007. Women who do not agree with any justification for wife beating are less likely to use: a contraceptive method (28%), any modern method (23%), female sterilisation (9%) and modern female methods (12%) than women who agree with at least one justification for justifying wife beating. Although it is expected that the use of contraceptives is inversely related to the acceptance of wife beating, there is no strong evidence of this in either the 2015 or 2006–2007 findings.

Table 15.9: Current use of contraception by women's empowerment

Percent distribution of currently married women aged 15–49 by current contraceptive method, according to selected indicators of women's status, Solomon Islands 2015

Empowerment indicator	Any method	Any modern method	Modern methods				Any traditional method	Not currently using	Total	Number of women
			Female sterilisation	Male sterilisation	Temporary modern female methods[1]	Male condom				
Number of decisions in which women participate[1]										
0	23.2	18.7	6.9	1	9.8	0.9	4.5	76.8	100	315
1–2	31.3	26.7	9.7	0.8	15	1.2	4.6	68.7	100	1,094
3	29.3	24	9	0.4	13.7	0.9	5.3	70.7	100	2,677
Number of reasons for which wife beating is justified[2]										
0	28.2	23.2	8.8	1.1	12.4	0.8	4.9	71.8	100	939
1–2	29.5	23.4	9.1	0.5	12.7	1.1	6.1	70.5	100	1,425
3–4	30.5	25.8	8.9	0.2	15.7	1	4.6	69.5	100	1,196
5	28.5	25.2	9.7	0.3	14.7	0.6	3.3	71.5	100	526
Total	**29.3**	**24.3**	**9**	**0.6**	**13.8**	**1**	**5**	**70.7**	**100**	**4,086**

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

[1] Pill, intrauterine device, injectables, implants, female condom, diaphragm, foam/jelly and lactational amenorrhoea method.

[2] See Table 15.6.1 for the list of decisions.

[3] See Table 15.7.1 for the list of reasons.

15.10 IDEAL FAMILY SIZE AND UNMET FAMILY PLANNING NEEDS BY WOMEN'S STATUS

The extent of a woman's empowerment and her control over her fertility and contraception has implications for her chances of becoming pregnant and having a say in her unmet need for limiting childbearing and spacing of births. It is argued that as a woman becomes more empowered, she is more likely to have a say in decisions around an ideal family size and spacing of children. She is also likely to have more control over her ability to use and access contraceptives. An unmet need for family planning is defined in terms of women who have a desire to limit their births but are not using family planning.

The findings from Table 15.10 show mixed relationships between the empowerment of women in participating in household decision-making and their ideal family size and unmet family planning needs, similar to those of the SIDHS 2006–2007. Although women who do not participate in household decision-making have a lower desire for children (3.4) as expected, they have the greatest unmet need for family planning in spacing childbearing (26%), and a moderate desire for limiting children. The results also show

that women who participate in one to two household decisions have the greatest desire for having children (3.6) and the greatest desire for limiting births (16%). However, they have the lowest unmet need for family planning for spacing births (18%).

The 2015 results show a strong negative association between the empowerment indicator regarding women's perceptions of wife beating, and the desire for children and unmet needs. Surprisingly, women who agree with all justifications for wife beating have the highest desire for children (3.3), the highest desire for family planning for spacing births (23%) and the lowest desire for limiting births (13%). Although women who do not participate in decision-making have the lowest desire for children (3.0), they also have the lowest (18%) unmet need in spacing births.

Table 15.10: Ideal number of children and unmet need for family planning by women's empowerment

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 2015

Empowerment indicator			Percentage of currently married women with an unmet need for family planning[2]			
	Mean ideal number of children[1]	Number of women	For spacing	For limiting	Total	Number of women
Number of decisions in which women participate[1]						
0	3.4	307	26.2	14.7	40.9	315
1–2	3.6	1,035	17.9	15.9	33.8	1,094
3	3.5	2,574	20.1	14.1	34.3	2,677
Number of reasons for which wife-beating is justified[2]						
0	3	1,363	18.2	15.2	33.4	939
1–2	3.1	2,056	19.4	15.7	35.1	1,425
3–4	3.2	1,740	21	13.8	34.8	1,196
5	3.3	754	22.5	12.9	35.3	526
Total	**3.2**	**5,914**	**20**	**14.7**	**34.7**	**4,086**

[1] Mean excludes respondents who gave non-numeric responses.

[2] See table 7.12.1 for the definition of unmet need for family planning

[3] Restricted to currently married women. See Table 15.6.1 for the list of decisions.

[4] See Table 15.7.1 for the list of reasons.

15.11 WOMEN'S STATUS AND REPRODUCTIVE HEALTH CARE

The relationship between women's status and the availability of reproductive health care has implications on women's ability to access reproductive care. In societies where health care is widely available, women's status may not affect their access to health services. However, in other societies such as Solomon Islands, increased empowerment is expected to enhance women's ability to seek and use health services to better meet their own reproductive healthcare needs.

Table 15.11 presents the percentage of women aged 15–49 who had a live birth(s) in the five years preceding the survey, and among these women, those who received antenatal care, delivery assistance, and postnatal care from health personnel for their most recent birth, by indicators of women's empowerment.

The findings show less significant variation in the use of reproductive health care among women who do not participate in any decisions and those who participate in at least one decision. The findings are mixed and are unexpected, similar to the 2006–2007 results. Women who do not participate in household decisions are less likely to receive antenatal care from a skilled provider but more likely to receive delivery care from a skilled provider and postnatal care from a health personnel. On the other hand, women who participate in at least one household decision have more likely to receive antenatal care but less likely to receive delivery care and postnatal care from a skilled and a health personal, respectively. The percentage of women

accessing reproductive health care in Solomon Islands is relatively high, which is encouraging; and although this confirms the provision of antenatal and delivery assistance to most women in the country, it also supports evidence of improvements in access to postnatal care since 2006–2007.

Table 15.11 presents information showing that women who disagree with wife beating and women who do not participate in decision-making account for the highest percentage of all women (75% and 76%, respectively) who received postnatal care. Similar findings were observed in 2006–2007.

Table 15.11: 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 2015

Empowerment indicator	Percentage receiving antenatal care from a skilled provider[1]	Percentage receiving delivery care from a skilled provider[1]	Received postnatal care from health personnel within the first two days of delivery[2]	Number of women with a child born in the five years preceding survey
Number of decisions in which women participate[1]				
0	91.1	89.5	75.5	197
1–2	92.6	86.9	66.8	707
3	95.4	88.3	69.2	1,588
Number of reasons for which wife beating is justified[2]				
0	93.8	87.5	74.9	612
1–2	95.6	90.7	69.6	977
3–4	93.2	86	64.9	851
5	92.3	87.8	67.3	367
Total	**94**	**88.2**	**69**	**2,807**

[1] 'Skilled provider' includes doctor, nurse/midwife, auxiliary midwife, registered nurse or nurse aid.

[2] Includes women who received a postnatal checkup from a doctor, midwife, registered nurse, nurse aid, community health worker or traditional birth attendant in the first two days after the birth. Includes women who gave birth in a health facility and those who did not give birth in a health facility.

[3] Restricted to currently married women. See Table 15.6.1 for the list of decisions.

[4] See Table 15.7.1 for the list of reasons.

CHAPTER 16 CHILD LABOUR AND CHILD DISCIPLINE

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KEY FINDINGS

- Over 3 out of 5 children (62%) aged 5–11 in Solomon Islands are involved in child labour activities; this percentage is higher than that of its neighboring country, Vanuatu, at 50%.
- The majority of children aged 5–11 who are involved in child labour activities work for a family business for at least 1 hour per week and do household chores for less than 28 hours per week.
- Children aged 5–11 are more likely to be involved in child labour activities if they reside in rural areas; and, more female children are involved in child labour activities than male children. The percentage of children engaged in labour declines with the mother's increasing level of education and wealth.
- About 12% of children aged 12–14 are involved in child labour activities in Solomon Islands, with the majority working for a family business, followed by doing household chores for less than 28 hours per week.
- Child labour among children aged 12–14 is more common among female children, children living in rural areas, and children whose mother has no education.
- The majority of children (86%) aged 2–14 receive some form of violent discipline, with children living in rural areas, those living in lower wealth quintile households, and those whose mother or caretaker has very little education, are more likely to experience this type of disciplinary method.
- The most common method of child discipline is psychological aggression, with 78% of children aged 2–14 having received this type of discipline in the month prior to the survey.

INTRODUCTION

This chapter presents information and findings related to child labour and child discipline in Solomon Islands based on data collected during the SIDHS 2015. Child labour is an important issue that affects the development and health of children worldwide. Great effort has been made to combat child labour at the international and national level, through the development of policies and conventions.

Article 32 of the Convention on the Rights of the Child (CRC) proclaims that: 'States parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child seduction, or to be harmful to the child's health or physical, mental, spiritual, moral or social development…' Solomon Islands became a member of the United Nations in 1978 and as a member country, considers the CRC to be a cornerstone of human rights. Solomon Islands ratified and became a signatory to the CRC in 1995.

Similarly, one of the core functions of the International Labour Organization (ILO) since its inception is to combat child labour. Solomon Islands became a member of the ILO in 1984 and ratified the Worst Forms of Child Labour Convention in 1999 (No.182) and the Minimum Age Conventions 1973 (No.138) in 2012 and 2013, respectively, as part of enforcing and monitoring child labour in the country.

With support from the ILO's Pacific Subregional Child Labour and Trafficking programme, Solomon Islands conducted the first-ever National Child Labour Forum in the country in August 2014 with excellent participation and collaboration from stakeholders, including government ministries, employers organisations, workers unions, United Nations agencies, non-governmental organisations, and the media. The stakeholders identified key areas of child labour that needed to be addressed immediately. One of the priorities identified was the need for adequate information regarding the nature of child labour in Solomon Islands. A rapid assessment was undertaken by the ILO in September 2014 as a direct outcome of the forum, and the assessment has found that child labour, especially the 'Worst Forms of Child Labour', is found in Solomon Islands.

A child is considered to be involved in child labour activities if, during the week preceding the SIDHS 2015:

- children aged 5–11 were involved in at least 1 hour of economic work or 28 hours of domestic work per week; and
- children aged 12–14 were involved in at least 14 hours of economic work or 28 hours of domestic work per week.

This definition allows differentiation between child labour and children doing household chores in order to identify the type of work that should be eliminated. As such, the estimate provided here is a minimum of the prevalence of child labour because some children may have been involved in hazardous labour activities for a number of hours that could be fewer than the number specified in the criteria above. Table 16.1 presents child labour activities by type of work. Percentages do not add up to total labour because children may be involved in more than one type of work.

Culturally, households in Solomon Islands consider children's involvement in domestic chores as part of their upbringing and discipline. Young children are taught by their parents to help out at home with gathering firewood, going to the shop, washing up after a meal, and cleaning around the house. These practices have been examined from a wider perspective in regards to the rights of children in the context of the CRC. The SIDHS 2015 was instrumental in capturing data on child labour.

16.1 CHILD LABOUR BY BACKGROUND CHARACTERISTICS

The child labour module was included in the SIDHS 2015 household questionnaire, which contains a list of questions asking children aged 5–14 residing in the selected household about their involvement in economic activities and household chores. The module of child labour is administered only to the most knowledgeable adult of the household: mainly the child's father, mother or caretaker. Children's ages were split into two groups: children aged 5–11 and children aged 12–14.

Table 16.1 presents child labour by children's background characteristics. More than 3 out of 5 children aged 5–11 are involved in child labour activities. Child labour in Solomon Islands is higher than in neighbouring Vanuatu (62% vs 50%). Of the total number of children involved in child labour activities, the majority work for a family business (69%). This is followed by children who are engaged in an economic activity for at least 1 hour per week (62%), and those who do household chores for less than 28 hours per week (54%). Child labour is more common among children aged 5–11 residing in rural areas, and is more common among female children than male children. Child labour declines as a mother's education level and wealth status increases.

Table 16.1: Child labour

Percentage of children who are involvement in an economic activity and household chores during the week prior to the survey, according to age groups and the percentage of children aged 5–14 who are involved in child labour, Solomon Islands 2015

Background characteristic	Percentage of children aged 5–11 involved in:								Percentage of children aged 12–14 involved in:										
	Paid work outside household (HH)	Unpaid work outside HH	Working for family business	Economic activity for at least one hour/ week[1]	HH chores for less than 28 hours/ week	HH chores for 28 hours or more hours/ week	Child labour[2]	Number of children aged 5–11	Paid work outside HH	Unpaid work outside HH	Working for family business	Economic activity less for less than 14 hours/ week	Economic activity for 14 hours or more/ week	HH chores less than 28 hours/ week	HH chores for 28 hours or more/ week	Child labour[3]	Number of children aged 12–14	Total child labour[4]	Number of children aged 5–14
Sex																			
Male	2.2	7.8	66.2	59.6	47.1	0.5	59.6	2,787	5.9	13.5	84	74.5	10.2	67.8	1.1	10.4	1,006	46.6	3,793
Female	2.3	8.5	71.2	63.7	62.1	0.8	63.8	2,560	3.1	9.8	85.3	73.4	12.8	82.1	1.9	13	1,046	49	3,606
Residence																			
Urban	1	7.5	42.2	35.3	39.1	0.5	35.4	797	1.9	9.9	56.2	54.1	3.8	64.8	1.6	4.5	329	26.4	1,126
Rural	2.5	8.3	73.3	66.2	56.9	0.7	66.2	4,550	5	12	90.1	77.8	13	77	1.5	13.1	1,723	51.6	6,273
Region																			
Honiara	0.7	8.5	31.5	25	35.4	0.1	25	488	2.2	11.2	44.4	46.3	0.7	63.4	0.7	1.1	192	18.2	681
Guadalcanal	1.5	8	66	57.6	46.5	0.1	57.6	959	4	13.3	87	78.8	8.8	69	0.5	8.8	337	44.9	1,296
Malaita	2.8	3.6	69.9	63.5	57	0.3	63.5	1,500	5.4	6.9	89.7	74.8	15.9	77.3	1.4	15.9	633	49.3	2,133
Western	3.3	7	73.4	61.5	56.1	0.2	61.5	775	5.1	7.8	87.1	80.7	6.5	72.1	0.9	6.7	288	46.7	1,063
Other provinces	2.1	12.9	77.9	73.2	61.2	1.6	73.3	1,625	4.2	17.7	89.8	76	14.3	81.2	2.6	14.8	601	57.5	2,226
School attendance																			
Yes	2.6	8.6	72.2	65.5	57.8	0.6	65.5	4,114	4.5	11.8	85.3	75	11.2	75.7	1.4	11.3	1,861	48.6	5,976
No	1.1	6.8	56.5	48.6	42.3	0.7	48.6	1,210	4.8	10.7	78.4	64.1	14.9	69	2.7	15.6	185	44.2	1,395
Don'tknow/Missing	0	2.3	66.8	47.7	51.8	0	47.7	23	0	0	95.2	66.8	28.3	56.7	0	28.3	5	44.1	28
Moter's education																			
No education	3.5	8.1	70.1	63.3	54.9	1	63.3	613	6.3	15.3	88.5	70.3	19.2	77.5	2.4	19.2	307	48.6	919
Primary	2.1	8.1	71.4	64.2	55.7	0.2	64.2	2,403	4.8	11.9	88.9	79	10.3	76.2	0.5	10.5	902	49.6	3,305
Secondary	2.9	11.6	60.5	54.4	48.7	1	54.6	983	4.3	15.2	77.2	71.2	8.4	75.9	1.1	8.4	207	46.5	1,190
More than secondary	1.1	5.6	49.2	38.8	48.7	0.7	38.8	209	3.9	4	62.3	56.9	5.4	55.8	2.4	5.9	74	30.2	283
Missing	0	0	35.4	15.2	45.5	0	15.2	3	0	15.8	42.9	27	15.8	58.3	0	15.8	5	15.6	8
Wealth quintile																			
Lowest	2.1	8.8	72	65.4	53.7	0.8	65.4	1,216	4.8	14	88.5	78.4	10.3	79.3	0.7	10.3	424	51.2	1,639
Second	3.4	7	74.7	68.5	58	0.6	68.5	1,172	6.9	13.7	92.1	77.5	15.2	75.4	1.6	15.2	433	54.1	1,605
Middle	2.1	9.5	73.8	66	54.8	0.4	66	1,094	4.9	11.3	90.5	79.3	11.9	75.3	2.2	12.2	427	50.9	1,521
Fourth	1.6	8.5	69.6	62.8	56	0.8	62.9	1,032	3.9	9.1	89	74.9	14.8	77.1	1.6	15	389	49.8	1,421
Highest	1.8	6.7	47.2	38.8	47.1	0.6	38.9	834	1.3	9.6	61	57.8	4.9	67.6	1.2	5.4	378	28.4	1,212
Total	**2.3**	**8.2**	**68.6**	**61.6**	**54.3**	**0.6**	**61.6**	**5,348**	**4.5**	**11.6**	**84.7**	**74**	**11.5**	**75.1**	**1.5**	**11.7**	**2,052**	**47.8**	**7,399**

The results show that total child labour among children aged 12–14 in Solomon Islands is about 12%. This means that 12% of children aged 12–14 are involved in 14 hours of economic work per week and 28 hours of domestic work. The most common labour activities that children in this age group are engaged in include working for a family business (85%), doing household chores for less than 28 hours per week (75%), and doing some other type of economic activity for less than 14 hours per week. Child labour in this age group is common among female children, children living in rural areas, and among children whose mother has no education. Children living in the highest wealth quintile households are less likely to be involved in child labour.

16.2 CHILD LABOUR BY SCHOOL ATTENDANCE

Education is a crucial element of any effective effort to eliminate child labour. Children with no access to quality education have little alternative but to enter the labour market, where they are often forced to work in dangerous and exploitative conditions. Table 16.2 shows the percentage of children aged 5–14 who are involved in child labour, and the percentage of children aged 5–14 who attend school.

Table 16.2: Child labour and school attendance

Percentage of children aged 5–14 who are involved in child labour and who are attending school, and the percentage of children aged 5–14 years attending school who are involved in child labour, Solomon Islands 2015

Background characteristic	All children aged 5–14			Children aged 5–14 involved in labour		Children aged 5–14 attending school	
	Percentage of children involved in child labour	Percentage of children attending school	Number of children aged 5–14	Percentage of child labourers who are attending school	Number of children aged 5–14 involved in child labour	Percentage of children attending school who are involved in child labour	Number of children aged 5–14 attending school
Sex							
Male	46.6	80.6	3,793	82.2	1,767	47.4	3,059
Female	49	80.9	3,606	82.2	1,769	49.9	2,917
Residence							
Urban	26.4	83.1	1,126	84.7	298	26.9	936
Rural	51.6	80.3	6,273	82	3,238	52.7	5,040
Region							
Honiara	18.2	82.3	681	82.7	124	18.3	560
Guadalcanal	44.9	85.7	1,296	89.2	582	46.8	1,111
Malaita	49.3	77	2,133	79.7	1,053	51.1	1,642
Western	46.7	78.6	1,063	80	496	47.5	835
Other provinces	57.5	82.1	2,226	81.8	1,280	57.3	1,828
Age							
5–11	61.6	76.9	5,348	81.8	3,295	65.5	4,114
12–14	11.7	90.7	2,052	87.4	241	11.3	1,861
Mother's education							
No education	48.6	76.8	919	81	447	51.2	706
Primary	49.6	80.4	3,305	82.4	1,638	50.8	2,658
Secondary	46.5	83	1,190	84.7	554	47.5	987
More than secondary	30.2	87.5	283	90	85	31	248
Missing	15.6	69.6	8	42.3	1	9.5	6
Wealth quintile							
Lowest	51.2	74.5	1,639	74.9	839	51.4	1,221
Second	54.1	79.9	1,605	81.9	869	55.5	1,283
Middle	50.9	82.3	1,521	84	775	52	1,252
Fourth	49.8	82	1,421	86	708	52.2	1,166
Highest	28.4	87	1,212	88.7	345	29	1,054
Total	**47.8**	**80.8**	**7,399**	**82.2**	**3,535**	**48.6**	**5,976**

At the time of the SIDHS 2015, there were 7,399 children aged 5–14, and of this total, 48% (3,535) were involved in child labour activities, and 82% attended school. The proportion of child labourers who attend school is higher in urban areas, is more common among older children aged 12–14, and increases with an increase in household wealth.

Another 81% (5,976) of children aged 5–14 are children who attend school, and about 49% are children who attend school and are involved in child labour activities. This situation is more common in rural areas, among younger children, and among children whose mother has no education.

16.3 CHILD DISCIPLINE BY BACKGROUND CHARACTERISTICS

Discipline is used to prevent future ill behaviour. The manner in which parents or caretakers discipline their child can have long-term consequences to the child's development and wellbeing. A child discipline module was incorporated into the SIDHS 2015 household questionnaire with the purpose of obtaining information on the types of disciplinary methods used with children aged 1–14 by parents and caretakers living in the same household. The module aimed to elicit a range of disciplinary practices, from non-violent approaches to psychological aggression to moderate and severe forms of physical punishment.

The questions included are especially designed to measure some of the common ways in which parents discipline their children. These questions are not intended to cover all practices that parents use to discipline children, but rather to cover some of the more common methods.

The module has a unique structure and approach such that information is gathered on only one randomly selected child aged 1–14 years within a household. The first part of the module lists all eligible children within the household and then randomly selects one child within that household. Interviewers then posed questions to the child's parents (mother/father) or caretaker about whether the respondent or anyone else in the household used any of a list of methods to discipline the child in the previous month. Responses were grouped into the following categories: 1) only non-violent discipline (e.g. taking away privileges, explaining to the child why his or her behaviour is wrong); 2) any physical punishment (e.g. hitting the child either with or without a tool); and 3) severe physical punishment (e.g. hitting the child on the face or head, or hitting the child very hard with a tool); 4) psychological aggression (e.g. shouting, yelling or screaming at the child or giving the child something else to do); and 5) any kind of violent discipline method (e.g. any physical punishment, severe punishment or psychological aggression). The results are presented in Table 16.3.

The majority of children (86%) receive some form of violent discipline. These children received some form of physical punishment, severe physical punishment, and psychological aggression in the month preceding the survey. Children living in rural areas, children with mothers or caretakers who have little education, and children living in lower wealth quintile households are more likely to experience some form of violent discipline.

The most common disciplinary method used by mothers or caretakers is psychological aggression. A greater percentage of children receive this disciplinary method (78%), which includes shouting, yelling or screaming at the child or given a child something else to do, while 68% receive any type of physical punishment. Children living in rural areas, living in the lowest wealth quintile households, and whose mothers or caretakers have little education are more likely to experience or receive these types of disciplinary actions.

The data also show that 22% of children receive severe physical punishment. Few children (13%) receive non-violent discipline.

Table 16.3: Child discipline

Percentage of children aged 2–14, according to method of disciplining the child, Solomon Islands 2015

Background characteristic	Only non-violent discipline	Psychological aggression	Any physical punishment	Severe physical punishment	Any violent discipline method	Number of children aged 2–14	Respondent believes that the child needs to be physically punished	Number of respondents to the child discipline module (2–14)
Sex								
Male	11.8	78.3	70.2	23	86.2	5,141	2,338	4,985
Female	13.3	77.3	66.2	21	84.7	4,862	2,157	4,555
Residence								
Urban	19.9	65.7	59.5	15.2	75.7	1,540	536	1,475
Rural	11.2	80.1	69.9	23.3	87.3	8,462	3,958	8,065
Child's age								
2–4 years	12.6	74	72.7	22.4	84.6	2,514	1,107	2,321
5–9 years	10.5	79.9	73.1	25.1	87.8	3,912	1,882	3,867
10–14 years	14.8	78.1	59.7	18.2	83.6	3,575	1,505	3,352
Caretaker education								
No education/ Pre-school/ Other	12.2	80.7	66.9	18.2	86.8	1,474	704	1,425
Primary	11.3	79.3	69.7	24.2	86.8	5,563	2,559	5,288
Secondary	12.3	76.2	69.8	20.3	85.4	2,324	1,022	2,252
More than secondary (Tertiary/Vocational)	24.8	63.7	51.1	15.3	71.4	530	186	522
Caretaker not in household	–	–	–	–	–	47	0	0
Missing	28.3	67.9	67.9	47.8	67.9	64	22	53
Wealth index quintile								
Lowest	10.7	83.4	71.4	26	87.8	2,246	1,113	2,124
Middle	10	81.1	71.7	22	88.5	2,076	988	2,009
Fourth	14.4	73.8	66.3	20.1	83.7	1,919	805	1,836
Highest	19.5	65.9	58.7	13.3	76.1	1,616	544	1,552
Total	**12.5**	**77.9**	**68.3**	**22**	**85.5**	**10,002**	**4,494**	**9,540**

na = not applicable

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APPENDIX A: SAMPLE DESIGN AND IMPLEMENTATION

A.1 INTRODUCTION

The 2015 Solomon Islands Demographic Health Survey (SIDHS 2015) is the second survey of its kind and follows the first survey implemented in 2006–2007. The survey is a nationwide and calls for a nationally representative sample of about 5 domains namely, Western, Guadalcanal, Malaita, Honiara (as a separate province) and all other provinces are combined under 'Other' provinces, which gives a full coverage of the country. All women and men aged 15–49 living in the selected households or staying in the households the night before the survey were eligible for individual interview. All women age 15–49 and children between age 6-59 months in all of the selected households were eligible for an anaemia test. The survey is designed to provide estimates on the levels of fertility, infant and child mortality, use of contraception and family planning, and family welfare and health indicators.

Solomon Islands is divided into 9 main provinces. Honiara, the national capital city is on Guadalcanal province, but is treated as a separate province from Guadalcanal and is regarded as the 10th province. It is subdivided into wards and enumeration areas. Each province is subdivided into districts and each district into villages. In addition to these administrative units, during the last census in 2009, each sector was subdivided into convenient areas called census enumeration areas (EAs). In total, Solomon Islands has about 1,342 EAs. The list of EAs has census information on households and population counts, and also the census cartographic materials. This list of EAs was used as the sampling frame for the SIDHS 2015.

The survey estimates of the SIDHS 2015 will be reported for the country as a whole, for urban and rural areas, and for Honiara, the capital city, and each of the other 4 provinces, namely, Guadacanal, Malaita, Western and Other Provinces.

A.2 SAMPLE FRAME

The sampling frame used for the SIDHS 2015 is based on the Solomon islands Housing and Population Census conducted in 2009 by the National Statistics Office. The frame consists of 1,342 EAs. An EA is a convenient geographical area with an average size of about 60 to 100 households. The frame contains information about each EA location, the type of residences, the number of households, and the population. Each EA has a cartographical map that delimits the boundaries and shows the main landmarks of the EA. Table A.1 shows the 2009 census household distribution by province.

Table A1: Population and households distribution by province, 2009 Census

Province	Population	%	Households	%
1. Choiseul	26,372	5.1	4,712	5.2
2. Western	76,649	14.9	13,762	15.1
3. Isabel	26,158	5.1	5,143	5.6
4. Central	26,051	5.0	4,905	5.4
5. RenBell	3,041	0.6	688	0.8
6. Guadacanal	93,613	18.1	17,163	18.8
7. Malaita	137,596	26.7	24,421	26.8
8. Makira	40,419	7.8	7,173	7.9
9. Temotu	21,362	4.1	4,303	4.7
10. Honiara	64,609	12.5	8,981	9.8
Total	**515,870**	**100**	**91,251**	**100**

A.3 SAMPLE DESIGN AND IMPLEMENTATION

The sample for the SIDHS 2015 was a stratified sample, selected independently in two stages from the sampling frame. Stratification was achieved by separating each geographical domain into urban and rural areas (10 stratums in total).

In the first stage, EAs were randomly selected from each of the 10 stratas with probability proportional to size. In total, 211 EAs were selected. After the selection of the EAs and before the main survey enumeration, a household listing operation updating was carried out in all of the selected EAs. The household listing consisted of visiting each of the 211 selected EAs, drawing a location map and a detailed sketch map, and recording on the household listing forms all occupied residential households found in the EA with the address and the name of the head of the household. The resulting list of households served as the sampling frame for the selection of households in the second stage.

In this second stage of selection, a fixed number of 24 households per EA were selected in every urban and rural EA through equal probability systematic sampling based on the newly updated household listing. Table A.2 shows the sample allocation of EAs and households according to province and by urban and rural.

Table A2: Sample allocation of EAs and households according to province and by region, 2015 SIDHS

Distribution of enumeration areas and households in the sampling frame by province, 2015 SIDHS

Province	Enumeration Area			Households		
	Urban	Rural	Total	Urban	Rural	Total
Honiara	29	na	29	696	na	696
Guadanacal	12	33	45	288	792	1,080
Malaita	8	37	45	192	888	1,080
Western	12	33	45	288	792	1,080
Other Provinces	8	39	47	192	936	1,128
Total	**69**	**142**	**211**	**1,656**	**3,408**	**5,064**

A.4 SAMPLE PROBABILITIES AND SAMPLE WEIGHTS

Due to the non-proportional allocation of the sample across domains and urban/rural areas, and differential response rates, any analysis of SIDHS data requires the data to be weighted. Weights are applied to the data to ensure that survey results are representative at both the national and domain level. Since the XDHS sample is a two-stage stratified cluster sample, sampling weights are calculated based on sampling probabilities for each sampling stage and for each cluster. We use the following notations:

P_{1hi}: first-stage sampling probability of the i^{th} cluster in stratum h

P_{2hi}: second-stage sampling probability within the i^{th} cluster (households)

Let a_h be the number of clusters selected in stratum h, M_{hi} the number of households according to the sampling frame in the i^{th} cluster, and $\sum M_{hi}$ the total number of households in the stratum. The probability of selecting the i^{th} cluster is calculated as follows:

$$\frac{a_h M_{hi}}{\sum M_{hi}}$$

Let b_{hi} be the proportion of households in the selected cluster compared to the total number of households in cluster i in stratum h if the cluster is segmented, otherwise $b_{hi} = 1$. Then the probability of selecting cluster i in the sample is:

$$P_{1hi} = \frac{a_h M_{hi}}{\sum M_{hi}} \times b_{hi}$$

Let L_{hi} be the number of households listed in the household listing operation in cluster i in stratum h, let g_{hi} be the number of households selected in the cluster. The second stage's selection probability for each household in the cluster is calculated as follows:

$$P_{2hi} = \frac{g_{hi}}{L_{hi}}$$

The overall selection probability of each household in cluster *i* of stratum *h* is therefore the product of the two stages selection probabilities:

$$P_{hi} = P_{1hi} \times P_{2hi}$$

The design weight for each household in cluster *i* of stratum *h* is the inverse of its overall selection probability:

$$W_{hi} = 1/P_{hi}$$

Next, the design weight is adjusted for household non-response and individual non-response to get the sampling weights for households and for women and men, respectively. Non-response is adjusted at the sampling stratum level. For the household sampling weight, the household design weight is multiplied by the inverse of the household response rate, by stratum. For the women's individual sampling weight, the household sampling weight is multiplied by the inverse of the women's individual response rate, by stratum. For the men's individual sampling weight, the household sampling weight is multiplied by the inverse of the men's individual response rate, by stratum. After adjusting for non-response, the sampling weights are normalized to get the final standard weights that appear in the data files. The normalization process is done to obtain a total number of un-weighted cases equal to the total number of weighted cases at the national level, for the total number of households, women, and men. Normalization is done by multiplying the sampling weight by the estimated sampling fraction obtained from the survey for the household weight, the individual woman's weight, and the individual man's weight. The normalized weights are relative weights which are valid for estimating means, proportions, ratios, and rates, but are not valid for estimating population totals or for pooled data.

A.5 SAMPLE IMPLEMENTATION

Table A.3 and Table A.4 present response rates for women and men, respectively, by urban and rural areas and by region. The male subsample constituted one in two of the households selected for the women's sample.

Table A3: Sample implementation – Women

Percent distribution of households and eligible women by results of the household and individual interviews, and household, eligible women and overall women response rates, according to urban-rural residence and region (unweighted), Solomon Islands 2015

Result	Residence		Region					Total
	Urban	Rural	Honiara	Guadalcanal	Malaita	Western	Other provinces	
Selected households								
Completed (C)	99.6	99.6	99.3	99.4	99.6	99.6	99.8	99.6
Household present but no competent respondent at home (HP)	0	0.1	0	0.2	0	0	0	0
Refused (R)	0.1	0.2	0.3	0.4	0.1	0.1	0.2	0.2
Household absent (HA)	0.1	0.1	0.3	0.1	0.3	0	0	0.1
Dwelling vacant/address not a dwelling (DV)	0.1	0	0	0	0	0.1	0	0
Other (O)	0.1	0	0.1	0	0	0.2	0	0.1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of sampled households	1,632	3,432	696	1,080	1,080	1,080	1,128	5,064
Household response rate (HRR)[1]	99.9	99.7	99.7	99.4	99.9	99.9	99.8	99.8
Eligible women								
Completed (EWC)	92.6	95.2	96.6	93.1	94.1	94	92.9	94.1
Not at home (EWNH)	4.6	1.7	2.1	3.7	2.3	3	3.5	2.9
Postponed (EWP)	0.1	0.1	0.1	0.6	0	0	0	0.1
Refused (EWR)	1.7	1.6	0.5	1.8	1.9	1.6	2.1	1.6
Partly completed (EWPC)	0.2	0.1	0.2	0.2	0.3	0.1	0.1	0.2
Incapacitated (EWI)	0.3	0.9	0.2	0.4	1	0.7	1	0.7
Other (EWO)	0.4	0.4	0.3	0.2	0.3	0.7	0.4	0.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of women	2,713	3,944	1,303	1,311	1,334	1,352	1,357	6,657
Eligible women response rate (EWRR)[2]	92.6	95.2	96.6	93.1	94.1	94	92.9	94.1
Overall women response rate (ORR)[3]	92.5	94.9	96.3	92.6	94	93.9	92.7	93.9

[1] Using the number of households falling into specific response categories, the household response rate (HRR) is calculated as:

$$\frac{100 * C}{C + HP + P + R + DNF}$$

[2] The eligible women response rate (EWRR) is equivalent to the percentage of interviews completed (EWC)

[3] The overall women response rate (OWRR) is calculated as:

OWRR = HRR * EWRR/100

Table A4: Sample implementation – Men

Percent distribution of households and eligible men by results of the household and individual interviews, and household, eligible men and overall men response rates, according to urban-rural residence and region (unweighted), Solomon Islands 2015

Result	Residence		Region					Total
	Urban	Rural	Honiara	Guadalcanal	Malaita	Western	Other provinces	
Selected households								
Completed (C)	99.8	99.7	99.4	99.3	99.6	100	100	99.7
Household present but no competent respondent at home (HP)	0	0.1	0	0.2	0	0	0	0
Refused (R)	0	0.2	0	0.6	0.2	0	0	0.2
Household absent (HA)	0.1	0.1	0.3	0	0.2	0	0	0.1
Other (O)	0.1	0	0.3	0	0	0	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of sampled households	820	1,724	349	542	543	545	565	2,544
Household response rate (HRR)[1]	100	99.7	100	99.3	99.8	100	100	99.8
Eligible men								
Completed (EMC)	91.5	91.7	96.9	85.9	93.8	90.7	90.9	91.6
Not at home (EMNH)	5.2	4.1	1.2	8.6	3	5.4	4.6	4.6
Postponed (EMP)	0.1	0.1	0	0.4	0.1	0.1	0	0.1
Refused (EMR)	2.1	1.5	1.1	3.4	0.8	1.7	1.9	1.8
Partly completed (EMPC)	0.1	0.3	0.1	0.4	0.3	0.1	0.1	0.2
Incapacitated (EMI)	0.4	1.5	0.1	0.9	0.8	1	2.3	1
Other (EMO)	0.7	0.7	0.5	0.4	1.2	1	0.3	0.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of men	1,597	2,323	752	746	739	894	789	3,920
Eligible men response rate (EMRR)[2]	91.5	91.7	96.9	85.9	93.8	90.7	90.9	91.6
Overall men response rate (ORR)[3]	91.5	91.4	96.9	85.3	93.6	90.7	90.9	91.4

[1] Using the number of households falling into specific response categories, the household response rate (HRR) is calculated as:

$$\frac{100 * C}{C + HP + P + R + DNF}$$

[2] The eligible men response rate (EMRR) is equivalent to the percentage of interviews completed (EMC)

[3] The overall men response rate (OMRR) is calculated as:

OMRR = HRR * EMRR/100

APPENDIX B: ESTIMATES OF SAMPLING ERRORS

The estimates from a sample survey are affected by two types of errors: non-sampling errors and sampling errors. 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 SIDHS 2015 to minimize 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 SIDHS 2015 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 error is 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 as a simple random sample, it would have been possible to use straightforward formulas for calculating sampling errors. However, the SIDHS 2015 sample is the result of a multi-stage stratified design, and, consequently, it was necessary to use more complex formulae. Sampling errors are computed in either ISSA or SAS, using programs developed by ICF Macro. These programs use the Taylor linearization method of variance estimation for survey estimates that are means, proportions or ratios. The Jackknife repeated replication method is used for variance estimation of more complex statistics such as fertility and mortality rates.

The Taylor linearization 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:

$$SE^2(r) = var(r) = \frac{1-f}{x^2}\sum_{h=1}^{H}\left[\frac{m_h}{m_h-1}\left(\sum_{i=1}^{m_h} z_{hi}^2 - \frac{z_h^2}{m_h}\right)\right]$$

in which $z_{hi} = y_{hi} - rx_{hi}$, 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 SIDHS 2015, there were 211 non-empty clusters. Hence, 211 replications were created. The variance of a rate *r* is calculated as follows:

$$SE^2(r) = var(r) = \frac{1}{k(k-1)} \sum_{i=1}^{k} (r_i - r)^2$$

in which

$$r_i = kr - (k-1)r_{(i)}$$

Where r is the estimate computed from the full sample of 211 clusters,

$r_{(i)}$ is the estimate computed from the reduced sample of 212 clusters (i^{th} cluster excluded), and

k is the total number of clusters.

In addition to the standard error, the design effect (DEFT) for each estimate is also calculated The design effect 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. Relative standard errors and confidence limits for the estimates are also calculated.

Sampling errors for the SIDHS 2015 are calculated for selected variables considered to be of primary interest. The results are presented in this appendix for the country as a whole, 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 through B.9 present the value of the statistic (R), its standard error (SE), the number of un-weighted (N) and weighted (WN) cases, the design effect (DEFT), the relative standard error (SE/R), and the 95% confidence limits (R±2SE), for each variable. The sampling errors for mortality rates are presented for the five year period preceding the survey for the whole country and for the ten year period preceding the survey by residence and region. The DEFT is considered undefined when the standard error considering a 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 un-weighted cases is not relevant, as there is no known un-weighted value for woman-years of exposure to childbearing.

The confidence interval (e.g., as calculated for *children ever born to women age 40–49 [code: EVB40]*) can be interpreted as follows: the overall average from the national sample is 4.829 and its standard error is 0.094. Therefore, to obtain the 95% confidence limits, one adds and subtracts twice the standard error to the sample estimate, i.e., 4.829±2×0.094. There is a high probability (95 percent) that the *true* average number of children ever born to all women aged 40 to 49 is between 4.642 and 5.016.

For the total sample, the value of the DEFT, averaged over all variables, is 1.393]. This means that, due to multi-stage clustering of the sample, the average standard error is increased by a factor of 1.393 over that in an equivalent simple random sample.

Table B1: List of selected variables for sampling errors, Solomon Islands 2015

Variable code	Estimate	Base population
Urban (URBAN)	Proportion	All women and all men
Illiterate (ILLITER)	Proportion	All women and all men
No education (NOEDUC)	Proportion	All women and all men
Secondary education (SECOND)	Proportion	All women and all men
Net attendance ratio (ATTEND)	Ratio	
Never married (NEVMAR)	Proportion	All women and all men
Currently married (CURMAR)	Proportion	All women and all men
Married before age 20 (AGEM20)	Proportion	All women and all men
Currently pregnant (PREGNANT)	Proportion	All women and all men
Children ever born (EVBORN)	Mean	All women and all men
Children surviving (SURVIV)	Mean	All women and all men
Children ever born to women aged 40 -49 (EVB40)	Mean	All women and all men
Know any contraceptive method (KMETHO)	Proportion	Currently married women and currently married men
Currently using any contraceptive method (CUSE)	Proportion	Currently married women
Currently using pill (CUPILL)	Proportion	Currently married women
Currently using IUD (CUIUD)	Proportion	Currently married women
Currently using female sterilization (CUFSTER)	Proportion	Currently married women
Currently using periodic abstinence (CUPABS)	Proportion	Currently married women
Used public sector source (PSOURC)	Proportion	Current users of modern methods
Want no more children (NOMORE)	Proportion	Currently married women and currently married men
Want to delay birth at least two years (DELAY)	Proportion	Currently married women and currently married men
Ideal family size (IDEAL)	Mean	All women and all men
Perinatal mortality (PERINAT)	Rate	All live births
Mothers received tetanus injection for last birth (TETANU)	Proportion	
Mothers received medical assistance at delivery (MEDELI)	Proportion	Births occurring 1-59 months before interview
Having diarrhoea in two weeks before survey (DIAR2W)	Proportion	Children age 0-59 months
Treated with oral rehydration salts (ORSTRE)	Proportion	Children with diarrhoea in the two weeks before interview
Taken to a health provider (MEDTRE)	Proportion	Children with diarrhoea in the two weeks before interview
Vaccination card seen (HCARD)	Proportion	Children aged 12 -23 months
Received BCG (BCG)	Proportion	Children aged 12 -23 months
Received Penta (3 doses) (PENTA)	Proportion	Children aged 12 -23 months
Received Polio (3 does) (POLIO)	Proportion	Children aged 12 -23 months
Received measles (MEASLE)	Proportion	Children aged 12 -23 months
Weight-for-ag (WGTAGE)	Proportion	Children aged 12 -23 months
Neonatal mortality (0-4)*	Rate	Children exposed to the risk of mortality
Neonatal mortality (5-9)*	Rate	Children exposed to the risk of mortality
Neonatal mortality (10-14)*	Rate	Children exposed to the risk of mortality
Neonatal mortality (0-10)*	Rate	Children exposed to the risk of mortality
Post-neonatal mortality (0-4)*	Rate	Children exposed to the risk of mortality
Post-neonatal mortality (5-9)*	Rate	Children exposed to the risk of mortality
Post-neonatal mortality (10-14)*	Rate	Children exposed to the risk of mortality
Post-neonatal mortality (0-10)*	Rate	Children exposed to the risk of mortality
Infant mortality (0-4)*	Rate	Children exposed to the risk of mortality
Infant mortality (5-9)*	Rate	Children exposed to the risk of mortality
Infant mortality (10-14)*	Rate	Children exposed to the risk of mortality
Infant mortality (0-10)*	Rate	Children exposed to the risk of mortality
Child mortality (0-4)*	Rate	Children exposed to the risk of mortality
Child mortality (5-9)*	Rate	Children exposed to the risk of mortality
Child mortality (10-14)*	Rate	Children exposed to the risk of mortality
Child mortality (0-10)*	Rate	Children exposed to the risk of mortality
Under-5 mortality (0-4)*	Rate	Children exposed to the risk of mortality
Under-5 mortality (5-9)*	Rate	Children exposed to the risk of mortality
Under-5 mortality (10-14)*	Rate	Children exposed to the risk of mortality
Under-5 mortality (0-10)*	Rate	Children exposed to the risk of mortality

* Total population only

Table B2: Sampling errors for total women, Solomon Islands 2015

Variable Code	R	SE	N	WN	DEFT	SE/R	R-2SE	R+2SE
URBAN	0.228	0.006	6266	6266	1.092	0.025	0.216	0.239
ILLITER	0.163	0.01	6189	6183	2.04	0.059	0.144	0.182
NOEDUC	0.092	0.007	6266	6266	1.83	0.073	0.079	0.105
SECOND	0.458	0.011	6266	6266	1.714	0.024	0.436	0.48
ATTEND	0.591	0.012	4467	4605	1.594	0.02	0.566	0.615
NEVMAR	0.309	0.008	6266	6266	1.332	0.025	0.293	0.325
CURMAR	0.652	0.008	6266	6266	1.405	0.013	0.635	0.669
AGEM20	0.398	0.01	5026	5025	1.383	0.024	0.379	0.417
PREGNANT	0.064	0.003	6266	6266	1.127	0.055	0.057	0.071
EVBORN	2.315	0.038	6266	6266	1.269	0.016	2.239	2.391
SURVIV	2.246	0.036	6266	6266	1.253	0.016	2.173	2.319
EVB40	4.829	0.094	1129	1052	1.276	0.019	4.642	5.016
KMETHO	0.97	0.004	4024	4086	1.415	0.004	0.962	0.977
CUSE	0.293	0.011	4024	4086	1.532	0.037	0.271	0.315
CUPILL	0.011	0.002	4024	4086	1.154	0.17	0.008	0.015
CUIUD	0.02	0.003	4024	4086	1.148	0.126	0.015	0.025
CUFSTER	0.09	0.007	4024	4086	1.483	0.074	0.077	0.104
CUPABS	0.026	0.003	4024	4086	1.211	0.116	0.02	0.032
PSOURC	0.874	0.018	1103	1104	1.82	0.021	0.837	0.91
NOMORE	0.357	0.01	4024	4086	1.353	0.029	0.337	0.377
DELAY	0.215	0.008	4024	4086	1.238	0.037	0.199	0.231
IDEAL	3.158	0.029	5912	5914	1.457	0.009	3.1	3.217
PERINAT	14.416	2.403	3888	4147	1.238	0.167	9.61	19.223
TETANU	0.228	0.012	2677	2807	1.505	0.052	0.205	0.252
MEDELI	0.862	0.013	3860	4119	2.024	0.015	0.836	0.889
DIAR2W	0.08	0.006	3779	4033	1.274	0.073	0.069	0.092
ORSTRE	0.366	0.033	299	325	1.15	0.09	0.3	0.432
MEDTRE	0.548	0.04	299	325	1.355	0.074	0.467	0.628
HCARD	0.837	0.015	776	826	1.158	0.018	0.807	0.867
BCG	0.918	0.012	776	826	1.22	0.013	0.895	0.941
PENTA	0.834	0.017	776	826	1.347	0.021	0.799	0.869
POLIO	0.824	0.017	776	826	1.318	0.021	0.79	0.859
MEASLE	0.615	0.021	776	826	1.225	0.034	0.573	0.656
WGTAGE	0.154	0.009	3413	3516	1.434	0.06	0.135	0.172

DEFT = design effect; N = number of unweighted cases; R = vaule of the statistic; R+-2SE = 95% confidence limit;

SE = standard error of the statistic; SE/R = relative standard error; WN = number of weighted cases

Note: Variable codes are defined in Table B.1.

Table B3: Sampling errors for urban women, Solomon Islands 2015

Variable Code	R	SE	N	WN	DEFT	SE/R	R-2SE	R+2SE
URBAN	1	0	2513	1427	-	0	1	1
ILLITER	0.076	0.009	2484	1411	1.701	0.119	0.058	0.094
NOEDUC	0.049	0.007	2513	1427	1.54	0.135	0.036	0.062
SECOND	0.657	0.018	2513	1427	1.907	0.027	0.621	0.694
ATTEND	0.662	0.021	1302	686	1.47	0.031	0.62	0.703
NEVMAR	0.362	0.013	2513	1427	1.397	0.037	0.335	0.389
CURMAR	0.585	0.014	2513	1427	1.466	0.025	0.557	0.614
AGEM20	0.299	0.017	1967	1156	1.666	0.057	0.265	0.334
PREGNANT	0.052	0.005	2513	1427	1.211	0.103	0.042	0.063
EVBORN	1.761	0.053	2513	1427	1.31	0.03	1.655	1.868
SURVIV	1.718	0.052	2513	1427	1.307	0.03	1.615	1.822
EVB40	4.059	0.129	398	208	1.146	0.032	3.802	4.316
KMETHO	0.988	0.003	1447	835	1.038	0.003	0.982	0.994
CUSE	0.259	0.014	1447	835	1.253	0.056	0.23	0.288
CUPILL	0.009	0.003	1447	835	1.019	0.274	0.004	0.015
CUIUD	0.028	0.005	1447	835	1.04	0.16	0.019	0.037
CUFSTER	0.082	0.009	1447	835	1.24	0.109	0.064	0.1
CUPABS	0.028	0.004	1447	835	1.013	0.157	0.019	0.037
PSOURC	0.803	0.028	399	214	1.387	0.034	0.748	0.859
NOMORE	0.323	0.018	1447	835	1.502	0.057	0.286	0.36
DELAY	0.225	0.012	1447	835	1.095	0.053	0.201	0.249
IDEAL	2.628	0.043	2366	1353	1.39	0.016	2.543	2.713
PERINAT	15.22	3.452	1246	741	1.004	0.227	8.316	22.124
TETANU	0.236	0.018	898	530	1.313	0.077	0.2	0.273
MEDELI	0.96	0.006	1238	738	0.986	0.006	0.948	0.973
DIAR2W	0.075	0.011	1209	720	1.38	0.145	0.053	0.096
ORSTRE	0.449	0.068	89	54	1.265	0.152	0.313	0.586
MEDTRE	0.623	0.061	89	54	1.149	0.098	0.501	0.746
HCARD	0.777	0.025	242	144	0.967	0.033	0.726	0.827
BCG	0.944	0.016	242	144	1.082	0.017	0.912	0.975
PENTA	0.886	0.019	242	144	0.938	0.021	0.848	0.923
POLIO	0.889	0.019	242	144	0.971	0.022	0.85	0.927
MEASLE	0.677	0.035	242	144	1.2	0.052	0.607	0.748
WGTAGE	0.119	0.012	1038	564	1.18	0.103	0.095	0.144

DEFT = design effect; N = number of unweighted cases; R = vaule of the statistic; R+-2SE = 95% confidence limit;

SE = standard error of the statistic; SE/R = relative standard error; WN = number of weighted cases

Note: Variable codes are defined in Table B.1.

Table B4: Sampling errors for rural women, Solomon Islands 2015

Variable Code	R	SE	N	WN	DEFT	SE/R	R-2SE	R+2SE
URBAN	0	0	3753	4839	-	-	0	0
ILLITER	0.189	0.012	3705	4772	1.877	0.064	0.165	0.213
NOEDUC	0.105	0.008	3753	4839	1.676	0.08	0.088	0.121
SECOND	0.399	0.013	3753	4839	1.581	0.032	0.374	0.425
ATTEND	0.578	0.014	3165	3919	1.508	0.024	0.551	0.606
NEVMAR	0.293	0.009	3753	4839	1.251	0.032	0.275	0.312
CURMAR	0.672	0.01	3753	4839	1.321	0.015	0.652	0.692
AGEM20	0.427	0.011	3059	3869	1.248	0.026	0.405	0.45
PREGNANT	0.067	0.004	3753	4839	1.034	0.063	0.059	0.076
EVBORN	2.478	0.047	3753	4839	1.17	0.019	2.385	2.571
SURVIV	2.402	0.044	3753	4839	1.155	0.019	2.313	2.491
EVB40	5.019	0.111	731	844	1.215	0.022	4.796	5.241
KMETHO	0.965	0.005	2577	3251	1.308	0.005	0.956	0.975
CUSE	0.302	0.013	2577	3251	1.469	0.044	0.276	0.329
CUPILL	0.012	0.002	2577	3251	1.093	0.197	0.007	0.017
CUIUD	0.018	0.003	2577	3251	1.133	0.164	0.012	0.024
CUFSTER	0.092	0.008	2577	3251	1.42	0.088	0.076	0.109
CUPABS	0.026	0.004	2577	3251	1.174	0.142	0.018	0.033
PSOURC	0.891	0.022	704	889	1.84	0.024	0.848	0.934
NOMORE	0.366	0.012	2577	3251	1.257	0.033	0.342	0.389
DELAY	0.213	0.01	2577	3251	1.19	0.045	0.193	0.232
IDEAL	3.316	0.035	3546	4561	1.389	0.011	3.245	3.387
PERINAT	14.241	2.829	2642	3405	1.162	0.199	8.583	19.9
TETANU	0.227	0.014	1779	2276	1.414	0.062	0.198	0.255
MEDELI	0.841	0.016	2622	3382	1.829	0.019	0.809	0.872
DIAR2W	0.082	0.007	2570	3313	1.158	0.082	0.068	0.095
ORSTRE	0.35	0.037	210	271	1.047	0.107	0.275	0.424
MEDTRE	0.533	0.047	210	271	1.258	0.088	0.439	0.626
HCARD	0.849	0.017	534	682	1.102	0.02	0.815	0.884
BCG	0.913	0.014	534	682	1.118	0.015	0.885	0.94
PENTA	0.823	0.021	534	682	1.251	0.025	0.781	0.864
POLIO	0.811	0.021	534	682	1.221	0.026	0.769	0.852
MEASLE	0.601	0.024	534	682	1.125	0.04	0.553	0.649
WGTAGE	0.16	0.011	2375	2952	1.356	0.067	0.139	0.182

DEFT = design effect; N = number of unweighted cases; R = vaule of the statistic; R+-2SE = 95% confidence limit;

SE = standard error of the statistic; SE/R = relative standard error; WN = number of weighted cases

Note: Variable codes are defined in Table B.1.

Table B5: Sampling errors for total men, Solomon Islands 2015

Variable Code	R	SE	N	WN	DEFT	SE/R	R-2SE	R+2SE
URBAN	0.230	0.007	3591	3591	0.963	0.029	0.216	0.244
NOEDUC	0.047	0.005	3591	3591	1.488	0.112	0.036	0.057
EDUC	0.500	0.013	3591	3591	1.518	0.025	0.475	0.525
NEVMAR	0.356	0.010	3591	3591	1.237	0.028	0.336	0.376
CURMAR	0.623	0.010	3591	3591	1.256	0.016	0.603	0.643
KMETHO	0.987	0.003	2258	2237	1.215	0.003	0.981	0.993
KMODME	0.985	0.003	2258	2237	1.228	0.003	0.979	0.991
CUSE	0.296	0.017	2258	2237	1.819	0.059	0.261	0.331
CUMODE	0.136	0.011	2258	2237	1.499	0.079	0.115	0.158
CUPILL	0.004	0.001	2258	2237	1.038	0.368	0.001	0.006
CUIUD	0.009	0.002	2258	2237	1.243	0.281	0.004	0.013
CUINJ	0.024	0.004	2258	2237	1.211	0.163	0.016	0.032
CUNORP	0.006	0.002	2258	2237	1.072	0.296	0.002	0.009
CUCOND	0.046	0.005	2258	2237	1.238	0.119	0.035	0.057
CUFSTER	0.042	0.006	2258	2237	1.309	0.132	0.031	0.053
CUMSTER	0.006	0.002	2258	2237	1.056	0.295	0.002	0.009
CUPABS	0.048	0.007	2258	2237	1.480	0.139	0.035	0.061
CUWITH	0.110	0.014	2258	2237	2.128	0.128	0.082	0.138
NOMORE	0.444	0.013	2258	2237	1.286	0.030	0.417	0.471
DELAY	0.214	0.010	2258	2237	1.181	0.048	0.194	0.235
IDEAL	3.551	0.046	3475	3467	1.468	0.013	3.459	3.644

DEFT = design effect; N = number of unweighted cases; R = vaule of the statistic; R+-2SE = 95% confidence limit;

SE = standard error of the statistic; SE/R = relative standard error; WN = number of weighted cases

Note: Variable codes are defined in Table B.1.

Table B6: Sampling errors for urban men, Solomon Islands 2015

Variable Code	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
URBAN	1	0	1461	826	0	0	1	1
NOEDUC	0.027	0.005	1461	826	1.143	0.180	0.017	0.036
EDUC	0.711	0.021	1461	826	1.764	0.029	0.669	0.753
NEVMAR	0.420	0.014	1461	826	1.081	0.033	0.392	0.448
CURMAR	0.549	0.014	1461	826	1.097	0.026	0.521	0.578
KMETHO	0.997	0.002	804	454	0.909	0.002	0.994	1.001
KMODME	0.997	0.002	804	454	0.909	0.002	0.994	1.001
CUSE	0.234	0.018	804	454	1.231	0.079	0.197	0.271
CUMODE	0.129	0.011	804	454	0.938	0.086	0.107	0.152
CUPILL	0.004	0.002	804	454	0.954	0.557	0	0.008
CUIUD	0.004	0.002	804	454	0.755	0.448	0	0.007
CUINJ	0.019	0.006	804	454	1.236	0.314	0.007	0.031
CUNORP	0.006	0.003	804	454	1.059	0.486	0	0.012
CUCOND	0.060	0.009	804	454	1.033	0.144	0.043	0.077
CUFSTER	0.030	0.006	804	454	0.922	0.184	0.019	0.042
CUMSTER	0.003	0.002	804	454	1.018	0.626	0	0.007
CUPABS	0.049	0.010	804	454	1.265	0.197	0.03	0.068
CUWITH	0.055	0.010	804	454	1.299	0.189	0.03	0.076
NOMORE	0.391	0.022	804	454	1.295	0.057	0.35	0.436
DELAY	0.219	0.017	804	454	1.153	0.077	0.19	0.253
IDEAL	3.035	0.051	1427	812	1.178	0.017	2.93	3.136

DEFT = design effect; N = number of unweighted cases; R = vaule of the statistic; R+-2SE = 95% confidence limit;

SE = standard error of the statistic; SE/R = relative standard error; WN = number of weighted cases

Note: Variable codes are defined in Table B.1.

Table B7: Sampling errors for rural men, Solomon Islands 2015

Variable Code	R	SE	N-UNWE	N-WEIG	DEFT	SE/R	R-2SE	R+2SE
URBAN	0	0	2130	2765	0	0	0	0
NOEDUC	0.053	0.007	2130	2765	1.372	0.126	0.039	0.066
EDUC	0.437	0.015	2130	2765	1.382	0.034	0.407	0.467
NEVMAR	0.337	0.012	2130	2765	1.205	0.037	0.312	0.361
CURMAR	0.645	0.013	2130	2765	1.226	0.020	0.619	0.670
KMETHO	0.984	0.004	1454	1783	1.113	0.004	0.977	0.992
KMODME	0.982	0.004	1454	1783	1.124	0.004	0.974	0.990
CUSE	0.312	0.021	1454	1783	1.759	0.068	0.269	0.355
CUMODE	0.138	0.013	1454	1783	1.469	0.096	0.111	0.165
CUPILL	0.003	0.002	1454	1783	0.996	0.442	0	0.007
CUIUD	0.010	0.003	1454	1783	1.158	0.304	0.004	0.016
CUINJ	0.025	0.005	1454	1783	1.131	0.185	0.016	0.034
CUNORP	0.006	0.002	1454	1783	1.018	0.352	0.002	0.010
CUCOND	0.042	0.006	1454	1783	1.226	0.153	0.029	0.055
CUFSTER	0.045	0.007	1454	1783	1.250	0.151	0.031	0.058
CUMSTER	0.006	0.002	1454	1783	0.979	0.324	0.002	0.010
CUPABS	0.048	0.008	1454	1783	1.428	0.167	0.032	0.064
CUWITH	0.124	0.017	1454	1783	2.002	0.140	0.089	0.158
NOMORE	0.457	0.016	1454	1783	1.219	0.035	0.425	0.489
DELAY	0.213	0.012	1454	1783	1.124	0.057	0.189	0.237
IDEAL	3.709	0.059	2048	2655	1.395	0.016	3.592	3.827

DEFT = design effect; N = number of unweighted cases; R = vaule of the statistic; R+-2SE = 95% confidence limit;
SE = standard error of the statistic; SE/R = relative standard error; WN = number of weighted cases
Note: Variable codes are defined in Table B.1.

Table B8: Sampling errors for childhood mortality rates for the 5 year periods preceding

Variable	R	SE	SE/R	R-2SE	R+2SE
0–4 (2011–2015)					
Neonatal	8.946	1.793	0.200	5.360	12.531
Postneonatal	9.734	1.981	0.204	5.771	13.697
Infant mortality	18.680	2.657	0.142	13.366	23.994
Child mortality	5.631	1.268	0.225	3.094	8.168
Under-5 mortality	24.205	2.878	0.119	18.449	29.962
5–9 (2006–2010)					
Neonatal	10.293	2.046	0.199	6.202	14.384
Postneonatal	9.299	1.809	0.195	5.681	12.917
Infant mortality	19.591	2.864	0.146	13.863	25.320
Child mortality	8.417	1.853	0.220	4.711	12.123
Under-5 mortality	27.844	3.592	0.129	20.660	35.027
10–14 (2001–2005)					
Neonatal	10.425	2.406	0.231	5.613	15.237
Postneonatal	6.537	1.544	0.236	3.448	9.625
Infant mortality	16.962	2.852	0.168	11.257	22.667
Child mortality	5.064	1.874	0.370	1.316	8.812
Under-5 mortality	21.940	3.481	0.159	14.979	28.901

Table B9: Sampling errors for childhood mortality rates for the 5 years preceding

Variable	R	SE	SE/R	R-2SE	R+2SE
Urban					
Neonatal	11.139	2.339	0.210	6.460	15.817
Postneonatal	7.409	2.232	0.301	2.945	11.872
Infant mortality	18.547	3.843	0.207	10.861	26.233
Child mortality	4.455	1.406	0.316	1.642	7.267
Under-5 mortality	22.919	3.888	0.170	15.143	30.696
Rural					
Neonatal	9.223	1.685	0.183	5.853	12.592
Postneonatal	9.984	1.765	0.177	6.454	13.514
Infant mortality	19.207	2.534	0.132	14.139	24.275
Child mortality	7.404	1.227	0.166	4.949	9.859
Under-5 mortality	26.468	2.862	0.108	20.745	32.192
Total					
Neonatal	9.561	1.445	0.151	6.670	12.451
Postneonatal	9.536	1.509	0.158	6.519	12.553
Infant mortality	19.096	2.194	0.115	14.709	23.484
Child mortality	6.897	1.047	0.152	4.802	8.992
Under-5 mortality	25.862	2.459	0.095	20.944	30.780

APPENDIX C: DATA QUALITY TABLES

Table C1: Household age distribution

Single-year age distribution of the de facto household population by sex (weighted), Solomon Islands 2015

	Women		Men	
Age	Number	Percent	Number	Percent
0	415	3.1	439	3.3
1	404	3	405	3
2	389	2.9	426	3.2
3	430	3.2	457	3.4
4	386	2.8	412	3.1
5	373	2.7	408	3
6	401	3	398	3
7	359	2.6	439	3.3
8	327	2.4	420	3.1
9	361	2.7	408	3
10	421	3.1	367	2.7
11	341	2.5	362	2.7
12	383	2.8	331	2.5
13	338	2.5	330	2.5
14	327	2.4	350	2.6
15	295	2.2	296	2.2
16	245	1.8	271	2
17	203	1.5	233	1.7
18	225	1.7	219	1.6
19	249	1.8	180	1.3
20	244	1.8	209	1.6
21	223	1.6	183	1.4
22	223	1.6	162	1.2
23	197	1.5	166	1.2
24	185	1.4	182	1.4
25	199	1.5	164	1.2
26	211	1.6	173	1.3
27	202	1.5	180	1.3
28	237	1.7	187	1.4
29	224	1.6	194	1.4
30	247	1.8	219	1.6
31	171	1.3	155	1.2
32	227	1.7	182	1.4
33	135	1	166	1.2
34	149	1.1	143	1.1
35	170	1.3	175	1.3
36	177	1.3	165	1.2
37	160	1.2	156	1.2
38	195	1.4	165	1.2
39	155	1.1	161	1.2
40	162	1.2	221	1.6
41	123	0.9	107	0.8
42	126	0.9	116	0.9
43	131	1	134	1
44	111	0.8	80	0.6
45	131	1	135	1
46	76	0.6	104	0.8
47	89	0.7	85	0.6
48	122	0.9	113	0.8
49	90	0.7	107	0.8
50	191	1.4	116	0.9
51	112	0.8	68	0.5
52	124	0.9	88	0.7
53	85	0.6	70	0.5
54	102	0.8	74	0.6
55	66	0.5	77	0.6
56	81	0.6	64	0.5
57	57	0.4	61	0.5
58	67	0.5	73	0.5
59	41	0.3	50	0.4
60	95	0.7	96	0.7
61	36	0.3	49	0.4
62	41	0.3	55	0.4
63	36	0.3	52	0.4
64	40	0.3	42	0.3
65	68	0.5	53	0.4
66	21	0.2	25	0.2
67	22	0.2	40	0.3
68	37	0.3	45	0.3
69	39	0.3	39	0.3
70+	262	1.9	327	2.4
Don't know/missing	1	0	4	0
Total	13,585	100	13,408	100

Note: The de facto population includes all residents and nonresidents who stayed in the household the night before the interview.

Table C2.1: Age distribution of eligible and interviewed women

De facto household population of women age 10–54, interviewed women age 15–49; and percent distribution and percentage of eligible women who were interviewed (weighted), by five-year age groups, Solomon Islands 2015

Age group	Household population of women age 10–54	Interviewed women age 15–49		Percentage of eligible women interviewed
		Number	Percentage	
10–14	1,810	-	-	-
15–19	1,216	1,147	19.2	94.3
20–24	1,073	1,017	17	94.8
25–29	1,073	1,023	17.1	95.3
30–34	930	882	14.8	94.8
35–39	857	811	13.6	94.7
40–44	653	604	10.1	92.5
45–49	507	492	8.2	96.9
50–54	614	-	-	-
15–49	6,308	5,976	100	94.7

Note: The de facto population includes all residents and nonresidents 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 questionnaire.

na = Not applicable

Table C2.2: Age distribution of eligible and interviewed men

De facto household population of men age 10–95, interviewed men age 15–95 and percent of eligible men who were interviewed (weighted), by five-year age groups, Solomon Islands 2015

Age group	Household population of men age 10–59	Interviewed men age 15–54		Percentage of eligible men interviewed
		Number	Percentage	
10–14	886	-	-	-
15–19	563	516	15.2	91.8
20–24	451	415	12.2	91.9
25–29	451	419	12.3	93
30–34	440	405	11.9	92.1
35–39	393	364	10.7	92.6
40–44	324	302	8.9	93.3
45–49	286	268	7.9	93.8
50–54	199	186	5.5	93.6
55–59	160	148	4.3	92
60–64	141	131	3.9	93.2
65–69	112	105	3.1	93.8
70–74	76	66	2	86.8
75–79	47	42	1.2	90.6
80–84	31	22	0.6	70.1
85–89	8	4	0.1	46.8
90–94	4	2	0.1	60.2
95	2	-	-	-
15–95	3,687	3,396	100	92.1

Note: The de facto population includes all residents and nonresidents 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 questionnaire.

na = Not applicable

Table C3: Completeness of reporting

Percentage of observations missing information for selected demographic and health questions (weighted), Solomon Islands 2015

Subject	Percentage with information missing	Number of cases
Month Only (Births in the 15 years preceding the survey)	0.96	10,503
Month and Year (Births in the 15 years preceding the survey)	0.26	10,503
Age at Death (Deceased children born in the 15 years preceding the survey)	0.14	266
Age/date at first union[1] (Ever married women age 15–49)	1.81	4,330
Age/date at first union (Ever married men age 15–49(64))	3.63	2,313
Respondent's education (All women age 15–49)	0.01	6,266
Respondent's education (All men age 15–49(64))	0.08	3,591
Diarrhea in last 2 weeks (Living children 0–59 months)	3.38	4,033
Height (Living children age 0–59 months from the Household Questionnaire)	8.77	4,153
Weight (Living children age 0–59 months from the Household Questionnaire)	7.42	4,153
Height or weight (Living children age 0–59 months from the Household Questionnaire)	9.01	4,153
Height (Women age 15–49 from the household questionnaire)	6.88	6,308
Weight (Women age 15–49 from the household questionnaire)	7.01	6,308
Height or weight (Women age 15–49 from the household questionnaire)	7.18	6,308
Height (Men age 15–49 from the household questionnaire)	13.64	2,907
Weight (Men age 15–49 from the household questionnaire)	13.64	2,907
Height or weight (Men age 15–49 from the household questionnaire)	13.69	2,907
Anemia (Living children age 6–59 months from the Household Questionnaire)	8.84	3,764
Anemia (All women from the Household Questionnaire)	7.72	6,308
Anemia (All men from the Household Questionnaire)	100	3,686

[1] Both year and age missing

Table C4: 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 2015

Calendar year	Number of births			Percentage with complete birth date[1]			Sex ratio at birth[2]			Calendar year ratio[3]		
	L	D	T	L	D	T	L	D	T	L	D	T
0	436	8	444	100	100	100	105.8	43.8	104.2	-	-	-
1	881	17	898	99.8	100	99.8	101.3	99.9	101.3	-	-	-
2	763	27	791	100	100	100	116.5	141	117.2	88.1	160.8	89.5
3	851	17	868	100	100	100	108.4	159.5	109.2	111.7	97.6	111.4
4	761	7	768	99.8	100	99.8	103.8	101.7	103.8	94.8	40.5	93.6
5	754	19	773	99.9	100	99.9	108.9	106.4	108.8	100.1	147.5	100.9
6	747	18	765	98	77.9	97.5	96.4	447.6	99.4	105.1	99.4	105
7	666	18	684	97.8	79.8	97.3	117.6	183.1	119	94.8	82.1	94.4
8	658	25	684	98.3	74.4	97.5	136.9	140.8	137	100.3	143.6	101.4
9	647	17	665	98	100	98	113.2	230.5	115.2	100.6	70.4	99.5
0–4	3,692	77	3,768	99.9	100	99.9	107	115.4	107.2	-	-	-
5–9	3,473	97	3,570	98.4	85.5	98.1	113.2	182.7	114.6	-	-	-
10–14	2,840	84	2,924	98.2	96.7	98.2	95.3	127.3	96.1	-	-	-
15–19	2,093	62	2,156	98	95.3	98	108.7	117.9	108.9	-	-	-
20+	1,976	111	2,086	96.7	96	96.7	100.8	110.3	101.2	-	-	-
All	14,074	431	14,504	98.5	94.4	98.4	105.3	129	106	-	-	-

NA = Not applicable

[1] Both year and month of birth given

[2] (Bm/Bf)x100, where Bm and Bf are the numbers of male and female births, respectively

[3] [2Bx/(Bx-1+Bx+1)]x100, where Bx is the number of births in calendar year x

Table C5: 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 2015

Age at death (days)	Number of years preceding the survey				
	0–4	5–9	10–14	15–19	Total 0–19
<1	14	8	2	1	25
1	12	14	11	10	48
2	2	2	4	0	8
3	3	1	6	3	13
4	0	1	2	0	3
5	1	0	1	1	3
6	0	1	0	0	1
7	4	3	0	3	9
10	1	0	0	0	1
12	0	0	1	0	1
14	0	0	3	2	4
21	1	0	0	0	1
Total 0–30	**38**	**30**	**29**	**20**	**117**
Percentage early neonatal[1]	85.1	91.1	87.1	78.4	86

[1] 0–6 days / 0–30 days

Table C6: 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 2015

Age at death (months)	Number of years preceding the survey				
	0–4	5–9	10–14	15–19	Total 0–19
<1	38	30	29	20	117
1	2	5	3	1	11
2	2	2	1	2	8
3	8	4	3	2	17
4	4	1	2	0	7
5	2	2	3	1	8
6	4	5	4	2	15
7	2	1	3	0	6
8	3	2	3	0	8
9	1	6	4	0	11
10	0	2	0	0	2
11	4	0	0	0	4
15	0	1	0	0	1
1 Year	10	7	8	5	30
Total 0–11	**70**	**60**	**54**	**29**	**213**
Percentage neonatal[1]	54.6	50.9	53.7	68.6	55.2

a Includes deaths under one month reported in days

[1] Under one month / under one year

Table C7: Nutritional status of children based on the NCHS/CDC/WHO international Reference Population

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-age,by background characteristics, based on the NCHS/CDC/WHO International Reference Population, Solomon Islands 2015

Background characteristic	Height-for-age[1]			Weight-for-height				Weight-for-age				Number of children
	Percentage below -3 SD	Percentage below -2 SD[2]	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-score (SD)	
Age in months												
<6	2	5.8	-0.1	1.7	4.1	5.9	0.3	0.9	2.1	9.1	0.3	276
6–8	1.7	11.9	-0.6	1.1	5	5.9	-0.2	0.6	8.2	3.2	-0.6	185
9–11	4.9	24.6	-1.2	1.7	6.2	1.7	-0.4	5	25.8	0.5	-1.3	181
12–17	12.9	36.5	-1.7	2.3	12	4.1	-0.7	8.5	36.3	2.5	-1.6	380
18–23	15.3	36.2	-1.6	3	12.8	3.8	-0.7	7.4	28.8	1.4	-1.4	335
24–35	9	25.8	-1.3	2.1	8	1.7	-0.6	4.8	25.6	1.4	-1.3	716
36–47	6.1	24.3	-1.3	1.2	5.3	1.4	-0.5	2.5	17.5	0.6	-1.2	769
48–59	6.7	25.6	-1.4	0.9	3.8	1	-0.6	2.4	18.2	0.5	-1.3	669
Sex												
Male	8	26.2	-1.3	1.7	7.3	2.6	-0.5	3.5	20.4	1.6	-1.1	1,804
Female	7.6	24.2	-1.2	1.6	6.6	2.3	-0.5	4.5	21.8	2.1	-1.1	1,707
Birth interval in months[3]												
First birth[4]	7.7	24.3	-1.2	1.7	6.5	2.8	-0.4	2.9	18.9	1.8	-1	743
<24	9.8	29.1	-1.3	1.5	6.2	2.9	-0.3	4.8	22.6	1	-1.1	656
24–47	8	25.7	-1.2	1.6	7.1	3.3	-0.3	3.3	21.8	2.5	-1	1,057
48+	5.6	19.4	-1.1	1.8	8	1.4	-0.5	3.8	20	1.7	-1.1	648
Size at birth[3]												
Very small	15	43.3	-1.7	4.2	9.5	2.3	-0.6	7.5	39.2	1.4	-1.5	92
Small	13.6	36.2	-1.5	2.6	11.4	3.4	-0.6	6.4	35.1	1.5	-1.4	334
Average or larger	6.6	22.3	-1.1	1.3	6.4	2.6	-0.3	3	18.3	2	-1	2,548
Missing	12.4	32	-1.4	4.4	5.6	2.4	-0.4	4.6	23.5	1.2	-1.2	126
Mother's interview status												
Interviewed	7.8	24.8	-1.2	1.7	7	2.7	-0.4	3.6	20.9	1.8	-1.1	3,105
Not interviewed but in household	6.2	26.4	-3.2	2.5	7.8	0	-2.7	5.3	21.8	0	-3.2	93
Not interviewed and not in the household[5]	8.5	29.2	-1.4	1.6	6.6	1.2	-0.9	7.2	22.9	1.9	-1.4	313

Mother's nutritional status[6]												
Thin (BMI<18.5)	15.5	42.5	-1.7	3.5	11.3	0	-0.8	5.5	44.9	0	-1.7	52
Normal (BMI 18.5–24.9)	8.7	26.9	-1.3	1.9	7.7	3.3	-0.4	4	22.9	2	-1.2	1,384
Overweight/ obese (BMI >= 25)	5.6	20.7	-1	1	5	2.5	-0.3	2.2	16.6	1.8	-0.9	1,272
Residence												
Urban	4.8	22.3	-1.1	0.9	4.8	2.7	-0.4	1.5	16	1.6	-0.9	567
Rural	8.4	25.8	-1.3	1.8	7.4	2.5	-0.5	4.4	22.1	1.8	-1.2	2,944
Region												
Honiara	4.6	21.6	-1	0.8	3.8	2.9	-0.3	1	15.5	1.9	-0.8	375
Guadalcanal	11.1	30.5	-1.3	1.2	6	6.3	-0.3	4.7	19.1	3	-1	574
Malaita	7.9	26.1	-1.3	1.3	3.8	2.1	-0.2	3.7	14.6	1.4	-1	1,002
Western	8.4	25.8	-1.2	3.7	13.7	1.4	-1	4.7	31.3	1.1	-1.5	496
Other provinces	6.8	22.6	-1.2	1.6	8.4	1.2	-0.7	4.5	25.5	1.9	-1.3	1,063
Mother's education												
No education	8.4	29	-1.4	2.1	7.6	3.2	-0.4	5.5	24.9	1	-1.2	325
Primary	8.2	25.8	-1.3	1.5	6.3	2.4	-0.4	2.9	20.3	2.1	-1.1	1,546
Secondary	7.6	23.7	-1.2	2	7.8	3	-0.5	4.4	21.3	1.9	-1.1	1,176
More than secondary	3.4	14.7	-0.9	0.7	6.3	1.4	-0.5	1.7	16.1	0	-0.9	148
Missing	0	21.8	-3.5	0	0	0	-2.7	0	0	0	-3.5	2
Wealth quintile												
Lowest	10.1	28.9	-1.4	2.3	8.9	2	-0.6	6.9	27.6	2	-1.3	836
Second	6.3	24.5	-1.2	0.8	6	2.7	-0.4	3.3	19.5	1.1	-1.1	761
Middle	9.2	27.3	-1.4	2.4	7.6	2.3	-0.5	3.7	22.1	1.1	-1.2	699
Fourth	7.8	24.2	-1.3	1	5.2	2.1	-0.4	3	17.8	1.6	-1.1	672
Highest	4.8	19.2	-1	1.7	6.6	3.7	-0.6	1.8	16.1	3.5	-1	543
Total	**7.8**	**25.2**	**-1.3**	**1.7**	**7**	**2.5**	**-0.5**	**4**	**21.1**	**1.8**	**-1.1**	**3,511**

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 International Reference Population. Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight

[1] Recumbent length is measured for children under age 2, or in the few cases when the age of the child ids unknown and the child is less than 85cm; standing height is measured for all other children" to be consistent with table 11.1.1

[2] Includes children who are below -3 standard deviations (SD) from the International Reference Population median

[3] Excludes children whose mothers were not interviewed

[4] First born twins (triplets, etc.) are counted as first births because they do not have a previous birth interval

[5] Includes children whose mothers are deceased

[6] Excludes children whose mothers were not interviewed, children whose mothers were not weighed and measured, and children whose mothers are pregnant or gave birth within the preceding 2 months. Mother's nutritional status in terms of BMI (Body Mass Index) is presented in Table 11.10.1

[7] 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 SIDHS 2015

SIDHS 2015 FINAL TEAM COMPOSITION

HONIARA PROVINCE

TEAM 1

	NAMES	*POSITION*	*ID CODE*
1.	*Michael D. Barasi*	*Supervisor*	*111*
2.	*Priscilla Ma'au*	*Field Editor*	*112*
3.	*George Noah*	*Male Interviewer*	*113*
4.	*Emilio Max Ma'au*	*Male Interviewer*	*114*
5.	*Joy Ohasio*	*Female Interviewer*	*115*
6.	*Margaret Toata*	*Female Interviewer*	*116*
7.	*Cecilia Betele*	*Female Interviewer*	*117*
8.	*Rose Natei*	*Female Interviewer*	*118*
9.	*Maeda Piri*	*Nurse*	*119*

TEAM 2

1.	*Eroni Kaui*	*Supervisor*	*121*
2.	*Janet Tuhaika*	*Field Editor*	*122*
3.	*Francis Mete Jnr*	*Male Interviewer*	*123*
4.	*Henry C. Liufimae*	*Male Interviewer*	*124*
5.	*Rhonna Marita*	*Female Interviewer*	*125*
6.	*Sera Sade*	*Female Interviewer*	*126*
7.	*Alzalia Olita'a*	*Female Interviewer*	*127*
8.	*June Magasu*	*Female Interviewer*	*128*
9.	*Narenda Furai*	*Nurse*	*129*

WESTERN PROVINCE

TEAM 3

	NAMES	*POSITION*	*ID CODE*
1.	*Kiko Lemasi*	*Supervisor*	*231*
2.	*Viniana Tome*	*Field Editor*	*232*
3.	*John Mavor Tuke*	*Male Interviewer*	*233*
4.	*Jack Hickie*	*Male Interviewer*	*234*
5.	*Florence Maelalo*	*Female Interviewer*	*235*
6.	*Veronica Nonga*	*Female Interviewer*	*236*
7.	*Allenah Hatimoana*	*Female Interviewer*	*237*
8.	*Joyce Zoti*	*Female Interviewer*	*238*
9.	*Alira Rose Karibule*	*Nurse*	*239*

TEAM 4

1.	*Sonter Roger*	*Supervisor*	*241*
2.	*Chelma Tauku*	*Field Editor*	*242*
3.	*Henry Alu*	*Male Interviewer*	*243*
4.	*Mason Tuku*	*Male Interviewer*	*244*
5.	*Ellen Magu*	*Female Interviewer*	*245*
6.	*Georgia Molia*	*Female Interviewer*	*246*
7.	*Shantie Zala*	*Female Interviewer*	*247*
8.	*Fiona Timothy*	*Female Interviewer*	*248*
9.	*Verlyn Gagahe*	*Nurse*	*249*

TEAM 5

1.	*Tender Lianga*	*Supervisor*	*251*
2.	*Molina Ziru*	*Field Editor*	*252*
3.	*Douglas Poa*	*Male Interviewer*	*253*
4.	*Licson Teu*	*Male Interviewer*	*254*
5.	*Nerolyn Victor*	*Female Interviewer*	*255*
6.	*Nora Nunala*	*Female Interviewer*	*256*
7.	*Dorin Isaac*	*Female Interviewer*	*257*
8.	*Tizziana Hivu*	*Female Interviewer*	*258*
9.	*Teronga Isaac*	*Nurse*	*259*

GUADALCANAL PROVINCE

TEAM 6

	NAMES	*POSITION*	*ID CODE*
1.	*Joseph Mari*	*Supervisor*	*361*
2.	*Stella Lee*	*Field Editor*	*362*
3.	*Moses Iro*	*Male Interviewer*	*363*
4.	*John Maeli*	*Male Interviewer*	*364*
5.	*Andella Sera*	*Female Interviewer*	*365*
6.	*Margaret Koevani*	*Female Interviewer*	*366*
7.	*Anastacia Kokopu*	*Female Interviewer*	*367*
8.	*Joan Fafale*	*Female Interviewer*	*368*
9.	*Nelson Thoa*	*Nurse*	*369*

TEAM 7

1.	*Christopher Lihoti*	*Supervisor*	*371*
2.	*Angeline Zamabule*	*Field Editor*	*372*
3.	*Justin Cheffers*	*Male Interviewer*	*373*
4.	*Robert Rukale*	*Male Interviewer*	*374*
5.	*Maria Sikua*	*Female Interviewer*	*375*
6.	*Hellen Waitara*	*Female Interviewer*	*376*
7.	*Rachel Maomai*	*Female Interviewer*	*377*
8.	*Betty Afuna*	*Female Interviewer*	*378*
9.	*Nancy Tapalia*	*Nurse*	*379*

TEAM 8

1.	*Ian Ghesimate*	*Supervisor*	*381*
2.	*Florence To'orumae*	*Field Editor*	*382*
3.	*David Dau*	*Male Interviewer*	*383*
4.	*Edson Saeni (Jnr)*	*Male Interviewer*	*384*
5.	*Wendy Changuri*	*Female Interviewer*	*385*
6.	*Jinnel Keni*	*Female Interviewer*	*386*
7.	*Aroma Agi*	*Female Interviewer*	*387*
8.	*Ranjila Kila*	*Female Interviewer*	*388*
9.	*Patrick Aduino*	*Nurse*	*389*

MALAITA PROVINCE

TEAM 9

	NAMES	POSITION	ID CODE
1.	Linus Ogali	Supervisor	491
2.	Theresah Aniboli	Field Editor	492
3.	James Haemanu	Male Interviewer	493
4.	Vincent Waletobata	Male Interviewer	494
5.	Mary Mafaeliu	Female Interviewer	495
6.	Cynthia Samani	Female Interviewer	496
7.	Anna Basi	Female Interviewer	497
8.	Samantha Tome	Female Interviewer	498
9.	Philip Osa	Nurse	499

TEAM 10

1.	Wilson Iroi	Supervisor	401
2.	Agnes Ludawane	Field Editor	402
3.	Peter Nazu	Male Interviewer	403
4.	Wolrick Futai	Male Interviewer	404
5.	Fakani Patricia	Female Interviewer	405
6.	Irine Rofeta	Female Interviewer	406
7.	Adriana Baidani	Female Interviewer	407
8.	Lois Oitalana Iputu	Female Interviewer	408
9.	Joyce Riafa'asia	Nurse	409

TEAM 11

1.	Athnasius Kaipuru	Supervisor	411
2.	Betty Julyn Puipui	Field Editor	412
3.	Pathros Manea'a	Male Interviewer	413
4.	Elvis Godwin Aima'a	Male Interviewer	414
5.	Ella Korasi	Female Interviewer	415
6.	Judith Horo'au	Female Interviewer	416
7.	Catherine Anisimae	Female Interviewer	417
8.	Freda Oloka	Female Interviewer	418
9.	Dino Saramo	Nurse	419

OTHER PROVINCE

TEAM 12

	NAMES	POSITION	ID CODE
1.	Blaize Nonge	Supervisor	521
2.	Sherol Panda	Field Editor	522
3.	Trevor Puairana	Male Interviewer	523
4.	Rodney Telovae	Male Interviewer	524
5.	Vaelyn Palmer	Female Interviewer	525
6.	Rachel Jina Baku	Female Interviewer	526
7.	Susan Mareta	Female Interviewer	527
8.	Annette Pitanapi	Female Interviewer	528
9.	Lorraine Ladomea	Nurse	529

TEAM 13

1.	*Michael Kuali*	*Supervisor*	*531*
2.	*Laurina Selevale*	*Field Editor*	*532*
3.	*Peter Pahili*	*Male Interviewer*	*533*
4.	*Richard Davidson*	*Male Interviewer*	*534*
5.	*Enif Tara*	*Female Interviewer*	*535*
6.	*Nester O. Meke*	*Female Interviewer*	*536*
7.	*Cynthia Ou'ou*	*Female Interviewer*	*537*
8.	*Janet Sulu*	*Female Interviewer*	*538*
9.	*Nancy Vagha*	*Nurse*	*539*

TEAM 14

1.	*John Ta'o*	*Supervisor*	*541*
2.	*Violet Agosi*	*Field Editor*	*542*
3.	*Patrick Bonie*	*Male Interviewer*	*543*
4.	*David Taisia*	*Male Interviewer*	*544*
5.	*Muriel Osikana*	*Female Interviewer*	*545*
6.	*Denise Kaiwori*	*Female Interviewer*	*546*
7.	*Betty Tafoa*	*Female Interviewer*	*547*
8.	*Cecilia Bagi Tagua*	*Female Interviewer*	*548*
9.	*John Murphy W.*	*Nurse*	*549*

DHS DATA ENTRY CLERKS ID CODES

	NAMES	*ID CODES*
1.	*Simas Tekulu*	*01*
2.	*Adip Tawainao*	*02*
3.	*Denis Vevix*	*03*
4.	*Anthony Gwaliasi*	*04*
5.	*Stephen Rauona*	*05*
6.	*Desmond Papage*	*06*
7.	*Jeffrey Konai*	*07*
8.	*Selina Lilo*	*08*
9.	*Chrisharly Billy*	*09*
10.	*Juanita Tovusia*	*10*

APPENDIX E: SIDHS 2015 QUESTIONNAIRES

FIGURE E.1: HOUSEHOLD QUESTIONNAIRE

March 2015

DEMOGRAPHIC AND HEALTH SURVEY
HOUSEHOLD QUESTIONNAIRE

SOLOMON ISLANDS
NATIONAL STATISTICS OFFICE/MINISTRY OF HEALTH

IDENTIFICATION

NAME OF HOUSEHOLD HEAD _____

HOUSEHOLD NUMBER . . . . . | | |

PROVINCE _____ | | |

WARD _____ | | |

EA NUMBER . . . . . | | | |

VILLAGE NAME _____

TOWN / PROVINCIAL CENTRE / RURAL
TOWN = 1, PROVINCIAL CENTRE = 2, RURAL = 3 . . . . . | |

HOUSEHOLD SELECTED FOR MALE SURVEY? 1 YES 2 NO | |

GPS WAYPOINTS

LATITUDE **LONGITUDE**

|__|__|º |__|__|' |__|__|.|__|'' |__|__|__|º |__|__|' |__|__|.|__|''

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY | |
				MONTH | |
				YEAR | | | |
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER | | |
RESULT*	_____	_____	_____	RESULT* |
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS |
TIME	_____	_____		

*RESULT CODES:

1 COMPLETED
2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT
3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
4 POSTPONED
5 REFUSED
6 DWELLING VACANT OR ADDRESS NOT A DWELLING
7 DWELLING DESTROYED
8 DWELLING NOT FOUND
9 OTHER _____ (SPECIFY)

TOTAL PERSONS IN HOUSEHOLD | |

TOTAL ELIGIBLE WOMEN | |

TOTAL ELIGIBLE MEN | |

LINE NO. OF RESPONDENT TO HOUSEHOLD QUESTIONNAIRE | |

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____ | | |	NAME _____ | | |	| |	| |

INTRODUCTION AND CONSENT

Hello. My name is _____. I am working with National Statistic Office. We are conducting a survey about health all over Solomon Islands. The information we collect will help the government to plan health services. Your household was selected for the survey. I would like to ask you some questions about your household. The questions usually take about 15 to 20 minutes. All of the answers you give will be confidential and will not be shared with anyone. Your participation in this survey is very important as it will help improve the health services provided by the government for our country. We hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.
In case you need more information about the survey, you may contact the National Statistics Office.

Halo. Nem blong mi _____Mi waka wetem National Statistic Office. Mifala duim wanfala savei abaot helt long ful Solomon Islands. Infomeson wea mifala kolektim bae hem helpem Gavman fo planim olketa helt sevis.Haos blong iu olketa siusim tu for disfala savei.Olketa kuesten hem save tekem 15 or 20 minit nomoa. Evri ansa u givim bae tambu tumas fo mifala talem go long eniwan moa . For iu joinem disfala savei bae hem impotent tumas bikos bae hem help lo saed fo improvim olketa helt sevisis wea gavman hem provaedim fo kandere blong iumi. Bae hem gud tumas sapos iu agri fo ansarem olketa kuesten bikos tingting blong iu hem impoten tumas. Sapos mi askem iu eni kuesten wea iu les fo ansarem, iu talem mi mekem mi save muv go long nara kuesten or iu save stopem intaviu enitaem.Sapos iu nidim moa infomeson abaotim savei, iu save kontaktim olketa pipol wea stap insaed lo National Statistics Office.

Do you have any questions?
Waswe iu garem eni kuesten?
May I begin the interview now?
Mi save statem intaviu distaem?

SIGNATURE OF INTERVIEWER: _____ DATE: _____

RESPONDENT AGREES TO BE INTERVIEWED . . . 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 → END

HOUSEHOLD SCHEDULE

							IF AGE 15 OR OLDER							
LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	MARITAL STATUS	ELIGIBILITY						
1	2	3	4	5	6	7	8	9	10	11	11a	11b	11c	11d
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household. AFTER LISTING THE NAMES AND RECORDING THE RELATIONSHIP AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-20 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? *Wat nao konekson bituin (NEM) wetem hed blong haos?* SEE CODES BELOW.	Is (NAME) male or female? *Waswe, (NEM) hem gel or boe?* M F 1 2	Does (NAME) usually live here? *Waswe, (NEM) hem save stap fultaem long hia?* Y N 1 2	Did (NAME) stay here last night? *Waswe, (NEM) hem stap long hia las naet?* Y N 1 2	How old is (NAME)? *Hao ol nao (NEM)?* IF 95 OR MORE, RECORD '95'. IN YEARS	What is (NAME)'s current marital *Hao nao maret blong (NEM) long disfala taem?* 1 = MARRIED OR LIVING TOGETHER 2 = DIVORCED/ SEPARATED 3 = WIDOWED 4 = NEVER-MARRIED AND NEVER LIVED TOGETHER	CIRCLE LINE NUMBER OF ALL **WOMEN AGE 15-49** Eligible for Woman Quest.. measure/ anaemia test	CIRCLE LINE NUMBER OF ALL **MEN AGE 15 AND OLDER** Eligible for Man Ques.. measure/ anaemia test	CIRCLE LINE NUMBER OF ALL **CHILDREN AGE 0-5** Eligible for measure/ anaemia test	CIRCLE LINE NUMBER OF ALL **CHILDREN AGE 5-14** Eligible for interview with child labour questions (Qs.21-32)	CIRCLE LINE NUMBER OF ALL **CHILDREN AGE 1-14** Eligible for interview with child discipline questions (Qs.33-54)	CIRCLE LINE NUMBER OF ALL **CHILDREN AGED 0-14** Eligible for interview hardship for children related questions (Qs.150-161)	CIRCLE LINE NUMBER OF ALL **ADULT AGE 15+** Eligible for interview hardship for adults related questions (Qs.162-172)
01			1 2	1 2	1 2			01	01	01	01	01	01	01
02			1 2	1 2	1 2			02	02	02	02	02	02	02
03			1 2	1 2	1 2			03	03	03	03	03	03	03
04			1 2	1 2	1 2			04	04	04	04	04	04	04
05			1 2	1 2	1 2			05	05	05	05	05	05	05
06			1 2	1 2	1 2			06	06	06	06	06	06	06
07			1 2	1 2	1 2			07	07	07	07	07	07	07
08			1 2	1 2	1 2			08	08	08	08	08	08	08
09			1 2	1 2	1 2			09	09	09	09	09	09	09
10			1 2	1 2	1 2			10	10	10	10	10	10	10

CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HOUSEHOLD

01 = HEAD
02 = SPOUSE
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 = OTHER RELATIVE
10 = ADOPTED CHILD
11 = FOSTER
12 = STEP CHILD
14 = NOT RELATED
98 = DON'T KNOW

			M F	Y N	Y N	IN YEARS							
11			1 2	1 2	1 2			11	11	11	11	11	11	11
12			1 2	1 2	1 2			12	12	12	12	12	12	12
13			1 2	1 2	1 2			13	13	13	13	13	13	13
14			1 2	1 2	1 2			14	14	14	14	14	14	14
15			1 2	1 2	1 2			15	15	15	15	15	15	15
16			1 2	1 2	1 2			16	16	16	16	16	16	16
17			1 2	1 2	1 2			17	17	17	17	17	17	17
18			1 2	1 2	1 2			18	18	18	18	18	18	18
19			1 2	1 2	1 2			19	19	19	19	19	19	19
20			1 2	1 2	1 2			20	20	20	20	20	20	20

TICK HERE IF CONTINUATION SHEET USED ☐

2A) Just to make sure that I have a complete listing: are there any other persons such as small children or infants that we have not listed?
YES ☐ → ADD TO TABLE NO ☐

2B) Are there any other people who may not be members of your family, such as domestic servants, lodgers, or friends who usually live here?
YES ☐ → ADD TO TABLE NO ☐

2C) Are there any guests or temporary visitors staying here, or anyone else who stayed here last night, who have not been listed?
YES ☐ → ADD TO TABLE NO ☐

CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HOUSEHOLD

01= HEAD
02 = WIFE OR HUSBAND
03 = SON OR DAUGHTER
04 = SON- IN- LAW OR DAUGHTER- IN- LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT- IN- LAW
08 = BROTHER OR SISTER
09 = OTHER RELATIVE
10 = ADOPTED
10a = FOSTER
10b = STEP CHILD
11= NOT RELATED
98 = DON'T KNOW

	IF AGE 0-17 YEARS				IF AGE 0-14 YEARS	IF AGE 5 YEARS OR OLDER		IF AGE 5-24 YEARS		IF AGE 0-4 YEARS
LINE NO.	SURVIVORSHIP AND RESIDENCE OF BIOLOGICAL PARENTS				MOTHER OR PRIMARY CARE TAKER	EVER ATTENDED SCHOOL		CURRENT/RECENT SCHOOL ATTENDANCE		BIRTH REGIS-TRATION
	12	13	14	15a	15b	16	17	18	19	20
	Is (NAME)'s natural mother alive? *Waswe, ril mami blong (NEM) hem laef iet?*	Does (NAME)'s natural mother usually live in this household or was she a guest last night? IF YES: What is her name? RECORD MOTHER'S LINE NUMBER. RECORD IF NO, RECORD '00'.	Is (NAME)'s natural father alive? *Waswe, ril dadi blong (NEM) hem laef iet?*	Does (NAME)'s natural father usually live in this household or was he a guest last night? IF YES: What is his name? RECORD FATHER'S LINE NUMBER. IF NO, RECORD '00'.	ENTER LINE NUMBER OF MOTHER FROM COLUMN 13 INDICATED. IF COLUMN 13 IS BLANK OR "00" ASK. Who is the primary care taker of (NAME)?	Has (NAME) ever attended school? *Waswe (NEM) hem schol tu o?*	What is the highest level of school (NAME) has attended? *Wat nao haes levol long skul wea (NEM) hem kasem?* SEE CODES BELOW. What is the highest grade (NAME) completed at that level? *Wat nao haes gred (NEM) hem kasem long dat fala levol?* SEE CODES BELOW.	Did (NAME) attend school at any time during the 2015 school year? Waswe, (NEM) hem atendim skul tu enitaem insaed long disfala yia 2015?	During this/that school year, what level and grade [is/was] (NAME) attending? SEE CODES BELOW. *Insaed disfala/datfala skul yia, wat levol an gred nao (NEM) hem atendim distaem or bin atendim las taem?*	Does (NAME) have a birth certificate? *Waswe, (NEM) hem garem setifiket taem hem bon?* IF NO, PROBE: Has (NAME)'s birth ever been registered with the civil authority? *Taem (NEM) hem bon oketa registam wetem lokol atoriti?* 1= HAS CERTIFICATE 2 = REGISTERED 3 = NEITHER 8 = DON'T KNOW
01	Y N DK 1 2 8 GO TO 14		Y N DK 1 2 8 GO TO 15b			Y N 1 2 GO TO 20	LEVEL GRADE	Y N 1 2 GO TO 20	LEVEL GRADE	
02	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
03	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
04	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
05	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
06	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
07	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
08	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
09	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		
10	1 2 8 GO TO 14		1 2 8 GO TO 15b			1 2 GO TO 20		1 2 GO TO 20		

CODES FOR Qs. 17 AND 19: EDUCATION

LEVEL
0 = PRE SCHOOL
1= PRIMARY (Grades 01-07) (Forms 01-07)
2 = SECONDARY
3 = TERTIARY
4 = VOCATIONAL
8 = DON'T KNOW
9 = OTHER

GRADE
00 = LESS THAN 1 YEAR COMPLETED (USE '00' FOR Q. 17 ONLY. THIS CODE IS NOT ALLOWED FOR Q. 19)
98 = DON'T KNOW

	Y N DK		Y N DK			Y N	LEVEL GRADE	Y N	LEVEL GRADE	
11	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
12	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
13	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
14	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
15	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
16	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
17	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
18	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
19	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		
20	1 2 8 → GO TO 14		1 2 8 → GO TO 15b			1 2 → GO TO 20		1 2 → GO TO 20		

CODES FOR Qs. 17 AND 19: EDUCATION

LEVEL	GRADE
0 = PRESCHOOL	00 = LESS THAN 1 YEAR COMPLETED
1= PRIMARY	(USE '00' FOR Q. 17 ONLY.
2 = SECONDARY	THIS CODE IS NOT ALLOWED
3 = TERTIARY	FOR Q. 19)
4 = VOCATIONAL	98 = DON'T KNOW
8 = DON'T KNOW	
9 = OTHER	

CHILD LABOR (FOR ALL CHILDREN AGED 5 THROUGH 14)

(21) **CHECK COLUMN (11a) FOR ELIGIBILITY: AT LEAST ONE CHILD AGE 5-14** ☐ **NO CHILDREN AGE 5-14** ☐ → **33**

THE MODULE OF CHILD LABOUR IS TO BE ADMINISTERED ONLY TO THE MOST KNOWLEDGEABLE ADULT (MOTHER, FATHER, OTHER PRIMARY CARETAKER OR GUARDIAN OF THE CHILD.

Now I would like to ask about any work that children in this household may do.

LINE NUMBER	NAME OF CHILD FROM COL. 2	AGE OF CHILD FROM COL. 7	WORK LAST WEEK						HOUSEHOLD CHORES	
(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)
WRITE CHILD'S LINE NUMBER FROM COLUMN 11a IN THE HOUSEHOLD SCHEDULE	WRITE CHILD'S NAME FROM COLUMN 2 IN THE HOUSEHOLD SCHEDULE	WRITE CHILD'S AGE FROM COLUMN 7 IN THE HOUSEHOLD SCHEDULE	During the past week, did (NAME) do any kind of work for someone who is not a member of this household: IF YES: Was that for pay (cash or in kind) or unpaid?	Since last (DAY OF THE WEEK), about how many hours did (NAME) do this work for someone who is not a member of this household s? INCLUDE ALL HOURS AT ALL JOBS	During the past week, did (NAME) fetch water or collect firewood for household use?	Since last (DAY OF THE WEEK) about how many hours did (NAME) fetch water or collect fire wood for household use?	During the past week, did (NAME) do any paid or unpaidwork on a family farm or in a family business or selling goods in the streets? INCLUDE WORK FOR A BUSINESS RUN BY THE CHILD ALONE, OR WITH ONE OR MORE PARTNERS	Since last (DAY OF WEEK), about how many hours did (NAME) do this work for his/her family or himself/herself?	During the past week, did (NAME) help with household chores such as shopping, cleaning, washing clothes, cooking or caring for children, old, or sick people?	Since last (DAY OF WEEK) about how many hours did (NAME) spend doing these chores?
Child 1 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 2 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 3 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 4 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 5 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 6 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 7 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT LINE	☐☐
Child 8 ☐☐		☐☐	PAID 1 UNPD 2 NO 3 → GO TO 27	☐☐	Y 1 N 2 → GO TO 29	☐☐	Y 1 N 2 → GO TO 31	☐☐	Y 1 N 2 → NEXT PAGE	☐☐

IF NO MORE CHILD, GO TO QUESTION 33

CHILD DISCIPLINE MODULE
LIST OF ALL CHILDREN AGE 1-14

33	**CHECK COLUMN (11b) FOR ELIGIBILITY. AT LEAST ONE CHILD AGED 1-14** ☐ ↓	**NO CHILDREN AGED 1-14** ☐ → **55**

LIST EACH OF THE CHILDREN AGED 1-14 YEARS BELOW IN THE ORDER THEY APPEAR IN THE HOUSEHOLD SCHEDULE. DO NOT INCLUDE OTHER HOUSEHOLD MEMBERS OUTSIDE OF THE AGE RANGE 1-14 YEARS.

THE MODULE OF CHILD DISCIPLINE IS TO BE ADMINISTERED ONLY TO THE MOST KNOWLEDGEABLE ADULT (MOTHER, FATHER, OTHER PRIMARY CARETAKER OR GUARDIAN OF THE CHILD)

CHILDREN AGED 1-14 YEARS

CHILDREN RANK NUMBER	LINE NUMBER	NAME OF CHILD	CHILD'S AGE	MOTHER'S OR PRIMARY CARETAKER'S LINE NUMBER AND NAME
	WRITE CHILD'S LINE NO. FROM COLUMN 11b IN THE HHOLD SCHEDULE ONLY INCLUDE CHILDREN AGED 1-14	WRITE CHILD'S NAME FROM COLUMN 2 IN THE HOUSEHOLD SCHEDULE ONLY INCLUDE CHILDREN AGED 1-14	WRITE CHILD'S AGE FROM COLUMN 7 IN THE HOUSEHOLD SCHEDULE	WRITE MOTHER'S OR PRIMARY CARETAKER'S LINE NUMBER AND NAME FROM COLUMN 15b IN THE HOUSEHOLD SCHEDULE IF NOT AVAILABLE, RECORD '00' AND CONTINUE TO THE NEXT CHILD IN COLUMN 34, IF NO MORE CHILD CONTINUE TO QUESTION 38
	(34)	(35)	(36)	(37)
1	☐☐	_____	☐☐	☐☐ _____
2	☐☐	_____	☐☐	☐☐ _____
3	☐☐	_____	☐☐	☐☐ _____
4	☐☐	_____	☐☐	☐☐ _____
5	☐☐	_____	☐☐	☐☐ _____
6	☐☐	_____	☐☐	☐☐ _____
7	☐☐	_____	☐☐	☐☐ _____
8	☐☐	_____	☐☐	☐☐ _____
9	☐☐	_____	☐☐	☐☐ _____
10	☐☐	_____	☐☐	☐☐ _____

CHILD DISCIPLINE MODULE

TABLE FOR SELECTION OF CHILDREN FOR THE CHILD DISCIPLINE QUESTIONS

NO.	QUESTIONS AND FILTERS	SKIP
38	CHECK COLUMN 34: ☐ MORE THAN ONE CHILD AGE 1-14 ENTER TOTAL NUMBER IN BOX AND GO TO INSTRUCTIONS BELOW ☐ ONLY ONE CHILD AGE 1-14 → 41 ☐ NO CHILDREN AGE 1-14 → 55	
39	**INSTRUCTIONS** LOOK AT THE LAST DIGIT OF THE HOUSEHOLD NUMBER ON THE COVER PAGE. THIS IS THE ROW YOU SHOULD CIRCLE BELOW. LOOK AT QS 38 AND RECORD THE TOTAL NUMBER OF ELIGIBLE CHILDREN AGE 1-14 FROM COLUMN 34_____. THIS IS THE COLUMN NUMBER YOU SHOULD CIRCLE. IF THERE ARE MORE THAN 8 ELIGIBLE CHILDREN IN THE HOUSEHOLD, CIRCLE '8' IN THE ROW AT THE TOP OF THE TABLE. FIND THE BOX WHERE THE CIRCLED ROW AND THE CIRCLED COLUMN MEET AND CIRCLE THE NUMBER THAT APPEARS IN THE BOX. THIS IS THE RANK NUMBER OF THE ELIIGIBLE CHILD WHOSE PARENT OR CARETAKER WILL BE ASKED THE QUESTIONS ON CHILD DISCIPLINE. THEN, GO TO COLUMN (34) AND PUT A * NEXT TO THE HOUSEHOLD LINE NUMBER OF SELECTED CHILD AND RECORD CHILD'S HOUSEHOLD LINE NUMBER IN Q.41 AND RECORD CHILD'S PARENT OR OTHER MOST KNOWLEDGEABLE ADULT'S NAME AND LINE NUMBER IN Q.42. FOR EXAMPLE, IF THE HOUSEHOLD QUESTIONNAIRE NUMBER IS '3716', GO TO ROW 6 AND CIRCLE THE ROW NUMBER ('6'). IF THERE ARE THREE ELIGIBLE CHILDREN IN THE HOUSEHOLD, GO TO COLUMN 3 AND CIRCLE THE COLUMN NUMBER ('3'). DRAW LINES FROM ROW 6 AND COLUMN 3 AND FIND THE BOX WHERE THE TWO MEET, AND CIRCLE THE NUMBER IN IT ('2'). THIS MEANS YOU HAVE TO SELECT THE SECOND ELIGIBLE CHILD. SUPPOSE THE HOUSEHOLD LINE NUMBERS OF THE THREE ELIGIBLE CHILDREN ARE '02', '03', AND '07'; THEN THE ELIGIBLE CHILD FOR THE QUESTIONS ON CHILD DISCIPLINE IS THE SECOND ELIGIBLE CHILD, I.E.,THE CHILD WITH HOUSEHOLD LINE NUMBER '03'. PUT A * NEXT TO THIS CHILD'S LINE NUMBER IN COLUMN (22) OF THE LIST AND ALSO ENTER THE TWO DIGIT LINE NUMBER AND CHILD'S NAME IN Q.41. THEN, RECORD THE LINE NUMBER AND A NAME OF CHILD'S PARENT OR OTHER MOST KNOWLEDGEABLE ADULT IN Q.42	
40		

LAST DIGIT OF THE HOUSEHOLD NUMBER	TOTAL NUMBER OF CHILDREN AGE 1-14 IN THE HOUSEHOLD							
	1	2	3	4	5	6	7	8+
0	1	2	2	4	3	6	5	4
1	1	1	3	1	4	1	6	5
2	1	2	1	2	5	2	7	6
3	1	1	2	3	1	3	1	7
4	1	2	3	4	2	4	2	8
5	1	1	1	1	3	5	3	1
6	1	2	2	2	4	6	4	2
7	1	1	3	3	5	1	5	3
8	1	2	1	4	1	2	6	4
9	1	1	2	1	2	3	7	5

CHILD DISCIPLINE - FOR ONE CHILD AGED 1 THROUGH 14			
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
41	LINE NUMBER AND NAME OF THE SELECTED CHILD AGE 1-14 YEARS FROM COLUMNS 34 AND 35	LINE NUMBER . . . . . ☐☐ NAME _____	
42	LINE NUMBER AND NAME OF CHILD'S MOTHER OR OTHER PRIMARY CARETAKER FROM COLUMN 37	MOTHER/CARETAKER NOT AVAILABLE . . . . . 00 → 55 LINE NUMBER ..... ☐☐ NAME_____	
THE FOLLOWING QUESTIONS 43-54 ON CHILD DISCIPLINE ARE TO BE ADMINISTERED ONLY TO THE MOST KNOWLEDGEABLE ADULT (MOTHER, FATHER, OTHER PRIMARY CARETAKER OR A GUARDIAN OF A CHILD)			
	Adults use certain ways to teach children the right behavior or to address a behaviour problem. I will read various methods that are used and I want you to tell me if you or anyone else in the household has used this method with (NAME) in the past month. *Olketa big pipol save usim samfala weis fo tisim olketa pikinini raet fala wei or stretim nogud actions blong olketa .Bae mi readim kam samfala metod wea olketa save usim an mi laekim iu fo talem mi if iu or nara wan moa insaet long haus ia hemi usim disfala metod wetem(NEM) insaet long las mans .*		
43	Took away privileges, forbade something (NAME) liked, or did not allow him/her to leave the house (in the past month)? *Stopem olketa raets o stopem samting (NEM) hem laekim,or no letem hem fo go aot from haus(insaet long las mans)?*	YES . . . . . 1 NO 2	
44	Explained why (NAME's) behaviour was wrong (in the past month)? *Iu save talem wae na (NEM) hemi duim olketa wrong actions (insaet long las mans?*	YES . . . . . 1 NO 2	
45	Shook him/her (in the past month)? *SEkem hem (insaet long las mans)?*	YES . . . . . 1 NO 2	
46	Shouted, yelled or screamed at (NAME) in the past month? *Shoutem,kolem big (NEM) insaet long las mans?*	YES . . . . . 1 NO 2	
47	Gave him/her something else to do (in the past month)? *Givim hem nara samting difren fo duim (insaet long las mans)?*	YES . . . . . 1 NO 2	
48	Spanked, hit or slapped him/her on the bottom with bare hand (in the past month)? *Hitim o slapem hem long botom wetem hand nomoa(insaet long las mans)?*	YES . . . . . 1 NO 2	
49	Hit him/her on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object (in the past month)? *Hitim hem long botom o eni nara ples lo bodi blo hem wetem samting olsem belt ,bras fo hair,stiki o eni strong samting (insaet long las mans?.*	YES . . . . . 1 NO 2	
50	Called him/her dumb, lazy, or a similar name (in the past month)? *Kolem pikinini long karage,lezi tumas ,o olketa kaen rabis nem olsem (Insaet long las mans)*	YES . . . . . 1 NO 2	
51	Hit or slapped him/her on the face, head, or ears (in the past month)? *Hitim o slapim pikinini lo face,head o ear blong hem (insaet long las mans)?*	YES . . . . . 1 NO 2	
52	Hit or slapped him/her on the hand, arm or leg (in the past month)? *Hitim o slapim pikinini lo hand ,arm o leg (Insaet long las mans)?*	YES . . . . . 1 NO 2	
53	Beat him/her up, that is hit him/her over and over as hard as one could (in the past month)? *Hitim pikinini nogud tumas staka taem long taem iu hitim hem (Insaet long las mans)?*	YES . . . . . 1 NO 2	
54	Do you believe that in order to bring up, raise, or educate a child properly, the child needs to be physically punished? *Waswe iu beliv dat fo bringim ap o rasim o tisim pikinini gud fala,pikinini ia,hem mas wip o hitim bodi blong hem nao?.*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

DISABILITY QUESTIONS

DURING THIS MODULE AVOID USING THE TERM "DISABILITY." THIS TERM CARRIES A NEGATIVE IMPLICATIONS AND COULD INTERFERE WITH THE ACCURACY OF THE RESPONDENT'S RESPONSE.

THE FOLLOWING DISABILITY QUESTIONS SHOULD BE ASKED OF ALL MEMBERS OF THE HOUSEHOLDS (USUAL RESIDENCE AND VISITORS WHO SPENT THE PREVIOUS NIGHT IN THIS HOUSEHOLD). MAKE SURE THAT ALL SMALL CHILDREN SHOULD BE ALSO ASKED ABOUT THEIR DISABILITY RELATED PROBLEMS. THE MOTHER, FATHER OR ANY CARETAKER OF THE CHILD SHOULD ADMINISTERED THE QUESTIONS FOR THE CHILD. FOLLOW THE LIST OF PERSONS IN COLUMN 1 OF THE HOUSEHOLD SCHEDULE.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES			
55	LINE NUMBER FROM COLUMN 1 (HOUSEHOLD SCHEDULE)	PERSON 1 LINE NUMBER ☐☐	PERSON 2 LINE NUMBER ☐☐	PERSON 3 LINE NUMBER ☐☐	PERSON 4 LINE NUMBER ☐☐
56	ENTER NAME FROM COLUMN 2 (HOUSEHOLD SCHEDULE)	NAME: _____	NAME: _____	NAME: _____	NAME: _____
	Now I would like to ask the following questions about difficulties you may have doing certain activities because of a HEALTH PROBLEM. *Distaem mi laekfo askem iu abaot eni problem iu maet garem wetem oketa aktiviti olem*				
57	Do you have difficulty seeing, even if wearing glasses? *Waswe iu garem problem fo lukluk nomata iu wearem ae glas?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT SEE AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT SEE AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT SEE AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT SEE AT ALL 4
58	Do you have difficulty hearing, even if using a hearing aid? *Waswe iu garem problem wetem herehere blong iu nomata iu wearem hiaring eid?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT AL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
59	Do you have difficulty walking ? *Iu garem problem taem iu wakabaot?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT AL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
60	Do you have difficulty climbing steps? *Waswe iu garem problem taem iu klaemapum step?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
61	Do you have difficulty remembering or concentrating? *Waswe iu garem problem fo rimemba or iu tingim wan samting an no tingim eni ting moa?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT AL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
62	Do you have difficulty (with self-care such as) washing all over or dressing? *Waswe iu garem problem for luk aftarem iu seleva olsem(waswas or havem kaleko?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
63	Using your usual (customary or other) language, do you have difficulty communicating, for example understanding or being understood? *Sapos iu iusim nomol (kastomari o nara) langus, iu faendem had fo komiuniket fo eksampol, nao fo andastandim iu?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
64	GO BACK TO QUESTION 57 IF THERE ARE MORE THAN ONE PERSON AND CONTINUE WITH THE QUESTIONS. USE THE NEXT PAGE IF MORE THAN 4 PERSONS. USE CONTINUATION QUESTIONNAIRE IF MORE THAN 8 PERSONS. IF NO MORE PERSONS IN THE HOUSEHOLDS THEN GO TO QUESTION 101.				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES			
55	LINE NUMBER FROM COLUMN 1 (HOUSEHOLD SCHEDULE)	PERSON 5 LINE NUMBER ☐☐	PERSON 6 LINE NUMBER ☐☐	PERSON 7 LINE NUMBER ☐☐	PERSON 8 LINE NUMBER ☐☐
56	ENTER NAME FROM COLUMN 2 (HOUSEHOLD SCHEDULE)	NAME: _____	NAME: _____	NAME: _____	NAME: _____
	Now I would like to ask you about any problems you might have with the following activities. *Distaem mi laekfo askem iu abaot eni problem iu maet garem wetem oketa aktiviti olem*				
57	Do you have difficulty seeing, even if wearing glasses? *waswe lu garem problem fo lukluk nomata iu wearem ae glas?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT SEE AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT SEE AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT SEE AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT SEE AT ALL 4
58	Do you have difficulty hearing, even if using a hearing aid? *waswe lu garem problem wetem hiaring blong iu nomata iu wearem hiaring eid?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT AL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
59	Do you have difficulty walking ? *waswe lu garem problem taem iu wakabaot?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT AL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
60	Do you have difficulty climbing steps? *waswe lu garem problem taem iu klaemapum step?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
61	Do you have difficulty remembering or concentrating? *waswe lu garem problem fo rimemba or iu tingim wan samting an no tingim eni ting moa?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT AL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
62	Do you have difficulty (with self-care such as) washing all over or dressing? *waswe lu garem problem for luk aftarem iu seleva olsem(waswas or havem kaleko?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
63	Using your usual (customary or other) language, do you have difficulty communicating, for example understanding or being understood? *Sapos iu iusim nomol (kastomari o nara) langus, iu faendem had fo komiuniket fo eksampol, nao fo andastandim iu?*	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . ..... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4	NO, NO DIFFICULTY ..... 1 YES - SOME DIFFICULTY ..... 2 YES-A LOT OF DIFFICULTY . .... 3 CANNOT DO AT ALL 4
64	GO BACK TO QUESTION 57 IF THERE ARE MORE THAN ONE PERSON AND CONTINUE WITH THE QUESTIONS. USE THIS PAGE IF MORE THAN 4 PERSONS. USE THE HOUSEHOLD CONTINUATION FORM IF MORE THAN 8 PERSONS. IF NO MORE PERSONS IN THE HOUSEHOLDS THEN GO TO QUESTION 101				

HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	How often does anyone smoke inside your house? Would you say daily, weekly, monthly, less than monthly, or never? *Eniwan insaet long haus blong iu hem save smoke,bae iu se evri dei,wan taem insaet wan wik,,wan taem insaet wan Mans,no kasem wan mans or nating nomoa?*	DAILY . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER 5	
102	What is the main source of drinking water for members of your household? *Wat na barava mein sos long wata fo dringim fo olketa memba insaet long household blong iu?*	PIPED WATER PIPED INTO DWELLING . . . . . 11 PIPED TO YARD/PLOT . . . . . 12 PUBLIC TAP/STANDPIPE . . . . . 13 TUBE WELL OR BOREHOLE . . . . . 21 DUG WELL PROTECTED WELL . . . . . 31 UNPROTECTED WELL . . . . . 32 WATER FROM SPRING PROTECTED . . . . . 41 UNPROTECTED SPRING . . . . . 42 RAINWATER . . . . . 51 TANKER TRUCK . . . . . 61 SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL) . . . . . 71 BOTTLED WATER . . . . . 81 OTHER _____ 96 (SPECIFY)	→ 105 → 105
103	Where is that water source located? *Long wea na wata sos hem stap?*	IN OWN DWELLING . . . . . 1 IN OWN YARD/PLOT . . . . . 2 ELSEWHERE 3	→ 105
104	How long does it take to go there, get water, and come back? *Hao long na hem tekem iu fo go tekem wata an kam baek?*	MINUTES . . . . . [ ][ ][ ] DON'T KNOW 998	
105	Do you do anything to the water to make it safer to drink? *Waswe iu duim enithing lo wata ia fo mekem hem safe fo dringim?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 107
106	What do you usually do to make the water safer to drink? *Wat na iu save duim olowe fo mekem wata ia safe fo dringim?* Anything else? *Eniting moa?* RECORD ALL MENTIONED.	BOIL . . . . . A ADD BLEACH/CHLORINE . . . . . B STRAIN THROUGH A CLOTH . . . . . C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC.) . . . . . D SOLAR DISINFECTION . . . . . E LET IT STAND AND SETTLE . . . . . F OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	

107	What kind of toilet facility do members of your household usually use? *Wat kaen taep toilet facility na olketa memba long household blong iu save iusim olowe?*	FLUSH OR POUR FLUSH TOILET FLUSH TO PIPED SEWER SYSTEM . . . . . 11 FLUSH TO SEPTIC TANK . . . . . 12 FLUSH TO PIT LATRINE . . . . . 13 FLUSH TO SOMEWHERE ELSE . . . . . 14 FLUSH, DON'T KNOW WHERE . . . . . 15 PIT LATRINE VENTILATED IMPROVED PIT LATRINE . . . . . 21 PIT LATRINE WITH SLAB . . . . . 22 PIT LATRINE WITHOUT SLAB/ OPEN PIT . . . . . 23 COMPOSTING TOILET . . . . . 31 HANGING TOILET/HANGING LATRINE . . . . . 41 NO FACILITY BUSH/FIELD . . . . . 51 SEA/OCEAN/BEACH . . . . . 52 → 110 OTHER _____ 96 (SPECIFY)	
108	Do you share this toilet facility with other households? *Waswe iu sharim disfala tiolet facility wetem olketa memba blong nara household?*	YES . . . . . 1 NO . . . . . 2 → 110	
109	How many households use this toilet facility? *Hao meni long olketa nara household na iufala usim disfala toilet facility*	NO. OF HOUSEHOLDS IF LESS THAN 10 . . . . . [0][ ] 10 OR MORE HOUSEHOLDS . . . . . 95 DON'T KNOW 98	
110	Does your household have: *Household blong iu garem:*		
	Electricity?	ELECTRICITY . . . . . YES 1 NO 2	
	A radio?	RADIO 1 2	
	A television?	TELEVISION 1 2	
	A mobile telephone?	MOBILE TELEPHONE 1 2	
	A bed?	BED . . . 1 2	
	A working sewing machine?	SEWING MACHINE . . . 1 2	
	A working microwave oven?	MICROWAVE . . . 1 2	
	A working electric fan?	FAN . . . 1 2	
	A working freezer?	FREEZER . . . 1 2	
	A working washing machine?	WASHING MACHINE . . . 1 2	
	A working Video set/VCD/DVD player?	VIDEO SET . . . 1 2	
	A working chainsaw?	CHAINSAW . . . 1 2	
	A dining table?	DINING SET . . . 1 2	
	A pressure lamp?	PRESSURE LAMP . . . 1 2	
	A refrigerator?	REFRIGERATOR 1 2	

111	What type of fuel does your household mainly use for cooking? *Wat nao household blong iu save usim fo kuki?*	ELECTRICITY . . . . . 01 LPG . . . . . 02 KEROSENE . . . . . 03 CHARCOAL . . . . . 04 WOOD . . . . . 05 SAW DUST . . . . . 06 STRAW/SHRUBS/GRASS . . . . . 07 AGRICULTURAL CROP . . . . . 08 ANIMAL DUNG . . . . . 09 NO FOOD COOKED IN HOUSEHOLD . . . . . 95 OTHER _____ 96 (SPECIFY)	→ 114
112	Is the cooking usually done in the house, in a separate building, or outdoors? *Iufala save kuki insaet long haus,insaet long nara separate buiding or outsaet?*	IN THE HOUSE . . . . . 1 IN A SEPARATE BUILDING . . . . . 2 OUTDOORS . . . . . 3 OTHER _____ 6 (SPECIFY)	→ 114
113	Do you have a separate room which is used as a kitchen? *Iufala garem separate room wea iufala usim olsem kitchen?*	YES . . . . . 1 NO 2	
114	MAIN MATERIAL OF THE FLOOR. RECORD OBSERVATION.	NATURAL FLOOR EARTH/SAND . . . . . 11 CORAL/PEEBLES . . . . . 12 RUDIMENTARY FLOOR WOOD PLANKS . . . . . 21 PALM/BAMBOO . . . . . 22 FINISHED FLOOR PARQUET OR POLISHED WOOD . . . . . 31 CERAMIC TILES . . . . . 32 CEMENT . . . . . 33 CARPET . . . . . 34 OTHER _____ 96 (SPECIFY)	
115	MAIN MATERIAL OF THE ROOF. RECORD OBSERVATION.	NATURAL ROOFING NO ROOF . . . . . 11 THATCH/PALM LEAF . . . . . 12 RUDIMENTARY ROOFING RUSTIC MAT . . . . . 21 PALM/BAMBOO . . . . . 22 WOOD PLANKS . . . . . 23 CARDBOARD . . . . . 24 FINISHED ROOFING CORRUGATED IRON . . . . . 31 OTHER METAL . . . . . 32 WOOD . . . . . 33 CERAMIC TILES . . . . . 34 CEMENT . . . . . 35 ROOFING SHINGLES . . . . . 36 OTHER _____ 96 (SPECIFY)	

116	MAIN MATERIAL OF THE EXTERIOR WALLS. RECORD OBSERVATION.	NATURAL WALLS NO WALLS . . . . . 11 CANE/PALM/TRUNKS . . . . . 12 RUDIMENTARY WALLS BAMBOO . . . . . 21 STONE . . . . . 22 PLYWOOD . . . . . 24 CARDBOARD . . . . . 25 REUSED WOOD . . . . . 26 MASONITE/FIBRO . . . . . 27 FINISHED WALLS CEMENT . . . . . 31 STONE WITH LIME/CEMENT . . . . . 32 BRICKS . . . . . 33 CEMENT BLOCKS . . . . . 34 WOOD PLANKS/SHINGLES . . . . . 36 OTHER _____ 96 (SPECIFY)	
117	How many rooms in this household are used for sleeping? *Hao meni room insaet haus ia na iufala usim fo sleep insaet?*	ROOMS	
118	Does any member of this household own: *Eni memba insaet long household ia hem ownim:* A watch? A bicycle? A motorcycle or motor scooter? A car or truck? A boat with a motor?	YES NO WATCH . . . . . 1 2 BICYCLE . . . . . 1 2 MOTORCYCLE/SCOOTER . . . 1 2 CAR/TRUCK . . . . . 1 2 BOAT WITH MOTOR 1 2	
119	Does any member of this household own any agricultural land? *Eni memba insaet long household ia hem ownim eni agricultural lan?*	YES . . . . . 1 NO 2	→ 121
120	How many hectares of agricultural land do members of this household own? *Hao meni hectares long disfala agricultural lan na olketa memba long disfala household hem ownim?* IF 95 OR MORE, CIRCLE '950'. *10,000 m^2 = 1 hectare*	HECTARES . . . . . . 95 OR MORE HECTARES . . . . . 950 DON'T KNOW 998	
121	Does this household own any livestock, herds, other farm animals, or poultry? *Waswe disfala household hem ownim eni livestock,herds,or other farm animals or poultry?*	YES . . . . . 1 NO 2	→ 123

122	How many of the following animals does this household own? *Hao meni long olketa following animals na disfala household ia ownim?* IF NONE, ENTER '00'. IF 95 OR MORE, ENTER '95'. IF UNKNOWN, ENTER '98'. Milk cows or bulls? Horses, donkeys, or mules? Goats? Pigs Ducks Chickens? Other?	COWS/BULLS . . . . . [ ][ ] HORSES/DONKE . . . . . [ ][ ] GOATS . . . . . [ ][ ] PIGS . . . . . [ ][ ] DUCKS . . . . . [ ][ ] CHICKENS . . . . . [ ][ ][ ] OTHER . . . . . [ ][ ]	
123	Does any member of this household have a bank account? *Eni memba long disfala household hem garem bank account?*	YES . . . . . 1 NO 2	
124	At any time in the past 12 months, has anyone come into your dwelling to spray the interior walls against mosquitoes? *Long enitaem insaet long las tuelv mans,waswe eniwan hem kam insaet long haus fo sprayim olketa wallings from mosquito?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 126
125	Who sprayed the dwelling? *Hu nao sprayim disfala haus?*	GOVERNMENT WORKER (MALARIA PROGRAM) . . . . . A PRIVATE COMPANY . . . . . B NONGOVERNMENTAL ORGANIZATION (NGO) . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
126	Does your household have any mosquito nets that can be used while sleeping? *Waswe household blong iu hem garem eni mosquito nets wea save usim taem sleep?*	YES . . . . . 1 NO 2	→ 137
127	How many mosquito nets does your household have? *Hao meni mosquito nets na household blong iu hem garem?* IF 7 OR MORE NETS, RECORD '7'.	NUMBER OF NETS . . . . . [ ]	

		NET #1	NET #2	NET #3
128	ASK THE RESPONDENT TO SHOW YOU ALL THE NETS IN THE HOUSEHOLD IF MORE THAN 3 NETS, USE ADDITIONAL QUESTIONNAIRE(S).	OBSERVED . . . . . 1 NOT OBSERVED . . . 2	OBSERVED . . . . . 1 NOT OBSERVED . . . 2	OBSERVED . . . . . 1 NOT OBSERVED . . . 2
129	How many months ago did your household get the mosquito net? *Hao meni mans go finis nao household blong iu tekem mosquito net?* IF LESS THAN ONE MONTH AGO, RECORD '00'.	MONTHS AGO . . . [ ][ ] MORE THAN 36 MONTHS AGO . . . 95 NOT SURE 98	MONTHS AGO . . . [ ][ ] MORE THAN 36 MONTHS AGO . . . 95 NOT SURE 98	MONTHS AGO . . . [ ][ ] MORE THAN 36 MONTHS AGO . . . 95 NOT SURE 98
130	OBSERVE OR ASK THE BRAND/ TYPE OF MOSQUITO NET. IF BRAND IS UNKNOWN AND YOU CANNOT OBSERVE THE NET, SHOW PICTURES OF TYPICAL NET TYPES/BRANDS	LONG-LASTING INSECTICIDE-TREATED NET (LLIN) OLYSET . . . . . 11 PERMANENT . . . 12 NETPROTECT . . 13 OTHERS . . . . . 14 DK BRAND . . . 16 (SKIP TO 134) 'PRETREATED' NET 21 (SKIP TO 132) OTHER BRAND . . . 96 DK BRAND 98	LONG-LASTING INSECTICIDE-TREATED NET (LLIN) OLYSET . . . . . 11 PERMANENT . . . . . 12 NETPROTECT . . . . . 13 OTHERS . . . . . 14 DK BRAND . . . 16 (SKIP TO 134) F 'PRETREATED' NET 21 (SKIP TO 132) OTHER BRAND . . . 96 DK BRAND 98	LONG-LASTING INSECTICIDE-TREATED NET (LLIN) OLYSET . . . . . 11 PERMANENT . . . . . 12 NETPROTECT . . . . . 13 OTHERS . . . . . 14 DK BRAND . . . 16 (SKIP TO 134) 'PRETREATED' NET 21 (SKIP TO 132) OTHER BRAND . . . 96 DK BRAND 98
131	When you got the net, was it already treated with an insecticide to kill or repel mosquitoes? *Taem iu tekem net ia,waswe olketa tritim long insecticide fo kilim or raosim mosquitoes?*	YES . . . . . 1 NO . . . . . 2 NOT SURE 8	YES . . . . . 1 NO . . . . . 2 NOT SURE 8	YES . . . . . 1 NO . . . . . 2 NOT SURE 8
132	Since you got the net, was it ever soaked or dipped in a liquid to kill or repel mosquitoes? *From iu tekem net ia, waswe eni taem hem bin soaked or dipim insaet eni liquid fo kilim or raosim mosquitoes?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 134) NOT SURE 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO 134) NOT SURE 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO 134) NOT SURE 8
133	How many months ago was the net last soaked or dipped? *Hao meni mans go finis nao net ia hem bin soaked or olketa dipim?* IF LESS THAN ONE MONTH AGO, RECORD '00'.	MONTHS AGO . . . [ ][ ] MORE THAN 24 MONTHS AGO . . . 95 NOT SURE 98	MONTHS AGO . . . [ ][ ] MORE THAN 24 MONTHS AGO . . . 95 NOT SURE 98	MONTHS AGO . . . [ ][ ] MORE THAN 24 MONTHS AGO . . . 95 NOT SURE 98
134	Did anyone sleep under this mosquito net last night? *Eni wan hem bin sleep insaet disfala mosquito net las naet?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 136) NOT SURE 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO 136) NOT SURE 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO 136) NOT SURE 8

135	Who slept under this mosquito net last night? *Hu nao sleep undernit long mosquito net ia las naet?* RECORD THE PERSON'S NAME AND LINE NUMBER FROM THE HOUSEHOLD SCHEDULE.	NAME_____ LINE NO.	NAME_____ LINE NO.	NAME_____ LINE NO. . . . .
		NAME_____ LINE NO.	NAME_____ LINE NO.	NAME_____ LINE NO. . . . .
		NAME_____ LINE NO.	NAME_____ LINE NO.	NAME_____ LINE NO. . . . .
		NAME_____ LINE NO.	NAME_____ LINE NO.	NAME_____ LINE NO. . . . .
136		GO BACK TO 128 FOR NEXT NET; OR, IF NO MORE NETS, GO TO 137.	GO BACK TO 128 FOR NEXT NET; OR, IF NO MORE NETS, GO TO 137.	GO TO 128 IN FIRST COLUMN OF A NEW QUESTIONNAIRE; OR, IF NO MORE NETS, GO TO 137.

137	Please show me where members of your household most often wash their hands. *Mi laekem fo u showem mi wea na membas long household blong iu save washim hands blong olketa.*	OBSERVED . . . . . 1 NOT OBSERVED, NOT IN DWELLING/YARD/PLOT . . . . . 2 NOT OBSERVED, NO PERMISSION TO SEE . . . . . 3 NOT OBSERVED, OTHER REASON . . . . . 4 (SKIP TO 140)
138	OBSERVATION ONLY: OBSERVE PRESENCE OF WATER AT THE PLACE FOR HANDWASHING.	WATER IS AVAILABLE . . . . . 1 WATER IS NOT AVAILABLE 2
139	OBSERVATION ONLY: OBSERVE PRESENCE OF SOAP, DETERGENT, OR OTHER CLEANSING AGENT.	SOAP OR DETERGENT (BAR, LIQUID, POWDER, PASTE) . . . . . A ASH, MUD, SAND . . . . . B NONE C
140	ASK RESPONDENT FOR A TEASPOONFUL OF COOKING SALT. TEST SALT FOR IODINE.	0 PPM (NO IODINE) . . . . . 1 ABOVE 0 PPM & BELOW 15 PPM . . . . . 2 15 PPM AND ABOVE . . . . . 3 NO SALT IN HOUSEHOLD . . . . . 4 SALT NOT TESTED _____ 6 (SPECIFY REASON)

HOUSEHOLD HARDSHIP

141 THE FOLLOWING QUESTIONS WILL BE USED TO MEASURE FAMILY/HOUSEHOLD MATERIAL WELL-BEING OR HARDSHIP
ASK THE HEAD OF THE HOUSEHOLD OR ANY ADULT MEMBER OF THE HOUSEHOLD

		Is it essential for everyone? *Hem important fo evriwan?*	Do you have it? *Waswe iu garem?*	Is it because you cannot (CA) afford it? OR Is it because you don't want it (DW)
142	Enough money to replace any worn out furniture NAME) have?	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
143	Enougn money to purchase or repair electrical goods such as refrigerator or *washing machine, etc.* *(If no electicity in the area, skip to Q. 144)*	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
144	Make regular savings for emergencies? *(eg. SI$1,000 a fortnight/month)*	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
145	Have all medicine prescribed by your doctor, when you are sick?	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
146	Having your own means of transportation (car, boat, motorcycle, canoes, etc.)	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2

147	Which one of the following statements best decribes how well your household has been keeping up with bills and credit commitments in the <u>last 12 months</u>?	KEEPING UP WITH BILLS AND/OR CREDIT COMMITMENTS WITHOUT ANY DIFFICULTIES ..... 1 BUT IT IS A STRUGGLE FROM TIME TO TIME ... 2 BUT IT IS A CONSTANT STRUGGLE ..... 3 HAVE FALLEN BEHIND WITH SOME OF THEM ... 4 HAVE FALLEN BEHIND WITH MANY OF THEM ... 5
148	Generally, how would you rate your standard of living?	WELL ABOVE AVERAGE ..... 1 ABOVE AVERAGE ..... 2 AVERAGE ..... 3 BELOW AVERAGI ..... 4 WELL BELOW AVERAGE 5

HARDSHIPS FOR CHILDREN AGED 0-14 YEARS

149 CHECK COLUMN 11c FOR CHILDREN AGED 0-14 IN THE HOUSEHOLD SCHEDULE
IF THERE IS ONE OR MORE CHIDREN IN THE HOUSEHOLD, MARK THE FIRST BOX AND ASK THE FOLLOWING QUESTIONS
IF NO CHILDREN AGED 0-14, MARK THE SECOND BOX THEN ASK QUESTION IN COLUMN 1 (ESSENTIAL PART) ONLY. DO NOT ASK COLUMN 2 AND COLUMN 3.

NOTE THAT THE HEAD OF THE HOUSEHOLD OR SPOUSE OR ANY ADULT SHOULD ANSWER ALL QUESTIONS ABOUT ALL CHILDREN IN THIS HOUSEHOLD.

150 CHECK COLUMN 11c:

ONE OR MORE CHILDREN AGED 0-14 ASK COLUMNS 1, 2 AND 3 ☐

NO CHILDREN AGED 0-14 ASK COLUMN 1 ONLY ☐

151		Is it essential for everyone? (1)	Do you have it? (2)	Is it because you cannot afford it? OR Is it because you don't want it (3)
152	New properly fitting, shoes	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
153	Three meals a day	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
154	Some new, not second-hand clothes	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
155	Celebrations on special occasions such as birthdays, Christmas or religious festival?	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
156	One meal with meat, chicken, fish or vegetarian equivalent daily	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
157	All school uniform and equipment required (eg. Books,pen, etc)	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
158	Enough beds and bedding for every child in the household	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
159	To participate in school trips and school events that costs money	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
160	Outdoor leisure equipment *(eg. bicycles,* sport equipment,etc)	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2
161	A suitable place to study or do homework	YES . . . . . 1 NO 2	Y N 1 2 →	Can't afford..... 1 Don't want..... 2

HARDSHIPS FOR ADULTS AGED 15 YEARS AND OVER

162 CHECK COLUMN 11d AND COLUMN 2 FOR ADULT ELIGIBILITY AND NAME IN THE HOUSEHOLD SCHEDULE
RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE ADULTS AGED 15 AND OVER TO BE ASKED THE FOLLOWING QUESTIONS
IF MORE THAN SIX ADULTS IN THIS HOUSEHOLD, USE CONTINUATION QUESTIONNAIRE

163 CHECK COLUMN 11d:
ONE OR MORE ADULTS AGED 15 AND OVER → ☐
NO ADULTS AGED 15 AND OVER → ☐ → 201

		ADULT 1			ADULT 2			ADULT 3		
164	LINE NUMBER FROM COLUMN 11d NAME FROM COLUMN 2	LINE NUMBER ..... ☐☐ NAME _____			LINE NUMBER ..... ☐☐ NAME _____			LINE NUMBER ..... ☐☐ NAME _____		
		Is it essential for everyone?	Do you have it?	Is it because you cannot (CA) afford it OR is it because you don't want it (DW)	Is it essential for everyone?	Do you have it?	Is it because you cannot (CA) afford it OR is it because you don't want it (DW)	Is it essential for everyone?	Do you have it?	Is it because you cannot (CA) afford it OR is it because you don't want it (DW)
165	Two pairs of properly fitting shoes, including a pair of all-weather shoes	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
166	Two meals a day	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
167	A small amount of money to spend each week on yourself	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
168	Clothes to wear for social or family occasions such as parties or special church occasions?	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
169	Replace worn-out clothes by some new (not second-hand) ones	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
170	To get together with friends/ family for a drink/meal at least monthly	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
171	Presents for friends or family once a year	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
172	Enough money to be able to visit friends and family in hospital or other institutions	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
			(GO TO 165 FOR NEXT ADULT OR, IF NO MORE, GO TO 201)			(GO TO 165 FOR NEXT ADULT OR, IF NO MORE, GO TO 201)			(GO TO 165 FOR NEXT ADULT OR, IF NO MORE, GO TO 201)	

		ADULT 4			ADULT 5			ADULT 6		
164	LINE NUMBER FROM COLUMN 11d NAME FROM COLUMN 2	LINE NUMBER ..... ☐☐ NAME _____			LINE NUMBER ..... ☐☐ NAME _____			LINE NUMBER ..... ☐☐ NAME _____		
		Is it essential for everyone?	Do you have it?	Is it because you cannot (CA) afford it OR is it because you don't want it (DW)	Is it essential for everyone?	Do you have it?	Is it because you cannot (CA) afford it OR is it because you don't want it (DW)	Is it essential for everyone?	Do you have it?	Is it because you cannot (CA) afford it OR is it because you don't want it (DW)
165	Two pairs of properly fitting shoes, including a pair of all-weather shoes	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
166	Two meals a day	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
167	A small amount of money to spend each week on yourself	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
168	Clothes to wear for social or family occasions such as parties or special church occasions?	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
169	Replace worn-out clothes by some new (not second-hand) ones	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
170	To get together with friends/ family for a drink/meal at least monthly	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
171	Presents for friends or family once a year	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
172	Enough money to be able to visit friends and family in hospital or other institutions	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2	YES.....1 NO.....2	Y N 1 2 →	CA..... 1 DW..... 2
			(GO TO 165 FOR NEXT ADULT OR, IF NO MORE, GO TO 201)			(GO TO 165 FOR NEXT ADULT OR, IF NO MORE, GO TO 201)			(GO TO 165 FOR NEXT ADULT OR, IF NO MORE, GO TO 201)	

WEIGHT, HEIGHT AND HEMOGLOBIN MEASUREMENT FOR CHILDREN AGE 0-5

		CHILD 1	CHILD 2	CHILD 3
201	CHECK COLUMN 11 IN HOUSEHOLD SCHEDULE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN 0-5 YEARS IN QUESTION 202. IF MORE THAN SIX CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S).			
202	LINE NUMBER FROM COLUMN 11 NAME FROM COLUMN 2	LINE NUMBER . . . . . ☐☐ NAME _____	LINE NUMBER . . . . . ☐☐ NAME _____	LINE NUMBER . . . . . ☐☐ NAME _____
203	IF MOTHER INTERVIEWED, COPY MONTH AND YEAR OF BIRTH FROM BIRTH HISTORY AND ASK DAY; IF MOTHER NOT INTERVIEWED, ASK: What is (NAME)'s birth date?	DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR ☐☐☐☐	DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR ☐☐☐☐	DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR ☐☐☐☐
204	CHECK 203: CHILD BORN IN JANUARY 2010 OR LATER?	YES . . . . . 1 NO . . . . . 2 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214)	YES . . . . . 1 NO . . . . . 2 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214)	YES . . . . . 1 NO . . . . . 2 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214)
205	WEIGHT IN KILOGRAMS	KG. ☐☐.☐☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996	KG. ☐☐.☐☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996	KG. ☐☐.☐☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996
206	HEIGHT IN CENTIMETERS	CM. ☐☐☐.☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996	CM. ☐☐☐.☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996	CM. ☐☐☐.☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996
207	MEASURED LYING DOWN OR STANDING UP?	LYING DOWN . . . . . 1 STANDING UP . . . . . 2 NOT MEASURED 3	LYING DOWN . . . . . 1 STANDING UP . . . . . 2 NOT MEASURED 3	LYING DOWN . . . . . 1 STANDING UP . . . . . 2 NOT MEASURED 3
208	CHECK 203: IS CHILD AGE 0-5 MONTHS, I.E., WAS CHILD BORN IN MONTH OF INTERVIEW OR FIVE PREVIOUS MONTHS?	0-5 MONTHS . . . . . 1 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214) OLDER 2	0-5 MONTHS . . . . . 1 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214) OLDER 2	0-5 MONTHS . . . . . 1 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214) OLDER 2
209	LINE NUMBER OF PARENT/ OTHER ADULT RESPONSIBLE FOR THE CHILD (FROM COLUMN 1 OF HOUSEHOLD SCHEDULE). RECORD '00' IF NOT LISTED.	LINE NUMBER . . . . . ☐☐	LINE NUMBER . . . . . ☐☐	LINE NUMBER . . . . . ☐☐
210	ASK CONSENT FOR ANEMIA TEST FROM PARENT/OTHER ADULT IDENTIFIED IN 209 AS RESPONSIBLE FOR CHILD.	As part of this survey, we are asking people all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat We ask that all children born in 2010 or later take part in anemia testing in this survey and give a few drops of blood from a finger or heel. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test. The blood will be tested for anemia immediately, and the result will be told to you right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team. Do you have any questions? You can say yes to the test, or you can say no. It is up to you to decide. Will you allow (NAME OF CHILD) to participate in the anemia test?		
211	CIRCLE THE APPROPRIATE CODE AND SIGN YOUR NAME.	GRANTED . . . . . 1 _____ (SIGN) REFUSED 2	GRANTED . . . . . 1 _____ (SIGN) REFUSED 2	GRANTED . . . . . 1 _____ (SIGN) REFUSED 2
212	RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA PAMPHLET.	G/DL ☐☐.☐ NOT PRESENT . . . . 994 REFUSED . . . . . 995 OTHER 996	G/DL ☐☐.☐ NOT PRESENT . . . . 994 REFUSED . . . . . 995 OTHER 996	G/DL ☐☐.☐ NOT PRESENT . . . . 994 REFUSED . . . . . 995 OTHER 996
213	GO BACK TO 203 IN NEXT COLUMN OF THIS QUESTIONNAIRE OR IN THE FIRST COLUMN OF THE NEXT PAGE; IF NO MORE CHILDREN, GO TO 214.			

		CHILD 4	CHILD 5	CHILD 6
202	LINE NUMBER FROM COLUMN 11 NAME FROM COLUMN 2	LINE NUMBER . . . . . ☐☐ NAME _____	LINE NUMBER . . . . . ☐☐ NAME _____	LINE NUMBER . . . . . ☐☐ NAME _____
203	IF MOTHER INTERVIEWED, COPY MONTH AND YEAR OF BIRTH FROM BIRTH HISTORY AND ASK DAY; IF MOTHER NOT INTERVIEWED, ASK: What is (NAME)'s birth date?	DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR ☐☐☐☐	DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR ☐☐☐☐	DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR ☐☐☐☐
204	CHECK 203: CHILD BORN IN JANUARY 2010 OR LATER?	YES . . . . . 1 NO . . . . . 2 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214)	YES . . . . . 1 NO . . . . . 2 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214)	YES . . . . . 1 NO . . . . . 2 (GO TO 203 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE CHILDREN, GO TO 214)
205	WEIGHT IN KILOGRAMS	KG. ☐☐.☐☐ NOT PRESENT . . . . . 9994 REFUSED . . . . . 9995 OTHER 9996	KG. ☐☐.☐☐ NOT PRESENT . . . . . 9994 REFUSED . . . . . 9995 OTHER 9996	KG. ☐☐.☐☐ NOT PRESENT . . . . . 9994 REFUSED . . . . . 9995 OTHER 9996
206	HEIGHT IN CENTIMETERS	CM. ☐☐☐.☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996	CM. ☐☐☐.☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996	CM. ☐☐☐.☐ NOT PRESENT . . . 9994 REFUSED . . . . . 9995 OTHER 9996
207	MEASURED LYING DOWN OR STANDING UP?	LYING DOWN . . . . . 1 STANDING UP . . . . . 2 NOT MEASURED 3	LYING DOWN . . . . . 1 STANDING UP . . . . . 2 NOT MEASURED 3	LYING DOWN . . . . . 1 STANDING UP . . . . . 2 NOT MEASURED 3
208	CHECK 203: IS CHILD AGE 0-5 MONTHS, I.E., WAS CHILD BORN IN MONTH OF INTERVIEW OR FIVE PREVIOUS MONTHS?	0-5 MONTHS . . . . . 1 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214) OLDER 2	0-5 MONTHS . . . . . 1 (GO TO 203 FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO 214) OLDER 2	0-5 MONTHS . . . . . 1 (GO TO 203 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE CHILDREN, GO TO 214) OLDER 2
209	LINE NUMBER OF PARENT/ OTHER ADULT RESPONSIBLE FOR THE CHILD (FROM COLUMN 1 OF HOUSEHOLD SCHEDULE). RECORD '00' IF NOT LISTED.	LINE NUMBER . . . . . ☐☐	LINE NUMBER . . . . . ☐☐	LINE NUMBER . . . . . ☐☐
210	ASK CONSENT FOR ANEMIA TEST FROM PARENT/OTHER ADULT IDENTIFIED IN 209 AS RESPONSIBLE FOR CHILD.	As part of this survey, we are asking people all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat We ask that all children born in 2010 or later take part in anemia testing in this survey and give a few drops of blood from a finger or heel. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test. The blood will be tested for anemia immediately, and the result told to you right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team. Do you have any questions? You can say yes to the test, or you can say no. It is up to you to decide. Will you allow (NAME OF CHILD) to participate in the anemia test?		
211	CIRCLE THE APPROPRIATE CODE AND SIGN YOUR NAME.	GRANTED . . . . . 1 _____ (SIGN) REFUSED 2	GRANTED . . . . . 1 _____ (SIGN) REFUSED 2	GRANTED . . . . . 1 _____ (SIGN) REFUSED 2
212	RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA PAMPHLET **(11)**.	G/DL ☐☐.☐ NOT PRESENT . . . . . 994 REFUSED . . . . . 995 OTHER 996	G/DL ☐☐.☐ NOT PRESENT . . . . . 994 REFUSED . . . . . 995 OTHER 996	G/DL ☐☐.☐ NOT PRESENT . . . . . 994 REFUSED . . . . . 995 OTHER 996
213	GO BACK TO 203 IN NEXT COLUMN OF THIS QUESTIONNAIRE OR IN THE FIRST COLUMN OF AN ADDITIONAL QUESTIONNAIRE; IF NO MORE CHILDREN, GO TO 214.			

WEIGHT, HEIGHT AND HEMOGLOBIN MEASUREMENT FOR WOMEN AGE 15-49

214	CHECK COLUMN 9 IN HOUSEHOLD SCHEDULE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE WOMEN IN 215. IF THERE ARE MORE THAN THREE WOMEN, USE ADDITIONAL QUESTIONNAIRE(S).			
		WOMAN 1	WOMAN 2	WOMAN 3
215	LINE NUMBER FROM COLUMN 9 NAME FROM COLUMN 2	LINE NUMBER . . . . . ☐☐ NAME _____	LINE NUMBER . . . . . ☐☐ NAME _____	LINE NUMBER . . . . . ☐☐ NAME _____
216	BLOOD PRESSURE IN MMHG	SYSTOLIC . . . . . ☐☐☐ DIASTOLIC . . . . . ☐☐☐	SYSTOLIC . . . . . ☐☐☐ DIASTOLIC . . . . . ☐☐☐	SYSTOLIC . . . . . ☐☐☐ DIASTOLIC . . . . . ☐☐☐
217	RESULT OF BLOOD PRESSURE MEASUREMENT	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6
218	WEIGHT IN KILOGRAMS	KG. ☐☐☐.☐☐ NOT PRESENT . . . . . 99994 REFUSED . . . . . 99995 OTHER 99996	KG. ☐☐☐.☐☐ NOT PRESENT . . . . . 99994 REFUSED . . . . . 99995 OTHER 99996	KG. ☐☐☐.☐☐ NOT PRESENT . . . . . 99994 REFUSED . . . . . 99995 OTHER 99996
219	HEIGHT IN CENTIMETERS	CM. ☐☐☐.☐ NOT PRESENT . . . . . 9994 REFUSED . . . . . 9995 OTHER 9996	CM. ☐☐☐.☐ NOT PRESENT . . . . . 9994 REFUSED . . . . . 9995 OTHER 9996	CM. ☐☐☐.☐ NOT PRESENT . . . . . 9994 REFUSED . . . . . 9995 OTHER 9996
220	AGE: CHECK COLUMN 7.	15-17 YEARS . . . . . 1 18-49 YEARS . . . . . 2 (GO TO 225) ↵	15-17 YEARS . . . . . 1 18-49 YEARS . . . . . 2 (GO TO 225) ↵	15-17 YEARS . . . . . 1 18-49 YEARS . . . . . 2 (GO TO 225) ↵
221	MARITAL STATUS: CHECK COLUMN 8.	CODE 4 (NEVER IN UNION) . . . . . 1 OTHER . . . . . 2 (GO TO 225) ↵	CODE 4 (NEVER IN UNION) . . . . . 1 OTHER . . . . . 2 (GO TO 225) ↵	CODE 4 (NEVER IN UNION) . . . . . 1 OTHER . . . . . 2 (GO TO 225) ↵
222	RECORD LINE NUMBER OF PARENT/OTHER ADULT RESPONSIBLE FOR ADOLESCENT. RECORD '00' IF NOT LISTED.	LINE NUMBER OF PARENT OR OTHER RESPONSIBLE ADULT ☐☐	LINE NUMBER OF PARENT OR OTHER RESPONSIBLE ADULT ☐☐	LINE NUMBER OF PARENT OR OTHER RESPONSIBLE ADULT ☐☐
223	ASK CONSENT FOR ANEMIA TEST FROM PARENT/ OTHER ADULT IDENTIFIED IN 220 AS RESPONSIBLE FOR NEVER IN UNION WOMEN AGE 15-17.	As part of this survey, we are asking people all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat anemia. For the anemia testing, we will need a few drops of blood from a finger. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test. The blood will be tested for anemia immediately, and the result will be told to you and (NAME OF ADOLESCENT) right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team. Do you have any questions? You can say yes to the test for (NAME OF ADOLESCENT), or you can say no. It is up to you to decide. Will you allow (NAME OF ADOLESCENT) to take the anemia test?		
224	CIRCLE THE APPROPRIATE CODE AND SIGN YOUR NAME.	GRANTED . . . . . 1 PARENT/OTHER RESPONSIBLE ADULT REFUSED . . . . . 2 _____ (SIGN) (IF REFUSED, GO TO 229)	GRANTED . . . . . 1 PARENT/OTHER RESPONSIBLE ADULT REFUSED . . . . . 2 _____ (SIGN) (IF REFUSED, GO TO 229)	GRANTED . . . . . 1 PARENT/OTHER RESPONSIBLE ADULT REFUSED . . . . . 2 _____ (SIGN) (IF REFUSED, GO TO 229)

		WOMAN 1	WOMAN 2	WOMAN 3
	NAME FROM COLUMN 2	NAME _____	NAME _____	NAME _____
225	ASK CONSENT FOR ANEMIA TEST FROM RESPONDENT.	As part of this survey, we are asking people all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat anemia. For the anemia testing, we will need a few drops of blood from a finger. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test. The blood will be tested for anemia immediately, and the result will be told to you right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team. Do you have any questions? You can say yes to the test, or you can say no. It is up to you to decide. Will you take the anemia test?		
226	CIRCLE THE APPROPRIATE CODE AND SIGN YOUR NAME.	GRANTED ..... 1 RESPONDENT REFUSED ..... 2 _____ (SIGN) (IF REFUSED, GO TO 229)	GRANTED ..... 1 RESPONDENT REFUSED ..... 2 _____ (SIGN) (IF REFUSED, GO TO 229)	GRANTED ..... 1 RESPONDENT REFUSED ..... 2 _____ (SIGN) (IF REFUSED, GO TO 229)
227	PREGNANCY STATUS: CHECK 226 IN WOMAN'S QUESTIONNAIRE OR ASK: Are you pregnant?	YES ..... 1 NO ..... 2 DK 8	YES ..... 1 NO ..... 2 DK 8	YES ..... 1 NO ..... 2 DK 8
228	RECORD HEMOGLOBIN LEVEL HERE AND IN ANEMIA PAMPHLET	G/DL ..... ☐☐.☐ NOT PRESENT ..... 994 REFUSED ..... 995 OTHER 996	G/DL ..... ☐☐.☐ NOT PRESENT ..... 994 REFUSED ..... 995 OTHER 996	G/DL ..... ☐☐.☐ NOT PRESENT ..... 994 REFUSED ..... 995 OTHER 996
229	GO BACK TO 215 IN NEXT COLUMN OF THIS QUESTIONNAIRE OR IN THE FIRST COLUMN OF AN ADDITIONAL QUESTIONNAIRE; IF NO MORE WOMEN, GO TO QUESTION 331.			

WEIGHT, HEIGHT AND HEMOGLOBIN MEASUREMENT FOR MEN AGE 15 AND OVER

331	CHECK COLUMN 10 IN HOUSEHOLD SCHEDULE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE MEN IN 332. IF THERE ARE MORE THAN THREE MEN, USE HOUSEHOLD QUESTIONNAIRE CONTINUATION(S).			
		MAN 1	MAN 2	MAN 3
332	LINE NUMBER FROM COLUMN 10 NAME FROM COLUMN 2	LINE NUMBER . . . . . [ ][ ] NAME _____	LINE NUMBER . . . . . [ ][ ] NAME _____	LINE NUMBER . . . . . [ ][ ] NAME _____
333	BLOOD PRESSURE IN MMHG	SYSTOLIC . . . . . [ ][ ][ ] DIASTOLIC . . . . . [ ][ ][ ]	SYSTOLIC . . . . . [ ][ ][ ] DIASTOLIC . . . . . [ ][ ][ ]	SYSTOLIC . . . . . [ ][ ][ ] DIASTOLIC . . . . . [ ][ ][ ]
334	RESULT OF BLOOD PRESSURE MEASUREMENT	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6
335	WEIGHT IN KILOGRAMS	KG. . . . . [ ][ ][ ].[ ]	KG. . . . . [ ][ ][ ].[ ]	KG. . . . . [ ][ ][ ].[ ]
336	HEIGHT IN CENTIMETERS	CM. . . . . [ ][ ][ ].[ ]	CM. . . . . [ ][ ][ ].[ ]	CM. . . . . [ ][ ][ ].[ ]
337	RESULT OF WEIGHT AND HEIGHT MEASUREMENT	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6
338	IF MORE THAN 3 ELIGIBLE MEN, CONTINUE TO 'MAN 4', 'MAN 5' AND 'MAN 6' BELOW IF NO MORE ELIGIBLE MEN AT THIS STAGE, CHECK THAT ALL QUESTIONS ARE FILLED IN CORRECTLY, THANK THE RESPONDENTS AND END THE INTERVIEW FOR THE HOUSEHOLD QUESTIONNAIRE			
		MAN 4	MAN 5	MAN 6
332	LINE NUMBER (COLUMN 10) NAME (COLUMN 2)	LINE NUMBER . . . . . [ ][ ] NAME _____	LINE NUMBER . . . . . [ ][ ] NAME _____	LINE NUMBER . . . . . [ ][ ] NAME _____
333	BLOOD PRESSURE IN MMHG	SYSTOLIC . . . . . [ ][ ][ ] DIASTOLIC . . . . . [ ][ ][ ]	SYSTOLIC . . . . . [ ][ ][ ] DIASTOLIC . . . . . [ ][ ][ ]	SYSTOLIC . . . . . [ ][ ][ ] DIASTOLIC . . . . . [ ][ ][ ]
334	RESULT OF BLOOD PRESSURE MEASUREMENT	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6
335	WEIGHT IN KILOGRAMS	KG. . . . . [ ][ ][ ].[ ]	KG. . . . . [ ][ ][ ].[ ]	KG. . . . . [ ][ ][ ].[ ]
336	HEIGHT IN CENTIMETERS	CM. . . . . [ ][ ][ ].[ ]	CM. . . . . [ ][ ][ ].[ ]	CM. . . . . [ ][ ][ ].[ ]
337	RESULT OF WEIGHT AND HEIGHT MEASUREMENT	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6	MEASURED . . . . . 1 NOT PRESENT . . . . . 2 REFUSED . . . . . 3 OTHER 6
338	IF MORE THAN 6 ELIGIBLE MEN, USE HOUSEHOLD CONTINUATION QUESTIONNAIRE IF NO MORE ELIGIBLE MEN, CHECK THAT ALL QUESTIONS ARE FILLED IN CORRECTLY, THANK THE RESPONDENTS AND END THE INTERVIEW FOR THE HOUSEHOLD QUESTIONNAIRE			

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____

Figure E2: Women's Questionnaire

March 2015

DEMOGRAPHIC AND HEALTH SURVEYS
WOMAN'S QUESTIONNAIRE

SOLOMON ISLANDS
NATIONAL STATISTICS OFFICE/MINISTRY OF HEALTH

IDENTIFICATION

NAME OF HOUSEHOLD HEAD _____

HOUSEHOLD NUMBER . . . . . | | |

PROVINCE _____ | |

WARD _____ | |

EA NUMBER . . . . . | | |

VILLAGE NAME _____ | |

TOWN / PROVINCIAL CENTRE / RURAL
TOWN = 1, PROVINCIAL CENTRE = 2, RURAL = 3 . . . . . | |

NAME AND LINE NUMBER OF WOMAN _____ | |

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY | |
				MONTH | |
				YEAR | | | |
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER | | |
RESULT*	_____	_____	_____	RESULT |
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS |
TIME	_____	_____		

*RESULT CODES:

1	COMPLETED	4	REFUSED		
2	NOT AT HOME	5	PARTLY COMPLETED	7	OTHER _____ (SPECIFY)
3	POSTPONED	6	INCAPACITATED		

LANGUAGE OF INTERVIEW 1 ENGLISH 2 PIDGIN 3 OTHERS _____

LANGUAGE OF RESPONDENT 1 ENGLISH 2 PIDGIN 3 OTHERS _____

TRANSLATOR USED? 1 YES 2 NO

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____ | | |	NAME _____ | | |	| |	| |

SECTION 1. RESPONDENT'S BACKGROUND

INTRODUCTION AND CONSENT

INFORMED CONSENT

Hello. My name is _____. I am working with National Statistic Office. We are conducting a survey about health all over Solomon Islands. The information we collect will help the government to plan health services. Your household was selected for the survey. The questions usually take about 30 to 60 minutes. All of the answers you give will be confidential and will not be shared with anyone. Your participation in this survey is very important as it will help to improve the health services provided by the government for our country. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

In case you need more information about the survey, you may contact the National Statistics Office.

Do you have any questions? May I begin the interview now?

Halo. Nem blong mi _____Mi waka wetem National Statistic Office. Mifala duim wanfala savei abaot helt long ful Solomon Islands. Infomeson wea mifala kolektim bae hem helpem Gavman fo planim olketa helt sevis.Haos blong iu olketa siusim tu for disfala savei. Olketa kuesten hem save tekem 30 or 60 minit nomoa.Evri ansa u givim bae tambu tumas fo mifala talem go long eniwan moa. Fo iu joinem disfala savei bae hem gut tumas and hem impotent bekos bae hem help fo improvem nao olketa health sevisis wea gavman hem providem fo kandere blo iumi. Sapos mi askem iu eni kuesten wea iu les fo ansarem, iu talem mi mekem mi save muv go long neks kuesten or iu save stopem intaviu enitaem.

Sapos iu nidim moa infomeson abaotim savei, iu save kontaktim olketa pipol lo National Statistics Office.

Waswe, iu garem eni kuesten? Mi save statem intaviu distaem?

SIGNATURE OF INTERVIEWER: _____ DATE: _____

RESPONDENT AGREES TO BE INTERVIEWED . . . 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 → END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME. RECORDIM TAEM	HOUR . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
102	In what month and year were you born? *Long wat manis an yia nao iu bon?*	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
103	How old were you at your last birthday? *Hao ol nao iu long las betdei blong iu?* COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.	AGE IN COMPLETED YEARS [ ][ ]	
104	Have you ever attended school? *Waswe, iu skul tu or nomoa?*	YES . . . . . 1 NO 2	→ 108
105	What is the highest level of school you attended: primary, secondary, or higher? *Wat nao haes levol iu kasem: long praemari, sekondri or eni levol go up moa iu kasem?*	PRE SCHOOL . . . . . 0 PRIMARY . . . . . 1 SECONDARY . . . . . 2 TERTIARY . . . . . 3 VOCATIONAL . . . . . 4 DON'T KNOW . . . . . 8 OTHER 9 _____ (SPECIFY)	

106	What is the highest (grade/form/year) you completed at that level? *Wat nao haes(class/fom/yia) iu kasem long dat fala levol?* IF COMPLETED LESS THAN ONE YEAR AT THAT LEVEL, RECORD '00'.	. . . . . . GRADE/FORM/YEAR ☐☐	
107	CHECK 105: PRE SCHOOL OR PRIMARY ☐ SECONDARY OR HIGHER ☐ → 110		
108	Now I would like you to read this sentence to me. *Distaem mi laekem iu fo ridim disfala sentens kam long mi.* SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me? *Waswe, iu save ridim eni pat long sentens ia kam long mi?*	CANNOT READ AT ALL . . . . . 1 ABLE TO READ ONLY PARTS OF SENTENCE . . . . . 2 ABLE TO READ WHOLE SENTENCE 3 NO CARD WITH REQUIRED LANGUAGE _____ 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED 5	
109	CHECK 108: CODE '2', '3' OR '4' CIRCLED ☐ CODE '1' OR '5' CIRCLED ☐ → 111		
110	Do you read a newspaper or magazine at least once a week, less than once a week or not at all? *Waswe, iu save ridim niuspepa or magazin insaed wan wik, samfala taem insaed wan wik or barava no moa nao?*	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL 3	
111	Do you listen to the radio at least once a week, less than once a week or not at all? *Waswe, iu save lisin long redio, wantaem insaed wan wik, samfala taem insaed wan wik,or barava nomoa nao?*	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL 3	
112	Do you watch television at least once a week, less than once a week or not at all? *Waswe iu save lukluk televisin insaed wan wik, samfala taem insaed wan wik or barava nomoa nao?*	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL 3	
113	What is your religion? *Wat kaen lotu nao iu go long hem?*	ANGLICAN . . . . . 1 ROMAN CATHOLIC . . . . . 2 UNITED CHURCH . . . . . 3 SOUTHSEAS EVANGELICAL . . . . . 4 SEVENTH DAY ADVENTIST . . . . . 5 OTHER _____ 6 (SPECIFY)	
114	What is your ethnicty? *Waswe iu tingim iu seleva olsem wanfala Melanesian, Polynesian, Micronesian, waet man or wat kaen grup?*	MELANESIAN . . . . . 1 POLYNESIAN . . . . . 2 MICRONESIAN . . . . . 3 EUROPEAN . . . . . 4 CHINESE . . . . . 5 OTHER _____ 6 (SPECIFY)	

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask about all the births you have had during your life. Have you ever given birth? *Distaem mi laek fo askem iu olketa pikinini iu bonem lo laef taem blo iu.Iu bonem eni pikinini tu?*	YES . . . . . 1 NO 2	→ 206
202	Do you have any sons or daughters to whom you have given birth who are now living with you? *Iu garem eni pikinini boe o gele wea iu seleva bonem an olketa stap wetem iu distaem?*	YES . . . . . 1 NO 2	→ 204
203	How many sons live with you? *Hao meni pikinini boe nao stap wetem iu distaem?* And how many daughters live with you? *An hao meni pikinini gele nao stap wetem iu?* IF NONE, RECORD '00'.	SONS AT HOME . . . . . [ ][ ] DAUGHTERS AT HOME . . . . . [ ][ ]	
204	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you? *Waswe lu garem eni pikinini-boe o pikinini-gele wea iu nao iu bonem an olketa stil laif distaem bat olketa no stap wetem iu lo hia distaem?*	YES . . . . . 1 NO 2	→ 206
205	How many sons are alive but do not live with you? *Hao meni long olketa boe nao laef bat olketa no stap wetem iu?* And how many daughters are alive but do not live with *An hao meni long oketa gele nao laef bat oketa no stap wetem iu ?* IF NONE, RECORD '00'.	SONS ELSEWHERE . . . . . [ ][ ] DAUGHTERS ELSEWHERE [ ][ ]	
206	Have you ever given birth to a boy or girl who was born alive but later died? *Waswe iu bonem eni pikinini boe o gele,wea hem laef nomoa taem iu bonem;bat gogo hem dae bihaen?* IF NO, PROBE: Any baby who cried or showed signs of life but did not survive? *Eni bebi hu i krae or som saen dat hem laef bat gogo hem dae nomoa?*	YES . . . . . 1 NO 2	→ 208
207	How many boys have died? *Hao meni long olketa pikinini boe nao dae?* And how many girls have died? *An hao meni long olketa pikinini gele nao dae ?* IF NONE, RECORD '00'.	BOYS DEAD . . . . . [ ][ ] GIRLS DEAD . . . . . [ ][ ]	
208	SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL. IF NONE, RECORD '00'.	TOTAL BIRTHS . . . . . [ ][ ]	
209	CHECK 208: Just to make sure that I have this right: you have had in TOTAL births during your life. Is that correct? *Jas fo mek-sua mi getem stret:Iu bin bonem Total _____ pikinini lo laef taem blo iu.Waswe,hem tru?* YES ☐ NO ☐ → PROBE AND CORRECT 201-208 AS NECESSARY.		
210	CHECK 208: ONE OR MORE BIRTHS ☐ NO BIRTHS ☐ → 226		

211 Now I would like to record the names of all your births, whether still alive or not, starting with the first one you had.
Distaem mi laek rekodem nem blo evri pikinini iu bonem,olketa wea laef an olketa dae tu;bae iumi stat wetem fasbon.

RECORD NAMES OF ALL THE BIRTHS IN 212. RECORD TWINS AND TRIPLETS ON SEPARATE ROWS.
(IF THERE ARE MORE THAN 12 BIRTHS, USE AN ADDITIONAL QUESTIONNAIRE, STARTING WITH THE SECOND ROW).

212 What name was given to your (first/next) baby? *wat nao nem iu givim lo faswan/ neks bebi?* RECORD NAME. BIRTH HISTORY NUMBER	213 Is (NAME) a boy or a girl? *Waswe (NEM) hemi boe o gele?*	214 Were any of these births twins? *Eniwam lo olketa pikinini ia hemi tuin o nomoa?*	215 In what month and year was (NAME) born? *Lo watkaen mans an iia nao (NEM) hemi bon?* PROBE: When is his/her birthday? *Wanem nao botde blo hem?*	216 Is (NAME) still alive? *waswe (NEM) hemi laef iet?*	217 IF ALIVE: How old was (NAME) at his/her last birthday? *Hao olo nao (NEM) lo las botde blo hem?* RECORD AGE IN COMPLETED YEARS.	218 IF ALIVE: Is (NAME) living with you? *waswe (NEM) hemi stap wetem iu o nomoa?*	219 IF ALIVE: RECORD HOUSEHOLD LINE NUMBER OF CHILD (RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD).	220 IF DEAD: How old was (NAME) when he/she died? *Hao olo nao (NEM) taem hemi* IF '1YR', PROBE: How many months old was (NAME)? *Hao meni mans olo nao (NEM)* RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.	221 Were there any other live births between (NAME OF PREVIOUS BIRTH) and (NAME), including any children who died after birth?
01	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (NEXT BIRTH)	DAYS ... 1 MONTHS 2 YEARS .. 3	
02	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
03	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
04	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
05	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
06	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
07	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH

212 What name was given to your (first/next) baby? *wat nao nem iu givim lo faswan/ neks bebi?* RECORD NAME. BIRTH HISTORY NUMBER	213 Is (NAME) a boy or a girl? *Waswe (NEM) hemi boe o gele?*	214 Were any of these births twins? *Eniwam lo olketa pikinini ia hemi tuin o nomoa?*	215 In what month and year was (NAME) born? *Lo watkaen mans an iia nao (NEM) hemi bon?* PROBE: When is his/her birthday? *Wanem nao botde blo hem?*	216 Is (NAME) still alive? *waswe (NEM) hemi laef iet?*	217 IF ALIVE: How old was (NAME) at his/her last birthday? *Hao olo nao (NEM) lo las botde blo hem?* RECORD AGE IN COM-PLETED YEARS.	218 IF ALIVE: Is (NAME) living with you? *waswe (NEM) hemi stap wetem iu o nomoa?*	219 IF ALIVE: RECORD HOUSE-HOLD LINE NUMBER OF CHILD (RECORD '00' IF CHILD NOT LISTED IN HOUSE-HOLD).	220 IF DEAD: How old was (NAME) when he/she died? *Hao olo nao (NEM) taem hemi* IF '1YR', PROBE: How many months old was (NAME)? *Hao meni mans olo nao (NEM)* RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.	221 Were there any other live births between (NAME OF PREVIOUS BIRTH) and (NAME), including any children who died after birth?
08	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
09	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
10	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
11	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH
12	BOY 1 GIRL 2	SING 1 MULT 2	MONTH YEAR	YES .... 1 NO .... 2 → 220	AGE IN YEARS	YES .... 1 NO 2	HOUSEHOLD LINE NUMBER (GO TO 221)	DAYS ... 1 MONTHS 2 YEARS .. 3	YES .... 1 ADD BIRTH NO ..... 2 NEXT BIRTH

222	Have you had any live births since the birth of (NAME OF LAST BIRTH)? IF YES, RECORD BIRTH(S) IN TABLE. *Waswe,iu bin bonem eni moa pikinini afta (NEM Blo)?*	YES ..... 1 NO 2
223	COMPARE 208 WITH NUMBER OF BIRTHS IN HISTORY ABOVE AND MARK: NUMBERS ARE SAME → ; NUMBERS ARE DIFFERENT → (PROBE AND RECONCILE)	
224	CHECK 215: ENTER THE NUMBER OF BIRTHS SINCE JANUARY 2010 TO 2015.	NUMBER OF BIRTHS ..... NONE ..... 0 → 226

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
225	**C** FOR EACH BIRTH SINCE JANUARY 2010, ENTER 'B' IN THE MONTH OF BIRTH IN THE CALENDAR. WRITE THE NAME OF THE CHILD TO THE LEFT OF THE 'B' CODE. FOR EACH BIRTH, ASK THE NUMBER OF MONTHS THE PREGNANCY LASTED AND RECORD 'P' IN EACH OF THE PRECEDING MONTHS ACCORDING TO THE DURATION OF PREGNANCY. (NOTE: THE NUMBER OF 'P's MUST BE ONE LESS THAN THE NUMBER OF MONTHS THAT THE PREGNANCY LASTED.)		
226	Are you pregnant now? *Waswe, iu babule distaem?*	YES . . . . . 1 NO . . . . . 2 UNSURE 8	→ 230
227	How many months pregnant are you? *Iu hao meni mans babule nao?* RECORD NUMBER OF COMPLETED MONTHS. **C** ENTER 'P's IN THE CALENDAR, BEGINNING WITH THE MONTH OF INTERVIEW AND FOR THE TOTAL NUMBER OF COMPLETED MONTHS.	MONTHS . . . . . ☐☐	
228	When you got pregnant, did you want to get pregnant at that time? *Lo taem iu babule ia,waswe iu laek fo babule long dat taem o nomoa?*	YES . . . . . 1 NO 2	→ 230
229	Did you want to have a baby later on or did you not want any (more) children? *Waswe iu laek fo garem pikinini lelbet taem bihaen,o iu barava no laekem fo garem narafala(Samfalal moa) pikinini nao?*	LATER . . . . . 1 NO MORE 2	
230	Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth? *Eni babule blo iu hemi nogud,o olketa dokta an nes helpem iu fo aotem,o hemi bon an die nomoa?*	YES . . . . . 1 NO 2	→ 238
231	When did the last such pregnancy end? *Wat taem nao kaen babule olsem bin happen?*	MONTH . . . . . ☐☐ YEAR . . . . . ☐☐☐☐	
232	CHECK 231: LAST PREGNANCY ENDED IN JAN. 2010 OR LATER ☐ ↓ LAST PREGNANCY ENDED BEFORE JAN. 2010 ☐ →		238
233	How many months pregnant were you when the last such pregnancy ended? *Hao meni mans nao iu babule lo taem wea kaen ia happen?* **C** RECORD NUMBER OF COMPLETED MONTHS. ENTER 'T' IN THE CALENDAR IN THE MONTH THAT THE PREGNANCY TERMINATED AND 'P' FOR THE REMAINING NUMBER OF COMPLETED MONTHS.	MONTHS . . . . . ☐☐	
234	Since January 2010, have you had any other pregnancies that did not result in a live birth? *Lo Januari 2010 go kasem distaem,waswe iu bin babule bat wea hemi nogud nomoa?*	YES . . . . . 1 NO 2	→ 236
235	ASK THE DATE AND THE DURATION OF PREGNANCY FOR EACH EARLIER NON-LIVE BIRTH PREGNANCY BACK TO JANUARY 2010. **C** ENTER 'T' IN THE CALENDAR IN THE MONTH THAT EACH PREGNANCY TERMINATED AND 'P' FOR THE REMAINING NUMBER OF COMPLETED MONTHS.		

236	Did you have any miscarriages, abortions or stillbirths that ended before 2010? *Iu bin garem eni babule wea hemi nogud o olketa dokta o nes helpem fo aotem o hemi dae insaet bele befoa hemi bon bifoa 2010?*	YES . . . . . 1 NO 2	→ 238
237a	When did the last such pregnancy that terminated before 2010 end? *Watkaen taem nao diskaen ia olsem bin happen bifoa 2010 finis?*	MONTH . . . . . [ ][ ] YEAR . . . . . [ ][ ][ ][ ]	
237b	What was the cause of the miscarriage, abortion, or stillbirth? *Wat na kosim babule wea hemi nogud,o olketa dokta an nes helpem fo aotem o hemi dae insaet bele befoa hemi bon ?*	NATURAL/SPONTANEOUS/ACT OF GOD . . . . . 1 INDUCED HEALTH WORKER GAVE A TABLET OR INJECTION . . . . . 2 TRADITIONAL HEALER PROVIDE LOCAL MEDICINE . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
237C	Did you seek medical care as a result of the miscarriage/abortions/stillbirths? *Waswe iu go long eni clinic o hospitol fo babule wea hemi nogud,o olketa dokta an nes heplem fo aotem o hemi dae insaet bele befoa hemi bon?*	YES . . . . . 1 NO 2	→ 238
237d	Where did you seek advice or treatment for the miscarriage/abortions/stillbirths? *Lo wea na iu ask fo help o tekem meresin fo babule wea hemi nogud ,o olketa dokta an nes helpem fo aotem o hemi dae insaet bele befoa hemi bon?*	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ..... A PROVINCIAL HOSPITAL ..... B URBAN AREA HEALTH CENTRE ..... C AREA HEALTH CENTRE ..... D RURAL HEALTH CENTRE ..... E FAMILY PLANNING CLINICS ..... F NURSE AIDE POST ..... G SATELLITE CLINICS ..... H OTHER PUBLIC _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC ..... J PHARMARCY ..... K PRIVATE DOCTOR ..... L OTHER PRIVATE MEDICAL FACILITIES M _____ (SPECIFY) CHURCH HOSPITAL ..... N RURAL HEALTH CLINIC ..... O NURSE AIDE POST ..... P SATELLITE CLINIC ..... Q OTHER OUTLET ..... R NGO/OTHER SOURCE SIPPA CLINIC ..... S SIPPA CBD ..... T SAVE THE CHILDREN FUND ..... U SHOP ..... V FRIEND/RELATIVE ..... W OTHER _____ X (SPECIFY)	

238	When did your last menstrual period start? *Wat taem nao las taem iu lukim mun hemi stat?* _____ (DATE, IF GIVEN)	DAYS AGO . . . . . 1 [ ][ ] WEEKS AGO . . . . . 2 [ ][ ] MONTHS AGO . . . . . 3 [ ][ ] YEARS AGO . . . . . 4 [ ][ ] IN MENOPAUSE/ HAS HAD HYSTERECTOMY . . . 994 BEFORE LAST BIRTH . . . . . 995 NEVER MENSTRUATED 996	
239	From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant? *From wanfala taem iu lukim mun go fo neks wan,waswe hemi tru o nomoa dat insaet lo samfala de lo disfala taem mere bae hemi save babule winim olketa narafala de insaet lo disfala taem?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 301
240	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods? *Waswe disfala taem ia hem jas bifoa hem lukim mun blong hem,o taem hemi lukim mun blong hem,stret afta hem lukim mun finis,o haf-we between tufala taem hem lukim mun?*	JUST BEFORE HER PERIOD BEGINS . . . . . 1 DURING HER PERIOD . . . . . 2 RIGHT AFTER HER PERIOD HAS ENDED . . . . . 3 HALFWAY BETWEEN TWO PERIODS . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	

SECTION 3. CONTRACEPTION

301	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. *Distaem mi laek tok abaot hao fo planim famili - olketa difren wei or metod wea olketa man an woman save iusim fo holemap fo lelebet taem o fo mami no babule nomoa.* Have you ever heard of (METHOD)? *Waswe, iu bin herem eniting olsem (METOD)? (1)*		
01	**Female Sterilization**. PROBE: Women can have an operation to avoid having any more children. *Olketa woman save garem cut fo stopem rod blong eg fo no save garem eni moa pikinini.*	YES . . . . . 1 NO 2	
02	**Male Sterilization**. PROBE: Men can have an operation to avoid having any more children. *Olketa man save garem cut fo stopem rod blong spem fo no save garem pikinini .*	YES . . . . . 1 NO 2	
03	**IUD**. PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse. *Dokta o nes save putim wanfala ring o coil blong spring insaed long mere.*	YES . . . . . 1 NO 2	
04	**Injectables**. PROBE: Women can have an injection by a health provider that stops them from becoming pregnant for one or more months. *Olketa woman save tekem nila from olketa long helt fo stopem olketa fo no babule fo wan mans o winim go moa?*	YES . . . . . 1 NO 2	
05	**Implants**. PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years. *Olketa woman save garem wanfala or moa rod wea dokta or nes bae putim antap am blong olketa fo no babule fo wan or moa yias.*	YES . . . . . 1 NO 2	
06	**Pill**. PROBE: Women can take a pill every day to avoid becoming pregnant. *Olketa woman save tekem meresin evridei fo no babule..*	YES . . . . . 1 NO 2	
07	**Condom**. PROBE: Men can put a rubber sheath on their penis before sexual intercourse. *Olketa man save putim raba wea kavam koko blong olketa bifoa olketa havem seks.*	YES . . . . . 1 NO 2	
08	**Female Condom**. PROBE: Women can place a sheath in their vagina before sexual intercourse. *Olketa woman save putim raba insaet kan blong olketa bifoa olketa havem seks.*	YES . . . . . 1 NO 2	
09	**Lactational Amenorrhea Method (LAM)**. *Olketa woman wea susum bebi fultaem fo siks manis save holemap babule.*	YES . . . . . 1 NO 2	
10	**Rhythm Method**. PROBE: To avoid pregnancy, women do not have sexual intercourse on the days of the month they think they can get pregnant. *Fo no babule, olketa woman no havem seks long olketa deis long manis wea olketa ting bae olketa save babule.*	YES . . . . . 1 NO 2	
11	**Withdrawal**. PROBE: Men can be careful and pull out before climax. *Olketa man save mek sua olketa pul aot bifoa olketa bosta.*	YES . . . . . 1 NO 2	
12	**Emergency Contraception**. PROBE: As an emergency measure, within three days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy. *Olsem wanfala kuik an strong wei,woman save tekem pil insaet long tri deis afta hem havem anprotekted seks fo no babule.*	YES . . . . . 1 NO 2	
13	Have you heard of any other ways or methods that women or men can use to avoid pregnancy? *Waswe, iu bin herem eni nara we moa wea olketa woman or man bae save iusim fo no babule?*	YES . . . . . 1 _____ (SPECIFY) _____ (SPECIFY) NO 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
302	CHECK 226: NOT PREGNANT OR UNSURE ☐ ↓ PREGNANT ☐ → 311		
303	Are you currently doing something or using any method to delay or avoid getting pregnant? *Waswe,distaem iu duim samfala samting o iusim eni we fo holemap o stopem iu seleva from babule o nomoa?*	YES . . . . . 1 NO . . . . . 2 → 311	
304	Which method are you using? *Watkaen we nao iu iusim ia?* CIRCLE ALL MENTIONED. IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD IN LIST.	FEMALE STERILIZATION . . . . . A MALE STERILIZATION . . . . . B → 307 IUD . . . . . C INJECTABLES . . . . . D → 308A IMPLANTS . . . . . E PILL . . . . . F CONDOM . . . . . G → 306 FEMALE CONDOM . . . . . H DIAPHRAGM . . . . . I FOAM/JELLY . . . . . J LACTATIONAL AMEN. METHOD . . . . . K → 308A RHYTHM METHOD . . . . . L WITHDRAWAL . . . . . M OTHER MODERN METHOD . . . . . X OTHER TRADITIONAL METHOD . . . Y	
305	What is the brand name of the pills you are using? *Wat na nem blong kaen meresin wea iu usim distaem ia?* IF DON'T KNOW THE BRAND, ASK TO SEE THE PACKAGE.	MICROLUT . . . . . 01 MICROGYNON . . . . . 02 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	→ 308A
306	What is the brand name of the condoms you are using? *Wat na nem blong kondom wea iu iusim distaem ia?* IF DON'T KNOW THE BRAND, ASK TO SEE THE PACKAGE.	HIS . . . . . 01 SURE . . . . . 02 ROUGH RIDER . . . . . 03 SAFE RIDER . . . . . 04 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	→ 308A
307	In what facility did the sterilization take place? *Lo watkan fasiliti nao dokta katem iu fo stop garem pikinini?* PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . 11 PROVINCIAL HOSPITAL . . . . . 12 OTHER PUBLIC SECTOR _____ 16 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC . . . . . 21 PRIVATE DOCTOR'S OFFICE . . . . . 23 CHURCH HOSPTI . . . . . 24 OTHER PRIVATE MEDICAL SECTOR _____ 26 (SPECIFY) OTHER _____ 96 (SPECIFY) DON'T KNOW 98	

308 308A	In what month and year was the sterilization performed? *Lo wat iia an mans nao olketa katem iu olsem?* Since what month and year have you been using (CURRENT METHOD) without stopping? *Stat lo wat mans an iia nao iu bin stat fo usim disfala we (METHOD DISTAEM) bat no stop kam kasem distaem?* PROBE: For how long have you been using (CURRENT METHOD) now without stopping? *Hao long nao iu bin iusim (CURRENT METHOD) go kasem distaem?*	MONTH . . . . . . YEAR	
309	CHECK 308/308A, 215 AND 231: ANY BIRTH OR PREGNANCY TERMINATION AFTER MONTH AND YEAR OF START OF USE OF CONTRACEPTION IN 308/308A — YES ☐ NO ☐ GO BACK TO 308/308A, PROBE AND RECORD MONTH AND YEAR AT START OF CONTINUOUS USE OF CURRENT METHOD (MUST BE AFTER LAST BIRTH OR PREGNANCY TERMINATION).		
310	CHECK 308/308A: YEAR IS 2010 OR LATER **C** ENTER CODE FOR METHOD USED IN MONTH OF INTERVIEW IN THE CALENDAR AND IN EACH MONTH BACK TO THE DATE STARTED USING. YEAR IS 2009 OR EARLIER **C** ENTER CODE FOR METHOD USED IN MONTH OF INTERVIEW IN THE CALENDAR AND EACH MONTH BACK TO JANUARY 2010. THEN SKIP TO → 322		
311	I would like to ask you some questions about the times you or your partner may have used a method to avoid getting pregnant during the last few years. *Distaem mi laek askem iu an patna blong iu abaotem olketa taem iutufala bin iusim we(metod) fo stopem iu from babule,lo insaet lo las tu tri iia hemi go finis.* USE CALENDAR TO PROBE FOR EARLIER PERIODS OF USE AND NONUSE, STARTING WITH MOST RECENT USE, BACK TO JANUARY 2010. USE NAMES OF CHILDREN, DATES OF BIRTH, AND PERIODS OF PREGNANCY AS REFERENCE POINTS. **C** **IN COLUMN 1**, ENTER METHOD USE CODE OR '0' FOR NONUSE IN EACH BLANK MONTH. ILLUSTRATIVE QUESTIONS: * When was the last time you used a method? Which method was that? *Wat taem nao las taem iu iusim eni we? Wat kaen we nao dat wan?* * When did you start using that method? How long after the birth of (NAME)? *Wat taem iu stat fo iusim we ia? Hao long afta(NEM) bon?* * How long did you use the method then? *Hao long nao iu bin iusim disfala we ia?* **IN COLUMN 2**, ENTER CODES FOR DISCONTINUATION NEXT TO THE LAST MONTH OF USE. NUMBER OF CODES IN COLUMN 2 MUST BE SAME AS NUMBER OF INTERRUPTIONS OF METHOD USE IN COLUMN 1. ASK WHY SHE STOPPED USING THE METHOD. IF A PREGNANCY FOLLOWED, ASK WHETHER SHE BECAME PREGNANT UNINTENTIONALLY WHILE USING THE METHOD OR DELIBERATELY STOPPED TO GET PREGNANT. ILLUSTRATIVE QUESTIONS: * Why did you stop using the (METHOD)? Did you become pregnant while using (METHOD), or did you stop to get pregnant, or did you stop for some other reason? *Wae na iu no usim moa (METOD? Waswa iu babule taem iu usim disfala (METOD) o iu no laek fo usim fo iu babule,o iu les fo usim becos fo samfala reson?* * IF DELIBERATELY STOPPED TO BECOME PREGNANT, ASK: How many months did it take you to get pregnant after you stopped using (METHOD)? AND ENTER '0' IN EACH SUCH MONTH IN COLUMN 1. *Hao mani mans na hem tekem iu fo iu babaule afta iu no laek fo usim (METOD) ia?*		

312	CHECK THE CALENDAR FOR USE OF ANY CONTRACEPTIVE METHOD IN ANY MONTH NO METHOD USED ☐ ANY METHOD USED ☐ → 314		
313	Have you ever used anything or tried in any way to delay or avoid getting pregnant? *Waswe iu bin usim eniting o traem samfala wei fo mekem iu no babule?*	YES . . . . . 1 NO . . . . . 2 → 324	
314	CHECK 304: CIRCLE METHOD CODE: IF MORE THAN ONE METHOD CODE CIRCLED IN 304, CIRCLE CODE FOR HIGHEST METHOD IN LIST.	NO CODE CIRCLED . . . . . 00 → 324 FEMALE STERILIZATION . . . . . 01 → 317A MALE STERILIZATION . . . . . 02 → 326 IUD . . . . . 03 INJECTABLES . . . . . 04 IMPLANTS . . . . . 05 PILL . . . . . 06 CONDOM . . . . . 07 FEMALE CONDOM . . . . . 08 DIAPHRAGM . . . . . 09 FOAM/JELLY . . . . . 10 LACTATIONAL AMEN. METHOD . . . . . 11 RHYTHM METHOD . . . . . 12 → 315A WITHDRAWAL . . . . . 13 OTHER MODERN METHOD . . . . . 95 → 326 OTHER TRADITIONAL METHOD 96	
315 315A	You first started using (CURRENT METHOD) in (DATE FROM 308/308A). Where did you get it at that time? *Iu fes usim (CURRENT METOD) lo (DATE FROM 308/308A).Taem ia iu tekem lo wea ia?* Where did you learn how to use the rhythm/lactational amenorrhea method? *Disfala rhythm/lactational amenorhea metod ia, iu lanem hao fo usim lo wea ia?* PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . 11 PROVINCIAL HOSPITAL . . . . . 12 URBAN AREA HEALTH CENTRE . . . 13 AREA HEALTH CENTRE . . . . . 14 RURAL HEALTH CENTRE . . . . . 15 FAMILY PLANNING CLINIC . . . . . 16 NURSE AID POST . . . . . 17 STATELLITE CLINICS . . . . . 18 OTHER PUBLIC SECTOR _____ 19 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC . . . . . 21 PHARMACY . . . . . 22 PRIVATE DOCTOR . . . . . 23 OTHER PRIVATE MEDICAL SECTOR _____ 26 (SPECIFY) NGO/OTHER SOURCE SIPPA CLINIC . . . . . 31 SIPPA CBD . . . . . 32 SAVE THE CHILDREN FUND . . . . . 33 CHURCH . . . . . 34 SHOP . . . . . 35 FRIEND/RELATIVE . . . . . 36 OTHER _____ 96 (SPECIFY)	

316	CHECK 304: CIRCLE METHOD CODE: IF MORE THAN ONE METHOD CODE CIRCLED IN 304, CIRCLE CODE FOR HIGHEST METHOD IN LIST.	IUD . . . . . 03 INJECTABLES . . . . . 04 IMPLANTS . . . . . 05 PILL . . . . . 06 CONDOM . . . . . 07 FEMALE CONDOM . . . . . 08 DIAPHRAGM . . . . . 09 FOAM/JELLY . . . . . 10 LACTATIONAL AMEN. METHOD . . . . . 11 RHYTHM METHOD 12	→ 323 → 320 → 326 → 326
317 317A	At that time, were you told about side effects or problems you might have with the method? *Taem ia, hao, olketa talem iu abaotim side ifekt iu maet garem sapos iu iusim disfala we ia?* When you got sterilized, were you told about side effects or problems you might have with the method? *Waswe olketa talem iu nogud stori blo metod ia taem iu go klinap?*	YES . . . . . 1 NO 2	→ 319
318	Were you ever told by a health or family planning worker about side effects or problems you might have with the method? *Eniwan lo famili planing o helt bin talem iu abaotem saed ifekt o samting nogud iu maet garem wetem metod ia ?*	YES . . . . . 1 NO 2	→ 320
319	Were you told what to do if you experienced side effects or problems? *Olketa talem iu wanem fo duim sapos iu garem saed ifekt o problem?*	YES . . . . . 1 NO 2	
320	CHECK 317: CODE '1' CIRCLED At that time, were you told about other methods of family planning that you could use? *Lo taem ia,hao,olketa talem iu abaot samfala nara we moa iu save iusim fo planem famili blo iu?* CODE '1' NOT CIRCLED When you obtained (CURRENT METHOD FROM 314) from (SOURCE OF METHOD FROM 307 OR 315), were you told about other methods of family planning that you could use? *Taem iu tekem (CURRENT METHOD FROM 314)lo (SOURCE OF METHOD FROM 307 OR 315)waswe olketa talem iu abaot samfala nara wei moa fo planem famili blo iu?*	YES . . . . . 1 NO 2	→ 322
321	Were you ever told by a health or family planning worker about other methods of family planning that you could use? *Eniwan lo helt o famili planing talem iu abaotim eni nara we moa iu save iusim fo planem famili blo iu o nomoa?*	YES . . . . . 1 NO 2	

322	CHECK 304: CIRCLE METHOD CODE: IF MORE THAN ONE METHOD CODE CIRCLED IN 304, CIRCLE CODE FOR HIGHEST METHOD IN LIST.	FEMALE STERILIZATION . . . . . 01 MALE STERILIZATION . . . . . 02 IUD . . . . . 03 INJECTABLES . . . . . 04 IMPLANTS . . . . . 05 PILL . . . . . 06 CONDOM . . . . . 07 FEMALE CONDOM . . . . . 08 DIAPHRAGM . . . . . 09 FOAM/JELLY . . . . . 10 LACTATIONAL AMEN. METHOD . . . . . 11 RHYTHM METHOD . . . . . 12 WITHDRAWAL . . . . . 13 OTHER MODERN METHOD . . . . . 95 OTHER TRADITIONAL METHOD . . . 96	→ 326 → 326
323	Where did you obtain (CURRENT METHOD) the last time? *Wea nao iu bin tekem (CURRENT METHOD) las taem?* PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . 11 PROVINCIAL HOSPITAL . . . . . 12 URBAN AREA HEALTH CENTRE . . . 13 AREA HEALTH CENTRE . . . . 14 RURAL HEALTH CENTRE . . . . . 15 FAMILY PLANNING CLINIC . . . . . 16 NURSE AIDE POST . . . . . 17 STATELLITE CLINICS . . . . . 18 OTHER PUBLIC SECTOR _____ 19 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC . . . . . 21 PHARMACY . . . . . 22 PRIVATE DOCTOR . . . . . 23 OTHER PRIVATE MEDICAL SECTOR _____ 26 (SPECIFY) NGO/OTHER SOURCE SIPPA CLINIC . . . . . 31 SIPPA CBD . . . . . 32 SAVE THE CHILDREN FUND . . . . . 33 CHURCH . . . . . 34 SHOP . . . . . 35 FRIEND/RELATIVE . . . . . 36 OTHER _____ 96 (SPECIFY)	→ 326
324	Do you know of a place where you can obtain a method of family planning? *Iu save lo eni ples wea iu save tekem infomeisin abaotim metod blo famili planning?*	YES . . . . . 1 NO 2	→ 326

325	Where is that? *Wea nao ia?* Any other place? *Eni nara ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERA . . . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CEI . . . . . C AREA HEALTH CEN . . . . . D RURAL HEALTH CENT . . . . . E FAMILY PLANNING CLINIC . . . . . F NURSE AIDE POST . . . . . G SATELLITE CLINICS . . . . . H OTHER PUBLIC SECTOR _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC . . . . . J PHARMACY . . . . . K PRIVATE DOCTOR . . . . . L OTHER PRIVATE MEDICAL SECTOR _____ M (SPECIFY) NGO/OTHER SOURCE SIPPA CLINIC . . . . . N SIPPA CBD . . . . . O SAVE THE CHILDREN FUND . . . . . P CHURCH . . . . . Q SHOP . . . . . R FRIEND/RELATIVE . . . . . S OTHER _____ X (SPECIFY)	
326	In the last 12 months, were you visited by a health fieldworker who talked to you about family planning? *Eniwan visitm iu insaet las 12 mans fo stori lo iu abaotim famili planniing?*	YES . . . . . 1 NO 2	
327	In the last 12 months, have you visited a health facility for care for yourself (or your children)? *Waswe,insaet lo las 12 mans,iu bin go lo eni helt centa fo iu seleva(o olketa pikinini blo iu)?*	YES . . . . . 1 NO 2	→ 401
328	Did any staff member at the health facility speak to you about family planning methods? *Eniwan lo olketa hu waka lo klinik o hospitol stori lo iu abaotim olketa we fo planem famili o nomoa?*	YES . . . . . 1 NO 2	

SECTION 4. PREGNANCY AND POSTNATAL CARE

401	CHECK 224: ONE OR MORE BIRTHS SINCE JANUARY 2010 TO 2015 ☐ ↓ NO BIRTHS SINCE JANUARY 2010 TO 2015 ☐ → 573			
402	CHECK 215: ENTER IN THE TABLE THE BIRTH HISTORY NUMBER, NAME, AND SURVIVAL STATUS OF EACH BIRTH SINCE JANUARY 2010 **UP TO 2015**. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. (IF THERE ARE MORE THAN 3 BIRTHS, USE LAST 2 COLUMNS OF ADDITIONAL QUESTIONNAIRES). Now I w ould like to ask some questions about your children born in the last five years. (We w ill talk about each separately.) *Distaem mi laek fo askem iu abaotim olketa pikinini blo iu wea bon insaet las 5 iaa.(Bae iumitufala tok abaotim wanfala fastaem,den narawan moa olsem.*			
403	BIRTH HISTORY NUMBER FROM 212 IN BIRTH HISTORY	LAST BIRTH BIRTH HISTORY NUMBER ☐☐	NEXT-TO-LAST BIRTH BIRTH HISTORY NUMBER ☐☐	SECOND-FROM-LAST BIRTH BIRTH HISTORY NUMBER ☐☐
404	FROM 212 AND 216	NAME _____ LIVING ☐ ↓ DEAD ☐ ↓	NAME _____ LIVING ☐ ↓ DEAD ☐ ↓	NAME _____ LIVING ☐ ↓ DEAD ☐ ↓
405	When you got pregnant with (NAME), did you want to get pregnant at that time? *Lo taem iu babule wetem (NEM) waswe iu laek fo babule lo dat taem tu o nomoa?*	YES . . . . . 1 (SKIP TO 408) ← NO 2	YES . . . . . 1 (SKIP TO 430) ← NO 2	YES . . . . . 1 (SKIP TO 430) ← NO 2
406	Did you want to have a baby later on, or did you not want any (more) children? *Waswe iu wande waet fo nara taem bihaen o iu barava nating laek garem eni (samfala) pikinini moa?*	LATER . . . . . 1 NO MORE . . . . . 2 (SKIP TO 408) ←	LATER . . . . . 1 NO MORE . . . . . 2 (SKIP TO 430) ←	LATER . . . . . 1 NO MORE . . . . . 2 (SKIP TO 430) ←
407	How much longer did you want to wait? *Hao long nao iu laek fo wet bat iu babule moa ia?*	MONTHS . .1 ☐☐ YEARS . . 2 ☐☐ DON'T KNOW 998	MONTHS . .1 ☐☐ YEARS . . 2 ☐☐ DON'T KNOW . . . 998	MONTHS . .1 ☐☐ YEARS . . 2 ☐☐ DON'T KNOW . . . 998
408	Did you see anyone for antenatal care for this pregnancy? *Iu go lo eni klinik o hospitol fo chek-ap wetem disfala babule o nomoa?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 415) ←		
409	Whom did you see? *Hu nao iu lukim?* Anyone else? *Eniwan moa?* PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.	HEALTH PERSONNEL DOCTOR . . . . . A NURSE/MIDWIFE B AUXILIARY MIDWIFE . . . . . C OTHER PERSON TRADITIONAL BIRTH ATTENDANT D COMMUNITY/ VILLAGE HEALTH WORKER . . . . E OTHER _____ X (SPECIFY)		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
410	Where did you receive antenatal care for this pregnancy? *Wea nao iu go tekem diskaen antenatal kea lo hem?* Anywhere else? *Eniwea moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	HOME YOUR HOME .... A OTHER HOME .... B PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ..... C PROVINCIAL HOSPITAL ..... D URBAN AREA HEALTH CENTRE ..... E AREA HEALTH CENTRE ..... F RURAL HEALTH CENTRE ..... G NURSE AID POST ... H SATELLITE CLINICS I OTHER PUBLIC SECTOR J _____ (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC ..... K OTHER PRIVATE MED. SECTOR _____ L (SPECIFY) CHURCH HOSPITAL ..... M RURAL HEALTH CLINIC ..... N NURSE AIDE POST ..... O SATELLITE CLINIC P NGO/OTHER SOURCE SIPPA CLINIC ..... Q OTHER _____ X (SPECIFY)		
411	How many months pregnant were you when you first received antenatal care for this pregnancy? *Iu hao meni mans nao taem iu tekem fas antenatal care lo babule blo iu?*	MONTHS ... ☐☐ DON'T KNOW 98		
412	How many times did you receive antenatal care during this pregnancy? *Hao meni taem nao iu tekem antenatal kea lo taem iu babule ia?*	NUMBER OF TIMES ☐☐ DON'T KNOW 98		

413	As part of your antenatal care during this pregnancy, were any of the following done at least once: *Olsem pat lo antenatal care fo iu lo disfala taem iu babule ia,eniwan lo olketa samting olsem olketa duim eni wan taem fo iu?* Was your blood pressure measured? *Testem blad presa blo iu?* Did you give a urine sample? *Testem mimi blo iu?* Did you give a blood sample? *Iu givim eni blad blo iu fo olketa testem?*	YES NO BP . . . . . 1 2 URINE . . . . . 1 2 BLOOD . . . 1 2	
414	During (any of) your antenatal care visit(s), were you told about things to look out for that might suggest problems with the pregnancy? *Lo (eni lo) olketa antenatal kea visit blo iu ia,waswe eniwan talem iu olketa problems wea iu maet garem from babule?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
415	During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth? *Olketa givim eni nila go lo arm blo iu lo taem iu babule ia fo stopem bebi from garem tetanus,o sik we bebi bae seksek afta hemi bon kam?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 418) ← DON'T KNOW 8	
416	During this pregnancy, how many times did you get a tetanus iniection? *Hao meni taem nao olketa givim diskaen nila fo tetanus lo iu taem iu babule?*	TIMES . . . . . ☐ DON'T KNOW 8	
417	CHECK 416:	2 OR MORE TIMES ☐ → (SKIP TO 421) OTHER ☐ →	
418	At any time before this pregnancy, did you receive any tetanus iniections? *Eni taem bifoa disfala babule blo iu distaem ia,olketa givim eni nila fo iu ?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 421) ← DON'T KNOW 8	

419	Before this pregnancy, how many times did you receive a tetanus injection? *Hao meni nila fo stopem tetanus nao olketa givim iu bifoa disfala babule blo iu distaem?* IF 7 OR MORE TIMES, RECORD '7'.	TIMES . . . . . ☐☐ DON'T KNOW 8
420	How many years ago did you receive the last tetanus injection before this pregnancy? *Hao meni iia go finis nao olketa givim iu las nila blo tetanus bifoa disfala babule blo iu distaem?*	YEARS AGO . . . . . ☐☐
421	During this pregnancy, were you given or did you buy any iron tablets or iron syrup (Tonic)? *Lo team iu babule distaem,waswe,olketa bin givim iu o iu bin baem eni iron tablets o iron syrup?* SHOW TABLETS/SYRUP.	YES . . . . . 1 NO . . . . . 2 (SKIP TO 423) ←┤ DON'T KNOW 8
422	During the whole pregnancy, for how many days did you take the tablets or syrup? *hao meni deis nao iu tekem olketa tablet o syrup ia insaet ful babule blo iu distaem ia?* IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS ☐☐☐ DON'T KNOW 998
423	During this pregnancy, did you take any drug for intestinal worms? *Iu tekem eni meresin againstem smol worm insaet intestine lo babule distaem ia o nomoa?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
424	During this pregnancy, did you take any drugs to keep you from getting malaria? *Iu dringim meresin fo stopem malaria lo babule blo iu distaem o nomoa?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 430) ←┤ DON'T KNOW 8
425	What drugs did you take? *Wat kaen meresin nao iu tekem?* RECORD ALL MENTIONED. IF TYPE OF DRUG IS NOT DETERMINED, SHOW TYPICAL ANTIMALARIAL DRUGS TO RESPONDENT.	CHLOROQUINE A SP/FANSIDAR . . . . B OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z

426	CHECK 425: CHLOROQUINE TAKEN FOR MALARIA PREVENTION.	CODE 'A' CIRCLED ☐ → (SKIP TO 429A) CODE A' NOT CIRCLED ☐	
427	How oftern did you take (CHLOROQUINE) during this pregnancy? *Hao meni taem nao iu tekem (Chloroquine) taem iu babule distaem?*	WEEKLY ..... 1 DAILY 2 DON'T KNOW 8	
428	CHECK 409: ANTENATAL CARE FROM HEALTH PERSONNEL DURING THIS PREGNANCY	CODE 'A', 'B' OR 'C' CIRCLED ☐ → (SKIP TO 429A) OTHER ☐	
429	Did you get the (CHLOROQUINE) during any antenatal care visit, during another visit to a health facility or from another source? *Iu tekem (chloroquine) insaet taem iu go fo antenatal visit,insaet nara visit go lo klinik o hospitol o from different source?*	ANTENATAL VISIT .. 1 ANOTHER FACILITY VISIT ..... 2 OTHER SOURCE 6	
429A	During this pregnancy,did you suffer from malaria? *Long taem iu babule distaem,waswe iu bin sik lo malaria tu o nomoa?*	YES ..... 1 NO ..... 2 (SKIP TO 430) DON'T KNOW 8	
429B	Were you diagnosed by a health worker then? *Waswe man hem waka lo helt nao bin faedim aot dat iu garem malaria datfala taem?*	YES ..... 1 NO ..... 2 (SKIP TO 430)	
429C	How many times were you diagnosed with malaria during this pregnancy? *Hao meni taem nao iu bin garem malaria an olketa waka man long helt bin faedim aot dat iu garem malaria lo taem iu babule distaem?*	TIMES ..... ☐☐	
429D	Were you admitted for malaria then? *Waswe,iu bin go stap long haos siki bikos iu garem malaria datfala taem?*	YES ..... 1 NO ..... 2 (SKIP TO 430)	
429E	How many times were you admitted for malaria during this pregnancy? *Hao meni taem nao iu bin go stap lo haos sik bikos iu garem malaria long taem iu babule distaem ia?*	TIMES ..... ☐☐	

430	When (NAME) was born, was he/she very large, larger than average, average, smaller than average, or very small? *Taem (NEM) hemi bon,waswe hemi bik tumas,bik lelbet winim average,average,smaller than average,o barava smol tumas?*	VERY LARGE ...... 1 LARGER THAN AVERAGE ...... 2 AVERAGE .... 3 SMALLER THAN AVERAGE ...... 4 VERY SMALL ...... 5 DON'T KNOW 8	VERY LARGE ..... 1 LARGER THAN AVERAGE ..... 2 AVERAGE .... 3 SMALLER THAN AVERAGE ..... 4 VERY SMALL ..... 5 DON'T KNOW 8	VERY LARGE ..... 1 LARGER THAN AVERAGE ..... 2 AVERAGE .... 3 SMALLER THAN AVERAGE ..... 4 VERY SMALL ..... 5 DON'T KNOW 8
431	Was (NAME) weighed at birth? *Waswe (NEM) olketa weim taem hemi bon o nomoa?*	YES .... 1 NO .... 2 (SKIP TO 433) ← DON'T KNOW 8	YES .... 1 NO .... 2 (SKIP TO 433) ← DON'T KNOW 8	YES .... 1 NO .... 2 (SKIP TO 433) ← DON'T KNOW 8
432	How much did (NAME) weigh? *Wanem nao weit blo (NEM)?* RECORD WEIGHT IN KILOGRAMS FROM HEALTH CARD, IF AVAILABLE.	KG FROM CARD 1 [ ] . [ ][ ][ ] KG FROM RECALL 2 [ ] . [ ][ ][ ] DON'T KNOW 99998	KG FROM CARD 1 [ ] . [ ][ ][ ] KG FROM RECALL 2 [ ] . [ ][ ][ ] DON'T KNOW 99998	KG FROM CARD 1 [ ] . [ ][ ][ ] KG FROM RECALL 2 [ ] . [ ][ ][ ] DON'T KNOW 99998
433	Who assisted with the delivery of (NAME)? *Hu nao helpem iu lo taem (NEM) hemi bon?* Anyone else? *Eniwan moa?* PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED. IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.	HEALTH PERSONNEL DOCTOR ...... A MIDWIFE .... B REGISTERD NURSE C NURSE AID .... D OTHER PERSON TRADITIONAL BIRTH ATTENDANT .. E RELATIVE/FRIEND . F OTHER __________ X (SPECIFY) NO ONE ASSISTED Y	HEALTH PERSONNEL DOCTOR ..... A MIDWIFE .... B REGISTERD NURSE C NURSE AID ... D OTHER PERSON TRADITIONAL BIRTH ATTENDANT .. E RELATIVE/FRIEND . F OTHER __________ X (SPECIFY) NO ONE ASSISTED Y	HEALTH PERSONNEL DOCTOR ..... A MIDWIFE .... B REGISTERD NURSE C NURSE AID ... D OTHER PERSON TRADITIONAL BIRTH ATTENDANT .. E RELATIVE/FRIEND . F OTHER __________ X (SPECIFY) NO ONE ASSISTED Y
434	Where did you give birth to (NAME)? *Wea na iu bonem (NEM) ?* PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. ________________ (NAME OF PLACE)	HOME YOUR HOME .... 11 (SKIP TO 438) ← OTHER HOME .... 12 PUBLIC SECTOR NATIONAL REFERAL HOSPITAL .... 21 PROVINCIAL HOSPITAL .... 22 URBAN AREA HEALTH CENTRE .... 23 AREA HEALTH CENTR .... 24 RURAL HEALTH CENTRE .... 25 NURSE AID POST ... 26 SATELLITE CLINICS '27 OTHER PUBLIC SECTOR __________ 28 (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC .. 31 PRIVATE DOCTOR 32 OTHER PRIVATE MED. SECTOR __________ 36 (SPECIFY) CHURCH HOSPITA .... 41 RURAL HEALTH CLINIC .... 42 NURSE AIDE POST .... 43 SATELLITE CLINIC 44 NGO/OTHER SOURCE SIPPA .... 51 OTHER__________ 96 (SPECIFY) (SKIP TO 438) ←	HOME YOUR HOME ... 11 (SKIP TO 448) ← OTHER HOME ... 12 PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ...... 21 PROVINCIAL HOSPITAL ...... 22 URBAN AREA HEALTH CENTRE .... 23 AREA HEALTH CENTRI .... 24 RURAL HEALTH CENTRE .... 25 NURSE AID POST ... 26 SATELLITE CLINICS '27 OTHER PUBLIC SECTOR __________ 28 (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC .. 31 PRIVATE DOCTOR 32 OTHER PRIVATE MED. SECTOR __________ 36 (SPECIFY) CHURCH HOSPITA .... 41 RURAL HEALTH CLINIC .... 42 NURSE AIDE POST .... 43 SATELLITE CLINIC 44 NGO/OTHER SOURCE SIPPA .... 51 OTHER__________ 96 (SPECIFY) (SKIP TO 448) ←	HOME YOUR HOME ... 11 (SKIP TO 448) ← OTHER HOME ... 12 PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ...... 21 PROVINCIAL HOSPITAL ...... 22 URBAN AREA HEALTH CENTRE .... 23 AREA HEALTH CENTR .... 24 RURAL HEALTH CENTRE .... 25 NURSE AID POST ... 26 SATELLITE CLINICS '27 OTHER PUBLIC SECTOR __________ 28 (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC .. 31 PRIVATE DOCTOR 32 OTHER PRIVATE MED. SECTOR __________ 36 (SPECIFY) CHURCH HOSPITA .... 41 RURAL HEALTH CLINIC .... 42 NURSE AIDE POST .... 43 SATELLITE CLINIC 44 NGO/OTHER SOURCE SIPPA .... 51 OTHER__________ 96 (SPECIFY) (SKIP TO 448) ←

434A	How long after (NAME) was delivered did you stay there? *Hao lon afta (NEM) hemi bon nao iu stap lo dea?* IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS 1 ☐☐ DAYS 2 ☐☐ WEEKS 3 ☐☐ DON'T KNOW 998		
435	Was (NAME) delivered by caesarean, that is, did they cut your belly open to take the baby out? *Waswe (NEM) hem bon from olketa katem mami o nomoa?*	YES ..... 1 NO 2	YES ..... 1 NO 2	YES ..... 1 NO 2
436	I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health while you were still in the facility? *Distaem mi laek fo tok abaotem helt blo iu afta iu go aot from klinik? Olketa questen olsem eni nes jekem helt blo iu afta iu go aot from klinik.Waswe olketa nes jekem helt blo iu tu taem iu insaet lo klinik?*	YES ..... 1 (SKIP TO 439) ← NO 2		
437	Did anyone check on your health after you left the facility? *Afta iu go aot from klinic o hospitol ,eni nes jekem helt blo iu o nomoa?*	YES ..... 1 (SKIP TO 439) ← NO ..... 2 (SKIP TO 442) ←		
438	I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health after you gave birth to (NAME)? *Distaem mi laek fo tok abaotem helt blo iu afta iu go aot from klinik? Olketa questen olsem eni nes jekem helt blo iu afta iu go aot lo klinik.Waswe olketa nes jekem helt blo iu tu taem iu bonem (NEM)?*	YES ..... 1 NO ..... 2 (SKIP TO 442) ←		
439	Who checked on your health at that time? *Hu nao jekem helt blo iu lo dat taem?* PROBE FOR MOST QUALIFIED PERSON.	HEALTH PERSONNEL DOCTOR ..... 11 MIDWIFE ..... 12 REGISTERED NURSE 13 NURSE AID 14 OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH WORKER .... 22 OTHER _____ 96 (SPECIFY)		

440	How long after delivery did the first check take place? *Hao long afta bebi bon nao hemi givim fas jek-ap lo iu?* IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS 1 ☐☐ DAYS 2 ☐☐ WEEKS 3 ☐☐ DON'T KNOW 998	
442	In the two months after (NAME) was born, did any health care provider or a traditional birth attendant check on his/her health? *Bihaen tufala mans wea (NEM) bon, eni nes o mere lo hom hu helpem iu fo bonem bebi hemi jekem helt blo bebi o nomoa?*	YES ..... 1 NO ..... 2 (SKIP TO 446) ← DON'T KNOW 8	
443	How many hours, days or weeks after the birth of (NAME) did the first check take place? *Hao meni aoa,dei,wik bihaen (NEM) hem bon nao fas jek lo helt blo hem tek place?* IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS.	HRS AFTER BIRTH .. 1 ☐☐ DAYS AFTER BIRTH .. 2 ☐☐ WKS AFTER BIRTH .. 3 ☐☐ DON'T KNOW 998	
444	Who checked on (NAME)'s health at that time? *Hu nao jekem helt blo (NEM) lo taem ia?* PROBE FOR MOST QUALIFIED PERSON.	HEALTH PERSONNEL DOCTOR ..... 11 MIDWIFE ..... 12 REGISTERED NURSE 13 NURSE AID ..... 14 OTHER PERSON TRADITIONAL BIRTH ATTENDANT ..... 21 COMMUNITY/ VILLAGE HEALTH WORKER .... 22 OTHER _____ 96 (SPECIFY)	

445	Where did this first check of (NAME) take place? *Wea na disfala fas jek blo (NEM) hem tek ples?* PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	HOME YOUR HOME .... 11 OTHER HOME .... 12 PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ..... 21 PROVINCIAL HOSPITAL ..... 22 URBAN AREA HEALTH CENTRE ..... 23 AREA HEALTH CENTR ..... 24 RURAL HEALTH CENTRE ..... 25 NURSE AID POST ... 26 SATELLITE CLINICS '27 OTHER PUBLIC SECTOR _____ 28 (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC . 31 PRIVATE DOCTOR 32 OTHER PRIVATE MED._____ 36 (SPECIFY) CHURCH HOSPITAL . 41 RURAL HEALTH CLINIC ..... 42 NURSE AIDE POST ..... 43 SATELLITE CLINIC 44 NGO/OTHER SOURCE SIPPA CLINIC . 51 OTHER_____ 96 (SPECIFY)	
446	In the first two months after delivery, did you receive a vitamin A dose like (this/any of these)? *Insaet tufala fas mans bihaenim iu bonem bebi,waswe iu tekem eni Vitamin A meresin (olsem diswan o olsem olketa ia) o* SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
447	Has your menstrual period returned since the birth of (NAME)? *Waswe,iu lukim mun blo iu hemi kam baek nao since iu bonem bebi (NEM)?*	YES . . . . . 1 (SKIP TO 449) ←┘ NO . . . . . 2 (SKIP TO 450) ←┘	

448	Did your period return between the birth of (NAME) and your next pregnancy? *Waswe iu lukim mun blo iu hemi kam baek tu bitwin taem (NEM) hemi bon an neks babule blo iu o hao?*		YES . . . . . 1 NO . . . . . 2 (SKIP TO 452) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO 452) ←
449	For how many months after the birth of (NAME) did you not have a period? *Hao meni mans afta iu bonem (NEM) nao iu no lukim mun blo iu?*	MONTHS . . . ☐☐ DON'T KNOW 98	MONTHS . . . ☐☐ DON'T KNOW 98	MONTHS . . . ☐☐ DON'T KNOW 98
450	CHECK 226: IS RESPONDENT PREGNANT?	NOT PREG-NANT → ☐ PREGNANT OR UNSURE → ☐ (SKIP TO 452) ←		
451	Have you had sexual intercourse since the birth of (NAME)? *Waswe iu bin havim seks moa sins taem (NEM) hem bon?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 453) ←		
452	For how many months after the birth of (NAME) did you not have sexual intercourse? *Hao meni manis afta (NEM) hem bon nao iu bin no havem seks?*	MONTHS . . . ☐☐ DON'T KNOW 98	MONTHS . . . ☐☐ DON'T KNOW 98	MONTHS . . . ☐☐ DON'T KNOW 98
453	Did you ever breastfeed (NAME)? *Iu givim susu tu lo (NEM)?*	YES . . . . . 1 (SKIP TO 455) ← NO 2	YES . . . . . 1 NO 2	YES . . . . . 1 NO 2
454	CHECK 404: IS CHILD LIVING?	LIVING → ☐ (SKIP TO 460) DEAD → ☐ (GO BACK TO 405 IN NEXT COLUMN; OR IF NO MORE BIRTHS, GO TO 501)		
455	How long after birth did you first put (NAME) to the breast? *Hao long bihaen bebi (NEM) hemi bon nao bifoa iu stat fo susum hem?* IF LESS THAN 1 HOUR, RECORD '00' HOURS. IF LESS THAN 24 HOURS, RECORD HOURS. OTHERWISE, RECORD DAYS.	IMMEDIATELY . . . . 000 HOURS 1 ☐☐ DAYS 2 ☐☐		

456	In the first three days after delivery, was (NAME) given anything to drink other than breast milk? *Insaet fas trifala dei bebi (NEM) hemi bon,waswe,iu givim eni nara dring fo hemi dringim wea difren from susu melek?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 458) ←		
457	What was (NAME) given to drink? *Wat nao iu fala givim (NEM) fo dringim?* Anything else? *Enisamting difren moa?* RECORD ALL LIQUIDS MENTIONED.	MILK (OTHER THAN BREAST MILK) A PLAIN WATER . . . . B SUGAR OR GLU-COSE WATER . . . . C GRIPE WATER . . . . D SUGAR-SALT-WATER SOLUTION . . . . . E FRUIT JUICE . . . . . F INFANT FORMULA G TEA/INFUSIONS . . . . H COFFEE . . . . . I HONEY . . . . . J OTHER _____ X (SPECIFY)		
458	CHECK 404: IS CHILD LIVING?	LIVING ☐ → DEAD ☐ → (GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501)	LIVING ☐ → DEAD ☐ → (GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501)	LIVING ☐ → DEAD ☐ → (GO BACK TO 405 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501)
459	Are you still breastfeeding (NAME)? *Iu stil givim susu melek lo bebi (NEM) o nomoa?*	YES . . . . . 1 NO 2		
460	Did (NAME) drink anything from a bottle with a nipple yesterday or last night? *Waswe (NEM) hemi dringim eni botol wetem nipol iestade o las naet?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
461		GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501.	GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501.	GO BACK TO 405 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501.

SECTION 5. CHILD IMMUNIZATION AND HEALTH AND CHILD'S AND WOMAN'S NUTRITION

501 ENTER IN THE TABLE THE LINE NUMBER, NAME, AND SURVIVAL STATUS OF EACH BIRTH SINCE JANUARY 2010 TO 2015.
ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH.
(IF THERE ARE MORE THAN 3 BIRTHS, USE LAST 2 COLUMNS OF ADDITIONAL QUESTIONNAIRES).

		LAST BIRTH	NEXT-TO-LAST BIRTH	SECOND-FROM-LAST BIRTH
502	LINE NUMBER FROM 212	LINE NUMBER	LINE NUMBER	LINE NUMBER . . . . .
503	FROM 212 AND 216	NAME LIVING ☐ DEAD ☐ (GO TO 503 IN NEXT COLUMN OR, IF NO MORE BIRTHS, GO TO 573)	NAME LIVING ☐ DEAD ☐ (GO TO 503 IN NEXT COLUMN OR, IF NO MORE BIRTHS, GO TO 573)	NAME LIVING ☐ DEAD ☐ (GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE, OR IF NO MORE BIRTHS, GO TO 573)
504	Do you have a baby book where (NAME'S) vaccinations are written down? IF YES: May I see it please? *Waswe, iu garem bebi buk wea (NEM'S) nila (vaccinations) olketa raitim daon?* IF YES: *Mi save lukim plis?*	YES, SEEN . . . . . 1 (SKIP TO 506) YES, NOT SEEN . . . . . 2 (SKIP TO 509) NO BABY BOOK 3	YES, SEEN . . . . . 1 (SKIP TO 506) YES, NOT SEEN . . . . . 2 (SKIP TO 509) NO BABY BOOK 3	YES, SEEN . . . . . 1 (SKIP TO 506) YES, NOT SEEN . . . . . 2 (SKIP TO 509) NO BABY BOOK 3
505	Did you ever have a baby book for (NAME)? *Iu bin garem bebi buk fo (NEM) tu?*	YES . . . . . 1 (SKIP TO 509) NO 2	YES . . . . . 1 (SKIP TO 509) NO 2	YES . . . . . 1 (SKIP TO 509) NO 2

506 (1) **COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD OR BABY BOOK.**
(2) **WRITE '44' IN 'DAY' COLUMN IF CARD OR BABY BOOK SHOWS THAT A VACCINATION WAS GIVEN, BUT NO DATE IS RECORDED.**

	LAST BIRTH DAY	LAST BIRTH MONTH	LAST BIRTH YEAR	NEXT-TO-LAST BIRTH DAY	NEXT-TO-LAST BIRTH MONTH	NEXT-TO-LAST BIRTH YEAR	SECOND-FROM-LAST BIRTH DAY	SECOND-FROM-LAST BIRTH MONTH	SECOND-FROM-LAST BIRTH YEAR
BCG (At birth)				BCG			BCG		
HEPATITIS B1 (24 HRS within)				Hep B1			Hep B1		
HEPATITIS B1 (24HRS AFTER)				Hep B1			Hep B1		
POLIO 1				Polio1			Polio1		
POLIO 2				Polio2			Polio2		
POLIO 3				Polio3			Polio3		
PENTA 1				Penta1			Penta1		
PENTA 2				Penta2			Penta2		
PENTA 3				Penta3			Penta3		
MEASLES				M			M		
MEASLES RUBELLA				MR			MR		
VITAMIN A (100,000u)				V A1			V A1		
VITAMIN A 1 (200,000u)				V A1			V A1		
VITAMIN A 2 (200,000u)				V A2			V A2		
VIT. A 3 (200,000u)				V A3			V A3		
VIT. A 4 (200,000u)				V A4			V A4		
VIT. A 5 (200,000u)				V A5			V A5		
VIT. A 6 (200,000u)				V A6			V A6		
VIT. A 7 (200,000u)				V A7			V A7		
VIT. A 8 (200,000u)				V A8			V A8		
VIT. A 9 (200,000u)				V A9			V A9		
ALBENDAZOLE 1 (200 mg)				AL1			AL1		
ALBENDAZOLE 1 (400 mg)				AL 1			AL 1		
ALB. 2 (400 mg)				AL 2			AL 2		
ALBE. 3 (400 mg)				AL 3			AL 3		
ALB. 4 (400 mg)				AL 4			AL 4		
ALB. 5 (400 mg)				AL 5			AL 5		
ALB. 6 (400 mg)				AL 6			AL 6		
ALB. 7 (400 mg)				AL 7			AL 7		

507	CHECK 506:	BCG TO MEASLES/R ALL RECORDED → (GO TO 511)	OTHER →	BCG TO MEASLES/R ALL RECORDED → (GO TO 511)	OTHER →	BCG TO MEASLES/R ALL RECORDED → (GO TO 511)	OTHER →

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ______________	NEXT-TO-LAST BIRTH NAME ______________	SECOND-FROM-LAST BIRTH NAME ______________
508	Has (NAME) had any vaccinations that are not recorded on this card, including vaccinations given in a national immunization day campaign? *Waswe (NEM) hemi bin getem eni nila wea olketa no stap lo disfala kad blo hem,diskaen shud kavam olketa nila hemi tekem lo nasinol nila kampein?* RECORD 'YES' ONLY IF RESPONDENT MENTIONS BCG, HEP. B.O, PENTA 1-3 POLIO 1-3, AND MEASLES VACCINES.	YES . . . . 1 (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 506) (SKIP TO 511) NO . . . . 2 (SKIP TO 511) DON'T KNOW 8	YES . . . . 1 (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 506) (SKIP TO 511) NO . . . . 2 (SKIP TO 511) DON'T KNOW 8	YES . . . . 1 (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 506) (SKIP TO 511) NO . . . . 2 (SKIP TO 511) DON'T KNOW 8
509	Did (NAME) ever have any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign? *Waswe (NEM) bin tekem eni nila fo stopem fo getem eni sikinis, kavam tu eni nila hemi tekem from wanfala nasinol nila kampein?*	YES . . . . 1 NO . . . . 2 (SKIP TO 511) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 511) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 511) DON'T KNOW 8
510	Please tell me if (NAME) had any of the following vaccinations: *Plis talem mi sapos (NEM) bin getem eniwan lo olketa nila olsem?*			
510A	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar? *Wanfala BCG nila agenstem TB,diswan minim nila lo arm o sholda wea hemi shud livim wanfala mak lo sholda blo hem.*	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8
510B	Polio vaccine, that is, drops in the mouth? *Polio meresin,wea hemi samfala drop go insaet lo maot?*	YES . . . . 1 NO . . . . 2 (SKIP TO 510E) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 510E) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 510E) DON'T KNOW 8
510C	Was the first polio vaccine given in the first two weeks after birth or later? *Waswe hemi tekem fas meresin blo polio ia insaet fas tu wiks bihaen hemi bon o lelbet taem bihaen?*	FIRST 2 WEEKS . . . 1 LATER 2	FIRST 2 WEEKS . . . 1 LATER 2	FIRST 2 WEEKS . . . 1 LATER 2
510D	How many times was the polio vaccine given? *hao meni taem nao hemi tekem meresin blo polio ia?*	NUMBER OF TIMES . . . . . [ ]	NUMBER OF TIMES . . . . . [ ]	NUMBER OF TIMES . . . . [ ]

510E	A Pentavalent vaccination - that is, a vaccine that combines DPT, hepatitis and Hib in one vaccine? *Pentavalent nila hem nila wea olketa three fala meresin kobaen DPT,hepatitis an Hib lo onefala nila?*	YES . . . . . 1 NO . . . . . 2 (SKIP TO 510G) ← DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO 510G) ← DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO 510G) ← DON'T KNOW 8
510F	How many times was a Pentavalent vaccination received? *Hao meni taem nao hemi bin risivim Pentavalent meresin ia?*	NUMBER OF TIMES . . . . . [ ]	NUMBER OF TIMES . . . . . [ ]	NUMBER OF TIMES . . . . . [ ]
510G	A measles injection or an MMR injection - that is, a shot in the arm at the age of 9 months or older - to prevent him/her from getting measles? *Nila blo misols ia wea olketa nilam arm blo pikinini taem hemi 9 mans o ovam go fo stopem pikinini from getem misols.*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
511	Within the last six months, was (NAME) given a vitamin A dose like (this/any of these)? *Insaet long las six mans,waswe (NEM) bin risivim eni vitamin A dose (olsem diswan/eni lo olketa ia?* SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
512	In the last seven days, was (NAME) given iron pills, sprinkles with iron, or iron syrup like (this/any of these)? *Insaet las sevem deis,waswe (NEM) tekem iron pills,sprinklets wetem iron o iron syrup (olsem diswan/eni lo oloketa ia)?* SHOW COMMON TYPES OF PILLS/SPRINKLES/ SYRUPS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
513	Was (NAME) given any drug for intestinal worms in the last six months? *Waswe (NEM) bin tekem eni meresin fo olketa worm insaet intestine insaet las six mans?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8

514	Has (NAME) had diarrhea in the last 2 weeks? *Waswe (NEM) bin garem daeria insaet las two wik o nomoa?*	YES . . . . 1 NO . . . . 2 (SKIP TO 525) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 525) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 525) DON'T KNOW 8
515	Was there any blood in the stools? *Eni blad lo siti blo hem?*	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8
516	Now I would like to know how much (NAME) was given to drink during the diarrhea (including breastmilk). *Nao,mi laek fo save hao mas wata nao (NEM) bin dringim lo taem hemi garem diarea (diswan incudim tu susu melek)* Was he/she given less than usual to drink, about the same amount, or more than usual to drink? *Hemi bin dringim less than usual,abaot sem amount o more than* IF LESS, PROBE: Was he/she given much less than usual to drink or somewhat less? *Waswe iu givim lelebet winim evri taem o barava smol tumas winim everi taem?*	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 NOTHING TO DRINK 5 DON'T KNOW 8	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 NOTHING TO DRINK 5 DON'T KNOW 8	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 NOTHING TO DRINK 5 DON'T KNOW 8
517	When (NAME) had diarrhea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? *Taem (NEM) garem daeria,iu givim less than usual fo kaikai,abaot sem amaont,more than usual,o no eni samting fo kaikaim?* IF LESS, PROBE: Was he/she given much less than usual to eat or somewhat less? *Waswe iu givim lelebet winim evri taem or barava smol tumas winim evri taem?*	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 STOPPED FOOD 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 STOPPED FOOD 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 STOPPED FOOD 5 NEVER GAVE FOOD 6 DON'T KNOW 8
518	Did you seek advice or treatment for the diarrhea from any source? *Iu lukaotem advais an meresin fo daeria from eni sos?*	YES . . . . 1 NO . . . . 2 (SKIP TO 522)	YES . . . . 1 NO . . . . 2 (SKIP TO 522)	YES . . . . 1 NO . . . . 2 (SKIP TO 522)

519	Where did you seek advice or treatment? *Wea nao iu lukaotem advais an meresin?* Anywhere else? *Eniwea moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ..... A PROVINCIAL HOSPITAL ... B URBAN AREA HEALTH CENTRE ..... C AREA HEALTH CENTR ..... D RURAL HEALTH CENTRE ..... E NURSE AID POST ... F SATELLITE CLINICS G OTHER PUBLIC SECTOR _____ H (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC I PHARMACY J PRIVATE DOCTOR DOCTOR ... K OTHER PRIVATE MED. FACILITY _____ L (SPECIFY) CHURCH HOSPITAL ..... M RURAL HEALTH CLINIC ..... N NURSE AIDE POST ..... O SATELLITE CLINIC ..... P OTHER SOURCE SIPPA CLINIC ..... Q SHOP ..... R FRIEND ..... S TRADITIONAL PRACTITIONER T OTHER _____ X (SPECIFY)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ..... A PROVINCIAL HOSPITAL ... B URBAN AREA HEALTH CENTRE ..... C AREA HEALTH CENTR ..... D RURAL HEALTH CENTRE ..... E NURSE AID POST ... F SATELLITE CLINICS G OTHER PUBLIC SECTOR _____ H (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC .. I PHARMACY ..... J PRIVATE DOCTOR DOCTOR ..... K OTHER PRIVATE MED. FACILITY _____ L (SPECIFY) CHURCH HOSPITAL ..... M RURAL HEALTH CLINIC ..... N NURSE AIDE POST ..... O SATELLITE CLINIC ..... P OTHER SOURCE SIPPA CLINIC ..... Q SHOP ..... R FRIEND ..... S TRADITIONAL PRACTITIONER T OTHER _____ X (SPECIFY)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ..... A PROVINCIAL HOSPITAL ... B URBAN AREA HEALTH CENTRE ..... C AREA HEALTH CENTR ..... D RURAL HEALTH CENTRE ..... E NURSE AID POST ... F SATELLITE CLINICS G OTHER PUBLIC SECTOR _____ H (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC I PHARMACY J PRIVATE DOCTOR DOCTOR ... K OTHER PRIVATE MED. FACILITY _____ L (SPECIFY) CHURCH HOSPITAL ..... M RURAL HEALTH CLINIC ..... N NURSE AIDE POST ..... O SATELLITE CLINIC ..... P OTHER SOURCE SIPPA CLINIC ..... Q SHOP ..... R FRIEND ..... S TRADITIONAL PRACTITIONER T OTHER _____ X (SPECIFY)
520	CHECK 519:	TWO OR MORE CODES CIRCLED ☐ → (SKIP TO 522) ONLY ONE CODE CIRCLED ☐ → (SKIP TO 522)	TWO OR MORE CODES CIRCLED ☐ → (SKIP TO 522) ONLY ONE CODE CIRCLED ☐ → (SKIP TO 522)	TWO OR MORE CODES CIRCLED ☐ → (SKIP TO 522) ONLY ONE CODE CIRCLED ☐ → (SKIP TO 522)
521	Where did you first seek advice or treatment? *Wea nao fas ples iu lukaotem advais an meresin?* USE LETTER CODE FROM 519.	FIRST PLACE ... ☐	FIRST PLACE ... ☐	FIRST PLACE ... ☐

522	Was he/she given any of the following to drink at any time since he/she started having the diarrhea: *Waswe iu givim eni wan lo olketa dring olsem bihaen taem hemi stat garem daearia?* a) A fluid made from a special packet called [LOCAL NAME FOR ORS PACKET]? *Dring from wanfala spesol dring"oral rehydration salt" lo paket olketa kolem ORS PACK)?* b) A pre-packaged ORS liquid? *Wanfala dring lo paket olketa kolem ORS Liquid?* c) A government-recommended homemade fluid? *Kokonat dring wea gavman nao apruvum fo daearia?*	YES NO DK FLUID FROM ORS PKT 1 2 8 ORS LQD 1 2 8 HOMEMADE FLUID . . . 1 2 8	YES NO DK FLUID FROM ORS PKT 1 2 8 ORS LQD 1 2 8 HOMEMADE FLUID . . . 1 2 8	YES NO DK FLUID FROM ORS PKT 1 2 8 ORS LQD 1 2 8 HOMEMADE FLUID . . . 1 2 8
523	Was anything (else) given to treat the diarrhea? *Eni nara samting moa iu givim fo tritim daearia?*	YES . . . . 1 NO . . . . 2 (SKIP TO 525) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 525) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 525) DON'T KNOW 8
524	What (else) was given to treat the diarrhea? *Wanem moa nao iu givim fo tritim daearia ia?* Anything else? *Eni samting moa?* RECORD ALL TREATMENTS GIVEN.	PILL OR SYRUP ANTIBIOTIC . . . . . A ANTIMOTILITY B ZINC . . . . C OTHER (NOT ANTI-BIOTIC, ANTI-MOTILITY, OR ZINC) . . . . D UNKNOWN PILL OR SYRUP . . . E INJECTION ANTIBIOTIC . . . . . F NON-ANTIBIOTIC G UNKNOWN INJECTION . . . H (IV) INTRAVENOUS I HOME REMEDY/ HERBAL MED-ICINE . . . . J OTHER ________ X (SPECIFY)	PILL OR SYRUP ANTIBIOTIC . . . . . A ANTIMOTILITY B ZINC . . . . C OTHER (NOT ANTI-BIOTIC, ANTI-MOTILITY, OR ZINC) . . . . D UNKNOWN PILL OR SYRUP . . . E INJECTION ANTIBIOTIC . . . . . F NON-ANTIBIOTIC G UNKNOWN INJECTION . . . H (IV) INTRAVENOUS I HOME REMEDY/ HERBAL MED-ICINE . . . . J OTHER ________ X (SPECIFY)	PILL OR SYRUP ANTIBIOTIC . . . . . A ANTIMOTILITY B ZINC . . . . C OTHER (NOT ANTI-BIOTIC, ANTI-MOTILITY, OR ZINC) . . . . D UNKNOWN PILL OR SYRUP . . . E INJECTION ANTIBIOTIC . . . . . F NON-ANTIBIOTIC G UNKNOWN INJECTION . . . H (IV) INTRAVENOUS I HOME REMEDY/ HERBAL MED-ICINE . . . . J OTHER ________ X (SPECIFY)
525	Has (NAME) been ill with a fever at any time in the last 2 weeks? *Waswe,(NEM) hemi bin sik lo cold eni taem insaet las 2 wik o nomoa?*	YES . . . . 1 NO . . . . 2 (SKIP TO 527) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 527) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 527) DON'T KNOW 8

526	At any time during the illness, did (NAME) have blood taken from his/her finger or heel for testing? *Long enitaem taem hemi sik ia,waswe,(NEM) olketa nurse takem blad from finger or heel blo hem tu o nomoa?*	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8
527	Has (NAME) had an illness with a cough at any time in the last 2 weeks? *Waswe (NEM) bin sik wetem wanfala kof insaet las 2 wik o nomoa?*	YES . . . . 1 NO . . . . 2 (SKIP TO 530) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 530) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 530) DON'T KNOW 8
528	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty breathing? *Taem (NEM) hemi sik wetem kof ia,waswe,briting blo hem fast winim normal taem,o faendem had lelebet for brit?*	YES . . . . 1 NO . . . . 2 (SKIP TO 531) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 531) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO 531) DON'T KNOW 8
529	Was the fast or difficult breathing due to a problem in the chest or to a blocked or runny nose? *Diskaen fast briting ia hemi kam bikos problem lo chest o nose hem block o hem ran?*	CHEST ONLY . . . 1 NOSE ONLY . . . . . 2 BOTH . . . . 3 OTHER ______ 6 (SPECIFY) DON'T KNOW . . . . . 8 (SKIP TO 531)	CHEST ONLY . . . 1 NOSE ONLY . . . . . 2 BOTH . . . . 3 OTHER ______ 6 (SPECIFY) DON'T KNOW . . . . . 8 (SKIP TO 531)	CHEST ONLY . . . 1 NOSE ONLY . . . . . 2 BOTH . . . . 3 OTHER ______ 6 (SPECIFY) DON'T KNOW . . . . . 8 (SKIP TO 531)
530	CHECK 525: HAD FEVER?	YES ☐ NO OR DK ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	YES ☐ NO OR DK ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	YES ☐ NO OR DK ☐ (GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 570)
531	Now I would like to know how much (NAME) was given to drink (including breastmilk) during the illness with a (fever/cough). Was he/she given less than usual to drink, about the same amount, or more than usual to drink? *Distaem mi laek save hao mas dring nao iu givim lo (NEM) fo dringim (including breastmilk) lo taem hem sik wetem fiva o kof.* *Iu givim smol wata winim evri taem,aboat sem amaont olsem evritaem.o staka wata winim evritaem?* IF LESS, PROBE: Was he/she given much less than usual to drink or somewhat less? *Iu givim smol wata tumas winim nomol nao o barava smol go moa nao?*	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 NOTHING TO DRINK 5 DON'T KNOW 8	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 NOTHING TO DRINK 5 DON'T KNOW 8	MUCH LESS . . . . . 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE . . . . 4 NOTHING TO DRINK 5 DON'T KNOW 8

532	When (NAME) had a (fever/cough), was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? *Taem (NEM) hemi sik waswe iu givim lelebet kaikai nomoa,sem olsem olowe nomoa,staka winim evri taem o iu nating givim eni kaikai fo hem nomoa?* IF LESS, PROBE: Was he/she given much less than usual to eat or somewhat less? *Waswe iu givim smol kaikai tumas no kasem normal size nao,o barava smol go moa nao?*	MUCH LESS ..... 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE .... 4 STOPPED FOOD 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS ..... 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE .... 4 STOPPED FOOD 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS ..... 1 SOMEWHAT LESS 2 ABOUT THE SAME 3 MORE .... 4 STOPPED FOOD 5 NEVER GAVE FOOD 6 DON'T KNOW 8
533	Did you seek advice or treatment for the illness from any source? *Iu lukaotem advice o meresin fo (SIK ia) lo eniwea o?*	YES .... 1 NO .... 2 (SKIP TO 537)	YES .... 1 NO .... 2 (SKIP TO 537)	YES .... 1 NO .... 2 (SKIP TO 537)
534	Where did you seek advice or treatment? *Wea nao iu go lukaotem advais o meresin fo tritmen?* Anywhere else? *Eniwea moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. ____________ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ...... A PROVINCIAL HOSPITAL ... B URBAN AREA HEALTH CENTRE .... C AREA HEALTH CENTR .... D RURAL HEALTH CENTRE .... E NURSE AID POST ... F SATELLITE CLINICS G OTHER PUBLIC SECTOR ________ H (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC I PHARMACY CLINIC .... J PRIVATE DOCTOR ... K OTHER PRIVATE MED. FACILITY ________ L (SPECIFY) CHURCH HOSPITAL M RURAL HEALTH CLINIC .... N NURSE AIDE POST .... O SATELLITE CLINIC P NGO/OTHER SOURCE SIPPA CLINIC Q SHOP .... R FRIEND/RELATIVE S TRADITIONAL PRACTITIONER T OTHER ________ X (SPECIFY)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ...... A PROVINCIAL HOSPITAL ... B URBAN AREA HEALTH CENTRE .... C AREA HEALTH CENTR .... D RURAL HEALTH CENTRE .... E NURSE AID POST ... F SATELLITE CLINICS G OTHER PUBLIC SECTOR ________ H (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC I PHARMACY CLINIC .... J PRIVATE DOCTOR ... K OTHER PRIVATE MED. FACILITY ________ L (SPECIFY) CHURCH HOSPITAL M RURAL HEALTH CLINIC .... N NURSE AIDE POST .... O SATELLITE CLINIC P NGO/OTHER SOURCE SIPPA CLINIC Q SHOP .... R FRIEND/RELATIVE S TRADITIONAL PRACTITIONER T OTHER ________ X (SPECIFY)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL ...... A PROVINCIAL HOSPITAL ... B URBAN AREA HEALTH CENTRE .... C AREA HEALTH CENTR .... D RURAL HEALTH CENTRE .... E NURSE AID POST ... F SATELLITE CLINICS G OTHER PUBLIC SECTOR ________ H (SPECIFY) PRIVATE SECTOR PRIVATE CLINIC I PHARMACY CLINIC .... J PRIVATE DOCTOR ... K OTHER PRIVATE MED. FACILITY ________ L (SPECIFY) CHURCH HOSPITAL M RURAL HEALTH CLINIC .... N NURSE AIDE POST .... O SATELLITE CLINIC P NGO/OTHER SOURCE SIPPA CLINIC Q SHOP .... R FRIEND/RELATIVE S TRADITIONAL PRACTITIONER T OTHER ________ X (SPECIFY)

535	CHECK 534:	TWO OR MORE CODES CIRCLED ☐ ONLY ONE CODE CIRCLED ☐ (SKIP TO 537)	TWO OR MORE CODES CIRCLED ☐ ONLY ONE CODE CIRCLED ☐ (SKIP TO 537)	TWO OR MORE CODES CIRCLED ☐ ONLY ONE CODE CIRCLED ☐ (SKIP TO 537)
536	Where did you first seek advice or treatment? *Wea nao iu fas go lukaotem advais o meresin fo tritmen?* USE LETTER CODE FROM 534.	FIRST PLACE . . . ☐	FIRST PLACE . . . ☐	FIRST PLACE . . . ☐
537	At any time during the illness, did (NAME) take any drugs for the illness? *Lo enitaem taem hemi sik ia,waswe,(NEM) hemi tekem eni meresin fo sik blo hem tu o nomoa?*	YES . . . . 1 NO . . . . 2 (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570) DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 570) DON'T KNOW 8
538	What drugs did (NAME) take? *Watkaen meresin nao (NEM) hemi tekem?* Any other drugs? *Eni nara meresin moa?* RECORD ALL MENTIONED.	ANTIMALARIAL DRUGS SP/FANSIDAR . . . A CHLOROQUINE B PRIMAQUINE C QUININE . . . . D ARTEMISININ E ARTAMETAR F ARTESUNATE G COARTEM H OTHER ANTI-MALARIAL ________ . . . I (SPECIFY) ANTIBIOTIC DRUGS PILL/SYRUP . . . J INJECTION . . . K OTHER DRUGS ASPIRIN . . . . L PANADOL .... M OTHER ________ X (SPECIFY) DON'T KNOW . . . . . Z	ANTIMALARIAL DRUGS SP/FANSIDAR . . . A CHLOROQUINE B PRIMAQUINE C QUININE . . . . D ARTEMISININ E ARTAMETAR F ARTESUNATE G COARTEM H OTHER ANTI-MALARIAL ________ . . . I (SPECIFY) ANTIBIOTIC DRUGS PILL/SYRUP . . . J INJECTION . . . K OTHER DRUGS ASPIRIN . . . . L PANADOL .... M OTHER ________ X (SPECIFY) DON'T KNOW . . . . . Z	ANTIMALARIAL DRUGS SP/FANSIDAR . . . A CHLOROQUINE B PRIMAQUINE C QUININE . . . . D ARTEMISININ E ARTAMETAR F ARTESUNATE G COARTEM H OTHER ANTI-MALARIAL ________ . . . I (SPECIFY) ANTIBIOTIC DRUGS PILL/SYRUP . . . J INJECTION . . . K OTHER DRUGS ASPIRIN . . . . L PANADOL .... M OTHER ________ X (SPECIFY) DON'T KNOW . . . . . Z

539	CHECK 538: ANY CODE A-I CIRCLED?	YES ☐ ↓ / NO ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	YES ☐ ↓ / NO ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	YES ☐ ↓ / NO ☐ (GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 570)
540	Did you already have (NAME OF DRUG FROM 538) at home when child became ill? *Iu garem finis (NAME OF DRUG FROM 538) lo haus taem pikinini hemi stat fo siki o waswe?* ASK SEPARATELY FOR EACH OF THE DRUGS 'A' THROUGH 'J' THAT THE CHILD IS RECORDED AS HAVING TAKEN IN 538. IF YES FOR ANY DRUG,CIRCLE CODE FOR THAT DRUG IF NO FOR ALL DRUGS CIRCLE 'Y'	ANTIMALARIAL DRUGS SP/FANSIDAR . . . A CHLOROQUINE B PRIMAQUINE C QUININE . . . . D ARTEMISININ E ARTAMETAR F ARTESUNATE G COARTEM. . . . H OTHER ANTI-MALARIAL . . . I ANTIBIOTIC PILL/ SYRUP . . . . . . J NO DRUG AT HOME. Y	ANTIMALARIAL DRUGS SP/FANSIDAR . . . A CHLOROQUINE B PRIMAQUINE C QUININE . . . . D ARTEMISININ E ARTAMETAR F ARTESUNATE G COARTEM.. . . . H OTHER ANTI-MALARIAL . . . I ANTIBIOTIC PILL/ SYRUP . . . . . . J NO DRUG AT HOME. Y	ANTIMALARIAL DRUGS SP/FANSIDAR . . . A CHLOROQUINE B PRIMAQUINE C QUININE . . . . D ARTEMISININ E ARTAMETAR F ARTESUNATE G COARTEM.. . . . H OTHER ANTI-MALARIAL . . . I ANTIBIOTIC PILL/ SYRUP . . . . . . J NO DRUG AT HOME. Y
541	CHECK 538: ANY CODE A-I CIRCLED?	YES ☐ ↓ / NO ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	YES ☐ ↓ / NO ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	YES ☐ ↓ / NO ☐ (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)
542	CHECK 538: SP/FANSIDAR ('A') GIVEN	CODE 'A' CIRCLED ☐ ↓ / CODE 'A' NOT CIRCLED ☐ (SKIP TO 545)	CODE 'A' CIRCLED ☐ ↓ / CODE 'A' NOT CIRCLED ☐ (SKIP TO 545)	CODE 'A' CIRCLED ☐ ↓ / CODE 'A' NOT CIRCLED ☐ (SKIP TO 545)
543	How long after the fever started did (NAME) first take (SP/Fansidar)? *Hao long afta sik bin stat nao bifoa(NEM) fes takem SP?Fansida?*	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8
544	For how many days did (NAME) take the SP/Fansidar? *Hao meni deis nao (NEM) hem dringim SP/Fansida?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . ☐ DON'T KNOW . . . 8	DAYS . . . . ☐ DON'T KNOW . . . 8	DAYS . . . . ☐ DON'T KNOW . . . 8

545	CHECK 538: CHLOROQUINE ('B') GIVEN	CODE 'B' CIRCLED ☐ CODE 'B' NOT CIRCLED ☐ (SKIP TO 548)	CODE 'B' CIRCLED ☐ CODE 'B' NOT CIRCLED ☐ (SKIP TO 548)	CODE 'B' CIRCLED ☐ CODE 'B' NOT CIRCLED ☐ (SKIP TO 548)
546	How long after the fever started did (NAME) first take chloroquine? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem Chloroquine?*	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8
547	For how many days did (NAME) take the Chloroquine? *Hao meni deis nao (NEM) hem dringim Klorokuin?* IF 7 DAYS OR MORE,RECORD 7.	DAYS .... ☐ DON'T KNOW ... 8	DAYS .... ☐ DON'T KNOW ... 8	DAYS .... ☐ DON'T KNOW ... 8
548	CHECK 538: PRIMAQUINE ('C') GIVEN	CODE 'C' CIRCLED ☐ CODE 'C' NOT CIRCLED ☐ (SKIP TO 551)	CODE 'C' CIRCLED ☐ CODE 'C' NOT CIRCLED ☐ (SKIP TO 551)	CODE 'C' CIRCLED ☐ CODE 'C' NOT CIRCLED ☐ (SKIP TO 551)
549	How long after the fever started did (NAME) first take primaquine? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem primakuin?*	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8
550	For how many days did (NAME) take the Primaquine? *Hao meni deis nao (NEM) hem dringim Primaquine?* IF 7 DAYS OR MORE,RECORD 7.	DAYS .... ☐ DON'T KNOW ... 8	DAYS .... ☐ DON'T KNOW ... 8	DAYS .... ☐ DON'T KNOW ... 8
551	CHECK 538: QUININE ('D') GIVEN	CODE 'D' CIRCLED ☐ CODE 'D' NOT CIRCLED ☐ (SKIP TO 554)	CODE 'D' CIRCLED ☐ CODE 'D' NOT CIRCLED ☐ (SKIP TO 554)	CODE 'D' CIRCLED ☐ CODE 'D' NOT CIRCLED ☐ (SKIP TO 554)
552	How long after the fever started did (NAME) first take quinine? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem Kuinin?*	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8	SAME DAY .... 0 NEXT DAY .... 1 TWO DAYS AFTER FEVER .... 2 THREE OR MORE DAYS AFTER FEVER .... 3 DON'T KNOW ... 8

553	For how many days did (NAME) take the Quinine? *Hao meni deis nao (NEM) hem dringim Quinine?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8
554	CHECK 538: ARTEMISININ ('E') GIVEN	CODE 'E' CIRCLED [ ] CODE 'E' NOT CIRCLED [ ] (SKIP TO 557)	CODE 'E' CIRCLED [ ] CODE 'E' NOT CIRCLED [ ] (SKIP TO 557)	CODE 'E' CIRCLED [ ] CODE 'E' NOT CIRCLED [ ] (SKIP TO 557)
555	How long after the fever started did (NAME) first take (ARTEMISININ)? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem (ARTEMISININ)?*	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8
556	For how many days did (NAME) take the ARTIMISININ? *Hao meni deis nao (NEM) hem dringim ARTIMISININ?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8
557	CHECK 538: ARTAMETAR ('F') GIVEN	CODE 'F' CIRCLED [ ] CODE 'F' NOT CIRCLED [ ] (SKIP TO 560)	CODE 'F' CIRCLED [ ] CODE 'F' NOT CIRCLED [ ] (SKIP TO 560)	CODE 'F' CIRCLED [ ] CODE 'F' NOT CIRCLED [ ] (SKIP TO 560)
558	How long after the fever started did (NAME) first take (ARTAMETAR)? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem ARTAMETAR?*	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8
559	For how many days did (NAME) take the ARTAMETAR? *Hao meni deis nao (NEM) hem dringim ARTAMETAR?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8
560	CHECK 538: ARTESUNATE ('G')	CODE 'G' CIRCLED [ ] CODE 'G' NOT CIRCLED [ ] (SKIP TO 563)	CODE 'G' CIRCLED [ ] CODE 'G' NOT CIRCLED [ ] (SKIP TO 563)	CODE 'G' CIRCLED [ ] CODE 'G' NOT CIRCLED [ ] (SKIP TO 563)
561	How long after the fever started did (NAME) first take (ARTESUNATE)? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem (ARTESUNATE)?*	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8

562	For how many days did (NAME) take the ARTESUNATE? *Hao meni deis nao (NEM) hem dringim ARTESUNATE?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8
563	CHECK 538: COARTEM 'H'	CODE 'H' CIRCLED [ ] CODE 'H' NOT CIRCLED [ ] (SKIP TO 566)	CODE 'H' CIRCLED [ ] CODE 'H' NOT CIRCLED [ ] (SKIP TO 566)	CODE 'H' CIRCLED [ ] CODE 'H' NOT CIRCLED [ ] (SKIP TO 566)
564	How long after the fever started did (NAME) first take (CBD ANTIMALARIAL DRUG)? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem (CBD ANTIMALARIAL DRUG)?*	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8
565	For how many days did (NAME) take the CBD ANTIMALARIAL DRUG? *Hao meni deis nao (NEM) hem dringim CBD ANTIMALARIAL DRUG?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8
566	CHECK 538: OTHER ANTIMALARIAL ('I') GIVEN	CODE 'I' CIRCLED [ ] CODE 'I' NOT CIRCLED [ ] (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	CODE 'I' CIRCLED [ ] CODE 'I' NOT CIRCLED [ ] (GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570)	CODE 'I' CIRCLED [ ] CODE 'I' NOT CIRCLED [ ] (GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 570)
567	How long after the fever started did (NAME) first take (OTHER ANTIMALARIAL)? *Hao long afta sik bin stat nao bifoa(NEM) fes tekem (OTHER ANTIMALARIAL)?*	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8	SAME DAY . . . . 0 NEXT DAY . . . . 1 TWO DAYS AFTER FEVER . . . . 2 THREE OR MORE DAYS AFTER FEVER . . . . 3 DON'T KNOW . . . 8
568	For how many days did (NAME) take the OTHER ANTIMALARIAL? *Hao meni deis nao (NEM) hem dringim OTHER ANTIMALARIAL?* IF 7 DAYS OR MORE,RECORD 7.	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8	DAYS . . . . [ ] DON'T KNOW . . . 8
569		GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570.	GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 570.	GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 570.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
570	CHECK 215 AND 218, ALL ROWS: NUMBER OF CHILDREN BORN IN 2010 OR LATER LIVING WITH THE RESPONDENT ONE OR MORE ☐ NONE ☐ → 573 RECORD NAME OF YOUNGEST CHILD LIVING WITH HER AND CONTINUE WITH 571 _____ (NAME)		
571	The last time (NAME FROM 570) passed stools, what was done to dispose of the stools? *Las taem pikinini (NEM from 570) hemi siti,wanem na iu duim fo torowem siti blo hem?*	CHILD USED TOILET OR LATRINE . . . 01 PUT/RINSED INTO TOILET OR LATRINE . . . . . 02 PUT/RINSED INTO DRAIN OR DITCH . . . . . 03 THROWN INTO GARBAGE . . . . . 04 BURIED . . . . . 05 LEFT IN THE OPEN . . . . . 06 OTHER _____ 96 (SPECIFY)	
572	CHECK 522(a) AND 522(b), ALL COLUMNS: NO CHILD RECEIVED FLUID FROM ORS PACKET OR PRE-PACKAGED ORS LIQUID ☐ ANY CHILD RECEIVED FLUID FROM ORS PACKET OR PRE-PACKAGED ORS LIQUID **(14)** ☐ → 574		
573	Have you ever heard of a special product called [LOCAL NAME FOR ORS PACKET OR PRE-PACKAGED ORS LIQUID] you can get for the treatment of diarrhea? *Iu bin herem tu spesol prodak wea olketa kolem wanfala paket blo ORS meresin iu save iusim fo tritim daearia lo hem?*	YES . . . . . 1 NO 2	
574	CHECK 215 AND 218, ALL ROWS: NUMBER OF CHILDREN BORN IN 2012 OR LATER LIVING WITH THE RESPONDENT ONE OR MORE ☐ NONE ☐ → 601 RECORD NAME OF YOUNGEST CHILD LIVING WITH HER AND CONTINUE WITH 575 _____ (NAME)		

575	Now I would like to ask you about liquids or foods that (NAME FROM 574) had yesterday during the day or at night. I am interested in whether your child had the item I mention even if it was combined with other foods. *Distaem mi laek askem iu abaotem olketa (other)liquids o dring wea (NEM from 574) iu maet kaikaim o dringim lo dei taem o naet.Mi laek save sapos iu o pikinini bo iu nao kaikaim o dringim nomata hemi olketa nara kaikai.*					
	Did (NAME FROM 574) (drink/eat):		YES	NO	DK	
	a) Plain water?	**a)**	1	2	8	
	b) Juice or juice drinks?	**b)**	1	2	8	
	c) Clear broth?	**c)**	1	2	8	
	d) Milk such as tinned, powdered, or fresh animal milk?	**d)**	1	2	8	
	IF YES: How many times did (NAME) drink milk? IF 7 OR MORE TIMES, RECORD '7'.	NUMBER OF TIMES DRANK MILK				
	e) Infant formula?	**e)**	1	2	8	
	IF YES: How many times did (NAME) drink infant formula? IF 7 OR MORE TIMES, RECORD '7'.	NUMBER OF TIMES DRANK FORMULA				
	f) Any other liquids?	**f)**	1	2	8	
	g) Yogurt?	**g)**	1	2	8	
	IF YES: How many times did (NAME) eat yogurt? IF 7 OR MORE TIMES, RECORD '7'.	NUMBER OF TIMES ATE YOGURT				
	h) Any [BRAND NAME OF COMMERCIALLY FORTIFIED BABY FOOD, E.G., Cerelac]?	**h)**	1	2	8	
	i) Bread, rice, noodles, porridge, or other foods made from grains?	**i)**	1	2	8	
	j) Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?	**j)**	1	2	8	
	k) White potatoes, white yams, manioc, cassava, or any other foods made from	**k)**	1	2	8	
	l) Any dark green, leafy vegetables?	**l)**	1	2	8	
	m) Ripe mangoes, papayas, melons or [ANY OTHER LOCALLY AVAILABLE VITAMIN A-RICH FRUITS]?	**m)**	1	2	8	
	n) Any other fruits or vegetables?	**n)**	1	2	8	
	o) Liver, kidney, heart or other organ meats?	**o)**	1	2	8	
	p) Any meat, such as beef, pork, lamb, goat, chicken, or duck?	**p)**	1	2	8	
	q) Eggs?	**q)**	1	2	8	
	r) Fresh or dried fish or shellfish?	**r)**	1	2	8	
	s) Any foods made from beans, peas, lentils, or nuts?	**s)**	1	2	8	
	t) Cheese or other food made from milk?	**t)**	1	2	8	
	u) Any other solid, semi-solid, or soft food?	**u)**	1	2	8	

576	CHECK 575 (CATEGORIES "g" THROUGH "u"): NOT A SINGLE "YES" ☐ ↓ AT LEAST ONE "YES" ☐ →		578
577	Did (NAME) eat any solid, semi-solid, or soft foods yesterday during the day or at night? *Waswe (NEM) hemi kaikaim eni strong kaikai lelbet soft o barava soft kaikai iestadaei, lo dei taem o lo nite?* IF 'YES' PROBE: What kind of solid, semi-solid or soft foods did (NAME) eat? *Wat kaen strong kaikai,lelebet soft o barava soft kaikai na (NEM) hemi kaikaim?*	YES . . . . . 1 (GO BACK TO 575 TO RECORD FOOD EATEN YESTERDAY) ← NO . . . . . 2 →	601
578	How many times did (NAME FROM 574) eat solid, semi-solid, or soft foods yesterday during the day or at night? *Hao meni taem nao (NEM from 574) hemi kaikaim olketa strong kaikai,lelebet soft o barava soft kaikai iestadai,lo dei taem o lo nite?* IF 7 OR MORE TIMES, RECORD '7'.	NUMBER OF TIMES . . . . . ☐ DON'T KNOW 8	

SECTION 6. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Are you currently married or living together with a man as if married? *Waswe, iu maret distaem or iu stap tugeda wetem eni man olsem iu tufala maret?*	YES, CURRENTLY MARRIED . . . . . 1 YES, LIVING WITH A MAN . . . . . 2 NO, NOT IN UNION 3	→ 604
602	Have you ever been married or lived together with a man as if married? *Waswe, iu bin maret bifoa or stap tugeda wetem eni man olsem iu tufala maret?*	YES, FORMERLY MARRIED . . . . . 1 YES, LIVED WITH A MAN . . . . . 2 NO 3	→ 612
603	What is your marital status now: are you widowed, divorced, or separated? *Waswe, iu maret iet distaem: or iu wido, divos, or sepret?*	WIDOWED . . . . . 1 DIVORCED . . . . . 2 SEPARATED 3	→ 609
604	Is your (husband/partner) living with you now or is he staying elsewhere? *Waswe, (husband/patna) blo iu hem stap wetem iu distaem or hem stap long nara ples?*	LIVING WITH HER . . . . . 1 STAYING ELSEWHERE 2	
605	RECORD THE HUSBAND'S/PARTNER'S NAME AND LINE NUMBER FROM THE HOUSEHOLD QUESTIONNAIRE. IF HE IS NOT LISTED IN THE HOUSEHOLD, RECORD '00'.	NAME _____ LINE NO.	
606	Does your (husband/partner) have other wives or does he live with other women as if married? *Hasban o patna blo iu hemi stap wetem olketa nara mere moa olsem olketa maret o nomoa?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 609
607	Including yourself, in total, how many wives or live-in partners does he have? *Wetem iu ,waswe,hao meni nara mere moa na hasban blo iu stap wetem,olketa olsem olekta maret?*	TOTAL NUMBER OF WIVES AND LIVE-IN PARTNERS . . . . . DON'T KNOW 98	
608	Are you the first, second, ... wife? *Iu 01 ,o 02 wife?*	RANK	
609	Have you been married or lived with a man only once or more than once? *Waswe, iu bin maret or stap wetem eni man wan taem nomoa or moa den wan taem?*	ONLY ONCE . . . . . 1 MORE THAN ONCE 2	

610	CHECK 609: MARRIED/ LIVED WITH A MAN ONLY ONCE In what month and year did you start living with your (husband/partner)? *Long wat manis an yia na iu stat stap wetem (husband/partner)* MARRIED/ LIVED WITH A MAN MORE THAN ONCE Now I would like to ask about your first (husband/partner). In what month and year did you start living with him? *Distaem mi laek askem iu abaot fes(husband/patna).Long wat manis an yia nai iu stat for stap wetem hem.*	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] → 612 DON'T KNOW YEAR 9998	
611	How old were you when you first started living with him? *Hao ol nao iu,fes taem iu stat stap wetem hem?*	AGE . . . . . [ ][ ]	
612	CHECK FOR THE PRESENCE OF OTHERS. BEFORE CONTINUING, MAKE EVERY EFFORT TO ENSURE PRIVACY.		
613	Now I would like to ask some questions about sexual activity in order to gain a better understanding of some important life issues. *Distaem mi laek askem iu samfala kuesten abaot samfala aktiviti blong iu long saed long seks,fo iu save moa abaotim olketa problem hem kasem iumi?* FOR NEVER MARRIED, FIRST ASK: Have you ever had sexual intercourse? *Waswe iu bin havem sex wetem eniwan tu?* IF YES: How old were you when you had sexual intercourse for the very first time? *Taem iu hao meni yias old na iu fes havem sex?*	NEVER HAD SEXUAL INTERCOURSE . . . . . 00 → 628 AGE IN YEARS . . . . . [ ][ ] FIRST TIME WHEN STARTED LIVING WITH (FIRST) HUSBAND/PARTNER 95	
614	Now I would like to ask you some questions about your recent sexual activity. Let me assure you again that your answers are completely confidential and will not be told to anyone. If we should come to any question that you don't want to answer, just let me know and we will go to the next question. *Distaem mi laek askem iu samfala kuesten abaot samfala aktiviti blong iu long saed long seks. Mi laek talem iu moa dat evri ansa iu givim kam hem tambu fo talem aot long eniwan. Sapos iumi kasem eni kuesten an iu les fo ansarem, iu talem mi mekem iumi muv go moa long neks kuesten.*		
615	When was the <u>last</u> time you had sexual intercourse? *Wat taem nao iu las havem seks?* IF LESS THAN 12 MONTHS, ANSWER MUST BE RECORDED IN DAYS, WEEKS OR MONTHS. IF 12 MONTHS (ONE YEAR) OR MORE, ANSWER MUST BE RECORDED IN YEARS.	DAYS AGO . . . . . 1 [ ][ ] WEEKS AGO . . . . . 2 [ ][ ] MONTHS AGO . . . . . 3 [ ][ ] YEARS AGO . . . . . 4 [ ][ ] → 627	

		LAST SEXUAL PARTNER	SECOND-TO-LAST SEXUAL PARTNER	THIRD-TO-LAST SEXUAL PARTNER
616	When was the last time you had sexual intercourse with this person? *Wat taem nao iu las havem seks wetem disfala peson?*		DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3
617	The last time you had sexual intercourse (with this second/third person), was a condom used? *Las taem iu havem seks (wetem disfala sekon/mek tri peson), iu tufala iusim condom tu?*	YES . . . . 1 NO . . . . 2 (SKIP TO 619)	YES . . . . 1 NO . . . . 2 (SKIP TO 619)	YES . . . . 1 NO . . . . 2 (SKIP TO 619)
618	Was a condom used every time you had sexual intercourse with this person in the last 12 months? *Iufala iusim condom tu evri taem iu havem seks wetem disfala peson insaed las tuelv manis?*	YES . . . . 1 NO 2	YES . . . . 1 NO 2	YES . . . . 1 NO 2
619	What was your relationship to this person with whom you had sexual intercourse? *Wat nao konekson blong iu wetem peson ia wea iu havem seks wetem?* IF BOYFRIEND: Were you living together as if married? *Iufala stap tugeda olsem iufala maret?* IF YES, CIRCLE '2'. IF NO, CIRCLE '3'.	HUSBAND . . . . 1 LIVE-IN PARTNER . . . 2 BOYFRIEND NOT LIVING WITH RESPONDENT . . . 3 CASUAL ACQUAINTANC . . . 4 CLIENT/PROSTITUTE 5 OTHER ___________ 6 (SPECIFY) (SKIP TO 622)	HUSBAND . . . . 1 LIVE-IN PARTNER . . . 2 BOYFRIEND NOT LIVING WITH RESPONDENT . . . 3 CASUAL ACQUAINTANC . . . 4 CLIENT/PROSTITUTE 5 OTHER ___________ 6 (SPECIFY) (SKIP TO 622)	HUSBAND . . . . 1 LIVE-IN PARTNER . . . 2 BOYFRIEND NOT LIVING WITH RESPONDENT . . . 3 CASUAL ACQUAINTANC . . . 4 CLIENT/PROSTITUTE 5 OTHER ___________ 6 (SPECIFY) (SKIP TO 622)
620	CHECK 609:	MARRIED ONLY ONCE MARRIED MORE THAN ONCE (SKIP TO 622)	MARRIED ONLY ONCE MARRIED MORE THAN ONCE (SKIP TO 622)	MARRIED ONLY ONCE MARRIED MORE THAN ONCE (SKIP TO 622)
621	CHECK 613:	FIRST TIME WHEN STARTED LIVING WITH FIRST HUSBAND (SKIP TO 623) OTHER	FIRST TIME WHEN STARTED LIVING WITH FIRST HUSBAND (SKIP TO 623) OTHER	FIRST TIME WHEN STARTED LIVING WITH FIRST HUSBAND (SKIP TO 623) OTHER
622	How long ago did you first have sexual intercourse with this (second/third) person? *Sins wat taem nao iu fes havem seks wetem disfala (sekon/mek tri) peson?*	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3 YEARS AGO 4	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3 YEARS AGO 4	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3 YEARS AGO 4

623	How many times during the last 12 months did you have sexual intercourse with this person? *Hao meni taem insaed las tuelv manis nao iu havem seks wetem disfala peson?* IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF TIMES IS 95 OR MORE, WRITE '95'.	NUMBER OF TIMES ☐☐	NUMBER OF TIMES ☐☐	NUMBER OF TIMES ☐☐
624	How old is this person? *Hao ol nao disfala peson?*	AGE OF PARTNER ☐☐ DON'T KNOW 98	AGE OF PARTNER ☐☐ DON'T KNOW 98	AGE OF PARTNER ☐☐ DON'T KNOW 98
625	Apart from (this person/these two people), have you had sexual intercourse with any other person in the last 12 months? *Waswe,bisaed (disfala peson/wetem tufala pipol ia),waswe iu bin havem seks wetem eni wan moa insaed las tuelv manis?*	YES . . . . . 1 (GO BACK TO 616 IN NEXT COLUMN) NO . . . . . 2 (SKIP TO 627)	YES . . . . . 1 (GO BACK TO 616 IN NEXT COLUMN) NO . . . . . 2 (SKIP TO 627)	
626	In total, with how many different people have you had sexual intercourse in the last 12 months? *Ol tugedal, wetem hao meni difren pipol nao iu havem seks wetem insaed las tuelv manis?* IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS 95 OR MORE, WRITE '95'.			NUMBER OF PARTNERS LAST 12 MONTHS . . . ☐☐ DON'T KNOW . . . 98

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
627	In total, with how many different people have you had sexual intercourse in your lifetime? *OI tugeda,hao meni difren pipol nao iu havem seks wetem long ful laeftaem blong iu?* IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS 95 OR MORE, WRITE '95'.	NUMBER OF PARTNERS IN LIFETIME . . . . . [ ][ ] DON'T KNOW 98	
628	PRESENCE OF OTHERS DURING THIS SECTION	YES NO CHILDREN <10 . . . . . 1 2 MALE ADULTS . . . . . 1 2 FEMALE ADULTS 1 2	
629	Do you know of a place where a person can get condoms? *Waswe, iu save long eni ples wea iu save tekem Condom?*	YES . . . . . 1 NO 2	→ 632
630	Where is that? *Wea nao ia?* Any other place? *Eni ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C AREA HEALTH CENTRE . . . . . D RURAL HEALTH CENTRE . . . . . E FAMILY PLANNING CLINICS . . . . . F NURSE AID POST . . . . . G SATELLITE CLINICS . . . . . H OTHER PUBLIC SECTOR _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC . . . . . J PHARMACY . . . . . K PRIVATE DOCTOR . . . . . L OTHER PRIVATE MEDICAL SECTOR _____ M (SPECIFY) CHURCH HOSPITAL . . . . . N RURAL HEALTH CLINIC . . . . . O NURSE AIDE POST . . . . . P SATELLITE CLINIC . . . . . Q OTHER OUTLET . . . . . R NGO/OTHER SOURCE SIPPA CLINIC . . . . . S SIPPA CBD . . . . . T SAVE THE CHILDREN FUNDS . . . . . U SHOP . . . . . V FRIENDS/RELATIVES . . . . . W OTHER _____ X (SPECIFY)	

631	If you wanted to, could you yourself get a condom? *Sapos iu wandem, iu save go tekem condom seleva?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW/UNSURE 8	
632	Do you know of a place where a person can get female condoms? *Iu sav eni ples wea eniwan save tekem condom blong olketa woman?*	YES . . . . . 1 NO 2	→ 701
633	Where is that? *Wea nao ia?* Any other place? *Eni ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C AREA HEALTH CENTRE . . . . . D RURAL HEALTH . . . . . E NURSE AID POST . . . . . F SATELLITE CLINICS . . . . . G OTHER PUBLIC SECTOR _____ H (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC . . . . . I PHARMACY . . . . . J PRIVATE DOCTOR . . . . . K OTHER PRIVATE MEDICAL SECTOR _____ L (SPECIFY) CHURCH HOSPITAL ..... M RURAL HEALTH CLINIC ..... N NURSE AIDE POST ..... O SATELLITE CLINIC ..... P OTHER OUTLET ..... Q NGO/OTHER SOURCE SIPPA CLINIC ..... R SIPPA CBD ..... S SAVE THE CHILDREN FUNDS ..... T SHOP . . . . . U FRIENDS/RELATIVES . . . . . V OTHER _____ X (SPECIFY)	
634	If you wanted to, could you yourself get a female condom? *Sapos iu wandem, iu save go tekem condom blong olketa woman seleva?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW/UNSURE 8	

SECTION 7. FERTILITY PREFERENCES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 304: NEITHER STERILIZED ☐ ↓ HE OR SHE STERILIZED ☐ → 712		
702	CHECK 226: PREGNANT ☐ ↓ NOT PREGNANT OR UNSURE ☐ → 704		
703	Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children? *Distaem mi garem samfala kuesten abaot fiutsa. Bihaen (pikinini/olketa pikinini) iu wetem (waef(olketa waef)/patnas(s)wea babule distaem, iutufala laekem nara pikinini moa, or les fo garem eni moa pikinini?*	HAVE ANOTHER CHILD . . . . . 1 NO MORE . . . . . 2 UNDECIDED/DON'T KNOW 8	→ 705 → 711
704	Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children? *Distaem mi garem samfala kuesten abaot fiutsa. Waswe, iu laekem fo garem (wan/nara) pikinini moa, or iu tingting fo no garem eni (moa) pikinini?*	HAVE (A/ANOTHER) CHILD . . . . . 1 NO MORE/NONE . . . . . 2 SAYS SHE CAN'T GET PREGNANT 3 UNDECIDED/DON'T KNOW 8	 → 707 → 712 → 710
705	CHECK 226: NOT PREGNANT OR UNSURE ☐ ↓ How long would you like to wait from now before the birth of (a/another) child? *Hao long nao iu laek weit stat distaem bifoa iu bonem (wan/nara) pikinini ?* PREGNANT ☐ ↓ After the birth of the child you are expecting now, how long would you like to wait before the birth of another child? *Afta pikinini iu babule lo hem ia hem bon, hao long moa nao iu laek weit bifoa nara pikinini hem bon?*	MONTHS . . . . . 1 ☐☐ YEARS . . . . . 2 ☐☐ SOON/NOW . . . . . 993 SAYS SHE CAN'T GET PREGNANT 994 AFTER MARRIAGE . . . . . 995 OTHER _____ 996 (SPECIFY) DON'T KNOW 998	 → 710 → 712 → 710
706	CHECK 226: NOT PREGNANT OR UNSURE ☐ ↓ PREGNANT ☐ → 711		
707	CHECK 303: USING A CONTRACEPTIVE METHOD? NOT CURRENTLY USING ☐ ↓ CURRENTLY USING ☐ → 712		
708	CHECK 705: NOT ASKED ☐ ↓ 24 OR MORE MONTHS OR 02 OR MORE YEARS ☐ ↓ 00-23 MONTHS OR 00-01 YEAR ☐ → 711		

709	CHECK 704: WANTS TO HAVE A/ANOTHER CHILD → You have said that you do not want (a/another) child soon. *Iu se iu no laek garem eni(wan/nara) moa pikinini.* Can you tell me why you are not using a method to prevent pregnancy? *Iu save talem mi wae nao iu no usim eni we fo stopem iu fo no babule?* Any other reason? *Eni nara reason?* WANTS NO MORE/ NONE → You have said that you do not want any (more) children. *Iu se iu no laek garem eni moa pikinini kuitaem* Can you tell me why you are not using a method to prevent pregnancy? *Iu save talem mi wae nao iu no usim eni we fo stopem iu fo no babule?* Any other reason? *Eni nara reason?* RECORD ALL REASONS MENTIONED.	NOT MARRIED . . . . . A FERTILITY-RELATED REASONS NOT HAVING SEX . . . . . B INFREQUENT SEX . . . . . C MENOPAUSAL/HYSTERECTOMY D CAN'T GET PREGNANT . . . . . E NOT MENSTRUATED SINCE LAST BIRTH . . . . . F BREASTFEEDING . . . . . G UP TO GOD/FATALISTIC . . . . . H OPPOSITION TO USE RESPONDENT OPPOSED . . . . . I HUSBAND/PARTNER OPPOSED . . . J OTHERS OPPOSED . . . . . K RELIGIOUS PROHIBITION . . . . . L LACK OF KNOWLEDGE KNOWS NO METHOD . . . . . M KNOWS NO SOURCE . . . . . N METHOD-RELATED REASONS SIDE EFFECTS/HEALTH CONCERNS . . . . . O LACK OF ACCESS/TOO FAR . . . . . P COSTS TOO MUCH . . . . . Q PREFERRED METHOD NOT AVAILABLE . . . . . R NO METHOD AVAILABLE . . . . . S INCONVENIENT TO USE . . . . . T INTERFERES WITH BODY'S NORMAL PROCESSES . . . . . U OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
710	CHECK 303: USING A CONTRACEPTIVE METHOD? NOT ASKED → NO, NOT CURRENTLY USING → YES, CURRENTLY USING → 712		
711	Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future? *Iu ting bae iu iusim eni contraceptive we fo holem up o stopem iu fo no babule moa eni taem lo fiutsa?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

712	CHECK 216: HAS LIVING CHILDREN ☐ ↓ NO LIVING CHILDREN ☐ ↓ If you could go back to the time 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? *Sapos iu save go baek lo taem iu no garem eni pikinini an save siusim barava namba long pikinini fo garem lo hol laef blo iu,bae hao meni nao ia?* If you could choose exactly the number of children to have in your whole life, how many would that be? *Sapos iu save siusim barava namba lo pikinini iu laek garem long hol laef blo iu,bae hao meni nao ia?* PROBE FOR A NUMERIC RESPONSE.	NONE . . . . . 00 → 714 NUMBER . . . . . ☐☐ OTHER _____ 96 → 714 (SPECIFY)	
713	How many of these children would you like to be boys, how many would you like to be girls and for how many would it not matter if it's a boy or a girl? *Hao meni lo olketa pikinini nao iu bae laekem fo boe , hao meni nao iu bae laekem fo gele an hao meni nao iu bae laekim nomata hem boe o gele?*	BOYS GIRLS EITHER NUMBER ☐☐ ☐☐ ☐☐ OTHER _____ 96 (SPECIFY)	
714	In the last few months have you: *Insaet las two,three mans hao iu* Heard about family planning on the radio? *Herem redio tok abaotem family planning?* Seen anything about family planning on the television? *Lukim tv tok abaotem family planning?* Read about family planning in a newspaper or magazine? *Ridim niuspepa o magasin wea tok abaot family planning?*	YES NO RADIO . . . . . 1 2 TELEVISION . . . . . 1 2 NEWSPAPER OR MAGAZINE . . . 1 2 OTHER . . . . . 1 2 OTHER _____ 96 (SPECIFY)	
715	Have you ever heard about the message: "Not too early, not too late, not too many, not too soon"? *Waswe iu bin herem disfala mesej bifoa:* *"Not too early,not too late,not too many,not to soon"?*	YES . . . . . 1 NO 2	
716	CHECK 601: YES, CURRENTLY MARRIED ↓ YES, LIVING WITH A MAN ↓ NO, NOT IN UNION →		801
717	CHECK 303: USING A CONTRACEPTIVE METHOD? CURRENTLY USING ↓ NOT CURRENTLY USING OR NOT ASKED →		720

718	Would you say that using contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together? *Hu nao tingting blo hem fo iu usim contraception,iu seleva, hasban o patna blo iu,o iutufala evriwan nao agri?*	MAINLY RESPONDENT . . . . . 1 MAINLY HUSBAND/PARTNER . . . . . 2 JOINT DECISION . . . . . 3 OTHER _____ 6 (SPECIFY)	
719	CHECK 304: NEITHER STERILIZED ☐ HE OR SHE STERILIZED ☐ → 801		
720	Does your (husband/partner) want the same number of children that you want, or does he want more or fewer than you want? *Waswe hasban o patna blo iu hem laekem sem namba lo pikinini iu laekem o hemi laekem staka winim o smol namba winim wanem iu laekem?*	SAME NUMBER . . . . . 1 MORE CHILDREN . . . . . 2 FEWER CHILDREN . . . . . 3 DON'T KNOW 8	

SECTION 8. HUSBAND'S BACKGROUND AND WOMAN'S WORK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	CHECK 601 AND 602: CURRENTLY MARRIED/ LIVING WITH A MAN ☐ ↓ FORMERLY MARRIED/ LIVED WITH A MAN ☐ → 803 NEVER MARRIED AND NEVER LIVED WITH A MAN ☐ → 807		
802	How old was your (husband/partner) on his last birthday? *Hao olo nao hasban o patna blo iu lo las botde blo hem?*	AGE IN COMPLETED YEARS ☐☐	
803	Did your (last) (husband/partner) ever attend school? *Waswe,(last) hasban blo iu hemi skul tu o nomoa?*	YES . . . . . 1 NO 2	→ 806
804	What was the highest level of school he attended: primary, secondary, or higher? *Wat nao haes levol hem kasem: long praemari, sekondri or eni levol go up moa hem kasem?*	PRE SCHOOL . . . . . 0 PRIMARY . . . . . 1 SECONDARY . . . . . 2 TERTIARY . . . . . 3 VOCATIONAL . . . . . 4 DON'T KNOW . . . . . 8 OTHER 9 _____ (SPECIFY)	→ 806
805	What was the highest (grade/form/year) he completed at that level? *Wanem nao haes (grade/form/year) hemi completim lo dat fala levol?* IF COMPLETED LESS THAN ONE YEAR AT THAT LEVEL, RECORD '00'.	GRADE/FORM/YEAR . . . . . ☐☐ DON'T KNOW 98	
806	CHECK 801: CURRENTLY MARRIED/ LIVING WITH A MAN ☐ ↓ What is your (husband's/ partner's) occupation? That is, what kind of work does he mainly do? *Hasban/patna blo iu waka long wea? Diswan minim watkaen waka nao hem save duim?* FORMERLY MARRIED/ LIVED WITH A MAN ☐ ↓ What was your (last) (husband's/ partner's) occupation? That is, what kind of work did he mainly do? *Wanem nao waka bo las hasban/patna blo iu? Diswan minim watkaen waka nao hemi bin duim?*	_____ ☐☐ _____ _____	
807	Have you done any work in the last seven days? *Iu putim difren waka long own haus blong iu,waswe iu duim eni waka insaed lo las seven deis?*	YES . . . . . 1 NO 2	→ 811
808	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. In the last seven days, have you done any of these things or any other work? *Olsem iu save,samfala woman duim waka wea olketa save peim lo selen o samfala difren kaen pei.Samfala salem olketa samting,ranem smol bisnis,iu duim eniwan lo olketa waka olsem insaet las seven dei o eni nara kaen waka moa o nomoa?*	YES . . . . . 1 NO 2	→ 811

809	Although you did not work in the last seven days, do you have any job or business from which you were absent for leave, illness, vacation, maternity leave, or any other such reason? *Nomata iu no waka long las seven deis,bata waswe iu garem eni waka o bisnis wea iu no go atendim bikos iu tekem liv,o iu siki,holidei,bonem bebi o eni nara fala rison olsem ?*	YES . . . . . 1 NO 2	→ 811
810	Have you done any work in the last 12 months? *Waswe iu duim eni waka tu insaet las tuelv manis?*	YES . . . . . 1 NO 2	→ 815
811	What is your occupation, that is, what kind of work do you mainly do? *Wat nao waka blong iu,olsem,wat kaen waka nao iu save duim olowe?*	_____ ☐☐☐☐ _____ _____	
811a	What is the main industry that you work in? *Wat na barava mein industry iu waka long hem?*	_____ ☐☐☐☐ _____ _____	
812	Do you do this work for a member of your family, for someone else, or are you self-employed? *Waswe iu duim wkw ia fo memba long famili blong iu o nara man o iu duim waka ia seleva?*	FOR FAMILY MEMBER . . . . . 1 FOR SOMEONE ELSE . . . . . 2 SELF-EMPLOYED 3	
813	Do you usually work throughout the year, or do you work seasonally, or only once in a while? *Iu save waka truaot long yia,or waka folom sison nomoa,or fo wan team nomoa?*	THROUGHOUT THE YEAR . . . . . 1 SEASONALLY/PART OF THE YEAR 2 ONCE IN A WHILE 3	
814	Are you paid in cash or kind for this work or are you not paid at all? *Waswe olketa peim iu lo seleni o givim iu eni samting fo waka iu duim o iu no tekem eni pei?*	CASH ONLY . . . . . 1 CASH AND KIND . . . . . 2 IN KIND ONLY . . . . . 3 NOT PAID 4	→ 815
814a	What sector are you working in? *Wat nao sekta wea iu waka insaet?*	PUBLIC SECTOR ..... 1 PRIVATE SECTOR ..... 2 RELIGIOUS ORGANISATION ..... 3 OTHER 9 _____ (SPECIFY)	
814b	How many hours you worked a week? *Hao meni haos nao iu waka fo hem insaet long wan wik?*	☐☐	

814c	How long have you been working at this job? *Hao long nao iu bin waka kam long disfala waka?* (IF LESS THAN A YEAR RECORD MONTHS)	MONTHS ☐☐ YEARS ☐☐	
814d	How much did you earn from this work/job in the last 12 months ? *Hao mas seleni nao iu tekem from disfala waka insaet long las tuelv manls?*	GROSS CASH ☐☐☐☐☐☐ NET CASH (TAKE HOME PAY) ☐☐☐☐☐☐	
815	CHECK 601: CURRENTLY MARRIED/LIVING WITH A MAN ☐ NOT IN UNION ☐ → 823		
816	CHECK 814a: CODE 1 OR 2 CIRCLED ☐ OTHER ☐ → 819		
817	Who usually decides how the money you earn will be used: you, your (husband/partner), or you and your (husband/partner) jointly? *Hu nao fo disaed hao nao baebae iusim seleni iu waka fo hem: iu,(Hasban/patna blong iu),or iu tufala evriwan (Hasban/patna) tugeda?*	RESPONDENT . . . . . 1 HUSBAND/PARTNER . . . . . 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY . . . 3 OTHER _____ 6 (SPECIFY)	
818	Would you say that the money that you earn is more than what your (husband/partner) earns, less than what he earns, or about the same? *Bae iu se seleni iu save tekem hemi staka winim hasban/patna o smol winim selen hasban/patna save tekem o hemi kolsap semsem?*	MORE THAN HIM . . . . . 1 LESS THAN HIM . . . . . 2 ABOUT THE SAME . . . . . 3 HUSBAND/PARTNER HAS NO EARNINGS . . . . . 4 → 820 DON'T KNOW 8	
819	Who usually decides how your (husband's/partner's) earnings will be used: you, your (husband/partner), or you and your (husband/partner) jointly? *Hu nao fo disaed hao fo usim seleni wea hasban/patna blo iu tekem:Iu seleva,iu an hasban/patna o iutufala evriwan tugeda.*	RESPONDENT . . . . . 1 HUSBAND/PARTNER . . . . . 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY . . . 3 HUSBAND/PARTNER HAS NO EARNINGS . . . . . 4 OTHER _____ 6 (SPECIFY)	
820	Who usually makes decisions about health care for yourself: you, your (husband/partner), you and your (husband/partner) jointly, or someone else? *Hu nao save disaed abaot helt kea blong iu ,iu,(hasban/patna) blo iu , iutufala tugeda eni narawan moa?*	RESPONDENT . . . . . 1 HUSBAND/PARTNER . . . . . 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY . . . 3 SOMEONE ELSE . . . . . 4 OTHER 6	

821	Who usually makes decisions about making major household purchases? *Hu nao save mekem disison long wat na mein samting fo peim fo haos?*	RESPONDENT . . . . . 1 HUSBAND/PARTNER . . . . . 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY . . . 3 SOMEONE ELSE . . . . . 4 OTHER 6	
822	Who usually makes decisions about visits to your family or relatives? *Hu nao save mekem disison abaotim visitim olketa famili o wantok blong iu?*	RESPONDENT . . . . . 1 HUSBAND/PARTNER . . . . . 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY . . . 3 SOMEONE ELSE . . . . . 4 OTHER 6	
823	Do you own this or any other house either alone or jointly with someone else? *Iu onam diswan or eni haos moa wea iu onam seleva or iu onam tugeda wetem eni wan moa?*	ALONE ONLY . . . . . 1 JOINTLY ONLY . . . . . 2 BOTH ALONE AND JOINTLY . . . . . 3 DOES NOT OWN 4	
824	Do you own any land either alone or jointly with someone else? *Iu onam eni lan seleva or iu onam tugeda wetem eni wan moa?*	ALONE ONLY . . . . . 1 JOINTLY ONLY . . . . . 2 BOTH ALONE AND JOINTLY . . . . . 3 DOES NOT OWN 4	
825	PRESENCE OF OTHERS AT THIS POINT (PRESENT AND LISTENING, PRESENT BUT NOT LISTENING, OR NOT PRESENT)	PRES./ LISTEN. / PRES./ NOT LISTEN. / NOT PRES. CHILDREN < 10 . . . . . 1 2 3 HUSBAND . . . . . 1 2 3 OTHER MALES . . . . . 1 2 3 OTHER FEMALES . . . 1 2 3	
826	In your opinion, is a husband justified in hitting or beating his wife in the following situations: *Long tingting blo iu , hasban hem garem raet fo hitim waef from olketa samting olsem?* If she goes out without telling him? *sapos hemi go aot bat no talem hem?* If she neglects the children? *Sapos hem no ting hevi an tek kea long pikinini?* If she argues with him? *Sapos hemi raoa wetem hem?* If she refuses to have sex with him? *Sapos hemi les fo havem sex wetem hem?* If she burns the food? *Sapos hemi bonem olketa kaikai team hemi kuki?*	YES / NO / DK GOES OUT . . . . . 1 2 8 NEGL. CHILDREN . . . 1 2 8 ARGUES . . . . . 1 2 8 REFUSES SEX . . . . . 1 2 8 BURNS FOOD 1 2 8	

SECTION 9. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	Now I would like to talk about something else. Have you ever heard of an illness called Acquired Immunodeficiency Syndrome (AIDS)? *Distaem mi laek tok abaot nara samting. Iu herem tu abaot disfala sik olketa kolem long (AIDS)?*	YES . . . . . 1 NO 2	→ 921
902	Can people reduce their chance of getting the Human Immunodeficiency Virus (HIV) by having just one uninfected sex partner who has no other sex partners? *Waswe,olketa pipol save ridiusim sans blong olketa fo no garem HIV vaeres sapos olketa garem wan seks patna wea hem no garem HIV vaeres an no eni ada seks patna?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
903	Can people get the HIV from mosquito bites? *Waswe, HIV save kasem pipol from moskito baet?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
904	Can people reduce their chance of getting the HIV by using a condom every time they have sex? *Waswe, pipol save ridiusim sans fo HIV no kasem olketa sapos olketa iusim condom evri taem olketa havem seks?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
905	Can people get the HIV by sharing food with a person who has AIDS? *Waswe, HIV save kasem pipol sapos olketa searem kaikai wetem peson wea garem AIDS ?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
906	Can people get the HIV because of witchcraft or other supernatural means? *Waswe,pipol save garem HIV bikos from majik wetem samfala unusual spirit wea hem hapen ?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
907	Is it possible for a healthy-looking person to have HIV? *Waswe, eni peson wea hem luk helti, HIV save kasem hem tu?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
908	Can the HIV that causes AIDS be transmitted from a mother to her baby: *Waswe, HIV wea save kosim AIDS hem save pas on from Mami go long bebi:* During pregnancy? *Taem hem babule ?* During delivery? *Taem hem bonem pikinini?* By breastfeeding? *Susum bebi?*	YES NO DK DURING PREG. . . . . 1 2 8 DURING DELIVERY . . . 1 2 8 BREASTFEEDING . . . 1 2 8	

909	CHECK 908: AT LEAST ONE 'YES' ☐ ↓ OTHER ☐ → 911		
910	Are there any special drugs that a doctor or a nurse can give to a woman infected with HIV during pregnancy to reduce the risk of transmission to the baby? *Waswe, eni spesol meresin hem stap wea dokta or nes save givim long woman wea garem HIV fo katem daon risk fo pasim go long bebi?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
911	I don't want to know the results, but have you ever been tested to see if you have the HIV? *Mi no laek save long risalt, bat eni taem iu bin duim test nogud iu garem HIV?*	YES . . . . . 1 NO 2	→ 915
912	How many months ago was your most recent HIV test? *Hao meni manis go finis nao iu duim las HIV test blong iu?*	MONTHS AGO . . . . . ☐☐ TWO OR MORE YEARS 95	
913	I don't want to know the results, but did you get the results of the test? *Mi no laek save risalt, bat waswe iu tekem risalt blong test blong iu?*	YES . . . . . 1 NO 2	
914	Where was the test done? *Wea nao olketa duim test ia?* PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . 11 PROVINCIAL HOSPITAL . . . . . 12 URBAN AREA HEALTH CENTRE . . . 13 RURAL HEALTH CENTRE . . . . . 14 STAND-ALONE VCT CENTER . . . . . 15 FAMILY PLANNING CLINIC . . . . . 16 MOBILE CLINIC . . . . . 17 SCHOOL BASED CLINIC . . . . . 18 OTHER PUBLIC SECTOR _____ 19 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR . . . . . 21 STAND-ALONE VCT CENTER . . . . . 22 PHARMACY . . . . . 23 MOBILE CLINIC . . . . . 24 FIELDWORKER . . . . . 25 SCHOOL BASED CLINIC . . . . . 26 OTHER PRIVATE MEDICAL SECTOR _____ 27 (SPECIFY) OTHER SOURCE HOME . . . . . 31 CORRECTIONAL FACILITY . . . . . 32 OTHER _____ 96 (SPECIFY)	→ 917

915	Do you know of a place where people can go to get tested for HIV? *Waswe, iu save long eni ples wea pipol save go fo duim test fo HIV?*	YES . . . . . 1 NO 2	→ 917
916	Where is that? *Wea nao ia?* Any other place? *Eni nara ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSP . . . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE C RURAL HEALTH CENTRE D STAND-ALONE VCT CENTER . . . . . E FAMILY PLANNING CLINIC . . . . . F MOBILE CLINIC . . . . . G SCHOLL BASED . . . . . H OTHER PUBLIC SECTOR _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR . . . . . J STAND-ALONE VCT CENTER . . . . . K PHARMACY . . . . . L MOBILE CLINIC . . . . . M FIELDWORKER . . . . . N OTHER PRIVATE MEDICAL SECTOR _____ O (SPECIFY) OTHER _____ X (SPECIFY)	
917	Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV or AIDS? *Waswe, Iu bae stil peim vejtabol from eni stoa keeper or olketa wea save sel long smol maket nomata iu save dat hem garem HIV or AIDS?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
918	If a member of your family got infected with HIV, would you want it to remain a secret or not? *Sapos wanfala memba long famili blong iu hem infekted wetem HIV, bae iu wandem fo kipim olsem sikret or nomoa?*	YES, REMAIN A SECRET . . . . . 1 NO . . . . . 2 DK/NOT SURE/DEPENDS 8	
919	If a member of your family became sick with AIDS, would you be willing to care for her or him in your own household? *Sapos wanfala memba long famili blong iu hem sik wetem AIDS, bae iu wiling fo lukafterem hem long oun haos blong iu?*	YES . . . . . 1 NO . . . . . 2 DK/NOT SURE/DEPENDS 8	
920	In your opinion, if a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in the school? *Long tingting blong iu, sapos wanfala mere tisa hem garem HIV bat hem no sik, hem olraet fo olketa letem hem fo gohed tisa nomoa long skul?*	SHOULD BE ALLOWED . . . . . 1 SHOULD NOT BE ALLOWED . . . . . 2 DK/NOT SURE/DEPENDS 8	

921	CHECK 901: HEARD ABOUT AIDS ☐ → Apart from AIDS, have you heard about other infections that can be transmitted through sexual contact? *Bisaed lo AIDS, iu bin herem abaot olketa nara sik wea save pasim raon tru seks?* NOT HEARD ABOUT AIDS ☐ → Have you heard about infections that can be transmitted through sexual contact? *Waswe,iu bin herem abaotem olketa sik wea save pasim raon tru seks?*	YES . . . . . 1 NO 2	
922	CHECK 613: HAS HAD SEXUAL INTERCOURSE ☐ NEVER HAD SEXUAL INTERCOURSE ☐ → 930		
923	CHECK 921: HEARD ABOUT OTHER SEXUALLY TRANSMITTED INFECTIONS? YES ☐ NO ☐ → 925		
924	Now I would like to ask you some questions about your health in the last 12 months. During the last 12 months, have you had a disease which you got through sexual contact? *Distaem mi laek askem iu samfala kuesten abaot helt blong iu insaed las tuelv manis.Insaed las tuelv manis, iu garem eni sik wea hem kasem iu bikos from seks kontakt.*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
925	Sometimes women experience a bad-smelling abnormal vaginal discharge. During the last 12 months, have you had a bad-smelling abnormal discharge from your vagina? *Samfala taem,olketa mere save experiensim rabis wata wea hem smel nogut,save kamaot from kan blo olketa?* *Insaet long las 12 mans, iu bin garem rabis wata wea hem smel nogud,hem kamaot long kan blo iu?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
926	Sometimes women have a genital sore or ulcer. During the last 12 months, have you had a genital sore or ulcer? *Samfala taem olketa mere save garem soa o ulcer lo praevet pat blo olketa.* *Insaet lo las 12 mans,waswe iu bin garem eni soa o ulcer olsem lo praevet pat blo iu o nomoa?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

927	CHECK 924, 925, AND 926: HAS HAD AN INFECTION (ANY 'YES') ☐ HAS NOT HAD AN INFECTION OR DOES NOT KNOW ☐ → 930		
928	The last time you had (PROBLEM FROM 924/925/926), did you seek any kind of advice or treatment? *Long las taem iu garem (PROBLEM FROM 924/925/926), iu go faendem advaes or tritmen?*	YES . . . . . 1 NO 2	→ 930
929	Where did you go? *Wea nao iu go?* Any other place? Eni nara ples? PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPIITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C RURAL HEALTH CENTRE . . . . . D HIV TESTING HEADQUATE . . . . . E HIV TESTING CLINICS . . . . . F OTHER PUBLIC SECTOR _____ G (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC ..... H PRIVATE DOCTOR . . . . . I OTHER PRIVATE MEDICAL SECTOR _____ J (SPECIFY) CHURCH HOSPITAL ..... K OTHER _____ L (SPECIFY) OTHER SOURCE SIPPA CLINIC ..... M OTHER _____ X (SPECIFY)	
930	Is a wife justified in refusing to have sex with her husband when she knows he has sex with other women? *Waswe, waef hem garem raet fo se hem les fo havem seks wetem hasban blong hem taem hem save dat hasban blong hem havem seks tu wetem olketa nara woman?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

SECTION 10. OTHER HEALTH ISSUES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1001	Have you ever heard of an illness called tuberculosis or TB? *Waswe, iu bin herem finis wanfala siknis olketa kolem tuberculosis o TB?*	YES . . . . . 1 NO 2	→ 1008
1002	CHECK Q. 108: CODE '2', '3' OR '4' CIRCLED OR NO ANSWER ↓ CODE '1' OR '5' CIRCLED →		1004
1003	The following is a list of sources of information on tuberculosis or TB. Have you ever done any of the following? *Diswan hemi list blong olketa source blong informeisin abaot tuberculosis o TB. Waswe, iu bin duim eniwan lo olketa samting olsem?* a. Read messages about TB in newspapers or magazines? *Ridim mesej abaot TB insaet niuspepa o magasin?* b. Seen leaflets, brochures, or booklets on TB? *Ridim smol buka abaotem TB?* c. Gotten information on TB from the internet? *Tekem infomeisin abaot TB lo internet?*	YES NO NEWSPAPER/MAGAZINE . 1 2 LEAFLETS/BOOKLETS . . . 1 2 INTERNET 1 2	
1004	READ INTRODUCTORY STATEMENT ONLY IF Q1003 WAS NOT ASKED: The following is a list of sources of information on tuberculosis or TB. *Diswan hemi list blong olketa sos blong informeisin abaot tuberculosis o TB?* Have you ever Waswe, iu bin a. Seen messages about TB on billboards, signs or posters? *Iukim meseg abaotim TB lo advataisbod, lo olketa saen an posta?* b. Seen messages about TB on TV? *Lukim meseg abaotim TB lo TV?* c. Heard messages about TB on radio? *Herem meseg abaotim TB lo redio* d. Attended a community event about TB? *Bin atendem wanfala komunity mitin abaotem TB?* e. Received information about TB from an outreach work, that is, one who came to your community and talked about TB? *Risivim infomesen abaotim TB from wanfala toktok and visit abaotim TB?* f. Participated in a TB peer education program? *Bin tekpat lo wanfal TB grup edukeisen program?* g. Participated in another type of TB education program such as a wokshop or school program? *Bin tekpat lo nara fala taep TB edukeisen program olsem woksop o skul?* h. Discussed TB with other persons such as friend, family members, or work colleagues? *Tokabaotem TB wetem narafala pipol olsem frens, olketa memba blo famili o olketa man-mere iu wok wetem?*	YES NO SIGNS/POSTERS . . . . . 1 2 TV . . . . . 1 2 RADIO . . . . . 1 2 COMMUNITY EVENT . . . 1 2 OUTREACH WORKER . . . 1 2 PEER EDUCATION . . . . . 1 2 OTHER EDUCATION . . . . . 1 2 FAMILY/FRIENDS 1 2	

1005	How does tuberculosis spread from one person to another? *Hao nao tuberculosis o TB hem spred from wanfala go lo narawan?* PROBE: Any other ways? *PROBE: Eni narawe moa?* RECORD ALL MENTIONED.	THROUGH THE AIR WHEN COUGHING OR SNEEZING ..... A THROUGH SHARING UTENSILS ... B THROUGH TOUCHING A PERSON WITH TB ..... C THROUGH FOOD ..... D THROUGH SEXUAL CONTACT ... E THROUGH MOSQUITO BITES ..... F OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
1006	Can tuberculosis be cured? *Waswe TB garem mersin fo kiurem o nomoa?*	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1007	If a member of your family got tuberculosis, would you want it to remain a secret or not? *Sapos eni memba blong famili blo iu garem TB, waswe bae iu laekem fo stap haid nomoa o waswe?*	YES, REMAIN A SECRET ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/ DEPENDS 8	
1008	**INJECTIONS** Now I would like to ask you some other questions relating to health matters. Have you had an injection for any reason in the last 12 months? *Distaem mi laek askem iu samfala kuestin moa abaotem helt. Waswe eniwan bin givim iu eni meresin lo nila insaet las 12 mans o nomoa?* IF YES: How many injections have you had? *IF YES: Hao meni nila nao iu bin tekem?* IF NUMBER OF INJECTIONS IS GREATER THAN 90, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.	NUMBER OF INJECTIONS . ☐☐ NONE ..... 00 → 1012a	
1009	Among these injections, how many were administered by a doctor, a nurse, a pharmacist, a dentist, or any other health worker? *Long olketa nila iu talem ia, hao meni nao dokta, nes, man blo meresin (famasis), dokta blo titi o eni nara man o mere wea wak lo helt nao nilam iu?* IF NUMBER OF INJECTIONS IS GREATER THAN 90, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.	NUMBER OF INJECTIONS . ☐☐ NONE ..... 00 → 1012a	

1010	The last time you had an injection given to you by a health worker, where did you go to get the injection? *Long las taem iu tekem nila wea dokta o nes bin givim lo iu ia wea nao iu go, fo olketa nilam iu ia?* PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. IF UNABLE TO DETERMINE IF HOSPITAL, HEALTH CENTER OR CLINIC IS PUBLIC, PRIVATE, CHURCH OR NGO MEDICAL FACILITY, THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR GOVT. HOSPITAL ..... 11 RURAL HEALTH CENTRE ..... 12 RURAL HEALTH CLINIC ..... 13 NURSE AIDE POST ..... 14 SATELLITE CLINIC ..... 15 OTHER PUBLIC _____ 16 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC ..... 21 PHARMACY ..... 22 PRIVATE DOCTOR ..... 23 OTHER PRIVATE MEDICAL/FACILITIES 26 _____ (SPECIFY) CHURCH HOSPITAL ..... 31 RURAL HEALTH CLINIC ..... 32 NURSE AIDE POST ..... 33 SATELLITE CLINIC ..... 34 OTHER OUTLET ..... 36 NGO/OTHER SOURCE SIPPA CLINIC ..... 41 SIPPA CBD ..... 42 SAVE THE CHILDREN FUND ... 43 SHOP ..... 44 FRIEND/RELATIVE ..... 45 OTHER _____ 96 (SPECIFY)	
1011	Did the person who gave you that injection take the syringe and needle from a new, unopened package? *Waswe, datfala man o mere wea givim iu datfala nila lo iu ia, hem bin tekem syrin and nila ia from wanfala niu paket wea hemi jas openem o nomoa?*	YES ..... 1 NO ..... 2 DON'T KNOW 8	
	CIGARETTES AND TOBACCO USED Now I am going to talk about tobacco and cigarettes use as they are the main causes of health problems.		
1012a	*Distaem mi laek fo tok aboatim tobako an cigaret use an olketa nao barava mein kos blo helt problem?*	YES 1	
	Have you ever tried cigarettes smoking even one or two puffs? *Waswe iu bin traem smokim sigaret nomata hem one o two puffs??*	NO 2	→ 1014a
1012b	Do you currently smoke cigarettes? *Waswe, iu smokem sigaret distaem o nomoa?*	YES ..... 1 NO 2	→ 1014a
1013	In the last 24 hours, how many cigarettes did you smoke? *Insaet lo las 24 hours, hao meni sikaret nao iu smokem?*	CIGARETTES ..... ☐☐	
1014a	Have you ever tried any smoked tobacco products other than cigarettes, such as cigars, water pipe or pipe? *Waswe iu bin traem eni smoke tobako prodakt from sigaret,olsem siga,wata pipe o pipe?*	YES ..... 1 NO 2	→ 1016
1014b	Do you currently smoke or use any other type of tobacco? *Waswe, iu smok distaem o iu iusim eni nara kaen tobako?*	YES ..... 1 NO 2	→ 1016
1015	What (other) type of tobacco do you currently smoke or use? *Wat nao olketa nara taep tobako wea iu smokem o iusim distaem?* RECORD ALL MENTIONED.	PIPE ..... A CHEWING TOBACCO ..... B SNUFF ..... C ROLLED LEKONA ..... D OTHER _____ X (SPECIFY)	

1016	**ACCESSING MEDICAL TREATMENT** Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not? *Staka difren samting nao save stopem olketa mere from go getem medikol advaes o tritment fo olketa seleva. Taem iu sik an iu wandem fo getem medikol advaes o tritment, waswe eniwan lo olketa samting olsem ia hemi bik problom o nomoa?*	BIG PROB-LEM / NOT A BIG PROB-LEM	
	a. Getting permission to go? *Fo oloketa alaom iu fo go?*	PERMISSION TO GO . 1 / 2	
	b. Getting money needed for treatment? *Fo tekem selen wea iu nidim fo peim tritmen*	GETTING MONEY . . . . . 1 / 2	
	c. The distance to the health facility? *Klinik o hospitol hemi farawe tumas?*	DISTANCE . . . . . 1 / 2	
	d. Having to take transport? *Mas tekem transpot bifoa save go?*	TAKING TRANSPORT . 1 / 2	
	e. Not wanting to go alone? *No wande go seleva?*	GO ALONE . . . . . 1 / 2	
	f. Concern that there may not be a female health provider? *Fraet bikos no eni mere nao wak lo klinik?*	NO FEMALE PROVIDER 1 / 2	
	g. Concern that there may not be any health provider? *Fraet bikos maet no eni helt wakman o mere stap?*	NO PROVIDER . . . . . 1 / 2	
	h. Concern that there may be no drugs available? *Wari bikos no eni meresin nao stap?*	NO DRUGS . . . . . 1 / 2	
1017	Are you covered by any health insurance? *Waswe iu cover lo eni helt insurens ?*	YES . . . . . 1 NO . . . . . 2 → 1019	
1018	What type of health insurance? *Wat taep helt insurens nao ia?* RECORD ALL MENTIONED.	MUTUAL HEALTH ORGANIZATION/ COMMUNITY-BASED HEALTH INSURANCE . . . . . A HEALTH INSURANCE THROUGH EMPLOYER . . . . . B SOCIAL SECURITY . . . . . C OTHER PRIVATELY PURCHASED COMMERCIAL HEALTH INSURANCE. D OTHER _____ X (SPECIFY)	
1019	**ALCOHOL AND DRUG USE** Now I would like to ask you about alcohol and drug use. Remember that your responses are completely anonymous and confidential and will not be released to anyone. During the last 12 months, how often did you have drinks containing alcohol, such as beer, wine, liquor, spirits, homebrew, kwaso, toddy, yeast? Would you say: 4 or more times a week? 2 to 3 times a week? 2 to 4 times a month? Monthly or less? *Distaem mi laek askem iu abaotem alkahol an drug. No foget dat olketa ansa blo iu baebae tambu tumas fo mi talem o givim lo eniwan moa.* *Insaet las 12 mans, hao meni taem nao iu bin dringim alkohol olsem bia, waen, hotstaf, olketa nara hot dring, kwaso, hom-bru o todi?* *Bae iu se hemi:* w inim 4 taem insaet w anfala w ik? 2 go kasem 3 taem insaet w an w ik? *2 go kasem 4 taem insaet wan mans?* *no kasem 2 lo evri mans?*	NEVER . . . . . 0 → 1022 4+ PER WEEK . . . . . 1 2-3 PER WEEK . . . . . 2 2-4 PER MONTH . . . . . 3 < 2 PER MONTH . . . . . 4 NO ANSWER/REFUSED . . . . . 7 DON'T KNOW 8	

1020	During the last 12 months, how many standard drinks containing alcohol did you have on a typical day when drinking? A standard drink is a can of beer, a glass of wine, a shot of liquor, etc. 20 or more? 10 to 19? 7, 8, or 9? 5 or 6? 3 or 4? 1 or 2? *Insaet las 12 mans hao meni standad dring wea hem kontenim alkahol nao iu save dringim lo wanfala tipikol dei? Standad dring nao iumi minim wan fala tin-bia, wanfala glas lo waen o wan sisimol glas lo lika.* *20 o winim go? 10 go kasem 19? 7, 8 or 9?* 5 or 6? 3 or 4? 1 o 2?	NUMBER OF STANDARD DRINKS 20 OR MORE . . . . . 1 10 TO 19 . . . . . 2 7, 8 OR 9 . . . . . 3 5 OR 6 . . . . . 4 3 OR 4 . . . . . 5 1 OR 2 . . . . . 6 DON'T KNOW . . . . . 8 NO ANSWER/REFUSED 7	
1021	During the last 12 months, how often did you have five or more standard drinks at one time? drinking? A standard drink is a can of beer, a glass of wine, a shot of liquor, etc. Daily or almost daily? Weekly? Monthly? Less than monthly? Never? *Insaet las 12 mans hao ofen nao iu bin dringim faefala an go-ap long olketa standad dring ia long eniwan taem?* *Standad dring hem minim wanfala tin-bia, wanfala glas logn waen wan o wan sisimol glas long lika an olketa samting olsem.* *Evride o kolsap evride? Evri Wik?* *Evri mans? No kasem wan mans?* *Nating nao.*	NEVER . . . . . 0 DAILY OR ALMOST DAILY . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NO ANSWER/REFUSED . . . . . 7 DON'T KNOW 8	
1022	Next I would like to ask you about use of the following items. Have you <u>ever</u> tried…? IF YES, ASK: Did you use it in the last 30 days? *Distaem, mi laek askem iu abaotem ius blo olketa samting wea bae mi talem kam.* *Iu bin traem?* *IF YES, ASK:* *Iu bin iusim insaet las 30 days?*	NEVER TRIED / EVER TRIED / USED IN LAST 30 DAYS / NO ANSWER, REFUSED a Betel nut? *Bilnat?* 1 2 3 7 b. Sakau/Kava? *Kava* 1 2 3 7 c. Marijuana/Cannibis *Maruana* 1 2 3 7 d. Ectasy/E/Eccies? *Ektasi tablet* 1 2 3 7 e. Inhalants including gas? *Samting fo britim olsem gas* 1 2 3 7 f. Speed/Base/Other amphetamines? *Spid* 1 2 3 7 g. Ice/Crystal meth? *Ice* 1 2 3 7 h. Cocaine/Crack/Freebasing? *Koken* 1 2 3 7 i. Heroin? *Heroin* 1 2 3 7 j. LSD/Acid/Hallucinogens? *LSD/Acid* 1 2 3 7	
1023	Some people have tried injecting drugs using a syringe. In the last 12 months, have you injected drugs (not including injections for medical reasons or treatment of an illness)? *Samfala pipol save trae fo nilam olketa seleva wetem drugs. Waswe, iu bin nilam iu seleva wetem drugs insaet las 12 mans o nomoa (no includim nila wea iu tekem saed lo medical helt an tritmen for sik blo iu)?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	

1024	**CONDITIONS OF BONES AND MUSCLES** The following questions will ask about conditions of the bones, muscles and joints. *Disatem olketa questen bae hem folo ia,bae hem ask abaotim condison blong bones,masol an olketa samting wea conectim olketa bone olsem joints.* In the past **4 weeks**, have you had pain in your low back? (SHOW LOW BACK DIAGRAM TO RESPONDENT) *Insaet lo las 4 wiks ,iu bin garem pein lo low baksaed blo iu?* SHOW DIAGRAM TO RESPONDENT	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 1026
1025	Was this pain bad enough to limit your usual activities or change your daily routine for more than one day? *Waswe disfala pein ia hemi nogud tumas wea hem mekem iu fo no save duim olketa normal waka blo iu o sensim dei to dei waka blo iu fo ovam wanfala dei?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
1026	In the past **4 weeks**, have you had pain in your neck? (SHOW NECK DIAGRAM TO RESPONDENT) SHOW DIAGRAM TO RESPONDENT *Insaet lo las 4 wiks,waswe iu bin garem pein lo nek blong iu?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 1028
1027	Was this pain bad enough to limit your usual activities or change your daily routine for more than one day? *Pain ia hemi sore tumas an hemi stopem iu fo duim evri day waka blong iu o hem disturbim nomal waka blo iu fo two three daes?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
1028	In the last 4 weeks have you had any pain in your hips or knees? (SHOW HIP AND KNEE DAIGRAM TO RESPONDENT) *Insaet lo las 4 wiks,waswe iu bin garem pein lo hips o knees blong iu?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 1033
1029	Was this pain bad enough to limit your usual activities or change your daily routine for more than one day? *Waswe disfala pein hem nogut tumas wea hem mekem iu fo no save duim olketa normal waka blo iu o sensim dei to dei waka blo iu fo ovam wanfala dei?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
1030	Has this problem lasted for **3 months or more?** *Waswe disfala problem hem stap kasim 3 manis o ovam?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
1031	For this problem have you been told by a medical doctor what the diagnosis is? *Fo disfala problem,eni dokta blo helt bin talem iu wanem nao siki ia?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 1033
1032	What was the diagnosis? *Wanem nao siki ia?*	☐☐ _____	
1033	RECORD THE TIME.	HOUR . . . . . ☐☐ MINUTES . . . . . ☐☐	

WOMAN'S CALENDAR

INSTRUCTIONS:
ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
COLUMN 1REQUIRES A CODE IN EVERY MONTH.

INFORMATION TO BE CODED FOR EACH COLUMN

COLUMN 1: BIRTHS, PREGNANCIES, CONTRACEPTIVE USE**

- B BIRTHS
- P PREGNANCIES
- T TERMINATIONS

- 0 NO METHOD
- 1 FEMALE STERILIZATION
- 2 MALE STERILIZATION
- 3 IUD
- 4 INJECTABLES
- 5 IMPLANTS
- 6 PILL
- 7 CONDOM
- 8 FEMALE CONDOM
- 9 DIAPHRAGM
- J FOAM OR JELLY
- K LACTATIONAL AMENORRHEA METHOD
- L RHYTHM METHOD
- M WITHDRAWAL
- X OTHER MODERN METHOD
- Y OTHER TRADITIONAL METHOD

COLUMN 2: DISCONTINUATION OF CONTRACEPTIVE USE

- 0 INFREQUENT SEX/HUSBAND AWAY
- 1 BECAME PREGNANT WHILE USING
- 2 WANTED TO BECOME PREGNANT
- 3 HUSBAND/PARTNER DISAPPROVED
- 4 WANTED MORE EFFECTIVE METHOD
- 5 SIDE EFFECTS/HEALTH CONCERNS
- 6 LACK OF ACCESS/TOO FAR
- 7 COSTS TOO MUCH
- 8 INCONVENIENT TO USE
- F UP TO GOD/FATALISTIC
- A DIFFICULT TO GET PREGNANT/MENOPAUSAL
- D MARITAL DISSOLUTION/SEPARATION
- X OTHER _____ (SPECIFY)
- Z DON'T KNOW

				1	2	
	12	DEC	01			
	11	NOV	02			
	10	OCT	03			
	09	SEP	04			
2	08	AUG	05			2
0	07	JUL	06			0
1	06	JUN	07			1
5	05	MAY	08			5
*	04	APR	09			*
	03	MAR	10			
	02	FEB	11			
	01	JAN	12			
	12	DEC	13			
	11	NOV	14			
	10	OCT	15			
	09	SEP	16			
2	08	AUG	17			2
0	07	JUL	18			0
1	06	JUN	19			1
4	05	MAY	20			4
*	04	APR	21			*
	03	MAR	22			
	02	FEB	23			
	01	JAN	24			
	12	DEC	25			
	11	NOV	26			
	10	OCT	27			
	09	SEP	28			
2	08	AUG	29			2
0	07	JUL	30			0
1	06	JUN	31			1
3	05	MAY	32			3
*	04	APR	33			*
	03	MAR	34			
	02	FEB	35			
	01	JAN	36			
	12	DEC	37			
	11	NOV	38			
	10	OCT	39			
	09	SEP	40			
2	08	AUG	41			2
0	07	JUL	42			0
1	06	JUN	43			1
2	05	MAY	44			2
*	04	APR	45			*
	03	MAR	46			
	02	FEB	47			
	01	JAN	48			
	12	DEC	49			
	11	NOV	50			
	10	OCT	51			
	09	SEP	52			
2	08	AUG	53			2
0	07	JUL	54			0
1	06	JUN	55			1
1	05	MAY	56			1
*	04	APR	57			*
	03	MAR	58			
	02	FEB	59			
	01	JAN	60			
	12	DEC	61			
	11	NOV	62			
	10	OCT	63			
	09	SEP	64			
2	08	AUG	65			2
0	07	JUL	66			0
1	06	JUN	67			1
0	05	MAY	68			0
*	04	APR	69			*
	03	MAR	70			
	02	FEB	71			
	01	JAN	72			

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____

sFigure E.3: Man's Questionnaire

March 2015

DEMOGRAPHIC AND HEALTH SURVEYS
MAN'S QUESTIONNAIRE

SOLOMON ISLANDS
NATIONAL STATISTICS OFFICE/MINISTRY OF HEALTH

IDENTIFICATION

NAME OF HOUSEHOLD HEAD _____

HOUSEHOLD NUMBER . . . . . | | | | |

PROVINCE _____ | |

WARD _____ | |

EA NUMBER . . . . . | | | |

VILLAGE NAME _____ | |

TOWN / PROVINCIAL CENTRE / RURAL
TOWN = 1, PROVINCIAL CENTRE = 2, RURAL = 3 . . . . . | |

NAME AND LINE NUMBER OF MAN _____ | |

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY / MONTH / YEAR
INTERVIEWER'S NAME				INT. NUMBER
RESULT*				RESULT
NEXT VISIT: DATE				TOTAL NUMBER OF VISITS
TIME				

*RESULT CODES:

1	COMPLETED	4	REFUSED		
2	NOT AT HOME	5	PARTLY COMPLETED	7	OTHER _____ (SPECIFY)
3	POSTPONED	6	INCAPACITATED		

LANGUAGE OF INTERVIEW 1 ENGLISH 2 PIDGIN 3 OTHERS _____

LANGUAGE OF RESPONDENT 1 ENGLISH 2 PIDGIN 3 OTHERS _____

TRANSLATOR USED? 1 YES 2 NO

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____	NAME _____		

SECTION 1. RESPONDENT'S BACKGROUND

INTRODUCTION AND CONSENT

INFORMED CONSENT

Hello. My name is _____. I am working with National Statistics Office. We are conducting a survey about health all over Solomon Islands. The information we collect will help the government to plan health services. Your household was selected for the survey. The questions usually take about 30 to 60 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your household.
Do you have any questions? May I begin the interview now?

Halo. Nem blong mi _____Mi waka wetem National Statistics Office. Mifala duim wanfala savei abaot helt long ful Solomon Islands. Infomeson wea mifala kolektim bae hem helpem Gavman fo planim olketa helt sevis.Olketa kuesten hem save tekem 30 or 60 minit nomoa.Haos blong iu olketa siusim tu fo disfala savei. Evri ansa iu givim bae tambu tumas fo mifala talem go long eniwan moa. Fo iu joinem disfala savei, bae hem impotent tumas bikos bae hem help lo saed fo improvem olketa helt sevisis wea gavman hem provaedim fo kandere blong iumi. Bae hem gud tumas sapos iu agri fo ansarem olketa kuesten bikos tingting blong iu hem impotent tumas. Sapos mi askem iu eni kuesten wea iu les fo ansarem, iu talem mi mekem mi save muv go long nara kuesten or iu save stopem intaviu enitaem.
Sapos iu nidim moa infomeson abaotim savei, iu save kontaktim olketa pipol wea waka long National Statistics Office.
Waswe, iu garem eni kuesten? Mi save statem intaviu distaem?

SIGNATURE OF INTERVIEWER: _____ DATE: _____

RESPONDENT AGREES TO BE INTERVIEWED . . . 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 → END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME. RECORDIM TAEM	HOUR . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
102	In what month and year were you born? *Long wat manis an yia nao iu bon?*	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
103	How old were you at your last birthday? *Hao ol nao iu long las betdei blong iu?* COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.	AGE IN COMPLETED YEARS [ ][ ]	
104	Have you ever attended school? *Waswe, iu bin skul tu or nomoa?*	YES . . . . . 1 NO 2	→ 108
105	What is the highest level of school you attended: primary, secondary, or higher? *Wat nao haes levol iu kasem: long praemari, sekondri or eni levol go up moa iu kasem?*	PRE SCHOOL . . . . . 0 PRIMARY . . . . . 1 SECONDARY . . . . . 2 TERTIARY . . . . . 3 VOCATIONAL . . . . . 4 DON'T KNOW . . . . . 8 OTHER _____ 9 (SPECIFY)	

106	What is the highest (grade/form/year) you completed at that level? *Wat nao haes(class/fom/yia) iu kasem long dat fala* IF COMPLETED LESS THAN ONE YEAR AT THAT LEVEL, RECORD '00'.	GRADE/FORM/YEAR	
107	CHECK 105: PRIMARY ☐ SECONDARY OR HIGHER ☐ → 110		
108	Now I would like you to read this sentence to me. *Distaem mi laekem iu fo ridim disfala sentens kam* SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me? *Waswe, iu save ridim eni pat long sentens ia kam*	CANNOT READ AT ALL . . . . . 1 ABLE TO READ ONLY PARTS OF SENTENCE . . . . . 2 ABLE TO READ WHOLE SENTENCE 3 NO CARD WITH REQUIRED LANGUAGE _____ 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED 5	
109	CHECK 108: CODE '2', '3' OR '4' CIRCLED ☐ CODE '1' OR '5' CIRCLED ☐ → 111		
110	Do you read a newspaper or magazine at least once a week, less than once a week or not at all? *Waswe, iu save ridim niuspepa or magazin wantaem insaed wan wik, samfala taem insaed wan wik or*	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL 3	
111	Do you listen to the radio at least once a week, less than once a week or not at all? *Waswe, iu save lisin long redio, wantaem insaed wan wik, samfala taem insaed wan wik,or barava nomoa*	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL 3	
112	Do you watch television at least once a week, less than once a week or not at all? *Waswe iu save lukluk televisin wantaem insaed wan wik, samfala taem insaed wan wik or barava nomoa*	AT LEAST ONCE A WEEK . . . . . 1 LESS THAN ONCE A WEEK . . . . . 2 NOT AT ALL 3	
113	What is your religion? *Wat kaen lotu nao iu go long hem?*	AGLICAN . . . . . 1 ROMAN CATHOLIC . . . . . 2 UNITED CHURCH . . . . . 3 SOUTHSEAS EVANGELICAL . . . . . 4 SEVENTH DAY ADVENTIST . . . . . 5 OTHER _____ 6 (SPECIFY)	
114	What is your ethnicity? *Waswe iu tingim iu seleva olsem wanfala Melanesian, Polynesian, Micronesian, waet man or wat kaen grup?*	MELANESIAN . . . . . 1 POLYNESIAN . . . . . 2 MICRONESIAN . . . . . 3 EUROPEAN . . . . . 4 CHINESE . . . . . 5 OTHER _____ 6 (SPECIFY)	

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask about any children you have had during your life. I am interested in all of the children that are biologically yours, even if they are not legally yours or do not have your last name. Have you ever fathered any children with any woman? *Distaem mi laek fo askem iu abaotim eni pikinini wea iu garem long laef blong iu. Mi intares nao lo olketa pikinini hu barava blood blong iu, no mata hem no stap wetem iu o nomata hem no garem las nem blong iu.* *Waswe, iu bin putim eni pikinini wetem eni woman?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 206
202	Do you have any sons or daughters that you have fathered who are now living with you? *Waswe, iu garem eni pikinini boe or pikinini gele wea iu nao ril dadi an oketa stap wetem iu distaem?*	YES . . . . . 1 NO 2	→ 204
203	How many sons live with you? *Hao meni pikinini boe nao stap wetem iu distaem?* And how many daughters live with you? *An hao meni pikinini gele nao stap wetem iu?* IF NONE, RECORD '00'.	SONS AT HOME . . . . . [ ][ ] DAUGHTERS AT HOME . . . . . [ ][ ]	
204	Do you have any sons or daughters that you have fathered who are alive but do not live with you? *Waswe, iu garem eni pikinini boe or gele wea iu nao ril dadi an olketa laef distaem bat olketa no stap wetem iu?*	YES . . . . . 1 NO 2	→ 206
205	How many sons are alive but do not live with you? *Hao meni long olketa boe nao laef bat olketa no stap wetem iu?* And how many daughters are alive but do not live with you? *An hao meni long olketa gele nao laef bat olketa no stap wetem iu ?* IF NONE, RECORD '00'.	SONS ELSEWHERE . . . . . [ ][ ] DAUGHTERS ELSEWHERE . . . [ ][ ]	
206	Have you ever fathered a son or a daughter who was born alive but later died? *Waswe, iu garem pikinini boe or gele wea hem laef nomoa taem hem bon bat gogo hem dae bihaen ?* IF NO, PROBE: Any baby who cried or showed signs of life but did not survive? *Eni bebi hu i krae or som saen dat hem laef bat gogo hem dae nomoa?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 208
207	How many boys have died? *Hao meni long olketa pikinini boe nao dae?* And how many girls have died? *An hao meni long olketa pikinini gele nao dae ?* IF NONE, RECORD '00'.	BOYS DEAD . . . . . [ ][ ] GIRLS DEAD . . . . . [ ][ ]	
208	SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL. IF NONE, RECORD '00'.	TOTAL CHILDREN . . . . . [ ][ ]	
209	CHECK 208: HAS HAD MORE THAN ONE CHILD HAS HAD ONLY ONE CHILD → 212 HAS NOT HAD ANY CHILDREN → 301		

210	Did all of the children you have fathered have the same biological mother? *Waswe, evri pikinini wea iu nao ril dadi blong olketa i garem sem mami?*	YES . . . . . 1 NO 2	→ 212
211	In all, how many women have you fathered children with? *Ol tugeda, hao meni woman nao u givim pikinini long oketa?*	NUMBER OF WOMEN	
212	How old were you when your (first) child was born? *Hao ol nao iu taem (fes) pikinini blong iu hem bon?*	AGE IN YEARS	
213	CHECK 203 AND 205: AT LEAST ONE LIVING CHILD ☐ ↓ NO LIVING CHILDREN ☐ → 301		
214	How old is your (youngest) child? *Hao ol nao (las) pikinini blong iu?*	AGE IN YEARS	
215	CHECK 214: (YOUNGEST) CHILD IS AGE 0-2 YEARS ☐ ↓ OTHER ☐ → 301		
216	What is the name of your (youngest) child? *Hu nao nem blong (las) pikinini blong iu?* WRITE NAME OF (YOUNGEST) CHILD _____ (NAME OF (YOUNGEST) CHILD)		
217	When (NAME)'s mother was pregnant with (NAME), did she have any antenatal check-ups? *Taem mami blong (Nem) hem babule wetem (Nem), hem save go long klinik fo sek ap tu?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 219
218	Were you ever present during any of those antenatal check-ups? *Waswe, iu save go wetem waef blong iu taem hem go fo sek ap taem hem babule?*	PRESENT . . . . . 1 NOT PRESENT 2	
219	Was (NAME) born in a hospital or health facility? *Waswe, (NEM) hemi bon long hospitol or long eni helt senta/klinik ?*	HOSPITAL/HEALTH FACILITY . . . . . 1 OTHER 2	
220	When a child has diarrhea, how much should he or she be given to drink: more than usual, about the same as usual, less than usual, or nothing to drink at all? *Taem bele ran hem kasem pikinini, hao mas nao iu sud givim fo dringim : ovam wanem hem save dringim olowe, semsem wetem wanem hem save dringim olowe, smol nomoa bat no ovam wanem hem save tekem olowe, or no eniting fo dringim nomoa?*	MORE THAN USUAL . . . . . 1 ABOUT THE SAME . . . . . 2 LESS THAN USUAL . . . . . 3 NOTHING TO DRINK . . . . . 4 DON'T KNOW 8	

SECTION 3. CONTRACEPTION

301	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. *Distaem mi laek tok abaot hao fo planim famili - olketa difren wei or metod wea olketa man an woman save iusim fo holemap fo lelebet taem or fo mami no babule nomoa.* Have you ever heard of (METHOD)? *Waswe, iu bin herem eniting olsem (METOD)?*		
01	**Female Sterilization**. PROBE: Women can have an operation to avoid having any more children. *Olketa woman save garem cut fo stopem rod blong eg fo no save garem eni moa pikinini.*	YES . . . . . 1 NO 2	
02	**Male Sterilization**. PROBE: Men can have an operation to avoid having any more children. *Olketa man save garem cut fo stopem rod blong spem fo no save garem eni moa pikinini .*	YES . . . . . 1 NO 2	
03	**IUD**. PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse. *Dokta o nes save putim wanfala ring o coil blong spring insaed long mere.*	YES . . . . . 1 NO 2	
04	**Injectables**. PROBE: Women can have an injection by a health provider that stops them from becoming pregnant for one or more months. *Oketa woman save tekem nila from olketa long helt fo stopem olketa fo no babule fo wan mans o winim go moa.*	YES . . . . . 1 NO 2	
05	**Implants**. PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years. *Olketa woman save garem wanfala or moa rod wea dokta or nes bae putim antap am blong olketa fo no babule fo wan or moa yias.*	YES . . . . . 1 NO 2	
06	**Pill**. PROBE: Women can take a pill every day to avoid becoming pregnant. *Olketa woman save tekem meresin evridei fo no babule..*	YES . . . . . 1 NO 2	
07	**Condom**. PROBE: Men can put a rubber sheath on their penis before sexual intercourse. *Olketa man save putim raba wea kavam koko blong olketa bifo olketa havem seks.*	YES . . . . . 1 NO 2	
08	**Female Condom**. PROBE: Women can place a sheath in their vagina before sexual intercourse. *Olketa woman save putim raba insaet kan blong olketa bifoa olketa havem seks.*	YES . . . . . 1 NO 2	
09	**Lactational Amenorrhea Method (LAM)**. *Olketa woman wea susum bebi fultaem fo siks manis save holemap babule.*	YES . . . . . 1 NO 2	
10	**Rhythm Method**. PROBE: To avoid pregnancy, women do not have sexual intercourse on the days of the month they think they can get pregnant. *Fo no babule, olketa woman no havem seks long olketa deis long manis wea olketa ting bae olketa save babule.*	YES . . . . . 1 NO 2	
11	**Withdrawal**. PROBE: Men can be careful and pull out before climax. *Olketa man save mek sua olketa pul aot bifoa olketa bosta.*	YES . . . . . 1 NO 2	
12	**Emergency Contraception**. PROBE: As an emergency measure, within three days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy. *Olsem wanfala kuik an storong wei, woman save tekem pil insaet long tri deis afta hem havem anprotekted seks fo no*	YES . . . . . 1 NO 2	
13	Have you heard of any other ways or methods that women or men can use to avoid pregnancy? *Waswe, iu bin herem eni nara we moa wea olketa woman or man bae save iusim fo no babule?*	YES . . . . . 1 _____ (SPECIFY) _____ (SPECIFY) NO 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
302	In the last few months have you: *Long las tu tri manis iu :* Heard about family planning on the radio? *Herem radio tok abaotem hao fo planim famili?* Seen anything about family planning on the television? *Lukim eniting long TV abaot hao fo planim famili?* Read about family planning in a newspaper or magazine? *Ridim long niuspepa or magazin abaot hao fo planim famili?*	YES NO RADIO . . . . . 1 2 TELEVISION . . . . . 1 2 NEWSPAPER OR MAGAZINE 1 2 Other . . . . . 1 2 _____ (SPECIFY)	
303	In the last few months, have you discussed family planning with a health worker or health professional? *Long las tu tri manis, iu bin stori abaot hao fo planim famili wetem eni wakaman long helt?*	YES . . . . . 1 NO 2	
304	Now I would like to ask you about a woman's risk of pregnancy. From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant when she has sexual relations? *Distaem mi laek askem iu abaot denja taem wea woman save babule .* *From taem hem lukim mun go kasem nara taem hemlukim bak moa, waswe eni denja taem moa wea woman save babule taem hem havem seks ?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 306
305	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods? *Waswe disfala taem ia hem jas bifoa hem lukim mun blong hem, o taem hem lukim mun blong hem, stret afta hem lukim mun finis or haf wei bituin tufala taem hem lukim mun blong hem?*	JUST BEFORE HER PERIOD BEGINS . . . . . 1 DURING HER PERIOD . . . . . 2 RIGHT AFTER HER PERIOD HAS ENDED . . . . . 3 HALFWAY BETWEEN TWO PERIODS . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
306	I will now read you some statements about contraception. Please tell me if you agree or disagree with each one. a) Contraception is a woman's business and a man should not have to worry about it. b) Women who use contraception may become promiscuous. *Distaem bae mi ridm kam samfala toktok abaotem kontrasepson. Plis talem sapos iu agri or no agri wetem eni long olketa toktok ia.* *a) Kontrasepson hem bisnis blong olketa mere nomoa so olketa man sud no wari abaotim nomoa.* *b) Olketa woman wea iusim kontrasepson olketa maet save olbaot.*	AGREE DISAGREE DK CONTRACEPTION WOMAN'S BUSINESS 1 2 8 WOMEN MAY BECOME PROMISCUOUS 1 2 8	
307	CHECK 301 : KNOWS MALE CONDOM YES ↓ NO →		→ 311
308	Do you know of a place where a person can get condoms? *Waswe, iu save long eni ples wea iu save tekem Condom?*	YES . . . . . 1 NO 2	→ 311

309	Where is that? *Long wea nao ia?* Any other place? *Eni ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C AREA HEALTH CENTRE . . . . . D RURAL HEALTH CENTRE . . . . . E FAMILY PLANNING CLINICS . . . . . F NURSE AID POST . . . . . G SATELLITE CLINICS . . . . . H OTHER PUBLIC SECTOR _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC . . . . . J PHARMACY . . . . . K PRIVATE DOCTOR . . . . . L OTHER PRIVATE MEDICAL SECTOR _____ M (SPECIFY) CHURCH HOSPITAL . . . . . N RURAL HEALTH CLINIC . . . . . O NURSE AIDE POST . . . . . P SATELLITE CLINIC . . . . . Q OTHER OUTLET . . . . . R NGO/OTHER SOURCE SIPPA CLINIC . . . . . S SIPPA CBD . . . . . T SAVE THE CHILDREN FUNDS . . . . . U SHOP . . . . . V FRIENDS/RELATIVES . . . . . W OTHER _____ X (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
310	If you wanted to, could you yourself get a condom? *Sapos iu wandem, iu save go tekem condom seleva?*	YES . . . . . 1 NO 2	
311	CHECK 301 (08): KNOWS FEMALE CONDOM YES ☐ NO ☐ → 401		
312	Do you know of a place where a person can get female condoms? *Iu save eni ples wea eniwan save tekem condom blong olketa woman?*	YES . . . . . 1 NO 2	→ 401

313	Where is that? *Wea nao ia?* Any other place? *Eni ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C AREA HEALTH CENTRE . . . . . D RURAL HEALTH CENTRE . . . . . E FAMILY PLANNING CLINICS . . . . . F NURSE AID POST . . . . . G SATELLITE CLINICS . . . . . H OTHER PUBLIC SECTOR _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC . . . . . J PHARMACY . . . . . K PRIVATE DOCTOR . . . . . L OTHER PRIVATE MEDICAL SECTOR _____ M (SPECIFY) CHURCH HOSPITAL . . . . . N RURAL HEALTH CLINIC . . . . . O NURSE AIDE POST . . . . . P SATELLITE CLINIC . . . . . Q OTHER OUTLET . . . . . R NGO/OTHER SOURCE SIPPA CLINIC . . . . . S SIPPA CBD . . . . . T SAVE THE CHILDREN FUNDS . . . . . U SHOP . . . . . V FRIENDS/RELATIVES . . . . . W OTHER _____ X (SPECIFY)	
314	If you wanted to, could you yourself get a female condom? *Sapos iu wandem, iu save go tekem condom blong olketa woman seleva?*	YES . . . . . 1 NO 2	

SECTION 4. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Are you currently married or living together with a woman as if married? *Waswe, iu maret distaem or iu stap tugeda wetem eni woman olsem iu tufala maret?*	YES, CURRENTLY MARRIED . . . . . 1 YES, LIVING WITH A WOMAN . . . . . 2 NO, NOT IN UNION 3	→ 404
402	Have you ever been married or lived together with a woman as if married? *Waswe, iu bin maret bifoa or stap tugeda wetem eni woman olsem iu tufala maret?*	YES, FORMERLY MARRIED . . . . . 1 YES, LIVED WITH A WOMAN . . . . . 2 NO 3	→ 413
403	What is your marital status now: are you widowed, divorced, or separated? Waswe, iu maret iet distaem: or iu wido, divos, or	WIDOWED . . . . . 1 DIVORCED . . . . . 2 SEPARATED 3	→ 410
404	Is your (wife/partner) living with you now or is she staying elsewhere? *Waswe, (waef/patna) blong iu hem stap wetem iu distaem or hem stap long nara ples?*	LIVING WITH HIM . . . . . 1 STAYING ELSEWHERE 2	
405	Do you have other wives or do you live with other women as if married? *Waswe, iu garem eni waef moa or iu stap wetem nara woman olsem iu tufala maret?*	YES (MORE THAN ONE) . . . . . 1 NO (ONLY ONE) 2	→ 407
406	Altogether, how many wives or live-in partners do you have? *Oltugeda, hao meni waef or patna nao iu stap wetem or iu garem?*	TOTAL NUMBER OF WIVES AND LIVE-IN PARTNERS . . .	
407 408	CHECK 405: ONE WIFE/ PARTNER → Please tell me the name of (your wife/the woman you are living with as if married). *Plis talem mi nem blong(waef /woman iu stap wetem olsem iu tufala* MORE THAN ONE WIFE/ PARTNER → Please tell me the name of each of your wives or each woman you are living with as if married. *Plis talem mi nem blong olketa waef or eni woman iu stap wetem olsem iu tufala maret.* RECORD THE NAME AND THE LINE NUMBER FROM THE HOUSEHOLD QUESTIONNAIRE FOR EACH WIFE AND LIVE-IN PARTNER. IF A WOMAN IS NOT LISTED IN THE HOUSEHOLD, RECORD '00'. ASK 408 FOR EACH PERSON.	NAME / LINE NUMBER _____ ☐☐ _____ ☐☐ _____ ☐☐ _____ ☐☐	408 How old was (NAME) on her last birthday? **(1)** AGE ☐☐ ☐☐ ☐☐ ☐☐	
409	CHECK 407: ONE WIFE/ PARTNER → MORE THAN ONE WIFE/ PARTNER →		→ 411A

410	Have you been married or lived with a woman only once or more than once? *Waswe, iu bin maret or stap wetem eni woman wan taem nomoa or moa dan wan taem?*	ONLY ONCE . . . . . 1 MORE THAN ONCE 2	→ 411A
411 411A	In what month and year did you start living with your (wife/partner)? *Long wat manis an yia nao iu stat stap wetem (waef/patna) blong iu?* Now I would like to ask about your first (wife/partner). In what month and year did you start living with her? *Distaem mi laek askem iu abaot fes (wife/patna). Long wat manis an yia nao iu stat fo stap wetem*	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] DON'T KNOW YEAR 9998	→ 413
412	How old were you when you first started living with *Hao ol nao iu,fes taem iu stat stap wetem hem?*	AGE . . . . . [ ][ ]	
413	CHECK FOR THE PRESENCE OF OTHERS. BEFORE CONTINUING, MAKE EVERY EFFORT TO ENSURE PRIVACY.		
414	Now I would like to ask some questions about sexual activity in order to gain a better understanding of some important life issues. How old were you when you had sexual intercourse for the very first time? *Distaem mi laek askem kuesten abaot olketa aktiviti long saed long seks fo getem gud samfala impoten samting long laef.* *Hao ol nao iu, fes taem iu havem seks?*	NEVER HAD SEXUAL INTERCOURSE . . . . . 00 AGE IN YEARS . . . . . [ ][ ] FIRST TIME WHEN STARTED LIVING WITH (FIRST) WIFE/PARTNER 95	→ 501
415	Now I would like to ask you some questions about your recent sexual activity. Let me assure you again that your answers are completely confidential and will not be told to anyone. If we should come to any question that you don't want to answer, just let me know and we will go to the next question. *Distaem mi laek askem iu samfala kuesten abaot samfala aktiviti blong iu long saed long seks. Mi laek talem iu moa dat evri ansa iu givim kam hem tambu fo talem aot long eniwan. Sapos iumi kasem eni kuesten an iu les fo ansarem, iu talem mi mekem iumi muv go moa long nara kuesten.*		
416	When was the last time you had sexual intercourse? *Wat taem nao iu las havem seks?* IF LESS THAN 12 MONTHS, ANSWER MUST BE RECORDED IN DAYS, WEEKS OR MONTHS. IF 12 MONTHS (ONE YEAR) OR MORE, ANSWER MUST BE RECORDED IN YEARS.	DAYS AGO . . . . . 1 WEEKS AGO . . . . . 2 MONTHS AGO . . . . . 3 YEARS AGO 4	→ 430

		LAST SEXUAL PARTNER	SECOND-TO-LAST SEXUAL PARTNER	THIRD-TO-LAST SEXUAL PARTNER
417	When was the last time you had sexual intercourse with this person? *Wat taem nao iu las havem seks wetem disfala peson?*		DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3
418	The last time you had sexual intercourse (with this second/third person), was a condom used? *Las taem iu havem seks (wetem disfala sekon/mek tri peson), iu tufala iusim condom tu?*	YES . . . . 1 NO . . . . 2 (SKIP TO 420)	YES . . . . 1 NO . . . . 2 (SKIP TO 420)	YES . . . . 1 NO . . . . 2 (SKIP TO 420)
419	Was a condom used every time you had sexual intercourse with this person in the last 12 months? *Waswe iu iusim condom evri taem iu havem seks wetem disfala peson insaed las tuelv manis?*	YES . . . . 1 NO 2	YES . . . . 1 NO 2	YES . . . . 1 NO 2
420	What was your relationship to this person with whom you had sexual intercourse? *Wat nao konekson blong iu wetem peson ia wea iu havem seks wetem?* IF GIRLFRIEND: Were you living together as if married? *Iufala stap tugeda olsem iufala maret?* IF YES, CIRCLE '2'. IF NO, CIRCLE '3'.	WIFE . . . . 1 LIVE-IN PARTNER . . . . . 2 GIRLFRIEND NOT LIVING WITH RESPONDENT . . . . . 3 CASUAL ACQUAINTANCE . . . 4 CLIENT/PROSTITUTE 5 OTHER ___________ 6 (SPECIFY) (SKIP TO 423)	WIFE . . . . 1 LIVE-IN PARTNER . . . . . 2 GIRLFRIEND NOT LIVING WITH RESPONDENT . . . . . 3 CASUAL ACQUAINTANCE . . . 4 CLIENT/PROSTITUTE 5 OTHER ___________ 6 (SPECIFY) (SKIP TO 423)	WIFE . . . . 1 LIVE-IN PARTNER . . . . . 2 GIRLFRIEND NOT LIVING WITH RESPONDENT . . . . . 3 CASUAL ACQUAINTANCE . . . 4 CLIENT/PROSTITUTE 5 OTHER ___________ 6 (SPECIFY) (SKIP TO 423)
421	CHECK 410:	MARRIED ONLY ONCE ☐ MARRIED MORE THAN ONCE OR BLANK ☐ (SKIP TO 423)	MARRIED ONLY ONCE ☐ MARRIED MORE THAN ONCE OR BLANK ☐ (SKIP TO 423)	MARRIED ONLY ONCE ☐ MARRIED MORE THAN ONCE OR BLANK ☐ (SKIP TO 423)
422	CHECK 414:	FIRST TIME WHEN STARTED LIVING WITH FIRST WIFE (SKIP TO 424) OTHER ☐	FIRST TIME WHEN STARTED LIVING WITH FIRST WIFE (SKIP TO 424) OTHER ☐	FIRST TIME WHEN STARTED LIVING WITH FIRST WIFE (SKIP TO 424) OTHER ☐
423	*How long ago did you first have sexual intercourse with this (second/third) person?* *Sins wat taem nao iu fes havem seks wetem disfala (sekon/mek tri) peson?*	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3 YEARS AGO 4	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3 YEARS AGO 4	DAYS AGO 1 WEEKS AGO 2 MONTHS AGO 3 YEARS AGO 4

424	How many times during the last 12 months did you have sexual intercourse with this person? IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF TIMES IS 95 OR MORE, WRITE '95'. *Hao meni taem insaed las tuelv manis nao iu havem seks wetem disfala peson?*	NUMBER OF TIMES ☐☐	NUMBER OF TIMES ☐☐	NUMBER OF TIMES ☐☐
425	How old is this person? *Hao ol nao disfala peson?*	AGE OF PARTNER ☐☐ DON'T KNOW 98	AGE OF PARTNER ☐☐ DON'T KNOW 98	AGE OF PARTNER ☐☐ DON'T KNOW 98
426	Apart from (this person/these two people), have you had sexual intercourse with any other person in the last 12 months? *Waswe, besaed (disfala peson/wetem tufala pipol ia),waswe iu bin havem seks wetem eni wan moa insaed las tuelv manis?*	YES . . . . . 1 (GO BACK TO 417 IN NEXT COLUMN) NO . . . . . 2 (SKIP TO 428)	YES . . . . . 1 (GO BACK TO 417 IN NEXT COLUMN) NO . . . . . 2 (SKIP TO 428)	
427	In total, with how many different people have you had sexual intercourse in the last 12 months? IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS 95 OR MORE, WRITE '95'. *Ol tugeda, wetem hao meni difren pipol nao iu havem seks wetem insaed las tuelv manis?*			NUMBER OF PARTNERS LAST 12 MONTHS . . . ☐☐ DON'T KNOW . . . 98

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
428	CHECK 420 (ALL COLUMNS): AT LEAST ONE PARTNER IS PROSTITUTE ☐ NO PARTNERS ARE PROSTITUTES ☐ → 430		
429	CHECK 420 AND 418 (ALL COLUMNS): CONDOM USED WITH EVERY PROSTITUTE ☐ → 433 OTHER ☐ → 434		
430	In the last 12 months, did you pay anyone in exchange for having sexual intercourse? *Insaed las tuelv manis, iu peim eni wan fo hem havem seks wetem iu ?*	YES . . . . . 1 NO 2	→ 432
431	Have you ever paid anyone in exchange for having sexual intercourse? *Waswe, enitaem iu bin peim eni wan fo havem seks wetem iu?*	YES . . . . . 1 NO 2	→ 434
432	The last time you paid someone in exchange for having sexual intercourse, was a condom used? *Long las taem iu bin peim samwan fo havem seks wetem iu, iufala iusim condom tu?*	YES . . . . . 1 NO 2	→ 434
433	Was a condom used during sexual intercourse every time you paid someone in exchange for having sexual intercourse in the last 12 months? *Waswe, iufala save iusim condom evri taem iu peim samwan fo havem seks wetem iu insaed las tuelv*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
434	In total, with how many different people have you had sexual intercourse in your lifetime? *Ol tugeda, hao meni difren pipol nao iu havem seks wetem long ful laeftaem blong iu?* IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS 95 OR MORE, WRITE '95'.	NUMBER OF PARTNERS IN LIFETIME . . . . . ☐☐ DON'T KNOW 98	
435	CHECK 418, MOST RECENT PARTNER (FIRST COLUMN): NOT ASKED ☐ → 438 CONDOM USED ☐ NO CONDOM USED ☐ → 438		
436	You told me that a condom was used the last time you had sex. What is the brand name of the condom used at that time? *Iu talem mi dat iufala iusim condom long las taem iu havem seks. Wat nao bran nem blong condom iufala iusim long taem ia?* IF BRAND NOT KNOWN, ASK TO SEE THE PACKAGE.	HIS . . . . . 01 SURE . . . . . 02 ROUGH RIDER . . . . . 03 SAFE RIDER . . . . . 04 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	

437	From where did you obtain the condom the last time? *Wea nao iu bin tekem olketa condom ia long las taem?* PROBE TO IDENTIFY TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSP . . . . . 11 PRONCIAL HOSPITAL . . . . . 12 URBAN AREA HEALTH CENTRE . . . 13 AREA HEALTH CENTRE . . . . . 14 RURAL HEALTH CENTRE . . . . . 15 NURSE AID POST , , , , , , , , , , , , 16 SATELLITE CLINICS . . . . . 17 OTHER PUBLIC SECTOR _____ 18 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC . . . . . 21 PHARMACY . . . . . 22 PRIVATE DOCTOR . . . . . 23 OTHER PRIVATE MEDICAL SECTOR _____ 26 (SPECIFY) NGO/OTHER SOURCE SIPPA CLINIC . . . . . 31 SIPPA CBD . . . . . 32 SAVE THE CHILDREN FUND . . . . . 33 CHURCH . . . . . 34 SHOP . . . . . 35 FRIEND/RELATIVE . . . . . 36 OTHER _____ 96 (SPECIFY)	
438	The last time you had sex did you or your partner use any method (other than a condom) to avoid or prevent a pregnancy? *Long las taem iu havem seks, iu or patna blong iu bin iusim eni nara metod (no condom seleva nomoa) fo stopem babule?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 501
439	What method did you or your partner use? PROBE: Did you or your partner use any other method to prevent pregnancy? RECORD ALL MENTIONED. *Wat kaen metod nao iutufala patna blong iu iusim?* *Waswe, iutufala patna blong iu bin iusim nara metod fo stopem babule?*	FEMALE STERILIZATION . . . . . A MALE STERILIZATION . . . . . B IUD . . . . . C INJECTABLES . . . . . D IMPLANTS . . . . . E PILL . . . . . F FEMALE CONDOM . . . . . G DIAPHRAGM . . . . . H FOAM/JELLY . . . . . I LAM . . . . . J RHYTHM METHOD . . . . . K WITHDRAWAL . . . . . L OTHER MODERN METHOD . . . . . X OTHER TRADITIONAL METHOD . . . . . Y	

SECTION 5. FERTILITY PREFERENCES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	CHECK 401: CURRENTLY MARRIED OR LIVING WITH A PARTNER NOT CURRENTLY MARRIED AND NOT LIVING WITH A PARTNER → 509		
502	CHECK 439: MAN NOT STERILIZED MAN STERILIZED → 509		
503	(Is your (wife/partner)/Are any of your (wives/partners)) currently pregnant? *(Waswe(waef blo iu/patna)/ Eniwan long olketa (waef/patnas)) babule distaem?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	8 → 505
504	Now I have some questions about the future. After the (child/children) you and your (wife(wives)/partner(s)) are expecting now, would you like to have another child, or would you prefer not have any more children? *Distaem mi garem samfala kuesten abaot fiutsa. Bihaen (pikinini/olketa pikinini) iu wetem (waef(olketa waef)/patnas(s)wea babule distaem, iutufala laekem nara pikinini moa, or les fo garem eni moa pikinini?*	HAVE ANOTHER CHILD . . . . . 1 → 506 NO MORE . . . . . 2 UNDECIDED/DON'T KNOW . . . . . 8 → 509	
505	Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children? *Distaem mi garem samfala kuesten abaot fiutsa. Waswe, iu laekem fo garem (wan/nara) pikinini, or iu les nao an no laekem eni (moa) pikinini?*	HAVE (A/ANOTHER) CHILD . . . . . 1 NO MORE/NONE . . . . . 2 SAYS COUPLE CAN'T GET PREGNANT . . . . . 3 WIFE (WIVES)/PARTNER(S) STERILIZED . . . . . 4 UNDECIDED/DON'T KNOW 8	1 2 3 4 8 → 509
506	CHECK 407: ONE WIFE/ PARTNER MORE THAN ONE WIFE/ PARTNER → 508		
507	CHECK 503: WIFE/PARTNER NOT PREGNANT OR DON'T KNOW WIFE/PARTNER PREGNANT How long would you like to wait from now before the birth of (a/another) child? *Hao long nao iu laek weit stat distaem bifoa (wan/nara) pikinini hem bon?* After the birth of the child you are expecting now, how long would you like to wait before the birth of another child? *Afta pikinini hem bon, hao long moa nao iu laek weit bifoa nara pikinini hem bon?*	MONTHS . . . . . 1 YEARS . . . . . 2 SOON/NOW . . . . . 993 COUPLE INFECUND . . . . . 994 OTHER _____ 996 (SPECIFY) DON'T KNOW 998	→ 509

508	How long would you like to wait from now before the birth of (a/another) child? *Hao long moa nao iu laek weit bifoa (wan/nara) pikinini hem bon?*	MONTHS . . . . . 1 YEARS . . . . . 2 SOON/NOW . . . . . 993 HE/ALL HIS WIVES/PARTNERS ARE INFECUND . . . . . 994 OTHER _____ 996 (SPECIFY) DON'T KNOW 998	
509	CHECK 203 AND 205: HAS LIVING CHILDREN ☐ NO LIVING CHILDREN ☐ If you could go back to the time 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? If you could choose exactly the number of children to have in your whole life, how many would that be? PROBE FOR A NUMERIC RESPONSE. *Sapos iu save go baek long taem iu no garem eni pikinini an save siusim barava namba long pikinini fo garem long hol laef blong iu, bae hao* *Sapos iu save siusim barava namba long pikinini fo garem long hol laef blong iu, bae hao meni nao ia?*	NONE . . . . . 00 → 601 NUMBER . . . . . ☐☐ OTHER _____ 96 → 601 (SPECIFY)	
510	How many of these children would you like to be boys, how many would you like to be girls and for how many would it not matter if it's a boy or a girl? *Hao meni long oketa pikinini nao iu bae laekem fo boe, hao meni nao iu bae laekem fo gele an hao meni nao iu bae laekem nomata hem boy or gele?*	BOYS GIRLS EITHER NUMBER ☐☐ ☐☐ ☐☐ OTHER _____ 96 (SPECIFY)	

SECTION 6. EMPLOYMENT AND GENDER ROLES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Have you done any work in the last seven days? *U bin duim eni waka insaet long las seven deis?*	YES . . . . . 1 NO 2	→ 604
602	Although you did not work in the last seven days, do you have any job or business from which you were absent for leave, illness, vacation, or any other such reason? *Nomata iu no waka long las seven deis, bata waswe iu garem eni waka or bisnis wea iu no go atendim bikos iu tekem liv, or iu siki, holidei or eni nara fala*	YES . . . . . 1 NO 2	→ 604a
603	Have you done any work in the last 12 months? *Waswe, iu duim eni waka tu insaed las tuelv manis?*	YES . . . . . 1 NO 2	→ 607
604	What is your occupation, that is, what kind of work do you mainly do? *Wat nao waka blong iu, olsem, wat kaen waka nao iu save duim olowe?*	☐☐☐☐ _____ _____ _____	
604a	What is the main industry that you work in? Wat nao barava mein industry wea iu waka insaet?	☐☐☐☐ _____ _____ _____	
605	Do you usually work throughout the year, or do you work seasonally, or only once in a while? *Iu save waka truaot long yia, or waka folom sison nomoa, or fo wan taem nomoa?*	THROUGHOUT THE YEAR . . . . . 1 SEASONALLY/PART OF THE YEAR 2 ONCE IN A WHILE 3	
606	Are you paid in cash or kind for this work or are you not paid at all? *Waswe olketa peim iu long seleni or givim iu eni samting fo waka iu duim or iu no tekem eni pei?*	CASH ONLY . . . . . 1 CASH AND KIND . . . . . 2 IN KIND ONLY . . . . . 3 NOT PAID 4	→ 607
606a	What sector are you working in? *Wat nao sekta wea iu waka insaet?*	PUBLIC SECTOR . . . . . 1 PRIVATE SECTOI . . . . . 2 RELIGIOUS ORGANISATION . . . . . 3 OTHER _____ 6 (SPECIFY)	
606b	How many hours you worked a week? *Hao meni hours nao iu waka fo hem inside long wan*	☐☐	
606c	How long have you been working at this job? *Hao long nao iu bin waka kam long disfala waka?*	MONTHS ☐☐ YEARS ☐☐	

606d	How much did you earn from this job in the last 12 *Hao mas seleni nao iu tekem from disfala waka las 12 manis?*	GROSS CASH ☐☐☐☐☐☐ NET CASH (TAKE HOME PAY) ☐☐☐☐☐☐	
607	CHECK 401: CURRENTLY MARRIED OR LIVING WITH A PARTNER ☐ NOT CURRENTLY MARRIED AND NOT LIVING WITH A PARTNER ☐ → 612		
608	CHECK 606a: CODE 1 OR 2 CIRCLED ☐ OTHER ☐ → 610		
609	Who usually decides how the money you earn will be used: you, your (wife/partner), or you and your (wife/partner) jointly? *Hu nao fo disaed hao nao baebae iusim seleni iu wak fo hem: iu, (waef/patna blong iu), or iu wetem (waef/patna) tugeda?*	RESPONDENT . . . . . 1 WIFE/PARTNER . . . . . 2 RESPONDENT AND WIFE/ PARTNER JOINTLY . . . . . 3 OTHER _____ 6 (SPECIFY)	
610	Who usually makes decisions about health care for yourself: you, your (wife/partner), you and your (wife/partner) jointly, or someone else? *Hu nao save disaed abaot helt kea: fo iuseleva,(waef/patna), iu an (waef/patna) tugeda or eniwan moa?*	RESPONDENT . . . . . 1 WIFE/PARTNER . . . . . 2 RESPONDENT AND WIFE/ PARTNER JOINTLY . . . . . 3 SOMEONE ELSE . . . . . 4 OTHER _____ 6 (SPECIFY)	
611	Who usually makes decisions about making major household purchases? *Hu nao save mekem disison long wat nao oketa mein samting fo peim fo haos?*	RESPONDENT . . . . . 1 WIFE/PARTNER . . . . . 2 RESPONDENT AND WIFE/ PARTNER JOINTLY . . . . . 3 SOMEONE ELSE . . . . . 4 OTHER _____ 6 (SPECIFY)	
612	Do you own this or any other house either alone or jointly with someone else? *Iu onam diswan or eni haos moa wea iu onam seleva or iu onam tugeda wetem eni wan moa?*	ALONE ONLY . . . . . 1 JOINTLY ONLY . . . . . 2 BOTH ALONE AND JOINTLY . . . . . 3 DOES NOT OWN 4	
613	Do you own any land either alone or jointly with someone else? *Iu onam eni lan seleva or iu onam tugeda wetem eni wan moa?*	ALONE ONLY . . . . . 1 JOINTLY ONLY . . . . . 2 BOTH ALONE AND JOINTLY . . . . . 3 DOES NOT OWN 4	
614	In your opinion, is a husband justified in hitting or beating his wife in the following situations: *Long tingting blong iu, hasban hem garem raet fo hitim or kilim waef from oketa samting olsem :* If she goes out without telling him? *Sapos hem go aot bat no talem hem* If she neglects the children? *Sapos hem no ting hevi an tek kea long olketa* If she argues with him? *Sapos hem raoa wetem hem?* If she refuses to have sex with him? *Sapos hem les fo havem seks wetem hem?* If she burns the food? *Sapos hem bonem kaikai?*	YES NO DK GOES OUT . . . . . 1 2 8 NEGL. CHILDREN . . . 1 2 8 ARGUES . . . . . 1 2 8 REFUSES SEX . . . . . 1 2 8 BURNS FOOD 1 2 8	

SECTION 7. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	Now I would like to talk about something else. Have you ever heard of an illness called Acquired Immunodeficiency Syndrom (AIDS)? *Distaem mi laek tok abaot nara samting. Iu herem tu abaot disfala sik oketa kolem long (AIDS)?*	YES . . . . . 1 NO 2	→ 722
702	Can people reduce their chance of getting the AIDS virus by having just one uninfected sex partner who has no other sex partners? *Waswe,olketa pipol save ridiusim sans blong olketa fo no garem HIV vaeres sapos olketa garem wan seks patna wea hem no garem HIV vaeres an no eni ada seks patna?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
703	Can people get HIV from mosquito bites? *Waswe, HIV save kasem pipol from moskito baet?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
704	Can people reduce their chance of getting the HIV by using a condom every time they have sex? *Waswe, pipol save ridiusim sans fo HIV no kasem olketa sapos olketa iusim condom evri taem olketa havem seks?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
705	Can people get the HIV by sharing food with a person who has AIDS? *Waswe, HIV save kasem pipol sapos olketa searem kaikai wetem peson wea garem AIDS ?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
706	Can people get the HIV because of witchcraft or other supernatural means? *Waswe,pipol save garem HIV bikos from majik wetem samfala unusual spirit wea hem hapen ?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
707	Is it possible for a healthy-looking person to have HIV? *Waswe, eni peson wea hem luk helti, HIV save kasem hem tu?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
708	Can HIV that causes AIDS be transmitted from a mother to her baby: During pregnancy? During delivery? By breastfeeding? *Waswe, HIV wea save kosim AIDS hem save pas on from Mami go long bebi:* *Taem hem babule ?* *Taem hem bonem pikinini?* *Taem hem Susum bebi?*	YES NO DK DURING PREG. . . . . 1 2 8 DURING DELIVERY . . . 1 2 8 BREASTFEEDING . . . 1 2 8	
709	CHECK 708: AT LEAST ONE 'YES' ☐ ↓ OTHER ☐ →		→ 711
710	Are there any special drugs that a doctor or a nurse can give to a woman infected by HIV to reduce the risk of transmission to the baby? *Waswe, eni spesol meresin hem stap wea dokta or nes save givim long woman wea garem HIV fo katem daon risk fo pasim go long bebi?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

711	CHECK FOR PRESENCE OF OTHERS. BEFORE CONTINUING, MAKE EVERY EFFORT TO ENSURE PRIVACY.		
712	I don't want to know the results, but have you ever been tested to see if you have HIV? *Mi no laek save long risalt, bat eni taem iu bin duim test nogud iu garem HIV?*	YES . . . . . 1 NO 2	→ 716
713	How many months ago was your most recent HIV test? *Hao meni manis go finis nao iu duim las HIV test blong iu?*	MONTHS AGO . . . . . [ ][ ] TWO OR MORE YEARS 95	
714	I don't want to know the results, but did you get the results of the test? *Mi no laek save risalt, bat waswe iu tekem risalt blong test blong iu?*	YES . . . . . 1 NO 2	
715	Where was the test done? *Wea nao olketa duim test ia?* PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSP . . . . . 11 PROVINCIAL HOSPITAL . . . . . 12 URBAN AREA HEALTH CENTRE . . . 13 RURAL HEALTH CENTRE . . . . . 14 STAND-ALONE VCT CENTER . . . . . 15 FAMILY PLANNING CLINIC . . . . . 16 MOBILE CLINIC . . . . . 17 SCHOOL BASED CLINIC . . . . . 18 OTHER PUBLIC SECTOR _____ 19 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR . . . . . 21 STAND-ALONE VCT CENTER . . . 22 PHARMACY . . . . . 23 MOBILE CLINIC . . . . . 24 FIELDWORKER . . . . . 25 SCHOOL BASED CLINIC . . . . . 26 OTHER PRIVATE MEDICAL SECTOR _____ 27 (SPECIFY) OTHER SOURCE HOME . . . . . 31 CORRECTIONAL FACILITY . . . . . 32 OTHER _____ 96 (SPECIFY)	→ 718
716	Do you know of a place where people can go to get tested for HIV? *Waswe, iu save long eni ples wea pipol save go fo duim test fo HIV?*	YES . . . . . 1 NO 2	→ 718

717	Where is that? *Wea nao ia?* Any other place? *Eni ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C RURAL HEALTH CENTRE . . . . . D STAND-ALONE VCT CENTER . . . E FAMILY PLANNING CLINIC . . . . . F MOBILE CLINIC . . . . . G SCHOOL BASED . . . . . H OTHER PUBLIC SECTOR _____ I (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR . . . . . J STAND-ALONE VCT CENTER . . . K PHARMACY . . . . . L MOBILE CLINIC . . . . . M FIELDWORKER . . . . . N OTHER PRIVATE MEDICAL SECTOR _____ O (SPECIFY) OTHER _____ X (SPECIFY)	
718	Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV? *Waswe. Iu bae stil peim vejtabol from eni stoa keeper or olketa wea save sel long smol maket nomata iu save dat hem garem HIV?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
719	If a member of your family got infected with HIV, would you want it to remain a secret or not? *Sapos wanfala memba long famili blong iu hem infekted wetem HIV, bae iu wandem fo kipim olsem sikret or nomoa?*	YES, REMAIN A SECRET . . . . . 1 NO . . . . . 2 DK/NOT SURE/DEPENDS 8	
720	If a member of your family became sick with AIDS, would you be willing to care for her or him in your own household? *Sapos wanfala memba long famili blong iu hem sik wetem AIDS, bae iu wiling fo lukafterem hem long oun haos blong iu?*	YES . . . . . 1 NO . . . . . 2 DK/NOT SURE/DEPENDS 8	
721	In your opinion, if a female teacher has HIV but is not sick, should she be allowed to continue teaching in the school? *Long tingting blong iu, sapos wanfala mere tisa hem garem HIV bat hem no sik, hem olraet fo olketa letem hem fo gohed tisa nomoa long skul?*	SHOULD BE ALLOWED . . . . . 1 SHOULD NOT BE ALLOWED . . . . . 2 DK/NOT SURE/DEPENDS 8	
722	CHECK 701: HEARD ABOUT AIDS → Apart from AIDS, have you heard about other infections that can be transmitted through sexual contact? *Apat from AIDS, iu bin herem abaot olketa nara sik wea save pasim raon tru seks?* NOT HEARD ABOUT AIDS → Have you heard about infections that can be transmitted through sexual contact? Waswe iu herem abaotem sik wea hem save pas taem iu havem seks kontakt?	YES . . . . . 1 NO 2	

723	CHECK 414: HAS HAD SEXUAL INTERCOURSE ☐ ↓ HAS NOT HAD SEXUAL INTERCOURSE ☐ → 731		
724	CHECK 722: HEARD ABOUT OTHER SEXUALLY TRANSMITTED INFECTIONS? YES ☐ ↓ NO ☐ → 726		
725	Now I would like to ask you some questions about your health in the last 12 months. During the last 12 months, have you had a disease which you got through sexual contact? *Distaem mi laek askem iu samfala kuesten abaot helt blong iu insaed las tuelv manis.Insaed las tuelv manis, iu garem eni sik wea hem kasem iu bikos from seks kontakt.*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
726	Sometimes men experience an abnormal urethral discharge from their penis. During the last 12 months, have you had an abnormal urethral discharge from your penis? *Samtaem olketa man save expirensim rabis wata wea hem smel nogut save kam aot long koko blong olketa* *Long las tuelv manis, iu garem rabis wata wea smel nogut hem kamaot long koko blong iu?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
727	Sometimes men have a sore or ulcer near their penis. During the last 12 months, have you had a sore or ulcer near your penis? *Samtaem olketa man save garem soa or ulcer kolsap koko blong olketa. Insaed las tuelv manis,iu garem soa or ulcer kolsap koko blong iu?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
728	CHECK 725, 726, AND 727: HAS HAD AN INFECTION (ANY 'YES') ☐ ↓ HAS NOT HAD AN INFECTION OR DOES NOT KNOW ☐ → 731		
729	The last time you had (PROBLEM FROM 725/726/727), did you seek any kind of advice or treatment? *Long las taem iu garem (PROBLEM FROM 725/726/727), iu go faendem advaes or tritmen?*	YES . . . . . 1 NO . . . . . 2 → 731	

730	Where did you go? *Wea nao iu go?* Any other place? *Eni ples moa?* PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S))	PUBLIC SECTOR NATIONAL REFERAL HOSPITAL . . . A PROVINCIAL HOSPITAL . . . . . B URBAN AREA HEALTH CENTRE . . . C RURAL HEALTH CENTRE . . . . . D HIV TESTING HEADQUATER . . . E HIV TESTING CLINICS . . . . . F OTHER PUBLIC SECTOR _____ G (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR . . . . . H STAND-ALONE VCT CENTER . . . I PHARMACY . . . . . J MOBILE CLINIC . . . . . K FIELDWORKER . . . . . L OTHER PRIVATE MEDICAL SECTOR _____ M (SPECIFY) OTHER SOURCE SHOP . . . . . N OTHER _____ X (SPECIFY)	
731	Is a wife justified in refusing to have sex with her husband when she knows her husband has sex with other women? *Waswe, waef hem garem raet fo se hem les fo havem seks wetem hasban blong hem taem hem save dat hasban blong hem havem seks tu wetem olketa nara woman?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

SECTION 8. OTHER HEALTH ISSUES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	Have you ever heard of an illness called tuberculosis or TB? *Waswe, iu bin herem finis wanfala siknis olketa kolem tuberculosis or TB?*	YES . . . . . 1 NO 2	→ 808
802	CHECK Q. 108: CODE '2', '3' OR '4' CIRCLED OR NO ANSWER ↓ CODE '1' OR '5' CIRCLED →		804
803	The following is a list of sources of information on tuberculosis or TB. Have you ever done any of the following? *Diswan hemi list blong olketa sos blong informeisin abaot tuberculosis or TB. Waswe, iu bin duim eniwan long olketa samtinq olsem?*	YES NO	
	a. Read messages about TB in newspapers or magazines? *Ridim olketa mesej abaot TB long niuspepa or magazin?*	NEWSPAPER/MAGAZINE . 1 2	
	b. Seen leaflets, brochures, or booklets on TB? *Ridim olketa smol buka abaotem TB?*	LEAFLETS/BOOKLETS . . . 1 2	
	c. Gotten information on TB from the internet? *Tekem infomeisin abaot TB long internet?*	INTERNET 1 2	
	READ INTRODUCTORY STATEMENT ONLY IF Q803 WAS NOT ASKED: The following is a list of sources of information on tuberculosis or TB. *Diswan hem list blong olketa sos blong informeisin abaot tuberculosis or TB?*		
804	Have you ever *Waswe, iu bin*	YES NO	
	a. Seen messages about TB on billboards, signs or posters? *Lukim mesej abaotim TB long advataisbod, long olketa saen an posta?*	SIGNS/POSTERS 1 2	
	b. Seen messages about TB on TV? *Lukim meseg abaotim TB lo TV?*	TV 1 2	
	c. Heard messages about TB on radio? *Herem meseg abaotim TB lo redio*	RADIO 1 2	
	d. Attended a community event about TB? *Bin atendem wanfala komunity mitin abaotem TB?*	COMMUNITY EVENT . . . 1 2	
	e. Received information about TB from an outreach work, that is, one who came to your community and talked about TB? *Risivim infomeisen abaot TB from wanfala toktok an visit abaotim TB?*	OUTREACH WORKER . . . 1 2	
	f. Participated in a TB peer education program? *Bin tekpat lo wanfal TB grup edukeisen program?*	PEER EDUCATION 1 2	
	g. Participated in another type of TB education program such as a wokshop or school program? *Bin tekpat lo nara fala taep TB edukeisen program olsem woksop o skul?*	OTHER EDUCATION 1 2	
	h. Discussed TB with other persons such as friend, family members, or work colleagues? *Tokabaotem TB wetem narafala pipol olsem frens, olketa memba blo famili o olketa man-mere iu wok wetem?*	FAMILY/FRIENDS 1 2	

805	How does tuberculosis spread from one person to another? *ɔ nao TB save go from wanfala peson go long narawa* PROBE: Any other ways? *Eni nara wei moa?* RECORD ALL MENTIONED.	THROUGH THE AIR WHEN COUGHING OR SNEEZING ..... A THROUGH SHARING UTENSILS ... B THROUGH TOUCHING A PERSON WITH TB ..... C THROUGH FOOD ..... D THROUGH SEXUAL CONTACT ... E THROUGH MOSQUITO BITES ..... F OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
806	Can tuberculosis be cured? *Waswe, TB garem meresin fo kiurem or nomoa?*	YES ..... 1 NO ..... 2 DON'T KNOW 8	
807	If a member of your family got tuberculosis, would you want it to remain a secret or not? *Sapos eni memba blo famili blo iu garem TB, waswe bae iu laekem fo stap haed nomoa o waswe?*	YES, REMAIN A SECRET ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/ DEPENDS 8	
808	Some men are circumcised. Are you circumcised? *Samfala man olketa katem skin blo koko. Waswe iu kat tu?*	YES ..... 1 NO ..... 2 DON'T KNOW 8	
809	**INJECTIONS** Now I would like to ask you some other questions relating to health matters. Have you had an injection for any reason in the last 12 months? *Distaem mi laek askem iu samfala kuestin moa abaotem samfala samting moa abaotem helt. Waswe eniwan bin ɑivim iu eni meresin lo nila insaet las 12 mans o nomoa?* IF YES: How many injections have you had? *Hao meni nila nao olketa givim iu?* IF NUMBER OF INJECTIONS IS GREATER THAN 90, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.	NUMBER OF INJECTIONS . ☐☐ NONE ..... 00 → 813a	
810	Among these injections, how many were administered by a doctor, a nurse, a pharmacist, a dentist, or any other health worker? *Lo olketa nila iu talem ia, hao meni nao dokta, nes, famasis, dokta blo titi o eni nara man o mere moa wea wak lo helt nao nilam iu?* IF NUMBER OF INJECTIONS IS GREATER THAN 90, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.	NUMBER OF INJECTIONS . ☐☐ NONE ..... 00 → 813a	

811	The last time you had an injection given to you by a health worker where did you go to get the injection? *Lo las taem iu tekem nila wea dokta o nes bin givim lo iu ia wea nao iu go fo olketa nilam iu ia?* PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. IF UNABLE TO DETERMINE IF HOSPITAL, HEALTH CENTER OR CLINIC IS PUBLIC, PRIVATE, CHURCH OR NGO MEDICAL FACILITY, THE NAME OF THE PLACE. _____ (NAME OF PLACE) _____ (NAME OF PLACE)	PUBLIC SECTOR GOVT. HOSPITAL . . . . . 11 RURAL HEALTH CENTRE . . . . . 12 RURAL HEALTH CLINIC . . . . . 13 NURSE AIDE POST . . . . . 14 SATELLITE CLINIC . . . . . 15 OTHER PUBLIC _____ 16 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE CLINIC . . . . . 21 PHARMACY . . . . . 22 PRIVATE DOCTOR . . . . . 23 OTHER PRIVATE MEDICAL/FACILITIES 24 _____ (SPECIFY) CHURCH HOSPITAL . . . . . 31 RURAL HEALTH CLINIC . . . . . 32 NURSE AIDE POST . . . . . 32 SATELLITE CLINIC . . . . . 34 OTHER OUTLET . . . . . 36 NGO/OTHER SOURCE SIPPA CLINIC . . . . . 41 SIPPA CBD . . . . . 42 SAVE THE CHILDREN FUND . 43 OTHER _____ 96 (SPECIFY)	
812	Did the person who gave you that injection take the syringe and needle from a new, unopened package? *Waswe datfala man o mere wea tekem disfala nila lo iu ia, hem bin tekem syrin and nila ia from wanfala niu paket wea hemi jas openem o nomoa?*	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
813a	**CIGARETTES AND TOBACCO USED** Now I am going to talk about tobacco and cigarettes use and they are the main causes of health problems. *Distaem mi laek tok abaotim use blong tobako an sigaret an olketa nao barava mein kos blong helt problems.* Have you ever tried cigarettes smoking even one or two puffs? *Waswe iu bin traem smokim sigaret nomata one o two pufs?*	YES . . . . . 1 NO . . . . . 2 → 815a	
813b	Do you currently smoke cigarettes? *Waswe, iu smokem sigaret distaem?*	YES . . . . . 1 NO . . . . . 2 → 815a	
814	In the last 24 hours, how many cigarettes did you smoke? *Insaet lo las 24 hours, hao meni sigaret nao iu smokem?*	CIGARETTES	
815a	Have you ever tried any smoked tobacco products other than cigarettes, such as twist tobacco, cigars, water pipe or pipe? *Waswe iu bin traem any smoke tobako prodakt from sigaret, olsem siga, wata pipe or pipe?*	YES . . . . . 1 NO . . . . . 2 → 817	
815b	Do you currently smoke or use any other type of tobacco? *Waswe, iu smok distaem o iu iusim eni nara kaen tobako?*	YES . . . . . 1 NO . . . . . 2 → 817	
816	What (other) type of tobacco do you currently smoke or use? *Wat nao olketa nara taep tobako wea iu smokem o iusim distaem?* RECORD ALL MENTIONED.	PIPE . . . . . A CHEWING TOBACCO . . . . . B SNUFF . . . . . C ROLLED LEKONA . . . . . D OTHER _____ X (SPECIFY)	

817	Are you covered by any health insurance? *Iu garem eni helt insurance?*	YES . . . . . 1 NO 2	→ 819
818	What type of health insurance? *Watkaen taep helt insurens nao ia?* RECORD ALL MENTIONED.	MUTUAL HEALTH ORGANIZATION/ *MUTUELLE* /COMMUNITY BASED HEALTH INSURANCE . . . . . A HEALTH INSURANCE THROUGH EMPLOYER . . . . . B SOCIAL SECURITY . . . . . C OTHER PRIVATELY PURCHASED COMMERCIAL HEALTH INSURANCE. D OTHER _____ X (SPECIFY)	
819	**ALCOHOL AND DRUG USE** Now I would like to ask you about alcohol and drug use. Remember that your responses are completely anonymous and confidential and will not be released to anyone. During the last 12 months, how often did you have drinks containing alcohol, such as beer, wine, liquor, spirits, homebrew, toddy, yeast? Would you say? *Distaem mi laek askem iu abaotem alkohol an drag. No foget dat olketa ansa blo iu baebae tambu tumas fo mi talem o givim lo eniwan moa ia, so iu no fraet fo ansa.* *Insaet las 12 mans, hao meni taem nao iu bin dringim alkohol olsem bia, waen, hotstaf, olketa nara hot dring, kwaso, hom-bru o todi?* Bae iu se? a. 4 or more times a week? *4 o winim 4 taems insaet wanfala wik?* b. 2 to 3 times a week? *2 go kasem 3 taems insaet wan wik?* c. 2 to 4 times a month? *2 go kasem 4 taems insaet wan wik?* d. Monthly or less? *Wan taem insaed long mans o less?* e. Never *Nating nao.* f. Don't know *Iu no save.* g. No answer / refused *No eni ansa/les fo ansa.*	NEVER . . . . . 0 4+ PER WEEK . . . . . 1 2-3 PER WEEK . . . . . 2 2-4 PER MONTH . . . . . 3 < 2 PER MONTH . . . . . 4 NO ANSWER/REFUSED . . . . . 7 DON'T KNOW 8	→ 822
820	During the last 12 months, how many standard drinks containing alcohol did you have on a typical day when drinking? A standard drink is a can of beer, a glass of wine, a shot of liquor, etc. *Insaet las 12 mans hao meni standad dring wea hem garem alkahol insaed nao iu save dringim lo wanfala tipikol dei? Standad dring hem minim wan fala tin-bia, wanfala glas lo waen o wan sisimol glas lo lika.* a. 20 or more? *20 o winim go moa.* b. 10 to 19? *10 go kasem 19.* c. 7, 8 or 9? d. 5 or 6? e. 3 or 4? f. 1 or 2? g. Don't know *(Iu no save)* h. No answer / refused *(No eni ansa/les fo ansa)*	NUMBER OF STANDARD DRINKS 20 OR MORE . . . . . 1 10 TO 19 . . . . . 2 7, 8 OR 9 . . . . . 3 5 OR 6 . . . . . 4 3 OR 4 . . . . . 5 1 OR 2 . . . . . 6 NO ANSWER/REFUSED . . . . . 7 DON'T KNOW 8	

821	During the last 12 months, how often did you have five or more standard drinks at one time? drinking? A standard drink is a can of beer, a glass of wine, a shot of liquor, etc. *Insaet las 12 mans hao ofen nao iu bin dringim faefala an go-ap lo olketa standad diring ia lo eniwan taem?* *Standad dring hem minim wanfala tin-bia, wanfala glas lo waen wan o wan sisimol glas lo lika an olketa samting olsem.* a. Daily or almost daily? *Evride, o kolsap evri de?* b. Weekly? *Evri Wik?* c. Monthly? *Evri mans?* d. Less than monthly? *Less than wan mans?* e. Never f. Don't know g. No answer / refused	NEVER . . . . . 0 DAILY OR ALMOST DAILY . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NO ANSWER/REFUSED . . . . . 7 DON'T KNOW 8	

822 — Next I would like to ask you about use of the following items. Have you ever tried…?

Distaem mi laek askem iu abaotem olketa samting olsem moa: Iu bin traem…

IF YES, ASK: Did you use it in the last 30 days? *Iu iusim insaet las 30 days o?*

	NEVER TRIED	EVER TRIED	USED IN LAST 30 DAYS	NO ANSWER, REFUSED
a. Betel nut?	1	2	3	7
b. Sakau/Kava?	1	2	3	7
c. Marijuana/Cannibis	1	2	3	7
d. Ectasy/E/Eccies?	1	2	3	7
e. Inhalants including gas?	1	2	3	7
f. Speed/Base/Other amphetamines?	1	2	3	7
g. Ice/Crystal meth?	1	2	3	7
h. Cocaine/Crack/Freebasing?	1	2	3	7
i. Heroin?	1	2	3	7
j. LSD/Acid/Hallucinogens?	1	2	3	7
k. Steroids (non-medical use)?	1	2	3	7
l. Viagra/Cialis/Sex enhancers?	1	2	3	7

823	Some people have tried injecting drugs using a syringe. In the last 12 months, have you injected drugs (not including injections for medial reasons or treatment of an illness)? *Samfala pipol save trae fo nilam olketa seleva wetem drugs. Waswe, iu bin nilam iu seleva wetem drugs insaet las 12 mans o nomoa (no includim nila wea iu tekem saed lo medical helt an tritmen for sik blo iu)?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
824	**CONDITIONS OF BONES AND MUSCLES** The following questions will ask about conditions of the bones, muscles and their attachements such as joints. *Distaem bae olketa questens bae hem folo ia, bae hem ask abaotem condison blo bones, masols and olketa samting wea conectin olketa olsem joints.* In the past **4 weeks**, have you had pain in your low back (in the area shown on the diagram)? *Insaet long las **4 weeks** iu bin garem pein long low backsaed blong iu?* SHOW DIAGRAM TO RESPONDENT	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 826

825	Was this pain bad enough to limit your usual activities or change your daily routine for more than one day? *Waswe disfala pein hem nogut tumas wea hem mekem iu fo no save duim olketa nomol waka blo iu or sensim day to day waka blo iu fo ovam wanfala dei?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
826	In the past **4 weeks,** have you had pain in your neck (in the area shown on the diagram)? SHOW DIAGRAM TO RESPONDENT *Insaet long las 4 wiks, iu bin garem pein insaet long neck blong iu?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 828
827	Was this pain bad enough to limit your usual activities or change your daily routine for more than one day? *Waswe disfala pein hem nogut tumas wea hem mekem iu fo no save duim olketa nomol waka blo iu or sensim day to day waka blo iu fo ovam wanfala dei?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
828	In the last 4 weeks have you had any pain in your hips or knees? *Insaet long las 4 wiks, iu bin garem pein insaet long hips* or knees blong iu?	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 833
829	Was this pain bad enough to limit your usual activities or change your daily routine for more than one day? *Waswe disfala pein hem nogut tumas wea hem mekem iu fo no save duim olketa nomol waka blo iu or sensim day to day waka blo iu fo ovam wanfala dei?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
830	Has this problem lasted for **3 months or more?** *Waswe disfala problem hem stap kasim **3 manis or ovam?***	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	
831	For this problem have you been told by a medical doctor what the diagnosis is? *Fo disfala problem, eni dokta blo helt bin talem iu wanem nao sik ia?*	YES . . . . . 1 NO . . . . . 2 NO ANSWER, REFUSED 8	→ 833
832	What was the diagnosis? *Wanem nao sik ia?*	☐☐ _____	
833	RECORD THE TIME.	HOUR . . . . . ☐☐ MINUTES . . . . . ☐☐	

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____

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