ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Magnitude of long-acting reversible contraceptive use and associated factors after elective Cesarean delivery at three teaching hospitals of Addis Ababa: A cross sectional hospital-based study 2025.

By Obstetrics & Gynecology Resident Dr. Adugnaw Getachew, MD

In partial fulfillment of the requirements for the Obstetrics and Gynecology specialty, a thesis submitted to the department of Obstetrics and Gynecology at Addis Ababa University's College of Health Sciences.

October 2025

Addis Ababa, Ethiopia

ADDIS Ababa University

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Magnitude of Long-Acting Reversible Contraceptive use and associated factors after elective CS delivery at three teaching hospitals of Addis Ababa, A cross sectional hospital-based study,2025

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Declaration

In compliance with graduate study requirements, I, Dr. Adugnaw Getachew, hereby declare that I have completed this thesis, "Magnitude of Long-Acting Reversible Contraceptive Use and Associated Factors After Elective Cesarean Delivery at Three Teaching Hospitals of Addis Ababa: A Cross-Sectional Study 2025," under the supervision of my advisors. I have, to the best of my knowledge and effort, avoided plagiarism and duplication of materials unless otherwise cited and/or acknowledged, and it has not yet been submitted for consideration or proposal application.

Dr. Adugnaw Getachew, Principal Investigator…….

As part of the resident's research project for the Department's partial fulfillment of the Degree of Specialty in Obstetrics and Gynecology, we hereby acknowledge that we have read and assessed the thesis, "Magnitude of Long Acting Reversible Contraceptive use and associated factors after elective Cesarean delivery at three teaching hospitals of Addis Ababa, A cross-sectional study 2025," under our supervision from the beginning to the end, including ethical concerns. We also declare that the thesis may be submitted to the DRPC for additional administrative processing and documentation of the proposal.

Advisor: Abera Bedada, Dr.…….

Ashebir Getachew,Dr ……

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Acronyms and Abbreviations

AAU University of Addis Ababa

ANC Antenatal care

AOR Adjusted Odds Ratio

CD Cesarean Delivery

CI Confidence Interval

CS Caesarean section

ETB Ethiopian Birr

FP Family Planning

GMH Gandhi Memorial Hospital

IPPLARC Immediate Postpartum Long-Acting Reversible Contraceptives

IUDs Intrauterine devices

LARCs Long-Acting Reversible Contraceptives

OR Odds Ratio

PPLAFP: Post-Partum Long-Acting Family Planning

TASH Tikur Anbesa Specialized Hospital

WHO World Health Organization

ZMH Zewditu Memorial Hospital

Abstract

Background: - Cesarean Section (CS) deliveries are becoming increasingly common worldwide, and women who deliver via CS may have unique contraceptive needs and preferences. The immediate postpartum period, particularly during the period of hospital stay following an elective CS, presents a valuable opportunity to counsel and initiate long-acting reversible contraception.

Objective: To evaluate the use and utilization of immediate postpartum long-acting reversible contraceptive methods and associated factors among pregnant women who gave birth by elective CS in the three teaching hospitals of Addis Ababa .

Methods: A facility-based cross-sectional study design was conducted, and 422 post-elective CS-delivered women were planned by a systematic random sampling method from those delivered by elective cesarean section. Data were collected using a structured questionnaire and entered and analyzed by SPSS version 25 for further analysis. The impact for the uptake of LARC was measured by logistic regression. Those variables having a *P*-value < 0.25 in the bivariate logistic analysis were entered into the multivariate logistic regression model to identify the association of independent variables with the outcome variable. In the multivariable analysis, a *P* value of < 0.05 was used to declare the statistical significance, and AOR with 95% CI was calculated to determine association.

Results: - Only 22.9% of participants were using immediate postpartum LARCs. Among users (n=95), Implanon was the most common method (64.2%), followed by IUCDs (20%) and Jadelle (15.8%). Multivariate analysis showed that women residing in rural areas were 3.8 times more likely to use LARCs compared to those in urban areas (AOR = 3.8, 95% CI: 1.88–16.57). Women with a college education or higher had 3.1 times higher odds of LARC use compared to those who were illiterate (AOR = 3.1, 95% CI: 1.41–23.56). Additionally, larger family size (>4 members) (AOR = 6.3), grand multiparty (AOR = 8.8), being the main decision-maker for contraception (AOR = 9.6), and having a favorable attitude toward LARCs (AOR = 20.2) were all significantly associated with increased postpartum LARC use.

Conclusion: The utilization of immediate postpartum LARCs was low despite their proven benefits. Strengthening education, male involvement, counseling services, and addressing misconceptions are critical to improving postpartum LARC uptake.

Key words: Cesarean Section, Long-Acting Reversible Contraceptives, AA

1. Introduction

1.1 Background

Because pregnancy and childbirth are the main causes of illness, mortality, and disability among women of reproductive age, maternal health continues to be a major global concern (1). With an annual average of 64 pregnancies per 1000 women, there were 121 million unwanted pregnancies worldwide (2). This prevalence is higher in Ethiopia (100 per 1000) and Sub-Saharan Africa (99 per 1000 pregnancies) (3). For CS deliveries, the World Health Organization (WHO) advises a minimum of two years between pregnancies (4). Short birth intervals increase the risk of health issues for both mother and child, such as low birth weight, small size for gestational age, preterm birth, and increased risk of chronic malnutrition, stunted growth, and infant death (5–6).

The period after childbirth is important, as many women wish to restart or initiate contraceptive use in order to avoid unintended pregnancy. Use of contraception is found to depend on perceptions of motherhood, likelihood of pregnancy, and attitudes from partner and family but also on the characteristics of the contraceptive methods and services, perceived side effects and health risks, and the capability to make decisions (7).

For optimal mother and child health outcomes, the World Health Organization (WHO) advises postpartum women to wait at least two years after giving birth before becoming pregnant again (8). By preventing unwanted pregnancies and closely spaced pregnancies, immediate postpartum intrauterine contraceptive devices, which are placed after the placenta is delivered and can be placed up to 48 hours after a vaginal or cesarean delivery, can enhance the health of both the mother and the newborn and reduce maternal mortality by 30% (9–10).

Immediate postpartum long-acting reversible contraceptives can be more widely accepted and more widely used if both mothers and partners receive early counseling starting during ANC. Even the utilizations of modern contraception in sub-Saharan Africa had gradual change from 13% to 29% from 1990 to 2019 but still were lower as compared to other regions (11). Intentions of postpartum women to use contraceptives have a positive impact on the utilizations of immediate postpartum long-acting reversible contraceptives (IPPLARC) even if they have poor awareness about contraceptives (12).

Postpartum contraceptive utilization is a primary strategy for reducing unintended pregnancy and optimizing birth spacing (13). Long-acting reversible contraception methods are the most effective method of modern contraception. The LARC method is user-independent, and once the device is inserted, the woman does not need any action to support ongoing effective utilization of the contraceptive (14). It is more effective in preventing unintended pregnancy and birth spacing (15-16).

~~1.~~1.2 . Statement of the Problem

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LARCs, which include intrauterine devices (IUDs) and subdermal implants, are among the most effective forms of contraception, offering extended protection and convenience without the need for daily adherence. Despite their effectiveness and safety, the uptake of LARCs remains suboptimal in many settings, especially following childbirth (17).

CS deliveries are increasingly common worldwide, and women who deliver via CS may have unique contraceptive needs and preferences. The immediate postpartum period, particularly during the hospital stay following an elective CS, presents a valuable opportunity to counsel and initiate LARCs (18). Initiating contraception before discharge can ensure women leave the hospital with an effective method in place, thereby reducing the risk of rapid repeat pregnancies, which are associated with adverse maternal and neonatal outcomes (19).

The immediate postpartum period, particularly following CS delivery, represents an underutilized opportunity for initiating LARCs. However, the use of LARCs postpartum, especially after elective CS, is influenced by various factors, including patient knowledge and attitudes, healthcare provider practices, and sociocultural contexts.

There is a significant gap in the utilization of LARC devices among women following elective CS deliveries. Despite the known benefits of LARCs, including high efficacy and long-term protection against pregnancy, their adoption in the postpartum period is not as widespread as it could be. This discrepancy necessitates a thorough investigation into the magnitude of LARC use and the determinants influencing their adoption after elective CS delivery. Understanding these determinants is crucial for designing interventions that increase LARC use in the three teaching hospitals of Addis Ababa .

1.3 Significance of the Study

The significance of this study will be an impact on maternal and child health, healthcare policy, and individual reproductive health. So, it signifies to exploring the LARC use and associated factors after elective CS delivery. The study will be addresses critical gaps by identifying factors that influence LARC use in postpartum. Enhancing LARC use postpartum can help ensure adequate birth spacing, contributing to better health outcomes for both mothers and children.

The study's findings will provide for healthcare providers with valuable insights into the factors influencing LARC use. This knowledge can be used to develop more effective counseling strategies that are tailored to the needs and concerns of postpartum women, those who have undergone elective CS delivery. The finding of the study helps to highlighting the role of healthcare provider practices and hospital policies in promoting LARC use, the study can inform the development of standardized protocols for postpartum contraceptive counseling and LARC.

The study's outcomes can provide policymakers with evidence to advocate supporting postpartum contraceptive services, particularly for the provision of LARCs. This study can serve as a foundation for further research into postpartum contraceptive use, identifying gaps in knowledge and paving the way for longitudinal studies that track long-term outcomes of LARC use after elective CS delivery.

2. Literature Review

2.1. Magnitude of LARCs Utilization

According to a study conducted in Tanzania, the frequency of PPLAFP was 10.5%, while the prevalence of IPPIUD was 5.4% in Nepal (20–21). According to a Rwandan study, 28.1% of women had immediate postpartum intrauterine devices (22).

According to a study conducted in 37 U.S. states with pregnancy risk assessment and monitoring systems, the overall prevalence of long-acting reversible contraception was 15.3% (23). In North Showa, Amhara, Ethiopia, the overall prevalence was 21.3% (24), with 81% and 13.1% of women using implants and IUDs, respectively, during the postpartum period.

53.2% of immediate postpartum women in the Jima, Ethiopia study reported using the LARC method, while 78.0% of participants used Implanon, followed by 10.3% who used IUD and 11.5% who used Jaddelle (25). A research conducted in West Gojjam, Amhara, Ethiopia, found that 4.02% of people had IPPIUD (26). In the Sidama region of Southern Ethiopia, another facility-based cross-sectional study revealed that 21.6% of people used IPPRLAC (27). Approximately 14% of research participants used immediate PPIUCD, according to a study done in Gamo Gofa, southern Ethiopia (9).

A study done in Chicago on factors associated with short inter pregnancy intervals in women who plan postpartum LARC found that 36.5% received LARC and 11.4% conceived after a short inter pregnancy interval (28).

Prevalence of LARC utilization coverage of immediate postpartum long-acting reversible contraception has improved birth intervals for at-risk populations. It revealed that overall, during our study period, 12.3% of women (n=23,028) received a postpartum LARC, while 0.1% (1,646) received an IPP LARC. Pre-policy, 8.8% of births were followed by a postpartum LARC (29).

A study done at Jimma University Medical Center on LARCs in the postpartum period showed that the prevalence of current LARC use was 53.2%. Over three-fourths (78%) used Implanon, 11.5% used Jadelle/Sino Implant, and 10.5% used IUD (30). Utilization of immediate PPIUCD among participants who gave birth in Addis Ababa public hospitals was 26.6% (31). A study done in Addis Ababa found that 30.7% [95% CI (26.1, 35.3)] utilized immediate postpartum family planning (**32).**

2.2. Associated Factors of LARCs Utilization

A study done in Chicago on factors associated with short inter pregnancy intervals in women who plan postpartum LARC revealed that women who were multiparous [OR= 0.7791] or chose a temporary contraceptive "bridge" to LARC (OR 0.74) were less likely to attend their postpartum visit (PPV). Women who missed their PPV (OR 0.06) or chose a bridge (OR 0.66) were less likely to receive LARC. Finally, women who did not receive LARC (OR 4.8), were multiparous (OR 1.69), or were teenaged (OR 2.12) were more likely to conceive after a short inter pregnancy interval.

A study done at Jimma University Medical Center on determinants of LARCs in the postpartum period showed that mothers who had a monthly family income of 1000 ETB or more (AOR=2.4), more than four alive kids (AOR=2.6), a completed family size (no desire for future fertility) (AOR=2.0), planned to extend the next birth beyond 2 years (AOR=4.0), previously used LARC (AOR=3.0), and were counseled for LARC during ANC visits (AOR=2.0) were the determinant (30).

A study done in public hospitals of Addis Ababa revealed that occupation as housewife (AOR = 0.19), discussion about PPFP with their partner (AOR = 1.21), need for partner approval (AOR = 0.19), counseling about PPIUCD (AOR = 1.13), and good knowledge about PPIUCD (AOR = 7.50) were significant for the utilization of LARCs (31). A study in Addis Ababa public hospital indicates that women at the age of 25–34 years (AOR = 3.228) who had discussions with their partners about family planning (AOR = 1.891), received counseling about immediate postpartum long-acting reversible contraceptives (AOR = 3.146), and had positive attitudes towards immediate postpartum long-acting reversible contraceptives (AOR = 3.0) were related with the use of immediate postpartum long-acting reversible contraceptives (32).

According to a study conducted in Dendi District (46), family size has a relationship with use of LARCs. Fertility desire has a statistically significant relationship with LARC use, according to a study conducted in the Bati, Amhara region (33). In addition, in a study conducted in Egypt (34), the number of live births is closely related to the use of LARCs. Long-acting reversible contraceptives (LARCs) were also found to be positively associated with a history of abortion in a study in Areka Town (35), history of unintended. Pregnancy in a study conducted by Mazandaran and Tehran Medical Sciences (36) and previous use of LARC from the studies done in Adama town (37) and Jimma town (38).

2.3 Study Framework

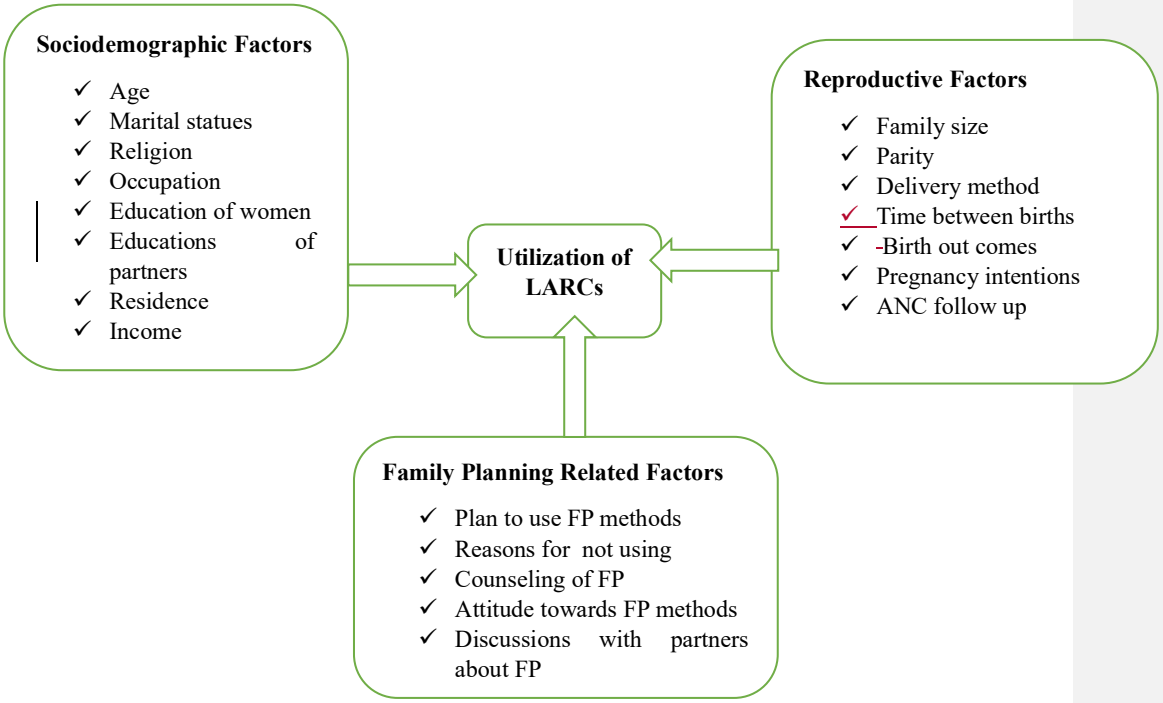

Figure 1.Study framework for post-partum reversible long-acting contraception utilization among mothers who gave birth by elective cesarean section in the three teaching hospitals of AAU, Ethiopia, 2025.

3. Objectives

3.1 General objective

To evaluate postpartum long-acting reversible contraception use and related factors among women who had elective caesarean sections at Addis Ababa's three teaching hospitals.

3.2 Specific Objectives

To determine utilization of postpartum long-acting reversible contraceptives among mothers who gave birth by elective cesarean section.

To assess the pattern of long-acting reversible contraceptives among mothers who will give birth by elective cesarean section

To identify factors affecting the utilization of postpartum long-acting reversible contraceptives among mothers who give birth by elective cesarean section.

4. Methods

4.1. Study Area and Period

Zewditu Memorial Hospital (16 catchment areas), Gandhi Memorial Hospital (21 catchment areas), and Tikur Anbessa Specialized Hospital (33 catchment areas) are the hospitals. The first two are regional hospitals under the Addis Ababa Health Bureau, which is connected to Addis Ababa University. These facilities can offer labor and delivery services, including elective cesarean sections, as well as full care for expectant mothers. Beginning on January 1, 2025, and continuing until the necessary sample size is obtained, this study will be carried out in the three teaching hospitals of Addis Ababa University in Ethiopia. All of these facilities offer maternal and child health services, such as ANC, postpartum care, family planning, and delivery.

4.2. Study Design

To evaluate the use of postpartum long-acting reversible contraceptives and related factors in the three teaching hospitals of AA, an institution-based cross-sectional study was conducted.

4.3. Source of Population

All of the mothers who gave birth in the three AA teaching hospitals were the population's source.

4.4. Study Population

Those mothers who gave birth by elective CS in the three teaching hospitals of AA.

4.5. Eligible Criteria

4.5.1. Inclusion Criteria

All mothers who gave birth by elective CS in the three teaching hospitals of AA.

4.5.2. Exclusion Criteria

Women who were critically ill/in a coma and admitted to the intensive care unit.

Women who were prepared for referral to other health facilities.

Women who did not fulfill the WHO eligibility criteria for both implants and PIUD

4.6. Sample Size Determination

I. Sample size by the second objective

In this research, a single population proportion calculation was used to determine the sample size. Because there are not many researches on LARCs specifically on elective CS women in the literature, the prevalence of immediate postpartum long-acting reversible contraceptive utilization (p) was assumed 50%. Based on the following assumptions, the 95% confidence interval, 5% margin of error (d), and 10% non-response rates are used to calculate the sample size.

$n=z_{1/2})^2 p(1-p)/d^2$

$n =(1.96)^2 x0.5(1-0.5)/ (0.5)^2=384$ after adding 10% none response rate the final sample size was 422.

II. Sample size by the second objective

The sample size was calculated by sing both single and double population proportion formula using epi-info calc software.

Sample size for the second objective								
variable	% of outcome	% of outcome exposed	Odd ratio	power	Sample size	10% non-response	Final sample	reference
Number of kids	15.05	6.6	2.6	80	360	36	396	30
Haven't plan the next delivery within 2 years	89.5	63.8	3.8	80	98	10	110	30

Therefore, the final sample size was the sample from the single population proportion, which is 422.

4.7. Sampling Procedure

All women who gave birth by elective CS in the three teaching hospitals of AA during the study period and who fulfilled the inclusion criteria were selected. In each hospital, all elective CS delivery mothers were selected during the study period until the maximum sample size.

4.8. Data Management and Quality Assurance

By creating a suitable data extraction tool, data quality was assured. To assure the quality of the data, experienced researchers assessed the modified data and extraction procedure. Two weeks before the actual data collection period, 5% of the data were used for a pretest with a similar population outside the study area. Two days before to the data collection task, supervisors and data collectors received training on data collection, and a training guide was created to help with the training.

Additionally, the supervisor handled the assignment when the investigator was not there, and the investigator monitored each aspect of the review. The recording data extraction technique was being randomly evaluated by the primary investigator. Every day, the primary investigator and supervisors reviewed the completed data extraction tool forms and verified that they were complete.

4.9. Data Collection Tools and Techniques

A standardized, pre-tested data collection questionnaire was used to analyze the medical chart and conduct in-person interviews in order to gather data. The results of many studies on LARC were used to create a structured questionnaire (Annex III). Sociodemographic, reproductive, family planning, and LARC use-related parameters are all included in the questionnaire. In each study site, three midwives were enlisted and given training on how to collect data.

The investigator provided supervisors and data collectors with pertinent two-day training to familiarize them with the data collecting tool, interview technique, eligible study subjects, sample techniques, and ethical considerations. Before the real data collection period began, 5% of the sample underwent pretesting. The data collectors obtained the study participants' spoken informed consent before collecting any data (both for the interview and to check the medical chart).

Each participant was asked to answer the interview after providing their informed consent and being screened for exclusion criteria. On the day of discharge, the postnatal ward at a few chosen medical facilities provided the data. One healthcare professional was assigned with gathering data for each site.

Data collectors were supervised, and the questionnaire was checked daily for completeness and accurateness to determine the validity of the questionnaire. The principal investigator appropriately intervened upon any problems that arose during the data collection process.

4.10. Data Analysis

Version 25 of the Statistical Package for Social Sciences (SPSS) was used to enter, clean, and analyze the data. Frequencies and percentages were used to elaborate on the LARCs uptake results. The association between each independent variable and the dependent variable was evaluated using both bi-variable and multi-variable logistic regression models. The independent variables that fit the bivariate regression with a significance level of less than 0.25 were added to the multivariable analysis after the variable logistic regression was fitted. The outcome variable was evaluated using multiple logistic regressions with 95% CI at the 0.05 level of significance. The multivariable analysis was deemed statistically significant when the p-value was less than 0.05. The strength of correlation at 95% Cl was assessed using the AOR.

4.11. Study Variables

4.11.1. Dependent Variable

Postpartum elective CS long-acting reversible contraceptive use

4.11.2. Independent Variables

Socio demographic related factors

~~I.~~✓ Age

~~II.~~✓ Marital statues

~~III.~~✓ Religion

~~IV.~~✓ Occupation

~~V.~~✓ Education of women

~~VI.~~✓ Educations of partners

~~VII.~~✓ Residence

~~VIII.~~✓ Income

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Reproductive and Obstetric related factors

1)✓ Family size

2)✓ Parity

3)✓ Mode of delivery

4)✓ Birth to birth interval

5)✓ Birth out comes

6)✓ Pregnancy intentions

7)✓ ANC follow up

Family planning related factors

I.✓ Plan to use FP methods

II.✓ Reason for not using FP methods

III.✓ Counseling of FP

IV.✓ Attitude to FP

V.✓ Partner discussions about FP

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4.12 Operational Definition

Postpartum Long-acting Reversible Contraceptives: -Within 48 hours of giving birth, a postpartum woman using postpartum reversible long-acting modern contraceptives (implants intrauterine contraceptive devices).

4.13. Ethical Consideration

The DRPC granted ethical clearance after the proposal was submitted to the department of obstetrics and gynecology. The annexed information sheet (annex 1) was used to explain the study's purpose to all study participants, and the data collector observed the verbal consent obtained prior to the interview for the one-page consent letter that was attached to the cover page of each questionnaire (annex 2). We informed the participant that the inquiry is not included in your service assessment and that it takes less than forty minutes.
Each respondent's information was kept private, and the respondents were informed that they cou ld decline participation or end their involvement at any time during the administration process. Additionally, the report will be written without mentioning any particular respondent.

4.14 Distribution of the findings

The results of this study will be presented and shared with the Department of Obstetrics and Gynecology at the AAU College of Health Science. They will also be shared with the Federal Ministry of Health and the Addis Ababa Health Bureau. The papers will then be submitted to appropriate journals for publication following their presentations at various conferences.

5. Results

5.1 Sociodemographic traits of the study participants

Most of the participants resided in urban areas, accounting for 94.9% (n=393), and most (63.8%, n=264) respondents were aged 25–34 years. Regarding religion, 66.2% (n=274) identified as Orthodox Christians, 99.0% (n=410) of the participants were married, and 48.6% (n=201) of the partners had secondary education. Forty-three percent (n=178) of the participants were housewives, and 32.4% (n=134) worked in private employment. 67.6% (n=280) had less than 4 family members in the household, and 26.8% (n=111) had a household monthly income of 5,000–10,000 ETB.

Table 1. Socio-demographic traits of post-operative mothers at the three teaching hospitals of Addis Ababa (GMH,TASH ,ZMH)

Variable	Frequency (n)	Percent (%)
Residency		
Urban	393	94.9
rural	21	5.1
Age in years		
18-24	99	23.9
25-34	264	63.8
≥35	51	12.3
Religion		
Muslim	61	14.7
Orthodox	274	66.2
Protestant	79	19.1
Marital status		
Married	410	99.0
Single	3	.7
Divorced	1	.2
Education level		
Illiterate	38	9.2
Primary	68	16.4
Secondary	206	49.8
collage and above	102	24.6
Partner education level		
Illiterate	40	9.7
Primary	32	7.7
Secondary	201	48.6
collage and above	141	34.1
Occupation		

Housewife	178	43.0
private employee	134	32.4
government employee	41	9.9
merchant	55	13.3
daily labor	6	1.4
Family size		
≤4	280	67.6
>4	134	32.4
Household monthly income		
<5000	76	18.4
5000-10000	111	26.8
10000-15000	73	17.6
>15000	154	37.2

5.2 Obstetrics and maternal health service-related characteristics of study participants

Among the participants, 56.8% (n=235) were multiparous, and 60.6% (n=251) had given birth two to four times, while 39.4% (n=163) had only one birth. Of those who had a previous delivery (n=263), 74.1% had undergone a cesarean section, while 25.9% delivered via spontaneous vaginal delivery. Among those with a history of cesarean delivery (n=195), 64.1% had two previous CS scars. All respondents (100%, n=414) had attended antenatal care during the current pregnancy.

Regarding the number of ANC visits, 65.9% had eight or more visits, whereas 34.1% had fewer than eight. The interval between the most recent and current birth was more than 24 months for 70.9% of participants, while 29.1% had an interval of less than 24 months. Ninety-nine percent of births resulted in a live baby, while 0.7% were stillbirths. Most pregnancies were wanted, as reported by 88.9%, while 11.1% were unwanted. 86.5% planned to have another child, while 13.5% did not. Among those who intended to have another child, the majority (78.8%) planned to conceive in 2–4 years.

Table 2. Obstetrics and maternal health service-related characteristics of the study participants

Variable	Frequency	Percent
Gravidity		
1	151	36.5
2-4	235	56.8
≥5	28	6.8
Number of births		
One	163	39.4

Two-four	251	60.6
Previous mode of delivery (n=263)		
CS	195	74.1
SVD	68	25.9
Number of previous cesarean delivery (n=195)		
One	55	28.2
Two	125	64.1
three	15	7.7
ANC in this pregnancy		
yes	414	100
Number of ANC		
<8	141	34.1
≥8	273	65.9
Birth Interval between the recent and the current in months		
<24	76	29.1
>24	185	70.9
Birth outcome of the current pregnancy		
Alive	411	99.3
Still birth	3	0.7
The intention of the current pregnancy		
Unwanted	46	11.1
wanted	368	88.9
Was the current pregnancy was planned (n=368)		
Yes	254	69
no	114	31
Plan to have another child		
Yes	358	86.5
no	56	13.5
Time to plan conceive the next in years (n=358)		
<2	64	17.9
2-4	282	78.8
>4	12	3.4

5.3 Attitude of study participants on immediate postpartum long-acting reversible contraceptive use

A majority of respondents, 50.5% (n=209), strongly agreed, and 45.7% (n=189) agreed that contraceptive utilization is beneficial for their health. Similarly, 54.1% (n=224) strongly agreed that contraceptive use can help make them stronger during pregnancy. When asked whether the use of modern contraceptives contributes to living a good life, 51.4% (n=213) strongly agreed, and regarding the impact on child health, 52.9% (n=219) strongly agreed and 42.5% (n=176) agreed that modern contraceptive use can improve the health of their child. For the belief that

contraceptives are good for the growth of a baby, 53.6% (n=222) strongly agreed. Despite generally positive perceptions, the overall attitude toward contraceptive use revealed that 53.1% (n=220) of participants held an unfavorable attitude, while 46.9% (n=194) had a favorable attitude.

Table 3. Attitude of study participants on immediate postpartum long-acting reversible contraceptive device use at three teaching hospitals of Addis Ababa.

Variable	Strongly Disagree (%)	Disagree (%)	Neutral (5)	Agree (%)	Strongly Agree (5)
Do you believe using contraceptives is good for your health?		5(1.2)	11(2.7)	189(45.7)	209(50.5)
Do you believe using contraceptives throughout pregnancy can help you stay strong?	1(0.2)	5(1.2)	25(6)	159(38.4)	224(54.1)
Do you believe that using modern forms of contraceptives can improve your quality of life?		3(0.7)	13(3.1)	185(44.7)	213(51.4)
Do you believe your child's health may be improved by using modern contraceptives?		4(1)	15(3.6)	176(42.5)	219(52.9)
Do you think use of modern contraceptives is good for growth of your baby?	1(0.2)	3(0.7)	13(3.1)	175(42.3)	222(53.6)
Overall attitude	Frequency			Percent	
Favorable	194			46.9	
unfavorable	220			53.1	

5.4 Family planning related characteristics of study participants

Current use of immediate LARCs, only 22.9% (n=95) were using postpartum LARCs, while 77.1% (n=319) were not as shown the figure 2 below

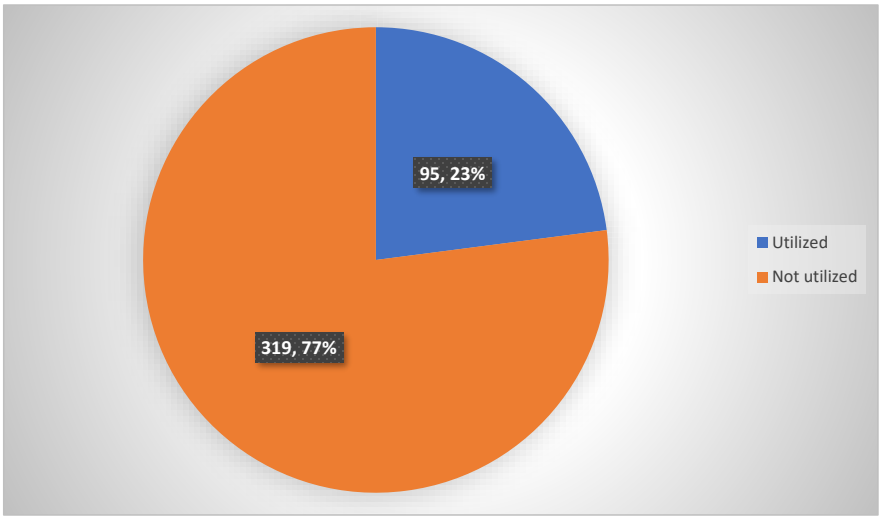

Figure 2. Utilization of LARCs among women delivered by elective cesarean section at the three teaching hospitals of Addis Ababa

The majority of participants, 87.2% (n=361), reported using family planning services before their most recent pregnancy. During ANC follow-up, 84.5% (n=350) of the women received counseling on family planning. A large proportion, 91.8% (n=380), had discussions with their partners about contraceptive use, while only 8.2% (n=34) did not engage in such discussions. When it came to decision-making about contraceptive use, the majority, 75.6% (n=313), reported that both partners jointly made the decision, while 17.1% (n=71) said the wife was the primary decision-maker and 7.2% (n=30) indicated the husband made the decision alone.

Among those using LARC, Implanon was the most commonly used method at 64.2% (n=61), followed by IUCD at 20% (n=19) and Jadelle at 15.8% (n=15). The timing of contraceptive initiation showed that 80% (n=76) used it postpartum, while 20% (n=19) used it intraoperatively. In terms of the time the decision was made, 52.6% (n=50) decided during ANC visits.

Table 4. Study participants response to questions related to family planning behaviors and services .

Variable	Frequency	Percent
Did you use FP service before recent pregnancy		
Yes	361	87.2
no	53	12.8
Have you been counseled about family planning in your ANC follow		
Yes	350	84.5
no	64	15.5
Did you discuss with partner on use of contraceptives		
Yes	380	91.8
no	34	8.2
Who is main decision maker on use of contraceptives		
wife	71	17.1
husband	30	7.2
both	313	75.6
Current immediate long-acting reversible contraceptive device		
Yes	95	22.9
no	319	77.1
Pattern of contraceptive used (n=95)		
Implanon	61	64.2
IUCD	19	20
Jadelle	15	15.8
Timing of contraceptive use (n=95)		
Intraoperatively	19	20
Post partum	76	80
Time of decision (n=95)		
ANC	50	52.6
Post partum	45	47.4

5.5 Reason of study participants for not use long-acting reversible contraceptives

For those not using long-acting methods (n=319), the most common reasons were the need to discuss with others, 23.5% (n=75), and concerns about its effect on breastfeeding, 23.2% (n=74). Other reasons included preference for natural methods 19.7% (n=63), preference for pills 17.6% (n=56), fear of side effects 11.6% (n=37), and waiting until after baptism 4.4% (n=14).

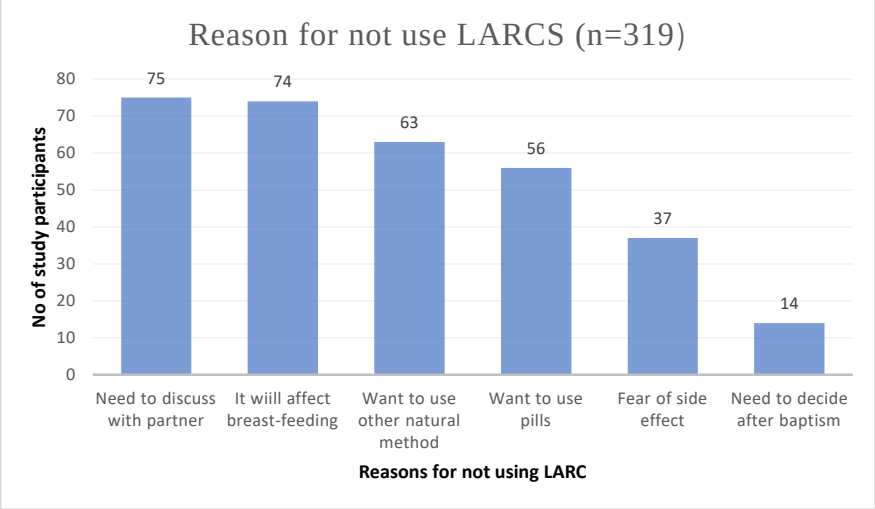

Figure 3. Reasons of study participants for not using long-acting reversible contraceptives

5.6 Factors related to utilization of postpartum long-acting reversible contraceptives

In this study, variables such as residency, age, education level, partner's education, family size, gravidity, number of ANC visits, intention of the current pregnancy, decision-maker on contraceptive use, and attitude toward long-acting contraceptives were found to be associated with the utilization of postpartum long-acting contraceptives in the bivariate logistic regression analysis [AGT1]. The multivariate logistic regression revealed that women residing in rural areas were 3.8 times more likely to use postpartum long-acting contraceptives compared to those in urban areas (AOR = 3.8, 95% CI: 1.88–16.57). Women with a college education or higher were 3.1 times more likely to use postpartum long-acting contraceptives compared to those who were illiterate (AOR = 3.1, 95% CI: 1.41–23.56).

Those with a family size greater than four had 6.3 times higher odds of using postpartum long-acting contraceptives compared to those with a family size of four or fewer (AOR = 6.3, 95% CI: 2.53–15.76). Grand multiparous women were 8.8 times more likely to use postpartum long-acting contraceptives than primiparous women were (AOR = 8.8, 95% CI: 1.39–55.67). Additionally, women who were the main decision-makers regarding contraceptive use were 9.6 times more likely to use postpartum long-acting contraceptives compared to those whose husbands made the decision (AOR = 9.6, 95% CI: 3.45–26.68). Finally, women with a favorable

attitude toward postpartum long-acting contraceptives were 20.2 times more likely to use them compared to those with an unfavorable attitude (AOR = 20.2, 95% CI: 6.97–58.48).

Table 5.The bivariate and multivariate logistic regression of association between postpartum LARCs use and independent variable among women delivered by elective cesarean section at the three teaching hospitals of Addis Ababa university, 2025.

Variable	Utilization of Postpartum LARC		p-value	COR with 95%CI	P-value	AOR with 95%CI
Residency						
Urban	85	308	1		1	
Rural	10	11	0.009	3.3(1.35, 8.02)	0.043	**3.8(1.88, 16.57)**
Age in years						
18-24	22	77	1		1	
25-34	50	214	0.485	0.82(0.47, 1.44)	0.060	0.29(0.12, 2.74)
≥35	23	28	0.004	2.9(1.39, 5.95)	0.922	2.9(0.23, 3.72
Educational status						
Illiterate	10	28	1		1	
Primary	3	65	0.003	0.13(0.03, 0.51)	0.336	0.36(0.04, 2.92)
Secondary	31	175	0.092	0.49(0.22, 1.12)	0.762	0.74(0.11, 5.23)
Collage and above	51	51	0.014	2.8(1.23, 6.36)	0.024	**3.1(1.41, 23.56)**
Parental education						
Illiterate	9	31	1		1	
Primary	7	25	0.949	0.96(0.32, 2.95)	0.577	1.8(0.24, 12.85)
Secondary	17	184	0.012	0.32(0.13, 0.78)	0.221	0.38(0.08, 1.79)
Collage and above	62	79	0.017	2.7(1.19, 6.09)	0.563	1.5(0.36, 6.53)
Family size						
≤4	43	237	1		1	
>4	52	82	0.000	3.5(2.17, 5.62)	0.000	**6.3(2.53, 15.76)**
Gravidity						
Prim parous	33	118	1		1	
Multiparous	45	190	0.519	0.85(0.51, 1.40)	0.284	0.62(0.26, 1.49)
Grand multiparous	17	11	0.000	5.5(2.36, 12.94)	0.021	**8.8(1.39, 55.67)**
Number of ANC						
<8	22	119	1		1	
≥8	73	200	0.012	1.9(1.16, 3.34)	0.147	1.9(0.80, 4.36)
The intention of the current pregnancy						
unwanted	17	29	0.019	2.2(1.14, 4.17)	0.125	2.6(0.77, 8.55)
wanted	78	290	1		1	
The main decision maker for contraceptive						
Wife	33	38	0.000	4.1(2.35, 7.06)	0.000	**9.6(3.45, 26.68)**
Husband	7	23	0.435	1.4(0.58, 3.49)	0.125	3.3(0.72, 15.21)
both	55	258	1		1	

Attitude on use of long-acting contraceptives						
Favorable	83	111	0.000	12.9(6.78, 24.77)	0.000	**20.2(6.97, 58.48)**
unfavorable	12	208	1		1	

6. Discussion

The present study found that only 22.9% of participants were using immediate postpartum long-acting reversible contraceptives. This prevalence is comparable to findings from North Shoa, Amhara, Ethiopia (21.3%), and the Sidama Region, Southern Ethiopia (21.6%) (24, 27). However, it is higher than the rates reported in Nepal (5.4%), Tanzania (10.5%), West Gojjam, Ethiopia (4.02%), and Gamo Gofa, Southern Ethiopia (14%) (20–21, 26, 9). Conversely, the current study's prevalence is much lower than that found in Jimma, Ethiopia (53.2%), and Addis Ababa public hospitals (30.7%) (25, 32). These differences might be attributed to variations in study settings (urban vs. rural), sample characteristics, the availability of postpartum family planning services, and differences in the timing of counseling.

Among the women who used LARCs in this study, Implanon was the most commonly used method (64.2%), followed by IUCD (20%) and Jadelle (15.8%). This pattern is consistent with other studies conducted in Ethiopia, in Jimma, where Implanon accounted for 78% of LARC use, followed by Jadelle (11.5%) and IUD (10.3%) (30). similarly, the study in North Shoa reported that 81% used Implants and 13.1% used IUDs (24). The preference for Implanon may be due to its technical ease of insertion for the provider and fewer perceived side effects. It may also reflect provider bias, where healthcare workers are more familiar or comfortable offering implants than IUDs.

This study found that rural women were 3.8 times more likely to use postpartum LARCs than urban women were. This contrasts with many studies where urban residency is often linked to higher contraceptive use due to better healthcare access. College education in Addis Ababa (31, 32) and other urban settings typically show urban women having greater utilization. However, the current finding aligns with research suggesting rural outreach programs and community health workers effectively increase LARC uptake in rural Ethiopia's rural districts (33, 35).

Women with college or above education had 3.1 times higher odds of LARC use compared to illiterate women. This is in line with studies from Addis Ababa and Jimma, where higher education was associated with increased LARC use (30, 32). Educated women may better understand contraceptive benefits and are more likely to seek out healthcare services (30, 32).

Women with more than four family members were 6.3 times more likely to use LARCs. This finding is supported by studies from Jimma, Dendi District, and the Amhara region, which also showed a positive relationship between larger family size and LARC uptake (30, 33, 46). Grand multiparous women were 8.8 times more likely to use LARCs than primiparous women were. This association has been observed in studies from Egypt and Areka Town, where higher parity was a strong motivator for long-term contraception (4, 35).

Women who were the main decision-makers about contraception were 9.6 times more likely to use LARCs. This highlights the importance of women's autonomy and empowerment in reproductive health, consistent with findings from Addis Ababa (31). A favorable attitude was the strongest predictor, with women being 20.2 times more likely to use LARCs. Similar associations were reported in studies from Addis Ababa, where women with positive attitudes were more likely to adopt LARC methods (32).

7. Conclusion

The current use of immediate postpartum long-acting reversible contraceptive devices among the study participants was relatively low, with only one in five women utilizing these methods. Implanon was the most commonly used LARC, followed by IUCDs and Jadelle. Several key factors were significantly associated with higher utilization of postpartum LARCs. Women residing in rural areas, those with college-level education or higher, women from larger families (more than four members), and grand multiparous women. Moreover, the likelihood of LARC use was significantly higher among women who were the main decision-makers regarding contraception and those who held a favorable attitude toward postpartum LARC use.

8. Recommendations

Based on the findings of this study, the following recommendations are suggested to improve the utilization of immediate postpartum long-acting reversible contraceptives:

- Efforts should be made to improve women's education, particularly beyond the primary level, as higher educational attainment was significantly associated with increased LARC use.

- Women's involvement in the decision-making for the use of LARC is important.

-Attention should be given to grand multiparous women and those with larger families, encouraging timely LARC uptake to reduce the risks associated with closely spaced or unintended pregnancies.

-Efforts should be made to change the attitude of women on use of long acting reversible contraceptive use because women with favorable attitude are highly likely to use LARC.

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Annexes

Annex 1: Information sheet for the participants

My name is _____. I am working as data collector in the research conducted by Dr. Adugnaw Getachew who is conducting his research for partial fulfillment of the requirements for Department of obstetrics and gynecology at Addis Ababa University in Partial Fulfillment of the Requirements for a Specialty Certificate in Obstetrics and gynecology. This study aims to assess Magnitude of **Long Acting Reversible Contraceptive** use and associated factors after elective Cesarean delivery at three teaching hospitals of Addis Ababa. We would like your honest opinion pertaining to the questions.

Procedure: In order to assess magnitude and associated factors of Long-Acting Reversible Contraceptive, we invite you to take part in this research project. If you are willing to participate in our project, you need to understand and give consent through verbally. Then, you will be asked to give your response by the data collectors.

Risk and/or Discomfort: By participating in this research project, you may feel that it has some discomfort specially on wasting your time (about 50 minutes). Unless, there is no risk by participating in this research project.

Benefits: If you participate in this research project, you may not get direct benefit but your participation is likely to help as for future short inter-pregnancy -related complication prevention among CS mothers.

Incentives: You will not be provided any incentive to take part in this project.

Confidentiality and Anonymity: The information that we will collect from this research project will be kept confidential. Information about you that was collected from the study will be stored in a file, which will not have your name on it, but a code number assigned to it. It will not be revealed to anyone except the principal investigator.

Right to Refuse or Withdraw: You have the full right to refuse from participating in this research (you can choose not to respond to some or all of the questions) if you do not wish to participate, this will not affect your health services you get at any health facilities. You have also the full right to withdraw from this study at any time you wish to, without losing any of your rights as a client of this facility.

Persons to contact: If you have any question, you can contact and ask at any time you want.

Name*:* - Dr Adugnaw Getachew

Phone number: +251918578263

Annex 2. Consent form of the participants

I have been fully informed about this study and given written information and understand the aim of this study. I also understand that the result will be helpful to improve the maternal women's health and child health by spacing pregnancy using LARCD. I understand that there are no risks by participating in this study. I agree to participate in this study. I understand that by participating I will not be entitled to any special services or be given payment or gifts. I was told that the information obtained will be confidential. I understand that any information that identifies me will be excluded from any report or publication. This authorization is only valid for this study.

Are you willing to participate in the study? 1- Yes 2 - No

If the answer is yes, thanks! Conduct the interview. If the answer is no, thanks!

Don't force or reinforce an individual to participate in the survey.

Interviewer's code ---------name ---------- signature -------

Date of interview: ---------- date ----------month/2017 E. C.

Time of interview began _____ hours: minutes.

Time of interview finished: _____ hours: minutes

Checked on ---------- date ----------month/2017 E.C.

Complete 1

Incomplete 2 Other (specify) ----

Annex-3: Questionnaire

Annexes

Consent Form

Information sheet and data collection tools English versions

Greetings, My name is _____. I am a data collector for Dr. Adugnaw, a resident in obstetrics and gynecology at Addis Ababa University, to study the magnitude of use of immediate postoperative long-acting reversible contraceptives and related factors after elective cesarean section for the partial fulfillment of a specialty in obstetrics and gynecology. Your participation in the study will not directly benefit you, but the results will be utilized to create evidence-based policies, strategy recommendations, manuals, and treatments for the immediate postpartum implementation of postpartum family planning. It takes a lot of time—at least 30 minutes for the interview—but there is no risk associated with taking part in the study. I want to reassure you that confidentiality will be upheld at all times. Your name does not need to appear on the questionnaires. It could take 30 minutes to participate in this study. You have complete control over whether or not to take part in the study. Your information is crucial to the success of my research. Do not hesitate to ask the investigator questions if you need clarification on anything.

Investigator address

Name- Dr. Adugnaw Getachew

Phone: +251918578263

Thank you very much for your commitment!

I understand that my participation is voluntary. I would like to take part in this study.

o No

o Yes

Institution Name?

o TASH

o GMH

o ZMH

MRN:

Questionnaire

Part 1:- Questioners related to socio-demographic characteristics of post-operative women at the three teaching hospitals of Addis Ababa.

~~I.~~1) How old are you? _____in years

~~II.~~2) _____Residency

I. Urban

II. Rural

~~III.~~3) _____What is your Religion?

I. orthodox

II. Muslims

III. protestants

IV. Catholics

V. others_____

~~IV.~~4) _____Marital status of the mothers?

I. Married

II. Divorced

III. Single

IV. widowed

~~V.~~5) _____Mothers educational background

~~1.~~I. ___No formal education

~~2.~~II. ___primary school

~~3.~~III. ___secondary school

~~4.~~IV. ___college and beyond

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~~VI.~~6) Husbands educational background

~~1.~~I. No formal education

~~2.~~II. primary school

~~3.~~III. secondary school

~~4.~~IV. College and beyond

~~VII.~~7) Occupational status of women?

I. Daily laborer

II. Student

III. Governmental

IV. employee

V. House wife

VI. Merchant

VII. Farmers

VIII. Others_____

~~VIII.~~8) What size family do you have? _____in number

~~IX.~~9) What is the monthly income of the family? _____in birr

Part 2:- Obstetrics and maternal health service-related characteristics of postpartum women

1. How many times have you been pregnant? _____
2. How many times did you have given birth? _____
3. How many Cesarean Section scars do you have ?
4. Do you have follow-up prenatal care?

~~a.~~I. Yes

~~b.~~II. No

5 .If yes for the above question frequency of prenatal care follow up_____

6. How many alive children do you have? _____
7. How long was it since your last pregnancy?

_____ Years (for those having pregnancy history)

8. Birth out- come of the neonate (for those having more than one pregnancy).

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~~1.~~I. Alive

~~2.~~II. Dead

9. What were your intentions on the current pregnancy ?

~~a.~~I. Wanted

~~b.~~II. Unwanted

10. Was your most recent pregnancy planned ahead of time?

I. Yes
II. No

11 Did you intend to have more children?

I. Yes

II. No

12 If yes when do you plan to conceive next child? ____________ Years, If Q 10 “NO” skip to next Q.

Part 4:- Attitude related questioners on the assessment of immediate postpartum long acting reversible contraceptive.

~~I.~~1. Do you believe using contraceptives is good for your health ?

I. Strongly disagree

II. Disagree

III. Neutral

IV. Agree

V. Strongly agree

~~II.~~2. Do you think contraceptive utilization can make you strong during pregnancy?

I. Strongly disagree

II. Disagree

III. Neutral

IV. Agree

V. Strongly agree

~~III.~~3. Do you think use of modern contraceptives can help you to live a good life?

I. Strongly disagree

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~~✓~~II. Disagree

~~✓~~III. Neutral

~~✓~~IV. Agree

~~✓~~V. Strongly agree

~~IV.~~4. Do you believe use of modern contraceptives can improve the health of your child?

~~✓~~I. Strongly disagree

~~✓~~II. Disagree

~~✓~~III. Neutral

~~✓~~IV. Agree

~~✓~~V. Strongly agree

~~V.~~5. Do you think use of modern contraceptives is good for growth of your baby

I. Strongly disagree

II. Disagree

III. Neutral

IV. Agree

V. Strongly agree

Part 4:- Family planning related questioners of postpartum women

~~I.~~1. Prior to the current pregnancy did you Use FP?

I. Yes

II. No

~~II.~~2. Have you received family planning advice during ANC follow up of this pregnancy?

I. Yes

II. No

~~III.~~3. Did you and your partner discussed on use of contraceptives?

~~1.~~I. yes

~~2.~~II. No

~~IV.~~4. Who is main decision maker on use of contraceptives?

I. Husband

II. Me

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III. Both

IV. Other, specify________

~~V.~~5. Did you have immediate post-partum long acting reversible contraceptive methods now?

I. Yes

II. No

~~VI.~~6. If your answer is, yes which method did you prefer to use?

I. Jaddele

II. Implanon

III. Intra uterine device

IV. Others_________

~~VII.~~7. Have you used long acting reversible contraceptive method now?

I. Yes

II. No

~~VIII.~~8. If yes----which type? Mention --------

~~IX.~~9. When to use long acting contraceptive

a) Intraoperatively

b) Postpartum?

~~X.~~10. When is the decision made?

a) ANC

b) Postpartum.

~~XI.~~11. Where did you get the information?

a) Counseled during ANC

b) Requested myself.

12. If no why?

I. Need to decide after baptism

II. It will affect breast-feeding,

III. I did not know that it can be inserted during surgery

IV. Need to discuss ----

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አባሪ-3፡ የጥያቄ ዝርዝር

አባሪዎች

የስምምነት ቅጽ

የመረጃ ወረቀት እና የመረጃ አሰባሰብ የእንግሊዝኛ ቅጂዎች

ሰላም ስሜ _____ ነው። እኔ ዶ/ር አዱኛዉ በአዲስ አበባ ዩኒቨርሲቲ የፅንስና የማህፀን ህክምና ሬዚደንት ስሆን በፅንስና የማህፀን ህክምና ዘርፍ ውስጥ ስፔሻሊቲ ሙያን በከፊል ለማሟላት በምርጫ ከሚደረጉ ከቀዶ ጥገና በኋላ የሚደረጉ የረጅም ጊዜ እርግዝና መከላከያዎችን የጠጠቃሚ መጠን እና ተዛማጅ ምክንያቶችን ለማጥናት የዳታ ሰብሳቢ ነኝ። በጥናቱ ውስጥ መሳተፍዎ በቀጥታ ባይጠቅምዎትም ውጤቶቹ በማስረጃ ላይ የተመሰረቱ ፖሊሲዎችን፣ የስትራቴጂ ምክሮችን፣ መመሪያዎችን እና የድህረ ወሊድ የቤተሰብ እቅድ አፋጣኝ ትግበራ ሕክምናዎችን ለመፍጠር ጥቅም ላይ ይውላል። ለቃለ መጠይቁ ቢያንስ 30 ደቂቃዎች ያክል ጊዜ የሚወስድ ሲሆን በጥናቱ ውስጥ ከመሳተፍዎ ጋር የተያያዘ ምንም አይነት አደጋ የለውም። ሚስጥራዊነቱ ሁልጊዜ እንደሚጠበቅ ላረጋግጥልዎ እፈልጋለሁ። ስምዎ በመጠይቁ ላይ መታየት አያስፈልገውም። በዚህ ጥናት ውስጥ ለመሳተፍ 30 ደቂቃዎች ሊወስድ ይችላል። በጥናቱ ውስጥ መሳተፍ አለመሳተፍ ላይ ሙሉ መብት አለዎት። መረጃዎ ለምርምር ስራዬ ስኬት ወሳኝ ነው። በማንኛውም ነገር ላይ ማብራሪያ ከፈለጉ ጥያቄ አቅራቢውን ለመጠየቅ አያመንቱ።

የጥያቄ አቅራቢ አድራሻ

ስም- ዶ/ር አዱኛዉ ጌታቸው

ስልክ: +251918578263

ለቁርጠኝነትዎ በጣም አመሰግናለሁ!

ተሳትፎዬ በፈቃደኝነት ላይ የተመሰረተ መሆኑን ተረድቻለሁ። በዚህ ጥናት መሳተፍ እፈልጋለሁ።

○ አይ

○ አዎ

የተቋሙ ስም?

○ ጥአስሆ

○ ጋመሆ

○ ዘመሆኤምአርኤን:

መጠይቅ

ክፍል 1፡- በአዲስ አበባ በሚገኙ ሶስት የማስተማሪያ ሆስፒታሎች ውስጥ ከቀዶ ጥገና በኋላ ሴቶችን ማህበራዊ-ስነ-ሕዝብ ባህሪያትን የሚመለከቱ መጠይቆዎች::

1) ዕድሜዎ ስንት ነው? _____በዓመት

2) መኖሪያ

I. ከተማ

II. ገጠር

3) ሃይማኖትዎ ምንድን ነው?

I. ኦርቶዶክስ

II. ሙስሊሞች

III. ፕሮቴስታንት

IV. ካቶሊክ

V. ሌሎች_____

4) የእናቶች የጋብቻ ሁኔታ?

I. ያገቡ

II. የተፋቱ

III. ያላገቡ

IV. ባል የሞተባት

5) የእናቶች የትምህርት ደረጃ

I. መደበኛ ትምህርት የለም

II. የመጀመሪያ ደረጃ ትምህርት ቤት

III. ሁለተኛ ደረጃ ትምህርት ቤት

IV. ኮሌጅ እና ከዚያ በላይ

6) የባሎች የትምህርት ደረጃ

I. መደበኛ ትምህርት የለም

II. የመጀመሪያ ደረጃ ትምህርት ቤት

III. ሁለተኛ ደረጃ ትምህርት ቤት

IV. ኮሌጅ እና ከዚያ በላይ

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7) የሴቶች የሥራ ሁኔታ?

I. የቀን ሰራተኛ
II. ተማሪ
III. የመንግስት ሰራተኛ
IV. የቤት እመቤት
V. ነጋዴ
VI. ገበሬዎች
VII. ሌሎች ___________

8) ምን ያህል ቤተሰብ አለዎት? በቁጥር ________________

9) የቤተሰቡ ወርሃዊ ገቢ ስንት ነው? በብር _________________

ክፍል 2፡- በሴቶች ላይ ከወሊድ በኋላ ከሚከሰቱ የወሊድ እና የእናቶች የጤና አገልግሎት ጋር የተያያዙ ባህሪያት

1. ምን ያህል ጊዜ አርግዘዋል? ________________
2. ምን ያህል ጊዜ ልጅ ወልደዋል? ________________
3. ምን ያህል የቀዶ ጥገና ጠባሳዎች አሉዎት?
4. የቅድመ ወሊድ እንክብካቤ ክትትል አለዎት?
   I. አዎ
   II. የለም
5. ከላይ ለተጠቀሰው ጥያቄ ምላሽዎ አዎ ከሆነ የቅድመ ወሊድ ክትትል ድግግሞሽ ይግለፁ ______
6. በህይወት ያሉ ምን ያህል ልጆች አሉዎት? __________
7. ያለፈው እርግዝናዎ ምን ያህል ጊዜ ይሆነዋል? ዓመት __________ (የእርግዝና ታሪክ ላላቸው)
8. የአራስ ሕፃን የልደት ውጤት (ከአንድ በላይ እርግዝና ላላቸው)፡፡
   I. በሕይወት ያለ
   II. የሞተ
9. የዚህ እርግዝና ዓላማዎ ምን ነበር?
   I. በፍላጎት

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II. ያልተፈለገ

10. የቅርብ ጊዜ እርግዝናዎ አስቀድሞ የታቀደ ነበር?

I. አዎ

II. አይደለም

11. ተጨማሪ ልጆች ለመውለድ አስበዋል?

I. አዎ

II. አይ

12. ምላሽዎ አዎ ከሆነ የሚቀጥለውን ልጅ መቼ ለመፀነስ አቅደዋል? ዓመት _____ ፣

ለጥያቄ 10 ምላሽዎ "አይሆንም" ኮሆነ ወደሚቀጥለው ጥያቄ ይገለሉ።

ክፍል 4፡- ከወሊድ በኋላ ለረጅም ጊዜ የሚቆይ ሊወጣ የሚችል የወሊድ መከላከያ ከአመለካከት ጋር የተያያዙ ግምገማ ጥያቄዎች።

1. የወሊድ መከላከያ መጠቀም ለጤናዎ ጥሩ ነው ብለው ያምናሉ?

I. በጣም አልስማማም

II. አልስማማም

III. ገለልተኛ

IV. እስማማለሁ

V. በጣም እስማማለሁ

2. የወሊድ መከላከያ መጠቀም በእርግዝና ወቅት ጠንካራ ሊያደርገኝ ይችላል ብለው ያስባሉ?

I. በጣም አልስማማም

II. አልስማማም

III. ገለልተኛ

IV. እስማማለሁ

V. በጣም እስማማለሁ

3. ዘመናዊ የእርግዝና መከላከያዎችን መጠቀም ጥሩ ህይወት እንዲኖርዎት ሊረዳኝ ይችላል ብለው ያስባሉ?

I. በጣም አልስማማም

II. አልስማማም

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III. ገለልተኛ

IV. እስማማለሁ

V. በጣም እስማማለሁ

4. ዘመናዊ የእርግዝና መከላከያዎችን መጠቀም የልጅዎን ጤና ሊያሻሽል እንደሚችል ያምናሉ?

I. በጣም አልስማማም

II. አልስማማም

III. ገለልተኛ

IV. እስማማለሁ

V. በጣም እስማማለሁ

5. ዘመናዊ የእርግዝና መከላከያዎችን መጠቀም ለልጅዎ እድገት ጥሩ ነው ብለው ያስባሉ?

I. በጣም አልስማማም

II. አልስማማም

III. ገለልተኛ

IV. እስማማለሁ

V. በጣም እስማማለሁ

ክፍል 4፡- ከወለዱ በኋላ የሚመጡ ሴቶችን የቤተሰብ እቅድ ጋር የተያያዙ መጠይቆች

1. ከአሁኑ እርግዝና በፊት የቤተሰብ እቅድ ተጠቅመዋል?

I. አዎ

II. አይ

2. በዚህ እርግዝና ወቅት የቤተሰብ እቅድ ምክር አገልግሎት ተቀብለዋል?

I. አዎ

II. አይ

3. እርስዎ እና የትዳር ጓደኛዎ ስለ የወሊድ መከላከያ አጠቃቀም ተወያይተዋል?

I. አዎ

II. አይ

4. የእርግዝና መከላከያዎችን አጠቃቀም ዋና ውሳኔ ሰጪ ማን ነው?

I. ባል

II. እኔ

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III. ሁለቱም

IV. ሌላ፣ ይግለጹ_____

5. ከወሊድ በኋላ ወዲያውኑ ለረጅም ጊዜ የሚቆዩ የእርግዝና መከላከያ ዘዴዎችን አሁን አግኝተዋል?

I. አዎ

II. አይ

6. መልስዎ አዎ ከሆነ የትኛውን ዘዴ መጠቀም ይመርጣሉ?

I. ጃዴል

II. ኢምፕላኖን

III. በማህፀን ውስጥ ያለ መሳሪያ

IV. ሌሎች_____

7. ለረጅም ጊዜ የሚቆዩ የሚቀለበሱ የእርግዝና መከላከያ ዘዴዎችን አሁን ተጠቅመዋል?

I. አዎ

II. አይ

8. ምላሽዎ አዎ ከሆነ የትኛውን አይነት? ጥቀስ --------

9. ረጅም ጊዜ የሚቆይ የእርግዝና መከላከያ መቼ መጠቀም እንዳለቦት

ሀ) በቀዶ ጥገና ወቅት

ለ) ከወሊድ በኋላ

10. ውሳኔው መቼ ነው የሚሰጠው?

ሀ) ኤኤንሲ

ለ) ከወሊድ በኋላ

11.መረጃውን ከየት አገኙት?

ሀ) በኤኤንሲ ወቅት ምክር ተሰጥቶኛል

ለ) በራሴ ጥያቄ

12.ካልሆነ ለምን?

I. ከተጠመቅኩ በኋላ መወሰን አለብኝ

II. ጡት ማጥባት ይጎዳል

III. በቀዶ ጥገና ወቅት ሊገባ እንደሚችል አላውቅም ነበር

IV. መወያየት አለብኝ ----

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