



Knowledge, attitude, practice and barriers regarding safe sex and contraceptive use in rural women in Fiji.

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ABSTRACT:

Background: Fiji has a low contraceptive uptake rate and high rates of unplanned pregnancy and sexually transmitted infections (STIs). In this paper, we report the result of a study on Knowledge, Attitude, Practice and Barriers (KAPB) to safe sex and contraceptive use, conducted on 1494 rural women aged between 18 to 75 years in Fiji. The objectives of this paper are to explore the knowledge, attitudes, practice and barriers regarding safe sex and contraceptive use in rural women of Ba, Lautoka and Nadi, in Fiji.

Methods: Structured questionnaires were administered to women presenting to rural outreach Sexual and Reproductive Health (SRH) education sessions and clinics by trained health educators.

Findings: Knowledge on how pregnancy occurred and how to avoid pregnancies was high (86% and 83% respectively), but when it came to practice 43% of women had never used a contraceptive. Despite 81% of women having completed either secondary or tertiary education, 88% were not aware of emergency contraception. Fifty-three percent of respondents were unaware that condom use provided protection against both pregnancy and STIs. Sixty-three percent knew how an STI is contracted, but 48% were unaware of any of the symptoms of STIs. Women offered 'lack of knowledge' (53%), 'being married' (17%), 'difficulty accessing' (10%) or 'partner disagrees' (7%) as the common barriers to condom use. Forty percent of women were unable to articulate a barrier to contraceptive use and said they 'did not know' whereas 21% said 'fear', 15% said 'partner objecting' and 5% said 'religion' were barriers.

Conclusion: While a high percentage of women had some knowledge of how to avoid pregnancies and how STIs were contracted this did not translate to the practice of safe sex or use of contraceptives. Review of current education and health programs is necessary to ensure that misinformation and false perceptions do not act as barriers. The influence of the partner needs further research.

Key Words: safe sex, contraceptives, knowledge, attitude, practice, barriers

BACKGROUND

Fiji has a population of 837 271 dispersed over some 300 islands with the majority living on the largest island of Viti Levu.¹ The Fiji population consists of two main ethnic groups namely iTaukei (indigenous) Fijian 56.8% and Fijians of Indian Descent (FIDs) 37.5%. The remaining 5.7% includes people of Chinese, European and part European and other descent.¹

The Fiji Ministry of Health and Medical Services (MOHMS) identified three key health challenges

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pertaining to sexual and reproductive health (SRH) in Fiji. These include the high prevalence of cervical cancer, the low rate of contraceptive use and high rates of sexually transmitted infections (STIs).² Despite international declarations and concerted efforts by the Fiji Government in collaboration with United Nations (UN) agencies and others, the Fiji MOHMS reported that Fiji has a maternal mortality rate of 44.4 per 100 000 live births.³ Pregnancy, many of which are unplanned,⁴ and childbirth remain a common cause of morbidity in women. The rate of contraceptive coverage is only 45%,² alongside high prevalence of STIs, particularly gonorrhoea and syphilis, with rates of 135 and 61 per 100 000 population respectively.³ Adolescent pregnancy rates are high at 35 per 1000 females in the age group 15-19 years.² Furthermore, the prevalence of cervical cancer in Fiji is between 37.5 and 50.0 per 100 000 women, one of the highest in the Pacific.^{5,6}

The Fiji MOHMS statistics are consistent with the World Health Organisation (WHO) 2014 report, which states that complications from pregnancy and childbirth are a leading cause of death and disability for women aged 15-49 in most developing countries.⁷ Poor SRH awareness and services are responsible for more than a third of the global burden of disease for women of childbearing age, and one-fifth of the burden for the whole population.⁷ The need for increased family planning education and services for women globally is being recognised.⁸

The WHO reports that globally each year, at least 289 000 women die during pregnancy and childbirth, and 99% of these occur in developing countries.⁷ These deaths are more common amongst poor women who do not have access to good health care. In many countries, as in Fiji, termination of pregnancy remains illegal (unless certified by doctors as a risk to maternal or foetal life) and safe abortion services are not easily accessible to the most vulnerable. The WHO reports that on average, globally 47 000 women die from complications of unsafe abortions each year.⁸

The 1994 International Conference for Population Development (ICPD) declared access to SRH information and services a fundamental human right.⁹ This recognises the rights of all individuals to enjoy their sexuality without fear of disease or unwanted pregnancy. The United Nations Sustainable Development Goals are designed to end poverty, protect the planet, and ensure prosperity for all.¹⁰ Each goal has specific targets to be achieved over the next 15 years and to achieve these goals, universal access to SRH

information and clinical services for all, especially women, is essential.¹⁰

In many countries, the neglect of women's reproductive rights severely limits their opportunities for educational, economic and social empowerment. In Fiji, 64% of women who have ever been in a relationship have experienced physical and/or sexual violence by a husband or intimate partner in their lifetime.¹¹ The ability of women to control their own fertility forms an important basis for accessing other rights.

In 1995, the Ministers of Health for Pacific Island Countries committed themselves to the concept of 'Healthy Islands' where strategies suggested included awareness raising in the community through education and advocacy.¹² Viseisei Sai Health Centre (VSHC) conducted a project entitled 'Strengthening Rights of Rural Women by providing them with Knowledge, Access and Control of their Reproductive Health'. This baseline survey was conducted as part of this project between April 2013 and September 2014. In this paper, we report the findings on the KAPB of rural women on safe sex practices, contraceptive use and family planning. Cervical cancer and Pap smear data has been covered in a previous paper on this cohort.⁵

METHODS

Study Design

This was a descriptive cross-sectional study of women presenting for SRH outreach sessions in the rural areas of Ba, Lautoka and Nadi in Fiji and was conducted between April 2013 and September 2014. Pre-tested standardised structured KAPB questionnaires were administered by three trained health educators. They were able to converse in English (official national language), as well as either iTaukei or Fiji Hindi languages, which are the other ethnic languages.

Women aged 18 and over, who gave verbal and written consent took part in this KAPB study. During the outreach sessions, the survey questionnaires were administered first, followed by education and counselling in SRH. All questionnaires were administered in privacy and took approximately 20 minutes to complete. Women arriving after the educational activities had commenced were excluded from participating in the study.

Data collection and statistical analysis

All data were collected on standardised, pre-tested and de-identified questionnaires, by

trained health educators. Epi Data software¹³ was used to create a data set for the survey questionnaire, and the data were analysed using the statistical software SPSS version 24.¹⁴

Ethical Approval

Ethical approval was obtained from the College of Medicine and Health Sciences' Research Ethics Committee of Fiji National University (FNU) and the Fiji National Research Ethics Review Committee of the Fiji Ministry of Health.

FINDINGS

Sociodemographic Variables

There were a total of 1494 respondents, with a mean age of 37 (SD +/- 11.79) years with a range of 18 to 75 years; 56% of the participants were iTaukei, 43% Fijian of Indian Descent (FIDs) and 2% Others. A full summary of the sociodemographic details of the study population have already been reported in detail in an earlier paper 'Knowledge Attitude Practice and Barriers regarding Cervical Cancer and its Screening with Pap smear'.⁵

Knowledge

The majority of women knew how pregnancy occurred and how to avoid pregnancy (86% and 83% respectively). However, when participants were asked about emergency contraception, 88% of the respondents did not know about it.

Table 1 shows the percentage of women with lack of knowledge of emergency contraception was significantly different over age groups ($p < 0.004$), education levels ($p < 0.001$) and employment categories ($p < 0.001$), and marginally significantly different over ethnic groups (0.048). Those with primary level education, teenagers (aged 18-19), older women (over 60 years) and iTaukei had the highest level of 'no knowledge'. Those women who were professional/skilled workers had better knowledge when compared to the other working class.

Only 47% of women knew that condoms protect against both STIs and pregnancies. The percentage of women with lack of knowledge on condoms being the contraceptive that can protect from both STIs and pregnancies was significantly different over age group, education level and employment status ($p < 0.001$ for all categories); but not for ethnicity ($p = 0.270$). The groups with the lowest knowledge were older (over 60 years), those with only primary level of education and

Table 1: Percentage of women with 'no knowledge' of (1) emergency contraception and (2) condom protection from STIs and pregnancies; by age, education level, ethnicity and employment.

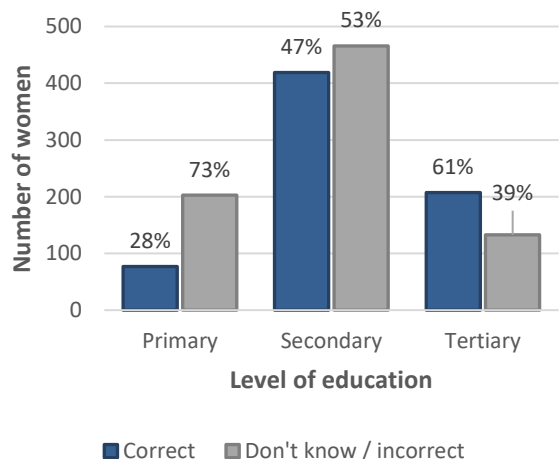
	Emergency contraception N (%)	Condom use N (%)
Age group		
18-19	21 (96)	12 (55)
20-29	381 (85)	216 (48)
30-39	380 (86)	214 (49)
40-49	287 (92)	168 (54)
50-59	205 (92)	141 (64)
60+	47 (96)	45 (92)
	$p = 0.004$	$p < 0.001$
Education		
Primary	263 (94)	202 (72)
Secondary	802 (92)	461 (53)
Tertiary	256 (75)	133 (39)
	$p < 0.001$	$p < 0.001$
Ethnicity		
iTaukei	755 (90)	446 (53)
FID	547 (86)	342 (54)
Other	19 (86)	8 (36)
	$p = 0.048$	$p = 0.270$
Employment		
Professional/skilled	164 (71)	84 (37)
Unemployed	108 (93)	76 (66)
Housewife	911 (92)	564 (57)
Hotel worker	28 (88)	16 (50)
Non-skilled	30 (91)	15 (46)
Self employed	29 (85)	15 (44)
Student	21 (88)	11 (46)
Other	30 (83)	15 (42)
	$p < 0.001$	$p < 0.001$

those participants who were unemployed or housewives. Those respondents with professional/skilled employment had a better knowledge on this subject ($p < 0.001$).

There was also a significant difference between the income groups ($p < 0.001$). The highest percentage of participants (62%) lacking knowledge was from the lowest income group (0-\$200 Fijian Dollars (FJD) per month). The impact of parity and marital status was not significant.

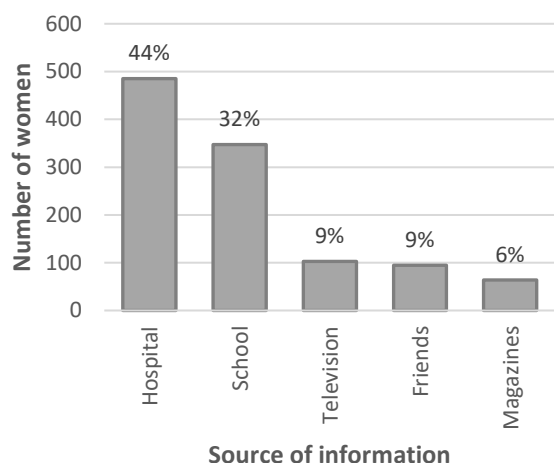
The women who had tertiary education had the highest percentage with knowledge that condom use can provide protection against both STIs and pregnancies (60.9%) (**Figure 1**).

Figure 1: Knowledge of contraceptive that protects from both STIs and pregnancies by level of education.



Almost two-thirds (66%) of the respondents had heard of the term 'safe sex'. Of those, 44% had heard about safe sex from hospitals and schools (Figure 2).

Figure 2: Source of information on safe sex.



When asked what safe sex was, over a third of the responses given (38%) were 'don't know'; while 34% were 'condom use'; 16% were 'abstinence' and 13.3% 'being faithful to partner'.

Sixty three percent of respondents knew how an STI is contracted however almost half of the participants were unable to offer knowledge of any of the symptoms of STIs (Table 2). Of greater concern is that only 6% were aware that there could be no symptoms with STIs.

Table 2: Responses to 'What are some of the symptoms of STIs?'

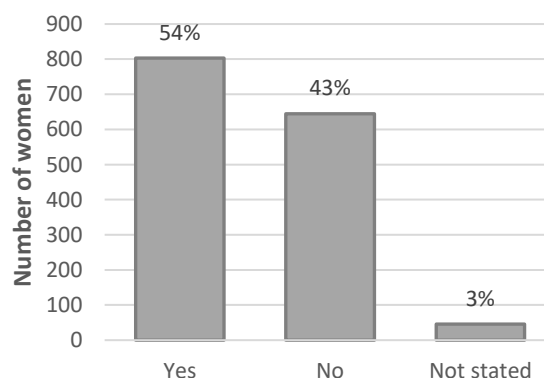
	N (%)
Don't know	800 (48%)
Vaginal discharge	180 (11%)
Bad odour	170 (10%)
Dysuria	124 (7%)
No symptoms	98 (6%)
Ulcers/rashes	73 (4%)
Weight loss	73 (4%)
Penile discharge	68 (4%)
Pain during sex	58 (4%)
Other	31 (2%)

Attitudes and Practice

When asked what should one do if someone has a suspected STI, over 60% (n=905) of women knew to attend a local health centre or a STI Hub Centre; 35.4% (n=529) did not know or did not answer; the others would either use herbal medicine or a traditional healer (3.5%; n=53). A small percentage would keep it a secret (1.1% n=16). Education level (p<0.001), employment (p<0.001) and income (p<0.001) are all significant predictors of knowledge of correct practice for suspected STI. Categories with the highest percentage of women with incorrect or no knowledge are: low level of education (primary); students and unskilled workers; and those with either low income or without knowledge of their income. Ethnicity, age, number of children and marital status were not associated with knowledge of correct practice.

Only 54% (n=803) women had used contraceptives at some stage and 43% (n=645) had never used a contraceptive (Figure 3). Of women of reproductive age (18-49 years), 57% had ever used a contraceptive, compared with 48% of women over reproductive age who had ever used. This difference is statistically significant (p=0.006).

Figure 3: Number of women who had ever used a contraceptive.



When women with children were asked how many of their pregnancies were planned, 18.2% had not planned any of their pregnancies and 37% of all pregnancies were reported to be unplanned.

Table 3 shows that age, education, employment, income group, number of children and marital status are all significant predictors of having ever used contraceptives. The groups reporting the highest 'ever used' contraceptive are the 30 to 39 year age group; those with secondary or tertiary education; students; FJD\$501 - FJD\$1000 income group; those with 3-8 children; and married women. Ethnicity was not significantly associated with contraceptive use.

When women did use contraception, injectable contraceptives (e.g. Depo Provera) (26%), oral contraceptive pill (23%) and condoms (20%) were most commonly used. Of women who use contraceptives, 92% used them primarily to prevent pregnancy, whereas only 4% of women said they used them to prevent pregnancy and STI.

Among the iTaukei women, injectable contraceptives were used most commonly followed by the oral contraceptive pill; whereas among FID women, condoms and oral contraceptive pills were the most commonly used (**Figure 4**).

Barriers

The most common response to the question of barriers to condom use from the participants was that they did not know, followed by 'being married'. Another 13% reported this was due to 'partner not agreeing' to its use or perceived 'loss of sensation' during sex. (**Figure 5**).

Of those who used condoms, only 10.6% used it each time they had sex. The rest used it sometimes only.

Figure 6 shows that apart from those women that offered 'Lack of knowledge' as the barrier (40%), the commonest reason was the 'fear' of contraceptives (21%) and 'partner's objection' (15%).

There is a significant knowledge-practice gap for safe sex and contraceptive use (**Table 4**).

Table 3: Percentage of women who have ever used contraceptives by age, education, ethnicity, employment, income group, number of children and marital status.

	N (%)
Age group	
18-19	5 (31)
20-29	219 (53)
30-39	276 (63)
40-49	174 (56)
50-59	109 (49)
60+	20 (43)
	<i>p < 0.001</i>
Education	
Primary	130 (47)
Secondary	500 (58)
Tertiary	173 (56)
	<i>p = 0.004</i>
Ethnicity	
iTaukei	440 (54)
FID	352 (58)
Other	11 (50)
	<i>p = 0.291</i>
Employment	
Professional/ skilled	111 (53)
Unemployed	43 (41)
Housewife	577 (59)
Hotel worker	15 (50)
Non-skilled	15 (47)
Self employed	18 (53)
Student	10 (63)
Other	14 (39)
	<i>p < 0.001</i>
Income	
\$0 - \$200	213 (53)
\$201 - \$500	297 (55)
\$501 - \$1000	175 (63)
\$1000+	68 (56)
Don't know	50 (49)
	<i>p = 0.040</i>
Number of children	
0-2	337 (43)
3-5	406 (71)
6-8	57 (69)
9+	3 (23)
	<i>p < 0.001</i>
Marital status	
Married	701 (58)
Single	44 (36)
Separated/Divorced	17 (52)
Widowed	38 (49)
De facto	3 (30)
	<i>p < 0.001</i>

Figure 4: Types of contraceptive ever used by the two major ethnic groups.

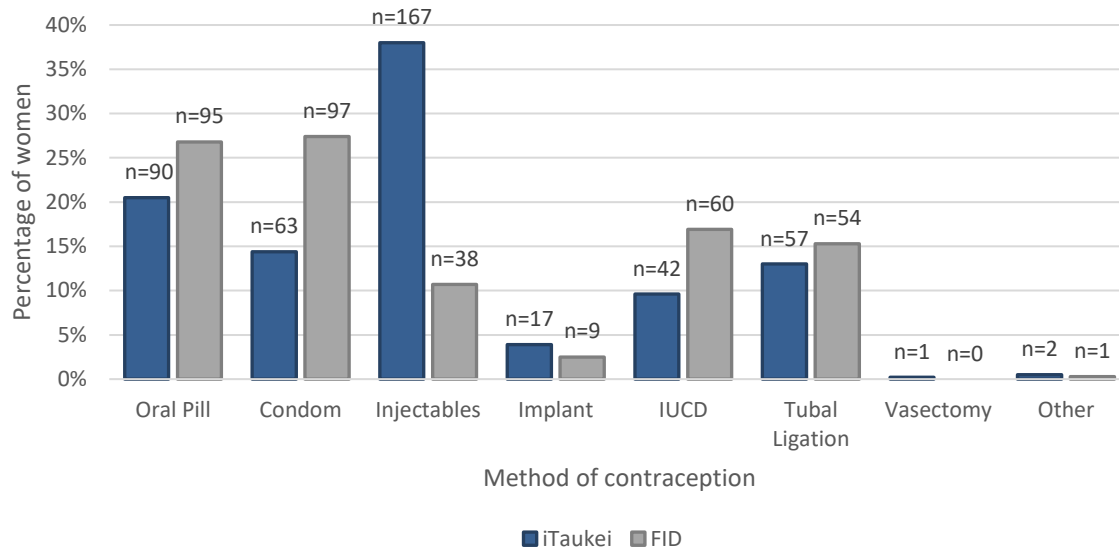


Figure 5: Barriers to condom use.

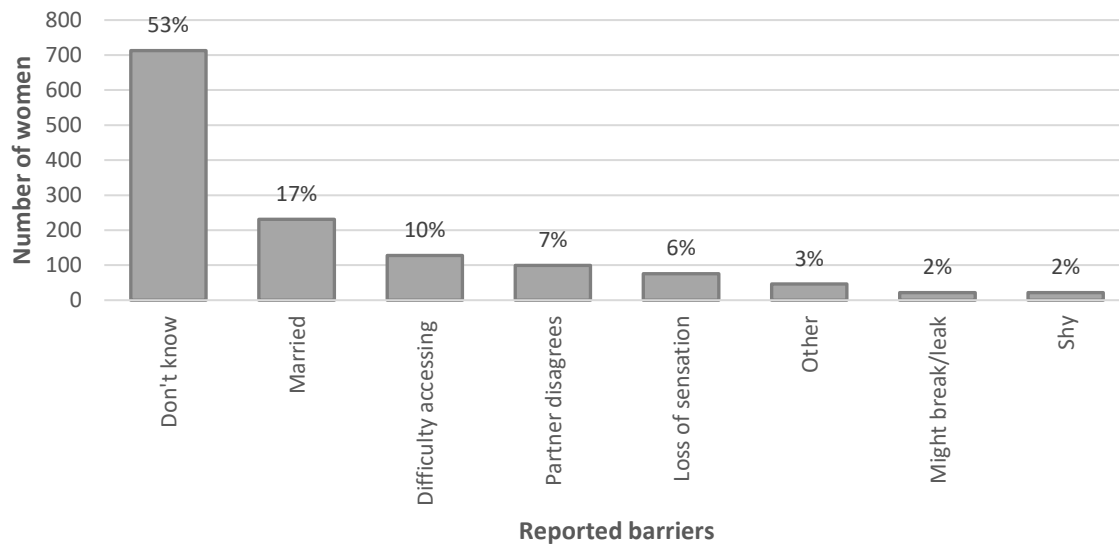


Figure 6: Barriers to contraceptive use.

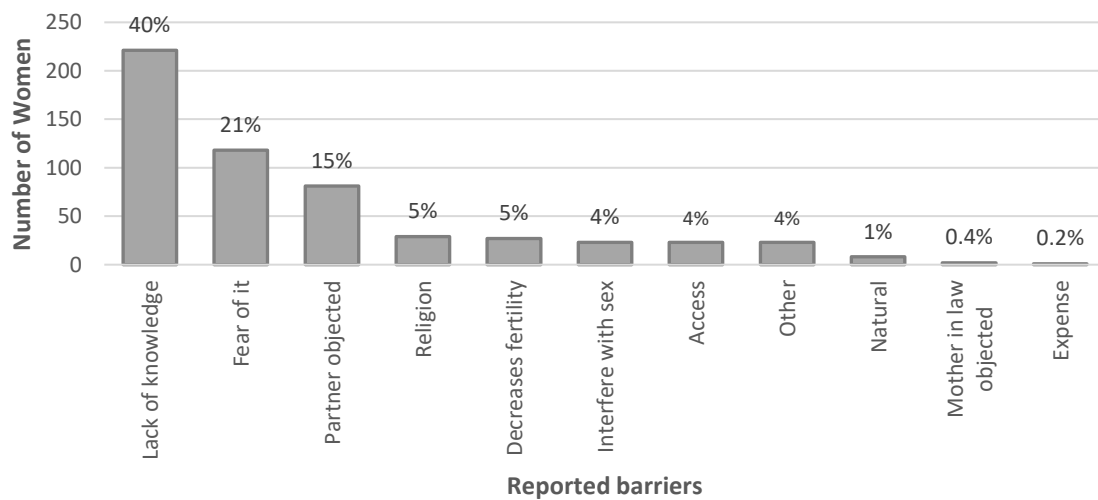


Table 4: Percentage of women with knowledge versus practice on contraceptive use and safe sex.

Knowledge	N (%)	Practice	N (%)
Knowledge of how to avoid pregnancy	83%	Ever used contraceptives	54%
Knowledge on:		Ever used condoms	20%
• How STIs are contracted	63%		
• Condom's dual protection against STIs and pregnancy	47%		
• What is 'safe sex'?	33%		

DISCUSSION

This study targeted the rural women of Ba Province in the Western Division of Fiji.

It has been reported that over 44% of the rural population live below the poverty line.¹⁵ As reported in a previous paper on this cohort,⁵ majority of respondents were married (81%) and 74% were not gainfully employed even though 81% had at least secondary (59%) or tertiary education (23%).

Although education and awareness increases a woman's likelihood to use contraception, there are several other barriers which prevent women from using contraceptives. Several studies^{16,17,18,19,20} from developing countries have consistent results reporting that many women, having had education on safe sexual practices, do not translate this knowledge into practice. Saha *et al*¹⁶ from India report that the majority of women (84%) were aware of contraceptive methods, yet only 26% of respondents had ever used contraceptives. Delahunt *et al*¹⁷ also found that Ethiopian women had high knowledge (96%) of at least one contraceptive method however only 43% of women were using contraceptives at the time of the study.

Our study had similar knowledge (83%) practice (54%) gap with regards to contraceptives.

The barriers to contraceptive use offered was 'lack of knowledge' even though initially most had said they knew about contraceptives. This most likely indicates lack of sufficient knowledge to overcome the other barriers such as 'fear', which is often based on incorrect information and myths regarding contraceptives. 'Partners disagreeing' to the use of contraceptives is important barrier in our mostly patriarchal societies. Further study of male partners needs to be undertaken to assess their knowledge attitudes, practices and barriers regarding safe sex and contraceptive use to fully understand the knowledge practice gaps amongst women.

Of note is that 18% of women did not plan any of their pregnancies and 37% of all pregnancies were unplanned. As parity increased, the likelihood of it being a planned pregnancy reduced, which is consistent with the overall low rates of use of contraception.

Only 12% of women had knowledge of emergency contraception. This lack of knowledge was also prevalent in the Sahaj *et al.* study, where 99% of respondents had no knowledge of emergency contraception.¹⁶ The highest level of ignorance in our study was found in those respondents with lower levels of education and those aged 18-19. This lack of awareness about emergency contraception removes the potential use of effective post coital contraception especially for the young who are more likely to have unplanned, unprotected sex. The consequence of unplanned conception resulting in unplanned deliveries or terminations of pregnancy, often unsafe, in an environment where these services are not readily accessible can have long lasting impact on women's lives.

Forty seven percent of women had knowledge that condom use could protect from both pregnancy and STIs but only 20% had ever used it. The Fiji MOHMS reported in 2015 that STIs are increasing, particularly gonorrhoea and syphilis with prevalence rates of 135 and 61 per 100 000 population respectively.³ The high prevalence of STIs in Fiji may be attributable to both the lack of knowledge as well as the knowledge practice gap. The role of partners in this lack of use needs further evaluation. There was poor knowledge of STI symptoms or lack of symptoms as well as knowledge of the correct practice of suspected STI. These findings indicate a significant need to empower individuals on safe sex practices and STIs as well as the need to seek medical assistance in the case of a suspected exposure to STI or risk of pregnancy.

Most of the respondents had heard of the term 'safe sex' either from schools or hospitals. The sex education programs in schools and health

promotional activities by SRH providers need strengthening to reach the most vulnerable. It is important that both these sources provide accurate, user-friendly information relevant to the local context.

An Ethiopian study showed that women aged 20 to 29 years old with secondary or higher education marry at an older age (3.2 years older on average) than women of the same age with no education. These women with increased education also have an average of 1.7 fewer children than their counterparts with no education.²¹

Tilahun *et al* and Nsubuga *et al* reported higher use of contraception among women was associated with being literate.^{17,18} This was demonstrated by a rate of contraceptive use among female university students in Uganda of 46.6%; nearly twice as high as the contraceptive prevalence of the rest of the country.

Our findings from this cohort show that those with higher education and professional or skilled employment are more likely to use contraceptives, have knowledge of emergency contraceptives; know that condoms protect from both STIs and pregnancies and undertake appropriate health seeking behaviour to suspected STIs.

Limitations of the study

Bias may have occurred as the study subjects were recruited when they presented to outreach educational sessions and clinics. This study will therefore not provide information about women who do not seek health care, even if this was brought close to their homes via rural outreach. Furthermore, in all family planning/safe sex activities, both partners' participation needs to be considered and our cohort consisted of women only.

Recommendations

Public health promotion and health education in safe sex and contraceptive use needs to be improved and made accessible to rural women and partners to dispel their fears and address other barriers. A concerted effort is required to promote and make accessible emergency contraception and condom use to decrease the high levels of teenage pregnancies and STIs in the young in Fiji. Educational programmes in schools, particularly in secondary schools, need to be strengthened to ensure students receive adequate information on SRH to equip them with enough tools to practice safe sex whenever this

may occur. Every effort should be made at all levels of society to empower girls with higher education as this has been shown to improve the overall knowledge and practice of safe sex and contraceptive use which has major implications for their lives, their families and societies.

CONCLUSION

This study reveals that among rural women in Lautoka, Ba and Nadi there was a significant knowledge practice gap for safe sex practices and contraceptive use. A higher level of education of women was an extremely important factor in better knowledge and practice of safe sex and the likelihood of contraceptive use.

The barriers to contraceptive usage would suggest that higher education level and SRH knowledge alone is not enough. Motivation to use contraception requires dealing with barriers, which includes access to accurate knowledge to allay fears and negative influences from a woman's partner and religion.

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