

Knowledge, Attitude, and Practice (KAP) towards Family Planning among Women of Reproductive Age in Fiji

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Abstract

Background: Globally, family planning is one of the most important public health issues in both developed and developing countries due to high unmet needs.

Objective: To assess the level of knowledge, attitudes and practice (KAP) towards family planning among women of reproductive age in Suva, Fiji.

Methods: The study applies a cross-sectional quantitative method using a self-administered questionnaire to collect data. Using random sampling, a sample of 325 women was used for the study and they were sought from three health clinics in Suva, Fiji. The questionnaire was administered to the respondents who met the inclusion criteria and they provided information that mostly involved rating the different issues and identifying their level of KAP. This data was analyzed using the statistics program SPSS version 25.

Results: The mean age of the participants was 31.53 (± 7.35) years. A majority of the participants (64.6%) belonged to a Christian church while 65.2% belonged to iTaukei ethnic group. Approximately half of them (45.6%) had a high level of knowledge while 53.5% had moderate knowledge with only 0.9% reporting that they had poor knowledge. In terms of attitudes, 54.2% of the participants had high level or positive attitudes towards family planning with only a small proportion of 0.3% had low level or poor attitudes. In terms of practice, a majority of the participants (65.9%) had medium level of practice towards family planning while 24.6% showed a poor level with 9.5% having a high or good level of practice towards family planning.

Conclusions: This study identified that women had medium level of knowledge and practice towards family planning, but their attitude was relatively high. Using behavioral change models such as health belief model (HBM) that focus on perceived benefits and barriers may help to promote KAP towards family planning among Fijian women.

Keywords: contraception, birth control, knowledge, attitude, practice, family planning, Fiji

1. Introduction

Family planning refers to the use of different methods and strategies for enabling men and women to make informed decisions about child bearing. It consists of the methods that men and women use to space their pregnancies and control the numbers of off springs that they want to have (Brown et al., 2014). Understanding the levels of contraceptives use in the community is essential in understanding changes in fertility and the reproductive health across regions worldwide. Studies such as the UN world report indicate that 64% of all women in unions or marriages globally use contraceptives (United Nations, 2015). However, the level of such usage is relatively low in developing nations such as the Oceania region where the rate was 40% in 2015 (Alkema et al., 2006). There are significant regional differences with 12% of women in civil unions or marriages globally having an unmet need for family planning (McMurray & Lucas, 1990). This rate of unmet contraceptive needs was high at 22% in least developed countries (Kennedy et al., 2011). The women with unmet contraceptive needs are those who want to stop or delay childbirth but are not using any method of contraception. The prevalence of contraceptive use is expected to grow towards 2030 with the highest rates being expected in Oceania and Sub Saharan Africa (Alkema et al., 2006; Cates et al., 2010).

Low motivation for the use of family planning in different settings is cited as resulting from lack of adequate information about contraceptives, lack of accessibility, fear of side effects, and negative attitudes due to social and

religious sentiments (Dehlendorf et al., 2010). The quality of education available on the subject can be associated with provider bias and most of the challenges are associated with lack of awareness (Naidu et al., 2017).

In Fiji, reproductive health services are delivered through all health centers in the Central, Eastern, Northern and Western divisions. These services are free of charge for Fijian population (Ministry of Health, Fiji, 2016). According to Gyaneshwar, et al., (2016), Fiji's population growth rate declined to 0.83% in 2010 from between 1.39% to 1.41% in the period 2000-2009. However, the decline is not attributed to family planning but to other factors such as the movement of women away from the home to non-familial work in the labor market (Kuang et al., 2016).

In Fiji, one of the key issues that have been identified as a barrier to the uptake of contraception is the lack of female providers. This was cited as a key issue for a third of the women in Fiji and New Zealand (Cammock et al., 2017). The issue of cost was also identified as a major barrier contributing to unmet needs for contraception (Bradley et al., 2012). The role of KAP in using contraception is always questionable. As there is no study conducted yet in Fiji among women regarding the family planning it important to measure the level of KAP. Therefore, this study focuses on the issues and challenges facing Fiji in terms of low uptake of family planning to evaluate the level of knowledge about the concept of family planning, its methods, health aspects and barriers, the level of attitudes toward family planning approaches, use of contraceptive approaches and barriers and the level of family planning practices and use of contraceptive methods among women of reproductive age in Suva, Fiji in 2017.

2. Methods

This quantitative, cross – sectional study was conducted among women who attended three designated health clinics around Suva, Fiji from 15 March to 28 April 2017. The study population included all Fijian women of reproductive age. The inclusion criteria included women, ages 15-49 who were married (target group for family planning services) and were attended any one of the three identified family planning clinics under study from 15 March to 28 April 2017. Furthermore, the study participant must have been a Fijian – anybody in Fiji who possesses Fijian citizenship. The exclusion criteria included women under the age of 15 or age 50 and over and those women who are not happy to participate in the study. Participants who met the inclusion and exclusion criteria who consented to participate in the study were asked to fill a questionnaire survey to identify the level of KAP towards family planning. The sampling was conducted randomly and proportional sampling was applied to determine the sample size by considering a 50% prevalence of KAP about family planning, 95% confidence interval, 5% margin error, and 5% non-respondent rate which gives a total sample size of 342.

A self-administered questionnaire was used to collect data (Table 1), which was tested in a pilot study for validity. Face validity was conducted among 10 women who met the study inclusion criteria and content validity was done by three experts in the field of family planning. Based on the geographical distribution and covering a large number of population, three randomly selected family planning health clinics were chosen including; Nuffield Clinic in Tamavua, Wellness Center for Women/Oxfam) at the Colonial War Memorial Hospital (CWMH) in Suva, and Samabula Health Center in Suva. These health centers provide reproductive health services such as; safe motherhood, infant and child care, adolescent health care, family planning and prevention of abortion, STI-HIV prevention and management, and basic infertility services and management of gynaecological morbidity including reproductive tract cancers & infections (Ministry of Health Fiji, 2016).

Table 1. Questions were tested for the KAP

Knowledge related Questions
1. Have you ever heard of contraceptive?
2. Birth control pills are effective even if a woman misses taking them for two or three days in a row.
3. Female sterilization is one way to avoid pregnancy.
4. Health education is important for women who want to use contraception.
5. Contraceptive pills do not guarantee 100% protection.
6. Condoms prevent STIs.
7. Common side effects of contraceptive pills include mood swings and weight gain.
8. There is an increased risk of breast cancer in women taking estrogen-containing contraceptives.

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9. Women using the birth control shot must get an injection every three months.
 10. If a woman is having side effects of one kind of contraceptive pill, switching to another type might help.
 11. Using both a condom and the pill is considered to be a very effective contraceptive.
 12. Using the pill increases a woman's risk of ovarian, endometrial or cervical cancer.
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Attitude related Questions

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1. Contraceptives should be used to limit my number of children.
 2. Contraceptives should be used to increase the time interval between my childbirths.
 3. Spacing will allow a child to be healthier.
 4. The ideal age of having a first child is 20-30.
 5. The ideal number of children should be between 3-5
 6. Contraceptives provide a sense of safety.
 7. The method of contraception I am using is adequate.
 8. Contraceptives benefit males too.
 9. Discussion about contraception with spouse is embarrassing.
 10. My husband does not approve my use of contraceptives.
 11. Contraceptive methods can protect the health of family and community.
 12. Religious beliefs can prevent women from using contraceptives.
 13. Cultural beliefs can prevent women from using contraceptives.
 14. Husband's objections to contraceptives can prevent women from using contraceptives.
 15. Change in male attitudes on contraceptives may improve contraceptive use.
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Practice related Questions

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1. How many times a year do you visit a health center for family planning services?
 2. Do you use contraceptives to prevent unplanned pregnancy?
 3. Have you ever had any unplanned pregnancy due to lack of contraceptive use?
 4. Do you use contraceptives every time when you do not intend to get pregnant?
 5. I use different types of contraceptives.
 6. My current method of contraceptive changes from time to time.
 7. Do you practice any traditional contraceptive methods including withdrawal, infertility period, herbal and breast feeding if you were not using any contraceptives?
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There were 12 knowledge related questions that carried a total of 24 correct responses. Each correct response was given a score of 2 and a wrong response a score of 0 whereas a don't know response carried a score of 1. Total points to be scored were 24 and the minimum was 0. On assessment, a modified Bloom's cut off points were used where a score of 80-100% of correct responses meant a good knowledge, a score of 50-79% was a level of medium level knowledge and a poor knowledge was for the respondents with a score less than 50% of the correct responses. Modified Bloom cut off points were adopted from John's knowledge, attitude and practice study (John, 2011; Yimer et al., 2013). The scores, with their respective knowledge levels were (a) 0 – 11 as "Poor" (low level) knowledge (b) 12– 18 as "Moderate" (medium level) knowledge and (c) 19 – 24 as "Good" (high level) knowledge.

The participants' attitudes was assessed using 15 questions with Likert scale. The questions on a Likert scale were ranged from high level to low level responses such as 5 as "Strongly Agree", 4 as "Agree", 3 as "Neutral", 2 as "Disagree" and 1 as "Strongly Disagree". The total score obtained for respondents was a maximum of 75 with a minimum of 15. Combined scores of less than 35 were categorized as low level attitude, from 35 to 56 as medium level attitude, and 57 and above as high level attitude. The mean score was calculated and those scoring above the mean were classified as high level attitude and scores below the mean was classified as low level attitude towards family planning whereas those scores within between low and high level attitude were classified as medium level

attitude.

The participants' practice was assessed by 7 questions about family planning in a scale of 1 – 5 with 1 as Never, 2 as Seldom, 3 as Sometimes, 4 as Usually and 5 as Always. The maximum score was 35 whereas the minimum score was 7. Therefore, 7 – 15 was scored as Poor (low level) practice; 16– 24 were scored as Moderate (medium level) practice and 25 – 35 was scored as Good (high level) practice (Tavoosi, 2004; Mohammadnezhad, 2015; Tekanene et al., 2017). The data was analyzed with SPSS Version 22 statistical software. The frequency and percentage of KAP are presented in tables and graph.

Data was collected from the selected study sites by the main researcher after the required ethical approvals of the study had been secured from the College of Health Research Ethics Committee (CHREC) and MHMS Fiji National Health Research and Ethics Review Committee (FNHRERC). All participants were informed about the objectives of study using an information sheet and were asked to sign a consent form before participating in this study. They were informed that participating in this study is totally voluntary and their information will be confidential. Participants were given 15-20 minutes to fill the questionnaire. If they needed support to complete the questionnaire, the main researcher assists them. To ensure the questionnaire is filled completely, all the questionnaires were checked by the main researcher before collecting from the participants.

3. Results

The focus of the study, which was conducted on a sample of 325 women visiting the three designated health clinics for this study, was to evaluate the KAP that women have towards family planning. The average age of the participants was 31.53 (± 7.35) years and most of the participants were in the age bracket of 25-29 years accounting for 26.8% of the sample. About two-thirds (65.2%) of the participants were from the iTaukei ethnic group. Majority of the participants were Christians accounting for 64.6%, which were 210 respondents. Another interesting element of the sample was that it consisted mostly of women that were involved in non-familial work as active participants in the labor market where 60.6% were employed compared to 39.4% that were housewives. The sample was mostly based in urban areas where 70.5% were residents in urban centers. In terms of the number of children, 63.1% has 1-3 children indicating the declining fertility rates in the country caused by higher education levels in the community coupled with the involvement of the women in the labor market. The income level for 34.2% of the women was \$8,000.00-\$14,999.00 (Table 2).

Table 2 Demographic characteristics of participants (n=325)

Variables	Categories	Frequency (n)	Percentage (%)
Age	15-19yrs	5	1.5
	20-24yrs	48	14.7
	25-29yrs	87	26.8
	30-34yrs	72	22.2
	35-39yrs	55	16.9
	40-45yrs	37	11.4
	45-49yrs	21	6.5
Religion	Christian	210	64.62
	Hindu	69	21.23
	Muslim	16	4.92
	Others	30	9.23
Ethnicity	iTaukei	212	65.2
	Indian	88	27.1
	Others	25	7.7
Employment	Employed	197	60.6
	Unemployed	128	39.4

	<7,999	90	27.7
Annual income (FJD)	8,000-14,999	111	34.2
	15,000-24,999	109	33.5
	25,000-35,000	15	4.6
	0	36	11.08
Number of children	1-3	205	63.08
	4-6	82	25.23
	>7	2	0.61
	Urban	229	70.5
Area of residence	Rural	96	29.5

The defiles of participants answer to KAP questions is presented in previous publication (Lincoln et al., 2018). In terms of knowledge, 53.5% had moderate level knowledge while 45.6% had a high level knowledge with only 0.9% having low level knowledge of family planning. Most of the participants had positive or high level of attitudes towards family planning as shown by the high level recorded by 54.2% of the sample while 45.5% indicated a moderate level. Only 0.3% had low level of attitudes towards family planning. In terms of practice, most participants were found to have a moderate level of practice towards family planning. This was almost two-thirds of the sample (65.9%) while 24.6% had a low level. Only 9.5% had a high level of practice in relation to using family planning (Table 3).

Table 3. Level of KAP towards family planning

Variables	Frequency (n)	Percentage (%)
Knowledge		
Good (High Level) Knowledge (>19)	148	45.6
Moderate (Medium Level) Knowledge (12-18)	174	53.5
Poor (Low Level) Knowledge (<11)	3	0.9
Attitude		
Good (High Level) Attitude (>57)	176	54.2
Moderate (Medium Level) Attitude (36 - 56)	148	45.5
Poor (Low Level) Attitude (15-35)	1	0.3
Practice		
Good (High Level) Practice (25 – 35)	31	9.5
Moderate (Medium Level) Practice (16 – 24)	214	65.9
Poor (Low Level) Practice (7 – 15)	80	24.6

4. Discussion

The focus of the research was to identify the level of KAP of Fijian women towards family planning. These results of the study revealed that the participants have relatively medium level of knowledge and practice towards family planning and high level of attitudes towards family planning. The results of the analysis indicate that health education and family planning initiatives that have been undertaken in the country have not improved the usage of family planning in Fiji as evidenced by the chronic low contraceptive prevalence rate (CPR) in the 40s over the last three decades (Kennedy, 2013). Yet despite the lack of improvement of the overall CPR in Fiji to date, the results indicate that the initiative implemented by the government have played a some role in improving women's knowledge towards the availability of modern family planning methods as evidenced by the KAP results noted in table 2. The results are in line with the findings of studies such as Gyaneshwar et al., (2017), which have indicated that government initiatives have produced beneficial outcomes in reducing the crude birth rate in Fiji to sustainable

levels.

An interesting element of the findings is that most people are knowledgeable about family planning. There are regional differences in practice but these are mainly affected by the cultural and social practices of the community. This view is supported by the findings of Alkema, et al., (2006). In Fiji, a key challenge cited as preventing some women from seeking family planning services is that they lack female providers. The cultural practices bar them from going to male doctors in search of contraceptive services as found out in Cammock et al., (2017). While awareness regarding contraceptives is available, there are some challenges in relation to its application and the depth of how much the women know. One interesting element of knowledge was that only 54% of the respondents acknowledged that missing contraceptives for 2-3 days consecutively could make them ineffective. It would be better for the community if the women had better knowledge of contraceptives, because this would directly affect their practice. The fact that the respondents with high knowledge about contraceptives made up 45% of the sample means that there is a lot of room for improving awareness / attitudes levels.

It is clear that most of the respondents identified themselves as Christians, which makes up 64.6% of the sample. This may have a significant influence on the practice and attitudes that the women reported towards family planning. The basis of the Christian beliefs in Fiji about contraception as being unacceptable can be associated with the colonial foundations implemented by the missionaries (Gyaneshwar et al., 2016; Hodges, 2008). The issue of contraception uptake has also been associated with gender disparities and the views of men that are in some cases a barrier for women in using contraception (Vasilenko et al., 2015; Sewak & Singh, 2012). As indicated in a study by Delaibatiki-Cammock (2015), the issue of male domination of reproductive health decisions is a significant barrier to the uptake of contraceptives in Fiji (Delaibatiki-Cammock 2015). This issue is highly apparent in the Indo-Fijian community, but has also been highlighted as a major factor in many developing nations and regions (Chandra & Lewai, 2005). Another major issue that needs consideration in understanding family planning in Fiji is that there are significant differences in the rates of usage as well as awareness across regions and demographics. For example, Mustafa et al., (2008) indicated that the issue of contraceptives use differs considerably between rural and urban populations. There is lower awareness in rural populations in many developing nations. This element means that the findings of the current study have to be interpreted with caution (Naidu et al., 2017). While the population of Fiji is mostly rural, the sample only had about 29% of rural respondents. This means the findings may be skewed towards the awareness levels, practice and attitudes of urban women.

These findings indicate the need for more educational strategies for the community on family planning. Social marketing has been cited as a significant strategy for ensuring that the needs of the community for contraceptives are effectively addressed (Mustafa et al., 2008; Cleland et al., 2006). It also shows that the Fiji government needs to consider ways of enhancing the uptake of contraceptives by moving beyond providing awareness (Cleland et al., 2014). This can be achieved by including men in awareness and educational programs on family planning. Addressing cultural and social barriers would also play a major role in reducing the level of unmet family planning needs (Bongaarts, 2014).

The findings of this study highlight the urgency of implementing policies that would seek to educate women about proper family planning methods and techniques specially targeted at women with poorer socioeconomic backgrounds

4.1 Limitation of the Study

Although, this study is evidenced by the fact that it is one of very few studies concerned with the state of KAP of family planning in Fiji involving women of all races and social status and as such it provides a useful source of empirical information and as such this study is relevant primarily for public health policy makers in this country, there were few limitations such as; lack of generalizing the results to all pregnant women as that usually happens in cross-sectional studies. The results can be affected as the data collected used a self - report questionnaire. Lastly, the lack of causality from the results could have been attributed to the type of study used in this study

5. Conclusions

From the results of this study, it is concluded that the quantitative findings showed that women of reproductive age (15-49) had a fair (moderate) level of knowledge towards family planning. From the findings of this study, it is clear that the level of knowledge of family planning in Fiji is moderate which leaves much room for improvement. The majority of the sampled women have medium level of knowledge and practice towards family planning, but their attitude considerations are relatively high. It is important for the government to develop ways of responding to the cultural, social, and religious barriers to the uptake of family planning by Fijian women. Gender disparities

require further research to identify how they influence the perceptions and practices.

Ethical Considerations

Data collection was done after the researcher received ethical approval from the College of Health Research Ethics Committee (CHREC) of Fiji National University and the Ministry of Health's Fiji National Health Research Ethics Review Committee (FNHRERC).

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Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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