FAMILY PLANNING SERVICE PROVISION IN SOLOMON ISLANDS:

A CASE STUDY APPROACH

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A thesis submitted to fulfil the requirements of the degree of Doctor of Philosophy

College of Medicine and Dentistry

James Cook University

Date: 13 February 2023

Acknowledgements

I would like to sincerely thank all my advisors—A/Prof Michelle Redman-MacLaren, A/Prof Nichole Harvey, Dr Karen Cheer and Prof Sarah Larkins—for your unending support and guidance throughout my PhD journey. Thank you for believing in me, that I can do it, and your passion for building and strengthening research capacity in the Pacific region. Your genuine support for me as an emerging Indigenous researcher motivates and inspires me to keep pushing to the end despite challenges. To my primary advisor, A/Prof Michelle Redman-MacLaren, you are my inspiration and an exemplar of striving for quality research. You went the extra mile to ensure I received the best support in my research work. I salute you all.

This PhD could not have progressed without living financial support. Thanks to:

- The Solomon Islands Government for the Scholarship Award (2019–20)
- James Cook University Postgraduate Scholarship (2021–22)
- James Cook University College of Medicine and Dentistry Burry Fund—for rescuing me in the additional months of 2022.

I am also grateful for the support I received from institutions, groups and individuals throughout my PhD study. I may not mention you all by name, but you are remembered:

- Solomon Islands Ministry of Health and Medical Services
- Freda Pitakaka-Lusi, Chief Research Officer, Solomon Islands Health Research Ethics and Review Board (SIHRERB) Secretariat
- Dr Divinold Ogaoga—Director, Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH)
- Case study sites
- Honiara—Dr Sarah Habu, Director Honiara Urban Nursing Service
- Helena Goldie Hospital—Dr Richard Hapa, Chief Medical Officer
- Isabel—Ms Helen Marau, Director of Provincial Health Services
- Family planning service managers, providers, women, men and young people from all study sites who participated in the interviews

- PhD colleagues at James Cook University and my Solomon Islands colleagues who provided additional support with data collection and checking
- Doctoral Cohort Program mentors and colleagues
- James Cook University, Cairns Campus librarians
- Elite Editing, for editing this thesis
- Student Support Services —including the Cairns Campus 'mid-week mingle' where I could de-stress during the lunch hour
- Allan Rolland, my research assistant for Case Study Three—your invaluable support and going the extra mile made data collection during the COVID-19 Pandemic possible

Last but not the least, I am grateful to my family and friends. Completing this thesis has been a major life achievement. It would have not been possible without the loving support of my family all through. My mum, dad and siblings for waiting patiently for me to come home. To my children, Calvin, Venessa, Jay and Lelanie, for your endurance and patience as we lived through the four years together as students from high school to university level. It was challenging, but we've made it! To my beloved husband, Humpress Harrington, I know it was not easy as we simultaneously strived together in our PhD journeys. Your persistence and hard work, though faced with immense difficulties, inspired me to also persist to the end. Finally, I want to thank my God, whom I believed has sustained me and my family throughout my PhD study.

Statement of the Contributions of Others

Intellectual Support

My advisors provided advice and guidance on study design, data collection and reporting consistent with their advisory roles. I also received additional support and advice from the Doctoral Cohort Program mentors and colleagues, and the university librarians.

Jointly Authored Works Contained in the Thesis

Thesis chapter	Details of the publication	Nature and extent of the intellectual input of each author
2	Harrington, R B., Harvey, N., Larkins, L., & Redman-MacLaren, M. (2021). Family planning in Pacific Island countries and territories: A scoping review. PLoS One 16(8): e0255080.	RBH, MRM, NH and SL conceptualised the study and contributed to the study design. RBH carried out the database search, literature review, data extraction and analysis, and drafted the paper. MRM and SL independently reviewed articles included. All authors revised and edited the draft paper, approved the final manuscript for submission and agree to the inclusion of this publication for a chapter in this thesis.

Financial Support

I gratefully acknowledge financial support from the following sources:

- The Solomon Islands Government for the Scholarship Award for the stipend (2019–20)
- International fee waiver, James Cook University (2019–23)
- James Cook University Postgraduate Scholarship (2021–22)
- Burry Fund, College of Medicine and Dentistry, James Cook University (2022)
- Editorial assistance: This thesis was edited by Elite Editing, whose editorial intervention was restricted to Standards D and E of the *Australian Standards for Editing Practice*.

Published Works by Author, Advisors, and Colleagues Relevant to the Thesis but not Forming Part of it

Harrington. R., Redman-MacLaren. M., Harvey. N., Puia. M., Carlisle. K., and Larkins. S. (2020). Barriers and enablers to using contraceptives for family planning at Atoifi Hospital, East Kwaio, Solomon Islands. *Pacific Society for Reproductive Health*, *1*(10). https://doi.org/10.18313/pjrh.2020.003

Abstract

Universal access to sexual and reproductive health (SRH) services, including family planning (FP), improves the lives of people of reproductive age and prevents maternal deaths. However, low- and middle-income Pacific Island countries report high maternal mortality rates from pregnancy-related complications, despite an increase in FP services. In Solomon Islands, most FP providers are committed to improving access to services for people of reproductive age and offer male and female contraceptives; yet many women, men and young people do not access FP services and have limited knowledge about, or use of, contraceptives. Contraceptive prevalence rates in Solomon Islands have been persistently low (~27%) over the past 20 years, with high unmet need for FP and prevalent gender-based violence. To inform FP service provision in Solomon Islands, it is crucial to understand how services are currently provided, including the experiences and perspectives of FP service providers, and users and non-users of FP services. This PhD study addresses this gap to identify strategies for service providers, policymakers and health facilities that will ensure FP services and contraceptives are available, accessible and acceptable to everyone in Solomon Islands.

Solomon Islands is a small, low-income Pacific Island nation with a rapidly growing young and largely rural population of over 700,000. Although health outcomes have been reasonable relative to the fiscal challenges in recent decades, the country is facing the challenge of a growing population of young women in reproductive age, thus increasing the demand for maternal, newborn and child health services, as non-communicable diseases and related disabilities also rise.

This PhD thesis, conducted by a midwife academic from Solomon Islands, reports a multiple case study designed to explore and analyse the provision of FP services and contraceptives in urban, peri-urban and rural health clinic settings in Solomon Islands. Each health clinic setting was designated as a single ‘case study’, with all three cases then combined to inform a cross-case analysis. In each case study, four types of data were collected and analysed: 1) context data extracted from reports and observations, which provided descriptions about the setting and the health facility; 2) an audit of FP services using a FP checklist tool, data from which provided details about services and available contraceptive options; 3) an audit of FP records and reports between 2015 and 2019

examining FP activities, which identified trends in service provision and access; and 4) semi-structured qualitative interviews to understand purposively sampled participant experiences and perspectives in clinical settings. A total of 73 male and female FP service managers and providers (n = 14), users (n = 25), and non-users of FP (n = 34) were interviewed across the three case studies and thematically analysed. All interviews were conducted and analysed in Solomon Islands Pijin, and key quotes translated into English to include in the thesis.

Case Study One is an urban government-run clinic in Honiara City that provided FP services once a week, integrated with the postnatal clinic. The clinic is predominantly attended by married women who access contraceptives. Men and young people attend the clinic less often. Lack of accurate information, service providers' judgmental attitudes and women-focused FP contribute to less access and low acceptability for men and young people.

Case Study Two is a peri-urban hospital in the Western Province. FP services are provided at the Reproductive Health Clinic once a week, integrated with the postnatal clinic and provided any time to women who live far from the hospital. Contraceptives are also available to postnatal women at the maternity ward, provided by midwives who work in the hospital. Services focus predominantly on women. Men and young people are rarely involved, but are willing to participate in FP.

Case Study Three is a clinic in a rural setting. FP services and contraceptives are available once a week, integrated with the postnatal clinic and provided to women who live far from the clinic at any time they visit the clinic. FP services are focused on women; however, some men and young people are able to access the services.

According to cross-case analysis, FP service provision across the three case studies was similar in approach and focus, regardless of geographical locations, setting, staffing numbers and gender, catchment population and clinic facility types. While services were available at all clinics, they were mostly accessible to women and not to men and young people. Challenges in accessing FP at these clinic facilities included clinic structures and service focus; inadequate and unbalanced knowledge about FP through lack of consistent awareness raising and misinformation; negative attitudes of service providers; and sociocultural and religious influences on values and beliefs of participants. Access could be improved by resolving context-specific challenges at each clinic.

The study results correspond with those of other research about FP and contraceptive use across the Pacific, and internationally. Application of public health frameworks including the 1978 *Declaration of Alma-Ata* ('the Alma-Ata Declaration') and the 1986 *Ottawa Charter for Health Promotion* ('the Ottawa Charter') elicited both theoretical and practical insights about the study results and reiterated that access to and acceptance of FP services and contraceptives cannot be narrowly determined by their availability at the health clinic. Responding to the study results requires consideration of social and cultural factors that influence service access and acceptability in the context of where people live.

Improved FP service provision requires service providers and policymakers to obtain a holistic understanding of the context and factors influencing peoples' interactions with FP. Improved FP service provision also requires relevant strategies to advocate, enable and mediate in ways that are acceptable to the community. In Solomon Islands, FP counselling, 'awareness raising' (education) and provision of contraceptives must consider the gendered nature of society, limited literacy levels and the sociocultural values and beliefs that underpin people's behaviour and understanding about FP. For example, although religion was not directly reported as the main barrier to contraceptive use, it informed participants' judgments about contraceptive use. FP service providers need to be non-judgmental, provide privacy and be culturally sensitive.

This study is the first exploration of FP service availability, accessibility and acceptability in Solomon Islands by a Solomon Islander researcher. This PhD research recommends refocusing FP clinic approaches to include men and young people, consistent with the global agenda to 'leave no one behind'. This recommended refocus needs to consider multisectoral approaches, such as the nursing education curriculum incorporating subjects of transcultural nursing and its application to the local cultural context. For example, the curriculum could incorporate building interpersonal relationship skills for practitioners working in SRH, FP and adolescent health services. These professional behaviours require sensitivity, privacy and confidentiality. Further research is needed to assess the suitability and sustainability of culturally accessible and acceptable community-based FP services that can reach men and young people in Solomon Islands.

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List of Abbreviations

AAAQ	**Availability, accessibility, acceptability and quality**
AHC	Area health centre
COC	Combined oral contraceptive pill
CPR	Contraceptive prevalence rate
DFAT	Department of Foreign Affairs and Trade
FBO	Faith-based organisation
FP	Family planning
HGH	Helena Goldie Hospital
HIS	Health Information System
HIV	Human immunodeficiency virus
HUNS	Honiara Urban Nursing Service
ICPD	International Conference on Population and Development
IEC	Information, education and counselling
IMCI	Integrated management of childhood illnesses
IUCD	Intrauterine contraceptive device
LAM	Lactation amenorrhoea method
LARC	Long-acting reversible contraceptive
MAP	Men as Partners (programme)
MCH	Maternal Child Health
MDG	Millenium Development Goal
MHMS	Ministry of Health and Medical Services
MIRH	Men's Involvement in Reproductive Health (programme)
NAP	Nurse aide post
NCD	Non-communicable disease
NGO	Non-government organisation

NRH	National Referral Hospital
OCP	Oral contraceptive pill
PHC	Primary healthcare
PICTs	Pacific Island Countries and Territories
PoA	Program of Action
POP	Progestogen-only pill
RHC	Rural health centre
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
SBD	Solomon Island dollar
SDG	Sustainable Development Goal
SIHRERB	Solomon Islands Health Research Ethics and Review Board
SINSO	Solomon Islands National Statistics Office
SIPPA	Solomon Islands Planned Parenthood Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
STI	Sexually transmitted infection
TFR	Total fertility rate
UHC	Urban health centre
UN	United Nations
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Thesis Structure

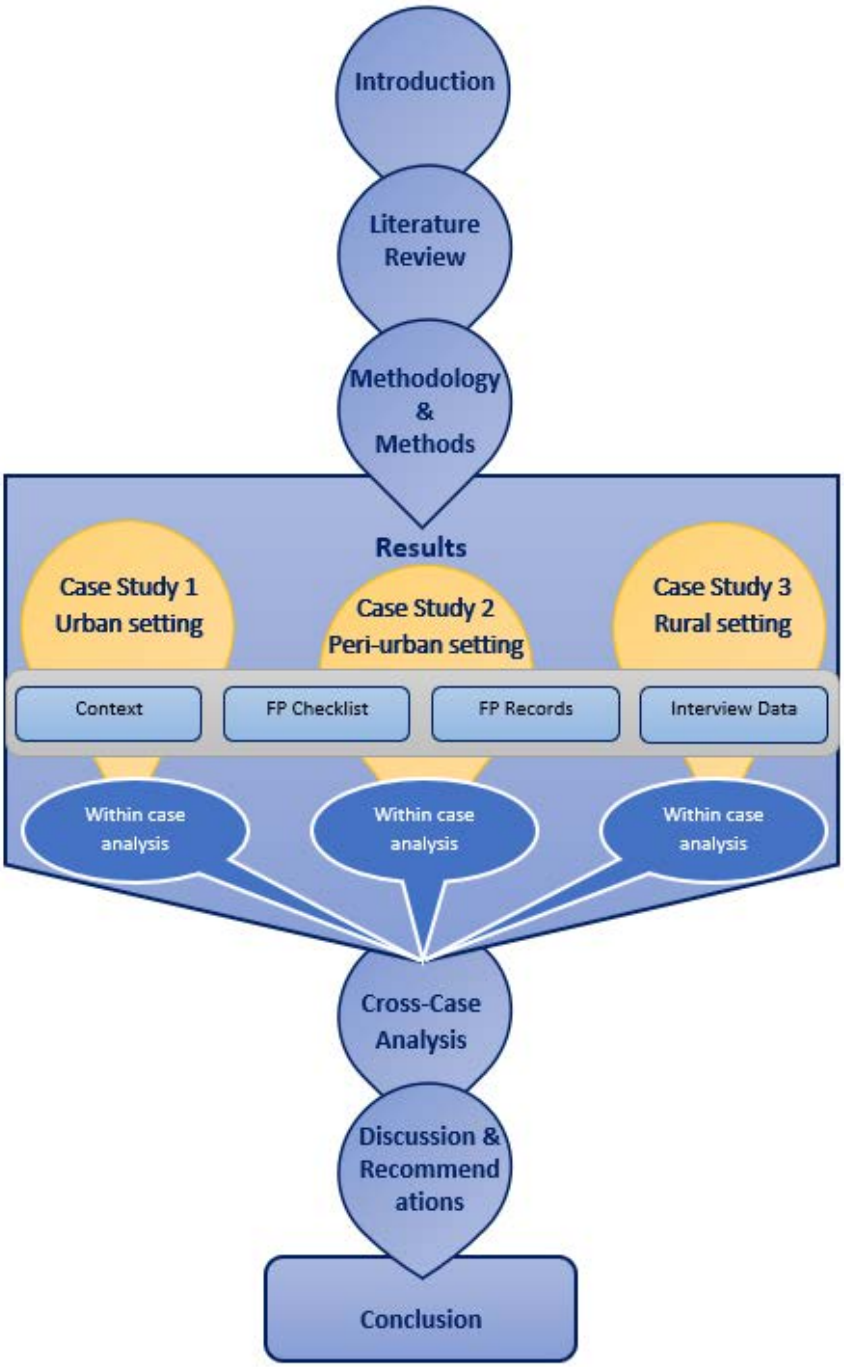

Figure 0.1. Thesis structure outline

Chapter 1: Introduction

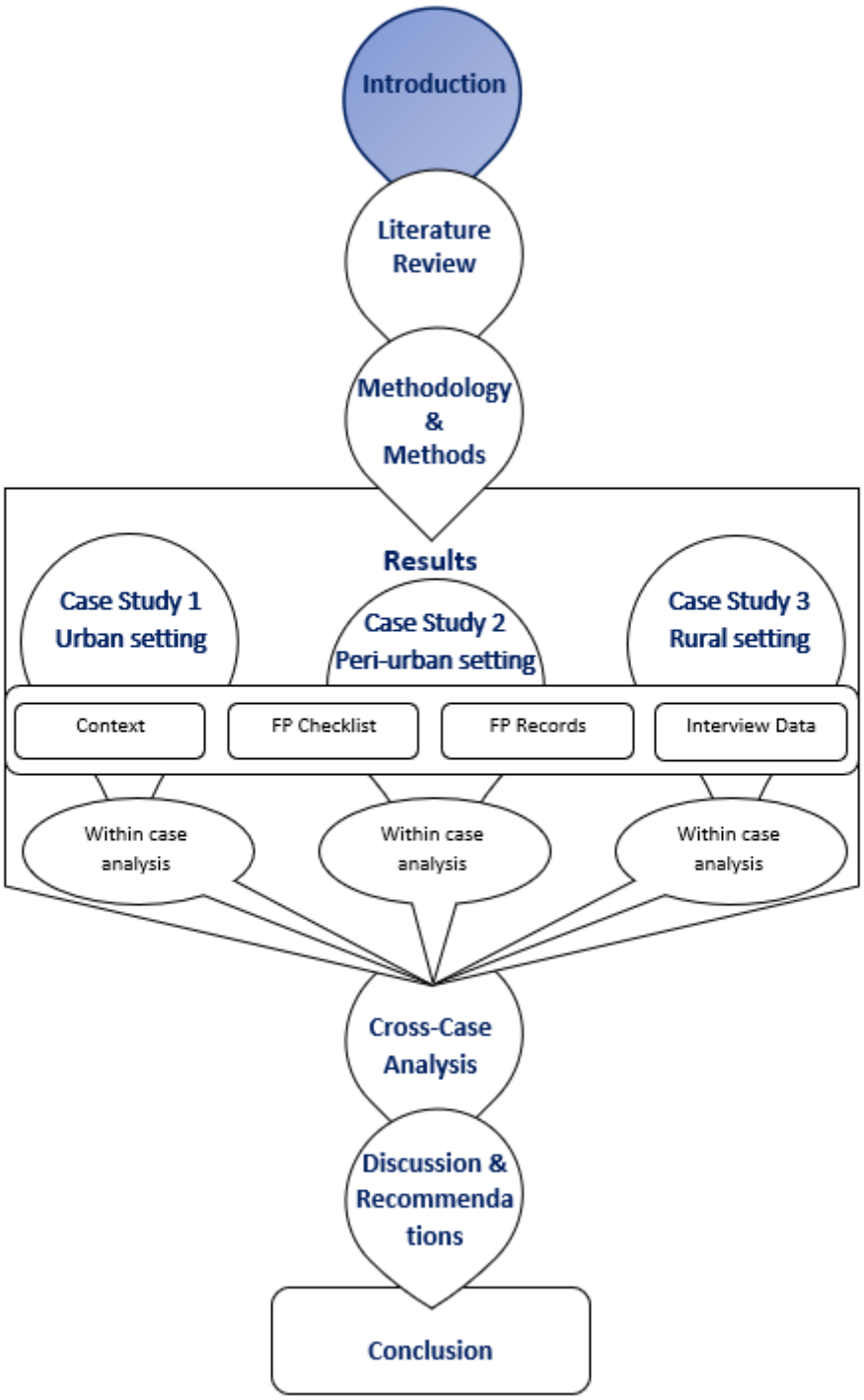

Figure 1.1. Thesis structure—Introduction

Dora* and her husband Dony* were in their mid-30s, together they had five children, the youngest being five weeks old. They lived next door to Dora's sister with their nieces and nephews. Between them they were struggling to feed their families via subsistence gardening. Dora heard from her sister about the Jadelle implant, a new family planning (FP) contraceptive recently available at the clinic. Dora was interested and discussed it with Dony. He was very supportive as they both felt the challenge of having so many children and future implications for their education and wellbeing. Without having much knowledge about the contraception, they agreed that Dora would take the implant in the next week when she and the baby went to the clinic for their six-week postnatal visit (after birth visit).

There were no cars in the village; their main means of transport was by foot and hand-paddled wooden dugout canoes to travel to places. Dony paddled Dora and the baby to the clinic on FP clinic day (as Dora cannot paddle on her own while she holds the baby). It took them an hour to reach the clinic. When they got to the clinic, Dony sat outside while Dora took the baby inside the clinic, as it was mother and baby clinic day, and no other men were around. After having herself and the baby checked, Dora told the nurse that she also wanted to take contraceptives for FP. The nurse told Dora to wait, and she would be called when the other nurse who dealt with FP was free, as she was still with other FP clients. Dora went and sat with her husband outside while waiting. The FP nurse came outside and called Dora to go in for her FP. Dony was told to wait outside.

While sitting outside, Dony was thinking about this new contraceptive method: Is this new method safe for my wife and baby? When would I be able to have sex with my wife again? Do I need to do anything while Dora is on contraception? How often do I have to paddle Dora to the clinic? I wish I could also hear from the nurse too about this new method or is it just women's things? Not for us men?

The availability, accessibility and acceptability of FP services was the focus of this PhD study undertaken in urban, peri-urban and rural settings in Solomon Islands. In this thesis I present evidence that FP services were available at most health clinics but not everyone can access these services. Married women were the primary focus of FP service delivery, with men and young (unmarried) people rarely accessing FP. Acceptability was facilitated when services were provided in a culturally

sensitive and friendly environment. These findings among others, generated by a midwife academic from Solomon Islands, will inform service provision across Solomon Islands and similar contexts.

**Dora and Dony are not real people, but the facts of this story are real*

1.1 Chapter Outline

In Chapter 1 I define FP, introduce issues surrounding FP globally, in the Pacific region and in Solomon Islands. I then provide a detailed description of the study setting of Solomon Islands, including the geography and history, language, religion and healthcare system. I include a detailed standpoint statement, consistent with my identity as a woman, midwife and researcher from Solomon Islands, and with the research methodology employed to address my research aim and objectives. Chapter 1 provides a context for understanding how FP services are delivered in the country.

1.2 Background

FP is defined as the use of modern contraceptive methods and the treatment of infertility that 'allows people to attain their desired number of children—if any—and to determine the spacing of their pregnancies' United Nations Populations Fund [UNFPA], p. 64). FP also includes information about a wide range of contraceptive methods including oral contraceptive pills (OCPs); long-acting reversible contraceptives (LARCs) such as implants and injectables; intrauterine contraceptive devices (IUCDs); surgical procedures that limit fertility (tubal ligation and vasectomy); barrier methods such as condoms as well as non-invasive (natural/traditional) methods such as the calender method, withdrawal method and abstinence (UNFPA, 2023).

1.2.1 Family Planning Globally

1.2.1.1 Historical Evolution of Family Planning

FP was first placed on the United Nations (UN) international agenda during population conferences in Rome (1954) and Belgrade (1965), as concerns for population growth and the fear of starvation emerged (R. B. Harrington, Harvey, Larkins & Redman-MacLaren, 2021; Pizzarossa, 2018; Robertson, 2013). While many governments support FP programmes to slow population growth, such programmes have sparked criticism and controversies over associated coercive practices to control population. These practices have included forcing women to undergo abortions and applying social

pressure; for example, women being offered financial incentives for fertility control (Eager, 2004; Zeidenstein, 2009). During the inaugural *International Conference on Human Rights* in Teheran in 1968, UN member states first adopted a resolution that links population control to advance human rights (UN, 1968). However, the prioritising of FP as a human right did not eliminate coercive and discriminative practices.

Subsequent world population and women's conferences in Bucharest in 1974 and Mexico in 1975 (Mauldin, Choucri, Notestei, & Teitelbaum, 1974; United Nations General Assembly, 1975) gave voice to religious groups, and less developed countries further denounced coercive and discriminative population control programmes and unequivocally shifted discussions to population growth and development centralising FP as a human right (UNFPA, 2009). Although global discussions continued during subsequent conferences, FP, sexual and reproductive health rights (SRHR) and abortion have been controversial subjects. The controversies centred on how these concepts should be defined and applied in real-world practice. For example, the words 'all couples and individuals have the right to decide freely and responsibly the number and spacing of their children', in a world population conference paper presented at Beijing in 1995 (UN, 1995, p. 59-60) signified a success for the human rights narrative. However, religious groups such as the Catholic Church and Islamic states expressed reservations, concerned that the phrasing 'all couples and individuals' may mean contraceptives are also available and provided to the unmarried (Pizzarossa, 2018).

Amid ongoing controversies, the 1994 *International Conference on Population and Development* (ICPD) in Cairo brought a shift in the global discussions and approaches to population issues (UNFPA, 1994). This shift not only encompassed fertility control but took a broader approach to FP to include safe sex and pregnancy and the right to access FP 'free from coercion, discrimination and violence' (UNFPA, 1994, p. 43). The term 'reproductive rights' was adopted during the ICPD in Cairo and was introduced to the international community, which adopted a twofold definition. First, it conceptualised reproductive rights as 'the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children … and the right to attain the highest standard of sexual reproductive health'. Second, these rights 'embrace certain human rights that are

already recognised in national and international laws, and international human rights and other consensus documents' (UN, 1994, p. 40–43).

The ICPD Program of Action (PoA) established a consensus that governments must base their population policies on the principles of human rights (UN, 1994). Following this, emphasis was given to comprehensive and integrated approaches to women's reproductive health needs, and women's rights were recognised as already established in human rights law. Reproductive health was then defined and endorsed in the ICPD PoA, in line with the World Health Organization's (WHO's) definition of health but greater emphasis on the reproductive rights of individual men and women. The ICPD PoA defines reproductive health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes' (UN, 1994, p. 40; WHO, 1948). The ICPD's approach promoted a holistic and human rights-based reflecting a horizontal approach unlike the former narrowly focused FP progams (Gilby, Koivusalo & Atkins, 2021; Pizzarossa, 2018). This commitment was also reaffirmed in the *Beijing Declaration and Platform for Action* in 1995 (UN, 1995).

The definitions of reproductive rights and reproductive health—especially those aspects of the definition that related to abortion and adolescent sexuality—sparked much controversy from conservative, political and religious entities (Cleland, Shah & Daniele, 2015; Robertson, 2007). While various religious entities expressed similar positions in the agenda, their interests also differed; for example, the Roman Catholic Church leadership, the 'Holy See's concern was abortion while some Islamic states opposed FP services for adolescents, a situation referred to as an 'unholy alliance' in the literature (Pizzarossa, 2018; Starrs et al., 2018). Although universal resolutions about abortion were not reached, part of the compromise at the ICPD was that abortion should not be promoted as a method of FP and should only be performed to save lives. The UN member states were to ensure that abortion be performed safely, where it is not against the law.

In addition to issues with abortion, sterilisation and the use of condoms, the Holy See argued that the use of the term 'couples and individuals' in the ICPD PoA should only apply to couples in a traditional heterosexual monogamous marriage and not to people who are not married. However, the

adoption of various human rights treaties and conventions such as the *International Convention on Civil and Political Rights;* the *UN Committee on Economic, Social and Cultural Rights*; and the *Convention on the Elimination of all forms of Discrimination against Women* provided strong support and a basis for the development of SRHR for all people regardless of marital status, sexuality or gender identity. Hence, enshrined in the definition is that SRHR is a 'basic human right of all couples and individuals and that all should be able to decide freely and responsibly about the number, spacing and timing of their children; this includes the right to access sexual health services, information and education' (Hulme, 2009; Pizzarossa, 2018; UN, 1995, p. 59-60).

1.2.1.2 The Millenium Development Goals (2000–15)

The controversial evolution of SRHR continues to affect progress and realisation of SRHR globally (Ghebreyesus & Kanem, 2018; Singh, Siddiqi, Parameshwar & Chandra-Mouli, 2019). The period following the 1994 ICPD saw an era of fragmentation; SRHR was attended to in a fragmentated manner and only included quantifiable goals, with the focus only on sexual reproductive health (SRH) but not rights. This fragmentation was evidenced when the importance of SRH was not fully realised when the Millenium Develoment Goals (MDGs) were formulated in the year 2000. For example, MDG 5 (Target 5A) was limited to reducing maternal mortality (improved maternal health). Five years later, in 2005, Target 5B, 'universal access to reproductive health'was added as a result of intense lobbying by SRH advocates (Crossette, 2005). Contraceptive prevalence rates (CPRs) were not initially included in MDG 5 and the unmet need for contraception was also not included as an indicator to monitor SRH services (Ghebreyesus & Kanem, 2018; Zuccala & Horton, 2018).

The MDGs have failed to address women's rights (Crossette, 2005). The omission of SRHR from the MDGs, and competition for limited resources with the human immunodeficiency virus (HIV) prevention agenda, meant that donors shifted their focus elsewhere. As a result, FP was overlooked in the MDGs with fewer resources made available for FP programmes. The limited advances made against MDG Target 5B were believed to be the lack of a comprehensive, human rights-based approach to SRH, including FP (Galati, 2015). The narrowed approach to SRHR also hampered the achievement of gender equality (Yamin & Boulanger, 2013).

1.2.1.3 The Sustainable Development Goals, 2015–30

The UN's current 2030 *Agenda for Sustainable Development* aims to 'Transform Our World' and includes 17 goals (with related targets and indicators; UN, 2015, p. 14-27). Sustainable Development Goal (SDG) 3, 'Good Health and Wellbeing', includes targets related to SRHR. The SDG 3 targets also refer to human rights consistent with the Cairo ICPD PoA and *Beijing Platform for Action* agreements, despite them not mentioning sexual rights (Pizzarossa, 2018; Starrs et al., 2018; Zuccala & Horton, 2018). Under SDG 3, Target 3.7, the UN member states agreed to 'ensure universal access to SRH care services including FP, information and education, and the integration of reproductive health into national strategies and programs' (UN, 2015, p. 20). Under SDG 5 (Gender Equality), Target 5.6 also states that its aim is to 'ensure universal access to sexual reproductive health and reproductive rights' aligning with both the Cairo (1994) and Beijing (1995) conferences (UN, 2015, p. 22). In addition to these two goals, SRHR is one of the key objectives of the SDGs embraced in a broader development agenda. In contrast to the MDGs, the SDGs adopt a more holistic approach and are not limited to maternal health (Zuccala & Horton, 2018).

1.2.1.4 Universal Health Coverage

Central to achieving the targets of the SDGs is the concept of universal health coverage. Universal health coverage ensures that 'all people have equal access to the health services they need, when and where they need them without financial hardship. It involves coverage with the full range of essential health services from health promotion to prevention, treatment, rehabilitation and palliative care', of which FP is an essential service (WHO, 2012, para. 1). In recent decades, notable gains have been achieved globally regarding the availability, accessibility and acceptability of SRH services including FP. However, gains within and among countries are unequal and inequitable. Many people do not have sufficient access to SRH services, including FP, and their SRHR are not respected or protected. Global evidence shows that every year in low- and middle-income countries (LMICs) or regions:

- More than 200 million women wanted to avoid pregnancy but are not using modern contraception.

- Twenty-five million unsafe abortions are performed worldwide.
- More than 350 million people (men and women) need treatment for at least one sexually transmitted infection (STI) and approximately two million people become infected with HIV.
- More than 800 women die from pregnancy and birth complications (including unsafe abortions) everyday. More than 90% of these deaths occur in LMICs (Crossette, 2005; Starrs et al., 2018; Vega, 2013).

It is evident that improvements in health service outcomes depend on the availability, accessibility and acceptability of health service provision as well as the capacity of healthcare workers to provide people-centred integrated care (Vega, 2013; WHO, 2016a).

1.2.2 Family Planning in the Pacific

FP was introduced in the Pacific Island Countries and Territories (PICTs) in the 1960s as concerns arose about population growth and, later, a need for cost-effective interventions to improve overall health and socioeconomic wellbeing of individuals, families and communities in the Pacific. Recognising the importance and relevance of FP, Pacific countries have made commitments to the international community about advocating and prioritising FP as part of their national agendas. This has resulted in FP being a key component of primary healthcare (PHC) and part of the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) programmes available in most health clinics across the Pacific. Commitments were made at the 1994 ICPD with subsequent agreed actions decided to reposition FP more strongly in the health and development agenda and expand national population policies to reflect agreed targets in the former MDGs and current SDGs (Homer et al., 2018; WHO, 2018b; Zuccala & Horton, 2018).

While there are positive trends in RMNCAH indicators, progress in many PICTs is slow and inconsistent. Many have not fully achieved targets outlined in the former MDG 5A and MDG 5B (Dawson et al., 2021; Homer et al., 2018). The uptake of FP remains low, with reports of high unmet needs for FP at 20% or more (Dawson et al., 2021). There are high STI prevalence rates among young pregnant women and increasing adolescent birth rates (Homer, 2018). Common barriers such as a lack of contraceptive knowledge, poor service access, objections from spouses or sexual partners, fear of

side effects, religious concerns and misconceptions about contraceptives persist. A rights-based FP service is still lacking in most health centres across the Pacific, with a demonstrated gap between knowing about contraception and its actual use (R. B. Harrington et al., 2021).

Most PICTs recognise the importance of human rights programmes and rights-based interventions, especially for women and children, as evidenced by the ratification of a number of international conventions and treaties (Pacific Community, 2020). However, there is still limited understanding on how human rights principles relating to SRH, including FP, could be applied. Perceived conflict between international standards and cultural rights and practices persists in the area of SRHR. It was recommended by participants at the *Pacific Judicial Conference* in Vanuatu in 2005 (Australian Human Rights Commission, 2005) that human rights interventions be understood and delivered in a culturally appropriate manner and that programmes to inform communities need to reach the grass root level in the Pacific. In addition, reviews of development programmes show 'top-down' approaches to human rights that predominantly address the 'supply side' but do not consider peoples' needs and 'demands', especially those of the disadvantaged and marginalised. The dominant top-down approach to human rights also diminshes a sense of ownership and participation to be part of SRHR agendas moving forward; hence the need to promote 'bottom-up' approaches when working with civil societies and communities. It is clear that Pacific countries need to prioritise SRHR interventions, according to their local contexts.

1.2.3 Family Planning Services in Solomon Islands

It was not until the 1960s that rapid population growth became a concern in Solomon Islands; however, as reported by Rowling, Hartley, Owen & Strachan (1995):

> 'the British Protectorate [that ruled Solomon Islands at that time]—and then respective Solomon Islands governments—have shown reluctance in dealing with this problem. Many Solomon Islanders are mindful of past population losses such as young men taken by force to work on sugarcane plantations in Queensland and Fiji at the turn of the 20th century; high mortality rates from malaria and infectious diseases; and the devastation suffered by these Islands in World War II (WWII)' (p. 616).

These factors are thought to contribute to slow population growth after WWII, however, improvements in preventative healthcare have also resulted in reduced infant mortality and deaths from infectious diseases, despite rates remaining higher than in other countries (Pulea, 1986; Rowling et al., 1995).

In 1975, the Solomon Islands *Family Health* programme was implemented, overseen by the Ministry of Health and Medical Services (MHMS). With Solomon Islands still a British Protectorate until Independence in 1978, this initiative was funded by United Kingdom Aid from 1975 to 1980 (Saint-Yves, 1996). The emphasis of the *Family Health* programme was maternal and child health, reducing infant mortality and improving the quality of life through FP education and services, rather than population control. A WHO expert helped to develop courses to train FP nurses and the UNFPA supported this programme from 1977 to 1979, mainly by supplying contraceptives (Pulea, 1986). A further positive step was taken in 1975 when the Solomon Islands Nurses and Midwives Board agreed to allow registered nurses with special training to prescribe OCPs, administer contraceptive injections and distribute condoms (Rowling et al., 1995). Since then, records of contraceptive use have shown OCPs to be the most popular method, especially among the younger-age group, with vasectomies the least popular (Bage, Foliaki & Healy, 1992).

In 1983, the prime minister of Solomon Islands at that time did not think that the increase in population growth was affecting the country's resources, concluded that the use of modern contraception was a form of genocide and thus denounced its use (Rowling et al., 1995). Preferences for large families was also the norm and children are highly valued in most cultures. Despite the cautious approach from the government, people who were interested in family health, including FP and child spacing have seen improvements in the health of women, and continued to promote FP measures. The provision of a coordinated FP service through an established health service and a careful awareness-raising to inform people of the benefits of a reduced population growth rate both for families and the nation were growing in importance.

The 1986 census (Solomon Islands Census Office, 1988) confirmed a population growth rate of 3.5% and total fertility rate (TFR)—the number of births per woman—of 6.4, were among the highest rates in the world (Rowling et al., 1995). Children under 15 years accounted for 45% of the

total population. Women aged 15–49 years, made up 44% of the population (Solomon Islands Census Office, 1988). This raised concerns from various groups in Solomon Islands who argued that if nothing was done to reduce the fertility rate, the population would continue to grow. Following consultation processes that included governments, non-government organisations (NGOs), church leaders and donor agencies, a *National Population Policy* was appproved in 1988. The policy aimed to reduce the TFR to 3.7 by 1996 and to 2.6 by 2011. However, it was later realised that the targets were too ambitious and later a more realistic TFR of 5.6 was reflected in the 1990–94 *National Health Plan*. Despite National recognition for the need of FP services, the government has never allocated funding for national FP programme (Strachan, Hartley, Owen, Rowling & Pikacha, 1995).

The Maternal Child Health (MCH) unit was established at the MHMS after the 1988 *Population Policy* was released, and the MCH unit coordinates FP services at the national level. However, at this stage, there was no proper coordination on implementing the MCH policy, and all FP programme activities were funded by international donors. Furthermore, there were no available research data about FP contraceptive use and people's attitudes towards the service. The first formal study of FP behaviour and contraceptive use in Solomon Islands was conducted in Honiara and the neighbouring rural Guadalcanal Province, primarily reporting data about an urban population (Bage et al., 1992). The second prevalence study was conducted by Rowling et al. (1995) in a rural population in Choisuel Province. Both studies found great interest in FP services among study participants; however, participants lacked sufficient information about the services and available contraceptive methods.

In the Choisuel study, Rowling et al. (1995) found, people's religious affliliation and knowledge influenced their use of FP. The study also found that people in the villages including the service providers recognised the need for further FP education. The enthusiasm for modern contraceptives at the time, was thought utilisation of services would continue if existing logistics, cultural and religious beliefs could be attended to. However, the health sector faced insufficient funding to implement FP within the *National health Plan* (Strachan et al., 1995). Simultaneously the growing population increases the demand for health and other social services, which resulted in health budget allocations have been reduced and diverted to projects that will generate income. This shift

affected the implementation and expansion of MCH and FP services (Strachan et al., 1995; Saint-Yves, 1996).

The MCH unit later became the Reproductive and Child Health Program (RCHD) at the national level and this unit currently coordinates FP, with other MCH services. Until recently the programme was known as Reproductive, Maternal, Newborn, Child, and Adolescent Health. FP was delivered with the support of the MHMS's RMNCAH programme and was available in almost all health clinics. A FP manual is available (though outdated) that guides the delivery of FP services throughout the country. Midwives, registered nurses and some nurse aids were the main staff trained to provide the available contraceptive methods in the country. When new methods are introduced, such as the Jadelle implant and intrauterine contraceptive device (IUCD), health workers are required to undertake specialised training in how to administer these contraceptive insertions.

A 2015 SRHR needs assessment conducted by the UNFPA in Solomon Islands found that, although there was no reproductive health policy in the country, a draft SRH plan (*Reproductive Health Strategic Implementation Plan*: 2014–16) was sighted (UNFPA, 2015c). The SRH plan included FP, maternal and newborn health, preventing unsafe abortion, preventing STIs including HIV and sexual health. A national HIV policy and multisectoral strategic plan (2005–10) was available. Other related national policies available include the population policy, youth and health policy and gender equality and women's development. Despite service gaps and challenges to service delivery, reproductive health services including FP have been incorporated in the country's *National Health Strategic Plans* and have remained a priority. In October 2016, Solomon Islands reached another milestone when it launched its 2017–26 *National Population Policy* (UNFPA, 2016). This policy, the responsibility of the national RMNCAH, ensures inclusivity for all people in all their diversity, including the most vulnerable in rural areas. The policy also recognises the critical role men play in a couple's use of contraception and recommends promotion of male involvement in FP. Meeting the intentions of this policy will require broader collaboration with the health system and cannot depend on individuals and their families alone.

1.2.3.1 Status of Family Planning

Solomon Islands, along with other Melanesian nations, has experienced a constantly high population growth rate in the 21st century and the least to achieve satisfactory target SRH indicators compared to other Pacific countries (UNFPA, 2015c). The estimate of population growth for 2023 remains at 2.3%, similar to that of neighbouring Vanuatu (United Nations Children's Fund [UNICEF], 2022). The reason for the high growth rate is the high fertility level. In 2015, the TFR was lower in urban (3.0) than in rural areas (4.5), with an overall TFR of 4.1 (Solomon Islands National Statistics Office [SINSO], 2017). Although this rate is still among the highest in the Pacific, there has been marked improvement since the 1986 census; however, the adolescent fertility rate (births per 1,000 women aged 15–19 years) in 2020 had increased to 79—the highest among the Pacific countries—followed by Fiji and Vanuatu at 49 and 48 respectively (The World Bank, 2020). The modern CPR during 2015–20 ranged from 27% to 29%, which is less than half the average for low-income countries globally, and there is still high unmet need (35%) for FP (UNICEF, 2022). Solomon Islands's progress towards achieving the 2015 MDGs had been slow and available data show that access to quality FP services must significantly improve to reach the 2030 SDG targets (MHMS, 2017; SINSO, 2017). In 2019 the Solomon Islands Government reaffirmed its commitments made at the 1994 ICPD in the ICPD25 Nairobi Summit, to increase its efforts to 'achieve policy goals and strategic actions in the National Population Policy 2017–2026, and to implement the unfinished business of the ICPD fully and effectively in Solomon Islands' (Solomon Islands Government, 2019). In doing so, the government is working to achieve the goals of the UN's 2030 Agenda and meet SDGs (Solomon Islands Government, 2022a).

1.2.4 Non-government Organisations

NGOs also contribute to health service delivery in Solomon Islands. Local NGOs such as the Solomon Islands Planned Parenthood Association (SIPPA) and the Red Cross Society, along with faith-based organisations (FBOs) such as Caritas, World Vision, the Adventist Development Relief Agency and church groups provide specific services such as FP, rural water supplies and malaria control programmes (including bed net distribution). Donor partners have specific programme areas

they supported within the MHMS, and these were implemented according to agreements and Memoranda of Understanding with the MHMS. For example, UNFPA's key priority is FP, and it supports most of the FP activities at the national and provincial levels in the country (UNFPA, 2022).

1.2.4.1 Solomon Islands Planned Parenthood Association

SIPPA is an NGO whose staff provide comprehensive SRH information, education and services. SIPPA is a full member of the International Planned Parenthood Federation (International Planned Parenthood Federation, 2023). Established in 1973, it was initially called the Family Planning Association, a small active society focused on providing FP information and education. SIPPA eventually opened a clinic in Honiara to provide contraceptives. It has an active community FP education programme involving film screenings, home visits, workshops and seminars. Despite a lack of initial support from the British Colonial Government and opposition from politicians and the Catholic Church, SIPPA thrived. By 1976 it was active with clinics in Guadalcanal, Malaita, Western and Choiseul provinces and was receiving funding from the International Planned Parenthood Federation (Saint-Yves, 1996). Today, SIPPA is one of the main NGOs that provides SRH information and FP services for young people and has partnered with the MHMS to expand its programmes to six other provinces.

1.2.4.2 Faith-Based Organisations and Women Support Programs

As an alternative to the SIPPA programme, the Catholic Church in Solomon Islands provides and has sponsored a non-clinical FP service based on the ovulation method, which is used at a specialist clinic to assist sub-fertile and infertile couples. The specialist clinic was called the 'O' clinic, representing the 'ovulation' method, as the only FP option provided. The 'O' Clinic was established in 1978 in Honiara and assisted around 230 couples by the end of 1978 (Rowling et al., 1995). In addition, the previous social welfare department, the government women's interest section, the University of the South Pacific and the Solomon Islands Christian Association have all supported FP objectives, including alternative non-clinical FP service and messages. However, there were limitations to the effectiveness of education messages—primarily the lack of programmes aimed at specific groups, and language barriers: the Pijin language was primarily used despite not being spoken

in all areas at that time. Programme content was general and FP methods were not discussed in detail. Today, there is increased interest and support for SRH and FP programmes from FBOs and women's groups with the government and NGOs supporting young people (Saint-Yves, 1996).

In rural areas, some FBOs and private companies also provide healthcare services and follow the government's hierarchy of service levels. The country has three faith-based hospitals that provided healthcare services: Helena Goldie Hospital (HGH) managed by the United Church; Atoifi Adventist Hospital, managed by the Seventh Day Adventist Church; and the Good Samaritan Hospital managed by the Roman Catholic Church. Although the respective churches administered and managed the hospital independently of the MHMS, these hospitals receive government support such as funding, medical supplies and the provision of healthcare providers as seconded staff. The hospitals also contribute in the MHMS annual planning event and attend budgeting meetings and training (Hodge, Slatyer & Skiller, 2015).

1.3 Solomon Islands Healthcare System

Solomon Islands is a donor-dependent country and received most of its funding and technical advice from overseas development assistance. The country also benefited from philanthropic bodies and NGOs. The MHMS represents the government and acts as the funder, regulator and provider of all health services and takes the responsibility to ensure relevant resources are used to improve health outcomes. Donor organisations such as the WHO, UNFPA, UNICEF, Australian Aid and New Zealand (NZ) Aid, along with FBOs and NGOs, make significant contributions to funding and delivery of health services, while the MHMS manages national and provincial health systems. Health services provided by private entities such as mining and logging companies in the country play a minimal role in the health sector (Hodge et al., 2015).

The Solomon Islands Government, in its revised 2016 *Role Delineation Policy* (RDP), adopted the principles of 'universal health coverage, to guide the provision of health services and ensure everyone in Solomon Islands has access to a package of quality health services without financial hardship' (MHMS, 2016, p. 6). The Solomon Islands health system is in transition and has begun to devolve health services to the provinces and integrate them with its RDP. Based on the

principles of PHC, the RDP was consistent with the WHO global strategy on people-centred and integrated health services (WHO, 2016a) and in line with the former *National Health Strategic Plan* 2016–2020, which envisioned a 'healthy, happy and productive' people (Solomon Islands Government, 2015, p. 3). Among the six priority intervention areas in the former *National Health Strategic plan 2016-2020*, FP was listed as the second priority behind immunisation and the focus is on improving health outcomes as well as managing and preventing communicable diseases and non-communicable diseases (NCDs). The plan aims to improve people's health, focusing on the most vulnerable and isolated (MHMS, 2016). This same focus was anticipated in the recently launched Solomon Islands *National Health Strategic Plan* 2022–2031. This new strategic plan envisioned, 'A healthy future for all Solomon Islands', ensuring all Solomon Islanders have universal access to equitable quality, preventative, curative, rehabilitative and promotional services, regardless of where they live (Solomon Islands Government, 2022a).

The country has a publically funded health services available to all Solomon Islanders and the MHMS is committed to ensuring everyone can access SRH including FP services. However, with the ambitious plan described above, the country's health system is constantly stretched because of its vulnerability to natural disasters and the increasing effects of climate change. In 2018, more than 80% of medical doctors and 45% of nurses/midwives were based in Honiara, and 75% of nurse aides were in the provinces (MHMS, 2017). The lack of adequate health workers remains an ongoing issue with the ageing workforce and challenges in retaining senior nurses who leave the country to look for better working conditions in other Pacific Countries. A desire for a better pay and conditions has resulted in more than 100 senior nurses moving to Vanuatu since 2011 (Ragaruma, 2018). This development, along with unequal distribution of staff in urban and rural settings has exacerbated staffing issues. Declining funding from government and donors is also a growing concern (Botfield, McGowan, Gagahe, Tashkeel & Stuart, 2021).

In addition, the people of Solomon Islands are facing an epidemiological transition as they experience communicable diseases and NCDs. The change in peoples' lifestyle from being active to adapting sedentary habits including changes in diet have contributed to increased risk for NCDs such as diabetes and hypertension, while still battling the common communicable diseases such as malaria

and dengue fever (Hodge et al., 2015; MHMS, 2017). Gender inequality has also not been fully understood and remains a concern in implementing human rights policies. A recent study conducted by World Vision in Solomon Islands reported 63% of men still believe it is acceptable to hit a woman in certain circumstances; 38% of women reported their first sexual experience as being forced (World Vision, 2022). Women and young people in rural areas, continue to face difficulties in accessing healthcare services including FP. In addition to variations on availability and access of healthcare services between provinces, a lack of effective community-based health promotion model challenged further universal access. (Hodge et al., 2015).

The MHMS delivers three types of service: curative and preventative services through fixed health facilities and outreach; community-based preventative activities ('healthy settings'); and non-individual services such as mass media and regulation. Healthcare services are predominantly provided through a nurse-led PHC system. The PHC approach was also strengthened by the 1995 Yanuca Declaration made in Fiji that Solomon Islands signed. The Yanuca agreement promotes a Healthy Islands setting, which states essential services such as clean water, good sanitation and preventable measures such as immunisation and antenatal care, including FP services, are offered in a way that is most appropriate to each country and the resources they have (WHO, 1995).

Referrals are sent to larger provincial hospitals or the National Referral Hospital (NRH) where most doctors are working. The health system offers five levels of care from the NRH with specialist hospital care (Level 5) to nurse aide posts (NAPs), with the most basic service (Level 1). The current five-level healthcare system was transistioned to a six-level healthcare system in the MHMS' RDP vision (MHMS 2016). The current five levels and the proposed six levels of healthcare services are outlined in Table 1.1. These levels provide pathways that patients should follow when seeking healthcare services. Normally, referrals flow from Level 1 up to Level 5 consecutively; however, this does not always occur because some NAPs and rural health centres (RHCs) may be closer to provincial hospitals or the NRH; also, for economic reasons, direct referrals to Level 4 or 5 care often happen. Patients follow the pathway and are referred to the next level if they did not receive adequate treatment required, until they reach NRH which is the highest level of care. Area health centres (AHCs) offer Level 3 care and act as major referral points for catchment areas for patient flow

and referrals from RHCs and NAPs (Hodge et al., 2015; MHMS, 2016). The key elements of the 'Health System In Transition Report' (Hodge et al., 2015) and the Role Delineation Policy (MHMS, 2016) are compiled in Table 1.1.

Table 1.1

Current and Proposed Levels of Healthcare Services in Solomon Islands

Level of service	Description of existing levels of care in service delivery	Levels of service and service delivery model in the RDP
1	NAPS are the basis of all healthcare services in Solomon Islands. They are usually located in remote areas and staffed by local nurses, thus providing strong links with the local community. Trained nurse aides working at NAPs provide basic first aid care including the treatment of mild ailments or injuries; and facilitate normal births, immunisation services and basic FP services (Hodge et al., 2015, p. 18-19)	Community-level health services Services delivered will be delivered by facility-based staff in collaboration with communities, including community volunteers, FBOs, community groups, NGOs and other stakeholders. Services delivered here will be largely population-based integrated services including immunisation, FP, community case management of childhood diseases, self-care, health promotion and education on prevention activities. Services will be provided on an outreach basis from AHCs and RHCs. NAPs have been converted into community centres and will not be staffed. Existing NAPs will be either upgraded to RHCs or downgraded to community centres depending on minimum requirements (MHMS, 2016, p 10).
2	RHCs offer the next level of care and generally play a supervisory role to multiple NAPs in the same area. Multiple RHCs feed into larger AHCs. Rural health clinics provide more healthcare services than the NAPs, such as a range of inpatient and outpatient care. A registered nurse and a nurse aide usually staff each RHC (Hodge et al., 2015, p 19)	RHCs are the next level up from community centres. Service delivered here will be a basic service delivery package of essential clinical services including first line emergency trauma care, reproductive, maternal, neonatal, child and adolescent health services. They will manage simple births and provide referrals and point-of-care testing for communicable and non-communicable diseases. A strong focus on outreach is advocated to ensure all communities in the catchment area are visited regularly (MHMS, 2016, p. 10-11).

Level of service	Description of existing levels of care in service delivery	Levels of service and service delivery model in the RDP
3	AHCs are the next level of care and immediately below provincial hospitals in the organisational system. They provide a supervisory role to multiple RHCs. Both inpatient and outpatient care are offered, although inpatient care is limited because of bed and service constraints. They also offer specific birthing facilities as well as space for administration and staff housing. At least two registered nurses, one of whom may be a trained midwife, and one or two nurse aides usually staff AHCs (Hodge et al., 2015, p 19)	AHCs will be the next level up from RHCs and immediately below provincial general hospitals. The level will be divided into two. Urban health centre (UHCs) will provide health services primarily in the urban areas of Honiara and in provincial capitals and will be classified the same as AHCs with two levels. AHC1 In addition to the RHC package of services, AHC1 will provide general clinical services including mental health service follow-up care, and general and obstetric services. They will also service a health zone or more densely populated area (1,000–2,500 people) and be responsible for supervision of RHCs in health zones where there is no AHC2. The UHC1will provide primary healthcare services to people living in or on the outskirts of the urban community in their zone areas. Provincial urban clinics and smaller Honiara clinics (current RHCs) will be reclassified as UHC1 and will have visiting general doctor clinics (MHMS, 2016, p. 11).
4	Provincial health hospitals currently provide what is often the highest standard of care logistically available, particularly to people who have limited access to Honiara. Provincial hospitals generally lack the infrastructure and staffing levels to offer any surgical or specialist services, although national and international specialist teams visit regularly. The provincial hospitals outside Guadalcanal also serve as the home of provincial health offices, which oversee the health service network in that province (Hodge et al., 2015, p 19)	The AHC2 will service larger zones or more densly populated areas with large and often growing populations (2,500+). In addition to the full package of services delivered by AHC1, it will have one full time resident medical officer in addition to the nursing staff and be responsible for the supervision of RHCs within a health zone. Faith-based hospitals will be classified as AHC2. The UHC2, in addition to services provided by UHC1, will provide normal delivery services and short-term inpatient services. Based on need, they may have a resident doctor and dental therapist/dentist, where there is a very large catchment population, and will aim to relieve pressure on services provided by the NRH (MHMS, 2016, p. 12).

Level of service	Description of existing levels of care in service delivery	Levels of service and service delivery model in the RDP
5	The NRH based in Honiara is the highest level of care offered in Solomon Islands. It receives all medical referrals from the country and provides specialised medical services such as surgery, inpatient and outpatient services. The hospital also serves as a provincial hospital for Honiara City and Guadalcanal Province. In Honiara there are also some specialised primary care services, such as family FP or disability services, which do not fit the model. However, all services are expected to follow MHMS standards and policies (e.g., the *Essential Medicines List*) and report to the Health Information System (HIS). There is a small number of private sector medical clinics in Honiara and some private practice at the NRH (Hodge et al., 2015, p 19)	General (provincial) hospitals will provide general acute curative and chronic care inpatient and outpatient services to the population of a province with more than 20,000, or where the facility is the only general facility for a province. General hospitals will accept patient referrals from lower-level facilities and provide all types of medical services. Larger general hospitals will also provide general surgical and operating theatre services as well as some specialist surgery (MHMS, 2016, p. 13).
6		The NRH[1] will provide teritary and general hospital services to the population of Honiara and referred patients from general hospitals and other health facilities throughout Solomon Islands. Specialist services will be provided on an outreach basis to provincial hospitals or larger AHCs where required infrastructure is available (MHMS, 2016, p. 13).

References: (Hodge et al., 2015, pp. 18-19; MHMS, 2016, pp. 10-13; WHO, 2016b)

[1] Although six levels of service are anticipated, at the time of this research the process of implementing the new service levels had just begun. Therefore, in this thesis, I use the five levels of service care as described by participants in the study.

1.3.1 Referral System

Funding from the government to the national and provincial hospitals is often used to cater for the cost of referral and referred patients must comply with referral procedures to access this assistance (H. Harrington, Asugeni & MacLaren, 2013). The provincial hospital pays for referrals from the provincial hospital to NRH and the NRH pays for referrals back to patients' island provinces if referral procedures have been complied with; if not, individuals are required to meet return costs. However, this is not always the case for referrals from AHCs to provincial hospitals as these costs may sometimes be borne by patients themselves.

Many times, people bypass this referral system and go straight to a hospital first instead of going to the nearest clinic. The reasons for this can be for conveniency, cost or past negative experiences with the clinic. While the cost of referrals was provided by the government, the daily living expenses such as food and for personal need are covered by the patients and their families and whom they lived with either in Honiara or the provincial hospital (Hodge et al., 2015).

1.4 Geography and History

Solomon Islands is a sovereign country situated approximately 1,800 km north-east of Australia in the South Pacific Ocean, sharing ocean borders with other Melanesian countries: Papua New Guinea to the west; Vanuatu to the east; and New Caledonia and Fiji to the south. It is a double-chain volcanic archipelago consisting of six major islands—Choisuel, Guadalcanal, Malaita, Makira, New Georgia and Santa Isabel—and more than 900 smaller islands and atolls with a total land area of 28,400 km^2. The capital, Honiara, is located on the island of Guadalcanal (the largest island). Situated within the Pacific 'ring of fire', Solomon Islands is more prone to earthquakes and tsunamis than many other Pacific nations (Jupiter, McCarter, Albert, Hughes & Grinham, 2019). Like many countries in the Pacific, the terrain in parts of Solomon Islands is vulnerable to rising sea levels and tides (Asugeni, MacLaren, Massey & Speare, 2015; Commonwealth Scientific and Industrial Research Organisation, 2020). Solomon Islands experiences a tropical climate, temperatures are warm year-round with high levels of precipitation and humidity. Figure 1.2 shows a map of Solomon Islands and its neighbouring countries.

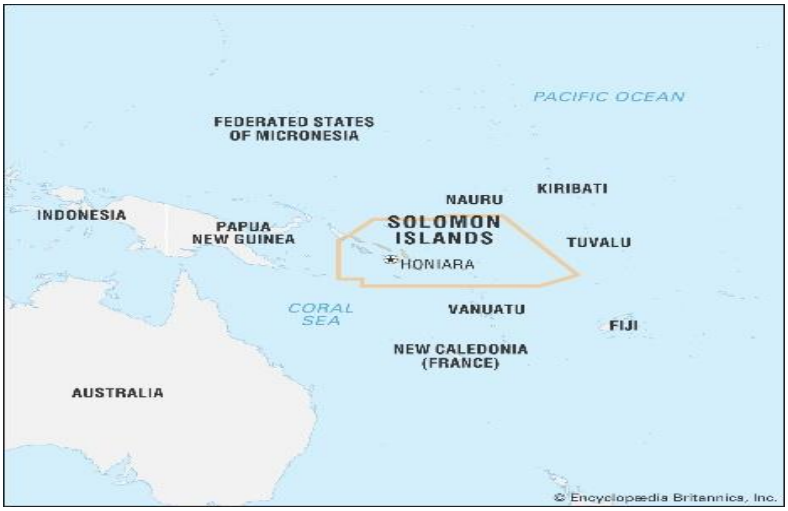

Figure 1.2. Map of Solomon Islands (Source: https://www.britannica.com/place/Solomon-Islands)

Long before European contact, Melanesian people first settled on the islands in approximately 2,000 BC, long before archeological records begin; later, Polynesian people settled on outlying islands such as Sikaiana, Reef Islands and Temotu. For example, the pottery of the Lapita Culture was in use in Santa Cruz and Reef Island in around 1,500 BC (Encyclopedia Britannica, 2016). Materials dating back to 1,000 BC have also been excavated at Vatuluma Cave in Guadalcanal, on Santa Ana Island and on the outlying islands of Anuta and Tikopia (Encyclopedia Britannica, 2021).

Spanish explorer Alvaro de Mendana first visited Solomon Islands in 1568 and named it Islas Salomon, which means 'Solomon Islands', as it was thought to be the place where the biblical King Solomon obtained his great riches. Following this there was no European contact for two centuries before a wave of French and British explorers arrived in the late 18th century. Contact by French missionaries in the 1840s was short lived. Between 1871 and 1904, European 'blackbirders' collected labourers for colonial sugarcane plantations in Queensland and Fiji. Initially Islanders were kidnapped to join the labour trade, although from the mid-1880s onward most were said to be 'recruited' to the plantations (MacLaren, 2006). To counter the abuses of the blackbirders who had begun recruiting labourers for the sugarcane plantations, and to keep the French out, the British colonised the islands and declared them a British Protectorate in June 1893. The British Solomon Islands Protectorate became known and placed under the jurisdiction of the Western Pacific High Commission headquarters in Fiji (Pulea, 1986). Before the British proclaimed the protectorate in 1893, no

centralised politico-cultural system existed among the Melanesian people on the islands, unlike in Polynesian societies, which were known to have overall monarchs ruling their islands. People existed in various clans often headed by tribal leaders who were mostly men (Encyclopedia Britannica, 2021).

At first Britain placed Guadalcanal, Malaita, Makira and New Georgia under 'her' protection. Rennell, Santa Cruz and various outlying islands were added in 1898 and 1899. Finally, under the *Samoa Convention of 1900*, Santa Isabel, Choisuel, Ontong Java and the Shortland Islands—all of which had been German protectorates since 1885—passed to British control (Atkin, 1993). In May 1942, Solomon Islands was occupied by the Japanese forces and became the scene of some of the most intense WWII fighting in the Pacific during WWII. The pre-war capital at Tulagi had been destroyed completely and the new headquarters for the protectorate was transferred to Honiara (New World Encyclopedia, 2022).

Although Britain took Solomon Islands as a protectorate it seemed to have little enthusiasm for its added imperial responsibility. For over 50 years there was no real attempt at 'social, economic, or political development' (Pulea, 1986). Real political and constitutional development began only in 1960 with the new constitution when the first legislative council was established. At first all the members were appointed but from 1964, elected members were included and their number increased gradually. Constitutional reforms in 1970 and 1974 preceded self-government in January 1976. The legislative assembly was enlarged, and Solomon Islands became an independent state within the Commonwealth on 7 July 1978 (New World Encyclopedia, 2022).

1.5 Politics and Ethnicity

At Independence, Solomon Islands became a constitutional monarchy, with the late Queen Elizabeth II as the Queen of Solomon Islands. King Charles III is now its head of state with a governor general who is a local Solomon Islander representing him in the country (Chevalier, 2021). Solomon Islands has a parliamentary system of government. A single member from each constituency represented the people at the parliament and is voted into parliament at a general election every four years.

In total, there are 50 constituencies represented by their own member. The prime minister is the head of government, who is elected by parliament and chooses the cabinet. With the national government based in Honiara, the national capital, Solomon Islands is further divided into provinces with their own administrative offices. The provincial adminstrations are headed by provincial premiers located in their provincial capitals and administered locally by elected provincial assemblies. There are nine provinces: Central Islands, Choisuel, Guadalanal, Isabel, Makira-Ulawa, Malaita, Rennell-Bellona, Temotu and Western. In addition to these, Honiara City is considered a separate province in terms of service delivery to its population. The provincial governments are responsible for social services such as education, health and social developments in the provinces. Population sizes range from just over 3,000 in Rennel and Bellona to more than 137,000 in Malaita which is the largest province by population size (Moore, 2022; Solomon Islands Government, 2018). Figure 1.3 shows a map of Solomon Islands and its provinces.

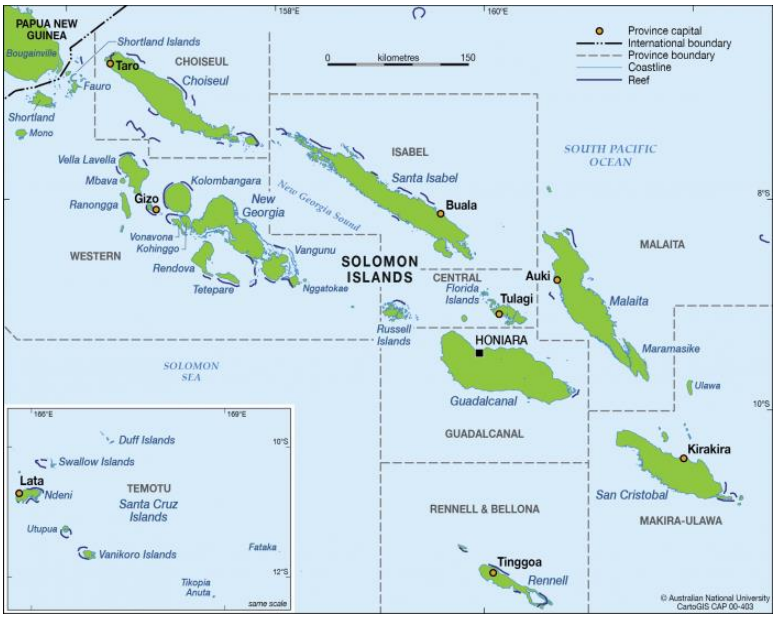

Figure 1.3. Map of provinces in Solomon Islands (Source: Google Maps: https://www.google.com/mymaps/viewer?mid=1oEZMzspiLgFRsn_20Jy07rARZnw&hl=en_US)

Solomon Islands is a collective society. Relationships among tribes, clans and families are very strong as in an immediate family circle. This is evident in the Pijin word *wantok*, derived from 'one talk', which means people from the same language or island group to indicate blood relatives or

extended family. Most people (95.3%) in Solomon Islands are ethnically Melanesian with other ethnic groups including Polynesians (3.1%), Micronesians (1.3%); and minor groups (0.3%) of European, Chinese and other ethnicities (MHMS, 2017). Solomon Islands, also known as the 'Happy Isles' had been a peaceful country until ethnic-based violence known as the 'Ethnic Tensions', as it was between two groups of Melanesians. The violence broke out in 1998–2001 between the Melanesian people of Guadalcanal and Malaita and had its roots in the migration of Malaitans to Guadalcanal during WWII. Many Malaitans stayed in on what is now the capital Honiara. Over population and worse soil conditions on Malaita including the pull and push factors of city life encouraged further migration, heightening tensions between the two groups about land ownership issues (Encyclopedia Britannica, 2021).

In Solomon Islands, people adhere to strong sociocultural norms that are mostly defined by gendered roles for men and women. As a predominantly patriarchal society, men often are the primary decision makers in the family. Studies in Solomon Islands report that male-dominant decision making plays a key role that can either positively influence women's access to SRH information and services or restrict women's decisions or ability to access healthcare, including the use of contraceptives and birthing support (Botfield, McGowan, Gagahe, Tashkeel, & Stuart, 2021; Lukere and Jolly, 2002); Raman, Nicholls, Pitakaka, Gapirongo & Hou, 2015; R. B. Harrington et al., 2021).

1.6 Economy and Population Issues

Given the limited data available for Solomon Islands and that the 2019 census data are still being described as provisional, I use the 2009 census data in this thesis. Although these are old data, with my knowledge of the country's context I can attest that the information is sufficiently accurate for the purpose of this thesis.

Solomon Islands is a small Pacific country with a young and growing largely rural population of more than 700,000. In 2016, children aged 0–19 years represented 50% of the population and women of reproductive age comprised 25%. The TFR was 4.0, indicating a highly fertile population (UNFPA, 2019). Most people (80%) live in rural or remote areas with limited access to healthcare and other basic services. The distribution of healthworkers in the country was also uneven between

urban and rural settings, as healthworkers preferred to work in urban rather than rural areas. In 2018, on average, Solomon Islands had 1.4 nurses per 1,000 population (MHMS, 2017). While this is comparable with other Pacific countries, it remains below international recommendations for worker population densities. With only 600 Solomon Island dollars (SBDs) per capita of spending, the health system seeks to provide equitable access to basic health services through primary care facilities and outreach services; at the same time strengthening the health system within financial and human resource constraints (Hodge et al., 2015).

In recent years, health outcomes have been relatively good given the country's contextual challenges, however, the country is facing health challenges of a growing population (see Figure 1.4) that could potentially undermine development gains. The challenges brought by the growing population are:

- A high TFR of 4 results in a growing youthful population that shows no sign of slowing down, as shown in Figure 1.4.
- A growing young population means, more young women will reach their reproductive age, which will then increase the need for maternal, newborn and child health services.
- With more people living longer within a high prevalence of NCD risk factors meant that more people will also need care for related NCD disabilities.

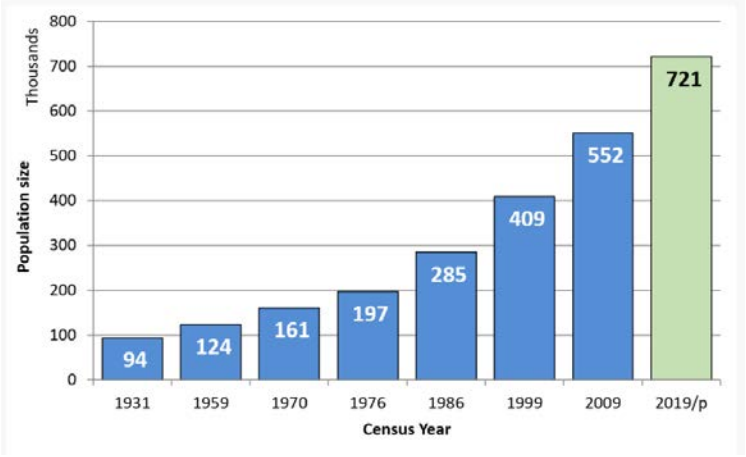

Figure 1.4. Solomon Islands population trend 1931–2019

The Solomon Islands' population is estimated to reach 722,392 in 2022 (Solomon Islands Government, 2022b) and expected to increase if the current TFR did not change (SINSO, 2009d). Solomon Islands has one of the highest TFRs compared to other neighbouring countries in the region.

To reduce a high fertility rate within a predominantly rural and widely dispersed population would require more than a health systems approach. Although the preference to have many children are likely to be high in rural village settings, it is evident there is a gap between preferred and actual fertility, hence an opportunity to fill this gap with improved FP education FP service approaches (SINSO, 2017).

A significant gap also exists between adolescent fertility rates in urban and rural areas. Adolescent fertility rates are higher in rural than urban areas. Although sociocultural factors are believed to contribute to higher fertility in rural areas, the lack of SRH services available to address adolescent reproductive health in rural areas is an important contributing factor that must also be considered. Maternal mortality remains a significant issue in countries with high fertility rates such as the Solomon Islands. Accurate data are needed to determine factors that contributed to maternal deaths. The UNFPA, the main funder for FP in Solomon Islands, now recognises the need to expand choices and ensure rights in FP in its current *Strategy for Family Planning 2022–2030* (UNFPA, 2022). Solomon Islands and the UNFPA also foresaw the need to expand the vision of FP beyond contraception and the health sector to social and gender norms and breaking down silos to intergrate fit-for-purpose FP programmes.

1.7 Religion

Prior to European colonisation, Solomon Islanders practised ancestral worship as evidenced through cultural practices, artefacts and taboos (i.e., cultural restrictions) that continued to be practised (Atkin, 1993). People believed their acestors remained with them in the local setting either as spirits, or lived on in animals, for example birds or dolphins or sharks. Taboo places are still respected sites where ancestral remains are kept and people believe where ancestral spirits live (Encyclopedia Britannica, 2021). Before becoming a British Protectorate, trading and warring networks known as ‘head hunting’ or tribal warfare were common between tribal island groups in some areas of Solomon Islands. When churches and the government arrived, intertribal warfare and conflicts were ended, and a new culture emerged. The predominant cultures of Melanesia and

Polynesia merged with the cultures of various churches, and created a distinction between urban and rural lifestyles as well as the Western culture and education (D. Gegeo, 1995).

Under the leadership of the British Administration, Western missionaries came and converted many Solomon Islanders to Christianity. Many plantation labourers from Queensland and Fiji also returned, bringing a new language, 'Pijin', which steadily spread across the islands well after blackbirding ended (Encyclopedia Britannica, 2021). Five mainstream churches were initially established in Solomon Islands: the Roman Catholic Church (1845); the Melanesian Mission in 1861 (now Anglican Church); the Methodist Church in 1902 (now the Uniting Church); the Seventh Day Adventist Church (1914); and the South Seas Evangelical Mission (1907). The latter has its roots in returning 'blackbirded' labourers who had been involved with the Kanaka Mission in Queensland (McDougall, 2016; G. White, 2007).

Today, the majority (95%) of the population professes adherence to a Christian church (SINSO, 2009d). The main religions according to SINSO are Church of Melanesia (Anglican; 29%); Roman Catholic (19%); South Seas Evangelical Church (17%); Uniting Church (11%); and Seventh Day Adventist (10%). More recently, Baha'i Faith, Jehovah's Witness, Assembly of God and the Baptist Church were included. Around 5% of the population (mainly in the Kwaio mountains in Malaita) consider themselves ancestral worshippers and—consistent with an anti-colonial position—are not affiliated with any Christian religion.

Christian churches are the most influential institutions among the rural communities in the provinces, much more so than the government or NGOs. Apart from various religious activities and programmes, churches contribute directly to national and provincial development programmes. Churches also take an active part in the delivery of social services throughout the country, particularly in the education and health sectors (Cassells, 2019).

1.8 Language and Education

English is the official language, but majority of people use Solomon Islands Pijin, a lingua franca (commonly spoken language). There are more than 70 local languages, with additional dialects. English is the formal language for education, business and government however it is not commonly

used in social contexts or rural areas. Solomon Islands Pijin developed during the blackbirding days when locals tried to communicate with their colonial masters in sugarcane plantations. The use of English has become embedded in Pijin. Pijin spoken by urban, educated people uses one or two English words in a sentence. In rural areas, most people speak traditional languages, unless communicating with people from different islands. As people who speak English often access more education opportunities to obtain a paid job, therefore are more likely to achieve material prosperity and power. In today's rapidly modernising society, Pijin has also evolved with various meanings and ways in which people use it to communicate with each other (Kabutaulaka, 1999; K. Sanga & Reynolds, 2021).

Obtaining an education in Solomon Islands is competitive and costly. Education is neither free nor compulsory. The most recent adjusted net attendance rate for children of primary school age was 66% (UNICEF, 2022). School enrolment rates were higher for males than for females. The 2009 census (SINSO, 2009d) reported that the majority of 9–13-year-old students enrolled in primary school would leave school and only half of all students remained in school by the age of 18. School enrolment rates rapidly decline from 14 years of age, and it is a worrying situation to see children as young as 8–12 who have already left school (UNICEF, 2022). In addition, around 7% of all adolescents/young people in Solomon Islands (aged 10–19 years) have never been to school. Literacy rates reported to be generally high (above 80%) in Solomon Islands; with male literacy higher than female, however, information about literacy obtained during the census is self-reported and may be biased. Sometimes people are embarrassed to admit their literacy status.

Enrolment rates vary by province and urban and rural settings. Generally, urban settings have higher school enrolment rates than do rural areas, although enrolment rates could be higher now with the recent increased number of schools erected in rural areas. The Solomon Islands Government aims to achieve universal education for children up to senior secondary school level by 2030; however, there are limited spaces because of increasing population growth in this age group. In 2016 there were around 50 births per day, which is the equivalent to two classrooms of children per day. The country's rapid population growth will continue to undermine the government's capacity to achieve universal

education by 2030. This will also continue to negatively influence young people's ability to understand FP concepts to enable acceptability issues (Solomon Islands Government, 2017).

1.9 Standpoint—A Journey of Opportunities

Standpoint theory is concerned with the effect of one's location in society and one's ability to know. We are all gendered differently, all have different social and cultural experiences; and our ways of knowing, being and doing are different. The important concept in standpoint theory is that our perspectives are shaped by our own social and political experiences. We use this perspective to see and understand our world (Paradies, 2018).

Standpoint theory is based on the view that power relationships shape knowledge and there are different ways in which people understand the world from their own perspectives (Kinitz, 2022). The concept of the standpoint was built on Marxism (Cockburn, 2015), where power relationships between groups of people were seen as exploitative and could potentially create class conflict. In the late 1980s, standpoint theory developed when feminists expanded this understanding with concerns of masculine monopolisation of what is true and what people should believe and accept (Paradies, 2018). Though developed with concern for the oppressed, the theory is asserted by scholars as a 'theory for justice' that recognises societal power. More recently, standpoint theory is being used as a critical lens to explore our understanding of social conditions. Given the role that science plays in the Western notion of objectivity, and the privileging of scientific methods in knowledge creation, Indigenous researchers have expanded standpoint theory to challenge the largely debunked perception of objectivity in science and to create knowledge informed by their worldview (Datta, 2013).

So, who am I? I come from Solomon Islands, a small island country in the PICTs. I identify my origin as a Melanesian ethnic group in Choiseul Province. I grew up in a Christian home where my father was a missionary primary school teacher. As the eldest of five children, my three sisters and brother were my company as we moved from place to place, and we helped each other with our daily chores. As there were no shops to buy food and no water supplies nearby other than the streams, we grew our own food garden and collected water from streams. Among my chores after school was to care for my siblings when my parents went to work in the garden. I would fetch drinking water and

help prepare dinner for my family. My childhood years were spent in rural and remote communities. By the time I had completed my six years of primary education, I had attended four primary schools and fluently spoke three local languages and understood two other languages.

My early exposure to living in different cultural contexts and learning new languages brought some challenges growing up. However, looking back I count this as a unique experience, and I treasure those memories of my family life. My parents came from big families; my dad had five siblings and my mum had seven, so I have many uncles, aunties and cousins. We all cared for each other and depended on each other in many ways. This made me think that having a big family is a good thing as I could also see the benefits.

1.9.1 Educational Experiences

After completing grades 7–11 at Kukudu High School in the Western Province, I successfully passed my Pacific Senior Secondary School Exams to continue to Grade 12 at Betikama High School in Honiara. During the 1980s and early 1990s, only a limited number of senior high schools in Solomon Islands offered Grade 12 and competition for entry was strong. However, at the time it was quite easy to obtain an in-country college-level education and direct employment (employment after high school). Although I had always wanted to go to university elsewhere with the government scholarship, my grades did not reflect my aspiration; the chances of obtaining a government scholarship to university outside the country appeared low. At the end of the school year, most of my classmates received government scholarship awards to attend university. I did not get one; I lodged two in-country applications for business and nursing courses, just to secure a place to continue my studies. To my surprise, both applications were successful. The business course was offered with an ‘in-country’ government scholarship at the Solomon Islands College of Higher Education in Honiara. The nursing course was self-sponsored at Atoifi College of Nursing, Atoifi Adventist Hospital, a church institution in a remote setting. I had to decide. It was difficult as I was equally interested in both courses. However, reflecting on my father’s humble service as a missionary teacher and the simple rural life experience, I decided to take the nursing course, be a missionary nurse and help people.

I enjoyed my nursing course, and from the very start, I fell in love with midwifery subjects. The art and science of pregnancy, birthing and care of newborn babies continue to amaze me. The first cry of life is the music I love to hear after long hours caring for women in labour; it is a song of celebration. However, this is not always the case and sometimes, there are cries of mourning for the loss of a newborn and/or mother. I often recalled growing up hearing stories about women dying when giving birth and wondered what caused the women to die and if these deaths could be prevented. As a student nurse, witnessing the loss of a mother at a time that was supposed to be a celebration of a new life haunted me. Late, in my training I learnt that most maternal deaths could be prevented by educating women and improving the care given by nurses. After exploring potential career pathways following my nursing training, I decided to become a midwife, with my specialty being to help care for women during pregnancy and childbirth. I successfully completed my nursing training and graduated.

1.9.2 Nursing and Midwifery Career

In the years 2000 and 2001, I received a NZ Government Scholarship and studied a Bachelor of Midwifery in NZ. This additional training expanded my knowledge and complemented my clinical experience in maternal healthcare. I had new insights into working in partnership with women in midwifery care. I returned to Atoifi Adventist Hospital after my training as a charge nurse-midwife (2002–04) in the maternity unit, while concurrently overseeing weekly antenatal, postnatal and FP clinics. At the FP clinic, only women attended and, most were married. I noticed men rarely came to the clinic. My early experiences as a midwife were quite challenging. I often cared for women who had ‘high-risk’ pregnancies. The main risk factors were higher parity (more than seven children); previous labour complications such as postpartum haemorrhage; and prolonged labours. Some of these high-risk women never attended antenatal clinics and just showed up when in labour. Therefore, it was crucial that we were always prepared, and a medical doctor was present for emergencies. Together with the doctors we saved many lives but at other times we faced situations that inevitably resulted in the loss of mothers and/or newborn babies. I would hear stories from women who came to the hospital about other women who had given birth at home and then died from excessive blood loss.

I sometimes cared for women in shock who were rushed to the maternity unit. These experiences disturbed me greatly because I knew some of these high-risk pregnancies and deaths could be prevented with the use of contraception, and if FP services were freely available to everyone. We gave health-awareness education about FP and conducted FP outreach clinics at various community sites in our catchment area, but the uptake of contraceptives remained low, and many women still presented with avoidable complications.

Towards the end of 2004, I was accepted into a teaching role and taught midwifery subjects at the nursing school at which I had trained. Although transitioning from a clinical to a teaching environment without a teaching qualification was challenging at first, I found teaching what I had practised helped clarify some concepts in midwifery that I had previously not fully understood. Things began to make sense and I enjoyed my new teaching career. This experience helped me effectively teach midwifery subjects to nursing students. Later, I completed a Certificate in Adult Learning Education from Solomon Islands College of Higher Education, in Solomon Islands.

Realising there were limited opportunities for higher degree studies in Solomon Islands, I looked for opportunities where I could attend professional development courses. Such courses were not usually available at the institution where I worked. As a midwife and lecturer, I was invited by the MHMS to attend national conferences and in-service training in reproductive health and FP. This is where I connected with the Pacific Society for Reproductive Health (PSRH) and started attending their bi-annual conferences. Although I had limited experience in conducting research, I am curious and wanted to do research.

In 2009, I received a fellowship through the PSRH for a six-week placement at the Middlemore Hospital in NZ with a colleague from another Pacific Island country. At the completion of the fellowship, we were assigned to undertake a small research study and present it at the next bi-annual PSRH conference. A research topic on FP first came to mind, but I did not know where to start with my research. Around this time, a team from James Cook University (JCU; including my primary advisor) came to run grassroots-level research training at Atoifi Adventist Hospital where I worked, and everyone was invited to attend. I eagerly accepted the opportunity, and this is where I learnt to do research using a learn-by-doing approach (Redman-MacLaren et al., 2012).

1.9.3 My Research Journey

Later, in 2017–18 the Tropical Partners through JCU, funded by the Australian Department of Foreign Affairs and Trade (DFAT), conducted the *Structured Operational Research and Training Initiative* in Solomon Islands. Although I was not initially selected as a fellow, I took the opportunity to complete the training when an invitation was opened more broadly to interested individuals. This was the beginning of my research journey. I piloted my first FP research on the 'Barriers and enablers of family planning services at Atoifi Hospital' (R. Harrington et al., 2020), which helped me to apply my research knowledge into practice. The opportunity also enabled me to enrol in an MPhil and later upgrade to a PhD at JCU. I extended the FP study to explore the availability, accessibility and acceptability of FP services and contraceptives in Solomon Islands to understand other contexts of FP services in the country. These are the experiences that underpin the PhD study reported in this thesis.

1.10 Research Aim and Objectives

The aim of this PhD study was:

- To explore the availability, accessibility and acceptability of FP services including contraceptives, in urban, peri-urban and rural clinical settings in Solomon Islands.

The objectives of this study were to:

1. describe the availability, accessibility and acceptability of FP services including contraceptives at urban, peri-urban and rural health clinics
2. identify facilitators and barriers to providing FP services and contraceptive choices at these clinics
3. identify what sexual health services were available, accessible and acceptable to adolescents and men at these clinics
4. make recommendations to improve FP and contraceptive use for urban, peri-urban, and rural health settings to inform FP service managers, providers and policymakers in Solomon Islands.

1.11 Chapter Summary

In this chapter I have provided background context to FP services globally, in the Pacific and in Solomon Islands. I provided a detailed description of the study setting of Solomon Islands, including a description of the geography and history, language, religion and healthcare system, to provide the background to the provision of FP services. The standpoint statement situated me as the researcher in relation to the research topic.

In the next chapter, I report on a scoping literature review about FP service provision in PICTs, including facilitators and challenges. The review helped to identify gaps in FP research in the region and informed the design of my PhD study. Figure 2.1 is the thesis structure showing the literature review in the thesis.

This thesis is a little longer than some as the three cases in this multiple case study design rely heavily on qualitative data collected in Solomon Islands Pijin. Consistent with my commitment to a decolonising approach to research, I have included quotes in Pijin and provided translations in English; thus, extending the length of the thesis.

Chapter 2: Literature Review

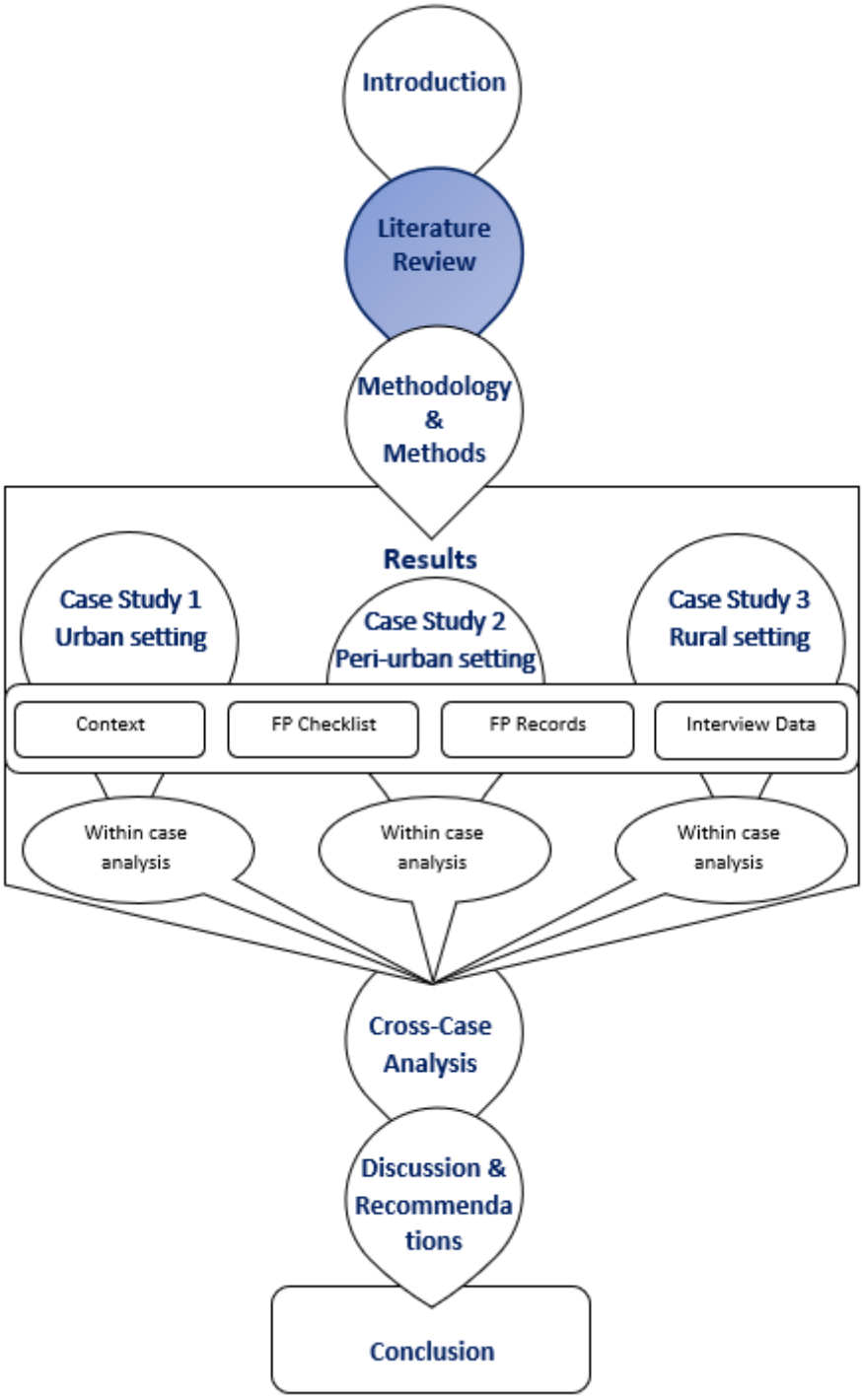

Figure 2.1. Thesis structure—Literature Review

2.1 Chapter Outline

In this chapter, I examine literature reporting the provision of FP services in the Pacific Island PICTs to identify how FP services and contraceptives are provided. I also discuss what facilitates and challenges access to FP services, including use of contraceptives. This review informed the research topic, aim and objectives reported in this thesis. This work has been published and is reproduced here in full:

Harrington, R B., Harvey, N., Larkins, L., & Redman-MacLaren, M. (2021). Family planning in Pacific Island countries and territories: A scoping review. *PLoS One* 16(8): e0255080. https://doi.org/10.1371/journal.pone.0255080

2.2 Family planning in Pacific Island Countries and Territories (PICTs): A scoping review

Abstract

The use of contraceptives for family planning improves women's lives and may prevent maternal deaths. However, many women in low and middle-income countries, including the Pacific region, still die from pregnancy-related complications. While most health centres offer family planning services with some basic contraceptive methods, many people do not access these services. More than 60% of women who would like to avoid or delay their pregnancies are unable to do so. This scoping review identifies and analyses evidence about family planning service provision in Pacific Island Countries and Territories (PICTs), with the aim of better informing family planning services for improved maternal health outcomes in the Pacific. We used Arksey and O'Malley's scoping review guidelines, supported by Levac, Colquhoun and O'Brien to identify gaps in family planning service provision. Selected studies included peer-reviewed publications and grey literature that provided information about family planning services from 1994 to 2019. Publication data was charted in MS Excel. Data were thematically analysed and key issues and themes identified. A total of 45 papers (15 peer-reviewed and 30 grey literature publications) were critically reviewed. Five themes were identified: i) family planning services in the Pacific; ii) education, knowledge and attitudes; iii) geographical isolation and access; iv) socio-cultural beliefs, practices and influences; and v) potential enabling factors for improved family planning, such as appropriate family planning awareness by health care providers and services tailored to meet individual needs. While culture and religion were considered as the main barriers to accessing family planning services, evidence showed health services were also responsible for limiting access. Family planning services do not reach everyone. Making relevant and sustainable improvements in service delivery requires generation of local evidence. Further research is needed to understand availability, accessibility and acceptability of current family planning services for different age groups, genders, social and marital status to better inform family planning services in the Pacific.

Introduction

In 2017, more than 800 women around the world died every day from preventable causes related to pregnancy and childbirth complications [1-3]. Many of these deaths occurred in low and middle income countries (LMICs) including those in the Pacific region [4]. Adolescent females and women living in rural areas face higher risks of unintended pregnancies, complications and death compared to other women [5, 6]. Health education and contraception knowledge, with access to appropriate health services can empower women and men to make informed decisions about their reproductive choices [7]. Increasing evidence also showed that empowering women empowers humanity: families are healthier, and better educated, and economies also grow faster [8]. Ensuring access to sexual and reproductive health (SRH) services including family planning (FP), is a fundamental human right and can be a cost-effective approach to prevent pregnancy complications that lead to maternal deaths [9, 10].

The United Nations (UN) population conferences in Rome (1954) and Belgrade (1965) highlighted the issue of FP in light of rising populations and the threat of mass starvation [11, 12]. Population control policies were created, but, these policies failed to address the dimensions of social inequality in terms of human rights [11]. Subsequent UN population conferences, including the Committee on the Elimination of Discrimination against Woman, 1979; Bucharest 1974; the International Conference on Population, Mexico, 1984; and World Human Rights, Vienna 1993 continued the discussion with greater contributions from women, religious groups and less developed countries [13]. The need to change approaches to population control and its relationship to development became evident. The status of men and women in the family and society were then fully realised in FP discourse. This recognition led to the initiation of the reproductive and sexual health rights concept as an alternative to the former narrowly FP program approach [9, 14].

At the International Conference on Population and Development (ICPD), Cairo 1994, the international community reached an unprecedented global consensus on population issues and the concept was endorsed by 179 countries. The ICPD Program of Action (ICPD PoA) set out a series of priority issues including among others, population and development, gender equality and equity,

reproductive health and rights and adolescents and youth [15]. The Beijing Declaration (1995) further supported the notion of gender equality and the empowerment of women everywhere [8]. Central to the ICPD PoA [16] is the attainment of reproductive rights and reproductive health. All countries are expected to ensure that comprehensive reproductive health services including FP are accessible, affordable and acceptable to all individuals through the Primary Health Care (PHC) system. This comprehensive package includes: (i) FP counselling, information, education, communications and services; (ii) education and services for safe pregnancy, childbirth and postnatal care; (iii) prevention and appropriate treatment of unsafe abortion; (iv) treatment of reproductive tract infections and appropriate information education and counselling for sexually transmitted infections (STIs), including human immunodeficiency virus (HIV); and (v) promoting sexual health [17, 18]. Family planning is a component of reproductive health that has a strong natural link with the other four program components and is a pre-requisite for achieving all other sustainable development goals [19]. Family planning, according to the World Health Organization (WHO), allows individuals and couples to anticipate and attain their desired number of children, and the spacing and timing of their births, through the use of modern contraceptive methods [20].

The review of the ICPD PoA goals in the United Nations Funds for Population Activities (UNFPA) Pacific progress reports [3, 18, 21] identified that these goals remain relevant. Although significant progress was made, greater action is needed. The Millennium Development Goals (MDGs: 2000-2015), provided the global framework following the ICPD, with Targets 5a "To Improve Maternal Health" and 5b "Universal Access To Reproductive Health" [22]. The Sustainable Development Goals (SDGs: 2015-2030) continue to provide the platform for this global agenda [11, 23]. The third SDG, Good Health and Wellbeing, espouses inclusivity and not leaving anyone behind, regardless of their age. Targets 3.1 and 3.7 respectively supported reproductive health and FP, aiming to reduce the global maternal mortality ratio to below 70:100,000 live births and provide universal access to SRH services. Underpinning the provision of services in the SDG era is the notion that services focus on the marginalised and most at risk groups such as adolescents and the principle of "informed free choice" governs FP programs [18, 24]. This shift in global thinking has had major policy and programing implications for reproductive health in the Pacific region. The diversity of the

Pacific region reflects the complexities in establishing a one-size-fits-all FP program. Contraceptive needs may not be met due to limited, inconvenient or inappropriate services, cultural factors or religious beliefs [25]. Reaching these SDG targets by 2030 will require context relevant programs and policies to be incorporated into each country's national strategic plan [22, 26].

For the purpose of this review, the Pacific region comprises of 21 Pacific Island Countries and Territories (PICTs) dispersed throughout the Pacific, often referred to as 'large ocean states' [27]. These countries represent an enormous diversity in physical geography and culture, languages and social-political organisations, population size and development, and are classed in three main ethnic sub-groups. Melanesia includes Fiji, New Caledonia, Papua New Guinea (PNG), Solomon Islands, and Vanuatu. Polynesia includes American Samoa, Cook Islands, French Polynesia, Guam, Niue, Samoa, Tokelau, Tonga, Tuvalu, Wallis and Futuna, while Micronesia includes The Federated States of Micronesia, Kiribati, Marshall Islands, Nauru, and Northern Mariana Islands [14]. With small populations and land areas amongst vast ocean spaces, limited resources and a narrow economic base affect these countries - most rely heavily on official development assistance from higher income countries and international partners [27]. Modern FP programs were introduced in PICTs in the 1960s to promote population reduction and socio-economic development as well as to improve women's and children's health [28]. At the ICPD, the Pacific community accepted the PoA and recognised sexual and reproductive health rights (SRHR) as fundamental to human rights [29], and have since committed to improving the reproductive health of their people [30]. While significant global achievements have been made, such as decreased maternal and infant mortality ratios, improved access to contraception, falling fertility rates, and increased life expectancy, progress for improved SRH in the Pacific has been slow and inconsistent [8]. With low Gross National Income per capita (<$3,000) and high population growth rates (>2.0%), Pacific countries such as Solomon Islands, Vanuatu and PNG have inadequate resources to support current population growth [10, 14]. The realisation of rights and social protection for vulnerable groups such as women and children, the elderly, youth and people with disabilities is inadequate. Integrated and comprehensive approaches to achieving SRHR across the region are yet to be fully established. Pacific countries are in various stages of implementing the "Family Life Curriculum" [3, 31] in schools and establishing youth

friendly services. However, the integration of population issues into education systems is still under development. Enabling women to enjoy full participation in political and economic life remains a challenge and gender-based violence is prevalent in many PICTs [21].

Contraceptive Prevalence Rates (CPR) and 'unmet need for FP' have been used as indicators to measure the uptake of contraceptives in FP programs. The CPR in the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) is defined as the percentage of women age 15-49 years currently married or in union, who are using or whose partner is using any contraceptive method at the time of the survey. 'Unmet need for FP' is the percentage of married women or women in union who want to stop or delay childbearing but are not using any contraception [32]. Both indicators were used to determine if women or couples were taking any action or using any method to delay or avoid getting pregnant [23]. In the Pacific, the CPR is estimated to be 18-48%, well below the 62%, average for Low Income Countries [14]. There is also a relatively high level of unmet need for FP (8-46%) when compared to global estimates of less than 10% unmet need for FP [23]. The persistently high total fertility rate of 3-4% compared to 1% globally reflects the low CPR and high unmet need for FP in PICTs [10, 24, 33].

Before the 1994 Cairo conference, FP was delivered within the Maternal Child Health and Family Planning (MCH/FP) context, and primarily targeted married women. After 1994, the integration of these services into more holistic and comprehensive approaches including SRH was considered [28, 34]. More recently, this MCH/FP approach included the broader context of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) to reach the unmarried and adolescents [35, 36].

However, many adolescents, women and men do not access these services [36]. Little is known about how FP services are accessed and provided at health facilities throughout the Pacific [37, 38]. For this reason, a scoping review was conducted to map key concepts from a wide range of literature to identify gaps to inform further research and for improved FP services in the Pacific region [39-41]. To understand how FP services have been implemented in PICTs, we reviewed and synthesised the literature on provision of FP services in PICTs and the successes and challenges of service implementation. This review focused on two research questions:

1. How have FP services been implemented in PICTs between 1994 and 2019?
2. What are the successes and challenges in providing FP services in PICTs?

For the purpose of this review, 'FP service' refers to any service within SRH care that provides contraception and counselling services purposely to prevent or delay pregnancy.

Method

Scoping reviews are useful in health research, to map key concepts and identify literature gaps. They are particularly useful when little is known about a topic. We followed the guidelines for conducting scoping reviews established by Arksey and O'Malley [39], Levac, Colquhoun and O'Brien [40]and the Joanna Briggs Institute [42], to summarise peer reviewed journal papers and relevant grey literature including government and organisational reports. This review follows an unregistered protocol (S1 Appendix in published article) developed prior to conducting the study and structured consistent with the Preferred Reporting Items for Systematic Reviews and Meta-analysis Protocols extension for Scoping Reviews (PRISMA-ScR) checklist [41].

Eligibility criteria

Original research studies of all designs including grey literature conducted in PICTs were considered. To be included in the review, papers had to meet the following inclusion criteria (S2 Appendix):

1. Report on the FP service component of the SRH Care Services in PICTs or world regions that include countries in the Pacific;
2. Report on the successes/enablers and challenges/barriers to FP service provision;
3. Published in the English language; and
4. Published between 1994 and 2019 to capture the 1994 ICPD focus on the global commitment strategy for universal access to SRH including FP, and also encompass the period of the MDG and commencement of the SDGs. The PICTs also signed an agreement to ICPD in 1994 and this guides their progress towards achieving targets for the SDGs.

Papers discussing SRH and STIs that did not include aspects of FP were excluded, as were papers focused on surgical termination of pregnancy as a form of FP, antenatal care and pregnancy services.

Information sources and search

Informed by the research questions, we determined keywords (S3 Appendix), before constructing search strategies. University librarians assisted to review and confirm search strategy drafts for electronic databases and grey literature searches, which were then refined through author group discussion. Scopus, MEDLINE (Ovid), CINAHL and PsycINFO databases were searched using key words and database-specific subject headings to identify relevant studies. These databases were chosen as they provide most relevant peer reviewed articles about family planning in the Pacific. The search strategy was adapted for each database. The search was conducted between 2018 and 2019. The final search strategy for MEDLINE (Ovid) can be found in S4 Appendix. Searches were performed for published and unpublished work on Google Scholar, organisational websites (WHO, UNFPA, United Nations International Children's Emergency Fund, UN), Pacific-based journals and reports (i.e. Pacific Journal for Reproductive Health, South Pacific Commission) including government reports such as Demographic and Health Surveys. Organisational websites and Pacific-based journals and reports were selected to augment papers identified by electronic sources, as these were known to report on reproductive health services including FP in PICTs.

Selection of sources of evidence

All papers were imported into Endnote bibliographic software and duplicates removed. Two authors (RH and MRM) performed the initial screening. Papers that did not clearly meet the inclusion criteria were reviewed by the other two authors (NH and SL) before a decision was made to either include or exclude the papers from the review. We extracted data using a MS Excel spreadsheet designed for this review to capture information about the study characteristics (publication year, country of study, study focus, design), and a data extraction sheet (Table 1) where key findings of FP services were recorded (S5 Appendix). The PRISMA flow chart in Figure 1 shows the procedure for selecting papers for inclusion.

Data charting process

Full-text papers that met the inclusion criteria were thoroughly read to capture relevant information required in the review [39, 40]. Findings were analysed using content analysis and synthesised using a thematic, narrative approach [42, 44]. During this stage, decisions about what information should be recorded from the primary studies were made using an iterative process [40]. Given that limited peer reviewed research was conducted on FP service provision in the Pacific region, studies were not excluded on quality grounds but included purposely to map available evidence as consistent with the scoping review methodology. However, the overall quality of the included studies was limited.

Table 2: Data extraction sheet

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
Brewis et al., 1998 [45] Samoa	Assess family planning (FP) acceptance	Original research	Qualitative (n=155) women 15-49 years	Awareness and use of contraception have markedly increase in both rural and urban areas Availability and accessibility to contraceptives reportedly high Contraceptives made accessible and affordable for rural and urban woman by government Younger women desired larger families FP needs further investigation to be clearly understood
Burslem et al., 1998 [46] Solomon Islands	*Teenage pregnancies and sexually transmitted infections*	Descriptive research	Questionnaire (n=266) high school students. Focus group (n=12) women and girls. Interview (n=24) college students, pregnant single mothers	FP services unavailable to unmarried people regardless of age Poor knowledge about FP services Poor access to condoms A sympathetic health worker is needed
Cammock et al., 2017 [47] Fiji	Socioeconomic and cultural contexts	Original research	Cross sectional study (n=212, women of childbearing age)	FP service not culturally-sensitive Cost of service and language are main barriers Need culturally relevant services
Daube et al., 2016 [48] Kiribati	Knowledge, use and barriers to contraceptive uptake for women and men	Descriptive research	Mixed method (n=500) women (15-49 years) and men (15-54 years)	Unsuitable service delivery Barriers include, not interested in FP, knowledge gaps, personal reasons, family & social obligation
Davis et al., 2016 [49] Cook Islands, Solomon Islands, Fiji,	Attitudes and belief regarding benefits, challenges, risks and approaches to male	Descriptive research	Qualitative study	FP services not focused on men/men are not involved

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
Vanuatu, Papua New Guinea	involvement in reproductive health		(n=17) senior Maternal Child Health policy makers and practitioners	Perceived challenges – socio-cultural norms, physical layout of clinic, health workers attitudes and work loads To engage boys and men early in the life cycle
Hayes and Robertson, 2012 [50] Pacific Island Countries	Current status and prospects for repositioning FP on the development agenda	Report	Not provided	Distribution and dispensing of contraceptive in the Pacific mainly through Government-operated health facilities, Family Health Associations and Private pharmacies or doctors in private practice Generally free services Most Pacific countries incorporate reproductive health including FP into national and subnational development plans CPR ranged from 17-49% in PICTs. Method of measurement may not be comparable and accurate Recently introduced DHS in PICTs
House and Ibrahim, 1999 [51] Pacific Island Countries	Adolescent birth rates	Discussion paper	Not provided	Focused on adolescent services and no special attention to older women's reproductive health needs Inconvenient and unsatisfactory services Higher fertility and unmet needs among women aged over 35 Rising reproductive health status of adolescents, resulted in declining fertility rates over three decades
House and Katoanga, 1999 [28] **Pacific Island Countries**	Reproductive health and FP in Pacific island countries	Discussion paper	Not provided	Before Cairo conference MCH/FP centred on the pregnant mother and her child FP targets married women. In practice MCH/FP implemented separately from other SRH components (STI/HIV)

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Challenges: raising awareness, identifying priorities for adolescents SRH needs and integrating services into more holistic and comprehensive approach Success: reproductive health training program was established in Fiji
Kennedy et al., 2011 [2] East Asia and Pacific Island Countries and Territories	Adolescent fertility-current use, knowledge and access to FP information and service	Review	Not provided	Married and unmarried adolescents have less access, low use and high-unmet need for contraceptives. Adolescents lack knowledge about services compared older women Concerns about gender of health providers, poor geographical access and financial barriers
Kennedy et al., 2013a [10] Vanuatu and Solomon Islands	Health, demographic and economic consequences of reducing unmet need for FP	Intervention research	Using demographic modelling	Increasing investment in FP could contribute to improved maternal and infant outcomes and substantial public savings and lower dependency ratio
Kennedy et al., 2013b [5] Vanuatu	Service providers' perceptions of youth-friendly SRH services in Vanuatu	Original research	Qualitative study (n=66 Focus group) with 341 male and female adolescents. (n=12 interviews) with policy makers and service providers	Government provides most SRH service. Small number of youth facilities provided by non-government organisations Service focused mainly on STIs and HIV Adolescents lack knowledge about prevention of pregnancy, condom use, puberty and sexual relations; early sexual debut Need friendly service providers and context-specific strategies
Kennedy et al., 2014 [52] Vanuatu	SRH information preferences of	Original research	Qualitative study (n=66 Focus group) with 341	Adolescents mostly access the service to seek information or advice

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
	adolescents in Vanuatu		male and female adolescents. (n=12 interviews) with policy makers and service providers	Non-government services more accessible than government facilities Barriers include socio-economic norms and taboos Lack of confidentiality and privacy Schools an underutilised source of information. Need a wide range of media sources of SRH information
Kenyon and Power 2003 [34] Pacific Island Countries	Getting the basics of FP in the Pacific region	Discussion paper	Not provided	Pacific health centres traditionally operate a once a week session for FP. This is likely to be inconvenient for many clients No privacy in clinics, confidentiality easily breached in small village clinics, Health worker attitudes (negative) Outdated population policies/no policies/policies lack details and coordinating structure/policies that emphasise approaches to FP not shown to be effective Socio-cultural values & beliefs
Kiribati Demographic health survey, 2009 [53] Kiribati	Contraceptive knowledge, use, attitudes and sources	Report	Mixed method: 1,978 women aged 15-49, 1,135 men aged 15-54	Contraceptive prevalence rate – 22% (married women), 16.5% (all women) Government/public sector strategically important in providing service through health facilities. Few use private sectors. Others source contraceptives from relatives overseas. Service offered for free Challenges in contraceptive use include the desire for many children and religious prohibition

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
Kura et al., 2013 [54] Papua New Guinea	Male involvement in sexual reproductive health (including FP)	Original research	Mixed method, 122 married men aged 21-44 years	FP clinic services are usually female oriented; men are never targeted on awareness/education on safe motherhood initiatives Inadequate services for men, male literacy also contributed to men's participation Challenges: illiteracy, inadequate knowledge (importance and benefits of FP), cultural factors, lack of appropriate services. Other factors include wanting more children and fear of religious condemnation
Lee, 1995 [55] Pacific Island Countries	Assess current situation in reproductive health and FP and the way forward	Discussion Paper	Not provided	Reproductive health and FP are an integral part of MCH/FP framework and focuses on pregnancy and contraception Services confined to married women and narrowly focused. Do not address needs of special groups like teenagers and women over 40 years Sexually transmitted infections are separate programs from MCH Low male and adolescent participation
Lincoln et al., 2018 [56] Fiji	Identify the level of knowledge, attitudes and practices of FP among women of reproductive age	Descriptive research	Qualitative cross-sectional study, 325 women (15-49 years)	Health centres were the primary sources of in-depth knowledge and awareness regarding contraceptive use compared to other highly influential initiatives Barriers to contraceptive use include religious beliefs, cultural beliefs, gender disparities, the need for regular visits to health centres Ideal number of desired children in families is between 3 and 5

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Way forward –greater gender equality, programs to address issue by describing the number of children in an ideal family unit
Marshall, 2017 [57] Kiribati	Strengths and gaps of SRH services	Report	Mixed method (n=14) community clinics and staff	Basic FP service provided at most community clinics No FP guidelines, lack of standardisation of care across all clinics Staff need further education to increase knowledge, confidence and skills to enable contraceptive choices
Marshall Islands Demographic health survey, 2007 [58]	Contraceptive use, knowledge, attitudes and behaviour	Report	Mixed method: 1,626 women aged 15-49 1,055 men aged 15-54	Contraceptive prevalence rate – 45% (married women), 37% (all women) Government is the main source of modern contraception. Services provided for free Almost universal contraceptive knowledge for men and women Common reasons for non-use are fear of side-effects, loss of fertility and desire for more children
Mody et al., 2013 [59] Asia-Pacific Countries	Impact of strategic partnership programs to improve evidence-based guidance	Program description	Multiple methods: Sample not provided	Key informants who provide information are often program administrators who may not be aware of the actual use of FP materials in the clinics Evidence based tools were used to improve training curriculum and materials in Pacific Islands and Territories FP guidelines and tools only effective if supplies to meet the increased demand are available

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
Morisause et al., 2017 [60] Papua New Guinea	*Contraceptive prevalence and barriers to using modern contraception*	Descriptive research	Mixed method (n=193) women of childbearing age 15-49 years	Service not culturally accessible Village health workers discourage use of contraception Low contraceptive prevalence, high unintended pregnancies and unmet need Lack of knowledge, staff attitudes, costs, stock availability Worried about side-effects, use traditional methods Husband/partner opposition, clinic too far
Naidu et al., 2017 [61] Fiji	Knowledge, attitudes, practices and barriers to safe sex and contraceptive use	Descriptive research	Cross-sectional study (n=1490) of rural women aged 18-75 years old who present to sexual reproductive health outreach sessions	Unmarried people had difficulties accessing service High knowledge about pregnancy and how to avoid it (>80%, but low knowledge about the practicalities of contraception (43%) Higher education level of women does not correlate with knowledge about emergency contraception and condom use and pregnancy prevention Barriers: partner disagreement, lack of contraceptive knowledge
Nauru Demographic health survey, 2007 [62]	Information on contraceptive use, knowledge and attitudes pertaining to contraception	Report	Mixed method: 667 women and 653 men aged 15-49	Contraceptive prevalence rate– 36% (married women), 27% (all women) FP service not integrated with other reproductive health services Wide knowledge of condom use High use among younger women and currently married men and lower use in women 35 years and older. Men are reported to use 4 male methods

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Lack emphasis on discussing FP issues due to lack of home visits Desire for more children is the common reason for non-use
Papua New Guinea Demographic health survey, 2016-18 [63]	Awareness and use of FP methods	Report	19,200 households selected from 800 census units. Women and men aged 15-49 selected for individual interviews	Contraceptive prevalence rate – 37% (married women), 33% (all women) Health facilities common places to source services and contraception. Free services from public sector Married educated women most users of service Men and adolescents have less access Common challenges: lack of knowledge, want more children, side-effects, hard to get methods and religion
Raman et al., 2015 [6] Solomon Islands	Barriers to adolescent SRH service provision	Descriptive research	Mixed method (n=147) teachers, school principals, youths & health workers	Services are theoretically available, but some services may be inaccessible due to cultural beliefs Unmarried people may not be offered contraception Lack of clarity in health workers role for adolescent reproductive health programs, social norms, shortage of resources (understaffing), lack of incentives, ambivalent attitudes, knowledge gaps Inadequate training for adolescent sexual reproductive health services
Robertson, 2007 [36] Pacific Island Countries	Repositioning FP as an integral development strategy	Discussion paper	Not provided	Global waning of FP services and emerging threat from HIV/AIDS Emphasis on FP diminishes High total fertility rate

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Under-reporting of contraceptive prevalence rates, no information on unmet need is available DHS data not available in most Pacific countries, prior to 2016
Roberts, 2007 [64] Fiji and Solomon Islands	Evaluation - design, efficacy and effectiveness of MIRH	Program description	Male workers: Solomon Islands (n=16), Fiji (n=21)	Concept of male involvement in reproductive health well received in Pacific countries but services lack strategies to deal with sensitivities in sexual health issues Need to measure unmet need for contraceptives Contraceptive prevalence rates need to be validated through demographic health surveys or related surveys in order to monitor progress
Rowling et al., 1994 [65], Solomon Islands	Family planning knowledge, attitudes and practices among married men and women of reproductive age	Descriptive research	Mixed method: (n=150) women 15-49 years, (n=90) male 15-54 years	FP service focuses on married couples, not available to unmarried couples regardless of age Women access service more than men Poor knowledge about reproduction Beliefs, cultural norms and distance influenced use of service and contraception
Samoa Demographic health survey, 2014 [66]	Contraceptive use, knowledge, attitudes, sources and attitudes	Report	Mixed method: 4,805 women aged 15-49 and 1,669 men aged 15-54	Contraceptive prevalence rate – 27% (married women), 17% (all women) Government sector is the main source of provider Contraceptives are free Women had more access than men Knowledge increase over the last 5 years, almost the same in both men and women

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Challenges: respondents and husband/partner opposition, religious beliefs, method related, health concerns and wanting many children
Solomon Islands National Statistics Office, 2015 [67], Solomon Islands	Information on fertility, FP, infant and maternal mortality	Report	Mixed method: women 15-49years (n=6226), men 15 years and above (n=3591)	Contraceptive prevalence rate – 29% (married women), 21% (all women) Contraception mostly provided in government/public sectors, few by private, faith based and non-government organisations. Service is mostly free High unmet need in rural than urban areas, high fertility rate and mortality rates Unmarried and young women and men have less access
Tonga Demographic health survey, 2012 [68]	Contraceptive knowledge, use, attitudes and sources	Report	Mixed method: 3,068 women and 1,336 men 15-49 years	Contraceptive prevalence rate – 34% (married women), 20% (all women) Women in rural areas more likely to use a method than urban women. Knowledge high among currently married women and men The government provided most services and contraception. Condoms distributed in clinic through peer educators. Services are provided free Reasons for non-use include: fear of side-effects, desire for many children, health concerns, husband/partner opposition and religious prohibition
Tuvalu Demographic health survey, 2007 [69]	Contraceptive use, knowledge, attitudes and behavior	Report	Mixed method: 850 women and 428 men aged 15-49	Contraceptive prevalence rate – 30.5% (married women), 23.1% (all women) Source mainly from public/government sector.

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				High knowledge in all women and men including unmarried sexually active men Reasons for intending to use contraceptives include fear of side-effects, desire for more children, health concerns, opposition by respondent and religious beliefs (fear of side-effects and desire for more children are common reasons)
UNFPA, 2004 [18] Pacific Island Countries	Progress at 10 years after ICPD	Report	Not provided	Pacific countries remain highly supportive of ICPD but progress in implementing its recommendations varied across the region Some countries developed population policies others have taken steps to prepare but not reaching implementation stage Less progress in integration of population into sector plans and strategies Most countries now capable of conducting a population census but the capacity to process, analyse, and interpret census survey results from policy perspective remains limited
UNFPA, 2009 [3] Pacific Island Countries	Progress at 15 years after ICPD	Report	Not provided	SRH not well coordinated and holistic due to vertical, fragmented and under resourced nature of programs. FP not reaching groups who need it High unmet need in older women, lifetime fertility remains above 4 children per woman in several countries Programs require renewed political support and innovative strategies to meet needs of disadvantaged groups

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Conduct more socio-cultural research on factors inhibiting use of FP
UNFPA, 2014a [21] Pacific Island Countries	Progress at 20 years after ICPD	Report	Not provided	Progress made but pace and extent varied greatly between countries Integrated and comprehensive approach to achieving SRH rights yet to be fully established Integration of population issues into education systems still under development High costs of transport because of remoteness of many communities, a significant barrier Effective stakeholder engagement and partnerships reported as common facilitators by governments To devote resources to research and understand behaviours of Pacific peoples so that programs on STIs, contraception, and FP are based on best evidence
UNFPA, 2014b [14] 15 Pacific Island Countries	Report - Summary of updated population and development profiles	Report	(n=6) reproductive health program officers	Social and heterogeneous culture in the Pacific Challenges differ among countries Very religious, sensitive issues challenging to discuss Weak statistics, high unmet need, high total fertility rate, low contraceptive prevalence rate below 62% average for developing countries
UNFPA, 2015a [70] Kiribati	Existence and use of relevant SRH services, policies and laws (rights)	Report	Mixed method: health facilities visited (n=16). Interviews and focus group discussions with (n=8) senior Ministry of Health	Service relies heavily on development partners funding, sustaining progress is a challenge. SRH policy still in draft Need to improve integration of service for both men and women. Poor service to outer islands

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
			officers, medical assistants and relevant non-government officers	A signatory to the international health regulations FP services observed to be available and accessible Issues include: understaffing, outdated policies/guidelines, inadequate reporting systems, fiscal and geographical challenges in outer islands
UNFPA, 2015b [71] Samoa	Existence and use of relevant SRH services, policies and laws (rights)	Report	Mixed method: health facilities visited (n=11). Consultation/interview with government and non-government health service providers, managers and technical advisors (n=33)	Has policy and remains committed to upholding sexual reproductive health rights. All health facilities provide FP service Samoa invests in youth focused programs/infrastructure Challenges include: cultural and attitudinal barriers at all levels (individual/communities; village/church leaders; school management committees; government ministries and service providers) and young people limited access to contraception
UNFPA, 2015c [72] Solomon Islands	Existence and use of relevant SRH services, policies and laws (rights)	Report	Mixed method: interview with the health sector officer (n=1), and non-government officers (n=6)	Contraceptives provided in most public sectors, few in private/non-government and faith-based organisations. Lack of integration in all SRH services No SRH policy available but uses the country's Reproductive Health Strategy Implementation Plan 2014-2016, HIV policy, and multi-sectoral strategic plan 2005-2010. Service less accessed by younger women and adolescents. Poor service delivery to outer islands Mixed progress in incorporating gender and rights into SRH agenda

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Economic issues, cultural and fiscal constraints, understaffing. Outdated policies and guidelines, inadequate health infrastructures, and poor reporting system challenges progress
UNFPA, 2015d [73] Tonga	Existence and use of relevant SRH services, policies and laws (rights)	Report	Mixed method: health facilities visited (n=14). Key informant interviews Ministry of Health (n=11), non-government organisations (n=4). Focused group discussions (n=4)	All facilities assessed provide range of SRH services (in clinic or outreach) including FP. Services are free No current SRH policy but National Integrated SRH Strategic Plan 2014-2018 guides SRH program Achieved mixed progress to incorporating gender and rights Challenges to improved access: understaffing, outdated policies; preventing stock-outs; no mentoring programs to monitor skills retention. Others include: geographical isolation, economic, cultural and fiscal constraints Actively conducted outreach programs through "settings approach" (schools, villages, workplaces, churches, daily talk back shows)
UNFPA, 2015e [74] Vanuatu	Existence and use of relevant SRH services, policies and laws (rights)	Report	Mixed method: key informant interviews: Ministry of Health service managers/providers (n=25); non-government organisations (n=5); partners (n=4)	Committed to upholding human rights of its citizens, evidence through national constitution and signing international conventions and treaties Reproductive health policy (2008) and strategy (2008-2010) is the guiding document for delivery of STI/HIV and FP

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
				Higher-level health facilities provide comprehensive range of SRH. Aid posts reported not meeting FP promotion Challenges: young and growing youth population; understaffing, outdated policies, inadequate reporting systems/processes
UNFPA, 2019 [75] Pacific Island Countries	The State of Pacific's RMNCAH workforce	Report	Not provided	Most countries have sufficient nurses to meet need for RMNCAH care but shortage of nurse-midwives Most have official policy to access RMNCAH care but out of date and not fully costed Barriers to service integration – staff shortage and need for further training Gender barriers significant, concerns about confidentiality in small settings Integration of youth-friendly RMNCAH services rare in the region
Vanuatu Demographic Health Survey, 2013 [76]	Contraceptive use, knowledge, attitudes and sources	Report	Mixed method: 2,508 women and 1,333 men aged 15-49	Contraceptive prevalence rate - 49% (married women), 38% (all women) The government sector is the primary source of service and contraception, service is generally free Use is high among currently married women and high wealth quintile Knowledge is high among currently married and those with 3 to 4 children Reasons for not intending to use: fear of side effects, opposition from respondent/husband/partner, fertility reasons and lack of knowledge

Authors/Date/ Location	Focus	Publication type	Methods/Sample	Key Findings
White et al., 2018 [77] Cook Islands	Social and contextual factors that inform contraceptive knowledge, attitudes	Original research	Qualitative study (n=10) women who were mothers before aged 20 years old	Access to contraception is not sufficient, rates of adolescent pregnancy remains the same despite availability of services Early sexual debut Insufficient and inaccurate knowledge about fertility and SRH services Beliefs about sexuality, sex considered taboo
Zaman et al., 2012 [78] Asia and Pacific Islands	Current situation of fertility decline and status of FP programs in selected countries in Asia and the Pacific	Report	Not provided	Initial FP were often embedded in economic development plans Some common characteristics across the Pacific but also great variation made it difficult to generalise. Analysis of Pacific programs showed a relationship between fertility transition and FP Some FP programs stalled, reversed or slowed down Adolescents faced largest barriers to the use of contraceptives for socio-cultural reasons

Results

After duplicates were removed, a total of 136 articles were identified from electronic databases and grey literature. Based on title and the abstract, 47 were excluded with 89 articles retrieved and assessed for eligibility. Of these, 44 were excluded for the following reasons: 16 studies did not focus on FP service provision; 13 papers were studies on SRH risks and behaviours; seven studies were from the DHS and MICS, which showed the same findings as the included DHS reports; four papers discussed reproductive health training and working frameworks and two papers were editorial and commentary. Another two studies were excluded because they were unable to be accessed. The remaining 45 papers, peer-reviewed (n=15) and grey literature (n=30), were reviewed in full (Table 1). Publication types were categorised according to the Sanson-Fisher typology (Table 1) [44]. The majority (80%) of these studies included Melanesian countries such as Solomon Islands, Fiji, Vanuatu and PNG and were mostly descriptive studies of limited quality, focused mainly on: knowledge, attitudes and barriers to FP; factors that influence use of contraception; and access to reproductive health services. Meaning units from included papers were identified and extracted to develop codes, categories and themes (S6 Appendix) [39]. Five themes were identified from the literature, as outlined below

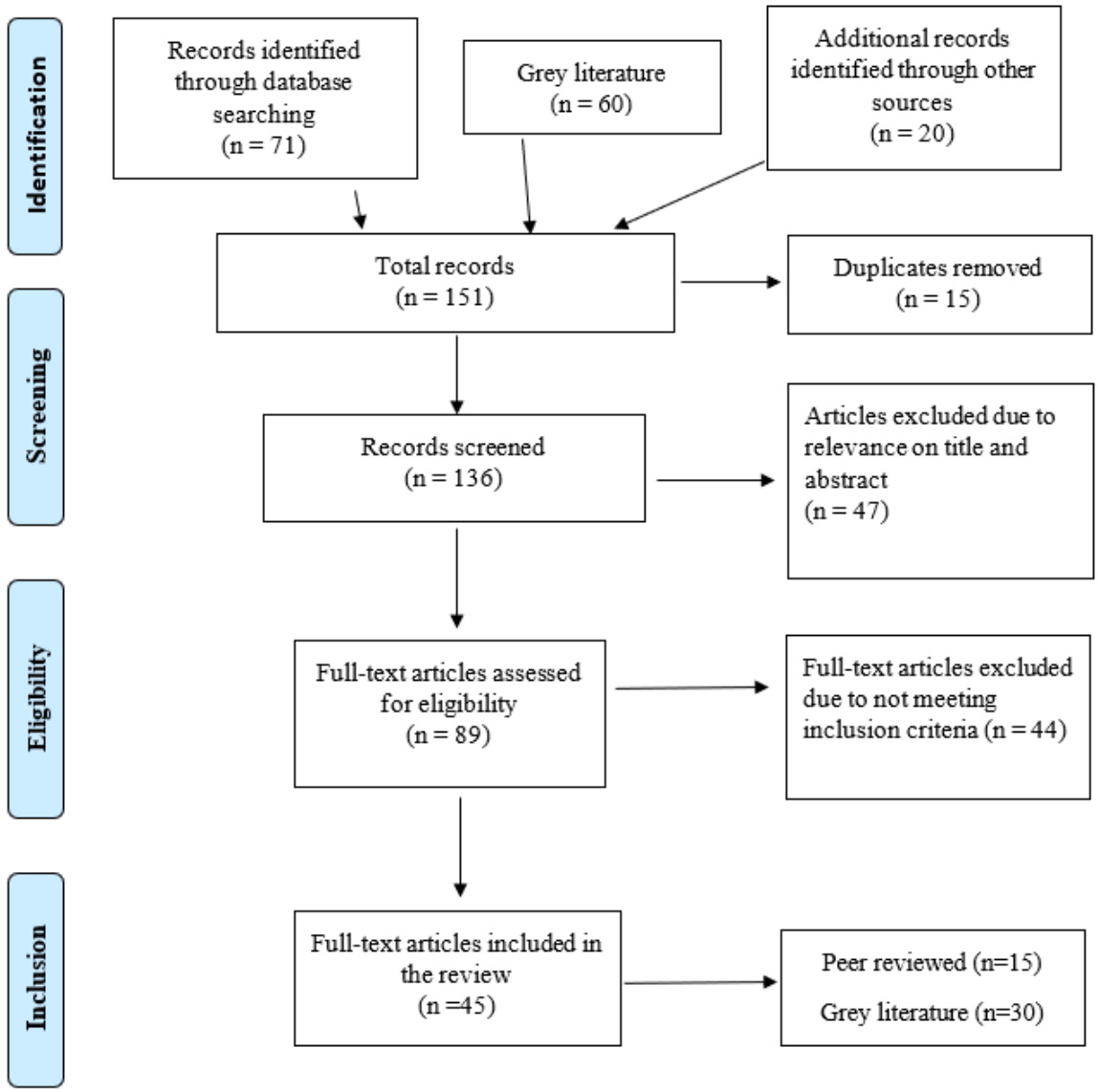

Figure 2: PRISMA flow chart for inclusion of articles [43]

Family planning services in the Pacific

Family planning services in the Pacific region were available in most health facilities. Thirteen papers [5, 45, 50, 53, 58, 63, 66-69, 72, 76, 79] described government operated public health facilities as the main provider where contraceptives are usually free. A further five papers [5, 52, 53, 67, 72] described services provided in a variety of venues such as family planning associations, non-government organisations (NGOs) and faith-based organisations (FBOs). In addition, FP services could also be obtained from private pharmacies and doctors working in private practices [50]. One paper reported people sourcing contraceptives from relatives overseas [53]. Overall, the most available way to access FP services was reported to be via the government public health system.

Pacific health facilities traditionally operated a once a week session for FP within the context of MCH/FP [34, 54]. This context now included RMNCAH, which means FP was made available along with other SRH services in the RMNCAH platform. Some settings also provided outreach RMNCAH to extend services to community villages [73]. Most health facilities in PICTs offered three to five modern contraceptive methods: oral contraceptive pills, long-acting reversible contraceptives (injectable and implant), intrauterine contraceptive device, condoms and permanent methods (vasectomy and tubal ligation). Emergency contraceptives are the least known and used method and not available in most health facilities. The use of traditional methods such as the 'rhythm' and 'withdrawal' methods were also reported but were not recommended because they were unreliable [36, 50]. The availability of these methods depend on the level of health facilities. Higher-level facilities like hospitals and urban centres often provide comprehensive options compared to community facilities like rural health clinics and aid posts where less options and expertise are available [57, 74].

Overwhelmingly, 18 papers [2, 6, 30, 34, 46, 49, 54, 55, 60, 61, 63, 65-67, 72, 76, 78, 80] reported that FP services provided were not always accessible to everyone. Services that provide FP were perceived as inconvenient, unsatisfactory, and not culturally sensitive [51]. Services were usually female oriented; men were not involved and often not targeted in educational awareness of safe motherhood initiatives [54, 55, 78]. Married women aged 20 to 35 were the most common cohort accessing FP services [2, 46, 55, 63, 65, 66]. Unmarried women or unmarried adolescents (12-19 years) [2, 55, 61, 65, 67, 71, 78], older women (over 40 years) [30] and men aged 15-54 [47, 49, 54] years were relatively neglected in FP clinics. Pacific countries with dispersed island populations and remote locations also received poor services [63, 70, 72]. Although the emphasis on providing services for outer islands and rural communities has been articulated, the actual implementation has varied depending on available resources and support including staffing, political commitment and logistic systems. Evidence about the extent to which FP services are reaching those who use the service and how the service was provided at the health facility level was lacking in the literature [30, 47].

Most PICTs are committed to upholding human rights and have adopted policies based on the principle of free and 'informed choice' for all couples and individuals [50]. Reports on the existence and use of relevant SRHR policies in five Pacific countries (Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu, [70-74] including ICPD progress reports, [3, 18, 21] showed some PICTs have used some form of SRH policies. Other PICTs have SRH policies in either draft form or under development. The incorporation of these policies into national strategies in PICTs occurred in varying degrees. These policies aim to provide an enabling environment where reproductive rights of women and men can be fully recognised and exercised. However, for those PICTs who have polices, most are outdated. In some cases, policies are not visibly available and approaches to FP shown to be ineffective [34]. For example, in Tonga, [73] there are no mentoring programs to monitor skills retention. In Kiribati [70] SRH care is not standardised across all health facilities due to lack of FP guidelines. Where guidelines and tools are available, they can only be effective if supplies to meet increased demand are available [59]. The UNFPA progress report [14] also highlighted that achievement of reproductive health rights are yet to be fully established in the Pacific region.

The integration of SRH, including FP within PHC service is part of the comprehensive SRH package prioritised in PICTs. Integration in this review refers to integration of population policies into sector plans and strategies and integration of FP services within the SRH platform at the program and health facility levels. Hayes and Robertson [50] reported most Pacific countries have incorporated reproductive health including FP into national and subnational development plans. However, assessments of SRH programs in some Pacific countries showed integration was not fully implemented [70-74]. There is less progress in the integration of population policies into sector plans [21]. At the program level, although the MCH/FP focus has changed to RMNCAH to enhance inclusivity for everyone, there is little focus on STIs including HIV, abortion, infertility, and adolescent health by FP clinics [57, 72]. Evidence also suggests that clinics for STIs, including HIV, are delivered separately from routine reproductive health clinics in some PICTs [14, 28, 55, 62, 63, 65, 68, 69, 72].

The availability of quality and relevant SRH, including FP data was a common and ongoing challenge in PICTs. Robertson [36] and UNFPA [14, 70, 72, 74] documented poor reporting systems

and processes that made it difficult to determine whether valid data existed for most countries. Prior to 2006, DHS were undertaken in only two countries in the region: PNG and Samoa. As such, the use of contraceptives could be under-reported. One example is the difference in CPRs reported in the DHS when compared to Ministry of Health (MOH) reports. This difference could be because women are accessing contraception from private pharmacies, private practitioner and other NGOs and this data is not routinely being captured in the national data [78]. Therefore, there is an urgent need to improve current reporting systems so that all parties communicate more effectively to produce an accurate reflection of CPRs in the Pacific context.

Information on unmet needs for contraceptives was not initially included [36]. The sociocultural and demographic diversity of PICTs made it difficult to interpret certain indicators and targets such as maternal mortality rates, within the context of very small populations. The disparities that existed across socio-economic groups contributed to the challenge of monitoring progress to achieve target goals [21]. While most countries are now able to conduct population census, the capacity to process, analyse and interpret survey results from policy perspectives remains limited [18]. Routine health information systems will need to be validated, and capture contextual issues, that can inform relevant policies and FP service outcomes.

Education, knowledge and attitudes

The education, knowledge and attitudes of FP service users was a common theme among the reviewed literature [2, 5, 6, 46, 48, 49, 53, 54, 56, 58, 61-63, 65-69, 76, 77]. The service user's knowledge about the different contraceptive methods varied across countries by education levels, gender, marital status, parity, age group, wealth quintiles and where they live. While it is expected that women with higher education levels (more than secondary education) are more likely to use contraceptives to delay pregnancy because they may have greater exposure to contraceptive knowledge and options, some exceptions and inconsistencies were reported [46, 48]. For example, some women were unaware of important information about contraceptives, such as the availability and use of emergency contraceptives and the use of condoms to prevent pregnancy [61]. Nine reports of DHS conducted in PICTs between 2007 and 2018 [53, 58, 62, 63, 66-69, 76] showed a consistent

result of almost universal contraceptive knowledge among married women and men above 40 years of age but lower knowledge levels in the unmarried and adolescent cohorts. Increased contraceptive knowledge was also seen in women with higher parity (>3) compared to women with lower parity (<2). Contraceptive knowledge according to wealth quintiles and rural or urban dwelling also showed inconsistent findings throughout PICTs. This knowledge is defined as having heard about a method, however, for adolescents, they lack knowledge about services and important information on pregnancy prevention, condom use, puberty, sexuality and relationships [2, 48].

Contraceptive use was relatively low in PICTs. Davis [49] and Naidu et al., [61] reported that having high contraceptive knowledge did not always translate to use of contraceptives and having heard about a method did not always influence individual decisions. For example, in Kiribati and Marshall Islands, contraceptive use was high among those with low or no education and lower among the highly educated populations, compared to Solomon Islands and PNG [53, 58, 63]. In Samoa, there was no difference by use in rural and urban settings, [66] whereas in Tonga, women in urban settings are less likely to use contraceptives than their rural counterparts [68]. In PNG, men's educational background increases the likelihood of women's use of contraceptives, and male literacy contributed to men's participation in FP [54]. The DHS reports included in this review [53, 58, 62, 63, 66-69, 76] further detailed that more than half of the men interviewed say they knew that their wives or partners used contraceptives, but only a few countries reported it was a joint decision. In addition, many women in PICTs (>70%) did not intend to use contraception in the future regardless of their knowledge of contraceptives. Contraceptive knowledge, use and attitudes will need to be understood within the respective PICT contexts before relevant strategies can be implemented.

A health worker's education, knowledge and positive attitude is essential to the success of FP services in PICTs. Health workers need education to increase knowledge, confidence and skills to empower couples and individuals to make informed contraceptive choices [57]. Marshall [57] and the UNFPA report on the Pacific's RMNCAH workforce [81] reported that not all health workers had adequate knowledge about the risks, uses and options for contraceptives available to women. There was also a lack of knowledge and skills to dispense contraceptives and how best to deliver FP services. This includes the ability to give appropriate contraceptive counselling advice; practical skills

to insert uterine devices or implants; and communicating with and managing adolescents [6, 48, 77]. This means planners in PICTs will need to explore if skill mix and task shifting will be beneficial in their context.

Some health workers also lack the training required and slowly abandon their moralistic attitudes to deliver effective adolescent SRH services [78]. In some PICTs contexts, even if training in FP was provided, negative attitudes and beliefs of health workers about contraceptives influenced whether the health workers promoted or discouraged adolescents from accessing the service and using contraceptives [5, 34, 60]. A recent report on the status of the RMNCAH workforce in the Pacific region [81] stated that most countries in the region have sufficient nurses who are competent to provide the RMNCAH care, including FP. However, there is also an overall shortage of nurse-midwives, and these healthcare workers will have multiple responsibilities additional to RMNCAH, meaning FP may not be prioritised or provided when needed. Adding to this challenge is the high staff turnover and the education and recruitment of RMNCAH workers, as many smaller countries did not have their own education institutions to provide this specialised training. For health workers working in remote areas, further training opportunities are often limited, therefore, the lack of training incentives also influenced the way health workers deliver FP services in PICTs.

Geographical isolation and access

Accessibility of SRH services in PICTs is a particular challenge due to geography and climate. These countries are predominantly sparsely populated, small island nations dispersed across the Pacific. Some remote geographical locations make access to family planning services difficult [2, 73]. The majority of the population in most PICTs live in rural, often isolated areas or atolls with limited infrastructure such as roads, electricity and running water [14, 21, 55, 70, 73]. Access to health services is often threatened by bad weather, rough seas for those who live in coastal islands and flooded rivers for those who live on large islands [60]. People survive on subsistence farming and fishing, and the health centre is often too far away to reach. Irregular supplies of medical equipment and drugs to the clinic can result in unavailability of contraceptives for women and men at point of need. The cost of travelling is expensive, and additionally prohibitive if people have to make return

visits to the health centre or if contraceptives are out of stock [3, 9, 13, 21]. Access to FP services depends upon the adequate geographical spread of health facilities and a health workforce supported by reliable transport and communication networks [81]. Therefore, reliable and updated information about the country's health systems and effective planning are important to address resource allocations to prepare for expected and unexpected adverse situations.

Socio-cultural beliefs, practices and influences

Most of the reviewed papers acknowledged the strong negative influence of socio-cultural and religious beliefs and practices relating to SRH issues in the Pacific [3, 5, 6, 14, 30, 34, 36, 46-49, 52, 54, 56, 58, 60, 62, 63, 65, 66, 68, 69, 73, 74, 76, 77]. Socio-cultural and religious beliefs and practices are very important to people in the Pacific. These beliefs and practices play a major role in community life, and the ubiquitous Christianisation of the Pacific by missionaries that enabled colonisation is associated with the idea of refusing contraception. [5, 60]. The common reasons reported in the literature as barriers to contraceptive use mainly rose from misconceptions, health concerns and a mixture of cultural and religious beliefs. Understanding and acknowledging these sociocultural influences is important to identify acceptable ways to reach people with FP services.

Although socio-cultural practices are seen to constrain progress in SRH including FP, [3] in some PICTs, culture is viewed both as a way to promote, as well as constrain, SRH [21]. This reflects the hyper-diverse culture in the three main ethnic groups: Melanesia, Polynesia and Micronesia [14]. For example, in Samoa, women hold important traditional roles in society and can promote FP. In Kiribati, men have the traditional role in taking care of their wives during pregnancy and childbirth; therefore, they will have already fulfilled the role of men as partners in reproductive health [21, 70]. In Solomon Islands, an 'O clinic' (Ovulation clinic) was provided for those who wish to use the natural methods for cultural, religious or health reasons. Such opportunities to promote FP will need to be further explored when dealing with constraining issues in the socio-cultural context in PICTs [34].

The physical layout of health facilities and how services are delivered present barriers to service access in some PICTs. Burslem et al., [46] and Kennedy et al., [5] reported that some health

facilities in Solomon Islands and Vanuatu, including those providing FP services, were considered not culturally suitable or accessible according to acceptable norms surrounding modern contraceptive use. These norms include gender-access issues, husband/partner opposition and beliefs that using contraceptives will encourage promiscuity, and use is therefore morally wrong for unmarried women and young people [34, 49]. One barrier that stands out in the reviewed literature is the culturally insensitive FP services that are not conducive for men or young people to access [36, 47, 49]. The gender of the service provider often affected men or women's access, and the lack of privacy and confidentiality was a common hindrance for young people and the marginalised groups [52]. While adolescents may have adequate knowledge about the importance of using contraception, they may be denied access because the service did not offer culturally appropriate options to ensure inclusivity [6, 46, 52, 55, 60].

The desire for many children is consistently described in the DHS reports, with men expressing wanting more children than women [53, 58, 62, 63, 66-69, 76]. Having larger families is an accepted cultural norm in the Pacific region. Children are valued as future social and economic gains and security [34, 50]. Although the number of children per woman in PICTs has been declining since the 1970s, one paper recently reported having three to five children was seen as ideal [56]. It is important to note that remnants of traditional practices and ideologies to limit fertility still exist in some Pacific countries. However, Hayes and Robertson [50] considered using traditional 'modes of reproduction' to encourage Pacific Island people to adopt family planning has not been an effective strategy. The reasons are many and complex, and can be traced back to the initial contacts with missionaries and later colonial authorities, which resulted in the criminalisation of some traditional population control methods such as abortion and infanticide; postpartum abstinence and abstinence from sexual activity during ceremonial events. However, Lincoln et al., [56] suggested, if future family planning programs could also address the number of children in an ideal family unit, this could potentially be a way forward to ensure contraceptives are acceptable in PICTs.

With the introduction of pronatalist policies by missionaries and colonial authorities, some earlier control practices were considered immoral. Formal laws regarding marriage, births and deaths were formulated, and most derived from the Christian 'laws'. One belief the church has instilled, that

has become a common religious barrier to contraceptive use, was that children are a "gift from God" and having more children is a good thing [50]. However, despite this barrier, some PICTs have found ways to deal with this belief. For example, in Kiribati, although faced with religious opposition, the injectable contraceptive Depo Provera was acceptable and commonly used by Catholics, as opposed to longer-term methods which are considered unacceptable [53]. In Vanuatu, traditional leaders and religious groups were becoming more accepting of reproductive health and rights [21]. Hence, opportunities can be sought in the diverse cultures of PICTs to promote acceptable strategies to deal with religious beliefs.

Potential enabling factors for improved family planning

Strategies to improve FP service provision and access in PICTs are outlined in nine of the reviewed papers [2, 36, 55, 59, 70-74].The importance of effective collaboration between government sectors, NGOs and private sectors was shown to increase access and avoid duplication of services. For example, adolescents in Vanuatu [5] prefer services provided by NGOs, as they were perceived to be more accessible, friendly and competent in helping people in this age group compared to government services. Integration of population policies such as SRH into other government sector plans were found to be beneficial in these small island states, where a lack of resources such as funding and staffing is prevalent [81]. Where contextual challenges such as cultural norms, religious obligations and geographic limitations occur, friendly service providers and context specific strategies are needed to implement relevant services [5, 47, 72].

Family planning education and health programs have been shown to positively influence contraceptive use. However, this review also identified that FP education in schools is underutilised in PICTs [2, 52, 57, 77] and there is a need to utilise peer educators, parents and schools to promote FP education in PICTs. Health education programs need to invest in a broad range of informational resources and utilise a multi-faceted approach to reach young people who are attending or not attending school and to reach other adolescents in both geographically isolated areas and urban settings [2, 52, 77]. In Tonga, a 'settings approach' to SRH program including awareness talks in schools, villages, workplaces, churches and radio talkback shows, was shown to improve young

people's knowledge about SRH services [73]. Reproductive health and FP education have been implemented in PICTs, but education materials need to be translated into local languages and presented in culturally sensitive ways [28, 59]. Different strategies are required for male, female, adolescent or mixed audiences. Attaining higher education levels and obtaining education on SRH and FP are not enough [49]. Evidence-based motivational interviewing and behavioural change action are required to meet individual contraceptive needs and deal with contextual barriers.

Educating and involving men in reproductive health has been a missed opportunity to improve services [49]. It is important to engage boys and men early in the reproductive life cycle [49]. Most RMNCAH care services in PICTs do not actively engage expectant fathers and fathers of young children. An evaluation of male involvement in reproductive health (MIRH) in Fiji and Solomon Islands [64] and a study of MIRH in PNG [54] showed an acceptance of MIRH in Pacific contexts, with MIRH seen as a key opportunity to break down cultural barriers and norms to accessing FP services and the use of modern contraceptives by women and men. A qualitative study [49] on perspectives of policy makers and practitioners in Cook Islands, Fiji, PNG, Solomon Islands and Vanuatu also noted that the inception of MIRH prompted men to appreciate their role in FP and to better support their wives. However, context-appropriate strategies are needed for health service providers to engage men and deal with sensitivities relating to culture when discussing sexual health issues with them [36].

The increasing youth population and their early sexual debut in PICTs compared to other world regions suggest that this group warrants more attention [52]. Adolescent-focused services have been recently implemented but these lack culturally sensitive approaches, confidentiality and privacy [81]. In rural communities, engaging community gatekeepers in education awareness is vital [57, 73]. This will enable community involvement in distributing SRH information and extending FP awareness. Overall, FP needs further research to understand the changing behaviours of Pacific peoples so that SRH care including contraception service approaches are based on current evidence for PICTs [21, 45].

Discussion

This is the first scoping review to explore and summarise the provision of FP services in PICTs. The results provide a baseline for researchers, policy makers and program managers as they seek to implement relevant strategies to improve FP services in the Pacific region. This review shows that PICTs did not follow the expectation of the standard demographic transition model. The transition from high to low fertility and death rates and increasing CPR did not translate to economic progress [78, 82]. Growing environmental pressures including urgent threats of climate change compound new challenges to population growth, increasing urbanisation and migration from rural to urban centres [83]. While some common characteristics are seen across PICTs in the provision of FP, progress and challenges, there are also great variations and diversities in country contexts, which make it difficult to generalise across countries. This is consistent with the WHO and UNFPA reports for LMICs [7, 29].

Since the ICPD, FP services in PICTs have been provided by government public health systems; while typically free of charge, FP services are not accessible to everyone. Subsequent reviews of ICPD progress [3, 18] revealed inequitable access to FP provided from health facilities. Men, adolescents and geographically marginalised groups including those on outer islands, are still not adequately reached [21]. The increasing growth in the youth population and a consistent lack of access to service among this group in PICTs warrants an urgent review of individual country strategies to reposition FP in country contexts.

At the political and policy levels, there is strong support and commitment for SRHR among PICTs and most have an official policy to guide SRHR implementation. However, these political commitments and policies have had little impact on achieving reproductive health and rights for PICT populations. This could reflect the ongoing global controversy about SRHR [84]. There are also possibilities that either research evidence has not informed current policies or health workers were not aware of existing policies. This is consistent with a study in PNG [85] where most health workers had not viewed official policy or statements about HIV.

Funding issues, contextual factors, staff shortages and the need for further training are ongoing challenges faced by PICTs and other LMICs [86, 87]. At the program level, many reproductive health programs have worked in "silos" (working in isolation, not sharing information, goals, priorities or processes) rather than integrating with other SRH services (for example STI services and FP) [72]. Existing strategies such as the RMNCAH to integrate family planning into other SRH services are not fully implemented [72]. This requires country-specific strategies to evaluate what may work best in each context. In addition, the inadequate reporting systems in PICTs raises the question of the quality of data that reports SRH and FP indictors. The targets or goals could be too ambitious for these small developing states to achieve. For example, patterns of unmet needs for FP and CPRs varied so much across PICTs that it was necessary to take a country-by-country approach [88].

Health workers often lack appropriate knowledge about FP services [14]. Staff numbers, skills and resources including funding remain inadequate [89]. Strategies such as skill mix and task shifting have been found to alleviate workforce challenges and skill mix imbalances in low income countries [90]. It is essential to engage and collaborate with local community leaders and women's groups to empower the community, as they know what is required to inform strategic planning to enhance universal access. One program in Fiji demonstrated the power of moving out of silos in health settings and engaging community members [91]. This empowerment program including workshops attended by disempowered young mothers was conducted in a rural community with high rates of teenage pregnancies and low contraceptive use. Topics such as reproductive health and rights, available support services, networking and financial literacy were presented. The results revealed a 30% increase in uptake of SRH services and young mothers were motivated to make positive changes in their lives [91].

The PICTs are culturally and spiritually diverse, and this needs to be taken into account when planning and delivering health services. This diversity is reflected in the way men participate in FP and how health workers deliver services. In most PICTs, the negative attitudes of some health workers and service users towards FP and modern contraception have widened the gap between knowledge and practice [6, 61, 77]. These attitudes are mainly influenced by the socio-cultural and religious

beliefs of people. A study on community influences on young women in LMICs concluded that young women's contraceptive decision-making is greatly shaped by their social contexts [92].

However, cultural shifts in societal attitudes observed in some PICTs may facilitate progress [88, 93]. In Vanuatu, village leaders are now more open to discussions about SRH and young people are more receptive to information, so this can be a potential way to explore how to deal with cultural and spiritual barriers to access [21]. Culture and religion influence access to and use of contraception and could serve as barriers. Unexpectedly, we found PICTs have experienced situations when religion and culture could support a process towards FP [78]. For instance, the Catholic Church policy may not promote the use of modern contraception but international evidence suggests that people who identify as Catholic do make use of contraceptives [94, 95]. Although patterns of unmet need in contraception varied among PICTs, analysis from DHS reports showed that the main reason for high unmet need was not access but 'unwillingness' arising from fear of side-effects, health concerns and some form of socio-cultural opposition [10, 78]. This means DHS reports may need further analysis.

The relationship between education and contraceptive use is inconclusive in PICTs. As evidenced in the literature, despite several decades of FP programs including information, education and communication (IEC) campaigns to improve knowledge and awareness of contraceptive methods, women continue to report lack of knowledge and fear of side effects [60, 61]. In addition to providing relevant and simplified IEC materials to increase understanding, spousal communication and male involvement in decision–making can positively influence FP use and continuation [96]

Education alone is not enough; dealing with barriers in a culturally sensitive manner may reduce socio-cultural issues. A study based in Timor-Leste and PNG revealed that although men had good knowledge in some areas of SRH, their attitudes regarding gender roles and violence against women reflected the social norms of more patriarchal societies [97]. In these settings, most men view the husband as the primary decision-maker, and a small percentage of men surveyed believed it was acceptable for a husband to beat his wife. However, in another study conducted in rural PNG, young men were more receptive to biomedical information than older men, and were more likely to engage with health services directly and support their wives to use implants [98]. In PICTs, men's involvement showed improvement in women's access to FP services, but culturally appropriate

strategies are needed to ensure universal access by men. Achieving gender equality in SRH will require strategies to be explored for their applicability and sustainability in local settings.

The ways that health services are delivered and the location of FP clinics are causes for limited access. A recent study from a setting that holds strong cultural taboos in reproductive issues in Solomon Islands showed that the FP clinic could not be accessed because of its location and how it was made available [99]. Inappropriate models of service delivery were identified in this review, such as service providers' insensitivities to different cultural, social and gendered groups. Furthermore, evidence shows that adolescents do not want a separate clinic, only a friendly service provider who is non-judgmental and assures confidentiality [5, 48, 52, 57, 61, 100]. A review of confidentiality in FP services for young people by Brittain et al., [101] concluded that further research should consider how to best educate young people and providers about state-specific laws related to adolescents and confidential healthcare services, as there is limited research on the relationship of confidentiality and reproductive health outcomes in young people.

The PICTs are culturally and geographically diverse and one approach does not fit all, but there is potential for change at the health service level and for contextual approaches to FP to improve service and access to contraceptives. Given that women in PICTs have more options of modern contraceptives than men, further studies are needed on strategies to enable men in PICTs to fully engage in decision-making regarding the number of children, to ensure universal access.

The following recommendations are based on the evidence presented in this review:

1. The rights-based approach to SRH, including FP, as outlined in the ICPD program of action [29], needs to be culturally contextualised in PICTs.
2. Current approaches to service delivery need to reflect the reproductive and contraceptive needs of users and potential users of the service.
3. Appropriate and relevant community engagement, education and awareness tailored to meet community needs is required.

Limitations

We found limited peer-reviewed studies conducted on FP service provision in most PICTs, therefore the results in this review may not represent and reflect issues for each PICT. The scoping review methodology may not have identified all sources. Results as reported could be limited by the methodological quality of the articles, as the majority of papers included are from the grey literature. The quality of data analysed in the papers may be of low quality given the challenges of poor reporting systems and incomplete data available in PICTs. Hence, reported literature may not give an accurate and clear picture of the situation in all PICTs.

Conclusion

Family planning services in PICTs do not reach many people: a person's age, gender, marital and social status, religion, ability or proximity to health centres can impact access to FP services. If this trend continues, universal access to reproductive health services including FP will be an ongoing challenge. The higher education level of girls, high contraceptive knowledge and mostly free services in PICTs do not necessarily lead to increased use of modern contraceptives and access to FP services. Many contextual challenges remain in each Pacific country and territory in terms of both supply and demand side of FP and SRH services. Considering the heterogeneous cultural diversity of PICTs, generation of local evidence is crucial to make relevant and sustainable improvements in service delivery. Further research is required to understand availability, accessibility and acceptability of current FP services to meet the needs of people of different genders, age groups, and social and marital status to inform FP services in PICTs that leaves no one behind.

Acknowledgement

The authors would like to thank James Cook University Librarians, for assistance with database literature searches and Endnote software referencing and Dr Karen Cheer for editing the manuscript.

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2.3 Chapter Summary

The scoping review findings showed FP services are available in most health centres in PICTs, yet not everyone is able to access the services available. Many contextual challenges exist; however, there is potential for enhanced access and acceptance of FP services, including contraceptives, at the health clinic level if context-specific strategies are applied.

In the next chapter, I outline and describe the methodology and methods employed to conduct this PhD study. Figure 3.1 is the thesis structure showing the methodology and methods chapter in the thesis.

Chapter 3: Methodology and Methods

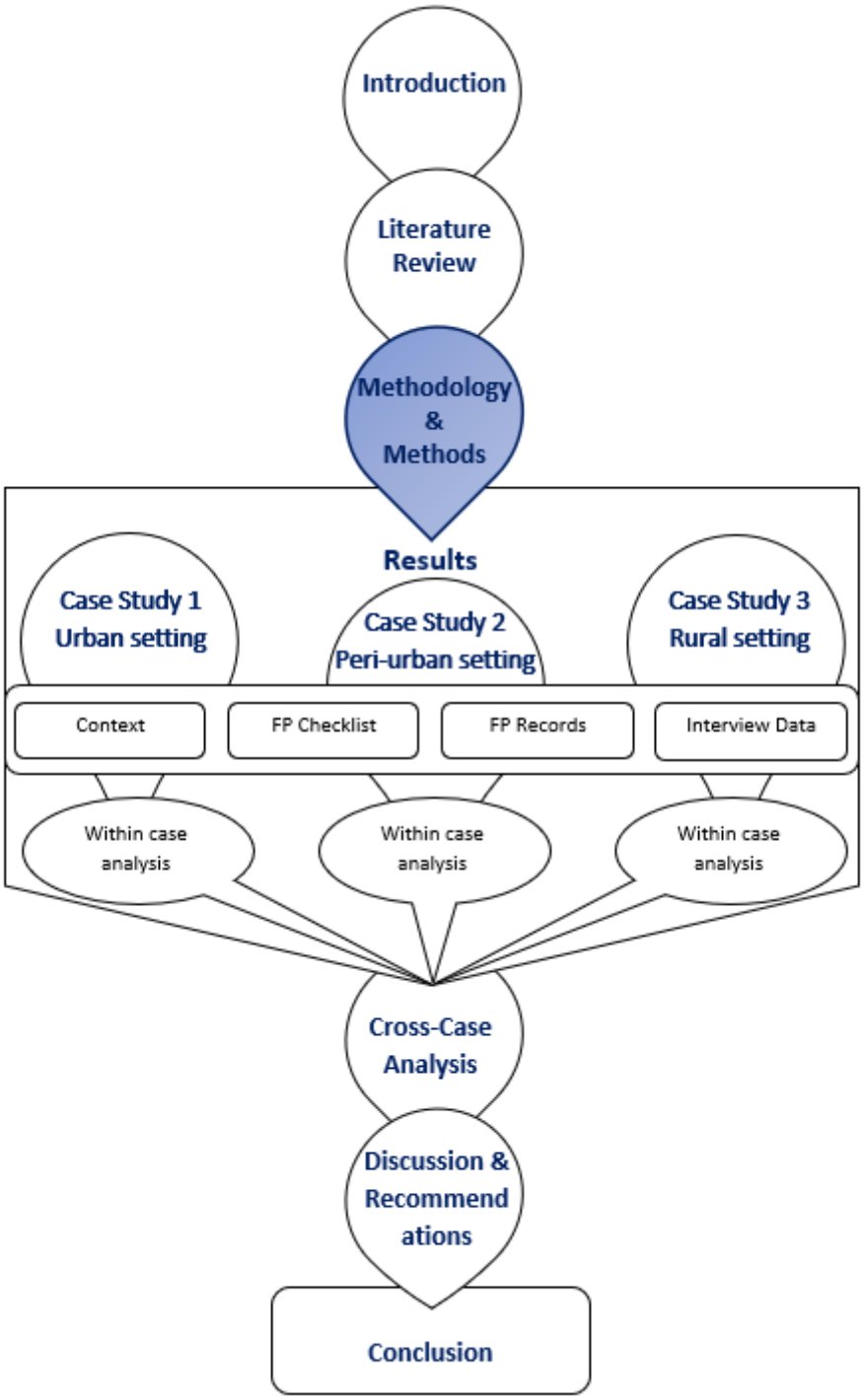

Figure 3.1. Thesis structure—Methodology and Methods

3.1 Chapter Outline

Applied research is facilitated to create new knowledge about identified issues or problems that require solutions. Research methodology is informed by broad assumptions about how knowledge is created, while research methods are the detailed steps taken to implement research. Application of research methodology and methods informs findings about the reality of the problem and possible solutions (J. W. Creswell, 2014). This chapter explains my philosophical position in this research, explores why I used a pragmatic approach underpinned by an Indigenous worldview, examines my choice of case study methodology as a relevant methodology for creating new knowledge about FP, and outlines how I selected the three case studies. In addition, I report methods of data collection, use of language in interviews, sampling and recruitment, ethics approvals and steps taken to process and analyse data.

3.1.1 Research Philosophy and Worldview

Research is a planned activity that involves systematically generating new knowledge that can be used to provide answers to health problems or evidence for healthcare practice (Liamputtong, 2017). As researchers, our reality is shaped by previous experiences, educational background, culture and social influences (Mills & Birks, 2014). Before we start research, it is important to examine our worldview including the assumptions we have about reality (J. Creswell, 2013). Worldview is a belief that guides action (Guba, 1990) and inform what we believe as real in our natural or social world, and where we fit into this reality for knowledge creation (Denzin & Lincoln, 2005). These insights influence how we undertake our research and interpret research findings (Mills & Birks, 2014). Philosophy means ‘the love of wisdom’; it is the study of ideas about knowledge and how one makes sense of the world based on their worldview (J. W. Creswell, 2014). Philosophy can be understood in many ways. In research, philosophy can also be understood as ‘how one views the world encompassing the questions and mechanisms for finding answers that inform that view’ (Mills & Birks, 2014, p. 18). These philosophical assumptions are variously understood as worldviews (J. W. Creswell, 2014; Polit & Beck, 2018) and paradigms (Mertens, 2010).

Worldview can be understood using three major concepts: axiology, ontology and epistemology. In the next paragraphs, I describe the application of my worldview in this research. In this thesis, worldview and paradigm are used interchangeably when discussing philosophical assumptions about knowledge creation.

Axiology is the role of values in research (Redman-MacLaren & Mills, 2015). As a researcher, I bring my own values to the research; therefore, it is crucial that I make my values explicit so that my position in the research is transparent and known to myself and others (Mertens, 2010). I am a Pacific Islander woman raised in the Christian faith. I grew up with strong adherence to my cultural and religious values in a collective society. The people in my community are considered my immediate family and we depend on each other in a communal living setting—hence my desire to care for them and others like them so that they receive equitable FP services. The values of community, faith, respect, culture, service, fairness, collaboration and compassion underpin my position as a researcher.

Ontology describes the nature of beliefs about reality (Mertens, 2010; Richards, 2003). Ontology includes assumptions about what is true; whether one believes in one verifiable truth (realist) or that there are socially constructed multiple truths (relativist) about the world around one (Charmaz, 2014; Mertens, 2010). My ontological assumption is that there is one truth about the use of contraceptives that comes from my profession (informed by a science-based health degree), which is more aligned with a realist or positivist approach. However, I acknowledge that just like the service providers, service users and non-users in this study, my realities may differ from each of theirs in relation to the use of contraceptives, depending on values, beliefs and experiences (Mertens, 2012).

Epistemology explains how knowledge is created, validated and communicated to others (Birks & Mills, 2015). Knowledge about research has evolved over the years as have the worldviews that underpin research activities (Mertens, 2009). There have been shifts from predominantly scientific methods of knowledge creation to acceptance of socially constructed knowledge (Guba & Lincoln, 2005; Mertens, 2009). Epistemological worldviews have evolved over time. A brief discussion follows on the five major epistemological worldviews: 1) positivism, 2) postpositivism, 3)

constructivism or interpretivisim (Denzin & Lincoln, 2005), 4) the transformative position and 5) pragmatism (J. W. Creswell, 2014; Mertens, 2009).

Positivism assumes that an objective world exists; reality is independent of experience; and the researcher is not part of the research process, employing an objective approach to data collection and analysis (Polit & Beck, 2018). Postpositivism emerged from 19th century researchers who, while retaining a focus on empirical data, challenged the belief of absolute truth of knowledge (Philips & Burbules, 2000) and argued that positivists cannot objectively claim the knowledge when they study the behaviour and actions of humans (J. W. Creswell, 2014).

With constructivisim or interpretivism, Charmaz (2002) posited that reality or knowledge is not fixed and can be co-created from people's experiences when interacting with them in their social, cultural and structural contexts. This means that some knowledge may exist within multiple realities through different experiences, and it is important to understand the context or setting to interpret findings. In constructivism, the researcher is a participant in the research process and seeks to explore and understand from a subjective perspective (Charmaz, 2014).

The transformative worldview arose in the 1980s and 1990s (J. W. Creswell, 2014) among researchers who saw that postpositivist assumptions have not considered the marginalised group or individuals in their society as reflected in their beliefs. Hence, the transformative worldview focuses on groups or individuals that may be marginalised or disenfranchised. These researchers advocated for addressing issues for social justice and employing politics to bring about change (Mertens, 2010).

Pragmatism comes from the work of Peirce, James, Mead and Dewey (Cherryholmes, 1992) and others (Patton, 1990; Rorty, 1990). It is about the application of strategies that work to solve problems (Patton, 1990). Researchers in a pragmatist worldview emphasise the research problem and they can choose multiple ways the research problem could be understood (J. W. Creswell, 2014). Between the perspectives of positivism and constructivism lies pragmatism. It is the middle ground between these two worldviews (Liamputtong, 2017). Pragmatism (Bazeley, 2021) is underpinned by the worldview that an individual's social experiences influenced the way they see their world and knowledge is based on this experience.

Pragmatists accept that single or multiple realities (truths) can be investigated or observed as they happen in the real world (J. W. Creswell, 2011).

3.1.2 An Indigenous Worldview

Within Indigenous epistemology, Gegeo and Watson-Gegeo (2002), Sanga (2004) and Smith (1999) posit that knowledge claims are always socially and culturally situated, rather than universal. This means knowledge is created in a certain situation by a group of people. It may or may not be universal in nature but is always created contextually. Therefore, it is assumed to be relative, inseparable from the context and represents the social realities of people living in that context. In this PhD study, epistemology questions what I thought I knew and what I now hold as new knowledge having undertaken this research. Complementing a pragmatic approach (Bazeley, 2021) and drawing from perspectives of Indigenous methodologists such as Tuhiwai Smith (1999) and Maggie Kovach (2010), as well as Pacific scholars (D. W. Gegeo & Watson-Gegeo, 2002; K. F. Sanga, 2004), I learnt that as an Indigenous researcher conducting research in my own context, it is important that I examine and reflect on the worldview that I carry into my research. There is no "one" worldview held by everyone in Solomon Islands. People have their own worldviews depending on where they come from and where they live. People's worldviews are also influenced by external forces such as colonisation, as expressed through, for example, the Western-influenced systems of governance, education, and Christianity. There are common shared values such as collectivism and wantokism that are demonstrated in mutual respect, reciprocity and relationships among Indigenous people (D. Gegeo, 2001). My cultural obligation as an Indigenous researcher is to respect and adhere to existing systems and processes in the context I research and to maintain our shared values.

As a Pacific woman I grew up in a patriarchal colonised society and was educated in a Westernised education system. Therefore, I need to have a critical understanding of the underlying assumptions, motivations and values that inform how I conduct the research to ensure that my analysis is explicit and consistent with my worldview. While I may not need to address specific gatekeeping issues, I still need to uphold my cultural and ethical values that centred on maintaining respect, reciprocity and relationships as an Indigenous researcher. A reflection on my rural upbringing

in Solomon Islands has helped me understand my ways of knowing, being and doing (Bazeley, 2021), including the challenges and opportunities I have encountered as an Indigenous Solomon Islander woman.

However, sometimes I do not see issues as problems that need solutions, instead accepting that some things will always remain the same. This is the challenge, I realise, with colonial-informed thinking. Also, as an insider outsider researcher, I have identified myself as a FP service provider and service user in the research context, and an outsider as a PhD scholar examining this phenomenon. To balance my insider and outsider position, it is important that I declare my position and demonstrate that I am genuinely interested in my research participants experiences (Dwyer & Buckle, 2009), as well as assuming that I have much to learn about the individual's experience and remaining reflexive throughout the research (Adler & Adler, 1987).

Consistent with Indigenous Pacific views on axiology, ontology and epistemological stance, truth is value bound because it is historically and socially set. Hence, ways of describing knowledge and reporting must allow for backgrounds and multiple realities, and must capture contextual processes, which aligns with constructivisim (K. F. Sanga, 2004). Indigenous ontology views reality as subjective to the context and people (Watson-Gegeo, 2016). This is expressed in people's experiences in their social, spiritual and cultural worlds. Therefore, the values (axiology) and worldview (ontology) that I brought into the research process shaped my beliefs about reality and my ways of knowing (epistemology). These determined the approach (methodology) I have taken to create knowledge in my research study.

3.1.3 A Pragmatic Approach

Pragmatists argue that reality exists not only as the natural and physical world but also as psychological and social realities (Bazeley, 2021). That knowledge can be generated from diverse sources and in many ways through different research methods (Liamputtong, 2017). As pragmatism assumes that knowledge is based on experiences that happen in the real world in which people live, pragmatism supports the use of both positivism and constructivism paradigms in generating research knowledge (Mertens, 2012). This assumption is expressed in situations where, whenever problems are

uncovered, solutions do exist and can be trialled and evaluated (Liamputtong, 2017). Furthermore, pragmatism proposes that researchers can use philosophical and or methodological approaches that work best for the problem being investigated (J. W. Creswell, 2014; Tashakkori & Teddlie, 1998). In this PhD study, knowledge about FP service provision is obtained from health science and the lived experiences constructed by FP service managers, providers, users and non-users.

3.2 Methodology

Methodology is the approach to knowledge creation. It is 'a set of principles and ideas that inform the design of a research study' (Birks & Mills, 2015, p. 4). A quantitative or objective methodology takes an objective approach to reality and data collection whereas qualitative methodologies aim to uncover the meaning of phenomena experienced by people from a subjective perspective (Mills & Birks, 2014). With a pragmatic approach to research, I collected both quantitative and qualitative data, as both data sources were required to fully address my research aim and objectives.

Indigenous methodologies assume that research methods and strategies focus on obtaining contextual details, insider perspectives and particularities as they unfold during investigation (Kovach, 2010). Strategies that are qualitative in nature—such as storytelling and the use of thick descriptions—are important characteristics of Indigenous approaches as they ensure active participation of insiders and allow for multiple truths to be identified and captured, and for voices to be heard (K. F. Sanga, 2004). In this research, given that I was working in a health service system where quantitative and qualitative data were available, I sought to bring together all evidence available about FP from the health service setting and from participant experiences to capture a complete story about FP in the context the service provided.

3.2.1 Choosing the Research Methodology

The research methodology chosen in this study helps to achieve the research aim and objectives and is congruent with my philosophical position. Methodological congruence occurs when there is alignment in the researcher's philosophical position with the research aim and the methodological approach employed to achieve these aims (Mills & Birks, 2014). Methodological

coherence can occur with attention to this alignment even if using multiple paradigms or worldviews in the research (Tracy, 2010).

The need to understand how FP is provided in specific settings was important to improve service provision. I chose a case study design to enable me to look deeply into the issue and use a variety of data collection approaches. I believe the accepted truth about FP services provided from the health facility must be compared with socially and culturally constructed beliefs about FP held by users and non-users to gain a more contextualised knowledge about FP services in each setting. Thus, a multiple case study design was selected as the appropriate methodology to understand how FP services were provided across three sites in Solomon Islands.

3.2.2 Case Study Design

Case study research is 'an empirical inquiry that investigates a contemporary phenomenon in-depth and within its real-life context … when boundaries between phenomenon and context are not clearly evident' (Yin, 2018, p. 18). Previous understandings of case study research as both a methodology and method have led to ambiguity about what a case study entails (Harrison, Birks, Franklin & Mills, 2017). In the literature case study is also referred to as as an approach, a research, research design, research strategy or a form of enquiry (Brown, 2008; Merriam, 2009; Stake, 2006; Yin, 2014). The mixed use of terminology has been confusing for some researchers, 'given the definitional separations between methodology and methods and the varied application of case study in research endeavours' (Harrison et al., 2017, p. 7).

Furthermore, case study design can be adapted in multiple paradigms and is not fixed to a particular philosophical position (Rosenberg & Yates, 2007). Thus, prominent case study researchers such as Merriam (2009), Stake (2006) and Yin (2014) have emphasised that case study researchers will need to describe what underpins the methodology they use and how it aligns with their philosophical assumptions and the methods they choose. This provides the opportunity for researchers to decide on the methodological orientation (Harrison et al., 2017) that aligns with the purpose of their inquiry.

Although case study design has been criticised for its lack of rigour and the ability to generalise findings (Creswell, 2013; Edwards, 1998) it is a trustworthy form of research and is useful when executed with sufficient rigour and quality and when multiple methods and data sources sources are used (Lincoln, Linham & Guba, 2011; Mills & Birks, 2014). In this research, case study design was selected as the appropriate research methodology to understand how FP services are provided, to describe FP activities in the context in which they occur and to identify opportunities that are available to improve FP service provision.

3.2.3 Case Study—an Appropriate Choice

To address the research aim and objectives, I chose the Yin approach to case study design (Yin, 2014, 2018). This approach was chosen over those of Merriam (1998, 2009) and Stake (1995, 2006) because it advocates using more than one method of quantitative and qualitative data collection and analysis, consistent with a pragmatic paradigm (Bazeley, 2021). While all three scholars recommended drawing data from multiple sources, Yin (2014) supported both qualitative and quantitative approaches to how case study can be developed and describes three ways it can be implemented: explanatory, exploratory and descriptive case studies, with an intention that data can be reproduced in similar settings. He emphasised using multiple methods so that errors can be overcome by comparing different data sources (triangulation) in interpretation, to enable understanding of a phenomena as it happens within its real context (Lincoln et al., 2011). This approach is aligned with my pragmatic Indigenous worldview where I sought to understand provision of FP services in a biomedical setting as well as exploring how people experience the services in their cultural contexts.

Merriam (2009) maintained a constructivist approach and assumed that reality is constructed when people interact with each other in their social world and in what they experience during their interaction. In agreement with Yin (2014), Merriam asserted that processes for data collection, analysis and reporting must be clear and applicable to the results. However, Merriam gave weight to the constructivist inquiry, as seen in her exclusive use of qualitative data (Harrison et al., 2017; Yazan & Vasconcelos, 2016).

Stake (2006) took this constructivist approach a step further by centralising story telling as the way to collect data. As opposed to Yin (2014), Stake did not support the use of quantitative data because his version of case study design was exclusively qualitative and aligns with a constructivist orientation. Although Stake recognised the use of multiple data collection method and analysis, interviews and observations were preferred as the main data collection methods. Stake's use of vignettes such as episodes of storytelling and use of thick descriptions to convey findings demonstrated his exclusive use of qualitative data (Harrison et al., 2017).

Informed by Yin's (2014) approach to case study design, I facilitated multiple methods of quantitative and qualitative data collection in a multiple case study design.

3.2.3.1 Multiple Case Study Design

A multiple case study research design is used when more than one case is included in the case study. One of the purposes of a multiple case study design is to replicate the study so that individual case study findings can be compared, to help understand and answer the 'how' and 'why' about a phenomenon under investigation. Yin (2018) described multiple-case designs as holistic or embedded. A holistic design involves a single unit of analysis within the case that can be compared with other cases, whereas an embedded design focuses on the subunit level—for example, within the case—and cannot be brought to the larger unit of analysis and replicated. I chose to employ a multiple case study (holistic) approach given the diverse sociocultural contexts and levels of healthcare centres that provide FP services in Solomon Islands. This approach allowed for deeper understandings and comparisons across diverse settings. Table 3.1 outlines the philosophical underpinning of this research.

Table 3.1 Philosophical Underpinning, Adapted from Mertens (2012)

Philosophy underpinning this research	Characteristics
Axiology (values)	Caring, equity, social justice
Ontology (nature of reality)	Pragmatism

Epistemology (how knowledge is gained)	Positivism and constructivism (knowledge can be described and can be co-created)
Methodology (principles that inform steps taken to gain this knowledge)	Case study (Yin informed approach) underpinned by Indigenous methodology

3.2.3.2 Case Selection and Definition

I commenced this research study as a MPhil candidate in August 2018 at JCU. The original research design with the masters-level project had two case study sites, represented in the thesis as Case Study One and Case Study Two. In February 2020, I successfully completed the required milestone to upgrade to the PhD degree. At this time an additional case study site was added, represented in the thesis as Case Study Three.

FP and contraceptive services are available and provided at all levels of health clinics throughout Solomon Islands; however, the uptake of contraception is low. Many women experience pregnancy complications and some die from childbirth complications. There are also increasing pregnancies among young adolescents, which could be prevented by using contraceptives. I purposely selected settings and clinic types that represent all levels of healthcare service delivery in Solomon Islands, and the phenomenon is FP service provision.

A case in this study is defined as a health clinic facility that provides FP and/or SRH services. Participants recruited for interviews were service providers who provided FP or SRH services in a clinic and were posted as permanent staff, or community members of reproductive age (both users and non-users of health services) in the clinic's catchment area. Visitors were not included in the case. This definition ensured that the perspectives shared reflect the reality of the context.

The three case study sites selected represented different facility levels, providers and locations. Case Study One was a government-operated urban FP clinic service located in Honiara City. Case Study Two was a FP clinic operated by an FBO in a peri-urban setting in the Western Province. Case Study Three was a FP clinic in a rural (village) setting in Isabel Province and was also operated by the government.

3.3 Methods

Methods are practical steps that are followed to generate (create) and analyse data (Birks & Mills, 2015). Quantitative and qualitative data were collected so that a diverse range of information was available to help understand the phenomenen (Creswell, 2011; Liamputtong, 2017).

3.3.1 Data Sources

In this study, data were collected from four sources.

1. context—information about the study setting (context of the case)
2. audit of FP clinic services using a validated checklist tool
3. review and audit of clinical records and reports between 2015 and 2019
4. qualitative interviews—semi-structured interviews with service managers, providers, service users and non-users.

Context data were gathered through talking to service managers and providers, my existing knowledge about the setting, ethnographic observations during field visits (including written memos) and reports and background information available about the settings. Information about the context is included in the *setting and context* section under each case study result chapter (Chapters 4-6.

The second data source was an audit of the FP service using the *WHO FP/HIV Integration Quality Assurance Tool* ('the WHO tool'; Appendix 1) and adapted to reflect the *Solomon Islands Family Planning Manual* ('the Solomon Islands FP Manual'; Appendix 1). The FP service checklist contained seven headings with questions relating to i) services; ii) FP counselling; iii) staffing and training; iv) supervision; v) drugs and supplies; vi) clinic infrastructure and resources; and vii) referrals (Appendix 1—adapted version). The audit was conducted via discussions with FP service providers at the clinics. Responses to the questions and observations conducted were recorded using the audit tool.

The third data source was the review and audit of the clinical records related to FP, created between 2015 and 2019 at each clinic. The array of FP activities reviewed in these records included types of available contraceptive methods/devices; contraceptive options chosen by individuals; number of contraceptive users; and demographic details of clients such as gender, age and marital

status. The numbers of FP attendances are absolute numbers and are counted and reported as occasions of service. Missing records, incomplete and inconsistent record entries, and differences in calculating current FP user attendances posed challenges in the data collection process. Along with the clinical records, monthly reports (2015–19) of FP clinic activities were reviewed. This information provided a better understanding of how FP services were made available and who accessed FP services and contraceptives at the three case study sites. The years 2015–19 were chosen to capture and record trends and current uptake of FP contraceptives; however, not all records from 2015 to 2019 were available and accessible for review.

The clinical records included reference to marital status. There were unclear and inconsistent entries in the marital status column in the FP register. Unmarried service users included those who were single, divorced, widowed and those living together without being legally married. The marital status column often showed 'M' for married, 'S' for single, 'D' for divorced, 'Def' for de facto or 'W' for widowed. However, no standard guide or definitions for these abbreviations were sighted. Furthermore, health workers and clients used these terms differently, according to their own definition or interpretation of what 'divorced' or 'de facto' meant to them. In Solomon Islands, 'de facto' can mean living together without legal or customary recognition. De facto can also refer to a young woman pregnant with or mother to a child as a single mother but supported by the father of the child and his parents; the couple may not necessarily live together. Therefore, it is possible that some service users ascribed as divorced or de facto were single mothers considered divorced or de facto according to nurses' understanding of the term, or because of the service users' preference to identify themselves as de facto instead of single. Being a single mother attracts social criticism in the village.

The fourth data source was qualitative interview data generated from semi-structured individual interviews conducted in Solomon Islands Pijin, using an interview guide with English and Pijin versions (Appendix 2). The interview guide was developed based on the research aim and objectives, and further informed by the scoping review of the literature (R. B. Harrington et al., 2021). The interview guide was formulated to help gather information about the availability, accessibility and acceptability of FP and contraceptive services. The interview guide had two parts. Part One included participant demographic details such as age, gender, education level, marital status and

religious affiliations. Such demographic details are important to understand the basis of participant responses when analysing data. Part Two was comprised of the interview questions and was divided into three sub-sections (service users and non-users guide; reproductive/FP managers guide; and FP service providers guide) to direct relevant questions to the three groups of participants recruited. This study used both quantitative and qualitative data to understand the provision of FP services in both the biomedical system and experiences of participants in varied sociocultural settings.

3.3.2 Use of Solomon Islands Pijin

The interview guide was translated from English to Solomon Islands Pijin, the lingua franca in Solomon Islands. The interviews were conducted in Pijin at Case Study One and Case Study Two sites; a mix of Pijin and the local Isabel language (Zabana) was used for Case Study Three, which was a rural setting. An Indigenous researcher from Isabel conducted most of the interviews in the setting because of COVID-19 travel restrictions. As language can make the researcher more powerful in research (Temple & Young, 2004) and the qualitative component of this research relied on words as data, it was important that researchers are aware of how language is used and the cultural implications of the use of language to communicate with participants (Redman-MacLaren, Mafile'o, Tommbe & MacLaren, 2019). As a Solomon Islander, I speak fluent Pijin, so I understand common Pijin expressions and correctly interpret them. Although there are more than 70 Indigenous languages in Solomon Islands, use of Pijin was appropriate as all participants understood and spoke it fluently in the settings in which the research was conducted. However, I still needed to simplify certain medical terminology for clarity, and I carefully selected appropriate Pijin terms that were culturally acceptable and appropriate to be used in communicating sensitive topics such as FP. This was especially important when I interviewed male participants and young people. My insider/outsider perspectives as a Solomon Islander enabled me to transition through possible language barriers to communicate effectively with participants during semi-structured interviews.

In each interview, I wanted to understand participant experiences, thoughts and feelings about FP services, and to explore what other SRH services were available for young people and men in these contexts. Semi-structured interviews are commonly used in health and social sciences research

to carry out interviews and allow participants to elaborate on their responses (Liamputtong, 2017). Given the sensitivity of the topic, and cultural and social considerations, individual rather than group interviews were used. This was to ensure participants felt safe, experienced greater confidentiality and therefore were more confident to talk and share their experiences and perspectives about these sensitive health topics. The semi-structured framework helped me gently probe for further information when participants appeared too shy to volunteer the information initially and ensured that I correctly understood their responses by allowing for clarification and follow-up questions.

3.3.3 Sampling

To obtain a broad perspective about FP services, participants were purposively sampled in this study to represent those who had knowledge and experience of managing, providing and receiving/using FP services, including those who had limited or no experience with FP. The carefully sampled participants helped provide the rich information required to meet the research aim and objectives. Participants were categorised into three groups:

1. FP managers and providers—managers were selected if they were involved in planning and coordinating FP activities for a clinic. FP providers were those who delivered or provided FP services and contraceptives to clients at a clinic. In most provincial and rural settings, the same person often had both responsibilities—service manager and provider. In Case Study One (urban setting), representative national FP managers in the RMNCAH programme of the MHMS were also included to obtain national perspectives about FP in the country.
2. FP service users included men, women and young people who were either married or unmarried, of reproductive age and had used FP services at a clinic, either to access contraceptives or receive FP counselling from the FP provider.
3. FP service non-users included men, women and young people who were either married or umarried and of reproductive age, but for a variety of reasons choose not to attend a clinic to access FP and contraceptive services.

Men and young people are often poorly represented among users in FP clinics (Davis, Vyankandondera, Luchters, Simon & Holmes, 2016; Kennedy, Gray, Azzopardi & Creati, 2011).

Therefore, males and females, including young service users and non-users, were purposefully sampled to ensure diversity of gender and age, and thus a diversity of perspectives about FP.

3.3.4 Recruitment of Participants for Interview

All participants were identified and recruited from their respective clinic catchment areas (study sites). After participants were identified, consent was sought first before participants were recruited for an interview. Participants were also informed that they could withdraw or end the interview at any time if they did not wish to continue. As a female Indigenous researcher, I also needed to be sensitive to participants' concerns for gender and age variations that may influence the interview process. For example, I needed to check to ensure male participants are comfortable talking to a female interviewer.

FP managers and providers were identified in consultation with the national RMNCAH manager in Honiara and when visiting provinical RMNCAH managers and clinic sites. The FP service providers assisted to identify users and non-users invited to participate in this study, The FP service providers were, in effect, the gatekeepers for this study population. The non-users were asked a screening question to determine if they had ever attended the FP clinic or used any contraceptives. This was also done with the assistance of FP providers. Male users and non-users, including young people, were recruited when they visited the outpatient clinic or when they brought their sick children to the clinic. Again, they were asked about their previous attendance for contraceptives and FP counselling. FP service providers also helped to screen potential male users and non-users to be recruited. A small gift was given to all participants interviewed in all case study sites as a token of appreciation for their time and information they provided. This token of appreciation assisted to fulfil my obligations of reciprocity as an Indigenous researcher.

3.3.5 Study Sites and Participants

The three study sites were purposely chosen to obtain perspectives from government and faith-based health systems; urban, peri-urban and rural contexts; and a mixture of healthcare service levels. Figure 3.2 shows the locations of the case studies. The three case study sites were:

1. Case Study One—Rove Urban Clinic, Honiara City Council (HCC), Honiara, Guadalcanal

2. Case Study Two—HGH, Munda, Western Province

3. Case Study Three—Kia Health Clinic, Isabel Province.

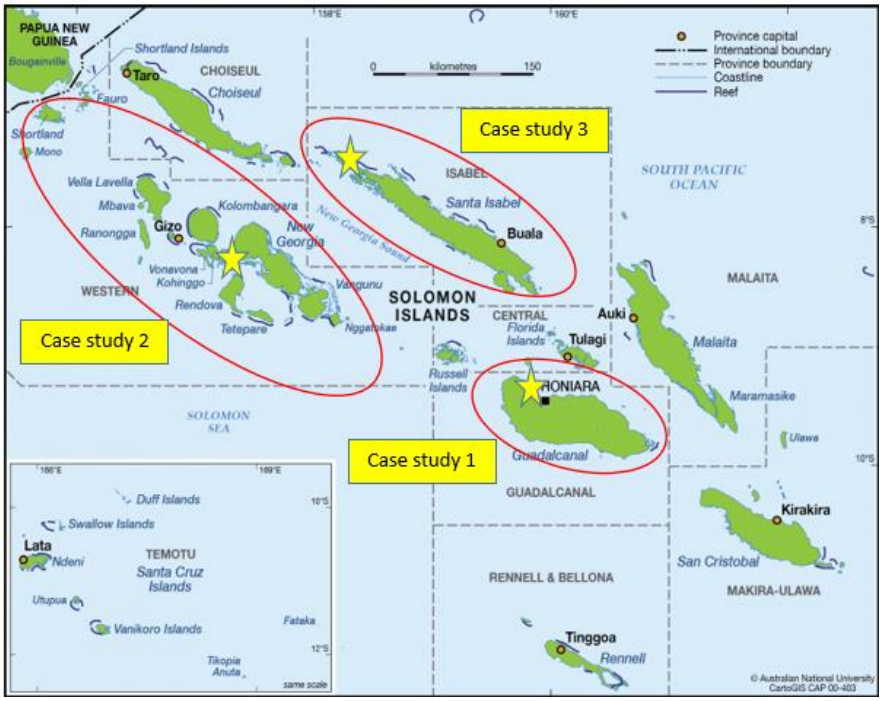

Figure 3.2. Map showing study sites (Source: (Source https://www.google.com/mymaps/viewer?mid=1oEZMzspiLgFRsn_20Jy07rARZnw&hl=en_US)

Prior to conducting an interview, a participant information sheet and a verbal explanation in Pijin was provided to potential participants (Appendix 3). If a person agreed to participate in the research, they signed a consent form (Appendix 3). Most participants understood Pijin better than English, so participant information sheets, consent forms and interview guides were translated to Pijin from English to enhance understanding and ensure informed consent. However, for Case Study Three (rural context), a translator was also available if participants required assistance to understand the Pijin or if they preferred to be interviewed in their own language. The semi-structured interviews were audio-recorded. All interviews were conducted in Pijin as each participant identified Pijin as their preferred language, including those in Case Study Three. A total of 73 participants was interviewed from the three case study sites (see Table 3.2). Results from the audit, review and interview data provided evidence to address Research Objectives 1, 2 and 3.

Table 3.2

Interview Participant Demographics

Participant/gender	Case Study One (urban)	Case Study Two (peri-urban)	Case Study Three (rural)	Total
Managers/providers				
Female	6	4	3	13
Male	0	0	1	1
Service users				
Female	2	5	7	14
Male	1	1	9	11
Service non-users				
Female	3	3	10	16
Male	4	3	11	18
Total	16	16	41	73

3.3.6 Ethics Approval

Preliminary discussions were undertaken with the national and provincial directors (HCC, Western and Isabel provinces) of the MHMS RMNCAH programme about this research study prior to submission of an ethics application to the Solomon Islands Health Research Ethics and Review Board (SIHRERB). It was important to establish relationships and obtain stakeholder support to enhance the success of the study (Creswell, 2014). Following initial consultation and subsequent official requests for support, the three study sites and the national RMNCAH programme provided letters indicating support for the research (Appendix 4).

Ethics approval for the study was obtained from SIHRERB (Ethics number HRE024/19 see Appendix 5), and reciprocal approval was provided by JCU, Human Research Ethics Committee (Ethics number: H7959, see Appendix 5). In early 2020, I was granted an amendment to the ethics approvals to include the third case study site after I upgraded my candidature. In 2021, I was granted another amendment to involve research assistant Allan Rolland as I could not travel to the Solomon Islands myself to collect data because of COVID-19 travel restrictions (see Appendix 6 and 7.).

3.3.7 Feedback to Participants

As an Indigenous researcher and being part of a professional community to support my colleagues with best practice in FP, I had hoped to facilitate member checking in all case study sites to ensure I had interpreted participant voices correctly (Candela, 2019), but COVID-related travel restrictions made this impossible. I was only able to provide feedback to case study three participants with the help of the research assistant and to case study one and two service managers/providers through email and Facebook messenger. In addition to providing feedback to the remaining participants, I will return to the Solomon Islands at the end of my study and provide in-person feedback and present a one-page summary of relevant findings to the national and provincial health divisions, including the health clinics at which I conducted the studies.

3.4 Data Management

Following data collection for Case Study One and Two, I organised and labelled audit data and audio-files for each case and securely stored them in a digital format on a password-protected laptop. De-identified printed documents of the audit data were also locked in a cabinet in a secure room at JCU before commencing analysis and transcriptions. For Case Study Three, a laptop and flash drive were provided for the research assistant to securely store data, which he did using password protection. Because of unavailability of a voice recorder, a phone was used to record the interviews for Case Study Three. I advised the research assistant to put a password on his phone and provided him with training about how to manage data during field trips. For Case Study Three, audit data were captured on camera and uploaded to a secure drive as image files. Recordings and audit data were sent via my JCU email in secure files. As soon as I received and safely stored all data files, I advised the research assistant to remove all data from the laptop, phone and flash drive and I uploaded the data and removed them from my email account. Data management has been completed, with the primary advisor also having a complete copy of data collected during the study.

3.5 Data Processing and Analysis

There were two stages in the data analysis. First, data from each case study were individually analysed (within-case analysis). In each case, the four data sources were analysed separately and then

later integrated to determine if the results converged or diverged within the case (Yin, 2018). Second, a cross-case analysis was conducted (see Chapter 7). In the cross-case analysis, integrated results of the three individual case studies were compared for differences, commonalities and what facilitated and challenged provision of FP services, including participant experiences in the different settings (Yin, 2018).

3.5.1 Stage One: Within-case Analysis

3.5.1.1 Context Data

Reports, observations and information about the contexts of individual case studies were selected to ensure information provided relevant background to understand the context of the case. Analysis included descriptions of the setting, locations of the clinics and levels of healthcare services provided by the clinic, including population data and clinic staffing. A description of FP clinic services at each setting was also provided. Details of context data were included in the result chapters (Chapter 4-6).

3.5.1.1.1 Family Planning Clinic Service Audit

The FP clinic service checklist (audit tool) used in this study was adapted from the WHO tool (Appendix 1) and the Solomon Islands FP Manual (Appendix 1). The tool contains seven questions to assess how FP clinic facilities providing integrated FP meet the minimum standards of quality FP services provision. The WHO tool was compiled with reference to other validated WHO toolkits for FP, HIV and SRHR. It is relevant for this study as it can be used by a broad range of healthcare personnels including healthcare managers, providers and community-based organisations, and can be used at any time with any frequency as appropriate. The checklist was modified, in that answers to the seven questions were not scored in percentages but notes were used to report findings in a table (Appendix 1—adapted tool).

Responses to the checklist questions were collated using Microsoft Excel and descriptively analysed in written notes to the checklist questions. The results provided a snapshot of the services under the seven headings. The checklist was initially designed to quantify answers to checklist questions in percentages; however, in the process of analysing the data, I found that the true status of

the clinic under the seven headings was not reflected in the quantified data because of the smaller clinical settings, variation in the context of FP provision and missing or incomplete clinic records. The poor record keeping and data quality found in these case study sites were consistent with the findings in my pilot study (R. Harrington et al., 2020) and a country-wide study in Solomon Islands (Nair et al., 2021). Therefore, notes were used to report findings in a table under the seven headings. The table has three columns, from left to right: 1) checklist item—contains the seven checklist headings and information examined; 2) results—records of what was reported and direct answers to questions; and 3) assessment narrative —my interpretation based on observations of the results, providing additional information. The results of the audit are reported in the result chapters for each case (Chapter 4–6).

3.5.1.2 Family Planning Clinical Records

The clinical records audit reviewed and examined FP clinic records and the monthly FP reports between 2015 and 2019 at the three clinics. The review examined records of FP service activities that were implemented and manually recorded in record books kept at the clinic, and the monthly HIS report. At the end of each month, a summary of the activities implemented in the previous month are transferred to the hard copy of the HIS report form and sent to the MHMS statistics division and the national RMNCAH manager for MCH and FP contraceptive reports. The FP clinic record book contains personal details, contraceptive methods prescribed, the purpose of visits or attendance and return dates for the next visit. This is where details such as marital status, age, gender and type of contraceptives prescribed are recorded.

Information gathered from the FP clinical records and reports was aggregated, transferred and organised in a Microsoft Excel spreadsheet, and then later analysed using simple descriptive statistics to identify patterns in FP clinic attendances; number and type of contraceptive methods available and chosen by users; and age, gender and marital status of clients attending FP clinics. Results are presented in graphs. The review was limited to some extent by poor record keeping and storage at the clinics, including incomplete and inconsistent manual record entries.

3.5.1.3 Qualitative Data from Semi-structured Face-to-face Interviews

Interviews were transcribed verbatim, coded and analysed in Solomon Islands Pijin to ensure the meanings of what participants said remained unchanged (Charmaz, 2014). For this reason, reporting of qualitative data is presented in Pijin first, followed by the English translation. Pariticpant responses were de-identified and assigned a code as FP manager (FPM), FP provider (FPP), FP provider/manager (FPPM), female user (FU), female non-user (FNU), male user (MU) or male non-user (MNU). The prefix represents the case study site (i.e. 1, 2 and 3). The number at the end of the code represents the participant number. In Case Study One the national FP manager was identified as NFPPM. The transcriptions, codes and analysis were checked and verified by the primary advisor who understands and speaks fluent Solomon Islands Pijin. Transcripts were organised, prepared and analysed (J. Saldana, 2021) using NVivo 12 software.

Thematic analysis was conducted drawing on methods described by Braun and Clarke (2006) for analysing qualitative data: 'Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006, p. 79). Although I executed Braun and Clarke's six phases of thematic analysis, I also integrated elements of coding and analysis from J. Saldana (2013), Charmaz (2014), Birks and Mills (2015) and J. Creswell (2013). Listed below are the six phases I used in my data analysis.

1. familiarising yourself with the data
2. generating initial codes
3. searching for themes
4. reviewing themes
5. defining and naming themes
6. producing themes.

3.5.1.3.1 Phase 1: Familiarising Yourself With the Data

I collected all quantitative and qualitative data for Case Study One and Two myself. I transcribed all the interviews and read all the transcripts and clinical documents. This process meant that I was very familiar with the data. During this stage I started to think about interpretations of the

data. The initial steps I employed during this phase helped me to immerse myself in the data and begin to see ideas and themes from an early stage. I wrote memos (J. Saldana, 2021) about the issues that stood out to me and I felt were potentially important or potential codes. Having a research assistant for Case Study Three meant that I spent more time reading and going back and forth listening to the interview recordings from this site than I did for Case Study One and Two. This process also included checking with the research assistant via email and Facebook Messenger to confirm my familiarity with the data and to ensure I had correctly heard and understood the recordings. Having collected and transcribed the first two batches of interview data helped me to easily immerse in the third dataset.

3.5.1.3.2 Phase 2: Generating Initial Codes

I drew on Saldana's coding approach (J. Saldana, 2013, 2021) to code the qualitative data. During initial coding I codified—which means I applied and reapplied codes to qualitative data (Shenton, 2004)—keeping my research topic, aim and objectives in mind. As a novice researcher I initially coded everything using NVivo Software and later exported the codes to a Microsoft Word document. In the document table, I added a column in which I wrote memos alongside the codes as I proceeded with focused coding (J. Saldana, 2021). When I started to code, coding seemed overwhelming as I tried to select appropriate code names that truly reflected what participants meant. In this phase, I shared the codes with my advisors and explained why I had selected the code names or labels. In our discussions they asked me questions about the data and why I had chosen the code labels. They reminded me about selecting code labels that represented the data and to expect code labels to change during the analysis process. We also discussed 'In Vivo' coding as an option I could use (J. Saldana, 2013). To help with assigning code labels, I inserted all my initial codes in a table and alongside the codes I wrote what participants said verbatim. This meant I used the Pijin alongside my English codes. This reinforced and reminded me what the participants' words meant—the contextualised meaning. Via this process, I was able to maintain the original meaning of the experience while coding, recoding and re-categorising the data. Later, when I reviewed the codes, it was easier to regroup and rename the codes as the code names reflected the interview data.

3.5.1.3.3 Phase 3: Searching for Themes

With my qualitative data, I applied inductive analysis, a common approach in Grounded Theory research (Birks & Mills, 2015; Charmaz, 2014), which means I looked for patterns of ideas or themes that came from within the data. Following coding, I added a step in this phase by first organising and grouping similarly coded data into 'categories' or 'families' (J. Saldana, 2013), before I searched for the themes that would best describe the categories. I used my understanding and instinctive senses about what participant said to determine which data 'looked alike' or 'felt alike' when searching for the themes (J. Creswell, 2013; J. Saldana, 2013). Although the terms 'codes' and 'categories' can be used interchangeably, Dey (1999) posited, that they are separate elements and did not mean the same in data analysis. Dey considered that 'categories' asign meanings and codes compute the meaning. After grouping codes into categories, I searched for themes that represented groups of categories. I spent some time moving back and forth reflecting, collapsing and renaming the codes, categories and potential themes to be used. I learnt that sub-codes were specific observable types of realistic actions related to the codes and the major category labels and themes were more conceptual and abstract in nature (J. Saldana, 2013).

3.5.1.3.4 Phase 4: Reviewing Themes

Phase 4 involved two levels of reviewing and checking to determine if the selected themes truly reflected the data or not. Level 1 involved reviewing the coded data extracts to see if they formed a coherent pattern. Level 2 was a similar process but more advanced as it included the entire dataset and examined whether the evidence represented by the themes accurately reflected the meaning in the whole data set. (Braun & Clarke, 2006; Braun, Clarke, Hayfield & Terry, 2019). I revised, collapsed, separated and renamed the categories and themes (Patton, 2002). At one point I found myself having to recode data and repeat Phase 2 and 3 to reach Phase 4, as I became immersed with the common themes in the data. To help me grasp the flow of main ideas in the data, I constructed a storyline (Charmaz, 2002, 2014), where I lay aside all codes and themes and wrote the story as I understood it was told by the participants in the interviews. This process, popular in Grounded Theory (Birks & Mills, 2015; Glaser & Strauss, 1967; Mills, Bonner & Francis, 2006) helped me to map the themes and categories to identify whether they fitted or needed further shifting,

collapsing and renaming. This phase involved regular discussions with my advisors, who helped me to review and refine my themes.

3.5.1.3.5 Phase 5: Defining and Naming Themes

Once a thematic map had been satisfactorily constructed, Phase 5 began with further defining and refining of the themes. In this phase, I constructed a table with columns for themes, categories and codes, and provided a summary of each concept to represent the dataset. This table provided a visual display of all codes I generated, as well as categories (sub-themes) and themes. I could visually examine all the codes I generated, and the categories (sub-themes) and themes. This table helped me to reflect and revise the themes and was valuable when working with my advisors to refine and redefine the themes.

3.5.1.3.6 Phase 6: Producing Themes

The last phase involved the final analysis and writing of report. I learnt that when the codes, categories and themes are fully worked out and layered with a coherent pattern that represents the bigger picture about the data, it is easier to write the story and make a clear argument to achieve the aim and objectives of the research. In the writing phase, I found myself constantly thinking about the themes and narrative to ensure they were coherent. In some cases, I reviewed and renamed themes to be clearer with the logic and narrative of the story.

3.5.2 Stage Two: Cross-case Analysis

The aim of cross-case analysis or synthesis is to better understand what is happening across the cases, not just an individual case study, and identify whether findings can be replicated in similar situations (Yin, 2018). Following the within-case analysis, a cross-case synthesis was undertaken by looking at how findings from the three case studies showed the availability, accessibility and acceptability of FP and contraceptive services in the contexts in which they are provided in Solomon Islands. In the cross-case analysis, the similarities and differences were highlighted along with what factors facilitated FP service provision at each case study site. The challenges, strengths and limitations were noted between participants' experiences to identify any broader systematic or cultural issues affecting the provision of FP services (J. W. Creswell, 2013).

Opportunities and success stories unique to one case study site could potentially help to improve services at other case study sites. Results from this analysis helped to address Objective 4, 'to recommend strategies' that will inform health service providers and policymakers. Following inductive thematic analysis of qualitative interviews, the *Availability, Accessibility, Acceptability and Quality* (AAAQ) *Framework* (Tanahashi, 1978; UN Economic and Social Council, 2000) was used as a template to deductively analyse the integrated results in the cross-case analysis on the availability, accessibility and acceptability of FP service provision and contraceptives across the three case studies.

In this study, only the first three dimensions (availability, accessibility and acceptability) of the framework are explored. Quality of service delivery was not included, as this was always an ongoing challenge in Solomon Islands. Among other fiscal and health system challenges, the lack of reliable data and local research evidence on FP services—including unequal distribution of staffing with outdated FP protocols—meant it would be difficult to determine the quality of services. In addition, most strategies addressing acceptability would also address quality. This was the reason for excluding the quality dimension, as solutions to availability, accessibility and acceptability will also eventually address the quality dimension (Homer et al., 2018). Table 3.3 provides a summary of the AAAQ Framework as applied in the cross-case analysis. The AAAQ Framework on Table 3.3 was extracted and compiled from two sources: the UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 (UN Economic and Social Council, 2000, p. 4-5) and (Homer et al., 2018, p. 3-6).

Table 3.3

Dimensions of Effective Coverage—the AAAQ Framework

Dimensions of effective FP service coverage	Description
Availability	• Availability of services requires that public and private healthcare facilities that provide FP services and contraceptives are available in sufficient quantity according to the country's development and economic situation. This includes a FP clinic building or available space, trained FP provider and contraceptive methods.
Accessibility	• FP facilities must be accessible to everyone without discrimination within the jurisdiction of the country's policies. Accessibility has four overlapping dimensions.
Non-discrimination	• Health facilities and FP services must be accessible to all including vulnerable and marginalised populations.
Physical accessibility	• Health facilities and FP services must be within physical reach for all catchment populations including vulnerable or marginalised groups and women, men, adolescents, older persons and persons with special needs (disabilities).
Economic accessibility (affordability)	• FP services and contraceptives must be affordable for all, based on the principle of equity, ensuring services are affordable for all including socially disadvantaged groups.
Information accessibility	• Includes the right to seek, receive and impart information about health issues; maintains confidentiality with personal health data.
Acceptability	• Health facilities and FP services must be respectful of medical ethics and culturally appropriate; that is, they must respect the culture of individuals, minorities, peoples and communities; and be sensitive to gender and age and designed to respect confidentiality.
Quality	• FP client interests. • FP practice standards/policies or regulation must be updated. • Quality is addressed through effective education, regulation (professionalism) and regular supervision and monitoring including availability of essential supplies in facilities.

Adapted from UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 (UN Economic and Social Council, 2000) and the AAAQ Framework (Homer et al., 2018).

3.5.3 Rigour and Trustworthiness

A case study methodology is an appropriate approach to health services research as it can provide insights into the subtle differences of diverse contexts. In addition, as health systems and health services such as FP are constantly evolving with changing expectations and diverse motivations in service provision, they can be difficult to identify and understand with a single data collection

method using traditional methodologies such as purely quantitative or qualitative approaches. Therefore, methods that incooperate context-specific information on the provision of FP programmes are more likely to be successful (Sibbald, Paciocco, Fournie, Van Asseldonk & Scurr, 2021).

To ensure rigour and trustworthiness in this study, I have reported my philosophical position and ensured it was coherent with the methodology and methods used. Data collection involved both quantitative and qualitative methods using multiple data collection methods, to provide a variety of evidence. Both quantitative and qualitative techniques were used in the analysis, which included a cross-case synthesis. To ascertain transparency and reflexivity, I acknowledged the influences that my experience and disciplinary lenses may have on my assumptions about FP as I analysed the data and developed the findings employing both deductive and inductive analysis techniques. My insider lens enabled me to interpret findings from a context-specific perspective. Drawing on the Ottawa Charter framework helped me situate findings in the broader context and thus improved quality. In addition to giving participant feedback, the findings of this study were translated into practical recommendations that will be available in a policy document and presented to planners, policymakers and service providers in Solomon Islands (Bazeley, 2021; Birks & Mills, 2015; Harrison et al., 2017).

3.6 Chapter Summary

This chapter has described the selected research approach and study design, the construction of the data collection tools, and how they were used in this study. I have explored and adhered to ethical considerations and respect for gender and cultural differences. I have explained the data collection and analysis process, and my plan to return to Solomon Islands to provide in-person feedback to my colleagues and national leaders about the findings of this study.

In the following result chapters (Chapter 4–6), I describe the analysis of the case study results and findings from the four data sources for each case study, integration of the data results within each case study and a summary of integrated findings about the availability, accessibility and acceptability of FP and contraceptives in each case study setting. Figure 4.1 is the thesis structure showing Case Study One chapter in the thesis.

Chapter 4: Case Study One Results—Urban Setting

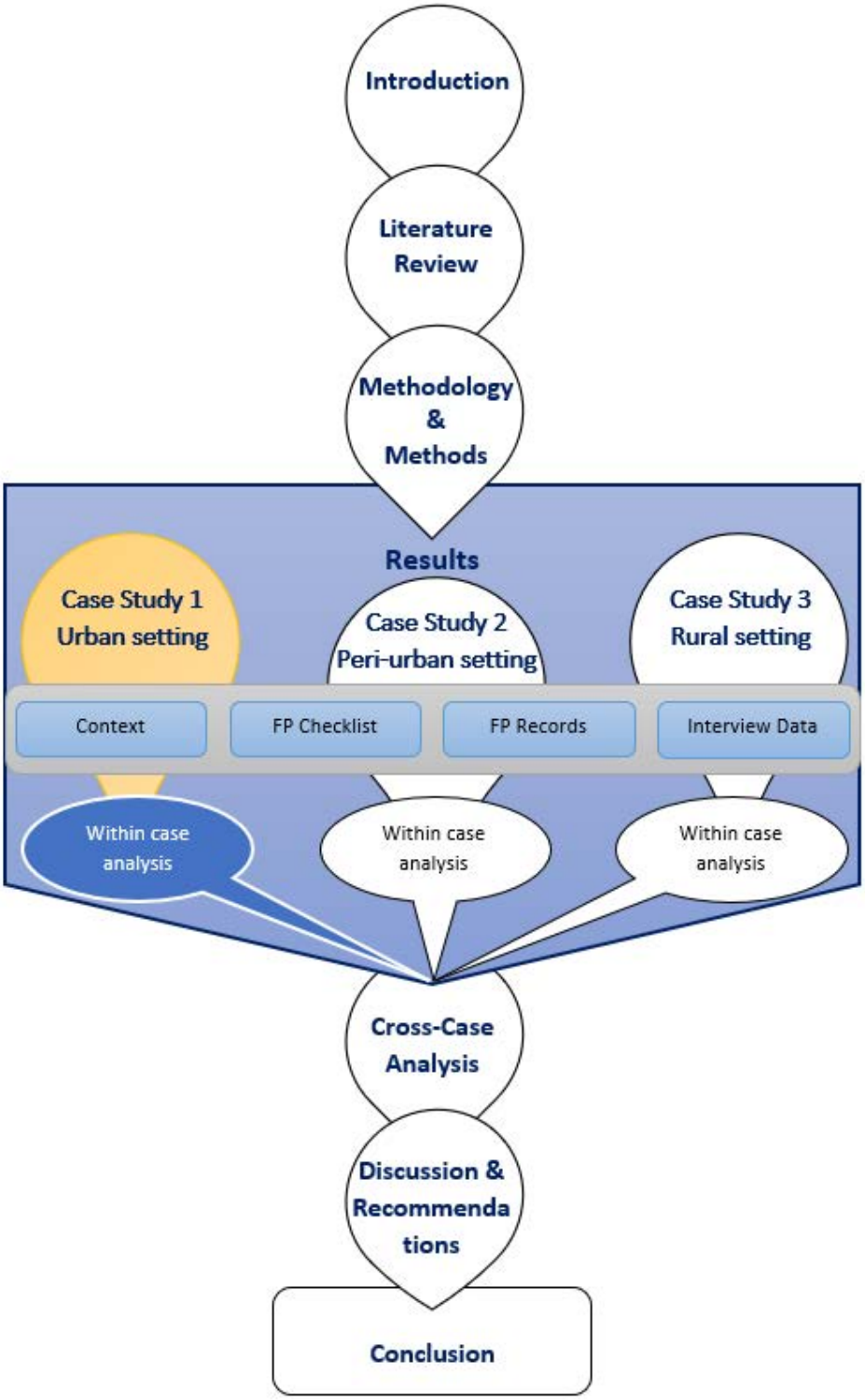

Figure 4.1. Thesis structure—Case Study One

4.1 Chapter Outline

This chapter presents the results of Case Study One, an urban FP clinic. The chapter presents the setting and context of the clinic, data collection methods, results and within-case analysis. Figure 4.2 illustrates the sequence of this chapter.

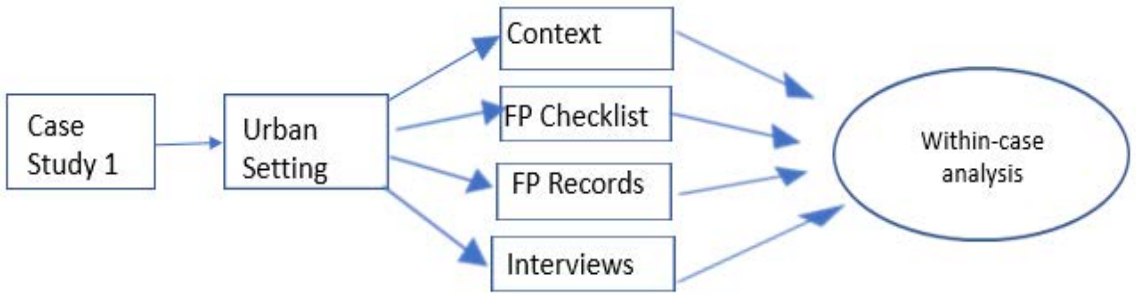

Figure 4.2. Outline of Chapter 4

4.2 Setting and Context

Case Study One is an urban clinic situated in the city of Honiara, the capital of Solomon Islands located in the island province of Guadalcanal (Figure 4.3). Honiara serves as the administrative, educational and economical centre for the country (UN Human Settlements Programe [UN-Habitat], 2012a). Honiara is served by an international airport and seaport that provide a gateway to Solomon Islands provinces and international destinations. The city inlcudes the NRH that provides tertiary healthcare to Solomon Islanders.

Rove Urban Clinic representing the urban setting is in a suburb located approximately 3.7 km west of Honiara City and the NRH (Figure 4.4). It is one of the main clinics in Honiara City and provides daily health services to residents of the city's West Zone.

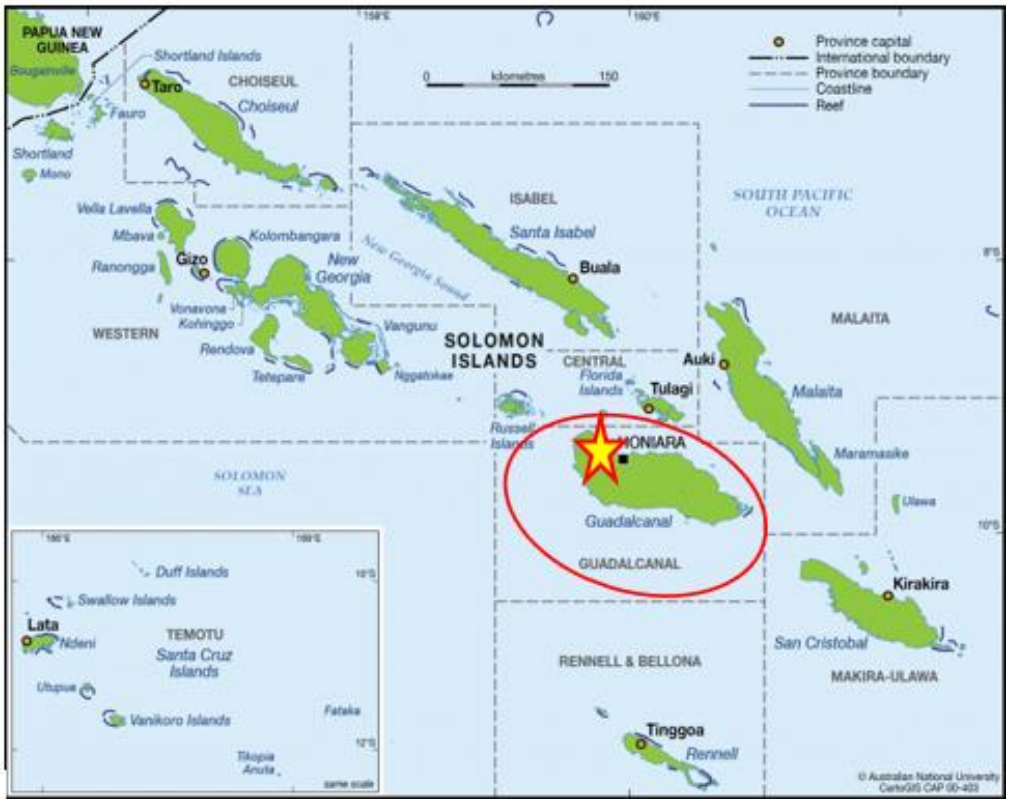

Figure 4.3. Map showing the location of Guadalcanal Province and the national capital Honiara (Source:https://www.google.com/mymaps/viewer?mid=1oEZMzspiLgFRsn_20Jy07rARZnw&hl=en_US)

Figure 4.4. Honiara City boundaries and the suburb of Rove (red circle) (Source: Honiara Urban Nursing Service [HUNS])

4.2.1 Governance

The HCC is the governing body responsible to deliver basic services to city residents, including education, health and basic social services. The HCC is connected to the national government through the Ministry of Home Affairs, however reports on urban city profiles show that residents in Honiara experience less than ideal service delivery because of a number of factors including lack of public sanitation, poor city planning, shortage of housing, and high cost of living (UN-Habitat, 2012b). An increase in informal settlements in Honiara has resulted from increasing rural–urban migration from lack of adequate services reaching rural areas, a weak administrative and technical capacity, and limited finances within the HCC (Lacey, 2017). Honiara City is regarded by the government as a province (SINSO, 2009c).

HCC depends on the national government for financial support to implement major infrastructure requirements. Estimating unemployment rates can be challenging in Solomon Islands because many people work in the informal sector and there is a lack of unemployment data. Unemployment rates are reported to exceed 40% and more than half of unemployment is in Honiara

(D. Evans, 2016-17). The increasing number of unemployed people living in Honiara do not provide an income stream for the HCC, but still require services such as water and sanitation. This places a large financial burden on the government (Pauku, 2015; Solomon Islands Government, 2017).

4.2.2 Informal Settlements in Honiara

Informal settlements are groups of households that settle illegally, mostly on state-owned land, without proper planning and building approvals (Moore, 2022). These settlements are characterised by haphazard and sub-standard housing, with poor access to water, sewage systems and electricity (UN-Habitat, 2012b). Pressures from rapidly growing rural populations, and the search for employment opportunities, cash economies and access to urban services drove people from rural areas to informal settlements in Honiara (Chand & Yala, 2011). More than 30% of Honiara residents live in informal settlements within the city boundary. (Community Access Urban Services Enhancement Project [CAUSE] Solomon Islands, 2022; Kiddle & Keen, 2016; Pauku, 2015).

As most people who live in informal settlements did not engage in formal employment, unemployment was high, and people depend on gardening and street vending to sustain their living. (Pauku, 2015). Unemployment is an important issue in Honiara and Solomon Islands (D. Evans, 2016–17). It is also a social determinant of SRH for young people in Honiara (Jourdan, 1995).

4.2.3 Population Structure and Growth

Population growth in Honiara is a concern for the national government because of the increasing demands for housing as well as all other basic services, especially within health and the education sectors which means the government will need to intervene (Kaukui, 2020). Figure 4.5 shows the constant growth in the Honiara population from 1999 to 2019. In 2009 Honiara had an estimated population of 64,609, with 2,953 people/km^2; this number is expected to increase to more than 100,000 with a population density of 5,950 km^2 (Solomon Islands Government, 2022b). The city has the highest population density of all provinces and makes up 12% of the country's total population.

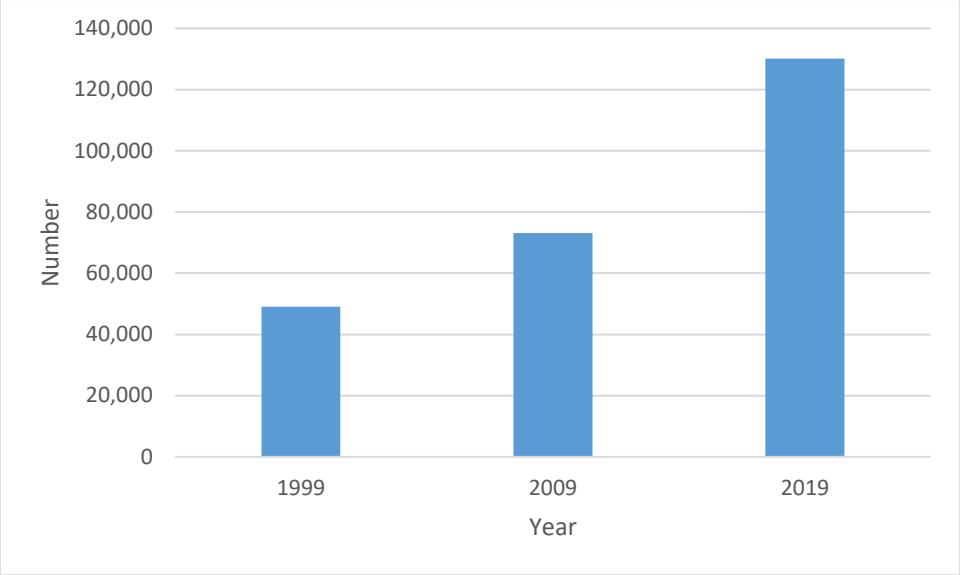

Figure 4.5: Population growth in Honiara 1999–2019 (Source: 1999 and 2009 census reports & 2019 provisional census report)

4.2.3.1 Education

Enrolments in formal education in Honiara are the lowest among all provinces. Proportionally, fewer females than men attend formal education in Honiara; however, male and female aged 15–24 years literacy rates are respectively higher than other provinces: 96.6% and 95.4% respectively (SINSO, 2009a). All public schools (primary and secondary) in Honiara City are run and managed by the HCC. A significant number of primary and secondary schools in and around Honiara are also run by church groups.

4.2.3.2 Ethnic Groups and Languages

People who live in Honiara city come from all ethnic groups from the nine provinces in Solomon Islands. Most residents are Melanesians (91%), followed by Polynesians (5%), Micronesians

(2%), Chinese (1%) and Europeans (1%). Most still uphold their various cultural practices, such as the 'Bride Price'[2] in Malaita Province (SINSO, 2009a; Akin, 1999a).

Since Honiara City is the central business district of Solomon Islands, English is formally spoken for professional purposes. Pijin is mostly spoken (84%) in informal conversations and around 78% of people still speak their local Indigenous language, with 33% also able to speak languages other than their own (SINSO, 2009a).

4.2.3.3 Religion

Almost all (95%) of Honiara's population identify as Christians and this is where most church headquarters are located. The main religions in Honiara are Anglican (Church of Melanesia; 32%), South Seas Evangelical (23%), Seventh day Adventist (16%), Roman Catholic (14%) and Uniting Church (6%). Other smaller denominations such as Jehovah's Witnesses and the Baha'i Faith consititute 4% of the population (SINSO, 2009a). Active participation and regular attendance at church programmes is common, with strong social support and identity around church membership.

4.2.4 Honiara Urban Nursing Service

PHC is provided by eight suburban clinics operating under the HUNS. The clinics are staffed by more than 80 healthcare providers. Most clinic staff are registered nurses and midwives. Medical doctors on staff visit the centres from 8 am to 4 pm on allocated weekdays to respond to non-urgent referrals. Services provided include:

- general outpatient services—diagnostics, treatment, dressings, injections, patient consultations and counselling
- child welfare services—immunisation and monitoring of child development, and provision of nutritional advice to mothers

[2] In a traditional wedding the groom's family gives shell money to the bride's family and then she leaves her family to settle with her husband. The shell money is a traditional currency mainly used in Malaita for social-reproduction ceremonies (Bride Price) and many aspects of local market exchange in the villages.

- pregnancy services—registration of mothers at first visit, pregnancy checkup and free blood tests
- FP and postnatal services—parenting, counselling, issuing of contraceptive FP methods, breastfeeding checks and weight monitoring at baby clinics (general clinics—HCC).

People can access free health services from these clinics on weekdays. On the weekends and public holidays, two clinics (Kukum and Rove) are open but only for outpatients. Private clinics in the city provide PHC services, but not everyone can afford the cost (SINSO, 2012; B Warereau, personal communication, 22 November 2021).

The HUNS coordinates and implements health services for residents within Honiara City boundaries. The city is divided into three health zones: East, Central and West and the eight general health clinics are geographically distributed within Honiara (see Table 4.6). The West Zone has a smaller population (23,629) than the other two zones (East 36,378 & Central 32,337) (B. Warereau, personal communication, 22 November 2021). In addition to general health clinic services, HUNS provides other specialised clinics: the Seifples, for gender-based violence issues; the Pikinini Clinic, which attends to sick children using an integrated management of childhood illnesses (IMCI) approach; and eye and NCD clinics that attend to eye conditions and monitoring and treatment of NCDs, respectively (B Warereau, personal communication, 1 October 2019).

Three HUNS clinics (Kukum, Mataniko and Rove) function as AHCs and five (Vura, Naha, Bokonavera, Bokona and White River) as RHCs. All AHCs and RHCs provide primary healthcare including FP to residents living in a designated catchment area within each zone boundary.

AHCs have a supervising role over the RHCs located within their catchment. A day clinic funded and operated by the SIPPA NGO is also located in Honiara City and serves populations from all three health zones and people from the provinces who seek a more private, confidential consultation for SRH issues and FP. The SIPPA clinic works closely with the HUNS by providing additional SRH services including FP. It provides monthly FP reports to the HUNS (UN-Habitat, 2012a; B. Warereau, personal communication, 5 May 2022).

Although the HUNS clinics are designated to serve the population within the Honiara health zones, they are utilised by people from Guadalcanal and visitors from other provinces who appreciate

the easy access to clinics. Therefore, the HUNS clinics often provide services beyond their catchment populations and thus at times are overwhelmed because their current staff allocations do not match these additional demands (UN-Habitat, 2012b; B. Warereau, personal communication, 12 December 2021).

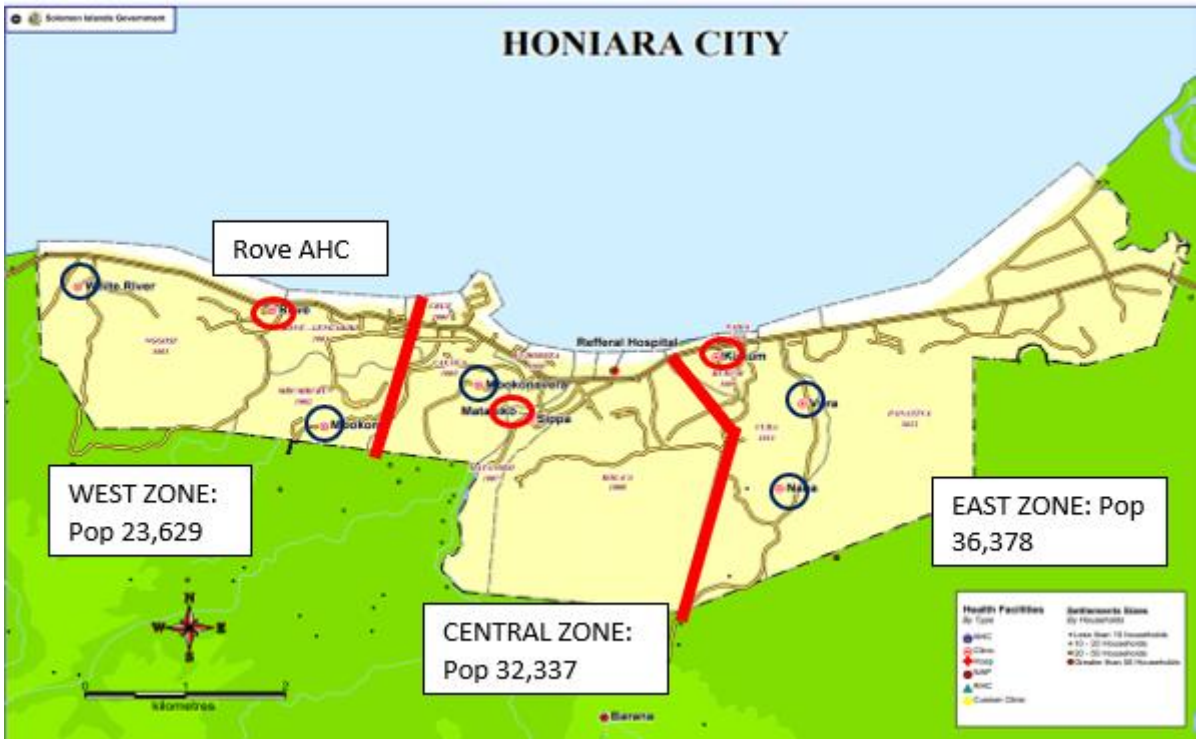

Figure 4.6. Map showing zone divisions and HUNS clinic locations. Map kep: Zone boundary AHC RHC (Source: HUNS Office)

Each clinic schedules routine services on different days and at different times. People living in the specified zones are expected to attend their respective clinics, yet typically people attend the most convenient and accessible clinic. Figure 4.7 shows a typical daily urban clinic programme, from Rove Urban Clinic.

Figure 4.7. Rove Urban Clinic daily programme (Photo credit: Author, September 2019)

4.2.4.1 Rove Urban Clinic

Case Study One is a study of Rove Urban Clinic, one of the three AHCs in the HUNS (Figure 4.8). Rove Urban Clinic works with two RHCs (Bokona and White River clinics) in the West Zone. At Rove Urban Clinic, the FP clinic is available weekly on a Wednesday afternoon, together with the postnatal clinic. This is convenient for mothers who bring their babies for postnatal examination as they can access FP services at the same time; hence, the service is mostly accessed by women. Apart from the weekly clinic, FP is expected to be made available by all nursing staff at every opportunity when people seek contraceptives, preferably every day. However, this does not always happen.

Figure 4.8: Rove Urban Clinic (Photo credit: Author, September 2019)

At the time of data collection for this study in 2019, Rove Urban Clinic had just re-opened after renovations; it had been closed for four to five months. The clinic was staffed by 11 healthcare providers (two midwives, eight registered nurses, one nurse aide). However, this number was expected to reduce as a (non-specified) number of midwives and registered nurses planned to leave to work in Vanuatu, where they were expecting to access better salary packages. FP services are provided by female midwives and registered nurses trained in FP.

Outreach, or satellite clinics are provided by the West Zone Urban Clinic Mobile Team based in the Rove Urban Clinic. The outreach clinic is an extension of the general clinic and provides services other than FP services to communities within the catchment area. Follow up of FP clients by clinic staff is sometimes conducted by phone, but this is inconsistent and ineffective as there is no landline or mobile phone at the clinic; in any case most women cannot be reached by phone. Service providers use their personal phone credit, which makes outreach an expensive exercise for staff, if it is even possible.

4.3 Data Collection and Results

Four types of data were collected to provide a comprehensive understanding about FP service provision at Rove Urban Clinic. All data were collected on the same field visit. The methods for sourcing these data are outlined in detail in Section 3.3.1:

1. context

2. audit of FP clinical services
3. review and audit of FP clinic records
4. qualitative interviews

On arrival in Honiara, and before data collection began at the Rove Urban Clinic, I spoke with the national leaders at the MHMS, HUNS and then Rove Urban Clinic to advise that I had arrived. I presented my ethics approval and plans for data collection during the week. Following this contact, and with the support of both the MHMS and Rove Urban Clinic, I proceeded to assess the FP services using the WHO/MHMS checklist, reviewed and audited FP clinic records, and then undertook qualitative interviews with users, non-users and service providers. I purposely followed this order to help me identify issues and be aware of background information about the context that I could later explore during the semi-structured interviews.

Each data collection method is described below, followed by the presentation of the results.

4.3.1 Context Data

As Rove Urban Clinic was the first site for my field vist, I first paid a courtesy visit and spoke with the national managers at the RMNCAH programme at the MHMS. This was a show of respect to the authorities of MHMS and informed them that I had officially arrived to collect data for my study. I initially wanted to meet with the national director of RMNCAH but he was not available during that week. Next, I met with two other leaders—the director of HUNS and the urban clinic RMNCAH manager—and discussed with them my plans. The leaders were happy and very helpful and informed the service providers at Rove Urban Clinic about my research plans before I arrived at the clinic.

During my week at Rove Urban Clinic, I collected the following data: observations and reports for contextualising the case, audit of FP clinic services, review and audit of clinic records and face-to-face qualitative interviews. I was familiar with the clinic setting as I had frequently visited it during my previous teaching role in Honiara as a midwifery tutor in 2005–06 and as a midwifery lecturer/coordinator in 2015–16. I also personally knew most service providers, some of whom were my former colleagues and students.

Although I was familiar with the nature of FP services, I needed to make the services 'unfamiliar' to myself to be able to see and be aware of issues to which I might have been blinded because of my insider researcher lens. To enable me to make the familiar strange and the strange familiar (Macionis, 2010), I talked to the service providers during a friendly and relaxed conversation, asking questions about how they provided FP services, and observed what they did on different clinic days. Some service providers felt they did not need to tell me about how FP services were provided at the clinic as I would have known about it. I reminded them that sometimes we need to talk about our routines out loud before we can recognise issues that we so often overlook. This process often resulted in 'a-ha moments'. The service providers and I learnt this together and I saw enlightment in their faces when they realised features of the services they were providing that they often took for granted. For example, realising that men had never been the focus at the FP clinic was a new insight for some.

I noticed that few women and no men or young people came for FP that week. Men sat in the outpatient waiting area while women waiting for outpatient services occupied the seating area where the women and children's clinics were usually held. The service providers were very helpful and provided the information that I needed for this study without reservation, knowing that the information I gathered had the potential to help them improve their FP services.

4.3.2 Audit of Family Planning Clinic Services

I used the adapted FP checklist (Appendix 1) as described in Chapter 3 to audit FP clinic services using the seven headings and related questions. As recommended by the charge nurse, who was unavailable, I talked through the questions with the assistant charge nurse to obtain these data because they worked together at the FP clinic. The service provider's responses were noted on the checklist and later aggregated with notes into a table (Table 4.1) where results were also presented. This is the first time I had used this tool and I learnt that some closed-ended questions on the checklist did not provide sufficient explanation about the audit. I reviewed and noted that for future site visits I would need to include small notes on the side to explain the reasons behind the closed-ended questions on the audit checklist for analysis purposes. Table 4.1 outlines the Rove Urban Clinic checklist results. A summary of the results is then provided below the table.

Table 4.1

Audit of the FP Service Using the Checklist Audit Tool

Checklist item	Results	Assessment narrative
Services		
1.1 Contraceptives		
Fertility awareness counselling	Not routinely provided	Depended on nurse's knowledge about fertility and confidence to discuss with women or couples.
Natural methods counselling (ovulation/mucus, calendar, symptothermal methods)	Not always provided	Depended on nurse's knowledge about natural methods and client ability to understand (e.g. a nurse might have had the knowledge but not the ability to share that knowledge with client; and the client's ability to understand may have been linked to the methods the nurse was using to explain, not their own intellect).
Male condoms	Mostly available and provided	Only registered female FP clients (attendees) accessed condoms from the FP clinic. A condom 'house'[3] was also available inside the clinic for the public (including young people) to collect when needed, which did not require consultation with service providers. However, the number of condoms in the condom house was not recorded or monitored. It was unclear if condoms had been used for contraceptive purposes, STI prevention or both. Some people commented that condoms had been used as lures for fishing or games; for example as water balloons.

[3] A condom house is a wooden box designed as a small house stationed at the clinic where condoms are stored for the public to collect as needed.

Checklist item	Results	Assessment narrative
Female condoms	Always available at the clinic	Since their introduction, no women had used female condoms.
Lactation amenorrhoea method (LAM) counselling	Counselling usually provided at the postnatal clinic	Depended on nurse's knowledge about the LAM method. At this clinic the two midwives knew how to advise on the use of LAM.
Progestogen-only pills/combined OCPs (POP/COC)	Yes, available	
Emergency contraceptive pills (Prostino)	Not available at the clinic	Available at the pharmacy and national medical store but not accessed by the public.
Injectable contraceptives (e.g. Depo Provera)	Available and provided at the clinic	
Interuterine contraceptive device (IUCD) insertion	Available and provided at the clinic	Providers were trained and available.
IUCD removal	Service provided at the clinic	Providers were trained and available.
Jadelle implant insertion	Available, service provided at the clinic	Providers were trained and available.
Jadelle implant removal	Service provided at the clinic	Providers were trained and available.
Female sterilisation (tubal ligation)	Service not provided at the clinic	Women were referred to the NRH for procedure.
Male sterilisation (vasectomy)	Service not provided at the clinic	Men were referred to the NRH or to a trained provider.
1.2 STI screening (syndromic or clinical)	Syndromic screening provided	Not routinely performed for FP clients.
1.3 Male-friendly services (promote male involvement in FP)	Rarely provided	Trained male provider unavailable.
1.4 FP guideline or protocol		
Has guideline or checklist for FP service	Yes, Solomon Islands FP Manual	The 2005 edition was available and used.
Recent version of FP guideline	Not available	Recent version not available at the time of assessment (2019)
1.5 FP services to STI/HIV clients. (Are FP services to STI/HIV clients captured at this clinic?)	Yes	STI/HIV services were separate from FP services and provided at the outpatient clinic.

Checklist item	Results	Assessment narrative
1.6 FP data (Are FP data captured clients by methods?)	Yes	Most FP data were captured.
1.7 STI/HIV service clients		
In the last 6 months, have clients left before receiving services because the wait time is too long?	Service not available	STI/HIV services were not integrated with FP service at this clinic.
1.8 Outreach services (satellite clinics)	No outreach services provided for FP (all methods)	Outreach services were provided for other primary healthcare services such as immunisation, antenatal, NCDs, tuberculosis/leprosy and so on, but did not include FP at the time of audit.
Counselling		
Routinely assess client's need for FP services based on their clinical history and reproductive intentions	Yes, most of the time (weekly but not daily)	During FP clinic visits.
Routinely screen clients, to determine what FP services are appropriate (reproductive goals, infertility issues, FP knowledge, family situation, any FP-related concerns)	No, never done	
Provide FP counselling (number of children, intentions of next pregnancy, attitudes about FP, risks of STIs/HIV)	Yes, most of the time (weekly but not daily)	During FP clinic visits.
FP counselling includes correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy (dual method-barrier against STIs and protection for unintended pregnancy)	Yes, most of the time for male condoms; not for female condoms	Counselling given to women who came to access condoms from FP clinic but not to those who collected condoms from the condom house.
Provide safe pregnancy counselling for young women and young men and for women who are currently pregnant or wish to become pregnant	Yes, some of the time (provided only during visits)	Only to those who visited the FP clinic.

Checklist item	Results	Assessment narrative
FP counselling for young girls and boys (14–18 yrs) including future preparation for FP	No, never done	
Provide and promote male involvement in FP	Yes, some of the time (only during clinic visits)	Only to men who visited the FP clinic by invitation when their wives had high-risk pregnancies.
Provide and promote couples counselling	Yes, some of the time (only during clinic visits)	Only to those who visited the FP clinic; most of the time by service provider's invitation to discuss women's health issues (e.g. pregnancy)
Does this clinic provide counselling services for single mothers and elderly women? (e.g. preventing future unintended pregnancies and menopausal issues)	Yes, some of the time (only during clinic visits)	Only to those who visited the FP clinic.
Staffing and training		
3.1 Clinic staff	The clinic was staffed with 2 midwives, 8 registered nurses and 1 nurse aide	Only 4 staff were providing FP (2 midwives and 2 registered nurses).
3.2 Training		
Training on FP	All registered nurses and midwives	
Training on youth and adolescent-friendly services	2 midwives	
Training on the provision of key population or high-risk population friendly services (adolescence, single mothers, men)	1 midwife	
Training on the provision and removal of IUCDs	2 midwives and 2 registered nurses	
Training on the provision and removal of Jadelle implants	2 midwives and 2 registered nurses	
Training on SRH and FP services e.g. midwifery training, FP, reproductive health, the Men's	2 midwives and 2 registered nurses	Midwives had received in-depth training on midwifery, SRH and FP. Registered nurses had received basic training during their pre-service training and when attending

Checklist item	Results	Assessment narrative
Involvement in Reproductive Health (MIRH) programme		refresher courses or workshops (on-the-job training). No one was trained in MIRH.
In the past 6 months, have clients been turned away or asked to return on a different day because there were not enough trained staff available to provide the method requested?	Yes	This happened multiple times in a month.
Do you think the clinic has enough staff trained in FP services to respond to current demand for FP services?	Yes	
Supervision		
Do staff that provide FP services receive external supervision (from national coordinators) to monitor their performance?	No	FP staff could not remember if external supervision had been provided in the previous year.
Do supervisory visits that include review of FP services happen at least 4 times per year?	Yes	Remembered only once in the previous year; was not happening 4 times a year.
Is feedback provided to FP service providers after supervision is conducted?	Yes	Visits were inconsistent (not happening 4 times a year).
Is there a mechanism for documenting supervision visits?	Yes	There was a section in the monthly report where supervision visits were reported, but not specifically in relation to FP services.
When gaps are found during supervision, is a plan developed to address gaps that includes the following information?		The process of identifying gaps and creating plans to address gaps was not clearly defined.
Actions identified to address gaps	No	
Person assigned to complete actions	No	
Due date for completion of actions	No	

Checklist item	Results	Assessment narrative
Is additional FP training available to service providers if needed? (this includes on-the-job training, extra support, on-site mentorship, off-site training)	Yes	Small provincial onsite training was available but National Reproductive Health and Midwifery Conferences had not taken place since 2015.
Drugs and supplies		
5.1 Of the contraceptive methods provided at this facility, which are available today?		
Male condoms	Available	
Female condoms	Available	Not used by women or girls.
POPs	Available	
COCs	Available	
Emergency contraception (Prostino)	Not available	
Injectable contraceptives (Depo Provera)	Available	
IUCDs (Copper T)	Available	
Jadelle implants	Available	
Natural cycle (ovulation chart, cycle beads)	Available	
5.2 Of the contraceptive methods provided at this facility, which have experienced stock-out?		
Male condoms	No	
Female condoms	No	
POPs	No	
COCs	Yes	
Emergency contraception (Prostino)	Not offered/not available	
Injectable contraceptives (Depo Provera)	Yes	

Checklist item	Results	Assessment narrative
IUCDs (Copper T)	No	
Jadelle implants	No	
Natural cycle (ovulation chart, cycle beads)	Depended on provider's knowledge	Availability depended on the nurse's capacity to discuss the method with the client and the client's ability to understand.
5.3 Of the following services offered at this clinic, which have been available at all times in the last 3 months? This means that adequate supplies, equipment and trained staff have always been available.		
Female sterilisation (tubal ligation)	Not offered	Referred to the NRH for procedure.
Male sterilisation (vasectomy)	Not offered	Referred to the NRH for procedure.
Jadelle implants insertion	Yes	
Jadelle implant removal	Yes	
IUCD insertion	Yes	
IUCD removal	Yes	
Urine test for pregnancy	Yes	
5.4 Does the facility have pregnancy tests onsite?	Yes	Clients paid for the urine pregnancy test kit.
5.5 Does this clinic have a supply management system that is used to track FP commodities? This can include stock cards, monthly summaries etc	Yes	
5.6 Have the staff providing FP at this clinic received training on how to track FP commodities?	Yes	
5.7 In the last year, when have you experienced a stock-out of one or more contraceptives, what is the longest time it has taken to replace them?	Between 1 week and 1 month	This clinic was 4 kms from the National Medical Store and 3 kms from the NRH, which had a large pharmacy department.

Checklist item	Results	Assessment narrative
Clinic infrastructure and resources		
6.1. Go to the room where FP clients are examined. Are the following true of the exam room?		
Has respective seating areas for the client and the provider	Yes	
Is lit well	Yes	Used to be, but the lighting was not currently working.
Has examination bed	Yes	
Provides visual privacy for individual clientencounters	Yes	
Has a sound barrier for privacy (the room should be completely enclosed)	Yes	The room was not soundproof.
Has a hand-washing station	Yes	
Has soap for washing	Yes	
Has a receptacle for waste disposal	Yes	
Has clinical equipment for vaginal exams including vaginal speculums	Yes	
Has equipment (sterile) for IUCD insertion	Yes	
Has equipment (sterile) for IUCD removal	Yes	
Has equipment (sterile) for Jadelle implant insertion	Yes	
Has equipment (sterile) for implant removal	Yes	
6.2 Go to the room where FP counselling takes place. Are the following job aids available?		
Samples of available FP methods/FP demonstration tray	Yes	
FP choices chart or poster	Yes	

Checklist item	Results	Assessment narrative
FP screening checklist	Yes	
Penile model	Yes	
Pelvic model	No	
6.3. Go to the room where FP clients wait to be seen. Are following true of the waiting area?		
Seating is available for clients	Yes	
The area is shaded or covered by a roof	Yes	
6.4. What types of FP IEC materials are available for clients?		
Posters	No	Posters were taken down when the clinic was renovated and staff were unable to locate them.
Flip charts	Yes	
Brochure/pamphlet/information sheet for clients to keep (at least 10)	Yes	
Videos and CDs	Yes, in past years, not now	The clinic had videos and CDs in the past, but they were not used anymore. The equipment was no longer functioning so the staff could not screen them.
6.5. Are the IEC materials comprehensible by those who cannot read or translated into local languages?	No	Most brochures were written in English, with a few (~ 5) written in Solomon Islands Pijin.
6.6. Are permanent signs displayed on the street or on the exterior indicating that FP services are available at this clinic?	Yes	Displayed on the sign outside the clinic building.
6.7. Does the clinic have a space for appropriately storing contraceptives away from water, heat and direct sunlight?	Yes	
Referrals		

Checklist item	Results	Assessment narrative
Does this clinic provide referrals for FP services?	Yes	
Does this clinic maintain a directory of referral sites?	Yes	
Is the directory easily retrievable and accessible to all staff making referrals?	Yes	Not used at the time of the field visit.
Is the directory regularly updated? For example, if something were to change at a clinic, would the directory be updated to reflect that change?	Yes	Mobile phone contacts were the updated contacts available at the clinic.
What method is used to refer clients?	Written referral letter/form	A hard copy of the form was mostly used. Referrals were sent to the NRH.
In the last 3 months, has this clinic ever run out of referral forms?	No	
7.1 What information is provided to the client in the referral?		
Location of site	Yes	
Hours that the services are available	Yes	
Expected fees	No fees required/charged for the service	Government services were free. The cost of travelling to the referral site and living expenses were typically at the client's expense.
Contact person	Yes	
Instructions for reaching site	Yes	
7.2 In your opinion, are the facilities to which you refer clients for FP services easily accessible to all clients? For a service to be readily accessible, transport to the facility should be readily available and affordable, and services should be provided at reasonable price for all clients.	Yes	In the context of Rove Urban Clinic, it was more likely that clients would find their own transport and pay for it themselves as the facility is in the city.

Checklist item	Results	Assessment narrative
7.3 Is there a system in place to track whether a client has completed a referral?	No	There was no system to track referred clients in this clinic.
If a referral is not complete, is an attempt made to contact the patient?	No	No attempt was made because no follow up was conducted for referred patients.
Is the status of tracked referrals recorded? Each referral should be recorded as complete or not complete. Select NA if there is no system in place to track referrals	NA	No system was in place to track referrals.
What percentage of tracked referrals are tracked? Verify referral records for at least 10 referrals, skip recent referrals if not tracked. Select NA if there is no system in place to track referrals	NA	No system was in place to track referrals.
What percentage of tracked referrals are completed?	Not known	

4.3.2.1 Checklist Audit Summary

Seven service delivery areas were included in the Rove Urban Clinic FP services audit: services, counselling, staffing and training, supervision, drugs and supplies, clinic infrastructure and resources and referrals. Below is a summary of the results.

4.3.2.1.1 Services

FP services and contraceptives were available weekly and integrated with the postnatal clinic at Rove Urban Clinic. Outreach services were available but did not include FP services and contraceptives. Male-friendly services were rarely provided. STI/HIV services were not provided at the FP clinic, with STI consultations provided at the outpatient clinic. A youth-friendly service was available at a separate clinic.

4.3.2.1.2 Counselling

Routine counselling was mainly provided to those who attended the FP clinic—mainly married women. Men and young people rarely received counselling at the FP clinic. Married heterosexual couples received counselling on an as-needed basis. Counselling mostly centred on contraceptive methods and rarely referred to socioeconomic issues.

4.3.2.1.3 Staffing and Training

Of the 11 service providers staffing Rove Urban Clinic, only four female providers were working at the FP clinic. All staff had received basic training on FP, but only two midwives and two registered nurses had specialised FP training, including FP for youths and the high-risk population. Service providers felt that the current number of staff was sufficient to respond to FP service demands at Rove, yet clients were often turned away or asked to return on a different day because trained staff were not available.

4.3.2.1.4 Supervision

No regular supervision visits occurred at Rove Urban Clinic. No specified visits to review FP services were recorded. Follow up after supervision visits was rare. No plans were developed to identify and address service gaps, although additional ‘on-the-job training’ could be requested from the national RMNCAH and FP managers when needed.

4.3.2.1.5 Drugs and Supplies

All short- and long-acting reversible contraceptives were available at the time of audit. Clinic staff were well versed with the supply management system to monitor contraceptive stock. Stock-outs (i.e. no stock) had been experienced. The longest time taken to replace contraceptive stock was between one week and one month, despite the short distance to the National Medical Store.

4.3.2.1.6 Clinic Infrastructure and Resources

There was a sign outside the clinic building indicating days and times when the FP clinic was available. The clinic had two enclosed examination rooms with adequate examination beds that provided privacy but were not soundproof. Sterile equipment was available for pelvic examinations and insertion and removal of implants and IUCDs. The clinic had sufficient storage space for contraceptives. Basic counselling aids were available in simple English or local Pijin, but these needed to be updated and were incomprehensible to those who could not read.

4.3.2.1.7 Referrals

Clients requiring tubal ligation and vasectomy were referred to the NRH. Clients typically paid for their own transport to the hospital, usually via public bus or in private vehicles. The cost of the procedures was covered by the Solomon Islands Government, but clients paid for their living expenses during admission. There was no system in place to track clients referred for FP procedures, with no follow up conducted; the number of referrals are not tracked.

4.3.3 Review and Audit of Family Planning Clinical Records

The clinic records audit examined FP clinic records and the monthly FP reports between 2015 and 2019, as described in Chapter 3. All clinic records were manually recorded and kept at the clinic. At Rove Urban Clinic, most records (2015–19) were available, including clinic copies of monthly reports. These records were kept together in a folder. The reports also included some data about adolescent reproductive health services provided at the outpatient clinic, such as those for STIs and contraception. I noted that the record books used to register clients at the FP clinic had not been updated; therefore, outdated contraceptives such as ‘Lippes Loop’ were crossed out and new contraceptive labels such as ‘implants’ were handwritten on the records as needed. Therefore,

additional record books were used to record implants and other FP variables (target FP indicators) that were not included in the original FP register book and were required for current reports.

Some entries recording services provided to current FP users in the HIS reports showed inconsistencies, potentially meaning that incorrect entries had been made or that calculations may be incorrect. Sometimes the records included illegible handwriting. Missing, incomplete and inconsistent information were common features of the records and reports at Rove Urban Clinic. When examining these records and reports, I only collected data that related to FP services. The available audit data were compiled and analysed using descriptive statistics as discussed in Chapter 3.

4.3.3.1 Clinical Record Audit Results

Although most clinic records were available, examination of Rove Urban Clinic records and reports showed some incomplete, erroneous and/or missing data. The audit of aggregated data, along with diagrammatic representations, is reported on below for the occasions of service: for all years and months between 2015 and 2019; by the client's marital status; by parity; and by youth clients.

4.3.3.1.1 Rove Urban Family Planning Clinic Occasions of Service: All Years and Months

There was a gradual increase in occasions of service from 2015 to 2018, followed by a decrease in 2019. Figure 4.9 shows cumulative Occasions of Service at the clinic. The estimated number of women of reproductive age for the West Zone was 1,971. On average, there were 5–10 occasions of service at the FP clinic each week.

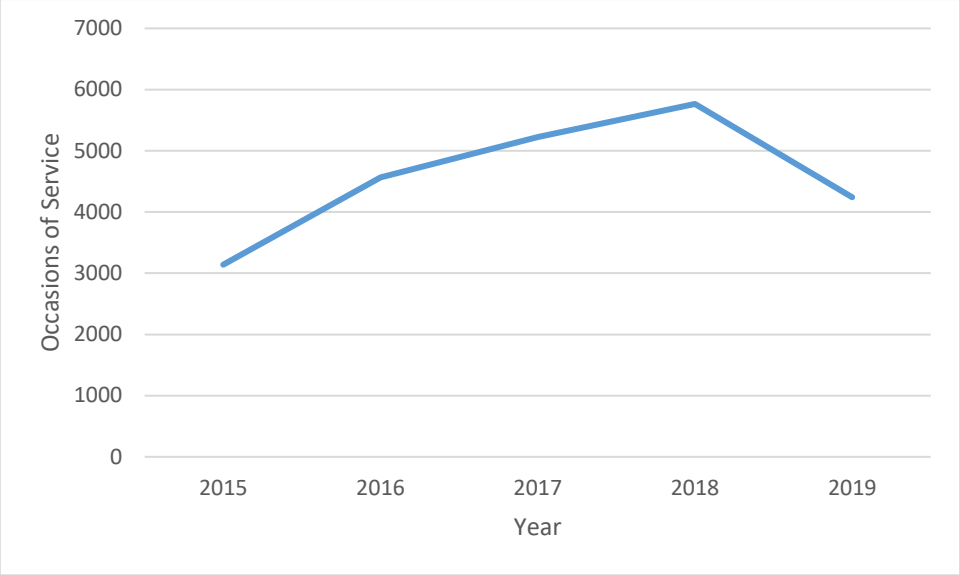

Figure 4.9. Rove Urban FP clinic occasions of service: all years and months

4.3.3.1.2 Rove Urban Family Planning Clinic Occasions of Service by Contraceptive Method

Figure 4.10 shows that clients appeared to prefer to use LARCs rather than short-acting contraceptive methods as a temporary contraceptive measure. No attendance was recorded for female condoms as this method was not used by clients. Attendance to obtain male condoms at the FP clinic was predominantly by women. It was unclear if condoms dispensed at the outpatient clinic were included in the FP records. The number of condoms available for collection from the condom house were not recorded and are thus not reflected in the graph.

Tubal ligation and vasectomy are irreversible procedures in Solomon Islands, and thus are considered permanent contraceptive methods. Both procedures require minor surgery, and while tubal ligation is only performed as an inpatient procedure at the NRH, vasectomy can also be performed by trained healthcare providers as an outpatient procedure. The audit did not find occasions of service for vasectomy. The number of tubal ligation referrals recorded was inconsistent in the audited reports, which were most likely prepared by different personnel in alternating months. The audit found some errors in the calculation of numbers of current contraceptive users.

Adults often undergo a tubal ligation or vasectomy when they decide to stop having children. When speaking with an FP provider, clients can choose permanent methods following life-threatening situations during pregnancy or childbirth, supported by appropriate counselling from nurses.

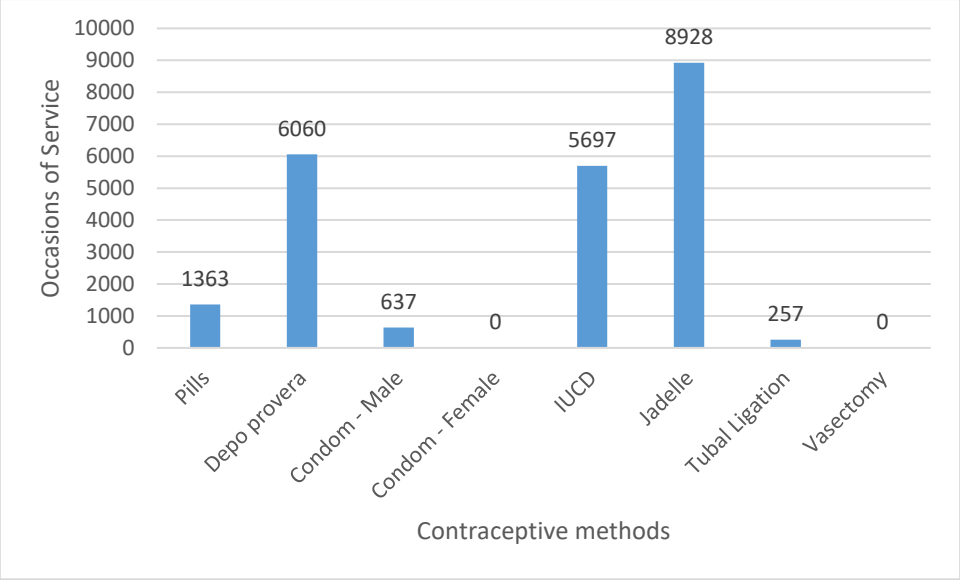

Figure 4.10. Rove Urban FP occasions of service by contraceptive method

4.3.3.1.3 Rove Urban Family Planning Clinic Occasions of Service by Age

FP attendance data were extracted from a manually recorded FP register book that listed the details of clients who attended the Rove FP clinic on FP days. Records were available for the year 2019. The charge nurse reported that records for 2015–18 existed but could not be located for review.

Data collated from January to August 2019 showed 100% female attendance at FP clinics. No male attendance was recorded on the FP register, nor were any records of attendance shown for young people aged 14 years or less; the 25–44-year age group was the main cohort attending the clinic (see Figure 4.11).

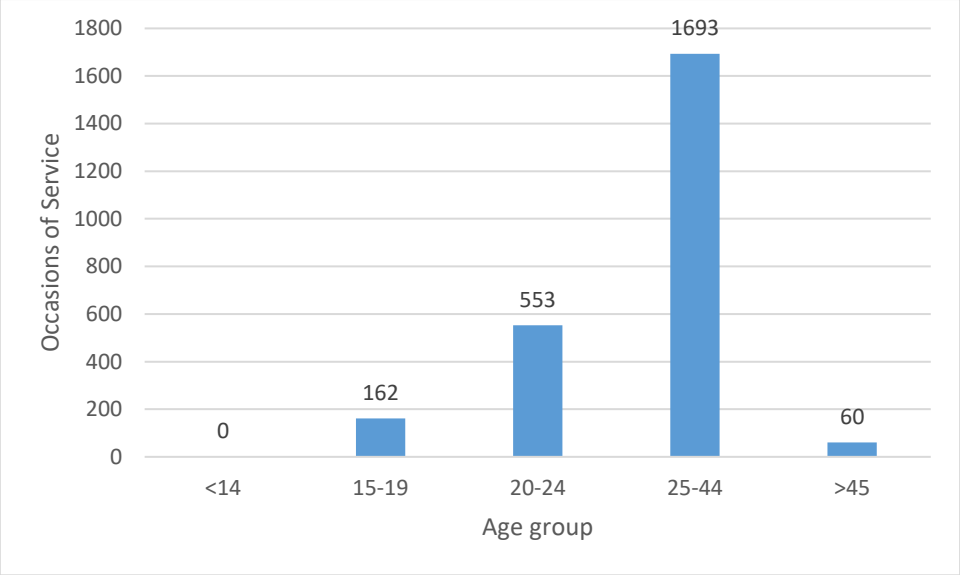

Figure 4.11. Rove Urban FP clinic occasions of service for women by age

4.3.3.1.4 Rove Urban Family Planning Clinic Occasions of Service by Marital Status

It was predominantly married women who attended the FP clinic (see Figure 4.12). The unmarried group consisted of single women, women who were divorced, separated or widowed, and women in de facto relationships.

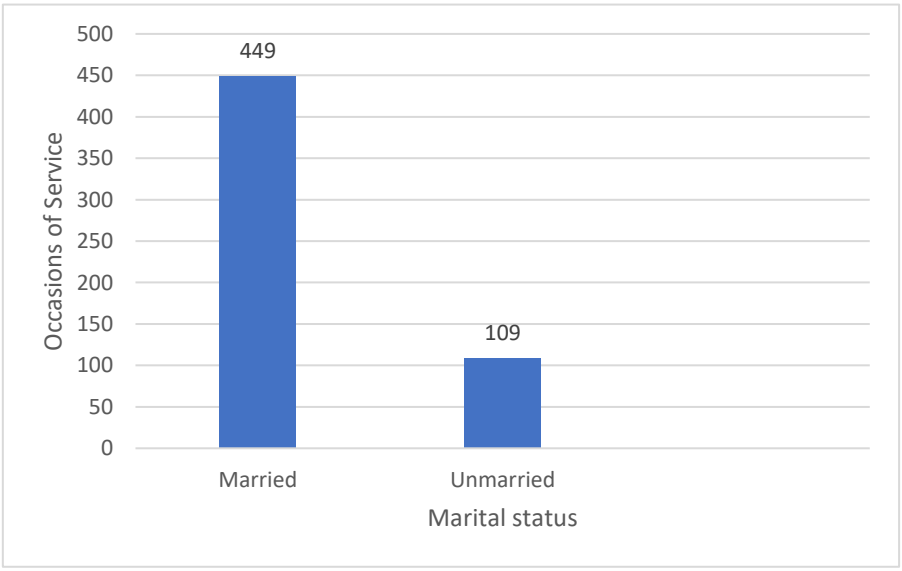

Figure 4.12. Rove Urban FP clinic occasions of service for women by marital status

4.3.3.1.5 Rove Urban Family Planning Clinic Occasions of Service by Parity

The data showed that women without children or women with four or more children were less likely to attend the FP clinic (see Figure 4.13).

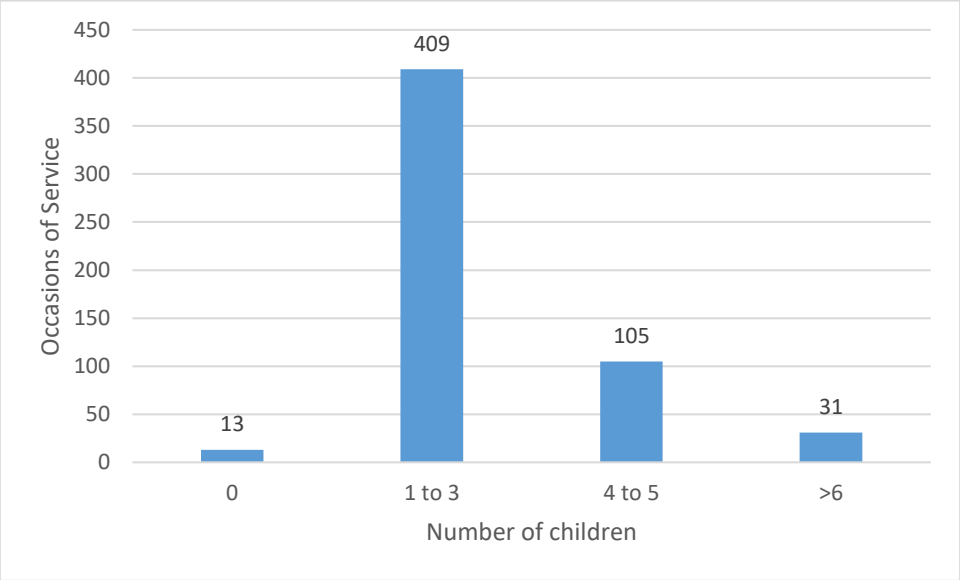

Figure 4.13. Rove Urban FP clinic occasions of service for women by parity

4.3.3.1.6 Occasions of Service by Youth Clients at Rove Urban Clinic

Youth clients often attended the general outpatient clinic for youth-friendly services and FP needs. Attendance data for youth clients at the Rove clinic were extracted from the outpatient clinic records and compiled with the SRH reports. I included this report in the audit as it included information about FP services. Among other SRH services, FP was also included in the youth-friendly service provided at the outpatient clinic. Here, only age, gender and occasions of service of youth clients were reported.

There were limited records available about youth clients attending the clinic for the years prior to 2018. For 2018, only the December report was available, and this may not accurately represent youth clients' access to contraceptives. However, this audit presents a snapshot of the contraceptive services that are available and accessible to youth clients at a clinic level.

Since 2018, youth clients from the Rove clinic catchment area have visited the 'Youth-Friendly Corner' at White River Clinic. In the clinic's report on services for youths, no community and school visits were recorded. This could mean no visits were conducted or that these visits were

recorded in a different record such as the outreach clinic records, which is beyond the scope of this study.

Youth clients aged 14 years or less accessed services from the outpatient clinic rather than the FP clinic. Overall, there were fewer young people aged less than 20 years than those over 20 years who attended the outpatient clinic for SRH and FP purposes. Females outnumbered male attendances across all youth age groups. The age group 20–24 years had the highest number of FP clinic attendances (see Figure 4.14).

a) Youth client Occasions of Service by age and gender

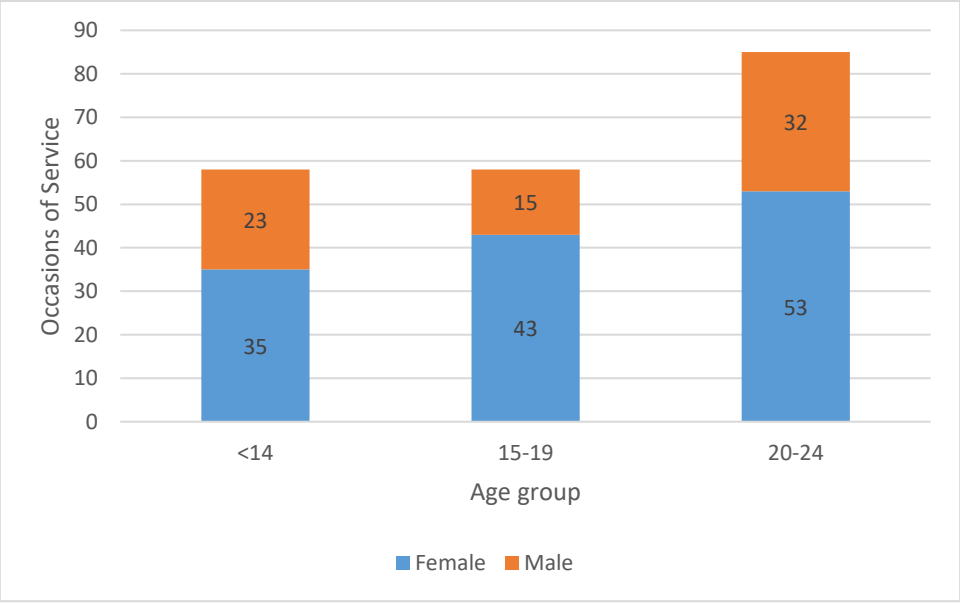

Figure 4.14. Rove Urban Clinic youth clients occasions of service by age and gender, December 2018

b) Youth client Occasions of Service by contraceptive methods

Among youth attending for FP, young female clients preferred implants over other temporary female contraceptive methods. Male condoms were available as the only temporary method of contraception for use by men (see Figure 4.15). As noted with other audited records, provision of male condoms was not accurately recorded at the clinic as a contraceptive method, but these were dispensed for prevention of STIs. No records of emergency contraceptives were found in the clinic records. Permanent methods are not recommended options for young people in Solomon Islands but are offered when couples or individuals have had some children and have decided to have no more or when pregnancy and childbirth are life threatening for a woman.

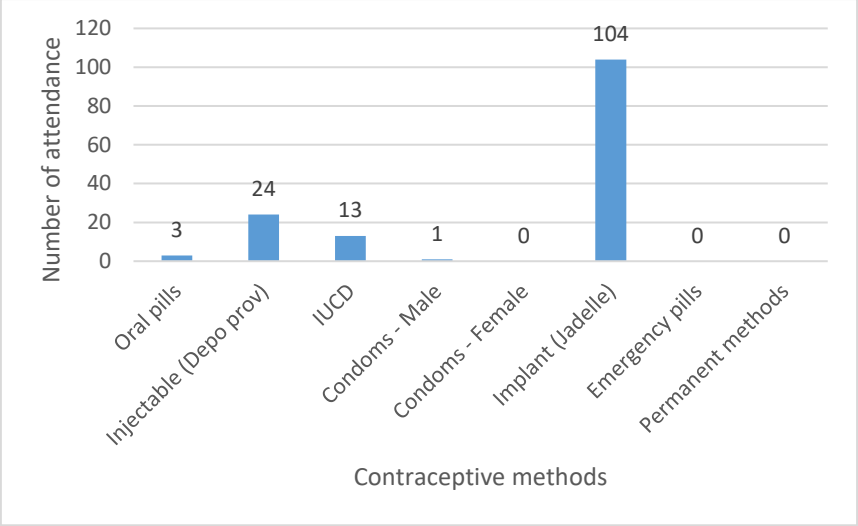

Figure 4.15. Rove Urban Clinic youth client occasions of service by contraceptive method, 2018

4.3.4 Qualitative Interview Data

Qualitative interviews were conducted with 16 participants: service users (n = 3), non-users (n = 7), service providers and managers (n = 6) as described in Chapter 3. I interviewed service users and non-users first, followed by service providers and managers. In addition, I interviewed national RMNCAH managers from the MHMS while I was in Honiara, to obtain national perspectives about FP services in Solomon Islands. I purposely carried out the interviews in this order so that I listened to users' and non-users' perspectives before hearing the perspectives of the service providers. This helped me add a new layer of understanding from my insider view as a FP provider to an outsider, where I was able to see familiar things differently.

Before beginning the interviews, I explained the research, obtained consent for audio-recording and provided the information sheet. When participants agreed, they signed the consent form. All participants recruited for an interview at Rove Urban Clinic voluntarily agreed to participate, and a gift of appreciation was provided at the end of the interview.

I invited female users and non-users at the FP, postnatal and antenatal clinics to participate in the study as they came in for a service. The service providers helped me identify FP users and non-users by referring to the clinic record book. Non-users were identified at the clinic with a screening question to determine if they had ever used contraceptives. I asked participants where they lived, and the service providers assisted by confirming that participants were from the West Zone catchment

area. Before an interview, I asked each potential participant to confirm with me if they were users or non-users of any FP services or contraceptive methods. I then went on to interview them in a room where examinations were usually conducted for reproductive health issues. This room was provided for privacy reasons and was quiet, enabling me to hear participants clearly. All female participants were interviewed in this room. Despite the room being private, several of the unmarried young women were shy about talking openly. However, all the married female participants were confident and openly shared their experiences about FP services at the Rove clinic.

As it was mostly women who attended the FP, postnatal and antenatal clinics, I did not recruit men via these clinics. Instead, I returned another day during a child welfare clinic session and interviewed two men who had brought their sick children for examination. I interviewed another two men who were accompanying their wives and children to the outpatient clinic for other purposes. To be culturally sensitive, I interviewed these men in a room where female clients were not present. The service providers recommended a male user who was willing to participate in an interview. He agreed and chose to be interviewed later at his workplace.

Male participants who were non-users provided little information about FP services as they had not accessed or experienced FP services themselves, but they appeared happy to talk about what they knew. One male non-user who brought his child to the Child Health Clinic consented to be interviewed so was recruited. However, during the interview process he seemed uneasy to talk to me as a female interviewer, so when I sensed his discomfort, I diplomatically ended the interview. Apart from this experience, I found most young male participants very open and willing to share their perspectives about FP services.

Service providers were interviewed at the clinic. The HUNS RMNCAH manager was interviewed in her work office and national RMNCAH managers were interviewed in their offices at the MHMS headquarters in Honiara.

Qualitative interviews were facilitated using the semi-structured qualitative interview guides respectively for service users and non-users, and service providers and managers (Appendix 2), as described in Chapter 3. Findings were grouped into five main themes. Participant demographics showing gender, age and education level are provided in Table 4.2.

Table 4.2

Participant Demographic Description: Gender, Age and Education Level

Participant category	Gender		Age group in years					Education level		
	Female	Male	<20	21–30	31–40	41–50	>50	Primary	Secondary	Vocational/ teritiary
National manager	2	0	0	0	0	1	1	0	0	2
Service manager/ provider	4	0	0	0	1	2	1	0	0	4
Service user	2	2	1	2	0	1	0	1	1	2
Service non-user	3	3	1	4	0	1	0	1	2	3
Total	11	5	2	6	1	5	2	2	3	11

The availability, accessibility and acceptability of FP at Rove Urban Clinic was explored in 16 interviews, with data thematically analysed. Findings from this analysis are represented through five themes: 1) awareness raising and counselling about FP; 2) women-focused FP services; 3) FP services need men's involment; 4) the need for culturally sensitive and friendly FP services; and 5) national and provincial perspectives about FP.

4.3.4.1 Awareness Raising and Counselling About Family Planning

Awareness raising about FP involves dissemination of information about FP and contraceptives provided by health workers (mostly nurses) to inform, promote and educate the public in the use of contraception. Awareness sessions are usually provided at clinics, schools and communities. Findings showed that awareness in FP had been targeting women who attended FP clinics and did not reach young people, men or people in the general community. Awareness-raising sessions had been limited to the use of contraceptive methods and did not include a holistic approach. Counselling sessions were also not delivered in culturally appropriate ways.

4.3.4.1.1 Family Planning Awareness Raising Did Not Reach Young People and Men

Awareness raising about FP had contributed to people's understanding of the availability and accessibility of FP services, and the important contribution of FP to better health outcomes. However,

FP awareness had not reached everyone in Rove clinic's catchment area, including young people and men. At Rove clinic, FP awareness raising was typically provided during FP and antenatal clinics, targeting women. Only women attending these clinics were able to hear FP messaging. A service provider reported that:

> *current awareness lo family planing ia hem no really work aot wanem tumas tu, bikos mifala only targetim olketa women ia seleva nomoa lo taem blo famili planing and taem blo antenatal nomoa, mifala no really duim awareness lo taem blo outpatient tuia* [Current awareness in FP did not really work well, because we only targeted women during FP and antenatal clinics; we did not really provide awareness during outpatient clinics as well]. (1FPP1)

Young people lacked understanding about FP, with many young participants thinking FP is only for people who have had children. A young male non-user said it would be easy for young people to visit the clinic if they were more knowledgeable about the service: '*hem bae isi bat bikos olketa young pipol no garem gud understanding aboutim so dasta wae olketa no save go tumas*' [it would be easy for young people to go to the clinic, but they do not have a good understanding about FP; that is why they do not go] (1MNU2). A young female non-user said she had heard about FP and contraceptive methods but did not understand what they were: '*O ia mi herem nomoa lo skul, bat mi no save wat na hem minim ia. Wanfala mi herem olketa save talem olsem depo or samting olsem*' [Oh yes, I heard about FP at school (high school), but I did not understand what it means. One I heard them talking about is depo or something like that] (1FNU2).

With FP awareness typically provided at the FP clinic, men who rarely visited or attended the clinic were not exposed to FP messaging. A male user stated that FP awareness raising should be consistent and extended outside the health facility to reach more people: '*Fo famili planning ia, olketa sud mekem aweanes hem continue bae pipol kam ia … so ating hemi nid fo mekem gud aweanes lo aotsaed* [communities] *ia*' [FP awareness should be regular; this will make people come forward … I think there needs to be good awareness to outside communities] (1MU1).

4.3.4.1.2 Family Planning Awareness Raising is Not Engaging

Participants believed current FP awareness methods were ineffective because people were unable to engage with the information presented. One participant noted, '*if yumi advocate an sem taem umi tasim laef blo pipol, olketa garem tingting bae come forward ia*' [if we advocate and at the same time touch people's lives, they will be thinking about these things and come forward (for FP)] (1FPP3). To 'touch people's lives' meant FP information must be related to people's life situations so that people understand how it will affect their own lives.

Participants described how awareness must focus on factors that directly affect people's lives, such as economic benefits and the health and wellbeing of mothers and their children. A national manager said:

> *Iumi evritaem tok abaotim commodities nomoa … bat iumi mas tok abaotim wat na olketa benefits blo hem an den iumi tok abaotim saed lo seleni blo famili, helt blo baby blo hem and future siblings ia so hem na wanfala samting mi lukim ia* [Most of the time we talk about commodities (contraceptive methods) … but we must also talk about the benefits, including financial implications and future health status of the woman's baby and children; this is one thing I realised.] (1NFPM2).

Participants noted that to be effective, awareness programmes need to present all sides of the FP story—the advantages, disadvantages, benefits and side effects. One male non-user stated that awareness, '*mas talem gud an bad abaotim na FP … so dat lo early stage olketa garem gud tingting mekem olketa prepare tu taem olketa kam lo FP klinik*' [must tell them the good and bad things about FP … so that they have time to think about the information and come prepared (informed), when they visit the FP clinic] (1MNU2). When there is limited or no awareness raising to correct the misinformation, people are confused and cannot make informed decisions about use of contraception.

Community-wide awareness raising may assist the potential user to feel supported in their decision. When people meet opposition (from husbands/wives or others), they find it hard to come forward to seek the service. A service provider reported that, '*wanfala main contributing factor na rumas … narawan ating no aweanes. Olsem mifala tu ating fail fo duim aweaness so olketa no save what na family planning abaot, olketa methods ia, oketa side effects olsem*' [one main contributing

factor is rumours … I think the other one is no awareness. We (nurses) also fail to do awareness so people will not know what FP is, including the methods and their side effects] (1FPP1).

4.3.4.2 'Story Good' About Family Planning in Culturally Appropriate Ways

'Story good' (correct counselling) refers to the ability of FP clinic staff to provide a balanced (good and bad sides) story about the concept of FP. 'Story good' is especially important when there is misinformation in the community that results in people feeling afraid. A national manager shared an experience about common rumours regarding the new Jadelle implant and the importance of correct counselling:

> *staka rumas, enikain na olketa talem, olketa se hem satalait, antenna so bae trakim yu, radar moa, hem taoa blo telekom [telecommunication company], bae yu sok lo hem an dae olsem…others se hem garem big screen lo USA bae olketa monitorim yu everiwea yu go, taem silipi wetem husband bae olketa lukim yu … So wanfala taem mi kasem one klinik, ful vilej kam nao, olketa wea usim Jadelle ia kam for remove olketa se, so olketa kolem mi go lo dea den stori gud wetem olketa, stretem tingting blo olketa. In the end no body removed, everyone just went back and were happy. So olsem correct counseling lo kain samting olsem hem important tumas* [There are many rumours that go around, they said it (Jadelle implant) was a satellite, an antenna so it will track you, it's a radar, or a telecommunication tower that can electrocute you and you will die … others say there is a big screen in the USA (United States of America) and they can monitor you everywhere you go; they can even see when you sleep (have sex) with your husband … Once I visited one clinic, when all the village women who took Jadelle came to the clinic to have their implants removed because they had heard the rumours. I went and 'story good' with them and corrected the misunderstandings they had. In the end no one removed their implants; they all went back home happy] (1NFPM1).

Participants stated that 'story good' must be clearly communicated in simple language and presented in culturally acceptable ways to groups or individuals by a service provider who is sensitive to cultural ways of talking to people. A male non-user recommended culturally sensitive ways as, '*olsem lo klinik mas separetim fo olketa gele bae eni nes blo gele lukim olketa. Olketa boys bae*

wanfala nes boy mas go lukim olketa' [In the clinic, FP service providers for girls (also refer to women) and boys (also refer to men) must be separate. Girls must be seen by a female nurse, and boys must be seen by a male nurse] (1MNU1). Another male non-user reported that although he had heard 'story' from nurses, he still did not get the complete story. '*O olketa samfala klinik, nes save go go lo dea olketa save stori, bat kain fo storim gud ia nomoa yet ia*' [Oh, in some clinics, nurses often go there to story about FP but not a complete (balanced) 'good story'] (1MNU4).

Just as participant users and non-users preferred to be seen by someone of the same gender as themselves, service providers also struggled with their own cultural values when delivering FP services. A service provider reported that she was not confident to talk about FP to mixed groups of men and women, but could only talk to women groups: '*olsem hem lelebet … umi sud brekem dat fala beria fo tokabaotim (FP) lo pipol bat olsem fo mi ia, mi no courage yet fo tok lo olketa mix pipol taem olketa stei araon olsem*' [it's like … we should break that barrier to discuss (FP) to people, but for me I still did not have courage to talk to mixed people groups when they are around] (1FPP1).

However, another healthcare provider was confident that a good explanation is what matters for most women: '*lo hia family planning ia, if olsem mifala explenim gud lo olketa woman bae olketa tekem nomoa ia*' [with FP, if we explain it well to women, they will take it] (1FPP2).

FP awareness raising did not reach everyone. It was mostly targeted at women and provided at the health clinic. Information about FP also focused more on contraceptive benefits and did not balance the disadvantages and side effects of contraceptives. Counselling on FP needs to be relatable to people's current needs and presented in simple language and in culturally acceptable ways. When people are engaged, they can relate to the information received, practically apply it to their situation and use the information to make informed decisions about selecting and using contraceptive methods.

4.3.5 Women-focused Family Planning Services

The traditional women-focused FP clinic services made many non-user participants believe that FP provided at the clinic was only for women. This focus also influenced service providers' expectations so that they only expected to see women and were surprised to see men at the FP clinic.

4.3.5.1 Family Planning is Not For Boys

Mostly women and girls attended the Rove FP clinic, and predominantly female midwives and nurses provided the FP services. When people observed this pattern, they believed the service was only for women and not for men. A young male non-user said, '*mi ting se family planning hem no blo mifala boys, only fo olketa gele and woman nomoa, so olsem fo go ia bae mi say nomoa yet*' [I think FP is not for us boys, it's only for girls and women, so I have not even visited the clinic yet] (1MNU2). The same participant further explained why women dominated FP clinic attendance: '*olketa wea providim sevis ia olketa woman so hem na beria fo man no go tumas lo FP klinik ia*' [those who provide the service are also women, so this is the barrier for men to go to the FP clinic] (1MNU2).

Another male non-user shared his experience when he accompanied his wife and newborn baby to the FP/postnatal clinic, '*after skelem pikinini bae kolem olketa woman go insaed … Mi bae sidaon aotsaed, mi no save wat na hapen insaed. So olsem tingting blo mi, ating blo olketa woman nomoa so olketa no kolem man go insaed ia?*' [After weighing the baby, they (nurses) call women to go inside … I sit outside, I do not know what happens inside. So, this made me think—maybe it's only for women so they do not call men to go inside?] (1MNU3).

Service providers also did not often think of men as potential FP clients because men rarely attended FP clinics. Therefore, no provisions had been made at the clinic to accommodate them. A service provider reported factors that may have hindered men from attending the FP clinic at Rove:

> *saed lo man so far, mi no lukim eni man really kam laekem fo family planing, … maybe setting blo mifala na mekem olketa man no save kam tuia, bikos taem olketa kam lo hia evri woman nomoa sidaon lo dea, olsem no proper ples fo olketa man save kam involve lo saed lo postnatal or antenatal olsem … samfala taem ating samfala attitudes blo mifala health workers taem olketa man kam, 'ae yu kam fo babule tu?' kain olsem so ofum olketa man na*
>
> [so far, I have not really seen men who wanted FP coming here … I think maybe our clinic setting discourages men from coming; there's no proper place to accommodate men and involve them in postnatal or antenatal clinics. Mostly women are occupying these seats

(waiting area) when men come in … sometimes it could be our (health workers) attitudes towards men. When men come to the clinic, health workers often say (jokingly), 'oh are you also coming for pregnancy purposes?', so this kind of thing will put men off (and they will never come back)] (1FPP1).

It was clearly reported that the clinic environment and attitudes of health workers discouraged men from attending.

4.3.5.2 Availability of Contraceptive Choices at The Clinic

Most of the modern temporary contraceptive methods available at Rove Urban Clinic were female methods (OCPs, injectables, IUCDs and implants), with male condoms the only temporary option for men. Married men rarely attended the FP clinic for male condoms, as their wives often collected the condoms. However, the distribution of condoms was not recorded. A man may attend at the request of the service provider to sign the consent form for their wife's tubal ligation or for vasectomy (though rarely): '*fo other methods ia, mi no lukim olketa man kam forward, bat only TL (tubal ligation) nomoa and vasectomy, hem nomoa olketa man save kam … so taem tufala kam mifala save stori gud an den mifala signim na consent form*' [for other methods I do not see men coming forward, except for tubal ligation and vasectomy … when they come, we give them a good story (counselling) and then they sign the consent form (for tubal ligation)] (1FPP1).

Young unmarried men and women sometimes accessed condoms from the condom house located at the back-door entrance to the clinic, where they could collect condoms without consulting the service provider: '*kondom haus ia mifala putim fo kain olsem olketa youth or adolescents ia, wea bae olketa save kam enitaem fo tekem … hem gud olketa save kam tekem ia bata mifala na no rekodim na kondoms lo kondom haus ia*' [we put the condom house especially for the youths and adolescents, so they can come at any time to take condoms … it is a good approach and they come to collect condoms; but we do not keep records of the condoms we put in the condom house] (1FPP1).

The way FP services had been provided and the attitudes of service providers posed the most common barriers to accessing FP services and contraceptives. In addition, the limited contraceptive options available for men made men think the service was not for them.

4.3.6 Family Planning Services Did Not Actively Involve Men

Men were not actively involved in FP, although they wanted to be involved. As men were the primary decision makers in Solomon Islands, they needed to be involved. The previously implemented *Men as Partners* (MAP) programme where male health workers were trained to support men with SRH issues did increase men's involvement, but its use has waned over the years in Solomon Islands.

4.3.6.1 The 'Men as Partners' Program

Participants recognised the need for FP services at Rove Urban Clinic to involve men. A young male non-user said, '*olketa man mas save lo FP tu, no woman seleva nomoa*' [men also need to know about FP; not only women] (1MNU2).

Participants were aware of the MAP programme but were unsure if it was currently being offered. A service provider reported the status of the MAP programme at Rove Urban Clinic: '*MAP ia, mifala lo West Zone ia hem nomoa long taem na mifala no garem … ating wanfala lo Central Zone … bat mi no save gud olketa sevis hem providim, hem continue yet or no really save wat na hem duim destaem*. [we did not have a MAP person in the West Zone for a long time … I think there's one for the Central Zone … but I do not really know what services he provides, and if he continues to provide services for men at this time.] (1FPP1).

A national manager further explained why it was important to reactivate the MAP:

we need to revive MAP again bikos yu save, men they are decision makers here in famili planing so if we get those men on board they will support family planning … if they are not involved, olketa mere bae nomoa tuia … sapos woman hem go haed go tekem FP, bae man se 'go aotim' … we need to get the initiative going bikos hem na fo go aot an try fo tok lo olketa man blo yumi [we need to revive MAP again because you know, men are decision makers here in FP, so if we get those men on board they will support FP … if they are not involved, women will not be able to access FP … if a woman takes FP without her husband's consent, the man will say 'go and remove it' … we need to get the initiative going because this is how we can reach men and talk to them] (1NFPPM).

4.3.6.2 Men Are Willing to be Involved

When men are involved in decisions about FP, women are more likely to come forward for FP. A service provider reported that many young mothers had begun to come forward to take FP having already discussed FP with their husbands or partners: '*mi tigim olketa man bae willing nomoa fo kam ia … bikos staka young mothers olketa tekem family planning distaem … olketa se hem oraet mi stori wetem husband finis*' [I think men would be willing to come … because many young mothers come to take FP now … they (mothers) said, their husbands agreed after they discussed] (1FPP1).

Men are more receptive and better understand concepts when hearing about FP from another man. A male user described his involvement as a FP advocate in Honiara:

> *mifala lelebet go aot lo samfala awareness lastaem taem olketa usim mi olsem wanfala advocator, so mi sharim ideas lo olketa fathers and husband … olketa husband seleva na mi stori fo olketa an olketa herem gud … dat wan na mi minim bae waka lo olketa ia* [I once joined the awareness team when they used me to advocate (for men), so I shared ideas to fathers and husbands … I talked to all the husbands, and they understood … this is what I think will work for them (men)] (1MNU1).

The MAP had an important role in providing advice and services for men who could not access the clinic to seek consultation and information about contraceptive options. While some men may know where to access the service, others may have no idea about service availability. The same male user reported how he accessed the vasectomy service:

> *so wat hapen, mi no save go lo FP klinik ia, bat mi seleva lukim hem barava important fo mitufala (wife) … so mi hev tu decide seleva nomoa na … mi seleva go lo olketa man nes wea mi save gud lo olketa … mi askem olketa olsem bae hao nao ia? olketa advaesim mi and helpem mi wea fo mi go, den mi go lo ples ia na* [so what happened is, I never go to a FP clinic, but I knew that this is very important for me and my wife … so I had to make the decision myself … I went to see the male nurse whom I knew very well … I asked them how do I go about accessing this service? They advised me and directed me where to go; then I went to that place (for the procedure)] (1MU1).

A national manager had also noticed a change in men's attitudes towards FP. People were more open than in past years: '*pipol nao olketa open fo askem kueson … oketa wiling fo listen, olketa husbands sit in and listen so mi lukim olsem hem wanfala chenge*' [people now are open to ask questions … they are willing to listen; the husbands also sit in (FP awareness raising) and listen so I see this is a change] (1NFPM1).

Men also need to know about FP themselves, for them to realise their roles as partners in FP. The MAP programme provides the avenue to involve men in FP and needs to be revived and strengthened within the health system.

4.3.7 The Need for Culturally Sensitive and 'Friendly' Family Planning Services

4.3.7.1 Family Planning is a Gendered Issue

FP is a sensitive issue in Solomon Islands because of established values, beliefs and sociocultural norms. Thus, the topic of FP was reportedly not easy to discuss generally or in public domains. A national manager explained:

> *bifoa yumi cannot toktok family planning, hem tabu…we have to be careful of how we talk, who na yumi tok lo hem, wat kain ples olsem … bat now a days hem difren, olsem you can talk, pipol olsem acceptim yu fo go* [In the past you could not talk openly about FP, it was a 'taboo' (sacred) … we had to be careful of how we talked, who we talked to and where we held the talk … but nowadays it's different, you can talk about it and people seem to accept it] (1NFPM1).

Although people in recent years have been more receptive to FP, this does not mean that service providers would neglect culturally acceptable ways that will help people access the service. FP service users and non-users expressed the need for a 'friendly', culturally sensitive FP service. Participants described a friendly service provider as someone who keeps confidentiality, ensures privacy, is non-judgmental and provides a culturally safe environment where clients are not ashamed to freely express their FP needs. A male non-user explained,

> *frenli famili planing sevis, tingting blo mi olsem … yu providim a good comfortable environment (mas polite), wea evriwan bae olketa feel free fo atendim na disfala sevis ia …*

sevis ia hem balance gender, boys and girls save go … an explenim gud olketa samting ia [I think a friendly FP service is … you provide a good and comfortable environment (must be polite), where everyone feels free to attend the service … the service also provides opportunity for both boys and girls (young men and young women) to attend … and give good explanations about things (service and contraceptives)] (1MNU2).

A female non-user explained what would be comfortable and acceptable when they seek FP service: '*if olketa gele nes den bae save tok wetem gele, den boy nurse, boy osem na bae gud*' [if female nurses would see women and girls and male nurses see men and boys, this would be good] (1FNU3).

When people are seen in a friendly environment and know about the services they sought, they are more likely to return to the same clinic. A female user reported that she was more likely to visit Rove clinic for FP: '*olsem mi no get use lo olketa nara klinik ia, kain yu go den bae staka long line den enikain, I mean taem iu go, bae talem go olsem go olsem, so lo Rove nomoa olsem mi save*' [I am not used to going to the other clinics; there are a lot of people in a long queue, I mean when you go, they tell you 'go this way and that way'. I only know about Rove clinic] (1FU1).

4.3.7.2 Confidentiality and Privacy in Family Planning

A service provider reported that clients wanted a space, where they could discuss their FP needs. '*wan ting na ating privacy and confidentiality … oketa likem ples wea hem private and confidential … hem mekem olketa fil gud*' [one thing is privacy and confidentiality … they wanted a place where there is privacy and their affairs kept confidential … this makes them feel good (feel safe to discuss sensitive issues)] (1FPP3).

A male user also expressed the need for privacy for men when sought FP services: '*kain yumi sem na fo exposim olketa kain olsem ia … so mi go lo man mi save nomoa mi lukim, mi no go lo olketa woman lo klinik*' [We (men) are ashamed to expose ourselves with such things … for me I only go and see men (service providers), I do not go to women (service providers) at the clinic] (1MU1).

Some young people feared being criticised if their friends saw them going to the FP clinic. This fear resulted in delays in seeking contraceptives: '"*ey man ia laek go ia … ating laek maret ia*

kain olsem" ... so stei nomoa til olketa garem problem den jes go lo family planning' ['hey this person wanted to go (to the clinic) … maybe he/she wanted to get married'… so they did not go until they had a problem before they got to the clinic] (1MNU2).

FP is a sensitive issue; therefore, it needs to be approached with sensitivity. A service provider should be friendly, able to provide services that are culturally sensitive, handle privacy and confidential issues, to ensure universal access and acceptance of FP services.

4.3.8 Integrating Family Planning With Other Services

Integrating FP with other clinic services can be a cost-effective strategy to reach more people with FP. At Rove clinic, service providers were encouraged by their managers to also offer FP during outpatient and child welfare clinics; however: '*mifala save duim family planning during outpatient and child welfare clinic samtaems if mifala no busy tumas*' [we can only do family planning during outpatient and child welfare clinics if we are not very busy (at the clinic)] (1FPP1).

Although FP should be offered at every opportunity at the clinic, a service provider reported this was rarely done:

> *lo luluk blo mi most times, outpatient ia nomoa tuia, wait fo wednesday na ... mifala sapos fo duim tu lo child welfare bat mifala no save duim ... mifala no moa no askem, ating bikos mind nomoa hem say, 'O hem taem blo pikinini' so mifala no ting folom moa family planing, but mifala sud duim tuia ... olsem mifala concentrate lo wan samting ... taem blo nara samting moa mifala no duim na* [from my observations, most times we do not do it during outpatient clinic; we wait for Wednesdays … we are supposed to do (FP) during child welfare clinics but we do not do it … we just don't ask them, I think because our mind is thinking, 'oh it's time for children', so we don't think of FP, but we should do it… when we concentrate on doing one thing, we cannot do another thing at the same time] (1FPP2).

While service providers providing FP may want to reach women at every opportunity and in a variety of clinics, some clinic staff were unaware of this intention and told women to come back on FP clinic day. A service provider described a common occurrence: 'samfala nes se naia … "*woman ia laekem family planing ia ... bat mifala talem hem kam bek lo Wednesday next week"... mifala sud*

talem olketa nes fo no refusim olketa …sapos olketa talem, bae mifala givim olketa nomoa ia. [sometimes nurses tell us, 'a woman wanted FP … but we told her to come back next week Wednesday' … we should tell our nurses not to refuse them … if they had told us, we could have given them contraceptives] (1FPP2). If women were sent away after attempting to access FP outside FP clinic day, they were unlikely to return.

The Rove Urban Clinic Mobile Team provided immunisations and other maternal and child health services but not FP: '*satelite klinik ia, mifala no save go go wetem olketa satelite ia, mi no lukim tu olketa kakarem family planning (methods)*' [we do not usually go with the outreach clinic team; I also have not seen them carry FP methods with them] (1FPP2). The FP service manager explained that the Mobile Team was responsible for providing outreach FP; however, 'it depends on the team leader/charge nurse of the Mobile Team … and as stated by some Mobile Team staff, they only do general outpatient services' (1FPM1).

FP was not integrated with other clinic facility services, including outreach services. Findings suggest there was no clear communication and understanding about integration of FP services at the clinic and management level.

4.3.9 National and Provincial Perspectives About Family Planning

This theme was informed by the perspectives of the national managers from MHMS and provincial managers and providers on reported issues affecting the national FP programme.

4.3.9.1 Family Planning is a National Priority

The FP programme is planned and supported by the national RMNCAH division and implemented in the provinces. Each year the RMNCAH division works on its respective annual operational plans where budgets are created for priority activities to be implemented at the national, provincial and zone levels. FP activities are often discussed with provincial service managers. A national manager reported that, '*famili planning hem priority blo country, mifala lo national level, samting mifala laik fo duim mifala bae mas askem provinces wat na really need blo olketa …ifala mas toktok an agri*' [family planning is a priority in our country; at the national level, when planning, we must ask the provinces what their needs are … we must discuss and agree (on the plan)] (1NFPM1).

However, another national manager thought that to improve service delivery, the planning stage needs to involve the community; those who use the service—not just provincial and national administrators: '*olketa (provinces) sud go daon lo communities, herem from olketa nes an clients bifoa planim kamap … ating lo dea na bae bottom up approach lo planning ia*' [those from the provinces should go down to the communities to hear from the nurses and clients before they create their plans … I think this way will be a bottom-up approach to planning] (1NFPM2). This way planned activities were more likely to be implemented at the provincial level, as some provinces did not implement plans created for them at the national level.

While service managers agreed that FP is the country's priority, it was seen as only a priority on paper and was not reflected in funding support from the government: '*Barava priority naia olsem mi lukim olketa raetim lo paper nao olsem … bat saed lo funding support ia na … ating Gavman sud stat fo helpem olketa donor partners fo putim seleni fo family planning*' [It was really a priority as I saw it written on paper (*National Strategic Plan*) … but with funding support … I think the government should start helping our donor partners to put money into FP] (1NFPM2).

Although FP is a national priority and planned at the national level in consultation with the provinces, it is important that the community voice be included at the planning stage. Despite FP being a national priority, the implementation of the service does not reflect this.

4.3.9.2 Training

In-service and on-the-job training were provided by the MHMS through the RMNCAH programme. Over the previous 10 years, the annual national reproductive health manager's conference and the bi-annual midwifery conferences were held as a platform at which service managers and providers from the provinces came to present their reports (successes and challenges). Although few smaller in-service training activities had been undertaken, these annual conferences were no longer happening. A national manager reported that: '*saed lo selen na mifala stop, mifala cannot continue lo kain ia, although olketa nurses lo province laekem … bat ating hem depend tu lo who na olketa boss, whether olketa lukim importance blo that wan, kain olsem*' [we stopped because of funding issues, we could not continue with this; although nurses in the provinces really liked these

training events … but I think it depends on the leaders there, and if they see the importance of these things, something like that] (1NFPM1).

A service manager also commented that training events had been very helpful '*las wan na lo 2015 den nomoa na … hem na mekem umi lane from each other olsem ia*' [the last one (conference) was held in 2015 and then nothing after that … this conference helped us to learn from each other] (1FPM1).

A service manager reported that the number of staff trained for FP at the HUNS had improved in recent years: '*staffing fo FP sevis, mi lukim hem improve, bikos a lot of training for HUNS hem done, a lot of staff olketa go through training blo FP*' [the number of staff trained for FP services has improved, because a lot of training has been done, and a lot of staff have been through FP training] (1FPM1). One of the challenges in service delivery at the provincial and community level is lack of human resources. The chronic shortage of staff presents an important opportunity to coordinate programmes with churches and community leaders.

4.3.9.3 Funding Support for Family Planning

Most of the funding support for FP programmes in Solomon Islands has come from external donor partners such as the UNFPA; some from DFAT; and only a small portion from the government. When these external funds were not available, FP programmes were affected: '*ating two years ago mifala garem lelebet problem lo UNFPA funding bikos ating 80% funding for RMNCAH for sapotim FP hem kam from UNFPA ia*' [I think two years ago we had some problems with the UNFPA funding] (1NFPM2). This funding problem has affected national programmes such as supportive supervision and training to reach the provinces and zone clinics in the past two years. The national manager further assessed that to sustain FP programmes, the national government needs to support the donor partners with funds for FP: '*maybe now they are starting to see it, that hem true na ating government sud stat fo helpem olketa donor partners fo try putim seleni lo family planing olsem*' [maybe now they (government) are starting to see it, that its true I think the government should start to help the donor partners to try and put some funds towards FP] (1NFPM2).

Another national manager reported that much awareness still needed to be created among people about FP: '*bata olsem lo hia selen fo go aot hem nomoa tu, so olketa lo hia laek go aot bat hem hard, olketa lo provinces like go aot but hem hard tu*' [but there's no money (funding) to go out (outreach), so those from the national programme and those in the provinces may want to go but its hard (they can't go)] (1NFPM1). However, even if funding was not available, participants reported that FP could still be part of the clinic service at the facility, like motivation, awareness and contraception services. However, outreach activities could not be performed as funds were needed for transport costs given the geographical situation of the country.

4.3.9.4 Challenges with Funding

When funding was available at the national level, delays in fund disbursement often delayed implementation of activities. The process to access funds was often challenging for service managers and providers. In most cases funds were available in the later part of the year and the money would then go through a process (at the Ministry of Finance) that often took months: '*dis taem family planing selen hem kam in naia bat iu lukim nomoa longo September, October and November ia hem rushing hour naia, and then bae hem go through process olsem so … hem wanfala problem moa*' [Now we have funds for FP available, but it's already September then October and November; these are usually the busiest times, but the money will go through another process (before it can be accessed) … so this is another problem] (1NFPM2).

Some activities funded by donor partners were implemented according to the donor's expectations and may not accord with the country's priority needs. This resulted in certain planned activities not being carried out as outlined in the MHMS annual operational plan. In some situations, when the funding period had expired or available funds had been exhausted, implementation of planned activities may have been incomplete or absent. A service manager reported that:

> *they have their own wanem tuia … like when they give money, olketa garem requirements blo olketa tuia … Olketa no folom na wat iumi laekem or nidim. So taem eniting hem no go according to expectation blo olketa, bae funds hem hold up and if that activity is to be funded by that funding body or donor then hem hold up, hem problem naia* [they (donors) have their

own thing (criteria) … when they give money, they have their own requirements … they do not follow what we want or need. So, if anything does not go well with their expectations, funds will not be released; then the activity that is supposed to be funded … will not be implemented … this is a problem] (1FPM1).

Challenges with funding at the national level directly affected provision of services at the provincial and zone levels. At the provincial and service delivery level, a further challenge commonly faced was a budget cut from the MHMS following submission of annual operational plans. A FP manager recalled: '*nara samting tu, taem mifala save submitim plans blo mifala wetem budget, olketa lo ministry level save katem fo reducim, without consultim mifala so hem affectim na olketa annual activities blo mifala, mifala planim ia*' [the other thing, when we submit our plans with our budget, those at the ministry level often cut our budget without consulting us, so this affects the annual activities we have planned for] (1FPM1).

These constraints in funding reportedly affected clinics receiving their budget allocations for their clinic activities. A service provider reported that Rove clinic, despite submitting plans each year for clinic activities, had not received funding for FP in recent years: '*yes mifala duduim annual operational plan ia … bata fo hamas years ia … so far no eni funding nomoa mifala recivim for family planning ia*' [yes, we used to do annual operational plans … but for some years … we have not received any funding for family planning] (1FPP1).

The cost of transport and communication was another challenge in all settings when funding was not available. Sometimes service managers and providers used their own money, especially for supervisory visits and to contact FP clients over the phone for follow-up visits. A service manager in Honiara reported: '*mifala nidim transport fo luk aftam an ranim na program ia … samfala taem supervisory ia mifala usim own seleni nomoa*' [we need transport to run the programme (as managers) … sometimes we use our own money for supervisory visits (to the clinics).] (1FPM1). A vehicle was available for the whole HCC health services, but it ran daily clinic errands. A service provider reported the difficulties in communicating with FP clients for follow-up visits over the phone: '*hemi lelebet costim mifala bikos mifala have to usim own phone blo mifala, bikos klinik phone hem breakdown almost two years naoia, no eni communication line lo klinik*' [it costs us because we have

to use our own phones (mobiles); the clinic phone has been out of service for almost two years now; there is no communication line at the clinic] (1FPP1).

4.3.9.5 Working with Communities and Collaboration with Stakeholders for FP

One of the strengths of FP provided within the RMNCAH platform was that RMNCAH was already established at the national level and in all provinces, right down to the community clinic level. Thus, if nurses were in clinics and had received their allocated funds, they could provide services, even to areas that were hard to reach. However, they must work in partnership with the community: '*RMNCAH hem evriwea lo province na … hem na wanfala strength blo RMNCAH ia*' [RMNCAH is already established in all provinces … this is one of RMNCAH's strengths] (1NFPM2). The same participant also emphasised the importance of working with communities in 'hard-to-reach' areas:

> *Maybe olketa hard to reach areas iumi no kasem lo provinces olsem … ating yumi nid fo waka wetem olketa community fo helpem fo tekem kam olketa mothers kam lo klinik … ating hem garem staka groups finis ia olsem churches, community leaders and mothers groups ia … yumi mas involvim tu olketa NGOs wea stap raonim yumi … mi tigim bae waka, bikos at least yumi targetem one population nomoa ia … olketa pipol wea usim sevis ia … bata luk olsem program lo mifala lo national and provincial ia hem no involvim tumas olketa lo communitie* [Maybe in 'hard-to-reach' areas in the provinces … I think we need to work with the community to help bring those mothers to the clinic … I think we already have many existing groups such as churches, community leaders and mothers' groups … we must also involve the NGOs that live among us … I think it should work, because after all we are targeting the same population … those people who use the service … but it looks like our programmes at the national and provincial levels do not involve community groups] (1NFPM2).

A female non-user also suggested strengthening existing FP awareness-raising approaches with stakeholders such as the police and medical officers, to promote a combined team effort during awareness programmes. She relayed an experience she had when working with the medical team: '*taem olketa go tok abaotim marijuana; effects blo hem lo health, mifala lo saed lo law … an hem*

waka gud … yumi mas waka togeta wetem olketa programs blo yumi, taem yumi go lo community' [when they talk about the effects of marijuana in health; we talk about the law side (effects on criminal activities) … and it works well … we must work together in our programmes when we go to the community] (1FNU1).

A national manager reported her observation that while integration was emphasised at the national level, it is not reflected in service implementation at the clinical level, '*mifala evritaem se tokaboutim integration … bat taem mifala go aot hem stil semsem nomoa, so dat fala integration na mi tigim hao na bae umi really duim?*' [we always talk about this integration … but when we go out, it's still the same, so I am thinking, how can we really do this?] (1NFPM2).

National managers also reported that greater awareness about FP still needed to reach the broader community:

> *aweanes olsem, there needs to be a lot of awareness that needs to go out. Olketa pipol still need to hear about family planning. We need to talk more, mekem iu mekem olketa pipol ('oh ia'), they see the importance of using family planning* [With awareness, a lot of awareness still needs to go out. People still need to hear about FP. We need to talk more, so that we make people realise 'oh yes', and they see the importance of using FP] (1NFPM1).

FP is well established in the RMNCAH programme at the MHMS and one of Solomon Islands'' priority public health services. However, this priority was not reflected in the governments funding support and how it was implemented with a geographically dispersed context and ongoing constraints in funding availability. FP cannot be a siloed service; it must be made available with the community's involvement and collaboration with stakeholders with a common goal to universal access.

4.4 Integration of Data

Table 4.3 outlines the key findings form the analysis and integration of findings from data sources.

Table 4.3

Integration of Results from Case Study One, Rove Urban Clinic

Context	FP clinic services audit	FP clinical records audit	Qualitative interviews	Integration of data sources
Case Study One is Rove Urban Clinic, a government-run health clinic, representing a health facility in an urban setting, located in Honiara, the capital of Solomon Islands. Rove Urban Clinic manages the West Zone in Honiara with an estimated population of 23,629. Rove Urban Clinic not only provides services to residents of West Honiara (West Zone); it also provides services to the rural population from nearby Guadalcanal Province, including those visiting from other provinces in the country. Four staff (all female) provide FP services at Rove Urban Clinic.	FP services with five temporary contraceptive methods available once a week at the clinic, integrated with postnatal services. STI/HIV services not available at the FP clinic but could be accessed at the outpatient clinic. Outreach services available but did not include FP. Counselling services mostly available for women. Young people and men received less counselling. Fertility awareness and counselling for natural methods not routinely provided. All staff had basic FP training. Only two midwives and two registered nurses had specialised skills to manage youths and provide contraception that required specialised skills. External supervision from FP supervisors to review FP	Female clients (including youth clients) preferred to use LARCs. Higher acceptance of long- than short-acting temporary contraceptives. Low records of male condoms prescribed and none for female condoms. Clients aged 25–44 years had more occasions of FP service than those younger than 20 years. Young people aged 14 or below had no recorded occasions of service at the FP clinic but had records of attendance at the outpatient clinic. Women with children had higher occasions of FP services than women with no children (single or unmarried). Men (including male youth clients) had fewer occasions of service than women at the FP clinic.	Lack of awareness raising and counselling on FP: • FP awareness raising mostly provided at the clinic and not reaching young people and men (less in communities) • FP awareness raising not engaging focus on contraceptives • correct counselling that includes broader socioeconomic issues about FP lacking. Barriers to accessing FP services: • focus of FP clinic • availability of contraceptive choices. FP services did not actively involve men: • the MAP program • men are willing to be involved.	FP services available at Rove clinic but mostly attended by married women aged 25–44 and not reaching everyone. Men and young people had less occasions of service at the FP clinic. Factors influencing access and acceptance of FP services included: • FP awareness raising not reaching everyone including men and young people, as most awareness raising conducted at the FP clinic. Less awareness also reaching schools and communities. • focus of FP on women with children; men not actively involved and be-friended in the FP space • service providers used less culturally sensitive and friendly approaches such as privacy, confidentiality. and sensitivity to gender of FP clients, (especially men and young people).

Context	FP clinic services audit	FP clinical records audit	Qualitative interviews	Integration of data sources
	services not regular; however, 'on-the-job training' available if needed. Short- and long-acting reversible contraceptives (implants, injectables, IUCDs, OCPs and male condoms) mostly available at the clinic. Clients seeking permanent contraceptives were referred to the NRH. Commonly used contraception often experienced stock-outs. Stock-outs took 1–6 months to replace. Clinic well organised with adequate examination rooms and sterile equipment available for insertions and removals of implants and IUCDs. Basic counselling job aids available, such as flip charts, posters and penile models but IEC materials need to be updated and comprehensible. Referrals made only for tubal ligation and vasectomy.	Young people visited the outpatient clinic for SRH and FP matters, rather than the FP clinic.	The need for culturally sensitive and friendly FP approaches: • FP is a gendered issue • confidentiality and privacy in FP service. Integrating FP with other clinic services. National and provincial perspectives about FP services: FP is a national priority • training • funding support for FP • challenges with funding • working with communities and collaboration with stakeholders for FP activities.	The reliability and easy access of LARCs made them preferred over short-acting contraceptives. Low use of male condoms because of stigma/values and lack of promotion. Correct counselling that includes broader socioeconomic topics needed to reach everyone, not only women. FP only integrated with MCH services; not with STI/HIV including adolescent services. Lack of planning, communication and available funds impacted outreach activities for FP. In addition to refocusing FP services, working with communities and collaborating with stakeholders are potential ways to improve FP services at Rove clinic.

4.5 Summary Discussion

The FP clinic at Rove was available alongside the postnatal clinic on half a day each week. Services included counselling and provision of contraceptives as well as postnatal checks for mothers and their babies within six weeks following childbirth. The rationale for combining these two clinics was that when women came for their postnatal checks, they could be offered contraceptives at the same time. An older version of the FP manual was used, the updated version was not available.

Providing women with contraceptives during the postnatal period made FP more easily accessible for women with children. Most of the women attending the postnatal clinic were married; therefore, married women with children had greater access to FP than did single women, men and youth clients.

While the audit of clinic records showed fewer men and youth clients attended, this does not mean they did not accept FP and contraceptives. Youth client records of attendance to the clinic and the female youth preference for using LARCs indicated acceptance of the service and contraceptives.

Men and youth clients also had less access to FP counselling and awareness as these were typically offered during the FP clinic. Men and youth clients often visited the outpatient clinic for SRH and FP matters, but the outpatient clinic did not provide awareness raising on FP.

Men were willing to be involved in FP but were often forgotten as important partners in FP. Service providers would invite men for FP counselling if their wives were identified as high-risk mothers. People readily accepted the need for contraceptives when they understood the health and socioeconomic benefits.

FP is a sensitive issue in Melanesian society; therefore, services must be provided with cultural sensitivity, including consideration of confidentiality and privacy. Men and male youth clients were concerned that all FP service providers were female; they preferred to be seen by someone of their own gender who was friendly and would ensure confidentiality and privacy. This would help ease their shame and they would be able to openly talk about sensitive issues such as FP and other SRH needs.

Although FP is considered a priority in Solomon Islands, this priority was not reflected in the way it was made available, accessible and acceptable at the clinic level at the time of this study. At the national level, funding for FP had not been available when it was needed, especially for outreach services and supervision purposes at service delivery points. This explained the lack and inconsistent provision of outreach services. The lack of outreach FP services may also have contributed to the lack of FP awareness raising in communities.

One contributing factor resulting in low acceptability of FP in communities was the lack of accurate information being clearly and regularly communicated. This information needs to be communicated in a language that people can understand and presented in a culturally acceptable manner so that people can make informed decisions for themselves and their partners. In the absence of accurate and clear information, misinformation from the public will go uncorrected and cause much confusion and hesitancy in people accepting contraceptive methods.

Service providers knew that FP needs to be made available and accessible to people at every opportunity of contact in addition to the weekly clinic. However, integrating FP with other services such as the child welfare clinic and outpatient clinic was challenging. Challenges included difficulties in shifting the focus and concentration from one service to another at the same time. Some service providers were not comfortable talking about FP to mixed groups of men and women. Although being busy with the daily running of clinic services was also challenge for service integration, it was reported that current staffing at the clinic was sufficient to meet FP service demands.

While funding and logistic issues were challenging, FP service and contraception could still be provided at the clinic facility, as it was part of the clinic services. Service providers were trained with relevant FP skills, and equipment and contraceptive methods were available most times. Potential opportunities could be sought outside the clinic boundaries, to connect and work with existing stakeholders in FP and community groups to integrate the concept of FP in a holistic approach.

4.6 Chapter Summary

In this chapter, I have described the setting and context of an urban FP clinic, described how data were collected, reported data analysis results and findings, and provided a summary of within-case analysis. In the next chapter, I report results of the Case Study Two research on FP services in a peri-urban setting. Figure 5.1 is the thesis structure showing Case Study Two chapter in the thesis.

Chapter 5: Case Study Two Results—Peri-urban Setting

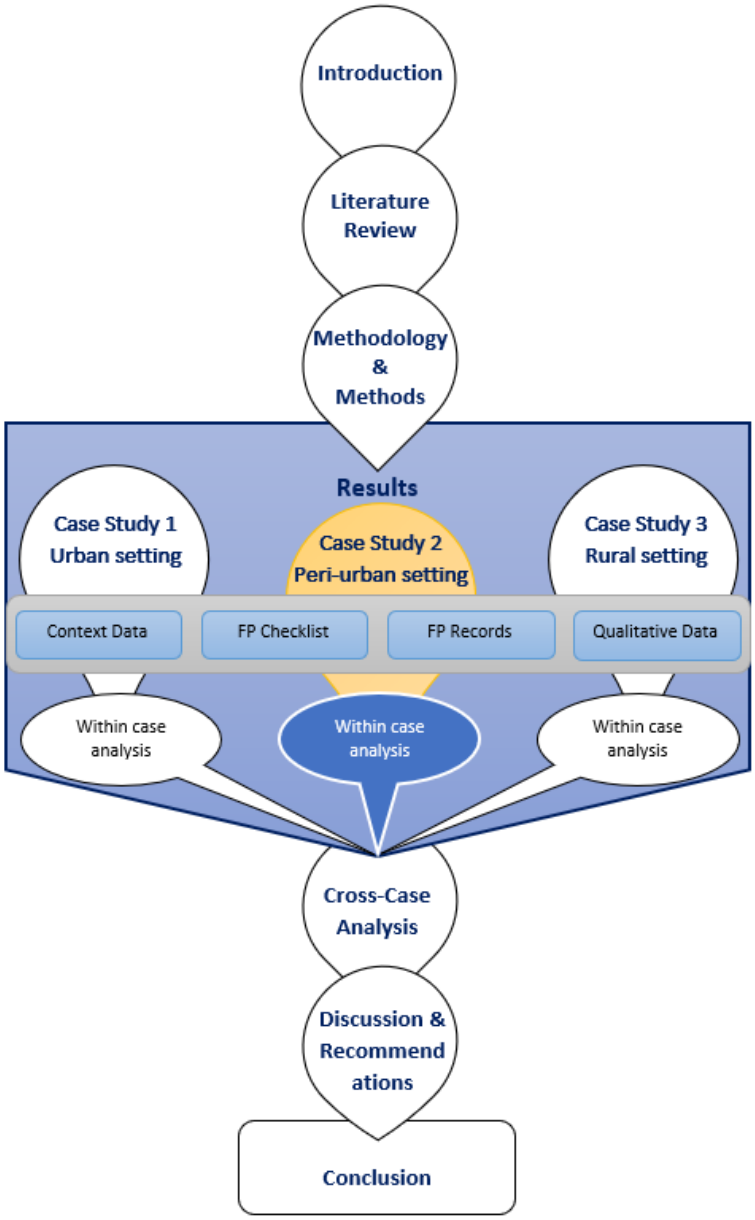

Figure 5.1. Thesis structure—Case Study Two

5.1 Chapter Outline

This chapter presents the results of Case Study Two, a peri-urban FP service facility in a faith-based hospital. The chapter presents the setting and context of the clinic, data collection methods, results and within-case analysis. Figure 5.2 shows an outline of the chapter.

Figure 5.2. Outline of Chapter 5

5.2 Setting and Context

Case Study Two is HGH, a small hospital situated in Munda, a regional sub-centre[4] located on the West of New Georgia Island in the Western Province of Solomon Islands. Western Province is an archipelago of islands stretching from Alu, south of Bougainville Island in PNG, to Mborokua Island, south-west of Russell Islands in the Central Islands Province. Western Province is the largest province in Solomon Islands by land area, with 7,509 km^2 and a population density in 2009 of 10 people per sq/km (SINSO, 2009b). New Georgia is the largest island with a land area of 2,145 km^2. Other main islands in the Western Province are Kolombangara, Vella Lavella, Vangunu, the Shortland Islands, Rendova and Ranogga (Kii, Lulei, Foimua & Rausi, 2006). The province has three of the largest lagoons in the country: Roviana Lagoon, Vonavona Lagoon and the Marovo Lagoon—the latter being one of the world's largest lagoons. These lagoons and their inner islands have a

[4] A sub-centre may also be considered a small town in Solomon Islands with one or more shops, a police station, a bank agency and a health centre. Some economic activities such as local food markets are also undertaken.

variety of habitats from cloud forests to low-lying atolls, pristine coral reefs and mangrove forests, which contribute to scenic beauty, tourism and logging industry, and are a source of livelihood for Indigenous people (Bennett et al., 2014; A. P. Green et al., 2006; SINSO, 2017). The provincial capital, Gizo is located on Gizo Island. Figure 5.3 shows the location of Western Province.

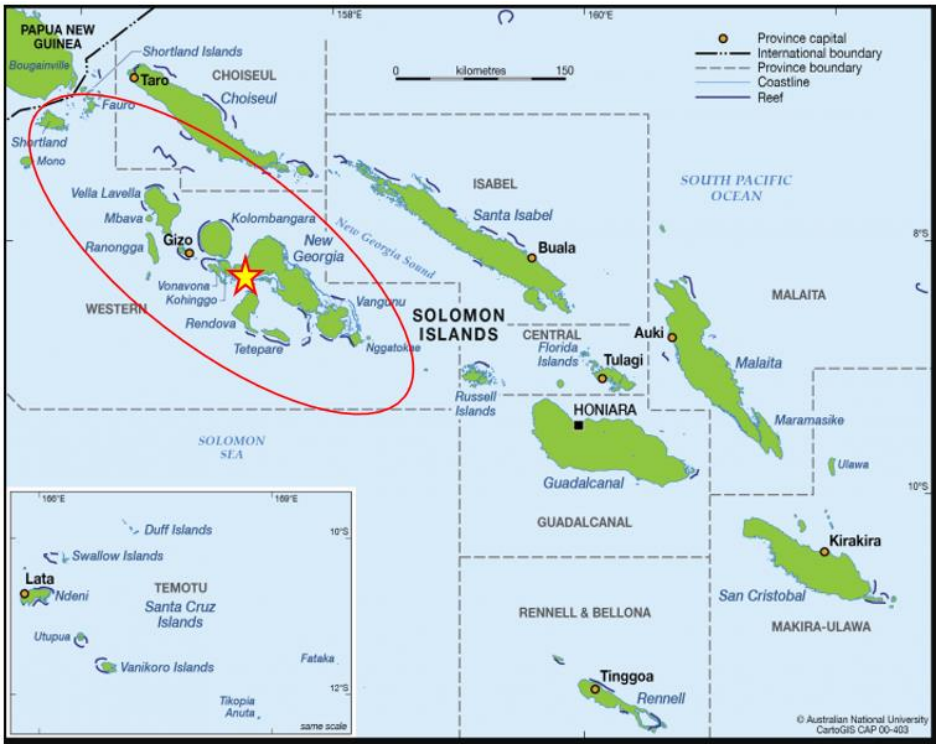

Figure 5.3. Map of Western Province in Solomon Islands. (Source: https://www.google.com/mymaps/viewer?mid=1oEZMzspiLgFRsn_20Jy07rARZnw&hl=en_US)

5.2.1 Governance

Gizo is where all government services and commercial activities such as health, education, bankings and shops in the province are centralised. The premier is the political leader of the provincial government (Cox & Morrison, 2004). The province is separated into nine constituencies, broadly based on their geographical location: 1) North Vella Lavella; 2) South Vella Lavella; 3) Gizo/Kolombangara; 4) Shortland Islands; 5) Simbo/Ranogga; 6) Marovo; 7) North New Georgia; 8) West New Georgia/Vonavona; and 9) South New Georgia (Cox & Morrison, 2004; Solomon Islands Government, 2018; see Figure 5.4). The Western Province is represented by a member from each constituency at the National Parliament. The Provincial Government Act, 1986 also contemplated a

third tier of government that allows provincial assemblies to create local area councils which have direct connection with the village level, however, area councils were abolished in 1996, thus disconnecting the provincial administration and the village level. The abolishment of area councils led to closure of some sub-stations because of financial cuts. Western Province is further divided into 26 wards, each ward was represented in the provincial government by an elected member. (Solomon Islands Government, 2018). In Western Province, *kastom*, or traditional forms of government are not included in the formal government structure (Kii et al., 2006).

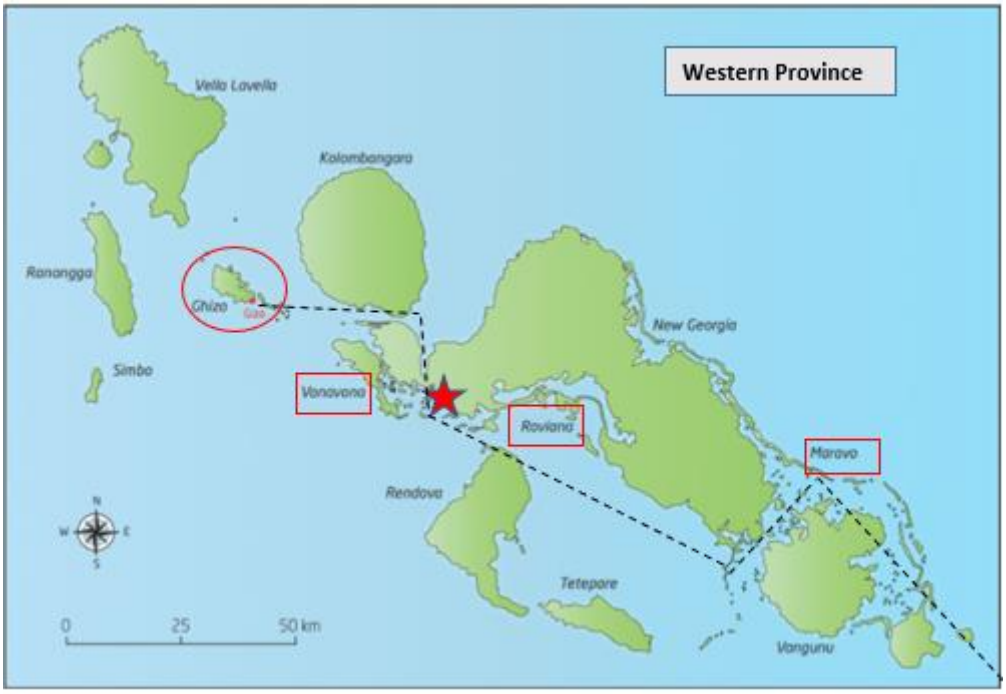

*Figure 5.4. Map of main islands in Western Province*Key: Gizo Island ◯ HGH (Munda) ★ ; Lagoons ▭ ; Shipping route from Gizo to Honiara - - - - - -

(Source: (https://www.google.com/search?q=map+of+Western+Province+Solomon+Islands/)

5.2.2 Transport

The sea is the main 'highway' in Western Province. The main means of transport are by foot, non-motorised wooden dugout canoes around islands, and motorised boats between islands. Motor vehicle use is restricted to semi-urban areas such as Gizo, Noro and Munda and areas of commercial activity, particularly commercial logging sites. The province is served by a weekly shipping service from Honiara through the chain of islands. Munda is served by an international airport and seaport.

The Solomon Airlines operates daily domestic flights to Munda and Gizo (Kii et al., 2006; SINSO, 2009b).

5.2.3 Population

5.2.3.1 Livelihood

Subsistence agriculture is the main source of livelihood in rural communities and includes subsistence farming or traditional gardening and harvesting of marine resources. However, logging and deforestation have contributed to deterioration of the environment: thus, there is increasing soil erosion, landslides and decreasing soil fertility, making it difficult to maintain subsistence gardening and other agricultural activities (Eriksson et al., 2020). Despite the continuous harvesting of natural resources such as logging and commercial fishing activities, Solomon Islands's land and seas have remained productive and resilient. However, with increasing population growth rates, coupled with shifts toward cash economies will increase demand for unsustainable harvesting of marine and other natural resources. The impacts of climate change such as sea level rise and increasing soil erosions will challenge current and future sustainable subsistence living in the Western Province (Bennett et al., 2014; Chevalier, 2001; Jupiter et al., 2019).

5.2.3.2 Education

Despite a higher school enrolment rate than other provinces, school enrolment in the Western Province varies by age. Many 5–7-year-olds have not yet started school. The highest enrolment rates are found among 9–12-year-olds and enrolment rates drop by14 years of age. In 2009, 4 % of 6–15-year-old children had already left school, and around 6% had never been attending formal school ing (SINSO, 2009b). The literacy rates for males and females aged 15-24 years were 95.3% and 97.2%) respectively, however, information about literacy obtained during the census is self-reported and may be biased, as some people may be embarrassed to admit their literacy status when providing information about their education status (SINSO, 2009b).

5.2.3.3 Population Growth

Most of the growing population in Western Province resides in coastal rural areas. However, since 1986, populations in urban areas have been steadily increasing (Solomon Islands Government,

1999; SINSO, 2009d). The distribution of population by each local area varies through migration to urban areas. The strong underlying population growth rate through reproduction in these areas is offset by migration to urban areas. Although the populations in Gizo, Noro, Munda and Nusa Roviana were described as urban in the 2009 census report (SINSO, 2009b), most people in Munda and Nusa Roviana were more peri-urban and most adopted a rural lifestyle. This means they lived on their own tribal lands and could grow their own food and freely use marine resources for their livelihoods.

The population of Western Province increased from approximately 62,739 in 1999 to 76,649 in 2009 and was estimated to exceed 90,000 by 2019 (SINSO, 2019). The province has a relatively young population with 41% of people under the age of 15 years and around 36% under the age of 35 years. The high proportion of young people in the population places increasing demand on health, education services and employment opportunities (Bennett et al., 2014; SINSO, 2009b, 2019).

5.2.3.4 Ethnic Groups

Two main ethnic groups live in Western Province. Most of the population (95%) are Melanesians. Other groups include people of Micronesian descent (4%); and Polynesians, Chinese and Europeans, who make up only 1% (SINSO, 2009d). The level of integration of the Micronesians into the Melanesian sociocultural context is very low and occurs only through intermarriage.

5.2.3.5 Cultural Environment

Land ownership is predominantly customary, where land is owned by tribal groups. A small amount (~20%) of land is alienated land, that is land owned by the government, individuals or interest groups on perpetual estates. It is estimated that around 75% of alienated land in the province is on Kolombangara Island (Chevalier, 2001; Kii et al., 2006).

In the Western Province, the chief is usually the head of tribe, and the first-born son often inherited the chielfly title. Although traditionally in Western Province, land rights and inheritance were passed through the matrilineal descent system, in practice women may still have less influence in the decisions about the use of the land and the natural resources they had rights to (Bennett et al., 2014; Cox & Morrison, 2004). In most villages, the village chief's role is to maintain peace and harmony in the community (Aswani, 1999; Hviding, 1993). However, today, the influences of case

economy such as commercial logging industries in rural areas imposed negative effects in the chiefly system (Lawless et al., 2019).

Most people (90%) in the province survive on subsistence and artisanal fishing and farming in rural areas (Bennett et al., 2014). However, the effects of colonisation and Christian conversion mean that more formal education and employment opportunities have greatly influenced the shift from subsistence livelihood to a cash economy, and women's and men's traditional roles have also changed (Eriksson et al., 2020). In contrast to the traditional norm that decision making rests with men, men and women now strongly agree that a husband and a wife should share decision making in the household (Lawless et al., 2019). As well as domestic duties such as gardening and child rearing, women now participate in cash-based activities. Men also engage in employment to provide additional income for the family instead of just fishing and hunting. In recent years a growing number of people have moved to urban areas, such as Noro and Gizo, because of the 'pull' factors such as employment opportunities and an education (Cox & Morrison, 2004).

Although traditional chiefs or elders remain custodians of matters pertaining to culture and land, some communities today are governed by a village committee system. Village committee leaders often oversee the daily programmes and activities of the community and their implementation by villagers. Reflecting the complete adoption of Christianity across the Province, most village-based committees are embedded in Christian principles; thus, Christian values and beliefs influence the committee's decisions about community programmes and activities. The Melanesian communities in the Shortland Islands practice a more regimented traditional chiefly system than do other communities in the province. The chiefly title is inherited and power is exercised with full authority. For example, in Pirumeri village, the chief rings the bell for church service, which signals the entry of all intending worshippers—an integration of traditional and imported systems (Kii et al., 2006).

Among Micronesians (mainly Kiribati communities who migrated in the 1960s to live in Gizo and surrounds), the role of village leader is assumed through maturity. A committee of elders makes decisions for the community. Such elders are clearly distinguished in the *maniaba* (meeting house) where only elders sit leaning against a post at meetings. The designated posts are placed around the

central part of the *maniaba*. Non-elders sit behind their elder. These communities do not have a traditional chiefly system (Cox & Morrison, 2004).

5.2.3.6 Language

Approximately 16 Indigenous languages along with different dialects of these languages are spoken by the people of Western Province (Bennett et al., 2014). However, Roviana and Marovo languages are the most used languages as they were used by missionaries to communicate with people. Solomon Islands Pijin is also used across language lines and with people from different islands within and outside the province. English is sometimes used in educational and more formal business and governance settings (Bennett et al., 2014; SINSO, 2009c).

5.2.3.7 Religion, Including Delivery of Education and Health Services

Most (95%) of the population in the Western Province follows one of four Christian denominations: Uniting Church (39%); Seventh Day Adventist Church (28%); Christian Fellowship Church (15%); and Roman Catholic Church (7%). Other Christian churches are attended by less than 5% of the population (SINSO, 2009b). In addition to religious activities and programmes, churches take an active part in the delivery of social services throughout the province, particularly in the education and health sectors (SINSO, 2017).

The Uniting Church runs the HGH in Munda, co-located with the church's administrative headquarters. It also runs a NAP in Goldie College, a national secondary school and two rural training centres in Munda and Seghe, and seven schools operated under the Uniting Church's administrative authority. The Uniting Church Women's Fellowship Group runs village-based informal education and health awareness programmes (Cassells, 2019; Kii et al., 2006).

5.2.4 Provincial Health Services

The Western Provincial Health headquarters and the provincial hospital are located in Gizo. Western Provincial Health oversees one hospital, six AHCs, 22 RHCs and nine NAPs to serve a total population of more than 97,000 (Ministry of Women, Youth, Children and Ecclesiastical Affairs, 2010; SINSO, 2009b). Some of these health facilities are managed and run by FBOs. Health services in Western Province are managed in zones (Solomon Islands Government, 2015). There are six health

zones, grouped and described according to their proximal locations or regions (E. Tanito & C Galo, personal communication, 15 May 2022). Figure 5.5 maps the locations of the six zones: Zone 1, Central Islands; Zone 2, Ranogga/Simbo; Zone 3, West New Georgia; Zone 4, East New Georgia; Zone 5, Shortland Islands; and Zone 6, Vella La Vella.

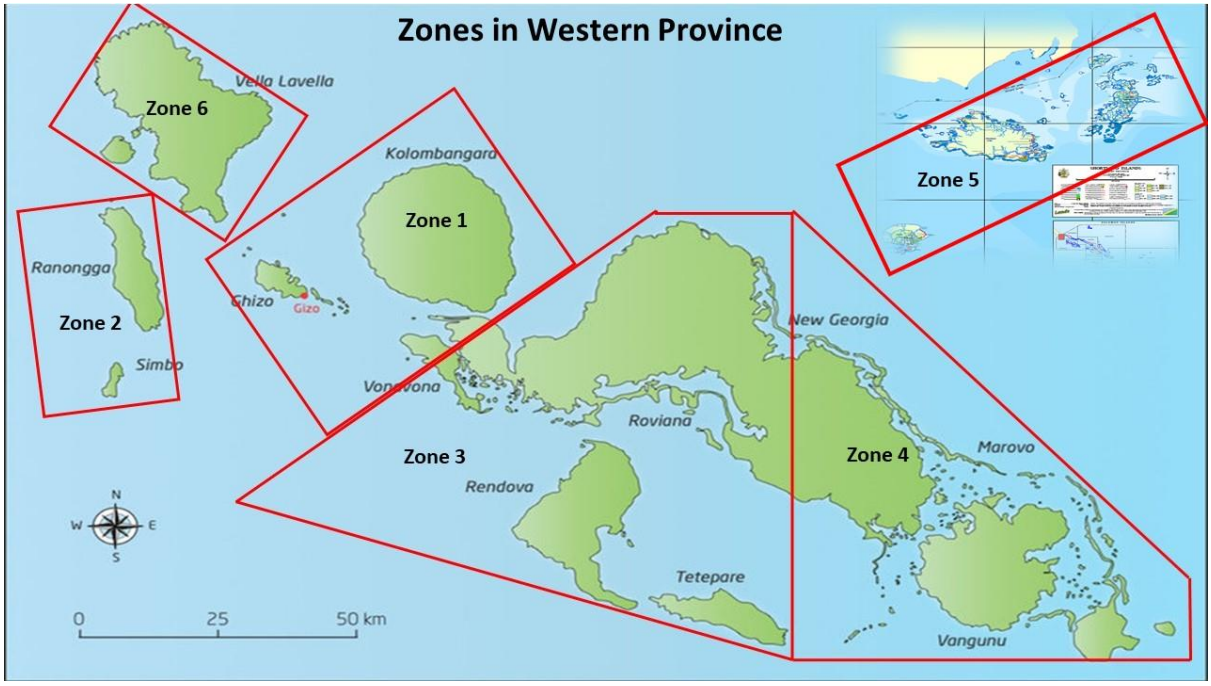

Figure 5.5. Western Province health zones (Source: Gizo Provincial Health)

5.2.4.1 Helena Goldie Hospital

HGH (Figure 5.6) is a 68-bed hospital categorised as an AHC2 hospital (MHMS, 2016). The hospital is set in beautiful tropical scenery overlooking the Vonavona lagoon and is approximately 15 minutes by road from Noro township in the greater Munda area. With a tuna factory and international seaport, Noro has become a centre for commercial activities. These factors and the growing urban population have contributed to increasing number of teenage pregnancies and STIs in the area. Many rural communities living around Noro and Munda areas access commercial services at Noro and health services at HGH (I. Sipakana, personal communication, 10 October 2019). The long distance to Gizo and Honiara affects delivery of health services to many of the provincial communities who live farther from the regular shipping routes (Kii et al., 2006).

HGH was established in 1903 by Methodist missionaries and previously run by overseas missionary doctors but is now operated by the Uniting Church. The hospital was named after the wife of John Goldie (Helena 'Marama' Goldie), a Methodist missionary and one of the first missionaries to establish a mission in Munda (Hilliard, 1974). Recently, Solomon Islander health professionals have taken responsibility for the management of the hospital. Services provided are underpinned by overt Christian values, with a daily church service and religious community projects run by the hospital. HGH is managed by a medical superintendent, medical doctor, director of nursing, hospital matron and other administrative and supportive staff. The hospital administration is associated directly with the Uniting Church Assembly Office (K. Gapirongo, personal communication, 29 May 2022).

Figure 5.6. Helena Goldie Hospital (Photo credit: Author, 2019)

At the time of the field visit, there was one doctor working at the hospital and around 80 employees including administrators, midwives, nurses, nurse aides, paramedics and support staff. More than 20 staff were employees of the government health service seconded to work at HGH. The hospital had very basic facilities such as a medical laboratory that can perform blood transfusions, imaging services and a pharmacy. Surgical procedures, including caesarean section, appendectomy, amputation, tubal ligation and vasectomy were previously performed when a surgeon was working at the hospital. However, at the time of data collection, there was no surgeon. A doctor qualified to

perform minor surgery arrived in late 2019. Patients needing further surgical care such as tubal ligation and vasectomy were referred to Gizo Provincial Hospital.

HGH is in Zone 3, the largest by catchment area and population of the Western Provincial Health zones. Zone 3 has one hospital that is categorised AHC2 and one as AHC1; four RHCs; and three NAPs now categorised as community centres. For a description of service levels as determined by the MHMS see Table 1.1 in Chapter 1.

As an AHC2, HGH is responsible for supervising eight health clinics within its zone catchment area serving a population of over 27,000 (E. Tanito, personal communication, 15 November 2021). There had been more clinics in Zone 3, but some had been closed or upgraded to a new facility level in recent years (E. Tanito, personal communication 2022). The locations and estimated population of the health zones are shown in Table 5.1.

Table 5.1

Western Province Health Zone Populations

Zone description	Population (est)
Central Islands	15,630
Ranogga/Simbo	11,706
West New Georgia	27,916
East New Georgia	18,376
Shortland Islands	8,011
Vella Lavella	15,557
Total	97,196

(Source: Gizo Provincial Hospital, 2019)

Zone 3 has the largest population, in part because it is a migration zone. People from other provinces moved with their families to Noro to work in the tuna factory and for logging companies operating in the area. The Munda area, including the Vonavona and Roviana lagoons, are common tourist destinations so the substantial movement of people in this zone is also associated with tourism and other commercial activities. Health facility types in Zone 3 are listed in Table 5.2.

Table 5.2

Zone 3 Health Facility Types

Health facility type	Number
AHC 2	1
AHC1	1
RHC	4
NAP	3
Total	9

(Source: E. Tanito, personal communication, 2022)

5.2.4.1.1 Family Planning Clinic and Services

FP services at HGH are provided through the Reproductive Health Clinic integrated with postnatal services once a week and daily in the maternity ward. The Reproductive Health Clinic is a separate building attached to the outpatient clinic. In addition to providing FP, the Reproductive Health Clinic provides services such as antenatal care, postnatal care, child welfare (well-baby clinic and immunisations) and a 'sick child clinic' for children 1–5 years old. The sick child clinic, also called the IMCI, provides services to children who present with common childhood illnesses such as acute or chronic respiratory infections, diarrhoea or fever. Children are assessed and managed based on accepted protocols (WHO, 2005) or referred for further investigation and treatment at HGH. At the maternity ward, nurses and midwives counsel mothers for FP every day.

The head of the Reproductive Health Clinic manages staff rosters separately from the outpatient clinic and the hospital wards. The Reproductive Health Clinic opens Monday to Friday from 8 am to 4 pm. The various services provided by the Reproductive Health Clinic are available once on specific days of the week, although the clinic may provide more than one service each day on an as-needed basis. Therefore, FP services are available only one day a week (see Table 5.3). The Reproductive Health Clinic is also responsible for its twice-weekly outreach or satellite services. However, these trips are not always implemented because of financial constraints and the need to meet transport costs to travel to satellite sites.

Table 5.3

HGH Reproductive Health Clinic Weekly Program

Day	Morning 8 am–12 pm	Lunch hour	Afternoon 1–4 pm
Monday	Child welfare	12–1 pm	Child welfare
Tuesday	Outreach/sick baby—IMCI		Outreach/sick baby—IMCI
Wednesday	Postnatal and FP*		Postnatal and FP
Thursday	Antenatal		Antenatal
Friday	Outreach/sick baby—IMCI		Outreach/sick baby—IMCI
Saturday	Clinic closed		Clinic closed
Sunday			

*FP was also provided Monday–Friday on an as-needed basis. (Source: HGH Reproductive Health Clinic)

5.3 Data Collection and Results

Four types of data were collected to provide a quantitative and qualitative understanding about FP service provision at HGH. All data were collected during the same field trip on 7–11 October 2019 and their collection is detailed in Section 3.3.1. These data sources are described in Chapter 3 in the order listed below:

1. Context
2. Audit of FP clinic services
3. Review and audit of FP clinical records
4. Qualitative interviews.

5.3.1 Context Data

I spent a week at HGH collecting context data. I was familiar with the surroundings and known to some staff members from previous visits related to my midwifery work. To understand the context of the study site I spoke with hospital leaders, FP service managers and providers. I observed how FP services were made available and provided at the hospital during the week; for example, what days FP clinic services were open, who came to the clinic and what tasks staff provided on FP clinic day. My existing relationship with HGH staff enabled me to have open communication with hospital administrators, service managers and providers who willingly provided information without reservation, knowing that the information I gathered would help them improve their FP services.

5.3.2 Audit of Family Planning Clinic Services

I used the adapted FP checklist (Appendix 1), as described in Chapter 3 to audit FP clinic services using the seven headings with related questions. These data were obtained by speaking with the FP service provider in charge of the FP clinic using prompting questions from the checklist. Service provider responses were noted on the checklist and later aggregated by writing notes in a table. I first used this tool with Case Study One and learnt that some closed-ended questions on the checklist did not provide enough explanation about the audit. Therefore, with Case Study Two, I took more notes as the service provider explained the reasons behind responses to the closed-ended questions. With this experience, I later went back to visit the Case Study One site to ensure I obtained data I had missed earlier.

I used the adapted FP checklist (Appendix 1) as described in Chapter 3 to audit FP clinic services using the seven headings with related questions.

5.3.3 Review and Audit of Family Planning Clinical Records

The clinic records audit examined FP clinic records and monthly FP reports between 2015 and 2019, as described in Chapter 3. The record books were challenging to examine as more than one book was used and some of these books could not be located during data collection. For example, the FP clinic record book that kept attendances at the clinic from 2015 to 2018 could not be located at the time of audit. A new record book used only in 2019 was available. Therefore, I reviewed monthly reports only for 2015, 2016 and 2019.

Some entries about current FP users in the HIS reports showed inconsistencies that could potentially indicate erroneous entries, which I could not verify given the missing record book, and sometimes included illegible writing. Missing, incomplete and inconsistent information were common features of the records and reports. I only collected data relating to FP services when examining these records and reports.

The clinical audit data reported here covered five months in 2015, one month in 2016 and four months in 2019. Reports for 2017 and 2018 were not available on site. I contacted the Gizo

Provincial Health HIS personnel to access copies of HGH's 2017 and 2018 reports but did not receive a response. The data were compiled and analysed using descriptive statistics as outlined in Chapter 3.

5.3.4 Qualitative Interview Data

Qualitative interviews were conducted with a total of 16 participants: 12 service users and non-users, and four service providers as outlined in Chapter 3. I began recruiting participants presenting at the Reproductive Health Clinic. The service providers helped me identify FP users and non-users using the clinic record book. Non-users were identified at the clinic with a screening question about their use of contraceptives. Service providers also assisted by confirming whether or not participants were from the Zone 3 catchment area. Before an interview, I asked potential participants to confirm with me if they were users or non-users of any FP services or contraceptive method. I conducted interviews in a clinic examination room to ensure privacy and clear audibility. All female participants were interviewed here.

It was mostly women who sought services provided at the Reproductive Health Clinic, which included the FP clinic, so I found it difficult to recruit men. One father came to the clinic with his sick child and I approached him to ask if he would be happy to be interviewed, but he did not consent. I then considered two other places to recruit men: at the outpatient clinic, and at the children's ward where I noticed several fathers taking care of their children admitted to the ward. I decided to recruit men from the children's ward as they had younger children and may find it relevant to discuss information about FP. They would also be less likely to be unwell themselves to fully participate in the interview. I ensured their children were taken care of by a family member or nurse before I proceeded with interviews. I talked to the nurse in charge of the children's ward, who was very helpful and explained to the men what I wanted to do. I successfully interviewed the men who provided consent, using the nurses' office as it provided privacy in terms of overhearing the conversation but also had open space, which was culturally appropriate for me as a female when interviewing males. Participant demographics including gender, age and education level are shown in Table 5.4.

Table 5.4

Participant Demographic Description: Gender, Age and Education Level

Participant category	Gender		Age in years					Education level		
	Female	Male	<20	21–30	31–40	41–50	>50	Primary	Secondary	Vocational/ teritiary
Service provider	4	0	0	0	0	1	3	0	0	4
Service user	5	1	1	3	1	1	0	2	4	0
Service non-user	3	3	3	2	1	0	0	0	5	1
Total	12	4	4	5	2	2	3	2	9	5

5.3.5 Family Planning Clinic Service Audit

Table 5.5 presents the audit results for FP clinic services under the seven headings as described in Chapter 3. A summary of the checklist result is provided after the table.

Table 5.5

HGH FP Clinic Services Audit

Checklist item	Results	Assessment narrative
Services		
1.1 Contraceptives		
Fertility awareness counselling	Yes, only when they presented with problems; maybe monthly, not very often	Not routinely provided. Provision depended on service provider's knowledge and confidence to discuss with clients.
Natural methods counselling (ovulation/mucus, calendar, symptothermal methods)	Yes, but not always done, only alerted by reports	Not routinely provided, depended on provider's knowledge about topic.
Male condoms	Available at the clinic and provided	Mainly used for STI prevention; rarely advised for contraceptive purposes.
Female condoms	Available at the clinic but never issued to clients	Women did not accept female condoms.
Lactation amenorrhoea method (LAM) counselling	Yes, only during postnatal clinics	Provision depended on provider's knowledge and confidence to discuss LAM.
Progestogen-only pills/combined OCPs (POP/COC)	Yes, provided and available every day when clinic open	All staff could provide this method.
Emergency contraceptive pills (Prostino)	Yes, available in theory but not provided at the clinic	Only kept in pharmacy, not used/dispensed by nurses.
Injectable contraceptives (e.g. Depo Provera)	Yes, available at the clinic	All staff could provide this method.
IUCD insertion	Yes, available at the clinic	Only provided by trained service provider so depended on staff availability.
IUCD removal	Yes, but not done very often	Both trained providers were able to remove IUCDs.
Jadelle implant insertion	Yes, available at the clinic	Only provided by trained providers; method not available when trained providers were unavailable.

Checklist item	Results	Assessment narrative
Jadelle implant removal	Yes, service available	Only performed by a trained service provider.
Female sterilisation (tubal ligation)	Not available in 2019	Procedure could only be done by a trained medical doctor so service depended on doctor's availability. Hospital doctor preferred to refer to provincial hospital (Gizo) than perform tubal ligation at HGH.
Male sterilisation (vasectomy)	Not available nor provided	No vasectomies recorded.
1.2 STI screening (syndromic or clinical)	Not provided at FP clinic but could be provided to women attending FP clinic as needed	This service was available at the outpatient clinic.
1.3 Male-friendly services (promote male involvement in FP)	Not available	No male was trained for male-friendly services at HGH; female FP providers often provided this when they had the opportunity to speak to men.
1.4 FP guideline or protocol		
Has guideline or checklist for FP service	Yes	Solomon Islands FP Manual, 2005 edition was available and used.
Recent version of FP guideline	Not available	No recent version available at the time of field trip (2019).
1.5 FP services to STI/HIV clients. (Are FP services to STI/HIV clients captured at this clinic?)	Not captured in this clinic	STI service available at outpatient clinic. HIV service only provided by trained HIV providers and counsellors. Counsellors not always available.
1.6 FP data (Does FP data capture clients by methods?)	Yes	This was recorded in the FP register records.
1.7 STI/HIV service clients		
In the last 6 months, have clients left before receiving services because the wait time is too long?	Yes, sometimes	Only for STIs, but HIV service not provided as it required HIV counsellors.
1.8 Outreach services (satellite clinics)	Yes, provided weekly to HGH catchment areas	The reproductive health team planned for weekly outreach clinics to catchment areas; however, this

Checklist item	Results	Assessment narrative
		depended on funding being available to meet fuel travel costs. Therefore, weekly outreach did not always happen as planned.
Counselling		
Routinely assess clients need for FP services based on their clinical history and reproductive intentions	Yes	Mostly provided for uptake of temporary contraceptive methods for birth spacing and permanent contraception.
Routinely screen clients, to determine what FP services are appropriate (reproductive goals, infertility issues, FP knowledge, family living situation, any FP-related concerns)	Yes	Mostly for temporary contraceptives but not always for infertility issues and family situations.
Provide FP counselling (number of children, intentions of next pregnancies, attitudes about FP, risks of STIs/HIV)	Yes	Mostly counselling for number of children; not routine for attitiudes about FP and risks of STIs/HIV unless counselling young people.
FP counselling includes correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy (dual method—barrier against STIs and protection for unintended pregnancy)	Yes	This counselling was provided to those attending FP clinic but rarely to those who collected condoms from the outpatient clinic.
Provide safe pregnancy counselling for young women and young men and for women who are currently pregnant or wish to become pregnant	Yes, most of the time	Only for girls when they presented with problems, but not for boys.
FP counselling for young girls and boys (>15 years) including future preparation for planning their families	Yes, some of the time	Mostly during school visits, but not done very often.
Provide and promote male involvement in FP	Yes, some of the time	When speaking to some husbands.
Provide and promote couples counselling	Yes, some of the time	Not done routinely but provided as needed when opposition to use of contraceptives arose as an issue between husbands and wives.

Checklist item	Results	Assessment narrative
Does this clinic provide counselling services for single mothers and elderly women? (e.g. menopausal issues)?	Yes, most of the time; for mixed groups	The mixed group refers to married/single/young/elderly but not provided individually to these groups.
Staffing and training		
3.1 Clinic staff	2 midwives, 2 registered nurses, 2 nurse aides	A total of six staff were working at the Reproductive Health Clinic; all females.
3.2 Training on FP	Yes, all staff trained	Basic FP training was included in the nursing training course (pre-service).
Training on youth and adolescent-friendly services	Yes	Only 2 midwives were trained.
Training on the provision of key population or high-risk population friendly services (adolescents, single mothers, men)	Yes, 2 midwives trained	However, service not properly set up; no separate services and location available for adolescents at the time of visit.
Training on the provision and removal of IUCDs	Yes,	2 midwives and 1 registered nurse were trained.
Training on the provision and removal of Jadelle implants	Yes, 2 midwives, 2 registered nurses, and 1 nurs aide trained	
Training on SRH and FP services, e.g. midwifery, FP, reproductive health, MIRH	2 midwives had received specialised training, 2 registered nurses had received basic training during their pre-service training	Refresher courses or workshops were provided for all service providers by the National Reproductive Health Department for upskilling purposes.
In the past 6 months, have clients been turned away or asked to return a different day because there were not enough trained staff available to provide the method requested?	Yes, sometimes	
Do you think the clinic has enough staff trained in FP services to respond to current demand for FP services?	Yes	Some nurse aides had been trained to insert implants.
Supervision		

Checklist item	Results	Assessment narrative
Do staff that provide FP services receive outside supervision to monitor their performance?	Only one visit by the national FP supervisor	Supervision from the provincial reproductive health coordinator who rarely checked on work performance; simply collected reports every month.
Do supervisory visits that includes review of FP services happen at least 4 times per year?	No regular supervisory visits to review FP services	Visits from the provincial reproductive health coordinator were for the purpose of collecting monthly reports.
Is feedback provided to FP service providers after supervision is conducted?	No	As no visits were conducted.
Is there a mechanism for documenting supervision visits?	Yes, only recorded in monthly reports	Manual reports, no patient management database.
When gaps are found during supervision, is a plan developed to address gaps that includes the following information?		
Actions identified to address gaps	No	
Person assigned to complete actions	No	
Due date for completion of actions	No	
Is additional FP training available to service providers if needed? (this includes on-the-job training, extra support, on-site mentorship, off-site training etc)	Yes	Additional training was available to providers from the national level, if provincial coordinators identified this as a need at the service delivery level.
Drugs and supplies		
5.1 Of the contraceptive methods provided at this facility, which are available today?		
Male condoms	Available	
Female condoms	Available but not used	
POPs	Available	
COCs	Available	

Checklist item	Results	Assessment narrative
Emergency contraception (Prostino)	Available in pharmacy	Not used at the FP clinic.
Injectable contraceptives (Depo Provera)	Available	
IUCDs (Copper T)	Available	Trained staff to insert and remove were available.
Jadelle implants	Available	Trained staff to insert and remove were available.
Natural cycle (ovulation chart, cycle beads)	Available during counselling	Not routinely available.
5.2 Of the contraceptive methods provided at this facility, which have experienced stock-out?		
Male condoms	Yes	
Female condoms	No	Not used by women so stock always available.
POPs	Yes	
COCs	No	
Emergency contraception (Prostino)	No	
Injectable contraceptives (Depo Provera)	Yes	
IUCDs (Copper T)	No	
Jadelle implants	Yes	
Natural cycle (ovulation chart, cycle beads)	No	This depended on whether providers had the capacity to offer; not currently available.
5.3 Of the following services offered at this clinic, which have been available at all times in the last 3 months? This means that adequate supplies, equipment and trained staff have always been available.		
Female sterilisation (tubal ligation)	No	Not offered; referred to provincial hospital for procedure.
Male sterilisation (vasectomy)	No	Not offered; referred to provincial hospital for procedure.
Jadelle implants insertion	Yes	

Checklist item	Results	Assessment narrative
Jadelle implant removal	Yes	
IUCD insertion	Yes	
IUCD removal	Yes	
Urine test for pregnancy	Yes, sometimes	Depended on stock available in the pharmacy.
5.4 Does the facility have pregnancy tests onsite?	No	
5.5 Does this clinic have a supply management system that is used to track FP commodities? This can include stock cards, monthly summaries etc.	Yes, done monthly	
5.6 Have the staff providing FP at this clinic received training on how to track FP commodities?	Yes	
5.7 In the last year, when have you experienced a stock-out of one or more contraceptives, what is the longest time it has taken to replace them?	1–6 months	Depended on stock availability from the National Medical Store and provincial health, and if new stock orders were submitted on time.
Clinic infrastructure and resources		
6.1. Go to the room where FP clients are examined. Are the following true of the exam room?		
Has respective seating areas for the client and the provider	Yes	
Is lit well	Yes	
Has examination bed	Yes	
Provides visual privacy for individual client encounters	Yes	
Has a sound barrier for privacy (the room should be completely enclosed)	Yes	Had locked door and was soundproof.
Has a hand-washing station	Yes	
Has soap for washing	Yes	

Checklist item	Results	Assessment narrative
Has a receptacle for waste disposal	Yes	
Has clinical equipment for vaginal exams including vaginal speculums	Yes	
Has equipment for IUCD insertion	Yes	
Has equipment (sterile) for IUCD removal	Yes	
Has equipment (sterile) for Jadelle implant insertion	Yes	
Has equipment (sterile) for implant removal	Yes	
6.2 Go to the room where FP counselling takes place. Are the following job aids available?		
Samples of available FP methods/FP demonstration tray	Yes	
FP choices chart or poster	Yes	
FP screening checklist	Yes	
Penile model	Yes	
Pelvic model	Yes	
6.3. Go to the room where FP clients wait to be seen. Are following true of the waiting area?		
Seating is available for clients	Yes	
The area is shaded or covered by a roof	Yes	
6.4. What types of FP IEC materials are available for clients		
Posters	Yes	
Flip charts	Yes	
Brochure/pamphlet/information sheet for clients to keep (at least 10)	Yes, not much available	Fewer than 10; not routinely offered.

Checklist item	Results	Assessment narrative
Videos and CDs	Yes, in the past, not now	They used to have them in the past, equipment no longer functioning.
6.5. Are the IEC materials comprehensible by those who cannot read or translated into local languages?	Yes	Some in the local Roviana language, but not readily available.
6.6. Are permanent signs displayed on the street or on the exterior indicating that FP services are available at this clinic?	Yes	
6.7. Does the clinic have a space for appropriately storing contraceptives away from water, heat and direct sunlight?	Yes	
Referrals		
Does this clinic provide referrals for FP services?	Yes	Referred to Gizo Provincial Hospital for tubal igation and vasectomy.
Does this clinic maintain a directory of referral sites?	Yes	Referral site was the Gizo Provincial Hospital.
Is the directory easily retrievable and accessible to all staff making referrals?	Yes	Gizo Provincial Hospital contact phone number for referrals was available.
Is the directory regularly updated? For example, if something were to change at a clinic, would the directory be updated to reflect that change?	Yes	Contact with Gizo Provincial Hospital was via telephone.
What method is used to refer clients?	Written referral letter (hard copy)	Most travelled by outboard motorboat, some by ship to Gizo Provincial Hospital, which took less than 2 hours to reach on a 40 hp motorboat during fine weather. The hospital covered the cost of transport by motorboat. Clients preferred to travel via motorboat as the cost was covered by the hospital. If clients organised their own transport, they had to pay for themselves.

Checklist item	Results	Assessment narrative
In the last 3 months, has this clinic ever run out of referral forms?	Yes	This may mean they had more referrals in the previous 3 months or that they had limited stock of forms that were not restocked.
7.1 What information is provided to the client in the referral?		
Location of site	Yes	
Hours that the services are available	Yes	May depend on available booking for surgery; may require a 2–5-day hospital stay.
Expected fees	Service at the hospital was free	HGH provided the transport for patients referred to Gizo; however travel depended on whehter there were enough patients to send in one trip. Clients met the cost of food and living while on referral.
Contact person	Yes	
Instructions for reaching site	Yes	
7.2 In your opinion, are the facilities to which you refer clients for FP services easily accessible to all clients? For a service to be readily accessible, transport to the facility should be readily available and affordable, and services should be provided at reasonable price for all clients	Yes	
7.3 Is there a system in place to track whether a client has completed a referral?	Yes	But not consistently followed.
If a referral is not complete, is an attempt made to contact the patient?	No	
Is the status of tracked referrals recorded? Each referral should be recorded as complete or not complete. Select NA if there is no system in place to track referrals	NA	No system in place to track clients after they were referred.

Checklist item	Results	Assessment narrative
What percentage of tracked referrals are tracked? Verify referral records for at least 10 referrals, skip recent referrals if not tracked. Select NA if there is no system in place to track referrals	Referrals not often tracked, but they were recorded in the referral register book	
What percentage of tracked referrals are completed?	Not known	

5.3.5.1 Checklist Audit Summary

Seven headings were included in the audit checklist: services, counselling, staffing and training, supervision, drugs and supplies, clinic infrastructure and resources and referrals. Below is a summary of the results.

5.3.5.1.1 Services

FP services and contraceptives were available at HGH on a weekly basis, integrated with the postnatal clinic, and available every day at the maternity ward and opportunistically to those who live far. Procedures for permanent methods were not available. Sexual health services such as STI/HIV were not integrated with FP but were available at the outpatient clinic. Outreach services depended on availability of funds.

5.3.5.1.2 Counselling

Counselling for FP was mainly provided to those who attended the FP clinic; it was mostly married women who were counselled. Men and young people received less counselling from service providers. Counselling for couples was rarely provided at the clinic.

5.3.5.1.3 Staffing and Training

FP services were provided by two midwives, two registered nurses and two nurse aides, all of whom were female. All were trained to provide FP, but not everyone was trained to manage youths and high-risk populations. The current number of staff was thought to be sufficient to respond to service demands at the clinic.

5.3.5.1.4 Supervision

There was no regular supervision to monitor FP performance at HGH. Visits were made only to collect monthly clinic reports. No plans were developed to identify and address gaps in service, although additional ‘on-the-job training’ was available if needed.

5.3.5.1.5 Drugs and Supplies

All common temporary contraceptives were available at the time of audit (September 2019). Service providers were well versed with the supply management system to monitor contraceptive

stock. The longest time taken to replace contraceptive stock-out was one to six months, with FP nurses reporting that the most common length of time to wait was one to two months.

5.3.5.1.6 Clinic Infrastructure and Resources

The clinic was well set up, with waiting areas and seating for clients and providers. The clinic had adequate examination rooms that provided privacy, good lighting and sterile equipment for examinations. Teaching aids were available, but only in English. There was no signboard outside the clinic building to indicate that FP services were available.

5.3.5.1.7 Referrals

Referrals for tubal ligation and vasectomy were to Gizo Provincial Hospital. Hospital services were free of charge; however, the client needed to meet the cost of food and living expenses while receiving treatment. A system to track referrals existed but was not consistently followed, with no follow up in most cases. While client referrals were recorded in the referral register, most referrals were not tracked for service access, progress, discharge planning and/or post-surgical care requirements.

5.3.6 Family Planning Clinic Records Audit

Given the limited data available for audit at the clinic, only partial information on trends in service occasions, attendance by methods and age group is reported. The numbers of attendances are absolute numbers and are counted as occasions of service. I could not compile attendances by marital status as most records either did not specify the status, or this variable was not included in the audited records. It was predominantly women who attended the FP clinic; no data on men's attendance was recorded in the clinic records. I also noted that multiple record books were used. One reason for this was that the original FP register book used had not been updated to include newly introduced contraceptives such as Jadelle implants and other information required in current monthly reports.

Not all FP clinic data for 2015–19 were available at the time of data collection. Figure 5.7 shows HIS reports for 2015, 2016 and 2019. The increased number of service occasions in 2019 corresponds with the roll out and availability of implants at the clinic. HIS reports for 2017 and 2018 were not available for inclusion.

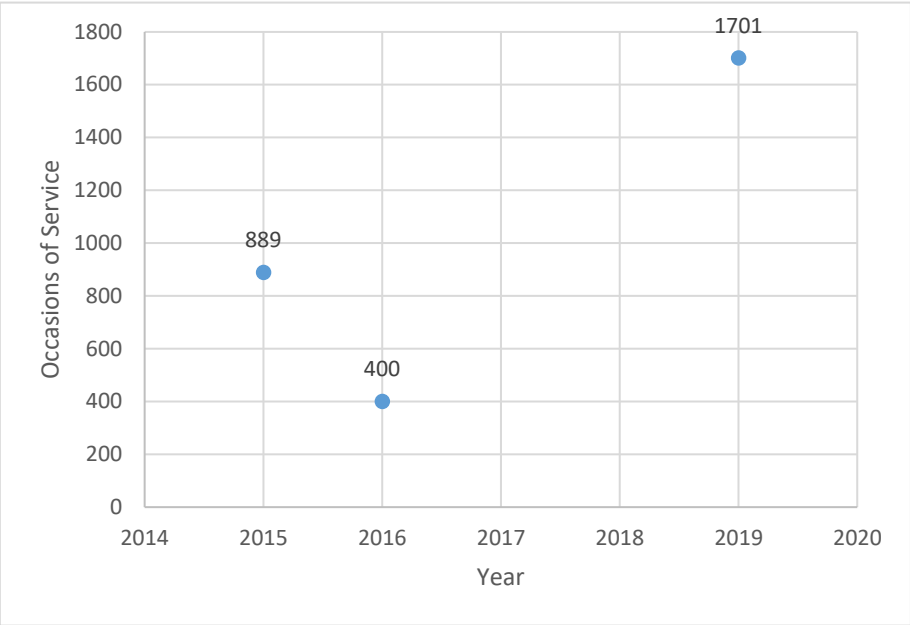

Figure 5.7. HGH FP clinic occasions of service 2015, 2016, and 2019

Figure 5.8 shows attendees' preferences for using LARCs rather than short-acting contraceptive methods, with more women using implants than other methods. Although attendance by men seeking male condoms was low at the FP clinic, men could access condoms at the outpatient clinic and at Noro reproductive health clinic, data for which were not captured in this report. Most women who required tubal ligation were referred to the provincial hospital, as were men seeking vasectomies. No vasectomies were performed at HGH. Surgeries for tubal ligation and vasectomy usually depended on the availability of the medical practitioner who could perform the procedure. However, I was informed there could be records of tubal ligations and vasectomies from HGH that may be recorded in the provincial data records but are not captured in the audited records here.

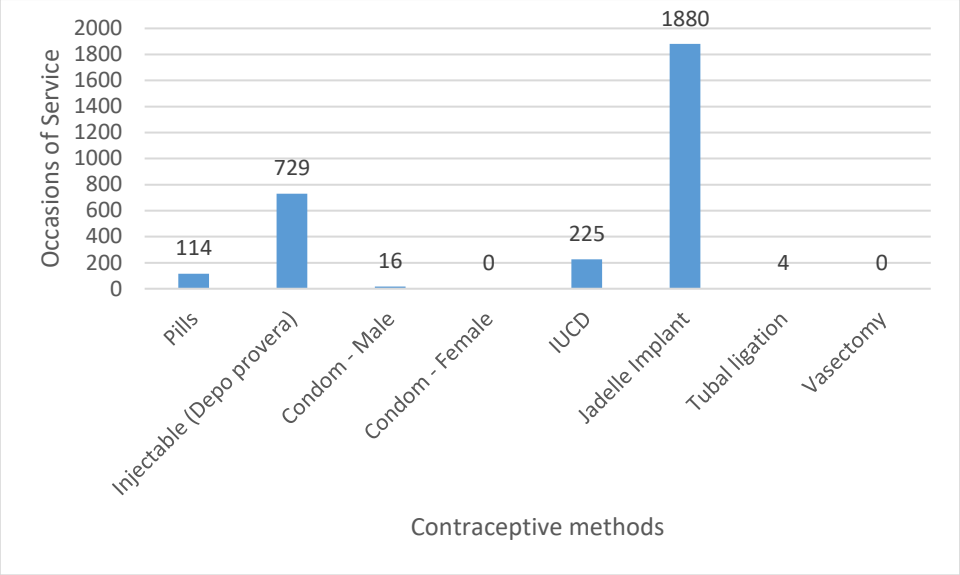

Figure 5.8. HGH FP clinic occasions of service by method

Figure 5.9 indicates the age groups of people attending the FP clinic. This age group distribution was audited from the HIS report for 2019, as the FP record book was not available to extract specific age groups. Young people had fewer occasions of service than did older people at the FP clinic.

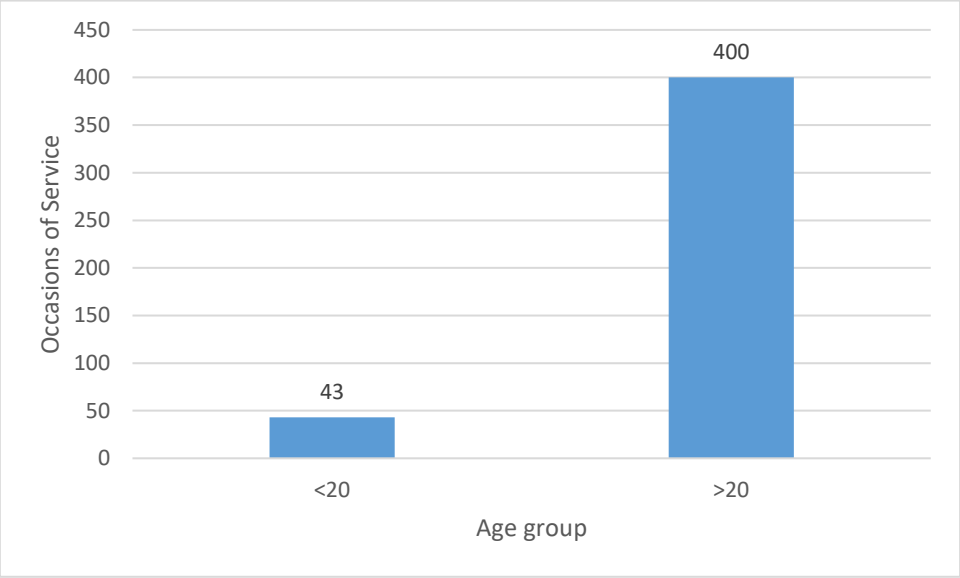

Figure 5.9. HGH FP clinic occasions of service by age, some months 2019 only

5.3.7 Qualitative Interview Findings

The availability, accessibility and acceptability of FP services and contraception provided at HGH was explored in 16 interviews, with qualitative data thematically analysed. Findings from this

analysis are represented through four themes: 1) FP services are focused on women; 2) building relationships and connecting with people; 3) people need good explanations; and 4) sociocultural challenges.

5.3.7.1 Family Planning Services Are Focused on Women

FP services at HGH were focused solely on women. This theme describes how FP services were delivered and to whom.

5.3.7.1.1 Clinic Services

FP clinic services were available once a week on Wednesdays, with the service also provided on an as-needed basis to those who lived far from the clinic. As reported by a FP provider, '*Lo hia family planning klinik hem wan dei lo wan wik nomoa ia fo olketa stap kolsap lo hia … bata fo olketa mama wea kam aotsaed munda bae evri dei … bikos staka klinik lo zone klos tuia*' [The family planning clinic here is available once a week to those who live near the hospital … but if mothers (women) come from outside Munda, we offer it every day (Monday to Friday) to them … because many clinics in our zone are closed] (2FPPM2).

In 2018, FP services were also made available in the hospital's maternity and postnatal wards after nurses noticed that not every woman returned for their postnatal check or to collect contraceptives from the FP clinic. A service provider shared this information about the initiative:

> *sometimes even for postnatal check ia samfala women bae no save come back for hem … mi luk lo olketa books (mother and baby book) ia, no attendim nomoa ia (postnatal visits) … so mifala se umi start for putim Jadelle lo postnatal na, mekem after delivery … eniwan hem chusim Jadelle, mifala insert before discharge olsem, hem wanfala new approach mifala duim lo hia naia* [sometimes women did not come back for their postnatal checks … When I looked in their books (Mother and Baby books), there were no records of attendance (for postnatal visits) … so we decided to start giving Jadelle implants after women had their babies … if anyone chooses to use Jadelle, we insert before they are discharged from the hospital; this is one new approach we do here] (2FPP1).

Modern contraceptives provided at the clinic included implants, injectables, IUCDs, OCPs and male condoms. Permanent methods such as vasectomies and tubal ligations were not provided. Those who required these were referred to Gizo Provincial Hospital for the procedure. However, men were rarely, if ever, referred for a vasectomy, as stated by a service provider: '*vasectomy mifala no provaedim lo hia, bat so far olsem no eniwan mi kam akross hem laekem vasectomy*' [We do not provide vasectomy services here, but so far, I have not come across anyone who wanted to have vasectomy] (2FPP1). The service provider further elaborated that despite high demand for tubal ligations, the referral system did not prioritise women for tubal ligations at the time they needed it:

> *lo side lo TL (tubal ligations), samfala woman olketa likem tumas ia but bikos no eni specialist (Obstetrician) lo hia for duim that wan so mifala save refer lo Gizo na ... bat referal blo olketa go fo Gizo ia bae hem depend nomoa wat taem boat hem go fo other patients moa olsem naia, so hem had fo se or "hemia TL so arrangim boat for hem go", that wan ia bae hem no hapen ia. If olketa staka lelebet osem bae hem ok* [some women really want to have tubal ligation here but we do not have a specialist (obstetrician) so we refer them to Gizo … however this referral depends on the availability of the boat to take other patients and if there are enough patients to go on this trip, so it is not possible to make referrals only for TLs (tubal ligations)] (2FPP1).

The delay in actioning referrals often resulted in women reversing their decision to have a tubal ligation given that the waiting time for transport can be longer than a week and women needed to return to their home villages to care for their children, their husband and other family members, and grow food in their gardens.

5.3.7.1.2 Women-focused Service

FP service providers reported that FP services at the Reproductive Health Clinic were focused on women. Usually, women attended the FP clinic without their husbands. A FP nurse often counselled a woman alone, although sometimes a woman attended with her mother or aunt. If the FP nurse identified the need to talk to the husband, a request for him to attend the FP clinic was communicated through the woman: '*so mi save talem olketa (women) fo talem olo (husband) fo kam lo klinik ... olketa olo save kam an mifala stori*' [I usually tell them (wives) to tell their husbands to

come to the clinic … sometimes the husbands come, and we talk] (2FPPM2). Most participants expressed that it was predominantly married women attending the FP clinic.

Men were not often seen attending FP consultations or accompanying their wives to the clinic. Some men (e.g. fathers of sick children) attended the sick child clinic when they brought their sick children but they did not attend for FP. Men believed that the service was only for women. As a male non-user stated:

> *lo tingting blo mi olsem, ating family planning blo olketa gele or woman nomoa, so olsem man ia nomoa ia. Taem olketa woman kam den talem, family planning olsem ia, den seke karage nomoa lo hem* [I thought family planning was only for girls and women, not for men. When women came and told us what family planning was all about, we just realised what it is about then] (2MNU1).

A male non-user said he had never visited the FP clinic, but he knew his wife did: '*mi barava no kasem klinik (FP) ia, wife blo mi nomoa hem save go*' [I never went to the FP clinic, only my wife went there] (2MNU2). Another male non-user who worked at the hospital said he never saw men and women coming together specifically for FP: '*barava mi no lukim kain bae man an woman kam for duim famili planning osem tu lo hia ia*' [In reality, I do not see such things as men and women coming together for family planning here] (2MU1).

Service providers reported that they did not actively engage men, with most focusing on women and their needs when providing FP services. One service provider reflected on her approaches to providing FP service:

> *family planning lo Helena Goldie bae mi se hem low tumas … ating approach blo mifala or the way mifala providim disfala sevis ia? … Mi ting disfala approach mifala go hed lo hem ia, osem hem no longer waka lo disfala generation … or mifala no involvim olketa 'olo' (husbands) so mas involvim na olketa man? mifala ignorim olketa man tuia* [I would say the uptake of family planning at Helena Goldie is very low … it could be due to our approach or the way we provide this service. I think the current approach we use is no longer effective in this generation … or could it be that we do not involve the husbands, so we need to involve men. We often ignore men in FP] (2FPPM2).

While providing services to women was reported as the norm, another service provider explained she was open to the idea of providing FP services to men, stating, '*ia olketa man tuia … bat olsem maen blo mi no catchim na olketa man ia, olketa woman nomoa olsem mi tigim, bat hem gud idia tuia fo olketa man kam den umi kanselim olketa ia*' [oh, yes—men too … but my mind does not think of men; I only think of women. It would be a good idea for men to come and we can counsel them too] (2FPPM1).

Providing FP services only to women is seen as normal; even service providers had not really thought of including men. Therefore, men are often ignored and forgotten as important partners in FP. This led non-users to think that FP is a service for women, and only available and accessible to them.

5.3.7.1.3 Access to Family Planning for Young People

Although the FP clinic was intended for everyone (women, men and young people), it was predominantly married women who accessed the service. Most participants reported that unmarried young people (commonly known as 'young girls' and 'young boys') rarely accessed the FP clinic for contraceptive services. Fewer young men attended compared with young women. A service provider said, '*olsem olketa young boys mi no save lukim olketa kam lo famili planing ia, olketa girls samfala kam, olketa young gels wea stil skul yet olsem … olsem taem Jadel kam aot ia, olketa students na go fo hem ia*' [I do not see young boys come to the family planning clinic, some girls come, especially those who still attend school … when Jadelle was introduced, many students went for it] (2FPP2).

The lack of attendance by young men at the FP clinic was evidence of a lack of acceptability of the service as currently provided. A service provider explained a previous approach they used to make male condoms available to young men: '*lelebet taem mifala putum condom outside lo Reproductive klinik lastaem ia olketa boys save go tekem lo dea … so ating sapos separate klinik bae olketa go, bikos ating olketa sem fo kam?*' [in the past we put condoms outside the reproductive clinic and the boys used to go and collect them from there … so I think if they have a separate clinic they may attend, because I think they may be ashamed to come here?] (2FPP2).

Shame and fear of being stigmatised by others were some of the reasons young people did not access the FP clinic. A female user reported, '*olketa young gele ia olketa save sem tumas ia*' [young

girls feel ashamed to come to the clinic] (2FU5). A male non-user further explained the experience of shame and possible drivers of that feeling:

> *samfala gele mi save lukim olketa save kam … hao mi lukim ia ating hem na only ples olketa putim fo olketa boe, gele fo kam lo hem. Bat samfala gele sem ia, hem garem samting olketa sem lo hem. Nogud kam den 'e gele ia mas garem siki ia', kain taip ia so, hem na bae kain tingting blo olketa se frait fo kam bat sapos putim difren ples fo taem olketa kam bae pipol no lukim olketa ia, bae olketa save kam nomoa ia* [I used to see some girls come to the FP clinic … the way I see it, I think this is the only place set aside for boys and girls to come. But some girls are ashamed; there could be something they are shy about. If they come (people will say) 'oh that girl must be sick' (with an STI), so this is why they are afraid to come but if they have a different place to go (separate from FP clinic) where people will not see them, I think they will just come] (2MU1).

Teenage pregnancy is common among young women in rural communities around Munda. Many teenage pregnancies are unintended. A male non-user made this observation about his community: '*staka young gele distaem, olketa stap gagarem pikinini finis bata olketa no marit, no eni plan nomoa*' [many young girls in the village have children already but are not married; they did not plan (for the pregnancy)] (2MNU2). One service provider observed, '*Staka teenage distaem olketa babule tu, olketa single gels still skul yet*' [Today, many teenage girls are pregnant, they are still single (not married) and attending school (high school)] (2FPP2).

Young women who were unmarried often visited the FP clinic when they already had SRH problems such as unintended pregnancies or STIs—they would rarely go to the clinic to seek contraception for prevention. A service provider said:

> *Evriwan kam lo mifala lo hia olketa problem wan nomoa ia, olketa walk in wetem problem finis. So no mata hao mifala givim tok, ma hem insaed lo problem ia, hao na bae tanem gud mind blo hem? If hem no problem yet then information go, mi ting bae hem waka ia, even family planning*' [Everyone (young women) that comes to us at the clinic already had problems before they came. So even if we counsel them, it will not be effective; how can we

prevent their problems now? I think it would work better if they had not had problems, and we gave them information and family planning contraceptives] (2FPPM2).

5.3.7.2 Integration with Other Reproductive Health Services

5.3.7.2.1 Sexually Transmitted Infection and Human Immunodeficiency Virus Services

SRH services such as STI and HIV diagnosis and treatment services were not routinely provided at the FP clinic, but these services were provided as women needed them. Services for STIs were provided in the outpatient clinic along with those for HIV, where a trained provider and counsellor provided confidential, voluntary counselling. Services for adolescent health were rarely provided at the FP clinic.

5.3.7.2.2 Youth Corner

A youth-friendly SRH service (Youth Corner) has been planned at the HGH for young people to access both FP and sexual health services. Although service providers saw the need for and importance of youth services, Youth Corner had not yet been established. As one FP service provider shared, '*disfala klinik ia mifala se fo olketa save wokabaot in nomoa lo taem olketa garem problem olsem ia … bat mifala no duim. Ating if mifala advertisim dat fala?*' [we wanted to set up this clinic, where young people can walk in when they have problems … but we did not do it. I think if we advertise it?] (2FPPM2).

This importance of making available a youth-friendly service was also realised at the administration level. A service provider who also coordinates reproductive health services in the zone explained why young people need a location and service designated specifically for them:

> *mi tingting fo setim up wanfala area blo famili planing seleva includim adolescent mekem evri dei wanfala nes hem stap lo dea, fo eni wan wea kam, go stret lo dea bikos taem olketa kam lo outpatient, mifala bisi, ma olketa go na* [I am thinking to set up one area for FP that will include adolescent health, so that one nurse will be stationed there every day. Anyone who comes can go straight in there, because if they come to the outpatient and we are busy (we cannot see them) and they are gone] (2FPPM1).

Not all participants thought a separate clinic for young people would be enough to improve the access of young people to FP services, A male non-user stated, '*tingting blo mi olsem, olketa nes or hospitol fo mekem smol wokshop lo vilij fo olketa man or young boys olsem kam … fo herem, bikos kain fo yu go go seleva bae hem had ia*' [I think the nurses or the hospital should hold small workshops (training sessions) in the village for men or young boys to come and listen in … because it's not easy to go by yourself (to the clinic)] (2MNU1). The Reproductive Health Clinic has been predominantly focusing on MCH services and has not routinely included other SRH such as the adolescent health component. At the time of the field visit, the space designated for the Youth Corner was being used to store hospital equipment.

5.3.7.2.3 Men's Involvement in Reproductive Health

In Solomon Islands, male service providers can receive additional training to work with men in reproductive health through a formal programme previously known as MAP but now called *Men's Involvement in Reproductive Health* (MIRH). At HGH no one was trained for the MAP programme, or its successor the MIRH to work with and advocate for men on FP and sexual health matters. There were also too few male service providers available to take on this responsibility. A service provider explained:

> *Men as partners na nomoa lo hia, bikos olketa male nes blo mifala ia few nomoa ia, then olketa garem other responsibilities like wanfala hem TB coordinator, then other male RNs blo mifala waka lo wards, bat hem gud samting tumas ia for garem men as partners for help aot wetem famili planning* [We did not have anyone taking the role of MAP providers here, because we only have a few male nurses. These nurses also have other responsibilities: like one (male nurse) is a TB (tuberculosis) coordinator. Other male registered nurses work in the hospital wards, but it's good to have men as partners to help with family planning] (2FPP2).

5.3.7.2.4 Outreach Clinic Services

HGH's catchment location spans scattered coastal areas and small islands in the lagoons. Although some villages can be reached by foot, most can only be reached by travelling in a canoe with an outboard motor that needs fuel (petrol). Most families living on islands far from the hospital could not come to the hospital if they did not have access to boats and money to pay for fuel. For

these villagers, FP services were provided via HGH outreach clinics. However, financial constraints had limited the provision of outreach services including FP, and sometimes the local parliament member used his Rural Development Fund, a discretionary constituency fund, to pay for the fuel. As a FP service provider described:

> *No olowe na famili planing folo ap ia, problem blo mifala lo hia olsem ia, olketa lo hia no save givim fuel fo go, so samfala folo ap blo mifala distaem ia mifala link wetem olketa lo Gizo. Samfala taem mi askem honourable member, an hem givim mifala petrol. Osem mi lukim staka no reachim famili planing and immunisation coverage … Lo dea nomoa mifala go, bat fo hospital seleva hem givim fuel olowe olsem ia nomoa* [We do not regularly do family planning follow up here; our problem is they (hospital) do not give us fuel to go, so we link with Gizo hospital (Provincial Health) to do some of our follow-up visits. I sometimes asked our honourable member (for the local area) and he has given us petrol, because I could see we did not reach our FP and immunisation coverage. … This is how we go but the hospital does not always give us fuel] (2FPPM2).

Another service provider reported that they waited for people to come to the clinic, rather than facilitating satellite clinics: '*Satellite tu mifala no duduim tu distaem ia, mifala stap nomoa … waitim nomoa olketa kam lo klinik ia den talem olketa, which is hem no gud tumas … kliniks blo mifala zone 3 staka clos tuia*' [We do not do satellite clinics very often now; we just stay in the clinic … waiting for them to come … which is not very good … most of our clinics in Zone 3 are also closed (not operating)] (2FPP2).

People who lived far from health facilities at HGH viewed outreach clinic services as an important way to make FP available and accessible. Service users would like to see service providers visit them where they lived. A service user stated, '*Nes sud raon lo olketa ples fo sekim olketa woman, no stei lo klinik nomoa*' [The nurse should go around places to check the women; not just stay in the clinic] (2FU2).

5.3.7.3 Building Relationships and Connecting with People

Building relationships and establishing positive connections with people were seen by participants as important facilitators to enable available, accessible and acceptable FP for those who sought the service. Service users and non-users reported that when nurses were happy at work, they were more likely to provide friendly services. Likewise, service providers reported that establishing positive relationships with users and non-users could sustain and improve access and acceptance of FP service into the future.

5.3.7.3.1 Happy Nurses are Open to Talking: Service Users' and Non-users' Perspectives

Service users and non-users reported that their relationships with service providers were positive when staff were happy. A female user stated, '*Olketa nes sud hapi an open fo tok lo olketa woman taem givim advaes for kam lo klinik, fo olketa woman hapi tu*' [Nurses should be happy and open to talk with women when they give them advice to come for check at the clinic, so that women can be happy too] (2FU3).

Many young people in the village did not go to the clinic because there was no confidentiality and they perceived nurses were not open to talking to them. They feared stigma or judgment from the nurses. A male non-user saw this as a barrier for young people to access FP services:

> *lo vilej staka olketa yang boys n gels save frait fo go lo klinik, an samfala taem olketa nes no save open ap hem na wanfala beria blo olketa, bikos sapos nes open ap for mekem aweanes lo vilej or lo klinik bae olketa gels n boes olketa fri fo tok lo olketa an bae olketa no frait. Samfala taem olketa herem stori olsem 'olketa gele olsem, olsem', bat ating kain olsem sud no stostorim lo klinik so hem na olketa save fafaraitim. Ating hem tu save spoelem olketa yang pipol les fo go na lo klinik. Taem olketa go lo klinik, hao olketa nes tok lo olketa na mekem no enkaregim olketa fo go baek moa fo herem olketa samting ia, hem na tingting blo mi ia* [Many young boys and girls in the village feared going to the clinic; sometimes nurses are not open to talking to them. This is one of their barriers. If the nurse is open to making awareness in the village or clinic, these boys and girls will be free to talk to them and will not be afraid of them. Sometimes they (boys and girls) hear stories such as 'some girls are like

this and that', but I think such things should not be discussed at the clinic so that is why they fear going there. I think that makes young people not want to go to the clinic. When they go to the clinic, it is how nurses talk to them that does not encourage them to go back to hear about FP; this is what I think] (2MNU3).

When a service provider was seen as happy, it was a sign that the environment was conducive to users asking about sensitive issues and service providers more likely to facilitate sensitive and non-judgmental conversations.

A female user shared her positive experience at the FP clinic: '*lo hia hem naes, olketa nes save tok gud lo mifala an stori abaotim FP, so mifala mami kam skelem baby, mifala laek, kam tekem na osem*' [It is nice here, the nurses talk nicely to us about FP so although we (mothers) came to weigh our babies, we can also talk about FP if we want to] (2FU1).

A service provider's positive outlook was reported as an assurance to users and non-users that the service provider was ready to listen. It also made them feel more at ease, took away their fears and brought confidence to find the right words to communicate their needs or complaints to the service provider. A new user of FP was nervous during her first visit to the clinic: '*hem fest taem mi kam lo hia so me sem. Hao fo tok lo olketa nes tu bata mi no save*' [This is the first time I have come here so I am ashamed. I do not even know how to talk to the nurse] (2FU4). Another female user reported a negative experience at another clinic she had visited: '*nes lo dea ia olsem no stret wan tu … samfala taem bae hem willing fo go, samfala taem hem lesi … bae hem ranawe, olsem na problem blo mifala, bikos wanfala nes nomoa tu lo mifala*' [the nurse there seemed not to behave normally (follows her own programme, does not care) … sometimes she was willing to go (to the clinic), other times she did not want to go … she would run away (would not attend to clients at clinic), so this is our problem, and we also have only one nurse] (2FU2).

5.3.7.3.2 Connecting with People: Service Providers' Perspectives

Service providers expressed that when positive connections between service providers and users were established, a relationship developed; thus, people would easily come forward at a convenient time to seek information about FP. A service provider shared her experience: '*samfala gels olketa gagarem kweson ia, so taem olketa mitim mi lo rot olsem olketa wea save lo mi or mitim*

olketa nara nes ia olketa save askem kweson ia' [some girls usually have questions about FP, so when they meet me or other nurses along the road, especially those who know me, they will ask questions] (2FPPM2).

Another service provider described how she used established relationships with clients to remind them of clinic appointments:

> *everitaem mi filim form blo olketa, mi mas tekem mobile naba, so bifoa taem blo next visit bae mi kolem olketa, 'O depo blo iu lo taem olsem bae iu kontiniu or nomoa'? 'ke mi foget na' bae olketa se naia … so hao mi faendem, drop aot blo mi hem no tumas* [Every time I fill in their forms (during their initial visits) I take their mobile phone numbers. Before their next visit I call them to remind them, 'oh your depo is due at such a date, are you going to continue or not?' and they will say, 'Oh I forgot' … I found this has reduced dropout rates for contraceptives] (2FPPM1).

When service providers had positive connections with users and showed empathy towards them, clients felt free to approach the provider when they needed contraceptives. The service provider quoted above shared an experience of providing FP services after hours: '*samfala taem bae lo nait olketa kam ia, kam for tekem depo nomoa, kam fo kondom nomoa olsem … mi save go nomoa*' [Sometimes they come at night just to take depo or condoms … I just go and give it to them] (2FPPM1). Another service provider shared how she connected with young unmarried women for access to FP contraceptives:

> *mifala lo hia gagarem olketa single mama tuia … wanfala yang single mama wea mi givim Jadelle lo hem las wik, hem kam astede, hem se, 'staka gels laekem na what yu putim lo mi ia' so mi se yu talem olketa for kam. So mi save usim na olketa yang gels wea single mothers wea mifala putim Jadelle lo olketa fo go encouragim and motivatim na friends blo olketa ia. So ating that fala wei bae olketa come. Wanfala taem lo last year, wanfala student na come an hem se 'mi mama blo mi na talem mi fo tekem this wan (FP)' hem say ia* [We also have unmarried women here … one young unmarried mother to whom I gave a Jadelle implant last week came yesterday and said, 'many girls want what you put on me'; so I said tell them to come. This is how I engage young unmarried mothers who currently use contraceptives to

encourage and motivate their friends. In this way, I think they will come. Last year one student came and said, 'my mother told me to come and take this' (FP contraceptive)] (2FPP1).

5.3.7.3.3 Service Users Connecting with Non-users (Sharing Experiences)

FP service users shared their experiences of using FP contraceptives, and the resultant benefits for people who did not currently use FP. Service users reported that when they employed FP it freed them to participate in paid employment and better manage their family responsibilities. Service users shared with non-users of FP their positive experiences in the context of relationships and positive connections, which motivated non-users to accept contraception and promoted access to FP services.

A service user reported how she encouraged her sisters through sharing her experiences of FP: '*mi save stori lo olketa sister blo mi, mi talem olketa "samting ia barava gud tumas ia", olsem lelebet stap fri bifoa tekem naravan olsem, so staka mi save encouragim olketa, olketa kam tekem family planning na*' [I used to talk to my sisters and told them that 'this thing is very good', it helps you to be free before you have another one (baby). I encouraged many of them and they came to take family planning] (2FU1).

Young people connecting with their peer group to share positive lived experiences could be a way forward to enhancing access and acceptance of contraceptive use. A non-service user who was a current school student accompanied her friend to the FP clinic. The friend was now an ex-student who had a baby. The non-user said, '*mi folom kam nara gele karem pikinini ia fo tekem family planning, an mi like kam tuia ... hem se naia, "bae yu tekem tuia"'* [I accompanied the other girl who had a baby to take family planning, and I also wanted to come too … she told me 'you must also take it'] (2FNU2).

5.3.7.4 Need Good Explanations About Family Planning

Widespread misinformation about contraceptives warrants the importance of good explanations in a language people understand, to help people make informed decisions about FP. Service users and potential users of FP require a clear and precise explanation about FP services

delivered in ways that suit the people receiving the information. In a low-literacy environment where misinformation abounds, giving talks to raise awareness in an accessible language and using an approach that is appropriate for people to understand is critical. This theme examines the issues affecting dissemination of IEC about FP service and contraceptives at HGH.

5.3.7.4.1 Low-literacy Environment

Many people living in the HGH catchment area had only a primary level education and poor literacy skills; others had no formal education and were functionally illiterate. A service provider described the difficulty providing services in this context: '*lo hia kain education hem low so olsem mi faendem challenging lelebet … samfala no skul so yu explen go bata olsem olketa no minim tuia … sapos usim visual aid bae olketa minim*' [People's education level here is low so I find it quite challenging … some are not formally educated so when you try to explain things, they do not seem to understand … unless you use visual aids] (2FPPM2).

5.3.7.4.2 Sources of Family Planning Information

Increasing misinformation available through social media and the internet, the lack of awareness in the community and the fact that not every service provider was attending regular FP refresher courses meant that relevant information about FP may not be readily accessible to many people. Misinformation often emerged when people did not have accurate and complete information about the concept of FP. Most people had heard about FP from others; for example, some husbands had heard about contraceptives from their wives but may not have understood how contraceptives worked. A common belief in the area serviced by HGH was that contraceptives were life threatening and could cause diseases in women's reproductive organs. A service provider shared a common experience she faced while working at the FP clinic:

> *hem se, 'ufala bae spoilem wife blo mi…bae mekem hem sick, hem no waka, no duim eniting'. So bae mi herem hem gud finis bae mi pikim na wanfala chart (flip chart), den bae mi se, ok hem gud na stori blo yu, ating mifala tu no explen gud lo ufala, ating wife no stori gud lo yu, so gud u kam tu. Waka blo disfala meresin osem nomoa ia, hem go nomoa lo tube ia nomoa, hem go thickenim or if mifala putum lup (IUCD), samting hem stap insaed basket blo pikinini, so hem stopem mami fo babule … hemia fo jes givim speis nomoa, bikos olketa pikinini blo*

yutufala smol tumas … den mi save explenim olketa side-effects osem ia … den olketa man ia save se, 'O ia man, mifala ting se hem bae spoilem olketa ba?' [He (husband) said, 'you have harmed my wife … it makes her sick, she does not work or do anything now'. So, I listened to him first, then picked up a chart (flip chart) and acknowledged his concerns, then told him, 'maybe we did not explain it well to you or maybe your wife did not accurately tell you the details, so it's good that you come so we can talk'. The action of this medicine is like this, it goes to the tube and thickens it or if we put an IUCD, it occupies the womb (uterus) to stop the mother becoming pregnant … this is just to give spacing for your children because your children are too small without giving enough time between births … then I also explained the possible side effects … then the man said, 'Oh, we thought it would harm their body'] (2FPPM2).

Young people in Solomon Islands are increasingly exposed to advances in information technology, seeking out and using FP information from books, the internet and social media platforms. This has caused them considerable confusion and led to dissemination of unsubstantiated information among their peer groups. Some young people reported that they did not seek health workers' advice; instead, they relied on their own research and understanding. When asked if he ever visited the FP clinic, a male non-user responded, '*mi no go nomoa, mi riridim olketa books den mi save nomoa so mi no bother fo go nomoa*' [I do not go; I just read books and I know so don't bother to go to the clinic] (2MNU3). One service provider shared an encounter with a young woman who came back to the clinic demanding that her Jadelle implant be removed: 'hem se, "*yu aotim jadelle lo mi na" so mi se ae hao? "yu givim mi samting blo pigpig ia, mi search lo internet den mi lukim, aotim na samting blo animol yufala givim mifala ia*"' [she said, 'remove my Jadelle implant', so I asked why? 'You gave me something from pigs, I searched the internet and found it; remove this thing from animals that you gave us'] (2FPPM2). Despite this emerging dynamic, there were young people who wanted advice from service providers: '*mifala yang gel ia olketa samting hem had fo mifala so mi laekem olketa nes mas help tu fo givim mifala advaes*' [we (young girls) sometimes find things hard, so we want nurses to help us with advice] (2FU4).

5.3.7.4.3 Awareness and Promotion of Family Planning

FP awareness talks were typically delivered in FP clinics, with few delivered in schools and other settings. Therefore, people who rarely visited the clinic did not hear about FP. A service provider confirmed that, '*famili planing aweanes hem save hapen lo reproductive health clinic an kam in lo taem blo antenatal nomoa an may be lo child welfare clinics, Samtaems olketa nes save kam in wetem aweanes blo olketa taem bebi siki olsem*' [family planning awareness usually happens at the reproductive health clinic, antenatal and maybe in child welfare clinics. Sometimes nurses come in with awareness when the baby is sick] (2FPP1). One service provider thought service providers did not provide enough awareness of FP:

> *ating wanfala failure blo mifala lo hia na aweanes … bata taem olketa kam lo klinik, woman nomoa kam, husband no kam so hem no herem. Taem woman go stori lo husband bae hem no bilivim moa … so ating mifala lo hia barava no duim gud ia* [I think one of our failures here is awareness … but when they come to the clinic, only women come. The husbands do not come so they do not hear the awareness. When the wife tells the husband about family planning, he does not believe her … I think we do not do well with FP awareness here] (2FPP2).

Service providers also reported that awareness about FP must be linked to the consequences of having many children, such as increased school fees; mothers' and children's wellbeing; and the cost of living for families, to make them think more seriously about it. This quote from a FP service provider highlights the need for this approach: '*bikos staka ia olketa unplanned (pregnancies) wan nomoa gogo hem staka na … olketa multigravida na*' [Because many of these pregnancies are not planned and they just end up having too many children without realising it] (2FPPM2). Another service provider learnt that role plays about FP presented during international nurses' or midwives' days captured peoples' interests: *'lo olketa international days ia mifala save duim role play and samfala skit, an olketa public laekem tumas, so hem one opportunity fo umi reachim pipol lo FP'* [during international days, we use to perform role plays and skits about real FP issues and the public was very interested in our performances, so this is one opportunity for us to reach people with FP messaging] (3FPP1).

Young women who often do not realise the negative consequences of unintended pregnancies may also benefit from FP awareness. A young female service user reported how she felt when she had to leave school because she had a baby: '*Filing blo mi taem mi aot lo skul ia olsem mi no fil gud tu bikos mi stil skul yet an mi garem pikinini. Family planing helpem mi, mekem mi komplitim skul blo mi bikos mi laek go bek skul*' [I felt bad when I left school because I was still in school and had a baby. Family planning helped me not to be pregnant again because I wanted to go back to school] (2FU4).

FP awareness and promotion provided only in the clinic meant that many people had not received important information about FP. Therefore, these community members were not prepared to make informed decisions when they visited FP clinics, or they continued to believe inaccurate information about FP. A male non-user said:

> *mi tingting blo mi nomoa … olsem wat mi save lukim lo hia tufala ples nomoa provaedim family planning so mi laek save nomoa, hao ufala save duim olketa aweanes lo komuniti tu? Olsem samfala no save kam lo hospital ia* [I think, from what I saw here, only two places provide FP awareness so I want to ask, would it be possible for you to come and conduct FP awareness in the communities, because some people do not come to the hospital regularly to hear about this] (2MNU2).

5.3.7.4.4 Family Planning Training

Although all FP service providers received basic training on FP, not everyone had completed specialised training for IUCD and Jadelle insertions. Service providers believed it was important that ongoing refresher training was provided. They understood that sharing consistent and updated information was crucial for clear understanding about FP among health workers and service users. However, a service provider stated that not everyone had the opportunity to attend refresher training on FP:

> *mi ting olsem mifala sud go fo trening tuia bikos ino mifala everiwan na save go … so olketa wea save go lo olketa workshops ia sud kam beck and tisim mifala wat na olketa lanem … fo mifala talem olketa clients olsem … Men as partners lo hia no eni wan lo mifala go fo dat fala trening tuia, so mifala no duduim guti tuia* [I think we should go for training because not all

of us usually go … so those who attend those workshops should come back and teach us what they learnt … so that we can tell our clients too … We also do not have anyone here trained for the men as partners (programme) so I think we do not do it properly here] (2FPP2).

However, another service provider voiced concern about staff motivation to attend training sessions: '*samfala colleagues ating olketa smart so olketa save wat na waka blo olketa. Others ia ating olketa jes go sidaon nomoa (training workshop), ating hem tu problem mifala no save update lo hem*' [some colleagues might be smart, so they know their responsibilities. Others might be just there for the sake of attending the training, I think this could also be our problem; that is why we are not updated with family planning] (2FPPM2).

Trained and enthusiastic FP service providers were more likely to provide good explanations to reach more people at every opportunity, thus increasing the availability of accurate FP education and awareness. Conversely, FP staff who did not receive additional refresher training on FP felt they did not have the skills to advocate for FP. A service provider recounted how:

> *samfala taem other nurses bae olketa se, 'O yu na tren fo duim dat wan' so bae olketa no really bother fo motivate or kain olsem ia, bat yumi se dat taem olketa patients, mothers or women olketa kam in lo outpatient or eniwea yumi mas always tekem opportunity fo advocate or motivate or sostori wetem olketa … den hem na hao bae olketa come through naia. Bat bikos samfala no train for hem ating olketa fil osem olketa no laek for discuss wetim others or olketa women aboutim this wan* [sometimes other nurses will say, 'oh you are the one trained for that', and they will not be bothered to motivate or counsel for FP, but we say that when patients, mothers or women come to outpatients or anywhere we must all take the opportunity to advocate or talk to them (about FP). This is how people will come forward for FP. But because some (nurses) are not trained, they may feel reluctant to discuss with others or women about FP] (2FPP1).

5.3.7.5 Sociocultural Factors Affecting Family Planning

In most Melanesian societies men makemost decisions in the family, especially when deciding on the number of children in the family. Children are considered family assets as they will

care for their parents when they age, and provide increased perceived social and financial security, even in extended families. This is a common cultural reason for not accepting contraceptives.

5.3.7.5.1 Power Issues: Men are Perceived as More Powerful Than Women

Although not everyone experienced husband or partner opposition with FP, female participants reported this dynamic as a common challenge to accepting and using contraception. However, when husbands/partners received a satisfactory explanation about FP and understood the benefits, they often agreed on FP methods or allowed their wives to use FP. Although men were not the primary focus of FP, service providers were confident that when husbands or partners were consulted and included in the dialogue, they could be very cooperative. A service provider described using this approach:

> *Wanfala taem mifala garem wanfala wea hem se 'eh husband na stopem mi' … so mi se 'olsem mi laek stori lo husband blo iu fastaem'. So mi stori wetem husband … after stori finis husband hem se, 'hem true mitufala bae nidim na FP ia'. Hem lukim importance blo famili planing and olketa benefits lo famili. So mi ting olketa husband ia, ating sapos stori wetem oketa bae hem orait ia. Olsem nara approach moa naia, fo stori wetem husband tu, mekem gud decision fo wife tu* [We have someone who came to us and said, 'oh my husband stopped me from taking FP'… so I said, 'If that's the case, I want to talk to your husband'. So, I talked with the husband … after the talk he said, 'It's true, we would need FP'. He saw the importance of family planning and the benefits to his family. So, I think talking to the husbands would help. Talking to the husband is another approach that will help with good decisions for the wife] (2FPP1).

Some women who faced opposition from their husbands used hormonal contraception without their husband's knowledge and consent. A male non-user shared his own experience with FP:

> *taem hem tekem fest pikinini hem tekem injection, bata mi no kwiktaem save so mi no herem bikos hem no talem mi. After hamas mans na hem jes talem mi, 'O man samting olsem na mi duim'. Mi kros bata had na, den taem mi lukluk go folom dat wan ia, den mi lukim hem helpem famili blo mitufala moa olsem lo saed lo finance and mekem isi fo famili olsem na, hem mekem mi acceptim na* [After she (wife) had our first child, she took injections, but I did

not know because she did not tell me. A few months later, she just told me, 'oh this is something I did'. I was angry but it was too late; then as I looked at our situation after she took FP, I could see that it helped with our family finances and made life easy for our family, so that made me accept it] (2MNU2).

5.3.7.5.2 Gendered Nature of Society

Melanesia is a gendered society where gendered women's and men's group discussions about topics such as reproductive health and FP are often preferred. This is a challenge for service users and those providing the service as some service providers may have relatives who are users, preventing a clear discussion about FP. However, the service would be deemed accessible and acceptable if female providers saw women and male service providers saw men for FP. A service provider reported that the lack of male service providers was a barrier to men attending FP: '*ating samfala boys laek kam bat bikos olketa sem fo kam, den female nes moa lo dea … kastom tu … ating sapos woman lukim female nes and man lukim male nes bae helpem mifala tu lo family planing*' [I think some boys may want to come but they may be shy to see the female nurse … our culture too … if women come to see a female nurse and men see a male nurse, it may also help us with FP] (2FPP2).

5.3.7.5.3 Social Issues

The increasingly common phenomenon of married people having sexual partners in addition to their spouses has affected acceptance of FP. A male non-user shared a social reason why men would oppose their wives or female partners taking FP:

samfala olketa heherem (about FP), bat sapos olsem kain '01' or '02' osem ia, go go samfala bae faitim fo lainim pikinini na lo olsem second wife blo olketa olsem … ma nogud woman ia lusim hem, ranawe lo hem, so putum go staka pikinini mekem woman no ken ranawe den stap nomoa. Lo village an saed lo work force ia, if you man garem staka pikinini bae saed lo waka olsem bae yu no problem naia [some heard (about family planning) but for reasons such as

'01' or '02'[5], some people (men) will try to have more children with the second wife for example … just in case the woman runs away from him. Having many children with her will make her stay with him and not run away. In the village if you have many children, you will have no problem with your workforce] (2MNU3).

5.3.7.5.4 Religious Beliefs

Solomon Islands is predominantly a Christian country, with religious beliefs relating to contraceptives being common among church members. Some beliefs considered as religious include misinformation that people take on as beliefs and it is possible, they do not believe as such but may deliberately spread misinformation dissuade people from using contraceptives because of their religious agenda but the church hierarchy itself may be ignorant about contraception.

A service provider shared a common belief considered as religious: '*samfala sios ting se jedel ia satalait so bae olketa save folom yu ples yu go an hem foreign body, hem save kosim cancer an radiation*' [some churches believe that the Jadelle implant is a satellite object, so you can be monitored wherever you go; it is a foreign body that can also cause cancer and radiation] (2FPPM1). of FP. A service provider stated:

wan or tu pipol bae se, Bible hem se fo iumi multiply ia, wanfala samting hem save kam ap ia … bat lotu not really an issue lo hia, olketa nidim thorough explanation an information wetem other things like school fees, well-being blo pikinini … ating bae mekem olketa ting serious lo FP … den bae olketa save mekem decision fo acceptim nomoa ia [one or two people might say, 'the Bible tells us to multiply' this is one thing that often comes up … but religion is not really an issue here, they just need a thorough explanation and information associated with things like school fees, children's wellbeing … I think they can make the decision to accept it] (2FPP1).

[5] A common term used in Solomon Islands referring to a person (men or women) who has been married but also has multiple sexual partners. Often the first legal wife is referred to as '01', the second partner will be '02' and the third '03', depending on how many partners a person has.

However, overall, very few participants reported religious beliefs as a barrier to access and acceptance. Social, cultural and religious barriers to FP are often intertwined, so it is important that service providers know how to unpack these issues during awareness-raising and respond to them accordingly with accurate information and right attitides.

5.4 Integration of Data

Table 5.6 outlines the main results and findings from analysis of the data collected.

Table 5.6

Integration of Results from Case Study Two, HGH

Context	FP clinic services audit	FP clinical records audit	Qualitative interviews	Integration of data sources
Case Study Two is HGH, a FBO, representing a health facility in a peri-urban setting in the Western Province of Solomon Islands. HGH manages Zone 3 in the Western Province, with an estimated population of 27,916. The hospital also frequently receives patients from outside its zone for access reasons and availability of other related hospital services (e.g. medical doctor) Six staff (all female) provide FP services at the HGH.	FP services with five temporary contraceptive methods available once a week at the clinic, integrated with postnatal services. STI/HIV services not available at the FP clinic but could be accessed at the outpatient clinic. Outreach services available but only provided when funds available. Counselling mostly available for women; young people and men received less counselling. Fertility awareness and counselling for natural methods not routinely provided. All staff had basic FP training. Only two midwives and two registered nurses had specialised skills to manage youths and provided contraceptives that required specialised skills.	Though records were incomplete and inconsistent, they showed a preference for using implants and injectables over short-acting contraceptives (pills and condoms). There was an increase in FP clinic attendance after the Jadelle implant was introduced in 2015. Few records of tubal ligations and none for vasectomy because of need for referral. Poor records of male condoms, none for female condoms. Around 90% of attendees at the FP clinic were aged 20 or above and the majority were marred with children; around 10% were younger than 20 years (young people).	FP services available once a week for those who lived close to the hospital and every day for those who lived far away. FP services also provided at the maternity ward by hospital nurses. FP services focused and targeted towards women (predominantly married); not men and young people. Outreach clinic not always run; depended on available funds for transport costs. Young people (especially unmarried and young men) rarely attended FP. No separate SRH (including STI and HIV) clinic available for young people and men. Building relationships and positive connections with people (providers/users/non-users) promoted access to services. Lack of FP awareness raising reaching young people and the community amid increasing	Although discrepancies noted in clinic records and reports, all three data sources showed similar findings: FP services and contraceptives were available at the HGH Reproductive Health Clinic and maternity ward, but not accessed by everyone: • Women-focused FP services, with only female service providers; not culturally appropriate for men and young people (especially young men) to access • Low literacy, prevalent misinformation and very limited FP awareness raising in communities/outside FP clinic, resulting in inaccurate knowledge and limited opportunity for access and acceptance of FP • Men and young people did not have separate clinic to attend for SRH and FP; men not actively involved or

Context	FP clinic services audit	FP clinical records audit	Qualitative interviews	Integration of data sources
	External supervision from FP supervisors regularly conducted, but not to review/monitor FP services. 'On-the-job training' was available if needed. Short- and long-acting reversible contraceptives (implants, injectables and oral pills) mostly available at the clinic. Clients seeking permanent contraceptives referred to Gizo Provincial Hospital. Stock-outs frequent for LARCs (injectables and implants). Stock-outs took 1–6 months to replace. The clinic was well organised with adequate examination rooms and sterile equipment available for contraceptive insertions and removals. Basic counselling job aids available, such as flip charts, posters, pelvic and penile models, but IEC materials not up to date. Referrals made only for tubal ligation and vasectomy.		misinformation, low literacy and ongoing sociocultural challenges. People need good explanations about FP presented holistically (incorporating sociocultural and economic context). Not all service providers received refresher training on FP. FP services not inclusive of everyone in the community.	considered important partners in FP • Sociocultural values and beliefs influenced access and acceptance of FP services. STI/HIV services not integrated with FP. No regular outreach services because of financial constraints. Use of LARCs preferred by women as they were promoted as reliable methods. Services for permanent methods not available; clients referred to Gizo Provincial Hospital. Fewer counselling services offered to men and young people than to women. Holistic FP services enabled when service providers happy and kind. These positive attitudes formed the basis of trusting relationships that promoted the availability, accessibility and acceptability of FP services to potential clients.

5.5 Summary Discussion

Although discrepancies such as missing, incomplete and inconsistent data entries were noted in the clinic records and reports, the FP checklist audit, clinical records review and audit and qualitative interviews revealed similar findings.

FP services and contraceptives were available at HGH at two places: the Reproductive Health Clinic once a week—mostly alongside other MCH clinics—and the maternity ward. It was also available at any time to those visiting from far away. An older version of the FP manual was used, the updated version was not available. FP service providers were all female. Most attendees were married women. Young people and men rarely accessed the FP clinic. There was higher uptake of female contraceptive methods (LARCs) than male methods (male condom and vasectomy). The location and context of how the services were delivered and the gender of service providers made it women focused.

There were no STI/HIV services provided or integrated in the FP clinic. There were fewer counselling services offered to young people and men, and less FP awareness raising reaching the community. Outreach services included FP and other SRH clinics and were an important way to reach community people who could not come to the clinic. However, these were only implemented when funds were available to meet transport costs.

Men were often not considered primary partners in the FP dialogue at the clinic. There were also no other services available for young people and men to access FP at the Reproductive Health Clinic. Young people and men were able to access SRH services including FP at the outpatient clinic when they needed it.

The theoretical availability of FP services and contraceptives did not mean that FP was necessarily accessible and acceptable to people in the community. Access was often compromised by structural or contextual barriers; lack of relevant information or misinformation; inappropriate approaches to service delivery; and sociocultural values and beliefs. It was also evident in the results that FP services and contraceptives provided through HGH were generally accepted, although not everyone was able to access the services. Young people and men would accept contraception if they

accessed the service that provided it. Most challenges to access and acceptance of FP contraceptives could be overcome by a welcoming service provider who was able to relate well with people using a non-judgmental approach. Ideally, they would provide FP education explaining contraceptives with strong regard to individual situations and in a holistic manner.

5.6 Chapter Summary

In this chapter, I have described the setting and context of Case Study Two, a peri-urban FP clinic, and how data were collected; reported data results and findings; and provided a summary of the within-case analysis. In the next chapter, I report the results for Case Study Three involving FP services in a rural setting. Figure 6.1 is the thesis structure showing Case Study Three chapter in the thesis.

Chapter 6: Case Study Three Results—Rural Setting

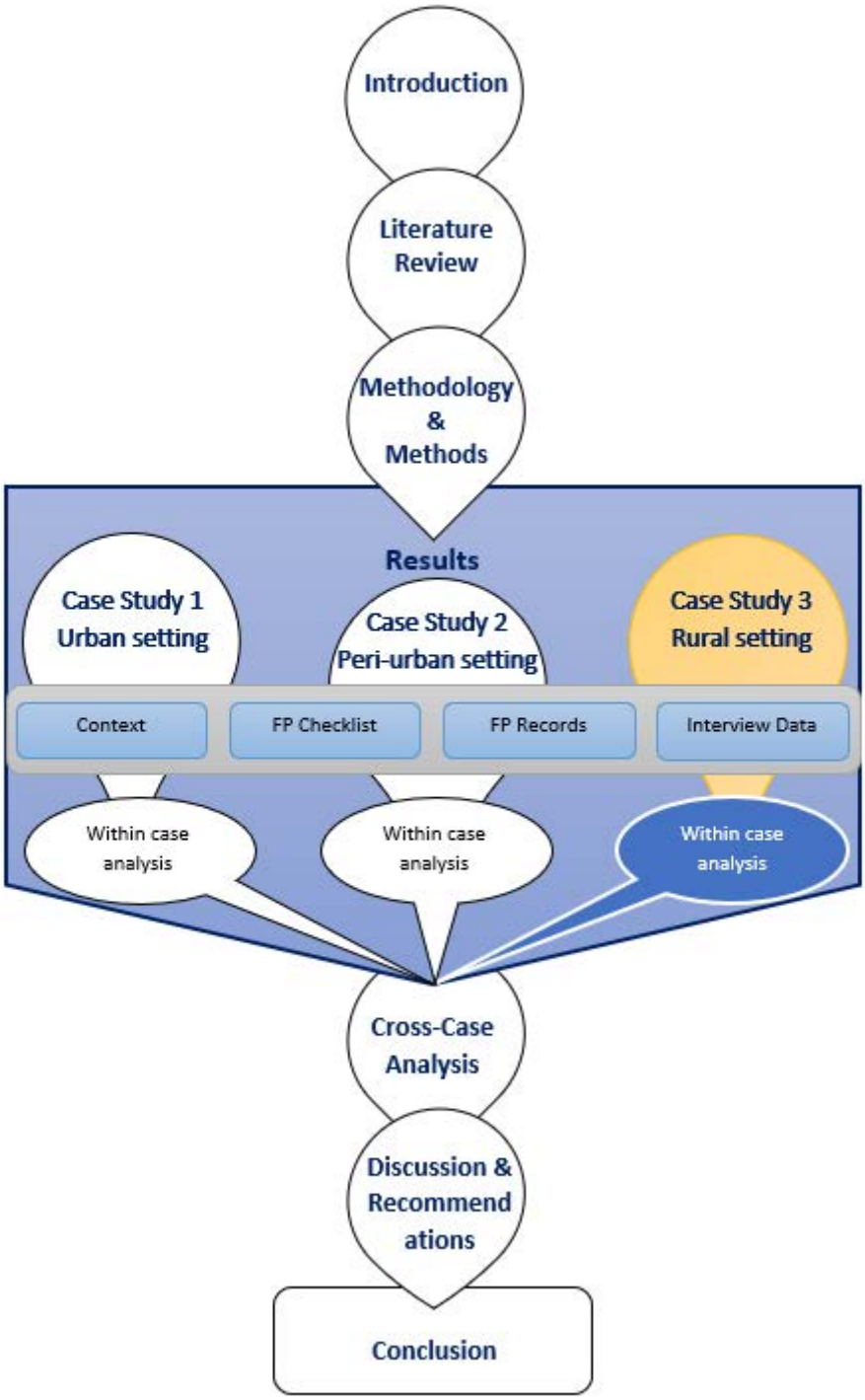

Figure 6.1. Thesis structure—Case Study Three

6.1 Chapter Outline

This chapter presents the results of Case Study Three, which represents a rural FP service facility. The chapter presents the setting and context of the clinic, data collection methods, results and within-case analysis. Figure 6.2 outlines the order of reporting the results.

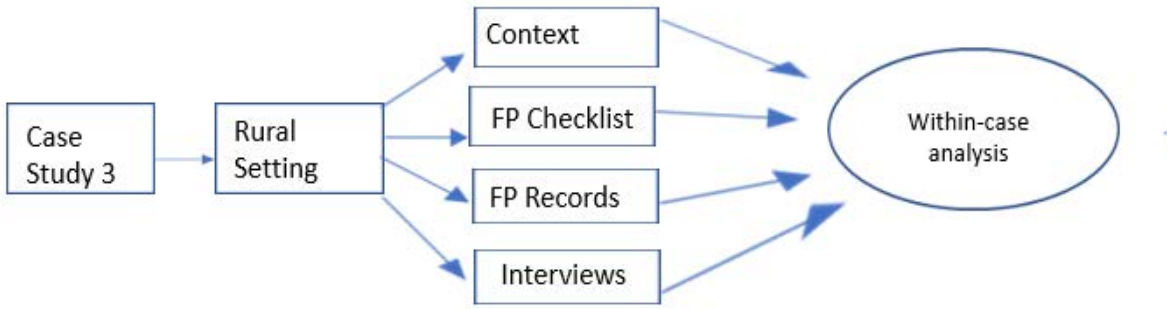

Figure 6.2. Outline of Chapter 6

6.2 Setting and Context

The third case study site is the clinic in Kia, in Isabel Province. Santa Isabel, also called Isabel (and often spelt 'Ysabel') is one of Solomon Islands' nine provinces. The first Spanish navigator to the Solomon Islands, Alvaro de Mendana de Neira, named the island Santa Isabel in 1568 after the Queen of Spain, but the island had been previously known as Mahaga (Encyclopedia Britannica, 2016). Located north-west of Guadalcanal, Isabel Province consists of Isabel Island including the smaller surrounding islands. Isabel is the longest land mass in Solomon Islands, measuring 200 km in length. The total land area is 4,136 km^2 with a population density of 6 people/km^2 (SINSO, 2009e). Kia AHC was chosen as the third case study because of its rural locality representing a rural context for this study. There were also pragmatic reasons for the choice, as the site could be accessed for data collection within the research study time frame. The health clinic at Kia was the case study site, as described later in the chapter. Figure 6.3 shows the location of Isabel Province in Solomon Islands map.

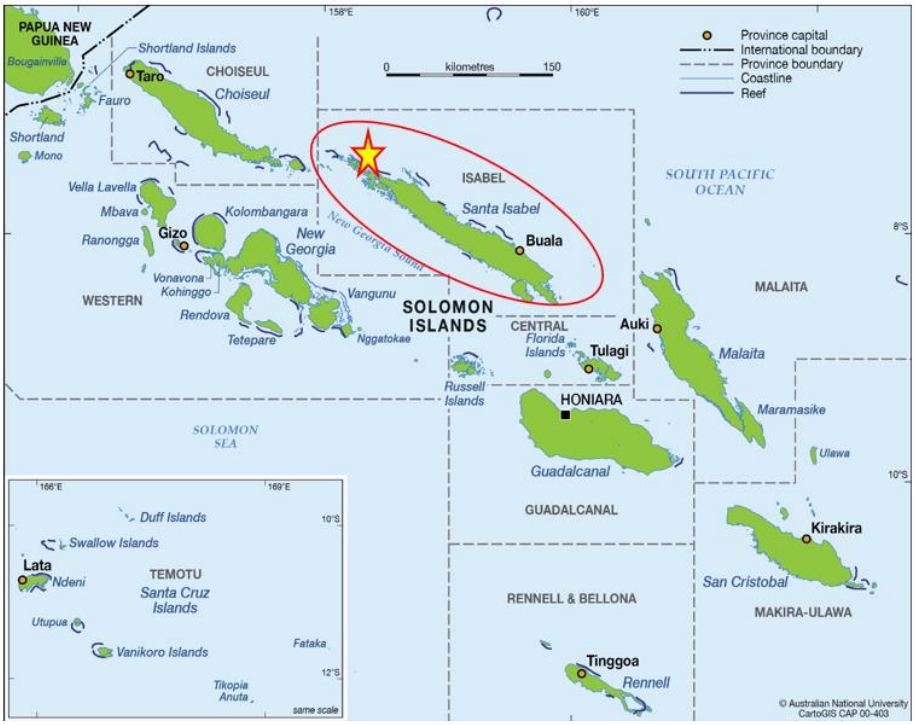

Figure 6.3. Map of Isabel Province in Solomon Islands (Source: https://www.google.com/mymaps/viewer?mid=1oEZMzspiLgFRsn_20Jy07rARZnw&hl=en_US)

6.2.1 Governance

The provincial capital is in Buala, located on the coastal south-eastern end of the island. The provincial government and commercial services are centralised in Buala, and the premier is the head of the government (Solomon Islands Government, 2018). Isabel Province differs from other provinces in relation to provincial administration and management of internal affairs through its use of a structure known as 'the Tripod'. The Tripod, established in 1984, is a unique local structure consisting of the chiefs, the church and the provincial government who are united as leaders in a governance structure (Tomlinson & McDougall, 2013). This unity stems from an existing alliance between village chiefs, the church and the provincial government in Isabel. The provincial government recognises the strong social influence of the church and chiefs as fundamental to future development of the province (G. White, 2007).

Isabel Province is divided into three constituencies: 1) Gao/Bugotu, 2) Maringe/Kokota and 3) Hograno-Kia-Havulei, whose elected members sit in the national parliament. Like other provinces,

Isabel is divided into 26 wards and each ward is represented by an elected member in the provincial government (Kii et al., 2006; Solomon Islands Government, 2018).

6.2.2 Population, Ethnic Groups and Languages

The estimated total population as of 2019 was 34,548 compared with 26,158 in 2009, showing a growth of approximately 24% over this 10-year period (SINSO, 2019). Isabel has a relatively young population. In 2009, 40% of the population were 15 years of age or younger and 54% were in the 15–59 age group (SINSO, 2009e).

Most people live in coastal villages and a few villages are located in rugged inland areas. Most people live in the south-east part of the island. Outmigration occurs to urban centres such as Buala and Honiara because of a lack of social service amenities and economic incentives in rural areas. Intermarriages, together with availability of services in the provincial headquarters has resulted in movement of people into the Buala area. This explains the larger population in the Buala area (south-east of the island) than in other parts of the island (Kii et al., 2006).

Isabel has a very homogenous population: 99% are Melanesian, and the other 1% includes Polynesians and other groups. Isabel is a matrilineal society in which traditional inheritance and land rights are passed through women and/or mothers. The people in Isabel are relaxed, friendly and peace loving. There are five distinct cultural groups and eight languages, however five languages: *Maringe, Blanga, Gao, Bugotu and Zabana* are mainly spoken in Isabel (Encyclopedia Britannica, 2021; O'Sullivan et al., 2011).

6.2.3 Education

In the 2009 census, approximately half (52%) of the eligible students in Isabel attended primary schools, 16% in secondary schools, 25% in pre-schools and less than 1% attended a tertiary or vocational institution. Around 4% of those aged 6–15 years had left school and 9% had never attended school. The literacy rate only captures basic reading and writing skills. Literacy rates for males and females aged 15–24 years were almost the same, at 89.3% and 89.2% respectively. As the literacy rate was self-reported, these figures might represent a biased report of actual literacy levels as

people who cannot read and write might be ashamed to reveal their literacy status when asked in person during the census (SINSO, 2009e).

6.2.4 Cultural Practices

6.2.4.1 Land Use and Rights

Land ownership in Isabel is characterised as either customary or alienated land. Eighty-four % of land is customary, owned by different tribes. The remaining 16% is alienated land owned by various churches, expatriates and the provincial government. The land tenure system was establised by clans (Tomlinson & McDougall, 2013).

Land is an important asset to the people of Isabel. More than 98% of the population depend on land for survival. Most live a subsistence lifestyle where they depend entirely on what they produce on the land and from the sea. Land is mostly used for subsistence farming and small-scale commercial purposes. Most people adopt shifting cultivation[6] to create gardens on steep hillsides. Today, there are numerous land disputes as a result of increasing population growth and intense commercial land use for logging and mining industries, which have become major sources of income (SINSO, 2009e).

Being predominantly matrilineal, land is inherited through the maternal line. In tribes or families, the ownership of land is passed through the eldest daughter. Male children inherit the right to use land through their mother, not their father; and a husband cannot inherit land from his wife. Regardless of ownership rights, women are still considered responsible for the whole tribe on any issue of land use (Kii et al., 2006; G. White, 2007).

Children in Isabel are taught about their geneological attachments as well as their daily household chores when growing up. Women undertake domestic tasks such as cooking and caring for

[6] A form of traditional gardening where an area of vegetation is cleared and cultivated and then left to naturally restore its soil fertility while a new area is again cleared for gardening.

their home as well as planting and weeding gardens. Boys and men normally perform hard physical tasks like canoe making, fishing and building houses (Tomlinson & McDougall, 2013).

6.2.4.2 Chiefly System

The chiefly system is still practised in Isabel. A chief is a person who has good leadership qualities or is chosen from a chiefly family. Today, as a result of the local community's strong affiliation with the Church of Melanesia, Anglican priests or catechists can also take on the duties of a village chief (Tomlinson & McDougall, 2013). Priests and catechists are seen as leaders in their spiritual endeavours and therefore are viewed as appropriate village leaders (David, 2009; SINSO, 2009e).

6.2.5 Provincial Services

Service provision in the province is insufficient to meet the needs of the people. Most services are provided by the national government through the provincial government; others through churches, NGOs, private companies and other small business sectors. Like other provinces in Solomon Islands, Isabel is totally dependent on the national government for grants to fund services in the education and health sectors. However, these are not enough to cater for the running costs of vocational schools; hence the Church of Melanesia is commited to supporting church schools including vocational training in the province. The provision of services such as health, education and support services remains channelled through the national government (Solomon Islands Government, 2018; SINSO, 2009e, 2017).

6.2.5.1 Economic Activities

The provincial economy is predominantly subsistence agriculture and occasional cash crops such as copra and unsustainable logging activities. Most people live subsistence lifestyles such as traditional gardening and fishing for domestic purposes, with subsistence duties unpaid. The two main components of the formal economic sector in Isabel are small-holder agriculture and plantations. Copra was the primary source of income for the people before the emergence of the current patterns of exploitation of the rainforest and nickel mining (SINSO, 2009e).

6.2.5.2 Transport

Most of the main Isabel Island is rugged mountains with natural rainforest. There is minimal infrastructure such as roads. People mainly walk in foot tracks to reach the interior part of the island. Most villages are on the coast and people rely on boats for transport. Two airports, in Buala and Suavanao, service the island with daily flights and a number of seaports service the island on weekly and fortnightly shipping schedules (O'Sullivan et al., 2011; SINSO, 2009e).

6.2.6 Religion Including Delivery of Education, Health and Community Services

The Church of Melanesia (Anglican Church) is the dominant denomination in Isabel, with 89% of the population as members, followed by the Roman Catholic Church (5%). All other denominations including the South Seas Evangelical Church, the Seventh Day Adventists, Uniting Church and the Christian Fellowship Church include less of the population as members (SINSO, 2009e).

In addition to church duties, churches in Isabel provided primary, secondary and vocational (Rural Training Centres) education services. The Church of Melanesia is perceived as playing a vital role in maintaining morality and encouraging religious advancement in most communities. Churches are seen as major peace builders. In most communities the people help finance construction of church buildings (Kii et al., 2006; SINSO, 2009e).

Churches in Isabel are actively involved in community development along with the critical role of provision of educational and medical services. Most church-run schools are operated by the Church of Melanesia. The Melanesian Brothers and the Mothers' Union of the Anglican Church, including the women's and men's groups in other churches, play important social and spiritual roles in the communities (G. White, 2013).

6.2.7 Provincial Health Services

Isabel Provincial Health currently consists of one hospital (Buala), five AHCs, 17 RHCs and 14 NAPs. Two dispensaries and two clinics are currently closed. The hospital, located in Buala, has 49 beds as well as a pharmacy, small pathology laboratory, an X-ray machine and division units such as health education, environmental health and reproductive health units. The reproductive health unit

also called RMNCAH oversees all MCH clinic activities including FP programmes at all clinics within the province (H. Marau, personal communication, 5 August 2021). Figure 6.4 shows a map of Isabel Island.

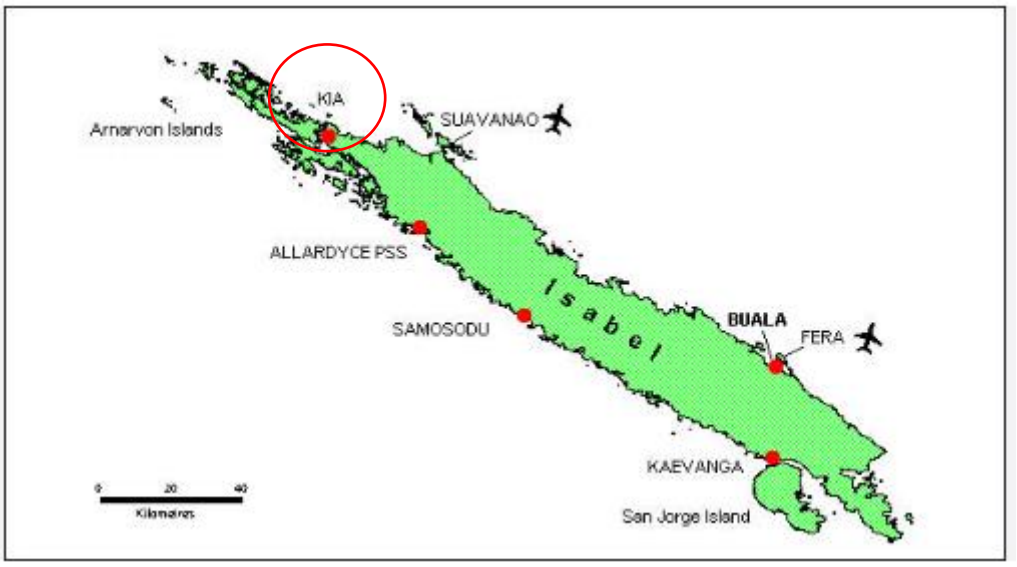

Figure 6.4. Map of Isabel Province (Source: http://www.commerce.gov.sb)

Health services on the island are divided into five main zones with their own designated catchment population areas headed by AHC staff working with health staff at the RHCs and NAPs. The five zones are Buala, Tatamba, Konide, Bolotei and Kia. Figure 6.5 shows the zone divisions for catchment areas and population in Isabel Province.

Zone 1 – Buala Hospital (population: 10,771)
Zone 2 – Tataba AHC (population: 9,634)
Zone 3 – Konide AHC (population: 5,560)
Zone 4 – Bolotei AHC (population: 3,697
Zone 5 – Kia AHC (population: 4,886)

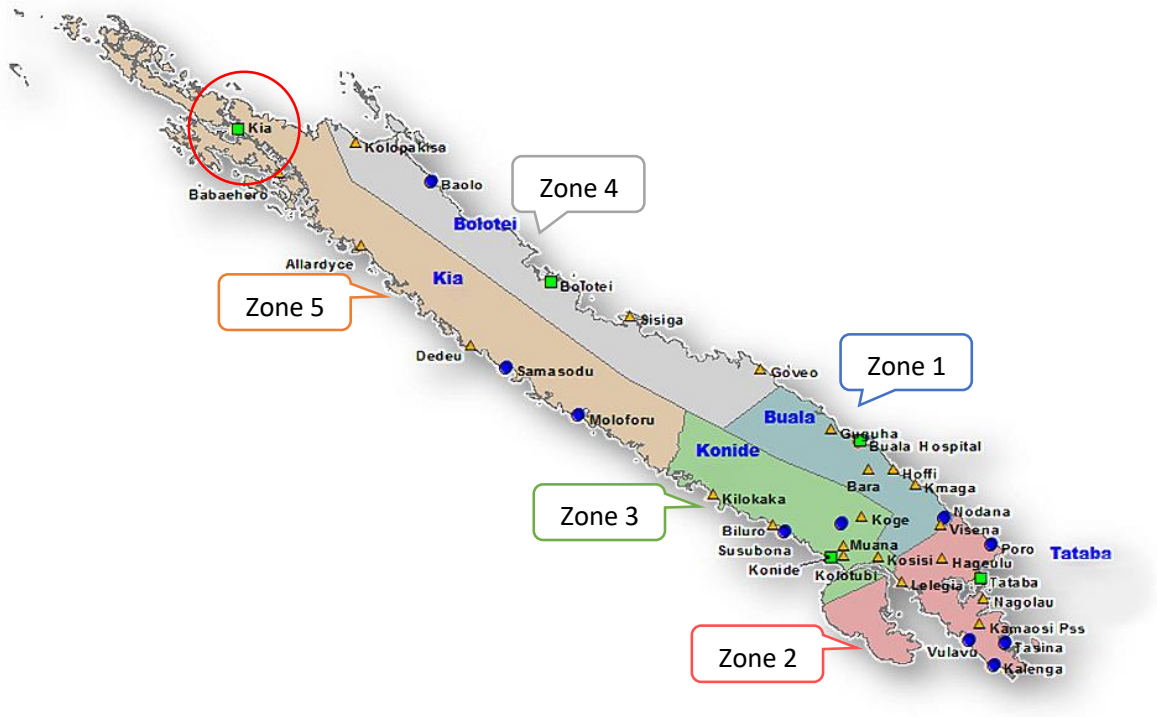

Figure 6.5. Zones and population distribution in Isabel Province (Source: Buala Provincial Health)

6.2.7.1 Kia Area Health Clinic Description

Kia AHC is one of the five AHCs in Isabel and is located at the most northerly part of the island. It is responsible for two RHCs and three NAPs in its zone. The RHCs and NAPs also have designated catchment areas to which they provide services within the zone (refer to Table 1.1 in Chapter 1 for a description of AHCs, RHCs and NAPs). Figure 6.6 shows a photograph of Kia AHC.

Figure 6.6. Kia AHC (Photo credit: Allan Rolland, February 2021)

The clinic services include both inpatient (8 beds including birthing bed) and outpatient services, with main services provided as:

- general outpatient clinics and emergency services
- child welfare clinics
- communicable disease/NCD clinics
- postnatal and FP clinics
- antenatal care clinics
- outreach clinics

- inpatient services, including births and very sick people needing monitoring and regular treatment (often or before referrals to the provincial hospital).

Table 6.1 outlines the expected daily clinic services provided by the Kia AHC

Table 6.1. Kia AHC Daily Programme

Day	Morning 8 am–12 pm	Lunch hour	Afternoon 1–4 pm
Monday	Outpatient clinic	12–1 pm	Outpatient clinic
Tuesday	Child welfare		Child welfare
Wednesday	NCD clinic		NCD clinic
Thursday	Postnatal and FP clinic		Antenatal clinic
Friday	Outpatient and outreach clinic		Outpatient and outreach clinic
Saturday Sunday	Clinic closed but available only for Emergencies, births and continuing injections only		Clinic closed but available only for Emergencies, births and continuing injections only

(Source: Kia Clinic)

6.3 Data Collection and Results

As with other case studies, four types of data were used to provide quantitative and qualitative understanding about FP service provision at Kia AHC, representing a rural setting. With Case Study Three, data collection differed sligthly from that in Case Study One and Two because of COVID-

related restrictions and bad travel weather; therefore, data collection proceeded in the following order as described in Chapter 3:

1. Context
2. Qualitative interviews
3. Audit of FP clinic services
4. Review and audit of FP clinical records.

However, I describe each method and present the results and findings in the same order as the other cases for consistency: 1) the context, 2) audit of FP clinic services, 3) review and audit of clinical records, and 4) qualitative interviews.

6.3.1 Context Data

6.3.1.1 Preparation

Data collection for Case Study Three was conducted by research assistant Allan Rolland, who was already living in Solomon Islands, as I had to activate my contingency plan as a response to international COVID-19 travel restrictions in 2020 and 2021.

After deciding to include Isabel Province, I wrote a letter to Buala Provincial Health Administration requesting their support and informing them of my plan to include Kia AHC in my research study. Buala accepted my request and provided me with a letter of support (Appendix 4). As Case Study Three was not included in my initial ethics application, I submitted the first amendment for the ethics application to the SIHRERB to include Case Study Three (Appendix 6) and planned to collect data in August 2020.

Given the sensitivity of my topic and that I have never been to Isabel Province I realised that I would need someone to accompany me to the study site. I would require an assistant who is familiar with the place, culture and language and with basic knowledge about research, to interview male participants and perform as a cultural broker and translator if needed. I also initially planned to involve a female assistant from Isabel who was a newly graduated registered nurse for the field trip. However, the COVID-19 outbreak forced me to revert to my contingency plan, to train someone

currently living in the country to collect the data. On that basis I submitted my second amendment of the ethics application to include only Allan as the female assistant is not available.

6.3.1.2 Recruiting the Research Assistant

Allan agreed to assist me in collecting research data from Isabel. He was recruited to the role based on the following characteristics:

- He is a male registered nurse for 10 years and willing to travel (not engaged in formal employment at the time of data collection).
- He had orginated partly from the Kia community and knew the place, language and the people.
- He had participated in community-based research capacity building activities and previously assisted in collecting data.
- He had just (less than two years previously) graduated with a Bachelor of Nursing degree, which had a research component so he had basic knowledge about research methodology and understood basic research terminology such as quantitative data, qualitative data, interview questions, consent form and confidentiality.

For these reasons, I was confident he would be able to collect quality data for my study.

We then planned that in situations where girls or women were not willing or comfortable talking to the male research assistant about FP, he could train a female nurse at the clinic or a trusted woman in the community in interview techniques so they could conduct the interviews. However, this was not necessary because Allan was a nurse and the community trusted him; thus, female participants were comfortable and happy to be interviewed. During the interview, most women and girls were open to talking about FP and no concerns arose, so Allan conducted all the interviews by himself.

6.3.1.3 Training the Research Assistant

While waiting for the approval of amendments to the research ethics application, I trained Allan in the process of data collection: how to use the checklist to audit services; what to examine and extract from records and reports from the clinic; and how to conduct interviews, including qualitative

interview techniques. Before explaining what, he needed to do, I gave him the opportunity to ask me about the field trip and if he had any concerns. I contacted Buala Provincial Hospital to inform them that I was not able to travel to collect data and that a research assistant would undertake the data collection and visit them during the field trip.

The training occurred via four Zoom meetings from October to December 2020, with follow-up meetings via Facebook Messenger to clarify issues and questions. I emailed him the research protocol to provide the broader picture of the research for his background knowledge. This included the checklist tool, semi-structured interview guide, information sheets and consent forms. I also sent him the research ethics certificate to present to the Isabel provincial health director and the RMNCAH manager so they could correctly identify him when he visited. To ensure consistency in his data collection, I provided him with a step-by-step written script of activities (Appendix 8) to guide him during the process. I used my university research funds to pay for his travelling expenses, per diems and small 'thank you' gifts such as soaps to give to interview participants as a token of appreciation. I received approval for both amendments to my ethics application in May 2020 and we planned that data collection would begin between December 2020 and January 2021.

6.3.1.4 Field Trip and Recruiting Participants

Allan travelled by ship to Buala in the first week of December 2020, paid courtesy visit to the provincial health director and RMNCAH manager and interviewed current and former FP managers at Buala Provincial Hospital. He spent a week in Buala. The RMNCAH manager contacted Kia AHC and informed them of Allan's visit in the following week. However, because of bad weather, Allan returned to Honiara from Buala to catch the next boat to Kia. He was delayed a further two weeks and arrived in Kia near the end of December 2020. By the time he arrived in Kia, the nurse had already left for annual leave and the clinic was closed, so he could not start with FP clinic services and clinical record audits as planned.

In Kia, bad weather had disconnected telecommunication lines from Allan's village so he could not contact me to provide an update on his plans. In mid-January 2021, he informed me he had not started collecting data from the clinic and asked if he could start the interviews and recruit

participants from the community while waiting for the nurse to return. I agreed and instructed him to ensure he correctly identified participants; and whether they were users or non-users of FP living in the Kia catchment area and not visitors; and, further, to be sensitive of where clients wanted to be interviewed for privacy reasons. At this stage we discussed where he would recruit participants for the interview, as Kia AHC's catchment area included settlements in the Kia islands outside the main Kia village that accessed Kia AHC services. Given that Allan lived in one of the island settlements, we agreed that he would recruit half the participants from village settlements in the Kia islands to represent those who lived farther from the clinic and half from the main Kia village, representing those who lived closer to the clinic. This way, the qualitative data would be more representative of the population in the Kia catchment area. This was why the field data collection began with qualitative interviews with service users, non-users and service providers, followed by the audit of FP clinic services and clinic records.

6.3.2 Audit of Family Planning Clinic Services

Reflecting on how I had used the checklist tool for Case Study One and Two, I revised the checklist form (Appendix 9) to include a column for comments. Learning from my first field trip experience, I was able to provide specific instructions and examples to Allan about the use of the tool. To help me verify responses to the checklist questions, I asked him to obtain consent from the service provider to audio-record their conversation during the audit process. This consent was granted, and he obtained a recording of the audit when he talked to the charge nurse. The main responses to the checklist questions were also documented on the form. The checklist was sent to me, and I analysed and organised the results into Table 6.2 under the seven headings as described in Chapter 3. Table 6.2 outlines the FP clinic audit results and a summary is provided after the table.

Table 6.2

Audit of Kia AHC FP Service

Checklist item	Results	Assessment narrative
1. Services		
1.1 Contraceptives		
Fertility awareness counselling	Not routinely provided	Depended on the nurse's knowledge about fertility and confidence to discuss this topic with the woman and/or couple. If the service was delivered, it was usually provided during weekly antenatal or FP clinics.
Natural methods counselling (ovulation/mucus, calendar, symptothermal methods)	Not routinely provided	If information was provided it was given during weekly child welfare and antenatal clinics. Depended on the nurse's knowledge of natural methods, and the woman's ability to understand (education level).
Male condoms	Available at the FP clinic and provided	Mainly used for STI prevention when needed, not for FP purposes. Users could go and ask the nurse if they wanted condoms.
Female condoms	Available at the clinic	Although they were available, women never used (or asked for) female condoms.
Lactation amenorrhoea method (LAM) counselling	Usually provided when needed	Often provided to postnatal women when requested.
OCPs (POP, COC)	Available at the clinic and provided	Accessed on a weekly basis at the FP clinic.
Emergency contraceptive pills (Prostino)	Available	No records of their use at the FP clinic.
Injectable contraceptives (eg Depo Provera)	Available and provided at the FP clinic	Accessed on a weekly basis at the FP clinic.
IUCDs	Not provided at the FP clinic	No trained provider for this procedure at the clinic. Women were referred to the hospital for IUCD insertion or this service was provided by trained provincial health nurses during supervisory visits.
IUCD removal	Same as IUCD insertion	Same as for IUCD insertion.

Checklist item	Results	Assessment narrative
Jadelle implant insertion	Available and provided at the FP clinic	There were trained staff to provide this service.
Jadelle implant removal	Available and provided at the FP clinic	There were trained staff to provide this service.
Female sterilisation (tubal ligation)	This service was not provided at the clinic	Women were referred to the hospital for surgery. Procedure only performed by trained medical doctors.
Male sterilisation (vasectomy)	This service was not provided at the clinic	Men were referred to the hospital for surgery. Procedure only performed by trained medical doctors and healthcare staff.
1.2 STI screening (syndromic or clinical)	Service provided on syndromic diagnosis and treatment provided and contact tracing	There were no laboratory services to confirm STI infections at the clinic.
1.3 Male-friendly services (promote male involvement in FP)	Available and provided at the FP clinic	However, no documentation of services was provided.
1.4 FP guideline or protocol		
Has guideline or checklist for FP service	Yes, the Solomon Islands FP Manual, 2005 edition was available and used	Updated protocols that were not included in the 2005 edition were usually provided during refresher courses.
Recent version of FP guideline	Not available	No recent version available; the 2005 edition was used.
1.5 FP services to STI/HIV clients. (Are FP services to STI/HIV clients captured at this clinic?)	No, these data were not captured at the FP clinic	STI/HIV services were separate from FP services and were being captured at the outpatient services.
1.6 FP data (Does FP data capture clients by methods?)	Yes, contraceptive/FP methods were captured and recorded against demographic data	
1.7 STI/HIV service clients		
In the last 6 months, have clients left before receiving services because the wait time was too long?	Yes, clients did leave before being seen	This service was not clearly documented in the FP clinic. It was more common for this service to be offered at the outpatient clinic.

Checklist item	Results	Assessment narrative
Outreach services (satellite clinics)	Outreach services included FP and all clinic services	Usually offered weekly to villages far from the clinic, but outreach trips depended on availability of funds to buy petrol; could be monthly or 6-monthly.
2. Counselling		
2.1 Routinely assess clients need for FP services based on their clinical history and reproductive intentions	Yes, most of the time (weekly but not daily)	During FP clinic visits.
2.2 Routinely screen clients to determine what FP services are appropriate (reproductive goals, infertility issues, FP knowledge, living family situation, any FP-related concerns)	Yes, most of the time (weekly but not daily)	During FP clinic visits.
2.3 Provide FP counselling? (number of children, intentions of next pregnancies, attitudes about FP, risks of STI's/HIV)	Yes, most of the time (weekly but not daily)	During FP clinic visits.
2.4 FP counselling includes correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy (dual method—barrier against STIs and protection for unintended pregnancy)	Yes, most of the time (weekly but not daily)	At the FP clinic male condoms were mostly given to women whose husbands used condoms. Other times the men themselves went to collect condoms, but mainly for STI prevention.
2.5 Provide safe pregnancy counselling for young women and young men and for women who are currently pregnant or wish to become pregnant	Yes, most of the time (weekly but not daily)	Reported to be provided but not clearly documented in the FP records.
2.6 FP counselling for young girls and boys including future preparation for planning their families	Yes, most of the time (weekly but not daily)	Mostly to young girls rather than boys who visited the clinic.
2.7 Provide and promote male involvement in FP	Yes, most of the time (weekly but not daily)	Sometimes this service was provided outside FP clinic hours.

Checklist item	Results	Assessment narrative
2.8 Provide and promote couples counselling	Yes, most of the time (weekly but not daily)	Provided when providers saw a need to talk to the couple; e.g for a high-risk pregnancy[7] or poor health of the mother.
2.9 Does this clinic provide counselling services for single mothers and elderly women? (e.g. preventing future unintended pregnancies and menopausal issues)	Yes, most of the time (weekly but not daily)	Provided when clients visited the FP clinic to seek the service.
3. Staffing and training		
3.1 Clinic staff	2 registered nurses, 1 nurse aide	Three service providers were available at the clinic to provide all clinic services including FP.
3.2 Training		
Training on FP	All clinic staff were trained	Although registered nurses received more advanced training in FP than nurse aides.
Training on youth and adolescent-friendly services	1 registered nurse was trained	Nurse manager only.
Training on the provision of key population or high-risk population friendly services (adolescence, single mothers, men)	1 registered nurse	Nurse manager only.
Training on the provision and removal of IUCDs	No one trained to provide this service on site	Service sometimes provided by provincial health nurses on supervisory tours.
Training on the provision and removal of Jadelle implants	Yes, 2 registered nurses were trained	

[7] A high-risk pregnancy is a pregnancy that has high chances to lead to life-threatening complications either on the pregnant mother/person and the unborn baby or both.

Checklist item	Results	Assessment narrative
Training on SRH and FP services; e.g. midwifery, FP, RH, MIRH	All clinic staff received training during their pre-service training	Training was usually provided as refresher courses annually or when updated FP protocols or new contraceptives were introduced in the country. However, not all registered nurses were trained in provision of IUCDs.
In the past 6 months, have clients been turned away or asked to return on a different day because there were not enough trained staff available to provide the method requested?	Yes	Usually when contraceptives sought were not available at the time of visit or when clients requested IUCDs and they had to return at a date when a provincial nurse was visiting the clinic.
Do you think the clinic has enough staff trained in FP services to respond to current demand for FP services?	No	Not all staff were trained for certain services such as IUCDs and implants. Strain was usually experienced during outreach clinics when the demand for other clinic services compromised the provider's time to provide FP; in most cases only one nurse went out to provide outreach services.
4. Supervision		
Do staff that provide FP services receive outside supervision to monitor their performance?	Yes, from provincial reproductive health/FP managers,	However, these supervision visits were not only to monitor FP, but for other clinic services as well.
Do supervisory visits that includes review of FP services happen at least 4 times per year?	No, only once a year	These visits were always integrated with other programmes such as cervical screening, immunisation and NCD follow up; never for FP only.
Is feedback provided to FP service providers after supervision is conducted?	Yes	Mostly verbally.
Is there a mechanism for documenting supervision visits?	Yes, had visits recorded in a book	
When gaps are found during supervision, is a plan developed to address gaps that includes the following information?	Yes, planning done to address the gap	
Actions identified to address gaps		

Checklist item	Results	Assessment narrative
Person assigned to complete actions	No	No person assigned to carry out plan.
Due date for completion of actions	No	No person to do it so it was not done.
Is additional FP training available to service providers if needed? (this includes on-the-job training, extra support, on-site mentorship, off-site training etc)	Yes, mostly on-the-job training, provided as refresher courses	Extra support and mentorship was often provided off site.
5. Drugs and supplies		
5.1 Of the contraceptive methods provided at this facility, which are available today?		
Male condoms	Available	
Female condoms	Available	
POPs	Available	
COCs	Available	
Emergency contraception (Prostino)	Not available	
Injectable contraceptives (Depo Provera)	Available	
IUCDs (Copper T)	Not available	
Jadelle implants	Available	
Natural cycle (ovulation chart, cycle beads)	Available on counselling	Women who used natural methods were not registered for attendance at the FP clinic.
5.2 Of the contraceptive methods provided at this facility, which have experienced stock-out?		
Male condoms	Yes	
Female condoms	No	
POPs	No	
COCs	No	

Checklist item	Results	Assessment narrative
Emergency contraception (Prostino)	Not provided	
Injectable contraceptives (Depo Provera)	Yes	
IUCDs (Copper T)	Not provided	
Jadelle implants	Yes	
Natural cycle (ovulation chart, cycle beads)	Not recorded as a contraceptive method at the clinic	
5.3 Of the following services offered at this clinic, which have been available at all times in the last 3 months? This means that adequate supplies, equipment and trained staff have always been available.		
Female sterilisation (tubal ligation)	Not offered	Referred to NRH or Buala Provincial Hospital.
Male sterilisation (vasectomy)	Not offered	Referred to NRH or Buala Provincial Hospital.
Jadelle implant insertion	Available	
Jadelle implant removal	Available	
IUCD insertion	Not offered at the clinic	Available on provincial health supervisory visits to clinic.
IUCD removal	Not offered at the clinic	Available on provincial health supervisory visits to clinic.
Urine test for pregnancy	Available	
5.4 Does the facility have pregnancy tests onsite?	Yes	Rapid tests for pregnancy.
5.5 Does this clinic have a supply management system that is used to track FP commodities? This can include stock cards, monthly summaries etc	Yes	Done monthly using FP stock cards.
5.6 Have the staff providing FP at this clinic received training on how to track FP commodities?	Yes	
5.7 In the last year, when have you experienced a shortage of stock of one or more contraceptives,	3 months ago	Often because of shipment delay or if stock orders were not submitted on time.

Checklist item	Results	Assessment narrative
what is the longest time it has taken to replace them?	1–6 months	
6. Clinic infrastructure and resources		
6.1. Go to the room where FP clients are examined. Are the following true of the exam room?		
Has designated seating areas for the client and the provider	No	FP clients used the same seats as the outpatient clinic.
Is lit well	No	The room had poor lighting.
Has examination bed	No	Used either antenatal or delivery (birthing) beds.
Provides visual privacy for individual client encounters	No	No, private rooms for client encounters.
Has a sound barrier for privacy (the room should be completely enclosed)	No	No room available.
Has a hand-washing station	No	No sink.
Has soap for washing	No	No soap nor antibacterial handwash.
Has a receptacle for waste disposal	Yes	Used outpatient receptacle.
Has clinical equipment for vaginal exams including vaginal speculums	No	Done in antental clinic room if required.
Has equipment for IUCD insertion	No	Not available.
Has equipment (sterile) for IUCD removal	No	Not available.
Has equipment (sterile) for Jadelle implant insertion	Yes, available	Equipment brought from Buala Provincial Hospital or sterilised at the clinic using a pressure cooker.
Has equipment (sterile) for implant removal	Yes, available	Equipment brought from Buala Provincial Hospital or sterilised at the clinic using a pressure cooker.
6.2 Go to the room where FP counselling takes place. Are the following job aids available?		

Checklist item	Results	Assessment narrative
Samples of available FP methods/FP demonstration tray	Yes,	But not all equipment available.
FP choices chart or poster	No	They used to have them but they have gone missing.
FP screening checklist	Yes	In the Solomon Islands FP Manual.
Penile model	Not available	
Pelvic model	Not available	
6.3. Go to the room where FP clients wait to be seen. Are the following true of the waiting area?		
Seating is available for clients	Yes	In the same waiting area as the outpatient clinic.
The area is shaded or covered by a roof	Yes	Inside the clinic building.
6.4. What types of FP IEC materials are available for clients?		
Posters	Yes	
Flip charts	Yes	
Brochure/pamphlet/information sheet for clients to keep (at least 10)	Yes	Fewer than 10 brochures, but not regularly distributed to all clients who visited the clinic.
Videos and CDs	No	They used to have them in the past but no longer.
6.5. Are the IEC materials comprehensible by those who cannot read or translated into local languages	Yes	May not be for all people; some in Solomon Islands Pijin and English.
6.6. Are permanent signs displayed on the street or on the exterior indicating that FP services are available at this clinic?	Yes	Available on the clinic notice board.
6.7. Does the clinic have a space for appropriately storing contraceptives away from water, heat and direct sunlight?	Yes	In a room designated as a pharmacy at the clinic.
7. Referrals		

Checklist item	Results	Assessment narrative
Does this clinic provide referrals for FP services?	Yes	
Does this clinic maintain a directory of referral sites?	Yes	Usually two referral sites: Buala Provincial Hospital and the NRH in Honiara
Is the directory easily retrievable and accessible to all staff making referrals?	Yes	There were no sites other than Buala and Honiara.
Is the directory regularly updated? For example, if something were to change at a clinic, would the directory be updated to reflect that change?	Yes	
What method is used to refer clients?	Handwritten referral letters	Clients are sent to Buala or Honiara by ship.
In the last 3 months, has this clinic ever run out of referral forms?	No	Not many clients were referred for FP.
7.1 What information is provided to the client in the referral?		
Location of site	Yes	The client was told where to go and the location was provided in the written referral letter.
Hours that the services are available	No	The clinic nurse may not know how long and when the service would be available at the hospital.
Expected fees	No fees required for the service	The government usually paid for referral services from remote clinics to the provincial and referral hospitals. However, if funds were not available at the clinic, the clients usually paid for their own transport.
Contact person	Yes	This was usually the nurse at the referral clinic in Honiara or Buala who would be receiving the client. The client was often instructed where to go and present the referral letter.
Instructions for reaching site	Yes	
7.2 In your opinion, are the facilities to which you refer clients for FP services easily accessible to all clients? For a service to be readily accessible,	No	Not everyone could afford the cost of living (food) while on referral, especially to Honiara; and the support person

Checklist item	Results	Assessment narrative
transport to the facility should be readily available and affordable, and services should be provided at reasonable price for all clients		accompanying the referred client may need to pay for their own transport.
7.3 Is there a system in place to track whether a client has completed a referral?	Yes	Usually tracked via phone calls, but no clear system of communication from hospital to clinic for non-emergency referrals.
If a referral is not complete, is an attempt made to contact the client?	Yes	Contact made by mobile phone calls to clients.
Is the status of tracked referrals recorded? Each referral should be recorded as complete or not complete. Select NA if there is no system in place to track referrals	Yes	Recorded in the FP record book but not consistently done. Referral records not examined during the audit.
What percentage of tracked referrals are tracked? Verify referral records for at least 10 referrals, skip recent referrals if not tracked. Select NA if there is no system in place to track referrals	Estimated less than 25%	Follow up not consistent because of communication issues from the referral sites back to the clinic.
What percentage of tracked referrals are completed?	Estimated 50%	Although estimated as 50%, in most cases referrals are not often tracked.

6.3.2.1 Checklist Audit Summary

6.3.2.1.1 Services

FP services and contraceptives were available at Kia AHC once a week, integrated with the postnatal clinic and opportunistically to those who lived far away. STI treatment was provided at the outpatient clinic; however, HIV services were not available at Kia AHC. An older version of the FP manual was used; the updated version was not available. Outreach services included FP and all clinic services. Outreach trips were only implemented if funds were available, so were not regular as planned.

6.3.2.1.2 Counselling

Counselling was provided largely to women who attended the FP clinic. Some men and young people also received counselling. Counselling was mainly provided for contraceptive methods and rarely encompassed socioeconomic issues.

6.3.2.1.3 Staffing and Training

Two registered nurses and a nurse aide (two female and one male) staffed the Kia AHC. The three staff provided all clinic services including FP at Kia. Although all were trained to provide FP, only the registered nurses were trained to provide contraceptives that required more technical skills, such as insertion and removal of implants and IUCDs. Only one was trained to provide services to manage the young and adolescents.

6.3.2.1.4 Supervision

Supervisory visits were regular at Kia AHC, but visits to review FP services were not happening regularly. In most cases these visits included provision of general clinic services, such as NCDs, cervical screening, antental and child health services. Therefore, it was challenging for staff to identify and understand what the gaps were in FP and how they could be addressed.

6.3.2.1.5 Drugs and Supplies

The common contraceptives available were implants, injectables, OCPs and male condoms. These contraceptives were often out of stock. The time taken to replace stock was between one and six months. Male condoms, although available, were not used for dual protection against HIV and

other STIs, and unintended pregnancy. Male condoms were also reported to be used to make fishing lures and their dispensing was not properly recorded. Female condoms were always available but were never requested by clients.

6.3.2.1.6 Clinic Infrastructure and Resources

No separate room or area was available for the FP clinic. The main outpatient space was used to conduct the FP clinic on a FP day. Sterile equipment and insertion trays were supplied by Buala Provincial Hospital, although sterilisation could also be done at the clinic using a pressure cooker. There was no hand-washing station. IEC materials were scarce, outdated and in English, which was not relevant for all audiences.

6.3.2.1.7 Referrals

Kia AHC provided referrals for insertion and removal of IUCDs, tubal ligation and vasectomy. The most common referrals were for women who requested tubal ligations. Often women were referred at the end of their pregnancy. Referral procedures were clear with the government paying for referral services from Kia AHC to either the provincial hospital in Buala or NRH in Honiara. However, a lack of available funds at the clinic often meant that referred clients had to meet the cost of travel, as did their family members. Adequate tracking and follow up of referred FP clients was poorly done because of communication issues and could be referrals for contraception are non-urgent and most women would be referred during pregnancy, especially for tubal ligations.

6.3.3 Review and Audit of Family Planning Clinical Records

The clinic records audit at Kia examined FP records between 2015 and 2019. Monthly reports were not available at the clinic; copies were all sent to Buala. Having undertaken audits of clinic records for Case Study One and Two, I realised that not all records about contraceptives are kept in the FP clinic records; other services such as outpatient and outreach clinics also keep separate records of adolescent attendance for FP, teenage pregnancies and school visits. Realising this, I advised Allan to also examine other records that may contain information about FP consultations in addition to the weekly FP services. Images of all available clinic records pertaining to FP were captured and sent to me as documents and I compiled and analysed the data using basic descriptive statistics.

6.3.3.1 Kia Areah Health Clinic Records Audit

The relevant documents reviewed at Kia AHC included the FP clinic register and records of STI from the outpatient clinic. I contacted Buala Provincial Hospital to request access to the monthly reports but by the time of writing had not received a response from them. The following results report FP clinic attendance for all years (2015–19) by method, age group and marital status. Attendance for condoms and STIs were included to show access to SRH services in a rural setting and were extracted from the outpatient records from 2019 and 2020 as these were the only available records at the time of audit. Overall, records were limited, inconsistent and missing considerable data/information. There was minimal explanation provided as to why information was missing from the record books.

Important to note that data were not available for all months. Figure 6.7 shows the trend in occasions of service at the FP clinic for some months in the years where data were available. The records showed an average of 20 occasions of service per year. The increase in FP attendances after 2016 coincides with the introduction and availability of implants in Solomon Islands.

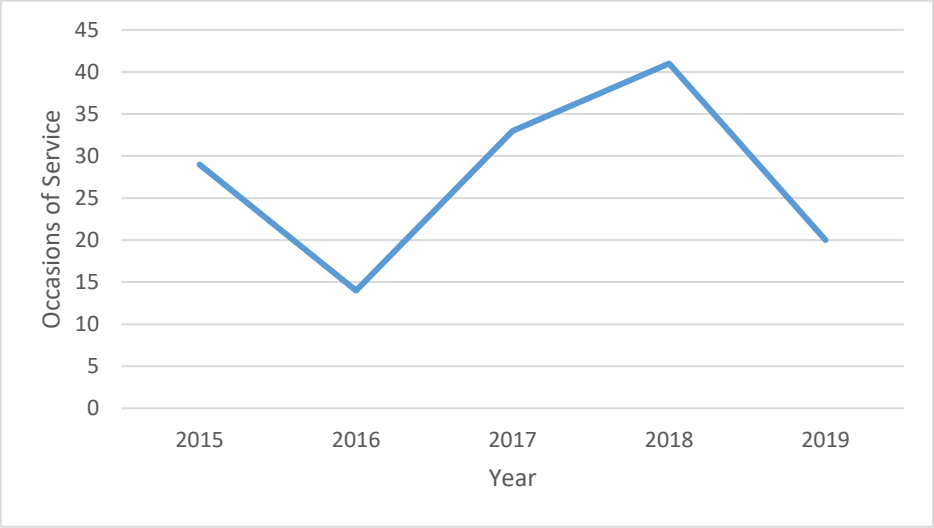

Figure 6.7. Kia FP clinic occasions of service 2015–19, some months only

Figure 6.8 shows occasions of service by method. Most women attending the Kia AHC preferred using LARCs. The IUCD became less popular when the Jadelle implant became available. The majority of IUCD users changed to using implants as they were more accessible and feasible and could be inserted at the clinic or during outreach. There were no attendances recorded for condoms, although it was understood that some married women did collect male condoms from the FP clinic for

their husbands, and some men and boys accessed condoms from the outpatient clinic. The outpatient STI records showed that male condoms were dispensed, but the number dispensed was not recorded, although it was understood that records of condoms dispensed at the outpatient clinic should be included in the FP report. There were no records of tubal ligation and vasectomy procedures as services were provided at the hospital and performed by medical doctors or trained health workers (for vasectomy).

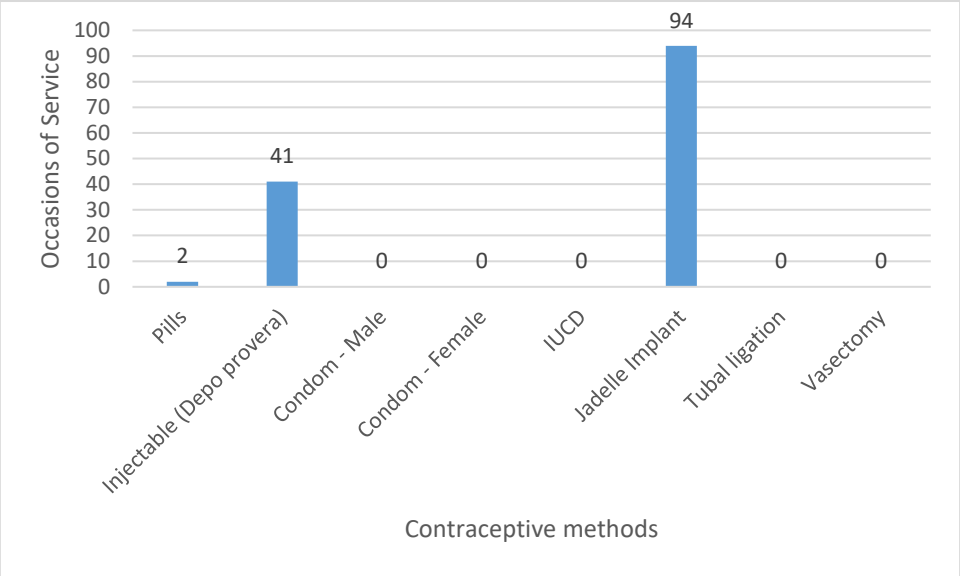

Figure 6.8. Kia FP clinic occasions of service by method 2015–19

Figure 6.9 shows the ages of people attending the clinic. The younger and older age groups had fewer records of attendance at the FP clinic. Although no person younger than 14 years old attended the FP clinic, some did attend the outpatient clinic for SRH or contraceptive needs, such as diagnosis and treatment of STIs. The records showed that all attendances at the FP clinic were female, with no records of males attending.

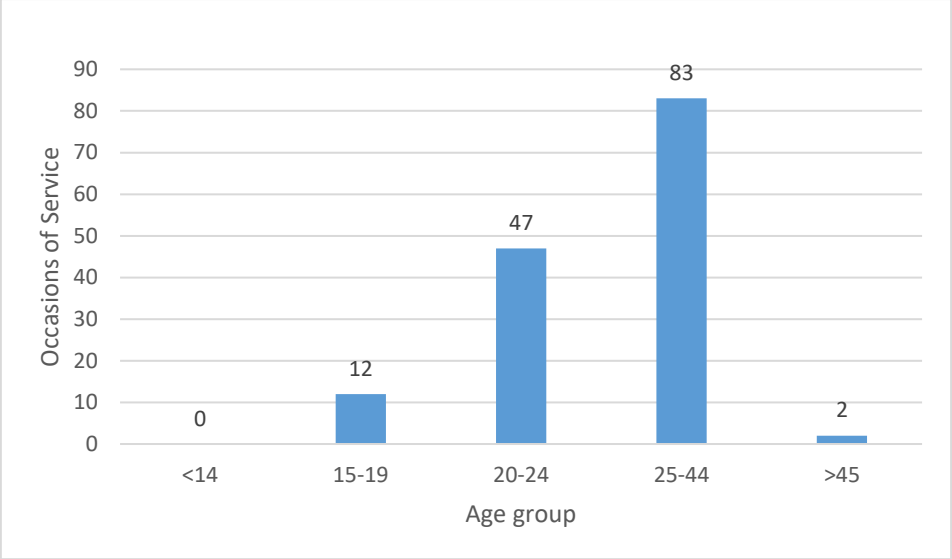

Figure 6.9. Kia FP clinic occasions of service by age group 2015–19

It was mostly married women who were registered as attending the FP clinic; few were unmarried (see Figure 6.10). The unmarried group included those who were single, divorced, widowed or living with a man without legally being married. There were also unclear and inconsistent entries in the marital status (as explained in Chapter 3). No standard guide or definitions for these abbreviations were sighted in the records.

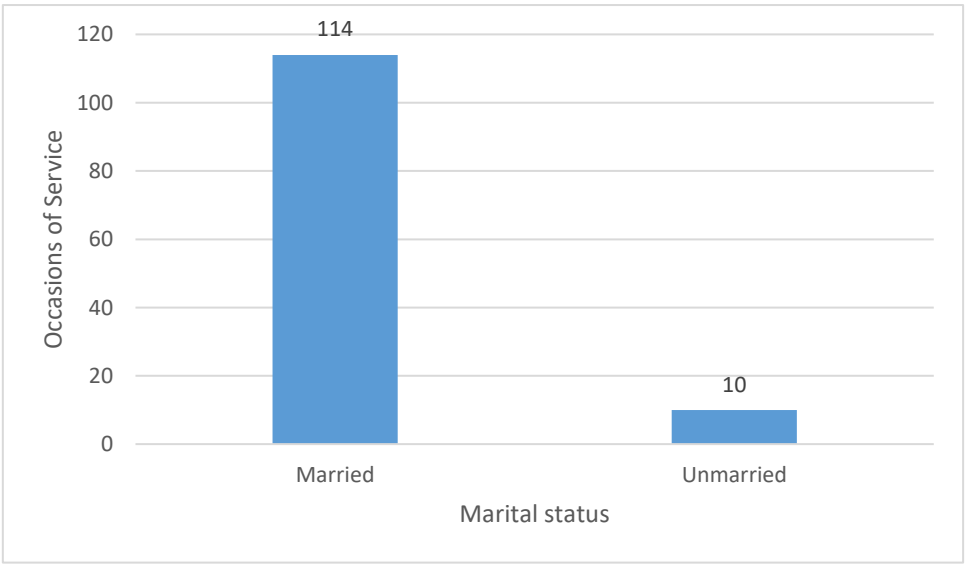

Figure 6.10. Kia FP clinic occasions of service by marital status 2015–19

Treatment of STIs was the only SRH service provided by the clinic, apart from MCH and FP. This service was accessible through the outpatient clinic and offered as needed. More males than

females attended this service, which may imply that men were more likely to develop STI symptoms and thus sought service more often than women or that women may also sought treatment of STI at the FP clinic.

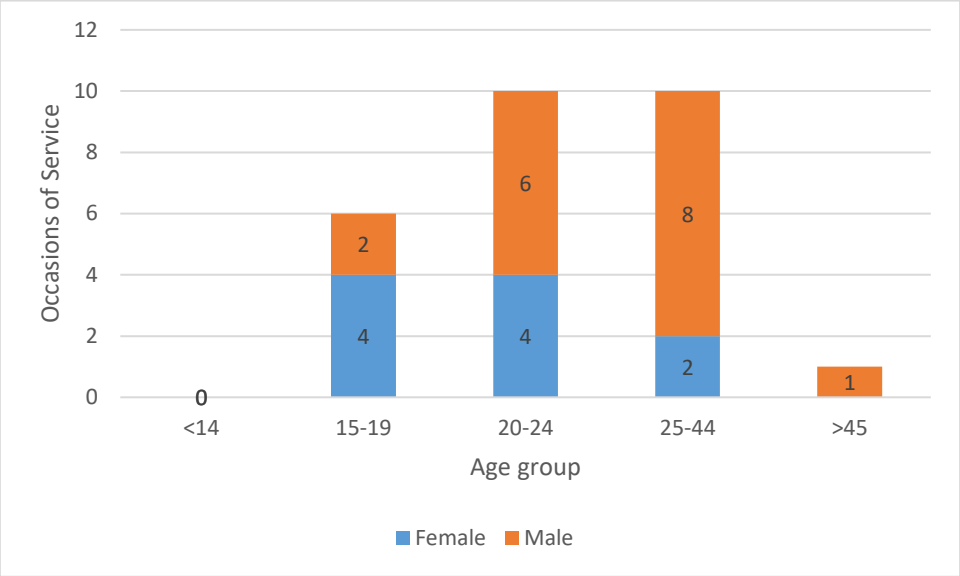

Figure 6.11. Kia outpatient clinic occasions of service for STI by age group and gender 2019–20

6.3.4 Qualitative Interview Data

Qualitative interviews were conducted with a total of 41 purposively sampled participants: service users (n = 16), non-users (n = 21), service providers (n = 3) and a service manager (n = 1). Both women (n = 20) and men (n = 21) were interviewed. Table 6.3 shows details of participant categories, gender, age groups and education level.

There were more user and non-user participants interviewed in Case Study Three than in the other two case studies. The reason for this was because Allan recruited participant users and non-users from the community, many people heard about the interview and volunteered to talk to him, given he is a nurse and went back to his place. To respond in a culturally and acceptable way, he accepted additional community members' offer to be interviewed. Though not strictly necessary from a research perspective, the extra interviews have been integrated in the data. Probably because a male researcher was conducting the interviews, there were slightly more males than females among the service user and non-user participants.

Interviews began with the service manager and provider at the provincial level in Buala, followed by interviews with users, non-users at Kia communities. The last interviews were with service providers at Kia AHC. This order was employed given the context of the case study and the events around the time of data collection, as explained in Section 6.3.1

Table 6.3

Participant Demographic Description: Gender, Age and Education Level

Participant category	Gender		Age group in years					Education level		
	Female	Male	<20	21–30	31–40	41–50	>50	Primary	Secondary	Tertiary
Service provider	3	1	0	0	2	1	1	0	0	4
Service user	7	9	0	7	6	2	1	3	5	8
Service non-user	10	11	10	8	2	0	1	3	15	3
Total	20	21	10	15	10	3	3	6	20	15

6.4 Qualitative Interview Findings

Users' and non-users' knowledge and understanding about FP services and contraceptives, their relationships with service providers and how FP was delivered at the clinic all affected the availability, accessibility and acceptability of FP services, including use of contraceptives in Kia. Three major themes were identified in the qualitative data: users and non-users save (knowledge and understanding) about FP; service providers' positive connections with the community; and delivery of FP services. Each of these themes is now discussed in turn.

6.4.1 Users and Non-users Save About Family Planning

FP save (meaning, knowledge and understanding of FP) was attained by users and non-users through informal and formal educational processes. Informal save was gained through storying (talking) about FP and was a central process in dissemination of FP information and improved understanding about FP services and contraception. Formal save involved users and non-users gaining knowledge from service providers raising awareness about FP, attending formal schooling or enrolling in a course at an educational institution.

6.4.1.1 Informal Save (Knowledge and Understanding)

The community's informal save (knowledge and understanding) about FP came from storying. Storying took place during casual meetings between groups of people who shared common interests. During these meetings and conversations, individuals talked about FP topics based on their own knowledge of the topic and/or if another person spoke about a specific topic, because of their own curiosity or need for information. The accuracy of information shared between individuals in this way may be limited and could not be verified without having access to a qualified health worker. These conversations reportedly happened in community groups such as in families, among young people (peer groups) and between men and women. Most non-users in this rural community acknowledged such conversations were the main way some people heard and learnt about FP.

In families, SRH topics such as FP were often discussed in gendered groups; for example in groups of men or women. A typical gendered family group of women would consist of cousins, sisters and aunties; and for men, brothers and uncles. One example of this was when a female non-user said, '*mi herem lo samfala kasin sista na olketa tekem na datawan ia, hem na mi herem*' [I heard from some cousin sisters who took that thing (Jadelle implant); this is where I heard it] (3FNU5). Sometimes within families, wives and husbands learnt about FP from each other: '*disfala FP ia, funny ting is taem mi yang boe mi no save wat na FP, taem mi stei wetem wife blo mi nao, hem jes talem lo mi*' [The funny thing is when I was young (unmarried) I did not know about FP; my wife just told me about it after we lived together] (3MU1). An uncommon response came from one male user, who said his mother had told him about FP. He relayed, '*oh that wan ia mami blo mi na talem mi ia, mi garem meke 2 pikinini hem se lo mi, iu mas go tekem FP, so mi go lo Kia ia … dat fala taem na mi save lo FP*' [Oh, my mother told me about it when I had my second child; she told me to go and take FP, so I went to Kia … that is when I found out about FP] (3MNU7). There was no mention throughout any of the interviews of fathers talking to their daughters about FP.

Young people usually gathered with their peers in gendered groups to discuss FP. Some young people who attended school obtained information from teachers as well as from their peers,

while others said they had never been exposed to FP information: '*lo hia nomoa, tude ia nomoa mi jes herem na FP ia*' [it's just here today that I heard about family planning] (3FNU3).

All young people interviewed were identified as non-users of FP services. A young male non-user said he had heard about condoms from another young male: '*lo (I heard from) olketa boes wea olketa save usim condom*' [I heard from the boys (young men) who used condoms] (3MNU11). A young female non-user said she had obtained FP information at school and from other women: '*mi save herem lo school samtaems olketa tokabaotim lo school and samtaems mi save herem lo aotsaed lo samfala woman stori abaotim FP*' [I heard it (FP information) at school, sometimes they talk about it at school and other times I heard it outside (of school), from some women who talked about FP] (3FNU2).

The final community group in which informal save was acquired about FP topics was in men's and women's non-family gendered groups. A male non-user said he had heard about FP from other men: '*mi herem lo olketa man taem olketa stostori … so ating olketa nurse na talem olketa? So olketa storim, mi no save*' [I heard about this (FP) from some men when they told stories among themselves … I think the nurses must have told them; I don't know. That is what they told me] (3MNU9). A type of group that appeared to have a lot of influence was women's groups, especially women who had previously used contraceptives. Women who were users of contraceptives were able to clearly explain the benefits and the side effects of their chosen FP method and were able to share this information with other women in a balanced and informative way, making their stories pertinent and influential. A female non-user relayed stories she had heard from women who had used contraceptives:

> *olketa meresin ia, mi no herem from klinik tuia, mi lukim and herem from olketa woman wea kam bek wetem pikinini blo olketa taem olketa diliva. Olketa kam bek, olketa se, 'O mi tekem Jadelle ia, hem na lo hia', ota sowim lo mi tuia, hemia fo stopem pikinini ia fo mi no tekem pikinini. Olketa nara wan se 'O mi usim pills or tablet' olsem … lo dea na mi save abaotim FP, mi herem from olketa woman … olketa storim mi* [I did not hear about all these contraceptive methods from the clinic. I saw and heard from women who came back after giving birth to their babies. They came back and said, 'Oh, I took Jadelle and its here'; they

showed me where it was and they told me it would stop them from having children. Others said they used pills or tablets, so this is how I know about FP, I heard from other women … they told me] (3FNU9).

Although storying within women's groups about FP can be an effective way to disseminate FP information, there were concerns that inaccurate information may be disseminated that influenced people's decision. One female user believed that:

Nes sud kolem everi community den awareness aboutim kain type osem ia. Kain type no kolem pipol fo awareness tu so olketa pipol herem laea story, olketa se barava tru wan na so hem na kosim oketa no kakam for tekem FP ia [The nurse should call all community people together to give awareness about this type of thing (FP). If you don't call people together and provide awareness, people will hear these untrue stories and will think they are true and that is why they will not come to take FP] (3FU4).

In addition to the considerable amount of knowledge and understanding about FP services emanating from informal educational processes such as the family, peers and men's and women's groups, formal educational processes were evident throughout the interviews.

6.4.1.2 Formal Save (Knowledge and Understanding)

Formal save (knowledge and understanding) was obtained from service providers who gave talks that raised awareness about FP services. These formal talks were delivered via face-to-face presentations to individuals or groups at the clinic; during community gatherings including church groups; in schools and through radio health programmes. Service providers tended to deliver most of their talks at the clinic during official clinic times. In community awareness talks, service providers were invited by the community to speak either on health topics chosen by community leaders or health issues considered important by service providers for the community to know.

Talks about FP services were delivered by FP service providers on a regular basis, with the clinic the main venue for these talks. This meant those who attended the clinic were more likely to be exposed to FP information than those who did not attend the clinic. A female user said she heard about FP when she attended the clinic: *mi herem lo olketa nes, taem mi garem fest pikinini blo mi, mi*

go lo klinik olketa nes talem mi abaotim FP ia [I heard it from the nurses when I had my first baby at the clinic and the nurses told me about FP] (3FU5). Others said they learnt about FP through organised community talks by nurses. One male user said, '*fest taem mi herem FP taem olketa nes kam an givim samfala awareness lo komiunity lo hia nomoa, so mifala save go heherem, olsem na mi jas garem samfala idea na lo FP ia*' [The first time I heard about FP was when the nurses came and gave some awareness in this community and we used to go along and listen. This is where I got some ideas about FP] (3MU3).

However, participants who did not live in Kia, but more remotely, reported they had not been visited by a service provider to raise awareness about FP services, in a long while. A female non-user stated, '*nes hem mas come kasem iumi pipol outside … bat kain if bae hem no kam fo ful ia na olsem bae pipol lo vilij bae find had lelebet for save and fo tekem olketa methods ia bae mi say*' [the nurse must come to us who live outside (of Kia) … but if the nurse did not come for a whole year then people in the village will find it hard to know about FP and take (use) the methods] (3FNU9). Even for those who lived in Kia, there were reportedly fewer FP awareness presentations happening in the community compared with previous years. A male non-user reflected on past awareness raising programmes:

> *bifoa yet na mi kam akrosim olketa nes, bifoa na olketa save givim na awareness tok lo olketa komiunity bat according lo olketa grups, hem na olketa save duim, bat distaem mi no save lulukim na olketa nes gogo raon fo duim awareness abaot olketa things ia, so lo dea na olsem mi herem disfala word FP* [It has been quite a long time since I have come across nurses who go out to give awareness talks in the community—they used to give talks according to respective groups (women and men). However, today I do not see nurses go around doing awareness about such things, this (previous awareness-raising activities) is where I heard the word FP] (3MU2).

Formal sharing of FP knowledge by health workers was important in promoting contraceptive services. However, a service provider was not convinced that nurses provided accurate and consistent information to people:

iumi putim moa lo awareness and … letem pipol na disaed bat iumi tu mas provaedim right information. Wanfala misteke blo iumi na, bae mi talem wanfala information, nara nes kam talem difren information moa … bikos taem bae olketa kam ia bae olketa se, 'eh ma nara nes ia se olsem olsem olsem' so hem mekem hem hard lelebet bikos sevis ia iumi evri nes nomoa provaedim so taem nara man hem, putim boundry lo dea bae iu faendem hard fo brekem dat fala wall ia moa olsem, for mekem hem biliv that, oh FP ia hem fo savim laef tu olsem, so hem naia [We just put it to awareness … and let people decide, but we (nurses) must also provide the right information. One of our mistakes as nurses is, I will deliver information and another nurse will come with different information … When people come to the clinic, they say, 'oh but the other nurse says this and this' so it makes things hard because it's us nurses who provide this service so when another person puts a barrier there, you will find it hard to break down that wall to make people believe that FP is a method to save lives] (3FPP2).

The Christian churches were also influential within the community, and often invited service providers to present health awareness, such as FP, to their congregations. A female non-user said she had first heard about FP at her church: '*fest taem mi herem FP na lo las ia nomoa taem nara nes hem kam ranem lo sios na mi herem*' [The first time I heard about FP was just last year when a nurse came to run awareness in our church] (3FNU4).

FP education is included in the curricula of primary and secondary schools in Solomon Islands. This is where many young people first learnt about FP: '*lo school nomoa ia taem mi form 5 olsem, long taem lelebet naia*' [I heard it in school in my eleventh grade, so it was a long time ago] (3MU5). The main topic taught in school was how to avoid making girls pregnant because of the increasing population. A young male non-user reported, '*olsem taem mi skul main samting olketa tisa talem abaotim FP olsem fo mifala stident … oketa olwes tisim mifala hao fo mifala duim samting fo no mekem olketa gele babule bikos lo populeson*' [The main thing the teachers told us about FP at school is to do things that will avoid making girls pregnant because of the increasing population] (3MNU4).

Although the use of condoms was taught in schools, this did not necessarily increase their use. The same participant as above said, '*bata ating mifala fogetem wat olketa tisa talem lo skul, mifala*

olsem jes enjoy nomoa so fogetem na FP olsem. Mifala ting mifala yang yet so kain enjoe nomoa' [but I think we forgot about what the teachers told us in school and we just enjoyed so forgot about things like FP. We thought we were still young so just wanted to enjoy ourselves] (3MNU4).

Service providers also visited schools to give FP awareness talks. These visitations were part of school health visits or at the invitation of the school: '*samfala taem olketa nes kam awareness lo school olsem tuia*' [Sometimes nurses come and give awareness at the school] (3MU2). A male user also acknowledged obtaining FP knowledge in both informal and formal ways: '*Olsem staka man tu talem ia, samfala taems olketa nes kam awareness, harem taem mi school olsem ia*' [Many people also talked about it, sometimes nurses came to give awareness, and I heard it at school as well] (3MU6). Although schools taught FP, they did not provide FP services such as counselling and contraceptives. Students needed to access the FP service at the community clinic to obtain contraceptives.

Not every young person in the Kia catchment area was able to attend formal schooling. Therefore, many young people had not heard about FP via formal education and relied on informal sources. A service provider reported, '*staka pikinini bat no skul na iu lukim lo hia, bikos due to no school fee. Olketa parents no save provaedim for olketa na lo evriting pikinini nidim ia, nomoa na*' [many children do not go to school here due to no school fees. Parents cannot provide for all their children's needs] (3FPP2). This has contributed to low literacy levels in remote communities. Many young people will have only completed primary level education; some will continue to secondary education; and very few to tertiary. Low literacy levels were found to negatively affect understanding of FP concepts. A male user identified low literacy as a problem in the community:

> *wanfala big problem lo komiuniti ia olsem, problem ia na yumi lo home naia, staka umi no save read moa, umi no save rait moa olsem ia … hem low tumas lo literacy level so pipol olketa no minim wat na FP. Taem olketa lukim eniwan go fo lukim nes fo FP olsem, man go tekem condom or whatever method, olketa kain tokaboutim hem na, 'eh mania like muv wild moa ia … so iumi olketa health workers sud garem samfala ideas fo mekem na hao na umi save teachim olketa pipol ia'* [One big problem in the community is you know we live in remote villages; most of us cannot read or write. The problem is low literacy levels, so people

do not understand what FP really means. When people see someone go to consult the nurse for FP, such as to access condoms or whatever contraceptive method, they start gossiping about that person, 'oh this man wants to move wild (be sexually active) now'] (3MU2).

In addition to literacy issues, educating everyone on FP can potentially change the community's perception and behaviour about FP.

There were four formal educational avenues via which people developed knowledge about FP services. The first was through their schooling. However, this did not reach everyone as many young people living in the Kia catchment area were unable to afford to send their children to school. The second way was through social media such as radio and the internet; however, this was not a popular option among those interviewed. The third was through organised community events at which a service provider was invited to talk, such as in general community gatherings or church. Even though this was a useful option, it was noted by one participant that these community talks were happening less and less and were not easily accessible for people living outside Kia. The most common method was the FP nurse giving talks at the clinic during official opening hours. People that attended the clinic benefited from this, and it was thus important that all nurses provided accurate information so as not to confuse people or create unnecessary fear about using contraceptives.

6.4.2 Service Providers' Positive Connections with the Community

In addition to knowledge and understanding about FP service and contraception, a positive connection and good relationship with people in the community are important determining factors to ensure FP is available, accessible and acceptable in rural communities. Three main categories were identified in this theme: i) being friendly; ii) working together; and iii) communicating clearly. Building and developing relationships is key to reaching different community groups for the purpose of providing education about FP.

6.4.2.1 Being Friendly

Participants acknowledged the invaluable presence of a happy and friendly FP service provider who was welcoming and open to talking. A friendly smile was experienced as a 'welcome' sign and contributed to a sense of trust in the service provider. A young female non-user said, '*taem*

olketa nes kam olsem, tok gud lo pipol, no ken sap feis lo olketa olsem' [when nurses come (to the clinic) they must talk nice to people, and not put on a 'sharp face' (an angry or unhappy outlook)] (3FNU3). Another female non-user defined a nurse being kind as, '*hem save tok isi, sapos yu tok harsh tumas bae pipol fafarait fo kam tuia*' [They (nurses) must speak slowly (calm voice); if they speak harshly, people will be afraid to come to the clinic] (3FNU9). One male non-user also expressed being kind as the most important thing the nurse should do, so that people would not be afraid to visit the clinic: '*samfala best samting nes mas kain lo olketa pipol … hem na pipol bae no frait an laik go visitim na klinik*' [The best thing the nurse should do is to be kind to people … then people will not fear and will want to visit the clinic] (3MNU5).

Being friendly also means being patient with those who came to the clinic and being open to leading a conversation that was non-judgmental—in essence, speaking well with them. This created an environment where clients were comfortable to discuss their FP questions and needs. A female user said, '*olketa (nes) mas patient lo olketa wea kam lo klinik, tok gud lo olketa*' [nurses must be patient with those who come to the clinic and speak well with them] (3FU2). A male non-user expressed that, '*olketa nes ia mas open ap, no kokoros tu*' [nurses must 'open up' (ability to start a friendly conversation) and not being angry] (3MU7).

The simple act of an FP provider being friendly and non-judgmental to people made the service more accessible and encouraged users to continue coming. When first visiting the clinic for contraceptive supplies, a male user experienced friendliness and this meant he was no longer afraid to seek FP services:

> *first taem mi sem fo go bata den hao olketa nes olketa save aprosim mi, olketa mek sua mi mas fil welkam, olketa veri open fo taem iu go tok, so mi fil fri and mi faendem dat olketa kipim confidentiality ia. Olsem wat iu talem olketa, olketa no go talem olbaout olsem, so mi no frait fo go ask moa nex taem, 'eh next wan more' olsem* [At first, I was too shy to go but then how the nurses approached me, they made sure I felt welcomed, they were very open for you to talk, so I felt free and knew that they could keep confidentiality. Whatever you tell them, they do not go around and tell others, so I am no longer afraid to ask the next time if I want some more (of condom supplies)] (3MU8).

A service provider also affirmed that nurses with a welcoming attitude made a difference to contraceptive access for people: '*hem attitude blo iumi nurses nomoa ia, if we are not welcoming then bae olketa no nap kam naia*' [It's just our (nurses') attitudes; if we are not welcoming then people will not come] (3FPM1). People assumed a service provider was friendly when they were welcoming, kind, patient and spoke calmly to people while they were providing the service.

This service provider then continued to share her experience in another clinic setting when she befriended young people in the commity:

> *ok bae mi talem iu what I did, mi frenim evri youth people as my best friends. So evri youth, boy and girl, mi frenim in a way iu fren na and then they are able to talk freely wetem mi, mitim mi lo street, halo moning, hey mi likem 'soks' (condom). Mi olwes asuarim olketa that whatever iu kam duim lo hia, it is a secret, between you and me finis naia, bae mi no stori lo mum or dad … nothing will leak out from this room, so hem na wat mi duim honestly lo hia, so all the youths olketa save lo mi* [Okay I will tell you what I did; I befriended every youth as my best friends. All the youths, boys and girls I befriended them in a way you are friends, and they were able to talk freely with me. When they met me on the street, they would say hello and good morning and ask for 'socks' ('condoms'). I always assured them that whatever they came to do there was a secret between you and me that's it, I will not tell your mum or dad, nothing will leak out from this room, so that is what I honestly told them; so all the youths knew me.] (3FPM1).

Developing a trusting relationship with young people meant that the FP nurse was able to help young people in the rural setting feel comfortable enough to ask for contraceptives. The important interpersonal skills of being welcoming, kind and patient, and speaking in a kind and open manner encouraged people to talk freely and access FP services as needed.

6.4.2.2 Working Together

The category 'working together' included cooperation and understanding about FP in three distinct settings: the family, community and health settings.

In the family setting, husbands and wives (as couples mostly are in Solomon Islands), reported the need to understand their respective roles in relation to FP, as this determined how they communicated FP information between themselves and to young people. Jealousy between married people often caused disagreements about the acceptance of contraceptives. Jealousy often arose when couples did not trust each other and thought that their spouse may use contraceptives for extra-marital relationships. One female user explained:

> *jeles ia hem had fo iumi stori wetem olketa, bikos olketa jeles lo wife naia, so ating gud fo nes nomoa mas kam toko na lo husband and wife, fo mekem husband letem na wife blo hem fo go tekem FP ia osem* [Jealousy makes it hard to talk with them; they (husbands) are jealous of the wife so it would be good for the nurse to talk to the husband and wife, so that the husband would allow his wife to take FP] (3FU5).

One male non-user explained jealousy as the main driver of opposition to FP use: '*ia jeles ating lo tingting blo mi, bikos if you putim FP lo wife bae olman save tingting rong tuia, kain ia*' [Yes, I think it was jealousy, because if you put FP contraceptives on the wife, the old man (husband) will have some wrong thinking, something like that] (3MNU1). A male user further elaborated with an additional reason behind this thinking—concern that contraceptives would prevent a woman from becoming pregnant, thus encouraging promiscuity:

> *ating wanem mi, olsem mi seleva lo tingting nomoa, that wanfala problem lo FP especially taem tekem olketa medicine kain olsem ia, ating samfala, bikos olketa medicine ia for mekem iu no garem pikinini naia. So wan or tu case mi tigim mi faendim that bae samfala woman olketa wea no mas stret wan ia olketa no kea naia, hem na wanfala problem mi findim, go samfala husband no save letem tu wife for tekem from olketa cases osem* [I think from my own thinking, one problem with FP especially when women take those medicines is that they will not get pregnant. Therefore, in one or two cases I know, I found that some women who may not be very sensible would not care. This meant some husbands did not allow their wives to take FP] (3MU4).

Parents not willing to provide consent for their children to use contraceptives was another issue reported by participants. However, some parents did support their children if they understood

the issues they faced. These issues included risks of teenage pregnancy and then girls not being able to complete their education. For boys, the costs associated with compensating a girl's family if they made her pregnant was a concern. A service provider said, '*Samfala parents ia bae acceptim nomoa ia, bikos olketa understandim wat na life distaem, bata samfala barava nomoa na, so hem na mekem samfala pikinini save kam hide fo tekem na FP*' [Some parents will accept FP for their children because they understand what life today is like, but some will not; so this is why some children come without their parents' consent to take FP] (3FPP1). Another service provider shared that some parents supported their unmarried daughters who wanted to use FP: '*samfala parents save tekem kam olketa dotas blo olketa wea no marit ia fo FP tuia*' [some parents do bring their unmarried daughters to the clinic for FP] (3FPM1).

Although it is commom practice in Western society for young people at the age of 18 to give consent for themselves, this is not always the case in Solomon Islands. In most cases, if the adolescent is still in school and not married, parents still assume responsibility for making decisions about their need for contraception. Some parents were not happy with service providers who gave contraceptives to their daughter. In such cases, a consent form signed by the young person was used to protect the staff nurse, but not the vulnerability of the young people. However, if parents supported their children, the consent form was not required and service providers supported their decision. A service provider shared this experience:

> *Samfala taem mifala encounterim problems wea olketa parents kam tok, no hapi lo mifala bikos mifala insetim na contraceptive lo olketa pikinini blo olketa, hem na mekem olketa pikinini ia go astre na. So mifala especially Ministry of Health devisim wanfala konsent fom for olketa saenem bifoa mifala givim. Dis wan hem fo protektim olketa lo kain problem olsem ia. Sapos olketa kross tumas den umi save showm go 'oh hem na hem laekem, hem seleva na saenem fom ia osem', dat wan ia mifala encounterm olowe nomoa ia* [We sometimes encounter problems when parents came to talk to us and say they are not happy we inserted contraceptives (implants) in their children. They (parents) said that this led their children astray. Therefore, the MHMS devised a consent form for them (the young person) to sign

before we can give them contraceptives. This is to protect them from problems like this. This is what we encountered most of the time] (3FPP2).

A male user said it was the Elders' responsibility to educate young people about FP: '*hem diuti blo mifala nao, olketa olda pipol fo talem olketa yang wans fo go sek olsem*' [it is our duty as Elders to tell the young ones to go and check] (3MU5). Another male user explained an acceptable approach to talk to young people about FP: '*umi save stori wetem olketa yang boes ia … lo olketa yang gels bae iumi no storim olketa bikos bae saed lo mami na bae stori lo olketa*' [We (men) can talk to young boys … we will not talk to girls because their mothers will talk to them] (3MU9).

Participants expressed the importance of working together with the clinic nurse. The community setting requires the whole community to work together. Village chiefs are often responsible for the welfare of the people in the community. Institutions in the communities such as schools and health clinics are seen as owned by the community and the community is also responsible for looking after them:

> *iumi pipol lo komiuniti iumi mas help tu fo sapotim olketa nes…umi putum ap na klinik ia, nes ia kam fo lukim iumi pipol nomoa ia...encouragim olsem olketa komiti lo klinik olketa mas mekem gud klinik* [We the community people must help to support the nurse … the clinic is here to benefit us and the nurse just comes to see us … clinic committees must be encouraged to improve the clinic] (3FNU10).

A male user further explained how the whole community including the church should be involved:

> *hem gud sapos FP lo vilej for involvim staka pipol ia, ino nurse nomoa go. Olketa church man ia, olketa mothers grup ia, mothers union, or dorcas grup ia, olketa mas reach aot lo olketa pipol blo iumi, at least iumi brekem disfala tingting wea eh FP ia blo olketa woman nomoa ia olsem ia* [When it comes to FP in the village, it would be good to involve many people, not only the nurse. The church people, mother's groups such as the mother's union (Anglican Church group) and Dorcas (Seventh Day Adventists) group, they must also reach out to our people, at least to break the common belief that FP is only for women] (3MU5).

Participants also realised that one or two nurses alone could not reach everyone in their community with FP information and awareness. They thought that working together with the community was the way to reach everyone. A male user wanted to see community leaders and nurses working together.

> *so lo community, olketa nes and olketa komiuniti lidas sud waka togeta an fo helpem na komuniti fo muv ap to the standard wea iumi likem, wea iumi save lukim na olketa outcomes blo hem in the new future* [In our community, nurses and community leaders should work together to help the community to move up to the standard we want and where we can see the outcomes in the future] (3MU8).

Communicating clearly refers to the process of exchanging information at any group level to ensure individuals understand the risks and benefits of using FP for themselves. Clear communication about FP between family members, community leaders and service providers is integral to making FP services available, accessible and acceptable to those who need and seek the service.

Clear communication can successfully connect individuals, families, communities and health workers to achieve FP goals. When FP messaging is communicated clearly and understood at various levels, everyone will make informed choices and take responsibility for their actions. A male user said, '*yumi parents mas olwes talem olketa pikinini dat, son yu mas usim samting olsem, bikos taem yu babulem nara gele bae seleni naia*' [As parents we must always tell our children that, 'son you must use something like this (contraceptive), because if you make a girl (young woman) pregnant, it costs money' (an expense)] (3MU1).

Clear communication between service providers and communities about nurses' availability and clinic schedules can greatly reduce frustration and misunderstanding such as expressed by this female non-user:

> *sametaems taem olketa pipol go lo klinik nes bae hem save absent lo klinik nao. Samtaems hem lukim olketa pipol siki bae olketa wait wait, bae olketa go kol olsem, bata bae hem stei stei nomoa … ating nes hem garem rison fo no kam tuia … yumi mas help tu fo sapotim olketa nes … ating samfala failures blo yumi pipol lo vilij na mekem olketa nes lesi lo yumi ia*
>
> [sometimes when people go to the clinic, the nurse is not in the clinic. Sometimes nurses see

sick people waiting or hear them calling but do not come … maybe they have genuine reasons for not coming to the clinic … we must help to support the nurses … I think it could be our (village people) failure that the nurse do not like us] (3FNU9).

Therefore, FP messaging and clinic services will need to be clearly communicated by service providers at different levels with a friendly approach to enhance a positive connection and eventually build rapport with people.

6.4.2.3 Delivery of Family Planning Services

Several factors influenced the delivery of FP services at Kia AHC. These factors included how FP planning services were provided; the context of where people lived in relation to the clinic; sociocultural values and beliefs of people; availability of contraceptive supplies; and the extent of FP training service providers had received. These factors are discussed in detail in the following.

6.4.2.3.1 Women-focused Services

The FP service at Kia AHC was offered once a week and integrated with the postnatal clinic. The postnatal clinic was where mothers brought their babies for routine checks at two–six weeks following birth. This was seen as an opportunity to provide FP information to women. The service provider explained the reason for the integration:

> *mitufala evri Tosde na fo family planing, mifala putim wetem posnetol seleva, mekem taem olketa kam lo siks wiks, mitufala stori wetem olketa den bae olketa save tekem fp … or taem lo entinatol bae mifala talem hem (mama) stori wetem hasban fo tufala disaed bae tekem fp or nomoa* [We put every Thursday for family planning with the postnatal clinic, so that when they come for their six-week check, we discuss FP with them … or during the antenatal clinic we tell her (woman) to discuss with her husband whether they would decide to take FP or not] (3FPP3).

Furthermore, all contraceptives available at the clinic were predominantly for women, and included injectables, Jadelle implants and OCPs. Male condoms were available, but these were usually accessed by women for their husbands. Therefore, many more women than men attended the FP clinic: '*mostly olketa woman na kam, olketa man ia mi no lukim olketa kakam tumas, lo Jadelle ia,*

yang gels na barava staka' [mostly women come. I do not often see men come to the clinic. Many young girls use Jadelle implants] (3FPP3).

Although FP services at the clinic were available to everyone (including men and young people), women were the main consumers of this service. This made some people think that FP services were only for women: '*evri sevis lo hia ia, bat onli ting nomoa is lo mentaliti blo pipol, taem klinik lo hia hem fo babule woman, fo family planning, for nila, fo sick olsem nomoa ia*' [All services are here, but the only thing is people's mentality; they think the clinic here is just for pregnant women, FP, immunisations and for sick people etc.] (3MU5). A male service provider explained why men's attendance at the FP clinic was poor:

> *evritaem taem FP olsem iumi se olketa woman olsem nomoa na … so taem fo givim metods olsem ia, bae olketa woman nomoa go, bikos taem aweanes olsem, no eni man so hem na olketa man iumi lelebet poor lo hem lo saed lo turn up fo FP* [Whenever it's time for FP, we always call on women … so when it's time to give FP methods only women will go, and during FP awareness (at the clinic) men are not present, so that is why men's turnout for FP is poor] (3FPP2).

Although a day was set aside for FP services each week at the clinic, young people felt they were not prioritised at the FP clinic: '*tingting blo mi osem, nes sud garem taem an dei putum dei, fo ranem awareness or FP fo evri yang pipol bikos staka taem hem no save duim kain ia, olsem siki nomoa ia, olketa kain ia nomoa, hem no garem na taem fo yang pipol go olsem*' [I think the nurse should allocate a day dedicated for FP awareness for young people because this is not happening; many times nurses mostly attend to the sick and have no time for young people] (3MNU4).

To make FP available, accessible and acceptable to everyone, participants reported that the focus of FP needs to shift from women and be more inclusive of men and young people.

6.4.2.3.2 Users' Need for Privacy at the Family Planning Clinic

SRH services, like FP, require privacy so that sensitive issues can be discussed without the fear of others finding out. Privacy is paramount to ensure peoples' comfort when discussing personal issues or if requesting contraception. In Kia, the lack of privacy for service users had affected the way

people accessed and used the service, with participants reporting they chose not to attend the clinic for fear of their privacy being breached.

While participants acknowledged the importance of FP, it did not negate their fear of other people hearing their private conversations with the nurse; this fear resulted in most participants expressing a reluctance to attend FP services. A male user shared his experience when visiting the clinic:

> *Samting mi lelebet expiriensim na mi fil shame ia bikos ples (klinik) ia hem pablik ples tumas ia so umi had for haid ia. So if umi go askem kuestin olsem, bae olketa pipol save stostorim iumi tuia … so nidim rum blo hem seleva fo pipol no fil sem osem* [One thing I experienced was shame, because the clinic is a public place so we cannot hide. If we go to ask questions, other people will talk about us … so we need a room for FP so that people will not feel ashamed to go] (3MU6).

The sentiment expressed above was echoed by most users and non-users. The lack of privacy made people feel ashamed to go to the clinic. A female user shared why she was ashamed: '*hem sud … ples blo hem seleva olsem … kain type lo hia ia staka tumas pipol na stap, save herehere go nomoa ia*' [it should … have a place of its own … what happens here, many people stay around here and can hear the conversation (with the nurse)] (3FU4). Another female user further expressed the need for privacy, '*if olsem praevet na fo iu save tok, iu save talem aot wat yu filim, olsem gud or bad or olsem. hem na mi nidim separet rum ia*' [if you have privacy, you can talk, you can express your feelings, whether good or bad, so that is why I need a separate room] (3FU2).

Young people rarely attended the FP clinic, with one of the reasons being reported as lack of privacy. A female user said young people and parents should be provided a separate consultation room at the clinic: '*sud wakem wanfala rum seleva fo olketa young boes or gels or parents save go. Samtaems ating olketa save lukim pipol ful ap lo klinik so olketa sem fo go*' [there should be a separate room for young people or parents to go. I think sometimes when they see a lot of people around, they are ashamed to go in] (3FU1).

A service provider agreed that the lack of privacy affected their counselling services at the clinic:

ia dat wan ating barava turu wan bikos mifala trae fo stori bat yu tigim go mifala duim nomoa lo outpatient ia, den bae samfala peep kam insaed den olketa quiet moa so hem barava distebim na taem mifala duim counselling ia, so ating hem tu nara problem olketa pipol sem fo kam ia [I think that is very true because when we try to talk (counselling), but just think about it, we are doing it in the outpatient area; if someone peeps inside they (client) will be quiet, so it really disturbs us when we give counselling sessions, I think this could be another problem in why people are ashamed to come] (3FPP3).

6.4.2.3.3 Distance from the Clinic and Cost of Travelling

Almost half of Kia's catchment population live in different settlements outside Kia village in the Kia islands, and along the coast of the main Island, Santa Isabel. The travel distances ranged from 30 minutes to more than 1 hour by outboard motorboat. Although people often paddled their wooden dugout canoes to Kia from their villages, strong currents and winds made the journey challenging for people living in the outer islands. The same challenges were faced by nurses when they delivered outreach services to these outer settlements.

Those who lived in settlements outside Kia village found it challenging to reach the clinic when needed. A male user expressed this difficulty: '*lelebet hard ia, bikos ples ia no kosap, bae mi folom enjin moa, bae expensiv moa bae iu go, so hem na osem hem lelebet hard*' [It is quite hard because the place (Kia) is far from where we live. I will have to go on an outboard motor and it is expensive, so that makes it hard] (3MU6). A male non-user also had the same concern: '*lo vilej ia, selen tuia, petrol moa den bae go kasem na kia ia*' [In the village, money is needed to pay for petrol to go to Kia] (3MU7). Despite this challenge a female user explained how she afforded her clinic visits: '*osem mi tekem nila ia bikos mi stei fo tri manis na so ating bae mi save tekem selen baek fo mi go baek lo klinik ... so hem gud lo mi*' [I took injections because this last for three months; so I think I can save some money to go back to the clinic … so it is okay for me.] (3FU2). To attend FP services required motivation, determination and careful planning.

Another way FP was made available at Kia was through outreach services, also called satellite clinics. Through these satellite clinics, health services were made available to people who lived in communities far from the clinic facility. Given the remoteness of communities within the clinic's

catchment area, these communities could only be reached by motorised boats: '*hem no isi bikos staka pipol stap aotsaed lo olketa setolment, so hem had fo kasem olketa tu. Olketa seleva nomoa bae kam lo mifala lo hia (klinik)*' [It is not easy because many people live in settlements, so it is hard to reach them. They themselves will come to see us at the clinic] (3FPP3). However, outreach services could only be implemented if money was available for travelling expenses, and FP was not the only primary focus of outreach services; other clinic services were equally important, as a service provider noted:

> *satalait klinik, mitufala save duim nomoa taem mifala garem impres (seleni). Mitufala save putim evri fraede … bat bae everi program hem insaed ia, no FP seleva, everiting nomoa u duim lo satalait klinik ia* [We only do satellite clinics when we have the imprest (money). We allocate satellites on Fridays … but this includes all other clinic programmes, not only FP, and we also do everything during satellite clinics] (3FPP2).

Another issue with the imprest system was that the funds did not always arrive on time, which meant that outreach activities could not be carried out as planned: '*taem mifala aplae bae quata finis na bifoa impres ia save kam so mifala save dilei*' [when we apply for funds, the funds are usually available after the first quarter of the year and this delays our activity implementation] (3FPP3). Although outreach clinics delivered important services to remote communities, activities could only be done if funding was available to meet transport costs. In addition, adequate clinic staffing was required to cover for routine clinic hours as well as outreach services, to ensure clinic-based activities continued.

When outreach services could not be carried out, service providers ensured that FP services and contraceptive services were provided on any day to individuals who lived a long distance from the clinic. However, this was not routinely available for those who lived near the clinic facility as one service provider shared: '*sapos mi lukim hem stap farawe an hem onli sens blo hem fo kam lo klinik bae mi atendim hem, bat sapos hem stap lo Kia nomoa bae mi talem hem fo kam lo dei blo FP*' [if I see them coming from far and this is their only chance to come to the clinic, I will attend to them but if they just live in Kia, I will tell them to come on the day for FP] (3FPP3).

6.4.2.3.4 Sociocultural Values and Religious Beliefs

Differing sociocultural values and beliefs of users, non-users and service providers could reportedly cause conflicting views on how FP could be made available, accessible and acceptable in rural communities. However, there were ways in which FP could be tailored so that it was acceptable and culturally appropriate to the person's context. One sociocultural barrier mentioned by a male user pertained to the gender of the service provider:

> *Wanfala beria nao olsem saed lo blad rilesonsip ia, kain olsem man blo Kia nomoa hem nes lo hia, bae olketa reletiv sem fo kam naia. I mean, hem bat bae hem ting 'eh sista blo mi or brata blo mi osem so bae hem no laek fo open ap fo talem go lo olketa nomoa ia. Bat sapos hem rili duim waka blo hem or hem tigim hem waka blo hem bae hem help nomo ia, olsem* [One barrier I see is in blood (family) relationships; for example, if the nurse is from Kia, then the relatives will be ashamed to come to the clinic. What I mean is the nurse may think, 'Oh she is my sister or my brother so may not open up to tell them about FP'. But, if the nurses really do their work or think that this is their job, they will help them anyway] (3MU8).

Although sociocultural values and beliefs could be a barrier, there were acceptable ways FP could reach people in rural communities. A nurse explained what was often done at the clinic:

> *iumi garem staka bilifs, staka values, staka traditions so hem na mekem FP lo olketa man hem poor lelebet. No mata olketa woman bat, samtaems kam wetem samfala problem bat datwan tu mifala providim lo klinik. If olo hem no agri den tufala evriwan bae save kam den mifala bae duim counseling lo tufala aboutim olketa methods ia* [we have many beliefs, values and traditions (relating to FP) so this makes FP access for men quite poor. Women also come with problems and we provide services for them at the clinic. If the husband does not agree, then both the husband and wife will come, and we counsel them together about the methods] (3FPP2).

Some male non-users may not have visited the FP clinic but were aware of FP methods and wished they could use FP but may not have had the opportunity to do so. They expressed a positive attitude towards FP and sought to have FP service accessible and available to them. A male non-user said regretfully:

mi ia laekem tufala pikinini nomoa ia … bat mi no tekem kuiktaem FP so mi ovam finis na tufala pikinini ia … mi sori lo misis blo mi tu … mi siki so had fo faedem selen lo helpem olketa pikinini so mi laek fo stop na [I intend to have only two children … but I did not take any FP earlier, so I've had more than two children now … I feel sorry for my wife too … I am sick, so find it hard to earn money to help my children, so I want to stop] (3MNU2).

Religious affiliations and beliefs were known to cause opposition to the use of FP contraceptives; however, participants expressed that these issues could be resolved with suitable explanations of FP. A service provider explained:

taem iu go storim FP, olketa save givim na olketa nogud samting abaotim FP. Famili planing hem save spoelem bodi and olketa se God wakem iumi se mas garem pikinini … bat bae umi takolem na olketa tingting olsem ia lo stori wetem olketa [when you go to talk people about FP, they will mention the negative things about FP. They say FP can spoil the body and God made us to have children … but we can explain these negative things when we talk (counsel) with them] (3FPM1).

A service provider felt that the purpose of using FP had changed and thought FP users had different intentions (to have multiple sexual partners) for using it. He observed that when there was increased use of Jadelle implants in young people, the number of STI cases in young people also increased. This was reportedly occurring not only among young people; he also saw the problem in husbands and wives who still did not understand each other and the reason for using contraceptives:

bata wanfala samting mi laek talem na olsem, mi no againstim FP bata hao mi luluk lo diswan osem meaning blo FP lo umi hem go difren moa ia … FP iumi barava abusim nao bikos FP hem for spacim nomoa ia, fo garem hamas pikinini iumi likem nomoa … hem sud not use for more than five years, bata samfala gogo ovam 10 years na … so umi no save wat na really meaning blo hem, hem laek stopem pikinini or hem laek o olsem nomoa … luk olsem pipol usim fo difren samting moa ia, mi seleva duduim counselling lo samting ia mi talem olketa tuia [One thing I want to say is, although I am not opposing the use of FP but in my observation, I think people's understanding and intention of using FP contraceptives is different now … we have abused the use of FP, because FP is just for spacing and limiting the

number of children we wanted … it should not be used for more than five years, but some have used it for more than 10 years … so we don't know what this means, they want to stop having children or just doing it like that … it looks like people are using it for a different purpose, I used to tell them this when I counselled them for FP] (3FPP2).

As providing counselling to FP clients can also be seen as storying with people from a cultural perspective, it is easy for service providers to unwittingly impose their values and beliefs on the way they provide FP information. In such an environment, relevant training on culturally appropriate counselling techniques and clear guidelines on how to communicate information with clients are equally important.

6.4.2.3.5 Availability of Contraceptive Supplies

The main contraceptives available at the clinic were injectables (Depo Provera), Jadelle (implant), OCPs and condoms. IUCDs were available when trained health providers visited the Kia AHC. Those wishing to have permanent methods such as tubal ligation and vasectomy were referred to the provincial hospital in Buala or the NRH.

Contraceptive supplies were usually ordered and obtained from the National Medical Store in Honiara, with the exception of Jadelle implants, which were sourced directly from the RMNCAH at the MOH. Shortages of contraceptive supplies were commonly experienced at the clinic: '*ia mifala save sot tu bikos samfala taem saplae from Buala na hem save sot, so taem mifala save oda go olketa say hem nomoa*' [we often have short supplies here when Buala is also short. When we place our order, they say they do not have them] (3FPP3). Apart from stock-outs (no stock) from Honiara and transport delays, service providers reported that sometimes it was their failure too: '*Samfala taem mifala nes foget tu olsem failure blo mifala seleva tu mifala no oda kuicktaem, so mifala problem moa lo FP ia bikos olketa metods ia araev leit lo klinik*' [Sometimes we nurses also forget; it is our own failure that we do not submit our orders on time, so we have problems with FP because the methods also arrive late at the clinic] (3FPP3).

Despite this challenge, service providers considered other options if contraceptives like Depo Provera were out of stock: '*wat mi save duim, mi save givim kodom nomoa, bikos kodom na hem save ful olowe lo hia, den taem meresin araev mi talem olketa kam tekem*' [what I used to do is I would

give them condoms because condoms are always available here; when the other contraceptives arrive, I tell them to come and take them] (3FPP3). However, this was not always acceptable to everyone. Some people accepted using male condoms, but others did not want to use them: '*so go go olketa babule kam back moa…olketa woman bat no usim female codom tuia*' [so, they ended up getting pregnant again … women also did not use female condoms] (3FPP1). Although condoms were always available at the clinic, they may not have been readily accessed and used for contraceptive purposes alone: '*mifala givim folom record blo mifala lo FP klinik tuia, bata samfala man kam askem ia ating olketa go fishing moa lo olketa samting ia*' [we give, according to our FP clinic records, but some people who come to ask for condoms might use them for fishing.] (3FPP2).

At the provincial level, a FP manager also expressed concern about contraceptive availability when their team recently visited all the clinics to do a stocktake on FP commodities:

> *mifala go raon kaontim an go lukim evri pharmacy ia olketa ia aot of stok nomoa, an olketa nes kipim expae wans tu … olketa se mifala hospital garem bata mifala tu aot of stok tuia lo samfala komoditis … mi wis everiting hem avaelabol … so hao na bae mekem olketa komoditis ia avaelabol lo klinik everitaem?* [we went around to count (FP contraceptives) and look at every pharmacy, they were out of stock and nurses kept expired ones … they thought we had them at the hospital, but we were also out of stock with some commodities … I wish everything was available … so how can we make all these commodities always available at the clinic?] (3FPPM1).

The effect of inconsistent supplies of contraceptives has had adverse effects on women and men in rural communities, where unintended pregnancies have occurred because a preferred contraceptive was not available.

6.4.2.3.6 Training for Family Planning Service Providers

In the past, training for contraceptives that required specialised skills, such as IUCD insertion, had been provided only to midwives and a few registered nurses. However, when Jadelle implants were introduced in the country, training for implant insertion was extended to include registered nurses working in rural areas to improve access for women and girls in those areas: '*taem mitufala train lo Jadelle den mitufala save givim … bat lo putum IUCD na mitufala no train lo hem*' [After our

training on Jadelle implants, we are able to give implants … but we are not trained to insert IUCDs] (3FPP3). Women who requested IUCDs could either access this method of contraception during a provincial FP manager's supervisory visit to the clinic or could be referred to Buala Provincial Hospital if they missed the service provider's visit. The provincial FP manager confirmed:

> *evritaem mifala go tua, famli planing hem olwes kam insaed tu…mi tekem evri tul blo famili planing osem jadel, copper T, everiting mifala go wetem. Famili planig hem integret wetem olketa nara programs mifala ranem* [Family planning is always included every time we go for tour (supervisory visits) … I take all my family planning tools like Jadelle implants and Copper T (IUCD device); we go with everything. Family planning is integrated with all other programmes we deliver] (3FPPM1).

For contraceptive methods beyond the service provider's scope of practice—such as vasectomy and tubal ligation—clients were referred to the hospital. Interestingly, only service providers commented on their need for FP training; users and non-users did not mention service providers' lack of competence in providing FP services. This may mean that service users and non-users trust that service providers were capable and could provide FP services and contraceptives.

6.5 Integration of Data

Table 6.4 outlines the main results and findings from analysis of the data collected for the Kia AHC.

Table 6.4

Integration of Results from Case Study Three, Kia AHC

Context	FP clinic services audit	FP clinical records audit	Qualitative interviews	Integration of data sources
Case Study Three is Kia AHC, a government-run health clinic representing a health facility in a rural setting in Isabel Province of Solomon Islands Kia AHC manages Zone 5, with an estimated population of 4,886. Two female and one male staff provide FP services at Kia AHC.	FP services with four temporary contraceptive methods available once a week at the clinic, integrated with postnatal services. HIV services not available and not provided at Kia. STI services not integrated with FP but available at the outpatient clinic. Outreach services not regular. Counselling services mostly available for women. Fewer young men than young women received counselling from the clinic. Fertility awareness and natural methods counselling not routinely provided. Two registered nurses and one nurse aide (two female, one male) staffed Kia AHC. All staff had basic FP training. Two registered nurses had additional training to provide implants but not IUCD insertion. Only one registered nurse had specialised skills to manage youths and high-risk populations at the clinic.	There was an increase in occasions of service for FP when the Jadelle implant was introduced in 2015. Most recorded occasions of FP service were implants, followed by injectables and OCPs. There were no records for IUCDs, male and female condoms, including permanent methods. Most occasions of FP service were recorded for clients aged 25–44 years, followed by those ages 20–24. No occasions of FP service recorded for those 14 years and under. Few occasions of service reported for clients above 45 years. Married women had more (>90%) occasions of service than the unmarried group.	FP services available once a week to clients who lived close to the clinic and offered everyday to those who lived far from Kia AHC. FP services focused on women (predominantly married). However, some young people and men also attended FP clinic. Outreach clinic did not always occur; depended on funds being available for transport costs. STI services provided at the outpatient clinic, not integrated with FP. HIV service not available at Kia AHC. There was lack of FP awareness raising in communities and thus strong dependence on informal sharing about FP through storytelling. Most people gained FP information and knowledge through informal sources. Involved existing community groups in FP to reach people in communities.	With limited available audit data at Kia. Results showed FP services available with four temporary contraceptive methods at Kia AHC, however, not everyone accessed the services. FP service integrated with postnatal clinic, so predominantly focused on and attended by women. The availability of a male service provider enabled some men to access FP at Kia. Recognising young people's concern for privacy and their desire for a friendly service provider at the clinic important for reaching young people. Clients seeking STI treatment at the outpatient could potentially be reached with FP at the same time. No regular outreach services, because of financial constraints. LARCs preferred by women.

Context	FP clinic services audit	FP clinical records audit	Qualitative interviews	Integration of data sources
	Kia AHC received supervisory visits from the provincial health FP supervisor; however visits included all other clinic services, not only FP. Visits to review FP services were often compromised. LARCs such as implants and injectables available and used more often than oral pills. Stock-outs often took 1–6 months to replace. Clients seeking permanent methods referred to Buala Provincial Hospital in Isabel or the NRH in Honiara. No separate rooms available for FP clinic at Kia. Outpatient clinic used for consultation and delivery room used for physical and internal examinations. Hand-washing station not available, with very few IEC materials. Basic counselling job aids available such as flip charts, posters, pelvic and penile models but IEC materials not up to date. Referrals made only for tubal ligation and vasectomy.	More male than female clients reported attending the outpatient clinic for treatment of STIs.	Friendly and non-judgmental attitudes of service providers created demand for FP services and encouraged users and non-users to visit the clinic. FP service users and non-users need privacy at the clinic for consultation in FP. Distance and cost of travel to Kia AHC affected access to FP for those who lived in settlements outside Kia. Sociocultural values and religious beliefs posed challenges to access and acceptance of FP. FP services need to be provided in culturally acceptable approaches, to reach people in the community. Commonly used contraceptives available at the clinic, with trained staff. Consistent supply of preferred contraceptives important.	Service for permanent methods not available; referral required. Fewer counselling services offered to men and young people than to women. Recognition of importance of informal knowledge sharing about FP and strong trusting relationships with outreach into wider communities. This space could be used as an opportunity for future counselling and awareness raising.

6.6 Summary Discussion

FP services and contraceptives were available at the clinic facility one day a week, integrated with the postnatal clinic where mostly married women attend. Kia AHC did not have a separate space for FP consultation nor a private room for counselling and examination. The area for outpatient clinics was used for FP consultation and counselling. Outreach services were also available and planned for weekly visits to communities living outside Kia; however, these communities could only be reached by outboard motorboat if funds were available to meet transport costs and fuel. Furthermore, outreach services included all other clinic services, meaning adequate staffing and time was required to make FP available and accessible during outreach. Those who needed treatment for STIs or presented with sexual health issues would visit the outpatient clinic. Services for HIV were not available at the clinic.

Four types of contraceptives were available at the clinic: the injectable (Depo Provera); Jadelle implant; OCPs; and condoms (male and female). Contraceptive stock-out often took between one and six months to rectify. Counselling for specific methods was usually offered when clients indicated they wanted to access/take FP at the clinic. However, counselling for natural FP methods such as ovulation or calendar were rarely done and not routinely offered. Although all staff at the clinic had received basic training to provide FP services, not all could provide effective counselling sessions for all methods. Some staff needed additional training for specific skills such as insertion of IUCDs and implants. Those seeking tubal ligation and vasectomy were referred to hospital for the procedure.

Differing sociocultural values and beliefs about FP were expressed by some participants and seen as affecting access and acceptance. However, users and non-users did not resist FP because of their values and beliefs; rather, they acknowledged its importance and benefits to themselves and their community. FP will need to be provided considering how it can be made accessible and acceptable to the community and not only convenient for the service provider. The sociocultural or religious barriers could be resolved by listening and talking to people to understand their context and dealing with barriers accordingly. Health workers need training to improve interpersonal relationships and deal with young people and men in the context where they live.

Findings from qualitative interviews were consistent with those from the audit of FP services and review of FP clinic records. Women, mostly married, were accessing and using the service. While men and young people rarely accessed FP, the availability of a male provider enabled some men and young people to access FP at the clinic. Current FP services were seen as focusing only on women. Although FP services and contraceptives were available, the lack of accurate information and understanding about the service by people; service providers not establishing positive relationships with people; and privacy at the clinic facility, had together exacerbated other challenges and barriers to access and acceptance of contraceptives.

Storying of FP information will need to accompany a friendly approach at an individual level to build and maintain a working relationship with people at the community level. This FP story must be clearly communicated between individuals, community groups and health workers wherever appropriate to deal with the challenges of availability, accessibility and acceptability.

6.7 Chapter Summary

In this chapter, I have described the context and setting of Case Study Three, described the methods of data collection, presented the results and findings, and provided a summary of within-case analysis.

In the next chapter, I synthesise the results and findings of the three case studies and analyse the differences and commonalities that I have identified across them. Figure 7.1 is the thesis structure showing cross-case chapter in the thesis.

Chapter 7: Cross-case Analysis

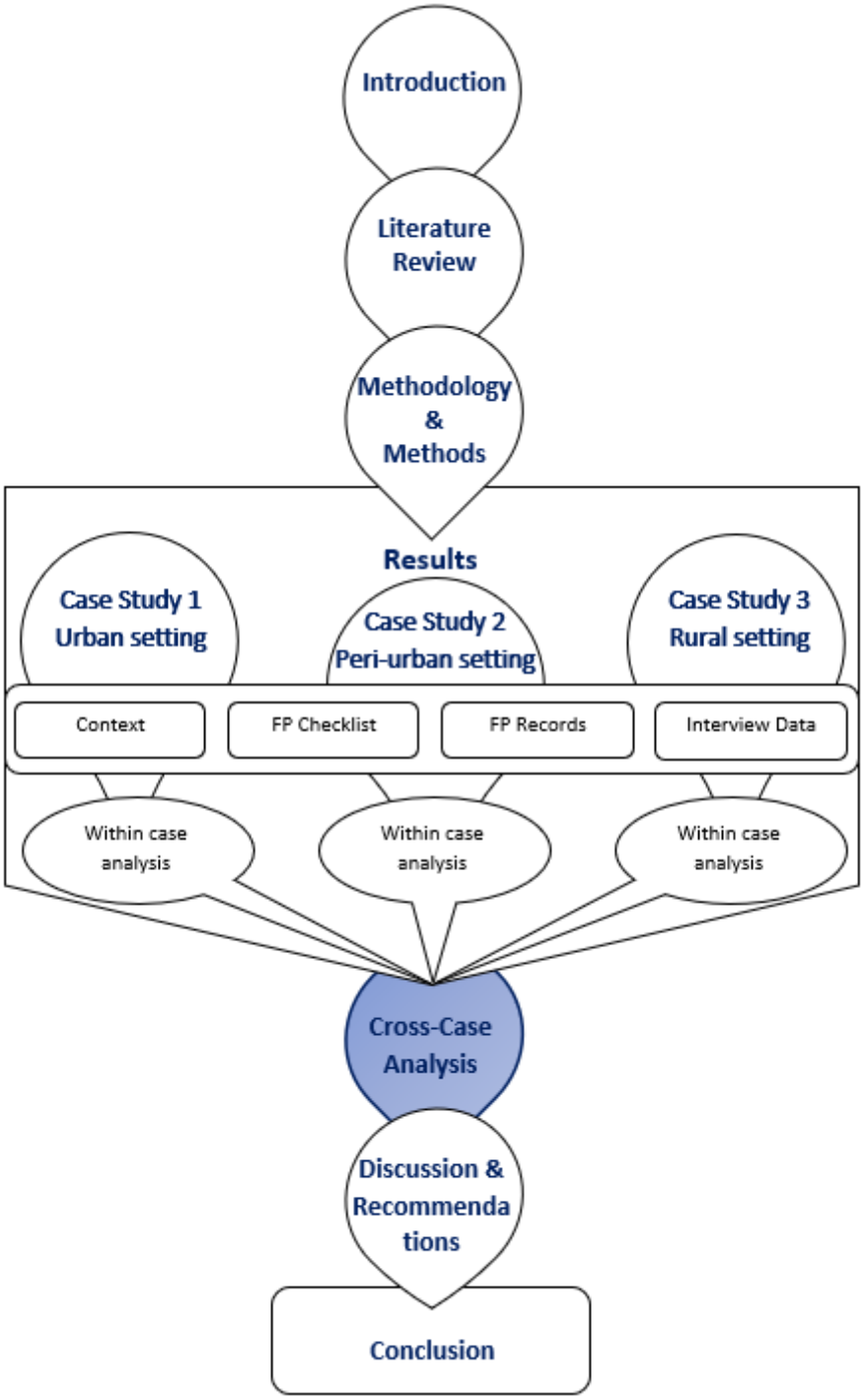

Figure 7.1. Thesis structure—Cross-case Analysis

7.1 Chapter Outline

This chapter presents a synthesised cross-case analysis of Case Study One, Two and Three. The chapter includes a table summarising the key findings across all three case studies and a comparative analysis of the main issues identified across each case. Figure 7.2 outlines the integration of all three case studies into the cross-case analysis.

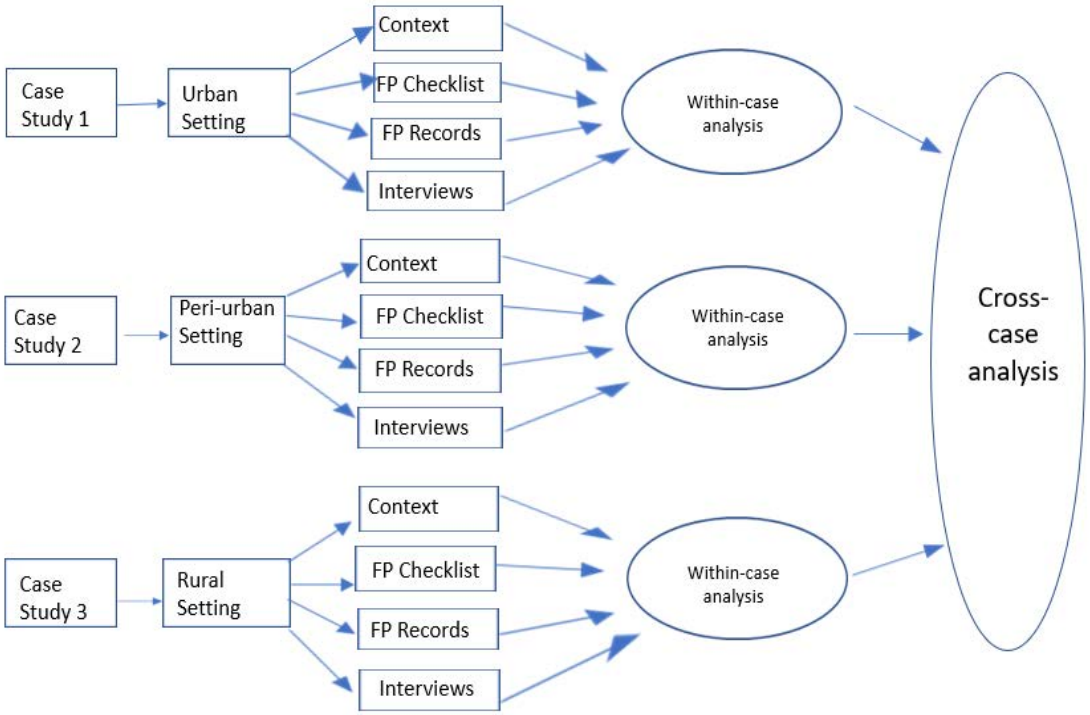

Figure 7.2. Outline of Chapter 7

Table 7.1

Summary of Key Findings Across the Three Case Studies

Key results	Case Study One: Rove Urban Clinic	Case Study Two: Helena Goldie Hospital	Case Study Three: Kia AHC

1. Context data	• UHC in Honiara
	• Government-run service
	• Catchment population: 22,646
	• Total staffing: 11 (10 female, 1 male)
	• Staff providing FP: 4 (all female)
	• Services offered:
	  o general outpatient
	  o child health/IMCI
	  o antenatal
	  o FP and postnatal
	  o outreach
		• Peri-urban hospital in Western Province
		• Faith-based service
		• Catchment population: 27,916
		• Total staffing: 6 (all female)
		• Staff providing FP: 6 (all female)
		• Services offered:
		  o child health/IMCI
		  o antenatal
		  o FP and postnatal
		  o women's health
		  o outreach
			• AHC in a rural setting in Isabel Province
			• Government-run-service
			• Catchment population: 4,886
			• Total staffing: 3 (2 female, 1 male)
			• Staff providing FP: 3 (2 female, 1 male)
			• Services offered
			  o general outpatient
			  o child health/IMCI
			  o antenatal
			  o FP and postnatal
			  o outreach
			  o after-hours emergencies

2. FP clinic checklist	• Weekly FP clinic integrated with postnatal • Trained female FP staff available • Irregular external supervision to review FP • No outreach service for FP	• Weekly FP clinic integrated with postnatal, but available any day to those who lived far from the hospital; FP available every day in the maternity ward • Trained female FP staff available • Regular external supervision but excluding review of FP • Outreach FP focused on MCH and FP	• Weekly FP clinic integrated with postnatal, but available any day to those who lived far from clinic • Trained staff available (limited) • Regular external supervision including review of FP and other clinic services • Outreach FP available including all other clinic services

Key results	Case Study One: Rove Urban Clinic	Case Study Two: Helena Goldie Hospital	Case Study Three: Kia AHC
3. FP clinic records audit	• Sufficient records and reports accessed • Incomplete and inconsistent entries in records; additional record book used to record attendances for Jadelle implants • More attendances by married women for FP thatn for unmarried women, men and young people	• Limited records and reports accessed • Missing record books, incomplete and inconsistent entries; additional record book used to record attendances for Jadelle implants • More attendances by married women for FP than for unmarried women, men and young people	• Only records accessed, no reports • No reports kept at clinic; incomplete and inconsistent entries; one record book used for all FP contraceptive attendances • More attendances by married women for FP than for unmarried women, men and young people
4. Qualitative themes			
Availability of FP services and contraceptives	• Weekly FP integrated with postnatal service • FP counselling for those who attended clinic • Five temporary contraceptives available (implants, injectables, IUCDs, OCPs and condoms) • Adequate space, equipment and providers trained in provision of FP • Outreach FP not provided • Youth-friendly services provided when sought, service available at another clinic	• Weekly FP integrated with postnatal service; every day at the maternity ward and to those who lived far • FP counselling for those who attended clinic • Five temporary contraceptives available (implants, injectables, IUCDs, OCPs and condoms) • Adequate space, equipment and providers trained in provision of FP • Outreach FP provided; depended on funding to implement • No clinic space for youth-friendly services, advice provided outside clinic facility	• Weekly FP integrated with postnatal service; any day to those who lived far • FP counselling to those attending clinics • Four temporary contraceptives available (implants, injectables, OCPs, condoms); provider for IUCDs not available at clinic • Less adequate (compared to case one and two) facility and equipment; not all providers trained for FP • Outreach FP provided; depended on funding to implement • No clinic space for youth-friendly services: some young people served outside clinic facility, some signed consent forms for themselves to receive contraceptives

Key results	Case Study One: Rove Urban Clinic	Case Study Two: Helena Goldie Hospital	Case Study Three: Kia AHC
Accessibility of FP services and contraceptives			
Non-discrimination	• FP services not accessible to all. Stigma, providers' negative attitudes and focus of FP clinic prevented access for young, unmarried and the male population	• FP services not accessible to all. Stigma, providers' negative attitudes and focus of FP clinic prevented access for young, unmarried and the male population	• FP services not accessible to all. Stigma, providers' negative attitudes and focus of FP clinic prevented access for some young people and men; however, young people and men were able to access FP
Physical accessibility	• Clinic within physical reach, for catchment population • Could be reached by foot or vehicle • Physical layout and focus of FP room only accommodated women • Men were involved when spouses had issues with childbearing	• Some people in the catchment area lived near the hospital; most lived far away • Clinic could be reached by foot, bus, hand-paddled canoe and motorised boat • Physical layout and focus of clinic facility: MCH/women's health services • Men were involved when spouses had issues with childbearing, or children had health issues	• Some people lived near the clinic; most lived far away • Clinic could be reached by foot, hand-paddled canoe and motorised boat • Physical layout: no designated room for FP, lacked privacy • Men were involved when there was a need to discuss FP with both husband and wife

Key results	Case Study One: Rove Urban Clinic	Case Study Two: Helena Goldie Hospital	Case Study Three: Kia AHC
Economic accessibility (affordability)	• FP and contraceptives free for all • Delays in disbursement of government funds affected follow up of FP clients and supervision • Participants paid travels costs to reach the clinic	• FP and contraceptives free for all • Delays in disbursement of government funds limited outreach services; church management unable to support outreach programmes • Participants paid travel costs to reach the clinic	• FP and contraceptives free for all • Delays in disbursement of government funds limited outreach services; participants paid travel costs to reach the clinic; expensive to travel from village to clinic
Information accessibility	• FP awareness raising mostly provided at FP clinic and schools and was inconsistent, information targeted women • Less awareness in communities; thus not reaching everyone • Weekly FP radio programmes not reaching everyone • Participants unable to engage with FP information: need to balance advantages and disadvantages of FP story • Participants wanted to know more about FP • FP information not clearly communicated in simple language and culturally acceptable ways: preferred to be in gendered groups (male/female) • Participants with limited FP knowledge less likely to visit FP clinic	• FP awareness raising provided at FP clinic, school and community visits (inconsistent) • FP information not reaching everyone; preferred presentation in gendered groups (women, men and youths) • Access to many information sources and low literacy contributed to misinformation about FP • Role play/dramas relating to real-life situations enabled understanding and access • Participants wanted to know more about FP • Information not simplified for participants with limited literacy and formal education • Participants with low literacy or education level hesitant to visit the clinic because of fear and not knowing how to talk to the nurse	• FP awareness raising mostly provided at FP clinic • School and community awareness inconsistent, awareness did not reach everyone • Low literacy in rural villages affected accurate understanding about FP • Informal storying and formal schooling were main ways of receiving FP information • Participants wanted to know more about FP • Participants with limited FP knowledge less likely to visit FP clinic

Key results	Case Study One: Rove Urban Clinic	Case Study Two: Helena Goldie Hospital	Case Study Three: Kia AHC
Acceptability of FP services and contraceptives	• FP service provision not culturally sensitive: only women-focused FP provided by female providers, acceptable for women • No male provider meant men not involved: FP not acceptable to men • Providers expected to see more women than men at FP clinic • Lack of confidentiality and privacy and judgmental attitudes from service providers affected unmarried young people's and men's acceptance of services	• FP service provision not culturally sensitive: only women-focused FP provided, by female providers, acceptable for women • No male provider meand men not involved: FP services not acceptable to men • Providers not thinking about men when providing FP service • Service providers' unhappy outlook and judgmental attitudes affected unmarried young people's and men's acceptance of FP services	• Availability of a male service provider enabled FP to reach men, despite women-focused FP • Family relationships with service provider (brother/sister) and perceived confidentiality hindered acceptance of FP • Having both male and female service providers enabled acceptance of FP for men and women • Being kind, friendly, accepting and establishing good relationships removed sociocultural barriers and enhanced acceptance of FP

7.2 Cross-case Summary

7.2.1 Organisation and Structure of Family Planning Services

FP services and contraceptives were available at all three case study sites. Overall, there were more similarities than differences in the ways the FP clinics operated, the services provided and the challenges to inclusive service provision. As described in Chapter 1, all health clinics studied similarly functioned as AHC Level 1, except Case Study Two where the facility was classified as AHC Level 2, being a small hospital that provided additional health services, including inpatient, outpatient and PHC services such as the Reproductive Health Clinic. Case Study One, an urban setting and Case Study Three, a rural setting, were both government-run health clinics whereas Case Study Two was operated by a FBO in a peri-urban setting. Nonetheless, all health clinics were supported by the government in terms of funding and training of staff for FP, including provision of commodities such as contraceptive methods and supplies. All three services faced supply inconsistencies because of delays in distribution of finances and supplies through government systems.

7.2.2 Availability of Family Planning Services

Located in urban, peri-urban and rural settings, these clinics served different population and cultural groups, yet their clinic structures and approaches to providing FP were similar. FP was one of the many services provided at the clinic facilities, integrated with the postnatal service on a weekly basis. In contrast to the urban and rural settings, FP in the peri-urban case was uniquely provided alongside other MCH services at a separate Reproductive Health Clinic. In addition, FP was available every day at the hospital maternity ward to reach women after giving birth, and to women admitted to the children's ward with sick children. Aside from weekly FP services, FP and contraceptives were available opportunistically at any other time for those who lived far away and visited the clinic.

Basic clinic infrastructure and FP services, contraceptives, equipment and trained staff were available in each of the three settings, although resources, infrastructure and staff training for all contraceptive methods were minimal and inadequate in the rural setting relative to the urban and peri-urban settings. More contraceptive options were available in the urban and peri-urban setting than in the rural setting. Lack of availability was attributed to inadequacy of distribution systems and lack of

trained staff, rather than availability or policy settings. For example, the urban clinic is very close to the National Medical Store in Honiara, which supplies contraceptives, and the peri-urban clinic is near the provincial health headquarter in Gizo and has potential for regular transport of supplies.

FP services provided at the clinic facilities did not require specific funds from the government as they were part of routine clinic activities. However, taking FP to the communities in outreach or satellite clinics depended heavily on availability of funds to meet staff travel expenses. At the peri-urban and rural case sites government funding was needed to pay for petrol to reach remote villages with FP services and contraceptives. At the urban case site, however, FP was not included in outreach services; funding affected only supervisory visits by FP managers and follow-up phone calls to FP clients. Supervisory visits at the peri-urban and rural case study sites occured regularly, but at the peri-urban site these visits did not include review of FP services, unlike in the rural setting where FP was included along with other clinic outreach services.

Outreach clinics were a cost-effective way to reach many people with FP in peri-urban and rural settings but were not included as an outreach service by the urban clinic. People living remotely from the rural clinic setting who could not afford transport to the clinic facility depended on outreach services to reach them in their villages. However, while outreach services conducted at the peri-urban setting provided focused reproductive health including FP services with an adequate number of staff, outreach provision was challenging in the rural setting. Usually only one service provider was available and expected to provide multiple clinic services including outpatient and preventative services such as NCD screening and MCH, including FP. This situation resulted in FP becoming less prioritised and provided only when the service provider had time. Importantly, women hesitated to seek FP during outreach clinics if the service provider was a male.

In terms of clinic record keeping, more records were available and audited at the urban case study site than in the peri-urban and rural settings. The audit highlighted issues with record keeping and the quality of data available across all cases. Missing or incomplete records, and inconsistent entries of primary information were common features in the records. There were challenges in retrieving reports from the peri-urban and rural settings and their respective provincial headquarters.

7.2.3 Accessibility of Family Planning Services

FP services at the three clinics were more focused on women and less on men and young people, with mostly female providers providing the service. Consequently, FP clinics were predominantly attended by older, married women. This was a common feature in the provision of FP services across all cases, despite qualitative findings indicating men were willing to be involved in discussions about FP. FP clinics were mostly attended by married women who already had a strong intention to use contraceptives. Men were only actively involved when service providers identified life-threatening health risks for their spouses or when they had many children (more than four) with less than a one-year birth interval who presented with recurrent childhood illnesses.

In all three cases young people, especially young women, sought FP advice or services when they had already encountered health issues such as unintended pregnancies or STIs; they rarely sought FP advice for prevention. Young people feared being judged and stigmatised because unmarried pregnancy was socially unacceptable and religiously condemned. Most young people who could not attend the FP clinic were expected to attend the outpatient clinic for FP or other sexual health needs. In the urban setting, young people's needs were also being met through a youth-friendly space at a nearby clinic attended by most young people in the city because the peri-urban and rural settings lacked a separate space for youth services. In the peri-urban case, most attendees at the FP clinic were young women; young men were rarely seen at the clinic, although some young people frequently sought the service after hours and informally outside the clinic facility from the service provider. In the rural case study, young people were provided with information and FP anytime and anywhere they met a service provider. The availability of a male service provider made access easy for the young men. In the rural case study, though some parents supported their sons and daughters in utilising FP, this was not universal.

Contraceptives and FP services were provided for free at the three clinics but participants met the cost of reaching the clinic facility to access FP. Those who wanted contraceptives went to the clinic and talked to the service provider about their needs and intentions regarding FP. Unlike participants living in peri-urban and urban settings, participants living in the rural setting reported that

reaching the clinic was expensive as most villages were remotely located from the clinic and it required money for fuel to travel on motorised boats.

Although there were no procedural steps for participants to follow when seeking FP services at the three case study sites, service users expressed a need for clear and consistent information to realise their FP needs and be motivated to seek the service. Participants in all three settings expressed that FP information was mainly given at the FP clinic on scheduled FP clinic days, and that awareness of the service was lacking in communities. People who had information were motivated to seek FP services, unlike those who did not know much about FP and available contraceptives. Participants who had less knowledge about FP or had low literacy or education levels were often reluctant to visit FP clinics as they did not know how to communicate their FP needs to the service provider. While lack of knowledge was not prominent in the urban case study, it was particularly an issue in the peri-urban and rural case study settings where most people had only completed primary education, and some had never entered formal schooling.

In all three case study settings, there was siloing of SRH services, with STI and HIV services not integrated with FP services. Both STI and HIV services were provided at the general outpatient clinic in the urban and peri-urban cases, whereas in the rural case only the STI service was provided and the HIV service was unavailable. Men, young people and some women visited the outpatient clinic when they needed these services.

7.2.4 Acceptability of Family Planning Services

In all three cases, the provision of FP services was dependent on self-referral, meaning that clients consulted the service provider and expressed their need for use. As such, the positive attitude of a service provider was important to facilitate access to FP and contraceptive services. Participants from all case study settings expressed that a friendly service provider who was kind and non-judgmental with a caring attitude helped them to be calm, and to feel safe and confident to communicate with the service provider about their personal circumstances and FP needs. Responses from the urban setting demonstrated a need to provide space for male clients and to work with community groups. In addition, in the peri-urban and rural settings, clear communication and mutual relationships with service providers were drivers that enabled people in the community to access FP.

Current FP service provision in the three case study settings showed limited consideration for people's culture including sensitivity to the gender and age of those who sought the services. Most participant users and non-users expressed preferences for male providers to see men, and female providers to see women for FP and contraception. Therefore, it was proposed that having both female and male service providers may resolve gender barriers to accessing FP in the urban and peri-urban settings. In the rural setting, if the service provider was posted to work in their own community, there were concerns that service providers' family relationships (e.g. brother/sister) within the community may hinder acceptance of FP, as it was a cultural taboo for siblings of the opposite sex to discuss SRH topics with each other.

Positive attitudes of men and young people towards FP services and contraceptives were observed in the three case studies, yet they had limited access as the services were not focused on them, and only one of the three case study sites had a male service provider. The idea of a separate FP clinic for men was proposed by service providers but not universally welcomed by men and young people in the peri-urban setting. In the rural setting, however, men and young people were happy to attend FP services at the clinic—they just needed privacy. Another challenge to young people's access to contraceptive services in the rural setting was parental disagreement. Young people aged 14 years or under were mostly under the control of their parents regarding decisions about contraceptive use. In response to this challenge, young people in the rural case study setting signed consent forms to access contraceptives

7.3 Chapter Summary

In this chapter, I have presented a cross-case analysis of the results for the three case studies and compared and contrasted the results to highlight important issues that are discussed in the next chapter.

In the next chapter, I discuss the important issues revealed by the results in relation to the five action areas of the Ottawa Charter—the theoretical framework applied to expand and situate study results. I also link findings with the literature, explore strengths and limitations of this work and

develop some recommendations for future FP and SRH care in Solomon Islands. Figure 8.1 is the thesis structure showing the discussion and recommendation chapter in the thesis.

Chapter 8: Discussion and Recommendations

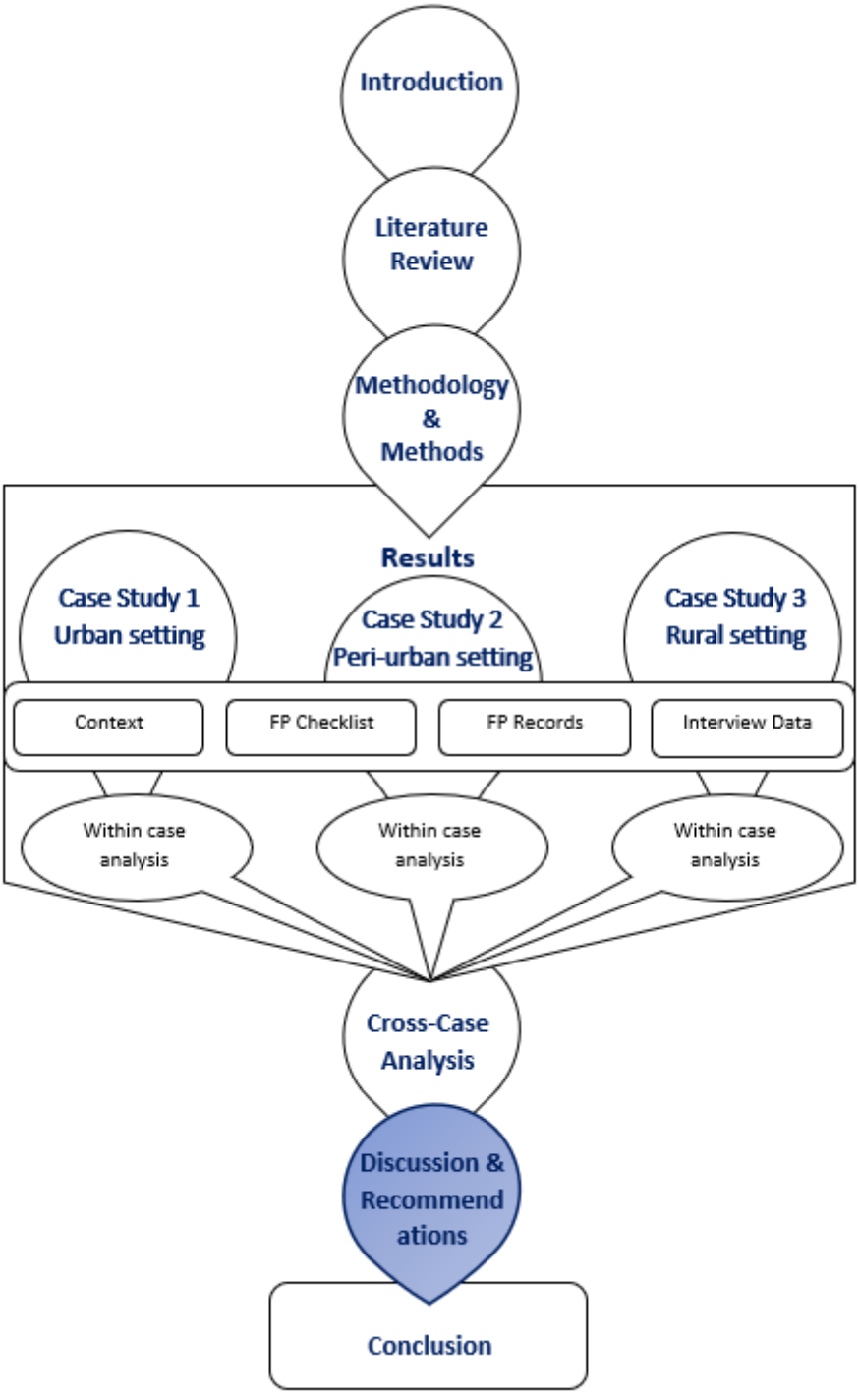

Figure 8.1. Thesis structure—Discussion and Recommendations

8.1 Chapter Outline

In this chapter I revise the study aim and provide a summary of the results in relation to relevant literature. I describe the Alma-Ata Declaration and the Ottawa Charter as the theoretical frameworks used to expand and situate results. Specifically, relevant results are discussed in relation to the five action areas outlined in the Ottawa Charter. I demonstrate the quality of the research by applying the principles of Yin (2018); identify the strengths and limitations of the study; and present practical recommendations for improved FP service provision in Solomon Islands.

8.1.1 Summary of Research Results

This multiple mixed methods case study research aimed to explore the availability, accessibility and acceptability of FP services in an urban, a peri-urban and a rural health clinic in Solomon Islands. A comparative case study design was used, with context data collected from reports and field trip observations, and quantitative data collected from FP clinic checklists and record and report audits. Analysis of quantitative data was undertaken using descriptive statistics in Microsoft Excel. Qualitative data were generated from semi-structured interviews with women, men, service providers and managers. Interview data were thematically analysed using NVivo software. It was found that FP services and the most common contraceptives were available at all three clinics; however, not everyone was able to access these services.

FP services at the clinics were predominantly provided as MCH services; thus, they mostly focused on married women. FP services were usually provided by female service providers. Men and unmarried young people had much less access to FP services and use of contraceptives, despite contraceptives notionally being available at the FP clinic for everyone. Between three and five modern temporary contraceptive methods were available at the clinics included in the study, with men having one option available to them; that is, condoms. Men and women seeking permanent contraceptive methods were referred to provincial health services or NRH.

Access to, and acceptance of FP services and contraceptives were affected by the mother-centred focus of services and organisational and physical structure of clinic facilities. In addition, a lack of information, awareness and promotion of FP, along with negative attitudes of service providers

and lack of sociocultural sensitivity in the provision of services, affected access and acceptance of FP services. Despite barriers to access, participants reported acceptance of FP services and contraceptives at all three clinics when they were provided in a friendly and culturally sensitive manner.

8.1.2 Theoretical Frameworks to Expand Understanding of Research Results

Theories can assist with understanding causal pathways between the various factors that result in health or disease, or health promoting behaviours, and can thus guide the planning and design of interventions or implementation strategies (Collins & Stockton, 2018). Theoretical frameworks draw on theory to describe identified factors and relationships between the factors to interpret and situate findings (Bazeley, 2021; Datta, 2013). Given the multilayered and interacting biological, sociocultural processes and environmental factors that determined access and acceptance of FP services and contraceptives in Solomon Islands and beyond, application of a theoretical framework is crucial to understanding how existing factors influence the availability, accessibility and acceptability of FP services and contraceptives, as evidenced in the case study results (Paradies, 2018).

8.1.3 Rationale for Choice of Theoretical Frameworks

In this study, I apply the Ottawa Charter (WHO, 1986) as a theoretical framework underpinned by the earlier Alma-Ata Declaration (WHO, 1978). I chose the Ottawa Charter as a theoretical framework for my study as it was evident that people in this study did not act in isolation; therefore, it was important to understand the ways people interacted within their families, communities and environments to understand their experience of FP. The need for a holistic approach in healthcare is outlined in seminal international health documents, including the Alma-Ata Declaration and the Ottawa Charter (WHO, 1978, 2018a, 2020). Through the application of the elements contained in the Ottawa Charter in relation to my data I was able to expand understanding of the research results. This enabled me to develop context-specific strategies to help promote and improve the availability, accessibility and acceptability of FP services in Solomon Islands.

8.1.4 Alma-Ata Declaration

Health over the past two centuries has traditionally focused on doctors, hospitals and biomedical advances (Gillam, 2008). Building on the WHO's 1948 definition of health as 'a state of

complete physical, mental and social wellbeing and not merely the absence of disease' (WHO, 2020, p. 1), the Alma-Ata Declaration in 1978 introduced a more holistic understanding of health by focusing on improving health for all people by moving beyond doctors and hospitals to include social determinants of health and social justice (Rifkin, 2018). The Alma-Ata Declaration was a statement of the International Conference on Primary Healthcare jointly convened by the WHO and UNICEF and held in Alma-Ata, a city in the country we now know as Kazakhstan (WHO, 1978). The focus of the declaration was human rights, concern for equity and community participation. PHC was then declared as the priority for member countries as key to attaining the 'Health for All' goal. The emphasis was that 'Good Health' can be achieved through access to services, education, social and economic status, politics and individual choices (WHO, 1998).

PHC is an essential healthcare service that aims to bring healthcare closer to where people live and work (WHO, 2018c). It is the first level of contact where the national health system meets individuals, the family and the community where they are. Essential healthcare is described as practical and scientifically proven methods that are thought to be acceptable and accessible to all people in the community where everyone can fully participate. (D. B. Evans, Hsu & Boerma, 2013)

The concept of PHC is underpinned by the achievement of universal health coverage and health as a human right (Vega, 2013). The aim of universal health coverage is to ensure that all people obtain the health services they need, while minimising financial hardship. These include essential services from health promotion to prevention, rehabilitation and palliative care across the life span (WHO, 2012). As PHC provides evidence of improvement in access to healthcare, it gained credibility for improving health status and healthcare for large populations. The contributions of the Alma-Ata Declaration that are relevant to this study include holistic care, focus on equity of access to PHC for all and community participation in healthcare (Gillam, 2008). The key elements contained in the Alma-Ata Declaration informed the development of the 1986 Ottawa Charter.

8.1.5 The Ottawa Charter

The Ottawa Charter expands on the deliberations contained in the Alma-Ata Declaration in 1986 (WHO, 1986) following international concern about the need to comprehensively understand people's lifestyles and enact different approaches to remedying public health problems (WHO, 1998).

Evaluation of health education, as an element of public health, showed that education strategies that did not consider social and cultural contexts of health were not effective—there was a need for holistic approach (Dudley & Garner, 2011; Thompson, Watson & Tilford, 2017). The first International Conference on Health Promotion was held in November 1986, where delegates agreed upon and launched the Ottawa Charter. This charter aims to provide a roadmap of 'Health for All' by the year 2000 (Walraven, 2019). The charter empowers people globally to promote public health, including consideration of determining factors of health such as individual, sociocultural, socioeconomic and environmental factors—all preconditions for health for all (Potvin & Jones, 2011).

The historical significance of the Ottawa Charter includes its reorientation away from efforts to only avoid disease towards health promotion using a broader multisectoral approach (WHO, 2018a). In addition, priorities were given to empower individuals, communities and governments, with a focus on contexts where people live and how these contexts influence healthy behaviours, or not. The Ottawa Charter defines health promotion as 'the process of enabling people to increase control over, and to improve their health' (WHO, 1986, p. 1). The prerequisites for health are identified as 'peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity'. The Ottawa Charter articulates core values of 'equity, participation and empowerment' as originally highlighted in the Alma-Ata Declaration. Below is the Ottawa Charter framework, which outlines three strategies and five areas for action (Thompson et al., 2017; WHO, 1986, pp. 1–3).

Strategies:

1. advocacy for favourable conditions for health
2. enabling all people to reach their full health potential
3. mediating between different interests in society for the pursuit of health.

Areas of action:

1. building healthy public policy, at all sectors and levels of government
2. creating supportive environments, to improve living and working conditions
3. strengthening community actions in priority setting and in strategies
4. developing personal skills, through education for health and life skills
5. reorienting health services towards health promotion.

The Ottawa Charter is highly relevant to Solomon Islands given its cultural and linguistic diversity, geographically dispersed and largely rural population, ongoing challenges to health service access, low health centre staffing levels and limited health services funding. The people of Solomon Islands have inhabited the archipelago for over 2,000 years (Encyclopedia Britannica, 2021), before the British Solomon Islands Protectorate declaration in 1893. In 1978, the people of Solomon Islands gained independence from Britain, with the new nation founded on strong Christian principles and values. Today both religion and culture inform the way of life in Solomon Islands and have unifying or divisive influences on Solomon Islands society (Solomon Islands Government, 2017). Much of the population still adhere to some traditional beliefs and values about causes of illness and good health, along with Christian interpretations of disease and its causation.

Following the 1986 Ottawa Charter, Pacific Island countries have also realised the importance of the elements of health promotion and PHC as stipulated in the Ottawa Charter. In 1995 Pacific Island countries agreed to adapt the Healthy Islands Initiative also known as the 'settings approach' and signed an agreement at the Health Ministers Meeting at the Yanuca Island Declaration in 1995 in Fiji. In their subsequent meeting in Madang in 2001, they reaffirmed that the Healthy Islands approach provides an overarching framework for health promotion and health protection in the Pacific. The core elements of this settings approach were community action, managing the environment policy and infrastructure development (WHO, 1995). However, despite these hopes, this settings approach has been constrained by the same things I find in the delivery of FP services at the clinic level such as resource constraints, timeliness, professionalism, accountability and support from the government (WHO, 2015). Prevention and health promotion have received less attention than direct service delivery, including limited community participation and intersectoral collaboration (WHO, 2019).

Current health services in Solomon Islands focus more on treating individual illnesses than on community prevention and health promotion. Despite progress made with some health indicators, a vast gap still exists in Solomon Islands that requires reducing inequality in health service to improve population health. Although the aim of the Ottawa Charter to promote a societal-wide approach to health is still relevant today and its principles have been widely applauded, they have not been transferred to practical solutions to improve health in different contexts (Thompson et al., 2017). I

have chosen this framework as it is relevant to the shift that is required—as evidenced by my results—to a more societally situated FP service. While many of these results could be examined against all elements of the Ottawa Charter, I have chosen to discuss the results that are most relevant and have the most potential for informing practice, policy and actions under the five Ottawa Charter action areas. I now discuss the five elements or areas of action in relation to the findings.

8.1.6 Building Healthy Public Policy

The Ottawa Charter highights that health promotion actions must not only be implemented within health sectors and healthcare service delivery (WHO, 1986). It emphasises that policymakers in all sectors at all government levels should put health as a priority on sectoral agendas. Building healthy public policy requires all levels of government, or organisations that focus on improving health, ensure that legislation and/or relevant policy consider's the health needs of all people. It involves assessing if policies about population health are effective or if changes to policies are required. Governments, public bodies, unions and NGOs are responsible for ensuring relevant public health policies are built (Fry & Zask, 2017; WHO, 2016a). This action area discusses issues with SRHR policies in FP and clinical record keeping as important contributions to informing public health policies relating to FP.

8.1.6.1 Sexual Reproductive Health Rights

As described in Chapter 1, enshrined in the definition of SRHR is FP as a basic human right of all couples and individuals. This right includes the ability to decide freely and responsibly about the number, spacing and timing of children, and the right to access sexual health services, information, and education (Starrs et al., 2018). Responses from participants in this study demonstrated that SRHR has not been fully realised for many in Solomon Islands. This is evident in the way FP and other SRH services were provided by service providers and accessed, or not, by users at the clinics.

8.1.6.1.1 Sexual Reproductive Health Rights for All

Although the concept of SRHR intends to ensure every individual, including young unmarried people, can access SRH services including FP as their right, this study revealed inconsistent understanding about SRHR and what it meant for FP service providers, users and the community in

the context where FP is provided. The lack of contextual understanding about SRHR often resulted in conflict when incorporating SRHR into a FP service. For example, in the rural setting, service providers knew young people had the right to access contraceptives and on occasions provided them with contraceptives at the FP clinic. Unfortunately, some parents of young people disagreed with the health service provider, arguing that young people should not be given contraceptives as this promotes 'promiscuity', and therefore is not acceptable. This kind of incident led to young people having to sign consent forms to access contraceptives, although consent forms are not generally required to access contraceptives in Solomon Islands and other parts of the world. A signed consent form can be used to show parents that young people have exercised their right to a service, have made the choice themselves and were not 'forced' by service providers to take contraceptives. This typical scenario is an example of tension between individual rights and the sociocultural context in which a service is being delivered. With a currentlly growing youth population (over 50% of the population), increasing rates of teenage pregnancies, limited access to FP and SRH services for young people and outdated FP guidelines, urgent attention to FP service provision is needed in Solomon Islands (Solomon Islands Government, 2017).

While FP is understood to be a basic human right of all couples—that is, that they should be able to decide freely and responsibly the number of children they have, and access sexual health services and information—in Solomon Islands, this understanding is not universal. As mostly women visit FP clinics and obtain contraceptives and counselling without their spouses, as demonstrated by this study, conflict can arise between couples when there is lack of communication and transparency about the woman's intention to use contraceptives. In the same way, when men collect condoms from the clinic without their wife's knowledge, conflict can also arise. Such rights-based SRH issues affect access and acceptance of FP and contraceptives in Solomon Islands.

SRHR may not be fully implemented where these rights appear counter to societal or individual values, cultural obligations and expectations of people in the local context. There seems to be a lack of awareness and understanding about SRHR and their application in the local context. In situations where SRHR are understood, promoted and implemented, there seems to be conflict between service providers, service users and family members who understand these rights differently.

With Solomon Islands being a predominantly communal and patriachal society, the ideas and values of a human rights agenda that embraces individualism, autonomy and choice collide with the values and cultural practices of people in a collective society where decisions about FP may not be an individual decision.

Findings on SRHR issues in this study are similar to reports of SRHR needs assessment in Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu showing that most countries either have no SRH policy in place (or policy is being drafted) or that policies and guidelines are outdated (UNFPA, 2015a, 2015b, 2015c, 2015d, 2015e). These needs assessment reports highlight the commitment of all five countries to preserve the human rights of all population groups, as evidenced by their agreement to a range of international conventions and treaties and are also outlined as priority key result areas in each country's national health strategic plans. However, these countries also recognise an urgent need to develop and implement SRH policies that are socially and culturally acceptable in the local context.

Although SRHR may be challenged by misunderstanding and cultural influences in the Pacific region, there is global evidence for a need to contextualise human rights such as SRHR (WHO, 2014) to the local context. This means that human rights concepts such as SRHR must be enacted in an acceptable context, for them to fulfil their intended purpose. Transnational human rights—that is, rights adopted across national boundaries—need to be applicable to the local context and must resonate with the local cultural framework/values to be relevant and accepted (Merry, 2006). Just as SRHR needs contextual recognition, its application in clinical services also needs to be documented so that relevant policies are created.

8.1.6.2 Clinical Record Keeping

FP clinic records and reports are important because they document implemented activities and are essential for informing and planning important decisions such as determining workforce needs, resourcing health clinics and strategic programme planning. To ensure strong and relevant FP policies are built, access to accurate data is essential.

FP clinic records in the three case studies were completed by service providers who attended to FP clients. Audits of clinic records showed lack of standardised record entries, poor record keeping and inconsistencies in calculating the number of current FP users. For example, in all three case

studies, male condoms were reportedly distributed, but they were either not recorded at all, or inconsistently. Poor record keeping also reflected service providers' lack of knowledge and understanding about the importance and use of information (data) useful for evaluating current practices for improved future FP services. Furthermore, the official FP clinic register book was only used in the urban clinic. The peri-urban clinic used an A4 notebook with relevant FP particulars (demographic and contraceptive data) filled in. At the rural clinic an outpatient register record book was used, and FP particulars were added as required. As the official FP clinic register has not been updated, particulars in the register were either manually added (e.g. new contraceptive methods) or outdated details removed. In all three settings, multiple record books were used to record other SRH indicators such as teenage pregnancy. This resulted in omissions of certain particulars if records were not carefully checked or when multiple service providers completed the records without having common understanding about how to record the information.

Rahman et al. (2019) reported that the data entry phase and omission of entering the data at all are probably the most common errors of data management. These errors can be due to misspellings, missing information or invalid data. Higher incidences of error were seen when multiple personnel entered data. However, Rahm and Do (2000) found that most errors are based on a lack of understanding of data. A recent study involving reproductive health assessment data in Solomon Islands (Nair et al., 2021) reported similar findings of inconsistent data entry and recording in terms of the format in which data are entered or recorded. Another study on SRH involving multiple Pacific Island Countries (Dawson et al., 2021) revealed a widespread lack of data on contraception and SRH indicators, posing challenges to service planning and evaluation. Dawson et al. (2021) also highlighted limited research on contraceptive use, types and the quality of contraceptive services conducted in the Pacific; stressing the importance of standardising data beginning from the initial data entry phases.

To adapt PHC as the national policy to fulfil the 'Health for All' agenda, the WHO recommends that all member states tailor strategies based on country-specific gaps (Homer, 2018; WHO, 2018d). In Solomon Islands, the lack of context-specific health research conducted and the limited capacity to translate research evidence into practice (H. Harrington, 2022) continues to hamper availability of contextually relevant data to inform the building of effective healthy public policy.

8.1.6.3 Recommendations

8.1.6.3.1 Sexual and Reproductive Health and Family Planning Policies Need to Consider Local Values and Beliefs

Policies relating to SRH and FP will need to adopt and incorporate local values and beliefs and needs to be available across multiple sectors. Service providers need to correctly understand policies and how they can be carried out in practice.

8.1.6.3.2 Local Research on Family Planning Issues to Inform Family Planning Policies and Practices

To build strong FP policies in Solomon Islands, context-specific research is needed to create relevant evidence that can be translated into local practice. Service providers also need to be provided with skills to interpret and use evidenced-based information to improve their work.

8.1.6.3.3 Complete and Accurate Clinical Data are Needed to Make Important Clinical Decisions

Quality data are needed to inform effective policy planning and implementation to meet local needs and deal with contextual challenges. In hindsight, implementing more local research in FP will create demand for accurate data recording. It is crucial that urgent attention be given to proper record keeping—ideally in digital form, as this will facilitate future research and provide baseline evidence for important decisions about FP service provision. Access to accurate data is essential for achieving equitable access to SRH including FP, and will inform comprehensive SRH planning, implementation and reporting. Poor record keeping may mean relevant strategies to improve FP for universal access are not identified, and services may not be accurately evaluated for their effectiveness and quality.

8.1.7 Creating Supportive Environments

People's interactions with their environment and with other people are complex, with health also interconnected with other key aspects of societal living (World Health Assembly, 2016; WHO, 2008). The complexity of the people-environment relationship means that a socio-ecological approach to health is critical to enable supportive environments (Golden & Earp, 2012). Responsive action that promotes the creation of supportive environments focuses on where people live, work and play as well as enabling people to make choices that promotes healthly living. Creating supportive environments is defined by the WHO as enhancing healthy social, physical and spiritual environments so that people

can expand their capabilities to be self-reliant in making healthy choices (WHO, 1986). This also involves linking support networks and community services such as specialised programmes that can support people's emotional or financial wellbeing. The supportive environment identified in this action area is the provision of a holistic FP service, where services are provided by friendly FP service providers in a socioculturally sensitive approach (Kilanowski, 2017).

8.1.7.1 Holistic Family Planning Services

Providing holistic approaches to FP services can assist in creating enabling environments for people to make informed choices about FP. Holistic FP services mean that FP takes into consideration the physical, social, cultural and spiritual dimensions of the people seeking FP services (Mitchell et al., 2021). Traditionally, FP is a sensitive topic in Solomon Islands because it requires discussions about sexual and reproductive organs, which is considered taboo in a highly Christianised context. Typically, sexuality and sexual health is not often discussed with the opposite sex (R. B. Harrington et al., 2021). A sensitive approach by FP service providers is required. Providing holistic care requires that service providers are non-judgmental, 'friendly'—that is, they take care of relationships with people (unmarried and married people)—incorporate culturally sensitive approaches (respect and work around people's beliefs and values) and engage the community to be part of the process. Although adaptations to Westernisation and globalisation have influenced people's cultural practices and individual behaviours, holistic culturally and socially relevant FP services are still required.

8.1.7.1.1 Friendly Service Providers

The need for friendly FP providers is an important finding of this study. Participants defined a friendly service provider as one who is happy, speaks kindly, is empathetic and non-judgmental, provides privacy and assures confidentiality. A friendly service provider is needed to break down walls of fear, shame and stigma associated with accessing FP services and using contraceptives. Participants in all three case studies reported how negative staff attitudes negatively affected contraceptive access. The service users wanted to be accepted and not judged when seeking FP services. Service providers, users and non-users recognised the need for someone who is friendly to provide FP services.

When service providers are friendly, positive relationships are created and this enhances cost-effective strategies to improving FP access. In addition to being competent, a positive attitude is a powerful attribute that enables positive connections with clients. Being friendly also reduces the power differential that exists between providers and users. Regardless of how knowledgeable and competent service providers are, if they do not have the right attitude to providing FP services, client access and acceptance of FP services can be affected. A friendly environment is conducive to access and acceptance of FP services. Alternatively, an unfriendly environment sends a preconceived message to potential users that they may be judged if they disclose their intentions to use FP to service providers (Mitchell et al., 2021). Such a perception eventually results in people feeling hesitant to visit the FP clinic, creating less demand for FP.

The need for a friendly FP service provider as echoed in this study reflects ongoing calls for holistic approaches in FP made in other LMICs (Rifkin, 2018; WHO, 2018b). Despite strong evidence of successful outcomes in incorporating holistic care—such as increasing use of contraception; greater participation by both men and women; and lower maternal and neonatal mortality rates—strategies to date have far from reflected the holistic nature of providing SRH services including FP. This same finding was reported in studies conducted in Vanuatu (Kennedy, Bulu, Humphreys & Gray 2013) and Solomon Islands (Raman et al., 2015). Recent global progress reports on SRHR also highlight the importance of friendly service providers in SRH services (Starrs et al., 2018).

8.1.7.1.2 Socioculturally Sensitive Approach

A socioculturally sensitive approach to FP means that gender issues must be seriously considered when creating supportive environments, and men must be included in FP service provision. Most participant users and non-users in this study reported that the gender of the service provider is critical to access and acceptance of FP services at the clinic. As FP is a culturally sensitive and gendered issue (Ram and Jolly, 1998), having both female and male service providers providing FP will enable equal access for both men and women. This was a central finding in this study and was consistent across case studies

The main cultural issue that concerned most men was the lack of sensitivity to gender in FP services. As FP services were mostly focused on women and provided by female providers, men were

not able to participate freely. In all three clinics studied, men were not the focus of FP services, yet in Melanesian societies such as the Solomon Islands, men are afforded and exercise greater power than women in almost every sphere of life, including decisions regarding the size of their family (K. C. Brown, 2017; Davis et al., 2018). Having many children is an accepted norm in traditional Solomon Islands culture and is often reported as the reason for men's opposition to FP. However, men in this study reported that they were concerned more for the health of the woman and the socioeconomic pressure that having more children created. Men in the rural setting further expressed concern about the reduced arable land for subsistence gardening and for commercial activities because of the increase in population. Concerns about the health of women are also widely reported in studies conducted in PICTs as a common reason for not taking contraceptives, rather than husband or partner opposition (Daube, Chamberman & Raymond, 2016; SINSO, 2017).

Many studies conducted in low-income settings, including low-income PICTs have reported positive outcomes such as increased women's access and use of contraceptives, and reduced maternal mortality rates, when men are involved in making decisions about FP (Tokhi et al., 2018; Yargawa & Leonardi-Bee, 2015). Despite this evidence, very small numbers of men in Solomon Islands are involved in FP. Most men interviewed in this study positively responded that FP is a good thing and must be promoted, so that individuals, couples and community leaders must know about FP. However, men expressed that FP services mostly involved women and they themselves did not have much opportunity to participate, although they were willing to be involved and wanted to know more about contraceptives. While most studies and reports on FP focus on formal service provisions, it should be noted that men including young people often access contraceptives informally outside of clinic facilities. This informal space is a potential opportunity to explore to ensure that further supportive environments are created for FP in the Solomon Islands context.

Despite growing acknowledgement in the literature of intersectionality and people-centred approaches, little information on these topics is reflected in reported data (Sciortino, 2020). Many categories of information currently collected are gender binary in Solomon Islands (UNFPA, 2015c). For example, in this study, variables recorded for those who accessed FP services were limited to gender (as male and female), age group and marital status. There were no specific records indicating

special needs/disability or variation in sexual orientation or gender identity. As such, FP services may not reach people with special needs and other gender identities. A recent review (Dawson et al., 2021) of FP services in selected Pacific countries reported a lack of data about people with special needs and sexual diversity is not recognised in many Pacific countries. This lack of data leaves a lack of evidence to inform actions that will create supportive environments. Gender diversity needs to be recognised at the national policy level and perharps at the community level before it can be reflected in the data.

Studies from Pacific countries and LMICs about men's involvement in FP (Brown, 2017; Davis et al., 2016; M. E. Green, Berger, Hakobyan, Stiefvater & Levtov, 2019; Tokhi et al., 2018; Yargawa & Leonardi-Bee, 2015) reported similar findings about men's positive responses and willingness to be involved. In contrast to evidence about male masculinity and culture as key barriers to men's lack of involvement in FP (Holmes et al., 2012), most men interviewed in this study were willing to be involved and wanted more information about FP. However, they did not know where to access information within the health system and had no service available to them to go and seek the service. An evaluation of the MIRH programme in Fiji and Solomon Islands reported that many men had great interest in SRH services, but that health services were not prepared to make provisions for men at the clinic to manage sensitivities in sexual health issues, including FP (Roberts, 2007). Globally, country-level strategies have also been heavily focused on women and children, as they are the most vulnerable in the population (M. E. Green et al., 2019). However, in the Solomon Islands context, men as fathers, husbands and partners need to be included in the focus before FP services can be holistically provided, to ensure no one is left behind.

8.1.7.2 Recommendations

8.1.7.2.1 A friendly Family Planning Service Provider—Central to a Holistic Approach in Family Planning Service Provision

In Solomon Islands, FP service provision requires a holistic approach; that is, services should include all individuals or couples (women, men, young people), and consider social, economic, cultural and spiritual dimensions rather than simply focusing on contraceptive methods. This can be achieved via a friendly service provider who is sensitive to gender issues and who executes culturally acceptable approaches to providing FP services.

8.1.7.2.2 Men Must be Actively Involved in FP

A supportive environment for FP is one in which husbands or partners of women who seek FP are involved in FP decision making. They also need counselling and the opportunity to ask questions and hear balanced information about advantages and disadvantages of FP. This is to improve understanding about FP and promote informed decision making about FP options. Men's lack of involvement in FP should not be assumed to imply that men will always disagree with FP for cultural reasons. FP services must be gender sensitive and culturally available and accessible, to meet men's FP needs.

8.1.8 Strengthening Community Actions

The action area of Strengthening Community Action focuses on empowering communities to navigate actions that can be implemented by people to address their own health problems. This means communities must take ownership of health issues that are affecting people. Community actions can be strengthened with relevant FP information and a clear two-way communication strategy that provides the space to express needs and concerns within their community groups/clubs. Likewise, local agencies such as schools, the various levels of government and planning bodies need to work together to achieve this action. Actions identified in this study that would strengthen communities include promoting community participation and involving church groups.

8.1.8.1 Community Participation

The fundamental principles of health promotion are centred around community participation and empowerment. Encouraging community members to participate in health promotion activities is essential to sustain health promoting behaviours. A people-centred approach is also critical to enable people to exercise control of their own health and how they live in their environment. In this study, participants reported that community people were not engaged with FP and the way FP services were currently provided did not promote community engagement. Therefore, community members also lacked influence over the provision of FP services. In Solomon Islands participation in FP that does occur is mostly individually focused and does not involve community-level actions. In most cases service providers waited for people to visit the FP clinic.

People will effectively participate in community health initiatives if they have adequate access to information and have a clear understanding about what they need to do to keep healthy (UNFPA, 2022; United States Agency for International Development, 2019a). However, in all three case studies, participants expressed the need to access FP information through community visits or greater access to healthcare centres. Participants reported that less FP education will hinder community engagement in FP services. Although FP is taught in schools, not everyone attends formal schooling, with many leaving school at Year 6, the last year of primary school (Solomon Islands Government, 2017). FP messaging also focuses more on reducing population growth than empowering people with relevant information to help them make informed decisions about childbearing.

'Community participation', 'community engagement' and 'empowerment' are contested terms that need to be defined and contextualised for each community setting (Lebetkin, 2015; United States Agency for International Development, 2019a). When applying these terms to FP in Solomon Islands, comprehensive FP information needs to be simplified so that community members can contribute to inform relevant FP services that are socially and culturally contextualised (R. Harrington et al., 2020).

Despite the intentions of the Ottawa Charter (WHO, 2020), there is evidence that the lack of community involvement in health promotion programmes has persisted. Co-designed approaches to FP that involve different community-based organisations and individuals are expanding, with voices of users and service providers being incorporated into the design of FP services (WHO, 2017). Community-based FP programmes aim to bring FP information and methods to men and women in communities where they live as opposed to them having to visit the clinic. This is most beneficial for hard-to-reach places (Silumbwe et al., 2020). A study in Malawi used a variety of channels to distribute FP information, including community health workers, other trained health cadres, mobile services and the private sector. Results showed that FP users doubled from 40% to 80%. The programme helped breakdown barriers such as distance, access and social or cultural barriers (United States Agency for International Development, 2019b). In Zambia, the use of marriage counsellors in pre-marriage counselling improved relationships in married people such as sexual and interpersonal communication including sharing roles and responsibilities in the family, resulting in positive uptake of contraceptives (Nyundo, Whittaker, Eagle, & Low, 2021).

8.1.8.2 Involving Church Groups

Christian churches are very influential in villages, peri-urban and urban settings in Solomon Islands. This was evidenced in interviews with health workers—some of whom work in faith-based services—along with users and non-users of FP. Although religious values and beliefs have reportedly been barriers to providing and accessing FP across the Pacific, potential opportunities to work within church structures to promote FP options do exist (Cassells, 2019; Durrant & Phoebe, 2022). Churches are in a strong position to be agents for change as they are well-respected and highly influential structures, especially at the village level. Opportunities for churches to be involved in promoting FP including contraceptives were suggested by participants in all three case studies. Christian churches in Solomon Islands have structures in place such as men's, women's and youth groups, with members enacting voluntary roles as part of their service to their community to fulfil religious obligations. Some Christian churches promote extreme value systems that impose barriers to FP, but these barriers can be negotiated with specific communities as they may also contribute their own solutions (Cassells, 2019). A community-based intervention to promote FP in a male-dominated pastorlist community with significant religious barriers in Ethiopia has been engaging existing community structures targeting men's and women's groups. Results include significant improvements in contraceptive use and intention to use with community-based health education in Ethiopia (Alemayehu, Medhanyie, Reed & Bezabih, 2021). Service providers and policymakers have an opportunity to move beyond perceived barriers and explore opportunities with community partnerships that empower and promote community action for improved FP.

8.1.8.3 Recommendation

Community-based interventions are potential strategies to improve FP uptake in contexts where structural, cultural and religious barriers are prevalent. In Solomon Islands, communities already have structural organisations (churches, schools, and women's, men's and youth groups) in which appropriate community-based strategies could be explored. Families make up communities in Solomon Islands; therefore, it is important to think about and reach individual families within communities. These existing community structures and groups must be recognised, respected and

strengthened with relevant and balanced information about FP and SRH to help people realise and take ownership of their family's health. Health system structures also need to align services with community structures and expectations.

8.1.9 Developing Personal Skills

When people have access to health information and education, they are more likely to improve their decisions and effectively communicate their personal health needs with service providers as well as establish healthier social interactions with others. People can be more assertive and confident because they understand the language used in health settings. Personal and social development can be facilitated in schools, home, work and in communities through educational, professional, commercial and voluntary bodies (WHO, 1998). In this action area, enhancing knowledge about FP services and contraceptives and relevant approaches to awareness-raising and counselling for FP are important to developing personal skills.

8.1.9.1 Enhancing Knowledge About Family Planning and Contraceptives

Sexual health topics such as FP, although sensitive to discuss in public, often trigger interesting discussions in which women, men and young people want to be involved. This was evident in interviews where it was reported by users and non-users that they wanted to know more about FP and be involved in discussions. The participants also sought answers to their questions. This high level of interest in wanting to know more provides an opportunity for health workers to reach people with relevant information and help them make informed decisions. Opportunities for this interest to be used for improved FP action include increasing FP awareness and engaging people respectfully. However, despite interest in FP matters, users and non-users had less opportunities available to them to learn about FP, including about available methods. Further FP education opportunities should help people in Solomon Islands to obtain balanced comprehensive information that will enable them to assess the risks and benefits of FP options and make informed decisions.

Participants' knowledge of FP in this study included recognition of contraceptive methods and their benefits but rarely included knowledge about the outcomes of using the methods, potential side effects, how to manage unwanted side effects, and what to do if there were concerns or questions. In

addition to low FP awareness and prevalent misinformation and misinterpretation of side effects reported in all case studies, only a few people—mostly women—attended the clinic to learn about FP. This may mean that current approaches to disseminating FP information are not effectively influencing individual decision making. Other possible reasons include people not being engaged because of unclear explanations, language barriers, cultural insensitivities and a predominantly one-way dialogue. However, it is possible to encourage those who are not confident to ask questions or speak up in public as long as providers understand contextual issues. The commonly reported fear of side effects of contraception in Solomon Islands and other PICTs reflects the ongoing lack of accurate information and understanding about FP and highlights the need to increase the delivery of appropriate and effective FP counselling services (R. B. Harrington et al., 2021; Raman et al., 2015; UNFPA, 2015e).

8.1.9.2 Approaches to Awareness-raising and Counselling for FP

The very low proportion (~30%) of the people who complete formal primary education in Solomon Islands (Solomon Islands Government, 2017) means there is low literacy across the nation. Low literacy also affects accurate understanding about FP (Hinton & Earnest, 2011). Terminology and language used to disseminate information about FP is more effective when combined with simple teaching aides, role plays and accessible language in settings such as Solomon Islands. For example, service providers reported that the use of visual aides and clear story-based explanations enhanced understanding and acceptance of FP contraceptives. As topics related to sex or sexual reproductive organs are culturally and religiously considered sacred or 'taboo', such topics should be treated with sensitivity. This means that appropriate and accepted terms and descriptions used in presentations must be checked with people before they are used for educational purposes. A report as part of the 2016 Shanghai Declaration (WHO, 2017) showed that health literacy is failing in many parts of the world because societal and structural forces that shape people's understanding of health issues are neglected when providing health education.

Visiting the health clinic just to obtain FP information was not the norm at the three case study settings. Participants reported that FP clients visited FP clinics when they had already encountered health issues. This finding is consistent with people's mentality about health clinics as being mainly

for curative rather than preventative purposes (Gillam, 2008; Walraven, 2019). This means that people's orientation of health is still embedded in the biomedical model of care and has barely shifted to a health promotion orientation. Promoting an understanding of the benefits of preventative FP services may assist users to develop personal skills that aid use of FP.

This strategy can provide confidentiality and privacy for clients to ask questions and obtain the information they need. Although this type of service may be more informal, service providers still need to be professional in their approach—just as they would provide the service in the health clinic. Telephone communication has also been found to be effective for health consultations (Rajkhowa & Qaim, 2022).

8.1.9.3 Recommendation

Further research may be required at the service provision level to create culturally safe FP counselling approaches for effective FP awareness-raising in Solomon Islands.

8.1.10 Reorienting Health Services

This action area of the Ottawa Charter refers to changing health promoting approaches from a 'curative' to 'preventative' focus. The aim of the 'Reorienting Health Services' action area is to promote a more holistic attitude among health professionals and to consider the whole person's wellbeing, not just disease manifestations or parts of the body (Wise & Nutbeam, 2007). To reorient health services, everyone shares the responsibility including individuals, community groups, healthcare professionals, healthcare service institutions and the government. Reorienting health services also requires changes in delivery of services, professional education and training, and more health research. This action area discusses the focus of FP services and training of service providers.

8.1.10.1 Family Planning Services Focus

Consistent with the 1994 ICPD PoA and adopting UNFPA's recommendation to achieve progress towards the former MDGs (Zuccala & Horton, 2018), a comprehensive SRH package with reference to MCH services was to be delivered through PHC services. Thus, FP services in Solomon Islands were being provided within MCH services as part of the primary care focus. Subsequent WHO resolutions following the 1986 Ottawa Charter (WHO, 1986, 1991, 1997, 2017) have also

continuously emphasised comprehensive SRH services through PHC as the recommended strategy in service provision. More recently, the UNFPA's 2022–2030 strategy has positioned FP as the foundation of SRHR; it acknowledges that there has been less focus on social, cultural and gender-related issues and aligns the SDGs in its strategies (UNFPA, 2022).

Within this comprehensive package, the focus has broadened to equitable service provision, ensuring equal opportunities and resources are available to all women and men. However, the results for all three case studies showed that FP services had been confined to the MCH context and focused on married women, resulting in predominantly married women attending FP clinics, with many fewer men and unmarried young people. With FP and contraceptive services focusing on women and provided once a week, this further limits the availability of services for everyone. Men and young people who wanted SRH services including FP went to the outpatient clinic, but often did not receive the services they sought. This focus creates an accepted belief that FP services are only for women and are thus not accessible and acceptable for men and young people. This in turn drives men and young people to less likely seek out FP services, believing that they are not the intended recipients.

8.1.10.1.1 Family Planning Services—Curative Rather Than Preventative Focused

Although the Alma-Ata Declaration and the Ottawa Charter have broadened the perception of health beyond doctors and hospitals to understanding the social environment of health and health promotion (WHO, 1978), health services in Solomon Islands including FP remain embedded in the individualistic biomedical approach instead of population health outcomes. Preventative services such as FP and curative services such as the outpatient services are all provided in health clinics, so that the focus and provision of FP services and contraceptives encompass a disease-oriented space rather than having a health promotion focus. At the clinic level, disease-focused programmes have driven clinic services to be more curative (Hilliard, 1974; Rifkin, 2018; Thompson et al., 2017) than preventative, and have instilled a curative focus in service providers' and service users' mindsets about FP services. For example, in the urban and peri-urban settings in this study, service providers would involve men or husbands in FP when life-threatening issues for their spouses were identified but would rarely engage men in discussions when no health issues existed. In the peri-urban setting, young unmarried people (mostly women) visited the FP clinic when they already had issues such as unintended

pregnancy or were experiencing symptoms of STI; they would never come forward to seek counsel or contraceptives to prevent pregnancy or STIs from service providers.

8.1.10.1.2 Family Planning Service—a Vertical Programme, Lacks Integration Outside of Clinic Facilities

Findings in this study include that FP services are provided vertically along with other SRH programmes and were rarely integrated outside formal clinic services. From the national to the clinic level, SRH services are managed vertically. For example, at the national level, MCH services including FP are managed under the RMNCAH programme and STI/HIV services are managed separately. In the urban setting, FP was not available outside the clinic facility. At the peri-urban hospital, FP services were implemented through the Reproductive Health Clinic and maternity ward, and STI/HIV services provided at the outpatient clinic. At the rural clinic, provision of all clinic services including FP was the responsibility of one person who was multi-tasking and was mostly provided at different daily clinic schedules. In addition to clinical duties, FP service providers in all case study settings also held administrative roles in their clinics, which often compromised efficient provision and continuity of FP care.

The WHO defines 'integrated health services' as comprised of health promotion, disease prevention, diagnosis and treatment services. 'Integrated health services promote continuity of care and are coordinated across different levels and sites of care, within and beyond the health sector and throughout people's life course as needed' (WHO, 2016a, p. 2). However, FP services provided in the three clinics in this study were mostly integrated within MCH services and rarely with other services such as outpatient clinics and beyond clinic settings. FP services had been positioned to mainly address the contraceptive needs of women with less attention to other social and economic needs. For instance, a client would visit the FP clinic for her contraception but the outpatient clinic for other medical ailments, either on the same or a different day. There were no formal FP services outside clinic hours available for people in the communities unless outreach clinics were regularly provided. However individual service providers in the peri-urban and rural settings had made provisions for those who sought services outside formal clinic hours. This is evidence that it is possible to

innovatively tailor FP services to individual or community needs and provide opportunistic, holistic care at the time of presentation.

Although FP was integrated mainly with MCH services, service providers often understood this integration differently. This understanding resulted in fragmentation of care at the service provision level, causing service providers to think vertically when providing services. Service providers' understanding of service integration also fell short of the WHO definition, as evidenced by a service provider's response: '*I think because our mind is thinking, "oh it's time for children", we don't think of family planning … when we concentrate on doing one thing, we cannot do another thing at the same time*' (1FPP2).

This finding is consistent with reports and evaluation of SRH services in Pacific countries (Dawson et al., 2021; Rao & Pilot, 2014; WHO, 2016a), showing services are largely planned and implemented as vertical programmes (Rifkin, 2018). An example is the focus on health improvement siloed in the year 2000 with the publication of the MDGs (Starrs et al., 2018; Walraven, 2019), which focused on disease cure and prevention. Therefore, interventions such as immunisation, FP and nutrition are delivered through vertical programmes, assuming this approach will have the best outcomes. However, as many SRH conditions occur throughout the course of life and overlap at some stages, integrated services need to address multiple rather than specific needs. A review of the availability, accessibility, acceptability and quality of the sexual reproductive, maternal, newborn and adolescent workforce in different world regions (Homer et al., 2018) found the lack of an integrated approach is one of the main barriers to addressing accessibility and subsequent availability of FP. Dawson et al. (2021) further asserted that a lack of vision or national planning corresponds with ineffectiveness of an integrated approach.

The provision of horizontal SRH services requires people seeking SRH services know where to go and also requires service providers clearly understand and utilise the referral system to maximise health service delivery (Starrs et al., 2018). Many opportunities to integrate FP were missed in the cases in this study, because integration of FP only occured in the MCH context. In Kenya and other African countries (Cohen et al., 2017) integration of FP into HIV care services has led to sustained increases in the use of more effective contraceptives and reduced unintended pregnancies. However, in

Solomon Islands, local contextual challenges and opportunities influencing availability, accessibility and acceptability of FP services will need to be first understood before such integration could be considered. This is where local knowledge about priority country issues must drive planning, along with contextual understanding of service integration that is applicable to the local context. In addition, a system to make relevant linkages and referrals will need to be created for each case study setting to ensure FP extends outside formal vertical programmes to reach everyone with multiple needs.

8.1.10.1.3 Outreach Family Planning Services

Outreach services extended to the community provide critical opportunities to reach people who cannot come to the health clinic for FP. However, if the same limited approach to service integration in the clinic facility is implemented during outreach (as currently occurs), it may still not reach everyone. Further research is needed to explore and evaluate how outreach FP services have been conducted in communities, to understand the context and ensure appropriate integration strategies are utilised in all available opportunities to reach people with FP.

8.1.10.2 Training of Family Planning Service Providers

Critical to the provision of FP services is the availability of trained service providers. In Solomon Islands, FP services are only provided by trained health workers such as midwives, registered nurses, nurse aides and medical doctors. Medical doctors perform procedures for permanent methods (tubal ligation and vasectomy). Midwives, registered nurses and nurse aides provide temporary contraceptives. Provision of contraceptives requiring advanced skills, such as insertion of implants and uterine devices is by midwives and some registered nurses who have received specific training. Traditionally RMNCAH services are predominantly provided by female service providers. While most male nurses hold management roles or manage medical conditions, some male nurses who work in rural settings do provide FP and MCH services, when a limited number of female staff is available.

8.1.10.2.1 Selective Training for Family Planning

Midwifery training in Solomon Islands currently enrols only female registered nurses, so there will be more female than male RMNCAH and FP providers, unlike in PNG where both males and females are trained as midwives (Cheer, 2019). In most urban and hospital settings in Solomon Islands

female providers work in maternity wards and FP clinics. In this study, FP services at the urban and peri-urban case study sites were predominantly provided by female providers, except in the rural setting where a male provider was available and provided FP services. As most of the country's population live rurally, this selective training for female providers on FP will need to be reconsidered to achieve universal access in Solomon Islands. The women-focused FP services provided by female providers have unintentionally excluded men's participation and involvement in FP and contributed to the current approach to FP services.

8.1.10.2.2 Family Planning Refresher Courses

With support from UNFPA as a major partner donor, FP training has been provided for service providers, but mostly for health workers who work in FP and RMNCAH services. This has created a belief among service providers that only those who are trained can provide awareness and counselling on FP. The lack of an updated FP manual and minimum dissemination of current information may cause conflicting and outdated FP information to be relayed to clients by service providers.

Although some providers at the peri-urban and rural case study sites expressed that they had not attended refresher training, one positive finding was that participant users and non-users did not comment on service providers' competency skills. This may mean that providers in this study were perceived as clinically competent or simply that there were no complaints or comments about their competency. This finding is consistent with the Pacific-wide report (UNFPA, 2019) on the RMNCAH workforce, which found most nurses in the Pacific region who provide RMNCAH care are competent to provide these services. However, they need training on their interpersonal skills and attitudes to provide holistic FP to help clients make informed decisions about contraceptives.

8.1.10.2.3 Ongoing Support for Family Planning Service Providers

Service providers need continuous support and guidance when providing FP. The lack of regular supervision for FP revealed in this study meant that FP services were rarely evaluated for their current provisions at the clinic level. The monthly clinic reports were rarely used to make decisions and further analysis may be required to identify issues needing urgent attention. While funding availability appeared to challenge the conduct of supervisory visits from the national level and the

urban setting, it was encouraging that supervisory visits continued in the peri-urban and rural settings. The variability in the occurrence and purpose of supervisory visits conducted in the peri-urban and rural settings suggests differing understandings and priorities of provincial managers about their multiple roles as RMNCAH managers, supervisors and service providers.

Service provider enthusiasm for providing FP services in all case study sites was a strength revealed by the findings. This enthusiasm was expressed in a passion to work with women and children and a willingness to adapt to changes need to improve FP services. However, they require ongoing support and appraisal as well as support to evaluate innovations implemented in FP activities. Service providers also need clear and consistent direction from their superiors as well as strong peer support from RMNCAH colleagues. The lack of funds available for FP activities expressed from the national RMNCAH to the service provision level is consistent with the situation for wider Pacific RMNCAH and global FP services (Gilby et al., 2021; Homer, Turkmani & Rumsey, 2017; Zuccala & Horton, 2018), where funding for FP has waned in the past decade. This may affect supervision roles. However, findings in this study show the potential for improvement at the service provision level, even with limited funds.

8.1.10.3 Reconsidering Dissemination of Family Planning Information in Solomon Islands

Service providers and users in this study reported that a friendly environment should accompany whatever approaches are used for disseminating FP information. A friendly environment was defined by participants as involving a happy, kind and non-judgmental service provider and a clinic facility that provides privacy. Young people at the three case study sites preferred a confidential service that could be accessed anywhere (including the clinic) from a friendly service provider in a friendly environment. The results reported in this study are consistent with those of other studies reported from Pacific Island contexts showing that friendly, non-judgmental services increase accessibility and acceptability of FP (R. B. Harrington et al., 2021).

With readily available information on the internet and access to telecommunications, FP services need to engage other health professionals such as health promotion officers to respond appropriately to those who are self-taught in the use of information technology. In addition, understanding different generational age groups such as Millennials and Generation Z, who may have

different expectations and concepts about FP is crucial to execute appropriate strategies to provide FP information (Horvath, Azman, Kennedy & Rutherford, 2012; Rajkhowa & Qaim, 2022). It is also important that service providers are well versed with updated information and are technically savvy regarding the different ways people access information, so that they are providing appropriate counselling to minimise misinformation and people's dependence on unsubstantiated information. Although telephone or online counsultations may be more informal and provide confidentiality for FP clients when asking questions and obtaining information, service providers still need to be professional in their approach.

Informal storying with each other was the main means by which participants in the rural study site shared information about FP. In Melanesia, social conversations that embed the storied negotiation of information in relational activities are commonly known as 'tok stori' (K. Sanga, Reynolds, & Paulsen, 2018). Although tok stori is generally associated with informal activities, it has the potential to be used as a teaching process locally in Solomon Islands (K. Sanga, Reynolds, Houma, & Maebuta, 2020).

Strategies to provide FP awareness including formal counselling services provided at the clinics will need to be reconstructed and diverted from a contraceptive focus to include a broad range of topics presented in holistic stories that will enable people to relate to information and apply it to their situation. This means the usual formal counselling service may need to consider incorporating informal storying in places where people could be reached, at every opportunity. In Solomon Islands, this tok stori approach can be given careful consideration when planning future approaches to providing FP information, to ensure local ways of knowing are incorporated to enable people to learn better in their own contexts.

8.1.10.4 Recommendations

A refocus to an inclusive FP service is required in the health service, given variation in understanding about FP service integration among service managers and providers. A clear definition of service integration in SRH and FP is required and is applicable to the local context of service delivery. This is where local knowledge about priority country issues must drive planning and service delivery. In addition, relevant linkages and referrals will need to be created for each type of health

clinic setting to ensure FP extends outside formal vertical programmes to reach everyone with multiple needs.

Given the chronic shortage of RMNCAH providers in Solomon Islands, more male service providers need additional training with RMNCAH or midwifery knowledge and skills to reach men with FP before the country can equitably and sustainably meet unmet needs in FP and meet global goals such as 'leaving no one behind'.

Solomon Islands also needs an appropriate skill mix including male service providers with RMNCAH knowledge to prepare and train future RMNCAH providers. Consideration needs to be given to increasing the number of male RMNCAH providers in order to provide gendered FP services to reach men. This will mean men can access culturally sensitive FP as well as SRH services, and therefore assist their families with FP.

Updated FP protocols with adequate financial support and evidence-based FP approaches relevant to the Solomon Islands context are needed. National and provincial managers will need to understand their specific roles in FP and clearly communicate and negotiate their plans with service providers who will then negotiate care with clients and communities. The existing structure of RMNCAH from the national level to service delivery points in Solomon Islands provides potential for improving FP services without having to make major structural changes. This existing structure needs to be strengthened with a refocus of current practices and training needs to fulfil community-level needs for FP services.

Nursing and midwifery training curricula may need to incorporate local cultural values and knowledge into professional nursing subjects and their application to the Solomon Islands context. This includes building interpersonal skills and how professional languages and behaviours can be manifested and translated in the local real world of privacy issues, confidentiality and when dealing with adolescent health and other SRH services.

As most urban, peri-urban and rural settings in Solomon Islands have optimum coverage of communication networks, telephone or online consultations could be considered for advice and counselling. While telephone communications have been found to be effective for health

consultations, further research may be required to create culturally safe consultations using online platforms in the Solomon Islands context.

Further research is needed into locally accessible and acceptable community-based FP and youth-friendly services.

8.2 Strengths of the Study

8.2.1 Understanding of the Context of the Study

Growing up in rural Solomon Islands and understanding the peri-urban and urban settings provides an Indigenous worldview with my 'insider' and 'outsider' perspective to the study. My Indigenous worldview helps me relate to experiences of participants in the different clinic settings and is likely to have enhanced the accuracy of interpretations of interview findings. My profession as a nurse-midwife and having worked in various FP clinics in Solomon Islands is a strength that leads to my familiarity of the context and issues about FP explored in this study. Being a Christian who has worked in a FBO and government institution adds value to my understanding about perspectives of FP from faith-based and government FP services. Consequently, using a strong reflexive approach to reflect on how the elements of my background influenced both data collection and analysis is also a strength.

8.2.2 Case Study Methodology Enabled Understanding of Specific Contexts

A multiple case study design gathering quantitative and qualitative data from rural, peri-urban and urban settings strengthens the study, as it represents the common settings where FP is provided in Solomon Islands. This adds richness to the data and analysis of results and validity of the study.

8.2.3 Strong Participation in Interviews

Interviews conducted in Solomon Island Pijin, a lingua franca, helped participants to accurately express themselves about their understanding of FP and how this affected them when they wanted to access FP services. Recruitment of women, men and young people who were married and unmarried provided broad representation of the population that is eligible to access and use FP services.

8.2.4 Perspective and Fact Checking of Results

Member-checking for Case Study Three was carried out by research assistant Allan. I prepared a summary powerpoint presentation of the findings and emailed to Allan who went back to the village and did a group presentation using a data projector. Participants verbally responded and agreed to the findings and confirmed the analysis of what they contributed during their interviews. Member-checking did not eventuate for all participants in Case Study One and Two, however it was achieved with some participants through email and Facebook Messaging correspondences. This confirmed the accuracy of the findings.

8.3 Limitations

8.3.1 The Use of Solomon Islands Pijin in Research Interviews

While the use of Pijin can be a strength, the evolving nature of the language over time has brought changes to some original meanings of words and expressions. Thus, the meaning of words in Pijin may be variously understood by the researcher, supervisor and participant, giving rise to potential for misunderstanding.

8.3.2 Other Contextual Settings Not Explored

Not exploring other contextual settings may lead to lack of transferability. However, the consistency of findings across diverse case study sites in this study increases the likelihood that the findings are transferable across Solomon Islands and possibly other Melanesian settings.

8.3.3 Lack of Quality in Quantitative Data

The lack of consistent available reports and incomplete clinical data records present a weak component of the quantitative data analysis. However, the need to standardise data collection and record keeping is an important finding and recommendation from the study that will be important in future quality improvement efforts. In addition, the exclusion of the ‘quality’ dimension of the AAAQ Framework in this study is a limitation.

8.4 Recommendations

Recommendations for Policy and Practice

For MHMS/Policymakers

- The health system should refocus its approach to providing FP services including through:
    - an inclusive focus on men and young people and creation of culturally relevant strategies to meet their FP needs
    - reconsideration of the structure of FP service provision to be inclusive for everyone, consistent with the universal coverage goal and global agenda to 'leave no one behind'; this includes integrating FP services at the service delivery level
- promotion of local research into context-specific FP isues to enable locally relevant evidence to inform FP policies
- policies that govern delivery of SRHR including FP will need to incorporate cultural values and practices of people in the communities they serve; policies need to be applicable in the Solomon Islands context
- provision of clear strategies to engage/involve communities in RMNCAH programmes in community clinics
- prioritisation of ways to improve consistent and uniform clinical record keeping in all clinics.

For Nursing and Midwifery Training

- More male nurses should be trained in nursing and midwifery to provide SRH services and FP information for men (this can make a difference in resolving current gender imbalances in providing FP services).
- Health training curricula (nursing/midwifery/health promotion/public and community health) should:
    - incorporate local cultural values/beliefs and knowledge on discussing SRH issues, especially when educating community people
    - emphasise the importance of professionalism and incorporate or link professional nursing subjects to transcultural nursing and its application in the local context.

For Service Providers

- They should be more friendly and kind to clients seeking SRH and FP services. A friendly provider can transform social, cultural and religious barriers into opportunities to reach people with FP.

Further Research

- This is required to explore with men and young people how and where they would like to access FP services in the context in which they live.
- Culturally sensitive approaches to FP awareness-raising and counselling skills for all gender and age groups.

8.5 Chapter Summary

In this chapter, I have discussed the findings in the literature under the five action areas of the Ottawa Charter. I outlined what I did to ensure research quality in a case study design, discussed strengths and limitations and outlined recommendations to inform policy and practice for FP services in Solomon Islands.

In the next and final chapter, I summarise the thesis and reflect on my research journey. Figure 9.1 is the thesis structure showing the conclusion chapter in the thesis.

Chapter 9: Conclusion

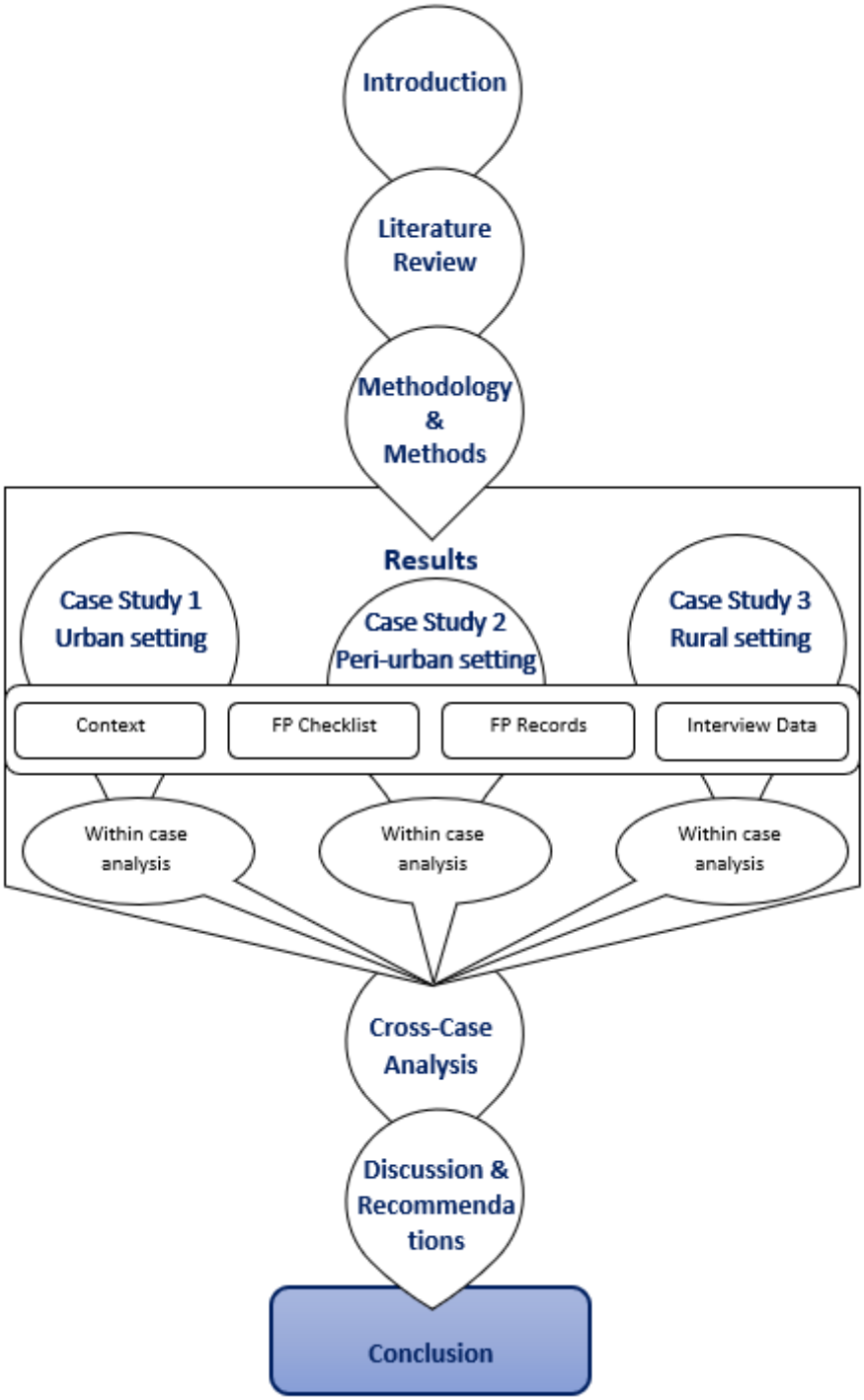

Figure 9.1. Thesis structure—Conclusion

9.1 Chapter Outline

This chapter includes a summary of the motivations for the research study, concluding statements about the study results and a reflection of my journey in undertaking this research.

This PhD research was motivated by my experience when I worked as a nurse-midwife in a remote hospital in Solomon Islands. I struggled to manage high-risk pregnancies and birth complications such as postpartum and antepartum haemorrhages, near miss maternal deaths and actual maternal and neonatal deaths because of limited resources, capacity and timely referral systems. These experiences made me think that if these pregnancies could have been prevented or did not happen at this time, such complications and problems may have been avoided. I concluded that the use of FP contraceptives that were available at the FP clinic was a simple way to save these lives and reduce morbidities in our remote hospital setting.

Culturally, I knew that SRH issues such as FP are sensitive issues that people do not often openly discuss among themselves. While previously working at the FP clinic, I rarely saw men and young people, other than young women, visiting the FP clinic to receive counselling about FP, although I was available to provide the service. I thought men and young people were not interested in FP and could not be easily persuaded to visit FP clinics for sociocultural reasons. Therefore, I conducted a pilot qualitative study and explored with women, men and young people their perspectives on the barriers and enablers of using contraceptives at the FP clinic in which I had worked. Surprisingly, I found that most participants including men and young people were interested in FP contraceptives but had limited knowledge, and the location of the FP clinic was not culturally and socially accessible and acceptable to them. Participants' concerns about the location of the FP clinic were something I had not realised at the time I was working at the clinic.

Once I commenced my higher degree research, I built upon new knowledge from the pilot study by conducting a scoping review on FP service provision in PICTs. This helped expand my understanding of FP service provision in the broader Pacific context. The review showed there was progress in FP, but it varied in different country contexts: one approach to FP does not work for all countries. Furthermore, evidence of FP service users' and non-users' experiences were lacking in the

literature. However, there is potential for improving FP service provision at the service delivery level if well-informed contextual approaches can be applied. This evidence informed the focus and design of the PhD study.

This PhD study aimed to explore and understand how FP services and contraceptives in Solomon Islands were made available, accessible and acceptable at three health clinics representing urban, peri-urban and rural settings. A multiple case study design using mixed methods was used to enable detailed understanding about contextual FP issues in common settings where FP is provided. Case Study One was an urban setting in Honiara; Case Study Two, a peri-urban setting in the Western Province; and Case Study Three, a rural setting in Isabel Province. Quantitative and qualitative data were collected to provide evidence for the study. FP clinic services audit and clinical records and reports provided sources for quantitative data. Qualitatve interviews with male and female FP service managers/providers, FP service users and non-users provided understanding of different perspectives about FP.

The study found evidence that FP services and contraceptives were available at all three case study sites, but not everyone was able to access these services. FP services were predominantly attended by married women. Men and young people had less access to FP services in all case study settings. Current FP services have been focusing on women and are not sensitive to people's gender, cultural values and beliefs. FP service providers' attitudes towards those seeking FP services at the clinics could either facilitate access and acceptance of FP services and contraceptives or cause potential barriers to accessibility and acceptability.

In comparing the findings with the literature, it was evident that there are similarities in issues across the Pacific region as well as with other LMICs. Through application of study findings to the five action areas of the Ottawa Charter, it was evident that FP services provided at the three clinic settings did not meet the expectations of holistic health service provision, The Ottawa Charter points to the need for health services to advocate for health-promoting actions, including the delivery of health services, to be socially and culturally contextualised.

Current FP services in Solomon Islands would benefit from refocusing FP clinic services to centralise inclusivity. Service providers need to incorporate a holistic FP service provision approach

that is friendly, culturally and socially accessible and acceptable in the context in which the services are provided. This kind of approach to FP will likely create demand for quality FP that will drive demand for more appropriate FP services, including contraceptive options.

9.2 Epilogue

My realisation of the world inside me could not have occured without undertaking this PhD journey, although I often found it challenging to move in and out of my 'inside world' to the 'outside world'. This unexpected journey enabled me to know more about my assumptions through the issues I explored and has been a truly humbling experience. I feel I have come out of this journey refined in my attitudes and knowledge towards research and the potential benefits it can bring to society.

To be able to think differently and write my thoughts using a foreign language, and doing this in a different place meant misunderstandings, distractions and recurrent slips into 'rabbit holes'. Yet I had a strong advisory team who complemented each other to support and keep me on track. The value of this support is immeasurable.

My gratitude goes to the women, men, children and young people who have given me experiences that built my confidence and competence as a nurse-midwife. These experiences provided the steppingstones that led me to pursue this PhD journey. The unexpected journey that brought me to my reality ends with the completion of this PhD; however, it opens up new opportunities for me to ensure future women, men and children are healthy, happy and safe in their planned families.

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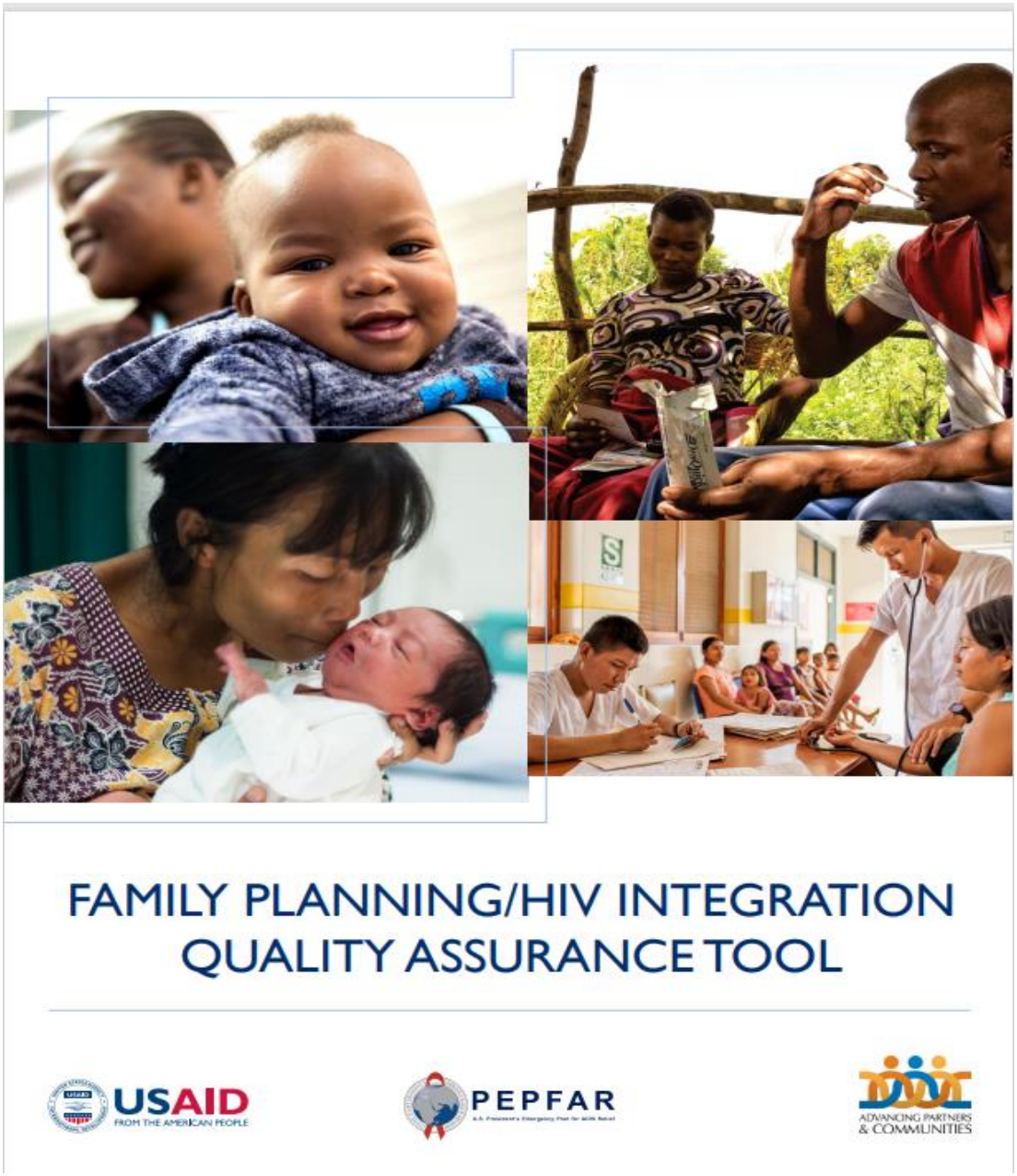
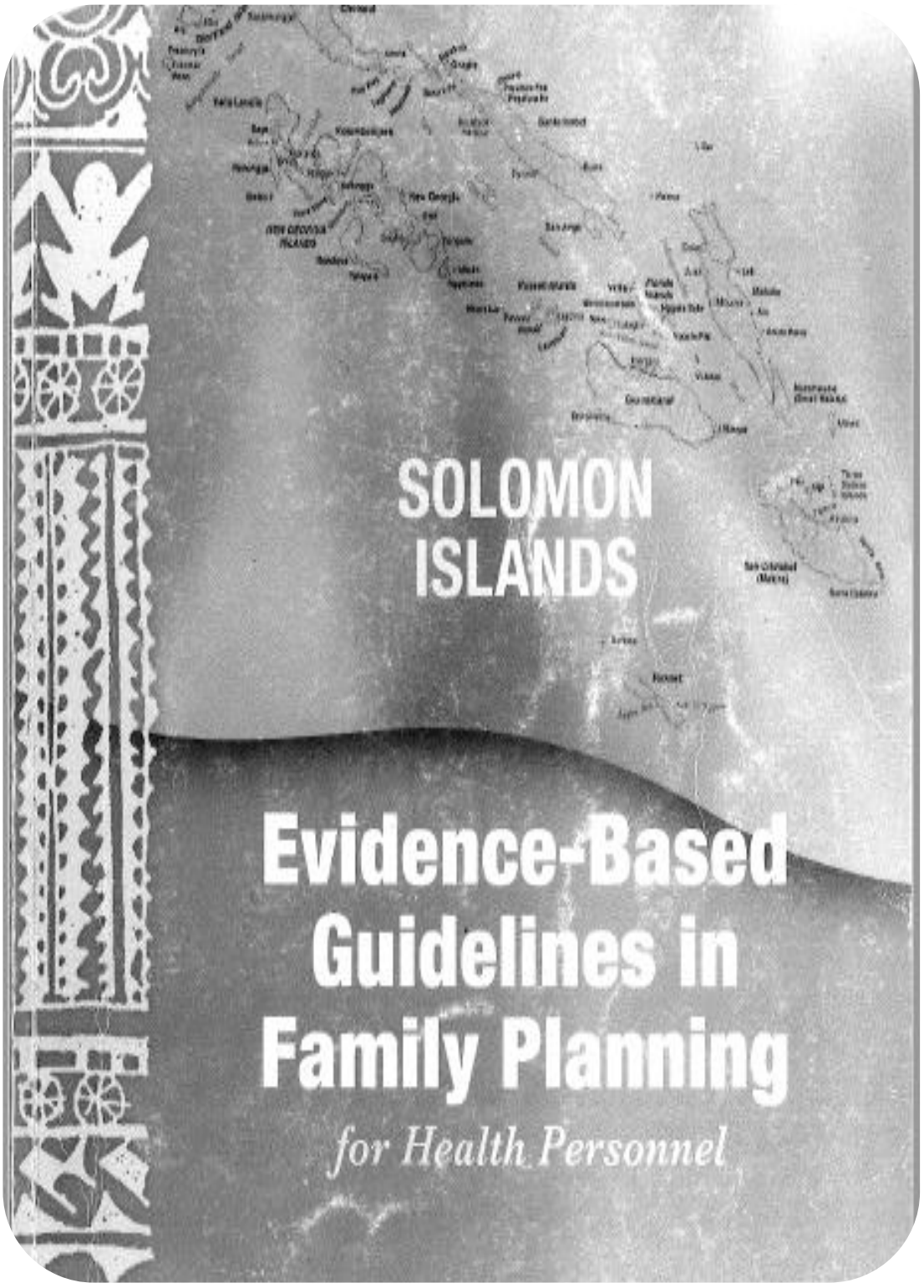
Appendices

Appendix 1: Family Planning Service Audit Tools (*WHO FP/HIV Integration Quality Assurance Tool* and *Solomon Islands Family Planning Manual*; Adapted Versions for Case Study One, Two and Three)




SOLOMON
ISLANDS
Evidence-Based
Guidelines in
Family Planning
for Health Personnel

Family Planning Clinic Checklist

1. Services

Question	Response	
1. Does this clinic provide or refer for any of the following family planning methods? Select "yes" if the clinic provides the method or refers clients to another facility for the method. Please select one response for each line. If you selected yes (1) above and it was because you refer clients for the method stated, please provide information about which facility you would refer client to Note, if an outside organization comes to the clinic to provide the method, but otherwise the method is not provided, do not select provided at this clinic.		
Family planning Method	**Yes – provided or referred**	**No- Do not provide or refer**
Fertility awareness counselling	1	0
Natural methods counseling (Ovulation/Mucus, Calendar method, Symptothermal method)	1	0
Male condoms	1	0
Female condoms	1	0
Lactation Amenorrhea Method (LAM) counselling	1	0
Oral contraceptive pills (POP, COC)	1	0
Emergency contraceptives (e.g. Prostino)	1	0
Injectable contraceptives (e.g. Depo provera)		
IUCD insertion	1	0
IUCD removal	1	0
Jadelle Implant Insertion	1	0
Jadelle Implant removal	1	0
Female sterilisation (tubal ligation)	1	0
Male sterilisation (Vasectomy)	1	0

2. Typically how often can clients access the following family planning methods?

Please select one response for each line

Family Planning Method	Less than once per week	Weekly but not everyday	Every day the clinic is open	Not provided at this clinic
Fertility awareness counselling	0	0.50	1	NA
Natural methods counselling (Ovulation/mucus, Calendar method, Symptothermal method)	0	0.50	1	NA
Male condoms	0	0.50	1	NA
Female condoms	0	0.50	1	NA
Lactation Amenorrhea method (LAM) counselling	0	0.50	1	NA
Oral contraceptive pills	0	0.50	1	NA
Emergency Contraception (e.g. Prostino)	0	0.50	1	NA
Injectable contraceptives e.g. Depo Provera)	0	0.50	1	NA
IUCD insertion	0	0.50	1	NA
IUCD removal	0	0.50	1	NA
Janelle Implant insertion	0	0.50	1	NA
Janelle Implant removal	0	0.50	1	NA
Female sterilisation (tubal ligation)	0	0.50	1	NA
Male sterilisation (Vasectomy)	0	0.50	1	NA

3. Typically how often does the clinic offer outreach family planning services in the community?				
Family Planning Methods offered during outreach visits	**Less than once per week**	**Weekly but not every day**	**Every day the clinic is open**	**Not provided at this clinic**
Fertility awareness counselling	0	0.50	1	NA
Natural methods counselling (Ovulation/mucus, Calendar method, Symptothermal method)	0	0.50	1	NA
Male condoms	0	0.50	1	NA
Female condoms	0	0.50	1	NA
Lactational Amenorrhea method (LAM) counselling	0	0.50	1	NA
Oral contraceptive pills (POP. COC)	0	0.50	1	NA
Emergency Contraception e.g. Prostino	0	0.50	1	NA
Injectable contraceptives e.g. Depo Provera	0	0.50	1	NA
IUCD insertion	0	0.50	1	NA
IUCD removal	0	0.50	1	NA
Jadelle Implant insertion	0	0.50	1	NA
Jadelle Implant removal	0	0.50	1	NA
Female sterilisation (tubal ligation)	0	0.50	1	NA
Male sterilisation (Vasectomy)	0	0.50	1	NA

	Question	Yes	No	NA
4.	**Does this clinic provide STI screening prior to IUCD insertion**? *(This assessment may be syndromic or clinical. Select "NA" if clinic does not provide IUD insertion)*	1	0	NA
5.	**Does this clinic provide male-friendly services to promote male involvement in FP?** *(Examples include: condom demonstrations for men and boys, inclusion of men and boys in ANC visits etc.*	1	0	NA
6.	**Does this clinic have written protocols/ guidelines for delivering FP services?** *(This may include algorithms for service provision, standard operating*	1	0	NA

procedures, national family planning guidelines/policies or checklists for services			
7. Does this clinic have the most recent versions of such protocols/guidelines? *(Select "NA" if this clinic does not have written protocols /guidelines*	1	0	NA
8. Are data on the FP services provided to STI/HIV service clients being captured at this clinic?	1	0	NA
9. **Do the captured FP data bread down patients by FP methods?** *(Select "NA" If this clinic does not capture FP data for HIV service)*	1	0	NA
10. In the past six months, have STI/HIV service clients at this facility who are waiting to access FP services ever left before receiving services because the wait time is too long?	1	0	NA

HOW TO SCORE THIS SECTION	
1. Sum the circled responses and record in row A	
2. Count the number of circled NAs and record it in row B	
3. Subtract the value in row B from the maximum number of questions, 31 record this in row C	
4. Divide the number in row A by the number in row C	
5. Multiply by 100 and record this as the score	
A. SUM OF CIRCLED RESPONSES:	
i. NUMBER OF NA:	
B. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	%

2. Counselling

Question	Yes, always	Yes most of the time	Yes a little of the time	No, Never	NA
1. Does this clinic routinely assess clients need for FP services based on his/her clinical history and reproductive intentions?	1	0.75	0.5	0.25	0
2. When a client is found to have a need for FP, does this clinic routinely screen the client to determine what FP services are appropriate? (reproductive goals, infertility issues, FP knowledge, living family situation, any FP-related concerns)	1	0.75	0.5	0.25	0
3. Does this clinic provide FP counselling? (number of children, intentions of next pregnancies, attitudes about FP, risk of STIs/HIV)	1	0.75	0.5	0.25	0
4. Does FP counselling include correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy? (Dual method – barrier against STIs and protection for unintended pregnancy)	1	0.75	0.5	0.25	0

5. Does this clinic provide safe pregnancy counselling for young women and young men, and for women who are currently pregnant or wish to become pregnant?	1	0.75	0.5	0.25	0
6. Does FP counseling for young girls and boys, including future preparation for planning their families?	1	0.75	0.5	0.25	0
7. Does this clinic provide and promote male involvement in FP?	1	0.75	0.5	0.25	0
8. Does this clinic provide and promote couples counseling?	1	0.75	0.5	0.25	0
9. Does this clinic provide counseling services for single mothers and elderly women (e.g. menopause issues)	1	0.75	0.5	0.25	0

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record this in row A
2. Divide by the number of questions, 9
3. Multiply by 100 and record this value as the score

A. SUM OF CIRCLED RESPONSES:	
SCORE:	%

3. Staff and Training

Question	Response		
1. How many staff in this clinic provide FP services to clients?	Nursing	Midwifery	N/Aide
	1	2	3
2. How many staff have received the following training, either pre-service or in-service?	**No of trained staff who provide FP services**	**Total number of trained staff**	**Score**
a. Training on FP			
b. Training on youth and adolescent-friendly services			
c. **Training on the provision of key-population or high risk population friendly services** (Adolescence, single mothers, men)			
d. **Training on the provision and removal of IUCDs** (if IUCDs not provided at this clinic, record NA in the response and score columns			
e. **Training on the provision and removal of Jadelle implants**. (If Jadelle implants are not provided at this clinic record NA in the response and the score columns)			
f. Training on sexual and reproductive rights of adolescent girls and boys			
g. **Training on sexual reproductive health and family planning services** e.g. Midwifery, Family			

planning, reproductive health, Men's involvement in RH			

Question	Yes	No
3. In the past 6 months, have clients been turned away or asked to return a different day because there were not enough trained staff available to provide the method requested?	1	0
4. Do you think the clinic has enough staff trained in FP services to respond to current demand for FP services?	1	0

HOW TO SCORE THIS SECTION

1. For questions 2a-2g, divide the number of trained providers (in the response column), by the number of total providers (response to question 1). Record this in the score column. Note the maximum score is 1.
2. Sum the circled responses and the numbers and the numbers in the score column. Record this number in row A.
3. Count the number of NAs in the score column, if any and record it in row B
4. Subtract the value in column B from the maximum numbers of questions, 9. Record this in row C.
5. Divide the number in column A by the number in row C.
6. Multiply by 100 and record this as the score.

A. SUM OF CIRCLED RESPONSES:	
B. NUMBER OF NA:	
B. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	%

4. Supervision

Question	Yes	No
1. Do staff that provide FP services receive outside supervision to monitor their performance?	1	0
If no, skip the section and record score as 0%		
2. Do supervisory visits that include review of FP services happen at least 4 times per year?	1	0
3. Is feedback provided to service providers after supervision is conducted?	1	0
4. Is there a mechanism for documenting supervision visits?	1	0
5. When gaps are found during supervision, is a plan developed to address gaps that includes the following information:		
Actions identified to address gap?	1	0
Person assigned to complete actions?	1	0
Due date for completion of actions?	1	0
6. Is additional FP training available to service providers, if needed? *This include: on the job training, extra support, on-site mentorship, off-site training etc.*	1	0

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record this in row A
2. Divide by the number of questions, 8.
3. Multiply by 100 and record this value as the score

A. SUM OF CIRCLED PRESONSES:	
SCORE:	%

5. Drugs and supplies

Question	Response		
1a. Of the contraceptive methods provided at this facility, which are available today? *If the method is available for demonstration but none are available for provision, select no. IF the method is not offered select "NA"*			
	Yes	**No**	**Not offered**
Male condoms	1	0	NA
Female condoms	1	0	NA
Oral contraceptives - POPs	1	0	NA
Oral contraceptives - COCs	1	0	NA
Emergency contraception (Prostino)	1	0	NA
Injectable contraceptives (Depo Provera)	1	0	NA
IUCDs (Copper T)	1	0	NA
Jadelle Implants	1	0	NA
Natural methods – Ovulation Chart, cycle beads	1	0	NA
1b. Of the contraceptive methods provided at this facility, which have experienced stock out? *To determine if there has been stock out in the last 3 months, ask a staff member in charge of FP services or the Pharmacist or by checking records. If a stock out is indicated by either the staff member or by the records, choose 'yes' even if the method is available today. If the method is not offered select "NA".*			
	Yes	No	Not offered
Male condoms	1	0	NA
Female condoms	1	0	NA
Oral contraceptives – POPs	1	0	NA
Oral contraceptives – COCs	1	0	NA
Emergency contraception (Prostino)	1	0	NA
Injectable contraceptives (Dep Provera)	1	0	NA
IUCDs	1	0	NA
Contraceptive Jadelle Implants	1	0	NA
Natural method – Ovulation chart, cycle beads	1	0	NA
2. **Of the following services offered at this clinic, which have been available at all times in the last 3 months?** *This means that adequate supplies, equipment and trained staff have always been available. If method is not offered select "NA"*			
Female sterilisation (Tubal Ligation)	1	0	NA
Male sterilisation (Vasectomy)	1	0	NA
Jadelle Implant insertion	1	0	NA
Jadelle implant removal	1	0	NA
IUCD insertion	1	0	NA
IUCD removal	1	0	NA
Urine test for pregnancy			

Question	Yes	No	Not offered
3. Does the facility have pregnancy tests onsite?	1	0	NA
4. **Does this clinic have a supply management system that is used to track FP commodities?** *This can include stock cards, monthly summaries etc.*	1	0	NA
5. **Have the staff providing FP at this clinic received training on how to track FP commodities?**	1	0	NA

Question	One week or less	Between one week and one month	Between one month and six months	More than six months	NA
6. In the last year, when have you experienced a stock out of one or more contraceptives, what is the longest time it has taken to replace them?	1	0.75	0.5	0.25	NA

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record in row A
2. Count the number of circled NAs and record it in row B
3. Subtract the value in column B from the maximum number of questions, 28. Record this in row C
4. Divide the number in column A by the number in row C
5. Multiply by 10 and record this as the score

A. SUM OF CIRCLED RESPONSES	
1. NUMBER OF NA:	
B. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	

6. Clinic infrastructure and resources

Question	Yes	No	NA
1. Go to the room where FP clients are examined. Are the following true of the exam room?			
Has respective seating areas for the client and the provider	1	0	NA
Is well lit	1	0	NA
Has examination bed	1	0	NA
Provides visual privacy for individual client encounters	1	0	NA
Has a sound barrier for privacy (The room should be completely enclosed	1	0	NA
Has a hand washing station	1	0	NA
Has soap for washing	1	0	NA
Has a receptacle for waste disposal	1	0	NA

8

Has clinical equipment for vaginal exams including vaginal speculums	1	0	NA
Has equipment for IUCD insertion (Select NA if clinic does not insert IUCDs)	1	0	NA
Has equipment (sterile)for IUCD removal (select NA if clinic does not remove IUCDs)	1	0	NA
Has equipment (sterile) for Jadelle implant insertion (Select NA if clinic does not insert implants)	1	0	NA
Has equipment (sterile) for implant removal (select NA if clinic does not remove implants)	1	0	NA

Question	Yes	No	NA
2. Go to the room where FP counseling takes place. Are the following job aids available?			
Samples of available FP methods/ FP demonstration tray	1	0	NA
FP choices chart or poster	1	0	NA
FP screening checklist	1	0	NA
Penile model	1	0	NA
Pelvic model	1	0	NA
3. Go to the room where FP clients wait to be seen. Are the following true of the waiting area?			
Seating is available for clients	1	0	NA
The area is shaded or covered by a roof	1	0	NA
4. What types of FP information, education, and counseling (IEC) materials are available for clients?			
Posters	1	0	NA
Flip chart	1	0	NA
Brochure/pamphlet/information sheet for participants to keep (at least 10)	1	0	NA
Videos /CDs	1	0	NA
5. Are the IEC materials comprehensible by those who cannot read or translated into local language?	1	0	NA
6. Are permanent signs displayed on the street or on the exterior indicating that FP services are available at this clinic?	1	0	NA
7. Does the clinic have a space for appropriately storing contraceptives, away from water, heat and direct sunlight?	1	0	NA
HOW TO SCORE THIS SECTION			
1. Sum the circled responses and record this in row A 2. Divide by the number of questions, 25. 3. Multiply by 100 and record this as the score			
A. SUM OF CIRCLED RESPONSES:			
SCORE:	%		

7. Referrals

Question	Yes	No	NA
1. **Does this clinic provide referrals for FP services?** *This question is not scored*	1	0	NA
IF NO, skip this section and record as "NA"			
2. **Does this clinic maintain a directory of referral sites?**	1	0	NA
3. **Is the directory easily retrievable and accessible to all staff making referrals?**	1	0	NA
4. **Is the directory regularly updated?** For example, *if something were to change at a clinic, would the directory be updated to reflect that change*	1	0	NA

Question	Escort client, written (hard copy/e-copy),	Verbal	Other
5. **What method is used to refer clients?**	1	0.5	0.25

Question	Yes	No	NA
6. **In the last 3 months, has this clinic ever run out of referral forms?** *Select "NA" if referral forms are not used.*	1	0	NA
7. **What information is provided to the client in the referral?** *Select one answer for each line*			
Location of site	1	0	NA
Hours that the services are available	1	0	NA
Expected fees	1	0	NA
Contact person	1	0	NA
Instruction for reaching site	1	0	NA
8. **In your opinion, are the facilities to which you refer clients for FP services easily accessible to all clients?** *For a service to be easily accessible, transport to the facility should be readily available and affordable, and services should be provided at reasonable price for all clients.*	1	0	NA
9. **Is there a system in place to track whether a client has completed a referral?**	1	0	NA
10. **If a referral is not complete, is an attempt made to contact the patient?** *Select "NA" if there is no system in place to track referrals*	1	0	NA
11. **Is the status of tracked referrals recorded?** *Each referral should be recorded as complete or not complete. Select "NA" if there is no system in place to track referrals.*	1	0	NA

Question	0-25%	26-50%	51-75%	76-100%
12. What percentage of tracked referrals are tracked? *Verify referral records for at least 10 referrals, skip recent referrals if not tracked. Select "NA" if there is no system to track referrals*	0.25	0.5	0.75	1
13. What percentage of tracked referrals are completed*? Verify referral records for at least 10 referrals. select "NA" if there is no system in place to track referrals*	0.25	0.5	0.75	1

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record in row A
2. Count the number of circled NAs and record it in row B
3. Subtract the value in column B from the maximum number of questions, 16. Record this in row C
4. Divide the number in column A by the number in row C
5. Multiply by 10 and record this as the score

A. SUM OF CIRCLED RESPONSES:	
B. NUMBER OF NA:	
C. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	

Appendix 2: Interview Guides (English Version, Pijin Version, Specific Guide for Case Study Three)

Interview guide questions: English version

Participant Name_____ Date: _____

A. Demography (Please circle the option that is true for you-Circle 1 only)

1. What age group do you belong to?
   a. Below 20 years
   b. 20-30 years
   c. 31-40 years
   d. 40 – 50 years
   e. Above 50 years

2. What is your gender?
   a. Male b. female. c. others

3. What is your education level?
   a. Primary b. Secondary c) Vocational training d). Tertiary (College or University graduate).

4. What is your marital status? (mark 1 only)
   a. Never married/single
   b. Widowed
   c. Divorced
   d. Separated
   e. Married (legal or customary)
   f. Defactor relationship

5. Which Church do you belong to?
   a. Roman Catholic
   b. Anglican
   c. SDA
   d. SSEC
   e. JW
   f. Uniting Church
   g. Others: please write here_____

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B. Interview questions

Service Users & Non-users guide

1. Can you tell me about your experiences at this family planning clinic?
    a. Do you think family planning is important?
    b. Yes/No explain
2. Can you tell me the different FP methods you know?
    a. Where do you hear about the methods you mentioned?
    b. How do you access/ reach family planning service? Is it easy?
    c. Do you use any methods? Can you share your experience on the use?
3. Can you tell me what made some men, women, young boys and girls not come to the family planning clinic to take contraceptives/family planning method?
    a. What would make them want to come to the clinic?
4. What do you think should be done differently in family planning clinics?
    a. Any comments/advise/ recommendations to improve family planning services as a whole?

Reproductive health/Family planning managers guide

5. Can you tell me about your experiences in planning and managing family planning programs?
    a. How do they plan programs/activities?
    b. What directs planning and implementation of program?
    c. What about supervisory visits or tours?
    d. How do you monitor or evaluate their programs?
    e. What are the challenges? Success stories? Of their programs
    f. What do you think should be done differently in planning family planning programs?
6. Can you tell me what made some men, women, young boys and girls not come to the family planning clinic to take contraceptives/family planning method?
    a. What would make them want to come to the clinic?
7. What do you think should be done differently in family planning clinics?
    a. Any comments/advise/ recommendations to improve family planning services as a whole?

Family planning Service providers guide

8. Can you tell me about your experiences in delivering family planning services?
    a. How family planning services are delivered in the clinic.
    b. What other approaches to service is offered in this clinic? who came/ did not come
    c. How often do you run family planning clinics? Opportunistic services/follow up services?
    d. How did you manage your contraceptive supplies? Any issues with funds for family planning activities?
    e. What is your target CPR for your clinic, zone, province, country? How often did you evaluate your family planning service?
9. Can you tell me what made some men, women, young boys and girls not come to the family planning clinic to take contraceptives/family planning method?
    a. What would make them want to come to the clinic?
10. What do you think should be done differently in family planning clinics?
    a. Any comments/advise/ recommendations you wish to make about FP services as a whole?

B. Interview questions

Service Users & Non-users guide

1. Iu save talem mi wat na iu findim (experiences) taem iu save kam lo family planning clinic lo hia?
    - Waswe iu tink family planning hem gud samting? (important)
    - If iu se ja, iu save talem wae na iu tok osem? Or if nomoa, iu save talem mi wae na iu se nomoa?
2. Iu save talem mi wat na samfala family planning method or meresin oketa save usim fo family planning iu save lo hem?
    - Lo wea na iu herem oketa method or meresin ia?
    - Sapos iu laekem meresin blo family planning, hao na iu save tekem?
    - Waswe hem isi nomoa for kam lo clinic en tekem tu?
    - Waswe iu usim or tekem eni meresin blo family planning tu?
    - Iu save talem mi samfala gud samting and nogud samting lo taem iu usim? (experience).
3. Iu save talem mi wat na mekem or wae na samfala man, woman or gele en boy no laek kam lo family planning klinik fo tekem meresin osem?
    - Wat na bae mekem oketa laek fo kam lo family planning klinik?
4. Lo tingting blo iu wat na samfala samting iu laek fo lukim oketa nurse mas mekem gud insaed lo family planning klinik fo mekem eniwan nomoa save kam?
    - Waswe iu garem eni last toktok iu laek talem fo mekem gud go moa na family planning klinik lo Kia?

Reproductive health/Family planning managers guide

5. Iu save talem me wat na iu findim (experience) lo taem iu planim or managim family planning program lo hia?
    - Hao na iufala save planim oketa program or activities lo family planning?
    - Wat na samfala samting hem save mekem or directim na hao iu planim and implementim family planning program?
    - Hao na oketa supervisory visits or tours osem? Iu save go tu? Hamas taem lo one year na iu save duim oketa visits ia?
    - Hao na ufala save checkim or monitor or evaluatim oketa family planning programs?
    - Wat na samfala challenges iu findim lo planim and ranem family planning?
    - Wat na samfala Success stories iu findim lo family planning?
    - Wat na iu tink hem mas happen lelebet different lo saed lo planim and implementim family planning programs?
6. Iu save talem mi wat na mekem samfala man, woman, young gele en boys no kam lo family planning clinic fo tekem contraceptives/family planning method?
    - Wat na bae mekem oketa laek fo kam lo klinik?

7. Lo lukluk blo iu wat na hem mas happen for mekem family planning klinik or sevis hem kamap gud moa, for mekem eniwan save kam and tekem contraceptive method?
    - Waswe eni last toktok iu like talem or comments/advise/ recommendations osem fo improvim family planning service lo hia?

Family planning Service providers guide

8. Iu save talem mi wat na iu findem (experiences) lo taem iu save ranem family planning sevis lo hia?
    - Hao na iufala save ranem family planning sevis lo klinik lo hia? Osem hamas taem or days na klinik hem open?
    - Wat na samfala diferen wei iufala save givim or mekem family planning fo mas kasem staka woman or man?
    - Oketa hu na save kam staka lo klinik and hu na no save kam tumas lo klinik?
    - Iu save talem mi about satellite klinik or Opportunistic sevis, or follow up blo ufala lo family planning?
    - Hao na iufala save managim contraceptive supplies or meresin?
    - Iufala findem problem lo seleni for olketa family planning activities tu?
    - Wat na target contraceptive prevalence rate (CPR) fo klinik, zone, province, country?
    - Hamas taem and lo wat taem nao iufala save evaluatim family planning sevis blo iufala?
9. Iu save talem mi wat na mekem samfala man, woman, young boys and girls no come lo family planning klinik fo tekem contraceptives/meresin/method?
    - What would make them want to come to the clinic?
10. Lo tingting blo iu wat na samfala samting for duim moa lo klinik ia fo mekem sevis lo family planning hem gud?
    - Iu garem eni last toktok/advise/ recommendations iu laek talem aboutim FP sevis lo hia?

Appendix 3: Participant Information Sheet and Consent Form

JAMES COOK UNIVERSITY
AUSTRALIA

INFORMATION SHEET

PROJECT TITLE: **Family planning service provision in Solomon Islands: A Case Study Approach.**

You are invited to take part in a research study to explore perspectives of family planning managers, service providers, service users and non-users on how family planning is provided at the family planning clinic. The study will use **i)** family planning checklist, ii) review of family planning documents and iii) face to face semi-structured interviews. The study is being conducted by **Relmah Harrington** and will contribute to the **PhD research** in the **Doctor of Philosophy (Health)** at James Cook University.

The aim of this project is to explore the availability, accessibility and acceptability of family planning services at three health clinics (Rove, Helena Goldie and Kia) family planning clinics. To find out what people think about family planning services and the contraceptive methods that are available. This is an important study because it will provide some information on ways that we can improve future family planning programs that people can freely use whenever they wish so that it can bring better health to women and their families. Studies have shown that women who use family planning contraceptives are healthier and are more empowered to make better decisions about their reproductive choices. The result of the study will be used to inform local health policies and practices relating to family planning services.

If you agree to be involved in the study, you will be invited for an interview. The interview, with your consent, will be undertaken on a one-on-one basis. The interviews will be audio-taped or video recorded via a secure online platform, translated where required. The interview may take approximately 30 to 60 minutes of your time.

Taking part in this study is voluntary and you can stop taking part in the study at any time without explanation or prejudice. Your responses and contact details will be strictly confidential/anonymous. The data from the study will be used in research publications such as report, journal articles, conference presentations and Doctoral thesis.

If you have any questions about the study, please contact Relmah Harrington.

Principal Investigator:
Relmah Harrington
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James Cook University
Phone:
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Supervisor:
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College of Medicine and Dentistry
James Cook University
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If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

INFORMED CONSENT FORM

PRINCIPAL INVESTIGATOR: Relmah Harrington
PROJECT TITLE: Family planning service provision in Solomon Islands: A case study approach
COLLEGE: College of Medicine and Dentistry

I understand the aim of this research study is to explore the provision of family planning service in Solomon Islands. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written information sheet to keep.

I understand that my participation will involve an in-depth interview and I agree that the researcher may use the results as described in the information sheet.

I acknowledge that:

- taking part in this study is voluntary and I am aware that I can stop taking part in it at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
- that any information I give will be kept strictly confidential/anonymous and that no names will be used to identify me with this study without my approval;
- confidentiality cannot be assured in focus group discussions.

(Please tick to indicate consent)

I consent to be interviewed		**Yes**		**No**
I consent for the interview to be audio taped		**Yes**		**No**
I consent for the interview to be video recorded via a secure online platform		**Yes**		**No**
		Yes		**No**
		Yes		**No**

Name: *(printed)*	
Signature:	**Date:**

Appendix 4: Support Letters (RMNCAH, HUNS, HGH, Buala)

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Appendix 5: Ethics Approval (SIHRERB and James Cook University HREC

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Appendix 6: First Ethics Amendment

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Appendix 7: Second Ethics Amendment

Appendix 8: Step-by-step Script of Activities Prepared for the Research Assistant

Tentative data collection guide for Allan Rolland – Isabel field trip (November 2020)

Research topic:

Family planning service provision in Solomon Islands: A case study approach.

Research Aim:

To explore the availability, accessibility and acceptability of family planning services, including contraceptives, at three health clinics in Solomon Islands.

The research objectives are to:

1. Describe the availability, accessibility and acceptability of family planning services, including contraceptives, at an urban health centre, a rural hospital and a remote health centre in Solomon Islands;
2. Identify the facilitators and barriers of providing family planning services and contraceptive choices at these three centers;
3. Identify sexual and reproductive health services that are available, accessible and acceptable to young people and men in an urban, rural and remote setting; and
4. Recommend strategies to improve family planning service delivery, including contraceptive use, to inform health service providers and policy makers in Solomon Islands.

No	Field trip activities	What to do
1.	***Confirm date of travel to Isabel and preparations*** Paper copies to print • Information sheet (x35) • Consent form (x35) • Interview guide English version (x1) • Interview guide pijin version (x35) • Family planning checklist (x2) • Guide to data collection (x1) • Ethics approval (Research certificate- 2 sets) x3	When travel dates are confirmed; 1. Let me know the expected start date at Kia and Buala so that I can inform Hellen Marau (Director of Provincial Health - Buala). Hellen will inform the nurse at Kia of your arrival. (RH will obtain contact phone from Helen to give to Allan) 2. Call the Director and inform her the date you will start at Kia and arriving at Buala. 3. Ensure you have paper copies of all related documents, including ethics approvals, interview guides; get phone credit ($100); check voice recorder and batteries (have spares) and check that your phone voice recorder is working and phone is password protected. Lecture pads, pens, folder, flash drive. 4. Please do not delete all audio recordings until I inform you.
2.	***Courtesy visit/call***	1. On your arrival to Kia village, go and see the nurse in charge and introduce yourself, and explain what you will do in the next 1-2 weeks. Check if the Provincial Director informed the clinic about the proposed study at the clinic facility. Inform the nurse the date you will start and thank them for assisting to communicate about the study and recruit participants. 2. On your arrival at Buala Hospital, go and see Hellen Marau, introduce yourself and explain what you will do in a couple of days. Inform her

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		the time and date you will start and who you would interview.
3.	***Data collection*** On this field trip you will collect two types of data: 1) Quantitative data –from documents like reproductive health (RH) and family planning (FP) register books, clinic reports on FP, and reproductive health reports etc or any documents the nurse thinks will be important for this study. 2) Qualitative data – from face to face interviews with participants.	• **At Kia clinic** - you will collect both the quantitative (existing health records; clinic checklist) and qualitative data (interviews). • **At Buala hospital** - you will **ONLY** do the interviews (qualitative). You will **NOT** collect the reports (quantitative). • Take as many photos as you can – clinic, village (different shots of entire village), you travels by boat and OBM, during interview-not faces but may be back or side. These photos will help tell the story of your data collection trip that I will write in my thesis. • I will send you a photo permission form, you will give this to those whose photos are taken to sign if they are happy/agree for me to use their photos for publications etc.
	a) Quantitative data collection – KIA/BUALA Here, you will look at the • FP/RH register books and reports • And complete the clinic checklist (attached). This checklist will be sent to you on email and you print it.	Kindly ask the nurse that you would like to look at the family planning register books and clinic reports from 2015-2020.(Note: if you cannot retrieve everything for those years requested, just get whatever reports available). • **FP/RH register books and reports include**: o Family planning register book 2015-2020. o Monthly HIS reports of clinic activities 2015-2020. o Other reproductive health (RH) reports reporting STI, teenage pregnancy, men as partners, family planning contraceptives by age, adolescent health and development program report in Solomon Islands etc. o Other register books that the clinic has created (exercise books) to record Jadelle implants or other FP/RH activities that are not captured in the original FP register books or HIS report form. Two ways you can collect the above reports: i.) take a photo of the pages using your phone and download to computer and save them in a flash drive (ensure it is clear and readable).Label and number the pages if possible OR ii.) Write the details/variables in total per year on a lecture pad and this can be scanned and sent to me from Honiara. • **Clinic checklist**

		○ This checklist has questions. Go through the checklist with the nurse and always write comments (on comments column) if options available in the checklist did not capture what is actually happening at the clinic etc. You can also audio record your conversation with the nurse about the checklist – this will be very helpful to me. ○ The checklist has seven (7) main headings (*FP services provided at the clinic, Counselling, Staffing and training, Supervision, Drugs and supplies, clinic infrastructure and resources, and Referrals). Will elaborate further on zoom meeting*
	Qualitative data collection – KIA Here, you will conduct face-to-face interviews with participants in the following categories: 1. FP nurse/s or service provider/s (n=depends on number of clinic nurses) (5) 2. Women/girls (n=4) who currently or previously used contraceptives 3. Women/girls (n=4) who never use contraceptives or never visited FP clinics. 4. Men/boys (n=10) who currently or previously used/had condoms/ vasectomy for contraceptive reasons or visited the clinic for counselling on FP/RH issues. 5. Men/boys (n=10) who never used/ had condoms/vasectomy nor attended the FP clinic for counselling	In Kia, I want you to interview as many men and boys as possible. Use the interview guide and complete demographic details of each participant in the same sheet. Interviews can be 30-60 minutes long. *Before you begin your interviews, first explain the research and its importance, what you will be doing during the interview (use the Information Sheet provided as your guide). Provide all participants with an Information Sheet (even if they can't read – someone in their family might). Ask for any questions, if they are happy, give them consent form to sign. Do not forget to get consent for recording their interviews as well, being sure to explain how you will keep the recordings safe and confidential, how the recordings will be used etc).* How do you recruit participants or where you find them? You can either recruit them from: • ***The clinic*** - when they attend to services like family planning, or child welfare etc (for women). The nurse may help you identify who is using FP but for others, you can ask them if they have used any contraceptives or not. Men/boys can be recruited from Outpatient services etc. • ***The community*** – seeing that the clinic is right in the village, you can recruit them from the village. (Note: do what is appropriate in the culture of your community, if men/women are more comfortable to be interviewed at the clinic then you may identify them in the community and can do the interview in the clinic where there is privacy for them). This will be the same for boys

		and girls recruited for interviews. See where they are comfortable to be interviewed, as long as others are not near to hear your conversations with them. If the person who agrees to be interviewed wants a support person with them, that is OK – but please record this is the case.
	b) Qualitative data collection – BUALA	• As stated earlier you will only conduct interviews with RH/FP coordinator/managers for the province in Buala (usually the RH coordinator is also the FP nurse etc so find out). • I am thinking if you could interview **Hellen Marau** (previous FP coordinator) and **Wendy Kikolo** (check if she is the current RH coordinator) and if there is another nurse working with Wendy at the FP clinic.
4	**Interview tips**	• My research topic, aim and objectives are written at the top of this guide for your reference guide when you probe your questions further during the interview (will talk more of this in our Zoom meeting). • When you begin your first interviews, read through all the interview questions for the specific audience (FP users/non-users, FP managers, FP service providers) you are interviewing. This will help give you some ideas to ask further probing questions. • Use the interview questions as your guide to start the conversation. • As the conversation flows, let them speak as much and as long as they can speak, try not to interrupt them often unless they are off track or very quiet. • When they say something sensitive or that you do not agree with, avoid being critical and judgmental about what they say, assure them confidentiality and encourage them to talk • When probing try use more open-ended questions (e.g. why, can you tell me more about what you are saying? Or can you explain a little more about this idea etc.) than close-ended (e.g. Yes or No answers) • Finish the interview by thanking them for participating
5	**Extra important information to ask the clinic nurse**	• Ask about the Traditional Birth Attendants (TBA) practice in Kia. Do they still have TBA's? • If TBA is still practiced, what are some good things and bad things about having them? • Is teenage pregnancy or STI's an issue at Kia? • If yes/no explain your answer
		Please write the information below:

	1. Total population at Kia village 2. Total of women of childbearing age. 3. Total of youth population 4. Total of children (5 yrs and under) 5. Where is the catchment area of Kia Clinic (boundary – from where to where) 6. Find out if Kia is a Rural or Area Health Centre 7. Staffing at Kia clinic	

Appendix 9: Revised Checklist Form

Family Planning Clinic Checklist **Clinic Name: _____**

1. Services

Question	Response		
1. Does this clinic provide or refer for any of the following family planning methods? Select "yes" if the clinic provides the method or refers clients to another facility for the method. Please select one response for each line. If you selected yes (1) above and it was because you refer clients for the method stated, please provide information about which facility you would refer client to Note, if an outside organization comes to the clinic to provide the method, but otherwise the method is not provided, do not select provided at this clinic.			
Family planning Method	**Yes – provided or referred**	**No- Do no not provide or refer**	**COMMENTS**
Fertility awareness counselling	1	0	
Natural methods counseling (Ovulation/Mucus, Calendar method, Symptothermal method)	1	0	
Male condoms	1	0	
Female condoms	1	0	
Lactation Amenorrhea Method (LAM) counselling	1	0	
Oral contraceptive pills (POP, COC)	1	0	
Emergency contraceptives (e.g. Prostino)	1	0	
Injectable contraceptives (e.g. Depo provera)			
IUCD insertion	1	0	
IUCD removal	1	0	
Jadelle Implant Insertion	1	0	
Jadelle Implant removal	1	0	
Female sterilisation (tubal ligation)	1	0	
Male sterilisation (Vasectomy)	1	0	

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2. Typically, how often can clients access the following family planning methods?

Please select one response for each line

Family Planning Method	Less than once per week	Weekly but not everyday	Every day the clinic is open	Not provided at this clinic	COMMENTS
Fertility awareness counselling	0	0.50	1	NA	
Natural methods counselling (Ovulation/mucus, Calendar method, Symptothermal method)	0	0.50	1	NA	
Male condoms	0	0.50	1	NA	
Female condoms	0	0.50	1	NA	
Lactation Amenorrhea method (LAM) counselling	0	0.50	1	NA	
Oral contraceptive pills	0	0.50	1	NA	
Emergency Contraception (e.g. Prostino)	0	0.50	1	NA	
Injectable contraceptives e.g. Depo Provera)	0	0.50	1	NA	
IUCD insertion	0	0.50	1	NA	
IUCD removal	0	0.50	1	NA	
Janelle Implant insertion	0	0.50	1	NA	
Janelle Implant removal	0	0.50	1	NA	
Female sterilisation (tubal ligation)	0	0.50	1	NA	
Male sterilisation (Vasectomy)	0	0.50	1	NA	

3. Typically how often does the clinic offer outreach family planning services in the community?					
Family Planning Methods offered during outreach visits	**Less than once per week**	**Weekly but not every day**	**Every day the clinic is open**	**Not provided at this clinic**	**COMMENTS**
Fertility awareness counselling	0	0.50	1	NA	
Natural methods counselling (Ovulation/mucus, Calendar method, Symptothermal method)	0	0.50	1	NA	
Male condoms	0	0.50	1	NA	
Female condoms	0	0.50	1	NA	
Lactational Amenorrhea method (LAM) counselling	0	0.50	1	NA	
Oral contraceptive pills (POP. COC)	0	0.50	1	NA	
Emergency Contraception e.g. Prostino	0	0.50	1	NA	
Injectable contraceptives e.g. Depo Provera	0	0.50	1	NA	
IUCD insertion	0	0.50	1	NA	
IUCD removal	0	0.50	1	NA	
Jadelle Implant insertion	0	0.50	1	NA	
Jadelle Implant removal	0	0.50	1	NA	
Female sterilisation (tubal ligation)	0	0.50	1	NA	
Male sterilisation (Vasectomy)	0	0.50	1	NA	

	Question	Yes	No	NA	COMMENTS
4.	**Does this clinic provide STI screening prior to IUCD insertion?** *(This assessment may be syndromic or clinical. Select "NA" if clinic does not provide IUD insertion)*	1	0	NA	
5.	**Does this clinic provide male-friendly services to promote male involvement in FP?** *(Examples include: condom demonstrations for men and boys, inclusion of men and boys in ANC visits etc.*	1	0	NA	
6.	**Does this clinic have written protocols/ guidelines for delivering FP services?** *(This may include algorithms for service provision, standard operating procedures, national family planning guidelines/policies or checklists for services*	1	0	NA	
7.	**Does this clinic have the most recent versions of such protocols/guidelines?** *(Select "NA" if this clinic does not have written protocols /guidelines*	1	0	NA	
8.	**Are data on the FP services provided to STI/HIV service clients being captured at this clinic?**	1	0	NA	
9.	**Do the captured FP data bread down patients by FP methods?** *(Select "NA" If this clinic does not capture FP data for HIV service)*	1	0	NA	
10.	**In the past six months, have STI/HIV service clients at this facility who are waiting to access FP services ever left before receiving services because the wait time is too long?**	1	0	NA	

HOW TO SCORE THIS SECTION	
1. Sum the circled responses and record in row A	
2. Count the number of circled NAs and record it in row B	
3. Subtract the value in row B from the maximum number of questions, 31 record this in row C	
4. Divide the number in row A by the number in row C	
5. Multiply by 100 and record this as the score	
A. SUM OF CIRCLED RESPONSES:	
i. NUMBER OF NA:	
B. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	%

2. Counselling

Question	Yes, always	Yes most of the time	Yes a little of the time	No, Never	NA	COMMENTS
1. **Does this clinic routinely assess clients need for FP services based on his/her clinical history and reproductive intentions?**	1	0.75	0.5	0.25	0	
2. **When a client is found to have a need for FP, does this clinic routinely screen the client to determine what FP services are appropriate?** (reproductive goals, infertility issues, FP knowledge, living family situation, any FP-related concerns)	1	0.75	0.5	0.25	0	
3. **Does this clinic provide FP counselling?** (number of children, intentions of next pregnancies, attitudes about FP, risk of STIs/HIV)	1	0.75	0.5	0.25	0	
4. **Does FP counselling include correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy?** (Dual method – barrier against STIs and protection for unintended pregnancy)	1	0.75	0.5	0.25	0	
5. **Does this clinic provide safe pregnancy counselling for young women and young men, and for women who are currently pregnant or wish to become pregnant?**	1	0.75	0.5	0.25	0	
6. **Does FP counseling for young girls and boys, including future preparation for planning their families?**	1	0.75	0.5	0.25	0	
7. **Does this clinic provide and promote male involvement in FP?**	1	0.75	0.5	0.25	0	
8. **Does this clinic provide and promote couples counseling?**	1	0.75	0.5	0.25	0	
9. **Does this clinic provide counseling services for single mothers and elderly women** (e.g. menopause issues)	1	0.75	0.5	0.25	0	
HOW TO SCORE THIS SECTION						
1. Sum the circled responses and record this in row A 2. Divide by the number of questions, 9 3. Multiply by 100 and record this value as the score						
A. SUM OF CIRCLED RESPONSES:						

SCORE:	%

3. Staff and Training

Question	Response			
1. How many staff in this clinic provide FP services to clients?	Nursing	Midwifery	N/Aide	COMMENTS
	1	2	3	
2. How many staff have received the following training, either pre-service or in-service?	**No of trained staff who provide FP services**	**Total number of trained staff**	**Score**	
a. Training on FP				
b. Training on youth and adolescent-friendly services				
c. **Training on the provision of key-population or high risk population friendly services** (Adolescence, single mothers, men)				
d. **Training on the provision and removal of IUCDs** (if IUCDs not provided at this clinic, record NA in the response and score columns				
e. **Training on the provision and removal of Jadelle implants**. (If Jadelle implants are not provided at this clinic record NA in the response and the score columns)				
f. Training on sexual and reproductive rights of adolescent girls and boys				
g. **Training on sexual reproductive health and family planning services** e.g. Midwifery, Family planning, reproductive health, Men's involvement in RH				

Question	Yes	No	COMMENTS
3. In the past 6 months, have clients been turned away or asked to return a different day because there were not enough trained staff available to provide the method requested?	1	0	
4. Do you think the clinic has enough staff trained in FP services to respond to current demand for FP services?	1	0	

HOW TO SCORE THIS SECTION

1. For questions 2a-2g, divide the number of trained providers (in the response column), by the number of total providers (response to question 1). Record this in the score column. Note the maximum score is 1.
2. Sum the circled responses and the numbers and the numbers in the score column. Record this number in row A.
3. Count the number of NAs in the score column, if any and record it in row B
4. Subtract the value in column B from the maximum numbers of questions, 9. Record this in row C.
5. Divide the number in column A by the number in row C.
6. Multiply by 100 and record this as the score.

A. SUM OF CIRCLED RESPONSES:	
B. NUMBER OF NA:	
B. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	%

4. Supervision

Question	Yes	No	COMMENTS
1. Do staff that provide FP services receive outside supervision to monitor their performance?	1	0	
If no, skip the section and record score as 0%			
2. Do supervisory visits that include review of FP services happen at least 4 times per year?	1	0	
3. Is feedback provided to service providers after supervision is conducted?	1	0	
4. Is there a mechanism for documenting supervision visits?	1	0	
5. When gaps are found during supervision, is a plan developed to address gaps that includes the following information:			
Actions identified to address gap?	1	0	
Person assigned to	1	0	

complete actions?			
Due date for completion of actions?	1	0	
6. Is additional FP training available to service providers, if needed? *This include: on the job training, extra support, on-site mentorship, off-site training etc.*	1	0	
HOW TO SCORE THIS SECTION			
1. Sum the circled responses and record this in row A 2. Divide by the number of questions, 8. 3. Multiply by 100 and record this value as the score			
A. SUM OF CIRCLED PRESONSES:			
SCORE:		%	

5. Drugs and supplies

Question	Response			COMMENTS
1a. Of the contraceptive methods provided at this facility, which are available today? *If the method is available for demonstration but none are available for provision, select no. IF the method is not offered select "NA"*				
	Yes	**No**	**Not offered**	**COMMENTS**
Male condoms	1	0	NA	
Female condoms	1	0	NA	
Oral contraceptives - POPs	1	0	NA	
Oral contraceptives - COCs	1	0	NA	
Emergency contraception (Prostino)	1	0	NA	
Injectable contraceptives (Depo Provera)	1	0	NA	
IUCDs (Copper T)	1	0	NA	
Jadelle Implants	1	0	NA	
Natural methods – Ovulation Chart, cycle beads	1	0	NA	
1b. Of the contraceptive methods provided at this facility, which have experienced stock out? *To determine if there has been stock out in the last 3 months, ask a staff member in charge of FP services or the Pharmacist or by checking records. If a stock out is indicated by either the staff member or by the records, choose 'yes' even if the method is available today. If the method is not offered select "NA".*				
	Yes	No	Not offered	COMMENTS
Male condoms	1	0	NA	
Female condoms	1	0	NA	

Oral contraceptives – POPs	1	0	NA	
Oral contraceptives – COCs	1	0	NA	
Emergency contraception (Prostino)	1	0	NA	
Injectable contraceptives (Dep Provera)	1	0	NA	
IUCDs	1	0	NA	
Contraceptive Jadelle Implants	1	0	NA	
Natural method – Ovulation chart, cycle beads	1	0	NA	
2. **Of the following services offered at this clinic, which have been available at all times in the last 3 months?** *This means that adequate supplies, equipment and trained staff have always been available. If method is not offered select "NA"*				
Female sterilisation (Tubal Ligation)	1	0	NA	
Male sterilisation (Vasectomy)	1	0	NA	
Jadelle Implant insertion	1	0	NA	
Jadelle implant removal	1	0	NA	
IUCD insertion	1	0	NA	
IUCD removal	1	0	NA	
Urine test for pregnancy	1	0	NA	
Question	Yes	No	Not offered	COMMENTS
3. **Does the facility have pregnancy tests onsite?**	1	0	NA	
4. **Does this clinic have a supply management system that is used to track FP commodities?** *This can include stock cards, monthly summaries etc.*	1	0	NA	
5. **Have the staff providing FP at this clinic received training on how to track FP commodities?**	1	0	NA	

Question	One week or less	Between one week and one month	Between one month and six months	More than six months	NA	COMMENTS
6. **In the last year, when have you experienced a stock out of one or more contraceptives, what is the longest time it has taken to replace them?**	1	0.75	0.5	0.25	NA	

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record in row A
2. Count the number of circled NAs and record it in row B
3. Subtract the value in column B from the maximum number of questions, 28. Record this in row C
4. Divide the number in column A by the number in row C
5. Multiply by 10 and record this as the score

A. SUM OF CIRCLED RESPONSES	
1. NUMBER OF NA:	
B. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	

6. Clinic infrastructure and resources

Question	Yes	No	NA	COMMENTS
1. Go to the room where FP clients are examined. Are the following true of the exam room?				
Has respective seating areas for the client and the provider	1	0	NA	
Is well lit	1	0	NA	
Has examination bed	1	0	NA	
Provides visual privacy for individual client encounters	1	0	NA	
Has a sound barrier for privacy (The room should be completely enclosed	1	0	NA	
Has a hand washing station	1	0	NA	
Has soap for washing	1	0	NA	
Has a receptacle for waste disposal	1	0	NA	
Has clinical equipment for vaginal exams including vaginal speculums	1	0	NA	
Has equipment for IUCD insertion (Select NA if clinic does not insert IUCDs)	1	0	NA	
Has equipment (sterile)for IUCD removal (select NA if clinic does not remove IUCDs)	1	0	NA	
Has equipment (sterile) for Jadelle implant insertion (Select NA if clinic does not insert implants)	1	0	NA	
Has equipment (sterile) for implant removal (select NA if clinic does not remove implants)	1	0	NA	

Question	Yes	No	NA	COMMENTS
2. Go to the room where FP counseling takes place. Are the following job aids available?				
Samples of available FP methods/ FP demonstration tray	1	0	NA	
FP choices chart or poster	1	0	NA	
FP screening checklist	1	0	NA	
Penile model	1	0	NA	
Pelvic model	1	0	NA	

3. Go to the room where FP clients wait to be seen. Are the following true of the waiting area?				
Seating is available for clients	1	0	NA	
The area is shaded or covered by a roof	1	0	NA	
4. What types of FP information, education, and counseling (IEC) materials are available for clients?				
Posters	1	0	NA	
Flip chart	1	0	NA	
Brochure/pamphlet/information sheet for participants to keep (at least 10)	1	0	NA	
Videos /CDs	1	0	NA	
5. Are the IEC materials comprehensible by those who cannot read or translated into local language?	1	0	NA	
6. Are permanent signs displayed on the street or on the exterior indicating that FP services are available at this clinic?	1	0	NA	
7. Does the clinic have a space for appropriately storing contraceptives, away from water, heat and direct sunlight?	1	0	NA	

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record this in row A
2. Divide by the number of questions, 25.
3. Multiply by 100 and record this as the score

A. SUM OF CIRCLED RESPONSES:	
SCORE:	%

7. Referrals

Question	Yes	No	NA	COMMENTS
1. **Does this clinic provide referrals for FP services?** *This question is not scored*	1	0	NA	
IF NO, skip this section and record as "NA"				
2. **Does this clinic maintain a directory of referral sites?**	1	0	NA	
3. **Is the directory easily retrievable and accessible to all staff making referrals?**	1	0	NA	
4. **Is the directory regularly updated?** For example, *if something were to change at a clinic, would the directory be updated to reflect that change*	1	0	NA	

Question	Escort client, written (hard copy/e-copy),	Verbal	Other	COMMENT
5. **What method is used to refer clients?**	1	0.5	0.25	

Question	Yes	No	NA	COMMENTS
6. **In the last 3 months, has this clinic ever run out of referral forms?** *Select "NA" if referral forms are not used.*	1	0	NA	
7. **What information is provided to the client in the referral?** *Select one answer for each line*				
Location of site	1	0	NA	
Hours that the services are available	1	0	NA	
Expected fees	1	0	NA	
Contact person	1	0	NA	
Instruction for reaching site	1	0	NA	
8. **In your opinion, are the facilities to which you refer clients for FP services easily accessible to all clients?** *For a service to be easily accessible, transport to the facility should be readily available and affordable, and services should be provided at reasonable price for all clients.*	1	0	NA	
9. **Is there a system in place to track whether a client has completed a referral?**	1	0	NA	

10. **If a referral is not complete, is an attempt made to contact the patient?** *Select "NA" if there is no system in place to track referrals*	1	0	NA	
11. Is the status of tracked referrals recorded? *Each referral should be recorded as complete or not complete. Select "NA" if there is no system in place to track referrals.*	1	0	NA	

Question	0-25%	26-50%	51-75%	76-100%	COMMENTS
12. What percentage of tracked referrals are tracked? *Verify referral records for at least 10 referrals, skip recent referrals if not tracked. Select "NA" if there is no system to track referrals*	0.25	0.5	0.75	1	
13. What percentage of tracked referrals are completed*? Verify referral records for at least 10 referrals. select "NA" if there is no system in place to track referrals*	0.25	0.5	0.75	1	

HOW TO SCORE THIS SECTION

1. Sum the circled responses and record in row A
2. Count the number of circled NAs and record it in row B
3. Subtract the value in column B from the maximum number of questions, 16. Record this in row C
4. Divide the number in column A by the number in row C
5. Multiply by 10 and record this as the score

A. SUM OF CIRCLED RESPONSES:	
B. NUMBER OF NA:	
C. NUMBER OF RELEVANT QUESTIONS:	
SCORE:	