SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

EMERGENCY CONTRACEPTION: PERCEPTION AND USE
AMONG THE FEMALE YOUTH OF CHORKOR.

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HEALTH DEGREE

JULY, 2017
DECLARATION

I do hereby declare that apart from references of works from other people which have been duly acknowledged, this work is the result of my own original research. This dissertation, either in whole or in part, has not been presented in this university or somewhere else for another degree.

SIGNATURE………………………………………
DATE……………………………………

RAPHAEL AMOANOR
(CANDIDATE)

SIGNATURE………………………………………
DATE……………………………………

DR. EDWIN A. YAWSON
(ACADEMIC SUPERVISOR)
DEDICATION

I bestow this final work to God, for His mercy and loving kindness which has brought me this far in pursuing this program, and to my entire family especially to my late mother, Mrs. Lydia Akpatsu.

I also dedicate this dissertation to my friends and work colleagues for their support in diverse ways throughout the program. I will always be appreciative of their kindness.
ACKNOWLEDGEMENT

I wish to express my profound thanks my supervisor, Dr. Edwin A. Yawson for his immense contributions and guidance from the beginning till the final research work. God richly bless you, Dr. Yawson.

My sincere gratitude also goes to the female youth of Chorkor who participated in the data collection for their cooperation in this research. Special thanks goes the leaders of the Chorkor community as well as the parents/guardians who consented for their children/wards to participate in the data collection.

My deepest appreciation to Mrs. Jessica Agbeli, Mrs. Bridgette Abaka, Mr. Courage Daneku and Mr. Justice Agbo, for their diverse support. My special gratitude also goes to Mr. Maxwell Dzokoto and Mr. Joseph Omani Boateng for his guidance during the analysis of my data.
ABSTRACT

Introduction

Emergency contraception (EC), or post-coital contraception is the method of contraception that can be used to prevent pregnancy in the first 5 days after sexual intercourse. Unprotected sexual intercourse leads to unwanted pregnancies, resulting in abortions, abortion-related complications, and other health problems. The study considered the perception and use of EC among the female youth of Chorkor to help inform contraceptive policy and use.

A descriptive cross-sectional survey was carried out employing quantitative method. A structured questionnaire was used to conduct an interview. The sample was selected using stratified systematic random sampling technique. The data collected was analyzed using Stata version 14 and SPSS. Three hundred and fifty female youth of chorkor Lantemamli, Alaji and Chemuanaa were interviewed.

More than 80% of the study participants had ever heard EC. Among the sources of information on EC, the media represented the highest (24.82%) followed by source from friend/mates. About 50% of the participants perceived that EC are against their religious doctrines, however, 39% of them will use it even if it against their religious beliefs. Also more than 60% of the study participants perceived high side effects of EC thus fear to use it. Among the participants who know where to access EC, 31.6% of them got EC drugs over the counter at the pharmacy (highest source).

Though most of the participants have ever heard of ECs, majority of them are not using it appropriately due to lack of detailed information on EC to prevent unwanted pregnancies. It is thus, recommended that intervention to improve continual education of the youth through the formation of centers which are youth-friendly for reproductive health services is highly suggested.
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<tbody>
<tr>
<td>AMA</td>
<td>Accra Metropolitan Assembly</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraception</td>
</tr>
<tr>
<td>ECPs</td>
<td>Emergency Contraceptive pills</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence Interval</td>
</tr>
<tr>
<td>COC</td>
<td>Combined oral contraceptive</td>
</tr>
<tr>
<td>IUDS</td>
<td>Intrauterine Copper-bearing Device</td>
</tr>
<tr>
<td>GDHS</td>
<td>Ghana Demographic and Health Survey</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
</tr>
<tr>
<td>GSS</td>
<td>Ghana Statistical Service</td>
</tr>
<tr>
<td>PFRH</td>
<td>Population, Family and Reproductive Health</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER ONE

INTRODUCTION

1.1 Background to study

Emergency contraception (EC), or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first 5 days after sexual intercourse (WHO, 2016). EC is grouped into three types: emergency contraceptive pills (ECPs), combined oral contraceptive pills or the Yuzpe method, and copper-bearing intrauterine devices (IUDs). ECPs involves the use of either Levonorgestrel used as a single dose (1.5 mg) or Ulipristal acetate, used as a single dose at 30 mg within 5 days (120 hours) of unprotected sexual intercourse while Yuzpe method uses combined oral contraceptive pills which are taken in 2 doses (WHO, 2016). The copper-bearing IUD method on the other hand is used by inserting within 5 days of unprotected intercourse.

Female adolescents become susceptible to unwanted pregnancies, which may lead to abortion, abortion-related complications, and other health and social problems after having unprotected sexual intercourse (Okereke, 2010; Yen & Martin, 2013). About 80 million unplanned pregnancies occur in the world every year (Speidel et al, 2008). This resulted in 50 million abortions worldwide, many of which being unsafe and subsequently resulting, in approximately 80 000 maternal deaths (Hoque & Ghuman, 2012). Assessing the perception and use of contraceptive is an important step towards gaining access to family planning services and adopting a suitable contraceptive method.

However, WHO (2016) “estimates that 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception”. This results in one in three women giving birth before the age 20 and pregnancy-related death
during child birth which is two times higher compared to women older than 20 years (Nsubuga et al, 2016).

Ghana is however not different. The current use of any method of contraception in Ghana is 23 percent among all women and 27 percent among currently married women (GDHS, 2014). Moreover, the median age at first sexual intercourse among urban women age 25-49 years in Ghana is 18.8 years. It is thus not surprising that about one-fifth of Ghanaian women age 25-49 years (22 percent) had given birth before reaching age 18, while nearly two-fifths (39 percent) had given birth by age 20.

The study therefore assessed the perception and use of EC among the female youth of Chorkor to help inform contraceptive policy and use.

1.2 Problem statement

Unintended pregnancy poses a major challenge to the reproductive health of young adults in developing countries (WHO, 2007). Lack of contraceptive knowledge, poor quality of and access to family planning services, method, cost, women’s concerns about side effects, and women’s, husbands’ or family members’ objections to contraceptive use results in unplanned and unprotected sexual intercourse leading to unwanted pregnancy and invariably abortions (WHO, 2016).

Sexual intercourse in Ghana is perceived as reserved of only adults who are married due to cultural, social and religious (Awusabo-Asare et al, 2008). Therefore, matters concerning sex and contraception may, not be discoursed mainly amongst adults and young people at home (Awusabo-Asare et al, 2008). This may limit adolescent’s access to information on issues related to sex and contraception.
A study by (Appiah-Agyekum & Kayi, (2013) at the University of Ghana, reported that even sexually active University students stand a high risk of using contraceptives wrongly due to their insufficient knowledge, and perhaps misinformation about the use of contraceptives. Again, it is on record that 16% of all births in Ghana are unwanted, 40% are unplanned, and 24% are mistimed (GSS), GHS, 2009). Young people are most vulnerable to unsafe induced abortions and its complications. Studies have shown that widespread of EC usage may significantly reduce unintended pregnancies and thus the number of abortion-related morbidity and mortality.

In the Ablekuma sub-Metropolitan Assembly where Chorkor is located, is one of the most populated districts in Ghana with majority of the people, 388,403 and 458,075 in the (15-19) years and (20-24) years range respectively (GDHS, 2014). The disparity between those who know about EC and those who use it is alarming. This has implication on unwanted pregnancies in the Chorkor community. This study therefore engaged an exploratory community-based cross-sectional approach using a quantitative design method in study to help inform contraceptive consumption policies.

1.3 General Objective
To assess the perception and use of Emergency Contraception amongst the female youth of Chorkor

1.4 Specific Objectives
To assess the perception of young females in Chorkor on Emergency Contraception.

To assess attitudes of young females in Chorkor towards Emergency Contraception use
To identify factors that influence use of Emergency Contraception among young females in Chorkor.

1.5 Research Questions

1. What is the perception of the young females in Chorkor on ECs?
2. What attitudes do young females in Chorkor have towards EC usage?
3. What factors influence the use of ECs among the young females in Chorkor?

1.6 Justification

The study assessed the perception of the female youth at Chorkor in relation to emergency contraception. This unraveled the myths and misconceptions regarding contraception, helping inform policies and strategies on contraception.

Additionally, the assessment of the attitudes of the youth towards contraception use revealed the predominant gaps in knowledge, access and use of contraception. Moreover, the factors influencing the use of contraception among the youth were identified. Appropriate policies can be formulated based on findings, to help boost the utilization of contraception.

Additionally, lessons learnt can be extended to other communities in Ghana. The discoveries of this study contributed to current literature on contraception.
1.7 Conceptual Framework

Independent variables

**Socio-demographic factors**
- Age
- Marital Status
- Educational level
- Employment status
- Religious affiliation
- Exposure to social media

**Other factors**
- Peer influence
- Fear of unknown outcome of side effects of emergency contraceptives
- Sources of contraceptive
- Alcohol consumption
- Parenting styles (e.g. communication about reproductive health)
- Parents’ educational level

**Intermediate Variable**
- Exposure to unprotected sex due to non-use or improper usages of Emergency contraceptives and its consequences (unintended pregnancy, included abortions, unplanned birth, maternal mortality etc.)

**Dependent variables**
- Perception and use of emergency contraception

**Figure 1.1: Conceptual framework**

A conceptual framework according to Wondimu (2008) is a model that controls what questions need to be answered by the person conducting the research, as well as how empirical procedures are to be used as an instrument when answering these questions. From conceptual framework, the socio-demographic factors (age, marital status, educational level etc) and the other factors such as peer influence, fear of unknown outcome of side effects of emergency contraception, sources of contraceptives etc are the independent variables.
The exposure to unprotected sex and its consequences are considered as the intermediate variable and the dependent variables as perception and Emergency contraception use.

The independent variables determine the perception and attitudes of the youth towards the use Emergency Contraceptives and unprotected sex exposure and its consequences.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviewed literatures on the subject matter and important published studies by other researchers applicable to this study. The literature review was structured around the objectives of this study and research process and presented as follows:

2.1 Background

Globally, youth sexual activity is increasing with a trend towards early onset (Grimes et al, 2006; WHO, 2015). It is estimated that as many as 20-50% of adolescents have started sexual activity with age at first sexual intercourse ranging from fourteen to eighteen years (Yen & Martin, 2013). However, a key challenge to the reproductive health of young adults is unintended pregnancy. Nevertheless, the percentage of young women reporting unintended pregnancy and unmet need for contraception remains high especially in the developing countries (Akintade, Pengpid & Peltzer, 2011). For instance, one in three women give birth before the age of 20 and pregnancy-related death during child birth is two times higher compared to women older than 20 years (Nsubuga et al, 2016). Unplanned pregnancies and sexually transmitted diseases may be prevented by the use of emergency contraceptives (WHO, 2015).

2.2 Types of Emergency Contraceptives

Emergency contraceptive (EC) is intended for use after unprotected sexual intercourse, contraceptive failure or misuse, rape or coerced unprotected sex (WHO, 2016). EC is grouped into three main types: emergency contraceptive pills (ECPs), combined oral
contraceptive pills or the Yuzpe method, and copper-bearing intrauterine devices (IUDs) (WHO, 2016). ECPs involves the use of either Levonorgestrel taken as a single dose (1.5 mg) or Ulipristal acetate, taken as a single dose at 30 mg within 5 days (120 hours) of unprotected sexual intercourse while Yuzpe method uses combined oral contraceptive pills which are taken in 2 doses (WHO, 2016). The copper-bearing IUD method on the other hand is used by inserting within 5 days of unprotected intercourse.

2.3. Attitudes and EC use

According to study done by Shiapacasse and Diaz, (2006), fundamentalist opinion leaders and conservative politicians have stood against the introduction EC in many countries of the world, mentioning moral issues. This was a result of strong opposition by the catholic church as well as anti-abortion groups (Smugar et al., 2011). Thus women are hesitant to use EC if they believe it is an abortifacient (Keesbury et al, 2011). A study done in Sweden by Larsson et al., (2004) showed that 33% of the respondents considered EC pills as a kind of abortion drug. This finding was not different from a study done in Nigeria in which 25.8% of the participants also considered use of EC as a form of abortion.

A study done by Florence Ugoji in 2013 found that it is the youth attitude that influence the knowledge they acquire towards the use of contraception thus indicating that there was actually a significant difference in the knowledge of contraceptives and the attitude towards the actual use of it.

In Ghana, is on record that 16% of all births in Ghana are unwanted, 40% are unplanned, and 24% are mistimed (GSS, GHS & ICF Macro, 2009). Married Ghanaian women, approximately 55% are at risk of unintended pregnancy (Johnson & Madise, 2011). Several studies in Ghana exposed low knowledge about contraceptive types and its usage indicative
of lack of awareness about the various types of contraceptive methods (Appiah-Agyekum and Kayi, 2013). Moreover studies conducted among the intellects in one of the public Universities indicate that sexually active university students stand a high risk of using contraceptives wrongly due to their inadequate knowledge, and perhaps misinformation about the use of contraceptives, e.g. the pill or emergency contraceptives (Appiah-Agyekum and Kayi, 2013).

“The Ghana Demographic and Health Survey (GDHS, 2008) reports levels of contraceptive use to be low among female adolescents, 24.0%” (GSS, GHS & ICF Macro, 2009; Eaton et al., 2012). Generally, one in four contraceptive users stopped using a method within 12 months of starting its use. A study of contraception use among adolescents randomly selected among seven secondary schools in the greater Accra showered that main reason leading to low use of contraception was the fact that most of them were ignorant and also felt shy buying. Study by Winskell et al., (2011) revealed that adolescents whose parents had prior communication with them before the onset of sex were three times likely to use contraception during their first sexual encounter. The youth attitude towards the use of EC is also influenced by the attitude of health care providers. Some of these health care providers such as physicians, nurse, pharmacists etc discourage the youth especially those who seek for services related to abortion whilst others also impose their values on the youth thus stereotyping them. These attitudes create barrier in the way of the youth’s access and attitude towards use of contraceptives and seeking sexual reproductive health services (Awuasabo-Asare et al, 2008).

2.4. Factors Influencing Contraceptive Use

Numerous factors affect the use of contraceptives. These are presented as follows:
2.4.1. Knowledge of Contraceptive Methods

Several studies conducted among adolescents in Ghana revealed low level of knowledge about contraceptive methods (Awusabo-Asare, Bankole & Kumi-Kyereme, 2008). The lack of knowledge about EC has resulted in women resorting to unsafe or illegal abortions in several low income countries. Current use of any method of contraceptive in Ghana for instance is 23 percent among all women, 27 percent among currently married women, and 45 percent among sexually active unmarried women (GDHS, 2014). Among presently married women, 22 percent are using a modern method and 5 percent are using a traditional method. Similarly, the use of injectables as a modern method among currently married women is only 8 percent, followed by the implants and the pill 5 percent each (GDHS, 2014). “This has lead about in the estimated 225 million women in developing countries who would like to delay or stop childbearing but are not using any method of contraception” (WHO, 2015).

Worsening these is the lack of source of information on contraceptives. It has been reported that peers and friends as the commonest source of information on emergency contraception (Akani et al, 2008). This leads to the increase in poor knowledge of correct methods of contraception (Abasiattai et al, 2007). This has far reaching repercussions as women who genuinely desire to use emergency contraceptives may end up using non-conventional methods and subsequently face the risk of unintended pregnancy and unsafe abortion.

2.4.2. Knowledge of Their Use

A number of studies has shown that apart from the awareness about EC by women, knowledge of the correct time-frame within which it should be used is generally poor (33.3%) (Babatunde et al, 2016). Poor knowledge of correct time-frame of EC use might inhibit someone who could still prevent a pregnancy from taking EC (Awusabo-Asare, Abane & Kumi-Kyereme, 2014)
According to national survey of adolescents in Ghana conducted by Awusabo-Asare, Abane and Kumi-Kyereme, (2014) reported knowledge of contraceptive types was not positive.

2.4.3. Access to Contraceptive Methods

Emergency contraceptives are accessed from health facilities. However, “adolescents feel embarrassed going to these facilities for information or services pertaining to sex and contraception” (Awusabo-Asare, Abane & Kumi-Kyereme, 2014). This is due to the fact that service providers meet them with hostile attitudes at the facility.

Adolescents are most likely to be scorned, rebuked, ridiculed, labeled, or sometimes driven away by service providers at health facilities (Boamah et al, 2014). This unfavorable attitude by service providers could limit the source of acquisition of contraceptives.

2.4.4. Sociodemographic Characteristics

The use of EC is influenced by socio-demographic characteristics. “In Ghana, sexual intercourse is seen as a reserve of only married adults due to religious, cultural, and social reasons” (Boamah et al, 2014). Issues regarding sex and contraception may, therefore, not be discussed at home, particularly amongst adults and young people. “This scenario is likely to limit adolescent’s access to information on issues related to sex and contraception” (Awusabo-Asare, Abane & Kumi-Kyereme, 2014). Also, “adolescents feel embarrassed going to these facilities for information or services pertaining to sex and contraception due to the fact that they recognize that they will be met with an unreceptive attitude at the facility given that service providers are the same adults that they live with, in the community” (Ezebialu & Eke, 2013).

Studies have found that “early adolescents have significantly lower levels of knowledge of at least one contraceptive method, as compared to the late adolescents” (Rondini & Krugu, 2009). “Several factors such as level of knowledge, sex, age, cost, and contraceptive
availability, among others, account for low levels of consistent contraceptive use” (Boamah et al., 2014).

2.4.5. Fear of side effects and misconception

Fear of side effects of EC happens to be one the common but serious reasons why most people do not use it or may discontinue usage. Parents and teachers who did not approve the EC use by sexually active youth stated that Contraceptives kill and will destroy their reproductive organs (Briggs, 1998). Others reasons why the youth should use contraception mentioned were fear of future infertility and promotion of sexual promiscuity.

There is low EC usage by the youth or discontinuation by those who are using due to false beliefs and misconceptions about it. This upsurges the risk of unwanted pregnancies (Hamani et al., 2007). In Nigeria, a study done by Otoide et al., in 2001 revealed that the youth depended on induced abortion (mostly unsafe) to control their fertility instead of use of modern contraception. The respondents said that the effects of modern contraception on fertility is continuous, prolonged and might cause future infertility whilst abortion was seen as the solution to an unwanted pregnancy.

EC and modern contraception in general have a lot of benefits beyond the false beliefs and misconceptions. The advantages of contraception should be highlighted whilst misconceptions are strongly debunked. This enable sexually active youths to rightly use EC to the maximum benefit.

2.5. Consequences of Unintended Pregnancies

Unintended pregnancy remains a major challenge to the reproductive health of women especially in the developing countries. Adolescent females susceptible to unwanted pregnancies, which may lead to abortion, abortion-related complications, and other health
and social problems such as infertility and dropping out from school due to unprotected sexual intercourse (Okereke, 2010; Yen & Martin, 2013). This contributes profoundly to maternal morbidity and mortality (Hoque, 2012). It has been estimated that each year, unintended pregnancies results in not less than 50 million abortions globally, a lot of them being unsafe and consequently leading, in approximately 80,000 maternal deaths (WHO, 2014).

Studies have shown that some teenagers with unintended pregnancies resort to abortions, which are often performed under unhygienic and potentially life threatening conditions and others bear their pregnancies to term, inviting the risk of morbidity and mortality related to pregnancy and delivery, together with serious social risks (Ebuehi, 2006). This led to a quarter of the estimated 20 million unsafe abortions and 70,000 related deaths each year that occur among women aged 15–19 years (UNDP, 2012). It is estimated that 14 million unintended pregnancies occur every year in sub-Saharan Africa alone, with almost half occurring among women aged 15–24 years (Hubacher, Mavranezouli, & McGinn, 2008). It is evident that use of effective contraceptive methods would potentially prevent 90% of abortions, 20 % pregnancy-related morbidity and a third (32 %) of maternal deaths worldwide(Cleland et al, 2012).
CHAPTER THREE

METHODOLOGY

3.0 Introduction
This chapter presented the methods that were employed to carry out the study. It discussed
the research design, study area, population, sample size, sample and sampling procedure.
Others were data collection method, data analysis and ethical considerations.

3.1 Research Design
This was a descriptive community-based cross-sectional study using a quantitative method.
A cross-sectional study was used because it involved the analysis of data collected from a
population at one specific point in time.

3.2 Study Area
The study was conducted in the Chorkor catchment area. Chorkor is located within the
Ablekuma South sub-district of the Accra Metropolitan Assembly of Ghana. The population
of Accra Metropolitan Assembly (AMA), according to the 2010 Population and Housing
Census, was 1,665,086 representing 42 percent of the region’s total population. Males
constitute 48.1 percent and females represent 51.9 percent. The Metropolis is entirely urban
(100%). It has a youthful population (42.6%) depicting a broad base population pyramid
which tapers off with a small number of elderly persons (60+ years) constituting 5.9 percent.
Accra Metropolitan Assembly where Chorkor is located is the most populated district in
Ghana with majority of the people, 388,403 and 458,075 in the (15-19) years and (20-24)
years range respectively (GDHS, 2014) and 28.7 prevalence of contraceptive usage.
3.3 Study Population

The study population will be all females within the reproductive age group in the Chorkor catchment area.

3.3.1. Inclusion criteria

All female youth from age 15-24 years in the Chorkor catchment area. Respondents who had the assent of parents to be part of the study and also had acknowledged consent.

3.3.2 Exclusion Criteria

All female youth who do not consent to be part of the study.
3.4 Variables

Table 1: presents variables measured

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>INDICATOR</th>
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<tbody>
<tr>
<td>Dependent Variable</td>
<td></td>
</tr>
<tr>
<td>Perception and use of emergency contraception</td>
<td></td>
</tr>
<tr>
<td>Independent Variables</td>
<td></td>
</tr>
<tr>
<td>Sociodemographic characteristics</td>
<td>Age, living arrangement etc</td>
</tr>
</tbody>
</table>

3.5 Sample Size Determination

Adopting sample size formula by Cochran for cross-sectional study:

\[ n = \frac{(Z_{\alpha/2})^2 p (1-p)}{d^2} \]  \( (1) \)

where:

\( n \): sample size

\( p \): the prevalence of contraceptive usage among women (15-49) in the Accra Metropolis

\( p = 28.7\% \) (GDHS, 2014)

\( d \): margin of error, 5%

\( Z_{\alpha/2} = 1.96 \) since \( \alpha = 5\% \) at 95\% Confidence Level

Inputting the above into equation (1), the minimum sample size for external clients required for this study is given by:

\[ n = \frac{(1.96)^2 \times 0.422 \times (1-0.422)}{(0.05)^2} = 314.44 \]

Using expected loss ratio of 10\%, the final minimum sample size was:

\[ n = \frac{314.44}{0.9} = 349.378 \approx 350. \]

Therefore, the final minimum sample size for the clients is 350.
3.6 Sampling Method

Stratified with systematic random sampling with stratum technique was employed to select 350 female participants from age 15 to 24 years. Chorkor was stratified into five strata as 1. Chemunaa, 2. Chorkor Lantemamli, 3. Chorkor Alaji, 4. Woleiamli, 5. Mantsulumli. Random selection of three strata out of the five strata was done for the study. Within each stratum, a systematic random sampling technique was used. The houses in each stratum were numbered and the first house was selected using random number generator and the rest of the houses were selected using random sampling and female youth was selected in a household. Simple random sampling was done depending on the number of the female youth and only those who agreed to partake in the study were randomly selected to participate through balloting, where there were more than one qualified participants. The qualified participants were interviewed until the 350 was obtained. In the absence of a qualified participant, the researcher moved to the next house.

3.7. Questionnaire Design and Administration

A self-administered questionnaire was used. Participants were given consent form to read and sign prior to answering the questionnaire. Questionnaire and consent forms were read out and explained to participants who were not able to read or write and consent form signed by a witness. The questionnaire has six (6) sections. Section A encompassed the demographic characteristics (age, marital status, religion, educational level). Section B consisted of other predictor variables such as age of first sexual encounter, condition of sex (planned/unexpected), to assess the knowledge and awareness of ECs. Section C consisted of questions to assess the attitude of the female youth towards ECs usage. Section D consisted of questions to assess the of perception of ECs usage. Sections E and F helped to
answer questions on the factors influencing EC use and ways of promoting positive perception and use of ECs respectively. Each questionnaire took 15-30 minutes to complete.

3.8 Quality Control

- Pretesting of Data collection tool was done at the James Town community prior to the data collection to validate the survey tools.
- Content of study materials were explained to participants prior to data collection.
- Research assistants (3) were trained to carry out survey accurately.
- Questionnaires were cross checked by principal researcher.

3.9 Data Processing and Analysis

Data from the questionnaires were entered into Microsoft Excel and then transferred to STATA Version 14 and SPSS for cleaning, merging and analysis. Cleaning of the data was done by running frequencies of the variables. This checked inconsistently coded data. Inconsistently coded data were double checked with raw data from the questionnaire. Categorical and numerical data were calculated using simple portions and mean respectively. The results were presented as frequencies, proportions, and percentages. A confidence interval of 95% was used to show significant relations between the dependent and the independent variables.

3.10 Data Storage / Data Protection

Questionnaires were kept in a locked file and stored in a locked cabinet. A soft copy of data collected were coded and locked on a computer using a password and only accessible to principal researcher.
3.11 Pretesting

The questionnaires were designed to reflect objectives of the study. Pretesting of Data collections tools was done at James Town with 10 participants to validate survey tools. The purpose was to establish if the tool was clearly worded and devoid of major biases and can seek the type of information intended. Pretesting was also carried out with the aim of eliminating irrelevant questions so as to make it reliable.

3.12 Ethical Consideration

Ethical clearance and approval was obtained from The Ghana Health Service Ethical review committee Board. Introductory letter from the Department of Population, Family and Reproductive Health (PFRH) of the School of Public Health (SPH) introducing the principal investigator and purpose of the study was sent to Greater Accra Regional Health Directorate for permission prior to the study. Letter was also sent to the head of fishermen, the traditional head of Chorkor.

Written consent was sought from parents or guardians of participants between 15 and 17 years. Participants aged (15-17 years) whose parents/ guardians gave consent but the adolescent refused to participate in the study were excluded as well as an adolescent whose parent refused. Thus, both parties had to agree before the participants were enrolled in the study. Participants were made aware that, participation in this study was entirely voluntary and participants had the option not to participate or to discontinue their participation without any adverse consequence. Participants were given sufficient information about the study to enable them decide whether to take part or not. Participants were assured of the fact that this work is purposely academic and that no harm was intended.

The study did not incur any major cost for participants except the participants’ time that was spent in answering the questionnaire. Written informed consent forms were given to
participants to sign. All informed consents were in English. However, consent forms were read out to participants who could not read and write. Thumbprint of those who agreed were obtained in provided box before signed by witness.
CHAPTER FOUR

RESULTS

4.1 Socio-Demographic Characteristics

This chapter presented the demographic characteristics as well as results and analysis from data gathered from the same respondents. The statistical package used in the analysis were the Stata version 2014 and SPSS version 20. A total of 350 self-administered questionnaires were distributed to the study participants. Table 1 shows the background characteristics of the participants. The age group (18-20) formed the largest participants (36.49%) whilst 25.86% were below 18 years (15-17). only 8.05% (28) of the study participants were married with more than 80% of them (279) being single. Majority of the Study participants (46.26%) reported SHS as their highest level of education followed by 37.64% of participants with up to JHS education. The majority of the participants (95.11%) were Christians. More than one-third 137 (39.48%) of the study participants were living with both parents, 112 and 12 were living with only mother and father respectively. The rest either lived with other family members or had other living arrangements. On the employment status, 136(39.08%) of the participants were employed with the majority 27.21% of them involved in trading. However, 154(44.25%) of participants were students and not working as at the period of the survey.
### Table 2. Background characteristics of study participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
</tr>
<tr>
<td>15 – 17</td>
<td>90 (25.86)</td>
</tr>
<tr>
<td>18 – 20</td>
<td>127 (36.49)</td>
</tr>
<tr>
<td>21 – 22</td>
<td>58 (16.67)</td>
</tr>
<tr>
<td>23 – 24</td>
<td>73 (20.98)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5 (1.44)</td>
</tr>
<tr>
<td>Primary</td>
<td>19 (5.46)</td>
</tr>
<tr>
<td>Middle/JHS</td>
<td>131 (37.64)</td>
</tr>
<tr>
<td>Secondary</td>
<td>161 (46.26)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>32 (9.20)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3 (0.86)</td>
</tr>
<tr>
<td>Christian</td>
<td>331 (95.11)</td>
</tr>
<tr>
<td>Islam</td>
<td>12 (3.45)</td>
</tr>
<tr>
<td>Traditional</td>
<td>2 (0.57)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>279 (80.17)</td>
</tr>
<tr>
<td>Married</td>
<td>28 (8.05)</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>4 (1.15)</td>
</tr>
<tr>
<td>Cohabitation</td>
<td>37 (10.25)</td>
</tr>
</tbody>
</table>
### Table 2. Background characteristics of study participants con’t

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>154(44.25)</td>
</tr>
<tr>
<td>Employment</td>
<td>136(39.08)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>58(16.67)</td>
</tr>
<tr>
<td><strong>Parents/Guardian</strong></td>
<td></td>
</tr>
<tr>
<td>Both parents</td>
<td>137(39.48)</td>
</tr>
<tr>
<td>Mother</td>
<td>100(28.82)</td>
</tr>
<tr>
<td>Father</td>
<td>12(3.46)</td>
</tr>
<tr>
<td>Other family members</td>
<td>32(9.22)</td>
</tr>
<tr>
<td>Others</td>
<td>66(19.02)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Beautician</td>
<td>7(5.15)</td>
</tr>
<tr>
<td>Hairdressing</td>
<td>22(16.18)</td>
</tr>
<tr>
<td>Seamstress</td>
<td>29(21.32)</td>
</tr>
<tr>
<td>Trading</td>
<td>37(27.21)</td>
</tr>
<tr>
<td>Other professionals</td>
<td>41(30.15)</td>
</tr>
</tbody>
</table>

### 4.2 Awareness and knowledge of EC

Regarding the awareness and knowledge of ECs, more than two-third (81%) of the study participants had ever heard of ECs as shown in fig 2. Moreover, 74.71% of the participants reported they knew the purpose of family planning. Study participants were asked to indicate the source of EC information by ticking from multiple choice answers provided. Among those who heard about EC, 24.82% of participants reported they heard it from the media (Television and Radio) followed by 12.41% and 7.09% hearing from friend/mates and
health professionals respectively. Generally, 48.94% of the total had heard about ECs from more than one source as shown in fig.3.

**Respondents’ knowledge and awareness of emergency Contraceptives**

**Figure 4.1: Participant’s knowledge on purpose of family planning**

![Bar chart showing participant's knowledge on purpose of family planning](image1.png)

**Figure 4.2: Information on Emergency contraceptive**

![Pie chart showing information on emergency contraceptive](image2.png)
Figure 4.3: Participant’s sources of information on Emergency Contraceptive

4.3 Access and attitude towards ECs use

Majority of the study participants (76%) had never used EC. Among the sexually active, less than one-third (22%) of the participants reported ever using EC. 59(77%) reported that they used EC sometimes whilst 11(14%) and 7(9%) indicated having used EC most of the time and all the time respectively. More than two-third (72.9%) of the participants indicated that they do not know when EC can be used to effectively avoid unwanted pregnancy. However, 13.22%, 7.47% and 1.72% of participants were correct, reported effective EC use within 24, 72 and 120 hours respectively after unprotected sexual intercourse. Most of the participants (31.61%) who used EC reported the source of access as the pharmacy, over the counter followed by access from friends as indicated by 10.96% of the participants. Majority of them (69%) use either drug such as oral contraceptives or methods such as douching as emergency contraceptives, however about 9% used Levonorgestrel (Postinor - 2) as emergency contraceptives.
Figure 4.4: Participant’s use of Emergency Contraceptive

Figure 4.5: Frequency of Emergency Contraceptive usage by participants (who ever use EC).
Figure 4.6: When to use Emergency Contraceptives effectively

Figure 4.7: Participants knowledge on how Emergency Contraceptives can be accessed
4.4. Study participants’ perception of ECs

About 50% of study participants indicated that emergency contraceptive use was against their religious doctrines, however, 39% of them said they would use emergency contraceptives even if it is against their religious beliefs. In addition, 63% of them considered the side effects of emergency contraceptive to be high and thus fear to use it. Regarding promiscuity, about 60% of study participants were of the opinion that emergency contraceptives promote promiscuity hence increase the prevalence of HIV/AIDS and other STIs. 51% of them reported they would use some form of emergency contraceptive if they have unintended sexual intercourse. Emergency contraceptives are perceived by 196 out of the total number to be safe for its users whilst about 30% will not use emergency contraceptives because they value a lot of children.

4.5 Factors that influence the use of emergency contraception

From table 3 as shown below, 128 (36.78%) of the study participants reported multiple factors such as availability, Religious reasons, spouse consent, regular contraceptive use, desire of pregnancy and others (cost) influencing their use of EC.

Table 3. Factors that influence the use of EC

<table>
<thead>
<tr>
<th>Factors</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>60(17.24)</td>
</tr>
<tr>
<td>Regular use</td>
<td>12(3.45)</td>
</tr>
<tr>
<td>Spouse consent</td>
<td>18(5.17)</td>
</tr>
<tr>
<td>Religious reasons</td>
<td>25(7.18)</td>
</tr>
<tr>
<td>Desirous of pregnancy</td>
<td>7(2.01)</td>
</tr>
<tr>
<td>Multiple factors</td>
<td>128(36.78)</td>
</tr>
<tr>
<td>Others</td>
<td>4(1.15)</td>
</tr>
<tr>
<td>None</td>
<td>94(27.01)</td>
</tr>
</tbody>
</table>
Emergency contraceptive use and other variables

A Pearson chi-square test at 95% confidence interval and p-value of < 0.005 was calculated to establish any association between EC use and other variables. From the result, marital status (p< 0.001), employment status (p<0.001) and religious affiliation(p=0.005) revealed significant association with EC use as showed in the table below. However, educational level and age at sexual debut had no association with EC use.

Table 4. EC use by socio-demographic characteristics of participants

<table>
<thead>
<tr>
<th>Variables</th>
<th>Ever used EC</th>
<th>X^2 Chi-square</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>2</td>
<td>8.44</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>JSS</td>
<td>24</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>SSS</td>
<td>42</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td>6</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>0</td>
<td>12.77</td>
</tr>
<tr>
<td>Christian</td>
<td>69</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Trad</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>49</td>
<td>232</td>
<td>21.37</td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cohabit</td>
<td>16</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>17</td>
<td>138</td>
<td>21.16</td>
</tr>
<tr>
<td>Employed</td>
<td>39</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>21</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Age @ sex debut</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 18</td>
<td>30</td>
<td>39</td>
<td>0.65</td>
</tr>
<tr>
<td>More than 18</td>
<td>35</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER FIVE

DISCUSSION

This chapter discussed the findings of the study. Also, it involved comparison of the study findings with similar studies carried out elsewhere. The study was aimed at assessing the perception and use of Emergency contraception among the female youth of Chorkor.

The source of information on EC plays a very important role in determining its accurate use especially with respect to correct perception and attitudes towards EC use. In this study, majority (81%) had ever heard of EC. This result was by far higher than study by Ellen, A. B. et al 2014 among adolescents on the use of contraceptives in Kintampo, Ghana. The mass media and friends were reported to be most sources of information rather than health workers in health facilities who have received formal training. The implication could be that most of the health workers do not have adequate knowledge or some of them feel reluctant to discuss with youth because they have negative attitudes towards premarital sex by the youth. However, the source of access on EC in the study concurred with the same study which showed that majority of the respondents reported accessing contraceptives from the pharmacy with very few of them from health care facilities. This could probably be due to availability and easy access to pharmacy shops in these communities. In contrast, the youth especially adolescents are more likely to be rebuked, ridiculed, stigmatized as ‘bad girls’ or sometimes driven away at health facilities by service providers. However, this could also be due to unavailability of health facilities to provide reproductive health services. In spite of this, EC usage was low among the female youth 81% who have heard of EC, only 22% used EC. This thus concurs with study done by Harper and Ellertson (1995) who found that despite convenient access and high basic awareness of EC, usage was low mainly because specific knowledge was lacking leading to misconception. Findings on correct timing of
EC showed that majority of participants (77.99%) do not when to correctly use EC. This result can be compared with study done by Musah, M. B. 2016 among university students of Professional Studies, Ghana, who reported that majority (80.2%) of participants indicated not knowing when to use. However, 31.3% and 21.4% of the participants said they use EC within 24 and 72 hours respectively which is higher than 13.22% and 7.47% of study respondents in Chorkor correctly reporting EC effective usage within 24 and 72 hours respectively.

The use or non-use of EC is dependent on the perception of the respondents about EC. Some of the perceptions are indication of lack of in-depth knowledge on EC. In this study, majority (63%) of the study participants perceived side effects of EC therefore fear to use it. This corroborates with study done earlier (Wambugu Constala Judy Njeri, 2013) which reported that 46.8% of the participants strongly agree that EC has side effects thus fear to use. This remains a key barrier to EC use among the youth. Thus, the creation of health information centers in the community where in privacy questions on family planning services can be discussed should be addressed. Also, more than half of the study participants perceived EC use to promotes promiscuity and hence increase the prevalence of HIV/AIDS and STIs. This concurred with Wambugu, C. J., N. 2013 where 54% and 49.2% of the participants strongly agreed EC use promotes the prevalence HIV/AIDS and promiscuity respectively.

Findings with regards to factors that influence participants’ use of EC, 36.78% of them reported multiple factors such as availability (17.24), religious reasons (7.18%), spousal consent (5.17%) and desirous of pregnancy and value of children (2.01%).

The result on EC use and other variables showed significant association with employment status, marital status and religious affiliation. This finding corroborates with study done by Musah M. B. 2016 which showed marital status had significant association (P<0.017) with
EC use. However, a study done by Wright, K. O. et al (2014) in Nigeria revealed no significant impact of religion on EC use and this was inconsistent with this current study.

5.1 Study Limitations

The survey addressed sensitive subject matter which involved asking the female youth sensitive questions about their private sexual lives. These enquiries had possibility of making them feel unease to give their answers. High level of privacy and confidentiality was however maintained to ensure that participants were at ease to give their answers. Also, similar age groups trained field workers as the study participants administered the questions to help make the participants comfortable to talk.

The study focused on only females and used only quantitative design.

Data collection process was interrupted intermittently due to approval for data collection in June, a raining season in Ghana. This prolonged the data collection process.
CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presented the summary of the research activities and the concerns that were noticed from the study. It also presented key findings and provides conclusions and vital recommendations. The study aimed to assess the perception and use of EC among female youth of Chorkor. The high awareness of EC among the female youth of Chorkor is not reflected in positive attitudes towards its use. Although majority of the participants had heard about EC with the highest source of information from the media, there was low use of EC as well as the right time to use EC effectively to prevent unwanted pregnancy after unprotected sexual intercourse. Moreover, low usage of EC among the youth was due to factors such as fear of side effects of EC, religious reasons, increased promiscuity leading to high prevalence of HIV/AIDS. Clearly, the study evidenced major gaps in accurate information, timing and correct use of EC. These gaps hampered the youths’ ability to benefit from the purpose of EC Thus, there is the need to improve availability and accessibility of accurate information on EC and its correct usage to the youth of Chorkor to help them make informed choice regarding EC.

6.2 Recommendations

Policy-related recommendation

Establishment of youth-friendly centers in the community by Ghana Health Service and NGOs such as Plan Parenthood Association of Ghana (PPAG) is important for the youth to confidently seek Contraceptive services.
**Practice-related recommendations**

Health education programs need to be organized by the Accra metropolitan health directorate to avail accurate information about EC to the youth. This will help to dispel fear of side effects of EC and other misconceptions about EC.

Health promotion strategies should also be directed towards improving EC and other contraceptives utilization among the sexually active youth as part of the package of comprehensive reproductive health in schools.

**Research-related recommendation**

The study focused on only female youth. Thus, the need for public health researchers to conduct similar study in the community comprising both male and female youth of Chorkor.
REFERENCES


Ellen, A. B; Kwaku, P. A; Emmanuel, M; Grace, M; Emmanuel, K. A; Elisha, A. & Seth, O. A. 2014. Use of contraceptives among adolescents in Kintampo, Ghana: A cross-sectional study.


APPENDICES

APPENDIX 1

INFORMED CONSENT FOR RESPONDENTS

Title: Emergency Contraception: Perception and use among Female Youth of Chorkor

Principal Investigator: Raphael Amoanor

Address: College of Health Sciences, School of Public Health, Department of Population Family and Reproductive Health (PFRH), University of Ghana, Legon.

Email: ralphamoanor@yahoo.com Telephone: 0574122557

Supervisor: Dr. Alfred E. Yawson

Email: aeyawson@ug.edu.gh Telephone: 0206301049

Introduction

Dear Participants, Emergency contraception (EC), or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first 5 days after sexual intercourse. Adolescent females after unprotected sexual intercourse are susceptible to unwanted pregnancies and its consequences. This study therefore seeks to assess the perception and use of EC among the female youth (15-24years) of Chorkor to help inform contraceptive policy and use.

Procedure, Possible Risk and Benefits

It will involve the use of questionnaire with both close and open ended questions. You may feel uncomfortable talking about some of the topics during the answering the questionnaire. Each questionnaire will take 15-20 minutes on the average to complete. No direct benefit to
participant, however the outcome of this study will be used to inform policy on the utilization of emergency contraceptives.

**Right to Refuse and Confidentiality**

Your participation in this study is voluntary and you are at liberty to withdraw at any time. There will not be any penalty in opting out of this study or not answering any question. This study has been reviewed and approved by the Ethical Review Committee of Ghana Health Services. Participant personal identification such as names and address will not be written on questionnaire. Each questionnaire will be given a unique identification number.

**PARTICIPANT CONSENT FORM**

I have been thoroughly briefed on the entire methodology and significance of the ongoing study which is being conducted by Raphael Amoanor. On my own free will, I hereby consent to be part of the study, based on my understanding of what the study entails.

I am doing this on condition that under no circumstance should my references be made to my actual identity to any other person(s) after providing all the information requested from me for this particular study as promised by the researcher.

Respondent signature…………………… Date ……………………………

Thumbprint .

Date ……………………………
INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the respondent has been given ample time to read and learn about the study.

All questions and clarifications raised by the respondent have been addressed.

Name ………………… signature…………………… Date……………………

If you have questions you may contact Ms. Hannah Frimpong on 0243235225, hannah.frimpong@ghsmail.org and Raphael Amoanor, SPH, UG on 0574122557.
APPENDIX 2:

LETTER OF ASSENT

I am Raphael Amoanor, a student from the School of Public Health, University of Ghana, Legon. I am conducting a research on the Perception and use of Emergency Contraception among the female youth of Chorkor.

The youth after unprotected sexual intercourse are vulnerable to unwanted pregnancies which may lead to unsafe abortion and its related consequences. As a participant, your child will help Public Health professionals and government to make good policies on Emergency Contraception accessibility and right usage.

The study will take an average of 20 minutes to complete the questionnaire. Your child’s participation is voluntary and you have the right to refuse her from participating or withdraw from the study at any time. No penalties or negative consequences will result from withdrawal. All responses will be treated as confidential as no names will be placed on the testing instrument; neither will it be shown to anyone without you or your child’s permission. However, I hope you will allow your child to participate fully since her view like other female youth is important.

If you want to ask anything more about the exercise, I am ready to answer.

Please confirm your consent by ticking in the box below.

☐

I, by ticking inside the box give my informed consent for my daughter to participate in the study with full awareness of the purpose and conditions of the information given.

Signature…………………… Date……………………

P.I/ Research Assistant’s name…………………… Date……………………
## APPENDIX 3: QUESTIONNAIRE FOR RESPONDENTS

### SECTION 1: DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>RESPONSE</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 What is your age?...............................(In completed years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 What is your highest level of education?</td>
<td>• None [ ]</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Primary [ ]</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Middle/JSS [ ]</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• Secondary [ ]</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• Tertiary [ ]</td>
<td>5</td>
</tr>
<tr>
<td>3 What is your religious affiliation?</td>
<td>• None [ ]</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Christianity [ ]</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Islam [ ]</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• Traditional [ ]</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• Other (Specify)……………</td>
<td>5</td>
</tr>
<tr>
<td>4 How often to you attend Religious services?</td>
<td>• At least once a year [ ]</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• At least a month [ ]</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• At least once a week [ ]</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• Daily [ ]</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• Never [ ]</td>
<td>5</td>
</tr>
<tr>
<td>5 What is your current marital status?</td>
<td>• Single [ ]</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Married [ ]</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Divorced/Separated [ ]</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>• Cohabitation [ ]</td>
<td>4</td>
</tr>
<tr>
<td>6 What is your employment status?</td>
<td>• Student [ ]</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Employed [ ]</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>• Unemployed [ ]</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>If employed, what is your occupation?</td>
<td>state...............................</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>8</td>
<td>Whom do you live with?</td>
<td>• Both parents [ ]&lt;br&gt;• Mother [ ]&lt;br&gt;• Father [ ]&lt;br&gt;• Other family members&lt;br&gt;• Other (Specify)</td>
</tr>
</tbody>
</table>

**SECTION B: RESPONDENTS’ KNOWLEDGE AND AWARENESS OF ECs**

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>RESPONSE</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Are you familiar with the purpose of family planning or Planned Parenthood?</td>
<td>• Yes [ ]&lt;br&gt;• No [ ]</td>
</tr>
<tr>
<td>10.a</td>
<td>Have you ever heard or received information on ECs?</td>
<td>• Yes [ ]&lt;br&gt;• No [ ]</td>
</tr>
<tr>
<td>10.b</td>
<td>If YES, which was/ were the source(s) of information? Tick the appropriate</td>
<td>• Family [ ]&lt;br&gt;• Partner/Boyfriend [ ]&lt;br&gt;• Friend/classmates [ ]&lt;br&gt;• Health professional [ ]&lt;br&gt;• Church [ ]&lt;br&gt;• Media [ ]&lt;br&gt;• Other sources (please state)</td>
</tr>
</tbody>
</table>

**SECTION B: RESPONDENTS’ KNOWLEDGE AND AWARENESS OF ECs Con’t**

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>RESPONSE</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Have you ever been involved in sexual intercourse?</td>
<td>• Yes [ ]&lt;br&gt;• No [ ]</td>
</tr>
<tr>
<td>12</td>
<td>Are you aware of the risks associated with unprotected sex?</td>
<td>• Yes [ ]&lt;br&gt;• No [ ]</td>
</tr>
</tbody>
</table>
13. What are some of the risks? Tick the appropriate

- Unwanted pregnancies [ ]
- Contracting HIV/AIDS [ ]
- Contracting STIs
- Other (Specify)………..

14. Do you know that ECs can be used to prevent unwanted pregnancy after unprotected sex?

- Yes [ ]
- No [ ]

15. Which of the following modern ECs have you heard of?

- Progesterone Only Pills [ ]
- Combined oral contraceptive pills
- Intrauterine Copper Device [ ]

16. What are some of the traditional methods used to prevent unwanted pregnancies?

………………………………

### SECTION C: ACCESS AND ATTITUDES TOWARDS THE USE OF ECs

17. Have you ever used any form of Contraception?

- Yes [ ]
- No [ ]
- Don’t know [ ]

18.a Have you never used ECs?

- Yes [ ]
- No [ ]
- Don’t know [ ]

18.b If Yes, how frequently do you use ECs

- Sometimes [ ]
- Most of the time [ ]
- All the time [ ]

### QUESTIONS RESPONSE CODE

19. When do you use ECs to effectively prevent pregnancy after sex? Tick as many as are appropriate

- Within 24 hrs [ ]
- Within 72 hrs [ ]
- Within 120 hrs [ ]
- Until one’s period [ ]
- Even after a missed period[ ]
- I don’t know [ ]

20. How can you access ECs? Tick as many as are applicable

- Friends [ ]
- Parents [ ]
- Other family members [ ]
<table>
<thead>
<tr>
<th>21</th>
<th>What drugs/method do you use as EC? Tick as many as are applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Combined oral pills [ ]</td>
</tr>
<tr>
<td></td>
<td>• Intrauterine copper device [ ]</td>
</tr>
<tr>
<td></td>
<td>• Levonorgestrel-only pills (portinor2 [ ]</td>
</tr>
<tr>
<td></td>
<td>• Herbal vaginal pessaries [ ]</td>
</tr>
<tr>
<td></td>
<td>• Bitter medications e.g. Quinine [ ]</td>
</tr>
<tr>
<td></td>
<td>• Strong alcoholic drinks e.g. Brandy, Whisky</td>
</tr>
<tr>
<td></td>
<td>• Hot bath and douching immediately after sex [ ]</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22</th>
<th>When did you last use EC?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Has experienced condom breakage or slippage [ ]</td>
</tr>
<tr>
<td></td>
<td>• Has experienced failed Interruptus Coitus (withdrawal) during sex [ ]</td>
</tr>
<tr>
<td></td>
<td>• Has a miscalculation of rhythm method [ ]</td>
</tr>
<tr>
<td></td>
<td>• Has just had unexpected unprotected [ ]</td>
</tr>
<tr>
<td></td>
<td>• Other (please state) ……</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

SECTION D: PERCEPTION OF ECs. Q23. Please tick your opinion using the scale indicated, SA: Strongly agree, A: Agree, N: Neutral, D: Disgrace and SD: Strongly disagree

<table>
<thead>
<tr>
<th>CODE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>OPINION</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>

It is against religious doctrines to use ECs

I use ECs even if it is against my religious beliefs
EC has significant side effects thus fear to use it

ECs promotes promiscuity hence increase the prevalence of HIV/AIDS and other STIs

If I have unintended sexual intercourse, I would use a form EC

ECs are safe for its users

I don’t use ECs to prevent pregnancy because I value a lot of children

<table>
<thead>
<tr>
<th>24</th>
<th>What factors influence your use of ECs? Tick as many as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Availability of ECs [ ]</td>
</tr>
<tr>
<td></td>
<td>Use of regular contraception method [ ]</td>
</tr>
<tr>
<td></td>
<td>Partner/Spousal consent [ ]</td>
</tr>
<tr>
<td></td>
<td>Religious reasons [ ]</td>
</tr>
<tr>
<td></td>
<td>Desirous of pregnancy and value of children [ ]</td>
</tr>
<tr>
<td></td>
<td>Other (please state)........</td>
</tr>
<tr>
<td></td>
<td>None of the above</td>
</tr>
</tbody>
</table>

SECTION F: STRATEGIES TO PROMOTE POSITIVE PERCEPTION AND USE OF ECs

25 In your opinion what strategies can be used to promote positive perception and use of ECs.

THANK YOU FOR YOUR CO-OPERATION