

**ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE OF EMERGENCY
CONTRACEPTION AMONG FEMALE STUDENTS AT KAMPALA
INTERNATIONAL UNIVERSITY-WESTERN CAMPUS.**

BY

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BMS/0080/91/DU

**A DISSERTATION SUBMITTED TO THE FACULTY OF CLINICAL MEDICINE
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DECLARATION

I **Muwesi Daniel (BMS/0080/91/DU)** declare that this research titled “Assessment of knowledge attitude and practice of emergency contraception among female students at Kampala International University- Western Campus ” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE

DATE:

SUPERVISOR'S APPROVAL

This research project report has been done under my supervision and is ready to be submitted for examination with my approval.

Supervisor: **Dr. Saima**

.....

SIGNATURE

.....

DATE

Table of Contents

DECLARATION	i
SUPERVISOR’S APPROVAL	ii
DEDICATION	vi
ACKNOLWEDGMENT	vii
ABSTRACT	viii
LIST OF ACRONYMS	ix
CHAPTER ONE: INTRODUCTION	1
1.1 BACKGROUND	1
1.2 PROBLEM STATEMENT	3
1.3 OBJECTIVES	3
1.3.1 BROAD OBJECTIVE	3
1.3.2 SPECIFIC OBJECTIVES	3
1.4 RESEARCH QUESTIONS.....	3
1.5 JUSTIFICATION	4
CHAPTER TWO: LITERATURE REVIEW	5
2.1 Introduction.....	5
2.2 Knowledge about emergency contraception	5
2.3 Attitude towards emergency contraception.....	6
2.3 Practice of emergency contraception	6
CHAPTER THREE: METHODOLOGY	8
3.1 STUDY AREA	8
3.2 STUDY DESIGN.....	8
3.3 STUDY POPULATION	8
3.4 SAMPLE SIZE DETERMINATION	8
3.5 SAMPLING METHOD	8
3.6 INCLUSION AND EXCLUSION CRITERIA	9
3.7 STUDY LIMITATIONS.....	9
3.8 DATA ANALYSIS.....	9
3.9 OPERATIONAL DEFINITIONS	9
3.10 DISSEMINATION OF RESULTS	9
3.11 ETHICAL CONSIDERATIONS	9

CHAPTER FOUR RESULTS	10
4.1 Participation rate	10
4.2 Demographic distribution	10
4.3 Knowledge about emergency contraception	10
4.4 Attitude towards emergency contraception.....	11
4.5 Practice of emergency contraception	11
FIGURE 1: Religious distribution of respondents	12
FIGURE 2: Distribution of respondents according to year of study	13
FIGURE 3: Distribution of awareness about emergency contraception	14
TABLE 1: Age distribution of respondents	15
TABLE 2: Source of information about emergency contraception	15
TABLE 3: Methods used in emergency contraception.	16
TABLE 4: Distribution of respondents according to knowledge about emergency contraception.....	16
TABLE 5: Attitude of respondents towards emergency contraception	17
FIGURE 4; Comparing year of study and level of knowledge about emergency contraception	18
CHAPTER FIVE DISCUSION	19
5.1 Knowledge about emergency contraception	19
5.2 Attitude towards emergency contraception.....	19
5.3 Practice of emergency contraception	19
5.4 Limitations of study	20
5.6 Conclusion	20
5.7 Recommendations.....	20
REFERENCES	21
APPENDICES	24
APPENDIX I; CONSENT FORM.....	24
APPENDIX II: QUESTIONIER.....	25
APPENDIX II; BUDGET	27
APPENDIX III; Map of Uganda showing location of Bushenyi district	28
APPENDIX IV; Map of Bushenyi District	29
APPENDIX V; Map of Ishaka showing Kampala International University Western Campus.	30
APPENDIX VI; TIME FRAME.	31

DEDICATION

I dedicate this research to my family, especially my father and mother Mr. and Mrs. Muyingo Godfery for your unconditional support with my studies. I am honored to have you as my parents. Thank you for believing in me and giving me a chance to prove and improve myself through all my walks of life please do not ever change. I love you.

To my classmates and to the KIU-WC lecturers that have been my guidance throughout this course I wish you all the best and may God continue blessing you.

ACKNOWLEDGMENT

I would like to thank the Almighty God for giving me the opportunity to be where I am, what I've become and what he has done and so far accomplished in my life, I would also like to acknowledge my supervisor Dr. Saima whose scholarly advice, help, constant encouragement and support have contributed generously to my study. My gratitude goes to medical library staff for making reference books available for my study.

My appreciation also goes to students at KIU-WC who willingly accepted to participate in the study and helped me in carrying out the study.

To you all, may the good Lord Almighty reward you accordingly.

ABSTRACT

OBJECTIVE: The objective of this study was to estimate the general knowledge, attitude and practice of Emergency Contraception (EC) among female students at Kampala International University-Western Campus.

METHOD: A questionnaire was constructed to assess knowledge, attitudes and practice of EC. There were 217 female students approached and each filled a questionnaire which was used to assess the knowledge, attitude and practice of EC.

RESULTS: 67% of the female students knew about ECs while 33% didn't know. Majority 40% obtained the information from health education/lecture. Those that knew about EC were assessed further for knowledge attitude and practice. The generally knowledge about EC was fair at 47%. The attitude toward EC was positive and the practice of EC was generally low at only 4%. There was a significant number of students with poor knowledge about EC of 31%.

CONCLUSION: The general level of knowledge about ECs was fair. The general attitude of students towards ECs was positive. The practice of EC was low at only 4%. This study will help policy-makers by providing evidence-based knowledge to promote EC use among university students.

Keywords: Female student, Knowledge, Attitude, Practice, Emergency contraception

LIST OF ACRONYMS

COCs:	Combined Oral Contraceptives
EC:	Emergency contraception
ECPs:	Emergency contraceptive pills
FDA:	Food and Drug Administration
IUDs:	Intrauterine devices
KIU-WC:	Kampala International University Western Campus
OTC:	Over The Counter
POPs:	Progestin Only Pills
WHO:	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

Emergency contraception, or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first few days after intercourse. It is intended for emergency use following unprotected intercourse, contraceptive failure or misuse (such as forgotten pills or torn condoms), rape or coerced sex (WHO 2012).

Emergency contraception is a method of preventing unwanted pregnancy resulting from unintended sexual activity, contraceptive failure or sexual assault (Gebeyohanis 2009) as well as from a lack of knowledge about or access to contraception. Its primary use is in reducing the need for abortions and the negative maternal health consequences associated therewith (Lemma 2009). In the early 1990s, nearly one-third of emergency contraception pills (ECP) prescribed in the USA were for rape victims (Grossman 1994)

The history of emergency contraception (EC) dates back to 1500 B.C. when sneezing, hopping, jumping, dancing, and douching with various herbs and roots were used to prevent contraception. In the late 1960s, post-coital douching with Coca Cola was rumored to work (LaValleur 2000). Earlier methods relied primarily on douches and disinfectants, sometimes marketed as famine hygiene products to avoid restrictive legislation concerning birth control apparatus.

The first documented EC was published in the 1960's when physicians in the Netherlands administered estrogen extracts to 13 years old girl who had been sexually assaulted to prevent pregnancy (Ellertson 1996).

There are two methods of emergency contraception and these are emergency contraception pills (ECPs) and copper-bearing intrauterine devices (IUDs).

Trials on ECPs were first described in the 1930s using high doses of stilbestrol (Morris et al 1966), high rates of gastrointestinal side effects limited the widespread use of this method. The ECP regimen first approved by the U.S. Food and Drug Administration (FDA) is commonly called the Yuzpe regimen, named after A. Albert Yuzpe a Canadian Professor who in 1974 published the first studies demonstrating the safety and efficacy of an EC regimen (Yuzpe 1977). The initial regimen contained 0.1 mg ethinylestradiol and 0.5 mg levonorgestrel, given within 72 hours after sexual contact and repeated after 12 hours (Yuzpe et al 1977).

In September 1998, the FDA approved the application of Gynetics, Inc. (Belle Mead, NJ) to market Preven, the country's first dedicated EC product. The Preven regimen consisted of four combined hormonal pills, each containing 0.1 mg of ethinyl estradiol and 0.5 mg of

levonorgestrel. The package contained a urine pregnancy test, instructions, and 4 pills to be taken two at a time, 12 hours apart (Hatcher et al. 2004)

In July 1999, the FDA approved Plan B, the second dedicated EC product. Now produced by Barr Pharmaceuticals (Woodcliff Lake, NJ), Plan B is a progestin-only medication that consists of 2 pills, each containing 750 mcg of levonorgestrel. The regimen not only requires fewer pills than the Preven regimen (2 pills with Plan B, as opposed to Preven's 4), but has been shown to have similar efficacy with fewer side effects (Ellertson et al. 2003)

Although Preven is still considered safe and effective, it was withdrawn from the market in 2004 because of the high demand for Plan B,

The currently recommended ECP by WHO is 1.5 mg of levonorgestrel as a single dose (WHO 2007). In recent WHO study, the pregnancy rate after use of levonorgestrel (1.1) was significantly lower than that following Yuzpe use (3.2) (WHO 1998). When taken the Levonorgestrel ECPs prevent pregnancy by preventing or delaying ovulation. They may also work to prevent fertilization of an egg by affecting the cervical mucus or the ability of sperm to bind to the egg, however they are not effective once the process of implantation has started (WHO 2012).

Based on reports from nine studies including 10 500 women, the WHO-recommended levonorgestrel regimen is 52–94% effective in preventing pregnancy and is more effective the sooner after intercourse it is taken. Levonorgestrel-alone ECPs are very safe and do not cause abortion or harm future fertility. Side-effects are uncommon and generally mild.

Postcoital insertion of a copper IUD for EC was first reported in the literature in 1976 (Lippes et al 1976). WHO recommends that a copper-bearing IUD, as an emergency contraceptive, be inserted within five days of unprotected intercourse. This may be an ideal emergency contraceptive for a woman who is hoping for an ongoing, highly effective contraceptive method. One of the advantages of this method of EC is that once inserted it can be used as an ongoing contraceptive method.

The primary mechanism of action of the copper IUD is to work as a spermicide to prevent fertilization if inserted days prior to ovulation. The copper IUD can also function to prevent implantation by causing an inflammatory response of the endometrium. The IUD does not act as an abortifacient and does not disrupt an already implanted embryo. The copper IUD is 94% to 99% effective at preventing pregnancy when inserted up to 120 hours after unprotected intercourse (Hatcher et al 2004).

Related literary sources suggest that, for most of the youth, tertiary education represents a shift toward greater independence from home – an opportunity to form new friendships and, for some, an opportunity to experience romantic and/or sexual relationships.

Higher education students' unwanted pregnancies pose a major public health problem globally. This problem is also presents in Uganda. Unwanted pregnancies have a notable detrimental impact on the learners' trajectory and have been associated with jeopardising the students' educational progress and future career prospects. These pregnancies are mostly unplanned and unintended and many result in unsafe abortions.

Predecessor research suggests that 'emergency contraception (EC) can substantially reduce a woman's chance of becoming pregnant when taken soon after sex. By inference, this offers protection from the negative consequences of unplanned pregnancies as described above.

1.2 PROBLEM STATEMENT

Unintended pregnancy poses a major challenge to reproductive health of young adults in developing countries. Some young women who had unintended pregnancies obtain abortion. Many of which are performed in unsafe condition and others carry their pregnancies to term, incurring the risk of morbidity and mortality higher than those for adult women. This poses a range of major public health problems – including an increased risk of complications associated with illegal abortions in the country – and may be associated with dropout and non-completion of education amongst students due to unintended pregnancies.

Among various forms of contraception emergency contraceptive are the only one that can be used after sexual intercourse offering chance to prevent unwanted pregnancy. Therefore the objective of this study is to determine knowledge, attitude and practice of emergency contraception.

1.3 OBJECTIVES

1.3.1 BROAD OBJECTIVE

To assess knowledge, attitude and practice of emergency contraception among female student at Kampala International University Western Campus (KIU-WC).

1.3.2 SPECIFIC OBJECTIVES

1. To assess the knowledge about EC among female students at KIU-WC
2. To assess the attitude towards EC among female students in KIU-WC
3. To assess the practice of EC among female students in KIU-WC

1.4 RESEARCH QUESTIONS

1. How much do female students at KIU-WC know about emergency contraception?
2. How did the female students get to know about emergency contraception?
3. What is the attitude towards emergency contraception among female students at KIU-WC?
4. What is the prevalence of practice of emergency conception among female student at KIU- WC?

1.5 JUSTIFICATION

One of the issues in primary health care, is family planning which plays an effective role in the reduction of unwanted pregnancy (Byamugisha et al 2010). Unwanted pregnancies are a major public health problem in the developed and developing countries. These pregnancies usually result into unsafe abortion.

Each year an estimate of 19 million unsafe abortions are done costing some 68000 women their lives (WHO 2007). Unsafe abortion is one of the greatest health risk that a young woman can face and the primary reason for this, is unintended pregnancy (Sedgh, Bankole et al. 2006).

With increased knowledge and use of ECs the number of unwanted pregnancies occurring mostly among young women can be reduced and this will in turn reduce on the rate of unsafe abortions.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

One of the issues in primary health care, is family planning which plays an effective role in the reduction of unwanted pregnancy (Byamugisha et al 2010). Unwanted pregnancies are a major public health problem in the developed and developing countries. These pregnancies usually result into unsafe abortion.

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2.2 Knowledge about emergency contraception

Knowledge of EC is crucial since women must know that there is a method that can prevent pregnancy after intercourse in order to seek treatment (Westley 1998). It is important that potential users have information and are educated about EC before they can actually need it (Virjo et al 1999). Friend or media are at times the best sources of information about EC (Wetterholm et al. 1998).

Research has been done Kenya (Gichangi, Karanji et al. 1999), Ghana (Steiner, Raymond et al. 2000) and Ethiopia (Kebede 2006). In all these studies it was found that the awareness and knowledge about EC is insufficient.

The efficacy of EC is dependent on how soon after the unprotected intercourse treatment is administered. If women are to benefit from EC they need to have prior knowledge and easy access to the method since it has a time limit. One study reported that 74% of the students had heard of emergency contraception (EC); however, less than one-third knew the prescription status, common side effects or mechanisms of ECP (Jamili et al. 2007).

Studies have shown that EC options are under-utilized because of the lack of client awareness (Jamieson et al. 1999). Studies have shown that there is limited knowledge of EC among health providers ranging from obstetricians/gynecologists (Delbanco et al. 1997), and nurses and midwives (Gichangi et al.1999), to students and potential users (McDonald et al. 1999). EC has been regarded as the “best kept secret” (Bell et al 1999). However in high income countries, it is no longer a secret (CTU 1998) as opposed to low income countries.

A survey conducted among tertiary level students in Trinidad to measure their awareness and knowledge of ECs found that although young people knew about EC, they were not clear about its mechanism of action, how it works, its contraindications and the time frame for use.

According to data from Demographic and health surveys (DHS) there has been an increase in EC knowledge among women 10.3% (2000-01), 13.6% (2006) upto 30.7% (2011)

A literature review conducted in 2000 concluded that the media (newspapers, magazines, TV, radio) is a popular source of information for many people. Respondents stated the media was a more frequent source of information specifically concerning EC, more than health care provider or school (Ellertson et al. 2000).

However media is also contributes to the confusion regarding EC. In 2005 a study on content coverage about EC in newspapers between 1992 and 2002 and found that approximately 40% of all the articles included atleast one instance of confusion between EC and medical abortion (Pruitt et al 2005)

2.3 Attitude towards emergency contraception

The attitude towards EC is mostly determined by the religious and cultural norms, and media information. Many misconceptions and misunderstandings abound regarding Emergency Contraceptive (ECs) pills. Some of the misconceptions are that The emergency contraceptive pill can only be taken the “morning after” unprotected sex, The emergency contraceptive pill can only be taken three times over a woman’s lifetime, and The emergency contraceptive pill encourages women and girls to have unprotected sex and to stop using regular methods of contraception. All these myth affect the use of EC.

A review article reveals that ECs may act by interference with tubal transport of sperm, egg or embryo or by histological or biomedical changes within the endometrium that may result in failure of implantation (Rivera et al 1999). This uncertainty regarding the mechanism of EC causes many of the misconceptions.

There is also concern that EC is often confused with the "abortion pill", RU-486, this confusion has a great impact on the attitude towards EC since some people will consider EC as abortion which is illegal in Uganda. Also the use of drugs like mifepreston as an EC and yet its also used as in abortion leads to still more confusion among individuals as to if EC is the same as abortion and affects the rate at which people may seek EC services.

2.3 Practice of emergency contraception

EC was officially introduced in Uganda by the Ministry of Health in November 1998 with the aim of improving reproductive health (RH), however the method remained poorly known and unavailable. In 2001, the method was reintroduced by many authoritative people signing a document, which was published in the leading national newspapers to coincide with international Women’s Day

EC is the only contraception method that can be used after sexual intercourse offering chance to prevent unwanted pregnancy. Currently, various methods that can be used as emergency contraceptives are available in Uganda. These include: the low dose combined oral contraceptive

pills (COCs) e.g. Lofemenal, Microgynon and pilplan, the progestin only pills (POPs) e.g. Ovrette and the copper T 380A intrauterine contraceptive device. However, the utilization has been low.

Contraceptive prevalence rates have correlated with maternal mortality and it has been shown that countries with low contraceptive prevalence rates are also countries with very high maternal mortality ratios (Okonofua 2003)

Availability of EC varies from country to country. Some countries like South Africa have EC available over the counter (OTC), while others hardly use EC (Myer, Mlobeli et al 2007). As a result of this the practice of EC is affected by its availability to the user.

The lack of a product specifically packaged, labeled, and marketed as an emergency contraceptive was a major obstacle to more widespread use of emergency contraception in the United States until the fall of 1998, when Preven was approved (it was withdrawn from the market in 2004). A second specially-packaged emergency contraceptive pill, Plan B, was approved a year later. A one-pill version, Plan B One-Step, was approved in 2009, and a generic version of Plan B (Next Choice) was also approved in 2009. A second generic product, Levonorgestrel Tablets, entered the market in 2010, two more products (Next Choice One Dose and My Way), one-pill products) were approved in 2012. Additional generic products, including Take Action and AfterPill, have become available recently. While availability of these products has helped, the pharmaceutical companies initially distributing them were very small and were not able to promote the products on the same scale as most contraceptives. Plan B was acquired from the tiny company Women's Capital Corporation by Barr Pharmaceuticals in February 2004 and subsequently by Teva Pharmaceuticals in December 2008, but Barr did not and Teva will not spend heavily on direct-to-consumer advertising. Neither has Actavis Pharmaceuticals, the maker of Next Choice One Dose and ella (ella is now distributed in the United States by Afaxys Pharmaceutical). Nevertheless, among women aged 15-44 who have ever had intercourse, the fraction who had ever used ECPs increased from 2% in 2002 to 10% in 2006-2008. (Mosher et al 2010)

CHAPTER THREE: METHODOLOGY

3.1 STUDY AREA

Kampala international university western campus (KIU-WC) located in Ishaka town, Bushenyi District, western Uganda.

3.2 STUDY DESIGN

A prospective cross-sectional study on knowledge attitudes and practice of emergency contraception among female students at KIU-WC was conducted and data was collected using self-administered questionnaire.

3.3 STUDY POPULATION

The study was carried out on a sample of female students at Kampala International University Western Campus.

3.4 SAMPLE SIZE DETERMINATION

Using a sample size formula by Kish Leslie for cross-sectional studies

$$N = \frac{Z^2 P (1 - P)}{d^2}$$

Where N= sample size estimate of clients to be recruited into the study.

P= an estimate of the population falling within the group of interest (in our case represents the estimate of the proportion of female students in KIU-WC)

Z = Standard normal deviate at 95% confidence interval corresponding to 1.96

d = Absolute error between the estimated and true population prevalence of MA of 5%.

The calculated sample size $N = \frac{1.96 \times 1.96 (0.83 \times 0.17)}{0.05 \times 0.05}$

$$0.05 \times 0.05$$

$$N=217$$

From the above formula our sample size was 217 respondents

3.5 SAMPLING METHOD

Simple random sampling method was used in which selected study participants were given questionnaires which they filled and returned.

3.6 INCLUSION AND EXCLUSION CRITERIA

The study included all female students at KIU-WC that had consented to participate in study. However female students that were found not in the appropriate sense of mind to consent were not included in study.

3.7 STUDY LIMITATIONS

Financial constraints delayed the process of data collection. However, this was mitigated by seeking funding from sponsors.

3.8 DATA ANALYSIS

Data was entered into Microsoft office excel 2007 and manual analysis using calculators was used. Results were presented in form of pie charts, tables and graphs.

3.9 OPERATIONAL DEFINITIONS

Knowledge- Awareness about the types, time limit to be taken after unprotected sex and dosage of emergency contraceptives.

Attitude - The way to which clients are thinking or behaving towards emergency contraceptive.

Practice - Trend of use of emergency contraceptives.

3.10 DISSEMINATION OF RESULTS

The research findings were compiled into a dissertation, and a copy was availed KIU-WC library.

3.11 ETHICAL CONSIDERATIONS

1. Ethical clearance was obtained from Kampala international university western campus.
2. Ethical issues were considered in all steps of the research.
3. Detailed explanation about the objective, purpose and benefit of the study were given to the study population.
4. Study participants full cooperation and verbal consent was taken.

CHAPTER FOUR RESULTS

4.1 Participation rate

In this study 217 female students were approached and all accepted and consented to participate in the study. All the 217 female students returned the questionnaires, giving a total participation rate of 100%. Of the 217, 145(67%) knew about ECs Figure 1 and these were assessed further for knowledge, attitude and practice of EC.

4.2 Demographic distribution

Of all the respondent 24 (11%) were between 15-19 years of age, 98(45%) between 20 and 24 year, 85(39%) were between 25 and 30 years while 10(5%) were above 30 years of age Table 1. For the religious break down of the respondents 135(62%) were Christians, 76(35%) Muslims, and 6(3%) had other affiliations as shown in Figure 2.

Of the respondents 44(20%) were in there first year, 52(24%) second year, 41(19%) third year 39(18%) forth year and 41(19%) fifth year as shown in Figure 3.

4.3 Knowledge about emergency contraception

When asked if they knew about EC 145(67%) knew about EC and 72(33%) did not know about EC. Only the 145 students who knew about EC were further assessed for knowledge, attitude and practice of EC.

Of the 145 respondents who knew about EC majority 58(40%) got there information from health education/lecture as shown in Table 2.

When asked on the use of oral contraceptive pills as ECs, majority 142(98%) agreed and 3(2%) disagreed Table 3 (b). Also when the respondents were asked on the use of the copper T IUD as an EC, majority 77(53%) disagreed and only 30(21%) the rest didn't know Table 3(a).

All the 30 respondents that agreed that the copper T IUD is used as EC also agreed that OCPs can be used for EC thus only 21%(30) of the respondent knew that both methods were used in EC.

To assess the level of actual knowledge, a series of five knowledge questions (on method identification; mechanism of action; generally recommended time; maximum acceptable time; and availability emergency contraception) were posed to those students who had heard of emergency contraception. To generate the summarised level of knowledge, the response on each question was first scored and tallied and then the total of each respondent was scored ranging from 0–5 (0% – 100%). A cumulative/total score was calculated and then the respondents were classified as poor, fair or good with respect to their level of knowledge about emergency contraception. Hence, respondents who scored 0%–20% were considered as 'poor knowledge'; those who scored 40% – 60% as 'fair knowledge'; and those who scored more than 60% as 'good knowledge'. Table 4

4.4 Attitude towards emergency contraception

Majority 139(96%) of the respondents stated that they would use EC and only 6(4%) stated that they would not use EC. Also when asked if they would recommend EC to a friend, the same number of respondents who had admitted that they would use EC would also recommend it to a friend. Basing on this there is direct proportion on use and recommendation to a friend Table 5

Of the 145 respondents majority 126(87%) stated that it was safe to use ECs and only 19(13%) thought of using EC as unsafe. Also when asked if the use of ECs would increase the prevalence of HIV/AIDS and other STIs majority 97(67%) thought that it would and only 48(33%) disagreed.

When asked if they would refuse to use ECs because of fear of side effects most of the respondents 61(85%) disagreed.

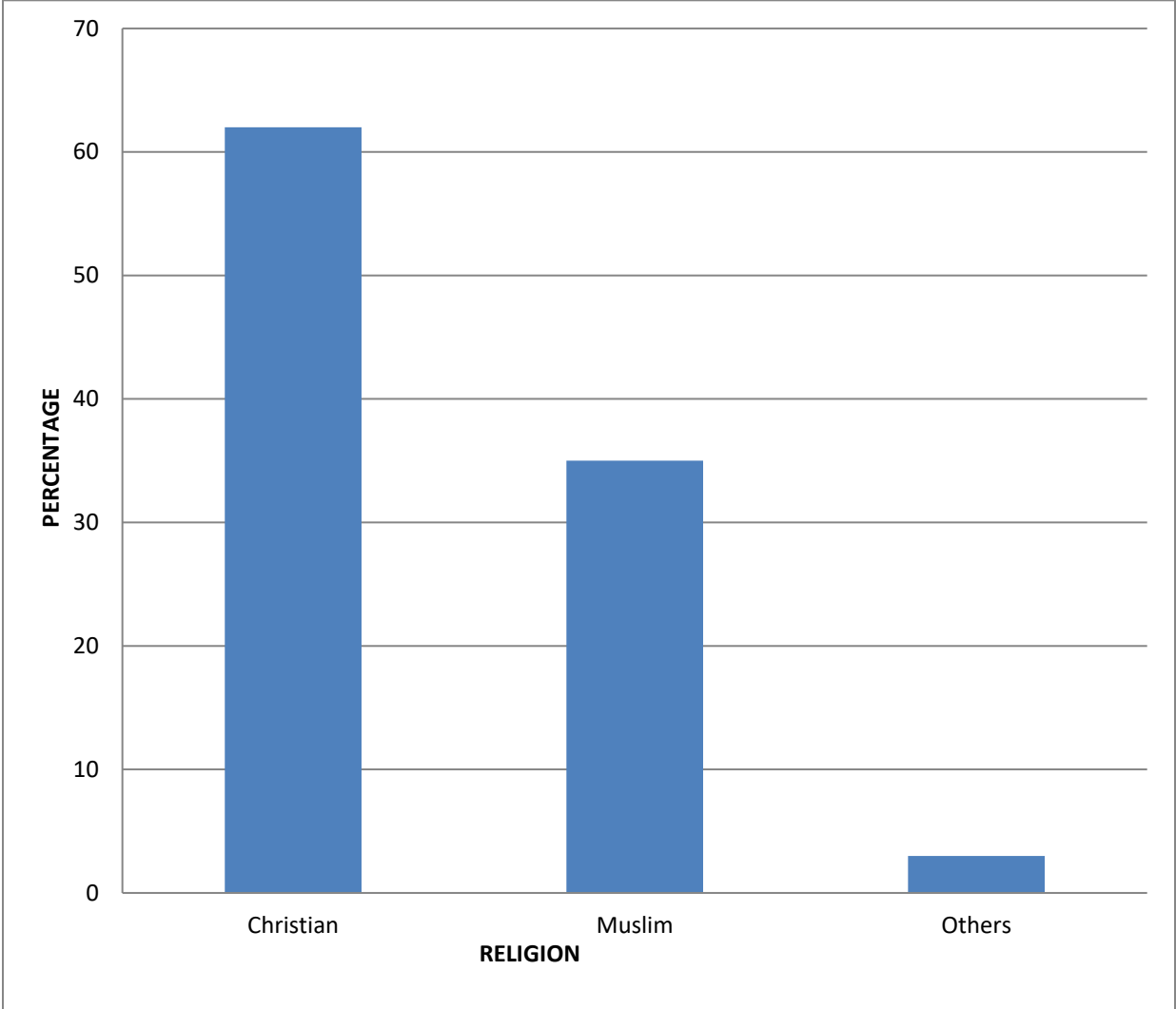
4.5 Practice of emergency contraception

69(96%) admitted that they would use ECs incase need arise and only 3(4%) stated that they would not use ECs, they stated there reason for not using ECs was due to fear of side effects.

Majority 65(94%) preferred to use pills as the mode of EC and only 4(6%) stated that they would use IUD. 69(96%) felt that ECs are beneficial and would recommended them to a friend while 3(4%) would not recommend them to a friend, basing on this it can be seen that there is a direct relation between those that would use ECs and those that consider EC beneficial to recommend it to a friend.

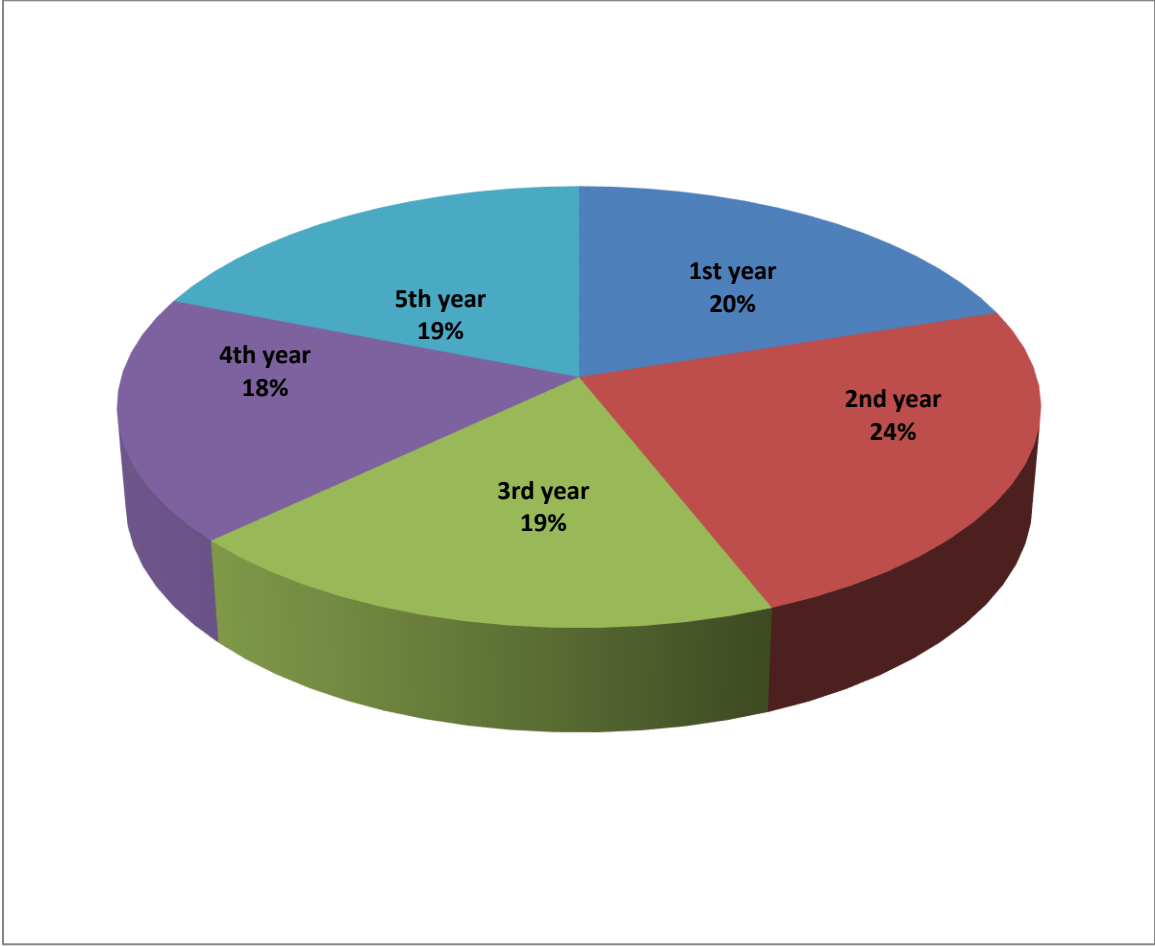
Only 6(4%) of the respondents admitted to having used ECs and they all used the pills, while the majority 139(96%) had never used ECs. However when asked if they knew anyone that has ever used EC 22(15%) knew someone and the majority 123(85%) did not know anyone.

FIGURE 1: Religious distribution of respondents



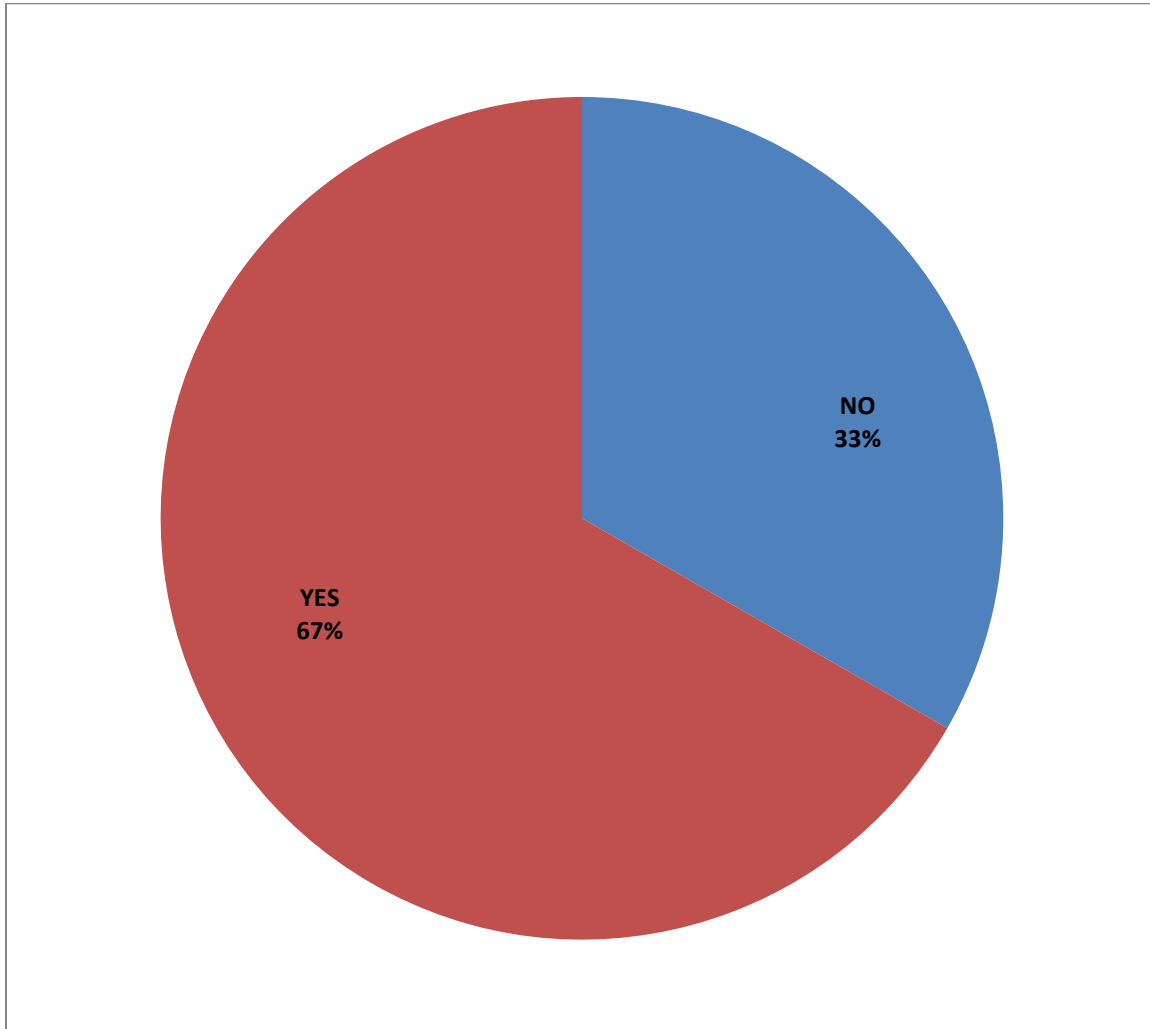
According to the figure majority of the participants where Christians representing 62% followed by Muslims 35% and only 3% belonged to other religious affiliations.

FIGURE 2: Distribution of respondents according to year of study



According to the figure the number of respondents is almost equally distributed with the year of study.

FIGURE 3: Distribution of awareness about emergency contraception



Majority of the females knew about emergency contraception representing 67% while the remaining 33% didn't know about ECs.

TABLE 1: Age distribution of respondents

Age in years	Frequency	Percent
15-19	24	11%
20-24	98	45%
25-30	85	39%
>30	10	5%
TOTAL	217	100%

TABLE 1 table shows that majority of the participants were in the age range of 20-24 years 45%, followed by 25-30 years 39% then by 15-19 year 11% and the least being >30 year with 5%.

TABLE 2: Source of information about emergency contraception

Source of information	Frequency	Percent
Friend	27	19%
Health education/lecture	58	40%
TV/radio/newspaper	25	17%
Internet	26	18%
Others	9	6%
TOTAL	145	100%

TABLE 2 table indicates that most of the respondents who knew about EC got the information from health education/lecture representing 40% while those that got information from a friend, TV/radio/newspaper and internet are almost equal with percentages of 19%, 17%, and 18% respectively while only 6% cited others as their source of information.

TABLE 3: Methods used in emergency contraception.

	Frequency	Percent
Agreed	30	21%
Disagreed	77	53%
Didn't know	38	26%
TOTAL	145	100

(a) IUDs

	Frequency	Percent
Agreed	142	98%
Disagreed	3	2%
TOTAL	145	100%

(b) OCPs

TABLE 3 (a) shows that majority of the respondent (53%) disagreed with the use of IUDs as EC, while **(b)** majority agreed the OCPs where used in EC (98%)

TABLE 4: Distribution of respondents according to knowledge about emergency contraception

Knowledge	Frequency	Percent
Good	32	22%
Fair	68	47%
Poor	45	31%
TOTAL	145	100%

TABLE 4 Table indicates that overall knowledge about EC was fair

TABLE 5: Attitude of respondents towards emergency contraception

Item	YES (%)	NO (%)
Would you use EC	139 (96)	6 (4)
Would you recommended EC to friend	139 (96)	6 (4)
EC is unsafe	19 (13)	126 (87)
EC will increase STD/HIV prevalence	97 (67)	48 (33)
Refuse to use EC due to of side effects	22 (15)	123 (85)

TABLE 5 table generally indicates a good attitude towards EC with a majority of respondent admitting that they would use and recommend EC to a friend, and also most of the respondent 87% considered EC to be safe.

FIGURE 4; Comparing year of study and level of knowledge about emergency contraception

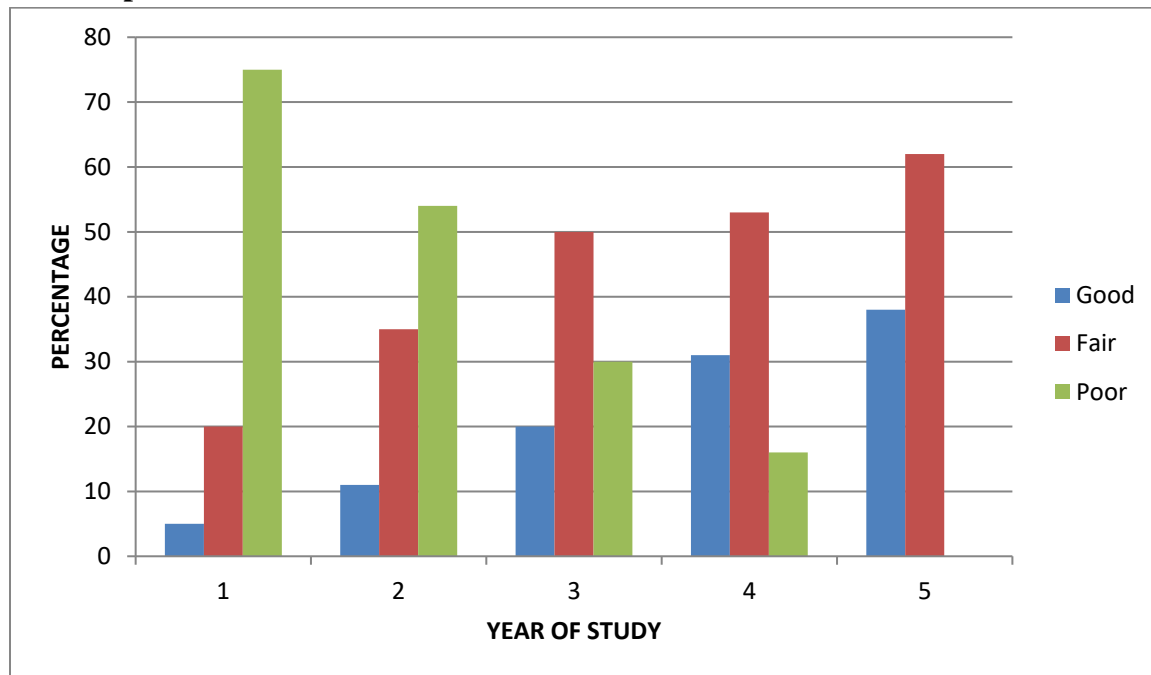


FIGURE 3 Figure indicates that the knowledge increases with the year of study as there is a high number of respondents with poor knowledge (75%) in year1 as compared to those in other year.

CHAPTER FIVE DISCUSSION

5.1 Knowledge about emergency contraception

The awareness of EC among female students in our study was 67% FIGURE 1. This level of awareness was in line with the levels found among university students in Cameroon (63%) (Eugenen et al, 2007), and Kathmandu (66%) (Hafiazur et al, 2010) but higher than the findings from Ghana (43.2%) (Baiden et al, 2002) and Kenya (39%) (Ellertson et al, 1999).

The majority of respondent (40%) stated that their source of information was from health education/lecture TABLE 2, this is not in line with other studies which found that the most important source of information on EC was from friends/family and media/internet (Vahratian et al, 2008). However, the study in the Cameroon reported that knowledge gained from friends and family was often misleading and inadequate (Kongnyuy et al, 2007) while those associated with medical sources like health education had better knowledge just like in our study.

Knowledge about methods of EC, TABLE 3 shows majority (89%) stating that OCPs are used, this is in line with a study in Ethiopia where 83% stated OCPs as a method of EC (Wegene et al, 2007). Only 20% stated that the copper T IUD as EC this is higher than that in Haryana (14.9%) but low than that from Ethiopia (34%) (Wegene et al, 2007)

The general knowledge of respondents was fair, TABLE 4 with majority (47%) having fair knowledge about EC however those with poor knowledge had a significance contributing 31%. This calls for more health education about EC so as to increase the awareness about EC. On comparing the knowledge level with the year of study it was found that respondents in their first year had poor knowledge as compared to those in higher years FIGURE 3.

5.2 Attitude towards emergency contraception

The general attitude towards EC was positive since most of the respondents (96%) admitted that they would use EC when need arose, and still majority (96%) found EC beneficial and would recommend it to a friend (96%), TABLE 5. Most of the factors that were assessed for attitude towards EC pointed towards a positive attitude about EC among the respondents, this is in line with other studies conducted in Addis Ababa University (Tamire, 2007) and Bahirdar University (Atsede 2007).

5.3 Practice of emergency contraception

The practice of EC is lower as only 4% admitted to ever using EC this is in line with studies conducted in Adama University (4.7%) (Tilahun et al, 2010), all the participants that admitted to using EC had used OCPs. 15% of respondents knew someone that had used EC, and the method used was OCPs. However 96% admitted that they would use EC and the preferred method was OCPs (94%).

The practice of EC among the female students is generally very low, this might be an indication that most of these students are using their contraceptive method well and thus the rate of

unintended pregnancies is low and this is good in way that they don't have to go through the stress of worrying if an EC method has worked or not.

5.4 Limitations of study

Study was carried on a convenient sample of students therefore limiting the generality and ability to study.

Self-reported information is subjected to reporting errors, missed values and bias, just as it is the case in this study the questionnaire where self-administered and therefore the information given by the respondents could not be validated.

5.6 Conclusion

The study suggested that the students had fair knowledge about emergency contraceptives and also had a positive attitude toward EC use, however it also disclosed that a significant number of students had poor knowledge about EC and this calls for more education about EC.

There was a increase in knowledge about EC with increasing year of study as suggested by the high level of poor knowledge among first years as compared to fifth years where majority had fair knowledge and none had poor knowledge level.

It was also found that the practice of EC is low and this might be an indicator of proper use of other contraceptive method. The study also found that majority of students would use EC if need arise and the preferred method was OCPs.

Even if the knowledge level was fair majority did not know about the availability of EC and if it could easily be acquired from over the counter.

5.7 Recommendations

- I. More effort should be put on educate students about emergency contraceptive as there is a significant number of female students with poor knowledge and most of them in there in their first year of study.
- II. Special education centers providing information and EC services should be put up within the university premise so as students that need the services can easily access them at their conveniences.
- III. Students should be educated about the use of IUDs as EC because this method is more effective and has bigger time frame of upto 5days compared to that of OCPs
- IV. Students should also be educated about other available contraceptive methods cause if used properly then there would be no need for them to go through the stress of worrying if an EC has worked or not.

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APPENDICES

APPENDIX I; CONSENT FORM

Dear Participant

I am Muwesi Daniel a student at Kampala International University-Western Campus Bushenyi district. Am conducting a study to assess knowledge, attitude and practice of emergency contraception among female students at Kampala International University-Western Campus.

Am requesting you kindly to spare me some time and fill this questionnaire related to the topic above. The information you give to me will be treated as confidential. I am not going to take your names for record purposes.

You are free to join the study or not to join, you may leave the study at any point for any reason if you decide to drop out, you should also know that you will not get any direct benefit or payment for being part of the study, however your participation will be of great importance in this study and will be appreciated.

8. What is the maximum acceptable time to take emergency contraception after unprotected sex?

24-48hours

48-72hours

72-120hours

I don't know

9. Is emergency contraception a method of abortion?

YES

NO

10. Are emergency contraceptives available in easy retail outlets?

YES

NO

Attitude towards emergency contraception

1. Would you use emergency contraception?

YES

NO

2. Would use advice a friend to use emergency contraceptive?

YES

NO

3. Do you think its unsafe to use emergency contraception?

YES

NO

4. Do you think emergency contraceptive will increase prevalence of HIV/AIDS or other STIs?

YES

NO

5. Would you refuse to use emergency contraception because of fear of side effect?

YES

NO

Practice of emergency contraception

1. Would you use emergency contraception if need arise?

YES

NO

2. Would you recommend a friend to use emergency contraception?

YES

NO

3. If yes in 1 OR 2 above please tick on the method you would recommend?

Pills

Intrauterine devices

4. Have you ever used?

YES

NO

5. Do you know anyone that has used emergency contraception?

YES

NO

APPENDIX II; BUDGET

Item	Quantity	Unit cost/ UG shs	Total cost
Pencils	10	300	3000
Pens	10	700	7000
Typing			35,000
Printing			60,000
Data collectors	7	5000	35,000
Data analysis			45,000
TOTAL			185,000

APPENDIX III; Map of Uganda showing location of Bushenyi district



Bushenyi District

APPENDIX V; Map of Ishaka showing Kampala International University Western Campus.



APPENDIX VI; TIME FRAME.

ACTIVITY	AUG 2014	SEP 2014	OCT 2014
<ul style="list-style-type: none">• Project proposal writing.• Approval of project proposal• Securing support from stakeholders			
<ul style="list-style-type: none">• Data collection			
<ul style="list-style-type: none">• Data Analysis			
<ul style="list-style-type: none">• Submission of thesis			