International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Omotayo RS et al. Int J Reprod Contracept Obstet Gynecol. 2026 Feb;15(2):439-447
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20260160

Original Research Article

Emergency contraception: awareness, use and choices amongst antenatal women in a South West Nigeria teaching hospital

Ramon S. Omotayo[1]*, Olumide Akadiri[1], Adesina L. Akintan[1], Ndidi A. Okunnuga[2], Michael O. Gbala[1], Sade E. Omotayo[3], Olorunfemi O. Owa[4]

[1]Department of Obstetrics and Gynecology, University of Medical Sciences Teaching Hospital, Akure Complex, Ondo State, Nigeria
[2]Department of Radiation Oncology, University of Medical Sciences Teaching Hospital, Akure Complex Ondo State, Nigeria
[3]Department of Nursing Service, State Specialist Hospital, Oke-Aro, Akure, Ondo State, Nigeria
[4]Department of Obstetrics and Gynecology, Federal Medical Centre, Owo, Ondo State, Nigeria

Received: 02 November 2025
Revised: 18 January 2026
Accepted: 19 January 2026

***Correspondence:**
Dr. Ramon S. Omotayo,
E-mail: dromotayo@yahoo.com

ABSTRACT

Background: Emergency contraception is a worthwhile innovation by all considerations in that it affords women of the opportunity to avert being pregnant even after sexual intercourse had occurred and they do not desire pregnancy or when an on-going contraceptive method is suspected to have failed. The study assessed the level of awareness, level of usage and the choices of emergency contraception among antenatal women.
Method: Women that met the inclusion criteria were serially recruited as they came by convenient sampling method until the required number of 300 which included the allowance for attrition was completed. The questionnaire was administered to the consented patients by antenatal clinic nurses and intern doctors under the supervision of the researchers.
Results: The mean age of the respondents was 34.5±3.2 years. More than half (52.7%) have never used contraceptives before. Almost half of the respondents 51.3% have not had any information about emergency contraceptives The major source of information about emergency contraception for the majority (42.7%) of the respondents was through their friends. Only 18.7% of the respondents have ever used emergency contraceptives before with postinor being the commonest used by 78.6% of them.
Conclusions: It is part of the rights of women to control the number of children they desire and time they desire to give birth to them. There is need to improve on the awareness of emergency contraceptives among the study population in order to prevent morbidity and mortality related to unwanted pregnancy.

Keywords: Emergency contraception, Yuzpe method, Progestin contraceptives, Intrauterine contraceptives

INTRODUCTION

It is part of the rights of women to control the number of children they desire and time they desire to give birth to them. Most contraceptive methods are use before or during sexual intercourse but some methods can be used even in the duration after the intercourse. Emergency contraception (EC) can significantly reduce the rate of unintended pregnancies and unsafe abortions especially in Sub-Saharan Africa. It helps prevent women from being compelled to carrying pregnancy that they never wanted or desired and by extension, goes a long way in reducing the incidence of voluntary abortion and its associated complications which may even include mortality.

Several claims exist in myths and rumored folks of some methods for post coital prevention of pregnancy that are of unfounded and dubious efficacy such as post-coital body stretching, intake of salt water solution and post coital douching with Coca-Cola. Despite the increasing awareness of EC in Nigeria, the rate of utilization remains low.[1]

EC can prevent up to over 95% of pregnancies when taken at the appropriate time within 5 days after intercourse. However, a recent analysis showed that the copper intrauterine device (IUD) is highly effective at any point in the menstrual cycle as long as a urine pregnancy test is negative prior to insertion.[2] For ongoing contraception, efficacy is usually measured by number of pregnancies that occurred amongst users over a period of time but for emergency contraception, it is the number of expected pregnancies that are averted by the method.[3]

EC can be used in the following situations: unprotected intercourse, concerns about possible contraceptive failure and sexual assault if without contraception coverage. Some other indications for emergency contraception include two or more missed pills of regular oral contraceptives, breakage of condoms or inappropriate use of other contraceptives.[4] Pills with Levonorgestrel brand names include Plan B one step, Take action, My way, Option 2, Preventeza, AfterPill, My Choice, Aftera, EContra, Postinor. The Ibadan data give strong support to a suggestion emanating from scattered findings elsewhere that there is a special pattern of sub-Saharan contraceptive use: it begins with use in premarital and extramarital relationships; then is increasingly employed as a substitute for postmarital sexual abstinence, and only later becomes the means for limiting the size of the family.[5]

A study amongst unmarried girls aged 15-19 years in Ogun State Nigeria where 12024 were interviewed revealed that 15.3% reported sexual intercourse in the past 1 year, 79.6% had heard of contraception while 45.3% of the sexually active respondents were using modern contraceptive with male condoms being the most widely used (50.3%) followed by emergency contraceptive pills (6.7%).[6] Use of contraception among women is usually predicated upon the perception about its effectiveness and ease of use.[7] It may be surprising that some women still rely on unconventional and unproven agents as like Ampiclox, Alabukun, salt water solution and lime/ perceiving them to be effective in preventing unplanned pregnancies.[8] Some even have some far-fetched assumptions that stretching the body very well immediately after sexual intercourse may prevent pregnancy. These are probably as a result of wide spread misinformation about emergency contraception. These kinds of misinformation need to be corrected at every opportunity like the health education sessions at the antenatal care clinics.

Our pregnant women must be introduced to the concept of family planning which is a way of thinking and living that is freely adopted by a woman or a couple upon the bases of knowledge, attitude and understanding to improve the health of the family group and contribute effectively to the development of the nation.[9] The age of commencing sexual activity seems to be reducing as suggested by the findings of Maswanya et al in their Tanzanian study that found 54% of secondary school students have commenced sexual activity with 39% having regular sexual partners.[10]

There are 2 groups of emergency contraception: intrauterine device also called copper coil and emergency contraceptive pills.

There are 2 types of IUDs, copper-containing IUD brand name copper T or paragard) and IUDs that release the hormone progestin (this only applies to IUDs that contain 52mg of levonorgestrel; brand names mirena or liletta). In the US, the food and Drugs Administration (FDA) has approved only two methods of emergency contraception: oral levonorgestrel and oral ulipristal acetate. Although the copper IUD is not approved by the FDA for emergency contraception, substantial observational evidence supports that it is highly effective, failing to prevent pregnancy in less than 0.1% of cases.[11] Persons selecting IUD for long term contraception have shown a strong preference for the Levonorgestrel IUD, probably because the levonorgestrel IUD reduces menstral bleeding and discomfort.[12] Many patients do not ask for emergency contraception because they do not know of its availability.[13]

Emergency contraception is 75-85% effective and it is most effective when initiated within 72 hours after unprotected intercourse. Use of emergency contraception contributes significantly to reduction in rates of abortion for unwanted pregnancy as research analyzing abortion trends from year 2000, when only 2% of women reported ever using emergency contraception supports that fact that significant number of abortions were prevented by emergency contraception use that year, suggesting that increased use of emergency contraception as a back-up method may have accounted for up to 43% of the total decline in abortion rates between 1994 and 2000.[14]

Immediate use of an emergency contraception reduces a woman's risk of pregnancy to 1-2 percent, the effectiveness therefore depends on the regimen used and the time between unprotected intercourse and treatment.[15] like fire extinguishers, emergency contraception may be most useful if stored where the need may arise.[16] The longer a woman waits before starting emergency contraception, the less well it works.[17] Emergency contraception agents are now readily available without restriction; it has not always been the case.

Margaret Sanger, a public health nurse in 1914, believing that enforced Motherhood is the most complete denial of a woman's right to life and liberty, she coined the term 'birth control' and began her decades-long campaign to make contraceptives legal and available to women in America. By 1916, Margaret Sanger opens the first birth control

clinic in the United States in Brownsville, Brooklyn. The next year, a New York court convicts Sanger of 'maintaining a public nuisance' by dispensing contraceptives devices and sentenced her to jail for 30days. She however remains undeterred thereafter.[18]

The advent of EC dates back to 1920 when Edgar Allen and Edward A. Doisy used animal experiment to learn the effect of ovarian hormone (later known as estrogen) on pregnancy. Allen and Edgar later found that estrogen they extracted could interfere with animal pregnancy/this information was later used in development of emergency contraception. The first large scale trial of the pill took place in 1956, and it has been refined since then not until 1960s that women first received emergency contraception by giving them high dose of estrogen known then as the 5×5 regimen: 5mg Ethinyl estradiol per day for 5 days.[19,20]

In 1972, Canadian doctor Albert Yuzpe conducted a study on combined estrogen and progesterone. He researched on using 100mcg estrogen and 1mg progestin dl-norgestrel which came to be known as 'Yuzpe Method' having fewer side effects than the high estrogen dose.[21] Because this formular was similar to combination birth control pills, doctors started recommending multiple birth control pills (4 tablets) for emergency contraception. By comparing observed and expected pregnancies, investigators have demonstrated that the Yuzpe method reduces the chances of pregnancy by about 75%.[22]

In 1973, landmark research trying five different dosages of progestin levonorgestrel between 150-400 mcg leading to progestin only morning after pills used today was carried out. It works by stopping or delaying ovulation.[23] Still in the 1970s, the Copper IUD was developed for long term contraception and later discovered to be effective emergency contraception when inserted within 5 days of unprotected intercourse.in the late 1990s, the prescription 'Preven Contrception Kit' was developed and modeled after the Yuzpe Method.[24] The Kit consists 4 combination pills, instructional paper and a urine pregnancy test strip. It was approved by FDA in 1998.

In August 2006, the FDA approved Plan B as over the counter drug to solve the Challenge quickly accessing the drug by women aged 18years and above after unprotected sexual intercourse since the progestin-only- morning after pill is better taken within 72hours of unprotected intercourse.[25] It became without age restriction in 2013.

In 2010, an emergency contraception pill called Ella (Ulipristal acetate) was approved which is more effective than progestin only pills but only available by prescription.

Emergency contraception is a worthwhile innovation by all considerations in that it affords women of the opportunity to avert being pregnant even after sexual intercourse had inadvertently occurred and they don't desire pregnancy or when an on-going contraceptive method is suspected to have failed. This helps prevent women from being condemned to carrying pregnancy that they never wanted or desired and by extension, goes a long way in reducing the incidence of voluntary abortion and its associated complications which may even include mortality.

Aim of the study

The study was aimed at assessing the level of awareness of pregnant women attending antenatal clinic about emergency contraception, their level of usage and their choices of emergency contraception.

Objectives of the study

The objectives of the study were to find out the level (in terms of proportion) of awareness of pregnant women about methods of prevention of pregnancy despite sexual intercourse. Find out their level of usage and choices among the various types of emergency contraception methods available.

METHODS

Design

The study was a descriptive cross-sectional study.

Site

The study was carried out at the booking clinic of the antenatal clinic in the Obstetrics and Gynaecology department, University of Medical Sciences Teaching Hospital Complex/State Specialist Hospital, Akure.

Study population

About 300 pregnant women coming for their first antenatal visit in index pregnancy (booking clinic) were recruited into the study after giving their consent. This number includes the allowance for attrition.

Inclusion criteria

Any pregnant woman that has presented for antenatal clinic and is ready to participate in the study will be recruited for the study.

Data collection instrument

A simple structured questionnaire was used as instrument for collecting data. It was written in plain English language and provision for interpretation made for those that could not understand or read English.

Sampling method

Women that met the inclusion criteria were serially recruited as they came until the required number of 300

which includes the allowance for attrition was completed. The questionnaire was administered to the consented patients by antenatal clinic nurses and intern doctors under the supervision of the researchers.

Sample size calculation

The Study was a descriptive study. The following formula was used to calculate the sample size.

$$N = 4(Z_{crit})^2 p(1-p)/D^2$$

Where, Zcrit = standard normal deviate corresponding to chosen confidence interval. For confidence interval of 95%, it is 1.96, P=pre-study estimation of proportion to be measured, and D=the width of confidence interval.

$$N = 4 \times (1.96)^2 \times \frac{0.95(1-0.95)}{0.052} = 291.9 = 292$$

Adding the allowance for attrition of 8 to above gives total sample size of 300.

Data management

Data was processed by feeding the information into statistical package for the social sciences (SPSS) and then analyzed using the SPSS version 29.0. Proportions were calculated using percentages and cross-tabulation of related variables were done to find out relationship between the variables and statistical significance by Chi-square.

RESULTS

Proportions were calculated using percentages and cross-tabulation of related variables were done to find out relationship between the variables and statistical significance by Chi-square. Majority of the respondents, 168 (56.0%) were in the age group 30-39 years with mean age of 34.5±3.2 years and only 5 respondents were below the age of 20 years. Thirty-four (11.3%) of the respondents were single pregnant women while 261 (87.0%) were married and 5 respondents just lost their husbands. The majority of the respondents 261 (87.0%) were of Yoruba ethnic group, 19 respondents and 2 respondents were of the Igbo and Hausa extraction respectively while 40 (13.3%) respondents were from the other minor ethnic groups like Ijaw, Urhobo, Tiv and Ebira. Most of the respondents 278 (92.7%) were Christians, 20 (6.7%) were Muslims and only 2 (0.7%) were neither of the Christian nor the Muslim religion.

Majority of the respondents 206 (68.7%) were graduates, 72 (24.0%) were secondary school leavers while 7 (2.3%) were primary school leavers. The various occupations the respondents engage in include private business 176 (58.7%), civil service 55 (18.3%), artisans 43 (14.3%) and only 15 (5.0%) were full house wives. However, their husbands' occupations were majorly skilled labour 118 (39.3%), professionals 99 (33.0%), civil servants 57 (19.0%) and 5 (1.7%) were artisans.

Table 1: Sociodemographic biodata.

Parameter	Frequency (N)	Percentage
Age group (years) mean age 34.5±3.2		
<20	5	1.7
20-29	113	37.7
30-39	168	56.0
40-49	14	4.7
Total	300	100
Marital status		
Single	34	11.3
Married	261	87.0
Widowed	5	1.7
Total	300	100
Ethnicity		
Yoruba	239	79.9
Igbo	19	6.3
Hausa	2	0.7
Others	40	13.3
Total	300	100
Religion		
Islam	20	6.7
Christianity	278	92.7
Others	2	0.7
Total	300	100
Education		
Primary	7	2.3
Secondary	72	24
Post-secondary	15	5
Graduate	206	68.7
Total	300	100
Occupation		
Full house wife	15	5.0
Artisian	43	14.3
Business	176	58.7
Civil servant	55	18.3
Others	9	3
Total	300	100
Husband occupation		
Unskilled	21	7
Artisian	5	1.7
Skilled labour	118	39.3
Civil servant	57	19
Professional	99	33
Social class		
1	12	4.0
2	96	32
3	168	56
4	14	4.7
5	10	3.3

The couples were categorized into social class categories using the Olusanya et al social class classification system

which entails adding the social class score of the wife to that of the husband. The social class score of the wife is based on her educational attainment while that of the husband is based on hid occupation. Wives without any formal education or holders of only primary education certificate have a score of 3. Holders of only secondary education certificate have a score of 2 while those with tertiary education attainment have a score of 1. Husbands who are engaged in unskilled labour have a score of 2, those who are engaged in skilled labour have a score of 1 and husbands who are professionals have a score of 0. Social class 3 has the majority 168 (56.0%) of the respondents, 96 (32.0%) were in social class 2 while on 12 (4.0%) of the respondents were in social class 1 (Table 1).

Majority of the respondents, 151 (50.3%) were at gestational age of 17-32 weeks at the time of the survey while 103, (34.3%) were at gestational age of 33-40 weeks. Majority 181 (60.3%) of the respondents have had 2 or more babies by the time of the survey. Only 50 (16.7%) have had history of unwanted pregnancy before. Majority 263, (86.7%) had their previous babies alive, only 10 respondents had history of stillbirths. The index pregnancy at the time of survey was unplanned in 23, (7.7%) of the respondents (Table 2).

Table 3 above shows that Amongst all the respondents, only 142 respondents (43.7%) of them have ever used any form of contraceptive before out of which 101 (33.6%) used modern contraceptives and 41 respondents (13.7%) used natural methods. The method used were said to be effective by 90 (63.4%) of those that used contraceptives. Only 56 respondents (13.7%) have used emergency contraceptives before, 244 (81.3%) have not used emergency contraceptives before. Almost half of the respondents 51.3% have not had any information about emergency contraceptives before while amongst those that were aware of emergency contraceptives, only 56 of them have used it before. The major source of information about emergency contraception for the majority (42.7%) of the respondents was through their friends.

Assessing the knowledge of the respondents about emergency contraception shows that majority 193 (64.3%) of the respondents know that emergency contraception prevents pregnancy. One hundred and seventy, 170 (56.7%) of the respondents know that there are specific indications for emergency contraceptives. More than half (51%) of the respondents agree that pregnancy can be prevented even after sexual intercourse. Only 85 respondents (28.3%) agree that pregnancy can be prevented up-till 7 days after sexual exposure 107 (35.7%) and 108 (36.0%) disagreed and undecided respectively. Only 41 (13.7%) of the respondents agree that Cupper IUCD is an example of emergency contraceptive agent. One hundred and seven respondents (35.7%) believe that emergency contraception is same as abortion while more than a quarter (28.7%) believe that emergency contraception is not proper.

Table 2: Obstetrics biodata.

Parameter	Frequency (N)	Percentage
Gestational age (in weeks)		
<8	12	4.0
8-16	27	9.0
17-32	151	50.3
33-40	103	34.3
>40	7	2.3
Total	300	100
Parity		
0	27	9.0
1	40	13.3
2	181	30.3
3	37	12.3
4	15	5
Total	300	100
Had unwanted pregnancy before		
Yes	50	16.7
No	250	83.3
Total	300	100
Last delivery outcome		
Baby survived	263	86.7
Baby died	10	3.3
No previous delivery	29	9.0
Total	300	100
Present pregnancy planned		
Yes	277	93.3
No	23	7.7
Total	300	100
Previous caesarean section		
Yes	53	17.7
None	209	69.6
No previous delivery	28	12.7
Total	300	100
Indication for caesarean section		
Prolonged distress	11	20.8
Feral distress	6	11.3
Antepartum bleeding	5	9.4
Hypertension	2	3.8
PROM	3	5.7
Other medical conditions	8	15.1
Fetal macrosomia	7	13.2
Failure to progress	1	1.9
Obstructed labour	2	3.8
Multiple gestation	5	9.4
Advanced maternal age	3	5.7
Total	53	100

Majority of the respondents 232 (77.3%) agree that emergency contraception can fail. Majority of the respondents 163 (54.3%) are aware of the fact that emergency contraception cannot prevent sexually transmitted disease. Almost half of the respondents

(48.0%) disagree with the notion that emergency contraceptives are expensive while only 84 (28.0%) agree that some emergency contraceptives can be continued as permanent contraceptive agents.

The level of knowledge of the respondents about emergency contraception is fair with the majority of the patients' responses being in the 'Fair" category (Table 5).

The social and obstetrics factors that affect the usage of emergency contraception with high likelihood ratio include Husband's occupation (likelihood ratio 4, p value=0.000), Patients level of Education (likelihood ratio 3, p value=0.016), Patients occupation (likelihood ratio 4, p value=0.000), and Parity (likelihood ratio 4, p value=0.000).

Table 3: Contraceptive use by respondents.

Parameter	Frequency (N)	Percentage
Ever used contraceptives		
Yes	142	47.3
No	158	52.7
Total	300	100
Past general contraceptive used		
COCP	29	20.4
Implant	26	18.3
Injection	20	14.1
IUCD	16	11.3
Condoms	10	7.0
Natural methods	41	28.9
Total	142	100
Was method used effective?		
Yes	90	63.4
No	52	36.6
Total	142	100
Emergency contraceptive use		
Yes	56	18.7
No	244	81.3
Total	300	100
Type of emergency contraceptive used		
Postinor	44	78.6
IUCD	0	0
Condom	10	17.9
Multiple minipills	0	0
Traditional non-medical	0	0
Don't know	2	3.6
Total	56	100
Source of information about emergency contraception		
Friends	128	42.7
Social media	4	1.3
Electronic mass media	2	0.7
Husband	2	0.7
Drug seller	10	3.3
No information	154	51.3
Total	300	100

Table 4: Knowledge of respondents about emergency contraception.

Knowledge about emergency contraception	Agree (%)	Disagree (%)	Undecided (%)	Total (%)
EC prevents pregnancy	193 (64.3)	40 (13.3)	67 (22.3)	300 (100)
Indication for EC are specific	170 (56.7)	45 (15.0)	85 (28.3)	300 (100)
Pregnancy can be prevented after sex	153 (51.0)	63 (21.0)	84 (28.0)	300 (100)
EC can prevent pregnancy up to 7 days	85 (28.3)	107 (35.7)	108 (36.0)	300 (100)
Copper IUCD is example of EC	41 (13.7)	118 (39.3)	141 (47.0)	300 (100)

Continued.

Knowledge about emergency contraception	Agree (%)	Disagree (%)	Undecided (%)	Total (%)
Emergency contraception is same as abortion	107 (35.7)	149 (49.7)	44 (14.7)	300 (100)
Emergency contraception is not proper	86 (28.7)	164 (54.7)	50 (16.7)	300 (100)
Emergency contraception can fail	232 (77.3)	42 (14.0)	26 (8.7)	300 (100)
Emergency contraception prevents STI	90 (30.0)	163 (54.3)	47 (15.7)	300 (100)
Some EC can be continued as permanent	84 (28.0)	137 (45.7)	79 (26.3)	300 (100)
EC are very expensive	59 (19.7)	144 (48.0)	97 (32.3)	300 (100)

Table 5: Level of knowledge of respondent about emergency contraception.

Grading level of knowledge of respondents about emergency contraception	Poor (< 50% correct response)	Fair (50-60% correct response)	Good (>60% correct response)
EC prevents pregnancy			√
Indication for EC are specific		√	
Pregnancy can be prevented after sex		√	
EC can prevent pregnancy up to 7 days	√		
Copper IUCD is example of EC	√		
Emergency Contraception is not same as abortion		√	
Emergency Contraception is proper		√	
Emergency Contraception can fail			√
Emergency Contraception doesn't prevents STI		√	
Some EC can be continued as permanent	√		
EC arent very expensive		√	

Table 6: Likelihood ratio tests by multinomial regression analysis of social/obstetric factors affecting use of emergency contraception.

Variables	Model fitting criteria	Likelihood ratio test		
		Chi square	df	P (sig.)
Religion	139.621	3.027	2	0.220
Social class	143.021	6.428	4	0.169
Husband occupation	164.132	27.539	4	0.000
Education	146.879	10.286	3	0.016
Patient occupation	152.710	16.117	4	0.003
Parity	164.452	27.859	4	0.000
Tribe	139.289	2.695	3	0.441
Marital status	137.883	1.290	3	0.732

DISCUSSION

The largest age group of multiparas attending antenatal clinic at the study center was 30-39 years with 56%, this is consistent with the findings from another study on child spacing amongst parous women which reported that majority (82.4%) of the respondents were aged 31-46 years.[26] In terms of highest educational qualification, the majority of the respondents 68.7% were tertiary education graduates while only 2.3% had just primary school education. The south western part of the country usually has high literacy rate amongst women with literacy rate as high as 85.1% previously reported in other studies.[27]

Unwanted pregnancy rate found in this study was 7.7%. This is slightly lower than the national rate of 5.9% reported in Nigeria by Bankole et al in 2015.28 but is far lower than the value reported by another study in The Gambia that quoted unwanted pregnancy rate of 25.3%.[29] The low rate of unwanted pregnancy in this study may be due to the high literacy rate in the study area being an urban setting. Also, the study recorded a very high rate of unwanted pregnancy in the area 75% of women aged 16-49 years in Great Britain used at least one form of contraception. This study showed that about forty-eight percent (47.3%) of the respondents have ever used one form of contraceptives or the other before, majority (52.7%) have never used before. The Nigeria national demographic health survey had reported in 2018 that majority, 69% of women had never used a contraceptive before while 31% had either previously used a contraceptive or were currently using one.[30] Effectiveness of previous contraceptive use of the respondents was 64.3% in this study. The most commonly used modern contraceptive by respondents in this study was COCP (20.4%). None (0%) of the respondents that use emergency

contraceptive have ever used IUCD for that purpose, this may be due to lack of awareness of possible usage of IUCD for emergency contraception. General usage of IUCD for contraception has been previously reported to be low in Nigeria with about 4.7% using them.[31] The prevalence of emergency contraceptive use in this study was 18.7%. The most commonly used emergency contraceptive method in this study was Postinor which was used by 78.6% of those that have used emergency contraceptive before. this is in agreement with similar studies that have previously reported levonorgestrel pills as the most commonly used emergency contraceptive agents.[32] The source of information about emergency contraception for the majority of respondents (42.7%) in this study was through friends similar to the report from another Nigerian study that said the main source of information about emergency contraception was through friends in 43.1% of their respondents.[33] 146 (48.7%) of the repondents were aware of emergency contraception but only 56 (38.4%) of those that were aware actually used emergency contraception. A similar study in Northwest Nigeria had reported an emergency contraception awareness rate of 37.9% and that only 31.1% of those that were aware had used it. The proportion of those that used emergency contraception.[34]

The level of knowledge about emergency contraceptives amongst respondents was fair as the responses of the majority fall in the fair category of knowledge rating in this study. There is paucity of studies on knowledge level of married women on emergency contraception. A Cameroonian study that assessed knowledge of undergraduates about emergency contraception reported low level of knowledge amongst the group they studied.[35]

CONCLUSION

It is part of the rights of women to control the number of children as they desire and the time they desire to give birth to them. It is part of the rights of women to control the number of children they desire and time they desire to give birth to them. The prevalence of emergency contraceptive use in this study was very low (18.7%). More than half of the respondents have not heard about emergency contraceptives before. There is need to improve on the awareness of emergency contraceptives among the study population in order to prevent morbidity and mortality related to unwanted pregnancy.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Ellertson C. History and Efficacy of Emergency Contraception: Beyond Coca-Cola. Family Plan Perspect. 1996;28(2):44-8.
2. Caldwell JC, Ware H. the evolution of family planning in an African City: Ibadan, Nigeria. Population Stud. 1977;31(3):487-507.
3. Cleland K, Raymond EG, Westley E, Trussell J. Emergency contraception review: evidence-based recommendations for clinicians. Cin Obstet Gynecol. 2014;57(4):741-50.
4. Ranganathan S, Gupta V. Post Coital Contraception. In: StatPearls. Treasure Islands (FL): StatPearls Publishing. 2024.
5. Caldwell JC, Ware H. the evolution of family planning in an African City: Ibadan, Nigeria. Population Studies. 1977;31(3):487-507.
6. Crawford EE, Atchison C, Ajayi YP, Doyle AM. Modern Contraceptive use among unmarried girls aged 15-19 years in South Western Nigeria: results from a cross sectional baseline survey for the Adolescent 360 (A360) impact evaluation. Reprod Health. 2021;18(6).
7. Abiodun O. Use of emergency contraception in Nigeria: An exploration of related factors among sexually active female university students, Sex Reprod Healthc. 2016;7:14-20.
8. Ajayi AI, Nwokocha EE, Akpan W, Adeniyi OV. Use of non-emergency contraceptive pills and concoctions as emergency contraception among Nigerian university students: results of qualitative study. BMC Public Health. 2016;16(1):1046.
9. World Health Organization. Standards for Maternal and Neonatal Care. Geneva: World Health Organization. 2007. Available at: https://www.who.int/publications/i/item/standards-for-maternal-and-neonatal-care. Accessed on 03 November 2025.
10. Maswanya ES, Moji K, Horiguchi I, Nagata K, Aoyagi K, Honda S, et al. Knowledge, risk perception of AIDS and reported sexual behavior among students in secondary and colleges in Tanzania. Health Educ Res. 1999;14(2):185-96.
11. Cleland K, Zhu H, Goldstuck N, Cheng L, Trussell J. The efficacy of intrauterine devices for emergency contraception: a systematic review of 35 years of experience. Hum Repod. 2012;27:1994-2000.
12. Sanders JN, Myers K, Cawron LM, Simmons RG, Turok DK. Contraceptive method use during the community-wide HER Salt Lake contraceptive initiative. Am J Public Health. 2018;108:550-6.
13. Weismiller DG. Emergency Contraception. Am Fam Physician. 2004;70(4):707-14.
14. Jones RK, Darroch JE, Henshaw SK. Contraceptive use among US women having abortions in 2000-2001. Perspect Sex Reprod Health. 2002;34:294-303.
15. Westhoff C. Clinical practice emergency contraception. N Eng J Med. 2003;349:1830-5.
16. Glasier A, Baird D. the effects of self-administering emergency contraception. N Engl J Med. 1998;339:1-4.
17. Cates W Jr, Raymond EG. Emergency contraception-parsimony and prevention in the medicine cabinet. Am J Public Health. 1997;87:909-10.

18. Baker Carrie N, Thompson Kirsten. A Brief History of Birth Control. Our bodies ourselves Today. Stuffolk University. 2024. Available at: www. ourbodies.ourselves today.org. Accessed on 03 November 2025.
19. Carol QA. History of contraception. Womens Health Med. 2005;2(5):28-30.
20. Gunardi ER, Fernando D. Emergency Contraception-a neglected option for birth control. Med J Indones. 2013;22(4):248-52.
21. Charllottee E. History and efficacy of of emergency contraception: Beyond Coca-Cola. Family Planning Perspectives. 1996;28(2):44-8.
22. Trussell J, Ellertson C, Stewart F. "The Effectiveness of the Yuzpe Regimen of Emergency Contraception." Family Plan Perspect. 1996;28:58-64.
23. Edwards M, Can AS. Progestins. In: StaPearls. Treasure Islands (FL): StatPearls Publishing: 2024.
24. Wensley G. PREVEN, The Newly-Released "Emergency Pregnancy Kit" New Name-Same Old Stuff. Linacre Quarterly. 1999;66(4):44-7.
25. Rodrigues I, Grou F, Joly J. Effectiveness of emergency contraceptive pills between 72 and 120 hours after unprotected sexual intercourse. Am J Obstet Gynecol. 2001;184(4):531-7.
26. Harold I, Amaechi JC, Ajie PC, Harold AI. Determinants of Birth Spacing Practice Among Parous Mothers. Biomed Target J. 2024,2(2):64-70.
27. Umar AS. Does female education explain the disparity in the use of antenatal and natal services in Nigeria? Evidence from demographic and health survey data. Afr Health Sci. 2017;17(2):391-9.
28. Bankole A, Hussain R, Singh S. Akinyemi JO. The incidence of abortion in Nigeria. Int Perspect Sex Reprod Health. 2015;41(4):170-81.
29. Barrow A, Jobe A, Barrow S. Prevalence and factors associated with unplanned pregnancy in The Gambia: findings from 2018 population-based survey. BMC Pregnancy Childbirth. 2022;22:17.
30. Abubakar IB, Abubakar HB. Nigerian women's modern contraceptive use: evidence from NDHS 2018. Reprod Fertil. 2024;5(2):2.
31. Uhuo EN, Oguaka VN, Egba IS, Ugwu OG, Ugwu CE, Oji MN. Predictive factors to access and use of family planning services by rural and semi-urban dwellers in Afikpo North Local Government area, Ebonyi State Nigeria. African J Reprod Health. 2020;24:132-7.
32. Kwame KA, Bain LE, Manu E. Use and awareness of emergency contraceptives among women of reproductive age in sub-saharan Africa: a scoping review. Contracept Reprod Med. 2022;7:1.
33. Ojiyi EC, Anolue FC, Ejekunle SD, Nzewuihe AC, Okeudo C, Dike EI, et al. Emergency Contraception: Awareness, Perception and Practice among Female Undergraduates in Imo State University, Southeastern Nigeria. Ann Med Health Sci Res. 2014;4(6):904-9.
34. Nwankwo B, Mohammed MH, Usman NO, Olorukooba AA. Knowledge, Attitude and Practice of Emergency Contraception among Students of Tertiary Institution in Northwestern Nigeria. J Med B Sci Res. 2020;2(1):13-28.
35. Alain DC, Tabah EN, Evrard K, Mabou GT, Nabuin LN, Bate AE, et al. Assessement of knowledge, Attitudes and Practices of Emergency Contraceptive Methods among Female Students of the University of Dschang, Cameroon. J Adv Med Pharm Sci. 2025;27(4):14-26.

Cite this article as: Omotayo RS, Akadiri O, Akintan AL, Okunnuga NA, Gbala MO, Omotayo SE, et al. Emergency contraception: awareness, use and choices amongst antenatal women in a South West Nigeria teaching hospital. Int J Reprod Contracept Obstet Gynecol 2026;15:439-47.