



RESEARCH ARTICLE

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Identifying and overcoming barriers to adolescent sexual and reproductive health in the Solomon Islands: perspectives and practices of health, education and welfare workers

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ABSTRACT

Introduction: Young people are regarded as one of the most vulnerable groups in the Solomon Islands (SI). While improving adolescent sexual and reproductive health (ASRH) and rights is acknowledged as being critical to the wider development agenda of SI, there is little known about ASRH service delivery.

Aims: To identify barriers to ASRH service provision in SI, and explore opportunities to effectively address them.

Methods: In this mixed methods study, we conducted focus group discussions, semi-structured interviews and a specialised survey, which provided a snapshot of ASRH skills and service provision with 147 teachers, principals, youth and health workers. Stakeholder meetings were held at the beginning and end of data gathering to generate stakeholders' suggestions on policy recommendations.

Results: Survey responses by health and education workers identified ambivalent attitudes toward providing ASRH services, knowledge gaps and inadequate adolescent specific training. The workers identified several barriers to young people accessing ASRH services including cultural issues, poor access to information, resource and infrastructure constraints, uncertainty about professional roles, and a poor understanding of policy related to youth and ASRH. A number of strategies to overcome these barriers were identified: including ASRH in education, welfare and health sector job descriptions; investing in training in ASRH and counselling skills; improving supply of contraceptives; and building sustainable partnerships between sectors.

Conclusion: Improving ASRH provision in the SI is possible given the right support from government and global agencies; and a commitment to collaborative inter-sectoral action.

Key words: Solomon Islands, adolescent sexual and reproductive health, barriers, facilitators

BACKGROUND

Adolescent sexual and reproductive health (ASRH) has received substantial international attention in recent years as it is fundamental to social and economic development and attainment of Millennium Development Goals (MDGs).^{1,2} Improving ASRH and rights is critical to the wider development agenda of Solomon Islands (SI), particularly as more than half the population is under 20 years³ and the country has one of the highest population growth rates in the Pacific.⁴ Major sexual and reproductive health (SRH) issues facing young people are; high

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levels of teenage pregnancies and sexual violence⁵ and rising rates of sexually transmitted infections (STI).⁶

It is not usual for parents to discuss SRH issues with their children or amongst themselves.^{7, 8} Knowledge of SRH is generally poor, and this combined with a lack of power over health decisions, means that it is very difficult for adolescents to make informed decisions about their sexual and reproductive life.⁹ This study sought to better understand health, education and welfare workers views of ASRH education and service delivery in SI; to identify the barriers and explore ways to overcome these barriers. We selected Honiara Town Council (HTC), a largely urban population, and Malaita province (MP) with a largely rural population; in order to gather a range of views from both an urban centre and provincial/rural area.¹⁰

METHODS

We used a mixed methods approach, combining key informant interviews, focus group discussions and a knowledge, attitudes and competency survey involving 148 education, health and youth sector workers who directly provide or supervise health services or education activities with a SRH component (**Table 1**). Information was also obtained from grey and peer reviewed literature to further inform context and findings.

Ethics approval was granted by the Ethics committee of the University of New South Wales, Sydney Australia and the National Research and Ethics Committee of the Ministry of Health and Medical Services, Solomon Islands.

Data collection and participant selection

Health, education and welfare workers survey: a paper survey, modified from Pathfinder International Tools¹¹ was sent to 80 randomly selected education, youth and health workers, identified through the government employment lists (response rate n=74, 92.5%). The survey consisted of 4 sections: (1) demographic information (2) experience and training in ASRH (3) perceptions, attitudes and practices related to the provision of ASRH services and (4) awareness/views on ASRH institutional policies.

Focus Group Discussions (FGDs): Health, education and welfare workers in each district were randomly sampled from government lists, stratified by health and education authority (primary, secondary, faith-based, private and

public). Seven FGDs were held (four in HTC, three in MP) involving 55 participants in total. A topic guide was used to lead the discussions in four key areas: (1) current ASRH services (2) gaps and obstacles to service delivery (3) attitudes to adolescent needs (4) training needs and (5) opportunities for inter-sectoral collaboration between sectors.

Sector workers within each focus group were kept discrete to allow detailed exploration of issues pertaining to each sector. Experienced local facilitators were employed to run the groups in Solomon Islands Pidgin and/or English, depending on preferences of the group.

Semi structured key informant interviews:

Health (n=6), education (n=8) and youth welfare (n=5) workers from HTC and MP were interviewed. These workers were purposively selected based on their reputation as 'opinion leaders' in their field. The interviews were guided by the topic guide above, and presented as open-ended questions.

Analysis

Each focus group and informant interview was audio-taped, transcribed verbatim, and translated into English by the SI research team. The researchers (SR, RN) identified and analysed the key themes and coded data in NVivo 9 software (QSR International Pty Ltd, 2010). The quantitative data were tabulated and imported in to MS Excel for analysis. Findings from the informant interviews, FGDs and survey were triangulated. We used framework analysis as it is adapted to health systems research with specific questions and a limited time frame.¹² Two stakeholder meetings were held in Honiara in September 2012 to provide feedback on the findings and to generate stakeholders' suggestions on policy recommendations.

FINDINGS

Quantitative findings: the survey

Characteristics of the 74 survey respondents are detailed in **Table 2**. In HTC, health participants worked in one of the three designated youth-friendly SRH facilities, and in the country's only tertiary hospital. In MP, the participants were based at the provincial hospital and rural clinics (one designated youth-friendly service). The majority of the educator sector participants were principals or teachers who were involved in overseeing or directly providing ASRH education to adolescents.

Table 1: Summary of methods and number of participants

Sector	Key informant Interviews	Focus Discussions	Group	Survey Responders
Health	6	2 FGDs (x1 MP, x1 HTC) 18 participants		25
Education	8	3 FGDs (x2 HTC, x1 MP) 22 participants		49
Youth/welfare	5	2 FGDs (x1 HTC x1 MP) 15 participants		-
Total	18	55		74

MP: Malaita Province

HTC: Honiara Town Council

Table 2: Survey respondent characteristics

Item	Health care sector		Education sector	
	N= 25	%	N= 49	%
Gender				
Male	8	32	32	65
Female	17	68	17	35
Religious Affiliation				
Roman Catholic	8	32	7	14
Protestant	16	64	34	69
No response	1		8	
Professional Qualification				
None	1	4	8	16
Nurse Aide certificate	6	24	-	-
Diploma/degree	14	56	18	37

Provision of ASRH education: attitudes and competencies of educators

Table 3 outlines the attitudes and competencies of education workers in the provision of ASRH education to school students. The majority supported sexuality education being taught at their school, and stated that they were comfortable discussing ASRH issues with students, although further questions elicited a number of contradictions.

Provision of ASRH services: attitudes and competencies of health workers

Table 4 lists health workers' attitudes, competencies and practice in ASRH. Health workers had some contradictory attitudes and practices with respect to youth and ASRH service provision. A third would not prescribe condoms to youth, none were aware of institutional policies with respect to SRH.

ASRH training: health and education sectors

Table 5 lists the SRH training reported by health and education workers. Nearly all health workers and over half the education professionals had

received basic training in SRH; none had adolescent-specific training.

Qualitative findings: health, welfare and education sectors

Analysis of the interview and focus group discussion data revealed a number of key barriers to the delivery of ASRH services and education:

Cultural norms

Certain cultural norms and customs were reported as being a major barrier to delivering ASRH services, primarily because it is considered 'taboo' for sector workers to provide either clinical services or information to people of the opposite gender, or to those they are related to. SRH is a topic that is not openly discussed, between males and females in particular:

"If a young boy talks with a young girl, the girl's people will bring knives, but educating them is very important....Custom is a big barrier because Solomon Islands is a multi-ethnic group." (Youth welfare worker)

All of the sector workers believed that adolescent embarrassment of SRH issues was an obstacle,

but the vast majority emphasised that it was the attitudes of other teachers, health workers, and

parents that hindered the provision of services.

Table 3: Education participants' attitudes, competencies and practices (N=49)*

Questions	N	%
Is sexuality education taught at your school?		
Yes	26	84
Who should teach sexuality education?		
Health workers	24	49
School teachers	23	47
Do you support provision of sexuality education to students?		
Yes	39	84
Are you comfortable discussing ASRH issues with students?		
Yes	35	76
Which topics do you support? (for grades 10-11)		
Anatomy	24	49
Contraception	23	47
Sexuality, gender & norms	24	49
Human relationships	27	55
Action you would take for student with SRH problem		
Refer to health clinic	35	76
Counsel student themselves	24	52
Refer to counselling	25	54
Inform principal	19	41
Inform students' parents	17	31
Aware of SRH institutional policy?		
Yes	7	14

*Not all questions responded to by all survey participants

Parents were perceived by many teachers to be ignorant of the benefits of educating children about SRH, and teachers were often fearful of parent responses to sexuality education being offered in the classroom. Furthermore, some educators reported that they inform their students' parents if the student seeks help about a SRH issue from them. They also viewed some colleagues as unwilling or embarrassed to teach SRH:

"Some of the teachers at times they don't feel good about teaching reproductive health...some teachers always hold back, so information does not all go in one day, they leave some for later." (Education worker)

Health worker attitudes were also viewed by participants as discouraging adolescent access to SRH services either because they would inform their client's parents or turn away young clients:

"The problem being encountered is the confidentiality and attitude of health service

providers turning away young people." (Welfare worker)

Scarce resources

A shortage of health staff was seen as an obstacle because high workloads often did not permit attentive counselling of young people:

"Inside the clinic...if it's full with outpatients who came, then I will not have enough time to sit down with the adolescents. So sometimes it is not complete what we want to tell them, because we want to rush things up to see other sick patients waiting." (Health worker)

A lack of funds or delays in funding, poor resourcing, including basic equipment such as condoms were constraints also consistently raised by the participants. Roads which were could be impassable in the rainy season, also hindered workers access to remote villages and there was an identified a lack of suitable facilities for adolescents and overcrowding.

Table 4: Health worker ASRH attitudes, competencies and practices (N=25)*

Questions	n	%
Willing to provide RH services to client with HIV/AIDS?		
Yes	18	85
Comfortable discussing sexual behaviour relating to HIV/AIDS with youth client?		
Yes	18	85
Willing to provide contraception to unmarried youth clients?		
Yes	19	90
Contraceptive method you will not prescribe to youth		
Condoms	8	32
Injectable	6	24
Intra-Uterine Contraceptive Device	5	20
Oral Contraceptive pill	4	16
Emergency contraceptive pill	1	4
Minimum number of children client has before you will prescribe contraception		
No minimum	8	38
1	7	33
1 or more	6	28
Do you require parental consent before prescribing contraception?		
Yes	6	28
Action taken if 14 year old requests contraception		
Advise sexual abstinence & prescribe condoms	14	67
Prescribe contraception only	7	33
Counselling & information only	2	9
Action taken if client suspected of having STI		
Diagnose	11	52
Laboratory test	20	95
Counselling	6	28
Treat	19	85
Issue notification slip	14	66
Aware of any SRH Institutional policies?		
Yes	0	0

*Not all questions responded to by all survey participants

Table 5: ASRH training for health and education workers

Training	Health		Education	
	N	%	N	%
Basic training in SRH	19	90	26	53
SRH Refresher course	18	72	-	-
In-service training	-	-	17	35
Teaching assistance	-	-	15	31
Performance assessed	-	-	15	31

*Not all questions responded to by all survey participants

Uncertainty about roles and lack of incentives

Many of the health workers did not have a job description or were not aware of one and felt that they were carrying out roles that they were not paid to do and were performing tasks beyond the scope of what they believed was expected. Some health workers felt that they did not have the capacity to do their job and found it overwhelming.

Participants complained about the lack of recognition and incentives for working with adolescents and limited training and motivation of staff was also a concern. A lack of rewards for staff who had gained additional qualifications or training was seen as de-motivating and they were often *“just put back in the same position as before”* (health worker).

On the whole, principals did not view their role to facilitate ASRH in schools and it was not a part of their documented job descriptions. Science and home economic teachers were generally those responsible for teaching SRH topics, and they commented that their job descriptions were ‘broad’. Youth sector workers mostly appeared to be more adequately prepared for the jobs they were expected to perform and many confidently described their roles, their lines of authority and viewed collaboration with other sector workers as a key aspect of their job.

Interventions to address identified barriers:

The participants suggested a number of measures which they believed would improve the quality of services and make care and information more readily available. These were:

Engaging community gatekeepers:

It was suggested by some that difficulties in discussing SRH due to dominant cultural norms could be overcome by seeking ‘buy-in’ of key community leaders. Participants also highlighted the important role the churches have in providing ASRH education, particularly as a way to capture out-of-school adolescents. Religious beliefs weren’t necessarily seen as a barrier, particularly if awareness programs were put in place.

More transparency and collaboration:

Participants would like to see the government having a more transparent decision making process around ASRH. This means that development of standard training manuals and/or curriculum should involve those organisations concerned with adolescent issues:

“A standard reproductive health curriculum where all youth service providers or stakeholders should be speaking the same language.” (Education worker)

In addition, there was a lot of emphasis on organisations working together to improve practices and services, with the proviso that government should lead any joint effort.

Regular dissemination of information and appropriate training:

Education professionals emphasised that they need regular updates on SRH issues and opportunities for further education. There was an emphasis on any initiative to also involve the provinces.

A lack of adolescent-specific training was acknowledged as a problem for health workers. There was some support for joint training initiatives between health, education and welfare workers. Training and incentives for health staff would also improve attitudes. Any further education provision should include ‘gender balance’ training.

Changes to the school curriculum

There was general acknowledgement that the new curriculum with its emphasis on integrating ASRH into the broader education curriculum was a positive step; however there was concern about whether teachers were appropriately trained to deliver this curriculum.

In situations where teachers feel that they cannot teach classes with their relatives present, further training was suggested:

“I think to solve this cultural barrier with teachers, it’s better to train them because I really believe after going through these trainings, these teachers, they will un-sympathize with themselves to remove these cultural barriers in teaching.” (Education worker)

Youth venues and accessible youth friendly clinics

Participants stated that more specialised ‘youth friendly clinics’ should be established in both rural and urban areas and existing services to better cater for adolescents. They stressed that training may help the health workers to see the need to be more welcoming to adolescents. The difficulty in treating or talking about ASRH to clients of the opposite gender could be dealt with by employing both male and female nurses at the same locations. Clinics should also hold dedicated adolescent clinic days and should be open longer:

"Eighty percent of our people are living in rural villages ... We need some space in our clinics that is accessible and available 24 hours because this age group is very [sexually] active, therefore, we need adolescent service that is specific for them." (Health worker)

Funding and policy for ASRH:

Some focus group discussion centred on the need to 'pool' funding from other government sectors to facilitate enhanced integration of planning and services at both national and provincial levels. There was also a perceived need for a change in the way ASRH services are budgeted for:

"NGOs... they seem to be funding the same projects... Everyone talks about HIV, HIV. Why don't we build a network with them and ask them to put in money so that we will be the ones dishing out funds for the much needed new programs like adolescent services?" (Health worker)

Transparency and good management was needed if international donors continue to invest in the Solomon Islands:

"We need to properly manage the money given to us; we use it for its purpose so that our donor partners can continue to trust us and throw in more money for the program." (Youth worker)

It was noted that new policy could provide guidance on service provision in the community and in school curriculums, and current policy that is effective should be utilised.

DISCUSSION

Our study is the first of its kind to engage frontline workers and administrators in identifying barriers and solutions to ASRH service provision in SI. The findings from this study indicate that there are complex barriers which hinder the provision of these services. In particular, participants identified certain cultural norms and attitudes that have been described before,¹³ lack of staff incentives, poor infrastructure, and an acknowledged lack of skills and knowledge.

Though SRH services are theoretically available to young people, we found that in reality, some services may be inaccessible due to cultural beliefs. According to participants, the taboo nature of sex and sexuality poses a major barrier as it limits open discussion not only within families but also in communities, schools and health services and prohibits opposite genders and kin providing SRH health services to each other.

The majority of sector workers supported the provision of sexuality education and services to adolescents, and were directly providing or administering these much needed services; however, we also identified judgemental attitudes and beliefs which will limit appropriate care or access to information. Surveyed education workers for example overwhelmingly supported sexuality education, but many did not support the teaching of core topics such as anatomy, sexuality, gender and norms, contraception, HIV/STIs and human relationships. Our findings suggest that teachers are avoiding topics which they perceive as inappropriate.

Health worker responses reflected similar ambivalent attitudes and a worrying lack of skills and confidence in core health practices relating to adolescents. Although they reported that they were willing to prescribe contraception to unmarried adolescents, there was some reluctance when questioned further; for example, over half would refuse to prescribe any form of contraception to young women unless they had already had one or more children. This suggests that health worker willingness to prescribe contraception may not only be dependent on the parity of their clients, but also their marital status, as sex and pregnancy outside of marriage is widely condemned in SI. They may perceive their main role as serving the needs of married women, and indeed participants stated that some health workers were turning unmarried adolescents away from their health service.

The lack of knowledge of relevant ASRH policies is concerning, given the role of policy in providing appropriate guidelines for practice. The Pacific Policy Framework for Universal Access to Reproductive Health (2008-2015) represents the government's commitment to achieving universal access to RH services and removing barriers, especially for adolescents.¹⁴ Overarching this framework is the United Nations International Conference on Population and Development, which speaks specifically of the right of adolescents to SRH education, information and care and establishes their rights to privacy and confidentiality and informed consent.¹⁵ The majority of the sector workers were unaware of such government policies: 30% of health workers surveyed, for example, would require the consent of their young client's parents before prescribing contraception. There was also a lack of clarity regarding roles of the health workers in ASRH: workers were not provided with job descriptions and no workers role was solely dedicated to ASRH. As a result,

many of the workers felt that ASRH work was not officially part of their official duties and added to their already overburdened workloads.

Welfare workers in this study tended to provide health promotion and non-formal education activities to youth both in and out of school. Considering that the majority of SI youth are not at school, their activities can be considered essential if any progress is to be made in changing harmful community attitudes and empowering youth to make informed decisions. However, their actions to engage and inform community stakeholders were severely hampered by inconsistent and scarce funding, a lack of support and the remoteness of the communities in which they served. Many of the programs were only offered in urban centres and reaching scattered communities over hundreds of islands was constrained by their remoteness, poor roads, and a lack of transport and meeting space, severe weather and staff shortages. Welfare workers were therefore concerned that rural adolescents had limited ASRH knowledge and were unaware of or unable to access appropriate health services.

The scarcity of workers and significant resource and infrastructure constraints were clearly beyond the scope of any individual worker to influence; however there are signs that the government is beginning to prioritise ASRH. Recent changes to the SI National Health Plan have seen SRH identified as a core priority, and national guidelines have been developed in recent years. Despite this growing recognition, there was a general feeling amongst the participants that this was not 'filtering down' to the provinces. In Malaita province for example, ASRH is not included in the health operation plan and therefore the specific needs of adolescents are not being addressed. Participants consistently raised concerns that donor priorities did not correspond with needs of the realities on the ground – they perceived that majority of international funding was directed towards HIV prevention awareness at the expense of measures to prevent early pregnancy and other STIs. In real terms, funding for family planning in the Pacific has fallen over the past decade to less than \$US1 million per year, whereas \$US31 million is allocated to HIV prevention programmes, when family planning is one of the most cost-effective investments a country can make towards sustainable development.¹⁶

With regards to training, nearly all the health workers in this study had received basic training in SRH, but only half had received any refresher

training. None had received any ASRH training, despite the acknowledged need for workers to have the knowledge and skills to provide appropriate information and services to young people in a compassionate manner, respecting confidentiality and rights. Many teachers had also received basic training in SRH, but few had had this training updated, nor were the majority receiving any kind of teaching assistance from fellow teachers or public health nurses. Furthermore, many of the participants felt that incentives for extra training were low as there were few opportunities to use new knowledge.

Importantly, SI professionals felt empowered enough to identify simple strategies to address many of the barriers. Collaboration between sectors was seen as way to enhance practice and avoid duplication of services. Other strategies commonly mentioned were receiving relevant training and the ability to use this training to alter their practice; improving youth health venues; targeted funding for ASRH; and developing stand-alone or adolescent friendly services that would operate seven days a week. Clearly this last suggestion is challenging, however youth friendly guidelines have recently been developed and evaluated,¹⁷ many of which may be implemented at low cost. For SI, there is a clearly articulated need to expand this training, and continue to further standardise and evaluate adolescent-friendly policies and services.

Practical suggestions such as collaboration with respect to training in ASRH, and having standard manuals for all sector workers, are feasible. Evidence from the Asia-Pacific region suggests that school-based and peer sex education and increasing school retention actually increase adolescents' access to reproductive health services.¹⁸ Pooling funds, reducing duplication of services and improving the policy environment for ASRH were all suggestions that could be put into practice, with the right political support.

This study was limited by focusing on two provinces; we could not logistically include workers from smaller provinces. There was also relatively a small sample of health workers and no medical staff recruited. However, the focus on nurses was deliberate given their frontline role as providers of SRH services. We also acknowledge the diversity of ethnic groups in the Solomon Islands; this study therefore provides only a snapshot of the situation.

CONCLUSIONS

We know, from all the available evidence that it pays to invest in adolescents.¹⁹ We would argue that this is particularly the case in SI, where adolescents are a significant and growing proportion of the population with high needs. Our study suggests that sector professionals in SI are acutely aware of the barriers to providing quality services and are also able to identify simple strategies to address these barriers. Given the right support from the government of SI and global health and development agencies, adolescents can and should be prioritised in policy and service provision and this would help address challenges such as poverty, gender inequality, HIV/STIs and urbanisation.²⁰

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