



Planem Gud Famili Blong Yumi

KNOWLEDGE, ACCESS AND BARRIERS TO
FAMILY PLANNING IN RURAL VANUATU

Report by **FAMILY PLANNING NEW ZEALAND**
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Acronyms

HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IUD	Intrauterine Device
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmissible Infections
VFHA	Vanuatu Family Health Association
UNFPA	United Nations Population Fund

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Executive Summary

It is widely acknowledged that investing the sexual and reproductive health and rights (SRHR) of individuals will lead to improvements in health, development and economic outcomes. Vanuatu faces a range of persistent SRHR challenges.¹⁻³ These challenges include low levels of SRHR knowledge, limited access to family planning services and inconsistent availability of contraceptives. For the large proportion of the population who live in the remote and geographically dispersed areas of the country, these challenges are more pronounced compared to their urban counterparts. Addressing these gaps in knowledge and services and increasing the availability of commodities will improve the SRHR outcomes and general wellbeing for those living in these areas.

To understand these challenges more deeply and consider possible solutions, this study explores the experiences and perspectives of people living in the rural area of Big Bay Bush in Espiritu Santo, Vanuatu.ⁱ We conducted focus groups and interviews with both residents and health care providers in the area. They were asked to share their knowledge, perceptions and access to family planning services along with their reproductive decision making and

values. They were also asked to describe their knowledge and perceptions of sexually transmissible infections (STIs) and human immunodeficiency virus (HIV), including prevention knowledge and practices, and access to treatment services.

Key findings

- Many respondents demonstrated low levels of knowledge on basic anatomy, sexual activity, STIs, reproduction and family planning, including different contraceptive methods.
- Respondents described several barriers in seeking sexual and reproductive health (SRH) services including:
 - Logistical issues with infrastructure, transportation, and reliable supply of family planning commodities;
 - Social stigma and embarrassment as family planning is generally not openly discussed;
 - Conflicting views of the role of family planning within traditional/cultural values and belief systems;

ⁱ This research was part of a larger project by Family Planning New Zealand and the Vanuatu Family Health Association, Planem Gud Famili Blong Yumi ('Planning Our Families Well') which aims to increase access to SRHR services and education in the islands of Espiritu Santo, Gaua, and Pentecost in Vanuatu. This component of the project was designed to support, inform, and extend this project by assessing the realities of SRHR knowledge, access, and barriers in one of the project locations.

- Negative perceptions of family planning including myths and misinformation about modern contraceptive methods and their negative impact on fertility.
- Some respondents felt that family planning (including birth spacing and timing) was beneficial in that it:
 - Improves maternal health;
 - Decreases pressures on household finances and land resources;
 - Decreases domestic and childrearing workload for women.
- Respondents described how sexual and reproductive health decisions were primarily made by men and the strong cultural preference for women to have a several children.
- Respondents report that gender-based and sexual violence is common in their communities.

In light of these findings, the following recommendations are proposed to help improve SRHR in rural Vanuatu:

Recommendations

1. Develop educational programmes to increase knowledge and awareness of SRHR, including family planning methods and the spread of STIs with tailored programmes for young people and married couples.
2. Create family planning promotion messages that dispel myths and misinformation about modern contraceptive methods.
3. Design programmes on healthy relationships, consent and gender-based violence tailored for men, women, young people and service providers.
4. Develop training programmes for young people to become SRHR peer educators so that they can communicate their knowledge to others in their community.
5. Improve access to health facilities and explore new strategies to increase access to services in rural Vanuatu including mobile clinics and home visitations.
6. Prioritise making a wide variety of SRH commodities consistently available throughout Vanuatu, focussing on rural communities.
7. Conduct training with service providers on how to provide high-quality, non-judgemental sexual and reproductive health (SRH) care.

Introduction

Sexual and reproductive health and rights (SRHR) are fundamental to the overall health and wellbeing of individuals and their communities,¹ and crucial aspects of a person's sense of self, identity, and autonomy. SRHR 'is not merely the absence of disease, dysfunction or infirmity,'⁴ but includes the right to make the choices that affect their bodies including the ability to choose the timing, spacing and number of pregnancies⁴. To fulfil these rights, all individuals need to be able to access accurate and affordable SRHR information and services regardless of their age, sexual orientation, socioeconomic or marital status.

Kennedy *et al.*¹ note that investment in family planning is 'one of the most cost-effective global health and development initiatives', contributing to improved maternal and child health, women's empowerment, HIV and STI prevention, economic and educational development, and environmental sustainability.^{1,5-10} In the South Pacific region, and particularly in Vanuatu, significant SRHR gaps have been identified and persist; many of these could be effectively addressed with strategic investments.^{1-3,11,12}

The Sustainable Development Goals¹³ (SDGs) include several objectives which are relevant to the challenges in Vanuatu; target 3.7 on universal access to SRH information and services and target 5.2 on eliminating violence

against women and girls in all spheres of life, are particularly salient. These global objectives are also reflected in Vanuatu's SDG strategy, including targets around gender responsive planning, gender equality, and quality healthcare for all.¹⁴

The purpose of this research was to understand more about people's knowledge, access, and barriers to family planning and other SRHR services in the rural area of Big Bay Bush of Vanuatu. The area of Big Bay Bush constitutes the central inland area of the island Espiritu Santo in Vanuatu (see Figure 2¹⁵); it is a relatively remote area and one about which little is known regarding SRH access and provision. Researchers gathered data by conducting 17 focus groups (nine with men and eight with women) and in-depth interviews with 12 women in five communities in Big Bay Bush, as well as six interviews with SRHR stakeholders, including medical practitioners and policy makers. This research is a component of a parent project, *Planem Gud Famili Blong Yumi*, conducted by Family Planning New Zealand and Vanuatu Family Health Association (VFHA) and designed to increase access to SRH services, including family planning services, and improve knowledge of SRHR issues and facilities.

This report provides background information on the context of the research, and issues related to SRHR

in Vanuatu. The research methods are detailed and followed by the findings which are divided into:

- Knowledge and perceptions of family planning, STIs and HIV;
- Perceptions, access and barriers to condom use;
- Participants' ability to make decisions about reproduction and sex;
- Broader community values about reproduction and childrearing;
- Barriers to uptake of family planning and sexual health services.

The in-depth interviews undertaken by the primary researcher involved women sharing many details of their sexual and reproductive life journeys, including many stories related to cross cutting issues such as domestic violence and arranged marriage. In order to capture the depth of these stories, this report includes vignettes of some of these women's narratives.

This report ends with a discussion of the research findings as they relate to internationally agreed standards for the Right to the Highest Attainable Standard of Health, as outlined by the Committee on Economic, Social and Cultural Rights¹⁶. United Nations Population Fund (UNFPA) has adapted these standards to fit SRHR¹⁰; these include:

- Ensuring *availability* of family planning methods (including approachable services to provide these range of methods);
- *Accessibility*, or the ability for people to freely act to utilise SRHR services and access information. Accessibility can be influenced by attitudes of family members and the wider community, as well as costs and the geographical location of services;
- *Acceptability*, or the broader social, cultural, and religious acceptance of family planning;
- *Quality* of SRHR services, including a range of contraceptive methods, accurate and full information, follow-up, appropriate arrangement of services, and technical proficiency of providers as well as respect for privacy, confidentiality and the informed decision making of service users.

The findings of this research reveal a variety of ways access to SRHR information, education and services in rural Vanuatu needs to be enhanced. If appropriate and targeted investment was made, the enabling environment for the access and acceptance of SRH services would be vastly improved, allowing women, men, girls and boys to make pro-active decisions about their

futures which would lead to overall enhanced wellbeing. The conclusion of the report includes recommendations on how to address these challenges.

Background

The Republic of Vanuatu is a Melanesian archipelago made up of 80 islands, 68 of which are inhabited; the population is approximately 285,000.¹⁷ Vanuatu has a population growth rate of 2.1% per year, and the vast majority of inhabitants (98.5%) are Ni-Vanuatu¹⁷ who live rurally (80%) and engage in subsistence agriculture.¹⁸ The large proportion of people based in rural locations translates to a higher cost of service delivery; this is due to longer and more complex transport required to reach dispersed populations, as well as challenges with the existing infrastructure.¹⁸

Prior to gaining independence on the 30th of July 1980, Vanuatu was a plantation colony for approximately 100 years, jointly administered by Britain and France. Vanuatu has around 100 indigenous languages, however, Bislama (an English-based creole language) is Vanuatu's most common spoken language. In addition to Bislama, English and French are also the country's official languages; children in formal schooling will be taught one of these languages.

The Republic of Vanuatu has a democratically elected government which selects its president. Locally, Christian pastors and traditional leaders, or chiefs, wield a significant level of influence.¹⁸ Kastom (a catchall term referring to a multitude of traditional practices, values, systems, and beliefs) remains highly valued and a key source of indigenous identity.

Current trends and barriers to sexual and reproductive health and rights in Vanuatu

There is ample evidence on the high rates of sexually transmissible infections (STIs), unwanted pregnancies, and sexual and intimate partner violence in the Pacific Islands,^{1,3,11,12} including Vanuatu.^{2,3} Over half of population (57%) in Vanuatu is under 25 which means that a large proportion of the population is reproductively capable.^{1,8,19,20}

Young people are having sex in Vanuatu, and a relatively high proportion had their first sexual encounter before the age of 15.^{21,22} The majority of the qualitative studies on SRHR in Vanuatu focus on urban youth. These studies have generally found that young people (particularly urban based) have a broad knowledge of STIs, including HIV, and family planning but this knowledge may lack depth, or be subject to concurrent misconceptions.^{21,23} Other studies have focussed on specific groups such as sex workers and men who have sex with men in order to highlight their SRHR needs and the significant risks to their health and wellbeing.^{12,19,20}

Key barriers to achieving sexual and reproductive health and rights for Vanuatu youth include limited access to information and sexual and reproductive services and commodities (particularly for rural young people),



Figure 1: Map of Vanuatu

cultural taboos and general shame or shyness around SRHR which inhibits open discussion and access to services, and a lack of comprehensive sex, sexuality, and relationship education and information.^{21,23} The shame and fear associated with the prospect of seeking information from parents and community gate-keepers (e.g. pastors and chiefs), and even fear of the judgemental attitudes of service providers, have been noted as a significant barrier for young people realising their SRHR.²⁶ These fears are due to the lack of confidentiality around service and information provision. Other barriers include the cost of some services and young people's lack of knowledge about SRHR (e.g. STI symptoms).

Methods

It is difficult for women to realise their SRHR in Vanuatu.^{20,27} This is due, in part, to high rates of sexual violence against women which can inhibit a woman's ability to seek health care and make choices about her own reproductive health and outcomes. There are also conflicting messages around condom use; if a young woman carries condoms she may be labelled as promiscuous, yet women are simultaneously told to carry condoms to protect themselves if they get raped.^{2,21,23} These social norms limit women's sexual and reproductive autonomy, including the ability to negotiate condom use.²³

Targeted investment to meet the family planning needs in Vanuatu could bring about a significant increase in modern contraceptive uptake (i.e. an additional 38,164 users), resulting in an estimated drop in unintended pregnancies from 76 per 1000 women aged 15-49 to 12 per 1000, and a 54% decline in high-risk births.¹ The net national savings (particularly in education and health) as a result of meeting the family planning needs in Vanuatu are also estimated to reach \$82 million.¹

This research had a qualitative design as it aims to produce an in-depth of understanding of rural men and women's perceptions of SRHR and their related needs.ⁱⁱ In November 2018, Ni-Vanuatu peer educators facilitated 17 focus groups; nine were with male respondents and eight with female respondents. The primary researcher also undertook 12 in-depth interviews (IDIs) with women, and six interviews with SRHR stakeholders. The focus groups covered the topics of:

- Family planning
- STIs and condom use
- Puberty and menstruation
- Relationships and consent
- Gaps and challenges in accessing SRH services, and suggestions for addressing those gaps/challenges

Focus group participants were asked to discuss their understanding of each subject, whether and where they can access relevant information and services, as well as community perceptions, beliefs and practices on each topic. The in-depth interviews covered the topics listed above as well as detailed information about their experiences of childbirth, motherhood, relationships, and sexual activity. Interviews with SRHR stakeholders, including government and non-

ii Recruitment for the research was done by a representative from VFHA who contacted leaders in each of the five villages in advance to coordinate the focus groups and IDI participants. The VFHA representative explained the research to the leaders that male and female focus groups would be conducted separately, and that participants would be separated by the following age groups: 16 – 29 years, 30 – 50 years, and 50+ years.

Focus group number	Number of Participants	Age group
FOCUS GROUPS WITH MEN		
1	7	16-29 years
2	2	30-50 years
3	17	16-29 years
4	12	30-50 years
5	5	30-50 years
6	9	30-50 years
7	2	50+ years
8	4	16-29 years
9	5	16-29 years
Total	63	
FOCUS GROUPS WITH WOMEN		
1	13	16-29 years
2	6	30-50 years
3	24	16-29 years
4	14	30-50 years
5	9	30-50 years
6	7	30-50 years
7	7	16-29 years
8	5	30-50 years
Total	85	

Table 1: Focus Groups conducted December 2018 in Big Bay Bush: focus group number, number of participants per focus group and their age range

government health workers, covered the topics of attitudes and perspectives on family planning and barriers to access.

Before data collection began in Big Bay Bush, the primary researcher trained four peer educators and one VFHA

staff member on how to conduct focus groups. Due to the taboo nature and general discomfort of discussing topics related to SRHR with the opposite gender, the focus groups were separated by gender; the facilitators

conducted groups of their own gender. The primary researcher conducted all of the IDIs. Male and female focus groups and IDIs were often conducted concurrently which helped to ensure the privacy of the discussions.

All focus groups, IDIs and interviews with SRHR stakeholders were conducted in Bislama, except for one interview with a health worker which was conducted in English as this was her first language. As seen in Table 2, many participants did not know their own age.

Stand-alone quotes from participants are first presented in Bislama and then in English; all of this text is italicised. Quotes which show dialogue from

the focus groups and IDIs distinguish the participants from the facilitator and primary researcher by italicising the text of the participants; a change in speaker among the participants in focus groups is indicated by a new line with a dash (-) preceding the text. The focus group number is also provided for context on age group and number of participants. SRHR stakeholders are referred to as Health Worker 1–6 and the IDI participants have been given pseudonyms to protect their identities.

In addition, there are five vignettes presented throughout the Findings section under the pseudonyms of the IDI respondent; these briefly summarize the respondent's SRHR experiences over the course of their life.



Figure 2: Map of Espiritu Santo Island

Pseudonym	Age (if known)	Number of Children	Married (Y/N)	Family Planning Methods Tried
Mary	21 years	1	Yes	Depo Provera
Rose	27 years	3	Yes	Calendar/fertility tracking
Grace	Unknown; estimated 60+ years	5	Yes	Kastom leaf
June	Unknown; estimated 25+ years	4	Yes	Pill (taken on and off), Tubal Ligation
Airine	Unknown; estimated 25+ years	2	Yes	Depo Provera
Chay	Unknown; estimated 35+ years	6	Yes	Calendar/fertility tracking
Sera	Unknown; estimated 35+ years	9	Yes	Calendar/fertility tracking
Janet	Unknown; estimated 30+ years	7	Yes	Depo Provera, Pill
Donna	Unknown; estimated 30+ years	3	Yes	Pill, Depo Provera, Jadelle, withdrawal
Cathy	22 years	1	Yes	Pill, Depo Provera
Christine	Unknown; estimated 35 years	4	Yes	Pill, Depo Provera, Calendar/fertility tracking
Gina	Unknown; estimated 30+ years	4	Yes	Depo Provera, Jadelle

Table 2: In-Depth Interviews conducted December 2018 in Big Bay Bush: pseudonym of each participant, their age (if known), number of children, marital status, and methods of family planning they had tried.

Findings

This research includes data on knowledge, use, access and barriers to family planning and STI prevention, as well as factors influencing their ability to make decisions around contraception and protection from STIs/HIV.

Respondents also describe attitudes and perceptions of topics related to SRHR.

The findings of this research are divided into:

- Knowledge and perceptions of family planning, STIs and HIV;
- Perceptions, access and barriers to condom usage;
- Participants' ability to make decisions about reproduction and sex;
- Community values about reproduction and childrearing;
- Barriers to uptake of family planning and sexual health services.

Knowledge and perceptions of family planning, STIs and HIV

Many participants acknowledged the value of having control over their reproductive decisions with respect to maternal health and pregnancy spacing. Many also noted the importance of sexual health, specifically limiting the transmission of STIs and HIV. Health care providers articulated the challenges of providing comprehensive service delivery and accurate information

due to the way that the communities are geographically dispersed in the region; they also cited limited human resources and unreliable infrastructure as part of this challenge. Misinformation and value-based concerns were also identified as barriers for the uptake of family planning and other SRH services, particularly for women and young people.

Access and use of family planning

Accessing family planning and SRHR services is not a simple task for many people in Big Bay Bush, and it is particularly difficult for women and young people. Participants identified Saramauri clinic in Big Bay Bush as the key place for accessing modern family planning services, such as contraception or advice around fertility tracking. This clinic also provides referrals to the main hospital in Luganville for vasectomy and tubal ligation procedures which several IDI participants noted. Some participants also noted other clinics or dispensaries in their area that distribute some methods of contraception. The Luganville-based nurses who were interviewed noted that when women come into town from rural areas to sell produce at the market they have an opportunity to access family planning services from clinics.

In Big Bay Bush, methods of contraception that are available and

were noted by participants were:

- Depo Provera;
- Jadelle;
- The Pill (specifically, Microgynon and Microlut);
- The calendar method or fertility tracking;
- Kastom or traditional methods.

Intrauterine devices (IUDs) were also mentioned in three female and two male focus groups. The clinic in Big Bay Bush does not currently administer IUDs due to a lack of supply; the midwife who works there, however, had received training on how to insert them.

Not all women in the focus groups used contraception; some women noted that their use was inconsistent due to side effects or other concerns. Other women described their regular use, particularly to space their pregnancies, reflecting the widely accepted function of family planning by their communities.

For several participants, fertility tracking was the preferred method of birth control. This may be due to hesitancy around the use of hormonal contraceptives and their perceived or experienced side effects, or because of the reproductive decisions of their partner. Withdrawal was also noted, but this was the least common method that was discussed.

Hem nao [man blo hem] I talem lo mi olsem se hemia enough. Afta mifala, olsem, work blo calendar, taem sikmun blo mi I stap, taem ten day I finis, ale. [...] Hemia, olsem mi stori wetem hem [man blo hem], hemi talem lo mi, be hemi se bai mi no tekem family planning nomo. Mifala on lo calendar nomo. Hemi se, olsem, hem nao I talem se naoia yumi wok lo calendar nomo from pikinini blo mitufala, last one ia nao. From olsem tingting blo hem I kam strong se I finis.

He [her husband] said to me that this is enough [children]. Then we, like, use the calendar rules, when I have my period, when ten days pass, then... Like this, like I talked with him, he told me, but he said I'm not to take family planning. We only use the calendar [fertility tracking] because our children, this is the last one. His mind was already set.

Sera IDI

Participants also discussed the use of kastom or traditional methods. Kastom or traditional methods often involve a traditional healer combining plant products into a tonic for women to consume in order to prevent pregnancy. Participants expressed varying views about kastom methods of birth control;

Christine

Christine's first pregnancy was unintended. Her boyfriend at the time had been drinking kava and ignored her request to use a condom. Christine was unmarried at the time and felt she was too young to have a baby. Her attempt to have an abortion was denied and people in her community expressed their moral opposition to her attempt to access the procedure.

Christine married the man with whom she became pregnant. Her husband expressed his desire for four children, two girls for her, and two boys for him, which they now have. Christine's first child was born in the village after two days of labour. After her first birth Christine started using Depo Provera to space her pregnancies. Her second was born at the hospital in Luganville; her third and fourth children were born at the Big Bay Bush clinic; she walked there while in labour. She used Depo Provera between the second and third and the pill after the fourth. She stopped using contraception a year ago when the clinic ran out of contraceptive pills; she and her husband now track her ovulation cycle to avoid another pregnancy. She has raised the possibility of a vasectomy with her husband but he has refused.

Christine is now in her mid-thirties. Her marriage has improved in recent years but her husband uses both physical and sexual violence to control her. She does most of the domestic work and childcare and he refuses to listen to her concerns and needs. She misses her own family as she is not able to see them often.

some highlighted it as a preferred option, while others understood these methods to be ineffective and contributing to unplanned pregnancies. Katsom methods of birth control were noted as still being fairly widely available and used in Big Bay Bush.

Some participants spoke about permanent methods of contraception, including vasectomy and tubal ligation. They explained that they had heard about or discussed these methods with health practitioners and their partners. One female participant from an in-depth interview, for example, described a conversation she had had with her husband about these permanent methods, while another had had the procedure performed after she gave birth in the hospital in Luganville.

Mi toktok wetem hem [man blo hem] se, spos yu bai yu go daon, oli katem yu, bai I gud from woman I hard, I no gud. Yufala, man, isi nomo. Hemi talem se, 'no, ol tingting we yu kam wetem I gud, be ol hard wok, ol heavy wok, man ia nao, mimi nao mi stap mekem ol heavy wok.'

I spoke with him [her husband], 'if you go down [to the hospital], they should cut you [perform a vasectomy], this would be good because it's hard [to perform tubal ligation] on women, it's not good. You men, it's easy.' He said,

'no, these thoughts you've come with are good, but all the hard work, heavy work, men – I do all the heavy work.'

Christine IDI

Yes, afta nao, time we mi go blo bonem small bebe ia lo hospital lo Santo, Luganville, mi go nao, mitufala I disaed se, spos mi go, bai oli mas katem mi blo pikinini I nogat. Olsem mitufala I disaed blo mekem olsem nomo.

Yes, then when I went to have my baby in the hospital in Santo, Luganville, I went, we [she and her husband] decided that, if I go [to hospital], they must cut me [perform a tubal ligation] so I will no longer have children. Like, we decided to do this.

June IDI

Abortion (illegal in Vanuatu, except where there are 'good medical reasons' for the woman to have an abortion²⁸) was brought up a few times during focus groups and in-depth interviews in the context of unplanned pregnancies. Participants shared their own view on abortion or those of their community or church; all perceptions of abortion were negative. Abortion was deemed a moral wrong, particularly through the lens of Christianity.

Abortion was also discussed by several women who provided in-depth

interviews. One woman shared her experience of terminating her own pregnancy which she did at some risk to her health. Another woman described how she attempted to access an abortion when she fell pregnant unintentionally to her boyfriend as a young woman. A third woman relayed a story of a young woman terminating her pregnancy and being arrested as a result. The midwife in Big Bay Bush also shared a story of a woman and her husband terminating a pregnancy after kastom methods of contraception proved ineffective; the method of termination they used involved physical force, risking the health of the woman.

Miscarriages may also be treated as suspicious by the wider community; some may believe that the woman has intentionally taken action to bring harm to the foetus. One woman described her concerns after her miscarriage:

Ating sam man oli stap tingting no gud lo mi se, ating mi spoilem pikinini ia. Be mi no spoilem.

Perhaps some people thought badly of me, thought that I had ruined this child. But I didn't ruin them.

Mary IDI

This concern could prevent women from seeking medical support if they experience a miscarriage.

Community perceptions of the value and purpose of family planning in Big Bay Bush

When asked generally about family planning and its purpose in communities and families in Big Bay Bush, research participants expressed a positive perception of family planning. Key perceptions of the purpose and use of family planning related to:

- Protecting women and their health;
- Spacing pregnancies;
- Reducing financial pressures and workload;
- Improving the health and development of children;
- Contributing more broadly to slowing population growth in Vanuatu to protect its land and other resources.

Many participants noted maternal health and wellbeing as key reasons for using family planning. Some participants felt that having too many children could cause serious problems to the woman's physical health, although these perceived impacts could be subject to misconceptions, as explained by one focus group participant:

Olsem yumi ol man I gud, be ol woman oli save mekem fulap samting. Mas mekem bai pikinini bai I no fulap tumas, mas mekem se bai woman bai I gat fulap,

olsem bai I rest gud, ale save gat pikinini bakegen. Be taem fulap tumas, mekem se bodi blo woman bai I no gud, blood blo hem bai I, mekem se bai sik bai I save kasem.

Like, us men, we are fine, but women do a lot. We have to make sure that there are not heaps of children, we have to make sure that women have plenty, like, they can rest, then she can have another child. But when there are too many [children], this can harm women's bodies, her blood can, she can get sick.

Men FG 2

The focus on positive perceptions of family planning on maternal health and wellbeing notably overlooks younger women's reproductive health and decisions. A few of the young female participants describe the need to "protect" themselves in order to delay their first pregnancy:

Yumi save mekem nomo [use family planning], ah? From wanem?

– Blo protektem yumi.

– Yes, be hemia blo, olsem eksampol bai mi talem mi, spos mi no go daon, samtaem mi mitim wan boyfriend blo mi olsem lo wan gud taem o bad taem, be mi save gat [bel] nao, be mi mas go

nomo blo protektem mi.

We can just go and do this [access family planning], ah? Why?

– *In order to protect ourselves.*

– *Yes, that's it. Like, example, I'll talk about myself, if I don't go down [to the clinic], I may go and see my boyfriend, like it may be a good time or a bad time [to meet him, referring to her ovulation cycle], but I could get [pregnant]. But I must go [to the clinic] to protect myself.*

Women FG 1

For others, family planning was more commonly noted as a tool for spacing pregnancies and controlling the number of pregnancies, particularly once the desired number of children had been reached.

Sam lo ol family planning tingting naoia lo ol mummy, oli tingting se oli usum family planning taem we oli gat evri namba blo ol bebe we oli wantem, then oli come for depo until menopause.

Some of the current thoughts around family planning for mothers, they think that they will use family planning once they have had all of their desired number of babies, then they come for Depo [Provera] until menopause.

Health Worker 1

Rose

Rose's marriage had been arranged without her knowledge so the change in her life was sudden and shocking. She had to move away from her family to live with a man she'd never met. During the first months of their marriage she was filled with uncertainty and apprehension. Once she was married, her embarrassment about having her period was elevated. This may have been due to the way she learned about it: she was deeply concerned about finding blood between her legs for the first time and when she sought help from her mother, she responded that it was 'sik blo ol woman' or 'women's sickness'. Rose did not know what sexual intercourse entailed and found sex frightening in the early months of marriage. Her husband was knowledgeable and patient and allowed her the opportunity to understand and approach it in her own time.

When Rose became pregnant a few months after she married, she didn't know that she was pregnant until she disclosed to her mother that her period had stopped. The birth of her first son was traumatic. She gave birth in a village with only the support of other women in the village and a traditional healer; her labour lasted four days. She experienced excessive post-partum bleeding, and continues to experience chronic pain in her lower abdomen, making sex with her husband painful. She has accessed medication from a clinic in Luganville to manage the pain.

Rose is now in her late-twenties and has three sons. She and her husband have also adopted a little girl, and plan to have a girl of their own one day. Currently, Rose and her husband track her ovulation cycle as a method of birth control.

Family planning hemi wan gudfala samting from hemi save spacem pikinini blo yu. Taem yu gat one pikinini, spos igat five year blo hem, or four year blo hem, bai yu save gat one more.

Family planning is a good thing because it can [be used to] space your children. When you have one child, when they are five or four, you can have another [child].

Women FG 6

Family planning was also perceived as a symptom of changing ways of life, relationships, and notably, a lack of sexual restraint. As a result, family planning was perceived negatively by some participants, or their families and communities, who felt it facilitated sexual promiscuity and infidelity, including sex outside of marriage which remains largely stigmatized. This negative perception of family planning was primarily raised by male participants, and could incite shame in women, or even fear of punishment from their partners if they accessed family planning services.

Spos we woman I no mared, bai I tekem samting ia [family planning], olgeta tu hemia bai oli tokabaot hem nao, se 'wan solmit, stap ronem ol man.'

Truia, oli talem ol strong toktok olsem?

Yes, 'hemia I salem bodi blo hem nomo.'

If an unmarried woman uses this [family planning], people will talk about her now, saying, '[she's] a solmitⁱⁱⁱ who's chasing men.'

Really, they'd use that kind of strong language?

Yes, 'she is selling her body.'

Cathy IDI

Ale sam, sam gel oli fright lo mama blo ol, oli stap h nomo, oli go karem. [...]

Yu save from wanem nao sam lo ol mama ia, or ol papa ia oli no laekem family planning?

Oli no laekem nomo from oli se, wan tingting olsem, spos girl blo mi hemi go karem family planning, hemia bai hemi mekem solmit olabaot.

And some, some girls are scared of their mothers, [when] they go and get it [contraception], they'll do it in secret.

Do you know why some mothers or fathers don't like family planning?

They don't like it because they say, their thinking is like, 'if my

iii 'Solmit' ('salty meat') is a derogatory term used to describe women with multiple sexual partners.

daughter goes and gets family planning, she'll go and be a solmit^{iv} everywhere.'

Gina IDI

Some participants, again primarily male focus group participants, expressed that too many children could bring about issues regarding the future distribution and maintenance of land resources:

Wan lo ol risen blo family planning hemi from naoia lo saed blo graon, I stap semak, be population istap bigwan. Mekem se wan lo ol samting blo oli nidim hem blo traem blo appliem family planning blo mekem se population bai I no spid tumas.

One of the reasons for family planning is because now, regarding land, it remains the same, but the population is getting larger. So, one of the applications of family planning is to ensure that the population doesn't increase too much.

Men FG 6

Generally, family planning was not spoken about openly in community spaces, such as churches and nakamals (meeting houses), or in the home, although there was some support for more open dialogues about family planning. When it was discussed,

however, some participants' families and communities contributed to misconceptions and myths about family planning and its impacts on physical health.

Knowledge and perceptions of STIs and HIV

HIV was the most commonly identified STI, and some focus group participants could also name chlamydia, gonorrhoea and syphilis. Some focus group participants could also name some signs of infection, for instance painful urination and smelly discharge. Generally, younger participants had a greater awareness of STIs and HIV.

While participants identified clinics as a key source of treatment services for STI and HIV infection, kastom or bush medicine was also mentioned as a remedy. Older students in secondary school receive information about STIs and HIV but unfortunately many young people do not attend school to this level. Occasionally, health providers may provide STI and HIV awareness programmes in these communities, but this appears to be relatively uncommon, and the information provided is sometimes confusing and inconsistent; some participants expressed a desire for more programmes to raise awareness.

iv See Footnote iii.

Sera

Sera's first sexual experience was confusing as she did not know what sex was or that it could result in pregnancy. She became pregnant in her mid-teens and was married at the age of 17. It was not until after having her first child that she was able to access clear information about menstruation, ovulation, and conception.

While Sera was interested in modern contraceptives, her husband didn't allow her to use them. Sera gave birth to five sons, and Sera's husband was determined for them to have four daughters as well. She has had nine children; all born either at the local drug dispensary or the clinic.

Sera's husband is very controlling of her and her children, and has been both physically and verbally violent. While various people have tried to intervene regarding his violent behaviour, Sera and the children still can't go anywhere and do anything that he does not sanction, including attending community celebrations. Sera now also experiences chronic pain in her hip and leg.

Participants' and their families and communities' perceptions of STIs and HIV

Many participants' families, communities and church members either did not know about or talk about STIs or HIV. Among participants who had a sense of the opinions of their families, communities and churches, they expressed that the prevailing belief was that STIs and HIV are bad; as such, participants anticipated that they would feel ashamed if they contracted one and this feeling would be compounded by the association between infidelity or sexual promiscuity and STI or HIV transmission. This cultural stigma may limit people's willingness to seek advice and treatment for STIs and HIV, and may even inhibit conversations about safe sexual practices, as shared during one focus group:

Tingting blo ol mama, oli no wantem story gud lo ol girl blo ol from oli fraet se ol girl blo ol bai oli harem olsem bai oli ting se olgeta oli stap givim right lo olgeta ia nao blo oli stap go wokabaot, lukaotem ol man. Hemia nao, oli fraet.

The thinking of mothers is they don't want to talk to their girls [about STIs/HIV] because they are frightened that their girls will feel that, like, they'll [the girls] think that they [their mothers]

are allowing them to go walk about, looking for men [to have sex with]. This is what they are frightened of.

Women FG 5

Conversely, some participants also noted that even when parents do attempt to engage in conversations with their young people about STIs and HIV, the young person's embarrassment may inhibit full engagement in these conversations.

Lo home, olsem yumi ol mama, samtaem yumi tokabaot lo ol gel, ol boi blo yumi?

Si, sam lo ol mama bai oli save tokabaot lo ol gel, be ol gel bai oli no save tekem from oli semsem.

At home, like, us mothers, sometimes do we talk about [STIs] to our girls or our boys?

Yes, some mothers can talk about it with girls, but the girls won't take it [on board] because they are too embarrassed.

Women FG 8

Some participants did have discussions about STIs and HIV with their families and communities and found that adults believe young people in particular need to protect themselves against the infections and take personal responsibility to limit transmission.

OK wanem tingting blo yufala lo ol family? Oli tingting wanem lo saed blo ol rabis sick ia – ol daddy, ol uncle, aunty?

Olsem, yu we, spos we yu kasem, mas faendem rod blo yu, olsem bai, lo saed blo blokem, bai I mas finis lo yu.

OK what are your thoughts about your families? What do they think about these bad sicknesses [STIs] – daddies, uncles, aunties?

Like, you who, if you catch one, you have to find a way, like, regarding prevention, it [the STI] has to end with you.

Women FG 2

Several participants indicated the need for better information about safe sexual practices and a safe and non-judgemental environment to access sexual health services.

Perceptions, access and barriers to condom usage

Condoms^v are available in clinics, as well as local stores and dispensaries in Big Bay Bush. The majority of participants, but not all, were aware that condoms serve as a protection against STIs and HIV. A smaller number of participants noted that condoms could also be used as a method of birth control.

Wan samting, bai yu mas usum condom nomo from spos yu no usum condom, bai yu kasem sik. O spos yu no kasem sik, bai woman I gat bel, be bai problem blo yu.

One thing is you have to use a condom because if you don't use one, you'll catch an infection. Or if you don't catch an infection, the woman will get pregnant, but this will be your problem.

Men FG 5

Some young men noted that they may get distracted or forget to access condoms to have them at hand when opportunities arise for sexual intercourse, or forget to use them in the moment, only to later realise the associated risks of unprotected sex.

Taem we mi hang lo woman finis olsem, hem bai evri gudgudfala tingting we I stap lo ples ia, evri

tingting blo sik or wanem, hemia bai I nomo gat ia nao.

When I am hooking up with a woman, then every good thought that I had had, every thought about these infections, they'll disappear.

Men FG 5

Many younger participants noted that they had used condoms at some point, however consistent use is questionable. Alongside the sense of apathy or forgetfulness mentioned above, the perception that condoms inhibited pleasure proved to be a significant barrier to their use.

– From man I olsem, I no save usum condom from oli stap tingabaot olgeta wanwan, oli no filim bodi blo woman.

– Yes, oli no filim gud taem oli usum condom.

– Skin-to-skin nomo I gud.

– Because men are like this, they will not use condoms because they just think about themselves, that they don't feel the woman's body [when they use a condom].

– Yes, they don't feel good when they use a condom.

– Only skin-to-skin is good.

Women FG 4

^v Here we are referring only to male condoms; the majority of participants did not know about or use female condoms.

Some female focus groups also mentioned that they had heard that condoms have a bad smell, that they make a noise when they are used, or that they may come off inside the vagina during sex.

Some participants expressed that insisting on condom use was akin to confessing to having an STI and that men only use condoms for sexual encounters with women whom they perceive to be sexually promiscuous.

– *Olsem spos we yu faedem wan gel lo taon we olsem yu wantem go wetem hem, kwestin igat lo taem blo slip wetem hem.*

– *Yu askem festaem lo hem...*

– *Slip wetem, go wetem wan man finis, or...*

– *Yu no mas lukaotem wan blo yu terem plastic [hemi laflaf].*

– *Like if you find a girl in town who you want to go [have sex] with, you will have questions when you go to sleep with her.*

– *You ask her first...*

– *Sleep with her, [she's] already gone [had sex with] a man, or...*

– *You mustn't go and find one [a sexual partner] where you have to tear plastic [use a condom with] [laughs].*

Men FG 8

Donna

Donna did not have access to formal education, and her first period came as a shock. She approached her mother about it and her mother told her not to 'pleplei wetem man' or 'play with men' because she could get pregnant. She did not know what 'playing with men' meant.

Her mother and her husband's family arranged her marriage at a young age; her husband is much older than she. Her first sexual experience was frightening and painful. Her husband is jealous, possessive and violent towards her and has coerced her into sexual activity. The village chief has had discussions with him about his violent behaviour, which has resulted in some changes in how he treats her.

When she became pregnant with her first child, she did not know she was pregnant until some friends pointed out she had put on weight. Donna now has three children all of whom were born at the local clinic with the help of a midwife.

Her husband has allowed her to get the Jadelle implant. Her mother has tried to discourage her from using family planning and rumours circulate about Jadelle causing illness and cancer in her community but Donna has not let these pressures deter her use of the contraceptive. She has had a discussion with the clinic midwife about having a tubal ligation after she has a fourth child.

In this same vein, some participants expressed concern that access to condoms enabled infidelity and multiple sexual partners. Given this association between condom use and sexual promiscuity, some younger people in this research expressed concern over lack of confidentiality in the context of accessing condoms.

Wanem nao I mekem I had blo bai yu mas go askem condom lo we?

*-Samtaem se, 'eh, mi go askem condom ia, lukaot bai oli taltalemaot mi se mi stap go karem condom blo go f**k lo laffet [hemi laflaf].'*

Si, yes, yes, afta sam more bakegen?

Sam mo bakegen, olsem ol yangfala oli se, 'lukaot bai oli talemaot lo daddy blo mi se, 'boy ia hemi stap kam karem condom, hemi stap go lo laffet.'

What makes it hard for you to ask for condoms?

*Sometimes you say, 'eh, I go and ask for condoms, but watch out, they will tell everyone that I am picking up condoms to go and f**k at a party [laughs].'*

Yes, yes, others?

-Some more [thoughts], like, young people say, 'look out, they'll tell our dads 'this boy is

coming to pick up condoms, he is going to a party.'

Men FG 9

Furthermore, some women noted that men may lie about using condoms, or intentionally tamper with them without their partner's knowledge or consent.

Sam lo ples ia lo yumi, oli usum be oli stap giaman se oli usum, oli no usum, be ol gel oli gat bel. Minim se hem nao, pikinini blo hem, be naoia hemi se, 'no, hemia I no pikinini blo mi ia, mimi usum condom.' Be I giaman nomo.

Some from our community, they lie that they will use them [condoms], but they don't use them, then the girls get pregnant. This means that this is their child, but he'll say, 'no, this is not my child, I used a condom.' But they are lying.

Women FG 6

.....
Samfala oli se, spos yu stap usum, bai yu forse tumas blo karem samting ia, hemia bai hemi brekem eye blo hem. Samfala man olsem ia nao.

Some [men] say, if you use them [condoms], you are too insistent on using them, they will break the tip of them [the condom]. Some men are like this.

Women FG 4

As with other methods of family planning, participants also expressed concerns related to myths and misinformation about condoms. This misinformation was mostly centred on concerns related to the physical health outcomes from condoms use, specifically that they can cause cancer including from exposure to the lubricant on condoms.

These findings illustrate how condom use to prevent STIs, HIV and unintended pregnancy is significantly inhibited by values and norms related to sex, relationships and sexuality.

Participants' ability to make decisions about reproduction and sex

Many participants expressed that reproductive decisions should be made between the couple. Findings indicate that husbands and families appear to have dominant roles in reproductive decision making within marriages and women may experience pressure to have many children.

Oli go, oli andastandem se oli gat smolsmol right blo mekem sam jois be plente time oli faendem I hard, olsem ol mama lo village oli faendem I hard lelebet blo oli mekem sam disisin from oli fraet lo maet man blo hem I no glad or famili bai I no glad lo hem. From, olsem, lo kommuniti plente

taem ol family tu oli stap part lo decisions blo ol, wan man wetem wan woman. Spos tufala isave decide se, inaf – olsem, mi stap luk samfala naoia oli stap talem se, ol abubu blo hem I stap tok lo hem, istap tok lo hem se, 'mifala itekem yu yu kam blo yu bonem pikinini.'

They go, they understand they have some rights regarding making choices, but often they find it hard, like, the mothers in the villages, they find it quite hard to make some decisions because they are frightened that their husbands or families won't be happy with them. Because, like, in the community often families are also part of their decisions, a man and a woman's. If the two of them decide, enough [children] – like, I see some patients, they say their grandparents talk to them, talk to them and say, 'we have brought you here so that you'll have children.'

Health Worker 1

The majority of participants observed that men largely determine final reproductive decisions, either explicitly by controlling access to family planning services, or more implicitly as women generally defer to their husbands' reproductive desires. This is not to say that all women were passive when it

came to decisions about reproduction but rather that the decision making was not equally shared.

Bai woman nomo folem tingting blo husband. Taem I no folem tingting blo husband, samtaem rao, rao lo home nao. [...] Lo ples ia, ol mama oli wantem tekem saefti, be ol papa oli strong tumas. Oli no wantem mama I go tekem family planning. Oli no wantem nomo.

The woman will just follow her husband's thinking. When she doesn't follow her husband's thinking, sometimes there will be arguments, fights in the home. [...] Here, mothers want to take it [family planning] for safety, but fathers are too strong [headed]. They don't want mothers taking family planning. They just don't want it.

Christine IDI

.....
Taem hemi talem se one mo bakegen, mi harem mi tired. Mi tired, be mi se, 'OK I stret,' from hemi wantem. From spos yumi no lisen lo hem bai still bai I gat, bai hemi stap tingting nogud nomo.

When he said one more [child], I felt tired. I was tired, but I said, 'OK, that's fine,' because that's what he wanted. Because if we

don't listen to him, there will still, he will have bad thoughts [i.e. think badly of her or feel justified in punishing her].

Gina IDI

When women attempted to use contraception on their own and without their husband's consent it was usually perceived as a wrongdoing and a sign of marital infidelity on the part of the wife. It was understood that a woman's unsanctioned use of family planning could be met with violence should her husband find out.

Jealousy nao I kam insaed lo hed blo ol man ia, oli even kilim olgeta from family planning, faetem olgeta.

Jealousy enters these men's heads, they even beat them [their wives] because of family planning, fight them.

Health Worker 1

(Interview conducted in English)

I've known [incidences] when they [women] have got the implant [Jadelle], that their husbands have cut it out of their arm.

Health Worker 6

Mary

Mary was shocked by the arrival of her first period. She found menstruation to be embarrassing and would stay home from school until the bleeding stopped. She disclosed to a friend that she had found blood between her legs and her friend shared that the same thing had happened to her. They then went to the friend's mother who told them that they were mature now, and could no longer walk around and mustn't 'go with men' as they would get pregnant. This euphemism was all Mary knew about sex before she had her first sexual experience with her now husband.

When Mary was attending school in another village, she started communicating with the man who she later married. They would speak over the phone for several years. Eventually, Mary's family could no longer afford to pay for her schooling, and when her husband-to-be came and spoke to Mary's parents to arrange their marriage, they accepted, although Mary did not know until later that the agreement had been made.

Mary recalled her first sexual experience as traumatic. She did not know what to do or what was going on, so she felt very vulnerable when her husband told her to remove her clothes. She did not enjoy the sexual experience. Her husband did not know about menstruation which contributed to Mary's feeling of shame around her period.

Mary's first pregnancy resulted in a miscarriage which was a very distressing experience, made worse by concerns that people thought she terminated the pregnancy intentionally, or that she was

poisoned by someone. She managed to access clinic services, and also sought the powers of a healing spring that is guarded and regulated by a local man.

After her miscarriage, her husband started verbally and physically abusing her. He refuses to contribute to household labour and finances, preferring to spend money on kava and cigarettes, so Mary is largely left alone to cope with childrearing and domestic work.

Not long after her miscarriage, she became pregnant with her daughter, currently her only child, who was born in the village as access to the clinic was blocked due to flooding. When she went into labour, she had no information about what would happen as no one had spoken to her about it. She had minimal support for what was an intense and rapid labour and delivery. Her husband was resentful that the baby was a girl and not a boy, and Mary is concerned about what may happen if her next child is also a girl.

Mary is now 21 years old and uses Depo Provera, although she is worried as she no longer gets her period. She intends for her daughter to be a few years older before thinking about having another child. While she tries to discuss family and home life with her husband, he usually either forgets or disregards what she says, or ignores her outright. He angers quickly if he does not get his way or cannot do what he wants.

Sexual Violence

The unequal power dynamics around reproductive decision-making echo the high rates of sexual and domestic violence, an issue raised by many participants. Several comments from respondents indicated a general lack of awareness about sexual consent; participants provided many accounts of men forcing sexual intercourse with women, or having a general sense of entitlement regarding sexual intercourse.

Samtaem wan boy ikam lo wan girl we hemi no wantem olsem ia, bai I forseem se, 'yu ia, spos yu no mekem olsem wanem, bai I mas fight nao.'

Sometimes, a boy will come to a girl who doesn't want to do this [have sex], he will force her, 'you here, if you don't do this [have sex], I will fight you.'

Women FG 1

I olsem wanem lo yu [sex]?
Samtaem bai mi talem no, be samtaem I [man blo hem] ras lo mi olsem ia. Samtaem I rao wetem mi.

How is it [sex] for you?
Sometimes, I'll say no, but sometimes he [her husband] will rush at me like this. Sometimes he'll shout at me.

Christine IDI

Yu go, yu askem gel ia, gel ia I no wantem. Be wanem nao bai yu mekem?

Bai mi forseem hem.

Forseem hem?

Spos hemi no wantem, be mi stap stikim hem wetem naef nomo nao. [oli laflaf].

You go, you ask this girl [to have sex], she doesn't want to. What do you do now?

Force her.

Force her?

If she doesn't want to, I'll just stab her with a knife. [laughter].

Men FG 5

Oli [yangfala boi] kranke smol. Hemia oli luk yu, karem knife, spos oli askem yu, yu no letem body blo yu lo olgeta, oli karem knife oli katem yu.

Oli katem?

Bai oli holdem yu wetem.

They [young men] are a bit crazy. They'll come and see you, carry a knife, if they ask you and you don't allow them your body, they'll carry a knife and cut you.

They'll cut you?

They'll hold you [down] with it.

Cathy IDI

As noted, women's, particularly young women's, ability to access family planning information and services is restricted by the shame related to appearing sexually active. While women seem to carry the burden of shame associated with being sexually active, the findings indicate they may not always have much choice regarding whether, when and with whom they engage in sexual activities.

Community values about reproduction and childrearing

Community values around reproduction and childrearing contribute to individual and familial perceptions of family planning. Many participants noted certain ideals regarding childrearing including children's critical contribution to subsistence living and broader community development through, for example, creating demand for greater schooling facilities.

Sam [lida blo kommuniti] oli luk se oli no gat pikinini blo kindly, oli se, 'ol woman, hemia, oli go tekem stick, ol tablet, be naoia pikinini I no enough blo kindly.'

Some (community leaders) consider that there are not enough children for the kindly [kindergarten], they say, 'women here, they go get injections [Depo], tablets [the pill], but now there are not enough children for the kindly.'

Women FG 6

Wanem tingting blo yu lo saed blo family planning?

Lo yumi lo ol rural areas, yumi no tingabaot tumas point blo hem. from se tingting blo yumi hemi stap se, no, from we mi mas mekem plente pikinini blo sellaot copra, blo karem samting iko, blo

hemia nao. Tingting ia nao istap lo mind blo yumi we yumi live lo rural.

What are your thoughts about family planning?

Us in rural areas, we don't really think about its purpose because we think it's here, that, no, because we have to make lots of children to process coconuts, carry things, for this kind of thing. These thoughts are in our minds, us who live rurally.

Men FG 6

Participants stated that producing children was an integral component of marriage agreements. Couples who get pregnant out of wedlock may be pressured by their families and communities to become married. If a woman is unable to have a child, she may be rejected by her husband's family due to her failure to fulfil this core component of the marriage agreement, placing her in a precarious social and economic situation.

Olsem, bai man I talem se, papa I talem tu se, no, i no wantem pem woman ia we, no pem woman ia we hemi no bonem pikinini.

Like, the man will say, and the father will say, 'no, we don't want to pay^{vi} for this woman who,

we're not paying for this woman who can't have children.'

Janet IDI

.....
Sam oli rao lo woman from oli stap pem ol woman nomo. Samfala bai oli se, 'naoia bai yumi no pem from hemi no gat bebe.'

Some will scold women [if they don't have babies] because they have been paid for. Some people will say, 'we will not pay for her because she doesn't have a baby.'

Mary IDI

Women perform the majority of childrearing duties in Big Bay Bush. In-depth discussions with women in Big Bay Bush looked at how life changes for women when they become mothers and the burden of childrearing on women compared to men. Understanding the division of labour in households and in relation to childrearing helps us to grasp where gains in increased knowledge, access and usage of family planning could be made.

Time we yu kam olsem one mama, yu save se wok blo yu istap. Yu kuk, yu go lo garen yu karem kakae I kam, yu brum, hemia.

OK, fulap samting. Be ol man?
Time we oli kam olsem one papa?

.....
^{vi} 'Pem woman' ('paying for a woman') refers to the exchange of money, gifts, and other traditional goods such as pigs and woven mats from the man's family to the woman's. These exchanges can be made both when the marriage is arranged (called 'blocking'), and also during the marriage ceremony. For a more in depth discussion of these exchanges, see Jolly, 2005.

Samfala oli ting se, time oli kam wan papa, oli tingting blo olgeta, oli basem olgeta lo yangfala yet, oli no save samting lo home – oli no save kuk blo pikinini, oli no save wash. Be olgeta oli save karem kakae, oli save putum lo house, yu nao, mama, yu stap cook. I hard work.

When you become a mother, you know, you always have work. You cook, you go to the garden, you carry the food back, you sweep.

OK, lots of things. But men?
When they become a father?

Some men think that, when they become a father, they think, they base their lives as if they're still young, they don't know anything about the home [life] – they can't cook for the children, they can't wash...

Janet IDI

Barriers to uptake of family planning and sexual health services

Participants noted several barriers to accessing family planning and other sexual health services including:

- Shame and embarrassment (for young men, this may be compounded by having female nurses at clinics);
- Lack of, or conflicting information about contraceptive side effects;
- Misinformation and myths about contraceptives (including condoms) causing infertility, and illness, including cancer;
- Limited of knowledge about fertility, menstruation, sex and conception;
- Limited information around clinic services, including for the treatment of STIs;
- The physical distance of clinic services from villages (even more challenging in poor weather conditions, or if someone needing services is ill or pregnant);
- Lack of supply of contraceptives at clinics.

Olsem, sem nomo, sem nomo I mekem se bai man mo woman I no save go lo haos blo clinic or health centre.

Like, they are ashamed, shame

makes men and women unable to go to the clinic or health centre.

Men FG 6

For some participants, the shame and embarrassment regarding accessing clinic services may lead them to try and hide their symptoms, thereby delaying treatment and exacerbating health risks for the infected individual, and the potential for further transmissions.

– Ale narawan tu olsem, samtaem, spos mi kasem, smol nomo be mi luk se, no, taem we mi luk se – olsem se, mi hidem. Taem mi luk ikam bigwan nao, mi se, 'oh, bai mi go nao.' I olsem nao. Be I no gud. Taem we yu kasem festaem, bai yu go, yu no se yu stap...

– Givim janis lo hem.

– And another thing as well, sometimes, if I catch one [an STI], and I notice a few [symptoms], when I notice them – like, I'll hide it [the STI]. Only when I notice them [the symptoms] getting worse I say, 'oh, now I'll go [to the clinic].' But this is not good. When you first catch it, you go, don't keep...

– Give it [the infection] a chance [to worsen].

Men FG 6

The side effects of hormonal contraceptives proved to be a significant barrier for uptake of family planning. Women were especially concerned about subsequent changes in their menstrual cycle. Female participants also complained about weight gain, fatigue, weakness, shortness of breath, and headaches that they experienced while using such methods.

Participants also expressed concern that taking contraceptives could risk their future sexual and reproductive health and ability to get pregnant, sometimes even affecting the health of children already born. Another common concern that was brought up during interviews and focus groups was that contraceptives can cause cancer in women.

Wan samting hemi mifala, olsem, wari blo tekem family planning. Sam oli stap tokabaot se, spos yu tekem bai I kausem kansa lo basket blo bebe blo yu. O sam bai oli talem se hemia bai yu stap mekem gogo, bai igogo, bai yu nomo save karem pikinini.

One thing is that we, like, worry about taking family planning. Some people say if you take it, it will give you cancer in your uterus. Or some say that if you keep taking it, after some time you will no longer be able to get pregnant.

Women FG 6

Kleva antap lo hem, hemi no wantem blo ol mama blo oli usum family planning. Taem we mimi askem bihaen, ol mama oli talem lo mi se, 'taem pikinini blo mi l sik, [...] afta hemi talem risin blo hem lo olgeta se 'pikinini blo yu ia hemi stap sik from yu stap stik."

The kleva [traditional healer] up there [in the village], he doesn't want mothers to use family planning. When I went around and asked, the mothers all told me that 'when my child is sick, [...] then he [the healer] will say that the reason for this – 'your child is sick because you are using the injection [Depo Provera]."

Health Worker 1

Participants noted a lack of knowledge about fertility, menstruation, sex and conception as a barrier to uptake of family planning services, including amongst young men. For many female participants, especially those who had limited access to schooling, their first period came as a shock to them. Many women's experiences of disclosing the arrival of their period to someone, usually a female family member or friend, resulted in limited information about what menstruation entails, or vague suggestions that they not go near any boys because it could result in a pregnancy.

This last point relates to the frequent recollections of IDI participants regarding the lack of information they had about sexual intercourse before their first sexual experience. This lack of knowledge significantly limited their ability to plan and negotiate their own safety and wellbeing during their first sexual encounters.

Finally, some participants including many of the health practitioners, noted instances where they had insufficient supplies of contraceptives. This situation necessarily limits women's contraceptive options which is particularly problematic when the shortage includes women's trusted contraceptive method:

Ale blo talem stret lo yumi naoia, sins from yia ia l kam [2018], ol mama oli stap bonem ol pikinini lo September, August, July, go back bihaen ia from we l sot finis lo last yia lo pills [...] Oli no wantem pikinini ia, oli no wantem gat bel, be l nogat pills. Bigfala jelenj we l bigwan tumas.

OK, to be honest, since the start of the year [2018], the mothers who gave birth to children in September, August, July, and so on, this was because last year we were short of [contraceptive] pills [...] They don't want these children, they don't want to be pregnant, but there weren't any pills. This is a really big challenge.

Health worker 2

*Mi stap tekem tablet, tekem
tablet naoia, bai number four ia,
ale bai mi go bakegen lo manis
April, nurse I talem lo mi se tablet,
naoia, bai mi nomo givim tablet –
tablet I finis [...] stap nating nomo
olsem ia.*

*I took the pill, took the pill, then
had number four [child], then I
went back [to the clinic] in April,
the nurse told me that the pills,
'now, I can no longer give out
pills – the pills have finished'
[...] I am now not on anything
[contraceptive].*

Christine IDI

Discussion

UNFPA¹⁰ adopted the Committee on Economic, Social and Cultural Rights' criteria for meeting the Highest Standards of Health¹⁶, relating the achievement of SRHR in communities to improving the availability, accessibility, acceptability, and quality of services. The findings from this research correspond to these four domains and reveal significant opportunities for improvement. Given the challenges to the socio-cultural acceptance of SRHR in Big Bay Bush, any future work in this area needs to be participatory; it is crucial to allow people to discover how these services and initiatives could best meet their needs as they define them and in accordance with their values and identities.

Availability

Health practitioners who were interviewed highlighted the challenges related to the availability of SRH services and commodities. The sexual health nurses and the midwife in Big Bay Bush had all experienced insufficient supplies of contraceptive methods or having limited contraceptive options available to patients. For example, the midwife in Big Bay Bush had received the training to insert IUDs but none were available in the clinic. Without a range of contraceptive options available, men and women may find that none are suitable for their needs and preferences, leading a greater risk of unintended pregnancies.

Accessibility

The accessibility of SRH services was primarily limited by practical factors, such as long and difficult transport to health care centres. A woman's access to SRH health services may also be controlled by their husband and other family members. Embarrassment about sex and sexuality was also a significant barrier to accessing SRH services.

As noted previously, Big Bay Bush is an area with dispersed and remote populations which creates considerable challenges for people attempting to access clinic services, or for clinic staff conducting outreaches to communities. There are few SRH clinics throughout the Big Bay Bush area which makes it difficult for those living there to access trained, knowledgeable professionals. While the clinic in Big Bay Bush recently acquired a truck, the roads are still rough and vulnerable to flooding, and some villages do not have truck access necessitating lengthy hikes in order to access these communities.

Young people in particular face challenges accessing family planning and other SRH services. This difficulty could be addressed in part with services that are specifically designed to be youth-friendly. Moreover, training local peer educators to run SRHR awareness programmes in their communities and in youth-friendly spaces (such as youth groups or sports tournaments) could

enable more young people to engage with SRHR information, dispel myths, and offer familiar, knowledgeable peers from whom they could seek SRHR advice and information.

Acceptability

The acceptability of family planning and other SRH services relates to broader social, cultural, and religious attitudes around the concepts embedded in these services and rights. Family planning, including modern methods of contraception, is not routinely or openly discussed in communities in Big Bay Bush, and generally, it is not a typical topic of conversation for individuals and couples. There was, however, wider support for family planning as a means to support women's health, and an acknowledgement that too many children too quickly can be damaging to women's health and put a strain on family resources, such as land.

The findings of this research indicate that young people's understanding of their own bodies is limited, sometimes severely. Young women in particular seem to lack this knowledge which was revealed by the ways they described the onset of puberty and their first sexual experiences. Their lack of knowledge and education limits their ability to make informed SRHR choices, including planning their first and subsequent pregnancies and thinking about what

sexual intimacy looks like on their own terms. Respondents expressed interest in more discussion about family planning usage and other SRHR issues, including with young people, indicating that communication of this nature may be possible if parents and community leaders have the correct information and see the value in planning pregnancy and preventing STIs.

The level of acceptability of SRH services in Big Bay Bush was complicated by misinformation, rumours, and perceptions from participants and their families, communities, and churches of SRH services as contradicting traditional practices and values. In this research, values around childrearing (for example, children as contributing to subsistence livelihoods), sexual restraint, and fidelity in particular may be seen as under threat where family planning services are available. To this end, family planning runs counter to deeply held values and aspects of people's identities. As such, acceptance of family planning depends on a shift among community members and gatekeepers of traditional values and practices.

Childrearing in Big Bay Bush, according to the women in this research, disproportionately impacts the physical, emotional and mental lives of women. Men, however, are largely responsible for making reproductive decisions,

including the use of contraception; women are generally expected to defer to these decisions. In situations where women's husbands subscribe to moral fears around infidelity or concerns around the impacts of contraceptives on women's health, women are limited in their opportunities to gather more information and consider whether SRH services would be of use to them. Thus, the extent to which women can access family planning information and services seems to be dependent on the levels of acceptability of family planning amongst their male partners. Sexual and domestic violence against women in Big Bay Bush also speaks to the high rates of gender inequality in these communities, which inhibits women's opportunities to make free and informed choices about their sexual activity and subsequent reproductive outcomes.

Quality

Generally, quality SRH services refers to comprehensive SRHR education to enable informed decision making, matched with consistent and sufficient availability of SRH services. The quality of SRH services were limited in Big Bay Bush by practical factors such as poor infrastructure and transportation options, limited human resources (including for the purposes of regular and routine SRHR awareness and education), and irregular or insufficient supplies of SRH commodities. These

limitations impede SRH service providers from meeting the needs of the communities of Big Bay Bush. Additionally, while pregnancy termination was requested by women in the community, providing this service is legally restricted which means that women have limited access to safe, legal abortion; this is cause for concern given that, globally, up to 13.2% of maternal deaths can be attributed to unsafe abortion.²⁹

To ensure that people have access to quality services, it is crucial to provide culturally-responsive SRH services that are non-judgemental, private, and confidential. Community awareness programmes may enable more regular conversations about SRHR topics; many participants noted their interest in such programmes. Community educators could run workshops that include information on SRHR and SRH services, as well as consent and healthy relationships. By increasing access to quality SRHR information and services, people living in Big Bay Bush will have better information and tools to make pro-active SRHR decisions.

Conclusion and Recommendations

The findings of this research revealed practical challenges contributing to barriers regarding availability and access to SRH services as well as contradictions in people's understandings and attitudes around SRHR services and concepts in their lives and relationships.

Below are seven recommendations which relate to SRHR policies, services, and programmes. These are designed to help meet the current and potential SRHR needs of people in Big Bay Bush as they were articulated by the respondents. These recommendations seek to improve comprehensive SRHR education, access, and service delivery.

Recommendations

1. Develop educational programmes to increase knowledge and awareness of SRHR, including family planning methods and the spread of STIs with tailored programmes for young people and married couples.
2. Create family planning promotion messages that dispel myths and misinformation about modern contraceptive methods.
3. Design programmes on healthy relationships, consent and gender-based violence tailored for men, women, young people and service providers.
4. Develop training programmes for young people to become SRHR

peer educators so that they can communicate their knowledge to others in their community.

5. Improve access to health facilities and explore new strategies to increase access to services in rural Vanuatu including mobile clinics and home visitations.
6. Prioritise making a wide variety of SRH commodities consistently available throughout Vanuatu, focussing on rural communities.
7. Conduct training with service providers on how to provide high-quality, non-judgemental sexual and reproductive health care.

As education and access to information improves (alongside general acceptance of family planning), the unmet need for family planning is likely to increase, as is the desire for smaller families.^{6,10} Also, reduced stigma around unmarried women using family planning would help increase demand.⁶ Improvements in SRHR require long term investment, ensuring the supply side is comprehensive and sufficient to meet increased demand for SRH services. Investing time, funds and effort in SRHR education and services would bring about an overall improvement in wellbeing for women, children, and the community and society as a whole.

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