"It's easy for them to access, but they're frightened"

Exploring knowledge, access, and barriers to sexual and reproductive health for young people in Pentecost, Vanuatu

RESEARCH REPORT

Final Report
March 2025

Contents

Acknowledgements

This study, ***"It's easy for them to access, but they're frightened" – Exploring knowledge, access, and barriers to sexual and reproductive health for young people in Pentecost, Vanuatu***, was commissioned by Sexual Wellbeing Aotearoa. The study was funded by the New Zealand Government's Manaaki Fund and is a component of the Planem Gud Famili Blong Yumi (PGFBY) Phase 3 project, implemented in partnership between Sexual Wellbeing Aotearoa and the Vanuatu Family Health Association (VFHA). The author is Chloe Morrison.

We are honoured to share the stories and testimonies of young women and men from Pentecost and are grateful to the participants of the in-depth interviews and focus group discussions for trusting us to tell their stories and share their opinions on these sensitive topics. We are also grateful for the support and engagement of community stakeholders and leaders, including local chiefs, health stakeholders, and police who engaged in the research and supported community mobilisation and logistics.

This study would not have been possible without the significant contributions of Savianah Raynes (VFHA, PGFBY Project Coordinator), youth research facilitators Kasamita Gere, Angela Wai, and Claude Tao, and Mary Mason (Sexual Wellbeing Aotearoa, PGFBY Project Lead).

Sexual Wellbeing Aotearoa would also like to thank Christine Uljee of Bright Communications for overseeing the design and printing of this report.

Recommended Citation

Sexual Wellbeing Aotearoa. (2025). *"It's easy for them to access, but they're frightened" – Exploring knowledge, access, and barriers to sexual and reproductive health for young people in Pentecost, Vanuatu*. Sexual Wellbeing Aotearoa, Wellington, New Zealand.

Executive Summary

Access to sexual and reproductive health (SRH) education and services ensures that people can decide if, when, and how often to have children, have a safe pregnancy, and have a safe and satisfying sex life[1]. Essential to achieving SRH is the right of women and men to make informed choices and have access to safe and affordable methods of contraception.

Despite a recent decline, Vanuatu's adolescent birth rate is persistently high and ranks among the highest in the Pacific region. This is even amidst improvements in SRH services.

There is limited understanding and research on young people's access to and knowledge of family planning, safe sex, and modern contraception in Vanuatu. Most studies investigating SRH in Vanuatu have focused on Efate and Santo, the two most populous islands, which benefit from better healthcare access, connectivity, and proximity to urban centres.

This mostly qualitative study is the first to explore these issues among young people in Penama Province (Pentecost Island). Multiple definitions of "youth" exist in Vanuatu. Government of Vanuatu youth policies define youth as 12–30[2]. Given the complexities of small, dispersed communities and the study's sensitive nature, this study included young people aged 14–34.

The latest Multiple Indicator Cluster Survey (MICS) reports indicate Penama Province has the highest adolescent birth rate in Vanuatu: 84 births per 1,000 women aged 15-19, significantly exceeding the national average of 46[3]. Penama Province also recorded the highest percentage of women aged 15-19 who had a live birth before age 15, at 1.8%; this far exceeds the national average of 0.2%[4].

This study is part of the *Planem Gud Famili Blong Yumi* (PGFBY) Phase 3 project, funded by the New Zealand Government's Manaaki Fund and Sexual Wellbeing Aotearoa, and implemented by the Vanuatu Family Health Association (VFHA), in partnership with Sexual Wellbeing Aotearoa. The project aims to reduce unplanned pregnancies and sexually transmitted infections (STIs) in Vanuatu by increasing access to SRH services and information, particularly for youth, in rural areas. The study seeks to enhance understanding of young people's knowledge, attitudes, and practices regarding safe sex, STIs, and family planning, as well as the barriers they face in accessing SRH information and services.

Key findings:

Barriers to SRH Access:

- While contraceptive methods (e.g., condoms, oral contraceptives, and injections) were physically available in most areas, significant social, cultural, and informational barriers prevented effective and wide use
- Gender norms, which position men as the ultimate decision-makers in relationships, were a significant barrier to young women using family planning; young men expressed the belief that if a woman is using family planning, she is more likely to cheat
- Young people, especially young women, reported not accessing SRH services due to fear of being spoken about or judged for being sexually active, especially if they are unmarried or still in school
- Misinformation about contraceptives, such as fears of infertility, illness, or cancer, was pervasive among both young men and women.

Barriers to knowledge and understanding:

- There was limited understanding of STIs, with most participants only recognising HIV and gonorrhoea. There was little understanding about STI transmission and prevention
- There was low levels of knowledge of how modern contraception works and its side effects, which prevented some women from accessing family planning
- There was limited understanding of the reproductive system, especially menstruation, which contributed to misconceptions about long-acting reversible contraceptives (LARCs)
- Cultural norms further constrained discussions on SRH, with topics such as safe sex and contraception being considered taboo
- Some held concerning attitudes and understanding about consent and women's agency in relationships.

Teenage pregnancy and its impacts:

- Adolescent birth rates in Penama Province are the highest in Vanuatu, with health stakeholders and community leaders alike reporting not only increasing rates of teenage pregnancies but also a decreasing age of first-time parents
- Teenage mothers were reported to face greater community backlash and stigma as well as disruption to life than teenage fathers. It was, however, widely reported that teenage mothers could return to school and complete their education.

Summary of Recommendations:

1. Develop youth-focused programmes led by young people. Effective youth-focused programming should include the following components:
    - Healthy relationships and consent
    - Addressing common taboos and misconceptions about contraception, including fears of long-term infertility and recognised side effects, such as changes to menstruation
    - Information on STIs and the correct use of condoms.
2. Deliver school-based education on puberty & reproductive health. Introducing puberty and reproductive health sessions in late primary and early secondary schools can dispel misconceptions and improve understanding of SRH.
3. Explicitly promote that family planning services are available at outreach clinics and are available for youth.
4. Address confidentiality and privacy concerns of young people, including the ability to access outreach clinics. This could be facilitated through continung and expanding VFHA's training for Village Health Workers (VHWs) and clinic staff on confidentiality to improve service uptake.
5. Develop accessible information, education and communication (IEC) materials that explain the potential side effects of common contraceptive methods (e.g., Jadelle, Depo Provera) and dispel prevalent myths.
6. Train healthcare providers on the content of the IEC materials and engaging with community members to dispel misinformation effectively. This should also include the importance of confidentiality at health services.
7. Engaging young men in reproductive health conversations is essential to promote an understanding of family planning benefits, address common misconceptions, and foster supportive behaviours.

Background

Access to SRH information and services ensures that people can decide if, when and how often to have children, have a safe pregnancy, and have a safe and satisfying sex life[5, 6]. Essential to achieving SRH is the right of women and men to make informed choices and have access to safe and affordable methods of contraception.

Globally, young people face more significant barriers in accessing family planning, including fear of being judged for being sexually active, misinformation, and societal pressure to have children. These barriers can lead to further challenges, particularly for adolescent mothers (aged 15-19), who face heightened health risks such as eclampsia and infections compared to women aged 20-24[7]. The children of adolescent mothers also face elevated risks of low birth rate, preterm birth, and severe neonatal conditions[8]. In addition, adolescent mothers are also more likely to encounter stigma and discrimination that may impact access to educational and employment opportunities.

Despite improvements in SRH services and a decline in adolescent birth rates, rates remain persistently high in Vanuatu, ranking among the highest in the Pacific region. This is coupled with a low contraceptive prevalence rate for modern methods at 20.1% and a significant unmet need for contraception at 30% among sexually active women[9].

For adolescents and young people living in Vanuatu, the situation is even more concerning, with higher rates of unmet need for contraception and minimal use of modern contraceptive methods. Among young women aged 15-19, 58.5% reported having unmet contraceptive needs. For those aged 20-24, 49% of women reported having unmet contraceptive needs. This includes women who are married, in a union, or not in a relationship.

Additionally, only 2.9% of women aged 15-19 and 17.9% of women aged 20-24 reported using modern contraception[10].

Vanuatu is a deeply traditional society where customary beliefs, practices, and governance structures are central to community life[11]. The majority (83%) of the population identifies as Christian. However, scripture is often interpreted in ways that reinforce unequal power dynamics, perpetuating male dominance over women. These dynamics contribute to high rates of violence and harmful gender norms, which significantly impact the realisation of sexual and reproductive health and rights (SRHR). Vanuatu faces some of the world's highest rates of violence against women and children. A study by the Vanuatu Women's Centre (VWC) found that 60% of women who had ever been in a relationship experienced physical and/or sexual violence[12]. Child sexual abuse is also widespread, with nearly one in three women (30%) reporting they experienced sexual abuse before the age of 15[13]. These harmful gender norms and high rates of violence severely hinder women's access to SRH services, leading to unintended pregnancies, STIs, and unsafe abortions.

Improving access to SRH services is a priority of the Government of Vanuatu, and this is underscored by the inclusion of family planning initiatives in new and updated policies, including the Moana Declaration to 'ensure access to SRHR for all our peoples, without discrimination'. Achieving universal SRHR is also a priorityof the Sustainable Development Goals (SDGs) 3.7 and 5.2.

There is limited understanding and research on young people's access to and knowledge of family planning, safe sex, and modern contraception in Vanuatu. Most studies have focused on Efate and Santo, the two most populous islands, which benefit from better healthcare access, connectivity, and proximity to urban centres. This study is the first to explore these issues in Penama Province, where the latest MICS reports indicate Penama Province has the highest adolescent birth rate in Vanuatu, with 84 births per 1,000 women aged 15-19, significantly exceeding the national average of 46[14]. Penama Province also recorded the highest percentage of women aged 15-19 who had a live birth before age 15, at 1.8%, above the national average of 0.2%[15].

This study is part of the PGFBY Phase 3 project, funded by the New Zealand Government's Manaaki Fund and Sexual Wellbeing Aotearoa, and implemented by VFHA in partnership with Sexual Wellbeing Aotearoa. The project aims to reduce unplanned pregnancies and STIs in Vanuatu by increasing access to SRH services and information, particularly for youth in rural areas. The study seeks to enhance understanding of young people's knowledge, attitudes, and practices regarding safe sex, STIs, and family planning, as well as the barriers they face in accessing SRH information and services. Focusing on two Area Councils on Pentecost Island in Penama Province, the findings are expected to inform more effective intervention targeting, policy implementation, and strategies for the health sector in Vanuatu and the PGFBY project.

Methods

Study setting

The Republic of Vanuatu is a Melanesian Island nation in the South Pacific. It comprises a chain of over 80 islands, 65 of which are permanently inhabited. As of the latest census conducted in 2020, Vanuatu's population is estimated at 301,695[16]. The current growth rate is 2.4% per annum[17]. The average household size is 4.8 people. Of the total population in Vanuatu, 38% is under the age of 15. Youth (15-30) face many challenges in Vanuatu. They are often disenfranchised from community life and experience an unemployment rate of 18%, more than twice as high as the unemployment rate for women and men of working age (15-59), which is 9% and 7%, respectively[18].

Penama Province is the second-least-populated province in Vanuatu. Its population is 35,474, spread across three main islands: Ambae (the provincial centre), Maewo, and Pentecost. Pentecost is the most populated of the three islands, with a population of 21,676, and lies 190 kilometres due north of Vanuatu's capital Port Vila.

In Penama, 61% of the population lives within 30 minutes of travelling distance to the nearest health facility. Just 8% live within 30 minutes of a police station/outpost[19]. Notably, Penama Province has the highest adolescent birth rate in Vanuatu with 84 births per 1,000 women aged 15-19, significantly exceeding the national average of 46[20].

Kastom beliefs and traditions are pronounced in Penama, where there is a high demand for items of "traditional" value, such as mats and pigs, used for ceremonies and celebrations. The bride price often involves the transfer of three pigs, pig tusks, and mats.

The study took place in eight communities in two Area Councils, Central Pentecost 2 and South Pentecost.

Table 1: Study site population size by community provided by South and Central Pentecost Area Councils[21].

Area Council	Community	Total population
Central Pentecost 2	Enkul	200
Central Pentecost 2	Legafatgaimwel	65
South Pentecost	Pamgi	143
South Pentecost	Panlimsi	151
South Pentecost	Wali	253
South Pentecost	Londar	300
South Pentecost	Bay Barrier	475
South Pentecost	Ranwadi	103*

**Ranwadi population size refers to community only and does not include the secondary school population.*

Study design

The study design was informed following a review of existing research and literature, focusing on youth and adolescent knowledge, attitudes, and access to SRH services in the Pacific. A review of global research and evidence relating to youth SRH and methodologies and approaches for conducting SRH research with youth and adolescents was also conducted. The study was further informed by research conducted by Sexual Wellbeing Aotearoa and VFHA in 2019 exploring knowledge, access, and barriers to family planning in rural Vanuatu (Big Bay Bush, Santo Island) as well as significant consultations and interviews conducted with stakeholders, community leaders, and community members as part of the PGFBY Phase 2 evaluation in 2023.

The study was largely qualitative, with a small quantitative survey conducted for focus group discussion (FGD) participants.

Quantitative component:

A short voluntary multiple choice survey was administered to FGD participants at the end of each session. The anonymous survey aimed to provide a high-level understanding of sexual activity, contraceptive use, and decision-making around contraception. It also offered participants a safe space to share additional questions or topics of interest. While the survey results provide insights into youth (14-34 years old) in the study area, they are not statistically representative of Pentecost Island's youth population due to the voluntary nature of participation, the small sample size, and the lower number of male respondents than females.

Qualitative component:

Qualitative methods formed the core of the research design. These included:

FGDs using a fictional story (detailed under data collection) were designed to explore:

- Young people's knowledge and understanding of safe sex and consent, contraception, and STIs
- Access and barriers to family planning and SRH services and information
- Community attitudes toward family planning, teenage pregnancy, and young people's access to SRH services

- Types of SRH services or information that would be useful for young people.

In-depth interviews (IDIs): Conducted with a diverse cross-section of young men and women, including those with and without children and those who used and did not use contraception. These interviews explored topics such as puberty, first relationships, marriage, family planning, and childbirth and raising children (where relevant). They provided nuanced insight into consent, family planning barriers, knowledge of STIs, and the experiences of teenage parents, as well as different experiences and attitudes of men and women.

Key informant interviews: Ten interviews were conducted with health service providers, health staff, community leaders, and Provincial Government representatives. These interviews explored attitudes toward family planning and SRH services for young people and gaps in existing services.

Site selection, sampling, and recruitment of participants

Multiple definitions of 'youth' exist in Vanuatu. The International Planned Parenthood Federation (IPPF) defines young people as individuals aged 10–24, while the Vanuatu Government Ministry of Sport and Youth[i] consider youth to be 12-30[22]. Recognising the complexities of small, dispersed communities and the sensitive nature of the research topic, this study focused on young people aged 14-34.

Where participant numbers permitted, FGDs were stratified by age groups: 14-19, 20-24 and 24–34 year olds. This approach allowed for nuanced insights across different life stages within the youth demographic.

Community and site selection

The study was conducted across eight rural communities in Central and South Pentecost. Initially designed to coincide with VFHA outreach health clinics in Central Pentecost 2, unforeseen circumstances necessitated a modified approach. The research team began in Central Pentecost 2 before relocating to South Pentecost, where recent outreach clinics had been conducted, and logistical support was more readily available. Most communities were remote, with two accessible only by boat.

Communities were selected by the research team, including the research lead and PGFBY coordinator, as well as the youth volunteers accompanying the research, based on their collective knowledge of the area. They included communities that had previously received VFHA outreach services and those that had not previously engaged. One secondary school was included in the study and was selected as it will be the site for future outreach clinics.

Participant inclusion criteria and community engagement

Age was the sole participant selection criterion, with individuals aged 14-34 eligible to participate. No restrictions were placed on marital status, education level, or sexual activity, and participation remained entirely voluntary.

Community mobilisation occurred through preliminary discussions with local leaders and health staff. These stakeholders helped disseminate information about the research before the team's arrival and supported participant awareness. At the secondary school, the principal and key teachers were informed of the study's objectives and approved the research.

[i] This research was designed in 2024, when the Vanuatu Government had a dedicated Ministry of Youth and Sport. Following the snap election in January 2025, this Ministry has since been incorporated into the Ministry of Justice.

Data collection

Data collection took place over two weeks in October 2024. Based on existing literature exploring effective and appropriate methods for conducting SRH research with young people, the research lead developed a three-part vignette for men and women FGDs. Recognising the topic's sensitivity, the fictional story was designed to provide a realistic scenario that young people could provide their thoughts and opinions on without giving a personal account, promoting more open discussion. Reflections with the research team and the engagement during the FGD demonstrated that this was a highly effective approach suitable for the context.

The vignette follows Alex, an 18-year-old man, and Maria, his 17-year-old girlfriend, as they discuss having sex for the first time. The narrative explored topics of consent, contraception, STIs, and teenage pregnancy. At the end of each "part," participants responded to semi-structured questions that examined their knowledge, attitudes, and practices related to the scenario.

Most FGDs had a total of 3-8 participants, with the exception of the boys' secondary college FGD, which had 24 participants. A semi-structured interview guide was developed for individual IDIs. A total of 12 women and 10 men were interviewed. All FGDs and IDIs were conducted in Bislama. In accordance with cultural norms, the discussions were always facilitated by youth facilitators of the same sex as the participants.

The research team had extensive local expertise and qualitative research experience.

Youth volunteers who facilitated interviews were carefully selected based on their previous work with VFHA or Youth Challenge, a national youth organisation.

The research lead conducted comprehensive training for team members. The team collaboratively translated research tools into Bislama and refined the stories and scenarios through pilot testing and internal review before the data collection process began.

Data analysis

Throughout the research, data were analysed iteratively. The research team held daily debrief sessions, during which notes were reviewed, helping to triangulate emerging key themes and identify unexpected findings for further exploration.

Interview notes were typed, and voice recordings were transcribed and cross-checked against the field notes. At least two of the research team members also cross-checked notes and transcripts, correcting errors before they were finalised.

Transcripts were thematically analysed using an inductive approach in Dedoose software. The lead researcher read each interview at least twice and conducted first-level coding before developing a code book to ensure consistent coding. Transcripts entered into Dedoose were anonymised and encrypted for maximum data security.

Ethical considerations

Given the sensitivity of discussing SRHR, particularly among youth in rural Vanuatu, ethical protocols were established to ensure responsible data collection and respectful reporting of findings. These considerations informed the data collection tools, locations of interviews, composition of research team, and debriefing discussions. Safeguarding protocols were established to protect against any potential risks that could arise from discussing sensitive topics, and the research team's training incorporated Do No Harm and ethical research principles, including responding to disclosures of violence. The research participation was entirely voluntary,

with free and informed consent obtained from all participants before data collection. In addition, participants were assured that their decision to participate would not impact their access to VFHA clinical services.

A core component of ethical consideration was appropriately collecting data and protecting privacy throughout data collection which employed the following components:

- Use of vignettes: Instead of asking participants about personal experiences directly, vignettes were used in FGDs to create a more comfortable and less threatening environment when discussing sensitive topics
- Confidential interview settings: IDIs were conducted away from earshot of others to maintain privacy. FGDs were conducted in gender-segregated locations where possible
- Gender-sensitive data collection: Female researchers collected data from female participants, and male researchers from male participants to create a safer and more comfortable environment
- Researcher presence: At least two researchers conducted each IDI and FGD to ensure methodological rigour and participant and researcher safety.

Lastly, no identifying information was recorded in the study findings. As such, pseudonyms are used instead of real names, and identifying details such as community names have been removed throughout this report.

Limitations

As discussed, the research was intended to be carried out alongside the VFHA outreach clinics, which included two full days at secondary schools. As a result of the clinics not going forward, as well as both examination periods and ongoing issues relating to student school fees, it was only possible to carry out one FGD with boys and girls in a school setting, which led to an older average age group in FGD than anticipated.

A small number of quantitative surveys were completed. The small sample size limits the statistical significance of the results, though some insights can still be drawn, particularly when triangulating with findings from the qualitative research.

Two participants with disabilities took part in the study, and no participant openly identified as being of diverse SOGIESC. This limits the extent to which findings can be interpreted as relevant across these particular groups, which often may face more significant barriers to accessing SRH services and information.

Lastly, given the topic's sensitive nature, despite several strategies being put in place to address cultural and societal barriers to discussing the research topic, there remains potential bias in data collection. Some accounts may be influenced by cultural sensitivities and participants' reluctance to share their personal experiences, especially concerning topics like consent and family planning.

Table 2: FGDs conducted in October 2024 in Central Pentecost 2 and South Pentecost

FGD	Number of FGDs	Total number of participants	Age range of participants	Median age of FGD participants
Young Women	12	59	14-34	26
Young Men	7	43	14-34	18
Older Women	1	6	35+	NA

Table 3: IDIs conducted in October 2024 in Central Pentecost 2 and South Pentecost. Participants were given pseudonyms, and the table details their age, marital status, and number of children. NA denotes that a participant did not wish to answer the question or did not provide further information.

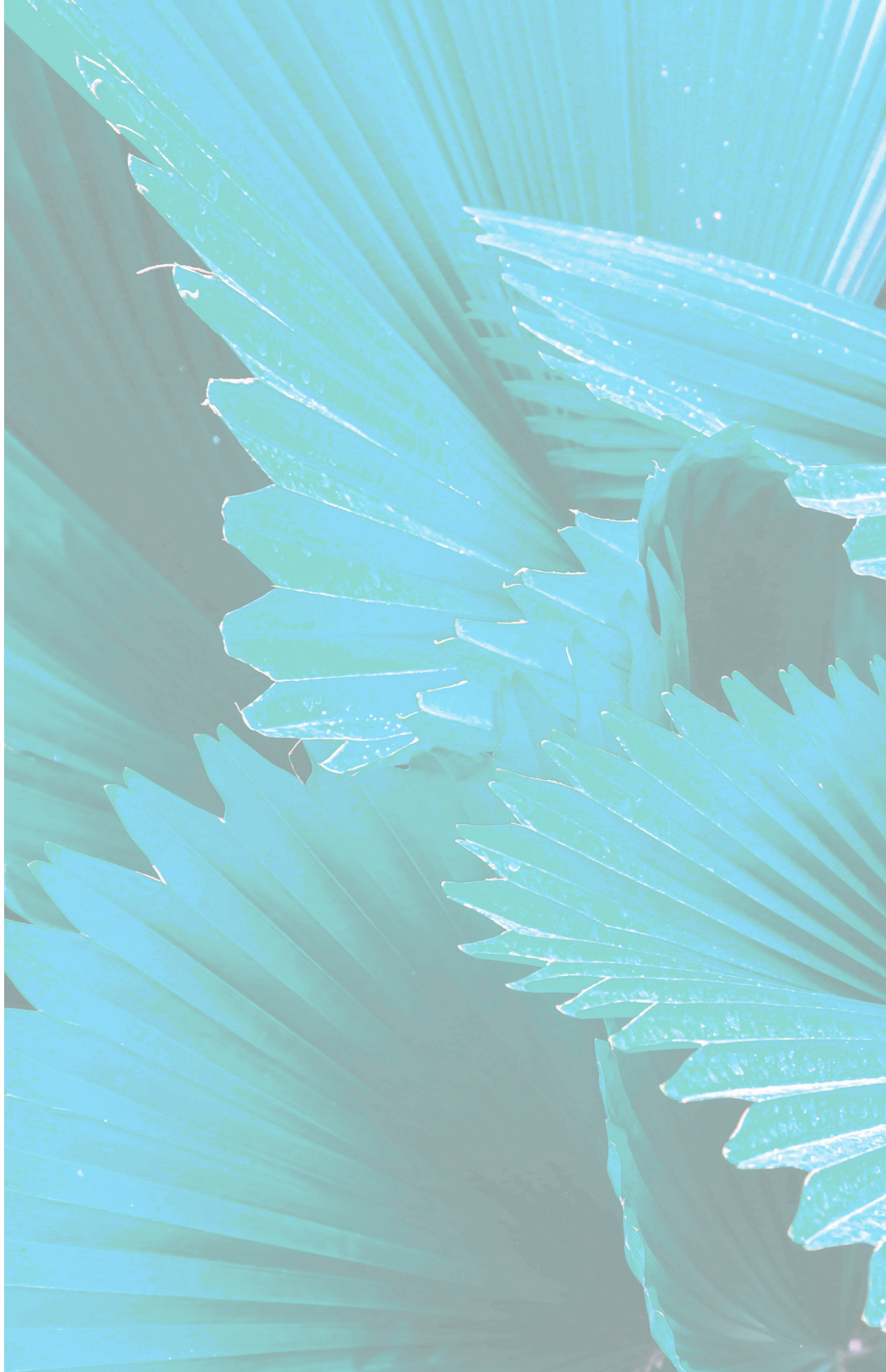
Pseudonym	Age	Marital status	Number of children	Reported currently using family planning	If so, what?
Women					
Jemima	21	In a relationship	0	Yes	Jadelle (implant)
Kelly	28	In a relationship	2	No	
Louisa	22	Married	1	No	
Vanessa	25	Married	3	No	
Monica	24	Married	0	No	
Esther	22	Single	0	No	
Sharyn	31	Married	1	No	
Sonia	32	Married	3	Yes	Depo Provera (injectable)
Frida	25	Single	0	No	
Flora	27	Married	2	Yes	Jadelle (implant)
Cassie	27	Married	3	Yes	Condoms, had previously used the pill
Julie	22	In a relationship	2	Yes	Depo Provera (injectable)
Men					
John	29	Married	2	NA	
Daniel	29	Married	2	Yes	Condoms
George	16	In a relationship	0	Yes	Condoms
Charles	29	Married	3	Yes	Wife uses family planning
Fred	32	Married	3	No	
Job	24	Married	2	Yes	Wife takes the pill
Carlo	24	Single	0	NA	
Richard	20	Married	1	No	
Jonathan	26	Married	1	No	
Remi	33	Married	4	Yes	Condoms

In addition, ten key informant interviews were conducted with key stakeholders; these included:

Table 4: Key Informant Interviews were conducted with a range of stakeholders.

Role/Position	Number interviewed
Health workers (including nurses, nurse aids, dispensary workers and VHWs)	6
Chiefs	2
Area Administrator	1
Police Officer	1

Quotes from qualitative interviews are presented throughout the Findings section, aligning with the participant's pseudonym. In addition, there are five case studies presented throughout the Findings section under the pseudonyms of the IDI respondent; these briefly detail the respondent's SRHR experiences over the course of their life. An accompanying case study annex detailing the experiences of eight IDI participants is also available.



Findings

Contraceptive use and access

Despite the research focusing on rural and remote communities in Pentecost, physical access was rarely listed as a barrier to family planning for women and men. Implants, condoms, injectables and the pill were commonly mentioned as being available at nearby clinics or the dispensary. In more remote communities, the pill and condoms were mentioned as being regularly available.

While cost was not mentioned as a prohibitive factor in accessing contraception, it should be noted that if women in some of the more remote communities were to access LARCs, they would need to walk at least 20 minutes to travel by boat for one hour and then walk for another 20 minutes, before making the return trip. A boat ride from the village to the clinic would be prohibitive for most households at 8000 VT (NZD $112). In addition, people with disabilities are also likely to be disproportionately impacted by hard-to-reach health services.

A nurse mentioned that a lack of financial resources sometimes prohibits positive health-seeking behaviours for communities from remote locations who need to travel by boat:

> *"It's hard (for them) to come when they are sick because they need money for boat and travel."*
>
> **Health Stakeholder 2, South Pentecost**

No research participant mentioned that they had ever sought a form of contraception that wasn't available. This may not accurately reflect the full range of available contraception; rather, it may suggest that people do not know about methods that are not readily accessible at their local clinic. Furthermore, when the research team was in South Pentecost, the clinic that provides contraception to several target communities closed in the morning as there was a lack of water, indicating there may be times when access to SRH services (and other health services) is limited. Furthermore, a Chief from a remote community in South Pentecost mentioned that the community dispensary had been damaged during Tropical Cyclone Lola (October 2023) and had yet to be rebuilt, which had interrupted some service provision. Recent research indicates that poor youth access to SRH services is exacerbated in the Pacific during disasters that are occurring at more frequent and severe rates in countries like Vanuatu[23].

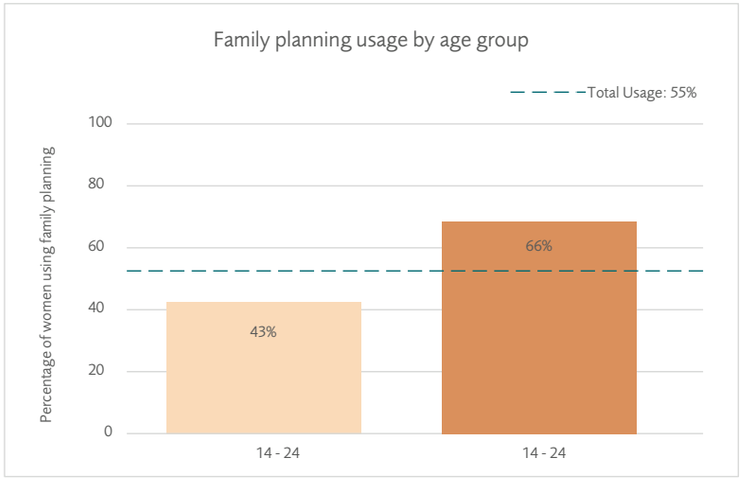
Availability of contraception at local clinics was also confirmed by clinic staff and nurses at two clinics, who reported having a good stock of supplies. They lamented that sometimes condoms expired and they occasionally ran out of implants, but they always had an adequate supply of the pill and injectables:

> *"Access to SRH is very accessible, but some services are not available at the clinic (e.g. STI testing), so it is only treated if symptoms are presented by the patient. All contraceptive methods are available except the IUD."*
>
> **Health Stakeholder 5, South Pentecost**

This aligns with a previous study carried out by the researcher in partnership with VFHA and Sexual Wellbeing Aotearoa, which found that supply chain issues have decreased following improvements facilitated through Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programmes. In Vanuatu RMNCAH is supported by the Ministry of Health, in collaboration with UNFPA, WHO, UNICEF, and other partners to enhance services and systems for accessible reproductive, maternal, newborn, and adolescent health care[24].

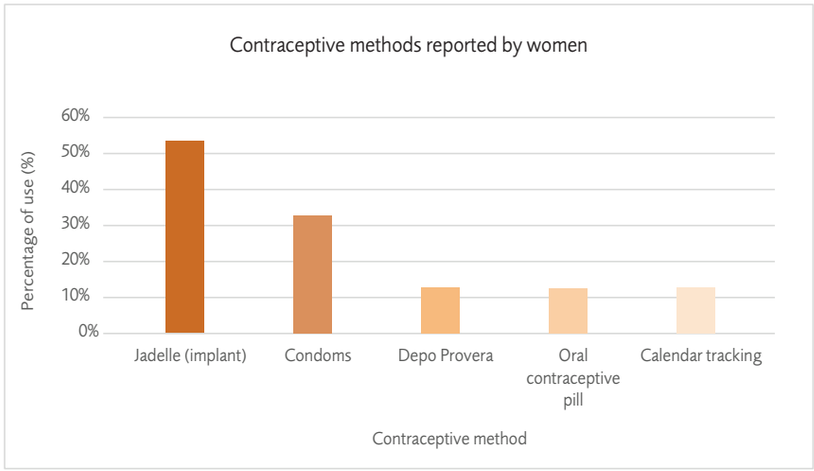
Of female FGD participants who responded to the survey, just over half (n=34, x=55%) reported using a form of contraception. While fewer women and girls aged 14-24 (n=10, x= 43%) reported using contraception compared to women aged 25-34 (n=24, x=66%), this difference is not statistically significant (p=0.137), however it may indicate potential age-related barriers to contraceptive access.

Graph 1: Comparison of women reporting using family planning by age



Of those who reported that they used contraception, the most commonly reported method was Jadelle (implant, n=18, x=53%), followed by condoms (n=11, x=32%), Depo Provera (injectable) (n=4, x=12%), the oral contraceptive pill (n=4, x=12%), and calendar tracking (n=4, x=12%). Note: results tally more than 100% as women were able to report using multiple methods such as condoms and implants, etc. The higher prevalence of Jadelle suggests a stronger preference for LARCs. This may reflect availability and awareness of Jadelle and a preference for a low-maintenance contraceptive method– that is one that does not require regular visits to clinics or dispensaries, especially for women in remote communities.

Graph 2: Contraceptive methods reported by women



Knowledge about family planning

Contraceptives

All FGDs and IDIs, with both men and women, demonstrated an understanding of modern contraceptive methods, and participants could name different types of contraceptive methods. However, misinformation about how modern contraceptive methods work and side effects were rife, especially related to either causing illness or cancer in women or stopping women from being able to become pregnant or have children when they stop using contraception. Furthermore, nearly half of all women's FGD participants did not know that it is possible to become pregnant the first time they have sex.

The widespread acceptance of this misinformation demonstrates a poor understanding of reproductive health and menstruation:

> *"When you take Depo (Provera) and you don't exercise, the blood flows back up the body."*
>
> Women's FGD, South Pentecost

> *"I am scared that all the blood is being piled up in my uterus and will develop into cancer and kill me later. So, I do not like that family planning is causing my period to stop and storing all the blood in me."*
>
> Julie, 22, South Pentecost

Interviews throughout the research revealed men and women alike were concerned that modern contraceptives cause women to become sick:

> *"Jadelle –(can) protect you from pregnancy, but Jadelle can give diseases to your wife."*
>
> Men's FGD, South Pentecost

> *"Sometimes people believe that if women take family planning like the injection (Depo Provera) it will cause cancer, and this can cause big arguments in the home if a man thinks his wife has taken family planning because he thinks she will get sick."*
>
> Health Stakeholder 2, South Pentecost

It was also often believed that contraceptives could have long-term side effects and can prevent women from getting pregnant in the future:

> *"Oh, I don't want to use family planning at all because when you use family planning, it stops you from having a baby. I'm frightened to use it."*
>
> Frida, 25, South Pentecost

Knowledge and understanding of STIs

There was limited understanding of STIs throughout IDIs with men and women and across FGDs. Of the men interviewed, just one had a good knowledge of STIs[ii], two had a limited understanding, and seven had not heard of STIs. Of the women interviewed, only half (n=6) had heard about STIs, and of those, just two demonstrated a good understanding of what STIs are, how they are transmitted, and how transmission could be prevented. Gonorrhoea and HIV/AIDS were the most frequently named types of STIs in FGDs, while some incorrect responses also included malaria and COVID-19 (referred to as "coronavirus"), further indicating a low understanding of STIs. Similar results were recorded across FGDs.

Strong responses explaining about STIs included:

> *"You should know how many partners your partner has had. Also, using condoms. You can go to the dispensary or clinic. For HIV/STIs, if you're a girl who hasn't had sex, but there's a boy who has had many partners, you can still catch STIs. If both have lots of partners, then the risk increases. If a boy gives it to you, you might not even know you've got an STI. It's important to get checkups at the clinic and use condoms. You must also try to get your partner to check up."*
>
> Women's FGD, Central Pentecost

However, more common responses included:

> *"I've heard of STI, but I don't know what it is. I only know that it is a disease that passes through sex, but I am not sure what it is."*
>
> Job 32, South Pentecost

Condom use

While condoms were the most frequently mentioned form of contraception reported being used across research participants, in FGDs, both men and women mentioned not liking to use condoms:

> *"I do not really like condoms cos it's not satisfying enough for me."*
>
> Men's FGD, South Pentecost

> *"Condom is good because it prevents pregnancy but it's not good because it smells."*
>
> Women's FGD, Central Pentecost

This was also confirmed by a nurse who reported low uptake of condoms:

> *"People use other forms of family planning, but none of the other types stop the spread of STIs. There hasn't been any change here in people using condoms. I try to get people to use them, but people here just don't use them."*
>
> Health Stakeholder 1, South Pentecost

Condoms were reported as being widely available in the community, including at local dispensaries and clinics:

> *"I have been telling people that we have female and male condoms at the clinic, but no one comes in for them. They actually expired. The condoms are kept inside the clinic, so people have to ask for them we don't keep them outside the clinic because some people just play with them, you know use them as balloons and things like that."*
>
> Health Stakeholder 1, South Pentecost

While condoms (male and female) were widely available at health clinics and dispensaries at no charge, health staff reported keeping them inside the clinic to ensure they weren't stolen or used as toys. For young people, however, the act of going to ask for condoms was seen as a barrier compared to if condoms could be accessed anonymously. For instance, they reported being afraid to go and access condoms even when they were freely available:

> *"(You could) steal condoms from the clinic at night."*
>
> Boys Secondary School FGD, South Pentecost

[ii] Respondents were considered to have a good understanding if they could explain how STIs are transmitted, name a type of STI, and correctly explain how they can be prevented.

Access to information

As demonstrated by the widespread incorrect understanding of family planning, such as it causing cancer or illness, especially if a woman no longer has their period, there was limited access to information about family planning in communities, including for women who use contraceptives.

Many target communities are far from formal health services such as clinics. They are serviced by VHWs or dispensary staff who themselves demonstrated limited understanding of SRHR in the research or were uncomfortable talking to young people about family planning, especially those who were not married or not mothers already. This was demonstrated by this question posed to the research team by the nurse aide:

> *"If a girl in secondary school comes to see me (for family planning), should I give it to her?"*
>
> Health Stakeholder 3, South Pentecost

While phones and technology were often cited as a reason for increasing teenage pregnancies and negative changes in the community, few young people reported using the internet to get information:

> *"We became good friends, and we had sex, but we didn't use a condom or go and seek more information because we didn't want people to talk about us because we were young, and we didn't know where to go and get information."*
>
> Sonia, 32, South Pentecost

It was unanimous that young people, especially teenagers, are afraid to go and seek information from nurses or dispensary staff, while sex and safe sex were considered a private topic. There were mixed responses around parents as a source of information, with some reporting that if parents did want to discuss family planning with teenagers, they did not always have the appropriate information to share, or young people may not listen to them. Aunties and uncles were considered a more appropriate source of information:

> *"She should go and talk to some of her friends who know. Sometimes girls might talk to her mum."*
>
> Girls' Secondary School FGD, South Pentecost

> *"Aunties are a good place to get information. Parents don't talk about it with their children.... In the community, all young girls are frightened to ask for information. A lot of girls are pregnant because they're afraid to ask for information or say no."*
>
> Women's FGD, Central Pentecost

> *"Sometimes mothers try and talk and teach but young people don't listen."*
>
> Esther, 22, South Pentecost

Similarly, while sourcing information from friends was also provided as a key source for young people, it was also recognised that peers and friends may not know the correct information either:

> *"In my opinion, the problem is that they (young people) go and ask their friends for information, but their friends don't know either, so they give out a lot of wrong information."*
>
> Women's FGD, South Pentecost

In some instances, it was felt that Maria (the fictional character in the FGD scenario) and young people in general shouldn't discuss family planning or having sex with their friends at all because, especially in more remote villages, it was considered a private or "tabu" topic:

> "Maria *shouldn't have told Serah about it because that's their private life and their secret. She should've kept it a secret from her friends."*
>
> Women's FGD, South Pentecost

Health staff shared that there often weren't suitable environments for young people to access information in a safe or comfortable way and that it can be hard for young people to ask for information:

> *"It's hard for young people to ask for information. There needs to be a day that deals with young people aged 15-19. The setting needs to make young people comfortable, so they don't feel ashamed discussing openly."*
>
> Health Stakeholder 2, South Pentecost

> *'...We don't allow people to talk about sex with young people. Like when they're finished year 10 or 11. ... We need nurses and teachers, chiefs and pastors to assist in raising awareness and talking to young people. Sometimes, young people don't listen... There needs to be influential people and leaders to help share the message."*
>
> Health Stakeholder 1, South Pentecost

Perceptions of family planning

Despite misinformation, family planning was widely perceived by women, men, and community leaders as beneficial for families. Most participants articulated that family planning helped families to space children and supported the health of mothers and children, while also reducing the workload on women as well as being appropriate given increasing cost of living expenses which have also changed from previous generations:

> *".... It's good to space children; it's better for us to have healthier children. I think a lot of mothers use it here. I see now we have less children. Now, most families have 2 children, some 3. Before, people had 5, 6, 7, 8 children. Families were bigger and it was a lot of work for women."*
>
> Women's FGD, Central Pentecost

While most saw the benefits of spacing children, the impact of smaller families and thus population size and or school enrolments were considered a negative by some interviewees:

> *"When we first heard about family planning, we just started to understand that it helps you space your children; it helped us a lot. Now, there's a vaccine that some people take for five years (Jadelle/implant), and then they must take it out, but some keep it. But now the size of the community has decreased, and it's a big complaint from the community that the population has gone down."*
>
> Chief, South Pentecost

> *"My husband thinks family planning is good because it means that when I take it, we don't have too many children, but other people don't think family planning is good because there's not as many children to go to kindy."*
>
> Frida, 25, South Pentecost

Perceptions of contraceptive use for young people

While family planning was widely considered appropriate for women who were already mothers (including teenage mothers), for young people without children or for those who were not married, there were more mixed feelings and an understanding that they faced greater barriers to accessing contraceptives due to a range of factors explored later in the report:

> *"In the community, sometimes everyone might talk and want to know why you're there (at the clinic). I think she's afraid (to get family planning), if she was married, it would be alright."*
>
> Women's FGD, Central Pentecost

Throughout FGDs and IDIs, it was reported that men commonly don't wish for their girlfriend or wife to use contraceptives because they believe it will lead to them cheating. For young women, especially teenagers, it was perceived, often by other young women, that the reason they would want to use contraceptives was so they could have multiple sexual partners:

> *"Let me tell you something: it might not be the right thing to say, but some girls take family planning because they want to go with lots of boys and not get pregnant. I think that's why they take it."*
>
> Flora, 27, South Pentecost

> *"I don't think it's a good idea for young girls to take family planning because then they will just start having affairs with married men if they know they can't get pregnant."*
>
> Sharyn, 31, South Pentecost

The same beliefs and attitudes about women using contraceptives to cheat were only rarely targeted at young men (as well as women):

> *"Some men and women take family planning and then have sex with different men or women."*
>
> Carlo, 24, South Pentecost

The barriers to SRH services for young people

Interviews revealed critical barriers that impede young people's access to SRH services. Young people reported feeling afraid or shame in accessing contraception from health services even if they were readily available. Young women and girls were disproportionately impacted both with male partners and other men (such as family members) identified as a leading barrier to accessing contraception. It was also recognised throughout the interviews that when an unplanned pregnancy occurs, young women overwhelmingly shoulder the increased responsibilities, while men often remain largely unaffected. These systemic challenges not only limit reproductive choice but also perpetuate cycles of inequality and reduced opportunity for young women.

Safe sex and consent: Agency and pressure in youth relationships

The FGDs revealed a deeply nuanced reality of power, consent, and relationship dynamics, particularly when exploring a scenario involving Maria, a 17-year-old girl who is unsure about having sex with her 18-year-old boyfriend Alex:

> *"Maria is in charge of her body and privates, and it's her property, so Maria can choose to have it (sex) or not."*
>
> Boys' Secondary School FGD, South Pentecost

> *"Life today is different from before. We have come to know that forcing someone to have sex is rape and it's dangerous. We need a lot of awareness around this so people are more informed."*
>
> Men's FGD, South Pentecost

The responses demonstrated a tension between recognising the individual agency of young women and the widespread societal pressures that can undermine a young woman's choice. Many participants, men and women, acknowledged Maria's right to refuse yet simultaneously described potential negative consequences. These consequences included:

- Potential break-up
- Likelihood of her boyfriend cheating
- Social stigma
- Physical and or sexual violence.

All female FGD participants mentioned that Alex would either cheat on Maria or break up with her if she did not have sex with him:

> *"Maria isn't sure whether she should sleep with Alex because it's her first time, but he might break up with her."*
>
> Girls' Secondary School FGD, South Pentecost

Multiple male FGDs explicitly discussed the possibility of force or rape if Maria refused, revealing concerning and problematic attitudes toward consent:

> *"Alex is the man here. He has the right to choose what he wants to do. He has the right to force Maria into having sex if he wants to."*
>
> Men's FGD, South Pentecost

> *"Maria will be scared, and Alex may beat her up because he will want to have sex. Alex's friends will hate Maria for not giving Alex what he wants. Rape is prone to happen."*
>
> Men's FGD, South Pentecost

Some FGD participants demonstrated an evolving understanding of consent with one respondent sharing:

> *"Alex cannot force Maria. They both can't sleep with each other 'cos they are very young and may not know what to do since it's their first [time]. I will tell Alex not to have sex with Maria since she is too young to have sex. Maria must make this decision because it's her body and she has the right."*
>
> Men's FGD, South Pentecost

Case Study 1

Cassie, 27, married mother of 3

At 20 years old, Cassie met her first boyfriend, now husband, Jack. Living on a different island with her family, she connected with Jack over the phone—a practice not uncommon in Vanuatu, where young people, often bored, dial random numbers in hopes of starting a conversation or relationship.

Two years later, at 22, Cassie married Jack and moved to his village in Pentecost. Shortly after, she gave birth to twin girls.

Cassie's relationship, however, has been marked by challenges. Early on, Jack forced her to have sex, a behaviour that has persisted throughout their marriage:

"Sometimes, if I tell him no, he forces me to have sex with him. He says, 'You must want to have sex.' Sometimes he accepts it when I say no, but sometimes he doesn't. Sometimes, he wants sex too much, but I don't want to."

After she gave birth to her twins, Cassie's husband wanted to have sex quickly, but she feels proud that she was able to say no, and he eventually respected her decision:

"We waited a little while after having the twins before having sex again. He asked me, but I wanted to see my period first. He tried to force me, but I made him listen and stayed strong.

Before her marriage, Cassie regularly used family planning and took the pill. However, this changed after moving to Pentecost:

"When I lived on my island, I took the pill. But now that I live here, we just use condoms. When I started living with my husband, he said, 'I don't want you taking family planning like the injection; just use condoms.' He believes it can make you sick."

Cassie believes that community attitudes about family planning use differ for married and unmarried women:

"I think it's different for young people. If women are married, they can take family planning like the injection or Jadelle, but if they're not married, their mothers don't talk to them about it."

Cassie recently had a third child, even though she felt content with her twin girls:

"I told my husband, 'Enough,' but he wanted more."

Looking to the future, Cassie hopes her daughters will have more opportunities and avoid the challenges she has faced. She emphasises the importance of education and waiting to marry:

"I want my girls to go to school and, when they're ready, get married—not too quickly."

Perceived vs actual agency: Who decides access to family planning in young relationships?

Similarly, nuanced and complex findings were demonstrated when discussing agency and choice regarding accessing contraception and family planning. Throughout the IDIs, women reported making decisions about family planning together with their husbands as a joint decision; however, this would often be contradicted when explaining more about the couple's views of contraception or their desires to use contraception:

> *"When I came here and started living with him (my husband), he said I don't want you taking it (contraception) like the injection, just use condoms. He believes it can cause you to get sick.... We make the decision together about family planning."*
>
> Cassie, 27, South Pentecost

This was further explored during the results of the FGD survey. Of the men and women focus group participants who responded to the survey question "Who decides what type of contraception you use?" a significant proportion of women (n=21, x=62%) reported deciding together compared to men, at just 8 per cent (n=2). Men were more likely to report not wanting to answer the question than women. Proportionally, more men reported deciding on their own compared to women; however, this was not statistically significant (men: n=11 x=33%, women: n=8, x=26%).

Throughout the research, men were frequently listed as the most significant barrier young women faced in accessing contraception of their choice:

> *"It is easy for women to access family planning, but their husbands are blocking them from receiving family planning."*
>
> Women's FGD, South Pentecost

> *"Sometimes girls want to use family planning because they don't want to get pregnant, but their boyfriends stop them from taking it. ... Because they want children or they think if their girlfriend takes it (contraception), they'll cheat on them."*
>
> Esther, 22, South Pentecost

> *"Women face more challenges in accessing family planning. They need to come together with their husbands. After a baby is born and when the parents are discharged, we talk to the parents together about family planning... sometimes when you put the implant in, the woman goes home but then there's a big argument: the man might beat her. So, we try and counsel couples together...but condoms women say men don't want them."*
>
> Health Stakeholder 1, South Pentecost

Why don't some men want women to use contraceptives?

Several reasons were provided as to why men don't want women to use contraceptives, including:

- Belief that women will then cheat on them
- Family planning causes cancer or other illness
- Wanting a greater number of children, and or that family planning means women won't be able to have children in the future
- Not being educated or understanding about family planning.

Several women in IDIs shared that their husbands didn't want or didn't like them using contraception. As the following excerpt below describes, there are often a multitude of inter-related reasons:

> *"My husband doesn't think family planning is good because he believes it means that you won't have children anymore or that women will cheat. But that's just because he doesn't know about it. And when I needed to go to Port Vila to study, he told me to stop taking it. Because he didn't trust me. So, I had to convince him that I would stop using family planning when I was in Port Vila, so if I was cheating, I would get pregnant. So, when I was in Port Vila I stopped using Depo Provera."*
>
> Sonia, 32, South Pentecost

Believing that women use contraception to cheat without becoming pregnant was widespread among men and women, with the following exchange with a local police officer demonstrating how entrenched these views are:

> *".....If a woman is involved in work and needs to travel and she's using family planning, then it can create emotional violence; it's domestic violence. When we go and make an investigation, we can see it's a type of emotional violence because when we go and talk to the man, he starts to explain his worries.... The man is the victim. It's emotional violence because he's worried that his wife will be cheating on him."*
>
> Police officer, Pentecost

A small minority of men shared that they believe that women should have full autonomy and agency about contraception:

> *"...Maria is in charge of her body, it's her property...so Maria can choose if she wants it (contraception) or not."*
>
> Men's FGD, South Pentecost

Case Study 2

Sonia, 32, married mother of 3

Sonia, 32, is a married mother of three living in her husband's village in Pentecost. Having completed Year 12 and vocational training, she actively participates in community committees while balancing traditional gender roles and creating a strong future for her children.

Sonia first learned about puberty and menstruation at school and through conversations with her mother. She felt prepared when she got her first period at 14:

"I knew what my period was before I got it. It felt normal because I already knew what was happening."

At 20, Sonia began a relationship with her now-husband but lacked an understanding of sex and family planning:

"We didn't use condoms or seek more information because we didn't want people to gossip about us."

At 22, they married in a customary ceremony with an 80,000 VT (NZD $1140) bride price. While Sonia values the tradition, she acknowledges the difficulties bride price can create for some women, keeping them isolated from their families:

"Bride price is a way to thank the bride's family, but sometimes it's set too high."

Though Sonia enjoys married life, decisions around sex rest with her husband:

"He decides when we have sex. If I don't want to, I explain why."

Initially, Sonia's husband opposed family planning, fearing it would lead her to cheat or prevent future pregnancies. After back-to-back pregnancies, Sonia persuaded him to allow her to use Depo Provera, which she used for eight years to space her pregnancies between her second and third child.

Sonia recalls mixed emotions during her first pregnancy at 22:

"I felt happy, but I wasn't ready or prepared to have a baby when I became pregnant, we didn't have good jobs or much money."

The challenges of having two children close together led Sonia to advocate for herself:

"When I realised I was pregnant again, I felt sad because my first baby was only 1 year old, and I knew it would be a lot more work compared to having one baby."

Having her first two children close together and many conversations with her husband helped convince him to allow her to use contraception:

"He didn't want it at first. So, we didn't use it, and then we had our first and second babies, who were very close to each other.

Because my husband isn't educated, he thought it was going to stop me from ever having children again. So, I had to explain it very clearly until he finally understood."

Sonia highlights the stigma surrounding young, unmarried women using contraceptives:

"If a young woman goes to take family planning and she's not married, people will say she's doing it so that she can be with many men.... People assume women use family planning to cheat. It's wrong, but it's what the community thinks."

Sonia faced the same accusations from her husband. When Sonia travelled for vocational training, her husband insisted she stop using contraception to prove her faithfulness.

Sonia dreams of a brighter future for her daughters, sharing the importance of education and independence:

"I want them to go to school, get jobs, and marry only when they're ready. Life is different now, and I want them to be able to take care of themselves."

Navigating reproductive rights: What would happen if a woman used contraception without her partner knowing?

In FGDs and interviews, men and women were asked what would happen if a woman were to use contraception without her partner knowing. Across the 11 FGDs with young women, all explained that men would be angry if they found out their wife or girlfriend had used contraception without them knowing, with seven of these explicitly mentioning that the boyfriend in the scenario would respond with violence:

> *"If she took contraception without Alex knowing, there would be a big fight. He would beat her."*
>
> Women's FGD, South Pentecost

Similarly, most FGDs with young men also revealed it is likely that a man would respond with anger or violence:

> *"Alex will beat Maria and be angry...and will explain that she needs to let him know before she does something like that because he is the boss."*
>
> Men's FGD, South Pentecost

While women reported making decisions with their partners, responses to the question "What would happen if a woman took family planning without her husband knowing?" illustrated that, in many instances, men were reported to make the final decision. The consequences of women making autonomous decisions could be harmful:

> *"I would talk to her the first time and say she should have told me. We should make the decision together. Send her back to the hospital to take out the family planning, if she doesn't want to.... then she would have black eyes."*
>
> Carlo, 24, South Pentecost

This was confirmed by a nurse who shared a similar event happening in the community:

> *"One woman had a baby, and after just one year, she had another. She decided that she wanted to use family planning. We talked with her husband as well, and he agreed, but after she had the implant, she went back to the house, and he beat her."*
>
> Health Stakeholder 1, South Pentecost

Case Study 3

Remi, 33, married father of 4

Remi, a father of four, married his wife at 18. While in Remi's community, men are often seen as being responsible for 'heavy' work, and women support household duties such as preparing food or assisting men, Remi shares responsibilities with his wife in his own household:

"In my home, my wife loves me, so we share our responsibilities and have a very good life."

Remi speaks positively about his marriage, reflecting on the traditional process of bride price and the involvement of both families in the ceremony. He emphasises equality in decision-making, explaining:

"Both the women and the men should decide together in a home, especially if they are married."

While Remi is now in a loving marriage, his account of his first sexual experience was not a positive one. Remi shared that he was forced into sex, expressing fear and confusion at the time:

"My first time to have sex I was forced to do it. So, I was really scared to do it, and I didn't even know what to do. I was told what to do, and we didn't even use a condom."

Though rare, Remi's experience illustrates that young men can also experience coercion and rape and may experience even greater barriers to reporting due to cultural and societal beliefs around young men and sex.

Remi stands out as one of the few men interviewed who explicitly supports a woman's autonomy in choosing family planning. He believes women should have the right to make decisions about family planning without fear of consequences:

"Women should decide to use family planning. If my wife doesn't tell me that she's using family planning, I will have to come to understand why."

Remi shared the benefits of family planning for spacing children and supporting women's health. However, he acknowledges that misinformation and rumours in his community can cause hesitation:

"I am not very worried about family planning. Some rumours made me have many questions, and I was a bit worried, but I still use it. I planned to have five kids. But my wife only wanted four."

Case Study 4

Carlo, 24, not married

Carlo, 24, was 17 when he took part in a traditional circumcision ceremony where he explained:

"Boys go and stay in the Nakamal. Men cook, and women aren't allowed inside. They use bamboo for circumcision, and boys stay in the Nakamal for about 10 days."

Despite the circumcision being seen as an important kastom ceremony and associated with 'becoming men', Carlo shared that puberty was never spoken about and is considered taboo. Despite finishing high school, he never learnt about it:

"Puberty is not spoken about; I've never learned about it."

It was also in high school where Carlo began his first sexual relationship.

Currently single, Carlo reflects on a shift in marriage customs and where men and women can now have more autonomy:

"Following our kastom means parents choose a man or woman for marriage. Now, men and women choose who they want to get married to."

Carlo understands family planning as an important way to support a mother's health and spacing children:

"Family planning is for spacing out children and making sure mothers recover well after giving birth."

However, he acknowledges misinformation and stigma in his community. Some men believe family planning promotes promiscuity, while others, especially youth, lack adequate education to understand how it works:

"Some young people don't have a very good education, so they take family planning but don't understand how it works."

While Carlo has not used family planning yet, he believes it should be a joint decision between a husband and wife:

"Wives and husbands should decide using family planning together."

Despite seeing family planning as a joint decision, Carlo expressed troubling attitudes regarding his response if his partner were to use family planning without consulting him:

"I would talk to her the first time and say she should have told me. We should make the decision together I would send her back to the hospital to take out the family planning. If she doesn't want to, she would have black eyes."

Village toktok: Why young people don't access information or contraception from health services

Throughout the FGDs and IDIs, it was often noted that young people are frightened or feel ashamed to go and ask for information or to access contraceptives. This was especially pronounced if the young person was still in school or unmarried. Feelings of fear or shame were reported to stem from being worried about:

- Being spoken about/subject to rumours or gossip, especially in a small village setting
- Facing judgement from clinic staff for being considered 'too young'
- Having clinic staff tell their parents that they are sexually active and or came to access contraception:

> *"She's ashamed to go and see the nurse because she might talk about them in the village and tell others why she was at the clinic and the questions they asked."*
>
> Women's FGD, South Pentecost

> *"Everyone who sees Maria there will talk about her. She's frightened because she's too young, and the nurse will know that she has a boyfriend and might ask her a lot of questions about why she wants to use family planning."*
>
> Women's FGD, South Pentecost

Young people being afraid to access family planning services was also confirmed by clinic staff who shared, while contraception was physically accessible, young people did not access it:

> *"Young people are not using family planning. I think it's easy for them to access, but they're frightened."*
>
> Health Stakeholder 4, Female, Central Pentecost

Additional barriers for young women and girls

Young women and girls throughout the FGDs reported an additional barrier of feeling uncomfortable accessing SRH services from male nurses or clinic staff. This is exacerbated in small villages where there is only one VHW or dispensary worker, meaning it is not always possible to seek health care from someone of the same gender:

> *"The nurse here (at the school) is an older man, so it's hard to go and ask questions."*
>
> Girls' Secondary School FGD, South Pentecost

Clinic staff also shared that young women face additional barriers when accessing reproductive health services:

> *"Some people are ashamed to ask questions. No girl has ever asked me a question, but the boys have. The girls are ashamed to speak to the nurses."*
>
> Health Stakeholder 1, Male, South Pentecost

> *"They're frightened because they might think that we might talk about them. We need to have men to talk with men and boys and women to talk with women and girls."*
>
> Health Stakeholder 2, Female, South Pentecost

Additional barriers for young people with disabilities

People with disabilities face unique challenges in accessing and utilising SRH services and information in Vanuatu. While physical access to services was rarely mentioned as a barrier in interviews to accessing family planning methods, accessing health services in most villages visited required long and, at times, difficult walks that would be challenging for a person with a physical impairment. In addition, while limited information is available, most of what is available includes visual IEC materials that would not be accessible for people with vision impairments.

Disability advocates shared challenges that people with disabilities, especially intellectual impairments, may have in fulfilling their SRHR. This was mentioned both in terms of accessing services due to beliefs and misconceptions about the reproductive system or health of people with disabilities and their ability to conceive, and concerns about impinging on the SRHR of people with disabilities by giving them contraception without their informed consent or knowledge. This aligns with global evidence showing that women with disabilities are more likely to experience forced or coerced sterilisation or contraception use[25]:

> *"Many mothers ask me if their daughters with intellectual (impairments) can get pregnant...they often think that they can't.... Many carers don't want their children (with disabilities) to have relationships even if it makes them happy."*
>
> Disability service provider, Port Vila

According to the most recent census, approximately 2% of youth (15-30) in Vanuatu have a disability[26]. Young people with disabilities are less likely to complete their education, which reduces their exposure to SRH information typically disseminated through schools. Interviews with health workers revealed that young people with intellectual impairments were also found to be at risk of sexual assault in target communities. This aligns with global evidence that women with disabilities experience an increased risk of sexual violence, especially women with intellectual disabilities[27]:

> *"There's a woman with a disability and she's got three children. I was with her when she delivered one of her children, and she didn't cope with it. She can't speak or hear. ...Some people, some men who live in her village, target her. We must talk with their carers to make sure they get the implant."*
>
> Health Stakeholder 1, Male, South Pentecost

Healthcare staff attitudes and responses when young people seek contraception

While FGD participant views were unanimous that young people, especially those who are unmarried, are frightened to access health services, interviews with formal and informal health workers explored nursing and clinic staff attitudes towards providing young people with contraceptives. Responses were mixed, with some healthcare staff overwhelmingly positive about providing contraceptives to young people and others more hesitant:

> *"We've all discussed this (reducing teenage pregnancy), us nurses, I think we should start offering implants for the 15, 16-year-olds."*
>
> Nurse aide, South Pentecost

"If a young person asks me about family planning, I will provide the options and tell them the different methods. I will also let them decide which one they want to use."

Health Stakeholder 5, Female, South Pentecost

Other health staff expressed some judgement towards young people in the community that could impact perceptions of health services or a hesitancy to talk to young people because of cultural barriers. Judgement was often shaped by deep-rooted cultural and gender norms that reinforce the belief that women and girls are responsible for men's behaviour and the harm or violence they experience:

"Parents must talk to their children.... otherwise, it ends up in pregnancy... Girls must dress up well, so they don't tempt and attract men."

Health Stakeholder 2, Female, South Pentecost

"If a girl is in school and she comes to see me, should I give her family planning?"

Health Stakeholder 3, Female, Central Pentecost

Misinformation and beliefs as a barrier to family planning

"There is a story they say that family planning medicine is made from animal blood, which makes them a bit scared of it."

Sonia, 32, South Pentecost

Widespread taboos and misinformation about the impact of family planning, especially on a woman's health and long-term fertility, were frequently cited as a barrier for young people not to use contraception. This was especially true if a young woman had not already had a child. While culture and religion are often believed to be barriers to accessing contraception, just one male youth mentioned that family planning was against his religion. At the same time, health staff felt that most Faith leaders were supportive, except Catholic denominations:

"All young people are afraid to take family planning. Older women say if you take family planning, it stops you from getting pregnant – you won't be able to have a baby in the future."

Women's FGD, South Pentecost

"Sometimes there's a lot of wrong information which makes young people afraid to take family planning."

Frida, 25, South Pentecost

"Some rumours made me have a lot of questions, and I was a bit worried, but I am (my wife) is still using it."

Remi, 33, South Pentecost

Health staff also confirmed that there was mistrust about family planning and misinformation, which prevented people from accessing contraception:

"Most community members don't trust family planning methods. The community believes family planning methods are causing other serious medical conditions. They believe that having more than 5 children is great... Because there is a lack of understanding, the community does not react well towards family planning."

Health Stakeholder 5, South Pentecost

Teenage pregnancy and the impact of parenthood on young people

Rates of teenage pregnancies

Coinciding with reports of low uptake of contraception by young people, communities are witnessing a shift in reproductive patterns with both increasing rates of teenage pregnancies, and in some instances increasingly younger individuals experiencing parenthood. Throughout the interviews, research participants including healthcare stakeholders mentioned a decreasing age for first-time parents, with some girls as young as nine or ten becoming mothers:

"Sometimes young girls, some who are 12 years or 9 years old, have children now. Some who are 10 or 11 years old already have children... Normally, if you're 20 or 19, then you get pregnant and have children. But now children who are 11 or 12, they get their period, and they're having sex and children."

Flora, 25, South Pentecost

"In the past, youth needed to be a certain age before they started to be in a relationship. Now there's a lot of underage pregnancy including girls who are 13 years old."

Health Stakeholder 2, South Pentecost

Abortion is illegal in Vanuatu unless deemed medically necessary to save the mother's life[28]. As a result, women and girls with unplanned pregnancies may resort to unsafe abortion practices, endangering their health and posing risks to foetal development if a miscarriage does not occur [29]. Healthcare staff also noted that along with increased rates of teenage pregnancies, they had observed increases in young people accessing unsafe and illegal abortions through kastom healers and traditional medicine.

The most common method of seeking an unsafe abortion in Vanuatu is consulting a kastom medicine healer (often a man) for a "traditional" or kastom leaf, which is taken orally[30]. Research on unintended pregnancies in Vanuatu has found that girls who attempt to induce a miscarriage using kastom leaf often find it ineffective[31]. When it does induce a miscarriage, excessive bleeding is reported as a common complication, placing a young woman's life at risk[32]:

"The rate of teenage pregnancy has increased, even access to abortion has increased. They go and access traditional healers/traditional abortion and take kastom medicine."

Health Stakeholder 1, South Pentecost

As abortions are illegal, it is not surprising that seeking an abortion was rarely mentioned in interviews with young people as an option for young girls with unplanned pregnancies. When "kastom leaf" or seeing a traditional healer was mentioned, it was often about an action a young girl might take should she have an unwanted pregnancy during the scenario in FGDs:

"If Maria accidentally got pregnant.... she might try to go to a herbal medicine person in the community to use the leaf to abort the baby (unsafe abortion)."

Boys' Secondary School FGD, South Pentecost

Interestingly, despite community leaders and young people alike sharing that there were many teenage mothers and teenage pregnancies in

the community, the research team did not meet any teenage girls who were currently pregnant. However, they did interview several women who had given birth as teenagers. It was explained that many young girls return to school after giving birth:

> *"Yes, there are plenty of teenage pregnancies here. Then they deliver the baby, and the baby stays with the grandparents, and they go back to school. Their parents still help support them to go to school…if you are pregnant, if your parents have money, if you want to go to school, you can still study."*
>
> Police Officer, Pentecost

Impact of being teenage parents on young men and women

It was widely reported that life for young parents in the community was difficult. Young women and men shared the impact being young parents had on their lives, including the pressure to get married:

> *"I was 19 when I got married…I didn't want to, but I had to because my girlfriend was pregnant."*
>
> Daniel, 29, Central Pentecost

> *"When I was pregnant, I didn't feel happy. I had regrets before I had my baby because I wasn't ready."*
>
> Louisa, 22 (mother at 19), Central Pentecost

While it was encouraging to hear throughout the research that there were opportunities for young women to continue their education after giving birth, some young women reported experiencing harsh interventions by their families, including being forced to give their babies up for adoption.

These sentiments were also shared throughout the FGDs when young men and women were responding to a scenario of what would happen should a teenage girl fall pregnant as well as other negative coping mechanisms young people might resort to:

> *"If my girlfriend gets pregnant, her parents might kill me or try to kill me or come to school to hurt me. If Maria accidentally got pregnant, Alex might hang himself out of frustration, run away from Maria or try to go to a herbal medicine person in the community to use a leaf to abort the baby (unsafe abortion)."*
>
> Boys' Secondary School FGD, South Pentecost

> *"She didn't take protection, and so now she is pregnant, she is scared because if she goes to the clinic and find out that she is pregnant, her parents will know, and they will be mad at her and will abuse her verbally. Some will talk about her."*
>
> Women's FGD, South Pentecost

Men and women shared that there are also different outcomes for young men and women in the instance of becoming teenage parents, with young girls typically facing more community pressure and stigma, especially if their partner leaves them:

> *"Some of my friends have children, but they aren't with the father, and they find it hard to find money and to feed their children."*
>
> Flora, 27, South Pentecost

> *"Their challenges will not be the same. Women are more likely to be in the house all day tending to the baby and doing all the house chores and everything that needs to be done at home while the men are walking freely in the streets and meeting their friends and not caring for the wife and child."*
>
> Men's FGD, South Pentecost

> *"People will talk about us and gossip about us. Alex will likely be cheating on Maria when she is at home and he is walking around most of the time. Alex and Maria will not have money for diapers, pads, kava and tobacco for Alex to enjoy. Alex will still have his freedom and can choose to spend his time with his friends and doesn't have to look after the child as much as Maria. Maria will do most of the work by herself. They do not have enough knowledge to be parents, and they will fail a lot along the way. Their parents will be very disappointed with them and will continue to mention their failures. The community will not be very supportive and will be mad at them."*
>
> Boys' Secondary School FGD, South Pentecost

Case Study 5

Julie, 22, mother of 2

Julie, 22, was 19 when she fell pregnant for the first time. Still a student, Julie's pregnancy was met with anger from her parents, who threatened her with violence:

"My parents were furious at me when they found out that I was pregnant. They wanted to hit me, and they wanted to whip me."

Despite their initial anger, her parents softened once her baby was born. However, their response devastated Julie, as they decided that Julie would return to school. They arranged for her baby to be raised by her older sister, who lived on a different island. This decision, made without Julie's consent, deeply impacted her:

"I was so angry at my parents for doing this to me. I didn't want to go back to school."

Ultimately, Julie did not complete high school while her parents stopped her boyfriend from contacting her.

Julie started a new relationship in the following years, which has also had challenges. Earlier this year, she experienced a late-term miscarriage – again devastating her:

"When I miscarried my second child, it was the second time I've given birth, but I still do not have the two babies I wanted. I didn't have a husband when I had my first child, and now I don't have a baby when I have a husband."

Following her miscarriage, a nurse advised Julie to use contraception to allow her body time to recover before becoming pregnant again. She began using Depo Provera, however her limited understanding of family planning methods has caused her to worry:

"I am currently using Depo (Provera), and I was advised to go on family planning due to my miscarriage. But my period stopped coming for three months now after I started using it. From what I understand, a period means my stomach is being cleaned, and so without it, I know that the blood is stuck in me and rotting. And family planning is causing that. All the blood is stuck in me, and it's going to develop into cancer if I'm not careful."

While Julie's boyfriend is happy for her to use family planning, some of her friends are not able to take family planning because their partners believe it means they will cheat on them:

"Some men do not want their wives to use family planning because of jealousy. They think she might cheat on him since she won't get pregnant, and no one would find out."

Julie holds hope for a different vision for young girls in her community and hopes if she has daughters they would grow up in a more supportive and empowering environment:

"I want girls to finish school and get a better education because I didn't. If I have daughters, I want them to wait until they've achieved a lot in life before having boyfriends. I don't want men to control them."

Discussion

This study explored young people's knowledge and understanding of safe sex, contraception, and STIs on Pentecost Island, Vanuatu. It also examined barriers to accessing information and family planning services to inform the PGFBY project. While previous research has explored youth knowledge of family planning, most studies have been conducted in urban areas, with limited attention given to rural populations like those on Pentecost Island. This study adds to the limited evidence base by providing critical insights into the reproductive health challenges young people face in rural Vanuatu.

Improving access to SRHR is a key priority for the Government of Vanuatu, reflected in its integration of family planning and SRHR initiatives into national and international policy frameworks. Achieving universal SRH is essential for implementing the National Gender Equality Policy (NGEP) 2020–2030[33], the National Disability Inclusive Development Policy 2018–2025[34], the Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy and Strategy 2021–2025[35], and the Vanuatu Health Sector Strategy (HSS) 2021–2030[36].

Regionally, this research aligns with Vanuatu's commitments to the Moana Declaration[37] and the IPPF Niu Vaka II Strategy[38], reinforcing its leadership in advancing SRHR in the Pacific. Internationally, it supports obligations under the International Conference on Population and Development (ICPD) Programme of Action[39] and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[40], while contributing to SDGs 3.7 on universal SRH access [41] and 5.2 on eliminating violence against women and girls[42].

Availability of contraceptives

Our findings reveal a complex landscape of reproductive health issues extending beyond the physical availability and accessibility of family planning. Contrary to common assumptions about limited access to family planning in remote areas, we found that condoms, oral contraceptives (the pill), and injections (Depo Provera) were generally accessible at the village level. LARCs such as implants (Jadelle) were also available at larger health centres within the Area Council, indicating that physical access to contraception was not a significant barrier for young people in this study. Although given young people were not proactively seeking out contraception, this may be a greater barrier than was reported, especially in remote communities requiring boat travel. In addition, physical access is a significant barrier for people with disabilities to access health services in Vanuatu, however, few people with disabilities took part in the research, and as such, this is likely to be under-reported[43].

Misinformation about contraception and poor knowledge about STIs

Despite the widespread availability of contraceptives, the study revealed substantial gaps in knowledge and understanding regarding how these methods work and their potential side effects that impacted their uptake and use. Widespread misinformation—such as fears that contraceptives cause infertility, illness, or cancer—discourages their use. Additionally, young women reported concerns and misconceptions about irregular menstruation associated with certain contraceptive methods, reflecting a broader need for improved counselling and follow-up care and improving understanding of menstruation.

Recent evidence suggests that improving understanding of menstrual health can be a vital component for young people to fully realise their SRHR and increase uptake of more holistic SRH services[44].

Similarly, STI knowledge among young people was minimal, often limited to naming infections such as HIV and gonorrhoea, with little awareness of symptoms, transmission routes, or preventive measures. This lack of comprehensive understanding underscores the need for more targeted STI education programmes for youth, particularly in rural areas where information may be scarce.

Gender, power dynamics, and family planning

Beyond individual knowledge gaps, gender dynamics significantly influence access to contraception and reproductive decision-making. While male community leaders, including chiefs, generally support family planning for maternal and child health benefits, patriarchal beliefs still dictate household decision-making. Men are often the primary decision-makers regarding contraception, with many expressing fears that women using contraception are more likely to be unfaithful. Such beliefs restrict women's agency to make decisions about their reproductive health matters and, in some cases, contribute to coercion or intimate partner violence.

Power imbalances also shape sexual relationships, particularly for young women, who often experience pressure to engage in sex to maintain relationships or avoid conflict. While married women reported slightly greater autonomy in refusing sex, some still faced coercion or forced sex, underscoring the persistence of gendered power imbalances. These dynamics highlight the intersection of reproductive health and gender-based violence, reinforcing the need for gender-transformative approaches in SRH programming.

The impact of stigma on young people accessing SRH services

Barriers to SRH services also include stigma and fear of judgment among young people accessing these services. There is a growing body of evidence about the need for youth friendly and youth-led SRH services and information[45, 46]. Health centres were commonly identified as places where young people could seek information, but several barriers hindered their access to these services. Young people, particularly those who are unmarried, often feel ashamed or reluctant to seek contraception or STI treatment at health centres, particularly when health staff are male. This aligns with regional research showing that adolescents and unmarried women face additional barriers such as greater discrimination and stigma from community members and healthcare providers to access SRH services[47].

For marginalised groups—such as young people with disabilities and of diverse SOGIESC—access to SRH services is compounded by societal misconceptions and discrimination. Young people with disabilities are often perceived as asexual or undeserving of sexual agency[48], while those with diverse SOGIESC identities may fear violence or community backlash if their sexual health needs become known[49]. Ensuring confidentiality and providing youth-friendly services is essential for improving SRH access for all young people.

The impact of teenage pregnancy

The study also highlights the increase in teenage pregnancies reported across the communities despite the growing availability of contraceptive methods and the reported overall decrease in unwanted pregnancies in the broader community. Adolescent pregnancy can have stark consequences, including heightened risks of medical complications such as eclampsia, puerperal endometritis and systemic infections[50], unsafe abortions[51], disrupted education, and increased exposure to intimate partner violence[52]. In Vanuatu, where rates of gender-based violence are among the highest in the world, unintended pregnancy can exacerbate vulnerabilities for young women.

Social stigma surrounding teenage pregnancy further disadvantages young mothers, particularly when male partners abandon them. While teenage fathers also experience social consequences, the burden of child-rearing disproportionately falls on young women, reinforcing traditional gender roles and limiting the opportunities for young mothers, even when they are able to finish their education.

Conclusion and Recommendations

Young people in rural areas of Vanuatu face a myriad of intersecting and at times complex barriers to fully realising their SRHR. There are often a range of underlying issues that prevent young people from attempting to access family planning services and information that mean physical access and cost, even when they are significant, are not perceived as the greatest barrier.

A range of recommendations informed by discussions with young people and stakeholders are provided to promote greater positive SRH seeking behaviours from young people and ultimately increase access to family planning services.

1. Youth-focused programmes led by young people

There is a critical need for culturally sensitive, youth-friendly communication channels to address the gaps in reproductive health education and services. These could include peer education or youth-led health programmes to improve disseminating accurate reproductive health information. Given the reported disengagement of youth from traditional influences such as parents, chiefs, and church leaders, these programmes must be tailored to meet young people's needs. Effective youth-focused programming should include the following components:

- Healthy relationships and consent
- Addressing common taboos and misconceptions about contraception, including fears of long-term infertility and recognised side effects, such as changes to menstruation
- Information on STIs and the correct use of condoms.

To reach out-of-school youth in communities, outreach is needed at both secondary schools and community levels.

2. School-based sessions on puberty and reproductive health

Introducing sessions in late primary and early secondary schools focused on puberty and understanding one's body is crucial. Misconceptions about contraception often stem from limited knowledge about menstruation and reproductive health. Many young women reported not knowing about menstruation at the time of their first period. Educating students at an earlier age can help address these knowledge gaps before they become barriers to informed decision-making.

3. Explicitly promote that family planning services are available at outreach clinics

For the most recent planned outreach clinic, flyers for community notice boards promoted PGFBY outreach clinics as providing "free health checkups and free clinic" however family planning services including counselling were not explicit. At target areas such as secondary schools advertising 'youth friendly' services could also be advantageous to promote greater access by young people and break down perceived barriers from nurses.

4. Address confidentiality and privacy concerns of young people

Youth expressed concerns that they cannot access SRH services privately or confidentially, especially in small communities where health staff are well-known. Clinics often lack privacy, particularly for LARCs. Expanding VFHA's training for VHWs and clinic staff on confidentiality can improve service uptake. Similarly, ensuring that VFHA clinic staff receive training in confidentiality and privacy could further strengthen these practices.

5. Develop accessible IEC materials to address misinformation and myths

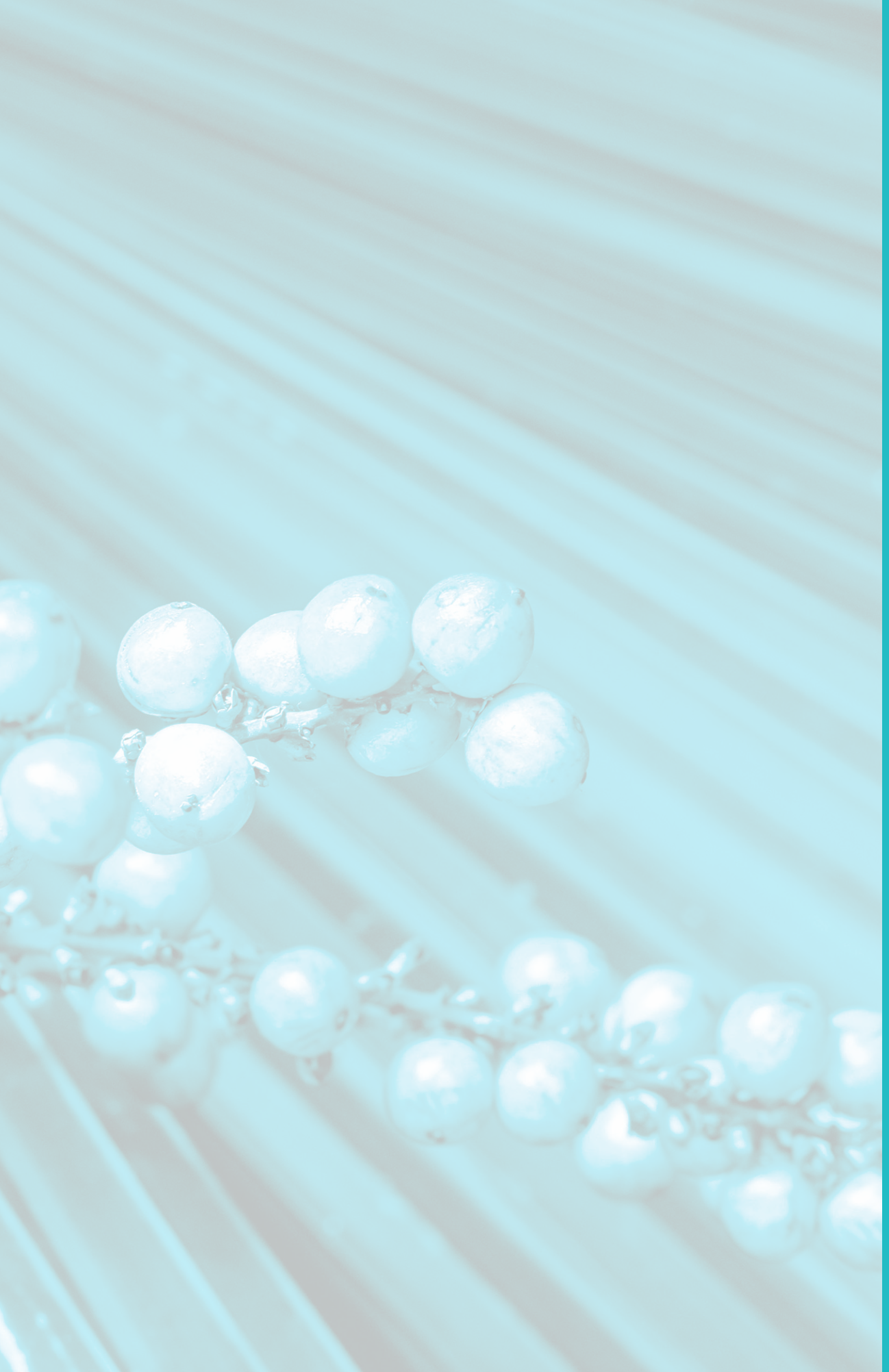
Easy-to-understand informational materials should explain the potential side effects of common contraceptive methods (e.g., Jadelle, Depo Provera) and dispel prevalent myths. These materials should be made readily available at health clinics and dispensaries where family planning services are offered. A radio or SMS campaign could also support an increased understanding of contraceptives.

6. Training for healthcare providers

Healthcare providers, including nurses and VHWs, must be equipped to address common myths and misconceptions about family planning in communities. The current PGFBY programme's training for VHWs could incorporate modules on facilitating the use of IEC materials and engaging with community members to dispel misinformation effectively. This should also include the importance of confidentiality at health services.

7. Engaging young men in reproductive health conversations

Engaging young men is essential to promote an understanding of family planning benefits, address common misconceptions, and foster supportive behaviours. Addressing deeply entrenched gender norms that limit women's agency in family planning decisions will require sustained efforts, and to be successful would likely require longer-term presence in communities; however, this can be fostered through youth healthy relationship programming that discusses consent and agency and dispels common myths regarding family planning.



Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
HSS	Health Sector Strategy
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraception
MICS	Multiple Indicator Cluster Survey
NGEP	National Gender Equality Policy
PGFBY	Planem Gud Famili Blong Yumi
RMNCAH	Reproductive, Maternal, Newborn, Child, Child, and Adolescent Health
SDGs	Sustainable Development Goals
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
VFHA	Vanuatu Family Health Association
VHW	Village Health Worker
VT	Vanuatu Vatu, the currency of Vanuatu
VWC	Vanuatu Women's Centre

References

1. World Health Organization. (2022). *Critical considerations and actions for achieving universal access to sexual and reproductive health in the context of universal health coverage through a primary health care approach*. World Health Organization.

2. Ministry of Youth Development and Sports. (2019). *Vanuatu national youth policy 2019–2024*. https://moysd.gov.vu/images/Publications/MYDS%20NYP%20National%20Youth%20Policy%202019-2024.pdf

3. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

4. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

5. Sully, E. A., et al. (2020). *Adding it up: Investing in sexual and reproductive health 2019*. Guttmacher Institute. https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019

6. World Health Organization. (2022). *Critical considerations and actions for achieving universal access to sexual and reproductive health in the context of universal health coverage through a primary health care approach*. World Health Organization.

7. World Health Organization. (2024). *Adolescent pregnancy fact sheet*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

8. United Nations, Department of Economic and Social Affairs, Population Division. (2020). F*ertility among young adolescents aged 10 to 14 years*. United Nations.

9. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

10. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

11. Braaf, R. (2017). *Initial gender and social inclusion assessment for Vanuatu NGO Green Climate Fund Consortium*.

12. Vanuatu Women's Centre. (2011). Vanuatu National Survey on Women's Lives and Family Relationships. Vanuatu Women's Centre & Vanuatu National Statistics Office.

13. Vanuatu Women's Centre. (2011). *Vanuatu National Survey on Women's Lives and Family Relationships*. Vanuatu Women's Centre & Vanuatu National Statistics Office.

14. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

15. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

16. Hakkert, R., & Pontifex, S. (2020). *Vanuatu 2020 National Population and Housing Census: Analytical Report - Volume 2*. Vanuatu National Statistics Office.

17. T World Bank. (2020). *Population growth (annual %) - Vanuatu*. Retrieved from https://data.worldbank.org/indicator/SP.POP.GROW?locations=VU

18. Hakkert, R., & Pontifex, S. (2020). *Vanuatu 2020 national population and housing census: Analytical report - Volume 2*. Vanuatu National Statistics Office.

19. Hakkert, R., & Pontifex, S. (2020). *Vanuatu 2020 National Population and Housing Census: Analytical Report - Volume 2*. Vanuatu National Statistics Office.

20. Vanuatu Bureau of Statistics. (2024). *Vanuatu Multiple Indicator Cluster Survey 2023: Key Indicators Report*. Port Vila, Vanuatu: Vanuatu Bureau of Statistics. Retrieved from https://vnso.gov.vu/index.php/vanuatu-mics-2023-survey-findings-report

21. South Pentecost Area Council. (2024). *Community household data set 2024*

22. Ministry of Youth Development and Sports. (2019). *Vanuatu national youth policy 2019–2024*. https://moysd.gov.vu/images/Publications/MYDS%20NYP%20National%20Youth%20Policy%202019-2024.pdf

23. Murphy, N., Azzopardi, P., & Bohren, M. A. (2023). Safeguarding youth sexual and reproductive health and rights in the context of increasing climate-related disasters in the Pacific: A scoping review of policies and responses. *International Journal of Disaster Risk Reduction*, 86, Article 103561. https://doi.org/10.1016/j.ijdrr.2023.103561

24. Vanuatu Ministry of Health. (2021). R*eproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) policy, strategy & implementation plan 2021–2025*. Available at: https://www.sistalibrary.com.vu/wp-content/uploads/2021/12/FINAL-RMNCAH-Policy-Strategy-Implementation-Plan-2021-2025.pdf

25. Pacheco, L., Mercerat, C., Aunos, M., Cousineau, M.-M., Goulden, A., Swab, M., Brenton, B., & Moyo, S. (2024). Uncovering reproductive injustice toward women with disabilities: A scoping review. *International Perspectives in Psychology: Research, Practice, Consultation*. Advance online publication. https://doi.org/10.1027/2157-3891/a000103

26. Vanuatu National Statistics Office. (2021). *Well-being in Vanuatu: 2019–2020 NSDP baseline survey*. https://vbos.gov.vu/sites/default/files/Wellbeing_report.pdf?

27. Ledingham, E., et al. (2022). *Sexual violence against women with disabilities: Experiences with force and lifetime risk*. *American Journal of Preventive Medicine*, 62(6), 895–902. https://doi.org/10.1016/j.amepre.2021.12.015

28. Republic of Vanuatu. Penal Code [Cap 135]: *Laws of the Republic of Vanuatu Consolidated Edition*. (2006). Available at: https://fiu.gov.vu/docs/Penal%20Code%20%5BCap%20135%5D.pdf

29. McMillan, K., Linhart, C., Gorman, H., Kepa, B, O'Connor, C., O'Connor, M., & Rokoduru, A. (2020). *Adolescent unplanned pregnancy in the Pacific: Vanuatu*. Sydney: School of Public Health and Community Medicine, UNSW.

30. McMillan, K., Linhart, C., Gorman, H., Kepa, B, O'Connor, C., O'Connor, M., & Rokoduru, A. (2020). *Adolescent unplanned pregnancy in the Pacific: Vanuatu*. Sydney: School of Public Health and Community Medicine, UNSW.

31 McMillan, K., Linhart, C., Gorman, H., Kepa, B, O'Connor, C., O'Connor, M., & Rokoduru, A. (2020). *Adolescent unplanned pregnancy in the Pacific: Vanuatu*. Sydney: School of Public Health and Community Medicine, UNSW.

32. McMillan, K., Linhart, C., Gorman, H., Kepa, B, O'Connor, C., O'Connor, M., & Rokoduru, A. (2020). *Adolescent unplanned pregnancy in the Pacific: Vanuatu*. Sydney: School of Public Health and Community Medicine, UNSW.

33. Vanuatu Department of Women's Affairs. (2020). *National gender equality policy 2020–2030*. https://mjcs.gov.vu/images/reporting/National_Gender_Equality_Policy_2020-2030_ADD_1.pdf

34. Ministry of Justice and Community Services. (2018). *Vanuatu national disability inclusive development policy 2018–2025*. https://mjcs.gov.vu/images/policy/DID_Policy_2018-2025.pdf

35. Vanuatu Ministry of Health. (2021). *Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) policy, strategy & implementation plan 2021–2025*. Available at: https://www.sistalibrary.com.vu/wp-content/uploads/2021/12/FINAL-RMNCAH-Policy-Strategy-Implementation-Plan-2021-2025.pdf

36. Ministry of Health, Vanuatu. (2021). *Vanuatu health sector strategy (HSS) 2021–2030*. Available at: https://moh.gov.vu/images/Strategic_Plan/

Health_Sector_Strategy_HSS_2021-2030_.pdf

37. United Nations Population Fund. (2013). *Moana Declaration*.Available at: https://pacific.unfpa.org/en/publications/moana-declaration

38. International Planned Parenthood Federation. (2023). *Pacific Niu Vaka Strategy Phase II 2023–2028*. Available at: https://eseaor.ippf.org/resource/pacific-niu-vaka-strategy-phase-ii

39. United Nations Population Fund. (1994). *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994*. https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pd

40. United Nations General Assembly. (1979). *Convention on the Elimination of All Forms of Discrimination Against Women*. https://www.un.org/womenwatch/daw/cedaw/cedaw.htm

41. United Nations. (n.d.). Target 3.7: *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes*. https://sdgs.un.org/goals/goal3

42. United Nations. (n.d.). Target 5.2: *Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation*. https://sdgs.un.org/goals/goal5

43. United Nations Population Fund, Women Enabled International, & Pacific Disability Forum. (2022). *Women and young people with disabilities in Vanuatu: Needs assessment of sexual and reproductive health and rights, gender-based violence, and access to essential services*.

44. UNFPA East and Southern Africa Regional Office. (2022). I*ntegration of menstrual health management (MHM) and sexual and reproductive health and rights (SRHR): A toolkit for practitioners*. United Nations Population Fund. Retrieved from https://esaro.unfpa.org/sites/default/files/pub-pdf/mhm-srhr_integration_digital.pdf

45. Kennedy, E. C., et al. (2013). "Be kind to young people so they feel at home": A qualitative study of adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu. *BMC Health Services Research, 13*, 455. https://doi.org/10.1186/1472-6963-13-455

46. Braeken, D., & Rondinelli, I. (2012). *Sexual and reproductive health needs of young people: Matching needs with systems. International Journal of Gynecology and Obstetrics, 119*(Suppl. 1), S60–S63. https://doi.org/10.1016/j.ijgo.2012.03.019

47. Harrington, R. B., Harvey, N., Larkins, S., & Redman-MacLaren, M. (2021). Family planning in Pacific Island Countries and Territories (PICTs): A scoping review. *PLOS ONE, 16*(8), e0255080. https://doi.org/10.1371/journal.pone.0255080

48. United Nations Population Fund, Women Enabled International, & Pacific Disability Forum. (2022). *Women and young people with disabilities in Vanuatu: Needs assessment of sexual and reproductive health and rights, gender-based violence, and access to essential services*.

49. De Lind van Wijngaarden, J. W., & Ojanen, T. T. (2016). Identity management and sense of belonging to the gay community among young rural Thai same-sex attracted men: Implications for HIV prevention and treatment. *Culture, Health & Sexuality, 18*(4), 377-390. https://doi.org/10.1080/13691058.2015.1087595

50. World Health Organization. (2024). *Adolescent pregnancy fact sheet*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

51. Family Planning New Zealand. (2019). *Planem Gud Famili Blong Yumi: Knowledge, access and barriers to family planning in rural Vanuatu*. Wellington, New Zealand.

52. Deuba, K., Mainali, A., Alvesson, H. M., & Karki, D. K. (2016). Experience of intimate partner violence among young pregnant women in urban slums of Kathmandu Valley, Nepal: A qualitative study. *BMC Women's Health, 16*, 11. https://doi.org/ 10.1186/s12905-016-0293-7

The Planem Gud Famili Blong Yumi project is supported by
the New Zealand Aid Programme

NEW ZEALAND
FOREIGN AFFAIRS & TRADE
Aid Programme

Sexual
Wellbeing
Aotearoa