EMERGENCY CONTRACEPTIVE USE AND ASSOCIATED FACTORS AMONG UNDERGRADUATE FEMALE STUDENTS IN METTU UNIVERSITY, SUOTH WEST ILLU ABBA BORA ZONE, OROMIA, ETHIOPIA



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# SUMMMERY

**Background:** Despite the availability of contraceptive methods, annually anestimated 40-60 million women seek termination of their pregnancy globally and the largest percentages taking place in the developing world. Complications from pregnancy, childbirth and unsafe abortion are the major causes of death for adolescents aged 15 to 19 in developing countries. Even though knowledge of family planning is universal the utilization rate is low among women in a reproductive age group and adolescents in particular. Unintended pregnancy and induced abortion can be prevented and reduced by expanding and improving family planning services and choices. Emergency contraception is one of the family planning methods of pregnancy prevention, which reduces risk of unwanted and untimely pregnancy after unprotected intercourse.

**Objective:** To assess emergency contraceptive use & its associated factors among female students of mettu University during academic year 2016.

**Methods:** Institutional based descriptive cross-sectional study design will be conducted among X sampled under graduate female students of mettu University from ***Februar*y** to ***March***. Data on socio-demographic variables, sexual & reproductive factors, knowledge, attitude & practice of contraception, exposure to unprotected sex & its consequences will be collected by him and friends using self administered questionnaire.

Binary logistic regression will be used to examine association between dependent and independent variables. A 95% CI and p-value of <0.05 will be considered to be statistically significant. To assess the effects of each independent variable on the outcome variables multivariate logistic analysis will be carried out and fit to the final model

**Budget and work plan:the budget to accomplished this research is estimated to be\_\_\_\_\_\_Ethiopian birr.**

**Key words**: Emergency Contraception, use, associated factors, Undergraduate Female students, mettu University, Ethiopia

### 

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### 

### Abbreviations and Acronyms

AOR - Adjusted odds ratio

AIDS - Acquired Immuno Deficiency Syndrome

CI - Confidence Interval

COR - Crude odds ratio

EC - Emergency Contraceptive

ECP - Emergency Contraceptive Pill

HIV - Human Immuno suppression Virus

HSDP- Health Sector Development Program

IEC - Information Education and Communication

IUCD- Intrauterine Device

MMR- Maternal Mortality Ratio

MOH - Ministry Of Health

NGO - Non Governmental Organization

OCP - Oral Contraceptive Pill

OR - Odds Ratio

PPS - Probability Proportion to Size

RH - Reproductive Health

SPSS - Statistical Package for Social Science

SRH - Sexual and reproductive health

SRS - Simple Random Sampling

STI - Sexually Transmitted Infection

UPSI- Unprotected Sexual Intercourse

UNFPA - United Nations Population Fund

WHO - World Health Organization

WU- Wollega University

# 

# CHAPTER-ONE INTRODUCTION

## 1.1 Background

Despite surprising technological advancements in modern contraception methods still unintended pregnancy is a worldwide problem that affects women, their families and the society as a whole. Unintended pregnancy can result from contraceptive non-use, misuse, contraceptive method failure and less commonly from rape. Adolescent women are more likely not to use and to misuse contraceptive than older women. Unintended pregnancy and its negative consequences can be prevented by access to contraceptive services & including emergency contraception [1,2]. Emergency contraception (EC) (post coital contraception) is a method of preventing pregnancy as a result of unanticipated sexual activity, contraceptive failure, or sexual assault. Higher Education students’ unwanted pregnancies pose a major public health problems in the developed and developing countries [5, 6, 7], including Ethiopia [8,9] and are associated with far reaching effects such as jeopardizing students’ educational progress and future careers [5,6,7,8,9 ]. Around 30%-50% of women presenting for choice on termination of pregnancy will be not using contraceptives at the time of contraception, and similar numbers of pregnancies will be unplanned and unwanted [5, 6].

According to a 2009 report, an estimated 215 million women in the developing world have an unmet need for modern contraceptives, meaning they want to avoid a pregnancy but are using a traditional family planning method or no method [10].

Some 82% of unintended pregnancies in developing countries occur among women who have an unmet need for modern contraceptives; women using modern contraceptives account for only 18% of unintended pregnancies [10].The reasons why women (married and unmarried) do not use contraceptives most commonly include concerns about possible health and side-effects and the belief that they are not at risk of getting pregnant [11].

Emergency Contraception refers to several contraceptive methods that can be used to prevent pregnancy after sex. World Health Organization endorsed EC and researches over the past 30 years have shown that these methods are safe and effective [12]. Using of EC pills avoided about 51000 abortions in 2000. Overall 43% of abortion rates reduction in the US between 1994 and 2000 is attributable to increased EC use [13].

In several African countries, survey among University students showed that only three quarter of youth had heard about EC, and minimal accurate knowledge about its use [14.15].

In about half of all unwanted pregnancies conception occurs due to inadequate guidance to use contraception effectively, including the users’ inability to address their feelings, poor attitudes towards contraceptives, and lack of motivations [16]

A study on barriers to the use of EC, shows that limited knowledge regarding time frame and availability of EC, had a negative impact on EC practice and lack of awareness of pregnancy risk may be the most important factor limiting EC use [17].

The need for emergency contraception is clearly demonstrated by the occurrence of unwanted pregnancy and induced abortion [18].If emergency contraception will be easily available and distributed through clinics and non clinics channels along with appropriate advocacy and IEC activities millions of unwanted pregnancy and abortions could be averted [19,20].

Reports from developed countries show that the use of EC varies from place to place [21] and the knowledge on correct use varies from 83% in Sweden [22] to less than 60% in developing countries [23]. One of the lowest percentages (10%) will be observed in a study done in Ethiopia at the Addis Ababa University and Unity University College, Ethiopia [8] on the knowledge, attitudes, and practices affecting the use of EC. Findings from several studies indicate that women, who indicate that they know how to use EC, often report they have never used it [7, 8, 21, 22, 23, and 24].

Introduction and promotion of emergency contraception in the country would greatly reduce the rate of unwanted pregnancy and thereby decrease the high rate of maternal deaths associated with unsafe abortion. Emergency contraception should be available at all levels of the health care system and, where possible [25, 26]. Experts agree that widening the menu of contraceptive choice is desirable, and that a method to prevent pregnancy after unprotected intercourse or after a contraceptive failure is critically needed [27].

## 1.2 Statement of the Problem

The practice of emergency contraception is very low in every regions of the world including Ethiopia; as result of these the health consequences related to unintended pregnancy &its complications are devastating the life of the women and adolescents particularly. Beside this long-term disability like infertility and death may be a direct result of unsafe abortion complications such as sepsis, hemorrhage, genital and abdominal trauma and perforated uterus [28].

An estimated 536,000 maternal deaths occur worldwide each year, 99% (533,000) of them in developing countries. Slightly more than half of the maternal deaths (270 000) occurred in the sub-Saharan Africa region alone. The World Health Organization estimates that 13% of world wide maternal deaths are due to unsafe abortions[2]. Forty to sixty million abortions are performed each year and among these twenty million are unsafe abortions. This represents almost one in ten pregnancies, or a ratio of one unsafe abortion to seven births [31].

The proportion of women aged 15–19 years in Africa who have had an unsafe abortion is higher than in any other region; almost 60% of unsafe abortions in Africa are among women aged less than 25 years and almost 80% are among wom3en below age 30 [31].

Each day 192 women die because of complications arising from unsafe abortion; that is one woman every eight minutes, nearly all of them in developing countries. These women are likely to have had little or no money to procure safe services; many of them are young, perhaps in their teens, living in rural areas and having little social support to deal with their unplanned pregnancy. Some of them have been raped, and some have experienced an accidental pregnancy due to the failure of the contraceptive method they were using or the incorrect or inconsistent way they used it. Some of them lacked knowledge of methods to prevent unintended pregnancy or did not have the means to obtain them. Some may have found contraceptive services hard to reach, while others may have been turned away by insensitive providers. A large percentage of them may have first attempted to self-induce the abortion and failing that, they may have turned to an unskilled, but relatively inexpensive and affordable provider [29].

Unintended pregnancy poses a major challenge to the reproductive health of young people in developing countries. Some women with unintended pregnancies obtain abortions many of which are performed in unsafe conditions and others carry their pregnancies to term, incurring risks of morbidity and mortality higher than those for adult women [31]. Compared with women in their twenties, adolescents ages 15 to 19 are two times more likely to die during childbirth, and those ages 14 years and younger are five times more likely to die [31,32].

In addition to the higher risk of morbidity and mortality, adolescent pregnancy can lead to serious social stigma and health consequences for both mother and child. The adverse social and economic consequences for an adolescent who becomes pregnant will be depend on her particular marital, cultural, familial, and community situation. However, in many developing countries, pregnancy severely limits an adolescent in pursuing education and in having broader economic opportunities in the future. By preventing unintended pregnancy, ECPs can help avert the risks to the mother and child associated with pregnancy and childbearing [30].

Ethiopia is one of the top five countries with the highest number of maternal deaths worldwide and estimated maternal mortality ratio (MMR) of 673 per 100,000 live births in 2005 equates with 19,000 maternal deaths per year[30,31].

Ensuring the availability of modern contraceptive methods and life-saving maternal/reproductive health in health service delivery is crucial in the provision of quality primary health care. It is also one of the important tasks policy makers and program managers need to consider in the design of appropriate intervention strategies toward reducing maternal mortality and achieving MDG 5. There are few studies which document the extent of emergency contraception use and the influencing factors on its use among university girls in Ethiopia. This study will be carried out to assess EC use and its associated factors among regular female students at mettu University. I hope that this study wil be provide baseline data to assist policy makers in developing appropriate evidence-based strategies to promote the need based use of emergency contraceptive methods amongst eligible individuals in Ethiopia.

**1,3 Significance of the study**

Emergency contraception ,which prevents pregnancy after unprotected sexual intercourse,has the potentials to significantly reduce the incidence of unintended pregnancy and the consequent need for[71] abortion.emergency contraception is especially important for outreach to the 4.6 million women at risk of pregnancy but not using regular method by providing a bridge to use of an ongoing contraceptive method[72].

In Ethiopian more than 60% of the pregnancy in adolescents are unwanted which is alarming figure and most of these pregnancies in particularly in adolescent end up as unsafe abortion, 20% of abortion occurs in girls between 15-19 years of age. Practice of emergency contraceptive plays a vital role in preventing unwanted pregnancies and would serve as a backup to others family methods. improving the existing family planning services through broadening of the method mix and ensuring access and availability of contraceptive methods including EC should prevent unintended pregnancies and will ultimately contribute to the reduction of the morbidity and mortality of women particularly the youth.

Thus,understanding of emergency contraceptive use and associated factors is critical for countries like Ethiopian with population policy aiming at reducing unwanted pregnancy, unfortunately little research has been conducted in this areasarea in the country. the finding of these study will help the programmer and service providers in identifingal areas where emphasis has to be given in development of strategies that will be promote the utilization of modern contraceptives in generaly and emergency contraception in particularly.

# 

# CHAPTER TWO

## 2.1. LITERATURE REVIEW

### 2.1.1 Emergency Contraception

Emergency contraception is a safe and effective birth control method taken after unprotected sex or when it is suspected that another contraceptive method may have failed. They are intended as last chance to prevent pregnancy for women who have been exposed to unprotected coitus and who do not wish to become pregnant [20, 32].

The EC products are:

***Copper-bearing intrauterine device (Cu-IUD):-*** Copper is toxic to the ovum and sperm and thus the copper-bearing intrauterine device (Cu-IUD) is effective immediately after insertion and works primarily by inhibiting fertilization(34,35,36).

An emergency Cu-IUD should be fitted within the first 5 days (120 hours) following the first UPSI in a cycle or within 5 days from the earliest estimated date of ovulation & protect pregnancy by 99%[37 ].

***Levonorgestrel (LNG):-*** The common emergency contraception pills brand in our set up is Posinor-2. It is an oral emergency contraceptive pill that can help to prevent pregnancy if taken within 72hrs of unprotected sexual intercourse or failure of contraceptive method by 75%. Each of the tablets contains levonorgestrel 0.75mg .It is one of the brand names for progestin-only emergency contraceptive pills [32]

***ELLA/ UPA (Ulipristal acetate****)*:-Ella is an emergency contraceptive product shown to be safe and effective for use to reduce the risk of pregnancy up to five days (120 hours) after unprotected intercourse or contraceptive failure [38]. Ella contains 30mg of ulipristal acetate and is a selective progesterone receptor modulator (SPRM). The efficacy of UPA has been demonstrated up to 120 hours after UPSI [38, 39 ,40] and there is no apparent decline in efficacy within that time period [39,40].

***Yuzpe method (Combine oral contraceptive)***:-The most commonly used method of emergency contraception. The method is simple, relatively inexpensive and could be made readily available as the steroids involved are available world-wide [41].The most typical formulation contains 200 mg of ethinyl estradiol and 2.0 mg of dl-norgestrel (or 1 mg of levonorgestrel) which is given in two divided doses. The treatment is initiated within 72 hours of the unprotected sex and the second dose is repeated 12 hours late &it protects pregnancy by 85% [41].

## Indications for emergency contraception

Determining a woman’s precise risk of pregnancy is complex as it depends on a number of factors including when ovulation is likely to occur, the fertility of both partners and whether contraception has not been used or has been used incorrectly. ECPs are indicated to prevent pregnancy after unprotected or inadequately protected sexual intercourse [42], including

* when no contraceptive has been used
* when there is a contraceptive failure or incorrect use including -Condom breakage, slippage, or incorrect use
* Two or more consecutive missed combined oral contraceptive pills.
* Progestin only pills (mini pills) taken more than three hours late
* More than two weeks late for progestin only contraceptive injection
* Dislodgement, delay in placing or early removal of a contraceptive hormonal skin patch or ring.
* Dislodgement, breakage tearing or early removal of a diaphragm or cap
* Failed coital interrupts (e.g. ejaculation in the vagina or on external genitalia)
* Failure of a spermicidal tablet or firm melts before intercourse
* Miscalculation of the periodic abstinence method or failure to abstain on fertile day of cycle
* IUD expulsion
* In cases of sexual assault when the women weren't protected by an effective contraceptive methods [42].

### 2.1.2. Socio-Demographic Factors

Women ability to control their fertility is limited in many countries. Gender roles, power imbalances, cultural norms concerning sexuality and women vulnerability to rape and violence put them at high risk for unwanted pregnancy [43]. In different countries the differences in socio-demographic characteristics among the societies affect the perception and utilization of contraceptives.

In Southern Ethiopia study explained that on Contraceptive use and intentions in countries with a large Muslim population, the number of children ever born is generally found to be greater and the use of contraceptives less likely among Muslims than among members of other religious groups [44].Knowledge of contraception both among women and men varies by the background characteristics of the respondents. According to EDHS 2005, about 88 percent currently married women and 93 percent men know at least one method of contraception. Women and men age 20-24 are more likely than those of age 15-19 to have heard of contraception methods. In addition to this among unmarried women who are sexually active, Knowledge and use of any contraception method is more likely higher than among those who are currently married at the time of surveys [45].On the other hand, the study shows that a normative economic factor inheritance of land by sons from their fathers considerably reduces the likelihood of contraceptive use, perhaps because it weakens the economic power of the wife and necessitates the birth and survival of sons [44].

A study shows in south west Nigeria that the respondents in the age group 16-25 years and those who were aware of emergency contraception were likely to have used ECP. This also applies to respondents from Pentecostal Churches and those with traditional religion [46].Ethnic groups are also a major cultural force in reproduction, however, different religions affiliations are present within the ethnic groups, providing a context following greater understanding of the effects of religion on birth control. Based on the findings the study concluded that the main factors that increase the likelihood of a woman’s intending to use one is her living in a family with a higher level of education or in a community with access to health services [44].

### 2.1.3. Sexual &reproductive health factors

## Parent, Peer/husband/boy friend Related Factors

Studies regarding this issue showed that parents can be influential source of knowledge, belief, attitudes and values for their children.

Study suggests in America show that parent child communication about sexuality appears to play an important role in reducing the onset of sexuality and to increase contraception practice among sexually active adolescents [47].Findings in Australia indicated that female youth are more likely to seek advice to and look for information to prevent unplanned pregnancy and parents are the most likely sources of information followed by friends and media (48).

In south west Nigeria the study result explained that the commonest sources of emergency contraception were magazines (33.7%) and friends (32.8%) of the respondents [46]. Similarly a study conducted in Kenya demonstrated that the main sources of emergency contraception were friends and schools [49].

A study in two inner cities of US reported that youth communication with their parents were almost 15% more likely to abstain from sexual intercourse and almost 20% more likely to use birth control if sexually active [50,51].

Study shows in Ethiopia among post abortion service seeking women, health institutions were cited as the first source of information about EC (40.8%) followed by friends/relatives (33.9%) and the media (16.9%) [52].

1. **Knowledge and attitude of service provider**

## Health service providers need to be not only technically competent, but should be empathetic and capable of delivering holistic services that is client centered. Providers should not object to provision of emergency procedures. When a provider has a conscientious objection to medical procedure or any intervention, she is obliged to refer the client to a facility where the service can be provided. Provider should organize user friendly clinics recognizing the reproductive health needs of the Adolescents [53]. In order to run an effective EC program, there is a need to deploy a well trained provider, ensure an adequate supply of contraceptive commodities [54].

1. **Fear Related Factors**

Almost all women can use emergency contraception pills safely. Because, they are taken for a brief time, the contraindications for regular contraceptive pill use don't apply for emergency contraception pills [20,32, 42]. But young adolescents does not practice contraception including EC, because of concerned to side effects such as experience of nausea, vomiting, upper abdominal pain, altered bleeding and pattmerns, dysmenorrhea, back pain, breast tenderness, headache, dizziness, ectopic pregnancy, fatigue and infertility[55].laboratory test, pelvic examination, Lack of knowledge about modern contraception, loss of privacy, provider & parental disapproval, social negativity about teen age sexuality & cost of the EC play a key role for adolescents’ not using emergency contraceptives[55]. So providing emergency contraception without a pelvic examination or pregnancy test, reducing financial and psychological barriers, encourage teens seeking emergency contraception to adopt a regular contraceptive method in the future & can create a bridge to regular reproductive health care for sexually active teens [56].

### 2.1.4, Contraception Related Factors

1. **Contraception Experience**

A study on South West Nigerian post-secondary female students had found that the rate of contraceptive use about 32.8% among sexually active adolescents [46].Whereas, a study among female undergraduate students in Nigeria conducted three years later the prior indicated that the rate of contraception practice among sexually active respondents was 81.3% [57] and also 62% among young South African women [58].

Concerning with EC experiences, 58% of female Nigerian undergraduates heard about the method [57] and only 50% of the Kenyan university students [49].Moreover, only 17% of young South African women heard about the method and 1% ever used it [58] as compared with 98% among Princeton University students [61].

In Ethiopia the DHS 2005 report revealed that, about 52% of unmarried but sexually active respondents of age group 15-24 used modern contraceptive. A study on students of ACTE indicated that 48.3% male and 47% female respondents had an experience of using modern contraceptives [59].Finding of a survey on female students of Jimma University explained that among one–third of sexually active respondents only one – fifth was using regular method of FP at the time of the study [60]. On the other hand, the rate of contraceptive practice among female students of Bahir Dar University is found to be 99.1% of sexually experienced students [51].

Concerning EC it is indicated that even far less than the developing nations; 22.2% and 34.8% in Jimma and Bahir Dar Universities female students ever heard about EC, respectively; and only five students in each practiced the method [60,51].

## Improving access to emergency contraception

Service delivery innovations can help to increase access to emergency contraception. One that benefits women aged 16 and under, who cannot purchase Plan B One Step or Next Choice OTC, is enabling them to obtain ECPs directly from a pharmacist without having to see a physician [62].Changing provider practices is important step, so that women seen by primary and reproductive health care clinicians would be routinely informed about emergency contraception before the need arises.

## Cost effectiveness

Studies based on economic models have shown that emergency contraception is nearly always cost effective. Use of combined or progestin‐only ECPs reduces expenditures on medical care by preventing unintended pregnancies. Insertion of a copper IUD also provide continuous contraceptive protection for up to 10 years thereafter producing savings if used as an ongoing method of contraception for as little as four months after emergency insertion[63].Not only would making emergency contraception more widely available save medical care dollars, but additional social cost savings would result as well. These include not only the financial costs of unwanted pregnancies and births but also the considerable psychological costs of unintended pregnancy. Moreover, the average medical care cost of unintended births is likely to be greater than the average cost of all births [64].

### 2.1.5. Knowledge, Attitude and Practice of EC

## In spite of the increased number of health facilities for service delivery, the Health Sectors Development Program I (HSDP-I) had no major impact on the utilization of Reproductive Health Services (SRH) nationally and RH status in general, since the mortality and morbidity rates did not decrease [66].

A study on Nigerian female undergraduates showed that 43% of respondents were sexually active, 39% had ever practiced contraception and 34% had ever had an induced abortion [67].

From the respondents 58% of them know about emergency contraceptives, however, only 18% them knew the correct time frame in which EC should be used to be effective [68].

According to the analysis conducted by the Alan Guttmacher Institute (AGI), from 1994-2000 estimates that increased use of EC may account for up to 43% of the total decline of induced abortion. The study found that 46% of women having abortions were not using a contraceptive method in the month they became pregnant, including 8% who had never practiced contraception. %) [70].

Similar survey done among students of Addis Ababa University and Unity University College showed 43.5% of students have heard about EC, but lesser proportion (10%) of those who have heard about EC could tell the correct timing of administration [8] and only 5% of the respondents have used emergency contraception. In the same study, 19.5% were sexually active and 51.7% have ever used regular modern contraceptives. Of those who were sexually active 35.1% have experienced pregnancy one or more times and 73.5% of these pregnancies were unwanted. More than 71.7% of unwanted pregnancy had induced abortion and 29% were under unsafe condition. About 53% of the students have positive attitude towards the importance of emergency contraceptives [8].

Induced abortion patients also were significantly more likely to be null parous, students, and determined to use contraception in the future than their counterparts in the spontaneous abortion group. Overall, 234 (82%) of respondents stated their pregnancy was unwanted; 62% of women with unwanted pregnancies had used contraceptive method at some point in the past 12 months, primarily the pill (66.9%) and abstinence (29.7%). The most frequently cited reasons for non use of contraception were health-related concerns (33.9%), failure to anticipate sexual intercourse (39.9%), and a negative attitude toward or lack of knowledge about contraception (32.2%[69].

# CHAPTER THREE

# 3 OBJECTIVES

## 3.1 General Objective

* To assess emergency contraceptive use & associated factors in undergraduate female students of mettu University south west illu abba bora zone Oromia.

## 3.2 Specific Objectives

* To describe level of practice of emergency contraception among undergraduate female students
* To identify Socio demographic factors associated to emergency contraception practice among undergraduate female students
* To identify fear related factors associated with practice of emergency contraception among undergraduate female students

# CHAPTER-FOUR

# 4. Methods and Materials

## 4.1 Study area and period

This study will be conducted in mettu University, south west illu Abba bora zone, Oromia Regional state. The main Campus of mettu University (MU) is located near the town of mettu, on the ......hectares of land surrounded by evergreen forest and natural scenery of landscape,

Mettu town is located 600km south west of Addis Ababa. The average daily minimum and maximum temperatures range between 15 and 27° C, respectively. Mettu town is a capital city for the south west illu Abba bora Zone with a population of over 100 000 inhabitants and it will be the capital of the former mettu province and home to a museum of mettu Oromo culture.

At present, the University runs 15 undergraduate, and 2 post graduate programs in maine campuse and it has a total of ...... students and a female accounted for ...... Today, ME is a comprehensive University engaged in the provision of all rounded education, research and community service. The university has one clinic in the main campus which provides health services to the university students

This Study will be conducted on undergraduate female students in the main campus of mettu University from –February to March 2016.

## 4.2 Study design

A cross-sectional descriptive study will be conducted from February to March 2016 among mettu University undergraduate Female students.

## 4.3 Population

### 4.3.1 Source population

The source population for this study will be all regular undergraduate female students of mettu University.

### 4.3.2 Study population

The study population will be randomly selected from regular undergraduate female students of mettu University those who will fulfill inclusion criteria

## 4.4 Eligibility criteria

### 4.4.1 Inclusion criteria

* + All regular undergraduate female students of mettu University will be included in the study.

### 4.4.2 Exclusion Criteria

* Female students attending extension &those who have visual impairment will be excluded from the study.

4.5. Sample Size Determination and Sampling Technique

### 4.5.1 Sample Size Determination

The sample size will be calculated using single population proportion formula. By taking into consideration, 26.7% of proportion of emergency contraception practice (which is stated by Mr Dejene in 2011), 95% confidence level, 5% tolerable margin of error, possible non-response rate of 10% and the final sample size was:

n= ( Zα/2)2 P (1-p)

d2

Where n= number of the study subjects

Z= is standardized normal distribution value for the 95% confidence interval (1.96)

P =proportion of female students with emergency contraception practices (26.7%).

d = the margin of error taken as 5%

n= (Zα/2)2 P (1-p) = (1.92)2 (0.267x0.733)2 = 301

d2 (0.05)2

**the final sample size(NF) will be calculated after the we known the total population and 10% none respondent will added.**

### 4.5.2 Sample procedures and technique

After calculating the sample size, all colleges and year of study will be considered in the sampling process for the selection of the study subjects. Total university female undergraduate students will be stratified in to the five colleges and the determined sample size will be distributed to each colleges using probability proportional to their size. Secondly using Simple Random Sampling (SRS) departments from the five colleges were identified. The required number of female undergraduate students (sample size) will bedistributed to each year of study and department again using probability proportional to size. The study subjects were selected from each department and year of study using simple random sampling. The questionnaire will be distributed and collected back from the study subjects before class started.

## 4.6. Data Collection Procedures

### 4.6.1. Data Collection Instrument

Structured self-administered questionnaire will be adapted after review of different literatures in English and translated in to Amharic and back translated to English to check its consistency. The questionnaire contains six parts (socio demographic characteristics; sexual and reproductive history; and Knowledge of existence of emergency contraception methods, utilization and service provider related issues, Attitude towards EC and Fear related to EC).

### 4.6.2. Pre-test

### Before the actuall data collection,the questionnaire will be tested on 5% of the total study population before study period.then possible modification will be made on the check lists using the findings of the pre-test.

### 4.6.3. Data Collection Method

The data will collected using a pre-tested structured self-administered questionnaire. Students who were randomly selected from each class room and year of study of respective colleges were taken to one classroom or hall/different classrooms according the number of students.

They will be informed about the purpose of the study and importance of their participation. After getting verbal consent & their willingness to participate in the study, they were provided the questionnaire and oriented how to fill the questions. After they have completed filling the questionnaire they returned to the data collectors.

## 4.7. Data Quality Control

The questionnaire will be pre- tested on similar settings (college students other than selected collage) and necessary modification will be made based on the nature of gaps identified in the questionnaire. Data collectors were trained for one day on objective of the study, how to gather the appropriate information and the whole contents and subject matter of the questionnaire. Day to day supervision will be carried out during the whole period of data collection by the supervisor. At the end of each day, the questionnaire will be reviewed and cross checked for completeness by the investigator and corrective discussion will be under taken with all the data collectors. Data will be entered, cleaned and analyzed using SPSS version 16.0 computer program software.

## 4.8. Data Processing and Analysis

The collected data will be entered into SPSS version 16.0 computer program and will be checked for its completeness, cleaned and analyzed accordingly. Descriptive analysis will be done to describe the numberand frequency of socio-demographic variables and other variables in the study**.** Frequencies and graphs will be used to describe some variables. Binary logistic regression will be used to examine significance association between dependent and independent variables. A 95% CI and p-value of < 0.05 will be considered to declare the statistically significant results to see the effects of each independent variable on the response variables. The results will be presented using text, table and graphs based on the types of data.

## 4.9. Variables

### 4.9.1. Dependent Variables

* Practice of emergency contraceptive

### 4.9.2 Independent Variable

* Socio demographic characteristics
* Age
* Previous place of residence (area of origin)
* Religion
* Marital status
* Year of study
* Parent’s educational level
* Exposure to media
* Sexual and reproductive health factors
* Exposure to sex education (parents-daughters communication & peer/boy friend/husband communication on RH issue)
* Sexual experience
* Providers’ knowledge & attitudes towards EC
* Contraception related factors
* Contraceptive practice
* Knowledge & practice on EC (use, timing, accessibility, side effects, effectiveness , and indication of EC)
* Attitude towards EC
* Exposure to unprotected sex & its consequences
* Fear related factors
* Laboratory tests
* Disapproving health care personnel/parents/partner
* Societal negativity about teenage sexuality
* Cost of emergency contraceptives
* Infertility/Side effects

## 4.10. Operational Definition

* **Emergency contraception (EC)** - is a contraception method that can be used within 72 hours following unprotected intercourse to reduce risk of pregnancy
* **Unwanted /intended pregnancy**- is a pregnancy that has occurred when the woman doesn't want to have children, which may be because she already had the desired no. of children or it may not be time.
* **Mistimed (unplanned) pregnancy**- is pregnancy which was unwanted during the time of conception; But it doesn't imply unwanted or unloved child.
* **Knowledge**- knowledge of EC is awareness of the presence of contraception methods after unprotected sex, its sources, and ability to identify when EC should be taken, its side effect, its effectiveness, and whether it is effective after a lady has amenorrhea.
* **Attitude-** attitude is the study subject's opinion, outlook, position or ideas toward emergency contraceptive methods.
* **Women with Unmet need for contraception** -Women want to avoid a pregnancy but are not using any method.
* **Practices**- a study subject who have knowledge about emergency contraception and who have ever used it to prevent unplanned pregnancy after unprotected sex, or regular contraceptive method failure.

## 4.11. Ethical Consideration

Ethical clearance will be obtained from mettu University Ethical Review Board and Letter of permission will be obtained from mettu University, college of public health and medical science Integrated midwifery dapretment Program Coordinating Office. It will be presented to selected respective body of mettu university . Informed verbal consent from study subjects prior to interview will be obtained. The study participants were informed about the purpose of the study and the importance of their participation in the study by contributing information that may help in assessing the practices of female students towards general contraceptives and in particular about emergency contraceptives. Also the study subjects were informed as they can skip question or questions that they do not want to answer fully or partly and also to stop at any time if they want to do so. Confidentiality of the information will be assured by not including their name and ID, and privacy of the respondents will be maintained by using self-administered questionnaire.

## 5.12 Dissemination of the Result

The finding of the study will be presented MU College of public health and medical science, Integrated midwifery dapertement Program Coordinating Office, south west illu Abba bora zonal health office department and respective mettu University. Further attempt will be made to publish it on national and international scientific journal

### 

# CHAPTER FIVE

# Project work plan

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NO | Expected activities | Responsible agent | January | | Feburary | | March | | April | | May | | June | |
| 1 | Title selection |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 | Topic approval |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 | Development of research proposal and obtaining feed back |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 | Proposal submission |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 | Resource securing and obtaining |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 | Pre-test |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 | Data collection |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 | Data compilation and analysis |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 | Reproting writing and obtaining feed back |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 | Submission of final report |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 | Dissemination of result |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 | Monitoring and evaluation of all research activities |  |  |  |  |  |  |  |  |  |  |  |  |  |

# CHAPTER SIX

# Budget break down

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S,NO | Budget category | Qualification | Unit cost | NO.days | Total cost | justification |
| 1 | Pricnipal investigqtor |  |  |  |  |  |
| 2 | Data collectors |  |  |  |  |  |
| 3 | Supervisors |  |  |  |  |  |
|  | Sub total |  |  |  |  |  |

Part II

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.NO | Type | Unit of measurement | Unit cost | Quantity | Total cost | Justification |
| 1 | Paper |  |  |  |  |  |
| 2 | Pen |  |  |  |  |  |
| 3 | Pencil |  |  |  |  |  |
| 4 | Eraser |  |  |  |  |  |
| 5 | Sharper |  |  |  |  |  |
| 6 | Printing |  |  |  |  |  |
|  | Sub total |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.NO | Transport | Unit cost | NO.of trib | Total cost | Justification |  |
|  |  |  |  |  |  |  |
|  | Sub total |  |  |  |  |  |

Budget summeryS

|  |  |  |
| --- | --- | --- |
|  | Category |  |
| 1 | Personal cost |  |
| 2 | Stationary cost |  |
| 3 | Transporation |  |
|  | Total |  |
|  |  |  |
|  |  |  |

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## Annex I. Conceptual Frame Work

Independent variables Intermediate variables outcome variables.

***Contraception related factors***

-Regular Contraceptive practice

- Knowledge on EC

-Attitude towards EC

-Exposure to unprotected sex & its consequences

Practice of EC

***Sexual &reproductive health factors***

- Exposure to sex education

(Parents-daughters communication about RH matters, Pear, Boy friend /husband communication about RH maters

- Sexual experience

-Providers’ knowledge & attitudes towards EC

***Fear related to EC***

-Laboratory tests

-Disapproving healthcare personnel/family/partner

-Societal negativity about teenage sexuality

-Cost of emergency contraceptives

-Infertility/side effects

## Annex II

## Individual consent form

Mettu University, College Of Public Health & Medical Science Post Graduate School, individual consent form for the study on knowledge, attitude and utilization of emergency contraceptive among mettu university undergraduate female students.

I am working as data collector in this research (study). The purpose of the study is to assess emergency contraceptive use & its associated factors among mettu University female under graduate students, in order to generate useful information for planning appropriate reproductive health strategies and interventions for university students. To attain this purpose your genuine participation in filling the questionnaire with truth information is very important and highly appreciated.

We would like to assure you, your name & ID No will not be written on this form and all the information gathered will be kept strictly confidential. You have full right to refuse, to take part of, or to interrupt the study at any time. But the information that you will give us is quite useful to achieve the study and to bring change in reproductive health in services for university student.

Thank you!

Are you willing to participate in the study? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and signature of data collector, Name \_\_\_\_\_\_\_\_\_\_\_\_ signature \_\_\_\_\_\_\_\_\_\_\_\_date

Supervisor’s Name and signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person’s/ principal investigator’s name and address

Name Getachew ketema

Telephone 0910950514

E-mail getechewketema91@g-mail.com

*Instruction: Circle the code number given parallel to the answer you choose and for questions that you give direct answer, write the answer in the space provided.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NO | | | | **Questions** | | | **Responses** | | | **Code** | **Skip to** | |
| Section I- Socio-demographic and economic Characteristics | | | | | | | | | | | | |
| Q 101 | | How old are you? | | | | | | | Age in completed years ----------- | |  | |
| Q 102 | | What is your ethnic group? | | | | | | | Oromo 1  Amhara 2  Gurage 3  Tigrie 4  if other specify\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | |  | |
| Q 103 | | Where did you come from | | | | | | | Urban 1  Rural 2 | |  | |
| Q 104 | | What is your Religion | | | | | | | Orthodox Christian 1  Muslim 2  Catholic 3  Protestant 4  Other,specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | |  | |
| Q 105 | | How often you go to the church / mosque? | | | | | | | Daily 1  Once in a week 2  Occasionally 3  Accidentally 4  More than once in a week specify)\_\_ 5 | |  | |
| Q 106 | | What is your department /stream? | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | |
| Q107 | | What year of study are you now? | | | | | | | First year 1  Second year 2  Third year 3  Fourth year 4  Fifth year 5 | |  | |
| Q108 | | What is your current marital status? | | | | | | | Never Married 1  Married 2 | |  | |
| Q109 | | Number of children | | | | | | None 1  One 2  Tow 3 | | |  | |
| Q 110 | | What is your parents occupation | | | | | | One/both peasant 1  one/both employee 2  Traders 3  If other specify ­­­­­­­­­­­­­­­­­­––––––– 4 | | |  | |
| **Section II-** Sexual &reproductive related issue with Family, Peer, Partner/boy friend | | | | | | | | | | | | |
| Q 112 | what is the educational status of your father? | | | | | | | Illiterate 1  Primary education 2  Secondary education 3  Above secondary 4 | | |  | |
| Q113 | Do you talk/discuss about  RH issues with your father? | | | | | | | Yes 1  No 2 | | |  | |
| Q 114 | What is the educational status of your mother? | | | | | | | Illiterate 1  Primary education 2  Secondary education 3  Above secondary 4 | | |  | |
| Q 115 | Do you talk/discuss about  RH issues with your mother? | | | | | | | Yes 1  No 2 | | |  | |
| Q 117 | Have you ever discuss/ talk about reproductive health issues with your peer/boyfriend/ husband? | | | | | | | Yes 1  No 2 | | |  | |
| **Section III.** Fear related factors | | | | | | | | | | | | |
| Q201 | Have you ever used EC? | | | | | | | | Yes 1  No 2 | |  | |
| Q202 | If no what is the reason not to use? | | | | | | | | Fear of side effect 1  Lack of knowledge of the method 2  Fear of loss of privacy 3  Provider disapproval 4  Social negativity about teen age sexuality 5  Fear of parental disapproval 6  Cost 7  Fear invasive procurers 8 Laboratory examination 9 | |  | |
| **Section IV. Sexual experience , knowledge and practices of contraception** | | | | | | | | | | | | |
| Q 3O1 | Have you ever heard about  Family Planning Methods? | | | | | Yes 1  No 2 | | | | | | If No go to Q307 |
| Q302 | If ‘Yes’, which one do you know? (more than one response is possible) | | | | | Oral pills 1  IUD 2  Injectables 3  Condoms 4  Norplant 5  Withdrawal 6  Calendar/ Rhythm 7 | | | | | |  |
| Q 303 | |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  | | |   If yes to Q301 from where you got the information? | | | | | From health workers 1  Pharmacy 2  from friends/peers discussion 3  from teachers in the class 4  from clubs in the schools 5  From parents 6  From privet clinic 7  From mass media (TV, Radio) 8  By reading articles/news 9  if other specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | | |  |
| Q304 | Where do you feel comfortable to get information on contraception? | | | | | Health workers education 1  Friends/peers discussion 2  Teachers in the class 3  Clubs in the schools 4  parents 5  Mass media (TV, Radio…) 7  Reading articles 8 | | | | | |  |
| Q305 | Do you accept/approve that family planning methods prevent pregnancy? | | | | | Yes 1  No 2 | | | | | |  |
| Q 306 | Have you ever heard/seen information regarding family planning in the last six months? | | | | | Yes 1  No 2 | | | | | |  |
| Q307 | Have you ever discuss about reproductive health issues with your friends? | | | | | Yes 1  No 2 | | | | | |  |
| Q308 | If ‘Yes’, is there anyone who has an experience of sexual intercourse? | | | | | Yes 1  No 2 | | | | | |  |
| Q 309 | Do you have any sexual experience? | | | | | Yes 1  No 2 | | | | | |  |
| Q 310 | If yes at what age were you had the first sexual intercourse? | | | | | Age in complete years \_\_\_\_\_\_\_\_\_\_\_\_\_  I do not remember 96 | | | | | |  |
| Q 311 | How many partners have you ever had for sexual intercourse in your life time? | | | | | One 1  Two 2  Three 3  More than three 4  I do not remember 96 | | | | | |  |
| Q 312 | If your answer for Q207 is ‘Yes’, have you ever used contraceptive methods? | | | | | Yes 1  No 2 | | | | | |  |
| Q 313 | If ‘Yes’, which method have you ever used? | | | | | Oral pills 1  IUD 2 injectables 3  Condoms 4  Norplant 5  Withdrawal 6  Calendar/ Rhythm 7 | | | | | |  |
| Q 314 | For how many years you use the regular contraception (duration)? | | | | | For less than 1 year 1  For 1 year 2  For more than 1 year (specify)\_\_\_\_\_\_\_\_\_ 3 | | | | | |  |
| Q 315 | If your answer for question 212 is ‘No’ what was your reason? (more than one response is possible) | | | | | Contraceptive not available 1  Cost of contraceptive not affordable 2  Lack of Knowledge about Contraceptive 3  Partner opposed 4  Religious/moral reasons 5  Fear of side effect 6  Wanted to be pregnant 7  Infrequent sex 8  Other specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | | |  |
| Q 316 | Have you ever been pregnant? | | | | | Yes 1  No 2 | | | | | |  |
| Q 317 | If ‘Yes’ how many times? | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Q 318 | Is there a pregnancy which was unplanned? | | | | | Yes 1  No 2 | | | | | |  |
| Q 319 | If ‘Yes’, how did you fail to prevent pregnancy? | | | | | Forced sexual intercourse 1  Unavailability of contraceptives 2  Calendar method was not correct 3  Contraceptive failure 4  Condom slippage/ broken 5  Forget to take contraception 6  Religious/ moral reasons 7  Infrequent sex 8  Wanted to be pregnant 9 | | | | | |  |
| Q 320 | Have you ever had induced abortion? | | | | | Yes 1  Yes 2  No response 3 | | | | | |  |
| Q321 | If ‘Yes’, how many times? | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Q 322 | Place of induced abortion | | | | | Clinics/by skilled person 1  Untrained abortionist 2 | | | | | |  |
| Q 323 | Reason to have induced abortion | | | | | Fear of parents & family 1  Fear of discontinuing school 2  Economic problem 3 | | | | | |  |
| Q 324 | Do you intend to use any modern contraceptive method to delay or avoid pregnancy at any time in the future? | | | | | Yes 1  No 2  Not sure 96 | | | | | |  |
| Q 325 | If ‘No’, what is /are the main Reason/reasons?(More than one response is possible) | | | | | Contraceptive not available 1  Cost of contraceptive not affordable 2  Partner opposed 3  Religious/ moral reasons 4  Fear of side effects 5  No plan to have sex in the future 6  Infrequent sex 7  Other specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | | |  |
| Q326 | Have you ever had sexual intercourse without using condom or other contraceptive methods? | | | | | Yes \_\_\_\_ \_ 1  No \_\_\_\_ \_ 2  I don’t know \_\_\_\_ 3 | | | | | | If No go to 332 |
| Q 327 | If ‘Yes’, have you ever use EC methods to prevent pregnancy? | | | | | Yes 1  No 2 | | | | | | If No go  to 332 |
| Q328 | If ‘Yes’ for question 227 which method of EC have you used? | | | | | Combined oral pills 1  Progestin only pills (postinor-II) 2  Estrogen only pills 3  IUD 4  Do not remember 96 | | | | | |  |
| Q 329 | Why did you use it during that time? | | | | | Timing was miscalculated 1  Did not use any contraceptive 2  Condom slipped/broken 3  Missed pills 4  Forced to had sex 5  Contraceptive failure 6 | | | | | |  |
| Q 330 | Who recommended you to use it? | | | | | A friend 1  Partner/ boyfriend 2  Health care provider 3  Internet webpage 4  Parents 5  Don’t remember 96 | | | | | |  |
| Q 331 | Where did you get it? | | | | | Public hospitals 1  Private clinics/hospitals 2  Reproductive Health Clinics 3  Pharmacies 4  School/campus clinics 5  Partner/ boy friend 6  Female friends 7 | | | | | |  |
| Q 332 | If your answer for question 327 is ‘No’ what is your main reason? | | | | | I used contraceptives correctly and consistently 1  Used safe period correctly 2  Had no enough information about EC 3  Had no access to EC 4  Cost of EC is not affordable 5  Religious/moral reasons 6  Partner oppose 7 | | | | | |  |
| Q 333 | Have you ever had unwanted pregnancy because of not taking EC? | | | | | Yes 1  No 2 | | | | | |  |
| **Section IV. Knowledge About Emergency Contraception (for all respondents)** | | | | | | | | | | | | |
| Q 401 | Is there any method that could be taken to prevent unwanted pregnancy after unprotected sex? | | | | Yes 1  No 2 | | | | | |  | |
| Q 402 | If ‘Yes’, mention all the methods you know | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | |
| Q 403 | Have you ever heard about emergency contraceptives? | | | | Yes 1  No 2 | | | | | |  | |
| Q 404 | What was your first source of information? | | | | Television/Radio 1  Magazines/ news papers/ Internet webpage 2  Relatives / Parents 3  Boyfriend/partner / Female friends 4  Health care providers / Reproductive Health clubs 5  At campus/college clinic/ formal lecture/ course 6 | | | | | |  | |
| Q 405 | Of the listed, which can be used as emergency contraception?  ( More than one response is possible) | | | | Progestin only pills/postinor-II 1  Estrogen only pills 2  IUD 3  Herbal vaginal pessaries 4  do not know \_\_\_\_\_ 98 | | | | | |  | |
| Q 406 | How do you see the composition of drugs in ECPs compared to other regular modern contraceptive methods? | | | | The same as in the regular contraceptive pills 1  The same but a high does in the same hormones 2  completely different from the drug of regular  contraceptives 3  Don’t know 98 | | | | | |  | |
| Q 407 | To prevent pregnancy effectively, how long the first dose of ECPs should be taken after unprotected sexual intercourse? | | | | Immediately after sex 1  Within 24 hours after sex 2  Within 72 hours after sex 3  Within 4-6 days after sex 4  Even after a missed period 5  Don’t know 98 | | | | | |  | |
| Q 408 | Do you know when IUCD will be effective as an EC | | | | Within 72 1  Within 120 /5 days 2  I don’t know 98 | | | | | |  | |
| Q 409 | What is the mechanism of action of EC? | | | | Prevent pregnancy from occurring 1  Induced abortion 2  Prevent pregnancy and induced abortion 3  Don’t know 98 | | | | | |  | |
| Q 410 | How effective are emergency contraceptive pills in preventing pregnancy? | | | | Highly effective (99%) 1  Three-fourth (75%) 2  Half (50%) 3  Below one –third (30%) 4  Uncertain 96  Don’t Know 98 | | | | | |  | |
| Q 411 | In what situations that EC should be taken to prevent pregnancy?  (More than one response is possible) | | | | When forced to have sex 1  When condom slipped or broken 2  When there is missed pills 3  When there is failure of contraception 4  When there is infrequent sex 5  When there miscalculation of calendar Method 6  Don’t know 98 | | | | | |  | |
| **Section V. Attitude towards EC** | | | | | | | | | | | | |
| Q 501 | | | Do you believe that you will use EC or recommend others in case of need in the future? /Intention to use EC in the future/ | | | Yes 1  No 2  No response 96 | | | | |  | |
| Q 502 | | | If ‘Yes’, what is your reason to use EC in the future? (More than one response is possible) | | | It is safer than the regular contraceptives 1  It is more convenient than the regular contraceptives 2  It is more effective than the regular contraceptives 3  Other reason, specify\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |
| Q503 | | | If ‘No’, what is your reason to not use EC in the future? (More than  one response is possible) | | | It is against my religion 1  It is not effective 2  It is dangerous to one’s health 3  I am using regular contraceptive methods 4  My partner does not like it 5  It causes abortion 6  It may hurt the baby in case it does not work. 7  Results sterility in the future 8  Makes women to suffer from STI even HIV/AIDS 9  I don’t have enough information about EC 10 | | | | |  | |
| Q 504 | | | Unwanted pregnancy is a problem for all female | | | Yes 1  No 2  No response 98 | | | | |  | |
| Q 505 | | | EC is necessary to prevent abortion and its complications | | | Yes 1  No 2  Don’t know 98 | | | | |  | |
| Q 506 | | | Do you believe the service provided by health workers in campus or nearby clinic convenient to use EC? | | | Yes \_\_ \_\_ 1  No \_\_ 2  I don’t know---- 98 | | | | | If No go toQ507 | |
| Q 507 | | | No to Q406 what is the problem? | | | Health workers unwilling//unfriendly/ \_\_ \_\_ 1  Incompetent health workers \_\_ \_\_ 2  Drugs un available \_\_ \_\_ 3  Time for the service inconvenient \_\_ \_\_ 4  Privacy not kept \_\_ \_\_ 5  Health institute is far to get Services \_\_ \_\_ 6  mention if other \_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |
| Q 508 | | | Do you think it is good idea to avail emergency contraceptives for all females? | | | Yes \_\_\_\_ \_ 1  No \_\_\_\_ \_ 2  No response \_\_\_ 98 | | | | |  | |
| Q 509 | | | If yes to Q408 why? | | | Females can use it whenever they faced  risk of acquiring unwanted pregnancy 1 mention if other\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |
| Q 510 | | | If no to Q408 why? | | | Fear of rumors & misinterpretation of taking EC-- 1  May encourage youth for in responsive sexual activities, increase risk of HIV/AIDS & STIs \_\_ \_\_ 2  Mention if other \_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |
| Q 511 | | | Are you willing to use EC if you face a problem? | | | Yes \_\_ \_\_ 1  No \_\_ \_\_ 2  No response\_\_ \_\_ 98 | | | | |  | |
| Q 512 | | | If yes to Q412 why? | | | I prefer to use EC than having unwanted Pregnancy 1  mention if other\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |
| Q 513 | | | If no to Q412 why? | | | Fear of rumors & misinterpretation 1  Fear of religious prohibition 2  prefer to give birth than using EC 3  mention if other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |
| Q 514 | | | Do you recommend for other females or friend? | | | Yes \_\_ \_\_\_ 1  No \_\_ \_\_\_ 2  Do not know \_\_\_ \_\_ 3 | | | | |  | |
| Q 515 | | | If no to Q414what is your fear? | | | Religious prohibition 1  Fear of friends, providers, Parents 2  Fear of side effects of methods 3  Unavailability of methods 4  Lead females to prostitution 5  Friend do not agree 6  Fear of HIV/AIDS 7  Mention if other\_\_\_\_\_\_\_\_\_\_\_\_\_ 99 | | | | |  | |

***Thank you!!!!!***