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Association between rural workers' sociodemographic and reproductive characteristics and their reproductive autonomy

Associação entre as características sociodemográficas e reprodutivas com a autonomia reprodutiva das trabalhadoras rurais

Asociación entre características sociodemográficas y reproductivas con la autonomía reproductiva de trabajadoras rurales

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ABSTRACT

Objectives: to verify the association between sociodemographic and reproductive characteristics with rural workers' reproductive autonomy. **Methods:** a cross-sectional study, with a sample of 346 women and application of the Reproductive Autonomy Scale. Multinomial regression was performed to analyze associations between independent variables and outcomes. **Results:** in the analysis of subscales "Decision-making", "My sexual partner or someone else such as a parent", "Both me and my partner" and "Me", women experienced greater reproductive autonomy in relation to their partners. For outcomes "Decision about which method to use", "When to have a baby" or "About unplanned pregnancy", the highest prevalence was for category "Me", with statistically significant associations. **Conclusions:** the sociodemographic and reproductive characteristics among the most vulnerable women, in terms of the social, economic and cultural context in which they are inserted, may be associated with greater difficulties in exercising reproductive autonomy.
Descriptors: Decision Making; Reproductive Rights; Economic Status; Women; Reproductive Health.

RESUMO

Objetivos: verificar a associação entre as características sociodemográficas e reprodutivas com a autonomia reprodutiva das trabalhadoras rurais. **Métodos**: estudo transversal, com amostra de 346 mulheres e aplicação da Escala de Autonomia Reprodutiva. Foi realizada regressão multinomial para análises de associações entre as variáveis independentes e desfechos. **Resultados:** na análise das subescalas "Tomada de decisão", "Meu parceiro sexual ou alguém da família tem mais a dizer", "Eu e meu parceiro sexual" e "Eu decido", as mulheres experimentaram maior autonomia reprodutiva em relação aos parceiros. Para os desfechos "Decisão sobre qual método utilizar", "Quando ter um bebê" ou "Sobre gravidez não planejada", as maiores prevalências foram para a categoria "Eu decido", com associações estatisticamente significante. **Conclusões:** as características sociodemográficas e reprodutivas entre mulheres mais vulneráveis, tratando-se do contexto social, econômico e cultural que estão inseridas, podem estar associadas a maiores dificuldades para exercerem a autonomia reprodutiva.
Descritores: Tomada de Decisões; Direitos Sexuais e Reprodutivos; Status Econômico; Mulheres; Saúde Reprodutiva.

RESUMEN

Objetivos: verificar la asociación entre características sociodemográficas y reproductivas con la autonomía reproductiva de trabajadoras rurales. **Métodos:** estudio transversal, con una muestra de 346 mujeres y aplicación de la Escala de Autonomía Reproductiva. Se realizó una regresión multinomial para analizar las asociaciones entre las variables independientes y los resultados. **Resultados:** en el análisis de las subescalas "Toma de decisiones", "Mi pareja sexual o alguien de la familia tiene más que decir", "Mi pareja sexual y yo" y "Yo decido", las mujeres experimentaron mayor autonomía reproductiva en relación a su parejas. Para los desenlaces "Decisión sobre qué método utilizar", "Cuándo tener un hijo" o "Sobre el embarazo no planeado", las mayores prevalencias fueron para la categoría "Yo decido", con asociaciones estadísticamente significativas. **Conclusiones:** las características sociodemográficas y reproductivas de las mujeres más vulnerables, en función del contexto social, económico y cultural en el que se insertan, pueden estar asociadas a mayores dificultades en el ejercicio de la autonomía reproductiva.
Descriptores: Toma de Decisiones; Derechos Sexuales y Reproductivos; Estatus Económico; Mujeres; Salud Reproductiva.

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INTRODUCTION

Reproductive autonomy is defined as having the power to decide and control reproductive-related issues, such as pregnancy, using contraceptive methods. Abortion is a complex process, often including not only the woman, but her partner, family or community, but often the male partner is the one who plays a key role in reproductive decisions[1].

This reality is determined by gender inequality through socially accepted models by society[2], mainly patriarchal, which requires that women be shaped by the social context to which[3] are inserted . In addition to this context, studies indicate that reproductive autonomy can be influenced by women's sociodemographic characteristics, such as age, religion, marital status, educational level[4], color/race[5] and geographic location, such as rural areas[6].

Social characteristics in the rural area are marked by excluded social groups and often composed of blacks, young people and with low education[7]. The rural area in Brazil has about 14 million rural women, 24.8% with a low level of education, and of these, 52.3% were not literate or have three years of study, with low economic conditions and cultural diversity[8].

In addition to these aspects, the rural scenario is seen as a geographical area that can hinder access to women's health and reproductive demands. Therefore, it is essential to guarantee a policy related to the exercise of reproductive rights. However, even if access to contraception is a right guaranteed by the constitution, it is not satisfactorily met, which provides precarious or non-existent attention in some regions, harming, in particular, rural women[9].

In the case of reproductive decisions, women with unfavorable social conditions are more likely to experience limitations on their reproductive autonomy than women with better social and financial conditions[10]. Considering that a portion of rural women are part of a population in unfavorable social conditions and that may compromise their reproductive autonomy, we hypothesize that sociodemographic and reproductive characteristics may be associated with women's reproductive autonomy.

In general, women, when compared to men, have a disadvantage in terms of reproductive and sexual rights, due to their role as subordinate in sexual issues and the obligation in reproductive issues, which hinders communication with a partner, increasing vulnerability[11].

The realization of a fact about women's reproductive autonomy points to the importance of deepening the discussion, mainly focused on population groups with greater socioeconomic and cultural vulnerability, as is the case of women in rural regions, whose profile is still marked by patriarchal ideology, gender and power inequalities[12].

Although international studies on reproductive autonomy are found, the relevance of this research is also due to the scarcity of national studies using this theme, as only five Brazilian articles[9-10,12-14] were found. Thus, the study has as research question: are rural workers' sociodemographic and reproductive characteristics associated with their reproductive autonomy?

OBJECTIVES

To verify the association between rural workers' sociodemographic and reproductive characteristics with their reproductive autonomy.

METHODS

Ethical aspects

This study complies with the precepts of Resolution 466/12 of the Brazilian National Health Council. The project was approved by the Research Ethics Committee of the *Universidade Federal do Vale do São Francisco*.

Design

This is a cross-sectional analytical epidemiological study, which is characterized by direct observation of the study population, with regard to exposure variables and the outcome under study, in the same historical outcome.

Study site

This research was carried out in the state of Pernambuco with rural women workers, in the municipalities covered by the *Programa Chapéu de Palha Mulher* (Women's Straw Hat Program), in Petrolina, Lagoa Grande and Santa Maria da Boa Vista, from February 19 to 23, 2018.

Population and sample

Taking into account the total population base of 3,454 rural workers registered in the *Programa Chapéu de Palha Mulher* in 2018, for each municipality, according to the *Secretaria da Mulher de Pernambuc*o (Pernambuco Women's Department - SecMulher - PE), a sample was estimated based on the sample calculation equation for a finite population, considering a sampling error of 5%, a confidence level of 95% and a prevalence of 50%, which resulted in a number of 346 rural workers. The sample was divided into strata, according to the registration of the workers by municipality: Petrolina (2760), Lagoa Grande (656) and Santa Maria da Boa Vista (38). To ensure the representativeness of the population, a random sample of each stratum was proportionally selected (80%, 19% and 1%). Thus, 276 women from Petrolina, 66 from Lagoa Grande and 4 from Santa Maria da Boa Vista were analyzed, totaling 346 women[15].

Inclusion and exclusion criteria

We included rural workers residing in the municipalities covered by the *Programa Chapéu de Palha Mulher*, at reproductive age and at least 18 years of age. We excluded women who did not complete the answers to fill out the data collection instruments and did not present cognitive conditions to answer the questions.

Data collection

The enrollment of rural workers in the *Programa Chapéu de Palha Mulher* took place at the Convention Center in Petrolina, after the SecMulher-PE team checked the documentation on proof of residence or declaration from the Rural Workers Union. At this time, these women were presented with the objectives of the research, and those who agreed to participate in the study

signed the Informed Consent Form (ICF). Soon after, data were collected through individual interviews from February 19 to 23, 2018. As registration occurred in just five days, four nurses and two Community Health Workers (CHW), who were trained by the researcher responsible for the research, participated in data collection for all the aforementioned days.

Quantitative variables

The Reproductive Autonomy Scale was applied in its entirety; however, for the clipping of this manuscript, we chose to present the questions of the "Decision-making" subscale as outcomes: 1. "Who has the most say about whether you use a method?"; 2. "Who has the most say about which method you would use to prevent pregnancy?"; 3. "Who has the most say about when you have a baby in your life?"; and 4. "If you became pregnant but it was unplanned, who would have the most say about whether you would raise the child, seek adoptive parents, or have an abortion?". The answer options for these questions are: 1. My partner (or someone else such as a parent or mother in-law/father in-law); 2. Both me and my partner (or someone else such as a parent or mother in-law/father in-law), 3. Equally; and 4. Me.

Answer 4 was defined for the analyses of this research as "Me", to mention that women have greater autonomy for reproductive decision-making. Question 1 was excluded because it did not meet the methodological assumptions for the analysis. Thus, the analyses were performed for three outcomes.

Independent variables used were: age (continuous), education (<kindergarten, kindergarten, elementary school, >=high school); self-reported color/race (non-white, white); marital status (single/no partner, married/with partner); religion (no religion, with religion); and participation in family (reproductive) planning groups (no, yes).

Analysis of results, and statistics

Initially, descriptive statistics of the sample were calculated for the three outcomes, presenting frequency and respective proportions. In the main analysis, the association between independent variables and outcomes was verified by estimating multinomial logistic regression[16], with robust standard errors. The category of greater autonomy "Me" was used as a reference group in all estimates. The first item of the "Decision-making" subscale was not analyzed, as it did not meet the criterion of having at least ten observations per estimated coefficient, as suggested by the literature[17]. The results are presented using the adjusted coefficients, 95% confidence intervals, p-values and Relative Risk Ratio (RRR). All data analyses were performed using Stata, version 15.

RESULTS

The study population consisted of 346 rural workers, with ages ranging from 18 to 47 years, mean age of 29.6 years (SD 7.2). Self-declared non-white women (86%), with elementary school (49%), married or with a partner (66%) and with religion (89%) prevailed in the sample. Few participated in reproductive planning groups in the last 12 months (13%).

For the outcome variables referring to the three questions analyzed, such as "Who has the most say about which method you would use to prevent pregnancy?" - question 2, "Who has the most say about when you have a baby in your life?" – question 3 and "If you became pregnant but it was unplanned, who would have the most say - about whether you would raise the child, seek adoptive parents, or have an abortion"- question 4, statistics showed low proportions for the lowest autonomy response category, focused on "my partner or someone else such as a parent or mother in-law/father in-law has more to say" (question 2 = 5.20, question 3 = 4.60, question 4=5.50), and higher proportions for the category of greater autonomy, "Me" (question 2 = 66.7; question 3=49.4; question 4=56.1) (Table 1).

Through multinomial logistic regression, it was possible to obtain the results presented in Tables 2, 3 and 4. This analysis allowed comparing the women who reported "Me" in relation to the questions of outcomes of the other two categories ("My partner or someone else such as a parent or mother in-law/father in-law has more to say" and "Both me and my partner equally") and to verify association with the independent variables already highlighted previously.

The association between the outcome variable, represented by question 2, "Who has the most say about which method you would use to prevent pregnancy?", and the selected sociodemographic and reproductive variables verified that there is a strong negative association and statistically significant difference between the characteristics of rural women with a higher level of education (β = -14.525, p <0.001) and with white skin color (β = -14.885, p <0.001) in the group "My sexual partner or someone else such as a parent", when comparing with the characteristics of rural workers in the reference group ("Me"). In other words, these women have a higher relative risk of being in the reference group compared to the group "My sexual partner or someone else such as a parent" (Table 2).

For the outcome of question 3, "Who has the most say about when you have a baby in your life?", the results also showed a statistically significant negative association for white color/race women (β = -14.618, p <0,001) and for women who participated in reproductive planning groups (β = -14.822, p <0,001), demonstrating that women who have these characteristics have a higher relative risk of being in the reference group, compared to the "My sexual partner or someone else such as a parent" group. For the same outcome, it is observed that women married or with partners (β = 0.480, p = 0.042) have a higher relative risk of being in the group "Both me and my partner equally", compared to the reference group (Table 3).

For the outcome of question 4, "If you became pregnant but it was unplanned, who would have the most say - about whether you would raise the child, seek adoptive parents, or have an abortion", the only variable that was statistically significant in the analysis was participating in reproductive planning groups (β = -13.982, p <0.001), showing a negative sign for the group "My sexual partner or someone else such as a parent", which demonstrates that women participating in reproductive planning groups have a higher relative risk of being in the reference group, compared to the "My sexual partner or someone else such as a parent" group (Table 4).

Table 1 - Distribution of proportions of rural workers* according to outcome variables for the three questions assessed regarding the "Decision-making" subscale, Petrolina, Lagoa Grande and Santa Maria da Boa Vista, Pernambuco, Brazil, 2018 (N=346)

"Decision-making" outcome variables	**n**	**%**
Who has the most say about which method you would use to prevent pregnancy?		
My sexual partner or someone else such as a parent	18	5.20
Both me and my partner	97	28.03
Me	231	66.76
Who has the most say about when you have a baby in your life?		
My sexual partner or someone else such as a parent	16	4.62
Both me and my partner	159	45.95
Me	171	49.42
If you became pregnant but it was unplanned, who would have the most say – **...?		
My sexual partner or someone else such as a parent	19	5.49
Both me and my partner	133	38.44
Me	194	56.07

**From the Program Chapéu de Palha Mulher; **... whether you would raise the child, seek adoptive parents, or have an abortion.*

Table 2 - Multinomial logistic regression analysis between the outcome variable* and rural workers' sociodemographic and reproductive characteristics**, Petrolina, Lagoa Grande and Santa Maria da Boa Vista, Pernambuco, Brazil, 2018 (N=346)

Variables	**Coefficient**	***p***	**95% CI**	**RRR******
"My partner or someone else such as a parent or mother in-law/father in-law has more to say" (vs "Me")				
Age	0.004	0.897	-0.055; 0.063	1.004
Education				
< Kindergarten	Ref			Ref
Kindergarten	0.776	0.305	-0.707; 2.259	2.173
Elementary school	0.830	0.234	-0.538; 2.199	2.294
>=High school	-14.525	0.000	-15.743; -13.308	0.000
Color/race				
Non-white	Ref			Ref
White	-14.885	0.000	-15.550; -14.220	0.000
Marital status				
Single/without partner	Ref			Ref
Married/with partner	0.238	0.668	-0.848; 1.324	1.268
Religion				
Without religion	Ref			Ref
With religion	-0.111	0.892	-1.719; 1.497	0.894
Family planning				
No	Ref			Ref
Yes	0.480	0.450	-0.765; 1.726	1.617
"Both me and my partner (or someone else such as a parent or mother in-law/father in-law) equally" (vs "Me")				
Age	-0.005	0.741	-0.039; 0.028	0.994
Education				
< Kindergarten	Ref			Ref
Kindergarten	-0.516	0.143	-1.208; 0.175	0.596
Elementary school	-0.289	0.341	-0.911; 0.315	0.742
>=High school	-0.450	0.224	-1.177; 0.275	0.637
Color/race				
Non-white	Ref			Ref
White	0.178	0.0881	-0.484; 0.841	1.195
Marital status				
Single/without partner	Ref			Ref
Married/with partner	-0.038	0.528	-0.543; 0.466	0.962
Religion				
Without religion	Ref			Ref
With religion	0.256	0.838	-0.539; 1.052	1.292
Reproductive planning				
No	Ref			Ref
Yes	-0.079	0.346	-0.837; 0.679	0.924

**Who has the most say about which method you would use to prevent pregnancy?; **From the Programa Chapéu de Palha Mulher; ***RRR - Relative Risk Ratio, answers to question 2.*

Table 3 - Multinomial logistic regression analysis between the outcome variable* and rural workers' sociodemographic and reproductive characteristics**, Petrolina, Lagoa Grande and Santa Maria da Boa Vista, Pernambuco, Brazil, 2018 (N=346)

Variables	Coefficient	*p*	95% CI	RRR***
"My partner or someone else such as a parent or mother in-law/father in-law" (vs "Me")				
Age	0.033	0.420	-0.048; 0.115	1.034
Education				
< Kindergarten	Ref			Ref
Kindergarten	-0.525	0.548	-2.240; 1.190	0.591
Elementary school	0.483	0.438	-0.739; 1.706	1.622
>=High school	-0.164	0.857	-1.956; 1.626	0.848
Skin color				
Non-white	Ref			Ref
White	-14.618	0.000	-15.321; -13.914	0.000
Marital status				
Single/without partner	Ref			Ref
Married/with partner	0.590	0.334	-0.6083; 1.789	1.805
Religion				
Without religion	Ref			Ref
With religion	0.667	0.518	-1.357; 2.692	1.949
Reproductive planning				
No	Ref			Ref
Yes	-14.822	0.000	-15.540; -14.104	0.000
"Both me and my partner (or someone else such as a parent or mother in-law/father in-law) equally" (vs "Me")				
Age	-0.020	0.198	-0.051; 0.010	0.979
Education				
< Kindergarten	Ref			Ref
Kindergarten	0.243	0.454	-0.394; 0.881	1.276
Elementary school	0.329	0.259	-0.243; 0.901	1.390
>=High school	0.106	0.759	-0.574; 0.787	1.112
Color/race				
Non-white	Ref			Ref
White	0.302	0.356	-0.339; 0.943	1.352
Marital status				
Single/without partner	Ref			Ref
Married/with partner	0.480	0.042	0.016; 0.943	1.616
Religion				
Without religion	Ref			Ref
With religion	0.488	0.198	-0.254; 1.231	1.629
Reproductive planning				
No	Ref			Ref
Yes	-0.154	0.493	-0.794; 0.485	0.856

**"Who has the most say about when you have a baby in your life?; **From the Programa Chapéu de Palha Mulher; ***RRR - Relative Risk Ratio, answers to question 3.*

Table 4 - Multinomial logistic regression analysis between the outcome variable* and rural workers' sociodemographic and reproductive characteristics**, Petrolina, Lagoa Grande and Santa Maria da Boa Vista, Pernambuco, Brazil, 2018 (N=346)

Variables	Coefficient	*p*	95% CI	RRR***
"My partner or someone else such as a parent or mother in-law/father in-law has more to say" (vs "Me")				
Age	-0.027	0.487	-0.102; 0.048	0.973
Education				
< Kindergarten	Ref			Ref
Kindergarten	0.494	0.542	-1.093; 2.081	1.639
Elementary school	0.959	0.158	-0.373; 2.292	2.610
>=High school	0.689	0.403	-0.928; 2.307	1.993
Color/race				
Non-white	Ref			Ref
White	-0.374	0.643	-1.959; 1.209	0.687
Marital status				
Single/without partner	Ref			Ref
Married/with partner	0.237	0.650	-0.786; 1.260	1.267
Religion				
Without religion	Ref			Ref
With religion	0.174	0.829	-1.4106; 1.759	1.191

To be continued

Table 4 (concluded)

Variables	Coefficient	*p*	95% CI	RRR***
Reproductive planning				
No	Ref			Ref
Yes	-13.982	0.000	-14.607; -13.356	0.000
"Both me and my partner (or someone else such as a parent or mother in-law/father in-law) equally" (vs "Me")				
Age	-0.023	0.149	-0.053; 0.008	0.977
Education				
< Kindergarten	Ref			Ref
Kindergarten	-0.277	0.404	-0.928; 0.374	0.758
Elementary school	-0.155	0.605	-0.745; 0.434	0.855
>=High school	0.282	0.430	-0.417;0 .981	1.325
Skin color				
Non-white	Ref			Ref
White	0.209	0.533	-0.448; 0.866	1.232
Marital status				
Single/without partner	Ref			Ref
Married/with partner	0.382	0.119	-0.098; 0.863	1.466
Religion				
Without religion	Ref			Ref
With religion	0.517	0.206	-0.285; 1.319	1.677
Family planning				
No	Ref			Ref
Yes	-0.657	0.060	-1.380; 0.028	0.508

**If you became pregnant but it was unplanned, who would have the most say - about whether you would raise the child, seek adoptive parents, or have an abortion; **From the Programa Chapéu de Palha Mulher; ***RRR - Relative Risk Ratio, answers to question 4.*

DISCUSSION

Considering that reproductive autonomy is a complex decision-making process, this study points out that, for the three questions evaluated referring to the "Decision-making" subscale, such as "My sexual partner or someone else such as a parent", "Both me and my partner" and "Me", women experienced greater reproductive autonomy when compared to their partners. This result does not corroborate what occurred in a study conducted with Ghanaian women in Africa, because the man is pointed out as having a key role in reproductive decisions[18].

Considering these results, we can perceive that the rural women in this study are able to exercise their empowerment focused on reproductive decisions, freeing themselves from the undue influence of their partner. This effect can be seen as an advance, as rural women are part of a system marked by patriarchy and seen more likely to experience less reproductive autonomy when compared to their partner[10].

Regarding the association between rural workers' sociodemographic and reproductive characteristics with reproductive autonomy, for the outcome "Who has the most say about which method you would use to prevent pregnancy?", it was identified that women with a higher level of education were more likely to have autonomy over which contraceptive method to use. This result was similar in studies conducted in Africa[19] and Ethiopia[20], suggesting that women's low level of education can provide little knowledge and information about reproductive decisions, which may contribute to their partner having the final decision and permanence of gender inequality and power relations[19]. Studies have pointed out that education is one of the most important social determinants when talking about reproductive autonomy[21].

Additionally for this same outcome, white color/race behaved as a protective factor, meaning that white women have greater autonomy to choose contraceptive methods when compared to black women. In the United States, in a study of 20,252 women, 29% of black women had an unwanted pregnancy[22]. In Pennsylvania, in a survey of 60 women, 36 of them black, 53% of them had undergone reproductive coercion[23]. The oppressions suffered by black women, whether by racial or gender discrimination, can promote greater dependence on their partners[24], favoring the partner to make reproductive decisions[4].

For the item "Who has the most say about when you have a baby in your life?", self-declared white women who participated in reproductive planning groups were more likely to have reproductive autonomy. When women do not seek reproductive planning groups, there is certainly a limitation of knowledge about reproductive decisions[25]. This fact can be highlighted in a study conducted with 184 mothers in São Paulo, revealing that 50% had an unwanted pregnancy associated with non-participation in family planning groups[26].

However, on this above, a data draws attention in this study with rural women married or with partners, because the reproductive decision falls to both woman and partner. In the case of these women, the result reflects that they have collaborative participation of their partner, which may reflect on a sign of gender equality. What is not commonly found in other studies, in Ethiopia, of the 734 married women, only 11.4% reported that they had autonomy over having children[27]. In Tanzania, lower reproductive autonomy was identified among married women[28]. These results may be associated with the social and cultural construction that determines to be the man - husband, dominator, the woman - wife, the dominated[25], reinforcing that men must demonstrate their power in the relationship[29].

The importance of women participating in reproductive planning groups for the time of reproductive decision was observed in the question "If you became pregnant but it was unplanned, who would have the most say - about whether you would raise

the child, seek adoptive parents, or have an abortion", proving to be relevant when compared to those who did not participate in these groups, reinforcing the importance of women's participation in educational actions promoted by health services[29]. In another study, the simple discussion about reproductive coercion in reproductive planning groups resulted in a 60% probability of minimizing the risk of partner interference on women's reproductive autonomy[10].

Study limitations

The limitations of this research stem from the characteristics of the epidemiological method chosen, since data collection on exposure and outcome occurs at a single moment in time, not allowing to infer causality between variables and outcomes. Another challenge was the comparability of the findings, because few studies are identified in the literature using the Reproductive Autonomy Scale[3,10,12,14,19,29]. This resulted in a limitation in the comparability of the results of this study with those found in the literature.

Contributions to nursing, health, and public policies

This study allows for a better understanding of the concept of reproductive autonomy and the sociodemographic and reproductive variables that can interfere in reproductive decision-making, allowing health professionals, particularly nurses, to guide their preventive and support practices, respecting women's individuality and subjectivity, towards a reproductive planning that places women as co-author of the process and center of attention.

CONCLUSIONS

Although the results of this study indicate that women had greater reproductive autonomy for three questions on the subscale, when compared to their partners, it is also observed that this characteristic was not homogeneous for the entire sample of women, varying according to sociodemographic characteristics.

Reproductive autonomy for the outcome "Me" about the methods used to avoid pregnancy, "Who has the most say whether to have a baby or what to do in a scenario of unplanned pregnancy", was associated with higher level of education, color/race white or participation in family planning groups. Thus, it is suggested that the guarantee of the right to reproductive decision on the body itself permeates the guarantee of educational policies and access to information.

Therefore, it is essential for health professionals to develop strategies that directly affect the determinants of reduced reproductive autonomy, through female empowerment and dialogic practices that respect these women's choices and their social, economic, political and cultural context.

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