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Understanding health worker's views on addressing the ongoing unmet need for family planning in Guadalcanal, Solomon Islands.

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ABSTRACT:

Introduction: It is estimated that in the Pacific region the unmet need for family planning is among the highest in the world. This study supports access to family planning based on evidence that impacts of contraceptive use range from improved health to socioeconomic benefits and sustainable development. This study hears from health workers providing essential family planning care to women and their families in Guadalcanal, Solomon Islands. This region was chosen for this study as it has a subnational disparity of highest unmet need for family planning in the Solomon Islands. The aim was to understand health workers' perspectives on barriers to contraception in this region, and to hear their proposed solutions.

Methods: This mixed methods study was based on an exploratory descriptive research approach using a survey, which was distributed to health workers at rural and urban health centres in Guadalcanal, Solomon Islands. Fifty-six surveys comprised of 32 questions, both open and closed-ended, were completed and analysed. This included three demographic questions.

Results: Health workers identified multiple structural, social, and service-driven barriers to meeting the contraceptive needs of women in their communities. Structural barriers include gender inequity and religious influence. Social and service barriers that may be more amenable to influence include misinformation and fear about contraceptive side effects; contraceptive stigma; and access to contraceptive training and education for health workers. Health workers expressed eagerness to address the unmet need for contraception in their communities and are a resource that should be prioritised in programmes seeking to expand access to contraception in the Solomon Islands. Health workers are embedded in their communities and insightful about health service complexities in their settings. They identified solutions including increased access to education and training for Long-Acting Reversible Contraception; increased efforts in raising community awareness and ways of encouraging contraceptive acceptance; and a continued investment in enabling environments both for health workers, and women.

Conclusion: This study affirms health workers as a key resource in addressing the unmet need for contraception in Guadalcanal, Solomon Islands, and calls for programme and policy solutions informed by their perspectives. The two main priorities they emphasised to help tackle the persistent problem of unmet need for contraception are an increase in their capability to provide contraceptive implants, and an increase in community education to boost acceptance of family planning care from women and their families.

Key words: health workers, family planning, contraception, long acting reversible contraception (LARC), Solomon Islands

INTRODUCTION

Family planning is recognised globally as both a health and a human rights issue. Every aspect of well-being, from women's health and secure infant bonding, to strengthening outcomes in education, gender equality, employment, economic independence, and sustainable development is linked to family planning.

Family planning has been affirmed as fundamentally concerned with the empowerment of women. Evidence clearly shows that access to contraception leads to both mothers and babies

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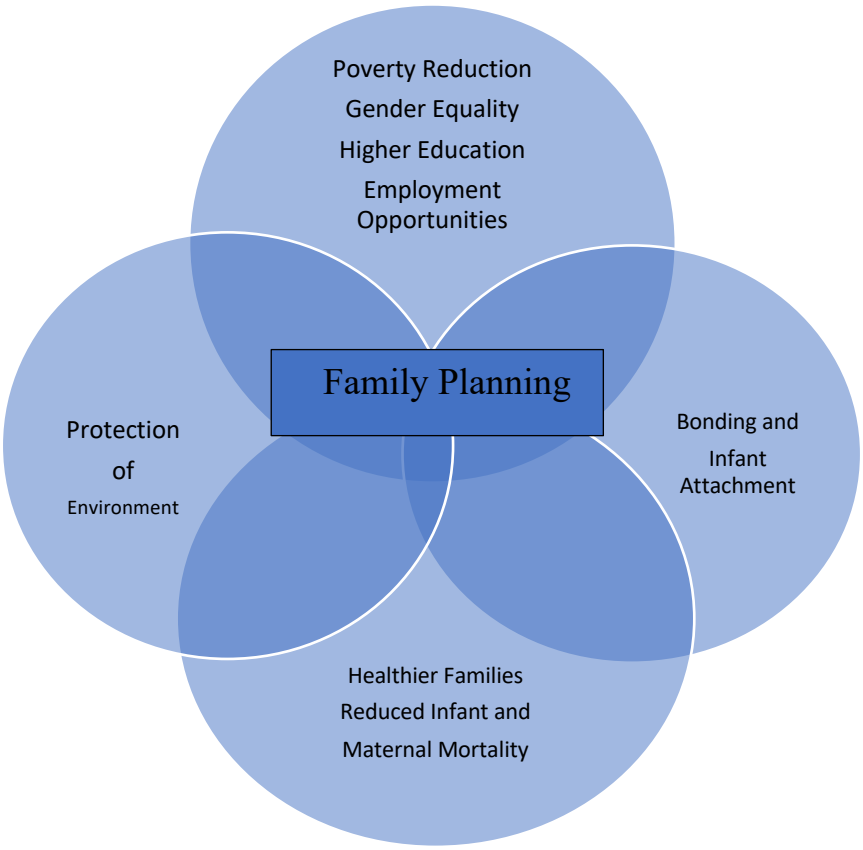
being healthier by ensuring births are well spaced, family size is limited, and that women do not give birth at the extremes of reproductive age.[1] Contraceptives prevent unintended pregnancies, reduce the number of induced abortions, and lower the incidence of maternal death and disability related to complications of pregnancy and childbirth.[2] In addition, planned pregnancies allow greater chances for children to survive and thrive. For example, when women give birth separated by less than two years, infant mortality is 45% higher than when births are 2-3 years apart, and 60% higher than when births are four or more years apart.[2]

At the initial International Conference on Population and Development (ICPD) in 1994 diverse views on human rights, population, sexual and reproductive health, gender equality and sustainable development merged into a global consensus that placed individual dignity and human rights, including the right to plan one's family, at the very heart of development.[3] Since then, it is globally recognised that fulfilling the rights of women and girls is central to development.[4] A quarter of a century later, the world has seen remarkable progress in reproductive rights, but progress has been slow and uneven. Hundreds of millions of women around the world are still not using contraceptives to prevent unwanted pregnancies, and global targets on reducing maternal deaths have not been met.[5,6]

Figure 1: Benefits of family planning.



Family planning is a key factor in reducing poverty.[1] Yet in developing regions, an estimated 217 million women who want to avoid pregnancy are not using safe and effective family planning methods for reasons ranging from lack of access to information and services to lack of support from their partners or communities.[2] This threatens a woman's ability to build a better future for herself, her family, and her community.[1] In the Pacific region access to and use of contraception lags behind other developing regions.[7] Concerningly, there are reports that in some Pacific countries the prevalence of contraceptive use is actually declining.[8] UNFPA data of Solomon Islands from 2006 to 2015 showed an unmet need increase from 11.1% to 34.7% across those years.[7]

UNFPA define modern contraception as including pills, depo injections, implants, intrauterine devices, surgical procedures, and barrier methods such as condoms.[1] Long-acting Reversible methods of Contraception (LARC) such as contraceptive implants, depo injections, and intrauterine devices are the most cost-effective contraceptive methods and provide the greatest health and financial benefits.[10] Family planning care has been described as a health promotion service in that the focus is on prevention of harm. Dr Glen Mola, obstetrician/gynaecologist in Port Moresby, Papua New Guinea sums up the evidence well when he states that "time spent on family planning counselling can be as effective in preventing maternal death as is antenatal, intrapartum, and postnatal care".[9]

Family planning services must address the 'unmet need' for contraception. 'Unmet need' is defined by UNFPA as the proportion of women of reproductive age who desire to delay childbearing or wish to stop having further children but are not using an effective method of contraception. Therefore, an unmet need is the gap between a woman's childbearing intention, and her contraceptive use.[1]

Context of this research

To date, a lack of equitable access to family planning services remains a challenge for the Solomon Islands as it is for much of the Pacific.[11,12,13,14] The Solomon Islands are made up of over 900 islands and atolls, with 80% of the population living dispersed throughout the islands.[15] Estimates of contraceptive coverage for the Solomon Islands range widely, from 19% Contraceptive Prevalence Rate (CPR) reported by the organisation Family Planning 2020, to UNFPA data that estimates a 32% CPR.[11,13] In 2019 it was estimated that for the Solomon Islands there were 12,000 unintended pregnancies.[16] Global consensus suggests 75% 'demand for contraception satisfied' is necessary to meet Sustainable Development Goals.[5]

In the 2019 UNFPA report 'Consultation on ending unmet need for family planning', it is noted that in Solomon Islands there is substantial disparity in unmet need by region. Guadalcanal has been identified as the region with a "disparity of highest unmet need".[11] A recently published study[14] found that over three quarters of women with unintended pregnancies surveyed in Honiara, on Guadalcanal Island, were not using contraception at the time of conception, and one in six pregnant women had no knowledge about modern contraceptive methods. Region specific research to understand the complex reality for health workers tasked with providing family planning services is minimal.

Through consultation with UNFPA staff in the region, a research gap became evident. This study was designed to hear from health workers in Guadalcanal, the region of highest unmet need for family planning in the Solomon Islands, and understand their views on barriers to contraception, along with their proposed solutions. Health workers' views on access to LARC, particularly contraceptive implants, were a focus for the study given the emphasis placed on these methods in UNFPA programmes. UNFPA implemented training for contraceptive implants in Guadalcanal in 2015, so this research sought to explore why a greater uptake of effective contraception has not been seen since then. The aim of this research was to help contribute to addressing the unmet need for family planning and increase the contraceptive prevalence rate in Guadalcanal by drawing on the insights of health workers who provide this essential service.

METHODS

Study design

This study had an exploratory descriptive research approach using a survey method. The questionnaire consisted of a set of open and closed-ended questions. As the goal was to understand the perspectives of those participating in the study, an important aspect to the research was to include the potential for qualitative responses. In addition, the contribution of the quantitative element to the survey was the outcomes which could be measured in numerical form.[18,19] This research explored views on contraceptive implants as they

are the focus of UNFPA efforts, and due to their effectiveness, reliability, and reversibility, which are especially beneficial for rural communities.

The survey was made up of 35 questions. Questionnaire design included 13 'tick-box' questions, two with extra space for additional qualitative comments respondents might choose to elaborate on. There were five questions that asked respondents to list or specify an answer; eight open qualitative questions; one question asking respondents to rank choices; two likert-style questions; and three demographic questions.

Study ethics and consultation process

The key principles of cultural safety in research were applied to this study design and procedure. Ethics approval was received from the Solomon Islands Health Research Ethics Review Board (SIHRERB), the Kaitohotohu Office and Ethics Committee of Otago Polytechnic, Aotearoa/New Zealand. Solomon Islands health authorities were consulted at every opportunity, including Solomon Islands Ministry of Health officials, and UNFPA representatives working in the Solomon Islands. Data collection was guided by a SIHRERB appointed research assistant.

Data collection

Overall, 56 surveys were completed and returned. Guadalcanal Island is divided into two health districts; 41 surveys were returned from the urban Honiara district, and 15 from the remote Guadalcanal Province region. Health workers from all clinics visited were invited to participate in the study in late 2019. Some health workers declined, saying they were too busy or reluctant to discuss family planning on religious grounds.

Data analysis

Data was transcribed from the paper survey and the quantitative responses were entered onto an Excel spreadsheet. Additional open-ended answers were thematically grouped, coded, and analysed using thematic analysis, as described by Braun and Clarke.[20]

RESULTS

This research confirmed existing evidence that there is an unmet need for contraception generally, and LARC specifically in Guadalcanal Solomon Islands. The results are grouped into three sections: Context, Challenges, and Solutions. In the first section, Context, a brief overview of the demographics of the health workers who responded to this survey and the methods of contraception available in their clinics is presented. In the second section, Challenges, the main barriers identified by the health workers to meeting the unmet need for LARC are reported in five themes: opposition; misinformation; side effects; geographical distance and unskilled staff. In the final section, Solutions, health workers' views are revealed on how the barriers/challenges they described can be addressed. These solutions are grouped across three main themes: education and skill of health workers; raising public awareness and countering misinformation; and addressing systemic issues.

Context

Of the participants, 50% were nurses, and 34% were midwives, and the majority of participants were female (84%). Thirty-two percent of participants reported they had more than 20 years of experience working in their current role. From the remote region, less than half (47%) reported that they could provide contraceptive implants. Health workers reported that they thought implants were the most common type of contraception that women want. Emergency contraception could be provided by 30% of respondents from Honiara, and by 1 of the health workers from the remote region. Health worker demographic information is captured in **Table 1**.

Table 2 shows the availability of methods of contraception described by health workers.

Figure 2 depicts what health workers believe are the methods of contraception that women want.

Health workers were asked what they believe influences women's preferences in their choice of family planning. This open question led to a wealth of qualitative data with several consistent themes emerging. The themes included: distance to a clinic; myths women had heard about the problems with contraception; fear of their partner's disapproval; fear of gossip; and fear of side effects specifically. Several health workers also commented that they were mindful of being in a position of influence when women come to the clinic looking for family planning care, indicating an awareness of their power and role in guiding women in their contraceptive choice. Health workers from both regions mentioned religious beliefs as a major influence on women. These themes that health workers pointed to as preventing women from choosing freely were consistent with barriers to family planning raised in other sections of the survey, as well as other research on barriers to family planning in the Solomon Islands and wider Pacific region.[8,12,14]

Table 1: Health worker demographics.

		Honiara Clinics n= 41 n (%)	**Remote Guadalcanal Clinics** n=15 n (%)	**Total** n=56 n (%)
Professional group	Nurse aide	4 (9.8%)	2 (13.3%)	6 (10.8%)
	Nurse	20 (48.8%)	8 (53.4%)	28 (50%)
	Midwife	16 (39%)	3 (20%)	19 (33.9%)
	Medical trainee	0	0	0
	Doctor	0	0	0
	Not stated	1 (2.4%)	2 (13.3%)	3 (5.3%)
Gender	Female	37 (90.3%)	10 (66.7%)	47 (83.9%)
	Male	3 (7.3%)	3 (20%)	6 (10.7%)
	Not stated	1 (2.4%)	2 (13.3%)	3 (5.4%)
Years in practice	0-4 years	2 (4.8%)	2 (13.3%)	4 (7.1%)
	5-9 years	6 (14.6%)	6 (40%)	12 (21.4%)
	10-14 years	8 (19.8%)	2 (13.3%)	10 (17.8%)
	15-19 years	9 (21.9%)	0	9 (16%)
	> 20 years	15 (36.5%)	3 (20.1%)	18 (32.4%)
	Not stated	1 (2.4%)	2 (13.3%)	3 (5.3%)

Table 2: Contraceptive methods health workers can provide.

Method	**Honiara Clinics** n=41 (%)	**Remote Guadalcanal** n=15 (%)	**Total** n=56 (%)
Condoms	41 (100%)	15 (100%)	56 (100%)
Pills	41 (100%)	15 (100%)	56 (100%)
Depo Injection (LARC)	41 (100%)	15 (100%)	56 (100%)
IUD (LARC)	35 (85.3%)	4 (26.6%)	39 (69.6%)
Implant (LARC)	35 (85.3%)	7 (46.6%)	42 (75%)
Vasectomy	8 (19.5%)	0	8 (14.2%)
Tubal ligation	0	0	0
Emergency pill	16 (39.0%)	1 (6.6%)	17 (30.3%)
Other	7 (17%)	2 (13.3%)	9 (16%)

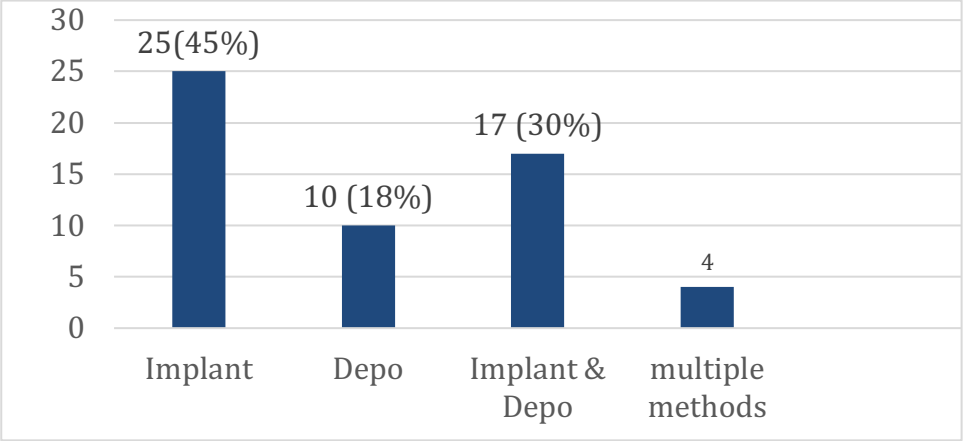


Figure 2: Health worker perceptions of what methods of contraception women want.

Challenges

There were five main themes that emerged from the data: opposition; misinformation; misunderstanding (including fear of cancer) and concerns about side effects; geographical distance to care; and finally, lack of skill to provide contraceptive care. The majority of health worker participants (79%) reported that women often decline family planning. As apprehension about side effects is such a recurrent theme, health workers were asked if they had any concerns that would lead them to discourage use of LARC. Below, results on fear of side effects, and access to LARC training are shown in **Figures 3 and 4**, as key findings from this research.

Health workers were asked several questions about their confidence to provide LARC, and if they had received training, whether they received any upskilling workshops on family planning while in their current role. They were also asked whether they felt confident about communicating and promoting long-acting contraception.

Of all health workers, 41.2% said they had received training for LARC. When broken down into regions, it is significant that 73% of remote participants said they had not received training. The results on training are shown by region in **Figure 4**

In addition, 50% of all health workers reported that they had "never" received any upskilling on family planning. Although 69.6% health workers reported that in their view women are not having their family planning needs met, only 50% said they felt confident with advising women about LARC.

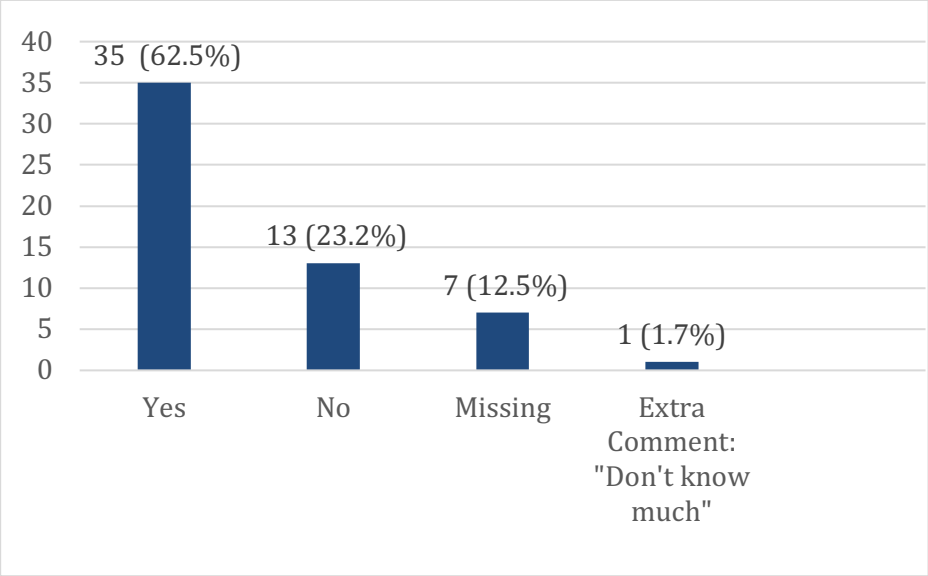
Potential solutions

Three clear themes emerged: participants called for increased training opportunities for health workers; they emphasised the need to raise awareness in the population generally about the importance of family planning; and they identified larger systemic issues that need to be addressed. Specifically, health workers identified that many of the challenges in providing contraceptive care to women had to do with wider systemic issues such as lack of infrastructure, limited resources, lack of government prioritisation, and social and religious challenges.

Many participants offered extra comments, again highlighting the themes of need for increased education, training, and infrastructure:

> *"Provide awareness to people/women to educate them regarding types of contraceptive methods. Other ordinary nurses are not train to insert such contraception methods, only specialist who train for inserting contraception methods can do such work. Provide funds to implement such training. Do logistics for outreach. Continue awareness for family planning clients through radio, newspaper etc [sic]"* (GP4).

Figure 3: Do you have concerns about side effects that would lead you to discourage use of LARC?



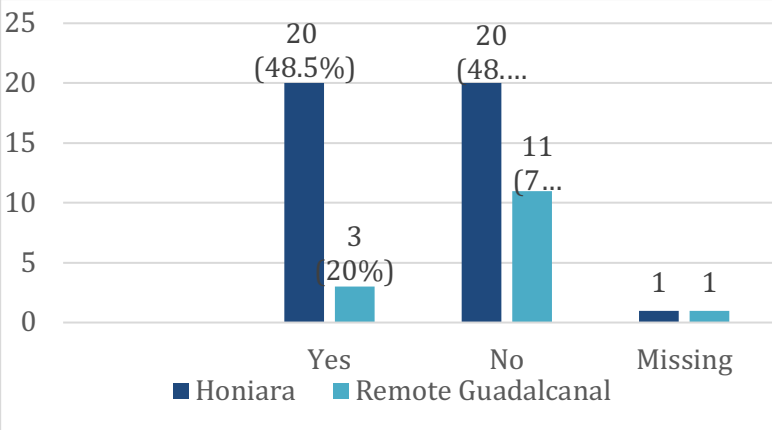


Figure 4: Have you received training for LARC? (by region)

In addition, when asked specifically how health workers can be supported best to strengthen their confidence and ability to provide LARC. The overwhelming majority of answers had to do with increased access to training, and public awareness of the benefits of LARC:

> *"Financial support are much needed to conduct more workshops or trainings for health workers, and also to provide more equipment in the health facilities [sic]" (H29); and "Funding available for logistic to do more awareness [sic]"* (H13).

DISCUSSION

Although there is consistent research and much is known about the unmet need for family planning in the Solomon Islands, nevertheless, the views of health workers need to be considered as they are the experts in their communities. There is global consensus that family planning underpins health, with personal to societal benefits.[5]

The Solomon Islands Ministry of Health have made significant advances to improving reproductive, maternal, child and adolescent health over the past 20 years despite the challenges of a lack of resources, high rates of disease, dispersed islands, and natural disasters.[21] Developing and maintaining a sufficient health workforce is challenging, and although it is clear progress has been made, new and ongoing efforts are necessary to meet the needs of women and their families.[22] It is also important to acknowledge that the global situation has changed since the time of data collection for this study, and that the impacts of COVID-19 place even more pressure and competing demands on health workers.[23]

Challenges – finding permission space for change

This study recognises that many barriers to contraception are rigid and difficult to overcome, but finding the space where change is possible is the important challenge to address. Participants consistently described structural barriers to contraception, such as socio-cultural and political norms, including "culture" (largely related to gender relations), "religion", and "infrastructure". These are intractable as they are beyond the healthcare system, however influence and in many ways underpin and result in health system barriers. Health system specific barriers are potentially more malleable barriers, susceptible to influence and change. Health workers identified a range of health system barriers that include misinformation about and fear of contraception; health workers' lack of confidence with LARC; health worker lack of skill with inserting LARC; and the importance placed on the gender of health workers.

This study found that more than half of the health workers surveyed said they had not been trained for implant insertion nor received any upskilling education on family planning care. In addition, findings confirm there is an ongoing need to educate the wider population on the benefits of contraception generally, and LARC specifically. In addition, health workers highlighted the need to continue to understand and develop strategies to address structural barriers. These findings offer up potential actions that will help address the unmet need for family planning in Guadalcanal, Solomon Islands.

Solutions – high impact change enablers

Health workers identified clear and practical solutions to the problem of unmet need for family planning. The themes they consistently raised include the need for listening to health workers and valuing the relationships they have; increasing training, information, and education about side effects; the need for public education programmes and enhancing community acceptance; addressing key reproductive healthcare priorities; and continuing efforts to acknowledge the need to address macro factors and invest in family planning.

Health workers are critical to improving the health of individuals and society. In order to fulfil their caring capacities, health workers have educational and professional needs, and developing a workforce that is supported by an enabling environment should be prioritised.[22] Resilience and sustainability of health workers will depend on recognition of the contribution, individually and collectively, that they make to improving health for their communities.

The findings from this research confirm the importance of health workers as potential agents of change and highlight their unique position at the interface of relationships between women and wider society. Health workers have multiple relationships within a community: with women, with men, with church leaders, government agencies, and aid organisations. At the heart of human rights are respectful relationships between individuals and communities.[24] There is increasing discussion in scientific literature that emphasises the phenomenon of relationship as a powerful catalyst for change, understanding that to uphold the integrity of a complex system, we must look at the relationships that make the system robust.[25] What seems particularly important to recognise is that context influences how the relationships form and communication develops, and health workers know this context better than any external "expert."

Health workers are critically important in counteracting misinformation and fear about contraceptive side effects. Health workers are in a unique position to explain normal physical effects from contraception and work towards educating men on the benefits of contraception. They can explain who contraception is for, countering contraception stigma, and other fears that result from the multiple barriers discussed above. A critical element of being trustworthy is that the health workers need to be viewed as knowledgeable and non-judgmental, offering contraception as a health promotion activity.[26] Conversation has profound potential to change views. There is a need to ensure health workers are informed, supported, and resourced to provide this key health promotion role with regard to contraception.

Increasing access to training is a central recommendation that comes out of this research. These findings are similar to other research[27] that suggests "bosses go on a lot of trainings", collect the skills, and then are promoted to management positions. This does little to increase the knowledge and practice of health providers in practice unless there are active efforts to pass the skills on. This is a clear message, reflecting that remote health workers see an opportunity to help address the unmet need for family planning if their skills were increased.

For sustainable solutions there is need for support in three critical areas: service delivery, social and behavioural change, and enabling environments.[26] Enabling environments such as

national policies, community norms and relationships among organisations influence interpersonal dynamics and behaviours and improve outcomes on an individual level. Addressing structural factors will require ongoing commitment and investment. Funding for family planning in the Pacific has fallen over the last decade despite good evidence that family planning is one of the most cost-effective investments a country can make towards sustainable development.[28] For sustainable individual and societal benefits, work must continue at every level.

CONCLUSION

This study has clearly demonstrated that health workers perceived multiple barriers for women to receive family planning care and highlighted that health workers are limited in their ability to provide LARC. This study affirms health workers as a key resource and calls for programme and policy solutions informed by their perspectives. The two main priorities they emphasised to help address the persistent problem of unmet need for contraception are an increase in their capacity to provide contraceptive implants, and an increase in community education to boost acceptance of family planning care from women and their families. Sexual and reproductive health training and education should be a national priority.

Limitations

This study was limited by resources, focusing on 15 accessible clinics in two districts from one of Solomon Islands nine provinces. This study therefore only provides a snapshot of the situation. Health workers from other areas could not logistically be included. Therefore, this study does not suggest results are generalisable to all health workers or other regions of the Solomon Islands, or to other countries.

Recommendations

Health workers identified direct strategies to address many of the barriers to family planning. Their practical suggestions, with the right political support, are feasible. The findings of this study support current literature and present health workers' perspectives on factors that will increase use of family planning. They identify many challenges but offer attainable solutions.

Key recommendations from this study are to:

Value health workers and the **relationships** they have with their communities.

Increase health workers' access to LARC **training**, information relating to the benefits of LARC, and education about side effects.

Undertake work to **counter misinformation** and educate women about expected effects from LARC. Work to understand the origins and drivers for commonly cited concerns about cancer as a side effect from contraceptive use. Address these through evidence-based education efforts, disseminated by local people within a local context.

Increase **public education** programmes to support community acceptance of LARC to provide a better understanding and thus allow women and families to make informed choices.

Focus on key reproductive healthcare **priorities** such as the aim for universal access to emergency contraception, improving access to contraception for teenagers, and strengthening postnatal implant insertion.

Continue efforts to address **structural factors** through basic behavioural change strategies, and to overcome logistical challenges such as trickle-down training programmes to reach remote health workers.

The recommendations from this study are, in essence, very clear: support health workers to optimise their ability to provide family planning care in their communities. Encourage health workers' pride and ownership of their vital role, support their agency, and provide resources. The findings from this study are a confirmation that strong relationships are what make any system robust.

Conflicts of Interest

The authors declare no conflict of interest.

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