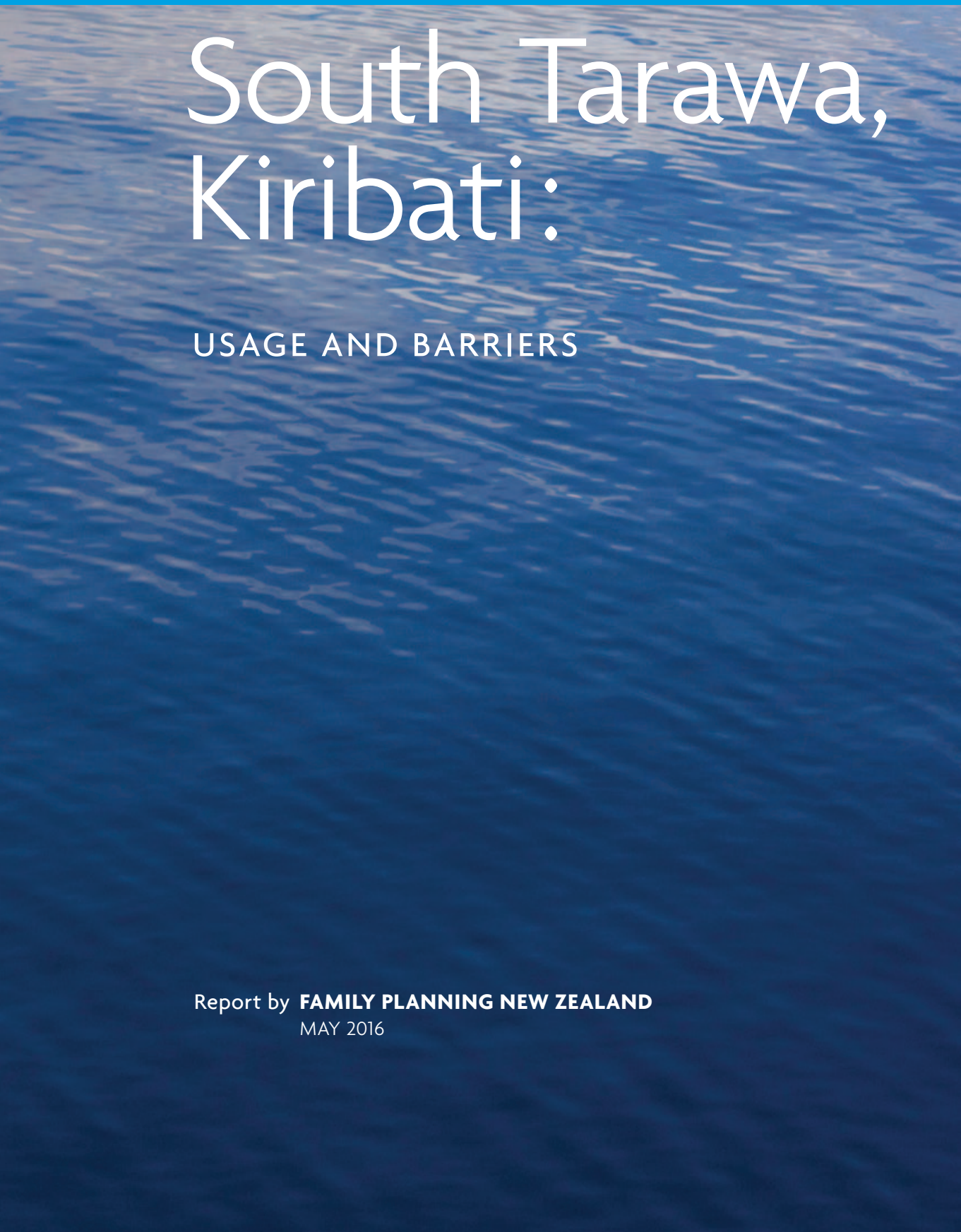
Family Planning in

South Tarawa, Kiribati:

USAGE AND BARRIERS



Report by **FAMILY PLANNING NEW ZEALAND**

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Acronyms and initialisms

CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Survey
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IUD	Intrauterine Device
KFHA	Kiribati Family Health Association
KUC	Kiribati Uniting Church
MHMS	Ministry of Health and Medical Services
MOE	Ministry of Education
NGO	Non-Government Organisation
SRH	Sexual and Reproductive Health
STIs	Sexually Transmissible Infections
UN	United Nations

Contents

Executive summary

Access to family planning is a fundamental human right. Enabling all women to plan their pregnancies would significantly reduce maternal deaths and child mortality and help ensure women and their children can live healthy lives.

Family planning use in the Pacific island nation of Kiribati has historically been low and subject to considerable barriers. This report investigates current levels of family planning knowledge and use and identifies barriers to uptake in South Tarawa, the capital and primary urban area of Kiribati. The report combines data from a community survey (n=500) and qualitative data from focus groups with key populations (n=4) and in-depth interviews with health professionals and community leaders (n=14).

The results indicate that people in South Tarawa have considerable exposure to family planning messages. Knowledge about family planning methods however appears to be low. Over half of men surveyed could not name two methods of contraception, and over half the women could not name three. Despite the low knowledge, family planning usage appears to have increased dramatically since the last official data collection in 2009. A total of 50% of currently married or in-union women surveyed were using contraception, compared to 19% of six years previous. Considerable potential for future increase was also identified with a further 28% of married women anticipating they will use family planning in the future.

A range of barriers to family planning use were identified in both the survey and the interviews. The barriers fall into four key areas: disinterest in family planning, knowledge gaps, personal, family and social objections, and service delivery. In light of these barriers, fourteen service delivery recommendations are proposed:

1. Consider desired fertility trends of men and women in South Tarawa when developing new family planning materials
2. Promote the use of contraception at first intercourse through family planning promotion programmes
3. Develop programmes to work with couples before marriage to educate them on family planning
4. Consider the terminology and language used in health promotion messages, in particular the use of moralistic language in regards to sex
5. Develop family planning promotion programmes to specifically target men in their role as partners

6. Create family planning promotion messages and materials that address myths around modern family planning methods
7. Review existing family planning consultation guidelines and practices to ensure adequate and accurate information is provided about possible side-effects
8. Promote awareness that condoms are a form of contraception
9. Use 'edutainment' materials as a tool for increasing awareness of family planning
10. Utilise family planning promotion channels that allow the public to ask questions
11. Review the confidentiality procedures for all clinics
12. Integrate family planning clinic services into existing youth safe-spaces, e.g. youth centres
13. Develop home visitation programmes for family planning promotion and low-level service delivery
14. Dedicate human and financial resources to family planning specific programmes.

Introduction

The ability to decide freely the number, spacing and timing of children is a fundamental human right. Enabling all women to plan their pregnancies would significantly reduce maternal deaths and child mortality and help ensure women and their children can live healthy lives.

Further, achieving universal access to family planning would also have much broader health and socio-economic benefits, contributing to universal education, women's empowerment, prevention of human immunodeficiency virus (HIV), poverty reduction and environmental sustainability, making it one of the most cost-effective global health and development interventions.[1, 2, 3, 4, 5]

Access to family planning in much of the Pacific however remains inadequate and inequitable. While use of family planning continues to increase in the region, in most countries the prevalence of modern methods of contraception is still well below the United Nations' (UN) global averages for 'less developed regions'. Furthermore, unmet need for contraception in the Pacific is among the highest in the world. Consequently, throughout the Pacific a significant proportion of pregnancies are unintended, with unplanned or mistimed pregnancies in some countries accounting for over half of all births.[6] High fertility and rapid population growth, coupled with a large and expanding youth population, increasing urbanisation and overcrowding, present considerable challenges for small island states.[7]

Context

The Republic of Kiribati is a remote island nation in the equatorial Pacific Ocean, consisting of 32 coral atolls and two raised coral islands spread over an area of 3.5 million square kilometres. The 2010 census recorded the total population at 103,058, with around 49% of the population living in the primary urban centre of South Tarawa.[8] Annual population growth is substantial (2.2% nationally), and especially high in South Tarawa (4.4%). Current population growth trends suggest that the population of Kiribati will exceed 200,000 between 2040-2050.[8] Like many nations in the region, Kiribati has a young population, with 57% of the population aged less than 25 years. In 2010, there were 24,278 women of reproductive age, or just over 24% of the population. By 2030, that number is expected to rise by 57% to approximately 38,000.[30]

Access to quality family planning services is variable. The 2009 Demographic and Health Survey (DHS), the most recent data available on family planning usage in Kiribati, reported that the modern contraceptive prevalence rate was just 18.0% and total contraceptive prevalence rate just 22.3%,[9] well below the United Nations (UN) average for developing countries.[10] Unmet need for contraception was 28.0%. Subsequently fertility rates are high, with the total fertility rate at 3.8 children per woman in 2010[8] and the adolescent fertility rate at 49 births per 1,000 teenage women, or one birth for every 20 teenage women.[8]

In Kiribati, family planning services are provided by the Ministry of Health and Medical Services (MHMS) via government community health clinics and public hospitals and through the Kiribati Family Health Association (KFHA), an International Planned Parenthood Federation member. From both sources, services are available free of charge. Nonetheless, there are considerable challenges to improving access to family planning.

In 2014, Family Planning New Zealand conducted a cost-benefit analysis of reducing unmet need for family planning in Kiribati. Results showed that meeting unmet need would have significant benefits for the health of women and children.[11] Achieving these goals would require a total of AUD$807,000 during 2010-2025 to meet all family planning needs.[11] However, reducing unintended pregnancies would significantly decrease required government expenditure in the health and education sectors, resulting in savings of AUD$18.8 million over the same period. At an average annual cost of just over AUD$50,000, meeting unmet need for family planning would make Kiribati's health and development goals more achievable, affordable and sustainable.

However, the analysis concluded that barriers to uptake would have to be addressed before unmet need could be met. Existing barriers were assumed to be numerous, including: poor physical access to health services; socio-cultural and religious objections to family planning; misconceptions around the safety or efficacy of family planning methods; commodity shortages caused in part by limited data to assist with forecasting and ordering; a lack of training in family planning provision for health workers in government community health clinics; and a shortage of clinicians and clinical space to administer permanent methods.

The Government of Kiribati has recognised this need to support family planning and address these barriers. The Kiribati Development Plan 2016-2019 identified 'increased access to and use of high quality,

comprehensive family planning services, particularly for vulnerable populations' as a key outcome.[12] In 2015, the Kiribati Parliamentary Select Committee on Population Management and Development produced a report for parliament on how to manage population growth.[13] The report focused on how family planning could be supported to help reduce population growth and contribute to economic development. The report investigated some barriers to uptake and made some high-level policy recommendations on how the Government could assist, including: strengthening government commitment to family planning, reviewing national strategies, building the capacity of the MHMS to provide services, and creating financial incentives for family planning usage.

Recently, anecdotal evidence has suggested that there have been considerable increases in the number of people using family planning since the last major data collection in 2009. This project intends to investigate what changes in usage there have been in South Tarawa and what barriers remain. From the data collected recommendations will be made on how to support men and women to access family planning services in South Tarawa. It is hoped that the findings from this project will provide a stronger evidence base for family planning programmes in Kiribati and add to the limited family planning literature in both Kiribati and the wider Pacific region.

Methods

This project uses a mixed methods approach combining quantitative data from a community survey and qualitative data from focus groups with key populations and interviews with health professionals and government officials. The study area is restricted to South Tarawa (population approximately 55,000), the principal urban area in Kiribati and the area with the greatest unmet need for family planning.[9]

A community survey of men and women of reproductive age (15-49) was developed to identify current levels of family planning knowledge, contraceptive usage and barriers, and future use desires. The survey forms were created in English, translated into Kiribati language and piloted to identify potential issues. Volunteers (n=20) from KFHA were chosen to administer the survey. These volunteers were trained in how to properly implement the survey, how to ask the questions, and how to ensure confidentiality. Each volunteer was also required to sign a confidentiality agreement.

In implementing the survey, it was decided that men would interview men and women would interview women. Volunteers went door-to-door asking people if they would be willing to take part in the survey. Each respondent was also read a short statement about informed consent. Respondents were further informed that the survey was completely confidential and that they could choose not to answer specific questions or could stop participating at any time. Each interviewer was tasked with completing a set number of interviews for their assigned communities. It must be noted that this method of data collection does not give a truly random sample and potential biases must be considered.

A total of 518 people of reproductive age were surveyed. People were interviewed from all villages in South Tarawa. A total of 18 surveys were excluded due to incomplete responses, leaving a total of 500 surveys for the final analysis. The survey forms from the community survey were manually entered into Survey Monkey. The results were then exported into and analysed in Microsoft Excel.

Focus groups (n=4) of target populations were undertaken to interpret survey results, further investigate barriers and generate ideas for mitigation strategies. Target populations were identified as young men (15-24), men (25-49), young women (15-24) and women (25-49). Focus groups were

conducted in Kiribati language by a skilled moderator (male for the male groups, female for the female) and capped at eight participants each: big enough to generate a discussion but small enough that people are not left out. Participants were recruited through visiting *Maneaba (meeting houses)* and asking for volunteers that met the age/gender requirements. The focus groups were held at KFHA. When investigating sensitive topics, the focus group moderators employed hypothetical questioning techniques as necessary. Following the groups, the responses were translated into English for analysis.

Interviews (n=14) were also conducted with community health professionals and government officials to further interpret survey results, identify further barriers and successful strategies or recommendations for meeting unmet need. Interviews were generally conducted in English. Where they were conducted in Kiribati language, a skilled translator was employed. The interviews were recorded and transcribed for analysis.

Findings

Community Survey

Of the 500 people surveyed, 300 were women and 200 were men. Approximately 70% of both the men and the women surveyed were currently married or in-union. As the survey did not explicitly ask whether the respondents were sexually active, marital/in-union status was used as a proxy for sexual activity. This was done to minimise potential discomfort for the respondents. For questions relating to usage of family planning, results are reported for respondents who were married or in-union. For questions relating to knowledge, results are reported for all respondents.

A breakdown of respondents by key demographic indicators can be seen in Table 1.

Table 1: Demographic variables by marital status or sex

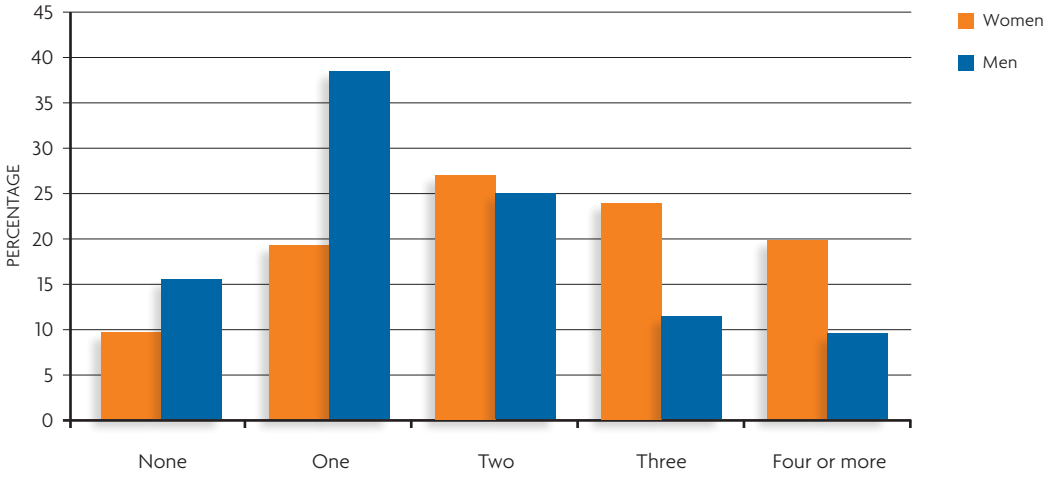
		Currently married or in-union			Total		
		Women	Men	Total	Women	Men	Total
Age							
	15-24	37%	30%	34%	48%	48%	48%
	25-49	63%	70%	66%	52%	53%	52%
Children							
	0	22%	30%	25%	34%	52%	41%
	1	24%	14%	20%	22%	10%	17%
	2	16%	20%	17%	13%	14%	13%
	3	19%	16%	18%	16%	11%	14%
	4+	19%	20%	20%	16%	14%	15%
Education							
	None	3%	15%	8%	2%	13%	7%
	Primary	6%	6%	6%	5%	5%	5%
	Junior secondary	31%	18%	26%	28%	24%	26%
	Senior secondary	54%	56%	55%	56%	54%	55%
	Tertiary	6%	4%	5%	5%	4%	4%
	Still in school	1%	1%	1%	4%	2%	3%
Paid Employment							
	Yes	16%	46%	28%	16%	37%	24%
	No	84%	54%	72%	84%	63%	76%
Religion							
	Catholic	46%	49%	47%	44%	51%	47%
	KUC	43%	40%	42%	44%	38%	42%
	Other	11%	11%	11%	11%	12%	12%

Respondents appeared to be broadly reflective of the national demographic cohorts observed in the 2010 Census.[8] Catholics were notably under sampled, representing 47% of respondents compared with 56% of the national population.

Knowledge

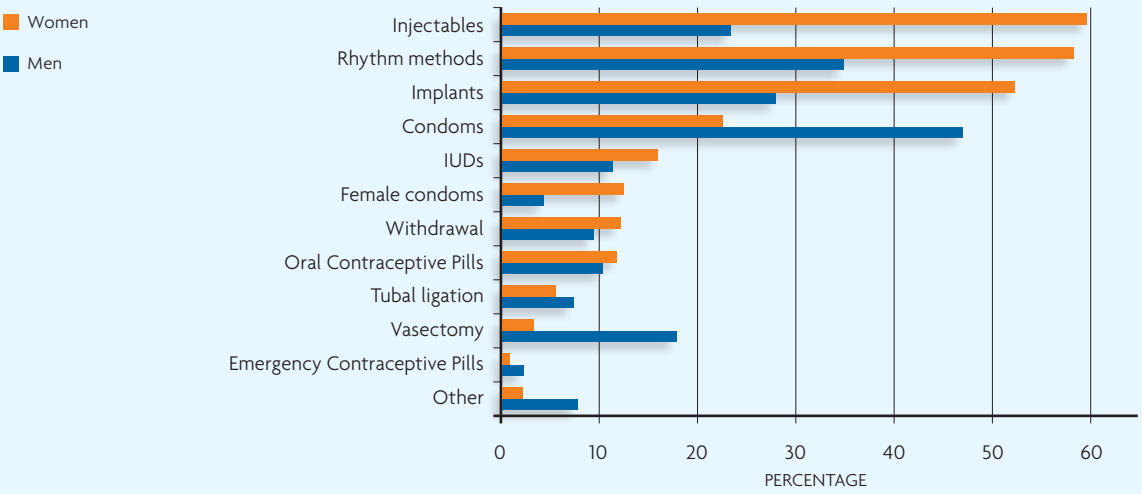
The first set of questions sought to identify levels of basic family planning knowledge among respondents. Respondents were asked to name as many contraceptive methods as they could. Their answers were unprompted with interviewers recording all methods stated. Where people could describe the method without knowing the exact name, they were recorded as knowing the method.

Figure 1: Number of methods named



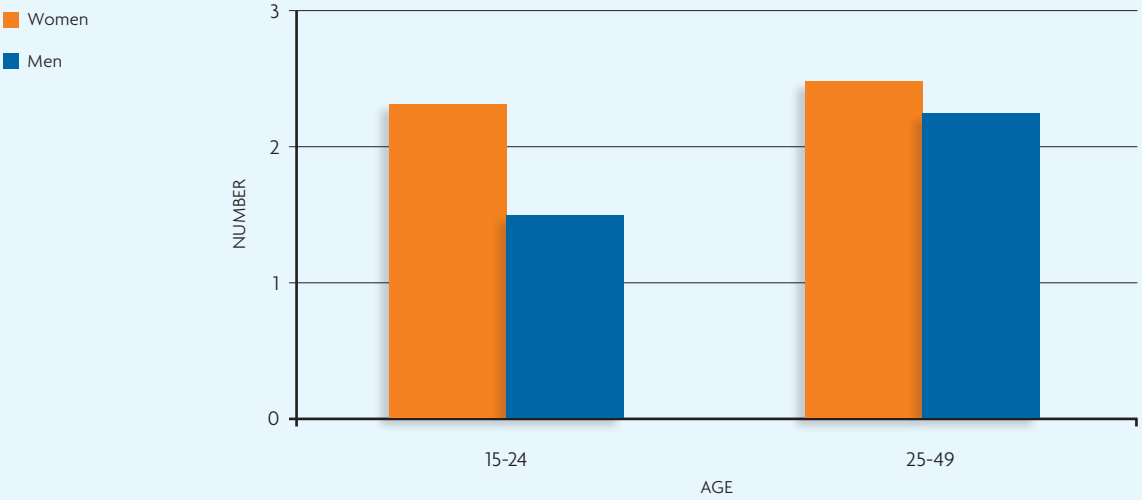
There was a considerable spread of knowledge observed. Women generally knew more methods than men, with 20% of women able to name four or more methods. Men were most likely to know just one method. A total of 10% of women and 16% of men were unable to name a single method of contraception.

Figure 2: Contraceptive methods named by method type and sex



Injectables, natural methods (primarily Dr Billings method and cycle beads method), and implants were the most common methods stated by women, much higher than any other methods. Men were slightly more evenly divided between knowledge of methods, with condoms the most commonly known by some margin, followed by natural methods and implants. The other male-specific method, vasectomy was named by 18% of men.

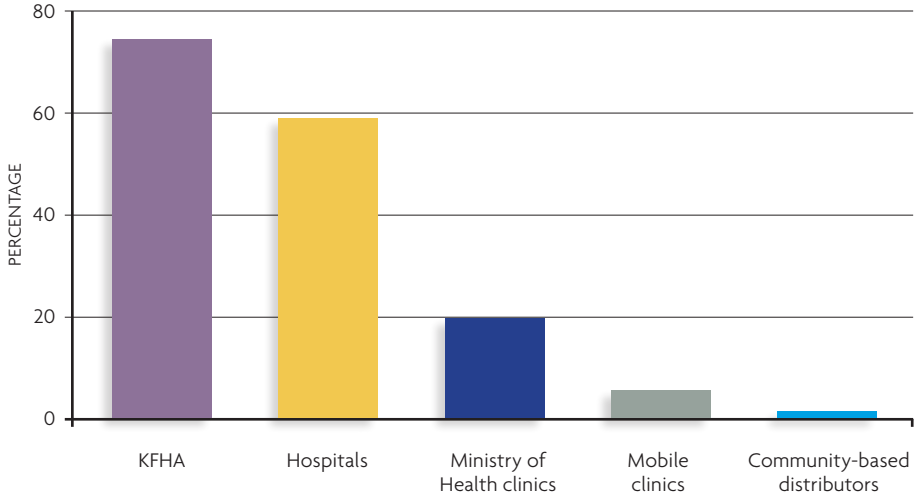
Figure 3: Mean number of contraceptives methods known by age and sex



When split by age, differences emerge further. Men, and young men in particular could name fewer methods than women, with men aged 15-24 only able to name just over one method on average. However knowledge among men 25-49 neared that of women.

To assess practical knowledge around where contraception could be procured, respondents were asked to name where they could get contraception (Figure 4).

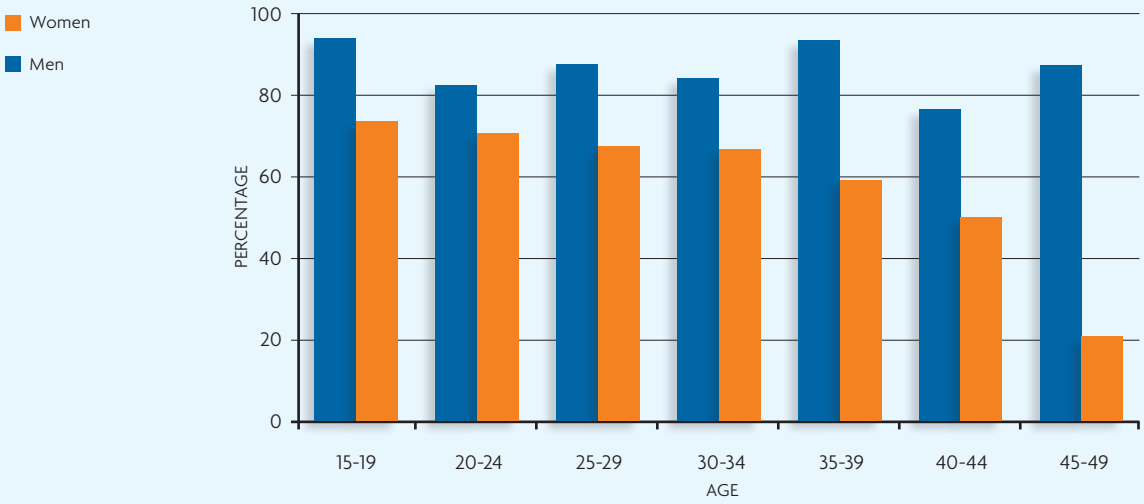
Figure 4: Knowledge of contraceptive access points



As the KFHA volunteers were conducting the interview, it was to be expected that most respondents would be able to name KFHA as a provider. Among the MHMS service delivery points, hospitals were the most commonly stated locations at 59%.

Respondents were also asked if they had ever attended a condom demonstration. A vital part of sexual and reproductive health (SRH) promotion programmes and comprehensive sexuality education (CSE), condom demonstrations allow people to become familiarised with condoms. These demonstrations build competency, condom use self-efficacy (the belief that they can use it properly), and motivate people to think about contraception and prevention of sexually transmissible infections (STIs) and HIV. Attendance at these programmes is also a good indicator of exposure to SRH promotion. The responses by age and sex are shown in Figure 5.

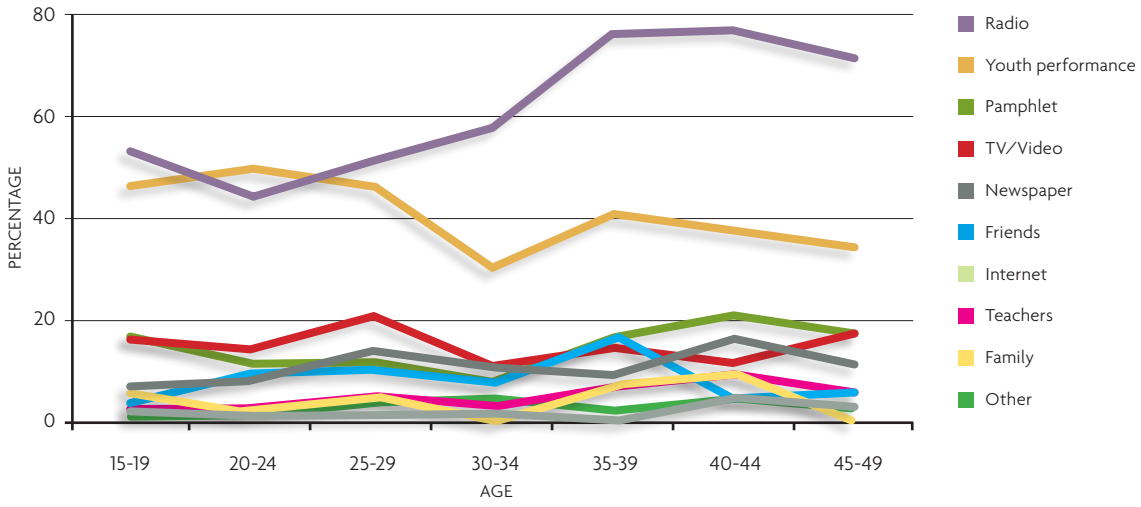
Figure 5: Ever attended a condom demonstration by age and sex



The majority of people surveyed reported having attended condom demonstrations. Men reported high attendance of condom demonstration programmes across age groups. Young men were the most likely to have attended at 94%. Women had a moderate level of attendance at younger ages (73% of 15-19 year olds), but tapered off sharply with only 21% of those 45-49 having ever attended a demonstration. The high rates of attendance however contrasted with the low numbers of people that named condoms as a method of contraception (Figure 2).

Finally, to assess exposure to SRH messages, respondents were asked whether they had heard or seen any SRH messages in the last three months. A very substantial 84% of respondents reported having been exposed to messages in the last three months. Respondents were also asked to name the media in which they heard/saw them. The results can be seen by age and sex (Figure 6).

Figure 6: Seen or heard family planning messages in last three months by method of transmission and age



Radio was the most common media overall, reaching 77% coverage among the 40-44 age group. Youth performances, a common SRH promotion method employed by both KFHA and some Government agencies was also commonly seen, especially among young people. Approximately half of those 15-30 had seen youth performances in the last three months. Several other media were seen by between 10% and 20% of respondents, including information, education and communication pamphlets (IECs) and video messages.

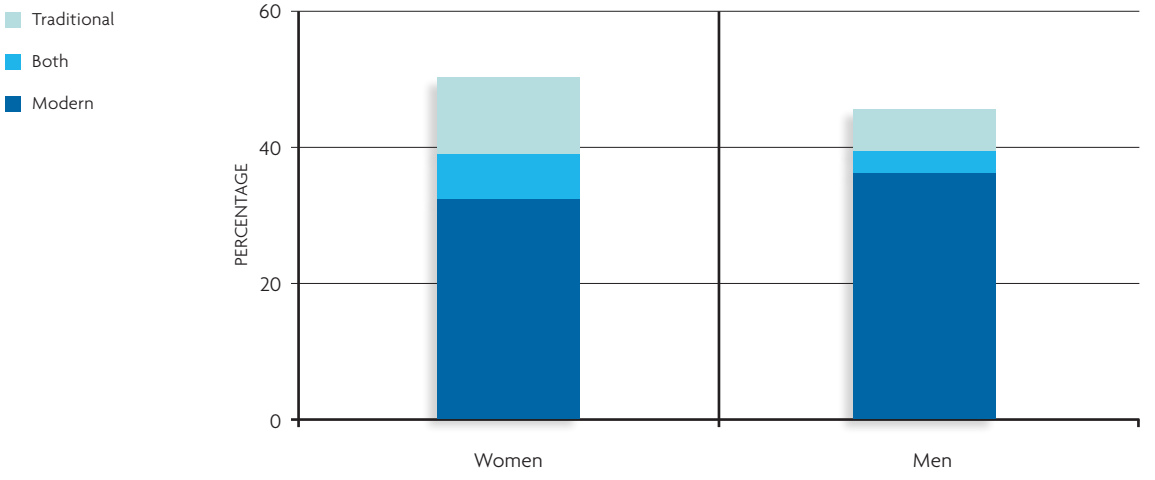
Exposure to messages and health promotion activities appears to be relatively high across ages and sexes. A couple of exposure gaps can be identified. Women 45-49 reported the lowest ever-attendance at condom demonstrations. Radio programming, despite being the most widely heard SRH messaging media, was considerably less likely to reach younger people. Knowledge of family planning messages on the other hand was also relatively low. Men and young men in particular could name considerably fewer contraceptive method types. Over half of men could only name one method or fewer, and over half of women only two or fewer.

Usage

Respondents were asked about their current contraceptive usage. As respondents were not directly asked if they were sexually active, marital/in-union status was used as a proxy for being sexually activity. Subsequently, the responses in this section will be reported for those who are currently married or in-union.

Respondents were asked whether they were currently using contraception and if so what methods. Results by broad contraceptive category and sex are shown in Figure 7.

Figure 7: Current use of contraception by sex and method (currently married, %)

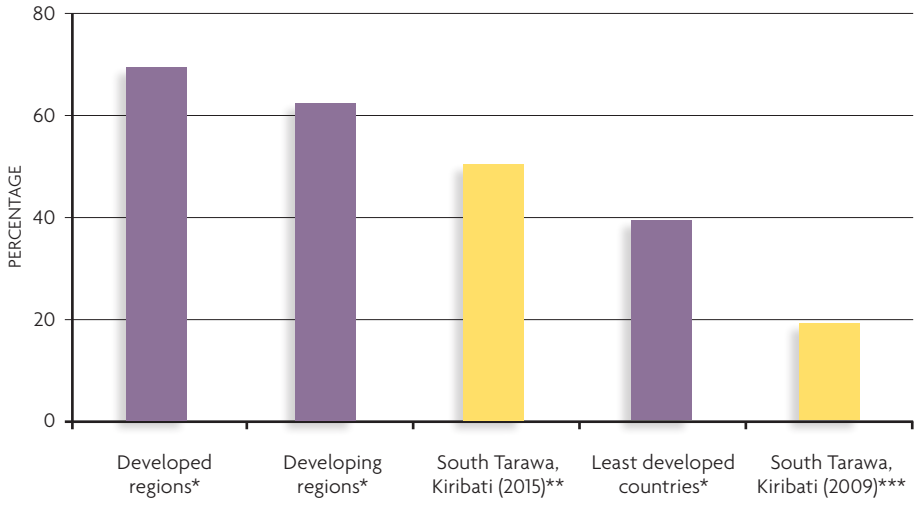


A large proportion of respondents reported that they were currently using contraceptive methods. A total of 50% of currently married or in-union women were using contraception, with 33% using only modern methods, 6% using modern and natural methods, and 11% using only natural methods. Among men the numbers were similar overall with 46% currently using contraception. Of those, 37% were solely using modern methods, 6% solely natural and 3% both.

To place these numbers in context it is useful to compare the numbers with the contraceptive prevalence rates for Kiribati in previous years and to international averages. Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception. It is usually reported for married or in-union women aged 15 to 49. While the study is too small to give us a contraceptive prevalence rate of sufficient accuracy suitable for national statistics it is nevertheless able to give us an indication

of how the respondents in this sample compare. The contraceptive prevalence from this study is compared to global averages (by development status) and the contraceptive prevalence for South Tarawa reported in the 2009 DHS (Figure 8).

Figure 8: Comparison of mean regional contraceptive prevalence rate (any method) by development status to South Tarawa, Kiribati

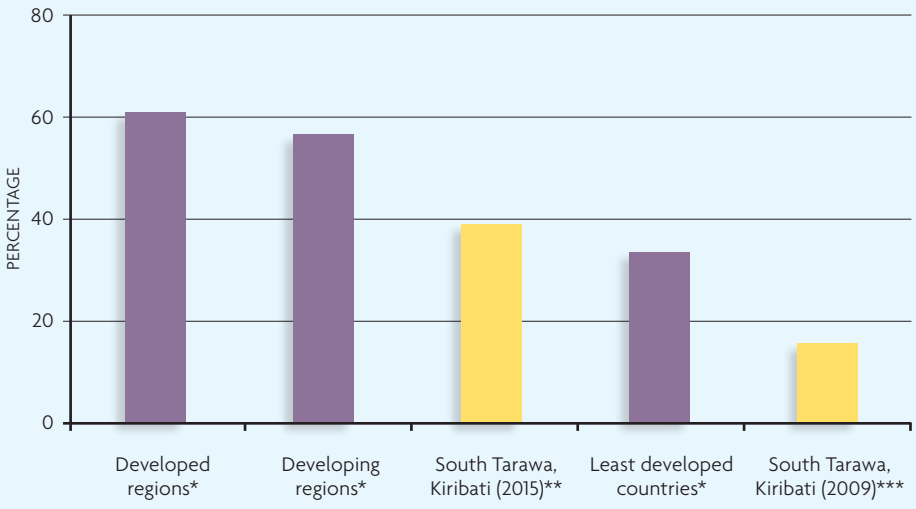


** United Nations [10]* *** This research* **** DHS [9]*

In 2009, Kiribati had some of the lowest contraceptive prevalence in the world and the lowest in the Pacific region at 22%. In South Tarawa it was poorer still at just 19%. Given the extremely low numbers in 2009, it is not unreasonable to expect a large increase in contraceptive prevalence with increased family planning promotion and investment. At 50%, the contraceptive prevalence from this sample is over 150% greater than that observed in 2009. If this is representative of South Tarawa it would suggest there has been an extremely large increase in contraceptive uptake.

This increase brings South Tarawa more in line with developing country averages. The contraceptive prevalence observed is greater than the average for 'least developed counties'. It is however, still 13% less than the average for 'developing regions', and 20% less than those generally found in 'developed regions'. The improvement was lesser for modern method prevalence (Figure 9).

Figure 9: Comparison of mean regional contraceptive prevalence rate (modern methods) by development status to South Tarawa, Kiribati

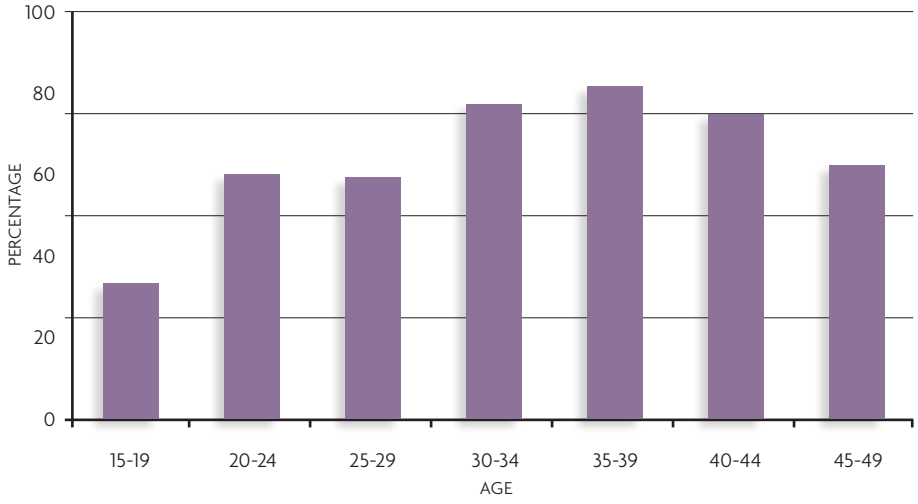


** United Nations [10] ** This research *** DHS [9]*

The increase from 2009 was still very large, at just under 150%. However, when comparing modern method prevalence to developing country averages, South Tarawa would now be 5% greater than 'least developed countries', but still 18% less than 'developing regions' and 22% less than 'developed regions'.

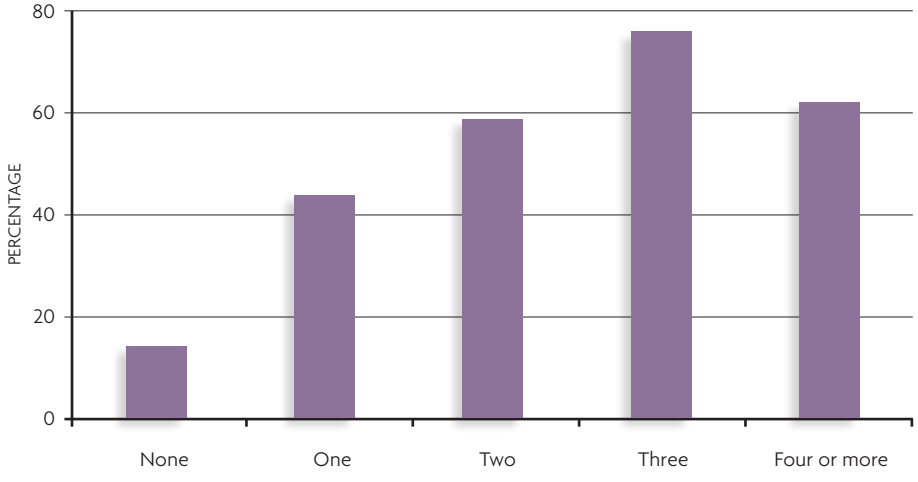
Responses were also analysed by key demographic indicators: age, number of children, education, employment and religion. When split by age, young married women were considerably less likely than their older counterparts to be using family planning (Figure 10).

Figure 10: Current use of contraception by age (currently married women)



Just 27% of currently married or in-union women aged 15-19 were using family planning, compared with 65% aged 35-39. When split by number of children however the most evident pattern was seen (Figure 11).

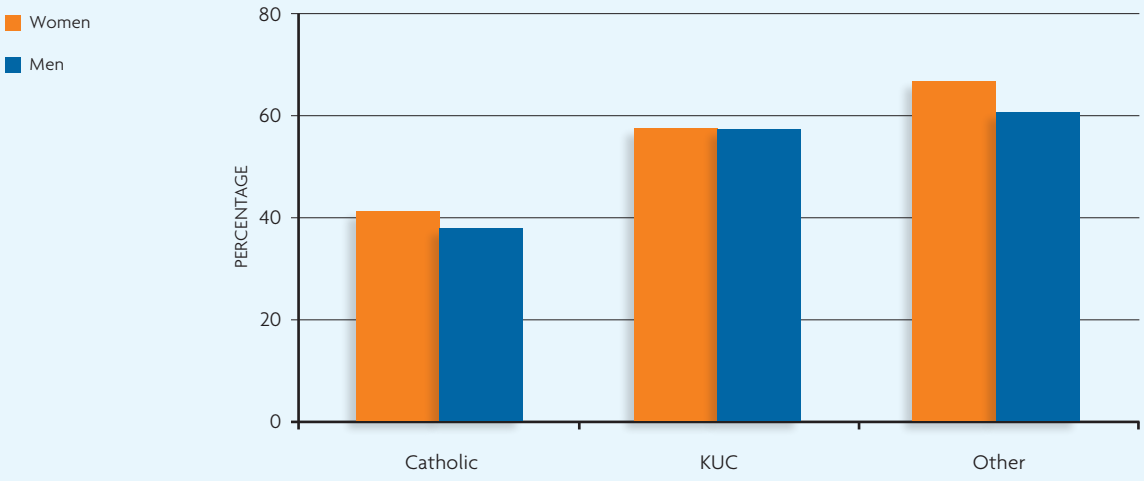
Figure 11: Current use of contraception by number of children (currently married women)



Current use of contraception increased markedly with the number of children that a women had up until four or more where it tapered off. Just 15% of those without children were using contraception compared with 76% of those with three. This appears to follow the same pattern as in the 2009 DHS.

The difference in contraceptive use (all methods) between religious groups was also investigated (Figure 12).

Figure 12: Current use of contraception by religion (all methods)

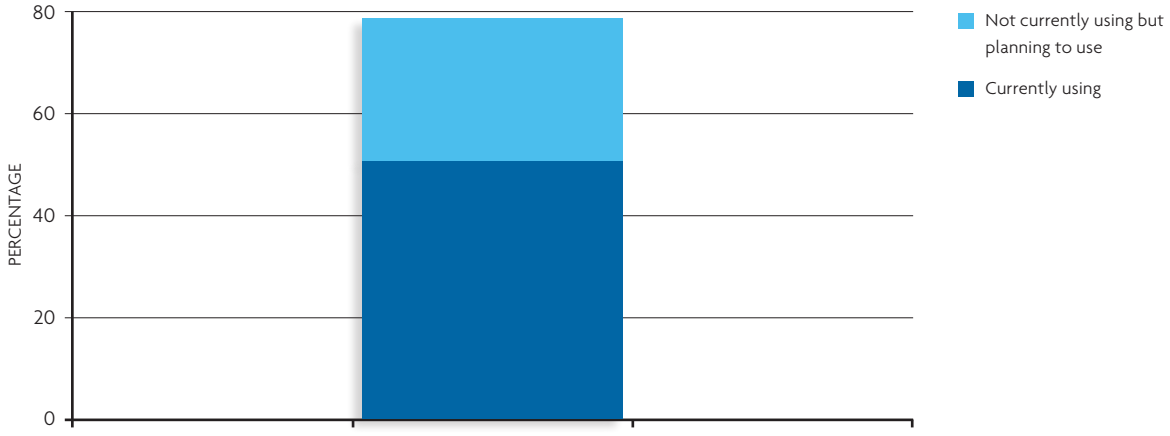


There was a considerable difference in use between groups. However the contraceptive prevalence of all groups was at least twice the figure for South Tarawa in 2009. The increase across all groups is likely in part to the increased cooperation between SRH service providers and church leaders to provide faith-appropriate SRH information and services.

Employment status was also strongly correlated with usage. Those in paid employment were considerably more likely than those not in paid employment to use family planning (women: 66% to 48%, men: 62% to 45%). Education appeared to have less effect. Contraceptive prevalence rate was similar for those with no education (men and women) and those with primary, junior and senior secondary (between 47% and 54%). Those with a tertiary education however were considerably more likely to use family planning (67%).

To try and anticipate the potential for future increases in contraceptive prevalence, respondents were asked whether they intended to use family planning in the future.

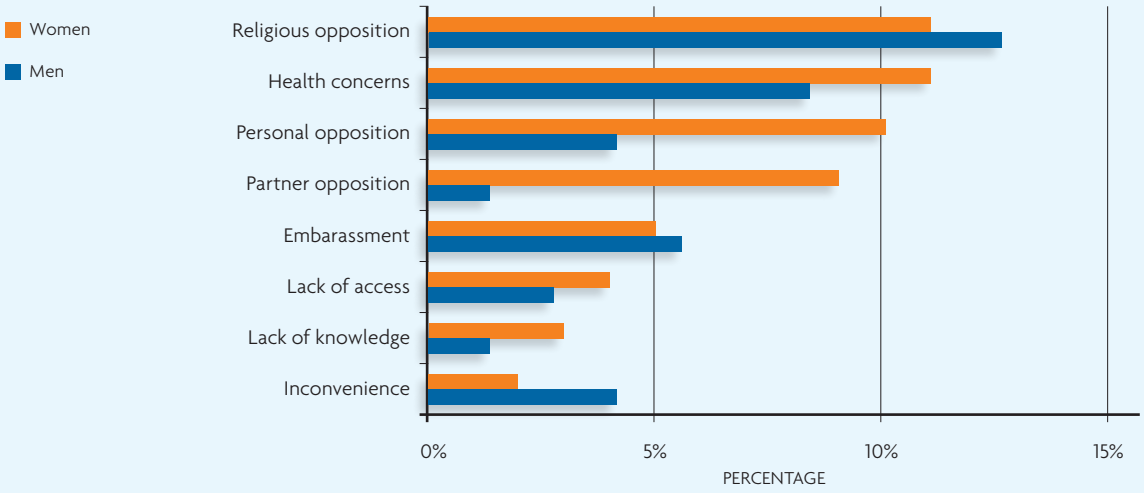
Figure 13: Current and intended future use (currently married women)



A further 28% of women were not currently using family planning but intended to in the future (coincidentally, in the 2009 DHS unmet need for family planning was also recorded at 28%). Though not a true measure of unmet need, it might be assumed that there is scope for growth in contraceptive prevalence of a similar magnitude to the growth since 2009.

Finally, non-users were asked about their reasons for not using contraception. The responses from currently married respondents are displayed overleaf.

Figure 14: Reasons given for non-use of contraception among currently married non-current users by sex



Respondents were somewhat reticent about their reasons for non-use, with many opting not to answer. After excluding those not using because of infertility/ menopause and those seeking to get pregnant there were several stated reasons. Most commonly for both men and women were religious opposition to family planning use (13% and 11% respectively). For women health concerns, personal opposition and partner opposition were all of similar impact (9-11%). Health concerns were reported as reasons by a few men (8%).

While the sample size of this survey makes it difficult to make definitive statements about the entire South Tarawa population, it appears that family planning usage has increased very considerably since 2009. A total of 50% of currently married or in-union women were using contraception, dramatically more than the 19% of six years previous. Age, the number of children a respondent has and whether they were in paid employment were all positively correlated with higher contraceptive prevalence. Consequently, lower age, fewer children and not being in paid employment were associated with lower contraceptive use. Among the stated reasons for non-use, religious beliefs, health concerns, personal and partner opposition were the most commonly cited reasons. Despite these barriers there remains considerable potential for increase to contraceptive prevalence with a further 28% of women anticipating they will use contraception in the future.

Interviews

Semi-structured interviews were conducted with health promoters, clinical staff, government and non-government organisation (NGO) decision makers (n=14). Interviewees were identified through personal networks and in consultation with KFHA. Participants were asked about their professional experiences working in family planning, what they thought the major barriers to family planning uptake in Kiribati were, and what could be done to address these barriers.

Four focus groups were also held with four key groups: men 15-24, women 15-24, men 25-49 and women 25-49. Interviewees were asked about their family planning experiences and attitudes of people in their communities, what they thought the major barriers to family planning uptake in Kiribati were, and what could be done to address these barriers.

In the interest of confidentiality the names and job titles of those interviewed are not stated. Quotes are attributed to three broad categorisations: government official, health professional, and focus group participant.

Disinterest in family planning

Among many of the interviewees there was a feeling that family planning use and controlling fertility was not a matter of big importance in peoples' lives. Family planning was seen to be something that was often accepted to be important but rarely prioritised.

> *It is not an urgent matter for people. People don't think it is a need so they leave it. They think 'if possible'. If by chance a service is coming (to their communities) they go 'okay we'll go!' But it is very hard otherwise.*
> Focus group participant

Interviewees had many theories on the causes of this disinterest. These theories ranged from broad cultural reasons to pragmatic justifications. For some, the disinterest was attributed to traditional ideas around children as wealth:

> *Traditionally, the more babies you have the richer you are because you are a king and you have so many daughters and sons to look after you. That is a mentality that has to be changed (before family planning use can increase further).*
> Government official

> *(People) want to have children, because the more children you have the more you will receive.*

Your children could become doctors or seamen and they will bring benefits to you.
Focus group participant

For many it was suggested, that children are seen as an investment for the future. People with more children would have more children to look after them as they age. Conversely, others suggested that financial reasons were one of the principal reasons for uptake, particularly if the user was not in paid employment. Several interviewees described the financial hardships faced by those with more children than they could comfortably support.

Some (users) are not working and they say that 3 children are enough for them to support.
Health professional

The most common reasons are that women have so many babies that they can't cope with. Some they just want to lengthen the interval and others feel that they can't afford any more children.
Health professional

Fertility was commonly presented as something that only needs to be controlled if issues start to arise and not prior. There was a feeling among interviewees that many people only begin to use family planning when their number of children reaches the maximum that they can support. For some this maximum will be dictated by health reasons.

(People only use family planning) when they have some health issues. Maybe they have been told or advised by the doctor that they cannot bear any more children. That is the time that they start family planning.
Government official

One of my children died. That is when I realised it is good to use family planning to ensure good spacing for children.
Focus group participant

In a similar mode was the idea that women in Kiribati often decide to use contraception when their maximum desired fertility is reached. This pattern of family planning usage seems to be reflected in the strong correlation found in the survey between current use of family planning and number of children (see Figure 11).

The lack of contraception in the early years of reproductive age was highlighted by many interviewees. Contraceptive use at first intercourse was thought to be unlikely for most.

No, (young women) never come forward for (contraception before first intercourse). I have never seen a woman brave enough to announce that she is

going to have sex and she needs something for protection. I have not met any.

Health professional

Similarly, when young couples got married contraception was not thought to be a priority.

They don't have a plan before getting married. This is because parents don't really talk to them about family planning or tell them what it is all about. That is why it is an issue. That is why they don't really know about family planning.

Focus group participant

As a lack of family planning at this stage in a couple's life is highly likely to lead to pregnancy, having a child very soon after marriage is expected.

I always say to people "It is funny that in other countries a couple when they get married they don't get a child in the first year! It is after many years when they sit down and talk about it and their circumstances." The first thing they achieve after marriage is a child! In other countries they don't get a child for ten years, but here it is the first thing they produce.

Government official

There was a general feeling among several health professionals that marriage could be a window of opportunity to engage with young people to educate them about reproduction and family planning and enable them to make safe contraceptive decisions. At the time of the interviews health professionals and the Catholic Church were preparing a programme by which couples would receive counselling from catechists on natural family planning as part of their preparations for the marriage sacrament.

We know that catechists prepare the new couples before their wedding. We thought that would be one entry-point. The meeting is a training of the couple on the wedding sacrament. They have to meet with the couples to prepare the couples before they take the holy sacrament. Now the Bishop agreed that they have to inform catechists that in preparing the couple they have to put in the SRH information (including natural family planning methods). This has been happening for one week already.

Health professional

Should this programme prove successful it was thought this could apply to other groups. It was suggested that programmes could be formalised where

SRH trainers are invited to teach couples about family planning prior to their wedding.

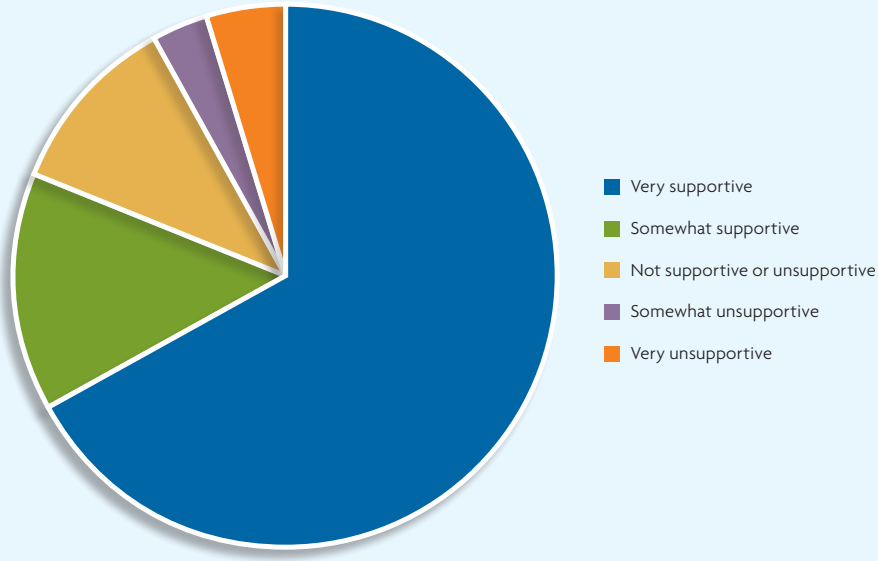
Personal, family and social objections

In the community survey, reasons for non-use were identified from non-users. Personal, family and social objections formed the majority of the barriers. The most common stated reasons for non-use for both men and women were religious opposition (see Figure 14). For women, health concerns, personal opposition and partner opposition were all often stated reasons. Among men, barriers were less defined.

In the interviews and the focus groups, respondents were asked about the barriers to uptake that they saw. As with the community survey respondents, many of the interviewees discussed the social pressures from others as barriers to family planning use. Pressures were described as coming principally from three areas: from themselves, from their partners, and from their faith.

Faith-based opposition to family planning in Kiribati has been explored in depth in previous studies.[13] In 2009, the Kiribati DHS cited religious prohibition as being the most common reason for not intending to use family planning.[8] In this survey however most people reported that they felt 'very supported' in their SRH decisions by their church leaders (Figure 15).

Figure 15: Respondents reported supportiveness of church leaders towards family planning



The respondents from this survey came from a spread of faiths. There was variation between faiths, but over 85% of respondents for each religion reported that they felt their religious leaders were either ambivalent or supportive of their contraceptive decisions. This may be in-part due to the active increase in the engagement of church leaders in SRH programmes in Kiribati, both by the MHMS and KFHA. It may also be in-part due to the increased promotion of faith-appropriate (natural) family planning methods by the MHMS and KFHA, including the Dr Billings method and the cycle beads method.

Many interviewees reported that faith-based pressures were still prevalent, particularly in regards to the use of modern methods.

> *I worry because my neighbours know that I received my sacrament. My neighbours know that we are using family planning. They might say "see they are still receiving the sacrament from the priest yet they are using family planning".* Focus group participant

An associated component of the religious pressures was attributed to the language used around family planning health promotion. There was the feeling that sexual activity was being presented to people, particularly young people, as being a shameful act. In particular the use of the phrase *wene ni bure* as the terminology for sex in health promotion messages:

> *Even now I still disagree with wene ni bure. It is the bible term, a sin, like committing adultery... Even if you sleep together with your own legal wife wene ni bure is still the word (that is used in family planning messages). I disagree with that.*
> Government official

It was suggested that the language used in health promotion and in comprehensive sexuality education should be more carefully considered to remove language that comes across as blaming. It was suggested that moving away from some of the formal, often biblical terminology that formed much of the early written Kiribati language may go some way towards achieving this. New words or new phrases should be developed that are 'friendlier'.

> *There is much vocabulary now that we haven't formalised the use of in our existing dictionary. We need to expand the dictionary to include these words. There are many loaned words, but what is wrong with that? ... That is what language is, it is changing all the time.*
> Government official

Employing newer phrasings or words to reflect changing attitudes towards sex and sexuality might assist in making health promotion messages more acceptable.

The next common subset was objection from partners. In the community survey women reported that objection from their partners was their reason for non-use with relative regularity (see Figure 14). Among men surveyed, very few reported partner objection as a reason. This was generally reinforced in the interviews. Several interviewees reported that women were often fearful about talking to their husbands about using contraception.

> *Sometimes women want family planning but they are afraid of their husbands.*
> Focus group participant

> *Most of them who say "no, they are not ready for family planning" it is because they have to ask their husband, to get their consent... Women really like family planning but the husbands don't like it.*
> Health professional

The reason for men not wanting their wives to use family planning was regularly given as jealousy. Interviewees reported that men would see the use of family planning as somehow facilitating unfaithfulness.

> *Some they say that they don't want the wife to take the (family planning) method that maybe because they are jealous that the partner will go out and (have sex with another person). So they don't want them to take the (family planning) method.*
> Health professional

> *They said that if they are going to use the family planning that means they can go out with other men. It is about jealousy and not trusting each other.*
> Health professional

> *We also have some cases of (secret family planning). They really intend to do it but it is not right for us to do that. The husband should know that the wife is using another method, but for the sake of these women we try to help them and do private cases like this.*
> Health professional

There was a feeling that actively engaging men in family planning, in their roles as partners, as fathers and as community leaders was essential to removing barriers to family planning uptake, in particular engaging men in more of the contraceptive decision-making process for themselves and their families. Getting men to take more responsibility for contraception, including male specific contraception was seen as vital.

A better way to help them would be to teach them that not only a woman but also a man need to think about contraception. Both of them need to decide.
Focus group participant

If they really understood about the importance of family planning, the benefits and whatever, then I think it would all be okay. That is a problem, the male dominance, it means we women just have to listen to them, even though we are not healthy and we need family planning. But if the husband doesn't like that we just have to listen or else... That is our problem.
Health professional

There was, however, a general feeling that men were more accepting of family planning than they were even a few years ago.

I think in the last three years they definitely allow their wives to use the family planning. We have seen the numbers start to increase. And we know that women come with their husband and visit the clinic and that they agreed to take the family planning. And we have had ten cases of men who have had a vasectomy already this year, compared with last year when there were seven.
Health professional

The last common subset was personal objections, primarily personal objections from women. In particular there was a large amount of concern about side-effects from modern family planning methods. Several interviewees reported serious side-effects from modern method use, including heavy bleeding, weight gain and infertility. Several reported that themselves, or people they knew stopped using family planning due to these side-effects.

Among health professionals there was the belief that many of these women were either frightened by myths about contraception or inadequately counselled about possible side-effects. Myths about the dangers of contraception were particularly prevalent about intrauterine devices (IUDs).

There are so many rumours, especially with IUDs - that IUD can cause cancer, that an IUD can be misplaced inside the abdomen - false and bad rumours about the method. Once I do good counselling with them and they understand they accept it.
Health professional

This lack of knowledge about methods and their side-effects was not limited to non-users but affected users as well. Insufficient counselling was blamed for much of the fear around side-effects, as women were not aware how the methods would affect their bodies and as such were perhaps unduly afraid of side-effects.

> *The side-effects of contraception are what really scare people away from using (family planning). We have lots of people that come forward for an implant, but then they come back to remove it because of the side-effects. I found out before they had the implant inserted there was no proper counselling for these women. The side-effect that is common with implants is the changing of bleeding patterns, prolonged intermittent bleeding. They call it in medical terms - spotting. That is a possible side-effect but (the women) never knew that before they had the implant and (so if the bleeding occurs) it makes them worry and so they come back. When they come with that sort of problem and I counsel them properly about the side-effects, then they are okay and they don't want to remove it.*
>
> Health professional

There was the feeling among health professionals that with adequate counselling people could properly understand the potential side-effects of different methods, choose the methods that they felt were best for them and be more prepared for side-effects. Without this, there would continue to be misinformation and fear around long-acting reversible contraceptives.

Knowledge gaps

Another common theme in the interviews was the perceived lack of practical knowledge about family planning and reproduction. There was consensus among most people interviewed that people were generally aware of family planning but that many had limited understanding of how it actually worked. This lack of knowledge meant that people faced a range of barriers from simply not being aware of family planning methods, to not knowing how to access them and not knowing how they affected their bodies.

> *People really need family planning, but they don't really know what the benefits are, what the procedure is, or are they going to have to pay?*
>
> Focus group participant

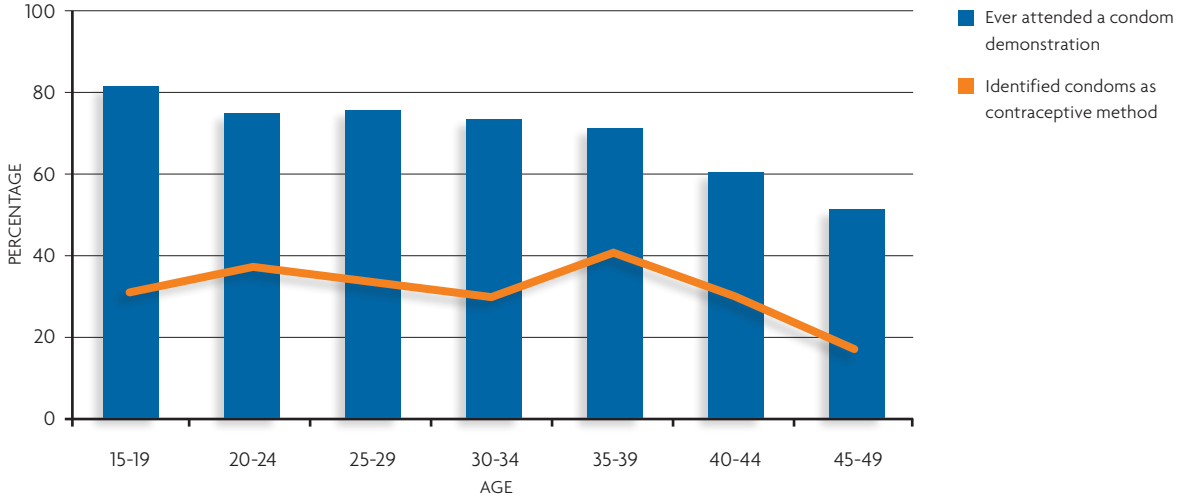
As with the lack of knowledge on side-effects, the lack of knowledge was also not limited to non-users. Over 30% of contraceptive users could only name

methods of contraception that they have used, and could not name any methods that they had not. Knowledge gaps were also prevalent around natural method users, having serious impacts on efficacy.

> *Most of these women who try to use natural methods, they always miss or get pregnant, because they don't really understand how to use it. They need to have knowledge about their menstrual cycle. Some women don't have a normal menstrual cycle so they can't use their own method... the natural method is not really a reliable thing. Not without knowledge.*
>
> Health professional

Perhaps a telling example of this for modern methods was the knowledge gap observed in the survey between respondents having attended a condom demonstration yet failing to identify condoms as a method of contraception (Figure 16).

Figure 16: Condom demonstration attendance vs identification of condoms as contraceptive method



Around half as many respondents correctly identified condoms as a method of contraception compared to the number who attended a condom demonstration. Health professionals were asked directly about this data. Responses were mixed between those who thought condoms were generally known as contraceptives and those who thought condoms were principally regarded as barriers against disease and infection and not seen as contraceptives. The latter thought that the health promotion messages about condoms for protection against STIs and HIV have been highly successful and perhaps not drawn attention to the dual function of condoms.

> *Maybe because there is a lot of promotion on STIs and HIV and the only way to protect that is the using of condoms. I think we need to add to this that condoms are a dual protection. We know it but maybe we forget to say that it is another way to protect you from getting pregnant. I know that you can see health promotions on HIV and STIs and they only talk about condoms being the only way to protect from these infections. Maybe we forget to add that they also protect you from pregnancy.*
> Health professional

> *I have a lot of friends, and a lot of the time we share things with each other. What they always tell me is that their girlfriends refuse to use condoms with them. They (the girlfriends) think that they are afraid that she will have an STI. (Interviewer: Do they ever think that it is because they don't want to get her pregnant?) No, it is all about STIs. My friends are really afraid of getting STIs but their girlfriends are offended. They say things like 'so you think I am having sex with others?' 'You have to trust me!' Health promotion messages say that you have to stay with one partner and trust each other, and so now that is how people think. I have many friends and many of them have their different hobbies and lives, but they are all similar in terms of STI protection and HIV protection.*
> Health professional

Focus group participants and health professionals were asked what could be done to improve peoples' knowledge of family planning. Responses typically suggested improved sexuality education in schools and improved health promotion messages. Comprehensive sexuality education enables young people to make informed decisions about their sexuality and health.

The need for comprehensive sexuality education in schools in Kiribati has been covered in detail elsewhere.[14,15] The Ministry of Education (MOE) is currently updating their curriculum to include more components of sexuality education in their school programmes.

Focus group participants who recommended improved health promotion messages suggested increasing the frequency of messaging through traditional channels (e.g. radio) and creating new content for other channels. The most commonly proposed new content was the creation of entertaining video content that people will enjoy watching. Health professionals who had used movies in other SRH promotion projects agreed.

> *The common practice is for people to watch DVDs. In the Maneaba they have one screen and maybe 50 people are watching... (if we had family planning promotion DVDs that would) help us reach out with the message.*
> Health professional

> *Three months ago we had an advocacy programme with all the mayors. One of my presentations was a DVD on teenage pregnancy. It came with a package with a pamphlet and a guide. It was designed for our peer-education programme. (This advocacy programme) was very hard for me because they were leaders, unimwane (elders), so I played the DVD. The good thing about a DVD is it is really short, maybe 20 minutes... They were really touched, there were sad parts. I gave them one question: What do you think is the best way to avoid teenage pregnancy? They all went silent and wrote down their answers, all of them. That is the impact of the DVD. If you are interested in a movie and you watch it, it can really affect you emotionally. There is an impact. And that is one way to really engage people in Kiribati... I had training with 50 youth and I played the same DVD and the same thing happened, they really liked the DVD.*
> Health professional

Several health professionals interviewed called for more reflective messaging that enabled people to ask questions. In messaging that was delivered publically and not in workshop settings there was the fear that people would not understand concepts and not be able to ask questions.

> *Announcements or promotions on media, you just give them information, but there is no way of people asking questions. We*

just give out information whether people understand it or not. How can they respond that they are not clear about something? It is not a two-way correspondence.

Health professional

Talk-back radio was given as a good example of a more reflective messaging.

There is another way of media promotion that they do now: there is a program called nimaua akea 50 minutes. That is a good way of giving more information to people. You give them a scenario and they (the listeners) can answer that. This is a good way because you have the response from the people, asking questions or answering your scenarios - "what is depo provera (injectable contraceptive)? What does it do?"

Health professional

Service delivery

Many of the interviewees raised issue with the traditional clinic-based delivery system of family planning in Kiribati. Accessing family planning in the clinical setting was viewed as problematic for several reasons, principally: confidentiality, acceptability and accessibility.

Confidentiality concerns typically stemmed from being seen to be going to a clinic. With the relatively small population of South Tarawa and the closeness of the communities there were fears that when one went to a clinic they would likely see people that they know.

The problem with the clinic is that "there are so many people there. Some of them are Catholic or whatever and they don't want the other members of the church to see them"

Health professional

Focus group participants were also concerned that the staff at the clinic would not treat their cases as confidential and would tell their families that they were sexually active. With the cultural taboos around sex before marriage young people felt that it was too risky to go to the clinic to get family planning.

Existing health clinics were also seen as unacceptable service delivery modes

for many, particularly younger men. In the focus groups young people reported that they or their friends felt uncomfortable going to the clinic to access family planning services or information. They felt that the services were often not designed for them and that people judged them. Several younger focus group participants felt that it would be best to provide services to young people in a more comfortable and youth-focused situation. Respondents suggested that clinical services and information could be provided in a youth centre where young people went anyway to play table tennis, listen to music or meet their friends. It was thought that having services provided where young people would already be would make youth more comfortable accessing services, but also make it less obvious to outsiders that they were there to get family planning.

Issues of accessibility of clinics were also raised. To attend dedicated SRH clinics people often had to travel considerable distance, often at considerable expense. For those in paid employment, attending clinics during work hours was difficult and inconvenient. If people were not prioritising the accessing of family planning it was thought that many would simply not go, despite wishing to space or limit their children.

Mobile clinics were brought up by all interviewees as successful interventions to encourage the use of family planning. Mobile sexual and reproductive health programmes are commonly used in Kiribati to reach communities that might otherwise not be able to access services. Typically these programmes are held in *Maneaba* and people from the surrounding village can attend. These were widely seen as an essential part of family planning activities.

> *I experienced that staying in the clinic is not very good for promoting family planning. We have to go out (into the communities) and convince women to use these contraceptive methods... They need more information about the methods provided. I noticed that we have more cases if we go out into the community.*
> Health professional

> *The mobile clinic... will help people to access family planning - visiting them in their respective villages rather than people having to travel on their own to visit the clinic.*
> Focus group participant

There was criticism on this mobile clinic model as well. For some the mobile clinics were seen to have the same confidentiality issues as clinical

services. It was raised that people would be reluctant to ask questions in a *Maneaba* as the talking in public forums is generally the role of the *Unimwane* or elders. Further, they would be surrounded by many people and might be afraid to answer questions or get services.

> *We need to go somewhere to do the one-to-one (away from the Maneaba). They can ask some questions in the Maneaba. But if we really need someone to be on family planning we need counselling in a more proper place.*
> Health professional

Several interviewees suggested the establishment of home visitation programmes for key populations to ensure that information could be delivered to people in a safer and more private setting. It was felt that providing information to people in the safety of their home would allow people to be more comfortable and perhaps be more receptive to the information.

> *Messages come out from the radio and they just pass by. It doesn't stay or stick in their homes or in their hearts. If you visit someone at their home, traditionally it is like you are respecting them. If you visit them in their homes they will abide to what is being offered. In our custom, if I ask you (to consider something) along the road, you can take it or not, it is an option. But if I come and pay a visit to your home, pay a courtesy call to your home, then it is a must. Taona tabon inaaim (sitting on the end of your mat) is the phrase.*
> Government official

> *Home visit is very good because you just visit and go straight to their home. And discuss the family planning, the benefits and everything.*
> Health professional

> *(People) say that they are more comfortable because it is just the husband and the wife and then they can share their problems without the judgement from other people.*
> Health professional

Support for this was given in the form of anecdotal evidence from a KFHA outer island health promotion programme. This promotion programme used peer-to-peer health promoters to go out to households to promote family planning. Individuals wishing to receive SRH services could give their name which would then be given to community clinic staff for follow-up.

> *We are using our (peer-to-peer health promoters) to go out and visit the households. One*

of the medical assistants (MAs) confirmed to us that from the programme they increased their number of family planning clients. Because the (peer-to-peer health promoters returned to the clinic) after the home visits to report that they have x cases of family planning, and that these are their names. So (the clinical staff) follow-up and that is how they get the clients.

Health professional

It was suggested that community clinic staff could be used to run home-visitation programmes on family planning.

They could assign someone (from the community clinic) to visit all the households (in the area)... They could organise that one (clinician) stay in the clinic, and the others visit the households.

Health professional

It was also suggested that lay educators could be used to deliver key family planning messages door to door in identified communities. Drawing from experience delivering non-health community education programmes, one interviewee discussed the success of a door-to-door programme educating a community on how to comply with a new waste collection programme which was struggling due to a lack of support from the community.

We formed a group and we invited 100 youths and we trained them over three days. We wanted every household to be visited by these hundred people so we mapped the areas and located the populations. And they (the youth) got some proof that they visited, the names and signature of the people they visited, and when they came back we collected this data. And we were quite satisfied that the message was put across. And the next week we enforced the bylaw and everybody followed the law. Because they are all aware. The way to get the message across is to ensure that the message reaches the household, and the only way to do that is to visit them.

Government official

Lastly, there was concern that family planning was getting lost within wider programmes and was not given the priority that it needs. In community clinics family planning was just one of many general health services provided. In sexual and reproductive health clinics, family planning was one of many SRH services provided. There was the thought that to make a real difference, there needs to be more human resources allocated solely to family planning.

The problem with the hospital is that they integrate family planning into other programmes, in huge programmes. The public health nurse in a clinic has to do immunisations, she has to do hypertension, she has to do child healthcare, she has to do deliveries, and she has to do out-patient, everything... And family planning is integrated in these too. I think it is a bit loaded for the nurses to properly concentrate on family planning.
Health professional

The approach here is that (family planning) is regarded as part of the normal health services. If you never ask any questions about family planning you will never get any information. But if you have a unit that is focussed on this issue then you may be able to get more results. (Currently) it is a passive approach. What we need is a more aggressive one.
Government official

We talked to a guy, a doctor, who ran a programme on TB. He had nothing else to do. He had eight nurses and he moved from island to island. They are beginning to make an impact. I think that may be a useful model to try and follow.
Government official

Discussion

The results of the community survey indicate that people in South Tarawa have had considerable exposure to family planning messages yet knowledge levels appear to be generally low. Over 50% of men could not name two methods of contraception, and over half of women could not name three. It appears however, that family planning usage has increased very considerably since 2009. A total of 50% of currently married or in-union women were using contraception, dramatically more than the 19% of six years previous. There also remains considerable potential for increases to contraceptive prevalence with a further 28% of married women anticipating they will use contraception in the future. Barriers, however, remain. Among the stated reasons for non-use, religious beliefs, health concerns, personal and partner opposition were the most common.

It must again be noted that the community survey did not employ random sampling methods to identify survey respondents. Potential respondents were identified by interviewers going out into the communities and asking if people would like to take part. Subsequently, the results of the community survey should not be treated with the same authority as official demographic or health surveys. Despite this, the substantial sample size (n=500) and that the respondents appeared to be broadly reflective of the national demographic cohorts, indicates that the data are likely to be reasonably reflective of the population.

The interviews with community leaders and health professionals and the focus groups with key populations provided considerably more detail about the barriers facing family planning use in South Tarawa. Barriers identified fall into four key areas: disinterest in family planning; knowledge gaps; personal, family and social objections; and service delivery.

There was a feeling among participants that family planning use and managing fertility were not matters of big importance in peoples' lives. Family planning was seen to be something that was often accepted to be important but rarely prioritised until fertility began to cause problems. Interviewees described a pattern in which once people had reached their maximum desired number of children they would begin family planning use. This pattern differs from that commonly promoted in health promotion materials and should be considered in the development of new materials. Yet care needs to be taken in doing so. Delaying non-use of family planning until such a time as maximum fertility is reached has a considerable impact on the health of women and their children. Research has shown that spacing of births is closely correlated

with infant survival, with babies born less than two years after the next oldest sibling more than twice as likely to die in the first year as those born after an interval of three years.[16] By avoiding closely spaced births, family planning could save the lives of over 2 million infants and children in developing countries.[17]

Similarly the delaying of first child birth allows women to safely bear children in their healthiest years. The age at which woman have their first birth can have serious implications for the health of the woman and her child. Early childbearing increases the risks for women and their children, with the younger the mother, the greater the risk to her and her baby. In low and middle income countries, babies born to mothers under 20 years of age face a 50% higher risk of infant death than those born to mothers aged 20-29.[18] They are also more likely to have low birth weight, leading to potential long-term health effects including inhibited growth and chronic disease. Ensuring women have access to family planning to delay first childbirth is vital for the health of woman and their children. Health promotion should continue to stress the importance of family planning for the delaying and spacing of children while recognising fertility preferences.

Personal, family and social objections were highlighted in both the community survey and the interviews. The most commonly stated reasons in the community survey for non-use were faith-based opposition, health concerns and partner opposition. Many of the interviewees reinforced these same barriers. There was however the impression that people generally felt supported in their contraceptive decisions by their church. Interviewees suggested that this may be in-part due to the active increase in the engagement of church leaders in SRH programmes in Kiribati, both by the MHMS and KFHA. It may also be in-part due to the increased promotion of faith-appropriate family planning methods by the MHMS and KFHA, including the Dr Billings method and the cycle beads method.

The promotion of natural family planning methods by service providers should be done with some care. Natural family planning methods are effective if used perfectly. When used in non-perfect scenarios however (inconsistently or incorrectly) the method effectiveness is very poor, with an estimated 24% of women using it becoming pregnant after one year of use.[19] To use these methods effectively, women must be very committed, very knowledgeable in the details of the method and highly attune to their personal cycles. Their sexual partners must also be supportive of their choice, and together they must abstain from

intercourse on fertile days or use an alternate contraceptive method. Lastly, those providing training in natural methods must be highly trained as well as highly effective teachers.

Lastly, the barriers described in this study are principally barriers to service delivery as described by the informants, and should not be seen as an exhaustive list of challenges influencing contraceptive uptake. Other reports have outlined further challenges faced, including commodity shortages and under-confident staff at clinics[20] and the need for stronger implementation of government policies.[13]

Recommendations

The following 14 service delivery recommendations are proposed for family planning policy, programmes and decision makers in South Tarawa, Kiribati. The recommendations are in no particular order.

1. Consider desired fertility trends of men and women in South Tarawa when developing new family planning materials. Highlight the importance of delaying and spacing children.
2. Promote the use of contraception at first intercourse through family planning promotion programmes.
3. Develop programmes to work with couples before marriage to educate them on family planning. Marriage should be viewed as a window of opportunity for health promotion.
4. Consider the terminology and language used in health promotion messages, in particular the use of moralistic language in regards to sex. Employing less judgmental phrasings or words might assist in making health promotion messages friendlier.
5. Develop family planning promotion programmes to specifically target men in their role as partners. Educating men on the benefits of family planning for the health of their families could address the partner barriers to family planning

uptake. Special attention should be paid to addressing jealousy.

6. Create family planning promotion messages and materials that address myths around modern family planning methods.
7. Review existing family planning consultation guidelines and practices to ensure adequate and accurate information is provided about possible side-effects.
8. Promote awareness that condoms are a form of contraception. Consideration needs to be given during the design of these programmes to the lower efficacy of condoms compared to other modern methods.
9. Use 'edutainment' materials as a tool for increasing awareness of family planning. 'Edutainment' movies are popular with health promoters and public alike yet only limited options exist for family planning in Kiribati.
10. Utilise family planning promotion channels that allow the public to ask questions. Possible examples include talkback radio, the use of social media (especially direct messaging functionality), or the provision of contact details for questions.
11. Review the confidentiality procedures for all clinics. Ensure that all staff are trained in confidentiality best practice. Engage in media promotion programmes to stress the confidentiality of family planning clinics.
12. Integrate family planning clinic services into existing youth safe-spaces, e.g. youth centres.
13. Develop home visitation programmes for family planning promotion and low-level service delivery. Delivering family planning promotion services in the home is thought to allow more privacy and give messaging more weight.
14. Dedicate human and financial resources to family planning specific programmes. There is concern that family planning is often not-prioritised within wider sexual, reproductive, maternal and wider health programmes.

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