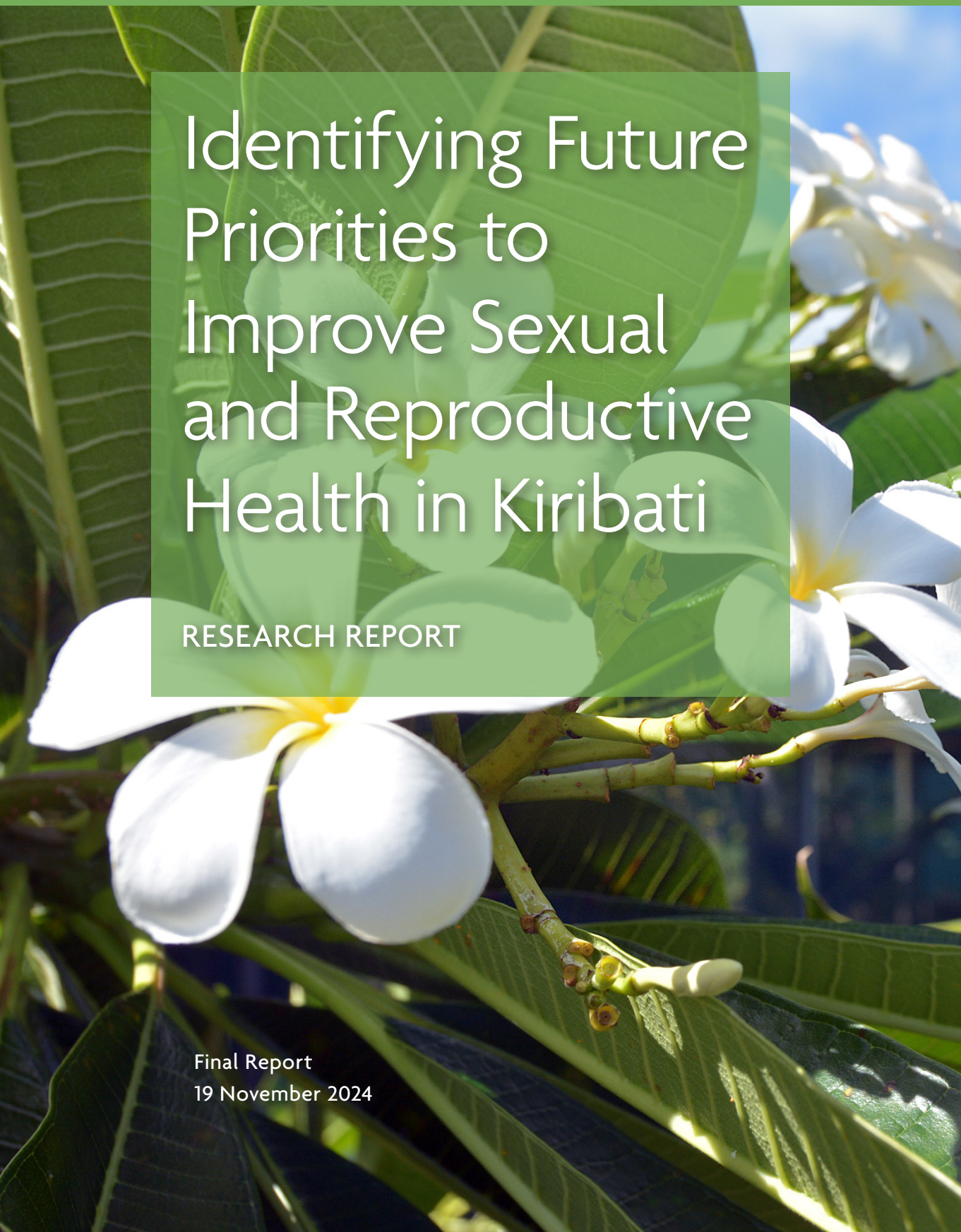

Identifying Future Priorities to Improve Sexual and Reproductive Health in Kiribati

RESEARCH REPORT

Final Report
19 November 2024

Contents

Authorship

Sexual Wellbeing Aotearoa (formerly Family Planning New Zealand) commissioned Future Partners Ltd to undertake a research project and produce a research report for the Kiribati Healthy Families Project (KHFP), a project funded by the New Zealand Ministry of Foreign Affairs (MFAT) and jointly led by the Kiribati Family Health Association (KFHA) and Sexual Wellbeing Aotearoa.

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We would also like to thank those who assisted us on Maiana and Butaritari with our fieldwork. This meant we were able to engage with a range of participants.

Last, but not least, to the 95 participants for providing their time and valuable insights. These have contributed to the findings and recommendations presented in this report.

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Executive Summary

Kiribati faces unique challenges when it comes to sexual and reproductive health (SRH) and family planning (FP). Its scattered geography, cultural diversity, and limited healthcare resources have made it important to tailor sexual health and FP intervention programmes to local contexts.

Over the last decade various initiatives and programmes have been implemented to improve FP accessibility and outcomes in Kiribati. In recognising the existing relevant research literature, Sexual Wellbeing Aotearoa (formerly Family Planning New Zealand) commissioned Future Partners Ltd to undertake a research project for the Kiribati Healthy Families Project (KHFP), a project funded by the New Zealand Ministry of Foreign Affairs and Trade (MFAT) and jointly led by Kiribati Family Health Association (KFHA) and Sexual Wellbeing Aotearoa. This research sits within the broader SRH landscape of Kiribati, noting that there are other key SRH stakeholders such as the United Nations Population Fund (UNFPA) and the Kiribati Ministry of Health and Medical Services (MHMS).

The overall objective of this research is to identify priorities to inform decision-making and planning for future FP and SRH initiatives in Kiribati, with a particular focus on the outer islands.

The research was conducted between May and November 2024, with field work conducted in South Tarawa and two outer islands (Maiana [Central] and Butaritari [Northern]) in July and August 2024. Data sources included the 2023-2024 KHFP community surveys, focus group discussions (FGDs), and in-person interviews with key stakeholders, including government officials, community, and church leaders in Maiana, Butaritari, and South Tarawa. In total 95 participants took part in the FGDs and stakeholder interviews.

Overall findings

The KHFP closely aligns with Government of Kiribati (GoK) priorities. KFHA plays a vital role in the community through delivering several SRH and FP services through the KHFP and other initiatives. This allows MHMS to focus on primary care and secondary care.

SRH and FP services are changing over time to respond to the different and growing needs in the community. Key players (MHMS and KFHA) and funders, including UNFPA, MFAT, the International Planned Parenthood Federation (IPPF) and the Australian Department of Foreign Affairs and Trade (DFAT), will need to work more closely together and better coordinate to ensure SRH and FP services are regularly accessible and available, regardless of where people live in Kiribati.

Participants all agreed that KFHA's SRH and FP services, training, and education programmes are working well, are good for the i-Kiribati people, and are largely addressing the needs of most key groups. Community access through mobile and after-hours clinics is seen as an important approach to reach those marginalised in the community.

KFHA's approach to working within i-Kiribati culture and with different faiths is seen as critical to its success, in particular for the outer islands. KFHA adapts its services and training to the different cultures on the different outer islands and uses a variety of approaches to deliver sensitive information. KFHA also works closely with Island Councils and Unimane (traditional leaders) to reach out to the villages and communities. KFHA is thoughtful in how it liaises with the different churches, and there is willingness among some churches to work more closely with KFHA. Responses from the community survey indicate that most respondents believe there is support for FP from church leaders, with only a small minority who think that church leaders are unsupportive. Participants also pointed out ongoing challenges with some religious groups that do not fully support modern FP methods. Several participants emphasised the need for regular training on the use of CycleBeads as a contraceptive method.

All participants identified the lack of a KFHA branch on their outer island or the lack of an outer island KFHA hub as a challenge. This is largely due to the irregular frequency of visits by KFHA and the government outreach teams, and also means that 'healthy family' messaging is not being reinforced or maintained regularly.

Cervical screening, especially in the outer islands, remains low, despite new methods that enable a quicker diagnosis. Misinformation may be contributing to these low numbers, with responses from the community survey indicating that lack of awareness and fear or embarrassment are contributing factors.

Recommended areas for future focus

Capacity building is of ongoing importance, in particular by KFHA for MHMS staff on SRH and FP, refresher training for KFHA finance staff, and SRH education for community and church leaders. Any further expansion of KFHA's role will need to be supported by MHMS.

Operational approaches to more effectively improve services include use of community and church maneabas for clinics and workshops. While these approaches may not be financially demanding, discussions with community and church leaders are time intensive.

Other operational strategies, such as KFHA's engagement with the Ministry of Women, Youth, Sports, and Social Affairs (MWYSSA)'s male behaviour change programme, may also increase pressure on KFHA staff. The use of trained volunteers and peer facilitators is seen as a way to overcome some resourcing challenges, and to reach communities on the outer islands not currently benefiting from SRH and FP services.

Operational priorities

To improve the operation of KFHA's work in Kiribati, resourcing is needed for:

1. The development of a KFHA database to record services and patient data.
2. New social media approaches for education and awareness campaigns.
3. More visual aids to help in appointments with patients.
4. Providing access to a free call line and better online access to information, including an online audiovisual platform.
5. The installation of condom dispensers to make it easier for youth to discreetly access condoms.

Strategic priorities

Strategies to improve FP and SRH initiatives in Kiribati will need to involve:

1. More frequent visits to the outer islands. This could involve either increasing the number of visits from South Tarawa, establishing KFHA branches on the outer islands, or creating a centralised 'hub' specifically focused on the outer islands. This hub could be based in South Tarawa or on one of the outer islands.
2. Exploring affordable transport options to the outer islands, along with expanding services. Improved collaboration between MHMS and KFHA would improve communication regarding visits to the outer islands, including providing longer advance notice and better coordination. Expanding clinics, whether in South Tarawa or on the outer islands (for example, at youth centres or secondary school campuses), or adding extra clinic days, would require additional nursing staff, along with a continual supply of commodities for clinics.

3 Specialised services for marginalised groups, such as sex workers and the LGBTQIA+ community.

4 Further research focused on prevention of maternal deaths during pregnancy and delivery as well as research to better understand the SRH and FP needs of southern outer island communities.

As the demand for SRH and FP services grows, KFHA risks overstretching its capacity, and losing its reputation and community trust if it cannot keep up with this demand, especially in the outer islands. Additionally, delays in core and donor funding could disrupt the continuity of services. Therefore, KFHA needs to explore new funding sources to meet the increasing demand, expand capacity, build resilience, and ensure the sustainability of its services. This will require collaborative support from Sexual Wellbeing Aotearoa, MFAT, DFAT, UNFPA and IPPF, particularly in avoiding unnecessary duplication of FP and SRH services.

1 Introduction and Background

Sexual and reproductive health (SRH) and family planning (FP) are important aspects of public health and social development in Kiribati. Accessible and effective SRH services are essential for improving maternal and child health, reducing unintended pregnancies, preventing sexually transmitted infections (STIs), and empowering individuals and families to make informed choices about their reproductive health to effectively realise their human rights.

1.1 Research problem

Kiribati faces unique challenges when it comes to SRH and FP. Its scattered geography, cultural diversity, and limited healthcare resources have made it important to tailor sexual health and FP intervention programmes to local contexts.[1]

Over the last decade, various initiatives and programmes have been implemented to improve FP accessibility and outcomes in Kiribati. In recognising the existing literature and evidence on SRH and FP initiatives in Kiribati and the wider Pacific region,[2-6] this research sits within the broader SRH landscape of Kiribati, noting other key stakeholders such as the United Nations Population Fund (UNFPA) and Kiribati's Ministry of Health and Medical Services (MHMS). Its objective is to identify future priorities to inform decision-making and planning for FP and SRH initiatives in Kiribati, with particular focus on the outer islands.

This research primarily relies on key stakeholder interviews and community focus group discussions (FGDs) to identify pressing needs, in particular from two outer islands (Sections 4.2 and 4.3). This report also includes analysis of MHMS data (Section 1.1.1), a summary of past reviews and evaluations of KHFP (Section 1.1.2), and findings from the KHFP community survey (Section 4.1).

1.2 Relevant statistical data from Kiribati's MHMS

The following MHMS information outlines data on adolescent birthrate, the use and type of contraceptive method by age and years (2019-July 2024), and first and second clinical visits for cervical screening also by year.

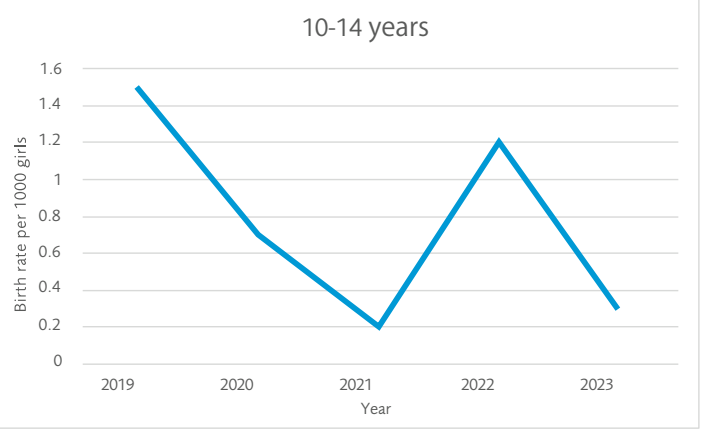
The data has been sourced from the Kiribati Health Information System (KHIS) and the Monthly Consolidated Statistical Report (MS1), and has been provided by the MHMS for this research. The MHMS notes that the data is likely to be affected by underreporting of the number of deliveries and weak fertility data collection in Kiribati, but does not provide an explanation for this underreporting.

Adolescent birthrate

The graphs below show birthrate from 2019-2023 for girls aged 10-14 years, and 2020-2023 for adolescents aged 15-19 years.[i] Recording of data in 2020 and 2021 would have been impacted by COVID-19, but there is a downward trend from 1.5 births per 1,000 adolescents aged 10-14 years old in 2019 to 1.2 births in 2022, and then a significant drop to 0.3 in 2023. The birthrates for 15-19-year-olds have, however, remained consistently high during this period; per 1,000 adolescents in 2020 there were 31.8 births which increased to 39.8 births in 2022, before returning to 31.8 births in 2023.

In comparison, the Solomon Islands had the highest adolescent fertility rate in the Pacific at 59 births per 1,000 adolescents aged 15-19 years in 2022. The Marshall Islands' rate was 57 births per 1,000 compared to Aotearoa New Zealand which has 12 births per 1,000 adolescents aged 15-19 years.[7]

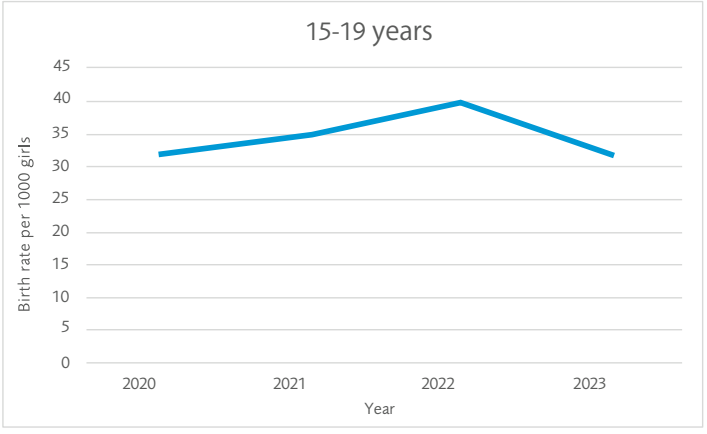
Graph 1.1. Birth rate per 1,000 girls aged 10-14 years



Data source: KHIS & MS1

[i] The 2019 data for girls aged 15-19 years has not been included as it is significantly higher compared to the other years, which suggests there is a data error.

Graph 1.2. Birth rate per 1,000 adolescents aged 15-19 years



Data source: KHIS & MS1

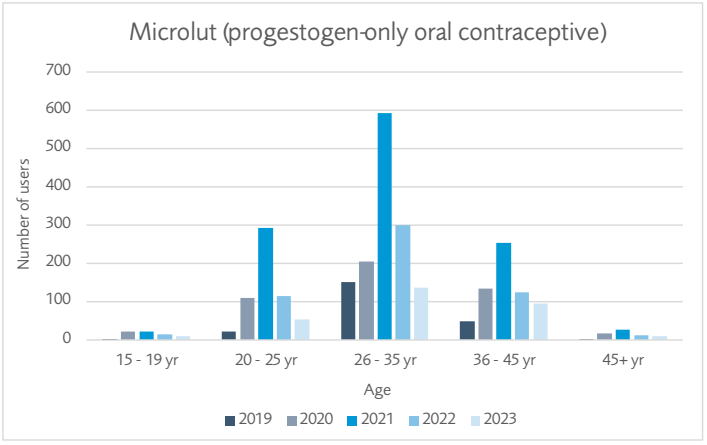
Contraceptive method use by age

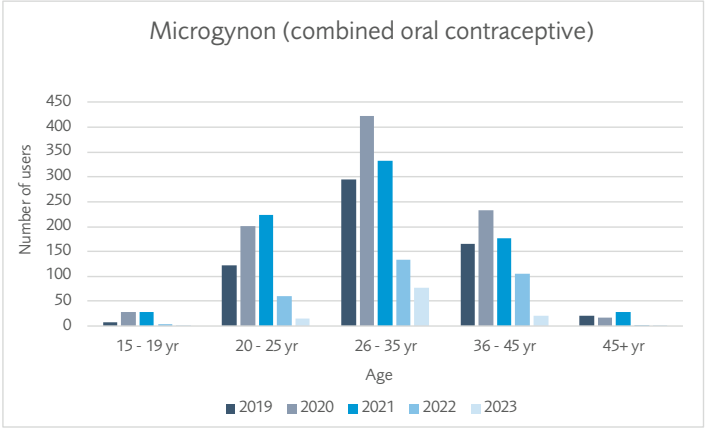
MHMS data for contraceptive use by age and by years records various interactions with different contraceptive methods. The following graphs show the different type of contraceptive by 'continuers at end of month'.

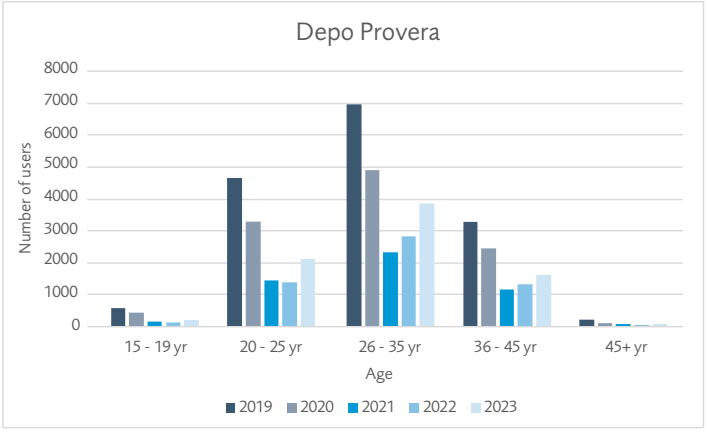
- The graphs overleaf show that each contraceptive method has different levels of uptake. Overall, Depo Provera (injectable contraceptive) is the most popular method for those aged 26 to 35 years, followed by Microlut (progestogen-only oral contraceptive), and then Microgynon (combined oral contraceptive).

Use of Microlut and Microgynon is declining in 2022 and 2023 from the peak use for each age group. Depo Provera is much more widely used, with numbers in later years lower for each age group than the 2019 peak, but with usage trends increasing in 2021, 2022, and 2023. Note the axis values are very different, particularly for Depo Provera.

Graphs 1.3-1.5. Microlut, Microgynon, and Depo Provera use by age



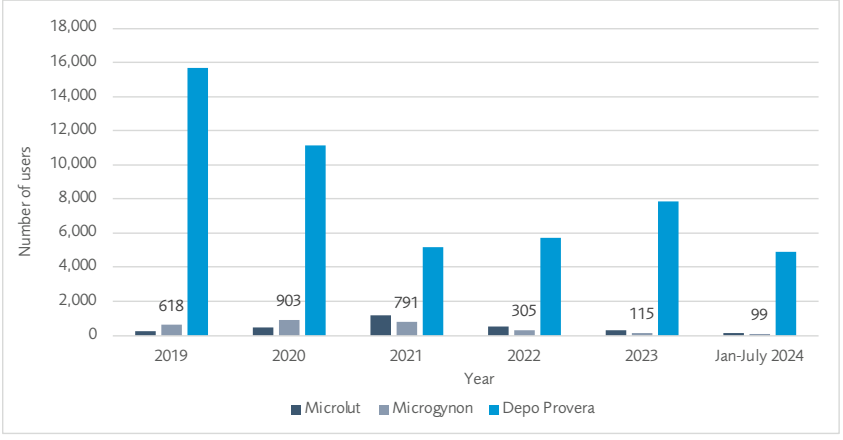




Data source: KHIS & MS1

Contraceptive method use by year

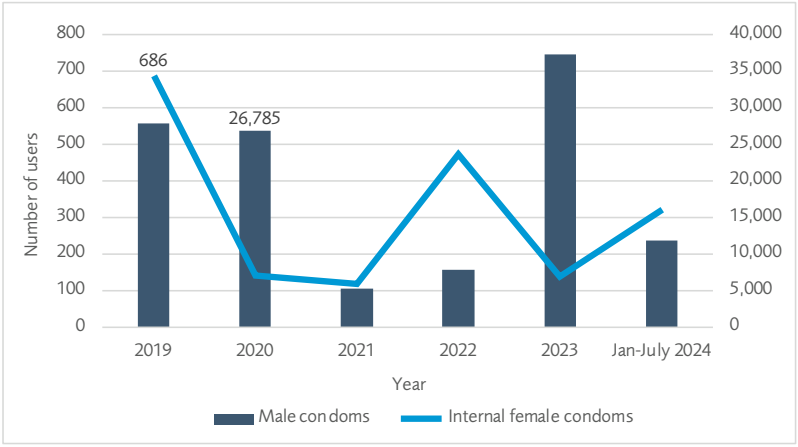
The following set of graphs show the use of contraceptive methods by year, from 2019 to the first half of 2024. The first graph shows that the use of Microlut, Microgynon and Depo Provera has been trending down. This could be due to the lack of access during COVID-19, and/or challenges with commodity supplies, which was raised several times in the stakeholder interviews and community FGDs.



Data source: KHIS & MS1

The graph overleaf shows that COVID-19 may have impacted the use of male condoms, but that in 2023 numbers have greatly increased. Except for the years 2021 and 2023, use of internal (female) condoms appears to be increasing.

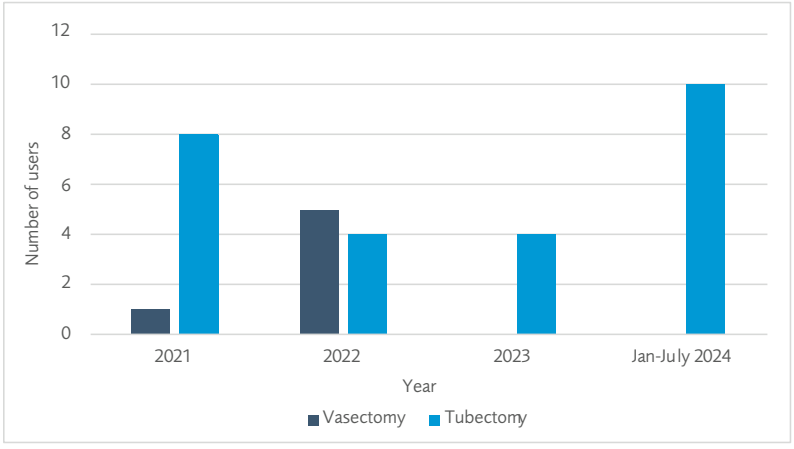
Graph 1.7. Condom use by years



Data source: KHIS & MS1

The graph below shows that vasectomy and tubectomy (tubal ligation) still have low use in Kiribati. MHMS has confirmed that since 2023 vasectomies are no longer undertaken in the main hospital in Tarawa. This could be due to a lack of skilled providers, coupled with low demand. We also note the recent death of KFHA's male nurse who was trained to undertake vasectomies, and that role has not been filled at the time of writing this report.

Graph 1.8. Vasectomy and Tubectomy (tubal ligation) use by years



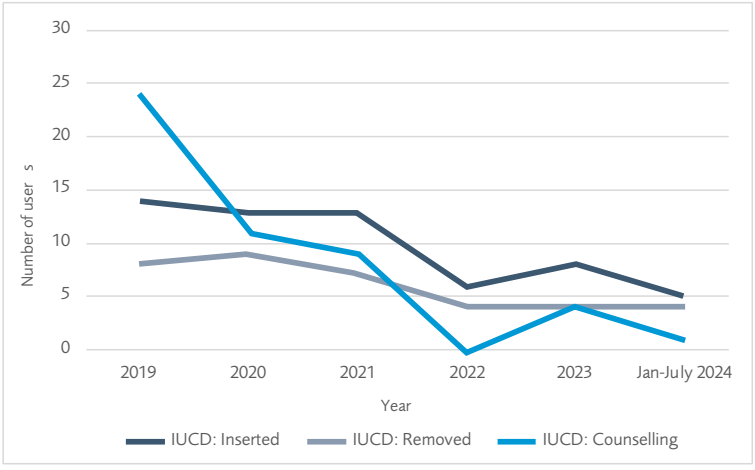
Data source: KHIS & MS1

The graphs on the next page show the number of Intrauterine Contraceptive Devices (IUCD) and Jadelle (contraceptive implants) inserted and removed, and the number of counselling appointments provided for each method. Note there were no counselling appointments in 2022. The graphs also show that the uptake of these contraceptive methods is declining. Note that the decline seems more significant in 2024 because the data does not cover the whole year. The overall decline between 2019 and 2022 could have been due to Government of Kiribati's (GoK's) COVID-19 preventive health order measures. Some of these could have disrupted SRH services with staff being shifted to the COVID response. The measures were not lifted until mid-2022. After 2021, numbers of removals are similar to insertions, likely meaning new implants are being inserted once the old ones are removed.[ii]

IUCD use is still very low compared to Jadelle. This could be due to women feeling more comfortable having an implant inserted just beneath the skin on the inside of the upper arm, instead of a more invasive procedure with a device inserted into the uterus. Misinformation and fears about women's cervical examinations was also raised in the FGDs, and this may also be a contributing factor in low usage of IUCDs.

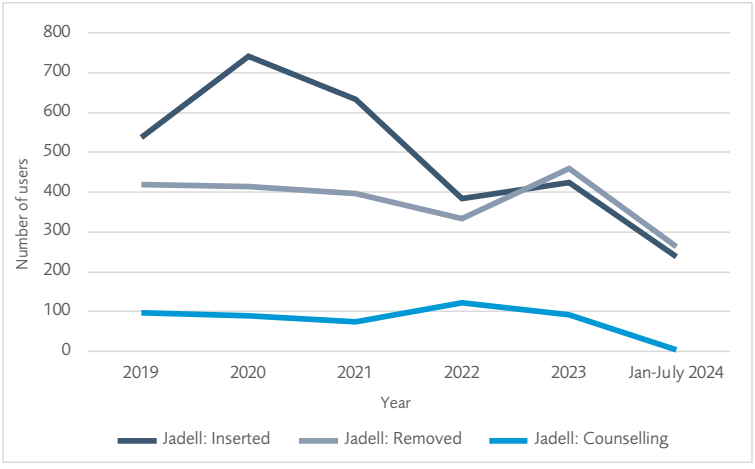
[ii] There is no age-specific data for long-acting reversible contraception (LARCs).

Graph 1.9. IUCD use by year



Data source: KHIS & MS1

Graph 1.10. Jadelle use by year

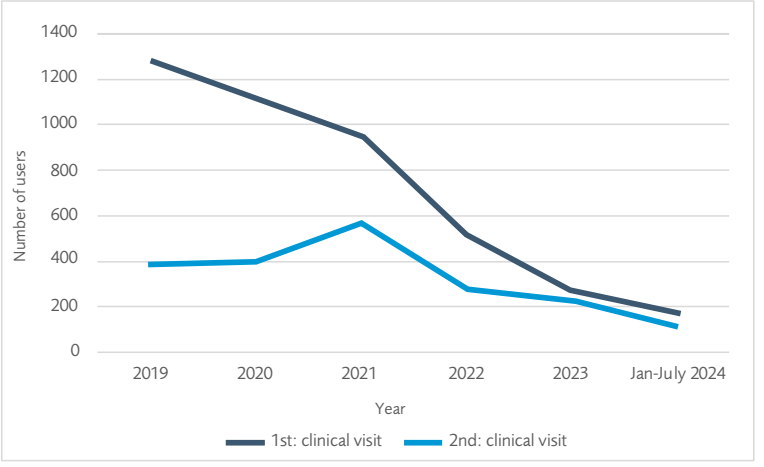


Data source: KHIS & MS1

Cervical screening

The graph below shows the higher number of people attending their first clinical visit for cervical screening (pap smear) compared to their second visit, noting that in 2021 and 2022 this would have been affected by COVID-19. A request for a second visit could be because results from the first visit were unclear. However, it also shows that numbers for both visits have not returned to pre-pandemic levels. Responses from the stakeholder interviews and FGDs indicate that this could be due to a range of reasons, such as a lack of privacy at the clinic, misinformation that the test had caused symptoms of heavy bleeding, or difficulty accessing the service because of a lack of transport.

Graph 1.11. Number of clinical visits for cervical screening by year



Data source: KHIS & MS1

1.3 Highlights from recent KHFP evaluations

KFHA is the main NGO provider of SRH and FP services in Kiribati, and spearheads several SRH initiatives, one of which is the KHFP. Phase One of KHFP started in 2012 in South Tarawa, and currently Phase Three is being run in South Tarawa and six outer islands: Abaiang, Abemama, Aranuka, Butaritari, Marakei, and North Tarawa. These six islands are home to around 72 percent of the total Kiribati population. The table overleaf shows some key highlights from the KHFP 2015 and 2020 evaluation reports[8] for Phases One and Two, respectively, and the 2023 mid-term review for Phase Three.

Table 1.1. Key findings from KHFP evaluations

	Phase One (2012-2015)
Goal/Objective	To improve the sexual and reproductive health and rights (SRHR) of i-Kiribati in South Tarawa, Kiribati.
Findings	Solid foundation laid in Phase One, with services delivered through the static clinic, mobile and after-hour clinics, as well as clinical and health promotion training, and SRH advocacy among community leaders. **Key achievements:** • 42 clinical service providers received five days of clinical training. • 45 health promoters received five days of health promotion training. Eight projects were subsequently implemented by 16 health promotion trainees bringing SRHR information and skills to a total of 1,024 people. • A total of 3,739 clients received SRH services through mobile clinics and after-hours clinics. • 279 community leaders participated in SRH advocacy meetings, including parliamentarians, mayors, councillors, parents, and teachers. • A cost-benefit analysis of investing in FP in Kiribati was completed, concluding that for every $1 invested in reducing unmet need for FP, $23 would be saved in health and education costs.

Phase Two (2015-2020)	Phase Three Mid Term Review (2020-2025)
To increase access to SRH information, skills, and services in South Tarawa and six outer islands resulting in a reduction of STIs and unplanned pregnancies.	A reduction in STIs and unplanned pregnancies resulting in the overall goal of all i-Kiribati in South Tarawa and six outer islands being able to realise their SRHR. To achieve the goal, three core pillars were developed: 1. Capacity development (trainees and KFHA have improved knowledge and use of skills). 2. Service delivery (increased use by the community of SRH services). 3. Enabling environments (community leaders have increased knowledge of SRHR and are supportive of i-Kiribati accessing SRH services).
Client numbers increased, in particular through village outreach visits. **Key achievements:** • An increased access to SRHR information and services through mobile and after hour clinics. • Training and capacity building through delivering training programmes to nurses and health educators on South Tarawa and six outer islands, mentoring and professional development, and a SRHR Community of Practice. • Positive community engagement, including community leaders increasing their SRH knowledge and skills, along with a more positive attitude to SRHR. • Youth volunteer engagement, including youth volunteers trained to provide SRHR awareness-raising and distribute condoms in South Tarawa. **Key challenges**: • High prevalence of STIs and teenage pregnancy. • Gender-based violence and low condom use. • KFHA premises and infrastructure. • Sustainability and funding issues. The report noted that further resourcing is needed to continue with capacity building, the building of a new KFHA complex, and continuation of community engagement and education.	Phase Three aligns well with a range of government's SRHR policies, but this is not reflected in its resourcing. **Key findings:** • KHFP is addressing the needs of youth, and is well supported by church leaders and Island Councils. • Adapting Phase Three to the i-Kiribati culture is highly effective. • There is insufficient resource management capability and capacity for the ambition of KHFP. • KFHA's current premises impact efficiency. • KHFP is slowly building widespread support within the community. • Planning for future disasters or pandemics is critical to ensure access to services continue to prevent possible population explosion. • There is a risk that demand for the service may outstrip KFHA's ability to deliver KHFP. Succession planning and ongoing discussions with the government will need to be part of the remaining implementation of Phase Three and any future phases.

2 Research Goal, Objectives, and Key Research Questions

2.1 Research goal

The research goal is to understand the impact and effectiveness of FP and SRH initiatives in Kiribati, and to identify future priorities to improve SRH initiatives in the country, including the outer islands.

2.2 Research objectives

The research objectives are:

- To do a broad assessment of FP and SRH initiatives in Kiribati, including different community and stakeholder experiences with access to services, both on South Tarawa and on two outer islands.
- To guide Kiribati's FP and SRH initiatives over the next several years, through identifying key gaps and challenges that need to be overcome.

2.3 Key research questions

- *What resources and strategies are needed to improve FP and SRH initiatives in Kiribati?*
- *What have been the key successes and challenges in delivering FP and SRH initiatives in Kiribati?*

3 Research Approach

The research project was conducted over the period 1 May 2024 - 29 November 2024, with field work conducted in two outer islands (Maiana [Central] and Butaritari [Northern]) and South Tarawa in July and August.

3.1 Quality and ethical considerations

Our engagement approach is based on respectful and meaningful relationships and ethics of care (to do no harm). Prior to any fieldwork, Sexual Wellbeing Aotearoa and KFHA applied for and obtained ethics approval from the Office of Te Beretitenti, Office of the President (OB 3/83). Participation was voluntary, and consent was obtained either verbally or in writing.

To ensure confidentiality, interview responses that were recorded and written-up by the research team have not been shared with anyone, as participants were clearly advised that their responses could be 'free and frank', and any opinions or experiences they shared would remain confidential. Where we have used a quotation in the report, an identification number (e.g. ID. No. 031) has been applied.

For cultural, linguistic, and logistical purposes, Dr Mireta Noere Batio from Kiribati was the lead researcher for the FGDs and stakeholder interviews undertaken in Maiana and Butaritari.

3.2 Method

The research used mixed methods[8] to increase the reliability of the findings. This approach ensured there is rigour through triangulation and that insights emerging from the data analysis were valid and credible.

Sources included:

- Community FGDs from the outer islands of Maiana[iii] (Central) and Butaritari[iv] (Northern), and South Tarawa.
- In-person interviews with key stakeholders.
- Data from the 2023-2024 KHFP community surveys carried out by KFHA.

3.2.1 KHFP community survey

The 2023-2024 KHFP community survey is the third round of community surveys carried out since the inception of the KHFP in 2012. These community surveys have been designed to periodically assess levels of FP knowledge, contraceptive use, barriers to access, and future needs among women and men of reproductive age (15-49), across South Tarawa and the

[iii] Maiana is about 44kms from South Tarawa and has a population of 2,345 (2020 Census).

[iv] Butaritari is about 188kms from South Tarawa and has a population of 3,250 (2020 Census).

six outer islands covered under the KHFP. The survey was initially created in English, translated into Kiribati, and has been slightly modified over time to include additional questions on topics that were identified as important for the project, such as being able to name the cause of cervical cancer, and reasons to get an STI test. The survey is carried out by staff and volunteers from KFHA, who have been trained on good practice survey administration, questioning techniques, and maintaining confidentiality. Each volunteer also signed a confidentiality agreement.

In carrying out the survey, male staff/volunteers interviewed men, and female staff/volunteers interviewed women. Staff and volunteers went door-to-door asking residents on the different islands if they would participate in the survey. A statement about informed consent was read to each participant, explaining that their responses were confidential and that they could skip questions or withdraw at any time.

Data from the community surveys forms were manually entered into the Kobo data collection app, then exported into and analysed in Microsoft Excel and Power BI. It's important to note that this method of data collection does not provide a completely random sample, and potential biases need to be considered.

3.2.2 Participant recruitment for the FGDs and stakeholder interviews

Culturally, the Northern and Central outer islands are quite different, and Maiana and Butaritari were chosen to represent different outer island contexts for the qualitative component. Activities under the KHFP have been implemented in Butaritari since 2020, whereas Maiana is not currently covered under the KHFP. South Tarawa was also included for interviews with government officials and KFHA, and FGDs with LGBTQIA+, and youth. See Table 3.1 for more detail on who participated.

3.2.3 Data collection and analysis

A purposive sampling approach[11] was used for the recruitment of FGD participants, with KFHA's assistance in identifying participants who have used or heard of FP services or attended an outreach clinic.

Thematic analysis was used for the qualitative data analysis.[12] While we were looking at differences in responses between the two outer islands, we were also aware that some of the numbers of participants in the FGDs, in particular the Maiana single mother group, were small. We also found that variances in responses were more likely to be between the different focus groups, rather than between these two outer islands.

3.2.4 Participation

Table 3.1 shows there were 50 participants that attended eight FGDs (14 youth, 11 single mothers, 10 young couples (20 participants), and five who self-identified as LGBTQIA+). Twenty-two of these participants were from Butaritari, 19 were from Maiana, and nine were interviewed in South Tarawa. The table also shows 45 key stakeholders that were interviewed over 41 interview sessions for this research, in Maiana (n=13), Butaritari (n=14), and Tarawa (n=18).

The FGDs and stakeholder interviews were undertaken separately in each region.

Table 3.1. Research FGD participants and stakeholder interviews by region (N=95)

Location	FGD participants (single mothers, youth, couples, LGBTQIA+)	Stakeholder interviews (island and government officials, community leaders, KHFA, NZHC, UNFPA)
Maiana	Single mothers (n=4) Youth (n=5) Couples (n=10)	Unimane, Mayor, Clerk, Council, Church leaders[v] , medical assistant (MA), Teacher, IEC (n=13)
Butaritari	Single mothers (n=7) Youth (n=5) Couples (n=10)	Unimane, Mayor, Clerk, Council, Church leaders, MA, Teacher, IEC (n=14)
South Tarawa	Youth (n=4) LGBTQIA+ (n=5)	Govt officials (MHMS, Ministry of Education, MWYSSA), Community leaders (Mayor, Church leaders), KHFA, KHFA Board, NZHC, UNFPA. (n=18)

[v] These included Catechists who are lay (not ordained Catholic priests), often married, and have the specific task of catechising, which includes educating young people and adults in the faith, preparing candidates and their families for the sacraments of Christian initiation, and helping with retreats and other meetings connected with catechesis (Guide for Catechists, Vatican City 1993).

The photo below shows the researcher interviewing a stakeholder on Butaritari.

3.3 Limitations

The scope, timeframe, and budget meant that travel could only be to two outer islands, with only one researcher. This component of the research drew on KFHA's strong networks within the community to identify stakeholders for participation. While there is a risk that we did not speak to stakeholders that may be more critical of the KHFP, we may not have been able to talk with as many people as we did without KFHA's support in identifying research participants.

Most participants referred to KFHA and the KHFP when they talked about SRH or FP services. They did not differentiate between KHFP and other KFHA services, and some participants also did not differentiate between government and KFHA.

4 Findings

This section presents an analysis of relevant responses from the 2023-2024 KHFP community survey (4.1), discusses the analysis from the stakeholder interviews (4.2), and provides summaries from the FGDs (4.3).

4.1 2023-2024 KHFP community survey

Cervical screening

Respondents were asked if they ever had a cervical screening test (pap smear). The table below shows that the majority of respondents had not, with nearly three-quarters in Marakei and South Tarawa stating they had not had one.

Table 4.1. Cervical screening test (pap smear) by percentage

	Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
No	57.7	69.0	56.1	73.2	63.8	53.0	65.8
Yes	42.3	31.0	43.9	26.8	36.3	47.0	34.2

The table below lists the most common reasons for not having a cervical screening test. Overall, they related to embarrassment, fear, or lack of awareness of cervical screening.

Table 4.2. Most common reasons did not have a cervical screening test by percentage

	Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
Don't Know	40.5	16.1	12.8	39.1	19.6	21.7	21.8
Never heard of it	13.5	14.3	17.0	11.4	21.6	17.4	16.4
Not aware I should	10.8	17.9	17.0	14.9	9.8	15.2	7.3
Not sexually active	2.7	14.3	17.0	10.4	7.8	6.5	10.9
Prefer not to say	5.4	10.7	2.1	1.5	7.8	2.2	7.3
Too embarrassed	5.4	7.1	4.3	6.4	2.0	19.6	10.9
Too scared	13.5	10.7	27.7	9.9	21.6	13.0	18.2
Too young	8.1	8.9	2.1	6.4	9.8	4.3	7.3

It is then perhaps unsurprising that when asked whether respondents could name the cause of cervical cancer, only a minority said they could (Aranuka [19.0%], Marakei [15.9%], North Tarawa [26.6%], Butaritari [22.1%], Abemama [11.5%], Abaiang [14.7%] and South Tarawa [19.3%]).

Sexual health

Respondents were asked questions about STIs and the human immunodeficiency virus (HIV). The table below provides a summary of 'yes' responses and show that STI/HIV testing is low.

Table 4.3 Tested for STI/HIV ('yes' responses by percentage)

	Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
Tested for an STI?	25.6	31.5	21.9	22.7	13.0	22.4	24.4
Tested for HIV?	37.0	33.3	24.8	28.5	25.6	29.9	38.2

Contraception

Respondents were asked about their contraceptive use. Table 4.4 shows that although respondents may not currently be using contraception, the majority thought their partners were supportive of them using contraception and that they want to use it in the future. The most common reasons given by respondents why they decided not to use the contraception they received from a clinic or health service included inconvenience of use, personal or partner opposition, and infrequent sex/no sex.

Respondents were asked to name a place where they can get contraception. Table 4.5 overleaf lists their replies. The hospital, followed by KFHA, were the most frequent responses.

Table 4.4. Contraceptive use ('yes' responses by percentage)

	Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
Ever used contraception	45.7	39.4	40.2	36.9	45.8	53.2	27.6
You/partner currently using contraception	50.9	41.0	43.4	38.2	47.4	56.6	30.9
Partner supportive of you using contraception	88.9	81.4	89.1	76.5	68.2	80.0	93.9
Want to use contraception in the future	74.6	53.5	65.1	56.1	77.2	69.8	58.1
Ever received contraception from a clinic/ health service, but not used it	38.8	24.8	29.5	27.4	35.0	31.7	21.9

Table 4.5. Place where you can get contraceptive methods (by percentage)[vi]

	Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
Hospital	52.2	58.0	53.0	53.1	72.5	35.7	43.5
KFHA (including mobile clinic[vii])	34.8	31.3	44.3	36.1	21.3	57.2	30.4
Condom distribution point	8.7	6.7	2.0	5.9	0.8	7.1	26.1
Other	2.5	4.0	0.7	3.7	2.3	0.0	0.0
Can't name place	1.9	0.0	0.0	1.2	3.1	0.0	0.0

[vi] The survey question asks, 'Can you name a place where you can get family planning methods?' The survey question does not allow for more than one response.

[vii] Mobile clinic: Aranuka (3.1%); Marakei (7.3%); North Tarawa (2.7%); South Tarawa (3.4); Abaiang (5.3%); Butaritari (17.9%); Abemama (4.3%).

SRH and FP services and messaging

The table below shows that less than half of the survey respondents have attended a KFHA clinic or mobile outreach service, but over half had heard or seen messages about FP and/or STIs/HIV.

Table 4.6. Percentage of 'Yes' responses to the following questions

	Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
Attended a KFHA clinic or mobile outreach service	48.0	42.0	40.8	38.1	40.6	39.1	38.5
Heard or seen messages about FP and/or STIs/HIV	59.2	56.2	51.2	54.5	60.0	61.7	57.8

Leadership and community support

Respondents were asked whether, in the last year, they have seen or heard their community leaders discuss the benefits of SRHR. A minority of respondents said 'yes' (33.3% in Aranuka, 21.1% in Marakei, 28.8% in North Tarawa, 33.3% in Butaritari, 26.7% in Abaiang, 23.2% in Abemama and 31.0% in South Tarawa). But when asked if they thought their church leaders and decision-makers in Kiribati are supportive of FP, they were more likely to respond with 'very supportive' or 'don't know' than with 'unsupportive'.

Table 4.7. Support for FP from church leaders and decision-makers by percentage

		Aranuka	Marakei	N Tarawa	S Tarawa	Abaiang	Butaritari	Abemama
Church leaders	Very supportive	47.3	50.8	45.7	40.9	47.3	60.3	48.9
	Don't Know	32.6	25.8	24.8	44.3	30.2	22.9	23.7
	Unsupportive	6.2	1.6	22.5	4.0	10.9	4.6	12.2
Decision-makers in Kiribati	Very supportive	48.8	60.5	58.1	44.1	53.4	64.9	60.0
	Don't Know	31.8	20.9	31.8	44.4	32.8	21.4	22.3
	Unsupportive	6.2	3.1	0.8	2.9	4.6	3.1	1.5

4.2 Stakeholder interviews

This section focuses on responses to the main questions asked of stakeholders. The questions were largely based on:

1) alignment of KHFP to government priorities;
2) changes to SRH and FP services in Kiribati over time;
3) gaps and challenges with current services; and
4) the needs and priorities for SRH and FP services in Kiribati, particularly the outer islands.

4.2.1 The KHFP closely aligns with Government of Kiribati (GoK) priorities

The GoK development priorities in its 20-year Vision 2016-2036 (KV20) centre around a 'wealthier, healthier and peaceful country'. For the health sector in particular, a highly skilled health workforce and an accessible and affordable quality healthcare system (KV20, pgs.32-34) are key priorities[viii]. It notes that women are vulnerable to domestic violence (KV20, pg.54) and one of its implementation targets involves strengthening support programmes for family welfare to reduce the number of domestic violence incidents (KV20, pg.64). In addition, one of its priorities is to reduce the country's fertility rate (KV20, pg.34).[ix]

> *"An improved healthcare system that is acceptable and accessible, will reduce the fertility rate from 3.1 to 2.8 by 2019 and to 1.8 by 2036. Looking at the complexity of the population growth, the diversity of our culture and religious beliefs, the reduction rate is set at a minimum rate of 0.3"* (KV20, pg.33).

Although stakeholders did not always differentiate between KHFP and KFHA's other services, they were of the opinion that the KHFP's objectives and KFHA's activities closely aligned with the government's priorities for a healthy population. Examples of how KFHA is helping government agencies to implement these priorities included: training of teachers on SRH in secondary schools; KFHA assisting MYSSWA's mandate to support women, youth, and disability rights by providing relevant information to help the Ministry with its own programmes; and through the MHMS national strategy focusing on SRH work in the community. Stakeholders

[viii] The Kiribati Development Plan (KDP) 2024 Development Budget notes donor allocation by KDP sectors. This shows Health receiving $10.9m from GoK and $18.1m from MFAT, followed by World Bank ($5.4m) and DFAT ($2m).

[ix] In Kiribati, the population in 2022 was 131,240 and is projected to increase by 44 percent to 188,568 by 2050. https://data.who.int/countries/296

added that KFHA collaborates with MHMS on the vital role of delivering SRH and FP services in the community, allowing the Ministry to focus on primary care and secondary care.

> *"KFHA's role in the community is very important. KFHA is outside the hospital and in the community. I see KFHA as always assisting the services of the Ministry of Health, especially vulnerable groups, and those with stigma. Most of those in the community don't want to visit the hospital, knowing there's a lot of people there. KFHA looks more like a home instead of a clinic. It's serving the people in the community the right way and providing different services such as in reproductive health, FP ..."* (ID. No. 106).

4.2.2 SRH and FP services are changing over time to respond to the different and growing needs in the community

When asked about SRH and FP services, stakeholders outlined the following occurring in Kiribati:

- outer island services to help women access FP services, and the community to access SRH information
- outreach mobile and after-hours services
- youth programmes, including training for peer groups on SRH, and workshops for church youth groups
- condom distributions
- collaboration between KFHA and government agencies on SRH. One example provided referred to KHFA's review of the Ministry of Education's school curriculum on family health
- KFHA work with local authorities and Island Councils so they can advocate for broader community wellbeing.

Stakeholders added that community access to information and SRH and FP services through mobile and after-hours clinics is important for marginalised people in the community. They noted that MHMS was originally responsible for delivering family wellbeing services, but that because of a lack of resources and its broad mandate it currently struggles to deliver FP services in the community. Stakeholders added that KFHA originally focused on FP, but that it has broadened its services to include SRH, youth and sexual safety, trying to be as responsive as they can with the staffing and resources they have. Despite broadening needs, some stakeholders still saw FP as a priority service.

"KFHA has been reaching out to communities, with peer-to-peer, workshops, training. They have tried different ways the best they can, with the resources and staff they have. But their services still need to care about young mothers and families, and young couples" (ID. No. 104).

Some stakeholders were concerned that without extra staff and resources KFHA could risk spreading itself too thin, especially as the government also lacks the resources to undertake SRH and FP service delivery in the wider community, including the outer islands. It was noted by a stakeholder that MHMS is exploring ways to help overcome some of these challenges, such as offering different forms of contraceptives (e.g. the self-injectable contraceptive Sayana Press).

Stakeholders also noted that approaches to information sharing are changing. They remarked that while the older generation likes community gatherings for information sharing, youth prefer to use modern technology, such as mobile and online social media platforms. Radio was still seen as a popular way of promoting upcoming services.

4.2.3 Current services are addressing the needs of most key groups

All stakeholders said that KFHA's FP services and SRH training and education programmes are working well,[x] are good for the i-Kiribati people, and are largely addressing the needs of most key groups, but there is still more work to be done. These needs are discussed further in Section 4.2.4.

Stakeholders provided several examples of what was working well on their island, such as how KFHA delivers on the government's priorities through working within i-Kiribati culture and different faiths. They remarked that KFHA adapts its services and training to the different cultures on the outer islands and uses different approaches to deliver sensitive information. Some participants noted that KFHA has been working closely with Island Councils and Unimane (traditional leaders) to get their support, and to help them reach out to their villages and communities.

KFHA has also been careful in how it liaises with different church leaders and communities. As a result, there appears to be a growing pragmatism and willingness by some churches to work more closely with KFHA, such as using the church maneaba[xi]

[x] As stated above, stakeholders did not always differentiate between KHFP and KFHA's other services.

[xi] A maneaba is a communal space or meeting house used for gatherings in the community.

for clinics when their community visits South Tarawa from the outer islands. A church representative was particularly concerned about members of their congregation who work overseas, and were at increased risk of bringing home STIs and/or HIV and recognised the need of 'condom use' workshops before they left Kiribati for employment. These workshops would raise awareness of the risks of having unprotected sex while overseas and potentially infecting their partners with STIs/HIV once they return, who then could unknowingly pass on STIs to their unborn child. The stakeholder's principal concern was to protect 'innocent' family members in their congregation from STIs/HIV.

On Maiana stakeholders noted the handover of patients between KFHA and the MA in the government clinic was working well. Communicating information through dance performances and songs was also viewed as an effective approach to convey information on SRH and FP.

In Butaritari (as well as in North Tarawa, Aranuka, and Abemama), KFHA, in partnership with the Island Council, GoK taskforce and traditional leaders, has spearheaded the progression and integration of the island's 'island development plan' (IDP) into a broader, government-supported island strategic plan (ISP) that focuses on different aspects of health and wellbeing. This partnership model addresses both the economic and social issues that can impact health, including SRH, while recognising the need for community support to reach people most effectively. Stakeholders in Butaritari therefore spoke about some health initiatives not in the research scope, with reference to some of the GoK's 2023 ISP objectives that had already progressed through the 2016 IDP. They noted that through government and KFHA initiatives, people's health has improved, water sources are better protected, and homes are better organised to improve healthy living.

> *"I've seen a lot of changes, there's more awareness from health education on family planning, how to farm, keep the home clean, and* [this] *helps to prevent sickness"* (ID. No. 215).

Other areas identified by stakeholders that are working well[xii] in Butaritari include:

- youth workshops. Youth are now more knowledgeable about SRH, for

[xii] Participants provided responses that were out of scope for this research. They referred to more controls over kava bar opening hours, with no drinking after midnight, Water, sanitation and hygiene programmes in schools, and home gardening.

example they know how to look after themselves and the consequences of unsafe sex. Stakeholders thought that this increased awareness, through roadshows and youth involvement in the KHFP, has led to better behaviour and less violence

- access to FP
- mobile clinics. More women are coming to the government clinic for check-ups
- the close collaboration between KFHA with women's associations on promoting women's health
- HIV and STI testing.

As previously discussed, some stakeholders were unclear whether these services were provided by the government or by KFHA, and whether they were part of a wider health scheme or a separate SRH and FP initiative.

4.2.4 Current gaps and challenges in SRH and FP services

Stakeholders were asked about gaps and challenges with SRH and FP services. All identified a lack of a KFHA branch on their outer island or the lack of an outer island KFHA hub. Some stakeholders noted that the lack of access to affordable transport options to the outer islands posed significant financial constraints in providing SRH and FP services.

They also noted that there are still challenges with some religious denominations, in particular the Catholic Church, and their lack of support for modern FP methods. Overall stakeholders called for more work to be done with advocacy from traditional, community, and church leaders for KFHA's work, people with disabilities through MYSSWA, and succession and resilience planning for KFHA. Table 4.8 overleaf lists other gaps and challenges in SRH and FP services identified by stakeholders in each location.

These responses again may reflect a growing expectation or realisation of unmet needs, and that service demand may be outstripping resources and available clinical capacity on South Tarawa and the outer islands. However, there is little or no data collected at the government clinics on the outer islands to confirm this.

Table 4.8. Gaps or challenges in SRH and FP services identified by stakeholders by the three research locations

Location	Gaps/Challenges in SRH and FP services
Maiana[xiii]	• Fewer people than expected attend the mobile clinics due to a combination of factors, including a lack of privacy, a lack of transport to access services, and a lack of advance notice of visits. This may be due to KFHA only being able to confirm planned travel shortly before the visit, and so people are not able to attend because they were not informed in time. • Poor coordination planning between MHMS and KFHA for outer island visits. • Women not wanting to visit the government clinic. The reason given is that they trust KFHA equipment over the government clinic's equipment. • Radio messages are focused on physical SRH issues and how to address them, but not on the emotional aspects.
Butaritari	• Lack of involvement by other stakeholders on the island, such as MAs, teachers, and women's groups, during the initial planning phase of SRH initiatives among KFHA, the Unimane, and Island Council. • Spreading of misinformation about women's cervical examinations. • Government clinics lacking sufficient resources and medical supplies. • Lack of SRH and FP professional development for government nurses, including regular refresher courses. • Lack of SRH and FP pamphlets for those who do not attend workshops but stay home.
South Tarawa	• Lack of initiatives on the prevention of maternal deaths during pregnancy and during birth. • Growing demand for more SRH services on Tarawa. • KFHA's inability to gather data on its services to help with its planning and funding. • No regular training on the CycleBeads contraceptive. • Some religious and community leaders still lack SRH knowledge. • Lack of targeted workshops towards men, noting the level of male violence against women and children.

[xiii] KFHA currently provides SRH service delivery and advocacy support to the Island Council leaders in Maiana under its Niu Vaka II programme. The range of services provided and frequency of visits to Maiana are much lower compared to what is offered under the KHFP, and capacity building in terms of clinical training is currently not conducted.

4.2.5 Future priorities and services for SRH and FP

Stakeholders suggested several areas for future priorities and services. These focused on operational and strategic issues involving long-term planning and increased funding.

Participants stressed that current services (in South Tarawa and outer islands) for FP and youth sexual health remain priorities. Stakeholders noted the continuing increase in teenage pregnancies and STIs in South Tarawa, and the lack of available robust data for the outer islands on teenage pregnancies and STIs. The focus on women's health is seen as important, in particular the promotion of cervical screening. MHMS data shows that there is still a large proportion of women not being screened, and the KHFP community survey indicates a need for awareness campaigns on cervical cancer, and the importance of regular cervical screening.

Better collaboration between stakeholders

Church and community leaders maintained that to increase reach in the outer island communities, KFHA can work with them, use their maneabas for clinics and train their leadership teams to reach people not comfortable with approaching KFHA directly.

Churches may be wanting to work more closely with KFHA due to pressure from their congregation to gain better access to FP services and SRH education, and responses from the FGDs highlight this demand. The churches also want to have more engagement around the different SRH and FP education topics that are covered during workshops at their maneaba.

The comment below reflects the perceived interconnectedness among communities across the outer islands and South Tarawa.

> *"Continue with South Tarawa as well as the outer islands. If you focus on South Tarawa, you focus on the outer islands as many come back and forth, and most stay in South Tarawa"* (ID. No. 231).

Stakeholders noted that KFHA has tried innovative ways to reach target groups with the resources and staff they have, such as reaching out to communities with peer-to-peer workshops and using visual inspection with acetic acid (VIA) instead of pap smears for cervical cancer screening.

They also noted that closer collaboration is needed between government clinics in the outer islands and KFHA. Examples include

opportunities for refresher training and use of government premises by KFHA, and better coordination of visits between KFHA and MHMS. Some added that KFHA training packages could be shared with teachers on the outer islands so they can teach their students about healthy families and SRH.

Stakeholders stated that KFHA's work with government agencies, including the Ministry of Education, MYSSWA, and MHMS, needs to continue, together with better collaboration between MHMS and other government agencies, UNFPA[xiv] and MFAT to avoid duplication of services. They suggested cost-effective approaches such as using government programmes already in place such as MWYSSA's male behaviour change programme which raises awareness about violence against women and children.

> *"We need to convince men to be champions and support women. Women are already empowered, but now need to work with men to make them understand that they are the root cause"* (ID. No. 101).

[xiv] Stakeholders interviewed in South Tarawa were aware that UNFPA provides funds and technical support to MHMS, and that it is up to the MHMS about how it uses these funds rather than delivering what UNFPA deems as priorities.

Stakeholders noted that there is a need for men to learn about and understand SRH and FP better, as in their culture men are the main influencers in their family about whether FP is used. Some participants added that women may want to use FP, but they don't because they also want to respect their partner's or their church's teachings.

Some stakeholders were concerned about KFHA's reputational risk and loss of community confidence if funds from donors are not received in time to ensure service continuity.

The tables below and overleaf outline other priorities and services for SRH and FP suggested by stakeholders. They are listed by operational and capacity building priorities (Table 4.9) and longer-term strategic priorities (Table 4.10). These are by most frequent response, however, as stakeholders were asked open-ended questions, their responses have not been quantified.

Table 4.9 Operational priorities identified by stakeholders

Operational capacity building priorities
• Improved notification of visits to the outer islands, i.e. a longer advance notice period. • Provision of access to a free call line and better online access to information, including an online audiovisual service. • Continued capacity building by KFHA for MHMS staff on SRH and FP. • The installation of condom dispensers to make it easier for youth to discreetly access condoms. • Use of both community and church maneabas for clinics and workshops. • Increase use of church and community groups as peer facilitators and volunteers. • Development of a KFHA database to record service/patient data. • More visual aids to help in appointments with patients. • Ongoing training for KFHA finance staff with MYOB.

Table 4.10 Strategic priorities identified by stakeholders

Strategic priorities
• Regular SRH and FP services to all outer islands, including improving KFHA presence in the outer islands (those already covered and those not yet covered), and use of volunteer groups on the islands to support KFHA.[xv]
• Establish a branch or a 'hub' in the outer islands to reduce travel costs, or improve the frequency and reliability of visits.[xvi]
• Regular connection with outer Island Councils and collaboration with Unimane, including a KFHA representative on Island Councils to ensure FP and SRH activities continue.
• Expand services and coverage to 'hard-to-reach' groups, such as sex workers and LGBTQIA+ communities.
• Continuity of medical supplies for both government and KFHA clinics on the outer islands. Include exploring use of different forms of contraceptives (e.g. the self-injectable Sayana Press) to overcome lack of access to regular FP services in the outer islands.
• Ongoing meetings with church leaders and work with community leaders to support KFHA by hosting education workshops.
• Continue working with youth to help raise awareness about SRH and promoting healthy families, in particular targeting school leavers.
• Look into reliable, regular, and cheaper transport to the outer islands.[xvii]
• Improve focus on maternal health to prevent maternal/newborn deaths.
• Adaptive planning to respond to changing demands. This was in reference to KFHA's five-year plan, with the suggestion that it should be reviewed each year.
• Increase support by other donors (i.e. World Bank) to increase income-generating projects, i.e. contracts for KFHA to undertake work in the Pacific region.
• Ongoing research to identify changing needs including in other outer islands and exploring both the emotional and physical aspects of community awareness and education.

[xv] All stakeholders agreed that further SRH and FP support in the outer islands is a priority for KFHA. They added that frequent and regular visits to the outer islands will encourage people to have check-ups. A few participants suggested that if incentives were given with activities, this could attract more people to the services and workshops. No examples were provided of what these incentives would involve.

[xvi] A branch focused on the outer islands would enable staff to continue to adapt services to the different island cultures, and training to their context. Stakeholders stressed that any outer island facility would need to be well-resourced and provide similar services as are available in South Tarawa.

[xvii] One stakeholder suggested that if KFHA owned a boat it could improve frequency of outer island visits, and also generate income through taking other paying passengers.

Stakeholders noted that KFHA would need additional resourcing to fund future priorities and services that they identified above.

Table 4.11 outlines challenges and areas for improvement raised by different focus groups. Their positive experiences are discussed in Section 4.3 as FGD summaries. All participants from the FGDs wanted to see SRH and FP services and training workshops continue on their island.

Table 4.11. Challenges and Areas for improvement by youth,

	Challenges
Youth	• Lack of regular KFHA services on their island. • Lack of regular online access for information. • Lack of privacy with government clinics on the outer islands. • Opposition by some faiths, particularly the Catholic Church, to modern FP. • Difficulty reaching KFHA because of the different phone services on their island.
Single mothers	• Lack of medical supplies at the outer island clinics. *"I needed assistance, there was a problem, a shortage of medication, and the clinic was not able to help, and I became pregnant. If only supplies can be available all the time"* (ID. No. 032c). • Government clinics deal with a range of health issues, whereas KFHA's focus is SRH and FP. *"The nurse tries to be supportive but is sometimes too busy if there is an emergency* [at the government clinic]" (ID. No.018).
Young couples	**Women** • Side effects such as weight increase from their contraceptive. • Reluctance by husbands for their wives to use contraceptives. **Men** • The government clinic often runs out of supplies, leading to a loss in confidence with the service. *"Once I suffered from a urinary infection and I went to the government clinic for help. There was no medication in stock, so I was not treated"* (ID. No. 022) • Lack of ongoing education on how to use the CycleBeads contraceptive.[xviii] *"A one-off session is not enough; it needs to be ongoing to make sure the approach is being used properly"* (ID. No. 102).
LGBTQIA+	See LGBTQIA+ case study

single mothers, and young couples focus groups

Areas for improvement
• Better accessibility to KFHA services on their island, such as increased visits to at least twice a year, or establishing a branch on their island. • Regular ongoing KFHA training on youth health to reinforce the learnings. • Regular online/offline access to SRH and FP information, or access to a free app and phone line. • Improving access to medical supplies on the outer islands. • KFHA to explore different ways to work with the different churches.[xix]
• Ensure there is continuity of supply of medications and other equipment for both government and KFHA clinics. Condoms to be made more readily available when clinics run out of other contraceptive supplies. • Better collaboration between KFHA and government-run clinics in the outer islands. • Increased visits by KFHA to the outer islands or having a KFHA clinic on their island. • Improved access to services for villagers who are unable to visit the clinic because of a lack of transport. Suggestions include nurses to visit these villages and/or provide training to volunteers who could help these villagers. • A media campaign to increase awareness of SRH and FP, in particular targeting men, including different media approaches to reach different age groups and genders. *"KFHA must open its clinics on the outer islands and continue mass awareness and education through media. Doctors or nurses to be readily available on outer islands. There should be funding available for single mums who really need the support provided by KFHA"* (ID. No. 018).
Women • More frequent visits to outer islands and better advance notice of visits. • KFHA to be well-equipped with medications and equipment for their outer island visits. • KFHA to establish a clinic in the outer islands, or a team to specifically service the outer islands. *"KFHA services are really needed, especially with ongoing women's cervical check-ups. This has resulted in the* [improved] *wellbeing of women. FP is also important and good in order to have a happy family"* (ID. No. 028). **Men** • More SRH workshops to ensure families continue to feel well-supported. • More SRH and FP awareness and education over the radio to increase community reach, especially for those who cannot easily access KFHA services. *"Visiting our island must be more frequent so that we can be reminded of its services"* (ID. No.021).
See LGBTQIA+ case study

[xviii] Although youth did not provide examples of what this might look like, other stakeholders we interviewed suggested KFHA engage more with church leaders to help KFHA reach communities on the outer islands.

[xix] This was also discussed by a stakeholder who thought that KFHA should be funded either by its funding partners or MHMS to provide ongoing support on CycleBeads because of the large Catholic population in Kiribati. *"A one-off session is not enough; it needs to be ongoing to make sure the approach is being used properly"* (ID. No. 102).

4.3 Summaries from the focus group discussions

This section provides a summary of personal, sometimes collective experiences from FGDs with youth, single mothers, young couples, and LGBTQIA+. The four summaries below provide a synthesis of responses from each FGD, with an additional case study of one youth's personal experience.

4.3.1 Youth

There were three FGDs with youth, one each in Maiana (n=5), Butaritari (n=5), and Tarawa (n=4). Of the 14 participants, only one youth in Maiana had not heard of KFHA services prior to the research.

There have been many positive changes in our lives since hearing about KFHA services or attending their workshops. These include awareness on how to prevent unplanned pregnancies and STIs, and improving the overall health and wellbeing of our families.

"I have increased my knowledge on the [side] *effects of drinking alcohol,* [the consequences of] *engaging in many* [unprotected] *sexual relations,* [and] *using condoms to protect myself from STIs and preventing unwanted pregnancies. These can lead to family problems if we do not have this knowledge"* (ID. No. 015).

Our increased knowledge of KFHA's services has meant better understanding of ourselves and our body. We now know how to protect our body from STIs and HIV, and to avoid unplanned pregnancies.

We have learnt some of this from the messaging in the youth dramas .... We feel well-supported in Kiribati as "youth are the future". With this increased knowledge comes an increased feeling of empowerment.

Some of us have used our new knowledge from KFHA workshops to help youth in need when KFHA is not on our island.

"KFHA's work can also change our lives for the better in comparison to before ... as a youth volunteer I have been able to help. I have some knowledge and skills, and tried to help a girl as there were no KFHA services on the island [at the time]. This girl felt suicidal, and we were able to support her and help her find professional help." (ID No. 038).

Some of us are also now using condoms and going for regular check-ups since we attended KFHA workshops.

A Case Study

This case study is a female participant's story where she shares the positive experiences for her and her family in receiving KFHA support, but also the challenges of balancing her faith and her family's faith with modern FP and SRH education.

"I have seen in my family how KFHA services have been really good in terms of my parents' ability to plan our family. I could see that my parents were better off and had less struggles to get food and other things that we might need, especially as my parents are not working...

I can see it's very good and useful to me because now for me especially I would not have any problem when I have my family. I now know what to do...

I can see challenges for some faiths who oppose the use of modern FP. It's an individual right to choose and I think KFHA needs to find other ways to not create issues with the different beliefs. I have received a lot of information for myself and also for my family. I'm more knowledgeable about how to care for the family, and for me in terms of how to plan out my family in the future. It should go well from the knowledge gained while I'm growing up...

We need KFHA to increase the volunteer service so that the services can increase, and more people can become aware, especially from the outer islands, so that people are more knowledgeable and aware for us and the future generations...

We need to strengthen KFHA services and continue raising awareness of the services, so people don't forget about it. We need to be constantly reminded to reinforce the learning, and to encourage KFHA to be more consistent with its visits to the outer islands, or to send volunteers" (ID. No. 037).

4.3.2 Single mothers

Eleven single mothers participated in the FGDs (Maiana (n=4) and Butaritari (n=7).

We have all heard of KFHA services. Some of us do not use family planning, and the rest of us use the government clinics on our island or visit KFHA services when they visit our islands. Those of us who use these services now know how to protect ourselves and look after our children.

"Family Planning allows me to be healthy and fit in order to face another pregnancy." (ID No. 032a).

"It's important, as women are the ones who care for the family" (ID No. 032c).

Education and awareness of our body is helpful for our family. In particular, feeling healthier, being able to better look after our children, and being able to better space out our pregnancies. Contraceptives also help to improve adverse menstruation symptoms.

Access to the services help us have cervical checkups and ready access to family planning services, including contraceptives, although sometimes supplies run out.

4.3.3 Young couples

Ten couples participated in FGDs on Maiana and Butaritari - five couples on each island - making a total of 20 participants. The women were interviewed separately from the men. While all couples had heard of KFHA services (on the radio and from dramas and dances), more couples from Butaritari had used their services to help with planning their family.

We (young married women) are more likely to access KFHA services for family planning and are positive about the impact it is having on our family, in particular the spacing of our children.

"KFHA services are very good for the people especially on family planning. We can also receive medical care which creates a happy and peaceful family" (ID. No. 026).

Our positive experiences and positive changes since receiving KFHA services are:

- increased knowledge and empowerment
- improved wellbeing of our family
- improved personal health through cervical check-ups, and STI and HIV testing
- feeling supported by KFHA staff.

"I am able to plan my family well. I also noticed that promiscuity and having sexual relations outside of marriage has reduced" (ID. No. 025).

"I believe KFHA services are good since it provides assistance on family planning, like how to space our children and many other things ... KFHA has helped me to check my cervix, and I felt healthier after my check-up. The change I experienced was that I now know how to plan my family, and I believe in my heart that I could" (ID. No. 029).

We (young married men) think that SRH education is overall good for our family. Some of us have not used KFHA services but have heard positive feedback from those who have used them. Those of us who have used the service now know how to plan our family and can go for check-ups when KFHA comes to their island.

4.3.4 LGBTQIA+

Boutokaan Inaomataia ao Mauriia Binabinaine Association (BIMBA) is an NGO focused on empowering the LGBTQIA+ community through advocacy, awareness, and action in Kiribati. The FGD consisted of five members from this NGO and was undertaken in South Tarawa.

There have been positive changes in our lives. We feel with the increase in our knowledge from the KFHA workshops, we are more empowered and better able to protect ourselves. We know where to go to get treatment for STIs and HIV, and that these appointments are confidential.

> *"However, some of our friends are too shy to go to KFHA. I have a neighbour who has a STI but is too shy to visit KFHA"* (ID. No. 039).

Although the KFHA services and workshops are very helpful, there are some areas that would help improve LGBTQIA+ access to SRH services. These include:

- targeted outreach services aimed at the LGBTQIA+ community, such as home visits
- an advertised free KFHA phone number to call
- education awareness workshops on sexual wellbeing tailored towards the LGBTQIA+ community
- improved distribution of condoms, demonstration leaflets on how to use condoms, along with information workshops on condom use
- better communication from KFHA staff about what upcoming education workshops will cover
- advanced notice and promotion through media of education workshops
- human rights education towards the LGBTQIA+ community in workshops
- a restaurant or gym in front of KFHA's office to make the compound look welcoming, and allow for easier access into KFHA's office
- a staff coordinator be assigned to their LGBTQIA+ community to make it easier to engage with KFHA.

We would like KFHA to use BIMBA members to help raise awareness of their services. We want to be useful as we have a lot to offer.

5 Conclusions and Recommendations

5.1 Concluding summary

The stakeholder interviews and FGDs confirm that KFHA plays a vital role in the community. KFHA delivers several SRH and FP services in the community through KHFP and its other initiatives and these closely align with the GoK priorities, allowing MHMS to focus on primary care and secondary care.

SRH and FP services are changing over time to respond to the different and growing needs in the community. Key players (MHMS and KFHA) and funders, including UNFPA, IPPF, MFAT, and DFAT, will need to work more closely together and better coordinate activities and plans to ensure SRH and FP services are regularly accessible, regardless of where people live in Kiribati.

Successes

Participants all agreed that KFHA's SRH and FP services, along with their training and education programmes, are effective, beneficial for the i-Kiribati people, and largely meet the needs of most key groups. The community values access to these services through mobile and after-hours clinics, recognising that they reach marginalised populations.

KFHA's success is attributed to its culturally sensitive approach, particularly in engaging with different i-Kiribati traditions and faiths, especially on the outer islands. The organisation tailors its services and training to the unique cultures of each island and uses various methods to convey sensitive information. KFHA collaborates closely with Island Councils and Unimane to engage with local villages and communities. It also handles its relationships with different churches carefully, evidenced by the growing willingness among some churches to work more closely with KFHA. According to the community survey, more respondents believe church leaders support FP compared to those who think they do not.

Challenges

All participants from the outer islands highlighted the lack of a KFHA branch on their island or the lack of an outer island KFHA hub as a barrier to service access and uptake. This feedback was attributed to the infrequent and irregular outer island visits by KFHA and the government's public health nurses. This service irregularity also hinders the consistent reinforcement of the 'healthy family' messaging.

Cervical screening, especially in the outer islands, is low, despite new approaches leading to faster diagnosis. Misinformation may be contributing to these low numbers, together with a lack of awareness and fear or embarrassment with regard to being tested.

There are still challenges with some religious denominations, in particular the Catholic Church, and its lack of support for modern FP methods. Several participants asked for ongoing/regular training on the CycleBeads contraceptive to address this.

5.2 Recommended areas for future focus

Areas for future focus will require additional funding and/or additional staff time. Without additional staffing, KFHA could risk overextending itself in attempting to address these focus areas. This is particularly challenging because the GoK lacks the resources to implement SRH and FP programmes across the wider community, including on the outer islands.

Capacity building remains a key priority, particularly through KFHA's ongoing support for MHMS staff in SRH and FP, refresher training for KFHA finance staff, and SRH education for community and church leaders.

To improve service effectiveness, operational approaches such as using community and church maneabas for clinics and workshops have been suggested. While these methods may not be financially burdensome, they require significant time for discussions with community and church leaders.

Other strategies, like KFHA's involvement with MWYSSA's male behaviour change programme, could also increase the workload on KFHA staff.

The use of trained volunteers and peer facilitators is seen as a way to overcome some resourcing challenges, and to reach communities on the outer islands that do not benefit from SRH and FP services.

Operational priorities

To further improve the operation of KFHA's work in Kiribati, additional resourcing would be needed for:

1. The development of a KFHA database to record services and patient data.
2. New social media approaches for education and awareness campaigns.
3. More visual aids to help in appointments with patients.
4. Providing access to a free call line and better online access to information, including an online audiovisual platform.
5. The installation of condom dispensers to make it easier for youth to discreetly access condoms.

Strategic priorities

Strategies to improve FP and SRH initiatives in Kiribati will need to involve:

1. More frequent visits to the outer islands. This could involve either increasing the number of visits from South Tarawa, establishing KFHA branches on the outer islands, or creating a centralised 'hub' specifically focused on the outer islands. This hub could be based in South Tarawa or on one of the outer islands.
2. Exploring affordable transport options to these areas, along with expanding services. Improved collaboration between MHMS and KFHA would improve communication regarding visits to the outer islands, including providing longer advance notice and better coordination. Expanding clinics, whether in South Tarawa or on the outer islands (for example, at youth centres or secondary school campuses), or adding extra clinic days, would require additional nursing staff, along with a continual supply of commodities for clinics.
3. Specialised services for marginalised groups, such as sex workers and the LGBTQIA+ community.
4. Further research focused on prevention of maternal deaths during pregnancy and delivery, as well as research to better understand the SRH and FP needs of southern outer island communities.

As the demand for SRH and FP services grows, KFHA risks losing its reputation and community trust if it cannot keep up with this demand, especially in the outer islands. Additionally, delays in core and donor funding could disrupt the continuity of services. Therefore, KFHA needs to explore new funding sources to meet the increasing demand, build resilience, and ensure the sustainability of its services. This will require collaborative support from Sexual Wellbeing Aotearoa, MFAT, DFAT, UNFPA and IPPF to enable this to occur and to avoid unnecessary duplication of FP and SRH services.

Acronyms

BIMBA	Boutokaan Inaomataia ao Mauriia Binabinaine Association
COVID-19	Coronavirus disease of 2019
FP	Family Planning
GoK	Government of Kiribati
IDP	Island Development Plan
IEC	Island Education Coordinator
ISP	Island Strategic Plans
KFHA	Kiribati Family Health Association
KHFP	Kiribati Healthy Families Project
KHIS	Kiribati Health Information System
LARC	Long-acting reversible contraception
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
MS1	Monthly Consolidated Statistical Report
MA	Medical Assistant
MFAT	New Zealand Ministry of Foreign Affairs and Trade Manatū Aorere
MHMS	Ministry of Health and Medical Services (Kiribati)
MWYSSA	Ministry of Women, Youth, Sports, and Social Affairs (Kiribati)
NGO	non-government organisation
NZHC	New Zealand High Commission
OB	Office of Te Beretitenti, Office of the President
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STIs	Sexually transmitted infections
UNFPA	United Nations Family Planning Association

Bibliography

1. United Nations Population Fund, University of Melbourne (Vaughan, C., Moosad, L., Rowe, J.) (2022). Sexual and reproductive health and gender-based violence in Kiribati: A review of policy and legislation. Available at https://pacific.unfpa.org/en/publications

2. Alexeyeff, K. (2020). Cinderella of the south seas? Virtuous victims, empowerment and other fables of development feminism. *Women's Studies International Forum 80* 102368

3. Burry, K., Beek, K. Worth, H., Vallely, L. & Haire, B. (2023) Framings of abortion in Pacific Island print media: Qualitative analysis of articles, opinion pieces, and letters to the editor. *Sexual and Reproductive Health Matters, 31*:1, 2228113

4. Burry, K.; File, R.; Cabia-Tongia, P.; Worth, H.; Beek, K.; Vallely, L.; Haire, B. (2023). *Ora'anga Meitaki no te Vainetini: Cook Islands women's wellbeing in the context of abortion*. Sydney: University of New South Wales

5. Family Planning New Zealand. (2014). I*nvestment in family planning in Kiribati. A Cost-benefit analysis*. Wellington, NZ: Family Planning New Zealand

6. Harrington R., Harvey N., Larkins S. & Redman-MacLaren, M. (2021). Family planning in Pacific Island Countries and Territories (PICTs): A scoping review. *PLoS One. Aug 5*;16(8): e0255080.

7. United Nations Population Division (2025). Adolescent fertility rate (births per 1,000 women ages 15-19). World Population Prospects, available at: https://data.worldbank.org/indicator/SP.ADO.TFRT

8. Whelen, A.K. (March 2020). Kiribati Healthy Families Project: End of Project Evaluation Final Report. Available at: https://www.mfat.govt.nz/assets/Aid-Prog-docs/Evaluations/2020/Evaluation-Full-Term-Review-Kiribati-Healthy-Families-Project-March-2020.pdf

9. Elman, C., Gerring, J. and Mahoney, J. (2020). The Production of Knowledge. Cambridge Press, p.17

10. Creswell, J. & Creswell, J.D. (2022). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 6th Edition. Thousand Oaks, CA: Sage.

11. Patton M.Q. (2002). Qualitative Research and Evaluation Methods. Thousand Oaks, CA: Sage.

12. Denzin, N.K. & Lincoln, Y.S. (1994). Handbook of Qualitative Research. Thousand Oaks, Calif.: Sage

13. Guest, G., MacQueen, K. K & Namey, E. (2012). Applied Thematic Analysis. Thousand Oaks, Calif.: Sage.

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