PACIFIC JOURNAL OF REPRODUCTIVE HEALTH

SHORT REPORT OPEN ACCESS

‘A snapshot of services’. Access, standardisation, education: Ministry of Health community clinics, South Tarawa, Kiribati.

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ABSTRACT:

Background: Maternal health care, and sexual and reproductive services are high priorities in the Kiribati Ministry of Health Plan and key targets areas in the Sustainable Development Goals. They are fundamental to reducing unsafe abortion, maternal and perinatal mortality, and improving social, financial and physical wellbeing. This review was conducted to determine strengths and gaps of sexual and reproductive health services across the 14 community clinics in South Tarawa, Kiribati.

Methods: An investigative approach using a questionnaire and an audit of basic resources, information and equipment was carried out in each of the 14 clinics over a 5-day period.

Findings: This review found specific areas for improvement are required across the 14 clinics if the key targets of the SDGs are to be met. Specifically, these are access, standardisation and education. Clinics are impacted by the availability of contraceptive commodities and staff characteristics. There was reduced access to cervical screening. Equipment was not standard in all clinics affecting safety, services and quality of care. There was a lack of standardized care evident in differences in numbers of antenatal visits, tetanus toxoid immunisation and scanning frequency in pregnancy. Staff identified areas for further education and training.

Conclusion: Despite challenges and limitations, community clinic staff demonstrated commitment in serving their communities to provide primary health care services. Recommendations include ensuring all frontline staff were knowledgeable, confident, and skilled to improve the quality of services. Improvements to maternal, sexual and reproductive health are likely to increase access, safety, and health outcomes for women and their families.

Key words: Kiribati, family planning, contraception, access, health education

BACKGROUND

Kiribati is an island nation of 33 low lying atolls spread across the equatorial Pacific. South Tarawa, is the most densely populated atoll with 56,000 people and challenged by high population growth, land density, and economic sustainability.[1] Ongoing issues include infrastructure, sanitation, land and water integrity, food security, infectious and non-communicable diseases. Kiribati is reported to have some of the highest rates of maternal, neonatal and infant mortality in the Pacific.[2] Forecasts are that this atoll will be increasingly vulnerable to impacts from climate change.

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Received: 04.11.2017; Published: 31.12.2017

Citation: Marshall. ‘A snapshot of services’. Access, Standardisation, Education: Ministry of Health Community Clinics, South Tarawa, Kiribati. *Pacific Journal of Reproductive Health* 2017;1(6):332-338. DOI: 10.18313/pjrh.2017.924.

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Maternal, sexual and reproductive health care includes cervical screening, antenatal care, postpartum contraception, family planning and contraceptive options, youth services, and sexual health care.

The Kiribati Family Health Association (KFHA), with support from Family Planning New Zealand (Healthy Families Project), the International Planned Parenthood Federation (IPPF) and the Kiribati Ministry of Health (MOH) provide services, information and education to I-Kiribati on sexual and reproductive health.

Thirteen Ministry of Health (MOH) Community clinics across South Tarawa and the Healthy Family Clinic at Tungaru Central Hospital (TCH) also provide free sexual and reproductive health care along with other services. These fourteen small clinics were dotted along a narrow strip of land stretching over thirty kilometres between lagoon and ocean. Staffed by advanced trained nurses (medical assistants), nurses with or without a midwifery qualification and nurse aids they operate on a primary care model, serving their individual communities. They also provided outreach care; collected demographic data, disease trends and health information which was reported back to the Ministry of Health.

Increasing access to and use of high quality comprehensive family planning services, and improving maternal health are objectives in the Kiribati Ministry of Health Strategic Plan (2016 - 2019).[3] The Sustainable Development Goals, Good Health and Wellbeing (Goal 3) and Gender Equality (Goal 5) specifically identify the need for universal access to sexual and reproductive health and reproductive rights.

METHODS

As part of an advocacy strategy to leaders at local and provincial government levels, the Safe Motherhood Alliance PNG (SMAll PNG)[8] hosted workshops with safe motherhood 'champions' as speakers.

A review of the clinics was identified by staff at KFHA as key to future development, to understand services, support integration and collaboration and share information. KFHA, the leading non-governmental organisation in Kiribati providing sexual and reproductive care and services was in alignment with the Ministry of Health and was well placed to lead this review.

After discussion and consultation, a proposal to review services was circulated to KFHA Executive Director, Family Planning New Zealand International Coordinator, and the Ministry of Health Director of Nursing, senior Ministry of Health management and UNFPA. Final document and questionnaire template were developed. Family Planning New Zealand agreed to financial support and KFHA management to the release of three staff to conduct the review.

The visits to the clinics were also used as an opportunity to promote cervical screening and specialist services at KFHA (insertion and removal of implants and intrauterine devices, cervical screening and vasectomy), provide I-Kiribati leaflets and posters on cervical screening, a large antenatal obstetric calculator and emergency birth kits.

The visits to all clinics and interviews with staff were conducted over five days. Three KFHA staff were involved; an I-Kiribati nurse who was the lead interviewer, New Zealand volunteer midwife and Japanese volunteer nurse. Despite challenges in informing the staff prior to the visits, all interviewees when approached and invited to participate were engaged and responsive. The most senior person available was interviewed and this was either the medical assistant, nurse, or nurse aid. Interviews took place in available clinic space in a mixture of I-Kiribati and English language.

Information was collected by structured interview with standardised questions. Staff were asked about services, contraceptive options available that day, systems, and resources. They were also asked to self-rate as either high, medium or low their knowledge of twelve contraceptive methods, confidence in discussing these with patients and skills in providing method.

Information about recent participation in education, influences on practice and identified areas for further education needs were recorded. Demographic data was collected about size of community, numbers of staff employed, and numbers of girls and women in the reproductive age group within the community served by the clinic.

Responses were recorded on a standardised form with additional notes recording responses to open questions. Data was collated and analysed.

FINDINGS

1. Access to services and resources

- Community clinics provided the first and subsequent antenatal visits, care at six weeks postpartum, non- communicable diseases clinics, family planning services and other services for child and family health.

- Five of the fourteen clinics (35%) performed circumcision as part of their services. Male circumcision is a culturally embedded practice. Most boys in South Tarawa from seven to nine years of age and upwards were circumcised.
- Cervical screening services were only available at the KFHA static and mobile clinics and the MOH gynaecology clinic at TCH. Community clinics did not have resources or staff skilled in cervical screening.
- In South Tarawa pregnancy testing services were only available at KFHA and TCH with completion of the pregnancy test for Human Gonadotrophic Hormone at laboratory facilities at both sites.
- At the first antenatal visit, half (50%) of all clinics provided a service for collecting blood for grouping, rhesus status, full blood count, hepatitis B, syphilis (VDRL) and human immunodeficiency virus (HIV) screening. In Kiribati, voluntary confidential counselling and testing (VCCT) was the process for screening for HIV.
    - Seven (50%) clinics provide VCCT
    - Eleven of the twenty (55%) nurses and medical assistants interviewed were VCCT counsellors but only eight (72%) were providing a service. Two nurses were unable to provide services because the clinics where they work do not meet the criteria of a separate counselling room and one other nurse required further training.
    - At one clinic, the MOH HIV Coordinator visits and provides this service.
    - At the six other locations, women were referred to other clinics
- Diagnosis and syndromic treatment of sexually transmitted infections were available in 11 clinics (78%). The other three clinics referred patients to KFHA, antenatal clinic or Tungaru Central Hospital outpatients' department.
- A checklist was completed regarding the availability of essential equipment and resources for antenatal care and sexual and reproductive health care. All clinics had adult scales, height measurement charts and fundal tape measures
    - seven clinics (50%) had no urine sticks.
    - four clinics (28%) did not have a fetal doppler.
    - three clinics (21%) did not have Body Mass Index charts.
- Medical Assistants and nurses were asked about contraceptive methods available on the day visited, information available for clinic users, necessary equipment to provide services, personal knowledge of methods, confidence talking to patients, and skill to provide a service.
    - **Condoms**: Seven of the clinics (50%) were able to provide male condoms on the day visited, with eight clinics (57%) having a small supply of female condoms. All professional staff rated themselves as having the high knowledge, confidence and skill with discussing the male condom, but lesser knowledge, confidence and skill with the female condom. Condoms were freely available and visible in some but not all of the clinics. None of the clinics had condom demonstrators and all wanted these as teaching aids.
    - **Depo Provera**: Rated as one of the most popular methods alongside the implant, Depo Provera was available in all fourteen clinics and almost all staff rated themselves as having the high knowledge, confidence and skill with this method.
    - **LARC - Jadelle Implant**: Implant insertion was available in 11 clinics (78%) and removal in 10 clinics (71%). Two other clinics could provide these services on another day when trained staff would be available. One of these clinics however had neither instruments nor sanitizer. Four clinics would like more equipment for removal of implants. Most staff rated themselves high for knowledge, and confidence with insertion and removal, although more had greater knowledge about insertion with skill level significantly less for removal. Clinics not providing implants referred clients to other clinics.
    - **LARC - Copper IUD**: Inserting and removing IUDs was only available at KFHA

and the Family Health Clinics. Knowledge and confidence in discussing IUDs was significantly less than other methods with staff rating themselves as low skill level.

- **Oral Contraceptives**: Contraceptive pills were available in 13 clinics (93%). Knowledge confidence and skill in providing the combined and progestogen only pill was rated high.
- **Emergency Contraception**: Emergency Contraception, using oral medication methods, was reported as available in 6 clinics (43%) with only one of these providing all three medication options (Postinor, Microgynon, and Microlut). Two clinics provided Postinor only but availability and use of this medication was uncertain, one clinic needs to order it from the main hospital pharmacy. One clinic sometimes uses Microgynon or refers women to the doctor at Betio hospital. While just over half of all staff rated themselves as having high knowledge, confidence and skill, this was not demonstrated by the information collected at interview.
- **Natural Methods**: Cycle beads, Lactational Amenorrhea (LAM): Cycle beads were a tool used to teach couples how to calculate the fertile phase of the menstrual cycle. Approved of by the Catholic Church across Kiribati, natural methods were widely taught and promoted. Cycle bead supplies have been unreliable in the past but more recently available. Staff indicate less knowledge (only 47% rate themselves as having a high level of knowledge), confidence and skill in providing this method over all other methods. Lactational amenorrhoea method was not widely discussed, however seen as an important inclusion in the Baby Friendly Health Initiative (BFHI) information.
- **Permanent Methods** - Tubal Ligation, Vasectomy: Staff rated themselves as having high knowledge about vasectomy and tubal ligation. Multiple referral systems were used to a wide range of different services for both vasectomy and tubal ligation. KFHA provided vasectomy at the static clinic or at home

2. **Lack of standardisation of care across clinics**

- It was usual practice that after the first antenatal appointment women complete a dating scan at the main hospital (TCH), however there were differences regarding the use of scans in the last trimester. Nine clinics (64%) routinely arrange a second scan between 28 to 38-week gestation, four clinics (28%) arrange a second scan only if there were concerns.
- When clinic staff were asked how frequently women were advised to come to the community clinic for antenatal care there were differences in response with some saying the minimum of four visits and others promoting greater frequency of visits in line with expectations for antenatal care in New Zealand.
- The Kiribati Ministry of Health Immunisation Policy 2015 document provides guidance on the administration of tetanus toxoid in pregnancy. This was in line with the World Health Organization (WHO) recommendations.
  - Seven (50%) of the 14 medical assistants and nurses interviewed give tetanus toxoid in pregnancy in line with MOH policy. However, two others were unsure or did not know what the recommendations were and five other staff each described a different protocol ranging from under to over immunising women during pregnancy.
  - Some medical assistants and nurses in the community clinics were unaware of the Ministry of Health Immunization Policy for tetanus toxoid and this document was not visible at all clinics.
  - Several clinic staff talked about a MOH workshop advising an immunisation schedule different to the WHO recommendations.

3. **Areas requiring further education as identified by staff**

    - Education courses clinical staff attended in 2015 were family planning, immunisations, introduction of rotavirus vaccine, NCD updates, surveillance and disease outbreak reporting and data systems.
    - Self-reported benefits to practice included increased confidence and knowledge of family planning, immunization, managing surveillance and reporting on disease outbreaks, use of reference systems, cold chain for safe storage and supply of immunizations.
    - Future requests for education included continuing family planning updates with a focus on IUD, cycle beads and other natural methods, ECP and vasectomy and VCCT counselling, STI treatment and diagnosis.
    - Nurse aids provide clinical care and backup to the professional staff at the community clinics. They were often in sole positions of responsibility at the clinics or providing care in the community. When asked about education needs topics included family planning, breast feeding updates and child health.

DISCUSSION

The 14 community clinics were providing cost-effective services through community-based locations. Clinical staff strived to meet the needs of their community, sustaining an available workforce, maintaining clinics and collecting data while working in environments that were often poorly resourced. Clinics had challenges to basic infrastructure, availability of equipment and commodities. This was vividly demonstrated when a 13-month-old semi-conscious baby in respiratory distress, was brought to a clinic during our visit and there was neither basic emergency resuscitation equipment nor a working phone to call the ambulance. This prompted a wider investigation and discussion about emergency response and resuscitation resources at community clinics.

Distribution of commodities was dependent on supply from international organisations. Freight into Kiribati and distribution out to community clinics rely on a number of processes. Disruptions to these processes impacts on services at the clinical interface meaning condoms were sometimes not available. Sustaining reliable supply and access was high priority.

Confirming pregnancy using a pregnancy test to detect human chorionic gonadotropin hormone in maternal urine was a simple and reliable test. This test was only available at two locations in South Tarawa meaning women have to travel distances across the atoll, expend resources and at one site were charged for this service. Using pregnancy tests to exclude or confirm pregnancy when making decisions about contraceptive method and medications for the treatment of sexually transmitted infections provides for effective and safe sexual and reproductive health care. Changing perceptions that this test needs to be completed in a laboratory setting and through a series of laborious processes will enable pregnancy testing kits to be supplied to all community clinics and would very easily transform this service.

Differences appeared in the use of scans in pregnancy. There was neither consistency in practice nor visible guidance document in clinics. Using scanning in pregnancy appropriately can give valuable information and influence care benefitting outcomes for women and babies.

Attendance for antenatal care was in part influenced by how it was prioritised and promoted by clinic staff. It appears that a minimum of four visits during pregnancy has been taken to mean only four visits by some providers whereas others were adopting an approach of frequency of visits comparable to global standards. A consistent approach promoting regular antenatal visits increasing in frequency to weekly visits in the last trimester of pregnancy would also benefit foetal maternal outcomes. Given the proximity of clinics to where women lived, this was achievable.

The process of screening for HIV known as VCCT has been developed as separate to any other blood screening test and has strict protocol, guidelines and counselling rules. Informing, consenting and collecting blood for testing for HIV was only provided by trained counsellors in clinics that provide a counselling room. This lengthy screening process has been observed to be impacting on women completing important blood tests in pregnancy. In western countries, this was now part of the routine blood tests with no special requirements apart from the usual explanations and consenting for any test. Making HIV

screening part of the routine blood tests completed by a health professional skilled in venipuncture will increase completion of all antenatal blood tests with safer outcomes for women and babies.

The WHO's recommendations for tetanus toxoid immunisation routinely given in pregnancy were not fully understood by all clinical staff and this has direct implications for safety in antenatal care. The MOH policy document was available and circulation, visibility and adherence to this would ensure consistency in practice.

While most clinics provide diagnosis and treatment of STIs, further education to increase knowledge for others on diagnosis and syndromic treatment will increase timely access to care without the need for referral.

Being positioned where people live, community clinics were key for access to contraception. Ensuring availability of methods with skilled staff was vital for equity, to achieve objectives in the MOH plan and SDGs, and most importantly reduce the unmet need for contraception limiting risks to women, babies and families. Contraceptive methods available in Kiribati include: male and female condoms, long acting injectable Depo Provera, long acting reversible (LARC) Adele implants and the copper IUD, combined and progestogen only contraceptive pills, natural methods (cycle beads, lactational amenorrhoea (LAM)), permanent methods (vasectomy, tubal ligation), emergency contraception.

Reliability of supplies and equipment; provider knowledge and skills impact on services. Only a few health professionals were trained to insert and remove IUDs in South Tarawa. Several staff expressed interest for education to insert IUDs. A requirement to maintain competence has been to complete a set number of IUD insertions each year and with current low demand for IUD this has been difficult to achieve for current providers.

Emergency contraception was a key method that has been identified as least well understood with myths held by some staff. An example being that Microgynon and Microlute were not used for emergency contraception because women "do not like taking lots of pills". Further education about emergency contraception was needed.

The many referral pathways to access vasectomy include operating theatre, KFHA, the family health clinic, the reproductive health coordinator and out patients' department and for tubal ligation the gynaecology clinic, operating theatre and antenatal clinic.

One community clinic nurse provided a written plan for tubal ligation in the antenatal notes of women who request this so that it was arranged directly from the maternity ward at the time of birth. Streamlining referral pathways for vasectomy and tubal ligation was likely to improve access and service.

CONCLUSION

Ensuring there was a uniform and reliable supply of emergency equipment and other resources and commodities across all clinics will improve safety, the quality of care and reliability of services. This includes upgrading clinics with essential resources, including pregnancy testing kits, for family planning antenatal care and sexual health care.

Developing consistent, evidence based approaches to clinical care supported by clinical guidelines which are agreed to will further improve access, the quality of care and safety in practice. This will impact on better health outcomes for women and their families. There was an urgent need for clarity and consistency in administering tetanus toxoid in pregnancy by adherence to the Ministry of Health Immunisation Policy.

There were identified areas for further education to increase knowledge, confidence and skills of providers to enable contraceptive choice as well as diagnosis and treatment of STIs. Further professional development was highlighted by the respondents request for future education focus.

ACKNOWLEDGEMENTS

Grateful thanks to the medical assistants, nurses and nurse aids who were so gracious and willingly participated in the interviews and to colleagues Rote Tong and Terada Michiko for assistance. Thanks to the Kiribati Ministry of Health, KFHA and Family Planning New Zealand who supported this review and New Zealand College of Midwives for donation of obstetric wheels.

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