



Barriers to contraceptive use in South Tarawa, Kiribati.

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ABSTRACT:

Background: Improving access to family planning in the Pacific region has been slow, especially for those living in remote and rural areas. Pacific countries consistently report contraceptive prevalence rates well below the United Nations' global averages for 'less developed' regions. The most recent data available on family planning usage in Kiribati from 2009 reported that the modern contraceptive prevalence rate was just 18.0% and total contraceptive prevalence rate just 22.3%.

The aim of the study was to investigate knowledge and use of family planning and identify barriers to contraceptive uptake for men and women of reproductive age in South Tarawa, Kiribati, to inform future approaches aimed at increasing access to family planning.

Methods: A mixed methods approach was used. A community survey of men and women of reproductive age (15-49 years) (n=500) was carried out to identify current levels of knowledge, contraceptive use and barriers to use. Focus groups (n=4) of target populations (men 15-24, men 25-49, women 15-24, women 25-49) were undertaken and in-depth interviews (n=14) were conducted with health professionals and government officials to interpret survey results, further investigate barriers and generate ideas for improving service delivery.

Findings: Considerable barriers to family planning use were observed in the community survey and explored in the interviews and focus groups. They can be categorised into four thematic groups: disinterest in family planning; knowledge gaps; personal, family and social objections; and unsuitable service delivery.

Conclusion: A broad range of solutions were identified and fourteen service delivery recommendations were made for family planning service providers in South Tarawa. The recommendations may also hold relevance to other Pacific countries, however we encourage service providers to consider their country context before initiating any recommendations provided in this study.

Key Words: Pacific, Kiribati, family planning, contraception, qualitative

BACKGROUND

Access to family planning in much of the Pacific 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 average for 'less developed' regions.¹ Furthermore, unmet need for contraception in the Pacific is among the highest in the world.² 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.³ 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.⁴

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Kiribati 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 most recently completed census (2015) recorded the total population at 110,110, with around half of the population living in the primary urban centre and capital of South Tarawa.⁵ Like many nations in the region, Kiribati has a young population, with 57% of the population aged less than 25 years.⁵

The 2009 Demographic and Health Survey (DHS), the most recent data available on family planning use in Kiribati, reported that the modern contraceptive prevalence rate was just 18.0% and total (modern and traditional) contraceptive prevalence rate just 22.3%.

Modern methods of contraception include, but are not limited to, the oral contraceptive pill, condoms, injectables, implants, tubal ligation and vasectomy. Traditional methods primarily refer to the monitoring of a woman's menstrual cycle, but also include methods such as withdrawal, abstinence, and breastfeeding.⁶

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 and the adolescent fertility rate at 49 births per 1,000 teenage women.⁷

In Kiribati, family planning services are provided by the Ministry of Health and Medical Services (MHMS) via government health centres and public hospitals and through the Kiribati Family Health Association (KFHA), an International Planned Parenthood Federation member. From both sources, services are generally available free of charge.

METHODS

This study used 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 community leaders. A mixed method was chosen because together the two methods provided a better understanding of the problem than either method alone.

The study area was centred on South Tarawa, the area with the greatest unmet need for family planning in Kiribati.⁷

The study was developed by Family Planning in close consultation with KFHA staff who offered

regular input and advice to ensure the study was suitable for the South Tarawa context.

To begin with, a community survey of men and women of reproductive age (15-49) was developed to identify current levels of family planning knowledge, contraceptive use and barriers to usage. While we acknowledge that some women can become pregnant earlier than 15 and later than 49, the age span used for this survey is consistent with the age span used by World Health Organisation when referring to reproductive age.⁸ A total of 518 men and women between the ages of 15-49 were surveyed. 18 of these surveys were excluded due to incomplete responses leaving a total of 500 surveys for final analysis. While the survey is too small to give us a contraceptive prevalence rate suitable for national statistics, the respondents appeared to be broadly reflective of the national demographic cohorts which indicates that the data is likely to be reasonable reflective of the population.

Volunteers (n=20) from KFHA were chosen to administer the survey. These volunteers were trained in how to implement the survey, how to ask questions and how to ensure confidentiality. Each volunteer also signed a confidentiality agreement. Because of the sensitive nature of the topic, men interviewed men and women interviewed women. To further ensure that the survey was grounded in ethical practice, each respondent was read a statement about informed consent and everyone was also informed that the survey was confidential and that they could choose not to answer specific questions or stop participating at any time. Each respondent was also informed about who to contact in case of wanting to lay a complaint.

Each interviewer was tasked with completing a set number of interviews for their given communities so it must be noted that this method of data collection does not give a truly random sample and potential biases must be considered.

The survey forms 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). Participants were recruited through visiting Maneaba (meeting houses) and asking for volunteers that met the age/gender requirements. When investigating sensitive topics, the Kiribati-speaking focus group moderators (male for the male groups and female

for the female) employed hypothetical questioning techniques. Each focus group was capped at eight participants; big enough to generate discussion but small enough that people would not feel left out. Following the focus groups, the responses were translated into English for analysis.

Interviews (n=14) were also conducted with health professionals and community leaders 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. All focus groups and interviews followed the same ethical rigour as the community survey and interviewees were informed about the study purpose, that their participation was voluntary and that they had the right to decline to answer and to withdraw.

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. To avoid discomfort for respondents, the survey did not explicitly ask whether they were sexually active. Instead the marital/in-union status was used as a proxy for sexual activity. 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.

It should be noted that there are limitations to this study including the small sample size of 500 respondents which is not sufficient for national statistics. Also, by only focusing on data from married and in-union participants when exploring the use of family planning, the study excludes valuable information from those who may have been sexually active but not married or in-union.

A breakdown of respondents by key demographic indicators can be seen in Error! Reference source not found..

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 (**Figure 1**). Their answers were unprompted with interviewers recording all methods stated. When asking respondents whether they had heard or seen any sexual and reproductive health (SRH) messages in the last three months, a substantial 84% of respondents reported having been exposed to messages in the last three months with radio being the most common media overall, reaching 77% coverage among the 40-44 age group.

Usage

Respondents were asked whether they were currently using contraception and if so what methods (**Figure 2**). As such we learnt that a total of 50% of currently married or in-union women were currently using contraception, with 33% using only modern methods, 6% using modern and traditional methods, and 11% using only traditional methods. Among men the numbers were similar overall with 46% currently using contraception.

The study also explored how the use of contraception increased with the number of children that a woman 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.

The survey further showed that there has been a large increase in the use of contraception among religious groups (Catholic, Kiribati Uniting Church and other) with at least twice the figure of contraceptive prevalence for South Tarawa since 2009.⁷

Finally, the survey explored why some people chose not to use contraception and most commonly for both men and women were religious opposition to family planning use (13% and 11% respectively). Health concerns, personal and partner opposition were also commonly identified barriers to contraception use. The responses from currently married respondents are shown in **Figure 3**.

Table 1: Breakdown of survey respondents by key demographic indicators.

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

†Kiribati Uniting Church

Interviews and focus groups

Four focus groups were also held with key groups of men and women of reproductive age, each group being capped at eight participants each. Then semi-structured interviews were held with health promoters, clinical staff, government and non-government decision makers.

Four key themes were identified from the focus groups and interviews:

1. Disinterest in family planning.
2. Personal, family and social objections.
3. Knowledge gaps.
4. Service delivery barriers

1. 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.

Interviewees had many theories on the causes of this disinterest, including broad cultural reasons and 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

Figure 1: Number of contraceptive methods named (currently married, %).

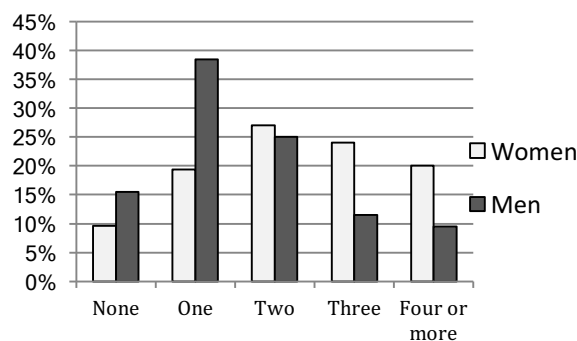


Figure 2: Current use of contraception by sex and method (currently married, %).

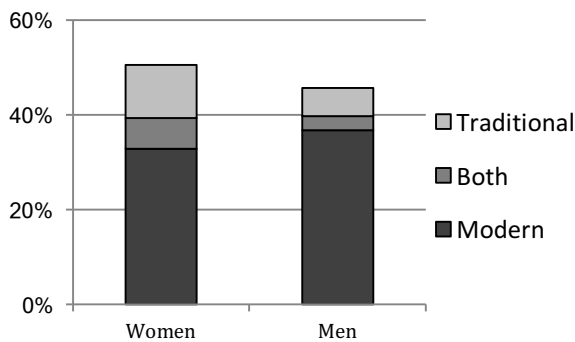
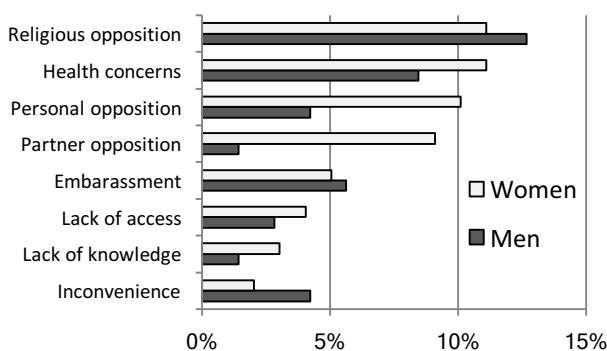


Figure 3: Reasons given for non-use of contraception among currently married non-current users, by sex, %.



Fertility was commonly presented as something that only needs to be controlled if issues start to arise or when the maximum desired fertility is reached. For some this maximum will be dictated by health reasons, in particular when given advice from health professionals that it would be unsafe to have further children.

Similarly, when young couples got married contraception was not thought to be a priority for many and having a child very soon after marriage is expected. There was a general feeling among 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.

2. Personal, family and social objections

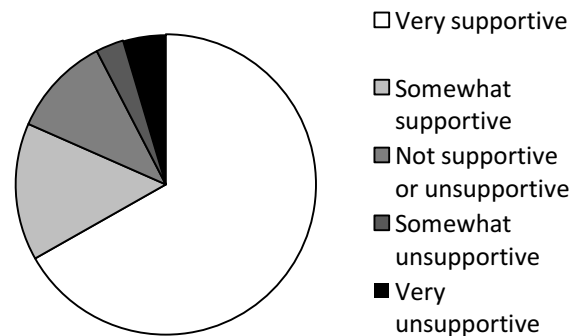
Many of the interviewees discussed the social pressures from others as barriers to family planning use. Social pressures were described as coming from three areas: from themselves, from their partners, and from their faith.

In 2009, the Kiribati DHS cited religious prohibition as being the most common reason for not intending to use family planning.² However, in

this survey most people reported that they felt “very supported” in their SRH decisions by their church leaders (**Figure 4**).

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

Figure 4: Respondents reporting supportiveness of church leaders towards family planning.



Another common subset was objection from partners. The reason for men not wanting their wives to use family planning was regularly given as jealousy and that family planning somehow could facilitate unfaithfulness.

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

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.

The last common subset was personal objections, primarily from women. There was a huge concern about side-effects from modern family planning methods. 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.

3. Knowledge gaps

The lack of practical knowledge about family planning and reproduction was also a common theme. 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

Knowledge gaps were also prevalent around natural method users, having serious impacts on efficacy.

Focus group participant and health professionals were asked what could be done to improve peoples' knowledge of family planning and responses typically included improved sexuality education in schools and improved health promotion messages.

Several health professionals also called for more reflective messaging that enabled people to ask questions with talk-back radio was given as a good example.

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

4. Service delivery

Accessing family planning in the clinical setting was viewed as problematic because of issues relating to 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 someone 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

There were also concerns that the clinic staff would not treat their clients' details as confidential and with a cultural taboo around sex before marriage young people felt that it was too risky to go to the clinic for family planning.

Existing health clinics were also seen as unacceptable service delivery modes for many, particularly younger men. 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 such as in a youth centre.

Issues of accessibility of clinics were also raised. To attend SRH clinics people often had to travel a considerable distance, often at a significant expense. 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.

Several interviewees suggested the establishment of home visitation programmes for key populations. It was suggested that community clinic staff and lay educators could be used to run these programmes.

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 health services provided.

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

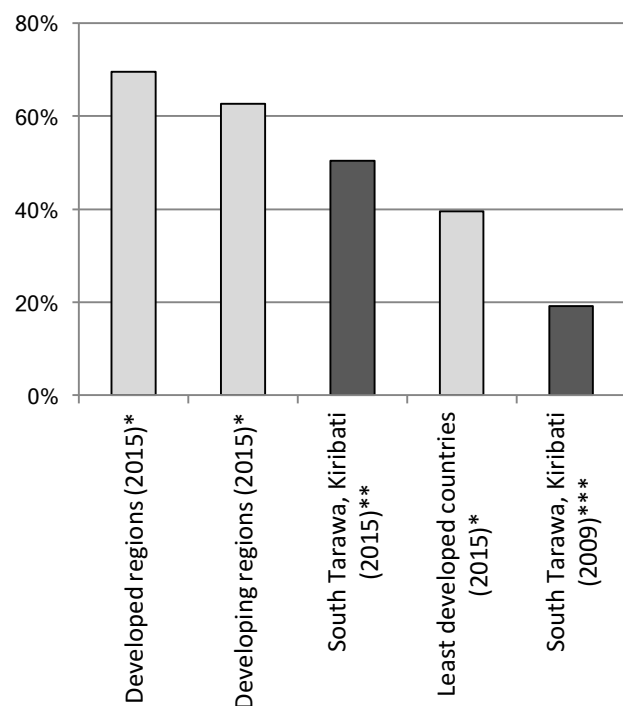
DISCUSSION

The results from the community survey indicate that the knowledge level of family planning is relatively low among people in South Tarawa. Still, the use of family planning has increased considerably since 2009 with a total of 50% of currently married or in-union women using contraception. This is dramatically more than the 19% of six years previous.⁷

The contraceptive prevalence from this study is compared to regional averages (by development status) and the contraceptive prevalence for South Tarawa reported in the 2009 DHS (**Figure 5**).

In 2009, Kiribati had one of the lowest contraceptive prevalence rates 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. This increase brings South Tarawa more in line with developing country averages.

Figure 5: Comparison of mean regional contraceptive prevalence rate (any method) by development status to South Tarawa, Kiribati.



*United Nations research¹

**Data from this research

***Kiribati National Statistic Office data²

Barriers, however, remain. Among the stated reasons for non-use were religious beliefs, health concerns, personal and partner opposition. The interviews and focus groups further identified four key areas for non-use: disinterest in family planning, knowledge gaps, personal, family and social objections, and service delivery.

It must again be noted that the community survey did not employ random sampling methods to identify survey respondents. Subsequently, the results of the community survey should not be treated with the same authority as official demographic and health surveys. Despite this, the data is likely to be reasonably reflective of the population.

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 use of family planning until such a time that 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.⁹

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 women 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. Ensuring women have access to family planning to delay first childbirth is vital for the health of women and their children.¹⁰

Personal, family and social objections were highlighted in the community survey. The most commonly stated reasons for non-use were faith-based opposition, health concerns, personal opposition 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.

This may be in-part due to the active increase in the engagement of church leaders in SRH programmes, both by the MHMS and KFHA. It may also be in-part due to the increased promotion of faith- appropriate family planning methods including the Billings Method and the use of cycle beads.

The promotion of natural family planning methods by service providers should be done with some care. Natural family planning methods are moderately effective if used perfectly. When used inconsistently or incorrectly however the method effectiveness is very poor, with an estimated 24% of women becoming pregnant after one year of use.¹¹

Knowledge gaps were identified in both the community survey and the interviews. There was a consensus among most people interviewed that people were generally aware of family planning but that many had limited understanding of how it actually worked.

An example of this knowledge gap was observed in the survey between respondents having attended a condom demonstration yet failing to identify condoms as a method of contraception (**Figure 6**). This specific knowledge gap may in

part be linked with health promotion messages primarily having focused on promoting condoms as a barrier against STIs and HIV, and not drawn enough attention to the dual function of condoms.

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.

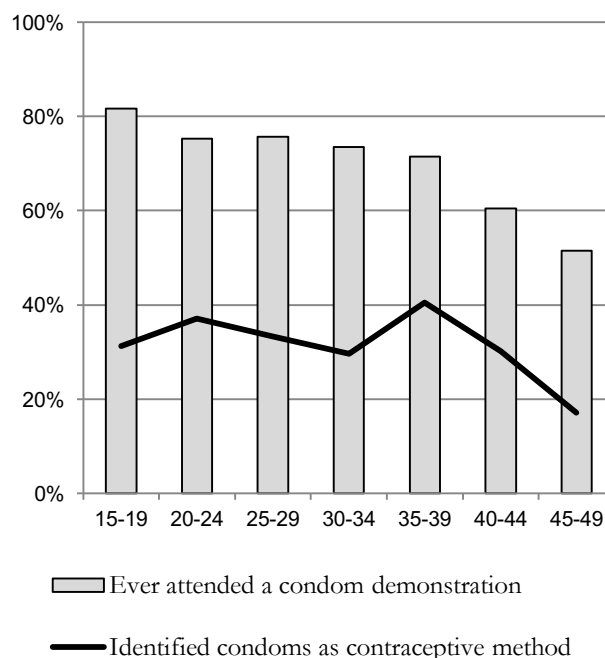
CONCLUSION

While the study identified a broad range of barriers to contraceptive uptake in South Tarawa, the focus groups and interviews highlighted several ways for family planning providers to address these barriers. Improving access to culturally appropriate family planning information and services is central to supporting women to determine the number and spacing of their children and ensuring that these women have the necessary information to do so.

The following 14 service delivery recommendations are proposed for family planning policy, programmes and decision makers in South Tarawa, Kiribati. We encourage other service providers in other countries to consider their context before initiating any of the recommendations.

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.
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.

Figure 6: Condom demonstration attendance versus identification of condoms as contraceptive method, by age.



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 the use of condoms as a contraceptive option. 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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