

THE KNOWLEDGE, ATTITUDE AND PRACTICE REGARDING  
THE USE OF ORAL CONTRACEPTIVE PILLS AMONG THE  
EVER MARRIED WOMEN IN H.DH.KUMUNDHOO

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THE MALDIVES NATIONAL UNIVERSITY

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H.DH.KUMUNDHOO

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## **DECLARATION**

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I hereby declare that this Project is the result of my own work, except for quotations and summaries which have been duly acknowledged.

Signature:

Date: 02/06/2014

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**ABSTRACT**

In South and South East Asia one third of pregnancies are not plan which results from low use of contraception, contraceptive method failure and the high unmet need for contraception (Sebastian, 2005).

The main objectives of this study were to determine the level of knowledge, explore the attitudes and identify the practices regarding the use of Oral Contraceptive Pills (OCPs) among the ever married women in H.Dh.Kumundhoo.

A cross-sectional study was conducted using a structured questionnaire and the sample size was 155 ever married women in H.Dh.Kumundhoo. The sample was selected randomly and the study was conducted from 26<sup>th</sup> April 2014 to 30<sup>th</sup> April 2014.

The participants were interviewed about their knowledge on OCPs, their perception and attitudes to use OCPs and the practice regarding the OCPs.

The study found that 14.2% (n=21) of the respondents were using OCPs while 85.8% (n=127) of them were not using any type of OCPs. Most of the participants had negative attitudes towards the usage of OCPS due to fear of side effects and husband's disapprovals. The majority of the women heard about OCPs and almost half of them knew the regular intake of OCPs. However, the knowledge about the side effects and the correct period to start OCP was low.

Despite 100% availability of OCPs at the health facility, the use of OCPs were considerably low due to negative attitudes and low knowledge on OCPs including the side effects, misinformation about the correct usage and other beliefs.

**Key words:** Oral Contraceptive pills, Knowledge, Attitude, Practice, H.Dh.Kumundhoo

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## TABLE OF CONTENTS

TITLE PAGE.....	
DECLARATION.....	ii
ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES.....	vii
LIST OF FIGURES.....	vii
LIST OF ABBREVIATIONS.....	viii
CHAPTER 1.....	1
INTRODUCTION.....	1
1.1 Background of the Island.....	1
1.2 Problem Statements.....	1
1.3 Overall objective.....	3
1.4 Specific objectives.....	3
1.5 Research Questions.....	4
1.6 Significance of the study.....	4
1.7 Scope of the study.....	5
1.8 Definitions of Terms.....	5
CHAPTER 2.....	7
REVIEW OF LITERATURE.....	7
2.1 Overview of health system in Maldives.....	7
2.2 Previous studies.....	8
2.3 Theoretical framework.....	20
2.4 Conceptual framework of the study.....	21
CHAPTER 3.....	22
METHODOLOGY.....	22
3.1 Study design.....	22
3.2 Study area.....	22
3.3 Study population.....	22
3.4 Study sample.....	23

3.5	Instrumentation .....	23
3.6	Data collection procedures .....	23
3.7	Inclusion Criteria.....	24
3.8	Exclusion criteria .....	24
3.9	Data analysis .....	25
3.10	Ethical Consideration.....	25
	CHAPTER 4 .....	26
	DATA ANALYSIS AND RESULTS .....	26
	CHAPTER 5 .....	35
	DISCUSSION AND CONCLUSION .....	35
5.1	Discussion of the results .....	35
5.2	Conclusion .....	41
5.3	Limitation.....	42
5.4	Recommendation .....	42
	REFERENCES.....	43
	APPENDICES .....	47
	Appendix A: Research questionnaire in English.....	47
	Appendix B: Research questionnaire in Dhivehi .....	54

## **LIST OF TABLES**

Table 4.1 Frequency of socio-demographic characteristics and use of OCPs by socio-demographic characteristics.....	26
Table 4.2 Number of people heard of OCP.....	28
Table 4.3 Source of information about OCP.....	28
Table 4.4 Known contraceptive methods.....	29
Table 4.5 Known types of OCP.....	29
Table 4.6 Knowledge about the correct period to start OCP.....	30
Table 4.7 Percentage of people agreed to take OCPs regularly.....	30
Table 4.8 Percentage of people who have heard of any side effects of OCPs.....	31
Table 4.9 Percentage of people who relate selected side effects to OCPs.....	31
Table 4.10 Attitude concerning on oral contraceptive method.....	32
Table 4.11 Status of practicing OCPs.....	33
Table 4.12 Reason for not practicing OCPs.....	33
Table 4.13 Number of people who practiced OCPs within the last 6 months.....	34
Table 4.14 Type of OCPs used within the last 6 months.....	34

## **LIST OF FIGURES**

Figure 2.4.1, The conceptual framework.....	21
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## **LIST OF ABBREVIATIONS**

HC	Health Centre
WHO	World Health Organization
OCP	Oral Contraceptive pill
OCM	Oral Contraceptive method
COCP	Combined Oral Contraceptive Pill
ECP	Emergency Contraceptive pill
IGMH	Indira Gandhi Memorial Hospital
MoHG	Ministry of Health and Gender
HPA	Health Protection Agency
OPD	Out Patient Department
DHS	Demographic Health Survey
SCT	Social Cognitive Theory
KAP	Knowledge, Attitude and Practice
SLT	Social Learning Theory
RH	Reproductive Health

## **CHAPTER 1**

### **INTRODUCTION**

#### **1.1 Background of the Island**

H.Dh.Kumundhoo is one of the inhabited islands of Haa Dhaalu Atoll administrative division and geographically part of Thiladhummathi Atoll in the north of the Maldives. The total population is 1,397 of which 713 are males and 684 are females (Mohamed, 2014). The island's Health Centre (HC) has a bed capacity of 5 and serves 8 hours a day. In addition the HC opens at any time during the emergency. The reproductive health services are provided by the health care workers in family health section of the Kumundhoo Health Centre.

#### **1.2 Problem Statements**

Contraception is the use of contraceptive drugs, sexual practice, devices and surgical methods for birth control, spacing of pregnancies and the limitation of family size (Iklaki CU, 2012). The World Health Organization (WHO) estimates that 210 million women become pregnant globally each year and approximately 130 million, two thirds, of women deliver live infants (WHO, 2011). The other one third of pregnancies results in complications like stillbirth, miscarriage or in induced abortions (WHO, 2011). The other

75 million pregnancies results in complications like stillbirth, miscarriage or in induced abortions (WHO, 2011). It was also estimated that in 2003 around 42 million pregnancies were terminated voluntarily and of which 22 million were terminated safely 20 million were unsafely (WHO, 2011). In 2008 approximately 21.6 million unsafe abortions took place worldwide, almost all in developing countries (WHO, 2011).

This eventually ends in deaths of approximately 68,000 women which are about 13% of all pregnancies (WHO, 2011). In abortion related complications approximately 5 million women are hospitalized every year (Singh, 2006).

In South and South East Asia it is estimated that about one third of pregnancies are unintended and results from low use of contraception, contraceptive method failure and the high unmet need for contraception (Sebastian, 2005).

However, around 200 million women who want to use effective family planning methods are not able to use it due to lack of access to information, services and lack of support from their husbands and the community (UNFPA, 2014).

In African society, people disagree to use contraception due to the society's inherent barriers (Iklaki CU, 2012). These barriers include a lack of awareness and access, cultural factors, religion, an opposition to the use of contraception by sexual partners or family members, and a fear of the health risks and side effects associated with contraceptives (Iklaki CU, 2012).

The surveys conducted in the past 10 years have shown that contraceptive prevalence rate has declined in the Maldives (MoHG, 2014). The proportion of using any modern

contraceptive methods by married women had declined from 33% in 1999 to 27% in 2009 (MoHG, 2014).

The aim of the research is to study the knowledge, attitude and practice (KAP) regarding the use of OCP among married women in H.Dh. Kumundhoo. It is essential for health care providers to understand the issues, knowledge, attitudes and practice by the users on this particular service to form proper policies for better services.

There are 356 women between the ages of 15 to 49 years in H.Dh.Kumundhoo of which 260 women are ever married and residing on the island (Kumundhoo Health Centre, 2014). According to data available in Kumundhoo Health Centre, only 18 women are currently using OCP (Kumundhoo Health Centre, 2014). There must be some reason that only a few women are using OCP, which will be the main focus of this study.

### **1.3 Overall objective**

The general objective of the study is to determine the level of knowledge, attitude and practice towards the use of OCP among the ever married women in H.Dh.Kumundhoo.

### **1.4 Specific objectives**

1. To determine the level of knowledge among ever married women aged 18-49 years on the use of oral contraceptive pills (OCP) in H.Dh.Kumundhoo.
2. To explore the attitudes of married women aged 18-49 about the use of OCP in H.Dh.Kumundhoo.

3. To identify the practices regarding the use of OCPs among married women aged 19-49 in H.Dh.Kumundhoo.

### **1.5 Research Questions**

1. Do ever married women in H.Dh. Kumundhoo have adequate knowledge about OCP?
2. What are the attitudes towards using OCPs among ever married women in H.Dh.Kumundhoo?
3. What are the practices regarding the use of OCPs among ever married women in H.Dh.Kumundhoo?

### **1.6 Significance of the study**

Contraceptive pills are freely available and easily accessible to married women in Maldives (Kumundhoo Health Centre, 2014). In spite of that, the number of women using OCPs is very low in H.Dh.Kumundhoo (Kumundhoo Health Centre, 2014). It was reported that only 6.9% of married women or 5.1% of women of reproductive age women are using OCPs in H.Dh.Kumundhoo (Kumundhoo Health Centre, 2014).

However, to understand the reason it is important to know the factors and issues related to users. Therefore determining and improving the knowledge, attitudes and practice of OCPs among married women in H.Dh.Kumundhoo could be an important strategy in planning for means of increasing the use of OCPs which will ultimately contribute to the reduction of unintended pregnancies and hence maternal morbidity and mortality due to unsafe abortions. The study findings may also help to the health care providers in developing new

approaches for increasing the awareness of about the attitudes and practice of OCPs among ever married women.

Although some studies has been done regarding reproductive health of women in the Maldives, more specific study about the knowledge, attitude and practice of OCPs among the married women in H.Dh.Kumundhoo is thought to be important for the study population and may also be generalizable for similar rural populations across the country. Therefore, this study focuses on the knowledge, attitude and practice of OCPs usage among the ever married women in H.Dh.Kumundhoo to determine the current situation concerning reproductive health and more specifically OCP in H.Dh.Kumundhoo.

### **1.7 Scope of the study**

The study focusses only on the knowledge, attitude and practice of OCPs among the ever married women aged 18-49 years in H.Dh. Kumundhoo during the past six months.

### **1.8 Definitions of Terms**

**Oral Contraceptive Pills:** Oral hormone medication for contraception or space the pregnancies.

**Ever married women:** The women those who are currently married, divorced and widowed.

**KAP:** A KAP survey means Knowledge, Attitude and Practices.

**Knowledge:** Knowledge is a set of understandings, one's capacity for imagining, and one's way of perceiving.

**Attitude:** This is an intermediate variable between the situation and the response to this situation.

**Practice:** Practices are the observable actions of an individual in response to a stimulus.

**Asaasee Level of education:** It is the basic level of education previously in the Maldives where most people had reached the level of literate.

## **CHAPTER 2**

### **REVIEW OF LITERATURE**

#### **2.1 Overview of health system in Maldives**

The health care delivery system in the Maldives was a four-tiered delivery system until 2001 (Health care status in the Maldives, 2011). The system was reorganized and established into a five-tiered referral system in 2001(Health care status in the Maldives, 2011). The referral system was structured as the central level, regional level, atoll level, sub-atoll level and Island levels (Health care status in the Maldives, 2011). Indira Gandhi Memorial Hospital (IGMH) serves at the central level as the main tertiary referral hospital of the country (Health care status in the Maldives, 2011). The regional hospitals serve at the regional level and the atoll hospitals serve at the atoll level (Health care status in the Maldives, 2011). The health centres are in the sub-atoll level while the health posts and family health sections are in the island level (Health care status in the Maldives, 2011). The Ministry of Health and Gender (MoHG) is the main policy making body responsible for planning and development of the health sector. The Health Protection Agency (HPA) is the main body under MoHG responsible for prevention and control of communicable diseases, non-communicable disease and provision of reproductive services including health promotion and several other areas of public health concern.



As the Maldives is an island nation, there are many challenges to deliver the health care (World Diabetes Foundation, 2014). High cost of transportation and delivering the medical resources are significant challenges for providing equitable access to health care services within and between the islands (World Diabetes Foundation, 2014).

## **2.2 Previous studies**

A study was conducted to examine contraceptive trends from 35 developing countries in Asia, Africa, Latin America, and Eastern Europe (Shane Khan, 2007). The study showed that women's knowledge on modern contraceptive method was high and use of modern methods was increasing worldwide (Shane Khan, 2007). It was found that in all regions the knowledge of at least one method of contraception was almost equal while in sub-Saharan Africa it was above 85% (Shane Khan, 2007). On the other hand, 85% of the women knew one or more modern methods of contraception in all countries in South and South East Asia, Latin America, Caribbean and North America (Shane Khan, 2007). However, in sub-Saharan Africa knowledge of one or more modern methods of contraception was lower (Shane Khan, 2007).

In addition, the most commonly known modern methods of contraceptives were OCP, injectable and male condom (Shane Khan, 2007). Moreover, in North and Western Africa and Europe the commonly known modern was IUD (Shane Khan, 2007). It was also found that the knowledge of female sterilization was low in sub-Saharan Africa than other regions in the world (Shane Khan, 2007). The study further revealed that modern methods of contraception such as OCP, injections and condoms were most ever used methods of

contraception (Shane Khan, 2007). However, most of the women did not discuss their choice of contraceptive methods with the husbands and the women preferred to choose themselves (Shane Khan, 2007).

The study also showed that the reasons for not using any method of contraceptives currently were due to fertility related reasons and method related reasons (Shane Khan, 2007). In many countries women were not using contraceptives due to spousal opposition, other person's opposition, religious opposition and their own opposition (Shane Khan, 2007). The women in sub-Saharan countries stated the main reason for not using contraception is due to lack of knowledge about contraceptive methods and where to get services (Shane Khan, 2007).

A national health survey was done to find out the trends in contraceptive need and use in developing countries in 2003, 2008, and 2012 (Darroch & Singh, 2013). The survey showed that 867 million (57%) women in developing countries in 2012, out of 1.5 billion reproductive age women, needed contraception (Darroch & Singh, 2013). In 2012, 645 million women in developing countries depended on modern contraceptives chosen by themselves or their partner (Darroch & Singh, 2013). The survey further showed that between 2003 and 2012 the number of modern contraceptive users increased to 139 million women with an average increase of 15 million (Darroch & Singh, 2013). However, the prevalence of contraceptives were very low ( $\leq 26\%$ ) in middle and Western Africa and moderate (46-66%) in eastern Africa, South Asia and Western Asia and in 69 poorest countries (Darroch & Singh, 2013). On the other hand, the prevalence was high ( $\geq 77\%$ ) in Southern Africa, Eastern Asia, Central and South America and also in higher income

countries (Darroch & Singh, 2013). Even though the contraceptive prevalence was higher in high income countries, in sub-Saharan Africa and outside Southern Africa, in Western Asia and among the poorest countries the contraceptive prevalence was low (Darroch & Singh, 2013).

In addition, the survey also showed that the number of women using modern contraceptive methods increased by 25% in Asia, 43% in South Asia, 29% in Latin America and the Caribbean, 51% in the 69 poorest countries and 16% was increased in higher income countries (Darroch & Singh, 2013).

Moreover the study results showed that sterilization (38%), of which 91% was female sterilization, was the most commonly used contraceptive method in 2012 in developing countries, followed by IUD (28%), OCP and condom (13%) and injection (9%) (Darroch & Singh, 2013). The survey revealed that there was a huge regional differences between the types of method used (Darroch & Singh, 2013). It was found that sterilization was the most commonly used modern contraceptive method in Asia, particularly in South Asia, Latin America and the Caribbean while IUD was the third modern method used in Asia (Darroch & Singh, 2013). On the other hand IUD was the most commonly used modern contraceptive method used in Eastern, Central and Western Asia (Darroch & Singh, 2013). Injectable method was most commonly used in sub-Saharan Africa while OCP (45%) was the most commonly used method in Northern Africa and condoms in Middle and Western Africa (Darroch & Singh, 2013). The usage of OCP was increased in Northern Africa between 2003 and 2012 (Darroch & Singh, 2013).

Population facts released by Department of Economic and Social Affairs under United Nations (UN) also revealed that OCP and injectable methods were most commonly used in Africa and Europe (United Nations Department of Economic and Social Affairs , 2013).

A study was conducted in Mangochi district, the southern region of Malawi in 2006 about the Contraceptive Knowledge, Beliefs and Attitudes among the women in Rural Malawi. Malawi is a long and narrow landlocked country in south-eastern Africa (worldvision, 2010). The objective of the study was to determine the factors that affect the intentions of men and women to use family planning methods (Chipeta, Chimwaza & Kalilani-Phiri, 2010). The study was found that the knowledge on family planning methods, including OCPs, was high in the study area as the majority of the people know that OCPs were available at the nearest health facilities (Chipeta, Chimwaza & Kalilani-Phiri, 2010).

Even though knowledge on OCPs was high in Mangochi district, most women do not like to use them due to negative attitudes, myths and beliefs (Chipeta, Chimwaza & Kalilani-Phiri, 2010). The women believed that using OCPs cause damage to organs like the intestines and uterus (Chipeta, Chimwaza & Kalilani-Phiri, 2010). Most women also believed that OCPs prevent women from becoming pregnant at the time they want to have children (Chipeta, Chimwaza & Kalilani-Phiri, 2010). Apart from this, the study also found that fear of side effects and husband's disapproval were also factors influencing respondent's intention to use OCPs (Chipeta, Chimwaza & Kalilani-Phiri, 2010).

A similar KAP study was conducted in east Sikkim to determine the knowledge, attitude and practice of family planning among the women of reproductive age group (Prachi, Das, Ankur, Shipra & Binita, 2008). The study population was 443 women of reproductive age

(15-44) years who attended the Obstetrics and Gynecology Departments in STNM hospital and Central Referral Hospital during January 2004 to March 2005 (Prachi, Das, Ankur, Shipra & Binita, 2008). The objective of the study was to assess the knowledge, attitude and practice of family planning among the reproductive age women and also to understand the reason for unmet needs and factors influencing the family health program (Prachi, Das, Ankur, Shipra & Binita, 2008).

The study revealed that 94.2% of women had knowledge about contraceptives and 55.2% had used contraceptives (Prachi, Das, Ankur, Shipra & Binita, 2008). In addition 62% of women were currently using contraceptives and 37.9% of the women were using OCPs (Prachi, Das, Ankur, Shipra & Binita, 2008). The study shows that about 54.4% of the women obtained information regarding contraception from mass media (Prachi, Das, Ankur, Shipra & Binita, 2008). Apart from this 95.8% of the women had heard about OCPs, 74.2% of the women had heard of condoms, 72% of the women had heard about IUD, 67% of the women had heard about female sterilization and 34% of the women had heard about male sterilization (Prachi, Das, Ankur, Shipra & Binita, 2008). The majority of the women (62.8%) knew that contraceptives were available at the government hospital and 52.5% of the women knew that contraceptives were also available at the medical shops (Prachi, Das, Ankur, Shipra & Binita, 2008).

The study shows that 44.6% of the women had attitude of not using contraception but will use it in future (Prachi, Das, Ankur, Shipra & Binita, 2008). There were 62% of women who were practicing contraceptive use, while 25.5% of the women were not practicing any contraceptives, and among the users 85% of them were satisfied with the contraceptives (Prachi, Das, Ankur, Shipra & Binita, 2008). According to the study there were 55.5% of

the women who chose the contraceptive method themselves as it was easy and comfortable, while 41.6% of the women used contraceptives decided by their husbands (Prachi, Das, Ankur, Shipra & Binita, 2008).

Another study was conducted to assess the knowledge, attitudes and practices of secondary school girls towards contraception in Thulamela Municipality of Limpopo Province, South Africa (Ramathuba, Khoza & Netshikweta, 2012). A quantitative descriptive study design was used and a self-administered questionnaire was used to collect data (Ramathuba, Khoza & Netshikweta, 2012). The study sample was 273 secondary school girls in Grades 10–12 (Ramathuba, Khoza & Netshikweta, 2012). The study shows that only 43% of the girls have knowledge about contraceptive pills, condom 58%, injection 50% and 10% of the girls had knowledge about Intra Uterine Device (IUD). (Ramathuba, Khoza & Netshikweta, 2012). Most of the girls got information about contraceptive pills from their parents and the media (Ramathuba, Khoza & Netshikweta, 2012).

On the other hand, 51% of the girls were using contraceptives among them only 3% were using contraceptive pills, 9% injection and 1% of the girls were using female condoms (Ramathuba, Khoza & Netshikweta, 2012). The majority of the girls (63%) have negative attitude towards the usage of contraceptive pills and injections (Ramathuba, Khoza & Netshikweta, 2012). The reason for negative attitude was that they believed contraceptive pills and injections cause side effects such as weight gain, amenorrhea, irregular menstruation, period pains and headache (Ramathuba, Khoza & Netshikweta, 2012). Of the 63% girls who have negative attitudes, 4% of them believed that if they use contraceptive pills or injections that their boyfriend may leave them, or that it may cause damage to their womb, or that they may get fat or may never have children and that it was dangerous to use,

may cause long menstruation, that they were not ready for family, or that they may not have sexual relations or that their mother will be angry (Ramathuba, Khoza & Netshikweta, 2012). The study also found that 72% of the girls did not discuss about the contraceptives with their parents and 51% did not discuss with their boyfriends (Ramathuba, Khoza & Netshikweta, 2012). Some of them wanted to use if their boyfriends and friends agreed and others did not want to discuss because they felt it was uncomfortable (Ramathuba, Khoza & Netshikweta, 2012). The study also found that the girls were not satisfied with the services provided as they felt shy, culturally not permitted and service provides were not friendly with the clients which affects the contraceptive usage (Ramathuba, Khoza & Netshikweta, 2012).

A similar study was conducted in 2007 at New Civil Hospital, Surat, which is located in Gujarat state in western part of India to determine the factor affecting the usage of oral contraceptives (Chudasama, Kavishwar, Godara and Moitra, 2009). This study revealed that use of contraceptives was influenced by the husband. Husbands had the authority to decide the type of contraceptives (Chudasama, Kavishwar, Godara and Moitra, 2009). It was found that 57% of women used OCP advocated by their husbands and half of the women included in the study used OCP for less than one year (Chudasama, Kavishwar, Godara and Moitra, 2009). This study also showed significant association between women education and use of OCP (Chudasama, Kavishwar, Godara and Moitra, 2009). It showed that higher education level of women increases the use of OCP (Chudasama, Kavishwar, Godara and Moitra, 2009).

A cross-sectional observational study was conducted to determine the contraceptive knowledge, attitude and practice among eligible couples of rural Haryana in India from

November 2008 to February 2009 among 260 randomly selected eligible couples (Saluja et al., 2011). This study showed that knowledge was higher for female sterilization among the women (92.2%) and low for ECP (10.8%), Injection (39.2%), male sterilization (79.6%), IUD (82.4%) and OCP (90.4%) (Saluja et al., 2011). The study also revealed that the main source of knowledge was mass media (68.8%), health care providers (46%) and information from friends or relatives was lower (24.8%) (Saluja et al., 2011). This study further revealed that very few women were practicing OCP i.e only (1.6%) of the women (Saluja et al., 2011). Majority of the women (45.1%) were not using OCP as they need more children, 28% were not using as husband not disapproved, 20.6% were not using due to fear of side effects and 5.9% of the women were not using as they did not have enough knowledge (Saluja et al., 2011). The study also showed that 79.2% of the women have positive attitude for contraception and 20.8% have negative attitude for contraception (Saluja et al., 2011). The study was concluded that contraceptive knowledge and practice including OCP was influenced by media and husband opposition (Saluja et al., 2011).

A study conducted in Nigeria refugee camp among the youths showed that knowledge of contraceptive was high among the female youth (94%) (Okanlawon, Reeves and Agbaje, 2011). Majority of the female youth had knowledge about OCP and condoms (Okanlawon, Reeves and Agbaje, 2011). This study showed that 29% of the female used OCP (Okanlawon, Reeves and Agbaje, 2011). The study showed the reason for OCP among the females revealed that majority of the females believed OCP were harmful and dangerous and the chemicals in OCPs causes damage to the female reproductive system (Okanlawon, Reeves and Agbaje, 2011). The study further revealed that 33.6% of the female youths were not using any contraceptive method to avoid future pregnancies while 79.5% of the



women have fear of side effects, 10.3% of them mentioned other health concerns and 10.2% the females the use of OCPs change their body's normal process (Okanlawon, Reeves and Agbaje, 2011).

A study was done Pakistan, Rawalpindi, to assess the knowledge and practice of contraceptives in females of reproductive age group at tertiary care hospital (Nabeela Fazal Babar, 2009). The study sample was 339 females of age between 15-49 years who attended Outpatient Department (OPD) of Fauji Foundation Hospital and a structured questionnaire was used in the study (Nabeela Fazal Babar, 2009). The study showed that 72.2% females were familiar with combined oral contraceptive pill (COCP) while 60.7% of female knew IUD and 76% of them knew about condoms (Nabeela Fazal Babar, 2009). The study further revealed that 34.6% of females were using COCP and 46% of the female said that contraceptive methods were suggested by their husbands, by health professionals 44% and only 10% of the females were using contraceptive methods of their own choice (Nabeela Fazal Babar, 2009). In addition, this study showed that there was a gap between knowledge (88%) and use of contraceptives (64.6%) including OCP (Nabeela Fazal Babar, 2009).

Another study was conducted in Pakistan, Karachi, from October 2008 to March 2009 to determine the knowledge, attitude and practice of Parous women regarding contraception (Naqvi, Hashim, Zareen and Fatima, 2011). This study revealed that there was good knowledge and positive attitude of women regarding contraception (Naqvi, Hashim, Zareen and Fatima, 2011). The study results showed that 33% of the lower middle class women used OCPs and the majority of the women (94%) had no knowledge about the safe period (Naqvi, Hashim, Zareen and Fatima, 2011). On the other hand majority of the women

968%) had knowledge about female sterilization and only 22% of the women had knowledge about male sterilization (Naqvi, Hashim, Zareen and Fatima, 2011). The study further showed that 70% of the women got information about family planning from health care professionals, 33% from family members or friends and only 9% received information from media (Naqvi, Hashim, Zareen and Fatima, 2011). Majority of the women (67%) in the study population made decision to choose contraceptive method while 42% of the husbands were involved in decision making (Naqvi, Hashim, Zareen and Fatima, 2011). The study also showed that majority of the women (65%) believed that use of contraception for family planning is prohibited in Islamic religion (Naqvi, Hashim, Zareen and Fatima, 2011). This study also showed that more than half of the study sample, (57%) believed that contraceptive use negatively affects their health while 43% believed that it would not affect health (Naqvi, Hashim, Zareen and Fatima, 2011). In addition 41% of the women experienced weight gain after using OCPs, 60% observed irregular menstruation, 31% experience menorrhagia, 30% experience amenorrhea and 18% of the women experience subfertility (Naqvi, Hashim, Zareen and Fatima, 2011). Unlike previously mentioned study findings, in this study, 66% of the husbands were willing to take contraception including OCP by the women (Naqvi, Hashim, Zareen and Fatima, 2011).

A very similar KAP study was conducted in the rural southern region of Jordan to determine the knowledge, attitudes and practices towards family planning methods among the ever married, rural Jordanian women age 15-49 years (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). The majority of the studied population i.e 91.4% of the women knew at least one method of contraception (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). This study showed that OCP (31.1%) and IUD (24.6%) were the most

ever used contraceptive methods among the rural Jordanian women (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). In addition, 36.6% of the women had knowledge about the side effects of OCP while 33.2% of the women had knowledge about effects IUD (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). The study revealed that the most common reason for not using contraceptives were fertility related reason (39.4%) including the effects of pregnancy and breastfeeding (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). In addition, very few women (0.37%) reported their husband's opposition as a reason for not using contraceptives while only 0.12% of the women were not using contraceptives due to religious reasons (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). Furthermore, this study showed a positive attitude towards the contraceptive methods as 95% of the women agreed about the benefits of spacing the pregnancies and benefits of maternal health with using contraceptive methods (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). The Jordanian women reported that most common source of information was television (61.9%) which was followed by health care providers (60.3%), newspapers (16.%) and radio (10.6) (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012).

A similar survey, Demographic Health Survey (DHS), was also conducted in Maldives in 2009 (Ministry of Health and Family, ICF Macro, 2009). The survey showed that knowledge of contraceptive methods among the married women was nearly equal in Maldives (Ministry of Health and Family, ICF Macro, 2009). It was found that majority of the women knew at least one method of contraception (Ministry of Health and Family, ICF Macro, 2009). The survey further showed that the most common heard method was male condom (98%) and which was closely followed by OCP (96%), female sterilization and

injections (90%), IUD and male sterilization more than 80% and 71% of the women heard of implants (Ministry of Health and Family, ICF Macro, 2009).

In addition, the most commonly used method among the ever married women was male condom (28%) which was followed by OCP (23%) (Ministry of Health and Family, ICF Macro, 2009).

However, one third of the currently married women were using contraceptive methods in Maldives (Ministry of Health and Family, ICF Macro, 2009). The survey showed that female sterilization (10%) was the most commonly used contraceptive method among the currently married women while used of male condom (9%) closely followed (Ministry of Health and Family, ICF Macro, 2009). It was also found that only 5% of the currently married women used OCP in Maldives (Ministry of Health and Family, ICF Macro, 2009). The survey further revealed that 13% of the currently married women used OCP in 1999 but this rate was decreased to 5% among the currently married women in the 2009 DHS (Ministry of Health and Family, ICF Macro, 2009).

The survey also showed that most of the women (18.8%) stop using OCPs due to side effects, 17.3% of the women discontinued as they wanted to become pregnant and 14.8% of the women were not using OCPs due to health concerns (Ministry of Health and Family, ICF Macro, 2009). Moreover, majority of the women do not intend to use contraceptives in future (Ministry of Health and Family, ICF Macro, 2009). Opposition to use (45.3%) was the main reason for non-intention to use contraceptives in future (Ministry of Health and Family, ICF Macro, 2009). It showed that 38.8% of the women did not want to take

contraceptives while 5.5% of the women were reported to not to use as husband opposed (Ministry of Health and Family, ICF Macro, 2009).

### **2.3 Theoretical framework**

The research follows Social Cognitive Theory (SCT) as a framework to guide the research. As it is a KAP study knowledge, attitude and practice are the important determinants which may affect by the factors such as behavior, environmental and social factors ( University of Twent , 2014).

In 1960s the Social Learning Theory (SLT) was developed by Albert Bandura and in 1986 the SLT was revised as SCT in 1986 (Boston University School of Public Health, 2013). The SCT explains how people obtain and continue different behavioral patterns ( University of Twent , 2014). According to the Bandura's SCT a person's perception depends on certain factors such as environment, personal or cognitive and behavior which provide a framework for evaluating a person's knowledge, attitude and behavior ( University of Twent , 2014). The SCT also have social influence on a person's internal and external reinforcement (Boston University School of Public Health, 2013).

A person's behavior may be affected by social environmental factors such as family members, friends and colleagues ( University of Twent , 2014). These factors may change a person's perception for the usage of OCPs among the women. The behavioral factors include a person's skill, practice and self-efficacy (Boston University School of Public

Health, 2013). In addition, the personal factors also called cognitive factors include knowledge, expectations and attitude (Boston University School of Public Health, 2013).

The three factors environment, personal and behavior are influencing each other ( University of Twent , 2014). A person’s knowledge and attitude may affect their behavioral factors such as skills and practice. In the same way social environmental factors such as family members including husband and wife, friends and colleagues influence their knowledge and attitude.

Therefore the three factors environment, personal or cognitive and behaviour are included to guide the rest of the reseach areas.

#### **2.4 Conceptual framework of the study**

The conceptual framework was generated from the literature review and only common factors were taken into consideration. This framework helps to make questionnaire.

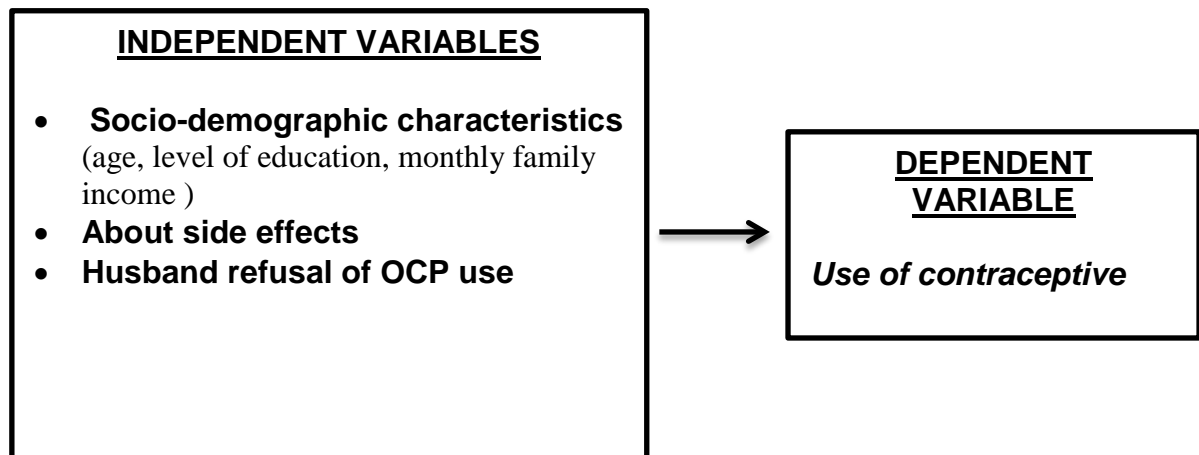


Figure 2.4.1, The conceptual framework.

## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1 Study design**

The study was conducted using descriptive cross sectional study design. A cross-sectional study is an observational study (Iwh.on.ca, 2014). Cross-sectional studies carried out at one time point or over short period of time (Levin, 2006). A cross-sectional study estimates prevalence of the outcome of a given population for public health purposes time (Levin, 2006). A cross-sectional study design was selected as it is inexpensive and takes little time to conduct and many outcome and risk factors can be assessed.

#### **3.2 Study area**

The study was conducted in H.Dh.Kumundhoo from 26<sup>th</sup> April 2014 to 30<sup>th</sup> April 2014.

#### **3.3 Study population**

The population was ever married women in H.Dh.Kumundhoo between the ages 18-49 years. Even though the reproductive age is 15-49 years, the Maldives Family Law does not allow marriage before 18 years of age unless under special request with parental consent

(Attorney General Office Republic of Maldives, 2004). Therefore, for this study only married women aged 18-49 was included.

### **3.4 Study sample**

The sample size was calculated using an online sample size calculator (surveysystem.com, 2014). The confidence interval was takes as 5% and the confidence level as 95%. The study population was selected as 260 ever married women. Therefore, the study sample size was 155 ever married women. 155 women were randomly selected from the total population.

### **3.5 Instrumentation**

The data were collected using a structured questionnaire. The questions were close ended questions. The questions were mainly YES or NO and the appropriate answer has to be ticked according to their knowledge, attitude and practice of OCPs. The questionnaire was used to collect information on use of OCPs, knowledge, attitude, practice, and personal and socio- demographic factors influencing the use oral contraceptive pills. The questionnaire prepared for the data collection was translated to Dhivehi to make easy for the participants. Both the copies of questionnaire, Dhivehi and English, were in Appendix.

### **3.6 Data collection procedures**

The data were collected using the structured questionnaire form 26<sup>th</sup> April 2014 to 30<sup>th</sup> April 2014 with the help of two trained female family health workers who are staff of Kumundhoo Health Centre. The training included explanation of the study objectives, how



to introduce to the respondents, taking consent from the respondents, how maintain privacy during data collection and how to ask questions and complete the questionnaire.

To increase the response rate, female health workers were appointed for data collection as the study concerned reproductive health matters and since the study population was female. The questionnaire was self-administered due to the sensitive nature of the subject and for those who could not read the questionnaire, the health workers read out the questionnaire and helped them to fill the questionnaire. The names of the respondents were not written on the questionnaire to maintain their confidentiality and anonymity, and also to improve the response rate of the study.

The health workers selected 155 ever married women by simple random selection method. The women were selected according to the inclusion criteria and exclusion criteria mentioned below.

The family health workers went to the respondent's household for data collection. On average 31 respondents were interviewed each day for 5 days.

### **3.7 Inclusion Criteria**

- Ever married women in H.Dh.Kumundhoo who were between ages of 18-49 years.

### **3.8 Exclusion criteria**

- Women who were not married or currently not married in H.Dh.Kumundhoo.

- Women who were below 18 years and above 49 years of age.
- Ever married women who were not mentally sound, who did not want to give verbal consent and were not willing to participate in the study.

### **3.9 Data analysis**

The collected data were entered into an excel sheet and later analyzed using SPSS 17.0 software. The entered data were double checked for mistakes and incorrect entries to minimize the errors. Descriptive statistics such as frequencies, percentages and means were calculated and tabulated.

### **3.10 Ethical Consideration**

As the study involved human subjects, before being conducted informed consent was obtained from each study participant. During the study, no ethical issue was faced because the participants accepted to respond after the objectives had been clearly explained. The participants had given privacy as they were interviewed in a place where no other person was present at the time of interview. The participants were informed of their rights, participation was voluntary and they were allowed to withdraw at any time of the study without the fear of any penalty. The participants who were willing to complete the questionnaire were not required to enter their identity and also the consent form and the questionnaire were separated to ensure the anonymity of the participants.

## CHAPTER 4

### DATA ANALYSIS AND RESULTS

**Table 4.1 Frequency of socio-demographic characteristics and use of OCPs by socio-demographic characteristics (N=148)**

Characteristics	n	%	Use of OCPs			
			YES		NO	
			No.	%	No.	%
<b>Age (years)</b>						
18-24	25	16.9	4	16.0	21	84.0
25-29	38	25.7	7	18.4	31	81.6
30-34	24	16.2	0	0.0	24	100.0
35-39	20	13.5	1	5.0	19	95.0
40-44	18	12.2	5	27.8	13	72.2
45-49	23	15.5	4	17.4	19	82.6
Mean= 33.23    Min=20    Max=49						
<b>Marital Status</b>						
Married	130	87.8	21	16.2	109	83.8
Divorced	12	8.1	0	0.0	12	100.0
Widowed	6	4.1	0	0.0	6	100.0
<b>Level of Education</b>						
Asaasee	87	58.8	13	14.9	74	85.1
Primary	32	21.6	5	15.6	27	84.4
O' Level	29	19.6	3	10.3	26	89.7
University	0	.0	0	0.0	0	0.0
<b>Family income monthly</b>						
< 4999	8	5.2	2	25.0	6	75.0
5000 – 9999	55	35.9	4	7.3	51	92.7
10000 – 14999	75	49.0	12	16.0	63	84.0
>15000	10	6.5	3	30.0	7	70.0

Of the 155 study subjects, 148 completed the questionnaire and seven of them were not respond. The overall response rate was 95.5%. The results in table 1 show that more 25.7% (n=38) of respondents were among the ages of 25-29 years. The use of OCPs was more among respondents (27.8%) (n=5) between the ages of 40-44 years, followed by 18.4% (n=7) between the ages of 25-29 years, 17.4% (n=4) between the ages of 45-49 years, 16% (n=4) between the ages of 18-24 years and 5% (n=1) between the ages of 35-39 years. There were no OCP users between the ages 30-34 years.

Of the 148 respondents, 87.8% (n=130) of them were married, 8.1% (n=12) of them were divorced and 4.1% (n=6) were widowed. Looking at the marital status, its shows that 16.2% (n=21) of the married women were using OCPs while others were not using.

The study shows that majority of the people (58.8%) (n=87) had “Asaasee” level of education while 21.6% (n=32) of the respondents had primary education and 19.6% (n=3) of them completed O’ Level. None of the respondents had university education. Compare to the level of education and OCP users, it shows that 15.6% (n=5) of the users had primary education, 14.9% (n= 13) of the users had “Asaasee” level of education and 10.3% (n=3) of the users completed O’ Level.

The results also show that the majority of the respondents (49%) (n=57) get a family income between Rf. 10000-14999 while 35.9% (n=55) of them get family income between Rf. 5000-9999. Only 6.5% (n=10) of the respondents get income >15000 and 5.2% (n=8) of them get income <4999. It shows that the percentage of OCP use was high among the

respondents who get income Rf >15000 (30%), followed by 25% who get income Rf <4000, 16% who get income between Rf 10000-14999 and 7.3% who get income between Rf 5000-9999.

**Table 4.2 Number of people heard of OCP  
(N=148)**

	n	%
<b>YES</b>	117	79.1
<b>NO</b>	31	20.9

Table 2 shows that out 148 respondents 79.1% (n=117) of them heard of OCP while 20.9% (n=31) did not hear about OCP.

**Table 4.3 Source of information about OCP  
(N=148)**

Sources	n	%
Parents	2	1.4
School	11	7.4
Friends	23	15.5
Radio	74	50
T.V	68	45.9
Newspaper	10	6.8
Internet	5	3.5
Health care providers	67	45.3

The table 3 shows that the most frequent source of information about OCP was from Radio (50%) (n=74), followed by T.V (45.9%) (n=68), health care providers (45.3%) (n=67), friends (15.5%) (n=23), school (7.4%) (n=11), newspaper (6.8%) (n=10), internet (3.5%) (n=5) and parents (1.4%) (n=2).

**Table 4.4 Known contraceptive methods  
(N=148)**

Methods	n	%
OCM	114	77
Injection	110	74.3
IUD	45	30.4
Male condom	111	75
ECP	14	9.5
Female Sterilization	89	60.1
Male Sterilization	68	45.9
Norplant	39	26.4

The table 4 shows (77%) (n=114) of the respondents had knowledge about oral contraceptive methods, followed by 75% (n=111) knew about male condom, 74.3% (n=110) knew about injection, 60.1% (n=89) knew about female sterilization, 45.9% (n=68) knew about male sterilization, 30.4% (n=45) knew about IUD, 26.4% (n=39) about Norplant and 9.5% (n=14) knew about ECP.

**Table 4.5 Known types of OCP (N=148)**

Type of OCPs	n	%
Microgynon	30	23.3
Regividone	19	12.8
Micronor	18	12.2
ECP	4	2.7

The table 5 shows that 23.3% (n=30) of the respondents had knowledge about Microgynon, 12.8% (n=19) of respondents had knowledge about Regividone, 12.2% (18) had knowledge about Micronor and only 2.7% (n=4) of the respondents had knowledge about ECP.

**Table 4.6 Knowledge about the correct period to start OCP (N=148)**

Period	n	%
First 5 days of menstruation	7	4.7
Mid-cycle of menstruation	47	31.8
Five days before menstruation	3	2.0
Do not know	91	61.5

The table 6 shows that only 4.7% (n=7) of the respondents had knowledge about the correct period to start OCP while the rest of the 95.3% respondents had poor knowledge about the correct period.

**Table 4.7 Percentage of people agreed to take OCPs regularly (N=148)**

	n	%
YES	80	54.1
NO	10	6.8
Don't Know	58	39.2

The table 7 shows that 54.1% (n=80) of the respondents had knowledge about the regular intake of OCPs while 6.8% (n=10) of the respondents did not agree that OCPs have to take regularly. On the other hand, 39.2% (n=58) of the respondents did know have knowledge about the regular intake of OCPs.

**Table 4.8 Percentage of people who have heard of any side effects of OCPs (N=148)**

	N	%
YES	56	37.8
NO	92	62.2

The table 8 shows that 37.8% (n=56) of the respondents had knowledge about any side effects of OCPs while 62.2% (n=92) of them had no knowledge about the side effects of OCP.

**Table 4.9 Percentage of people who relate selected side effects to OCPs (N=148)**

Side effects	Yes		No	
	n	%	n	%
Nausea/vomiting	18	12.2	130	87.8
Headache	16	10.8	132	89.2
Painful breast	3	2	145	98
Weight gain	49	33.1	99	66.9
Scanty menstruation	5	3.4	143	96.6
Amenorrhea	2	1.4	146	98.6
Acne	5	3.4	143	96.6
Depression	5	3.4	143	96.6

The table 9 shows the percentage of respondents who had knowledge about the common side effects due to OCP. The results show that 33.1% (n=49) of the respondents heard that weight gain is a side effect due to OCP, followed by 12.2% (n=18) of them heard about nausea/vomiting, 10.8% (n=16) of them heard about headache, 3.4% (n=5) of them heard about scanty mensuration, acne and depression respectively. It shows that only 2% (n=3) of them heard about painful breast and 1.4% (n=2) of them heard about amenorrhea.



**Table 4.10 Attitude concerning on oral contraceptive method (N=148)**

Statement	Strongly agree		Agree		Disagree		Strongly disagree	
	n	%	n	%	n	%	n	%
Use of oral contraceptives improves maternal health.	17	11.5	41	27.7	85	57.4	5	3.4
Use of oral contraceptives is against Islamic religion.	7	4.7	30	20.3	87	58.8	24	16.2
Oral Contraceptive use has negative effects on menstrual cycle.	49	33.1	67	45.3	27	18.2	5	3.4
Oral contraceptive pills can increase the risk of breast cancer.	1	0.7	37	25	88	59.5	22	14.9
Husband do not approve of using OCPs.	7	4.7	76	51.4	24	16.2	41	27.7
Not satisfied with the service providers.	6	4.1	35	23.6	81	54.7	26	17.6
Feel uncomfortable to obtain the service.	10	6.8	83	56.1	32	21.6	23	15.5

The table 10 shows that 33.1% (n=49) of the respondents strongly agreed use of OCPs have negative effects on menstrual cycle while 45.3% (n=67) of them agreed, 18.2% (n=27) of them disagreed and 3.4% (n=5) of them were strongly disagreed. The results also shows that 11.5% (n=17) of the respondents strongly agreed use of OCPs will improve maternal health while 27.7% (n=41) of them agreed, 57.4% (n=85) of them disagreed and 3.4% (n=5) of them were strongly disagreed. In addition, 6.8% (n=10) of the respondents strongly agreed that they felt uncomfortable to obtain family planning services while 56.1% (n=83) of them agreed, 21.6% (n=32) of them disagreed and 15.5% (n=23) of them were strongly disagreed. The result further shows that 4.7% (n=7) of the respondents strongly agreed use of OCP was against Islamic religion while 20.3% (n=30) of them agreed, 58.8% (n=87) of the disagreed and 16.2% (n=24) of them were strongly disagreed. It was also found that 4.7% (n=7) of the respondents strongly agreed their husbands did not approve

using OCP while 54.4% (n=76) of them agreed about this, 16.2% (n=24) of them disagreed and 27.7% (n=41) of them were strongly disagreed. Furthermore, the results show that 4.1% (n=6) of the respondents were strongly agreed that they were not satisfied with the service provider while 23.6% (n=35) of them agreed with this statement, 54.7% (n=81) of them were disagreed and 17.6% (n=26) of them were strongly disagreed. There were only 0.7% (n=1) of the respondents who strongly agreed use of OCPs can increase the risk of breast cancer while 25% (n=37) of them agreed with this, 59.5% (n=88) of them disagreed and 14.9% (n=22) of them were strongly disagreed.

**Table 4.11 Status of practicing OCPs  
(N=148)**

	n	%
YES	21	14.2
NO	127	85.8

The table 11 shows that 14.2% (n=21) of the respondents were practicing OCPs while 85.8% (n=127) of them were not using any type of OCPs.

**Table 4.12 Reason for not practicing OCPs (N=148)**

Reason	Yes		No	
	n	%	n	%
Husband disapproves	24	16.2	124	83.8
I don't approve	102	68.9	46	31.1
Because of side effects	6	4.1	142	95.9
Inconvenient to use	4	2.7	144	97.3
Not available	0	0	143	100
Religious reason	8	5.4	140	94.6

The table 12 shows that 68.9% (n=102) of the respondents were not practicing any type of OCP as they don't approve themselves while 16.2% (n=24) of them had a reason for their husbands disapprovals, 5.4% (n=8) of them had religious reasons, 4.1% (n=6) of them said

due to side effects and 2.7% (n=4) of them said it was inconvenience to use OCPs. The result shows that unavailable of OCPs was not a reason for practicing OCPs among the respondents.

**Table 4.13 Number of people who practiced OCPs within the last 6 months (N=148)**

	n	%
YES	21	14.2
NO	127	85.8

The table 13 shows 14.2% (n=21) of the respondents had practiced OCPs within the last 6 months while 85.8% (n=127) of them did not practice any type of OCPs within the last 6 months.

**Table 4.14 Type of OCPs used within the last 6 months (N=148)**

Type of OCPs	Yes	
	n	%
Microgynon	18	12.2
Regividone	4	2.7
Micronor	1	0.7
Don't Know	1	0.7

The table 14 shows 12.2% (n=18) of the respondents used Microgynon within the last 6 months, 2.7% (n=4) of them used Regividone, 0.7% (n=1) of them used Micronor and 0.7% (n=1) of them did not know the type of OCP practiced within the last 6 months.

## CHAPTER 5

### DISCUSSION AND CONCLUSION

#### 5.1 Discussion of the results

This study has shown that the use of contraception by the ever married women in this community is low. The study showed that 14.2% (n=21) of the respondents were using OCPs while 85.8% (n=127) of them were not using any type of OCPs. This result is similar to the national health survey conducted to find out the trends in contraceptive need and use in developing countries in 2003, 2008, and 2012 (Darroch & Singh, 2013). This survey showed that in developing countries 13% of the women are using OCPs (Darroch & Singh, 2013). The national health survey also revealed that there was a huge regional difference between the type of method used and it was found that sterilization was the most commonly modern contraceptive method used in Asia which was particularly in South Asia (Darroch & Singh, 2013). As Maldives is a country in Asia region, the result of the national health survey may apply to Maldives and it may be a reason for low use of OCPs.

However, a study conducted in east Sikkim, India showed that 37.9% of the women were using OCPs (Prachi, Das, Ankur, Shipra & Binita, 2008) but a study conducted in Thulamela Municipality of Limpopo Province, South Africa showed much lower the use of OCPs (3%) among the reproductive age women than this study (Ramathuba, Khoza &

Netshikweta, 2012). On the other hand a study conducted at New Civil Hospital, Surat, which is located in Gujarat state in western part of India showed that 57% of the women were using OCPs (Chudasama, Kavishwar, Godara and Moitra, 2009). But a study conducted in rural Haryana in India showed that only 1.6% of the women were using OCPs (Saluja et al., 2011). However, a study conducted in Maldives showed that 23% of the ever married women were using OCPs (Ministry of Health and Family, ICF Macro, 2009). The result of this study compare to the other studies may vary due to the sample size, socio economic status and culture.

The low use of OCPs in the study may depend on their attitudes and even knowledge. The study results showed that majority of the women (68.9%) were not using OCPs as they don't approve themselves while 16.2% said as a reason for husband's disapprovals and 4.1% of the women were not using OCPs due side effects. Similarly, results from other studies which showed that spousal opposition and fear of side effects significantly contributed to hesitation to use OCPs (Shane Khan, 2007; Chipeta, Chimwaza & Kalilani-Phiri, 2010; Saluja et al., 2011).

The study also showed that no participant mentioned that the reason for not using OCPs was due to unavailability of services. It is a clear picture that 100% of the women have accessibility to OCPs which is a very remarkable achievement in terms of public health, especially despite the geographical challenges and limitations in medical supplies at isolated islands in Maldives such as in Kumundhoo. Since the health authorities have reached an important milestone in this regard, it is very important to continue in providing OCPs within the island health facilities without interruption. However, the next step is to

make people more aware to increase uptake of reproductive health services as and when necessary.

The results showed that most of the women had of negative attitude towards the usage of OCPs. It showed that majority of the women (57.4%) disagreed that use of OCPs improves maternal health while 45.3% of the women agreed that use of OCPs have negative effects on menstrual cycle, 59.5% disagreed that use of OCPs can increase risk of breast cancer, 76% agreed that their husband's not agree to use OCPs and 83% of the women felt uncomfortable to obtain family planning services. This is a clear picture of negative attitude towards the use of OCP among the ever married women and also among their spouses. A similar result was obtained from a study conducted to assess the knowledge, attitudes and practices of secondary school girls towards contraception in Thulamela Municipality of Limpopo Province, South Africa (Ramathuba, Khoza & Netshikweta, 2012). The result of the study also showed that majority of the girls (63%) have negative attitude towards the usage of OCPs (Ramathuba, Khoza & Netshikweta, 2012). The major reasons for negative attitude were that they believed OCPs and injections cause side effects. Of the 63% of the girls, 4% of them believed that if they use contraceptive pills or injections, boyfriend may leave them, can damage to their womb, get fat, may never have children, it was dangerous to use, long menstruation, not ready for family, may not have sexual relations or their mother will be angry, felt uncomfortable to obtain the services and girls were not satisfied with the services provided as they felt shy, culturally not permitted and service provides were not friendly with the clients (Ramathuba, Khoza & Netshikweta, 2012). A study conducted in Pakistan, Karachi also founds negative attitudes towards the usage of OCPs. The study found that (65%) of the women believed use of contraception for family

planning is prohibited in Islamic religion and (57%) of the women, believed that contraceptive use affects their health (Naqvi, Hashim, Zareen and Fatima, 2011). These are also similar reasons found in this study. The results are almost same, may be due to similarity of culture and economic status of the study population as both settings were rural settings. However, a study conducted in the rural southern region of Jordan showed a positive attitude towards the contraceptive methods as 95% of the women agreed about the benefits of spacing the pregnancies and benefits of maternal health with using contraceptive methods (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). A positive attitude towards OCP was also found in a study conducted in rural Haryana in India as 79.2% of the women have positive attitude for contraception and 20.8% have negative attitude for contraception (Saluja et al., 2011). Even though participants had negative attitudes their perception can be changed through health educational awareness programs regarding the reproductive health (RH) services.

The study found that majority of the participants (79.1%) had heard about OCP while 20.9% did not hear about OCP. This means majority of the people had knowledge about OCPs through various sources of information. The main sources of information were Radio (50%), TV (45.9%) and health care providers (45.3%), while some participants stated that their friends (15.5%) were also a source of RH information. The other sources such as parents, school, newspapers and internet were the least used sources of information. A similar result was obtained from a study conducted in East Sikkim, India, where 95.8% of the women had heard about OCPs and about 54.4% of the women obtained information regarding contraception from mass media (Prachi, Das, Ankur, Shipra & Binita, 2008). There were other studies which showed that TV, Radio and healthcare providers were the

main sources of information similar to the results from this study (Saluja et al., 2011; Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). However a study conducted in Thulamela Municipality of Limpopo Province, South Africa showed that main source of RH information were parents (Ramathuba, Khoza & Netshikweta, 2012).

The difference between these information sources may depend on the popularity and the availability of the sources in remote islands like Kumundhoo. Almost every house in the island has at least a TV and a radio and through which most housewives get information about various health topics. However, internet and newspapers were rarely available and even if, most women at rural islands don't use them, although internet use amonger the younger generation is increasing nowadays. Apart from this most young girls felt uncomfortable to share the reproductive information with their parents as it is a very sensitive issue. Therefore most of the young girls share the ideas with their friends instead of with their parents.

The study further revealed that the most commonly known contraceptive method was OCM (77%) followed by male condom (75%), injection (74.3%) female sterilization (60.1%) and male sterilization (45.9%). However, other contraceptive methods such as IUD (30.4%), Norplant (26.4%) and ECP (9.5%) were also known methods but few of the participants had knowledge about these methods. Moreover, very few of the participants (4.7%) had knowledge about the correct period to start OCPs and 54.1% of the participants had knowledge about the regular intake of OCPs. A similar result was found in a study conducted in rural Haryana in India in which 90.4% of the women had knowledge about OCPs but knowledge about female sterilization (92.2%), male sterilization (79.6%) and



IUD (82.4%) was much higher in this study than the study conducted in Kumundhoo (Saluja et al., 2011). However, the knowledge about injection (39.2%) was much lower in this study than the study conducted in Kumundhoo (Saluja et al., 2011). The knowledge about ECP was almost same in both the studies (Saluja et al., 2011).

It is a welcoming finding that the majority of the participants had knowledge about OCP and other contraceptive methods like injection, male condoms, female sterilization and male sterilization. It seems that most of the participants were familiar and had more knowledge about only the available methods at the island and the information about sterilization methods had through radio, TV and health care providers. On the other hand, it is very important to deliver the information to the service seekers by the health care providers about the regularity and the correct period to start OCPs. Otherwise there would be chances to miss the pills and may even affect the effectiveness of the RH program.

In addition, the study results found that the majority of the participants did not have knowledge about side effects of OCPs. It was found that 37.8% had knowledge about the side effects while 62.2% of the participants did not have knowledge about the side effects. Most of the participants reported weight gain (33.1%), nausea/vomiting (12.2%) and headache (10.8%) as side effects. Knowledge about scanty menstruation, acne and depression (3.4%) were same and very few participants had knowledge about painful breast (2%) and amenorrhea (1.4%). A study conducted in the rural southern region of Jordan found almost same result as 36.6% of the women had knowledge about the side effects of OCP (Mahadeen, Khalil, Hamdan-Mansour, Sato & Imoto, 2012). Another study conducted in Pakistan, Karachi, showed that 41% of the women experienced weight gain after using

OCPs, 60% observed irregular menstruation, 31% experience menorrhagia, 30% experience amenorrhea and 18% of the women experience subfertility (Naqvi, Hashim, Zareen and Fatima, 2011). On the other hand, the DHS 2009 conducted in Maldives found that the knowledge about the side effects among the women were slightly lower than the study conducted in Kumundhoo (Ministry of Health and Family, ICF Macro, 2009). The results of the DHS 2009 found that 18.8% of the women stop using OCPs due to the fear of side effects (Ministry of Health and Family, ICF Macro, 2009). It is very important to build the knowledge about the side effects and the adverse reactions followed by the use of OCPs. The women may have little knowledge or want know more about OCPs after they had experienced some of the adverse reactions. Even though few resources are available at the rural remote islands still there are more opportunities to increase the level of knowledge among the reproductive age women. This can be achieved by implementing awareness programs at the schools specially targeted to teenage girls in a suitable environment in an age appropriate way. Such programs will be effective and efficient if there is a strong coordination between the health authorities and the schools.

## **5.2 Conclusion**

The use of OCPs by the ever married women in Kumundhoo is low. Only a small percentage of the ever married women were using OCPs and majority of them had negative attitudes towards the usage of OCPs. However, majority of the women heard about OCPs and almost half of them knew the regular intake of OCPs. However, the knowledge about the side effects and the correct period to start OCP was low. Therefore, there is a strong need for increased awareness, continuous counselling and health education to increase the

reproductive health knowledge among women and to change their perception on contraception and family planning.

### **5.3 Limitation**

Even though the reproductive age was 15-49 years the study population was limited between the ages of 18-49 years as the Maldives Family Law does not allow to get married before 18 years of age (Attorney General Office Republic of Maldives, 2004). The study was also limited to the information gathered by the questionnaire only and the results of the study depend on the truthfulness of the participant's responses.

### **5.4 Recommendation**

- 1- Even though there is already 100% availability of OCP it is recommended to continue providing reproductive commodity (OCP) availability within the island without interruption.
- 2- To improve health service delivery to increase uptake of RH services as and when needed by women and families (e.g. opening HC 1 hour per week in the evening where nurse may provide RH services in the health facility. This means other service seekers will not be there at that time in the facility, which in turn may make women more comfortable to seek RH services)
- 3- To plan and conduct public health interventions and programmes in a targeted manner that makes the audience feel comfortable environment and increase awareness on RH services. May be sessions specific to women in friendly and confidential atmospheres might tackle the issue of women feeling hesitant to ask for information and seek services.
- 4- Also conduct sessions targeting spouses as some reported husbands disapproval of OCP.

- 5- Also conduct information sessions from a religious perspective highlighting important of family planning and child spacing, delivered by Islamic scholars might be more well received by people who have religious reasons for not using OCP.
- 6- Providing training to health service providers such as health workers to improve their skills in communicating and delivering RH services is important. This will help them communicate information better, create more awareness, reach more people, and plan better public health activities to improve reproductive health and family wellbeing in the community.
- 7- At present, all couples have to undergo an education session before marriage which includes a health component. It is recommended that relevant authorities review the content of this and revise to improve family planning information. In Male' this information is provided comprehensively, however, in islands a personnel from the Magistrate's Court will conduct the session, leading to compression of information on health component. This might lead to comprehensive information not being provided as per the intention of this programme. It is recommended that the health facility provide input and support to conduct the health component so that all couple will get comprehensive RH information before their marriage.
- 8- The future researchers can conduct research on same topic as there may be other confounding factors that may give a better result or they can conduct research on other topics of family planning services.

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## APPENDICES

### Appendix A: Research questionnaire in English

#### Questionnaire for factors affecting the Knowledge, attitude and practice oral contraceptive pills among the married women in Kumundhoo

Date of Interview: DD/MM/YYYY

Time: \_\_ \_\_: \_\_ \_\_

Write or Tick [✓] the appropriate box that corresponds to your choice.

#### **I. Socio-demographic information**

##### 1. Sex

Male

Female

2. Age

##### 3. Marital Status

Married

Divorced

Widowed

##### 4. Level of education

“Asaasee”

Primary

O’ Level

University

##### 5. Family income monthly

< 4999 .....

5000 – 9999 .....

10000 – 14999 ....

>15000 .....



## II. Knowledge concerning oral contraception

1. Have you ever heard of oral contraceptive method?

YES

NO  ( If NO go to III )

2. If the answer for the above question is 'YES', what was your source of information? Tick [] the appropriate box.

Parents .....

School .....

Friends .....

Radio .....

T.V .....

Newspaper .....

Internet .....

Health care providers .....

3. Have you ever known the following contraceptive methods? Tick [] the appropriate box.

Oral Contraceptive methods .....

Injection .....

IUD .....

Male Condom .....

Emergency contraceptive pills .....

Female sterilization .....

Male sterilization .....

Norplant .....

**4. Have you ever heard of the following oral contraceptive pills? ( Y or N )**

- Microgynon   
Regividone   
Micronor   
Emergency contraceptive pill

**5. Which period do you need to start contraceptive pills? Tick [] the appropriate box.**

- First 5 days of menstruation   
Mid-cycle of menstruation   
Five days before menstruation   
Do not know

**6. Do you need to take oral contraceptive pills every day?**

- YES   
NO   
Don't know

**7. Have you ever heard of any side effects of oral contraceptive pills?**

- YES  ( If YES identify the side effects below)  
NO

**What are the side effects?**

- Vomiting/nausea .....   
Headache .....   
Painful breast .....   
Weight gain .....   
Scanty menstruation ...   
Amenorrhea .....   
Acne .....   
Depression .....

**III. Attitude concerning on oral contraceptive method**

#	Statement	Strongly agree	Agree	Disagree	Strongly disagree
1	Use of oral contraceptives improves maternal health.				
2	Use of oral contraceptives is against Islamic religion.				
3	Oral Contraceptive use has negative effects on menstrual cycle.				
4	Oral contraceptive pills can increase the risk of breast cancer.				
5	Husband not agreed to use oral contraceptive pills.				
6	Not satisfied with the service providers.				
7	Feeling uncomfortable to obtain the service.				

**IV. Practice of oral contraception**

**1. Are you practicing any oral contraception now?**

YES

NO

**2. If NO, why do you not use any oral contraceptive method? Tick [√] the appropriate box.**

Husband disapproves

I don't approve

Because of side effects

Inconvenient to use

Not available

Religious reason

**3. Have you practiced any oral contraceptive method within the last 6 months?**

YES

NO

**4. If YES, what type of oral contraceptives do you use / have you used?**

Microgynon

Regividone

Micronor

Do Not know

## **Informed consent form**

Dear Participant

I am a student currently studying Bachelor in Primary Health Care in Faculty of Health Sciences of Maldives National University. As a part of my study, I am doing a research to understand the factors related to the knowledge, attitude and practice of oral contraceptive pills among the married women in H.Dh.Kumundhoo.

The findings of this research can be used for health care providers to improve the use of oral contraception among the married women which leads to the reduction of maternal deaths and improves maternal health.

If you decide to take part in this study voluntarily, you will be asked about knowledge, attitude and practice of oral contraceptive pills. This interview will only be used for research purposes and the interview will take only about 15 - 20 minutes.

In the interview, your name will not be asked and no identification number will be used to identify you. If you are willing to agree to participate in this study, all the information you provided will be kept confidential and anonymity will be observed.

You have the full right to agree or disagree to participate in this study and also you have the full right to refuse or withdraw from the study at any time. If you decide to withdraw from the study at any point, the information you provided will be discarded and will not affect any of your rights.

I would really very much appreciate your valuable time for this interview as your opinions are very important to complete my research. If you have any questions before, during, or after the study please feel free to ask me.

I declare that oral and written information has been given as well as the declaration of consent to the participant.

Thank You

I consent voluntarily to participate in the research conducted by Ali Adam from Faculty of Health Sciences of Maldives National University. I am informed that the study entitled, Knowledge, attitude and practice regarding the use of oral contraceptive pills among the ever married women in H.Dh.Kumundhoo, is an educational study and the data will be used for research purpose only. I am also informed that my identity will not be disclosed and I have my full authority to remove from the study at any point of the study.

Date :.....

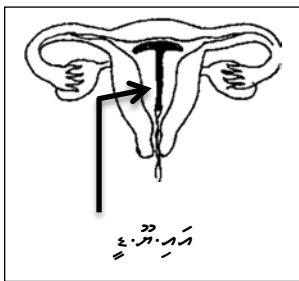
Signature:.....







3. چه بیماری در جوف شکم که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد؟



[✓] قوی به این روش.

- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... این روش را بزن
- ..... این روش
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد

4. چه بیماری در جوف شکم که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد؟

به این روش.

- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد
- ..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد

..... که در آن بافت‌های نرم و گوشتی در شکم و سینه‌ها قرار می‌گیرد









