

**A STUDY TO DETERMINE THE KNOWLEDGE, ATTITUDE  
AND PRACTICES OF EMERGENCY CONTRACEPTION  
AMONG WOMEN SEEKING ABORTION AT KITWE  
CENTRAL HOSPITAL**

**BY**

SPR  
MED  
BWA  
2007

**LILIAN BWANALI**

**UNZA 2007**

**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF POST BASIC NURSING**

**A STUDY TO DETERMINE THE KNOWLEDGE, ATTITUDE  
AND PRACTICES OF EMERGENCY CONTRACEPTION  
AMONG WOMEN SEEKING ABORTION AT KITWE  
CENTRAL HOSPITAL**

**BY**

**LILIAN BWANALI**  
ZRN (LUSAKA, 1995)  
ZRM (LUSAKA, 2001)

**Research Submitted to the Department of Post Basic Nursing,  
School of Medicine, University of Zambia in Partial Fulfilment of  
The Requirements for the Bachelor of Science Degree in Nursing**

**2007**

## ACKNOWLEDGEMENTS

I am greatly indebted to my sponsors, Ministry of Health for making it possible for me to pursue my studies for Bachelor of Science Degree in Nursing and for funding this study.

My heartfelt gratitude goes to my supervising lecturer, Dr M. Maimbolwa for patiently guiding me through this research study. I greatly appreciate her professional advice and critical analysis.

I also sincerely thank the following:

- Mrs. C. Ngoma the course coordinator and Head of Department for Post Basic Nursing for imparting knowledge on research.
- I am indebted to Dr. R. N. Likwa for her encouragement and hard work in ensuring that the Research Methodology course was well understood.
- Mr. Y Banda for his expert assistance with Biostatistics.
- The entire faculty of Post Basic Nursing Department for their various roles played in my academic achievement.
- Ms N. Mweemba at WHO office for assisting me with literature search on my topic.
- Ms J. Chilambwe at the Society for Family Health Organization for assisting me with literature search on my topic.
- The Kitwe Central Hospital and the Kitwe Schools of Nursing and Midwifery for assisting me in various ways too numerous to mention.
- Kitwe District Health Management Team for giving me statistics concerning my study topic.
- My classmates Munganga Juliet, Kaluba Dainess, Benkele Rodgers and all my peers (BSc IV 2006 – 2007) for their constructive criticism and assistance in various ways.

I also extend my gratitude to the following:

- My friends Muyangwa Nosiku, Muntanga Olivia, Mulenga Patricia, Banda Patricia, Banda Chanda and Mbewe Alverty Chela for encouragement and assistance in various ways.
- The UCZ Campus Fellowship members for the fellowship we had together and their encouragements.
- The women in the study, without their participation, the research would not have been written.
- My parents Mr. & Mrs. Chanda and all my family members for their moral support and encouragement rendered during this study.

Special thanks go to my husband, Mr. Kaluba Alick, for supporting me throughout this study.

Above all, I thank the Lord Almighty for the guidance, strength and health that I have enjoyed through out my life and my period of study.



<b>TABLE OF CONTENTS</b>	<b>PAGE</b>
• Acknowledgement.....	i
• Table of contents.....	iii
• List of tables.....	vi
• List of figures.....	vii
• List of abbreviations.....	viii
• Declaration.....	ix
• Statement.....	x
• Dedication.....	xi
• Abstract.....	xii
 <b>CHAPTER ONE</b>	
1.0 Introduction.....	1
1.1 Background information.....	2
1.2 Statement of the problem.....	5
1.3 Factors contributing/influencing the problem.....	6
1.3.2 Diagram of problem analysis.....	10
1.4 Justification.....	11
1.6 Research objectives.....	11
1.6.1 General Objective.....	11
1.6.2 Specific Objectives.....	11
1.7 Hypotheses.....	12
1.8 Operational definition of terms.....	12
1.9 Variables .....	12

**CHAPTER TWO**

2.0 Literature Review.....16

2.1 Introduction.....16

2.3Global perspective.....16

2.4 Regional perspective.....19

2.5 National perspective.....21

2.6 Conclusion.....23

**CHAPTER THREE**

3.0 Research methodology.....24

3.1 Introduction..... 24

3.2 Research design.....24

3.3 Research setting.....24

3.4 Study population.....25

3.5 Sample selection.....25

3.6 Sample size.....27

3.7Data collection tool.....27

3.8 Data Collection Technique.....28

3.9 Pilot study.....28

3.10 Validity.....29

3.11 Reliability.....29

3.12 Ethical and cultural consideration.....30

**CHAPTER FOUR**

4.0 Data analysis and presentation of findings.....31

4.1 Introduction.....31

4.2 Data analysis.....	31
4.3 Presentation of findings.....	31

## CHAPTER FIVE

5.0 Discussions of findings and implications to the health care system.....	46
5.1 Introduction.....	46
5.2 Characteristics of the sample.....	46
5.3 Emergency contraception.....	48
5.4 Other family planning methods.....	52
5.5 Implications to the health care system.....	54
5.6 Conclusion.....	56
5.7 Recommendations.....	57
5.8 Dissemination of findings.....	58
5.9 Limitations of the study.....	58
References.....	60

## Appendices

Appendix I: Questionnaire	
Appendix II: Request to undertake study	
Appendix III: Permission to undertake study	
Appendix IV: Work schedule	
Appendix V: Gantt chart	
Appendix VI: Budget	

## LIST OF TABLES

Table 1:	Variables and cut off points .....	14
Table 2:	Systematic sampling .....	26
Table 3:	Socio – demographic characteristics.....	32
Table 4:	Educational level, occupation and religious denomination.....	33
Table 5:	Whether the pregnancy was planned or not and gestational age of the last pregnancy.....	34
Table 6:	Understanding of family planning.....	35
Table 7:	Types of family planning.....	36
Table 8:	Situations in which EC can be used.....	37
Table 9:	Correct time when EC can be taken after Unprotected sex.....	38
Table 10:	Cultural beliefs on family planning.....	38
Table 11:	Why women support or do not support family planning.....	39
Table 12:	Why women would not use EC.....	40
Table 13:	Methods of family planning used by respondents.....	41
Table 14:	What women should do to prevent a pregnancy.....	42
Table 15:	Suggestions regarding the use of EC.....	44
Table 16:	Level of knowledge in relation to age.....	44
Table 17:	Knowledge of EC in relation to Educational level.....	45
Table 18:	Knowledge of EC in relation to marital status.....	45

**LIST OF FIGURES**

Figure 1: Problem analysis diagram.....10

Figure 2: Level of knowledge of EC.....35

Figure 3: Whether the respondents had heard  
about emergency contraception.....36

Figure 4: Mechanism of action of EC.....37

Figure 5: Whether women support family planning or not.....39

Figure 6: What religious people say about family planning.....40

Figure 7: Whether respondents were using any family  
planning method before they got pregnant.....41

Figure 8: Whether respondents knew of anybody who  
had ever used EC.....43

## LIST OF ABBREVIATIONS

BMC	Buchi Main Clinic
CSO	Central Statistical Office
DHMT	District Health Management Team
EC	Emergency Contraception
ECPs	Emergency Contraception Pills
FHI	Family Health International
FP	Family Planning
IEC	Information Education and Communication
IPPF	International Planned Parenthood
IRC	International Rescue Committee
KCH	Kitwe Central Hospital
KDHMT	District Health Management Team
MCH	Maternal and Child Health
MoH	Ministry of Health
PHC	Primary Health Care
PPAZ	Planned Parenthood Association of Zambia
PPFN	Planned Parenthood Federation of Nigeria
SFH	Society for Family Health
STIs	Sexually Transmitted Infections
TOP	Termination of Pregnancy
UTH	University Teaching Hospital
WHO	World Health Organisation
ZDHS	Zambia Demographic and Health Survey

## DECLARATION

I, *Lilian Bwanali*, hereby declare that the work presented in this study for a Bachelor of Science Degree in Nursing has not been presented either wholly or in part, for any other degree and is not being currently submitted for any other degree.

SIGNED *Lilian Bwanali*  
CANDIDATE

DATE *30<sup>th</sup> April 2007*

APPROVED BY: *Dr MC. Mainboke*  
SUPERVISOR

DATE *30<sup>th</sup> April 2007*

## STATEMENT

I, hereby, certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly acknowledged in the text and in the references.

Signed: Swami ..... Date: 3rd April 2007 .....

Candidate



## **DEDICATION**

To my husband and friend, Alick Kaluba for all the support.

To my mother Mrs R.K Chanda, my sisters and brothers for all the assistance rendered.

To my father, Mr. Samson Yotam Bwanali (late) who always encouraged me to work hard.

## ABSTRACT

**BACKGROUND:** Unintended pregnancy is a major medical, social, and public health concern. Emergency Contraception pills can prevent 75% to 85% of unintended pregnancies if administered within 72 hours of intercourse. Emergency Contraception (EC) refers to the methods that women can use to prevent pregnancy after unprotected sexual intercourse, method failure, or incorrect method use. There is growing worldwide acceptance and promotion of EC as a measure to reduce the level of unwanted pregnancies and, hence, unsafe abortion.

The Zambian government endorsed the use of EC in 1997. Since then, the government has mandated the provision and use of EC at all levels of the health care delivery. The adoption of the EC concept was part of a larger effort to reduce the high incidence of abortion due to unwanted pregnancy. Most of these victims of unwanted pregnancies would benefit from EC if they had knowledge and access to it.

**AIM:** The study was aimed at determining knowledge, attitude and practices of emergency contraception among women seeking abortion at Kitwe Central Hospital (KCH). Literature review included studies done both locally and internationally. Literature reviewed showed that there is inadequate knowledge amongst providers and client.

**METHODS:** A cross – sectional descriptive study design with both qualitative and quantitative dimensions was used. The study population was women seeking abortion at KCH aged between 15 and 45 years. A pilot study was done at the University Teaching Hospital (UTH). The actual study was conducted at KCH in September, 2006. Systematic random sampling was used to select a sample of 50. Data was collected using a semi-structured interview schedule. Questions covered knowledge, attitude and practices of emergency contraception. Data was analyzed manually using a data master sheet and has been presented in

form of frequency tables, pie charts, bar graphs and cross tabulations which were used to determine special relationships between variables.

**RESULTS:** The study revealed that only 12% of the respondents had heard about EC. Very few (6%) respondents correctly pointed out that it should be taken within 72 hours after unprotected sex. The respondents who knew about EC were mainly those who had attained secondary and college education. The study revealed that almost half of the respondents believed that modern family planning methods led to uterine growths with one-third indicating failure to conceive as one of the end result.

The study also revealed that only 8% of the respondents identified condom breakage as the appropriate situation when EC could be used. Six percent of the respondents identified rape cases as appropriate situations for EC use. Only 8% of the respondents correctly identified all acts of unprotected sex as appropriate situations for EC use. Despite the fact that most of the respondents had low knowledge about EC, two – thirds of them said that women would use EC provided they are given adequate information about it.

**CONCLUSION:** There is broad acceptance of emergency contraceptive pills to prevent pregnancy, but knowledge, availability, timing and proper use is limited. Adequate information on EC needs to be provided to family planning clients so that they could make informed choices.

The major recommendations of the study were that the Ministry of Health and the Hospital management should ensure that EC products were made available in all health facilities offering family planning services. The Ministry of Health and Hospital management need to ensure that there is adequate staffing in family planning clinics and those family planning providers have adequate information on EC. Literature should also be made available for the providers and clients. The family planning clinics should also be provided with adequate supplies of emergency contraceptives. Adequate information should be provided to women about the availability, use and benefits of EC.

## CHAPTER 1

### 1.0 INTRODUCTION

Family planning helps women protect themselves from unwanted pregnancies. Since the 1960s, family planning programs have helped women around the world avoid 400 million unwanted pregnancies. As a result, many women's lives have been saved from high – risk pregnancies or unsafe abortions (Hatcher *et al*, 1997).

Family planning plays a major role in reducing the maternal and infant morbidity and mortality. Many family planning methods also have other benefits. For example, some hormonal methods help prevent certain cancers, and condoms help prevent sexually transmitted infections. Family planning saves the lives of children by helping women space births. Between 13 and 15 million children under the age of five die each year due to various causes. If all children were born at least 2 years apart, 3 to 4 million of these deaths would be avoided (Hatcher *et al*, 1997).

The concept of Emergency Contraception (EC) was introduced on the world market as far back as 1960s. The first documented case of emergency postcoital contraception was established in the 1960s when physicians used this method to prevent pregnancy in a survivor of sexual assault [International Planned Parenthood Federation (IPPF), 2000]. In the 1990s, nearly one – third of EC prescriptions were made for rape survivors (IPPF, 2000). By the end of the decade, ECs were widely recognised as a safe and effective method of contraception for all women at risk of unintended pregnancy. ECs are now being prescribed worldwide for all women at risk of pregnancy after unprotected sexual intercourse which includes cases of unanticipated sexual activity, contraception failure, or sexual assault (IPPF, 2000).

In Africa, most countries started using ECs around the early 1990s. The concept was accepted by most African countries in an effort of trying to reduce the number of unsafe abortions resulting from unplanned pregnancies. It is estimated that 19 million unsafe abortions take place in developing countries each year with a mortality rate of 13% {International Family Planning Perspectives (IFPP), 2005}. Africa is the most affected.

The Zambian government endorsed the use of EC in 1997 following a needs assessment conducted by the World Health Organization (WHO) in 1995 {Plannedparenthood of Zambia (PPAZ), 1998}. Since then, the government has mandated the provision and use of EC at all levels of the health care delivery. The adoption of the EC concept was part of a larger effort to reduce the high incidence of abortion due to unwanted pregnancy.

## **1.1 BACKGROUND**

In Zambia, in the past, women used traditional family planning methods to space their children. These methods included herbs, breastfeeding a baby for about 2 years to avoid becoming pregnant. Some women were sent to their parents after delivery for about a year to prevent another pregnancy. This gave room for the baby to grow before the next one was born. The traditional family planning methods were used until the introduction of the modern family planning methods in the 1960s.

Modern family planning methods in Zambia came on the scene between 1970 and 1971 when the Family Planning and Warfare Association, a non – governmental organisation was formed in order to provide family planning services in the country. The formation of this association was prompted by high infant mortality and maternal mortality caused by illegal abortions. The Government of Zambia took a favorable position towards providing family planning services when

provision of Family planning services were integrated in the Maternal and Child Health (MCH) services in 1973 (Watson, 1977). The Family Health Unit was later established at the Ministry of Health in 1980, which was responsible for implementation of the Family Planning Programmes (Milupi, 1993).

In 1981, the Zambian government through the Ministry of Health adopted the Primary Health Care (PHC) concept with the vision of providing health to all by the year 2000. The first component of PHC relates to the provision of MCH and family planning services. Since then, the government has made a lot of strides in trying to encourage the use of Family Planning services. The government's policy has enabled Family Planning services to be integrated into MCH activities at service delivery points like rural health centers, urban health centers, hospitals and private clinics. In addition, non – governmental organizations such as Planned Parenthood Association of Zambia (PPAZ), Society for Family Health (SFH), Care International and others have also been providing Family Planning Services in Zambia (Milupi, 1993). Private health care institutions are also providing the service. The acceptance rate for family planning for the whole country is 25 % of all women of child bearing age, 15 – 45 years (CSO, 2003).

The Ministry of Health has also produced the Zambia Family Planning Guidelines and protocols, which provide updated information to health care providers (Ministry of Health, 2006). Family planning is one of the components included in the curriculum for nurse and midwifery training in Zambia (General Nursing Council, 2005). The skills taught include theory in the different methods of family planning and practical experience on the provision of the family planning methods. This has been part of the effort made to improve efficiency in family planning service delivery.

Several modern Family Planning methods such as oral contraceptives, injectables, emergency contraception, intra uterine contraceptive

devices, barrier methods and surgical contraception have become widely acceptable (Milupi, 1993). Among these modern Family Planning methods is the emergency contraceptive method. Emergency contraception can prevent pregnancy after unprotected sexual intercourse, family planning method failure or incorrect family planning method use {Family Health International (FHI), 2001}. Unprotected sexual intercourse may include coerced sex, as well as situations when no family planning method is used.

Emergency contraception was made available in Zambia in 1997 through the introduction of commercially packaged pills (PC4). PC4 contains levonorgestrone 250g and ethinyl-estradiol 50g. PC4 contains 4 tablets in each packet which should be taken within the first 72 hours after unprotected sex. It should be taken in two doses twelve hours apart.

Emergency Contraceptive Pills (ECPs) are hormonal methods of contraception that can be used to prevent pregnancy following unprotected sex (MOH, 2006). According to International Family Planning Perspectives (IFPP, 2005), other forms of ECPs contain either progestin alone or a combination of estrogen and progesterone in higher doses than regular oral contraceptives. If taken within 72 hours of unprotected sexual intercourse, they can reduce a woman's risk of getting pregnant by 75%. Women taking these pills may complain of short-term nausea and vomiting, neither of which poses a significant health risk. This is because the side effects do not take long and they usually subside with the second dose. ECPs typically prevent or delays ovulation, they do not affect a fertilized ovum, which has already been implanted in the uterus. This means that ECPs do not induce abortion.

The Family Health International (2001) states that ECs can help reduce the number of unplanned pregnancies, many of which result in unsafe abortion and take a large toll on the health of women. Despite

the efforts being made in provision of ECs, the method is underutilized. The situation calls for more efforts towards improving accessibility and utilization.

## **1.2 STATEMENT OF THE PROBLEM**

Kitwe Central Hospital (KCH) offers Family Planning services through its Maternal and Child Health (MCH) department which shares the family planning catchment population with Buchi Main Clinic (BMC). KCH family planning services are provided to high cost clients including staff and staff relations. The rest of the women seeking family planning services around the catchment area are attended to at BMC. The KCH family planning services are therefore drawn from BMC catchment population. The catchment population includes 5,667 women in the childbearing age (Chileshe, 2005).

In the year 2005, 2493 (44%) of the women accessed five (5) Family Planning methods namely oral contraceptives, injectables, loop, condoms and bilateral tubal ligation (Chileshe, 2005). Fifty six percent (56%) of the women in the child bearing age did not access the modern methods of family planning. Among the women who had used family planning methods, a number of them experienced method failure for example condom breakage or slippage and missing the pill for 2 to 3 days.

According to undocumented reports from family planning clientele attending the clinic, other women have been involved in unprotected sexual intercourse with no family planning method used leading to unintended pregnancies. The women talked to said that they did not do anything to prevent the pregnancy. In such cases, the best alternative would have been EC to prevent unplanned pregnancies.

In spite of EC being endorsed as a method of contraception in the National Family Planning Policy, the Providers at the KCH rarely



provide the service to clients. The health care providers attribute this to clients not requesting for the service.

The women who receive EC at KCH and BMC are mainly rape victims who are twelve years and above. Only 85 (2%) of the 4,213 women who accessed family planning, from January 2005 to June 2006 received EC (Chileshe, 2005). All these recipients were rape victims. This information is from Emergency Contraception Afrique project who are carrying out a study in the province. The project aims at reducing pregnancies among rape victims. They hope to achieve this by giving all rape victims EC.

If Emergency Contraception method was used whenever needed, there would be a reduction in pregnancy related complications resulting from unplanned pregnancies. The risk of dying from pregnancy related complications in Zambia is high. The maternal mortality rate is 729 per 100,000 live births in the period 2001 - 2002 compared to 649 per 100,000 in 1996 (CSO, 2003). Unsafe abortion is one of the leading causes of maternal mortality, which stands at 12.9% among all the causes of maternal deaths. Some maternal deaths occur due to other effects of unintended pregnancies other than abortions.

### **1.3 FACTORS INFLUENCING KNOWLEDGE, ATTITUDE AND PRACTICE OF EMERGENCY CONTRACEPTION AMONG WOMEN SEEKING ABORTION AT KCH**

There are a lot of factors that affect the knowledge, attitude and practice of EC.

#### **1.3.1 SOCIO – ECONOMIC FACTORS**

- **Educational level**

Illiterate women have no capacity to analyze issues hence are easily influenced such that making a decision on modern Family Planning

methods is difficult. Such women end up becoming pregnant even when they are near a health facility, which offers emergency contraception.

- **Religious beliefs**

Some religious groups only accept Natural Family Planning because they believe that modern Family Planning methods, which include ECs, cause abortion.

- **Inadequate knowledge**

Some women are not aware of emergency contraception, as a result they do not access the service when they need it and end up pregnant.

- **Misconception**

There is misconception in the society that when one uses modern contraception which includes EC, they will never have children. Others believe that ECs cause abortion. The women who have this misconception will end up becoming pregnant even when they are not ready for a pregnancy.

- **Peer Pressure**

Some women are easily influenced by their friends especially the misconception where the women believe that once one takes any form of modern contraception they will never have any children.

- **Age**

Unplanned pregnancies are mainly among adolescents who are scared to access Family Planning services or are not aware that they are eligible to access the service. These young women end up pregnant even when they could have prevented the pregnancy with EC.

### 1.3.2 SERVICE - RELATED FACTORS

- **Attitude of the health care providers towards clients**

Young women especially those who are not married and those who are still in school may be treated with resentment when seeking the service. Some health care providers do not want to provide information on Emergency Contraception for fear of people being careless leading to misuse of the service.

- **Inadequate IEC on EC**

Women are not given adequate IEC on Emergency Contraception for them to make an informed choice on whether to use it or not. Some women end up thinking that Emergency Contraception causes abortion leading to some women shunning the service. Some health care providers do not have adequate knowledge on EC.

- **Shortage of Health Care providers**

Shortage of health care providers has led to clients being subjected to long waiting hours. Some women end up going back home to come back on another day meanwhile EC is only effective in the first 72 hours after unprotected sex. Women end up shunning the service and unplanned pregnancies result.

- **Inadequate supply of the emergency contraceptives**

Sometimes there are shortages of the ECs such that women end up not accessing the service when they need it.

- **Inadequate knowledge of EC among providers**

Some family planning providers do not have adequate information about EC. This in turn leads to the providers being uncomfortable to discuss the method.

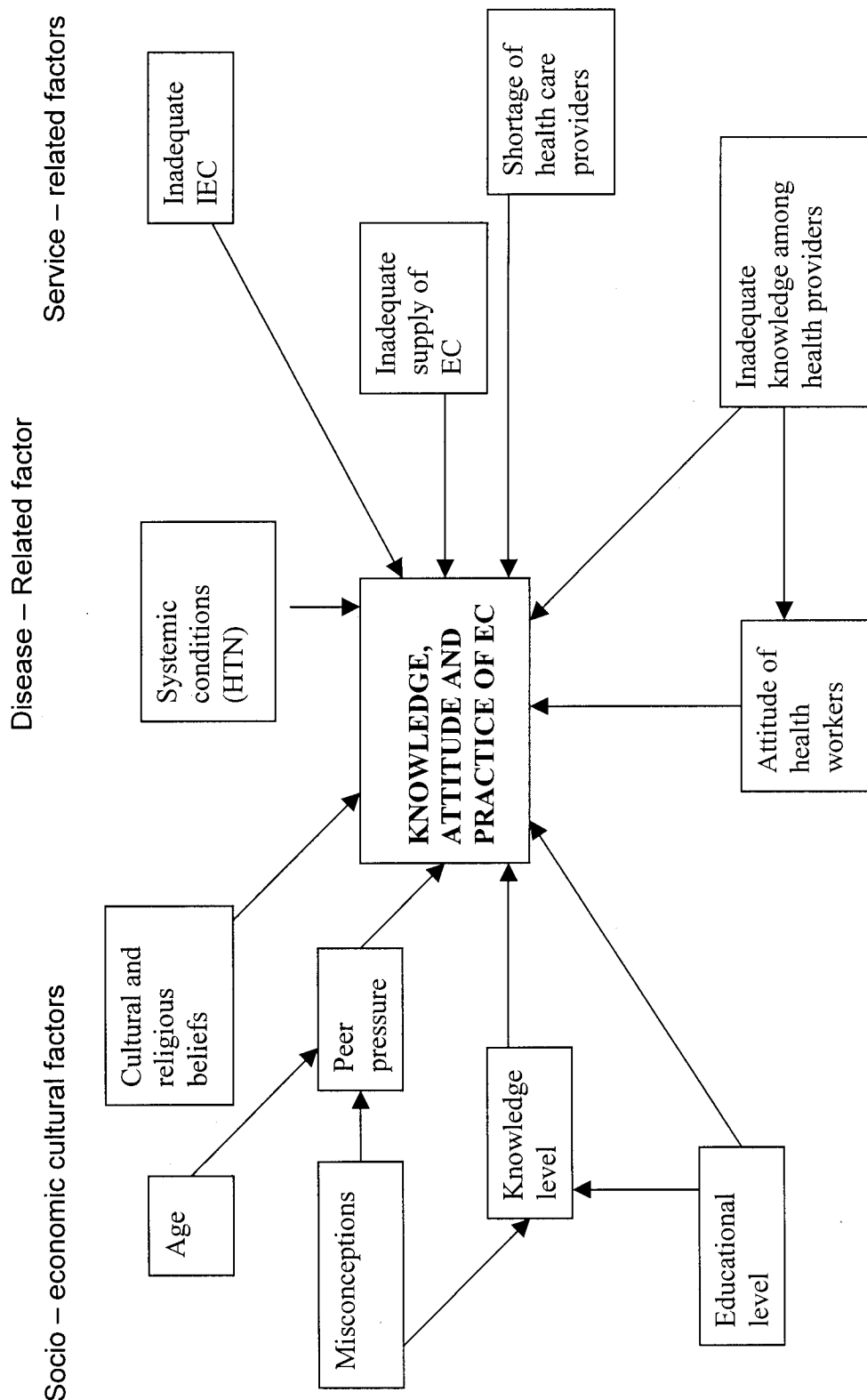
- **Lack of supermarket approach to services**

Women do not like a situation where they have to go to the clinic at specified times for services. They prefer a situation where they are attended to at any time they go to the clinic for all the services.

### **1.3.3 DISEASE – RELATED FACTORS**

Certain diseases can be aggravated if someone takes hormonal contraceptives. People with conditions like diabetes mellitus and hypertension cannot use hormonal contraception. These conditions are worsened when one uses hormonal contraception. The women with these conditions cannot benefit from this service and thus predisposed to unwanted pregnancy when no other method is used.

Fig. 1. PROBLEM ANALYSIS DIAGRAM



## **1.4 JUSTIFICATION**

Despite EC being endorsed as a family planning method in the family planning guidelines in Zambia, the method is still underutilized. A number of studies have been done towards utilization of EC and Sensitisation among family planning care providers but the service is still not provided. The researcher therefore feels that, by establishing factors that determine the knowledge, attitude and practice of EC among women seeking abortion at KCH, measures towards improving awareness on ECs among women will be intensified. This may increase the number of women seeking ECs and other family planning methods at KCH.

## **1.6 RESEARCH OBJECTIVES**

### **1.6.1 General Objective**

To determine the knowledge, attitude and practice of Emergency Contraception among women seeking abortion at KCH

### **1.6.2 Specific Objectives**

**1.6.2.1** To assess whether women seeking abortion use any Family Planning methods.

**1.6.2.2** To assess the level of knowledge on the use of EC among women attending family planning clinics.

**1.6.2.3** To assess the attitudes of women towards Emergency Contraception use.

**1.6.2.4** To elicit the cultural and religious beliefs that affects the use of EC.

**1.6.2.5.** To establish the practices of women seeking abortion towards EC.

**1.6.2.6** To make recommendations to KCH and Ministry of Health authorities.

## 1.7 HYPOTHESES

- 1.7.1 There is no difference in utilization of EC between women who have high knowledge on EC and those who have low knowledge.
- 1.7.2 Inadequate knowledge on EC among women is responsible for underutilization of EC.

## 1.8 OPERATIONAL DEFINITIONS

For the purpose of this study, the following terms will be defined as follows:

- 1.8.1 Utilization:** Using the health service to its full capacity.
- 1.8.2 Attitude:** Beliefs and feelings of respondents about ECs.
- 1.8.3 Knowledge:** Level of understanding or awareness of ECs.
- 1.8.4 Emergency Contraceptive Pills (ECPs):** Hormonal methods of contraception that can be used to prevent pregnancy after unprotected sexual intercourse.
- 1.8.5 Unsafe abortion:** Illegal termination of pregnancy outside health care facilities and without medical consent.
- 1.8.6 Unwanted pregnancy:** A pregnancy, which is not planned.

## 1.9 VARIABLES

A variable is a characteristic of a person, object or phenomena, which is measurable and can take different values. The two groups of variables used in this study are dependent and independent variables. A dependent variable is an outcome variable. It reflects the effects or response to the independent variable. An independent

variable influences other variables. It is perceived as contributing to or preceding a particular outcome.

The following variables will be used in this study;

**Dependent variable:**

- Knowledge, attitude and practice

**Independent variables:**

- Educational level
- Religious beliefs
- Level of knowledge
- Misconceptions
- Peer pressure
- Age
- Attitude of health workers
- Shortage of staff
- Supply of EC



**TABLE 1. INDICATORS AND CUT - OFF – POINTS**

<b>VARIABLES</b>	<b>INDICATORS</b>	<b>CUT OFF POINTS</b>	<b>Questions</b>
Knowledgeable	<p>i). <b>High</b></p> <p>ii) <b>Moderate</b></p> <p>iii) <b>Low</b></p>	<p>Score of 15-21</p> <p>Score of 8 - 14</p> <p>Score of 0 - 7</p>	<p>13,14</p> <p>15,16, 17,18, 19,20, 21</p>
Attitudes	<p>i) <b>Positive</b></p> <p>- When the respondent agrees that women support and can use family planning including EC</p> <p>ii). <b>Negative</b></p> <p>- If the respondent says that women do not support and cannot use family planning including EC.</p>	<p>Score of 3 - 5</p> <p>Score of 0 - 2</p>	<p>22- 26</p>

Practices	i). <b>Good</b> If the respondent has used or knows someone who has ever used EC	Score of 5 and above	28- 32
	ii). <b>Poor</b> If someone does not know anyone who has ever used EC	Score of 0 – 4	28 – 32

## **CHAPTER 2**

### **2.0 LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

Emergency contraception became available in most countries in the 1960s. ECs were initially introduced for rape victims. Today, the method has been accepted worldwide and the use has been expanded to include any woman who may be at risk of pregnancy as a result of an unanticipated sexual intercourse like coercive sex and ineffective use of other contraceptive methods. ECs also prevent the need for abortion (Mulenga, 2000).

#### **2.2 GLOBAL PERSPECTIVE**

Every year, unintended pregnancies lead to at least 20 million unsafe abortions resulting in the death of 80,000 women (FHI, 2001). FHI (2001) further indicates that 76 million unintended pregnancies occur every year in developing countries. The consequences of these pregnancies have been life threatening especially where abortion is legally restricted (IFPP, 2005). To reduce these high rates of unintended pregnancies, women need better access to both regular contraceptive methods and ECs. According to the Consortium on Emergency Contraception (1996), ECs can reduce the chance of pregnancy by about 75%. Studies show that ECs are underutilized leading to an increase in unplanned pregnancies.

In a survey carried out on adolescents by Klein (2005), in the USA, it was discovered that of the 71% who were sexually active, only 30% had heard of emergency contraception. In the year 2000, a survey of more than 500 women aged between 18 to 44 years in the USA, revealed that only 2% had used EC and only 25% had heard about the method. These findings demonstrate inadequate awareness and use of EC. In contrast, EC is often used in European countries to reduce teen pregnancy rate and thus reduce on abortion rates (Klein, 2005). For instance, one Finish study reported that 10%

of younger women than 25 years had used EC at least once in their lifetime (Klein, 2005).

Some health care providers are of the idea that knowledge and access to EC will encourage promiscuity and sexual irresponsibility especially among young people. This has led to information being withheld from young people. According to the Consortium on Emergency Contraception, there is no evidence to suggest that knowledge of EC increases sexual activity among people. In a study carried out in Britain, lessons on EC were incorporated into the school curriculum of British 12 to 15 year olds. The study found no difference in reported sexual activity for the 6 months interval after education intervention compared with students not receiving the educational intervention. The Consortium also revealed that if young people are aware of EC, the need for the EC will make them visit the family planning clinics where they will also receive other services like counseling on sexually transmitted infections and even on how to say “no” to sex (Klein, 2005).

Due to inadequate knowledge on use of ECs, some women have realized that they experienced a family planning method failure at the suspected time of conception but they have not done anything about it until after confirming that they were pregnant. Barnet in FHI (2001), reports that a study in Australia found that 22% of women requesting for an abortion had been using condoms at the time of conception. Many of these women reported having realized that they had a broken or slipped condom. In a related study of women seeking abortion in England, out of 309 clients who became pregnant while using condoms, 45 of them recognized condom failure, but only 20 attempted to use EC. If these women had adequate knowledge about EC, a lot of them would have used it to prevent pregnancy instead of going for an abortion (FHI, 2001).

To improve accessibility and knowledge about EC in Sri Lanka, an EC hotline was launched. The hotline receives more than 75 calls daily from women throughout the country. At the beginning, not many women were expected to call but surprisingly, 8000 calls were received within the first two years. A variety of questions were asked which illustrated a broad need for information.

About 25% of the callers wanted to know how to use EC, another 25% were concerned about delayed menstrual periods, 18% asked where they could access the product, 11% requested the name of the EC product, 9% asked about side effects while 6% inquired about the price. The study shows that a lot of people need detailed information about EC (FHI, 2001).

The population council conducted a survey before and after EC dissemination activities in Mexico to assess knowledge and opinion about the method. The findings were that one third of 807 female and male family planning clients surveyed in the year 2000 knew about EC compared with less than a fifth of 1,127 clients surveyed in 1997( FHI, 2001). The survey findings entails that with increased dissemination of information on EC, the peoples' knowledge will improve.

Other obstacles concerning provision of EC information to clients include a lack of perceived need, misconception that it causes abortion and inadequate staff training and guidelines for offering it by the family planning care providers. Best in FHI (2001), reports that a survey of 775 US family planning clinics found that 140 of them did not dispense EC pills. Reasons given included lack of demand (46%) and inadequate training for providing the method comprising of 22 percent (FHI, 2001).

In a US survey of physicians with expertise in adolescent health, 40% of 112 respondents who prescribed EC to adolescents restricted use to those who sought the method within 24 to 48 hours after unprotected sex rather than using the standard of 72 hours. Two thirds unnecessarily requested for pregnancy tests before prescribing the method.

From the above studies, it can be said that despite EC being widely accepted in reducing unwanted pregnancies, not much is known even among health workers.

Mulenga (2000), reports that studies conducted in 20 selected developing countries in Asia, Far East and Africa on the outcomes of pregnancies revealed that an average of 22% of births were unwanted. The report further

states that from an estimated 182 million pregnancies occurring each year in developing countries, 66 million of them were unintended. About 36% of these pregnancies were said to have ended up in abortion with half of them being performed in unsafe conditions. It therefore suffices to say that advocacy for dissemination of information on EC to people can go a long way in ensuring that the method becomes accessible to those who need it.

## **2.2 REGIONAL PERSPECTIVE**

EC was introduced in many African countries in early 1990s. Surveys conducted by the Consortium on Emergency Contraception shortly before its attempts to introduce the method revealed that a majority of prospective users were unfamiliar with the method (Mulenga, 2000).

A study in Kenya showed that only 10% of 282 female clients were aware of EC when an introduction program began in 1996. The baseline data showed widespread approval for the concept of EC pills but limited knowledge on the use of the method (FHI, 2001). In another study conducted in Kenyan refugee camps by International Rescue Committee (IRC), results showed that less than 50% of the 825 women interviewed while living in camps knew that they could prevent a potential pregnancy following unprotected sex. In the same study, only 11 percent of surveyed women who reported coerced sex in the camps said that they had heard about EC despite its availability at the camp hospital. In addition, the study also showed that the health care providers were uninformed on how to provide the EC.

High rates of teenage pregnancies and unsafe abortions in developing countries could be significantly lowered if young people knew about a preventive measure they could take to avoid these unwanted pregnancies. Bodrick in Advocates for Youth reports that in Nigeria, contraceptive use among adolescents is low. Bodrick in Advocates for Youth (2000), further reports that studies from Western and Southern Nigeria, revealed rates of about 30% for contraceptive use among sexually active adolescents, which is

low, compared with rates reported for developed countries (Advocates for Youth,2000).

Other studies have also shown that undergraduate college students have limited or incorrect information about EC. A study conducted by Alan Guttmacher Institute in 2001 showed that 880 undergraduate female students ages 15 - 24 were surveyed among other things knowledge of EC. Out of 880 respondents, 43% were sexually active, 39% had ever used contraception (mostly condoms, 26%; or withdrawal, 45%) and 34% had had an induced abortion. Overall, 58% of respondents reported knowing about EC but only 18% of the respondents who knew about EC also knew the correct time in which EC must be taken to be effective (Advocates for Youth, 2000).

Studies have also demonstrated that providers lack knowledge and have misconceptions about EC. In 1997, a survey conducted by FHI in Ghana, researchers evaluated health providers' knowledge of EC. The survey found that about one – third of 325 interviewed providers had heard of it but none knew how to prescribe it correctly (FHI, 2001).

To raise awareness and access to EC for young people, Nigeria is working with two notable organizations to help lower the pregnancy rates and provide youth – friendly services. The Planned Parenthood Federation in Nigeria (PPFN) has printed booklets in English and Hausa to provide accurate information on adolescent reproductive and health issues. PPFN offers EC as an emergency option to prevent pregnancy when, for any reason, a young woman cannot use her regular method of birth control. The other organization is Society for Family Health (SFH), which manufactures and distributes EC and condoms. This generally shows how committed developing countries are at reducing unwanted pregnancies and unsafe abortions (Advocates for youth, 2000).

## 2.3 NATIONAL PERSPECTIVE

The concept of EC was introduced in Zambia in 1997. This was after a contraceptive needs assessment conducted by the World Health Organization (Ahmed *et al*, 1998). Since then, the Government has mandated the provision and use of ECs at all levels of the health system. EC was introduced as part of the larger effort made to reduce high incidence of abortion due to unwanted pregnancies and broaden family planning choices (PPAZ, 1998).

Random surveys carried out during the Zambia Contraceptive Needs Assessment by WHO (1995) suggest that even among women who fear they could become pregnant after unprotected sex or method failure; very few seek immediate advice or information from health care providers. One of the possible reasons for this is that few women realize that contraceptive options exist even after unprotected sex. Increasing accessibility to EC, therefore, not only entails enhancing physical access to a product but also expanding access to information about the product.

Like adolescents everywhere, most young Zambians are sexually active by their mid teens. This clearly shows that young people are at high risk of unwanted pregnancies. Despite this situation, one of the most startling results that emerged from a UTH study by Skibiak *et al* (2001) on the use of EC was the relatively small percentage of young people seeking EC services. Instead of the nulliparous, unmarried non- family planning users initially believed to have the greatest unmet need for EC, the mean age of EC users was just over 29 years, with a range of 19 to 43 years. In this study, not only were young people who are at high risk of unwanted pregnancy not represented among EC users, they made up a very small percentage of clients at the MCH/ FP clinics.

The reasons among other things were lack of privacy or anonymity, cultural norms and provider biases that effectively withhold services from unmarried women or those who had not secured permission of a male partner. The 1995 Needs Assessment for Contraceptive Introduction in Zambia argued that EC could play a critical role in limiting unwanted pregnancies, reducing the need



for unsafe abortion and ultimately in lowering rates of maternal mortality and morbidity (skibiak, *et al* 2001).

In a study conducted at UTH by Ahmed *et al* (1998) among Termination of Pregnancy (TOP) clients, it was found that 179 out of 263 respondents did not know about EC. The women said that they would have used EC if they had known about it. Most IEC efforts in the area of EC are supposed to aim at the belief that women will readily identify the risk associated with a single act of unprotected sex and respond to it in an appropriate manner. Unfortunately, the study by Ahmed *et al* (1998) found that of the 263 Termination of Pregnancy candidates who agreed to discuss the circumstances leading to their pregnancy, 76.5% had absolutely no idea that they might become pregnant. 14% could not even identify the act of sexual intercourse that led to the current pregnancy.

Though EC still remains largely unknown in most parts of Zambia, there is growing interest on the part of many providers to introduce this method into their ongoing service delivery programs. According to Ahmed *et al* (1999), in July, 1997, eighty nine (89) health care providers were trained in emergency contraception in three separate workshops. The first training workshop was held in Lusaka and was attended by 23 participants. The participants included obstetrician/gynecologists; Health centre managers and family planning nurse practitioners. The second workshop was held in Ndola where 26 nurse/ family planning practitioners were trained. The third workshop was held in Lusaka at the Lusaka school of Nursing where 40 Lusaka – based health care providers were trained. The participants included postgraduates in obstetrics and gynecology, tutors from the nursing and midwifery school and nurse/family planning practitioners. The training material for all the training workshops was drawn from the packet developed and published by the Consortium for emergency contraception (Ahmed *et al*, 1998). The health care providers were given information on the dosage and correct timing for the EC to be effective which should be within 72 hours. They were also taught that they should be able to counsel clients about sexually transmitted infections and stress that emergency contraception provides no protection against these infections. The

training also included health care providers explaining to their clients how to start or resume routine contraception after use of EC. The training of the health care providers was part of the efforts done to overcome the difficulties associated with the introduction of EC. The training of health care providers in EC was to increase utilization of EC and knowledge about the product.

Despite efforts being made in increasing utilization, the method is still underutilized by those who need it. Some health care providers have inadequate knowledge and unfavorable attitudes towards EC. This leads to health care providers to hesitate in prescribing it.

In Zambia, there is still a great need to disseminate the information on EC to would be consumers. Mulenga (2000) reports that records at the University of Zambia Great East Road Campus clinic showed a sharp increase in the use of EC by female students when health care providers at the clinic publicized the method due to high rates of unsafe abortions at the institution.

## **2.4 CONCLUSION**

This literature review has brought out issues of knowledge and attitude as major problems leading to underutilization of EC. Some women have ended up with abortion of an unwanted pregnancy. EC therefore could be part of a larger effort to reduce the number of unwanted pregnancies and reduce the incidences of abortion and also reduce maternal morbidity and mortality rates. This would facilitate the achievement of the Millennium Development Goals by the year 2015.

## **CHAPTER 3**

### **3.0 RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

Research methodology necessitates a reflection of the planning and execution, of the research in order to comply with the demands of the truth, objectivity and validity (Brynard, 1997).

This chapter discusses the methodology for this study, which clearly indicates the research design used. It also discusses the study setting and sample size. It further indicates the instrument the researcher used to collect data.

#### **3.2 RESEARCH DESIGN**

Polit and Hungler (1995), defines a research design as the overall plan for addressing a research question, including specifications for enhancing the integrity of the study. It spells out in advance the strategies the investigator will adopt to develop information that is accurate and interpretable.

The purpose of this study was to determine factors on knowledge, attitude and practice of EC among women seeking abortion at KCH. For the purpose of this study, a descriptive study design with both qualitative and quantitative dimensions was used. This method enabled the researcher to explore the respondents' knowledge, opinions and practices on EC. Data was collected and presented systematically in order to show the relationship between the dependent variable and the various independent variables.

#### **3.3 RESEARCH SETTING**

A research setting is the physical location and conditions in which data collection takes place. The research was conducted at KCH in Kitwe district. This district has a population of 419,478. Women in the child bearing age comprise of 92,285. KCH is a third level referral hospital in the country with a

bed capacity of 600. It also acts as the first and second level hospital in the district. The hospitals' main departments are Nursing Education, Medicine, Nursing services and Administration.

The setting was selected because the hospital offers family planning services including EC at the family planning clinic. The hospital also receives patients with complications of abortion who are admitted to the gynecological ward called Chambeshi. There is also a theatre for Manual Vacuum Aspirations, which are done everyday in the same ward. The researcher felt that KCH was a good setting from which the sample could be drawn.

### **3.4 STUDY POPULATION**

A study population refers to the entire number of units under study (Treece and Treece, 1986). The study population was women seeking abortion at KCH. In order to establish factors that affect knowledge, attitude and practice of EC, the researcher felt that the women seeking abortion would be the right study population to give the needed information.

### **3.5 SAMPLE SELECTION**

Sampling is a process of selecting a portion of the population to represent the entire population (Polit and Hungler, 1995). The sample for this study was drawn from the study population using the systematic sampling method. Systematic sampling is a method of sampling in which the first unit is randomly selected within a sampling interval and thereafter every unit at the end of the sampling interval is picked. A sampling interval is population size divided by sample size (Nkhata, 2003).

The criteria for selecting the sample included; women who were admitted to the gynecological ward with bleeding per vaginum, less than twenty eight (28) weeks gestation period and between fifteen (15) and forty five (45) years old.

KCH gynecological ward receives approximately one hundred (100) clients with the above criteria per month. The researcher calculated the sampling interval by dividing 100 (population size) by 50 (sample size) which was two (2). That is  $100 \div 50 = 2$ . This meant that the sampling interval was (two) 2. Thereafter, every second subject was selected to be part of the sample size up to a sample size of fifty (50). A list of subjects with the above criterion was made as shown in the table below;

**TABLE 2: SHOWING THE SYSTEMATIC SAMPLING METHOD WHICH THE RESEARCHER USED**

<u>1</u>	2	<u>3</u>	4	<u>5</u>	6	<u>7</u>	8	<u>9</u>	10	<u>11</u>	12	<u>13</u>	14	<u>15</u>	16	<u>17</u>
18	<u>19</u>	20	<u>21</u>	22	<u>23</u>	24	<u>25</u>	26	<u>27</u>	28	<u>29</u>	30	<u>31</u>	32	<u>33</u>	
34	<u>35</u>	36	<u>37</u>	38	<u>39</u>	40	<u>41</u>	42	<u>43</u>	44	<u>45</u>	46	<u>47</u>	48	<u>49</u>	
50	<u>51</u>	52	<u>53</u>	54	<u>55</u>	56	<u>57</u>	58	<u>59</u>	60	<u>61</u>	62	<u>63</u>	64	<u>65</u>	
66	<u>67</u>	68	<u>69</u>	70	<u>71</u>	72	<u>73</u>	74	<u>75</u>	76	<u>77</u>	78	<u>79</u>			
80	<u>81</u>	82	<u>83</u>	84	<u>85</u>	86	<u>87</u>	88	<u>89</u>	90	<u>91</u>	92	<u>93</u>			
94	<u>95</u>	96	<u>97</u>	98	<u>99</u>	100										

The table shows that the first unit was “1” which meant that the first client the researcher came across who met the criteria in the gynecology ward was selected. Thereafter, every second client who met the criteria was selected until the sample size was reached. The numbers, which are bold and underlined, represent the clients who were selected to join the sample.

In this case, the researcher’s first unit was “1”, and that was where the counting started from. The sampling interval was 2 and so every second person who met

the criteria was selected. The women who met the criteria were selected as they were being admitted in the ward.

### **3.6 SAMPLE SIZE**

A sample is a subset of a population selected to participate in a research study (Polit and Hungler, 1995). The sample size was fifty (50). A small sample was decided upon because it was manageable considering the limited time in which the study had to be done and the limited resources, which were used.

### **3.7 DATA COLLECTION TOOL**

A data collection tool is an instrument that is used to measure variables and gather information. It is a formal written document used to collect data and record information, such as a questionnaire (Polit and Hungler, 1995)

A semi structured interview schedule was used to collect data from respondents. An interview schedule is a formal instrument, used in structured self report studies, that specifies the wording of all questions to be asked of respondents (Polit and Hungler, 1995). This instrument was thought to be the best for data collection in this study because the sample was chosen from a population of mixed socio – economic class and educational level. In a mixed class, some respondents may be literate, able to read and write, while others may not be able to do so.

The interview schedule consisted of both open and closed ended questions. The interview schedule was divided into five (5) sections (A, B, C, D and E). Section A elicited demographic data, section B elicited information on EC, section C elicited data on women's' attitude towards EC, section D elicited the women's religious beliefs towards EC and section E elicited data on the women's practices of EC.

### 3.8 DATA COLLECTION TECHNIQUE

Data collection technique is a process of gathering information needed to address a research problem (Polit and Hungler, 1995). Data was collected over a period of thirty (30) days using an interview schedule. To minimize some of the limitations of interviewing, the researcher established rapport with the respondents before starting the interview. The selected women were taken to a private room where they were interviewed using an interview schedule. The researcher reported to the gynecological ward at 0700hours before the patients were discharged on each interview day.

Subjects were promised anonymity and confidentiality. The respondents were told that not even the interviewer would know which subject answered which questionnaire. The purpose of the study was introduced by the researcher to the respondents and a verbal consent to interview the respondents was obtained from the respondents.

The researcher asked questions and followed the questions as they were listed down on the interview schedule. The interview schedule also gave chance to the interviewer to probe for more answers. The interviewer entered the responses as given by the respondents. Each respondent was given ample time to give their response and they were written down. At the end of the interview, the investigator went through the interview schedules to note for consistency in the answers given and for completeness of the interview schedule. The researcher thanked the respondents for taking part in the study.

The interview schedule was advantageous to this study because of a number of reasons. The method was flexible and the interviewer could explore responses and tailor the interview towards EC. The response rate was high in face-to-face interview since the respondent found it difficult to refuse to talk. If the interviewee did not understand one of the questions during the interview, the interviewer was able to rephrase the question. The interviewer was in a position to observe the respondent's level of understanding of EC. The information would be used when interpreting data. The interview also allowed the

interviewer opportunity to appraise the validity of the instrument, as she was present to observe what was happening

### **3.9 PILOT STUDY**

A pilot study is a small – scale version, or trial run of a major study. A pilot study was done to test the data collecting tool and to eliminate any ambiguous questions if any. A pilot study was done on five (5) respondents, with similar characteristics.

### **3.10 VALIDITY**

Validity is the degree to which an instrument measures what it intends to measure (Polit and Hungler, 1995). Validity was maintained by ensuring that all variables under study were covered in the interview schedule. Questions were clearly constructed to avoid ambiguity and were tested. The researcher translated the questionnaire in the locally spoken language (Bemba) so that questions could be well understood. The interview schedule was tested at UTH. This was done in order to ensure that the instrument measured what it was supposed to measure. The supervising lecturer and other experts checked the interview schedule. The pilot study was conducted at UTH in the gynecological ward. The main reasons for conducting a pilot study were; to detect any errors in the interview schedule before the main study and to assess the appropriateness and clarity of the questions. The pilot study was also used to test the feasibility, validity and reliability of the questionnaire. In cases of ambiguity in the questions, corrections were made.

### **3.11 RELIABILITY**

Reliability is the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit and Hungler, 1995). The instrument brought out accurate information whereby if the same instrument had to be used after some time, it would be able to produce the same results after collecting similar data.



### **3.12 ETHICAL AND CULTURAL CONSIDERATION**

Authority to conduct the study was obtained from the Managing Director and the Executive Director from UTH and KCH respectively. The UTH was used for the pilot study and KCH was used for the actual study. The purpose of the study was also explained to the respondents and consent to include them in the study was obtained. No respondent was forced to participate in the study. The respondents were also told that no names were to be used on the questionnaire; instead, numbers were used. This was to ensure confidentiality.

## **CHAPTER 4**

### **4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS**

#### **4.1 INTRODUCTION**

Data was collected from 50 women seeking post abortion care at KCH. The aim of the study was to determine knowledge, attitude and practice of emergency contraception among women at KCH. The data was collected by use of a semi - structured interview schedule. This chapter looks at the presentation of the findings and data analysis of the study.

#### **4.2 DATA ANALYSIS**

Data analysis is the process of categorizing, scrutinizing and cross - checking the research data (Treece and Treece 1986). Data can only be useful when arranged in a meaningful manner, in order to be able to derive patterns of relationships (Polit and Hungler, 1995).

Data was collected using a semi - structured interview schedule. The data was edited for completeness and recorded on each interview day. Responses to closed – ended questions were coded using numbers, and open – ended responses were categorized and coded. Data was processed manually and entered on a data master sheet. Frequency counts, percentages and comparison of variables and cross tabulations of variables were done to show relationships among variables in numerical terms.

#### **4.3 PRESENTATION OF FINDINGS**

The findings of the study were presented in terms of tables, pie charts, and cross tabulations. The tables and charts have been clearly numbered and carefully labeled with self – explanatory headings.

**TABLE 3: SOCIO – DEMOGRAPHIC CHARACTERISTICS**

VARIABLE	FREQUENCY	PERCENTAGE (%)
<b>AGE (YEARS)</b>		
15 – 19	10	20
20 – 24	15	30
25 – 29	17	34
30 – 34	3	6
35 – 39	3	6
40 – 45	2	4
<b>TOTAL</b>	<b>50</b>	<b>100</b>
<b>MARITAL STATUS</b>		
Single	12	24
Married	33	66
Divorced	4	8
Widowed	1	2
Separated	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>
<b>TRIBE</b>		
Bemba	19	38
Kaonde	7	14
Ngoni	5	10
Other	19	38
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Table 3 illustrates that age of respondents ranged from 15 to 45 years with a mean age of 27. Sixty six percent of the respondents were married while 12(24%) were single. The table also shows that 19 (38%) of those interviewed were Bembas while another 19 (38%) came from other tribes like Chewa and Luvale.

**TABLE 4: EDUCATIONAL LEVEL, OCCUPATION AND RELIGIOUS DENOMINATION**

VARIABLE	FREQUENCY	PERCENTAGE (%)
<b>EDUCATIONAL LEVEL</b>		
None	1	2
Primary	23	46
Secondary	21	42
College	5	10
University	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>
<b>OCCUPATION</b>		
House wife	10	20
Self employed	16	32
Professional	4	8
Non professional	9	18
School girl	8	16
Other	3	6
<b>TOTAL</b>	<b>50</b>	<b>100</b>
<b>RELIGIOUS DENOMINATION</b>		
RCC	15	30
SDA	2	4
UCZ	5	10
Other	28	56
<b>TOTAL</b>	<b>50</b>	<b>100</b>

The education level of the respondents ranged from none to college level. Table 4 shows that 23(46%) of the respondents had primary education while 5 (10%) of the respondents had gone up to college level. Thirty-two percent of the respondents were self-employed and 8(16%) were school girls. All respondents were Christians from different denominations mostly Roman Catholic (30%) and United Church of Zambia (10%).

**TABLE 5: WHETHER THE PREGNANCY WAS PLANNED OR NOT AND GESTATIONAL AGE OF THE LAST PREGNANCY**

WHETHER PREGNANCY WAS PLANNED	FREQUENCY	PERCENTAGE (%)
Planned	17	34
Not planned	33	66
<b>TOTAL</b>	<b>50</b>	<b>100</b>
<b>GESTATIONAL AGE OF THE LAST PREGNANCY (IN MONTHS)</b>		
Less than 2 months	19	38
3 – 4 months	17	34
5 – 6 months	6	12
<b>TOTAL</b>	<b>50</b>	<b>100</b>

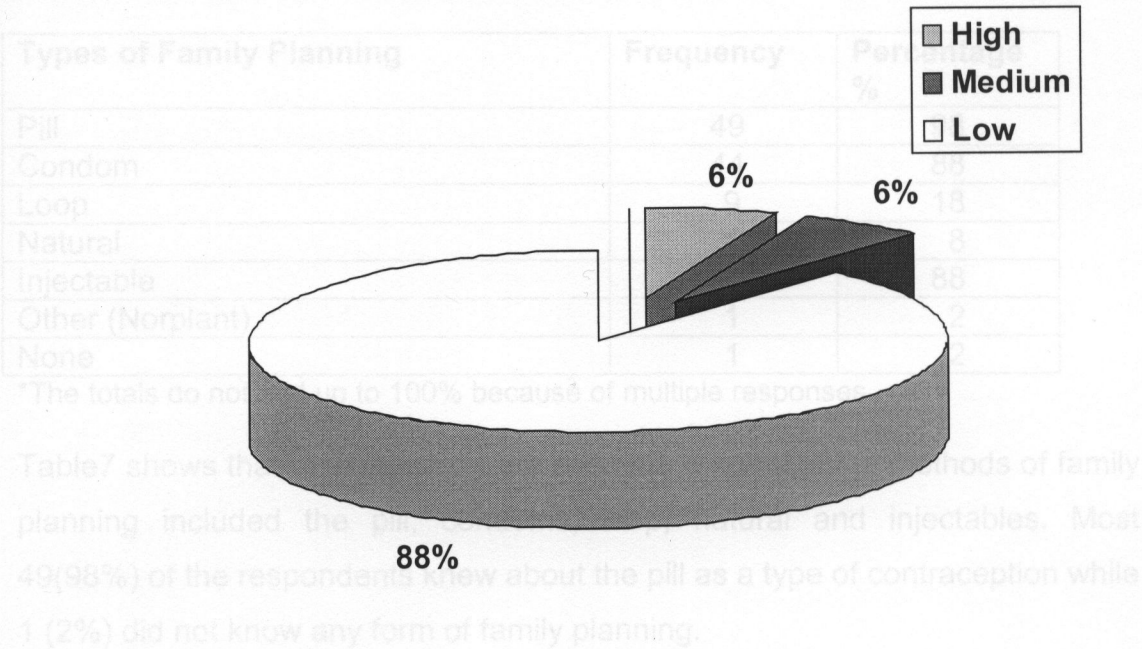
Table 5 shows that 33 (66%) of the respondents did not plan for a pregnancy. Thirty – eight percent of the respondents had abortions of the last pregnancy at less than 2 months gestational age while 6 (12%) aborted at 5 to 6 months.

**CHILDREN**

The number of children respondents had ranged from none to 6. Majority 19 (38%) of the respondents did not have any children while 17 (34%) of the respondents had between 1 and 2 children. Thirty six percent of the respondents had their last child aged between 2 and 5 years. Majority of the respondents 31(62%) said that they would like to have 3 - 4 children.

FIGURE 2: LEVEL OF KNOWLEDGE OF EMERGENCY CONTRACEPTION

TABLE 7: TYPES OF FAMILY PLANNING



The respondents' level of knowledge about EC ranged from low to high knowledge. Figure 2 indicates that only 3 (6%) of the respondents had high knowledge level on EC and another 3 (6%) had moderate level of knowledge while majority 44 (88%) had low knowledge about EC.

TABLE 6: UNDERSTANDING OF FAMILY PLANNING

FAMILY PLANNING	FREQUENCY	PERCENTAGE (%)
Having Children at the time convenient to the individual or couple	49	98
Stopping a couple or individual from having any more children	0	0
Limiting the number of children an individual or a couple can have	0	0
A Service offered to women only for the health of mother and child	1	2
Did not know	1	2
TOTAL	50	100

According to table 6, most 49(98%) of the respondents understood family planning as having children at the time convenient to the individual or couple while 1 (2%) of the respondents did not understand family planning at all.

Figure 3 illustrates that only 6 (12%) of the respondents had heard about EC while majority of the respondents 44(88%) had never heard about EC. Only 8

(12%) of all the respondents understood emergency contraception as a family planning method used to prevent pregnancy while the rest 44 (88%) had not

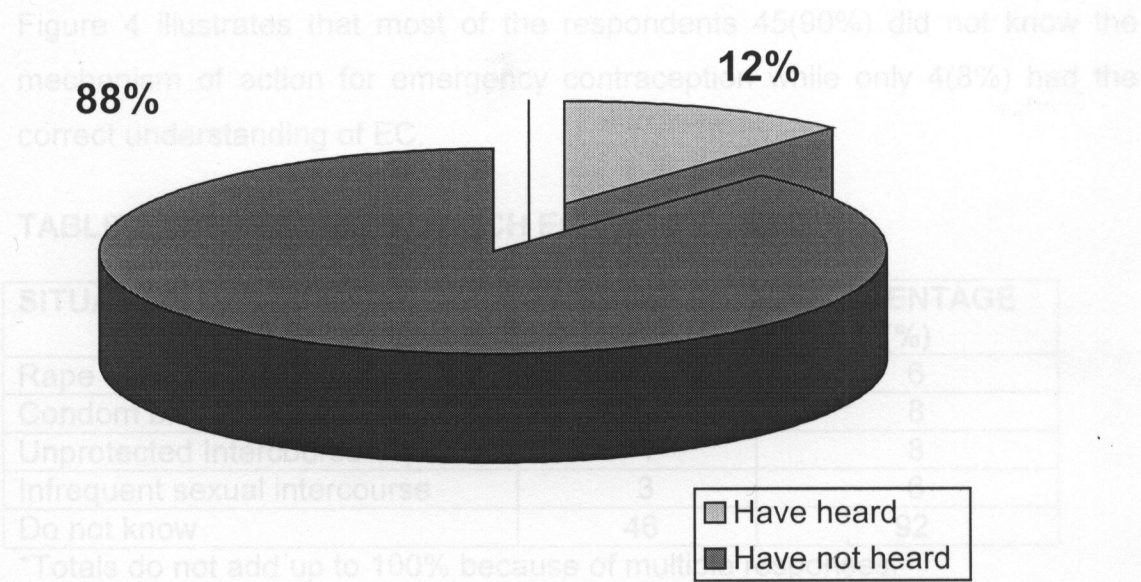
**TABLE 7: TYPES OF FAMILY PLANNING**

Types of Family Planning	Frequency	Percentage %
Pill	49	98
Condom	44	88
Loop	9	18
Natural	4	8
Injectable	42	88
Other (Norplant)	1	2
None	1	2

\*The totals do not add up to 100% because of multiple responses.

Table7 shows that respondents were aware that some of the methods of family planning included the pill, condoms, loop, natural and injectables. Most 49(98%) of the respondents knew about the pill as a type of contraception while 1 (2%) did not know any form of family planning.

**FIGURE 3: WHETHER THE RESPONDENTS HAD HEARD ABOUT EMERGENCY CONTRACEPTION**



Majority of the respondents 46(92%) did not know in which situations EC could be used. However, 4(8%) knew that EC could be used in situations of condom breakage. Only 6(8%) of the respondents knew that rape victims could use EC

Figure 3 illustrates that only 6 (12%) of the respondents had heard about EC while majority of the respondents 44(88%) had never heard about EC. Only 6



(12%) of all the respondents understood emergency contraception as a family planning method used to prevent pregnancy while the rest 44 (88%) had not heard about it.

FIGURE 4: MECHANISM OF ACTION OF EC

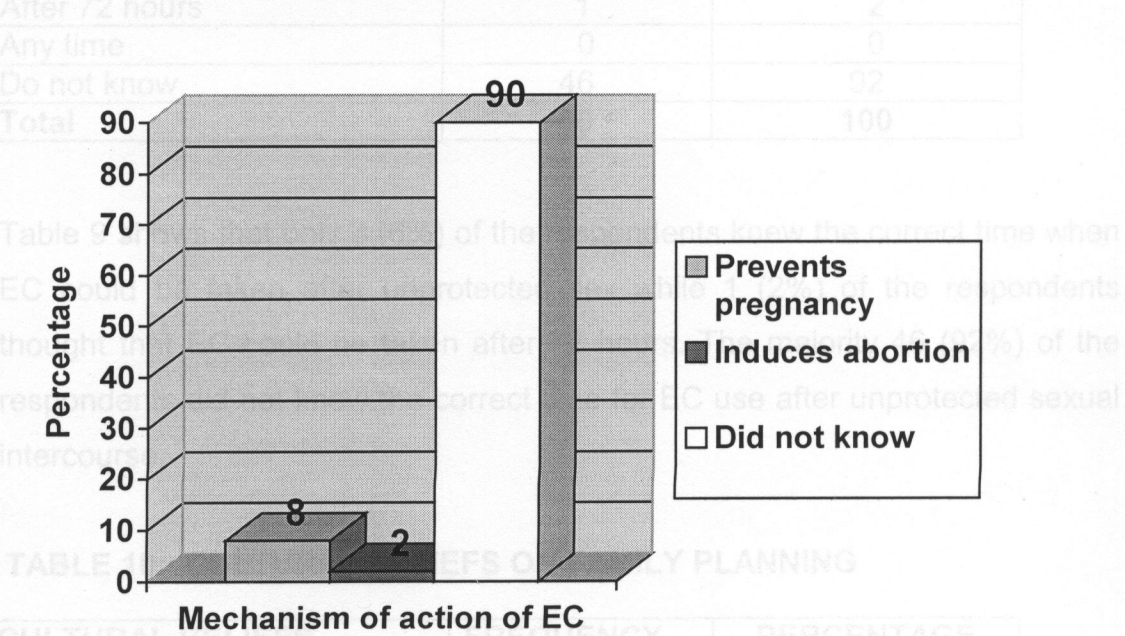


Figure 4 illustrates that most of the respondents 45(90%) did not know the mechanism of action for emergency contraception while only 4(8%) had the correct understanding of EC.

TABLE 8: SITUATIONS IN, WHICH EC CAN BE USED

SITUATION	FREQUENCY	PERCENTAGE (%)
Rape Victims	3	6
Condom breakage	4	8
Unprotected Intercourse	4	8
Infrequent sexual intercourse	3	6
Do not know	46	92

\*Totals do not add up to 100% because of multiple responses.

Majority of the respondents 46(92%) did not know in which situations EC could be used. However, 4(8%) knew that EC could be used in situations of condom breakage. Only (6%) of the respondents knew that rape victims could use EC.



**TABLE 9: CORRECT TIME WHEN EC CAN BE TAKEN AFTER UNPROTECTED SEX.**

CORRECT TIME OF TAKING EC	FREQUENCY	PERCENTAGE (%)
Within 72 hours	3	6
After 72 hours	1	2
Any time	0	0
Do not know	46	92
Total	50	100

Table 9 shows that only 3 (6%) of the respondents knew the correct time when EC could be taken after unprotected sex while 1 (2%) of the respondents thought that EC could be taken after 72 hours. The majority 46 (92%) of the respondents did not know the correct time for EC use after unprotected sexual intercourse.

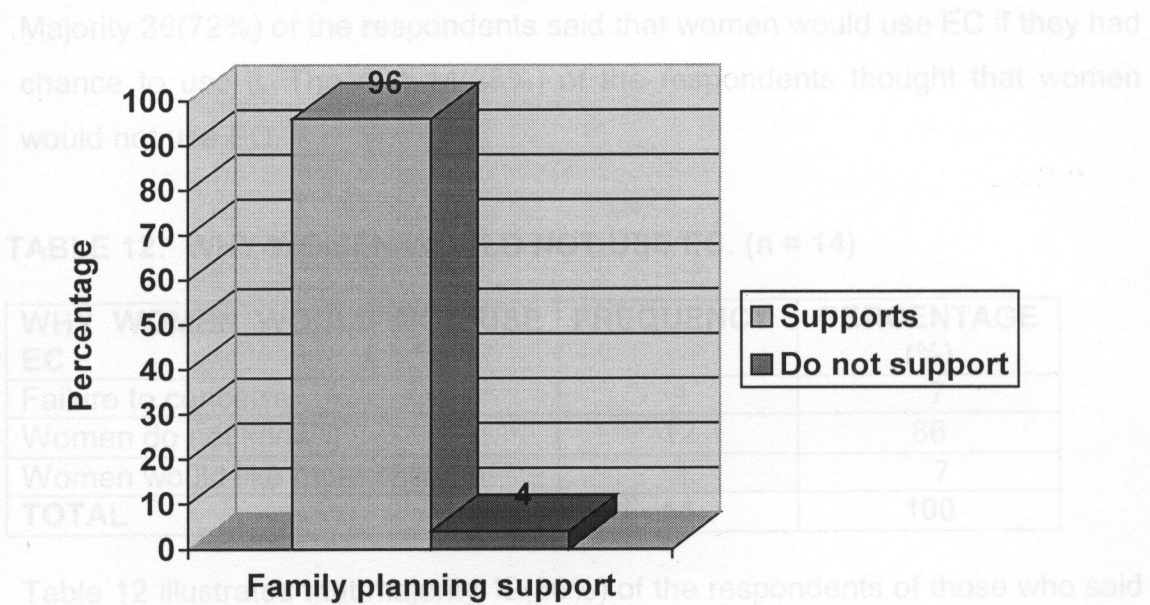
**TABLE 10: CULTURAL BELIEFS ON FAMILY PLANNING**

CULTURAL BELIEFS	FREQUENCY	PERCENTAGE (%)
Abdominal pains	8	16
Uterine growths	23	46
Failure to conceive	16	32
Deformities in the baby	1	2
Abortions	3	6
No Beliefs	7	14
Do not know	2	4

\*Totals do not add up to 100% because of multiple responses

According to table 10, 28 (46%) of the respondents believed that family planning brings about uterine growths while 8 (16%) of them believed that family planning is responsible for failure to conceive.

FIGURE 5: WHETHER WOMEN SUPPORT FAMILY PLANNING OR NOT



Most 48(96%) of the respondents reported that women support family planning while only 2 (4%) of the respondents said that women do not support family planning (Figure 5).

TABLE 11: WHY WOMEN SUPPORT OR DO NOT SUPPORT FAMILY PLANNING

WHY WOMEN SUPPORT OR DO NOT SUPPORT FAMILY PLANNING	FREQUENCY	PERCENTAGE (%)
Helps in Spacing of Children	44	88
Leads to abdominal problems	1	2
Helps women recuperate before the next child	2	4
More Children are a prestige	1	2
Do not know	2	4
Total	50	100

Table 11 shows that most 44(88%) of the respondents said that women supported family planning because it helps them space their children. Some of the respondents, 2 (4%) indicated that they did not know why women supported family planning. 12 (24%) of the respondents indicated that religion strongly agree with the use family planning.

USE OF EC

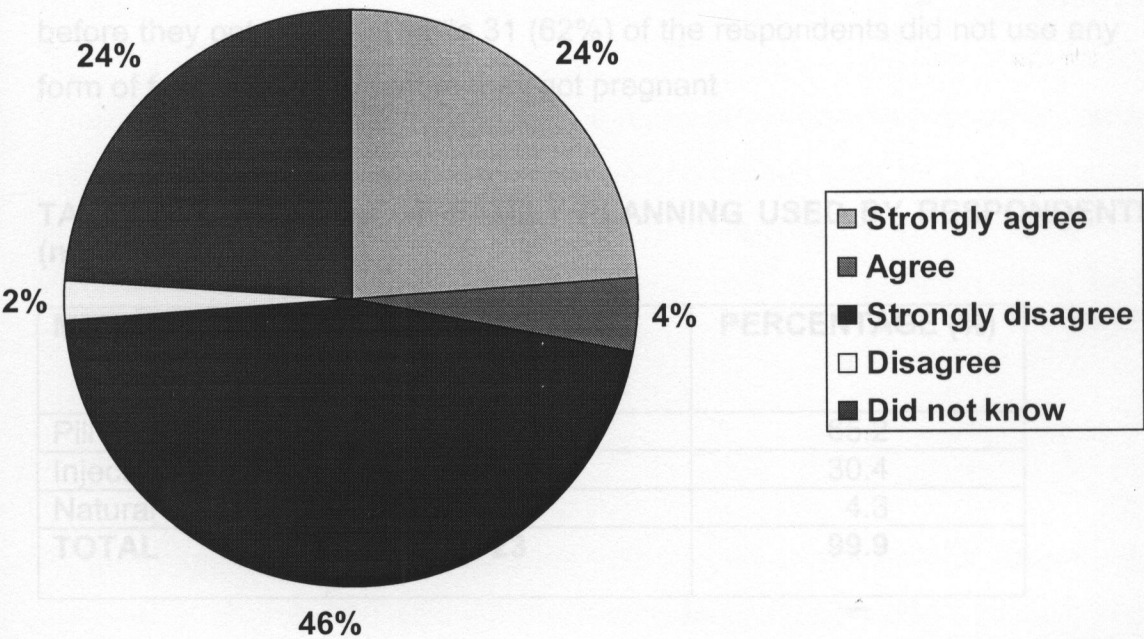
Majority 36(72%) of the respondents said that women would use EC if they had chance to use it. The rest 14(28%) of the respondents thought that women would not use EC.

TABLE 12: WHY WOMEN WOULD NOT USE EC. (n = 14)

WHY WOMEN WOULD NOT USE EC	FREQUENCY	PERCENTAGE (%)
Failure to conceive	1	7
Women do not know it	12	86
Women would like more children	1	7
TOTAL	14	100

Table 12 illustrates that majority 12(86%) of the respondents of those who said that women would not use EC indicated that women would not use EC because they did not know it.

FIGURE 6: WHAT RELIGIOUS PEOPLE SAY ABOUT FAMILY PLANNING



According to Figure 7, 23 (46%) of the respondents indicated that Religious people strongly disagrees with the use of family planning. 12 (24%) of the respondents indicated that religion strongly agree with the use family planning.

WHAT WOULD HAPPEN IF A WOMAN MISSED A PILL FOR 2 TO 3

FIGURE 7: WHETHER RESPONDENTS WERE USING ANY FAMILY PLANNING METHOD BEFORE THEY GOT PREGNANT

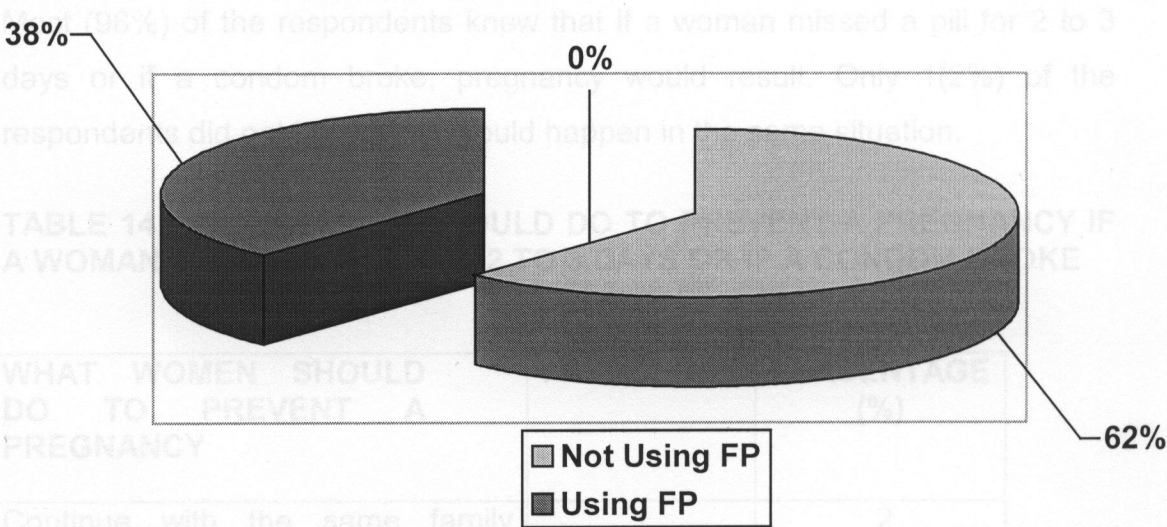


Figure 7 shows that 19 (38%) of the respondents were using family planning before they got pregnant while 31 (62%) of the respondents did not use any form of family planning before they got pregnant

TABLE 13: METHODS OF FAMILY PLANNING USED BY RESPONDENTS (n = 23)

METHOD	FREQUENCY	PERCENTAGE (%)
Pill	15	65.2
Injectable	7	30.4
Natural	1	4.3
TOTAL	23	99.9

Table 13 shows that majority of the respondents 15(65.2%) were on a pill for family planning before they got pregnant. One out of 23 (4.3%) of the respondents was using the natural family planning method before she got pregnant.

**WHAT WOULD HAPPEN IF A WOMAN MISSED A PILL FOR 2 TO 3 DAYS OR IF A CONDOM BROKE**

Most (98%) of the respondents knew that if a woman missed a pill for 2 to 3 days or if a condom broke, pregnancy would result. Only 1(2%) of the respondents did not know what would happen in the same situation.

**TABLE 14: WHAT WOMEN SHOULD DO TO PREVENT A PREGNANCY IF A WOMAN MISSED A PILL FOR 2 TO 3 DAYS OR IF A CONDOM BROKE**

WHAT WOMEN SHOULD DO TO PREVENT A PREGNANCY	FREQUENCY	PERCENTAGE (%)
Continue with the same family planning method	1	2
Take EC	6	12
Take all the missed pills in two doses	1	2
Take 2 tablets of cafenol	1	2
Take Microgynon	1	2
Do not know	39	78
<b>TOTAL</b>	<b>50</b>	<b>100</b>

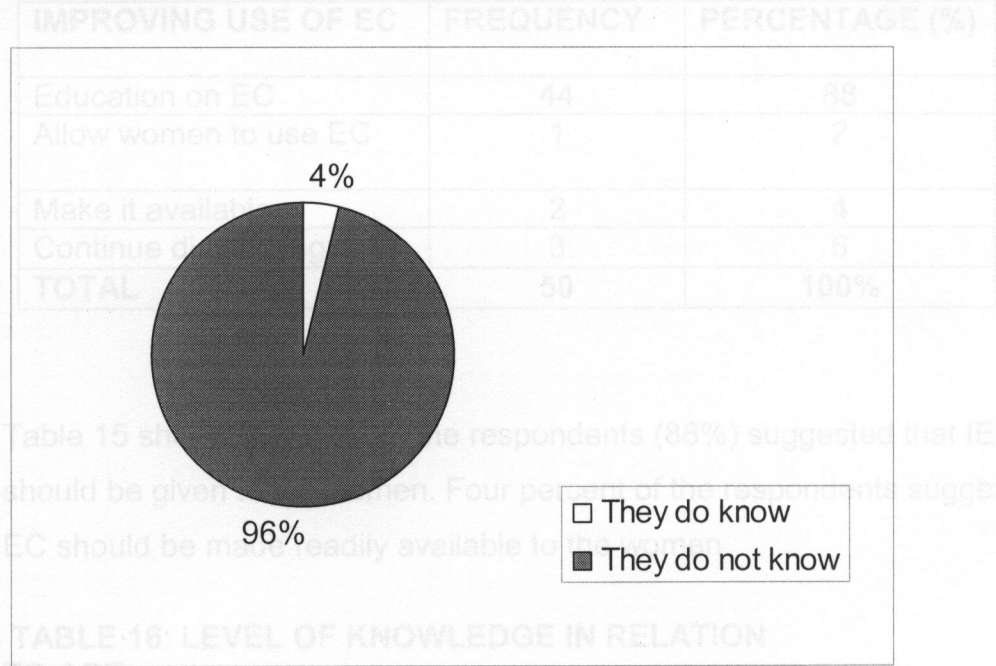
Table 14 shows that only 6 (12%) of the respondents correctly reported that EC could be used to prevent pregnancy when one missed a pill for 2 to 3 days or if a condom broke. Majority 39 (78%) of the respondents did not know what women should do to prevent a pregnancy in the same situation while 4(8%) gave wrong answers.

**USE OF EC AFTER UNPROTECTED SEX**

All the respondents (100%) indicated that women do not use EC after being involved in unprotected sex. All the respondents (100%) also indicated that women do not know EC pills.



**FIGURE 8: WHETHER THEY KNEW OF ANYBODY WHO HAD EVER USED EC.**



Most 43(96%) of the respondent's did not know of anybody who had used EC while only 2(4%) of the respondents knew of somebody who has ever used EC (Figure 8). All 2(100%) of the respondents who had heard of somebody who had used EC also said that the women used EC because they did not plan for a pregnancy.

**SOURCE OF SUPPLY FOR EC**

All the women who used EC went to the health center for the supply of EC and were given the supply.

Table 16 shows that 1(33.3%) of the respondents who were aged between 30 to 34 years had high knowledge while all 15 (100%) of those aged 20 to 24 had low knowledge. All the respondents who were aged between 35 to 39 and those aged 40 to 45 had low knowledge on EC.

**TABLE 15: SUGGESTIONS REGARDING THE USE OF EC.**

IMPROVING USE OF EC	FREQUENCY	PERCENTAGE (%)
Education on EC	44	88
Allow women to use EC	1	2
Make it available	2	4
Continue distributing it	3	6
<b>TOTAL</b>	<b>50</b>	<b>100%</b>

Table 15 shows that most of the respondents (88%) suggested that IEC on EC should be given to the women. Four percent of the respondents suggested that EC should be made readily available to the women.

**TABLE 16: LEVEL OF KNOWLEDGE IN RELATION TO AGE**

KNOWLEDGE OF EC	AGE						TOTAL
	15-19	20-24	25-29	30-34	35-39	40-45	
High	0	0	2 (11.8%)	1 (33.3%)	0	0	3 (6%)
Moderate	2 (20%)	0	1 (5.1%)	0	0	0	3 (6%)
Low	8 (80%)	15 (100%)	14 (82.3%)	2 (66.7%)	2 (100%)	3 (100%)	44 (88%)
<b>TOTAL</b>	<b>10 (20%)</b>	<b>15 (30%)</b>	<b>17 (34%)</b>	<b>3 (6%)</b>	<b>2 (4%)</b>	<b>3 (6%)</b>	<b>50 (100%)</b>

Table 16 shows that 1(33.3%) of the respondents who were aged between 30 to 34 years had high knowledge while all 15 (100%) of those aged 20 to 24 had low knowledge. All the respondents who were aged between 35 to 39 and those aged 40 to 45 had low knowledge on EC.

**TABLE 17: KNOWLEDGE OF EC IN RELATION TO EDUCATIONAL LEVEL**

KNOWLEDGE OF EC	EDUCATION LEVEL				TOTAL
	None	Primary	Secondary	College	
HIGH	-	-	1(1.4%)	2(40%)	3(6%)
MODERATE	-	-	3(14.3%)	-	3(6%)
LOW	1(100%)	23(100%)	17(80.9%)	3(60%)	44(88%)
TOTAL	1(2%)	23(46%)	21(42%)	5(10%)	50(100%)

The table indicates that 23 (100%) of the respondents who attained primary education had low knowledge on EC while 2 (40%) of the respondents who attained college education had high knowledge.

**TABLE 18: KNOWLEDGE OF EC IN RELATION TO MARITAL STATUS**

KNOWLEDGE OF EC	MARITAL STATUS				TOTAL
	Single	Married	Divorced	Widowed	
HIGH	-	3(9.1%)	-	-	3(6%)
MODERATE	1(8.3%)	2 (6.1%)	-	-	3(6%)
LOW	11(91.7%)	28(84.8%)	4(100%)	1(100%)	44(88%)
TOTAL	12 (24%)	33 (66%)	4 (8%)	1 (10%)	50 (100%)

Table 18 shows that 3(9.1%) of the respondents who were married had high knowledge while 11 (91.7%) of those who were single had low knowledge. All 4(100%) of the respondents who were divorced had low knowledge.



## **CHAPTER 5**

### **5.0 DISCUSSION OF FINDINGS**

#### **5.1 INTRODUCTION**

The purpose of this study was to determine the knowledge, attitudes and practices of emergency contraception among women at Kitwe Central Hospital (KCH). The sample consisted of 50 women seeking post abortion care at KCH. This chapter discusses the findings of the study and the implications to the Health Care System. Recommendations are also made to relevant authorities.

#### **5.2 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS**

The age range was 15 – 45 years with a mean age of 27. Majority of the respondents were aged between 15 – 29 years. This could be due to the fact that the median age at first sexual intercourse for Zambian women is 17 years (CSO, 2003).

More than half of the respondents were married. These women were at risk of getting unplanned pregnancies. About 25% of them had never been married. Kitwe district has a mixture of tribes though the common language is Bemba. It was not surprising to find that more than one third (38%) of the respondents were Bembas. The Bemba tribe and other tribes did not yield to any beliefs, which could hinder the use of modern contraceptives.

Almost half (46%) of the respondents had primary education. Forty – two percent had secondary education while only 10% of the respondents had college education. Less than a quarter of the respondents were school-girls with secondary education. Educated women with secondary education are more likely to get information and use family planning than the uneducated. Education is an important factor in family planning as it helps people in making informed decisions. According to CSO (2003), 62.8% of the women with higher education were using modern family planning compared to 23.2% who had no education at all.

All of the respondents were Christians from various denominations. Religion plays an important role in what people believe in even in terms of contraceptive choice. Some of the Christian denominations favor the use of natural family only as opposed to the modern contraceptives. Zambia is a Christian nation and most of the Zambians are Christians. This probably explains why all the respondents were Christians.

The number of children each mother had ranged from none to six. Although thirty – eight percent of the respondents said that they had no children, although the current pregnancy could have been their second pregnancy after experiencing a miscarriage. More than half of the respondents said that they wished to have 3 – 4 children while about a quarter of the respondents said that they would like to have 5 – 6 children. Having more children is a prestige in the African tradition. This result corresponds with the ZDHS 2001 –2002 survey where women who would like to have 4 children were many (28.6%) compared to other ideal numbers for women who had no children (CSO, 2003).

About one third (34%) of the respondents said that their last children were aged between 2 – 5 years old. This was an interesting result because it showed that the women were conscious of the need for spacing their children.

More than half of the respondents stated that they did not plan for the pregnancy. These respondents were at risk of the consequences of unintended pregnancies, which include abortion. A 1998 study aggregated data from studies in 27 countries on the reasons women seek to terminate their pregnancies. It concluded that common factors cited to have influenced the abortion decision were the desire to delay or end childbearing, concern over the interruption of work or education, issues of financial or relationship stability, and perceived immaturity (<http://www.mediawiki>).

It is important to note that some of the respondents lost their pregnancies spontaneously while others had induced abortions. The risk of spontaneous

abortion is greater in those with a history of three previous abortions although it could also be caused by infection and many other causes. Approximately 10 – 50% of pregnancies end in miscarriage, depending on the health and age of the pregnant woman ([http:// www.mediawiki](http://www.mediawiki)). Induced abortions are abortions which are intentionally done.

Thirty – eight percent of the respondents aborted pregnancies of less than two months old. Thirty four percent of the respondents aborted three to four months old pregnancies while 12% lost five to six months old pregnancies. Amongst those who induced the abortions at home, a number of them said that they took various concoctions to achieve the desired results. Common among them was the taking of cafenol with coca cola and taking of herbs. The risk of complications from an abortion is directly related to the duration of the pregnancy. The longer the woman has been pregnant, the greater the risk of complications ([http:// www.mediawiki](http://www.mediawiki)).

### **5.3 EMERGENCY CONTRACEPTION**

Another finding of this study was that the level of knowledge of EC was low among women seeking post abortion care. The results show that only 6% of the respondents had high knowledge on EC, another 6% had moderate level of knowledge whilst the majority of the respondents had low knowledge on EC. Lack of knowledge about EC predisposes the women to the risk of unplanned pregnancies. These results suggest the greater need for intensified IEC to the women about EC. The results correspond with the study carried out in Kenyan refugee camps where only 11% of the surveyed women who reported coerced sex in the camps, said that they had heard about EC despite its availability at the camp Hospital (FHI, 2001). The results are also in line with ZDHS 2001 – 2002 survey where it was found that EC was the least known method of family planning in Zambia with only 9% of all women aware of it (CSO, 2003).

Less than one fifth of all the respondents had heard about EC. The study also revealed that only 8% of the respondents correctly pointed out that EC prevent pregnancy. One respondent said that EC induces abortion. These findings

suggest that the level of knowledge of EC among women is poor and more information is needed. The low knowledge levels in this study could be attributed to health workers not sensitizing the community. Shortage of staff in family planning clinics may be a possible explanation for not sensitizing the community. Another potential explanation could be inadequate knowledge among the family planning providers. This information can be supported by a study done in 1997 by FHI in Ghana where researchers evaluated health providers' knowledge of EC. The survey found that about one – third of 325 interviewed providers had heard of EC but none knew how to prescribe it correctly (FHI, 2001).

According to FHI (2001), the primary mechanisms through which EC pills operate appear to occur prior to fertilization. Research has demonstrated that EC can prevent or delay ovulation. The EC pills cannot interfere with an established pregnancy because the pills have no effect after implantation has been established. Therefore EC is not an abortifacient. The view that EC could induce an abortion can negatively influence the decision to use EC by women.

The study also revealed that only 8% of the respondents identified condom breakage as the appropriate situation when EC could be used. Only 6% percent of the respondents identified rape cases as appropriate situations for EC use. Eight percent of the respondents identified all acts of unprotected sex as appropriate situations for EC use. Majority of the respondents had completely no idea when EC could be used. Health care providers do not always inform their clients about EC. A possible explanation could be the lack of knowledge amongst the providers themselves. This information can be supported by a study carried out by Mulenga (2000) who found that among the family planning providers who were interviewed, only 40% informed their clients about EC while 20% informed clients only on request. 40% of these respondents did not inform their clients at all. This could be attributed to the providers' inadequate knowledge about the method. A survey carried out in Ghana where providers' knowledge on EC was evaluated found that about one – third of 325 interviewed providers had heard of it but none knew how to prescribe it (FHI, 2001).

Respondents were also asked on the correct time when EC can be taken after unprotected sex. Very few (6%) respondents correctly pointed out that it should be taken within 72 hours. Two percent indicated that it should be taken 72 hours after unprotected sex. These results suggest that some of the respondents who had heard about EC did not know the correct time when it could be used to be effective. This result corresponds with the findings of Baiden *et al* (2002) who found that of the 194 respondents who had heard about the EC, only 11.3% of the respondents indicated correctly the recommended time within which ECPs are to be taken after unprotected sex. According to FHI 2001, if a woman uses EC within 72 hours after unprotected sex, progestin – only pills lower the chance of pregnancy by about 85%. Combined pills are about 75% effective if used within 72 hours.

Despite the fact that most of the respondents had low knowledge about EC, two – thirds of them said that women would use EC provided they are given adequate information. This result showed that they had a positive attitude towards EC. In Sri Lanka, an EC telephone hotline received 8000 calls during the project's first 2 weeks. Phone attendants received a variety of questions illustrating the broad need for information. About a quarter of callers wanted to know how to use EC; 18% asked where to buy the pills; 11% requested the name of an EC product; 9% asked about side effects, and 6% inquired about the price (FHI, 2001). This data shows how necessary adequate information is about the method.

The respondents, who said that women could not use EC, said that they did not know it. Other reasons were that the users might fail to conceive and that women would like more children. Inadequate information about the method could be a possible explanation for this outcome.

The respondents were asked on what would happen if a woman missed a pill for 2 to 3 days or if a condom broke. Almost all of them said that a pregnancy would result. Surprisingly, only 12% of the respondents were aware that EC could be used to prevent a pregnancy in such circumstances. These results

show that the respondents were able to identify situations, which would lead to an unplanned pregnancy though majority of them did not know that a pregnancy could be prevented even in such situations. The results further suggest that women are not aware that they can prevent a pregnancy even after unprotected sex.

Only 4% of the respondents indicated that they knew of someone who had used EC. These respondents reported that EC was used because the women involved did not plan for pregnancy. They further indicated that users got the supply of EC from the health center. In a similar study done in Kenya among nurses and nursing students, of those familiar with the method, only 3.5% had personally used EC in the past. As seen from the study, most women have inadequate knowledge about availability and use of EC.

The study established that there was a relationship between knowledge of EC and age. One - third (33.3%) of the respondents aged 30 - 34 had high-level knowledge and 11.5% of those aged 25 – 29 years also had high levels of knowledge. Twenty percent of the respondents aged 15 – 19 and 5.1% of the respondents from the 25 – 29 age groups had moderate level knowledge. All of the respondents aged 20 – 24 and those aged 35 - 39 had low knowledge about EC. The knowledge level for all age groups was generally low. These findings are in line with other studies like a United States (US) study on women 18 years and older which demonstrated a lack of knowledge and use. The survey, done in the year 2000, involved 500 women aged 18 – 44 years. It revealed that only 2% had used EC and only 25% of the women had heard of the method (Klein, 2004).

There was also an association between level of education and respondents' level of knowledge on EC. The study revealed that 40% of the respondents who had college education had high knowledge on EC compared with respondents with secondary education who had 80.9% low knowledge. All the respondents who had primary education and no education at all had low knowledge. The result shows a slight advantage for those who were at college level to obtain information about EC.

The study tried to establish whether there was an association between knowledge of EC and marital status. Only one respondent in the single category had moderate level of knowledge while the rest in the same category had low knowledge. More than three quarters of the married respondents had low levels of knowledge. Inadequate IEC by family planning providers could be responsible for such results.

This study, can therefore, prove the hypothesis that inadequate knowledge on EC among women is responsible for under utilization. It is important to educate women about EC so that they understand the method. Explaining to them can also dispel the myths that they may have about the method generally.

#### **5. 4 OTHER METHODS OF FAMILY PLANNING**

All of the respondents said that they had heard about family planning. Almost all of the respondents managed to define family planning correctly. Ninety – eight percent of the respondents were able to mention one or more methods of family planning. The ability of the respondents to define and mention a family planning method implies that the respondents understood family planning. This result further suggests that women are able to choose a method when given the chance. These findings are supported by CSO, 2003 findings which state that 98.7% of all Zambian women know of at least one method of family panning.

Regarding cultural beliefs, a lot of misconceptions about family planning were brought out. Forty six percent of the respondents believed that modern family planning methods led to uterine growths. About one third (32%) of the respondents believed that failure to conceive was one of the outcomes. Sixteen percent of the respondents associated family planning with abdominal pains. Increased utilization of EC is plagued with fear of infertility, anovulation, ill health and other sexually transmitted infections (<http://www.ncbi.nlm.nih.gov/entrezquery>).

These are misconceptions, which women believe in the communities. There is a danger that some women may not access family planning services because of the same fears. This calls for continuous IEC to dispel the beliefs and misconceptions that the women strongly hold.

Almost all of the respondents interviewed said that women support family planning. Notably, a great number of the respondents managed to give good reasons why women support family planning. A high proportion of the respondents said that women support family planning because it helps them space their children. The other reason for supporting family planning was that it gives women time to recuperate before having another child. However, one respondent reported that women did not support family planning because of the belief that it brings about abdominal problems. It was worth noting that one respondent who was highly knowledgeable and a college graduate also believed that family planning limits the number of children when more children are a prestige.

The study revealed that 46% of the respondents said that religious people strongly disagree with the use of family planning while a small fraction of the respondents said that religious people disagrees with the use of modern family planning. The reason for not supporting family planning could be because some religious groups or religious denominations believe that family planning is a form of abortion. Furthermore, abortion is considered as killing in the eyes of God, which is a sin. Another religious belief is that God has instructed man to fill the world and family planning is seen as a way of limiting the number of children. It is thus imperative that women understand the action and benefits of the various family planning methods.

About one – third of the respondents said that they were using family planning methods before they got pregnant. Of these, more than half of them were using the pill. This result shows that the women were able to practice family planning. A small proportion of the respondents who were using the pill revealed that they got pregnant because they missed the pill for some days.



The pill is the most commonly used method of contraception in Zambia (CSO, 2003).

EC pills are safe, effective, and low cost primary preventive and emergency care intervention. Information about their use should be made available. Patients should be advised not to abandon their use of barrier or other traditional contraceptives.

## **5.5 IMPLICATIONS TO THE HEALTH CARE SYSTEM**

The health sector has a major role to play in assisting women plan their families. Coordinated effort of all health care providers is vital if all the people have to be given the information about all family planning methods including EC. The women in the reproductive age (15- 45) are commonly affected with problems of frequent pregnancies, unplanned pregnancies and having a lot of children whom they fail to support.

The findings of this study revealed that very few (12%) of the respondents were knowledgeable about the contraception method, EC. This implies that women end up with unplanned pregnancies, which they could have prevented if they were informed about EC. In order for women to prevent a pregnancy after unprotected sex, they need to have information about EC.

It was also discovered that most of the respondents who were not knowledgeable were aged 15 - 34. This means that these women will not be able to use EC meanwhile this is the group that is also at high risk of unplanned pregnancies. The study also revealed that education level was one of the factors that influenced knowledge on EC. This implies that the more educated the respondents were, the higher the chance of getting the information even on EC. This is a challenge to the health sector because it is supposed to cater for everyone including those who are not educated.

The study also revealed that the level of knowledge of the respondents did not have much effect on the attitude of the respondents. The respondents

indicated that the women would use EC if they are given adequate information about EC. This implies that the women would not have problems in accepting the method when adequate information is given to them.

#### **5.6.1 Implications to Nursing Practice**

The nursing care outcome is the result of a nursing intervention. From the study, the care given to family planning clients is not adequate. Despite 98% of the respondents having shown an understanding of family planning, only 12% had heard about the concept of EC. This implies that nurses need to be adequately prepared so that they give adequate information to the clients about EC for them to prevent unplanned pregnancies.

#### **5.6.2 Implications to Nursing Administration**

The study showed that majority (88%) of the respondents had not heard about the concept of EC. Inadequate supervision of the family planning providers could have contributed to this result. Shortage of staff could also contribute to the problem. Despite the problem of staffing, there is need for adequate supervision of the nurses by nurse managers.

#### **5.6.3 Implications to Nursing Education**

One of the reasons for respondents having low knowledge about EC could be inadequate knowledge about EC by the family planning providers, which include nurses. This implies that if the providers have inadequate knowledge, they may not be competent to provide the service. Instead, they end up omitting the method when providing the service. Adequate knowledge of EC is therefore necessary for the nurses, which can be achieved by adequate education of the nurses during training and in service.

#### **5.6.4 Implications to Nursing Research**

The quality of care given to clients is an important factor in the determination of patient / client outcomes. Few researches have been done on EC in Zambia. This implies that it becomes difficult to improve practice even on provision of EC as a family planning method without evidence based knowledge. Research can show why people do not know much about the method thereby direct providers and policy makers on what to do. It is therefore necessary that nurses take interest in taking up research in areas like emergency contraception.

#### **5.6 CONCLUSION**

The study sought to determine the knowledge, attitude and practice of EC among women seeking abortion at KCH. The research was conducted in Chambeshi ward at KCH. The study yielded evidence that the level of knowledge among women was very low (12%). Among the few respondents who were knowledgeable, educational level played a role as all of the respondents who were knowledgeable had secondary level or college level of education.

The study also revealed the willingness of the women to use EC in spite of lacking knowledge about it. The study also showed that out of the 14(100%) respondents who indicated that women would not use EC, 12(86%) of them said that women would not use EC because they did not know it.

Adequate information on EC needs to be provided to family planning clients so that they can decide on whether to use it or not. These findings have implications on the IEC system especially with reference to EC. Health care providers should accept and provide information to all would be users of the method. Unless continuous IEC and sensitization is carried out about this effective family planning method, women will continue facing the challenges of unplanned pregnancies.

## 5.7 RECOMMENDATIONS

The researcher wishes to make the following recommendations in the light of findings of the study.

- **To the Ministry of Health**

The Ministry of Health should ensure that emergency contraception products are made available in all health facilities offering family planning services. The Ministry of Health should ensure that family planning providers have adequate information on EC. Literature should also be made available for the providers and clients. The Ministry of Health should also conduct periodic evaluation to check if information is being disseminated to the family planning clients and if the service is being provided.

The Ministry of health should also ensure that the family planning providers are given adequate information about EC for them to be able to provide the service. The Ministry of Health should work in conjunction with other departments like Broadcasting so that EC is advertised on mass media for all women to know about it and make informed choices. The Ministry should facilitate for a much larger study; including rural areas to enable generalization of the findings and to evaluate the effectiveness of measures, which will be put into place.

- **To the District and Hospital Management**

The District and Hospital management should ensure that the family planning clinics have adequate staffing for them to deliver quality service including IEC on family planning methods. The management should also provide IEC materials needed for family planning providers to teach about EC. Sensitization campaigns about EC should be carried out for the people to be informed. The family planning clinics should also be provided with adequate supplies of emergency contraceptives.

- **To the Health Care Providers**

Health care providers especially nurses need to acquire adequate education on EC and other related information related to emergency contraception in Zambia. Family planning providers should make deliberate efforts to inform women about EC. Adequate information should be provided to women about the availability, use and benefits of EC during Maternal and Child Health (MCH) activities.

## **5.8 DISSEMINATION OF FINDINGS**

The researcher intends to disseminate the study findings by submitting copies of the research project to the following;

- Department of Post Basic Nursing, UNZA
- The Medical Library, UNZA
- Ministry of Health Headquarters
- Kitwe Central Hospital
- Executive summaries will be submitted to WHO and SFH.

The researcher also hopes to conduct a dissemination workshop to disseminate the findings to the Ministry of Health, the Kitwe Central Hospital, and Society for Family Health and other non-governmental organization dealing with family planning. The community will be informed of the research findings through IEC programmes.

## **5.9 LIMITATIONS OF THE STUDY**

Some of the limitations to the study were as follows: -

- The time allocated to carry out the research and present the findings was not adequate because the research was being carried out alongside other courses.
- The sample size was too small (50) to be representative of the population of Kitwe, thus, the results cannot be generalized.

- Few studies have been done on emergency contraception both in Zambia and other countries. This made it difficult to get literature to review and also to make comparisons with the findings of the study.

## REFERENCES

- 1 Ahmed, Y., Ketata, M and Skibiak, J. P, (1998), ***Emergency contraception in Zambia - setting a new agenda for research and action***, Population Council, Nairobi.
- 2 Ahmed, Y., Skibiak, J. P and Ketata, M, (1999), ***Comparing Alternative Products in the Provision of Emergency Contraception***. Population Council, Nairobi.
- 3 Baiden F, Awini E, Clerk C (2002), ***Perception of university students in Ghana about emergency contraception***, Navrongo Health Researcher Center, Ghana.
- 4 Bodrick N, (2000), ***Emergency Awareness and Access in Nigeria***, Washington.
- 5 Brynard P. A, (1997), ***Applied Social Research methods series*** Vol. 3, Beverly Hills.
- 6 Central Statistical Office {Zambia}, Central Board of Health {Zambia}, and ORC Macro. 2003. ***Zambia Demographic and Health Survey 2001 – 2002***. Calverton, Maryland, USA: Central Statistical Office, Central Board of Health, and ORC Macro.
- 7 Chileshe (2005), ***Health Information Management Systems***, DHMT, MOH, Kitwe
- 8 Family Health International, (2005), ***Emergency Contraception Pills***, Vol. 21, Number 1.
- 9 General Nursing Council ( 2005), ***Registered Nurse Training Curriculum***,
- 10 Hatcher A, R., Rinehart, W., Blackburn, R., Geller, S.J and Shelton D.J, (1997), ***The Essentials of Contraceptive Technology***. John Hopkins Center for Communications Programs, USA.
- 11 <http://www.ncbi.nlm.nih.gov/entrez/query>.
- 12 [http:// www.mediawiki](http://www.mediawiki)
- 13 International Family Planning Perspectives, (2005, December): Vol. 31, Number 4.
- 14 Klein D. Jonathan (2005), ***Committee on Adolescence, Pediatrics***; vol.116, Number 4. Lusaka, Zambia.

- 15 Milupi, M. M. (1993), ***Factors affecting utilization of Family Planning by Women Seeking Termination of Pregnancy at the University Teaching Hospital***, Lusaka.
- 16 Ministry of Health, (2006), ***Zambia Family Planning Guidelines and Protocols***, Lusaka.
- 17 Mulenga, C. R. (2000), ***A Study to Determine Knowledge, Attitudes and Practices on Emergency Contraception among Family Planning Caregivers in Lusaka Urban***.
- 18 Nkhata L, (2003), ***Methodological Options in Policy – Oriented Social Research***, ZPC Publications, Lusaka, Zambia.
- 19 Planned Parenthood Association of Zambia, (1998). ***Strategies for family planning***, Lusaka.
- 20 Polit, D. F, and Hungler. B (1995), ***Research in Nursing: Principles and Methods***. Lippincott. Philadelphia.
- 21 Central Board of Health News, ***Reproductive Health News in Zambia***, issue 2, January 2004
- 22 Skibiak, P. J, Moyo, C. M and Ahmed, Y. (2001), ***Testing Alternative Channels for providing Emergency Contraception to Young Women***, The population Council, Nairobi.
- 23 Treece and Treece (1986), ***Elements of Research in Nursing***, C.V, Mosby Company, St Louis
- 24 Watson, B. W (1977), ***Family Planning in the Developing world- A review of programs***, Population Council, New York.
- 25 World Health Organisation (1995): ***An Assessment of the Need for contraceptive Introduction in Zambia. Expanding Family Planning Options***, UNDP/UNFPA / WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Geneva: World Health Organisation, WHO/HRP/ ITT/ 94.1



APPENDIX I

THE UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE  
DEPARTMENT OF POST BASIC NURSING

QUESTIONNAIRE FOR WOMEN SEEKING ABORTION AT KITWE  
CENTRAL HOSPITAL

DATE OF INTERVIEW:

.....

NAME OF INTERVIEWER:

.....

QUESTIONNAIRE NUMBER:

INSTRUCTIONS TO INTERVIEWER

1. Introduce yourself to the respondent
2. Explain the purpose of the interview
3. Reassure the respondent that all responses will be held in strict confidence
4. Individual names and addresses should not appear on the interview schedule
5. Ensure that all questions are answered and indicate response by ticking (✓) in the appropriate box or filling in the space(s) provided.
6. Thank the respondent at the end of each interview.

SECTION A: DEMOGRAPHIC DATA

1. How old were you on your last birthday?

(a)	15-19 Yrs	<input type="text"/>
(b)	20-26 Yrs	<input type="text"/>
(c)	27-34Yrs	<input type="text"/>
(d)	35-39 Yrs	<input type="text"/>
(e)	40- 45Yrs	<input type="text"/>

2. What is your marital status?

(a)	Single	<input type="text"/>
(b)	Married	<input type="text"/>
(c)	Divorced	<input type="text"/>
(d)	Widowed	<input type="text"/>
(e)	Separated	<input type="text"/>

3. Where do you live?

(a)	Low density	<input type="text"/>
(b)	Medium density	<input type="text"/>
(c)	High density	<input type="text"/>

4. How many children do you have?

(a)	None	<input type="text"/>
(b)	1-2	<input type="text"/>
(c)	3-4	<input type="text"/>
(d)	5-6	<input type="text"/>
(e)	More than 6	<input type="text"/>

5. How many children would you like to have?

(a)	None	<input type="text"/>
(b)	1-2	<input type="text"/>
(c)	3-4	<input type="text"/>
(d)	5-6	<input type="text"/>

(e) More than 6

6. Was this latest pregnancy planned for?

(a) Yes

(b) No

(c) Other, specify \_\_\_\_\_

7. How old was your pregnancy?

(a) Less than 2 months

(b) 3 to 4 months

(c) 5 to 6 months

(d) 7 months

9. What tribe are you? \_\_\_\_\_

10. What is your educational level?

(a) Primary

(b) Secondary

(c) College

(d) University

(e) None

11. What is your occupation?

(a) House wife

(b) Self employed

(c) Professional

(d) Non professional

(e) School girl

(f) Other, specify \_\_\_\_\_

\_\_\_\_\_

12. What is your religious denomination?

- (a) Roman Catholic
- (b) Seventh-day Adventist
- (c) United Church of Zambia
- (d) Others (specify) \_\_\_\_\_
- 

### SECTION B: KNOWLEDGE

13. Have you ever heard of family planning?

- (a) Yes
- (b) No

14. What is family planning?

- (a) Having children at the time convenient to the couple or individual.
- (b) Stopping a couple or individual from having children.
- (c) A service offered to women only for the health of women.
- (d) Do not know
- (e) Other, specify \_\_\_\_\_
- 
- 

15. What family planning methods do you know?

- (a) Pill
- (b) Condom
- (c) Loop
- (d) Natural
- (e) Other, please specify \_\_\_\_\_
-

16. Have you ever heard of emergency contraception?

(a) Yes



(b) No

17. If 'yes' to question 16 above, what is it all about?

18. How does emergency contraception work?

(a) Prevents pregnancy from occurring and cannot interfere with an established pregnancy?



(b) Induces abortion

(c) A service offered to women for the health of women only

(d) Do not know

(e) Others (Explain)

---



---

19. When is emergency contraception used?

(a) Rape (Coercive sex)



(b) Condom breakage

(c) Unprotected sex

(d) Infrequent sexual activity

(e) None

(f) Others (Explain)

20. What do you think is the correct time to take emergency contraception after unprotected sex?

(a) Within 72 hours



(b) After 72hours

(c) Anytime

☐

(d) Other, please specify

---

---

21. Do women know that EC allowed is Zambia?

(a) Yes

☐

(b) No

**SECTION C: ATTITUDE**

22. Would women use emergency contraception if they had chance to use it?

(a) Yes

☐

(b) No

☐☐

23. If no to question 22, why? (Explain)

---

---

☐

24. What cultural beliefs are related to emergency contraception?

---

---

☐

25. Do women support emergency contraception?

(a) Yes

☐

(b) No

☐☐

26. Give reasons for your answer

---

---

☐

**SECTION D: RELIGIOUS BELIEFS OF WOMEN  
TOWARDS EC**

27. What do religions say about emergency  
contraception?

- (a) Strongly agrees
- (b) Agree
- (c) Disagree
- (d) Strongly disagree

**SECTION E: PRACTICE OF WOMEN TOWARDS EC**

28. Were you on any family planning method before you  
got pregnant?

- (a) Yes
- (b) No


29. If yes to question 28, what family planning method did  
you use?

---

---

30. What would happen if a woman missed a pill for 2 to 3  
days or if a condom broke?

---

---

31. What should women do to prevent a pregnancy in the  
above situation?

---

32. Do you know of anybody who has ever used emergency contraception?

(a) Yes

☐

(b) No

☐☐

33. If yes to question number 32, what were the reasons for using it?

---

---

☐

34. Do women after being involved in unprotected sex use EC?

(a) Yes

☐

(b) No

☐☐

35. If no to question 33, Why? (Explain)

---

---

☐

36. Where did they go for the supply of emergency contraception?

(a) Hospital

☐

(b) Health centre

☐

(c) Drug store

☐

(d) Other, (specify)

---

---

☐



37. Were they given the supply of emergency contraception ?

(a) Yes


(b) No

--

38. If no, what reasons were they given for not being given the supply of emergency contraceptive?

\_\_\_\_\_

--

39. What suggestions would you give regarding the use of emergency contraception?

\_\_\_\_\_

--

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THANK YOU VERY MUCH FOR YOUR PARTICIPATION**

University Of Zambia  
School Of Medicine  
Department Of Post Basic Nursing  
P.O. Box, 50110  
Lusaka

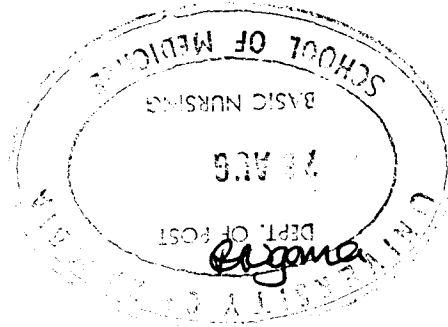
28<sup>th</sup> August 2006.

The Managing Director,  
UTH Board of Management  
P.O Box RW 1  
Lusaka



*Approved*  
*[Signature]*

UFS: The Head of Department  
University of Zambia  
School of Medicine  
Post Basic Nursing Department  
Box 50110  
Lusaka



Dear Sir/Madam,

**Re: PERMISSION TO CONDUCT A PILOT STUDY**

I am a fourth year student at the School of Medicine, University of Zambia. As part of the course requirement, I am required to carry out a research study entitled "**Knowledge, Attitude and Practice of Emergency Contraception**". I intend to carry out the pilot study on 28<sup>th</sup> to 29<sup>th</sup> August, 2006. The purpose of writing this letter is to request for permission to conduct the pilot study on five (5) clients at the University Teaching Hospital.

I shall be very grateful if my request will be considered.

Yours faithfully,



Lilian Bwanali

**4<sup>th</sup> year B.Sc. Nursing Student**



# Kitwe Central Hospital

P. O. BOX 20969  
KITWE  
ZAMBIA

Tel: 224927,224365,228604  
Fax: 228604  
E-mail: [kchmb@zamtel.zm](mailto:kchmb@zamtel.zm)

*All correspondence to be addressed to "The Executive Director"*

Our Ref:  
Your Ref:

29<sup>th</sup> August 2006

Ms. Lillian Bwanali  
University of Zambia  
School of Medicine  
Department of Post Basic Nursing  
P. O. Box 50110  
**LUSAKA**

Dear Madam

## **PERMISSION TO CONDUCT A RESEARCH STUDY**

We refer to your letter dated 21<sup>st</sup> August 2006 in which you requested for permission to carry out a study at our institution.

We hereby inform you that the permission has been granted.

Yours faithfully  
**KITWE CENTRAL HOSPITAL**

Dr. Anthony Mutiti  
Acting Director of Clinical Services  
**For/EXECUTIVE DIRECTOR**

## APPENDIX IV

### RESEARCH WORK SCHEDULE

<b>TASK TO BE PERFORMED</b>	<b>DATES</b>	<b>PERSONNEL</b>	<b>TIME REQUIRED</b>
Literature	Continuou s	Researcher and supervisor	Continuo us
Compiling Research Proposal	17 <sup>th</sup> April to 21 <sup>st</sup> Aug. 2006	Researcher	120 days
Clearance from School and authorities	21 <sup>st</sup> Aug to 27 <sup>th</sup> Aug. 2006	Researcher	7Days
Pilot study	24 <sup>th</sup> Aug. to 28 <sup>th</sup> Aug. 2006	Researcher	4 days
Data collection Actual study	29 <sup>th</sup> Aug to 29 <sup>th</sup> sept,2006	Researcher	30 days
Data analysis	1 <sup>st</sup> Oct to 31 <sup>st</sup> Oct. 2006	Researcher	30days
Report writing and typing	1 <sup>st</sup> Nov. to 10 <sup>th</sup> Dec. 2006	Researcher	40 days
Draft reporting to PBN	11 <sup>th</sup> Dec. to 31 <sup>st</sup> Dec. 2006	Researcher	20 days

Finalization of report	1 <sup>st</sup> Jan. to 28 <sup>th</sup> Feb. 2007	Researcher	28days
Monitoring and evaluation	Continuou s	Researcher and supervisor	Continuo us
Dissemination of results	1 <sup>st</sup> march to 31 <sup>st</sup> march, 2007.	Researcher	30days

10

[illegible]

APPENDIX VI

BUDGET

BUDGET CATEGORY	UNIT COST (K)	QUANTITY	TOTAL (K)
Stationery			
(a) Bond paper	25,000.00	4	100,000.00
(b) Pens	1,000.00	5	5,000.00
(c) Pencil	500.00	4	2,000.00
(d) Eraser	500.00	2	1,000.00
(e) Note books	1,000.00	4	4,000.00
(f) Correction fluid	8,000.00	2	16,000.00
(g) Staplers	20,000.00	2	40,000.00
(h) Staples	5,000.00	2 boxes	10,000.00
(i) Files	5,000.00	2	10,000.00
(j) Scientific calculator	75,000.00	1	75,000.00
(k) Flip chart	40,000.00	1	40,000.00
(l) markers	3,000.00	6	18,000.00
Subtotal			321,000.00
Personnel			
(a) Lunch Allowance			
(i) Researcher	50,000.00	30 days	1,500,000.00
(b) Transport			
(i) Researcher	30,000.00	30 days	900,000.00
Subtotal			2,400,000.00
Secretarial Services			
(a) USB disk	250,000.00	1	250,000.00



(b)	Bag for stationery	25,000.00	2	50,000.00
(c)	Questionnaire typing	3,000.00	10 pages	30,000.00
(d)	Questionnaire photocopying	300.00	600 pages	180,000.00
(e)	Research Report Writing	3,000.00	100 pages	300,000.00
(g)	Research Report photocopying	300.00	400 pages	120,000.00
(h)	Typing and binding Proposal	250,000.00	1	250,000.00
(i)	Binding Report	60,000.00	5	300,000.00
(j)	Hall hire for dissemination workshop	250,000.00	1	250,000.00
<b>Subtotal</b>				<b>1,630,000.00</b>
<b>Total</b>				<b>4,351,000.00</b>
Contingency 10%				435,000.00
<b>GRAND TOTAL</b>				<b>4,786,000.00</b>

## **BUDGET JUSTIFICATION**

### **1. STATIONERY**

Stationery was required for typing the research proposal, writing the final research report as well as typing and printing the report. In addition, 60 interview schedules had to be produced for the pilot study and the actual study.

The notebooks were needed for taking notes of all important points during data collection and analysis. The scientific calculator was used for data analysis. Stapler and staples were needed to put papers together and to maintain their proper arrangement. Correction fluid was used to erase errors. Files and bags were used for storing the interview schedules during the data collection and analysis period.

### **2. SECRETARIAL SERVICES**

There was need for funds to cater for the typing and photocopying services. A USB (512 MB) disk was required for data storage. The research bags were needed for carrying the interview schedules. Money was also required for binding the research proposal and report.

### **3. PERSONNEL**

Funds for transport were required to move to and from the area of data collection. There was also need for lunch allowance during the data collection period.

### **4. CONTINGENCY**

Contingency is the 10% of the total amount of the budget. It was required to cater for any unforeseen expenses during the research fieldwork.

## **5. DISSEMINATION WORKSHOP**

A dissemination workshop will be held to communicate to the stakeholders in the district such as the Kitwe Central Hospital, the Ministry of Health and some of the research participants.