ATATÜRK ÜNİVERSİTESİ YAYINLARI
ATATURK UNIVERSITY PUBLICATIONS

Research Article DOI: 10.62425/esbder.1624195

Reproductive Autonomy, Family Planning Attitudes and Affecting Factors in Married Women of Reproductive Age

Aslıhan TURAN[1]
[1]KTO Karatay University, Faculty of Health Sciences, Department of Midwifery, Konya, Türkiye

Merve YAZAR RENKYORGANCI[2,3]
[2]KTO Karatay University, Faculty of Health Sciences, Department of Nursing, Konya, Türkiye
[3]Necmettin Erbakan University, Health Sciences Institute of Obstetrics and Gynaecology Doctoral Student in Nursing, Konya, Türkiye

Berna BAYIR[3]
[3]KTO Karatay University, Faculty of Health Sciences, Department of Nursing, Konya, Türkiye

ABSTRACT

Objective: The aim of this study was to determine reproductive autonomy, family planning attitudes and influencing factors of married women of reproductive age.

Methods: A cross-sectional study was conducted with 344 women in Turkey between May and September 2024. Participants completed a sociodemographic form, the Reproductive Autonomy Scale, and the International Family Planning Attitude Scale. The data obtained were analysed using SPSS 25 software. Descriptive statistics and multiple linear regression analysis were used to evaluate the data. Statistical significance was assessed at the $p<.05$ level.

Results: Participants had a mean age of 33.53±7.81 years and 64.5% had university education or higher. The average reproductive autonomy level was 2.96±0.43 and the mean family planning attitude level was 138.28±23.69. Reproductive autonomy was positively correlated with educational level, family planning use and family planning attitude ($p<.05$). Educational level and employment status significantly predicted family planning attitude ($p<.05$).

Conclusion: This study contributes to the field by identifying the factors that influence the reproductive autonomy and family planning attitudes of married women in Turkey. This information can then be used to guide socio-economic planning of interventions targeting women's reproductive health. In this regard, it is recommended that educational programmes for women be expanded, employment opportunities be promoted, and community-based reproductive health services be increased.

Keywords: Family planning attitudes, reproductive age, reproductive autonomy, women.

This study was presented as an oral presentation at the 2nd International Health Services Congress, 2025, Mersin/Türkiye.

Received	21.01.2025
Accepted	02.07.2025
Publication Date	13.07.2025

Corresponding author:
Merve YAZAR RENKYORGANCI
E-mail: merveyazar011@gmail.com
Cite this article: Turan, A., Yazar Renkyorgancı, M., & Bayır, B. (2025). Reproductive Autonomy, Family Planning Attitudes and Affecting Factors in Married. *Journal of Midwifery and Health Sciences, 8*(2), 149-157.

Content of this journal is licensed under a Creative Commons Attribution-Noncommercial 4.0 International License.

Introduction

Reproductive autonomy is defined as a woman's power over childbearing, pregnancy and use of family planning (Upadhyay et al., 2014). A woman's degree of reproductive autonomy encompasses the capacity to make reproductive decisions independent of undue influence from her spouse, family, society, and government (Loll et al., 2021). Enhancing access to reproductive healthcare services, including contraception and safe abortion, is linked to improved reproductive health outcomes, such as lower incidences of cesarean delivery and preterm birth (Muoto et al., 2016). Restrictions on reproductive autonomy are linked to higher incidences of unintended pregnancy and unsafe abortion, along with a greater risk of adverse reproductive health outcomes (Gerdts et al., 2016; Roberts et al., 2016; Williams et al., 2018).

Reproductive autonomy can vary across different relationships and cultural contexts, depending on the extent to which one's spouse or community supports reproductive rights (Upadhyay et al., 2014). Dursun & Gözüyeşil (2024) reported that reproductive autonomy is at a moderate level in Türkiye, which is consistent with findings from Upadhyay et al. (2014), who also identified a moderate level of reproductive autonomy in the United States. In contrast, Litorp et al. (2022) found in their study conducted in Tanzania that the majority of women make family planning decisions jointly with their spouses, and that women's independent influence in this decision-making process is limited. Reproductive autonomy is generally low in low- and middle-income countries, where education, income, and spousal support have been identified as key determinants of the decision-making process (James-Hawkins et al., 2018). Several studies have shown that factors influencing reproductive autonomy include women's decision-making power, their ability to make choices related to sexuality and fertility, the quality of communication with their partners, prevailing gender norms, educational attainment, and economic independence (James-Hawkins et al., 2018; Litorp et al., 2022; Upadhyay et al., 2014). According to data from the Turkey Demographic and Health Survey (TDHS), although the vast majority (99%) of women of reproductive age in Türkiye are aware of family planning methods, the usage rate of modern methods remains at 54%. National studies emphasize that women generally hold positive attitudes toward family planning methods; however, lack of knowledge and the necessity of spousal approval remain significant determinants in method use (Korkmaz & Hacıalioğlu, 2019; Tekgündüz & Apay, 2021). Similarly, international research has indicated that although women often express moderate and positive attitudes toward family planning, these attitudes do not always correspond to actual usage rates (Blackstone et al., 2017; Kumari et al., 2024; Li et al., 2023). Other studies have highlighted that educational level, access to accurate information, spousal support, cultural norms, and religious beliefs are influential factors shaping attitudes toward family planning (Blackstone et al., 2017; Kumari et al., 2024; Li et al., 2023).

Reproductive autonomy, which is at the core of women's and girls' health and well-being, is recognized in internationally recognized human rights treaties such as the Universal Declaration of Human Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (Starrs et al., 2018). Reproductive autonomy is widely recognized as critical to the health of reproductive women (James-Hawkins et al., 2018; Litorp et al., 2022; Mandal & Albert, 2020). Improving access to reproductive health services, including contraception and safe abortion, is associated with better reproductive health outcomes, including lower rates of cesarean delivery and preterm birth (WHO, 2024). Many qualitative studies emphasize the impact of reproductive autonomy on family planning behaviors.

Factors such as women's powerlessness, peer pressure and lack of approval, as well as poor communication between women and their partners, can hinder the use and acceptance of contraceptive methods (Dansereau et al., 2017; Ketema & Erulkar, 2018; Olakunde et al., 2019). An important dimension of reproductive autonomy is the interference of another individual, like an intimate partner or mother-in-law, through reproductive coercion or actions aimed at controlling pregnancy outcomes. This interference has been shown to heighten the risk of unintended pregnancy (Grace & Anderson, 2018). Few studies have quantitatively assessed the role of reproductive autonomy on contraceptive behavior, although these findings support the role of reproductive autonomy in explaining underuse of family planning methods.

Reproductive autonomy has not been studied except for the validity and reliability study of the Reproductive Autonomy Scale in the Turkish population. Analyzing reproductive autonomy within these contexts enables a deeper understanding of its influence on reproductive behaviors, which may subsequently contribute to the development of effective strategies for preventing unintended pregnancies. In this context, our aim was to determine reproductive autonomy, family planning attitudes and influencing factors among married women of reproductive age.

Research Questions:

What are the levels of reproductive autonomy and family planning attitudes of married women?

What are the factors affecting reproductive autonomy and family planning attitudes of married women?

Methods

Type of Study

This descriptive and cross-sectional study was planned to determine reproductive autonomy, family planning attitudes and influencing factors of married women of reproductive age.

Setting

The study was conducted online between May – September 2024 with women living at urban center located in Central Anatolia region of Turkey.

Sample of the Study

G*Power software package (G*Power, Version 3.0.10, Franz Faul, Universität Kiel, Germany) was used to calculate the sample size. A minimum of 314 participants should be included in the study with an effect size of 0.17, which is a medium effect size for a 85% power and 0.05 Type I error. The study included a total of 344 married women to increase its statistical power. Women between the ages of 18-49 years, with an education level of primary school and above, and married/partnered were included in the study. Women with psychiatric diagnosis/pre-diagnosis (self-reported), menopausal women and women with communication problems were excluded.

Data Collection Tools

Data were collected using the “Personal Information Form”, “Reproductive Autonomy Scale” and “Family Planning Attitude Scale”.

Personal Information Form: The form, prepared by the researchers after reviewing the literature, includes 11 questions inquiring about socio-demographic characteristics (age, family type, income status, etc.), obstetric and family planning (number of children, family planning method used, whether she had an unplanned pregnancy, etc.) (Dalessandro et al., 2022; Pindar et al., 2020).

Reproductive Autonomy Scale: he Reproductive Autonomy Scale (RAS) was originally developed by Upadhyay et al. (2014), and its validity and reliability study was later conducted by Dursun and Gözüyeşil (2024). This scale is designed for use with women of reproductive age and consists of 14 items divided into three sub-dimensions. The first subscale, called Decision Making, assesses who has the final say in various reproductive matters, offering three response options: 'My sexual partner' (1 point), 'Both my partner and I equally' (2 points), and 'I' (3 points). The second subscale focuses on situations where women face difficulties, while the third subscale explores the extent of communication between women and their partners (or other figures like parents or in-laws) regarding sexual and reproductive decisions. Responses in the second and third subscales follow a Likert-type format: 'Strongly disagree' (1 point), 'Disagree' (2 points), 'Agree' (3 points), and 'Strongly agree' (4 points). Since the items in the Reproductive Coercion Avoidance subscale are conceptually opposed to reproductive autonomy, reverse scoring is applied to determine the absence of coercion. The total and subscale scores are calculated by dividing the total score by the number of items, with higher scores reflecting greater levels of reproductive autonomy (Dursun & Gözüyeşil, 2024). This study found that the Cronbach alpha coefficient of the scale was 0.86.

Family Planning Attitude Scale: The Family Planning Attitude Scale (FPAS) was developed by Örsal and Kubilay (2007) as a Likert-type scale comprising 34 items. Each statement in the scale is rated on a five-point scale: '1 = Strongly agree', '2 = Agree', '3 = Undecided', '4 = Disagree', and '5 = Strongly disagree'. The FPAS allows for a minimum score of 34 and a maximum score of 170. It includes three subscales: 'Attitude Towards Childbirth', 'Attitude Towards Family Planning Methods', and 'Society's Attitude Towards Family Planning'. The 'Society's Attitude Towards Family Planning' subscale consists of 15 items, with possible scores ranging from 15 to 75. The 'Attitude Towards Family Planning Methods' subscale includes 11 items, with a minimum score of 11 and a maximum of 55. The 'Attitude Towards Childbirth' subscale is made up of 8 items, with scores ranging from 8 to 40. In the scale's validity and reliability study, the Cronbach's alpha coefficient was determined to be 0.90 (Örsal & Kubilay, 2007). This study found that the Cronbach alpha coefficient of the scale was 0.96.

Data Collection

The research data were collected between 15.05.2024-01.09.2024 through a link that can be accessed online between 15.05.2024-01.09.2024 by random sampling method, one of the non-probability sampling methods. Informed consent was obtained from the participants before the data collection tools were applied. Those who checked “Yes” to the statement “I have been informed about the research. I agree to participate.” at the end of the Consent Form answered the web survey questions. The link was delivered to married women between the ages of 18-49 via

social platforms. It took approximately 15-20 minutes to complete the data collection tools.

Statistical Analysis

Data were analyzed using SPPS 25 (IBM SPSS Corp. Released 2017.IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp.) program was used for data analysis. The distributions of the data groups were examined and the means, standard deviations, quartile widths, normal distribution and histograms of the groups were evaluated. Multiple linear regression analysis was applied to determine the relationships between variables. Statistical significance was evaluated at $p<.05$ level.

Ethical Approval

The ethic approval was obtained from KTO Karatay University Drug and Non-Medical Device Research Ethics Committee (Decision Date: 09.05.2024, Decision No: 2024/015) before starting the study. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Results

The study included 344 women with a mean age of 33.53±7.81 years. Of the participants, 191 (55.5%) were 33 years of age or younger and 222 (64.5%) had a university education or higher. While 194 (56.4%) of the participants were not working, 203 (59.0%) of them had an income equal to their expenses. 287 (83.9%) participants lived in the province and 310 (90.1%) had a nuclear family. Sociodemographic characteristics are given in Table 1.

Participants' Reproductive Autonomy Scale-decision making, pressure, communication subscale scores and total mean scores were 2.11±0.29, 3.61±0.51, 2.99±0.87, 2.96±0.43, respectively. The mean family planning attitude scale-society, method, pregnancy-related attitude subscale scores and total scores of the participants were 62.14±10.05, 43.84±9.61, 32.30±6.70, 138.28±23.69, respectively (Table 2).

Multiple linear regression was used to test the prediction of reproductive autonomy and family planning attitudes in relation to age, educational level, employment status, income, place of residence, family type, pregnancy experience, abortion experience, number of children and presence of unintended pregnancy. A significant regression equation was found for reproductive autonomy with an R^2adj value of 0.170 ($F=6.853$, $p<.001$).

Table 1.
Sociodemographic and Obstetric Characteristics of Participants

Age	**n (%)**
33 years and below	191 (55.5)
34 years and older	153 (44.5)
Education level	
Primary education	42 (12.2)
High School	80 (23.3)
University and above	222 (64.5)
Employment status	
Yes	150 (43.6)
No	194 (56.4)
Income status	
Income more than expenses	81 (23.5)
Income equals expenses	203 (59)
Income less than expenditure	60 (17.4)
Place of residence	
City	287 (83.4)
District	41 (11.9)
Village	16 (4.7)
Family type	
Nuclear family	310 (90.1)
Extended family	34 (9.9)
Pregnancy experience	
Yes	276 (80.2)
No	68 (19.8)
Number of children	
None	3 (9)
1	168 (48.8)
2 and above	173 (50.3)
Abortion experience	
Yes	58 (16.9)
No	286 (83.1)
Presence of unwanted pregnancy	
Yes	20 (5.8)
No	324 (94.2)
Family planning use status	
Yes	246 (71.5)
No	98 (28.5)

n: number, %: percent, p<.05

Table 2.
Comparison of Participants' Mean Sub-Scores

Reproductive Autonomy Scale			
	X±SD	Min-Max	Scale Range (Min–Max)
Decision-making	2.11 ± 0.29	1-3	1-3
Avoidance of coercion	3.61 ± 0.51	1-4	1-4
Communication	2.99 ± 0.87	1-4	1-4
Total	2.96 ± 0.43	1.29-3.64	1-3.71
Family Planning Attitude Scale			
Community attitude	62.14±10.05	25-75	15-75
Method attitude	43.84±9.61	11-55	11-55
Pregnancy attitude	32.30±6.70	8-40	8-40
Total	138.28±23.69	52-170	34-170

X: mean, SD:Standard deviation, p<.05

Education level (β=0.202, *p*=.001, =.031), family planning use (β=-0.155, *p*=.005, =.023) and family planning attitude (β=0.353, *p*<.001, =.122) were found to be significant predictors. A significant regression equation with R^2adj value of 0.190 was found for family planning attitude (F=7.713, p<.001). Education level (β=0.128, *p*<.028, =.014), employment status (β=-0.127, *p*=.029, =.014) and reproductive autonomy (β=0.344, *p*<.001, =.122) were found to be significant predictors (Table 3).

Discussion

This study was conducted to determine married women's reproductive autonomy, family planning attitudes and the factors affecting them. The average scores for the Reproductive Autonomy Scale sub-dimensions (decision-making, pressure, communication) and the total score were found to be 2.11 ± 0.29, 3.61 ± 0.51, 2.99 ± 0.87 and 2.96 ± 0.43, respectively. The total score of the Reproductive Autonomy Scale can range from 1 to 3.71, the decision-making sub-dimension from 1 to 3, the avoidance of coercion sub-dimension from 1 to 4, and the communication sub-dimension from 1 to 4. Participants were found to have high reproductive autonomy based on the scale scores; however, they exhibited less autonomy in 'decision-making' processes and more in 'communication' and 'avoidance of coercion' situations. Dias et al. (2021) reported that women have high reproductive autonomy (2.94 ± 0.32). The highest levels of autonomy were found in the 'absence of coercion' (3.43 ± 0.58) and 'decision-making' (2.54 ± 0.41) sub-dimensions, while the lowest level of autonomy was found in the 'communication' (2.77 ± 0.47) sub-dimension. Fernandes et al. (2020) reported that women in Quilombola communities had a good level of reproductive autonomy in decision-making, with scores of 2.06 ± 0.30 and 2.40 ± 0.35 respectively. However, scores for avoidance of coercion (1.90 ± 0.47) and communication (1.95 ± 0.49) were lower in these communities than in our results, as was the total reproductive autonomy score. Considering that reproductive autonomy may be affected by factors such as personal and obstetric characteristics, family and community structure, and husband/partner characteristics, it is possible that decision-making, communication, avoidance of coercion, and total reproductive autonomy may differ among the women participating in the study.

The results of this study showed that education level, family planning use and family planning attitude significantly predicted reproductive autonomy. Saleem and Pasha (2008) and Fernandes et al. (2020) reported that family planning use was associated with reproductive autonomy. The results of this study were similar to litearture. Individuals' reproductive decisions can be directly affected by increasing their level of knowledge about family planning methods. In addition, women's independent decision-making in line with their own bodies and preferences may be directly related to reproductive autonomy. Similar to this study, Princewill et al. (2017) and Saleem and Pasha (2008) reported that education level is associated with women's reproductive autonomy. Education may lead to an increase in decision-making ability, awareness and knowledge.

The study revealed that factors such as age, income, employment status, place of residence, family type, pregnancy history, abortion history, number of children, and previous unwanted pregnancies were not significant predictors of reproductive autonomy (total score). Dias et al. (2021) reported that age was not a significant predictor of reproductive autonomy in the sub-dimensions of avoiding coercion, communication and decision-making. Wollum et al. (2023) reported in their study, which was conducted in Malawi, that the number of children and their employment status were significant predictors of the sub-dimensions of avoiding coercion and communication; however, age was not found to have a significant effect on these sub-dimensions (Wollum et al., 2023). Conversely, Mangimela-Mulundano et al. (2022) found that reproductive autonomy in women was significantly associated with educational level, income status and age. In a study conducted in Ghana, Loll et al. (2021) indicated that age was a predictive variable in the communication and decision-making sub-dimensions. However, employment status and abortion experience were not significant predictors, and education status was only significant in the communication sub-dimension.

Table 3.
Multiple Regression Analysis of Participants' Sociodemographic and Obstetric Characteristics

Reproductive Autonomy						
Variables	**B (SE)**	**Lower 95% CI for B**	**Upper 95% CI for B**	**β**	***p***	**Effect size[1]**
Constant	2.598	1.906	3.291		**<.001**	0.088
Age	6.579	-0.006	0.006	0.001	.982	0.000
Education Level	0.124	0.050	0.199	0.202	**.001**	0.031
Employment status	0.082	-0.025	0.189	0.094	.130	0.007
Income status	-0.068	-0.141	0.005	-0.100	.069	0.010
Place of residence	0.027	-0.063	0.117	0.032	.558	0.001
Family type	-0.123	-0.279	0.032	-0.085	.119	0.007
Pregnancy experience	0.084	-0.053	0.220	0.077	.228	0.004
Abortion experience	-0.063	-0.193	0.068	-0.054	.346	0.003
Number of children	0.043	-0.061	0.147	0.051	.419	0.002
Presence of unwanted pregnancy	0.129	-0.075	0.333	0.070	.213	0.005
Family planning use	-0.149	-0.253	-0.044	-0.155	**.005**	0.023
Family planning scale total	0.006	0.005	0.008	0.353	**<.001**	0.122
Family Planning						
Constant	97.223	59.364	135.083		**<.001**	0.219
Age	-0.205	-0.503	0.092	-0.068	.176	0.006
Education Level	4.307	0.459	8.156	0.128	**.028**	0.014
Employment status	-6.062	-11.499	-0.625	-0.127	**.029**	0.014
Income status	1.707	-2.024	5.438	0.046	.369	0.002
Place of residence	1.395	-3.167	5.958	0.030	.548	0.001
Family type	7.084	-0.811	14.979	0.089	.078	0.009
Pregnancy experience	2.011	-4.908	8.929	0.034	.568	0.001
Abortion experience	1.856	-4.766	8.478	0.029	.582	0.001
Number of children	-3.189	-8.476	2.099	-0.070	.236	0.004
Presence of unwanted pregnancy	-8.319	-18.683	2.045	-0.082	.115	0.007
Family planning use	-2.847	-8.208	2.514	-0.054	.297	0.003
Reproductive autonomy scale total	18.818	13.348	24.288	0.344	**<.001**	0.122

B: Unstandardized coefficients; β: Standardized coefficient (SC); R^2: Coefficient of determination; SE: Standard Error; CI: Confidence Interval 1: Partial eta squared effect size (η_p^2) ; p<0.05 is considered as statistically significant.

When we compare the results of our study with those in the literature, and take into account the characteristics of the samples and cultural issues, it seems that the links between reproductive autonomy and sociodemographic variables might change depending on the circumstances.

This study determined that the mean score for women's attitudes towards family planning was 138.28 ± 23.69. The scale ranges from 34 to 170, so this value shows that women have a positive attitude. When similar studies in the literature are examined, variability is observed between different samples. For example, Tezel et al. (2015) reported an average score of 130.72 ± 26.10, whereas Korkmaz and Hacıalioğlu (2024) reported an average score of 129.37 ± 20.17. Both studies indicated positive attitudes towards family planning. In contrast, Nazik et al. (2021) reported a lower average score of 109.1 ± 18.7 in their study of married women. Gur and Sohbet (2017) found a positive attitude, with an average score of 134.99 ± 23.07, in their study conducted in the Gaziantep province. Alan Dikmen et al. (2018) found that the family planning attitude score was 94.67 ± 17.48 among Syrian women living in Turkey, indicating a moderate attitude. Gozukara et al. (2015) determined the attitude score of women living in eastern Turkey to be 124.20 ± 27.34, noting that, while it was positive, it was not at the desired level. Similarly, Bucak and Karaman (2020) reported a score of 96.7 ± 11.5 in their study of pregnant seasonal agricultural workers, indicating a low attitude towards family planning. These differences in the literature suggest that attitudes may vary depending on the environment, sociocultural level and socioeconomic conditions in which individuals live.

The results of this study showed that education level and employment status significantly predicted family planning attitudes. Nazik et al. (2021), Korkmaz and Hacıalioğlu (2024) reported that women with higher education level and working status had more positive attitudes towards family planning, and Gür and Sohbet (2017) and Bucak and Karaman (2020) stated that the higher the education level, the more positive the attitudes towards family planning were perceived. The increase in the level of education may make it more possible for working women to gain awareness by developing socially, thanks to business life.

Conclusion and Recommendations

The mean total score of the Reproductive Autonomy Scale in this study was 2.96 ± 0.43, which corresponds to positive reproductive autonomy when evaluated in the range of 1-3.71 points. The mean score on the Family Planning Attitude Scale was 138.28 ± 23.69, corresponding to a positive attitude in the 34-170 point range. Therefore, it can be concluded that women are generally decisive in their own reproductive decisions and have a positive attitude towards family planning practices. Therefore, to sustain and strengthen these positive attitudes, it is necessary to increase women's level of education, promote women-centred counselling in health services and encourage family planning education that supports spousal participation at a societal level. Additionally, health professionals are encouraged to adopt an approach that respects women's decision-making processes and organise reproductive health services accordingly.

Ethics Committee Approval: The ethic approval was obtained from KTO Karatay University Drug and Non-Medical Device Research Ethics Committee (Decision Date: 09.05.2024, Decision No: 2024/015) before starting the study.

Informed Consent: After the women participating in the study were informed about the research, verbal consent was obtained from the individuals who wanted to participate.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept – AT, MYR; Design – AT, MYR; Supervision - BB; Data Collection and/or Processing – AT, MYR; Analysis and/or Interpretation – AT, MYR; Literature Search – AT, MYR, BB; Writing Manuscript – AT, MYR; Critical Review – BB.

Conflict of Interest: The authors have no conflicts of interest to declare.

Financial Disclosure: The authors declared that this study has received no financial support.

References

Alan Dikmen, H., Cankaya, S., & Dereli Yilmaz, S. (2018). The attitudes of refugee women in Turkey towards family planning. *Public Health Nursing*, *36*(1), 45-52. https://doi.org/10.1111/phn.12553

Blackstone, S. R., Nwaozuru, U., & Iwelunmor, J. (2017). Factors influencing contraceptive use in sub-Saharan Africa: a systematic review. *International Quarterly of Community Health Education,* 37(2), 79-91. https://doi.org/10.1177/0272684X16685254

Bucak, F., & Kahraman, S. (2022). Determination of seasonal agricultural worker pregnant women's attitudes towards family planning. *Gevher Nesibe Journal of Medicine and Health Sciences,* 5(7):61–66. https://doi.org/10.46648/gnj.89

Dalessandro, C., Kaiser, J., & Sanders, J. N. (2022). Reproductive autonomy and feelings of control over pregnancy among emerging adult clients in a Utah (USA) contraceptive initiative study. *Sexual & Reproductive Healthcare,* 31, 100688. https://doi.org/10.1016/j.srhc.2021.100688

Dansereau, E., Schaefer, A., Hernández, B., Nelson, J., Palmisano, E., Ríos-Zertuche, D., ... & El Bcheraoui, C. (2017). Perceptions of and barriers to family planning services in the poorest regions of Chiapas, Mexico: a qualitative study of men, women, and adolescents. *Reproductive Health*, *14*, 1-10. https://doi.org/10.1186/s12978-017-0392-4

Dias, A. C. D. S., Ferreira, S. L., Gusmão, M. E. N., & Marques, G. C. M. (2021). Influence of the sociodemographic and reproductive characteristics on reproductive autonomy among women. *Texto & Contexto-Enfermagem*, *30*, e20200103. https://doi.org/10.1590/1980-265X-TCE-2020-0103

Dursun, R. S., & Gözüyeşil, E. (2024). Reproductive Autonomy Scale: Turkish Validity and Reliability Study. *Turkish Journal of Family Medicine and Primary Care*, *18*(3), 293-302. https://doi.org/10.21763/tjfmpc.1369040

Fernandes, E. T. B. S., Ferreira, S. L., Ferreira, C. S. B., & Santos, E. A. (2020). Autonomy in the reproductive health of quilombolas women and associated factors. *Revista Brasileira de Enfermagem*, *73*(suppl 4), e20190786. https://doi.org/10.1590/0034-7167-2019-0786

Gerdts, C., Fuentes, L., Grossman, D., White, K., Keefe-Oates, B., Baum, S. E., Hopkins, K., Stolp, C. W., & Potter, J. E. (2016). Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas. *American Journal of Public Health,* 106(5), 857–864. https://doi.org/10.2105/AJPH.2016.303134

Gözükara, F., Kabalcıoğlu, F., & Ersin, F. (2015). Determination of women's attitudes towards family planning in Şanlıurfa province. *Journal of Harran University Faculty of Medicine*, *12*(1), 9-15.

Grace, K.T., & Anderson, J.C. (2018). Reproductive coercion: a systematic review. *Trauma, Violence, & Abuse*, *19*(4), 371-390. https://doi.org/10.1177/1524838016663935

Gür, F., & Sohbet, R. (2017). Knowledge, Attitudes and Behaviors of Women Coming to Hand Skill Courses in Gaziantep Province Towards Family Planning. *Medical Sciences*, *12*(1), 10-21. http://dx.doi.org/10.12739/NWSA.2017.12.1.1B0043

Hacettepe University Institute of Population Studies. (2019). *Turkey Demographic and Health Survey 2018 (TDHS 2018)*. Hacettepe University, Ankara.

James-Hawkins, L., Peters, C., VanderEnde, K., Bardin, L., & Yount, K. M. (2018). Women's agency and its relationship to current contraceptive use in lower-and middle-income countries: A systematic review of the literature. *Global Public Health*, *13*(7), 843-858. https://doi.org/10.1080/17441692.2016.1239270

Ketema, H., & Erulkar, A. (2018). Married adolescents and family planning in rural ethiopia: understanding barriers and opportunities. *African Journal of Reproductive Health*, *22*(4), 26-34. https://doi.org/10.29063/ajrh2018/v22i4.3

Korkmaz, T., & Hacıalioğlu, N. (2019). Knowledge and attitudes of married women towards family planning. *Gümüşhane University Journal of Health Sciences*, *13*(1), 263-273. https://doi.org/10.37989/gumussagbil.1410540

Kumari, B., Do, M., Madkour, A. S., & Wisniewski, J. M. (2024). Women's empowerment and current contraceptive use in Pakistan: informed by theory of gender and power. *Frontiers in Global Women's Health,* 5, 1360052. https://doi.org/10.3389/fgwh.2024.1360052

Li, A. N., Starnes, J. R., Omondi, A., Were, V., Vill, B., Were, L. P., ... & Moon, T. D. (2023). Prevalence and determinants of contraception utilization over time in Migori County, Kenya: Repeated cross-sectional household surveys. *African Journal of Reproductive Health,* 27(6), 17-26.

Litorp, H., Kågesten, A., Båge, K., Uthman, O., Nordenstedt, H., Fagbemi, M., ... & Ekström, A. M. (2022). Gender norms and women's empowerment as barriers to facility birth: A population-based cross-sectional study in 26 Nigerian states using the World Values Survey. *PloS one*, *17*(8), e0272708. https://doi.org/10.1371/journal.pone.0272708

Loll, D., Fleming, P. J., Stephenson, R., King, E. J., Morhe, E., Manu, A., & Hall, K. S. (2021). Factors associated with reproductive autonomy in Ghana. *Culture, Health & Sexuality,* 23(3), 349-366. https://doi.org/10.1080/13691058.2019.1710567

Mandal, M., & Albert, L. M. (2020). Reproductive empowerment scale: psychometric validation in Nigeria. *Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina*.

Mangimela-Mulundano A, Black KI, Cheney K. A cross-sectional study of women's autonomy and modern contraception use in Zambia. *BMC Womens Health.* 2022 Dec 27;22(1):550. https://doi.org/10.1186/s12905-022-02101-5

Muoto, I., Luck, J., Yoon, J., Bernell, S., & Snowden, J. M. (2016). Oregon's Coordinated Care Organizations Increased Timely Prenatal Care Initiation And Decreased Disparities. *Health Affairs,* 35(9), 1625–1632. https://doi.org/10.1377/hlthaff.2016.0396

Nazik, F., Mumcu, Ş., Sönmez, M., Yılmaz, A. N., & Yüksekol, Ö. D. (2021). Determination of attitudes of married women aged 15-49 years towards family planning. *Ordu University Journal of Nursing Studies, 4*(3), 326-336. https://doi.org/10.38108/ouhcd.881578

Olakunde, B. O., Sam-Agudu, N. A., Patel, T. Y., Hunt, A. T., Buffington, A. M., Phebus, T. D., ... & Ezeanolue, E. E. (2019). Uptake of permanent contraception among women in sub-Saharan Africa: a literature review of barriers and facilitators. *Contraception*, *99*(4), 205-211. https://doi.org/10.1016/j.contraception.2018.12.007

Örsal, Ö., & Kubilay, G. (2007). Development of a family planning attitude scale. *Florence Nightingale Journal of Nursing*, 15(60), 155-164.

Pindar, C., Lee, S. H., Meropol, S. B., & Lazebnik, R. (2020). The role of reproductive autonomy in adolescent contraceptive choice and acceptance of long-acting reversible contraception. *Journal of Pediatric and Adolescent Gynecology,* 33(5), 494-499. https://doi.org/10.1016/j.jpag.2020.06.013

Princewill, C. W., De Clercq, E., Riecher-Rössler, A., Jegede, A. S., Wangmo, T., & Elger, B. S. (2017). Education and reproductive autonomy: the case of married Nigerian women. *Narrative inquiry in bioethics*, *7*(3), 231-244.

Roberts, S. C., Turok, D. K., Belusa, E., Combellick, S., & Upadhyay, U. D. (2016). Utah's 72-hour waiting period for abortion: experiences among a clinicbased sample of women. *Perspect Sex Reprod Health,* 48(4), 179–187. https://doi.org/10.1363/48e8216

Saleem, A., & Pasha, G. R. (2008). Women's reproductive autonomy and barriers to contraceptive use in Pakistan. *The European Journal of Contraception & Reproductive Health Care*, *13*(1), 83-89. https://doi.org/10.1080/01443610701577107

Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., ... & Ashford, L. S. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *The lancet*, *391*(10140), 2642-2692.

Tekgündüz, S. E., Gür, E. Y., & Apay, S. E. (2021). Evli kadınların aile planlaması tutum ve niyetleri arasındaki ilişkinin belirlenmesi. *Sakarya Tıp Dergisi*, *11*(4), 743-750. https://doi.org/10.31832/smj.854295

Tezel, A., Gönenç, İ., Akgün, Ş., Karataş, D. Ö., & Yıldız, T. A. (2015). Women's attitudes towards family planning and factors affecting them. *Anatolian Journal of Nursing and Health Sciences*, *18*(3). https://doi.org/10.17049/ahsbd.23634

Upadhyay, U. D., Dworkin, S. L., Weitz, T. A., & Foster, D. G. (2014). Development and validation of a reproductive autonomy scale. *Studies in family planning,* 45(1), 19-41. https://doi.org/10.1111/j.1728-4465.2014.00374.x

WHO, 2024. SDG Target 3.7 Sexual and reproductive health. https://www.who.int/data/gho/data/themes/topics/sdg-target-3_7-sex ual-and-reproductive-health.

Williams, S. G., Roberts, S., & Kerns, J. L. (2018). Effects of legislation regulating abortion in arizona. *Womens Health Issues*, 28(4), 297–300. https://doi.org/10.1016/j.whi.2018.02.002

Wollum, A., Bornstein, M., Mopiwa, G., Norris, A., & Gipson, J. D. (2023). Assessing the relationship between reproductive autonomy and contraceptive use in rural Malawi. *Reproductive Health,* 20(1), 142. https://doi.org/10.1186/s12978-023-01688-8