ENSIGN GLOBAL UNIVERSITY, KPONG
EASTERN REGION, GHANA

FACULTY OF PUBLIC HEALTH

DEPARTMENT OF COMMUNITY HEALTH

FACTORS INFLUENCING THE USE OF EMERGENCY CONTRACEPTIVE PILLS AMONG REPRODUCTIVE-AGED WOMEN AT SOME SELECTED COMMUNITIES WITHIN THE LEDZOKUKU MUNICIPALITY IN THE GREATER ACCRA REGION OF GHANA

BY

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NOVEMBER, 2025

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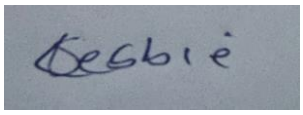
DECLARATION

I hereby declare that except for references to other people's work, which I have duly cited, this research project submitted to the Ensign Global University, Kpong, is the result of my investigation and has not been presented for another degree elsewhere.

Martina Lebbie (247100286)  5/11/2025

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Certified by:

Dr. Stephen Manortey …… ……

(Head of Academics) Signature Date

DEDICATION

This study report is exclusively dedicated to my beloved husband, Nii Amartey Amarteifio and my son, Sahr Cyrus Amarteifio. To my siblings Kumba, Tamba, Finda and Sonia Lebbie.

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DEFINITION OF TERMS

TERM	**DEFINITION**
Emergency Contraceptive	Pills or methods used to prevent pregnancy after unprotected sex.
Reproductive age	Planning when and how many children to have using contraceptives.
Accessibility	Age range when a person can biologically have children (usually 15–49 years).
Cost	How easy it is to get and use a service or product.
Family planning	The amount of money needed to buy a product or service.

LIST OF ABBREVIATIONS

ABBREVIATION	MEANING
EC	Emergency Contraceptives
WHO	World Health Organization
IUDS	Intrauterine device
COCs	Combined Oral Contraceptives
LMIC	Low and Middle-Income Countries
UN-DESA	United Nations Department of Economic and Social Affairs
OR	Odds Ratio
AOR	Adjusted Odds Ratio
C.I	Confidence Interval

ABSTRACT

Introduction: Unplanned or unintended pregnancy often leads to unsafe abortion. Unsafe abortion is one of the commonest causes of pregnancy related deaths in developing countries including Ghana (Yeboah et al, 2021). A lot of unplanned or unintended pregnancies can be avoided using emergency contraceptives (EC). Emergency contraceptives are mostly used after unprotected sexual intercourse and have a 99% chance of preventing unplanned pregnancy when taken within the first three days. Significant information gaps and misconceptions about the proper use, efficacy, and adverse effects of EC pills persist despite high awareness

Objective: The aim of the study was to examine factors that influence the use of emergency contraceptive (EC) pills among women of reproductive age range of 15 to 49 in some communities within the Ledzokuku Municipal Assembly in the Greater Accra Region of Ghana.

Methodology: A cross-sectional analytic study design was used in seven sub-areas on the Teshie municipality. Participants were selected from their homes through a systematic sampling procedure. In instances where there are more than 4 households in a compound house structure with eligible participants for the study, a simple random was used to select the houses for the study. Structured questionnaires were administered using google forms to 424 women and 401 valid responses were obtained. To guarantee representation across various demographic groupings, stratified random sampling was employed. Descriptive statistics and logistic regression were used in the data analysis.

Results: Results were analyzed using STATA 18. Overall, the findings revealed that the use of EC pills is significantly predicted by women within the age of (18–27 years) and those with higher education levels being more likely to take them. Despite the high level of awareness, usage is not always correlated with it. Usage patterns are also influenced by sociocultural variables, religious beliefs (Muslims and traditionalists use less), accessibility issues (cost, distance, attitudes of pharmacy attendants, perceived lack of privacy), and stigma. The main access points were pharmacies (26.37%) and medical facilities (26.62%).

Conclusion The study concludes that although there is awareness, some respondents within the Ledzokuku municipality's successful usage of EC pills is hindered by information gaps, misconceptions, sociocultural obstacles, and accessibility concerns. Strengthening public health education campaigns that emphasize proper usage, enhancing accessibility and affordability, training healthcare professionals on how to provide services without passing judgment, and enlisting the help of community and religious leaders to overcome cultural obstacles are some of the recommendations.

Keywords: Emergency Contraceptives, usage, reproductive age women, Ledokuku municipality

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Using emergency contraceptive (EC) pills play a vital role in supporting reproductive health by offering women a reliable option to prevent pregnancy after unprotected sex or contraceptive failure. EC pills are mostly effective when taken within 72 hours of unprotected sexual intercourse and can reduce the risk of unintended or unplanned pregnancy by 75% to 99% (Yeboah et al., 2022). EC pills serve as a critical backup method and not a regular form of birth control to empower women to make timely decisions about their reproductive choices (Yeboah et al., 2022). Increasing awareness and accessibility of EC pills is essential to promoting informed and safe reproductive health practices (Mishore et al., 2019).

Unplanned pregnancies are a global health concern, accounting for 44% of all pregnancies with 74 million in developing countries (Halidu & Sumaila, 2022). Globally, 74 million women living in low and middle-income countries have unintended pregnancies annually (Amaniampong et al., 2022).This leads to 25 million unsafe abortions and 47,000 maternal deaths every year (Amaniampong, Engelbert, Manu, & Tarkang, 2022). Global estimation shows that 222 million women who want to prevent pregnancy are not accessing effective, modern methods of contraception (Yeboah et al., 2021). As a result, the prevalence of unwanted pregnancy and abortion continues to rise in sub-Saharan Africa (Yeboah, Appiah, & Kampitib, 2022). Each year, between 4.7 and 13.2% of maternal deaths are attributed to unsafe abortion and the incidence of unsafe abortion stands at 25 million annually (Amamiampong et al., 2022). Three (3) out of four (4) abortions that occur in Africa are unsafe and the risk of dying from an unsafe abortion is highest in Africa (Amaniampong, Engelbert, Manu, & Tarkang, 2022).

The WHO stated that use of modern contraceptives in 2017 prevented an estimated 308 million unintended pregnancies (WHO, 2019). Meeting the full demand for modern contraceptive methods could prevent an additional 67 million unintended pregnancies each year (WHO, 2019). The United Nations Department of Economic and Social Affairs (UN-DESA) noted that despite the benefits of contraceptives, their use in Africa is 29.4% among women of reproductive age (WHO, 2019). An estimated 21.6 million unintended pregnancies occur in Africa, of which close to 38% end in induced abortions every year (Dawson, Earl, & Livezey, 2020).

Though Ghana has made significant progress in improving reproductive health outcomes, challenges like unwanted pregnancies persist and are very common, according to a study by Beson, Appiah & Adomah-Afari (2018). In a survey conducted by the Ghana Statistical Service in 2020, the Ghana maternal health survey showed that 34.6% of women of childbearing age had never used EC pills, while 27.4% of women had experienced unwanted pregnancies (Ghana statistical service, 2022). Majority of those pregnancies were due to not using emergency contraception as well and the mortality ratio in Accra was 120 deaths per 100,000 live births with 17.95 of such deaths occurring as a result of infection (Ghana Statistical Service, 2022).

This high level of unintended pregnancy and abortion is because of persistent social and cultural barriers to accessing reproductive health issues (Munakampe, Zulu, & Michelo, 2018). Unfortunately, little is known about the knowledge, awareness, attitude, utilization and barriers to emergency contraceptives among reproductive-age women in some communities in the Ledzokuku municipality.

EC pills are underutilized despite being available in some communities in the Ledzokuku municipality in the Greater Accra region of Ghana. Several factors, such as socioeconomic status, knowledge, accessibility, and cultural beliefs influence the adoption of EC pills (Amaniampong, Engelbert, Manu, & Tarkang, 2022).

According to a research done, many women do not know enough about EC pills, how they work, and when they are available (Eshun-Wilson, Rohwer, Hendricks, Oliver, & Garner, 2019). Women may be reluctant to use EC pills due to misconceptions about them, fear of stigma or receiving false information about possible health risks (Higgins et al., 2016). Women's willingness to seek and use EC pills can be strongly influenced by cultural attitudes and religious beliefs toward contraception and reproductive health (Asiedu et al., 2020; Adjei et al., 2015). Ghana's cultural norms regarding family planning and sexuality may make it difficult for people to access these important resources (Berhe et al., 2024).

Accessibility is another important component. Logistical issues like cost, accessibility to pharmacies, and availability of EC pills can impede timely access in many communities (Benson, Cobbold, Boamah, Akuoko, & Boateng, 2020). These issues are problematic for lower-income populations. Hence, the role of socioeconomic status is noteworthy, as women hailing from economically disadvantaged backgrounds may encounter more difficulties in accessing reproductive health services. In view of this, gaining an understanding of these elements is crucial to creating focused interventions that will improve the reproductive health outcomes of reproductive-aged women in the Ledzokuku municipality.

The World Health Organization (WHO) stated that emergency contraceptive pills can reduce the risk of unintended pregnancy by up to over 95% when taken within 72 hours after sexual intercourse. (WHO, 2021). The emergency contraceptive pill is also known as the morningafter pill and is effective when taken shortly after coitus. Emergency contraceptive pills can be grouped into two: combined oral contraceptive pills, which contain oestrogen and progestin, and progesterone-only pills containing only progesterone (Yeboah, Appiah, & Kampitib, 2022). Emergency contraceptive pills work by preventing ovulation, altering the lining of the uterus to prevent implantation, and thickening the cervical mucus to prevent sperm from reaching the egg. Emergency contraceptive pills though medically safe can cause the following minor side effects, nausea and vomiting, abdominal pain, fatigue, headaches, dizziness,

menstrual irregularity, and slight irregular vagina bleeding. It is worth noting that an emergency contraceptive does not terminate an existing pregnancy, nor does it protect against sexually transmitted infections.

Since the inception of EC in Ghana, some studies have been conducted to identify factors influencing the use of EC. However, the focus of most of these studies are on adolescents or university students with limited studies focusing on communities. This study, therefore, sought to fill the existing knowledge gap by assessing knowledge about EC pills, attitudes toward them, utilization, and barriers among the reproductive aged women in some communities within the Ledzokuku municipality in the Greater Accra region of Ghana.

1.2 Problem Statement

Ghana's unmet need for contraceptive usage among women aged 15 -49 years is 15.9% and for greater Accra is 15.2% (Ghana demographic and health survey, 2022). National surveys offer broad statistics, but there is a dearth of localized research in the Ledzorkuku Municipal, which creates a critical knowledge gap regarding the obstacles, attitudes, and access issues that women face in this particular setting. The magnitude of this issue affects a significant segment of the populace, particularly women between the ages of 15 and 49, who are most vulnerable to unplanned pregnancies (Henry et al, 2021). The frequency of unwanted pregnancies in some communities and the ensuing negative effects on health, society, and the economy raise the possibility that many women are not making enough use of EC pills; either they are not empowered, or they are impoverished (Engmann, Lamptey & Lawson, 2024).

Studies show that not much is known about the variables influencing the use of EC pills in particular Ghanaian communities including those in the Ledzokuku municipality (Rokicki & Merten, 2018). Even though EC pills have been around for decades, the issue still seems to exist, which suggests that more focused research is required to determine when these barriers first appeared and how they have changed over time (Beson, Appiah & Adomah-Afari, 2018).

To close this research gap, a methodical and sequential investigation of elements like awareness, accessibility, socio-cultural norms, and barriers within the health system is needed. This is to help policymakers, healthcare professionals, and leaders devise better plans to enhance the reproductive health outcomes of women in communities in the Ledzokuku municipality if they have a better understanding of these factors.

1.3 Rationale of the Study

Emergency contraceptive (EC) pill awareness and accessibility remain critical challenges to improving reproductive health outcomes in Ghana. Although previous studies have examined EC pill use in various settings, there is a lack of localized research specific to Ledzokuku municipality. Without context-specific data, it is difficult for health policymakers and practitioners to design effective interventions that address the unique barriers faced by women in this area (Yeboah et al., 2021). The absence of focused research leaves a critical gap in understanding how local factors influence knowledge, attitudes, and use of EC pills (Beson et al., 2018). Addressing this gap is essential to developing how local factors influence knowledge, attitudes, and use of EC pills. Addressing this gap is essential to developing targeted educational strategies and programs that promote informed reproductive choices among women in the municipality (Yeboah et al., 2021). This study is therefore necessary to generate evidence that will inform policies and interventions tailored to the needs of the Ledzokuku municipality, ultimately contributing to improved reproductive health outcomes. Thus, understanding the influence of reproductive-age women within the Lezdokuku municipality using EC pills is a critical need that this study attempts to fill.

This study will close a significant gap in literature by adding more information and viewpoints to the large conversation on reproductive health in Ghana.

1.4 Conceptual framework

The framework conceptualizes the Andersen healthcare utilization model. It is a conceptual model aimed at demonstrating the factors that lead to the use of health services. According to the model, usage is determined by three dynamics. These dynamics are predisposing factors, enabling factors and need.

Predisposing factors are characteristics such as the socio-demographic factors. Enabling factors are the knowledge and awareness, attitudes and factors. Need represents both perceived and actual need for health care services and in this case, the need to use EC pills.

This study is well-suited to this framework based on its objectives. Several factors come into play and are considered when the issue of emergency contraceptive use is raised. From the conceptual framework it starts with socio-demographic data which includes age, educational level, income, religion and marital status. These socio-economic data will influence variables such as knowledge and awareness level, attitude and factors such as accessibility, side effect and availability. All these variables will now lead to the usage of EC pills.it starts with elements at the individual level (awareness and knowledge). These variables are essential to comprehending health behavior in communities (Ofori et al., 2024).

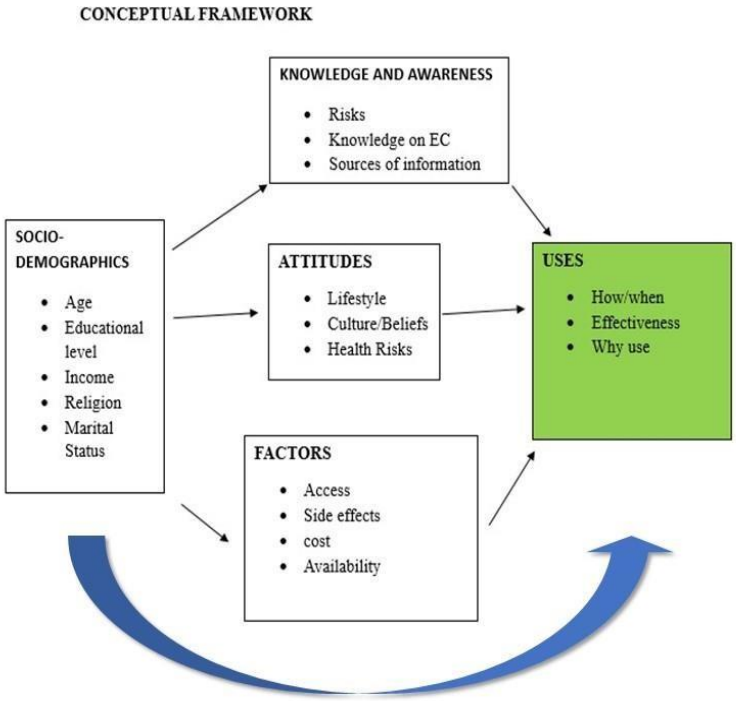

Figure 1.1 A Modified Conceptual framework based on Andersen healthcare utilization model

1.5 Research Questions

1. What is the level of knowledge the reproductive aged women have about emergency contraceptive pills?
2. What are the reproductive aged women's attitude on the use of EC pills?
3. What are the factors that influence the use of EC pills among reproductive-aged women in the Ledzokuku municipality?
4. What is the level of usage among the reproductive aged women in the Ledzokuku municipality?

1.6 General Objectives

The general research objective is to assess the factors influencing the use of emergency contraceptives among reproductive-aged women in the Ledzokuku municipality.

1.7 Specific Objectives

- To assess the level of knowledge and awareness of EC pills among reproductive aged women in the Ledzokuku municipality.
- To assess the attitude of the reproductive aged women on the use of C pills.
- To identify the factors that influence the use of EC pills among the reproductive-aged women in the Ledzokuku municipality.
- To assess the level of use of EC pills among the reproductive aged women.

1.8 Profile of the Study Area

The study was conducted within some communities in the Ledzokuku municipality in the Greater Accra region of Ghana. Ledzokuku Municipal is one of the 29 administrative areas in the Greater Accra region of Ghana. It is situated in the region's center. Teshie serves as the capital of the Ledzokuku Municipal. The total area of the municipality is 35.6 square kilometers. By population, 217,304 people are living in the Ledzokuku Municipality. The Ledzokuku Municipality was formally, the Ledzokuku-Krowor Municipal. It was formed in 1988 from the Accra Metropolis. In 2018, the Ledzokuku-Krowor Municipal was divided into the Krowor Municipal and the Ledzokuku Municipal was renamed for the remaining portion.

Geographically, the Ledzokuku Municipal is bounded to the north by the Accra – Tema Motorway, to the east by Spintex Road, and the south by the Gulf of Guinea. Due to its location, the municipality has drawn both domestic and foreign investors to set up businesses, industries, financial institutions, and real estate. Lekma Hospital, one of the most renowned hospitals in the Greater Accra area, is in the Ledzokuku Municipal. Other places include Labadi Beach, Fort Augustaborg, Kofi Annan International Peacekeeping Training Centre, and the headquarters of the Ghana Armed Forces and the Ghana Ministry of Defence. In terms of religion, Pentecostal churches and orthodox denominations like Catholics, Presbyterians, Methodists, and Anglicans are widely represented in the region. Common localities or

administrative areas under Teshie include Teshie North, Teshie South, Teshie-Ningua estates, Teshie Lascala, Teshie old and new town, Tsuibleoo, Teshie camp and Greda estates. For this research, I chose the North-Teshie area of the Ledzorkuku Municipal Assembly, which comprises six areas (Assembly, 2023).

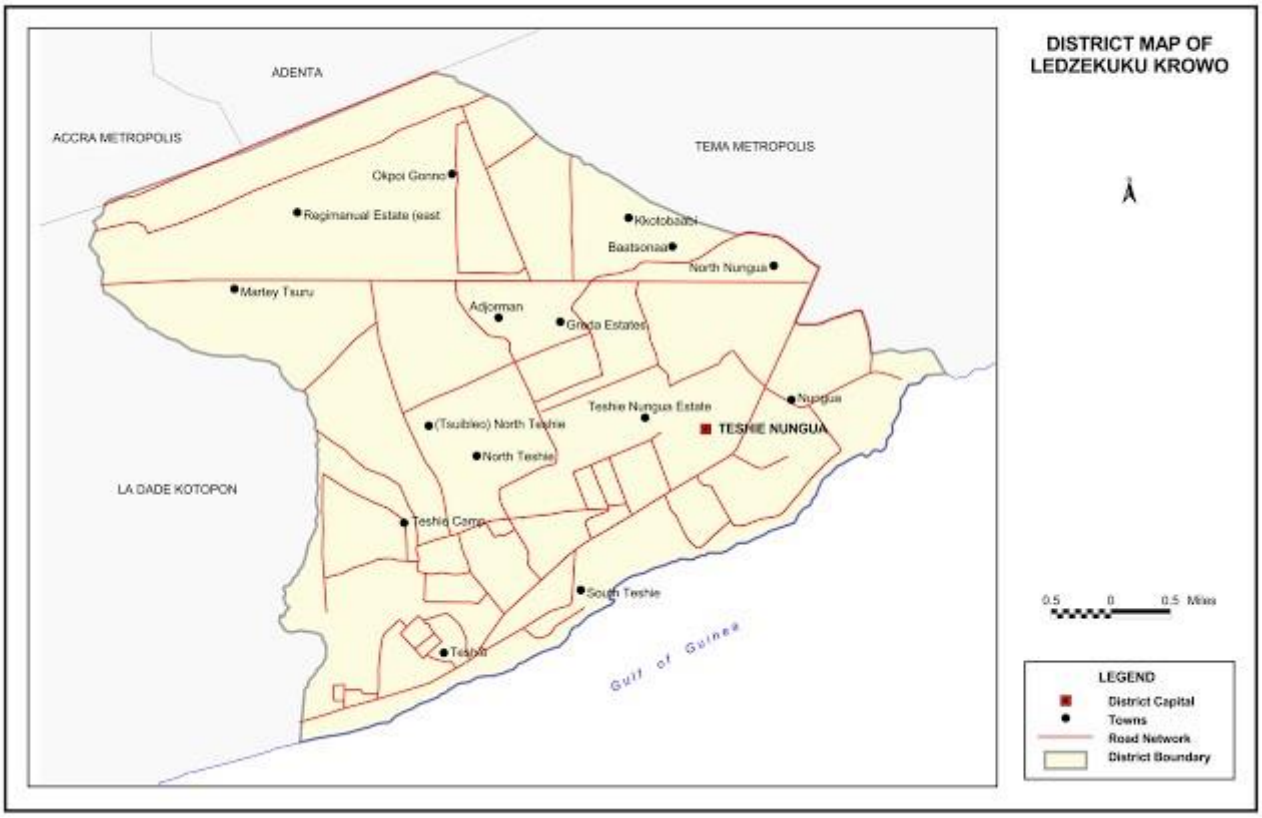

Figure 1.2 Map of Ledzokuku Krowo

Source: Ghana Statistical Service

1.9 Scope of study

This study examined the use of emergency contraceptive (EC) pills by reproductive-aged women in some selected communities within the Ledzokuku municipality, in Greater Accra Ghana. It emphasized the importance of EC pills in preventing unwanted pregnancies as well as the difficulties associated with low use because of socioeconomic, cultural, and knowledge gaps. The goal of the study was to assess women's awareness, influencing factors, attitudes and

accessibility challenges in these selected communities: Anumantu Biye Ashwe ye, Etschoo, Aye Kor Wor, Salinko and Manna. They were selected based on the time factor and availability of participants. These women were fertile and sexually active. They were expected to provide the information needed towards achieving this study's objectives via the use of a wellstructured questionnaire. The selected age range is within the age range recommended by the reproductive age –group by WHO, which guided the inclusion criteria for this study (WHO, 2018). The research participants were able to provide the necessary information on the use of emergency contraceptive pills.

Participants were briefed on the research procedures and consent forms were also signed show their readiness to participate in the study. This study was guided by the health belief model to address constructions that have not been investigated in this municipality.

1.10 Organization of the Study

The study is presented in six chapters. Chapter one, which is the first chapter, is the introduction. It comprises the background of the study, the problem statement, the rationale of the study, the conceptual framework, the research questions, general objective, the research objectives, the profile of the study area, the scope of the study and the organization of the study. Chapter Two is the literature review. It reviews the most relevant and available literature related to the topic under investigation. Chapter Three is the methodology which comprises of the research method and design, data collection techniques and tools, study population, study variables, sampling, pre-testing, data handling, data analysis, ethical consideration, limitations of the study and assumptions. Also included in chapter 3 are inclusion and exclusion criteria. Chapter Four is data analysis and results. It gives background information and presents results based on key study variables. Chapter Five presents interpretation and discussion of results of the study. It explains and evaluates the results of the study based on the research objectives and chapter six includes conclusions and recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Emergency contraceptive (EC) pills have become an essential component of reproductive health services. These tablets present a substantial chance to lower the risks of unwanted pregnancies and unsafe abortions and are especially important in cases of unprotected sexual activity or contraceptive failure (Kwame et al., 2022). Notwithstanding their significance, regional disparities in EC pill accessibility, awareness, and use persist due to a variety of factors, including socioeconomic circumstances, cultural norms, healthcare infrastructure, and legislative frameworks (Rokicki & Merten, 2018).

Globally, differences in cost, distribution, and societal perceptions of the use of contraceptives have impacted access to EC pills (Gbagbo, 2024). EC pills are typically sold over the counter in high-income nations, but their use is frequently restricted by societal stigma and financial constraints, particularly for low-income women and adolescents (Gbagbo, 2024). Stock outs, cultural restrictions, and a lack of healthcare facilities exacerbate access issues in Low- and Middle-Income Countries (LMICs) (Gbagbo 2024). As many studies around the world have shown, these obstacles together contribute to the notable discrepancy between awareness and usage (Gbagbo, 2024).

Africa has difficulties expanding access to EC pills because of a confluence of cultural, economic, and systemic healthcare barriers (Amaniamponget al., 2022). The need for EC pills is especially critical because of the high rate of unwanted pregnancies and unsafe abortions on the continent (Amaniampong et al., 2022). Nonetheless, underprivileged and rural communities frequently face financial and geographic obstacles, which exacerbate the disparities in access to reproductive healthcare (Amaniampong et al., 2022). Informal pharmacies try to bridge the

gap left by official healthcare systems in some places, but there are issues with product quality and cost inflation (Amaniampong et al., 2022).

The circumstances in Ghana are similar to those in other parts of Africa, but they are further complicated by regional sociocultural factors (Tawiah et al., 2024). There are more pharmacies and medical professionals in urban areas like Accra, hence EC pills are usually easier to obtain (Tawiah et al., 2024).

On the other hand, rural areas frequently lack sufficient infrastructure, forcing women to travel great distances to get these necessary prescription drugs. Accessibility and social stigma are still major barriers for many women, even when they are available. Accessibility is also influenced by the attitudes of healthcare providers; moral and religious objections can occasionally limit the sale and distribution of EC pills, especially to young or single women (Coombs et al., 2022).

To tackle the challenges of making EC available, it is very important to understand how distance and societal attitudes work together. This review aims to investigate these factors from Ghanaian, African, and global viewpoints, emphasizing the urgent need for focused interventions. Policymakers and healthcare professionals can enable women to make knowledgeable decisions regarding their reproductive health by removing these obstacles, which will ultimately lead to better health outcomes and increased gender parity (Yeboah et al., 2022).

2.1 Awareness of EC pills among women of reproductive age

Since they give women a vital alternative to avoid unwanted pregnancies following unprotected sexual activity or contraceptive failure, emergency contraceptive (EC) pills have emerged as a crucial part of reproductive healthcare (WHO, 2021). Due to sociocultural, economic, and policy-related factors, there are significant differences in the awareness and use of EC pills

around the world (WHO, 2021). When taken within a certain time frame following unprotected sexual activity, EC pills are a safe and effective way to prevent pregnancy, according to the World Health Organization (WHO, 2021). Studies show significant gaps in Awareness and utilization among women of reproductive age worldwide despite their safety and effectiveness (WHO, 2021).

There is comparatively high awareness of EC pills in high-income nations like USA, UK, and Australia. More than 85% of American women were aware of EC pills, according to a study by Trussell & Aiken (2016). However, only roughly 10 - 20% of women reported using EC pills at least once, indicating that awareness did not always translate into use. Misconceptions regarding the mode of action, adverse side effects, and the stigma attached to their use were among the obstacles to their use (Rokicki & Merten, 2018).

In contrast, awareness is typically lower in low- and middle-income countries (LMICs). For example, research conducted in South Asia by Sabharwal et al., (2022) found that fewer than half of women knew about EC pills, and even fewer used them. Significant obstacles were found to include restrictive policies, cultural taboos, and restricted access to reliable information (Rodriguez et al., 2013). Similarly, in Latin America, women were frequently discouraged from using EC pills due to issues like limited availability, high costs, and fear of criticism from medical professionals, even though awareness levels varied (Rodriguez et al., 2013).

A variety of cultural, socioeconomic, and structural factors impact the use and awareness of EC pills in Africa (Belachew et al., 2023). Due to the high rates of unwanted pregnancies, unsafe abortions, and maternal mortality on the continent, there is an urgent need for effective contraceptive options, such as EC pills (Belachew et al., 2023). However, research shows that in many African nations, awareness and use are still below ideal levels (Belachew et al., 2023) and the ideal level should be above 50% (Tolutope et al., 2024)

Only 35% of women in East Africa who were of reproductive age were aware of EC pills, and only 15% of them used them, according to a study done in Kenya by Kinaro et al., (2015). The stigma associated with talking about contraception, religious resistance, and a lack of sexual education were all cited for this low awareness (Kinaro et al., 2015). Similar findings were made by Dessalegn, Mohammed, & Wanamo (2021) in Ethiopia, who found that rural women frequently lacked access to education and healthcare services, whereas urban women were more likely to be aware of EC pills because of their improved access.

Similar patterns are seen in West African nations. According to a multi-country study conducted in Nigeria, Ghana, and Senegal by Bankole et al., (2017), educated urban women were more aware of EC pills than their rural counterparts. For example, in Nigeria, less than 10% of women had ever used EC pills, and only 40% had heard of them. The study emphasized the importance of cultural resistance, false information, and poor health infrastructure as major obstacles (Ibid).

The situation is a little different in Southern Africa. EC pills are more widely known and used in South Africa due to its more lenient reproductive health laws. According to a study by Mchunu et al., (2012), 60% of urban women knew about EC pills, but because of stigma and misunderstandings, usage rates were still low.

Numerous studies have examined the awareness and use of EC pills among women in Ghana who are of reproductive age. Unwanted pregnancies are a major problem in Ghana, which raises the country's rates of unsafe abortions and the health risks they pose (Yebaoh et al., 2022). Therefore, emergency contraceptives are essential in tackling these problems, but awareness and use of them vary among various demographic groups (Yeboah et al., 2022).

Research indicates that compared to rural settings, urban areas have a comparatively higher level of awareness regarding EC pills. About 50% of women in Ghana's capital, Accra, were

aware of EC pills, according to a study by Adanu et al., (2011), while only 20% of women in rural areas were. The main causes of this urban-rural divide are differences in media campaign exposure, healthcare access, and educational attainment. Urban women have easier access to pharmacies and clinics that sell EC pills, and they are more likely to come across public health messages that promote contraceptive options.

The use of EC pills is still low despite these awareness levels, Rokicki & Merten (2018) found that fewer than 10% of Ghanaian women who knew about EC pills had taken them. The study found several obstacles to use, such as the stigma associated with buying contraceptives, misunderstandings about the long-term effects on fertility, and fear of side effects. Further restricting access are sociocultural norms and religious convictions, which frequently forbid candid conversations about the use of contraceptives (Rockiki & Merten, 2018).

The part that healthcare professionals play in influencing public awareness and access to EC pills is another crucial issue in Ghana. According to a study (Awusabo-Asare, et al., 2017), although most medical professionals supported the use of contraceptives, many did not receive enough training on EC pills, which resulted in clients receiving contradictory information. Even among women who are aware of EC pills, their low use is a result of this disparity in provider attitudes and knowledge.

Accessing EC pills presents difficulties for Ghanaian young women and adolescents. According to a study by Amoah, Hinneh, & Aklie (2023), even though many young women learned about EC pills from peer networks and social media, they were frequently reluctant to buy or use them out of concern for criticism from community members and pharmacists. The study also discovered that many schools lacked comprehensive sexual education, which could help remove these obstacles (Amoah et al.,2023).

Due to sociocultural, economic, and policy-related factors, women of reproductive age in Ghana, Africa, and other countries have varying levels of awareness regarding emergency contraceptive pills (Hallidu et al., 2021). Although awareness levels are typically higher in high-income nations, stigma and misunderstandings continue to limit use. Awareness and use are lower in Africa, including Ghana, especially in underserved and rural areas where there are major obstacles due to cultural norms, poor education, and a lack of adequate healthcare infrastructure (Yeboah et al., 2022).

Addressing these obstacles through focused public health campaigns, thorough sexual education, and training for healthcare professionals should be the main goal of initiatives to increase knowledge of and use of EC pills (Belachew et al, 2023).To empower women and lessen the burden of unwanted pregnancies both locally in Ghana and internationally, policies that guarantee the accessibility and affordability of EC pills must be combined with community involvement to lessen the stigma (Yeboah et al., 2022).

2.2 Knowledge and use of EC pills among reproductive aged women

According to the World Health Organization (WHO, 2021), EC can be used in the following situations: unprotected inter course, possible contraceptive failure, incorrect use of contraceptives and sexual assault for victims without contraception coverage (WHO, 2021). EC methods include copper-bearing intrauterine devices (IUDs), LNG (levonorgestrel) IUDs, and emergency contraceptive pills (Mierzejewska et al., 2024). A copper-bearing IUD is the most effective form of EC available. The EC Pills regimens recommended by the WHO are ulipristal acetate, levonorgestrel, or combined oral contraceptives (COCs) consisting ethinyl oestradiol plus levonorgestrel. According to the WHO, EC can be used by all women of reproductive age, and this can be beneficial in preventing unplanned pregnancies and their associated complications (WHO, 2021).

In spite of the high risk of unintended pregnancy among reproductive aged women, the level of knowledge about EC pills can be highly inconsistent and dynamic as stated by a study conducted in Ethiopia in 2023 (Kinaro et al, 2021). Thus, having knowledge about emergency contraceptives significantly impacts reproductive health behavior (Kinaro et al., 2021). Some studies done have shown that when individuals, particularly reproductive aged women, have comprehensive knowledge of contraceptive methods, they are more likely to use them effectively. Some benefits of emergency contraceptive Knowledge and Use include Prevention of Unintended Pregnancies, Reduction of Maternal and Child Mortality: Proper family planning allows for safer pregnancies and reduces health risks for both mother and child, Empowerment of Women and Youth: When young people are educated about reproductive health, they are better equipped to make informed decisions about their bodies and future (Hallidu et al, 2021). A study done in the Ashanti region of Ghana among college students highlighted that the gap between knowledge and actual utilization remains a concern, as many either do not use emergency contraceptives consistently or avoid them due to fear and misconceptions (Ofori et al., 2021). In another study of student nurses and midwives in Ghana's Northern Region, 166 (86.91%) stated they had heard of EC before the research, but only 49 (25.65%) reported they had ever used it. Those with a rudimentary understanding of EC, on the other hand, lacked specific information of the content efficacy and temporal schedule after unprotected intercourse (Ti-enkawol Nachinab et al., 2022).

2.3 Factors that influence the use of EC pills among reproductive-aged women

A complex interaction of social, cultural, economic, and systemic factors influences the use of emergency contraceptive (EC) pills by women of reproductive age. Over the past few decades, EC pills have become more widely known, but actual usage rates are still inconsistent.

Research indicates that the decision to use EC pills is greatly influenced by policy environments, cultural beliefs, healthcare provider attitudes, accessibility, and knowledge (Trussel et al.,2016).

Knowledge and awareness are important factors influencing the use of EC pills worldwide. Although more than 85% of women in wealthy nations like the US are aware of EC pills, their use is frequently discouraged by misunderstandings regarding their mode of action and alleged adverse effects, according to Trussell et al., (2016). Similarly, there are psychological barriers to the use of EC pills in Europe despite widespread awareness and persistent false information about them causing infertility or abortion (ESHRE Capri Workshop Group, 2015). According to a systematic review by Sabharwal et al., (2022) on the other hand, lower awareness levels are caused by a lack of education and restricted access to reliable information in low- and middle-income countries (LMICs).

Affordability and accessibility are also crucial. Since EC pills are frequently sold over the counter, they are more accessible in affluent environments. For low-income women, the cost is still an obstacle, though Rodriguez et al., (2013). Usage is restricted in LMICs due to limited availability, especially in rural areas. For example, logistical challenges and a shortage of pharmacies in underserved areas are the main reasons why women in South Asia often report difficulty getting EC pills (Sabharwal et al., 2022).

EC pill use is also influenced by cultural and religious norms. Women are frequently discouraged from seeking EC pills in conservative societies due to the stigma associated with sexual activity and contraception (Singh et al., 2014). This is made worse by unfavorable opinions held by medical professionals, who might condemn or dissuade women who want to use post-coital contraception (Singh, Darrroch, & Ashford, 2014). Women frequently refrain from using EC pills, even when they are in need, out of fear of being judged or ashamed.

Africa has distinct sociocultural and economic contexts that influence the factors influencing the use of EC pills. The continent's high rates of unsafe abortions and unwanted pregnancies highlight how urgently accessible emergency contraception is needed. However, widespread obstacles continue to keep utilization rates low (Ofori et al., 2024).

In Africa, the use of EC pills is significantly influenced by knowledge and education. Research shows that educated, urban women are more aware than their less educated, rural counterparts. For example, urban women were three times more likely than rural women to have heard of EC pills, according to a study conducted in Kenya by Kinaro et al., (2020). This discrepancy is explained by the fact that cities have easier access to healthcare facilities and information. However, even among those who are aware, the effective use of EC pills is limited by a lack of thorough knowledge about them, including when and how to use them (Dessalegn et al., 2021).

The use of EC pills in Africa is also greatly influenced by sociocultural and religious factors. Women who use EC pills may be viewed as promiscuous, and talking about contraception is taboo in many communities (Kinaro et al., 2015). Women are deterred from seeking EC pills by this stigma, especially in situations where healthcare professionals and members of the community have judgmental views (Kinaro, et al., 2015). Women's autonomy in obtaining EC pills is further impeded by patriarchal norms, which frequently allow male partners to make decisions regarding contraception (Bankole, et al., 2017).

Another important consideration is economic barriers. EC pills are frequently left out of public health programs that offer free or heavily discounted contraceptives in some African nations. For example, the price of EC pills was found to be a significant barrier for low-income women in Ethiopia (Dessalegn et al., 2021). Similarly, access is restricted in rural and underserved areas by logistical problems like stock outs and insufficient distribution networks.

Systemic issues and the attitudes of healthcare providers also come into play. According to a 2018 study conducted in Nigeria by (Oladapo, et al., 2018), many medical professionals were unwilling to recommend EC pills due to moral or religious concerns and lacked sufficient knowledge about them. A major obstacle for women looking for post-coital contraception is this reluctance.

The use of EC pills by women of reproductive age is influenced by several factors in Ghana and other African countries. Although Ghana has made significant progress in expanding access to contraceptives, there are still issues with guaranteeing that EC pills are used and accessible to all (Yeboah et al., 2022).

There is still a disparity in knowledge and awareness among various demographic groups. According to a study by Adanu, et al., (2011), about 60% of women in Accra were aware that EC pills existed, which was higher among urban, educated women. However, awareness levels were much lower in rural areas, frequently as a result of restricted access to health promotion and education initiatives. Myths and misconceptions about EC pills, such as worries about infertility or birth defects, deter use even among women who are aware of them (Rokicki & Merten, 2018).

In Ghana, attitudes regarding the use of EC pills are significantly influenced by sociocultural norms and religious convictions. They associate EC pill use with promiscuity or a lack of selfcontrol, many women view it as morally dubious. Religious teachings and social norms that discourage contraception before marriage frequently support these views (Awusabo-Asare, et al., 2017). This is because they are afraid of being judged by their peers and medical professionals; women who could benefit from EC pills are frequently reluctant to seek them out.

The use of EC pills in Ghana is also impacted by systemic and economic obstacles. Despite being sold in pharmacies and some medical facilities, EC pills can be too expensive for lowincome women, especially those living in rural areas. Additionally, consistent access is restricted by systemic issues like insufficient supply chains and stock outs, particularly in remote areas (Amoah, Hinneh, & Aklie, 2023).

Women's access to EC pills is greatly impacted by the attitudes of healthcare providers. While many Ghanaian healthcare providers supported the use of contraceptives in principle, some had personal prejudices against EC pills, according to a study by Awusabo-Asare et al., (2017). As a result, women were frequently given inaccurate or insufficient information about EC pills or were flatly dissuaded from using them.

In the Ghanaian context, the role of adolescents and young women is especially significant. Accessing EC pills is particularly difficult for adolescents because of social stigma and restrictive laws. According to a study by Amoah, Hinneh, & Aklie (2023), although many young women were aware of EC pills, they were frequently too ashamed to buy them out of concern for criticism from community members or pharmacists. The issue is made worse by the fact that many schools still offer little comprehensive sexual education, which could help remove these obstacles.

Numerous factors, such as knowledge and awareness, sociocultural norms, economic barriers, healthcare provider attitudes, and systemic challenges, affect reproductive-age women's use of emergency contraceptive pills. Globally, high-income nations typically report greater levels of awareness, but they also encounter obstacles like stigma and misunderstandings. Cultural resistance, financial limitations, and insufficient healthcare infrastructure are the main causes of lower awareness and utilization rates in Africa, including Ghana.

Targeted interventions must be used to address these obstacles to increase the use of EC pills. Dispelling myths and giving correct information about EC pills should be the main goals of public health campaigns. Policies that guarantee EC pills' consistent availability and affordability are essential, especially in underserved and rural areas. It's also crucial to train medical professionals to provide nonjudgmental, fact-based advice on EC pills. In Ghana, addressing the particular difficulties faced by teenagers and incorporating thorough sexual education into the curriculum could greatly increase the use of EC pills and provide women with the knowledge they need to make decisions regarding their reproductive health.

2.3.1 Effects of accessibility (Cost and Distance) on the use of EC pills among reproductive-age women

One of the main factors influencing the use of emergency contraceptive (EC) pills worldwide is accessibility, which includes price and ease of access to pharmacies, licensed pharmacies, and over-the-counter stores (Akoto et al., 2022). Even though EC pills are widely acknowledged as a crucial part of reproductive health, disparities in access still exist across nations and demographic groups (Akoto et al., 2022).

Cost is still a major obstacle everywhere. EC pills are frequently available without a prescription in high-income countries like the US and many European countries, but their cost may put off low-income women. According to a study by Rodriguez et al. (2013), although EC pills are available in pharmacies, many people cannot afford their average price of $40 to $50.

This can be lessened by subsidies and insurance coverage, but these advantages are not consistently accessible to underserving women from low-income backgrounds (Sabharwal et al., 2022).On the other hand, low- and middle-income countries (LMICs) have to deal with both limited supply and high costs. The inability to pay for EC pills is a significant barrier for

low-income populations in places like South Asia, especially in rural areas, according to a systematic review by Sabharwal et al. (2022).

Another important factor is geographic proximity to pharmacies and authorized chemist shops. The concentration of pharmacies in urban areas frequently guarantees simpler access. Even in wealthy nations, rural areas might not have enough facilities (Rodriguez et al., 2013).This problem is made worse in LMICs by inadequate healthcare infrastructure. For instance, the closest pharmacy in Latin America and some regions of Southeast Asia may be several kilometres away, making it logistically impossible for women to take EC pills at all Rodriguez et al. (2013).

Accessibility is also affected by policy environments. Countries with progressive reproductive health policies frequently guarantee that EC pills are widely accessible and reasonably priced. In Sweden, for example, EC pills are widely accessible due to their supermarket availability and subsidy (ESHRE Capri Workshop Group, 2015). In contrast, access is restricted in conservative countries by restrictive policies, particularly for single women. Women are frequently forced by these limitations to obtain EC pills through unofficial or unlawful means, which presents further risks.

Economic inequality, cultural norms, and inadequate healthcare systems in Africa exacerbate accessibility problems about cost and distance. Although the value of EC pills is becoming more widely recognized, few women still take them, particularly those who live in rural areas or have low incomes. For many African women, the cost is a major obstacle. EC pills are frequently not included in the free or subsidized contraceptive programs that some governments and international organizations have implemented. According to a study conducted in Ethiopia by (Dessalegn, Mohammed, & Wanamo, 2021) women in rural areas, where incomes are frequently below subsistence levels, could not afford the average cost of EC pills. Low-income

women often cite the cost of EC pills as a deterrent, even in urban areas where they are more widely available (Kinaro et al., 2015).

The use of EC pills is also greatly impacted by the distance to pharmacies and authorized chemist shops. In Africa, rural areas frequently lack adequate healthcare infrastructure, and women may need to travel far to obtain EC pills. A study conducted in Kenya by Kinaro et al. (2015) found that it took women living in remote areas more than two hours on average to get to the closest pharmacy. The absence of transportation and the extra expenses related to travel exacerbate this logistical difficulty.

In Africa, unofficial providers like neighborhood pharmacies play a significant role. Although these stores frequently close access gaps, they might offer EC pills at exorbitant costs or give false information about how to use them. Additionally, the absence of regulations in these environments raises questions regarding the genuineness and quality of the goods being sold (Bankole, et al., 2017).

Social and cultural norms make accessibility even more difficult. Pharmacists, neighbors, and even family members may stigmatize and condemn women who seek EC pills. This is especially true in conservative cultures where it is frowned upon to have sex before marriage. Even when EC pills are financially and physically available, these attitudes deter women from openly buying them (Awusabo-Asare, et al., 2017).

Cost and distance are two accessibility issues in Ghana that are indicative of larger structural and cultural obstacles to the use of contraceptives. Disparities still exist, especially for EC pills, despite government and non-governmental organizations' efforts to increase access to contraceptives. Cost is still a major barrier. Although some public health facilities offer free or heavily discounted contraceptives, EC pills are frequently left out of these programs. According to a 2019 study by Boamah et al., the average price of EC pills in cities was between GH₵20

and GH₵40, which is too expensive for low-income women. These expenses are even more problematic in rural areas, where incomes are typically lower. Further difficulties are caused by the absence of uniform pricing guidelines among pharmacies, as some charge much higher prices than others (Boamah et al., 2019).

Accessibility is also impacted by proximity to pharmacies and chemist shops. Because pharmacies are concentrated in Accra and Kumasi, urban women in Ghana usually have easier access to EC pills. But because there aren't many pharmacies in rural areas, women have to travel far to get EC pills (Yeboah et al., 2022). According to Rokicki & Merten (2018), because EC pills are not readily available in remote areas, women frequently turn to traditional methods or forego contraception entirely.

In Ghana, the attitudes of healthcare providers are important. Some pharmacists and medical professionals were hesitant to sell EC pills to young or single women due to moral concerns, according to a study by (Awusabo-Asare, et al., 2017). This discourages women from seeking EC pills even when they are available, which not only restricts access but also reinforces stigma.

To overcome these obstacles, creative solutions have been proposed. For instance, communitybased distribution programs and mobile health initiatives seek to make EC pills more accessible to women living in remote areas. Nevertheless, these initiatives frequently lack the scale and funding necessary to have a meaningful effect (Amoah, Hinneh, & Aklie, 2023).

One important factor affecting the use of emergency contraceptive pills by women of reproductive age is their accessibility. Cost and travel time to pharmacies continue to be major obstacles worldwide, with low and middle-income countries encountering the most difficulties. These obstacles are made worse in Ghana and throughout Africa by cultural norms, systemic injustices, and inadequate healthcare facilities (Amoah et al., 2023).

To solve these problems, a multifaceted strategy is needed. The inclusion of EC pills in subsidized contraceptive programs should be a top priority for governments and policymakers, who should also make sure that pharmacies have uniform prices. It is crucial to extend the reach of medical facilities and community-based distribution initiatives, especially in rural regions. Equally important are initiatives to fight stigma and educate medical professionals to provide supportive, non-judgmental care. It is feasible to increase access to EC pills and provide women with the knowledge they need to make decisions regarding their reproductive health by removing these obstacles.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Methods and Design

A cross-sectional study design was used because it allows the collection of relatively large data in a short period of time which helped to investigate the factors influencing the use of emergency contraceptive (EC) pills among reproductive-aged women in some selected communities in the Ledzokuku municipality.

3.2 Data Collection Techniques and Tools

Data collection was done using structured questionnaires adopted from a study conducted in Kwadaso, Ghana. Questionnaire consisted of closed ended questions administered online through Google Forms. It was a 44 numbered questionnaire divided into 5 sections. **Section A** (Personal information), **Section B** (Socio demographics and economic characteristics), **Section C** (Knowledge and awareness of EC), **Section D** (use of EC), **Section E** (attitude towards EC).

3.3 Study Population

The study population consisted of women in their reproductive age (15–49 years) residing in Anumantu, Biye ashwe ye, Etschoo, Aye kor wor, Salinko, and Manna. This age range aligns with the World Health Organization (WHO) definition of reproductive-aged women, making it an appropriate target group for research on contraceptive use (WHO, 2021).

3.4 Inclusion Criteria

Inclusion criteria refer to the specific characteristics that individuals must possess to be eligible for participation in the study (Pattern & Newhart, 2017). This included women aged 15–49 years living in North-Teshie.

3.5 Exclusion criteria

Women who are younger than 15 or older than 49 were excluded since they fall outside the WHO-defined reproductive age group. Similarly, women who do not reside in the North-Teshie were not considered, as the study aimed to assess contraceptive use within this specific locality. Furthermore, women with cognitive impairments or medical conditions that hinder their ability to provide informed consent were excluded to ensure ethical research practices. Pregnant women were also excluded, as the study focused specifically on emergency contraception use rather than ongoing pregnancy.

3.6 Study Variables

Dependent Variable:

1. Use of emergency contraceptive pills (whether and how often EC pills are used)

Independent Variables:

1. **Socio-demographic factors:** Age, education, marital status, income.
2. **Knowledge and awareness:** Understanding of EC pills and sources of information
3. **Attitudes and beliefs:** Personal, cultural, or religious views about EC
4. **Accessibility:** Ease of getting EC pills, distance to source
5. **Cost:** Affordability and perception of cost
6. **Partner and social influence:** Partner support, peer pressure, community attitudes

3.7 Sampling

Determining an appropriate sample size is crucial for ensuring that the study findings are statistically significant, reliable, and generalizable to the broader population (Creswell & Creswell, 2018). The sample size was calculated using Cochran's formula (1963).

- Total Population (TP): 217,304
- Prevalence Female Population: 111,205

- Confidence Level: 95%
- Margin of Error (E): 5% (or 0.05)
- Z-score for 95% Confidence Level (z): 1.96

Population Proportion (p)

$$p = \frac{111{,}205}{217{,}304} \approx 0.512$$

Cochran's formula for sample size is:

$$n = \frac{z^2 \cdot p \cdot q}{E_2}$$

Where:

- $z = 1.96$
- $p = 0.512$
- $q = 1 - p = 0.488$
- $E = 0.05$ (5% margin of error)

$$n = \frac{(1.96)^2 \cdot 0.512 \cdot 0.488}{(0.05)^2}$$

$$n = \frac{3.8416 \cdot 0.512 \cdot 0.488}{0.0025}$$

$$n = \frac{0.9619}{0.0025} = 384.76$$

So, the sample size n is approximately **385**.

Therefore, a 10% non-response rate resulted in about 39 additional respondents, bringing the minimum sample size response to **424.**

3.8 Pretesting

Structured questionnaire was pretested on a group of 30 reproductive-aged women from a community outside the Ledzokuku municipality but with similar socio-demographic characteristics. During the pretesting process, research assistants will observe how respondents interpret and answer each question. They noted any difficulties in understanding the wording, ambiguity, or discomfort caused by certain questions. Respondents were also encouraged to

provide feedback on the clarity and relevance of the questionnaire items. Additionally, the pretest assessed the estimated time required to complete the survey, ensuring that it remains within an acceptable timeframe to encourage full participation.

3.9 Data Handling (Data Security and Confidentiality)

All collected data were kept anonymous and securely stored to protect participant privacy. All information was safely stored in password-protected electronic databases, as it will be collated digitally. Access to this data was strictly limited to authorized research personnel, ensuring that sensitive information remained protected.

3.10 Data Analysis

Both descriptive and logistics regression were used in this study to analyze the data and provide insights into the factors influencing the use of emergency contraceptive (EC) pills among reproductive-aged women in the Ledzokuku municipality. Respondents' level of knowledge and use was assessed using a series of structured, close-end questions that evaluated respondents' awareness, understanding and correct identification of EC related facts and practices. A total of 8 main knowledge based questions were used to calculate the overall knowledge based score of each respondent. Responses were scored dichotomously; correct answers indicating good knowledge were coded as 1, incorrect or I don't know responses indicated poor knowledge, were coded as 0. The individual score from all knowledge questions were summed up to create a composite knowledge score. The total score was then used to classify participants into two categories using the median. Good knowledge are participants who scored more than or equal to the median and poor knowledge are participants who scored less than the median (<50%).

Similarly, attitude towards EC was assessed using a set of 10 attitude – related statements.

Participants were asked to indicate their level of agreement on a 5 point Likert scale: strongly agree, agree, neutral, disagree and strongly disagree. Each responses across the ten attitude items were summed to generate an attitude score. To categorize the respondents into positive and negative attitude groups, the median score was used as the cut-off point. Respondents with a total score equal to or above the median were classified as having positive attitude, while those below the median were classifies as having negative attitude.

3.11 Ethical Consideration

Ethical clearance was sought from the Institutional Review Boards (IRB) and research ethics committee in Ensign Global University. Number **(ENSIGN/IRB/EL/SN-286/01).** A letter was also received from the Municipal Director of Health Services of the Ledzokuku granting permission for the study to be conducted. **Ref: LKMHD/GHS/ADMIN/01/25**. However, Consent was sought from the respondents before they completed the questionnaire explaining the study objectives, confidentiality measures, and their right to withdraw at any time without consequences. Participants were required to sign or verbally agree to the consent form before data collection proceeded. This study ensured that participants' rights, safety, and confidentiality were protected.

3.12 Limitations of study

One major limitation is its potential for selection bias, especially if certain subgroups within the population (e.g., younger women or those with lower literacy levels) are underrepresented in the sample (Rokicki & Merten, 2018). This could have affected the generalizability of the findings. Another limitation was the language barrier as the Ledzokuku municipality is a typical Ga establishment. Also questions that had sensitive nature like whether one had ever had protected or unprotected might produce social desirability bias.

3.13 Assumptions

The study assumed that respondents were in their right state of mind and completed the questionnaire based on their genuine understanding of the topic.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter presents the findings of the study in line with the specific objectives. This includes the data collected on the knowledge, attitudes, and usage patterns of emergency contraceptive pills (ECPs) among reproductive-aged women in the Ledzokuku municipality. The data is presented in tables and discussed in existing literature.

4.2 Response Rate

A total of 424 questionnaires were distributed to women of reproductive age within some communities in the Teshie municipality. Out of these, 413 were completed, representing a response rate of 97%. This high response rate indicates strong participant engagement.

4.3 Sociodemographic and economic characteristics of study participants

The socio-demographic and economic characteristics of participants were shown in table 4.1. The study team recruited 413 participants who were of reproductive ages in the Ledzokuku municipality. Majority of the respondents (44.1%) were within the 28 to 37 years age group followed by 38 to 47 years (24.5%). Most of them (71.9%) were of Christian background. Also, most of the respondents (44.1%) were married. Twenty-eight percent (28.8%) of the respondents had completed high school.

Regarding the economic status of the respondents, 381(92.3%) of them worked in the last month prior to the study period. Among those who did not work, most of them 128 (31.0) stated that they had household/family duties, others 93 (22.5%) were students, and some of them 3 (0.73%) were sick. Furthermore, 381(92.3%) of those who worked in the last month prior to the study received regular wages or salary as a form of payment. Also, 115(27.9%) of them had a monthly income of GHC 500 and 109(26.4%) earned more than GHC 500 to GHC 1,000.

Table 4.1 Sociodemographic and economic characteristics of respondents

Variable	**Frequency (N=413)**	**Percentage%**
Age		
Below 18 years	29	7.0
18-27 years	87	21.1
28-37 years	182	44.1
38-47 years	101	24.5
48 years and above	14	3.4
Religion		
Christianity	297	71.9
Islam	71	17.2
Traditional	45	10.9
Educational Level		
No formal education	7	1.7
Primary	13	3.2
Senior High School	110	26.6
Completed High School	119	28.8
Vocational degree or certificate	59	14.3
Bachelor's degree	88	21.3
Graduate or advanced professional degree	17	4.1
Marital Status		
Co-habitation	2	0.5
Divorced	34	8.2
Married	182	44.1
Separated	54	13.1
Single	138	33.4
Widowed	3	0.7
Partner's highest educational level		
No formal education	38	9.2
Primary	47	11.4
Some High School	91	22.0
Completed High School	103	24.9
Vocational degree or certificate	45	10.9
Bachelor's degree	63	15.3
Graduate or advanced professional degree	26	6.3

Do you do any type of work for pay in the last month?		
No	32	7.8
Yes	381	92.3
If you did not work in the last month, what was the main reason you did not work?		
No work available	63	15.3
Seasonal inactivity	92	22.3
Student	93	22.5
Household/family duties	128	31.0
Too young to work	18	4.36
Infirmity / sickness	3	0.73
Other, specify	16	3.87
How were you paid for your work (If currently unemployed use your last job)?		
Regular wages or salary	167	40.44
Payment in kind	60	14.5
Casual labor (hourly/daily)	67	16.2
Unpaid contribution worker	68	16.5
Self-employed or own my business	35	8.5
Not applicable	16	3.87
Monthly Income (Gross personal income per month, including allowances, bonuses and other benefits, before any deductions/expenditure without savings?)		
GHC 500	115	27.9
More than GHC 500, GHC 1,000	109	26.4
More than GHC 1,000, GHC 1,500	72	17.43
More than GHC 1,500, GHC 2,000	27	6.5
More than GHC 2,000	67	16.2
Don’t know	9	2.2
Refused	14	3.39

4.4 Knowledge and awareness of EC pills

Most of the respondents 405(98.1%) had heard of EC (Table 4.2). Amongst them, progesteroneonly pills (e.g., Lydia, Postinor2) were the most well-known EC 330(79.9%), followed by combined oral contraceptive pills 113 (27.4%) and intrauterine copper devices

(17.4%) (Figure 4.3). A greater number of the respondents 266 (64.4%) who had heard of EC had their source of information from a health professional (Figure 4.4). Also, less than half 139 (33.7%) knew that EC was not recommended as a regular contraceptive method. Most of them, 405 (98.1%) knew that EC can be used to prevent unwanted pregnancies. Similarly, many of them 360 (87.2%) knew that the recommended duration for EC use was within 72 hours after unprotected sex. Also, 10 (2.4%) of them did not know the time limit for taking emergency contraceptives.

Furthermore, most of the respondents, 378 (91.5%) and 109 (26.4%) knew that ECs could be obtained from the pharmacy and hospital/health center respectively. Amongst those who had heard about EC, most of them 370 (89.6%) were aware that ECs had an associated side effect. Fibroid, hormonal imbalances, menstrual irregularities, delayed fertility or infertility, breast tenderness, ectopic pregnancy, vomiting, drowsiness, spotting, and nausea were identified as the side effects associated with the use of EC. Overall, 230 (55.7%) of respondents had a good knowledge about EC (Figure 4.3)

Table 4.2 Respondents' knowledge and awareness about emergency contraception.

Variable	**Frequency (N)**	**Percentage %**
Are you familiar with family planning or planned parenthood?		
No	38	9.2
Yes	375	90.8
Have you ever heard of Emergency Contraception?		
No	8	1.9
Yes	405	98.1
If yes, which was/were the source(s) of information? (multiple select)		
Family	49	11.9
Partner / boyfriend	125	30.3
Friend	118	28.6
Health professional	266	64.4

Church	23	5.6
Mosque	2	0.5
Media	59	14.3
Are you aware of the risks associated with unprotected sex?		
No	2	0.48
Yes	411	99.5
What are some of the risks? (multiple select)		
Unwanted pregnancies	388	94.0
Contracting HIV/AIDS	359	86.9
Contracting other STIs (e.g. gonorrhoea, syphilis, etc.)	294	71.2
Do you know that ECs can be used to prevent unwanted pregnancy after unprotected sex?		
No	8	1.94
Yes	405	98.1
Which of the following ECs have you heard of?		
Combined oral contraceptive pills	113	27.4
Progesterone only pill. (e.g. Lydia, Postinor 2, etc.)	330	79.9
Intrauterine copper device	72	17.4
Ulipristal acetate	12	2.9
Don't know	8	1.9
Is EC recommended as a regular contraceptive method?		
No	139	33.7
Yes	274	66.3
What is the time limit for taking emergency contraceptive pills after unprotected sex?		
Within 12 hrs	15	3.6
Within 24 hrs	18	4.4
Within 48 hrs (2 days)	10	2.4
Within 72 hrs (3 days)	360	87.2
Don't know	10	2.4
Apart from EC do you know any other modern contraceptive method?		
No	19	4.6
Yes	394	95.4
If yes, which of the modern methods do you know? (multiple select)		
Injectable Depo Provera	74	17.9
Implants (e.g. Jadelle)	94	22.8
Combined oral contraceptive pill (e.g. Secure)	215	52.1

Mini pills (i.e. progesterone-only pills)	90	21.8
Condom	204	49.4
Intrauterine devices (IUD)	78	18.9
Where can emergency contraceptives be obtained? (multiple select)		
Hospital/health centre	109	26.4
Community health worker	63	15.3
Private clinic	72	17.4
Pharmacy	378	91.5
Supermarket	11	2.7
Are there side effects associated with the use of EC?		
No	43	10.4
Yes	370	89.6

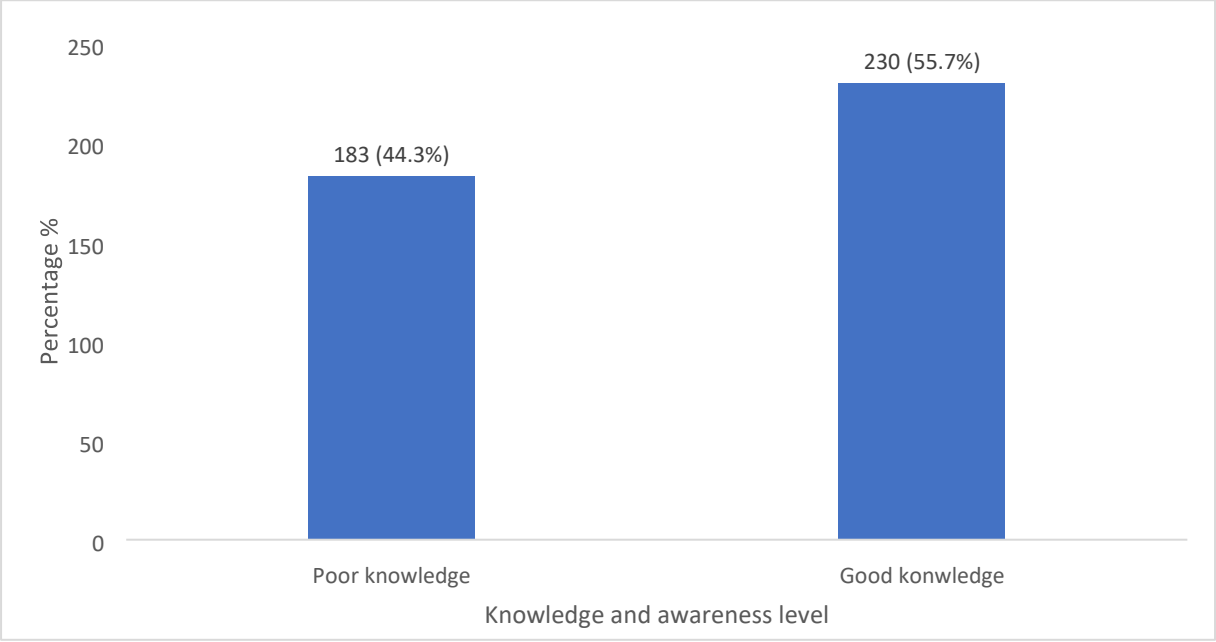

Figure 4.3 Respondents' knowledge and awareness about emergency contraception

Field Data, 2025

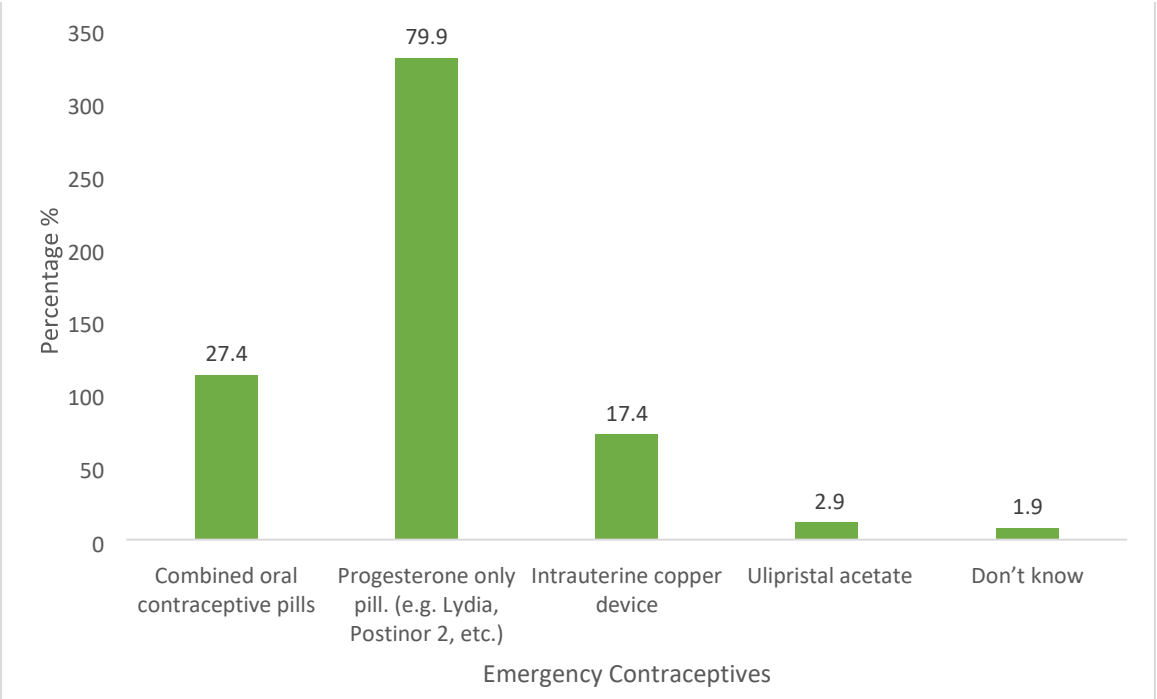

Figure 4.4 Respondents' knowledge on the methods of emergency contraception

Field Data, 2025

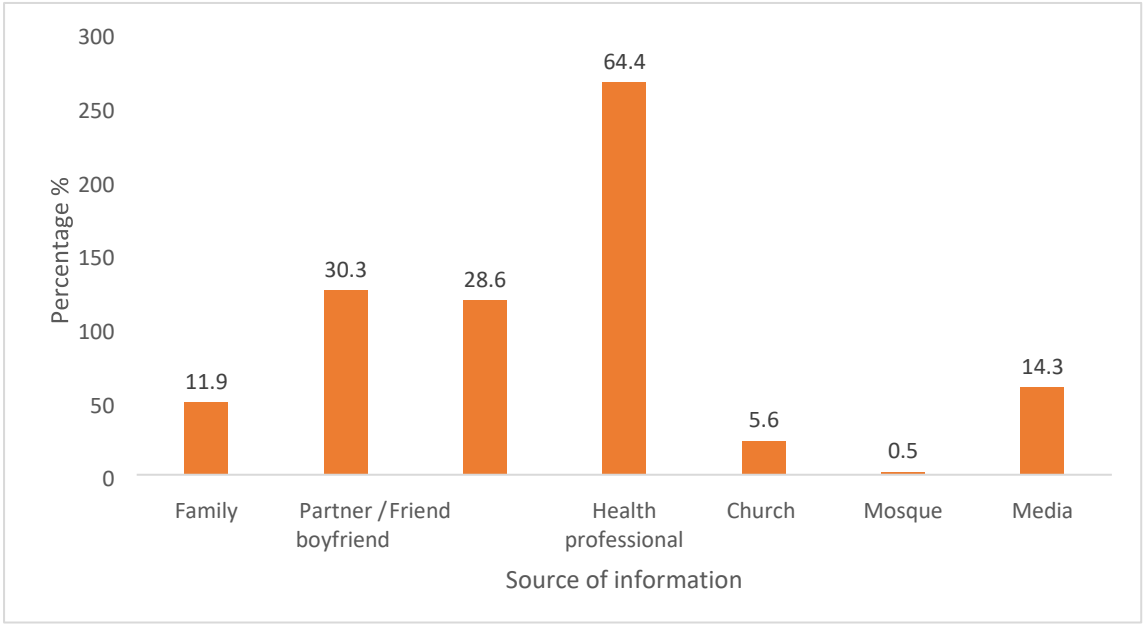

Figure 4.5 Respondents' source of information about emergency contraception

Field Data, 2025

4.5 Attitude towards usage of EC pills.

Table 4.3 presents the respondents' attitude towards the use of emergency contraceptives.

Twenty-nine percent (29.3%) of the respondents disagreed to the statement "The provision of EC to women would encourage promiscuity hence increasing the prevalence of HIV/AIDS and other STIs"

Also, most of the respondents 171 (41.4%) took a neutral position about "The provision of EC would discourage compliance with other contraceptive methods"

Similarly, many of the respondents 147 (35.6 %) agreed that "repeated use of EC pose a health risk" while 141 (3.4%) strongly disagree with the statement. Additionally, 172 (41.7%) of the respondents took a neutral position and 108 (26.2 %) disagree that "EC should be prescribed for a client to have on hand prior to an episode of unprotected sexual intercourse". Likewise, 111(26.9%) of them agreed that "EC should be available without a prescription" and 161 (39.0%) of them remained neural with such statement. More so, less than half of them 110 (26.6%) agreed that "EC should be easily made accessible to all females". Also, most of them 93 (22.5%) disagreed that "EC should be used regularly to prevent unintended pregnancy". Furthermore, many respondents 201(48.7%) agreed that EC is a safe method of preventing unplanned pregnancy. Moreover, 152 (36.8%) of respondents agreed that they will use EC in the future when the need arises, and 192(47.5%) remain neutral about whether they will advise family members and friends to use EC. Concerning the overall level of attitude toward EC, more than half of respondents 208 (50.4%) showed a positive attitude towards EC (Figure 5)

Table 4.3 Respondents' attitude towards the use of emergency contraceptives

Variable	**Frequency (N)**	**Percentage %**
The provision of EC to women would encourage promiscuity hence increasing the prevalence of HIV/AIDS and other STIs		
Strongly Agree	21	5.1
Agree	68	16.5
Neutral	141	34.1
Disagree	121	29.3
Strongly Disagree	62	15.0

The provision of EC would discourage compliance with other contraceptive methods?		
Strongly Agree	10	2.4
Agree	78	18.9
Neutral	171	41.4
Disagree	115	27.9
Strongly Disagree	39	9.4
Repeated use of EC poses a health risk		
Strongly Agree	61	14.8
Agree	147	35.6
Neutral	136	32.9
Disagree	55	13.3
Strongly Disagree	14	3.4
EC should be prescribed for a client to have on hand before an episode of unprotected sexual intercourse		
Strongly Agree	11	2.7
Agree	89	21.6
Neutral	172	41.7
Disagree	108	26.2
Strongly Disagree	33	8.0
EC should be available without a prescription		
Strongly Agree	11	2.7
Agree	111	26.9
Neutral	161	39.0
Disagree	100	24.2
Strongly Disagree	30	7.3
EC should be easily made accessible to all females		
Strongly Agree	17	4.1
Agree	110	26.6
Neutral	169	40.9
Disagree	85	20.6
Strongly Disagree	32	7.8
EC should be used regularly to prevent unwanted pregnancy		
Strongly Agree	13	3.2
Agree	84	20.3
Neutral	166	40.2
Disagree	93	22.5

Strongly Disagree	57	13.8
EC is a safe method of preventing unplanned pregnancy		
Strongly Agree	10	2.4
Agree	201	48.7
Neutral	96	23.2
Disagree	71	17.2
Strongly Disagree	35	8.5
Will use EC in the future when the need arises		
Strongly Agree	16	3.9
Agree	152	36.8
Neutral	153	37.1
Disagree	64	15.5
Strongly Disagree	28	6.8
Will advise family members and friends to use EC		
Strongly Agree	10	2.4
Agree	112	27.1
Neutral	196	47.5
Disagree	72	17.4
Strongly Disagree	23	5.6

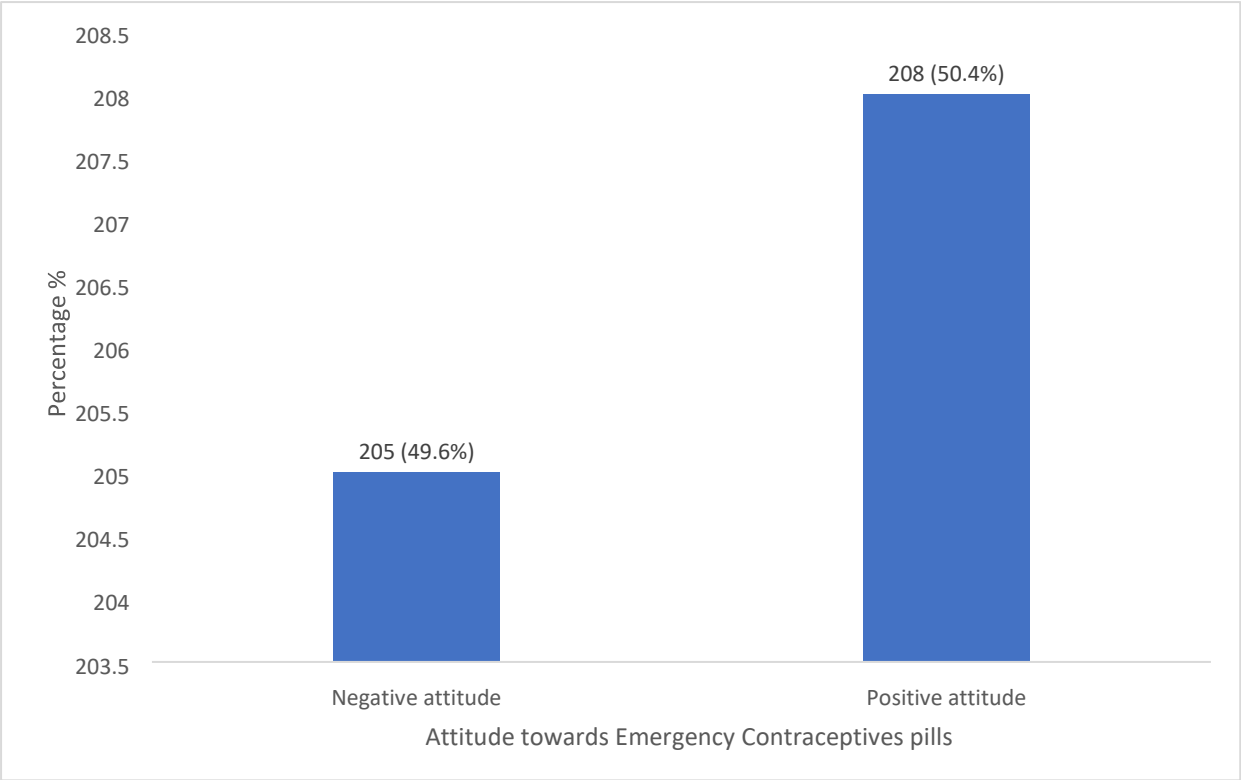

Figure4.6 Attitude towards Emergency Contraceptives pills

Field Data, 2025

4.6 Use of emergency contraception

Most of the respondents 366 (88.6%) indicated that they had ever used emergency contraceptives. Amongst them, 306 (74.1%) noted that they used EC during their last coital activity. Others 118 (28.6 %) also noted that they used EC because they experienced condom breakage or slippage during coitus. Also, most of them 329 (79.7%) used EC within 72 hours after sexual intercourse to prevent unwanted pregnancies. Most of the respondents obtained EC from the pharmacy, over the counter 367 (88.9%) followed by local clinic, without a prescription 26(6.3%). Only a few of them 24 (5.8%) obtained EC as a form of prescription from the pharmacy. Also, 194 (47.0%) use condom apart from ECs (Table 4.4)

Table 4.4 Use of emergency contraceptives among women of reproductive age

Variable	Frequency (N)	Percent age
Have you ever used any form of Emergency contraception?		
No	47	11.4
Yes	366	88.6
If yes, did you use EC during your last coital activity?		
No	107	25.9
Yes	306	74.1
Did you use EC during your last but one coital activity?		
No	107	25.9
Yes	306	74.1
Why did you use an emergency contraceptive?		
Because I experienced condom breakage or slippage	118	28.6
Because I experienced failed coitus interruptus (withdrawal) during sex	108	26.2
Because of miscalculation of rhythm method	84	20.3
Because I had unexpected, unprotected sex	97	23.5
Other, Specify	6	1.5
When did you use ECs to effectively prevent pregnancy after sex?		
Within 24 hrs	51	12.4
Within 72 hrs	329	79.7
Until menstrual period	1	0.24
I don't know	32	7.8
Where did you access ECs? (multiple select)		
Friends	24	5.81
Parents	6	1.5
Other family members	7	1.7
At a local clinic, with a prescription	20	4.8
At a local clinic, without a prescription	26	6.3
At the pharmacy, over the counter	367	88.9
At the pharmacy, prescription only	24	5.8
Apart from ECs, which other modern contraception do you use?		
Injectable Depo Provera		
Implants (e.g. Jadelle)	32	7.8
Combined oral contraceptive pill (e.g. Secure)	165	40.0

Mini pills (i.e. progesterone-only pills)	54	13.1
Condom	194	47.0
Intrauterine devices (IUD)	21	5.1
Other	8	1.9

4.7 Factors that influence the use of EC pills

Binary logistic regression analysis and multiple regression analysis was conducted to identify the factors influencing the use of EC and presented in Table 4.3. After adjusting for confounding variables, respondents aged 38-47 years were 5.36 times more likely to have had good knowledge regarding the use of EC pills [AOR= 5.36(C.I: 1.00, 28.65) p=0.050].

Also, educational level was significant such that those with no formal education were less likely [AOR=0.03(C.I: 0.00, 0.63) P=0.024] to use EC compared to respondents who completed high school with 8.41 chance of using EC [AOR=8.41(C.I: 1.25, 56.35) p=0.028]. To add to, marital status was significant such that respondents who were married [AOR=121.6(C.I: 1.23, 12052.46) p=0.041], separated [AOR=186.80(1.32, 26414.09) p=0.038] and single [AOR=102.55(C.I: 1.02, 10352.95) p=0.049] where more likely to use EC as compared to respondents who were co-habiting. Also, partner's highest educational level was significant, where partners completed high school were 7.85 more likely to use EC pills [AOR=7.85 (C.I: 1.64, 37.49) p=0.010] as compared to partners with graduate or advanced professional degree [AOR=0.22(C.I: 0.05, 0.94) (0.041)]. Also, respondents who worked in the last month prior to the study period were 59.63 times more likely to use EC [59.63(C. I: 10.24, 347.36) p=0.000]. Finally, how much you were paid for work was significant such that, respondents who receive regular wages or salary [0.06(C. I: 0.01, 0.52) p=0.011] and are self-employed or own business [0.03(C. I: 0.00, 0.38) p=0.006] were less likely to use EC.

Those with good knowledge are 5.58 times more likely to use EC pills compared to those with poor knowledge on EC and those with good attitude are 0.39 times more likely to use EC pills.

Table 4.3 represents various socio-demographic and economic factors associated with the use of emergency contraception (EC). Compared to those with a bachelor's degree, respondents with completed high school were 8.14 times more likely to use EC [AOR=8.41; 95% CI: 1.25–56.35; *p*=0.028]. Although those with senior high school education had extremely high crude odds (COR=48.25; *p*<0.001), this association was not significant in the adjusted model (*p*=0.070). Respondents with no formal education were significantly less likely to use EC [AOR=0.03; 95% CI: 0.00–0.63; *p*=0.024]. Marital status was an important predictor. Participants who were married [AOR=12.1; 95% CI: 1.23–12.05; *p*=0.041], separated [AOR=18.6; 95% CI: 1.32–26.41; *p*=0.038], and single [AOR=10.25; 95% CI: 1.02–10.35; *p*=0.049] were significantly more likely to have used EC compared to those in cohabiting relationships. Those whose partners had completed high school were 7.85 times more likely to have used EC [AOR=7.85; 95% CI: 1.64–37.49; *p*=0.010] compared to those whose partners had no formal education. Those with partners who held graduate degrees had significantly lower odds (AOR=0.22; 95% CI: 0.05–0.94; *p*=0.041), suggesting a potential inverse association at higher education levels. Women who reported working in the past month had significantly increased odds of EC use [AOR=59.63; 95% CI: 10.24–54.36; *p*<0.001] compared to those not working. Participants who were self-employed had significantly lower odds of using EC [AOR=0.03; 95% CI: 0.00–0.38; *p*=0.006] relative to those in casual labor roles. Additionally, those previously employed in regular wage jobs had lower odds of EC use [AOR=0.06; 95% CI: 0.01–0.52; *p*=0.011].

Other variables such as age, religion, if you did not work in the last month, what was the main reason you did not work, and monthly income did not show statistically associations of sociodemographic and economic factors with the use of EC

Table 4.5 Factors influencing the use of emergency contraception

Variable	**Ever used any form of Emergency Contraception**		**Chi-square (X2) (pvalue)**	**COR (95%C. I) (Pvalue)**	**AOR (95%C.I) (p-value)**
	No	Yes			
Age					
Below 18 years	3(10.3)	26(89.7)		2.42(0.66, 8.87) (0.182)	0.70(0.04, 11.37) (0.804)
18-27 years	19(21.8)	68(78.2)		Ref	Ref
28-37 years	15(8.2)	167(91.8)		3.11(1.49, 6.48) (0.002)*	3.06(0.81, 11.59) (0.100)

38-47 years	9(8.9)	92(91.1)		2.86(1.22, 6.70) (0.016)*	5.36(1.00, 28.65) (0.050)*
48 years and above	1(7.1)	13(92.9)	12.10(0.017)*	3.63(0.45, 29.56) (0.228)	5.40(0.07, 417.14) (0.447)
Religion					
Christianity	40(13.5)	257(86.5)		Ref	Ref
Islam	6(8.5)	65(91.6)		1.69(0.69,4.15) (0,255)	0.30(0.07,1.29) (0.106)
Traditional	1(2.2)	44(97.8)	5.63(0.060)	6.85(0.92,51.11) (0.061)	3.33(0.10,114.28) (0.505)
Educational Level					
Bachelor's degree	27(30.7)	61(69.3)		Ref	Ref
No formal education	2(28.6)	5(71.4)		1.11(0.20, 6.06) (0.907)	0.03(0.00, 0.63) (0.024)*
Primary	1(7.7)	12(92.3)		5.31 (0.66, 42.93) (0.117)	0.21(0.13, 3.52) (0.278)
Senior High School	1(0.9)	109(99.1)		48.25(6.40, 363.83) (0.000)*	27.22(0.76, 969.80) (0.070)
Completed High School	6(5.0)	113(95.0)		8.34(3.26, 21.29) (0.000)*	8.41(1.25, 56.35) (0.028)*
Vocational degree or certificate	7(11.9)	52(88.1)		3.29(1.32, 8.17) (0.010)*	0.78(0.17, 3.68) (0.758)
Graduate or advanced professional degree	3(17.7)	14(82.4)	52.11(0.000)	2.07 (0.55, 7.78) (0.284)	4.72(0.79, 28.0) (0.088)
Marital Status					
Co-habitation	1(50.0)	1(50.0)		Ref	Ref
Divorced	0(0.0)	34(100.0)		1	1
Married	16(8.8)	166(91.2)		10.38(0.62, 173.87) (0.104)	121.6(1.23, 12052.46) (0.041)*
Separated	2(3.7)	52(96.3)		26.00(1.16, 583.46) (0.040)*	186.80(1.32, 2641.09) (0.038)*
Single	28(20.3)	110(79.7)		3.93(0.24, 64.78) (0.339)	102.55(1.02, 10352.95) (0.049)*
Widowed	0(0.0)	3(100.0)	22.94(0.000)	11.20(1.38,9.17)(0.257)	14.90(1.38,16.64)(0.352)
Partner's highest educational level					
No formal education	5(13.2)	33(86.8)		Ref	Ref
Primary	2(4.3)	45(95.7)		9.72(2.14, 44.21) (0.003)*	4.61(0.39, 54.41) (0.225)
Senior High School	4(4.4)	87(95.6)		9.39(3.01, 29.29) (0.000)*	3.13(0.43, 22.80) (0.070)
Completed High School	4(3.9)	99(96.1)		10.69(3.43, 33.26) (0.000)*	7.85(1.64, 37.49) (0.010)*

Vocational degree or certificate	2(4.4)	43(95.6)		9.28(2.04, 42.30) (0.004)*	1.73(0.25, 11.68) (0.576)
Bachelor's degree	19(30.2)	44(69.8)		2.85(0.96,8.42)(0.058)	0.79(0.12,5.03)(0.805)
Graduate or advanced professional degree	11(42.3)	15(57.7)	61.46(0.000)	0.59(0.23, 1.52) (0.273)	0.22(0.05, 0.94) (0.041)*
Do you do any type of work for pay in the last month?					
No	19(59.4)	13(40.6)		Ref	Ref
Yes	28(7.4)	366(88.6)	79.23(0.000)	18.43(8.25, 41.15) (0.000)	59.63(10.24, 347.36) (0.000)*
If you did not work in the last month, what was the main reason you did not work?					
Others	5(31.3)	52(82.5)		Ref	Ref
Seasonal inactivity	2(2.2)	90(97.8)		20.45 (3.54, 118.32) (0.001)*	7.81(0.55, 110.60) (0.129)
Student	13(14.0)	80(86.0)		2.80(0.84, 9.37) (0.095)	2.40(0.35, 16.37) (0.373)
Household/family duties	13(10.2)	115(89.8)		4.02(1.21, 13.39) (0.023)*	0.69(0.12, 3.86) (0.677)
Too young to work	2(11.1)	16(88.9)		3.64(0.59, 22.23) (0.162)	0.43(0.02, 8.91) (0.588)
Infirmity / sickness	1(33.3)	2(66.7)	18,55(0.05)*	0.91(0.07, 12.52) (0.943)	0.26(0.01, 7.23) (0.428)
How were you paid for your work (If currently unemployed use your last job)?					
Casual labour(hourly/daily)	4(6.0)	63(94.0)		Ref	Ref
Regular wages or salary	24(14.4)	143(85.6)		0.38(0.13, 1.14) (0.083)	0.06(0.01, 0.52) (0.011)*
Payment in kind	3(5.0)	57(95.0)		1.21(0.26, 5.62) (0.811)	0.18(0.01, 2.74) (0.217)
Unpaid contribution worker	2(2.9)	66(97.1)		2.10(0.37, 11.84) (0.403)	0.23(0.01, 3.92) (0.312)
Self-employed or own my business	9(25.7)	26(74.3)		0.18(0.05, 0.65) (0.009)*	0.03(0.00, 0.38) (0.006)*
Not applicable	5(31.3)	11(68.8)	24.04(0.000)	0.14(0.03, 0.60) (0.008)*	0.20(0.01, 3.74) (0.280)

Monthly Income (Gross personal income per month, including allowances, bonuses and other benefits, before any deductions/expenditure without savings?)					
Don't know/refused	4(44.4)	5(55,6)		Ref	Ref
GHC 500	5(4.4)	110(95.7)		17.6(3.58, 86.41) (0.000)*	3.92(0.13, 116.43) (0.430)
More than GHC 500, GHC 1,000	8(7.3)	101(92.7)		10.1(2.26, 45.22) (0.002)*	0.81 (0.03, 23.99) (0.902)
More than GHC 1,000, GHC 1,500	8(11.1)	64(88.9)		6.4(1.42, 28.86) (0.016)*	3.44 (0 .15, 80.37) (0.442)
More than GHC 1,500, GHC 2,000	2(7.4)	25(92.6)		10(1.42, 70.30) (0.021*)	4.65 (0.15, 145.67) (0.382)
More than GHC 2,000	16(23.9)	51(76.1)		2.55(0.61, 10.65) (0.199)	2.47 (0.11, 55.34) (0.568)

Table 4.6 Factors influencing the use of emergency contraception

Variable	**Ever used EC**		**COR (95%C. I)**	**P-value**
	No	**Yes**		
Age				
18-27 years	19(21.8)	68(78.2)	Ref	Ref
Below 18 years	3(10.3)	26(89.7)	2.42(0.66, 8.87)	0.182
28-37 years	15(8.2)	167(91.8)	3.11(1.49, 6.48)	0.002*
38-47 years	9(8.9)	92(91.1)	2.86(1.22, 6.70)	0.016*
48 years and above	1(7.1)	13(92.9)	3.63(0.45, 29.56)	0.228
Religion				
Christianity	40(13.5)	257(86.5)	Ref	Ref
Islam	6(8.5)	65(91.6)	1.69(0.69, 4.15)	0.255
Traditional	1(2.2)	44(97.8)	6.85(0.92, 51.11)	0.061
Educational Level				
Bachelor's degree	27(30.7)	61(69.3)	Ref	Ref
No formal education	2(28.6)	5(71.4)	1.11(0.20, 6.06)	0.907

Primary	1(7.7)	12(92.3)	5.31 (0.66, 42.93)	0.117
Senior High School	1(0.9)	109(99.1)	48.25(6.40, 363.83)	<0.001***
Completed High School	6(5.0)	113(95.0)	8.34(3.26, 21.29)	<0.001***
Vocational degree or certificate	7(11.9)	52(88.1)	3.29(1.32, 8.17)	0.010**
Graduate or advanced professional degree	3(17.7)	14(82.4)	2.07 (0.55, 7.78)	0.284
Marital Status				
Co-habitation	1(50.0)	1(50.0)	Ref	Ref
Divorced	0(0.0)	34(100.0)	5.91(0.97, 36.62)	0.053
Married	16(8.8)	166(91.2)	10.38(0.62, 173.87)	0.104
Separated	2(3.7)	52(96.3)	26.00(1.16, 583.46)	0.040*
Single	28(20.3)	110(79.7)	3.93(0.24, 64.78)	0.339
Widowed	0(0.0)	3(100.0)	11.20(1.38, 9.17)	0.257
Do you do any type of work for pay in the last month?				
No	19(59.4)	13(40.6)	Ref	Ref
Yes	28(7.4)	366(88.6)	18.43(8.25, 41.15)	0.001***
Monthly Income				
Don’t know/Refused	4(44.4)	5(55.6)	Ref	Ref
GHC 500	5(4.4)	110(95.7)	17.6(3.58, 86.41)	0.001***
More than GHC 500, GHC 1,000	8(7.3)	101(92.7)	10.1(2.26, 45.22)	0.002*
More than GHC 1,000, GHC 1,500	8(11.1)	64(88.9)	6.4(1.42, 28.86)	0.016*
More than GHC 1,500, GHC 2,000	2(7.4)	25(92.6)	10(1.42, 70.30)	(0.021*
More than GHC 2,000	16(23.9)	51(76.1)	2.55(0.61, 10.65)	0.199

Knowledge about EC				
Poor knowledge	37(20.2)	146(79.8)	Ref	
Good knowledge	10(4.4)	220(95.7)	5.58(2.69, 11.56)	0.001***
Attitude towards EC				
Negative towards EC	14(6.8)	191(93.2)	Ref	
Positive attitude	33(15.9)	175(84.1)	0.39(0.20, 0.75)	0.005**

Note: COR= Crude Odds Ratio; Ref= reference

Dummy Variable: Ever used EC: yes=1, no=0

*p-value ≤ 0.05

**p-value ≤ 0.01

***p-value <0.001

4.7.1 Accessibility (cost, and distance to facilities such as over-the-counter stores, licensed chemists' shops and pharmacies)

The association between accessibility and the use of EC pills is shown in Table 5. The variable EC should be available without a prescription was significant. Respondents who were neutral about EC being available without prescription had the highest usage rates (96.3%) and were significantly more likely to use EC compared to those who agreed [AOR: 2.87 (CI: 1.04-7.89, p=0.042]. Also, the variable "where can emergency contraceptives be obtained" was significant. Pharmacy access emerged as the strongest predictor of EC use. Respondents who identified pharmacies as a source were 2.69 times more likely to use EC [AOR: 2.69, (CI: 1.22, 5.97), p=0.015]

Table4.7 Accessibility effects on EC pills use

Variable	**Ever used any form of Emergency Contraception**		**Chi-square (X2) (p-value)**	**COR (95%C. I) (P-value)**	**AOR (95%C. I) (p-value)**
	No	**Yes**			
EC should be available without a prescription					
Agree	18(16.2)	93(83.8)		Ref	Ref
Strongly Agree	1(9.1)	10(90.9)		1.93(0.23, 16.07) (0.541)	3.03(0.28, 33.25) (0.364)
Neutral	6(3.7)	155(96.3)		5.00(0.23, 16.07) (0.001)*	2.87(1.04, 7.89) (0.042)*
Disagree	14(14.0)	86(86.0)		1.19(0.56, 2.54) (0.654)	0.65(0.28, 1.52) (0.324)
Strongly Disagree	8(26.7)	22(73.3)	19.61(0.001)*	0.53(0.21, 1.38) (0.195)	0.47(0.16, 1.39) (0.173)
EC should be easily made accessible to all females					
Strongly disagree	3(9.4)	29(90.6)		Ref	Ref
Strongly Agree	3(9.4)	29(90.6		0.25(0.05, 1.21) (0.084)	0.26(0.04, 1.52) (0.134)
Agree	24(21.8)	86(78.2)		0.37(0.10, 1.32) (0.126)	0.37(0.09, 1.45) (0.153)
Neutral	10(5.9)	159(94.1)		1.64(0.43, 6.34) (0.470)	0.80(0.19, 3.38) (0.764)
Disagree	5(5.9)	80(94.1)	25.04(0.00)	1.65(0.37, 7.37) (0.508)	1.16(0.25, 5.44) (0.850)
Where can emergency contraceptives be obtained? (multiple select)					
Hospital/health centre	23(21.9)	82(78.1)		Ref	Ref
Community health worker	3(23.1)	10(76.9)		0.93(0.24, 3.68) (0.923)	0.80(0.18, 3.51) (0.764)
Private clinic	5(27.8)	13(72.2)		0.73(0.24, 2.26) (0.584)	0.80(0.24, 2.63) (0.708)

Pharmacy	16(5.8)	261(94.2)	26.72(0.000)	4.58(2.30, 9.07) (0.000)	2.69(1.22, 5.97) (0.015)**

CHAPTER FIVE

5.0 DISCUSSIONS

5.1 Introduction

This chapter discusses how the results provide insights into how the awareness and knowledge, attitude and influences factors such as accessibility of emergency contraceptive (EC) pills among reproductive-aged women in the Ledzokuku municipality.

5.2 Awareness and Knowledge of Emergency Contraceptive Pills

The study found that an overwhelming majority (98.1%) of respondents were aware of emergency contraception (EC), indicating widespread recognition of its existence. The finding of the study shows that the majority (98.1%) of respondents correctly understood that EC pills could prevent pregnancy when taken after unprotected sexual intercourse. This finding of this study is similar to the findings of a study conducted at Kwadaso in Ghana on reproductive aged women and in Ethiopia among selected females in Addis Ababa. It reported that 96.2% in Ghana have knowledge about EC pills and 98.7% in Addis Ababa (Yeboah et al., 2025; Erko et al., 2025). This high percentage reflects substantial awareness of EC as a post-coital contraceptive method. However, this finding is comparatively higher than the studies conducted in rural Ghana among female college students with 80.2% having knowledge about EC pills and Congo with 80.32% (Agomuo et al., 2024; Mishika et al., 2025). These differences can be due to a difference in study settings.

Despite this general awareness, a considerable portion of respondents (67.08%) mistakenly believed that EC pills could be used as a routine contraceptive method rather than being intended solely for emergencies. This finding is the opposite to that of a study done in Kwadaso, Ghana, where 61.33% of respondents rather believe that EC pills should not be used as regular contraceptive method (Yeboah et al., 2021). This misunderstanding suggests that while knowledge about EC is prevalent, misconceptions about its appropriate usage persist. These findings are consistent with previous research, as discussed in Chapter Two, which explains that high levels of EC awareness do not necessarily translate into a complete or accurate understanding of its proper use. For instance, Trussell & Aiken (2016) highlighted that although EC is widely known, there remains a persistent misconception that it can serve as a regular contraceptive method rather than a backup option in cases of unprotected intercourse or contraceptive failure.

The method with about 79.9 % responses that was mentioned as the most common EC pill is the Progesterone-only-pill, followed by combined oral CP (27.4%). This is also similar with that of a study done in kwadaso, Ghana, though the findings had higher figures as compared to the kwadaso study with 92 % choosing progesterone-only pill as the most used pill while 58% chose combined oral contraceptive pill. Inconsistent with this finding is that of the study conducted in Uganda where 31.7 chose combined oral contraceptive as the most mentioned method followed by progesterone-only –pills with 30.8%(Yeboah et al., 2021;Beja et al., 2025). The increased awareness of the progesterone-only-pills is likely due to it been available and most common.

Also, 87.2% of respondents knew the correct time to use EC pills. This finding is slightly higher than that two studies done in Kwadaso and Takoradi, Ghana with 68% and 59.3% respectively of those who knew the correct time frame to use the pills (Yeboah et al., 2021; Duah, 2016). This aligns with recommendations from the World Health Organization (WHO, 2021), which stresses that EC is most effective when taken as soon as possible after unprotected

sex, with its efficacy decreasing as time progresses. While this high percentage indicates a generally strong understanding of the recommended time frame for EC use, the remaining 10.47% of respondents who were misinformed about the correct timing highlight gaps in knowledge dissemination.

About 89.6% of participants knew about the side effects of EC pills and chose common side effects such as menstrual irregularities and hormonal imbalances. This findings are as well similar with that of the kwadaso study in Ghana with 93% respondents, though it is higher than a study conducted in rural Ghana among female college students with 58.7%(Yeboah et al., 2021;Agomuo et al.,2024).

Overall, 55.7% of respondents have a good level of knowledge about EC pills. This is consistent with the findings of studies done in Kwadaso, Ghana with 62%, Kenya 53.2% and northern Ghana 65.0% of participants having good knowledge about EC pills (Yeboah et al., 2021; Ngoussei et al., 2019; Shamsu-Deen et al., 2021). The findings are quite low compared to a study in Congo with 80.32% (Mishika et al., 2025). This level of knowledge could be linked with how the participants get their knowledge about EC from, as most of them were informed by a health professional followed by friends. These findings are however higher than studies conducted in the middle belt of Ghana among female tertiary students, were only 9.5% (Mustapha Hallidu et al., 2022) have good knowledge on EC. The good level of knowledge could be attributed to the participants' source of information about EC.

5.2 Attitude towards EC Pills

Respondents' attitude towards EC pills reflects the tension between perceived necessity and social norms. There is a positive correlation between high knowledge scores and appropriate EC attitudes, such as opposition to regular use and stronger intent to use EC when needed. 50.4 % had a positive attitude towards EC use as this finding is similar to that study done in kwadaso, Ghana with 53% of respondents' having a positive attitude (Yeboah et al., 2021), but relatively

low to a study done in Congo with 85.28% and rural Ghana 77.8%(Mishika et al., 2025; Agomuo et al., 2024). This variation in the level of attitudes could be as the result of the difference in the sociodemographic background of respondents.50.4% of the participants in the study also believed that providing EC pills to women will encourage promiscuity which will in turn increase the prevalence of HIV and other sexually transmitted infections, whiles 41.4% also agreed that the provision of EC pills will also discourage compliance with other contraceptive methods. 50.4% believed that repeated use poses health risks.

5.3 Use of emergency contraceptive

Considering the use of EC pills, 88.6% have used any form of EC in this study. This finding is similar to the Kwadaso study in Ghana but higher than other studies done in Takoradi and rural Ghana. Similarly, this finding is higher than studies conducted in Nigeria 52.1%, Uganda 65.2% and Tanzania 17.4% (Oshodi et al., 2020; Beja et al., 2025; Mashoto et al., 2024). The higher rate of EC among the women in this study might be attributed to their increased awareness and more favorable attitudes towards it.

Majority of those (28.6) who had used EC pills cited condom breakage as the reason for using EC pills, followed closely by unprotected sex (23.5%). Consistent with this finding with a much higher figure is a study conducted in Uganda 60.1% (Beja et al., 2025) among female undergraduate students. The result of this study however disagree with studies conducted in Ghana, Ethiopia and Uganda (Yeboah et al, 2021; Belachew et al.,20223; Acen et al., 2024) where unprotected sex was the reason EC pills was used. Also, 79.7% used EC correctly, that is within 72hrs of sexual intercourse and 88.9% of participants obtained EC pills at pharmacies. Consistent with this finding is that of studies conducted in Uganda, Ghana and Egypt (Acen et al., 2024; Sulemana et al., 2025; Medhat Araby Khalil et al., 2022). According to Rafie S et al, (2017), Family planning regulation suggests that Ulipristal acetate EC pills should be obtained

with prescription-only at the pharmacy. To further prevent any health complications with the use of EC, pharmacists have been included as point sources of access and allowed to prescribe EC to women in the community. The pharmacists can prescribe and provide EC directly to women.

5.4 Factors Influencing the Use of EC Pills

This study further investigated the factors influencing the use of reproductive age women among women within the Ledzokuku municipality. The study identified age and education as significant predictors of contraceptive (EC) pill use, while marital status, religion, and awareness exhibited varying degrees of influence. Among these factors, age was particularly notable, as younger women, specifically those between 28 and 37 years, were more likely to use EC pills. This finding aligns with a study done in Ethiopia among women between the ages 25 to 34 and 35 to 49 and were more likely to have knowledge on EC.

Education emerged as a particularly strong determinant of EC pill usage, with higher education levels being positively correlated with increased use. This finding aligns with a study conducted in Ethiopia (Belachew et al., 2023) stating that women with secondary and above education were 3.41 times more likely to have knowledge on EC than those with no formal education. This finding also aligns with the research conducted by Kinaro et al, (2020), which highlights that education enhances women's reproductive autonomy, equipping them with the knowledge and resources necessary to make informed contraceptive choices.

Marital status, although analyzed, did not exhibit a statistically significant relationship with EC pill use. However, single women reported higher usage rates than their married counterparts. This finding is consistent with research from the World Health Organization (WHO, 2021), which posits that single women particularly those in urban environments tend to rely more on EC due to inconsistent contraceptive use in non-cohabiting relationships. Married women, on

the other hand, are more likely to use long-term or regular contraceptive methods, such as oral contraceptive pills, intrauterine devices (IUDs), or injectables, reducing their dependence on EC. Religion also played a role in influencing EC usage, albeit to a lesser extent. Muslim and traditionalist respondents exhibited lower rates of EC pill use compared to Christians. This finding is similar to that of a study conducted in Ghana (Yeboah et al., 2021) citing religion as a factor. Coombs et al., (2022) suggest that religious beliefs can significantly shape contraceptive behaviors, as certain religious teachings discourage or even prohibit the use of modern contraceptives.

One of the most surprising findings of the study was that awareness of EC did not directly predict its usage, despite nearly universal recognition of EC pills among respondents. While 98.75% of participants were aware of EC, this widespread knowledge did not necessarily translate into higher usage rates. This finding supports arguments made by Trussell & Aiken (2016), who noted that even in high-income countries such as the United States, where over 85% of women are aware of EC pills, misconceptions about their mechanism of action and potential side effects deter many from using them. Misinformation, including concerns about EC causing infertility or severe health risks, may discourage women from considering it as a viable option, reinforcing the need for targeted educational interventions that address these myths and provide clear, evidence-based guidance on EC usage.

5.4.1 Accessibility of EC Pills

The study found that pharmacies (26.37%) and hospitals/health centers (26.62%) were the most common sources of EC pills, indicating that most women prefer regulated healthcare settings for contraception. The role of private clinics (17.66%) and community health workers (15.17%) also highlights the importance of decentralized healthcare services in contraceptive distribution. The results also showed that only 0.50% of respondents were unsure of where to obtain EC pills, indicating that knowledge of access points is widespread. However, as

discussed in the literature, knowledge does not always lead to utilization, as women may still face financial, social, or psychological barriers that discourage them from obtaining EC pills when needed (Trussell & Aiken, 2016).

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The study concluded that whilst awareness of emergency contraceptive (EC) pills among reproductive-aged women within some communities in the Ledzokuku municipality is high, significant knowledge gaps persist. Many women had only a superficial understanding of EC pills, with misconceptions about their effectiveness, side effects, and proper usage. Women with higher education and urban residence were more likely to be aware of EC pills, but even among them, misinformation was common. Conversely, women with lower education levels demonstrated significantly lower awareness and understanding.

The study also found that multiple socio-cultural, economic, and religious factors influence EC pill usage. Older women, particularly those aged 28-37, were more likely to use EC pills, possibly due to greater exposure to reproductive health education and a higher likelihood of unplanned sexual encounters. Education played a critical role, as women with higher levels of education were significantly more likely to use EC pills compared to those with little or no formal education. Marital status also influenced usage, with single women being more likely to use EC pills than married women, who often relied on regular contraceptive methods. Additionally, religious beliefs acted as a deterrent to EC pill use, with Muslim and traditionalist women less likely to use them compared to Christians.

Despite high awareness, actual usage of EC pills remained low. The study's findings highlighted that while awareness of EC pills exists, a combination of knowledge gaps, sociocultural barriers, and factors such as accessibility continue to hinder their effective use.

6.2 Recommendations

Based on the study findings, the following recommendations are proposed:

6.2.1 Public Health Education and Awareness Campaigns

There should continuous education on EC to increase education about it with emphasis on it to be used as a backup pill and not as a regular contraception.

The district health directorate and reproductive health focused NGOs should organize community outreaches through market associations and youth groups to address misconceptions even among those aware of EC.

Community health workers should engage in face-to-face education sessions to clarify doubts about EC.

Local health authorities and NGOs should develop and disseminate culturally friendly appropriate information on EC in local languages especially in Ga.

6.3 Recommendations for future Research

- While this study provides important insights, further research is necessary to explore deeper issues surrounding EC pill awareness, access, and utilization.
- Understanding adolescent and young women's experiences: Since younger women were more likely to use EC pills, additional research should focus on barriers faced by adolescents in accessing EC, including stigma, misinformation, and affordability.
- Examining the role of digital and social media platforms: Given that misinformation about EC pills remains prevalent, future research should analyze how digital and social media influence knowledge, attitudes, and misconceptions regarding EC pills.

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APPENDIX A: ETHICAL CLEARANCE

ENSIGN GLOBAL
COLLEGE

OUR REF: ENSIGN/IRB/EL/SN-286/01
YOUR REF:

January 3, 2025

INSTITUTIONAL REVIEW BOARD SECRETARIAT

Martina Lebbie
Ensign Global College
Kpong.

Dear Martina,

ETHICAL CLEARANCE TO UNDERTAKE POSTGRADUATE RESEARCH

At the General Research Proposals Review Meeting of the *INSTITUTIONAL REVIEW BOARD (IRB)* of Ensign Global College held on Friday, January 3, 2025, your research proposal entitled **"Factors Influencing the Use of Emergency Contraceptive Pills among Reproductive-Aged Women within Ledzokuku Municipal District, in the Greater Accra Region of Ghana"** was considered.

You have been granted Ethical Clearance to collect data for the said research under academic supervision within the IRB's frameworks and guidelines.

We wish you all the best.

Sincerely,

Dr. (Mrs.) Rebecca Acquaah-Arhin
IRB Chairperson

APPENDIX B: PERMISSION LETTER

In case of reply the number and the date of this letter should be quoted

My Ref:
LKMHD/GHS/ADMIN/01/25

Your Ref:

GHS CORE VALUES:
People Centeredness,
Professionalism,
Team Work,
Innovation / Excellence
Discipline and Integrity

GHANA HEALTH SERVICE
Your Health - Our Concern

TESHIE CAMP TWO HEALTH CENTR
LEDZOKUK
GH ANA HEALTH SERVI
PRIVATE MAIL B
TESHIE-ACC

14th January, 2025

THE REGISTRAR
ENSIGN GLOBAL COLLEGE
TEMA-AKOSOMBO
ACCRA

RE: LETTER OF INTRODUCTION

Reference to your letter No. ENSIGN/IRB/EL/SN-286-001 dated 23rd December, 2024, on the above subject matter, permission has been granted to Ms. Martina Lebbie to carry out her Research work within the Ledzokuku Municipality.

Thank you.

GIFTY OFORI ANSAH
MUNICIPAL DIRECTOR OF HEALTH SERVICES
LEDZOKUKU
TESHIE

APPENDIX C: RESEARCH QUESTIONNAIRE

ENSIGN GLOBAL COLLEGE

Study Title: Factors influencing the use of emergency contraceptive pills among reproductiveaged women within *North-Teshie*, in the Greater Accra region of Ghana

Section A: Background Information		
	ID …….	EC[__|__|__]
1	Date of interview (dd/mm/yyyy)	[__|__]/ [__|__]/[__|__][__|__]
	Name of interviewer ……	Code [__|__]
2	Name of Sub-municipality ……..	Code [__|__]

Section B: Socio-demographic and Economic Characteristics		
Q. No.	Questions and responses	Response code
1	How old are you? (**reference to last birthday**) (Write exact age in years) …….	[__|__]
2	What is your Religion? 01=Christianity | 02=Islam | 03=Traditional 04=Other (specify)…….	[__|__]
3	What is your highest educational level? 01= No formal education 02= primary 03= Some High School 04= Completed High School 05= Vocational degree or certificate (e.g. electrician's license, auto repair certificate) 06= Bachelor's degree (college or university undergraduate, BA, BS, BArch, BEng, etc.) 07= Graduate or advanced professional degree (MBA, PhD, JD, MD, etc.)	[__|__]
4	What is your current marital status? 01 = Married | 02 = Single | 03 = Divorced 04 = Separated | 05= Widowed | 06 = Co-habitation	[__|__]

5	If married, what is the highest educational level of your partner? 01= No formal education 02= primary	
	03= Some High School 04= Completed High School 05= Vocational degree or certificate (e.g. electrician's license, auto repair certificate) 06= Bachelor's degree (college or university undergraduate, BA, BS, BArch, BEng, etc.) 07= Graduate or advanced professional degree (MBA, PhD, JD, MD, etc.)	[__|__]
6	Do you do any type of work for pay in the last month? 01= Yes | 02 = No	[__|__]
7	If you did not work in the last month, what was the main reason you did not work? 01= No work available | 02 = Seasonal inactivity 03= Student | 04= Household/family duties 05= Too young to work | 06= Infirmity / sickness 07= Other, specify …….	[__|__]
8	How were you paid for your work (If currently unemployed use your last job)? 01= Regular wages or salary 02= Payment in kind 03= Casual labor (hourly/daily) 04= Unpaid contribution worker 05= Self-employed or own my business	[__|__]
9	Monthly Income (Gross personal income per month, including allowances, bonuses and other benefits, before any deductions/expenditure without savings?) 01= GHC 500 02= More than GHC 500, GHC 1,000 03= More than GHC 1,000, GHC 1,500 04= More than GHC 1,500, GHC 2,000 05= More than GHC 2,000 06= Don't know 07= Refused	[__|__]

Section C: Knowledge and Awareness of Emergency Contraception (EC)		
10	Are you familiar with family planning or planned parenthood? 01= Yes | 02 = No	[__|__]

11	Have you ever heard of Emergency Contraception? 01= Yes | 02 = No	[__|__]
12	If yes, which was/were the source(s) of information? (**tick all that apply)** 01= Family | 02 = Partner / boyfriend	[__|__] [__|__]
	03= Friend | 04= Health professional 05= Church | 06= Mosque 07= Media	[__|__] [__|__] [__|__] [__|__]
13	Are you aware of the risks associated with unprotected sex? 01= Yes | 02 = No	[__|__]
14	What are some of the risks? (**tick all that apply**) 01= Unwanted pregnancies 02 = Contracting HIV/AIDS 03= Contracting other STIs (e.g. gonorrhoea, syphilis, etc.) 04= Other(s) Specify…….	[__|__] [__|__] [__|__] [__|__]
15	Do you know that ECs can be used to prevent unwanted pregnancy after unprotected sex? 01 = Yes | 02 = No	[__|__]
16	Which of the following ECs have you heard of? (**tick all that apply**) 01= Combined oral contraceptive pills 02= Progesterone only pill. (e.g. Lydia, Postinor 2, etc.) 03= Intrauterine copper device 04= Ulipristal acetate 99= Don't know	[__|__] [__|__] [__|__] [__|__] [__|__]
17	Is EC recommended as a regular contraceptive method? 01 = Yes | 02 = No | 99= Don't know	[__|__]
18	What is the time limit for taking emergency contraceptive pills after unprotected sex? 01= Within 12 hrs | 02= Within 24 hrs 03= Within 48 hrs (2 days) | 04= Within 72 hrs (3 days) 99= Don't know	[__|__]
19	Apart from EC do you know any other modern contraceptive method? 01 = Yes | 02 = No	[__|__]

20	If yes, which of the modern methods do you know? (**tick all that apply)** 01= Injectable Depo Provera 02= Implants (e.g. Jadelle) 03= Combined oral contraceptive pill (e.g. Secure) 04= Mini pills (i.e. progesterone-only pills) 05= Condom 06= Intrauterine devices (IUD) 99 = Don't know	 [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__]
21	Where can emergency contraceptives be obtained? **(tick all that apply**) 01= Hospital/health centre	 [__|__] [__|__]

	02= Community health worker 03= Private clinic 04= Pharmacy 05= Supermarket 06= Other, specify ……. 99= Don't know	[__|__] [__|__] [__|__] [__|__] [__|__] [__|__]
22	Are there side effects associated with the use of EC? 01= Yes | 02= No	 [__|__]
23	If yes, what are they? …….	 [__|__]
Section D: Use of Emergency Contraception		
24	Have you ever used any form of Emergency contraception? 01 = Yes | 02 = No	 [__|__]
25	If yes, did you use EC during your last coital activity? 01 = Yes | 02 = No	 [__|__]
26	If yes, when did you use EC during your last coital activity? ……	 [__|__]
27	Did you use EC during your last but one coital activity? 01 = Yes | 02 = No	 [__|__]
28	If yes, when did you use EC during your last but one coital activity? ……	 [__|__]
29	Did you use EC during your last two coital activities? 01 = Yes | 02 = No	 [__|__]
30	If yes, when did you use EC during your last but two coital activities? ……	 [__|__]

31	Why did you use an emergency contraceptive? **(If yes to Q24, 25 or 26)** 01= Because I experienced condom breakage or slippage 02= Because I experienced failed coitus interruptus (withdrawal) during sex 03= Because of miscalculation of rhythm method 04= Because I had unexpected unprotected sex 05= Other, Specify …….	[__|__] [__|__] [__|__] [__|__] [__|__]
32	When did you use ECs to effectively prevent pregnancy after sex? 01= Within 24 hrs | 02= Within 72 hrs 03= Within 120 hrs | 04= Until menstrual period 05= After I missed a period | 06= I don't know	[__|__]
33	Where did you access ECs? ***(tick all that apply)*** 01= Friends 02= Parents 03= Other family members 04= At a local clinic, with a prescription 05= At a local clinic, without a prescription	[__|__] [__|__] [__|__] [__|__] [__|__]

	06= At the pharmacy, over the counter 07= At the pharmacy, prescription only	[__|__] [__|__]
34	Apart from ECs, which other modern contraception do you use? (tick all that apply) 01= Injectable Depo Provera 02= Implants (e.g. Jadelle) 03= Combined oral contraceptive pill (e.g. Secure) 04= Mini pills (i.e. progesterone-only pills) 05= Condom 06= Intrauterine devices (IUD) 07= Other, Specify…….	[__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__]
Section E: Attitude towards Emergency Contraception Use		
35	The provision of EC to women would encourage promiscuity hence increasing the prevalence of HIV/AIDS and other STIs 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
36	The provision of EC would discourage compliance with other contraceptive methods? 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]

37	Repeated use of EC poses a health risk 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
38	EC should be prescribed for a client to have on hand before an episode of unprotected sexual intercourse 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
39	EC should be available without a prescription 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
40	EC should be easily made accessible to all females 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
41	EC should be used regularly to prevent unwanted pregnancy 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
42	EC is a safe method of preventing unplanned pregnancy 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
43	Will use EC in the future when the need arises 01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]
44	Will advise family members and friends to use EC	
	01= Strongly Agree | 02= Agree | 03 = Neutral 04= Disagree | 05= Strongly Disagree	[__|__]

APPENDIX D: PARTICIPANT CONSENT FORMS

CONSENT FORM

STUDY TITLE: Factors Influencing the Use of Emergency Contraception among Reproductive Age Women in the Ledzokuk municipal in the greater Accra region of Ghana.

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand.

I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name of Participant……..

Participants' Signature ……...OR Thumb Print……

Date:…….

APPENDIX E: CHILD ASSENT FORMS

CHILD ASSENT FORM (UNDER 18 YEARS)

I have been informed that my parent(s) have permitted me to participate, if I want to, in a study on "Factors Influencing the Use of Emergency Contraception among Reproductive Age Women in the Ledzokuk municipal in the greater Accra region of Ghana."

My participation in this project is voluntary and I have been told that I may stop my participation in this study at any time. If I choose not to participate, it will not affect my grade (or treatment/care - select whichever applies) in any way.

Name of Child Participant ……..

Participants' Signature ……..OR Thumb Print……

Date……..

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