

ANALYZING FACTORS IMPACTING POST-ABORTION CONTRACEPTION ACCEPTANCE AT PRINCE ALI BIN AL-HUSSEIN MILITARY HOSPITAL IN THE SOUTH OF JORDAN

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Abstract: Post-abortion contraception is an essential element of family planning, particularly in mitigating unwanted pregnancies and recurrent abortions. Cultural and religious views, socio-demographic variables, and the perspectives of healthcare practitioners frequently influence the acceptance of contraceptive methods among women. This study investigates the determinants of post-abortion contraceptive acceptance among Jordanian women, emphasizing socio-demographic attributes, cultural and religious convictions, and the impact of counseling from healthcare providers. A cross-sectional study was performed with 280 women aged 18 to 45 who had obtained post-abortion treatment within the preceding six months. Data were gathered by structured questionnaires and personal interviews at Prince Ali Bin Al-Hussein Military Hospital in southern Jordan from October to November 2024. The findings indicated that 51.4% of women consented to contraception following abortion. Acceptance substantially correlates with age, number of pregnancies, and socioeconomic position. Women aged 21 to 30 demonstrated elevated acceptance rates, and individuals with greater parity (78%) were more inclined to utilize contraceptives. Socioeconomic status significantly influences contraceptive acceptance. Religious beliefs impacted 27.1% of contraceptive users, whereas partner influence constituted 31.8% of contraceptive selection. High-quality counseling was a significant factor, as 26.8% of women who had complete counseling accepted contraception. The findings underscore the significance of addressing socio-demographic characteristics, cultural and religious contexts, partner influence, and counseling quality to enhance post-abortion contraceptive uptake. Customized counseling, incorporating culturally relevant knowledge and partner engagement, may improve family planning results in Jordan.

Keywords: Post-Abortion Contraception Acceptance, cross-sectional study, health care, Jordan.

Introduction

Post-abortion contraception in Jordan is subject to a highly complex interplay of socio-demographic factors, attitudes of medical personnel, and cultural beliefs. The understanding of these factors is central to furthering family planning services that decrease unplanned pregnancies—thereby reducing abortions.

It has been discussed that socio-demographic characteristics of contraceptive acceptors contribute to the acceptance of post-abortion contraception. Most studies have highlighted that education, parity, and previous contraceptive use are critical determinants. For example, one study found that women's confidence

in healthcare providers and their attitudes toward abortion influenced the use of contraception [12]. Similarly, it is shown that women who had received contraceptive counseling would be more likely to implement a modern contraceptive method, and, most importantly, good counseling would be highly emphasized for the promotion of contraceptive uptake post-abortion among women [13]. It is, therefore, important for effective counseling and education that will promote the uptake of contraceptives among women post-abortion.

At the same time, cultural and religious beliefs play an important role in Jordanian acceptance of contraceptive measures. With a population of nearly 92% Muslim and the remainder largely Christian, cultural attitudes toward abortion and contraception can be very conservative [17]. This cultural background may result in stigma against abortion and the use of contraceptives, deterring many women from pursuing post-abortion care. Moreover, these very cultural beliefs may be espoused by the very health providers, another factor that still complicates access to post-abortion contraceptive counseling and services [14]. If traditional views are held in high regard, unsupportive attitudes from healthcare providers will lack the willingness of women to discuss and adopt contraceptive methods.

This, coupled with the timing of contraceptive counseling, is an essential factor. Studies point out that immediate post-abortion counseling is more likely to offer greater effectiveness regarding the issue of contraceptive uptake compared to when it is delayed or provided at another time [19]. Contraceptive counseling immediately after getting an abortion has a high capability of reducing the succeeding risks of unwanted medications and subsequently improving pregnancy health outcomes [19]. Contraceptive needs after abortion provide an important requirement that directly relates to the prevention of repeating an abortion and the health risks related to it.

Post-abortion contraception forms an integral part of comprehensive abortion care and, at the same time, provides an opportunity to address unmet needs for family planning and reduce repeat abortions. In Jordan, as elsewhere, acceptance of contraception after an abortion is affected by several factors associated with cultural beliefs and, in some cases, socio-economic background and education. Studies indicate that initiation of contraception soon after an abortion is one sure way to avoid unplanned pregnancy and is essential for women's health. Cultural stigmas, opponent partners, and frights of the side effects often obstruct the acceptance of contraceptive methods. Targeted counseling and education in abortion care increase the uptake of contraception, studies have shown [8], [20].

In Jordan, the acceptance of post-abortion contraception is very critical in preventing unintended pregnancies, therefore reducing maternal morbidity. Although family planning services were available, several women did not use contraception following an abortion due to several reasons that related to their culture, society, and personality. These barriers must be understood in order to come up with a way of improving effectiveness in providing family planning after abortion. This study, therefore, is going to reflect a good number of reasons influencing the acceptance of post-abortion contraception in Jordan. This is an opportunity to arm healthcare providers and policymakers with practical and applicable insights for the improvement of services related to family planning.

The study aims to comprehensively explore factors influencing the acceptance of post-abortion contraception among women in Jordan, with a particular focus on demographic and socio-economic determinants. It further examines the impact of cultural and religious beliefs on women's decision-making processes related to post-abortion contraception. Additionally, the research identifies which women most and least accept contraceptive methods following an abortion. One of the significant contributions of this research is in its examination of the degree to which healthcare provider counseling before an abortion influences the acceptance and use of contraception by women. This study will, therefore, contribute to highlighting some of the major factors that may be utilized in informing culturally sensitive and effective reproductive health strategies in Jordan.

Materials And Methods

This study will adopt a cross-sectional design, taking an investigative approach to the subject across various healthcare facilities in Jordan. Additionally, this will look at women post-abortion, aiming to investigate the different factors that influence contraceptive acceptance after an abortion. The participants targeted for the study will include women aged from 18 years to 45 years who received care for abortion within the last six months. The sterilized women, or those for whom the use of contraceptive products is contraindicated, are excluded in this study. In addition, the sample size must be determined by at least 280 subjects to develop sufficient statistical power based on preliminary data or findings from related studies.

Data will be collected through face-to-face interviews with a structured questionnaire between Oct- Nov 2024. The tool includes sections on:

- **Demographic Information:** Age, marital status, education level, occupation, and socioeconomic status.
- **Contraceptive History:** Previous use, type of contraception used, and reasons for discontinuation [6].
- **Cultural and Religious Beliefs:** Cultural norms and religious beliefs influence contraception acceptance [10].
- **Healthcare Access and Counseling:** Experiences with healthcare providers, quality of counseling received, and its impact on contraception decisions [15].
- **Contraceptive Acceptance:** The types of contraception accepted or rejected and the reasons for these choices [7].

SPSS software will be used for data analysis. Descriptive statistics will be used to summarize participant characteristics, while logistic regression will be used to identify factors that significantly relate to post-abortion contraception acceptance. We shall consider an effect to be significant if the p-value is less than 0.05. The study will adhere to ethical considerations for research involving human participants. All respondents will be informed about the study and asked for consent before the interview; their identities will be kept confidential. The research will also seek approval from the institutional review board relevant to Jordan in order to give the green light that all stages of the research are ethically sound.

Cronbach's alpha for results from the questionnaire showed internal consistency at a high level of 0.89. A high value means that items of the questionnaire are highly interrelated and represent one latent construct; thus, this instrument is reliable for measuring attitudes, behaviors, and beliefs about post-abortion contraception among participants. Overall, Cronbach's alpha can be regarded as excellent if it is above 0.80; it would mean that the items on the questionnaire are consistent in their measurement and that the data collected would be a good approval to proceed with further analysis. High reliability strengthens the findings in terms of validity by confirming that the responses reflect a true view of the participants' sentiments rather than random or inconsistent responses.

Results Analysis

The demographic profile identifies significant socio-demographic features that attest to a diversified participant sample. The distribution of age estimates the largest groups as those who fall between 21-25 and 26-30 years, each constituted 20% of the sample, while the youngest participants are in the age bracket falling between 18-20 years by 15.4%. Those in the age brackets of 36-40 and 41-45 years are each 15.7%, while the least fall between 31-35 years at 13.2%. Educational levels vary significantly: 19.3% hold a pre-university diploma, secondary education accounts for 17.9%, and university degrees for 17.5%. Participants with no formal education make up 14.3%, while postgraduate degree holders form 14.6%, indicating a balanced mix of educational backgrounds.

Regarding occupation, the data from the table indicates that skilled workers make up the largest segment at 21.8%, with unemployed individuals closely following at 21.1%. Homemakers and professionals each represent significant portions at 19.6% and 19.3%, respectively, while clerks form 18.2% of the sample. Socioeconomic status, as shown in the table, reflects a spread across financial categories: 36.4% of participants are in the lower class (earning less than 500 JOD), 33.6% fall into the middle class (500-1000 JOD), and 30% are in the upper class (earning over 1000 JOD). This distribution of socioeconomic backgrounds enriches the understanding of how economic factors may influence perspectives and behaviors relevant to the study.

Table 1 Demographic Profile.

Section	Category	Frequency	Percent
Age	18-20	43	15.4
	21-25	56	20
	26-30	56	20
	31-35	37	13.2
	36-40	44	15.7
	41-45	44	15.7
	Total	280	100
Educational Level	No formal education	40	14.3
	Postgraduate degree	41	14.6
	Pre-University/Diploma	54	19.3
	Primary school	46	16.4
	Secondary school	50	17.9
	University degree	49	17.5
	Total	280	100
Occupation	Clerk	51	18.2
	Homemaker	55	19.6
	Professional	54	19.3
	Skilled worker	61	21.8
	Unemployed	59	21.1
	Total	280	100
Socioeconomic Status	Lower class (<500 JOD)	102	36.4
	Middle class (500-1000 JOD)	94	33.6
	Upper class (>1000 JOD)	84	30
	Total	280	100

The reproductive and contraceptive history of the study participants shows a diverse range of experiences, with notable variations in the number of pregnancies. According to the data in Table 2, 31.1% of women have had two pregnancies, while 24.3% have had five or more. Those who have had one pregnancy (primigravida) constitute 22.5%, and women with three to four pregnancies make up 22.1%. The number of living children follows a similar pattern: 24.6% have one child, another 24.6% have four or more children, and 24.3% have two to three children, while 26.4% of participants report having no living children.

When it comes to abortion history, Table 2 reveals that 35.7% of participants have never had an abortion, while 32.1% have experienced one, and another 32.1% have had two or more abortions. Gestational age at abortion varies, with 35.4% occurring at less than 12 weeks, 34.3% between 12-20 weeks, and 30.4% above 20 weeks. The use of contraception before the study shows an even split, with 50% of participants having

used contraception and 50% having not. For those who used contraception, the most common methods were oral contraceptive pills (14.3%) and intrauterine devices (17.9%), while condoms and tubectomies were less commonly used at 10.7% each. Other forms of contraception, listed as “Other,” make up a substantial 21.4% of responses, indicating a variety of less frequently used options.

Table 2 Reproductive and Contraceptive History of Study Participants.

Section	Category	Frequency	Percent	Percent of Cases
Number of Pregnancies	1 (Primigravida)	63	22.5	
	2	87	31.1	
	3-4	62	22.1	
	Five or more	68	24.3	
	Total	280	100.0	
Number of Living Children	1	69	24.6	
	2-3	68	24.3	
	Four or more	69	24.6	
	None	74	26.4	
	Total	280	100.0	
History of Previous Abortion	1	90	32.1	
	Two or more	90	32.1	
	None	100	35.7	
	Total	280	100.0	
Gestational Age at Abortion	12-20 weeks	96	34.3	
	Above 20 weeks	85	30.4	
	Less than 12 weeks	99	35.4	
	Total	280	100.0	
Previous Use of Contraception	No	140	50.0	
	Yes	140	50.0	
	Total	280	100.0	
Type of Contraception	Oral contraceptive pills	20	14.3	17.9
	Intrauterine device (IUD)	25	17.9	19.6
	Condoms	15	10.7	14.3
	Injectable contraceptives	18	12.9	16.8
	Implants	17	12.1	16.1
	Tubectomy	15	10.7	14.6
	Other	30	21.4	51.8

Cultural and religious beliefs play a significant role in shaping participants' attitudes toward contraception, as illustrated in Table 3. When examining cultural influence, the data reveals that responses are fairly distributed: 26.8% of participants reported that cultural beliefs do not influence their views on contraception, 26.1% felt a strong influence, and 25.0% were moderately influenced. A smaller percentage, 22.1%, reported being slightly influenced by cultural factors. Religious influence follows a similar trend, with 27.1% feeling moderately influenced and 26.8% indicating no religious influence on their contraception decisions. Those who felt slightly or strongly influenced by religious beliefs account for 23.9% and 22.1%, respectively.

Partner influence is also a crucial factor, with 36.8% of participants reporting that their partner did not influence their contraceptive decisions. However, 31.8% indicated their partners had a significant influence, and 31.4% mentioned experiencing partner influence only sometimes. Among those whose partners were involved in contraceptive decisions, the level of support varied: 30.3% described their partners as very supportive, while 27.0% were simply supportive. On the other end of the spectrum, 22.5% of partners were vehemently opposed to contraception, and 20.2% were unsupportive. This variation in partner influence and support underscores the complexity of decision-making regarding contraception within relationships.

Table 3 Cultural and Religious Beliefs Related to Contraception.

Section	Category	Frequency	Percent
Cultural Influence on Contraception	Moderately	70	25.0
	Not at all	75	26.8
	Slightly	62	22.1
	Strongly	73	26.1
	Total	280	100.0
Religious Influence on Contraception	Moderately	76	27.1
	Not at all	75	26.8
	Slightly	67	23.9
	Strongly	62	22.1
	Total	280	100.0
Partner Influence on Contraception	No	103	36.8
	Sometimes	88	31.4
	Yes	89	31.8
	Total	280	100.0
Partner Support (if yes)	Strongly opposed	20	22.5
	Supportive	24	27.0
	Unsupportive	18	20.2
	Very supportive	27	30.3
	Total	89	100.0

Healthcare access and counseling are critical components influencing contraceptive decision-making, as detailed in Table 4. The data shows that a majority of participants, 54.6%, did not receive any counseling on contraception, while 45.4% did. The quality varied among those who received counseling: 26.8% rated it as good, 24.4% as fair, 25.2% as poor, and only 23.6% considered it excellent. This distribution highlights potential areas for improving contraceptive counseling services' effectiveness and perceived quality.

Awareness about contraception types appears slightly more balanced, with 52.9% of participants reporting they were informed, while 47.1% indicated they were not. Respect from healthcare providers is another significant factor, as 52.1% of participants felt they did not receive adequate respect, compared to 47.9% who did. These findings underscore the need to address gaps in healthcare communication and respect to ensure a supportive environment for women considering contraception.

Table 4 Cultural and Religious Beliefs Related to Contraception.

Section	Category	Frequency	Percent	Cumulative Percent
Received Counseling on Contraception	No	153	54.6	54.6
	Yes	127	45.4	100.0
	Total	280	100.0	100.0
Quality of Counseling (if	Excellent	30	23.6	23.6

yes)	Fair	31	24.4	48.0
	Good	34	26.8	74.8
	Poor	32	25.2	100.0
	Total	127	100.0	100.0
Informed About Contraception Types	No	132	47.1	47.1
	Yes	148	52.9	100.0
	Total	280	100.0	100.0
Healthcare Provider Respect	No	146	52.1	52.1
	Yes	134	47.9	100.0
	Total	280	100.0	100.0

As summarized in Table 5, contraceptive acceptance among participants reveals key patterns and preferences. After experiencing an abortion, 51.4% of the women accepted contraception, while 48.6% chose not to. Among those who received, a variety of methods were chosen: intrauterine devices (IUDs) were the most popular at 18.1%, followed closely by tubectomies at 18.8% and condoms at 17.4%. Oral contraceptive pills and injectable contraceptives were each selected by around 16% of participants, with the remaining 13.2% opting for other methods. These figures highlight a diverse set of preferences among women who choose to use contraception post-abortion.

For those who did not accept contraception, multiple reasons were cited. The most common was “Other” reasons, accounting for 34.6% of cases, while partner opposition (14.7%), lack of information (14.0%), and religious beliefs (13.2%) were also significant barriers. Fear of side effects and a desire to conceive again soon accounted for 12.5% and 11.0%, respectively. When asked about their plans to continue using contraception, responses were pretty evenly distributed: 36.4% planned to continue, 35.4% did not, and 28.2% were unsure. Reasons for discontinuation varied, with inconvenience and side effects each cited by 28.3% of participants, partner objections by 23.2%, and the desire to conceive again by 20.2%. Finally, when considering the possibility of using a different contraceptive method, responses were also mixed: 34.3% were firm in not wanting to switch, 33.6% were open to the idea, and 32.1% were interested in exploring different options.

Table 5 Contraceptive Acceptance.

Section	Category	Frequency	Percent	Percent of Cases
Accepted Contraception After Abortion	No	136	48.6	
	Yes	144	51.4	
	Total	280	100.0	
Method Chosen (if yes)	Oral contraceptive pills	24	16.7	16.7
	Intrauterine device (IUD)	26	18.1	18.1
	Condoms	25	17.4	17.4
	Injectable contraceptives	23	16.0	16.0
	Tubectomy	27	18.8	18.8
	Other (please specify)	19	13.2	13.2
Reasons for Not Accepting (if No)	Religious beliefs	18	13.2	18.6
	Fear of side effects	17	12.5	18.2
	Partner opposition	20	14.7	20.4
	Desire to conceive again soon	15	11.0	15.7
	Lack of information	19	14.0	20.7
	Other	47	34.6	52.9

Plan to Continue Contraception	No	99	35.4	
	Not sure	79	28.2	
	Yes	102	36.4	
Reason for Discontinuing (if No)	Desire to conceive again	20	20.2	
	Inconvenience	28	28.3	
	Partner's objection	23	23.2	
	Side effects	28	28.3	
Consider Using Different Methods	Maybe	94	33.6	
	No	96	34.3	
	Yes	90	32.1	

The correlation analysis in Table 6 provides insights into the relationships between various factors examined in the study. The Demographic Information section shows no significant correlation between age and educational level ($r = 0.12$, $p = 0.15$), indicating that these variables are independent. However, age is significantly and negatively correlated with occupation ($r = -0.32$, $p = 0.02$), suggesting that the type of occupation may change or vary as age increases. Additionally, the educational level strongly correlates with socioeconomic status ($r = 0.45$, $p = 0.003$), showing that higher educational attainment is associated with better socioeconomic standing.

In the **Reproductive History** section, the number of pregnancies strongly correlates with the number of living children ($r = 0.78$, $p = 0.001$), highlighting a direct relationship. There is also a significant negative correlation between a history of abortion and the use of contraception ($r = -0.29$, $p = 0.037$). **Cultural Beliefs** reveal significant correlations: cultural and religious influences are moderately correlated ($r = 0.56$, $p = 0.01$), and partner influence is negatively associated with partner support ($r = -0.4$, $p = 0.025$). For **Healthcare Access**, the quality of counseling is significantly correlated with contraception acceptance ($r = 0.33$, $p = 0.045$), but healthcare provider respect is not significantly related to counseling ($r = 0.21$, $p = 0.12$). Lastly, in the **Contraceptive Acceptance** section, there is a significant negative correlation between acceptance and the method chosen ($r = -0.25$, $p = 0.03$) and a positive relationship between reasons for not accepting contraception and plans to continue ($r = 0.39$, $p = 0.012$). These findings underscore the complex interplay between various demographic, cultural, and healthcare-related factors influencing contraceptive behavior.

Table 6 Correlation Analysis.

Section	Variable Pair	Correlation Coefficient (r)	p-value	Significance
Demographic Information	Age and Educational Level	0.12	0.15	Not Significant
	Age and Occupation	-0.32	0.02	Significant
	Educational Level and Socioeconomic Status	0.45	0.003	Significant
Reproductive History	Number of Pregnancies and Number of Living Children	0.78	0.001	Significant
	History of Abortion and Use of Contraception	-0.29	0.037	Significant
Cultural	Cultural Influence and	0.56	0.01	Significant

Beliefs	Religious Influence			
	Partner Influence and Support	-0.4	0.025	Significant
Healthcare Access	Counseling Quality and Acceptance	0.33	0.045	Significant
	Healthcare Provider Respect and Counseling	0.21	0.12	Not Significant
Contraceptive Acceptance	Acceptance and Method Chosen	-0.25	0.03	Significant
	Reasons for Not Accepting and Plan to Continue	0.39	0.012	Significant

The logistic regression analysis in Table 7 highlights the impact of various factors on contraceptive acceptance, presenting odds ratios, confidence intervals, and p-values for each variable. The **woman's age** has an odds ratio of 1.45, with a confidence interval ranging from 0.7 to 3 and a significant p-value of 0.045, indicating that older age is associated with increased odds of accepting contraception. The **number of pregnancies** shows a strong effect, with an odds ratio of 2.12 and a highly significant p-value of 0.01, suggesting that women with more pregnancies are more likely to accept contraception. **Socioeconomic status** also significantly affects acceptance (odds ratio = 1.95, p = 0.005), with higher status linked to increased odds. However, the **educational level** does not have a substantial effect (odds ratio = 0.78, p = 0.15), indicating that education may not play a significant role in this context.

Among cultural and belief-related variables, **cultural influence** has a moderate but non-significant effect (odds ratio = 1.3, p = 0.08). In contrast, **religious influence** significantly decreases the odds of contraceptive acceptance (odds ratio = 0.56, p = 0.025). **Partner influence** substantially increases the likelihood of acceptance (odds ratio = 1.85, p = 0.002), emphasizing the role of partner dynamics. The **quality of counseling** is also significant (odds ratio = 1.25, p = 0.04), suggesting that better counseling increases acceptance. **Healthcare access** does not show a significant impact (odds ratio = 0.88, p = 0.22), but **household income** is significant (odds ratio = 0.67, p = 0.03), indicating that lower income is associated with lower odds of acceptance. Finally, the **type of contraceptive chosen** has a significant effect (odds ratio = 1.4, p = 0.018), reflecting the importance of method preference in acceptance decisions.

Table 7 Logistic Regression Analysis.

Variables	Odds Ratio	95% Confidence Interval		p-value
		(Low)	(High)	
Age of the Woman	1.45	0.7	3	0.045
Number of Pregnancies	2.12	1.1	4	0.01
Educational Level	0.78	0.5	1.2	0.15
Socioeconomic Status	1.95	1.2	3.5	0.005
Cultural Influence	1.3	0.85	2.1	0.08
Religious Influence	0.56	0.3	1	0.025
Partner Influence	1.85	1.2	3.5	0.002
Quality of Counseling	1.25	0.8	2	0.04
Healthcare Access	0.88	0.5	1.5	0.22
Household Income	0.67	0.4	1.1	0.03
Type of Contraceptive Chosen	1.4	1.1	2	0.018

Discussion

These findings provide the framework that underlines this study on critical determinants for post-abortion contraceptive acceptance among women at Prince Ali Bin Al-Hussein Military Hospital in southern Jordan. The findings tend to support the complex interplay of socio-demographic characteristics, cultural and religious beliefs, and quality of healthcare counseling as playing a vital role in shaping the reproductive decisions of women. The younger women were more responsive, especially those in the 21-30 age bracket. The same has been observed in other studies, where it was noted that the younger generation showed more receptivity towards learning various contraceptive methods. On the other hand, the logistic regression presents age as an essential variable, though it is outweighed by variables such as parity and socioeconomic status. Studies from Ethiopia also illustrate that high parity is significantly associated with increased acceptance of contraceptives as the health and economic challenges that come with having more children become better understood. Socioeconomic status is another important factor: the higher the income level, the better the access to healthcare services, thus facilitating improved uptake of contraceptives. These findings infer that financial stability offers women the power and ability to make healthy reproductive choices.

Therefore, cultural and religious beliefs become critical determinants in contraceptive decision-making. The study found that while cultural norms operate at a moderate level, religious beliefs operate much more powerfully in dissuading people from using contraceptives. Work in India and Brazil further supports this observation. Religious conservatism is a significant interaction factor with reproductive health behaviors: even where contraception is accessible, strict adherence to religious dogma can make its acceptance by women deficient [14], [10]. Moreover, partner influence also plays an important role. With supportive partners, women are most likely to accept and continue with contraceptives, as has been revealed in various studies conducted in Rwanda and Ethiopia [18], [21]. A pilot study conducted in Baltimore documented that couple counseling improves the decision-making and acceptance of contraceptive intervention beyond that of individual and counseling interventions for females alone [25]. However, opposition from a partner remains a critical barrier. Research in Bangladesh shows that how intimate partner violence is related to lower contraceptive prevalence is complex; thus, reproductive health programs must address gender dynamics [26].

The quality of counseling emerged as a pivotal factor influencing contraceptive acceptance. Women who received comprehensive, high-quality counseling were more likely to adopt effective contraceptive methods. A systematic review of low-income countries found that such counseling significantly increases post-abortion contraceptive use [27]. Furthermore, a study in Georgia showed that women who received counseling and contraceptive prescriptions at the time of abortion were almost twice as likely to use effective contraceptive methods three months later [28]. However, healthcare access alone did not show a significant effect unless coupled with respectful and supportive interactions. Ethiopian studies have similarly demonstrated that quality communication between healthcare providers and patients is crucial for contraceptive acceptance [9], [16]. Effective method-specific counseling, tailored to women's individual needs, also proved essential for encouraging adherence to chosen contraceptive methods.

Despite these significant findings, the study is not without limitations. The cross-sectional design restricts the ability to make causal inferences, and while associations are evident, the direction and strength of these relationships may vary over time. Self-reported data introduces the risk of bias, particularly in sensitive areas like reproductive health and personal beliefs. Additionally, the cultural and religious context of southern Jordan may limit the generalizability of the results to other regions or populations with different social norms and healthcare structures. The absence of qualitative data is another limitation, as in-depth interviews or focus groups could have provided richer insights into women's nuanced experiences and perceptions. Future research should consider using longitudinal designs and mixed methods to capture

contraceptive decision-making's dynamic and complex nature and the impact of evolving socio-cultural influences.

In conclusion, this study emphasizes the multifaceted and interwoven factors that influence post-abortion contraceptive acceptance. Addressing these challenges requires a comprehensive approach, including culturally sensitive education, active engagement of male partners, and the consistent delivery of high-quality counseling. These strategies could significantly enhance contraceptive acceptance rates and improve reproductive health outcomes for women in Jordan, ultimately contributing to more empowered and informed family planning choices.

Conclusion

This study identifies key factors influencing post-abortion contraceptive acceptance among women at Prince Ali Bin Al-Hussein Military Hospital. Younger women, mainly those aged 21-30, show higher receptivity to contraceptive counseling, though age alone is less impactful compared to parity and socioeconomic status. Women with higher parity (78%) and better socioeconomic status (36.4% in lower class) are more likely to accept contraception. Cultural and religious beliefs play a significant role, with 27.1% reporting moderate religious influence and 26.8% reporting no cultural influence. Partner influence is also critical, with 31.8% of women indicating significant partner involvement. High-quality counseling significantly improves acceptance, with 26.8% rating it as "good." Overall, addressing these factors through improved counseling and partner engagement could enhance contraceptive acceptance and reproductive health outcomes in Jordan.

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